Child protection and welfare inspection report

Health Information and Quality Authority Regulation Directorate monitoring inspection report on child protection and welfare services under the National Standards for the Protection and Welfare of Children, and Section 8(1)(c) of the Health Act 2007

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<th><strong>Name of Service Area:</strong></th>
<th>Louth Meath</th>
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<tr>
<td><strong>Dates of inspection:</strong></td>
<td>19 January 2015 to 29 January 2015</td>
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<tr>
<td><strong>Number of fieldwork days:</strong></td>
<td>7</td>
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<td><strong>Lead inspector:</strong></td>
<td>Bronagh Gibson</td>
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| **Support inspector(s):** | Tom Flanagan  
                                Paul Tierney  
                                Sharron Austin |
| **Type of inspection:** | ☒ Announced  
                                ☐ Unannounced  
                                ☐ Themed |
| **Inspection ID:** | 709 |
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 and Youth Affairs 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 | ☒ |
1. Inspection methodology

As part of this inspection, inspectors met with children, parents and or guardians, other agencies and professionals. Inspectors observed practices and reviewed documentation such as child protection plans, policies and procedures, children’s files and staff files.

The aim of on-site inspection fieldwork is to gather further evidence of performance against the National Standards for the Protection and Welfare of Children.

During this part of the inspection, the inspectors evaluated the:

- timeliness and management of referrals
- effectiveness of assessment and risk management processes
- provision of immediate help where required
- effectiveness of inter-agency and multidisciplinary work
- outcomes for children.

The key activities of this inspection involved:

- the analysis of data
- the review of local policies and procedures, minutes of various meetings, 33 staff files, audits and service plans
- reviewing 177 children’s case files
- meeting with nine children and five parents
- meeting with area manager, seven social workers, six team leaders, two principal social workers, the chair of child protection conferences, three family support development workers, two administrators, one partnership, prevention and family support manager, one senior social work practitioner and one family support team leader
- questionnaires from eight external stakeholders and meetings or telephone interviews with 17 external professionals including, health services, youth workers, family support services and educators
- observing staff in their day-to-day work
• observing practice in one review child protection conference, one screening interview, one multi-agency meeting, three staff meetings, one professionals meeting.

Acknowledgements

The Authority wishes to thank the children, parents, staff and managers of the service for their cooperation with this inspection.
2. Profile of the child protection and welfare service

2.1 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, which is overseen by the Department of Children and Youth Affairs. 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
- service response to domestic, sexual and gender-based violence.

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 the Authority in each of the 17 areas.

2.2 The Louth Meath Area

Regionally, the service was under the direction of the service director for the Child and Family Agency Dublin North East Region. Louth Meath is one of 17 service areas in the Child and Family Agency. It is situated in the North East of the country and borders with Monaghan, Cavan, Dublin, West Meath and Northern Ireland (Armagh). Louth is the smallest county in the State. Louth Meath covers 3,171 square kilometres. Louth Meath is ranked as one of the most deprived areas in the country, three Electoral Districts with high deprivation scores (i.e. Dundalk Rural, St Mary’s, Drogheda and Kells, Co Meath). The State of the Nation’s Children Report, alongside the Central Statistics Office (CSO) Census 2011, indicates that Louth is underachieving across a range of indicators.

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1 Data source: Child and Family Agency
including educational attainment. Data on levels of unemployment and one-parent households show that the area is above the national average for these indicators\(^2\).

The overall population for the area based on the 2011 Census of Population was 307,032 which included 88,205 were children.

Louth Meath child protection and welfare services had three office bases within the service area. These offices were based in Dundalk, Drogheda and Navan. Additional office space was provided in a fourth office located in Dundalk but this was for administrative purposes only. In addition, there was a range of family resource services located across the counties. There were eight social work teams which were directly line managed by team leaders and reported to a principal social workers. There was a team leader in one office who managed adults of concern for Meath, a partnership, prevention and family support manager and a chair of child protection conferences who reported directly to the area manager.

There were 1497 cases open to the service prior to the inspection. The service could not provide dependable figures on how many open cases related to child protection or welfare cases. The area had received 3,509 referrals in the 12 months before the inspection but the area did not know how many of these required initial assessments. The area had 106 children on the Child Protection Notification System (CPNS) at the time of the inspection.

The organisational chart in Figure 1 describes the management and team structure of the child protection and welfare service, as provided by the Service Area.

\(^2\) Data source: Child and Family Agency
Figure 1: Organisational structure of the Child Protection and Welfare Service, Louth Meath Area

* Source: The Child and Family Agency
3. **Summary of inspection findings**

The Child and Family Agency has legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. These children require a proactive service which acts decisively to assess and meet their needs in order to promote their safety and welfare. As much as possible, children and families require a targeted service aimed at supporting families. However, there will always be some children who will need to be protected from the immediate risk of serious harm.

This report reflects the findings of the inspection, which are set out in Section 5. The provider is required to address a number of recommendations in an action plan which is published separately to this report.

In this inspection, the Authority found that of the 27 standards assessed, the service met one standard, required improvement in 18 standards while significant risks were identified in eight standards.

Inspectors found significant risks in the service during the first week of this inspection. As a result, the Authority issued an immediate action plan to the Area Manager. This required them to take urgent action in relation to:

- ineffective and unsafe information systems
- inconsistent allocation of social workers to children placed on the child protection and notification system
- inadequate and unsafe systems in place to review, monitor and manage waiting lists across the service.

The Authority was satisfied with the action plan returned by the Area Manager to address these risks as a matter of urgency.

Staff in the service valued the safety of children and although they endeavoured to keep children safe and meet their needs, this was not always possible. Aspects of the service were unsafe and although children’s cases were prioritised for a social work intervention, this did not always ensure children at greatest risk and with high levels of need received a timely service. The capacity of the service to meet the needs of all children was compromised by delays in allocating social workers to assess children’s needs and poor quality information systems. Waiting lists across the service were significant and were not always well managed. There were unsafe and ineffective systems in place to assess and manage actual or potential risk to children from adults of concern living in the community. This meant that risks to some children went unidentified and unmanaged.
The majority of children were included in decisions about their lives but their views were not always well recorded. Children and parents had mixed experiences of the service and said that communication and consultation could be improved. Not all were aware of their rights and the complaints process. They said that literature on their rights would be of benefit to them. There was a positive approach to complaints and social workers encouraged children and families to express their views of the service. However, the system of managing complaints required improvement as it did not ensure all complaints were dealt with appropriately.

Although inspectors acknowledge the impact of limited resources on the service, service managers did not always demonstrate the level of leadership required to deliver an effective service. The service had improved governance structures in place, but accountability was not always provided. The senior management team did not always operate as a cohesive unit with a collective vision and this was underpinned by an absence of agreed objectives and goals and a written plan for the delivery of the service at local level. Data and information collection and analysis within the service was not adequate and did not inform local service planning. The majority of staff said they felt supported by their managers. However, the service was not managed in a way that ensured it consistently met minimum standards and the systems in place were not always fully implemented.

Many children and families benefitted from the service they received from the Louth Meath social work department and these children had potentially improved life outcomes as a result. However, a significant proportion of children and families did not receive a timely or effective service. There were backlogs across the service that were not managed well and this was in a context of reduced staffing, budgetary constraints and an inconsistent approach to managing current resources based on sound evidence. Overall, the service was experiencing increasing demands from ever-present waiting lists and high rates of referrals and re-referrals. This limited the effectiveness of the service.
4. Summary of judgments under each standard

During the inspection, inspectors made judgments against the National Standards. They used four categories that describe how the Standards were met as follows:

- **Exceeds standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

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<tr>
<th>National Standards for the Protection and Welfare of Children</th>
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<tr>
<td><strong>Theme 1: Child-centred Services</strong></td>
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<tr>
<td><strong>Standard 1:1</strong> Children’s rights and diversity are respected and promoted.</td>
<td>Requires improvement</td>
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<td><strong>Standard 1:2</strong> Children are listened to and their concerns and complaints are responded to openly and effectively.</td>
<td>Requires improvement</td>
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<tr>
<td><strong>Standard 1:3</strong> Children are communicated with effectively and are provided with information in an accessible format.</td>
<td>Requires improvement</td>
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<tr>
<td><strong>Theme 2: Safe and Effective Services</strong></td>
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<tr>
<td><strong>Standard 2:1</strong> Children are protected and their welfare is promoted through the consistent implementation of Children First (2011).</td>
<td>Requires improvement</td>
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<td><strong>Standard 2:2</strong> All concerns in relation to children are screened and directed to the appropriate service.</td>
<td>Requires improvement</td>
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<td><strong>Standard 2:3</strong> Timely and effective actions are taken to protect children.</td>
<td>Significant risk identified</td>
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<tr>
<td><strong>Standard 2:4</strong> Children and families have timely access to child protection and welfare services that support the family and protect the child.</td>
<td>Significant risk identified</td>
</tr>
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<td><strong>National Standards for the Protection and Welfare of Children</strong></td>
<td><strong>Judgment</strong></td>
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| **Standard 2:5**  
All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence. | Requires improvement |
| **Standard 2:6**  
Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare. | Significant risk identified |
| **Standard 2:7**  
Child protection plans and interventions are reviewed in line with requirements in Children First (2011). | Significant risks identified |
| **Standard 2:8**  
Child protection and welfare interventions achieve the best outcomes for the child. | Requires improvement |
| **Standard 2:9**  
Interagency and inter-professional cooperation supports and promotes the protection and welfare of children. | Meets the standard |
| **Standard 2:10**  
Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children. | Requires improvement |
| **Standard 2:11**  
Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice at all levels. | Requires improvement |
| **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. | Significant risk identified |

**Theme 3: Leadership, Governance and Management**

| **Standard 3:1**  
The service performs its functions in accordance with relevant legislation, regulations, national policies and | Requires improvement |
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<td>standards to protect children and promote their welfare.</td>
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| **Standard 3:2**  
Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability. | Significant risk identified |
| **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. | Significant risk identified |
| **Standard 3:4**  
Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy standards. | Requires improvement |

**Theme 4: Use of Resources**

| **Standard 4:1**  
Resources are effectively planned, deployed and managed to protect children and promote their welfare. | Requires improvement |

**Theme 5: Workforce**

| **Standard 5:1**  
Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare. | Requires improvement |
| **Standard 5:2**  
Staff have the required skills and experience to manage and deliver effective services to children. | Requires improvement |
| **Standard 5:3**  
All staff are supported and receive supervision in their work to protect children and promote their welfare. | Requires improvement |
<p>| <strong>Standard 5:4</strong> | Requires improvement |</p>
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<tr>
<th><strong>National Standards for the Protection and Welfare of Children</strong></th>
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<tr>
<td>Child protection and welfare training is provided to staff working in the service to improve outcomes for children.</td>
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<td><strong>Theme 6: Use of Information</strong></td>
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| **Standard 6:1**  
All relevant information is used to plan and deliver effective child protection and welfare services. | Requires improvement |
| **Standard 6:2**  
The service has a robust and secure information system to record and manage child protection and welfare concerns. | Significant risk identified |
| **Standard 6:3**  
Secure record-keeping and file management systems are in place to manage child protection and welfare concerns. | Requires improvement |
5. Findings and judgments

Theme 1: Child-centred Services

Services for children are centred on the individual child, their care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use the services.

Summary of inspection findings under Theme 1

The service was not entirely child-centred in its approach to promoting and maintaining the rights of children and their families. The service valued the participation of children in making decisions about their lives, but practice varied and was inconsistent. Children with diverse needs were strongly advocated for and there was good inter-agency working to meet these needs. Supports were in place to facilitate children and families to communicate effectively with the social work department, but some improvements were required. Children and families were not always informed about their rights, particularly the right to complain and the process this involved. There were systems in place to deal with complaints but they did not ensure all complaints made were acknowledged and addressed. Practitioners raised individual children’s awareness of abuse and neglect, but the service did not have a strategy to raise public awareness of child protection and welfare issues.

Children’s rights

This inspection found that although the service acknowledged the universal rights of children as established under the United Nations Convention on the Rights of the Child, it did not consistently or fully promote these rights. Improvements were required to ensure children and their families were well informed about their rights so that they could exercise them. There was a need to ensure case decisions were child centred.

The rights of children and their families were promoted on a day-to-day basis by staff. Social workers and family support workers interviewed demonstrated a good knowledge of children’s rights and on the rights of the family in general. They were aware of their role in upholding these rights, particularly the right to safety, to a childhood and to remain in the family home unless it was not safe to do so. Children who took part in a focus group with inspectors were not fully aware of the role of the social work department in their lives.

Social workers made decisions about children at risk on a daily basis, and the majority of cases reviewed by inspectors showed that there was a rights based approach to
practice. Many children were facilitated to exercise their rights by staff and this was demonstrated in social work reports and case notes. However, parents who met with inspectors held mixed views on how their rights were upheld and some queried decisions made about their children’s care and safety as a result. Case records showed that in some cases, the social work department had taken sequential steps to ensure the safety of children such as obtaining a supervision order, holding a family welfare conference and a child protection conference, and placing children on the child protection notification system. However, there was and continued to be no social work interventions and no allocated social worker. This meant that although decisions about keeping children safe from harm through intervening in family life were made, they were undermined by inaction and did not fully promote children’s right to safety.

The provision of information on the rights of the child and their family by the social work department was inadequate. Inspectors found that community based services provided on behalf of the social work department had child friendly information leaflets on their service and children’s rights. Some of these were translated into different languages. Some social workers said that they told children about their rights, and explained the legal powers and limitations of the social work department to them. Inspectors observed this happening on a day-to-day basis, but case records showed that this practice was not always recorded. As such, consistency in practice could not be determined unless it was observed directly by managers.

Inspectors observed posters on the rights of children placed in some social work offices but not all. The service did not have information leaflets for children and families on their rights. This lack of written information meant that children and families may not be well enough informed of their rights to fully exercise them or to recognise if they were being impinged upon.

Case records showed that social workers elicited and presented the voice of children in their reports. However, there were also records where children’s views were not evident. Inconsistent practice was identified by a principal social worker and supervision records showed that there was a drive to improve practice in this area.

Children who took part in a focus group with inspectors were aware of some of their rights but they said this information was provided to them by professionals working in community based projects and not their social worker. They told inspectors that they were included in decisions about their lives whilst attending school and community projects. Parents who met with inspectors said that they were not informed of their rights and said they were at a disadvantage because of it. For example, parents were unaware that they could bring a friend or family member to support them at meetings with the social work department. Some mothers told inspectors that when there was a concern about their child, the child’s father was not always contacted by the social work department. They said that this did not ensure parents had an equal say in decisions about their child’s life.
Inspectors found that staff were respectful towards children and families. Records were written about children and their families in a respectful way and reflected their strengths and achievements. Inspectors observed staff interacting with parents and children in various meetings during which their views were sought and they were treated with respect and sensitivity. However, children and parents told inspectors that this was not always their experience. Some said that they were consistently treated with respect and courtesy, and they felt valued by the service. Others said that there were times when they felt disrespected and not listened to.

Staff advocated on behalf of children through various means. For example, case files showed that social workers advocated tirelessly for specialist services, alternative care placements for teenagers who displayed behaviour that challenged, increased family contact and reunification of families. There were cases where the social work department had advocated for a guardian ad litem to be appointed by the courts. Case records also showed that family support workers and child care leaders advocated for reduced social work interventions in families when there were significant reductions in risk to children.

**Diversity**

The diverse needs of children were acknowledged by the service and every effort was made to meet these needs. However, improvements were required in training for staff to work effectively with children and families from diverse backgrounds. The service required better knowledge about this group of service users. Written information about the service was not made available in a format that was accessible to these children.

The social work department provided services to children from different cultural backgrounds and a range of complex and diverse needs. However, data and information was not routinely gathered on these children and families. This was acknowledged by the area manager and principal social worker. One social work team leader told inspectors that although these children’s needs were currently being met, the service could not adequately determine and plan the level and type of resources it required.

Staff interviewed by inspectors were knowledgeable about the diverse needs of the children they worked with on an individual basis. Social work assessments reviewed by inspectors showed that these needs were identified and every available resource, including those provided external to the social work department were utilised. Cultural needs were clearly articulated in case records and they were found to include children’s religion and how their spiritual needs could be met. There was evidence of cases where children had significant needs due to varying levels of ability and complex medical conditions their needs were met. Inter-disciplinary and inter-agency working was effective for these children. All staff interviewed said that interpreter services were unlimited and inspectors found that Russian, Latvian and Chinese interpreters were
brought in to assist with cases. There were examples of cases where interpreters were engaged for the duration of parenting assessments.

Training provided to staff in relation to cultural diversity was limited. Training records showed that this training was provided in 2014, but staff interviewed said it was basic and in-depth training was required. Staff meeting minutes showed that one office had training on cultural issues by a social worker from a different service area. Staff said that although this was helpful, it was not sufficient.

**Communication**

The quality of communication between the social work department and children and families varied and this was reflected in the views of children and their parents. There was a need to improve formal systems of consulting with children on their experience of the service.

Case files reviewed by inspectors showed that communication between the social work department and children and families was inconsistent and not always well recorded. There were examples of good practice in cases where children were regularly visited and contacted by their social worker. There were also examples of social workers explaining outcomes of complex meetings and court decisions to children and their parents. Inspectors observed social workers communicating well with parents and children over the course of the inspection. At one child protection conference, the chair of the meeting met with parents to explain the process. Inspectors also observed social workers managing delicate issues with parents in a professional and sensitive way. Parents involved said they appreciated the direct and transparent manner in which the meetings were conducted. However, there were other cases that showed practice was much poorer across the service. Some case records held correspondence from parents requesting overdue reports and meeting minutes. Case notes did not always record social work visits and in some instances, contact was limited to phone calls. This meant that face to face contact with children was either not recorded or limited. Social workers acknowledged this inconsistency in practice.

Children and parents had mixed experiences of communication with the social work department. Some described positive experiences and said they felt listened to and were well informed about their case. Others expressed their dissatisfaction and said that they did not always feel informed or listened to, and were not always updated on case developments. They told inspectors that communication was difficult when several social workers were assigned to their case over time. A minority of parents interviewed said they were unaware if their case was open or closed to the social work department.

There was a lack of formal systems of consultation with children on their experience of the service. There was a sub group of the Meath children’s services committee established to facilitate children to have a voice in service improvements. Inspectors attended one planning meeting and found that this was a multi-agency forum that
intended to consult with children on a wide range of services including for example, education and social work. This was a work in progress. However, there was no evidence of other initiatives to capture the views of children accessing the service and as such, service improvements could not be informed by an accurate reflection of children’s views or experiences in this regard.

Complaints

There were systems in place to record and manage complaints but they were not always effective. There was no information available for children and families on the social work department’s complaints policy or procedure.

The system of managing complaints was not adequate. There was a system in place to receive and manage complaints that was based on national policy, ‘Your Service Your Say’. Data provided to the Authority showed that there were 15 recorded complaints in the year prior to inspection. Records of these complaints were held by the area manager and showed that 14 were closed and had been dealt with appropriately. One was in the process of being closed following investigation by the Ombudsman. Management and staff meeting minutes showed that complaints were reviewed and discussed across the service for the purpose of learning.

Records of complaints on case files showed that they were not always dealt with. The majority of recorded complaints reviewed by inspectors demonstrated a focus on resolution and there was evidence of good practice. However, inspectors found evidence of a serious complaint that was not managed in accordance with service policy or procedure. This complaint was brought to the area manager’s attention at the time of the inspection and inspectors were assured that it would be dealt with immediately.

The system to record complaints was not adequate. Inspectors found that although complaints were recorded on case files, they were not always reflected on office complaints logs. One office did not maintain a log of complaints and a social work team leader told inspectors that this was a new system that was not yet fully implemented. This meant that the area manager was not aware of all complaints made to the service. The flaws in systems of recording and responding to complaints meant that this was not a system that a service user could have full confidence in.

Children, parents and external professionals showed varying levels of knowledge about the complaints process. Some children and parents said they were aware of how to make a complaint and others were not. Inspectors visited all social work offices and a number of premises from which community based services were provided. These were places where children and families attended programmes and meetings. Some displayed information on complaints and others did not. Information provided to the Authority showed that a national information leaflet on complaints was being developed but in the interim, nothing was available locally.
Raising awareness in the community

The service did not adequately raise public awareness of child protection and welfare issues.

There were children’s services committees for Louth and Meath areas. Inspectors were provided with a copy of their three year plans which included developing and releasing information to the public on key services for children and families. This was ongoing.

The area manager held briefing sessions with community based services on their revised service delivery model which provided an overview of how child protection and welfare concerns would be dealt with by the social work department in conjunction with community based services. Children First briefings were also provided by the social work department in the two years prior to inspection. However, the area manager and principal social worker conceded that the service had no strategy or campaigns to raise public awareness on child protection and welfare issues. There were no information leaflets for the general public on child protection and welfare services and the area manager said that these were being developed nationally.
**Theme 2: Safe and Effective Services**

Services promote the safety of children through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect children. Safe services protect children from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the proper support mechanisms are in place to protect children and promote their welfare. Assessment and planning is central to the identification of children’s needs, the risks to which they are exposed and the supports which need to be put in place for each individual child to keep them safe and maintain their wellbeing.

**Summary of inspection findings under Theme 2**

Aspects of this service were delivered effectively and the majority of children at immediate risk at the point of referral were identified and responded to. However, there were wait lists across the service that were not well managed and although children at high risk were prioritised, this did not always ensure a timely or consistent social work intervention. The rate of re-referral to the service following case closure was moderate and in some cases, the cumulative effect of long term neglect was not identified or responded to effectively. Although the service made efforts to meet welfare needs of all children, strains on the service meant that cases of higher need were prioritised over welfare cases with lower levels of need. There were systems in place to manage risk in relation to adults of concern but they were not safe or effective and there was no standard assessment framework to assist social workers in this regard.

**Protecting children**

This inspection found that systems, policies and procedures for dealing with concerns were in line with Children First (2011) but they were not always implemented effectively. Children at immediate risk of harm at the point of referral were responded to in a timely manner but some children at serious risk of ongoing harm did not receive a timely or consistent social work intervention.

Inspectors found that there were systems in place to manage child protection and welfare concerns but they were not always applied effectively. There were standard business processes in place to support social workers to receive concerns and provide ongoing interventions and assessment as each case required. Staff demonstrated a good knowledge of these systems and processes and inspectors observed managers guiding staff on their implementation. Records showed that all staff were trained in Children First (2011).
Cases reviewed by inspectors showed that reports of child protection and welfare concerns were prioritised for a social work service in line with national guidance on thresholds of need, but the system in place was not always effective. Inspectors observed social workers applying national thresholds and prioritising cases where children were at immediate risk. Data provided by the service showed that emergency actions were taken by the service. Thirty four children were taken to a place of safety by Gardai in the year prior to inspection and although the service could not show how many of these children were taken into care, emergency care orders were sought and obtained for 15 children. Figures showed that two emergency child protection conferences were convened in the previous year and the chair of these conferences said that although this was an unusual intervention, it was available when required.

There were delays in children receiving a social work intervention. Inspectors found examples of cases where children at risk were not responded to. One example showed that an urgent referral was made about a child who was known to the service and was in receipt of a community based intervention. There was no social work response and this resulted in Gardai removing the child from their home to a place of safety. In another case, Gardai reported concerns about a young child who was home alone. No social work visit was made to this child at time of the inspection, 11 days after the referral.

There was a local protocol and system in place for managing wait lists but it was not fully implemented and did not have the desired impact. Staff interviewed were aware of policy and procedure on managing wait lists. This included routine review of cases, consideration of new information and re-prioritisation for a social work intervention. Standard templates were designed to record these reviews and priority levels. Cases examined by inspectors showed that many were managed well but the system was not used consistently. Case files and case lists held by team leaders showed that some wait lists were not routinely reviewed and managers had not prioritised cases. One team leader told inspectors that they had not reviewed their waitlists and could not assure inspectors that immediate risk in all cases was identified. The inconsistent approach to managing wait lists undermined the prioritisation system in place and left cases on wait lists for protracted periods of time. Information provided to inspectors showed that some cases remained on these lists for up to two years.

There was a caseload management system in place that aimed to ensure caseloads were equitable and workable so that children would receive a safe, effective and quality service. This was in the early stages of implementation, but caseload management reports provided to inspectors showed that they were not evenly distributed. Social workers and team leaders acknowledged this and also reported that despite the newly introduced system, some cases did not get the attention they required. They told inspectors that there was limited or no capacity to take on new cases, even those at
greatest risk. However, this was disputed by the area manager who was successful in ensuring 17 such cases were allocated during and immediately after the inspection.

Inspectors found that many neglect cases were well managed by the social work department and children’s lives had improved from social work and family support interventions. However, patterns of cases re-referred for a service were not clearly identified and this meant that cumulative harm due to ongoing neglect was not always well managed. Inspectors found that although figures related to the number of children re-referred to the service were not dependable, they indicated a 30% rate of re-referral. Inspectors sampled re-referrals and found that a significant number were cases of neglect. Although staff interviewed were knowledgeable about the cumulative effects of neglect, they described a system that was dependent on unreliable information systems, individual staff knowledge of cases and multiple referrals over an undetermined period of time. Case files showed that multiple referrals related to neglect were often dealt with on an incident by incident basis and the long term impact was not always considered in social work assessments. Case chronologies were not always in place and as such, monitoring of these cases was difficult.

**Referrals and assessments**

Screening of referrals to the service were delayed and managerial oversight of incoming concerns required improvement.

The social work department was configured in a way that ensured a social worker was available to take calls and screen all incoming concerns during office hours. Inspectors observed social workers dealing with incoming calls and providing practical information to members of the public and other professionals. Inspectors observed social workers carrying out screening interviews and found that appropriate information was shared and collected.

Some preliminary enquiries were delayed and lacked sufficient managerial oversight. Inspectors reviewed cases where preliminary enquiries took up to two weeks to complete and observed managerial sign off on one 11 days after the referral was received. Staff told inspectors that intake records were signed at weekly team meetings and that some preliminary enquiries could go without managerial oversight for up to one week after completion. This was evident from cases discussed at duty and intake team meetings observed by inspectors.

The quality of preliminary enquiries varied and this impacted on social work decision-making. Figures provided to the Authority showed that 3,509 referrals were made to the service in the year prior to inspection and that all of these were screened within the required timeframes. Inspectors reviewed a sample of intake records and found that in the majority of cases, preliminary enquiries were based on quality information from several sources, carried out within a reasonable timeframe and recorded priority levels and the classification of abuse concerned. However, some lacked enough detail to
inform good decision making, were not signed, and did not record actions required or priority levels. Some social workers said that initial assessments were recommended in cases where there was limited information, as it was too risky to close a case based on such limited information. A review of waiting lists carried out by a principal social worker and team leader identified such cases. Case reviews undertaken by a principal social worker showed that where no child protection concerns were identified, case closure was recommended, once several minor tasks were undertaken. This meant that the screening process did not always have the desired effect of closing cases appropriately and in a timely way.

The service did not know how many initial assessments were recommended following a preliminary enquiry, but figures provided to the Authority showed that in the year prior to inspection 458 initial assessments were carried out, 166 of which were completed within 20 days. This indicated that 292 initial assessments were delayed. The number of initial assessments ongoing was 217 and 296 were placed on a wait list. Memorandums circulated to staff by a principal social worker and provided to inspectors stated that Louth Meath service area had the lowest levels of completed initial assessments in the country.

Inspectors reviewed 25 samples of completed initial assessments and found that they varied in quality. The majority were good quality assessments based on detailed information from key sources and the views of children were clearly expressed. They identified children’s health, educational, social needs and previous history with the service was included. Social workers told inspectors that they were guided by an agreed assessment framework for vulnerable children and families. However, the quality of some initial assessments required improvement. Inspectors found examples of initial assessments that did not include the views of children and some children were not interviewed as part of the process. This was identified by a principal social worker and improvements were being monitored through supervision and file audits. There were some improvements as a result. Five assessments were not signed and this did not ensure accountability for practice. Eight were not dated and did not record the priority level assigned to the case. This meant that it was difficult to tell how long the assessment took and whether immediate allocation was required. There were initial assessments that took far longer than the timeframe of 20 days. Inspectors found five that had taken between five and eight months to complete.

The area manager and a principal social worker informed inspectors that although 473 notifications were made to Gardaí about suspected or confirmed abuse, it was not clear whether these notifications were made at preliminary enquiry or initial assessment stages. However, cases reviewed by inspectors showed that some notifications were not made until after an initial assessment was carried out, despite the fact that physical abuse was reported at the time of referral. Team leaders and social workers told inspectors that they did not routinely notify allegations of abuse until this had been
validated through the initial assessment process. Considering the delay in carrying out a significant number of initial assessments, this was not adequate.

The number of further assessments carried out by the service in the last 12 months was not known to managers but there were delays. This was confirmed by team leaders. Data provided prior to the inspection showed that 45 were required but were on a wait list.

Further assessments were comprehensive but took long periods of time to complete and the benefits to children from lengthy social work engagement were not clear. Inspectors reviewed a sample of completed further assessments and found that they were comprehensive. Recommendations made were followed through and children and families benefited from this. Several team leaders and social workers interviewed said that further assessments could take between six months and two years. They described the process as safe and in-depth. However, inspectors found that some cases did not benefit from such lengthy social work involvement, and they could have been referred for non-social work interventions and support. There was no evidence that current thresholds for a social work service were applied to these cases.

There was a standard framework in place to support social workers assess the needs of vulnerable children and families and social workers interviewed demonstrated a good knowledge of this and how it was applied in everyday practice. There was a national guidance on thresholds of need for a social work service and social workers told inspectors that this assisted them to determine what cases were held by the social work department. A principal social worker had developed a local guidance to support social workers make this determination and to assign a priority level to a case. However, national thresholds for a social work service were designed to work within a broader service model where cases that required a non-social work intervention, such as family support, could be dealt with in community based settings. As this model was not fully implemented, this approach did not always ensure welfare needs were always met. In response, the area had introduced a pilot scheme in one office to manage child protection and children in need cases separately and in line with national thresholds. The pilot was still in the early stages but a recent review had shown some positive results. The area manager and a principal social worker were hopeful that this pilot could be rolled out across the service.

Cases were prioritised but this was poorly recorded. Inspectors reviewed numerous case records that did not record the priority level assigned to the case. There was a system of changing the priority level of a case once new information was received or a social work assessment was completed and records showed that these changes were not always recorded.
Planning for children at risk

Planning for children at risk was not always effective and the service did not meet the needs of all children at risk. There were short delays convening child protection conferences but this did not place these children at unnecessary risk. The majority of children benefited from full implementation of their child protection plans, but others were not allocated a social worker and this meant plans could not be fully implemented. It was unclear whether review child protection conferences would proceed for children without an allocated social worker. The child protection notification system was well managed although there had been some delays updating the system prior to inspection. This system was to become a national one in September 2014 but this did not happen. As such, it was not accessible on a 24 hour basis.

Child protection conferences were well managed. Data and information provided to the Authority showed that 101 children were subject to an initial or review child protection conference in the year prior to inspection. The majority of these were within required timeframes but some were delayed to ensure all necessary parties were available to attend. The chair of these conferences said that national timeframes were sometimes ambitious in this regard. Minutes of child protection conferences showed that they were inclusive of children and families when appropriate. When children did not attend, the reason for this was recorded. Two emergency conferences were convened in the year prior to inspection. There was one chair of child protection conferences, but as there was an average of 4.6 conferences per week, a second chair was sometimes required to meet demands. The chair said that considering the size of the service area, an additional chair would be of benefit but there were no plans to this effect at the time of the inspection. Where there were short delays, inspectors found from records and interviews with social work team leaders that this did not place these children at unnecessary risk and social work visits and other professionals meetings, such as strategy and core meetings were convened.

Inspectors observed one review child protection conference and found that this was well attended and well managed, but reports could have been presented in a more effective manner. The chair of the conference met with families prior to the conference to explain the process. Social workers said that they visited families prior to these conferences to prepare children and their parents in advance. This was recorded on case records. However, some parents told inspectors that although conferences they attended went well, they were unaware they could bring someone to support them. Inspectors who attended a review conference found that lengthy reports were read out loud to attendees. Although the chair had requested a synopsis, this had not happened. This was an area of practice that could be improved upon.

Decisions at child protection conferences were clearly recorded and made clear to attendees. Minutes of child protection conferences showed that actions to be taken to reduce risk to children were clear. They also showed that reductions in risk to children
were identified and appropriate actions were taken as a result. The decision to list children as active or inactive on the child protection notification system was made during child protection conference. Inspectors observed the chair of the conference talking with a parent following the meeting to explain decisions made.

Attendance at child protection conferences varied but the chair worked closely with social work teams to ensure key professionals attended or at a minimum provided written reports. Dates of conferences were sometimes changed to ensure professionals required could attend. Case records showed that a broad section of professionals such as public health nurses, community youth programmes, family support services, school representatives, social protection officers, Gardai and general practitioners regularly attended conferences.

Inspectors found that child protection plans were of a good quality, but they were not always implemented. Child protection plans reviewed by inspectors were comprehensive and detailed. They clearly showed decisions made and actions required reducing or eradicating risk to children. Inter-agency working was evident and community based services and professionals worked in partnership with social workers to implement these plans. There was evidence of plans being revised following review to reflect reduced risks to children. However, inspectors reviewed one case where there was a letter on a child’s file stating concerns about parents not attending professional appointments. This case was closed shortly afterwards and there was no evidence on file that this had followed a child protection review conference. In addition, 17 children with a child protection plan did not have an allocated social worker. The chair of child protection conferences and a social work team leader said that this of course impacted on the implementation of the plan. The team leader confirmed to inspectors that plans were not implemented for some of these children and that s/he could not assure inspectors that these children had been met by a social worker since their child protection plan was initiated. Inspectors found through interviews that it was unclear if child protection plans would be reviewed for children whilst they were not allocated a social worker. Inspectors examined several of these case files and found that one child had not been visited by a social worker since October 2014. In another case, there were no records or case notes since 5 December 2014. The management of these cases were identified as a significant risk by inspectors and the Authority issued an immediate action plan that required the area manager to take urgent action. A satisfactory action plan was put in place by the area manager in the days after inspection to manage these risks and to allocate a social worker to these children’s cases.

The service had a child protection notification system that was not always well managed. There were times when the system was not updated to reflect significant information and some children continued to be active on the system for protracted periods of time with no alternative interventions put in place. Cases listed on the system
were not reviewed in line with national thresholds of need. This meant that some cases may have been active on the system unnecessarily.

Inspectors reviewed the child protection notification system and found that the list was up-to-date and held all the required information. There were 106 children active on this system at the time of the inspection. The system was managed by the chair of child protection conferences and there was oversight by the area manager. Through interviews with social workers and managers, inspectors found that the process to access the system was safe and robust and included a system to monitor enquiries about cases. There was process in place to ensure it was updated to reflect changes in social work allocations. However, the chair of child protection conferences and the area manager told inspectors that there was delay prior to inspection to update the list with regard to unallocated cases. This was significant deficit as the child protection notification system was a safeguard mechanism in place for the area manager to ensure the child protection system was operating safely. Inspectors issued an immediate action plan to the area manager for an urgent response. A satisfactory action plan was put in place to make the system safer.

Some children may have been active on the child protection notification system unnecessarily and that alternative measures were not always taken in some cases. The chair of child protection conferences told inspectors that the national office had directed in February 2014 that all cases listed on the child protection notification were to be reviewed in line with revised thresholds of need for a social work service. This was to ensure that all cases listed required such an intervention. This was not completed and meant that some cases may have been on the system unnecessarily. A review of the system showed that other cases were active on the system for over 12 months and others since 2010. A social work team leader told inspectors that this system was used as a long-term risk management strategy. This showed a reluctance to consider taking alternative interventions such as making these cases inactive or taking children at risk for such a long time into state care. This was not an effective use of the system or social work resources.

**Welfare services**

The value of early interventions was acknowledged by the service area and although these services were well established, their purpose was being developed further. Different types of interventions were being introduced. Children and families benefited from early interventions and there was a range of services available to them. However, external agencies said that these services were under resourced and had experienced significant cuts to their budgets. Family support plans were not routinely audited for improvements.

The service area was in the process of implementing the national local area pathways service delivery model (Meitheal). This contributed to a sometimes inconsistent approach to responding to the welfare needs of all children and families. Inspectors
found that current welfare services reflected the national model in many ways. The manager for partnership, prevention and family support services told inspectors that a training and information sharing programme was in place to inform workers about the model and services currently available. Meitheal training was being rolled out across the service area.

Family support services were in place and they provided support to many families. External professionals told inspectors that they worked with children and families both known and not known to child protection and welfare services. This meant referrals did not always have to be routed through the social work department. This was one aim of the national service delivery model. Data provided to the Authority showed that 125 families were in receipt of a family support service. However, the service did not know at what point a family was referred for family and community based supports. Therefore it could not tell how successful their system was at re-routing families with welfare needs away from child protection social work services. The service was unaware of how many families were in receipt of a community based welfare intervention. This meant that it could not adequately plan for required resources.

One social work office had introduced a pilot project that aimed to provide a differential response to incoming concerns, in that it separated out cases of a child protection nature from those of a welfare nature. The aim of this project was in part, to ensure that children and families with welfare concerns received timely interventions and supports. Staff told inspectors that this was successful to a point but as more and targeted community based resources were required; they were sometimes limited in what could be provided to families. However, they said that this was an improved approach to what was in place prior to the pilot project. External agencies agreed with social workers and told inspectors for example, that early intervention services, such as addiction services for teenagers, were not well resourced. A principal social worker had also identified a need for interventions for teenagers. External agencies said that new thresholds of need applied to cases referred to the social work department meant an increase in welfare cases being referred to community based services, but that resources could not meet demands. Some said that the revised thresholds had meant they were dealing with higher risk cases and they were concerned that they did not have the training or resources to meet the needs of these children and families.

Inspectors reviewed cases that received welfare interventions and found that services were wide ranging. They included parenting programmes, domestic violence accommodation and supports, educational supports and programmes for young people at risk. Children and parents told inspectors that they benefited from these interventions and some said these services intervened at a time when their lives could have gone in very different directions. Children told inspectors that they liked the community programmes they attended and they were supportive of them.
Inspectors reviewed a number of family support plans. Some were of good quality and others lacked detail. The manager of family support services had not begun the process of carrying out audits of these plans and acknowledged the value this would have to developing their services.

**Support and specialist services**

This inspection found that the system for prioritising cases was not consistently safe or effective. It did not always ensure cases of greatest need received a timely social work service. Waiting lists were not well known or managed and children at risk were not consistently allocated a social worker. The system of transferring cases between social work teams was not always effective and children experienced delays in receiving a social work service as a result. These findings raised significant concerns about the safety of the service and the Authority issued the area manager with an immediate action plan as a result.

There was a system in place to prioritise cases for allocation to a social worker but it was not effective. The service had a duty and intake system and its function was to receive incoming referrals, prioritise each case for a social work intervention and carry out an initial assessment if recommended. Inspectors found that cases were prioritised using national guidance and frameworks and a principal social worker had written and disseminated local guidelines to support staff to use these. However, inspectors reviewed intake records and found that priority levels were not always recorded and when asked about some of these cases, team leaders and social workers could not tell inspectors what their priority level was.

Cases were prioritised by team leaders on a weekly basis and this system meant delays in identifying and allocating high priority cases. This was observed at team meetings attended by inspectors. Data provided by the service over the course of the inspection fluctuated and was not dependable. However, data provided to the Authority prior to inspection showed that in November 2014, 1,809 cases were open to the social work department and 464 of these were unallocated high priority cases. The data showed that of these 464, 294 had gone unallocated for up to three months. In addition, the service provided figures to the Authority that showed 13 children active on the child protection notification system were not allocated a social worker. These were children identified as at ongoing risk of significant harm. During the inspection fieldwork, inspectors found that this number had increased to 17 and a principal social worker told inspectors that it was due to increase by another two in the weeks after the inspection. The area manager said s/he was not aware of these unallocated cases. Principal social worker reports submitted to the area manager in November 2014 stated that all of these cases were allocated. The system of prioritising cases based on thresholds of need was not safe and did not ensure children at greatest risk received a timely social work intervention.
Managers were not aware of some wait lists across the service. There was a system in place to manage wait lists but this was not always implemented and this posed a potential risk to children. Data provided to the Authority showed that six cases were awaiting a child protection conference. On review, inspectors found that these delays were not protracted and did not pose additional risks to the children involved. There were 296 cases on a waiting list for an initial assessment and inspectors found that some delays were so long, cases had been closed in late 2014 without an initial assessment being carried out. This was noted on case files examined by inspectors and acknowledged by a principal social worker and a social work team leader. Inspectors found that examples of these cases being re-referred back to the service after they had been closed and placed again on a wait list for an initial assessment.

The local waiting list protocol stated that all cases where there was an allegation of sexual abuse would receive an initial assessment but there was provision for placing these cases on a wait list, once there was a safety plan in place. The area manager and a principal social worker reported that there were approximately two such cases. However, inspectors found through a review of waiting lists held by social work team leaders that there were 35. A review of these cases showed that they were referred to the Gardai but no safety plans were in evidence. One case was delayed since August 2012, another since April 2013 and a third since January 2014. In the majority of these cases, there was no evidence of social work visits or other contact, and some did not have any case notes or intake records completed and on file.

There was a system in place to manage wait lists but it was not applied consistently and was not safe. Wait lists were managed in several ways by the service. One was called a “blitz” and this was when several staff reviewed a large number of cases over a short period of time with a view to closing or re-prioritising cases for allocation. Another was routine review of wait lists by team leaders. There was a local protocol in place for the management of wait lists on duty and intake teams. This prescribed a frequency of eight weeks for the review of wait lists related to high priority child protection cases, but stated that given the significant wait lists in existence, it was not based on good practice, but on achievable targets. There was a standard template to be completed at the time of review on which management decisions, such as case closure or re-prioritisations and concerns were to be recorded. Inspectors found through a review of case files, wait lists and interviews with team leaders that risks in some wait lists were minimised though other interventions, such as ensuring other agencies were involved and reported back to the service on any increased risks to children. However, team leaders told inspectors that they did not review their wait lists, were not aware of the immediate risks to children on these wait lists or whether adequate protective measures had been put in place to manage potential or actual risk to children. Another team leader had reviewed some of their unallocated cases on the child protection notification system, but not all. They were not confident that all children had a recent social work visit or any recent contact by another professional, and they could not assure inspectors
that all of these children were safe. This was not a system that ensured wait lists were managed consistently and did not promote the safety of children.

There was a protocol in place to transfer cases from the duty and intake team to the long term child protection team but it was not effective. The service could not provide an exact number of cases awaiting a transfer to the long term child protection team. However, a report from a principal social worker to the area manager in November 2014 identified a "significant number" were awaiting such a transfer. All staff interviewed described a transfer system that was not working effectively and said that this put pressure on duty and intake teams who had to hold cases until they transferred. Inspectors found that even when cases of greatest risk were transferred, some went straight onto a wait list for allocation. The area manager acknowledged this system was flawed and required revision as it did not ensure a timely or risk based social work intervention.

Data provided by the service showed that there were 13 families awaiting a family support service.

The service did not know how many children and families were on wait lists for services not provided by the social work department. For example, they were unaware if children received a prompt mental health or assessment service. However, inspectors reviewed a sample of files that showed children who required specialist supports received them. The area manager said that money was not an issue in this regard, and if a child needed a specific specialist service it would be paid for by the service area. Social workers interviewed confirmed that this was usually the case.

**Interagency cooperation**

This inspection found that inter-agency working and cooperation was good and children benefited from this. Children and parents who met with inspectors described interventions that included multi-agency and multi-disciplinary working. Cases reviewed by inspectors showed that the social work department fostered partnership working when this was required. There was evidence of professionals meetings, strategy meetings and joint working with Gardai to protect children as outlined in *Children First* (2011). The area manager and principal social workers were involved with children’s services committees and their subgroups. Inspectors observed one subgroup meeting and found a mutely-agency approach was taken to improving services for children at risk. Child protection conferences were well attended by external professionals. External professionals such as school principals and voluntary agencies, told inspectors during focus groups that they felt included in case interventions and that they worked closely with social workers on individual cases. Inspectors found that local protocols were in place to enhance inter-agency working and that children had benefited from this.
Organisational and institutional abuse

This inspection found that there were systems in place to manage referrals of institutional, organised and retrospective abuse in line with Children First (2011), but the management of risk associated with adults of concern was not safe.

There were no new referrals related to institutional abuse in the 24 months prior to inspection. The area manager reported that s/he maintained regular contact with safeguarding officers from the diocese and was confident that no new cases went unreported to the service.

Inspectors found that there was a dual system for managing retrospective allegations. Allegations that were made by children were managed by the duty and intake social work teams and those made by adults were managed by a social work team leader in each office. Data provided to the Authority showed that there were 108 retrospective allegations of abuse made to the service in the year prior to inspection. Inspectors reviewed a number of these cases and found that when they were dealt with, practice was in line with Children First (2011), and cases were managed in a sensitive manner by a skilled social worker. However, although a definitive figure was not provided for the whole service, data provided by one team leader showed that one office alone had 37 adults of concern on a wait list for interview and risk assessment.

Two team leaders told inspectors that they did not have the enough skilled staff to carry out these assessments or interviews. One team leader maintained full records of all their cases and had carried out many credibility interviews with those who made these allegations. A review of their caseload and case records demonstrated that immediate risks were identified and safety measures were put in place. S/he had also developed an assessment tool for this purpose. Case records also showed that their wait list was routinely reviewed. However, this was not the case in all offices. Another team leader told inspectors that they did not have a dependable system in place to regularly review their wait list, did not carry out an assessment to identify any immediate risks to children, and had no strategy or plan to deal with their backlog. They acknowledged that they did not know the risks to children involved in these cases. This meant that the actual or potential risks posed by a significant number of adults reported to the service were unknown. This was a significant risk and the Authority notified the area manager of immediate actions required to manage these risks.

The service had a system to record details of adults of concern in the community. Each office had a spreadsheet that recorded this information and it was informed by information provided by Gardai on known convicted offenders in the community and adults whose names were collected from allegations of abuse made to the service. There was a social work team leader identified in each office with the responsibility to maintain this list. Social workers said that these lists were included in checks carried out when a new referral was made to the service. Although this system had the potential to identify organised abuse and or link adults of concern across individual cases, it was
rendered ineffective by the lack of an integrated information system. Overall, the systems in place to manage risk related to adults of concern were not safe and social workers were not supported in their efforts by any common assessment framework or standard business process in this regard.

**Learning**

The service fully implemented national procedures related to serious incidents and adverse events, and learning from such events was identified and provided to staff for the purpose of improvement.

National policies and procedures for reporting serious incidents were implemented by the service. Information provided by the service showed that there were three serious incidents reported to the National Incident Management Team. One was reviewed by the National Review Panel and there was a local process of reviewing cases that did not meet the threshold of review by this national panel. There was one investigation carried out by the Ombudsman for Children and this was being concluded at the time of the inspection. Staff interviewed demonstrated a good knowledge of serious incidents related to the service and practice improvements required as a result. There was a system in place to identify learning and disseminate it throughout the service. Inspectors found that this happened in several ways. Staff memoranda were distributed by a principal social worker on learning from specific events and inspectors were provided with a folder of these memoranda. Inspectors were also provided with a “learning note” distributed to staff on one serious incident. An action plan was also put in place and internal memoranda followed. However, inspectors found that some practices continued to require improvement and these were related to best use of case chronologies, timely transfer of cases to the long term child protection team and consistent allocations of social workers to cases.

Inspectors read meeting minutes and reports that demonstrated learning from inspections of other service areas, policy and national guidance.

**Oversight of the child protection and welfare system**

Case planning was managed and monitored but required improvement. There were some systems in place to manage complex cases, but they were not adequate.

The complexity of a case emerged as each individual case progressed but there was no formal assessment process to identify such cases. Staff interviewed provided different descriptions of what the term “complex” meant in relation to a case. Some said it was the issues involved in the case such as chronic neglect with low parental co-operation. Others said it was the intensity of the case and amount of resources and level of court work attached to them. Team leaders and staff told inspectors that complex cases were identified through the priority levels assigned to them and the caseload management system that was in place. Inspectors asked staff to identify several cases they
considered complex and on review, found that they reflected the descriptions of complexity described by staff. They were labour intensive cases, with court involvement and multiple needs. The majority of these cases required multi-agency involvement and multiple interventions over long periods of time.

National guidance on caseload management was in the process of being implemented by the service and managers said that this was becoming the formal process of identifying complex cases. As this was in the early stages of implementation, the service had not fully benefited from the system as yet. However, social workers who had experience of this system said that it meant that children and families had received a better quality social work intervention and that they had more time to work directly with children. One team leader said that although this system was being implemented, demands on the service placed pressure on team leaders to increase workloads and this undermined the caseload management system.

Casework was monitored within the formal supervision process and through informal discussions on a daily basis. Case work decisions were recorded on files but some lacked detail and others did not record decisions over significant periods of time. This did not promote accountability for practice. A principal social worker had identified some of these issues and steps were being taken to improve case management records and transparency in decision making.

Inspectors reviewed 177 children's cases over the course of this inspection and found that the quality of case planning varied. This was particularly evident in records related to reviews of cases carried out by a principal social worker in 2014. Records of these reviews outlined actions to be taken such as case closure or additional information to be gathered. In several cases the principal social worker reversed or revised team leader decisions on interventions. This progressed cases through the system and children benefited from this as a result. As such, the quality of planning in all cases was not always effective on a day to day basis.

There was a process in place to close cases but it was not always timely. The decision to close a case was typically made in supervision between team leaders and social workers, and reasons for closure were noted on the case file. Inspectors found that although cases were closed to the social work department they were not always closed to other services. A review of closed cases showed that some were closed prematurely, resulting in re-referral. Others were not closed for protracted periods of time although there was no obvious benefit to them remaining open to the service. Family support cases were sampled by inspectors and there was evidence of case drift. Managers and staff told inspectors that in the majority of these cases, this was due to delays in carrying out administrative tasks. The issues related to closing cases had several effects on children and the service. Some children were in receipt of unnecessary social work interventions and this was in the context of a service that was stretched. Delays in carrying out administrative tasks related to closing a case meant that figures collected
by the service did not adequately capture the number of cases open and active to the service.
Theme 3: Leadership, Governance and Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed and the system is subject to a rigorous quality assurance system. Services provided on behalf of the area are robustly monitored.

Summary of inspection findings under Theme 3

This inspection found that elements of the service were managed satisfactorily. However, the management systems in place did not always provide accountability or ensure high quality practice. There was a need to develop better systems of data and information collection and analysis for the purpose of improving service delivery. Risk was not adequately managed and the delivery of the service was not sufficiently planned at local level. Inspectors identified significant risks in the service and as a result, the Authority issued immediate actions to the area manager that required an urgent response. A satisfactory action plan was put in place by the area manager to manage these risks. However, these were long-standing risks that required a risk management strategy that was sustainable into the future.

Statement of purpose

There was no statement of purpose and function for the service area. The service area did not have a statement of purpose and function. There was a statement of purpose and function that was developed at national level and outlined the statutory functions, national objectives and national service delivery model of the Child and Family Agency. Staff were aware of the national statement and there was evidence that the service was endeavouring to deliver its functions within the national service delivery model. Although this generic document supported the service area to operate within a national framework it was not revised and therefore did not reflect local area practice, needs and resources. The area manager acknowledged the lack of a local statement of purpose and function.

Management structures and systems

This inspection found that there was a management structure in place that aimed to provide clear lines of authority and accountability but this was not always achieved. The area manager provided inspectors with a diagram that clearly showed the reporting structures within the service. Staff across various grades were able to describe this structure and understood the lines of reporting within and external to the service area.
There were systems in place to hold staff accountable for practice, but they were not sufficient. Staff told inspectors that the systems in place that held them to account were supervision, case management and national and local reporting systems. They were aware of their individual and collective responsibilities to meet national expectations and that this was measured through the system of collecting and reporting monthly figures on their service’s performance overall. Staff also described their accountability to the courts in relation to individual cases. Several social work team leaders and social workers said that they were held more to account by the court system than by their management systems. Staff records showed that social workers were held to account for practice by their line managers during supervision. However, the service director and area manager told inspectors that there was no national performance management system in place. This did not support the management of under-performance across the service.

The service was managed by a team that were not functioning at an optimum level and this impacted on the quality of the service delivered. The management team comprised an area manager, two permanent principal social workers, two acting principal social workers, 16 social work team leaders, a manager of partnership, prevention and family support services and a manager of administrative services. Senior managers had extensive experience of child protection and welfare services and different levels of experience of managerial roles. However, the area manager had not benefited from leadership and management training although this was due in early 2015.

The senior management team included the area manager, two principal social workers, two acting principal social workers, a senior manager for the child protection notification system, a senior manager for prevention, partnership and family support and a manager of aftercare services. The area manager was permanently in post since July 2014 but had held the post on an acting basis since 2012. S/he was employed by the area for a number of years in a variety of positions that included child care manager and chair of the foster care committee in Louth. The two principal social workers for child protection and welfare services had been employed by the area for a number of years although their responsibilities had changed following the merging of two areas into one service area in 2013. These senior managers told inspectors that the transition had not been an easy one and continued to be fraught with challenges. They described a senior management team that did not always function as a cohesive unit with common goals and objectives. Some said that working relationships and communications were often strained and this affected the team’s capacity to make decisions and implement them fully. The area manager acknowledged that the challenges this senior management team faced had impacted negatively on the effectiveness of the service as a whole.

Social work team leader skill and competence varied across the service and they required targeted training and support to fulfil a complex and demanding role. Social
work team leaders demonstrated varying levels of skill in their roles as line managers. Some were knowledgeable about their staff team and the risks involved in the cases they managed. Supervision records showed that they provided guidance on complex cases and the management of risk. Most were motivated and open to taking on additional tasks and trying new approaches to practice. However, some team leaders presented as overwhelmed by the tasks assigned to their role and they struggled to carry them out effectively. This included effective management of wait lists and risk in unallocated cases, and maintaining basic dependable data and records. They said that the demands of the job were too high and not achievable. The area manager and a principal social worker acknowledged that although all team leaders would benefit from experience and ongoing training, some required targeted support through performance development and specific training. This had the potential to enhance their capacity to be more effective in what is currently a very demanding role.

The management systems in place were not effective at providing accountability. Monthly reporting systems were in place in the service. They included written reports from principal social workers on how their teams were functioning, data returns on how the service was managing incoming referrals and open cases, and management meetings, where managers were held to account for their areas of responsibility. There were also reporting systems in place from social work team leaders to principal social workers. Inspectors reviewed information provided to the area manager and data collected by the service and found that the systems in place did not always ensure accurate reporting to the area manager. This meant that there were times when staff and managers were not held accountable for their practice. For example, inspectors found that the area manager was not made aware of children on the child protection notification system without an allocated social worker, despite this presenting a significant risk to the service. The area manager was not made aware of two national directives not being implemented. They included allocation of a social worker to all children placed on the child protection notification system and the application of new thresholds to cases active on the child protection notification system. The area manager reported to the service director. The service director told inspectors that the reporting systems in place between him/her and the area manager had also failed to identify these issues. This meant that although reporting systems were in place to provide accountability, they were not always effective and did not benefit children by ensuring the service being delivered was safe and proportionate to levels of need.

There were systems in place to promote effective communication across the service but they were not always effective. Inspectors found that managers informed all staff about legislation, standards, policy, procedures and processes. Information folders were observed in each office. These provided staff with a quick view of all policies and procedures in place. Staff guidance on how to apply business processes to day-to-day practice was developed and disseminated by one principal social worker. Staff meeting and staff supervision records showed that information was provided to staff by their
managers. There was a national information hub available to all staff. Staff interviewed demonstrated a good knowledge of legislation, policy, standards and standard operating procedures and processes. They were aware of risk escalation processes.

Inspectors found that team meetings were not always effective. Staff meetings were held on a weekly basis. Inspectors attended two team meetings and found that they were not always used effectively. Inspectors observed that cases referred to the service in the week prior were discussed at these meetings. They were prioritised by the team leader and either allocated or placed on a waitlist. However, cases on waitlists and the capacity to allocate them was not discussed. One team did not record their team meetings. This meant for example, that there was no record of team decisions or the provision of new information on policy or procedures.

**Planning the service**

The service area was in the process of implementing a national service plan. However, the national plan was not supported by a regional or service area plan that would support its implementation at local level.

There was a national service plan that provided a framework for the current and future delivery of child protection and welfare services around the country. This provided common objectives and standard processes across all child protection and welfare services. Inspectors found that some service planning did take place in local forums such as local and regional management meetings. Minutes of these meetings showed that some service priorities were identified in these forums, and progress was measured from meeting to meeting. The area manager acknowledged that this was a fragmented system which was somewhat reactive and not adequate. There was no local service plan. The area manager told inspectors that although there was an expectation that one would be developed, it was not and that this was because their work had focussed on how the service would meet budgetary requirements and constraints. This meant that local service objectives, needs, capacity and priorities were not identified and progress in the implementation of the national plan could not be measured.

The area manager provided inspectors with a service improvement plan for the duty and intake element of the service. This was developed by a principal social worker that was based on bringing duty and intake systems into compliance with national standards. This plan identified issues, required actions, risks and challenges and timeframes for completion. Issues identified for improvement were related to record keeping, initial assessments, case closures, wait list management and information systems. Although this was of benefit to the duty and intake element of the service, the process was not replicated across the service area.
Risk management

There were ineffective systems in place to identify, assess and report risk, and risk was not well managed by the service. Long-standing patterns of risk existed and the Authority required urgent actions to be taken by the area manager in response to these. The area manager put a satisfactory interim plan in place to manage these risks.

The management of risk was informed by HSE risk management policies which provided a framework for the identification and management of a wide range of risks and procedures to report them at local, regional and national level. There was a national operating procedure on reporting risks that were specific to the Child and Family Agency. These included for example, child deaths and defined serious incidents, children missing in care and risks associated with any case which might draw public attention. Records showed that these systems were being fully implemented by the service area.

The role of the manager for quality and risk was not fully understood by service managers. The region had a manager who monitored risk and quality within the service. Reports and meeting minutes showed that this manager was notified of risks within the service and there were systems in place to monitor these risks. This was in the early stages of development. However, the area manager said that the role of the quality and risk manager was not fully established or understood but was being developed. This meant that it may not have been fully utilised by the service.

Risk reporting systems did not always correspond with risk management systems. There was a “need to know” system in place to notify national managers of specific cases that may come to the attention of the public. This was a reporting system and not a risk management system. Records showed that 14 such cases were notified to national managers in 2014. However, inspectors cross-referenced these with risk escalations to the service director and found one case that was not notified through the risk escalation process. This meant that although national managers may be aware of individual cases, the risk to children may not be known or managed through the risk escalation process. The area manager rectified this at the time of the inspection.

Risks were identified and reported in several ways and staff had a good awareness of their responsibility to report risk. Supervision records showed that social workers reported risks related to practice and cases during supervision to team leaders. Staff told inspectors that supervision was the forum where they would discuss risks to individual children that remained high, and risks related to meeting demands of caseloads. Staff meeting minutes showed that risks were identified such as staffing levels. Social work team leaders said that they reported risks to their principal social worker who in turn recorded and assessed these risks on standard risk assessment templates. These assessments were reviewed by inspectors. A social work team leader told inspectors s/he was assigned the responsibility of supporting and assisting principal
social workers to report and assess risks and to notify all risks to the area manager and the manager for risk and quality.

Systems of escalating and recording risks were not adequate. The area manager had the responsibility of determining which risks were to be managed locally or escalated to the service director with regional responsibilities. Management meetings showed that low level operational risks were managed by the management team. Risks related to individual children were managed through everyday social work interventions in line with standard business processes. However, the area manager told inspectors that there was no template for a local risk register, and that this was being developed nationally. The area manager and the team leader responsible for maintaining this register informed inspectors that in the interim, risk assessment templates submitted by service managers were considered the local risk register. A folder of this interim risk register was provided to inspectors. Risks recorded included wait lists, information systems and staff vacancies. The area manager said that these risks were reported to the service director. However, the service director reported to inspectors that the risks recorded at regional and national level were confined to staff vacancies. Although these had been escalated to national managers since 2014, staff vacancies remained. The service director said that long-standing risks related to wait lists and unsafe information systems were not recorded as a risk at regional or national level. These were risks that the Authority required an urgent response to during the inspection period. In correspondence with the Authority post interview, the service director reported that risks related to unsafe information systems were known nationally for some time, and that they would now be recorded formally as a risk on both regional and national risk registers.

Inspectors found that there was a pattern of risks that were not effectively managed. Completed risk assessments, monthly principal social worker reports and correspondence between principal social workers and the area manager were reviewed by inspectors and showed that there were recurring and persistent risks in the service. A letter to the area manager in June 2014 by a principal social worker stated that pressures on Louth Meath duty and intake service had a major impact on its ability to undertake assessments in a timely way let alone provide a safe service to children and families. It identified existing wait lists and increased rates of referrals alongside delays in the transfer of cases out of duty and intake and staff vacancies as major risk factors. Risk assessments provided to inspectors showed that these risks persisted and had not reduced. They identified ongoing risks related to intake wait lists, unassessed risks in duty wait lists and staff vacancies. Although controls were identified in risk assessments they were not put in place. Staff vacancies were not filled, wait lists were not significantly reduced, and reviews of cases awaiting allocation and assessment were not routinely carried out. This was not adequate or sustainable and potentially placed children at risk.
Quality assurance and monitoring

Quality assurance mechanisms were in place to monitor the quality of the service, but they were not effective. There was a system of audits, monitoring and learning from reviews that informed managers and staff about the quality of the service. However, the systems of monitoring the service were not robust and did not always ensure good quality practice. There was no evaluation of the service and children and families were not routinely consulted about their level of satisfaction with the service they received.

Monitoring of the service was not informed by quality data and information. The quality of the service was monitored at national level through routine monthly reporting on key performance indicators. Inspectors reviewed a number of these reports submitted in the year prior to inspection and found that although they fluctuated, significant improvements for example in the area of allocations or wait were not achieved. Managers and staff told inspectors that the only data routinely collected by the service was that which was required by the national office. This limited the capacity of the service to monitor the quality of all aspects of the service effectively.

There was a system in place to improve practice through monitoring of specific cases and national alerts. There was a regional quality and risk group that monitored individual cases, reports on these cases and national alerts. It also reviewed incidents and adverse events. A social work team leader who was part of this group told inspectors that one function of this group was to make recommendations for improved practice.

The systems in place to monitor performance at local level were not adequate and did not ensure the area manager and in turn, the national office was well informed. The area manager acknowledged difficulties in collecting dependable data and information, but additional monitoring systems were not put in place to bolster these systems and reduce the risk this presented. For example, the area manager was unaware of high risk cases that were unallocated, that there was a waitlist for carrying out initial and child sexual abuse assessments on cases where there was alleged child sexual abuse. Inspectors found that local monitoring systems posed a potential risk to children. As a result, the Authority required immediate actions to be taken by the area manager as a matter of urgency. A satisfactory plan was put in place by the area manager to introduce tighter systems of monitoring specific areas of performance within the service.

There was a system in place to monitor the service at national level that influenced some changes to service delivery. The national office carried out an audit of the service in relation to the implementation of standard business processes. This audit was not available to inspectors, but the area manager and a principal social worker had transferred some initial its findings into a plan to improve the duty and intake system. This resulted in a pilot project being put in place to manage and assess incoming concerns and a review of this pilot showed some improvements in practice. It also
identified barriers to improvement that were brought to management meetings for resolution.

File audits were carried out by team leaders and principal social workers on a regular basis. Findings were evident on case files and recommendations for practice were noted. Actions for improvement were also highlighted in an improvement plan for duty and intake teams. Reports provided by one principal social worker showed that audits were carried out on staff files and there were noted improvements to the quality of records held on these files such as training and supervision. However, records showed that file audits were not routine for other elements of the service such as family support services.

Monthly audits of the “Measuring the Pressure” reports were also carried out by a principal social worker and provided to staff teams. A sample of these were reviewed by inspectors and showed that trends and comparisons were made between offices. Some issues identified were found to be reflected in risk assessments carried out by principal social workers.

There was a system in place to monitor the quality and effectiveness of external services that received funding from the Child and Family Agency. However these were not sufficient. The area manager told inspectors that service level agreements were being developed and those in place were out of date. New templates were being developed for 2015. Services submitted annual reports and met with the area manager and the manager of partnership and prevention and family support four times a year. The area manager said s/he was not satisfied with the level of reporting from these services and that their performance would be measured in future against the requirements of the national service delivery model. The area manager said that this was a system under review within the development of the national service delivery model.
**Theme 4: Use of Resources**

The effective management and use of available financial and human resources is fundamental to delivering child-centred safe and effective services and supports that meet the needs of children.

**Summary of inspection findings under Theme 4**

The service was operating with limited resources and those available were not always managed well. This approach did not ensure the service was delivered in a consistently safe and effective way.

**Resources**

The service was not sufficiently resourced to meet the needs of the population it catered for. The service had not carried out a needs analysis and this did not ensure current resources were utilised efficiently or effectively. This approach was not sustainable.

This inspection found that there were some systems in place to monitor and allocate resources but they were not sufficient. Inspectors reviewed reports from principal social workers to the area manager and minutes of local, regional and national management meetings. These showed that resource issues were identified and discussed such as staffing and costs. These records demonstrated the need to provide a service of value within budgetary constraints with minimal adverse effects on children and families. The area manager was held to account for key expenditure. Oversight and support was provided to the area manager by the service director in relation to managing and commissioning resources.

Social work services were located in three offices across the two counties. All of the offices were accessible by public transport. One office was a new purpose built premises that was welcoming and spacious with lots of natural light and good heating systems. It was well decorated and provided private rooms that were equipped for children. Another office was adequate and provided ample space for staff, and private areas for children and families. A third office was not fit for purpose. Inspectors visited this office and observed that it had limited space for children and families and social workers. It was shared with other professionals and as such, privacy was not always guaranteed for service users. Social workers told inspectors that they bought play equipment for their offices as they were not confident these purchases would be funded by the service.

The area manager told inspectors that a comprehensive needs analysis was not carried out despite the significant changes the service had experienced in the two years prior to inspection. During this time, two areas providing separate services to the counties of Louth and Meath merged to become one service area. This meant that services were
now being delivered across two counties to a larger population. Case records showed that responsibility for some families had moved from one social work office to another during this transition and that this was well managed. However, there were examples of cases where services required for individual families ceased following the transition. This indicated that some children and families did not benefit from this transition.

One principal social worker had carried out a review of the duty and intake element of the service. This indicated a need for more resources to meet demands in dealing with incoming concerns and backlogs. The principal social worker also identified the need for alternative care services for teenagers who displayed behaviour that challenged.

Monthly reports from principal social workers to the area manager were read by inspectors and they identified gaps in service provision on an ongoing basis. Although the aforementioned review and monthly reports were useful to the service in determining need, they were not sufficient.

The service was involved with the children’s services committees in Louth and Meath and this went some way towards identifying needs of children in the region.

Inspectors found that many resources were available to children and families on an individual basis that included community based programmes and services. At service level, the area manager had reviewed quarterly activity reports from community based services and said that they did not adequately reflect the service they provided. As such, a new reporting mechanism was being put in place that would measure these services against the requirements of Meitheal. The area manager had presented to community based services on the Meitheal service delivery model that would ensure resources required in the community were being delivered. This was in progress at the time of the inspection.

Within the social work department, deficiencies in social work resources such as staffing and the impact this had on service delivery was monitored and reported as a risk to the area manager and service director. Data provided prior to and over the course of the inspection showed that wait lists were significant across all elements of the service. This resulted in agency staff being recruited and put in place in 2014 but this was not sufficient to deal with backlogs and increasing demands on the service.

The management of current resources was an ongoing issue of discussion and planning for managers of the service. This was evident in management and team meeting minutes and monthly reports from principal social workers to the area manager. It was also an issue that was reported as a risk by managers. Inspectors found through interviews with principal social workers and the area manager, that there was a lack of consensus amongst the management team on how for example, current staffing resources could be put to best use. Although there was a level of understanding of service needs and flexibility shown by staff and managers to deal with resource issues and prioritising cases, there was also an element of resistance to the required changes. Records and reports showed that for example, social work resources were not
consistently managed in a way that ensured all children placed on the child protection notification system were allocated a social worker. A review of social worker caseloads and lists of cases managed by teams across the service showed that although there was a caseload management system in place, some were significantly higher than others. Local protocols on the transfer of cases between teams reviewed by inspectors were found to have contributed to unequal caseloads, as some parts of the system were attempting to compensate for the incapacity of others to receive cases. This was acknowledged by the area manager and a principal social worker. This approach to managing current resources did not benefit children and families and did not ensure cases of high levels of need were prioritised for a social work service when resources were limited.
Theme 5: Workforce

Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children’s services recruit and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.

Summary of inspection findings under Theme 5

This inspection found that the service was provided by staff with a variety of experience and skills and some required support to build on their experience and competencies. The service had not determined the number of staff required to provide the service in a way that eradicated backlogs and met current service demands.

Recruitment

There were safe recruitment processes in place that were in line with legislation and policy, but there was a need to ensure information on staff files held by the service contained all relevant information so managers could be assured they were appropriately vetted.

There was national policy on the recruitment and induction of staff. Managers and staff were familiar with these policies. Staff recruitment was managed at national level through the National Recruitment Board. The area manager told inspectors that there was a delay in recruiting staff and filling vacant permanent posts. This meant that agency staff were recruited from time to time. Information provided to the Authority showed that acting positions were also in place and inspectors found that this went some way towards providing stability, particularly at social work team leader level.

The service maintained a register of all staff that recorded evidence of their recruitment, vetting and registration status. This supported managers to see if there were any deficits in information that required their attention. Personnel files were held nationally and locally. Inspectors sampled 33 staff files held by principal social workers and found that staff were recruited in line with national policy and procedures. The majority of personnel files contained evidence of appropriate vetting of staff including proof of identity, vetting by An Garda Síochána, certificates of registration with a relevant professional body and references. There were gaps in some files that were in the process of being created and managers were addressing these deficits. For example, one staff member had transferred from another service area and there was a delay in their file information being provided to the principal social worker. This was being addressed at the time of the inspection. Two staff were in the process of being registered with a professional body. The principal social worker held a copy of their applications and was monitoring progress in this regard.
There was an induction programme in place for all staff. Personnel files held completed records and checklists of induction being provided to newly recruited staff. Inspectors were provided with a copy of the local induction pack and found that it was a comprehensive programme that included induction into the service both at national and local level. Inspectors interviewed staff who had been recruited to the service in the year prior to inspection. They said that the process was lengthy, supportive and covered all aspects of the service. One social worker said that they would have liked more time to gain experience before they were required to manage their own caseload.

**Sufficient staff and skill mix**

The service was delivered by staff with varying levels of experience, competence and skills who were motivated to deliver a consistent, timely and safe service to children. However, access to training required improvement and although there was a caseload management system in place, strains on the service meant that flexibility was required. This varied across the service. The number of staff required to deliver the service was not fully determined by managers and the current staff could not meet increasing service demands and clear existing backlogs.

The service was delivered by staff teams with diverse skills and knowledge. Many had considerable experience of working in frontline child protection and welfare services that included statutory social work, residential care and community based family services. Staff and managers described social work teams that were made up of core staff with many years experience and more recently qualified social workers. The teams had grown over time to include increased numbers of family support workers and staff were of the view that this broadened the skill base of the department as a whole. Staff told inspectors that the staff mix brought new ideas and challenges to traditional ways of doing things which was viewed as a positive aspect of the team’s make-up.

Inspectors observed staff of all grades carrying out their duties in a professional way, and drawing on their knowledge, experience and strengths when working cases. This was particularly so in relation to responding to risk. This was demonstrated in many cases read by inspectors that described good quality direct working with children with sometimes diverse and complex needs. The number of senior practitioners had reduced in the year prior to inspection, but some were on hand to provide guidance and support to their team members. Staff said this was invaluable to them.

The area manager and principal social workers were suitably qualified and had significant experience in line management and of social work child protection and welfare services. The area manager had not received leadership and management training. S/he told inspectors that this was due to be provided in February 2015. Social work team leaders were found to be qualified social workers but three required training in leadership and management. Social work team leaders demonstrated different levels of skill and competence in their everyday practice, and some required targeted training and support to be as effective as possible in this demanding role.
This inspection found that the number of staff required to deliver the service was undetermined by service managers and current staffing levels were insufficient to deliver a consistent, safe and timely service. The service had 62.2 posts and figures provided by the area manager showed that eight of these were vacant full-time social work posts. However, the area manager told inspectors during the inspection fieldwork that there were 21 vacant posts overall within the service. This included vacant administration posts. There were five agency social work staff in place at the time of the inspection. Absenteeism was at a rate of 3.14% and the service did not know the rate of staff turnover in the year prior to inspection. Principal social workers and social work team leaders told inspectors that there were periods of time when extended leave such as maternity leave had impacted on staffing levels. Inspectors found that the majority of staff were flexible and this had benefited teams in the short-term when there was considerable pressure on them. However, this was not sustainable, as most elements of the service were stretched and flexibility was difficult to achieve as a result. The area manager and principal social workers said that even of all posts were filled on a permanent basis, they were not satisfied that this would be sufficient to meet increasing service demands, manage caseloads in accordance with current national guidance, and clear current backlogs. Inspectors found that insufficient staffing had impacted on children and families. There was correspondence on several case files from social work team leaders to families explaining that their cases could not be allocated a social worker due to low staff levels. Some children and parents told inspectors that they had experienced a high turnover of social workers allocated to their case because social workers had left and not been replaced. Data provided by the area manager showed that there was a significant number of cases waiting to be allocated a social worker that included high priority cases.

Administrative staff were found to be essential members of each social work office and provided key supports and functions on a day-to-day basis to the effective running of these offices. However, staff and managers told inspectors that there were insufficient numbers of administrative staff and that this placed an additional strain on staff and did not ensure administrative tasks were always carried out within acceptable timeframes.

**Support and supervision**

Staff were supervised in line with national policy and procedures and supported on a day-to-day basis by their managers. Decision making was clearly reflected in supervision records. There was an inconsistent approach across the service in relation to taking minutes of team meetings and as such, team decisions and the sharing of information was not always recorded.

Staff were provided with formal supervision by trained supervisors, but there was a need to improve how these meetings were recorded. Inspectors were informed that all relevant staff were trained in the provision of supervision. Staff told inspectors that they received good quality supervision and that it was of value to them. Inspectors examined
supervision records for nine staff across different posts and grades. They showed that supervision contracts and schedules were in place. There were records of when supervision was delayed due to other work demands and alternative dates were set. These records demonstrated that staff were held accountable for practice and were encouraged to be reflective. There were several elements to supervision that included case management, training, information sharing and team working. There was a clear link between supervision and developing performance. Records included plans for developing performance in terms of everyday practice and broadening skills through training. Case decisions were clearly outlined in the majority of records examined but some lacked detail. The area manager supervised the chair of child protection conferences and although records were kept, they were by way of notes taken by both parties. This meant that supervision notes may differ in terms of decisions made and actions for follow-up.

Staff were provided with informal support and this meant that there were limited delays when complex case decisions were required. Inspectors observed staff being supported by their managers on a daily basis and this was facilitated by the design of offices which meant that managers were located close to their teams. Staff told inspectors that they felt supported and that a manager was always accessible to them.

Staff were aware of national policy related to whistle blowing/protected disclosure. They said that they worked in an environment that supported them to challenge unsafe practice. One principal social worker had expressed their concern about the safety of the service in correspondence to the area manager and the local risk register showed that several of these concerns were recorded on this register.

**Training**

Staff training was provided in the year prior to inspection on a national and individual basis, but staff said that more training was required. Although a comprehensive training needs analysis was not carried out for the whole service, a range of training required was identified and a plan for the coming year was being developed.

The training needs of the service were determined through several means but they did not result in an overarching training plan. Records showed that social work team leaders recorded national training provided and social worker attendance for their individual teams. Supervision records showed that staff identified training they felt would be beneficial to them or their team. Training was then sourced by managers or individual social workers who could request funding to attend. Some of the training identified included neglect, culture and diversity and court work. However, a written training plan was not in place for 2015 and a principal social worker said that it would be provided based on dates provided by the national training department of the Child and Family Agency.
Core training provided in the year prior to inspection was limited to what was provided nationally, but records showed that all staff had core training such as Children First (2011). Other training provided included caseload management, court skills, child sexual abuse, report writing, and reflective practice. Staff interviewed said that generally, there was a good response from managers to training needs but that this had reduced in the two years prior to inspection due to budgetary constraints.
**Theme 6: Use of Information**

Quality information and effective information systems are central to improving the quality of services for children. Quality information, which is accurate, complete, legible, relevant, reliable, timely and valid, is an important resource for providers in planning, managing, delivering and monitoring children’s services. An information governance framework enables services to ensure all information including personal information is handled securely, efficiently, effectively and in line with legislation. This supports the delivery of child-centred, safe and effective care to children.

**Summary of inspection findings under Theme 6**

Information and data collected by the service was limited and the information systems in place to support the service in this regard were unreliable and unsafe. This meant that information about children and their families was not always protected or up-to-date and quality decisions about service planning and delivery were not possible or evidence based. Information systems were identified by inspectors as a major risk to delivering a safe child protection and welfare service.

**Collection and analysis of information**

This inspection found that the quality of information and data collected by the service was poor and did not support effective service planning or delivery. Although the area manager made efforts to validate all information and data provided to the Authority, this was not possible. This remained the case for the duration of the inspection and it was notified to the service as a significant risk that required an immediate response.

There was a system in place to routinely collect basic data and information on how the service was operating. This was based on monthly requirements of the national office and included for example details on staffing, referrals, cases and their priority levels, and length of time awaiting allocation to a social worker. There was a monthly reporting system in place between principal social workers and the area manager which included information and data collected by social work team leaders. On review, inspectors found that these reports provided figures related to incoming referrals and allocations and a brief analysis of what the data meant in terms of operations. For example, one principal social worker analysed time management and demands on the service due to court work. The primary finding of this report was insufficient staffing and the impact this had on service delivery. Another principal social worker provided a breakdown of national monthly figures on an office by office basis which assisted managers to identify elements of the service that were or were not working as effectively as others. The chair of child protection conferences updated the child protection notification system and this reflected conference activity and delays for example, in allocations to a social worker. Management meeting minutes showed that this information and data assisted
managers to identify where critical operational challenges lay. Although these systems highlighted the need for improved service delivery, the information and data was not thoroughly analysed and did not result in a written plan on improving the service as a whole.

Inspectors found that although systems were in place to collect basic data and information they were not dependable and this posed a potential risk to some children. Inspectors analysed and cross-referenced several sources of information and data provided to the area manager including the child protection notification system, monthly principal social work reports and databases on referrals and cases. In conjunction with interviews of social work team leaders, principal social workers and the area manager, inspectors found that information and figures reported to the area manager on case allocations were not always correct. For example, one monthly report to the area manager stated that all children on the child protection notification system were allocated a social worker. Evidence gathered by inspectors showed that this was not the case and 17 children on the child protection notification system were not allocated at the time of the inspection. Some had not been allocated a social worker for up to five months prior to the inspection. This posed a potential risk to children at ongoing risk of harm. This finding was notified to the area manager as a risk that required and immediate response. The area manager acknowledged the serious deficiencies and inadequacies in the systems of collecting and reporting information and data and s/he provided an action plan to the Authority to manage this risk to children.

Information and data collected was not of sufficiently high quality to maximise its use for managers in assessing how effective the service was at dealing with child protection and welfare concerns. For example, a written report to the Authority from a principal social worker stated that there was no system in place to collect data on the number of notifications of alleged or confirmed abuse made to An Garda Síochána. The service did not know at what point in the management of a concern these notifications were made. This meant that the service did not know if garda notifications were timely, or whether they were delayed and possibly placed children at unnecessary risk.

Information and data examined by inspectors showed that case outcomes were not collected and/or analysed effectively to improve service delivery. For example, the number of cases closed to the service was collected routinely. However, the service did not record at what stage a case was closed, for example at intake or following an initial assessment. Managers were unaware of how many cases were re-referred to the service having been closed previously. In addition, the service collected information and data on the type of cases it dealt with. However, this data reflected the report type, such as neglect or sexual abuse, at the point of referral and was not updated when the report type changed after a social work assessment. There was no data collected on the number of referrals that required an initial assessment or referral to another agency. The service did not know how many referrals resulted in an emergency intervention.
This dearth of information and data meant that managers could not assess through meaningful analysis, how effective or safe practice was at various stages of dealing with a concern.

Information provided by the area manager prior to the inspection showed that the service collected limited data and information on the population it catered for. The area manager and a principal social worker told inspectors that although specific figures were provided to the Authority, not all were routinely collected. For example, managers did not routinely collect data on the ratio of children in receipt of a service that had a disability. The service did not collect data on the ethnicity or religion of children. The service did not know how many children were awaiting a service provided external to the social work department, such as psychology or psychiatry. This lack of quality information and data compromised the service’ capacity to meet the needs of all children and families requiring an intervention.

**The information system**

Information systems in place were not safe, robust or dependable and did not support the delivery of a child protection and welfare service. This was identified as a major risk to the delivery of a safe service by inspectors.

One office had an electronic information technology system in place. Staff interviewed said that this was useful in relation to recording information on referrals but was limited in its functions. The remaining two offices had paper based systems and basic information technology packages such as spreadsheets created by individuals. Information on referrals was kept on index cards in these offices and administrative staff were in the process of transitioning to electronic records.

All offices had databases that collected basic information on referrals and cases. This system was not an integrated one and posed a challenge to the service in collecting, analysing and sharing information. The area manager and a principal social worker told inspectors that some of the data and information requested by the Authority was not collected using the systems in place and was not easy to retrieve manually. Inspectors found that this was the case throughout the inspection. One social worker provided inspectors with a printed list of their team’s caseload. On examination this was found to be incorrect. This was confirmed by a principal social worker. Another team leader could not provide basic data on cases requested by inspectors. The area manager said that a national information system was awaited and that the area was working towards making the information systems safer until the national system was available. The current systems were not safe or sustainable.

The lack of an integrated information system posed a potential risk to some children. One social work team leader explained to inspectors that each office held a separate database on alleged and convicted offenders in the community. On examination, inspectors found that these databases could not be accessed by each office. This meant
that contact between an adult of concern who is known to one social work office, and a child from another social work office, may go unnoticed. Similarly, social workers may not know that a child who has moved from Louth to Meath is known to the service. As such, risk to children may not be identified or responded to.

The integrity of the information systems in use in the area was of concern to staff. Staff told inspectors that the database in one office had crashed in late 2014 and information on some children and families was lost. Databases were inaccessible for a two week period. In addition, inspectors found from cross referencing paper and electronic records, that information on some case files did not correspond with information held electronically. For example, children’s names or gender were different on both records. Inspectors also found that when compared, lists of cases developed by individual team leaders did not correspond with those generated from the databases in place. This was not a safe system.

The Authority issued immediate actions to the area manager in relation to information systems in the service that required an urgent response. The Authority was satisfied that a plan was in place to address the immediate risks posed by this system, but this was not sustainable on a long-term basis. The area manager and service director told inspectors that the risks associated with the current system were known at national level and that a national information system was awaited.

**Record keeping**

The quality of children’s records varied across the service and required improvement to ensure they were safe and met the requirements of Children First (2011) and national policy.

There was a policy and procedure in place for the management of records and staff interviewed were familiar with this. Many records were maintained in line with policy and procedure but others were not. Principal social workers said that there was a system of auditing files to monitor their quality and inspectors found evidence of these audits in individual files. Some improvements in practice were noted as a result such as, better file structures and increased accessibility of information, but further improvements were required.

Inspectors reviewed paper and electronic records and found that there were inconsistencies in practice. Standard templates were in place to promote consistency, and inspectors found that although many were completed fully, others were incomplete and were not dated or signed. Inspectors found many examples of cases where the current priority level was not recorded on standard forms. This undermined the capacity of the system to respond appropriately to incoming referrals, particularly when the child was already known to the service.

Many records reviewed by inspectors were of good quality. They were up-to-date, chronological and held reports that reflected the type and level of interventions
provided to children and families on a needs led basis. These records clearly demonstrated the journey of cases through the social work system. Decision making processes were transparent and there was accountability for practice. However, poorly kept records were not up-to-date or chronological. Some lacked basic information such as the name of the current social worker or contact details for key people involved with the child, and there were no transfer reports to show how cases passed from one social worker or social work team to another. Records of social work visits to children and families were not always clearly recorded but buried in case notes and difficult to access. In these instances, it was difficult to follow the history of the case and there was a lack of transparency in decision making. Some social workers told inspectors that other demands on their time impacted on their capacity to keep all case records up-to-date. The area manager said that a reduction in administrative staff had impacted negatively on the quality of records keeping in the service. Inconsistent and in some cases, poor quality practice, meant that the service did not fully meet the requirements of Children First (2011) in relation to record keeping. There was a need to improve practice to support and demonstrate quality case planning and provide transparent accounts of practice.

There were systems in place to store children’s records but they required improvement. Inspectors observed dedicated secure areas where children’s records were stored and archived. These included administration areas and social work offices where records were locked away and only accessible by authorised persons. Computers and electronic records could only be accessed using passwords. However, one office had little storage space and filing cabinets were located on corridors that could be accessed by other professionals who had offices in the same premises. Although this was not ideal, social workers made every effort to ensure the cabinets were locked at all times. The area manager acknowledged the unsuitability of this premises but there were no alternative office locations available at the time of the inspection.