Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of service area:	Child and Family Agency Cork OSV - 4384
Dates of inspection:	30 – 31 August 2017
Number of fieldwork days:	2
Lead inspector:	Caroline Browne
Support inspector(s):	Ann Delany Ruadhan Hogan Rachel McCarthy
Type of inspection:	☐ **Announced** ☐ **Unannounced** ☐ **Full** ☐ **Themed** ☒ **Follow Up**
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About monitoring of statutory foster care services

The Health Information and Quality Authority (HIQA) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the 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.

HIQA is authorised by the Minister for Children and Youth Affairs under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency and to report on its findings to the Minister for Children and Youth Affairs. HIQA monitors foster care services against the *National Standards for Foster Care*, published by the Department of Health and Children in 2003.

In order to promote quality and improve safety in the provision of foster care services, HIQA carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children
- **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 HIQA's findings.

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

1. Profile of the foster care service

1.1 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
- domestic, sexual and gender-based violence services.

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

Foster care services provided by the Child and Family Agency are inspected by HIQA in each of the 17 service areas. The Child and Family Agency also places children in privately run foster care agencies and has specific responsibility for the quality of care they receive.

1.2 Service Area

The Cork Area is the largest of the 17 service areas of Tusla, The Child and Family Agency. It is an amalgamation of four previous Local Health Office (LHO) are North Cork LHO includes North County Cork (includes the suburbs of; Fermoy, Mallow, Mill street and Kanturk) and the local social work office is located in Mallow.

West Cork LHO includes West County Cork (includes the suburbs of Castletownbere, Bantry, Skibbereen, Dunmanway and Clonakilty). The local social work office is located in Skibbereen.

North Lee LHO includes Cork City north of the River Lee (includes the suburbs of Fairhill, Gurranabraher, Farranree, Knocknaheeny, Hollyhill, Blackpool, The Glen and Mayfield. Also parts of County Cork including; Midleton, Youghal, Cobh and Macroom). The local social work office is located in Blackpool.

South Lee LHO includes Cork City south of the River Lee (includes the suburbs of Douglas, Carrigaline, Mahon, Kinsale and parts of the County including; Kinsale and Bandon) with its office in St. Finbarrs Hospital, Douglas.

Data from the 2011[1] census showed that the area has a population of 519,032 people, and the number of young people 0 - 18 in Cork is 26%. The percentage of 0 – 18 year olds in Cork City is 19.2%, while the proportion in the County is 28%.

In Cork City disadvantage is found primarily in the North side of the City but also in some areas in the South. Deprivation in Cork City is of a much higher degree than in the County and certain areas reveal a convergence of factors that compound disadvantage. In Cork County deprivation is focused in the North and West of the County.

The area was under the direction of the service director for the Child and Family Agency South Region and was managed by the area manager.

The foster care service in the Cork area is provided by one Fostering Unit located in the city with two outreach offices, based in Mallow and Skibbereen. The fostering unit has responsibility for the recruitment, assessment, support and supervision of all foster carers. The fostering unit was made up of two social work teams line-managed by team leaders who reported to a principal social worker, who in turn reported to the child care manager. The chairperson of the foster care committee was also one of the principal social workers in a child protection and welfare team. The foster care social workers carried out assessments of foster carer applicants and carried out the role of link social workers supporting and supervising foster carers.

At the time of this inspection the principal social worker for the fostering unit had been appointed to the fostering team six weeks prior to this inspection.

There were 442 foster carer households in the service, 320 general foster carers and 108 relative foster carers. The area advised that there were also 14 dual carer households, who were both general and relative foster carers.

1 A breakdown of data relating to the 2016 census was not available at the time of writing.

2. Background to this Inspection

This was the second inspection of the Cork Foster Care Service in 2017. The Cork Foster Care Service was previously inspected by HIQA in February 2017. At that time inspectors identified a number of serious risks and of the eight standards inspected against, there were five major non-compliances identified over the course of the inspection.

At that time, 35 of 80 cases reviewed by inspectors were escalated to the child care manager with responsibility for alternative care services to address the risks and concerns arising.

The concerns identified were as follows:

- the adequacy of investigations following a child protection or welfare concern or allegation about a foster carer and unclear outcomes to strategy meetings; and the lack of a system to ensure that a child would not be placed with foster carers against whom there was an open concern or allegation
- unassessed and unapproved relative carers without Garda Síochána (police) vetting
- significant delays in the commencement and completion of relative assessments with many children placed for several years
- a lack of evidence of adequate safeguarding measures in place for these relative carers
- adults living in foster carers' households without Garda Síochána (police) vetting and for foster carers without link workers
- relative carers who had not been approved by the foster care committee
- inadequate support and supervision of foster carers
- foster carers with whom the number of unrelated children in placement exceeded the standards
- record keeping, information governance, and due diligence when foster carers transfer from one area to another.

As a result of the level of non compliance with the standards, the chief operating officer of Tusla was also written to by HIQA regarding these concerns.

A response was received from the child care manager in relation to all cases escalated, and this included the assignment of a link social worker to all unassessed and unapproved relative carers, and assurances that a process had commenced to ensure An Garda Síochána vetting was completed and updated for all foster carers.

Due to the risks identified in February 2017, HIQA returned to the Cork Fostering Service Area in August 2017 in order to assess the implementation of the assurances and agreed actions provided by Tusla. A focussed inspection took place on the 30 and 31 August 2017. This inspection focussed on the risks identified in the previous inspection which included safeguarding and child protection, assessment and approval of relative carers, supervision and support, and reviews of foster carers.

The key activities of this inspection involved:

- the interrogation of data
- reviewing of policies and procedures
- the review of 36 foster carers' files
- interviews with two team leaders
- interview with a principal social worker
- telephone interview with chair of Tusla foster care committee.

3. Summary of inspection findings

The Child and Family Agency has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Children in foster care require a high-quality service which is safe and well supported by social workers. Foster carers must be able to provide children with warm and nurturing relationships in order for them to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

This report reflects the findings of the focussed inspection, relating to safeguarding and child protection, assessment, supervision and review of foster carers, which are set out in Section 5. In this inspection, HIQA found that the service was major non-compliant in the four standards assessed.

A principal social worker had been appointed to the Fostering Service six weeks prior to this follow up inspection. The principal social worker identified that on her appointment the priorities for the team were to address the level of risk identified on the previous HIQA inspection. Therefore the management team initially focussed on developing a process to ensure Garda Síochána vetting was completed and updated for all foster carers, including unassessed and unapproved relative carers. The principal social worker had also completed an audit of concerns and allegations made against foster carers. In addition, she had completed an audit of cases previously escalated by HIQA in order to ensure appropriate safeguarding measures were in place as required.

While some agreed actions had been taken to address other identified risks, inspectors found that the majority of actions had not been fully implemented in order to effectively reduce risks. Inspectors escalated 13 cases on this inspection to the child care manager to address the risks and concerns arising.

While the timeframe had not yet been reached for a number of actions to be implemented, there were some actions which had not been implemented within the timeframes identified by the area. For example, the service area had indicated that all 73 relative carers awaiting an assessment had been allocated a link worker, however this action had not been fully implemented and 42 relative carers remained unallocated. Furthermore Tusla identified that outstanding Garda vetting for all carers had either been completed or was being processed by the Garda Vetting Bureau. However inspectors identified relative carers who still did not have Garda vetting and this vetting had not yet been sent to the Garda vetting unit to be processed, by the time of this inspection.

Furthermore, not all foster carers had up-to-date Garda vetting. While a mechanism had been developed to reduce the numbers of foster carers without Garda vetting

and without up-to-date Garda vetting, there remained a significant number of foster carers without up-to-date Garda vetting. Of the approved foster carers 82 did not have up-to date Garda vetting and 72 adults living in the foster carers' home did not have up-to-date Garda vetting.

On this inspection, HIQA escalated 10 cases which related to relative carers and or adults living in the foster care home who had not had Garda vetting. Data provided by the service area identified that 27 relative carers did not have Garda vetting. In addition, nine adults living in the relative carers' homes did not have Garda vetting.

While there were immediate actions taken, as required, to ensure children were safe, not all child protection and welfare concerns or allegations about foster carers were consistently responded to in line with Children First (2011). Similar to the last inspection, records of the management of allegations were not evident on files. There was not always recorded evidence of strategy meetings, home visits or outcomes of investigations, following an allegation made against a foster carer. As a result, it was not always clear what decisions were made or steps were taken and whether they were in line with Children First (2011).

Since the last inspection, a formal system had been put in place to ensure the foster care committee was notified of child protection and welfare concerns and allegations. However, this system was in the early stages of development as the backlog of previously un-notified cases was being notified to the foster care committee.

There remained significant delays in the commencement and completion of relative assessments. At the time of the last inspection there were 73 relative carers who were awaiting assessment and who did not have an allocated link worker. Since the last inspection, two of those 73 carers had an assessment completed and one was awaiting approval from the foster care committee. While 33 relative carers had now being assigned a link worker and their assessment was ongoing, 42 relative carers were still awaiting an assessment, and had not been assigned a link worker, despite assurances provided in February 2017 that this action would be taken as a matter of priority.

As a result, children were placed for many months with relative carers who had not yet been assessed by the fostering department. There was no Garda vetting for some of these relative carers. Furthermore, safeguarding visits had not been completed for some of the relative carers. These findings were similar to the previous inspection and therefore continued to pose a risk to children placed. HIQA sought and received assurances that immediate action would be taken to ensure

that appropriate safeguarding measures would be put in place for these relative carers.

While the approved foster carers were allocated a social worker, the level of support and supervision varied and inspectors found that, in some instances, the frequency of home visits was not sufficient.

Since the last inspection, a training audit had been completed related to the number of foster carers who had completed Children First (2011). There remained a large number of approved carers who had not yet received Children First (2011) training. Furthermore, inspectors found that relative carers had not received training in Children First (2011). There was no record of training provided in safe care practices. The principal social worker indentified that there were a number upcoming Children First (2011) training events scheduled for 2017. Dates for training in safe care practices had not yet been scheduled.

While some steps had been taken to ensure foster care reviews were comprehensive and completed in line with regulations, this had not occurred in a timely manner. Inspectors sampled a number of reviews which had taken place since the last inspection and found that they remained of poor quality and were not completed in a timely manner in line with regulations. While the principal social worker had taken steps such as verifying review reports before they were submitted to the foster care committee to ensure they contained all information in line with regulations, these steps had only been taken since her recent appointment.

Since the last inspection, the Cork service area had also established an Alternative Care Governance Group. The primary function of this group was to oversee the delivery of quality assured alternative care services. In particular this group was established to track actions from HIQA inspections, to guide and support high quality services and to ensure the dissemination of learning. This group had convened their first meeting one week prior to this follow up inspection.

Following the inspection, HIQA wrote to the chief operating officer of Tusla regarding the risks which had been identified on the previous inspection that remained a risk on this inspection. While a response has been received from the chief operating officer, a further update will be requested in November 2017 in order to ensure the risks identified have been addressed.

Due to the level of non compliance indentified on this inspection, HIQA will request a further update from the area manager in three months, on the implementation of the action plan following the inspection in February 2017.

Theme 2: Safe and Effective Services

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs. In order to provide the care children require, foster carers are assessed, approved and supported. Each child receives the supports they require to maintain their wellbeing.

Standard 10: Safeguarding and child protection
Children and young people in foster care are protected from abuse and neglect.

Inspection findings under Standard 10:

The last inspection in February 2017 identified a major non-compliance in relation to safeguarding and child protection. In particular, the findings of the last inspection were as follows:

- child protection and welfare concerns or allegations about foster carers were not consistently managed and investigated in line with Children First: *National Guidance on the Protection and Welfare of Children (Children First)* (2011)
- appropriate safeguarding arrangements such as An Garda Síochána (police) vetting, home visits by link workers and case supervision were not in place for relative foster carers
- summaries of all home visits, whether by the child's social worker or the link worker, had not been activated in line with area policy
- Garda vetting was not updated for all foster carers within the required timeframe and the system in place to ensure updated Garda vetting was not effective
- there was no evidence that all foster carers with children in placement were trained in Children First (2011) and safe care practice
- there was no formal system for notifying the foster care committee of allegations against foster carers or of serious or adverse incidents in order to provide oversight of investigations that were carried out.

Inspectors found that not all actions to address the above identified risks were implemented since the last inspection. As a result, some of the issues identified on the previous inspection were also identified as a risk on this inspection.

An interim protocol for managing concerns and allegations of abuse and neglect against foster carers had been implemented in July 2017 by the fostering department. The majority of allegations reviewed by inspectors were reported before July 2017 and therefore the new protocol had not been used in these cases. While some staff told inspectors that the new protocol was clearer, they informed inspectors that they had not received training or briefing in this new policy.

Since the last inspection, there had been 10 child protection and welfare concerns reported against foster carers. Inspectors reviewed five of these concerns and found that records relating to the management of allegations and decision making were not contained on the case files. Therefore inspectors were unable to establish if they were managed appropriately, in line with Children First (2011). Inspectors spoke with social workers and were assured that while the actions taken were not recorded on files, action had been taken by the social work team to ensure children were safe.

As a result of the poor records on case files, inspectors found that it was not always clearly recorded whether a child was met with on their own by the investigating social worker. It was unclear whether initial assessments were required, as records did not include minutes of strategy meetings, and decisions made were not recorded on files. A sample review of case files by inspectors indicated that, on receipt of allegations, visits to children were not always carried out in a timely manner and it was not always evident that foster carers were interviewed on receipt of an allegation. The principal social worker told inspectors that since her appointment, which was six weeks prior to the inspection, she was ensuring that strategy meetings were held on receipt of allegations, and that the minutes of these meetings, and the decisions made, were recorded on foster carers' files. Inspectors found that this practice had been recently developed and had been implemented on two of the more recent investigations of allegations. However, given this deficit was highlighted on the last inspection, this practice had not been implemented in a timely manner to all files for whom there was investigation of an allegation.

While there was oversight by the principal social worker of the investigations of child protection and welfare concerns, not all gaps in records had been identified. Since the last inspection, the fostering management team had undertaken an audit of all child protection and welfare concerns and allegations against foster carers from the period from March to June 2017. However, inspectors found that not all gaps had been identified in these audits. Therefore, it was not evident how the principal social worker could be assured that the child had received a safe and effective service in

the absence of recorded interventions. The findings of this audit in relation to the gaps in records had not been discussed with the fostering team in order to promote learning among the staff.

At the time of the last inspection, the management team were not assured that a child would not be placed with a foster carer for whom there was an open allegation. While the foster care panel was updated, the team leader advised that there was no system in place to ensure that a child was not placed with a foster carer for whom there was an open allegation. On this inspection, inspectors found that the status of some foster carers had not been updated on the foster care panel where an investigation was ongoing. The principal social worker acknowledged that the panel may not always be updated on receipt of an allegation or concern against a foster carer. The principal social worker told inspectors that the placement officer was informed of any allegation made against a foster carer. However, the placement officer was rotated on a monthly basis. As a result, the service could not be assured that this system would ensure that a child would not be placed with a foster family while an investigation was ongoing.

Since the last inspection, a formal system for notifying the foster care committee of allegations against foster carers had been developed. The chairperson of the foster care committee was sent a register of all open complaints /allegations made against foster carers and any update regarding the assessment by the fostering and child protection team on the case. The foster care committee were informed on a monthly basis of the status of ongoing investigations in order to ensure effective oversight. The principal social worker told inspectors that they were in the process of notifying all previous allegations on the register due to the backlog of allegations to be submitted.

A new mechanism had been developed in order to ensure that foster carers had up-to-date Garda vetting. However, this system was not robust and was in the early stages of development. A tracker spreadsheet with the names of foster carers and the date of the most recent Garda vetting was in place. This tracker identified the foster carers who required updated Garda vetting. There was an administration staff member who had a monitoring role of the tracker of Garda vetting. However, inspectors found that unassessed relative carers and persons over the age of 16 living in foster care households were not indentified on this tracker. Inspectors reviewed a number of relative carer’s files and found that there was no Garda vetting on file, however this was not indentified on the tracker. Therefore, the new system for tracking Garda vetting for foster carers and relative carers was not accurate, reliable or up to date.

On the first day of inspection, the area provided inspectors with data regarding the status of Garda vetting. This data identified that 103 foster carers required up to date Garda vetting and there were 29 households where adults living there required Garda vetting. This data also identified that there were 37 relative carers and eight households where there were persons' over the age of 16 and or adults for whom Garda vetting had not been completed. However, during the inspection inspectors found discrepancies in the data provided and as a result following the inspection, HIQA requested that the data provided relating to Garda vetting be reviewed and resubmitted. Subsequent data received by the area indicated that there were 442 foster care households in the service area. Of this figure, 87 foster carers did not have up-to-date Garda vetting and 72 adults living in the foster carer's homes did not have Garda vetting. There were 27 relative carers where Garda vetting had not been completed. The principal social worker also identified that there were nine relative care households where there were adults living but they had not been Garda vetted. HIQA escalated the issue of the lack of Garda vetting to the chief operating officer of Tusla in order to address the risks arising from the number of foster carers who had Garda vetting still outstanding.

The principal social worker told inspectors that all foster carers had been sent out Garda vetting forms and she anticipated that these forms would be back in the coming months and that link workers had sent out a reminder letter to foster carers. However, given the risks indentified during the last inspection regarding children who were already placed with these carers, this was not a satisfactory or timely response.

There was a lack of adequate safeguarding measures for relative carers awaiting assessments and this posed as a risk to children. At the time of the last inspection, there were 73 relative carers awaiting assessment who had not been allocated a link worker. At that time, this issue was escalated to the child care manager who provided assurances that a link worker would be assigned to all relative carers awaiting assessment as a matter of priority. However, this action had still not occurred at the time of this inspection. While 33 relative carers were undergoing an assessment, 42 carers were awaiting an assessment and had no allocated link worker. While some of these carers were identified as a priority for assessment and had children placed with them for several months, they remained unallocated.

The principal social worker told inspectors that all carers awaiting an assessment had a home visit as part of the screening process. While screening was carried out for some relative carers, inspectors found that five relative carers had not received a home visit by the fostering service since they had a child placed with them. For example, in one case there was no evidence of a home visits on file while a child was placed with them for over one year. Furthermore, there was no evidence of

liaison with the child's social worker. Some of these relative carers had no Garda vetting on file. In one case, a relative carer did not have a home visit for a period of two years. In this case, an allegation had subsequently been reported in relation to the relative carers. This may have been identified at an earlier stage if safeguarding visits had occurred. HIQA sought and received assurances from the child care manager that home visits had been arranged as a matter of priority to address this risk.

On review of the remaining five relative carers awaiting assessment, there was evidence that they had a screening visit, however there were no further home visits to ensure the relative carers was being supported sufficiently. Inspectors found that while a number of these foster carers had screening visits and the quality of records of these home visits were good; some foster carers did not have a record of a further home visit since the child was placed with them. In one case, it was five months before a screening visit was completed. In some cases issues identified as part of the screening visits had not been followed up appropriately.

Not all foster carers were trained in Children First and safe care practices. The link social workers completed audits of their caseloads to identify foster carers who had completed Children's First (2011) training. Data provided by the social work department identified that there were approximately 50% of foster carers who had not received training in Children First (2011). Six dates had been indentified in order to provide Children First Training in 2017. However, inspector's found that there were also relatives awaiting an assessment who had not received training in Children First (2011), this that had not been indentified on this audit.

In addition, there were no records of carers' attendance at safe care training. A team leader told inspectors that link workers would ensure relative carers were informed of safe care practice while on home visits. However, some carers had not received a home visit and other relative carer records reviewed did not indicate that safe care practice was discussed. While the principal social worker advised that safe care practices were discussed at relative carers' information meetings, there were no records on files of relative carers attending information meetings.

Judgment: Non Compliant - Major

14b. Assessment and approval of relative foster carers
Relatives who apply, or are requested to apply, to care for a child or young person under Section 36 (1)(d) of the Child Care Act, 1991 participate in a comprehensive assessment of their ability to care for the child or young person and are formally approved by the health board.

Inspection findings under Standard 14:

At the time of the last inspection

- the arrangements and oversight in place to ensure pre-placement checks were carried out prior to placement of a child with relatives in an emergency were not sufficiently robust
- there were long delays in the commencement and completion of relative assessments
- there was insufficient oversight by the fostering unit of placements with relatives who were not approved by the foster care committee
- the due diligence process for foster carers transferring into the area was not adequate.

In response to the last inspection, the service area identified actions to address the above deficits. However, inspectors found that some of these actions had not been effectively implemented.

The arrangements and oversight in place to ensure pre-placement checks were carried out prior to the placement of a child with a relative remained insufficient. Once a child was placed with a carer the fostering department were notified of the placement and a request for an assessment was made. Pre-placement checks such as Garda vetting, reference checks and a screening home visit should be completed prior to a child being placed in their care. In response to the previous inspection the area outlined that no child would be placed with any potential carers, including relative carers, until the person had been fully Garda vetted.

However, there were significant gaps in pre-placement checks of relative carers. Inspectors sampled ten files where children had been placed with relative carers who were awaiting assessment. Inspectors found that the pre-placement checks such as verbal checks with the local Garda Siochána and public health nurse's, references and child protection checks were not completed prior to a child being placed with the carers. In five of these cases, there was no record of home visits completed by the fostering department. The principal social worker also confirmed that these visits had not occurred. As a result, there was no oversight by the

fostering department of these families in order to safeguard the children placed. In one of those cases a child had been placed with the carers for 10 months without a safeguarding visit. During this inspection, inspectors also found two relative care households where children had been placed, however the fostering team was not aware of these placements or how long those children were placed as there was no record of communication from the placing social worker or no request had been made for a relative assessment. HIQA sought and received assurances that actions would be taken to address the risks identified in relation to these placements.

There continued to be long delays in the commencement and completion of assessments. At the time of the last inspection there were 73 relative carers awaiting assessment. Since the last inspection in February 2017, only two of the 73 carers had been assessed, and of these only one had been submitted to the foster care committee for approval. Data received from the area identified that 33 of these assessments were ongoing at the time of inspection. The principal social worker told inspectors that two dedicated social workers had been assigned to complete the assessment of eight relative carers. These new staff had been assigned to focus specifically on relative assessments. However, the remainder of the assessments which were ongoing were assigned to link workers who also had a caseload of approved foster carers. Both the child care manager and the principal social worker acknowledged that assessments were not always completed in a timely manner, when the link social worker also had a caseload of approved carers that required support and supervision. Given the major non-compliance in relation to the supervision and support of foster carers during the last inspection, it is concerning that these assessments had been allocated to social workers who were unable to fulfil the requirements of supervision and support. These social workers told inspectors that some of the assessments which were identified as ongoing had not in fact started to date, due to their busy caseloads. In addition there were still 42 carers on a waiting list for assessment.

Appropriate safeguarding measures had been implemented for relative carers who had not been approved by the foster care committee. At the time of the last inspection, three cases were escalated where children were living with relatives who had not been approved by the foster care committee. The reasons why these three relative carers had not been approved varied, and the reasons were outlined in the files reviewed by inspectors. At the time of the last inspection, inspectors found that there was insufficient oversight by the fostering unit of these placements. On this inspection, inspectors found that all of these carers had allocated fostering link social workers and those social workers confirmed that there was oversight of the placements. However, records of safeguarding visits had not been updated on files.

At the time of the last inspection, adequate due diligence was not evident for foster carers transferring into the area from another service area. On this inspection, this issue had been resolved.

Judgment: Non-Compliant Major

Standard 15: Supervision and support
Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high-quality care.

Inspection findings under Standard 15:

At the time of the last inspection, the area was majorly non-compliant in this standard. In particular, the following deficits were identified:

- not all approved foster carers had an allocated link worker which resulted in a lack of sufficiently frequent home visits and support and supervision
- there were a significant number of foster carers that required deregistering but they remained on the approved panel of foster carers
- the quality of support to foster carers and the frequency of home visits were not always sufficient
- formal supervision of foster carers was not carried out in line with national policy
- there was a lack of case supervision for the link worker for the purpose of oversight of the frequency of home visits and the quality of support provided to foster carers
- there were no audits of files taking place and the quality of some record keeping and case notes was poor
- there was no dedicated out-of–hours service to support foster carers outside of the office hours.

Not all actions to address the above deficits had been implemented at the time of this inspection.

At the time of the last inspection, there were a number of foster carers who required de-registration from the foster care panel. These foster carers were not continuing to foster for various reasons. As a result of not removing these carers from the panel, there was a risk that children could be placed with them. Actions had been taken to address this deficit and these foster carers had been removed from the panel of approved foster carers as required.

Foster carers did not receive regular support visits or formal supervision. Since the last inspection, all approved foster carers had been allocated a link worker. However, the quality of support and supervision provided to foster carers and the frequency of home visits remained insufficient. Inspectors reviewed 24 files of general foster carers and relative carers. There was no evidence of formal supervision of foster carers as set out in the national policy on the role of a link worker. Inspectors also found that home visits to foster carers were infrequent. Furthermore on cases sampled there was limited evidence of liaison with the child's social worker. Some foster carers had home visits for the purpose of assessment or foster care review, however, there was no evidence of home visits prior to this. In a number of cases, link workers told inspectors that they had visited foster carers but they had not updated case notes to reflect the home visits.

Following the last inspection, the principal social worker advised that she would be meeting with all social workers to assess their current workloads. However, this had not happened since the last inspection. Furthermore, the child care manager also advised that home visits and support provided to foster carers would be monitored in supervision. Inspectors found that while some case supervision was recorded on file this was not evident on the majority of files sampled.

Inspectors found that while some of the case notes following home visits, for the purpose of assessment and screening of foster carers, were of good quality, there remained significant gaps in case notes and the frequency of home visits. The principal social worker identified that a schedule of monthly audits would take place in order to ensure full compliance with the National Standards. The principal social worker and the child care manager told inspectors that the social work team leaders would be completing an audit of case files both monthly and quarterly from September in order to identify any areas which required action.

There was no out of hour's service and this was being progressed at a national level by Tusla.

Judgment: Non – Compliant Major

Standard 17: Reviews of foster carers
Foster carers participate in regular reviews of their continuing capacity to provide high quality care and to assist with the identification of gaps in the fostering service.

Inspection findings under Standard 17:

At the time of the last inspection, significant risks were found in reviews of foster carers. At that time:

- comprehensive reviews of foster carers were not carried out in line with the Standards and the majority of foster carers had not had a foster carer review for more than three years
- standard reviews of foster carers were not always sufficiently comprehensive
- standard reviews were completed without Garda Síochána (police vetting), medicals and health and safety checks always being updated
- there was no system in place for following through on recommendations from reviews in a timely manner and not all recommendations had clear timeframes for their completion.

On this inspection, inspectors found that some steps had been taken since the appointment of the new principal social worker to address deficits in the review of foster carers; however these steps had not been taken in a timely manner. As a result, there was little progress made since the last inspection.

According to the Standards, the first review should take place one year after the first placement and subsequent reviews should take place at three yearly intervals. The purpose of a review is to assess the foster carers continuing capacity to provide high quality care. At the time of the last inspection of 517 foster carers on the panel 240 had not had a review for more than three years.

On this inspection, inspectors found that 32 foster carers had a review since the last inspection. Twenty four reviews were standard foster care reviews and eight reviews were additional following an allegation or serious concern about a foster carer. 159 foster carers had not had a review for more than three years.

A system had been developed in order to allow the fostering team to prioritise reviews; however this process was in the early stages of development. Since the last inspection, an audit and planning tool was being completed by all link social workers with respect to each foster carer's last review. The planning and audit tool identified when the foster carer's most recent review was completed and when a

review was due. This information would be used to inform the scheduling process for completion of reviews. However, a schedule for standard foster care reviews was still not in place at the time of this inspection.

The child care manager indentified that a dedicated foster care review post would be in place in quarter three of 2017 to ensure that the backlog in reviews was addressed and to maintain the ongoing review of foster carers going forward. However, this post had not been filled to date. It is of concern that there was a lack of timely action to address this major non-compliance since the last inspection.

Both the principal social worker and team leaders told inspectors that they were prioritising special reviews which were to be completed following a concern or allegation against foster carers. Following this, they will begin to complete standard three yearly reviews for foster carers and these will be prioritized based on the time since the previous reviews.

The quality of standard reviews continued to require improvement. While steps had been taken to ensure reviews were comprehensive, these steps were not taken in a timely way. Inspectors reviewed six standard reviews. Team leaders chaired the review meetings which were attended by link workers and foster carers. Similar to the last inspection, inspectors found that standard reviews did not contain all the information required. Reviews continued to be completed despite Garda vetting pending for the foster carer. The foster care review report did not always reflect the voice of the child. Inspectors also found that reviews did not always consider any concerns or allegations made against foster carers or a change in the foster carer's circumstances.

Similar to the previous inspection, not all information relating to the standard review was provided to the foster care committee for approval. A summary review report was signed off by the team leader. Inspectors found that the practice of furnishing a synopsis of the reports and recommendations continued to be sent to the foster care committee therefore, they did not have effective oversight of reviews completed.

The principal social worker told inspectors that she was implementing a new system since her appointment to the fostering team. The principal social worker had oversight of reviews prior to them being sent to the foster care committee. Inspector's reviewed two recent reviews and found that this practice was occurring to ensure all required information was included in the review report which was also forwarded to the foster care committee. The chair of the foster care committee also acknowledged that this process had started occurring. However, steps had not been taken by the service area in a timely manner, prior to the appointment of the principal social worker.

There was no system in place for following through on recommendations from reviews in a timely manner. The chair of the foster care committee acknowledged

that the fostering team were still in the process of developing a system of tracking recommendations from the foster care committee to ensure that they are implemented.

Judgment: Non – Compliant Major