Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

10 YEARS OF REGULATING AND MONITORING

CHILDREN'S SOCIAL CARE SERVICES

2014 - 2024

Artwork

During the summer of 2024, HIQA held an art competition for children and young people. Children and young people designed a poster on the theme of ‘Hear my voice’, and the care and support they receive from social services..

Many great entries were submitted. The winner of the competition was a 15-year-old who receives care in a children’s residential centre. Their artwork is on the front cover of this report.

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.
- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Visit www.hiqa.ie for more information.

About the Chief Inspector of Social Services

The Chief Inspector of Social Services within the Health Information and Quality Authority (HIQA) (referred to in this report as 'the Chief Inspector') is responsible for registering and inspecting designated centres in Ireland.

The functions and powers of the Chief Inspector are set out in Parts 7, 8 and 9 of the Health Act 2007 (as amended) (from now on referred to in this report as 'the Act').

The Chief Inspector currently regulates designated centres for:

- older people
- people with disabilities
- special care units for children.

The role of the Chief Inspector includes inspecting and monitoring a range of services for children. This is achieved through desktop inspection of information received from the provider about centres, on-site inspection in centres and ongoing assessment of compliance by the provider with relevant regulations and national standards. The regulations and standards in effect for children's services are as follows:

- Health Act 2007 (as amended)
- Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017
- Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations 2018
- Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017
- Child Care Act 1991
- Child Care (Placement of Children in Residential Care) Regulations 1995. Statutory Instrument No. 259
- Child Care (Placement of Children in Foster Care) Regulations 1995. Statutory Instrument No. 260
- Child Care (Placement of Children with Relatives) Regulations 1995. Statutory Instrument No. 261
- *National Standards for Children's Residential Centres 2018*
- *National Standards for Special Care Units 2015*
- *National Standards for the Protection and Welfare of Children 2012*
- *National Standards for Foster Care 2003.*

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Foreword from the Chief Inspector of Social Services

Carol Grogan, Chief Inspector of Social Services

I am pleased to present this overview report which describes our experience of inspecting children's services, provided by or funded by the Child and Family Agency (Tusla) over the past decade. When Tusla came into being in 2014 as an independent agency responsible for the care and welfare of children, the country was still emerging from the global financial crisis. Austerity measures were limiting the resources available for health and social care services which was a challenge for service providers.

Significant changes have been made since 2014. The majority of services have become more focused on the rights of the child — listening to them and encouraging them, along with their parents, to be actively involved in decisions about their lives. As an organisation, HIQA has promoted children's rights through our monitoring programmes. Over time, we have found improvements in the quality of care and support provided for children in all types of settings — from more child-centred practice, such as enabling children to decorate their bedrooms in residential care, to the improvements in the physical environment of residential centres and better engagement with family members. Similarly, we have found significant improvements for the majority of children in foster care, whose needs are appropriately assessed, and improved supports for foster carers both in statutory and non-statutory foster care services.

Nonetheless, as set out in this report, there are continued challenges in the sector, specifically around adequate , appropriate staffing and ensuring that children get the right service when they need it. Children have consistently told us over the years that it is critically important for them to be able to build trusting relationships with the staff they interact with and that changes in social worker can be difficult for them. Similarly, parents tell us of the importance of having an allocated worker to assist in supporting their children.

It is widely acknowledged that in addition to the staffing issues, Tusla is currently facing other challenges. These include being able to provide a child protection service in a timely way to all children and a range of suitable care placements for

children. Tusla has endeavoured to ensure that those children assessed at highest risk have an allocated social worker to work with them and their families and it has reduced the number of children on waiting lists since 2014. However, there are still significant waiting lists in some services and Tusla is challenged in meeting its target time frames in dealing with all referrals. Our inspectors have found that there is a significant shortage of appropriate residential (including special care) and foster care placements for children who require care. This has resulted in some children living in unregulated special accommodation arrangements, which is of significant concern. Most children in care live in foster care, and one of the greatest challenges facing Tusla is the shortage of available foster families. Due to this shortage of placements, matching children to appropriate foster carers in their own local communities has not been possible in some cases.

On reflecting over the past 10 years, it is clear that significant work has been completed since 2014, but more is required to ensure that children's services can deliver for the diverse needs of our children and young people now and into the future. In HIQA we will continue to support Tusla to strive for improvements in services and also to reflect on how we, as a regulator, can improve how we work.

As an organisation, we have advocated for policy and legislative changes that we feel will improve and strengthen the social care system for children and young people in Ireland. I look forward to continuing to work closely with officals in the Department of Children, Equality, Disability, Integration and Youth, other Government Departments, Tusla and non-statutory foster care providers on progressing this agenda over the coming years.

I want to thank all of the children, parents, foster carers and staff who have met with us over the years and contributed to our work. I want to especially acknowledge the children who took part in our recent art competition. The winning entry is on the cover of this report.

Carol Grogan
Chief Inspector of Social Services
Health Information and Quality Authority

Executive summary

Introduction

This report presents an overview of the monitoring and regulation of children's social services provided by the Child and Family Agency (Tusla) and those non-statutory foster care services commissioned by Tusla from 2014 up to 2023. Information on our inspection programme for 2024 is included in Appendix 1.

While the Health Information and Quality Authority (HIQA) was founded in 2007 and has monitored children's social services since then, Tusla was founded in 2014 to deliver social services.

HIQA monitors child protection and welfare services, foster services and Tusla children's residential centres (CRCs). The Chief Inspector of Social Services within HIQA regulates special care units. Other than special care units, HIQA does not have any powers of enforcement to help bring about required improvements, and instead must rely on reporting inspections findings, monitoring compliance plans and escalating any significant concerns to the appropriate government department or Minister for Children, Equality, Disability, Integration and Youth.

Over the past 10 years, HIQA has observed a range of improvements across Tusla services and Tusla has been responsive to inspection findings. Many positive initiatives have been implemented by Tusla over the last decade ranging from the expansion of family support services to implementing national models of practice in child protection and welfare and residential services, which has provided for more standardised work completed with children and their families. Alongside these positive changes, Tusla services have experienced a huge increase in demand since 2014, with referrals to its child protection and welfare services doubling in that time span. Significant changes have occurred in our society over the last 10 years, including changes in family stuctures, a global pandemic and an increase in the complexity of cases being referred to Tusla. Unforeseen events, such as the war in Ukraine and other war torn countries has lead to an increase in the demand for Tusla services, including an increased demand in recent years for supports for new communities including supports for families in International Protection Accommodation Service (IPAS) centres and placements for unaccompanied children (children under 18 years who come to Ireland on their own).

Despite these societal changes, there has been a steady decrease in the number of children being received into the care of Tusla. This is likely due to Tusla trying to keep more children in the family home and out of care, wherever possible. Nonetheless, the pressure on services comes as Tusla is challenged with shortages of appropriately qualified staff, and an increased demand for their services which includes increasing numbers of children with complex needs. Positively, over the 10-

year period Tusla has consistently provided a good service to children assessed at immediate risk and has reduced the overall number of children waiting for child protection services. However, there is further work required in some specific services to further improve the timeliness and quality of service provided to children.

Another key challenge for Tusla is the availability of adequate numbers of placement options for children. There are not enough foster carers to meet the needs of children and young people and, at the time of publication, Tusla, despite on-going recruitment campaigns seeking foster carers does not have available an adequate number of alternative care (either children's residential centre or special care unit) placements to meet the demand for these services. This has resulted in some children in care being accommodated in inappropriate and unregulated special emergency arrangements, some for lengthy periods.

This report follows the pathway of a child's journey through care in the sequencing of the chapters. This typically begins when a child first comes into contact with local child protection and welfare services. For the vast majority of children in Ireland, their cases are referred because they, and their family require support in order to remain in the care of their parents or extended family members. A much smaller proportion of children however, cannot be safely cared for in their homes. In these circumstances, they are received into the care of the State either by the consent of their parents or through a decision of the courts. As such, this report details HIQA's work in child protection and welfare services, followed by foster care, children's residential services and special care units. Our key findings are presented in each chapter and these includes governance and safeguarding amongst others specific to the service type. Over the years, HIQA has found that good governance is central to the delivery of safe and effective services, and findings in relation to governance are included in each chapter in this report. Safeguarding children is at the core of every child protection service and this is discussed throughout the report. The report also reflects what children have told inspectors about their experiences over the past 10 years.

Child protection and welfare services

Overall, our inspections have found that Tusla has made incremental improvements in its ability to meet the *National Standards for the Protection and Welfare of Children*. There are better policies, practices and procedures in place, and there is much better use of technology, all of which have helped to improve services for children. Crucially, the majority of children assessed at the highest risk are receiving good quality services. However, despite significant investment in services, persistent challenges remain.

Over the years, HIQA has placed a sustained focus on governance in child protection and welfare (CPW) services through our inspections and by conducting a review and

a statutory investigation, which drove gradual improvements in governance arrangements. There is evidence that a more consistent approach to governance has emerged and a practice of shared learning across service areas within regions. Additionally, some cross-regional initiatives have also started to emerge. However, there remain areas where governance needs to be further strengthened.

HIQA's statutory investigation into the management of allegations of child sexual abuse against adults of concern recommended that a thematic quality improvement programme of inspection would be devised in consultation with key stakeholders which focused on two risks identified by the statutory investigation namely – screening and preliminary enquiries of referrals and safety planning. The programme also focused on initial assessments completed by social workers alongside the governance of the service. Inspections resulted in an improved quality of services for children in the community. Areas for improved governance were identified, such as Tusla's adherence to its own time frames for the management of referrals and standardising practices in relation to wait list management as there was no national policy in place. In recent years, HIQA has also undertaken inspections of specific areas of the child protection system in line with other recommendations of the statutory investigation, trends from information received from Tusla and unsolicited information which gave rise to concern. This included focused inspections of services for children on the child protection notification system (CPNS); separated children seeking international protection (SCSIP); and the Child Abuse Substantiation Process (CASP). Improved governance was identified as required in areas such as procedures for staff, risk management, quality assurance and management oversight.

Due to persistent and increasing risks in some CPW services during the period 2019 -2023, HIQA in consultation with Tusla made the decision to implement a risk-based programme of inspections focused on the provider's response to risks nationally in 2023. Tusla was requested to develop a national improvement plan, which was implemented at national, regional and local service levels. Tusla's CPW and or foster care services with 25% or more children without an allocated social worker met the criteria for the programme. An overview report outlining the findings from this risk-based inspection programme will be published in 2025.

Foster care services

HIQA has seen many improvements in both statutory and non-statutory foster care services across the country. These include improved ways for reviewing voluntary care agreements in statutory services; improvements in procedures for maintaining up-to-date police vetting on all foster carers and relevant adults; and more frequent and better quality reviews of foster carers in line with the requirements of the national standards. There have, however, been some ongoing challenges for Tusla

foster care services, particularly around recruiting, assessing and retaining sufficient numbers of foster carers to meet the needs of children, this has often resulted in children waiting to come into care or to move to a long-term foster care placement.

In general, non-statutory foster care services were well-run and resourced, and found to be providing good quality services. Nevertheless, some earlier inspections found similar failings to those seen in statutory (Tusla) foster care. For example, supervisory visits in some instances were not always timely and there were inconsistencies with access to link social workers for foster carers. In recent years, HIQA has found that the governance of both statutory and non-statutory foster care services has improved considerably, leading to better, safer and more stable placements for children and young people.

Children's residential centres

Throughout the last decade, inspections of Tusla Children's Residential Centres (CRCs) have noted an evolving and expanding profile of the circumstances and experiences of children accessing residential services. For instance, the number of separated children seeking international protection and in the care of Tusla has increased in recent years. The number of young people requiring higher levels of staff support or specialist services has also increased. This changing profile of children requiring care has impacted the capacity of some residential services to operate at full occupancy, thus reducing the number of available placements for children requiring residential care in the community. It has also impacted Tusla's ability to retain staff within some CRCs nationally.

When HIQA began inspections of CRCs operated by Tusla in 2014, management and oversight practices varied greatly, and poor governance and safeguarding practices were identified. In the past few years, inspections have found greater uniformity across the country in relation to governance and oversight of these services. There is evidence of improved systems for monitoring services at a local, regional and national levels. Similarly, safeguarding and child protection practices have improved and children are receiving nurturing, safe care. In a minority of centres, there was evidence that leadership structures were severely challenged and managerial systems were not being implemented consistently or effectively.Tusla has implemented a model of practice which has enabled it to measure outcomes for individual children who avail of their residential services and this is a very welcome development.

Similar to foster care services, capacity challenges exist in residential services in terms of lack of onward or suitable placement for many children and young people with highly complex needs.

Special care units

Special care units are high-security residential centres for children aged 11 to 17 years, where children cannot leave them voluntarily or without permission. Children and young people who are placed in special care receive therapeutic and educational supports in each unit. All special care units in Ireland are operated by Tusla and must be registered by HIQA's Chief Inspector. Due to the ongoing and persistent staffing challenges faced by Tusla, two out of the three special care units in Ireland have not been in a position to operate at full capacity since 2018. This has been a significant challenge in an environment where Tusla referrals are consistently increasing and young people that are in need of a special care unit placement cannot access a service.

More recent inspections of the three special care units between 2022 and 2023, have identified inconsistency and variation in the management and governance of their services, while there have also been issues with the quality of some of the premises. In 2023, the Chief Inspector took escalation action in two special care units to address poor findings on governance. In these cases, Tusla responded promptly and effectively and demonstrated a governance system that accepts findings of non-compliance and actively pursues means by which it can come back into compliance. All three special care units were re-registered by the Chief Inspector in 2024.

Working with our partners and future challenges

In developing the oversight framework for the children's services, HIQA and the Chief Inspector have worked closely with key stakeholders and interested parties over the years. HIQA has always endeavoured to consult with children and families using services, as well as advocacy groups, health and social care professionals, Tusla and non-statutory providers. HIQA has also engaged widely with the Department of Health and the Department and Minister for Children, Equality, Disability, Integration and Youth, their respective ministers, and other government departments.

Currently, the Chief Inspector in HIQA only has enforcement powers for special care units. Foster care and children's residential centres require similar regulation in order to help progress improvements in these services. It was envisaged that HIQA's role would grow to include the formal regulation of all types of children's residential centres, as Tusla services represent only 18% (37 of 201 CRCs) of such services. However, at the time of publication, despite an increasing number of children living in inappropriate, unregulated care arrangements, the regulation of children's residential centres has not been commenced and is with the Department for consideration.

In terms of focusing on outcomes, a key requirement is that national standards follow a child's pathway of care and support through the range of services they may use. Therefore, HIQA and the Mental Health Commission have developed draft overarching national children's standards to focus services on supporting a child's journey through children's health and social care services. Once approved, along with the current regulatory framework and other proposed supporting national standards for children who use social services, they will support providers to achieve the best possible outcomes for children. We look forward to progressing all of these important developments in the best interests of children.

Chapter 1: Introduction — Setting the scene

1.1 Introduction to regulation of children's services

When the Health Information and Quality Authority (HIQA) was established in 2007, it subsumed the former Social Services Inspectorate (SSI) and inspected statutory foster care services, special care units and statutory children's residential. HIQA inspections of child protection and welfare services began in late 2012 (when they were then being provided by the HSE), while a formal programme of inspections of non-statutory foster care services commenced in 2014.

This report focuses on 10 years (2014–2024) of HIQA oversight of children's services provided and non-statutory foster care agencies commissioned by the Child and Family Agency (Tusla), which was set up on 1 January 2014. This overview report focuses on the inspections of the following services set out in Figure 1 below.

Figure 1. Services monitored by HIQA and regulated by the Chief Inspector

Monitored by HIQA	Regulated by the Chief Inspector
Statutory and non-statutory foster care	**Special care units**
Child protection and welfare	
Statutory children's residential centres	

1.2 Setting up of HIQA

Oversight of children's social care services continued and was broadened with the establishment of HIQA on 15 May 2007 as part of the Government's overall Health Reform Programme. The 2001 Health Strategy — which had proposed the creation of HIQA to drive the quality agenda at national level[1] — had also stated that the SSI would be established on a statutory basis and its remit extended to include residential care for people with disabilities and older people.

1.3 Establishing the Chief Inspector within HIQA

The former SSI, interim Health Information and Quality Authority and the former Irish Health Services Accreditation Board (IHSAB) were all integrated into HIQA on its establishment in May 2007, with staff from the three bodies transferring across.

[1] Department of Health and Children. Quality and Fairness: A Health System for You: Health Strategy. Dublin: Government of Ireland; 2001, page 88.

The former SSI was given expanded functions and powers in the establishment of the Chief Inspector for Social Services within HIQA.[2]

HIQA and the Chief Inspector fulfil their statutory obligations set out in the Health Act 2007 (as amended) and other legislation under the stewardship of the Chief Inspector. HIQA's role with respect to children's social care services is to promote ongoing quality improvement through monitoring of national standards — which comprises the vast bulk of the monitoring and oversight work. The role also involves the regulation of special care units in order to provide safe and effective care and support to children, in addition to promoting quality improvement through the *National Standards for Special Care Units*.

Figure 1 (above) describes those Tusla services that are monitored or regulated and registered by HIQA or the Chief Inspector. Monitored services are inspected and reported on publicly against approved national standards. HIQA has no legal enforcement powers to compel action in the event of significant risk being identified through monitoring of these services.

Regulated services (special care units are the only type of children's service that are regulated in Ireland by the Chief Inspector[3]) must be registered with the Chief Inspector. There are a range of legal enforcement powers available to the Chief Inspector in the event of significant risks being identified through inspection or monitoring of these regulated services, up to and including prosecution or cancellation of registration.

In the context this report, Tusla and non-statutory providers of foster care services are the focus of this report.

1.4 Profile of Tusla services monitored or regulated by HIQA or the Chief Inspector

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency, or Tusla, which is overseen by the Department of Children, Equality, Disability, Integration and Youth.

Tusla is a statutory agency with responsibility for protecting children and promoting their welfare. It also provides and funds care placements for children who cannot live at home. Tusla has responsibility for a range of services, including the following which are monitored by HIQA or regulated by the Chief Inspector:

- Child protection and welfare services

[2] Annual Report 2007 Health Information and Quality Authority.
[3] In addition to regulation of special care units by the Chief Inspector, Tusla regulates pre-school services and crèches, and also registers non-statutory children's residential centres.

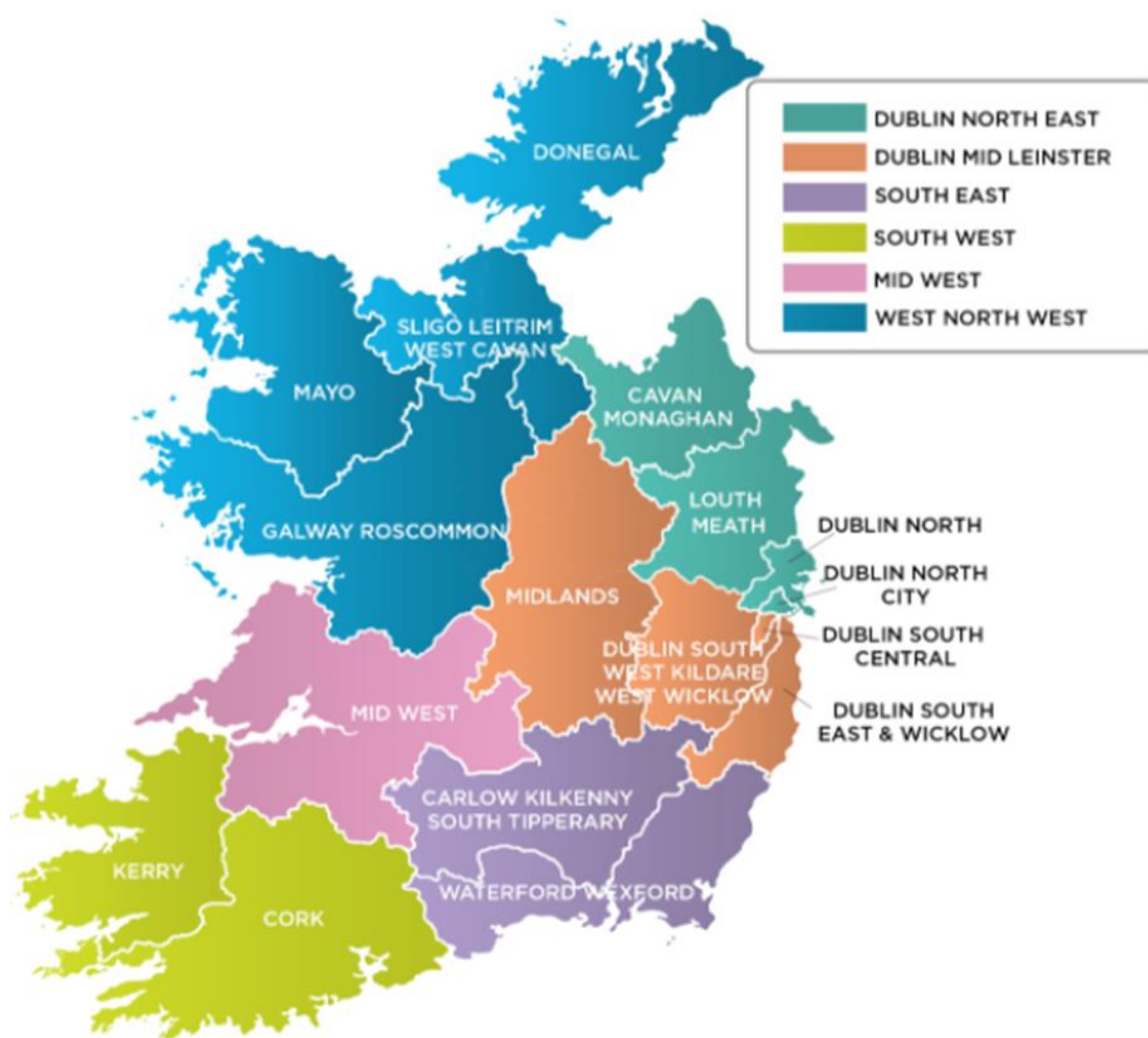
- Children's alternative care services:
  - foster care
  - residential care
  - special care.

Statutory children's residential care and special care services are managed by a national children's residential services (CRS) team which manage all placements including admission and discharge of all children in these services. Each service has local managers and regional or service-specific external managers all of whom report to a national director for children's residential services. The national director of CRS reports to the national director of services and integration, who is a member of Tusla's executive team.

Tusla's child protection and welfare and foster care services are organised into 17 service areas and are managed locally by area managers, who in turn report to six regional chief officers as set out in Figure 2. The regional chief officers also report to the National Director of Services and Integration.

In addition, Tusla also operates some national teams and teams at regional level. For example, there is a national out of hours social work service, CPW and foster care services for separated children seeking international protection, regional foster care recruitment teams and regional child abuse substantiation procedures (CASP) teams.

Figure 2. Tusla's service areas*



*Map source: Tusla website https://www.tusla.ie/.

1.5 Non-statutory foster care services

Tusla commissions other foster care agencies (non-statutory foster care agencies) to provide foster care placements for children in their care. In 2024, five foster care agencies are operational in Ireland – these are the Orchard Fostering Services, Fostering First Ireland, Five Rivers Ireland, Foster Care Ireland and Origins Foster Care.

These services have their own governance arrangements and are contracted by Tusla to provide foster care placements and or to complete fostering assessments on behalf of Tusla. Tusla retains responsibility for the children placed with non-statutory providers, but the responsibility for the foster carers sits with the individual provider. Tusla is responsible for the formal approval of all foster carers through its foster care committees. The non-statutory foster care agencies are required to

adhere to relevant standards and regulations when providing a service on behalf of Tusla. Both services are accountable for the care and wellbeing of children.

For more information on these services, see the individual chapters on child protection and welfare, foster care, children's residential services and special care.

1.6 Legal framework for inspection and monitoring

Each children's service has its own statutory framework that gives HIQA and the Chief Inspector the authority to monitor and inspect the service, using standards and or regulations that set out what is expected from the service. Table 1 (below) shows the statutory framework for each type of children's service monitored or regulated by the Chief Inspector in HIQA. This provides an overview of the regulatory and legislative authority HIQA has for each of the services, operated or commissioned by Tusla and therefore included in this report.

Table 1. Overview of regulatory and legislative authority

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Child protection and welfare services	Monitored under Section 8(1)c of the Health Act 2007 (as amended)	Health Act 2007 (as amended)		***National Standards for the Protection and Welfare of Children*** **(HIQA, 2012)**
Foster care services	Regulated and monitored under Section 69 of the Child Care Act 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act 1991 (as amended)	Child Care (Placement of Children in Foster Care) Regulations 1995 Child Care (Placement of Children with Relatives) Regulations 1995	***National Standards for Foster Care*** **(Department of Health and Children, 2003)**
Special care units for children and young people	Regulated and monitored under Section 41 of the Health Act 2007 (as amended)	Health Act, 2007 (as amended)	Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations 2018[10]	***National Standards for Special Care Units: November 2014*** **(published 2015) (HIQA)**
Children's residential centres	**Regulated and monitored under Section 69 of the Child Care Act 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011**	**Child Care Act 1991 (as amended)**	**Child Care (Placement of Children in Residential Care) Regulations, 1995**	***National Standards for Children's Residential Centres*** **(HIQA, 2018)**

1.7 Structure of this report

The chapters in this report are sequenced in a way that follows the same pathway a child or young person may follow when they require support from social services. This typically follows an established pattern, whereby the circumstances in a child's life and or their family result in concerns for their safety or welfare being brought to the attention of the local child protection and welfare service. This service is responsible for screening the case and determining the next steps. At all times, a child remaining in the care of their family is the key priority for services. When it is safe, it is preferable that a child remains in the family home with supports put in place in order to address the concerns that brought them and their family to the attention of child protection and welfare services in the first place.

Where it is not possible to keep a child in their home or where this is not considered in their best interests, a decision may then be made to take a child into care either with the consent of the parents or by court order. For the majority of children coming into care in Ireland, this means being placed in foster care and for many, these foster care placements are with relatives or people well known to their family. However, for some children, a placement with a foster family — either known to them or not — may not be their best option or indeed may not be available. For these children, the next level of support is a children's residential centre. Finally, those children and young people who require a higher level of support and typically have more complex needs may need to be accommodated in a special care unit for their own safety.

This report will focus on several key areas to highlight how children's lives have been impacted by the ongoing monitoring and regulation of children's services. Chapter 2 provides an overview of key data and our regulatory approach between 2014 and 2023. Chapter 3 focuses on child protection and welfare services. Chapter 4 reports on our experience of monitoring foster care services. Chapter 5 looks at children's residential centres. Chapter 6 provides an overview of special care unit regulation, and chapter 7 looks at the voice of children. Chapter 8 describes how we have engaged with a range of stakeholders over the past decade. Finally, chapter 9 reflects on the current and future challenges facing the regulatory framework in place to ensure a good quality of life for children using services and for those children in need of protection by the State.

Chapter 2: 10 years of oversight of children's services

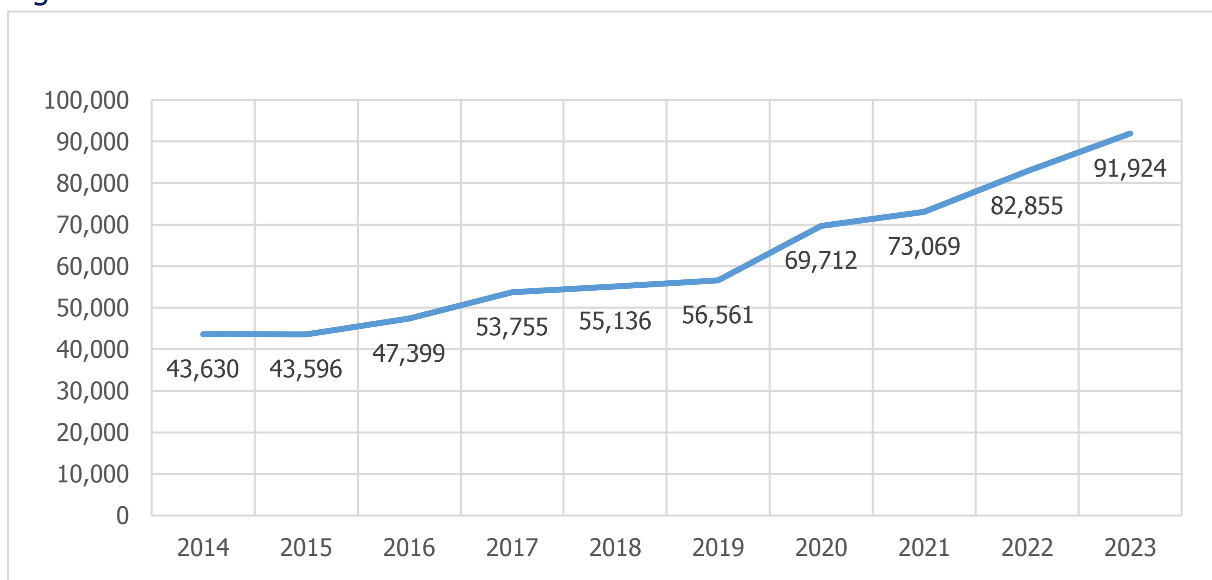
This chapter outlines some of the key statistics from the past 10 years which have informed HIQA's monitoring and regulation of Tusla services.

2.1 Data and information

Tusla submits validated data to HIQA on a quarterly basis and also makes data available to the public on a monthly, quarterly and annual basis. This data details certain statistics relating to services Tusla provides. This includes figures relating to number of referrals to their child protection and welfare services as well as numbers of children in care. Published data and information also include details relating to Tusla's compliance with some statutory requirements. For example, it reports on the numbers of children with an allocated social worker and those with an up-to-date care plan.

Statistics, which are key to the story of HIQA's monitoring of Tusla services over the past 10 years, include the sustained increase in the number of referrals received by Tusla's child protection and welfare service. These referrals provide some insight into the national picture with respect to vulnerable children as well as the increasing demand for Tusla's services. It is important to note that an increase in the number of referrals can have multiple causes and may actually indicate a positive development. For example, it may be that there is a greater level of awareness among certain professions, as well as the general public, of their responsibility to report concerns about children to Tusla. Nonetheless, the sustained increase places ongoing demands for services etc

Figure 3. Number of referrals to Tusla between 2014—2023



Source: Tusla Annual Reports

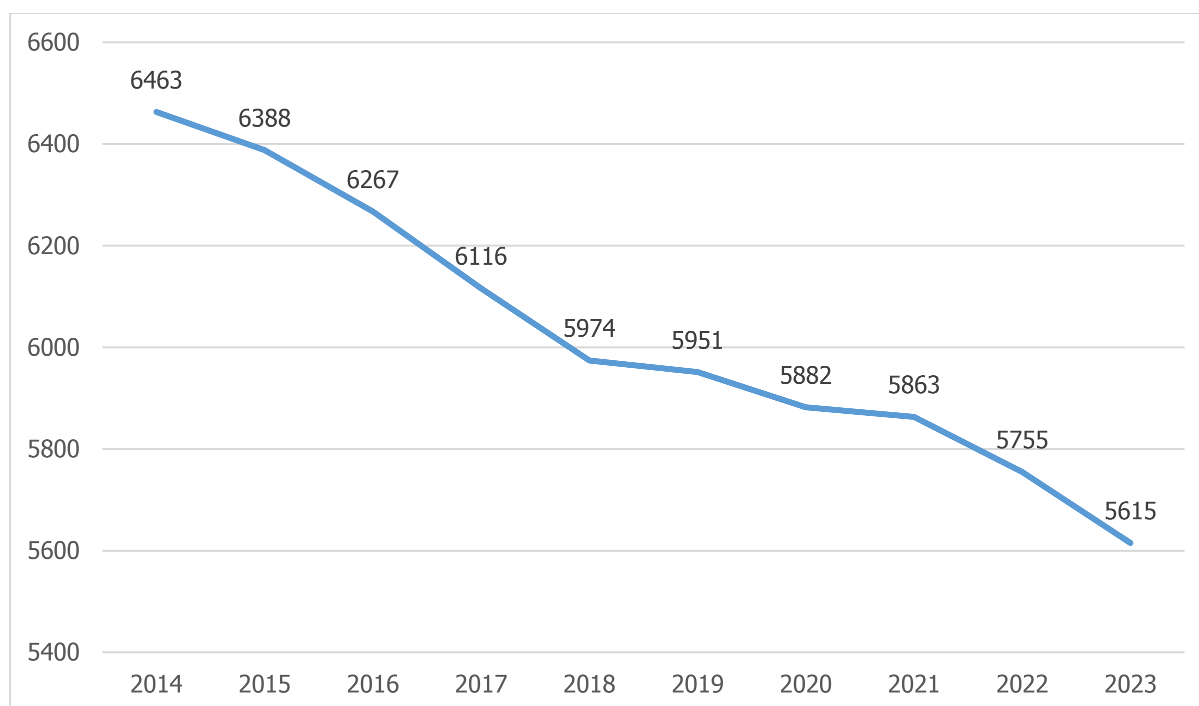
The data in Figure 3 shows that referrals to Tusla have increased year-on-year between 2014 and 2023. It is important to note that prior to 2020, Tusla did not include data in relation to referrals received that did not meet the threshold for a service and were, therefore, closed. From 2020 onwards, the counting of all reports of concern provides a more accurate account of activity and demand on child protection and welfare services but it has some implications for making comparisons with earlier years

In examining the data, it is difficult to determine what are the key causal factors in terms of the rise in referrals. Clearly, it is possible that the number of children requiring intervention may have increased. Similarly, it may be the case that increased awareness of legal reporting responsibilities, particularly those under the Children First Act 2015, may have led to an increase. Nevertheless, increases in referrals places additional demands on the resources of Tusla and its ability to effectively respond to all children and families who require supports. Data indicating significant increases in referral to child protection and welfare services may also inform HIQA's monitoring approach of inspectors.

Other key data published by Tusla relates to children in care. Examples of specific data which is analysed by inspectors on a routine basis includes: the number of children in care, the number of children without an allocated social worker and the number of children without an up-to-date care plan. This data can provide information to inspectors on the impact of service risks such as vacant social work posts, that impact directly on children in receipt of those services.

As stated previously, the vast majority of children in care are placed with foster families, while a smaller number are looked after in children's residential services and special care units. Data reported by Tusla over the past 10 years tells us that the number of children being received into the care of the State has declined steadily, despite the increase in referrals to CPW services.

Figure 4. Number of children in care between 2014-2023



Source: Tusla Annual Reports

Similar to the increase in CPW referrals, the reasons for the decrease in children being received into care during the same period are varied and complex in nature. One contributing factor worth noting is Tusla's introduction of a national approach to practice in child protection and welfare services in 2017,[4] whereby there was a renewed focus on trying to keep children safe within their families and communities and prevent the need for their receipt into care. HIQA inspections have found that this approach to practice has resulted in a growing number of children remaining in the care of their parents or extended families, with family-led safety plans in place.

2.2 Inspections

HIQA conducts both announced and unannounced inspections. Some inspections are announced in advance, with the notice period varying between 10 and 20 days, depending on the type and nature of the inspection. Others are unannounced, and inspectors show up to a service without prior notice in order to conduct an inspection.

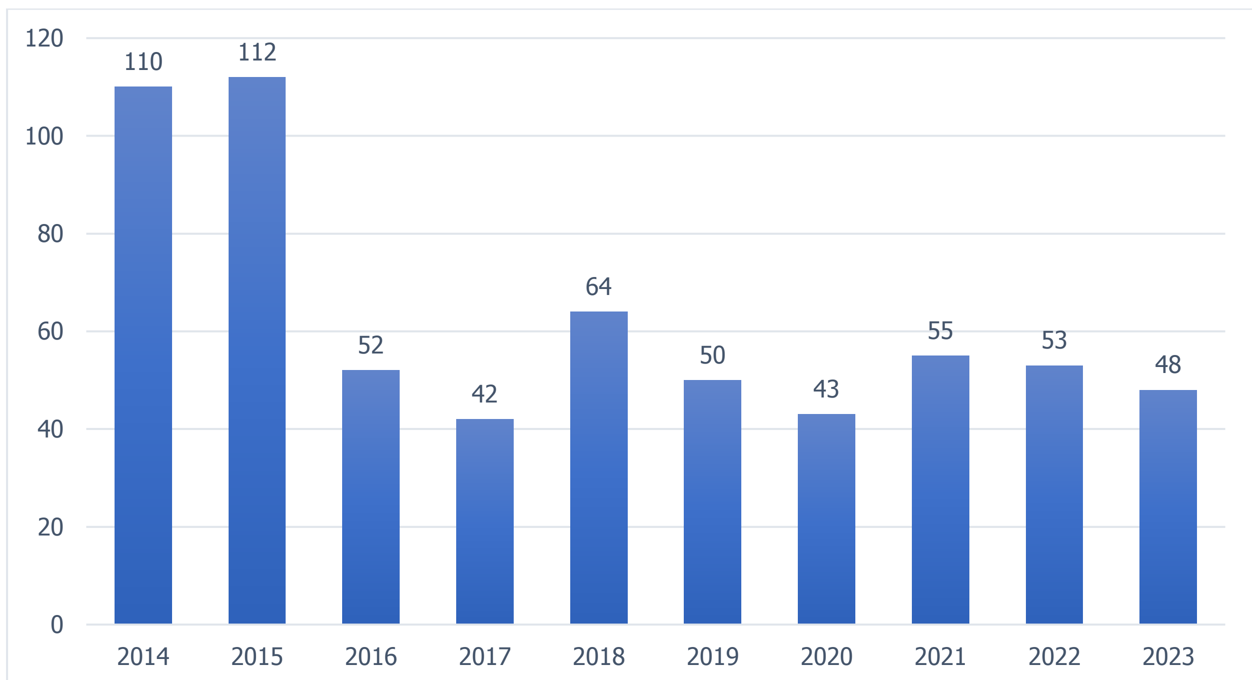
Announced inspections allow time and opportunity for Tusla teams to prepare for our arrival, enabling the services to provide data and information before our arrival and to inform children and their families of the inspection. The announcement period also enables inspectors to make arrangements to meet with staff, children, parents

[4] Tusla.ie — Child Protection and Welfare Strategy 2017-2022.

and foster carers if they so wish, so that their views can be considered as part of inspections.

Figure 5 (below) shows the number of inspections carried out each year since 2014. Table 2 (below) provides a breakdown of the inspections that took place in each of the various services. It is of note that during COVID-19, it became necessary to announce more inspections so as to ensure public health measures could be observed.

Figure 5. Number of inspections conducted by HIQA between 2014 and 2023



Note: the higher inspection numbers for 2014 and 2015 are due to HIQA's children's inspectors conducting inspections of designated centres for children with disabilities, which were then part of its remit. Since 2016, inspectors of disability services inspect residential centres for children with a disability. Fewer inspections in 2017 reflect the focus on the statutory investigation that was then being conducted, while 2020 data reflects the impact of the pandemic. Numbers of inspections from January – October 2024 are illustrated in Appendix 1.

Table 2. Breakdown of inspections by type of service between 2014 and 2023

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Child protection and welfare services	5	3	3	2	1	7	9	12	10	10
Statutory foster care	5	2	4	16	13	11	6	7	9	7
Non-statutory foster care	1	2	3	0	7	1	1	5	2	6
Children's residential centres	21	23	39	21	38	18	20	26	20	20
Special care units	3	4	3	3	5	4	5	3	5	5
Children's disability services*	75	78	0	0	0	0	0	0	0	0
Placement of children in residential care regulations, 1995^	0	0	0	0	0	8[#]	0	0	6	0
Service area inspections[#]	0	0	0	0	0	1[#]	2	2	1	0
Total	**110**	**112**	**52**	**42**	**64**	**50**	**43**	**55**	**53**	**48**

[*] HIQA was responsible for inspection of designated centres for children with disabilities in 2014 and 2015. These were provided by other service providers and not by Tusla. This responsibility subsequently transferred to another dedicated HIQA team in 2016. A breakdown of inspections completed between January-October 2024 are listed in appendix 1.

[^] S.I. No. 259/1995 - Child Care (Placement of Children in Residential Care) Regulations, 1995.

[#] These programmes of inspection of social work services for children in care against the requirement of these regulations. These programmes of inspection were specifically to review the regulations associated with the social work role, that is to say, visiting the child, care planning and child-in-care reviews.

Inspections of children's services vary in type and focus and typically fall into one of four categories; monitoring inspection, focused inspection, thematic inspection or risk-based inspection. In addition to these four types of inspection, regulation inspections which typically look at compliance with regulations and inform a decision on the registration of a designated centre, are conducted routinely as required, within the three special care units.

Monitoring inspections are undertaken to monitor the level of compliance against the relevant national standards and or regulations in a particular service, and they make up the majority of the work of inspectors.

Focused inspections concentrate attention on a particular area of service provision. A focused programme of inspections may be designed based on a particular area of concern or consistent non-compliance with national standards and are aimed at improving practice related to the area of focus on a wider scale.

Thematic inspections are undertaken by HIQA at times when a particular area of practice is targeted for monitoring and improvement. Thematic programmes of inspections are developed with engagement from all stakeholders on the purpose and aim of such programmes in advance of implementation. Examples of focused and thematic inspections are referenced throughout this report where relevant to a particular service.

Finally, risk-based inspections are undertaken in response to indicators of risks within a service. Risk-based inspections have been undertaken in Tusla services for a number of reasons including, as a result of data and information analysis by inspectors indicating risks that require review or closer scrutiny or on foot of information received by HIQA from a member of the public which would indicate risks requiring inspection. Details of some risk-based inspections are outlined in various sections of this report.

2.3 Unsolicited receipt of information

HIQA regularly receives information from members of the public who wish to report a concern about a health or social care service. Work is guided and informed by information received from members of the public. Such contacts are called 'unsolicited receipt of information'. Unsolicited information received from the public gives a valuable perspective on services or centres.

When unsolicited information is received in relation to a children's service it is risk-rated by the inspector to determine what regulatory action is required. While HIQA has been handling unsolicited information received from members of the public throughout the last 10 years, data in relation to individual children's services monitored and regulated have been collated in more detail over the last five years,

since 2019. In this five-year period a total of 403 individual contacts have been received in relation to children's services. Figure 6 below shows the number of items of unsolicited receipt of information received by HIQA between 2019 and 2023 and Figure 6 shows a breakdown of the number of contacts by concerned persons received per service type, over this five year period.

Figure 6. Unsolicited receipt of information between 2019–2023

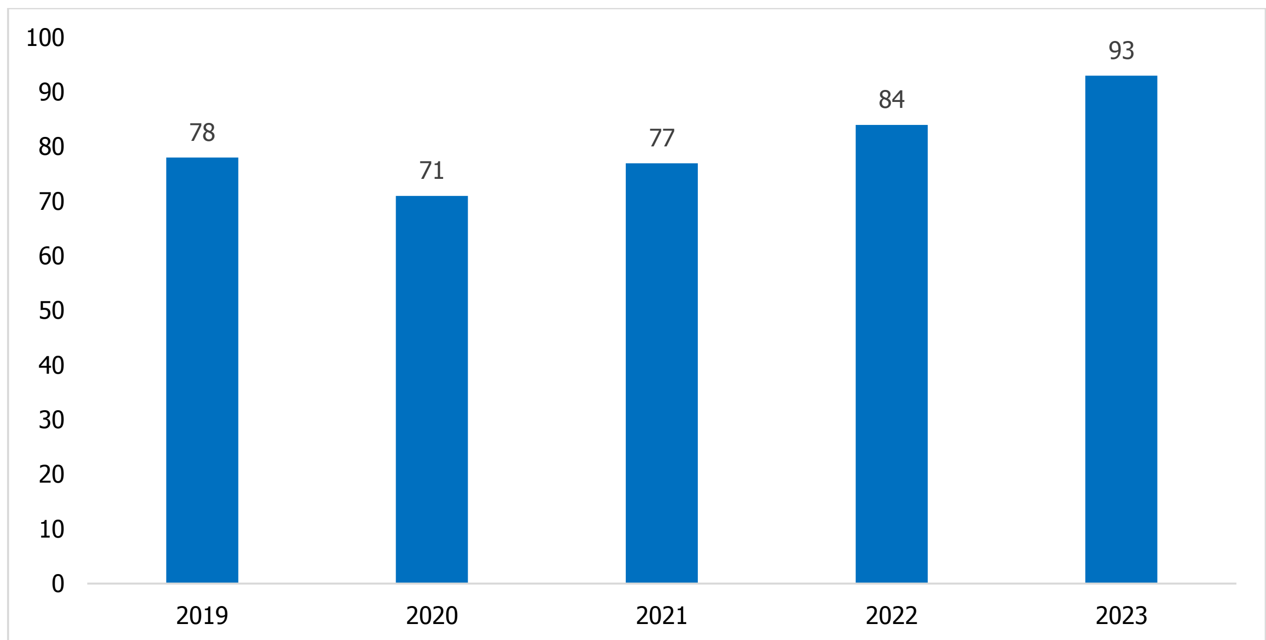
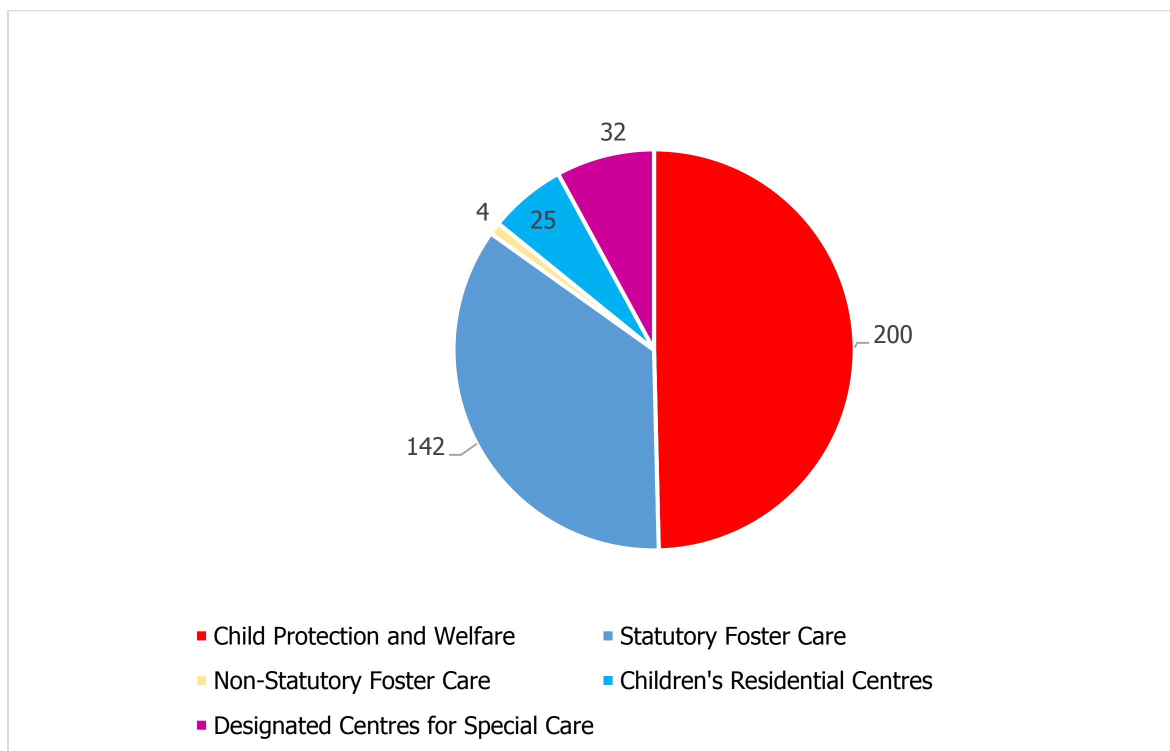


Figure 7. Unsolicited receipt of information per service type between 2019–2023

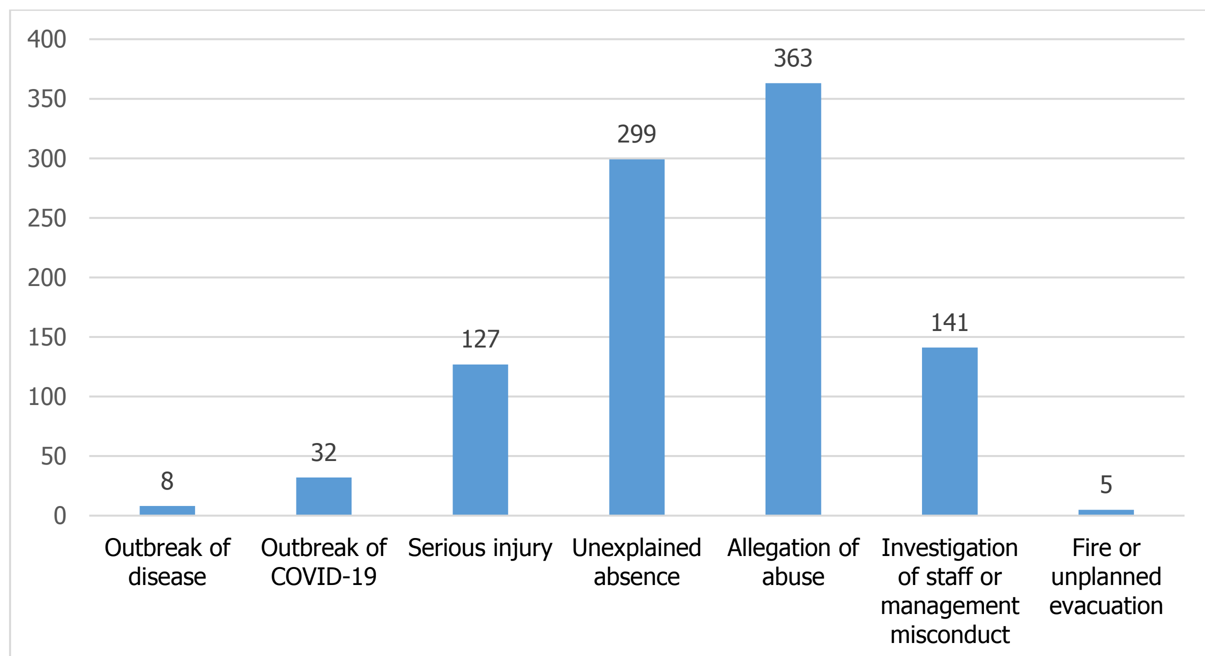


While data indicates a slight increase year-on-year since 2020, (see Figure 7 above), no significant spikes or trends are indicated. However, the volume of information received in relation to each service does reflect the numbers or volume of individuals in contact with or in receipt of Tusla services. For example, information relating to child protection and welfare services is consistently the highest amongst all services monitored and regulated by HIQA.

2.4 Statutory notifications from special care units

In addition to publicly available and published data and information related to Tusla services, there is a requirement on Tusla to submit certain information to HIQA on a routine basis. In regulated services, the Chief Inspector receives regulatory notifications from Tusla's three special care units. The regulatory requirement to notify the Chief Inspector of certain incidents in special care has been in place since the commencement of regulation of special care units in 2018. Figure 8 (below) shows the total number of regulatory notifications received since the commencement of regulation of special care units until the end of 2023.

Figure 8. Statutory notifications received from special care units between 2018–2023



While notifications of allegations of abuse were the highest across all of the notification types (363 notifications), it should be noted that such notifications include instances of suspected or confirmed abuse, including allegations of abuse disclosed by a child during their time in special care and reported to have occurred prior to a child's admission. Notifications of unexplained absence were the second largest type received. These are typically instances where a young person leaves a special care unit without permission or where they fail to return from a planned outing.

Upon receipt of such notifications, there is a standard process within HIQA which all inspectors must follow. This process involves inspectors reviewing the information and risk rating the notification. All notifications are risk-rated within three days of receipt and follow up action is taken where appropriate. Examples of follow-up actions vary greatly and decision on action required are based on all known information and risks pertaining to a service. Examples of actions include; seeking further details or assurances from a provider or conducting a risk-based inspection.

Overall, the vast majority of all regulatory notifications, following review by inspectors, are considered to be low risk. This risk rating would indicate that the service had responded appropriately and the matter reported has been satisfactorily resolved.

2.5 Notifications from Tusla's child protection and welfare and foster care services

Tusla notifies HIQA of any deaths and or serious incidents involving children known to their services. These notifications must be sent within three days of the incident or death occurring.

Notifications received relating to death or serious incidents involving children known to these services are managed in the same way as outlined above. Inspectors review and risk rate each notification and make a decision on a course of action to be taken to address any risks indicated.

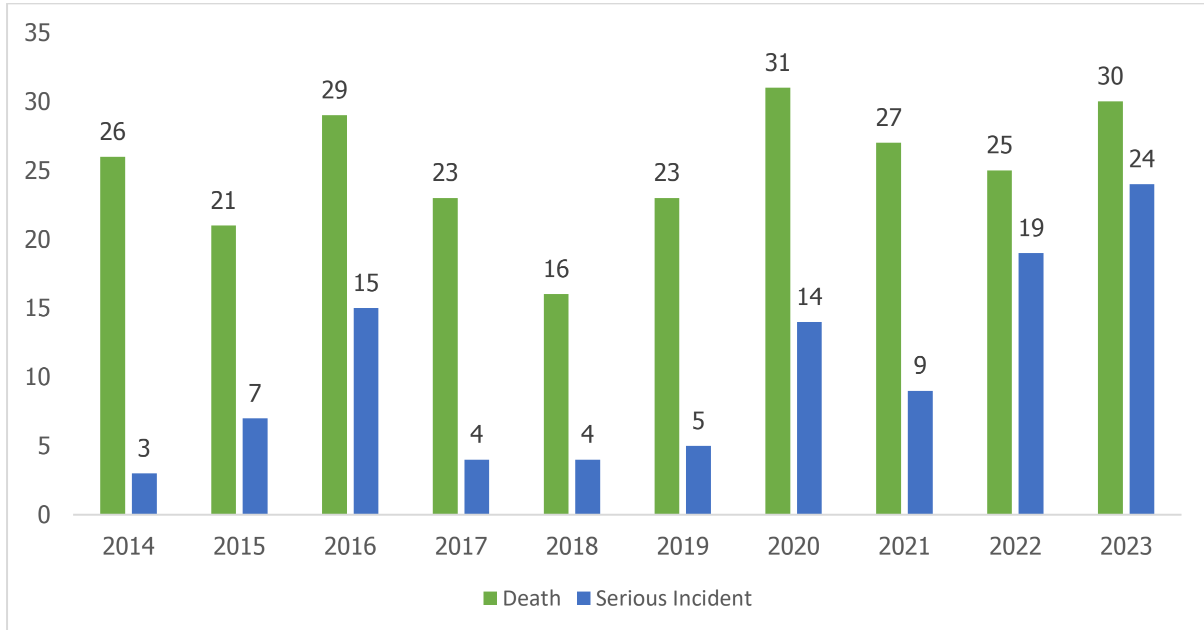
At times, the notification of a death or serious incident relating to a child known to Tusla services requires urgent action by inspectors. For example, if a notification indicates risk to additional children, inspectors may seek assurances that action has been taken to protect these children. At other times, more direct and immediate action by inspectors is required, an example of which is outlined below.

Example of how notifications influence our work and shaped improvements by Tusla

In September 2019, HIQA received a copy of a local review which was undertaken by a service area in response to a serious incident relating to a child on the Child Protection Notification System (CPNS). The CPNS is a national secure database, containing the names of children who have been assessed by Tusla as being at ongoing risk of significant harm and for whom there are ongoing child protection concerns. Following a review of that report, HIQA sought assurances from the service area manager in relation to management of all children on the CPNS and the response was not satisfactory. As a result, HIQA undertook an inspection of the service areas' management of children on the CPNS who were subject to a child protection safety plan and the aligned governance arrangements. The

findings of this inspection, which are outlined in greater detail in the relevant section of this report, identified significant risks related to children on the CPNS, which resulted in Tusla changes and improving practice in this area over the following two years.

Figure 9. Notifications of serious incidents involving children known to child protection and welfare services, including the deaths of children in care



2.6 Regulatory action in response to non-compliance

All types and categories of inspections of Tusla services by HIQA — child protection and welfare, foster care, children's residential centres and special care units — identify the level of compliance of the services with the relevant national standards and or regulations being inspected against. HIQA's inspection reports make a judgement in relation to the level of compliance of a service with the relevant national standards and or regulations being inspected against. We use 'compliance descriptors' to describe levels of compliance. These descriptors are sub-divided into the current classifications of compliant, substantially compliant and not compliant. Different descriptors were used in the past, such as 'met, met in part or not met' or 'exceeds standard, meets standard, requires improvement or significant risk identified'. At the time of this report, the descriptors are defined as follows:

Compliant: a judgment of compliant means the service is meeting or exceeding the standard and or regulation and is delivering a high-quality service which is responsive to the needs of children.

Substantially compliant: a judgment of substantially compliant means that the service is mostly compliant with the standard and or regulation but some additional action is required to be fully compliant. However, the service is one that protects children.

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

2.6.1 National service improvement programme

In 2019, in response to a trend of non-compliances and repeated poor findings on inspection of particular services by HIQA, Tusla's Chief Operations Officer put in place service improvement plans in four of its service areas (a fifth area had such a measure put in place in 2018).

These plans were effective in bringing about incremental improvements in areas of greatest risk. However, these improvements were not sustained and by 2021, inspectors identified further risks requiring additional measures to further improve service delivery. Between 2021 and 2023, monitoring activity by HIQA identified continuing, and in some cases escalating, levels of significant risk in three out of the five areas. As HIQA has no enforcement powers in the majority of services provided by Tusla, where there are significant risks, HIQA brings these risks to the attention to the Department of Children, Equality, Disability, Integration and Youth.

2.6.2 New approach to monitoring at-risk services in 2023-2024

Following a risk-based service area inspection of the child protection and welfare services service in one of the areas that had been subject to a national service improvement plan, in April 2023, HIQA escalated the child protection service to the Department of Children, Equality, Disability, Integration and Youth. This matter was brought to the attention of the Department due to the ongoing challenges in addressing persistent and escalating risks seen during this monitoring inspection. In

addition to this, ongoing monitoring of Tusla's published metrics indicated escalating risks across Tusla services nationally. Through ongoing analysis of data, it became evident that substantial numbers of children in care did not have an allocated social worker and increasing numbers of children referred to the child protection and welfare services were waiting significant periods of time for these vital services across the country.

Following internal discussions and discussions with Tusla, HIQA decided that a different approach was required to monitor these services and HIQA commenced an escalated risk provider programme in August 2023. The criteria for inclusion in this programme were defined as those services that had 25% or more of children in child protection and /or foster care services unallocated (that is to say, without a named social worker assigned to a case). HIQA requested Tusla's CEO and executive team to devise a national improvement plan focused on reducing waiting lists and achieving sustained improved compliance against relevant national standards. Monthly meetings chaired by HIQA and attended by representatives of Tusla's executive management team, other key local and regional Tusla managers, and HIQA staff, were scheduled to begin alongside inspections of these services in early 2024. Tusla presented updates on the progress of its national, regional and local service plans at these meetings. The provider approach programme is ongoing at the time of publication.

Chapter 3: Child Protection and Welfare Services

3.1 Regulatory framework for child protection and welfare services

As outlined previously, Tusla was established on 1 January 2014 following the commencement of the Child and Family Agency Act 2013. This legislation provided for the delivery of child and family services by one agency for the first time in Ireland. Tusla became an independent legal entity, merging child and family services of the Health Service Executive (HSE), Family Support Agency and the National Educational Welfare Board.

The Child Care Act 1991 (as amended) is the primary legislation governing child care in Ireland. It imposes a duty on Tusla to identify and promote the welfare of children who are not receiving adequate care and protection. Therefore, any instance where a child is deemed to be at risk of abuse or neglect, or where there are concerns about their care and welfare are required to be reported to Tusla's child protection and welfare services, who are responsible for their management.

3.2 Regulatory framework for child protection and welfare

The first dedicated national policy framework for Tusla was the *National Policy Framework, Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People (2014–2020)*[5] published by the then Department of Children and Youth Affairs. This was a whole-of-government national policy framework for children and young people,[6] which built on the previous national children's strategy covering 2000 to 2010.[7] The 2014–2020 framework was intended to provide a clear, comprehensive statement setting out how the nation intended to achieve the best for children, young people and families.

Children First: National Guidance for the Protection and Welfare of Children (first published in 1999 and revised in 2011 and 2017)[8] promotes the protection of children from abuse and neglect. This national guidance outlines what different statutory and non-statutory bodies, and the general public, should do if they are concerned about a child's safety or welfare. The Children First Act 2015 put elements

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[5] Gov.ie — Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People, 2014-2020. From Department of Children, Equality, Disability, Integration and Youth.

[6] whatworks.gov.ie — Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014 – 2020. Department of Children, Equality, Disability, Integration and Youth.

[7] The *National Children's Strategy (2000–2010), Our Children – Their Lives*, identified a series of objectives to guide children's policy over the 10-year period. This was the first strategic document by a government which stated that vulnerable children's lives required a coherent and common child protection and welfare approach.

[8] Children First: National Guidance for the Protection and Welfare of Children. Dublin: Department of Children and Youth Affairs; 2017.

of Children First on a statutory footing.[9] Following its enactment, Children First guidance (2011) was revised in 2017. Section 14 of the Children First Act 2015 requires mandated persons to report a mandated concern[10] to Tusla 'as soon as practicable'. Mandated persons are people, predominantly key professionals, who work with children and or their families, in various youth and child care sectors, who by virtue of their qualifications, training and experience, are in a key position to help protect children from harm. HIQA routinely reviews the implementation of Children First guidance during inspection of children's services.

As is evident from chapter 2, from December 2017, the introduction of this legislation led to a sharp rise in referrals to Tusla. Further details on this can be seen in referral data and information illustrated within this chapter.

Other additional key pieces of complementary legislation designed to improve child safety and protection include:

- Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012
- National Vetting Bureau (Children and Vulnerable Persons) Acts, 2012 to 2016.[11]

3.3 National Standards for the Protection and Welfare of Children

In 2012, HIQA published the *National Standards for the Protection and Welfare of Children* and HIQA initially monitored the HSE against the standards (because child protection and welfare services had originally fallen under the HSE's remit) and since 2014 has monitored Tusla's child protection and welfare services. HIQA monitors Tusla's performance against national standards. The standards outline Tusla's responsibility to provide adequate care and protection to children, under legislation and national policy such as:

- Child Care Act 1991
- Children Act 2001
- the Child and Family Agency Act 2013
- Children First Act 2015

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[9] HIQA. Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs: 14 June 2018. Dublin: HIQA; 2018, page 232.

[10] As a mandated person, under the Children First Act 2015 you are required to report any knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed, or is at risk of being harmed. See the mandated person's page on Tusla.ie.

[11] Tusla.ie — Children First Guidance and Legislation.

- Children First guidance.[12]

HIQA also reviews and risk-rates information it receives from the public and has the legal power to conduct a statutory investigation when it is deemed necessary and appropriate.[13]

3.4 Overview of child protection and welfare services

Child protection and welfare (CPW) services are of critical importance for the safety and welfare of children. It is often their first point of contact with a social worker and the first opportunity for the service to provide safety and protection in the event that the child requires this. Any person who has reasonable grounds for concern that a child may have been, is being, or is at risk of being abused or neglected should always inform Tusla or An Garda Síochána (police) of their concerns. In addition, since December 2017, mandated persons are legally obliged under the Children First Act 2015 to report any knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed, or is at risk of being harmed.[14]

This chapter will proceed with a focus on several key themes, related to the delivery of a safe and effective child protection and welfare service, which we have consistently reported on throughout the last 10 years of monitoring and inspecting. These are:

- inspection activity and overview of findings from past 10 years
- governance
- thematic and focussed inspections of CPW services
- staffing
- risk management
- the impact on children or the lived experience for children requiring a service or in receipt of a CPW service.

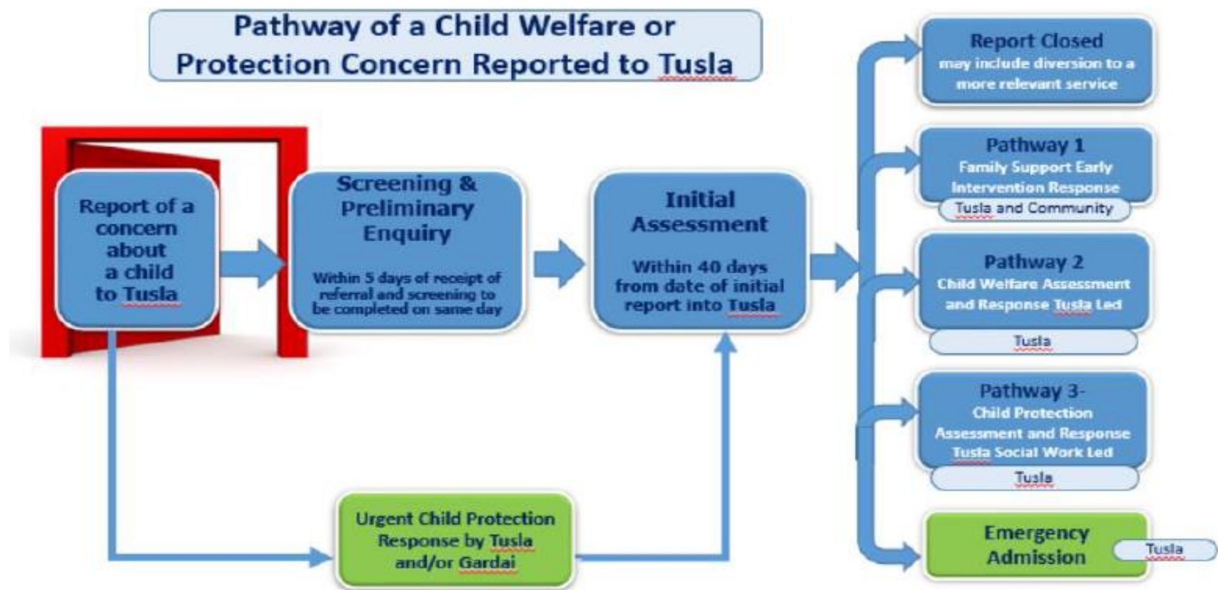
[12] Standard 3.1 of the 2012 *National Standards for the Protection and Welfare of Children* states: 'The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.'

[13] HIQA. Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs: 14 June 2018. Dublin: HIQA; 2018, page 42.

[14] Tusla.ie — How do I report a concern about a child?

3.5 Tusla Standard Business Process for Child Protection and Welfare

Figure 10: Tusla Standard Business Process for Child Protection and Welfare



3.6 Inspection activity 2014–2023

HIQA has carried out 66 inspections of CPW services in the years between 2014 and 2023, with the majority of these inspections occurring over the last five years. Each inspection involves a team of up to four HIQA inspectors visiting a CPW service engaging with staff, children and families and examining documents over three to four inspection days.

As outlined in this report, over that 10-year period, we have found that Tusla has made gradual improvements to meet the *National Standards for the Protection and Welfare of Children* in many aspects of the services. When one compares the findings of inspections and an investigation that took place over the period 2014 to 2018 to more recent inspections in 2021 and 2023, recurring and persistent challenges remain in some service areas. Despite substantial efforts to address non-compliances and major investments in services, Tusla has been unable to recruit and retain a sufficient number of social workers, social care workers or support staff to sustainably operate its CPW services. As a result, thousands of referrals to CPW services, including hundreds of high-priority referrals, regularly do not have a named social worker assigned to them (Figures 11 and 12). The unmanageable caseloads for social workers in some CPW teams is compromising their ability to ensure children's safety is maintained and that risks to their safety are effectively managed.

Figure 11. Number of cases allocated and unallocated, from 2014 - 2023[15]

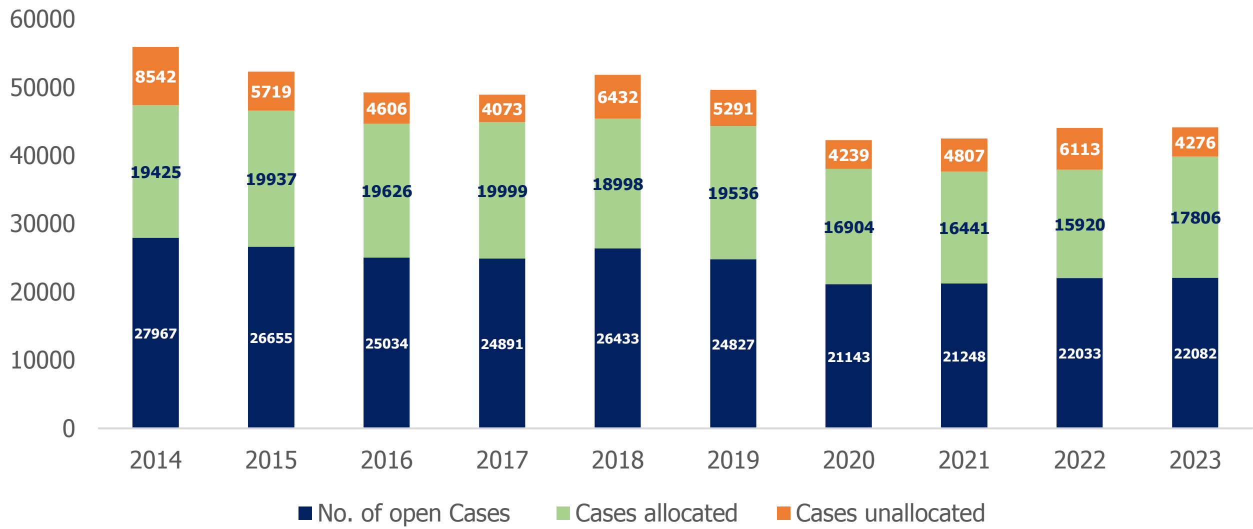
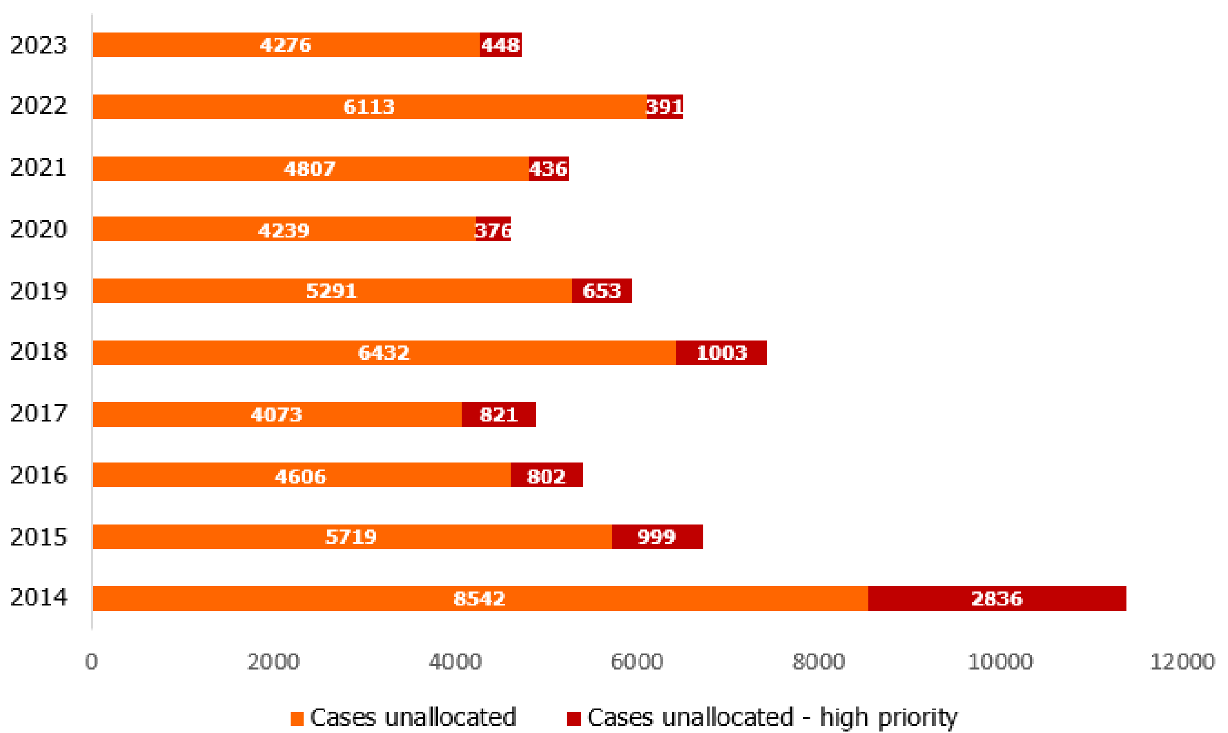


Figure 12. Unallocated including, high priority unallocated cases 2013-2023



[15] Tusla annual report 2023 and review of adequacy reports 2023

3.7 A snapshot of our experience of child protection and services 2014–2023

Tusla's remit is to support and promote the development, welfare and protection of children along with supporting families in their care of children. Its establishment in 2014 was a key milestone as, for the first time, one single agency was responsible for the protection of children. The Child and Family Act 2013 sets out the key responsibilities of Tusla which include offering care and protection to children in circumstances where their parents cannot. It also is responsible for placing the best interests of the child at the core of decision-making, along with working with other agencies to effectively safeguard children. Through our work with Tusla, it is evident that all grades of staff and management seek to put children at the centre of their practice on a daily basis so that children are safeguarded. This section follows Tusla's progress in child protection services.

In the early years, Tusla achieved much success in prioritising and managing significant risks for those children identified most in need of social work supports and services. Children at immediate risk received a timely service and emergency action was instigated to protect children when required. By 2017, inspectors found improved levels of compliance relating to notifications of abuse to An Gardaí Síochána and many areas were successfully reducing waiting lists for allocation to a social worker.

Inspections between 2016 and 2019 consistently reported that Tusla CPW teams effectively prioritised referrals for allocation to a social worker to those children at greatest risk. Children were quickly referred for child protection conferences and child protection plans were promptly agreed and of good quality, for children listed on the CPNS. Increasing participation by children and their families in decisions about their care became a key feature of day-to-day practice within Tusla's CPW services throughout the early years of inspection. By 2019 inspectors identified significant improvements in the quality of initial assessments, children were routinely seen and there was evidence of improvements in analysis of risks informing decisions on social work responses to referrals, something that was consistently reported to have been lacking from initial assessments, in the initial three years of inspection of CPW services.

Following reports of delays in screening and completing preliminary enquiries to Tusla CPW services in some service areas in 2015 and 2016, by 2019, although five-day time frames for completion had not been achieved, much improvement was noted by inspectors in the quality of screening and preliminary enquiries to assess the level of risk and category of abuse of each referral received by CPW services. Tusla restructured its child protection and welfare teams in 2019 and this was identified as a key action influencing improvements on the timeliness of screening of

referrals to CPW services. Action to divert referrals not requiring social work response was improved and inspectors found that social workers were promptly identifying the need to agree safety arrangements for children where required while initial assessments were ongoing, or indeed while children awaited initial assessments by a social worker.

For example, a self-assessment submitted to HIQA in September 2019 by one child protection service identified the requirement for significant improvements within their service.[16] A quality improvement plan was developed by the service area itself with the aim of achieving compliance with national standards. At the time of inspection of this service in 2020, inspectors found a high level of compliance. The area's quality improvement plan was at an advanced stage and governance structures in place supported the delivery of a good service to children and families. They were found to be proactive and responsive to risks to children right from the point of initial reporting of a concern to Tusla, through to the completion of an initial assessment.

In mid-2019, HIQA welcomed the development of a national guidance document on safety planning by Tusla. However, while the impact of this guidance saw a more consistent approach to safety planning across services, it did not effectively ensure that safety plans were monitored as required in all cases, nor that all children who required a safety plan had one. It is of note that at the time of report, these are risks which continue to be identified within CPW services.

Additionally, between 2018 and 2019, a national approach to practice in child protection and welfare and the National Child Care Information System (NCCIS), were introduced. NCCIS, at the time was a significant development for Tusla as this integrated ITC system replaced manual paper-based systems, as well as various ICT systems inherited from the HSE, on the establishment of Tusla in 2014.

Inspections of CPW services from 2019-2021 found continued improvements in a number of areas, however, an ever-increasing pressure on demand for services presented significant challenges to CPW services nationally. Despite this, Tusla CPW teams reported a quality improvement focus and inspections found services were determined to achieve goals set down in action plans devised in response to findings of non-compliances during previous inspections.

[16] The self-assessment was part of the methodology used for this inspection programme and it required the management team to assess its own performance against the five standards relating to leadership, governance and management, and workforce.

Inspections in this three-year period saw improvements nationally in compliance with Tusla's own requirements to screen referrals within 24 hours and where children were allocated to a social worker, the quality of safety planning and assessments continued to improve. There was consistent evidence of good interagency working in the best interest of children and direct engagement with children by social workers throughout assessments of risks to their safety.

By 2022, HIQA inspectors were consistently reporting improved leadership, governance and management arrangements in local service areas, however, gaps in service provision were beginning to widen and service capacity to safely manage the numbers and complexity of referrals were challenged. Management oversight and response to the risks associated with waiting lists for a child protection service became a key focus of inspection from 2022 and remain a key focus today.

By 2023, inspections of child protection and welfare services consistently identified that many CPW services are under considerable and ongoing strain, while the service as a whole has been experiencing year-on-year incremental rises in referrals for over a decade, with over 91,900 referrals during 2023 alone — compared to some 43,600 referrals in 2014. During that time, HIQA inspections and an investigation have found that some CPW services have been beset by persistent staff vacancies and some governance challenges which have impacted on services' ability to deliver the right service at the right time consistently to children.

In the absence of specific regulatory powers in this area, including powers of enforcement for children at significant and ongoing risk, HIQA has varied and adapted its approach to monitoring of Tusla CPW services to ensure that the areas of greatest risk are prioritised and progress in addressing those risks are routinely and effectively monitored.

3.8 Governance issues in child protection and welfare services, and statutory investigation

During the early years of monitoring of Tusla CPW services, inspectors found recurring governance challenges. Inspectors found:

- high levels of unallocated referrals (where a named social worker has not been assigned to a case)
- unmanaged retrospective referrals (these are allegations made by adults who allege they were abused when they were children)
- poor record-keeping
- a lack of an integrated information management system
- inadequate systems of data collection and analysis
- inconsistent risk management
- difficulties with retention and recruitment of staff.

Significant risks both relating to the management of risks to individual children, as well as systemic risks within CPW practices were highlighted in successive reports into CPW services across the country. Moreover, responses by Tusla were not adequately addressing the risks being identified. This indicated a greater concern about national governance arrangements and Tusla's capacity to effectively respond to identified deficiencies in the delivery of front-line services for children. As a consequence, in 2016 a decision was made to conduct a wide–ranging governance review entitled: *A review of the child protection and welfare service provided by the Child and Family Agency (Tusla) and the governance arrangements in place to ensure an effective, timely and safe service*. The findings of this review were later incorporated into a subsequent statutory investigation report (see below).

The governance review found significant risks associated with the management of unallocated child protection and welfare referrals. Managerial oversight at a local level was inadequate. There were inconsistencies in the quality of practice which went unidentified or unaddressed, and no effective procedures for sharing learning were in place. There were inconsistencies in the effectiveness of risk management arrangements across the country, and procedures for the identification, reporting and escalation of risks required attention.

In March 2017, the Minister of Children and Youth Affairs wrote to the Chairperson of the HIQA, formally instructing that HIQA carry out a statutory investigation under the Health Act 2007. This came about as a result of false allegations of child sexual abuse being notified by Tusla to An Garda Síochána, against a Garda whistle-blower, Sergeant Maurice McCabe. The Minister for Children and Youth Affairs at the time believed the apparent poor handling of this allegation by Tusla indicated concerns that a systemic issue may exist within the state agency. The *Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs* was published in June 2018 and is available on the HIQA website at www.hiqa.ie.

The statutory investigation outlined similar findings as the governance review. The statutory investigation found that many essential elements of governance were in place, but they required bedding down in order to provide safe, good quality care to children and their families.[17] Three systemic risks were identified in the management of referrals of child sexual abuse; they were risks associated with delays in screening and preliminary enquiry, safety planning and the management of retrospective

[17] HIQA. Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs: 14 June 2018. Dublin: HIQA; 2018.

allegations of child sexual abuse. The statutory investigation report also highlighted that Tusla managers frequently expressed concern about recruiting and retaining staff. The investigation found that critical social work posts were vacant across the country, and this had an ongoing, negative impact on the consistent delivery of a high-quality and timely service to children. These challenges were persistently reported as an organisational risk at board, executive and operational levels across Tusla.

3.8.1 Tusla response to statutory investigation findings

In response to recommendations in the HIQA statutory investigation report, Tusla developed a Strategic Action Plan in 2018. Implementation of this action plan was overseen by an expert assurance group, established by the then Minister for Children and Youth Affairs, to oversee progress on actions identified as required to address findings of the investigation report. One of the key actions undertaken to address deficits in practice highlighted by the investigation team, was the introduction by Tusla of revised Child Abuse Substantiation Procedures (CASP), to guide social workers through the process of responding to retrospective allegations of abuse. Later in this chapter, we will detail the development of actions as they relate to Tusla's management of allegations of child abuse, up to and including inspections of dedicated CASP teams in 2023.

This statutory investigation report informed the focus of Tusla from 2018 onwards as specific recommendations focused on the need to share learning across the organisation and to engage in comprehensive workforce planning and targeted work with third-level institutions to enhance their access to staff.[18]

There was a commitment in the statutory investigation report to designing an inspection programme to promote improvement in child protection and welfare services. This was to be done in consultation with Tusla, the relevant professional organisations and children's advocacy groups. Over the subsequent years, HIQA developed a quality improvement initiative which aimed to focus inspections of CPW services on assessing progress in addressing deficits and responding to the findings of the investigation report.

3.9 Focused and thematic inspection programmes of CPW services

3.9.1 Thematic inspections of CPW services

HIQA introduced a programme of thematic (quality improvement) inspections initially across 12 CPW services in 2019. Services that participated in this initiative had a good level of compliance against the national standards. The quality improvement

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[18] Ibid.

initiative focused on two out of three systemic risks as outlined above and identified during the statutory investigation; screening and preliminary enquiry and safety planning. The programme also reviewed the quality of initial assessments completed by social workers. In addition, governance and management of child protection services was a key focus for these inspections. In adopting a quality improvement approach to inspection, the purpose was to promote further improvement in service delivery to children and to further improve compliance with the *National Child Protection and Welfare Standards.*

Overall, services made progress in achieving compliance with the standards. Of the 12 areas inspected, six service areas were compliant or substantially compliant in all but one standard, which was assessed as partially compliant.[19] Two service areas were compliant or substantially compliant in five standards and partially compliant in two. There were varying levels of compliance with the remaining four services.

While some challenges remained in individual areas, particularly around staffing, our inspectors observed gradual improvements in governance arrangements throughout this thematic programme. There was evidence that a more consistent approach to governance was emerging as well as a practice of sharing learning across service areas within regions, as well as some cross-regional initiatives. It is noteworthy that one service area was removed from the programme due to the identification of significant risks and another area was added as it had improved its compliance levels.

Concurrent with the thematic programme of inspections, HIQA continued to routinely monitor CPW services through analysis of publicly-available data and information as well as responding to indicators of risks as they presented to us. Services which were not part of this programme continued to be monitored and inspected by the HIQA to assess ongoing progress in the management of identified risks, such as high levels of unallocated cases.

3.9.2 Focused inspections 2020–2023

Despite our inspectors being briefly curtailed by public health measures, we continued to carry out risk-based inspections of CPW services during 2020 and 2021. Restrictions related to COVID-19 and the 2021 cyber-attack that affected Tusla's IT systems were unexpected developments that impacted on the operation of Tusla services nationally. However, inspection by HIQA continued to identify improvements across all of the relevant standards, which indicated that governance improvements

[19] Partially compliant was a compliance descriptor used in 2019 to describe a service which was not fully compliant with national standards but some level of compliance was identified.

were having a positive impact. For example, in 2020, we found that all children on the CPNS had an allocated social worker.

Nevertheless, there remained areas where governance needed to be further strengthened as outlined below.

3.9.2.1 Child Protection Notification System (CNPS)

HIQA developed a programme of focused inspections of the CPW service provided to children listed on the Child Protection Notification System (CPNS) and who have child protection safety plans. This programme was undertaken over a two-year period concluding in 2023, and 17 focused inspections were undertaken across each of the 17 Tusla service areas. Seven inspections were completed in 2021, a further eight service areas were inspected in 2022 and the remaining two service areas were inspected in early 2023.

Overall, this inspection programme identified that the majority of children on the CPNS had an allocated social worker and had appropriate safety plans which were devised at multi-disciplinary case conferences, although not all children were visited in line with the requirements of their safety plan. Parents were actively engaged in these meetings; many children did not participate either by choice or due to the content of the meetings. Areas of improvement were identified to ensure that child protection conferences were convened promptly in line with national guidance. It also identified that further training and development was needed for social workers in the identification of risks associated with cumulative harm for children who remained at significant risk for long periods of time.

Some areas demonstrated higher levels of compliance with the standards than other areas. Those service areas that had higher levels of compliance demonstrated strong leadership and governance arrangements that ensured that children listed on the CPNS received a safe and effective service. They were also working to embed the new *National Guidelines for Tusla Child Protection Conference and Child Protection Notification System June 2022* into practice in the area. In the other service areas inspected, governance and staffing resource issues directly impacted on their capacity to deliver safe and effective services to all children listed on the CPNS.

An important finding from this inspection programme is the critical importance of taking the opportunities to share learnings from inspections of the CPNS. The level of non-compliance found during final inspection of the programme indicated that learning from previous inspections had not always been effectively shared and actions to mitigate risks had not been disseminated regionally or nationally. This informed the recent provider-level approach to CPW and foster care services.

3.9.2.2 Separated Children Seeking International Protection (SCSIP)

In 2022, due to the increasing numbers of unaccompanied minors coming into the country, it was decided to conduct an inspection of Tusla's national service for separated children seeking international protection (SCSIP). The SCSIP service is a Tusla CPW service with responsibility for the welfare and protection of all unaccompanied minors who enter Ireland.[20] The primary function of the SCSIP service is to promote the welfare of children who are not receiving adequate care and protection in accordance with the Child Care Act 1991.

While many young people who have been displaced by the war in Ukraine in 2022 are unaccompanied minors (UAM), they are not seeking international protection as they are beneficiaries of the European Temporary Protection Directive. They do, however, fall under the remit of the SCSIP as they may be in need of care and protection under the Child Care Act 1991.

The SCSIP service offers an urgent response to the presenting needs of unaccompanied minors who arrive in the jurisdiction. The service has a dual mandate to:

- offer care and protection to the young people while in the care of Tusla, to assist them with integration into life in Ireland, and
- to support them through their international protection application.

HIQA undertook two inspections of the SCSIP service, the initial inspection in February 2023 with a follow-up inspection in November 2023. Although the service was effective in dealing with the immediate crisis of placing all unaccompanied minors or separated children in accommodation (emergency foster care or special emergency accommodation) on the day of their arrival into the country, the specific and diverse range of vulnerabilities and needs of these children were not appropriately identified and managed. The February 2023 inspection found that significant improvements were required including in areas such as children rights; interagency working; governance of the service; the signing of children into voluntary care by Tusla staff; and the service's adherence to Children First.

Following this inspection, Tusla took steps to address the most urgent issues facing the service and this was validated during a follow up inspection later in 2023. Issues that had been progressed included prioritising applications to the courts for care orders for young people in voluntary care. The strategic direction of the service was

[20] Separated children seeking international protection are defined as children under eighteen years of age who are outside their country of origin, who may be in need of international protection and are separated from their parents or their legal and or customary care giver.

clearer, with actions identified in its service improvement plan to develop a consistent and effective service.

While Tusla had begun to align the SCSIP service with the Tusla CPW systems, it was, however, only at the initial stages of development and integration at the time of the second inspection in November 2023.

Further improvement action, in line with Tusla's response to the inspections, will be monitored by HIQA such as adequately resourcing the service, improved governance of the service in line with Tusla's existing governance and information systems.

3.9.2.3 Focused inspections of the Child Abuse Substantiation Procedure (CASP)

In order to meet its statutory obligations to protect children and promote their welfare, Tusla must carry out an assessment of allegations of child abuse in line with fair procedures. This is called a substantiation assessment – an assessment that examines and weighs up all the evidence and decides if the allegation is founded or unfounded on the balance of probabilities. This is not a criminal investigation. If the outcome of a substantiation assessment by Tusla is that the allegation is founded a determination is made that the person who is the subject of the abuse allegations poses a potential risk to a child or children. Tusla calls this process the CASP, Child Abuse Substantiation Procedure, and it is part of Tusla's child protection and welfare service.

In 2023, HIQA commenced a programme of inspection to monitor Tusla's implementation of CASP which was brought into effect in June 2022. The focus of the CASP inspections was on the management of the assessment of child abuse, including retrospective allegations of abuse, as well as the aligned service leadership and governance arrangements. Throughout 2023 four CASP inspections were completed. Three were regional inspections and one single area inspection.

The inspection programme found that there was inconsistency with respect to the delivery of CASP services by Tusla nationally. Overall compliance with national standards relating to CASP services varied. Figure 13 (below) provides an overview of the findings of each CASP service inspection.

Figure 13. Overview of findings of CASP service inspections 2023

Areas Inspected	Judgement Standard 1.3	Judgement Standard 2.12	Judgement Standard 2.5	Judgement Standard 3.1	Judgement Standard 3.2
1 Regional (DML)	Not compliant	Substantially compliant	Not compliant	Not compliant	Not compliant
2 Regional (Midwest)	Substantially compliant	Substantially compliant	Compliant	Not compliant	Substantially compliant
3 West North West (incorporating two service areas)	Substantially compliant	Not compliant	Not compliant	Not compliant	Substantially compliant

4 Single Service Area Inspection	Substantially compliant	Compliant	Compliant	Substantially compliant	Substantially compliant

An overarching finding of the child protection CASP inspections was that the timelines set out in the procedure were not consistently met. The procedure also did not fully address the findings of the HIQA 2018 investigation. There were significant delays in assessing allegations, which impacted Tusla's capacity to act quickly to safeguard not as yet identified children who may be at risk.

It was evident from this programme of inspections that staff working in the CASP teams demonstrated a good knowledge of legislation, policies and standards relevant to their roles.

Improvements were required in relation to

- the submission of notifications of bona fide concerns in relation to individuals to the National Vetting Bureau
- national guidance to support CASP teams with identifying and responding to children who may have been subjected to child sexual exploitation, organised, organisational and or institutional abuse and children who were deemed to be especially vulnerable
- communication with children and adults
- recording of information about safeguarding measures taken for identified children on the CASP file.

In 2024, Tusla updated their procedures to include the learnings from this programme.

3.10 Staffing and resourcing of child protection and welfare services

The level of staffing available to CPW services has been an ever-present difficulty since HIQA commenced inspections of Tusla services. A high number of vacant posts and high turnover of staff coupled with an increased demand for the service has consistently impacted on Tusla's ability to consistently manage excessively long waiting periods for some children to engage directly with a social worker. It has also created problems with continuity, as children sometimes have to engage with multiple different social workers which impacts on their ability to establish trusting relationships.

Tusla has limited control over the availability of social workers and is somewhat at the mercy of the labour market. Tusla has been active in calling attention to the need for additional supply of social workers, primarily arguing for higher numbers of

graduates through the university system. Additional courses have been provided in third levels institutions to train additional social workers and Tusla has sponsored staff to train as a social worker. They also have recruited from abroad, and in September 2024 the first social work apprenticeship programme commenced. It has also put in place extensive staff retention initiatives; however, all of these measures will take time. In the interim, Tusla is using social care staff to do some tasks which traditionally were completed by social workers.

3.11 Risk management in child protection and welfare services

A key component in the effective monitoring of children's services is to assess the capacity and capability of the services to identify, prioritise and effectively respond to risk. HIQA has identified risks to varying degrees within CPW services throughout the 10-year period being reported on and found that the quality of oversight and management of these risks varied.

It is important to note that the existence of a waiting list within a CPW service is, in itself, concerning. Where waiting lists exist, their management requires a clear and consistent understanding of the potential associated risks, as well as clear guidance and oversight in managing these risks to ensure children's safety. However, inspections found that where such risks existed, the governance and management of the waiting lists require further improvement and continual review.

In 2023, in response to recurring non-compliances and significant risks identified within CPW services, HIQA, following discussions with Tusla made the decision to conduct a programme of risk-based inspections of those services presenting at the highest level of risk nationally. In September 2023, Tusla was informed that all services with 25% or more unallocated cases would be included within this programme. It was agreed that HIQA would undertake this provider risk-based approach with a requirement on Tusla to produce and submit a national service improvement plan, which detailed actions to address risks presenting within the services meeting the criteria for inclusion in the programme. At the commencement of this programme, this provider risk-based approach included six child protection and welfare service areas, this increased to eight by the end of 2023. Tusla has worked in co-operation with HIQA throughout the programme and there have been regular meetings to report on progress against Tusla's improvement plan. The findings from this risk-based monitoring programme conducted in 2024 will be reported on separately in early 2025.

3.12 Impact on children

As referenced earlier, CPW services are usually a child's first engagement with Tusla. It is, therefore, important that this engagement is timely, appropriate to the presenting risk of the situation and child centred. Our inspections have consistently

found that children at serious and immediate risk have received a timely service. Furthermore, children, typically those in receipt of services from an allocated social worker and or social care worker, have spoken positively about CPW services, the support they received and the positive impact it has had on their lives.

However, timely and appropriate has not always been the experience for all children referred to Tusla's CPW services over the past 10 years.

Despite the pressure on CPW services, it must be noted that Tusla's capacity to allocate cases at all levels of priority has improved. At the end of 2023, there were 4,276 children on a waiting list for allocation to a social worker for a CPW service, which is less than half the figure seen in 2014 and this is welcome. HIQA continued to be concerned that at the end of 2023, eight child protection and welfare services were met the criteria to be included in its risk-based provider programme due to the numbers of children waiting for a service.

Inspections over the years have reported that those children who are at the highest risk of harm (ongoing risk of significant harm) are appropriately prioritised for a service. This means that they are usually allocated a social worker and that they and their families are prioritised for intervention to address their needs. However, there remains significant numbers of children at medium and low priority who are waiting for a service. In an effort to illustrate the potential impact on children waiting for a service in these circumstances, we have outlined below some examples escalated as part of inspections of CPW services in more recent years, where Tusla took action as a result of our findings.

A key priority for HIQA is to ensure that the experiences of children availing of services under our remit are clearly represented in all inspection reports. However, due to the nature of CPW services, opportunities to directly engage with children in contact with the service are limited. Therefore, representing the likely or potential impact of delays and gaps in service provision on these children is as important as representing those who receive and avail of a good quality, safe service from an allocated professional. Over the last 10 years, HIQA has changed its approach to reporting the impact and experience of services on children by seeking to give greater prominence to the voice of children in inspection reports. This aspect of our work will be discussed in greater detail in chapter 8 of this report. Below are some examples of what children in receipt of CPW services have told inspectors.

Child protection and welfare - what children told inspectors

"My social worker talks to me and I can trust them with what I say" and "they are helping us with our family."

"She cares and listens to me... wants to know what I think...she listens to what I want."

"She is a good one but not all of them were they all did not listen."

"I meet her on her own. She collects me and we go for hot chocolate or something."

"I like my social worker... she takes me out, otherwise I'd be stuck without anyone."

"You can have an easy conversation with her. She listens and understands."

"She is easy to talk to. It is what I like most."

"She keeps me up to date. She keeps up with my wellbeing, what mood I'm in and if I am ok. I can give my opinion on things. She listens and tries to work around it."

Child protection and welfare - what children told inspectors

"She asks for my opinion and involves me in meetings. She supports me and makes a difference."

"She asked me stuff like what I would like to happen, what I need and about my interests and feelings."

"I told that social worker everything about my situation then she was just gone."

"School has not been good with my situation but the social worker has said they will help with that.."

"Had about six [social workers] before I got this one.. just kept changing.. met loads of different ones and now getting another new one."

"Right now I am very happy...my life has completely changed because of my social care worker."

Child protection and welfare - comments from chldren in reciept of CPW services

"Right now I am very happy...my life has completely changed because of my social care worker."

"She asks for my opinion and involves me in meetings. She supports me and makes a difference."

"She asked me stuff like what I would like to happen, what I need and about my interests and feelings."

"I told that social worker everything about my situation then she was just gone."

"Had about six [social workers] before I got this one...just kept changing... met loads of different ones and now getting another new one."

Chapter 4: Foster care services

4.1 Regulatory framework for foster care services

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under section 69 of the Child Care Act 1991, to inspect and monitor foster care services provided by Tusla and by non-statutory providers, and to report on our findings to the Minister. HIQA also has statutory responsibility for monitoring these services against the *National Standards for Foster Care 2003.*[21] The national standards for foster care provide a framework to ensure that children in foster care receive the best possible care.

Foster care in Ireland is also directed by two sets of regulations:

- the Child Care (Placement of Children in Foster Care) Regulations (1995)
- the Child Care (Placement of Children with Relatives) Regulations (1995).

HIQA inspects statutory and non-statutory foster care providers under the two sets of foster care regulations and monitors against the *National Standards for Foster Care*.

4.2 Statutory and non-statutory foster care services

In circumstances where a child comes into contact with CPW services and cannot remain in the family home, foster care is often the next step on the care pathway. Most children in State care live with foster carers in the community, either with extended family (termed relative foster care) or with carers who are not related to the children (termed general foster care). These services are either directly provided and overseen by Tusla or provided by non-statutory foster care companies and voluntary organisations contracted by Tusla to do so.

Tusla has statutory responsibility for the assessment and approval of foster carers in Ireland. However, while all foster carers are approved by Tusla, there are non-statutory foster care services, commissioned by Tusla, that identify, assess and provide ongoing support and supervision to foster carers who provide placements for children in the care of Tusla. At the end of 2023, there were five non-statutory foster care agencies in Ireland.

In December 2023, 90% of children and young people in the care of the State were living with foster carers. Of the 5,034 children in foster care, 3,560 (71%) were in general (non-relative) foster care, 1,474 (29%), were in relative foster care.

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[21] Mary Dunnion, former Chief Inspector and Director of Regulation addressing the Oireachtas Joint Committee on Children and Youth Affairs, 17 May 2017.

Ongoing recruitment of foster carers has been a key priority for Tusla services across the country over the past decade. However, despite its ongoing efforts through national and regional recruitment drives, Tusla states that it does not have an adequate supply of foster carers to meet the needs of children and young people.[22]

4.3 Findings from our monitoring of foster care services

Over the past 10 years, HIQA has observed improvements in statutory foster care services, resulting in safer care of children and young people living with foster families throughout Ireland. Some of these improvements include:

- improved focus on children's rights including the provision of information on rights, and the management of complaints
- more robust and formalised procedures for matching children with the most appropriate foster families
- improved processes for the review of voluntary care agreements for children in foster care
- improved safeguarding – including the management of allegations and serious concerns
- more frequent, as well as better quality, review of foster carers in line with the requirements of the national standards
- improvements in procedures for maintaining up-to-date vetting on all foster carers and other relevant adults in regular contact with children in foster care.

In addition, HIQA inspections have informed improvements in auditing and oversight practices within Tusla. This has led to better governance and monitoring arrangements in areas including timely care planning; timely reviews of foster carers; and improved mechanisms for analysing and reviewing learning from disruptions or placement breakdowns.

While many improvements have been reported in the majority of foster care services nationally, there have also been significant risks identified throughout the last 10 years, some of which Tusla has been unable to fully addressed and remain a challenge today. Over the past number of years, Tusla's foster care services have faced increasing challenges related to resources, particularly around recruiting, assessing and retaining foster carers and having adequate numbers of appropriate placements to meet the demand of children requiring support. Additionally, staffing resources, which have been reported on in the previous chapters, have also impacted the capacity of many foster care teams. This is particularly the case with regard to ensuring all children are allocated a social worker as required under the

[22] Strategic Plan for Foster Care Services for Children and Young People 2022–2025. Dublin: Tusla.

National Foster Care Standards (2003).

This section will focus on four key areas with respect to statutory (Tusla operated) foster care services:

- governance
- resources
- risk management
- the impact on children.

In addition, there will also be an overview of HIQA's inspection and monitoring of non-statutory foster care services and their evolution and progression with respect to improved compliance with national standards throughout the last 10 years.

4.4 Governance in statutory foster care

Early inspections of foster care services in 2014-2016 found areas of good practice. For instance, services inspected in 2014 had clear lines of accountability and staff were being supported in decision-making and were confident in the leadership of their managers. Many children experienced good outcomes because of effective and responsive oversight of their care.

Despite this, there were some challenges in the provision of foster care services nationally. One major issue related to the consistent application of governance practices across all 17 Tusla service areas. Moreover, the learning from inspection reports, in particular from service areas that were performing well, was not being shared widely throughout the organisation. This meant that the quality of the service experienced by a child was often dependent on the service area in which they lived.

4.4.1 Progress and improvement on governance

Between 2014 and 2016, HIQA inspections of Tusla's foster care services included the assessment of all 26 standards of the *National Standards for Foster Care* (*2003)*. Findings from these inspections noted that significant work was required to bring Tusla services into compliance with all 26 standards, and actions plans arising from these inspections often resulted in service areas responding with plans detailing over 100 corresponding actions. HIQA sought to ensure that Tusla's foster care services were effectively prioritising actions in the areas of greatest risk. To achieve this, the method of inspection of foster care services was adapted. It was decided that a more focused approach to inspections, assessing a smaller number of standards at any one time, was required. The intention was to have more of an impact, allowing areas to concentrate and focus on particular standards, thus leading to incremental improvements across the wider service over time.

In 2017, HIQA commenced a three-phase, focused programme of inspection of foster care services across all 17 Tusla service areas. Phase one was completed during 2017 and 2018 and focused on the recruitment, assessment, approval, supervision and review of foster carers, including the arrangements in place for safeguarding and child protection of children in foster care placements.

Phase two was completed during 2019 and 2020 and focused on the arrangements in place for assessing children's needs, the care planning and review process, preparations for children leaving care, and safeguarding of children.

HIQA began the third and final phase of its foster care programme in 2021, a thematic (quality improvement) foster care programme, that focused on assessing the efficacy of the governance arrangements across foster care services and the impact of these arrangements on children in foster care. As this final phase of the programme focused on service quality improvement, only those service areas deemed to have previously had a high level of compliance with standards were included in the inspection programme. This programme inspected 12 of 17 Tusla foster care services. The five service areas not included continued to be monitored for progress against action plans submitted to address non-compliances with national standards identified during previous inspections.

HIQA published an overview report on the findings from each phase of this inspection programme, including a detailed overview report of the foster care thematic programme, which can be found on www.hiqa.ie.

Overall, improvements were noted throughout the 12 foster care services inspected and action plans to address non-compliances were targeted and achievable. For example, following phase two of the thematic programme, national initiatives were put in place by Tusla, such as the National Aftercare Implementation Project Group. This was effective in improving standards of care for young people aged 16 and over. Inspections found high levels of compliance with standard 13 (preparation for leaving care and adult life) in the majority of services areas inspected.

The overview also highlighted that, the implementation of improvements was not consistent nationally and in some service areas' governance arrangements were more effective than others. Thematic inspections identified significant risks associated with the lack of interrogation of data at local, regional and national levels. As the thematic programme of inspections progressed, inspectors found a lack of strategic governance and oversight from Tusla at national level with regards to the local and regional responses resulting in varying levels of success.

Examples of some of these areas of concern included:

- the growing number of unallocated children in care and the lack of adequate

management of their cases

- inconsistent and often inadequate approaches to the provision of foster care services for children with complex needs
- Tusla's approach to quality assurance, in addition to monitoring and oversight of progress in achieving strategic objectives for foster care services, required significant improvement.

In 2023, HIQA identified the need for increasing the focus towards a national response in an effort to address the potential systemic issues associated with the number of children in foster care who did not have an allocated social worker and the governance and management challenges faced by some foster care services. As a result, HIQA decided to include foster care services within the risk based provider approach programme established in 2023 which is outlined in chapter 3. As with CPW services, HIQA identified services with 25% or more children in foster care without an allocated social worker, as the services presenting the greatest risks and set this as the key criteria for inclusion in the programme. Six foster care services were inspected under this programme in 2024. This programme will be reported on separately in 2025.

4.5 Resources for statutory foster care

Some of the early inspection findings in statutory foster care services highlighted shortcomings with respect to staffing. Inspectors consistently found that some children in statutory foster care did not have an allocated social worker resulting in potential risks to the quality and consistency of care for these children. The risks associated with failure to allocate a social worker to a child in care are extensive and include:

- potential gaps in coordination of children's care
- potential delays in responding to children's everyday need as they relate to consent and or decisions about contact with their families
- potential that risks to children would go unnoticed due to being poorly supervised in their placements.

Inspections identified that Tusla's ability to assess and review new and existing foster carers was also adversely impacted by staff shortages. There were delays in the assessment and approval of relative foster carers, some of whom had children placed with them while they underwent assessment, resulting in long periods of uncertainty for families. For other children, there were ineffective arrangements in place to ensure a timely assessment process. This resulted in delays of up to 16 months for children while they awaited a placement with their relative carers.

During 2021 and 2022, in order to address challenges posed by staffing levels, HIQA saw the emergence of a practice of assigning social care workers to complete tasks relating to children's care while children awaited allocation of a social worker. Social care workers typically have responsibility for undertaking direct work with children and young people as outlined in plans for their care. Social work responsibilities that were delegated included conducting visits to children in care and reviewing or updating safety plans. While it is preferable that a child in care is visited and their care overseen by a professional from the foster care team, it is important to note that there is a distinction within legislation between both roles, with statutory responsibility for ensuring assessment, care planning and safety aspects of children's care specifically assigned to social workers. In 2021, the practice of delegation of social work tasks to social care workers and leaders within fostering teams was found in two inspected service areas. In the 2022 inspections, four other service areas had put this practice in place.

Tusla took this action in relation to the shortage of staff. In some service areas, procedures for managing unallocated cases were developed. These specifically set out the expectation that social care workers or social care leaders managed unallocated cases in the absence of an allocated social worker. Procedures outlined arrangements for oversight of their work through monthly supervision of their caseload by a social work manager. While Tusla made an effort to ensure that each child in foster care had a named social worker or in their absence a social care worker, it was found that the implementation of procedures in practice was inconsistent and required improvement.

In 2022, all service areas inspected had service improvement plans in place. However, increased pressures on the recruitment and retention of staff and insufficient social work graduates impacted on some service areas' ability to meet standards or implement all required actions of their own service improvement plans. Shortfalls in staffing continued to lead to risks. Key risks included children in care without an allocated social worker and insufficient numbers of suitable placements to meet the demand. These challenges continued in 2023, and inspectors found that some children's rights were impacted by the lack of resources as some children did not have an allocated social worker and this had impacted on the timeliness of reviews of their care plan. In addition, in two out of seven inspections, improvements were required in relation to the engagement of staff with young children and those with a disability. Some separated children were placed in foster placements long distances from where they were receiving Tusla services, and children were not visited in line with regulations. This was particularly concerning given the vulnerability of separated children. Tusla submitted compliance plans to address all of these issues and HIQA continues to monitor progress on against these.

4.6 Risk management in statutory foster care

Our early inspections of statutory foster care from 2014 to 2018 identified that risks were not being effectively managed to keep children safe and promote their wellbeing. For example, in one area inspected, basic checks such as vetting by An Garda Síochána had not been completed on all relative carers, meaning fundamental safeguards for children were not in place. In another example, in 2014, inspectors reported that there was no effective mechanism in place to record or monitor complaints. This issue had been previously highlighted in 2013 by HIQA when these services had been managed by the HSE.

Our inspectors continued to find evidence of poor risk management on inspections conducted in 2017 and 2018. Examples included: an insufficient number of supervisory visits being carried out by social workers to unallocated foster carers (foster carers without an allocated link social worker); not all allegations being dealt with in line with Children First; and where allegations had been made there had been delays in completing initial assessments. Inspections also found that statutory visits to children living in foster care were not being undertaken in line with regulatory requirements.

Risks relating to staffing shortages, including frequent changes in allocation of social workers to children and delayed child in care reviews (a meeting of the child, social workers, birth family and carers to form a plan for the child). Other risks concerned poor quality statutory visits to children by their social workers in foster care services in all regions. HIQA identified that mechanisms put in place designed to manage these risks varied both in quality and effectiveness.

During 2021, HIQA conducted three risk-based inspections of foster care services in two service areas. All three inspections were follow-up inspections to measure progress made since previous inspections. In one of the service areas, we conducted two separate risk-based inspections, and in the other area we undertook one inspection. Findings from the follow-up inspection in 2021 of one service area were generally positive, indicating significant progress since the previous inspection in October 2020. During this inspection, non-compliance was identified with regard to the support and supervision provided to foster carers. An urgent compliance plan was issued by HIQA following the inspection, requiring Tusla to put in place a plan of actions to address the risks associated with this non-compliance. The other service area risk-based inspections found that improvement was required in managerial oversight of statutory requirements.The service had been restructured but the impact of this had yet to be seen. There were significant gaps in children's records. While the area had put a plan in place for increased monitoring and oversight of visits, the previous action plan following the last inspection had not adequately addressed this issue. Not all children had an allocated social worker and staff leave and vacancies impacted on the service's capacity to address this.

During 2022, HIQA conducted two risk-based inspections of foster care services in two service areas. One inspection was a follow-up foster care inspection to measure progress with respect to agreed actions to address risks identified within the service in 2020 and 2021. In the second service area, HIQA commenced an announced foster care thematic inspection. Due to the risks identified this was changed to a risk-based inspection of the service. Risks included a lack of statutory visits to children in care and a lack of support visits to foster carers. Tusla submitted appropriate assurances in relation to these findings.

4.7 Impact on children

Entering foster care can be a traumatic time for a child. They must enter a new home environment and also deal with a change to their routines and social networks. That is why every effort is made to place children in foster care in a placement that is close to home and, preferably, with a known relative. Effective management of their cases and monitoring of their progress is important to ensure children achieve their full potential and the best outcomes from their time in care.

We have noted that over the last decade, children have a greater awareness of their rights and are encouraged to be actively involved in meetings about their care. They are supported to maintain relationships with their family. They are listened to and when they have concerns, they are generally appropriately followed up on by their social worker.

Our reports over the past 10 years have repeatedly cited children's positive experiences of foster care when they were allocated a social worker or other consistent worker with whom they had developed and maintained trusted relationships. For many children, this is not their experience as they have dealt with regular changes in their allocated social worker. The continued challenges for Tusla foster care teams to allocate social workers to all children in care continues to be a priority concern in many service areas across all regions of the country.

Children repeatedly tell us about the positive impact that having a stable foster care placement with supportive carers has had on their lives. One of the greatest challenges facing Tusla foster care services in 2024 is the shortage of available foster families as the demand for foster carers in Ireland far outnumbers the available placements for children requiring a foster family. While this has always featured as a challenge for fostering teams, particularly in identifying culturally appropriate or foster care placement for children with complex needs, this has now become a priority concern and key feature on registers of risks for fostering services nationally.

The impact of a shortage of placements options on children requiring a foster care placement is immense and fostering social work teams are challenged by this in a

number of ways. For example, matching children to appropriate carers in their own communities is not always possible and inspectors have identified an increased in the number children placed with foster families long distances from their own families and communities. A placement far away from home is not best practice or desired option for any social worker when seeking a foster family for a child, as this has the potential to increase the traumatic impact of coming into care on children as well as their families.

Below, we present a selection of feedback from children taken from various HIQA foster care inspection reports on the theme of what children 'like' about living in foster care.

Foster care — what children and young people like

"They give me the love and things I need, they love me and are kind to me when I want to talk to them about stuff."

"I would like to be listened to more."

"I am really happy in my foster care and I feel safe."

"Everything - they are my parents."

"They are nice, they look after us and we have our own rooms. We go on days out, we have nice friends, we love the dogs, go on holidays. My foster family and my real family get on really well. I love everything."

"They are very nice and special."

"They support and understand me. They supply me with my favourite chocolate biscuits. They are the best."

"I feel very lucky to be a part of this family...I wouldn't change anything in my life."

Living in Foster Care - Comments on challenges faced

"My family do not keep in contact with me"

"Mostly I am bored"

"The [social worker] should try more to prepare me for home and listen to me."

"I am only...years old so this [child in care reviews] is all new to me."

"Going to school is not easy and it is sad you only get like one and a half hours to see your mam."

Foster Care - Comments on social workers from children and young people

"I have had lots of social workers - eight in total."

"My social worker never listens to me."

"Social workers do not listen, sometimes they say no with no explanation."

"Too many kids in care for the amount of social workers."

"There have been a lot of changes of social worker. We need a consistent social worker we can rely on."

"My social worker is not good at keeping up with my culture."

4.8 Non-statutory foster care in Ireland

In circumstances where a child cannot be placed with a foster family identified and managed by Tusla, they are often cared for in a foster family managed by a non-statutory foster care company or voluntary organisation. In December 2023, 10% of children in foster care (508) were placed with non-statutory fostering agencies. At the end of 2023, there were five non-statutory foster care agencies in Ireland funded by Tusla to provide a fostering service on its behalf. The children who are placed in non-statutory foster care remain the responsibility of Tusla, but the non-statutory agencies recruit foster carers, assess them, and directly support them. Foster carers will have a link social worker from the non-statutory agency to look after their interests.

Tusla conducts its own quality assurance monitoring of non-statutory foster care agencies in Ireland[23] to assure themselves of the quality of these commissioned services. These reports are provided to HIQA by Tusla and are reviewed and risk-rated as part of our ongoing monitoring of non-statutory foster care services.

4.8.1 History of HIQA's monitoring of non-statutory foster care provision in Ireland

In 2014, when Tusla was established there were six non-statutory providers of foster care services operating in Ireland. These organisations were commissioned by Tusla to provide a foster care service for children in the care of Tusla. The role of the non-statutory providers is to identify, recruit, assess, supervise and support foster carers. Tusla retains its statutory responsibilities to children and maintains direct oversight of the care of children placed with these foster carers, through their allocated Tusla social worker. As per statutory requirements and in line with national standards, all foster carers are approved by their relevant Tusla local or regional foster care committee.

In 2014, HIQA commenced a monitoring programme of the six non-statutory foster care providers in Ireland. Findings of inspections of these services varied. In general, inspectors found good levels of compliance and safe, good quality care being provided to children. Inspectors noted that foster carers were receiving high levels of support that ensured stable and effective placements for children. Concerns were promptly notified to Tusla and there were appropriate safeguarding arrangements in place in most cases.

Non-compliances with national standards were also identified. In the early days of inspections, HIQA found that reviews of foster carers required improvement to ensure children were receiving good quality. Training, supervision and support to

[23] Tusla.ie — Non-statutory Foster Care agencies.

some foster carers also required improvement. Inspections identified a number of children did not have an allocated social worker or up-to-date care plans, which impacted on the non-statutory service's ability to appropriately match children to their foster carers, as well as monitor progress of their placements. It is the responsibility of Tusla to ensure that statutory requirements for children in care are met. Notwithstanding this, there is a role for non-statutory providers in overseeing and monitoring those who provide care, to advocate and escalate these issues when they arise, which HIQA did not routinely see occurring.

To put this into context, an inspection of one non-statutory provider in 2016 identified significant risks in relation to safeguarding practices. Child protection concerns went unidentified or were poorly managed and not all staff were appropriately vetted by An Garda Síochána prior to commencing work for the service. This non-statutory provider was subject to an inspection by Tusla upon notification of significant concerns identified by HIQA. This provider ceased in their provision of foster care services in 2017.

4.8.2 Re-inspections of all services

In 2018, a programme of re-inspections of all non-statutory services was undertaken. Inspectors found concerning gaps in practice as well as poor progress in addressing previously identified non-compliances. Non-statutory providers are responsible for ensuring that their services are in adherence with Children First and that children are appropriately safeguarded. HIQA found that safeguarding practices such as required vetting, allocation of a link social worker to all foster carers, unannounced visits to foster homes and the provision of training in Children First were in place in the majority of services. However, significant safeguarding risks were identified in two services, related to inadequate systems for ensuring allegations of abuse or concerns about carers were appropriately reported and responded to in one service, and inadequate safety planning in another. By the end of 2019, both of these providers had ceased operation.

4.8.3 Responding to risks in commissioned services

In 2018, HIQA sought assurances from Tusla on foot of repeated findings of poor safeguarding practices and risks to children within commissioned non-statutory foster care services. HIQA sought assurances on Tusla's arrangements for oversight of these services. In response, Tusla revised and strengthened arrangements for governance of these services which included appointing a service director with primary responsibility for oversight of non-statutory foster care service provision.

Between 2019 and 2021, HIQA inspected all non-statutory foster care services again, including two new services that began operating during this period. Generally, safeguarding practices were much improved with four of five agencies found to be compliant or substantially compliant with national standards. In addition, the

majority of services were found to be compliant or substantially compliant with the requirements of national standards under governance and management of the foster care service. However, two services were not compliant with this standard. Inspectors identified deficits associated with poor or ineffective systems for the identification and management of risks, as well as monitoring and oversight arrangements. One service required a review of their policies and improved systems for recognising and appropriately responding to complaints or serious concerns against foster carers. In another service, significant improvements were required in monitoring of progress and timeliness of foster care reviews, as significant delays were not effectively addressed.

In the three years since 2021 HIQA has undertaken inspections in all non-statutory foster care services with a number inspected twice in that period. During 2023, the findings of inspections in five of six services were very positive. The majority demonstrated high levels of compliance with *National Standards for Foster Care (2003)* and inspectors found that providers had an emphasis on quality improvement. Action taken by providers to address previous non-compliances were comprehensive and of good quality.

Arrangements for vetting by An Garda Síochána were well-established. All foster care households had a link social worker who provided information, support and supervision. Training delivered reflected needs of foster carers within services and, in the main, there were effective monitoring systems and quality assurances systems in place. In one of six services, information management systems, auditing and risk management was found to be ineffective. This service provider ceased operating in 2023, leaving five non-statutory providers of foster care services nationally, at the time of this report.

Table 3 details the findings of inspections of non-statutory foster care services in 2023.

Table 3. Findings of inspections of non-statutory foster care services in 2023

Non-Statutory Foster Care Services	Standard 8	Standard 10	Standard 15	Standard 16	Standard 18	Standard 19	Standard 21	Standard 25
Foster Care Service 1	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Foster Care Service 2	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Substantially compliant
Foster Care Service 3	Substantially compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Foster Care Service 4	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Foster Care Service 5	Compliant	Compliant	Compliant	Compliant	Compliant	Substantially compliant	Compliant	Compliant
Foster Care Service 6	Substantially compliant	Not compliant	Compliant	Compliant	Substantially complaint	Not compliant	Compliant	Substantially compliant

Chapter 5: Children's residential centres (CRCs)

5.1 Regulatory framework for children's residential centres

In 2018, HIQA published the *National Standards for Children's Residential Centres*, alongside a guide for children living in residential care, called *Your guide to children's residential care*. These standards were developed based on international best practice and the views of a wide range of stakeholders. They replaced previous 2001 standards, were approved by the Minister for Health in consultation with the Minister for Children and Youth Affairs, and apply to all children's residential centres. We also monitor compliance with the Child Care (Placement of Children in Residential Care) Regulations 1995 in relation to the role of the social worker for children in care.

HIQA inspects against its 2018 *National Standards for Children's Residential Centres* and also monitors compliance with the relevant Child Care (Placement of Children in Residential Care) Regulations 1995, as authorised by the Minister for Children, Equality, Disability, Integration and Youth under section 69 of the Child Care Act 1991 as amended. Up to 2018, we had inspected children's residential centres against national standards published by the Department of Health and Children in 2001[24] that had been based on the Child Care (Placement of Children in Residential Care) Regulations 1995.

5.2 Introduction to the monitoring of children's residential centres

Where a child cannot live at home and there are no foster care placements available which can meet their needs, the other care placement option is to live in a children's residential centre (CRC). Children's residential centres are residential houses in villages, towns and cities, and occasionally in rural areas across the country. They typically have between two to six children living there, usually in their teens. The children, like all others in their community, attend local schools and take part in local sporting and community activities. Tusla operates a small proportion of children's residential centres, which over the years has fluctuated between 35 and 40 centres. The majority of children's residential centres in Ireland are operated by non-statutory providers, both private and voluntary which do not fall within our remit. At the end of 2023, there were 201 CRCs nationally, with 164 of these non-statutory.[25] As of the end of September 2023, there were 397 children in CRCs.[26]

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[24] Department of Health and Children. National Standards for Children's Residential Centres. Dublin: Department of Health and Children. 2001.

[25] Tusla 2023 Annual Report & Financial Statements. Dublin: Tusla; 2024.

[26] oireachtas.ie — Children in Care. Dáil Éireann Debate, 14 December 2023. Parliamentary question to the Minister for Children, Equality, Disability, Integration and Youth.

Our inspection activity in CRCs between 2014 and 2023 is shown in Table 3. Each on-site inspection takes places over one to two days and may be carried out by one inspector or a team of two inspectors. Some inspection activity is also conducted remotely, such as making contact with children or family members by telephone. Most inspections have been unannounced (some were announced during the COVID-19 pandemic). Respite services may be notified of inspections a day in advance to enquire if children are in placement at the time. The number of CRC inspections fluctuates slightly each year as Tusla commissions new centres and or temporarily decommissions or repurposes other centres.

Table 4. Inspection activity in Tusla children's residential centres

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
CRCs inspected	21	23	39	21	38	18	20	26	20	20

HIQA monitors CRCs rather than regulates them. This chapter presents on overview of CRCs with a focus on five key areas:

- governance
- resources
- child protection and safeguarding
- impact on children.

5.3 Governance of children's residential centres

When HIQA began inspections of CRCs operated by Tusla in 2014, 21 centres were inspected. Management practices and governance arrangements were found to be varied in their quality and effectiveness. There were experienced and qualified managers who provided positive leadership and effective decision-making in some centres. As a result, children received good quality care. In other centres, however, management structures were unable to provide sufficient leadership and direction to guarantee a safe, good quality service. Tusla monitoring officers, who have responsibility for monitoring the quality and safety of care provided within CRCs, were not visiting all centres to assess the quality of care being provided.

In that initial year of inspections, a thematic programme of inspections, examining the management of behaviours that challenged within CRCs, was undertaken. Risks were identified and inspectors found that services were not always able to manage children's behaviour. This was the case in six of 22 centres inspected in 2014. There were concerns in relation to inappropriate admissions to centres, meaning children had been admitted to centres even though their needs exceeded the capability of the staff team. Multidisciplinary support services in 2014 had not always been available to children, even though some children's needs were highly complex. In

that first year, there were 20 actions issued under governance, leadership and management, and HIQA was concerned that in some centres, Tusla did not have suitably experienced, knowledgeable, skilled and well-trained staff in place.

None of the 10 centres inspected in 2015 under the thematic inspection programme, focusing on behaviours that challenged, met the standard related to governance and management. One centre was operating with significant risk and nine required improvement. Admission processes were not always child-centred in terms of managing behaviour that challenges. This was because they did not always take into account the dynamics between the children and the possible impact that a new resident might have on those already living in the centre. In addition, the premises from which some centres were operating, were not fit for purpose and not conducive to creating a safe, homely environment in which children could thrive.

In 2016, all CRCs were inspected and generally found to be providing good-quality care to children. While children's needs regarding their health and education were mostly being met, not all children had up-to-date care plans as required. Reviews of care for many children were not timely in line with regulations and national standards. Leadership, governance and management required improvement nationally, particularly with respect to risk management and oversight of care practices. Significant risks were identified in four centres including a lack of capacity to provide consistent safe care in two of these. National policies for the provision of CRCs were required as practice in significant areas were not consistent. Centres were operating within a combination of regional and locally adapted policies, some of which were outdated and not fit for purpose.

In 2017, inspectors observed a concerning lack of progress in addressing previously identified risks within residential services, with the standard on management and staffing being of most concern. HIQA continued to advocate to the Department of Children and Youth Affairs for the transfer of the registration and inspection function for non-statutory CRCs from Tusla to HIQA. By the end of 2018, the non-compliance trend in relation to the management and staffing standards continued. It was evident, however, that Tusla was becoming more proactive in dealing with these non-compliances. For example, non-compliances in 2017, such as the absence of up-to-date care plans for children, was an issue in the majority of centres inspected that year. This had significantly improved by the end of the following year.

5.3.1 Progress and improvements on governance in children's residential centres, 2019-2023

Since the implementation of new standards in 2019, our inspectors have observed significant improvements and consistency in practices nationally. During 2019, while governance and management practices varied across the 18 centres inspected, there were marked improvements to governance systems across many centres. Moreover,

inspections of these services in 2019 did not find any centre which was under-resourced in terms of staffing.

Governance of residential centres continued to improve in 2020. Inspections found greater uniformity across the country in relation to governance and oversight of these services and the systems of monitoring at a local, regional and national level. A culture of learning that supported continual improvement was a common finding. However, in a minority of centres, there was evidence that leadership structures were severely challenged and managerial systems were not being implemented consistently or effectively.

In more recent inspections in 2022 and 2023, inspectors found that the improvement trend in governance has been maintained and improvements continued. In addition, risk management systems were working well and this was particularly important in light of the impact that COVID-19 had on staffing resources and the continued safe operation of each centre.

Overall, since HIQA began to monitor CRCs in 2014, there has been a steady improvement with compliance against the national standards dealing with governance, leadership and management in these centres. In particular, the previous four years (2019 to 2023) have seen sustained improvement in governance of these centres following many years of poor findings and varied practice seen across the country. There are still some management practices that require improvement, although it is acknowledged that capacity challenges in terms of lack of onward or suitable placement for many children and young people with highly complex needs is a challenges for Tusla.

5.4 Resources in children's residential centres

Throughout the past decade, HIQA has seen that the vast majority of children in CRCs received good quality care in a safe and nurturing environment by committed staff teams. Inspectors have consistently reported observations of warm and considerate interactions between staff and children, and children regularly report feeling safe and well cared for. Throughout the earlier years of inspections (2014-2017), inspectors found that there were adequate numbers of qualified and skilled staff to care for children, albeit that in a small number of centres, children's needs could sometimes not be met within their placements. By 2018, gaps in full-time, consistent staff began to emerge and a practice of appointing centre managers in interim positions for long periods became apparent in a number of centres nationally. In addition, on-call arrangements to provide support to CRCs outside of typical business hours were unsustainable and inconsistent nationally. There was no formal out-of-hours support arrangements in place. Inspectors found that centre managers informally agreed to keep their phones on and be available to provide support to their teams during evenings and weekends.

As cited above, concerns relating to children placed in centres that could not adequately meet their needs emerged regularly throughout the last decade. HIQA found that when children needed to leave a CRC, it often took a significant period of time to achieve. This resulted in some children, both those requiring higher levels of support and those sharing their home with children in these circumstances, spending prolonged periods of time feeling unsafe or without adequate safe care and attention within their homes.

In 2020, Tusla made a decision to open two CRCs on a temporary basis to provide placements for children for whom it had no alternatives. One of these centres was opened in a building that had been closed previously as it was deemed not fit for purpose. At the end of 2020, HIQA took the decision that inspections in 2021 would be focused on Tusla's strategic planning and provision of services for children with complex needs.

The lack of alternative placements for a minority of children with complex needs and behaviours continued to pose a significant risk to Tusla in 2021. This risk was escalated by HIQA to Tusla at national level, seeking assurances as to how this reoccurring, systemic risk would be addressed and managed. A risk-based inspection of one temporary CRC found significant risks that were then escalated. Tusla took urgent action to remove the child to appropriate alternative placement before closing the centre. In October 2021, a further escalation by HIQA to Tusla at national level sought assurances that the potential for other similar unsatisfactory arrangements would be avoided and appropriate plans put in place to address the issue of lack of appropriate placements for children with complex needs. In response, Tusla committed to developing a new residential care strategy as part of its plan to respond to meet the needs of children requiring care.

In addition to gaps in availability of services, staffing deficits began to emerge through inspections of CRCs in 2021. Of 12 centres inspected in the first half of the year, five had a full complement of staff and seven did not. In the absence of full-time social care staff, CRCs became dependent on agency staff to safely operate. Despite staffing challenges, the vast majority of CRCs were found to have appropriate systems for planning and organising their workforce. Tusla has sustained improvement and progress within its residential services and has effectively maintained compliance with the national standards across the majority of its CRCs.

While the vast majority of centres are homely and inviting, there are a small number of residential care centres to be provided in buildings and locations that are not fit for purpose and not appropriately maintained. Plans to identify suitable alternatives have been slow to progress. Plans, as outlined within Tusla Residential Care Strategy 2022 - 2025, to further develop residential services — for example, to provide placement options for children leaving special care or to support foster care placements at risk through the provision of increased respite placement options —

have to date been slow to materialise. Tusla proposals to reduce dependency on non-statutory providers of residential care services continue to be developed. The challenges in terms of having adequate numbers of social care workers and social workers as well as other relevant disciplines to meet requirements of the service continues at the time of publication.

5.5 Child protection and safeguarding

Our monitoring inspections of CRCs in 2014 found that, overall, children and young people were well cared for by dedicated and committed staff members. Most children were in full-time education and were being supported to achieve their educational potential. In centres where behaviour was well-managed, inspectors found a positive behavioural support model in place which focused on developing children's self-esteem. However, some significant risks were identified and in 2014, Tusla made the decision to close two centres and move a third to a more appropriate premises, following concerns relating to fire safety raised by inspectors.

By 2016, inspectors found that safeguarding and child protection practices, including practices for managing incidents of children missing from care were, for the most part, good. Relevant standards relating to child protection were compliant in 14 of 18 centres inspected — therefore the majority of services were proactive in safeguarding children. Significant risks were identified in the remaining four centres. These included risks related to inappropriate placement of children, children's needs not being adequately met, and poor preparation for leaving care and aftercare planning. Inspectors found that, in a limited number of cases, there were poor or ineffective plans in place to inform staff practice in regard to behaviour that is challenging.

Inspections found improved practice throughout the subsequent years and in 2019 the majority of inspections found children being well cared for and experiencing nurturing and safe care. Inspectors found that children's safety was a key priority, and family members who spoke with inspectors were happy that their children were safe. Where inspectors found specific risks in individual centres, Tusla was proactive in addressing these issues. For example, in 2023, Tusla closed a children's residential centre as a response to poor practice and inadequate safeguarding practices.

Overall, more recent inspections found that there was good awareness among staff of the risks to the safety and welfare of children in their care. Children's care records included individual risk assessments and individualised strategies to safeguard children missing from care, which, identified particular vulnerabilities such as risks of self-harm or exploitation. Inspectors saw examples of good interagency practice to ensure children's safety, where multiagency professionals meetings were held to share learning and strengthen management of risk to young people who were

known to be vulnerable to exploitation or exposed to harm, including when missing from care.

Challenges arose for services when children presented with more complex needs, as specialist services were required and these were not always readily available within CRCs. As cited above, alternative or onward placements were challenging to source in many cases and arrangements for provision of services for children in care with a disability were not finalised between Tusla and the HSE until late 2020. As recently as 2022 and 2023, inspectors have found that statements of purpose for respite CRCs have been amended in order to provide care to children while they were awaiting specialist placements.

Throughout the last decade, inspections have noted an evolving and expanding profile of the circumstances and experiences of children accessing CRCs. For example, in more recent years, the numbers of separated children seeking international protection has increased and this has led to a change in the statement of purpose for some centres. In addition, Tusla has identified the need to establish dedicated step-down placements for some children leaving special care, and these centres are in development at the time of publication, with one having opened in 2023.

5.6 Impact on children

Overall, children have consistently reported to inspectors that they are well cared for and their rights were respected and promoted within their CRCs. Children in CRCs regularly report to inspectors that they are supported to access their educational placements and are facilitated to see their families and friends regularly. Children speak highly of staff and their homes, and typically engage openly with inspectors about their experience of living in CRCs.

When asked over the years about things they would change or improve about their homes, children have offered a range of opinions and suggestions. Children have alerted inspectors to risks associated with the premises and facilities which required updating or renovation. They have relayed frustrations with repeated changes in allocated social workers and delays in decision-making due to this. Older children have highlighted risks and frustrations associated with delays in accessing aftercare workers to help them prepare for their life after care. Frequently, children reported dissatisfaction with being long distances from their county of origin when placed in CRCs far from their families and communities.

On the following pages are some examples of what children living in CRCs told our inspectors throughout the course of the past decade.

What children 'liked' about living in children's residential care

"You know you are welcome."

"I have talked to staff and felt heard."

"I am able to talk to staff."

"I feel safe living here and staff talk to me about keeping safe."

"They [staff] make you feel involved."

"It is [centre] really good, I'm happy here."

"We get to do fun stuff and I'm happy living here."

"It is not how they [young people] think it is, staff are nice, always there for you. You will not feel like a new kid, you will enjoy it."

"Very homely and comforting."

What children 'found hard' about living in children's residential care

"I have not seen my care plan."

"I do not like the rules of the house."

Saw their social worker "sometimes."

"I do not know what the future plan is for me."

"I do not want to be here."

Staff "put veg in everything, I keep telling them no veg, no veg."

"This place is so different to a normal house."

"It looks like an old person's house. Give me the funds and I woll do it, knock down some walls, paint it."

"It is up to staff - not us."

Chapter 6: Special care units

6.1 Regulatory framework for special care units

In 2015, HIQA published *National Standards for Special Care Units*. The standards apply to special care provided to children under the Health Act 2007 and the Child Care (Amendment) Act 2011. These Standards superseded the 2001 *National Standards for Special Care Units* that had been developed by the Department of Health and Children.[27] The Chief Inspector in HIQA carries out inspections in order to assess compliance with the regulations for special care units and against these national standards.

The Chief Inspector in HIQA began the registration and regulation of special care units as designated centres on 1 January 2018, with three units registered by November 2018.[28] Within each three-year registration cycle, monitoring and inspection of these services assesses and ensures ongoing compliance with the regulations and the 2015 *National Standards for Special Care Units.*

6.2 Special care units

There are some children and young people for whom, at particular times in their lives, care in the community cannot meet their needs. Special care units (SCUs) are high security facilities[29] where children are placed by a High Court order in response to the risk they may pose to themselves and or others. All three special care units in Ireland are operated by Tusla and together can accommodate 26 young people nationally.[30] Special Care Units cater for children and young people aged between 11 and 17 years old, who are very vulnerable, with complex psychological and sociological profiles.[31] HIQA, prior to 2018, only monitored these units as part of the children's residential service programme.

The following sections of this chapter will outline the key developments with respect to SCUs and will focus on:

- monitoring inspections between 2014 and 2018
- commencement of regulation in 2018
- governance and management
- resources
- impact on children.

[27] National Standards for Special Care Units: November 2014. Dublin: HIQA; 2015.
[28] Annual Report 2018 Health Information and Quality Authority.
[29] Annual overview report on the inspection and regulation of children's services - 2022. Dublin: HIQA; 2023.
[30] Chief Inspector. Special Care Unit Register (download). Dublin: HIQA; 2024.
[31] tusla.ie — Alternative Care: Special Care.

6.3 Monitoring inspections of SCUs between 2014 and 2018

From January 2014 until the spring of 2015, HIQA monitored special care units against the *National Standards for Special Care* and subsequently under the current *National Standards for Special Care Units: November 2014*. During the four-year period from 2014 to 2018, HIQA undertook 15 monitoring inspections of three SCUs. Inspections throughout this period identified that, for the most part, young people were well cared for, their education needs were appropriately assessed and met, and they were supported and encouraged to participate in decisions around their care. In addition, there were good management systems in place that ensured effective communication and decision-making and there were clear oversight systems in place at national level monitoring the quality of service provided in each unit. Key findings by HIQA throughout this period also identified that improvements were required in a number of areas, including: the use of restrictive practices, the management of risk, preparation for young people leaving special care and the governance and management of SCUs nationally.

Inspections during this period saw incremental improvements which resulted in better quality of life for the young people using these services. For example, in 2014 HIQA reported on the over-use of restrictive practices, specifically, single separation[32], and identified the need for better recording and closer scrutiny over such practices. By 2016, HIQA inspections identified cultural changes within SCUs whereby staff were routinely exploring effective alternatives to this practice and incidents of single separation had decreased nationally.

In 2017, inspections of all three SCUs found significant risks with the premises and buildings. Inspectors found that risks and non-compliances relating to buildings, reported in the previous years, had not been adequately addressed. Centres were not child-centred or sufficiently stimulating for the children living there. Furniture was minimalistic and functional and spaces identified for family visits were not inviting. The general practice of locking all doors as you passed through them created an atmosphere that was institutional and, at times, unnecessary. In addition, young people who were required to have play therapy interventions could not have these needs met and inspectors found that fire safety plans were of poor quality. This was a cause of significant concern for HIQA heading into 2018 having regard to impending regulation of special care units and the significant deficits in compliance, which needed to be addressed prior to their registration.

[32] Single separation refers to confining of a young person in his or her bedroom or another room or area as a means of control, without the young person's permission or agreement.

6.4 Introduction of regulation for special care

The regulation of SCUs for the first time in 2018 marked a significant development in the provision of secure residential services to children and young people in Ireland. On 1 January 2018, SCUs became designated centres under the Health Act 2007 (as amended). In line with the transitional arrangements set out in section 48(6) of the Child Care (Amendment) Act 2011, the Chief Inspector had to determine whether these units were fit for registration by 31 December 2018 in order for them to operate.

SCUs are inspected at least every 18 months against the Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 to determine whether these units continue to be fit for registration. Inspection and registration of these units aims to ensure they are both fit for purpose and progressive in their approach to providing care and support to some of society's most vulnerable children. There are currently three such units in Ireland, all operated by Tusla.

In 2018, Tusla applied to register four special care units, (the fourth unit had previously operated as a high-support unit and had been inspected by HIQA as part of our Children's Residential Centre Programme). Inspections were undertaken shortly thereafter to assess the suitability and capacity to comply with required regulations. An inspection in April 2018 identified significant challenges to comply with regulations in one centre and Tusla informed the Chief Inspector of its intention to close this unit, and it ceased operating in December 2018. The remaining three SCUs were successfully registered and continue to operate as such today.

SCUs have continued to be regulated and monitored by the Chief Inspector to ensure ongoing compliance with the regulations and national standards.

6.5 Governance of special care units

The introduction of regulation for special care units in 2018 brought a sharp focus to governance and management practices. Inspectors found, as was found prior to regulation, that management systems required further development. An improved risk management framework was required. While initial registration inspections in 2018 found that all of the units were well-resourced in terms of staffing for the number of children living there, each of the three units were operating below full capacity due to staffing shortages.

The quality of care young people received continued to be good. Despite improvements, some concerns around the use of restrictive practices remained. For example, the routine application of certain practices (locking internal doors throughout the units and routine checking of children throughout the night) did not reflect children's individual needs and there was insufficient consideration of the extent to which such restrictive practices were necessary. In addition, delays in

securing an onward placement for the young people were evident and the impact of these delays on their progression was notable.

Throughout the period 2018 to 2023, the findings in relation to the governance of SCUs varied. Inspections throughout this period identified improved and effective auditing and monitoring of practices that bought about improvements in areas such as fire safety and medication management. Improvements were identified in child-centred practices nationally. Management structures had been enhanced and crucially, children's experience of special care improved as they were afforded as much freedom as possible within the secure environment and restrictive practices were only implemented in response to risk and safety.

The lack of appropriate move on placements for all children ready to leave special care meant that although they no longer required a special care placement, they remained in special care, some until they were young adults. Inspections over this period identified that the profile of young people being accommodated and cared for within special care had evolved somewhat as the complexities of children's needs were increasing. This compounded the challenges in identifying appropriate onward placements for many children. In addition, staff vacancies across SCUs nationally significantly reduced the number of beds available to children requiring special care.

More recent inspections of the three special care units between 2022 and 2023 have identified inconsistency and variation in the management and governance of these services, while there have also been issues with the quality of some of the premises. In 2023, the Chief Inspector took escalation action in two special care units to address poor findings on governance. In these cases, Tusla responded promptly and effectively and demonstrated a governance system that accepts findings of non-compliance and actively pursues means by which it can come back into compliance. All three special care units were re-registered by the Chief Inspector in 2024.

6.6 Resources

Similar to the other children's services referenced in this report, SCUs are challenged in terms of filling staff vacancies and ensuring that staff have the right skills and training to provide the care that children require. As cited above, Tusla has been unable to operate SCUs at full capacity since 2018 due to the gaps in staffing resources. In addition to the lack of staff, concerns have arisen about the capacity and experience of staff within special care services to provide the level of support required to care for children with complex needs.

In 2020, an inspection of one SCU identified that the skill-mix and experience of the team was insufficient and impacted negatively on the quality of care in the service. In addition, the inspection found that resources were not well organised and experienced and more skilled staff, including managers, were not being effectively utilised to address the shortfall in resources. Despite a high turnover of staff across

the services nationally, there has been a level of stability at managerial level which has ensured continued progress and improvements in areas that impact on staff recruitment and retention. Supports in place for staff and managers have improved and this, in turn, has led to improved practice.

Despite vacancies, each SCU has provided good quality care and there remains a stable, knowledgeable and skilled core group of staff in each of the units to support and provide oversight to newer or less experienced staff members. Tusla has had a consistent focus on recruitment and retention of staff, although initiatives put in place have had varying degrees of success.

Over recent years, there has emerged a concerning trend in young people with complex needs requiring specialist supports outside of those intended to be cared for within SCUs, such as medical detoxification. In recent years, SCUs have seen a shift in the profile of young people being referred for care within their services. As a result, there has been a need to adapt and expand on the resources and knowledge-base amongst special care staff to accommodate and adequately care for these young people.

In 2023, additional resources in the form of security staff were engaged by Tusla to address risks relating to challenging behaviours by young people. The engagement of security staff as a resource to support social care staff in managing children SCUs in 2023 constituted a breach in registration by the provider. The Chief Inspector escalated these concerns to Tusla. In response, safety arrangements and oversight mechanisms were introduced to address immediate risks identified.

6.7 Impact on children

Most inspections of SCUs have found that the vast majority of young people receive good quality care that addresses their specific and individual needs. Observations by inspectors routinely report positive and caring interactions between children and their carers. Young people regularly report good relationships with staff in all units and express that they feel supported in areas that are important to them, such as keeping in contact with their families.

Inspections have found that each young person has individualised programmes of care which are regularly updated and reviewed as required. Young people received supports including specialist therapeutic supports as required. For many young people, SCUs successfully supported them to stabilise their behaviours and develop skills to achieve ongoing success in community placements.

An outcome-based model of care introduced in SCUs saw an increased focus on individualised care plans tailored to meet young people's specific needs. Early on in the registration process, inspectors noted a shift in mind-set and culture around the use of restrictive practices, arising out of an increased awareness amongst staff on the impact of such practices on young people and their experience of special care.

Throughout the period of COVID-19, inspections of SCUs identified that, despite challenges related to restrictions, young people's rights were respected and promoted. Young people continued to have contact with their families and to actively participate in decisions about their care.

A lack of follow-on or step-down placements for young people that are ready to leave SCUs causes significant problems. Inspectors have met with a significant number of young people in this position throughout the last number of years and each reports similar sentiments: frustration, worry for their future and, for some, a loss of hope.

On the following pages are some examples from inspection reports describing what children and young people told our inspectors about their time in SCUs.

What children 'liked' about living in special care

"It is an alright place to be."

"As good as it can be."

"It is good...like the rules

"Staff were nice."

Helped them "tackle" individual "difficulties and issues."

"I really like it here but I know I have to move on."

"It [the centre] is not a place I ever wanted to go to but I am glad in a sense."

"Look at me now."

What children 'found hard' about living in special care

"If abscond you will be locked in."

"As good as it can be."

That "If you ascond it comes with consquences."

"Two to six weeks or eight weeks before you go out again."

"The minute I got a placement the last time, I did everything I had to do."

Had "lost hope for their future."

"You get depression in here, it makes you worse, it does not help and it is disgusting here"

"Got boring going out with the adults all the time, teenagers do not want ths."

"Management make the decisions, it is different every time. It depends on what happened [while you were on abscond], the risk of it happening again and the danger."

"It is an alright place to be."

Chapter 7: Children's voices

7.1 Introduction

A key element of HIQA's process is to seek the views of the children and young people using each of the diverse range of children's services we monitor and inspect. Children's experience of the services, the impact of services on their lives and their views on what is working well or what could be improved, provide vital insights to inspectors and are fundamental considerations which inform judgments on inspection.

Over the course of our inspections of Tusla services and of non-statutory foster care services, HIQA inspectors have met with thousands of children to hear about their experiences of social services in Ireland. Between 2014 and 2023 inspectors had more than 2,500 interactions with children and young people (Table 5). Our interactions have taken many forms, including face-to-face meetings, telephone conversations, video calls, group meetings and surveys completed by young people.

Table 5. Discussions with children and young people as part of inspections

Area of care	2014	2015	2016	2017	2018	2019	2020[33]	2021[34]	2022	2023
Foster	57	47	131	*	*	176	914	51	47	63
CPW	37	23	0	0	0	22	43	36	24	10
CRCs	53	59	98	61	88	35	60	63	65	45
SCUs	8	19	7	8	13	11	13	11	16	17
Total	**155**	**148**	**236**	**69**	**101**	**244**	**1,030**	**161**	**152**	**135**

* During thematic inspections in 2017 and 2018, inspectors only met with the relevant professionals involved in foster care services and with foster carers.

While every effort is made to speak with as many children as possible, some children prefer not to engage with inspectors. In such circumstances, it is still possible to represent their experience of care. This can be done, for example, through observations of interactions between them and their carers, examination of how their views and wishes are sought and recorded within files and through speaking directly with their carers or guardians. Furthermore, over the past 10 years, inspectors have encouraged communication from children through drawings and

[33] Children participated in inspections by talking directly with an inspector or by completing and returning a questionnaire.
[34] Children participated in inspections by talking directly with an inspector in the centre, by phone or in a focus group with an inspector, or by completing and returning a survey.

pictures, songs and poems as well as play, to express how they feel and convey their experiences of services.

7.2 What children told us about their experiences in care

For the most part, children speak very highly of those providing care or supporting them and their families. In child protection and welfare services, children who are allocated a social worker mostly tell inspectors that their lives have been improved by the involvement of Tusla with them and their families.

Over the course of the last 10 years, children and young people have reported a number of dislikes or suggested improvements to inspectors. For example, some children expressed frustration with accessing their social workers, indicating to that they may not be visited by their allocated social workers at the frequency required by regulations. Other children told inspectors about their upset at having to get to know several social workers over short periods as, for most, this meant losing contact with social workers they liked and had grown to trust. This feedback guided inspectors to examine the impact of changes in staff on consistency of care for children and young people.

Children in care who were placed significant distances from their homes frequently told inspectors about their unhappiness at being so far from their families and communities. At times, some children told inspectors about distressing experiences or incidents which they witnessed while living in care or expressed concerns about restrictive practices in use. Some older children approaching their 18th birthday reported upset and worry about uncertainty on their future plans as next steps were not clear and they awaited allocation of an aftercare worker.

Below is a sample of feedback received during various inspections carried out since 2014.

In 2014, children in residential services knew how to make a complaint and complaints were well managed when compared to foster care and child protection and welfare services. Children talked about their carers, their social workers and how they were able to keep in touch with their families and friends. They described their lives at school and opportunities they had for play, sport, exercise, hobbies and other recreational activities.[35]

[35] 2014 Children's overview. HIQA's Annual report of the regulatory activity of Children's Services in 2014.

During inspections in 2016, the majority of children told inspectors that they felt safe, were well supported by their carer or social care staff, were listened to, and that they had someone to talk to if they had a worry or were upset by something. However, similar to findings in 2015, there was a lack of knowledge among some children in some services about their rights, including their right to access information held about them and how to make a complaint.[36]

In 2018, most children living in residential centres were happy and felt safe in their placements. While one child mentioned having had many different social workers, many children said they saw their social workers regularly. Some children did not like having alarms on their bedroom doors and others said the kitchen door was sometimes locked at night. Some children were worried about what would happen to them when they turned 18 and were unsure of where they would live.[37]

In 2020, children and young people in secure care felt well cared for and looked after. They said that their rights were being promoted, and they felt listened to and valued. These children were happy with their level of participation in decisions about their placement and their lives. Some children reported being bored and this was difficult for them to manage. However, overall, they said they were kept active through sports, outdoor pursuits, indoor activities and school. Several children were not happy with the length of time they stayed in their placement.[38]

During inspections in 2022, the majority of children and young people who spoke with inspectors said they were given appropriate information on their rights, and, in some cases, had exercised them. Children and young people in secure care spoke about how staff ensured that they understood their rights. In relation to family contact, the majority of children and young people were happy with the arrangements in place, while some would like to see their families more often.

Most said they were involved in the discussions about the plans for their care and aftercare, and they understood their care plan. However, a number of children told

[36] 2016 HIQA overview. HIQA's Overview of 2016 HIQA regulation of social care and healthcare services.

[37] 2018 Children's overview.

[38] 2020 Children's overview. HIQA's Annual overview report on the inspection and regulation of children's services - 2020.

inspectors that they had encountered some challenges, including poor translation services, failure to follow through on decisions or agreed actions and limited interaction or engagement from social workers. Some of the young people also expressed uncertainty and a lack of information about planning for their aftercare.[39]

In 2023 Children who engaged with inspectors spoke positively about their participation in decision making. The majority said their rights and views were respected and promoted and they felt listened to and had a say in matters affecting them. Children who engaged with child protection and welfare services were happy about how their social workers supported them. Children's experience of the foster care services were good, they spoke highly of their foster carers and were well cared for. When children were allocated to a social worker they had good contact with them. However some children experienced challenges with the changes in social workers allocated to them over the years. Children and young people in secure care settings were generally positive about their experience of living there. Their voices were heard and acted upon appropriately, and they felt included in all aspects of their care.

7.3 Engaging with children

While children's voices were incorporated in reports in the early years of monitoring by HIQA, this was enhanced in 2018. In 2018, inspectors worked with the participation hub in the then Department of Children and Youth Affairs to develop a training programme in order to enhance communication and engagement with children and better capture the experiences of children in the care system. Inspectors received training in the 'Lundy Model' of child participation in 2018 and again in 2023. This model, developed by Professor Laura Lundy of Queen's University of Belfast, provides a way of conceptualising a child's right to participation, as laid down in Article 12 of the United Nations Convention on the Rights of the Child.[40]

In 2019, HIQA inspectors applied the participative principles of the Lundy model to improve our communication with children. Child-friendly consultation tools were incorporated into our inspection processes for foster care, child protection and welfare, children's residential centres and special care units. This meant that children could use writing or drawing, as well as talking with inspectors, to express how they

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[39] 2022 Children's overview.

[40] Laura, Lundy (2007) "Voice" is not enough: conceptualising Article 12 of the United Nations Convention on the Rights of the Educational. http://dx.doi.org/10.1080/01411920701657033.

were feeling about certain aspects of care. In addition, changes were made to our inspection reports by adding a new section on what children told us about their experience of their service.

Our ability to engage directly with children in 2020 and 2021 was severely curtailed by the COVID-19 pandemic. Nevertheless, inspectors adapted our approach to engaging with children in order to ensure that their voice continued to be heard through online formats and phone calls. In 2020, inspectors engaged with children in services provided or funded by Tusla on 1,030 occasions.[41] Inspectors were particularly focused on ensuring that young people in care continued to be supported to visit their families and communities and had access to their social workers as required, despite public health restrictions. The vast majority of children in care reported that they were effectively supported and their needs were met and rights respected during this time.

Many children in care also reported that their care staff and or social workers advocated for additional supports to ensure their care needs were met throughout the pandemic including: promptly providing technology for facilitating online education; supporting children and parents to travel for visits; and ensuring young people's healthcare needs were appropriately catered for.

In 2021, the level of direct engagement between children and inspectors declined sharply to 161 children, as the pandemic impacted on engagement opportunities.[42] Conversations with children and young people were mainly held through phone calls and online focus groups. A variety of service-specific, child-friendly questionnaires and other communication tools were devised and sent to residential services encouraging children to report their experiences and views during that difficult period. In addition, we developed a new survey which was designed to be used by any child accessing a service.

As public health restrictions eased in 2022, inspectors made a significant effort to recommence meeting with children in person, as well as continuing remote and online engagement. Between 2022 and 2023, HIQA engaged with 287 children, either directly, over the phone or by way of a questionnaire.[43]

7.4 Child-friendly initiatives and developments

Improving and expanding engagement and interaction with children and young people is a key driving force behind our work. In addition to eliciting their views on Tusla services, HIQA has sought input from children and young people on our service and how we might improve what we do from their perspective. We have

[41] Annual overview report on the inspection and regulation of children's services - 2020.
[42] Health Information and Quality Authority Annual Report 2021.
[43] Health Information and Quality Authority Annual Report 2022.

sought to encourage children and young people to share their positive experiences of social services and to recognise HIQA as an advocate for better safer services for them. Some examples of child-friendly initiatives are detailed below.

In 2016, HIQA organised an art competition for children in care in Tusla residential and special care services. The task was to design a thank you post card, for use by inspectors, to send to children to thank them for engaging with HIQA staff during inspections of their homes. The winning entrant was made into a thank you card and was used by inspectors until 2022

During 2020, HIQA organised a competition for children placed in Tusla residential and secure care settings. Children were encouraged to submit entries that demonstrated the theme of kindness during the pandemic. Children sent in examples of complex projects and activities, stories and poetry that they had created during restrictions and pictures representing expressions of their thoughtfulness and care of others. Examples of entrants received during this initiative can be seen below.

During the summer of 2024, HIQA ran a competition to design the cover of this report. It asked children to design a poster on the care and support they receive from children's social services under the theme of 'Hear my voice'. This provided another opportunity to showcase the extraordinary talent of children in receipt of care across Tusla services, as well as an opportunity for children to tell inspectors about their experiences. The winners of the competition are shown on the following page.

7.5 Incorporating children's voice in inspection reports

Writing and publishing inspection reports is an important responsibility for the Chief Inspector. These reports are often detailed and sometimes technical which makes them difficult to access for some children. In 2019, HIQA made changes to the format of its inspection reports to include a section entitled 'What Children Told Us and What Inspectors Observed'. The aim was to make the information shared by children and significant people in their lives more accessible and relatable in inspection reports. Furthermore, inspectorate staff received training in a human rights-based approach to care. Following on from this, HIQA sought to further increase engagement with children and young people by finding a way that they might be encouraged to read and understand inspection reports. The first step in achieving this was to write the first children's version of our overview report in 2022.

In 2023, HIQA organised a consultation group of children in statutory residential centres, with the aim of seeking their views on how best HIQA could keep them informed of findings of inspections of their residential homes. Children's feedback and ideas, as well as their experience of HIQA inspections, were used to inform the next steps in increasing our engagement. Following consultation, the team set about developing a format for producing a young person-friendly overview report which would detail the key findings of inspections that would be age-appropriate with easily-understood language and content. The aim of this initiative is to encourage children and young people to continue to express their views and assure them that their voices has been heard and represented. In 2023, HIQA began producing a

young person's report of each inspection of statutory children's residential centres which is provided to each service for children to access.

7.6 What has this meant for children?

Children's engagement with inspectors is a vital tool in understanding the impact of services involved with them and their families, on their lives. Over the last 10 years, children have guided and informed inspectors by telling their stories and sharing their lived experience. Equally, children's stories have informed inspectors of risks and deficits in service provision and the depth of impact that these risks have on them and their families.

By communicating our findings directly to children and young people it is our intention to empower them to have a say in how their service is being run and how they are being cared for. We will continue to produce inspection reports that place children's rights and the voice of the child in a prominent position. We will also continue to seek opportunities to improve our own practice and our impact on the experience for children engaged with social services across Ireland.

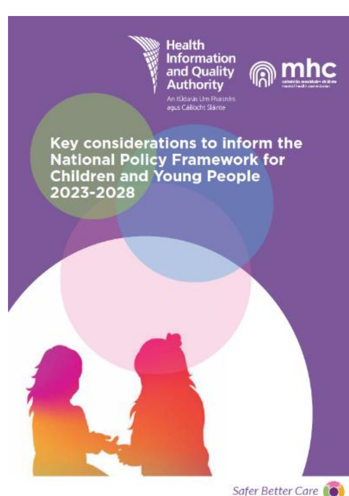
Chapter 8: Working in partnership with providers, residents and advocates

8.1 Introduction

Throughout the 10-year journey covered in this report, HIQA has actively worked with children, their families, providers and advocates to help improve the quality and safety of children's services. Collaborative working with stakeholders is at the core of our values and is indeed, essential to influence change and improvements in services. At a senior management team level, HIQA worked withwith policy makers, most recently the Department of Children, Equality, Disability, Integration and Youth to shape better services for all children. We have championed openness in our interactions with Tusla and non-statutory foster care providers and have sought to establish effective, collaborative relationships. This means being responsive to feedback, being accessible and accommodating to requests for feedback or clarification from Tusla managers and staff following inspections. In the interests of fair procedures, there is also a clear route for providers to challenge judgements on their service.

Through the publication of inspection and overview reports written especially for children and young people, HIQA has strived to engage more children to share their views and opinions on services. These engagements are now set out in the following chapter.

8.2 National Policy Framework for Children and Young People



In 2021, HIQA participated in a public consultation on the next policy framework for children and young people in Ireland and in 2023, HIQA submitted a paper to policy-makers in the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) and the Department of Health. The paper, entitled *Key considerations to inform the National Policy Framework for Children and Young People 2023-2028*, was developed in partnership with the Mental Health Commission.

The paper shares learning gathered over the development of the *Draft Overarching National Standards for the Care and Support of Children using Health and Social Care Services* regarding systemic challenges impacting the quality, consistency and coordination of care and support provided to children. The paper sets out three key areas where important advances can be made in. These are:

- improving interagency working

- supporting effective transitions from child to adult services
- supporting services to deliver timely and appropriate care and support.

The paper is available on the HIQA website here.[44]

8.3 Feedback and concerns about services

In 2019, the Information Handling Centre within HIQA, responsible for receiving all concerns and unsolicited information from members of the public, developed a concerns booklet specifically for children's services, entitled *We want to hear from you: How to provide feedback or make a complaint about a children's social care service*. This was updated in 2024 and is available on the HIQA website.[45] The booklet aims to explain what to do if children or young people, a family member or someone acting on a child's behalf wants to give feedback or make a complaint about care or treatment in a children's services under our remit. While HIQA is unable to investigate individual complaints about a children's service under the Health Act 2007, we will listen to what children, their families and significant people in their lives, have to say. This feedback will be used to establish if a service is safe, effective, caring, and well managed.

8.4 Working with policy-makers and providers

HIQA's mission is 'protecting service users, and working with stakeholders to enhance and enable equity, quality and safety of health and social care services for all people in Ireland'. Together with our stakeholders we seek to achieve our mission by regular communication and strong collaborative working.

Over the last 10 years, our work with providers and government departments has developed and regular engagement occurs at every level in Tusla from front line staff to the Executive, and up to the Secretary General in the Department. Between 2014 and 2024, senior managers within HIQA and the Chief Inspector endeavoured to work with our stakeholders outside the inspection process. The aim of this engagement was to reflect on good practices seen or to consider the best monitoring and regulatory strategies to address serious risks to the safety and welfare of children and young people. Each year, HIQA holds regular meetings with the CEO of Tusla and members of Tusla's executive management team as well as quarterly operational meetings with other key senior managers to share information on regulatory developments, risks, practice issues and service delivery. These meetings are of critical importance, in that they enable both HIQA and Tusla to

[44] HIQA submits paper to inform the National Policy Framework for Children and Young People – HIQA News.
[45] We want to hear from you: How to provide feedback or make a complaint about a children's social care service. Dublin: HIQA; 2024.

discuss key areas of concern for example, to discuss their strategic plans to address risks within their organisation such as structural changes. In addition, since 2021 HIQA also has held stakeholder meetings with staff from special care units, foster care, and child protection and welfare services around key developments and in relation to inspection programmes.

During the last 10 years, the CEO of HIQA and the Chief Inspector regularly met with the Secretary General of Department with responsibility for children's services and most recently the Secretary General of DCDEIY. These meetings exchanged relevant updates and information on risks across the sector, policy updates, and discussed progress on regulatory developments. Quarterly, operational meetings are held between the Chief Inspector and the Assistant Secretary General of the Child Policy and Tusla Governance Division.

HIQA also was involved in working groups with the Department and other stakeholders in relation to developments such as working groups or round table discussions about the development of regulations for special care units and draft children's residential services and legislative change in areas such as aftercare, adoption and regulation of children's services. For example, in 2020, HIQA participated in the consultation by the Department of Children, Equality, Disability, Integration and Youth on the review of the Child Care Act 1991. A representative from HIQA was also part of a working group chaired by the Department in relation to the single allocation of social workers in foster care. In 2021, HIQA participated in the Department's public consultation on the next Government Policy Framework for Children and Young People in Ireland. In 2022, HIQA participated in the public consultation in relation to the draft codes of practice under the Assisted Decision-Making (Capacity) Act 2015. In 2023, HIQA made submission on Child Care (Amendment) Bill 2023. We have also worked with the Participation Hub within the then Department of Children and Youth Affairs and the current Department of Children, Equality, Disability, Integration and Youth to develop a training programme for inspectors. The training sought to further enhance engagement skills with children during inspection activity.[46] HIQA routinely attends stakeholder meetings with the Department and Tusla. A representative from HIQA has also attended stakeholder meetings in the Department in relation to the *National Strategy on Children and Young People's Participation in Decision-Making*,[47, 48] which was published in 2019 and commits HIQA to a number of actions.

HIQA and the Mental Health Commission have worked together on a number of initiatives. The development of *Overarching National Standards for the Care and*

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[46] Ibid.
[47] Ibid.
[48] Gov.ie — National Strategy on Children and Young People's Participation in Decision-Making. From Department of Children, Equality, Disability, Integration and Youth; 2019.

Support of Children using Health and Social Care Services (see above and chapter 1) with the Mental Health Commission aims to improve the quality and consistency of services that children accessing care receive. In 2022, we submitted these standards to the Department of Health and the Department of Children, Equality, Disability, Integration and Youth for Ministerial approval. We look forward to engaging with the departments to progress their implementation for the benefit of children and their families.[49] Over the years, HIQA has presented to third level students in relation to our role and remit in Dublin Institute of Technology, University College Cork, Trinity College Dublin and University College Dublin. In addition, members of our team have participated and presented at conferences, such as the IFCA conference, European Social Services Conference, and the National Child Protection and Social Work Conference.

8.5 Working with advocates and other agencies

The following is a list of some of the organisations that HIQA has engaged with over the past decade:

- EPIC (Empowering People in Care) — an organisation that aims to advance the interests and welfare of children and young adults in the care system[50]
- Irish Foster Care Association (IFCA) — the national organisation that supports foster families and the wider fostering community[51]
- Ombudsman for Children's Office (OCO) — a statutory body that investigates complaints about services provided to children by public organisations and promotes children's rights[52]
- Department of Education and Skills Inspectorate
- Alliance of Birth Mothers — advocacy group for birth mothers whose children are in the care of Tusla
- Providers of non-statutory foster care services
- Oireachtas (parliamentary) committees, public representatives and representatives of the media.

8.6 Engagement on the development of thematic inspection programmes

As referenced earlier in this report, since 2018, HIQA has introduced quality improvement inspections called thematic inspection programmes, which have followed a prescribed methodology across the organisation. A key component in the development of these programmes is extensive engagement with an advisory group made up of key stakeholders such as representatives from the Department, advocacy groups and academics. Since 2018, two thematic programmes of

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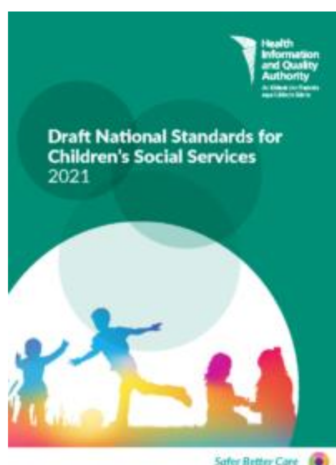
[49] HIQA News, Issue 50, 9 August 2022 — Message from our CEO.
[50] epiconline.ie — What we do.
[51] ifca.ie — What we do.
[52] oco.ie — About us.

inspection have been developed and implemented, firstly, a child protection programme thematic programme (2019–2021) which was a direct response to systems risks found during inspections and the statutory investigation. Secondly, a thematic programme (2021–2022) focused on Tusla's governance of foster care services. For more information on these programmes, see chapters 3 and 4.

8.7 New standards for children's social services under development



The *Draft National Standards for Children's Social Services 2021* were informed by a review of national and international literature on children's social services, as well as extensive engagement with stakeholders. HIQA met with over 340 people including children, young people, families, foster carers, advocates, staff and policy-makers during the development process. Work on these standards has been completed and the draft standards were submitted to the Minister for Health, and Minister for Children, Equality, Disability, Integration and Youth for approval. HIQA is working in partnership with the Department to develop further guidance in relation to these standards to support future implementation.

8.8 Overarching national standards for children's services

In addition to the *Draft National Standards for Children's Social Services*, HIQA identified a need to devise national standards that would encompass a wide range of children's services. In response, HIQA and the Mental Health Commission developed draft overarching national children's standards to focus services on supporting a child's journey through the range of services that they may use. The overarching standards were finalised in July 2022 and were submitted for Ministerial approval.[53] These are currently under consideration by the Department.

The *Overarching National Standards for the Care and Support of Children using Health and Social Care Services* aim to promote best practice in order to improve the experience of all children using health and social care services. It is anticipated that they will require supporting material such as guidance documents to ensure they are implemented consistently. One example of supporting material will be the *National Standards for Children's Social Services*.[54] Together with the current regulatory

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[53] Key considerations to inform the National Policy Framework for Children and Young People 2023–2028. Dublin: HIQA and the Mental Health Commission; 2023.

[54] *Evidence review to inform the development of Draft Overarching National Standards for the Care and Support of Children Using Health and Social Care Services*. Dublin: Mental Health Commission and HIQA; 2021.

framework, the overarching standards, when approved, will support providers to achieve the best possible outcomes for children.[55]

[55] Opening statement by Chief Inspector to the Oireachtas Joint Committee on Disability Matters, 8 November 2023.

Chapter 9: Current and future challenges

9.1 Introduction

Improvements across a range of services over the past 10 years of monitoring and regulating Tusla services have been observed. However, there remains work to do if children are to experience consistent and timely child-centred care services. The majority of inspections of children's services carried out since 2014 illustrate incremental improvements, and Tusla and providers of non-statutory foster care services have been responsive to the regulation and monitoring of services. Despite these incremental improvements, there have been some persistent challenges within children's services over the last 10 years.

9.2 Resource challenges

Challenges in relation to staffing and resourcing is a recurring concern across all Tusla services, and this issue is occurring in similar services across Europe. As referred to earlier in the report, external factors such as the increase in children displaced by the war in Ukraine or elsewhere, population increases along with an increase in complex cases presenting to Tusla is placing significant pressure on services. Despite these challenges, Tusla has to provide services to children, but high demand and vacant social work posts continue to impact on service provision for some children, despite the implementation of a range of recruitment and retention initiatives by Tusla. It is well-documented that Tusla has been unable to operate all of its special care beds due to resourcing issues, while the demand for special care placements increases.

To alleviate some risks in those services, Tusla has been using social care staff within child protection and foster care services. However, this is beginning to impact on the availability of appropriately qualified and experienced staff to work with children in residential care. Tusla has advised HIQA that it is in the process of consultation in relation to its allocation model and also plans to restructure its delivery of services in 2025. Some very positive steps have been taken to increase the number of social workers graduating in Ireland by increasing the number of courses and also by the introduction in September 2024 of the social work apprenticeship scheme. This work was achieved through collaborative work by Tusla, DCDEIY, the Department of Higher Education and individual colleges in third level institutions. The workforce planning challenges experienced by Tusla will not be resolved by Tusla alone and will only be resolved by continued collaboration and a national strategic approach as challenges in relation to a sufficient supply of appropriately qualified staff is an issue that is not unique to Ireland.

Notwithstanding this challenge, Tusla managed to provide a safe service to most children at immediate risk, and to those at ongoing risk of significant harm.

9.2.1 Impact of resource challenges

HIQA inspections have shown that Tusla, through its child protection and welfare and foster care services, endeavours to allocate named social workers to children who are at the highest risk. Although the number of children waiting for a service has reduced over the years, there still remains significant numbers of children waiting to receive a service from Tusla. These are generally children who Tusla has regarded as being at medium or low priority. As referenced in earlier in the report, in 2023 HIQA requested Tusla's executive to create a national improvement plan to reduce the number of children on waiting lists and to increase compliance against the national standards for child protection and welfare and foster care. It is of significant concern to HIQA that at the end of 2023, there were 10 Tusla service areas were of a level of risk to be included in risk-based monitoring programme. To date in 2024, HIQA has completed inspections of 10 services and met with regional chief officers and the executive team. In addition, regular provider meetings have been held with Tusla senior managers to measure progress against their improvement plans. A report of this programme's findings will be published in 2025.

Through inspection and ongoing monitoring, it is increasingly apparent that there is a need to urgently build in additional capacity within children's alternative care services (children's residential centres and special care units) in order to ensure that there is a range of appropriate regulated placements types available to meet children's specific needs.

As a result, there are some children living in unregulated special emergency accommodation – many of these children with complex needs. The number of statutory children's residential services has not altered significantly over the years, and at the end of 2023, there were 37 statutory children's residential centres. Tusla planned to open some new statutory residential services in 2024 and two such centres became operational during 2024. Despite, this the number of CRCs has remained the same, as other centres have closed.

9.3 Policy and legislative change

9.3.1 Need for a national strategic approach to child protection and welfare

Significant policy changes have occurred since 2014, and the Children First Act 2015 has significantly impacted on children's lives. HIQA inspections have found that the focus on children's right to be safe, to be consulted and to participate in decisions about their care has improved since 2014. The Child Care Act 1991 is currently under review and HIQA has contributed to the consultation process. HIQA has also has advocated for the review of the Child Care (Placement of Children in Foster

Care) Regulations 1995 to strengthen and update these regulations to reflect the changes in practice and align themselves to the changes in the amended act.

Both the national standards relating to children's residential centres and special care units have both been updated over the past 10 years, and they have placed more of an emphasis on the rights of children. HIQA believes they have impacted positively on the quality of services provided to children.

After reviewing evidence-based research on best practice in children's services, HIQA has developed two new sets of draft standards for children's services - Draft *Overarching National Standards for the Care and Support of Children using Health and Social Care Services* and the *Draft National Standards for Children's Social Services*. It is proposed that the *Draft National Standards for Children's Social Services* will replace the current foster care, child protection and welfare, residential care and special care unit standards. Once approved by the Minister for Children, Equality, Disability, Integration and Youth, HIQA will initially focus our monitoring of children's services against the *Draft National Standards for Children's Social Services*. In time, HIQA will use the *Overarching National Standards for the Care and Support of Children using Health and Social Care Services* to complete quality improvement initiatives.

9.3.2 Regulation of special care units

The registration and regulation of SCUs since 2018 has driven improvement in terms of the quality of service provided to children and young people living in them. The profile of children placed within special care means that these services have to be well-resourced, both from a staffing and specialist service provision perspective. A recurring issue that has arisen over the years is the need for suitable step-down placements for children leaving special care. Currently, there are frequent delays in children being discharged from special care, as the availability of suitable placements is limited. This means that some children remain in a special care service for longer than they require and, consequently, other children who require the service cannot be admitted.

9.3.3 Interagency working

Overall, our inspections have found that services are more children's rights-focused. Improvements have been made in safeguarding. Staff are good at listening to children and there have been good developments in using child-friendly tools to engage with children across services. Building a consistent relationship with a named staff member is essential for children and their families. There is always room for further improvement, especially in relation to strategic planning for children, as many children are presenting with complex needs. Many children in care and in the

community who are known to Tusla are waiting for services, some which are outside of the control of Tusla.

HIQA is of the view that, in order to sustain these improvements, there needs to be a multiagency approach to look at how we strategically plan for children, as every child engages in multiple services across various sectors. There needs to be a focus on how we effectively support children and their families in the community and children in alternative care. This must be with a view to being able to look back in 10 years' time and not see the same challenges.

9.3.4 Need for expanded regulatory powers and regulation of services

Without enforcement powers, HIQA relies on its reporting and escalation mechanisms to address significant risks to children and to keep children safe. Currently, the Chief Inspector's enforcement powers are limited to the three special care units. The exapansion of the Chief Inspector's regulatory powers to other children's services, would strengthen HIQA's ability to drive improvements through the sector.

Currently, there are two separate mechanisms in place to monitor children's residential units – Tusla registers and monitors those run by the voluntary and non-statutory sector while HIQA monitors those run by Tusla itself. While legislation is in place for the registration and monitoring all children's residential centres to come under the responsibility of the Chief Inspector, this has not yet commenced. Tusla is both a commissioner of residential services for children and regulator of these services. The benefit of the registration of children's residential centres coming under the remit of the Chief Inspector would ensure all children's residential services experiencing the same regulatory process. It may also enable Tusla to redirect some existing resources to other work within its remit.

9.3.5 Influencing change

To influence change in the sector, HIQA inspects services and requires providers to develop a compliance plan to outline how it will address any issues identified on inspection. Inspectors then monitor progress with compliance plans until the provider has demonstrated that all identified non-compliances have been addressed. HIQA also publishes its inspection reports to ensure that its findings are transparent to stakeholders and the general public. In 2023, our inspection of the separated children's service highlighted gaps in this service that led to Tusla arranging a meeting with key stakeholders in order to improve its service. HIQA will continue to monitor this service closely. In HIQA's role as a regulator, it has endeavoured to work with key stakeholders in their efforts to improve services for children through stakeholder engagement with Tusla, the Department of Children, Equality, Disability, Integration and Youth, and other groups as appropriate.

Chapter 10: Conclusion

This report has charted the journey of HIQA's monitoring and inspection of a range of social services for children in Ireland. In that time, inspectors have met with many children and listened to their experiences of care. HIQA inspection reports have sought to give children a voice, identify what is working well and what requires improvement.

As described in this report, there are many aspects of the children's services that are working well and which have improved over the last 10 years. Nevertheless, there continues to be challenges which are having an impact of the experiences of some children and young people in care or children in the community.

Over the years, children, parents and foster carers have consistently said that they receive a good service when they have a consistent staff member working with them.

There have been significant changes in the demand for services over the last 10 years. Changes in family structures, complex needs of children, the impact of a pandemic on children and families, increases in our population, cultural changes and unforeseen world events such as the impact of war in Ukraine and the increase in numbers of unaccompanied minors have presented as challenges for children's services. These additional challenges, together with existing resourcing gaps in the staffing of children's services and in alternative care placements for children, impacted on the timeliness and quality of service received by some children in care and children availing of child protection and welfare services. Tusla will not resolve its resourcing challenges on its own, and a continued collaborative national strategic approach to ensure that Tusla is resourced and enabled to ensure children receive the right support and service at the right time.

There are also significant changes on the horizon in relation to children's services. Changes in legislation, in standards and interagency cooperation must support the core goal that we are all working towards — providing children with services in the most effective, timely and safe way. HIQA will continue to work with all stakeholders to continue to seek further improvement in the sector so that all children are provided with consistent and effective services.

Appendix 1 - Number of Inspections from January – October 2024

Type of Fieldwork	No. of Inspections
Children's Residential Centre	23
Service Area (CPW & FC) - Provider Approach	4
Statutory Foster Care - Provider Approach	2
Statutory Foster Care Inspection	2
Child Protection & Welfare - Provider Approach	4
Child Protection & Welfare - Child Abuse Substantiation Procedure	1
Child Protection & Welfare – Out-of-hours service	1
Oberstown Children Detention Campus	1
Special Care Unit - Registration Inspection	3
Special Care Unit – Risk Based	1
Total	**42**

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