Around 30 unaccompanied minors in state care reported missing during HIQA service inspection

The Health Information and Quality Authority (HIQA) published an inspection report on the child protection and welfare service provided by the Child and Family Agency's (Tusla) Separated Children Seeking International Protection Service.

The Separated Children Seeking International Protection Service is a standalone Tusla service which offers an urgent response to the needs of unaccompanied minors and separated children seeking international protection who arrive in Ireland.

The inspection was carried out between 28-30 January 2025 and 5 February 2025 to assess the progress the service had made to address non-compliances since a previous inspection in 2023. Data received prior to the inspection identified that there were 50 children reported by the service as missing in care in the previous 12 months.

At the time of the inspection, data provided indicated that there were approximately 30 children missing and remained unaccounted for at the time of the inspection and 27 children had been reported missing at various stages and returned to their placements. During the last inspection in November 2023, 9 out of 10 standards were not compliant and one was substantially compliant.

This 2025 inspection found that 7 out of 8 standards were not compliant and one was substantially compliant. HIQA found that the service had not taken timely action to address the previously identified non-compliances. Inspectors found that despite some progress, there remained concerns about the child protection and welfare team's capacity to develop and sustain service improvement initiatives given the significant increase in referral rates to the service. In the previous 12 months, there had been 877 referrals to the service and there were continued deficits in resources, posing risks to children accessing the service. At the time of inspection, there were 321 open cases, with some children allocated to the intake and assessment team and a significant number of children unallocated.

Staff spoke of the challenges faced in the service, and particularly identified workload as the reason for staff leaving the service. The service responded in a

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timely, child-centred way to provide an emergency response to children when they presented to the service and children were met with, screened and placed in a timely manner.

Staff ensured children's immediate needs were met and they were placed in emergency accommodation following their arrival into the country. Improvement was required to ensure the service responded appropriately to this vulnerable cohort of children after they arrived as unaccompanied minors into the country.

Assessments required improvement in order to demonstrate the assessment of all aspects of the child's circumstances, including risks such as trafficking and child exploitation and in order to be aligned to Tusla's national assessment framework and Children First National Guidance for the Protection and Welfare of Children(2017), and the Children First Act 2015. Furthermore, safety planning was not routinely completed when a trafficking risk was identified for a child.

Not all children were allocated a social worker. A dedicated team was established as a short-term measure to ensure oversight of cases moving from intake and assessment teams and while awaiting transfer to the services alternative care team. Data showed that 61% of children were assigned to this dedicated team while they were awaiting the allocation of a social worker.

During this time, specific tasks were completed by an assigned social worker and social care staff. A review of case files demonstrated that there were gaps in communication with children once they were in their placements.

The monitoring and oversight systems in place were not effective at ensuring all referrals were managed in line with procedures, such as the management of child protection and welfare referrals, the review of all unallocated cases and the completion of safeguarding visits. Some governance arrangements were newly established and did not always ensure a safe and sustainable service was delivered. Improvement was required to ensure that the service was accountable, monitoring progress and reviewing performance to drive service improvement and provide a good-quality service in line with national standards. Not all child protection concerns were managed in line with Children First (2017).

There were gaps in the identification of child protection concerns by staff newly recruited to the team, gaps in referrals to An Garda S¡ochna, safety planning was not always completed and there was a lack of social work assessment of the concerns and risks to children. There were delays in carrying out safeguarding visits to children once children were accommodated. Furthermore, there were no

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records of safeguarding visits to children in three cases.

Following the inspection, HIQA escalated a number of cases to the area manager seeking assurances about the management of issues or gaps identified in those cases. HIQA received satisfactory assurance with respect to the management of those cases. HIQA also escalated a number of risks relating to the absence of effective governance and oversight of cases, information sharing, the capacity of the service to manage the workload and the known effect on staff health and wellbeing.

The area manager responded to HIQA with satisfactory assurances that a practice improvement plan would be put in place and a corresponding compliance plan was submitted outlining specific actions that would be taken to address the areas of non-compliance. HIQA will continue to monitor the service to support improvements.

Source(s)

- Health Information and Quality Authority | An tÚdarás Um Fhaisnéis agus Cáilioch Sláinte (12 June, 2025), [Health Information and Quality Authority Regulation Directorate monitoring inspection of Child Protection and Welfare Services], https://www.hiqa.ie/system/files?file=inspectionreports/8511_CPW_SCIP_20250128.pdf

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