

Regulation of
Health and Social
Care Services

Annual overview report on the inspection and regulation of children's services – 2018

June 2019

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority 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.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, 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 Office of the Chief Inspector 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 health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these 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 services, in conjunction with the Department of Health and the HSE.

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A message from the Director of Regulation and Chief Inspector of Social Services

This report provides an overview of the work undertaken by HIQA in relation to the inspection and regulation of children's services during 2018. It gives an insight into the quality and safety of these services and importantly, it reflects what children have said about their experience of these services.

The yearly work programme for the Children's Team is influenced by several factors, such as meeting legislative requirements, responding to risk and building on work carried out the previous year, and 2018 was no different. On 1 January 2018, special care units became designated centres under the Health Act 2007 (as amended), requiring HIQA to determine if they were fit for registration by year end. This work was completed and three special care units were successfully registered by November 2018.

In 2018, the Children's Team also began to prepare for the inspection of statutory children's residential centres under a new set of standards. The Minister for Health in consultation with the Minister for Children and Youth Affairs approved a revised set of standards for these centres which were published by HIQA in November 2018. These new standards replace the previous standards which were almost 20 years in existence (dated 2001), and their introduction marks a significant development in the provision of residential services to children in Ireland by promoting progressive improvements in the care and support these services provide.

Arising out of our monitoring and inspection activity in 2018, a number of key messages came to fore:

- ensuring that children in foster care are cared for by adults that have gone through a robust assessment and approval process, and receive the supervision, training and support that they need to support them in their caring task, is not only in the best interest of children in care but also represents a key safeguard
- the provision of safe, effective and reliable child-centred services relies upon a well-trained, supported and motivated workforce
- regulation is a driver of quality and safety.

Fostering services depend on families and individuals in the community who are willing to share their homes and lives with children and young people whose parents are unable to care for them on either a short or long-term basis. For this reason, our monitoring activity in foster care services focused on the assessment, approval, review, supervision and support of foster carers in 2017 and 2018. These inspections found little consistency across service areas and practice varied within the same regions. We then carried out

follow-up inspections during 2018 to ascertain the level of progress that had been made to address the areas which were found to require improvement.

Our 2018 follow-up inspections showed definite evidence of improvement in many service areas. At the time of the follow-up inspections, all regions were establishing regional forums in order to address the common issues found within the fostering service throughout their region. This is a welcome move, and should serve to ensure more consistent practice across the country. In addition, service directors were now strengthening auditing and oversight systems and, in turn, the accountability and reporting mechanisms in place in each region. In an environment where staffing resources are a significant challenge for many areas, it is more than ever important that individual initiatives, deemed effective in some areas are transferred to others and that operational practices are optimised to prevent duplication of effort and inconsistency in practice.

Further work is undoubtedly required by Tusla in relation to a small number of service areas that had not made sufficient progress to consistently raise compliance with the National Standards for Foster Care and to ensure that where risks remained, these risks are appropriately managed. It is hoped that the regional follow-up inspections will facilitate regions to promote the transfer of learning between service areas, and indeed nationally, in advance of the implementation of our 2019 focused inspections of foster care services.

A critical piece of work for the Children's Team in 2018 was the completion and publication of the statutory investigation into the Child and Family Agency's (Tusla) management of child sexual abuse allegations against adults of concern. The Tusla investigation was initiated at the request of the Minister for Children and Youth Affairs in March 2017, and HIQA published its findings in June 2018.

The work of the Children's Team in 2018 has demonstrated evidence of the significance of good governance arrangements and managerial systems in the delivery of safe, timely and effective services. This was particularly evident in the Tusla investigation, which found that while appropriate action had been taken by social workers when children were assessed as being at immediate and serious risk, some children were being left at potential risk due to a number of failures at operational level, failings that stemmed from a gap between national Tusla policy and what was actually happening on the ground, and the need to consistently embed existing governance structures in front-line practice.

While HIQA is acutely aware of staffing challenges in Tulsa's social services, good leadership, governance and management is essential for building resilience in services and its staff, and ensures the prioritisation of its work based on the resources it has available at any given time - in tandem with making plans for its future capacity and capability. This was not always evident in the services inspected in 2018 and these and other findings highlighted throughout this report, will inform the work of the Children's Team for 2019.

Our experience over the past 10 years in the overall regulation of health and social care services shows that regulation is a driver of quality and safety. Regulation affords protection to both vulnerable adults and children, and contributes to assuring a better quality of life for all people using regulated services. Children in care are a particularly vulnerable group. Failure to meet their needs can inhibit their ability to learn and develop at a key stage of their formative years. Many of the children who spoke with our inspectors expressed satisfaction with their residential service and spoke positively about the support they received from staff. However, our inspectors found that improvements were still required in relation to ensuring the best outcomes for children.

The expansion of the remit of the Chief Inspector of Social Services in regard to the formal regulation of all children's residential centres, statutory and non-statutory, will further enhance the protections available to at-risk children and better equip us to take appropriate enforcement action against poorly-performing service providers. HIQA will continue to work with the Department of Children and Youth Affairs to plan for the transfer of the registration and inspection functions for non-statutory children's residential centres from Tusla to the Chief Inspector in HIQA.

There is, however, no regulation of child protection and welfare or foster care services in Ireland. While HIQA can inspect services and report our findings publicly, we do not have the legal remit to take action when we uncover examples of poor or unsafe service provision. When risks are uncovered in these services, our only recourse is to escalate the situation to Tusla and to the Department of Children and Youth Affairs. Experience to date has shown us that a regulatory framework set out on a legislative basis in legislation, underpinned by regulations and supported by nationally mandated standards, is an effective measure of the quality and safety of care provided to vulnerable people. It provides assurances to the legislator, Government departments, services users and the wider population of the efficacy of those services.

In addition, as seen in HIQA's annual inspection overview reports, we have experienced the positive impact that regulation has on the quality of lives and safety of the people in social care services. Moreover, we have seen that the application of the regulatory framework and methodology of inspection and review is all that is required for the vast majority of designated centres in ensuring that the quality of life and safety of services is being delivered to a high standard. This is further evidenced by the Chief Inspector having only used the enforcement powers within the Health Act 2007 as a last resort and in a minority of cases to date.

The suite of regulations that underpins any regulatory framework must be dynamic and respond to the changing needs of the people in receipt of those services and the evolving range of services to meet their needs. To this end, over the last number of years, we have highlighted the changes required to the Health Act 2007 (as amended) for the current

regulatory framework to the Department of Health.

Based on our experience of regulation over the last number of years, the optimum framework for any child in receipt of child protection and welfare services or a child who is in care is having one pathway between those functions. It is HIQA's view that one regulatory framework for children's social services should underpin this pathway.

One of the recommendations arising out of our statutory investigation of Tusla was that the Department of Children and Youth Affairs, with the assistance of HIQA, should undertake an international review of best practice in the regulation of children's services. This literature review was commenced by the Department in 2018 and, at the time of writing, a draft of the review had been provided to HIQA for consideration. Conscious of HIQA's commitment to assist the Department in reviewing international best practice in the regulation of children's services, in May 2019 we embarked on a research project to complement the literature review carried out by the Department by examining the effectiveness of regulatory approaches across the wider social care service.

Finally, in producing this overview report for children's services, we hope not only to provide information on the inspection and regulation of children's services during 2018, but also to share the findings of that activity in a way that assists providers to inform their own quality improvement agenda in the interests of children and families who require their services.



Mary Dunnion

Director of Regulation and Chief Inspector, Health Information and Quality Authority

1. Introduction

The Health Information and Quality Authority (HIQA) and the Office of the Chief Inspector of Social Services within HIQA are responsible for regulating and monitoring the quality and safety of adult and children's health and social care services across Ireland.

The Regulation Directorate in HIQA encompasses the statutory functions under the Health Act 2007 (as amended) of the Office of the Chief Inspector of Social Services (hereafter referred to as the Chief Inspector). The Directorate oversees:

- the regulation, monitoring, inspection and registration of designated centres for older people, designated centres for people with disabilities and children's special care units
- the monitoring and inspection of certain healthcare and children's services.

This report provides an overview of HIQA and the Chief Inspector's 2018 regulatory programme for services for children in need of care or protection, including special care units, and children who are sentenced or remanded in custody by the courts. It primarily sets out how in 2018 HIQA met its business plan objectives in children's services⁽¹⁾, including to:

- Receive and assess all solicited and unsolicited information across children's centres and services, and respond to risk in a proportionate and timely manner.
- Complete the programme of monitoring of statutory foster care services assessing the efficacy of the recruitment, assessment, approval, supervision and review arrangements in place for foster carers.
- Carry out a programme of monitoring of private foster care services assessing the efficacy of the recruitment, assessment, approval, supervision and review arrangements in place for foster carers.
- Carry out a follow-up programme of monitoring statutory foster care services to assess progress with their action plans arising from the monitoring programme in 2017.
- Monitor and inspect the children's detention school (Oberstown Children Detention Campus).
- Complete the investigation into the management of allegations of child sexual abuse against adults of concern by Tusla upon the direction of the Minister for Children and Youth Affairs.
- Carry out a programme of registration of special care units (designated

centres).

- Carry out a programme of inspections of statutory children's residential centres.

The full inspection reports on each service inspected in 2018 are available on the HIQA website¹, www.hiqa.ie.

About this report

This report is set out in separate chapters which describe the overall findings of each of the various functions of the Children's Team. There are also chapters outlining how HIQA inspects and regulates; what children told inspectors during the course of the year; engagement with stakeholders; and a conclusion on work undertaken in 2018.

¹ Four of these reports were not published on the HIQA website due to the possibility of identifying the children. Tusla received a copy of these reports.

2. How we regulate services

The statutory framework – monitoring against standards and regulations

Each type of children's service has its own statutory framework that gives authority to HIQA and the Chief Inspector to monitor the service, using standards and regulations which set out what is expected from the service. Appendix 1 shows the statutory framework for each type of service monitored by HIQA or regulated by the Chief Inspector.

Inspection activity in 2018 – number and types of inspections

During 2018, the Children's Team conducted 65 inspections of the various children's services under its remit. Five inspections of special care units were carried out, four of which were for the purpose of registration.

The Children's Team conducted 60 inspections of other services such as statutory children's residential centres, foster care services and Oberstown Children Detention Campus. Table 1 provides a complete breakdown of all inspections by service type.

Table 1. Inspection activity for 2018 by service and inspection type

Service type	Inspection type	Number of inspections
Child protection and welfare	Monitoring	1
Statutory foster care	Monitoring	13
Private foster care	Monitoring	7
Statutory residential care	Monitoring	38
Special care unit designated centres	Monitoring ²	5
Detention schools (Oberstown)	Monitoring	1

² Four of these inspections were monitoring compliance against regulations to inform a registration decision.

3. What children told inspectors

The following chapter describes what children told our inspectors about living in care during the course of 2018.

Children's residential centres

Inspectors met with 88 children over the course of 38 inspections of residential centres operated by the Child and Family Agency (Tusla).

Many children were comfortable, relaxed and content in the presence of staff. Most children were happy in their placements and liked living in the centres. They told inspectors that they felt safe and were provided with good-quality, child-centred care. The majority of children were happy with the level of contact they had with family and friends. Children were satisfied with the welcome provided by staff to people that were visiting them.

Many children said they had good relationships with staff and had people to talk with whom they trusted. They felt supported by staff and said they could discuss their concerns with them. In addition, while one child said that they had had many different social workers, many children told inspectors that they saw their social workers regularly and in private.

Children said they were aware of their rights and that these were respected. Importantly, many children felt their opinions were valued and listened to. Children said they were kept informed about the plans for their care and felt included in the decision-making process. A number of children had attended their child-in-care review meetings where their care plans were discussed.

Children told inspectors they knew how to make a complaint and some had done so. Children who had made complaints said the complaint had been dealt with and that the situation had improved as a result. Children knew they had a right to access their records and some had read their daily logs.

Some children described the house rules as fair and flexible, such as later bedtimes at weekends and sanctions not being overused. However, some children did not like having alarms on their bedroom doors and others told inspectors that the kitchen door was sometimes locked at night.

Meanwhile, many children spoke positively about school and were ambitious to pursue their education further. Children said they were getting the supports they needed to help them achieve their goals and objectives.

Some children said they were happy with the various activities available to them and had developed friendships with their peers. They said they had a sufficient allowance for clothing and they were encouraged to make choices about their

personal appearance. Children said they were consulted about the food choices in their centre and most were satisfied with the food options available to them.

Where centres had been re-furbished, children commented on how the new furnishings and fittings provided more comfort and storage for personal items. One child told inspectors that their refurbished bedroom in the centre was the 'nicest bedroom' that the child had ever lived in.

Some children preparing to leave care were very clear about their future plans and were learning the skills required for independent living. However, a number of children expressed their dissatisfaction about planning for their future and, in particular, for when they would leave care. Some children were worried about what would happen to them when they turned 18 and were unsure where they would live and what future supports they would have.

Chapter 8 of this overview report gives more detail on inspections of these children's residential centres during 2018.

Special care units

Children who require care to address their behaviours and the risk of harm to their life, health and development are detained by a High Court order in special care units. These are run by Tusla and regulated by the Chief Inspector. Children's liberty is restricted for a specific period of time in these units in order to secure their safety and welfare needs.

Inspectors met with 13 children who live in the country's four special care units. Children told inspectors that they felt safe in their respective centres and that their personal belongings were safe. Children had their own rooms and their day-to-day care needs were being met and promoted by the staff teams in the special care units.

However, children's reported experiences of staff were mixed. They told inspectors that they liked some staff but not others. One child told inspectors that the best thing about living in the centre was the staff, as they felt that the staff provided good-quality care to them. Children said they could go to a favourite staff member when they needed to talk about something, but they did not like the amount of new staff as they did not like change.

Children also had access to social workers, guardians ad litem and solicitors if they wanted to raise an issue. Children said that staff gave them information about their rights when they were admitted. They also knew they had a right to make a complaint if they wished and knew how to contact an independent advocacy service or the Ombudsman for Children.

In two of the four units, children told inspectors that they took part in lots of activities; including woodworking in the school, board games in the evening, cycling, karting, gym work, cooking and baking, and martial arts. Children showed inspectors some educational projects that they had completed, some beautiful pieces of wooden furniture that they had made, flowers they had planted and painting they had completed on the external part of the premises.

However, in the third unit inspectors observed children sitting around with little impetus amongst staff to engage the children in stimulating activities. In the fourth unit, children were subject to stringent restrictions on day trips, which they felt were unjustified and made them extremely unhappy.

Children said that they were unhappy with a number of the rules in all four of the units. In particular, some children said that they did not like their bedroom door locked at night and, as a result, not all children were content with the bedtime routines. Children said it was stressful to live in the special care unit as it was very hard to stick with the rules. They said it was hard being locked in their room at 9pm and it felt like they were living in a youth prison.

The children in two units also said that the rules in the special care unit were not being applied in the same way every day, which they felt was not fair. For example, they said that some staff allowed them to use knives to prepare a meal on a particular day and on the next day they were not allowed to do so, which caused them to be confused and frustrated.

In one unit, children were focused on where they were going after their placement in the special care unit ended and what they needed to do to prepare for that. In two units, children expressed dissatisfaction with the lack of follow-on placements from the special care unit. This meant that children had to remain in the special care unit long beyond the intended duration of their placement.

Chapter 9 of this overview report gives more detail on these inspections.

Oberstown Children Detention Campus

Oberstown Children Detention Campus is the State's detention centre for children who have been sentenced or remanded in custody by the courts.

Inspectors met with 21 children while inspecting the campus in 2018. Children were aware of their rights, and improvements were found to have been made in children's participation in decision-making about matters concerning them.

Children's attendance and involvement in their placement planning meeting had also improved since the previous inspection. Children were now routinely invited to attend and were supported to contribute to these meetings.

However, some children were not clear about how and whether they could access information about their care. For example, there was inconsistent practice in relation to allowing children to read court reports completed by Oberstown staff in advance of their court appearances.

Children reported to inspectors that they were being afforded privacy if they wanted it, and they were facilitated to make phone calls in private to family and friends. Parents reported being kept well informed of what was happening with their child.

A campus council had been set up in 2017 for young people to be consulted on issues concerning them and to advocate for themselves and their future. The council provided children with an opportunity to raise and discuss issues with senior managers to improve day-to-day life on the campus and to promote a safe, secure and fair environment for all. However, while progress was made on several issues, children on the council did raise some concerns about resolving issues in a timely manner as they said they had on occasion become discouraged as a result of delays.

Children reported to inspectors that they knew how to make a complaint. Children were aware of who the complaints officer was and reported that he visited the units regularly. They told inspectors that if they had a complaint they could talk to this person, or they could fill in a form if they preferred. Children reported different experiences in relation to the responses to their complaints with the majority satisfied with how they were resolved.

While children were observed having access to and choice around activities, children told inspectors that if staff were required to respond to challenging behaviour or an incident within the campus, a consequence of this prioritisation of resources was that the campus could not also facilitate all young people to participate in their chosen planned activity.

Children were aware of their right to access independent advocacy services and this was facilitated by regular visits to the campus by representatives from the Empowering People in Care (EPIC) organisation, who met with children and assisted them with any concerns or complaints, as required. The Office of the Ombudsman for Children also held monthly outreach clinics in Oberstown. These clinics facilitated children to meet with representatives from the Ombudsman for Children if they so wished to discuss any complaints they may have.

Some children told inspectors that they did not get any support to help them deal with their offending behaviour. One child told inspectors that, since they had been committed to the centre, no one had discussed the reasons for their offending. Another child told inspectors that they had not been supported to address their

drug abuse, which they reported was the main factor associated with their offending behaviour.

Children also reported to inspectors that they liked attending the school in the centre. Chapter 10 of this overview report gives more detail on HIQA's inspection of this service during 2018.

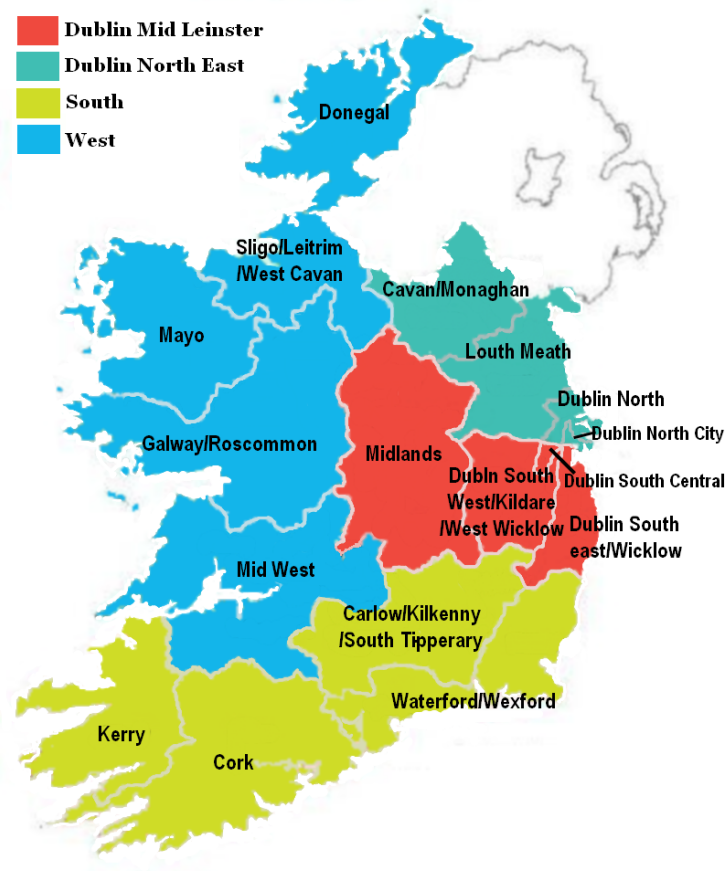
4. Child protection and welfare services

Tusla has statutory responsibility to protect children and promote their welfare under both the Child Care Act 1991 and the Child and Family Act 2013. It does this by directly providing services and by funding other organisations to do so on its behalf. The primary functions of Tusla include:

- Support and promote the development, welfare and protection of children and the effective functioning of families;
 - Offering care and protection for children in circumstances where their parents have not been able to, or are unlikely to, provide the care that a child needs. In order to discharge these responsibilities, the Agency is required to maintain and develop the services needed in order to deliver these supports to children and families and provide certain services for the psychological welfare of children and their families;
 - Responsibility for ensuring that every child in the State attends school or otherwise receives an education, and for providing educational welfare services to support and monitor children's attendance, participation and retention in education;
 - Ensuring that the best interests of the child guide all decisions affecting individual children;
 - Consulting children and families so that they help to shape the agency's policies and services;
 - Strengthening interagency co-operation to ensure seamless services responsive to needs;
 - Undertaking research relating to its functions and providing information and advice to the Minister regarding those functions; and
 - Commissioning services relating to the provision of child and family services.

Child protection and welfare services are provided by Tusla in 17 service areas, located within four regions across the country (see Figure 1). HIQA monitors and inspects these services against the National Standards for the Protection and Welfare of Children and providing advice to the Minister for Children and Youth Affairs and Tusla.

Figure 1. Tusla service areas



The Child Protection Notification System is a national record of all children who are assessed by Tusla as being at ongoing risk of significant harm. Children placed on the Child Protection Notification System have a child protection plan which is agreed at a child protection conference. At the end of 2018, Tusla reported that all children on the Child Protection Notification System³ (1,029 in total) had an allocated social worker.⁴ This has been a consistent finding since 2016, which indicates that Tusla continues to prioritise social worker allocation to children who are most at risk.

Tusla reported an increase in the number of open cases (26,433) — referrals either waiting for a service or being actively worked on by Tusla — at the end of 2018 (see Figure 2). There was also an increase in the number of cases awaiting allocation to a named social worker, representing 24.3% (6,432) of all open cases.

The number of high-priority cases awaiting allocation to a social worker showed an increase from 818 (3.3%) at the end of 2017 to 1,003 (3.8%) of all open

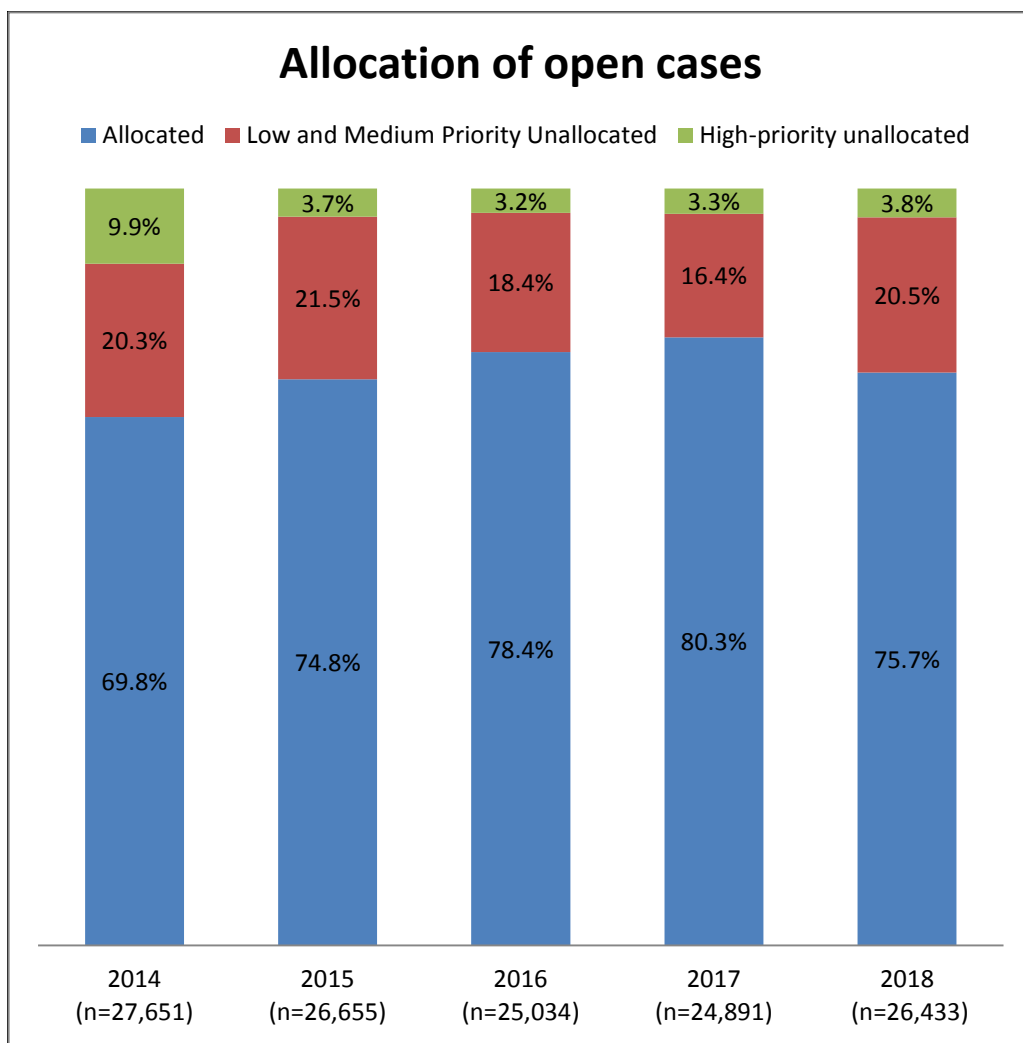
³ A national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern, resulting in each child being the subject of a Child Protection Plan (Children First, 2017).

⁴ End of 2018 data provided by Tusla Quality Assurance Directorate May 2019

cases.

Similar to findings in 2017, the absence or delay in completing assessments due to the lack of an allocated social worker presents a potential risk to children. This also delays a conclusion being reached for adults who may have had false or unfounded allegations made against them.

Figure 2. The number of open unallocated cases year-on-year from 2014–2018



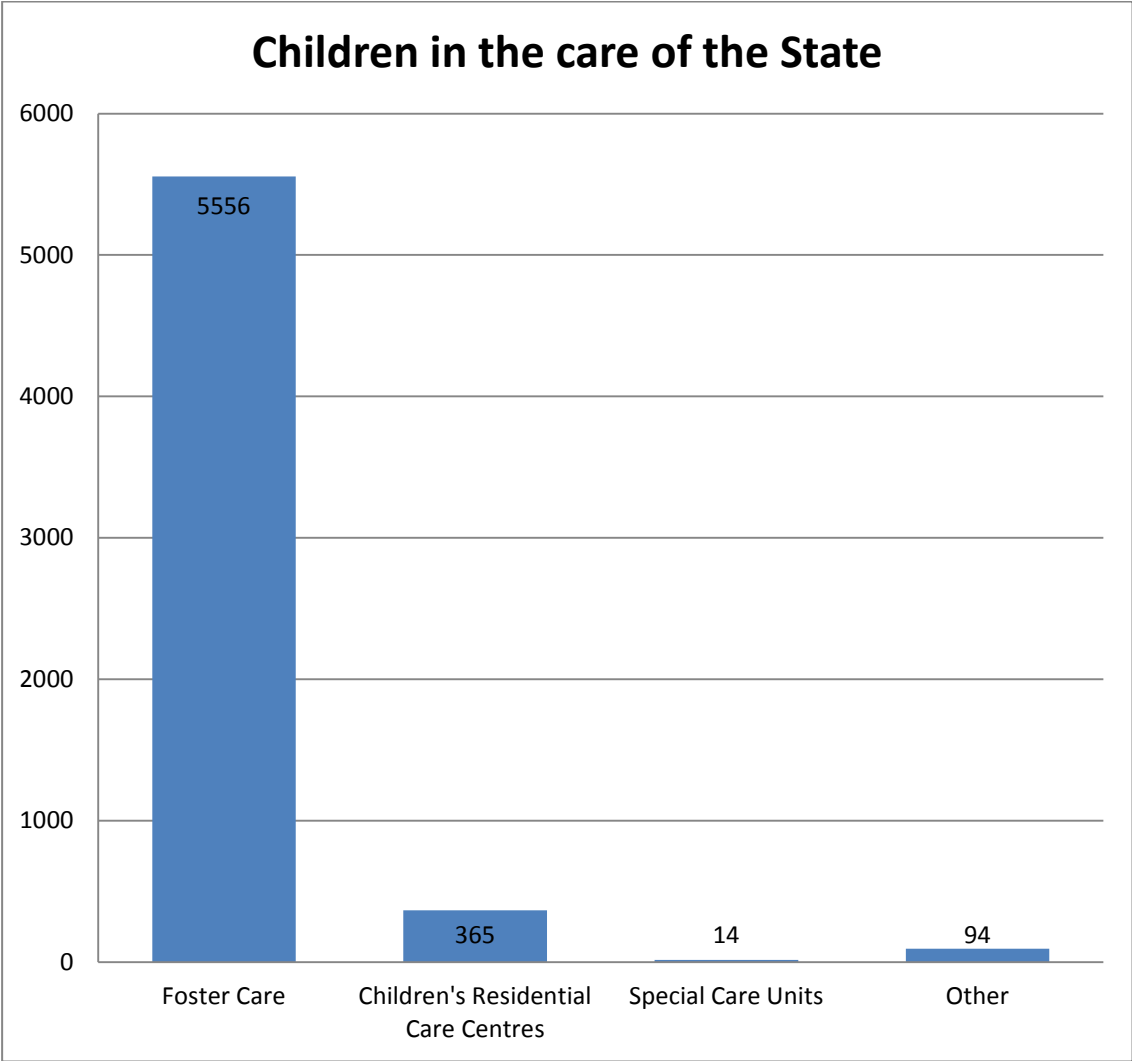
Where children cannot live at home, alternative care services in the form of foster care or residential care are provided by Tusla, or it funds private providers to do so on its behalf. At the end of 2018, Tusla reported that there were 6,029 children in the care of the State. Of those:

- 5,556 (92%) children were in foster care, of which:
 - 5166 (93%) were in Tusla placements
 - 390 (7%) were in private foster care placements

- 365 (6%) children were in mainstream residential care, of which:
 - 126 (34.5%) were in Tusla placements
 - 239 (65.5%) were in residential centres run by private and voluntary-body providers
- 14 children were in special care units.

A further 94 children were in other care facilities including supported lodgings, detention, youth homeless services and other residential services.

Figure 3. Children in the care of the State at 31 December 2018



5. The investigation into the management of allegations of child sexual abuse against adults of concern by Tusla

In June 2018, HIQA published *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.*⁽²⁾

This was the report of a statutory investigation requested by the Minister for Children and Youth Affairs under Section 9(2) of the Health Act 2007, following Tusla's handling of a false allegation against a Garda whistleblower.

HIQA's statutory investigation found Tusla needed to improve how it manages child protection and welfare referrals to ensure harm is identified and responded to in a timely manner. Crucially, to achieve this, it highlighted the need for improved governance at local and regional level to consistently embed existing governance structures in front-line practice. This was to ensure that staff understood and adhered to standardised policies and procedures, that there was sufficient management oversight to assure the executive and the board, and that poor performance was being identified and managed.

The investigation found that while appropriate action had been taken by social workers when children were assessed as being at immediate and serious risk, some children were being left at potential risk due to a number of failures at operational level. These included failures to:

- consistently implement Tusla's national policies and business processes
- accurately record important decisions made and actions taken
- monitor the effectiveness of the steps taken to protect children
- support staff members' personal development
- manage under-performance.

These failings stemmed from a gap between national Tusla policy and what was actually happening on the ground. It also identified a systems risk that was a result of three main defective points in Tusla's response to managing allegations of child sexual abuse:

1. shortcomings in how child abuse allegations were screened
2. the development and management of safety plans for children
3. the management of retrospective allegations of abuse against persons.

The investigation found that a shortage of qualified social work staff was contributing to delays in the appropriate management of referrals and early

assessment of children at risk. Tusla staff frequently expressed concern to the Investigation Team about staff recruitment and retention. Critical social work posts remained vacant across the country. This had an ongoing, negative impact on the consistent delivery of high-quality and timely services.

The challenges in recruiting staff were persistently reported as an organisational risk at board, executive and operational levels of Tusla. While a comprehensive workforce assessment was outside the scope and competencies of the investigation, at the time of the investigation HIQA did not find a comprehensive strategic approach to workforce planning within Tusla. Moreover, little evidence was found of attempts to identify efficiencies and improvements in work flow or evidence of consideration of upskilling other social care disciplines, along with targeted educational strategies with third-level institutions.

As a result, a key recommendation of the investigation was that Tusla and the Department of Children and Youth Affairs seek the assistance of the higher education and training bodies to create formal career-path mechanisms for students and graduates to support Tusla's workforce needs. It was also recommended that, in the interim, Tusla should review their operational arrangements to identify efficiencies and improvements in workflow, including a review of the existing social worker, social care worker and support staff skill-mix, and the development of a workforce strategy.

Arising from the investigation, HIQA committed to developing a thematic inspection programme to promote improvement of child protection and welfare services. While the investigation had the specific task of examining the management of child sexual abuse allegations, the thematic programme will include the management of all child protection and welfare referrals.

HIQA commenced a literature review of child protection and welfare practice in the latter part of 2018, the first stage in the development of thematic programmes. This will provide an evidence base and will outline best practice in the context of defined points along a pathway in child protection and welfare practice: from the point of initial contact or reporting of a concern; the screening and enquiry process; and subsequent safety planning and assessment as appropriate. The literature review will inform the development of the thematic programme of inspection which will commence in 2019 across Tusla's 17 service areas.

6. Inspection findings of statutory foster care services

At the end of 2018, Tusla's quarterly data reported that a total of 5,166 children were living in either general or relative foster care provided by Tusla. The majority of children, 69% (3,580), were in general foster care placements and 31% of children (1,586) were placed with relatives.

Between 2017 and early 2018, HIQA completed an inspection programme of the recruitment, assessment, approval, supervision and review of foster carers in statutory foster care services across all 17 service areas. These inspections also included safeguarding and child protection arrangements for children in foster care placements.

Throughout the focused inspection programme, it became apparent that similar findings were arising in each service area. Despite non-compliances being highlighted to Tusla in early 2017, these same findings were still evident at the end of 2017 and into the 2018 inspections.

In response to this, the Children's Team undertook a follow-up programme to assess progress with the action plans arising from the 2017 and 2018 monitoring programme. The follow-up inspections took a regional approach which focused on the four overarching Tusla regions, and the service areas within each region, which had the highest levels of non-compliance during 2017. Desktop reviews of the remaining service areas were also carried out.⁽³⁾

The follow-up inspections showed definitive evidence of improvement in many service areas, including ensuring that all foster carers were now allocated a link social worker. While there remained a small number of unallocated foster carers in six service areas at the time of the follow-up activity, these areas had put in place other safeguarding arrangements for these carers, such as:

- ensuring statutory visits by social workers were being conducted
- setting up a duty system to ensure they continued to receive a service if required or
- allocating a social care worker to provide support while the carers were unallocated.

However, significant challenges in relation to social work staffing resources meant that there continued to be high numbers of unallocated carers in two service areas.

Assessment backlogs

Several service areas had made progress in clearing their backlogs of assessments of relative carers. While there was now better oversight in all four regions, the

lack of adequate staffing in several service areas meant that they could not progress their backlogs of relative assessments in a timely manner. This raised a risk, as these relatives already had children placed with them, and therefore required more urgent assessments. When placing children with relatives, emergency checks of relatives prior to, or as soon as possible after, a child is placed with relatives is a key safeguarding requirement. The 2018 follow-up inspections found that each area had made concerted efforts to ensure that this process was now more reliable.

Safeguarding and child protection

Improvement was noted in the oversight and management of allegations and serious concerns against foster carers and with complying with Tusla's interim protocol for the management of serious concerns and allegations. This showed a commitment across Tusla's service areas to improving the management of serious concerns and allegations.

However, two service areas had not made adequate progress, and the management of serious concerns and allegations against foster carers remained significantly poor. As a result, allegations against foster carers had not been adequately addressed in a timely manner, and adequate safety measures, such as safety planning and supervision of foster carers by a link social worker, remained significant issues.

Foster care committees

The 2018 follow-up inspections noted significant improvements in relation to the role of foster care committees in monitoring and overseeing the progress of investigations of allegations and serious concerns. This was reflected in the systems in place to ensure that committees tracked and followed up on notifications of allegations and serious concerns, and outcome reports. However, some of these systems were at the early stages of implementation and therefore it was too early to determine their effectiveness in providing oversight of the management of allegations and serious concerns.

Reviews of foster carers' ongoing capacity to provide good-quality and safe care are required in order to ensure children continue to be safeguarded. The review process also allows other safeguarding practices to be completed such as updating of Garda Síochána (police) vetting and health and safety assessments to be completed. Therefore, it is an important aspect of safeguarding of children in care.

The 2018 follow-up inspection found that while some areas had made good progress in completing these reviews, others had made little progress, and there remained significant backlogs in some areas. However, unlike previous inspection

findings, areas were now able to clearly identify when reviews were due to be completed and managers were able to maintain better oversight of the process and the challenges they faced in progressing outstanding reviews

There was varied progress across the regions in relation to An Garda Síochána (police) vetting and updating of Garda vetting. Some areas had effective systems in place for tracking and updating Garda vetting when required. However, further work was required in some areas where a small number of adult household members still required vetting or updated vetting. However, these areas now had systems in place to identify these deficiencies and were in the process of progressing them.

Training in *Children First: National Guidance for the Protection and Welfare of Children* (2017) and on the responsibilities of foster carers as mandated persons still required significant action. Many areas still had very high numbers of foster carers for whom training in these areas had not yet been completed.

Our regional approach to the follow-up inspections allowed inspectors to look at the effectiveness of the overall governance of the foster care service. The lack of shared learning and development of common systems across the country, within regions, and between regions was noted in the variety of different systems that had been set up nationally. While there were some individual examples of where learning was transferred from one area to another, this was not done in a consistent or comprehensive way throughout the regions.

At the time of the follow-up inspections, all regions were putting in place regional forums to address common issues found within the fostering service throughout an individual region. This was a welcome move and should support more consistent practice across the country. In addition, service directors were strengthening their own auditing and oversight systems in order to strengthen the accountability and reporting mechanisms in place in each region. Several other welcome initiatives to improve governance in the regions were commenced in 2018 including:

- the establishment of regional fostering forums (albeit, this group is called a committee in the Tusla South region)
- enhanced regional arrangements to increase audit activity
- formal service improvement plans to address service area risk
- formal regional governance arrangements and operational structures to ensure the quality and safety of service delivery, the timely and effective identification and management of risk and managerial oversight and accountability.

Further work is undoubtedly required by Tusla to consistently raise compliance with the *National Standards for Foster Care* across and within its regions and to ensure that where risks remain that they are appropriately managed. It is hoped that the regional approach taken to the follow-up inspections will facilitate the transfer of learning between service areas within regions, and indeed nationally.

In an environment where social worker staffing resources are a significant challenge for many of Tusla's service areas, it is more important than ever that individual initiatives, which are deemed to be effective in some areas, are transferred to others. In the context of reported staffing shortages, it is essential that Tusla reviews such operational practices and make the best use of staffing resources to prevent duplication of effort and inconsistency in practice.

The second phase of this programme, due to commence in 2019, will focus on six of the *National Standards for Foster Care* and will examine:

- whether the child in foster care has an allocated social worker
- the extent to which the child's needs are assessed prior to, or as soon as possible after, placement
- whether the child's care is subject to a formal process of planning and review, including preparation for leaving care
- that the child is matched with foster carers that can meet their needs, and
- the systems in place to safeguard and protect the child.

It is hoped that the learnings from phase one of this programme will be reflected in the inspection findings of 2019.

7. Inspection findings of private foster care services

As part of its 2018 monitoring programme, HIQA conducted six focused inspections on the recruitment, assessment, approval, training, supervision and review of foster carers in private foster care services. Safeguarding practice was also considered during each inspection and, in regard to two services, the management and monitoring of foster care services was also inspected.

Inspectors found some good practices in supervision and support, training, reviews of foster carers and in the recruitment and retention of foster carers.

The quality of the assessments of foster carers varied significantly across the services. Two of the six services were in full compliance with the relevant standard, and there were comprehensive assessments with good oversight by managers. Deficiencies in meeting this standard in the other four services related to poor quality information gathering and a lack of appropriate managerial oversight.

In four of the six services inspected, all foster carers had an allocated link social worker, and foster carers were provided with good child-centred support through regular home visits by, and frequent contact with, these link social workers. Respite care and enhanced support services were provided to foster carers when they were caring for children with complex needs. There was also a dedicated out-of-hours service in each of the services. Foster carers were satisfied with the services they received from these providers.

Similarly, four out of the six private foster care services provided their foster carers with a thorough training programme, both prior to their approval and on an ongoing basis.

Reviews of foster carers

Reviews of foster carers' capacity to continue to provide high-quality care was assessed in five out of the six inspections.⁵ Reviews took place in line with the national standards and additional reviews were conducted following allegations or significant changes in foster carers' circumstances. The reviews were found to be comprehensive and of good quality in three of these five inspections. However, reviews in the other two services were not carried out in line with the standards, with one service not carrying out reviews in line with the identified time frames and no formal review meetings were taking place. In the other service, the quality of the reviews varied. Some reviews did not contain all of the required information in order to assess the ongoing capacity of the carers, and there was a lack of

⁵ As the sixth service was a relatively new service, the foster carers were not due a review at the time of the inspection.

oversight of reviews.

Four out of the six providers demonstrated a commitment to the recruitment and retention of foster carers. They had effective strategies in place to recruit foster carers with the capacity to meet a diverse range of children's needs. Two services did not have effective measures in place to support and retain foster carers; there was no retention strategy and no exit interviews conducted.

Concerns and safeguarding

Safeguarding practices were established in services to ensure children were kept safe, such as regular Garda vetting for all foster carers, allocation of a link social worker, provision of training in Children First (2017) and unannounced visits to the foster carers by link social workers.

All services required improvements in the process for escalating cases when there were delays by Tusla in investigating concerns. While the time frame for investigation of concerns lay outside the service's control, the process to escalate these delays to the appropriate manager within Tusla was not in place when required. In one service, there were gaps in the training of social workers in relation to protected disclosures.

Significant safeguarding risks were identified in two services and these were escalated by inspectors to service providers for their immediate attention. These related to inadequate systems being in place in one service to ensure that allegations were reported in line with Children First, and that all concerns and complaints were responded to appropriately; and a lack of effective safety planning in the other service.

HIOA liaised with these two services on an ongoing basis following inspection in regard to inadequate management and monitoring of their services. By the end of 2018, one of these providers had ceased to operate and the other had stated its intention to close in early 2019.

In addition, HIOA sought assurances from Tusla in relation to its oversight arrangements whenever it places a child with a foster carer through a private foster care agency. HIOA wanted to determine what measures Tusla had in place to ensure that children placed with private fostering services received safe and quality care that met their needs. In response, Tusla cited revised governance arrangements, which included designating a service director with a lead responsibility for private foster care services.

8. Inspection findings of children's residential centres

Children's residential centres are run by Tusla or a voluntary or private agency. These centres are home for 365⁶ children who have come into the care of the State when they cannot live with their own family. HIQA monitors and inspects the 36 children's residential centres run by Tusla.

What makes a good residential centre?

Delivering for young people in care requires the right resources, a qualified workforce and strong leadership. Without these key elements, young people in care can end up being failed. In England, Ofsted⁷ (Office for Standards in Education, Children's Services and Skills) has identified that the strengths of the very best children's residential centres include:

- stable staff teams made up of dedicated, experienced and often highly qualified staff and managers
- strong partnership work with other professionals, community groups, parents and families to improve outcomes and provide integrated care
- quality relationships between staff and children; staff nurture and trust the children, are open and honest with them, show them warmth and respect them
- a good range of quality experiences and activities that children can access
- listening to the voice of the child and involving them in decisions, no matter what their ability to communicate is.⁽⁴⁾

HIQA carried out 38 inspections of Tusla's children's residential centres in 2018, all of which were unannounced inspections. Overall, these inspections found that children were safe, well looked after, and enjoyed a good quality of life. The majority of children's rights were promoted, and children were involved in decisions about their care. The children were well supported by committed and experienced staff teams and other professionals. Staff and management teams worked collaboratively with other professionals to ensure children with complex needs had these needs met. Children were also encouraged to pursue and develop their talents and interests.

During 2018, inspectors saw children living good lives in Tulsa's children's residential centres, although many challenges seen previously by HIQA remained. Among those challenges were management and staffing, gaps in planning for

⁶ End of 2018 data provided by Tusla Quality Assurance Directorate May 2019.

leaving care, routine use of restrictive practices, the failure to keep children in school, and premises and fire safety issues.


Governance and management

Similar to findings since 2015, the compliance levels in children's residential centres throughout 2018 showed that the area of most concern related to compliance with the standard on management and staffing.

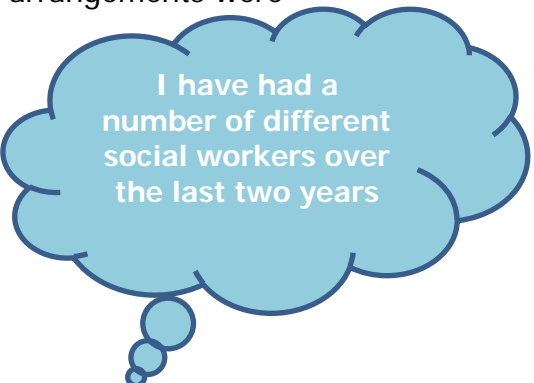
Inspectors found that there were managers in interim positions, a lack of shift leaders to co-ordinate tasks and activities on each shift and inadequate systems of monitoring, quality assurance and risk management. These are key elements to the delivery of safe and effective residential services and will inform the monitoring programme for the Children's Team going forward.

Management systems to ensure safe and effective service delivery were evolving in most centres and oversight and quality improvement measures were developing. Similar to previous years, inspectors found centres needed to improve in the following areas:

- management systems, particularly risk management and monitoring and oversight of care
- many policies and procedures had not been reviewed or revised for a number of years and did not reflect changes in various care practices over that time
- the frequency and quality of staff supervision
- gaps in mandatory training and continual professional development of the staff team to meet the needs of the children
- the number of full-time staff available to the centre in order to ensure consistency of care
- permanency of managerial posts to ensure the long-term stability of the centre
- the identification of a shift leader to co-ordinate the service when the manager is not on duty
- formal managerial on-call systems to ensure these arrangements were sustainable.



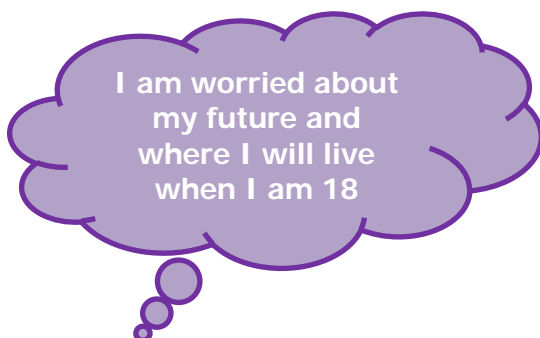
I have a say in what is happening



I have had a number of different social workers over the last two years

Care planning

The *National Standards for Children in Residential Centres* (2001) and the Child Care (Placement of Children in Residential care) Regulations 1995 require each child's social worker to develop, review and update a care plan in consultation with the child and significant others. Our inspectors found that, despite deficiencies in this area being highlighted as an area of concern in 2017, deficiencies remained in 2018. Not all children had up-to-date care plans and, in some cases, the quality of the care plan was poor, for example, lacking detail in relation to family contact.



In addition, planning for children who were due to leave care was not always adequate. Young people leaving care constitute one of the most vulnerable groups in our society. Although children were supported by residential care staff to acquire the skills needed for independent living, the planning for when they turned 18 was not always adequate. Some children had been allocated an aftercare worker and were actively working on aftercare assessments and plans.

However, for other children, allocated aftercare workers were not fully engaged to help them to plan for when they left residential care when they turned aged 18. This meant that some children who were nearly 18 years of age had no stable plan developed for their future adult life outside of residential care, where they may have spent a large part of their life.



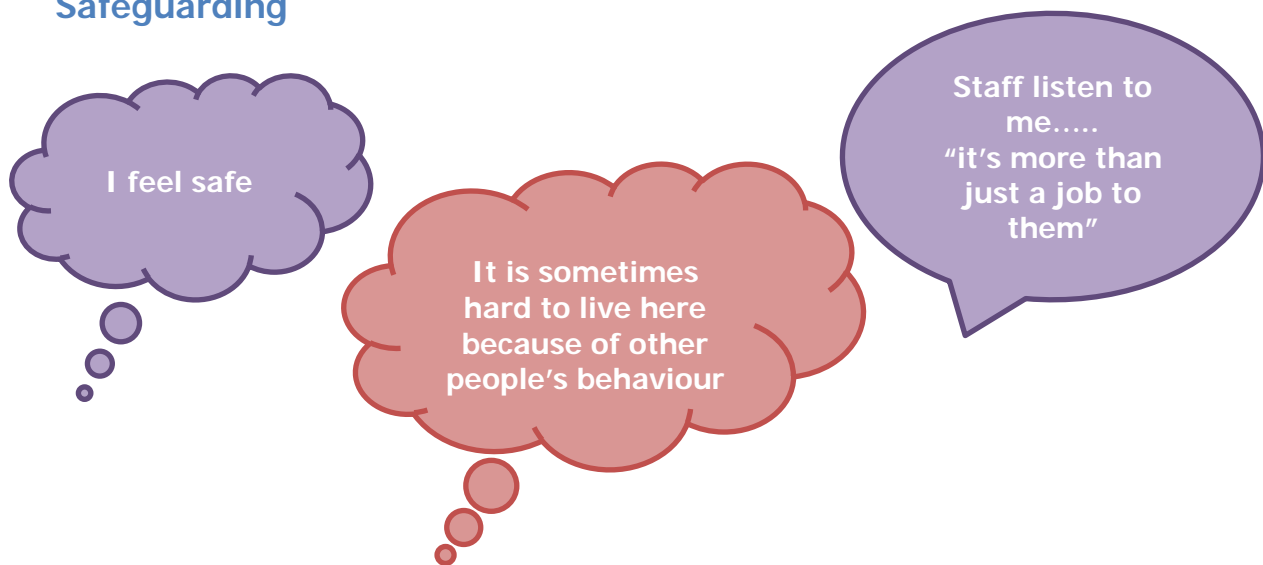
Restrictive practices

The use of unnecessary restrictive practices, where identified on inspection, was

found to be influenced by several factors such as staff shift patterns, where there were no staff members awake at night, and a misconception of the value of closed circuit television (CCTV) as a safeguard measure. To progress these areas, residential centres need to reconsider the role of social care workers in the 24-hour supervision of children and whether familiar practices remain appropriate in the current climate of promoting children's rights.

Inspectors found that institutionalised restrictive practices (such as alarms on children's bedroom doors, locked kitchen doors at night-time, routine checking of children throughout the night and room searches) were not adequately risk assessed on an individual basis in 16 centres to demonstrate why these practices were needed or the specific risk it was a control for. In some of these cases, there were insufficient records available for review to facilitate oversight of the restrictive practice by staff and managers to inform the continued use of the restrictive practice.

Safeguarding



Staff and managers in most centres demonstrated appropriate knowledge and understanding of safeguarding and child protection practice, and policies and systems were in place to support best practice in this area. Of the 35 centres where the standard on safeguarding and child protection was inspected, 11 (31%) were in full compliance. Systems were in place to ensure there was good communication, leadership and accountability around child protection practices.

However, while no children were living in unsafe situations, practices in some centres needed to improve to ensure all child protection concerns were reported in line with *Children First: National Guidance for the Protection and Welfare of Children* (2017). In addition, centre managers needed to adopt measures to be adequately assured that staff and other relevant parties had been appropriately vetted.



Medication management

Meanwhile, inspectors found improvements in the safe administration of medication. Tusla approved a national medication management policy for children's residential centres in early 2018. Inspectors found significant improvements in the storage and administration of medications in most of the 27 centres where this standard was inspected. In addition, the majority of staff in most centres had been provided with training in the safe administration of medications. Where appropriate, inspectors also found older children being supported to self-administer their own medication, which meant they would be ready to do this safely themselves when the time came to leave care.

However, in nine centres further improvement was required in relation to record keeping; safe administration of medication; and storage of medication.

Education

A child's education while in care is vital to the child's future prospects. Tusla data shows that 98% (3,764) of children in care aged six to 15 years and 970 (93%) of 16 to 17 year olds were in an educational placement at the end of 2018. Inspections found variances in practice in relation to educational achievement and attainment across all areas in the country. While 15 of the 28 centres inspected against the standard on education were in full compliance, the other 13 centres struggled to ensure children received an adequate education.

Educational challenges faced by the 13 centres included:

- children not having an educational or training placement
- delays in completing educational assessments
- efforts to address non-school attendance were not successful and
- no guidance being available to support staff to ensure there was an appropriate routine for children who were not attending school.



The physical environment

The majority of centres were houses based in local communities and they were homely and child-centred. However, there were two centres which were converted buildings located, for example, on the grounds of a hospital. These premises were not suitable for children to live in as they looked like institutions and did not support children's integration into local community life. One centre was found to be in urgent need of refurbishment. A follow-up inspection of this centre found that a significant amount of work had been undertaken with regard to upgrading the interior of the premises.



It was evident that Tusla was making efforts to refurbish residential centres around the country and to bring them up to a higher standard. This was welcomed by inspectors and the children who lived in these centres.

Fire safety issues were escalated for attention in two centres where inspectors found that fire doors were not functioning correctly – this matter was addressed in a timely manner in both centres. There were also fire safety deficiencies found in, for example, fire safety records, fire drills and fire safety training.

Monitoring of children's residential centres in 2018 provided assurance that the children living in these centres were well cared for. The vast majority of children had opportunities to keep in contact with their families, make friends, pursue their hobbies and interests, and to get an education. Children's right to participation and consultation in relation to their care was well promoted and their complaints were heard.

HIQA published new standards against which the provision of residential care to children in Ireland is measured in 2018, the *National Standards for Children's Residential Centres*.⁽⁵⁾ This increases the number of standards a service must meet from 10 to 29, with a broadening of standards related to the rights of children in care and governance and management. HIQA will inspect against these standards in 2019. In this regard, it is essential that the systems for governing, managing and resourcing children's residential centres are strong and result in improved capacity to care for children who are out of home.



9. Regulation of special care units

Special care units are secure, residential centres for children aged 11 to 17 years of age. Children are placed in a special care unit by a court when their behaviour poses a risk of harm to their life, health, safety, development or welfare, and the placement is needed for the child's care and protection. Special care units are buildings where the external perimeter doors are locked. In special care, children receive the additional help and supports that they require and also attend school on the grounds of the unit.

Registration

On 1 January 2018, special care units 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 Office of the Chief Inspector had to determine whether these units were fit for registration by 31 December 2018 in order for them to operate. The Chief Inspector's decision to register a centre is informed by the provider's capacity and capability to deliver a safe and effective service that complies with the Health Act 2007 (as amended), and the relevant regulations and national standards.

Three of Tusla's special care units were registered in 2018. Inspectors inspected against the Health Act 2007 (Care and Welfare of Children in Special Care units) Regulations 2017, the Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 and the *National Standards for Special Care Units (2014)*.

The Chief Inspector inspected all of the country's four special care units in operation during 2018. However, during the year, Tusla informed the Chief Inspector of its intention to close one centre — Gleann Alainn Special Care Unit in Cork — by the end of the year. The centre ceased operating as a special care unit in December 2018.

Monitoring and inspection

Registration relates to a judgment by the Chief Inspector of fitness of the provider and persons participating in management of a centre at a specific moment in time. However, it is the monitoring process that underpins continuing fitness and ongoing compliance with the standards and regulations and ultimately promotes continual improvement.

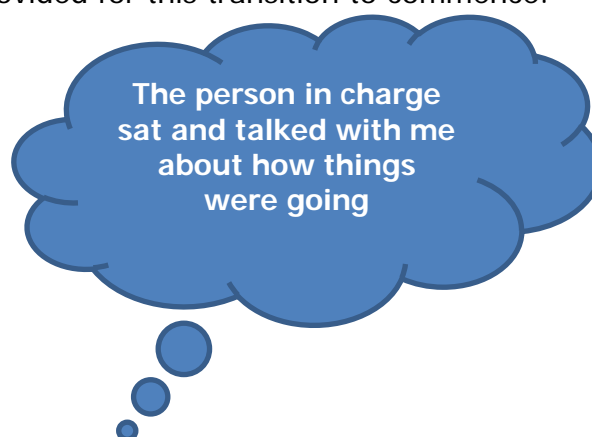
It is through ongoing monitoring that the Chief Inspector continues to be satisfied, or not, that the provider and those involved in the management of the designated centre are fit and that the centre is operating within the conditions that are attached at registration.

Monitoring involves a number of regulatory activities that inform an inspector's judgment about whether or not an appropriate standard of service is being delivered to the children accommodated in the designated special care unit. These activities include on-site inspections, review of compliance plans, reviews of unsolicited information and statutory notifications,⁸ and or escalation steps taken by the Chief Inspector. All of these activities inform our ongoing regulatory decision-making.



Inspections of the four special care units during 2018 found that the purpose, aims and objectives of each unit were clear. There was also good collaboration between staff in the units and the children's families and children's social workers, and between staff in the units and other professionals involved in the children's care.

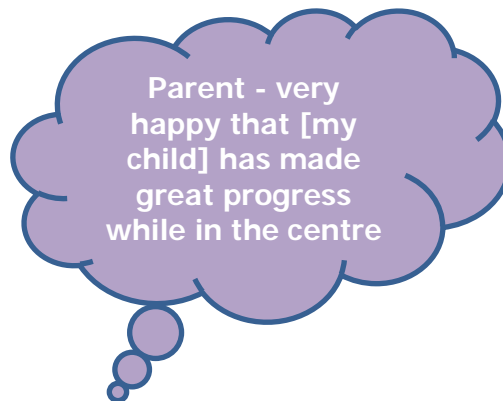
The governance and management arrangements for special care units required improvement to ensure sustainable positive outcomes for the children. Three of the four centres had clear organisational structures but the management structure in one unit was transitioning at the time of the inspection, following a short period of frequent changes in managerial personnel and their respective roles. In this centre, there had been three people identified as the person in charge since the commencement of the regulations. Other managers within the management structure were due to commence alternative roles outside of the designated centre. However, there was no clarity or timeframe provided for this transition to commence.



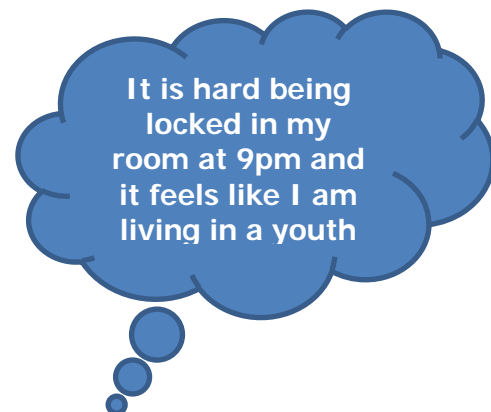
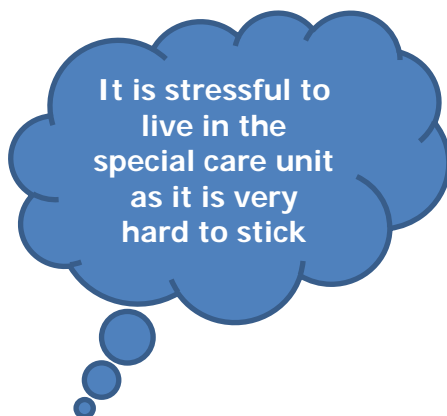
⁸ Notifications required under both the Health Act 2007 (Registration of Designated Centres) (Special care Units) Regulations 2017 and the Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017.

All of the units were well resourced in terms of staffing for the number of children living in the centres at the time of registration. However, increased staffing resources were required in order to operate at full capacity.

Management systems required further development in each of the four units to ensure that the units operated under a risk management framework for the identification, assessment and management of risk; and that the quality and safety of the programme of special care was monitored to improve the services in a systematic way.

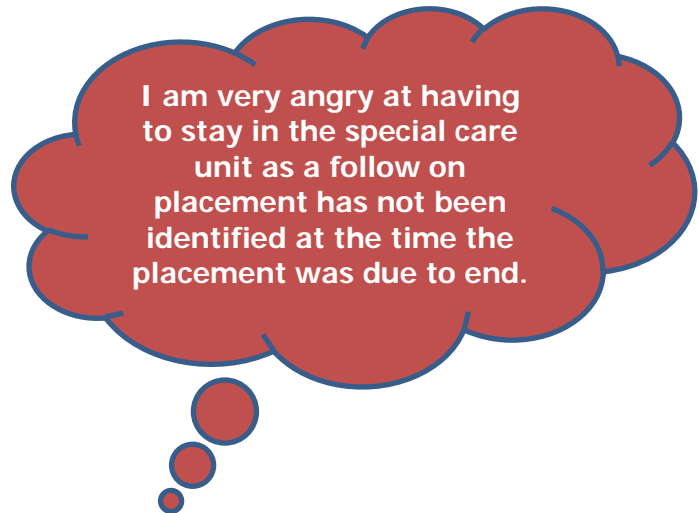


While children had good relationships with staff in all four units and were supported to maintain contact with their families, children were not happy about a number of the rules in the units. Inspectors found that the routine application of certain practices (locking internal doors throughout the units, locking all bedroom doors at night and routine checking of children throughout the night) did not reflect or take into account the needs and progress of individual children and the extent to which such restrictive practices were necessary. In addition, children in two of the units were not given opportunities to participate in meaningful activities appropriate to their needs and wishes.

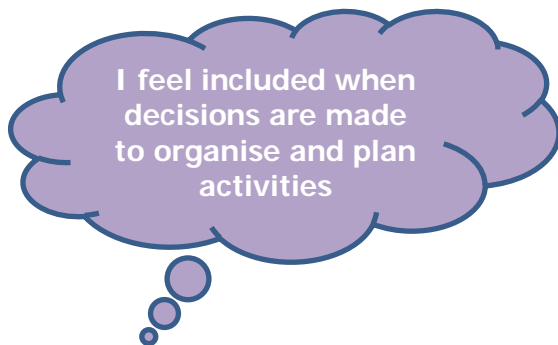


Each child had a documented programme of care. Children had access to a therapeutic team, and the programmes of special care were found to be having an impact on the stabilisation of some behaviours. Children were being supported to work through their difficulties without resorting to aggression, violence or other behaviours. However, inspectors found that in three centres, delays in securing an

onward placement for the children had the potential to undermine the progress that had been made with them.



The registration of special care units for the first time in 2018 has marked a significant development in the provision of secure residential services to children in Ireland. Along with monitoring against *National Standards for Special Care Units* (2014), the cyclical registration of these units ensures these services are both fit for purpose and progressive in their approach to improving the care and support they provide to some of society's most vulnerable children.



Ongoing monitoring of these units has identified that particular attention should be paid to certain aspects of service delivery. This includes the provision of secure care in an environment which acknowledges the responsibility of these services to limit the restrictions placed on children in an already secure setting, and to take account of children's progress. In doing so, these units will progress towards sustainable, positive outcomes for the children who are placed there.

The governance and management arrangements in these units need to progress to a level which can provide assurance that they are consistently well run, can manage emerging risks and can make the number of special care beds they are registered for available to the wider child care system. The assessment of progress in these areas will form the focus of monitoring of these services in 2019.

10. Inspection findings of Oberstown Children Detention Campus

HIQA inspectors are authorised by the Minister for Children and Youth Affairs under Section 185 of the Children Act 2001, as amended, to inspect Oberstown Children Detention Campus.

Oberstown Children Detention Campus is funded by the Irish Youth Justice Service, which is an office within the Department of Children and Youth Affairs, and is managed by a board of management. It offers care and education to boys and girls who have been sentenced following a conviction for criminal offences, up to age 18. It also provides places for boys and girls up to 18 years of age who are remanded in custody while awaiting trial, sentence or release.

HIQA inspects the facility to ensure that the wellbeing, welfare and safety of children is promoted and protected, and to measure its compliance with the *Standards and Criteria for Children Detention Schools* (2008) and its implementation of *Children First: National Guidance for the Protection and Welfare of Children* (2017).

In December 2017, the Oberstown Children Detention Campus Strategy 2017–2020 was launched. This strategy was devised in consultation with staff, management and external stakeholders and sets out five strategic objectives for the campus. The strategy identifies key approaches through which Oberstown will achieve its objectives, including:

- implementation of its new care framework
- having multiagency and specialist support in place
- enhancing accountability provided by management, including the board of management, for the campus.

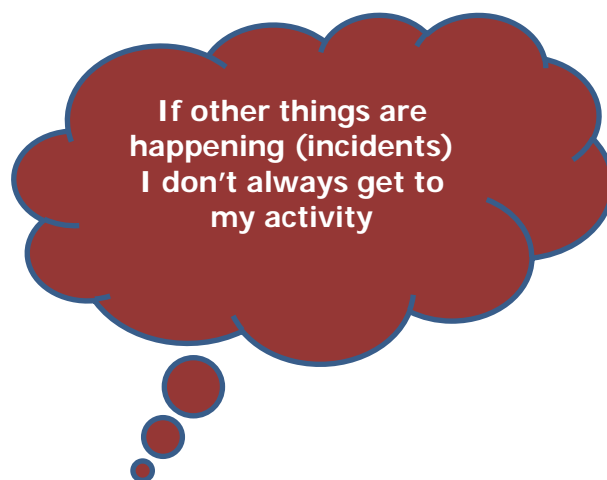
HIQA carried out an unannounced inspection of Oberstown Children Detention Campus in 2018. All 10 standards were assessed as part of this process, with half of all standards found to be compliant or substantially compliant. Moderate non-compliance was found in the remaining five standards.



At the time of inspection, Oberstown Children Detention Campus was undergoing a period of relative stability following a succession of major changes over the previous years. Over 307 recommendations to support the development of the campus arose out of a number of external reviews, commissioned in 2016. There was evidence that many of the recommendations relating to Oberstown had been implemented in full and work on the remainder was underway at the time of HIQA's 2018 inspection.

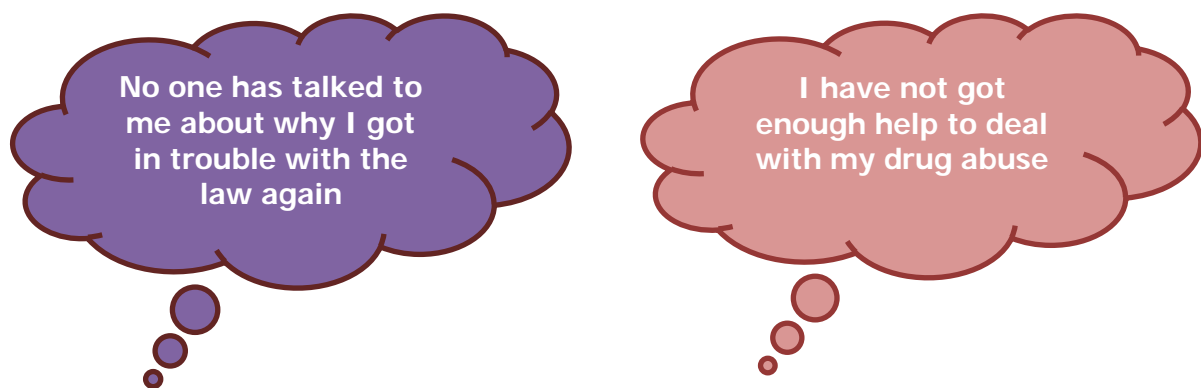
Overall, inspectors found that improvements were evident in the areas where the campus management team had focused and where the necessary resources had been deployed. These included:

- Strengthening and clarity of management structures and governance arrangements. A number of changes had been made to ensure that the campus functioned more efficiently and effectively and to enhance the service provided. A strategy for updating campus policies, procedures and guidelines was in the process of being implemented.
- Improvements in the management of risk with a focus on ensuring risk was effectively identified, assessed and managed.
- Significant improvements in relation to children's healthcare.
- Children's educational needs were appropriately assessed and met. There was good collaborative working between the school and campus staff and children were encouraged and supported to achieve their educational goals
- Improved systems to ensure children were safe and that child protection concerns were appropriately referred to the relevant agencies.
- Well thought-out improvement works had been completed on the premises, and the campus was generally fit-for-purpose within the constraints of safety and security. There was no major outstanding maintenance work to be carried out.



Meanwhile, HIQA found further improvements were required. These included:

- Consistent implementation of planning and review procedures to ensure children's needs and risk assessments were comprehensive and informed the planning process.
- Considering children's offending behavioural needs as part of the planning process.
- Recording, monitoring and management oversight of the use of restrictive practices to ensure they are the least restrictive for the least amount of time.
- Provision of supervision and performance development for staff.
- The process for responding to and recording complaints.
- Multiagency responses and necessary cooperative working arrangements to ensure effective responses following a child protection and welfare concern.



Oberstown Children Detention Campus has demonstrated a commitment to improving its services to the children placed there. It has taken on board the many recommendations made in relation to the safe and effective delivery of its services, which came about as a result of a past period of instability and considerable change. While this campus houses children in a secure setting, it has and continues to progress its approaches to providing an environment within which children are encouraged and supported to leave its care in a positive way and to reintegrate successfully into their communities.

Some of the challenges facing services which house young people who have been referred by the courts are evident in Oberstown, such as managing complex behaviours and high levels of need, and balancing the sometimes conflicting demands of providing care and custody. Delivering a service of this complexity safely and effectively requires strong leadership, effective management systems and a competent and skilled workforce which, when combined, promotes the rights and

safety of children and improves their outcomes, including redirecting them away from reoffending.

In response to these challenges, Oberstown has brought about changes to its systems of governing and managing and has initiated a holistic approach to planning the care and education of children. For further progress, HIQA's inspections have highlighted the need to ensure Oberstown's systems of accountability and authority are fully embedded and sustained in day-to-day practice. This is particularly important in relation to the management of risk, use of restrictive practices and ultimately the promotion of children's rights and safety. The campus has an opportunity to break an offending cycle for some children, and to do so it needs to ensure the programmes it has in place can make the most of this opportunity. These areas will be a focus of HIQA inspection in 2019.

11. Stakeholder engagement

During 2018, the Children's Team continued its programme of engagement with various informed and interested parties.

Children and families

Inspectors met with 122 children while on inspections in children's statutory residential centres, special care units and Oberstown Children Detention Campus. Inspectors also met with or spoke with foster carers, parents and advocates as part of our inspection activity.

Department of Children and Youth Affairs

The team continued to work with the Department of Children and Youth Affairs during 2018 to improve the standards of children's residential services and other children's services within our regulatory and monitoring remit.

The Chief Inspector and Director of Regulation and the Children's Head of Programme met with the Assistant Secretary, and Chief Social Worker, Child Policy and Tusla Governance Division, during 2018. These meetings were held to share relevant updates and exchange information on both improvements and actual and potential risk across the sector.

A representative from the Children's Team also attended collaborative meetings in the Department of Children and Youth Affairs in relation to the National Strategy on Children and Young People's Participation in Decision-Making.

The Children's Team also worked with the 'Participation Hub' within the Department of Children and Youth Affairs to develop a training programme for inspectors, to enhance communication and engagement with children and better capture the richness of the experiences of children in care.

Department of Education and Skills

The Children's Team liaised with the Assistant Chief Inspector in the Department of Education and Skills in relation to identifying opportunities for inspectors from both organisations to shadow an inspection with counterparts in the other organisation, which happened in July and October 2018.

The Child and Family Agency (Tusla)

The Children's Head of Programme and regional managers met regularly with Tusla's Chief Operations Officer; Director of Transformation and Policy; Director of Quality Assurance; and Director of Children's Services.

These meetings were held to share information in relation to annual business

objectives; to present on proposed changes to regulatory methodologies; to discuss practice issues requiring improvement; to provide general feedback on inspection findings; and to learn of new developments in Tusla (such as policies, management and structural changes).

To prepare for the commencement of statutory regulation of special care units in 2018, members of the team met with Tusla's Chief Operations Officer and its National Director of Children's Residential Centres to discuss the regulation of special care units. A briefing session was also held for key stakeholders from the four special care units.

Regional managers from HIQA met with Tusla's Director of Quality Assurance and its National Risk and Incident Manager to discuss submission of, and updates relating to, notifications in line with the Guidance for the Child and Family Agency on the Operation of The National Review Panel (2014).

In addition, regional managers from the Children's Team also met with Tusla's Director of Quality Assurance, its Director of Transformation and Policy and its Chief Social Worker to update HIQA on the rollout of Tusla's 'signs of safety' programme within Tusla.

Tusla presented to the Children's Team on its progress with implementing its new national approach to child protection and welfare — a key child safety commitment from Tusla following HIQA's investigation. We also received a presentation from Tusla on a new therapeutic model of care being introduced into special care units and residential centres that focuses on promoting the wellbeing and building the capacities of traumatised children.

In addition, in December 2018, a senior lecturer in social work — and Deputy Director of the Master of Social Work Programme and Research Associate in University College Cork — presented to the Children's Team on international research findings on child protection and welfare services.

Other stakeholders

The insights and experiences of other stakeholders are also very much valued by HIQA. The Children's Team met with the Empowering People in Care (EPIC) organisation and the Irish Foster Care Association in 2018. Members of the Children's Team also presented at the Irish Foster Care Association's Annual Conference in 2018.

Colleges

During the year, the team spoke about the role of HIQA to students of both the University College Cork (UCC) Masters of Social Work programme and the Dublin

Institute of Technology (DIT) Masters in Social Care Leadership and Management programme.

12. Concluding Statement

The activity of HIQA's Children's Team in 2018 was primarily influenced by inspection findings from the previous year. This approach to monitoring services for children in Ireland ensures that these services continually strive to improve, and by doing so, increase the probability that there will be better outcomes for the children they care for or come in contact with.

An analysis of the collective findings of inspections and the Tusla investigation, has reinforced an emerging trend from over the last number of years; that is, the critical importance of strong leadership and effective systems for governing and managing children's services.

Reports published by HIQA in relation to the broad range of services inspected by the Children's Team have highlighted many improvements in children's services, and the commitment of staff and managers to provide safer and effective care. This is welcomed. However, risks in children's services remain and risks invariably come back to how these services are governed and managed. This has been a common finding across all services inspected or investigated in 2018.

HIQA is acutely aware of the impact of staffing shortages across the child care system. Notwithstanding the inability of some of these services to operate at full capacity due to staffing levels, staffing is not the only factor in the mitigation of risk, or in the delivery of meaningful and impactful services to children. Within the context and limitations of inadequate staffing, prioritisation of risk-based work is critical; but this was not always evident in services inspected in 2018. Furthermore, although managerial systems in areas such as direct reporting, risk management, monitoring and quality assurance have been developed by the majority of children's services, inspections have consistently identified variance in their implementation locally. As a result, there is a demonstrated disconnection between what has been generated at senior management level, and what is actually happening operationally.

The resulting cumulative effect on children and their families has seen variance in the quality and timeliness of the services they have received. This has had a direct impact on the safety of some services and their ability to promote children's rights and wellbeing. It is on this basis that leadership, governance and management of children's services has and will continue to influence the focus of the children's team in propelling improvements across the child care system.

Appendix 1. Statutory basis for inspection and monitoring of children's services by HIQA and the Chief Inspector

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	Standards
Child Protection and Welfare Services	Inspected under Section 8(1)c of the Health Act 2007 (as amended)	Health Act 2007 (as amended)		<i>National Standards for the Protection and Welfare of Children</i> (HIQA, 2012)
Foster care services	Inspected 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	<i>National Standards for Foster Care</i> (DOHC, 2003)
Special care units	Inspected 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) Regulations 2018 ⁹	<i>National Standards for Special Care</i> (HIQA November 2014)

⁹ The 2018 regulations contain a minor amendment to regulation 26. All references to the Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 include this amendment.

Children Detention Units	Inspected under Section 185 and Section 186 of the Children Act 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006		<i>Standards and Criteria for Children Detention Schools (DOJELR, 2008)</i>
Children's Residential Centres	Inspected under Section 69 of the Child Care Act, 1991, as amended	Child Care Act, 1991, as amended	Child Care (Placement of Children in Residential Care) Regulations, 1995	<i>National Standards for Children's Residential Centres (HIQA 2018)¹⁰</i>

¹⁰ These standards replaced the National Standards for Children's Residential Centres, Department of Health and Children, 2005 on 7 November 2018.

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