



**SOCIAL SERVICES
INSPECTORATE**

**A CHILDREN'S RESIDENTIAL CENTRE IN
THE MIDLAND HEALTH BOARD
WESTMEATH/LONGFORD
COMMUNITY CARE AREA**

INSPECTION REPORT ID NUMBER: 44

**Publication Date: 24 Jun 2002.
SSI Inspection Period: 3
Centre ID Number: 11**

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1. Executive summary

This was a report of an inspection of a children's residential centre carried out by the Social Services Inspectorate (SSI) under Section 69 (2) of the Child Care Act 1991 over three days, 22nd – 24th January 2002. Michael McNamara was lead inspector and Mike Lindsay was in support.

The centre was one of a group of children's centres in County Westmeath run by the Midland Health Board (MHB). Prior to 1995, the Congregation of the Sisters of Mercy ran it. The centre offers care to a mixed gender group of four young people; and the referrals to the MHB residential service as a whole, along with the vacancies that arise, determine how children are placed. For the purpose of this report, the identity of the centre has been protected because its name would immediately reveal its geographical location, and would compromise the right to confidentiality of the young people resident in it. It has been called Children's Residential Centre MHB 1, and is referred to in the body of the report as "the children's centre".

The MHB residential child care services, which comprised eight residential children's centres, are managed by a manager and two deputies based in Moate, Co Westmeath. Since the inspection two of the centres have closed. In 1997 a working party of residential staff and social workers drew up common protocols describing policies and procedures for all the board's centres. Recently, the board had approved a new child care strategy, and the structure, policies and procedures governing residential child care are under review.

Inspectors found that the children's residential centre had a well-qualified and experienced staff group, which had good relationships with young people, parents, and schools. They have good systems in place for the administration of the centre, and keep children's records to a reasonably high standard. They respect the individuality of young people in their care, promote their health and education, and facilitate the practice of their religion.

Relationships with families are maintained, and staff at the centre are actively involved in facilitating contact. Parents and social workers told inspectors that they are consulted and notified appropriately about significant events in the lives of the young people. The rights of young people are respected, and there was a good standard of consultation on day-to-day issues.

The statement of purpose a function was not reflected in practice. Residential care was said to be an option of choice, but the young people in the centre have come to be there as a result of the breakdown of other health board care arrangements. Inspectors found that the procedures for processing admissions and discharges had collapsed, and the purpose and function of the centre needed to be reviewed. Since inspection, SSI has been informed that the admissions process and the purpose and function are being revised.

Inspectors found areas of concern. The accommodation was substandard, and had been poorly maintained over several years. It was rented from the local diocese by the board. A health and safety audit in March 2001 identified several significant hazards and recommended investment in safety measures to ensure fire prevention and provide fire-fighting equipment. Some of the recommendations were followed, but many were not, and at the time of inspection the centre had a conditional interim fire certificate for eight weeks issued on 14th January 2002. Prior to that date the centre did not have a fire certificate. Inspectors were concerned to discover that this was the case after recommendations regarding fire safety had been made during previous inspections of other MHB residential centres. This was in contravention of the requirements of *Child Care (Placement of Children in Residential Care) Regulations, 1995*, and was totally unacceptable. The board had

resolved the problem of the safety and standard of the accommodation by purchasing a modern house a few miles from the property that was inspected. The centre moved there in March 2002.

Another area of concern to inspectors was the management of behavioural difficulties in the centre. During the year prior to inspection there had been episodes of aggression and violence, damage, and a very high number of unauthorised absences. The number was a reflection of the centre's definition of unauthorised absence, but it also reflects the fact that rather than 'running away' from the centre, young people are coming and going as they please. Similar issues have been brought to the attention of the board after inspections of other MHB centres. The significance of the records of unauthorised absences was that they reflect the inability of staff to place consistently effective boundaries on the behaviour of some of the young people and consequently are limited in the extent to which they can purposefully engage with them. The policies covering management of behaviour need to be reviewed so that staff are empowered to take greater control of the centre and provide a safer environment for the young people. There also needs to be greater facilitation of constructive activities for young people.

The safeguarding of young people in the centre was a matter of concern to inspectors. There have been incidents where young people have been put at serious risk by other residents. These have been reported by centre staff in accordance with the board's procedures. However, there were delays within the system in the community care areas, and a risk situation continued for several months.

The child protection procedures of the board need to be reviewed in order to sharpen its focus on protection of young people in residential centres. The quality of vetting of staff was not of a satisfactory standard. During the preceding year young people in the centre had periods of time when they were not allocated to a social worker and visited in accordance with the regulations. The MHB had yet to appoint an authorised person to monitor the centre on a regular basis in accordance with *Child Care (Placement of Children in Residential Care) Regulations 1995, Part III, Article 17*. Staff require more training in the subjects of Children First, child protection in residential settings, and sexual development in adolescents; and they lack access to specialist consultancy in order to develop their skills in making assessments of risk and implementing risk management plans.

Generally, the young people at the children's residential centre have many difficulties and have experienced several changes in their lives. However, the centre had provided three of them with periods of stability in their lives, and they have viewed it as their home even though there have been problems as outlined above. The introduction of the board's new child care strategy and the move to a new property should be seen as good opportunities to initiate the changes necessary to ensure that they have a better quality of life in a safer environment.

2 Introduction

2.1 Methodology

1.1 The inspection of the children's residential centre was carried out under section 69 (2) of the Child Care Act 1991.

Michael McNamara (lead inspector) and Mike Lindsay (support) carried out the inspection over three days, 22nd – 24th January 2002. A pre-inspection visit took place on 16th January 2002 at which the inspection process was explained to the staff.

The inspectors examined the following documents during inspection:

The Midland Health Board's protocols for residential care
The Midland Health Board's children's residential services restraint policy
The Midland Health Board regional child protection guidelines
The Midland Health Board policy on bullying in the workplace
The young people's daily logs and case files
Incident Sheets
The medication book
The sanctions book
The fire safety book
Information collated from questionnaires completed by parents, teachers,
and social workers
Census information on staff and young people
Documentation about complaints, allegations, investigations, and outcomes
Job descriptions of managers and deputy managers

Three young people, two parents, one team leader, three social workers, six staff, the general manager, the residential services manager, the unit leader and one family support worker were interviewed.

2.2 Acknowledgements

The inspectors would like to express appreciation to all who provided information including managers, social workers, residential child care staff, parents, and of course the young people.

3. Setting the scene: background, the unit and its population

3.1 Background

The children's residential centre was in County Westmeath, and was one of a group of eight children's centres in the Midland Health Board area. For historical reasons, all of the children's centres run by the board are in Westmeath/Longford community area. At the time of the inspection there were no centres in the Laois/Offaly community area. Since the inspection the number of centres had reduced to six.

Prior to 1995 the Congregation of the Sisters of Mercy provided all children's residential services in the board's area. Since 1970, the centre had been housed in a building belonging to the local diocese. The health board had rented the building since 2000. The centre offers care to a mixed gender group; and the referrals to the service as a whole, along with the vacancies that arise, determine how children are placed. The centre was designed to take five, but following closure of a bedroom on the advice of a fire officer, capacity was reduced to four on the grounds of fire safety.

3.2 Data on Young People

The four young people at the centre at the time of the inspection were aged between 11 and 16 years. There were two boys, and two girls. Three were in care under Court Orders, and one was placed through voluntary agreement. There was no fixed age of admission. One young person had lived at the centre for over five

years. Others have been there for four years ten months, two years eleven months, and eleven months respectively.

Three of the current group were placed in a planned way, but the placement was not the option of choice. Two were placed after foster placement breakdowns, and another was placed after being in respite care. One resident was placed in an emergency following a crisis in another residential centre. As an interim measure, another resident had been transferred to another residential unit shortly before the inspection. He was interviewed as part of the inspection of the children's residential centre.

4. Standards: the findings

4.1 Statement of purpose and function

The unit has a clear written statement of purpose and function which accurately describes what the unit sets out to do with children and the manner in which that is provided. The statement is available, accessible and understood.

The centre had a statement of purpose and function produced by the health board. It stated that the children's residential centre was one of eight residential units in the board's area. Its specific purpose was to provide a caring environment for young people in medium to long term care and occasionally respite care, who could not remain in their own homes, for whom placement with relatives was not appropriate, or for whom foster care was not an option.

Residential care was described as the chosen option: for the protection of the young person; when maladaptive behaviour patterns presented by the young person are severe; where young people prefer to be in residential rather than in alternative family placements; and where young people have experienced numerous placement breakdowns.

It stated that the aims of the centre were to provide: a good experience of life in a homely environment that is structured so as to give a sense of belonging and acceptance. The centre was for mixed genders. The statement gives the age range of the current residents as between 12 and 18 years, but does not specify age limits for admissions. Although all the residential centres run by the board are in Longford and Westmeath, they cover the whole MHB area by taking young people from Laois and Offaly. The statement lists facilities available to the centre including: educational provision, local leisure facilities, and medical and psychological services. It makes special mention of the staffing and of the keyworker system in the centre.

A working party first drew up common protocols describing policies and procedures for all the centres in 1997. The protocols are a comprehensive range of documents covering areas of policy and practice, including: aims and objectives for the service; the principles and philosophy of residential care; respect for a child's dignity and individuality; admissions procedure; discharges; child placement meetings; care plans; reviews; key worker system; allegations, suspicions or disclosures of abuse; dispensing non-prescription drugs; smoking policy; illegal drugs and solvent abuse; absconding; assaults on other young persons or staff; damage to property; self-injurious behaviour; sanctions; complaints; pets; restraints; record and file keeping; day book; medical book; fire safety; petty cash book; meetings; general staff meetings; senior house parent meetings; children's house meetings. Some of these were updated in 2001. Managers have provided inspectors with others that

have been revised since the inspection. Several will be further reviewed as the new child care strategy for the board is implemented.

4.2 Management and care staffing

The unit is effectively managed, and care staff are organised to deliver the best possible care for young people. There are appropriate external management and monitoring arrangements in place

4.2.1 Management

The day-to-day management of the centre was the responsibility of the unit leader, who was appropriately qualified. He had been unit leader in other MHB centres, but had been at children’s residential centre MHB 1 since July 2001. He reports to the residential services manager. She had general management of all the residential provision of the board. In this task she was assisted by two deputies, one of whom had particular responsibility for the children’s residential centre. Along with leaders of other centres, the unit leader meets with either the manager or the assigned deputy once per week, and gives a report on the centre. He also receives supervision, but while this had been the case for some time, it had only recently been made formal.

4.2.2 Register

The centre had a register, and the manager of the residential children’s services kept a copy register in accordance with the Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 21. It stated the date of discharge and the destination to which the young person was discharged.

4.2.3 Notification of significant events

Inspectors found evidence that the centre had a prompt notification procedure. Both the residential services manager and the supervising social workers are notified of significant events.

4.2.4 Staffing

As the chart below shows, the centre had 19 staff: one unit leader, seven full time child care leaders, one part time child care leader, nine part time relief child care workers, and one part time relief trainee. Permanent full time staff work 39 hours per week, organised as three 12-hour shifts with three hours for attendance at the staff meeting. The permanent part time staff and four relief staff work 12 hours per week. The hours of other staff are variable. The unit leader works office hours, and generally, there are three members of staff on duty during the day and two waking night staff.

Staff at Children’s Residential Centre MHB 1 – January 2002

Staff member/ employment status	Length of service in centre	Qualification
Unit Leader #1 Full Time Permanent	6 months	National Diploma in Child Care
Child Care Leader #2 Job Share Permanent	17 years	National Diploma in Applied Social Studies in Social Care BA Applied Care in Social Care

Child Care Leader #3 Full Time Permanent	12 years	Diploma in Applied Social Studies in Social Care
Child Care Leader #4 Full Time Permanent	7 years	National Diploma in Applied Social Studies in Social Care
Child Care Leader #5 Full Time Permanent	4 years 3 months	Registered Psychiatric Nurse
Child Care Leader #6 Full Time Permanent	2 years 5 months	Diploma in Social Care
Child Care Leader #7 Full Time Permanent	2 years	National Diploma in Applied Social Studies in Social Care
Child Care Leader #8 Full Time Permanent	1 year 4 months	National Diploma in Applied Social Studies in Social Care
Staff member/ employment status	Length of service in centre	Qualification
Child Care Leader #9 Part Time Permanent	5 years	National Diploma in Applied Social Studies in Social Care BA in Applied Care in Social Care
Child Care Worker #10 Part Time Relief	3 years	No Qualification
Child Care Worker #11 Part Time Relief	2 years 9 months	Registered Psychiatric Nurse
Child Care Worker #12 Part Time Relief	2 years 7 months	BA Sociology & Philosophy
Child Care Worker #13 Part Time Relief	1 year 8 months	No Qualification
Child Care Worker #14 Part Time Relief	1 year 7 months	National Diploma in Applied Social Studies in Social Care BA in Applied Care in Social Care
Child Care Worker #15 Part Time Relief	1 year 7 months	National Diploma in Applied Social Studies in Social Care
Child Care Worker #16 Part Time Relief	1 year 6 months	No Qualification
Child Care Worker #17 Part Time Relief	1 year 1 month	National Diploma in Applied Social Studies in Social Care
Child Care Worker #18 Part Time Relief		No Qualification
Trainee #19 Part Time Relief	1 month	No Qualification

The chart gives details of staff in order of post and length of service. As the chart shows, 10 out of 19 staff have nationally recognised qualifications in child care, two are qualified psychiatric nurses, and one had a related degree. Some of those with child care qualifications also have other related qualifications. The average length of service in residential care overall was five years six months. The average length of service in the centre for all staff was three years eight months. These figures are indicative of a staff group that was well established in the centre and well experienced in residential care.

Inspectors were given information about the vetting of staff, and in only two cases were Garda clearances and references received prior to commencement of employment. Six of the staff whose details were supplied during the inspection did not have Garda clearances because they had commenced employment prior to the introduction of checks in September 1995. However, one more recently employed member of staff did not have Garda clearance. Five of the staff were employed after verbal checks with local Gardai. Managers told inspectors that this system is no longer in use. The board received references prior to appointment in accordance with Department of Health

procedures for four of the staff. Three staff were said to have cover through their colleges whilst they were on placement in the centre. Several staff had references from people other than previous employers, and many of the references were not appropriate for vetting staff of a residential children's centre. The guidelines are clear: Gardai clearance and three references are required prior to the commencement of employment. The standard has not been met, and the systems used by the board need to change so that practice is brought into line with the Department of Health and Children's guidance on vetting of staff for children's centres.

Recommendation

- 1 The board should ensure that all staff with substantial access to children in its care are appropriately vetted prior to appointment.**

4.2.5 Supervision and support

A formal supervision system was set up immediately prior to the inspection. The unit leader receives supervision from the residential services manager or deputy once a week. Generally, it was intended that permanent staff should receive supervision every four weeks from the unit leader or from the assigned residential services manager. Other staff were to receive supervision at five or six weekly intervals. Inspectors welcome the introduction of formal supervision, and urge the managers of the service to develop and maintain the system.

4.2.6 Training and development

Seventeen staff were trained in Therapeutic Crisis Intervention (TCI). Two of the staff had also trained as TCI trainers, and one had completed a refresher course. One member of staff had training in Children First, and two had received child protection training. Three attended a course in Best Practice in Residential Care provided by the MHB; and one had been trained in courtroom skills. Other training attended by individual staff included: counselling, addiction studies, and staff development. Six staff were engaged in degree and qualification courses. It was clear to inspectors that the board had provided relevant training for staff over the last three years. However, in order to equip themselves to respond to the challenges presented by the current population of the centre it is essential for all staff to have training in Children First, child protection in residential settings, and sexual development of adolescents.

Staff development was focused on supervision and in-service training. There was no staff appraisal system in place. Inspectors were informed after the inspection that the board has set up an appraisal programme for permanent staff.

Recommendation

- 2 The board should extend to all the staff at the centre training in the subjects of Children First, child protection in residential settings, and sexual development in adolescents.**

4.2.7 Administrative files

The administrative files were well organised and generally effectively maintained. Inspectors found evidence that they were regularly monitored by the managers of the residential child care services.

4.3 *Monitoring*

The Health Board, for the purpose of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the health board, to monitor statutory and non-statutory children's residential units.

There was no provision for monitoring by an authorised person who was not part of the line management of the centre in accordance with *Child Care (Placement of Children in Residential Care) Regulations 1995, Part III, Article 17*.

The residential services manager or her deputies visited the centre weekly. Inspectors found evidence that records were regularly checked during the visits. However, this does not fulfil the requirement of the regulation.

Recommendation

- 3 As a matter of priority, the board should arrange for an authorised person to monitor the centre on a regular basis in accordance with *Child Care (Placement of Children in Residential Care) Regulations 1995, Part III, Article 17*.**

4.4 *Children's rights*

The rights of young people are reflected in all unit policies. Young people and their parents are informed of their rights by supervising social workers and unit care staff.

4.4.1 *Consultation*

The views of the children in the children's residential centre were sought about some decisions that affect their daily lives and their future.

The young people were clear that they could express their views to staff, and that they were fully consulted by the staff and their social workers. The centre's keyworker system was a valuable means of ensuring that children have a focus for individual consultation, and the staff supported children in putting forward their views to care plan review meetings. The young people could attend their reviews, but they sometimes chose not to.

The centre had a policy on children's house meetings stating that they were held fortnightly and give each young person an opportunity to air their views, grievances and complaints. Any subject brought forward by young people was discussed. An example of an issue raised by a young person was personal belongings going missing. Minutes of the meetings are kept in a book, but inspectors found minutes of only six meetings since June 2001. There was no written evidence that matters discussed at the young persons' meetings were raised at staff meetings.

Inspectors found that all the young people at the centre were unclear about the future of the centre. The building at the centre had an interim fire certificate dated to the 14th March 2002. Beyond that date, it was necessary for the young people to be housed elsewhere. The young people themselves, and some of the social workers, were unaware of the plan to move. When asked about consultation with young people about the move the unit leader and managers explained the difficulties they faced. For example, there had been a search for an alternative property from June 2001 up to the inspection during which several properties were seen, and offers made by the board could not be finalised owing to collapse of the sale negotiations. The experience had made the managers wary of informing the young people or others involved with them because of a fear of disappointment when plans could not be realised. They told inspectors that young people's views would not influence the decision because it was difficult to find a property. The issue of the interim fire certificate changed the momentum of the search.

At the point of inspection the board was aware of the imperative to move, and were in the process of purchasing a property, but consultation with the young people about having to move their home had not taken place. Inspectors were of the view that since the move was imminent and the reason for the move was compelling, young people should have been told about it. Reviews should have been held in order to discuss the impact of the move on each young person, and to map out the details as far as possible, so that they could prepare for and adjust to the new situation. By the end of the inspection two of the children had seen the new property, and informal discussions with staff were taking place.

Inspectors also found that the young people were unclear about plans for their future. The older adolescents were unsure about what they would be doing after leaving school and after leaving residential care. One young person was aware of the board's plan to move him to another centre, but he had no indication of where or when, and felt that he had not been fully involved or informed in the decision-making process. Staff and managers said that no decision was made as to where he would go, and they were unable to give him firm information about the intended move.

The board needs to develop a policy on consultation and devise procedures to ensure that young people are made aware of their right and the policy is realised consistently in practice. Inspectors recommend that those charged with producing the policy and procedures refer to the Inspectorate's guidance notes on 'Children's Consultation'.

Recommendation

- 4 The board should develop policy and procedures to ensure that young people in its care are effectively consulted about matters that concern their day-to-day lives and their future.**

4.4.2 *Complaints*

The centre had a well-defined policy on complaints. It affirmed the principle that all young people have a right to be listened to and taken seriously. It identified three categories of complaint: an expression of unhappiness about everyday life; unfair treatment in the unit by other residents or staff; and serious complaints, such as of neglect, or emotional, physical or sexual abuse. It then described the procedures to be followed in order to pursue any of the three types of complaint. These included: talking to a keyworker or member of the care staff, raising the subject at a residents' meeting, talking to the unit leader, or if dissatisfied with the way the complaint was being handled, to the residential child care manager, or social worker, "or any other person the young person feels they can trust". There was a form to be completed by the young person making the complaint, and another form to be completed by the person handling the complaint which records action taken, feedback to the complainant, and whether the complainant was satisfied that the complaint had been dealt with.

The Inspectors were shown records of only four complaints covering the period of one year prior to the inspection. One was made in August 2001, and not fully processed until January 2002. An apology for the delay was given to the young person. One of the complaints fell into the second category of concern about unfair treatment by staff or young persons; two others fell into the other category of more serious allegations.

Staff and young people at the centre told inspectors that they were aware of what to do in order to make a complaint. However, while staff were of the opinion that young people knew whom the complaint would be handed on to and understood the timescale in which it would be considered and acted on, none of the young people interviewed were clear about what happens after they have filled in the form. This needs clarification, and the timescale in which the complaint will be dealt with should be defined in the procedures, with an undertaking to write to a young person setting a revised deadline and explaining delays when they occur.

Some allegations of abuse had been referred through the MHB's child protection procedures using notification forms in line with guidance in Children First. Some allegations that should have been referred through the notification procedure were dealt with as complaints. The distinction between a complaint and an allegation of abuse should be in the complaints' procedures, and all allegations of abuse should be referred in accordance with Children First guidelines. Inspectors recommend that those charged with reviewing the policy and procedures refer to the Inspectorate's guidance notes on 'Children's Complaints Work'.

Recommendation

- 5 The board should review its policy and procedures on children's complaints and clarify the distinction between complaints about dissatisfaction with the service and matters that are more appropriately addressed through the child protection procedures.**

4.4.3 *Access to information*

The centre did not have a written policy on access to information. However, staff told inspectors that young people could see their daily diaries. The young people confirmed this; but they were unclear about their right to see their care files. The unit manager told inspectors that if a request were made about information put in the daily diary by a member of staff on a previous shift a young person

would have to wait until that staff member was on duty again before accessing the information. Social workers interviewed were unsure how young people might access information about themselves, but assumed that they would have to help them make an application under the Freedom of Information Act. Staff who had received specific training on the Freedom of Information Act had held this assumption, but they told inspectors that practice had now changed. Centre staff told inspectors that when they see their records young people are told that they can add their own comments to staff reports.

There is a need for a policy, practice guidelines, and training regarding the young peoples' right to access to information so that confusion about what was permissible and how information was accessed can be resolved. Young people need to be properly informed of their rights and of ways in which they can exercise it. Inspectors recommend that those responsible for the production of guidelines refer to the Inspectorate's guidance notes on 'Children's Access to Information'.

Recommendation

- 6 The board should develop policy and practice guidelines on young peoples' access to information. The policy should be supported by training for staff, and information about rights for young people.**

4.5 Planning for children and young people

There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care

4.5.1 Suitable placement and admissions

The centre had an admissions procedure in common with the other MHB children's residential services. Within the range of residential provision the children's residential centre was described as having a higher staffing ratio in order to meet the more challenging needs of young people placed there. The procedure document stated that applications for placements were considered by an admissions/discharge committee. When the committee considered an application the referring social worker was required to attend and present the case. Deputies or representatives could attend, but the quorum of the committee was four. The document stated that no young person was considered to be discharged from a residential centre unless by a decision of the committee. It was originally intended that the committee would meet quarterly to consider referrals, discharges and vacancies, but inspectors were informed that the committee had not met for over a year and a half.

A further procedure in the MHB protocols for residential child care services required the social worker and other relevant professionals to meet with residential staff and agree a date for admission. The meeting was to receive all relevant pre-admission reports, formulate a care plan, consider dates for pre-admission visits, arrange for a medical examination, and set out a phased admission to the centre in consultation with the young person and his/her family.

The board had encountered difficulties in putting this procedure into practice. Of the four young people in the centre only one had a planned placement with pre-admission visits, according to the procedure. The other three were placed as a result of the breakdown of other care arrangements. In

two cases long-established foster care placements broke down, and in another case a young person was transferred after a serious disruption in another MHB residential centre. The placement there had followed three breakdowns of foster care arrangements in seven months.

On inspecting the children's care files, inspectors found that the intended length of placements was not clearly defined. One young person, who had been resident in the centre for several years, was said by the social worker to be inappropriately placed but could not be moved because the board did not have a resource appropriate to her needs. One was originally placed in the centre for a three-week period to allow other planning to take place, and had remained there for nearly three years. Another, who had been at the centre several years, was offered a medium term placement to allow time to find a suitable alternative foster family.

In the view of inspectors these facts demonstrate the problem faced by the board when residential services are seen in isolation from the general spectrum of care provision. Although the statement of purpose and function described residential care as the chosen option, in practice, for some young people, it was the placement of last resort after other options were exhausted.

There was a further difficulty in the MHB's residential service as a whole because it had been drawn into the cycle of transferring young people from a centre in crisis to another within the service. In some cases, the suitability of the placements in terms of the young people's needs was secondary to the need to manage the immediate challenges presented by their behaviour. The young people involved in this process did not have the facility to make choices about their placements; and the choices available to social workers, residential managers and staff were extremely limited. The service was bound by a lack of alternative placements, and several admissions and discharges had been the result of the need to manage a crisis. The residential child care services manager acknowledged that discrete differences between the MHB residential centres in terms of the age of young people on admission and the type of placement offered had been eroded by unplanned transfers of young people between centres.

Inspectors urge the board to review the statement of purpose and function so that residential provision is reflected as a genuine option in a continuum of care. For this to be realised in practice other care provisions need to be developed, and the reasons for breakdown closely examined. A review of the admissions procedure is also necessary in order to bring decision-making about placements back into the arena of care planning and away from crisis management.

Although inspectors were told that a booklet exists for young people explaining the keyworker system, and what they could expect when they went to live in the centre, none was provided, and the young people interviewed did not make reference to one.

There was evidence that social workers referring young people to the centre provided adequate information in the form of social histories. Inspectors also found a very detailed and well-constructed report from a previous foster carer written in support of the application for residential care.

Since the inspection, the board has produced a new policy document, and the admissions system has changed. Applications for admission are made to the office of the manager of the child residential services. They are discussed with the management team and unit leaders that have a vacancy. The young person may be placed in the unit that has a vacancy, or have his/her name placed on a waiting list, and be considered when another vacancy arises. There is an accompanying procedure describing pre-placement visits, and the requirement for a care plan meeting prior to admission, or within seven

working days of placement. The care plan is clearly distinguished from the placement plan drawn up by the keyworkers.

Recommendation

- 7 It was recommended that the board review the statement of purpose and function for the residential child care services as a matter of priority.**

4.5.2 Statutory care plans

The MHB residential child care service had a policy on care plans. It required all children in residential care to have a care plan before placement, or as soon as possible afterwards, in accordance with *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Section 23*. It made the formulation of the care plan the responsibility of the Senior Social Worker. It stated that the plan will be formulated at a child placement meeting, and listed the areas to be covered by the plan.

All the children had care plans. Staff told inspectors that plans were drawn up at pre-admission meetings for each resident, but no set format was used. Social Workers also said that there was no pro-forma at the moment, but one was being developed. Of the four care plans found on the files by inspectors, one had been prepared three months prior to admission, one on the day of admission, and the other two within three to five weeks of admission.

One plan, dating from 1998, was completed on a MHB form. One plan was extremely brief, consisting of some notes about the placement, health and education within a short paragraph. The newly allocated social worker in that case was in the process of drawing up another care plan. Only one of the care plans gave an indication of what was planned for the future of the young person. One plan, written several years ago, stated that the young person's needs would be met by foster care. This was a reflection of the belief at the time that the young person would be in residential care only long enough for the social worker to find a family placement. There had been no revision of this care plan during reviews in the light of changed circumstances.

1.2

- 1.3 In another case, a difference arose from the young person's wish to move towards independent living after leaving care and the board's reservations about the feasibility of the wish, but it was not clear that the young person was aware of the social worker's views. Only one original care plan was dated and signed. One was undated and unsigned, and the others were unsigned by any party: social worker, team leader, parent, or young person. One care plan had been updated twice through the review process by the newly allocated social worker, and it was signed by the social worker and principal social worker. There was no evidence that parents received copies of care plans. Social workers informed inspectors that the board had appointed a reviewing officer, and part of her task will be to standardise the formats for care plans and reviews. This is a welcome development for which the board is commended.

Practice was not consistent with the board's policy on care plans. The policy will be subject to revision as a result of the appointment of a reviewing officer, but the board is urged by inspectors to ensure that social workers and staff produce complete care plans, and update them as necessary at the point of review. The

new procedures should enshrine the involvement of the young person and parents in the process of drawing up the plan, and the author, parent and young person should sign the forms, and a copy of the plan should be sent to parents.

Recommendation

8 The board should review the policy, procedures and practice guidance in respect of care plans.

4.5.2 Statutory care plan reviews

The centre had a written policy and procedure on reviews. It stated that children's care plans are subject to review in accordance with *Child Care (Placement of Children in Residential Care) Regulations 1995, Part V, Articles 25 & 26*. The policy stated that the first review should take place within two months of placement if not sooner. The resident manager may arrange other reviews. Thereafter, reviews should take place every six months or sooner. If a review takes place sooner it was called an emergency review and may be called by any party with a legitimate interest in the welfare of the child. Reviews are to be held in the centre, and chaired by the senior social worker, team leader, or reviewing officer. There was a list of persons who should attend reviews. It included the young person, and stated that the young person should be present for all or part of their review depending on their age and emotional development. The procedure also stated that the involvement of young people and their parents was strongly encouraged through consultations.

In general, inspectors found that reviews were of a good standard. They had been within the requirements of the regulations and consistent with the board's policy and procedure, with the exception of special reviews that should have taken place after a critical incident involving two young people, which were delayed by several months because social workers were not allocated to the cases.

The young people were helped prepare for reviews by centre staff. They were given assistance to complete forms in which they were encouraged to record their views about their care and wishes for the future. Two of them attended part of their meetings. The others chose not to, but had an opportunity to present their views in a written form. The child, keyworker, social worker and school presented reports to all review meetings. In one case a parent reported also. The social work team leaders, social workers, residential child care managers, keyworkers, and parents attended all reviews. In three cases, psychologists also attended reviews. Where appropriate, school reports had also been presented. Managers told inspectors that at the end of each review the date was set for the next one, so that all parties could agree to attend.

Outcomes were recorded, and tasks were allocated to specified individuals, but there were no timescales for the tasks. However, evidence that the outcomes were in a format accessible to the young person and parents was found on only one file, and inspectors feel that this practice should extend to others, particularly those young people who do not attend their reviews. Two parents said that they regularly received review minutes; one said that she did not. Inspectors urge managers to standardise the practice of recording of decisions, and urge all the supervising social workers to ensure that parents receive minutes of them.

Recommendation

9 The board should adopt a standard practice for recording decisions at review meetings and ensure that all parents and young people receive copies of them.

4.5.3 Contact with families

The centre facilitated contact with families for all its residents. Parents reported good relationships with the staff at the centre. They were satisfied that their children were well cared for and that their individual needs were addressed. They were made to feel welcome when they visited, and they felt that they were kept informed of significant incidents in the lives of their children. Parents received practical support to get to the centre to see their children, and were afforded space and opportunity to speak privately with them. Two parents expressed a wish to see their children more often, though one acknowledged the difficulty in arranging this because of the long distance between her home and the centre.

4.5.4 Supervision and visiting of young people

At the time of inspection, all the young people were allocated to social workers. However, only one had the same supervising social worker for several years, and was visited in accordance with the requirements of *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 24*. Owing to shortages of personnel to fill posts, there had been periods of several months when young people had not been visited by a social worker. In one community care area there was a seriously depleted social work team. The team leader described to inspectors the difficulties experienced trying to arrange for the supervising of the placement by others during that time. It was noted by inspectors that in spite of these difficulties reviews were still carried out within the required timescales, but in some cases, visits were not. The newly appointed social workers have made efforts to visit the young people more frequently.

In spite of the difficulties in recruiting and retaining social workers in the MHB community care teams, inspectors urge managers to ensure that children in the care of the board have priority in terms of allocation, and that they are visited in the levels of frequency set out in the regulations.

Recommendation

10 The board should ensure that young people in their care are allocated to a social worker and visited in accordance with *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 24*.

4.5.5 Social work role

Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the centre to whom they can confide any difficulties or concerns they have in relation to any aspects of their care.

In three young persons' files inspectors found good reports outlining the history and background of the case. In all cases this was provided on various referral forms. A loosely structured narrative form was used in one, and did not include medical or educational information. In contrast, another was completed thoroughly by the social worker and supplemented by a detailed report from a previous foster carer. Care staff showed that they had a good grounding in the histories of the children in their care.

Social workers reported good relationships with staff at the centre. They told inspectors that much of the communication from the centre was by telephone, but it was supported by written reports. They were sent notification of significant events concerning the behaviour of the child they supervised. However, the absence of allocated social workers to take appropriate action on receipt of a child abuse referral was highlighted by an incident at the centre that gave rise to concerns about child protection issues.

Social workers involved with the young people about whom there had been child protection concerns told inspectors that they were not confident that young people were safe at the centre. The incident was reported through the notification system in accordance with Children First guidelines, but it was over three months before action was taken. The investigation into the initial concern was delayed pending the appointment and allocation of social workers to investigate the incident. During that time the risk to the child continued. At a later stage, the risk was acknowledged and the child at risk was transferred to another residential centre.

Inspectors found that social workers not directly involved with young people about whom there were child protection concerns were unaware of risk factors that might affect the child whom they supervised. Once inspectors made them aware of them, they too were not confident that the young people for whom they had supervising responsibility were safe in the centre.

It is essential that all social workers involved with young people in the centre be informed if a child protection issue arises for any of the residents. The social workers directly involved should have the opportunity to assess the situation, and to ensure that protective strategies are in place in the centre for the safety of the children concerned. The supervising social workers for other children in the centre should be informed so that they can assess the risk presented to the children for whom they have responsibility, and take appropriate action. Parents of all the young people have a right to know if risks to their children are being considered. There should also be a means whereby protective strategies are employed pending an investigation into an incident, or the allocation of a social worker to carry out the investigation. Good practice would determine that the residential child care services managers initiate a risk assessment immediately and formulate a risk management action plan which is the product of consultation and agreement between all the social workers involved and the staff in the centre who have responsibility for carrying out the plan. Protective strategies in the centre should be considered immediately, and not wait until a conference can be called.

Social workers interviewed were aware of the expectation in the National Standards for Children's Residential Centres 2001 that they should read the care files and daily diary from time to time, but they had yet to make this a regular part of their routines. It should be seen as an important means to assist them in assessing the standard of care and safety of the young people in the centre for themselves.

Recommendations

- 11 The board should develop procedures for informing all supervising social workers and parents about child protection concerns that arise in the centre.**
- 12 The board should provide practice guidance and training to social workers and staff to enable them to undertake risk assessments when child protection concerns arise in the centre.**

4.5.7 *Emotional and specialist support*

The centre had a policy on keyworkers that outlines several practical tasks such as collection of relevant information pertaining to the young person, arranging appointments, preparing the young person for reviews, and facilitating participation in hobbies and activities. The policy also stated that the keyworker should endeavour to engage the child in therapeutic work, and record the same.

Inspectors found evidence that relationships between staff and young people were characterised by a commitment to care on the part of staff, and warm interaction between both parties. Staff spoke of the young people with respect and considered sensitively their emotional needs. In turn, the young people said that they believed that staff had their welfare at heart, and showed considerable loyalty to them.

In practice, young people at the centre accessed specialist support individually through the community based services as they would if they were at home. Staff were aware of the needs of individual young people, but were not involved in therapeutic programmes overseen by a qualified specialist. They did not receive communication from community-based specialists about work being done with individual young people. Similarly, the psychologists working with young people received information about the behaviour of the young people mostly through the formal medium of the review. It was not clear that their findings were reflected in care plans or in the work of the centre with the young person. The managers of the centre are advised to define clearly the expectations of keyworkers in terms of therapeutic work, in particular, the boundary between what is offered by the centre and the therapy received from specialists in the community.

The social worker for one young person said that it was a consensus that his emotional needs were not being met. Another said that although the standard of primary care was good, and the young person was happy to live at the centre, she was in need of a more therapeutic environment. The residential child care services manager acknowledged that there were difficulties in establishing structures whereby centre staff could get support in responding to the emotional needs of the young people in their care.

Staff told inspectors that a psychologist once came to the centre to observe their interaction with one young person and make suggestions about changes to their practice. They all said that this was a valuable experience, and added to their understanding of the young person. However, there had been no continuous provision for specialist support to staff, and their confidence in dealing with complex problems and challenging behaviours had not been as strong as they would wish. The general manager and the residential services manager told inspectors that in the new child care strategy there was a policy and resources to promote a multi-disciplinary approach to the care of young people, but that there was a need for further inter-professional negotiation before it could be realised in practice.

The appointment of a psychologist with a particular brief for looked after children is a welcome development in the child care strategy. Inspectors urge the board to ensure that consultation to staff is made an integral part of the psychological provision.

Recommendation

- 13 The board should ensure that centre staff have access to psychological consultation in order to support them in responding to the emotional needs and challenging behaviour of the young people in their care.**

4.5.8 *Preparation for leaving care*

The centre did not have a policy for leaving care. One of the young people was involved in a preparation programme, and a place had been identified for her to move to which was within travelling distance of the centre and friends that she had made in the locality. However, she was unaware of a care plan, even though she confirmed that staff and social worker consult her about issues.

There were varying expectations between the young person, staff, and the social worker about her future that have yet to be reconciled, and the young person was apprehensive about having to move on from a place in which she had lived for several years.

Since the inspection, managers have supplied inspectors with a newly devised preparation for leaving care policy document. It puts a duty on staff to formulate specific, formal leaving-care plans, and to develop a leaving-care programme, which includes securing training or employment, and teaching the young person life skills.

4.5.9 *Discharges*

The centre had a policy on discharges. It stated that discharge forms should be completed, circulated to the social work team leader and placed on the child's file at the centre, and that no child was deemed to be discharged unless discharged by the admissions/discharge committee. The procedure thereafter was as for admissions. It was originally intended that the committee would meet quarterly to consider referrals, discharges and vacancies, but inspectors were informed that the committee had not met for over a year and a half. Since inspection managers have devised a new discharges policy that states that the decisions about discharges are to be made at a young person's statutory care plan review.

One young person was discharged temporarily from the centre after a conference in which child protection concerns were discussed. Another had been given an indication that he cannot stay at the centre, but was uncertain about where he will be going and when he will be discharged. The uncertainty was a reflection of the fact that at the time of inspection there was no other residential resource available to which he could transfer.

4.5.10 *Aftercare*

As part of the new child care strategy the board had agreed to the appointment of an after-care coordinator. A job description has been drawn up, and the post has been advertised. The incumbent of the new post will report to the principal social worker. The board's intention is that the person appointed will develop the after-care services and resources throughout the board's area. The centre has developed an after-care policy since the inspection. It includes a requirement to formulate an after-care plan after the 16th birthday of a young person placed in the centre, and incorporates procedures for allotting 2 hours per week specifically for keyworkers to carry out preparation for leaving tasks.

4.5.11 *Children's case and care records*

The centre had a policy on record and file keeping. It stated that a personal file was kept in relation to each young person in the residential child care services, and that they are to be written in an objective, sensitive, and professional manner,

and kept up to date. Daily observation records were also kept in relation to each young person. The policy listed other information to be kept on files: birth and baptismal certificates, referral and discharge forms, records of reviews and other reports, and records of incidents and accidents. A daybook recorded appointments, staff on duty, access visits, young persons in residence and incoming and outgoing phone calls.

Practice varied from policy, but most of the components identified in the policy document were present. The information on staff on duty and children present was in the daily diary, as were handover summaries. Birth certificates were not present on two of the files. Medical cards were stored separately; and there was a dedicated book for telephone calls and messages, with messages from one staff shift to another. Unauthorised absences were recorded on the young persons file, but sanctions and restraints were recorded separately. The administration of medication was appropriately recorded in a separate format, but inspectors advise that in time the medication records should be integrated with the individual child's care file.

Generally, the quality of the care records was good, and residential child care services managers checked them. The files were clearly indexed with separate, accessible sections. However, more attention needs to be given to the significance of the care plan and care plan reviews, and as circumstances change so should the plans for the care of individual young people. There should also be some record of changes in operational routines within the centre as a result of discussions about child protection concerns or challenging behaviour. The unit leader acknowledged that the daily log was not kept up to the same standard over time, and informed inspectors that staff were in discussion about improving its quality and receiving training staff on report writing. Inspectors commend the staff for the overall quality of the records and urge them to continue to maintain and develop the standard they have set for themselves.

4.6 Care of young people

Care staff relate to young people in an open, positive and respectful manner. Care practices take account of young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities and leisure experiences to their peers and have opportunities to develop talents and pursue interests. Care staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

4.6.1 Individual care in group living

The centre had a policy on respect for a child's dignity and individuality. It stated: "*The unique worth and individuality of each child as enshrined in the Midland Health Board Child Care Policy and the U.N. Declaration of the Rights of the Child was the basis of the principles behind the board's provision of Residential Care.*" It then gives a list of rights, including some that are particular to the board such as the right to a named keyworker. Some of the rights have yet to be exercised by the young people in the board's care, and some are realised in practice in a modified form.

Young people in the centre were cared for in a manner that respected and took into account their wishes, preferences and individuality. They were consulted about day-to-day aspects of their care. They had personalised their bedrooms, and were encouraged to make individual choices about their personal appearance, clothing and dietary preferences. They were sensitively encouraged in matters of personal hygiene and self-care. Issues of vulnerability and safety were discussed with young people by staff.

One young person spoke highly of the staff to inspectors, and said that she had been listened to and helped. Two young people saw that the fact that several members of the staff had been at the centre for as long as them as a positive feature. Another was concerned about not being listened to, and two had concerns that a decision to transfer them to other residential centres did not take their points of view into account. Staff were aware of their opinions, but circumstances dictated the limits of the decision options open to the child care service.

Festive occasions and achievements were celebrated. One parent complemented staff on the support her child received when being confirmed. Young people exercised choice in how they spent their pocket money. Clothing was bought as needed by the centre, and the centre had a policy of using sanctions that entail deductions of pocket money sparingly, - a fact that was borne out by the detailed pocket money record kept by staff. There used to be a sanction of a fine for smoking in rooms, but this had not been used for several months. As well as their standard amount, young people also had a deposit in savings made on their behalf each week. This was a practice particular to the centre. The money in the savings account was additional to the pocket money allowance and could not be accessed until the young person leaves the centre.

4.6.2 *Provision of food and cooking facilities*

The centre provided the young people with adequate and nutritious and appetising food. Preferences were taken into account when shopping and planning menus. Young people had easy access to food. Young people accompanied staff purchasing groceries for the centre, and cash was used rather than vouchers. Most of the young people ate meals with staff, but there were difficulties engaging one in the mealtime routines.

4.6.3 *Race, culture, religion, gender and disability*

Young people at the centre did not experience day-to-day discrimination, and they had free access to the local community with similar opportunities to their peers. They were facilitated in the practice of their religion in accordance with the wishes of their parents. The centre did not have a policy on diversity and anti-discrimination that informed daily practice. There was a child from a separate cultural background in the care of the board, and perceived discrimination was the subject of one of the young persons' complaints. Inspectors advise managers of the board that the formulation of such a policy should take place in consultation with staff and young people.

4.6.4 *Managing behaviour*

When behaviour is not managed effectively in a residential centre the caring environment can become unsafe. Inspectors found that providing a safe environment for young people presented staff at the children's residential centre with most difficulties. The difficulties may be cast in two broad categories: boundary setting, and effective intervention to ensure the safety of residents.

Several staff reported to inspectors that within the year previous to the inspection two young people with histories of aggression and violence had been placed at the centre. At the time the centre was accommodating five young people. The levels of aggression were serious. One young person became dominant in the centre, and challenged staff authority and disregarded boundaries. While staff relationships with young people at the centre remained warm and caring, after several episodes of aggressive behaviour, and defiant decisions by young people such as persistent absence without authority, staff felt that they were powerless to impose boundaries. The impact was that children were bullied and did not feel safe, and staff did not feel sufficiently empowered to handle episodes of aggression effectively and ensure safety. This view was expressed to inspectors by staff and social workers, particularly those who have received several notifications about significant incidents and events.

In the view of inspectors the lack of effective boundary-setting was reflected in observed practice. An example was a young person refusing to conform to the mealtime routine being told that his dinner would be put aside for him. Later in the evening he left the centre without permission and was absent for several hours. In the early hours of the following morning he returned to the centre and was served his re-heated meal by night staff, went to bed, and did not rise until after midday the following day. Boundary-testing in this case included the ignoring of house routines by the young person and the imposition of a schedule of his own which staff felt obliged to accept.

Along with other residents, this young person was frequently absent from the centre without authority. Several staff said that once young people walked away from staff and followed their own course of action, particularly outside the centre, there was little that could be done to influence them. On examining files it became clear that in one case the ease with which a young person ignored boundaries were the product of an earlier history of aggression towards staff and residents, and the adaptation of staff responses to a non-confrontational style. This left staff with a considerable degree of anxiety about the young person, and several expressed concern that the centre had lost its capacity to engage effectively with him. It also affected the capacity of staff to provide a safe environment within the centre, because his interactive behaviour towards other residents put them at risk.

Inspectors found that effective interventions against bullying, aggression and boundary testing were not in place, and policies designed to determine the strategies necessary to manage challenging and unsafe behaviour did not translate into practice. There was no written anti-bullying policy. The board's policy on assaults on other young people or staff, which was incorporated into its health and safety statement, was inappropriate and inadequate. It lacked balance in its assumption of rights in that it was primarily concerned with support for staff after an assault, and did not cover any range of support for young people who are bullied or assaulted. It provided for care staff assisting a young person who wished to press charges, which seemed to inspectors to lack the credibility which independent advocacy would afford.

There was a brief policy statement about damage to property within the protocols of the residential child care services indicating that damage to their own and others' property by young people was unacceptable. Young persons wilfully damaging property would be expected to make recompense, and in the case of serious damage may be reported to the Gardai. However, inspectors found several examples of damage in the centre, and young people did not feel that their personal belongings were safe.

The centre also had a policy on sanctions that emphasises the place of positive relationships in residential care. It stated that an integral part of its approach was acknowledgement of the need for a

young person to understand the relationship between actions and consequences, and the way in which it enables him/her to develop self-control. This was positive, but it needed to be balanced by reasonable sanctions for unacceptable behaviour. In the residential child care protocol documents sanctions were said not to be a punishment, but to ensure adherence to agreed responsibilities. They could include: partial withholding of pocket money, additional chores, selected withdrawal of television programmes, and time-limited withdrawal of personal possessions if these are causing offence to others. Sanctions were recorded in a separate book, which had provision for rewards for positive behaviour. One of these was the potential to earn extra pocket money over a period of time, or for the young person to suggest a desired outcome as a reward. The residential child care services managers checked the book every month. During the period from September 2001 to January 2002 there were 387 recorded episodes of unauthorised absences, and instances of significant damage in the centre. During the same period of time there were 30 recorded sanctions. Inspectors are of the view that the sanctions system was no longer effective as a means of managing the behaviour of young people at the centre.

None of these policies included provision for the operational routines and practices of staff to be rigorously reviewed in the light of serious incidents or a series of unacceptable behaviours. Nor was there a systematic assessment of the effectiveness of the deployment of staff and the measures taken by staff to ensure that behaviour was managed appropriately and that children and staff in the centre were safe.

Managers of the board are urged to develop an anti-bullying policy, and to engage in a radical review of the policies on assaults, damage to property, and sanctions. The review should include an assessment of staff responses and the centre's procedures and routines, in order to ensure that behaviour management is appropriate and effective in providing a safe environment for young people and staff, and is a means of learning and internalising self-control for the young people themselves.

Recommendations

- 14 As a matter of priority, the board should review its policies on assaults, damage, and sanctions.**
- 15 The board should develop an anti-bullying policy, and introduce effective behaviour management policy and practice.**
- 16 The policy should be supported by a regular review of practices and routines in the centre, and training for staff in setting boundaries, and challenging unacceptable behaviour.**

4.6.5 Restraint

The centre had a detailed policy on the use of physical restraints. It affirmed the commitment of the MHB to TCI as a means of dealing with episodes of physical aggression requiring restraint. It defined restraint as "the provision of a supportive environment where trained staff can hold a child in a safe, non-threatening, therapeutic manner". The circumstances in which restraint can be used were described as "acute physical and dangerous behaviour to him/herself, others or property". Standard MHB incident report forms were used to record episodes of restraint, and specific forms to record interventions before and after the restraint accompanied them.

During the year prior to the inspection there were only two recorded instances of restraint. In one, a member of An Garda Síochána carried out the restraint; in another, three members of staff. Incident report forms were completed, but the specifically designed pre- and post- restraint forms were not used. Both incidents took place late at night, and neither was recorded in the daily diary. It seemed to inspectors that the staff's lack of confidence in intervening effectively with young people who have lost their self-control may account for the low incidence of restraint alongside a high incidence of aggression. Inspectors advise managers to monitor the practice of TCI and ensure that the board's policy on recording episodes of restraint is realised in practice.

4.6.6 *Absence without authority*

The centre had a policy and procedure for unauthorised absences. It stated that “young people do not absent themselves from a unit without permission for no reason”, and then suggested three possible reasons: testing limits, part of the individual young person's history or culture, or as a cry for help because the young person was genuinely upset. The procedure was that in the first instance staff should search for the young person and try to persuade him/her to return. After that there was a list of persons who should be informed, including: social workers, parents, residential services managers, and the unit manager. There was provision for Gardai to be informed “where there was cause for concern, with due regard to age, maturity, mentality and past history of the child”. There were also procedures for when a young person returned to the unit requiring staff to support the young person, inform all relevant people, attend to the welfare of the young person, and later discuss the episode with the young person to pursue any underlying issues pertaining to it.

In practice, the centre had a major difficulty with unauthorised absences. In the year prior to the inspection there had been 793 unauthorised absences. Sixty-nine percent of these were attributable to one young person. Only two of his absences were overnight, but several were from late in the evening to the early hours of the morning.

The number of recorded absences was reflected in the centre's definition of unauthorised absence. If a young person was absent, without permission, for more than one hour, the young person was deemed to be absent without authority. Staff told inspectors that they were uncertain where the most frequent absentee went once he was outside the centre, but his options would have been limited in a small town, and there was no evidence that he was presenting problems that drew the attention of the Gardai when he was in the local community. Some of the time was spent in the homes of friends.

In reality, the recording of unauthorised absences showed that the young people can come and go throughout the day. However, if a young person had asked permission to go to the town centre, or stated where he was going, this would not be recorded as unauthorised absence. What was clear was that young people were not ‘running away’ from the centre, but rather coming and going as they please. Similar issues have been brought to the attention of the board after inspections of other MHB centres.

The significance of the records of unauthorised absences was that they reflected the inability of staff to place consistently effective boundaries on the behaviour of some the young people. As a consequence, they were limited in the extent to which they could purposefully engage with them. This issue must be addressed, taking into account the actions of staff as well as the behaviour of young people. The staff's attempts to place limits on the young peoples' behaviour had not worked, but equally the staff had little expectation that the young people would respond to any form of limit setting in relation to unauthorised absences.

A change of thinking is required that attempts to achieve a balance between age-appropriate structure and independence. It involves reviewing present practice in the centre to ensure that at least all efforts are being made to provide a programme of structured activities offered to the young people. It also involves the harnessing of the staff's existing skills so that they have greater confidence and belief in their ability to engage with the young people.

Recommendation

17 Managers should ensure that the level of absences from the centre, with and without authority, was reviewed and that all efforts are made to engage the young people in age-appropriate structured activities.

4.7 Safeguarding and child protection

4.7.1 Safeguarding

Attention is paid to keeping young people in the unit safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

The centre did not have a written policy on safeguarding. However, staff were aware of some of the practices associated with safeguarding such as leaving the door open when entering a young person's bedroom. They also described the use of two waking night staff as a safeguard for staff.

Young people had access to making and receiving telephone calls in private, but the house was small, and absolute privacy could not be guaranteed. They were not aware of groups and organisations set up to protect their rights.

Safeguarding touches on several aspects of residential care, such as children's rights, recruitment and vetting of staff, the overseeing of residential centres by managers, supervision of staff, professional boundaries, anti-bullying policies and procedures, and clear and accountable recording. Inspectors urge the board to develop policies and practice guidance on safeguarding, keeping all these factors in mind. Those with responsibility for drawing up the policy and procedures are advised to refer to the inspectorate's guidance notes on "Safeguarding and Child Protection".

4.7.2 Child protection

There are systems in place to protect young people from abuse. Staff are aware of and implement practices that are designed to protect young people in care.

The centre had a policy on allegations, suspicions or disclosures of abuse. It stated "*Some children may have been suspected or confirmed victims of child abuse when they were admitted to residential care. Other abuse may only come to light after admission*". The first procedure was that in cases where child abuse had occurred a careful record should be made of the physical and emotional condition of the child on admission. Additional signs of abuse sustained at a later date should be notified by staff to the residential child care services manager or a senior member of staff, who should record the facts and action taken. Concerns about another child in the residential home should be similarly reported and recorded. The resident manager or senior member of staff should immediately notify the designated officer for child abuse or senior social worker and follow up the

telephone call with a written referral on the standard notification form. After referral staff should be involved in child abuse investigation arrangements, including attending and providing reports for a child protection case conference and giving evidence in court. Social work staff should investigate the suspected abuse. The policy made no reference to Children First.

On examining files and complaints forms, and interviewing the unit leader, staff, and social workers, inspectors found evidence of significant child protection concerns in the centre. Centre staff had reported incidents as they happened, in accordance with the centre's policy. Thereafter, the variations in the board's practice influenced the procedures. Some months ago staff used the referral form to refer a child protection concern to the residential services manager. The information was passed on to the appropriate social work teams. However, there was a delay of three months before a conference was held and protective actions were taken.

Inspectors were told that several factors contributed to the delay: non-allocation of social workers to the case owing to shortage of staff; cases being placed on a waiting list for child protection assessments, owing to the shortage of staff; significant variations in investigative and assessment practice between the community care areas; and varying systems of response to child protection referrals within social work teams. For example, in one area the assessment team picked up referrals via a principal social worker, while in the other a discussion took place between the team leader and duty officers on a daily basis to determine which referrals were to be prioritised for investigation. One had a dedicated assessment team that covers referrals of any form of abuse. The other was a clinic-based practice that assessed only one category of abuse. There was no procedure in place to put interim protective strategies to ensure the safety of young people whilst awaiting an investigation and assessment into action immediately. There was also no provision for informing the social workers of other children in the centre that a referral had been made.

Inspectors urge the board to review policy and practice on child protection as a matter of urgency, and ensure that children and young people in the care of the board are safe, irrespective of the stage of investigation or assessment of child protection referrals. The review should include risk assessments and risk management action plans, and protective measures to be taken by staff in residential centres at the point of referral of a child protection concern.

Recommendation

18 The board should review the child protection policy and procedures for children in care as a matter of urgency.

4.8 Education

<p>All young people have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate education facilities.</p>

Two young people in the centre attended school. Another was past school-leaving age; and another, who was of school age, had not attended since November 2001. Inspectors were informed since inspection that the young person has been transferred to another centre and has been regularly attending school since. Special provision was made for one young person from a minority cultural background.

Teachers reported to inspectors that they enjoyed excellent relationships with the staff at the centre. Communication was good, and staff attended school meetings and events. They valued the education of the children in their care, and supported them in their schoolwork.

Parents were satisfied that their children were receiving a good education, and received reports from the schools. One parent expressed a wish to be invited to school meetings and events, but acknowledged that there might be difficulty in arranging attendance because of the distance of her home from the school.

4.9 Health

The health needs of the young people are assessed and met. They are given information and support to make age appropriate choices in relation to their health.

Inspectors found that the health needs of the young people in the centre were well met. Staff are to be commended for maintaining a high standard in their provision for the health of the young people.

In accordance with *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 20* medical assessments were found on the files of all the young people in the centre. All the young people at the centre were registered with a general practitioner at the local health centre. The girls at the centre were registered with a female GP. Medical cards were for the centre, but named each individual young person. Young people had access to dental, ophthalmic and other services as required. The administration of all medication administered, both prescribed and non-prescribed, was recorded in a book. It showed the name of the young person, date, medication, dosage and two staff signatures. It was used diligently.

Parents informed inspectors that they were consulted about the health care and treatment of their children. The young person at the centre who was over the age of sixteen gave consent in her own right to medical examinations and treatment. Care plans did not clearly specify which staff member had responsibility for imparting information and guidance on health. However, keyworkers covered some aspects of health promotion, such as diet. The centre had a no smoking policy that included the duty of staff to point out to young people the hazards of smoking and assist those who wish to stop. Those staff who smoked did so outside the building.

4.10 Premises and safety

The premises are suitable for the residential care of young people and their use is in keeping with their stated purpose. The unit has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 and 13 of the Child Care regulations, 1995.

4.10.1 Accommodation

The building at the children's residential centre was in an extremely poor state of repair. It had not been decorated for some time, and several rooms had long-standing damage and graffiti. There were areas of damage caused by leakage in a bathroom, and some of the fittings were beyond repair. There was a badly damaged payphone in the corridor, and one bedroom was out of use on the advice of the fire officer because the windows in it were so high from the floor they could not provide an escape if one were needed. The house stood in contrast to a range of new buildings around it.

Nonetheless, the young people saw it as home, and felt that measures should have been taken to bring it up to modern standards.

However, the centre was issued with an interim fire certificate, and the board was aware that a move to new premises would have to be effected by mid-March 2002. Inspectors were shown a new property that the board was in the process of purchasing. Since the inspection inspectors have received confirmation from the general manager and residential child care services manager that the move had taken place, and that the appropriate fire safety requirements are met.

4.10.2 Maintenance and repairs

The centre had a record of requests for maintenance and repairs. It showed the date, the nature of the problem, and a signature of the member of staff referring the problem. Some of the requests were not attended to. Given the poor state of the building inspectors found a surprisingly small number of referrals. Between August and the beginning of November 2001 there were only 12 reports, and seven during January 2002. Inspectors hope that the move to new premises will be used as an opportunity to invigorate the system of referral for repair so that standards of maintenance are ensured.

Recommendation

19 The board should ensure that external line managers routinely monitor the premises to ensure the maintenance of standards and safety.

4.10.3 Safety

The centre had a health and safety audit carried out on 5th March 2001 which identified several hazards and recommended measures to ensure the safety of the staff who work in and the young people who live in the centre. As a result of the audit some fire extinguishers were supplied to the centre, but the detection system consisted of a range of domestic smoke alarms, and only two emergency lights were fitted. Most of the hazards remained. Health and Safety hazards were reported along with maintenance and repair requests. Inspectors advise that they should be reported separately.

4.10.4 Fire Safety

On 14th January 2002 a certified engineer issued a conditional interim fire certificate for eight weeks. Among the conditions were that a bedroom be taken out of use, and a member of staff ensures that all exits are working properly on each shift. Staff devised a schedule of checks five times per day in order to comply with this condition. Inspectors were shown a fire logbook that recorded that three fire drills had taken place at the centre between July 2001 and January 2002. The engineer also stipulated that alternative accommodation be found in the eight-week period, or that complete renovation of the property commence.

Inspectors confirmed with managers that prior to 14th January 2002 the centre did not have a fire certificate. This was in contravention of *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part III, Article 12*, and follows recommendations regarding fire safety made

after previous inspections of other MHB residential centres. It is totally unacceptable that any residential centre run by the board does not have the necessary equipment for detecting and preventing fire, nor the fire certificate required by the regulations.

Inspectors have received written confirmation that the new premises to which the centre had moved had been issued with an interim fire certificate for three months, and will receive a full certificate once recommended actions, namely the installation of two fire doors, have been completed.

5. Summary of Recommendations

1. The board should ensure that all staff with substantial access to children in its care are appropriately vetted prior to appointment.
2. The board should extend to all the staff at the centre training in the subjects of Children First, child protection in residential settings, and sexual development in adolescents.
3. As a matter of priority, the board should arrange for an authorised person to monitor the centre on a regular basis in accordance with *Child Care (Placement of Children in Residential Care) Regulations 1995, Part III, Article 17*.
4. **The board should develop policy and procedures to ensure that young people in its care are effectively consulted about matters that concern their day-to-day lives and their future.**
5. The board should review its policy and procedures on children's complaints and clarify the distinction between complaints about dissatisfaction with the service and matters that are more appropriately addressed through the child protection procedures.
6. The board should develop policy and practice guidelines on young peoples' access to information. Training for staff, and information about rights should support the policy for young people.
7. It was recommended that the board review the statement of purpose and function for the residential child care services as a matter of priority.
8. **The board should review the policy, procedures and practice guidance in respect of care plans.**
9. The board should adopt a standard practice for recording decisions at review meetings and ensure that all parents and young people receive copies of them.
10. The board should ensure that young people in their care are allocated to a social worker and visited in accordance with *Child Care (Placement of Children in Residential Care) Regulations, 1995, Part IV, Article 24*.
11. The board should develop procedures for informing all supervising social workers and parents about child protection concerns that arise in the centre.
12. The board should provide practice guidance and training to social workers and staff to enable them to undertake risk assessments when child protection concerns arise in the centre.

- 13. The board should ensure that centre staff have access to psychological consultation in order to support them in responding to the emotional needs and challenging behaviour of the young people in their care.**
- 14. As a matter of priority, the board should review its policies on assaults, damage, and sanctions.**
- 15. The board should develop an anti-bullying policy, and introduce effective behaviour management policy and practice.**
- 16. The policy should be supported by a regular review of practices and routines in the centre, and training for staff in setting boundaries, and challenging unacceptable behaviour.**
- 17. Managers should ensure that the level of absences from the centre, with and without authority, was reviewed and that all efforts are made to engage the young people in age-appropriate structured activities.**
- 18. The board should review the child protection policy and procedures for children in care as a matter of urgency.**
- 19. The board should ensure that external line managers routinely monitor the premises to ensure the maintenance of standards and safety.**