Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Annual report of the regulatory activity of the Health Information and Quality Authority: Children's Services 2014

June 2015

About the Health Information and Quality Authority

The Health Information and Quality Authority (the Authority or HIQA) is the independent Authority established to drive high-quality and safe care for people using our health and social care services. HIQA's role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, and promote person-centred care for the benefit of the public. The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

Setting Standards for Health and Social Services – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.

Supporting Improvement – Supporting health and social care services implement standards by providing education in quality improvement tools and methodologies.

Regulation Directorate – Registering and inspecting residential centres for dependent people adults and children and inspecting children detention schools, residential services, special care units, foster care services and child protection and welfare services.

Monitoring Healthcare Quality and Safety – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.

Health Technology Assessment – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

Health Information – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

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Glossary of terms used in this report

Care order: the Child and Family Agency must apply for a care order if a child needs care and protection that he or she is unlikely to receive without an order.

When a care order is made, the child remains in the care of the Child and Family Agency for the length of time specified by the order or until the age of 18 when he or she is no longer a child. The Child and Family Agency has the rights and duties of a parent during this time.

Court orders: under the Child Care Act, 1991 the Child and Family Agency may apply to the courts for a number of different orders, which give the courts a range of powers in relation to children who are deemed to experience serious and ongoing risk of harm. See **Emergency care orders**, **Care order**.

In addition, courts may make orders to remand or detain children or for their supervision, in relation to criminal charges.

Emergency care orders: if the Garda Síochána has reason to believe that there is an immediate and serious risk to the health or welfare of a child, they have the power to enter the home and remove a child, by force if necessary, to safety. The child must be given into the care of the Child and Family Agency as soon as possible.

Designated centre: this is an institution at which residential services are provided, regulated under the Health Act 2007.

Detention schools: the detention schools provide places for a child to be detained in custody in relation to criminal charges. This can be when a Court remands a child in custody or, following a conviction, when a child is sentenced either to a period of detention only or for a period of detention to be followed by supervision in the community by the Probation Service. The principal objective of the schools under the Children Act 2001 is to provide care, education, training and other programmes with a view to reintegrating the child into society.

Foster care: where possible, the Child and Family Agency places children with foster parents. The Child Care (Placement of Children in Foster Care) Regulations 1995 require that a care plan for the child be drawn up which sets out, among other things, the support to be provided to the child and the foster parents and the arrangements for access to the child in foster care by parents or relatives.

Governance: the function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its objectives and stated purpose. A well governed service has leaders who manage risk at a

corporate level, make robust decisions and are assured about the quality of their service.

Guardian ad litem: the person appointed by the court to represent the rights and views of children and to provide an opinion on the plan for them.

High support units: high support units were established to provide residential services to children with more complex needs. High support units are open centres and the *National Standards for Children's Residential Centres* apply to them. There are no high support centres operating at present.

Leaving care and aftercare: services which prepare young people for leaving care and provide support to them after they have left care.

Link worker: the social worker assigned by the Child and Family Agency or a non-statutory provider to be primarily responsible for the supervision and support of foster carers.

Monitoring officer: a monitoring officer is an authorised person who monitors the residential, special care and foster care services on an ongoing basis to report on compliance with standards and regulations. They are employed by the Child and Family Agency but are not involved in the line management of the services they monitor.

Relative foster care: is a relative or friend of a child who has completed a process of assessment and approval as relative foster carers provide foster care.

Risk Management: the systemic identification, evaluation and management of risk. It is a continuous process with the aim of reducing risk to an organisation and individuals.

Residential Care: residential centres for children provided by the Child and Family Agency or by private and or voluntary organisations. Services run by the Child and Family Agency are inspected by the Authority. Services run by the private and or voluntary organisations are registered and inspected by the Child and Family Agency.

Special Care Units: residential units in which children taken into care under special care orders or interim special care orders are placed, all of which are run by the Child and Family Agency currently. These units are secure and children cannot leave them voluntarily.

Supervision orders: a supervision order is an alternative to taking children into the care of the Child and Family Agency. A supervision order gives the Child and Family Agency the authority to visit and monitor the health and welfare of the child and to

give the parents any necessary advice. The order is for up to a maximum of 12 months but may be renewed.

Special care orders: a high court order for special care is sought by the Child and Family Agency when a child needs special care and protection and because their behaviour poses a real and substantiated risk to their health, safety, development and welfare. For most children, this results in their placement in a secure service and their liberty is restricted.

Unsolicited Information is defined as information of concern which is received by the Authority from the public.

Foreword

I am pleased to present the Health Information and Quality Authority's annual overview report detailing the regulation and oversight of children's services undertaken by the Authority. The standards let children and parents know what they should expect from these services. Our inspections aim to ensure that each child or young person is being cared for safely and that they are actively supported to achieve their potential. The Authority is committed to providing assurance that children's rights are upheld, particularly those in the care of the State.

For the first time, the annual report for children's services regulation presents the findings of inspections for all the services which are monitored and inspected by the Authority's Children's Team. These services are statutory children's residential centres including special care units, statutory foster care services and those run by private providers, child protection and welfare, designated centres for children with disabilities and the detention schools. The Children's Team placed particular emphasis on children's rights during its 2014 programme of activity.

There have been a number of changes in the sector which have influenced the way in which the Authority carries out its work. Firstly, the Child and Family Agency (Tusla) was established on 1 January 2014 and for the first time all children's welfare and child protection services for child protection and welfare are delivered or funded by one agency. We believe that this should lead to more consistent and robust services delivered equitably to children and their families.

In addition, designated centres for adults and children with disabilities became regulated entities under the Health Act 2007 on 1 November 2013, and a full programme of monitoring and registration inspections started in 2014 for the first time. The Health Act 2007 states that all designated centres for children with disabilities must be registered by 1 November 2016 and inspectors are working with providers to achieve this goal. These services are provided or funded by the Health Service Executive (HSE). We have organised our inspection programme in keeping with the principle that children are children first and should not be defined by their disability.

The Authority will continue to monitor all these services using standards and regulations, and will work together with providers to promote improvement in the safety and quality of services to vulnerable children and young people.

Phelim Quinn, Chief Executive Officer, Health Information and Quality Authority and Chief Inspector of Social Services

Executive summary

During 2014, the Children's Team carried out a total of 111 inspections across a range of services, which included inspections of residential services, foster care and child protection and welfare services. The Children's Team monitored and regulated these services delivered by a number of different providers in the public, voluntary and private sectors.

In addition to the standards and regulations, our inspection teams take account of the UN Convention on the Rights of the Child and this overview report highlights areas where we believe these rights may have been breached. These rights include the right to identity, freedom of conscience, freedom of expression, access to information, protection of privacy, education, rest and leisure, play and recreation, and the right of children from ethnic minorities to their own culture. These are all critical components in the life of any child. A key part of HIQA's inspection methodology is to hear the voices of children receiving services. In 2014, inspectors met with and heard from a total of 202 children across a range of care settings.

The regulation of designated centres for children with disabilities under the Health Act 2007 started on 1 November 2013, and a full programme of inspection and registration by the Authority took place in 2014 for the first time. The majority of these centres are run by voluntary organisations and a minority by private for-profit providers. This is the first time that the sector has been subject to any form of regulation and some services were challenged in meeting the requirements of the regulations, with many needing to make improvements.

Of 65 disability centres inspected, escalation and enforcement issues were taken in 15 services, while eight services had immediate action plans issued to them by the Authority. These related to health and safety concerns in the centres. There were also concerns about poor medication management, inappropriate placements of children and poor management of some centres. Two notices of proposal to cancel registration were issued due to concerns about the fitness of the provider to provide safe care to children.

All residential centres for children with disabilities operating and notified to HIQA on 1 November 2013 are deemed in law to be registered and subject to inspection of the Authority. These centres await assessment and formal registration within a three-year period. In 2014, we assessed and registered eight centres.

The Child and Family Agency (Tusla) is the largest and most far-reaching of the providers that the Authority works with. Its services include foster care and residential services to children whose safety and welfare require protection. At the end of December 2014, there were 6,463 children in care in Ireland. Of these, 325

children were in a residential placement, 6,011 were in foster care and the remainder were in other care placements.[1] Sixteen children were in special care placements. Forty thousand children were referred to the Child and Family Agency's child protection and welfare services in 2014, demonstrating that the quantitative demand for services had not grown in the last year.

Although inspectors made positive findings, the Authority remained concerned about inconsistencies in the safety and quality of services nationally. As a result of these inconsistencies, the Authority is concerned that national and local management systems may not be adequate in providing assurance on:

- consistently safe, good-quality services
- robust quality assurance systems
- effective information systems
- effective risk management processes.

As a result of these findings through our local inspection processes, the Authority will commence a national review of the Child and Family Agency's (Tusla's) governance arrangements in 2015.

The Authority's inspections at local level noted that there were issues in relation to the use of data and information on services and the ability of Tusla to deploy resources in line with what that information was indicating in respect of risk within those services. This was manifested in some areas where children waited for significant periods of time before the level of risk to which they were exposed was assessed or until their cases were allocated to a social worker. In other areas, this was not the case.

As a result, these issues will also be looked at in the Authority's national review of Tusla's governance arrangements in 2015.

Nonetheless, the Child and Family Agency had made progress in improving its services. Standardised processes were further embedded in child protection and welfare services and some much-needed policies were launched. It had introduced a new service model, called Meitheal, to coordinate the provision of welfare services, and the Authority views this as a welcome development. However, the provision of welfare services was inconsistent across the country and some areas were under-resourced to provide such a service.

Inspectors found excellent examples of child-centred practices such as social workers interviewing children on their own, seeking children's views and ensuring they were kept informed and involved in decision-making. Children told inspectors they felt

[1] The Child and Family Agency Quarterly Report Metrics published 2014.

listened to and made informed decisions with the support of social workers. Resources such as language interpreters and advocacy services were in place to facilitate communication where necessary. Children said that they valued the input from social workers and described how things got better for them since their own parent or parents had become involved with the services. Inspectors observed respectful communication between social workers and families.

However, the Authority was concerned about high numbers of children awaiting allocation to a social worker. This means that a child's case has been screened as requiring initial assessment by social workers and or required allocation to a social worker for child protection or welfare reasons. While there had been some reduction from the 2013 figures for unallocated cases (that is, where children have not been assigned a social worker), at the end of the final three months of 2014, there were 2,731 high-priority unallocated cases out of a total of 8,351 cases unallocated nationally. The Authority is of the view that children's safety and welfare was put at additional risk because they had not received required social work interventions. This issue was escalated as a serious concern to the national senior management team in the Child and Family Agency.

During 2014, we received data on key indicators of service safety and performance from the Child and Family Agency. Both the data and our inspection findings revealed significant variation in the performance of the Child and Family Agency in the different service areas. For example, there were long waiting lists for initial assessments in four out of the five service areas inspected, but there was no waiting list in the Kerry service area at the time of the Authority's inspection. Similar discrepancies were found in the numbers of children waiting for allocation to a social worker.

When children are unable to live with their families of origin, they are placed in foster care or residential care. Some children in both foster care and residential care presented with behaviour that challenges, but services were not always able to meet their needs. Other children were well cared for and received a good quality of service. In many of the centres, inspectors found that the quality of child-centred practices was high. Children were aware of their rights and information about their rights was readily available. Children participated in care planning meetings, were consulted about the running of centres and were supported in accessing records and making complaints if there were unhappy. Practice in relation to managing, recording and resolving complaints was generally of a high standard.

When children are in residential care, the Child and Family Agency undertakes a corporate parenting role. This should be manifested through the allocation of a social worker for individual children. In some centres, children did not have an allocated social worker. This varied from one area to another.

The Authority remained concerned about the restriction of some children's liberty in both of the two services in which they may be legally detained, namely the detention schools and the special care units.

The detention schools are in a period of transformational change which will lead to significant increases in capacity and the placement of young people of 16–18 years of age in the service. While the Authority found that there were many positive practices and some further development of governance structures and management systems, areas of concern remained as children did not receive an offending behaviour programme to support their rehabilitation into the community.

The Authority was concerned about the impact on other children living in residential care of children with higher levels of care needs waiting for special care placements. The Authority raised this issue with the senior management team in the Child and Family Agency as inspectors had found that the behaviour of these children had resulted in serious disruption for others sharing the service. The Child and Family Agency managers provided an update on the strategy for special care services, a planned increase in bed numbers and a reform of the system by which children enter special care. The Agency assured the Authority that steps were being taken to reduce the time which some children waited for special care placements, and the Authority will monitor this issue in its inspections throughout 2015.

The Authority believes that there are particular responsibilities for all agencies and organisations in providing care and support to children. It will continue to monitor and regulate services to promote safe services and promote improvement.

This 2014 summary report is organised into a number of sections with introductory information, a summary of the team's inspection activity followed by inspection findings.

Part One – The work of the Children's Team

1. Introduction

The Health Information and Quality Authority and children's services

The Health Information and Quality Authority (the Authority, or HIQA) is responsible for regulating and monitoring the quality and safety of adult and children's health and social care services across Ireland. The Regulation Directorate of the Authority encompasses the statutory functions of the Chief Inspector of Social Services and operates in two distinct sections:

- the regulation of adult social care services and services for children with disabilities
- monitoring of healthcare and children's services, excluding residential services for children with disabilities.

This report provides an overview of the 2014 regulatory programme for services for children in need of care or protection and also children with disabilities living in designated centres. It primarily sets out how we met our business plan objectives to:

- conduct regulation programmes of health and social care services so that those services are driven to continuously improve, and in turn better safeguard children and achieve improved outcomes for them
- regulate effectively and efficiently, make an impact on national policy and communicate to all relevant stakeholders.[2]

Establishment of the Department of Children and Youth Affairs

In 2011, the role of Minister for Children and Youth Affairs was created as a full, Cabinet-level ministerial role, and the Office of the Minister for Children and Youth Affairs was formally established as the Department for Children and Youth Affairs (DCYA). This department has wide-ranging responsibilities including 'coordinating and harmonising policy and ensuring high-quality arrangements are in place for focused interventions dealing with child welfare and protection, family support, adoption, school attendance and reducing youth crime'.[3]

[2] HIQA Business Plan 2014, page 6.
[3] Source DCYA website http://www.dcya.gov.ie.

The Programme for Government 2011–2016 contains a commitment to 'fundamentally reform the delivery of child protection services by removing child welfare and protection from the HSE and creating a dedicated child welfare and protection agency, reforming the model of service delivery and improving accountability to the Dáil'.[4] The Minister for Children and Youth Affairs was given responsibility for the establishment of what became the Child and Family Agency, also known as Tusla. On its establishment in January 2014, the Minister assumed responsibility for comprehensive oversight'[5] of the Child and Family Agency.

Establishment of the Child and Family Agency (Tusla)

The Task Force Report on the Child and Family Support Agency, published in 2012, described the establishment of a dedicated agency for children and families as being 'a once in a generation opportunity to fundamentally reform children's services in Ireland that focused on putting the child at the centre of policy and services'.[6]

On 1 January 2014, the Child and Family Agency took over the functions, services, and staff of the Health Service Executive's (HSE's) Children and Family Services, the Family Support Agency and the National Education Welfare Board.

The Child and Family Agency's functions are set out in the Child and Family Agency Act 2013.[7] Within the new Agency, local services to children in need of care and protection are delivered by 17 service areas. The level of demand for services is demonstrated in the *Review of Adequacy for HSE Child and Family Agency 2012*[8] published by the Child and Family Agency in 2014. The review states that: 'During 2012 HSE Children and Family Services received over 40,000 reports; made over 2,000 admissions into care; provided alternative care services to over 6,300 children; over 92% of whom were placed with over 4,100 foster families; and supported over 1,450 young people in Aftercare.'[9]

At the end of December 2014, there were 6,463 children in care. Of these, 325 children were in a residential placement, 6,011 were in foster care and the remainder were in other care placements.[10] Sixteen children were in special care placements. There were approximately 40,000 referrals to the Child and Family

[4]Government for National Recovery 2011-2016, Government of Ireland 2011.
[5] DCYA website.
[6] Department of Health and Children, *Report of the Task Force on the Child and Family Support Agency* (July 2012) Dublin: Stationery Office, page iii.
[7] Child and Family Agency Act 2013, Section 8,
[8] Child and Family Agency, *Review of Adequacy for HSE Child and Family Agency 2012* (2014). available on www.tusla.ie.
[9] Child and Family Agency, *Review of Adequacy for HSE Child and Family Agency 2012* (2014) available on www.tusla.ie.
[10] The Child and Family Agency Quarterly Report Metrics published 2014.

Agency child protection and welfare services in 2014, demonstrating that the quantitative demand for services has not grown in the last year.

Commencement of new functions within the Health Information and Quality Authority, 2014

In line with the Programme for Government 2011–2016,[11] the Authority commenced the inspection of residential centres for adults and children with disabilities on 1 November 2013, under the Health Act 2007. The Children's Team in the Authority's Regulation Directorate now has responsibility for regulating 65 designated centres for children with a disability, run by 30 providers.

Inspection of detention schools

There are three schools are on a single campus and the Campus Manager reports to a board of management. In turn, the Chairperson of the Board reports to the Department of Children and Youth Affairs. Children are detained in these schools on remand or until their sentences have been completed.

The Children's Team in the Authority began inspecting the detention schools as three separate entities but now carries out one inspection of the three schools. The schools are in a state of transition and their purpose and function is changing significantly (see Part Three later in this report).

The detention schools are also inspected by the Council of Europe's European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment.

[11] Programme for Government 2011 – 2016: 'We will put the National Standards for Residential Services for People with Disabilities on a statutory footing and ensure that services are inspected by the Health Information and Quality Authority.'

2. How we regulate services

The statutory framework – monitoring against standards and regulations

Each type of children's service has its own statutory framework that gives authority to HIQA to monitor the service, using standards and regulations which set out what is expected from the service. Table 1 below sets out the statutory framework for each type of service monitored by the Authority.

Table 1. Statutory basis for inspection and monitoring of children's service by the Health Information and Quality Authority

Functions	Authority to inspect	Primary legislation	Regulations	Standards
Child protection and welfare services	Inspected under Section 8(1)c of the Health Act 2007	Health Act 2007		*National Standards for the Protection and Welfare of Children* (HIQA, 2012)
Foster care services	Inspected under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991	Child Care (Placement of Children in Foster Care) Regulations, 1995 Child Care (Placement of Children with Relatives) Regulations, 1995	*National Standards for Foster Care* (DOHC, 2003)
Residential care	Inspected under Section 69 of the Child Care Act, 1991	Child Care Act, 1991	Child Care (Placement of Children in Residential Care) Regulations, 1995	*National Standards for Children's Residential Centres* (DOHC, 2001)

Functions	Authority to inspect	Primary Legislation	Regulations	Standards
Special care units	Inspected under Section 69 of the Child Care Act, 1991	Children Act, 2001		*National Standards for Special Care* (DOHC, 2001)*
Children Detention schools	Inspected under Section 185 and Section 186 of the Children Act, 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006		*Standards and Criteria for Children Detention Schools* (DOJELR, 2008)
Designated centres for children with a disability	Inspected under Section 41 of the Health Act 2007	Health Act 2007	Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013	*National Standards for Residential Services for Children and Adults with a Disability* (HIQA, January 2013)

Inspectors make judgments on the quality and safety of services and report on the performance of services using standards and regulations. Standards aim to describe what a high-quality safe service should look like and what they should achieve for the children using them. Regulations are the statutory requirements with which service providers must comply. A key principle of inspections is to focus on children's experiences.

* In spring 2015, new HIQA standards superseded these National Standards for Special Care Units. See, http://www.hiqa.ie/publications/national-standards-special-care-units.

In addition to the standards and regulations, there are two important documents which apply to all children's services: the UN Convention on the Rights of the Child; and *Children First: National Guidance for the Protection and Welfare of Children* (2011).

The UN Convention on the Rights of the Child is embedded in the regulations and the standards and applies to services for children. The rights set out in the Convention apply to each child in the jurisdiction without discrimination. They include the right to identity, freedom of conscience, freedom of expression, access to information, protection of privacy, education, rest and leisure, play and recreation, and the right of children from ethnic minorities to their own culture. The Convention places duties on states which are party to the Convention to ensure children receive the protection and care that is necessary for their wellbeing and that institutions, services, and facilities responsible for the care or protection of children conform to standards established by competent authorities.

Children First: National Guidance for the Protection and Welfare of Children (2011) identifies children in residential settings, children in the care of the State and children with disabilities, as being especially vulnerable to abuse or neglect.[12] However, all services for children (such as schools) must adhere to the national guidance and report any concerns about children to the Child and Family Agency and or An Garda Síochána (the Irish police force).

Themes for inspection of services

In 2013, the Authority introduced a standardised monitoring approach to promote the consistent, timely assessment and monitoring of the quality and safety of services, using standards and regulations. This standardised approach includes the use of themes to group together related standards and regulations. Figure 1 shows these themes.

[12] Children First: National Guidance for the Protection and Welfare of Children, (2011) Page 56

Figure 1: Six themes for inspection of children's services by the Health Information and Quality Authority

Three of these themes have been selected in order to present some of the Authority's inspection findings, as these themes are considered to be the cornerstones of safe, good quality services which are well run and respect children, their rights and their dignity.

Child-centred Services

This theme is concerned with the extent to which services are centred on

- the individual child, and whether:
  - children's rights and diversity are promoted
  - children are listen to
  - they are communicated with effectively and assisted to participate in decisions made about them.

Safe and Effective Care

This theme is concerned with how services promote the safety of children through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect children. Safe services protect children from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and or neglect to the relevant authorities. Effective services ensure that the

proper support mechanisms are in place to protect children and promote their welfare. Assessment and planning is central to the identification of children's needs and ensuring better outcomes.

Governance, Leadership and Management
Effective governance is achieved by planning services and using good business practices. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed and the system is subject to a rigorous quality assurance system. Services provided on behalf of the service area are robustly monitored. Providers and managers act with integrity and have the best interests of children as their primary motivation.

Judgments

In 2014, the Authority engaged with informed and interested parties to determine the four categories of compliance judgments for child protection and welfare services and foster care services. The Authority wanted to present its findings in a way which would be both fair and clear to providers and for the public. Following this consultation, the following four categories of judgments were selected:

- **Exceeds Standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by robust systems.
- **Meets Standard** – services are safe and of good quality.
- **Requires Improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant Risk Identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

Different categories of judgments are used for designated centres for children with a disability. Providers are judged to be:

Compliant: a judgment of compliant means that the provider, manager or person in charge (as appropriate) is in full compliance with the relevant regulation.

Non-Compliant: a judgment of non-compliance means that some action is required by the provider, manager or person in charge to comply with a regulation.

When non-compliance is identified, inspectors determine the severity of impact on the individual or individuals that use the service and judge it as **Major, Moderate** or **Minor non-compliant**. These descriptions of grade are defined as follows:

- **Major non-compliance:** the care provided in the centre is poor and has a major impact on the safety, health and welfare of service users (or there is a risk that this may happen). The failings need to be immediately addressed as a matter of priority.
- **Moderate non-compliance:** the care provided in the centre is poor and has a moderate impact on the safety, health and welfare of service users (or there is a risk that this may happen). The failings may need to be immediately addressed as a matter of priority.
- **Minor non-compliance:** the care provided in the centre is poor and impacts on the safety, health and welfare of service users (or there is a risk that this may happen). The failings can be easily addressed.

When a judgment is made that a service is failing to meet a standard or regulation, the Authority provides an action plan for the provider to complete. The provider is required to return a detailed response within 10 working days, describing the actions it intends to take or has taken to address the deficits. Inspectors assess the action plan and decide whether the proposed actions will address the deficits in a timely manner and drive improvements in the service.

Monitoring

The Authority monitors services by carrying out inspections and reviewing information which it receives in between these inspections, which can take the form of notifications, requested and unsolicited information. In 2014, the Authority also began to supplement these sources of information with a quarterly data collection of key performance indicators (specific and measurable elements of practice that can be used to assess quality and safety of care) from the Child and Family Agency. This information alerts the Authority to possible risks in services which may affect the health, safety and wellbeing of children. All information is risk-assessed and used to inform inspectors' judgments about what actions they should take.

Regulatory actions can range from conducting an unscheduled inspection, issuing an immediate action plan, asking for assurances, more information, or requesting the provider to undertake a provider-led investigation. For designated centres, the Chief Inspector of Social Services has the option of taking enforcement action. This can take the form of prosecutions, changes to a centre's registration status, including the closure of a centre or the use of enforcement notices.

Inspection

Inspection is the most significant component in the ongoing monitoring of services. The type and frequency of inspection is based on the level of risk that the inspector deems to be present in the centre or service, the requirement for registration inspections, the provider's history of compliance and the Authority's requirements for a minimum number of inspections that each service must receive over a given period.

The different types of inspection are:

- **Monitoring inspections:** these monitor ongoing compliance with the national standards and regulations.
- **Registration inspections:** these are conducted to inform a registration decision and usually assess compliance with all standards and regulations. At the time of this report, only residential services for children with disabilities are registered by the Authority, under the Health Act 2007.
- **Follow-up inspections:** these assess the extent to which the provider has implemented required actions related to the findings of a previous inspection.
- **Single or specific-issue inspections:** these concentrate on a specific issue following the receipt of information about a service.
- **Thematic or focused inspections:** these relate to a particular issue and aim to raise quality of services under a predetermined theme or themes. However, any other risks identified by inspectors during the course of inspection are bought to the attention of the provider and are included in published findings and recommendations.

Stakeholder engagement

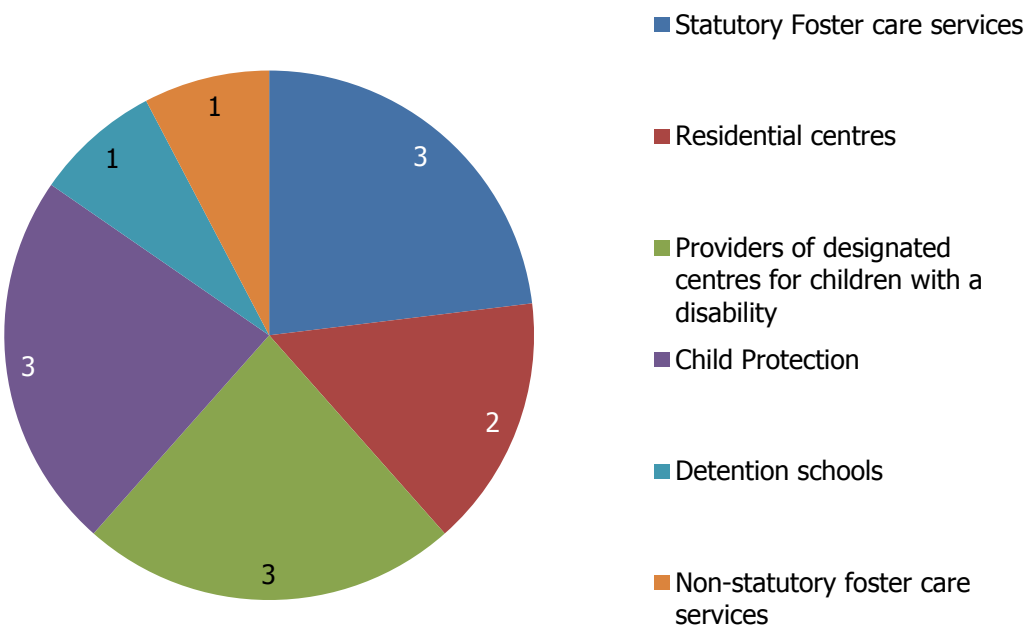
In line with our business objectives, the Children's Team continued to work closely during 2014 with diverse groups of people in the execution of our functions. These stakeholders included:

- children
- children's families and friends
- carers
- advocacy groups
- health and social care professionals
- public, private and voluntary providers
- the Department of Children and Youth Affairs
- the Department of Education and Science
- the Child and Family Agency (Tusla).

During 2014, the Children's Team reviewed its monitoring approach and developed standard frameworks and tools by which it would carry out all inspections. It also developed a formal escalation policy. In order to introduce the changes in a fair and transparent manner, the Children's Team made 10 presentations to personnel from the Child and Family Agency, non-statutory foster care providers and the detention schools throughout 2014 (see Figure 2).

Inspectors also provided guidance on the compilation of action plans to all of the services which the Authority monitors. In addition, our inspectors contributed to three presentations made to providers of designated centres for children and adults with disabilities. These presentations are available on our website, www.hiqa.ie.

Figure 2. Presentations by HIQA to stakeholders on HIQA's new monitoring approach



Listening to children's voices

In accordance with the goal of the National Children's Strategy 'that children would have a voice in matters which affect them' and Article 12 of the UN Convention, the Authority's children's services inspectors engage directly with children during inspections on an individual basis and in focus groups. Inspectors also obtain the views of children through child-friendly questionnaires.

In 2014, inspectors met with 155 children during their inspections of alternative care and child protection and welfare services. A further 15 children were met during the inspection of the detention schools and 32 children were met during the inspections of designated centres for children with a disability. In total, inspectors met and elicited the views of 202 children in 2014, which reflects the commitment of the Authority to seek the experiences of children as part of their inspections.

Listening to and investigating complaints is an effective way of listening to children's voices and an important safeguarding mechanism. In 2014, inspectors found that children in residential services knew how to make a complaint and complaints were well managed when compared to foster care and child protection and welfare services. The Authority has recommended that the Child and Family Agency promotes awareness of the complaints procedure to facilitate children and families to make complaints should they wish to do so.

Table 2. Children met with during inspection activity

Number and Type of inspections	Number of children met during these inspections
5 statutory child protection and welfare	37
5 foster care	57
1 detention school campus	15
21 children's residential centres	53
3 special care units	8
75 disability centres	32

Inspectors talked with children about their experiences, what they knew about their rights, and gained an insight into their day-to-day lives. They spoke to children living in foster care, residential centres, in designated centres and to children who were provided with child protection and welfare services. Children talked about their carers, their social workers and how they were able to keep in touch with their families and friends. They described their lives at school and opportunities they had for play, sport, exercise, hobbies and other recreational activities. Their views and experiences were considered alongside other sources of evidence to inform judgments about the quality of services. Not all children living in designated centres were able to speak and so inspectors observed them or communicated with them, supported by staff members at times.

3. Inspection activity in 2014

Number and type of inspections

The children's team conducted 111 inspections across the different services for children in 2014. There were 69 monitoring inspections, 19 registration inspections, 11 follow-up inspection inspections, one single-issue inspection, one assurance programme and 10 thematic inspections. Table 3 shows that the majority of inspections in 2014 (62%) were monitoring inspections.

Table 3. Types of inspections conducted in 2014

Type of inspection	Child protection and welfare	Foster care	Residential centres for children in care	Special care units	Children detention schools	Residential centres for children with a disability
Monitoring inspections	5	5	11	3	1	44
Registration inspection	N/A	N/A	N/A	N/A	N/A	19
Single-issue inspection	0	0	0	0	0	1
Follow-up inspection	0	0	0	0	0	11
Assurance programme inspection	1	0	0	0	0	0
Thematic or focused inspections	0	0	10	0	0	0

Assurance programmes and focused inspections

One themed inspection was added to the inspection programme for 2014, following proposals received through a public consultation conducted by the Children's Team in 2013. This inspection examined the management of child protection concerns by the Child and Family Agency about children from diverse ethnic backgrounds living in

direct provision accommodation in four service areas. The report on child protection and welfare services to children living in direct provision was published in May 2015.[¥]

The children's team also undertook 10 inspections that focused primarily on the management of children's behaviour that challenges in children's residential centres run by the Child and Family Agency.

Number of inspection reports published in 2014

The Children's Team published 71 reports in 2014 on inspections of:

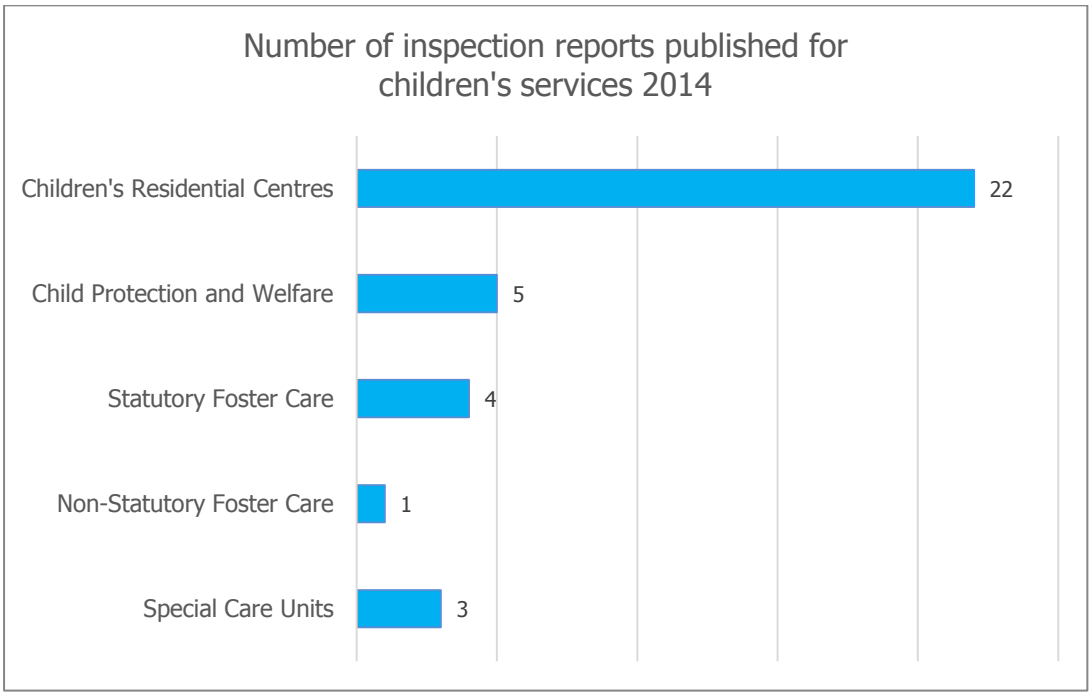
- child protection and welfare services in five service areas
- foster care services in four service areas
- one non-statutory foster care service
- 22 statutory residential care services (including one high support unit)
- 35 disability centre inspections.

See Figure 3 below for the breakdown of published reports per function.

Fieldwork for three special care unit inspections and one detention school inspection took place towards the end of 2014. Although the reports were not published until early 2015, the findings are included in this report in order to provide an up-to-date picture of the standard of care in these centres. In addition, reports published in 2014 by the Authority on special care units and the detention schools refer to inspections which took place in 2013.

[¥] See, http://www.hiqa.ie/press-release/2015-05-25-findings-hiqa-inspection-child-protection-and-welfare-services-provided-chi.

Figure 3. Number of inspection reports published for children's services in 2014



A number of registration inspection reports carried out during 2014 have not yet been published as the registration process is not completed for those centres.

Part Two – Monitoring and inspection findings of Child and Family Agency and one private provider of foster care

Introduction

The Child and Family Agency

The Child and Family Agency has responsibility to protect children and promote their welfare under both the Child Care Act, 1991 and the Child and Family Act 2013. It does this by providing direct services and funding other organisations to provide support to children and families living in the community. It delivers foster care placements, and in addition purchases places from private providers. The inspection of one such provider is also discussed in this section. In addition, the Child and Family Agency runs two types of residential services for children in the care of the State: children's residential centres and special care units. All these services are inspected by the Authority.

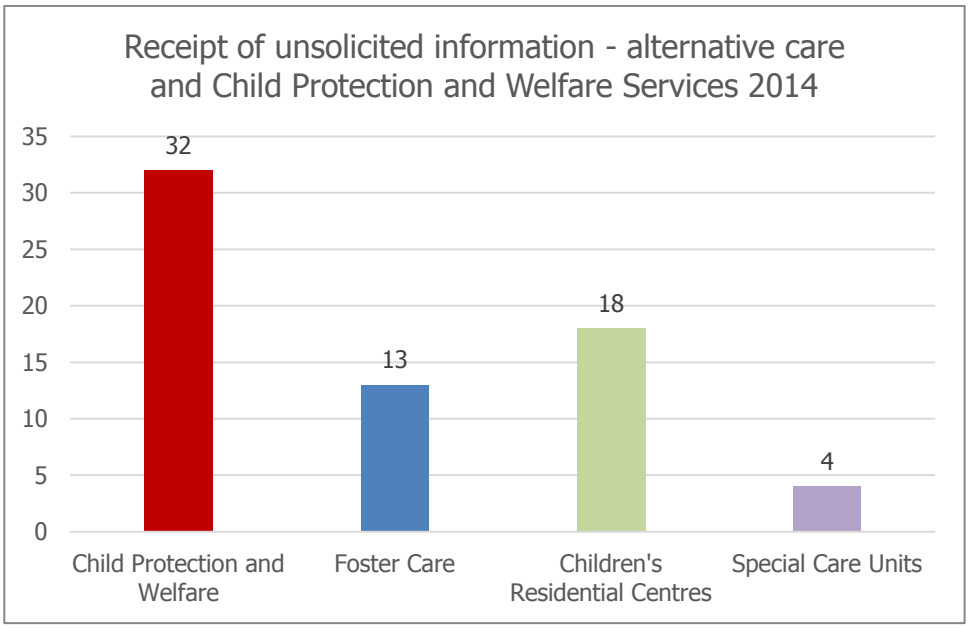
Monitoring activity and regulatory action in services provided by the Child and Family Agency and inspected by the Authority

During 2014, the Children's Team reviewed all available information about services and used it to monitor those provided by the Child and Family Agency. This included unsolicited information, Child and Family Agency monitoring reports and notifications as well as evidence gathered on inspection. All information was assessed, risk-rated and used to inform regulatory actions. The Authority also received data from the Child and Family Agency on a regular basis and this was analysed to identify any risks in services.

Receipt of unsolicited information

During 2014, the Authority continued to receive information from members of the public. The Children's Team received 67 pieces of unsolicited information relating to children's services during 2014 (see Figure 4).

Figure 4: Receipt of unsolicited information



Considering the high volume of work undertaken by the Child and Family Agency, the level of unsolicited information received by the Authority was very low for child protection and welfare services and foster care services. In comparison, the rates of unsolicited information about residential centres and special care units were higher even though these services cater for a much smaller population of children. It may be that there is a greater awareness of the Authority in residential services as these have been subject to monitoring by the Social Services Inspectorate since 2001.

Inspections of child protection and welfare services by the Authority began in 2012, and many children and families may be unaware of the role of the Authority in inspecting such services. However, it is important to note that unsolicited information received by the Authority differs from complaints about services which the Child and Family Agency manages itself. Inevitably, the number of complaints to the Agency is higher than the concerns received by the Authority.

Unsolicited information received by the Authority related to concerns about the quality and safety of care, aftercare supports for children leaving care, discharge decisions, access arrangements and lack of timely access to services. Inspectors risk-rated this information and took regulatory action where necessary. They sought information and assurances from the Child and Family Agency about the safety and quality of services. Unsolicited information was also used to inform the Authority's schedule of inspections. If the Authority deemed that information received from the public was of serious concern, an inspection took place.

Notifications of serious incidents including deaths of children in care or of children known to the child protection services

During 2014, the Child and Family Agency continued to notify the Authority of deaths and serious incidents involving children in care and of children known to the child protection and welfare system, as required by the *Guidance for the HSE for the Review of Serious Incidents including Deaths of Children in Care*, published by the Authority in 2010. In 2014, the Authority received 26 notifications of deaths of children in care or of children known to child protection and welfare services, and three serious incidents involving children. It should be noted that some children in care die of natural causes or in circumstances which could not be prevented.

A National Review Panel carries out formal reviews of some of the deaths and serious incidents. The Child and Family Agency submitted 12 reports from the Review Panel during the year to the Authority. All of these reports related to children who had died in previous years. The Child and Family Agency published four National Review Panel reports in 2014 – inspectors reviewed these reports and if any risks were identified, this information was used to inform the Authority's view of the safety of a service or centre and any regulatory action required.

Data received from the Child and Family Agency

The development of the Authority's business intelligence function and the analysis of the data supplied by the Child and Family Agency is a welcome addition to the information received through notifications and from the public. Inspectors could see areas in which the services were performing well and where the demand for services was not being met. For example, inspectors identified service areas which had significant numbers of high-priority unallocated cases or who had children on the Child Protection Notification System[13] without a social worker. The Authority received information on children in foster care without social workers and on the percentage of children in foster care without an up-to-date care plan. Inspectors sought further information on these findings and assurances that risks were being addressed. All information was considered by inspectors and used to generate risk profiles[14] for centres and services. This gathering of all types of information has allowed the Children's Team to prioritise the use of its resources effectively and concentrate on services which pose the highest perceived risk to children.

[13] The Child Protection Notification System contains the names of children for whom there are unresolved child protection issues, including neglect.

[14] Inspectors analyse all information available to the Authority and using a standard process determine the level of risk posed to children by the service or centre. This is called a risk profile.

Both the data and inspection findings revealed significant variation in the performance of the Child and Family Agency in the different service areas. For example, there were long waiting lists for initial assessments in four of the five areas inspected but there was no waiting list in Kerry at the time of its inspection. Similar discrepancies were found in the numbers of children waiting for allocation to a social worker.

Escalation – at national level

The Authority's regulatory strategy is to promote improvement wherever possible in the services it monitors. However, if a provider (which in this case is the Child and Family Agency at local, area or national level) continues to fail to meet standards and regulations or to work in a constructive way with the Chief Inspector, the Authority may escalate its concerns to the Child and Family Agency's senior management team or in extreme situations to the Department of Children and Youth Affairs. The Authority prioritises the rights of children to be safe and receive a good quality of care, while being fair and proportionate to providers. During 2014, the Authority escalated three specific issues with the Child and Family Agency which were affecting children nationally.

The Authority was concerned about high numbers of children whose cases were screened and awaited either an initial assessment or allocation to a social worker (see Table 4). This means that a child's case has been assessed by social workers and it has been recommended that a social worker be allocated for child protection or welfare reasons. At the end of quarter four of 2013, there were 9,742 unallocated cases nationally, of which 3,630 were high-priority cases. During 2014, the Authority escalated this issue to the senior management team in the Child and Family Agency and discussed the Agency's plan to reduce these figures. The Authority received limited assurances that the Child and Family Agency was taking action to address the issue, with senior managers citing resources as a significant issue. During the inspection of the Cork service area child protection and welfare service in late 2014 (the report for which was published on 24 March 2015), the number of high-priority, high-risk cases was the subject of an immediate action plan. At the end of the final three months of 2014, there were 2,731 high-priority unallocated cases out of a total of 8,351 cases unallocated nationally and this remains an issue of serious concern. While the reduction in numbers shows some improvement in the performance of the Child and Family Agency, the Authority remains seriously concerned that children's safety and welfare is put at additional risk because they are not receiving the required social work interventions.

Table 4. Number of children awaiting allocation to a social worker by area at the time of inspection

Local health or service area	Number of children awaiting allocation to a social worker
Galway	327
Roscommon	232
Donegal	169
Dublin North City	106
Kerry	0

Standard 2.12 of the *National Standards for the Protection and Welfare of Children* refers to the need for specific policies and procedures to inform practice in the management of retrospective allegations of organised and institutional abuse. There was no such policy or procedure in any area inspected in 2014. While the Child and Family Agency issued a procedure for responding to allegations of abuse, it did not include guidance on managing organisational or institutional abuse, and the Authority escalated this issue to the senior management team. *Children First: National Guidance for the Protection and Welfare of Children* (2011) acknowledges the complexity of this area of work. In 2015, the Child and Family Agency informed the Authority that it would be issuing such guidance.

The Authority was concerned about the impact of children with higher levels of care requirements waiting for special care placements on other children living in residential care. The Authority raised this issue with the senior management team as inspectors had found that these children's behaviour had resulted in serious disruption for others sharing the service. The Child and Family Agency managers provided an update on the strategy for special care services, a planned increase in bed numbers and a reform of the system by which children enter special care. The Child and Family Agency assured the Authority that steps were being taken to reduce the time which some children waited for special care placements and the Authority will monitor this issue in its inspections throughout 2015.

All risks were managed at a regional level only and there was no national risk register until the final three months of 2014. This was of particular concern as the senior management team in the Child and Family Agency did not have a formal overview of the risks which needed to be addressed at a national level, the measures

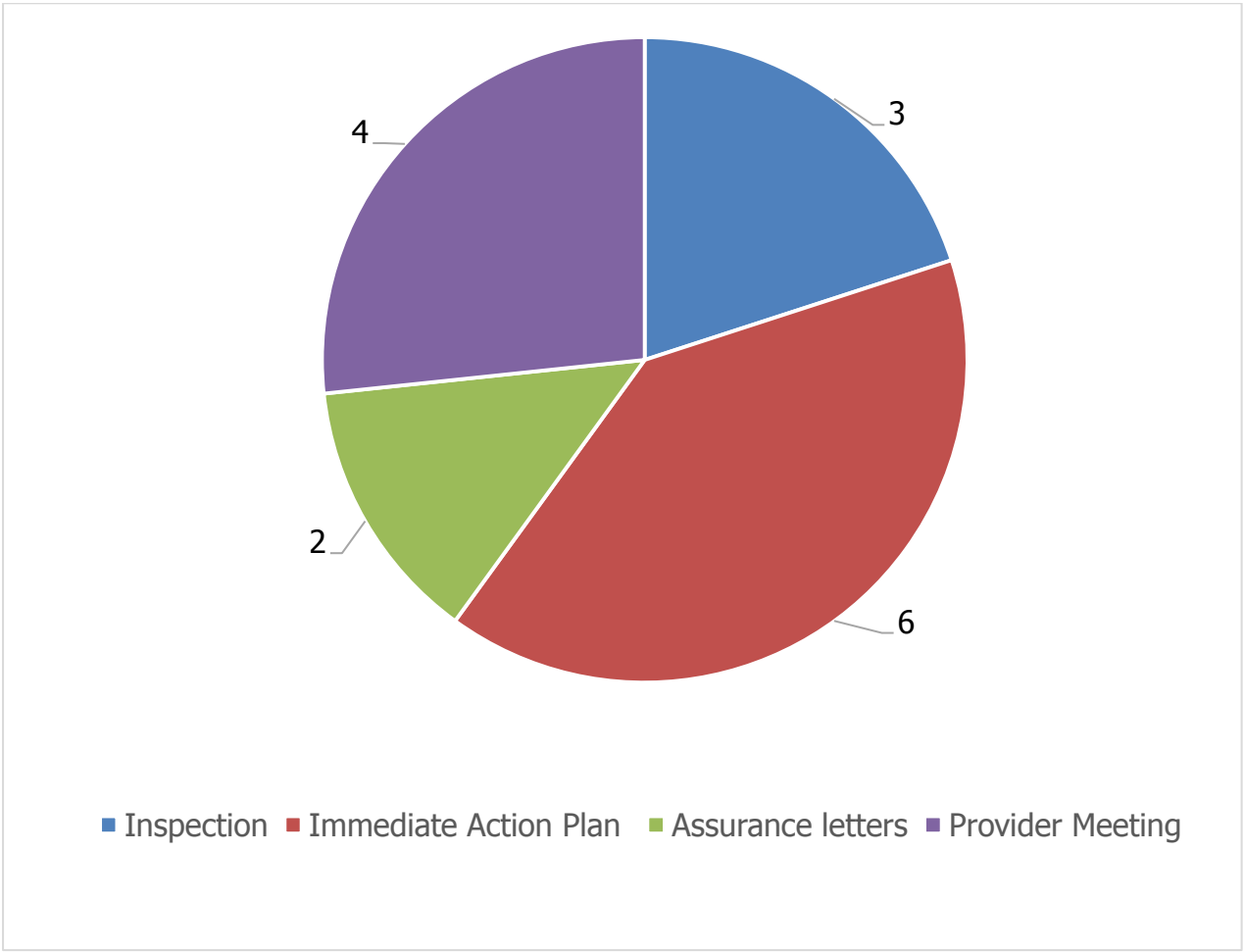
to be put in place to reduce the risks and an analysis of the effectiveness of these measures.

Escalation – at local level

At local level, the first step in responding to non-compliance with standards is the issuing of an action plan as part of the inspection report. However, if the Authority believes that no further improvements have been made, inspectors take further regulatory action. In 2014, there were 15 regulatory actions undertaken by the Children's Team. Figure 5 shows a breakdown of the different types of regulatory actions. These included:

- the issuing of immediate action plans to providers
- requesting further information
- provider meetings
- carrying out unscheduled inspection activity.

Figure 5. Types of further regulatory action taken by the Authority



Child protection and welfare inspections

Reports from the two inspections carried out in Galway and Roscommon (December 2013) and inspections in Kerry, Donegal and Dublin North City were analysed to inform overall findings for 2014. Two further inspections took place late in 2014 and these reports were published in 2015 but have not been considered as part of this overview.

While the Authority commends the good practice carried out by many practitioners, it remains concerned about the number of children waiting for initial assessments and for the allocation of a social worker.

Child-centred Services

Inspectors found excellent examples of child-centred practices such as social workers interviewing children on their own, seeking children's views and ensuring they were kept informed and involved in decision-making. Children told inspectors they felt listened to and made informed decisions with the support of social workers. Resources such as language interpreters and advocacy services were in place to facilitate communication where necessary. Children said that they valued the input from social workers and described how things got better for them since their own parent or parents had become involved with the services. Inspectors observed respectful communication between social workers and families.

In the areas inspected, children did not know how to make a complaint. This was of concern, considering the seriousness of some of the decisions made about children's lives. This was also a finding of 2013 inspections, and there had been few initiatives taken in this regard. Inspectors did not find any evidence that information leaflets had been developed to inform children and their families, and there was no child-friendly version of the complaints policy available to help children to understand how to make a complaint. In addition, three out of the five areas inspected had not taken any initiatives to inform and educate the public about reporting suspected child abuse and how to access appropriate services.

Safe and Effective Services

Inspectors found examples of the Child and Family Agency's prompt responses to immediate risks to children. Three out of five areas carried out comprehensive assessments which informed robust decision-making for children in such situations. There was evidence of timely and good quality child protection conferences, and again three out of the five areas held effective reviews of child protection plans to ensure children were safe and their lives improved. Referring families to early interventions services was prioritised in order to support families and carers. However, delays in making such referrals undermined the likelihood that children's

wellbeing would be improved and there was a possibility that risks to children would escalate and develop into child protection concerns.

The Authority had highlighted the need for services to have rigorous monitoring systems for identifying and managing risks to ensure that social work intervention was directed to children that most needed it. During 2014, the Child and Family Agency issued guidance on the use of 'thresholds'. The term 'threshold' refers to children's level of need and the criteria required before social work intervention is deemed necessary. The Authority welcomed this guidance, which should support a consistent approach in identifying children who are at risk of harm or whose welfare is not promoted and determine what action should be taken to protect them. However, inspectors found that in three areas, social workers needed training in the use of the thresholds framework and there was a risk that inconsistencies could still prevail for children who could be deemed to need services in one area but not in others.

The Authority was concerned about the delays for children waiting for initial assessments and allocation to a social worker. Principal social workers and team leaders found managing unallocated and unassessed cases of children at risk to be a significant challenge. In one area, inspectors found 15 children at risk of ongoing harm on the Child Protection Notification System who did not have an allocated social worker. This meant that there was no dedicated social worker monitoring their safety and wellbeing or working to improve it. These findings were also reflected clearly in the data received by the Authority from the Child and Family Agency. The Authority required that specific actions be taken to address risks to children associated with unallocated cases in each area where this was an issue. In addition, inspectors found that there were many cases which required closing and that this situation further delayed the delivery of services to children who were in greater need.

Governance, Leadership and Management

In all areas, inspectors found good examples of good operational management, supported and informed by effective communication systems. In some areas, roles and responsibilities were clearly defined with definite lines of accountability. Managers provided effective leadership and direction to teams, implemented policies and directed practices.

There were common areas of improvement required specifically in relation to effective organisational risk management and internal quality assurance systems for all services. The absence of an effective quality assurance system meant that managers did not know how safe the services they managed were, could not take remedial action if required and therefore could not lead improvements where

needed. During 2014, the Child and Family agency appointed a National Director of Quality Assurance and it is hoped that this role will improve quality assurance processes.

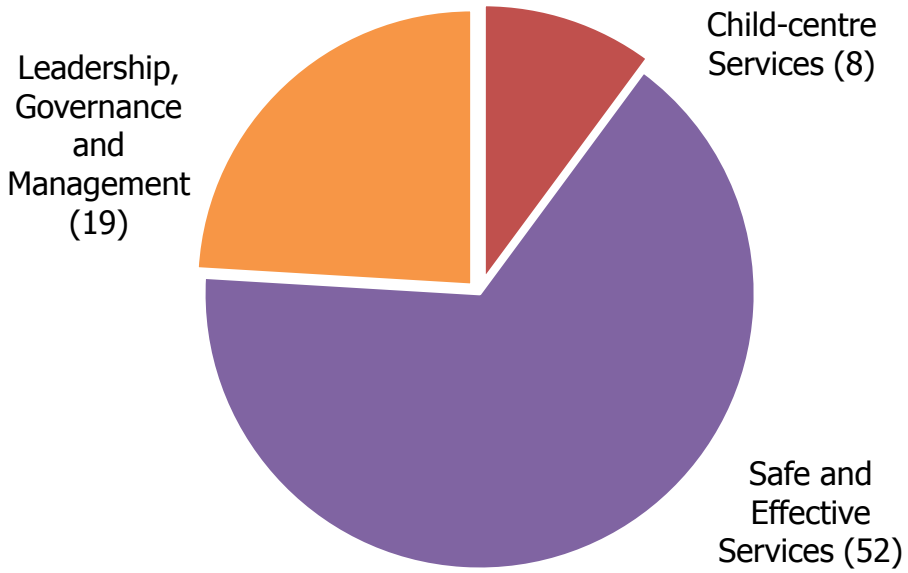
The assessment and management of risk for each area focused on individual children rather than organisational or corporate risks at a team, area or regional level. In some areas, inspectors found systemic risks were escalated through a risk register but actions to mitigate these risks were not evident. Again these findings had been identified to the then HSE Children and Family Services senior management team in 2013 when it was responsible for these services, but little progress had been made by the Child and Family Agency on this issue.

There was no information system to enable managers to gather data and outcomes about services they managed. This deficit also limited the capacity of managers to identify needs and strategically plan to meet them. This lack of information also hindered the ability of managers to allocate resources effectively. Again, these findings repeat the deficits identified in inspection reports of 2013. As a result, it remained a challenge for senior managers in the Child and Family Agency to diagnose problems and provide resources on a needs-led basis. The Child and Family Agency stated that it would be developing a process to identify and analyse demand for services across all areas in 2015 in order to deploy resources to meet need.

Analysis of action plans under the three themes for child protection and welfare services

There were 79 actions from the inspection of child protection and welfare services in the five areas inspected under the three themes selected for analysis in this report. Figure 6 on the following page shows a breakdown of all actions required.

Figure 6. Total number of actions required under the themes for child protection and welfare inspections in 2014



Eight actions were required under the theme of Child-centred Services and these related to the complaints and the requirement to educate the public on the reporting of suspected abuse issues.

The majority of actions (52) were under the theme Safe and Effective Services, which has 12 standards. As the Standards in this theme are critical to the protection of children, specific detail of a selection of key actions is provided in Table 5 on the following page.

Table 5. Actions required following child protection and welfare services

Action required to meet the standard	Number of areas in which this action was required.
Provide children with timely access to services	5
Make improvements in interagency working and use of strategy meetings	4
Monitor levels of risk to children and closing cases appropriately	4
Put in place policies and procedures in line with Children First (2011)	3
Put in place an effective Child Protection Notification System managed in line with Children First (2011)	5
Monitor and review the levels of risk to children to provide appropriate actions including the closure of cases	4
Implement a robust assessment process to identify children's needs and the risks to which they are exposed	2
Identify trends in adverse events and take action and disseminate learning from investigations and reviews	2

There were 19 actions required under the theme Governance, Leadership and Management. These related to deficits in organisational risk management, quality assurance processes, allocation of resources and monitoring of external services funded by the Child and Family Agency, in consultation with families, to improve services.

Statutory foster care services

Inspection of foster care services run by the Child and Family Agency were carried out in four areas: Dublin South Central; the Mid West; Carlow/Kilkenny/South Tipperary; and Dublin South/Kildare/West Wicklow.

Some findings, such as delays in the completion of assessments were common to foster care and child protection and welfare services. Other findings demonstrated inconsistency across the areas inspected in the level of service provided to children and foster carers.

Child-centred Services

Practice in this area was good and inspectors found that children were well looked after by caring and considerate foster carers. Social workers took an inclusive approach to working with children who participated in their care plan reviews and who were consulted about their care. Children spoke positively about their activities in the community, their progress at school and being part of carers' families. There was evidence that managers prioritised the placement of children with relatives and within their own community and the majority of children were placed with their siblings. Inspectors found that maintaining kinship ties was a priority and regular access arrangements were facilitated by carers and social workers. Children were happy with the frequency and quality of contact with their parents and relatives.

There were inconsistencies in practice relating to complaints and rights. Some but not all children knew about their rights. Some areas provided information leaflets on these issues for children and families while others did not. Children identified carers, parents and social workers as adults they would talk to if they had a concern, but did not know how to make a complaint and so might not be able to make their voice heard if they were unhappy about any aspect of their care. There was also no effective mechanism to record or monitor complaints which would enable managers to identify any trends and make improvements within the service. This was previously highlighted as a finding from inspections of foster care services in 2013.

A small number of children were placed in culturally appropriate placements which met their needs. However, there were challenges in attempting to provide such placements for all children from the growing number of children from diverse backgrounds. With the exception of one area, social workers tried to mitigate this issue by ensuring that foster carers were sufficiently informed about the cultural origins and care requirements for children from different ethnic backgrounds.

Safe and Effective Services

Children were well cared for and their needs identified through good quality assessments. The majority of children in care had an allocated social worker and comprehensive up-to-date care plan to inform interventions and achieve best outcomes for children.

Others did not and this is reflected in the information in Table 6.

Table 6. Number of children in foster care without a social worker, by service area

Child and Family Agency service area	Number of children in foster care without a social worker
Dublin South Central	0 out of 370 (0%)
Dublin South West/Kildare West Wicklow	111 out of 429 (26%)
Carlow/Kilkenny/South Tipperary	0 out of 369 (0%)
Mid West	79 out of 584 (14%)

Even allowing for regional differences, this data demonstrates the inequity in the child care service, depending on the area. For children in care, the social worker is the person who coordinates and reviews their care plan, ensures that their needs are being met, that they are safe and that there are plans for their everyday care and their future. Not to have a social worker is not only a statutory failing, but carries the risk that children's care will not be properly supervised.

The provision of aftercare supports was also inequitable across the areas inspected. While the Child and Family Agency has a comprehensive national policy for children leaving care and the provision of aftercare services, this had not been fully implemented in all areas inspected. The majority of children were taught independent living skills by their carers in preparation for adulthood but a number of children did not have aftercare plans or an allocated aftercare worker. This meant that children might not have the supports in relation to housing, finances, education and training and social relationships that they needed during this time of transition and extreme vulnerability.

Inspectors also found that many young people who were over 18 years of age were in full-time education and remained living with their foster carers, supported by the Child and Family Agency in doing so. This child-centred practice meant they continued to experience caring relationships and stable living arrangements.

As with findings from previous years, the majority of actions related to timely assessments and reviews of foster carers. These are the key mechanisms for services to be assured about the ongoing quality of care provided to children.

Inspectors found that there were a number of relative carers whose assessments had not been completed within the required time frame. This meant that children were living with relatives for considerable periods whose suitability to meet their care and safety needs had not been fully assessed and ascertained. This could potentially place children at risk. For example, in the Mid West service area, 28 carers were waiting for an assessment and some children had been living with unassessed carers for more than nine months and up to three years. This had been a national problem in 2013, and remained the case in 2014. Social workers cited staff resources as the main cause. Managers did not find it possible to prioritise these assessments, while assessments for non-relative foster carers were also slow. When completed, the assessments were detailed and comprehensive. In one area there was a significant number of relative foster carers who were not Garda Síochána vetted and this meant that a fundamental safeguard for children was not in place.

The formal matching of children to carers also needed to improve to ensure placement stability. This was because poor matching of children to carers had resulted in a significant number of placement breakdowns in the Mid West service area. Eighteen percent of the 584 children in foster care in this area had moved placements in the previous 12 months. The area was taking actions to address this at the time of the inspection, and the Authority continues to monitor progress in this regard.

Inspectors found that foster care committees in all areas now monitored placement breakdowns. Foster care committees received individual placement disruption reports and these were used to inform decision-making for future placements. This initiative should reduce future placement breakdown for individual children and inform strategic planning for foster care services.

As in 2013, the provision of quality training and supervision of foster carers was not adequate and not all foster carers had link workers or consistently attended training. The role of the link social worker is to support the foster carer, to ensure that the foster carer has the skills and knowledge to meet children's needs and to provide advice as required. In Dublin South City, 36% of foster carers did not have a link social worker and this figure rose to 43% in Dublin South West/Kildare West Wicklow. The response by the Child and Family Agency to the action plan for the latter area committed to putting resources in place to address this issue.

Safeguarding practice had improved and foster carers had a good understanding of safe care practices. All of the areas inspected had implemented Children First (2011), but in the Dublin South West/Kildare West Wicklow region allegations against foster carers were not always reported to the foster care committee. Social work practice in assessing allegations made by children against foster carers was generally good, although there were significant delays in one area in carrying out such assessments.

Governance, Leadership and Management

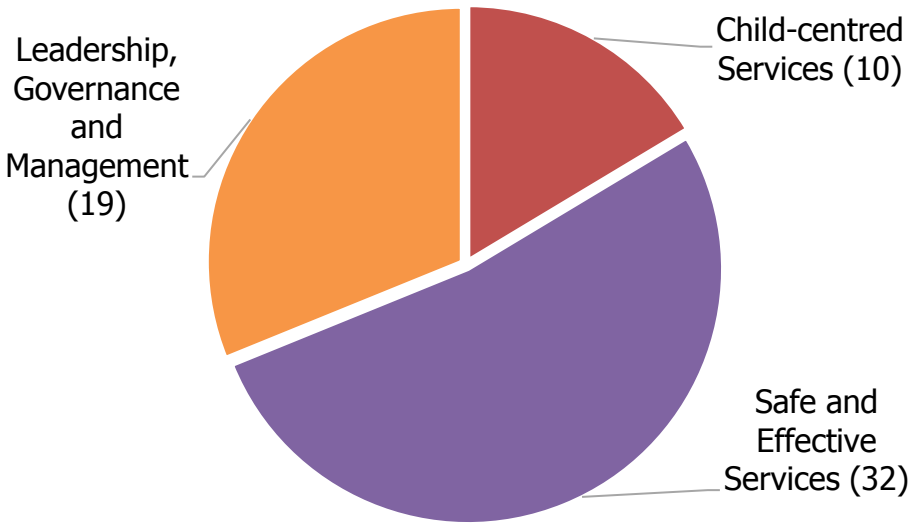
The services had clear lines of accountability with effective two-way reporting systems so that services would be able to respond to children's needs in a timely way. Staff were supported in decision-making and were confident in the leadership of their managers who demonstrated accountability for the service through supervision, team meetings and reporting systems. The majority of national policies were implemented and inspectors found that staff members were aware of them and used them in their practice.

A formal risk-management framework nationally is in the process of being developed at the time of this report. Inspectors found that risks were well managed on an individual basis for children, but less effectively at an organisational level, mirroring the findings in the child protection and welfare services. There was some monitoring of children's placements with external foster care agencies, but improvements were required to ensure all of these children had an allocated social worker and up-to-date care plans.

There were deficits in service planning, monitoring of the quality of services provided and the outcomes for children.

Analysis of action plans under the three themes for foster care services

Figure 7: Number of actions required under the themes applied for foster care inspections in 2014



There were 61 actions from the inspection of the four statutory foster care services under the three themes inspected. There were 10 actions under the theme of Child-centred Services which mostly related to complaints management. The majority of the required actions (32) fell under the theme of Safe and Effective Services and further detail is provided in Table 7 on the following page.

Table 7. Action required in foster care services under the theme of Safe and Effective Services

Action required	Number of areas in which failing was found (out of 4)
Put a robust matching process in place	4
Provide a good quality aftercare plan and service	4
Ensure that all children in foster care have a social worker and a good quality care plan	4
Carry out adequate reviews of foster carers	4
Allocate a link worker to all foster carers	3
Carry out foster care assessments in a timely way	4

There were 19 actions under the theme of Governance, Leadership and Management and many were common across all the areas inspected. The actions related to the monitoring of privately-provided foster care services, the management of risk at an organisational level, reviews of the quality of the service, the deployment of resources and the recruitment and retention of foster carers.

5. A foster care service run by a private provider

The inspection of foster care services run by private for-profit agencies falls under the remit of the Authority. One such inspection was carried out in 2014.

Child-centred Services

Inspectors met with children who told them that they felt safe in their placements and they had people they could talk to if they had any concerns. The rights of children were promoted, valued and respected by this service. Children were involved and participated in planning for their futures.

Safe and Effective Services

The quality of the service provided to children was good, with children experiencing stable placements, and quality care from carers who were well supported by link social workers. Foster carers were appropriately assessed by the service and approved by foster care committees. The quality of support to foster carers was good and all foster carers had an allocated link worker. There was evidence of prompt notification of child protection and welfare concerns to the Child and Family Agency in accordance with Children First (2011) and children were safeguarded by having the appropriate systems in place for the assessment of foster carers and supervision of foster carers. Reviews of foster carers needed to improve in order for managers to be assured about the ongoing quality of care provided to children. A number of children did not have a social worker or up-to-date statutory care plan and while this was the responsibility of the Child and Family Agency, the provider had a role to advocate and escalate these issues on behalf of children.

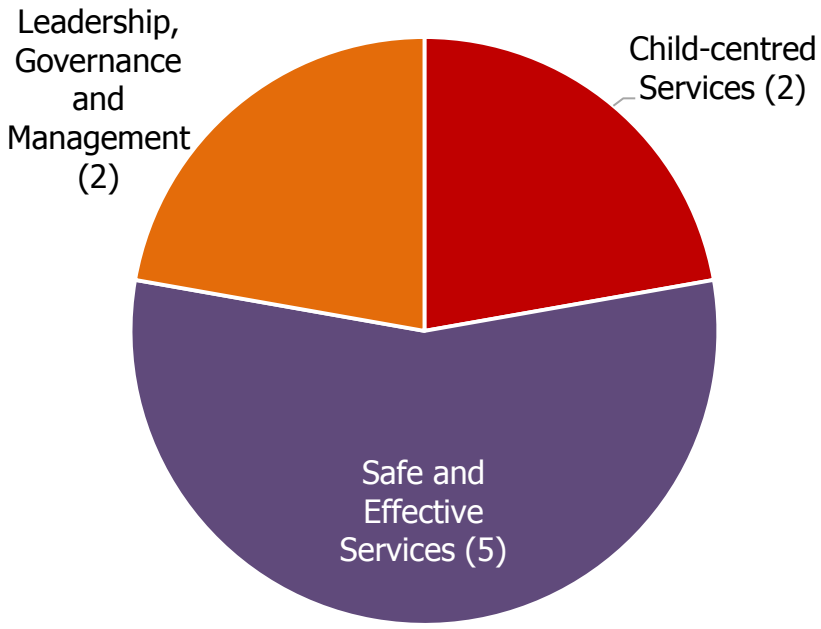
Leadership, Governance and Management

Managers made the best of the resources they had and showed strong leadership. There was a qualified and experienced staff team in place and staff members were provided with opportunities for training and supported in their professional development. The service was well managed and there were systems in place, supported by the provider's policies and procedures developed in line with relevant national policies, legislation, standards and regulations.

However, there were no robust quality assurance systems and significant improvement was needed in the identification and management of organisational risk. There was no robust system in place to gather information on outcomes for children placed with this service.

Nine actions were required to be taken under the three themes, reflecting the findings above (see Figure 8).

Figure 8. Actions required under inspection themes for non-statutory foster care



6. Children's residential centres

During 2014, inspectors carried out two types of inspection for children's residential services run by the Child and Family Agency. Some services received monitoring inspections, some of which took place in response to identified risks. Ten inspections were undertaken as part of a thematic programme to examine the quality of residential services when they work with children whose behaviour is challenging.

Child-centred Services

In many of the centres, inspectors found that the quality of child-centred practices was high. Children were aware of their rights and information about their rights was readily available. Children participated in care planning meetings, were consulted about the running of centres and supported in accessing records and making complaints if there were unhappy. Practice in relation to managing, recording and resolving complaints was generally of a high standard.

Safe and Effective Services

Inspectors found that children were well cared for by dedicated and committed staff members. The majority of children were in full-time education and supported to achieve their educational potential. They also had up-to-date care plans that guided and informed their lives.

The provision of aftercare services to children leaving centres was not equal. Some – but not all – children had access to aftercare services. This meant that not all children had the necessary supports in place in a timely manner to assist them leaving care at a vulnerable time in their lives.

Services were not always able to manage children's behaviour and this was the case for six out of the 22 (27%) of residential centres inspected in 2014. Inspectors escalated their findings and met with senior members of staff such as area managers and service directors to express their concerns about the children's safety. The purpose of individual centres was often broadly defined and allowed for the admission of children whose needs the staff could not meet. Staff needed more support and more training in order to look after such children. Five of these centres were located in the South region, two of which were closed in 2014 and two others the subject of formal reviews. One service moved premises due to fire safety concerns raised by the Authority.

In centres where behaviour was well managed, inspectors found a positive behavioural support model in place which focused on developing children's self-esteem. Emphasis was placed on children's rights and the development of relationships between team members and children. Managers and team members took prompt and decisive action in managing episodes of challenging behaviour to ensure the safety of all children and enable children to exercise self-control.

The Authority is planning to undertake a further 10 themed inspections of residential centres throughout 2015.

Governance, Leadership and Management

In some centres, there were experienced and qualified managers who provided positive leadership and effective decision-making, and as a result, children received good quality care. There was evidence of reflective practice, a rights-based approach and the development of positive relationships.

In other centres, managers were unable to provide sufficient leadership and direction to guarantee a safe, good quality service. Children were out of control at times, there were inadequate policies and infrequent supervision of staff members. Child and Family Agency monitoring officers were visiting some residential units, but not

all. There was also inconsistency in providing what is a key internal quality assurance mechanism which safeguards children.

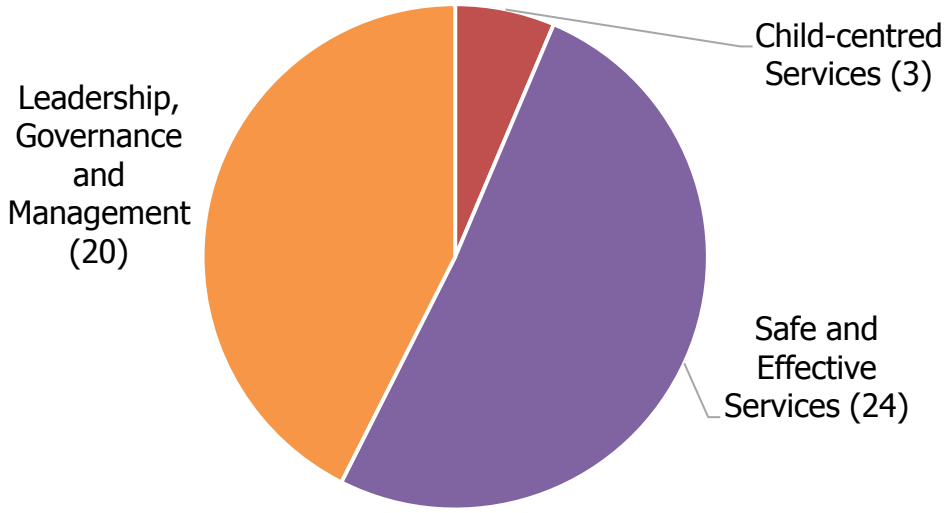
Inspectors were particularly concerned that children were admitted to centres even though their needs exceeded the capability of the staff team. The Child and Family Agency closed its national high support units in 2013 and 2014 and now all children in residential care live in children's residential centres, with the exception of those in special care units. The Child and Family Agency has stated that its own children's residential centres will provide a higher level of support, thus removing the necessity for high support units. However, inspectors found that some staff teams did not have the skills and knowledge to do this and that multidisciplinary support services were not always available to children in these centres, even though some children's needs were highly complex.

During 2015, the Child and Family Agency intends to manage residential services nationally, through a national director of children's residential services. It intended that this will provide a needs-led responsive service for the relatively small number of children living in state-provided services.

Analysis of action plans under the three themes for children's residential services

Figure 9 shows the number of actions required under each theme following inspections of children's residential services during 2014

Figure 9. Number of actions per theme required under the children's residential inspections, 2014



The Child and Family Agency was required to address 47 actions under the three themes for the 22 residential centres inspected by the Authority. Three related to the provision of information about their rights in a way in which children could understand. There were 24 actions under the theme of Safe and Effective Services and improvements were needed in:

- the safety of the service
- aftercare
- fire safety and suitable premises
- the admissions policy
- managing behaviour that challenges
- meeting children's psychological and emotional needs.

There were 20 actions issued under Governance, Leadership and Management and these were concerned with the statement of purpose, leadership, risk management and external monitoring. The Authority was concerned that in some centres, the

Child and Family Agency did not have suitably experienced, knowledgeable, skilled and well-trained staff in place.

7. Special Care Units

The Authority inspects special care units once every year and these inspections took place in the latter part of 2014. While the reports were published in 2015, they have been considered here for the purposes of this report.

Safe and Effective Services

Inspectors found that children were well looked after, staff members had a good understanding of children's rights and children had access to advocacy and guardian ad litem services. Complaints were well managed and inspectors found that children were consulted about the running of the units. The educational needs of children were appropriately assessed and met and there were good inter-professional relationships between teachers and care staff. Children had access to professionals on the Assessment Consultation Therapy Service (ACTS), which provided emotional and psychological support to children.

Statutory requirements, such as the allocation of a social worker to each child and monthly care planning reviews were fulfilled, while children participated in planning for their future. In two of the three centres, preparing children for leaving care and timely planning for onward placements needed to improve.

There were good safe care practices and practice in child protection was good. Overall, staff members managed incidents of behaviour that challenged appropriately, leading to positive outcomes for children. However, some of the security measures in one unit had the potential to adversely affect children's rights as children were routinely searched instead of searches being based on risk-assessment.

The number of restrictive practices had decreased overall, but some restrictive practices were still over-used, and in one unit children spent long periods in single separation. In this unit, the room used for single separation was unsuitable and poorly maintained. Records of single separation did not always clearly show risk-assessments as to why the intervention had been used.

Leadership, Governance and Management

Special care services were effectively managed, responsibilities were effectively delegated and there was clear oversight at national level to monitor the quality of services using weekly reports, supervision and regular visits to units. On-site managers of the units provided strong leadership and direction to team members.

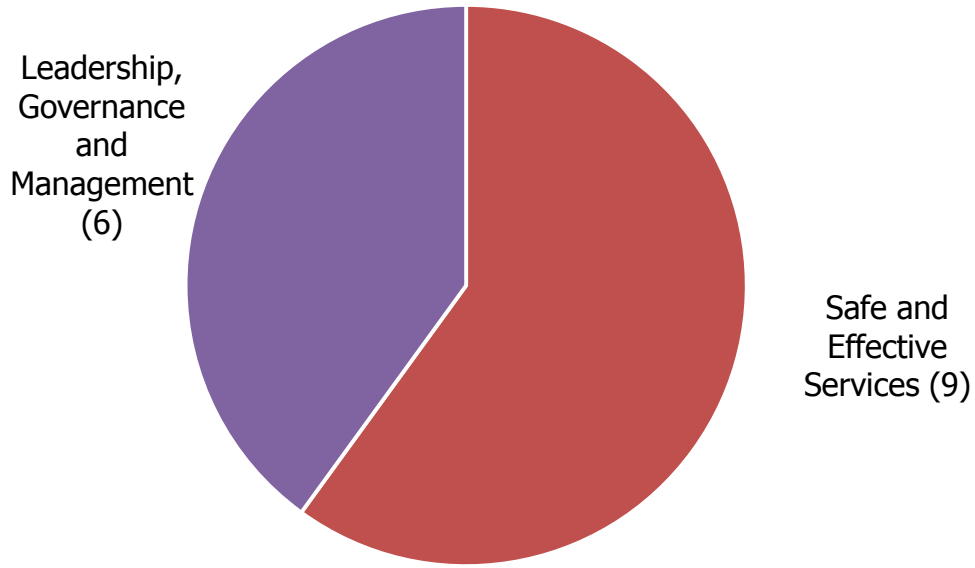
There were robust management systems with regular team meetings, communication and effective decision-making. However, in one unit, medication management practices and individual risk-assessments needed improvement.

The main actions under this theme related to gaps in risk-management systems. There was no risk register in place in any of the units to ensure the consistent identification of risks and implementation of actions to mitigate the risks. This system was being developed by the national manager responsible for special care services at the time of the inspections.

The external monitoring process to ensure compliance with the Standards and best practice was not adequate as the post of monitoring officer for special care services had been vacant for some time. This meant that senior managers could not be assured of the quality of what is a high-risk service, particularly in relation to children's rights and of their behaviour.

Figure 10 shows the number of actions required of special care units in 2014

Figure 10. Number of actions per theme required under the special care unit inspections, 2014



Due to the structure of the standards for special care units, the rights of children fall under the theme of Safe and Effective Services. There were nine actions required from the inspection of three special care units under the theme of Safe and Effective Services and six under Leadership, Governance and Management.

Part Three – the Detention Schools

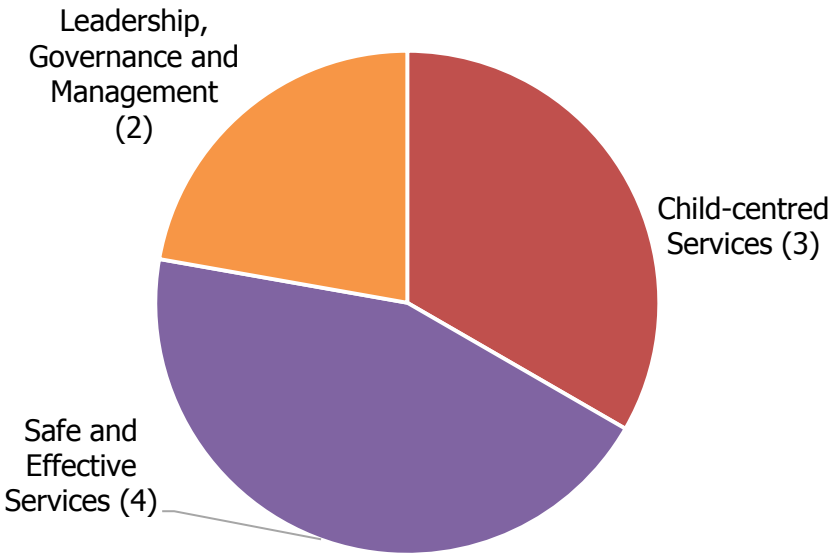
Introduction

The Children Act 2001 (as amended) is the main piece of legislation dealing with children and the criminal law in Ireland.[15] It enshrines the principles of detention, which should be considered as an option of last resort, to be used in the least restrictive way possible, and for as short a time as possible, reflecting the UN Convention on the Rights of the Child.[16] The Authority now inspects the detention schools as one service, although in statute they remain three centres. Children attend education while in detention and have access to multidisciplinary services. Whilst they are deprived of liberty as part of their sentence, the schools have a responsibility to rehabilitate children and to provide them with an offending behaviour programme.

Detention school inspection findings

Figure 11 shows the number of actions for the detention schools following inspections in 2014.

Figure 11. Total number of actions for the detention schools



[15] Main amendments relevant to this area are in Criminal Justice Act 2006.
[16] Articles 37 and 40 UN Convention on the Rights of the Child (1989) ratified by the Irish Government in 1992.

There were nine actions arising from the inspection of the detention school under the three themes and the deficits are outlined in the findings below.

Child-centred Services

Children were provided with information on their rights and independent advocates were available to them. Some, but not all, children knew about their rights. While children raised complaints on an informal and formal basis, it was not always clear how these complaints influenced change and learning across the service. Children had good access to advocacy from independent advocates and some children had court-appointed guardians ad litem.

However, consultation with children was poor and children told inspectors they did not feel listened to in terms of planning for their future or about life in the detention school. This was a safeguarding concern as it meant that children might not raise concerns or express their views on matters important to them.

Safe and Effective Services

Children's primary care needs were met and staff understood the impact of detention on children. There was a broad range of activities including summer programmes in which children were encouraged to participate, and their achievements were celebrated. However, not all children had a placement plan and the quality of such plans varied. Placement plans were not regularly reviewed and this meant it was difficult for staff members and management to monitor the progress of children towards their goals.

Children were not always safe due to poor practice in the management of medication and the management of behaviour. Due to these concerns, the Authority issued an immediate action plan and the service responded appropriately. At times, staff members struggled with caring for children safely and well. Inspectors found that not all restrictive practices were used as a last resort and their use did not comply with the detention schools' policy. Children were separated from their peers in locked rooms for long periods, and it was not always apparent that all other interventions had been tried first. Some children were in single separation to help manage staff shortages, which was not acceptable practice and which infringed on children's rights. The majority of children had no access to an offending behaviour programme to help prevent or reduce the likelihood of future criminal behaviour that had resulted in their detention.

Governance, Leadership and Management

Inspectors acknowledged that the detention campus was undergoing a process of major change including the development of a new campus, recruitment of new staff members, and standardisation of existing policies and practices. Management structures had also changed as the service moved from three distinct units into one school under the management of one single campus manager. There was a clear strategy in place to manage these changes and some progress had been made. Challenges remained in providing a safe and quality service to children residing in the detention school throughout this time of transition.

Some improvements had been made in corporate governance and in standardising policies and procedures since the last inspection. The Board of Management provided good oversight through effective reporting mechanisms and regular visits by board members to the campus.

Corporate risks were identified within the service by the senior management team and the Board of Management, and action plans were in place to mitigate these risks. There were limited quality assurance systems in place, which was of concern considering the context of significant change. The staffing rota was an area of contention between staff and managers and negotiations had recently commenced with trade unions in this regard.

There was a qualified and experienced staff team in place but the provision of training needed to improve to ensure children received quality care. Mandatory training had not been provided to all staff and the Authority issued an immediate action plan in this regard. Supervision was infrequent and the day-to-day management oversight within the units needed to improve to ensure all records were appropriately maintained and that staff members adhered to policies and procedures.

Part Four – designated centres for children with disabilities

Introduction

On 1 November 2013, in line with a commitment in the Programme for Government, 2011–2016, the Authority commenced regulating designated centres for adults and children with disabilities. Regulation is carried out through the process of registration, ongoing monitoring, and, where necessary, the application of powers of enforcement.

Inspections of residential care centres for children with disabilities are conducted using the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the *National Standards for Residential Services for Children and Adults with Disabilities* (May 2013, HIQA).

There are three types of residential centres for people with disabilities: centres for adults, centres for children, and centres that provide services for adults and children, which are often respite services. Centres for children only account for approximately 5% (65 as of December 2014) of all designated centres for people with disabilities and these are inspected by the Children's Team in the Authority.

Two main types of inspection were carried out on designated centres for children with disabilities: monitoring inspections and registration inspections. Registration is a process through which providers are assessed in respect of their fitness to deliver services, and services are inspected for their compliance with standards and regulations. All centres must be operating with a certificate of registration by 1 November 2016.

Monitoring activity and regulatory action in designated centres for children with disabilities

Notifications received in 2014 under the Health Act 2007

For designated centres for children with a disability, legislation requires providers to notify the Chief Inspector of specified incidents within three days of their occurrence. The purpose of these notifications is to alert the Authority to potential risks to the health, safety or wellbeing of residents.

Upon receipt, notifications were risk-assessed by the inspector assigned to the centre. As part of the assessment, the inspector considered the impact and the likelihood of any risk arising from the incident, together with the centre's regulatory history. The inspector's response to a notification ranged from reviewing the

information at the next inspection, requesting additional information or documentation from the provider, or scheduling an inspection visit.

The Authority received 96 of these notifications in 2014 (see Table 8). The highest number of notifications related to allegations of abuse (34). Of these, 12 were allegations of peer-on-peer abuse as a result of challenging behaviour between children. Thirteen were allegations of abuse by care staff or other professionals, seven were allegations of abuse by relatives and in two cases, the alleged abuser was unknown.

The Authority was particularly concerned about the unauthorised absences of what are extremely vulnerable children and followed up on these issues with providers. Providers submitted their investigations of such incidents, some of which were for very short periods of time, and where the Authority was not satisfied about the safety of the service further regulatory action was taken. Six of the 12 notifications related to one young adult (living in a children's centre) who left the centre without informing the staff team but who subsequently returned. The Authority took a uniform approach following the receipt of notifications about serious injuries, and inspectors sought further information if they were concerned about the safety of the service provided.

The number of notifications referring to loss of power or water in a centre was high during 2014, as even short utility outages were reported. In addition, the Authority receives quarterly reports on the occurrence of certain events in the centre, and notifications of periods when the person in charge is absent from the centre and of the arrangements in place during the absence.

Table 8 shows a breakdown of the number and types of notifications received during the year.

Table 8. Number and types of notifications

Description of notification	Number of notifications
NF01D Notification of the unexpected death of any resident	1
NF03D Any serious injury to a resident which requires hospital treatment	18
NF05D Any unexplained absence of a resident from the designated centre	12
NF06D Any allegation, suspected or confirmed abuse of any resident	34
NF07D Any allegation of misconduct by the registered provider or staff	6
NF08D Notification of a professional body review of a staff member	1
NF09D Any fire, loss of power, heating or water and any unplanned evacuation of the centre	24

Escalation and enforcement

For 65 disability centres inspected, 15 escalation activities were taken and there were eight immediate action plans issued. These related to concerns about health and safety issues in the centres. There were also concerns about poor medication management, inappropriate placements of children and poor management of some centres. Two notices of proposal to cancel registration were issued due to concerns about the fitness of the provider to provide safe care to children.

Inspection findings

Child-centred services

Inspectors found that practice was good in relation to children's rights, dignity and consultation, but the management of challenging behaviour affected the individual rights of some children.

Children were encouraged in their individual interests and were involved in meaningful activities. Children went out in the community but further improvements were required to maximise their involvement. There was some consultation with children and families on personal plans, but there was limited consultation with them about the running of the service. The majority of providers shared information about their service with children and families in an accessible format, however, information on advocacy services was not routinely available.

The children's communication needs varied and for some children without speech, other means of communication were required. Inspectors found that staff were generally aware of the individual communication needs of children and supported children to communicate. The majority of personal plans included the individual communication requirements of children, some of which were developed with speech and language therapists. These plans informed practice. Communication plans in some centres required improvement to ensure they had sufficient detail to inform practice. Inspectors observed staff listening to children and repeating back what they had heard in order to ensure they had understood what the children had said to them. They used communication systems such as signing or the use of the Picture Exchange Communication System, known as PECS. In the majority of centres, there was training provided to staff in different communication techniques.

Most staff teams had established positive relationships with families and supported good relationships between children and families through regular contact, often supplying transport and facilitating visits.

Safe and Effective Care

Inspectors found examples of good quality personal plans, developed in consultation with children and families. These plans informed the care of children and were regularly reviewed to ensure they continued to be meaningful in improving outcomes for children and ensuring services were meeting their needs.

There were also examples of poor quality plans which were not sufficiently detailed to inform the care of children. This meant that specific plans for the provision and monitoring of personal care to ensure that all children were safeguarded were not in place. Reviews of care plans were either infrequent or did not occur, which meant

that providers could not be assured that the care was meeting the needs of children and improving their lives as they were growing up.

There were good safe care practices in the majority of centres. Inspectors observed staff members interacting with children in a respectful, warm and dignified manner. Staff members interviewed by inspectors knew about the different types of abuse and the specific vulnerabilities of children with disabilities. The majority of centres had designated liaison persons as required under Children First (2011) and the majority met by inspectors had a good understanding of their responsibilities. Some staff members did not know how to make a protected disclosure, but were able to identify how they could raise concerns about practices.

However, not all staff had received training in *Children First: National Guidance for the Protection and Welfare of Children* (2011). In some centres, staff did not have a good understanding of their roles and responsibilities under this guidance.

There were insufficient formal systems or guidance in place in some centres for managing behaviour that challenges. Children with behavioural issues can be particularly vulnerable and some services had inadequate behaviour management procedures and poor behaviour support plans. This meant that children could be treated inconsistently or inappropriately. Inspectors found that on occasion, children's rights had been seriously neglected, or that staff actions had impacted negatively on these rights. Inspectors found some unnecessary or inappropriate use of CCTV, while some children's liberty was restricted excessively or unnecessarily.

There were adequate systems in place to report incidents and accidents, and such issues were notified to the Authority in the majority of centres. Staff members and managers interviewed demonstrated a good knowledge of their responsibilities in relation to recording and reporting such incidents.

Governance, Leadership and Management

Of the centres inspected, the majority had defined management structures with clear lines of authority and accountability. The persons in charge had a good understanding of most of their roles and responsibilities under the regulations and implemented them in practice.

Policies and practices in risk management needed improvement in a number of centres. Risk management policies were not up-to-date and the risk management process was not sufficiently understood or robust enough to allow further identification and management of all significant risks. A more effective system to identify and manage risk with regard to the specific vulnerabilities of children living in a number of centres was required.

Improvements were also required in managing the placement of children in centres to ensure the placement met the needs of individual children and did not place other children at risk. Effective assessment of needs and appropriateness of the placement did not occur in some centres. The impact was that some children moved placements following their admission because staff members were unable to provide them with quality and safe care.

Many actions related to the lack of strong internal quality assurance mechanisms. Inspectors found that few providers had annual reviews of the safety and quality of care as required by the regulations. This meant there was no formal internal system to check the ongoing quality and safety of the service provided to children.

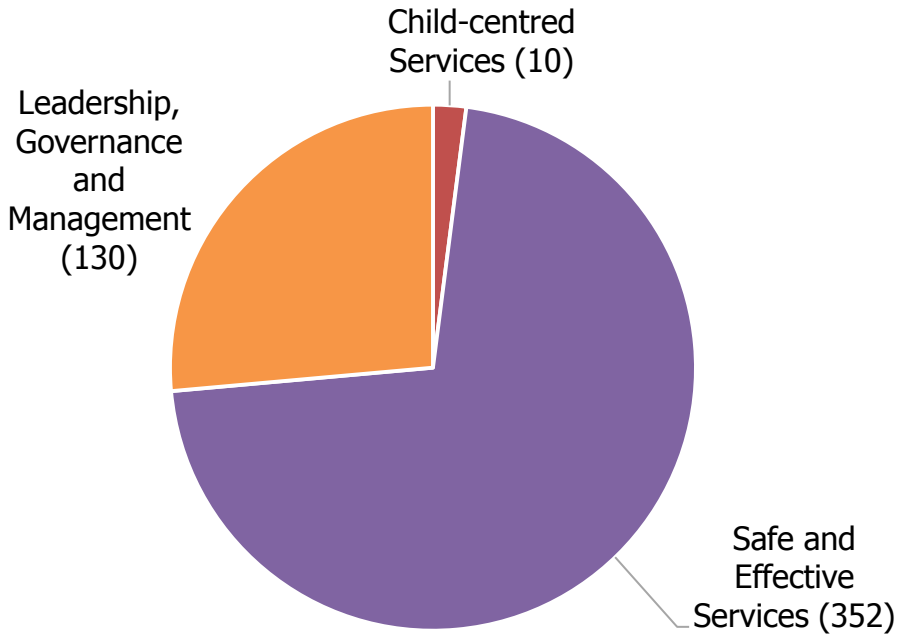
While some providers had comprehensive policies, a number did not. Some did have policies, but they were either not sufficiently detailed to guide safe practice, or had not been recently reviewed or revised.

Additional actions related to the centres' statements of purpose, as in many cases these did not meet all of the requirements of Schedule 1 of the regulations.

Analysis of action plans under the three themes for designated centres for children with disabilities

There are 65 designated centres for children with disabilities as of December 2014 and the 75 inspections were carried out in 2014, which generated 492 actions under the three themes. Figure 12 sets out the number of actions required under each theme.

Figure 12. Total number of actions for children's disability service inspections



It was encouraging to find that very few actions were generated under the theme of child-centred services as the sector has a long and often positive history in this regard. In the first year of regulation it is to be expected that providers will need to make many improvements to comply with regulations and meet standards. It is not surprising that the inspections generated significant numbers of actions under safe and effective services and for the leadership of those services. It will be possible in 2015 to undertake a more detailed analysis and draw conclusions about the regulations and standards on which inspectors and providers should focus.

Conclusion

During 2014, there was some evidence of improving services and good practice in children's social care. Most children in care were well cared for and the number of children in residential, special care units, designated centres for children with disabilities and detention schools was small in line with good practice. In the main, children received services provided by committed and hard working staff.

There were a significant number of cases unallocated to social workers, and in some cases children waited for key social work interventions. Some children in care did not have a social worker or a care plan and many foster carers did not have link workers. Some residential centres and special care units did not have external monitoring due to staff vacancies. Indubitably, resources had an impact on services, both in terms of personnel and in areas such as information systems and these issues arose in previous overview reports.

In some instances, the needs of children in residential care were not met across all types of service. Staff could not always manage behaviour that challenged and this affected other children. Some children's liberty was restricted inappropriately and their rights were undermined. Other issues such as poor matching processes for children moving to foster care or weak admissions processes for children entering children's residential or disability services undermined the quality of services and the stability of their placements.

In all sectors, leadership, governance and management were the key determinants of good quality safe services. For the Child and Family Agency, HSE Disability Services and other providers, planning, quality assurance and risk management were all areas which remained underdeveloped.

The findings of the 2014 overview inform the Authority's business plan for monitoring and regulating children's services in 2015, with the aim of driving their improvement and safety.

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