Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Opening statement to the Joint Committee on Children and Youth Affairs

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Chief Inspector of Social Services and Director of Regulation

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Chairperson, members, on behalf of the HIQA, I wish to thank you for the invitation to address the Joint Committee on Children and Youth Affairs this afternoon. I am accompanied by my colleague Eva Boyle, Inspector Manager in HIQA's Children's Team

HIQA's role in the monitoring and inspection of Oberstown Children Detention Campus

HIQA was established 10 years ago to improve health and social care services for the people of Ireland. Our role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA has statutory responsibility for monitoring and inspecting children's social services, including children's statutory residential centres, special care units, foster care services, child protection and welfare services and Oberstown Children Detention Campus.

HIQA is legislated to inspect Oberstown under sections 185 and 186 of the Children Act 2001, as amended by section 152 of the Criminal Justice Act 2006. This provides for the inspection of the Children Detention Campus at least every 12 months.

Oberstown is a national facility for the detention of young people. Secure care and education is provided to both boys and girls under the age of 18 years who have been remanded to detention while awaiting trial or sentence, or who have been committed to detention after conviction for criminal offences. Oberstown is governed by a board of management, who are appointed by, and report to, the Minister for Children and Youth Affairs.

External operational review — November 2016

A number of reviews were commissioned by the board of Oberstown in the latter half of 2016 and in early 2017, including an external operational review carried out by Professor Barry Goldson and Professor Nick Hardwick in October and November 2016. The purpose of this review was to "evaluate practice and policy in line with international standards and best practice, to identify obstacles or barriers to achieve greater implementation of international standards and best practice and to make recommendations to ensure greater and more successful implementation of these standards"[1].

[1] Oberstown Children Detention Campus, Summary Report of External Reviews, July 2017

To facilitate this operational review, HIQA deferred an announced inspection, which had been due to take place in the last quarter of 2016. HIQA met with the external reviewers at the end of October 2016 and an update was provided by Oberstown in December on the actions they had taken to address the findings of the HIQA inspection in 2015. The decision to defer the inspection was taken on the understanding that the report on the operational review would be made available to HIQA upon completion, as confirmed by the Chairperson of the Board of Oberstown in November 2016.

While HIQA received a copy of the recommendations arising out of the operational review from the Chairperson of the Board of Oberstown in August 2017, we were not provided with a copy of the review report. HIQA sought access to the report, but we were informed, again by the Oberstown chairperson, that following legal advice, these findings would not be published.

Summary of inspection findings — March 2017

Children residing in detention require a high-quality, safe service that helps them to address their offending behaviour. Staff must be able to maintain nurturing relationships in order to achieve positive outcomes. Furthermore, good governance is fundamental in order to achieve consistently good outcomes.

In March 2017, Oberstown Children Detention Campus was undergoing major changes. The enactment of the Children (Amendment) Act 2015 in June 2016 provided for the amalgamation of the three existing schools into a single entity and a new board of management was appointed in June 2016. Many new structures were subsequently put in place, including new governance arrangements; new senior managers were recruited and a human resources section was established. The workforce increased, the training programme improved and a system of formal supervision was introduced. In addition, a new system of placement planning for young people was also implemented.

<u>Findings of compliance</u>

The school is operated under the patronage of the Dublin and Dún Laoghaire Education and Training Board and is subject to inspection by the Department of Education and Skills. At the time of inspection, all children were attending school. All children interviewed said they loved school and their parents told us that they were very happy with their attendance. Children could undertake a broad range of subjects and sit state exams. In 2016, twenty children successfully undertook the Junior Certificate Examination, while 74 were awarded Quality and Qualifications

Ireland (QQI) certificates. Educational needs assessed as part of admission process, as well as the communication between teaching and care staff, were good.

A new statement of purpose and function was approved by the board of management in April 2017 and submitted to HIQA prior to completion of the inspection report. Key stakeholders were consulted in the 12 months prior to the inspection, which included a survey of the young people on the campus and consultation with agencies providing services to the young people.

Findings of moderate non-compliance

While the positive measures outlined above were acknowledged by inspectors, six inspection findings indicated the need for further improvement, particularly with regard to the consistent implementation and bedding-down of new structures, practices, and safeguards in the best interests of the young people detained on the campus. This included the need to ensure:

- the provision of a stronger complaints process for young people
- training in Children First for all staff
- that all young people's care was informed by placement planning
- that all young people had access to an offending behaviour programme,
- and that all staff received regular formal supervision.

Findings of major non-compliance

There were two findings of major non-compliance related to healthcare and the use of single separation.

1) Healthcare

The provision of healthcare on the campus had improved. Children had access to dental services once a week (a dentist and a dental nurse) and a psychiatrist was available on a weekly basis. A general practitioner service was available on campus three times a week and three nurses were employed, two of whom had commenced employment in February/March 2017. Inspectors were also informed of a plan to recruit a fourth nurse to enhance the service. All children received medical assessments on admission or shortly thereafter, and were referred for specialist treatment if required.

However, HIQA identified that children were not always provided with access to external medical services in a timely manner and that some medicines management practices were unsafe. Two significant incidents occurred in relation to accessing a

timely service: one child waited 19 hours before receiving hospital treatment despite the recommendations of a nurse; while another child who complained of a wrist injury waited a number of weeks before receiving an x-ray, as it was deemed too risky for the child to leave the campus.

Furthermore, medicines management practice was not always safe. An immediate action was required in relation to two issues:

- safeguarding a young person with regard to the administration of a prescribed medication, should it be required, and
- ensuring that measures were in place to store medicines securely.

The campus director was required to provide a written response to these issues and inspectors observed new controls being implemented over the course of the inspection.

All medication administration records reviewed by inspectors showed some gaps in terms of recording. The signature of the staff member administering the medication, the time of administration, or the strength of the dose administered in relation to non-prescribed medication were not recorded consistently.

2) Use of single separation

There were improvements in the analysis of single separation records from mid-2016, which allowed managers to identify the number of incidents based on the the reason the intervention was used. The reasons for placing young people in single separation were, in general, clearly recorded, as were the actions of the young people during that time. Records also pointed to good attempts by staff to interact with children while they were in single separation.

However, the policy on the use of single separation was not consistently adhered to by staff or management. The inspection team's judgement of major non-compliance related to the lack of strong management oversight of the monitoring of incidents of single separation, and poor recording of same. Records did not always show that single separation was the least restrictive practice available at that time, or outline what other interventions were used before or during the use of single separation, in line with policy.

The authorisations for the approval of the use of single separation, and the extensions to the periods of time spent in single separation, were not always completed by managers, in line with policy. Where signatures were in place, records did not always contain dates, times, and the reasons for extensions. For example, in

the case of two children, there was no evidence of the authorisation or review — for four out of six days for one child, and for three out of seven days for the other — of the time these children spent in single separation. Lack of access to fresh air or outdoor exercise while in single separation, and the reasons for same, were also not clearly recorded.

In the absence of good quality recording, assurances could not be provided to senior managers or to the members of the board that periods of separation were in line with safe practice, or that they were given adequate consideration and deemed necessary by the relevant managers.

Action plans following inspection

Following inspection in March 2017, Oberstown submitted an action plan outlining the measures to be taken to address the deficits in practice outlined in the inspection report. HIQA sought updates in relation to these deficits and the actions being taken to mitigate them, including specific timelines, and requested information to clarify some of the proposed actions.

The 2018 inspection of Oberstown will seek confirmation that the corrective measures outlined in response to the deficits identified during the 2017 inspection have been developed and consistently implemented across the campus. This will include the progress made in implementing the recommendations of various reviews, and the extent to which this exercise has served to safeguard and promote the safety and rights of the young people detained in Oberstown.

I would like to thank the committee for inviting us here this afternoon. We would be happy to answer any questions you may have.

ENDS

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