Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of Oberstown Children Detention Campus

Name of provider:	Oberstown Children Detention Campus
Type of inspection:	Announced
Date of inspection:	12 – 14 September 2023
Centre ID:	OSV - 0004225
Fieldwork ID	MON-0039831

About the service

Profile

Oberstown Children Detention Campus provides safe and secure care and education to young people between 10 and 18 years who have been committed to custody after conviction for criminal offences or remanded to custody while awaiting trial or sentence. Their aim is to support young people to improve decision-making capacity, move away from offending behaviour and prepare them to return to their community following their release from detention.

Accommodation

The Oberstown Children Detention Campus is located in a rural setting in north Dublin. It comprises six residential units for children, a school building, outdoor and indoor recreational facilities, and a reception and administration block which contains medical and dental facilities and facilities for young people to meet their visitors and other professionals involved in their care. The design and layout provided adequate private and communal facilities for the young people both in terms of indoor and outdoor space. The campus had external security fencing.

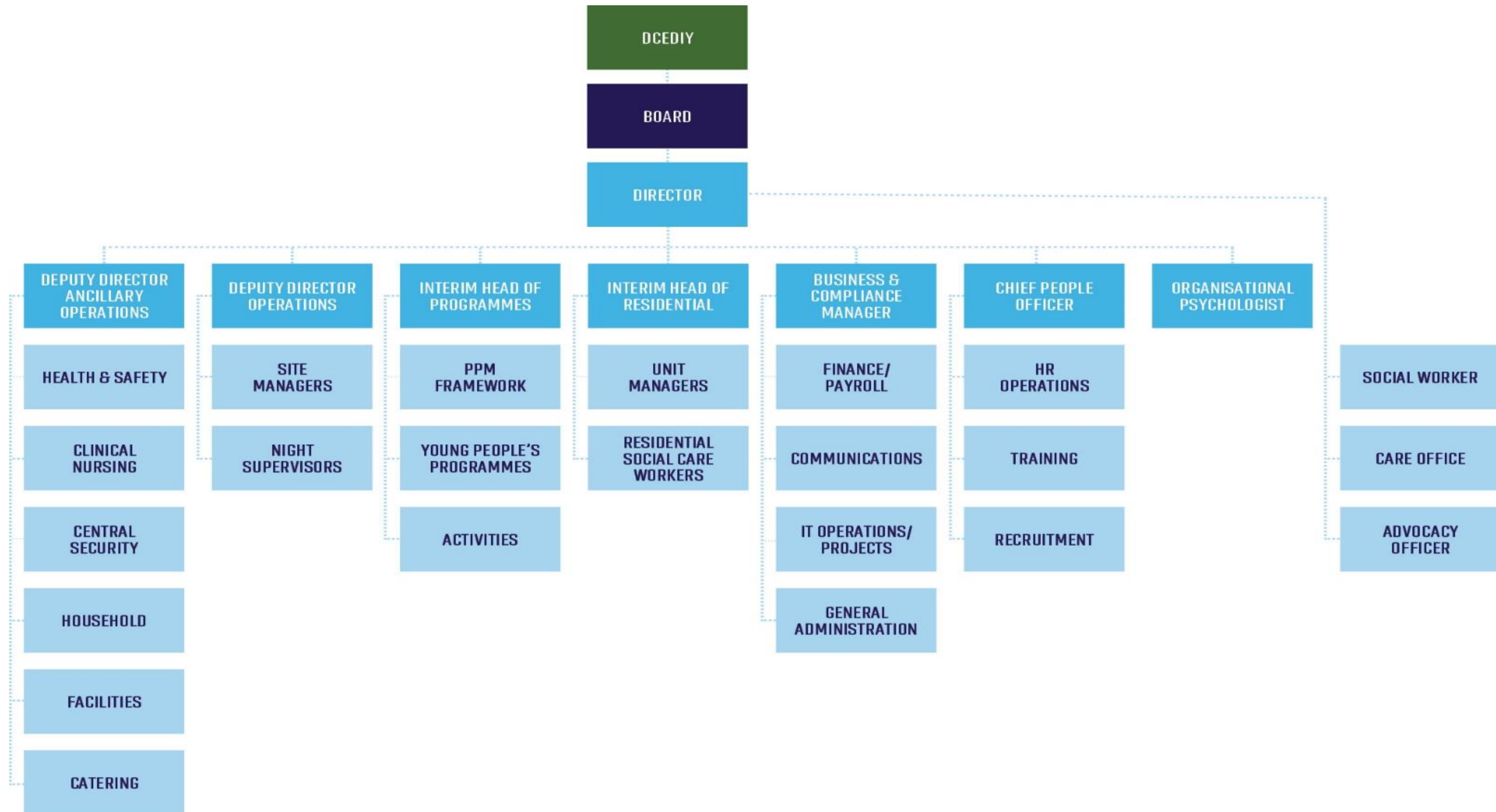
Management

Oberstown Children Detention Campus is managed by a board of management who were appointed by, and report to, the Minister for Children, Equality, Disability, Integration and Youth. The board of management has direct governance of the Oberstown Children Detention Campus in accordance with policy guidelines laid down by the Minister for Children, Equality, Disability, Integration and Youth through the Irish Youth Justice Service (IYJS), in accordance with the Children Act, 2001, as amended. The director is responsible for the day-to-day operation of the campus as well as acting in loco parentis[1] (in place of a parent) to each child in custody. Each unit within the campus is managed by a unit manager. The organisational chart in Figure 1 describes the current management and team structure and is based on information provided by the Oberstown Children Detention Campus following the inspection.

[1] Loco parentis: refers to an adult responsible for children in place of a parent.

[2]Organisational structure

Figure 1 - Oberstown Children Detention Campus organisational chart



[2] Submitted organisational structure as of September 2023.

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this service. This included any previous inspection findings and information received since the last inspection.

As part of our inspection, where possible, we:

- speak with young people to find out their experience of the service
- talk to staff and management to find out how they plan, deliver and monitor the care and support services that are provided to young people who are placed in Oberstown
- observe practice and daily life to see if it reflects what people tell us
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

The Oberstown Children Detention Campus Children's Rights Policy Framework contains the 'rules' against which the service is inspected by HIQA.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the rules under two dimensions:

1. **Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. **Quality and Safety of the service:**

This section describes the care and support children receive and if it was of a good quality and ensured that people were safe. It includes information about the care and supports available for people and the environment in which they live.

A list of all rules and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
12/09/23	10:00 – 17:15	Sheila Hynes	Lead Inspector
12/09/23	10:00 – 17:15	Adekunle Oladejo	Support Inspector
12/09/23	10:00 – 17:15	Caroline Browne	Support Inspector
12/09/23	10:00 – 17:15	Saragh Mc Garrigle	Support Inspector
12/09/23	10:30 – 17:15	Lorraine O'Reilly	Support Inspector
13/09/23	09:00 – 17:15	Sheila Hynes	Lead Inspector
13/09/23	09:30 – 17:15	Adekunle Oladejo	Support Inspector
13/09/23	09:00 – 17:15	Caroline Browne	Support Inspector
13/09/23	09:00 – 17:15	Saragh Mc Garrigle	Support Inspector
13/09/23	09:00 – 17:15	Lorraine O'Reilly	Support Inspector
14/09/23	07:45 – 16:15	Sheila Hynes	Lead Inspector
14/09/23	09:00 – 15:30	Adekunle Oladejo	Support Inspector
14/09/23	09:00 – 16:15	Caroline Browne	Support Inspector
14/09/23	09:00 – 16:15	Saragh Mc Garrigle	Support Inspector
14/09/23	09:00 – 15:00	Lorraine O'Reilly	Support Inspector

Number of children on the date of inspection:	38

What children told us and what inspectors observed

At the time of inspection there were 38 young people placed in Oberstown Children Detention Campus. Inspectors were on site for three days and had the opportunity to meet with 29 of these young people. Inspectors spent some time in all residential units and observed routines and interactions between staff and young people. Inspectors observed young people's meetings, two offending behaviour programmes sessions and attended a placement planning meeting.

Surveys were sent to the young people prior to the inspection to complete, asking them about their experience of the service. A total of 28 surveys were returned. Inspectors also spoke with eight parents and guardians, a social worker and a guardian ad litem[3] (an individual appointed by the court to represent the best interests of a minor child in legal proceedings) in order to gather their views and experience of the service.

Inspectors met with young people in the residential units at various times, during the young people meetings, during their lunch break and after attending an offending behaviour programme. Inspectors found that the young people appeared to be comfortable and relaxed in the company of staff and conversation flowed easily. Inspectors observed positive and supportive interaction between staff and the young people.

The young people spoke about their everyday experiences of their care, and most of them were positive about their experience, commenting they were "fed like a king" and "wake up and get fresh towels". Other young people felt that the food wasn't very good. In terms of their daily plan, young people stated they were "getting to do different programme and activities", "I would like to see more activities – more practical stuff" and "things (activities) they asked you to do are not helpful when you get back in the community". Two young people told inspectors that low staffing levels impacted on their care, stating "we have missed activities because there is not enough staff" and "get us more staff, it is not nice when we are being asked to go to our room because there is not enough staff". One parent told inspectors that their child said that they were stuck in their bedroom because there was not enough staff.

Young people were generally positive about their involvement in their placement plans. Almost all young people felt that staff listened to their views and that their views impacted on decision-making. Inspectors observed two young people's meetings that had good engagement from the young people, who were encouraged and reminded by

[3] An individual appointed by the court to represent the best interests of a minor child in legal proceedings

staff to raise issues they had discussed outside of the meeting setting. Generally, young people chaired the meetings, however, in one residential unit, the unit manager chaired the meeting as it was a new group and they felt it was important to demonstrate the process. Young people were positive about their meetings and felt that this was how they got things changed.

Some young people had the opportunity to be part of the campus council and could bring issues that impacted on them to these meetings for discussion. Meals and mealtimes were a big issue that resulted in a food convention being held. This was attended by the campus council, deputy director, catering manager, nurse manager, training manager, school principal, advocacy officer and residential social care workers. They discussed what was working well and where improvements could be made. This resulted in changes to mealtimes that were made possible with agreement by the catering staff to change their roster. There were also changes to the meals on offer, with young people requesting more nutritionally balanced meals. Young people were consulted on policy and procedures and interview questions for upcoming interviews for new roles in the service.

The young people were offered places on programmes to help them to address their offending behaviour. Over two thirds of young people surveyed felt that they were helped to understand their offending behaviour. One young person commented, "reflecting on my behaviour, thinking back, I got happier on the last day". Young people who spoke with inspectors had completed different programmes and said the programmes were "ok" and "passed the time". Inspectors observed two programmes where the facilitators provided good-quality, engaging programmes for the young people.

Almost all young people who spoke with inspectors and or completed a survey understood how to make a complaint. Young people knew the designated liaison person (DLP) and the advocacy officer who were both regularly in the residential units. Some young people said that they would go to their key workers[4] if they had a problem, stating "my key workers try to solve the problem for me". Most young people were aware of their rights and could remember being given information on their rights on admission. Fourteen young people surveyed said they had not been given information on what to do if they felt worried or upset.

Some of the young people had experienced restrictive practices. Overall, young people found single separation[5] difficult, some commenting that it was "depressing", "stuck in

[4] Key worker: Residential social care worker assigned to case management duties for young people detained in Oberstown Children Detention Campus.

[5] Single separation: This is when a young person is separated from his or her peers to a room for as short a period of time as is necessary, due to one or both of the following reasons: where a young person is likely to cause significant harm to him or herself or others; where a young person is likely to cause significant damage to property that would compromise security and impact on the safety of others.

your room all day" and "the experience is lonely". Other young people felt that "staff use their power to put us in single separation for no good reason" or for "banging a door". Some young people expressed that they did not mind single separation but "felt like it did not help with how I was feeling at that time, triggered more by being in separation". Some young people had experienced physical intervention and found this was a difficult experience they said, "it was overwhelming but understandable" and "disgusting, disrespectful to me and other peers".

Young people had access to their solicitor and legal advice, and staff would arrange a call or visit with these people if that is what they wanted.

Parents and guardians generally spoke positively about the impact that the service was having on the young person. Some of their comments included:

- "any child that goes in there is well looked after" and "it won't be like that in adult prison"
- "the staff are gems"
- "I think they are definitely engaging well"
- "enjoying activities"
- "good contact with staff"
- "hopefully gets on now and has a better future"
- "Staff are great"
- "can't fault staff"
- "staff have a good understanding"
- "can't give out about that" (quality of care)
- "kept safe in there"
- "I can't praise Oberstown enough, my son went off the rails, then the crime happened, but Oberstown has been a godsend"
- "my experience for my child is they are a blessing in disguise, he needed it"
- "I think the care is excellent that he is getting"
- "I find the staff very helpful and I wouldn't have a bad word to say against them".

There were some issues raised by parents and guardians. One parent told inspectors they had not been invited to a placement planning meeting, however, they visited their son every second week and that was very positive. Another parent said that their child was not able to leave their bedroom when there was not enough staff. A guardian raised concerns about the future planning for when the young person is released and the challenges that this will bring to their family. The visits behind glass were a challenge for some of the young people's younger siblings, however, the information booklet parents and guardians received from the service helped siblings understand the reasons why some rules were in place.
Both external professionals that spoke with inspectors felt that the young people were cared for, safe and the visiting facilities were good quality. However, they expressed

concern that there were delays in accessing offending behaviour programmes and therapeutic support. They both experienced communication difficulties from the service. They said there was "very little contact with staff" and it was "difficult to get information from Oberstown."

The next two sections of this report present the findings of this inspection on how the service was managed and governed and how this impacted on the quality and safety of the service provided to young people placed there.

Capacity and capability

This inspection focused on six of the 12 rules against which the service was inspected by HIQA under Oberstown Children's Rights Policy Framework.

The service had a clearly defined management structure that identified the lines of authority and accountability. The director and the senior management team had a clear vision for the service that was supported by well-defined service values, with a focus on continuous improvement. The director was highly experienced and provided good leadership to support the vision for the service. However, there were gaps in the governance and oversight of the service that impacted on service delivery. Significant improvements were needed in relation to the oversight of practice, not all staff had received supervision in line with the service's policy during the transition period from one model of supervision to a new model of supervision. There had also been issues regarding having a sufficient number of staff to meet the needs of the young people detained in the service. The revision dates for a number of procedures had passed and these needed to be reviewed and updated to reflect best practice. While progress was evident since the introduction of the electronic case management system (CMS), further improvements were required to ensure that the quality of record-keeping supported the oversight, management and governance of the service. Mandatory refresher training in *Children First: National Guidance for the Protection and Welfare of Children* (2017) was cancelled and had not been rescheduled, resulting in staff not having an appropriate level of up-to-date training in Children First.

The service is licenced for a maximum occupancy level of 46 young people (40 males and six females). At the time of the inspection there were no females detained on the campus. The statement of purpose and function was approved by the board of management on 14 September 2022. The statement included the vision for the service which was to provide young people with the highest standard of rights-based, child-centred care that meets their needs and enables them to maximise their potential. This was envisaged to be achieved through the individualised care framework in operation in the service. The business plan for 2023 and strategy for 2022 – 2026 supported the vision, values and strategies as set out in the statement of purpose and function.

The service had published an annual report for 2022. The report provided the public with an account of the service through an explanation of the model of care, life on the campus for the young people and how young people were supported to address their offending behaviour and have positive outcomes. The report detailed a wide range of programmes, activities and training provided to the young people, along with a bespoke interactive careers programme and a career file to support future planning. The report outlined how the voice of young people was captured throughout the year through engagement with internal systems such as the campus council and with external agencies such as the Ombudsman for Children's Office. There was an overview of working in the service that included a wellbeing framework which supported staff under four headings; work safe, work healthy, work well and work wise. The report outlined the activities that took place throughout the year that supported this framework.

The service is governed by a board of management appointed by the Minister for Children, Equality, Disability, Integration and Youth and operated in line with legislative requirements. The Board provided oversight and strategic direction to the service and supported the director to deliver the strategic plan. The service 'Strategy 2022 – 2026' was approved by the board of management in April 2022 which supported the purpose, vision and values of the service. It sets out five strategic goals with a focus on action planning with key performance indicators. A young person's version of the strategy was developed in consultation with the campus council and a copy was given to each young person. Inspectors reviewed a sample of board of management minutes and found that the strategy implementation and progress was discussed routinely. In terms of public accountability and transparency, the service had an informative website where the Annual Report 2022, the 'Strategy 2022 – 2026', statistical information and other information was available.

The service Business Plan 2023 was also linked to the five strategic goals in the service strategy. Inspectors found that the business plan was ambitious and reviewed the most recent update on the progress. It reported that 13% of tasks had been completed, 48% were in progress, 21% were at risk and 18% had not been started. The director spoke with inspectors about the challenges recruiting senior management roles, which appeared to have had an impact on aspects of the business plan progressing.

An external agency had completed a capability review of the service. A committee was established to oversee the implementation of the capability review, which included the implementation of the new organisational structure. Three roles associated with the new organisational structure were advertised, shortlisted and interviews had been conducted. At the time of the inspection, the role of the health and safety fire officer had not been filled.

There were a number of committees that supported the management team. These included a governance committee, performance committee, audit and risk committee, strategy committee, sustainability committee, people and culture committee and a young people's committee. The terms of reference for these committees was approved by the board of management and minutes arising from these committee meetings were reviewed by the board. Inspectors found that these committees performed important functions in progressing the provision of a safe and effective service.

Risk management was an integral part of the care and support provided to the young people, and was underpinned by a risk management framework. Risk was monitored and managed in the service with clear lines of accountability within the senior management team and specific action planning. The service risk register was regularly reviewed by the audit and risk committee. Inspectors reviewed the risk register for September 2023 and found that it covered the risks that would be associated with a detention campus, along with additional high risks such as insufficient staff due to unfilled vacancies. The risks were clearly described, categorised, with control measures in place, appropriately risk rated, assigned to a member of the senior management team, with clear action planning and time frames. At the time of the inspection there were 12 identified risks for the service, four of these were risk-rated 'high' and the remaining risks were rated 'moderate'. The security of the campus was maintained and monitored by management through the risk register.

The service had a schedule of routine meetings which included senior management, operational committees, multidisciplinary, and staff meetings. The senior management team met on a weekly basis to monitor the safety and the quality of the service. Inspectors found from a review of meeting minutes that there was good-quality oversight of most aspects of care and operations across the service. The senior management team provided updates on key developments in their area of responsibility. Additionally, there were discussions on matters arising and finding of audits carried out by an external service. These discussions were followed by agreed action plans.

Inspectors observed a number of meetings during the inspection which included care planning, multidisciplinary team[6] meetings and staff meetings. There was evidence of a collaborative and child-centred approach to discussions held. Staff, management and the multidisciplinary team had a high level of knowledge of the care needs of the young people and the supports that they required. There was also good communication between staff and school teachers regarding the needs and challenges young people were experiencing. The management and staff were committed to providing safe and appropriate care to the young people. It was evident that concerns regarding the service and the care of the young people could be raised through these meetings. Staff informed inspectors that they were aware of the service's protective disclosure process.

Twelve campus procedures had been updated and approved by the board of management in previous 12 months. These included procedures on hot debrief[7] , use of handcuffs on a young person in the care of Oberstown, implementation of the individual recovery programme, and visits. Operational policies and procedures were consistent with relevant legislation, professional guidance and international best practice. All changes to procedures were tracked and recorded centrally. Inspectors found that staff were knowledgeable on the policies and procedures and had access to these in written format. However, the revision dates for eight procedures were outside their required timelines. These included the admission procedure, placement planning procedure and procedure for making an incident, accident and assault notification. There were three additional procedures that had been updated but the review date was less than 12 months, and this date had passed. These included the procedure on single separation and two procedures regarding the types of searches conducted on the campus. This may have contributed to a lack of clarity, inconsistencies in practices and errors in recording. For example, inspectors found that young people's right to access fresh air was not always upheld and authorisations for single separation were not always within the procedure time frames and or recorded. Additionally, it was difficult to follow the young people's incidents of single separation, as the period of single separation ended either when the risk was resolved or at bedtime. If the risk was not resolved, another incident of single separation started once the young person woke up the following day. This created a difficulty in understanding the young person's experience of being in single separation as a single risk could result in multiple incidents been recorded.

[6] Multidisciplinary team: A team involving a range of health and social care professionals from different professions, such as psychology, psychiatry, medical, therapeutic and social care, with different areas of expertise, working together to ensure an integrated approach to care.

[7] Hot debrief: This is an immediate post-incident review.

The effectiveness of oversight, management and governance was dependent on the provision of high-quality information that can be analysed to inform service provision. However, the service's electronic case management system (CMS) required further improvements to best support the oversight, management and governance of the management team. The information gathered was to ensure that practice was in line with policies and procedures, and identified any trends and areas for improvement in practice which ultimately informed and improved the service delivered to the young people. However, it did not fully support this in practice. Since a previous inspection in 2022, the operational team had designed a training programme along with good practice templates to improve the standard of recording. A tracking system had been put in place and management was investigating how to best develop this system so as to be fully aligned with the children's rights policy framework. Inspectors spoke with unit managers on a number of occasions throughout the inspection to get clarity on the records that were poor quality or lacked the required detail. It was evident the unit managers were knowledgeable regarding the care of the young people. Notwithstanding the progress made on the CMS, inspectors found further improvements were required in the content and quality of record-keeping on the CMS.

At the time of the inspection there were six residential units on the campus, of which five were in operation. The sixth residential unit, reserved for the use of females, was not in operation at this time. Each residential unit had a staffing allocation of 15 residential social care workers and four night supervising officers. From the data received by the service prior to the inspection, there were 15 vacancies for residential social care workers across the campus. The director and senior management team were fully aware of the challenges in recruiting staff and were actively advocating for changes to pay and making the service an attractive place to work.

There had been a number of recruitment campaigns throughout the year. Four residential social care workers were due to begin induction in the coming weeks. Inspectors spoke with newly recruited residential social care workers who had completed the induction programme, which they described as thorough. During the induction programme, staff were made familiar with the service policies and procedures along with relevant legislation, government policy and regulations. Inspectors reviewed the induction programme and found that it covered all aspects of the service's care framework and explanation of the role of each department of the service. Newly recruited staff felt they had benefitted greatly when putting their induction knowledge into practice on the residential units and from discussion with their work colleagues and observing their practice.

Inspectors found that there were times in the service when there was an insufficient number of staff to meet the needs of the number of young people detained there. Inspectors saw the impact of staff shortages in a number of areas across the campus including, times when young people's activities were cancelled and other occasions when they were unable to leave their units for the day. Inspectors reviewed an incident when a period of single separation could not be ended due to staff shortages. Young people raised issue that they could not always come out of their bedrooms when requested at the weekend and Inspectors reviewed a complaint made by a young person that their activity was cancelled due to staff shortages and this complaint was upheld.

In addition to directly impacting young people in the service staffing shortages had a significant impact on the safe operation of the service in general. Inspectors found that not all staff had completed mandatory Children First training as required, as due to staff shortages this training had been cancelled on two occasions over the summer months. Inspectors reviewed a sample of rosters and corresponding clock cards for residential social care staff and found that there were periods when staff numbers fell well below the requirement as identified by the service management team.

The unit managers told inspectors that an insufficient number of staff on the roster was a challenge they were able to address, while acknowledging, it was more difficult to meet the short-notice absence of staff due to assault or illness. They found that working on the roster to fill vacant shifts took a significant amount of their time. Overtime was offered to cover a shortfall in staffing. Staff told inspectors that they felt exhausted, there was lot of overtime and that it was difficult to takes breaks. They said that the staff shortages impacted on young people's daily programme as their plans had to change as a result.

Staff who spoke with inspectors were clear on their role and responsibility, however, inspectors found from a review of case records that they did not always fulfil their responsibilities in practice. The management's responsibility for ensuring that practice was in line with relevant legislation, policy and procedure did not take place within formal supervision. Inspectors found from a review of a sample of supervision records for the previous 12 months that staff supervision was infrequent with gaps of seven months in some staff records. The records were largely poor quality, offering little context to discussion that had taken place and without any agreed actions to follow through on. Inspectors were told by staff that formal supervision was infrequent, however, they felt that managers were approachable if they had an issue they wished to discuss. Inspectors found the progress on addressing the shortcoming in staff supervision was slow since the previous inspection and staff were not adequately supervised. Management and staff had received training in a new model of supervision and this training was viewed by managers and staff as positive. Through consultation with all staff, it had been agreed that the supervision function would no longer be part of the role of the unit manager once new supervision model was implemented. Supervision would be provided by the service's occupational psychologist alongside a new staff position in the service which had not been implemented to date. The job description for this new role was developed, as well as a service's supervision policy which was with the board for approval. This new arrangement and a completion date to be implemented had been agreed for the last quarter of 2023.

The organisational psychologist was a member of the senior management team. Their role included the development of staff support, resilience and wellbeing. There was a recognition of the risks to staffs mental health and wellbeing due to working in a challenging environment. This risk was included in the risk register along with control measures and an action plan to manage this risk. Progress had been made in respect of the action plan and the monitoring of control measures. Inspectors found there were a number of initatives in place that supported staff such as wellbeing events that were held throughout the year, wellbeing information was circulated, staff surveys and one-to-one confidential support from the organisational psychologist. The organisational psychologst spoke with inspectors about the evidence-based accreditation framework that was in place. Additionally, the first audit had been completed and a second audit was in progress in order to achieve a quality standard in managing wellbeing risk in the workplace. There was a strong committment from senior management to improving workplace wellbeing and building a resilient workforce.

The service had a training plan in place with all mandatory and additional training scheduled. Despite this, there were some gaps in staff receiving mandatory training. Data received from the service showed that 72% of staff were up to date in Children First (2017) training, 74% in fire training, 77% in manual handling, 89% in safety intervention, 84% in self-harm and suicide prevention training and 90% in first aid. All

staff and management had received training in the new supervision model. Incident management training had been rolled out in 2022 and 2023 and this accounted for the majority of training days in the schedule. Unit managers told inspectors that training was a priority for the service and they scheduled staff to attend. While refresher training in Children First (2017) had been scheduled, a number of training days for this had to be cancelled due to staff shortages, and at the time of the inspection had not been rescheduled. This resulted in 28% of staff not having the appropriate level of up-to-date training.

In exceptional, emergency circumstances[8], the director may limit the effect of the rules of the children's rights policy framework to the extent that it is necessary to deal with that emergency. While no suspension of the rules had occurred since the introduction of the children's rights policy framework, inspectors found that there was a clear procedure in place which set out the procedures and escalation processes to be followed in the event of an emergency requiring a suspension of the rules. A critical incident management approach and operational procedure was in development and this would be fully rolled out in the first quarter of 2024.

Rule 10: Staffing, Management and Governance

The service had a clearly defined management structure that identified the lines of authority and accountability. The director and the senior management team had a clear vision for the service that was supported by well-defined service values, with a focus on continuous improvement. The director provided good leadership to support the vision for the service.

However, there were gaps in the governance and oversight of the service that impacted on service delivery. Staff had not received supervision in line with the service's policy. There had been issues regarding having a sufficient number of staff at times to meet the needs of the young people detained in the service. Staff vacancies had adversely impacted on children's care. Improvements were required to ensure that some procedures were reviewed and updated to reflect best practice, the quality of record-keeping on the case management system (CMS) supported the oversight, management and governance of service, not all staff had up-to-date mandatory refresher training.

Judgment: Non-compliant

[8] "Exceptional, emergency circumstances", are defined in the Children's Rights Policy Framework 2020, as an incident or situation which poses a serious threat to the safety of young people or staff, or to the security of the campus as a whole, which requires an immediate response, and which is not covered by normal policies and or procedures on campus.

Rule 12: Authority to Suspend the Rules

In exceptional, emergency circumstances, the director may limit the effect of the rules to the extent that it is necessary to deal with that emergency. There had been no suspension of the rules in the last 12 months. A critical incident management approach and operational procedure was in development and this would be fully rolled out in the first quarter of 2024.

Judgment: Compliant

Quality and safety

Young people's care was planned and their rights and best interests were central to decision-making. A multidisciplinary approach was taken to planning young people's care with input from young people, parents and or guardians. Young people were supported to maintain appropriate contact with their families. An individualised approach was taken to addressing offending behaviour and strengthen their capacity to assume positive lives in the community on release. However, improvements were required in the quality and accuracy of some record-keeping. There were gaps in the documentation and in the use of offending behaviour assessment and planning tools. Improvements were also necessary in the monitoring and oversight of child protection and welfare concerns, and to ensure that the use of restrictive practices were in line with the service's policies and procedures.

The model of care framework was embedded into practice, which included care, education, healthcare, offending behaviour and preparation for leaving care (CEHOP). Young people were actively encouraged by staff and managers to participate in decisions about their lives and to attend meetings regarding their care. The rules in relation to health, education and preparing to leave care were not assessed as part of this inspection. Nonetheless, the young people had access to high-quality healthcare, including general practitioner (GP), dentist, nursing staff and mental health professionals. They had access to on-site training, educational and recreational programmes. The care programmes were discussed with young people on admission to the service. There was an individualised approach to preparing young people for leaving care whether that was to return to the community or transfer to the Irish prison service.

Young people's rights were largely respected by the service. Staff worked to support the young people during their time in the service and carried out regular one-to-one work with them to ensure that their identified needs were being met. Young people had access to an internal advocacy officer and external independent advocates who could help in ensuring that their rights were protected and promoted. External advocates had visited and met with the young people in the service. The internal advocacy officer was

very active in their role and had frequent contact with the young people. On admission the young people received information on their rights, the model of care framework, routines, practices and interventions for managing behaviour. Inspectors reviewed the information given to young people and found that it was presented in a child-friendly format that was visually appealing and accessible. Young people who spoke with the inspectors understood the rules under the children's rights policy framework. However, some, but not all young people said that they had not been informed of their rights and they did not know about their rights.

Young people were supported to maintain contact with their families, friends and relevant professionals, in line with their views and best interests. Visits to young people were facilitated in the service in a private space where young people and their families could meet safely. Visits to young people in the service could either be screened or unscreened based on the assessed risks and the young person's custodial order. Young people's phone contact with their families and friends was regularly facilitated in line with their wishes and appropriateness of such contacts. However, inspectors found that there was a potential risk with regard to contacts in that the CMS was not up to date so as to reflect the list of sanctioned people that young people were allowed contact with.

One of the strategic goals of the service was to improve the participation and engagement of parents and guardians in the care of their child. A consultation process had begun with parents on how to best support their participation and how to present information to them. The director spoke with inspectors about barriers to participation that the service endeavoured to overcome, such as language barriers, long and difficult travel arrangements and time of meetings. Most parents and guardians who spoke with inspectors were positive about the communication they received from the service and felt supported to attend placement planning meeting. The service was at the early stages of progressing a family participation strategy and this responsibility was assigned to one of the deputy directors.

The service had written procedures in place aimed at supporting the implementation of the care rules of the service's children's rights policy framework. The procedures detailed the roles and responsibilities of staff across all roles and outlined steps to be taken by the relevant staff to ensure a unified and consistent approach to practice. These procedures set out the time frames for placement planning meetings, assessments and admission into a residential unit. The young person's immediate needs and risks were assessed at the time of their admission through a self-reporting mechanism whereby the young person was asked a set of questions and their responses guided staff in planning for their immediate needs and presenting risks. Risks were identified and assessed appropriately with adequate control measures put in place. A behaviour support plan[9] was developed in consultation with the young person, this

[9] Behaviour support plan: This is a document that outlines behaviours of a young person and the strategies of improvement.

meant that the young person had an input into the agreed strategies to manage their behaviours that challenged. Inspectors found for the most part, admission, assessment and placement planning procedures were followed. Additionally, the service responded to the negative impact on young people of having multiple assessments over a short period of time. The service's admission procedure outlines that assessments were completed on admission or after six months period in the community or if there are known recent concerns. Inspectors were told that staff familiarity with the young people and staff understanding of their presentation, risks and needs were essential to the process.

There was a multidisciplinary and child-centred approach to the planning of young people's care in the service. Central to this approach were young people's placement planning meetings. The quality of placement planning meetings records was mixed. Inspectors found that some meeting records lacked detail and the expressed views from those in attendance. While the records showed that relevant professionals such as probation officers or guardians ad litem (an individual appointed by the court to represent the best interests of a minor child in legal proceedings), and parents or guardians were invited to attend placement planning meetings, they did not accurately reflect who had actually attended the meetings. During the inspection, inspectors followed up on these errors with unit managers, who advised that these records would be updated to reflect attendance.

From the case records reviewed by inspectors, placement planning meetings were held in line with the placement planning procedure. The first placement planning meeting for a young person took place within 72 hours of admission. An initial health screening by a nurse took place within 24 hours and a medical assessment by a general practitioner (GP) took place within 72 hours. The second placement planning meeting took place within two weeks of the initial placement planning meeting. Staff and managers had a clear understanding of the schedule of placement planning meetings. The time frame for the first and second placement planning meetings was adhered to. The practice was that subsequent meetings were held at intervals of five weeks, however, the written procedure did not specify a time frame and this required alignment with practice.

Young people were encouraged and facilitated to attend their placement planning meetings. When a young person chose not to attend, their views were sought and presented in the meeting by a key worker or by the unit manager. Key workers prepared a report for the meeting and told inspectors that they read through the report with the young person prior to the meeting. The participation of the young people at each stage of care planning improved the quality of decision-making. Inspectors found from speaking with young people and the observation of a placement planning meeting that the young people had input into decisions about their care. However, young people's views were not always clearly captured in the records and the use of observations rather than expressed views were recorded.

There was multidisciplinary team input into the assessment of young people's needs. Relevant professionals such as clinicians from the Assessment Consultation and Therapy Service (ACTS) and Forensic Child and Adolescent Mental Health Service (FCAMHS) routinely met with young people in accordance with their assessed needs. Weekly multidisciplinary team meetings were a forum to discuss young people's progress or placement needs and any emerging issues that required clinical intervention and support. Unit managers communicated updates from these meetings to staff in the weekly team meetings and during daily handovers. A data sharing agreement between the service and ACTS had been developed, however, it was waiting to be approved by ACTS. As a result, care staff did not have access to written records or plans developed by ACTS to support young people's care, to ensure a consistent care approach.

There were systems in place to monitor the care of young people in the service. Day and night care records and weekly summary reports were present for the majority of case records reviewed by the inspectors. These records outlined the young person's daily activities and nightly routine in the service. Inspectors found that completion of these records required improvement as some records were blank or incomplete. This would ensure that young people's records accurately reflected all their care and activities, that clear records were available for staff coming on duty and to provide management with oversight of the young people's care, activities and supervision.

Weekly staff team meetings took place as scheduled and were well attended. Samples of team meeting records reviewed by inspectors were of good quality, with discussions and decision-making rationale recorded. Individual young people's needs, risks and overall presentation were discussed in detail with appropriate supports identified for implementation. It was clear from the inspector's observation of team meetings that the staff teams were child centred and proactive in their approach to the planning of young people's care.

Young people's meetings were held consistently on a monthly basis. Some of the items on the agenda included: group living, what is going well, what you would like to change and group behaviour. Records of these meetings demonstrated good levels of attendance and participation by the young people. Young people's requests made at these meetings were considered and approved where appropriate. Where a request was deemed inappropriate, the staff team offered an alternative choice to the young person. Staff provided regular feedback to the group of young people about their day-to-day living arrangement at these meetings.

Young people had access to supports and programmes to address their offending behaviour and prevent re-offending on release. The range of programmes delivered included understanding the impact of offending on victims, driving offences and others that addressed high-risk behaviour that can lead to offending, such as helping young people manage impulsive behaviour and addressing alcohol and drug use. The range of

offending behaviour programmes and supports on offer had increased since the previous inspection with one new programme and three new workshops introduced. The service responded well to the changing trends in offences. For example, a programme to address sexually harmful behaviour was in the final stages of development through a collaboration with an external expert agency, probation services, and ACTS. While this programme was being developed, existing programmes were in place which addressed sexually harmful behaviour, and one programme that addressed positive relationships and consent. When there was a lack of a suitable programme to address offending behaviour, ACTS provided one-to-one sessions with young people. Additionally, in the absence of an addiction counsellor the service used an external agency to deliver a programme addressing alcohol and drug use.

Young people were supported to understand and take responsibility for their offending behaviour, and programmes were provided to both young people on remand orders and those on committal orders. As such, there was a mix of young people who had been convicted of a crime and others that were awaiting to attend court. Previously, an admission of guilt was required to attend some of the programmes on offer, however, this was no longer the case. If a programme had been assessed as suitable for a young person, they had the option of attending the programme. The deputy director who had oversight of all programmes advised that young people could attend modules of programmes if that was the most suitable option.

An individualised approach was taken to addressing offending behaviour. An assessment tool was completed to assess young people's risks and needs associated with their offending behaviour and an offending behaviour plan was developed from this. However, from a sample of young people's records reviewed by inspectors showed, not all planning and assessment tools were used effectively to identify the specific needs of the young people. As such, there was an adhoc nature to assigning young people to the various programmes available. With the exception of one, the assessments and plans reviewed were of poor quality. From a review of placement planning meeting minutes, updates and discussion about programmes the young person attended were recorded, but there was no evidence of discussion regarding offending behaviour or seeking feedback from young people about the programmes they had completed. The records did not demonstrate the work completed on addressing offending behaviour. Inspectors observed a multidisciplinary team meeting where discussions were had on the appropriateness of specific offending behaviour programmes for some young people, and consideration was given to recommendations and reports given on young people's engagement in programmes. While the service supported young people to address their offending behaviour and strengthen their capacity to assume positive lives in the community on release, the assessment tools and offending behaviour plans did not capture the extent of the support and planning for the young people.

Inspectors spoke with a member of the offending behaviour programme team and found they were knowledgeable on the specific programmes and consideration was given to the mix of young people participating. Inspectors observed the delivery of two programmes and found the facilitators knew the programmes content well, set good boundaries and used a range of materials throughout the session. There was good engagement by the young people and the atmosphere was relaxed. Inspectors spoke with the young people after the programme sessions, who said that they had done other programmes before and found them 'OK' and 'passed the time'. There were session evaluations forms for each session the young people attended that detailed how the young person engaged.

Staff were trained in a restorative approach which formed part of a programme to address the impact of offending on victims and their rights and fundamental freedoms. Staff told inspectors they did not have enough time to implement the approach into their daily work, and that young people were not always ready to address their offending behaviour due to their immaturity or complex needs. However, inspectors found that the restorative approach was evident in post-incident records, one-to-one sessions with the young people, in which taking responsibility for their actions formed part of those discussions.

There were systems in place to protect young people from harm and abuse, underpinned by a number of safeguarding policies and procedures and a child safeguarding statement in line with Children First (2017). However, significant improvements were required in the monitoring and oversight of safeguarding and child protection and welfare concerns. This was identified by HIQA during the inspection of the service in 2022. In response the service had committed to implement a number of actions as outlined in the compliance plan following the inspection. Inspectors found that three of the four agreed actions had not been completed and in practice there were no changes to management and oversight of child protection and welfare concerns.

Young people were aware of the role of the DLP and advocacy officer and their picture and roles were displayed in all residential units. The DLP informed inspectors that they met the young people on admission to explain their role, advised them of the reporting procedure for any concerns, their availability to discuss any concerns and asked if the young person had concerns they wished to discuss. Staff told inspectors that along with meeting the DLP, the young people were given an information pack from the advocacy officer that included information on self-care and protection. There were programmes available for the young people to attend which developed knowledge, self-awareness, understanding and skills needed for self-care and protection.

The advocacy officer maintained an up-to-date register and high-quality records of complaints. From the data received from the service, in the previous 12 months there

were 14 complaints managed by the advocacy officer. Of these complaints, 12 were closed and two were in progress. Of the closed complaints, six young people were satisfied with the outcome, five young people were not satisfied and there was one unknown as the young person was discharged. Young people who were not satisfied with the outcome discussed the outcome with the advocacy officer and were offered the appeal process. However, none of the young people choose to use the appeal process. Inspectors reviewed a sample of complaints and found that they were clearly recorded with actions outlined and feedback given to the young people.

Governance and oversight of child protection concerns required improvement. The DLP maintained a database of incidents, referrals of safeguarding and child protection and welfare concerns in line with legislation and national guidance. From the data received from the service, there were 58 child protection and welfare concerns or allegations made by young people in the previous 12 months. Of these referrals, 22 were assessed as meeting the threshold to be reported to Tusla, six referrals had been closed and the remaining 16 referrals' status was unknown. Some of these concerns required a referral to the Garda Síochána Ombudsman Commission (GSOC) and or Tusla. Twenty nine of the 58 concerns or allegations related to professionals not working within the service, and of these 15 had not been reported to Tusla. The decision-making rationale for reporting concerns was not recorded and it was unclear why some concerns met the threshold to report to Tusla, while similar incidents did not require a referral. The category of referrals was not recorded.

Inspectors identified risks relating to the system to track referrals and found that this system was inadequate. Tracking of referrals did not capture how the concern had been progressed and details of any follow-up conversations and actions were recorded separately in a hand written notebook. Inspectors found there was no follow up communication by the DLP to Tusla regarding the status of referrals resulting in young people not being kept up-to-date regarding any incident or disclosure of abuse. There was insufficient oversight of allegations of abuse as there was no system in place to track trends for types of referrals or incidents reported to the DLP.

Inspectors identified significant delays in the reporting of some child protection and welfare concerns to Tusla. Inspectors found delays ranging from 27 days to 10 months. Additionally, they found three incidents where social workers had requested a mandated report to be made to Tusla, these reports were not completed at the time of the inspection.

Inspectors found that child protection concerns were not reported by staff as mandated persons as required by Children First, in all instances. Residential social care workers, as mandated persons must discharge their statutory obligations under Children First and it cannot be discharged by the DLP on their behalf, however, this was not practice in the service. The practice within the service was that social care staff reported allegations or

concerns to the DLP who determined whether or not to refer the concern to Tusla. The DLP then made the report if required.

Significant improvements were required to ensure comprehensive oversight and monitoring by senior management. The records regarding child protection and welfare concerns were not contained within the service's CMS. When a young person made a complaint or allegation, this was not clearly recorded on the CMS or in an area of the CMS with restricted access. Records held by DLP were incomplete and had limited information to ensure good governance and oversight. There was no requirement by the social worker (DLP) to report child protection and welfare concerns or safeguarding issues to the senior management team or the board of management.

In periods of absence of the DLP, there was no deputy DLP to oversee the child protection and welfare concerns. It was agreed following the inspection of the service in 2022, that a deputy DLP in the absence of the DLP would be identified and trained in the role. A deputy DLP was identified, however, they had not undergone all the necessary training to assume this role in the absence of the DLP. Inspectors found that during a period of annual leave for the DLP, an incident took place and a concern was raised by a member of the medical staff. The reporting of this concern did not take place in a timely manner and was poorly managed. There was no evidence of learning from the poor management of this incident. In the same time period, a young person alleged they had been assaulted prior to admission to the service, this was not reported to Tusla or followed up by the DLP on their return from annual leave. The procedure for safeguarding young people in Oberstown had not been updated to reflect the role of deputy DLP, as agreed following the inspection of the service in 2022.

The DLP was supervised by the director every two months and received external supervision from a qualified social worker on an almost monthly basis. However, there was limited monitoring and oversight of the role of the DLP. The director did not routinely review details relating to child protection concerns and there was no requirements for the DLP to provide regular statistical information on trends, repeated concerns and or status of reported concerns. There was no formal system of auditing of their work and any errors, delays or incidents not referred to Tusla were not identified by oversight arrangements in place. As a result of the findings in relation to the child protection, a provider assurance report was requested following the inspection. Satisfactory assurances were provided prior to the draft report being issued.

Data provided by the service showed that while only 72% of staff had up-to-date refresher training in child protection, inspectors found that staff understood their duty of care to young people, and had received training on child protection and safeguarding. However, the practice of joint reporting as mandated person's was not in line with Children First. Where an allegation had been made against a staff, appropriate safeguarding measures were put in place, such as safety plans. From a sample of safety

plans reviewed by inspectors, safety plans were followed by staff. Inspectors found that the service's social worker was not consistently involved in the development of safety plans in response to child protection concerns.

The DLP was notified of incidents in line with the service's procedure. Some incidents required the DLP to liaise with other professionals in the service such as advocacy officer, safety intervention trainers and medical staff. When concerns or complaints were raised by staff or young people regarding an incident, a review was conducted of the closed-circuit television (CCTV) footage and all relevant documentation. The DLP spoke with the young people and staff involved in the incident to find out their point of view. However, inspectors found that not all incidents that required review had been reviewed in a timely way and this delayed reporting of a child protection and welfare concern.

In order to promote the safety and protection of young people and others, a zero-tolerance approach to violence was maintained, and staff were committed to promoting a safe culture and environment to young people and to minimise incidents of violence. This was evident from initial assessment on admission, the development of behaviour support plans, consultation with the young people on behaviour management, collaboration with all relevant people and through placement planning meetings. Behaviour support plans were reviewed regularly by staff and management. Young people were informed about the use of restrictive practice and the management of risk on admission to the service. From the data received from the service, 89% of staff had up-to-date crisis intervention training. Since the previous inspection, incident management training had also been rolled out to staff and feedback from the staff team to inspectors was positive.

Young people's safety, welfare and dignity should be paramount in circumstances that required a restrictive practice. The use of restrictive practices should only be used as a response to immediate risk with the exception of room searches that could be routine. Restrictive practices should interfere with the rights of the young people as little as possible and with the aim to fully protect young people's rights. Restrictive practices in use within the service included, physical restraint, single separation, the use of handcuffs and searches conducted in young people's rooms or on their person. There were procedures to guide staff on the use of each of these restrictive practices with the exception of physical restraint. Inspectors identified there was no procedure regarding the use of physical interventions, staff were reliant on their professional knowledge to guide their practice in implementing these restrictive practices and any follow up actions required. In addition the procedures regarding single separation and conducting all types of searches were out of date at the time of inspection.

There were incidents when restrictive practices were used in the absence of immediate risk. Inspectors found that for a period in July 2023, when staffing levels were low,

young people were restricted to their bedrooms to allow for staff breaks. This action was not authorised by management and occurred over four days. Site managers were immediately aware of the practice taken by staff and informed senior management of this action who responded swiftly and appropriately to end this action to reduce the impact on young people. Notwithstanding the response taken, this action should not have been taken by staff as the practice was not in line with their single separation procedure and negatively impacted the young people. Inspectors reviewed a complaint from a young person regarding this issue that was upheld. The complaint was responded to appropriately by the advocacy officer and one of the deputy directors. Young people spoke with the inspectors about their unhappiness about the action of the staff and felt it was unfair to have to go to their bedrooms if there was not enough staff. During the inspection, the director provided assurances that this type of action would not be taken again by staff. In addition, staff that inspectors spoke with understood that young people should not be asked to go to their bedrooms to facilitate staff breaks.

Notwithstanding the improvements made in the records of restrictive practice since the previous inspection, there was more work to be done to improve the consistency and quality of records relating to the use of restrictive practices. Authorisation was sought for restrictive practice, however, from of sample of 16 single separation incidents reviewed by inspectors, seven did not have the required authorisation in line with the procedures time lines and the recording of these incidents required improvement. During periods of single separation, young people's right to food and contact with their family, when appropriate, was upheld. However, there were often delays in young people getting access to a phone. Inspectors found from a sample of seven incidents of single separation for over a period of four hours, facilitating a young people's right to access fresh air was not recorded in six incidents. For example, in one incident it was recorded on the second day of a three day incident of single separation only. Also, risk assessments regarding decisions to facilitate young people's right to access fresh air were not completed.

Data provided by the service showed that 102 physical or safety interventions were carried out by staff, 940 single separations, 36 individual recovery programmes[10], two incidents of use of handcuffs, 243 clothing searches and 512 room searches. While overall there was an increase in the use of some restrictive practices, this coincided with periods of full occupancy in the service in the male residential units and young people presenting with more complex needs. The management team monitored and analysed the use of restrictive practices and the use of early intervention to manage behaviour that challenged. This allowed for a greater understanding of trends and focused managerial oversight and responses of the service. For example the incidents and types of physical restraint were analysed for examining the threshold of risk and de-escalation

[10] Individual recovery programme: This is an interim behaviour support to mitigate a presenting risk that prevents a young person re-joining his or her full group of peers.

techniques used by staff. In the incidents of single separation and the use of handcuffs the reason for the use of the restrictive practice was also tracked.

There was an individualised approach taken to responding to the risk posed by the young people. Inspectors found that young people received good support and there was good communication and consultation with the young people during the development and implementation of their behaviour support plans. This was evident from initial information gathering at the early stages of admission along with consultation with the young people, parents or guardians and any other relevant professional. Each young person had an individual behaviour support plan that was reviewed regularly. There were also times outside of crisis intervention when young people required specific support to reintegrate back into their peer group or to lessen a risk following a period of single separation or other restrictive practices. In these instances, the use of individual recovery plans for young people were put in place. These plans provided a greater level of support for the young person and managed high-risk behaviour. These plans were put in place with authorisation from the site and or unit manager, and were reviewed on a regular basis for effectiveness. The continued use of these plans beyond 24 hours required consultation with a deputy director as well as a daily review. Inspectors found that individual recovery plans were discussed at team meetings, care meetings and multidisciplinary team meetings. Records of these plans were comprehensive.

Following serious incidents, there must be an immediate debrief, as outlined in the hot debrief procedure. This allowed for immediate learning to be obtained by summarising the event, what worked well and not so well, opportunities to make improvements, to develop a plan and agreed actions. These actions could include, a review of the young person’s behaviour support plan, need for medical attention or assign responsibility for recording and reporting details of the incident. Inspectors found that the learning from incidents was discussed at handovers and through staff meetings. Staff told inspectors that this was very helpful as the larger debrief following significant incidents could take place months after the incident. This issue was discussed with the organisational psychologist, who agreed that the speed of the review was not timely, as trying to accommodate all staff involved in the incident made scheduling difficult. A decision had recently been made to proceed when the majority of staff could attend and it was hoped that this would resolve the time-lapse issue and provide learning in a timelier manner.

Rule 1: Care

Overall, young people received good-quality, child-centred care. For the most part, their needs were assessed and their care was appropriately planned. Staff meeting records were good quality. Decisions were made in line with the best interests and rights of the young people. There was a multidisciplinary approach taken to planning young people's care that was reviewed regularly with input from parents and or guardians. Young people were encouraged and facilitated to participate in planning for their own care during their time in the service, and were supported to maintain appropriate contact with their families. The young people's meetings were good quality and well attended.

However, improvements were required with the quality and accuracy of some record-keeping to fully capture discussions and attendance in placement planning meetings. The day-to-day care records of the young people were required to be completed in a timely manner and young people's sanctioned phone contact list needed to be accurately updated on the CMS.

Judgment: Substantially compliant

Rule 4: Offending Behaviour

Young people had access to supports and programmes to address their offending behaviour and prevent re-offending on release. An individualised approach was taken to addressing offending behaviour and strengthen their capacity to assume positive lives in the community on release. However, there were gaps in the documentation, the assessment tools and offending behaviour plans that did not capture the extent of the support and planning for the young people.

Judgment: Substantially compliant

Rule 6: Safeguarding

There were systems in place to protect young people from harm and abuse, underpinned by a number of safeguarding policies and procedures and a child safeguarding statement in line with Children First (2017). Young people were aware of the role of the DLP and advocacy officer. The advocacy officer maintained an up-to-date register and high-quality records of complaints. There were programmes available for the young people to attend which developed their knowledge, self-awareness, understanding and skills needed for self-care and protection.

However, the system for recording incidents, child protection and welfare concerns and safeguarding concerns was inadequate for the purposes of monitoring and oversight. There was no tracking of trends that would inform the emerging needs of the service and young people. There was limited oversight of the role of the DLP and there was no system of auditing their practice. There was no deputy DLP in the absence of the DLP trained and in place and the procedure for safeguarding young people in Oberstown had not been updated to reflect the role of a deputy DLP.
Judgment: Non-compliant
Rule 9: Restrictive Practice
Young people's safety, welfare and dignity should be paramount in circumstances that required a restrictive practice. However, the procedures regarding single separation and conducting all types of searches were not up to date, and there was no procedure regarding the use of physical intervention. Aspects of the procedures were not consistently followed, such as, facilitating young people's right to access fresh air. This was not consistently recorded and there were no risk assessments regarding decisions to either facilitate this or not. Authorisation for the use of single separation were not always sought in line with the service's procedure. Notwithstanding the improvements made in recording from the previous inspection, there was more work to be done to improve the consistency and quality of records. In July 2023 restrictive practices were used without the necessary authorisation, whereby young people's rights were not protected and actions taken by staff were not in line with procedure.
Judgment: Non-compliant

Appendix 1 - Full list of rules considered under each dimension

Rules:	Judgment
Capacity and Capability	
Rule 10 – Staffing, Management and Governance: The care of young people shall be provided by a suitable number of appropriately qualified staff of various grades, and effective and transparent management and governance shall be in place to deliver public accountability.	Non-compliant
Rule 12 – Authority to Suspend Rules: In exceptional, emergency circumstances, the director may limit the effect	Compliant

of these Rules to the extent that it is necessary to deal with that emergency.	
Quality and Safety	
Rule 1 - Care: Young people shall receive the best possible care so that their full potential can be realised. Their needs shall be individually assessed, and personalised placement plans developed to ensure their needs are met. They shall be supported to maintain contact with family as appropriate.	Substantially compliant
Rule 4 – Offending Behaviour: Young people shall have access to a range of services, supports and programmes that address their offending behaviour and prevent further offending on release.	Substantially compliant
Rule 6 - Safeguarding: Young people shall be protected from all forms of harm and abuse and their welfare promoted.	Non-compliant
Rule 9 – Restrictive Practice: Practices that interfere with the rights of young people shall only be used with approval and in exceptional circumstances.	Non-compliant

Compliance Plan

This Compliance Plan has been completed by the Provider and the Authority has not made any amendments to the returned Compliance Plan.

Compliance Plan ID:	MON-0039831
Provider's response to Inspection Report No:	MON-0039831
Centre Type:	Oberstown Children Detention Campus
Date of inspection:	12th September 2012
Date of response:	15 November 2023

These requirements set out the actions that should be taken to meet the Oberstown Children's Rights Policy Framework.

It outlines which rules the provider must take action on to comply. The provider must consider the overall rule when responding and not just the individual non-compliances as outlined in the report.

The provider is required to set out what action they have taken or intend to take to comply with the rule in order to bring the campus back into compliance. The plan should be **SMART** in nature. **S**pecific to that standard, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Capacity and Capability

Rule 10 - Staffing, Management and Governance	**Judgment: Non-compliant**

Outline how you are going to come into compliance with Rule 10:
The care of young people shall be provided by a suitable number of appropriately qualified staff of various grades, and effective and transparent management and governance shall be in place to deliver public accountability.

- Until our new supervision policy is adapted and implemented Unit Manager's will deliver 1:1 meetings with each of their staff on a 6 weekly basis 31/01/24
- When our new supervision policy is adapted and implemented this responsibility will shift to someone we aspire to recruit. A date is not possible in this regard given then sectoral challenges in recruiting such a specialist.
- We will continue to recruit required grades of staff as appropriate; this will be ongoing and a completion date is not possible in this regard given the sectoral challenges at the moment.
- We will develop a talent management framework and graduate programme by 30/06/24.
- All procedures relevant to the Children's Rights Policy Framework that require review will be updated by 29/03/24.
- Record keeping training will be delivered to front line staff by 30/06/24.
- Unit Manager's will be responsible for the effective discharge of quality assurance relevant to record keeping by 01/09/24.
- Children First Training and other mandatory training that is required will be complete among all relevant staff by 01/11/24.

This compliance plan response from the Oberstown Children Detention Campus did not adequately assure the Health Information and Quality Authority that the actions will result in compliance with the Rules the service was inspected against.

Proposed timescale: 01/11/24	**Person responsible: Damien Hernon**

Quality and Safety

Rule 1 – Care	Judgment: Substantially compliant
Outline how you are going to come into compliance with Rule 1: Young people shall receive the best possible care so that their full potential can be realised. Their needs shall be individually assessed, and personalised placement plans developed to ensure their needs are met. They shall be supported to maintain contact with family as appropriate. • Placement planning records will record decisions made and attendance in full by 31/01/24. • Care records of young people will be completed in a timely manner by 31/03/24. • Unit Manager's will be responsible for the effective discharge of quality assurance relevant to record keeping by 01/09/24. • Unit Manager's will assure that phone contact lists are accurately updated by 31/01/24.	
Proposed timescale: **01/09/24**	**Person responsible:** **Michelle Griffin**

Rule 4 – Offending Behaviour	Judgment: Substantially compliant
Outline how you are going to come into compliance with Rule 4: Young people shall have access to a range of services, supports and programmes that address their offending behaviour and prevent further offending on release. • Unit Manager's will be responsible for ensuring that the relevant assessment tools are completed by 29/02/24. • Unit Manager's will be responsible for ensuirng that offending behaviour plans accurately capture the support and planning required for young people by 31/03/24.	
Proposed timescale: **31/03/24**	**Person responsible:** **Michelle Griffin**

Rule 6 - Safeguarding	Judgment: Non-compliant
Outline how you are going to come into compliance with Rule 6: Young people shall be protected from all forms of harm and abuse and their welfare promoted. • That all incidents of a child protection and welfare nature are reported in a timely manner in line with relevant procedures by 01/11/23. • Monthly reporting to the Board will commence in order to ensure oversight and governance by 01/12/23. • That staff member's statutory obligations as mandated reporters are facilitated and operational in Oberstown Children Detention Campus by 01/11/23. • This will require a level of communication with staff prior to its inception. Brian Hogan/Matthew Kelly will be responsible by 15/12/23. • Up-to-date, contemporaneous records are maintained relating to all incidents and reports in respect of safeguarding and child protection and welfare concerns. This will include appropriate oversight mechanisms to track all child protection and safeguarding concerns to conclusion by 01/12/23. • That incidents relating to safeguarding and child protection and welfare concerns are escalated to senior management without delay thus ensuring appropriate records of actions agreed are maintained as agreed in line with statutory requirements by 01/12/23. • That the current DLP and deputy DLP arrangements ensure that all child protection and safeguarding concerns are managed in line with Children First and supported by attendance at training as a matter of priority by 29/02/24. (This is subject to external factors related to training) • That appropriate systems and supports are in place to provide adequate clinical supervision and managerial support to the role of the DLP by 31/03/24. • The procedure for safeguarding will be updated to incorporate the role of the Deputy DLP by 31/01/24.	
Proposed timescale: **31/03/24**	**Person responsible:** **Damien Hernon**

Rule 9 – Restrictive Practice	Judgment: Non-compliant

Outline how you are going to come into compliance with Rule 9:
Practices that interfere with the rights of young people shall only be used with approval and in exceptional circumstances.

- In line with our procedure on single separation we will document that a dynamic risk assessment has taken place with regard to access to fresh air by 31/01/24.
- The procedure on single separation will be reviewed and amended if required by 31/01/24.
- Unit teams will receive refresher training on the single separation procedure by 29/02/24.
- Unit managers will be responsible for the effective discharge of quality assurance relevant to single separation by 31/03/24
- Procedures relating to other forms of restrictive practice will be reviewed if required and amended by 29/02/24

This compliance plan response from the Oberstown Children Detention Campus did not adequately assure the Health Information and Quality Authority that the actions will result in compliance with the Rules the service was inspected against.

Proposed timescale: 31/03/24	Person responsible: Michelle Griffin