Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of a Designated Centre Special Care Unit

Name of designated centre:	Ballydowd
Name of provider:	The Child and Family Agency
Address of centre:	Dublin
Type of inspection:	Unannounced
Date of inspection:	17 February 2020
Centre ID:	OSV 0004221
Fieldwork ID	MON- 0028660

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Children are detained in Ballydowd Special Care Unit under a High Court order, for a short-term period of stabilisation, when behaviour poses a real and substantial risk of harm to their life, health, safety, development or welfare. Ballydowd Special Care Unit caters for both male and female children, aged between 11 and 17 years and the group living unit is mixed gender. The unit is described as a secure unit, meaning that it is locked and the young people are not allowed to leave without permission.

The aim is to provide a safe and caring environment and therapeutic environment where children learn to make safer choices and develop their wellbeing, reduce their risk taking behaviours and so enable the child to return to a less secure placement as soon as possible based in the needs of that child.

The objective is to provide a welfare-based social care intervention through placements that are intensively supported with on-site education, vocational training, therapeutic supports and detailed programmes of special care aimed at supporting and achieving positive wellbeing outcomes that facilitate a timely return to the Child and Family Agency's community based centres, foster care or home as soon as this can be achieved.

The children we provide a service to have usually had a long history of challenging and troublesome behaviour and before entry into the secure intervention programme, the young person must be deemed not amenable to intervention in less restrictive settings due to the seriousness of the risk presented by such behaviour.

The following information outlines some additional data of this centre.

Current registration end date:	11th of November 2021
Number of children on the date of inspection:	5

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information and information submitted by the provider or person in charge since the last inspection.

As part of our inspection, where possible, we:

- speak with children and the people who visit them 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 children who live in the centre.
- 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.

In order to summarize our inspection findings and to describe how well a service is doing, we group and report on the regulations 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 people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations 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
17 February 2020	09:00hrs to 17:15hrs	Jane Mc Carroll Bronagh Gibson Conor Brady	Inspector Regional Manager Regional Manager

What children told us and what inspectors observed

Over the course of the inspection, it was obvious to inspectors that children's day to day care needs were being met. Children said that they experienced positive relationships with social care workers, within the confines of the special care unit. However, they also described times when they had absconded, and records of these absconds showed that these children's' safety and welfare was not ensured while in the community without appropriate adult supervision. This posed a risk to the children involved and to the service.

The special care unit is a place of detention for children whose behaviour poses a risk to them and or others. The unit comprised three separate residential units, an administration building and a school. There was a large green area in the centre of the campus which was accessible to children. Inspectors observed that in order to leave the campus, staff and children had to pass through an administration building which was secured, or through gates which had to be opened by staff. Each residential unit's external doors were seen to be locked at all times, and internal doors were open to allow free movement of children between living areas and bedrooms. Children could not leave individual residential units without staff assistance and supervision. Inspectors observed high levels of supervision for two children with a pattern of absconding, while they were taking a walk around the grounds. Inspectors saw another child returning to the unit after a planned outing, in the company of staff.

The children were observed in their respective units and as they were on mid-term break, inspectors had ample opportunity to see how well supervised they were, and their interactions with staff members. At the time of the inspection, inspectors found that there was minimal risk of a child absconding from the grounds. The campus was secure and there were appropriate safety and security measures in place to ensure safe movement of children, staff and visitors. Children who met with inspectors did not consider absconding from the unit due to the restrictions in place.

At the discretion of the management team, children can be approved or authorised to leave the special care unit for different reasons such as family visits or leisure activities. During this inspection, inspectors met with four children and spoke to two guardians ad litem, two social workers and one parent on the telephone. Inspectors asked children, parents and professionals about their experiences and views of outings for children from the special care unit, and how well they were managed. Inspectors queried if measures were taken to ensure the ongoing safety and welfare of the children concerned, and minimise the possibility of abscond.

Children said that they were well informed about the rules surrounding outings from the special care unit. One child said that 'if you abscond you will be locked in.' Another explained that 'if you abscond it comes with consequences.' Children told inspectors that the consequences for absconding varied for each child. One child said that 'management make the decision, it is different every time. It depends on what happened [while you were on abscond], the risk of it happening again and the danger.' They said that it could be 'two to six weeks or eight weeks before you go out again'. However, these consequences did not always deter children from absconding. Children told inspectors that outings from the unit presented an opportunity to abscond and it was evident in accounts of absconds maintained by the unit, that some children had planned their abscond, when they knew an outing was taking place.

Children explained that the service responded to absconding behaviour on an incident by incident basis, and tailored its response to each individual child. However, inspectors found that these responses were not always effective or consistent, and or proportionate to the level of risk involved. This was also the view of two external professionals who spoke to inspectors. One example provided to inspectors was that a child who contacted staff by phone while on abscond, was told that if they returned within a specified time, they would be given another outing. An external professional was of the view that negotiating with a child in this context was problematic. In other scenarios, children said that more staff might accompany them on outings to prevent them from 'running away' again. They said that this was not effective, as staff did not intervene in a way that prevented children from absconding if they wished. Inspectors found written accounts of incidents where children told staff they were going to abscond, and although staff members tried to persuade children verbally not to go, no alternative interventions were made, when this was not effective.

Children described some of the reasons they absconded to inspectors. Some children said that their detainment had continued for lengthy periods of time due to the lack of a follow on placement. One child said 'if it [duration of placement] is only three months, then I would not put a foot wrong, not one person would abscond'. Another child said that 'the minute I got a placement the last time, I did everything I had to do.' Inspectors heard from children that they had lost a sense of 'buy in' with their programme of care, because their placement had lasted longer than they were told, or what was initially planned for them. Some children said that they had 'lost hope for their future', and that they had no clarity in relation to their pathway out of special care, and no timeframe within which their discharge would happen. These children said that this was a significant factor of influence on their absconding behaviour.

The children who met with inspectors also explained that they were likely to abscond to see friends or family members, particularly if they were worried about them. They also said that they had the chance to get contraband such as drugs, when on abscond. They

told inspectors that outings 'got boring going out with adults all the time, teenagers don't want this'. They said that absconding had become part of the culture in the special care unit because 'other kids see kids running and it becomes a habit.' Another child absconded because they said 'you get depression in here, it makes you worse, it doesn't help, and it's disgusting here.' While some children portrayed their living experience in the special care unit as negative, inspectors observed caring and relaxed interactions between children and staff, and high levels of participation of children in the day to day running of the service, and this was valued by them.

All outings from the unit were planned and risk assessments were completed to support safe decision-making. Children told inspectors that they were encouraged to participate in these risk assessments. However, one child said that 'they [the risk assessments] were too much, if you are going to run, you are going to run'. One parent was not satisfied that risks assessments were working effectively and was concerned that despite the level of risk to their child in the community, outings continued to happen. This was a source of significant worry for them.

Children had mixed views about the support and help they received from staff during and after an incident of abscond. One child told inspectors that interventions by staff had lost meaning and value to them. They said that 'staff try to understand me but it's not helpful now, I have been here too long'. Children said that at the start of their placement, 'things went in and now it doesn't'. While inspectors did not find any practice by staff which raised concern, some children perceived talking about their time on abscond as a negative one, and one child said that 'some [staff] go back and gossip about you and others are genuine and want to help.' Another child told inspectors that 'when you come back [from an abscond] staff are nosey and want to know what happened'. On balance however, children did say that they felt safe while in the unit.

On return from abscond, children engaged in a structured conversations with a staff member, where their views were heard and there was space for reflection on their feelings, behaviours and actions. From this, plans and actions were identified to support the child to identify and address the triggers which may have led to their absconding behaviour. There was also evidence of direct work with children during keyworking sessions. Inspectors found that the quality of keyworking records was mixed. Some records portrayed good discussion with children in relation to their risks and needs, the rules and expectations of outings and the particular consequences of absconding, which they were able to describe to inspectors. However, other records did not portray appropriate and supportive discussions with children in relation to danger and risks they were exposed to on abscond, or appropriate guidance to support their self-care and self-protection in the event of an abscond. In some circumstances, inspectors found that there was no evidence of any conversation with a child following an abscond. External professionals who talked with inspectors were of the view that the service lacked specialism in this area.

Inspectors heard from some children that they were not engaging in any specialist therapeutic work, targeted at minimising the risks which led to their detainment in special care. Three external professionals were of the view that the service lacked expertise in the management of particular risks to children. They said there needed to be a clear protocol for staff which set out appropriate consequences and responses following absconds. They suggested for example, that if a child misused substances on abscond, then the child should be required to engage a specialised programme to address substance misuse – and this was not happening. However, it was widely accepted across unit managers and professionals that children could 'not be locked up forever' and outings from the unit are an integral part of preparing a child for safe discharge.

Children said that they felt safe in the special care unit, but from their accounts of their experiences and the risks they encountered when on abscond, inspectors were not assured that decision-making processes within the special care unit adequately balanced the need to support children to progress through their placement, and have positive, safe experiences outside of the unit. This was particularly the case for children with established patterns of absconding and for whom risk in the community remained substantial.

Capacity and capability

This inspection was carried out in response to the volume of notifications to the chief inspector related to absconds, and associated risks to children. The purpose of this inspection was to assess whether the special care unit had the necessary measures in place to reduce the number of absconds and to manage risk to children, who had an established pattern of absconds.

In March 2019, the director of the special care unit assured HIQA that actions were being taken to reduce the risk of absconds. A subsequent HIQA inspection of the service in July 2019 found that more needed to be done in this regard. The special care unit submitted a compliance plan to HIQA which included further actions it would take to address absconding behaviour and the associated risks, but notifications to the chief inspector over the course of 2019 demonstrated that these actions had not led to a sustained reduction, year on year.

This inspection found that the systems in place to ensure outings from the unit were safe, purposeful and resourced adequately were not strong enough. Similarly, the systems and decision-making processes in place to respond to absconds, particularly repeated absconds by a child, needed to be strengthened.

Inspectors enquired about the systems in place for monitoring and oversight of

absconds, and were informed by the person in charge that although absconds by individual children were reviewed and monitored, this was not the case for all absconds collectively. There was no formal review or analysis of absconds in 2019. This was a missed opportunity for the service to routinely analyse and trend absconding behaviour over time, in order to drive systemic improvements in a continuous way, which could then be monitored for effectiveness.

Inspectors reviewed policies and procedures in place for the special care unit and found that some were embedded in practice, such as the notification absconds to relevant parties like social workers and Gardaí. A guidance had been issued to staff in relation to revised security procedures on campus, to ensure children could not abscond from the premises. This was introduced in June 2019, in response to two absconds from the secure area. A second guidance was issued in relation to a revised process for assessing the risk of absconds prior to the approval of an outing by the person in charge. While these were welcome initiatives, they were in response to serious incidents related to specific children, and not as a result of monitoring and oversight systems embedded in routine managerial practice. While there was a national Tusla risk management policy and framework in place, it did not refer to absconds from the unit.

Furthermore, inspectors found that there was a gap in the guidance and strategies for staff to intervene when a child is or is about to abscond when on an outing. There was no reference to the use of physical intervention, if required, to ensure the child's safe return to the special care unit. Inspectors did not see records of physical interventions occurring when children told staff they were going to run away during outings.
The process for assessing the risk of abscond prior to the approval of an outing was not strong enough. The components of the assessment were open to too much subjective interpretation by staff and the views of stakeholders were not given appropriate consideration. The assessment criteria did not for example, include key areas such as the child's capacity to make safe choices when in the community, or their ability to refrain from risk-taking behaviours. Furthermore, there was no meaningful or objective analysis of any changes to a child's risk taking behaviour. As a result, the risk assessment process could not adequately inform decisions about outings from the unit through evidence-based measures of risk.

Inspectors enquired what steps were taken in cases where a child had a pattern of absconds and was at significant risk in the community. The person in charge informed inspectors of a case where outings were stopped for a child on the basis of ongoing risk, but this was an external decision made by a court. There was a noted reluctance by managers in the special care unit to stop outings for children at particular risk, despite it being within their power to do so, when necessary. Children who met with inspectors were aware of this reluctance.

Managers and staff were commended for the care they provded to children in the

special care unit by external professionals and a parent who spoke to inspectors. Inspectors found that the staff team were cohesive in their approach to care for children which was child-centred and focused on positive outcomes. The staff team held a complex and challenging dual role of providing care and containment for children, but they differed in their opinion and perspectives on outings for children who absconded. Some staff said that children had too many outings, while others were of the view that the unit was not designed to contain children, but to create possibilibites and opportunities for appropriate interaction and contact with the community. This disparity posed a potential risk of inconsistent practice in relation to risk assessments and the planning outings for children from the secure campus, and it was an aspect of practice that the children who met with inspectors had experienced and observed.

This inspection found that the governance and managerial systems in place for oversight and management of risks associated with absconds from outings were not strong enough. In situations where children repeatedly absconded from planned outings and experienced actual harm, the registered provider did not ensure that the safety and welfare of each child detained in the special care unit was always protected. Inspectors found that where there were indicators of risk of absconding for children and risk to their safety and welfare on abscond, that did not result in appropriate refusal of off-site activity. The special care unit did not always use their power of detainment appropriately in these instances.

Regulation 6: Care practices, operational policies and procedures Sub reg 1 and 2

The registered provider did not ensure that the safety and welfare of each child detained in the special care unit was always protected. Furthermore, the registered provider did not ensure that policies and procedures were provided to the special care unit in line with Schedule 2.

Judgment: Not compliant

Regulation 24: Governance and management Sub reg 24 (1)c (1)d and (3)

Management systems in the special care unit did not ensure effective oversight, monitoring and review of the rate of absconds from special care unit. There were inadequate systems in place to monitor the operation of the service and to review the quality and safety of the special care provided.

Judgment: Not compliant

Quality and safety

Children received good quality care in the special care unit, however, inspectors found that children were not always safe when on abscond and the service needed to improve on its approach to managing absconding behaviour and the risks it presented.

There was a high volume of absconds by children in 2019 and in some cases, the children involved experienced actual harm. The person in charge was the designated liaison person in line with Children First and she had a system in place to record, monitor and track the progress of child protection and welfare concerns which were reported to Tusla social work departments. Inspectors found that allegations of abuse and harm related to absconds were reported in line with Children First. However, the person in charge did not always track and record multiple allegations made by a child in circumstances where they alleged being abused more than once and by more than one perpetrator, while on abscond. This did not ensure good oversight of child protection concerns which, when analysed, may inform assessments of risk to children.

Although there were risk management systems in place, they were disconnected and therefore not being utilised effectively. For example, inspectors found a disconnect between the risk rating applied to absconds in the organisational risk register, the criteria for risk assessment contained in unit policy on outings (mobilities), and the components of risk assessment tools to inform decisions about outings, which was recently introduced to the service. This potentially impacted on the service' ability to reduce absconds in a strategic way.

There were structures in place to enable staff to support each child's development, self-awareness, understanding and skills for self-care and protection. Risk to children was identified through the care planning processes, which included statutory child in care reviews, multi-disciplinary consultation and input and internal placement plans for children. However, inspectors found that the staff team were challenged by complex and high risk taking behaviours, and in situations where children were not able or were reluctant to participate in meaningful interventions, such as therapeutic services provided on-site. Some records of direct work with children did not provide evidence of any measures or actions being taken to adequately equip children with skills for self-care and protection. This meant that some children were repeatedly afforded outings in the community, without supporting evidence of an appropriate level of engagement in supports to promote their self-care and protection.

The special care unit can protect children from the substantial risk of harm to their life, health, safety, development or welfare by virtue of their purpose and function to

provide secure care. However, inspectors were not assured that in all cases, the service had adequately balanced the provision of secure care and containment, with the need to support children to be safe in the community, in line with their programme of care and in preparation for their discharge.

This inspection found that overall, children were well cared for and the staff team and managers were endeavouring to provide them with positive experiences outside of the special care unit which may benefit them in their future lives and support their safe discharge. During this inspection, there were no children on abscond in the community. However, the provision of positive community experiences for children needed to be balanced with actual or potential risk of harm. As a result, children's safety and welfare was sometimes compromised when on abscond from the service, and this could not be sustained.

Regulation 12: Protection

Inspectors did not find evidence of appropriate measures being taken to try to equip all children with skills for self-care and protection. The registered provider was failing to keep children safe at all times in the service.

Judgment: Not compliant

Regulation 25: Risk management Sub reg 1 and 2

The registered provider did not ensure that an up to date risk management policy was in place in the special care unit, in line with requirements of the regulations.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 6: care practices, operational policies and procedures	Not compliant
Regulation 24: Governance and management	Not compliant
Quality and safety	
Regulation 12: Protection	Not compliant
Regulation 25: Risk management	Not compliant

Compliance Plan for Ballydowd OSV – 0004221

Inspection ID: MON-0028660

Date of inspection: 17 February 2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017, as amended, Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 and the National Standards for Special Care Units 2015.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 6: Care practices, operational policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Care practices, operational policies and procedures: The Director and Person in Charge will review and further enhance the risk assessment process relating to mobility's and ensure that there is a more robust assessment of risk prior to the commencement of all outings from the centre. The view of the Multi-disciplinary team will be sought in relation to the general provision of mobility's to each young person. All outings will only be permitted once the risk assessment has been reviewed by the Person in Charge and or the Director of Services and they are satisfied the risk of abscond is minimal. The updated suite of policies and procedures have been approved by the National Policy Oversight Committee and were scheduled to be rolled out in March 2020. This has been delayed as a result of the COVID-19 pandemic. It is planned that the policies and procedures will be fully implemented by June 2020.	
Regulation 12: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Protection: A programme of individual work will be completed with all young people in relation to absconding which will encompass outlining the risks associated with absconding and repercussions if they are not compliant in relation to the expectations of them when they are outside of the special care settings. The individual work completed with the young people in relation to the risk taking behavior they engaged in when on previous absconds will be reviewed and where it was	

insufficient or lacking in detail additional work will be completed with the young people before further outings are commenced.

Regulation 24: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Governance and management: All absconds in 2019-2020 will be reviewed through a significant incident review process to extract learning and to further inform our risk management processes in relation to mobility's from the centre. The risk management policy will be updated to reflect this learning. An annual review to assess the quality and safety of the special care unit will be completed by July 2020. The registered provider will ensure that 6 monthly unannounced inspections of the special care service are completed in a timely manner.	

Regulation 25: Risk management	Not Compliant
Outline how you are going to come into compliance with Regulation 25: Risk management: The registered provider will ensure that the risk management policy is updated to reflect the learning extracted from the review of all absconds. The registered provider will ensure that an updated risk management policy will be fully implemented in the service by the end of June 2020	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 6(1)	The registered provider shall promote and protect the life, health, safety, development and welfare of each child who is detained in the special care unit.	Not Compliant	Orange	15th May 2020
Regulation 6(2)	The registered provider shall ensure that the special care unit has care practices, operational policies and procedures in place in accordance with best practice and paragraph (1) having regard to the number of children detained in the special care unit and the nature of their needs, which practices, policies and procedures shall include, but shall not be limited to, the matters set out in Schedule 2 and the obligations of the person in charge under these Regulations.	Not Compliant	Orange	30th June 2020
Regulation 12(1)	The registered provider shall ensure that each child placed in the special care unit is	Not Compliant	Orange	30th April 2020

	assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.			
Regulation 12(2)	The registered provider shall protect all children placed in the special care unit from all forms of abuse.	Not Compliant	Orange	30th April 2020
Regulation 24(1)(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate to the child's needs, consistent and effectively monitored.	Not Compliant	Orange	30th May 2020
Regulation 24(1)(d)	There is an annual review to assess the quality and safety of special care provided in the special care unit and to confirm that such special care is in accordance with national standards, the interim special care orders or the special care orders generally, and the child's programme of special care.	Not Compliant	Orange	30th July 2020
Regulation 24(3)	The registered provider, or a person nominated	Not Compliant	Orange	30th June 2020

	by the registered provider, shall carry out an unannounced visit to the special care unit at least once every six months, or more frequently as determined by the chief inspector.			
Regulation 25(1)	The registered provider shall ensure that the special care unit has a risk management policy in place and that it is implemented throughout the special care unit.	Not Compliant	Orange	30th May 2020
	The registered provider shall ensure that the risk management policy includes the following: (a) the ongoing identification, assessment, management and review of risks throughout the special care unit, (b) the measures and actions in place to control the risks identified, (c) the measures and actions in place to control the following risks to a child— (i) child abuse, (ii) situations where a child may be removed or absconds from the special care unit,	Not Compliant	Orange	30th June 2020

Regulation 25(2)	(iii) accidental injury to a child, (iv) aggression and violence from or towards a child, and (v) self-harm, (d) arrangements for the identification, recording, investigation and learning from incidents involving children detained in the special care unit, (e) accidental injury to a staff member, an intern, a trainee or a person on a placement as part of a vocational training course in the special care unit, and (f) aggression and violence towards a staff member, an intern, a trainee or a person on a placement as part of a vocational training course in the special care unit.			