



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

**Social Services
Inspectorate**

BALLYDOWD SPECIAL CARE UNIT

In the

HEALTH SERVICE EXECUTIVE

DUBLIN MID-LEINSTER REGION

FINAL REPORT

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1. Introduction

The Health Information and Quality Authority (HIQA) Social Services Inspectorate (SSI) carried out an unannounced inspection of a special care service in the Health Services Executive Dublin Mid-Leinster region (HSEDML) under Section 69 (2) of the Child Care Act 1991, on the 1 July, 2 July and 8 July 2010. The inspection was carried out by Sharron Austin, lead inspector and Bronagh Gibson co-inspector.

The service was provided in two sites: Ballydowd Special Care Unit (SCU1) in the HSEDML, and Solas Special Care Unit (SCU2) which was located in a high support campus (HSU) in the Dublin North East region (DNE).

SCU2 was designated as a special care facility in agreement with the High Court for three children following a fire incident in the SCU1 campus on the 25 October 2009. It was the understanding of the inspectorate that the use of this facility would be temporary and phased out once onward placements were found for the three children who had been transferred from SCU1. Their placement in SCU2 was also intended to allow the plan for long-term change to be developed. Although SCU2 had met its primary purpose, it continued to be used as an SCU once the three children had moved to onward placements.¹ Between the 25 October 2009 and the time of this inspection there had been five admissions to and two discharges from SCU2. At the time of this inspection there were three girls resident in the unit.

Overall, inspectors found this unit to be unsuitable for the purpose of providing a good standard of special care. This was a secure unit operating in the open campus of a HSU. Operational management for the campus was the responsibility of the Director of the HSU and operational management for SCU2 was the responsibility of the Acting Director of SCU1. The campus itself was an open facility, but SCU2 had restricted access to it and limited facilities available to the children and the staff team.

SCU1 was previously inspected in June and August 2009 (Inspection report ID.366/341), with a follow-up inspection on 7 January 2010 (Inspection report ID.390). An action plan was completed by the HSEDML in response to the inspection report on 23 November 2009. Inspectors were initially satisfied that the actions proposed would address the concerns identified. As part of its response, the HSEDML proposed the closure of Ballydowd in November 2009. This did not happen. One young person remained living in the unit until 21 June 2010. It was the understanding of the inspectorate that the campus would close on that date. This did not occur and another young person was admitted to the unit nine days later on 30 June 2010.

The acting director of Ballydowd had responsibility for both units (SCU1 and SCU2) at the time of this inspection. Inspectors were told that it was the intention of the HSEDML to make one of the three accommodation blocks on the Ballydowd campus fit for purpose and to close SCU2. The refurbished block in SCU1 would provide four special care beds in total.

At the time of this inspection there was one boy resident in the unit. Inspectors noted that the environment and physical condition of the accommodation and campus in SCU1 had deteriorated

¹ The interim report published in December 2009 stated that: 'An action plan was completed by the HSE in response to the inspection report on the 23.11.09. As part of its response, the HSE decided to close Ballydowd SCU. The HSE report that this will be completed within timeframes set by the needs of the resident children.'

since the last inspection. The recommendations of the last SSI inspection report still stand. Inspectors expect SCU1 not to be used for the placement of children as it is not fit for purpose.

In summary, the HSEDML was found by inspectors to be operating two sub-standard SCUs at the time of inspection. Inspectors found that the HSEDML had not adhered to its proposed actions in response to the serious concerns of the inspectorate about the quality and safety of the special care service it delivered in Ballydowd SCU. The extension of the interim arrangement made to use SCU2 as a special care unit to facilitate the closure of SCU1 was not satisfactory, and did not conform to the HSE's action plan of 23 November 2009.

1.1 Methodology

Over the course of the inspection, inspectors' judgments are based on evidence verified from several sources gathered through direct observation, an inspection of accommodation on both campuses, interviews with two children, the acting director of the special care service, two unit managers, two team co-ordinators, three staff, and the National Specialist (Alternative Care) who had line management responsibility for special care and high support, telephone interviews with two clinical psychiatrists, one parent, two social workers, two social work team leaders, two guardians-ad-litem, and examination of the following records and documentation:

- a copy of the unit's register
- information on the children in the SCU
- two questionnaires completed by children
- two questionnaires completed by supervising social workers
- one questionnaire completed by parents
- two questionnaires completed by guardians-ad-litem
- children's care files
- children's care plans
- details of unauthorised absences since the last inspection (31)
- details of physical restraints since the last inspection (76)
- details of single separation since the last inspection (51)
- details of other notified significant events since the last inspection (2)
- copies of the HSE monitoring officer's reports (5).

1.2 Acknowledgements

The inspectors wish to acknowledge the cooperation of the young people, their relatives, the acting director and staff of the SCUs, the HSE managers and all the other professionals who participated in this inspection.

1.3 Data on young people

Since the last inspection in August 2009 there have been seven admissions and 14 discharges. At the time of the inspection in July 2010 there were four young people resident, three girls in SCU2 and one boy in SCU1, aged between 13 and 16 years. Details are shown in the table below. There had been a total of five admissions to SCU2 since October 2009.

Data on Young people in SCU2 – 1st July 2010

Child	M/F	Age	Placing HSE Area	Length of Placement	Number of previous placements
# 1	F	15 years 6 months	Dublin Mid Leinster	5 weeks	8 relative foster placements 3 out of hours placements 1 residential placement 1 high support placement
# 2	F	15 years	Kildare/West Wicklow	3 weeks	1 respite foster care placement 1 supported lodgings 1 residential placement
#3	F	13 years 9 months	Dublin North East	1 week	5 foster care placements 6 residential care placements

Listed in order of length of placement

Data on Young people in SCU1– 1st July 2010

Child	M/F	Age	Placing HSE Area	Length of Placement	Number of previous placements
# 1	M	15 years 6 months	Dublin Mid Leinster	1 day	2 residential placements

1.4 Management structure

At the time of the inspections, the two units, SCU1 and SCU2 were managed by an acting director based in SCU1 offices. The acting director reported to the National Specialist Alternative Care who had line management responsibility for special care and high support. Day-to-day management of both units was provided by one acting deputy director/head of care, one unit manager, one acting unit manager and one acting deputy unit manager. An acting deputy unit manager was assigned full time to SCU2. Inspectors found that a senior manager was on call at all times.

2. Summary of Findings

The inspectorate had concerns about the current overall governance of special care provision nationally. This was first brought to the attention of the HSE in May 2008 when the SSI recommended in a meeting with the National Management Team for special care and high support that the reporting and governance relationship between the national management group and senior managers of SCUs required clarification. Inspectors acknowledge the duty of the HSE to provide secure care placements; however, there was little evidence as to what the model of care in the service was. Inspectors were concerned that placements were being provided in two unsuitable, inadequate settings which did not meet required standards. Providing a 'secure' and 'contained' environment had taken precedence over providing a good quality service within a model of care for children in crisis.

Inspectors were aware of a national plan for the provision of special care placements that was awaiting approval by HSE senior management. Despite this, inspectors were concerned to hear different accounts across all levels of staff during interviews of what the plan would entail, and found that the timescale for long-term plans had been extended, and medium-term plans had changed. The inspectorate was informed that Ballydowd would close on two occasions in 2009 and 2010.

In this inspection inspectors found that the fabric of the buildings in SCU1 had deteriorated further from the poor state identified in the last full inspection report, but continued to be used as a place of detention for children. This represented an unsafe situation for the children placed in special care units.

The long-term plan for reform of the service nationally had been made known to the inspectorate. However, for a variety of reasons there has been a significant delay in its implementation. In the interim, unsafe and substandard facilities were being used for the placement of highly vulnerable children.

Due to serious concerns following the inspection of both units, the chief inspector of the SSI wrote immediately to senior management in the HSE. The HSE requested a meeting with HIQA/SSI to discuss the issues and to outline an interim plan for special care provision nationally. At the meeting the SSI outlined the concerns raised during the inspection and issued an interim set of actions that required immediate attention by the HSE. These related primarily to governance and the continued use of unsuitable, inadequate and unsafe settings for the provision of special care placements, but also focused on the standards of management and care planning. The HSE were required to address all the actions outlined by the inspectorate as a matter of urgency.

Practices that met the required standard

Register

Inspectors were provided with a copy of the unit's electronic register. This contained details for both units. It showed that in the 10 months since the last inspection there had been seven admissions and 14 discharges. The register contained all the required statutory information. In light of the Ryan Report, and the fact that recommendations regarding the archiving of SCU1's files have been reiterated over two years, inspectors advised that details of where a file is archived once a child has been discharged from the unit should be noted in the unit's register.

Meals

Inspectors were assured by staff and children that their meal preferences were well catered for. During both site visits, inspectors joined children and staff for meals and found them to be sufficient and healthy. The children could exercise choice and had opportunities to cook for themselves. They had access to snacks during the day and evening.

Contact with families

The standard on access to and contact with families was mostly well met. Children who completed the questionnaires and those interviewed acknowledged that they were encouraged and facilitated to make contact, could speak to family members in private, and were able to receive visits from them. Parents who completed questionnaires or spoke with inspectors confirmed that they were treated with respect and kept informed of their child's progress.

Education

The school term had finished at the time of inspection and as such, this standard was not assessed during the inspection. However, education was found to have been provided in both units by the on-site schools. The children in SCU2 attended the school on the HSU campus. This was an open facility, and the 'secure' element was provided by SCU2 staff members who sat near school doors to ensure the young people did not leave the campus. One child told inspectors that she liked school and had enjoyed attending. She was proud of her achievements there.

Child protection

Since September 2008 there had been six child protection notifications. Four allegations in December 2009 were made against staff members by one child. One allegation was withdrawn by the child in the presence of the social worker. The HSE carried out investigations into the allegations, three of which were concluded in February and March 2010 with no child protection concerns and three of which are still ongoing. All concerns were appropriately notified to relevant parties

Promoting good order

There had been few significant incidents in SCU2. The children told inspectors that they were aware of the rules and what was expected of them. There had been one fire incident in this unit on 20 March 2010 when two children obtained cigarettes and a lighter, and cardboard was set on fire in a bathroom. The unit was limited by the physical structure of the buildings if staff needed to separate children when behaviour became difficult to control. While SCU2 met the standard, some other areas in relation to SCU1 required improvement and are referred to in the sections on restraint, single separation and unauthorised absences below.

Practices that partly met the required standard

Purpose and function

SCU1 had a statement of purpose and function consistent with its national role as a special care facility in which boys and girls at risk aged 11 – 17 years on admission were detained under orders from the High Court. Inspectors found that the statement of purpose and function had not been revised following the HSE's decision to close Ballydowd and the subsequent establishment of an interim arrangement in SCU2. In the last inspection in August 2009 inspectors found that the SCU was unable to fulfil expectations in terms of the provision of some of its therapeutic services. This was still the case in this inspection and a number of the external professionals interviewed expressed concern about this. The recommendation of the previous inspection report that the HSE should ensure that the scope and limitations of Ballydowd's therapeutic provision are clearly explained to referring social workers still stands.

Training and development

Inspectors were told that all staff had training in child protection. However, on review of the training records, six care staff did not have training in *Children First: National Guidelines for the Protection and Welfare of Children*. This deficit should be remedied. Inspectors recommend that managers provide training in Children First for the care staff who have not received it as a matter of priority. Four of the staff were supported by the HSE to gain a qualification in social care.

Referral and placement of children

Referrals to special care in all three of the State's SCUs were processed by a national committee. Following the HSE's decision to close SCU1 special care placement capacity reduced significantly. Inspectors were told by the acting director that as a consequence of reduced capacity in the special care units nationally (Coovagh House SCU from five to three, Gleann Alainn SCU from seven to five) SCU1 had to remain open in order to meet the identified demand. Inspectors recommend that the HSE resolve this situation as a matter of urgency so that there are safer, suitable options compliant with regulations, standards and inspection recommendations available to the admissions committee.

Legal and court work

All of the young people had a guardian-ad-litem. All cases were judicially reviewed by the court on a monthly basis. The guardians-ad-litem interviewed told inspectors that SCU2 was not an appropriate setting and that recreational activities were inadequate. They told inspectors that they were concerned about the children placed in special care units being unable to avail of in-house therapeutic supports. Inspectors were told that in most cases, High Court orders to detain were still sought and granted, and children continued to be placed there. This was despite the inadequate settings for special care provision at both locations.

Monitoring

SCU1 and SCU2 had an HSE-appointed monitoring officer. This was a private arrangement and the person was not a HSE employee. She visited the SCUs frequently both in her capacity as monitoring officer and as member of the critical incident review group. Since the last annual inspection in August 2009, she had carried out five monitoring visits to both units and had written reports of her findings. In her reports, the monitoring officer had recommended on several occasions that "*senior managers in the HSE should continue their planned, focused and managed closure of Ballydowd and the Solas unit in as short a time as possible*". While some

recommendations were met, inspectors found no formal record of a response to the monitoring officer by either on-site or external managers.

The inspectors were of the view that the monitoring officer's role should be strengthened in a service that caters for a transient population of extremely vulnerable and at times volatile children. As a matter of priority, the inspectorate recommended as part of the interim actions required that:

- the HSE appoint one accountable HSE monitoring officer with clear terms of reference and lines of reporting
- visits to all SCU sites should be carried out by the monitoring officer under Section 22 of the Child Care (Special Care) Regulations 2004
- rigorous follow-up on the full implementation of the outstanding recommendations of the SSI reports be carried out by the HSE monitoring officer.

Statutory care planning and review

Each of the four children had care plans, and the plans were subject to monthly reviews. In the two children's questionnaires received by inspectors both said that they were aware that they had a care plan and that they attended the review meetings. Both questionnaires indicated that the care plan and reviews were discussed with the children involved and that they had a say in decisions made at the review meetings where the plans were discussed.

Most of the children in the SCU were aware of the plans for them to move on after the expiry of the detention order. However, it was not clear where the onward placement for one child who had been in SCU2 for a week was going to be. This was not in keeping with the agreed referral process. Follow-on placements should be identified at the point of referral to special care. The HSE should ensure that there are clear discharge plans in place for all children placed in special care and that everyone involved collaborates to the highest standard of partnership in the best interests of the child.

Social work role – supervision and visiting of children

All of the children were assigned a supervising social worker who visited them regularly. The supervising social workers told inspectors that the SCU provided a safe service for the children placed there, and this was reflected in the views expressed by the children in the questionnaires. The children interviewed spoke positively of their social worker's involvement and could talk to them about aspects of their care. Two social workers were not aware of the further limitations of placing a child in SCU2. This unit was a temporary interim arrangement and had limited facilities as a place of detention. One social worker told inspectors that he/she was not happy with the provision at SCU1. Inspectors recommend that social workers should read previous inspection reports and monitoring reports of SCUs and see the intended placement at the point of referral so as to make an informed decision as to the suitability and safety of the intended placement.

Emotional and specialist support

Staff had an awareness of the emotional and psychological needs of the children and social workers interviewed told inspectors that staff were "tuned in" to the children. There was evidence of key working with the children and some social workers assessed the quality of this work when reading unit files. The children interviewed were able to outline the areas that had been addressed with them in key working sessions which took place two to three times a week.

Other external professionals expressed their concern in relation to minimum therapeutic interventions available at the time of inspection such as psychology and speech and language therapy. This had a serious impact on the implementation of the model of care which includes clinical input for children, and consultation for staff. Inspectors were told by one social worker that these services had to be sourced privately for one particular child as the SCU was not in a position to provide them. Therapeutic services, which are described in the SCU's statement of purpose and function as integral to the service provided by the unit, should be available to all children detained in SCUs.

Complaints

Inspectors found that the children, both those interviewed and those who completed questionnaires, had a clear understanding about the SCU's complaints procedures and understood that they could refer a complaint to people outside the unit such as their social worker or guardian-ad-litem.

In the period since the last inspection, six complaints had been made by three children against staff relating to alleged unprofessional behaviour. Four staff had been put on leave in relation to three of the complaints. Two staff continued to be on leave during this inspection. The findings in relation to the remaining three complaints were inconclusive.

A child care manager independent of the line management system of the SCU had been assigned to the unit to manage complaints against senior managers. Staff were not clear of her role during the last inspection. During the follow-up inspection in January 2010, managers informed inspectors that the role of the external child care manager was known to all staff, however, inspectors found that some staff were still unaware of her role.

Access to information

Inspectors found that children were aware of their right to access to information, but in practice, access was mostly limited to log books on the units. There was little evidence that the staff were being proactive in promoting and facilitating the exercise of this right. Inspectors recommend that access to information is reviewed with staff to ensure that staff understand and actively promote and facilitate this right.

Consultation

Inspectors found evidence of consultation with children and their families in the drawing up of care plans and participation for reviews. However, there was little or no evidence of staff creating the appropriate time or encouraging the children to meet as a group on a regular basis to discuss issues as required by the standards.

Health

The standard on health was mostly met. Each child was able to access services as required. Each child had a medical on admission. However, health histories and records were poor. The children in SCU1 had full access to a gym and outside space. SCU2 provided limited access to the gym and outside space due to its location on the campus of an open unit.

Restraint and single separation

There were 76 instances of physical restraint involving 10 children and 51 of single separation involving nine children since the last inspection in August 2009. The majority of these were in SCU1. The majority of the restraints (55%) also took place in SCU1. Twenty-four of the restraints related to one child and the duration of these ranged from 30 seconds to 35 minutes. Eighteen restraints related to a second child in SCU1 and the duration ranged from 10 seconds to 15 minutes.

Twenty-eight of the single separations related to two children, mainly in SCU1, and the duration of these ranged from five minutes to six hours. Records reviewed by inspectors showed that all appropriate initial notifications were made to relevant people. Senior managers authorised the separations and reviewed their durations.

Absence without authority

All absences from SCU1 failed to meet the standard on security. Since the last inspection in August 2009 there had been 36 unauthorised absences by eight children in SCU1. Nineteen of these absences, ranging from one to 53 hours, related to one child. Eighteen of these occurred while the child was away from the unit with staff. The duration of these absences ranged from five minutes to three days. In total, 29 of these absences occurred while the children were away from the unit with staff. Records examined by inspectors indicated that all appropriate initial notifications were made to relevant people.

Practices that did not meet the standard

Management

There was a crisis in management in Ballydowd at the time of the last inspection (Inspection report IDs 341/366), where serious difficulties of trust between management and staff had developed and had impacted negatively on the running of the unit. It had presented itself in the management of several aspects of care as a crisis of confidence and authority.

During this inspection, the inspectors were concerned that this standard was still not met. Inspectors acknowledged that some changes had been introduced, but at the time of inspection, there was no clear brief for the acting director on what was expected of him in terms of running SCU2 on a high support campus. Although inspectors were told that the acting director was carrying out his duties as he saw fit, lines of accountability were unclear, for example, High Court orders were issued to the director of the HSU. Decisions about the security of the campus were determined by the director of the HSU in consultation with the acting director of SCU1 and SCU2 taking into account the needs of the populations of both services. Petty cash and maintenance requests were dealt with in a similar way.

Inspectors found that there was insufficient consideration of the risks presented by the physical buildings and other issues regarding security and accommodation on the Ballydowd campus when accepting the placement of children beyond the original proposed closure date of 5 November 2009.

From interviews at different levels throughout the service the strategy for managing the changes that were entailed in redeploying staff were conflicting. In the view of inspectors, the drive to meet the needs of staff took precedence over the need to provide safe care for children and ensure that the SCU met, and would meet in the future, the required standards. The children

interviewed were able to tell inspectors more about the proposed plans for the units than the staff could.

In SCU2 there was an over-reliance on team coordinators to make day-to-day decisions that were within the remit of the unit manager. Staff were not supervised to a satisfactory level. Inspectors found that there was no clear system to ensure that there was effective communication and continuity across shifts. Shift planning was poor. Effective practice in relation to record keeping was not ensured by unit managers on a regular basis.

Notwithstanding the appointment of managers in the SCU2 as a result of the previous inspection in March 2010, inspectors found that staff were unclear as to who was in charge on a day-to-day basis and all of those interviewed told inspectors that while managers were accessible by phone, they were not physically present on the unit on a regular basis. This requires urgent attention.

There was little service planning on a national level and this was made obvious through the inspection as inspectors found that other units were not working to full capacity. One of these units had gender-specific placements that had not been reviewed in light of where special care provision was and the other was not functioning adequately. All of these factors were cited by managers to inspectors as contributing to the necessity to make beds available in SCU1, irrespective of its condition.

Staffing

Inspectors were told there were 65 staff working across the two SCU sites which included all grades. From interviews with unit managers and staff, inspectors were told that the roster was determined on a weekly basis and did not indicate what managers were on duty. This was subsequently changed following the fieldwork in the SCU2. A review of the rotas over several months found that on average there were four staff on duty on each shift in SCU2 and three in SCU1. Two waking night staff worked 8pm to 8am in each location. There was a balanced ratio of agency to permanent staff in each location.

Following the HSE's decision to close SCU1, a redeployment process had been initiated and was ongoing during the inspection with managers of the service, the HSE human resources department, union officials and representatives of SCU1 staff. The national manager for special care and high support had meetings with staff to present the proposals for reform of special care. Inspectors were subsequently informed that even though the HSE had made a decision to continue to use the facility at SCU1 and not close it, the redeployment exercise continued. Inspectors were told by one supervising social worker that there appeared to be a lack of clarity about what was happening in relation to plans for special care provision and staffing issues. He/she described it as a "*disconnection*" between senior managers and staff and that in some instances the children knew more about what was happening than some staff.

Staff interviewed by inspectors said that they had not received supervision on a regular basis. This was particularly evident with the staff in SCU2. This was of concern as inspectors had been informed in a recent follow-up inspection to SCU1 in January 2010 that the issues in relation to supervision had been addressed.

Staff meetings and handover meetings were not taking place regularly to ensure good communication, cooperation and consistency between all staff.

Administrative files

During the last full inspection in August 2009 inspectors found archived records stored in a unit in SCU1 that was not in use. Files were not secure and were found in disarray. A recommendation was made to ensure that all care files were stored in a private and secure manner. During the follow-up inspection in January 2010 the inspectors noted that the files had been transferred to a secure off-site archiving facility belonging to the HSE.

However, during this inspection, inspectors found approximately 50 boxes of other case files and other unit documentation in a second vacant unit within SCU1. Inspectors were told by senior managers of the service that these were records gathered in preparation for the planned closure of SCU1. Inspectors found that the rear door to this unit was unlocked and that the room in which the boxes were stored did not have a door with a functioning lock. Inspectors pointed out to managers that the protection and security of archived files had not been assured and was still outstanding and a serious concern. The HSE should address this long outstanding recommendation.

Notification of significant events

In the last two annual inspections inspectors found that the standard on prompt notification of significant events was well met. Subsequently, there had been a significant change in practice and the standard was not met. Many supervising social workers and guardians-ad-litem told inspectors that while they were being notified on a regular basis there were delays in the receipt of notifications about serious incidents, and written reports were not received at all. The records examined by inspectors supported this. Social workers told inspectors that they had been informed that it was now SCU policy not to send written reports to them and several said that they had requested these as part of their own policy but were still not in receipt of any. To meet the standard the HSE should ensure that the SCU notifies all significant events to relevant parties without delay, and provide detailed reports about the incident as required by the relevant social work departments.

Children's individual care files

The quality of recording was poor. Information held on files was scant. There were some loose documents on files. Inspectors found evidence of deletion of computer records relating to individual children. The HSE and its entire staff have an obligation to store personal information in accordance with data protection legislation. This was an extremely serious matter in relation to the security of personal, confidential information and should be rectified as soon as possible.

Inspectors found that the centre did not have a policy of the use of computers and/or computer generated information. Inspectors recommend that a policy is developed on the use of computer for information purposes, and clear guidance should be issued to staff about the maintenance of records generated on computers.

Location and design and general accommodation

The location and condition of the premises at SCU1 has been raised in a number of previous inspection reports, and was specifically brought to the attention of the national management team by inspectors in a meeting in May 2008. The 2009 inspection report stated that the SCU was in considerable disrepair in many areas, and generally it was not fit for purpose. The report stated that managers and staff were struggling to meet a basic standard in relation to the physical condition of the building. Inspectors recommended at the time that as a matter of urgency, the HSE should address the fact that the SCU was no longer fit for purpose, and provide

for the lack of resources available to the maintenance department to address the considerable demands entailed in making the unit fit for purpose.

On foot of the inspection report, the HSE gave an undertaking that SCU1 would close on 5 November 2009. A young boy continued to reside in SCU1 until 21 June 2010. It was the understanding of the inspectorate that the campus would close on this date. This did not occur and a new admission was made nine days later on 30 June 2010.

SCU2, a facility on a high support campus, was designated as a special care facility for three children following a fire incident in the SCU1 campus in October 2009, and the understanding of the inspectorate was that the use of this facility would be phased out once onward placements were sourced for the three children who had been transferred. This interim arrangement has continued for the past eight months prior to this inspection and currently there were three girls resident in the unit. An inspection of SCU2 in March 2010 outlined concerns in relation to its unsuitability and limited facilities as a place of detention.

During this inspection (July 2010), inspectors were informed that one of three units within the SCU1 campus was to be redecorated and that the special care places available in SCU2 would transfer back to SCU1 campus. This would ensure four special care places were available to the High Court.

Notwithstanding the demand for placements, inspectors were concerned that special care was currently being provided in two unsuitable, inadequate settings which do not meet required standards. Providing a 'secure' environment has taken precedence over providing an adequate service for children in crisis. The need for 'containment' outweighs the quality of the service, its staff and the safety and quality of the buildings. The inspectorate requires that the HSE cease the use of both Ballydowd and Solas as a special care facility with immediate effect and not place children in either until the buildings and campus are brought up to standard and their safety is assured.

Accommodation – individual children

The standard on accommodation for individual children was not met. While the overall condition of the bedrooms in SCU2 was good and the children had personalised them as best they could, the condition of the bedrooms in SCU1 was poor and did not provide a comfortable environment for children. Inappropriate graffiti covered the exterior walls of some of the units in SCU1 and no attempt had been made to address this.

As a temporary arrangement, SCU2 posed challenges to both children and staff. There were poor recreational facilities and security issues as the campus was designated as an open facility, and there had been no review of policy and practice to accommodate the needs of the detained children. Inspectors noted that one parent was not happy about the poor physical condition of SCU1 and was concerned about the negative impact of the environment on the child.

Maintenance and repairs

As a consequence of the initial decision to close Ballydowd, repairs and maintenance became less of a priority and management set about clearing out the premises. On a visual inspection of the facility, inspectors were concerned about the overall condition of the physical environment and its visual impact on any child being placed there.

SCU2, while in good structural shape, was not equipped with the necessary special care features to ensure safety and good order. As an interim facility, there was no great effort made to make it more appealing and comfortable for children. Minor repairs were dealt with promptly.

Risk assessments had been carried out in both locations. However, inspectors had several serious concerns about safety and recommended that the HSE arrange for a competent person independent of the line management structure to carry out a full risk assessment of the current facilities without delay, including the assessment for the potential for self-harm in the population of children placed in the units.

Safety, Fire Precautions and Security

This standard was not met. Since the last inspection there had been several incidents in which the security of the SCU had been compromised. A significant fire incident in October 2009 rendered one of the units inoperable and three children were transferred to SCU2 immediately as an interim measure. During this incident, a child accessed the roof and had a fall from it resulting in a broken leg. The Authority requested a provider-led investigation into this incident at the time which was duly completed and returned. A fire incident occurred in SCU2 on 30 March 2010 where two children obtained cigarettes and a lighter and cardboard was set on fire in a bathroom. In both cases, the HSE reviewed the incidents and were satisfied that all appropriate safety systems functioned.

On a visual inspection of SCU1 campus, inspectors found disused units open at the rear which contained maintenance equipment, dangerous implements and other objects that posed a safety risk. Inspectors were told by managers of the service that children do not have access to the rear of the units. In spite of the explanation given to them, inspectors found that managers were unaware of the risks these objects presented if a child were to gain access to these areas, and recommended that both internal and external managers make regular checks to ensure that they and the staff make the environment safe, and have a raised level of consciousness about safety as required by health and safety legislation.

3. Findings

3.1 Purpose and function

Standard

The unit has a written statement of purpose and function that accurately describes what the unit sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood. The unit's role in relation to the wider child care services (including regional and national) is clearly set out by the Health Service Executive.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Purpose and function		√	

3.2 Management and staffing

Standard

The unit is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place. There is an adequate number of staff who are sufficiently experienced and qualified to enable the unit to achieve its purpose and function and to meet the needs of the young people.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Management Systems			√
Register	√		
Notification of significant events			√
Staffing			√
Supervision and support			√
Training and development		√	
Administrative files			√

3.3 Monitoring

Standard

The Health Service Executive, for the purposes of satisfying itself that the Special Care Regulations and Standards are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person on its behalf to monitor statutory and non-statutory young people's residential units.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Monitoring		√	

3.4 Planning for young people and families

Standard

There is a written care plan to promote the welfare of each young person, which is developed in consultation with parents and young people and subject to regular review. It stresses and practically supports contact with families, and preparation for adulthood. It promotes education and health needs and addresses the emotional and psychological needs of the young people. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care. Supervising social workers have clear professional and statutory obligations and responsibilities for young people in residential care. All young people need to know that they have access on a regular basis to an advocate external to the unit to whom they can confide any difficulties or concerns they have in relation to any aspects of their care.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Referral and placement of young people		√	
Statutory care planning and review		√	
Legal and court work		√	
Contact with families	√		
Supervision and visiting of young people		√	
Social work role		√	
Emotional and specialist support		√	
Preparation for leaving care and after care		√	
Young people's individual files			√

3.5 Care of young people

Standard

Young people are cared for by staff who can relate effectively to them in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse. Day-to-day care is of good quality and provided in a way that takes account of the individual needs of young people in relation to age, race, culture, religion, gender and disability.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Protection	√		
Staff relationships			√
Race, culture, religion, gender and disability	√		
Health		√	
Access to information		√	
Consultation		√	
Privacy, dignity and individuality		√	
Meals	√		
Personal appearance		√	
Leisure activities			√
Promoting good order	√		
Restraint and single separation		√	
Complaints		√	
Absence without authority		√	

3.6 Premises and Safety

Standard

The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose as a special care unit. The unit's buildings and associated outdoor areas are designed to prevent unauthorised entry or exit. They facilitate supervision and minimise opportunities for self-harm while providing accommodation that is, in so far as it is practicable, appropriate to its designation as a young people's unit. The unit is properly maintained and furnished. It has adequate arrangements to guard against the risk of fire and other hazards.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Risk assessment			√
Location and design			√
Accommodation general			√
Accommodation - individual young people			√
Maintenance and repairs			√
Safety and fire precautions			√
Security			√

3.7 Education

Standard

All young people have a right to education. Education is seen as an integral part of the care of the young person. The education of each young person in the unit is actively promoted by all involved. Supervising social workers and unit management ensure each young person in the unit has access to appropriate educational facilities. Where appropriate, and as far as it is practicable, young people over the age of 16 should be offered a programme of vocational preparation, training and work experience or transition to further education.

	<i>Practice met the required standard</i>	<i>Practice partly met the required standard</i>	<i>Practice did not meet the required standard</i>
Education	Not assessed		

4. Recommendations

Before children are placed in the special care units again, the following specific recommendations have to be met fully. They do not take away from the managers of the service the requirement that they satisfy themselves that the structure, governance, management, physical environment and service delivery in SCUs is fully compliant with legislation, regulations and standards.

The HSE should ensure that:

1. The use of the current units at Ballydowd and Solas as special care facilities ceases with immediate effect and children are not placed in them until they are completely brought up to standard.
2. The scope and limitations of Ballydowd's therapeutic provision are clearly explained to referring social workers.
3. Managers provide training in *Children First: National Guidelines for the Protection and Welfare of Children* for care staff who have not received it.
4. There are safer, suitable options compliant with regulations, standards and inspection recommendations available to the admissions committee when processing referral applications.
5. One accountable HSE monitoring officer is appointed with clear terms of reference and lines of reporting.
6. Visits to the SCUs should be carried out by the monitoring officer under Section 22 of the Child Care (Special Care) Regulations 2004.
7. Rigorous follow-up on the full implementation of the outstanding recommendations of the SSI reports are carried out by the HSE monitoring officer.
8. A review of cases/placements should be carried out by a competent person independent of the line management structure.
9. There are clear discharge plans in place for all children placed in special care.
10. There is a nationally directed requirement issued to all social work departments for referring social workers to read SCU inspection reports and monitoring reports prior to making referrals and to visit SCUs at the point of referral to satisfy themselves that the intended placement is suitable and safe. Social work managers to be held accountable if they have not.
11. Children's access to information is reviewed with staff to ensure that staff understand and actively promote and facilitate this child's right.

12. Staff encourage and enable the children to meet as a group on a regular basis to discuss issues as required by the standards.
13. Nationally, there are clear lines of accountability of all special care units to a person with national authority.
14. There is clarity of governance and reporting relationships.
15. Forums, such as staff meetings and handover meetings are maintained to ensure for clear communication between staff and continuity of care of children.
16. The standards on recording, maintaining files, security and archiving files is fully compliant with legislation, regulation and standards.
17. The SCU notifies all significant events to relevant parties without delay and promptly provide detailed written reports as required by the relevant social work departments and other professionals who have a right to the information.
18. A HSE national policy is developed on the use of computers for information purposes in all care settings, and clear guidance should be issued to staff about the maintenance of records generated on computers.
19. A full risk assessment of the current facilities is carried out by a competent person independent of the line management structure without delay, including the potential for self-harm.