



**SOCIAL SERVICES
INSPECTORATE**

**BALLYDOWD SPECIAL CARE UNIT
SOUTH WESTERN AREA HEALTH BOARD**

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1. Executive Summary

The Social Services Inspectorate (SSI) carried out an announced inspection of Ballydowd Special Care Unit in March 2002. The unit is a purpose built secure residential child care facility. It opened in the autumn of 2000 to cater for young people with serious emotional and behavioural difficulties. The young people are detained in Ballydowd for their own care and protection. Although intended as a national resource, at the time of inspection only young people from two health boards were being cared for in the unit. The South Western Area Health Board (SWAHB) manages Ballydowd.

SSI inspects annually centres where young people are detained. This was the second inspection of the unit, the first having taken place in June 2001. The 2002 inspection was brought forward by three months at the request of the board. Particular attention in this report has been paid to progress in the implementation of the recommendations of the last inspection report and in addressing difficulties identified by the board at the time such as those relating to the recruitment and retention of staff.

The 2001 inspection report was largely favourable. Concerns were raised about the practice of locking young people in their rooms and a number of recommendations were made in relation to this and other matters. The young people were being cared for well. Good systems for the support, supervision and training of staff, for dealing with complaints, for recording and for reporting of incidents were highlighted.

The situation deteriorated in the period between the two inspections. Fewer staff were available to run the unit at the time of the second inspection. Systems that were in place in early 2001 broke down in the latter half of the year. Few of the recommendations of the inspection report of 2001 were implemented in full. By early 2002 the unit was in crisis. Staff took industrial action and there was a group disturbance in the unit. Both of these events drew widespread media attention.

The board put a new management team in place in February 2002 to replace the director and two deputy directors who were simultaneously on sick leave. This helped to stabilise the situation in Ballydowd in the short term. However, the new team was an interim one, in place for six months in the first instance and, at the time of the inspection, no decision had been made for arrangements beyond that. This led to an unhelpful uncertainty and insecurity for staff and young people. However, in September inspectors learned that the new management team had been confirmed in post on a permanent basis.

The expectation that Ballydowd is or can be the answer to the problems of all the very troubled young people that present themselves as in need of the care and protection of the health boards is unrealistic. However, there were inadequacies in the service offered at Ballydowd and shortcomings in the way it has been managed by SWAHB.

Some staff and managers expressed the view that a number of the young people had not been appropriately placed in Ballydowd and that their needs could not be met

there. Professionals from outside of the unit stated that Ballydowd offered primarily physical containment and did not sufficiently address the therapeutic needs of the young people placed there. Ballydowd found it difficult to adhere to its stated purpose and function due to the lack of other forms of provision for troubled young people.

Many staff members were positive about their work, focused on the young people and optimistic about the future. However, not all staff attitudes were positive. There were problems to do with pay, conditions and contracts and many staff members expressed dissatisfaction with their treatment by the board. Staff members referred to inconsistent advice given to them by different managers. Established structures for the training, supervision and support of members of the care team broke down. There were high rates of assault on staff, staff sickness and staff turnover. Some staff members stated that some of their colleagues failed to observe proper professional boundaries in their dealings with each other.

Many social workers and guardians ad litem were positive about the care offered to their clients, despite being critical of aspects of the regime. Relationships between staff members and young people were generally good. However, the quality of care offered had undoubtedly deteriorated since the last inspection. Behaviour management by staff was poor and the use of physical restraint and, more particularly, single separation had increased.

There were care plans for the young people in Ballydowd and social work support was generally good. However, social workers and guardians ad litem were not consistently kept informed of incidents involving their clients. The decisions of review meetings were not always properly recorded and implemented.

The educational provision for the young people was excellent.

The board failed to make arrangements for external monitoring of standards at Ballydowd.

The board did not act on some complaints made by young people.

Access to some specialist and therapeutic services was problematic.

Young people were kept for a time in a badly damaged accommodation unit when there was an option to move them to another one in better repair.

The board was aware that Ballydowd was experiencing difficulties and measures had been taken to address them. Just prior to the completion of this report SSI was given a copy of a document entitled 'The Way Forward'. This set out the board's aspirations for the future of Ballydowd. It addressed many of the issues raised in this report. The board also indicated that it had already taken action in relation to a number of key areas such as providing stable management for Ballydowd, staff training and supervision. In addition many policies and procedures were under review. SSI intends to visit the unit again in the near future to ascertain and report on progress in implementing recommendations and addressing the difficulties identified in this report.

2. Introduction

The inspection of Ballydowd Special Care Unit (SCU) was conducted by the Social Services Inspectorate (SSI) under the provisions of Section 69(2) of the Child Care Act, 1991. The unit is a purpose built secure residential child care facility under the management of the South Western Area Health Board (SWAHB). It is a national facility, accepting referrals of young people throughout the country. The young people are detained in Ballydowd by order of the High Court for their care and protection, pending the enactment of the Children Act 2001. This Act will give district courts the power to make special care orders. Michael McNamara and Andrew Fagan (lead inspector) carried out the inspection on March 26th to 28th 2002, with a return visit on May 1st. In line with SSI policy of inspecting centres where young people are detained on an annual basis, this was the second inspection of Ballydowd since it opened in September 2000. At the request of the board the 2002 inspection was brought forward by three months.

2.1 Methodology

During the inspection inspectors met with both staff and young people and observed the routines of the centre. Interviews were conducted with two of the young people individually and with five of them in a group meeting. One of the young people opted not to meet with inspectors but communicated her views through her guardian ad litem. Inspectors met one parent and interviewed another by phone. Other interviews were conducted with the director, deputy director, two senior managers, the school principal, the external line manager, members of the staff team, social workers and social work team leaders, guardians ad litem, the speech and language therapist, a psychologist and members of the management advisory group.

Written information on staff and young people was made available to inspectors prior to inspection. Inspectors read the policy documents for the unit and undertook a detailed analysis of some files and records such as records of physical restraints and significant incidents.

2.1 Acknowledgements

Inspectors acknowledge the assistance of the various officers of SWAHB in carrying out this inspection and thank the young people, staff and all those who met with the inspection team.

3. Setting the scene: background, the centre and its population

3.1 Background

Ballydowd SCU was opened in September 2000. It has accommodation for up to 24 young people, boys and girls, aged between 11 and 17 years. Due to difficulties in recruiting staff it has not reached full capacity to date. At the time of this inspection there were six young people in one accommodation unit and one young person in a second unit. Agency staff cared for this young person.

In the period between the first and second inspection Ballydowd had experienced considerable instability. There were a number of factors involved and the difficulties became critical in February 2002.

Changes in management

The director of Ballydowd managed the unit from before the time it opened until she went on maternity leave in April 2001. She was assisted by two deputy directors. When she went on leave, one of the deputy directors acted in her place and he was assisted by the other deputy director and a unit manager who became acting deputy director. The acting deputy director left to take up another position in December 2001. The director returned from maternity leave in January 2002 and again managed Ballydowd with the assistance of the two deputy directors. During February, the director and both deputy directors were on sick leave simultaneously. There was no director or deputy director available to manage the unit. The board approached two people from outside Ballydowd and asked them to jointly manage the unit for an interim period of at least six months. They agreed and took up post. The director and the two deputy directors were requested not to resume their duties when their period of sick leave ended. At the time of inspection their status was unclear, though inspectors were subsequently informed that these matters had been resolved. From the point of view of the young people and staff, these changes meant that in a ten month period there were four different people in charge: the director, the deputy director who acted for the director while she was on maternity leave and two senior managers who, at the time of the inspection, were jointly managing the unit without taking the title of directors.

Staff shortages

The health board went to considerable lengths, detailed later in this report, to recruit staff to Ballydowd. Despite this, the staffing situation worsened through a combination of high levels of staff turnover and staff sickness. By the beginning of 2002, the remaining staff were tired from working extra hours to cover shifts and believed that the point was being reached where there were simply too few staff to run the unit. Supported by their union, they took one day industrial action in February, during which staff remained on duty. This attracted widespread media attention.

Disturbances within Ballydowd

Some young people admitted to Ballydowd in the latter half of 2001 proved difficult for staff to manage. There were assaults on staff. An accommodation unit was damaged. In February, a number of the young people refused simultaneously to accept direction from members of staff. They caused further damage to the building and presented a threat to their own safety and the safety of other young people and staff. Staff contacted the Gardai. Gardai entered the Ballydowd campus to restore

order. Shortly afterwards one of the young people involved was removed, temporarily, to a detention centre for offenders following court appearances. Another of the young people involved was subsequently discharged from Ballydowd.

Developments since the inspection of 2002

In September 2002, the board sent copies of two documents to SSI. One of these, named 'The Way Forward', was a strategic plan for the development of the service. It set out the board's aspirations for the future of Ballydowd. It highlighted and committed the board to act on many of the issues raised in this report. In addition, the board sent a response to the draft inspection report that SSI had sent to the board in June 2002. This stated that action had already been taken in relation to a number of key areas: that the board had introduced stable management, organised training for staff, re-introduced regular formal supervision of staff and informed staff of the policy in relation to freedom of information. The document further stated that many of the unit's policies, procedures and practices were undergoing review. Inspectors welcome these developments. The next inspection will report on the implementation of the changes outlined in these documents.

3.2 Details of current and previous placements

<i>Young person</i>	<i>Age</i>	<i>Care status</i>	<i>Length of time in Ballydowd</i>	<i>Previous placements</i>
# 1	12	High Court Order	7 months	3 foster, one residential placement
# 2	12	High Court Order	15 months	2 residential placements
#3	14	High Court Order	8 months	3 residential placements
# 4	14	High Court Order	5 months	6 residential placements
# 5	15	High Court Order	5 months	1 assessment centre placement
# 6	16	High Court Order	9 months	3 residential placements
# 7	17	High Court Order	15 months	Placements in residential units, supported lodgings and other.

All of the young people had been referred by the South Western Area Health Board or the Northern Area Health Board.

3.3 Management structure

Ballydowd is managed by SWAHB on behalf of the other health boards. A management advisory group offers general advice to the executive on policies and procedures.

4. Standards: the findings

4.1 Purpose and Function

Recommendation of 2001 Inspection report:

- *The management advisory group should reconsider the policy on the role of Ballydowd.*

Inspectors were informed that the management advisory group had discussed this matter. However the policy document remained as it was at the time of the last inspection. For instance, the document referred to Ballydowd as a regional facility though it is, in fact, a national resource.

4.1.1 Role of unit

The unit's role in relation to the wider child care services (including regional and national) is clear and set out by the Health Board or Area Health Authority.

The Ballydowd policy document stated a commitment on the part of the three health boards of the Eastern Regional Health Authority (ERHA) to develop an integrated system of community and family support and alternative care services for those young people who must be placed out of home. Special care, of the sort offered in Ballydowd, was seen as but one element within a network of services for young people and their families within the eastern region.

This policy failed to take account of two facts. One is that Ballydowd is a national, not a regional resource. Secondly, Ballydowd was not, in fact, well integrated with other services for children and families and this was particularly apparent at the point where post Ballydowd placements and services needed to be identified for the young people in placement. Statutory responsibility for care planning, including post placement planning rested with the referring social work teams. Some young people had been successfully discharged and had maintained contact with Ballydowd staff. However, this was an area of difficulty for both Ballydowd and the social work teams and inspectors formed the view that a more collaborative approach was required.

The policy on the role of Ballydowd ought to be changed to take account of the fact that it is now a national resource. The lack of integration of Ballydowd with other services will be considered later in this report.

4.1.2 *Statement of purpose and function*

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 Ballydowd policy document stated that: “Ballydowd Special Care Unit has been established to provide a safe and secure environment where young people (male and female) aged 11 to 17 years, can be helped to develop physically, socially, morally, emotionally and educationally, according to their individual needs. While the element of security is important, it does not override the ethos and requirements of good child care practice and the primacy of therapeutic relationships. When Ballydowd is used in a planned and positive way, it provides the only appropriate placement for young people who have been identified as presenting a significant risk of harm to themselves or others”. The statement also set out the objectives and guiding principles of Ballydowd.

At the time of the last inspection a reasonable balance had been achieved between the need for security and ‘the requirements of good child care practice’. This was supported by good systems for staff training and support and access to consultation. Some of the young people who had been in Ballydowd at the time of the last inspection had done well and had successfully managed the transition to open settings. As discussed in greater detail later in this report, care practices had changed in the period between the two inspections and this upset the balance between care and control of the young people. There was a greater reliance on locking young people in their rooms as a means of managing their behaviour. The staff consultant resigned from her post at the end of 2001 and had not been replaced. A psychologist was available to work with the young people but his availability was limited. There was little staff training during this period. There were ongoing difficulties accessing specialist therapeutic services for some of the young people.

At the time of this inspection Ballydowd was not providing sufficient opportunities for the young people to address the difficulties that led to their detention. This matter is considered in greater detail throughout this report. However, it is important to note here that this failure undermines the whole *raison d’être* of special care. It cannot be acceptable to deprive young people of their liberty for their own welfare and protection unless it can be clearly demonstrated that their liberty is being restricted in order to help them to overcome the difficulties that made this necessary.

Recommendations

1. The management advisory group should change the policy on the role of the Ballydowd to take account of the fact that it is a national rather than regional resource.

4.2 Management and staffing

Recommendation of 2001 inspection report: SWAHB should expedite the process of arranging for the monitoring of standards in Ballydowd.

This recommendation was not implemented.

4.2.1 Staffing

There is an adequate number of staff who are sufficiently experienced and qualified to enable the unit to achieve its purpose and function and meet the needs of the young people.

There were insufficient staff available to run the unit at the time of inspection due to problems with staff recruitment and retention, and high levels of sick leave.

Staff available at the time of inspection

As of 13/2/02, when the staff census form was completed, but before the new managers took up post, there were 22 full-time care staff employed in Ballydowd. Of these, five were on sick leave, three of whom were considered to be on long term sick leave. On this date, the director and one of the two deputy directors were also on sick leave. In addition to these staff, there was one unit manager, two acting unit managers and one acting deputy unit manager, all of whom were available for duty. This made a total of 29 staff, apart from teaching, agency and other staff. However, of these, only 22 were available for work on the day in question. This compared with 26 at the time of the last inspection. In the period between the two inspections 18 members of staff resigned. Half of these were employed and resigned in the period between the two inspections. Thirteen of the 29 staff were on temporary contracts compared with only one out of 26 at the time of the last inspection.

Staff recruitment and retention

SWAHB made considerable efforts to recruit staff to work at Ballydowd. Documentation provided by the board stated that during 2001 the board participated in a recruitment fair in Finland, run by FAS. An advertising campaign was held in Ontario, Canada and an interview board travelled to Toronto in March to interview applicants. Three Finns and 14 Canadians started work in Ballydowd in the summer. There was also a further national recruitment campaign as a result of which a number of people were employed on a temporary basis.

Some of those who had been recruited in Canada told inspectors that they had not clearly understood that Ballydowd was a locked unit. Members of the interview board said that the function of the unit had been explained to candidates. There was little disagreement, however, as to what happened next. When the Canadians arrived in Ireland they found that, contrary to undertakings they had been given, work permits had not been obtained for them. This meant that they could not be paid. Some were able to help each other out financially for a time. Others had to access savings or appeal to their families in Canada for money. After a time, some payments were made but, since these were made in advance of the work permits being issued, these payments placed the people involved in an invidious position as it is not lawful for non-European Union nationals to take up paid employment in Ireland without work permits. All were appointed to permanent posts but, up to the time of the staff census of 13/2/02, none of them had been given a permanent contract. At this point, six had resigned. The three Finns had also resigned. The Canadians interviewed by inspectors also complained about a lack of induction training, supervision and support, considered in more detail later in this report.

Inspectors learned of other workers who were not being paid the correct salary either because they had not been given incremental credit for their previous experience or because they were not being paid for assuming extra responsibilities. One person, for example, successfully applied for promotion within Ballydowd but the appointment had not been formalised by contract or payments due to some difficulty in relation to the processing of his application.

In January of 2002 the board nominated a person in Naas to deal with these difficulties. Up to that point various members of staff had been making their way into Eastern Health Shared Services in Dr Steevens Hospital on their days off to try to resolve these issues for themselves. However, in May, when inspectors revisited the centre for a day, staff members were still experiencing difficulties in relation to contracts and pay. Their frustration had increased. One person told inspectors of having dealt with seven different people over a six-month period in relation to a problem that was still unresolved.

Ensuring adequate staffing levels for Ballydowd has been problematic since before it opened. The failure to resolve the problem contributed in no small part to the upheavals experienced in Ballydowd in the latter half of 2001 and the early part of 2002. Despite recruiting new staff through national and overseas recruitment campaigns, there were fewer staff available to work in the unit at the time of the second inspection than there were during the first one. A majority of staff members interviewed by inspectors, both those newly recruited and other staff who were experiencing difficulties in relation to their pay and conditions, reported that they had become disenchanted and disillusioned with their treatment at the hands of the board. Finally, and perhaps most importantly, significant amounts of time, both staff time and managers' time, were taken up in trying to resolve the difficulties. This time was not, therefore, available for the care of the young people or for staff to rest between shifts, and managers' time was not available for the training, supervision and support of staff.

Sick leave

Many staff in Ballydowd worked extra hours particularly towards the end of 2001 and the beginning of 2002. Numerous staff had resigned. Others were off sick, some as a result of assaults by young people. It was difficult for managers to ensure sufficient staffing levels. Staff members interviewed by inspectors spoke of being asked repeatedly, sometimes on the same day, to work extra shifts. They spoke of a sense of letting down their colleagues if they refused. They became locked in an unhealthy cycle where they became tired and stressed due to the pressure of too much work and too little rest. Most of those interviewed eventually succumbed and had to take sick leave. What made these situations worse was that during this period there was little or no opportunity for training or supervision of staff, little opportunity to 'come up for air' and reflect on what was happening for young people, staff and Ballydowd generally.

Inspectors were given information on the number of days sick leave taken by staff between July 2001 and February 2002. While inspectors were informed that one particular staff member was off sick on a long-term basis, no details on when she went off and when she returned were given. Therefore, this was not included in the analysis which, as a consequence, underestimates the amount of sick leave taken. Despite this, the data gives an indication of the scale and trend of sick leave. Inspectors calculated that 36 care staff (including managers but excluding teaching and ancillary staff) had a total of over 900 sick days in the eight month period in question, an average of approximately 25 days each. It is not necessarily the case that each person missed 25 days off work as some of the sick days would have included days they were not scheduled to work. There were two peaks, one in September when there were over 150 sick days and another in February when there were over 200 days. The capacity of staff to manage the behaviour of the young people safely was seriously impaired through sheer lack of availability of staff for work during these two months.

Staff attitudes

For all the difficulties that staff members had experienced, those interviewed by inspectors were positive about their work. They saw Ballydowd as having potential to deliver a high quality service to the young people. It was clear from what staff members told inspectors and also from accounts given by outside professionals that the unit remained open during the turbulent period from the latter part of 2001 up to the time of inspection through the determination of certain staff members to persevere in the face of adversity. It is greatly to their credit that they did so.

Care staff of Ballydowd SCU as of 13/2/02

Staff member	Post	Contract	Length of time in Ballydowd	Qualifications
#1	Director	Permanent	2 years and 4 months	Diploma in Social Care
#2	Deputy Director	Permanent	1 year 11 months	B.Sc. Social Administration, Diploma in Social Work, Higher Diploma in Applied Social Studies
#3	Deputy Director	Permanent	1 year 11 months	B.A. Psychology, Masters in Care Management
#4	Unit Manager	Permanent	1 year 5 months	Certificate in Social Studies, Dip. Psych. Nursing, Dip. Forensic Nursing
#5	Acting Unit Manager	Temporary	3 months	Dip. Psych. Nursing
#6	Child Care Worker	Permanent	1 year 6 months	No qualifications
#7	Acting Unit Manager	Permanent	1 year 4 months	Diploma in Child Development
#8	Child Care Worker	Permanent	1 year 4 months	No qualifications
#9	Child Care Worker	Temporary	1 year 4 months	No qualifications
#10	Child Care Worker	Permanent	1 year 5 months	National Diploma in Applied Social Studies in Social Care
#11	Child Care Worker	Temporary	9 months	No qualifications
#12	Child Care Worker	Temporary	5 months	Certificate in Information Processing
#13	Child Care Worker	Temporary	3 months	No qualifications
#14	Child Care Worker	Permanent	1 year 4 months	B.Sc. Occupational Therapy. Dip. Health

				Studies
#15	Acting Deputy Unit Manager	Permanent	9 months	Diploma in Social Care
#16	Child Care Worker	Permanent	1 year 5 months	National Diploma in Sports Science
#17	Child Care Worker	Permanent	1 year 4 months	No qualifications
#18	Child Care Worker	Temporary	7 months	Child and Youth Worker Diploma
Staff member	Post	Contract	Length of time in Ballydowd	Qualifications
#19	Child Care Worker	Temporary	9 months	No qualifications
#20	Child Care Worker	Temporary	8 months	B.A. Sociology
#21	Child Care Worker	Temporary	9 months	Undergoing social work training
#22	Child Care Worker	Permanent	1 year 4 months	No Qualifications
#23	Child Care Worker	Permanent	1 year 7 months	B.A. Applied Care in Social Care
#24	Child Care Worker	Permanent	1 year 8 months	Diploma in Social Studies
#25	Child Care Worker	Permanent	8 months	No qualifications
#26	Child Care Worker	Temporary	8 months	Correctional Worker Diploma
#27	Child Care Worker	Temporary	8 months	Children and Youth Worker Diploma
#28	Child Care Worker	Temporary	9 months	B.S.W. Correctional Worker Diploma
#29	Child Care Worker	Temporary	9 months	No qualifications

At the end of February 2002, in the absence of the director and two deputy directors the board assigned two senior managers to Ballydowd.

Post holder	Contract	Commencement date	Qualifications
Senior Manager #1	6 months (minimum)	26/2/2002	C.Q.S.W.
Senior Manager #2	6 months (minimum)	26/2/2002	Dip. Youth and Community Work Dip. Management of Health Services

4.2.2 Staff Checks

The staff that were recruited from overseas with whom inspectors met said that they had been required to provide references, details of qualifications and local police checks before taking up employment at Ballydowd.

Information available on staff employed on temporary contracts demonstrated that necessary checks had not been carried out in some instances. One temporary staff member had been in post nine months but there was no record of Garda clearance or references. Another person was employed with no Garda clearance. Two other staff members did have Garda clearance but it was obtained after they commenced duties at Ballydowd. This is not safe practice and ought to cease immediately.

4.2.3 Staff rota

The rota system was as it had been at the time of the previous inspection. There were three shifts per day: an early day shift, a late day shift and a night shift when two night waking staff were on duty and checked the young people at regular intervals through the night.

At the time of the last inspection it was felt that the rota worked fairly well. There was plenty of time allowed for staff to hand over from one shift to another and for those coming on duty to prepare for their shift. At the time, managers commented that it was a constant struggle to ensure adequate staff cover, given annual leave, sick leave and staff training. In the intervening period the problem became much more acute, given staff shortages and high levels of sick leave.

4.2.4 Staff support and supervision

The inspection report of 2001 praised the systems that were then in place for the training, supervision and support of staff. These systems fell into abeyance in the latter half of that year. The policy was for each member of staff to have a nominated supervisor to meet with him or her on a monthly basis for formal supervision. Some staff interviewed by inspectors said that they did not know who their nominated supervisor was, and others said that they had only met with that person when they themselves requested it and that such meetings had not taken place on a regular basis. Some staff members had not had any formal supervision at all.

The perception of some of the staff was that there were divisions within the management team. They said that different members of the team gave conflicting advice about how to deal with particular situations. Others, while acknowledging that there were difficulties and a lack of formal supervision, nevertheless said that individual managers were available for informal consultation and supervision and described them as supportive.

4.2.5 Staff training and development

Some new staff had received induction training. There were courses in therapeutic crisis intervention (TCI) and report writing, and time with the staff consultant. While one newly recruited staff member was happy with the induction training she received other staff members interviewed by inspectors said that the training was inadequate. Some of those recruited from Canada were sent to an empty accommodation unit and told to read the policies and procedures document. This was not felt to be an adequate preparation for the work that they were expected to do. There was no post induction in-service training.

Staff spoke favourably about the work of a staff consultant who was responsible for staff development up to the end of 2001.

At the time of inspection one of the senior managers was conducting a training audit. New in-service training programmes were being planned.

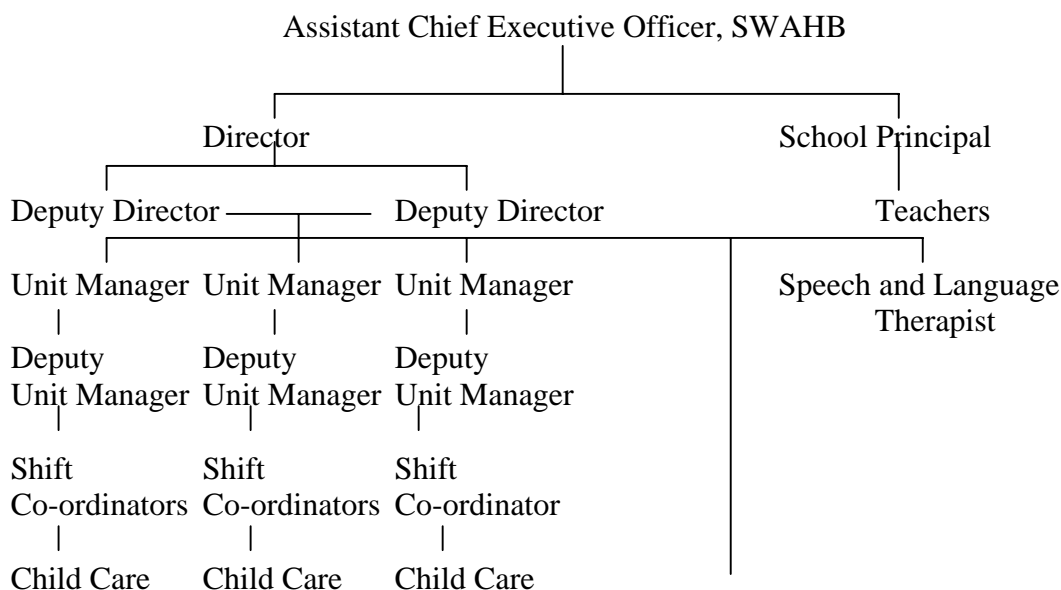
Staff cohesion had suffered. There were divisions within the staff team. A number of staff referred to the existence of a ‘clique’. Members of this group, they claimed, undermined some of their colleagues in various ways such as dismissing their opinions, ignoring them, or speaking to them in a disrespectful manner in front of colleagues and young people. The staff members who referred to this clique felt that their confidentiality was not respected and found themselves in uncomfortable situations where information about colleagues was shared among the staff group. Some of the staff members interviewed said that they had raised these matters with managers but that the behaviour continued and they saw no further point in complaining about the behaviour of their colleagues. When inspectors raised this issue senior managers stated that they were aware of some of the matters complained of and had taken steps to eradicate them.

Clearly there was a lack of trust within the staff team. A staff team that is internally divided cannot operate effectively. This issue needs to be fully addressed and resolved.

4.2.6 Unit Management

The unit is effectively managed and staff are organised and deployed so as to operate the unit effectively and efficiently to the required standard.

Up to February 2002 the management structure was as set out in the organisational chart below.



Workers Workers Workers Ancillary staff

This diagram represents the staffing structure if all posts were filled. At no stage have all these posts been filled but the structure remained more or less intact up until the end of February 2002. Some changes had been introduced in response to the fact that Ballydowd had been going through a difficult time with staffing problems and the management of the behaviour of the young people. The school principal had taken on some management responsibilities for the unit as a whole. For instance, he chaired some review meetings and participated in the 'on call rota', the system by which managers in Ballydowd make themselves available to members of the care staff for advice and consultation outside of normal working hours.

As mentioned earlier in this report, in February 2002 the board introduced two people from outside Ballydowd to jointly manage the unit for an interim period of at least six months. These two people, referred to as senior managers, reported directly to the assistant chief executive. The school principal retained some management responsibilities and a unit manager had been appointed senior assistant manager.

The board had had concerns about aspects of management of Ballydowd and had commissioned a report on the management of Ballydowd from an independent consultant. The decision to assign the two senior managers was precipitated, however, by the fact that all three directors were on sick leave at the same time.

The assistant chief executive chaired a management advisory group whose function was to offer general advice to the executive on the policies and procedures in operation in Ballydowd Special Care Unit. The group, which was made up of senior professionals working for the board, one professional from another health board and an independent, non-health board member, did not have an executive function. Two members of this group informed inspectors that they had not been consulted about the board's decision to commission a report on the management of Ballydowd.

Inspectors found evidence that the new management team had made a positive impact in the short time between taking up post and the inspection. The behaviour of the young people was appropriate and acceptable during the inspection. Some staff members were positive about the changes that the managers had introduced. An action plan had been drawn up that addressed issues to do with the supervision, training and support of staff. However, the impact of the new management team in the longer term was likely to be problematic due to its short-term tenure.

The needs of the young people cannot be adequately met unless cared for by a staff team that can provide continuity and consistency. Ballydowd experienced considerable instability because of the high turnover of staff. The introduction of a third management team in less than a year added to the instability. That the third management team was an interim one exacerbated the problem. Members of the staff team were unclear about the status of the directors. Some said that they thought they were still on sick leave. They were uncertain as to the role of the new managers and what would happen after the initial six-month period.

Not all of the problems experienced in Ballydowd during late 2001 and early 2002 can be attributed to inadequacies in the internal management of the unit. Any

management team would have struggled to provide an acceptable service without adequate numbers of staff. However, the managers in Ballydowd had to deal not just with staff shortages but also with the anger and frustration of the those who were unhappy about their pay and conditions.

The board's response to the problems of the overall management of Ballydowd was incomplete. While great efforts were made to recruit staff the issue of retention of staff was not adequately addressed. The board failed to make arrangements for the monitoring of standards, considered below. The introduction of an interim management team brought further instability to a situation where stability was badly needed and notably absent.

4.2.7 Monitoring

There was little external monitoring of standards in Ballydowd since the inspection report of 2001. This was despite a recommendation that the board should make arrangements for the monitoring of standards as soon as possible. In its response to the inspection report, the board stated that the issue of monitoring was the subject of national discussion as to the most appropriate model. Monitoring of standards is a statutory requirement under the Child Care Regulations that have been in force since 1995. Given the particular vulnerability of young people in secure care monitoring of standards must be seen as an essential safeguard.

The board's failure to make arrangements for monitoring of standards in Ballydowd is unacceptable.

Recommendations

2. SWAHB should undertake a thorough review of its approach to the recruitment and retention of staff in Ballydowd.
3. SWAHB should ensure that no staff member takes up duty at Ballydowd unless Garda and / or local police checks have been carried out and references have been taken up.
4. Managers in Ballydowd should ensure that staff members observe appropriate professional boundaries in their dealings with colleagues.
5. SWAHB should ensure that the arrangements for the internal management of Ballydowd are consistent with the young people's need for stability and continuity of care.
6. SWAHB should make immediate arrangements for external monitoring of standards in Ballydowd.

4.3 Planning for young people

Recommendations of 2001 inspection report:

- *The referrals committee should not process referrals to Ballydowd that are not accompanied by a comprehensive care plan.*
- *Social work managers should ensure that statutory reviews are carried in relation to young people placed in Ballydowd in accordance with the Child Care Regulations (1995).*
- *The health boards should apply to the court for the appointment of guardians ad litem for all young people who do not have separate legal representation at hearings where orders are being made for their detention.*

The first of these recommendations was implemented; the second was not implemented in relation to all of the young people in Ballydowd. The third recommendation was not implemented.

There is a written care plan to promote the welfare of each young person, which is subject to regular review. This stresses and practically supports contact with families, preparation for adulthood, promotes education and health needs and addresses the emotional and psychological needs of the young people.

4.3.1 Referral and placement of young people

The referral procedure was as it had been at the time of the last report.

There were seven young people in Ballydowd at the time of inspection, all of who presented with significant behaviour problems. During the inspection one young person was moved to a psychiatric hospital. Another young person was discharged from Ballydowd and, very soon afterwards, was placed in a detention centre for offenders. The social worker for a third young person had been told that an alternative placement would have to be found. Managers and staff expressed the view that the referral and assessment process needed to be changed so that young people would not be placed in Ballydowd inappropriately. They stated that some of the young people who had been placed in Ballydowd ought to have been placed in detention centres in the first place. Others disagreed. Some social workers and guardians ad litem wished for their clients to be given a chance to avail of what Ballydowd had to offer. They did not want them to be convicted of offences before they could get the sort of secure care that, in the opinion of the professionals, they required.

A crucial issue is how the decision as to whether or not a young person is appropriately placed in Ballydowd was assessed. Ballydowd could not meet the needs of the young person who was transferred to the psychiatric hospital. This was accepted by all of those working with the young person. However, in relation to the young person who went to the detention centre the issues were somewhat different and there was no unanimity among those working with him. His discharge was precipitated by his behaviour, which was seen as presenting a risk to staff and to other young people. The context in which the young person's behaviour occurred was one of an over stretched and stressed staff team, lack of training and support of staff and inadequacies in the approach to the management of the behaviour of the young people, discussed in further detail later in this report (4.4.4).

Inspectors believe that where a placement breakdown occurs that a review meeting should be convened and attended by all interested parties, including, where possible, the young person and his or her parents. This should consider in a supportive and non-blaming manner the positive and negative aspects of the placement. The aim should be to allow the young person to identify and hold on to the positive aspects of the placement and to generate information to feed back into the wider system on its strengths and weaknesses.

4.3.2 Care Plans

Inspectors commend the fact that there were care plans for all of the young people placed in Ballydowd at the time of inspection. However, the expectations of what Ballydowd could achieve, as set out in some of the plans, were unrealistic. Too often, the plans treated Ballydowd as a long-term option for the young people rather than as a short-term, transitional placement. This may be related to the lack of step down placements for young people coming out of special care and to the lack of a range of different placement options for very troubled young people.

A confusion in relation to care and placement plans, commented on in the last inspection report, had not been corrected in the Ballydowd policy document.

4.3.3 Reviews

The inspection report of 2001 recommended that statutory reviews be carried out in relation to the young people in Ballydowd. This recommendation was not consistently applied.

There were regular review meetings of the young people in Ballydowd at intervals of approximately six weeks. Practice in relation to the involvement of the young people and their families was good and in keeping with the positive findings of the inspection of 2001. The problem in relation to these meetings was, as identified in that report, that the focus in many instances was on the placement rather than the care plan.

There were two dimensions to the problem. The first related to the issue of control. It is accepted practice for social work departments to take responsibility for convening and conducting statutory care plan reviews. Social work team leaders typically chair them. In Ballydowd, a member of the management team usually chaired the review

meetings, though there were some chaired by social work team leaders. The second issue concerned the format of the reviews. This gave precedence to placement issues. This did not preclude consideration of the overall care plan but it skewed the discussion away from it.

It is not acceptable that no proper care plan reviews were taking place in relation to some of the young people. Social work team leaders should chair statutory care plan reviews to underline the responsibility of the social work department for the care planning process, even if Ballydowd managers chair other reviews.

Inspectors were informed by a number of people; both those working in and those from outside Ballydowd, that some of the decisions that were made at review meetings were not implemented. One person stated that she took copious notes at reviews so that she could refer to decisions that had been made at previous reviews that had neither been recorded nor implemented. Another spoke of a decision to refer a young person to another service. Three reviews later the referral had not been made. A third person referred to decisions arrived at during reviews as to how best to manage difficult behaviour not filtering down to those working directly with the young person in question.

The decisions of care plan reviews must be recorded along with arrangements for their implementation. It must be made clear who is responsible for implementing decisions and within what time frame.

4.3.4 Contact with families

In general, practice in relation to contact with families was good, in keeping with the findings of the inspection of 2001. One parent spoke of difficulties making contact with her son on some occasions and of conflicting messages from different staff members as to when she could phone him. Despite this, she was generally happy with her contact with the staff in Ballydowd. She was facilitated to attend reviews, believed that her views were taken seriously and she received copies of the review minutes.

4.3.5 Legal and court work

The inspection report of 2001 highlighted a concern that related to the rights of young people who are detained in special care units. It arose from a situation where a health board applied to the High Court for an order to detain a young person without the young person having been consulted about plans for his future. It was recommended that, in these situations, the health board should apply to the court for the appointment of a guardian ad litem. This was to ensure that the views of the young person were considered and that his or her needs were independently assessed.

Inspectors met with three guardians ad litem who represented five of the young people in Ballydowd. They were involved in care planning, safeguarding and advocating for the young people. Given the lack of monitoring (4.2.7), the breakdown of systems for the reporting and notification of incidents (4.3.6) and of the complaints procedures (4.4.3.3), the guardians played a key role in ensuring the safe care of the young people in Ballydowd. While acknowledging that social workers are in a key position to

ensure the safety of young people, inspectors believe that the vital role of guardians ad litem in ensuring that the rights of young people are respected needs to be recognised by the board.

The SWAHB in its response to the 2001 report said that the Ballydowd management advisory group had considered the matter but that the board had decided not to proceed with the recommendation. The board argued that it was awaiting the setting of standards and regulations in relation to the role of the guardian ad litem. Inspectors share the concern of the board in relation to the lack of standards and regulation and recommend that these issues be addressed as soon as possible. Nevertheless, the principle that young people have a right to be consulted is enshrined in domestic legislation and in international human rights instruments. SSI does not accept that the exercise of the rights of young people should be delayed. The case of a young person who was discharged from Ballydowd and subsequently placed in a detention centre has been considered earlier in this report (4.3.1). He did not have a guardian ad litem. There was no independent assessment of his needs. There was no child care professional specifically assigned to ascertain his wishes and to present them to the court.

4.3.6 Supervision and visiting of young people

All of the young people had allocated social workers. This is highly commendable, given the demands on social work departments and the number of unfilled posts. Social work support was good. Social workers and their team leaders impressed inspectors with the level of their engagement with the cases of the young people in Ballydowd. There was a genuine commitment to offering the young people a quality service and to ensuring a positive outcome for them.

Many of the social workers, their team leaders and the guardians ad litem spoke of good working relationships with staff of Ballydowd. However, there were also some difficulties. Some social workers and guardians ad litem complained of lack of consultation in some instances. The issue of the conduct of reviews has been referred to earlier in this report (4.3.3). Other issues concerned preparation for moving one (4.3.7) and emotional and specialist support (4.3.8). In addition, social workers, their team leaders and guardians ad litem reported difficulties in getting accurate information in relation to some incidents involving the young people with whom they were working. The social worker for one of the young people stated that she asked for written reports of damage allegedly done by her client during February but had not received these by the time of the interview with inspectors on April 8th. The social worker for another said she had requested details of all complaints made by her client over six weeks before the inspection but had not received them. Another matter concerned a complaint made by a young person that had not been reported to the social work department until over three months later (4.4.3.3).

The lack of written notification to social workers of significant incidents is a serious matter that must be addressed promptly by the new management team.

4.3.7 Preparation for moving on

In keeping with the finding of the 2001 inspection report, social workers identified difficulties in finding suitable follow-on placements for the young people in Ballydowd. At the time of the last inspection it was stated that the new high support unit being built by the Northern Area Health Board, Crannog Nua, would function as a step down unit for Ballydowd and that it would be operational in February 2002. However, it had not opened by the time of this inspection.

Responsibility for identifying a post-Ballydowd placement rested with the young person's social worker. This was not always satisfactory. It set up conflicts between Ballydowd and social work departments with Ballydowd insisting that social work departments provide placements that could not be found. Given the lack of dedicated step down placements, it seems likely that the best hope for moving the young people in Ballydowd out of special care is to negotiate individualised 'care packages' for them. These are most likely to succeed if seen as the joint responsibility of Ballydowd and the referring social work department and if they include some continuing, if time limited, role for Ballydowd staff. A good example of what might be possible was provided at the time of inspection. One young person was in the process of being discharged. It was proving difficult to identify a school placement for him. A successful school placement was felt to be essential to the viability of other parts of his after care plan. Arrangements were made for him to attend school in another residential centre and for a teacher from Ballydowd to teach him there for a period of three months.

Inspectors learned of one situation where a young person's social worker was informed that the young person would be discharged from Ballydowd. Managers of Ballydowd had taken this decision unilaterally. It was not part of the young person's care plan. The social work department was responsible for finding an alternative placement. This left the social worker in an invidious position. She was unlikely to find a residential centre willing to accept a young person whose behaviour was, as far as Ballydowd staff were concerned, too difficult to manage.

Although the statutory responsibility for care planning, including post placement planning, rests with the referring social work department inspectors consider that the best interests of young people in special care would be served if this responsibility is discharged through collaborative working between the unit and the social work department, as in the example given above.

4.3.8 Emotional and specialist support

At the time of the last inspection, a staff consultant was working with the staff team. Her role was to help the staff to understand and respond appropriately to the young people's behaviour. This input, when combined with staff training and supervision helped to develop the capacity of the staff team to respond to the emotional needs of the young people. The staff consultant left at the end of December 2001 and had not been replaced at the time of inspection. The training and supervision of staff fell into abeyance in the latter half of the year.

The issue of access to specialist services was considered in the 2001 inspection report. The ongoing efforts of health board managers to resolve difficulties were acknowledged. However, despite these efforts the situation had not improved.

Inspectors learned of a number of situations where access to psychiatric assessments was problematic. Psychiatric evaluation was recommended in court for one young man but had not taken place up to the time of the inspection. The social work department for another young person had to go outside of Ballydowd to arrange a psychiatric assessment. There was a continuing difficulty with accessing any psychiatric services for 16 and 17 year olds. Social workers and others also complained about lack of easy access to psychotherapy for those young people in Ballydowd who needed and could benefit from it. Play therapy was recommended for one young person. The social work department had to approach a voluntary agency to provide this. Another young person had not received any counselling in relation to abuse he had experienced.

During the period between the last and this inspection a forensic psychologist was contracted to work with the unit for ten hours per week. His input was valued by staff, social workers and guardians ad litem but they stated that ten hours per week was insufficient to meet the needs of all of the young people in Ballydowd, given the lack of other therapeutic inputs and the fact that he had to attend reviews, write court reports and consult with other professionals all within the ten hours.

Ballydowd requires a multi-disciplinary team if it is to have any chance of meeting the varied and complex needs of the young people who are placed there. Apart from the existing management and care staff, teaching staff and speech and language therapist, there ought to be a full time psychologist, both to work directly with the young people and to help the staff to develop therapeutic skills. A social worker is needed to work with families and to assist with discharge planning. A psychiatric service should be available to all the young people in Ballydowd, irrespective of their age. There should be easy access to the services of other specialists as required.

4.3.9 Young people's case files

The 2001 inspection report noted that the young people's case files were comprehensive and maintained to a high standard. In the period since that inspection the quality of recording deteriorated. There was a great quantity of information in the young people's case files but its quality was uneven and it was difficult to access easily.

There was a suggestion in the last report that the files have a summary sheet at the front with most frequently sought information: the name, date of birth, home address, date of admission, family details, personal and professional contacts, access arrangements, special health needs and so on. Although not in place at the time of inspection inspectors were later informed that this had been done.

Recommendations

7. Senior managers at Ballydowd should convene a review of any placement that ends in an unplanned way.
8. Social work managers should ensure that statutory care plan reviews take place at a frequency to be decided in consultation with Ballydowd staff but not less than that required by the Child Care Regulations (1995).
9. The referrals committee should ensure that no young person is placed in Ballydowd unless a guardian ad litem has been appointed.

10. The Department of Health and Children should convene a group to draw up standards and regulations for guardians ad litem.
11. Senior managers in Ballydowd should ensure that social workers and guardians ad litem receive prompt notification and reports of significant events.
12. Ballydowd should collaborate with social work departments in identifying and /or negotiating post Ballydowd placements for the young people.
13. SWAHB should increase the range of professionals employed at Ballydowd to ensure that a full multidisciplinary service is available to all young people placed there.

4.4 Care of young people

Recommendations of 2001 inspection report:

- *The management advisory group should formulate an appropriate policy in relation to young people's access to their files.*
- *The complaints procedure should be amended to allow for appeal to a person or body outside of Ballydowd for young people dissatisfied with the handling of a complaint.*
- *Assaults by young people on other young people should be dealt with under child protection procedures, in accordance with Children First.*
- *The Department of Health and Children should identify an appropriate body to develop statutory guidelines on the use of single separation.*
- *The management advisory group should review the policy in relation to single separation to clarify what is meant by the term in Ballydowd and how the practice is to be recorded and monitored. There should be clear guidelines and strict time limits on the practice of locking young people alone in their bedrooms.*
- *The Assistant Chief Executive should authorise the use of cash for the purchase of the young people's clothes.*

The board appointed an outside consultant to review the complaints procedure. The Department of Health and Children set up a group to produce guidelines on the use of single separation. The practice of purchasing clothes with order books stopped. The issue of assaults by young people on other young people did not arise in this inspection. The management advisory group had not produced guidance for staff on the use of single separation. Staff members were not aware on any new policy in relation to young people's access to their files.

4.4.1 Relationships between staff and young people

Young people are cared for by staff who can relate effectively to them.

Guardians ad litem, social workers and their team leaders, the parent and the young people interviewed by inspectors were generally positive about the day to day care offered to the young people in Ballydowd. All of them had criticisms to make and suggestions as to how the service could be improved but, at its best, Ballydowd

offered consistency to young people, clarity of expectations and the experience of the adults in the young person's life working together to do what was best for him or her.

However, it was not possible for Ballydowd always to operate at its best and the situation that obtained in Ballydowd in the time between the last inspection and this one did not support good relationships between staff and young people. This is not a criticism of individual staff members, but young people cannot feel safe and make the emotional commitment necessary to a satisfactory relationship in an atmosphere of constant crisis and where those looking after them are continually changing. In addition, it was not helpful to the young people that no explanation had been offered to them about the continuing absence of the directors.

4.4.2 Quality of care

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.

The inspection report of 2001 criticised the lack of individualisation of the care regime. For instance, all of the young people had the same bedtime, though they were different ages. This was still the case at the time of this inspection.

As with the last inspection, however, there was evidence that the education programme of each young person was constructed around the individual needs and talents of the young people.

4.4.3 Rights of young people

Young people are cared for in a manner that safeguards and actively promotes their legal and civil rights.

Concern has been expressed earlier in this report about the failure to implement a recommendation in relation to guardians ad litem (4.3.5). Inspectors consider that this is a key children's rights issue.

4.4.3.1 Access to information

In response to a recommendation in the report of 2001, the board stated that the management advisory group had formulated a policy in relation to access to information. There was no evidence that staff were aware of any new policy and the situation was as it had been at the time of the last inspection. The young people had access to their daily logs but not to other reports on their files.

4.4.3.2 Consultation

Practice in relation to consultation was good. The situation was as it had been at the time of the last inspection. Young people were consulted about their future through

the care planning and review process. In relation to day-to-day issues, there were young people's meetings in the unit. Any issues raised at these meetings were brought to the team meeting. A member of the team then informed the young people of the outcome of their request or query.

4.4.3.3 Complaints

The 2001 inspection report praised the approach to complaints within Ballydowd but recommended strengthening practice in this area by introducing an independent element. The board acted on this recommendation by approaching a consultant from outside of the board and asking her to take on this role. The consultant prepared a detailed and comprehensive report that recommended a range of measures including training for the young people and staff, access to advocacy for the young people and consultation with other units with well-developed complaints procedures and with the Irish Association of Young People in Care (IAYPIC). This report was due to be considered by the management advisory group at the time of this inspection. The board is commended for this initiative.

The policy document outlined a procedure to be followed in the event of a young person wishing to make a complaint and practice was in accordance with the policy up to the time of the last inspection. Since that time, the practice had fallen into abeyance. Complaints made by young people were supposed to be entered into a complaints book but while numerous complaints were written into the complaints book up to September 11th, there were none between then and January 23rd. Managers in Ballydowd asked one guardian ad litem for her record of complaints made by her client as the Ballydowd record was apparently missing. There were also entries in the book that recorded the complaints made by young people but not the action taken by the staff in response to these complaints. It was unclear whether action had been taken and not recorded or whether no action had been taken at all.

Inspectors learned of a number of complaints where there was no action taken. A young person complained about the fact that a person who was not a member of the care team had physically restrained him. The director initiated an investigation of the incident and took statements from various people involved. One of those involved, whose actions were called into question by a colleague, was not interviewed and the person did not submit a written report as requested by the director. The matter was referred to the external line manager who told inspectors that she had requested a person outside the unit to carry out an investigation. This was appropriate, as an internal investigation would have lack credibility. However, no action had been taken up to the time of the inspection nearly three months later. Indeed, inspectors were told that, at this point, the young person's social worker had not been notified of the incident. Inspectors were informed by one of those involved in his care that the young person repeatedly referred to the incident and asked why he had been treated in the manner he had. The young person was subsequently discharged without the matter having been resolved.

Inspectors found that another young person had spoken with a member of staff about his fear of being locked in a room. The young person told the member of staff that he

did not wish to complain about this and, perhaps for this reason, there was no record of any follow up. However, it was recorded in the complaints book. Inspectors consider that any expression of dissatisfaction by a young person ought to lead to a response from staff whether or not the young person expresses a desire to make a formal complaint. The matter raised by the young person was of major significance given that the young person, along with all of the other young people, was subsequently routinely locked in his room at night.

A young person made a complaint about an agency staff member in September 2001. It was decided not to employ this person at Ballydowd again. However, inspectors were informed that it was not until the director returned from maternity leave in January 2002 that it was explained to the young person how management at Ballydowd had dealt with her complaint. Agency records supported this account.

All of this is highly unsatisfactory. Proper complaints procedures are an essential safeguard for young people in care. The senior managers must take immediate steps to ensure that the policy on complaints is implemented in practice and the board must ensure that the whole procedure is subject to external monitoring.

4.4.4 Discipline

Young people whose conduct is unacceptable are dealt with in accordance with positive disciplinary measures approved by the health board.

4.4.4.1 Promoting good order

The 2001 inspection report noted with approval that staff worked mainly through the medium of relationships to win the co-operation of the young people and that minimal use was made of sanctions. This became more difficult to achieve with a constant turnover of staff. Despite this, inspectors found that some staff, who knew the young people well, were working in this way. Inspectors were told of a situation where a member of the staff team, through negotiation and distraction, was able to draw two highly aroused young people away from a particularly dangerous and potentially out of control situation.

A striking aspect of the situation in Ballydowd in the time between inspections was that while there were problems in maintaining good order in the accommodation unit these problems were not present to the same extent in the school. The physical presentation of the two buildings was instructive. Considerable damage was done to the accommodation unit but not to the school building.

It would be simplistic and unhelpful to suggest that the care staff should have been doing what the teachers did. The situations were entirely different. The school day was structured and time limited. The teachers worked shorter hours. There was no turn-over of teaching staff. They were able to provide consistency and continuity. The teachers could call on care staff to accompany the young people back to the accommodation unit if difficulties arose. Nonetheless, some lessons could have been learned and there was an attempt to engage with the care staff on this basis.

The speech and language therapist worked with groups of staff trying to identify positive aspects of the school regime that could be incorporated into the practices of the care workers. The issue of programme planning was highlighted, that the young people should be involved in planned activities outside of school hours. These interventions were not successful. Feedback from some staff indicated that, while some people were willing to attempt what was being suggested, they could not rely on the co-operation of colleagues. For some staff, things had become so difficult that they could only think as far as how to get through the next shift unscathed.

Several difficulties in relation to behaviour management were brought to the attention of inspectors. One person spoke of a lack of clarity in relation to the expectations of the young people. Some care staff, it was asserted, did not make explicit to the young people how they expected them to behave. It was as though staff expected the young people to know how to behave and interpreted any departure from expected behaviour as wilful disobedience on the part of the young people. Some of the care staff interviewed confirmed this and said that the approach to behaviour management was reactive rather than proactive. They spoke of inconsistencies in the approach of the team. For example, it had been decided at a team meeting only to put young people on individual programmes if they assaulted others. However, this decision was not adhered to and young people were put on these programmes for other reasons. The young people spoke of their confusion in relation to acceptable and unacceptable behaviour. They claimed that a piece of behaviour that drew no comment from staff on one occasion could lead to a sanction at a different time. As already discussed at 4.3.3, care staff did not consistently apply decisions made at reviews in relation to the management of young people's behaviour.

Certain strategies for managing behaviour may have produced consequences other than those intended. Young people on individual structured programmes were not allowed to attend school. This seemed rather self-defeating to inspectors as the young people liked school, valued the opportunity to attend and generally behaved well there. The young people interviewed by inspectors said that they objected to being locked in their rooms and often damaged them because of this. The parent of one of the young people said that locking her son in a room did not help to control his behaviour. Inspectors were informed that some of the young people did damage their rooms when locked in them.

Some of the young people interviewed by inspectors said that they objected to the way some staff members interacted with them. They spoke of staff members making reference to aspects of their personal history that the young people considered private and not for discussion. One young person spoke of being laughed at by staff members and a member of the staff team said that some colleagues spoke to the young people in a manner that she considered disrespectful.

4.4.4.2 Restraint and single separation

The only acceptable form of physical restraint in Ballydowd was holds associated with the therapeutic crisis intervention (TCI) method. There were special forms for recording TCI restraints.

There were 25 physical restraints in the period between opening and the inspection of 2001. Between then and the second inspection there were 40 restraints. However, a procedure followed at the time of the last inspection whereby use of physical restraint was monitored both internally and externally was not in use during the period April to December 2001. This is highly unsatisfactory.

Of even greater concern was the use of single separation. Inspectors expressed concern at finding single separation listed among acceptable sanctions in the Ballydowd policy document during the last inspection. Despite this, and assurances that single separation was only used to maintain the safety of young people and staff, single separation was still listed as an acceptable sanction in the Ballydowd policy document at the time of this inspection.

Inspectors in 2001 had difficulty in identifying what practices were being described when staff members used the term 'single separation'. Sometimes this appeared to mean a young person being locked up in a room alone. At other times, it meant a young person being on a programme that involved limited contact with peers but did not involve being confined to a room. It was recommended that the management advisory group give clear guidelines and direction to staff on the use of this form of single separation. A member of the management team contributed to the drawing up of guidelines on the use of single separation as part of a group convened by the Department of Health and Children. At the time of inspection, these guidelines were in draft form and had been sent to interested parties for consultation. However, there was no written guidance for staff in Ballydowd on the use of single separation as had been recommended in the 2001 report.

The confusion in relation to terminology was still apparent during this inspection. Considerable use was made of what were referred to as 'individual structured programmes'. Indeed these were used on 84 occasions in February 2002, though in other months their use was much less frequent. Individual structured programmes were recorded on separate recording instruments. These did not clearly identify whether young people were being locked in rooms on their own. Sometimes, young people were in rooms alone and subject to either '5 minute observations' or '15 minute observations'. If this was the case, it often (but not always) indicated that they were locked in rooms (usually their bedrooms) alone.

It can be argued that young people detained in special care units who are not at liberty to leave the unit should not have their rights further eroded by being detained in their bedrooms on their own. Indeed, the senior managers who took over the management of Ballydowd in February 2002 informed inspectors that they had put an end to this practice. At the very least, one would expect that the practice would be very closely monitored to ensure that it is not used as a routine form of control. However, if the records do not clearly indicate what is being done it becomes impossible to monitor properly. It was precisely this difficulty that was highlighted in the report of 2001 and it is very much to be regretted that the board allowed the situation to continue.

Notwithstanding the difficulties in relation to recording, inspectors are confident in stating that considerable use was made of the practice of locking up young people on their own in late 2001 and early in 2002. The use of this form of single separation peaked in January 2002. In the aftermath of a group disturbance in February several

of the young people were detained in their rooms continuously for a period of four to five days, though in the latter part of this time they were allowed limited periods out of their rooms. In addition, all of the young people were routinely locked in their bedrooms at night.

While inspectors commend the fact that the new senior managers have stopped the practice of locking the young people in their rooms, it seems likely that there will be renewed pressure to resort to unacceptable means of maintaining control if the young people in Ballydowd once again become very difficult to manage. It is, therefore, essential that the problems identified above such as lack of clarity in relation to expectations, reactivity and inconsistency are eliminated. Care staff need training in positive approaches to behaviour management. In addition, the procedures and practices of the care staff should be regularly evaluated as part of the monitoring process.

The board must ensure that there are guidelines and restrictions on the use of physical restraint and single separation, that these are carefully monitored, internally and externally, and that the social workers and guardians ad litem of the young people are notified every time these measures are used.

4.4.4.3 Unauthorised absences

There were five unauthorised absences involving four young people in the period between the last inspection and this one. All of these involved young people failing to return from planned trips from the unit. In each case, the Garda returned the young person. There was detailed guidance for staff for dealing with such situations. Policy and practice in relation to unauthorised absences was good.

4.4.5 Safeguarding and child protection

The inspection report of 2001 commented favourably on policy and practice in relation to safeguarding and child protection. Ballydowd had its own child protection officer who, at that time, was the acting director. The role of the child protection officer was to deal with complaints, monitor the use of TCI and of single separation and to be available to hear the concerns of staff and young people. Just before this inspection the senior assistant manager was appointed child protection officer.

Inspectors found no evidence to suggest that the young people in Ballydowd were at risk of harm except in so far as the breakdown in good order, described earlier, inevitably placed both staff and young people at risk of injury. Inspectors learned of a number of occasions where some young people asked to be locked in their rooms for their own safety. There were also risks inherent in the excessive use of single separation. There was, moreover, a breakdown in safeguarding procedures as described elsewhere in this report: complaints that were not being dealt with (4.4.3.3), lack of internal monitoring of TCI (4.4.4.2), lack of notification of significant events (4.3.6) and at least some of the staff interviewed by inspectors reported that, in their view, managers were not available to hear their concerns (4.2.5). Guardians ad litem were invited to reviews and other meetings, but, despite this, some stated that they encountered resistance to their role on the part of Ballydowd and the board generally. For instance, one guardian ad litem, stated that she was repeatedly asked why she

visited her client as often as she did. It may be that some staff were not aware of the important safeguarding role of guardians ad litem. These matters, considered in conjunction with the lack of external monitoring (4.2.7) and the failure to ensure that all staff were vetted (4.2.2) before taking up employment meant that the systems that ought to have been in place to ensure the safety of the young people were either lacking or were operating ineffectively during the period covered by this inspection. This must be rectified immediately.

4.4.6 Health

The health needs of the young people were addressed in Ballydowd. There was an arrangement with a local GP practice that involved each young person seeing a GP within 24 hours of admission. A GP attended the unit several times a week and dealt with whatever health issues arose for the young people. Unfortunately, the GP practice was finding this responsibility too onerous and had signalled its intention of withdrawing the service. However, an undertaking had been given that this would not happen until alternative arrangements have been put in place.

The young people were encouraged by staff to develop good self-care habits and to look after their own personal hygiene.

There was a no smoking policy and members of the staff team could only smoke out of sight of the young people.

There was a well-stocked first aid box in the residential block. Medication was kept in a secure metal cabinet on the wall of the staff office. The cabinet contained a quantity of paracetamol, in boxes of 24, all of which had been prescribed for individual young people by the GP. The GP kept a record of prescriptions on a cardex system called a 'drug prescription record'. It was completed and signed by the GP and kept in the accommodation unit. Each line of the card had an alphabetical prefix against the description of a particular drug. Each time a member of the care staff gave a young person medication he or she filled in a 'drug recording form' that recorded the date, time, the medication given and the signature of two members of staff. On this form the medication was referred to not by name but by the letter it had been assigned on the drug prescription record. Inspectors consider that it would be better to write down the name of the medication administered, as there was scope for confusion by using an alphabetical code.

While inspectors were told that only prescribed medication was kept on the accommodation unit and that all medications were kept in the locked cabinet, an inspector found tablets and cough mixture that were not in a locked cabinet and medication for which there was no prescription. There was a stock control system in place to monitor what medication was brought into the unit. A box of tablets had been consumed but there was no record to indicate to whom they had been administered. This contravened the procedures described to inspectors.

Parents were notified if young people were sick. If they just had minor ailments they were not notified immediately but the information was conveyed to them in weekly reports. However, inspectors found, on reading the files, that the system of weekly reports was not regularly maintained.

In this as in other areas, good systems had been allowed to fall into disuse. The senior managers need to ensure that medication is stored safely, administered only if prescribed by a doctor and that whatever is administered is properly recorded. The system for recording what medication has been administered needs to be reviewed to minimise the risk of the wrong medication being given to a young person.

4.4.7 Privacy dignity and individuality

The young people's privacy was respected in various ways. Staff members knocked on the young people's bedroom doors and waited to be invited in except when safety considerations indicated otherwise. They handed the young people their mail unopened. The young people were allowed to use the telephone in private.

One young person was in a room that he had very badly damaged. The ensuite facilities had been broken beyond repair and were boarded up. The room had been stripped of all its contents. The young person had been locked in this room for lengthy periods, though he was allowed out to use the bathroom and toilet. It was, effectively, a shell and unfit for human habitation. When asked about it a senior manager agreed that it was unacceptable and said that he 'could not stand over it'. Despite this the young person was not moved from this room for a further two weeks. During the period between the conversation with the senior manager and the young person being given a new room, two of the three accommodation units were unoccupied. Inspectors consider that it was wrong to keep the young person in conditions that the senior manager acknowledged were unacceptable.

Contact lists were used to ensure that young people did not have contact with people who might exercise a harmful or negative influence over them. A young person in Ballydowd was only allowed contact with people whose names were on a list drawn up at the time of admission. This appeared to inspectors as unnecessarily restrictive and to place obstacles in the way of a young person's contact with and re-integration to the wider community. Rather than being confined to contact with a narrow range of people, inspectors consider that the young people in Ballydowd should be encouraged and facilitated to have as wide a range of contacts as possible except where there is definite information to suggest that a particular person represents a risk to the safety or well being of the young person.

4.4.8 Aspects of daily living

The life of the young people in Ballydowd revolved around the routines of getting up, eating meals and going to bed. On weekdays there was school to attend and after school and at weekends there were various activities in the unit and some young people were allowed out of the unit on what were described as 'mobilities'. These were trips home or to outside activities.

There was a varied and nutritious diet served to the young people and the housekeeper went to considerable trouble to accommodate the individual wishes and preferences of the young people. They were asked each day what they wished to eat the following day and the housekeeper shopped for the dishes requested.

The young people were also involved in doing chores after each meal.

4.4.9 Personal appearance

The young people wore their own clothes in the unit. Inspectors were pleased to learn that a recommendation in the report of 2001 that young people's clothes no longer be purchased on account or by use of order form had been implemented.

4.4.10 Leisure activities

There was a good range of facilities and leisure activities available to the young people in Ballydowd as outlined in the 2001 report.

Recommendations

14. The senior managers should ensure that both staff and young people are aware of the policy on freedom of information and that steps are taken to encourage the young people to exercise their right to information.
15. The senior managers should ensure the immediate reactivation of the internal complaints procedures.
16. The senior managers, in consultation with the assistant chief executive and the management advisory group, should implement the recommendations contained in the report prepared by the independent consultant in relation to the complaints procedure
17. The senior managers should organise training for staff on positive approaches to behaviour management.
18. The senior managers, in consultation with the management advisory group, should produce written guidance for staff on the use of single separation and the senior managers and the external line manager should monitor its use closely and ensure that social workers and guardians ad litem are notified of its use.
19. The external line manager should take steps to ensure that the safeguarding systems are operating effectively.
20. The senior managers should ensure that the proper procedures for the storage and administration of medication are implemented and they should review the system for recording the administration of medication.
21. The management advisory group should consider the policy in relation to the use of contact lists.

4.5 Premises, safety and security

The premises and associated outdoor areas are designed to prevent unauthorised entry or exit. They should facilitate supervision and minimise opportunities for self harm while providing accommodation that is, in so far as practicable, appropriate to its designation as a children's home. It must also be properly maintained and furnished.

4.5.1 Risk Assessment

4.5.2 Location and design

4.5.3 Accommodation – general

4.5.4 Accommodation for individual young people

All of these issues were dealt with in the 2001 inspection report and there had been no significant change in the intervening period.

4.5.5 Maintenance and repairs

When inspectors visited the unit in March 2002 there was evidence of considerable damage to the accommodation unit in which the main group of young people were living. External windows had been shattered and inside the building fittings had been damaged or removed altogether and there was a stripped down appearance to the living area. Some things had been damaged or destroyed. Others appeared to have been removed for safety reasons.

Some of this damage was of fairly recent origin. Inspectors were told that considerable damage was done during the group disturbance towards the end of February. However, it was clear from documentation supplied to inspectors that the unit was extensively damaged when the director returned after eight months leave in January. The documentation referred to a decision to move out of the damaged unit into another one, referred to as unit three. This move never took place. Inspectors were informed that there was a plan to move some of the young people and, therefore, to split the group and, indeed, the other accommodation unit was brought into use for a time. In addition, during the inspection, one of the senior managers stated that a move into another accommodation unit only awaited the employment of extra staff. Inspectors were unable to ascertain why the young people were left in a badly damaged unit for months, that is, why the whole group had not been moved to one of the undamaged accommodation units.

Inspectors visited the unit again on May 1st. The external windows of the accommodation unit had been replaced and repairs had been carried out to the interior. However, there was still evidence of the damage both in the communal areas and the young people's bedrooms.

There were difficulties in replacing damaged items as some had to be ordered from abroad. The board, sensibly, had decided to buy in extra supplies and store them so that they would be on hand when next needed. However, other more routine matters seemed to take a long time to sort out. Inspectors noted that some damage that had been done in February had not been repaired by May 1st.

4.5.6 Safety and fire precautions

There were fire extinguishers in the unit and smoke detectors in most rooms. The extinguishers had been serviced. There were fire blankets in two rooms. Fire escape routes were clearly marked and unencumbered. There was an automatic fire alarm system and evidence of regular maintenance of it. Fire drills had been carried out regularly up until June 2001 but inspectors could not find records of any after that.

The deputy director had overall responsibility for safety issues until mid-February when she went off sick. The school principal then took over these responsibilities and, in addition, there were two staff members, one a teacher and one a member of the care staff, with specific responsibilities in relation to health and safety.

The board's safety officer had carried out a safety audit on February 4th 2002 and followed this up with a further audit on March 13th of the school and gymnasium. These identified a number of specific actions that needed to be taken to minimise the dangers associated with violent and aggressive behaviour. Subsequent to the inspection, inspectors were given reports that outlined the responses to the two audits. These reports indicated that the board had taken note of the findings of the safety audits and that appropriate actions had been taken or were under active consideration.

The board did not provide inspectors with a copy of a fire certificate. At the time of the last inspection the position was that fire certificates had been issued by South Dublin County Council in relation to all 6 buildings on the Ballydowd campus, that is, the 3 residential units, the administration unit, education and recreational unit. These certificates were issued subject to the buildings being completed as per plans and specifications submitted to the Council. In order to confirm that the conditions have been met a large amount of documentation had to be gathered and submitted to the Council. Inspectors were given a copy of a letter from a firm of architects stating that they would issue the necessary documentation once it was all completed. At the time of this inspection, inspectors were informed that issues in relation to the issuing of a comprehensive fire certificate were ongoing.

4.5.7 Security

Arrangements for security were described in the 2001 inspection report.

4.5.8 Insurance

Inspectors received confirmation that Ballydowd had been insured for public and employers liability and for fire and associated risks.

Recommendation

22. The senior managers should ensure that fire drills take place at regular intervals and that a record is made of each one.

4.6. Education

Recommendation of 2001 inspection report:

- *The Department of Education should approve the employment of a full time Physical Education teacher at Ballydowd.*

This recommendation was not implemented.

Education should be seen as an integral part of the care of the young person. The education of all young people should be actively promoted by all involved. In so far as it is practicable, units should aim to provide for those of school age, a broad and balanced curriculum appropriate to their age, ability and level of attainment with a view to continuing in open conditions or a return to mainstream school. Where appropriate young people over the age of sixteen should be offered a programme of vocational preparation, training and work experience or transition to further education.

- 4.6.1 *Attainment and progress*
- 4.6.2 *Attitudes, behaviour and personal development*
- 4.6.3 *Attendance*
- 4.6.4 *Quality of education provided*
- 4.6.5 *Curriculum*
- 4.6.6 *Support, guidance and welfare*
- 4.6.7 *The educational management of the unit*
 - 4.6.7.1 *Management and leadership*
 - 4.6.7.2 *Staffing, accommodation and learning resources*
 - 4.6.7.3 *Efficiency of unit*

The educational provision and arrangements were set out in the 2001 inspection report. The situation had not altered except in so far as the school had gone from strength to strength. The curriculum had been developed in line with the identified needs and interests of the young people.

All of those interviewed by inspectors: young people, parents, social workers, guardians ad litem and others spoke positively of the educational provision.

The principal and teachers must take great credit for the success of the school to date. Managers and care staff are also commended for their support for the educational programme.

5. Summary of recommendations

1. The management advisory group should change the policy on the role of the Ballydowd to take account of the fact that it is a national rather than regional resource.
2. SWAHB should undertake a thorough review of its approach to the recruitment and retention of staff in Ballydowd.
3. SWAHB should ensure that no staff member takes up duty at Ballydowd unless Garda and / or local police checks have been carried out and references have been taken up.
4. Managers in Ballydowd should ensure that staff members observe appropriate professional boundaries in their dealings with colleagues.
5. SWAHB should ensure that the arrangements for the internal management of Ballydowd are consistent with the young people's need for stability and continuity of care.
6. SWAHB should make immediate arrangements for external monitoring of standards in Ballydowd.
7. Senior managers at Ballydowd should convene a review of any placement that ends in an unplanned way.
8. Social work managers should ensure that statutory care plan reviews take place at a frequency to be decided in consultation with Ballydowd staff but not less than that required by the Child Care Regulations (1995).
9. The referrals committee should ensure that no young person is placed in Ballydowd unless a guardian ad litem has been appointed.
10. The Department of Health and Children should convene a group to draw up standards and regulations for guardians ad litem.
11. Senior managers in Ballydowd should ensure that social workers and guardians ad litem receive prompt notification and reports of significant events.
12. Ballydowd should collaborate with social work departments in identifying and /or negotiating post Ballydowd placements for the young people.
13. SWAHB should increase the range of professionals employed at Ballydowd to ensure that a full multidisciplinary service is available to all young people placed there.
14. The senior managers should ensure that both staff and young people are aware of the policy on freedom of information and that steps are taken to encourage the young people to exercise their right to information.
15. The senior managers should ensure the immediate reactivation of the internal complaints procedures.
16. The senior managers, in consultation with the assistant chief executive and the management advisory group, should implement the recommendations contained in the report prepared by the independent consultant in relation to the complaints procedure

17. The senior managers should organise training for staff on positive approaches to behaviour management.
18. The senior managers, in consultation with the management advisory group, should produce written guidance for staff on the use of single separation and the senior managers and the external line manager should monitor its use closely and ensure that social workers and guardians ad litem are notified of its use.
19. The external line manager should take steps to ensure that the safeguarding systems are operating effectively.
20. The senior managers should ensure that the proper procedures for the storage and administration of medication are implemented and they should review the system for recording the administration of medication.
21. The management advisory group should consider the policy in relation to the use of contact lists.
22. The senior managers should ensure that fire drills take place at regular intervals and that a record is made of each one.