Health Information and Quality Authority
Regulation Directorate

Monitoring Inspection Report -
Detention Schools Services under the Children Act, 2001 (as amended by section 152 of the Criminal Justice Act 2006)

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

Type of Centre:	Children's Detention School
Centre Name:	Oberstown Children Detention Campus
Centre ID:	OSV-0004225
Type of inspection:	Unannounced Full inspection
Inspection ID:	MON-0021170
Inspection dates:	7th and 8th, 10th, 12th and 13th March 2018
Lead inspector:	Erin Byrne
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Oberstown Children Detention Campus

About monitoring of the Oberstown Children Detention Campus.

The purpose of monitoring is to safeguard vulnerable children living in Oberstown Children Detention campus. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer lives.

Inspectors from the Health Information and Quality Authority (the Authority or HIQA) are authorised by the Minister for Children and Youth Affairs under section 185 and 186 of the Children Act 2001, as amended, to conduct inspections against the Standards and Criteria for Children Detention Schools.

Inspectors conduct inspections of Oberstown against the Standards and Criteria for Children Detention Schools and advises the Minister for Children and Youth Affairs.

In order to drive quality and improve safety in the provision of detention school services, the Authority carries out inspections to:

- **Assess** if Oberstown has all the elements in place to safeguard children
- **Seek assurances** from service providers that they are **safeguarding children** through the mitigation of serious risks
- **Provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **Inform** the public and **promote confidence** through the publication of the Authority's findings.

Monitoring inspections assess continuing compliance with the Standards, and can be announced or unannounced.

This inspection report sets out the findings of a monitoring inspection against the following themes:

Theme 1: Child Centred Services	☒
Theme 2: Safe and Effective Services	☒
Theme 3: Health and Development	☒
Theme 4: Leadership, Governance and Management	☒

1. Methodology

As part of this inspection, inspectors met with children, staff, and professionals from other agencies. Inspectors observed practices and reviewed documentation such as children's placement plans, policies and procedures, minutes of staff meetings, management meetings and board meetings, children's files and staff files.

The key activities of this inspection involved:

- The interrogation of data
- The review of policies and procedures, review reports, audits and strategy documents
- The review of children's admissions records, care files and medical records
- Meeting and/or interviews or conversations with 21 of the children
- Interviews with the chairperson of the Board of Management, the Director, senior managers, unit managers, residential care staff and other personnel on the campus
- Meetings/Telephone interviews with 8 parents
- Telephone interviews with/questionnaires received from 11 professionals such as social workers and probation officers and professionals from other organisations
- Meeting with the three nursing staff on the campus
- Meeting with the designated liaison person/complaints officer
- Meeting with the school principal
- Observation of campus meetings, including senior and middle management meetings, staff team and unit manager meetings, activity planning meetings and shift handover meetings
- Observation of the day-to-day life on the campus including evening and Saturday routines on units.

2. Profile

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

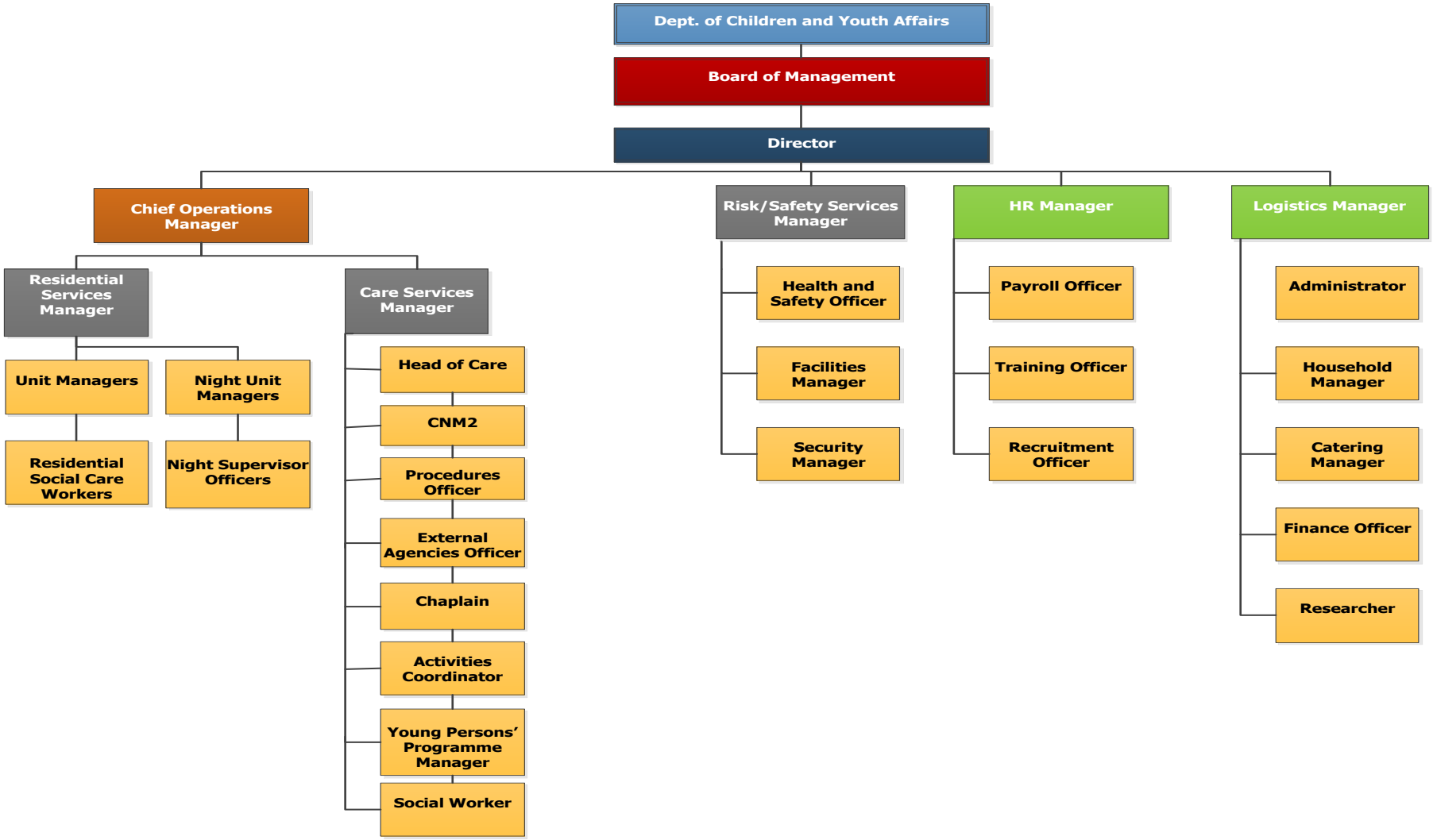
Accommodation

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

Management

Oberstown Children Detention Campus is managed by the Board of Management who were appointed by, and report to, the Minister for Children and Youth Affairs. The Board of Management has direct governance of the Oberstown Children Detention Campus in accordance with policy guidelines laid down by the Minister for Children and Youth Affairs through the Irish Youth Justice Service (IYJS) in accordance with the Children Act, 2001, as amended. The Director was responsible for the day-to-day operation of campus as well as acting in Loco Parentis to each child in custody. Each unit within the campus was managed by a unit manager.

The organisational chart in Figure 1 describes the current management and team structure and is based on information provided by the Oberstown Children Detention Campus following the inspection.


Dept. of Children and Youth Affairs
Board of Management
Director
Chief Operations Manager
Residential Services Manager
Unit Managers
Residential Social Care Workers
Night Unit Managers
Night Supervisor Officers
Care Services Manager
Head of Care
CNM2
Procedures Officer
External Agencies Officer
Chaplain
Activities Coordinator
Young Persons' Programme Manager
Social Worker
Risk/Safety Services Manager
Health and Safety Officer
Facilities Manager
Security Manager
HR Manager
Payroll Officer
Training Officer
Recruitment Officer
Logistics Manager
Administrator
Household Manager
Catering Manager
Finance Officer
Researcher

3. Summary of Findings

Children residing in detention have a wide range of complex needs which require a high quality holistic service that is safe. The majority of children remanded or committed to Oberstown have experienced high levels of challenges and/or trauma in their family lives and, addressing their offending behaviour requires a multi-disciplinary and multi-agency approach to be effective at helping children to develop and progress. Staff members must be able to provide them with nurturing relationships in order for children to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

This inspection was unannounced and took place over five days from the 7th to the 13th March 2018. All ten standards were assessed as part of this process. On the first day of the inspection, there were a total of 47 boys and three girls on campus. Data provided to inspectors showed that the campus was authorised to accommodate 48 boys and six girls.

This report reflects the findings of the inspection, which are set out in Section 5. The provider is required to address a number of recommendations in the attached action plan.

On this inspection, inspectors found that of the 10 standards assessed:

- three standards were compliant
- two standards were substantially compliant
- five standards were moderate non-compliance
- no standards were major non-compliance.

Oberstown Children Detention Campus was undergoing a period of relative stability following a succession of major changes within the campus over the previous years. A number of external reviews which were commissioned to support the development of the campus in 2016 had been finalised and over 307 recommendations formulated. At the time of the previous inspection in March 2017, the Minister had established an implementation group, chaired by the chair of the Board of Management, whose remit was to develop a comprehensive plan for implementing all of the recommendations from recent reviews and to oversee their implementation.

The implementation group met on a regular basis throughout 2017 and concluded its work in December 2017. Of those recommendations directly relating to Oberstown there was evidence that many were implemented in full and work on the remainder was underway at the time of this inspection.

In December 2017 the Oberstown Children Detention Campus Strategy 2017-2020 was launched. This strategy was devised in consultation with staff, management and external stakeholders and sets out five strategic objectives for the campus.

These are;

1. Provide the best possible care for young people
2. Develop our people and our organisation
3. Implement policies, procedures and standards consistent with the best model of detention for young people
4. Enhance communications aligned to our values and mission
5. Deliver robust governance at all levels and drive effective accountability.

Within this strategy Oberstown identifies key approaches by which they will achieve their objectives, examples include; implementation of their new care framework, having in place multi-agency and specialist support, promote collation, analysis and use of quality data to support quality of care, career development and performance management processes for staff, a revised policy and procedure framework, creation of a campus culture and enhancing accountability provided by management, including the Board of Management, for the campus.

A new management structure was in place to support the Director, including a Chief Operations Officer (COO), Human Resource (HR) Manager and three Deputy Directors with responsibility for Care services, Residential services and Risk and Safety respectively. The resources required to maintain and develop the service provided on the campus were subject to regular review and, in the 12 months prior to the inspection, a number of changes were made to ensure that the campus functioned more efficiently and effectively and that the service provided was enhanced. For example, in the area of campus personnel, a risk and safety manager was recruited. A project manager was appointed to further develop and roll out a programme on offending behaviour and to develop other relevant programmes. An organisational psychologist was appointed and psychiatric services from the HSE were also available on a weekly basis. In the area of buildings and facilities, a private company was awarded a contract to manage all the facilities of the campus.

Significant improvements were evident in relation to the children's health care whereby major non-compliances identified during the previous inspection were found to have been appropriately addressed and health care on the campus was now fully compliant with Standards and Criteria for Children Detention School. Progress was also evident in relation to premises, safety and security, children's rights and care of children.

Inspectors found that there were improvements with respect to the planning and review of children's care. A placement planning system which was inclusive of all key stakeholders, external professionals and family members, as well as the child was in place. There were clear procedures regarding timeframes for completion and review of children's placement plans. However, these procedures were not adhered to in all cases and the assessment of children's needs and risks, which informed this process, was not always comprehensive. Inspectors also found that external services were not consistently engaged in this system and this compromised planning for children's future after detention. Additionally, in the majority of plans reviewed by inspectors it was found that they were not fully inclusive of children's offending behaviour needs.

Children were aware of their rights and there were improvements with regard to children's participation in decision making about matters concerning them. Children knew how to make a complaint but, the process for responding to and recording complaints was not robust. The complaints policy had been finalised however the procedure to guide practice remained outstanding.

There were systems in place to ensure children were safe and that any child protection concerns were appropriately referred to the relevant agencies but, the multi-agency responses and necessary co-operative working arrangements to ensure effective responses were lacking.

While there was an improvement in the management of challenging behaviour and a reduction in the necessity for use of restrictive practices, there were deficits in the recording, monitoring and management oversight of restrictive practices, including single separation, physical intervention and the use of handcuffs.

Improvements were evident in relation to the management of risk, health and safety on the campus. There had been developments with respect to staffing in that there was now a deputy director with responsibility for risk and safety, a dedicated fire safety officer and a health and safety officer in place. The campus had an up-to-date health and safety statement which included a safety policy. Quarterly health and safety audits were carried out in each unit and corrective actions were followed up and documented appropriately. Improvements works completed on the premises were well thought out and in the main; the campus was fit for purpose within the constraints of safety and security. There was no major outstanding maintenance work to be carried out. However, not all staff had up-to-date training in fire safety, the emergency lighting system was not fully operational in all units and liaison with the local fire authority in relation to a fire safety management programme was overdue.

Children's educational needs were appropriately assessed and met. Collaborative working between the school and campus staff was evident and children were encouraged and supported to achieve their educational goals.

Children's health needs were appropriately assessed and met. Communication between medical staff and care staff had improved, the medical team were knowledgeable of children's health needs and their medical records were well maintained.

Management structures and governance arrangements in place were clear. A strategy for updating campus policies, procedures and guidelines was in the process of being implemented however, a number remained outstanding despite having been highlighted during the previous inspection of the campus. There were improvements with respect to the management of risk on the campus and there was an evident focus at all levels of management on ensuring risk was effectively identified, assessed and managed.

While staffing levels were adequate to safely care for children these were not ideal and this impacted on the level and quality of care provision at times.

Support mechanisms available to staff had increased since the previous inspection however, deficits were found in the provision of supervision and performance development for staff.

Overall, this inspection found that where the focus of campus management as well as necessary resources had been applied to address identified issues within the campus, improvements were evident. However, insufficient progress had been achieved to bring practices into compliance with Standards and Criteria for Children Detention Schools in several areas including; Care of Children, Planning for children, dealing with offending behaviour, premises safety and security and staffing and management.

4. Compliance with Standards and Criteria for Detention schools 2008

During this inspection, inspectors made judgments against the *Standards and Criteria for Detention Schools 2008*. They used three categories that describe how the Standards were met as follows:

- **Compliant**: A judgment of compliant means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation, if appropriate.
- **Substantially compliant**: A judgment of substantially compliant means that some action is required by the service/centre to fully meet a standard or to comply with a regulation, if appropriate.
- **Non-compliant**: A judgment of non-compliant means that substantive action is required by the service/centre to fully meet a standard or to comply with a regulation, if appropriate.

Actions required

Substantially compliant: means that action, within a reasonable timeframe, is required to mitigate the non-compliance and ensure the safety, health and welfare of the children using the service.

Non-compliant: means we will assess the impact on the children who use the service and make a judgment as follows:

- **Major non-compliance**: Immediate action is required by the provider to mitigate the noncompliance and ensure the safety, health and welfare of the children using the service.

- **Moderate non-compliance**: Priority action is required by the provider to mitigate the non-compliance and ensure the safety, health and welfare of the children using the service.

Standards and Criteria for Children Detention Schools	Judgment
Theme 1: Child Centred Services	
Standard 4: Children's Rights	Substantially compliant
Theme 2: Safe and Effective Services	
Standard 2: Care of Children	Moderate non-compliance
Standard 3: Child Protection	Substantially compliant
Standard 5: Planning for Children	Moderate non-compliance
Standard 9: Premises, Safety and Security	Moderate non-compliance
Standard 10: Dealing with Offending Behaviour	Moderate non-compliance
Theme 3: Health and Development	
Standard 7: Education	Compliant
Standard 8: Health	Compliant
Theme 4: Leadership, Governance & Management	
Standard 1: Purpose and Function	Compliant
Standard 6: Staffing and Management	Moderate non-compliance

5. Findings and Judgments

Theme 1: Child Centred Services

Services for children are centred on the individual child and their care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use services.

Inspection findings

Children's Rights

In October 2017 Oberstown published a "Strategy for the Participation of Young People in Decision-Making" in which commitments to ensuring the implementation of international children's rights standards were outlined. This strategy details the methods by which Oberstown intends to ensure that children views are sought and taken into account in matters that affect them. Inspectors found that some progress had been made with regard to implementing this strategy and improvements were evident.

Children had access to advocacy services, which is particularly important given the secure nature of the campus. An external advocacy service visited the campus on a regular basis and there were posters and information on accessing advocacy services prominently displayed throughout the campus. The ombudsman for children's office also visited the campus.

Children were aware of their rights. Children were informed of their rights by staff when admitted and in key working sessions. The campus had committed to producing an information booklet for children to be given to them when they were admitted, and while this had been drafted at the time of the inspection, it was still not in place. Children spoken to stated that they were aware of their rights. However some children were not clear on how and whether they could access their information. For example, practice in relation allowing children to read court reports completed by Oberstown staff in advance of their court appearances was inconsistent.

Children reported being afforded privacy if they wanted it, and that they were facilitated to make phone calls in private to family and friends. Parents reported being kept well informed of what was happening with their child.

Closed Circuit Television (CCTV) was used throughout the campus including; communal areas and specific rooms within each unit. Images from CCTV cameras within the units were visible on monitors in the staff offices on each unit. During the inspection inspectors noted that there was CCTV in the room where children were being subjected to what was termed an 'admission process'. This was a process whereby children were searched upon admission or re-admission to ensure they were not concealing any dangerous or prohibited items or substances. This process involved a child undressing, and covering themselves with a towel or dressing gown. Inspectors noted that while every effort was made by staff completing the admissions process to ensure, in as far as possible that the dignity and privacy of children was respected, consideration had not been given to the images visible on monitors within communal staff offices, which meant that they were visible to care staff, and other professionals who may be in the staff room at the time of the search.

Consultation and participation in decision making

A campus council had been set up in 2017 which had a clear purpose and objectives. This council was an opportunity for children to meet to discuss issues, and to meet with senior managers. Some of the objectives were to improve day-to-day life, to ensure a safe, secure and fair environment, for children to advocate for themselves, and be consulted on issues. The council was set up in May 2017, and there were five meetings held between August 2017 and March 2018. A review of these minutes showed that these meetings were held regularly, attended by the nominated children who were appointed to the council, and that they brought issues from other children to these meetings. While progress was made on several issues, the council did raise some concerns in relation to the resolution of issues in a timely manner as they had on occasion become discouraged as a result of delays.

The council produced an end of year reflection of work carried out by them in 2017 which showed an impressive list of achievements. These included acting as an advisory group for the Department of Children and Youth Affairs during the consultation on national standards. The campus council invited Minister Zappone to the campus to meet with them in November 2017, and Minister Zappone subsequently visited the campus on foot of their invitation.

Children had opportunities to participate in decisions that were made about them through the placement planning meetings (PPM). Inspectors found that children's attendance and involvement in their PPM's had improved since the previous inspection as children were now routinely invited to attend and supported to contribute to their PPM's. Family members also reported that they were involved in the decision making process through these meetings.

Inspectors found that there was a disparity between those children who were on a committal order and those children who were on remand. Children who were on remand did not always have their rights upheld to the same level as those who were committed. There was a delay in convening placement planning meetings for children on remand, and they did not have the same access to services and incentives as those children who were committed, for example children on remand could not access the full educational QQI programme, or the life skills group work programmes, to the same extent as their peers who had been committed to Oberstown.

Children's meetings in the units were not consistently held. One unit on the campus was operating a restorative practice model of care and was very pro-active in engaging with the children in the unit. Inspectors saw excellent communication and collaborative decision making on this unit through the use of this model of care and this was also evident in records of meetings held, as well as being reported directly to inspectors by children and staff. The other units however did not consistently hold meetings with children. They were infrequent, poorly recorded and unstructured, with no follow through or on-going engagement evident with children in relation to decisions about their care on the units.

Children were encouraged to exercise choice in regards to the activities that they participated in. This was at times compromised when an incident occurred where safety and security needed to be prioritised and staff redeployed to address such an incident. Inspectors observed and were told by staff and children that if staff were required to respond to challenging behaviour or an incident within the campus, a consequence of this prioritisation of resources was that the campus could not also facilitate all young people to participate in their chosen planned activity.

Complaints

There was an established complaints process in place and this was widely used by children but this was not sufficiently robust to provide assurances that all complaints were responded to and managed effectively. Issues highlighted during the previous inspection including; poorly recorded actions in response to complaints, outcomes or levels of satisfaction not recorded and absence of analysis of complaints, remained outstanding.

Inspectors reviewed a summary record retained in relation to complaints; however it was not clear if all of these were resolved. With the exception of one complaint, all were recorded as 'open' or 'open pending follow-up' with a high number (15 of 24) having no record of action taken to resolve the complaint.

The complaints officer told inspectors that where appropriate, complaints were referred to managers or to children's social workers to be addressed directly with the child by them. However, there was no procedure in place for reporting or recording follow-up action taken to resolve complaints, to the complaints officer. The level of satisfaction of the complainant was not recorded.

Children reported to inspectors that they knew how to make a complaint. Children were aware who the complaints officer was and reported that he visited the units regularly. They told inspectors that if they had a complaint they could talk to this person, or they could fill in a form if they preferred.

Children reported different experiences in relation to the responses to their complaints, one child told inspectors that s/he made a complaint and was supported by both the complaints officer and unit manager to resolve this satisfactorily, while another child reported making complaints in the past but not getting any feedback from the complaints officer in response. Parents told inspectors that they knew how to make a complaint if they so wished, none of those met with had made a complaint.

Inspectors reviewed a sample of complaints made by children since the previous inspection of the campus. There was evidence that children's complaints were taken seriously and responded to promptly where possible. For example, children complained that not all units had equal access to television channels, and as a result satellite television was subsequently provided in all units in response to the complaint. However, there were also complaints recorded without appropriate follow up with children as required. For example, children complained that reduced staff numbers impacted on activities and an explanation was provided by the complaints officer in relation to the particular instance however, no follow up occurred with children despite expressing their continued dissatisfaction when this issue re-occurred.

The Social Worker on campus was also the designated liaison officer (DLP) and complaints officer, and therefore maintained oversight of both child protection concerns and complaints. Inspectors found that there had been a number of complaints by children in relation to alleged mistreatment by members of An Garda Síochána in the 12 months since the previous inspection of the campus. The DLP had responsibility for categorising these complaints, informing the children of their rights in relation to making a complaint against members of An Garda Síochána as well as, supporting the children to make a complaint to the Garda Síochána Ombudsman Commission (GSOC) as required. Inspectors found that children were appropriately informed of the responsibility of GSOC to investigate complaints about members of An Garda Síochána and supported to make such complaints however, outcomes of these complaints were not clear from records reviewed.

The DLP told inspectors that often times delays by GSOC in responding to concerns meant that children had completed their sentence and therefore moved on, or declined to follow through with procedures associated with investigating complaints, due to the timeframe that had lapsed.

Inspectors were informed that a meeting had occurred between the Director, DLP and Garda Síochána Ombudsman Commission in November 2017, during which arrangements for dealing with child protection concerns and allegations/complaints by children were discussed. However, no formal arrangements or procedures for managing complaints by children had been agreed. At the time of inspection a number of complaints remained open having been appropriately referred to GSOC.

Inspectors found that there was a complaints policy in place which outlined the overarching purpose, principle, scope and legislative framework for children in detention wishing to make a complaint. However, this was brief and non-specific, did not offer guidance for best practice in the management of complaints or identify those responsible, timeframes or indeed rights and routes of appeal should the complainant be dissatisfied with a response to the complaint, in line with best practice standards. The supporting procedure document had not yet been finalised and there was no clear procedure in place to guide staff in the management, recording and analysis of complaints despite this having been highlighted during the previous inspection.

The complaints officer told inspectors that the complaints procedure had been drafted and was in the process of being reviewed by the Board of management for approval. The complaints officer indicated that this procedure includes guidance for staff on the management of complaints. In addition, the new procedure will implement a requirement for each unit to maintain a register of complaints including recording outcomes, and level of satisfaction of the complainant.

Children were aware of their right to access independent advocacy services and this was facilitated by regular attendance at the campus by representatives from Empowering People In Care (EPIC) who met with children and assisted them with any concerns or complaints as required. The office of the Ombudsman for Children also carried out in-reach clinics on a monthly basis in Oberstown, these in-reach clinics facilitated children to meet with representatives from the office of the ombudsman if they so wished, to discuss any complaints they may have.

It was reported to inspectors by a representative of the Ombudsman's office that those involved in this in-reach process have on-going engagement with various managers from Oberstown and have found staff and managers very helpful in facilitating the in-reach programme throughout the campus.

Theme 2: Safe and Effective Services

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs.

Inspection findings

Quality of Care

Since the last inspection, the centre had begun to implement a model of care which was developed in 2015. This model of care was defined by five pillars which described children's overarching needs in the detention campus. These included care, education, health care, offending behaviour and preparation for leaving care (CEHOP). Inspectors found that this framework was utilised to describe and plan for children's journey through detention, in three key points in time, that is: admission, placement and pre-release. Information on children's files which was gathered through their journey through detention was recorded on templates which explicitly referenced all five pillars of children's needs. Inspectors found this new model provided for a fuller and more systemic overview of children's needs. However, further action was required to integrate this model fully into existing care practices, systems and processes.

Inspectors found that the CEHOP model / framework of care was not yet fully embedded in practice. Staff on the units told inspectors that staffing shortages, coupled with a high level of administrative duties already associated with their work, meant that staff could not always give the time required to integrate this model into practice. It was the view of some staff that the development of new frameworks of care occurred without consultation with unit staff. Furthermore, some staff felt that they were not appropriately equipped with a set of standard deliverables to ensure the integration of this model into their practice.

With regard to the care needs of children, inspectors observed staff being warm, empathic and child-centred in their interaction with children on the units.
That said staff also appeared firm in their ability to establish safe and consistent boundaries with children.

Inspectors found that staff in the units had training in methods of de-escalation of potential and actual aggression. Staff were confident in their ability to problem solve with children in order to de-escalate heightened behaviours.

Children told inspectors that they had good relationships with staff. Some children identified their key workers or other unit staff as someone they could talk to if they had a problem. Some children placed value on the support and advocacy that staff provided to them during their period of detention or remand and also in planning for release. Inspectors observed good quality care practices in the centre during inspection. For example, inspectors observed staff responding to the needs of a child in one instance when a child was upset following a phone call with family. Staff were very skilled in supporting the child and their family to problem solve and help restore relationships.

Children had opportunities to engage in leisure activities in the evenings and at weekends. However, inspectors found that the provision of activities was not always consistent and available to all children in the centre. Staff were creative in the ways in which they developed activities for children. However, staff told inspectors that the provision of activities for children was sometimes compromised by redeployment of staff for the purpose of managing incidents of safety and security. For example, in one unit, where a child required two members of staff during a period of challenging behaviour, there was inadequate staff provision to ensure that another child could participate in a scheduled activity as planned. Inspectors found that while staff were required to manage challenging behaviour on the unit, the child who was behaving in line with their programme of care, was not enabled to take part in a scheduled activity. This was not in line with the centre's model of incentivising children.

Children's emotional, psychological and mental health needs were assessed on admission by staff in the units, using accredited assessment tools. These assessments were sent to a multi-disciplinary team of clinicians for review. The Assessment, Consultation and Therapeutic Services (ACTS) team was providing a therapeutic service to children at the centre and were employed by Tusla. The team comprised of a wide ranging mix of professionals, including a counsellor, psychologist, social worker, social care worker, and speech and language therapist. The team was represented weekly at a multi-disciplinary meeting on the campus, where the care and therapeutic support needs for children were discussed and interventions were planned. The team told inspectors that they were now meeting with all young people on the campus to determine clinical need. The team were also commencing a re-structuring process with the intention of providing a more standardised and consistent approach to their work in the centre.

Inspectors were informed that the provision of clinical services provided by ACTS and the HSE were to be reorganised into one dedicated team. However, working protocols between all services for the provision of services by this dedicated team had not yet been finalised at time of inspection.

Procedures for ensuring effective communication of information and integration of all aspects of a child's care required improvement. Unit staff told inspectors that they were not always informed or updated as to the progress and work undertaken with children, and their view was that this was at odds with the new model of care which required staff to have a fuller view of the overarching needs of children in all the CEHOP pillars.

Assessment and Care Planning

Inspectors found that there was a progressive system in place which coordinated the planning and review of children's care. This system was inclusive of all key stakeholders, external professionals and family members. There were clear procedures in place regarding timeframes for placement planning meetings and reviews. However, these procedures were not always adhered to. Furthermore, the assessment of children's needs and risks, which informed this process, was not always comprehensive. Inspectors also found that external services were not consistently engaged in this system and this compromised plans for the re-integration of children back to their communities.

According to the campus policy, the system of placement planning was initiated within 72 hours of the child's remand or committal to the detention campus. Within this timeframe, the campus policy required staff to complete a placement plan for the child which was then presented at a placement planning meeting. Thereafter, placement plans were reviewed systematically over a period of time. This review took place at a placement planning meeting which sought the inclusion of all stakeholders, professionals and family members related to the child.

The placement plan incorporated all elements of the CEHOP framework. This included care, education, health care, offending behaviour and preparation for leaving care. Inspectors found from a review of a sample of placement planning reports that these were not comprehensive as all the components were not consistently completed. Furthermore, actions devised to address needs were not always identified.

Some staff told inspectors that the CEHOP framework was evolving but had not yet been integrated into practice. Staff told inspectors that the overall co-ordination of a placement plan through the use of the CEHOP framework was fragmented. For example, staff told inspectors that while key workers on the unit were responsible for completing the placement plan, key information from other services such as the school or multi-disciplinary therapeutic team was not always shared with them to inform the plan. As such, key workers were not enabled therefore to have oversight of the placement plan. Other obstacles for staff in relation to integrating this model of practice into their work included staff shortages and an absence of formal key working programmes or resources.

This meant that staff had to prioritise the day-to-day care and safety needs of the children and this took precedence over completing specific work identified through the placement planning process.

Oversight of the placement plan was intended to be facilitated at placement planning meetings which systematically reviewed placement plans over time. Placement planning meetings were chaired by the manager for care (or Head of Care), who also had responsibility for quality assurance of this process. Improvements to this system since the last inspection were evident. The manager for care was now supported by administrative staff who ensured that the relevant stakeholders were invited to meetings. A system to track the schedule of meetings had been developed intended to ensure that all children were afforded placement planning meetings in line with policy and procedure. Improvements were evidenced also in the increase in children participating and attending their own placement planning meetings. However, further improvements were required to ensure that all children's placement plans were developed and reviewed in line with the organisations policy. At the time of inspection 16 children did not have an up-to-date placement plan, and seven of those 16 children were overdue their first placement planning meeting therefore had no placement plan in place.

The manager of care told inspectors that it was a difficult model to incorporate with the children on remand and that placement planning meetings didn't always happen for children on remand. The manager for care also identified challenges in the system. For example, planning for the future and life outside of detention was sometimes missed. Inspectors found through review of files that in particular deficits were evident on sections in relation to Offending behaviour and Planning for the future which were often brief, unspecific or blank.

Dealing with Offending Behaviour

Inspectors found that children's offending behaviour needs were not individually assessed. A process to ensure that children's individual (Criminogenic)1 needs in a consistent and accurate manner was absent. While it is widely accepted that risk factors for youth offending behaviour overlaps to a large degree with risk factors associated anti-social behaviour, substance misuse and educational underachievement and therefore a broad-based approach is required when caring for children in detention. The standards and criteria for children detention schools require that young people's needs are assessed and their programme developed taking account of his/her assessed criminal tendencies as an integral part of the young person's care plan.

[1] Criminogenic needs are characteristics, problems, or issues of an individual that increase likelihood to re-offend and commit another crime.

There was no procedure or processes in place to assess risk factors contributing to offending behaviour for individual children or to contribute to the development of individual offending behaviour programmes to target specific needs.

There were improvements in the provision of offending behaviour programmes on the campus since the last inspection, in that new group work programmes had been implemented. However, these programmes were very defined in both their focus and format. There was no overarching system to assess, develop and implement programmes which targeted the broad range of risks and needs which influenced offending behaviour for the children admitted to the campus.

Inspectors found that the campus did not have a standard process for the assessment of offending behaviour or tools which identify risk or predictors of recidivism and likelihood of re-offending. At the time of the inspection, information in relation to areas of risk and need for children was gathered by staff at the point of admission and subsequently through the placement planning process. However, inspectors found that this information was not comprehensive or fully inclusive of their offending behaviour needs.

During the 12 months prior to the inspection, new initiatives were evolving and developing in relation to offending behaviour programmes. In August 2017, a young person's programme manager was appointed to identify and coordinate young person's programmes suitable for delivery in a detention centre. The programme manager told inspectors that their remit was to co-ordinate a range of programmes across all aspects of the CEHOP model of care. This role was not specific to offending behaviour as the manager told inspectors that they were in the process of developing other group programmes such as sexual health and relationships. Inspectors found, where there were programmes targeted at addressing offending behaviour being delivered, there were inadequate resources in place to support the facilitation of these group programmes. The programme manager told inspectors that she also had to facilitate groups in the absence of further resources and staff being assigned to this role and, other staff members in full time positions were supporting the facilitation of these groups on an ad hoc basis, as an extra to their particular role and function on the campus.

There were two group programmes running on the campus at the time of the inspection. The groups ran for durations of between five and eight sessions, each with clearly defined objectives. One group was tailored to address decision making and life skills in order to encourage positive choices and behaviours. The second group was designed to increase awareness of empathy and the impact of offending for victims. A third group had been planned to commence later in 2018.

While inspectors could see developments in the provision of offending behaviour interventions, these groups engaged only a small number of children. Furthermore, the objectives of the groups covered a very defined aspect of offending behaviour. Programmes and interventions for other offending behaviours such as, sexual offending, violent offending and acquisitive crime, such as theft and robbery, for which the majority of the population of children in Oberstown were remanded or committed had not been developed.

Some children told inspectors that they did not get any support to help them deal with their offending behaviour. One child told inspectors that since they have been committed to the centre, no one had discussed the reasons for their offending. Another child told inspectors that they had not been supported to address their drug abuse, which they reported was the main factor associated with their offending behaviour.

Inspectors also found while there was some progress with respect to the availability of the programmes outlined above, there was a disparity in how children were referred or selected to participate in these programmes as the option to participate was not routinely offered to children who were placed on remand in Oberstown. Staff, children and parents told inspectors that a high number of children placed on remand, including those who had been on remand for significant periods of time were not eligible to participate in group work, including groups tailored to address decision making and life skills in order to encourage positive choices and behaviours.

Food and Nutrition

The catering manager had made significant efforts to promote healthy eating within the campus, and had contacted the Irish Heart Foundation to assist them in devising more healthy options. Dietary requirements were known to the catering manager, and specific needs of children such as those with diabetes or other dietary requirements were well known to him.

There was a range of menus provided and all of these were prominently displayed in each of the units. Alongside this, the catering manager's photograph was displayed, and a sign encouraging children or staff to contact him with any suggestions.

This had been put in place by the catering manager since the last inspection, in an effort to ensure that children and staff recognised him, in the hope that they would be more open to approaching him if they had any issues.

Children's views in relation to the food provided were mixed. Some children spoke very highly of the food in terms of quality, quantity and choice. Others were critical of the lack of choice and the quality.

The catering manager highlighted that given the significant number of children and staff on the campus it was difficult to accommodate everyone's requirements. Staff and children highlighted that because the food was delivered to the units at a set time each day, it often sat in the heated trolley used to transport it from the kitchen to the unit until such time as the children were ready for it, in which case it may not be at its peak. Some staff reported that dinner could be delivered at 2.30pm but not be eaten by the children until 5pm. The catering manager highlighted that staff had the option of contacting the kitchen to delay the delivery of the food, or alternatively to remove the food from the heater trolley to cool, and then reheat it as required; however not all staff on the units were aware of this.

Minutes of children's meeting contained references to children's dislike of the food, and their dissatisfaction with food sitting in heated trolleys for long periods of time. While these complaints were recorded and known to relevant staff members within the campus there was no evidence of action taken to address this and it remained a source of discontent for some children and staff.

Some parents spoken to by inspectors were concerned that their children gained weight following their admission and felt that more effort should be made to ensure that the children had healthy eating and exercise programmes. Inspectors found that there were healthy eating initiatives implemented within some units on campus and some children availed of the option to exercise with a qualified personal trainer who attended Oberstown regularly. The medical team and staff members on duty sought opportunities through one to one discussions and interventions with children to address issues of health, wellbeing, weight gain and exercise. However, these initiatives were not consistently implemented throughout all units in Oberstown and education and information relating to weight gain and exercise was in the main delivered informally by staff on duty through encouraging children's involvement in activities.

The catering manager provided inspectors with the plan for 2018 which included improving communication further between the kitchen and the units, attending a part of the unit managers' meetings, achieving Happy Heart accreditation and sourcing menus through the Irish Heart Foundation. The logistics manager told inspectors that she was aware of the complaints in relation to quality and choices of food and that a plan had been developed for 2018 to address these issues.

This plan included linking in with unit managers and care staff, and bringing in dieticians to advise on specific diets for young people with any special dietary requirements.

Inspectors found that there had been a creative initiative and welcomed progression since the previous inspection in relation to children working as part of the campus kitchen. At the time of inspection there were five young people working in the kitchen. This had previously been done informally, but now was being done in a more formal way. The catering department was now offering some children the opportunity to complete Fetac Level 3 qualification through their work alongside qualified chefs, in the campus kitchen. Children were selected and offered the opportunity to participate in this initiative as part of their placement plan based on interest, suitability and a specific risk assessment.

Restraint and Single Separation

A campus policy on single separation was in place since June 2017 which was aligned with the National policy on single separation used in secure accommodation for children[2]. It outlined that, as part of a continuum of behaviour management techniques, separation must only be used after all other interventions have failed and the use of this intervention must be safe, effective and proportionate. A protection room was the designated room for the purposes of separation on each unit. These rooms were designed to minimise the risk of the young person harming themselves or taking their life.

A review of single separation incidents showed that where this room was used, it was for a short period. Children on a period of single separation spent the majority of this period in their individual bedrooms.

It was evident from interviews that the senior management team were committed to driving improvements in the use of single separation. The data on the use of restrictive practices was presented to the Board of Management by the Director on a monthly basis for review and discussion.

Minutes of board meetings reviewed by inspectors confirmed this and noted the improvements in the collection and analysis of the data pertaining to the use of restrictive practices.

Data provided to inspectors showed that there were 1,701 incidents of single separation involving 140 individual children from January to December 2017. This reflected a significant reduction (56% or 1,326) in the use of this type of intervention of which there were 3,027 in the same period of 2016.

[2] Department of Children and Youth Affairs, National Policy on single separation use in secure accommodation for children: Special care and Oberstown, November 2016

Monitoring of and accountability for safe practice in the use of single separation requires a high standard of recording. Inspectors reviewed a total of 40 records relating to 16 periods of single separation, involving five children across five units on the detention campus. These incidents reviewed were randomly selected by inspectors for the purpose of examining the quality of record keeping. These incidents occurred during the period July 2017 to February 2018. Inspectors found that since the last inspection, some improvements were evident in the quality of the records maintained, for example, a clear rationale for initiating a period of single separation was noted in each record, regular checks by staff and recording of good interactions to help the child to problem solve and to end the period of separation as soon as possible was evident from the records, and children had access to food, drinks and snacks as well as, regular use of multipurpose rooms where appropriate, during the separation period.

The records also demonstrated that there was no excessive use of the protection room. This room was primarily used when a child was being admitted to the unit or when re-admitted following leave from the campus, such as for court appearances or hospital appointments.

Notwithstanding this, the quality of recording required further improvement, as the review of the records of single separation found that they were very difficult to read and demonstrated poor recording in relation to, for example, access to fresh air, which was not recorded in the majority (75%) of the records reviewed. While periods of separation ended, specific details in relation to the end time of the separation period was only recorded in two (5%) of records reviewed.

In addition, there was no evidence of the initial authorisation at the start of the separation period in five (31%) of 16 periods of separation and authorisations were not always timely, in line with campus procedure.

A key safeguarding measure outlined in the campus policy and guidelines on the use of single separation requires that a member of the senior management team reviews periods of separation which continued for several hours and or days. Of the 28 periods of separation requiring additional authorisation for extending the separation period, authorisation was only evident on 19 (67%). Managers did not always sign that they had reviewed the situation and the rationale for making the decision to extend a period of separation was not detailed on any of the records. Sometimes signatures were in place but dates and times as well as management's approval of each extension as required by the centre's policy and procedure for the use of single separation was absent. The signatories required for authorising the separation period and any subsequent extension to this period were often recorded as initials and did not specify which level of management had given the authorisation.

In the absence of good quality records, senior management and the board could not effectively monitor incidents of single separation to be assured that the periods of single separation were in line with the centre's own policy.

Data provided by Oberstown indicated that there were 285 incidents of single separation in January and February of 2018 involving 60 children. Inspectors found that there had been improvements in the efforts to engage children with the view to ending periods of single separation as soon as possible. However, where a child remained on single separation in their bedroom, night time hours were not counted and single separation continued the next day; this meant that there were a number of cases where children remained on single separation for extended time periods.

Of the 16 periods of single separation reviewed by inspectors the durations of time on separation varied from 25 minutes to 4 days, with one incident involving a child being on separation for 12 consecutive days, inspectors found that this was an exception and was treated as such by the staff team and management of the campus.

Inspectors found that records demonstrated regular and consistent attempts by staff to engage the children and efforts to end the child's period of separation. Details of conversations with the child were clearly recorded; offers of fresh air and food including the child's response, i.e. whether or not the child accepted or declined these offers, were clearly recorded. A structured programme was put in place for children who remained on separation for consecutive days, and regular supportive interventions including spending time out of their bedroom and using a multipurpose room for sporadic periods throughout the separation. In relation to the period of separation for 12 days inspectors found concerns were highlighted by staff and the head of care for this child due to their inability or unwillingness to engage with staff, including declining fresh air and attempts to engage by staff, and continuing challenging behaviour. A review of this child's presentation was undertaken by a member of the Assessment Consultation and Therapy services (ACTS) team along with the deputy director of care services.

Inspectors found that the recording and monitoring of use of physical interventions by staff, despite having been highlighted as requiring significant improvement during the previous inspection of the campus, these improvements had not occurred. Of the 40 records of single separation reviewed by the inspectors, ten incidents (25%) involved the use of physical intervention by staff. However, details of these physical interventions varied greatly. The type of restraint used was not always recorded and there were some references to children being "escorted" or "removed" to the protection room without descriptions of how this was done.

Additionally, on four (10%) of the records reviewed, staff had recorded that they had put their hands on a child to remove or escort them but this was not recorded as a physical intervention.

The lack of clarity as to what constitutes a physical intervention and the requirements to record same meant that inspectors could not be assured that practice was appropriate in all cases and could potentially distort data and information collected in relation to the use of physical intervention on the campus.

In some records where the use of physical intervention was noted, necessary details of the intervention used including: type of hold and duration of intervention, was not recorded. There was no evidence that these recording practices or indeed the use of all physical interventions were being monitoring in line with best practice.

The use of physical interventions were not being evaluated for their appropriateness, effectiveness and/or any potential or actual risks and concerns resulting from physical interventions to ensure effective monitoring and learning.

Data provided by Oberstown said that in the twelve months prior to this inspection handcuffs were used on five children by staff members for purposes other than for attendance at court. Three children were under apprehension from attempted escapes and the handcuffs were removed upon re-admission to the unit. Two children were handcuffed following incidents, one resulting in significant property damage, to assist staff members to complete a room search and the handcuffs were removed upon completion of the necessary search and the second to allow a child outside for fresh air and the handcuffs were removed upon return to their bedroom.

Inspectors reviewed three records where the use of handcuffs was recorded as being required for children's attendance at court. Inspectors found in each case these records did not provide sufficient details in relation to the use of handcuffs, other than noting it was due to a child's court attendance.

Records did not indicate duration of use of handcuffs, authorisations for use and when the handcuffs were removed and returned making it very difficult to effectively monitor their appropriate use.

In addition, inspectors reviewed the handcuff register which was a document signed by care staff members when handcuffs were being accessed through the security team by members of the care team. This register prompted staff members to record purpose of handcuffs i.e. medical/court trip or incident, time signed out, handcuffs used yes/no, time signed back in /returned. Inspectors found that this record was not maintained appropriately, relevant sections were frequently blank; record of authorisation for use of handcuffs was often absent, details of whether or not handcuffs were used as well as, times handcuffs were received and returned was incomplete in many cases. Monitoring of access to and use of handcuffs by staff members required significant improvement.

It was reported to inspectors by a member of the security staff with responsibility for maintaining the register of handcuffs that a new system was in the process of being implemented which would simplify and clarify the record and which would include a procedure for regular monitoring of same.

Parents and external professionals told inspectors that they were aware of the use of restrictive practices in the detention campus and were informed appropriately about its use when it occurred. They reported that incidents of single separation were few and staff were mindful of each child's situation and how best to manage the incident safely and appropriately.

Inspectors observed an internal meeting which reviewed incidents and accidents on the campus daily. While this review process was an improvement to the overall monitoring of these incidents, actions agreed as part of this meeting were not reviewed or followed up to ensure they were completed in all cases presented.

Child Protection and Safeguarding

There was a range of measures in place to safeguard children and protect them from abuse. A safeguarding policy and procedure had been developed since the last inspection, which included due consideration of the broad legal framework which underpins child protection and safeguarding. Outstanding actions to ensure compliance with Children First: National Guidance for the Protection and Welfare of Children 2017, were being developed at the time of the inspection. This included a safeguarding statement and mandated reporting procedures.

There was provision for Children First training within the centre. Training was provided on a weekly basis in order to ensure that all staff had completed up-to-date training which incorporated recent relevant legislative changes. At the time of inspection in March 2018, according to data provided by the centre, 63% of staff had received Children First training since its full commencement in December 2017. The centre was efficient in the provision of timely training for all staff.

There was a designated liaison person (DLP), who was a professionally qualified social worker, responsible for receiving all safeguarding and child protection concerns and managing them in line with child protection legislation and national guidance. A process was in place to record and track child protection concerns. There were 61 child protection concerns in total recorded in 2017.

A number of child protection concerns were made by staff, in relation to potential abuse or neglect of children following their release from Oberstown, or relating to particular vulnerabilities evident in children who posed a significant risk to their safety upon release. These included risk of substance misuse, homelessness and abuse.

Data provided to inspectors by Oberstown indicated that there was 38 child protection and welfare concerns or allegations made by children in the 12 months since the previous inspection, 25 of which were reported to Tusla and An Garda Síochána in line with standard reporting procedures.

These included, concerns relating to retrospective allegations of abuse, allegations of abuse which occurred on the campus, and/or during approved absences from campus such as motilities/home leave. Inspectors reviewed a sample of these child protection records and found that there was very limited or no follow up information on file. Acknowledgements of receipt of these child protection concerns were often delayed or not received from Tusla. Of the 25 reports forwarded by the DLP relating to allegations or concerns reported by children in Oberstown 13 acknowledgements had been received. Only one had been confirmed closed, the referral status was unknown for 24 of 25 reports forwarded to Tusla and no further information was available to the DLP.

Of the total 61 child protection concerns recorded for 2017, all were categorised as remaining open at the time of this inspection. The designated liaison person told inspectors, that there was often delay in receiving an acknowledgement or response to a child protection concern from the relevant child protection social worker, and therefore outside of their control. Inspectors found that there was no internal procedure in place to ensure that follow up action was taken to seek acknowledgements and assurances that child protection concerns had been received and understood. Additionally, there was no formal agreement or procedure in place with Tusla, Child and Family Agency, to ensure effective and consistent inter-agency communication between Tusla social work service and Oberstown. There had been a protocol (2012) between the HSE and the IYJS in relation to the role of HSE social workers but this had not been updated since Tusla came into being in 2014.

External professionals also told inspectors that welfare and child protection needs of children in detention were not always responded to by Tusla in the same way as children in the community. The Deputy Director told inspectors that there were cases which she had escalated to Tulsa area management in order to ensure that children's child protection and welfare needs would be addressed upon their release.

Inspectors found that one child, who had an allocated social worker with Tusla Child and Family Agency, had made a formal complaint about the lack of contact, support and guidance received from the social work department during their time in detention and also planning for release. The Director told inspectors that the director of care had been working on establishing a joint protocol with Tusla in relation to children in care however; this had yet to be finalised.

In addition, the chairperson of the board of management told inspectors there was no Tusla representative in attendance at board meetings for a number of months (June2017) and the absence of a representative from Tusla directly impacted the Boards ability to prioritise and address these inter-agency matters.

Children and staff were familiar with the designated liaison person (DLP), who provided training to staff across the whole campus on the subject of safeguarding and child protection. An information booklet for children to help them be informed of child protection policy and procedure was being developed at the time of the inspection.

There was a policy in place on protected disclosures. Inspectors found that staff were aware of the policy on protected disclosure and felt confident that they could raise any concerns they had about the welfare or safety of children.

There was an anti-bullying policy in place in the centre to ensure that children were protected from harm. Inspectors found that staff were mindful of the vulnerabilities of children and this was given due consideration by staff on the units. The senior management team and unit managers engaged in risk assessments to determine the suitability and safety of certain children mixing with others in the unit. Inspectors observed these discussions and found that, as far as practicable, relevant information was discussed and utilised to inform these decisions. However, the process of determining the mix of children in units and how decisions to place children in particular units were made and risks assessed, were not adequately recorded.

Admissions and Discharges

There were comprehensive policies and procedures in place to ensure the safe and effective admission of children to the campus. Children were detained on the campus by order of the criminal court, either on remand, while their criminal trial was progressing through the courts, or to serve a sentence following their conviction of a criminal offence. The court service contacted the campus directly to ensure the availability of a detention placement. Inspectors found that children understood the reason for their detention and the length of time for which they were to be detained.

Admissions were well managed in the centre. There was a standardised process to guide staff in all aspects of the admission process, including guidance for staff in relation to specific information to be imparted to children. This enabled staff to ensure that children were fully aware of their rights. It also enabled staff to ensure that children were aware of the parameters of their care whilst in detention. On arrival, an inventory was completed by staff detailing the children's belongings prior to their placement in a particular unit. Children were also searched to prevent illicit substances or other harmful articles from entering the centre.

Staff used a metal detector to search for any metal objects on/in the body. Urine testing was also undertaken to determine if children were under the influence of any illicit substances. However, inspectors found that the admission process did not adequately detect illicit substances and incidents of children having used illicit substances within the units had occurred since the previous inspection.

Upon admission, children's needs were determined through individual educational, medical, and psychological assessments. Unit staff also gathered information in relation to each child through the use of a standardised admission form. This included information regarding the child's key contacts in the community, including family and professionals, information regarding outstanding court appearances and health and behavioural vulnerabilities. Inspectors found that external clinicians providing therapeutic interventions to the centre were also gathering similar information as part of their assessment to determine the clinical needs of children. The campus was clearly committed to utilising all relevant and key information about children to inform their care and placement in detention. However, some staff told inspectors that the co-ordination of this information was fragmented. This meant that staff were not always equipped with all known information about a child. Inspectors found that a more collective process was required to ensure the sharing of risk relevant information amongst the staff team. This was also required in order to fully integrate the CEHOP model of care into practice.

There was a commitment to interagency planning in relation to the discharge of children. Planning had become an integral part of the model of care afforded to children through the CEHOP framework. Positive initiatives had been developed in this regard since the last inspection. A protocol was in place between the detention centre and the Irish Prison Service to ensure a standardised process for the transfer of 18 year olds to the Irish Prison Service. Inspectors found an example of good innovative practice in the centre to assist one child's transition to an adult prison, whereby the prison governor was invited and attended a placement planning meeting with a young person who was due to be transferred into the Irish prison system to serve the remainder of his sentence. However, this arrangement was not in place for all adult prisons and transitions to adult prisons, in particular what to expect, remained a cause of much anxiety for the young people.

Inspectors found that there was limited or no information available to children and or staff in relation to transferring from Oberstown at the age of 18 to the Irish Prison Service, there was uncertainty about the prison to which they were transferring or what to expect upon transfer. Therefore there were limited opportunities to support and prepare children which was a cause of apprehension for those concerned.

The discharge planning for children who were returning to their communities required improvement. Inspectors found that staff were actively involved in advocating for children in relation to their support needs upon release. The system of placement planning incorporated multi-disciplinary meetings where children's risks and needs were discussed with a view to establishing support networks for the child on release. Children and their families were included in this process. However, inspectors found that external services, which were key to supporting a child's return to the community, were not consistently engaged in the process. In particular, staff and external professionals told inspectors that they were challenged in ensuring consistent engagement of both Tulsa and the Probation Service in the release planning of children.

The director told inspectors, in relation to children who were in care or had involvement from Tusla social work department prior to their detention in Oberstown, that it was often a challenge to get social workers to engage actively in planning for their release. Where children required a residential placement upon release the Director said that this was often planned at the last minute.

In addition, inspectors found that in relation to children in care, aftercare services and preparation for leaving care was not provided by Tusla to children detained in Oberstown, in line with relevant legislation and best practice. Inspectors saw evidence of staff members, including the director of care and social worker, advocating for children in care who required supports and additional services following their release from Oberstown. However, responses to requests and concerns were often delayed or inadequate.

Family and friends

Children and parents/guardians all reported that they were facilitated to meet and have regular telephone contact with each other. Parents and guardians in particular reported that they were kept very well informed of all relevant updates in relation to their children. Children were encouraged to ring their family members, and there were no limits put on the length of these calls, once they were at lunch time, after school or at weekends. One parent reported that staff asked if there were other family members who the child could contact, in recognition that the child needed this support.

There was appropriate facilities on campus for families to visit, and visits could be either supervised or not, depending on the individual circumstances of each child or family.

While some family members told inspectors that they did not like when the visit was supervised, inspectors found that this was only the case when the risk was assessed and it was deemed necessary.

Staff supported families to visit by arranging practical support, such as collecting them from the train station. Staff showed an awareness of the importance of family to the children on the campus, and inspectors observed staff ringing family members to arrange visits and dealing very sensitively with children when they received a call to say a visit was cancelled.

Health and Safety

The health and safety of children at Oberstown Detention Campus was promoted and protected. There was an up-to-date health and safety statement which included a safety policy. This was comprehensive and set out duties and responsibilities of relevant staff. It included hazard identification and risk assessment methodologies.
Quarterly health and safety audits were carried out in each unit in line with the action plan of amalgamated recommendations appendixes to the Oberstown Review Implementation Report 2017 Any identified corrective action was risk rated. Inspectors saw evidence that the corrective action was followed up and documented when complete. The audits were comprehensive and sufficiently detailed.
Staff received training in risk assessment, with 86% of staff having completed the training.

In response to a recommendation within the 'action plan of amalgamated recommendations' referenced above, to implement a programme in relation to health and safety, there was now a deputy director with responsibility for risk and safety. Furthermore there was a dedicated fire safety officer and a health and safety officer in place.

The design and layout of the campus was in line with the statement of purpose and met the needs of children. The occupancy and allocation of units had changed since the previous inspection. There were nine residential units, comprising six modern units and three older units. Two older units, which had been vacant, were now being used as remand units and the third older unit was now vacant. As a result of identified operational and fire safety issues, the six newer units were subject to a programme of upgrading works. To accommodate these works, five of the six units were occupied, while the remaining unit underwent upgrading works.

At the time of inspection, the works were complete in one unit with a second unit almost complete. The remaining four newer units were planned to be upgraded one-by-one to minimise disruption to children and staff. Inspectors reviewed the completed unit in the presence of the Oberstown fire safety officer and health and safety officer.

Some of the improvements included the installation of new fire doors, additional security cameras, electrical isolation switches for higher risk areas and new furniture in multi-purpose rooms. It was evident that the improvement works were well thought out and provided solutions to operation difficulties reported by staff. Staff spoken with confirmed the upgrading works provided a safer and more secure environment, but highlighted that the door between the kitchen and dining area was still a key lock only door and staff indicated it was difficult at times to carry food while negotiating a key lock.

Premises

In the main, the campus was fit for purpose, within the constraints of safety and security. Each child was provided with adequate private facilities comprising their own bedroom with en-suite shower facility. Each child's bedroom was sparsely furnished and contained a bed and bedding and each child had access to a television in their room. Children also had adequate storage for their property and this was provided in locked cupboards on the bedroom corridors. Rooms were observed which had been personalised with posters and photographs.

Communal facilities included a living room, dining room and multi-purpose rooms. There were games consoles, televisions and table tennis available within the units, while each unit also had a secure external recreation area. There was also an all-weather playing pitch, an indoor sports hall, gym facilities and games rooms.
The premises were well maintained with adequate lighting, ventilation and heating in the units at the time of inspection. Each area was well lit and ventilated.

Bedroom windows were fitted with controls to adjust natural light and ventilation to suit the children's needs, however in the newer units, the top section of the windows did not have a facility to control natural light entering the room. When asked, children indicated they could put up posters to block the light when required. Each residential unit was laid out in a manner that maximised the availability of natural light and ventilation.

At the previous inspection, acoustic panels were in the process of being fitted in the communal areas of the newer units to mitigate loud echoes. These were now complete and staff told inspectors that they were effective and solved this issue.

There was a suitable heating system on campus and the heating equipment was serviced regularly. Staff told inspectors that there was an issue with heating in older units where in order to provide hot water; the heating was required to be turned on. This was a particular issue during warmer periods. The maintenance manager confirmed that, due to the age of the system, there was an on-going issue in relation to isolating the central heating from the hot water system for some rooms.

Inspectors noted a small multi-purpose room which was excessively warm. Inspectors were also informed that one of the newer units had issues with the heating, in that the unit was too warm.

There was now a total facility management system in place, the contract for which included the monitoring and servicing of all mechanical and electrical systems on site, landscaping, window cleaning and waste management. There was a means for staff within units to report maintenance issues. The level of urgency for the request was determined by priority rating and colour coding with defined periods of time allocated to each colour. The maintenance manager had oversight of the facility management system in place. There was significantly less maintenance issues reported and the scale of same was also reduced. Inspectors noted that the fabric of the buildings was in good condition. The maintenance manager confirmed at the time of inspection there was no major outstanding maintenance work to be carried out. Inspectors were also informed that there were plans to conduct regular walkthrough audits of the premises, but these had not commenced yet.

In the remand units, inspectors noted two windows which had been damaged. Recommendations in the 'action plan of amalgamated recommendations' included increasing the thickness of glazing where required. The thickness of all glazing was assessed in August 2017 and inspectors were told there was a plan in place regarding all glazing in these units.

Fire Safety

In the main, there were significant improvements in relation to fire safety and inspectors found that there were adequate precautions in place for the prevention of fire.

There was a fire safety policy in place dated October 2017. This had been approved by the Board of Management in February 2018 but had not been fully implemented. There was a meeting scheduled to develop an implementation plan in the weeks following the inspection. This plan was subsequently submitted to HIQA. This current policy states that it will be reviewed on an annual basis.

The initial stages of the implementation plan include producing fire and evacuation plans and to begin a programme of updated fire safety training for staff. Inspectors saw documentation to support training proposals. There was also a new fire safety register being developed. Although in draft format, when implemented inspectors were satisfied that this would provide comprehensive information and records for all aspects of fire safety in each unit such as: information on evacuation to be issued to children, information on the fire safety systems specific to the unit it relates to, fire risk assessment methodologies and in-house fire safety checks to be carried out.

It was noted that at the time of inspection, the existing fire safety registers were in place and of the samples examined they were completed and up-to-date.

Although significant progress was made in relation to additional fire safety measures at the detention campus, Oberstown had not liaised with the local fire authority since the previous inspection, in relation to the implementation of the fire safety management programme on site. This was brought to the attention of the director. In this regard, an invitation was extended to the local fire authority to visit the detention campus in relation to the reviewed fire policy and to discuss pre-fire planning and the fire safety implementation plan for the detention campus.

The children's bedrooms were equipped with fire safety systems to ensure the safety of the child and staff in the event of a fire. There was a fire detection and alarm system, emergency lighting system and appropriate fire fighting equipment within each unit.

Within the remand units, staff were provided with the means to fight fires manually using hose reels and fire extinguishers through access points directly into the bedrooms. Each bedroom was fitted with a smoke extraction system to remove smoke from the bedroom to assist staff to fight the fire and proceed with evacuation.

The approved fire safety policy was appended with a fire safety analysis of the effects of fire starting in a bedroom within the older units. This included computer based simulations to ensure the systems within the bedrooms were sufficient.

Within the newer units, bedrooms had a water mist system designed to be activated automatically in the event of a fire. The system included manual controls to allow staff to turn the system off if required. There was also a ventilation system in the bedroom corridors which would remove smoke to assist safe evacuation of children through the corridors to their designated place of safety.

Inspectors found that each unit was constructed to prevent the movement of fire and smoke and was found to be laid out in a manner to provide children and staff with an adequate number of escape routes and fire exits.

The 'action plan of amalgamated recommendations' identified the requirement to provide a more robust door to bedrooms in the newer units. Inspectors saw new fire doors fitted within one of the units. Staff spoken with were satisfied with the doors from the perspective of security and operational use.

Inspectors were satisfied that these doors were a significant improvement, were fit for purpose and there was documentation available certifying the required performance of the door type.

There was a comprehensive selection process for the door type used. This included physical destructive testing, ensuring appropriate performance in terms of fire safety and consultation with staff. The locking mechanisms on the doors were also considered to ensure the safety and security of children. Structural work was carried out to each door opening to ensure a consistent size and identical iron-mongery was provided to each door to ensure consistency for maintenance purposes.

Upon completion of the upgrade of one of the units, it was identified that further doors other than bedroom doors would benefit from being replaced with the new door type. These had been ordered and it was confirmed to inspectors that any further improvements identified during the course of the work in any of the units, would be retrospectively applied to units which had already been completed.

It had been identified that there was a potential risk to staff in areas of the new units where, during an incident, they may find themselves confined to an area where they would require the assistance of staff from another unit. For reasons of security, the doors from these areas were required to be secured in the closed position from the outside, until such time as the newer robust doors were fitted. There was a procedure in place where staff from other units would release the door from the outside. In this regard, a memo was sent to all staff and a comprehensive risk assessment carried out.

Inspectors found that children received information about what happens in the event of a fire. Orientation of the unit in which they were placed, included information on evacuation procedures. At the time of inspection, the procedure included that upon admission the child would receive a printed copy of the evacuation procedures to be placed in their personal locker. However, inspectors were told that there was difficulty keeping the procedures in place and there was now a plan to permanently mount the procedures directly to the surface of the wall via transfer or similar in a prominent place in each unit, in lieu of placing them within each locker. Inspectors were satisfied that this would ensure that the procedures were readily available for all children and staff.

Not all staff had up-to-date training in fire safety, with 27% of staff who required fire safety training or refresher training. Staff spoken with indicated that training was provided for the type of units they were based in but if providing cover in alternative units they were not always familiar with the systems in place in those units. It was recommended in the review of the fire safety policy last year that this would be implemented. Inspectors found progress in this regard required improvement to ensure the health and safety of children and staff.

Fire drills were being carried out simulating various fire scenarios. Since the last inspection, controls had been added to the smoke extraction system in the remand units. This allowed simulation of realistic environments during fire drill exercises and staff had found this very useful.

In the remand units, staff told inspectors of an issue regarding the lock to the access hatches to rooms. These access hatches were to be used for extinguishing a fire with a fire hose. The keys to the hatches were kept in a locked cabinet in the office and would require staff to go to the office to retrieve the key if there was a fire in a bedroom. This was brought to the attention of the fire safety manager, who confirmed this had been identified during a drill exercise however, this had not been rectified. Inspectors sought assurances that this would be addressed and were provided with assurance that keys would be copied and would be added to each set of keys so that staff would have a key to the access hatches at all times.

There was a record of all fire alarm activations, and a report generated for each one to ensure corrective action took place where required and to inform improvements in this regard.

The fire detection alarm system was being serviced at the appropriate intervals and documentation was available to demonstrate this.

The action from the previous inspection regarding the documentation for emergency lighting had been partially addressed. There was adequate provision of emergency lighting and they were being serviced at the appropriate intervals.

At the time of inspection, the annual certificate for emergency lighting for the Remand units was not available. Subsequently, documentation in this regard was submitted to HIQA. The emergency lighting system report for inspection and testing for one of the remand units indicated that there were some emergency lighting units not operational or meeting the full durational tests requirements. However the other remand unit was compliant with the technical Irish standards for emergency lighting (IS 3217 2013 Emergency Lighting).

Security

The action from previous inspection regarding the inconsistent colour coding of keys had been satisfactorily addressed. Inspectors saw records regarding the administering of keys to staff and found them to be comprehensive and up to date. The system was well thought out with backup systems in place to ensure effective management of key allocations.

Recommendations in the 'action plan of amalgamated recommendations' identified that additional security fencing was required and for the height of fencing to be increased in certain areas. Inspectors saw evidence that this work had commenced and was in line with their action plan.

There was an effective system in place for children to summon help where required. Call bells were provided in bedrooms, protection rooms and multi-purpose rooms. All of the call bells tested by inspectors were in working order.

At the last inspection, access fobs consisted of an access fob attached to a retractable key reel and they were fixed to a person's clothing. Inspectors were told that to improve security and ease of use during an incident, it was identified that a fob fixed to a watch type strap was a more secure option. This measure had been implemented.

Theme 3: Health and Development
The health and development needs of children are assessed and arrangements are in place to meet the assessed needs. Children's educational needs are given high priority to support them to achieve at school and access education or training in adult life.

Inspection findings

Education

There was a school on the campus which children attended, which offered a wide variety of subject options. The school is operated under the patronage of the Dublin and Dun Laoghaire Education and Training Board (DDLETB), and is subject to inspection by the Department of Education and Skills.

There was one child studying for leaving certificate and six children studying for junior certificate at the time of the inspection. Other children were facilitated to study for Quality and Qualifications Ireland (QQI) certificates, levels 2, 3 and 4. They also provided work experience programmes, such as catering, through the kitchen on the campus.

The school linked in with the ACTS team in order to ensure that they had all the information about the child that they required. The school principal attended senior management meetings and met with the deputy director on a regular basis. One teacher attended the ACTS meeting every week, and communicated any relevant information to the school. The school provided a report in relation to children's education for their placement planning meetings and attended if required.

There was good communication between the school staff and unit staff, and inspectors saw evidence that unit staff were proactive in advocating for children with the school staff.

There was a student council in place and some students had completed GÁISCE awards. The student council met every fortnight, facilitated by the teachers, and submitted a report to the schools board of management five times a year.

Parents and guardians reported that they were happy that their children attended school while on the campus, and some would not have been routinely attending school prior to that. One parent expressed a concern that because her child was on remand they did not have the same access to all the QQI levels as the other children who were on committal orders had. Children reported to inspectors that they liked attending the school.

Health

Significant improvements were made since the last inspection to ensure robust procedures were put in place to meet the children's' healthcare needs. There was a good level of healthcare provided to young people on the campus, through a full time medical team consisting of three registered nurses and a social care worker. The medical team had attended a range of training in the previous year including medication management, infection control, MAPA and first aid. In turn, the nursing staff provided training sessions to some staff on specific healthcare conditions such as diabetes and emergency treatment.

A general practitioner was available three days per week and more often if necessary with on call services also available at night and at weekends. There was documentary evidence of regular review of children by doctors where required. Children told inspectors their health needs were well cared for and they were seen engaging well with the nursing team.

The healthcare unit was clean, well maintained and well equipped with measures in place for infection control. Records were stored electronically with restricted access to ensure confidentiality of personal information.

Inspectors found that children's needs were met to a good standard as comprehensive nursing and medical records were maintained and kept updated, including information on vaccinations (where available). Each child had a comprehensive medical and nursing assessment completed on their admission. It was also found that they could access treatment from a range of health professionals such as dental, psychiatry, optical and chiropody. Inspectors found that children with health conditions had their medical needs well managed and nursing staff were actively engaged in advocating on behalf of the children. They had made significant efforts to gain a full medical history for each child and this included contacting services previously involved in the child's health to gain a full picture of their health needs. Inspectors saw instances where nursing staff contacted a range of different services on behalf of a child with a chronic medical condition, in an attempt to ensure the Childs medical needs were reviewed by an appropriate specialist team to ensure their complex needs could be assessed and addressed. Care plans were developed for children at unit level for specific healthcare related conditions, these were kept updated and included information on emergency treatment if required. Staff spoken to was aware of the children's health needs.

The nursing team informed inspectors that they were made aware by unit staff of instances where a young person may have sustained an injury and an assessment was promptly made to determine if any treatment was required. Procedures were also in place for recognition of potential head injuries and records were maintained of neurological observations where required.

There were some health promotion activities in place however inspectors found that improvements were required in this area as initiatives focused on health promotion were not consistently implemented across all units on the campus. Staff spoken with confirmed that health promotion and advice in relation to diet and exercise was for the most part delivered informally. Inspectors found that while specific needs for example children for whom their health conditions and treatments resulted in increased weight gain, were recognised by staff and attempts made to address these, specific programmes for health education were not consistently available or delivered throughout the campus. Staff told inspectors about plans for an education programme on sexual health to commence in April 2018 which was a positive step towards health promotion.

However, staff spoken with confirmed that health promotion and advice in relation to diet and exercise was given informally and there was a lack of a structured programme. For some children, their health conditions and treatments resulted in increased weight gain. This was recognised by staff and although some attempts were made to reduce weight, additional measures were required such as a structured child-centred exercise and healthy eating programme.

Significant improvements were made in medication management since the last inspection. Policies and procedures were in place for all aspects of medication management, informed by good practice. Records were clear, legible and securely stored. The nursing staff were responsible for administration of all medication and good practices were observed. Medication was stored securely and accurate records were maintained of all prescriptions and administration. Staff had received training in safe medication practices. There was also good access to pharmacy services and medications were dispensed in personalised packs which reduced the risks of error.

Emotional and specialist support

Children had their psychiatric and psychological needs assessed and managed while on campus. A psychiatrist visited the campus on a weekly basis, and the Assessment Consultation and Therapeutic Services provided other specialist supports as required, such as psychology, speech and language, and occupational therapy.

When children were first admitted, their needs were assessed using accredited tools, in addition to requesting reports from any external professionals who had been involved with the child prior to their admission. The ACTS team outlined to inspectors that they are trying to develop tools to standardise the collating of information, in order to ensure consistency. Once the assessment was completed then the child was allocated to the most appropriate ACTS clinician. However there was no dedicated team assigned to Oberstown campus and the role of the ACTS team within the campus had not been clearly defined at the time of inspection.

The child's allocated ACTS clinician was invited to attend the PPM's, and did so where possible. However, members of the ACTS team advised inspectors that earlier notice of dates and times for meetings would facilitate more frequent attendance. When a clinician could not attend, they still received the minutes of the meeting.

Theme 4: Leadership, Governance and Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed. The system is subject to a rigorous quality assurance system and is well monitored.

Inspection findings

Statement of Purpose

A statement of purpose and function was in place since it was approved by the Board in April 2017. It described the purpose of the campus, the particular group of children that could be accommodated there and its role in relation to the courts.

The key objectives of the campus were described as the provision of appropriate residential care, educational and training programmes and facilities for children referred to the campus.

It described the provision of a multi-agency response to meet young people's care needs, and the programme of placement planning in responding to children's needs, the availability of resources, including staff, and a variety of programmes, for this purpose.

During the 12 months prior to this inspection, the introduction of new initiatives such as the campus council and the regular meetings of the children on the units meant that there was increased consultation with children about the services provided on the campus.

The key features of the statement of purpose were included on the website of the campus and the service provided on the campus was in line with the statement of purpose.

The child-friendly statement of purpose had not been finalised at the time of inspection.

Management structures and systems

There were clear management and governance structures in place. Residential care workers (RCWs), who were the largest cohort of employees, reported to the unit managers. The unit managers reported to the residential care manager, who in turn reported to the chief operations officer (COO). The COO reported to the director and deputised for him, when necessary.

Suitable arrangements were in place for all other staff to report to their respective managers, all of whom reported to the director. The director reported to the board of management.

The director was an experienced manager who had been in post for over four years and demonstrated leadership through the continuous development of the campus. The director was supported by a senior management team that included the COO, three deputy directors with distinct areas of responsibilities, the human resources manager and the logistics manager. The director was accountable to the board and presented reports to the board at their monthly meetings.

There was a schedule of meetings in place to ensure the smooth operation of the campus. These included weekly meetings of the senior management team, the unit managers, and the unit staff teams, respectively. Up-to-date information on the operation of the campus was exchanged at morning and evening handover meetings. Inspectors observed some of these meetings and found that they were effective. During the 12 months prior to the inspection, children's meetings were held in individual units although inspectors found that these were held on an irregular basis rather than weekly as envisaged.

The board met monthly and the sub-committees, which had been established prior to the previous inspection, were actively engaged in oversight of the work of the campus.

A system was in place to ensure that policies, procedures and guidance were reviewed and updated. The manager responsible for policy development told inspectors that policies, procedures and guidance were developed in accordance with best practice, based on research and, on occasion involved visits to a similar facility in another jurisdiction to review their policies and practice. Consultation with managers, staff and children formed a part of this process of policy development and at the time of inspection the director was in the process of seeking expressions of interest from staff for inclusion in a newly re-constituted policy group on campus. Policies, procedures and guidance were sent to the board for review and consideration before they approved them. A range of new policies had been approved by the board in the 12 months prior to the inspection. There was evidence that the introduction of new policies and procedures were accompanied by training for staff. Inspectors viewed the records of workshops for staff on placement planning for children and on risk management.

Risk Management

Risk was well managed and significant improvements had been made in the area of risk management during the 12 months prior to the inspection.

During 2017, a risk and safety manager was appointed at deputy director level. A risk management policy was approved in October 2017 and the risk register for the service was reviewed and updated.

Inspectors met with the risk and safety manager who was clear about his role. He reported to the chief operations officer. He had organised a series of workshops on the management of incidents and crises and the training schedule showed that further training on this topic was scheduled for the remainder of the calendar year.

The risk management policy contained a number of objectives, including those of ensuring that an awareness of risk was clearly embedded in daily operations and that risk control measures were applied to each challenge and opportunity. Inspectors found that risk was reported and considered at various meetings throughout each day and that any incidents that occurred were reviewed with a view to learning about how risk could be better managed. Residential care workers (RCWs)were involved in the daily management of risk to children and the assessment of and mitigation of risk were evident to inspectors in their interaction with children and the decisions the RCWs made about their care.

Inspectors reviewed the new risk register. This was of a good standard and was sufficiently detailed. The board, especially through the audit and risk committee, had contributed to the development of the new risk register. While it was formally reviewed every three months, individual issues on the risk register were reviewed more frequently, if required. Inspectors observed that the risk register was reviewed at a meeting of the senior management team. All policies, procedures and guidance were informed by risks identified on the risk register.

Assessments of risk in relation to individual children were carried out on a daily basis and inspectors found that management and staff ensured that decisions on the care of children were informed by assessments of the risk involved.

Monitoring

Systems were in place to monitor the operation of the campus and there was evidence of learning from external reviews of the service and from internal reviews of incidents. At the time of the previous inspection in March 2017, the Minister had established an implementation group, chaired by the chair of the board of management, whose remit was to develop a comprehensive plan for the implementation all of the recommendations from recent reviews and to oversee their implementation.

The implementation group met on a regular basis throughout the remainder of 2017 and concluded its work in December 2017. Inspectors viewed the action plan which included the recommendations, the priority of the recommendations, the person, department or agency responsible, the status of the recommendation in December 2017, and detailed comments which included actions taken. As some of the recommendations related to outside agencies such as the Department of Children and Youth Affairs, Oberstown Children Detention Campus was not in a position to implement them. However, there was evidence that many of the recommendations were implemented in full and work on the remainder was underway. For example, the greater participation of children in decision-making on the operation of the campus was addressed in the board's engagement strategy and in the setting up of the campus council.

The need for a self-harm reduction policy was addressed by a review of the policy, and the training of a number of staff who could provide training to other staff. A response to the needs of different categories of children on the campus was addressed by designating two units for children on remand and facilitating children on committal orders to live in other units. The recommendations to have a less-restrictive environment was addressed by introducing a restorative practice programme in certain units, allowing children to take more responsibility for decision-making and the atmosphere in the unit.

In order to maintain oversight of all aspects of the service, the board introduced a management information report schedule, which came into effect in March 2018. According to this schedule, reports on issues such as use of restrictive practices, single separation, restraints and the use of handcuffs, and reports on the financial expenditure of the campus, were presented to the board each month. However, as previously cited inspectors found deficits in a number of areas in relation to recording of use of restrictive practices which require improvement to ensure the data and information being presented is accurate. Reports on the implementation of policies and procedures and strategic plans were presented every quarter as were the risk register and operational reports such as those on placement planning, staff training and supervision, accidents, injuries and incidents.

During the 12 months prior to the inspection, there were improvements in the information that was generated and published by Oberstown Children Detention Campus. A "point in time" analysis was published each month. This consisted of an overview of the current children resident on the campus and provided general information on their offending, their background, their health and well-being, and their education and care.

Occupancy statistics were also published monthly and this provided information on the numbers of young people on the campus by category (on committal or on remand) and their age-range. Apart from providing more information to the public on the work of the campus, this information was used to identify areas in which the service provided on the campus could be improved. For example, it was identified that a significant number of children had a history of self-harm which required greater attention by staff. Six members of staff completed a train the trainer course in the area of self-harm and suicide prevention in order that they could provide training to other staff with a view to enhancing their skills in this area of care.

Certain significant events on the campus were notified to the IYJS. Inspectors reviewed a sample of the notifications made to the IYJS for the early months of 2018, seven of which were made in January 2018, and 14 in February 2018. These notifications were graded according to their significance and copies of reports or investigations were attached when necessary. The Child Welfare Advisor of the IYJS told inspectors that verbal notifications were made in a timely manner and that these were followed by written notifications which contained more detail. He also told inspectors that incidents that occurred on the campus were recorded on the National Incident Management Systems (NIMS) and that IYJS personnel could view these records on NIMS for the purpose of oversight. Incidents on the campus were reviewed weekly by the senior management team and there was evidence of learning from this process.

While a number of audits were carried out on the campus, further audits were planned but had not been implemented at the time of inspection.

Oberstown had been subject to a financial audit by the Office of the Controller and Auditor General, whose mission is to provide independent assurance that public funds and resources are used in accordance with the law, managed to good effect and properly accounted for. Inspectors viewed correspondence which included audit findings, recommendations and an action plan from the campus in response to the recommendations. The finance and risk sub-committee of the board, which was established in 2017, had a key role in the oversight of the finances and the financial systems of the campus.

Children's journey through care documentation was audited every two weeks. The manager who carried these out told inspectors that results of the audits were communicated directly by email to the children's key workers and copied to the unit managers. There was, however, little evidence to show that this process was effective as the manager carrying out the audits told inspectors that some staff had poor IT skills which made it difficult for them to access the feedback that was sent to them.

The records of the use of handcuffs was audited and the staff member who carried this out told inspectors that they had identified gaps in the recording which meant that it was difficult to provide an accurate overview of the use of handcuffs, including the number of times they were used and the reasons why they were used. Inspectors viewed the records and found that the recording system had been changed during the previous 12 months to ensure that more detail was required and was included. However, it was acknowledged that this required further improvement and plans to address deficits were in the process of being developed at the time of inspection.

Inspectors found that child protection concerns, which were recorded by the DLP, were reviewed and signed by the director on a regular basis. However, the DLP, who was also the complaints officer, told inspectors that the introduction of an audit of children's satisfaction with the complaints process had been discussed by the management team but such an audit had not yet taken place.

All incidents that occurred on the campus were subject to internal review and learning from these was incorporated into the on-going development of the risk management framework. An example of the applied learning was the production of an aide memoire for managers and staff, which included a step-by-step guide on how incidents should be managed, what actions needed to be taken both during and after an incident, who needed to be informed at all stages, and how the incident should be properly recorded.

The resources required to maintain and develop the service provided on the campus were subject to regular review and, in the 12 months prior to the inspection, a number of changes were made to ensure that the campus functioned more efficiently and effectively and that the service provided was enhanced. For example, in the area of campus personnel, a risk and safety manager was recruited. A project manager was appointed to further develop and roll out a programme on offending behaviour and to develop other relevant programmes. An organisational psychologist was appointed and the provision of service from a psychiatrist was increased from one day per week to two days. In the area of buildings and facilities, a private company was awarded a contract to manage all the facilities of the campus.

Sufficient staff and skill mix

While there was sufficient staff in place to provide a safe service at the time of inspection, the number of staff on duty, particularly at weekends, was insufficient to provide an optimal level of care to the children.

Staff members told inspectors and this was observed during inspection fieldwork that there were insufficient staff on duty in the units and this had a negative impact on the operation of the units and impacted staff members ability to provide optimum level of care for example, there were not enough staff to provide the level of one-to-one work that the children required; all children did not have sufficient access to activities at

weekends when there was no school during the daytime; and staff found it difficult to take breaks during their working day due to lack of cover.

Inspectors found few records of staff having one-to-one sessions with children. They also found that, on occasions, staff that had been rostered for one unit were asked to work in another and this meant that staffing levels were lower in both units than had been provided for on the roster. This, in turn, meant that potential for one-to-one sessions with children was reduced. They also found that, in the case of three children in one unit, one child required two-to-one staffing which meant that the other children had one staff member to supervise them. This resulted in opportunities to access activities off the unit being limited for these children. The schedule of activities at the weekend of the inspection also showed that the options for children to access activities were limited and less varied than during the weekdays when more staff and managers were deployed. For example, inspectors observed in one unit that activities for one child were cancelled as staff were busy dealing with another child.

There was an appropriate mix of skills and experience among the unit managers and staff teams. However, not all the units visited by inspectors had unit managers on duty and, at times while unit manager were present on the campus, they were there in the role of on call managers throughout the campus.

Due to responsibilities associated with being the manager on call, unit managers were not able to spend sufficient time within their units. Inspectors observed that this resulted in lack of decision making ability within the units. There was no process of delegation of decision making responsibilities, in the absence of a unit manager and this resulted in delays in responding to requests and generally with regard to day-to-day management within unit. The grade of team leader/coordinator that had been proposed at the time of the previous inspection had not yet been implemented. This meant that there was not always a staff member designated to coordinate each shift. This was confirmed by staff and was reflected in the absence of a staff member on shift being able to respond to requests as well as absent evidence of timely review of records maintained on the unit.

Recruitment

Systems were in place to recruit suitable staff and staff were recruited in accordance with legislation, standards and policies. New staff were provided with a comprehensive induction process and additional support. However, there was a difficulty in recruiting staff in sufficient numbers.

The human resources manager outlined the systems in place to recruit staff. Due to the staff turnover rate of over 7%, recruitment campaigns were carried out on a regular basis but it proved difficult to recruit sufficient staff. For example, following a recent recruitment campaign for RCWs, 69 persons applied but only nine were subsequently

placed on a panel. She told inspectors that a further campaign would be undertaken before summer 2018 and that various methods of increasing awareness of opportunities in the service, including radio and on-line campaigns, were under consideration.

The human resources department ensured that staff were suitably qualified and that the required documentation such as Garda vetting, references and qualifications were in place before appointments were made. There was also a system to ensure that Garda vetting was updated when necessary and that certain staff were registered with their respective professional bodies.

The human resources manager attended the weekly senior management team meeting and provided updates on recruitment. She or members of her team also attended weekly operational meetings and quarterly resource planning meetings. Human resources personnel also attended a meeting each morning, at which any incidents or accidents were discussed, to ensure that they were apprised of any staffing issues arising on the residential units.

A comprehensive four-week induction process was in place for all new staff on the units. Their roles and responsibilities were outlined and were introduced to policies and procedures and provided with relevant training.

There were also provided with an orientation of the campus and had the opportunity to work alongside experienced members of staff before being rostered for duty.

A number of newly recruited staff confirmed that they had taken part in induction programmes and that they were satisfied with this. The supervision files of these staff contained induction checklists signed by the unit managers and the staff concerned.

Supervision and support

As at the time of the previous inspection, not all staff received regular formal supervision from their managers and many of the supervision records viewed by inspectors were not of good quality. Inspectors found that these deficits had not been addressed. There was no evidence that a system of performance management was in use.

A policy on the supervision of staff was approved in October 2017. The policy required prioritisation of and active engagement with supervision by staff and managers, appropriate recording and adherence to the disciplinary process in the absence of active engagement.

Data provided to inspectors showed that all unit managers working on the campus had been provided with training in group supervision and a number of unit managers told inspectors that they took part in group supervision each week. However, inspectors found that the deputy director's supervision of unit managers was not of good quality

and required significant improvement. Records were poor and there was no evidence of the tracking of actions and/or follow up.

A sample of supervision records across the units showed that the majority of staff were not receiving regular supervision in line with the policy. In one unit, the unit manager had a good system of supervision in place and staff received supervision approximately every eight weeks. However, the provision of supervision in other units was poor. For example, in one unit, staff had not received supervisor in over five months and several staff had engaged in only one or two supervision sessions in the 12 months prior to the inspection.

The records of supervision in one unit were reasonably good with clear actions, objectives and decisions being recorded but the records in several other units were poor. Brief notes of supervision were maintained. There were few actions arising from supervision and there was little evidence of accountability, as there were no timeframes for actions, clear identification of who was responsible for carrying them out, or review of actions at the next supervision session.

Supervision files seen by inspectors contained no evidence of a formal performance management system and the professional development needs of staff were not adequately addressed in supervision.

A number of staff told inspectors that, though they did not receive regular formal supervision, their unit managers were supportive of them in informal ways. They also spoke of the benefits of having colleagues trained in critical incident stress debriefing (CISD) and that this was an additional means of support in their work. Data provided to inspectors showed that 14 additional staff successfully completed their training in CISD since the previous inspection.

Training

The human resources department continued to provide a rolling programme of training for staff in order to ensure that they had access to up-to-date knowledge and the necessary skills to perform their roles.

The human resources department had a dedicated training officer. He described his role as the planning and organising of training across the campus in all departments (266 staff) and the development of a training matrix. The programme of training focussed on mandatory training such as Children First (2011) and the Children First Act (2015), managing behaviour and fire safety, and training was also provided in a range of other relevant topics. However, no formal training needs analysis had been carried out.

A number of improvements had been put in place since the previous inspection. An electronic programme was used to assist in recording staff training and this system provided alerts when staff were due refresher training.

There was also increased accountability for managers and staff in relation to staff attendance at training. The training officer maintained a weekly log of training completed. Details included the numbers of staff scheduled to attend and the numbers of those who actually attended. They had also introduced an absence log to record the names of staff members who did not attend training for which they were scheduled and the reasons for this. This was in an effort to track the attendance of all staff members and ensure that there was more accountability.

Data provided to inspectors showed that a high percentage of staff had received up-to-date training in several core modules and that this training was appropriately prioritised, for example first aid training was not prioritised for all staff member due to the availability of medical staff and senior care staff with occupational first aid training, on campus at all times. This is represented in the table below:

Percentage of Staff with up-to-date training		
Training Module	**Inspection March 2017**	**Inspection March 2018**
Fire Safety	73%	73%
Managing Behaviour	95%	90%
Crisis Prevention & Intervention	85%	90%
Child Protection & Safeguarding	88%	63%
First Aid	48%	28%
Manual Handling	53%	48%
National Incident Management System	91%	91%
Risk Assessment / Matrix		100%
Emergency Drugs		100%
Handcuffs		65%
Data Protection		100%

The percentage of staff trained in child protection and safeguarding was lower than at the time of the previous inspection. The training officer told inspectors that this was due to the need for additional training to be provided to all staff in relation to the implementation of recent legislation.

Inspectors reviewed a training plan in place for 2018 which detailed a schedule of training to be undertaken, including manual handling, behaviour management, critical incident management, safeguarding and induction training.

In addition, the campus had a budget for further education and, in 2017, provided support to 14 staff across various grades. Courses included a PhD in Criminal Psychology, MAs in Leadership & Management, and various relevant post-graduation studies.

Acknowledgements

The Authority wishes to acknowledge the cooperation of the children, parents/guardians, the Chairperson of the Board of Management, the Irish Youth Justice Service (IYJS), the campus manager, staff and other professionals who participated in this inspection.

Appendix 1

Standards and Criteria for Children Detention Schools
Theme 1: Child Centred Services
Standard 4: Children's Rights Children receive care in a manner which safeguards their rights and actively promotes their welfare. The practices of the centre should promote the additional rights afforded to children living away from home.
Theme 2: Safe and Effective Services
Standard 2: Care of Children Children are cared for by staff to whom they can relate effectively. Day-to-day care is of good quality and provided in a way which takes account of their individual needs without discrimination. The quality of care provided will be equivalent to that which would be expected of a good parent/guardian. Children are rewarded for the achievement of acceptable behaviour and measures of control must be expressly designed to help and not to punish the children.
Standard 3: Child Protection Children in the school shall be protected from abuse[3] and there are systems in place to ensure such protection. In particular, staff members are aware of and implement practices, which are designed to safeguard children in their care.
Standard 5: Planning for Children The school has a written care plan for each child entering its care. The plan is developed in consultation with parents/guardians and the child concerned and is subject to regular review. The plan stresses the need for regular contact with family and prepares the child for leaving care. The plan promotes the general welfare of the child including appropriate provision to meet his/her educational, health, emotional and psychological needs. The experience of children is enhanced by positive working relationships between professionals.
Standard 9: Premises, Safety and Security The school is located in premises which are suitable, safe and secure for the purpose of providing residential care to children.

[3] Physical Abuse, Sexual Abuse, Emotional Abuse & Neglect as defined in the Department of Health' publication – Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí, April 1995.

Standard 10: Dealing with Offending Behaviour Individual offending behaviour programmes consistent with the child's assessed needs, are in place. There are mechanisms in place to develop, monitor and evaluate the effectiveness of offending behaviour programmes.
Theme 3: Health and Development
Standard 7: Education Education is recognised as an important factor in the lives of children in detention. Each child has a right to receive an appropriate education, which is actively promoted and supported by those with responsibility for the care of the child.
Standard 8: Health Health Care is an essential element in the arrangements for the care of children. Each child has a right to receive appropriate health care and advice. Healthy lifestyles are promoted.
Theme 4: Leadership, Governance & Management
Standard 1: Purpose and Function The centre has a written statement of purpose and function which accurately describes what it sets out to do for children[4], the manner in which care is provided, and how this relates to the overall service provided for children as a whole. The statement takes account of relevant legislation and policies of the Irish Youth Justice Service and other agencies, where relevant; and best practice in the care of children.
Standard 6: Staffing and Management Staff in the school shall be organised and managed in a manner designed to deliver the best possible care and protection for children in an efficient and effective manner.

[4] The term "children" is used throughout to generically denote children, children and young adults.

Action Plan

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

Provider's response to Inspection Report No:	**MON - 0021170**
Name of Service Area:	Oberstown Children Detention Campus
Detention School ID:	OSV-0004225
Date of inspection:	7th, 8th, 10th, 12th and 13th March 2018.
Date of response:	17 September 2018 (accepted response)

These requirements set out the actions that should be taken to meet the *Standards and Criteria for Children Detention Schools.*

Theme 1: Child Centred Services

Standard 4 Children's Rights

Judgment: Substantially Compliant

The provider is failing to meet the National Standards in the following respect:

Children were not aware of their right to access their information and how to do so.

Children's right to privacy was not always maintained during the admission process.

There was a disparity between children on remand on children on committal orders and their equal access to all services and incentives, without clear rational indicating that consideration had been given to how this may impact on their rights.

Unit meetings were not consistently held with children in all of the units.

Procedures to support the implementation of the campus complaints policy were not in place.

Not all complaints were appropriately recorded to include action taken to address complaints, timeframes and level of satisfaction of the complainant.

Action required:
Under **Standard 4** you are required to ensure that:
Young people receive care in a manner that safeguards their rights and actively promotes their welfare. The practices of the centre should promote the additional rights afforded to young people living away from home.

Please state the actions you have taken or are planning to take:

In October 2017, the Board of Management approved the Oberstown Children Detention Campus Strategic Plan 2017-2020. Strategic Objective 1 states the Campus is to provide the best possible care for young people. One of the actions was to adopt a campus strategy to promote participation of young people in decision-making. In October 2017, the Board of Management approved a Participation Strategy, this informs on engagement, and consultation with young people and progress is reported to the Board of Management twice a year.

An information booklet for young people was developed in consultation with young people on the Campus in Q1, 2018. This provides information on life in Oberstown, young people's rights, placement planning, school/activities, health and wellbeing. It also informs on safety and security on the campus. Each young person receives a copy of the booklet on admission and discussion takes place between the allocated key workers and young people on their rights. Deputy Director, Care Services on a quarterly basis, will monitor the implementation of the action.

The right to privacy is maintained through the consistent implementation of the admission process. The viewing of the protection rooms through closed circuit television is a safety and security measure. Only permitted staff who are working on the campus are allowed access to the staff office where the protection room is viewed on CCTV. Staff and managers in each unit will be reminded to adhere to the admission process by the Deputy Director, Care Services by 30st September 2018, considering the need to ensure the highest level of dignity and respect for young people especially during the admission process.

Consideration has been given and actions taken to ensure the treatment of young people on remand is appropriate. A range of programmes to address offending behaviour has been implemented. Young people subject to remand in detention have the presumption of innocence and their criminal matters have not yet been adjudicated on. Consequently programmes and interventions undertaken with them do not target specific offending behaviour but seek to engage them in relation to thinking errors and day to day behaviours. General thinking skills programmes, that are brief interventions are appropriate for this group. Key-working and day to day engagement by campus staff in relation to these young peoples' behaviours in Oberstown is part of this.

A structured review of the access of services for young people on remand and committal will be undertaken in Q4, 2018 to determine if there are differences in treatment that are inappropriate given their different legal status. The Deputy Director, Care Services will lead on this process and issue a report to the Director by end of Q4, 2018.

The appointment of a Campus Advocacy Officer for young people will be completed by Q4, 2018. The role will include facilitating unit meetings for all young people on the campus and to embed this practice in all units across the campus. A job description has been finalised and the internal competition is due to commence in September 2018.The Human Resource Manager will hold responsibility for the appointment of this internal post.

The Advocacy Worker will hold the responsibility for the implementation of the campus complaints policy and procedures and will be the lead person in the management and oversight of the complaints process. The Deputy Director, Care Services will ensure full implementation of the complaints process by end of 2018.

Proposed timescale:	**Person responsible:**
End of Q4, 2018	**Deputy Director, Care Services, Director**

Theme 2: Safe and Effective Services

Standard 2 Care of Children

Judgment: Moderate non-compliance

The provider is failing to meet the National Standards in the following respect:

The model of care CEHOP was not fully integrated into practice.

Leisure activities were not always available to all children as planned. Monitoring of disruptions to planned programmes to ensure all children received equal access to activities as well as, contingency planning was insufficient.

External stakeholders and unit staff were unclear of the remit and professional interventions afforded to children in detention through the multi-disciplinary team of clinicians.

Food was at times left in heated trolleys for extended periods of time, which had the potential to affect its quality.

The quality of recording for incidents of single separation required further improvement.

The rationale and the authorisation for continuing episodes of single separation was not always clearly recorded and required further improvement.

Action required:
Under **Standard 2** you are required to ensure that:
Staff to whom they can relate effectively care for young people. Day-to-day care is of good quality and provided in a way, which takes account of their individual needs without discrimination. The quality of care provided will be equivalent to that which would be expected of a good parent/guardian. Young people are rewarded for the achievement of acceptable behaviour and measures of control must be expressly designed to help and not to punish the young people.

Please state the actions you have taken or are planning to take:

The implementation of CEHOP into practice for residential care workers and night supervising officers is underway and taking a number of formats.

1. The placement planning process is now chaired by the Deputy Director, Care Services for young people on committal orders. She brings knowledge and drive to the implementation of CEHOP through direct engagement with all relevant staff through informational sessions, coaching and mentoring.

2. The Oberstown Case Management System (Electronic Information System) has been developed in line with CEHOP and is due to be implemented in September

2018 with the Logistics Manager holding responsibility for the system development. Four external agency staff are trained on the Case Management System and they will support residential social care workers and night supervisor officers in the use of this system between September – December 2018.

3. An audit of care files across all units was undertaken in May 2018 to determine adherence to CEHOP and specific actions were identified to ensure compliance with CEHOP including direct engagement with staff on this framework.

4. A follow up audit is scheduled to occur in December 2018 to measure progress on compliance with CEHOP. An independent auditor undertook these audits and the Deputy Director, Care Services will oversee the audits and implementation of the recommendations.

A review of the campus activities (recreation and educational) is scheduled to occur in September 2018 following completion of the summer activities program which operated in July and August 2018. The Activities Coordinator will undertake the review and the Deputy Director, Residential Services, will contribute to the review concerning the resources necessary to ensure consistency in implementing planned programs.

The clinical teams to the various staff teams and external professionals on the campus will undertake briefing sessions on the remit and professional interventions afforded to children in detention through the multi-disciplinary team of clinicians. A written outline of the services will be developed and made available to staff and external services. The Deputy Director, Care Services will lead on this action and this will be completed by end Q4, 2018.

A review of the process of the availability of food in heated trolleys for extended periods will be undertaken by the Catering Manager and any improvements necessary undertaken. The Logistics Manager will ensure the review is undertaken and progressed by end of Q3, 2018.

A process of reviewing single separation on a daily basis has been underway since Q2, 2018. Reviews are undertaken each day by Deputy Directors, which includes a review of records. Direct engagement with care staff on the use of single separation and the records, are undertaken daily by Deputy Directors to ensure authorisation is in line with policy and procedures.

An improved and updated single separation form was introduced 1st August 2018 setting out the information required; Deputy Director, Care Services will review this in October 2018.

The Director is notified daily since June 2018, on the use of single separation on Campus for each young person. This process is expected to continue and will be reviewed in Q4, 2018.

The Board of Management review information on single separations monthly and at the Board of Management meeting in July 2018, case studies on specific circumstances were considered.

The Board of Management keep the use of single separation under review on a monthly basis to ensure full compliance with the national policy and campus procedures. The data is scrutinised through in-depth examination by the Board of Management to verify that improvements on use of single separation as a last resort are taking effect.

Proposed timescale: By end of Q4, 2018	**Person responsible:** **Deputy Directors, Care Services and Residential Services** **Logistics Manager** **Director** **Board of Management**

Standard 3 Child Protection

Judgment: Substantially compliant

The provider is failing to meet the National Standards in the following respect:

The campus' safeguarding statement and mandated reporting procedures were not in place.

There was no procedure in place to ensure timely and consistent inter agency communication between Tulsa social work services and the designated liaison person for the campus in relation to child protection concerns.

Improvements were required with regard to the decision making process in relation to the mix of children in units, including the completion and recording of risk assessments as required.

The duties and responsibilities of the social work role within the campus was unsustainable and a decision in relation to the introduction of another social worker remained outstanding since the previous inspection.

Action required:
Under **Standard 3** you are required to ensure that:
Young people in the school shall be protected from abuse and there are systems in place to ensure such protection. In particular, staff members are aware of and implement practices, which are designed to safeguard young people in their care.

Please state the actions you have taken or are planning to take:

The Oberstown Children Detention Campus, Safeguarding Statement was considered and approved by the Board of Management in March 2018. The Director in Q3, 2018, placed this on the Oberstown website for public reference. In line with Children First Act 2015, mandatory reporting procedures were implemented from March 2018. The Designated Liaison Person provides oversight on adherence to the reporting procedures. The Deputy Director, Care Services has oversight on compliance with child protection procedures.

A procedure for notifying Tusla of child protection concerns has been in place since the introduction of Children First Act 2015 and further enhanced through the mandatory reporting procedures. These continue to be monitored by the Director on a monthly basis. An inter agency communication protocol between Tusla and the Campus is due to be finalised by Q4, 2018.

The provision of the case management system will assist in the recording of the decisions in relation to mixing of young people. Engagement by the health and safety team with residential social care workers in the use of the risk matrix has been ongoing since Q2, 2018 and has assisted in the decision making process. The Deputy Director, Risk and Safety Services has oversight of this action.

A formal review of the non-mix structure is scheduled to take place in Q4, 2018 and will consider the safety and security aspects of the campus and the individual needs of young people. Deputy Director, Risk and Safety Services will lead on this process.

The appointment of a Campus Advocacy Worker will address some of the responsibilities held by the Campus Social Worker and this will be completed by Q4, 2018. A reformatting of the role of the social worker is underway and the provision of a principal social worker post for the campus will now not proceed. The reformatting of the social worker role will be completed by Q4, 2018 by the Director.

The Child and Family Agency (Tusla) representative on the Board of Management resigned in June 2018 and the Board of Management are awaiting the appointment of another representative. This appointment will also assist in assisting engagement with the Agency.

Proposed timescale:	**Person responsible:**
By end of Q4, 2018	**Deputy Director Care Services, Deputy Director Risk and Safety Services, Director**

Standard 5 Planning for Children

Judgment: Moderate non-compliance

The provider is failing to meet the National Standards in the following respect:

Placement planning procedures were not always adhered to.

Not all children had a placement planning meeting within 72 hours of admission, as per placement planning policy and procedure.

The assessment of children's risk and needs was not always comprehensive.

Planning for children was not inclusive of all relevant risks and needs as set out in the CEHOP model of care.

Unit staff were not enabled to have oversight of the placement plan due to the absence of an effective process which ensured that pertinent information was shared with all relevant professionals with responsibility for the care of children.

Planning for release from detention was not consistently afforded to all children.

Action required:
Under **Standard 5** you are required to ensure that:
The school has a written care plan for each young person entering its care. The plan is developed in consultation with parents/guardians and the young person concerned and is subject to regular review. The plan stresses the need for regular contact with family and prepares the young person for leaving care. The plan promotes the general welfare of the young person including appropriate provision to meet his/her educational, health, emotional and psychological needs. The experience of young people is enhanced by positive working relationships between professionals.

Please state the actions you have taken or are planning to take:

Since Q2, 2018, a new system has been in place to support the placement planning meetings. Deputy Director, Care Services chairs the placement planning meetings for young people on committal orders, while the Head of Care chairs the placement planning meetings for young people on remand.

The format and recording of the placement planning meetings has been agreed, a new recording format has been put in place and the participation at the placement planning meetings is in line with the CEHOP framework. A new database to record the timeframe for the placement planning meetings is retained centrally and reviewed by the Director on a monthly basis. The Board of Management reviews compliance with the placement planning process on a quarterly basis.

Compliance with the 72-hour time line for placement planning for new admissions (on remand) is monitored on a weekly basis by the Deputy Director, Care Services to ensure procedures are followed. A review of the assessment process considering risks and needs is underway in conjunction with the clinical team. This review will incorporate all aspects of the CEHOP framework. This process will be completed by Q4, 2018 and will inform delivery of care in 2019. The Deputy Director Care Services will lead out on this review process.

The implementation of the case management system will support access by all staff to the relevant information including information relating to placement planning. All professionals working with young people will retain pertinent information on the system, which will support planning, and engagement with young people. The Logistics Manager holds responsibility for the development and utilisation of the case management system. This system is due to come go live in September 2018 following implementation of a training program for all staff.

Planning for release is included in the placement planning process and the CEHOP framework. Young people subject to detention orders may avail of mobility and temporary leave in line with the provisions of the Children Act 2001. This allows young people attend training, spend time at home or be released from the Campus prior to release date as part of an agreed plan. Temporary leave as set out in the Children Act 2001 is used to support young people access community based services. Where supervision in the community is considered an option, agreement on such options must be provided by the Director of the Probation Service, who take responsibility for the supervision of young people in the community. This approach has been ongoing since Q2, 2017.

The introduction of the Probation Service on Campus from September 2018 will support the development of the pre-release approach and will inform the planning for young people on release.

The implementation of the case management system in Q3, 2018 and the monitoring of the placement planning process since Q1, 2018 will drive improvement in the consistency of the preparation for release. Progress will continue to be reviewed by the Deputy Director, Care Services on a quarterly basis.

Proposed timescale:	**Person responsible:**
By end of Q4 2018	**Deputy Director, Care Services** **Logistics Manager**

Standard 9 Premises, Safety and Security

Judgment: Moderate non-compliance

The provider is failing to meet the National Standards in the following respect:

In the remand units, there was an issue where in order to provide hot water; the heating was required to be turned on. One of the newer units had issues with the heating, in that the unit was too warm.

There was no system in place to ensure that liaison with the local fire authority, in relation to the implementation of the fire safety management programme on site occurred as required.

Not all staff had up-to-date training in fire safety, with 27% staff outstanding that required fire safety training.

In one of the remand units, the emergency lighting system report for inspection and testing indicated that there were some emergency lighting units not operational or meeting the full durational tests requirements.

Action required:
Under **Standard 9** you are required to ensure that:
The school is located in premises that are suitable, safe and secure for the purpose of providing residential care to young people.

Please state the actions you have taken or are planning to take:

A number of repairs and upgrades to the heating systems have been undertaken in Q2 and Q3, which have substantially addressed the issues raised. These are now completed.

A survey of the building, which houses the remand units, was completed in August 2018 and this will advise on other building works to be considered. The Deputy Director, Risk and Safety will progress actions from this survey.

Meetings were held with Dublin Fire Brigade (DFB) on 18th April 2018. Pre-fire planning, fire prevention, fire safety and access procedures for emergency vehicles was discussed. A tour of the Campus was facilitated focusing on:

- Access routes and turning areas for fire appliances.
- Central Hub CCTV operations as a command and control hub during a fire incident.
- Electronic and manual control procedures for all fire track gates.
- Access to the fire hydrant main from the secure and unsecure sides of the security fences.
- Building heights and emergency access/entry to all the buildings.

Following this meeting, it was agreed to meet both the DFB Fire Prevention Officer and the local District Officer on separate dates. These meetings subsequently took place on Campus. The Fire Prevention Officer from the DFB met with the Campus Fire Officer and reviewed fire registers and fire training. The Fire Prevention Officer also visited a residential unit to ensure that unit fire registers were routinely documented. The local District Officer, the Campus Fire Officer and the Campus Security Manager are planning to conduct a full fire exercise on the Campus in August/September 2018. This will involve fire crews and appliances from DFB. The Deputy Director Risk and Safety is leading on this action.

Fire training has been ongoing since the last inspection. It is anticipated that all staff are to have received training by the end of Q4, 2018. The Deputy Director, Risk and Safety Services will lead off on this action.

Emergency lighting on the Campus is inspected and tested on a quarterly basis. Remand Units proved to be challenging to achieve 100% of emergency lights working due to the age/quality of the light fittings and availability of the parts. Additional/spare/old fittings were identified and retrofitted with new parts. Faulty lamps/fittings are replaced on an on-going basis. Significant repair works are planned for Q3, 2018 to assure that all lights are operational on a consistent basis.

Alternative emergency lighting/fittings are being considered as part of this process. The current building survey of the remand building in terms of the mechanical and electrical systems includes a review of the lighting in general. The Deputy Director, Risk and Safety holds responsibility for the completion of the survey which is due to be completed in October 2018

Proposed timescale:	**Person responsible:**
By end of Q4, 2018	**Deputy Director, Risk and Safety Services**

Standard 10 Dealing with Offending Behaviour

Judgment: Moderate non-compliance

The provider is failing to meet the National Standards in the following respect:

Children's Criminogenic needs were not individually assessed.

The broad range of risks and needs, which influenced offending behaviour for children in the campus, were not fully addressed.

There were inadequate resources in place to develop and implement a range of offending behaviour groups or programmes required to cater for the needs of the children.

Action required:
Under **Standard 10** you are required to ensure that:
Individual offending behaviour programmes consistent with the young person's assessed needs, are in place. There are mechanisms in place to develop, monitor and evaluate the effectiveness of offending behaviour programmes.

Please state the actions you have taken or are planning to take:

One to one interactions between residential social care workers, teaching and activity staff and young people on a day to day basis aims to address thinking and attitudes underpinning offending behaviour and provide opportunities for skills development and competence building thorough the provision of education (including a Crime Awareness module). Formal key-working sessions and the use of a restorative approach to the management of 'Problem Solving' and reflection on behaviours and the use of the COPING model all contribute to addressing risk of further offending. On a more formal basis, offending behaviour and some of the risk factors associated with it, have been challenged within the population in Oberstown through group work programmes aimed at addressing cognitive distortions, and develop empathy.

The risk factors for youth offending and substance abuse overlap to a very large degree with those for educational underachievement, young parenthood, and adolescent mental health problems. Action taken to address these risk factors (and to increase levels of protection) therefore helps to prevent a range of negative outcomes. Moreover, because these outcomes are closely related (anti-social behaviour is strongly correlated with heavy alcohol consumption, for example, and vice versa), this broad-based approach to prevention offers the greatest prospect of securing lasting reductions in offending behaviour.

A review of offending behaviour programs, approach and engagement is scheduled to be undertaken in Q3, 2018. This review will consider individual needs, risks which influence offending behaviour, resources required, and the programs for young people on remand and committal. Oberstown also refers young people to the Bail Supervision Scheme, which also highlights the measures taken to support young people on remand address their offending behaviour through community-based intervention.

Young people on remand are being held at the request of the court pending a decision of the outcome of the court case. They are presumed innocent until the case is complete and it could be both prejudicial to their case and unlawful to provide them with an offending behaviour program.

Engagement with the Probation Service to have a liaison on-site has been underway since Q1, 2017. A collaborative approach between the Probation Service and Oberstown in the identification of areas of risk and needs associated with offending behaviour of young people in Oberstown and to address the risk and need areas identified will be progressed by Q4, 2018. A formalised approach and dedicated resources will be agreed with the Probation Service to progress this action and will be in place by Q4, 2018.
The Director will take a lead on this action.

Proposed timescale:	**Person responsible:**
By Q4 2018	**Director**

Standard 6 Staffing and Management

Judgment: Moderate non-compliance

The provider is failing to meet the National Standards in the following respect:

The number of staff on duty, particularly at weekends, was insufficient to provide an optimal level of care to the children.

In the absence of a unit manager there was no procedure in place for the delegation of decision-making responsibilities within the units.

There was no comprehensive training needs analysis undertaken to inform the campus-training plan.

The performance management system which had been introduced however was not fully implemented.

The quality of supervision of Unit Managers was poor.

The majority of staff were not receiving regular supervision in line with the policy.

Action required:
Under **Standard 6** you are required to ensure that:
Staff in the school shall be organised and managed in a manner designed to deliver the best possible care and protection for young people in an efficient and effective manner.

Please state the actions you have taken or are planning to take:
In line with the Campus Strategic Plan 2017-2020, a revised grading structure with promotional opportunities will be implemented. Agreement has also been reached to review and enhance our performance management development system by 2020. The Board of Management monitors these objectives periodically.

A review of the rosters for residential care staff is scheduled to commence in September 2018 following agreement with staff representatives and management. This will consider the needs of the Campus including demands on weekends and evenings. The process should be completed in Q4, 2018 and will be led by Deputy Director, Care Services.

A recruitment campaign was completed in June 2018 to allocate a unit manager to each residential unit and to have designated managers providing on call (site managers) outside of residential unit responsibility. This arrangement is due to come into effect beginning Q4, 2018 and the Deputy Director, Residential Services will implement this structure.

Discussions are underway with staff representatives on the introduction of a new grade of residential social care worker who will hold responsibility when unit managers are unavailable.

Approval has been received from DPER for this new grade and discussions will be finalised in Q4, 2018. The Human Resource Manager leads in this process.

A training needs analysis commenced in Q3, 2018 and will be completed in Q4, 2018 by the Human Resource Manager.

Performance management was introduced to unit managers in Q1, 2018. A program to implement performance management will be developed further by end of Q4, 2018 and implemented in 2019 for all staff as part of the Strategic Plan 2017-2020. Human Resource Manager will lead on this action.

The Deputy Directors, Care Services and Residential Services will ensure compliance with the supervision policy on the campus for unit managers, residential social care workers and night supervising officers. The Chief Operations Officer will undertake quarterly reviews on the compliance with supervision policy. Compliance with the supervision policy is also reported to the Board of Management twice a year.

Proposed timescale:	**Person responsible:**
By end of Q4 2018	**Human Resource Manager** **Chief Operations Officer**