Ombudsman for Children

A statement under Section 13(2) of the
Ombudsman for Children Act (2002)

Own Volition investigation into the HSE's (now Tusla – the Child and Family Agency) registration, inspection and monitoring service for private and voluntary children's residential centres.

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Introduction

Ombudsman for Children - Statutory role and remit

1.1 The Ombudsman for Children's Office provides an independent and impartial complaints handling service. The investigatory functions and powers of the Office are set out in the Ombudsman for Children Act 2002 and the Ombudsman Amendment Act 2012. This provides that the Office may investigate the administrative actions of a reviewable agency, school or voluntary hospital where, having carried out a preliminary examination, it appears that the action has or may have adversely affected a child and where those actions come within the ambit of Sections 8 (b) or 9 (1) (ii) of the 2002 Act (as referred to in Para 1.6 under).

1.2 The Office can receive complaints directly from children and young people or any adult on their behalf. The Ombudsman for Children may also initiate an investigation of his own volition where it appears to him, having regard to all the circumstances, that an investigation is warranted.

1.3 The Office aims to carry out investigations and to make recommendations which are fair and constructive for both parties. In the context of an investigation, the Office is neither an advocate for the child nor an adversary to the public body.

1.4 In accordance with Section 6(2) of the Act, the Office is obliged to have regard to the best interests of the child and in so far as practicable, to give due consideration, having regard to the age and understanding of the child, to his or her wishes.

1.5 The principal issues to be addressed through an investigation are:

- whether the actions of the public body have, or may have had, an adverse effect on the child involved; and
- whether those actions were or may have been:
    - taken without the proper authority;
    - taken on irrelevant grounds;
    - the result of negligence or carelessness;
    - based on erroneous or incomplete information;
    - improperly discriminatory;
    - based on undesirable administrative practice; or
    - otherwise contrary to fair and sound administration.

1.6 This statement is being prepared in accordance with Section 13 (2) of the 2002 Act, which requires the Ombudsman for Children to produce a statement outlining the results of an investigation. In accordance with the Act, this statement is for distribution to the public body under investigation, the complainant, other relevant parties involved in the investigation and any other persons to whom she considers it appropriate to send the statement.

1.7 A copy of this statement was sent to the Child and Family Agency, in accordance with Section 13 (6) in order to provide them with an opportunity to consider the findings and make representations in relation to same. The comments and representations received have been considered and where appropriate, amendments have been made.

Part 2 Investigation

2.1 In March 2013 the Ombudsman for Children decided to carry out a preliminary examination of her own volition into HSE registration, monitoring and inspection of voluntary and private residential centres for children in the care of the State.

2.2 There is a range of placement provision for children in care including foster care, mainstream residential care, high support and special care. Information obtained through the examination and investigation of complaints indicates that mainstream residential includes statutory centres as well as provision through the voluntary and private sector. The Health Information and Quality Authority inspect statutory children's residential centres and the HSE (at the time of initiation of this examination) inspect and register voluntary and private (for profit) children's residential centres. These services were provided by the Children and Family Services in the HSE but now come under the auspices of the Tusla – the Child and Family Agency since its establishment in January 2014. The Child and Family Agency is also responsible for the monitoring of all residential centres both statutory and those provided by the private and voluntary sector.

2.3 The Office decided to carry out a preliminary examination in order to gain an understanding of the HSE (now Tusla - Child and Family Agency) registration, inspection and monitoring processes on a national basis. A preliminary examination is carried out in the first instance in order to determine whether an investigation by this Office is required and warranted. As a result of the Preliminary Examination OCO had potential concern about the following:

- The process and procedures used to guide inspections of private and voluntary residential centres for children is unclear and potential concern about whether the same standards of inspection are applied as for children in statutory residential centres;
- A lack of clarity in relation to whether there is consistency across all inspection teams in relation to the process and procedures followed for inspection.
- The level of national oversight of monitoring and inspection is unclear including what review and audit of inspection and monitoring is undertaken by National office.
- A lack of independent oversight of the standards applied in the carrying out of such inspections.

2.4 Having carried out a preliminary examination the Ombudsman for Children's Office informed the HSE on 4th September 2013 that it had decided to proceed with an own volition investigation. Section 10 (1) (a) (ii) of the Ombudsman for Children Act, provides that the Ombudsman for Children may conduct an investigation of his own volition where it appears that an action may have adversely affected a child, where there may have been maladministration and where he considers that an investigation would be warranted having regard to all the circumstances.

2.5 The investigation focused on the administrative actions of the HSE (now Tusla - the Child and Family Agency) regarding registration, monitoring and inspection of private and voluntary residential centres for children in the care of the State. The terms of reference as set out at initiation of the investigation are listed below. While HSE are referred to in the terms of reference this specifically relates to the actions of the Children and Family services whose functions transferred to the Agency. The terms of reference are as follows:

a) Whether the current configuration of services ensures that the State's obligations are equally discharged in both statutory and non-statutory/voluntary services, in particular by ensuring the standard of care and inspection is adequate and of a similar standard.
b) The process and procedures followed in relation to registration, monitoring and inspection of private and voluntary children's residential centres for children in the care of the State including local, regional and national processes.
c) The level of consistency across the HSE areas in relation to the process and procedures followed in relation to inspections.
d) Consideration of monitoring and inspections carried out by the HSE (Children and Family services) in 2012 and up until August 2013, the findings and recommendations made and steps taken to ensure all recommendations are progressed.

e) The governance arrangements in place both locally and nationally in relation to registration, inspection and monitoring of private and voluntary children's residential centres for children in the care of the State.

f) The consideration given to publishing inspection reports of private and voluntary children's residential centres.

2.6 The Investigation involved:

- Review of documentation provided by Tusla - the Child and Family Agency including:
  - the policies and procedures operated by the 4 regions (South, West, Dublin North East and Dublin Mid Leinster) in relation to registration, monitoring and inspections,
  - Copies of inspection and monitoring reports from January 1st 2012 up until August 2013[1]. The Office received inspection reports for 49 centres and Monitoring reports for 60 centres; and
  - Review of 7 inspection files.
- Meetings with representatives from the inspection and monitoring teams for each of the 4 regions.
- Information provided by Children and Family Services National Office.
- Information from the Health Information and Quality Authority (HIQA)

Part 3 Analysis

Background

3.1. The registration of non-statutory (private and voluntary) children's residential centres is assigned to the HSE under Articles 60 and 61 of the Child Care Act 1991. Inspection and monitoring of children's residential centres are functions created under the Child Care Regulations 1996 and 1995. These functions are now carried out by Tusla - the Child and Family Agency.

3.2. Part VIII of the Child Care Act 1991 provides that the following :

- All centres in the non-statutory sector be registered with the HSE
- It is an offence to operate a non-registered centre
- For the application and administration processes for the operation of the registration system

[1] It is acknowledged that the Child and Family Agency provided information outside of this time frame in order to assist our understanding of the matters under investigation.

- Prescribes the powers of the registration body
- Prescribes the maximum period of registration allowable (3 years from the date of registration see Section 61(3) (b).
- Defines the offences that could be committed under the Act.

3.3. Inspections of statutory children's residential centres are carried out by the Health and Information Quality Authority which publishes all inspections on their website. Private and voluntary children's residential centres are registered and inspected by the Registration and Inspection Units of the Child and Family Agency (formerly under Children and Family Services within the HSE) as provided for in Article 63 of the Child Care Act 1991 and Part IV, Article 18 of the Child Care (Standards in Children's Residential Centres) Regulations 1996.

3.4. All residential centres are inspected against the National Standards for Children's Residential Centres which were published by the Department of Health in 2001.

3.5. Monitoring of children's residential centres is a function created under Part III, Article 17 of the Child Care (Placement of Children in Residential Care) Regulations 1995. The core task of the monitoring function is stipulated under Standard 3 of the current National Standards for Children's Residential Centres.

Registration, Inspection and Monitoring Services for Non Statutory Children's Residential Centres (Information provided by the Child and Family Agency)

3.6. At the introduction of the Child Care Act 1991 all existing children's centres were deemed registered via a legislative clause contained within the Act. Thereafter new centres and existing centres are required to be registered every 3 years. Centres are subject to various categories of visits and inspections as follows:

- Advisory Visit: usually occurs prior to application for registration to advise the provider if the proposed premises are fit for purpose and to advise on aspects of the registration process and application.
- Registration Inspection: upon receipt of a completed application for registration the centre will be inspected to determine compliance with the regulations, which must be satisfied prior to opening. A centre may not accept a young person into the centre until certified as fully registered. However, a centre may admit children after initial registration and before a full inspection is carried out. This is to allow the Registration and Inspection Unit to inspect actual practices in the centre.

- Initial full inspection: This inspection should take place within 3 to 6 months of achieving registration and is a full comprehensive inspection of the operation of the centre against national standards and to drive forward improvements in the standards of care for young people. The outcome of the inspection will determine the continued registration of the centre. The Registrar can register with or without conditions or revoke or remove the centres registered status. Centres with a repeated history of poor adherence to standards, or have demonstrated poor performance will tend to be granted shorter periods of registration usually with attached conditions designed to allow the inspectorate to make continuous assessment of centres where concerns have been identified.
- Follow up inspections: following a full inspection a follow up inspection will take place to ensure that all issues requiring action as identified during the inspection visits are complied with. Where conditions have been attached to any registration, compliance with same will be inspected.
- Unannounced inspections: are carried out both in a routine and non-routine manner. Every centre during their registration cycle will be subject to at least one announced full inspection and one unannounced inspection plus any required follow up inspections. In addition unannounced inspections can be triggered by notified concerns to the inspectorate or following reported concerns by the relevant Monitoring Officer.

3.7. The Child and Family Agency advise that in addition to inspection and registration, all centres are monitored to ensure continued and on-going adherence to regulation and standards. All children's centres, both statutory and non-statutory are subject to monitoring visits. Monitors are assigned geographically and the same Monitoring Officer will visit both sectors to ensure a standardised methodology is applied. Monitoring differs from inspection in that while both are regulatory and quality assurance in nature, inspection is more formal, linked to registration and less frequent, while the monitoring process is designed to complement the inspection process by ensuring compliance with regulations, standards and best practice. It is more frequent, immediate and thematic. Monitoring officers receive notifications of significant events from centres and are assigned the role of complaint investigation in certain instances.

3.8. All inspection and monitoring findings are issued with an expectation that all issues requiring action are responded to initially by a formal written action plan outlining the manner in which issues will be responded to and within what timeframe. The Chief Inspector in DNE and the appointed Registrars in other regions make the final decisions on all registration decisions or matters of conditions being attached to the service. The Agency advised that

both processes produce written reports and action plans and have regulatory powers to enforce issues requiring action although the powers of monitoring officers are more unprescribed by legislation than the powers of inspection officers.

3.9. The capacity of inspection teams is determined fundamentally by the legislative requirement of the three year inspection cycle and the number of centres present in any one area. In some areas where numbers of centres are low, the same team will act in both a monitoring and inspection capacity. In these areas the regulatory functions are combined but executed separately.

3.10. The Agency advised that there were 44 full inspections carried out nationally in 2012 and each would generate a follow up visit, none of which led to the removal from the register as a result of poor practice or non-adherence to standards. Any centres that ceased to operate did so as a result of becoming financially unviable as a result of a lack of placements being made to the centre in line with HSE budget management initiatives.

Structure

3.11. Originally the Registration and Inspection services were located within each health board area and unilaterally became regional services as a result of the various reforms of the Health Board structures and geographical areas. Currently the Agency has 4 regional Registration and Inspection services. The services were aligned to the former health board areas and subsequently the four HSE regions. For example in the South region there were two services operating covering the former South East and South regions. In the West there was the West, North West and mid – West regions. Dublin North East is the team that served the former Eastern Health Board area and more recently the Eastern Regional Health Authority and historically covers some of the geographic Dublin Mid Leinster area. The Dublin Mid Leinster region has 2 inspection officers and one monitoring officer.

3.12. The Agency advised in April 2013 that the private sector is the largest provider of services nationally. The number of centres registered nationally in the private and voluntary sector at the end of 2012 is set out in the table below. The following table sets out the structure of the Registration and Inspection teams in the Agency:

Area	Number of private and voluntary centres	Inspection officer posts	Monitoring officer posts	Dual Monitoring/ Inspection officer posts
Dublin North East (Dublin NE which covers some of the DML area)	63	5	2	
Dublin Mid Leinster (DML)	9	2	1	
South	27	2	1	2
West	6			2

The Office is aware from meeting with representatives of the Agency that the numbers of registered centres may have changed during the course of the investigation. It should also be noted the Monitoring officers have responsibility for statutory centres also. Monitoring officers are responsible for approximately 162 centres nationally.

3.13. Information provided by the Department of Children and Youth Affairs to a Parliamentary Question in June 2014 indicates that expenditure for private residential care was €49.323m in 2012 and €48.972m in 2013.

3.14. Registration and inspection services initially operated under the remit of individual health boards and the management of these has varied across the regions. In one area, the North East the Regional Director for Children and Family was the line manager to the service and a Chief Inspector has been operational for a number of years. In others, management has been through different structures with direct line management by Child Care Managers, Local Health Managers or Regional Specialists in some instances. In 2009 the National Children and Families Office was set up, initially as an administrative oversight office. As the National office's operational capacity increased a decision was made in late 2010 to formally nationalise the registration and inspection service. This was planned in two phases, phase one was the introduction of national oversight and phase two will involve

national governance. In 2011 management of the Registration and Inspection services became the remit of the Regional Directors for Children and Family Services. In 2013 Regional Managers for Quality and Risk were appointed and took over responsibility for Registration and Inspection services in 2 regions temporarily. Since 2014 all registration and inspection services report directly to Quality Assurance Section at National Office.

3.15. The Agency advised that all inspection reports are sent to the National Office for review and regular liaison with the team occurs. The Agency also makes regular reports to the Department of Children and Youth Affairs regarding its inspection and monitoring activity when requested

3.16. A central focus of the investigation carried out by this Office relates to the level of consistency in registration, inspection and monitoring services across the Agency.

HIQA inspection process (Information provided by the HIQA)

3.17. In the context of this review HIQA outlined that it takes a risk based approach to monitoring children's residential centres under the Child Care Acts 1991 and 2001. Prior to 2013, children's residential centres were inspected once every 3 years but from 2013 onwards this frequency was increased to once every two years. The centres which have always been inspected annually are deemed to be services which inherently pose a higher risk, as they provide services to children with the most complex needs and behaviour. In addition, further inspections are carried out on an unplanned basis:

- In response to information received (which may be solicited or unsolicited)
- Where a serious risk has been identified
- Where a history of non-compliance continues
- To follow up on an inspection where risks were identified in order to be assured that actions proposed and taken by the provider (the Agency) have mitigated the identified risks.

3.18. The schedule of inspection is informed by the on-going assessment of risk of individual centres and the time elapsed since the last inspection. Regular as well as responsive inspections are required in order to drive improvement and be assured of the safety of services. Inspection resources are targeted on centres which fail to meet standards or where serious risks are identified.

3.19. HIQA takes an escalating approach to non-compliance and risks to children, whereby concerns are raised with managers on inspection and are referenced in inspection

reports. Should such risks remain unmitigated, inspector managers raise issues with Area Managers and Service Directors in the Agency. If the situation continues HIQA may seek a meeting with the National Office or as a final escalation may report to the Minister for Children and Youth Affairs.

3.20. HIQA carries out both announced and unannounced inspections of children's residential centres. During 2013, the majority of inspections were unannounced. The decision to announce the inspection or not is made by the case holding inspector on a centre by centre basis. At times there can be benefits in having announced inspections as it allows for a data and information request to be made and for particular key post holders such as the person in charge to be interviewed. However if serious risks have been identified, an unannounced inspection is almost always undertaken. Inspections may also take place at night or at the weekend.

3.21. HIQA receive the monitoring reports of statutory centres which are reviewed by the case holding inspector, the information is risk assessed and is considered when determining regulatory activity. Up until recently HIQA also received a small number of monitoring reports for centres run by private providers. The reports were reviewed and on occasion assurances were sought from the monitoring officers about the safety and quality of care. This practice was reviewed in 2014 and HIQA made a decision that the information contained in the reports was not required for effective monitoring under the Child Care Act 1991 or the Health Act 2007. Should the non-statutory centres come under HIQA's remit in the future, as designated centres under the Health Act 2007, HIQA would then seek the monitoring reports.

Part 4 Findings

Registration

4.1 An application form for registration of a Children's Centre is dealt with in Article 4 and in the schedule attached to the Child Care Regulations 1996 (Standards in Children's Residential Centres). This sets out the details which must be submitted in support of an application for registration. The application and registration process is similar in all four regions, however there are some variations.

4.2 A new expression of intention to open a residential centre results in a visit to the premises to assess its overall suitability by Dublin NE and Dublin ML and West. Documents

from the South do not refer to such a visit but South state that the Registration and Inspection unit staff are available for consultation to potential applicants.

4.3 Following the submission of an application the approach varies between regions. In Dublin NE the Chief Inspector meets with the registered proprietor and visits the centre. The centre is registered pending the outcome of a full inspection usually 6 months later. There does not appear to be a Registration report prepared at this stage but the centre's details are entered onto the register and schedule of inspections. In one file reviewed a Certificate of Registration was issued on 8th February 2012 based on the centre having been "pre-inspected". It was registered pending a full inspection which took place 4 months later and thereafter registered without conditions for 18 months until August 2014.

4.4 In practice South advised that a service provider will make an application with a proposed identified facility and an early short inspection visit is carried out to comment on its suitability following which a formal application is made. The application includes documentation relating to staffing, insurance, fire certificates, safety requirements etc. If all the required paperwork is provided, the centre is registered pending inspection which is usually carried out within 6 months. This inspection is to see how the facility operates when children and staff are in place. In the former SE region, registration was dated from the time of application and in the South registration was dated from the time of inspection. Tusla advised that this practice ceased in early 2013 and all registrations since then are dated from the time of application.

4.5 In the West region, the practice is that information is sent to the provider following any enquiry regarding the requirements to be met for registration. All documentation is reviewed on receipt and a visit is carried out to view the premises. A registration report is then submitted to the Registrar with a recommendation which may be to register the centre, register with conditions or refuse registration. Once the registration report is signed and approved by the Registrar the centre is deemed to be registered from that date. The centre is inspected within six months of when children are placed.

4.6 In general centres are registered subject to full inspection. In two regions registration reports are produced but in the other two there is no evidence from the information provided that reports of this nature are produced. In Dublin ML a report is compiled and submitted to the Local Health Manager with a recommendation regarding registration and as noted above in the West a registration report is prepared based on the Child Care Regulations and submitted to the Registrar.

4.7 In the South there have been significant gaps in some centres between registration and the full inspection to confirm registration and the time period for this. One centre opened in May 2011 and was granted registration pending the outcome of full inspection. The inspection took place in July/August 2012. In another case a centre which was first registered in June 2008 and inspected in November 2008 and March 2010. Registration was granted on 31st December 2011 pending full inspection and was only inspected in February 2013. It was advised that this arose due to two staff vacancies for most of 2012 leading to a backlog in inspections.

4.8 Significant gaps between registration and inspection also occurred in Dublin NE. In one case the initial registration was in April 2011 and the inspection took place in February 2012. In another case a centre was registered to commence operations in June 2011 and the first full inspection was held in March 2012. The centre was registered without conditions until June 2014.

4.9 In three centres in the West issues were identified in relation to some standards met or partly met at the time of the inspection. West say that it is usual that practice issues arise and registration is only decided when an action plan is provided and the HSE (now the Child and Family Agency) is satisfied all are being addressed. Centres are registered if Regulations are met.

4.10 In two centres in Dublin NE similar issues were identified:

- In one centre inspection visits were made on 10-12/1/12. The date the report issued is not recorded. The inspection was based on all 10 national standards. Inspectors stated that the centre failed to meet a substantial number of the standard criteria and a number of regulations. None of the 10 standards were fully met. The report identified 40 issues requiring action and a response and action plan were provided by the proprietor. Re – registration was granted without conditions until April 2013.[2]
- In a second centre which commenced operations in May 2006, was inspected in 2009 and the centre was registered for the full three years with no conditions attached. Inspection visits for re-registration were made on 15-16/5/12. The date the report issued is not recorded. This inspection found that the centre was not meeting a significant number of standards and some regulations under the Child Care Act 1991. Nine standards were not fully met and the report identified 34 issues requiring action. A response and action plan was provided by and discussions were held with the proprietor. It was registered without conditions until 31/10/13.

[2] The Executive Summary of this report states that the home was registered with an attached condition but the section headed "Findings with Regard to Registration" states that registration is without conditions.

- It is important to note that these two centres which had been in operation for some time failed to meet standards and/or regulations at the time of their inspection for re-registration despite the fact that the HSE was supposed to be monitoring them for compliance with the standards and regulations.

4.11 The key issue is what occurs in terms of registration without conditions when Regulations are not met.

4.12 The registration process in the West involved a centre being registered for 1 year on the basis that the provider was new to the area, which does not accord with the criteria for registration. In response to the draft statement Tusla advised that when a new provider is coming into an area and they have never previously operated a children's centre an initial 12 months period of registration may be granted as a safeguard, pending a review inspection which would be undertaken within a specified period of time. Registration for a new provider for the full period of three years is generally not granted, and the shorter period is to allow the service time to demonstrate ongoing ability to meet and maintain the required standard.

4.13 Tusla advised that the policy is that the length of time between registration and full inspection should be as short as possible and that the examples of long periods between these was as a result of a delay in placing children in the centre. However, our analysis of the reports submitted by Tusla does not support this explanation in all cases.

Inspections

4.14 The procedures for the conduct of inspections are very similar. All regions use the 10 National Standards as a template for their reports. In order to carry out the inspections, the inspector consults and communicates with, among others, children and young people, parents, residential care staff, the manager and social work personnel. The inspectors visit the centre and observe care practices. Written records and files are examined. Visits by the Environmental Health Officer are requested by the inspection service.

4.15 Inspections are largely announced and are undertaken over a three day period. There is little evidence of unannounced visits and there was no evidence that visits are undertaken at night or weekends. However, inspectors do stay late in the evening and share a meal with young people. Tusla also advised that inspection staff are facilitated to carry out inspections at weekends if necessary and that this has occurred in the past.

4.16 Inspections of some centres have been delayed due to shortage of staff.

4.17 Dublin NE has a clear statement of the purpose and responsibilities of the Registration and Inspection Service. Other Regions do not have this. It also has the most comprehensive statement setting out the approach to inspections.

4.18 There are no standardised process and procedures documents across the country – this is being worked on by the Agency. The inspection/registration services were set up before HSE was established. While some steps were taken to address standardisation which involved a joint initiative with the SSI in 2002 and across the Health Boards in 2004, this focused on the inspection process, interpretation of standards and paperwork/templates. However, people's roles (i.e. dual or separate monitoring/inspection officers) and monitoring did not get standardised. Line management was also very different over the country – some had a chief inspector others reported to Child Care Manager (see paragraph 3.14).The joint HSE Registration and Inspection Units undertook a process in June 2011 to ensure Inspection Reports were standardised and questionnaire templates standardised.

4.19 There is no agreed policy on access to inspection reports. They are not published in any format. There has been some discussion nationally on the accessibility of reports over the past 2 years. However, no time frame has been set for publication by the Agency. The reports written by the Registration and Inspection Service are subject to the Freedom of Information Act 1997.

4.20 The layout of reports is not consistent – in particular, a number of reports did not include recommendations regarding registration, summary of issues requiring action or an action plan to address same. The quality of some reports is very poor. In some cases there was inconsistency in the narrative description of whether standards were met or met in part and the table completed. There was no oversight/auditing of the contents and quality of reports in all regions at the time of the investigation. However, the South stated that over a number of years several staff had oversight and commentary on all inspection reports. Despite this we remain concerned about the quality of some reports.

4.21 Generally the use of the 10 National Standards as the template for inspection reports is problematic for a number of reasons.

- The registration of centres is governed by the Child Care Act and the associated Regulations. Centres are expected to comply with Regulations 5-16 and failure to register a centre must be based on these Regulations only.

- The National Standards contain standards and criteria, some of which are beyond the control of proprietors and managers of private and voluntary centres. In particular the standard on Monitoring and some of the criteria relating to Planning for Children in Care – these are Care Plans, Reviews of Care Plans and the Social Work Role. It would not be possible to refuse registration or discontinue registration if these Standards and criteria were not met as registration is based solely on the regulations.
- Registration reports should focus on the requirements of the Legislation and Regulations.

4.22 The issue of Regulation and Inspection of children's services was considered by the Ryan Commission which recommended that independent inspections of services are essential which must include:

- a sufficient number of inspectors
- inspectors must be independent
- there should be objective national standards for inspection of all settings where children are placed
- unannounced inspections should take place
- Complaints to an inspector should be recorded and followed up
- Inspectors should have power to ensure that inadequate standards are addressed without delay.

4.23 The implementation plan developed by the Office of the Minister for Children and Youth Affairs in response to the Ryan Report states that the Health Act 2007 will be commenced to allow the SSI of the HIQA to undertake independent inspection of all children's residential centres and foster care, which was to take place by July 2010. In July 2010 the implementation plan for HIQA to undertake independent inspection of children's residential centres was altered by a Government decision and this is reflected in the annual report of the Implementation Plan as laid before the Oireachtas. In that it was decided to prioritise the inspection of child protection services and residential services for children with disabilities in advance of commencing the legislation to allow HIQA to regulate all residential services. The Department of Children and Youth Affairs advised that the thinking behind this was that there was no independent oversight of child protection or disabilities whereas the children's residential services were inspected, albeit by two different agencies and that it made greater safeguarding sense to put in place oversight for these two vulnerable groups of children. The inspection of non-statutory children's' residential centres continues to be carried out by the Child and Family Agency. This Office is of the view that this does not provide sufficient

level of independence in relation to inspection as the Child and Family Agency is responsible for the planning, commissioning and procurement of these services.

Monitoring

4.24 The requirement for the HSE, and now the Child and Family Agency to monitor children's centres is clearly set out in Standard Number 3 and associated criteria of the National Standards for Children's Residential Centres. The focus of this investigation is on monitoring of the non statutory sector.

4.25 Dublin NE and South have issued supplementary papers on Monitoring setting out their own requirements which are additional to the standard. Dublin ML and West have not issued comparable papers. Dublin ML has an information leaflet for young people and West has information leaflets for young people and parents. These leaflets give some information on the role of the monitor.

4.26 Dublin NE region states that the aim of the monitoring process is to support best practice and the provision of the highest standards of care, and at all times to promote the rights and welfare of young people as paramount. Monitoring visits can be announced or unannounced. Monitoring visits to children's residential centres will be scheduled to take place 12-16 weeks following the publication of an inspection report by the Health Information and Quality Authority (HIQA) or the registration of a centre by the Registration and Inspection Service. The purpose of such a monitoring visit will be to ensure that all recommendations made by the HIQA or the Registration and Inspection Service have been implemented and complied with. It will also be for the purpose of assessing whether Standards and Regulations are being maintained in the centre. Centres will be visited by the Monitoring Officers on an ongoing and regular basis. The purpose of these visits is to review findings of previous monitoring reports and to support residential centres and staff to maintain the Standards and Regulations. A written report of monitoring visits will be compiled and this report will comment on whether practices and operational policies continue to comply with the Standards, fall below the required Standard or improvements have been made in order to fully comply with the Standards. The report template uses the 10 National Standards and does not refer to the Regulations and the local policy.

4.27 According to the document the monitor receives all notifications of significant events from all the centres. These are reviewed on a weekly basis by the manager of the service and the monitors. The purpose of the meeting is to review the paperwork and ensure it is submitted correctly, that actions have been taken by the staff and management, to track

patterns of behaviour and to follow up on identified concerns. The monitors meet monthly with the residential co-ordinator and the alternative care managers to discuss the centres and any concerns arising from the review of significant events.

4.28 Fourteen Full Inspection reports submitted by the DNE Region were examined with particular reference to the standard on Monitoring. The inspection reports indicated that the standard was met in respect of 10 homes, partially met in respect of 3 centres and not met in respect of one centre. The inspection reports do not describe or analyse the performance of the monitors with regard to the procedures set out by the Registration and Inspection service for the Region nor with regard to the requirements set down in the National Standards.

4.29 The role of the monitor is more a supportive role to centres than inspectors and acts as an early alert system for safety issues. They monitor compliance with standards and follow up on recommendations made. Issues raised by monitors can trigger unannounced inspections. Inspectors also will look at monitoring reports as part of their pre-inspection preparation. The region states that a Monitoring report must be produced yearly and in practice a report is produced after each visit. However, this is not evident from the information submitted. As part of the process the monitor will try to build up a relationship with the centre including making themselves available to talk to young people.

4.30 In Dublin NE an inspection is seen as a snapshot of how things stand during the possible three days of an inspection. The role of the monitor will have a more on-going role. The frequency of monitoring is not as concrete as inspections as there are only two monitors with responsibility for 38 non-statutory centres (as of March 2014). There are also 11 statutory centres in the region. At an investigation meeting it was stated that visiting a centre once a year is not achievable with only one monitor. [One monitor was on maternity leave and had not been replaced.] However the significant events register is seen an important tool in keeping a watch on centres.

4.31 The Registration and Inspection Units assess private and voluntary homes under the 10 standards set out in the National Standards for Children's Residential Centres 2001, one of which is Monitoring. This results in the situation whereby those carrying out the Inspection will be assessing the performance of members of the monitoring team who are under the same management structure as themselves.

4.32 There were a number of Inspection reports in the Dublin NE which highlighted the fact that the monitoring standard had not been fully met.

1. *The monitoring office of the HSE Dublin North East conducted a formal monitoring visit to this centre in May 2011 which, according to centre management focused mainly on the content and organisation of young people's files. Centre management were given some direction following this process including the use of individual placement plans. The Monitors also met with the young people at a later date to talk to them about their placement in this centre. Inspectors spoke with one of the Monitoring Officers prior to this inspection and they indicated that there were no concerns in relation to the operation of the service and that they regularly have contact with this centre. Centre management stated that the Monitors offer support and consultation when necessary however they do not regularly receive feedback on significant events. A report of the monitoring process had not been issued to the centre or Inspectors at the time of this inspection in January 2012 and the Monitors should make this report available as a matter of priority so that centre management can ensure all relevant issues are addressed.*

2. *The HSE Dublin North East Monitoring Officer has not conducted a visit to the centre since it received their first admission in January 2012 for the purpose of ensuring compliance with regulations, standards and best practice. However, the Monitoring Officer and Centre Manager stated that a monitoring visit was scheduled around the time of the inspection but was postponed in order to optimise its usefulness for the centre after the inspection. The Centre Manager stated that they have regular phone contact with the Monitor and finds them supportive and a clear channel of accountability for the centre. Overall the Monitoring Officer informed the Inspectors that from updates and feedback from the Centre Manager on a regular basis and based on this information they were confident that the quality of care being provided to the young person was of a good standard. The Monitoring Officer stated that they have not received any notification of significant events and are satisfied that they would be reported promptly should they occur. The Inspectors recommended that the HSE Monitoring Officer should visit the centre and meet with the young person to ensure the Child Care Regulations 5-16 are being complied with.*

4.33 Dublin ML region did not submit a policy document on monitoring. Information submitted indicated that their work was guided by a number of Regulations, Standards and policy documents issued by central government or the HSE. There is an information leaflet for young people on the monitoring service. The leaflet states that the monitor will visit the

centre on a regular basis and will write a report on what they have found. Prior to a monitoring visit, a Self – Audit form is issued to Centre Managers. Information is also sought on the young people, staff, and health and safety. There is also a list of essential documents to be reviewed

4.34 Fourteen Inspection Reports from this region were reviewed. In two reports monitoring was not addressed. The monitoring standard was considered met in nine centres although in one of these there was no evidence to support the assessment. In another centre there was no monitoring report available, some five months after the Monitoring visit which focused on only one standard. This was apparently due to the monitor going on sick leave. The Standard was partially met in two centres and not met in one centre.

4.35 There were a number of Inspection reports in the Dublin ML which highlighted the fact that the monitoring standard had not been fully met.

> *1. The centre Manager maintains regular contact with the HSE Monitor ensuring that they receive notification of all significant events, including admissions and discharges to the centre. Inspectors interviewed the Monitor following the onsite inspection to discuss with them their fulfilment of the monitoring role. The Monitor confirmed that reporting of significant events was prompt and that they had been in regular contact with centre management to ensure that all information was being adequately documented. The Monitor was not aware of complaints made by young people in relation to physical restraints (in 2011) but informed Inspectors that they would follow up on these matters. The Monitor visited the centre last year as an 'introductory' visit and is of the view from this visit and based on incident reports that the layout of the premises is an influencing factor in the occurrence of incidents and difficulties associated with behaviour management. The Monitor has not met with the young person currently resident nor have they had any contact with the allocated social worker. The Monitor will compile a report for the HSE on the monitoring process of all centres in their area. The inspectors indicated that among the issues requiring action was that the Monitor takes the necessary action to ensure that this centre is in compliance with regulations, standards and best practice.*
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> *2. The Monitoring Officer for the HSE DML has visited the centre on a number of occasions [they] stated and has had phone contact with the team regarding specific matters. [They] have not completed a report on the centre to date due to a period of absence from work. The Monitor met with Inspectors for the purposes of this inspection and detailed the involvement of the monitoring office and the significant*

events review group with the centre. The Monitor had contacted the centre following certain incidents to gather further detail and to discuss matters arising. A copy of a monitoring report should be forwarded as soon as one is available.

3. A draft monitoring report was reviewed in relation to another centre, which had applied for registration on 7th July 2012 and a visit to the premises was made by the Inspector. This resulted in the production of a Registration report dated 16th October 2012 and the centre was registered for operation as a children's centre from July 30th 2012 to January 31st 2013 under a number of conditions and subject to the findings of a full inspection to establish its compliance with the Regulations and Standards. The conditions were that all Regulations are met as identified in the Registration Report and this is to include evidence of training and regular supervision of the acting team leader and staff team members. There were 14 Action Points included in the report and an action plan dated September 2012 on file dealing with the implementation of these points. There is no indication on file that a full inspection was carried out in advance of the expiry of the conditional registration.
A monitoring visit was completed by the Inspector in their role as Monitor over a number of days in November 2012 with a report completed and issued to the centre in June 2013 which contained a summary of requirements – 27 in all. In issuing the draft monitoring report to the centre the monitor indicated that it was likely that most, if not all of the action plan will have been implemented based on the feed-back to the centre manager and team leader during monitoring. An Inspection conducted in June 2013 by the Dublin NE Inspection team concluded that the monitoring standard had not been met.

4.36 The South region has a document which states that *"The Registration, Inspection and Monitoring team are authorised under Article 17 Child Care Regulations 1995 to enter and monitor children's residential centres in the statutory and non-statutory sectors including the voluntary sector and private providers so as to satisfy the HSE that National Standards and regulations are being complied with. Inspectors monitor all centres in accordance with the National Standards."*

4.37 The document then goes on to outline the practice of the monitors. Inspectors may monitor a centre together or individually depending on the circumstances. Inspectors, in their monitoring capacity, aim to visit each centre every six to eight weeks or as required. Young people, families, staff or anyone with a bona fide interest may contact inspectors as needs be. The Registration, Inspection & Monitoring Team endeavours to cover all the

National Standards in each centre over a twelve-month period. This entails monitoring one standard on each visit as well as significant events. When required, Inspectors will cover the same standard in all the centres giving a snapshot of practice in the area highlighted. Recommendations made either by the Social Services Inspectorate or by the HSE inspectors will also be monitored on subsequent visits.

4.38 This region is looking at standardising monitoring visits (between Cork/Kerry and South East). There are differences across the region which is currently being addressed. For example, in the South East the Monitor might visit once a year and go for 3 days and look at every standard. A full report will be written which looks like an inspection report. This has never been the practice in the Southern area. In Cork visits were more frequent (every 6 weeks) and look at one standard or group of standards – a more thematic approach to monitoring. Generally this region finds that the Monitoring function is more effective if visits are more often and build up relationships with young people and staff of the centre. They are trying to put this together but allowing Monitoring officer's flexibility and autonomy to visit as often as they need to. The absolute minimum standard would be 3 visits per year. There is an element of professional judgment with regard to what facility requires more monitoring, which is determined by the Monitor. Also the nature of the unit might require increased monitoring. For example there is a unit whose role is a 12 week assessment unit and so with the high turnover of young people regular monitoring is required to meet young people and ensure the social worker has visited and there are care plans in place etc.

4.39 In four reports submitted by the South the Regulations and Standard on Monitoring was not met and in another it was met in some respects only. In the former the Inspection report recorded that

> *There were no visits by an authorised person during the period under review, and therefore the monitoring standard was not met. The Inspectors were concerned that there were no visits to the young people by an authorised person for some time. The HSE South Monitoring Officer retired in May 2011, and an acting Monitoring Officer was now in post; [they] were planning to commence a programme of visits. The HSE South must ensure compliance with the Regulations."* This centre was inspected in November 2011.
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> *"The monitoring standard was not met. There were no visits by a HSE authorised person at the time of the inspection, the last visit to the centre was in January 2012. The HSE South must ensure compliance with the Regulations."* This centre was inspected in August 2012.

The Monitoring standard was not met. There were no monitoring visits by an authorised person for some time. The HSE South must ensure compliance with the Regulations. The centre was inspected in April 2012 and does not include details as to when the last Monitoring visits occurred. The only monitoring report provided to this Office related to March 2013.

The post of Monitoring Officer was unfilled for most of the period under review. Revised monitoring arrangements are now being put in place, following a recent appointment, and the newly appointed Monitoring Officer had visited the centre." This centre was inspected February 2013 and had been registered from December 2011.

4.40 The West did not submit a policy document on Monitoring. It submitted an Information Leaflet for Parents; an Information Leaflet for Young People. A Template for a Monitoring Report together with a number of Monitoring Reports were also submitted. The Monitoring Report Template refers to the 10 National Standards.

4.41 In the West, as in other regions, there is a support inspector for inspections. As staff here are dual monitor/inspectors, the support inspector usually inspects any aspects relating to monitoring and enquires with the service provider with regard to the monitoring role. The lead inspector leaves the room and the support inspector will have an interview with the service provider. They will then comment in relation to this in the Inspection report. The information leaflet for parents on the monitoring service states that the monitor will visit the centre on a regular basis and that the monitor will write a report on what has been found. The information leaflet for young people refers to the role of monitor as:

- Checking decisions made about how the centre cares for a young person and making sure the young person has a say;
- Receiving information about significant events a young person experiences;
- Receiving a monthly report from each centre that asks how staff included the young person in decisions about care. There is page for the young person to fill out;
- Visiting the centre;
- Making sure that young person's records are kept well and helping the young person to read them;
- Ensuring complaints are fully looked into.

4.42 There is no standardised way to write up reports. Some are under the Standards while some are completed against the Regulations. There are usually 2 comprehensive reports in

a year. The Monitoring Officers try to visit centres every 8-10 weeks and they are in weekly contact with all centres. If a child did not have a social worker the monitor would write to the Area Manager or person responsible for the child.

4.43 Summary of issues re monitoring across the 4 regions.

- There is large variation in frequency of visits, and reports. This is both within and across regions. The regulations state that the Monitor should visit centres from time to time and should produce an annual report. There is no national protocol on frequency of monitoring visits and the decision regarding the frequency of monitoring visits is made locally and is influenced by a number of factors including the number of centres (statutory and non statutory) in the area and other pieces of work the monitor has responsibility for. The Standard states that monitoring should be regular. Information obtained raises concerns that the level of monitoring is not sufficient which in some instances involves an annual visit only.
- A number of centres were opened and registered pending inspection but not adequately monitored during that period – some had no monitoring visits and others had very few. This meant that there was inadequate support for the units in such circumstances.
- There is variation both in the structure and frequency of reports. In some areas reports are produced after every visit and in others there is an annual report. In terms of structure, some reports focused on evaluation against the Regulations, others against the National Standards and some commented on both. Some had themed visits. Not all Regulations and Standards were consistently reviewed on an annual basis in some centres or there was insufficient evidence to this effect.
- In a number of centres the Regulations or Standards were not fully met. Some Regulations were not met and some Standards/sub criteria were partly met. In such circumstances, an annual visit is not sufficient to ensure that Regulations and Standards that were not met have been adequately addressed.
- Examination of the monitoring reports submitted did not indicate a consistent approach to the evaluation of care practices and operational procedures (Article 5, 1995 Regulations).
- The reading of records of sanctions, unauthorised absences etc. are not specifically referenced in many of the reports but significant events notifications are referred to. Some reports refer to reading centre records and care file but do not specifically address the records for these issues.
- Lack of standardisation in relation to Monitoring means accountability and oversight is difficult.

- Monitoring appears to be viewed as a discretionary activity. Centres are not visited by monitors when they are absent or have not been replaced on leaving the service. This leaves children vulnerable as inspections are usually carried out every three years and monitors are expected to be the "guardians" of standards of care in the intervening period
- In some regions there are posts for inspectors, who inspect the centres for registration purposes and posts for authorised persons who monitor the centres. However, in some regions the role of inspector and monitor is carried out by the same person.
- Overall there is a major gap between the national and local policies on monitoring and its implementation. The requirement for the Child and Family Agency to monitor children's centres is clearly set out in Standard Number 3 and associated criteria of the National Standards for Children's Residential Centres 2001. Dublin NE and South have issued supplementary papers on Monitoring setting out their own requirements which are additional to the standard. Dublin ML and West have not issued comparable papers. Dublin ML has an information leaflet for young people and West has information leaflets for young people and parents. These leaflets give some information on the role of the monitor. All of these documents refer to the authorised person monitoring the centre on a regular basis and the production of reports on the visits. However, there is no consistency in the approach to these matters.

4.44 In response to the draft statement issued under Section 13(6) of the 2002 Act Tusla indicated that it accepted the finding of the investigation that the processes of registration and inspection and monitoring of children's residential services were not standardised during the time period reflected in this report. However, the Agency did not accept the findings of potential adverse effect upon children and pointed out that while it accepted that in some parts of the country an insufficient number of posts were made available to the task the impact of the same was mitigated by the diversion of other resources to the task. The Office is not persuaded by this argument as the investigation has highlighted significant gaps in the task of monitoring homes which is an important component of the safeguarding of children living in alternative accommodation.

Conclusion

4.45 Following the conclusion of this investigation, pursuant to Section 13 of the Ombudsman for Children Act 2002, this Office found that the administrative actions of the HSE Children and Families services, now the Child and Family Agency in relation to registration, inspection and

monitoring of non statutory children's residential centres comes within the ambit of Section 8 of the Act:

a) Section 8 (a) has or may have adversely affected a child and

b) Section 8(b) (vi) has been based on an undesirable administrative practice and (vii) contrary to fair and sound administration

The finding under Section 8(a) has or may have adversely affected a child is based on two grounds:

a) Some centres were not monitored in accordance with the requirements of Standard 3 of the National Standards for Children's Residential Centres, 2001 or the requirements of Article 17 of the Child Care (Placement of Children in Residential Care) Regulations 1995. This was due to the failure to ensure that there were a sufficient number of posts to fulfil the requirements or vacancies in the Monitor posts.

b) Centres applying for re-registration which failed to comply with the Regulations. A number of centres which had applied for re-registration failed to fully meet Regulations despite being subject to monitoring in the three years for which they were registered. If the homes had been properly monitored then non-compliance with Regulations should have been identified and corrected in advance of an inspection for re- registration. Failure to meet the Regulations meant that the quality of care being provided for children was inadequate and therefore adversely affected them.

The findings under Section 8 (b) relate to the significant inconsistencies across the country, as detailed above, in respect of the arrangements for the registration, inspection and monitoring of centres .The approach to these matter has been developed at local level starting with the Area Health Boards and over the years there has been no significant attempt to rationalise the policies and procedures and develop a more coherent approach to these matters.

Recommendations

1. Inspection:
   - A clear gap in the approach to inspections of these centres has developed between HIQA and the Child and Family Agency and it is recommended that

the inspection of these centres and their registration should transfer to HIQA without delay.

- Pending the transfer of this responsibility to HIQA, the Child and Family Agency should give consideration to the following:
    - Improving standardisation and quality of the Inspection reports;
    - Ensuring a balance of announced and unannounced inspections are carried out including inspection at weekends and in the evenings;
    - separation of the roles of monitor and inspector;
    - publication of the inspection reports;
    - provision of a national training programme for inspectors to ensure consistency nationwide.

2. Registration:

- Registration of all centres should be progressed in line with the Health Act 2007.
- Newly registered centres should be given priority for Monitoring.

3. Monitoring:

Monitoring is an important safeguard for children who are living in residential centres. As noted above failure to carry out this function adversely effects a child placed in these centres. It is recommended that the Child and Family Agency ensure that there is oversight of this activity at national level. It is further recommended that the Child and Family Agency;

- Develops clear policies and procedures for the implementation of this activity
- Provides guidance on the structure and content of the monitoring reports
- Conducts regular audits of the quality of the reports
- Provides a national training programme for monitors to ensure consistency nationwide.

4. The Child and Family Agency should ensure that there are sufficient numbers of posts to discharge the Monitoring function. It is questionable whether any 1 or 2 staff can ably be expected to monitor the numbers of residential centres in some regions and to discharge this function adequately.

5. Mechanisms of Accountability need to be reviewed; in situations where inspectors or monitors conclude that Regulations have been met but the National Standards have not been fully met. The Child and Family Agency needs to consider the adequacy of the

mechanisms in place to ensure that residential centres are fully compliant with the Regulations and National Standards.

Tusla response in October 2014

When submitting its comments on the draft copy of the investigation statement, Tusla advised of the following:

Since July 2014 the registration, inspection and monitoring services are subject to national governance, quality assurance and oversight. The service improvement plan will comprehensively address the recommendations in the report apart from the recommendation related to the transfer of the functions to HIQA which is matter for the DCYA.

The service improvement plan has identified the highest area of practice inconsistency lies in the monitoring of children's residential services and will concentrate on implementing enhanced quality in the following areas:

- Review and standardisation of role and job description for all inspection and monitoring officers
- Development and Introduction of a suite of standardisation operation procedures and methodology for the monitoring and inspection service
- Standardised professional supervision and performance management for all inspection and monitoring officers
- Standardised report production and online publication
- Standardised resource allocation and case load management
- Reduction of service regions from 4 to 2 in order to increase resource allocation
- Enhanced quality assurance of registration decisions and administrative processes
- National Governance structures reporting to the national director for Quality Assurance
- Enhanced risk assessment and intelligent evidence lead inspection and monitoring service.

The implementation of this improvement plan will monitored approximately six months after the issue of this report.

Response to recommendations from TUSLA

The matter of the transfer of the registration and inspection function of children's residential centres to HIQA under the Health Amendment Act 2007 has been the subject of some discussion between the DCYA and HIQA. There has never been doubt that the functions would transfer, the matter of when and how has remained unanswered. Tusla have

commenced engagement with the DCYA in respect of same and will continue to make some service improvements in the area and will move to publication of reports during 2015. Any resource investment will understandably be considered for allocation in the context of any pending transfer.

The relevant sections of the service improvement plan which will focus on the matters relating to recommendations 3 and 4 was provided.

It is envisaged that once the inspection function has been transferred to HIQA that the agency will be able to re-deploy staff to the monitoring function. Tusla is about to introduce a standardised operating procedure to ensure that the funding of monitoring reports are responded to in a timely and thorough manner.

Service Improvement Plan for Registration, Inspection and Monitoring services -
Project Outcomes

- Publication of Inspection and Monitoring reports on the internet
- Establish National Editorial Consistency Group
- Implementation of new national standards and regulations in the Special Care Sector
- Establish a nationally governed Inspection and Monitoring service
- Establish a Centralised on line Registration System
- Establish a National Register for Residential child care and Private fostering providers,
- Develop a National Complaints management system and appeal of registration decisions.
- Develop a National Policy and Standardised Operating Procedures for the Service
- Develop a Training programme for Residential Care Inspectors and Monitoring officer.
- Introduction of a case load management system
- Develop a regulation support ICT system to manage documents, editorial, publication, performance management, schedules of inspection and monitoring.

A number of themes are addressed in the project deliverable including:

- Publication of reports
- Special care
- Governance and organisational arrangements
- IT enhancements
- Inspection and Monitoring planning
- Training and staff support
- Inspection and monitoring methodologies

Having considered the response received, the Ombudsman for Children is satisfied that Tusla is taking steps to progress the recommendations addressed to it and specifically that a Service Improvement Plan for Registration, Inspection and Monitoring has been developed and is being advanced. It is also noted that Tusla plans to move towards publication of reports during 2015.

It is unclear as to the steps being taken in relation to recommendation 5 and the Ombudsman for Children recommends that this should be reviewed as part of the Service Improvement Plan.

While the Department of Children and Youth Affairs were not part of the investigation, it is clear that they may have a role in relation to some of the recommendations made and the Office contacted them in this regard. In response the Department advised that the legislation to provide for the transfer of investigative functions from Tusla to HIQA functions is contained in the Health Act 2007 and may be commenced at a suitable point in time by the Minister for Health. In order to provide for an orderly transfer of the relevant investigative functions, consideration would need to be given to several matters including the drafting of appropriate regulations, the setting of standards and managing other issues of a logistical nature. The Department has asked HIQA, as part of its planned series of activities in 2015, to consider scoping such a project. It is anticipated following HIQA's views later this year, in-depth discussions will begin between Tusla, the Department and HIQA on progressing and managing the transfer of the relevant function. At that stage the Department will be in a position to identify a realistic timeframe based on a tripartite project plan.

I am pleased that the Department is taking steps to advance the transfer of these functions to HIQA and note that the Department is anxious to progress this matter.

Given the issues identified through this investigation and the importance of ensuring that all children in the care of the State receive the same standard of care and inspection, it is important that the transfer of these functions to HIQA is progressed without delay.