Milestones Missed

An investigation into the HSE's Public Health development checks for children



ombudsman
do leanaí
for children

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Glossary of abbreviations

Chief Nursing Officer	**CNO**
Child and Family Agency	**CFA**
Children's Health Ireland	**CHI**
Children's Disability Network Teams	**CDNTs**
Child and Adolescent Mental Health Services	**CAMHS**
Community Health Organisations	**CHOs**
Data Protection Office	**DPO**
Director of Public Health Nursing	**DPHN**
Health Services Executive	**HSE**
Irish Nurses and Midwives Organisation	**INMO**
Key Performance Indicator	**KPI**
National Healthy Childhood Programme	**NHCP**
Office of the Children's Ombudsman	**OCO**
Nursing and Midwifery Board of Ireland	**NMBI**
Psychological Society of Ireland	**PSI**
Regional Chief Officers	**RCO**
Regional Executive Officers	**REO**
Public Health Nurse	**PHN**
Registered General Nurse	**RGN**
Terms of Reference	**TOR**
UN Convention on the Rights of the Child	**UNCRC**

1. About the Ombudsman for Children's Office (OCO)

The Ombudsman for Children's Office (OCO) is an independent statutory body established under the Ombudsman for Children Act 2002 (2002 Act). Under the 2002 Act, the Ombudsman for Children has two core statutory functions:

- to promote the rights and welfare of children; and
- to investigate complaints made by or on behalf of a child concerning the administrative actions of public bodies, which have had, or may have had, an adverse effect on the child.

The Ombudsman for Children reports directly to the Oireachtas in relation to the exercise of these statutory functions.

1.



2.

2. Introduction

The OCO's Milestones Missed report details our investigation into the HSE's system for Public Health Development Checks for children in Ireland under the State's Child Health Programme. The OCO decided to investigate this issue because we are concerned that changes to the system for development checks introduced in 2022 to manage the high-volume of community nursing needs, have had a negative impact on children. These changes replaced universal access to development checks with a prioritisation system that aimed to ensure resources were directed to high-risk cases. However this has meant that not all children have been offered their routine developmental screening checks. The OCO has received several complaints in recent years from families who are deeply concerned about the impact of missed development checks and the potential consequences for their children.

We believe this has significant implications for children's rights, including their right to the highest attainable standard of health; their right to development and non-discrimination; and children's right to have their best interests considered in all actions affecting them. All these rights are protected under the UN Convention on the Rights of the Child (UNCRC). The OCO is also particularly concerned about access to development checks for children living in International Protection and homeless accommodation. The unsettled nature of these living arrangements can lead to frequent changes in address, making it more of a challenge for children and families to access Public Health Nurse (PHN) services.

Compounding our concerns is the lack of complete available data on exactly how many children have missed their development checks, and why. Figures given in response to a Parliamentary Question to the Minister for Health in January 2026 show that, in 2025, 85.8% of babies were seen by a PHN for their 9-11 month development assessment on time. Those figures therefore suggest that 14.2% of eligible children didn't receive those recommended checks before turning 12 months. According to the CSO, there were 54,125 registered births in 2025, which reasonably suggests nearly 7,700 babies were impacted.

Following our investigation, the OCO makes three findings and four recommendations which we believe are necessary for the State to ensure that every child in Ireland receives all their development checks when they are babies, as is their right. Our findings have been accepted by the HSE, and it has also given a commitment to setting up a National Oversight Group to drive, coordinate, and monitor the implementation of all four recommendations at a national level.



3.

3. Background: the important role of the Public Health Nurse in a child's life

The first years of a child's life are critical for their development and can have lasting implications for their health, wellbeing, learning and future outcomes. In Ireland, Universal child developmental health checks are carried out by Public Health Nurses as part of the State's Child Health Programme and are a cornerstone of our preventative health service. Public Health Nurses (PHNs) provide a crucial service to support children and families from the time they are born until they start school. Their role is to promote healthy development, monitor growth and development, identify concerns at the earliest opportunity, refer children for further assessment or intervention where needed, and offer advice and reassurance to parents.

After a child is born, a PHN typically visits them at home within the first few days of discharge from hospital or following a homebirth. During this visit, the nurse examines the newborn baby, weighs them, checks they are feeding well and checks in on how mum and baby are doing overall. The nurse provides support to parents, promotes safe sleep and child safety, and ensures that newborn screening and any follow-up needs are addressed. These contacts continue throughout infancy, with developmental reviews at approximately 3 months and 9 to 11 months, focusing on areas such as physical and social development, communication, hearing, vision and mobility.

More comprehensive assessments of children are carried out at two and four years of age, examining speech and language, motor skills, behaviour, emotional wellbeing, cognitive development, growth and family support needs. When a child starts school at around four or five years old, they will receive a health screening, including hearing and vision checks, and onward referrals are made if concerns are identified. This vital role played by PHNs helps to ensure that every child and family receives the support they need, which contributes to improved outcomes for children, reducing health inequalities, and strengthening population health.

Importantly, PHNs are also mandated persons under the Children First Act 2015[1] and occupy a critical position at the intersection of universal child health and child protection. In this way, they are an invaluable part of the safeguarding system in Ireland. PHNs play a key role in the early identification of risk, advocating for support and are an important safeguard for identifying unmet needs and preventing avoidable harm.

1 https://www.irishstatutebook.ie/eli/2015/act/36/section/14/enacted/en/html

In 2022 during the Covid 19 pandemic, the HSE introduced a new protocol for PHNs to manage an increased volume of community nursing needs. Under the new 'Public Health Nursing Caseload Prioritisation Procedure', all patients, children and adults were categorised according to clinical urgency, dependency and vulnerability. The HSE says this was to ensure that resources were directed to high-risk cases. However, this change has also meant that some babies are not offered their routine developmental screening assessments and checks and miss out on that vital contact with PHNs. The OCO is deeply concerned about the potential long-term consequences of this for children, and their ability to access the services and supports they may need if issues are identified.



4.

4. A child's right to Public Health development checks

Legislative and Policy context

International Children's Rights Standards

International human rights standards recognise children as independent rights holders. The most comprehensive international agreement on children's rights is the UN Convention on the Rights of the Child (UNCRC). It recognises that children are entitled to special care, assistance and protection due to their age and stage of development. The Convention contains 42 rights which cover all aspects of a child's life and set out the civil, political, economic, social and cultural rights that all children everywhere are entitled to.

Ireland ratified the UNCRC in 1992, and in doing so, committed itself to promoting, protecting and fulfilling the rights of all children. The rights engaged in the context of this investigation include those protected by Articles 2, 3, 6 and 24 of the Convention. Article 24 sets out a child's right to health.

It states:

"States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

Articles 2, 3 and 6 are part of the UNCRC's 'general principles', meaning they are considered vital to realising other rights in the Convention. They are:

- children's right not to be discriminated against on any grounds (Article 2);
- children's right to have their best interests treated as a primary consideration in all actions affecting them (Article 3); and
- children's right to life, survival and development (Article 6).

The UNCRC provides guidance to States on the interpretation of the Convention through General Comments. In General Comment No. 15 on the right to health, the Committee is clear that this is an inclusive right which extends beyond access to health services to include timely and appropriate prevention and health promotion and a child's right to grow and develop to their full potential.[2] The Committee further underscores that the best interests of the child (Article 3) must be a primary consideration in all health-related decisions, including legislation, policy development, resource allocation and service delivery. States are also obliged to support the physical, cognitive, emotional and social development of the child (Article 6) and to ensure that health services are available and accessible to all children on a non-discriminatory basis (Article 2).

2 Committee on the Rights of the Child, General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013) UN Doc. CRC/C/GC/15

Relevant Domestic Law and Policy

i) **Legislative framework**

The State has long recognised in law its responsibility to protect newborn, maternal and child health. The statutory framework for preventive child health services has developed progressively since the 1940s. The Health Act 1947 established a mother and child health service, which included measures for child health supervision. The duties of medical and public health personnel were subsequently clarified in the Health (Duties of Officers) Order 1949 and reflected a growing emphasis on prevention, population health and community-based care. Further reforms were introduced in the Health Act 1953 which separated out maternity care, infant welfare and child welfare into distinct services. The 1970s saw a major reorganisation of healthcare delivery via the Health Act 1970. The Act required health boards to provide "a health examination and treatment service" free of charge for children under the age of six.[3] These reforms established Public Health Nurses (PHNs) as key providers of preventive child health services within communities. The 1970 Act therefore provides the modern statutory foundation for preventive child health services, including development checks. The establishment of the Health Service Executive (HSE) in 2004 abolished regional health boards and enabled greater coordination and consistency in child health services nationally, including the development of national programmes and standards.

ii) **Policy framework**

PHNs have played an important role in child health surveillance, including developmental monitoring, since at least the 1940s, reflecting a broader State commitment to the health and welfare of its children. However, a nationally standardised programme of development checks was not developed until the late 1990s, arising primarily from the Best Health for Children report.[4] This was the first review of child health screening and surveillance services in over 30 years.[5] It established a standardised national framework for child health surveillance. This framework was further developed in Best Health for Children Revisited in 2005 which provided a core programme of PHN contacts in early childhood.[6]

Building on this work, the HSE launched the National Healthy Childhood Programme in 2018 (NHCP) as an integrated framework with the goal of improving the health and wellbeing outcomes of children and their families. The NHCP aims to provide free universal child health services including immunisations, developmental screening and child health reviews.

Importantly, the NHCP is the current mechanism through which the HSE meets its mandatory obligation under the 1970 Act to provide a free health examination service for young children, and developmental checks are a core component of that programme.

3 Health Act 1970, Section 66(1).

4 Best Health for Children: Developing a Partnership with Families (Report of the Child Health Review, 1999), available at Lenus, HSE Library Research Repository: https://www.lenus.ie/server/api/core/bitstreams/8ae8148e-0969-4e04-8cd1-fdfa46aa395b/content

5 Ibid.

6 Health Service Executive (HSE), Best Health for Children Revisited: Report from the National Core Child Health Programme Review Group to the Health Service Executive (2005), available at Lenus, HSE Library Research Repository: https://www.lenus.ie/entities/publication/3e6ca54f-b87b-4d35-8c6c-bd8b-d76e31e1

iii) **Specialist role of Public Health Nurses**

Circular 41/2000, issued by the *Department of Health and Children (2000)*, sets out the job descriptions for PHNs. The role is to provide a broad-based, integrated prevention, education, and health promotion service within the community, focusing on population-based care.[7] PHN caseloads include clinical services to both children and older people. In this regard in this model of service delivery PHNs are considered "generalists", where they manage diverse age groups and health aspects.

All PHNs are registered general nurses with a specialist level nine postgraduate nursing qualification and are registered in the PHN division of the *Nursing and Midwifery Board of Ireland (NMBI)*[8] register. The Directors of Public Health Nursing interviewed advised that the specialist postgraduate qualification uniquely qualifies PHNs to undertake developmental screening of children. They further advised that competencies associated with the child health role fall outside the scope of Registered General Nurse (RGN) practice and therefore cannot be delegated to that grade. It was however pointed out that an increase in RGNs can remove other clinical responsibilities from PHNs.

iv) **Developmental Checks**

The HSE advised that like other international models the components of the NHCP include screening, child health surveillance and immunisations. With respect to universal health and development checks, the programme sets out five core contacts with a PHN in early childhood:

Postnatal home visit, which takes place during the first three days at home with a baby.

3-month development check, which takes place in a local health centre.

- 9 to 11 months development check.
- 21 to 24 months development check.
- 46 to 48 months development check.

The HSE told the OCO that the NHCP applies a fundamental principle of *progressive universalism* and provides *"help for all and more for those who need it"*, with additional needs assessed through the Child and Family Health Needs Assessment process, building upon the core components of the NHCP.

7 https://www.nmbi.ie/NMBI/media/NMBI/Public-Health-Nursing-Education-Programme-Standards-and-Requirements.pdf?ext=.pdf#:~:text=The%20Department%20of%20Health%20and,to%20provide%20a%20broad%2Dbased%20integrated

8 https://www.nmbi.ie/NMBI/media/NMBI/Public-Health-Nursing-Education-Programme-Standards-and-Requirements.pdf?ext=.pdf



5.

5. OCO Investigation

The new 'Public Health Nursing Caseload Prioritisation Procedure' introduced by the HSE in 2022 has meant that patients, including children, are categorised according to clinical urgency, dependency and vulnerability. The OCO is deeply concerned that this has had a negative impact on children with potential long-term consequences for their ability to access the services and supports they may need if issues are identified. Rather than providing routine and standard developmental checks to every child, prioritisation means that only young children with proven medical risk or need are guaranteed to be seen. It also has implications for their rights under the UNCRC.



Priority 1

Identifies an immediate time sensitive response which requires actions to be delivered at the first contact within 24-72 hours



Priority 2

Identifies an early response (within 72 hours to 1 month) which requires actions to be delivered based on risk assessment and clinical judgement.



Priority 3

Identifies planned responses within 1 to 3 months, an assessed programme of support, advice information assistance in accessing services



Priority 4

Identifies a routine clinical response. Services that can be suspended for the duration of the priority status before normal levels of activity can be resumed, following risk assessment and implementation of control measures.

According to the *Psychological Society of Ireland (2022) (PSI)*[9] - *"This retrograde step will inevitably lead to later identification of developmental delay and consequent delayed access to intervention and further assessment."*

The PSI further warns that delays and missed care opportunities in one aspect of the system can have significant impacts elsewhere, such as waiting lists for paediatric hospital neurodevelopmental services, orthopaedic, and general paediatric hospital services.

The OCO notes that the reduction of this service is also happening at a time when children and young people are already facing unacceptable delays in access to assessment and intervention through Child Disability Network Teams (CDNTs), Primary Care Teams, and Child and Adolescent Mental Health Services (CAMHS).

These issues have the potential to be further compounded when a child and their family are living in transitory accommodation.

Investigation Process

The OCO has engaged with the HSE's Office of the Assistant National Director for Primary Care since launching our investigation. The OCO met with HSE senior managers and Directors of Nursing across the HSE.

Adverse effect

The World Health Organisation (WHO)[10] describes the first years of life as being critical to a child's development, with lasting implications for health, wellbeing, learning and future life outcomes. The HSE too says that PHN visits are an essential lifeline for the emotional wellbeing of parents, especially first-time parents.

"The foundations for virtually every aspect of human development, physical, intellectual and emotional are laid in early childhood. What happens during these early years has lifelong effects on many aspects of health and well-being from obesity heart disease and mental health to educational achievement and status"

Department of Health's "*Report of the Expert Review Body on Nursing and Midwifery. (2022)*"

PHNs can also identify and provide information and advice to parents experiencing postnatal anxiety and depression and support parents in having confidence in their parenting role.

9 https://www.psychologicalsociety.ie/source/Press%20Releases/PSI%20advises%20on%20the%20importance%20of%20public%20health%20nurse%20home%20visits.pdf

10 World Health Organization, UNICEF and World Bank Group, 2018. Nurturing care for early childhood development... Geneva: WHO.

The Irish Nurses and Midwives Organisation (INMO)[11], has also warned that delaying or missing routine developmental checks in early childhood can lead to an escalation of complex, unmanaged health, developmental, and behavioural issues in the long run.

OCO Analysis

The introduction of the NHCP represents a substantial positive evolution in the delivery of the State's child health obligations, reflecting an increased emphasis on prevention, early intervention, developmental surveillance and integrated multidisciplinary working.

While the statutory obligation to provide a free health examination and treatment service for young children considerably pre-dates the NHCP, the HSE should discharge this obligation in a manner that is responsive to current standards of healthcare delivery, evidence-based practice and children's rights.

The prolonged operation of the prioritisation procedure has resulted in reduced access to routine developmental health checks in several areas. Consequently, some children have, inevitably, not received developmental screening and monitoring in accordance with the NHCP.

While the HSE introduced the prioritisation procedure as an operational response to service pressures, the procedure has remained in place across multiple areas and for a prolonged period. This has had the effect of limiting children's universal access to health assessments designed to identify developmental, behavioural, emotional and health concerns at an early stage.

The OCO is also concerned that the HSE has not been able to adequately demonstrate that the impact of these service restrictions, on affected children, has been sufficiently assessed, monitored or mitigated.

Missing PHN developmental checks represents a missed opportunity to identify developmental, health or family support needs at an early stage. While a missed check does not in itself indicate that a child has been harmed, delays in developmental surveillance may result in delayed referral, assessment and access to early intervention should they be required. Thus, potentially affecting children's health, development, wellbeing and ability to reach their full potential.

PHNs also have an important role in child protection and welfare processes because they are mandated persons under the Children First Act 2015. They often hold valuable information about infants and young children's health, development, family circumstances and engagement with services.

While PHNs are recognised as key professionals in safeguarding infants and young children, national data is not routinely published on their attendance or participation in Child Protection Conferences or referrals to Tusla. This limits transparency regarding the contribution of the child health service to statutory child protection decision-making and makes it difficult to assess whether workforce pressures affecting Public Health Nursing capacity are impacting wider safeguarding functions.

11 https://www.inmo.ie/Home/

The OCO believes that this move to a prioritisation system has significant implications for children's rights. It may undermine a child's right to the highest attainable standard of health as delays to, or missed, developmental checks can result in health, developmental or additional needs going unidentified and unaddressed.

Furthermore, the prioritisation of access raises concerns regarding the right to non-discrimination if certain groups of children are disproportionately disadvantaged in accessing development checks. The move away from universal provision also raises questions under the principle that the best interests of the child should be a primary consideration in all actions concerning children, particularly where changes to service delivery reduce opportunities to identify and respond to children's needs at an early stage.

All these rights are protected under the UNCRC and Ireland has an obligation under international human rights law to take appropriate measures to realise them for all children.



6.

6. Issues identified by the OCO

1. Staff recruitment and retention issues: a 'serious national challenge'

The HSE told the OCO that the recruitment and retention of PHNs has been a serious national challenge for several years and was the main reason for the introduction of the new prioritisation model.

HSE staff told us that achieving NHCP programme goals, like early problem identification and parental support, is routinely not being achieved in the context of these staff shortages.

Inability to cover leave

Directors of Public Health Nursing (DPHNs) spoke at length about the impact of depleted staff numbers due to staff turnover, maternity leave, planned and unplanned sick leave. For example, they advised that a period of maternity leave may extend to up to 13 months when statutory and related leave entitlements are combined. There are also challenges cited in providing requisite cover with nurses of equivalent training/skills mix for the full duration required.

Aging workforce

The HSE says nearly 30% of PHNs and RGNs are expected to be eligible for retirement in the next 12 years.

The State's Chief Nursing Office says that a 2018 framework[12] for safe nurse staffing and skills is intended to guide services on how best to ensure the most appropriate, safe and effective nurse staffing levels. The OCO has been told that an update to the guidelines focusing on Public Health Nursing services is currently being piloted and 'provided soon' to the Department of Health with a view to determining next steps.

While the initiative that is the framework for safe staffing and skill mix is welcome, worryingly, concerns have been expressed by the DPHNs during investigation interviews that the benefits of this framework might not be seen for several years.

Another report[13] by the Department of Health projected a 46% rise in the demand for PHN appointments and a 70% rise in the demand for home support services by 2031. It also forecast the need for an increase of 73% in PHN grades. In 2016, there were 1500 PHNs in post, and, by 2031, it is forecasted that a total of 2600 PHN posts will be required to meet the increased need in line with population growth and health needs.

Staff numbers

The HSE said there were 1,540 PHNs working nationally in February 2026. Budget 2025 funded the equivalent of almost 27 additional PHN posts to support the training of new nurses. The HSE also sought funding for a further 30 PHN posts and 15 Registered General Nurse posts for 2026. Despite additional funding, there is limited evidence that frontline PHN staffing capacity increased, and it remains unclear whether the additional PHN and RGN posts sought for 2026 were recruited and filled.

Budget 2026 provided funding for 3,000 additional staff across the health service. However, these posts were not specifically allocated to PHN posts. Instead, Regional Executive Officers were given responsibility

12 https://www.gov.ie/en/department-of-health/publications/framework-for-safe-nurse-staffing-and-skill-mix-phase-1/

13 The Health Service Capacity Review (Department of Health (DOH), (2018)

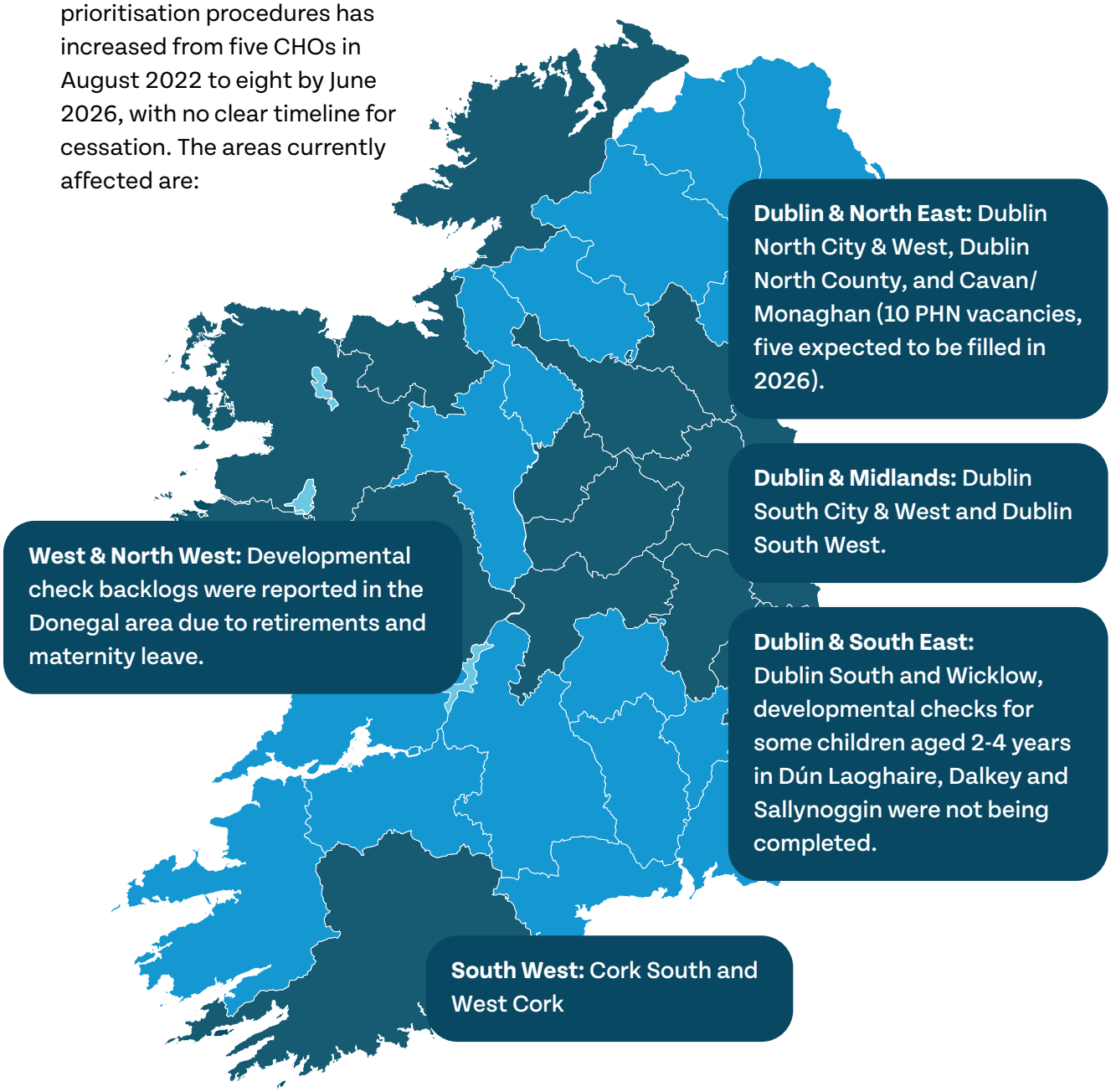
for deciding where staff would be assigned based on local needs.

The Irish Nurses and Midwives Organisation (INMO) has stated that around 6,000 funded health service posts remained vacant in 2025.

The OCO was also informed that the HSE's request for 45 additional PHNs and General Nursing posts was not specifically approved, as no dedicated funding was ring-fenced for these roles."

CHO Regions operating under the prioritisation procedure*

a) The HSE says that the number of areas operating under PHN prioritisation procedures has increased from five CHOs in August 2022 to eight by June 2026, with no clear timeline for cessation. The areas currently affected are:



* In October 2024, the HSE officially transitioned from its previous 9 CHO and Hospital Group structures into six unified Health Regions. This restructuring integrates hospital and community care into single, geographically distinct networks.

Data shortage: the national picture

- The most recent HSE Child Health Public Health Annual Report [14] from June 2025 focuses on programme activity, performance indicators, workforce developments, parental supports, practitioner resources, and service delivery across child health services, but doesn't include complete national information on how many children missed their developmental checks and why.

- The HSE is therefore unable to provide a complete national picture of the number of children who have either received or missed their scheduled developmental checks. It acknowledges the limitations in its national data collection systems and says that it doesn't routinely monitor several key developmental checks/assessments at a national level.

- In response to a Parliamentary Question by the Minister for Health, Jennifer Carroll MacNeill at the start of 2026[15], the Minister advised that in 2025, 98.1% of newborn infants received a PHN visit within 72 hours of discharge from maternity services. This was highlighted as a high level of compliance with the national target of 100% for early postnatal contact.

- The same data provided by the Minister shows that 85.8% of children received their 9 to 11month Child Health and Development Assessment before reaching 12 months of age.

- However, no national performance data was available about the routine 3-month developmental assessment. This, it was stated, reflected the wider gaps in national monitoring of developmental surveillance activities.

- On that basis, the OCO estimates that approximately 14.2% of eligible children did not receive the 9 to 11-month developmental assessment within the recommended timeframe. This shows that a significant proportion of children may not be accessing developmental screening at the intended stage of early childhood development. CSO figures there were 54,125 registered births in 2025[16], which reasonably equates to around 7,700 babies not receiving their 9–11-month checks on time.

14 Health Service Executive. (2025). Child Health Public Health Annual Report 2024. HSE. https://about.hse.ie/publications/child-health-public-health-annual-report-2024/

15 https://www.oireachtas.ie/en/debates/question/2026-01-28/191/ [Accessed 22 July 2026]

16 https://www.cso.ie/en/releasesandpublications/ep/p-vsys/vitalstatisticsyearlysummary2025/

The HSE provided the OCO with figures for May 2026 for missed development checks due to staff shortages or non-attendance. The information was collected manually by the HSE from individual records.

- The highest level of missed checks were recorded at the later stages of the programme, particularly at the 21- to -24 months and 46-to-48-month reviews.

- No information was provided for children in transitory accommodation

Blackspots
1) **Dublin Midlands recorded the highest number of missed developmental checks nationally across all age groups**
69 babies missed checks at the 72-hour review, rising to 93 babies at the three-month review
175 babies missed checks at 9-11 months
273 babies missed checks at 21-24 months
455 babies missed checks at 46 -48 months
2) **Dublin North East recorded the second-highest number of missed developmental checks.**
17 babies missed checks at the 72-hour review, rising to 73 babies at three months
125 babies missed checks at 9 to 11 months
160 babies missed checks at 21 to 24 months
296 babies missed checks at 46 to 48 months
3) **In the West North West region, missed developmental checks also increased consistently across each age category**
17 babies missed checks at the 72-hour review, rising to 20 babies at three months
27 babies missed checks at 9 to 11 months
50 babies missed checks at 21 to 24 months
70 babies missed checks at 46 to 48 months

4) **The Dublin South East region recorded comparatively low numbers of missed checks during the early stages of the programme but increased later, showing a similar pattern of reduced engagement over time.**
Two babies missed checks at the 72-hour review, rising to 8 at three months
17 babies missed checks at 9 to 11 months
48 babies missed checks at 21 to 24 months
80 babies missed checks at 46 to 48 months
5) **In the Mid-West region a similar pattern emerged**
3 babies missed checks at the 72-hour review rising to 16 at both the three-month and 9-to-11-month reviews
33 babies missed checks at 21 to 24 months
34 babies missed checks at 46 to 48 months
6) **The South West region displayed a somewhat different pattern, recording a relatively high number early on, before dipping, and rising later**
34 babies missed checks at 72 hours falling to 12 at the three months check
27 babies missed checks at 9 to 11 months
30 babies missed checks at 21 to 24 months
37 babies missed checks at 46 to 48 months.
These figures point to the need for further examination of barriers to attendance and the reasons for regional variation in the uptake of developmental screening services.

The HSE's Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service (2024)[17] establishes a national procedure for responding to non-attendance at child health and developmental reviews.

The procedure recognises that non-engagement may be an indicator of unmet health, developmental or safeguarding needs and requires PHNs to undertake appropriate follow-up, assess risk, maintain records, and escalate concerns in accordance with child protection procedures where necessary. Its stated aim is to support early identification of concerns, facilitate timely intervention, and ensure children remain visible to statutory services.

While the 2024 procedure provides for national monitoring and audit arrangements, there is limited publicly available information regarding levels of non-engagement, compliance with the procedure, or outcomes arising from its implementation.

17 *HSE's Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service (2024)*



7.

7. Children in temporary accommodation

The OCO is particularly concerned about the provision of developmental checks for children in temporary and transitional arrangements such as direct provision, emergency accommodation and those families living in insecure or unstable housing or who may be relying on family members and friends for accommodation. The HSE National Social Inclusion Office[18] categorises those in temporary, emergency, or international protection accommodation as highly vulnerable cohorts experiencing severe health inequities.

When it comes to public health checks, the HSE says all checks for children apply universally, regardless of where they live and whether that is considered permanent or transient. Children referred to PHNs are entered into the register and offered developmental checks in line with PHN policy. Accordingly, it says that children under the age of six who are International Protection Applicants or Beneficiaries of Temporary Protection are entitled to be visited and assessed by a public health nurse and then referred to the local PHN. For children in homeless services, developmental checks are carried out by the PHN who works in the geographical location of the accommodation.

Keeping in touch with children in the system

The HSE has told the OCO how difficult it is to ensure they can keep in touch with families who have to move between or out of accommodation in very short time frames. PHNs have told the OCO over the years how their ability to offer checks is hampered when families are regularly moved and no forwarding address is left.

There is also no uniform mechanism in operation to trace or track those children and families. This is seriously impacting on their ability to ensure child health records are appropriately transferred.

In practice, responsibility frequently falls to local PHN and Inclusion Health teams to prioritise those families within existing resources to develop local arrangements for tracing and tracking children and families who come to their attention.

OCO engagement with the HSE

The HSE says there has been an increase in transient populations in recent years, which is impacting the provision of PHN services and GP care.

A higher level of need requires additional assessment, engagement and follow-up. When combined with PHN staffing shortages, the HSE says this has reduced the capacity of services to provide timely care and developmental screening for some children.

This was echoed by the DPHNs and the Inclusion Heath Team at CHI, who say that prioritisation has impacted their capacity to service transitory populations. This has in turn led to an overreliance on families presenting to services themselves, which they say is not practical for a number of reasons, including:

- Families who might be reluctant to do due to other factors:
- Families who might not be aware the service exists;
- Families that might not fully understand the importance of developmental checks;

18 Health Service Executive (HSE) (2026) *Accessibility and Inclusivity: National Social Inclusion Office.* Available at: hse.ie.

- Families that might be overwhelmed or traumatised by their own circumstances.

The Inclusion Health Team told us that as no two babies are the same in how they meet their developmental milestones, it is simply unreasonable to expect parents, particularly new parents or those experiencing significant distress, to identify developmental delays or recognise when intervention for their child is needed.

Importantly, the OCO has been told that in areas where there is some service provision to children in temporary accommodation, those families can require 10-12 appointments compared to 1-2 in the wider population.

Children living in alternative accommodation are also three to four times more likely to require a referral for services, particularly for social and emotional support.

Safeguarding concerns for children in temporary accommodation

Tusla[19] advises that PHNs are a significant source of child protection and welfare referrals. These are categorised under "*HSE Officers*", which account for about 9% to 11% of all national reporting sources. PHNs also have a vital role in monitoring child protection concerns through home visits and attending child protection meetings.

The DPHNs and the Inclusion Health Team say that children living in transitory accommodation are typically more vulnerable due to their circumstances and that an important aspect of the PHN role with them is the consideration of possible child protection and welfare concerns.

While comprehensive national data is not currently available to quantify missed developmental checks among these groups, evidence indicates that housing instability, frequent changes of address, poverty and wider family stressors can disrupt continuity of healthcare engagement.

For children already experiencing disadvantage, any delay in developmental surveillance may increase the risk that emerging needs are identified later and that access to early intervention and support is delayed.

OCO analysis for children living in transitory accommodation

The HSE is responsible for adapting standard service delivery models to meet the unique needs of these families. This is run through the National Caseload Prioritisation Procedure, which requires the HSE to designate children in transitory settings as high priority. This means the HSE is obliged legally and operationally, to safeguard their developmental checks, even during periods of severe capacity constraints.

The OCO is particularly concerned that there is no way of identifying, tracing or tracking children living in transitory accommodation and ensuring the timely transfer of child health records when families move between locations. Therefore, the HSE cannot be assured that all children entitled to services under the NHCP are being identified, monitored or receiving the necessary developmental assessments.

19 https://www.tusla.ie/uploads/content/Q1_2025_Service_Performance_and_Activity_Report.pdf

The evidence further demonstrates that children living in transitory accommodation are a particularly vulnerable cohort; are more likely to require additional developmental, emotional and social supports and; may be less likely to know and engage with services due to the circumstances in which they are living.

This means that an administrative approach which relies heavily on families seeking out services does not sufficiently protect the rights and welfare of these children.

The OCO therefore finds that the HSE has not demonstrated that it has taken adequate steps to ensure the effective delivery of child health services for children living in transitory accommodation, or that the best interests of such children have been treated as a primary consideration in the administration of those services.



8.

8. OCO Findings

Finding 1

The OCO finds that the HSE has failed to ensure the effective delivery of a universal health examination service to all children under the age of six. The effect of reducing children's access to health assessments has increased the risk that developmental, behavioural, emotional and health needs may not be identified and addressed in a timely manner.

This failure is the result of undesirable administrative practice.

Finding 2

The OCO finds that the HSE failed to put in place adequate systems to ensure that children living in transitory accommodation remain visible to statutory child health services. This failure gives rise to a foreseeable risk that developmental concerns, welfare concerns and child protection concerns may go unidentified.

This operational failure is the result of undesirable administrative practice.

Finding 3

We find that the HSE has failed to establish and maintain adequate systems for the collection, monitoring and management of information necessary to support the effective operation of the legally mandated health examination service for children under the age of six.

The absence of reliable data and monitoring mechanisms undermines the HSE's ability to demonstrate that children's best interests are being effectively safeguarded and promoted in the delivery of statutory child health services.

We find this systemic failure to be the result of undesirable administrative practices.



9.

9. Recommendations

As per Section 13.3 of the Ombudsman for Children Act, (2002) the Ombudsman for Children makes recommendations which aim to be fair and constructive for all parties to a complaint. In this instance this office recommends the following.

Recommendation 1

The HSE should put in place a plan to meet their statutory obligations to ensure that all children receive their developmental health checks under the National Healthy Childhood Programme (NHCP) within a reasonable timeframe. This plan should reflect adequate workforce planning but also:

- A monitoring system of children due for developmental checks and automatic identification of children who have not received them within the recommended timeframe.
- Create a national 'missed contact' pathway with a consistent escalation process to identify children who have consistently missed developmental checks. This should be automatically cross referenced with children known to child protection services.
- Automatic reporting on completion rates and missed checks to the relevant NHCP governance groups and published in HSE reporting metrics.

Recommendation 2

The HSE should put in place a national approach to make sure that children living in temporary or transitory accommodation can access child health services and developmental checks, even when they move from one location to another. This should include:

- Outreach clinics in homeless accommodation and IPAS accommodation
- Proactive liaison with homeless services in each local authority
- Improved co-ordination between maternity services, PHNs and Tusla
- A national mechanism to support the identification, continuity of care and transfer of child health records;
- A standard process for transferring child health records when families move.

Recommendation 3

The HSE should recognise and strengthen the child protection and safeguarding role of PHN and this should be embedded as a core function of the role. This means ensuring PHN have sufficient time and capacity to complete home visits, make mandated reports to TUSLA, and attend child protection conferences if required.

The HSE should also undertake annual national audits of non-engagement with child health and developmental assessments, including rates of non-engagement, compliance with follow-up

requirements, escalation of safeguarding concerns, and outcomes for children identified through the process.

Recommendation 4

The HSE should develop a national system for collecting data and monitoring the performance of PHN child health services as a key child health performance indicator. The system should:

- Collect information on all developmental health checks provided under the NHCP,
- Record when checks are completed, delayed or missed;
- Use the same definitions and reporting standards across the country;
- Provide regular regional and national reports to support oversight and quality improvement; and
- Monitor outcomes for vulnerable groups, including children living in temporary or transitory accommodation.



10.

10. Outcome of the OCO's Investigation

As part of the investigation process, the HSE was provided with a draft Investigation Statement and give an opportunity to comment on the proposed findings.

In its response, the HSE fully accepted the OCO's findings, acknowledging that the prioritisation decisions identified were regrettable, and recognising the impact these decisions have had on the delivery of child health services.

The HSE further informed that it was taking steps, in collaboration with relevant agencies, to improve service provision.

Following engagement with the OCO regarding the implementation of the investigation's recommendations, the HSE said it is setting up a National Oversight Group to drive, coordinate, and monitor the implementation of all four recommendations at a national level.

The HSE advised that the Group would bring together representatives from key areas of the health service and would oversee the development of a clear and time-bound programme of work aimed at securing the full implementation of the recommendations arising from this investigation.

This commitment represents a significant step towards addressing the systemic issues identified and strengthening accountability for the delivery of child health services.

The OCO will monitor progression of the establishment of the National Oversight Group and subsequent implementation of our recommendations.

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