SOCIAL SERVICES INSPECTORATE

A

CHILDREN'S RESIDENTIAL CENTRE

IN THE

HSE DUBLIN MID-LEINSTER REGION,

INSPECTION REPORT ID NUMBER: 160

Publication Date: 29th August 2006
SSI Inspection Period: 8
Centre ID Number: 279

ADDRESS: Social Services Inspectorate, 3rd Floor, Morrison Chambers,
32 Nassau Street, Dublin 2
PHONE: 01-604 1780 FAX: 01-604 1799
WEB: www.issi.ie

Contents

1. Analysis of Findings

The Social Services Inspectorate (SSI) carried out an announced inspection of a children's residential centre in the Health Services Executive (HSE) Dublin Mid-Leinster region in July 2006. The centre is one of five centres that provide a regional service for the two local health office areas of Laois/ Offaly and Longford/ Westmeath. At the time of inspection, there were three young people living in the centre. A fourth young person was in a place of detention but remained on the centre register pending a decision on his long term care.

The centre was providing a good service to the three young people who were living there at the time of the inspection. Managers and centre staff are commended for good practice in primary care, children's rights, health and education. Recent difficulties at the centre, however, highlighted weaknesses in key areas such as management practice and behaviour management. These weaknesses impacted at times on the capacity of the centre staff team to ensure the safety of the young people living in it. The young people were sometimes at risk because care staff were not always able to ensure that behaviours such as aggressiveness and unauthorised absences were contained within safe boundaries.

Practices that met the required standard

The centre was located in domestic premises in a rural area adjacent to a large town. The premises were well decorated and well maintained, despite the fact that considerable damage had been done in the past. Some of this damage was awaiting repair and some renovations had yet to be completed but, overall, inspectors considered that the premises were homely and welcoming for the young people. There was a large garden planted with trees, shrubs and grass and this provided a pleasant outdoor play and recreation area.

The day to day care of the young people was good. Inspectors observed interactions between members of the care staff team and the young people that were respectful, relaxed and marked with a degree of humour and, in many instances, with an underlying affection. One young person, who had spent a considerable amount of time in the centre and was preparing to leave, spoke very warmly about the staff and the care that she had received. Each of the young people had a number of keyworkers and the young people saw their keyworkers as advocates for them.

There was a plentiful supply and variety of food. Care staff catered for the young people's preferences and they could, and did, prepare their own food at times. They were also encouraged in other ways to develop life skills. Clothes were purchased as required and were chosen by the young people. The young people each had their own rooms. Their privacy was respected and they had unsupervised access to the phone. Two of the young people were from minority communities and staff members went to some lengths to learn about cultural practices and to support the young people in the expression of their cultural identities. The young person who was preparing to leave the centre told inspectors that staff had worked with her over a prolonged period to help her to prepare for this.

The care staff attended to the health and educational needs of the young people. In particular, considerable efforts went into finding and supporting suitable school and/ or training placements for the young people. Teachers reported that there was good communication with centre staff.

Practice in relation to children's rights was of a good standard. There was an attractively presented children's information booklet. The young people had been given copies of the young people's version of the National Standards for Children's Residential Centres. They had access to information about organisations that could offer them support such as the Irish Association of Young People in Care (one of the young people had joined this organisation). The young people could access their care files, subject to certain restrictions relating to the protection of third parties. Care staff consulted with the young people and encouraged their participation in care plan reviews. There were complaint forms for young people who wished to use them. However, the young people told inspectors that they generally preferred not to and, instead, discussed their complaints with their keyworkers, the unit leader or other staff. Internal resolution of complaints was good and the monitoring officer, who had a role as an external advocate for the young people, helped with the resolution of those complaints that could not be resolved internally or where the young person wished to take the matter outside of the centre. This was working well at the time of inspection.

The standard on monitoring was also well met. The monitoring officer visited regularly. She furnished written reports to the centre that included recommendations for changes in care practice. She followed these up to ensure that they were implemented. Consequently, she was able to influence practice, for example, in relation to the use of sanctions in the centre.

There was good cooperation between the young people's social workers and centre staff. The social workers visited the young people regularly, had positive relationships with them and demonstrated a commitment to providing a good service for them.

The standard of care planning and review was very good. Each of the young people had a care plan and they were of a good quality. They set out what was to be achieved, the young peoples' needs, access arrangements, arrangements for review, and they were developed in consultation with the key stakeholders including the young people and family members. The care plans were reviewed regularly. Each of the two local health office areas from where the centre took its referrals had independent reviewing officers and practice in relation to reviews was very good. The reviews considered whether care plan objectives needed to be changed, they identified the people responsible for taking specific actions and they set timescales for their completion. This good practice was, unfortunately, undermined by overlapping procedures in relation to care planning and child protection, as discussed later in this report.

Practice in relation to family contact was good. One parent, in particular, was very positive about the level of communication with centre staff. She praised the centre staff for their helpfulness and stated that her son was benefiting from his placement in the centre.

The standard of recording in both the young people's care files and other records was very good. Information was easily accessible.

Practices that met the required standard in some respect only

1. Practices that met the required standard in some respect only where this impacted on the safety of the young people

In the months leading up to this inspection some young people in the centre had, at times, placed themselves, other young people in the centre, staff members and, in one instance in particular, members of the general public at risk of upset and injury through behaviour that members of the care staff team were unable to prevent or to control. Inspectors are of the view that these failures relate to a number of weaknesses in the service provided, particularly in relation to the purpose and function of the centre and the management and staffing of it.

The centre was, at the time of inspection, caring for a group of young people of mixed ability. This called for different approaches to managing the behaviour of the different individuals. However, it was not always possible to separate the young people when difficult to manage situations arose. This undoubtedly contributed to the difficulties members of the care staff team experienced in relation to behaviour management.

There was a written statement of purpose and function for the centre. It specified who the service was set up for and the number and age range of the young people. It described the centre as a medium to long term unit that could accept emergency admissions. As a written statement it was adequate. However, it made no reference to looking after young people with learning disabilities and, therefore, was not reflected in practice.

The care staff team in the centre had a difficult job. They were being asked to look after a mixed ability group of young people and they had dealt with very difficult, dangerous and stressful situations. Not all of the difficulties were external to the team. Some were internally generated, that is, there were aspects of the way the team was managed and the manner in which it operated that impaired its capacity to deal with the challenges that it faced.

There was a well developed management structure in the regional residential child care service. Two residential managers managed five centres between them. Each centre had its own unit leader. At the time of this inspection the unit leader was on leave and the centre was being managed by an acting unit leader. The unit leaders of all the children's residential centres in the region, between them, provided an on-call service for the five centres outside of normal office hours. Some aspects of management practice were good. Care staff reported that both the permanent and the acting unit leaders were available for informal consultation and support. There was evidence that they made themselves available to the young people, that they heard their concerns and complaints and, in most instances, resolved them. Their commitment to the welfare of the young people in their care was apparent.

Despite the management structure and the existence of some good management practices, the management of the centre was not of the required standard. Good management in a children's residential centre tends to be a function of both continuity in the holder of the management position and good management practice. The permanent unit leader had been on extended sick leave and, just over a year later, had opted for term time working. The unit leader at the time of inspection was in a temporary acting position. Neither the permanent unit leader nor the acting unit leader provided formal supervision for staff. Training in supervision had been

provided but the argument was made that, given the numbers involved, the unit leader could not do it. The HSE in the former Midlands area had issued a new job description for child care leaders. It allocated responsibility for formal supervision of child care workers to them. The child care leaders had objected to this and the matter was, at the time of inspection, subject to an industrial relations process involving the child care leaders' union. Meanwhile, the child care leaders (there were nine in a team of 21) were being paid more than the child care workers for doing the same work, a situation that had obtained for a number of years.

Formal supervision has a number of functions, one of which, accountability, is primary. As it was not happening, there was no formal process by which care staff in the centre accounted for their work. Its absence also deprived care staff of an opportunity to reflect on their work, process their experiences, learn new skills and develop insight. All of those interviewed stated that they wanted formal supervision.

The lack of accountability was apparent elsewhere. Two separate case conferences recommended the development of placement plans. The first recommended a plan to ensure the safety of a particularly vulnerable young person. The second recommended a plan to manage the behaviour of another young person. Neither plan was completed.

Some things that would have helped the staff team to manage the young people's behaviour: formal supervision and placement planning were not done. In addition, there was no coherent common approach to behaviour management among staff team members. Most of the staff had been trained in therapeutic crisis intervention (TCI) and applied its techniques but it was not always clear that staff knew what they were attempting to achieve by their interventions. For example, in some situations where the behaviour of some of the young people posed a risk to their safety or that of others, it appeared that care staff tried to minimise the impact of their behaviour rather than intervening to take charge and bring about a speedy and safe end to the situations. There was little evidence that the team evaluated their handling of such situations, despite the efforts of the monitoring officer to get them to do so.

When asked about how they responded to particular incidents, many staff referred to 'planned ignoring'. Inspectors were also told that staff sometimes withdrew to a safe distance when young people were acting in a dangerous or threatening manner. Though they had been trained to do so, the staff did not attempt to restrain the young people physically. Inspectors accept that this was appropriate in many instances but not in all of them. There were situations where the young people upset and hurt each other and staff members must understand that it is their responsibility to keep the young people safe.

In one particularly serious incident a young person was locked in his room with two others outside it abusing him verbally and threatening him with violence. The staff on duty had 'withdrawn' from the situation. The young person, in an effort to attract their attention, put his music on at maximum volume but to no effect. He next attempted to phone them but had no credit for his mobile phone. Eventually he dialled the emergency services, got through to the local Garda station and the Garda then contacted the care staff and asked them to go to his assistance.

The approach to behaviour management was reactive, not proactive. For example, one of the young people had a tendency to become challenging and difficult to manage late at night. He had difficulty settling down and was often awake until the early hours of the morning. Some of the more serious incidents in the centre occurred

at such times, including the one just described. There was no strategy in place to help the young person calm and settle at night. On the contrary, the young people were allowed to play loud music and some had televisions and DVD players in their bedrooms, regardless of the impact this had on other residents. Even after an incident where highly inappropriate videos were being played in the centre, no decision was taken to remove the DVD players and televisions from the young people's bedrooms. When asked about this, staff members variously replied that they could not interfere with the young people's property or that if they attempted to do so there would be serious incidents. Whatever the reason, the staff team would not or could not assert any authority.

There were 59 unauthorised absences in the year prior to inspection, though the majority related to one young person. The young people engaged in high risk behaviours during some of these absences.

The staff team were aware that their approach to behaviour management was not adequate. They had asked to have regular consultation with a psychologist, something that they had found useful in the past. Unfortunately, the person who had provided this left the service. A staff facilitator had been working with the team instead but there was little sense among team members that this was particularly helpful. This was not to do with the quality of the facilitator's input. Rather the team had identified a need for a particular type of support and had been given something different instead. It was not surprising that they were dissatisfied with this.

At the time of inspection the behaviour of the young people in the centre was being managed within acceptable boundaries. The young people told inspectors that they felt safe but two of them expressed concerns for their safety in the event of another young person returning to the centre from a place of detention. This was due to take place within days of the inspection but HSE managers decided not to proceed with this until such time as a further assessment is completed. Inspectors concur with this decision. It may be that this young person's needs cannot be adequately met in the centre. However, it would be inappropriate to conclude that the lesson of his placement was that it was never appropriate. When put under stress, the system within the centre fragmented along fault lines that were there before the young person arrived and will continue until they are addressed.

A much more authoritative approach to behaviour management is required in the centre. There have to be very clear boundaries for the young people. These can, and best practice would indicate that they should, be developed in consultation with the young people. The young people must have the confidence that staff can and will take charge when the young people behave in ways that pose a risk to their own safety or that of others. There has to be a pro-active approach both to responding to particular difficulties young people have (such as settling at night) and to managing behaviour generally. Staff team members need to be clear about the purpose of their interventions in dealing with high risk situations. These interventions should be aimed at ensuring, first and foremost, the safety of the young people. For such changes to come about in the centre, strong and decisive leadership is required.

2. Other practices that met the required standard in some respect only

All but one member of the care staff team had either a professional qualification in child care or nursing or was in the process of acquiring one. The members had, between them, considerable experience in residential child care. Those interviewed stated that morale was good within the team and referred to the high level of support

each got from colleagues. On the other hand, some of those interviewed during the inspection, who were not members of the care staff team, had a somewhat different perception. They referred to the difficulties the team had experienced and stated that there were high levels of stress within the team. One referred to an attitude of despair when it came to addressing some of the difficulties the team experienced. Inspectors came to the view that the staff team was not functioning at a level consistent with the level of qualification and experience of its members. The reasons for this, which include a lack of formal supervision, have already been discussed in this report.

There were 21 people on the staff team. Three of these were on extended leave (one on maternity leave, two on term-time leave) at the time of inspection. Three others were on reduced hours. Even taking these into account, the level of staffing was high when compared to similar centres in other parts of the country. Despite this, staff from other centres were sometimes employed at the centre. There was generally four staff on duty during the day and three at night. This is a pattern of staffing more often found in a high support unit than in a mainstream children's residential centre. Managers ought to consider whether deploying staff in this way is conducive to helping the young people to adopt normal patterns of living involving activity during the day and rest at night.

In response to safety concerns, extra staff were sometimes deployed. As a strategy for ensuring safety this was ineffective. Having many staff who are unsure how to deal with a difficult situation does not necessarily make it safer. Many young people find it difficult to relate to large groups of adults. The safety concerns could be better met by ensuring that staff members are clear about what is expected of them and that there are planned responses to dealing with high risk situations.

There was a good range of in-service training courses for care staff. However, at least in relation to therapeutic crisis intervention (TCI), the techniques taught were insufficiently integrated into care practice, as discussed earlier.

Inspectors were supplied with details of vetting of staff and checked these against the files of three staff members employed within the two years immediately prior to inspection. Not all of the information provided was consistent with what inspectors found on the staff files. For example, in some instance, the dates provided for references were incorrect. Nonetheless, there were Garda clearances and at least three references for each of the staff members.

The centre had a register but some information about some young people was missing from it.

Social workers were notified about significant events but only some of the notifications were sent also to the monitoring officer whereas she should have received all of them.

At the time of inspection, the centre was not a suitable placement for the young person who was temporarily absent from it. His safety and that of others could not be guaranteed.

Excellent practice in relation to care planning and review was undermined by a lack of clarity concerning the respective roles of the care planning and child protection systems. One social worker, for example, expressed considerable frustration at the manner in which a decision taken at a care plan review was revisited shortly afterwards at a child protection conference. Another social worker told inspectors that

the really important decisions were taken at child protection conferences, partly because certain senior people were present at these but not at care plan reviews. This is not in accordance with statutory requirements.

There was no dedicated after care service. The centre was committed to maintaining contact with the young person who was about to leave it, but given that she was going to be living a considerable distance away, it was by no means clear that care staff could provide the level of support required.

There was, in general, good access to specialist services for the young people in the centre. Care staff and social workers were proactive in seeking out appropriate services for the young people and funds were made available to purchase such services privately where they were not available from the HSE or partner organisations. However, there was a major exception when it came to disability services where a much needed service for one young person and his family was not provided.

There was good practice in relation to safety factors related to the premises with regular checks of equipment and appliances and also regular fire drills. A fire certificate had been issued in May 2006, subject to certain works being completed. A safety audit was also completed in May and recommendations made. The HSE Dublin Mid-Leinster must ensure that the conditions of the fire certificate are met and that the recommendations of the safety audit are implemented.

Summary and conclusion

There were no areas where practice failed to meet the standard in any respect. By contrast, there were some areas of practice where the required standard was reached. Practice in relation to primary care, children's rights, health and education was highly commendable. There were some areas where practice met the standards in some respects only. While this is found in every inspection, inspectors had grave concerns about a number of these. In the first instance, poor practice had implications for the safety of the young people in the centre. Secondly, concerns about poor management and a poor approach to behaviour management in children's residential centres in the Midlands area have been raised in successive inspection reports going back as far as 1999 and there was little sign, in this inspection, of progress. Thirdly, the confusion of roles apparent in the undermining of care planning by the child protection system, the failure to act on conference recommendations, combined with the failure to ensure that young people get all of the services they require, point to a fragmented, poorly joined-up system for the care of young people in this part of HSE Dublin Mid-Leinster.

2. Introduction

This is the report of an announced Social Services Inspectorate (SSI) inspection of a children's residential centre in the HSE, Dublin Mid-Leinster under Section 69(2) of the Child Care Act 1991. The inspection was carried out by Kieran O'Connor (support inspector) and Andrew Fagan (lead inspector) over a three day period from 18th to 20th of July 2006. The centre was previously inspected in 2002. The report of this inspection is available on www.issi.ie (Children's Residential Centre, MHB-1).

2.1 Methodology

The inspectors had access to the following documents during the inspection:

- The statement of purpose and function,
- The policies and procedures document for the centre,
- The monitoring officer's reports,
- Census forms for the young people,
- A census form for the staff team,
- Questionnaire returned by 4 social workers,
- Questionnaires returned by two teachers and a course tutor,
- The young people's care files
- The centre register
- Details of unauthorised absences (59 in 12 months)
- Various administrative files in the centre.

In the course of the inspection, inspectors spent time observing care practice and participating in centre meals. Inspectors interviewed:

1. The acting unit leader,
2. Four other members of the care staff team,
3. Three social workers,
4. Two parents (by phone)
5. Three young people,
6. A child care manager,
7. A regional residential manager,
8. The general manager with line management responsibility for the centre,
9. The regional monitoring officer,
10. The regional audit inspector.

2.2 Acknowledgements

Inspectors wish to acknowledge the co-operation of the young people, parents, acting unit leader and staff, social workers, external managers and all those who assisted in the work of this inspection.

2.3 Management structure

The acting unit leader reported to a residential manager with responsibility for a number of children's residential centres in the region. The residential manager reported to the general manager for the Longford/ Westmeath local health office. The centre had a permanent unit leader but this person was on extended leave at the time of inspection.

2.4 Data on young people

Young Person	Age	Legal Status	Length of Placement	Other placements
Boy	16	Care Order	3.5 years	HSU, Children Detention School, Juvenile Detention Centre
Boy	15	Voluntary Care	10 months	None
Boy	14	Voluntary Care	4 months	Three foster care and three residential (inc HSU)
Young Woman	18	Care Order (expired)	7 years	Three foster care placements

Note: one young person was temporarily absent from the centre at the time of inspection. It was not clear when he would be returning to the centre, if at all.

3. Findings

3.1 Purpose and function

Standard
The centre has a written statement of purpose and function that accurately describes what the centre sets out to do for young people and the manner in which care is provided. The statement is available, accessible and understood.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Purpose and function		√	

Recommendation:

1. The HSE Dublin Mid-Leinster should ensure that future admissions to the centre are consistent with its stated purpose and function.

3.2 Management and staffing

Standard
The centre is effectively managed, and staff are organised to deliver the best possible care and protection for young people. There are appropriate external management and monitoring arrangements in place.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Management		√	
Register		√	
Notification of significant events		√	
Staffing (including vetting)		√	
Supervision and support		√	
Training and development		√	
Administrative files	√		

Recommendations:

2. The HSE Dublin Mid-Leinster should review management practice in the centre with particular reference to ensuring that all care staff, including the unit leaders, receive regular formal supervision.

3. The HSE Dublin Mid-Leinster should ensure that the centre register includes all of the information required under the Child Care Regulations 1995.

4. The HSE Dublin Mid-Leinster should ensure that the monitoring officer receives written notification of all significant events in the centre.

5. The HSE Dublin Mid-Leinster should review the deployment and level of staffing of the centre.

6. The HSE Dublin Mid-Leinster should review the role of the staff facilitator in the centre.

3.3 Monitoring

Standard
The health board, for the purposes of satisfying itself that the Child Care Regulations 5-16 are being complied with, shall ensure that adequate arrangements are in place to enable an authorised person, on behalf of the health board to monitor statutory and non-statutory children's residential centres.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Monitoring	√		

3.4 Children's rights

Standard
The rights of young people are reflected in all centre policies and care practices. Young people and their parents are informed of their rights by supervising social workers and centre staff.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Consultation	√		
Complaints	√		
Access to information	√		

3.5 Planning for children and young people

Standard
There is a statutory written care plan developed in consultation with parents and young people that is subject to regular review. The plan states the aims and objectives of the placement, promotes the welfare, education, interests and health needs of young people and addresses their emotional and psychological needs. It stresses and outlines practical contact with families and, where appropriate, preparation for leaving care.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Suitable placements and admissions		√	
Statutory care planning and review		√	
Contact with families	√		
Supervision and visiting of young people	√		
Social work role	√		
Emotional and specialist support		√	
Preparation for leaving care	√		
Aftercare		√	

Recommendations:

7. The HSE Dublin Mid-Leinster should clarify roles and responsibilities in relation to child protection and care planning in order to ensure that care plans are developed and reviewed in accordance with the Child Care Regulations 1995 and the National Standards for Children's Residential Centres.

8. The HSE Dublin Mid-Leinster should ensure that young people with disabilities are in receipt of the services that they require.

9. The HSE Dublin Mid-Leinster should ensure that young people leaving the centre have access to an adequate, regular and predictable after-care service.

3.6 Care of young people

Standard
Staff relate to young people in an open, positive and respectful manner. Care practices take account of the young people's individual needs and respect their social, cultural, religious and ethnic identity. Young people have similar opportunities to develop talents and pursue interests. Staff interventions show an awareness of the impact on young people of separation and loss and, where applicable, of neglect and abuse.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Individual care in group living	√		
Provision of food and cooking facilities	√		
Race, culture, religion, gender and disability	√		
Managing behaviour		√	
Restraint		√	
Absence without authority		√	

Recommendations:

10. The HSE Dublin Mid-Leinster should ensure that there is a thorough review of the approach to behaviour management in the centre and that any new approach is subject to periodic evaluation to determine its impact on the number, duration and seriousness of aggressive incidents and unauthorised absences.

11. The HSE Dublin Mid-Leinster should ensure that the policy of never physically restraining young people in the centre is reconsidered to take account of those situations where young people are at risk of assault by peers.

3.7 Safeguarding and Child Protection

Standard
Attention is paid to keeping young people in the centre safe, through conscious steps designed to ensure a regime and ethos that promotes a culture of openness and accountability.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Safeguarding and child protection		√	

Recommendation:

12. The HSE Dublin Mid-Leinster should ensure that all care staff are aware of their responsibility for the safety of the young people in the centre including the development of:
    - planned interventions to prevent crises,
    - appropriate interventions to manage crises,

    and the expectation that care staff will use professional judgement and account for their actions.

3.8 Education

Standard
All young people have a right to education. Supervising social workers and centre management ensure each young person in the centre has access to appropriate educational facilities.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Education	√		

3.9 Health

Standard
The health needs of the young person are assessed and met. They are given information and support to make age appropriate choices in relation to their health.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Health	√		

3.10 Premises and Safety

Standard
The premises are suitable for the residential care of the young people and their use is in keeping with their stated purpose. The centre has adequate arrangements to guard against the risk of fire and other hazards in accordance with Articles 12 & 13 of the Child Care Regulations, 1995.

	Practice met the required standard	*Practice met the required standard in some respects only*	*Practice did not meet the required standard*
Accommodation	√		
Maintenance and repairs	√		
Safety		√	
Fire safety		√	

Recommendations:

13. The HSE Dublin Mid-Leinster should ensure that the premises meet with the conditions of the fire certificate.

14. The HSE Dublin Mid-Leinster should ensure that the recommendations of the safety audit are implemented.

4. Summary of recommendations

1. The HSE Dublin Mid-Leinster should ensure that future admissions to the centre are consistent with its stated purpose and function.

2. The HSE Dublin Mid-Leinster should review management practice in the centre with particular reference to ensuring that all care staff, including the unit leaders, receive regular formal supervision.

3. The HSE Dublin Mid-Leinster should ensure that the centre register includes all of the information required under the Child Care Regulations 1995.

4. The HSE Dublin Mid-Leinster should ensure that the monitoring officer receives written notification of all significant events in the centre.

5. The HSE Dublin Mid-Leinster should review the deployment and level of staffing of the centre.

6. The HSE Dublin Mid-Leinster should review the role of the staff facilitator in the centre.

7. The HSE Dublin Mid-Leinster should clarify roles and responsibilities in relation to child protection and care planning in order to ensure that care plans are developed and reviewed in accordance with the Child Care Regulations 1995 and the National Standards for Children's Residential Centres.

8. The HSE Dublin Mid-Leinster should ensure that young people with disabilities are in receipt of the services that they require.

9. The HSE Dublin Mid-Leinster should ensure that young people leaving the centre have access to an adequate, regular and predictable after-care service.

10. The HSE Dublin Mid-Leinster should ensure that there is a thorough review of the approach to behaviour management in the centre and that any new approach is subject to periodic evaluation to determine its impact on the number, duration and seriousness of aggressive incidents and unauthorised absences.

11. The HSE Dublin Mid-Leinster should ensure that the policy of never physically restraining young people in the centre is reconsidered to take account of those situations where young people are at risk of assault by peers.

12. The HSE Dublin Mid-Leinster should ensure that all care staff are aware of their responsibility for the safety of the young people in the centre including the development of:
    - planned interventions to prevent crises,
    - appropriate interventions to manage crises,

    and the expectation that care staff will use professional judgement and account for their actions.

13. The HSE Dublin Mid-Leinster should ensure that the premises meet with the conditions of the fire certificate.

14. The HSE Dublin Mid-Leinster should ensure that the recommendations of the safety audit are implemented.