Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

ON THE REGULATION AND MONITORING OF

CHILDREN'S SERVICES

IN 2024

December 2025

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.
- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.
- Visit www.hiqa.ie for more information.

About the Chief Inspector of Social Services

The Chief Inspector of Social Services within the Health Information and Quality Authority (HIQA) (referred to in this report as 'the Chief Inspector') is responsible for registering and inspecting designated centres in Ireland.

The functions and powers of the Chief Inspector are set out in Parts 7, 8 and 9 of the Health Act 2007 (as amended) (from now on referred to in this report as 'the Act').

The Chief Inspector currently regulates designated centres for:

- older people
- people with disabilities
- special care units for children.

The role of the Chief Inspector includes inspecting and monitoring a range of services for children. This is achieved through desktop inspection of information received from providers of these services, on-site inspections and ongoing assessment of compliance by the provider with relevant regulations and national standards. The regulations and standards in effect for children's services are as follows:

- Health Act 2007 (as amended)
- Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017
- Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations 2018
- Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017
- Child Care Act 1991
- Child Care (Placement of Children in Residential Care) Regulations 1995. Statutory Instrument No.259
- Child Care (Placement of Children in Foster Care) Regulations 1995. Statutory Instrument No. 260
- Child Care (Placement of Children with Relatives) Regulations 1995. Statutory Instrument No. 261
- National Standards for Children's Residential Centres 2018
- National Standards for Special Care Units 2015
- National Standards for the Protection and Welfare of Children 2012
- National Standards for Foster Care 2003
- Oberstown Children's Rights Policy Framework 202

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A message from the Chief Inspector Designate

Finbarr Colfer, Chief Inspector Designate, Health Information and Quality Authority

Children who come to the attention of social care services are among the most vulnerable in our society. It is essential that their needs are assessed properly and that help and support is provided to them in a timely and effective manner. Providers of children's services play a critical role in achieving this. Our work focuses on supporting these providers to deliver safe, high-quality care and support to children. Service providers must have strong governance arrangements in place to ensure the services they provide are safe and are delivered in line with legislation, national standards and regulations. A well-governed and well-monitored service ensures consistently high-quality care can be provided to those children and young people who require it.

This report details the regulation, monitoring and inspection activities of children's services in Ireland in 2024 by the Health Information and Quality Authority (HIQA) and the Chief Inspector. These services include foster care, child protection and welfare services, special care units, statutory children's residential centres and Oberstown Children Detention Campus. Importantly, it includes what children have told us about their experiences of these services, and it also provides an overview of the factors which have influenced their quality and safety.

Overall, a good standard of care and support was found in children's residential services. Staff in statutory residential centres were particularly skilled in their safeguarding of children, and in promoting their educational needs and wellbeing. Positively, all three special care units (locked facilities where young people temporarily live following a court decision) were compliant with the majority of regulations and staff were effective in their ability to be responsive to the individual needs of the majority of children. Inspectors found progress in the governance and management of child protection and welfare concerns in Oberstown Children Detention Campus. Improvements were found in foster care services, and although there were different systems in use across individual areas to manage unallocated children in foster care, these arrangements were generally effective.

The number of children waiting for a child protection service has been of significant concern to us, and our work since August 2023 has focused on working with Tusla to improve this situation. Our approach in 2024 focused on services which had 25% or more of children waiting for a service. The majority of our inspections showed that Tusla had more work to do to implement its service improvement plan in relation to unallocated cases. Increased referrals rates and difficulties in securing resources resulted in Tusla being challenged to provide the right service at the right time to children. Managers and staff in these services were committed to providing a service to those children at highest risk. However, there were differences in practice and governance across the service areas inspected. Tusla submitted a plan to address our findings, which will be implemented in 2025 and 2026, which includes achieving more equitable sizes of service areas to be of benefit to children and families.

A consistent finding from our inspections over the years is that when children have assigned staff members who are allocated to work directly with them, that the majority of children receive a good service. Staff strive to be child centred in their work, and we routinely find examples of excellent practice where staff go the extra mile for children. Supporting staff through regular supervision and focusing on their wellbeing is crucial and this is particularly critical when many services are stretched to meet current service demands.

There are well documented challenges within the children's sector in relation to the resourcing of services from recruiting and retaining staff, to sourcing suitable placements for children in care to live in. A national strategy is required so that as a country we can have a clear vision for how alternative care is to be provided and staffed into the future to meet the needs of those who require care and support. Our understanding is that this is imminent. Our goal, collectively, should be that all children in care can be supported in services where their human rights are protected and promoted. It is essential that all residential centres for children in care come within the legal remit of the Chief Inspector. We will continue to work with children, their families, friends and advocates, providers, staff, the Department of Children, Disability and Equality, and other stakeholders towards achieving that goal.

I want to acknowledge the ongoing participation and contribution of providers, foster carers and staff during our inspections. You continue to work in challenging circumstances with children and their families to provide safer and better services. I would like to especially thank the children, their families and advocates for their participation and the time they gave to our inspectors, which has helped contribute to this report.

Finbarr Colfer
Chief Inspector Designate
Health Information and Quality Authority

Introduction by the Head of Programme – Children's Service

Eva Boyle, Head of Programme – Children's Services, Health Information and Quality Authority

This overview report sets out the work and findings of our monitoring and inspections of children's services during 2024.

During 2024, we completed 47 inspections across children's services. Overall, inspectors found that children received a good standard of care in foster care, statutory residential care, detention, special care services and children assessed as at ongoing risk of significant harm in child protection and welfare services.

We focus our resources on areas of most need and risk to children.

As outlined in our report *10 years of Regulating and Monitoring Children's Social Services 2014 – 2024*, published at the end of 2024, we outlined how we adapted our approach to recurring risks in Tusla's child protection and welfare and foster care services. We found that Tusla had good measures in place to manage risks associated with unallocated children in foster care, while acknowledging that more work was required by Tusla to strengthen their approach in the governance of child protection and welfare services.

Over the course of 2024, a significant part of our work focused on working with Tusla to reduce the number of children waiting for a Tusla service and to achieve incremental improvements in its compliance with national child protection and welfare and foster care standards. At a national level, Tusla devised a compliance plan to further improve oversight and the quality of services provided to children. Our work in 2025 has focused on how specific service areas have implemented Tusla's national compliance plan.

The voices and experiences of children, young people, their families and carers is at the centre of the work completed by inspectors. A children's version of this overview report has also been published, and it provides a summary of this report and highlights the views of children, young people, their parents and foster carers. Inspectors spoke with or received information from 147 children and young people

across the services in 2024. Hearing children's experiences of services is vitally important to us, but sometimes it is not always appropriate for us to reach out to children given what is occurring in their lives at a particular point in time. During 2025, we undertook research looking at best practice in consulting with children during inspections and this work will continue into 2026.

I want to thank the children, young people, and their families for the time that they give to our inspectors when they speak to them about their experiences of services. I also want to acknowledge the ongoing support and co-operation of providers, foster carers and staff during our inspections. To the staff of all services, it is important to acknowledge your continued contribution to children and families in in doing all that you can to improve their lives.

Eva Boyle
Head of Programme - Children's Service
Health Information and Quality Authority

1. Introduction to regulation and monitoring

This report provides an overview of children's services monitored or inspected by HIQA and regulated in 2024 by HIQA's Chief Inspector Designate of Social Services (the Chief Inspector) in fulfilling its statutory obligations set out in the Health Act 2007 (as amended).

Figure 1 describes the services that are monitored or regulated and registered by HIQA or the Chief Inspector.

In Ireland, all regulated services must be registered with the Chief Inspector and currently the only type of children's service that is regulated are special care units. There are a range of legal enforcement powers available to the Chief Inspector in the event of significant risks being identified through inspection or monitoring of these regulated services, up to and including prosecution or cancellation of registration.

Monitored services are inspected and reported on publicly against approved national standards. Oberstown Children Detention Campus is inspected on an annual basis against its Children's Rights Policy Framework. While HIQA reports on its findings from these monitoring inspections, it has no legal enforcement powers to compel action in the event of significant risk being identified through monitoring of these services.

Figure 1. Services monitored by HIQA and regulated by the Chief Inspector

Non-regulated services monitored or inspected by HIQA	Regulated by the Chief Inspector
Statutory and non-statutory foster care	**Special care units**
Child protection and welfare	
Statutory children's residential centres	
Oberstown Children Detention Campus	

This report presents an overview of the monitoring and regulation of children's social services provided by Tusla and Oberstown Children Detention Campus.

It also outlines how the Chief Inspector and HIQA met its objectives in 2024 in

relation to children's services, including:

- Completion of a risk-based national monitoring programme of the governance and management of Tusla's child protection and welfare services and foster care services.
- Inspection of Oberstown Children Detention Campus.
- Inspection of the implementation of Tusla's Child Abuse Substantiation Procedure (CASP) in one service area.
- Inspection of Tusla's National Out-of-Hours Service (NOHS).
- Routine monitoring inspections of Tusla's foster care services in two service areas and in the Separated Children Seeking International Protection (SCSIP) team.
- Inspections of statutory children's residential centres to assess admissions, governance, health, education, safeguarding, premises, management of behaviour and information governance.
- Programme of regulation in special care units to include monitoring and inspection of all units and the processing of all applications to renew registration and vary conditions of registration received.
- Receipt and assessment of all solicited and unsolicited information across children's centres and services and response to risk in a proportionate and timely manner.

It also includes:

- What children told inspectors during the course of the year.
- Engagement with stakeholders and informed and interested parties.
- A concluding statement in relation to work undertaken in 2024 and focus for future inspections.

2. How we regulate services

2.1 The statutory framework — monitoring and regulating

HIQA and the Chief Inspector carry out three different types of inspections:

- Inspections to assess compliance with statutory regulations, in the case of registered designated centres, such as special care units.
- Inspections which monitor ongoing compliance with specified nationally-mandated standards, and monitoring against the rights framework of Oberstown Children Detention Campus.
- Thematic inspections which aim to promote quality improvement by focusing on national standards relevant to particular aspects of care and to improve the quality of life of people using services.

Our role in children's services operates in a complex legislative framework. Each type of children's service has its own statutory framework that gives authority to HIQA and the Chief Inspector to inspect, monitor and or regulate the service using standards and regulations which set out what is expected from the service.

Table 1 shows the statutory framework for each type of children's service monitored, inspected or regulated and legislative authority HIQA has for each of these services.

Table 1. Overview of regulatory and legislative authority

Functions	Authority to inspect	Primary Legislation	Regulations (where applicable)	National standards
Child protection and welfare services	Monitored under Section 8(1)c of the Health Act 2007 (as amended)	Health Act 2007 (as amended)		***National Standards for the Protection and Welfare of Children*** **(HIQA, 2012)**
Foster care services	Regulated and monitored under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, (as amended)	Child Care (Placement of Children in Foster Care) Regulations, 1995 Child Care (Placement of Children with Relatives) Regulations, 1995	***National Standards for Foster Care*** **(Department of Health and Children, 2003)**
Special care units for children and young people	Regulated and monitored under Section 41 of the Health Act 2007 (as amended)	Health Act, 2007 (as amended)	Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units)	***National Standards for Special Care Units: November 2014*** **(published 2015) (HIQA)**

			(Amendment) Regulations 2018[10]	
Statutory Children's residential centres	Regulated and monitored under Section 69 of the Child Care Act 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991 (as amended)	Child Care (Placement of Children in Residential Care) Regulations, 1995	***National Standards for Children's Residential Centres* (HIQA, 2018)**
Children's detention campus	Inspected under Section 185 and Section 186 of the Children Act 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006		***Oberstown Children's Rights Policy Framework (2020)***

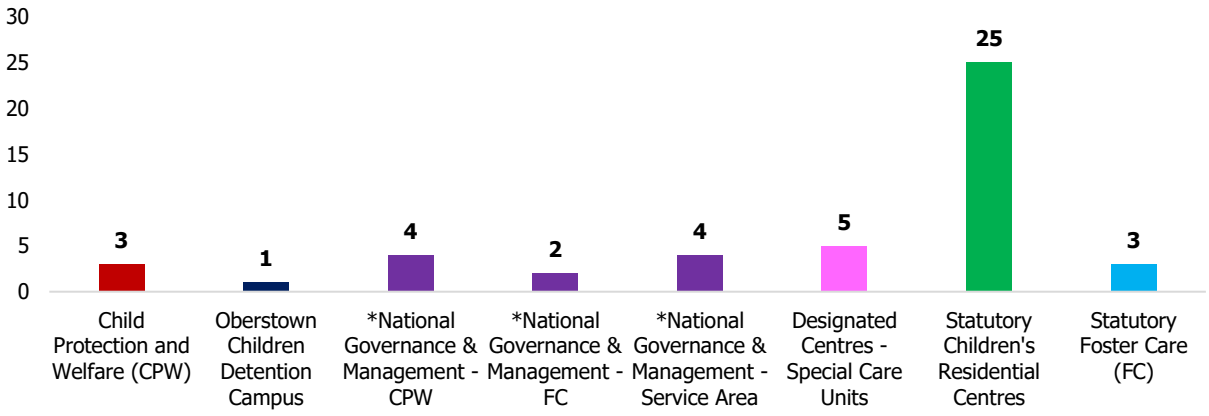
2.2 Regulation and monitoring activity 2024

During 2024, HIQA and the Chief Inspector conducted 47 inspections of the various children's services under their remit (as illustrated in Figure 2).

This included inspections of statutory children's residential centres, special care units, statutory foster care services, child protection and welfare services, and Oberstown Children Detention Campus.

Ten of the inspections were part of a national governance and management inspection programme of child protection and welfare inspections and included the inspection of four child protection and welfare and foster care services within individual service areas, as part of the one programme. The outcome of this programme, the *Overview Report on the Governance of the Child and Family Agency (Tusla) Child Protection and Welfare and Foster Care Services*, was published in January 2025.

Figure 2. Inspection activity in 2024 by service and inspection type



* Risk-based national inspections into the governance and management of child protection and welfare and foster care services. These inspections were compiled as one overall inspection report.

3. Child protection and welfare service inspections

HIQA monitors and inspects child protection and welfare services against the *National Standards for the Protection and Welfare of Children* (2012). The remit of child protection and welfare services is to assess the safety and welfare of children and enable appropriate safeguarding of the children as a result. Ultimately, these services work with parents to support them to care for their children in a safe and nurturing way.

Three routine inspections of child protection services in 2024 reviewed three different elements of the child protection and welfare service provided by Tusla, these were:

- The implementation of Tusla's Child Abuse Substantiation Procedure (CASP) in one service area. A 'substantiation assessment' examines and weighs up all the evidence and decides if an allegation of abuse is founded or unfounded on the balance of probabilities. If the allegation is founded, a determination is made that the person who is the subject of the abuse allegations poses a potential risk to a child or children.
- The National Out-of-Hours Service (NOHS). This service provides a child protection service nationally from 6.00pm to 7.00am daily and from 9.00am to 5.00pm at weekends and bank holidays. The service provides emergency placements for children as required and operates 365 days a year. The NOHS assists An Garda Síochána (Ireland's National Police Service) by phone in providing consultation and advice regarding their decision to remove children to a place of safety (Section 12 of the Child Care Act).[1]
- A focused inspection in one of Tusla's child protection and welfare service area. This was a focused inspection undertaken to validate the integrity of data regarding the number of unallocated cases published on the Tusla website and the management of unallocated cases from the point Tusla received the referral to the allocation of the referral to a social worker until a preliminary enquiry or initial assessment were completed.

A separate risk-based inspection programme focused on child protection and

[1] Where a member of An Garda Síochána has reasonable grounds for believing that (a) there is an immediate and serious risk to the health or welfare of a child, and (b) it would not be sufficient for the protection of the child from such immediate and serious risk to await the making of an application for an emergency care order by a health board under Section 13, the member, accompanied by such other persons as may be necessary, may, without warrant, enter any house or other place and remove the child to safety.

welfare and foster care services is outlined in Chapter 5.

These three services differed substantially in the services that they provided to children and families, however there are some relevant trends in relation to the cumulative findings of the three inspections.

Staff working in the National Out-of-Hours Service responded to all referrals when received and this was in keeping with the nature of an emergency service. These referrals ranged from providing advice and support to children, their families and their foster carers, to situations where a child required an alternative placement due to risks about their safety. At the time of inspection, the Child Abuse Substantiation Procedure (CASP) service had all CASP referrals allocated to a social worker. The focused child protection and welfare inspection of a service area was challenged to deal with all referrals in a timely way, but management had sought additional resources and endeavoured to use their available resources as best as they could in order to try and allocate those children who were most in need of a service.

Our three routine inspections found examples of good practice in all three services, and some examples included:

- A child's CASP case where effective planning meant that a trauma-informed care approach was taken to decide which staff member was best placed to interview the child.

- During out-of-hours inspections, an out-of-hours social worker placed a child seeking international protection into emergency foster care accommodation while they took steps to confirm the identification details of the child's relatives in Ireland. The case was transferred to the Separated Children Seeking International Protection Team (SCSIP) the following working day where further safeguarding checks would be undertaken.

- The focused child protection and welfare inspection in one service area found that completed initial assessments were of good quality with comprehensive analysis of current concerns and the impact of these on children. In a number of cases reviewed, the outcome was to proceed to child protection conferences which was appropriate.

3.1 Children at Immediate Risk

Positively, and in keeping with findings over the last ten years, children at serious and immediate risk of harm in all three services received an appropriate and timely response.

3.2 Interagency working with An Garda Síochána

Interagency working with An Garda Síochána was generally good in relation to sharing of information where both parties had concerns around child abuse or exploitation. However, improvements were required in one service area in relation to the convening of strategy meetings with An Garda Síochána and in meeting their obligations under the National Vetting Act.

3.3 Communication with children and families

Improvements were required in ensuring consistent and timely communication with children and their families, particularly if there were delays in receiving a service. Inspectors also found that two of the services needed to work on how they adapted their communication with children with a disability. Services routinely employed interpreters to facilitate communication with parents and children where required. There were also examples of good communication where children had an allocated worker and their cases were being actively managed.

3.4 Governance

Our expectation of providers is that they are continuously striving to improve their services by implementing their own plans for their improvement. Our inspectors found that there were variations in the governance of the three services, despite all three services being provided by the same provider (Tusla). Tusla's child protection and welfare services have a suite of national policies, procedures and business processes. Despite this, in all three services, there were variations in how services implemented relevant national policies in supervision, information governance, risk management and quality improvement. Supervision was provided consistently to staff in two out of three services with staff receiving good quality supervision in line with Tusla's own policies, while staff in the third service did not regularly receive supervision. Tusla had set time frames for the completion of specific tasks however, these time frames were not implemented in the NOHS. The other two services were not routinely meeting Tusla's time frames for their specific work, and reasons for the non-adherence provided by the services included insufficient staffing resources and issues outside of their control such as individual's non-attendance at appointments. Good information governance within a service ensures that information is accurate, safe, well organised and compliant with internal processes.

Good quality information is essential for managers so that they can identify trends, effectively plan and give assurances to senior management. All three inspections found variations in practice in relation to information governance. This included delays in updating case notes and the cloning of information between siblings, resulting in some records having inaccurate information pertaining to an individual child. Up-to-date case records are essential in order for services to operate safety. In

one service area, there were inaccuracies in the data gathered on allocated cases, resulting in inaccurate allocation data being reported publicly.

Better oversight of the implementation of risk management policies and procedures was required. All three services had risk registers, however this did not consistently result in the effective mitigation of risks. Regional oversight of risks varied, and the level of regional oversight was more successful in one service than the other two.

Quality assurance systems were more developed in two out of the three services, and some positive initiatives were in place to address identified areas of improvement. For example, a working group focusing on domestic violence was established in one service area after an audit highlighted the number of referrals where domestic violence was a factor. The consistent implementation of the learnings from audits was a challenge due to the daily demands on the services.

All three services submitted compliance plans to address areas of improvement and HIQA monitored the implementation of these plans over 2025. The respective reports are published and are available on HIQA's website at www.hiqa.ie.

3.5 What children said about their experience of these child protection and welfare services?

Hearing the voices of children who have experienced a particular service is an essential part of understanding what impact the service has had on their lives. Due to the sensitive nature of the experiences of children who have to navigate their way through child protection and welfare services, it was determined in all three inspections that a review of children's case files would provide an insight into their experiences and lessen any further distress. A dedicated telephone number was provided for any person who had experience of the services to contact HIQA and speak with inspectors during the inspections.

As the NOHS was primarily responding to emergencies, there was limited practice of staff speaking with children to hear about their views and experiences. There was also mixed practice of social workers meeting in person with children placed in special emergency arrangements.[2] Overall, when children had experienced crisis situations in their life and required the assistance of the NOHS, the team took immediate protective action.

[2] A Special Emergency Arrangement (SEA) refers to emergency settings where a child or young person is accommodated in a non-statutory and or unregulated placement (for example, a Hotel, B&B, Holiday centre, Activity centre, Tusla property or privately leased property). The child is supervised by Tusla staff, or staff provided by a private provider, or community and voluntary provider (or combination of those). The overall responsibility for the child remains with the placing service area and region.

Given the nature of the Child Abuse Substantiation Procedure (CASP), inspectors were also conscious that the reasons for children and adults being involved with this procedure were both sensitive and often traumatic. Their right to choose to engage or not engage in the inspection process was respected. While inspectors did not have an opportunity to speak directly to children and their families as part of the inspection, a review of files identified concerns with regard to the impact of the CASP on their lives. For example, there were significant delays in the progression of CASP for children who were the alleged victims of abuse. While most children who were alleged victims of abuse were safeguarded through the provider's national approach to practice, not all children who were identified, identifiable or yet to be identified were safeguarded.

The primary focus of the focused inspection in one service area was on the management of cases that were waiting for a preliminary enquiry or an initial assessment to be carried out. This meant that in many circumstances children and families had not yet received a service about which they could share their views and experiences. More importantly, inspectors were conscious about contacting families where the family may not yet be aware of the referral and, as a result, contact was not made with children and families that were awaiting the service. From the review of case files, inspectors were able to review some of the experiences of children, who as a result of being placed on a waiting list, or as a result of not being allocated to a social worker in a timely manner, experienced delays in receiving a child protection and welfare service.

Seven cases were identified over the course of this focused child protection and welfare inspection where the level of concern for children necessitated escalating the cases for the attention of the area manager. All of these cases had been unallocated at the time of the inspection and were waiting for preliminary enquiry or initial assessments to be completed. Three of the cases were allocated to a social worker immediately and all of the cases had actions completed to ensure children's safety. These cases illustrated how, due to the area not having capacity to complete assessments in a timely manner, children and young people had to wait long periods of time for the right interventions.

What children told inspectors about the child protection and welfare service they receive

Challenges children faced in the child protection and welfare service they received

A child told the inspector that they had a social worker but said, "I do not really know what it is they do. I do not understand what they are there for."

A child indicated that what they needed was "extra support and counselling. I have waited a long time and I am getting sick of waiting."

4. Alternative care services

Alternative care refers to both residential care and foster care services provided by Tusla or non-statutory (private or voluntary sector) organisations for children and young people who are unable to live with their own families. At the end of 2024, HIQA had monitored and inspected 24 out of 37 statutory residential centres. Two new centres opened during 2024, but the overall number of centres remained unchanged due to the closure of other centres. Two centres that provided respite services to multiple children had changed to single occupancy arrangements to meet the specific needs of two children for a short period towards the end of 2024; one of these went back to providing respite care in December 2024, and the second one did so in February 2025. In November 2025, the number of children's residential centres operated by Tusla increased to 42. HIQA's legal remit does not currently, however, give us powers to inspect non-statutory residential care services, which continue to be registered and monitored by Tusla. HIQA also inspects both statutory and non-statutory foster care services.

4.1 Statutory Children's Residential Centres - Inspection and monitoring findings

During 2024, HIQA completed 25 unannounced inspections of 24 statutory children's residential centres against the *National Standards for Children's Residential Centres* (2018). Of these 25, 20 were part of an inspection programme primarily focused on the leadership and management within children's residential centres and the quality and safety of care provided to children, including how their rights were promoted and realised. Three inspections completed were of new children's residential centres opened in 2023 and 2024 and two were follow-up inspections to assess progress against actions to address non-compliances identified in previous inspections of these centres.

4.1.1 Governance and management findings

Of the 25 inspections completed, all centres were assessed against standard 5.2 relating to effective leadership, governance and management arrangements, and six were assessed against standard 5.3, relating to a centre's statement of purpose. One residential centre was assessed against standard 5.4, relating to quality and safety. Eight centres were compliant, eight were substantially compliant and nine were not compliant with standard 5.2. Of the six centres assessed against standard 5.3, three were compliant, two were substantially compliant and one standard was not compliant. One centre assessed against standard 5.3 was judged to be substantially compliant. One of these centres had been inspected on two occasions in 2024 and moved from substantially compliant to compliant with this standard.

In the majority of centres that were compliant or substantially compliant with this standard, there were effective governance arrangements in place which ensured child-friendly practice and positive experiences for the children availing of placements. Clear lines of authority and accountability were seen by inspectors, staff were aware of their roles and responsibilities and effective systems were in place to manage risk. There was appropriate oversight of risk, as all risks had control measures in place which were regularly reviewed and risk-rated in order to continually manage and reduce the identified risks. In addition, there was a strong focus on the safety and rights of children. Regular audits were carried out in a number of areas of practice which included: care records; child protection; positive behaviour management; restrictive practice; supervision; health and safety; medication; and staff training. Appropriate actions were taken to address any gaps or risk in these audits.

However, nine of 25 residential centres judged as not compliant with standard 5.2 found that management practices and governance arrangements varied in their quality and effectiveness. For example, there were gaps in the frequency and quality of audits, as well as delays in progressing actions identified form audits. Two centres had seen a number of changes and challenges that impacted on the effective management of risks within the centres. Notwithstanding the processes put in place to ensure continuity of service delivery, there were times when systems did not adequately support a safe and effective service for all children in the centres. The management and oversight of significant events required strengthening in a number of centres to ensure effective behaviour management, the safety of all children and adherence to *Children First: National Guidance for the Protection and Welfare of Children* (2017).

Standard 5.3 relating to the centre's statement of purpose was inspected in the two new centres and included for inspection in three additional centres, following identification of potential risks relating to the accuracy of centres statement of purpose during inspection. Overall, the services defined in the respective statements of purpose reflected the day-to-day operation of the centres. Of the five centres that were assessed against this standard, two were compliant, two were substantially compliant and one was not compliant. In four of five centres assessed against this standard, their statement of purpose clearly described its aims and objectives, the services provided and the care and support needs of children that the centre intended to meet. Inspectors identified significant deficits with respect to the accuracy and suitability of their statement of purpose in one centre, when evaluated against the actual service being provided at the time of inspection.

4.1.2 Responsive workforce findings

Of the 24 children's residential centres assessed against standards 6.1, relating to the delivery of child-centred care and support and 6.3, relating to staff supervision, under the theme of responsive workforce, 13 were compliant, seven were substantially compliant and four were judged not compliant with standard 6.1. In relation to standard 6.3, five centres were compliant, 13 were substantially compliant and six were judged not compliant. One of these centres had been inspected on two occasions in 2024 and moved from not compliant to substantially compliant with this standard.

Significant challenges with workforce and staffing resources were identified within children's centres. The majority of centres managed to ensure an appropriate number of staff were employed with a mix of skills and experience to provide good quality and appropriate care to meet the diverse needs of children. However, there was a heavy reliance on the use of agency staff to fill vacant posts as well as Tusla staff working additional hours to make up shortfalls in staffing in other centres. Staff vacancies were noted as a risk on the centre's risk registers and steps were being taken by management to mitigate the risk and its impact on children. In 13 of the centres, workforce planning was effective to cover all types of staff leave. In the event of any unexpected absences, the use of consistent agency staff to ensure continuity of care for children was effectively managed. While there were plans to fill vacant posts, with some in the process of being recruited at the time of the inspections, staff vacancies continued to exist across 10 of these centres.

Four residential centres were judged to be not compliant with standard 6.1 as staffing resources were insufficient and not in line with their statements of purpose. There was an over reliance on the use of agency staff and it was not always possible to ensure consistent or familiar people were engaged with the children in the centres. This had the potential to impact on children's feelings of stability in their placement, and in some cases was a contributing factor in the level of incidents involving behaviours that challenged by children resident. For one centre providing respite placements, staffing resources had become significantly more challenging throughout 2024. On two occasions, the centre had to close for a number of nights due to inadequate staffing and it became necessary to reduce the overall number of placements available to children requiring respite.

Management regularly undertook workforce planning to mitigate against any disruption to children's continuity of care due to any reduction in staffing levels. These measures included the use of relief and agency staff to fill vacant shifts. Bespoke recruitment campaigns were held for three centres, while also being part of rolling recruitment campaigns. The result of these campaigns was mixed, as some

attracted very few candidates and continued to have vacancies across a number of grades.

There were appropriate arrangements in place to promote staff retention and continuity of care to children. For example, managers encouraged staff who qualified to apply for Tusla's careers pathway initiative. Other arrangements included a number of staff wellbeing initiatives, an employee assistance programme to support staff in their work, opportunities to avail of job sharing, shorter working year and career breaks where possible. Other supports to staff varied across the centres which included regional residential psychology services, 'peer supporter' role to staff following an incident, training in responding to violence, aggression and harm, coaching and counselling.

Notwithstanding the various arrangements and initiatives in place to ensure staff retention and continuity of care, some centres continued to have resourcing issues throughout 2024. Where staff vacancies were high, associated risks were appropriately escalated to senior management through the provider's 'Need to Know' procedure and recorded on the centre's risk register.

On-call arrangements were in place in all centres that ensured staff had access to immediate support and guidance in relation to any issues or concerns that arose during periods outside of working hours. This was provided primarily by the centre manager or their deputy and in some centres, social care leaders also provided additional support during evenings and weekends.

Staff were familiar with organisational policies and procedures, and their accountabilities for delivering safe and effective programmes of child-centred care and inspectors observed good practice in staff's care and attention to children. Management promoted a culture of learning that ensured quality and safe practices within centres as demonstrated in the records reviewed by inspectors and interviews with staff. Managers and staff worked well together and with other professionals to ensure children's needs were met. Team meetings and staff handover records reflected a child-centred approach to practice.

In the centres that were found to be compliant with standard 6.3, supervision was carried out in line with policy, appropriate written records were maintained and supervision was used to reflect on practice, address any practice issues and hold staff to account when necessary. Training and development were also regularly discussed and support was provided when appropriate. Mandatory training was up-to-date for the majority of staff and specified dates were scheduled for refresher training in the future. A tracker was maintained for all staff training and audits were completed in a number of centres.

In the centres that were found to be not compliant with this standard, the majority of staff outlined that they received good, regular support and supervision from their managers', however, the centre records did not always fully reflect this as there were a number of gaps found in records sampled across the various grades of staff, and some agency staff did not receive formal supervision. The recording of informal supervision was an area for improvement acknowledged by managers. Arrangements for staff appraisal were not yet fully embedded or there was no formal process for the evaluation of staff practice and the management of staff performance across most of the centres. While a team-based approach to working was promoted, the regularity of team meetings required improvement in some centres to ensure effective communication. The quality of team meeting records also varied across centres. Where improvements were required, these related to consistent recording of decisions made, review of previous decisions made, oversight and sign off of records.

4.1.3 Information governance findings

Of the 24 children's residential centres assessed against this standard, 12 were compliant, 11 were substantially compliant and one was not compliant. One of these centres had been inspected on two occasions in 2024 and moved from substantially compliant to compliant with this standard.

Effective arrangements were in place for information governance and records management to deliver child-centred, safe and effective care and support. A register of all children living in the centres in line with statutory regulations and up-to-date care records for children were maintained in the majority of centres. Where records were missing or required updating, such as care plans and medical information, records reflected the efforts made by staff to get the required information from children's allocated social workers or their carers as appropriate.

Children were informed of their right to review their records and staff supported children to access their information and to read through the different documents if required. Good practice was seen in the approach taken to encouraging children to read and sign their records, however, most children had no interest in doing this.

Staff were guided by national policy in relation to the management and sharing of information including the retention and disposal of records. There was good communication and information sharing between different agencies involved in the care planning needs of each child. This included educational providers, An Garda Síochána, social workers and other relevant services.

4.1.4 Child-centred care and support findings

Under the theme of child-centred care and support, standards 1.1 relating to children experiencing care and support and 1.2, relating to children's dignity and privacy, were assessed. High levels of compliance and a strong culture of respect for children's rights was found in the majority of centres inspected. A total of 23 children's residential centres were found to be compliant and one centre was substantially compliant with standard 1.1, and one centre assessed against standard 1.2 was judged to be compliant.

Inspectors observed caring and respectful interactions between the staff and children. Staff were aware of the varying and diverse needs of children and of the need to balance the individual needs of each child so as to ensure they received the most appropriate care and support to best meet these needs. Children were informed of their rights when they were admitted to the centre and had access to information about their rights and were encouraged to engage with advocacy services. Cultural, language and religious diversity were taken into account in day-to-day routines such as meals, as well as times of particular cultural importance.

There were systems in place to obtain the views of children on all aspects of their care as demonstrated through a review of children's records, individual direct work, observing children's interactions with staff and through regular children's meetings. While not all children wanted to participate in these meetings, staff recognised and respected this, and facilitated other ways for children to express their views.

Overall, children's concerns and complaints were responded to appropriately by staff as they spoke with the children, listened to their views and took steps to address the issues raised. They were able to express their views when they were unhappy or concerned about any aspect of their care, and some children had exercised their right to make a complaint.

4.1.5 Effective care and support findings

As part of the inspection programme for 2024, standard 2.1 relating to the appropriate planning for the admission of children to residential centres was included in inspections of centres who had children admitted in the six months prior to inspection. Of the 16 residential centres that were assessed against this standard, 11 were compliant, two were substantially compliant and three were not compliant.

Overall, admissions to the centres were considered and assessed against the centre's statements of purpose and were in line with policy. Staff worked closely with children's social workers prior to admission to ensure that the service was suitable to meet the child's needs. There were appropriate transition plans to support the child to become more familiar with the service. Children already living in

the residential centres were appropriately informed of new admissions and due consideration was given to any potential impact on their care. However, in one residential centre, there were delays in the receipt of essential care documentation to help direct the initial work with individual children.

In the four centres that were judged not compliant with this standard, admissions were not managed in line with policy and they were not effectively considered nor assessed against the centre's statement of purpose. The impact of the placement on both the children already living in the centre and the new admission had not been fully considered.

Standard 2.2 relating to the care and support based on a child's individual needs, was assessed in two children's residential centres. One of these centres had been inspected on two occasions in 2024 and moved from not compliant to compliant with this standard. Care plans, placement plans and placement support plans were in place. Staff worked collaboratively with the child's social worker in implementing the care plan. Placement plans were reflective of the child's needs and their individual goals. They were routinely reviewed and amended to reflect the changing needs of the child as required. Placement support plans were also of good quality and contained all the required information necessary to ensure a child's safety.

Standard 2.3 relating to the centre being a homely environment for children was included as part of the programme of inspection for 2024 to assess the premises from which children's residential centres were operating. Of the total of 25 inspections completed, nine centres were found to be compliant, nine were substantially compliant and seven were not compliant with this standard. One of these centres had been inspected on two occasions in 2024 and moved from compliant to substantially compliant with this standard as improvements were required to ensure full compliance with fire precautions.

Quality and suitability of premises and the general environment varied greatly with newly established or refurbished centres found to be welcoming, inviting and improved environments that promoted safety and wellbeing of children. In contrast, some significant risks were identified within the physical environment of some centres and others were outdated, poorly maintained and not inviting. Appropriate compliance plans were submitted by Tusla to address these issues.

For the residential centres that were compliant with this standard, the premises were child centred and homely and promoted the safety and wellbeing of each child. The layout, design and décor was suitable and provided appropriate communal, private and stimulating environments for children. Children had their own bedrooms and there were a sufficient number of bathroom facilities to ensure privacy in most residential centres. The internal environments of a number of centres were designed with the sensory needs of children in mind to promote a safe space for their health

and wellbeing. There were varying sizes of outdoor space for individual or shared activities with a variety of sports and play equipment and storage facilities across the residential centres.

There were appropriate procedures in place for managing risks to the health and safety of children, staff and visitors which included a national incident management reporting system and the children's residential services significant event notification process. Inspectors noted that these had been appropriately used to report incidents. With the exception of one centre, up-to-date safety statements were in place.

Seven of the 24 children's residential centres were not compliant with this standard. These included the location of two centres on larger campus grounds with several buildings which were not considered homely. Some of the rooms in one of these centres at the time of inspection were not maintained to an acceptable standard. There were plans for one centre to move to another premises and this was achieved by February 2025 at the time of writing this report. However, despite significant efforts, there was no clear plan or timeline for a move to a more appropriate premises for the other residential centre.

Safety aspects such as trip hazards, storage of combustible materials, floor plans not on display, internal and external maintenance issues, and safety equipment within centre vehicles required improvements. Fire safety issues included fire drills, the locking away of fire extinguishers, issues with the closure of some fire doors, personal emergency evacuation plans (PEEPs) and fire safety training. A number of these non-compliances were escalated by inspectors to the relevant managers at the time of the inspection. Immediate steps were taken where required or satisfactory assurances were received.

4.1.6 Safe care and support findings

Twenty-four children's residential centres were assessed against standards 3.1, relating to children being safeguarded from abuse and neglect and 3.2, relating to children's receiving care and support that promotes positive behaviour, under the theme of 'safe care and support. 17 were judged to be compliant, four were substantially compliant and four were not compliant with standard 3.1. In relation to standard 3.2, 17 were compliant, six were substantially compliant and two were not compliant.

Management and staff were aware of their responsibilities and the centres operated in line with Children First (2017). Children were safeguarded and their care and welfare was protected and promoted. Training in child exploitation and child trafficking was completed by some staff, as this was an area of concern given the vulnerability of the children in their care. The residential centres had up-to-date

safeguarding statements displayed which set out standards of child protection practice in line with Children First (2017) and Tusla's child protection policies and procedures. Staff had up-to-date training as mandated persons and they liaised with the relevant social work departments to ensure that concerns were investigated and outcomes were obtained for the child. Children were assisted and supported through direct work with staff to develop their knowledge, self-awareness and understanding to protect themselves.

Six residential centres were not compliant with standards 3.1 and 3.2. These centres were found to have ineffective measures in place to protect children. These included instances where the notification of child protection and welfare concerns had been delayed and where the status of notified concerns had not been consistently tracked. Significant risks included that some safeguarding concerns which were not recognised as such and were not notified in line with Children First (2017). When risks and individual vulnerability presented, safety planning was not completed in a timely manner. In addition, vetting of some staff was not up to date in one centre. HIQA sought and received satisfactory assurances following the inspections of the respective centres where these safeguarding concerns were identified.

Management and staff took a positive approach to the management of behaviours that challenged. Staff were trained in Tusla's approved behaviour management approach. Of the 24 centres assessed against this standard, 17 were found to be compliant. Children were encouraged to understand and appropriately express their needs and emotions. Behaviour support plans specific to a child's assessed needs were in place and were discussed at team meetings so as to understand the underlying causes of behaviour.

In the centres that were compliant with these standards, restrictive practices were used appropriately and were monitored and regularly reviewed. Examples of these included room searches, fitting of alarms on some doors, turning off the Wi-Fi at a certain time at night and children handing up their mobile phones to encourage good bedtime and sleep routines. Another example was of some doors being locked in very specific circumstances for the safety of a child. These practices were risk assessed and reviewed regularly to ensure their appropriate use. This ensured that children's rights were only restricted when necessary for their own, and others' safety.

Six residential centres were not compliant with this standard. Incidents in some centres were not managed appropriately and impacted on staff's ability to keep children safe at all times. In addition, the analysis of incidents were not adequate with regards to identifying trends so as to inform staff practices. Similarly, the recording, review and monitoring of the use of restrictive practices was not in line with policy in a number of centres. For example, the use of alarms as a restrictive

practice required a review to ensure proportionality to the presenting risk. Not all children had been informed of the rationale for the use of alarms or when they could be used.

4.1.7 Health, wellbeing and development findings

Of the 24 children's residential centres inspected, three standards were assessed under the theme of 'health, wellbeing and development'. Twenty-three centres were assessed against standards 4.1,relating to the promotion of the health and wellbeing of children and 4.2, relating to identifying any health and development needs of children, and all centres were assessed against standard 4.3, relating to education and training opportunities being provided to children. With the exception of two centres that were not compliant with standards 4.1 and 4.2, there was a high level of compliance across all three standards. A national policy to guide staff in promoting personal development, health and wellbeing of children was in place that provided guidance for staff on promoting positive lifestyle choices. The staff approach to children's care and support was aligned with this policy and the objectives of the centre. For children who were diagnosed with additional needs and or a disability, staff and managers collaborated with professionals, social workers and children to promote their health and development.

Older children were encouraged and supported to develop the skills necessary for independent living and to exercise autonomy. For example, encouraging them to be more confident in their ability to undertake tasks and enrol in alternative training programs when not engaged in school. Children were encouraged to take responsibility for managing their own pocket money, open bank accounts and consider their options for training, further education and accommodation in the future. While efforts were made to promote a child's health and wellbeing in the centre that was found to be not compliant, practices and initiatives to achieve this required improvement.

Overall, children had access to a healthy diet, recreational opportunities and medical services, as well as any additional specialist supports to meet their assessed needs as required. Arrangements for children who required support in the administration of medication were risk assessed and well managed. Children's care records contained clear information on their relevant medical and health information which included details of children's referrals to specialist services. Children had access to their general practitioner (GP) and appropriate information was shared with them as required. When children were unwell, staff cared for them in a manner that supported their full recovery. With the exception of three centres, medication management was in line with policy.

Medication errors were found in six of the 24 centres assessed against standard 4.2, these were appropriately recorded and responded to with no adverse impact on the

children involved. Only one centre required updated medication management training for staff. Good practice was found in a number of centres in the promotion of relevant topics such as sexual health education, healthy relationships, self-administration of medication as age appropriate and in preparation for leaving care, exploring children's identity to ensure they were equipped with information and resources through their journey.

Children were provided with education and training opportunities to maximise their individual strengths and abilities and to achieve their potential in learning and development. Where literacy or language difficulties presented that negatively impacted on a child's access to education, appropriate supports were organised. A number of children had completed state examinations and were progressing through their educational placements. Some children told inspectors of their ambitions for their future and had plans which included having their own accommodation, going on to third level education and possibly completing an apprenticeship. Where there was poor attendance in either educational or training placements, staff worked with individual children and relevant professionals to support and encourage them.

In summary, HIQA's inspections of statutory children's residential centres indicated a good level of compliance with the majority of the standards assessed. Management practices and governance arrangements were found to be varied in their quality and effectiveness across the centres. The majority of centres were led by experienced and dedicated managers who provided positive effective decision-making and were committed to ensuring high quality, safe and effective care for children and young people. However, deficits in the leadership, governance and management in some centres meant that risks to children were not effectively managed.

Staffing challenges were a feature for many centre managers and there were challenges with identifying move on placements for children who had disengaged or whose needs were no longer being safely met within the centre, contributed significantly to safeguarding risks identified during inspections throughout 2024. Notwithstanding the improvements required, the vast majority of children experienced care and support that encouraged positive behaviour, promoted their rights and supported their educational and training needs. Overall, children, parents and external professionals were very positive about the care and support they received.

4.1.8 What children told us about their experience of children's residential centres

Across the 24 children's residential centres inspected in 2024, inspectors engaged with a total of 66 children and young people. For those who exercised their right not to engage with an inspector, opportunities to observe children's interactions both

with staff and with each other occurred throughout the course of the inspections, which included mealtimes, activities and house meetings.

Overall, the majority of children said they felt safe and were happy living in their respective placements, and had built trusting relationships with staff and could speak to them if they had any worries or concerns. They were aware of and understood their rights, and said they were given appropriate information and support to exercise their rights. They were involved in decision-making processes about their care, and most were confident to express their views to staff or their social worker, or make suggestions about day-to-day life in the centre. Where appropriate, contact with families and friends was facilitated in line with care and placement plan processes.

Health, wellbeing and educational needs were considered and promoted. Children told inspectors how they were supported to access relevant medical or other health and social care services as required. They spoke about their school placements, training or work placements, favourite subjects and future ambitions.

Where required, children and young people were supported with skills for independence and spoke about cooking their own food, budgeting, and responsibility for self-medication, among others. Some young people had allocated aftercare workers assigned to them and spoke about how they were supporting them in their preparation to leave care and transition into adulthood.

While the majority of children expressed very positive views, there were a small number of children who described different experiences and challenges with living in residential care. Some felt they were not asked for their opinions about their care enough or were not given opportunities to make important decisions. Others said that it took a long time to get feedback on things. Where a child or young person did not have an allocated social worker or where there was a change of social worker, communication around this was seen as important to them as they felt unsure and no one had come to see them or speak to them about it. Others spoke about their placement being far away from their home and that they had to travel long distances to see their family, and wanted to move closer to home. Similarly, for a number of children, they said that sometimes they experienced challenges in seeing their social workers when they needed to as the centre was located a significant distance from the social work team that placed them. Some children and young people spoke about the condition of the residential centres they lived in, describing the renovations and decorations they were told about that had not happened.

What children 'liked' about living in children's residential care

4.1.9 What parents told us about their experience of children's residential centres

Inspectors spoke with 18 parents across 12 children's residential centres. Some parents had mixed views of the service provided, in that they were not happy with the level of communication from staff. However, most parents spoke positively about the level of care provided which they described as child focused and promoted children's rights and also said that staff were responsive to children's needs.

4.2 Statutory foster care service inspections

In Ireland, statutory foster care services are provided directly by Tusla on behalf of the State. Children's foster care services are also provided by non-statutory (private provider) foster care agencies under agreements with Tusla. However, Tusla retains its statutory responsibilities to children placed with these services. Tusla also approves the foster carers recruited by these agencies through its foster care committees.[3]

HIQA conducted two routine monitoring inspections of Tusla's foster care services in two service areas and one follow-up inspection in the Separated Children Seeking International Protection (SCSIP) team in 2024. These were to assess children's experiences in relation to their rights and the quality of children's assessments of need, including any specialist support children required and how these assessments informed the matching of children with foster carers. In addition, the inspections also focused on the management and monitoring of the foster care service and the availability of a range of suitable foster carers to provide child-centred care.

Across the two service areas, there were a total of 410 foster care households, of which 273 were general foster care households and 137 were relative[4] foster care households. There were 24 available foster care placements and 15 available respite placements in one service area, neither of which were available in the other service area. In the 12 months prior to the inspection, there had been a total of 134 enquiries received about becoming a foster carer across both service areas, of which a total of 24 had progressed to application stage. There were a higher number of foster carers (25) who had left the foster care panel voluntarily in the 12 months prior to inspection in one service area in comparison to three in the other service area.

A total of 481 children were placed in general foster care and 201 were placed in relative foster care placements across the two service areas. Forty-nine children in total were awaiting a foster care placement, with 22 of these waiting more than three months. There were 91 children awaiting approval of a long-term foster care placements across both service areas. In addition, a total of 246 children had been admitted to foster care in the previous 24 months to the inspection and 107 children had experienced a change of placement during that same period.

[3] A foster care committee is a prescribed group that meets to make recommendations regarding foster care applications and to approve long-term placements.
[4] A relative foster carer is defined as a person who is a friend, or relative of a child, or a person with whom the child or the child's family has had a relationship prior to the child's admission to care.

4.2.1 Key findings of the foster care inspections

Of the six national standards assessed in both service area inspections, HIQA made the following judgments:

National Standard	Service Area 1	Service Area 2
Standard 3: Children's Rights	Compliant	Compliant
Standard 6: Assessment of children and young people	Compliant	Compliant
Standard 8: Matching carers with children and young people	Substantially compliant	Substantially compliant
Standard 10: Safeguarding and child protection	Not compliant	Not compliant
Standard 19: Management and monitoring of foster care services	Substantially compliant	Not compliant
Standard 21: Recruitment and retention of an appropriate range of foster carers	Substantially compliant	Substantially compliant

4.2.2 Children's rights findings

Children's rights were promoted in line with their age and stage of development. Their views were sought and considered when decisions were being made, for example, in relation to contact with their families, education and suitability of placements. They were supported to understand and exercise their rights and were consulted about matters that affected them. Staff and managers were knowledgeable about children's rights and practitioners were skilled at engaging with children in meaningful ways.

Children were treated with dignity and respect and they were informed of the complaints process. They were encouraged to give feedback at various stages during their time in care, primarily through their child-in-care reviews, as well as conversations with their allocated social worker or the fostering link worker. Children had the opportunity to give their views and wishes by completing a child-in-care review form or through other mediums, such as drawing or storytelling, where they chose not to attend their child-in-care review. A children's fora was established in both service areas, which provided children in care the opportunity to meet other children with shared experience of being in care to come together as a group for events and activities, as well as opportunities to have their voices heard and to contribute to service development and delivery.

4.2.3 Assessment of children and young people findings

Across both service areas, the assessment of children's needs to find out about the child, their abilities and needs to inform the care planning process were primarily completed for children before they were placed in foster care. In the case of an emergency placement being required, the assessment was carried out soon after and in a timely manner. Children, their families and others involved in the child's care were encouraged and facilitated to participate in the assessment process, where appropriate.

Assessments of need were comprehensive and a multidisciplinary approach was used where required. Decisions were clearly recorded in the assessment reports, and actions were identified to meet those needs. Outcomes of assessments were shared with the foster carers, children and their parents as appropriate and recorded on children's care files.

The rights of children with complex needs and disabilities were promoted through the provision of the necessary support to fulfil their potential. A well-integrated multidisciplinary therapeutic team was in place in one service area that demonstrated positive impacts on children. The team worked directly with a number of children with complex or additional needs, and also served as a resource for staff and foster carers on how best to meet children's assessed needs. In the other service area, a clinical psychologist post had been vacant since 2023; however, at the time of the inspection, a newly-recruited clinical psychologist was due to commence employment in the service. The service area outlined the benefits of this therapeutic input in planning interventions and assessment work for children and awaited the person to be in post.

Collaborative working relationships and effective communication with external professionals or other agencies were clear in a sample of files reviewed. Joint working arrangements with the HSE were well established in the areas and formed an integral part of the process of assessing children's needs. The Joint Protocol for Interagency Collaboration between the HSE and Tusla was adhered to in both service areas. When services in the community could not be accessed in a timely manner for children, private services were sourced and referrals were made for any additional services to meet children's needs as required.

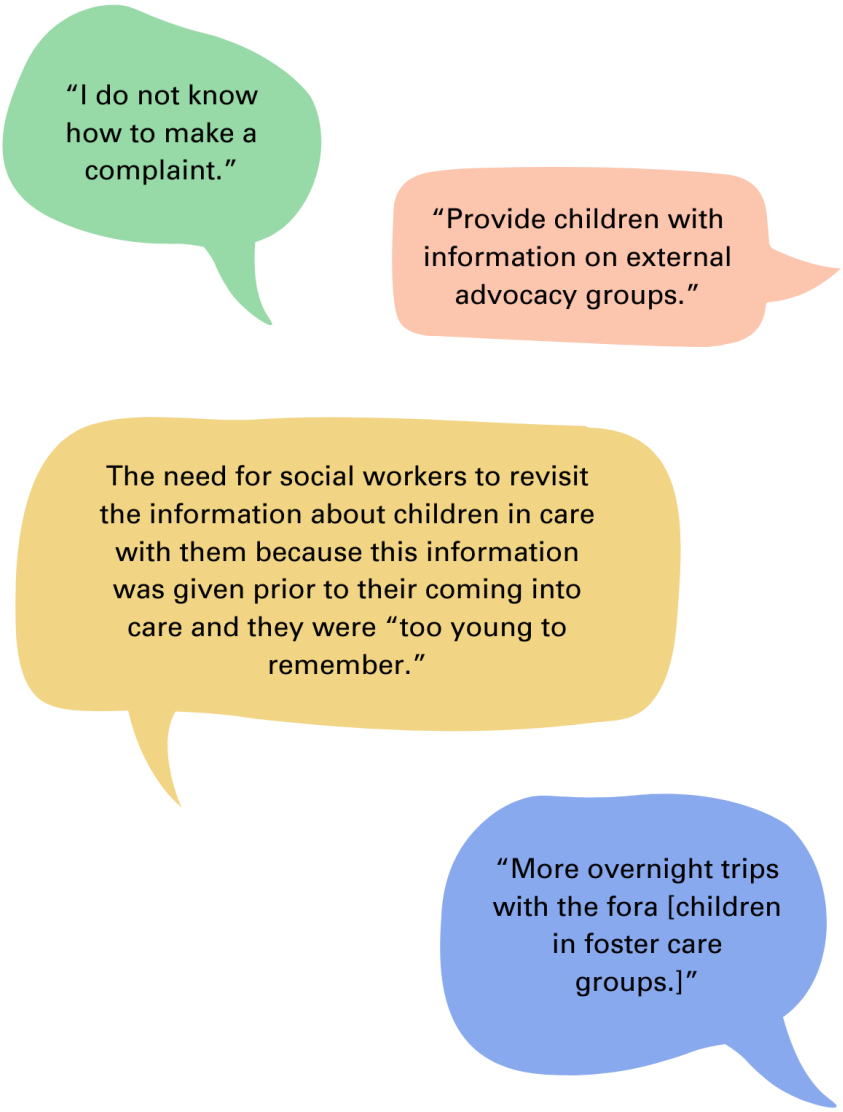
4.2.4 Matching carers with children and young people findings

The majority of children were appropriately matched with foster carers who were capable and experienced in meeting their assessed needs, and where possible were culturally appropriate. However, matching was challenging due to a shortage of suitable and available foster carers. Formal matching processes in place were child centred, and considered the child's assessed needs, contact with family and any associated risk factors such as identified behavioural issues. The process also

considered the proposed foster carer's capabilities, their family and any other children in the household. Children's views were sought and considered in accordance with their age, stage of development and individual needs. However, records of matching decisions were not consistently available on both foster carer and children's files. Where placements were at risk of breakdown, strategy meetings were held to explore their sustainability, and appropriate plans were implemented to support the placement.

What children told inspectors about the foster care service they receive

Challenges children told inspectors about the foster care service they receive



4.2.5 Safeguarding and child protection findings

While there were systems in place to keep children safe and protect them from risk of abuse and neglect, they required significant improvement. Both service areas were not consistently implementing Tusla's own policy with regards to the vetting and re-vetting of foster carers. In one service area, there were 16 households which consisted of 20 individuals where foster carers were not re-vetted as per Tusla policy. In the other service area, there were 43 households consisting of 73 individuals where foster carers and adult members of their households were not re-vetted in a timely manner, with a number significantly overdue.

Foster carers told inspectors that they had received the appropriate training and were knowledgeable about how to recognise and respond to the possibility of bullying, abuse or neglect of children. However, in one service area, 16 foster carers who had children placed with them had not completed Children First (2017) training, which was not in line with national guidance.

Allegations against foster carers received an appropriate response and were well-managed in line with Children First (2017) in one service area. There were effective systems in place to ensure that complaints, concerns and allegations were recorded, managed and tracked until a final outcome was reached. However, this required significant improvement in the second service area as allegations against foster carers were not being screened in line with Tusla policy.

A significant finding in one service area was that a high number of children's files sampled were not updated in a timely way. As such, there was a potential risk that important information about children's safety could be missed.

Across both service areas there were a total of 31 foster care households where the number of unrelated children placed exceeded standards. There were good oversight systems in place to mitigate the impact of this on the children being placed, existing children in the placement and on the capacity of the foster carers.

4.2.6 Management and monitoring of foster care services findings

Both service areas were managed by experienced managers who had overall responsibility and authority for the delivery of the service, under the direction of a regional chief officer. Staff vacancies impacted the capacity of the children in care teams that resulted in 21 children in one service area and 12 children in the other service area who did not have a professionally-qualified social worker allocated to them, in line with national standards. Three unallocated cases in one service area were assigned to social care staff, known as secondary workers. These staff were supported and supervised by managers to ensure consistent care and support was provided to children. In some cases, statutory duties were carried out by the managers to ensure compliance with regulations and standards. Similarly, a total of

eight foster carers in one service area had no allocated fostering link worker. In the other service area, there was one dual unallocated foster care household.[5]

While the governance arrangements and management structures in one service area were clearly defined, improvements were needed to ensure learnings from audits and action plans were consistently implemented, and that performance data was accurately reported. However, issues relating to information governance and Tusla's case management system[6] were found to be impacting on the effective oversight of service provision and risk, in one service area.

Across both service areas, oversight mechanisms for safeguarding practices that included the tracking and monitoring of Garda vetting and, in one service area, completion of Children First (2017) training by foster carers, required significant improvement.

4.2.7 Recruitment and retention of an appropriate range of foster carers findings

Retention and recruitment strategies were in place. However, both service areas did not have a sufficient number of foster carers to meet the needs of all the children in the area who required foster care placements. A total of 28 foster carers across both service areas had left the foster care panel voluntarily in the 12 months prior to the inspections. Exit interviews completed demonstrated a variety of reasons for leaving, such as the ageing out of children placed with carers, family circumstances and the age profile of the foster carers. The feedback received at these interviews were used to inform practice regarding training, support, supervision, recruitment and retention of foster carers.

4.2.8 Conclusion

Overall, the key findings from these two foster care inspections demonstrated that there was a high level of compliance in respect to children's rights and the assessment of children and young people. Both services were challenged with the lack of available foster carers which impacted on the matching process.

Safeguarding and child protection required improvement with regard to systems of tracking and monitoring the Garda vetting and vetting renewal of foster carers.

Information governance and data integrity in both service areas required improvements as there were inconsistencies with data provided and data published in respect to children in foster care without an allocated social worker.

[5] Dual unallocation is where neither the foster carer nor the child in placement with them had an allocated social worker.
[6] Tusla case management system is the digital front door for referrals, notifications or submissions to Tusla services.

Notwithstanding the strategies in place, recruitment and retention of foster carers remained a challenge in both services to meet the changing and diverse needs of children.

4.3 Foster care – Separated Children seeking International Protection (SCSIP) - inspection and monitoring findings

The primary function of Tusla under the Child Care Act 1991 is to promote the welfare of children who are not receiving adequate care and protection. When children arrive in Ireland who are separated from their parents and are in need of international protection they come under the remit of Tusla. Some of these children have experienced significant trauma. The children are assessed by a child protection and welfare social worker to ascertain if they are eligible to receive services from Tusla under the 1991 Act and in line with European definitions of a separated child and unaccompanied minors. If they are deemed eligible, they may receive services under various sections of the 1991 Act.

The previous inspection of this service in November 2023 found serious concerns about the capacity and capability of the foster care service and the impact this was having on children receiving a statutory service. The oversight and governance structures required strengthening, unallocated children were not visited in line with the standards and regulations, information systems did not support or facilitate the development and planning for the service, some safeguarding measures were not being adequately managed and the Children First (2017) reporting process was not adhered to. Data provided to HIQA prior to inspection demonstrated that the service had 18 separated children in foster care and had 10 approved foster carers. At the time of inspection, seven children had placements with the service's approved foster carers and 11 children were placed with non-statutory foster care providers (these are foster care services commissioned by Tusla) .

4.3.1 Key findings of the SCSIP inspection

The follow-up monitoring inspection of Tusla's foster care service in SCSIP team found that of the eight national standards assessed, one standard was compliant, two standards were substantially compliant and five standards were not compliant. The report of this inspection, was published on 13 March 2025 is available at www.hiqa.ie.

The inspection in 2024 found that the service had made some positive changes; these included the review and development of governance structures for the management and monitoring of the foster care service, all children in foster care had an allocated social worker and there was more effective auditing of foster carer files. In addition, improvements were also found with regard to care planning and review processes, case transfer processes, statutory support visits and the quality of the

associated records. Notwithstanding the improvements made, there were essential aspects of the foster care service that required further development and action. These included:

- care planning
- children's records
- information governance
- fulfilment of social worker's statutory responsibilities for children
- ensuring the service operated in line with Children First (2017)
- quality assurance systems
- the Foster Care Committee Chairperson was not independent of the management structure of the service as required by Tusla's policy and procedure
- due consideration of long-term placements for children in foster care.

In summary, some of the improvements in services provided to children and foster carers were, at the time the inspection took place, too recent to determine if the service could sustain the improvements. All of these factors impacted on the service's ability to deliver a safe and effective foster care service for children and foster carers.

4.3.2 What children, parents and foster carers told us about their experience of the foster care services

Children's experiences were established through speaking with a total of nine children, 31 foster carers and four parents across the three foster care inspections completed in 2024. Reviewing children and foster carer case files, complaints and records also provided additional evidence on the experience of children in foster care. Children were also observed by inspectors in the SCSIP service as they waited in the reception area to meet with a social worker.

Overall, children spoke highly of their social workers and other professionals working with them and said that they felt listened to. They said that they were aware of who to talk to if they have any issues or concerns. The majority of children said they were involved in decisions about their care and that their views were regularly sought. All children expressed a good understanding of the child-in-care review process. They felt their rights were respected as they were encouraged and supported to participate in decisions made about their lives and their care and to engage in education and a variety of other activities and interests. For the most part, children were visited by social workers in line with regulations, with some visits slightly overdue. Where children did not have an allocated social worker, a secondary worker such as a social care worker was assigned to them who was supervised by a social work team leader.

Some children gave feedback about areas for further improvement, for example, the need for social workers to revisit the information about children in care with them because this "information was given prior to their coming into care" and they were "too young to remember".

Inspectors spoke with a total of 31 foster carers and four parents across these three foster care services who gave mixed feedback on how children were supported by the respective services. While the majority of foster carers said that children placed with them were getting a good child-centred service that promoted children's rights, others noted that more could be done to support children in their care.

Overall, foster carers were well supported to care for the children placed with them, and that children with complex needs received additional supports as required. Their views on the matching process were positive and reported that they were given the necessary information about the needs of children placed with them and their capacity to meet the children's assessed needs was taken into account. Foster carers had access to training to further improve their knowledge and awareness for the safety of children in their care. Many said that they had positive relationships with birth parents and facilitated family contact as appropriate, which had enabled a good experience for the children and supported a collaborative approach to meeting their needs.

The views of four parents were received from across the two service area inspections, and these parents expressed mixed views about their experience of foster care services. All parents told inspectors that their views were sought about the care of their children and were involved in the child-in-care review process. However, not all parents were provided with regular updates about their child's care.

5. Risk-based monitoring programme examining Tusla's governance and management of child protection and welfare service and foster care services

Tusla has statutory responsibility to protect children and promote their welfare under both the Child Care Act 1991 and the Child and Family Act 2013. Child protection and welfare services and foster care services are provided by Tusla in 17 service areas located within six regions across the country. In response to recurring non-compliances and significant risks identified within the child protection and welfare and foster care services, and following discussions with Tusla, HIQA made the decision to conduct a programme of risk-based inspections of those services presenting at the highest level of risk nationally. In September 2023, Tusla was informed that all services with 25% or more unallocated cases would be included within this programme. It was agreed that HIQA would undertake this provider risk-

based approach with a requirement on Tusla to produce and submit a national service improvement plan, which detailed actions to address risks presenting within the services meeting the criteria for inclusion in the programme.The risk-based programme identified 10 Tusla service areas across the country where at least 25% of children had not been allocated a social worker in child protection and welfare and or foster care services. Inspections were carried out in these 10 service areas from February to May 2024. During this time, Tusla worked in cooperation with HIQA throughout the programme. Monthly meetings chaired by HIQA were attended by representatives of Tusla's executive management team, regional Tusla chief officers and area managers, and HIQA staff. Tusla presented updates on the progress of its national, regional and local service plans at these meetings.

5.1 Key Findings of the risk-based child protection and welfare and foster care inspections

The *Overview Report on the Governance of the Child and Family Agency (Tusla) Child Protection and Welfare and Foster Care Services* (published on 17 January 2025) is available at www.hiqa.ie.

Positively, when children were allocated a social worker, the quality of services provided to them or for their benefit was good. Inspectors observed examples of good practice and support being provided to some unallocated children, and also identified areas that required improvement, especially in the completion of preliminary enquiries and the timely assessment of children. Tusla was more effective at managing unallocated children in foster care than children waiting for a child protection and welfare service.

The majority of children spoken with who were receiving a child protection and welfare service had an allocated social worker were satisfied with the level of contact and the support they received from them. Positive feedback from parents included that their children received an appropriate and good quality service, which in their view promoted the rights of children and met their family's needs in a timely manner. Foster carers in some areas told inspectors that they felt listened to and were involved in discussions in relation to child-in-care reviews and care plans.

However, HIQA identified a number of challenges across service areas which were impacting on the delivery of timely, consistent care and support to children. Due to resourcing issues and an increased demand on its services, Tusla was challenged to deliver the right service at the right time to children and their families.

There were significant delays in children receiving a social work service, including from the management of new referrals through to providing statutory services to children in foster care. Improvements were required to ensure services were consistently implementing Children First (2017) and adhering to Tusla's standard

business processes particularly in relation to the completion of initial checks, preliminary enquiries and initial assessments. In some areas, there were significant time delays in establishing that a safety plan was required for children who were on waiting lists from the point of referral to initial assessment.

Inspections found that, overall, the full impact of Tusla's national service improvement plan and associated actions was not clear due to the different degrees of implementation of actions across the services at the time of the inspections. Improvements were required at an operational level to ensure that effective governance and supports are in place at regional and local levels.

Over the course of the risk-based monitoring programme, risks to 107 individual children were escalated to the respective area managers in seven service areas. The majority of the escalated cases related to cases at all the stages in the management of child protection and welfare referrals and were unallocated but also included a number of cases that were assigned or allocated to either a social care practitioner or a social worker team leader. It demonstrated that not all children at actual or potential risk were being assessed in a timely manner and, where necessary, protected by Tusla in a timely and effective manner. HIQA was satisfied with the assurances provided, which included visits to children, the creation of safety plans for children and the progression of assessment of child protection concerns.

During inspections, HIQA reviewed a sample of cases to determine if the systems which Tusla had in place to manage child protection referrals were effective and in line with national policy, standards, legislation and their own internal processes. Systems risks are identified where failures in these processes or not adhering to processes may mean that children have remained at potential risk – a situation which is unacceptable to HIQA.

HIQA escalated a number of systems risks to the regional chief officers, as eight service areas were not able to consistently fulfil their responsibilities to all children referred to the child protection and welfare service or placed in foster care due to increasing volume of new referrals and staffing capacity issues. Examples of these identified systems risks fell within the following categories:

- Governance
- Information governance
- Workforce
- Referral pathways
- Resources
- Notifications to An Garda Síochána

- Child Protection Notification System (CPNS)[7]
- Cumulative harm.[8]

Significant improvements are required to mitigate these risks and ensure the safety and welfare of children at actual or potential risk. The responses to these escalations were provided by Tusla at the monthly provider meetings with HIQA. However, the responses in two service areas did not provide the necessary assurances and, as a result, these risks were escalated to Tusla's CEO and executive management team, who provided appropriate assurances.

Overall, while there were examples of good practice in some areas, the risk-based monitoring programme found that some children were being left at potential risk due to failures at operational level to consistently implement Tusla's national policies and business processes. The findings demonstrated that Tusla is required to take action to ensure that it can consistently fulfil its statutory responsibility for the delivery of children's services and improve outcomes for children in participating service areas as there were variations in adherence levels with Children First (2017) and national standards to protect children and promote their welfare. Tusla's local and regional services were not consistently adhering to Tusla's own standard business processes, policies and procedures. The risks identified primarily related to the child protection and welfare services, in that there were more effective measures in place to manage unallocated children in foster care. In some cases, these failings led to a significant impact on some children and will continue to impact children in the future, unless these systemic risks are effectively responded to.

Governance and oversight of risk management, performance management, information governance and quality assurance systems required strengthening. Significant efforts and initiatives had been put in place by Tusla to recruit and retain staff, and at the end of the monitoring programme, Tusla was close to having all budgeted posts filled. However, this would not resolve Tusla's capacity issues and an inter-departmental approach is required to strategically plan for the resourcing and delivery of children's services into the future.

At a national level, Tusla developed a compliance plan to address the findings of this provider risk-based programme. The compliance plan outlined a vast range of

[7] The Child Protection Notification System (CPNS) is a national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern, resulting in each child being the subject of a child protection plan.

[8] Cumulative harm is the outcome of multiple episodes of abuse or neglect experienced by a child. It refers to the effects of patterns of circumstances and events in a child's life which diminish a child's sense of safety, stability and wellbeing.

measures and some aspects of the plan are scheduled to be implemented in 2026. An example of is the reconfiguration of all Tusla regions and service areas, along with changes to how their front door services[9] will operate from 2026. HIQA monitored Tusla's implementation of completed elements of their compliance plan through the inspection of services in 2025. Nationally, substantial work has been completed on the identification and management of cumulative harm of children. Some individual areas have managed to reduce wait lists for children in care and some had improved their oversight of unallocated cases in both child protection and foster care, while others have more work to do. The full impact of this programme will be clear at the end of 2026.

5.2 What children, parents and foster carers told us about their experience of the child protection and welfare and foster care services

Inspectors engaged with a total of nine children receiving a Tusla child protection and welfare service and 11 children in foster care as part of this risk-based monitoring programme. A decision not to directly contact children and their families who were waiting for a service was made by HIQA. This decision was made as there were many situations where the child protection service had not contacted families about the referral and it would have been inappropriate for HIQA to have contacted children and their families prior to this contact being made. Therefore, a decision was made to find out about the experience of these children and families who were not allocated from their case record.

The majority of children spoken with who were receiving a child protection and welfare service had an allocated social worker were satisfied with the level of contact with and support they received from them. When children were awaiting allocation in the child protection service, there was limited contact made with them, which meant that children did not have the opportunity to have their views heard or considered when decisions were made to allocate their case or keep their case on the waiting list for support.

Some children in foster care had an allocated social worker, while others were placed on a waiting list. Children who did not have an allocated social worker had their cases managed through various systems in different areas. This was due to the lack of a national approach to provide consistency to children requiring a social work intervention. There were negative impacts for many children when they did not have an allocated social worker or were not receiving an active social work service. This meant that children who were deemed at risk and requiring a social work service

[9] Tusla's front door service is where staff respond to initial contacts made by professionals who were concerned about a child.

were not adequately supervised to ensure the care they were receiving was safe and meeting their care needs.

Inspectors engaged with a total of 26 parents and 45 foster carers as part of this risk-based monitoring programme. Their views were obtained when possible and appropriate to do so.

Positive feedback from parents included that their children received an appropriate and good quality service, which in their view promoted the rights of children and met their family's needs in a timely manner. They said that they could call the social worker when they had any concerns and that they got a quick response from the social worker or someone on the social work team. They spoke about how changes to social workers allocated to their family was explained to them, and said that their children's voices had been heard. They felt involved in the decision-making process and that the social workers provided all the information they needed to understand the various processes. While the majority of parents viewed their experience of being involved with Tusla as positive, a number of parents expressed some dissatisfaction with the service they had received. They spoke about the change in social workers for their families and gaps in specialist services for children with high and complex needs.

Foster carers in some areas told inspectors that they felt listened to and were involved in discussions in relation to child-in-care reviews and care plans. They spoke about the importance of children having a consistent primary worker, being either a social worker or social care practitioner. Some foster carers raised concerns in relation to the frequent changes in social work allocation and the lack of consistency for children during their time in care.

6. Regulation of special care units

6.1 Monitoring and inspection findings

There are some children and young people for whom, at particular times in their lives, care in the community cannot adequately meet their needs. Special care units are secure (locked) facilities where children and young people aged between 11 and 17 are placed by a High Court order in response to the risk they may pose to themselves and or others. There are three special care units in Ireland, all of which are operated by Tusla and together are registered to accommodate a total of 17 young people. The Chief Inspector in HIQA began the registration and regulation[10] of special care units as designated centres on 1 January 2018, with three units registered by November 2018. Each unit's registration was renewed again in 2021 and in 2024. In 2024, we completed five inspections of special care units. Three inspections, one in each special care unit, took place for the purpose of informing registration decisions on the foot of applications to re-register each of the three units, and two additional risk-based inspections of one special care unit, for which significant risks were identified in June and November 2024.

HIQA conducted full announced inspections of all three special care units in June 2024, to inform a decision on the registered provider's application to renew the registration of the special care units. Each inspection assessed compliance with 29 regulations. Across the three special care units, inspectors found that children received good quality care and support that was child centred, rights based and responsive to children's individual needs. There were good oversight and risk management measures in place in all three services to ensure the safety of the children living there. For the two risk-based inspections of one special care unit, improvements were required in the provider's approach with regards to the review of serious incidents and to strengthen safeguarding in the service, as managers did not consistently identify safety risks for children. One special care unit was found to be compliant with 25 regulations and substantially compliant with four regulations. Inspectors found that the staff and management team were committed to helping children to grow and learn, and strived to achieve the best possible outcomes for them.

Children who spoke with inspectors expressed a positive view of the service they received and reported feeling safe living in the centre. Overall, there were good levels of compliance, with improvements required in relation to fire safety. A second

[10] Where the Chief Inspector refers to 'regulation' in this section of this overview report, it includes inspections, review of information submitted by the special care unit, information held about the unit and ongoing review of information. This is all taken into account when the Chief Inspector is assessing compliance with regulations and standards.

special care unit was found to be compliant with 23 regulations, substantially compliant with four and not compliant with two regulations. Children were positive about the care they received and told inspectors that they felt safe and listened to.

There was good quality regular supervision for staff. While risk management systems were in the main effective, improvement was required in some areas and these were identified on the risk register; for example, the risk associated with a lack of onward placements for children, staffing issues and safeguarding issues. While measures to protect children from the risk of fire were in place, improvements were required in some areas to ensure the service fully complied with regulations. Substantial progress was made in relation to the special care unit which had been subject to a previous unannounced inspection in March 2024, as the centre was found to be compliant with 19 regulations, substantially compliant with eight, and non-compliant with two regulations in June 2024. Improvements in the provision of training for staff was found to have a positive impact on the service provided to children. However, additional improvements were required with regard to the frequency of supervision for managers and fire safety measures to ensure full compliance. Tusla submitted a satisfactory compliance plan to address the regulations that were deemed substantially compliant or not compliant for each of the three special care units.

The profile of children being accommodated and cared for within special care continued to evolve as the complexities of their needs were increasing. This compounded the challenges in identifying appropriate onward placements for many children. As such, some children remained in special care despite the fact that they no longer required a special care placement. At the time of the inspections in 2024, none of the special care units were operating at full capacity in line with their statements of purpose, primarily due to staffing levels. This was a long-standing issue for these services which had not been addressed despite efforts undertaken by management and the provider to recruit staff. Each of the special care units were operating at 50%, 60% and 75% of their capacity, respectively.

In summary, the majority of children received good quality care and support and their safety and wellbeing was a primary consideration in all decisions that were made about their care and the interventions that were implemented to help each child to fulfil their potential. Furthermore, all special care units were required to make improvements to fire safety measures in the centres. The registered provider had commenced a review of the national set of policies and procedures in 2023; however, at the time of the inspections, this had not been completed as required by regulations.

6.2 What children and parents told us about their experience of special care

Across the three special care units, inspectors engaged with a total of 14 children, this included two children who were met more than once during the three inspections of one unit. For those who exercised their right not to engage with an inspector, opportunities to observe children's interactions both with staff and with each other occurred throughout the course of the inspections. Children were provided with opportunities to take part in a variety of activities to support their development, including off-site activities. Overall, the children were very positive about their experience of the special care units. The majority spoke highly of the staff and the relationships they had built with them, and felt safe and listened to. However, some children said they did not want to live in special care and felt some aspects of the service were unfair.

Across two of the three special care units, inspectors engaged with two parents and two other family members. Similar to the feedback from the children, parents and family members were also positive and felt that the children were being kept safe while in the special care unit. They spoke of how supportive the staff were of family contact, helping them build and maintain relationships with the young people. They felt their children were progressing well and understood that restrictive practices were a feature of special care which were only used when necessary and in order to keep their children safe. However, one concern was expressed with regards to the child's safety when the time came for them to leave the special care unit, but also felt that staff were helping children to prepare for when that time comes.

What children 'liked' about living in special care units

What children 'found hard' about living in special care units

7. Oberstown Children Detention Campus

Oberstown Children Detention Campus is a national service that provides safe and secure care and education to young people aged between 10 and 18 years who have been committed to custody after conviction for criminal offences or remanded to custody while awaiting trial or sentence. The service provides care, education, training and other programmes to support young people to improve their decision-making capacity, to move away from offending behaviour and prepare them to return to their community following their release from detention.

The service is managed by a Board of Management who have direct governance of the campus in accordance with policy guidelines laid down by the Minister for Children, Disability and Equality, in accordance with the Children Act 2001 (as amended).

HIQA inspects Oberstown Children Detention Campus annually under Section 185 and Section 186 of the Children Act 2001 (as amended), and against the Oberstown Children's Rights Policy Framework which consists of 12 rules, implemented since 2020. The 2024 inspection focused on eight of the 12 rules which included the care provided to children, safeguarding, health, education, preparation for leaving care, management and oversight of staff and restrictive practices. Of the eight rules assessed, four were compliant, two were substantially compliant and two were not compliant.

The 2024 inspection found that the provider was making improvements following significant risks that were identified in relation to safeguarding practices, including deficits in the management and monitoring of child protection concerns, gaps in oversight of restrictive practices and poor recording of incidents and significant events during the inspection in 2023. Improvements made included monitoring and oversight systems with regard to child protection and welfare concerns, the recording and tracking of concerns and the management of mandated reports in 2024. Other improvements that were in progress related to mechanisms for ensuring appropriate use of and monitoring of restrictive practices, specifically, single separation.[11]

On the 2024 inspection, inspectors found that the service was well-managed with clear lines of authority and good ongoing oversight and monitoring of campus operations by the senior management team. Arrangements for governance and management of child protection and welfare concerns, as well as the related oversight of practices, had improved in the nine months since the previous

[11] Single separation refers to the confining of a young person in his or her bedroom or another room or area as a means of control, without the young person's permission or agreement.

inspection. However, further improvements were needed, as the procedures for reporting child protection concerns by mandated persons were not being implemented in line with requirements. In addition, not all relevant staff had received up-to-date training in Children First (2017), as required. The service struggled at times to provide sufficient numbers of staff to meet the needs of young people and to facilitate attendance at mandatory training.

Young people were positive about the care they received, they felt listened to and were included in decision-making about their care. They were aware of their rights and who they could talk to if they had any worries, and had access to external advocacy services who visited the service. They were provided with educational, vocational and recreational programmes which were appropriate to their needs, with opportunities afforded to them to complete courses and obtain qualifications.

Inspectors found improvements in planning with young people for their life after detention as they were supported to complete a personal development programme which aimed at assisting them to develop social skills, encourage self-awareness and build their knowledge and confidence to navigate day-to-day living challenges. For young people who were transferring to the Irish Prison Service, transfers to prison were managed well, with a collaborative approach taken between the campus and the prison service.

There were instances when young people were subject to restrictive practices such as single separation and the criteria of exceptional circumstances and for the shortest period of time were not adhered to. While there were some improvements to practices relating to the management of incidents of the use of single separation, the need for significant improvements remained. Management oversight of restrictive practices did not ensure that their use was in line with the children's rights policy framework at all times and records of incidents involving the use of restrictive practices required further improvement. In addition, actions from the previous inspection relating to the development of procedures and guidance documents for the use of physical interventions had not been implemented within agreed timelines, which continued to impact young people's rights.

Fire safety improvements noted on previous inspections had been sustained, and established fire safety management systems were maintaining adequate fire precautions. Security systems were effective and there was good oversight of the management of keys, access to and maintenance of handcuffs and vehicles.

In summary, the 2024 inspection found that progress had been made in addressing the risks identified in the previous inspection in 2023, such as improvements to governance and oversight arrangements, staff supervision, updated procedures and better quality record-keeping. The findings from the 2024 report will inform the inspection of this service in 2025.

7.1 What young people and parents told us about their experience of Oberstown

Inspectors had the opportunity to meet with 28 young people residing in the service. In an effort to ensure all young people had the opportunity to participate in the inspection, surveys were sent to all the young people asking about their experience in the campus prior to the inspection. Thirty-five young people completed the surveys. Inspectors spent time in all of the residential units and observed interactions between staff and young people, as well as observing young people's meetings and a number of their activities.

Overall, young people were positive about the care they received. The vast majority of them said they were given support and information when they first arrived and that staff listen to them and they feel included in decision-making about their care. Additionally, they spoke positively about healthcare supports provided to them and liked attending the on-site school. They were aware of their rights and who they could talk to if they were worried or felt they were not being treated right, such as their key worker and the advocacy officer. However, some young people expressed frustration and dissatisfaction with regards to missing periods of time in school due to behaviours that challenge and how these incidents were dealt with. They also expressed dissatisfaction with staffing levels, particularly at the weekends, which they felt impacted on their activities.

Inspectors spoke with six parents who were generally positive about the service provided in Oberstown, and talked about how well the young people were doing and how supportive staff were to them. Parents said that communication was good and they felt included in decision-making about the young people as they were invited to relevant meetings and were informed of any incidents of restrictive practice. Parents believed the young people were safe and praised the experiences they had with education while in Oberstown. No areas for improvement were identified by the parents.

What children 'liked' about living in a detention centre

What children 'found hard' about living in a detention centre

8. Receipt of information

The Chief Inspector receives notifications from Tusla relating to designated centres for special care as well as non-regulated children's services. It also receives unsolicited information from people who have a concern about services provided to children.

8.1 Notifications relating to special care units

During 2024, 209 notifications were received from Tusla relating to designated special care units. These are notifications that special care units are required to submit to the Chief Inspector within specified time frames.

The majority of notifications received in 2024 were those prescribed in the care and welfare regulations for special care units and which are termed 'monitoring notifications'. They primarily related to issues such as absconsions, allegations of abuse and times when children were injured and required medical attention. Figures 3 and 4 below provide breakdowns of these notifications.

Figure 3. Number of monitoring notifications received from designated special care units by type of notification

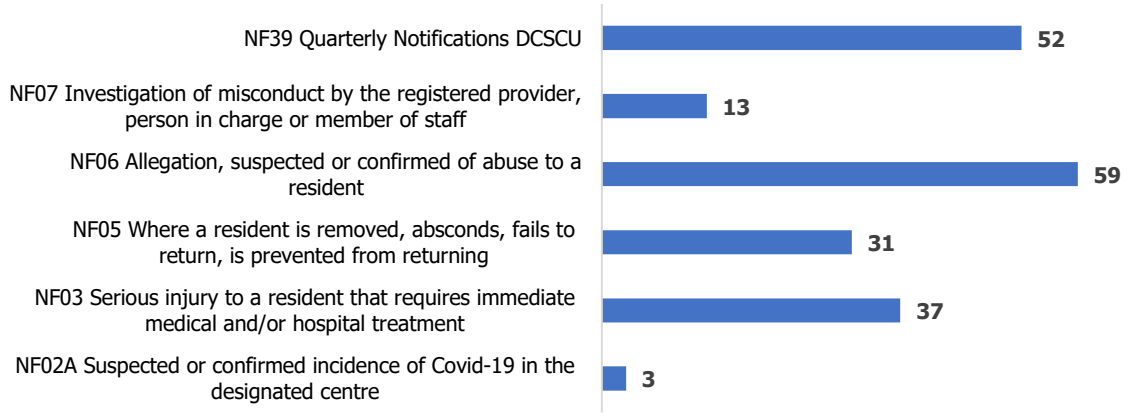
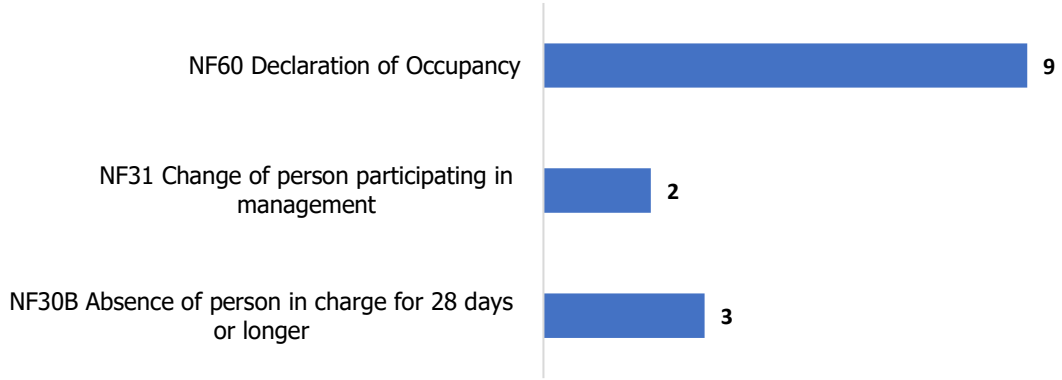


Figure 4. Number of registration related notifications received from designated special care units by type of notification



8.2 Other notifications from Tusla

Notifications of serious incidents involving children who are known to Tusla's child protection and welfare services, including the deaths of children in care, are submitted to HIQA by Tusla within three working days of the death or serious incident happening.

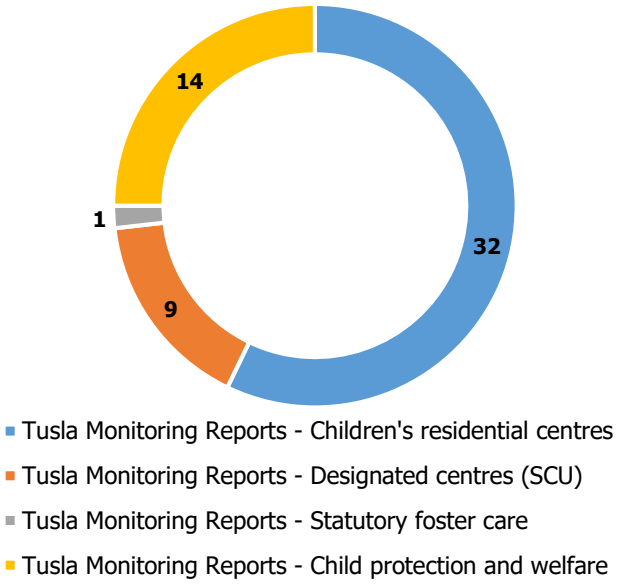
In 2024, HIQA received 25 notifications. Rapid or local reviews are carried out by Tusla following such incidents. These incidents are also referred to the National Review Panel[12] for a decision in relation to carrying out a further review.

As with all information received in 2024, reports of rapid or local provider-led reviews into these incidences were risk assessed by HIQA, and informed HIQA's regulatory activity in regard to the specific service area concerned.

HIQA also received 56 Tusla monitoring reports. Monitoring reports are completed by Tusla's Practice Assurance and Service Monitoring Team to provide assurances to Tusla's executive management team and board on the quality and compliance of services provided by or on behalf of Tusla. On receipt of these reports, they are reviewed, risk assessed and used as information to inform inspection activity.

[12] This is an independent panel established in 2010 to review serious incidents, including the deaths of children in care and those known to the child protection system.

Figure 5: Tusla monitoring reports received January to December 2024 by service type



8.3 Unsolicited information

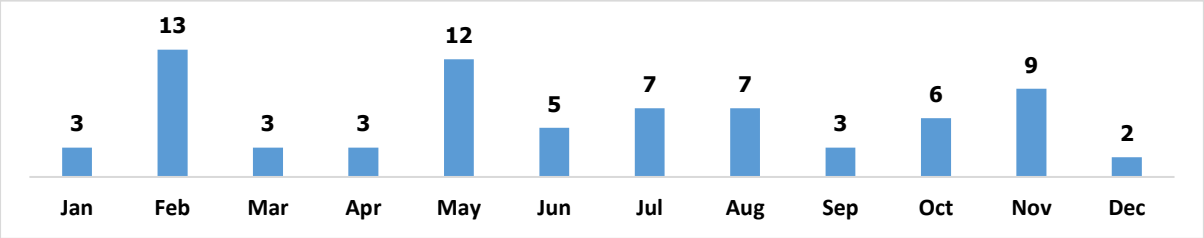
The Chief Inspector welcomes feedback about people's experiences of services to inform the assessment of the quality of care received within children's social care services. This information is referred to as unsolicited receipt of information (UROI) and can be received from children, their family members or advocates, health and social care professionals, employees and the general public.

While the Chief Inspector has no legal remit to investigate an individual complaint about care under the Health Act 2007 (as amended), it uses this information to monitor the quality and safety of care. All information received is reviewed, risk-rated and used alongside the other information gathered about a service to inform regulatory judgments.

This section of the report sets out a detailed analysis of all unsolicited information HIQA received in 2024 about children's social care services under its remit. It also sets out how HIQA used this information to inform its work. HIQA has a legal mandate to register and regulate three special care units and inspect Tusla's 17 child protection and welfare services, its 17 foster care services, its out-of-hours social work service, its child protection and welfare and foster care services for separated children and 42 statutory children's residential centres. In addition, HIQA monitors and inspects five non-statutory foster care services and Oberstown Children Detention Campus.

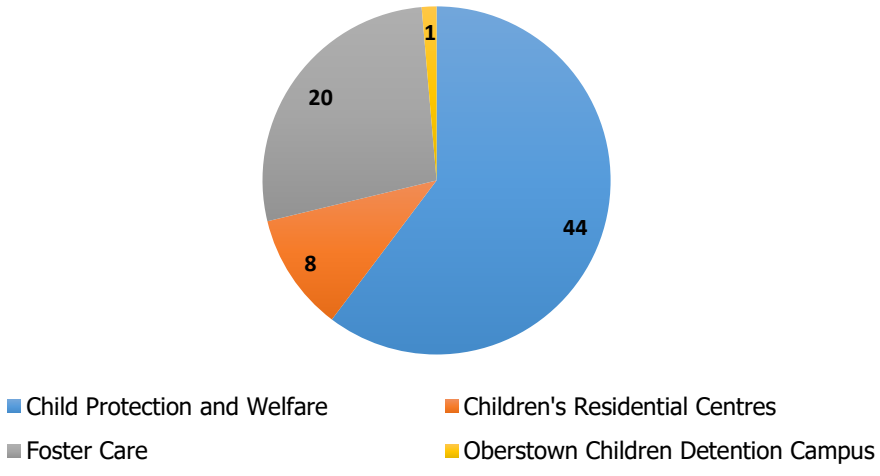
During 2024, the Chief Inspector received 1,769 pieces of unsolicited information, of which 73 (5%) related to children's social care services. Compared to the 93 pieces of unsolicited information received in 2023, this represents a 24% decrease in the volume of feedback received in 2024.

Figure 6. Number of Children's UROI received per month during 2024



Of the 73 pieces of feedback received, 44 (60%) related to child protection and welfare services, 20 (27%) related to foster care services, eight (11%) related to children's residential centres and one (2%) related to Oberstown Children Detention Campus (see Figure 7).

Figure 7. UROI received by service type for children's services in 2024



8.4 Qualitative review of feedback received

Of the 73 pieces of feedback received in 2024, 65 (89%) included themes under both the quality and safety and capacity and capability domains. These are the dimensions that the Chief Inspector uses to present regulatory findings in inspection reports. One UROI identified themes under the capacity and capability domain only. One UROI was complimentary feedback received from a foster carer, highlighting their satisfaction with the communication and governance and management within a foster care service. Six (8%) UROIs were created based on internally-generated surveillance.

Due to the smaller volume of UROIs generated for children's services, they have been analysed against service type to identify any trends in that particular sector or area of children's social care services.

When HIQA receives unsolicited information in relation to services within its legal remit, or the legal remit of the Chief Inspector, it is reviewed by an inspector. The inspector assesses whether there are any trends or patterns that suggest something is happening in a service that falls outside of what is expected in the national standards or what is required under the regulations. In many cases, the inspector will seek additional information and assurance from the service provider about the issue of concern. In responding to unsolicited information in 2024, inspectors:

- sought additional information on the issue
- requested plans from the service provider outlining how the issue would be investigated and addressed
- used the information to inform what areas of practice we would assess on inspection.

Where the information indicates that children's welfare may be at risk, HIQA reports the incident to Tusla in line with Children First (2017) requirements.

HIQA also receives information about services that are not within its remit. Whenever this happens, the person is offered advice as to the organisation best placed to address their concern; for example, the commissioner or provider of the service, the Office of the Ombudsman or the Ombudsman for Children's Office.

9. Stakeholder engagement

9.1 Children and their families

A key element of HIQA's process is to seek the views of the children and young people using each of the diverse range of children's services we monitor and inspect.

Children's experience of the services, the impact of services on their lives and their views on what is working well or what could be improved, provide vital insights to inspectors and are fundamental considerations which inform judgments on inspection. While every effort is made to speak with as many children as possible, children's right to engage or not in the inspection process was respected. In such circumstances, it was still possible to represent their experience of care, through observations of interactions between them and their carers, examination of how their views and wishes are sought and recorded within files and through speaking directly with their carers or guardians.

Across all services inspected in 2024, inspectors engaged directly with a total of 147 children and young people. Of this number, 66 were children in residential care, 20 children were in foster care, nine children who were supported by child protection services, 38 children in Oberstown Children Detention Campus and 14 in special care units. Inspectors also spoke with a sample of parents and or guardians, foster carers and other professionals such as guardians ad litem as part of our inspection activity.

Improving and expanding engagement and interaction with children and young people is a key driving force behind our work. During the summer of 2024, HIQA ran a competition to design the cover of HIQA's 10 years of regulation and monitoring children's social care services report. It asked children to design a poster on the care and support they receive from children's social services under the theme of 'Hear my voice'. This provided another opportunity to showcase the extraordinary talent of children in receipt of care across Tusla services, as well as an opportunity for children to tell inspectors about their experiences.

9.2 Department of Children, Disability and Equality

HIQA continued to engage with the Department of Children, Disability and Equality[13] during 2024 to inform our regulatory and monitoring remit.

Every three months, operational meetings are held between the Chief Inspector and the Assistant Secretary General of the Child Policy and Tusla Governance Division and Department officials. There meetings are used to exchange relevant updates and information on good practices as well as actual or potential risks across the sector.

Hub na nÓg, which comes under the auspices of the Department of Children, Disability and Equality, provided workshops to HIQA staff on the inclusion of disabled children and young people in participation in decision-making.

9.3 Child and Family Agency (Tusla)

Regular meetings with the CEO of Tusla and members of Tusla's senior management team were held to share information such as regulatory developments, risks, practice issues and service delivery developments.

Stakeholder meetings were held with staff from special care units, statutory foster care and child protection and welfare services in relation to the registration process for special care units and the programmes of inspection.

9.4 Oberstown Children Detention Campus

The chair of the Oberstown Children Detention Campus Board and the Campus Director met with the Chief Inspector and senior HIQA staff during 2024 and discussed service developments, risks and sharing of information.

9.5 Other stakeholders

Other stakeholders and professionals engaged with throughout 2024 included:

- The Ombudsman for Children
- EPIC – Empowering People in Care
- Department of Education and Science Inspectorate
- Academics at University College Dublin, Trinity College Dublin and University College Cork
- An Garda Síochána
- The Children's Rights Alliance
- The European Committee for the Prevention of Torture
- MECPATHs – an organisation which focuses specifically on the issue of child

[13] Previously the Department of Children, Equality, Disability, Integration and Youth.

trafficking in Ireland

- Penal Reform International Organisation regarding data for monitoring the safety of imprisoned children project (Data MOSAIC).

10. Conclusion

During 2024, HIQA found that children living in statutory residential care, foster care, special care and detention were receiving good quality safe care. For children in receipt of a child protection and welfare service, HIQA found that when children have assigned staff members who are allocated to work directly with them, that the majority of children received a good service. There are many aspects of children's services that are working well and which have improved over the last number of years. Examples of child-centred good practice were found throughout all services and the promotion of good safeguarding practice was central to the work of all staff. Nevertheless, there continues to be challenges which are having an impact on the experiences of some children. The majority of inspections of children's services in 2024 illustrate incremental improvements despite services being under significant pressure due to a range of issues, such as staff vacancies, lack of regulated alternative care placements and increasing referral rates across all service types.

Similar to last year's report, it is increasingly apparent that there is a need to urgently build in additional capacity within children's alternative care services (foster care, children's residential centres and special care units) in order to ensure that there is a range of appropriate regulated placement types available to meet children's specific needs. There are some children living in unregulated special emergency accommodation and many of these children have complex needs. Special emergency accomodation does not fall within the remit of HIQA, but we have raised concerns in relation to its use with Tusla, who have outlined that they have strengthened their governance of these arrangements. The number of statutory children's residential services had not altered significantly over the years, and at the end of 2024 there remained 37 statutory children's residential centres. By November 2025, Tusla had opened five new centres, with plans for more.

Despite these challenges, managers and staff have remained committed to continuing to improve their services and, in general, our regulatory approach highlighted that:

- There was a high level of compliance in respect to children's rights.
- The majority of children who were allocated a social worker and or social care worker or key worker received good quality care and support, their safety and wellbeing was a primary consideration in all decisions that were made about their care and the interventions that were implemented to help each child to fulfil their potential.
- Tusla had more effective systems in place to manage unallocated children in foster care than to manage children waiting for a child protection and welfare

service.

- There were improvements with regard to Tusla ensuring that it fulfilled its statutory duties to children in care in areas such as statutory visits and child-in-care reviews.
- There was an increase in the number of cases allocated to social care staff who were supervised by social work team leaders and generally, these arrangements worked well.
- Despite the implementation of intensive recruitment and retention initiatives by the statutory provider of child protection, foster care and residential services, some children's quality of service continued to be impacted by staff vacancies.
- While some progress had been made in addressing risks identified in previous inspections, management practices and governance arrangements were found to be varied in their quality and effectiveness across services.
- Some children were being left at potential risk due to failures at operational level to consistently implement national policies and business processes.
- Finally, an inter-departmental approach is required to strategically plan for the resourcing and delivery of children's services into the future.

10.1 Looking ahead

As highlighted in our *'10 Years of Regulating and Monitoring Children's Social Care Services 2014 – 2024'* report published in December 2024, HIQA relies on its reporting and escalations systems to address significant risks to children. Over the course of 2024, individual risks to children and systems risks were identified in services, and a national programme of risk was completed with Tusla resulting in Tusla devising a further national improvement plan for its child protection and welfare and foster care services. A significant part of our work in 2025, focused on whether Tusla's national improvement plan has driven improvement in its child protection and welfare and foster care services for children.

The identification of learnings and their implementation is the responsibility of the providers of services, and HIQA hopes to see the implementation of learnings across all of the services that we inspect. In addition to revisiting Tusla services that were part of our risk-based approach in 2024, we will also complete some routine inspections of foster care services and child protection and welfare services and statutory children's residential centres to review compliance against national standards.

As a regulator, it is essential that we drive quality improvement across the services that we monitor and regulate. During 2025, a thematic safeguarding programme of inspections was commenced by HIQA in children's residential centres that have good levels of compliance, with the purpose of this programme to drive further improvements in the sector. In addition, a thematic methodology of inspection focusing on the use of restrictive practices in special care units was devised and inspected against in 2025. Similarly, our inspection of Oberstown Children Detention Campus will focus on the service's progress in governance, safeguarding and restrictive practices.

HIQA has experienced challenges in finding out the views of children in child protection and welfare services in particular, and we have identified the need to review how we consult with children as part of our inspections. HIQA has set up a project to complete this work and a literature review of best practice in this area is underway. The outcome of this will inform our next steps in further developing and implementing new processes for consulting with children during inspections.

There are significant changes on the horizon in relation to children's services. Changes in legislation, in standards and interagency cooperation must support the core goal that we are all working towards — providing children with services in the most effective, timely and safe way.

HIQA and the Chief Inspector continue to engage with the Department of Children, Disability and Equality on the expansion of the Chief Inspector's regulatory powers to other children's services which would strengthen HIQA's ability to drive improvements through the sector. Since 2007, legislation is in place for the registration and monitoring all children's residential centres to come under the responsibility of the Chief Inspector. However, the specific section of this legislation has yet to commence. Tusla, as both a commissioner of residential services for children and regulator of voluntary and privately-run children's residential services, supports these services in coming under the future remit of the Chief Inspector.

Finally, HIQA and the Chief Inspector wish to acknowledge the participation and cooperation of children, their families, foster carers, advocates, providers and staff during our inspections. We are committed to listening to the experiences of children and all those who support them to improve the way we work in order to enable providers to continue to improve the quality of children's services.

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

Published by the Health Information and Quality Authority.

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