DÁIL ÉIREANN

AN COMHCHOISTE UM LEANAÍ AGUS GNÓTHAÍ ÓIGE

JOINT COMMITTEE ON CHILDREN AND YOUTH AFFAIRS

Dé Céadaoin, 17 Bealtaine 2017

Wednesday, 17 May 2017

The Joint Committee met at 9 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Lisa Chambers,	Máire Devine,
Kathleen Funchion,	Joan Freeman.
Tom Neville,	
Jan O'Sullivan,	
Donnchadh Ó Laoghaire,	
Anne Rabbitte.	

Teachta / Deputy Jim Daly sa Chathaoir / in the Chair.

Findings of HIQA Statutory Foster Care Service Inspection Reports: Discussion

Chairman: Today we will hear from witnesses from the Health Information and Quality Authority, HIQA, on the matter of foster care service inspection reports. Thereafter, we will move into private session to deal with any housekeeping matters that arise.

I welcome Ms Mary Dunnion, director of regulation and chief inspector, and Ms Eva Boyle, inspector manager of HIQA's children's team. I thank them for appearing before the committee. I note Mr. Marty Whelan of HIQA is seated in the Gallery.

Before we commence, in accordance with procedure I am required to draw witnesses' attention to the fact that, by virtue of section 17(2)(*l*) of the Defamation Act 2009, they are protected by absolute privilege in respect of their evidence to the committee. However, if they are directed by the committee to cease giving evidence on a particular matter and they continue to so do, they are entitled thereafter only to a qualified privilege in respect of their evidence. They are directed that only evidence connected with the subject matter of these proceedings is to be given and they are asked to respect the parliamentary practice to the effect that, where possible, they should not criticise or make charges against any person, persons or entity by name or in such a way as to make him, her or it identifiable.

Members are reminded of the long-standing parliamentary practice to the effect that they should not comment on, criticise or make charges against a person outside the House or an official either by name or in such a way as to make him, her or it identifiable.

I remind members and witnesses to turn off their mobile phones as they interfere with the sound system and make it difficult for the parliamentary reporters to report the meeting, as well as adversely affecting television and web streaming. I advise the witnesses that any submissions or opening statements made to the committee will be published on the committee website after this meeting. I understand the witnesses will make a short presentation, which will be followed by questions from members of the committee.

I invite Ms Dunnion to make her opening statement.

Ms Mary Dunnion: On behalf of HIQA, I thank the committee for the invitation to address the Oireachtas Joint Committee on Children and Youth Affairs this morning. I am accompanied by my colleague, Ms Eva Boyle, who is an inspector manager in HIQA's children's team.

HIQA was established ten years ago today to improve health and social care services for the people of Ireland. Our role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered. HIQA has a statutory responsibility for monitoring and inspecting children's social services. These include children's statutory residential centres, special care units, child protection services and Oberstown Children Detention Campus. We are authorised by the Minister for Children and Youth Affairs under section 69 of the Child Care Act 1991, as amended by section 26 of the Child Care (Amendment) Act 2011, to inspect foster care services provided by the Child and Family Agency, Tusla, and by private providers and to report on our findings to the Minister for Children and Youth Affairs. We also have statutory responsibility for monitoring foster care services against

the national standards for foster care, published by the then Department of Health and Children in 2003.

HIQA began its monitoring programme of statutory foster care services in Ireland in 2007. By the end of 2016, all of the 17 foster care service areas in the country had been inspected. In 2014, we commenced a monitoring programme of private foster care providers in Ireland and had inspected all of these services by the end of 2016. The majority of children in the care of the State live with foster carers. At the end of 2016, Tusla reported that there were 6,258 children in the care of the State. Of those, 5,817 were in foster care and living either with relatives or with general carers.

Fostering services depend on families and individuals in the community who are willing to share their homes and lives with children and young people whose parents are unable to care for them on either a short or long-term basis. A child comes into the care of the State when it is assessed that he or she is at risk and requires care or protection or both. Tusla is responsible for the child and the foster parents do not have guardianship. When a child is placed in foster care, maintaining links with his or her own family is very important. The child's parents should be involved as much as possible and, as appropriate, should be kept fully informed of how the child is getting on. The child should see his or her family as much as possible. Even though he or she may live with another family, the child's identity and name is always his or her own.

Foster care services are provided by Tusla and six private foster care providers. At the end of 2016, Tusla reported that of the children living in foster homes 5,456 or 94% were in Tusla placements, while 361 or 6% were in private foster care placements. Children can be placed in foster care either voluntarily, when a parent or family consents to the child being cared for by Tusla or by court order or both, when a judge decides that it is in the best interests of the child to be placed in the care of Tusla.

When a child is placed in foster care, the national standards for foster care set out that the child should be assigned a social worker to monitor his or her growth and development and ensure that his or her best interests are considered at all times. It is important to note that at the end of the fourth quarter in 2016, Tusla reported that 465 children in foster care had not been allocated a social worker.

Tusla is required by law to make a decision on the type of fostering that is most suitable for the child based on the child's needs and circumstances. There are two different types of fostering. Short-term fostering lasts from one week to a couple of months, whereas long-term fostering involves the child being cared for by a foster family for a number of years and sometimes until the child reaches adulthood.

Foster care in Ireland is governed by the Child Care Act 1991 and two sets of regulations that govern the placement of children in foster care and the placement of children with relatives. In addition, the national standards for foster care provide a framework to ensure that children in foster care receive the best possible care.

HIQA inspects the practices and procedures of public and private foster care providers under the two sets of foster care regulations and monitors against the national standards for foster care. There is, however, no regulation of foster care. Although HIQA can inspect services and report its findings publicly, it does not have the legal remit to take action when it uncovers examples of poor or unsafe provision. I repeat that there is no regulation of foster care and that HIQA only fulfils a monitoring role. Its only recourse when it uncovers risk is to escalate the

situation to Tusla and the Department of Children and Youth Affairs.

HIQA carried out a total of 22 inspections of statutory foster care services between January 2012 and December 2016. A number of key themes emerged from these inspections. Many foster carers made a concerted effort to provide a child-centred service and to ensure the well-being of the children living with them. Family contact was supported by foster carers and social workers, in line with the children's care plans. Some areas for improvement were identified during inspections, including that it was not always possible to match children with suitable foster carers which resulted in some placements subsequently breaking down. In addition, we found cases where sibling groups were not being placed together and where children were placed with foster carers who lived away from their local community. Generally, we found that children received good quality care from foster carers and that the majority of children lived in safe, homely environments with caring foster carers.

Children were largely positive about their social workers. However, some children were frequently reassigned new social workers, which had a negative impact as it meant that the children had to build new relationships each time. As I mentioned, at the end of 2016 some 8% of children in foster care had not been allocated a social worker to support them. This meant that some children went unsupervised in their placements, with no social worker monitoring their care, progress or safety.

Tusla tries to keep children in foster care living within their families - this is known as relative foster care - or at least in their local communities. However, this is only possible when adequate resources are available. In the majority of service areas there were insufficient numbers of foster carers which resulted in some children being placed in overcrowded settings with carers who did not have the skills to take care of them. This contributed to unplanned placement endings and multiple placements, with little stability for the child. There were delays in the assessment and approval of a number of relative foster carers who had children placed with them. In 2016 this issue was escalated to Tusla in three of the four statutory inspections completed. Furthermore, the level of support provided for foster carers across statutory foster care services required improvement.

Significant safeguarding and child protection risks were identified in two statutory foster care services during 2016, namely, in the midlands and Dublin south central. These risks related to ineffective safeguarding practices to promote children's safety, including Garda vetting of all staff prior to commencing work for the service; and poor management of allegations made against foster carers. Where significant risks were identified during inspections, they were escalated by our team to Tusla for immediate action. Furthermore, there were inadequate systems in place to provide for oversight of allegations made by children in care against foster carers. Foster care committees were not always informed of child welfare concerns or child protection allegations. Unfortunately, this has been a recurring finding since 2013.

All of the foster care services inspected during 2016 needed to improve their governance and management systems, including risk management and oversight of care practices. The midlands and Dublin south central foster care services were found to be operating with significant risk, including poor accountability arrangements; ineffective management systems for risk management and staff supervision; and inadequate oversight of care practices. Furthermore, lack of service planning has been an ongoing finding in the majority of inspections.

Inspections have consistently identified vacant posts, particularly for social workers, and difficulties in the retention of the existing skilled workforce within foster care services. In ad-

dition, a significant number of managerial posts are temporary positions. All of this has had an impact on Tusla's ability to meet the demands placed on the effective provision of foster care services. Risk management systems varied and were in the early stages of development in some areas. Oversight and monitoring systems varied and some service areas had monitoring officers, while others did not. Inspections identified some oversight mechanisms, for example, file audits and audits of supervision of staff, but they were consistently not completed.

With the exception of emergency out-of-hours placements, Tusla did not have service level agreements in place with private foster care agencies. While inspectors found agreements in place which related to the placement of individual children, they were not sufficient to ensure effective oversight of the overall quality, safety or effectiveness of the service being purchased. This finding underlines the key role played by the funder in ensuring good quality services and, in the opinion of HIQA, lends weight to the argument in favour of a model of commissioning. The absence of an integrated information system within Tusla impacted on the capacity of managers to collate, manage and share information to support effective decision-making and promote continual improvement within the service.

As I mentioned, HIQA began its inspections of private foster care services in Ireland in 2014 and had completed all of them by the end of 2016. The overall findings of these inspections showed that the majority of services were well run and resourced, with good supports in place for children and carers. Safe care practice was found and children were generally content and settled in their placements. However, two of the six services were not managed to an adequate standard and this was reflected in the quality of training for staff and foster carers, support and supervision of carers and, ultimately, the stability of placements for children. As a result, some children experienced multiple placement breakdowns and unplanned placement endings.

Significant safeguarding and child protection risks were identified in one private foster care service last year. The risks related to ineffective safeguarding practices to promote children's safety, including Garda vetting of all staff prior to commencing work for the service; and poor management of allegations made against foster carers. Again, where significant risks were identified during inspections, they were escalated to Tusla for immediate attention.

In the light of our findings between 2013 and 2016, we decided to focus our monitoring activity on the assessment, approval, review, supervision and support of foster carers in 2017. This year we have commenced a thematic inspection of Tusla foster care services and completed fieldwork in six inspections to date, in Dublin south east-Wicklow, Cork, Louth-Meath, the mid-west, Sligo-Leitrim-west Cavan and Dublin north. In all cases escalation procedures were followed and assurances sought from Tusla in respect of all of the inspections. While the reports on the inspections have yet to be published, it is clear that although there were examples of good and some very good practice, some of the issues identified between 2013 and 2016 remain. They include insufficient safeguarding measures such as the absence of up-to-date Garda vetting, poor training, significant delays in the assessment and approval of relative carers and the risk of inappropriate placements owing to an insufficient number of foster care families.

I have provided an overview of HIQA's inspection and monitoring role in the provision of foster care services. While there are many examples of good and very good practice in both statutory and private foster care services, some significant areas for improvement remain, particularly in the assessment and approval of foster carers, the management of allegations against foster carers and the governance and oversight of care practices. That said, our experience over the past ten years in the overall regulation of health and social care services shows that regulation itself is a driver of quality and safety. Regulation affords protection to both vulnerable

adults and children, and contributes to assuring a better quality of life for all using regulated services.

I thank the committee for inviting us here this morning. We would be happy to answer any questions the committee may have.

Chairman: I thank Ms Dunnion for an extensive overview of the role of HIQA in monitoring foster care services. On behalf of the committee, I wish her and the organisation a happy tenth birthday and congratulate her on all she has achieved in the intervening time.

At the outset, I thank Senator Devine who sought this meeting and began this. I wish to acknowledge that as well. Out of deference to Senator Devine, does she want to contribute first?

Senator Joan Freeman: Of course.

Senator Máire Devine: I thank Ms Dunnion. This, I suppose, came on the back of reading the report on Dublin South Central, which is my home area, and being shocked by it.

I have several points. Ms Dunnion's report is comprehensive, but there are some aspects of foster care I would not necessarily understand and I ask her to bear with me. I have been trying to match a grandmother with two young babies via Tusla since last September. There does not seem to be recognition of an infant's growth each day and an urgency in trying to get the foster placement with the family so that these infants have a family nurturing environment to go to. That is not within Ms Dunnion's remit, but that is one case. Babies can be six months old or eight months old in foster care when there is a willing grandmother sitting back waiting to embrace them, bring them up and rear them while her daughter gets her life on track. It is important that they maintain links. Sometimes it seems to the detriment of the child but in most cases, it is not. It is for the betterment of the growth of the child. Some 94% of the placements are with Tusla and 6% are in private placements. Ms Dunnion might explain the private placements and explain the resources that are put into private versus Tusla placements and if the private placements are causing more concern than the Tusla placements, albeit they account for only 6%.

On regulation, would HIQA be able for and welcome regulation to strengthen HIQA's remit and provide more safeguards for children? What resources would go into that and what would HIQA need to expand to ensure that?

The report, in any case the Dublin South Central one that I read comprehensively, is not explained away by understaffing. I understand understaffing causes burnout and chaos in the services throughout health, and obviously, social care as well, but there seems to be some lack of leadership, whatever way one wants to put it.

What happens when HIQA escalates those significant risks to Tusla? Do they get immediate attention, and if so, what immediate attention do they get? As a member of the committee attending meetings for the past year, I note these issues have come up and they seem to get it so wrong repeatedly. We need to protect the children who we are meant to be caring for.

Senator Joan Freeman: I thank Ms Dunnion for that presentation. She informed me of matters I did not know about. I am so grateful for HIQA and for the role that it plays in society.

First, the fundamental piece that struck me is how serious this is. Ms Dunnion highlighted that the areas that need to be looked at are the assessment of foster carers and management of

allegations - those were two issues. I am finding that difficult to accept because I am thinking that the most fundamental issue is that HIQA must see if foster care is suitable. That is the number one priority because if it is not, there should be no child going to it. The second issue of the management of potential allegations smacks of the concern as to whether a child could be suffering for a long time before anything is done. That terrifies me.

Third, HIQA's lack of autonomy as an organisation frightens me also. Ms Dunnion states that HIQA has no legal remit, that all it can do is escalate issues or speed them along. That makes me very frightened of the future for our children. If that is all HIQA can do, if it has no autonomy and it puts that request or problem in the hands of Tusla, what in God's name will happen then? I am sorry about my roundabout way of putting all this but I would like Ms Dunnion's comments about what I have said.

What is the timeframe here? What is the timeframe for a child who is in trouble at the hands of a foster carer or whoever before that child is seen to and sorted?

Deputy Kathleen Funchion: I thank Ms Dunnion for the presentation. It is, as Senator Freeman stated, scary, but it also would make one very angry. HIQA has a reputation that it can go in and potentially close down organisations that are not operating to standard, and yet we have a situation where 465 children have no assigned social worker and nothing can be done about it. I wonder where HIQA sees the accountability. Has HIQA advocated for a legal remit in that regard? Is that something it would welcome? Is it something we as a committee can try and look at?

In regard to the number of complaints, Ms Dunnion stated all HIQA can do is escalate them to Tusla. How many serious situations have been escalated to it? Of those, how many have been addressed or what happens once it is escalated?

Ms Dunnion stated that from 2014 HIQA was assessing private care. I wonder why it was only from 2014 and what was happening prior to that.

Deputy Jan O'Sullivan: I thank both the Chairman and Senator Devine for bringing this to our attention. Reading the reports yesterday in advance of the meeting, I found the different ones alarming, the worst being, I suppose, that with regard to the midlands with 20 of the 26 needing improvement and six with significant risk, but also the area of concern to Senator Devine, with five with significant risk and 20 out of the 26 requiring improvement. I note the others as well, for example, Donegal with 16 out of 26 requiring improvement and Cavan-Monaghan with 18 out of 26 requiring improvement. All of them are alarming and it is not only one part of the country that is affected. There is also what Ms Dunnion told us today, for example, that there are 465 children with no social worker allocated at the end of 2016. We want to see what can be done about it. Clearly, it is a situation that cannot be tolerated. These are some of the most vulnerable children.

The other aspect that would worry me and probably worries the Chairman, is that we need more foster parents and they need to be assured that they will be adequately supported when they are doing this important work.

What Ms Dunnion is telling us, first, is that there needs to be regulation. She referred to the fact that there is no regulation. The other questions that others have asked are around what happens when HIQA alerts Tusla to risk to children. The lack of vetting is a big part of that. Does HIQA monitor what happens after that? Can it monitor and ensure that something happens to

ensure that children are protected?

The other issue concerns the question of staffing. Ms Dunnion stated that there is an issue around temporary management posts and risk management being underdeveloped. Perhaps the witnesses will tell the committee what we should be recommending in terms of what needs to be done because it is absolutely clear that the current situation is putting children significantly at risk and especially the most vulnerable children.

Chairman: I thank the Deputy. I ask Mary Dunnion in her response to elaborate a little on the regulation by giving members an example of a comparative area that already has that regulation, so we could be more definitive in our pursuit of it.

Ms Mary Dunnion: I thank the Deputy for her questions. I will share them with my colleague, Ms Eva Boyle, who will deal with the questions specific to the reports as she was one of the leaders in the inspection teams in that regard.

I will go back to the question in the context of regulation. HIQA has a legal remit and the only services we formally regulate are older persons and disability services. We regulate those services through a statutory instrument with the regulations determined by the Government. The standards against which we monitor are mandated by the Minister for Health or the Minister for Children and Youth Affairs, depending on which area is being referred to.

HIQA has been regulating for ten years and I genuinely believe - we have the evidence to support this - that regulation is a significant contributor to improving quality of care and safety for vulnerable people. The difference between where we are with children's services and with regulated services is that within a regulated service, one has powers. The powers allow us to ensure that an action happens because the regulated entity is licensed and registered to deliver that service, which is dependent upon it being compliant with the regulations. It also gives us instant powers when we come across significant risk. These powers are such that we can go as far as prosecution, we can close the service if we feel it is so unsafe or we can impose conditions that the service must put in place. These fundamentally are the differences.

The best example is probably the most recent one of disability, which actually concerns disability for both adults and children. Because that is covered, there is regulation in respect of the disability service for children and we can see evidence of an improvement in the lives of very vulnerable people in institutions. The Act refers to the institutions where these people have been for long periods of time. During our inspections we have spoken with approximately 10,000 vulnerable people and they have begun to articulate how things have started to improve. Regulation is a significant contributor to that.

There is, however, a limitation in that it is not and should not be the regulator's job to deliver the service. The responsibility of delivery rests with the provider of the service and this must always be the case. This is why we forever talk of the importance of governance and management. Where one has good services, there is good leadership and a good framework that is always watching to make sure it is safe. This is a really critical piece and this is why we emphasise it.

We believe such regulation should be in place in children's services. Children's residential services are due to come under the remit of regulation in a legal framework in January 2018. We are working with the Department of Children and Youth Affairs and have a workforce plan with the Department of Health in that regard. That will, hopefully, happen in this timeframe.

We feel this is a really good step. We also feel that foster care services should be regulated. The safety net of regulation does not mean that one can walk away and say the service is 100% safe; terrible things will always happen. It is worrying to see the same themes reoccurring between 2013 and 2016 and this is why, right through our health and social care services, we see it as a challenge to learn from our mistakes, to investigate them in a timely manner, to learn from them and to make sure the learning is spread right across the service. This remains a challenge.

HIQA is very much in favour of the regulation of foster care services and would certainly present to the committee our desire for this. I shall put it into context. Children's services have 14 inspectors. The Deputy asked why HIQA was not in private care services. We have 14 inspectors and a total staff of 16 in children's services for all the areas we referred to. We did 48 inspections in 2016, we met more than 600 children, their families and people who work in the services. That is the reality of the resources in HIQA around which we must plan our services and inspections.

In foster care, however, what we have learned is why we are taking a new approach this year. This may answer some of the questions asked by the Deputy. If we can make sure that foster carers are assessed, trained and supported and that nobody works on the assumption that because they were good at the start they are still good three or four years later - then we would see this as a very fruitful approach to take now. This is why we have changed to the thematic we mentioned in our review.

With regard to understaffing, there is a resource issue. There is no point in us saying that there is not a resource issue. The resource issue is in respect of both social workers and the numbers of foster carers. There are not enough foster carers and this is imperative. Fostering is such a marvellous thing to do as a service to provide for children. There is an imperative that Tusla and other agencies make sure that foster care is an attractive option and that if a person is going to become a foster carer, he or she is assured that he or she will be supported, will have the proper training and will know there is a monitoring of the service he or she is providing. We see gaps in that provision currently. It would be foolish and wrong of us to say there is no resource issue. There are not enough social workers within the service currently and that is definite.

Deputy Jan O'Sullivan asked about Tusla. There is a huge concern about the information systems, or the lack of them, within Tusla. If we go, for example, into a regional area for foster care services, one office will have an IT system and another will have a paper-based system. The actual transfer of information is stymied before it begins. It is very difficult to deliver an effective service with that kind of system in place.

Before I hand over to my colleague, I will refer to the issue of escalating risk about which everybody, quite rightly, is hugely concerned. As an assurance to the committee, when our teams go into any area where there is an immediate risk, we do not leave unless that immediate risk is addressed. That is the key principle from where we are coming. Thereafter, we go into a formal escalation process where we put our concerns in writing, along with a timeframe of when Tusla must reply to us and with the timeframe we set out who is the accountable person for the action. We, of course, inspect. Where we see a risk we will always go back to make sure it has been mitigated.

My colleague, Ms Eva Boyle, will now cover some of the specific areas of the two sets of questions and the most recent foster care reports.

Ms Eva Boyle: I thank Ms Dunnion. I will start with Senator Devine's queries. On family placements, our finding over the years is that Tusla does endeavour to go to the child's family as the first port of call to explore placement options for children in foster care. We have found, however, that there is often a delay post finding somebody. There is a preliminary process that takes place first to establish whether, on an emergency basis, a child can be placed with a relative. There is a delay, however, between that process being finalised and the relative foster carer getting final approval from the area placement committee so they are fully approved as a relative foster placement. This is an issue we have escalated throughout 2016 in Dublin south central and the midlands.

Reference was made to the difference between statutory and private foster care organisations. Every child who comes in to the care of the State is the responsibility of Tusla. Tusla has its own fostering service in all its 17 service areas. In addition, there are six private companies which recruit foster carers and assess them. In order for the foster carers to be approved, their assessment report goes in front of a Tusla foster care committee for approval. The children who are placed in the private organisations remain the responsibility of Tusla and, according to our standards, should have a Tusla social worker to look after the child's interests, but the foster carer in the private company will have a social worker, a link worker, from the private company to look after their interests. The issue we have raised time and again in our reports is that there are agreements relating to individual children and their care but there is no overall service level agreement between Tusla and those organisations to have an ongoing formal monitoring process.

Senator Freeman raised the issue of allegations and the safety of children. That has been a significant risk we have escalated to Tusla for three of the statutory inspections. One of the issues we have identified in two of the areas has been a confused approach in that there has not been one common policy document in place for staff to use, so that the staff are very clear in terms of the process they follow. Tusla has managed that and has recently formulated an interim protocol relating to the management of allegations against foster carers, so that is progress.

We have found there have been some delays in respect of allegations by children against foster carers being investigated. There are numerous reasons for this. Some of these are the structures that are in place in individual areas relating to investigation. When we have found risk, however, we have always looked for a safety plan to ensure children are safe prior to us leaving, and post inspection we follow that up in writing to make sure allegations have been assessed and followed through on, but it is certainly an area of concern.

Deputy Jan O'Sullivan asked about more foster carers being required. It is certainly our view that foster carers need to be encouraged and feel that it is a safe place, that they will be well supported but also supervised, because that is important in terms of the child's safety but also for the foster carers.

In terms of our inspection activity for 2017, we recognise the importance of the assessment process being key to ensure the right people are coming into fostering and also that they will go through a process where they fully understand the responsibilities that are in place. If people are thoroughly assessed, the likelihood is that there will be less breakdown. We need more foster carers to be attracted into fostering because we need a pool of foster carers in order that when a child comes into the system, we know that if he or she has a disability, for example, we have a foster carer or a pool of foster carers who have the skills, experience and training to be able to meet the needs of the child. Certainly, it is an area that needs further development in terms of bringing more foster carers into the system.

Deputy Donnchadh Ó Laoghaire: I thank the witnesses for an excellent presentation. In the first instance, it should be recognised that the role of foster carers is vital. Generally, foster carers are motivated by very noble and selfless reasons. The system would collapse without foster carers, but nonetheless the report is quite frightening and worrying in many respects, in particular the fact there is no official regulation of foster care and that complaints or child protection concerns were not always passed on to the foster care committees. That is of particular concern. Much of the problem seems to come back to staffing, in particular in terms of Tusla. I refer to the support service annual review we received from the Irish Foster Care Association. One of the primary concerns foster carers flagged to the association is the lack of correspondence from social workers. It was said that many carers detailed ongoing difficulties relating to the inconsistency and unreliability of communication routes. For example, many stated that they need to phone or email several times to get a response. In some instances, individuals have reported that despite regular ongoing attempts to contact the relevant professional, some have been left without a response for many months. That is a very significant weakness in the entire system. My question is to what extent the very obvious weaknesses, gaps and challenges that exist in ensuring the quality of foster care is at the highest level, and whether we can be confident it is at the highest level, are driven by the lack of regulation and the lack of staff and resources. Which is the more significant weakness or difficulty with the system?

Deputy Tom Neville: I thank the witnesses for their presentation which I watched on the monitor in my office. Many of the questions have been answered. Reference was made to the formalisation of overall regulation as opposed to regulation per child. Do the witnesses believe that regulation is required per child and overall, or would overall be sufficient? We want regulation and to protect children as best we can, but we do not want to overburden the system with bureaucracy which we see right across the public service, because that stifles service delivery.

It was said that some foster carers were frequently assigned social workers. Why was that the case? It was also mentioned that there was distance between siblings. What was the longest distance? Were they in the next parish? I come from a rural area. One case related to the midlands. Were the siblings miles apart? I would welcome some statistics in this regard. Also, what distance were the children from their original locality?

It was stated that efforts are being made to attract more foster carers into the system. From the analysis that has been done, what can we do to get more foster carers to sign up?

Deputy Anne Rabbitte: I thank Senator Freeman for proposing the issue and for affording us the opportunity to have this discussion.

Senator Máire Devine: I am Senator Devine.

Deputy Anne Rabbitte: I am sorry. It was a very open and frank discussion. It is probably one of the most sobering presentations we have had. I have been observing progress accordingly as the reports have been produced and since I became spokesperson on children. The first report of which I became aware was the annual report from June 2016 and that is where I will start. It stated that in the course of 2015 the children's team received 175 notifications that alerted the Health Information and Quality Authority, HIQA, to potential risks to the health, safety and well-being of the residents. Of a total of 72 notifications related to allegations of abuse, 29 related to abuse by relatives, 19 to allegations of abuse by care staff or professionals, and 17 to allegations of peer to peer abuse. The document is very well put together. If I have learned anything this morning it is that, first, Garda vetting is not working; second, there are not enough social care workers, which we have known for some time; and three, there are not

enough HIQA staff members either. Will Ms Dunnion elaborate on what happens when an item is presented to her at an inspection concerning a significant risk? An unannounced visit was carried out on a special care unit last year where a child was missing. What happens in such a case? What happens in cases where significant risk is identified, as that is of the most serious concern? HIQA was visiting the foster care services in November, including Care Visions. I refer to a significant risk regarding the safety and protection of children. We have another one as well. There were two of them, actually, regarding significant risk to service delivery and child protection. That was down in the midlands. HIQA was in the midlands, which is why we are here. There is the significant risk and the safeguarding. That was huge because there were at least four to five significant risks in that report. Where significant risks are identified, where is the communication? Where is the repeat investigation? What is the timeline for that? It is the most crucial thing. I look at 2015 and those 72 allegations. Where are we with them at this moment in time?

Deputy Lisa Chambers: I thank the witnesses for their presentation which I watched remotely. The witnesses said HIQA had a monitoring role rather than an enforcement role. HIQA referred to potential enforcement powers such as closing a service or taking legal action. What enforcement powers would HIQA like to have? What would assist it in its role and move it from the monitoring status it has?

I am also interested in what Tusla is saying to HIQA when HIQA inspects a service and finds problems. When HIQA investigates a hospital, the management might say there are difficulties because of X, Y, or Z. What is Tusla saying when HIQA finds problems with its service, besides referring to the lack of social workers, which is fairly well publicised? One of the issues is that we do not have enough college places and cannot churn them out fast enough. There is definitely demand from students who want to do those courses, but that is a different issue. What does Tusla say it needs?

Ms Dunnion touched on the cumbersome process to become a foster carer. What are the barriers? What puts people off? What do we need to do to encourage more people to take on the role?

Ms Dunnion said that where HIQA finds a significant risk, it ensures a safety plan is put in place. What is a safety plan? What does it look like? Is there a timeframe and are there certain things that need to be completed in that plan? Does HIQA reinspect to see if the plan has been completed?

How does HIQA find out about problems? Do people report them or is it through random inspections? Is it possible that HIQA is only seeing part of the picture and that the figures and statistics we have are only those things HIQA has found? Could there be a wider issue?

Is there or should there be ongoing training and updating of skills and knowledge for foster carers? Would it be appropriate to have an annual conference or an update every three or four years for carers on the latest standards?

Chairman: I ask the witnesses to clarify what is meant by a model of commissioning as recommended in the opening statement. It is a pleasure to have a meeting like this where the witnesses come in with solutions. It is very easy to identify problems, but HIQA is recommending solutions, which is very heartening for us as a committee. It means we can see a step we can take forward. I ask if there is anything we can do as a committee to provide justice in respect of the appalling litany of tragedy in this area by shining a light on it. I thank Senator Devine in that

regard and the witnesses for attending. If we can push for regulation in this area and demand it happens today, it is to do the very least we owe to those who are in the system today and who were let down by it so appallingly in the past.

HIQA has really identified the gaping hole in the foster care system. The fact that service level agreements are not in place is beyond belief. Foster carers in Cork deal with south Lee and north Lee and there are major differences. Within one county there are major differences between two sectors. Very different dynamics are at play in how they are managed and organised. We have a big issue from a management point of view for Tusla. HIQA has pointed to that clearly here.

Something I am particularly interested in is the private service. Have the witnesses noticed any difference in standards in private services versus those provided by Tusla? I understand that Tusla has a role in private services and I understand the differences. I refer to the 6% of private providers. Is there a difference in the allocation of social workers? There are over 500 children without social workers. Is there a larger number of such children in private care versus public care? Are the standards different? Anecdotally, foster parents I have spoken to say the range of services is better with private providers. It is claimed but I cannot say it authoritatively. Has HIQA seen more proactive training for foster carers on the private side?

I saw a briefing document from the Minister during the week referring to me as having something of an obsession with value for money. My issue in talking about that is on how we are spending the money we spend. I want to see a child-centred value for money. As a committee, we must remember that we spend some €660 million on these services annually for the care of 6,000 children. It is valid to ask if we are getting child-centred value for money as such. From looking at the private operators, what are HIQA's views on child-centred value for money? We are spending a great deal of money through these providers.

Ms Mary Dunnion: It is fair to say there is a resource issue. However, a lack of resources is not a total determinant of a poor service. As we find in all our reports and inspections, what is important is what a child experiences and receives from the person looking after him or her. The people in charge must have controls in place to see that this happens. It is that circle which makes it work. While there may sometimes be a lack of resources, the importance of which I would not underestimate, I re-emphasise the importance of ensuring that the experience of a child as determined by those who deliver the service is monitored by those who have the responsibility of oversight. That is where we see significant gaps and where we talk about leadership management and governance as a particular requirement and focus.

When we talk about formal regulation, which Deputy Neville asked about, we would never be regulating the individual child. Regulation of foster care services, which we hope happens, means looking at the system in place to ensure that the child is being placed in a timely manner, that foster carers have been assessed as to their competence and confidence to be a foster carer and that controls are in place so the carer receives adequate training and obtains information in a timely manner. As Deputy Ó Laoghaire said, there should be a proper communication system. There should be proper recruitment processes and if someone leaves the foster care service, there should be a capacity to analyse why and what we can learn from it. It is about looking at the totality of arrangements in place to ensure there is a safe service. As such, one is never going down to the individual child, albeit one will engage with the individual child because that is who will tell one the story. What one is looking at in regulation is what system is in place to ensure this happens.

That brings us on to the point that the risk with regulation is that it can stop being dynamic. The model of regulation is determined by the legislators. Good evidence of this is in disability and older person services where there is a regulatory model determined by a building and the care. As such, it is the designated centre and the care. However, we advocate that the regulatory model should be about the service. That would allow a different approach to be taken to regulation which is based more on cost-benefit. It would allow providers to be more dynamic in the services they provide. We welcome regulation but we see that it must be dynamic and changing and we ask that legislators take account of this in their thinking about regulation.

Garda vetting should not be a problem. The system has been streamlined. Several years ago, it was difficult for any employer to get timely Garda vetting in respect of a prospective employee. It now takes, in essence, two weeks, so there is no issue with people being Garda vetted. What really concerns me is the thought process to the effect that it is not seen as one of the single easiest pieces to ensure safeguarding for vulnerable people. The safeguarding is the process but it is not high on the agenda of a manager or employer to ensure that employees have Garda vetting. We have seen this right across social services, not only in children's services. I can happily report that there has been a sea change, to which, I believe, regulation has contributed. When we carry out an inspection and discover people without Garda vetting, the employer must take them off the roster. If they are caring for the most vulnerable of people, they must have Garda vetting. Faced with such a risk, requiring the employer to take the relevant employees off a roster is one of the actions we might take.

Chairman: I apologise for interrupting Ms Dunnion. When she talks about Garda vetting, does she refer in the same vein to the renewal of Garda vetting?

Ms Mary Dunnion: From April 2016, it has been mandatory for any new employee to have Garda vetting. Employees hired before April 2016 have until the end of 2018 to have their Garda vetting renewed.

Chairman: I wish to get clarity on this. Is it every three or four years that one must renew one's Garda vetting?

Ms Mary Dunnion: Yes, there is a renewal process and the regulations set out that employees must have up-to-date Garda vetting.

Chairman: HIQA identifies this in some of its reports. Does Ms Dunnion know the number of years after which one must have one's vetting renewed?

Ms Mary Dunnion: I would have to come back to the Chairman on that.

Chairman: That is fine.

Ms Mary Dunnion: I do not have the exact information but we will come back to him.

Senator Joan Freeman: It is five years.

Ms Mary Dunnion: I thank the Senator.

Chairman: I apologise for throwing Ms Dunnion off.

Ms Mary Dunnion: We are totally focused on new employees at present. The legislative framework has been there for new employees since the start of the year. It has been very worrying to find action has not been taken on it, especially when the process has been so streamlined

for it to happen.

Before I hand over to Ms Boyle to discuss some specifics, I will deal with the Chairman's comments on commissioning. We see commissioning as an area of exploration, and the Chairman alluded to it in a service level agreement. That is part of commissioning. The term "commissioning" is sometimes regarded unfavourably because of its record in other jurisdictions and because it has been associated with high costs. However, what we are talking about is an accountability framework. If the State purchases a service - it does not matter whether it purchases child protection services, services for older people or health care services - that service is purchased from the public purse. What we have not seen is the responsibility both for the purchaser and the provider, and we see that as a dual responsibility. If one is handing over millions from the public purse to a body to provide a service, one should check that the service is being provided at a level commensurate with the cost of the purchase. Those controls need to be in place, and that is what we talk about in the context of an accountability framework. It can stretch out much further in the sense that there are cases, which we have identified in our presentation, where there has not been good service planning. That is part of an accountability framework. One begins to question what the needs of foster carers are, how many we anticipate that we will need over the next number of years, how many children we anticipate will require foster care and what our planning is, not only for now, but also for the next number of years. This is all encompassed in an accountability framework, or a commissioning model. Work has been done on this, and we can send papers on commissioning to the committee, although they were not done by HIQA. This is where the service level agreement comes into play because that would become a component of it. For the information of the committee, the HSE has done quite a good piece of work on commissioning. We will do some work with the HSE in that context, particularly on disability and health care. Perhaps Tusla will move in that direction as well - we do not know - but that is what we are talking about.

I now hand over to Ms Boyle to discuss some of the specific questions.

Ms Eva Boyle: I thank Deputy Neville for his question. He queried the distances children are placed away from their local communities. It very much varies. There are scenarios in which children are in the nearest town or village but others in which they are perhaps a few hundred miles away from their families of origin. We find that Tusla staff endeavour to make sure the child has regular contact, where appropriate, with his or her family, and a lot of time and resources have gone into those arrangements to ensure that happens.

I will come back to the issue of the notifications that Deputy Rabbitte raised.

Deputy Lisa Chambers queried what Tusla says when HIQA finds problems with a service, other than raising resource issues with us. Tusla is very clear that it is starting a number of new processes regarding monitoring and quality assurance. We have seen the start of some of those processes in individual areas and would reference some of those new management systems being in place but they are at a very early stage of implementation throughout the country.

The barriers to becoming a foster carer are varied. They can be societal. A greater number of women and men are working full-time outside the family home, and there are challenges there in terms of arrangements for individuals. That is just a personal observation rather than something that has come up through the course of inspection. However, the majority of foster carers tell us that they are well supported. When they do not have link workers, they find that difficult. They occasionally experience delays in staff getting back to them and they find that frustrating. Due to the fact that they care for children, they need someone at the end of the

phone to be able to answer to their questions. Service consistency is something foster carers highlight as important to them. They wish to be well supported and to be supervised so that they can run matters by their link workers. They might ask whether they are doing something right or ask for a little help with something. These are things they identify and, in turn, they are essential elements in attracting more people into fostering.

A safety plan is a basic plan whereby measures to keep a child safe are laid down. A practical example would be a child not having contact with a person against whom an allegation of abuse has been made. That would be at a very basic level. It may be that they have supervised contact, but it is a written plan that is laid down so that everyone caring for this child knows how to keep him or her safe. The plan should also be reviewed so that it does not stay the same. If there has been an investigation and no risk is found, the plan should be amended to reflect that it is now safe for the child in a certain situation or with a certain individual. We have mixed experiences of finding these. There is often a plan in place but it is not always written down. On occasions when we find that there is no safety plan, we would go to a manager while we are on site and ask what the plan is to keep the child safe. We make sure that there is a definite plan before we leave.

Regarding how HIQA knows about problems, information comes to us in a number of ways. We receive unsolicited information from members of the public who telephone us. This could consist of concerns; sometimes we receive compliments about a service. We also get some information from Tusla in the form of published statistics and we examine those figures regularly. We risk-rate that information and make decisions about our monitoring and what follow-up we need to carry out as a result of the information.

The area of foster care training requires ongoing development. Most foster carers are given a range of training options but those options are dependent on the areas in which they are based. That has improved in recent years. Foster carers who commence training generally receive a comprehensive foundation training package outlining expectations in terms of children meeting with their birth families, expectations in terms of foster carers' own families, safeguarding and so on. Children often have emotional needs and they may have a disability or educational needs and foster carers may therefore have additional training needs. At times, there are shortcomings in regard to those specific needs being met. There are training plans for foster carers in all areas. The training plans vary in terms of quality of content and what they offer for foster carers.

In regard to Deputy Jim Daly's queries on the 6% of placements that are in the private sector, the standard of service provision in the private sector varies. It is similar to the fact that children in some areas of the country have access to a range of services through the HSE and have no problem accessing those services. Some private organisations have professionals such as psychologists employed on a sessional or full-time basis which gives ease of access to children under their care. Foster carers in private agencies often tell us that a link person from the agency is available to them 24 hours a day, seven days a week, and that that is a motivating factor for the carers deciding to go with that particular agency.

I have not done an analysis in respect of value for money and therefore cannot comment on it.

Chairman: I thank the witness. Do members have any supplementary questions?

Deputy Anne Rabbitte: My question has not been answered.

Ms Eva Boyle: I will have to revert to the Deputy with further detail in respect of the notifications.

Deputy Anne Rabbitte: What immediate action will be taken in a case such as the one I have highlighted where a child was not on site and deemed missing by a HIQA inspection? What was the follow-up in regard to the 72 other cases of significant risk identified in the HIQA annual report 2016?

Ms Eva Boyle: HIQA ensures that the appropriate processes have been followed when there is an immediate action when a child is missing. There is a formal protocol there between Tusla and the Garda. We ensure that protocol has been followed so that everything within that process has been followed up in terms of looking for the child and that meetings are happening at the appropriate level. Depending on how long a child is missing, the case escalates within both Tusla and the Garda. That is our routine when a child is missing from the service.

Deputy Anne Rabbitte: Would it be a routine finding?

Ms Eva Boyle: Would it be a routine finding?

Deputy Anne Rabbitte: Is it routine that a child be discovered missing when an inspection is being carried out ? That is absolutely shocking.

Ms Eva Boyle: It does come up. We have referenced occasions when children have been absent without permission or missing from care in our foster care reports. It also arises in regard to children in residential care.

Chairman: Do members have supplementary questions?

Deputy Lisa Chambers: What enforcement powers would the witness like HIQA to have? If it were to move from monitoring, where does she envisage the organisation going and where does she think it should be?

Chairman: Do any other members have supplementary questions?

Deputy Anne Rabbitte: I am not satisfied with the answer I have received in regard to the 72 cases. It has not been clarified what was identified in the report as to the action plan in regard to the 72 cases. We are only talking about 12 months ago. The Grace case occurred over 30 years ago. We are not moving forward. My question relates to monitoring, follow-up and the policy governing those issues.

Senator Máire Devine: I have been listening for the past hour and 15 minutes. What I have heard could be summed up as "dysfunctional". The current situation is absolutely unacceptable in the context of the protection of our vulnerable children. There is something rotten in it and there is something that vulnerable children we are meant to protect have to revisit again and again and again. The term "care erosion" comes to mind. I am interested in the relationship between HIQA and Tusla. I encountered a defensive attitude when I recently asked Tusla to take a clinical view in the assessment of a child, knowing that it involves the whole family or neighbourhood. There is a problem in terms of resources and culture. Does the witness believe Tusla is so dogged, weary of fire-fighting and under-resourced that it has developed a defensive culture that does not allow emotional care and attachment to its job of getting in, signing, sealing and delivering? Does the witness find there is a barrier to her being there when she meets with Tusla?

Deputy Jan O'Sullivan: The witness said that people are taken off the list if they are not vetted. Perhaps I did not hear that accurately. The idea that people without Garda vetting would be in their own home looking after vulnerable children rings huge alarm bells. Could the witness clarify what happens when it is found that a family has not been vetted?

Chairman: In terms of the regulation issue raised by Deputy Chambers, I hope that the committee will make progress in bringing about regulation. We will further liaise with HIQA on the specifics. The witness can, of course, answer Deputy Chambers's question. This is the beginning of the investigation of this issue by this committee. It is intended to engage with Empowering Children In Care, EPIC, and the Irish Foster Care Association at forthcoming committee meetings, after which we will get the views of the Department and the Minister.

Ms Mary Dunnion: I must apologise to Deputy Rabbitte as we do not have the specific information to answer her question. However, we will revert to her with further information. A notification is not a validated piece of information. We get over 40,000 notifications per year in regulated services. We then carry out an investigation of those notifications, which are mandatory and have to be reported. They are not necessarily associated with a risk. I will look further into the specifics of the 72 cases and we will revert to the Deputy in that regard.

Deputy Anne Rabbitte: With the permission of the Chairman, in regard to the annual report-----

Chairman: I must treat all members equally. I cannot allow cross-examination such as that and we do not-----

Deputy Anne Rabbitte: It is in the report and my question has not been answered in this meeting-----

Chairman: I am not going to take statements.

Deputy Anne Rabbitte: It is not a statement. I am looking for a clarification of facts.

Chairman: The witness has said she will revert to Deputy Rabbitte with an answer in that regard.

Deputy Anne Rabbitte: It is 12 months on and the issue should be clearly explained to the committee today.

Chairman: I will not allow any further engagement on that issue.

Ms Mary Dunnion: In the context of enforcement models, one would look at whether the person providing the foster care service is fit to do so. That would be a type of licensing of foster care services. It would look at the fundamental structures that the service has in place to ensure a safe foster care service. That is the baseline. In terms of enforcement powers, the least attractive is to close a service. That is not where one wants to aim. It is desirable that, where risk is identified, there is an immediate action to respond to it and there is a statutory power to ensure that that happens. There are different models which can be used. It can be stipulated that service can only be provided on conditions. That is the type of area that would be considered in that context. It is our experience that many children have fared extremely well in services spanning child protection, foster care, residential care and detention because that is the spectrum of areas that we monitor. Any dealings we have had with Tusla have been positive. There is always a healthy tension between a regulator and the people who provide a service. That is

just the nature of regulation. HIQA has had a healthy engagement with Tusla. It has responded where we have identified risk. We recognise that Tusla is on a journey, that it has not existed long and it has a number of processes in place, and Ms Boyle alluded to some of them. We identify risk and escalate it, accordingly. We have a positive working relationship with Tusla.

In the context of Garda vetting, we are talking about where employees or the first group have not been Garda vetted. We have insisted that Garda vetting is secured before people can continue. In cases of foster care, we ensure that arrangements are in place to ensure that foster carers have completed their Garda vetting. We have seen an improvement in the situation across our regulatory fields. It was an area of significant concern to us when it was not evident that it was a process.

Deputy Jan O'Sullivan: I know that the Chairman does not want us to engage but I shall do so briefly. In other work situations people who have peripheral contact with children must be vetted.

Ms Mary Dunnion: Yes.

Deputy Jan O'Sullivan: In this case the people are with the children all of the time.

Ms Mary Dunnion: It was a very worrying finding for us. Garda vetting is a process. We were worried about what the situation said about the concept of safeguarding.

Ms Eva Boyle: To clarify, it was frequently a member of the household, not primarily the primary carer, but an adult who lived in the household or frequented the household.

Chairman: I sincerely thank members for their engagement. I thank the witnesses from HIQA for their assistance. This meeting is the beginning. We will take the clear and stark messages from HIQA that there are three principal requirements - regulation in the area, service level agreements between the care providers and a commissioning model. HIQA has clearly conveyed those messages and highlighted many other deficiencies here today. We sincerely thank HIQA for monitoring the services that are provided to the most vulnerable citizens in society. We look forward to making progress on the area of regulation and engaging with HIQA again. If members have questions they can give them to the secretariat and we will pass them on to HIQA.

Deputy Anne Rabbitte: Will I get a written response to my questions?

Ms Mary Dunnion: Yes. We will directly communicate with the Deputy. I apologise to her that we did not have the answer for her today.

Deputy Anne Rabbitte: Ms Dunnion can understand where I am coming from.

Ms Mary Dunnion: Yes. We will send our response to the Deputy this evening.

Deputy Anne Rabbitte: I thank Ms Dunnion.

Chairman: Very good. I propose that we go into private session to deal with correspondence. Is that agreed? Agreed.

The joint committee went into private session at 10.25 a.m. and adjourned at 10.45 a.m. until 9 a.m. on Wednesday, 31 May 2017.