Response to the Independent Child Death Review Group Report

Fintan O’Toole, responding to the Report of the Independent Child Death Review Group (ICDRG) in the Irish Times (Saturday, 23 June 2012), draws attention to the first meeting of the Dáil in January 1919:

“[T]he Dáil set out a very basic test: ‘It shall be the first duty of the Government of the Republic to make provision for the physical, mental and spiritual well-being of the children.’ Child welfare was to be the primary benchmark by which the new Republic would measure its success. It was a good standard to adopt and one by which, yet again, the report by the Independent Child Death Review Group this week showed the Republic to have failed.”

O’Toole goes on to note that the report evokes “tears and rage in equal measure. But neither response is much use to children at risk of the same fate. The real challenge is to face up to what the stories in the report tell us about the State. Ultimately these children are victims of systematic misgovernment. Their deaths shine a harsh light on three basic aspects of a functioning democracy: values, accountability and priorities.”

The Report emphasised the vulnerability of all young people in care, but one group, that of separated children, have unique vulnerabilities by reason of their isolation from family, friends and community. The State is bound by duty and by international law to provide for the welfare of these children in a manner that takes account of their special vulnerabilities and isolation.

‘Young Person in Care 13’ was a separated child who had been in the care of the HSE for 13 months when he committed suicide. From his admission, the child presented as ‘very distressed, isolated and vulnerable’ and showed signs of post-traumatic stress disorder. A psychological assessment concluded that he was at risk of self-harm if he remained in a hostel setting, yet it was seven months before a foster placement was made. He made two serious suicide attempts during his time in the hostel but these were dismissed as an ‘impulsive act’ and he was discharged. His Social Worker recorded concerns that a full psychiatric assessment was not performed before his discharge.

The young person made a further suicide attempt while in foster care and was hospitalised for four days. The Report notes that it is not clear whether the foster carers had been made aware of his previous suicide attempts. He met with a Social Worker following his discharge, who recorded that he was withdrawn and had lost weight. Two weeks later the foster carer left a message for the Social Worker over the weekend. The Social Worker was not on duty and texted the foster carer to say that he would be in contact the next day when he was on duty. By the time the Social Worker turned on his phone the next day the child was dead.

The Report identifies a number of risk indicators or issues for concern that have particular relevance for separated children:

- age, with those in late adolescence being at greatest risk – the vast majority of separated children are 14 years of age of above¹;
- mental health difficulties;
- absent or neglectful families;
- difficulties in relation to the consistency and appointment of social workers ²;

¹ The writers note that: “[M]ost deaths took place during older adolescence with over 80 per cent occurring at ages 14 years or over. This trend is also evidence in relation to the death of young people in after care and children known to the HSE.”
• the use of hostel accommodation;
• difficulty or delay in accessing psychological services;
• lack of out of hours service;
• poor flow of communications with external agencies and within the HSE;
• absence of aftercare.

The Report asserted the vital importance of developing a care plan for a child in care in order to provide consistency of care, yet no care plan had been made in 15 of the cases, including ‘Young Person in Care 13’. Lack of family or community, the likelihood of trauma in leaving the country of origin, and age should immediately flag each separated child as being within a high risk group and these factors need to be taken into account in developing a care plan.

The Report also highlighted the lack of long-term planning for children who reach the age of 18. For separated children, aftercare is a serious concern as most separated children are in their late teens and age out while still in the care process. The ICDRG examined the files of 32 young people who were in aftercare at the time of their death, of these seven died from suicide and 14 were drug related deaths.

“In some cases no aftercare at all was provided... In other cases aftercare was offered but solely at the option of the young person. Such an abdication of duty on the part of the HSE is unacceptable, and fails to properly meet the welfare needs of these vulnerable young people” (emphasis added).

A common thread evident throughout the Report is the need for every child in care to have a consistent adult figure to see the whole picture of the child’s needs and to ensure that their rights are vindicated. Children have individual rights – which the upcoming referendum is intended to strengthen - but without an adult figure to support and fight for the child, those rights are meaningless.

Tears and rage are not an adequate response to the death of these children. The findings of the report require an effective multi-disciplinary approach to securing the welfare of each child in the state. For separated children, that requires cooperation between ORAC, Department of Justice, HSE, Education, Health - and the Legal Aid Board in the following areas:

1. Care plans for every child
2. Child in Care reviews
3. After care planning for every child
4. Appropriate records in every case
5. A genuinely child friendly asylum process
6. A guardian for every child
7. Protocol for High Risk Children to be referred to mental health services without delay
8. Mental health services during after care as required

The HSE acknowledges that social workers may be reassigned for a variety of reasons (p. xiv) and resources are more stretched now than ever. In 11 of the cases examined there were issues of consistency and appointment of social workers and in 10 cases there were difficulties in finding suitable placements. The Report notes that: “These two issues coupled with the lack of a care plan seriously undermine the ability of the HSE to properly care for a child in care.” Despite evidence of good practice throughout, its application was “sporadic and inconsistent.”

The Report, p. xiii. “Once a child is in care it is imperative that a care plan is developed for the child, no such plan appeared on the file of 15 of the children or young people concerned. A care plan provides for consistency in the provision of care for a child.”
The Irish Refugee Council recently launched a pilot project to provide voluntary, independent advocates for a small number of separated children and ages out minors. You can find out more about the project here.