EXECUTIVE SUMMARY

OF

THE REPORT OF THE INDEPENDENT CHILD DEATH REVIEW GROUP

INTRODUCTION

The Independent Child Death Review Group ("ICDRG") received files relating to the deaths of 196 children during the period of 1 January 2000 to 30 April 2010 who were:

- in care within the meaning of the Child Care Act 1991 at the time of their death;
- in receipt of aftercare within the meaning of Section 45 of the Child Care Act 1991 at the time of their death;
- known to the child protection services within the meaning of the HIQA guidance to the HSE of 20 January 2010 at the time of their death

The breakdown of deaths over the ten year period amongst the 196 cases reviewed is:

Children in Care: 36 deaths

- 19 deaths from natural causes
- 17 deaths from non natural causes

Children & young people in Aftercare: 32 deaths

- 5 deaths from natural causes
- 27 deaths from non natural causes

Children & young people known to the HSE: 128 deaths

- 60 deaths from natural causes
- 68 deaths from non natural causes

Whilst individual case summaries relating to deaths arising from natural causes were not within the terms of reference of the ICDRG, nonetheless an overview of these cases is included in the report and review of each of these cases has informed the overall conclusions reached. The causes of death for the 84 children and young people who died of natural causes are shown at Table 1 below:

Table 1

- All Natural Deaths

Cause of Death	In Care	Aftercare	Known to HSE	Total
Asthma	1	0	1	2
Cancer	6	1	1	8
Complications from Development Delay	11	2	10	23
Sudden Child Death Syndrome	1	0	28	29
Complications from CF	0	0	2	2
Complications from Diabetes	0	0	1	1
Heart Problems	0	0	2	2
Genetic neurological condition	0	0	3	3
Stillborn	0	0	1	1
Undetermined/unknown	0	0	2	2
Miscellaneous	0	2	9	11
Total	19	5	60	84

In accordance with its terms of reference the ICDRG examined the files and reports of the HSE in respect of all 112 children who died from unnatural causes and a detailed and comprehensive case summary in respect of each child is set out in this report. In addition to providing an analysis of these files this report also summarises those aspects of good practice evident from the files, and also causes for concern. Table 2 below shows a breakdown of the non natural deaths in each of the three categories provided for in the ICDRG's terms of reference by year:

Table 2: All Non Natural Deaths by Year

Year	In Care	Aftercare	Known to HSE
2000	2	1	3
2001	1	0	6
2002	1	3	5
2003	2	1	4
2004	0	2	3
2005	1	4	8
2006	3	4	6
2007	1	4	12
2008	1	2	10
2009	4	4	4
2010	1	2	7
Total	17	27	68

The following is an overview of the child care system in Ireland together with a summary of the good practice and concerns that emerged during the conduct of this review. These concerns have informed both the learning identified from the review and the recommendations put forward by the ICDRG. Readers are advised to consider the detail as set out in the body of the report for a more thorough analysis of the issues.

OVERVIEW OF THE CHILD CARE SYSTEM IN IRELAND

The child care system in Ireland is governed by the Child Care Act 1991 ("1991 Act"), as amended. It imposes a positive mandatory obligation on the HSE to *"promote the welfare of children in its area who are not receiving adequate care and protection".* In carrying out this function the HSE is obliged to take such steps as it considers necessary to identify children not receiving such care and protection and coordinate information from all relevant sources concerning those children. If the HSE is of the view that a child requires care and protection that he/she is unlikely to receive unless a court order is made, then it is the duty of the HSE to apply for such an order in respect of that child.

Each and every child and their circumstances are unique. Therefore the level of HSE involvement will vary from case to case. To that end the 1991 Act provides a range of options available to the HSE in carrying out its functions. In identifying whether a child

ought to be placed into the care of the HSE, the HSE can interact with the parents and family and assist them as may be appropriate. If, however, the HSE is meeting resistance in that regard it can seek a Supervision Order from the court. This allows the HSE to visit the child periodically, as ordered by the court, so as to ensure that his/her welfare is being adequately cared for.

If the welfare of the child cannot be properly cared for within the family then that child should be placed in the care of the HSE. To that end the parents of the child may agree to voluntarily place the child into care. If they are not so agreeable the HSE can, depending on the circumstances, seek an Emergency Care Order or Interim Care Order. These Orders are limited in duration, but if a child is to be placed into the care of the HSE more permanently (including up until the age of 18 years) then a Care Order can be applied for. When a child is placed into care the HSE has like control over the child as if it were his parent. Where a child requires special care and protection the HSE may apply to the High Court for a Special Care Order which may result in the child being placed in a secure unit for his/her own protection. The HSE does not have powers to detain a child in a placement unless a Special Care Order has been granted by the High Court.

Whilst in the care of the HSE the welfare of the child is paramount. When a child reaches maturity, or is to leave the care of the HSE, the HSE may assist him/her by way of the provision of aftercare which may involve continuing visits by social workers, supporting completion of educational or training courses or arranging suitable accommodation.

It is against this backdrop that the following report is to be considered. The 196 children referred to in this report all interacted with the child care system summarised above. The purpose of this report is to examine, amongst other things, whether this system met the welfare needs of these children.

Many of the children the subject of this report had experiences and difficulties before coming into contact with the HSE which are not encountered to the same extent in the general child population and cognisance must be taken of this fact when evaluating the case summaries in this report. That said, the ICDRG concludes that the majority of the children the subject of this review did not receive an adequate child protection service.

The review covers deaths of children and young people from 2000 to 2010. Even in the case of deaths occurring at the end of this period much interaction with these children and their families took place at an earlier time. While it is clear that significant work has been undertaken to improve services both over this period and since, the ICDRG has sought to identify learning that can form the basis of a robust child protection system.

DEATHS OF CHILDREN & YOUNG PEOPLE IN CARE

As set out above, "in care" relates to the voluntary placement of a child in the care of the HSE or the placement under an Emergency Care Order, Interim Care Order, Care Order or Special Care Order issued by the courts. The circumstances where the HSE is required to intervene and take a child into care are complex and varied but by their nature they are adverse. They can relate to the absence of or lack of attachment to a stable parental figure or exposure to traumatic life events like loss, separation, abuse or serious neglect. In some cases issues such as alcohol, drug abuse or domestic violence that seriously impacts on consistent parenting will have posed a risk to the child's welfare. The impact on a child of early trauma, abuse or neglect is far reaching and poses challenges for their healthy development and the care interventions needed to address their needs. For some children the cumulative adverse experiences of their early years are of considerable significance for their subsequent outcomes, even where intervention by social services follows. It is also the case that the decision to take a child into care in order to promote their welfare must be based upon a balanced assessment of risk since such action itself carries with it risk of disruption and potentially harmful affects on the child's development where the placement does not fully meet the child's needs.

There are over 6,000 children in the care of the HSE at any one time. Over 90 per cent are placed with foster carers with the remainder in residential care.

In total the ICDRG examined the files of 36 children and young persons who were in the care of the HSE at the time of their death. Nineteen of these deaths were due to natural causes – the causes of these deaths are summarised at Table 1 above - and 17 were due to non natural causes. The age breakdown of these 17 children at the time of death is shown in Table 3 below.

Table 3: Non Natural Deaths of Children in Care

- Age at Time of Death

Age at Time of Death	Number of Deaths
< 4 years	0
4 years	1
5 years	0
6 years	0
7 years	1
8 years	0
9 years	0
10 years	0
11 years	0
12 years	1
13 years	0
14 years	2
15 years	2
16 years	4
17 years	6
Total	17

It is very apparent from this information that most of these deaths took place during older adolescence, with over 80 per cent occurring at ages 14 years or over. This trend is also evident in relation to the death of young people in after care and children known to the HSE.

The causes of the non natural deaths are shown at Table 4 below:

Table 4: Non Natural Deaths of Children in Care

- Cause of Death

Cause of Death	**In Care**
Asphyxia (accidental)	1
Drowning (accidental)	1
Drug Related	5
Suicide	5
Road Traffic Accident	3
Unlawful killing	2
Accidental fall	0
Head injuries (cause unknown)	0
House Fire	0
Unknown	0
Total	17

Ultimately and tragically the efforts to protect these children failed. A key issue to be emphasised is the vulnerability of these children. There are elements of good practice evidenced on some of the files reviewed. A considerable range of services were made available and there were certainly efforts made to intervene and build relationships in order to address the underlying vulnerabilities of these children. However, while good practice was adhered to in some cases, the fact remains that its application was sporadic and inconsistent. In many cases these children engaged in ever more risk taking during adolescence with tragic outcomes. The earlier and more consistent presence of good practice would have increased the chances that these children might have overcome their vulnerabilities, although it is not possible to conclude that the death of the child or young person would have been ultimately prevented. Notwithstanding this a uniform and structured approach to the provision of child care provides the best opportunity to manage and mitigate risk in the lives of such vulnerable children and young people.

The ICDRG has identified 12 indicators of good practice. In some, but by no means the majority of cases, there is evidence of:

Good Assessment, Risk Identification and/or Planning in Place

Care Plan in Place

Care Plan Followed and Reviewed or Planning Completed

Good/Consistent Care Provided by the Social Work Department

Childcare Regulations Followed

Good Record Keeping

Good Social Work Supervision/Support

Good Foster Care

Support for Family/Foster Carers

Good Interagency Cooperation

Appropriate Follow-Up after Child's Death

Review of Death

Each and every child or young person entering into the care of the HSE ought to be provided with a high standard of care commensurate with his/her needs. There are professionals and areas within the HSE which have demonstrated that they can achieve such standards, but sadly there are other parts that do not. Thus whilst the evidence of good practice is to be commended its absence in respect of other children or young persons is a cause for concern.

Summary of Concerns

In 12 of the 36 files there was evidence of delay in taking the child into care. Once welfare concerns in respect of a child warranting placement into care have been identified it is vital that the HSE moves expeditiously to ensure that this is done so as to avoid any further harm to the child. Once 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. In addition, appropriate procedures should be followed once a child is taken into care, e.g. the child should undergo a medical examination. In 9 of the files examined there was no evidence that the child underwent such an examination upon being received into care by the HSE.

It is acknowledged that social workers assigned to a child may be reassigned for a variety of reasons, however, in 11 of the files examined there was evidence of difficulties in relation to the consistency and appointment of social workers to a child. Furthermore, in 10 of the files examined there were evident difficulties in locating suitable placements for a child. 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.

As there may be inconsistency in the personnel assigned to a particular child it is imperative that a clear reporting structure is put in place so that any social worker who may be subsequently assigned to a child can read the file and be in a position to meet the needs of that child immediately. In 15 of the 36 files examined there was evidence of a poor standard of record keeping and incomplete records. Critical incident reports are to be completed in the event of a serious incident occurring whilst the child is in care. The death of a child would be such a serious incident. There was no such report in 26 of the 36 files examined. The recording of such incidents is critical as it allows the HSE to consider whether the child is being provided with the appropriate level of care or whether further additional services are required. In that regard 5 of the files examined evidenced a failure to pursue appropriate services for a child so as to deal with the particular issues of that child.

In addition to a proper recording structure being put in place, social workers must also be properly supervised by their Team Leaders. It is important that social workers are provided with adequate supports so as to enable them to carry out their duties to the best of their ability. Furthermore, if there is to be inconsistency in the assignment of social workers at least the Team Leader should be able to provide some consistency in terms of management and direction in respect of the care being provided to a particular child.

DEATHS OF YOUNG PEOPLE IN AFTERCARE

As explained above, when a child reaches maturity or is to leave the care of the HSE the HSE may assist him/her by way of the provision of aftercare which may involve continuing visits by social workers, supporting completion of educational courses or arranging suitable accommodation. Such aftercare is provided under Section 45 of the Child Care Act 1991. A young person entering aftercare will not be under the same degree of supervision from the HSE as when he/she was in care. Since young people who are 18 years or over are legally adults, the approach to aftercare provision must be informed by the wishes of the young person; otherwise there is less liklihood that the young person will engage with the HSE.

In total the ICDRG examined the files of 32 young people who were in aftercare at the time of their death. The causes of death for the five young people who died from natural causes are shown in Summary Table 1 above.

The ages of the 27 young people who died from non natural causes are shown below (Table 5). This age range reflects the point in their lives when many young people in the long term care of the HSE leave care. However, the age when these deaths took place adds further weight to the conclusion reached above that there is heightened risk for children who have been taken into care as they go through later adolescence and emerge into adulthood.

Table 5: Non Natural Deaths of Children and Young People in After Care

- Age at Time of Death

Age at Time of Death	**Number of Deaths**
18 years	11
19 to 23 years	16
Total	27

The causes of the non natural deaths are shown at Table 6 below:

Table 6: Non Natural Deaths of Children and Young People in After Care

- Cause of Death

Cause of Death	**Aftercare**
Asphyxia (accidental)	1
Drowning (accidental)	0
Drug Related	14
Suicide	7
Road Traffic Accident	3
Unlawful killing	1
Accidental fall	0
Head injuries (cause unknown)	0
House Fire	0
Unknown	1
Total	27

In some of the cases reviewed 12 indicators of good practice identified by the ICDRG specific to young persons in aftercare were found to be evidenced:

Good Assessments, Risk Identification and Aftercare Plan
Aftercare Plan Followed and Reviewed or Planning Completed
Good/Consistent Care Provided by the Social Work Department
Appropriate Placement/Support
Good Social Work Supervision/Support
Regulations Followed
Good Interagency Cooperation
Good Foster Care
Support Provided to Family/Carers
Good Record Keeping
Appropriate Follow-Up after Child's Death
Review of Death

Again, whilst there is evidence of good practice being adhered to in some cases, the fact remains that its application was sporadic and inconsistent. A uniform and structured approach to the provision of aftercare is essential. Each and every young person who has been cared for by the HSE and is about to leave that care ought to be provided with the services and supports necessary to make the transition. Some areas within the HSE provide such services and supports to a high standard, but sadly the evidence over the period reviewed shows that others do not. Thus whilst the evidence of good practice is to be commended its absence in respect of other young persons in aftercare is a cause for concern.

Summary of Concerns

In some cases no aftercare at all was provided to young persons who left the care of the HSE. This is a very serious cause for concern. 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. Whilst the age of maturity of a young person for legal purposes is clearly defined it does not necessarily accord with the actual maturity of that young person. The HSE is

statutorily charged with the duty of caring for young people in care. A young person who leaves care cannot be said to be necessarily capable and competent to care for themselves. The statutory provision for aftercare should be strengthened by placing a mandatory statutory responsibility on the HSE/Child and Family Support Services Agency to ensure adequate supports are in place for vulnerable young people leaving the care system. Therefore if a young person refuses to engage in aftercare the HSE should not automatically accept this and close their file. Whilst it is the right of an adult to refuse aftercare, any such refusal ought to be considered and informed. To that end the HSE should take steps to guide a young person to making a considered and informed decision. Such steps taken by the HSE ought to be recorded in the file so that in the event of the file being reviewed it will be evident as to what steps the HSE followed to ensure the welfare of the young person. The steps to be taken will vary depending on each case, however, the objective will be same and that is to ensure that the young person is making a considered and informed decision. Counselling and advisory services ought to be offered by the HSE in that regard. In addition, the young person ought to be informed of the option of returning to the HSE for aftercare assistance in the event of a change of mind.

There is a fear that when young people leave the care of the HSE and go into aftercare that they are almost forgotten about. This fear is based on a number of concerns arising from the files examined. Eight of the files could only be described as being in complete disarray with little or no recording as to what happened when the young person entered into aftercare. In 3 other files it was impossible to assess what work had been done with the young person in aftercare. The recording process undertaken by the HSE in respect of the young persons in aftercare left a lot to be desired and thereby giving rise to serious concerns as to whether the HSE was properly carrying out its duties in respect of these young people.

The failure to keep proper records may stem from the inconsistency in social workers or aftercare workers assigned to these young people. In 3 of the files no worker was assigned which gives rise to the obvious question as to how these young people were expected to access aftercare services.

A young person entering aftercare will not be under the same degree of supervision from the HSE as when he/she was in care. Therefore it is critical that the HSE identify and provide the necessary support services for such a young person when in aftercare so as to meet the

particular needs of that young person. This is a particular cause for concern in respect of mental health issues. Interagency cooperation is essential so as to ensure that a global approach is taken to meeting the welfare needs of a young person in aftercare. In 5 of the files examined there was a lack of such cooperation.

Mistakes have to be learned from. Questions need to be asked when a young person dies whilst in aftercare. Surprisingly out of the 32 files examined no review of the death of the young person is recorded or planned. The concerns raised in this report are largely systemic in nature. A lack of clear procedures, reporting and supervision amongst HSE staff is evident. This needs to be remedied immediately throughout the child care system so as to help prevent the further deaths of children and young people in care.

DEATHS OF CHILDREN AND YOUNG PEOPLE KNOWN TO THE HSE

Of the 196 files furnished to the ICDRG 128 related to children and young people who were known to the HSE before or at the time of their death. The ICDRG's terms of reference specify that known to the HSE in this context is within the meaning of the HIQA guidance to the HSE of 20 January 2010. The HIQA guidance defines "known to the HSE child protection system" as child protection cases which are open or which have been closed in the past two years.

It is worth noting that HSE figures indicate that reports to the HSE's child protection services are of the order of 27,000 or more annually, although it is noted that these figures may include a number of referrals from different sources in respect of the same child. Of these over 15,000 cases per annum are considered to potentially concern welfare issues, physical abuse, sexual abuse, emotional abuse or neglect while subsequently approximately 2,000 of these cases have such concerns confirmed.

The HSE's powers in relation to children which come to its attention are different from those children in its care, although its overarching duty to promote the welfare of children not receiving adequate care and protection extends to all children. In such cases the HSE has not been given either voluntarily or, on its application, by the determination of a court the power to act *in loco parentis.*

Of the 128 deaths in this category 60 of these children and young people died of natural causes as shown in Table 1 above. Sixty eight died of non natural causes and their age ranges are shown in Table 7 below. The tendency for most of the deaths to be in the older age range is somewhat less pronounced than that seen in respect of children in care, although over half do occur at 13 years and over.

Table 7: Non Natural Deaths of Children Known to the HSE - Age at Time of Death

<table>
<tr><th>Age at Time of Death</th><th>Number of Deaths</th></tr>
<tr><td><1 year</td><td>6</td></tr>
<tr><td>1 year</td><td rowspan="3">11</td></tr>
<tr><td>2 years</td></tr>
<tr><td>3 years</td></tr>
<tr><td>4 years</td><td rowspan="3">10</td></tr>
<tr><td>5 years</td></tr>
<tr><td>6 years</td></tr>
<tr><td>7 years</td><td>0</td></tr>
<tr><td>8 years</td><td rowspan="5">5</td></tr>
<tr><td>9 years</td></tr>
<tr><td>10 years</td></tr>
<tr><td>11 years</td></tr>
<tr><td>12 years</td></tr>
<tr><td>13 years</td><td>7</td></tr>
<tr><td>14 years</td><td>7</td></tr>
<tr><td>15 years</td><td>9</td></tr>
<tr><td>16 years</td><td>9</td></tr>
<tr><td>17 years</td><td>4</td></tr>
<tr><td>Total</td><td>68</td></tr>
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The causes of death amongst the 68 children and young people who died from non natural causes are shown at Table 8 below.

Table 8: Non Natural Deaths of Children Known to the HSE
- Cause of Death

Cause of Death	Known to HSE
Asphyxia (accidental)	3
Drowning (accidental)	3
Drug Related	11
Suicide	16
Road Traffic Accident	11
Unlawful killing	13
Accidental fall	2
Head injuries (cause unknown)	2
House Fire	5
Unknown	2
Total	68

Having examined all 128 of the files the ICDRG identified 12 indicators of good practice that would be expected in respect of files relating to children or young persons known to the HSE and found the following to be present:

Risk assessment and planning in respect of children and young people

There was evidence of quick and appropriate reaction by the HSE in respect of concerns relating to particular families. Where risk assessments were carried out there was evidence of consistent follow up from services thereby demonstrating the positive effect risk assessments may have. There was also clear evidence of excellent decision making processes and follow through in some cases, including taking steps to bring the matter before the courts. Where there were agreed plans in place regular reviews were conducted, again demonstrating the necessity to plan in advance in order to provide appropriate care and support for a child or young person.

The voice of the child or young person

The voice of the child is often a vital factor to be taken into account as it may enable the HSE to obtain a true account as to what is happening in the family. This was evident in some cases. Relations with school counsellors and other persons who may interact with children regularly and with whom children might confide should be promoted.

Prompt follow up on referrals

Where concerns are expressed it is critical that the HSE follow up on these in a prompt manner so as to prevent any future or further harm to the welfare of the child. Such prompt follow ups were evident in some cases.

Support to family

An examination of the files demonstrates that often the support and assistance offered by social workers to families is resisted by parents despite what might be in the best interests of a child. Yet, through the sheer determination on the part of social workers evident in a number of files such supports were provided. In a number of cases clear support services were provided ranging from parenting courses, securing accommodation, addiction services, respite care and family support workers. The persistence of individual social workers in this regard is to be commended.

Support to family or guardians post death of child or young person

This was evident in some of the files examined.

Child protection concerns identified and discussed

In a number of cases child protection plans were put in place and followed up by child protection case conferences. There is evidence to show that where appropriate planning and reviews took place the system did enable the appropriate protection mechanisms to be put in place within the family unit, sometimes with the added authority of a Supervision Order. In appropriate cases interim care orders were obtained.

Supervision

Professional supervision of HSE staff was evident in a small number of the files examined.

Interagency cooperation

Good interagency cooperation and good communication between services was evident amongst the cases examined. These cases show that where professionals work together the level of support and services provided to a child tend to meet the needs of that child. Positive learning opportunities were evident in cases where there was a high standard of interagency work.

Record keeping and files

Amongst the files examined there were those which could be said to be of a high standard in terms of presentation, organisation and recording.

Critical incident report

A critical incident report was completed in a number of of the files examined.

Need for appropriate accommodation

In some cases there was a lack of appropriate accommodation to meet identified needs and the evidence shows that the social work teams involved constantly sought to address the situation.

Summary of Concerns

Of particular concern in a number of files is the fact that the HSE was aware of drug and alcohol abuse within a number of families, in particular by parents, which must as a natural consequence have given rise to concerns as to the welfare of the children, yet the HSE closed their files in a number of these cases despite the drug and alcohol abuse continuing. Children are vulnerable by their very nature and not to continue to attend to these issues and the implications for their welfare is to expose them to too great a risk of harm. Risk indicators such as this were not followed up adequately, or at all, by the HSE in a number of the files. In some cases no social worker was assigned to these families.

For some reason a number of the files evidence particular difficulties for the HSE in dealing with children who suffered from mental health difficulties, or who lived in a household with parents who suffered from such difficulties. Greater links between the HSE's child welfare & protection services and child and adolescent mental health services need to be forged so as to provide proper support and services to children in such situations.

The lack of resources within the HSE to provide appropriate support and services to these children is evident from the files provided to the ICDRG. A particular concern evident from the files is the lack of out of hours social work services. This is coupled with an overuse of the duty social worker in respect of a number of cases instead of assigning a particular social worker to each case. This is simply not an acceptable standard of care provision.

Suitable accommodation arrangements must be made available to children and young people who present to the HSE as being homeless. Similarly such arrangements must be made available for mothers and children in an environment that precludes substance abuse. A failure to provide necessary services is evident in a number of the files examined. In other cases there was delay in providing the necessary services. Often this was due to lack of resources but in some cases it was due to poor communication. In one case a child had to wait over a year to obtain an appointment with a psychologist.

The files demonstrate an evident problem with communications within the HSE and between the HSE and others. In a number of cases there was a failure within the HSE to discuss cases in full and review the options available for a child or his/her family. These communication problems are further exacerbated by the lack of professional supervision or supports for social workers. There is also evidence of the failure of HSE departments in one region to communicate with the department in another region following the child moving to that region. Some files also show that the HSE failed to communicate issues of serious concern, including assaults, to the Gardai or delayed in doing so in some cases. Sadly and perhaps most worrying is the failure on the part of the HSE to communicate properly with the child in question or his/her family. The focal conduit through which an improvement is to be made to the welfare of a child must be through communicating with that child's family. If that cannot be done then serious doubts must arise as to the effectiveness of any steps taken by the HSE thereafter.

REVIEW OF EMERGING ISSUES

The opportunity to review 196 case files – albeit those with the most tragic outcomes – has provided the ICDRG with a unique insight into both the difficulties experienced by some of the most vulnerable children in our community and the issues to be addressed by child welfare and protection and other services.

Table 9 below summarises some common issues found by the ICDRG to reoccur in a number of the cases reviewed. The nature of these issues was such as to be a factor which contributed to the problems experienced by the children and young people and the difficulties in addressing their needs. The identification of the potential impact of these factors, particularly in combination, should inform any risk assessment of a child's welfare.

Table 9: Prevalence of Certain Issues Amongst Cases Reviewed

Factor	Children in Care	After Care	Known to HSE	Total
Alcohol in home	6	13	18	37
Drugs in home	5	5	9	19
Physical or sexual abuse	7	14	13	34
Neglect	6	15	23	44
Bereavement	3	4	3	10
Domestic violence	4	11	15	30
Mental illness experienced by parents/guardians	4	5	13	22
Children experiencing severe behavioural problems (largely undiagnosed)	5	9	8	22
Problematic alcohol use by child/young person	4	7	6	17
Problematic drug use by child/young person	8	13	8	29
Criminal activity: family and child/young person	7	11	11	29
Non school attendance	6	5	9	20
Homelessness	1	12	10	23

The following are amongst the issues most worth particularly highlighting:

Resilience and early exposure to adverse experiences – In reviewing many of the case histories the ICDRG discovered that the problems that faced a number of these children began early in life. Children and young people admitted to care tend to come to the attention of the HSE after a serious incident or series of incidents giving rise to concerns as to their welfare. In a large number of cases the child has already been subjected to negative experiences and influences before coming to the attention of the HSE. The child/young person has not had an opportunity to build up their own resilience and to learn positive coping mechanisms. This is likely to place the child's welfare at risk. A number of steps are taken in order to protect one's own welfare, these steps may be categorised as detection, recognition, protection and coping. So as to protect one's welfare from negative influences it is first necessary to detect and recognise the negative influence in order to avoid same. It is essential that the appropriate risk assessments are conducted immediately upon a child or young person coming into care. The self-protection skills of a child need to be assessed and any deficiences in same need to be addressed immediately through the construction of an appropriate care plan in which the appropriate services are identified and provided to the child.

Adolescence – the identification of many of the deaths examined as occurring in adolescent years is important. Some element of risk taking may be a feature of young people emerging into adulthood but in the cases reviewed the judgment and tolerance of risk was extremely problematic. More effective engagement around this issue with children in care or known to child protection services is likely to be critical to achieving improved outcomes. A more effective approach to influencing behaviour amongst adolescents with complex needs and vulnerabilities is an issue not just for child protection services but for all of those involved with young people e.g. schools, youth services, mental health services, the justice system and others. It is critical that all these services work together.

Alcohol – in reviewing many of the case histories which are the subject of this report the ICDRG cannot help but be struck by the adverse consequences for the welfare of many of these children posed by alcohol. In some but by no means all of the cases alcohol contributed to children being exposed from their earliest years to poor parenting, neglect, abuse and psychological trauma. Some of these children and young people never recovered

and went on themselves to engage in problematic alcohol and substance misuse. The complexity of many of such cases in many instances goes well beyond the single issue of alcohol but addressing other underlying issues is made very much more difficult where serious misuse of alcohol is the established pattern. It is wholly unrealistic to assume that the social work profession or any other - no matter how well trained, supervised and supported by best practice - can remedy the damage for younger family members of serious alcohol misuse other than in a very limited and partial way. Failure on the part of society to comprehensively address the alcohol problem as a major threat to the proper functioning of individuals, families and communities is to leave child protection systems to deal with insurmountable consequences.

Multi Service/Agency Requirements:
The nature of the factors highlighted in Table 9 above highlights the requirement for a range of services and professionals to be involved with these families and to coordinate care in respect of the children and young people. Such inter disciplinary and inter agency work is not simple and poses challenges for children's services in all countries. However, this issue has emerged repeatedly in child protection reviews conducted in Ireland and it is imperative that improvements are achieved in the interests of children and young people. In particular, review of these cases has emphasised the importance of linkage between child protection and welfare services and mental health services, addiction services, education and justice.

Other Issues: Most, if not all, of the issues highlighted above demand careful assessment; planning; communication; continuity of care; review; timely and comprehensive supports for children and young people, carers and professionals and excellent information management – often across multiple agencies or service settings. We pay particular regard to these issues in formulating our recommendations in the next section.

RECOMMENDATIONS

Recommendation for Future Child Death Review Unit

The report examines in detail the various different forms of child death review units in a number of different jurisdictions so as to recommend the establishment of a Child Death Review Unit ("CDRU") in the Republic of Ireland based on best practice around the world.

First and foremost it is recommended that a CDRU be established in Ireland. It ought to be independent of the agency responsible for child protection, i.e. the HSE. It is recommended that the new unit be established within the Department of Children and Youth Affairs. Other models, such as incorporation within the Office of the Ombudsman for Children, are also possible. The CDRU should automatically have the power to investigate the death of any child or young person in the care of the HSE or in aftercare and those known to the HSE. Such a review ought to examine the circumstances in which the child or young person came into contact with the HSE and the circumstances leading up to and giving rise to his/her death. Recommendations ought to be made where required and an annual report published to the Oireachtas. A register of the deaths of such children and young persons should also be maintained.

Operation of In Camera Rule

So as to enable the CDRU carry out its task in a proper manner the operation of the *in camera* rule must be addressed so as to allow for transparency and accountability in child care cases. Information gathered in child care proceedings must be the subject of review and reporting, whilst all the time protecting the identity of the child and family members, so as to ensure that our child protection system is operating properly. In addition there must be a free flow of information shared between agencies involved in child protection services so as to ensure consistency in the level of protection provided to vulnerable children.

Reform of Child Protection

A root and branch reform of the child protection system in Ireland is required. The ethos needs to change to one whereby each and every person involved takes responsibility for his/her role in promoting the welfare of children and ensuring their protection. Thorough and comprehensive audits need to be conducted of the systems and procedures operating in the child protection system.

Many of the concerns raised in this report arise from systematic failures. Proper procedures need to be put in place and adhered to once a child comes into contact with the HSE. Some basic yet essential steps need to be followed. The following is a sample of such steps:

i. Conduct a risk and mental health assessment in respect of the child.
ii. Intervene at the earliest stage when warranted.
iii. Put in place a care plan for the child as soon as possible having regard to the results of the risk assessment.
iv. Ensure regular and clear communication between the HSE and families.
v. Seek the assistance of the courts where necessary, e.g. Supervision Orders.
vi. Assign a social worker to the child and avoid constant changing of social workers.
vii. Identify appropriate placements for the child.
viii. Identify the necessary services to meet the needs of the child and refer the child to those services promptly.
ix. Conduct regular care reviews.
x. Ensure that adequate professional supervision and support is in place.
xi. Ensure that all those who work within the child protection system have sufficient knowledge of the child protection legal system.
xii. Complete critical incident reports when required.
xiii. Keep proper records in respect of the child.
xiv. Create and maintain a proper information management system.
xv. Promote interagency communication, cooperation and support.
xvi. Provide adequate supports for foster families.
xvii. Provide suitable aftercare provision.
xviii. Review and audit systems on a regular basis.

The factors set out above are not thought to be overly complicated in the context of a child protection system, however, the files as provided to the ICDRG demonstrate that these logical steps are not been taken in the majority of cases thereby giving rise to concerns in respect of the welfare of children who are in the child protection system. Obviously each case will present its own challenges, but it is thought that these steps will at least go some way towards identifying those challenges so as to enable the appropriate supports and services be provided to the child.

The death of any child is tragic. Many of the cases reviewed were from natural causes, others were unnatural and may have been preventable and still others were unnatural and not preventable. It is the earnest hope of the ICDRG that this review of the deaths of 196 children and young people between 2000 and 2010 involved with the care system will provide a basis on which to provide greater support and protection of such vulnerable children and young people in the future.