Introduction

The Act governing our child protection system is the Child Care Act 1991. This Act refers to the health boards, whose function was taken over by the HSE. The child welfare and protection function of the HSE has now been taken over by the Child and Family Agency (the “CFA”), so it can be taken that all references to a health board in the Act now refer to the CFA, or Tusla (as it now calls itself), though this title does not exist in the legislation.

The opening statement of the Act, after definitions, is: “It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection.”

The Act then goes on, inter alia, to provide for: children to be cared for outside their families in voluntary care; adoption services; services by voluntary bodies; the power of the Gardaí to take children into care on an emergency basis; the duty of health boards to institute proceedings to take children into care on an interim or long-term basis or to seek Supervision Orders; various jurisdictional and procedural matters; and the maintenance of children in care and the supervision of pre-school services.

The Child Care Law Reporting Project (the “project”) was established to report on the proceedings where the HSE seeks Care Orders or Supervision Orders in the District Court, whose decisions may be appealed to the Circuit Court. Previously all such proceedings were covered by the in camera rule, and the HSE was extremely resistant to any information being released from them. Thankfully, this has now changed. The project may also report on proceedings in the High Court where children are placed in special care, though these proceedings have always been open to the media, subject to the maintenance of the anonymity of the parties. We may also follow cases on appeal to the Circuit Court or different High Court challenges to the District Court proceedings.

In practice, there have been very few Circuit Court appeals. Since we began our work in November 2012 there has been a handful of judicial reviews and Article 40 (habeas corpus) challenges to child care applications. The bulk of our reporting, therefore, and all the statistics we have collected, are drawn from District Court proceedings. These reports and statistics demonstrate the working out of certain provisions of the Child Care Act in practice. In the course of our work we are able to make some tentative observations on weaknesses in the Act and in the child protection system. The reports, and our first Interim Report which contains some initial observations, are available on our website, www.childlawproject.ie.

The legislation
Section 3(2) of the Child Care Act 1991 states that the health board shall take such steps as necessary to identify children who are not receiving adequate care and protection. It continues: “having regard to the rights and duties of parents, whether under the Constitution or otherwise” and “having regard to the principle that it is generally in the best interests of a child to be brought up in his own family”. These fleeting references to parents and the child’s family are the only acknowledgement of the place of a child’s parents in his or her life, and the need to protect and promote that relationship.

It can be said that there is an abundance of jurisprudence on this constitutional principle, but very little of that jurisprudence relates to the child protection system, and the provisions of the Constitution or the judgments of the higher courts are, in practice, very rarely cited in District Court proceedings, though they may be in the minds of at least some members of the District Court bench. The issue of how the rights of parents, and the right of children to be brought up in their own families, are defended and protected in child care proceedings is one which requires some attention.

It should be remembered that the place of the family in Irish constitutional law, and therefore within the legal system generally, is fundamentally different from the place of the family in the British constitutional and legal order. England and Wales, along with Northern Ireland, have no written constitution, so the law relating to child protection is not grounded in a constitutional presumption that the child is best cared for within his or her own family. This obviously informs social work practice in that jurisdiction. A significant number of social workers in the Irish system have been trained in the UK or spent some time practising there, and the majority of the available literature on child protection is based on that experience. The situation in many other EU member states is very different. In France, for example, as in Ireland, the presumption is that it is generally in the best interests of children to be reared within their families. It may be useful for Irish legal and social work practitioners in this area to consider the lessons of child protection practice within the EU broadly, rather than limit the focus to practice in the Anglophone world.

Part II of the Child Care Act 1991 deals with taking children into care with the agreement of their parents, known as voluntary care. This system operates outside the courts, so we have no way of knowing the circumstances that lead to children being placed in voluntary care or the services available to them in care, especially if they have special needs. This has to be a matter of serious concern, as it is part of the statutory provision for the care of children, and we know from our statistics that a significant proportion of children have special needs. Section 47 proceedings (seeking directions from the court relating to the welfare of the child) can be brought where children are in voluntary care, but this happens rarely.

While the Child Care Law Reporting Project has no role in relation to voluntary care, we are aware there is an intimate connection between the voluntary care system and court-ordered care. We know that some of the cases that come to the District Court involve children who were previously in voluntary care. Some children are released from court-ordered care into voluntary care; so the two systems are not hermetically sealed from each other, and issues that arise in court-ordered care are likely to arise similarly in voluntary care.

The statistics we gathered, which were published in the project’s first Interim Report last October, showed that 27 per cent of District Court cases involved children with special needs and one in eight of the cases involved a parent with mental illness or cognitive disability. It is reasonable to assume that these issues also arise, at least to some degree, with the children in voluntary care and their parents. Further research into voluntary care and how it operates for children and their families is needed.

The Legal Aid Board provides legal assistance to parents when care proceedings are instituted. But it does not always provide such assistance when there are no proceedings, and there are no proceedings involved in voluntary care, so the assistance of the Legal Aid Board may be difficult to access when voluntary care is mooted. We do not know whether parents obtain private legal advice when they consent to voluntary care, but it is likely that many of them do not, and we do not know either whether parents with cognitive or mental health difficulties have the assistance of an advocate.

We know from our statistics from the project so far that a significant proportion of the respondent
parents have cognitive or mental health difficulties. Without evidence to the contrary, there must be a question mark over whether consent to voluntary care is always fully informed consent, or whether people may sometimes feel pressurised into giving their consent, perhaps because they perceive they may be the subject of a more draconian court order if they do not.

Part III of the Child Care Act 1991 includes provision for a member of An Garda Síochána to seize a child thought to be in danger, and the making of an Emergency Care Order. The Act requires there to be “an immediate and serious risk to the health or welfare of a child which necessitates his being placed in the care of a health board”, or that such a risk will arise if the child is not removed from the place where he or she is for the time being.

This is a high threshold, and we have seen a number of cases, especially in Dublin District Court, where the judge has refused to grant an Emergency Care Order on the basis that the threshold has not been reached. Examples include the withdrawal of an Emergency Care Order application following a DNA test on a Roma child, and the refusal of the court to grant an Emergency Care Order for an African child sought because she was not the daughter of the father in the case, though she was related to him and she, the father and his children saw her as an integral member of the family. It appears that the number of applications for such Emergency Care Orders in Dublin has declined following the publicity around some recent cases. It also appears that some Emergency Care Orders are withdrawn when the parents opt instead for voluntary care, though that in turn raises other issues.

However, in other District Courts such orders have been granted where the threshold did not suggest an “immediate and serious” risk. I attended a case recently, for example, where the evidence of an “immediate and serious risk” to a baby, who had been living with her mother without incident under a Supervision Order for over six months, was that the mother tested positive for cannabis when she and the baby were admitted to hospital with suspected carbon monoxide poisoning. She was later returned to her mother when further tests were negative.

The question of thresholds, and variations in the threshold at which applications are sought by the local HSE/CFA and granted by the courts, is therefore one which requires further examination by the CFA and further clarification in a new Child Care Act, which I understand is under preparation in the Department of Children and Youth Affairs.

Statistics

This question is raised by statistics produced by the Courts Service on child care applications and published on our website along with the reports of child care proceedings and the Interim Report. The most recent are for the year 2012; the 2013 statistics will not be available until later this year. For various reasons, they should be read with considerable caution. Nonetheless, the Courts Service statistics provide a very useful insight into the volumes of child care proceedings taken throughout the State, and to the great variation that exists between different areas.

The statistics are not directly related to the number of children in care or the number of families who come to the attention of the HSE. They do not, of course, include the children who are in voluntary care, as these families do not come before the courts. In addition, the largest single category of applications is for Interim Care Orders, which make up 62 per cent of all applications. Many, and probably most, of these are extensions of existing Interim Care Orders, which must be renewed on a monthly basis.

One of the striking features of these statistics is that the volume of applications varies greatly between towns of roughly similar size. For example, the town of Letterkenny is approximately the same size as Carlow and not much bigger than Tullamore, yet there were 229 child care applications in Letterkenny in 2012, compared with 10 in Carlow and nine in Tullamore. Other substantial towns with very few applications were Longford (31), Mullingar (38) and Portlaoise (22).

It is also noticeable from the statistics that some District Courts appear to be more likely to grant the applications than others. Cities and towns with high volumes of applications are particularly likely to grant most, if not all, applications, though this is not true of Dublin. For example, Cork city granted 100 per cent of the 702 applications made in 2012, as did Limerick (500), Clonmel (427
applications), Tralee (176) and Trim (140) and a number of towns with smaller numbers of applications. Letterkenny, Mallow, Drogheda, Ennis, Kilkenny, Donegal and Clonakilty all granted more than 95 per cent of the applications made. In Dublin, the proportion of applications granted was 74 per cent.

The statistics do not show, of course, whether the application sought by the HSE is always granted by the court in the terms in which it was sought, and local practitioners have queried the statistics on the basis that they are not. In many instances, the HSE/CFA may seek a Care Order until a child is 18, but the court may only grant it for a much shorter period, perhaps one or two years; or the agency may seek an Interim Care Order, or a renewal of an existing ICO, and the judge may refuse it but ask that an application be made for a Supervision Order instead. These measures are particularly noticeable in Munster. In Cork and Waterford, for example, Care Order applications are more than double the number of Interim Care Orders, and Care Orders for a number of months are sought instead of Interim Care Orders in order to allow the HSE/CFA and the family to work on issues without repeated visits to court. If a short Care Order expires, the expiry is not noted in the Courts Service statistics.

Thus, these figures appear to reveal different practices in these cities and elsewhere in the country. Short-term care orders appear to be used instead of Interim Care Orders as part of the management of cases, with tasks set for both the parents and the CFA with an objective of reuniting the family if the conditions are met. Because of the absence of figures for the lapse or expiry of such short Care Orders, we do not know how often the families are reunited.

Yet we are still left with wide discrepancies between the applications brought to court in different cities and towns. There are various possible explanations, including that different courts count proceedings differently and that care proceedings are less likely to be taken where there is a good network of family support services. The latter explanation is supported by A Review of Practice and Audit of the Management of Cases of Neglect Report on the Findings of the Pilot Phase of the National Audit of Neglect, published recently on the website of the Child and Family Agency, which studied three HSE areas—Roscommon, Waterford and Dublin South-East. It found that Roscommon had very good family support services, compared to the other two. Roscommon had only 57 child care applications in 2012, of which 42 were Interim Care Order applications and therefore likely to include a large number of renewals. The populations of Waterford and Dublin are, of course, far greater, so it is not surprising that they record a much higher number of applications. They also may not have enough family support services to meet the greater need.

However, it is also likely that different thresholds operate in different areas, with lower thresholds sparking care proceedings in certain parts of the country compared with others.

Interpretation of Act

This is probably inevitable as the Act is open to variations in interpretation. It is the duty of the HSE to seek an Interim Care Order where “there is reasonable cause to believe” that a child has been or is being assaulted, neglected, ill-treated or sexually abused; or his or her health, development or welfare has been or is being avoidably impaired or neglected; or is likely to be unless the order is made. A Care Order should be sought where “the court is satisfied that” these conditions exist.

This latter provision—that the health, development or welfare of the child is likely to be impaired if an order is not made—in both sections requires an assessment of the risk to the child into the future, which involves predicting the behaviour of the parents and children. No guidance for the assessment of such risk is provided by the Act and there are wide variations in how risk is assessed by social work teams in different parts of the country.

The literature on risk factors in child protection lists a number of factors that are present when children are at risk of abuse or neglect. These include domestic violence, drug or alcohol addiction, single parenthood, mental illness, cognitive impairment and general poverty. This mirrors what our first Interim Report found. Forty-one per cent of the respondents were single, with almost 13 per cent divorced or separated and five per cent in hospital or prison, so almost 60 per cent were parenting alone; 12 per cent had a disability, either mental or intellectual; either
drug or alcohol abuse featured in almost 20 per cent of cases. Domestic violence also featured, though it was not the main reason given in evidence for the care proceedings to be brought. We recorded “multiple” reasons in many cases.

However, most of these problems are widely prevalent in society. According to Violence against women: an EU-wide survey, published by the EU Agency for Fundamental Rights (FRA) last March, 26 per cent of women in Ireland experienced physical or sexual violence by a partner or non-partner, of whom 15 per cent experienced the violence from a partner. One in 11 children in Ireland say parental alcohol use has a negative effect on their lives, according to Alcohol Action Ireland, who calculate the number affected as 109,684 children. If we combine this with children who have seen some domestic violence, this figure will greatly increase.

There are no overall figures for drug use, but according to the latest Drug Prevalence Survey, almost one in five young people say they have used cannabis, amphetamines have been used by 4.5 per cent of the population and 9.4 per cent said they have used cocaine. That suggests a substantial proportion of the young population have used illegal drugs, though of course it does not mean they are addicts. Nor are all of them parents. However, we have seen that mere suspected drug use, rather than debilitating addiction, can be the basis for seeking a Care Order. Yet the majority of drug addicts retain custody of their children.

In considering the impact of poverty on parents and children, it was reported that 25 per cent of young mothers in poorer areas suffer from maternal depression, which is a risk factor for children, and 21 per cent of children in these areas go to school or to bed hungry, which is an indicator of neglect. In addition, we know from media reports of the increase in homelessness among families with children, due to the recession rather than any fault on the part of the families. Homelessness is also a serious risk for child welfare.

All of these issues are frequently cited in social work reports as reasons for applications being made for Care Orders, but it is obvious from the figures that there is no possibility that everyone who has one or more of these issues, and is a parent, is coming to the attention of the social services, as we have just over 6,000 children in care. Nor should they; we cannot answer the risks to children from poverty, homelessness, drug abuse, alcoholism, domestic violence, mental illness and other issues primarily by taking the children into care.

This does mean, however, that once these issues are identified it is difficult to argue that the children are not at some level of risk. But neither the legislation nor the HSE Child Protection and Welfare Practice Handbook provide a clear definition of the threshold of risk at which care proceedings should be brought, or what attempts should be made to address these issues before concluding that the only option is to take the children into care.

The jurisprudence of the European Court of Human Rights and, indeed, of our courts, is clear that taking children into the care of the State is sometimes necessary in order to protect them, but should only be a measure of last resort. Most recently, Hogan J., in J.G. & Ors v Staunton & Ors, said: “The loss of parental rights… is a serious matter which the organs of the State should not lightly undertake,” adding that Art.42.5 envisages that there will be cases where this is necessary to safeguard the child’s own constitutional rights. He also states that it is impossible to catalogue ex ante the precise nature of the parental failure which might justify the removal of the child from the custody of its parents.

No-one can argue that children should be left in circumstances where they are in danger of abuse or severe neglect; but the cases seen by the Child Care Law Reporting Project has indicated a wide variation in the thresholds which prompt proceedings being brought. Successive reports on the child protection system have revealed many instances of children being left at home and at serious risk for years on end, including the Child Deaths Report; the Child Care Law Reporting Project has also seen instances where supports for parents who were not drug- or alcohol-abusing, who were devoted to their children but finding it difficult to cope, if brought into play in a timely way, might have averted the bringing of care proceedings.

In this situation it is difficult for the parents to oppose the application. By definition, they have difficulty in coping with family life. They may not have received adequate parenting themselves and have no knowledge of how to parent their children in a consistent and organised way. If
impoverished, as most are, they may find it difficult to provide and cook nourishing food on a regular basis—the newspapers are full of stories of struggling families affected by social welfare cutbacks where the food has run out one or two days before the next welfare payment is due. If the parents suffer from cognitive impairment, they may find it difficult to understand what is being asked of them, the nature of the proceedings, and how to instruct their lawyers. The supports for people with cognitive impairment in such situations are patchy, to say the least.

Representation of parents

This raises the issue of “equality of arms”—or indeed, a rough equivalence of arms—in child protection proceedings. Some would argue that this issue does not arise, as the proceedings are not an adversarial contest. The role of the court is to inquire into what is in the best interests of the child; as such the proceedings are “investigative” rather than adversarial. They are not like criminal proceedings, as the parents are not accused of any crime. They resemble civil proceedings in that the burden of proof is not beyond reasonable doubt, but on the balance of probabilities, though they are not strictly civil proceedings either, in that there is no dispute between the parties.

While the role of the court is indeed to inquire into what is in the best interests of the child, it is difficult to convince parents that this is not an adversarial process. Their parenting is on trial, even if they may not be. The sanction that arises at the end of the proceedings—the removal of their children from their care—is the gravest one imaginable and cannot be seen as of lesser weight than the removal of a person’s liberty.

As O’Malley J. put it in HSE v O.A. which deals with the right of a parent in child care proceedings to the lawyer of his or her choice, irrespective of whether or not he or she is entitled to legal aid:

“[I]t is agreed that the judge’s role is inquisitorial but, it is contended, the process itself is adversarial. Parents who contest the application made by the HSE can only do so by challenging the HSE’s evidence and adducing their own. There are always issues to be determined, the primary one being whether the HSE was justified in making the application.”

Acknowledging that child care proceedings are not directly analogous to other forms of litigation, in that the judge’s function is different, she continues:

“[T]hat is not to say that it is wholly unlike other litigation. The concept that ‘there are no winners or losers’ is an appropriate one for the attitude of the professional staff of the HSE and its lawyers, but it asks a degree of detachment that is very unlikely to be shared by a parent. The procedure is, as a matter of fact, adversarial.”

This is the context in which the issue of representation for respondents comes into focus. Most respondents are represented by solicitors of the Legal Aid Board. But we all know that these resources are stretched to breaking point, squeezed by the exponential growth of demand for their services on the one hand, and de facto cuts in funding on the other. It may be difficult, especially outside of the major cities, for the local law centre to provide the kind of attention to such cases that they deserve, especially where the client is particularly vulnerable due to cognitive impairment or mental health issues. Given the pressure on law centres, there may be little time for the solicitor to examine all reports, take full instructions and prepare the client for the case. While the Legal Aid Board has a number of highly experienced solicitors working in this area, they are hampered by having far less resources than the HSE/CFA’s legal advisers, especially when it comes to access to funding for independent experts.

On the other side, the CFA is represented by lawyers with years or even decades of experience in piloting care applications through the courts and witnesses who usually have given evidence in such cases many times before and know what is expected of them. They have access to experts, like paediatricians and psychologists, whom they can ask to present evidence supporting the application. It is virtually impossible for respondents to obtain expert witnesses to counter this evidence.

Once the process begins, the issues in the case can multiply. The children may have come to the
attention of the HSE/CFA due to neglect, e.g. coming to school hungry or dirty, showing some
developmental delay when having regular medical check-ups, the house being dirty and untidy
when visited. Often the children will be taken into care under an Interim Care Order, where,
according to the legislation, the “court has reason to believe” that they are being neglected.

The HSE/CFA will then apply for a Care Order, as the legislation requires that a Care Order is
being considered when an Interim Care Order is made. When in care the children should be
assessed in order to establish the extent of their neglect, whether they have been abused and
what their needs are. This should be done before a Care Order is sought, so that the court may
be “satisfied” that the grounds exist for sundering the parent-child relationship. However, this
does not always happen. I am at present attending Care Order proceedings (until they are 18) for
a large number of children from three families where the majority of the children have not been
assessed and the parents’ cognitive abilities and risks to their children were not assessed either.
This is not uncommon in parts of the country where there are no specialist units for assessing
child sex abuse, for example.

Here, assessments of children for sex abuse may come from social workers with little specialist
training, who react to sexualised behaviour on the part of the children or to remarks made by
parents or children during access visits. The assessment of child sexual abuse is highly
specialised, and indeed sometimes a definitive diagnosis may be very difficult to obtain.
Sexualised behaviour from children is not, in itself, proof of abuse. Frequently, also, children
make disclosures of abuse after some time away from an abusive situation. The implications of a
diagnosis of sexual abuse are devastating for the child and the family. Yet, access to such a
diagnosis by an appropriate specialist depends on a geographical lottery. Nonetheless, such
diagnoses are made by whoever is available in that area, whether or not they possess the
necessary specialist training.

The access visits between parents and children, which are supervised where a level of risk is
presumed, are also problematic. While they are intended to be for the benefit of maintaining the
parent-child relationship, they also become evidence-gathering opportunities for the HSE/CFA in
the ongoing proceedings, thus giving rise to hostility between parents and social workers and
intensifying the adversarial nature of the whole process. Interim Care Orders which are contested
must be renewed every 29 days. As the renewal hearings progress, it is likely that the evidence
for the continuation of the order will contain critical accounts of the conduct of the parents during
supervised access. If the social work department has formed the view that it is necessary to take
the children into care, based on its experience with the family prior to court proceedings being
brought (and which are outside the scope of the CCLRP), the social workers are likely to place a
negative construction on interactions between parents and children that may appear quite benign
to another observer. It is hard to imagine how parents can be relaxed and spontaneous with their
children when they meet them under such conditions.

This raises the issue of the dual role of social workers when care proceedings are instituted. On
the one hand, their role is to promote the welfare of children and their families, mindful of the
principle that children are best cared for within their families. But they may also have to take child
protection measures against the families, which inevitably pit them against the parents of the
children and cast them in the role of the enemy.

Early lessons from the project

So what lessons are there for practitioners from the work so far of the Child Care Law Reporting
Project? It is too early to be definitive, but from what we have seen there is a need for greater
precision in the Child Care Act 1991 and in supporting material within the CFA so that there can
be greater consistency in the thresholds at which care proceedings are brought. There is a need
for the integration of child protection services with other services aimed at those suffering from
mental health problems and addictions.

There is also a clear need for the early identification of children at risk and their parents, along
with an assessment of the needs of those parents so that they can parent their children and
receive assistance if necessary. This requires the wide availability of family support services, so
that families where children are at risk can receive the support they need. These could be
combined with much greater use of Supervision Orders, which at present only make up eight per
cent of the orders sought. There should be an obligation on the CFA to demonstrate to the court that such supports have been offered and put in place, and have failed to ameliorate the risks, before care proceedings are brought. Of course, this would not apply where there was an immediate and serious risk to the child, for example, through non-accidental injury or evidence of physical or sexual abuse.

*40 Parents against whom care proceedings are brought should always have access to adequate legal representation, including expert opinion where necessary, and also access to advocacy services where they have cognitive or mental health issues. All children who are the subject of proceedings should have access to appropriate assessments, including timely assessments by specialist units where sexual abuse is suspected or alleged. This could include establishing a panel of experts from which the courts could seek agreed reports.

Above all, however, there is a need for a public discussion on child welfare, the child protection system and the risks to children, so that parents realise what society expects of them, and as broad a consensus as is possible on what is an acceptable level of risk. It is not possible to eliminate all risks to children. Unfortunately, there will always be children who have accidents, who acquire preventable illnesses, who do not receive optimum nourishment and intellectual stimulation, who may have a parent who emotionally abuses them, occasionally hits them or suffers from a mental health issue that impacts on the children. For example, we should note that of about a dozen examples of children killed by their parents in recent years, only one, the Monageer case, involved a family already known to the HSE. The others were middle class families, in most of which there were some mental health problems, but they fell under the HSE radar.

Above all, we know there are hundreds of thousands of children living in impoverished families, with all the risks that brings. Care proceedings, while sometimes necessary, cannot answer all these challenges to child welfare. Nor can they be the principal response to the injunction in the Child Care Act 1991 that "it shall be the function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection". Care proceedings should truly be the last resort.

This journal may be cited as e.g. [2005] 2 I.J.F.L. 1 [[year] (Volume number) I.J.F.L. (page number)]


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1. Child Care Act 1991 s.3(1).


9. [2013] IEHC 172 at 64.