Annual Report of the Special Rapporteur on Child Protection 2021

A REPORT SUBMITTED TO THE OIREACHTAS

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JUNE 2021

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Chapter 1: Annual Review

Chapter 1 of this Report provides an update on issues raised in the 2020 Report of the Special Rapporteur on Child Protection, followed by an examination and discussion of the findings of a range of reports by national and international bodies and NGOs published during the reporting period of January 2020 to June 2021. Positive progress is noted on the review of the Child Care Act 1991 and associated issues (section 1.2.1); the expansion of the Barnahus/Onehouse project (section 1.6) and the establishment of Divisional Protective Services Units (DPSUs) within An Garda Síochána (section 1.3.6). On some issues, it is noted that significant efforts are evident, but the need for further improvement remains; these include child homelessness (section 1.3.2); the provision of adequate special care placements within the jurisdiction (section 1.2.3); the prevention, detection and prosecution of child trafficking (section 1.3.8) and inter-agency collaboration (section 1.9). Areas highlighted as being of concern include the absence of proposals to raise the minimum age of criminal responsibility (section 1.2.2); inadequate resourcing provided to An Garda Síochána to examine ICT devices in cases of suspected online child abuse (section 1.3.6); the cancellation of 999 calls related to domestic abuse by An Garda Síochána (section 1.3.7); the level of support provided to separated children who are seeking to apply for citizenship, or who are ageing out of the care system (section 1.5.4); and ongoing delays in the provision of redress for victims of sexual abuse in National Schools (section 1.8.2).

Chapter 2: The Impact of COVID-19 on Child Protection in Ireland

Chapter 2 examines in detail the various ways in which the COVID-19 pandemic has impacted on child protection by examining evidence from research both in Ireland and abroad. It begins by examining general impacts on child welfare in the areas of education (section 2.2.1); social interaction and play/leisure (section 2.2.2); economic impacts (section 2.2.3) and physical and mental health (section 2.2.4). Following on from these general impacts, Chapter 2 examines specific impacts within the child protection system. Evidence is examined indicating that children were forced to stay in unsafe home environments, at a time when levels of domestic abuse increased significantly (section 2.3.1), and that the flow of referrals to child protection services was disrupted due to school closures and other lockdown measures (section 2.3.2). Home visits by social workers and access visits were limited or conducted in difficult circumstances due to social distancing requirements (sections 2.3.3 and 2.3.6). The risk that children would be exposed to cyberbullying or other forms of harm online increased in tandem with an increase in unsupervised screen time (sections 2.3.4 and 2.3.5). Finally, children were affected by delays in assessments, courts hearings and access to therapeutic and support measures (section 2.3.6 to 2.3.8). Child protection practice had to change considerably during the pandemic, and section 2.4 examines a selection of new practices, including innovative use of technology and adapted social work visits; policing measures such as Operation Faoiseamh; the prominent role played by helplines; targeted resourcing measures, and public awareness campaigns. Chapter 2 concludes that in spite of enormous efforts made to mitigate the impact of the COVID-19 pandemic, all children were negatively impacted,

with these impacts falling disproportionately on disadvantaged and marginalised children. It recommends that efforts be made to forecast the impact of the pandemic on demand for services for children and to provide additional resources to meet this demand; and that a proactive pandemic response plan aimed at keeping schools open to the greatest extent possible be developed and kept under regular review in light of the latest public health research.

Chapter 3: The Final Report of the Commission of Investigation into Mother and Baby Homes—A Human Rights Analysis

Chapter 3 provides a detailed examination of the extent to which the Final Report of the Commission of Investigation into Mother and Baby Homes provides evidence of violations of human rights in the broad sphere of child protection, including infant deaths; ill-treatment of women and children; forced labour; deprivation of liberty; consent to adoption; and vaccine trials. The Chapter takes a systematic approach of applying standards applicable under the European Convention on Human Rights (ECHR) (which was binding on Ireland from 1953 onwards) to the evidence cited in the Commission Report. It concludes that the Report discloses substantial evidence on all of the themes considered that is indicative of violations of provisions of the ECHR. Examples include a high rate of infant deaths due to poor living conditions, overcrowding, and inadequate medical care (section 3.2); degrading treatment of women and children in Mother and Baby Homes and County Homes, and of children in foster homes (section 3.3), as well as forced labour practices in the same settings (section 3.4); deprivation of liberty of women who were forced to stay in Homes, isolated from the outside world, against their will (section 3.5); consent to adoption that is of questionable validity due to pressures placed on women by various actors (section 3.7); and vaccine trials conducted on children in Mother and Baby Homes without proper parental consent (section 3.8). In some of the above instances, the State was directly involved (through the management of some Homes, or the approval of adoption orders); in others, it bore responsibility because it was aware or ought to have been aware of the risk of rights violations at the hands of private actors, but failed to take effective measures to mitigate that risk. Recommendations made in Chapter 3 include that any redress scheme designed on foot of the Commission Report should take a flexible approach that allows for recognition of the similarities in people's experiences, instead of highlighting their differences to justify refusing applications; and that all children who experienced rights violations in Mother and Baby Homes, County Homes or foster homes be fully included within the scope of the scheme.

Chapter 4: Legal Developments and Research Update

Chapter 4 considers the latest legal developments in the area of child protection in both international law and domestic law. At international level, the Committee on the Rights of the Child published General Comment No 25 (2021) of the Committee on the Rights of the Child on children's rights in relation to the digital environment (section 4.2.1), while the European Court of Human Rights delivered a range of significant judgments on issues including compulsory vaccination, protection of children from harm, investigation of abuse

and neglect and human trafficking (section 4.2.2). At domestic level, the Supreme Court delivered a landmark judgment interpreting the effect of the 2012 children referendum on the State's power to intervene in family life to protect children's rights (section 4.3.1). Other judgments considered a variety of issues, including the investigation of allegations of sexual abuse (sections 4.3.1 and 4.3.2), juvenile justice (sections 4.3.7 and 4.3.8) and the naming of victims of child homicide (section 4.3.9). Chapter 4 also provides an update on academic research in the broad sphere of child protection that was published during the reporting period. Significant examples include child welfare removals of newborns (section 4.4.1), disclosures of sexual abuse by children and adults (section 4.4.4), sexuality education (section 4.4.6) and social worker retention (section 4.4.9).

Appendices

The Appendices to the Report reproduce a number of invited submissions made by the Special Rapporteur on Child Protection to Oireachtas Committees and law reform working groups during the reporting period, including:

- Appendix A: Submission on the General Scheme of the Family Court Bill
- Appendix B: Submission to the Family Justice Oversight Group
- Appendix C: Submission on the General Scheme of the Online Safety and Media Regulation Bill
- Appendix D: Observations on the Birth Information and Tracing Bill
- Appendix E: Submission to the Child Maintenance Review Group

Recommendations made in these submissions include the importance of specialist training for staff and of suitable facilities in family courts; the inclusion of an individual complaints mechanism in the Online Safety Bill that would allow individuals to secure the removal of harmful content; the gathering of adoption records into a consolidated archive under the auspices of a single agency to allow for more efficient adoption tracing; and the establishment of a State child maintenance agency.

TERMS OF REFERENCE OF THE SPECIAL RAPPORTEUR ON CHILD PROTECTION

The role of the Special Rapporteur on Child Protection was established following the Supreme Court Decision in May 2006 in *CC v Ireland*, which held that section 1(1) of the Criminal Law (Amendment) Act, 1935, which made it an offence to have unlawful carnal knowledge of a girl aged under 15 years, was unconstitutional as it did not allow for a defence of mistaken belief as to the age of the girl. The term of office for the Rapporteur is three years and he/she is required to prepare, annually, a report setting out the results of the previous year's work.

The terms of reference for the Special Rapporteur are as follows:

1. The Rapporteur shall, in relation to the protection of children and on the request of the Minister for Children, Equality, Disability, Integration and Youth:

   a) Review and report on specific national and international legal developments for the protection of children;

   b) Examine the scope and application of specific existing or proposed legislative provisions and to make comments/recommendations as appropriate; and

   c) Report on specific developments in legislation or litigation in relevant jurisdictions.

2. The Rapporteur shall report on relevant litigation in national courts and assess the impact, if any, such litigation will have on child protection.

3. The Rapporteur shall prepare, annually, a report setting out the results of the previous year's work in relation to 1) and 2) above.

4. The Rapporteur will provide, if requested by the Minister, discrete proposals for reform prior to the submission of the annual report.

5. The annual report of the Rapporteur will be submitted to the Government for approval to publish and will be laid before the Oireachtas and published.

All of the Reports of the Child Protection Rapporteur are published on the *website of the Departmentof Children, Equality, Disability, Integration and Youth*.

Dr Geoffrey Shannon held the post from 2006 to 2019. He was succeeded in 2019 by Professor Conor O'Mahony, who was appointed for a three-year term from 2019–2022.

Professor Conor O'Mahony is Professor of Law and Deputy Dean at the School of Law at University College Cork, where he specialises in child law, children's rights and constitutional law. He is the Director of the Child Law Clinic, which supports litigation and advocacy on a range of children's rights issues. His research on child protection law, children's rights, educational rights and constitutional law has been published in leading international journals including the *Human Rights Law Review*, the *Child and Family Law Quarterly*, *Children and Youth Services Review*, the *International Journal of Law Policy and the Family*, the *Journal of Social Welfare and Family Law*, *Child and Family Social Work*, the *British Journal of Social Work*, *Public Law* and the *International Journal of Constitutional Law*. With colleagues in UCC, he has jointly produced award-winning research on District Court child care proceedings and led child protection research and training projects funded by the EU Commission and the Department of Children and Youth Affairs. He has also contributed to expert reports for the Council of Europe Venice Commission and the Department of Children and Youth Affairs.

The production of a lengthy report is not a solitary endeavour, and as always, I am indebted to a number of people for their assistance over the past 12 months:

- Dr Elaine O'Callaghan, who has worked with me as a researcher on each of the reports I have completed as Special Rapporteur to date. Elaine has taken on more responsibility on each occasion and made a significant contribution not just to the researching of this Report, but to the drafting of sections of three of the four chapters and several of the submissions in the Appendix. I am immensely fortunate to be able to rely on her rigour, her efficiency and her collegiality.

- University College Cork, and in particular the Dean of Law Professor Mark Poustie, for affording me the flexibility to balance my role as Special Rapporteur with my commitments in the School of Law.

- Multiple staff of the Department of Children, Equality, Disability, Integration and Youth; Tusla; the Ombudsman for Children's Office; the Child Care Law Reporting Project; the Irish Human Rights and Equality Commission; the Children's Right Alliance; Barnardos, and Rape Crisis Network Ireland who willingly responded to queries and engaged with me on a range of issues.

- Colleagues in academia who responded to specific queries or provided general support during the year, including Dr Kenneth Burns, Professor Ursula Kilkelly and Dr Claire Fenton Glynn.

- My family for supporting me throughout the challenges of the last 12 months as I attempted to balance my commitments as Special Rapporteur, as a Professor in UCC and as a father and son in the midst of the COVID-19 pandemic.

Any errors or omissions in the report are mine alone.

Professor Conor O'Mahony
School of Law, University College Cork
30 June 2021

The 2021 Annual Report of the Special Rapporteur on Child Protection departs from the approach taken in the 2020 Report in a number of respects. First, the period that is covered by the Report (which will be referred to throughout as the "reporting period") runs up to the time of submission, and not to the end of the previous calendar year (as in previous reports). The rationale for this change is that there is typically a time-lag of several months between submission of the Report and its publication by Government. For example, last year's report (which covered developments up to 31 December 2019) was submitted in June 2020, but did not publish until December 2020. To avoid this lengthy gap, this year's report covers developments from January 2020 to June 2021, and thus covers an 18 month reporting period. Next year's reporting period will run from July 2021 to the time of submission.

Second, the work undertaken by the Special Rapporteur on Child Protection during the reporting period has been driven by events this year more than it was last year. Several significant requests were made to produce reports and submissions on a variety of law reform projects. The most substantial of these was a request made by the Minister for Children and Youth Affairs in June 2020 to undertake a review of children's rights and best interests in the context of parentage in cases of donor-assisted human reproduction, including surrogacy. This report was submitted in December 2020 and published in March 2021.[1] It accounted for approximately one-third of my work as Special Rapporteur during the reporting period.

In addition to the Report on AHR and surrogacy, I was invited to make multiple submissions to Oireachtas Committees and law reform working groups, including on family justice reform, online safety, adoption information and tracing, and child maintenance. These are reproduced in full in the Appendices to this Report.

Finally, in March 2021, following the publication of an independent review into illegal birth registrations,[2] the Government requested that I examine this issue and propose next steps. I have been asked to revert to Government by the end of September 2021. Work on responding to this request commenced immediately and is ongoing at the time of writing.

These various requests to undertake specific pieces of work limited time available to work on the Annual Report, which limited the amount of choice available on what could be covered. In addition, the reporting period encompassed two events of exceptional significance to child protection in Ireland which effectively dictated the focus of this year's thematic chapters: namely, the COVID-19 pandemic, and the publication of the Final Report of the Commission of Investigation into Mother and Baby Homes. It was essential to devote detailed consideration to both of these developments in this year's report, and this is provided in Chapters 2 and 3. These thematic chapters are bookended (as in last year's report) by an annual review of child protection in Ireland during the reporting period in Chapter 1, and a legal developments and research update in Chapter 4.

1. C O'Mahony, *A Review of Children's Rights and Best Interests in the Context of Donor Assisted Human Reproduction and Surrogacy in Irish Law* (Department of Children, Equality, Disability, Integration and Youth, December 2020), available at https://assets.gov.ie/130886/e66b52d7-9d3e-4bb4-b35d-cf67f9eea9fa.pdf.

2. M Reynolds, *A Shadow Cast Long: Independent Review into Incorrect Birth Registrations* (Department of Children, Equality, Disability, Integration and Youth, May 2019, available at https://www.gov.ie/pdf/?file=https://assets.gov.ie/126409/d06b2647-6f8e-44bf-846a-a2954de815a6.pdf.

Chapter 1
Annual Review

1.1 INTRODUCTION

The purpose of this chapter is to take stock of the state of play in the Irish child protection system in the reporting period of January 2020 to June 2021, as evidenced in reports published by a variety of national and international bodies and civil society organisations, as well as a small number of significant media reports. The main issue to have arisen during the reporting period was the impact of the COVID-19 pandemic on children and on the child protection system; this merits in-depth examination and is the subject of a dedicated chapter in Chapter 2 of this Report. Chapter 1 will focus on issues other than COVID-19, and will follow a similar structure to Chapter 1 of the 2020 Report of the Special Rapporteur on Child Protection. Issues to be considered will include protecting children from harm; court proceedings involving children; the treatment of children within the care system; meeting the needs of victims of abuse; children's participation in decisions affecting them; and addressing historical rights violations. The chapter will begin with a brief update on developments of relevance to issues highlighted in the 2020 Report of the Special Rapporteur on Child Protection, and will conclude with discussion of key themes emerging from the variety of source material that has been considered.

1.2 UPDATE ON ISSUES RAISED IN 2020 REPORT

The following is a brief overview of work undertaken in respect of issues raised in the 2020 Report of the Special Rapporteur on Child Protection.[1] This update is based on information provided directly by Government Departments in response to a request made during the preparation of the 2021 Report. This section only addresses issues which do not feature in dedicated sections later in the Report. Further detail will be provided below on child homelessness (section 1.3.2), the Barnahus/Onehouse project (section 1.6) and redress for sexual abuse in National Schools (section 1.8.2).

It must be acknowledged at the outset that 12 months can be a relatively short window in which to effect change in the child protection system, especially in circumstances where primary legislation or workforce measures are required. The difficulty in making substantive progress in the space of one year was greater than usual in 2020-21 due to the wide-ranging impact of the COVID-19 pandemic on Government in general and on the child protection system in particular (as explored in detail in Chapter 2 of this Report). What otherwise might seem like a lack of progress on some issues must be viewed in that context. The discussion here will focus on pace and momentum more than on whether specific processes have reached completion.

1.2.1 Review of the Child Care Act 1991

The bulk of the 2020 Report of the Special Rapporteur on Child Protection focused on issues falling under the umbrella of the ongoing review of the Child Care Act 1991, which commenced in 2019. As of June 2021, this review is ongoing; the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) has indicated that policy approval and permission to draft a General Scheme will be sought from Government in the third quarter of 2021. Key policy proposals at this point in time include:

- The inclusion of a general principles section in the Child Care Act which is intended to strengthen the child-centred focus of the Act and to provide guidance on its interpretation;
- The inclusion of a list of factors to be taken into account in determining the best interest of the child;
- The introduction of a range of measures aimed at facilitating the participation of children in Child Care proceedings;
- Ensuring provision of child-friendly information on all processes and decisions;
- Including explicit provision that the child should be made aware of the options they have to express their views in care proceedings;
- Amendments relating to jurisdiction, procedure and the *in camera* rule, aimed at tying in the proposed reform of the family courts system;
- Amendments related to the duration and extension of supervision orders and interim care orders;

1. C O'Mahony, *Annual Report of the Special Rapporteur on Child Protection* 2020, available at https://www.gov.ie/en/collection/51fc67-special-rapporteur-on-child-protection-reports/.

- Supervision orders would be expanded to cover directions to the parent; to allow meeting the child on their own or outside of the family home; and to allow consultation with extended family members;

- Provision to be made for applications for time-limited care orders where Tusla believes this is in the child's best interests;

- Shortening the period of time after which foster carers may apply for enhanced decision-making rights in respect of children in their care;

- Allow for an Emergency Care Order to be extended to 14 days (from 8) at the discretion of the court.

- Allow child care related warrants to specify that a child can be removed from any place where they are "reasonably believed to be located";

- If the child is already known to Tusla and there is a safety plan in place with a named person, it is proposed that Tusla, or the Gardaí, following consultation with Tusla, could arrange for the named person to take short-term custody of the child until an application for an Emergency Care Order is made, or Tusla returns the child to his/her legal guardians.

The above proposals are generally welcome and the Special Rapporteur looks forward to reviewing and commenting on the detailed proposals in due course. The following updates have been provided in respect of specific aspects of the review of the Child Care Act 1991 covered in detail in Chapters 2, 3 and 4 of the 2020 Report of the Special Rapporteur on Child Protection:

1.2.1.1 Investigations of Child Sexual Abuse

DCEDIY is actively engaging with the Department of Justice to explore the potential of the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 to provide a statutory framework for a comprehensive resolution to the important issues identified in the 2020 report. The two Departments have agreed a paper on the issues arising with questions for legal advice on whether there is any legal obstacle, subject to the enactment of amending legislation, to the introduction of a requirement for re-vetting of persons in relevant organisations where the National Vetting Bureau has been notified of a *bona fide* concern by Tusla prior to the expiry of an existing vetting disclosure. The request has now been submitted to the Attorney General's office. This is broadly in line with the recommendations made in Chapter 2 of the 2020 Report of the Special Rapporteur, although no detail beyond this broad description has been provided.

Tusla has advised that work has continued on the Child Abuse Substantiation Procedure (CASP). CASP leads are preparing for internal and external consultations and have reviewed online feedback. Once this has been incorporated into consultation workshops, the re-writes required within the CASP policy can be completed in tandem with finalisation of training for implementation. The cyber-attack on the HSE of May 2021 also impacted on Tusla, whose systems are hosted on the HSE network; CASP consultations are on hold until systems are restored to allow for video consultations. Work on finalising and implementing CASP is necessary as a holding measure until legislative reforms can be

implemented in this area; but the need for those legislative reforms remains as pressing as ever, and was highlighted in a recent High Court judgment (discussed in section 4.3.2 of this Report).

1.2.1.2 Voluntary Care Agreements

As part of the review of the Child Care Act 1991, it is proposed to amend section 4 of the Act to limit voluntary care agreements to a maximum of 12 months, following which renewal will only be allowed where Tusla (a) satisfies itself that renewal is in the best interests of the child and (b) acquires renewed consent from the parent who must have access to legal advice. It is also proposed to legislate for a 3-day period following the withdrawal of parental consent during which the agreement would remain in effect to allow Tusla time and space to apply for a care order if necessary. These proposals directly correspond with recommendations made in Chapter 3 of the 2020 Report of the Special Rapporteur. Other recommendations related to reviews of voluntary care agreements and the assent of children were not specifically mentioned in the update provided for this Report, and the Special Rapporteur will continue to advocate on these points.

Members of the *Voluntary Care in Ireland Study* team have engaged numerous times over the past 12 months with Tusla in relation to the findings of the study. Tusla is reviewing its *Practice Guidance on Voluntary Consent for Admission to Care*, and is also actively considering findings of the study in relation to "private family arrangements" (which were not discussed in the 2020 Report, but which are considered in section 4.4.7 of this Report).

1.2.1.3 Ascertaining the Views of Children in Child Care Proceedings

DCEDIY is awaiting legal advice from the Attorney General's office on a specific proposal that departs from the approach taken in the Child Care (Amendment) Bill 2019. Significant delays in receiving this advice due to the impact of the COVID-19 pandemic have held up progress on this Bill. DCEDIY hopes to receive this advice shortly and to seek Government Approval to draft a General Scheme along the lines of the previous Bill, but with some amendments to reflect stakeholder concerns. No specific detail was provided in the update regarding DCEDIY's intentions with respect to amendments to the 2019 Bill that were recommended in Chapter 4 of the 2020 Report of the Special Rapporteur.

1.2.2 Minimum Age of Criminal Responsibility

The 2020 Report of the Special Rapporteur on Child Protection recommended that Ireland align its laws with *General Comment No 24 on children's rights in the child justice system*, which was published by the Committee on the Rights of the Child in September 2019, and which encouraged States Parties to raise the minimum age of criminal responsibility from 12 years to "at least 14 years".[2] In its response, the Department of Justice stated that it has "no proposals to change the existing legislative provision in relation to the age of criminal responsibility", for the following reasons:

2. O'Mahony (n 1 above) at sections 5.2.2 and 5.5.2.

> The age of criminal responsibility provisions we have in our legislation are designed to balance the rights of the child with the rights of victims and the rights of society to protection. Given that there have been 13 year olds convicted for murder and other high profile and serious crimes in recent years, the DoJ does not believe that removing criminal liability in such cases would be appropriate. The DoJ notes that countries with higher ages of criminal responsibility have provision to detain children who commit equivalent acts. However, the DoJ view is that there is a strong argument that such decisions should be made by properly constituted courts rather than mental health or social worker structures that do not operate to the same level of public scrutiny and do not have the same built in protections for the human rights of an accused person.

The response also pointed to the rehabilitative focus of Ireland's youth justice system, and to the Garda Diversion programme, which seeks to avoid prosecution "except for the most serious crimes and for the most prolific repeat offenders. Prosecution is always the last resort and the default option is diversion."

While the points made by the Department of Justice in its response are carefully considered, the fact remains that they represent a deliberate policy choice by the Irish Government which is at odds with the interpretation of the Convention on the Rights of the Child (CRC) that has been adopted by the Committee on the Rights of the Child. Inevitably, this will place Ireland in a position of conflict with the Committee in future reporting cycles, or possibly in individual petitions under Optional Protocol 3. The Government should consider not only its domestic policy choices, but Ireland's role within the international human rights community. Ireland ratified the Convention without making any reservation with respect to this issue (and indeed Ireland has objected to reservations made by numerous other States Parties). It now risks being seen to pick and choose which provisions of the CRC to comply with. If countries like Ireland who claim to take children's rights seriously are seen to deliberately and repeatedly reject recommendations made by the Committee on the Rights of the Child, it becomes far easier for other countries who are less committed to children's rights to do so. Over time, this serves to de-legitimise and undermine the machinery of international human rights law, and to lessen Ireland's influence when we call on other States to uphold their commitments under international law.

1.2.3 Special Care Facilities

The 2020 Report of the Special Rapporteur on Child Protection recommended that efforts should be made to ensure that children in need of special care placements can access such placements in Ireland and do not need to be sent to facilities overseas. The update provided for this year's report indicates that the number of special care placements available in Ireland has increased from 13 beds in 2019 to 18 beds in 2020, and that a recruitment campaign is underway to increase this to a full capacity of 26 potential beds as soon as possible. It was noted that every effort is made to find a service within Ireland that can support the child appropriately, and that placement overseas is a last resort. 14 children were placed in special care placements overseas at the end of 2020.

While the increase in capacity in special care facilities in Ireland is clearly welcome, it is significant that even if the capacity reaches the highest figure of 26 beds, this still seems

likely to be insufficient to meet the level of demand that currently exists (given that 32 children were in special care either in Ireland or overseas at the end of 2020). To say that an overseas placement is a "last resort" is not meaningful if the number of placements available or planned to be available within the country does not meet current needs. Planning to have fewer placements available in Ireland than are currently needed makes overseas placements a built-in aspect of the system. The update suggests that matters are improving, but that further efforts are needed to ensure that the most vulnerable children in the care system can have their needs met within the jurisdiction and do not have to be placed in services that are far removed from their families, friends and support networks.

1.2.4 Inter-Agency Collaboration

The 2020 Annual Report of the Special Rapporteur highlighted inter-agency collaboration as a persistent weak spot in the Irish child protection system, as highlighted in reports of multiple national and international bodies during 2019. In its update, DCEDIY has indicated that the review of the Child Care Act 1991 includes proposals to enshrine inter-agency cooperation in law, so as to provide a framework for greater cooperation from other State Agencies to enable Tusla to fulfil its mandate. It is proposed that a duty to co-operate be introduced into the Act, which requires named Government agencies and bodies to co-operate with Tusla in the provision of child care and family support services. In addition, a statutory local co-ordination role will be created with relevant bodies having a statutory function under the Act to map existing services, identify gaps in service provision, plan and co-ordinate measures to promote the welfare of children, including implementing joint commissioning in the future. A dedicated national oversight group with membership from relevant Government Departments and Agencies will oversee the implementation of the duty to cooperate, monitor local collaboration, share learning across sectors and develop joint approaches to service needs.

The intention to create a clear legal framework that both obliges and facilitates effective inter-agency collaboration is welcome; however, it will be some time before these proposals find their way into law, and so interim measures to improve inter-agency collaboration in the meantime are also important. One such measure is a Joint Protocol agreed in September 2020 between Tusla and the HSE in respect of disability services. This protocol clarifies funding matters, delineates clinical and case management responsibilities and aims to place the needs of the child or young person at the centre of all deliberations and decisions. It includes a commitment to children who are not in State care, but fall within the active remit of both Tusla and the HSE, that they will receive fully coordinated and joined up assessments, care plans and interventions as agreed in a joint meeting of operational and clinical personnel from both agencies. The agreement of this protocol is most welcome in light of a number of investigations published by the Office of the Ombudsman for Children which have repeatedly highlighted difficulties in collaboration between Tusla and the HSE in respect of children with disabilities in the care system (see, eg, section 1.5.1 below), and it is to be hoped that it will operate as intended.

1.3 PROTECTING CHILDREN FROM HARM

1.3.1 Accommodation for the Traveller Community

The Ombudsman for Children's Office (OCO) published an important account of children's living conditions on a local authority halting site in May 2021.[3] This report came about following a complaint from a Traveller Advocacy Group regarding multiple issues in the halting site, including rodent infestation, inadequate sanitation, overcrowding and unacceptable fire safety risks. There were 66 children living in this halting site and evidence from the HSE Director of Public Health Nursing showed that they were suffering from many illnesses, such as skin conditions and respiratory problems, resulting from their poor living conditions. These concerns were reported to the Local Authority in the *Public Health Department Report* in August 2012.[4] The fact that children have had to endure such poor living conditions for many years—and that this was known by the local authority—raises significant breaches of both domestic and international law.[5]

The OCO spoke with 17 children as part of their investigation. One 12-year-old girl commented that "it's like an abandoned place that people forgot about, it's like we're forgotten, we feel like garbage".[6] The OCO made a number of findings and recommendations, and stated that the local authority failed "to consider the best interests of children, including those with additional needs … and to act to ensure that children residing on the site enjoy a safe, suitable standard of accommodation".[7] The local authority responded to the OCO by committing to "prioritise this matter", and make practical arrangements for a risk assessment, new temporary welfare pods, refurbished facilities, refuse collection, pest control and better access to school.[8] Among other commitments, the local authority pledged to establish a complaints mechanism for the Traveller Accommodation Unit.[9] As part of its role, the OCO requested an update in six months and again in twelve months.

The issues highlighted by the OCO in this report are not new, and are not confined to the halting site at the centre of the investigation. Part of the difficulty has been a persistent failure of local authorities to spend allocated budgets for Traveller accommodation.[10] While it is positive to note that the full allocation was drawn down in 2020 (for the first time in 6 years), it remains to be seen whether this is a genuine sign of progress or an outlier caused by issues related to the COVID-19 pandemic.[11] Too many local authorities have failed for too long to take the issue of Traveller accommodation seriously, and careful consideration should be given to removing responsibility for this issue from local authorities and transferring it to a unit within the Department of Housing, Local Government and Heritage or to a dedicated State agency.

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3. Ombudsman for Children's Office, *No End in Site: An investigation into the living conditions of children on a local authority halting site* (May 2021), available at https://www.oco.ie/app/uploads/2021/05/No-End-in-Site-FINAL-..pdf.

4. *Ibid* at p 35.

5. The relevant law and policy context is set out *ibid* at pp 24-29.

6. *Ibid* at p 21.

7. *Ibid* at p 57.

8. *Ibid* at p 63.

9. *Ibid* at pp 65-66.

10. See, eg, K Holland, "More than €4m in Traveller housing funding left unspent", *Irish Times*, 18 May 2020; V Clarke, "Underspending on Traveller accommodation 'shameful', says advocacy group", 7 December 2020, available at https://www.breakingnews.ie/ireland/underspending-on-traveller-accommodation-shameful-says-advocacy-group-1047326.html.

11. See M O'Halloran, "Funding for Traveller accommodation fully spent last year for first time in six years", *Irish Times*, 3 June 2021.

1.3.2 Child Homelessness

The 2020 Report of the Special Rapporteur on Child Protection documented the concerning child protection implications of the increasing rate of child homelessness during 2019.[12] The latest homelessness figures available at the time of writing indicate that in May 2021, the number of children has reduced to 2,148;[13] this represents a 44% decrease from the figure of 3,826 in October 2019,[14] and is the lowest number since April 2016.[15] The Programme for Government adopted in 2020 committed to increasing the social housing stock by 50,000 units by 2025, with an emphasis on new builds.[16] As of the end of March 2021, 9,000 social homes were under construction.[17] The closure of building sites for a number of periods due to the COVID-19 pandemic has impacted on the pace of delivery, and renewed efforts will be necessary if the target set in the Programme for Government is to be achieved.

The 2020 Report of the Special Rapporteur on Child Protection endorsed recommendations made by the Joint Oireachtas Committee on Children and Youth Affairs and the Joint Oireachtas Committee on Housing, Planning & Local Government to amend the Constitution to enumerate a right to housing.[18] The Programme for Government adopted in 2020 commits to holding a referendum on housing during the lifetime of this Government.[19] This broad commitment is welcome, but it is expressed in extremely vague terms. It is to be hoped that proposals for a constitutional amendment on housing provide for a meaningful provision that can provide a safety net in cases where Government policy fails to adequately address homelessness, and not merely a symbolic measure that lacks any enforceable quality. The recommendation made in the 2020 Report of the Special Rapporteur on Child Protection that any such provision should be modelled on the South African Constitution, which allows courts to review the reasonableness of Government policy on housing (as well as on other socio-economic rights), is repeated here.

The reduction in the number of children experiencing homelessness is significant and welcome; but it is set against the extremely high peak of 2019, and the fact that over 2,000 children remain homeless is far from being a cause for celebration. While matters have improved during the reporting period, evidence continues to emerge of the impact that Ireland's ongoing housing crisis is having on children. It was reported in April 2021 that children experiencing homelessness are twice as likely to require emergency hospitalisation and have a higher risk of scabies, obesity, scalds, abuse and sexually transmitted infections. Temple Street Hospital has experienced an increasing number of homeless

12. O'Mahony (n 1 above) at section 1.2.1.

13. Department of Housing, Planning and Local Government, *Monthly Homelessness Report May 2021*, available at https://assets.gov.ie/138403/3c95cf84-850d-406d-8a03-377067fce2a2.pdf.

14. Department of Housing, Planning and Local Government, *Homelessness Report October 2019*, available at https://rebuildingireland.ie/wp-content/uploads/2019/12/homeless-report-October-2019.pdf.

15. Department of the Environment, Community & Local Government, Homelessness Report April 2016 available at http://www.housing.old.gov.ie/housing/homelessness/other/homelessness-report-april-2016.

16. Department of the Taoiseach, *Programme for Government: Our Shared Future* (October 2020) at p 54, available at https://www.gov.ie/en/publication/7e05d-programme-for-government-our-shared-future/.

17. Department of Housing, Local Government and Heritage, *Social Housing Construction Projects Status Report Q1 2021* (May 2021), available at https://www.gov.ie/en/publication/23911-social-housing-construction-projects-status-report-q1-2021/.

18. O'Mahony (n 1 above) at section 1.8.1.

19. Department of the Taoiseach (n 16 above) at p 120.

children presenting at its emergency department, with Dr Ellen Crushall stating that some families were using it as a "primary care service".[20]

Focus Ireland published a report examining the impact of homelessness on children's mental health.[21] The report included a literature review and a synopsis of interviews with staff from Focus Ireland and a round table discussion. The lack of mental health services for children is flagged, and particular difficulties experienced by homeless children are outlined. For example, an "address used when a child is placed on the waiting list is unlikely to be valid by the time an appointment is offered; consequently families can miss a badly needed appointment with a mental health professional … the child is returned to the back of the queue".[22] The report cited research from the Ombudsman for Children's Office (OCO) regarding the use of family hubs as accommodation for homeless families. While noting many positive aspects of this accommodation, there still remain many difficulties for children which can impact on their mental health as well as "attachment and development":

> … individual and family privacy; children's ability to get adequate rest and sleep; children's health, wellbeing and development; children's ability to learn and study; children's opportunities for play and recreation; children's exposure to inappropriate behaviour, aggression and fighting; children's freedom of movement; and children's ability to maintain relationships with extended family and friends.[23]

The report also considered international literature regarding what "'home' means to children", noting that it includes: feeling "connected to family", "being and feeling safe", "space and privacy", "permanent and predictable", ownership and control over own lives" as well as "community and opportunity".[24] It also highlighted that in Ireland, "families typically spend much longer living in emergency accommodation … than is the experience internationally".[25] The report recalled research by the Ombudsman for Children's Office that found that "greater access to Child Support Workers and therapeutic supports" are necessary,[26] and identified "key components of providing appropriate care for children who are homeless with their families":

- Routine assessment for developmental and mental health problems;
- Timely and appropriate therapeutic supports, including clinical evaluation and treatment when indicated by assessment;
- Staff working with homeless families at all levels should be knowledgeable about the effects of trauma and the course of normal child development …[27]

20. O Kelly, "Homeless children twice as likely to need emergency hospitalisation", *Irish Times*, 23 April 2021.

21. R Siersbaek and C Loftus, *Supporting the mental health of children in families that are homeless: a trauma informed approach* (December 2020), available at https://www.focusireland.ie/wp-content/uploads/2021/02/Focus-Ireland-therapeutics-FINAL_01-12-2020-1.pdf.

22. *Ibid* at p 18.

23. *Ibid* at pp 18-19.

24. *Ibid* at p 20.

25. *Ibid*.

26. *Ibid* at p 19.

27. *Ibid* at p 25.

A further report by Focus Ireland published in December 2020 examined four models of emergency accommodation for homeless families that currently operate in Ireland.[28] The models detailed in the Report were the Childers Road Family Initiative in Limerick City; the Social Rental Model in Limerick City; the Tallaght Cross Transitional Housing Initiative in Dublin 24, and the WCCC/Focus Ireland Emergency Family Service in Waterford City and County.[29] The report considered the merits of these models of accommodation in an effort to inform discussion around emergency accommodation in Ireland. The methodology included "a review of national and international literature, an analysis of project-related documentation for each of the four models and a series of interviews with relevant stakeholders" including 16 Focus Ireland Services Staff and Management, 9 representatives of partner agencies with Focus Ireland on the various models and 21 families who experienced the models.[30]

According to the authors, "evidence garnered through interviews with family representatives indicates that being accommodated in hotels and B&Bs can further exacerbate the feelings of stress, uncertainty and instability that are felt by families whilst homeless".[31] It was observed that the "models of accommodation reviewed in this study provide endorsement of the value of own-front door models in reducing the impact of homelessness, particularly in the areas of family wellbeing and family functioning".[32] Specifically in relation to children, the report detailed the value of targeted supports including child support workers and noted that current resources are inadequate.[33] In addition, the report demonstrated the importance of ensuring that "other supports are provided" to families, as well as accommodation, where there is a need for this.[34]

1.3.3 Section 12 of Child Care Act 1991

Devaney *et al* published a report commissioned by Tusla in relation to Tusla's "actions and decision-making processes" following the removal of a child to safety by An Garda Síochána under section 12 of the Child Care Act 1991, as amended.[35] This report followed the publication of an *Audit of the exercise by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991* in 2017 by the previous Special Rapporteur on Child Protection, Geoffrey Shannon.[36] The report included a literature review examining the approach taken in other jurisdictions to emergency removals of children, out-of-hours services, decision-making and interagency cooperation. The researchers also employed a mixed-method approach involving quantitative data analysis of data collected by Tusla

28. N Haran and S Ó Siochrú, *Exploring Own-Door Models of Emergency Accommodation for Homeless Families in Ireland: A Comparative Case Study of Four Models* (December 2020), available at https://www.focusireland.ie/wp-content/uploads/2020/12/Exploring-Own-Door-Models-of-EA-Exec-Summary.pdf.

29. *Ibid* at p 13.

30. *Ibid* at p 17 and 19.

31. *Ibid* at p 82.

32. *Ibid* at p 83.

33. *Ibid* at p 84.

34. *Ibid* at p 85.

35. C Devaney, R Crosse, L Rodriguez and C Silke, (2020) *A Study of Tusla—Child and Family Agency's actions and decision-making process following An Garda Síochána's application of Section 12 of the Child Care Act 1991*. Galway: UNESCO Child and Family Research Centre, National University of Ireland Galway.

36. G Shannon, *Audit of the exercise of by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991* (2017), available at https://www.drugsandalcohol.ie/27362/1/Audit%20of%20Section%2012%20Child%20Care%20Act%201991.pdf.

of 452 section 12 notifications from 1 July 2016 to 30 June 2017, as well as qualitative semi-structured interviews with 28 Tusla social workers and Tusla management.

It was reported that of the 452 children removed, 56 of these were removed more than once during the period of research, with 5 of these children removed 4 times or more. (Given that the research covered a period of just one year, it must be questioned why some of these children were not in care if circumstances in the family home were so unsafe as to warrant multiple section 12 removals within such a short timeframe.) Most of the children who were removed were aged between 15 and 17 years old. Further, "the most commonly reported reasons for invoking a Section 12 were Parenting Difficulties (n = 103) or Parental Alcohol/Drug Abuse (n = 88), closely followed by Child Behaviour Difficulties (n = 72). For 14 cases, information about the reason a Section 12 had been invoked was not recorded in the database".[37] Gardaí contacted Tusla "prior to invoking S12 in 81.4% of the S12s" and the majority of this contact was with the Tusla National Out-of-Hours Service.[38] This section of the report contains a vast amount of detail, including with regard to the extent to which the children were already known to Tusla and what actions Tusla had taken in their cases. Information is also provided about the subsequent placement of children, including differences in the treatment of children who were removed once as opposed to removed multiple times.

The report also outlined the results of the qualitative research. This research provided useful insight into the practicalities of quickly obtaining suitable accommodation for children who have been removed. Some interviewees were critical of the types of placements available for "young people with behavioural issues" and the lack of "emergency beds in residential units".[39] Difficulties with children being kept overnight in Garda stations and hospitals were cited as well as children being placed outside their locality.[40] The interviewees also highlighted gaps in information provided by members of An Garda Síochána to the out-of-hours team, meaning that the assigned social worker must then spend a considerable amount of time trying to clarify information.[41] The importance of joint training, interagency collaboration and developing good working relationships with the Gardaí was emphasised. The report drew attention to the role of an "on-call social worker" and it was noted that "many areas have little awareness of the role and despite the fact that social workers are on call nightly, this resource is not being accessed".[42] The potential for expanding this, with a view to how other jurisdictions such as Victoria, Australia, operate, was discussed. Crucially, the report also pointed to the need for prevention and early intervention, "to reduce vulnerability and respond to needs in a timely manner, thus avoiding the need for one or more S12s".[43] The importance of recording data was also flagged.

37. Devaney *et al* (n 35 above) at p 41.
38. *Ibid* at p 42.
39. *Ibid* at pp 72 and 73.
40. *Ibid* at p 73.
41. *Ibid* at p 75.
42. *Ibid* at p 89.
43. *Ibid* at p 90.

1.3.4 OCO Report on Safety and Welfare of Children in Direct Provision

In April 2021, following an investigation of a complaint received in 2017 regarding an Emergency Reception and Orientation Centre (EROC) in which the majority of residents were Syrian programme refugees arriving from refugee camps in Greece and the Lebanon, the Ombudsman for Children's Office (OCO) undertook an own volition investigation of a range of concerns across all Direct Provision centres (DPCs), Emergency Accommodation Centres (EACs) and EROCs.[44] These concerns included child protection concerns, including non-compliance with the Children First Act 2015 and the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The report made a number of striking findings. In respect of IPAS (previously the Reception and Integration Agency (RIA)), it was found that the level of oversight of accommodation centres is not in line with the recognised vulnerability of children, and IPAS had failed to implement safeguards necessary to ensure that children residing in DPCs, EROCs and EACs are safe from harm. There was no evidence of monitoring of accommodation centre compliance with the Children First Act 2015; there was a significant backlog in Children First training; and it was unclear how this backlog would be addressed within allocated resources.[45] In respect of Tusla, the report found that Tusla has no specific policies (either currently or under development) to guide social work teams in their work with children and families in accommodation centres. Tusla's failure to recognise the inherent vulnerability of minors in the international protection process and to make reasonable adjustments from standard procedures was described as "improperly discriminatory".[46] It was also found that Tusla has no effective mechanism to gather data about children living in DP accommodation which might identify risks and inform strategic planning.[47] Finally, it was found that IPAS and Tusla do not have effective inter-agency and inter-professional protocols to ensure that all decisions concerning children residing in State provided accommodation have the children's best interests as their primary consideration; this is contrary to fair and sound administration and undesirable administrative practice.[48]

The report made a number of specific recommendations aimed at improving child protection in Direct Provision Centres, EACs and EROCs. These include unequivocal recognition of the inherent vulnerability of children in the system by both IPAS and Tusla; ceasing the use of commercial hotels as accommodation centres; implementing a robust quality assurance framework; monitoring compliance with the Children First Act 2015 by accommodation centres; improving complaints mechanisms for residents; implementing a procedure for the identification of children with special reception needs; a review of child protection referrals to Tusla from April 2017 onwards emanating from accommodation centres; and the development of an inter-agency protocol between IPAS and Tusla.[49]

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44. Ombudsman for Children's Office, Safety and Welfare of Children in Direct Provision—An Investigation by the Ombudsman for Children's Office (April 2021), available at https://www.oco.ie/app/uploads/2021/04/Safety-and-Welfare-of-children-in-Direct-Provision.pdf.
45. *Ibid* at pp 36-37.
46. *Ibid*.
47. *Ibid*.
48. *Ibid* at p 38.
49. *Ibid* at pp 40-46.

1.3.5 Parental Problem Alcohol Use

Alcohol Action Ireland (AAI), in conjunction with the School of Applied Psychology in University College Cork (UCC), published a paper documenting "parental problem alcohol use and how children who are exposed to this Adverse Childhood Experience (ACE) cope during their school years".[50] The paper estimated that some "200,000 children in Ireland are living with the traumatic circumstances of a childhood where parental problem alcohol use is a frequent event" and a further 400,000 are "adult children from alcohol-impacted families".[51] Leslie Keating, a student at UCC, examined 17 short stories which were anonymously contributed to AAI regarding the "lived experience" of parental problem alcohol use, and "interviews with 7 adults who identify as ACOAs" or adult children of alcoholics.[52] The paper set out a number of practical recommendations regarding the role which teachers and schools can play in assisting children in these circumstances. It was recommended, for example, that "training in relation to trauma-informed approaches and adverse children [*sic*] experiences (ACEs) should be implemented at teacher training level, and at all levels of professional development—from teachers to principals to education welfare officers to SNAs and administrative staff".[53] Other recommendations were also made around the need for guidance on this subject for educators, as well as deeper collaboration between Tusla and An Garda Síochána, similar to "Operation Encompass" in the UK.[54] Operation Encompass is an early information sharing partnership that enables schools and teachers to offer immediate intervention and support for children and young people experiencing domestic abuse. Where police attend a domestic abuse incident, information is shared with a school's designated officer prior to the start of the next school day, with the aim of ensuring that appropriate assistance and care is given (depending on the needs and wishes of the child).[55] The Ombudsman for Children has endorsed the introduction of this measure in Ireland,[56] and this Report also calls for further exploration of how Operation Encompass might be adapted and introduced in the Irish context.

1.3.6 EU Strategy For a More Effective Fight Against Child Sexual Abuse

In July 2020, the European Commission published the *EU Strategy For a More Effective Fight Against Child Sexual Abuse*, which outlines a range of priority measures planned by the EU to enhance measures to prevent, investigate and prosecute child sexual abuse.[57] The strategy begins by referencing the 2011 Child Abuse Directive,[58] calling on Member States to finalise its implementation as a matter of priority and flagging that the Commission will be conducting an assessment of whether the Directive may need to be

50. L Keating, *Parental Problem Alcohol Use and Education*, Alcohol Action Ireland (September 2020), available at https://alcoholireland.ie/wpfb-file/annotated-fyp20final2028129-docx-pdf/.

51. *Ibid* at p 1.

52. *Ibid* at p 2.

53. *Ibid* at p 16.

54. *Ibid* at p 16.

55. See details at https://www.operationencompass.org/.

56. E Coyne, "Calls for gardaí to warn school if child sees domestic abuse", *Irish Independent*, 8 October 2020.

57. European Commission, *EU Strategy For a More Effective Fight Against Child Sexual Abuse*, COM(2020) 607 final (24 July 2020), available at https://ec.europa.eu/home-affairs/sites/default/files/what-we-do/policies/european-agenda-security/20200724_com-2020-607-commission-communication_en.pdf.

58. Directive 2011/92/EU on combating the sexual abuse and sexual exploitation of children and child pornography (13 December 2011).

updated.[59] The online dimension is a particular focus of the strategy, which notes that end-to-end encryption, "while beneficial in ensuring privacy and security of communications, also facilitates the access to secure channels for perpetrators where they can hide their actions from law enforcement, such as trading images and videos"; this issue "needs to be immediately addressed through possible solutions which could allow companies to detect and report child sexual abuse in end-to-end encrypted electronic communications."[60] It notes that plans by Facebook to implement end-to-end encryption in its instant messaging service may reduce the number of reports of child sexual abuse in the EU and globally by between half and two-thirds.[61] In 2021, the Commission will propose legislation requiring online services providers to detect known child sexual abuse material and report it to the authorities.[62] The EU also plans "a technical expert process to map and assess possible solutions which could allow companies to detect and report child sexual abuse in end-to-end encrypted electronic communications, in full respect of fundamental rights and without creating new vulnerabilities criminals could exploit."[63]

Elsewhere, the strategy notes the importance of specialist units within national police organisations, and welcomes the increase in the number of officers in such units in a number of Member States. The strategy states that Member States should consider setting up national victim identification teams; and where such teams already exist, Member States should consider extending national level capacity to regional and local teams.[64] The importance of technical expertise and capacity in combatting child sexual abuse online is noted, and the strategy indicates that Europol will set up an Innovation Hub and Lab and the Commission will provide funding aimed at allowing law enforcement keep up with technological developments.[65] It also stresses the importance of prevention work, noting that "[t]he exponential increase of child sexual abuse reports has overwhelmed law enforcement in the EU and globally" and consensus that the problem of child sexual abuse "is impossible to solve through law enforcement action only".[66] Accordingly, the Commission plans to develop a prevention network at EU level to "facilitate the exchange of best practices and support Member States in putting in place usable, rigorously evaluated and effective prevention measures to decrease the prevalence of child sexual abuse in the EU."[67]

The EU Strategy highlights a number of issues of relevance to Ireland. For example, delays in the examination of ICT devices to secure evidence have been a recent difficulty, with a recent Policing Authority report noting a two-year backlog due to "insufficient internal capacity to process the high number of devices seized" that "has the impact of delaying investigations".[68] A report by Conor Gallagher in the Irish Times described this as an "intractable problem", as a result of which some prosecutions for possession or

59. European Commission (n 57 above) at pp 3-4.

60. *Ibid* at p 2.

61. *Ibid* at p 15.

62. *Ibid* at p 6.

63. *Ibid* at p 16.

64. *Ibid* at p 7.

65. *Ibid* at pp 8-9.

66. *Ibid* at p 12.

67. *Ibid*.

68. Policing Authority, *Assessment of Policing Performance 2020* (February 2021) at p 16, available at https://www.policingauthority.ie/assets/uploads/documents/Policing_Authority_Assessment_of_Policing_Performance_2020.pdf.

distribution of child sexual abuse material are taking nearly five years to complete.[69] These delays risk undermining the prosecution, and leave the perpetrators at large, posing an ongoing risk to children. Gallagher cites a 2011 case identified by the Garda Inspectorate in which a three year delay in examining a device which contained an image of child sexual abuse "prevented the earlier identification and rescuing of that child."[70]

On the plus side, a significant development during 2020 was the establishment by An Garda Síochána of Divisional Protective Services Units (DPSU) within every Garda division in Ireland.[71] This is in line with commitments in *A Policing Service for the Future*[72] and recommendations set out in the *Review of Protections for Vulnerable Witnesses in the Investigation and Prosecution of Sexual Offences* by Tom O'Malley.[73] The roll out of these units was completed in September 2020, and they have been established "for those who require specialist assistance (such as victims of sexual crime, domestic violence or child abuse)".[74] These units comprise over 300 staff, including Gardaí, sergeants and inspectors.[75] Staff undertook training in the "investigation of sexual crime, child protection, investigation of domestic abuse, online child exploitation and sex offender management".[76] The Policing Authority has noted "early indicators of success, such as feedback from rape crisis centres, victim groups and other state agencies [which] has been overwhelmingly positive".[77]

1.3.7 Garda Cancellation of Domestic Abuse Calls

An inquiry by An Garda Síochána in the first half of 2021 has established that over 3,000 999 calls in 2019 and 2020 in respect of domestic abuse were cancelled by Gardaí before there was a policing response and without the calls being recorded on the PULSE system. While approximately 1,000 of these cancellations were for legitimate reasons, over 600 have already been established to be problematic by the inquiry (which is ongoing at the time of writing). The Garda Commissioner has publicly apologised to domestic abuse victims who made emergency calls for help but did not receive the standard of service from Gardaí that they required and to which they were entitled.[78]

While the full details of this issue are yet to emerge, the revelations to date are clearly very disappointing and worrying (particularly as the timespan overlaps with a huge spike in domestic abuse during the COVID-19 pandemic, as will be seen in section 2.3.1 of this Report). The Irish State is obliged pursuant to Articles 3 and 8 of the European Convention on Human Rights (ECHR) to respond to complaints of domestic abuse by fully investigating

69. C Gallagher, "Backlogs a dangerous flaw in child porn and abuse inquiries", *Irish Times*, 7 January 2020.

70. *Ibid*.

71. See details at https://www.garda.ie/en/about-us/our-departments/office-of-corporate-communications/press-releases/2020/september/an-garda-siochana-divisional-protective-services-units-now-operational-nationwide-.html.

72. Department of Justice, *A Policing Service for the Future* (2019), available at http://justice.ie/en/JELR/A_Policing_Service_for_the_Future.pdf/Files/A_Policing_Service_for_the_Future.pdf.

73. T O'Malley, Review of Protections for Vulnerable Witnesses in the Investigation and Prosecution of Sexual Offences (July, 2020) at p 39, available at http://www.justice.ie/en/JELR/Review_of_Protections_for_Vulnerable_Witnesses_in%20the_Investigation_and_Prosecution_of_Sexual_Offences.pdf/Files/Review_of_Protections_for_Vulnerable_Witnesses_in%20the_Investigation_and_Prosecution_of_Sexual_Offences.pdf.

74. Commission on the Future of Policing in Ireland, *The Future of Policing in Ireland* (September 2018) at p 21, available at https://www.garda.ie/en/about-us/a-policing-service-for-the-future/the-future-of-policing-in-ireland.pdf.

75. See n 71 above.

76. *Ibid*.

77. Policing Authority (n 68 above) at p 9.

78. P Reynolds, "Harris apologises to domestic violence victims over handling of 999 calls", *RTE News*, 24 June 2021, available at https://www.rte.ie/news/ireland/2021/0624/1231029-policing-authority/.

them and taking reasonable measures to protect family members who are at risk of harm (both direct harm, and indirect harm caused by witnessing domestic abuse perpetrated on others).[79] This obligation specifically applies to An Garda Síochána pursuant to section 3 of the European Convention on Human Rights Act 2003, which obliges organs of the State to perform their functions in a manner compatible with the State's obligations under the Convention provisions. The revelations to date are indicative of a failure to discharge these obligations under human rights law. It is of further concern that the response by An Garda Síochána to the issue has been criticised by the Policing Authority, which has expressed "intense frustration" with its inability to secure detailed information from the Gardaí, and described meetings with the Garda Commissioner as "deeply dissatisfying".[80] Immediate efforts must be made to establish the reasons for the failures and to prevent future re-occurrences, and full transparency from An Garda Síochána is essential as part of these efforts.

1.3.8 Child Trafficking

In the 2020 Report of the Special Rapporteur on Child Protection, it was noted that the US State Department's *Trafficking in Persons Report* for 2019 had seen Ireland remain at Tier 2, where it had fallen to in 2018 following a sustained period at Tier 1.[81] The 2020 *Trafficking in Persons Report* has seen Ireland's rating fall further to the Tier 2 Watch List.[82] As in 2019, the report found that Ireland does not fully meet the minimum standards for the elimination of trafficking, but is making significant efforts to do so; however, the Government did not demonstrate overall increasing efforts compared to the previous reporting period. It highlighted that no trafficking conviction had been obtained since the law was amended in 2013, which weakened deterrence, contributed to impunity for traffickers, and undermined efforts to support victims to testify.[83] Ongoing difficulties included systematic deficiencies in victim identification, referral, and assistance, and a lack of specialised accommodation and adequate services for victims.[84]

Notably, since the publication of this report, Ireland's first conviction for human trafficking was secured in June 2021 in a case involving a prostitution ring in Mullingar.[85] The *Trafficking in Persons Report* notes that 39 investigations were underway in 2019, which marked a significant decrease compared to 64 investigations in 2018.[86] It concludes that "human traffickers exploit domestic and foreign victims in Ireland, and traffickers exploit victims from Ireland abroad. Traffickers subject Irish children to sex trafficking within the country."[87] In that context, while news of a first conviction in Ireland for human trafficking is welcome, there is no room for complacency; efforts to prevent, detect and prosecute child trafficking must be redoubled.

79. See, eg, *Kontrová v Slovakia* (7510/04, 31 May 2007); *Talpis v Italy* (41237/14, 2 March 2017); *TM and CM v Moldova* (26608/11, 28 January 2014), and *Eremia v Moldova* (3564/11, 28 May 2013).

80. C Brennan, "Policing Authority raises 'intense frustration' with gardaí over 999 calls controversy", *Irish Examiner*, 24 June 2021.

81. O'Mahony (n 1 above) at section 1.2.4.

82. US State Department, *Trafficking in Persons Report* (June 2020) at p 55, available at https://www.state.gov/wp-content/uploads/2020/06/2020-TIP-Report-Complete-062420-FINAL.pdf.

83. *Ibid* at p 269.

84. *Ibid*.

85. S McCárthaigh, "Two women guilty of human trafficking in first conviction of its type", *Irish Times*, 11 June 2021.

86. US State Department (n 82 above) at p 270.

87. *Ibid* at p 272.

1.4 COURT PROCEEDINGS INVOLVING CHILDREN

1.4.1 Child Care Law Reporting Project

The Child Care Law Reporting Project published 53 reports of cases in its first volume from 2021. The reports covered a wide range of areas including many applications for interim care orders, emergency care orders and full care orders in the context of issues around domestic abuse and addiction. Children's mental health issues and a lack of resources to serve these also featured in some of the reports. One report concerned an unaccompanied minor who is missing from care for some four months.[88] The judge in that case raised concerns about "the length of time" some aspects of the investigation were taking and urged the Gardaí and the CFA to "treat this matter as if the child was their own".[89] It appears from the report that the missing child in this case was found to be in possession of drugs and according to the social worker, "the child 'may still hold a fear of criminal charges'".[90] The judge appeared to suggest that the child may have been a victim of trafficking and "put to work to carry drugs".[91] The GAL stated that "there was a 'lot of mistrust' in that community about the Gardaí as 'a lot are in the country illegally'".[92] The community involved was not identified in the report. The facts of this case appear to resemble those presented in the case of *VCL and AN v United Kingdom* (discussed in section 4.2.2.7 of this report), where it was held that States have positive obligations under the ECHR to protect "potential victims" of trafficking and "a procedural obligation to investigate situations of potential trafficking".

1.4.2 Family Law Proceedings and Domestic Abuse/Coercive Control

A number of organisations raised concerns during the reporting period about the level of protection afforded to children in family law cases in which domestic abuse or coercive control is a feature. A report published by Women's Aid in June 2021 argued that that the Family Law system "fails many women and children who are separating from a domestic abuser":

> The process is prolonged, costly and dis-empowering. It often results in unsafe custody and access arrangements which disregard the impact of domestic abuse including coercive control on children and overlook the risk of their direct abuse and/or exposure to domestic violence. The safety of the mother is rarely, if ever, considered in custody and access hearings.[93]

The report states that during 2020, Women's Aid had 114 reports of a child being abused during access visits, and 515 reports of women being abused while facilitating access,[94]

88. Child Care Law Reporting Project, "Search continues for unaccompanied minor missing in care", Case Reports 2021, Volume 1, available at https://www.childlawproject.ie/publications/search-continues-for-unaccompanied-minor-missing-in-care/.

89. *Ibid*.

90. *Ibid*.

91. *Ibid*.

92. *Ibid*.

93. Women's Aid, *Annual Impact Report 2020* (June 2021) at p 40, available at https://www.womensaid.ie/assets/files/pdf/womens_aid_annual_impact_report_2020.pdf.

94. *Ibid* at p 39.

and refers to a "pro-contact culture that prioritises the right of access of the abuser over the safety and welfare of the child and mother."[95] Women's Aid argue that the voices of mothers and children who seek to resist access due to a fear of domestic abuse are often not listened to by the courts, and that supervised access in cases where there are child protection concerns does not work properly either because it is not ordered or because suitable facilities are not available.[96] The report also refers to a lack of consistency around the extent to which criminal behaviour is taken into account in family law proceedings.[97]

The points made by Women's Aid were broadly echoed in a submission to the Family Justice Oversight Group by a coalition of organisations including Barnardos, Safe Ireland, Women's Aid, the ISPCC and the Daughters of Charity.[98] Two common themes emerge from these documents. One is that the interaction between private family law proceedings, criminal proceedings and child protection proceedings can be problematic, with different proceedings existing in silos and at times pulling in opposite directions. The second was that family law cases often display a lack of understanding of the dynamics of domestic abuse and coercive control. The importance of addressing these in proposed reforms of the family courts system was emphasised. In a submission on the General Scheme of the Family Court Bill 2020 (reproduced in Appendix A to this Report), reference is made to proposals by the Australian Law Reform Commission that judges and lawyers receive specific training in both family law and family violence.[99] Given the concerns which have been raised by organisations that have been outlined above, it is recommended that specific training in family violence should be incorporated into the establishment of specialist family courts.

1.4.3 Establishment of Family Courts

2020 saw the commencement of work on the long-awaited establishment of a system of specialist family courts in Ireland. Progress to date includes the establishment of the Family Justice Oversight Group, which is engaging with stakeholders as part of the development of a family justice strategy, and the publication of the General Scheme of the Family Courts Bill. The Special Rapporteur on Child Protection was invited to make written submissions to both of these processes. The submission on the Family Courts Bill is reproduced in Appendix A of this Report, while the submission to the Family Justice Oversight Group is reproduced in Appendix B. The Special Rapporteur has also joined an Advisory Group to the Family Justice Oversight Group and will continue to contribute to this process in 2021 and 2022.

95. *Ibid* at p 40.

96. *Ibid* at p 41.

97. *Ibid* at pp 40-41.

98. See K Holland, "Family law system endangers women and children, report warns", *Irish Times*, 4 March 2021.

99. Australian Law Reform Commission, *Family Law for the Future – An Inquiry into the Family Law System* (ALRC Report 135, March 2019) at p 400 and 405, available at https://www.alrc.gov.au/publication/family-law-report/.

1.5 TREATMENT OF CHILDREN WITHIN THE CARE SYSTEM

1.5.1 OCO Report on Jack's Case

The Ombudsman for Children's Office (OCO) published a report detailing its investigation of a case involving the HSE and Tusla concerning the care of a child with profound disabilities.[100] The OCO received a complaint from a hospital where "Jack", an eight-year-old boy, was a patient. Jack was involved in a serious road accident while abroad in 2016 and suffered profound disabilities as a result. The hospital contacted the HSE Disability Services in Jack's catchment area in May 2017, outlining Jack's requirements for occupational therapy, physiotherapy, dietetics and speech and language. By October 2017, the hospital had not received a reply from the HSE and, accordingly, made a complaint to the HSE Service Manager. Having received no response, the hospital contacted the OCO in January 2018. Jack was transferred to a specialist hospital for weekdays and a paediatric hospital at weekends. In April 2018, Jack's mother sought voluntary care for Jack as she stated that she could no longer care for Jack along with her other child. A senior social worker made a referral to Tusla. The OCO sought updates from Tusla but these appear to have been lacking. In February 2020, Jack was placed with a host family by the HSE.

The OCO made a number of findings against both the HSE and Tusla when assessing their actions against national and international law and policy. For example, "Jack was deemed medically ready for discharge in August 2017 but remained in inappropriate settings for over 29 months"; the OCO stated that this was "wholly inappropriate and negligent".[101] The OCO was also critical of the lack of a "coherent strategy" to deal with Jack's case, as well as poor communication, poor administrative practices and delays.[102] The OCO also found that Jack's placement with a host family was carried out "in the absence of any legal or formal regulatory framework, and without proper authority".[103] The OCO queried the consent provided by Jack's mother placing him with a host family as she was not made aware "of the serious concerns expressed in the Report of the National Expert Group Report (2016) and the fact such placements lacked a legislative or regulatory basis".[104] Further, Jack's estranged father does not appear to have been consulted. The OCO found that Tusla's actions "were improperly discriminatory on grounds of his disability".[105] Of note, the OCO stated that "Tusla's decision not to undertake a comprehensive initial assessment of Jack's circumstances was unduly informed by him having a disability".[106] The OCO was also critical of Tusla's communication which led to delays in this case.

This report described the responses from both the HSE and Tusla to the recommendations made by the OCO. The HSE, for example, convened a number of multi-disciplinary meetings about Jack's care and established a formal care plan for him. Further, a new "HSE/Tusla Joint Protocol (2020)" sets out "that, in partnership with Tusla, the HSE Community

100. Ombudsman for Children's Office, *Jack's Case: How the HSE and Tusla, the Child and Family Agency, provided for and managed the care of a child with profound disabilities* (November 2020), available at https://www.oco.ie/library/ombudsman-for-children-launches-report-on-jacks-case/.

101. *Ibid* at p 12.

102. *Ibid* at pp 12-13.

103. *Ibid* at p 16.

104. *Ibid.*

105. *Ibid* at p 18.

106. *Ibid.*

Operations and Acute hospital services will commit to reviewing all cases where a child remains in hospital settings beyond medical need to ensure adherence to the relevant legislation, policy and guidance documents".[107] The HSE and Tusla also committed to reviewing "family circumstances. This will also include a determination of the viability of a return to home, or to shared caring arrangements with their family or extended family".[108] Further, the HSE and Tusla have committed to "undertake a national review of the current need for alternative care" for children whose parents are unable or unwilling to care for them.[109] These bodies also pledged to "provide a clear pathway as to how disagreements and complaints between different HSE services will be managed".[110] The HSE stated that "the shortcomings identified in the current Home Sharing in Intellectual Disability: Report of the National Expert Group (2016) … is a matter for the Government" and that legislation is necessary.[111]

1.5.2 National Review Panel Reports

Six reports were published by the National Review Panel (NRP) during the reporting period; five related to the death of a child whose family had had contact with Tusla and/or the HSE, and one related to a serious case of abuse in a family setting. The reports are all publicly accessible, and it is not necessary to detail them individually; instead, this discussion will highlight common themes to emerge in the reviews. The most common issue identified by the NRP was shortcomings in inter-agency collaboration. This is a recurring theme in the work of the NRP and of other bodies who report on matters related to child protection in Ireland, and was previously highlighted in the 2020 Report of the Special Rapporteur on Child Protection.[112]

The most recent NRP reports highlighted several further examples of poor inter-agency collaboration in cases in which children died or experienced serious abuse. For example, in the case of Ava (a 14-year-old who committed suicide some months after making a disclosure of child sexual abuse), the NRP found that the response received by Ava was "uncoordinated", while "[t]here was poor communication between the SWD [social work department] and the Gardaí in this case; no strategy meeting was held and notifications were not sent in a timely way by the Gardaí."[113] The review of the case of abuse in a family setting found that the children were in contact with a wide range of services, and the social work department had expected that any concerns would be passed on; however, these expectations were implicit rather than explicit, and an "absence of meetings meant the omission of opportunities to aid communication, share and analyse information, provide feed-back and support for all involved and clarify expectations."[114] In the case of David, who died following an assault at age 16 some weeks after the tragic death of his

107. *Ibid* at p 24.

108. *Ibid*.

109. *Ibid* at p 25.

110. *Ibid*.

111. *Ibid* at p 27.

112. O'Mahony (n 1 above) at section 1.8.2.

113. National Review Panel, *Review undertaken in respect of a death of a young person who had contact with Tusla: Ava* (July 2020) at p 6, available at https://www.tusla.ie/uploads/content/Ava_Executive_Summary.pdf.

114. National Review Panel, *Review of a serious incident: abuse of children in a family setting* (December 2019) at p 5, available at https://www.tusla.ie/uploads/content/Summary_Family_Abuse_Case_NRP_FINAL.PDF.

mother, it was "not evident in the records that both the PPFS [Prevention, Partnership and Family Support service] and the social work department were aware of each other's involvement in the case … Greater inter-agency communication would have provided more detailed information regarding David's needs which in turn would have enhanced shared intervention to support him and his family."[115] In the report on Declan, who died at age 16 of an accidental overdose while in voluntary care, the NRP concluded that his case "fell into the gaps between services and agencies"; although this "fundamental service deficit" was recognised by both practitioners and managers, they "felt powerless to do anything about it".[116] Multi-agency working arrangements and protocols were described as "underdeveloped", while attendance at Child in Care Reviews by key partners was "poor".[117] The NRP concluded that its review of Declan's case indicated that "agencies and departments with responsibilities for children are not clearly mandated, or held to account, by government to coordinate their work effectively."[118]

A second issue highlighted by the NRP was the pressure on social work services due to resources and capacity being insufficient to meet demand on services. This was associated with the operation of high thresholds for intervention and with insufficient follow-up on some referrals. This factor was evident in Declan's case, in which "a family identified as having a multiplicity of needs (children with complex needs, compromised parenting, concerns about physical and sexual abuse and neglect, a fear and reluctance to engage, and trauma) was never comprehensively assessed and remained unallocated".[119] Strikingly, the NRP concluded that in this case, "[t]he SWD was not compliant with its statutory duty to provide for the protection and care of children … The SWD failed to assess parental capacity and family functioning for most of Declan's childhood, despite the accumulation of specific and general concerns."[120] In David's case, the social work department closed the case once David's sibling (who was caring for him) informed them that David was accessing community-based services and that support was no longer required. The NRP described the response to the referral as "prompt though somewhat limited … An assessment undertaken following his mother's death would have established the capacity of David's older sibling to meet the needs of his younger siblings."[121] It was acknowledged that "the basis for a decision not to pursue an assessment at the time of the second referral was influenced by pressure of work in the area".[122] The review of the case of abuse in a family setting found that "when the case first came to attention, the child protection threshold had been reached and that the follow up was inadequate … assessments were needed at critical points in the case: at the outset, over the following years and when one of the children disclosed child sexual abuse by an unrelated male. None of the assessments that were conducted were considered to be adequate."[123]

115. National Review Panel, *Review undertaken in respect of a death experienced by a young person whose family had contact with HSE/Tusla: David* (June 2019) at p 3, available at https://www.tusla.ie/uploads/content/David_Executive_Summary.pdf.

116. National Review Panel, *Review in respect of a young person who died while in the care of Tusla: Declan* (2020) at pp 13-14, available at https://www.tusla.ie/uploads/content/Declan_Executive_Summary.pdf.

117. *Ibid* at pp 8 and 9.

118. *Ibid* at p 20.

119. *Ibid* at p 11.

120. *Ibid*.

121. National Review Panel (n 115 above) at p 3.

122. *Ibid*.

123. National Review Panel (n 114 above) at p 3.

The third theme related to gaps in Child and Adolescent Mental Health Services (CAMHS). Ava was discharged from the CAMHS service after her second appointment as she was "judged to have no evidence of treatable mental illness".[124] The only support provided to Ava was a referral to a local youth justice project. Her mother felt completely unable to address Ava's challenging behaviour, describing herself as being "like a rabbit caught in the headlights".[125] The NRP concluded that Ava's mother had been " isolated", and that her case "raises the issue of young people who have mental health services but are not considered eligible for a medical psychiatric service such as CAMHS which will offer services only where a treatable mental illness is diagnosed."[126] The review recommended that Tusla "publish clear guidance for practitioners about the appropriate channels through which to access mental health services for young people experiencing ongoing emotional distress which often includes suicidal ideation and self-harming behaviour."[127] In Mary's case (which involved a 16-year-old who committed suicide while in care), the review noted that Mary had refused to engage with CAMHS and all services involved in her case had done their best to keep her safe; nonetheless, there were "certain shortcomings in the planning and provision of care for Mary which were related to the availability of placements for young people at risk of self-harm and suicide".[128] The NRP concurred with the view expressed by Mary's guardian *ad litem* that "there are deficits in the provision of mental health care for young people with serious attachment difficulties and suicidal ideation" and that "Mary required a type of intensive therapeutic environment that is not available in Ireland."[129]

1.5.3 HIQA Inspection Reports

HIQA did not publish an annual report during the reporting period; but numerous individual inspection reports on the work of child protection and welfare services were published. The reports highlighted ongoing efforts in all social work teams inspected to improve the level of service provided to children and families in their areas, as well as a number of issues which indicated persistent concerns. It is not necessary to examine all of the reports in full; instead, a number of themes emerging from a sample of the inspections will be drawn out.

Inspectors received some notably positive feedback from parents and children on their interactions with social workers in Galway/Roscommon,[130] Dublin North City[131] and Donegal.[132] Inspection reports made positive findings in respect of the receipt and

124. National Review Panel (n 113 above) at p 3.

125. *Ibid*.

126. *Ibid* at p 9.

127. *Ibid*.

128. National Review Panel, *Review undertaken on the death of a young person who was in the care of Tusla: Mary* (February 2021) at pp 4-5, available at https://www.tusla.ie/uploads/content/Mary_Executive_Summary.pdf.

129. *Ibid*.

130. HIQA, *Report of an inspection of a Child Protection and Welfare Service: Galway/Roscommon* (January 2020) at p 7, available at https://www.hiqa.ie/system/files?file=inspectionreports/4398-CPW-Galway%20Roscommon-28%20January%202020.pdf.

131. HIQA, *Report of an inspection of a Child Protection and Welfare Service: Dublin North City* (September 2020) at p 7, available at https://www.hiqa.ie/system/files?file=inspectionreports/4407_DNC_CPW_160920.pdf.

132. HIQA, *Report of an inspection of a Child Protection and Welfare Service: Donegal* (March 2020) at p 6, available at https://www.hiqa.ie/system/files?file=inspectionreports/4392-CPW%20Donegal-10%20March%202020.pdf.

screening of child protection referrals in Dublin North City[133] and in Cork,[134] although delays were noted in Donegal.[135] The management of waitlisted cases was criticised in Carlow/Kilkenny/South Tipperary[136] and in Dublin North City,[137] but significant improvements in this respect were noted in Kerry.[138] Safety planning was another issue to be raised in several inspection reports, with HIQA raising concerns in Carlow/Kilkenny/South Tipperary[139] around the quality and consistency of safety planning, as well as delays in safety planning meetings in Cork.[140] A further point of concern was that social work visits and child-in-care reviews were not always conducted within the statutory timeframe, or records of reviews were inadequate, in Kerry[141] and in Carlow/Kilkenny/South Tipperary.[142] High caseloads and demand on services outstripping the available resources were cited as contributory factors to these difficulties.[143]

One contributory factor to staff shortages in social work departments that has been well-documented in recent years has been the issue of staff retention (discussed further in section 4.4.9 of this Report). In this regard, it was significant that inspection reports were generally positive about efforts being made to improve work conditions for staff in social work departments. Initiatives that were highlighted included staff team days, complex case forum, access to employee assistance programmes and a staff retention/morale group in Dublin North City.[144] The quality of supervision provided to social workers was noted to be good in some areas,[145] but more variable in others, with lengthy gaps between supervision in some cases.[146]

1.5.4 Separated Children

Two notable reports were published during the reporting period of relevance to separated children arriving in Ireland. Oxfam published *Teach Us for What is Coming* in June 2021;[147] the report provides case studies from five European countries (including Ireland) examining the transition into adulthood of separated children. It notes that Ireland had 50 applications for international protection from separated children in 2019, and there were 59 separated children in the care of Tusla in July 2020; the majority were male and

133. See, eg, HIQA (n 131 above) at p 18.

134. HIQA, *Report of a risk based inspection of Cork child protection and welfare services* (November 2020) at p 10, available at https://www.hiqa.ie/system/files?file=inspectionreports/4383-cpw-cork%2024%20november%202020.pdf.

135. HIQA (n 132 above) at p 18.

136. HIQA, *Service Area Inspection: Carlow/Kilkenny/South Tipperary* (October 2020) at pp 33-35, available at https://www.hiqa.ie/system/files?file=inspectionreports/4389-CKST-CPWFC-19-October-2020.pdf.

137. HIQA (n 131 above) at pp 19-20.

138. HIQA, *Service Area Inspection: Kerry* (January 2021) at p 35, available at https://www.hiqa.ie/system/files?file=inspectionreports/4374_CPW_Kerry_18%20January%202021.pdf.

139. HIQA (n 136 above) at pp 33-34.

140. HIQA (n 134 above) at pp 13-15.

141. HIQA (n 138 above) at p 24.

142. HIQA (n 136 above) at pp 39-41.

143. See HIQA (n 136 above) at p 41; HIQA (n 134 above) at p 7; HIQA (n 131 above) at p 18; and HIQA (n 138 above) at p 25.

144. HIQA (n 131 above) at p 13..

145. See, eg, HIQA (n 136 above) at p 23 and HIQA (n 134 above) at p 8.

146. See, eg, HIQA (n 130 above) at p 13 and HIQA (n 131 above) at p 13.

147. Oxfam, *Teach Us for What is Coming: The transition into adulthood of foreign unaccompanied minors in Europe* (June 2021), available at https://www.oxfamireland.org/sites/default/files/teach_us_for_what_is_coming_report1.pdf.

aged between 16 and 17.[148] The process through which applications for international protection are made on behalf of separated children is outlined, as is the fact that these applications are often only processed "when they are nearing the age of adulthood, where they are often removed from the care system and transition to adult reception for asylum seekers" (ie Direct Provision).[149]

It is pleasing to note that the report describes the care supports provided to separated children during their time in the care system as "robust" and a "wrap-around care" system.[150] Of more concern is what happens when the child turns 18, when the support provided to the child is "cut drastically", especially if they have not yet received a positive decision on an application for international protection:

> How an UAM and how a recently turned 18 year old are cared for can be vastly different. Civil society actors describe the change from the wrap-around care a UAM [unaccompanied minor] receives to the hands-off approach of Direct Provision as being very jarring and anxiety producing for young people undergoing the transition to adulthood. This drastic difference in services and care brings many new risks to young migrants.[151]

These risks are described as "numerous", including the stress and anxiety associated with relocation from foster care to Direct Provision (described by one young person as "the darkest period of their life") and the possibility of relocation to another part of the country, away from support networks.[152] All of the young people interviewed for the report stated that they would end this practice and allow for a more flexible system based on individual needs,[153] and this view was supported by frontline workers and academics.[154] On the plus side, the assignment of aftercare workers to all aged-out separated children, regardless of status, was identified as an example of good practice.[155] Young people interviewed for the report stated that their aftercare worker "took on a maternal role, helped remind them of deadlines and continued to check in on their well-being".[156] The report also praises the Youth Advocacy Project run by the Irish Refugee Council, and notes that "the system in practice as [*sic*] often kinder and more flexible than in it appears in law."[157]

A separate report authored by Samantha Arnold on behalf of the Ombudsman for Children's Office examined the related issue of pathways to Irish citizenship for separated, stateless, asylum seeking and undocumented children.[158] The report provided an overview of children's eligibility to apply for citizenship, beginning with the constitutional amendment in 2004, and including proposals for reform such as the Irish Nationality and

148. *Ibid* at p 15.
149. *Ibid* at p 16.
150. *Ibid* at p 31.
151. *Ibid* at pp 31-32.
152. *Ibid* at p 32.
153. *Ibid* at p 62.
154. *Ibid* at pp 75-76.
155. *Ibid* at p 43.
156. *Ibid* at p 44.
157. *Ibid* at pp 44-45.
158. S Arnold, *Pathways to Irish Citizenship: Separated, Stateless, Asylum Seeking and Undocumented Children* (Ombudsman for Children's Office, June 2020), available at https://www.oco.ie/library/pathways-to-irish-citizenship/.

Citizenship (Restoration of Birthright Citizenship) Bill 2017 and the Irish Nationality and Citizenship (Naturalisation of Minors Born in Ireland) Bill 2018.[159] The report also provided an overview of citizenship by naturalisation and the steps involved in registering status and residence. A number of gaps were highlighted, including that "there is no system in place whereby persons under the age of 16 can register their residence in Ireland",[160] "children in care and their care staff may not be aware of the obligation to register themselves/children with INIS/GNIB [Irish Naturalisation and Immigration Service/Garda National Immigration Bureau] once they turn 16" and the fact that proof of identity can be difficult, if not impossible, for some children to attain.[161] The report also noted that because children "ordinarily derive their status from their parents/guardians", and "cannot apply for international protection independently", they "are at an increased risk of delays in securing access to citizenship".[162] Arnold suggested a number of proposals for reform, including that INIS and Tusla "come together to develop a case management procedure" in respect to separated children seeking asylum and that there should be a clear procedure put in place for stateless children, similar to the system used in France,[163] and the implementation of "a scheme to regularise undocumented children".[164] It was also recommended that children should have access to legal aid, and that "individual statuses for children, not derived from the status of parents" be introduced.[165] In conclusion, it was noted that "children should be regularised at the earliest possible point to ensure eligibility for citizenship from an earlier age".[166]

1.5.5 Free Legal Advice for Children in Care

In January 2021, the commencement of a free legal advice clinic for children and young people in the care system was announced as a collaborative initiative between two organisations: Empowering People in Care (EPIC) and Community Law and Mediation (CLM).[167] Funding for the clinics has been provided by the Community Foundation for Ireland and RTÉ Does Comic Relief, and they will run on a monthly basis for an initial period of 12 months. The clinics aim to assist children and young people in the care system to be able know their rights, have their voice heard and have their rights upheld by combining the advocacy experience of EPIC with legal expertise of CLM solicitors. This is an exciting initiative that is child-centred and has important potential to enhance the protection of children's rights within the care system. The clinics can be contacted by phone (01 8727661); online (www.epiconline.ie/advocacy-forms/) or by e-mail (legalhelpline@epiconline.ie).

159. *Ibid* at p 9.
160. *Ibid* at p 15.
161. *Ibid* at p 16.
162. *Ibid* at p 22.
163. *Ibid* at p 23.
164. *Ibid*.
165. *Ibid* at p 24.
166. *Ibid*.
167. S Bowers, "New free legal advice clinic launches for children in care system", *Irish Times*, 26 January 2021.

1.6 MEETING THE NEEDS OF VICTIMS OF ABUSE

It was noted in the 2020 Report of the Special Rapporteur on Child Protection that the Barnahus/Onehouse project is one of the most welcome developments in the child protection system in Ireland in recent years.[168] As such, the update provided by DCEDIY that the single pilot site in Galway is to be extended to two other locations in Dublin and Cork is extremely welcome and is to be commended. The adoption of the Barnahus model is overseen by an Inter-Departmental Group chaired by the Chief Social Worker of DCEDIY. This group is responsible for policy agreement among the three core departments DCEDIY, Department of Health and the Department of Justice and for securing relevant funding commitments from the three departments and from EU sources. A separate group, independently chaired, the National Agency Steering Committee (NASC) is responsible for the agency co-ordination and progress of the pilot project and roll out of the model nationally. Progress on the pilot site during the past 12 months was impeded by the COVID-19 lockdowns. It is anticipated that the construction and retrofitting of the chosen site in Galway will be concluded in September 2021. The model is currently operating in Galway, and the NASC is progressing the roll out nationally of the model to sites in Cork and Dublin.

In February 2021, Aoife O'Malley, the manager of Barnahus Onehouse Galway and Fiona Geraghty, Principal Social Worker at the Family Centre in Cork presented at a seminar on the "Barnahus model of service provision to children in sexual abuse cases", hosted by the Institute for Social Science in the 21st Century in University College Cork.[169] O'Malley noted that practitioners working in Onehouse Galway "have all signed up to the Barnahus ethos within the interagency team", which means that staff are committed to a "rights-based approach … to promoting child participation" and to "being collaborative and adhering to high professional standards".[170] She emphasised the importance of inter-agency collaboration, noting that "[i]nteragency service delivery works best when all members work within their area of expertise under a set of shared values".[171] O'Malley also emphasised the importance of providing children with "the right intervention at the right time".[172]

1.7 CHILDREN'S PARTICIPATION IN DECISIONS AFFECTING THEM

The *National Framework for Children and Young People's Participation in Decision-Making* was launched in April 2021.[173] This framework seeks to improve "practice in listening to children and young people and giving them a voice in decision-making".[174] It was developed with Professor Laura Lundy of Queen's University, Belfast, and incorporates the Lundy

168. O'Mahony (n 1 above) at section 1.5.3.

169. A recording of the seminar is available at https://www.ucc.ie/en/iss21/news/moving-towards-a-barnahus-model-setting-the-scene-for-an-integrated-response-to-child-sexual-abuse.html.

170. See *ibid* at slide "Organisational Culture".

171. See *ibid* at slide "So what?"

172. *Ibid*.

173. Department of Children, Equality, Disability, Integration and Youth, National Framework for Children and Young People's Participation in Decision-Making (2021), available at https://hubnanog.ie/wp-content/uploads/2021/04/5587-Child-Participation-Framework_report_LR_FINAL_Rev.pdf.

174. *Ibid* at p 2.

model of participation. The framework also incorporates the CRC, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the National Strategy on Children and Young People's Participation in Decision-making. Practical resources are provided to enhance children's participation, including a number of checklists for organisations and feedback forms for children. These resources embody the Lundy model of participation, and each one has a series of questions under the four elements of the model: space, voice, audience and influence, ensuring that organisations are facilitated to address each element.

An appendix to the framework outlines some examples of good practice for participation, including the development of the world's first LGBTI+ youth strategy. Detailed explanations are provided as to how the young people involved were identified, how their views were garnered and how these views subsequently influenced the strategy. Some important learnings about participation emanated from the development of this youth strategy, especially given the impact of COVID-19 which meant that the views of young people were ascertained online. It was observed, for example, that it is necessary to give more consideration "to the use of online participation methods, for example examining the impact of screen burn-out on attendance".[175] In addition, "accessibility barriers to online participation" was highlighted as well as the use of "a more open consultative methodology" to enable "blue-sky thinking".[176] All of these issues will likely continue to be important for the future and this framework could usefully be read in conjunction with the Committee on the Rights of the Child's General Comment No 25 (2021) on children's rights in relation to the digital environment (discussed in section 4.2.1 of this Report). Overall, the framework provides important practical resources supporting children's rights under Article 12 CRC. In June 2021, DCEDIY invited applications from organisations for capacity building grants to enable participation in training from Hub na nÓg and to develop and/or purchase resources to support use of the 'Everyday Spaces Checklist' in their work with children and young people.[177]

1.8 ADDRESSING HISTORICAL RIGHTS VIOLATIONS

1.8.1 Final Report of the Commission of Investigation into Mother and Baby Homes

The Final Report of the Commission of Investigation into Mother and Baby Homes was published in January 2021. This major report relates to a range of historical child protection issues, including infant deaths; ill-treatment of children and of mothers who were still minors; forced labour; deprivation of liberty; adoption without consent; and vaccine trials without consent. It warrants detailed analysis, and will be the focus of Chapter 3 of this Report.

175. *Ibid* at p 50.

176. *Ibid*.

177. See details at https://www.gov.ie/en/press-release/ff9c2-minister-ogorman-announces-capacity-building-grant-and-training-from-hub-na-nog-to-support-implementation-of-the-national-framework-for-children-and-young-peoples-participation-in-decision-making/.

1.8.2 Sexual Abuse in National Schools

The 2020 Report of the Special Rapporteur on Child Protection documented the determination of the Independent Assessor that the *ex gratia* scheme established to provide redress to survivors of sexual abuse in National Schools failed to comply with the terms of the judgment in *O'Keeffe v Ireland*.[178] It also outlined lengthy delays in the review of the scheme to bring it into line with the terms of the *O'Keeffe* judgment. 12 months later, it is highly disappointing to report that the scheme remains closed and under review. Seven and a half years after the judgment of the European Court of Human Rights in *O'Keeffe*, only 16 payments to survivors have been made.[179] This is out of 360 potential claims identified by the Government in 2016.[180] While the precise number of potential claims cannot be accurately predicted, it is clear that a considerable number (indeed, a large majority) of individuals who experienced sexual abuse in National Schools during a period in which the European Court of Human Rights (ECtHR) found that the State had failed to adequately protect children from sexual abuse in those schools have been unable to access a remedy for this violation. This falls short of the State's obligations under Article 13 of the ECHR. It also causes ongoing distress to the survivors (many of whom are of advanced age and cannot afford to wait for years for a remedy). One survivor recently told the *Irish Examiner* that he feels like "[t]hey are trying to sweep us under the carpet, and wait for us to die."[181]

In its latest Action Plan submitted to the Council of Europe, the Government has indicated that the review of the scheme was delayed by the COVID-19 pandemic.[182] (Given that the decision of the Independent Assessor was given over eight months before COVID-19 began to impact on Ireland, this is clearly an issue that should have been resolved before the pandemic began.) The Action Plan indicates that "[i]t is anticipated that the State will be in a position to commence any such new or modified ex gratia scheme during the third quarter of 2021."[183] The announcement of a concrete timeline is welcome.

The Special Rapporteur remains concerned about the potential for any revised scheme to impose conditions that could exclude survivors who should be entitled to redress (as the previous version of the scheme was found to have done). The latest Action Plan states that "the views of the Independent Assessor that the prior complaint requirement is an excessive burden for applicants attempting to satisfy the real prospect test are being taken into account."[184] This is an incomplete account of the determination of the Independent Assessor, which focused on whether the *O'Keeffe* judgment had turned on the issue of prior complaint (finding that it did not) rather than on the difficulty in satisfying the condition *per se*.[185] Any conditions on eligibility for redress under a revised scheme must

178. O'Mahony (n 1 above) at section 1.7.1.

179. Communication from Ireland concerning the case of O'KEEFFE v. Ireland (Application No. 35810/09), DH-DD(2021)594, 11 June 2021 at [15], available at http://hudoc.exec.coe.int/eng?i=DH-DD(2021)594E.

180. Committee of Ministers of the Council of Europe, 1259 Meeting, 7-9 June 2016, available at https://search.coe.int/cm/pages/result_details.aspx?objectid=090000168064e699. This figures comprises 210 cases where litigation had been discontinued, and 150 new claims. It excludes cases where no litigation had ever been commenced, of which at least 32 applied to the *ex gratia* scheme; see Decision of the Independent Assessor at [2], available at https://www.education.ie/en/Learners/Information/Former-Residents-of-Industrial-Schools/ECHR-OKeeffe-v-Ireland/independent-assessment-process/okeeffe-v-ireland-decision-of-the-independent-assessor.pdf.

181. J Casey, "'They're waiting for us to die'—Day school pupils still await redress for abuse", *Irish Examiner*, 28 June 2021.

182. Communication from Ireland concerning the case of O'KEEFFE v. Ireland (Application No. 35810/09), DH-DD(2021)594, 11 June 2021 at [19], available at http://hudoc.exec.coe.int/eng?i=DH-DD(2021)594E.

183. *Ibid*.

184. *Ibid* at [17].

185. See Independent Assessor (n 180 above) at [35] to [52].

be compatible with the ECtHR decision in *O'Keeffe*; the determination of the Independent Assessor cannot be read as suggesting that other, less burdensome conditions that have no basis in the judgment might be legitimately imposed on applicants. The true finding made by the Independent Assessor was that any *ex gratia* scheme must provide compensation for the fact that the State failed to have in place effective mechanisms for the detection and reporting of sexual abuse, with "detection" including "pro-active measures".[186]

In a previous Action Plan submitted to the Council of Europe, the Government stated that any revised scheme must "not open the State to an interpretation of strict liability for day school sexual abuse before 1992 in relation to existing or future claims in the domestic courts given that neither the domestic courts, the Grand Chamber nor the Independent Assessor has found that the State has strict liability for sexual abuse in a day school during that period."[187] However, there is no question of strict liability (defined as liability without a finding of fault) arising in respect of the sexual abuse of children in National Schools, for the very reason that the ECtHR found the State to have been at fault in the *O'Keeffe* case. That fault was systemic and not confined to the specific applicant or school involved in that case; it was that Ireland "entrust[ed] the management of the primary education of the vast majority of young Irish children to non-State actors (national schools), without putting in place any mechanism of effective State control against the risks of such abuse occurring."[188] This fault applied throughout the entire school system and impacted on every child who was sexually abused in that defective system. Liability does not become strict on the mere basis that it encompasses every child in the system. Liability would only be strict if there had been no finding of fault, and any suggestion of strict liability ignores the clear finding of fault on which *O'Keeffe* was based.

For these reasons, the determination of the Independent Assessor must not only be "taken into account"; its core finding that the *ex gratia* scheme must comply with the *O'Keeffe* judgment must be accepted in full. This can only be achieved through a prompt re-opening of the scheme with the condition of prior complaint completely removed, and with no other conditions imposed that do not have a basis in the reasoning of the *O'Keeffe* judgment. Since the fault of the State that was identified by the ECtHR in *O'Keeffe* applied across the National School system, anyone who can demonstrate that they experienced sexual abuse in a system that failed to include effective safeguards against such abuse should be provided redress under the revised *ex gratia* scheme. Failure to do so will result in continuing violations of ECHR rights and potentially in repeat applications to the ECtHR.

1.8.3 Scouting Ireland Review

In March 2020, Scouting Ireland published a review conducted by independent safeguarding consultant Ian Elliot examining the incidence of sexual abuse that is believed to have happened within scouting, with a view to learning from past mistakes and ensuring that similar events could not happen again in future.[189] The review identified multiple historical failures in child protection in Scouting Ireland, describing it as "a seriously dysfunctional

186. *Ibid* at [37] to [40] and [50].

187. Communication from Ireland concerning the case of O'KEEFFE v. Ireland (Application No. 35810/09), DH-DD(2020)1134, 9 December 2020 at [5], available at http://hudoc.exec.coe.int/eng?i=DH-DD(2020)1134E.

188. *O'Keeffe v Ireland* (35810/09, 28 January 2014) at [168].

189. I Elliot, *Historical Sexual Abuse in Scouting: A Learning Review* (March 2020), available at https://www.scouts.ie/News/2020/Ian-Elliott-Learning-Review-Scouting-Ireland.pdf.

organisation with sex offenders dominating the leadership, for decades":[190]

Sex abuse was known about and tolerated within scouting in some situations. Known offenders were protected, and there are examples of those individuals being replaced in those roles by others against whom we now hold allegations of sexual abuse … Individuals who held senior positions who were thought to be sex abusers, supported others who held a similar sexual interest in children. This is how scouting functioned for an extended period through the eighties, and nineties.[191]

However, the failings in the organisation were not confined to those who were actively involved in abusing children. A central theme of the review was that certain individuals within the organisation were widely known to be abusing children; and yet they were actively protected by some members, while others turned a blind eye, or failed to report knowledge or suspicion of abuse to the Gardaí or to child protection social work services. One case is documented in relation to a scout leader referred to as Subject B, who was described as a "senior volunteer" who eventually stood down from his position of his own volition and left scouting in good standing.[192] The review noted that Scouting Ireland's files referred to Subject B as a "difficult person", but made no reference to concerns about him being a risk to children. This is in spite of the fact that a senior volunteer from the same time period who spoke to the reviewer stated that it was known that Subject B was an alleged offender, and that he had been tasked with keeping an eye on Subject B when he attended camps.[193] When Subject B died, the Chief Scout attempted to arrange a guard of honour for the funeral, but no one would agree to participate. The Reviewer noted that "[t]his would indicate that knowledge of Subject B's alleged abuse was more widely known than is currently admitted to".[194] Multiple individuals have independently reported similar stories of violent assaults (including rape) perpetrated by Subject B, involving the same pattern of the use of alcohol.[195]

Other cases documented in the report are indicative of utterly inadequate record keeping, ranging from wilful blindness to active suppression of details of abuse. Subject D, who had several previous convictions for child sexual abuse, was involved in Scouting for three years "before allegations emerged about him which had been reported in writing and verbally to scouting headquarters"; however, "no records could be found relating to the abuse he committed and was prosecuted for."[196] Subject A, when confronted, had admitted that he was unable to control his sexual impulses around young people; but his initial requests to resign from the organisation had been refused. Although his resignation was later accepted, no report was made to the Gardaí.[197] Subject C had had multiple complaints of sexual assaults made against him, and a detailed letter was written to the scouting organisation including written statements from five of his victims. He was asked to leave scouting, but did not do so, and continued to have access to children. The reviewer noted that an examination of records found no reference to the existence of the letter or

190. *Ibid* at p 19.
191. *Ibid* at p 28.
192. *Ibid* at p 23.
193. *Ibid.*
194. *Ibid.*
195. *Ibid.*
196. *Ibid* at p 26.
197. *Ibid* at p 21.

the written statements; it was eventually found in the home of a deceased senior scouting volunteer, making it "reasonable to assume that the senior volunteer suppressed it".[198] This lack of record keeping hindered knowledge and awareness within the organisation of the risks associated with child abuse, while individuals within the organisation sought to protect the reputation of the organisation or to leave the issue to others to deal with.[199]

The Scouting Ireland review documents a range of organisational, cultural and personal failings that combined to allow many children involved in the organisation to be abused when they could and should have been kept safe. Scouting Ireland issued a response to the review accepting its findings and recommendations in full, and outlining a range of governance, record-keeping and safeguarding measures that will be implemented by the organisation.[200] It should also be noted that recent legislative interventions including the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012; the National Vetting Bureau (Children and Vulnerable Persons) Act 2012; and the Children First Act 2015 combine to require far higher standards of safeguarding and reporting in organisations working with children.

However, as demonstrated by the review, active abusers will seek to evade laws and safeguarding measures, and to assist each other in doing so. Accordingly, the role of bystanders is critical to avoiding future occurrences of the failures documented in the review. The efficacy of safeguarding and mandatory reporting legislation is partly dependent on the level of awareness and cultural acceptance of them within organisations; enforcement can only ever be one part of the puzzle. Awareness of legal obligations requires the provision of regular training to members in respect of the legal framework, but cultural acceptance of the need to comply with these obligations requires something more. The Scouting Ireland review is just one of many examples of ongoing and serious child sexual abuse of which many people were aware, at least on some level; but where few (if any) took active steps to intervene. The principles of bystander intervention (as successfully adopted in Irish universities in recent years)[201] provide a strong framework for changing this culture, and should be embraced by all organisations working with children (most especially those with a legacy of serious child protection failings).

1.8.4 St John Ambulance Investigation

In March 2021, it was announced that child protection expert and former Special Rapporteur on Child Protection Dr Geoffrey Shannon would lead an independent review into the handling of historical child sexual abuse at St John Ambulance, as well as the organisation's current safeguarding.[202] The review was commissioned by the Board of St John Ambulance and welcomed by the Minister for Children. Its establishment followed

198. *Ibid* at p 25.

199. *Ibid* at p 31.

200. Scouting Ireland Board of Directors, *Scouting Ireland Response to Mr. Ian Elliott's 'Historical Sexual Abuse in Scouting: A Learning Review'* (May 2020), available at https://www.scouts.ie/News/2020/Scouting-Ireland-Response-to-Learning-Review.pdf.

201. See, eg, details of the bystander intervention programmes in UCC (https://www.ucc.ie/en/bystander/). For a discussion of the evidence base underpinning this approach, see Public Health England, *A review of evidence for bystander intervention to prevent sexual and domestic violence in universities* (April 2016), available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/515634/Evidence_review_bystander_intervention_to_prevent_sexual_and_domestic_violence_in_universities_11April2016.pdf.

202. A Bray, "Expert to head review into child sex abuse allegations at St John Ambulance", *Irish Independent*, 8 March 2021.

commendable advocacy work undertaken by Mick Finnegan, a former volunteer with St John Ambulance, who experienced serious and repeated sexual abuse when he was 14 at the hands of a senior figure in the organisation (who is also alleged to have abused numerous other volunteers).[203] The review is expected to be completed by the end of 2021; some concerns have been expressed around whether the St John Ambulance has done enough to publicise the review among its former members.[204] Anyone with any information of relevance to this review process has been urged to contact the review team via its website.[205]

1.9 DISCUSSION AND RECOMMENDATIONS

The reporting period of January 2020 to June 2021 was the most challenging period facing the Irish child protection system in many years. The enormous impact of the COVID-19 pandemic will be discussed in detail in Chapter 2 of this report; this was exacerbated by the significant cyberattack on the HSE in May 2021, which also impacted on Tusla's ICT systems. Against such a challenging backdrop, it is pleasing to be able to report positive steps and progress in a number of areas. The review of the Child Care Act 1991 and the development of a specialist family courts system have made progress, and although there is a distance yet to travel and many details have yet to be finalised, the general direction and momentum is to be welcomed and commended. The *National Framework for Children and Young People's Participation in Decision-Making* provides Ireland with a strong policy foundation for vindicating the right of children to participate in decisions affecting them across a wide spectrum of activities. The establishment of DPSUs within An Garda Síochána and the continuing roll-out and expansion of the Barnahus/Onehouse project brings Ireland closer to implementing international best practice in meeting the needs of children who experience sexual abuse.

The reduction in the number of children accessing emergency accommodation is significant and welcome; however, this is relative to the peak figures 2019, and there is still much to do if child homelessness is to be eliminated (particularly given the ongoing pressures on the housing market in general). Moreover, progress on the issue of children in emergency accommodation must be placed in the context of significant issues regarding accommodation and living conditions experienced by other marginalised children—in particular, members of the Traveller community and children living in Direct Provision. The standard of accommodation may have improved for a large number of children over the 18 months of the reporting period, but it remained problematic for far too many children overall.

The 2020 Report on the Special Rapporteur on Child Protection highlighted the under-resourcing of key features of the child protection system, leading to delays in the assessment of referrals, excessive caseloads in courts, and poor availability of therapeutic services for victims of abuse.[206] The continued development of the Barnahus/Onehouse project should, over time, help to address the last of these problems. However, various reports

203. 3. 20.

204. J Power, "St John Ambulance urged to publicise child-abuse review", *Irish Times*, 14 June 2021.

205. See details at https://stjohnambulancereview.ie/.

206. O'Mahony (n 1 above) at section 1.8.3.

discussed in this Chapter have identified examples of demand on services (in particular Tusla and CAMHS) exceeding the resources available to them. This was a recurring theme in reviews published by the National Review Panel (discussed in section 1.5.2 above) and in inspection reports published by HIQA (discussed in section 1.5.3 above). It will be seen in Chapter 2 of this Report that demand on these services is likely to increase further due to the impact of the COVID-19 pandemic. Urgent attention to the level of resourcing provided to these key child protection services is required.

Section 1.2.4 above outlined a number of important measures that have been introduced or that are planned with a view to enhancing inter-agency collaboration. The focus being placed on this issue by Government is appropriate and welcome, and it is pleasing to note that a number of HIQA inspection reports published during the reporting period made positive findings in respect of the level of inter-agency collaboration between Tusla and An Garda Síochána in a number of areas.[207] At the same time, the report by the Ombudsman for Children's Office on Jack's Case (discussed in section 1.5.1 above) and the National Review Panel reports (discussed in section 1.5.2 above) appear to indicate that inter-agency collaboration continues to pose problems in cases involving children with more complex needs. A continued focus on this issue is needed.

Finally, this Chapter identified a number of other areas where further efforts are needed to ensure that child protection needs are met and that the State is compliant with international human rights standards. These included the provision of adequate special care placements within the jurisdiction (section 1.2.3); the resourcing provided to An Garda Síochána to examine ICT devices in cases of suspected online child abuse (section 1.3.6); the prevention, detection and prosecution of child trafficking (section 1.3.8); the provision made for separated children who are seeking to apply for citizenship, or who are ageing out of the care system (section 1.5.4); and the provision of redress for victims of sexual abuse in National Schools (section 1.8.2).

207. See, eg, HIQA (n 131 above) at p 22 and HIQA (n 136 above) at p 31.

Chapter 2

The Impact of Covid-19 on Child Protection in Ireland

2.1 INTRODUCTION

The COVID-19 pandemic has had an extraordinary impact on all aspects of life and society. Not least among these impacts is the wide range of ways in which lockdown measures have impacted on children and young people. The UN Special Rapporteur on the sale and sexual exploitation of children (hereafter "the UN Special Rapporteur") has stated that "[c]hildren may well be among the biggest victims of the crisis in the long term, because their education, nutrition, safety and health will be significantly undermined by the socioeconomic impact and by unintended consequences of the pandemic response."[1] While all children and young people will have experienced elements of this general trend, there is "a growing body of evidence that the impacts of Covid-19 did not land, are not felt equally and that many children (especially those living in poverty, children with disabilities, migrants, asylum seekers and refugees) were disproportionately adversely affected."[2]

1. UN Special Rapporteur on the sale and sexual exploitation of children, *Impact of coronavirus disease on different manifestations of sale and sexual exploitation of children*, A/HRC/46/31, 22 January 2021 at [13].

2. L Lundy *et al*, "Life Under Coronavirus: Children's Views on their Experiences of their Human Rights" (2021) 29 *International Journal of Children's Rights* 261 at p 281.

This chapter will examine literature documenting and analysing these impacts, with a particular focus on the exposure of children to increased risks of abuse or neglect and other types of harm (including, for example, cyberbullying and adverse mental health impacts). Direct empirical evidence of the experiences of children in Ireland will be cited where available; however, there are considerable gaps in the range and quality of data available specifically examining child protection concerns and responses, and it is recommended that this be rectified through the funding of targeted research as soon as possible. This chapter will attempt to fill the gaps in the current state of knowledge about Ireland by examining evidence from international literature regarding common trends in similar countries during the pandemic. Where such common trends can be identified, it would seem reasonable to suggest that Ireland may have experienced similar effects (or at the very least, to be at significant risk of experiencing similar effects). Finally, examples of innovative practice and responses to child protection during COVID-19 both from Ireland and from other jurisdictions will be identified.

2.2 GENERAL IMPACT OF COVID-19 ON CHILD WELLBEING

2.2.1 Education

The most obvious impact of COVID-19 on children and young people has been the closure of schools. In Ireland, all schools were closed from 12 March 2020 until late August 2020, and again from Christmas 2020 until a phased re-opening commenced in late February and early March 2021. Many post-primary students did not return until mid-April. As a result, children and young people lost between 90-110 school days.[3] Primary school students lost approximately half the standard school year of 183 days, while some post-primary students lost up to two-thirds of the post-primary year of 167 days. The school closures figures for Ireland one year into the pandemic were in line with or slightly higher than the global average; higher than the European average; and considerably higher than the Western European average.[4]

To mitigate the educational impact of school closures, efforts were made to provide remote learning options, both nationally (through the Homeschool Hub programme broadcast on RTE) and at individual school level. School level measures were intensified during the second closure in January and February 2021. It must be acknowledged that considerable efforts were made in difficult circumstances by all concerned; and teachers who were endeavouring to provide remote learning were themselves dealing with the adverse impacts of the lockdown. The findings that follow are reflective of the inherent challenges rather than an attribution of fault.

3. At the time of writing, no official figure is available. The Department of Education has stated that a maximum of 49 days were lost during 2021 (see Parliamentary Question 19888/21, 21 April 2021, available at https://www.oireachtas.ie/en/debates/question/2021-04-21/1047/#pq_1047). No figures have been provided for 2020. It is estimated (based on the experience of the author's own primary school-age children) that schools were closed for 63 school days during 2020 (13 days in March; 12 in April; and 19 each in May and June). This gives a maximum of up to 112 school days lost for some children and young people who did not return to school until April 2021.

4. As of 2 March 2021, Save the Children estimated the global average at 74 days; the European average at 45 days; and the Western European average at 38 days. See "Children have lost more than a third of their school year to Covid-19 pandemic", 2 March 2021, available at https://www.savethechildren.org.au/media/media-releases/children-have-lost-more-than-a-third. As of 2 February 2021, UNICEF estimated the global average at 95 days; the European average at 56 days; and the Western European average at 52 days. See UNICEF, *COVID-19 and School Closures: One Year of Education Disruption* (February 2020), available at https://reliefweb.int/sites/reliefweb.int/files/resources/COVID-19-and-school-closures.pdf.

In spite of best efforts, it was not possible for remote learning to fully bridge the gap. International evidence strongly indicates that the educational experience of all children suffered to some extent[5] and points to significant demotivation among all students, even those who are normally focused and hard-working.[6] Children in Ireland spent considerably less time engaged in schoolwork compared with before the lockdown.[7] A survey of 3,301 12-year-old participants in the *Growing Up in Ireland* study, 53% reported having difficulty with study.[8] 27% of respondents in a survey of 797 parents of primary school children reported that they did not feel that their child continued to learn during school closures in 2020; this figure rose to 38% of parents of children with disabilities, and the figures were consistent across socio-economic groups.[9] Significant adjustments were made to the Leaving Certificate process in recognition of the negative impact on children's education. The Junior Certificate was cancelled entirely in both 2020 and 2021; this disproportionately impacted on teenagers from disadvantaged backgrounds who do not go on to complete the Leaving Certificate, and as a result would leave school without any formal qualification.[10]

Significantly, the impact of school closures on educational development was unevenly spread. Evidence clearly indicates that the biggest impact was concentrated on children with special educational needs[11] and children from disadvantaged backgrounds. This was particularly acute in Ireland, where—unlike in many comparable jurisdictions[12]—school closures affected all children for the vast majority of the period, with no exceptional openings for specific groups of children until the final two weeks of February. When schools did re-open, many children with special educational needs had difficulty re-integrating.[13] A further issue that has been well documented is the so-called "digital divide"—namely,

5. E Hanushek and L Woessman, *The Economic Impacts of Learning Losses* (OECD, September 2020), available at https://www.oecd.org/education/The-economic-impacts-of-coronavirus-covid-19-learning-losses.pdf, state at p 5: "There is no doubt that the school closures in the first half of 2020 have resulted in significant learning losses to the affected cohort of students—and some of the re-opening strategies being implemented will only further exacerbate these already incurred learning losses." The authors cite research indicating that the time that children spent on school-related activities was considerably reduced, while time spent on passive activities was considerably increased.

6. R Adams, "Teachers in England face 'epidemic' of demotivation in lockdown children", *The Guardian*, 17 March 2021.

7. T Milosevic, D Laffan and J O'Higgins Norman, *KiDiCoTi: Kids' Digital Lives in Covid-19 Times: A Study on Digital Practices, Safety and Wellbeing—Key findings from Ireland* (2021) at p 10, available at https://antibullyingcentre.b-cdn.net/wp-content/uploads/2020/08/Short-report_Covid_for-media_TM_with-Author-names-1-2.pdf.

8. ESRI, *Growing Up in Ireland: Key findings from the special COVID-19 survey of Cohorts '98 and '08* (March 2021) at p 6, available at https://www.esri.ie/system/files/publications/BKMNEXT409.pdf.

9. A Devitt, C Ross, A Bray and J Banks, *Parent Perspectives on Teaching and Learning During Covid-19 School Closures: Lessons Learned from Irish Primary Schools* (Trinity College Dublin, July 2020) at pp 51-52, available at http://www.tara.tcd.ie/handle/2262/92899.

10. E O'Kelly, "Schools appeal for Junior Cert exams for vulnerable students", RTE News, 12 March 2021, available at https://www.rte.ie/news/education/2021/0312/1203642-junior-cert-exam-appeal/.

11. Inclusion Ireland, *The Implications of COVID-19 on the Education of Pupils with Intellectual Disabilities and Autism* (May 2020), available at https://inclusionireland.ie/wp-content/uploads/2020/09/covid-submission-1064-version.pdf, reported at p 13 that "[f]or children with complex behaviour and medical needs home education is very difficult, despite the best efforts of parents and teachers … The experience of parents across the country varies widely with some children having daily class via Zoom and access to educational materials and smart applications from their teacher but some other children are having little or no contact or education provision. Parents are struggling to provide any form of education to disabled children while also trying to work from home, work on the front line and isolate at home, or minding other children or elderly adults." See further S Smyth and N McLaughlin, *Autism Specific Transition Resources (T-Res Study) Phase 1 Survey, Wave 1 Report* (July 2020), available at http://tres.ie/docs/tres-p1-report.pdf.

12. See, eg, N O'Leary, "Covid-19: How are other EU countries dealing with schools?", *Irish Times*, 25 January 2021.

13. Joint Oireachtas Committee on Education, Further and Higher Education, Research, Innovation and Science, *The Impact of COVID-19 on Primary and Secondary Education* (January 2021) at p 17, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/33/joint_committee_on_education_further_and_higher_education_research_innovation_and_science/reports/2021/2021-01-14_report-on-the-impact-of-covid-19-on-primary-and-secondary-education_en.pdf.

the fact that access to technology such as laptops and tablets is unevenly distributed, with children from economically disadvantaged backgrounds less likely to have access to the technology necessary to participate effectively in remote learning.[14] Lower levels of engagement were reported among students from disadvantaged communities and in schools supporting large numbers of Traveller and Roma pupils;[15] while access to technology was a particular difficulty in Direct Provision centres, in which computer rooms (where they existed) were closed down and WIFI was often unreliable.[16] A compounding factor for children from disadvantaged backgrounds was that they were less likely to have access to a suitable study space.[17] Access to broadband and reliable internet connections is also unevenly distributed, both geographically and across socio-economic groups, with up to one-fifth of households lacking access to a good quality connection.[18] The digital divide and the impact on children with special educational needs featured prominently in complaints to the Ombudsman for Children during 2020.[19]

Even after schools fully re-opened in September 2020, approximately 4,500 children did not return to school; of these, 57% did not return due to vulnerability to COVID-19, while the remainder either dropped out or entered further training or employment.[20] While remote learning was provided to children who were themselves medically vulnerable, no such provision was made for children who were cocooning due to medical vulnerability of a family member who may be placed at risk as a result of the child's attendance at school; the Ombudsman for Children has called for this anomaly to be rectified.[21]

2.2.2 Social Interaction and Play/Leisure

Lockdown measures deprived children of a wide range of social interaction and play/leisure opportunities, including with extended family members, friends, clubs and other activities.[22] Exceptions were made in Ireland for outdoor sports training for some periods, but these exceptions were removed again following the surge in COVID-19 cases in January. International research has found that one of the main issues highlighted by children themselves during the pandemic was loneliness and missing their friends,[23] and this has been echoed in the Irish research available to date. A survey of 2,173 young people (including 834 aged 15-17) conducted by SpunOut in June and July 2020 found

14. M Darmody, E Smyth and H Russell, *The Implications of the Covid-19 Pandemic for Policy in Relation to Children and Young People*, ESRI Survey and Statistical Report Series Number 94 (July 2020) at pp 36-38; C Ross, M Kennedy and A Devitt, "Home School Community Liaison Coordinators (HSCL) perspectives on supporting family wellbeing and learning during the Covid-19 school closures: critical needs and lessons learned" (2021) *Irish Educational Studies*, https://www.tandfonline.com/doi/full/10.1080/03323315.2021.1915842 at pp 5-7.

15. Joint Oireachtas Committee on Education, Further and Higher Education, Research, Innovation and Science (n 13 above) at p 19.

16. Ombudsman for Children's Office, *Life in Lockdown: Children's views and experiences of living in Direct Provision during the Covid-19 pandemic* (2020) at pp 4-5, available at https://www.oco.ie/app/uploads/2020/12/15469-OCO-Life-in-Lockdown_Interior_V4.pdf.

17. *Ibid* at p 37.

18. Devitt *et al* (n 9 above) at p 61.

19. Ombudsman for Children's Office, *Childhood Paused: Ombudsman for Children Annual Report 2020* at p 16, available at https://www.oco.ie/annual-report-2020/Annual_Report_en.pdf.

20. C O'Brien, "Covid-19: Thousands of children did not return to school following closures", *Irish Times*, 30 April 2021.

21. *Ibid*. See further Ombudsman for Children's Office (n 19 above) at pp 17-18.

22. UN Special Rapporteur (n 1 above) at [19]; Darmody *et al* (n 14 above) at p 14.

23. L Chamberlain, M Karlsen, G Sinitsky, S Bennett, L Plowright-Pepper, and P Vackova, *Coronavirus and my life: What children say* (Children Heard/The Open University, 2021), available at http://wels.open.ac.uk/sites/wels.open.ac.uk/files/files/FINAL%20Coronavirus%20and%20my%20life%20REPORT.pdf.

that the most common response to the question "What have you been finding hard during COVID-19" was "missing friends", with 35% of respondents giving this answer. 16% said "isolation/loneliness"; 14% said "missing family", and 10% said "loss of social life."[24]

Researchers in DCU who surveyed children and parents in the Dublin City Council area reported that children were missing their friends; participants in the survey stated that the top priorities for the Government in improving the ability of children to hang out and play during the pandemic should be to allow children to meet their friends face to face, and to re-open schools. Allowing more interaction was a preferred option over reopening clubs or playgrounds.[25] A survey of 1,700 families by Barnardos in May 2020 found that 84% of children reported missing their friends.[26] A study of 48 Irish families by O'Sullivan *et al* reported that parents felt that their children "struggled the most with the lockdown measures"; children were "socially withdrawn and socially isolated", with "limited peer interaction throughout the lockdown".[27] Parents described children going "into themselves" and becoming shy, and were more concerned about this impact on their children than about the academic impact of loss of schooling.[28]

Although the loss of social interaction was reported to be a greater concern for children, the closure of playgrounds and other leisure facilities also had an adverse impact. This was particularly felt by children who have less access to suitable play spaces in their living accommodation, such as children living in Direct Provision.[29]

2.2.3 Economic

The COVID-19 pandemic had a catastrophic impact on the global economy; this led to an inevitable impact on children, whose parents had less money to provide for their families (particularly in marginalised groups).[30] In Ireland, the economic impact of COVID-19 caused the number of people unemployed to treble, resulting in a decrease in living standards for many families and children.[31] In some cases, this may have caused families to fall below the poverty line, possibly for the first time. The ESRI warned in July 2020 that child poverty rates may increase by between one sixth and one third as a result of the economic impact of the pandemic.[32] Families already living below the poverty line faced heightened risks such as food poverty or homelessness. These were mitigated to a degree

24. SpunOut, *How's Your Head? Young Voices During COVID-19* (October 2020) at p 13, available at https://spunout.ie/news/covid-19/hows-your-head-young-voices-during-covid-19-report.

25. C Barron and MJ Emmet, "Report on the Impact of COVID-19 on children's play and friendships in the Dublin City Council area" (June 2020), available at https://www.researchgate.net/publication/342788476_Report_on_the_Impact_of_COVID-19_on_children's_play_and_friendships_in_the_Dublin_City_Council_area.

26. Barnardos, *Impact on Family Life During COVID-19 Pandemic*, available at https://www.barnardos.ie/policy/the-issues/COVID-19-impact-survey.

27. K O'Sullivan, S Clark, A McGrane, N Rock, L Burke, N Boyle, N Joksimovic and K Marshall, "A Qualitative Study of Child and Adolescent Mental Health during the COVID-19 Pandemic in Ireland" (2021) 18 *International Journal of Environmental Research and Public Health* 1062.

28. *Ibid*.

29. Ombudsman for Children's Office (n 16 above) at p 6.

30. Lundy *et al* (n 2 above) at pp 270-271 and 275.

31. K McQuinn, C O'Toole, M Allen-Coghlan and C Coffey, *Quarterly Economic Commentary Autumn 2020* (September 2020), available at https://www.esri.ie/system/files/publications/QEC2020AUT_0.pdf, reported at p 1 that the adjusted unemployment rate in September 2020 was 14.7%, compared with 4.9% in 2019.

32. M Regan and B Maître, *Child Poverty in Ireland and the Pandemic Recession*, Budget Perspectives 2021 Paper 4 (July 2020), available at https://www.esri.ie/system/files/publications/BP202104_1.pdf.

by a temporary moratorium on evictions,[33] a temporary rent freeze[34] and the continuation of school meals both during school closures and during the summer holidays.[35] In spite of this, there is evidence of families experiencing significant hardship as a result of the pandemic. In a survey of 1,026 adults carried out by Red C on behalf of charity St Vincent de Paul,[36] 24% of respondents said they had cut back on food, heating or electricity; 22% said they were using savings to meet ordinary living expenses; 14% said they were falling behind on bills; and 7% are going into debt to meet ordinary living expenses. Over a third of one parent families had to cut back on heating or had fallen behind on bills, and 25% had cut back on food due to the additional financial pressures associated with school closures. Families who were already struggling before the advent of COVID-19 were hit harder; 85% reported experiencing financial strain due to COVID-19, compared to just 21% of respondents who had previously been living comfortably.

2.2.4 Physical and Mental Health

In the first instance, the pandemic exposed children to the risks associated with infection by COVID-19; and while children are in general less susceptible to becoming seriously ill from the disease than adults, this does not apply equally to all children. However, the impact of the pandemic on the physical health of children extends beyond infection with the virus itself. Children in Ireland faced delays in access to health services and increased waiting lists. Medical investigations such as radiology and elective procedures were deferred; outpatient clinics were severely curtailed; and space available in hospitals to treat children was limited due to social distancing requirements and the relinquishment of paediatric facilities and staff to treat adults with COVID-19.[37] Reports indicated a 41% increase in the number of children waiting more than 18 months for an outpatient appointment at a children's hospital.[38] Routine child development and health screenings on very young children have in some cases (estimated to be around 50% of children under one year of age) been cancelled or delayed, while many appointments have been conducted via phone or video call.[39]

A further common impact of lockdown measures was a decline in physical health due to limited opportunities for physical activity and an increasingly sedentary lifestyle[40] and

33. Emergency Measures in the Public Interest (Covid-19) Act 2020, s 5.

34. Emergency Measures in the Public Interest (Covid-19) Act 2020, s 6.

35. See Department of Education, "Government confirms continued funding for Schools Meals Programme", 26 March 2020, available at https://www.education.ie/en/Press-Events/Press-Releases/2020-press-releases/PR20-03-26.html. As an exceptional measure, the school meals programme continued during the summer holidays in 2020; see "School meals for children to be provided over the summer, government confirms", *TheJournal.ie*, 25 June 2020, available at https://www.thejournal.ie/school-meals-supports-business-covid-19-schools-coronavirus-taoiseach-5133307-Jun2020/.

36. Details of the survey are reported by R McGreevy, "A quarter cutting back on food, utilities due to financial strain of pandemic, says SVP", *Irish Times*, 25 March 2021.

37. E Crushell, J Murphy and J de Lacy, *National Clinical Review on the Impact of COVID-19 Restrictions on Children and Guidance on Reopening of Schools and the Normalisation of Paediatric Healthcare Services in Ireland* (Health Services Executive, August 2020) at p 16, available at https://researchrepository.ucd.ie/handle/10197/11619.

38. See E Grace, "'Very concerning' is the IMO's reaction to the number of children waiting over 18 months for an outpatient appointment in Ireland's children's hospitals", KCLR FM, 14 December 2020, available at https://kclr96fm.com/very-concerning-is-the-imos-reaction-to-the-number-of-children-waiting-over-18-months-for-an-outpatient-appointment-in-irelands-childrens-hospitals/.

39. See S Wyman, "Child development checks in a time of pandemic", *Irish Times*, 24 March 2021 and E Loughlin and S Bowers, "Half of babies missing health checks due to Covid-19", *Irish Examiner*, 9 April 2021.

40. Barron and Emmet (n 25 above).

an increase in the consumption of junk food.[41] Dunton *et al* expressed concern that "older children may adopt new behavioral habits of physical inactivity during the pandemic that are extremely difficult to change when pandemic-related school closure and organized sports cancellations end", and that "short-term changes in behavior in reaction to COVID-19 may become permanently entrenched, leading to increased risk of obesity, diabetes, and cardiovascular disease in children as they get older".[42] On the other hand, in the SpunOut survey, 22% of the respondents aged 15-17 stated that an improvement in their exercise and diet was a positive change that they made during the pandemic;[43] and so the impact here seems to have varied somewhat on an individual basis. However, the overall trend for children seems to have been towards less physical activity. Among 12-year-old participants in the *Growing Up in Ireland Study*, 38% reported spending less time on sports and exercise, compared to just 18% who reported spending more time.[44]

In addition to physical health, international evidence points to a significant impact of the pandemic on the mental health of children.[45] In Ireland, SpunOut suggested that the results of their survey of young people indicated that the mental health impacts of the pandemic "far outweighed" the physical health impacts.[46] Children experienced an overall decrease in wellbeing associated with limited opportunities for physical activity; increased isolation; increased stress and anxiety;[47] exposure to the increased stress of other family members;[48] and in many cases through bereavement and the loss of family members to COVID-19 (the impact of which may have been compounded by restrictions on contact before and after death).[49] Engagement with youth work projects was reported to have fallen by 70%,[50] and research by the Irish Youth Foundation in March and April 2021 documented what they described as a "mental health catastrophe". 82% of youth workers who participated in the research predicted serious long-term damage to the mental health of young people in their communities, and suggested that future fallout will

41. ESRI (n 8 above) at p 4 found that 41% of 12-year-olds reported eating more junk food and sweets than that used to ear before the pandemic. A survey by Safefood published in May 2021 found that that almost 50% of parents and guardians who participated in the survey reported that their children have been eating more treats since the start of the pandemic; see C Pope, "Half of children eating more junk food since pandemic began—study", *Irish Times*, 6 May 2021.

42. GF Dunton, B Do and SD Wang, "Early effects of the COVID-19 pandemic on physical activity and sedentary behavior in children living in the US" (2020) 20 *BMC Public Health* 1351.

43. SpunOut (n 24 above) at pp 21 and 56.

44. ESRI (n 8 above) at p 4.

45. See, eg, H Cowie and C Myers, "The impact of the COVID-19 pandemic on the mental health and well-being of children and young people" (2021) 35 *Children & Society* 62; YoungMinds, *Coronavirus: Impact on young people with mental health needs*, Survey 4: February 2021, available at https://youngminds.org.uk/media/4350/coronavirus-report-winter.pdf; M Jeffery *et al*, *Emerging Evidence:*

Coronavirus and children and young people's mental health (Evidence Based Practice Unit Issue 6 Research Bulletin, 16 February 2021), available at https://www.annafreud.org/media/13037/emerging-evidence-6_final.pdf.

46. SpunOut (n 24 above) at p 14.

47. Barnardos (n 26 above) reported that in their survey of 1,700 families in May 2020, 63.5% of parents said their child was having more tantrums or outbursts, while 49% said their child was arguing with them more. One grandmother who responded to the survey commented that "[t]he boys are extremely stressed …. They are terrified I will be infected by them or others and will die. The total focus everywhere on the virus is really upsetting children, irrespective of their circumstances, it is adding stress." See also Ombudsman for Children's Office (n 16 above) at p 3 (detailing the stress experienced by children living in Direct Provision due to the experience of communal living during a pandemic).

48. See, eg, UN Special Rapporteur (n 1 above) at [24]; Darmody *et al* (n 14 above) at p 13.

49. Crushell *et al* (n 37 above) stated at p 18: "Being restricted from visiting or seeing seriously ill family members (e.g. parents or grandparents) or having more limited access to preparatory grief work in these exceptional times can have lasting effects on children's experience of grieving."

50. National Youth Council of Ireland, *COVID-19 and Youth Work: A Review of the Youth Work Sector Response to the COVID-19 Pandemic* (June 2020) at p 16, available at https://www.youth.ie/wp-content/uploads/2020/09/Review-of-the-youth-work-sector-response-to-the-COVID-19-pandemic.pdf

include a rise in early school leaving and in criminality or anti-social behaviour, as well as increased cycles of poverty and diminished resilience.[51]

One in five 12-year-olds and almost half of 22-year-olds in the *Growing Up in Ireland* study scored in the low mood range of their respective measures, suggesting that this tendency increased with age. Girls were more likely than boys to experience low mood.[52] The national waiting list for Child and Adolescent Mental Health Services (CAMHS) increased by 20% during 2020, and a spokesperson for the College of Psychiatrists of Ireland has stated that "[o]ur big worry is that there will be a tsunami of mental health issues when this pandemic finally finishes".[53] O'Sullivan *et al* document how stress levels for children in Irish families increased due to social isolation and the challenges associated with home schooling, manifesting itself through anxiety, frustration and clinginess.[54] Adolescents suffered through the absence of routine, disrupted sleep patterns, and the loss of milestones and rites of passage.[55] The authors argue that "there is a growing need to implement policies that will help children and adolescents cope with the short-term and long-term psychological effects of the pandemic … and ensure that mental health services for young people are easily accessible if we are to prevent longer-term mental health impacts".[56]

2.3 SPECIFIC IMPACTS OF COVID-19 ON CHILD PROTECTION

2.3.1 Children Forced to Stay in Unsafe Home Environments

By requiring children to stay at home for extended periods, lockdown measures greatly increased the risk that children living in unsafe home environments be exposed to direct harm (through neglect or physical or sexual abuse) or indirect harm (eg through witnessing domestic abuse). International research indicates that family violence in all forms was reported to have increased during lockdowns, with the pattern being consistent internationally.[57] Helplines in multiple countries have reported an increase in the number of calls reporting physical violence against children,[58] while the number of children treated in hospital for abuse-related injuries also increased.[59] In addition to leaving children with

51. Irish Youth Foundation, *Generation Pandemic* (June 2021) at pp 11-12, available at https://www.rte.ie/documents/news/2021/06/generationpandemicjune2021report.pdf.

52. ESRI (n 8 above) at pp 11 and 18.

53. D Bermingham, "Concerns over 'tsunami' of child mental health issues", *Irish Examiner*, 21 February 2021.

54. O'Sullivan *et al* (n 27 above).

55. *Ibid*.

56. *Ibid*.

57. K Usher, N Bhullar, J Durkin, N Gyamfi and D Jackson, "Family violence and COVID-19: Increased vulnerability and reduced options for support" (2020) 29 *International Journal of Mental Health Nursing* 549; C Cappa and I Jijon, "COVID-19 and violence against children: A review of early studies" (2021) 116 *Child Abuse and Neglect* 105053; B Donagh, "From Unnoticed to Invisible: The Impact of COVID-19 on Children and Young People Experiencing Domestic Violence and Abuse" (2020) 29 *Child Abuse Review* 387.

58. See, eg, UN Special Rapporteur (n 1 above) at [25] to [26]; Cappa and Jijon (n 57 above); C Larkins *et al*, *Building on Rainbows Supporting Children's Participation in Shaping Responses to COVID-19 Rapid Evidence Report* (April 2020), available at https://www.researchgate.net/publication/341042616_Building_on_Rainbows_Supporting_Children's_Participation_in_Shaping_Responses_to_COVID-19_Rapid_Evidence_Report; N Petrowski *et al*, "Violence against children during COVID-19: Assessing and understanding change in use of helplines" (2021) 116 *Child Abuse and Neglect* 104757.

59. Cappa and Jijon (n 57 above); M Kovler *et al*, "Increased proportion of physical child abuse injuries at a level I pediatric trauma center during the Covid-19 pandemic" (2021) *Child Abuse and Neglect*, https://doi.org/10.1016/j.chiabu.2020.104756; S Sharma *et al*, "COVID-19: Differences in sentinel injury and child abuse reporting during a pandemic" (2021) 116 *Child Abuse and Neglect* 104990.

no way of escaping homes which were already violent, the stress of lockdown also tends to increase the propensity for violence. Usher *et al* note that:

> "While social isolation is an effective measure of infection control, it can lead to significant social, economic, and psychological consequences, which can be the catalyst for stress that can lead to violence. Isolation paired with psychological and economic stressors accompanying the pandemic as well as potential increases in negative coping mechanisms (e.g. excessive alcohol consumption) can come together in a perfect storm to trigger an unprecedented wave of family violence."[60]

Evidence to date in Ireland shows that this pattern is also evident here. Figures from An Garda Síochána show that serious domestic assaults (ie assault causing harm) increased by 24% in the first 12 months of the pandemic,[61] while calls for help in relation to domestic abuse during 2020 had increased by 17% on 2019.[62] (Note that the latter figure is potentially unreliable due to the issues discussed in section 1.3.7 of this report in respect of Garda cancellation of 999 calls in relation to domestic abuse.) Women's Aid experienced a 43% increase in contacts during 2020 compared with 2019, and a 24% increase in contacts specifically relating to domestic abuse against children (the majority of which consisted of emotional abuse).[63] Child protection referrals to Tusla from domestic abuse refuges in the first three months of 2021 were 62% higher than the first three months of 2020.[64] SAFE Ireland reported that the number of children accessing domestic abuse services increased steadily throughout 2020.[65] Calls to Childline showed a 25% increase on normal levels between March and June 2020, including "a significant number of calls from children living in abusive homes"; one child caller said that "they keep saying I'm safer at home but I'm not, I'm not safe here".[66] Traffic on the Childline website was up by 100% on the same period in 2019.[67] The Chief Executive of the ISPCC noted that "[w]hile many children enjoyed spending time in the love and warmth of their family, for others this was a frightening time in which they were at home with their tormentor 24 hours a day, every day."[68] The spike in domestic abuse led to the implementation of Operation Faoiseamh by An Garda Síochána, which will be discussed in section 2.4 below.

In relation to neglect, the Child Care Law Reporting Project documented some particularly severe cases, including one where a child who had scabies and "the most serious case of head lice" that a paediatric consultant had ever seen. The level of skin

60. Usher *et al* (n 57 above) at p 550. See further E Romanou and E Belton, *Isolated and struggling: Social isolation and the risk of child maltreatment, in lockdown and beyond* (June 2020), available at https://learning.nspcc.org.uk/media/2246/isolated-and-struggling-social-isolation-risk-child-maltreatment-lockdown-and-beyond.pdf.

61. C O'Keeffe, "Serious domestic assaults rise by 24% during pandemic", *Irish Examiner*, 3 March 2021. Minor domestic assaults also increased by 5% in the same period.

62. J Feegan, "Pandemic brought prevalence of domestic abuse in society to the fore", *Irish Examiner*, 14 December 2020. This report notes that Women's Aid responded to a 43% increase in calls from women who were trapped with abusers at home, compared with the same period in 2019.

63. Women's Aid, *Annual Impact Report 2020* (June 2021) at pp 13 and 22, available at https://www.womensaid.ie/assets/files/pdf/womens_aid_annual_impact_report_2020.pdf.

64. K Holland, "Domestic violence rises by third in Dublin's north inner-city", *Irish Times*, 23 March 2021.

65. Safe Ireland, *Tracking the Shadow Pandemic—Lockdown 2* (February 2021), available at https://www.safeireland.ie/wp-content/uploads/Tracking-the-Shadow-Pandemic-Lockdown-2-Report.pdf.

66. N Baker, "A Covid Christmas brings a whole new set of challenges for Childline", *Irish Examiner*, 18 December 2020.

67. "Childline answered over 70,000 contacts from children during peak Covid-19 restrictions", 30 June 2020, available at https://www.ispcc.ie/childline-answered-over-70000-contacts-from-children-during-peak-covid-19-restrictions/.

68. *Ibid*.

infection was so serious that the girl was admitted to intensive care due to fears that she would go into septic shock.[69] Dr Carol Coulter said the project had seen "instances of severe neglect" coming before the courts, which raised "the question as to whether the prolonged closure of schools meant that teachers, often at the front line of protecting such children, were cut off from them and the neglect went unnoticed for far too long".[70] This leads to the next impact of COVID-19 on child protection services: the disruption of the flow of referrals to Tusla.

2.3.2 Disruption in Flow of Referrals to Child Protection Services

The impact on children of being forced to stay in unsafe home environments during lockdown was exacerbated by the fact that the lockdown measures kept children out of the sight of people outside of their immediate family (such as teachers, doctors and sports coaches) who would normally act as key sources of information and referrals to child protection services. Consequently, although the impact of lockdown restrictions was shown above to have resulted in increased exposure of children to risks of violence, abuse and neglect, the number of referrals to child protection services decreased, at least initially.[71] This pattern has been well documented internationally. For example, the UN Special Rapporteur has noted that "[t]he city of New York, the epicentre of the pandemic in the United States in 2020, had witnessed a 51 per cent drop in child abuse reporting, which experts believe very likely signals a proportional increase in unaddressed abuse, neglect or mistreatment indicative of a 'shattering' of the child protection system."[72] Similar figures were reported in the UK.[73]

In Ireland, there was also an initial drop in referrals at the beginning of lockdown, albeit less pronounced than seen in New York or the UK. Average weekly referrals for the first 11 weeks of 2020 were 1,491; this fell by 35% to 963 for the first four weeks of school closures.[74] However, referrals increased again steadily as restrictions began to lift. Referrals for the second quarter of 2020 (13,458) were 9% lower than for the first quarter (14,826), and slightly higher than the third quarter (13,149) or fourth quarter (12,623) of 2019. Figures for the third quarter of 2020 showed a considerable increase to 15,137;[75] and by October, there was a year-on-year increase of 4% from 2020.[76] It should be expected that the number of referrals would increase due to the increasing incidence of family violence and other child protection concerns documented in section 2.3.1 above. The fact that this has occurred to date suggests that information flow began to catch up in

69. Child Care Law Reporting Project, "Interim care order for child admitted to intensive care with severe infection", Case Reports 2020 Volume 2, available at https://www.childlawproject.ie/publications/.

70. K Holland, "Cases of 'severe' child neglect discovered during lockdown", *Irish Times*, 18 January 2021.

71. See, eg, EJ Baron, EG Goldstein and CT Wallace, "Suffering in silence: How COVID-19 school closures inhibit the reporting of child maltreatment" (2020) 190 *Journal of Public Economics* 104258 and PR Martins-Filho, NP Damascena, RCM Lage and KB Sposato, "Decrease in child abuse notifications during COVID-19 outbreak: A reason for worry or celebration?" (2020) 56 *Journal of Paediatrics and Child Health* 1980.

72. UN Special Rapporteur (n 1 above) at [35]. See further E Rapoport, H Reisert, E Schoeman and A Adesman, "Reporting of child maltreatment during the SARS-CoV-2 pandemic in New York City from March to May 2020" (2021) 116 *Child Abuse and Neglect* 104719.

73. Romanou and Belton (n 60 above) at p 16.

74. S Bowers, "Covid-19 resulted in decrease of child welfare referrals to Tusla", *Irish Times*, 5 August 2020.

75. These figures are all taken from Tusla's Quarterly Service and Activity Reports (available at https://www.tusla.ie/data-figures/2021-performance-data/).

76. Dáil Debates, 4 February 2021, Question 146, available at https://www.oireachtas.ie/en/debates/question/2021-02-04/146/?highlight%5B0%5D=covid.

the second half of 2020, but the initial drop in referrals is likely to have resulted in delays in some cases coming to the attention of Tusla. At the time of writing, it is not yet fully clear how the closure of schools in January and February 2021 impacted on the flow on information; there has been a lag in data reporting associated with the cyberattack of May 2021. The latest available data indicates that referrals in January 2021 were 16% lower than January 2020, which the Tusla activity report directly attributes to the closure of primary schools.[77] Thus, it seems likely that the pattern began to repeat itself during the second round of school closures.

2.3.3 Restrictions on Home Visits by Social Workers

There were no formal restrictions on social workers carrying out home visits in response to child protection and welfare concerns; but in the early stages of the pandemic, home visits reduced to 30% of normal levels, before increasing again later on.[78] Social work was listed as an essential service[79] and the policy was that home visits could be conducted with social workers wearing personal protective equipment (PPE) and observing social distancing. The CEO of Tusla stated in April 2020:

> Child protection and welfare home visits are a very important part of the work of the Agency in responding to both current open cases and new referrals. Indicative reports show that face to face contact and visits are happening and are particularly focused in the most concerning situations. Very appropriate and adequate measures to mitigate the impact of this are being undertaken using technology/inter agency working and staff are reporting high public engagement and co-operation with these measures.[80]

Nonetheless, concerns remained that the circumstances of the pandemic were undermining the effectiveness of home visits, and the CEO of Tusla admitted that "the altered arrangements and the measures to mitigate should not be viewed as a model for future working patterns".[81] One concern was that parents could evade home visits by claiming that people in the household had symptoms of COVID-19; social workers were required to check this before carrying out a visit, and "suddenly every house has someone with a cough".[82] A second issue was that wearing PPE and observing social distancing was "an alien experience to social workers and presents a barrier to meaningful engagement".[83] In a survey of 456 social workers completed in May and June 2020, 54% of respondents

77. Tusla, *Monthly Service Performance and Activity Report* (January 2021) at p 4, available at https://www.tusla.ie/uploads/content/Monthly_Service_Performance_and_Activity_Report_Jan_2021_V1.0.pdf.

78. B Gloster, Joint Oireachtas Committee on Children, Disability, Equality and Integration, 24 November 2020.

79. See https://www.gov.ie/en/publication/c9158-essential-services/?referrer=http://www.gov.ie/en/publication/dfeb8f-list-of-essential-service-providers-under-new-public-health-guidelin/.

80. B Gloster, *CEO Briefing to Party/Grouping Spokespeople—Children & Youth Affairs*, Department of Taoiseach, 29 April 2020.

81. *Ibid*. See also M Baginsky and J Manthorpe, "The impact of COVID-19 on Children's Social Care in England" (2021) 116 *Child Abuse and Neglect* 104739.

82. Child Care Law Reporting Project, "Observations on Concerns for Vulnerable Children Arising from the Covid-19 Pandemic", 3 April 2020, available at https://www.childlawproject.ie/wp-content/uploads/2020/05/CCLRP-Observations-on-Covid-19-Pandemic-April-2020.pdf.

83. J Finn, "The Role of the Children in Care Social Worker during the Covid-19 Crisis and exploring the Utilisation of Video Messaging for younger Children in Foster Care", *Irish Social Work Blog*, 21 April 2020, available at https://irishsocialwork.wordpress.com/2020/04/21/the-role-of-the-children-in-care-social-worker-during-the-covid-19-crisis-and-exploring-the-utilisation-of-video-messaging-for-younger-children-in-foster-care/.

identified restricted, or lack of, direct face to face work with clients as their biggest challenge; other concerns included that some of the most vulnerable children were not being visited, and that conducting risk assessments via phone call was not effective.[84] The Irish Association of Social Workers (IASW) concluded that the survey indicated that:

> Children and adults living with violence, abuse or neglect, family carers, people with disabilities, people with mental health difficulties, those with drug/alcohol problems were all [too] often left without essential social work and primary care services. Social workers saw that the absence of, and drastic reduction in, essential support services coupled with the reduced access to personal networks during restrictions, dramatically increased the risks and stresses experienced by these populations.[85]

Unlike child protection and welfare home visits, visits to foster homes were curtailed as a matter of policy, particularly in cases where a child was settled in a foster home and the placement was working well. The regulations governing visits to foster homes were amended[86] so that for the duration of the pandemic emergency, the requirements of the regulations regarding assessment of placements in advance of placement could be complied with "as soon as practicable, having due regard to all public health notifications and obligations". The requirements regarding supervision and visiting of children in foster placements were relaxed so that instead of visits taking place at least every six months, children would be visited "as often as the Child and Family Agency considers practicable" (although new placements were subject to a visit within the first 4 weeks). In lieu of visits, the revised regulations provided that children should be "contacted" by the Child and Family Agency as often as necessary, but at least once every three months during the first two years of the placements, and once every six months thereafter. These measures were a proportionate response to the pandemic, in that they were time limited for periods of three months and reviewed at the expiry of each period;[87] and they proposed only to limit visits to established placements that were known to be functioning well. The emergency regulation lapsed on 9 May 2021 and the pre-pandemic position was restored as the country gradually re-opened.

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84. C Murphy and S McGarry, *IASW Social Work During Covid-19 Survey: Final Report* (November 2020), available at https://www.iasw.ie/download/845/IASW%20Social%20Work%20During%20Covid-19%20Survey_Final%20Report.pdf.

85. *Ibid* at p 17.

86. See Child Care (Placement of Children in Foster Care) (Emergency Measures in the Public Interest - COVID-19) (Amendment) Regulations 2020 (S.I. No. 170 of 2020) and Child Care (Placement of Children with Relatives) (Emergency Measures in the Public Interest - COVID-19) (Amendment) Regulations 2020 (S.I. No. 171 of 2020).

87. See Child Care (Placement of Children in Foster Care) (Emergency Measures in the Public Interest - COVID-19) (Amendment) (No. 1) Regulations 2020 (S.I. No. 312 of 2020); Child Care (Placement of Children in Foster Care) (Emergency Measures in the Public Interest - COVID-19) (Amendment) (No. 2) Regulations 2020 (S.I. No. 540 of 2020); Child Care (Placement of Children in Foster Care) (Emergency Measures in the Public Interest - COVID-19) (Amendment) Regulations 2021 (S.I. No. 41 of 2021); Child Care (Placement of Children with Relatives) (Emergency Measures in the Public Interest - COVID-19) (Amendment) (No. 1) Regulations 2020 (S.I. No. 313 of 2020); Child Care (Placement of Children with Relatives) (Emergency Measures in the Public Interest - COVID-19) (Amendment) (No. 2) Regulations 2020 (S.I. No. 541 of 2020); and Child Care (Placement of Children with Relatives) (Emergency Measures in the Public Interest - COVID-19) (Amendment) Regulations 2021. (S.I. No. 42 of 2021).

2.3.4 Increase in Online Activity Related to Child Abuse

There is considerable evidence that the volume of child sexual abuse material circulating online increased dramatically during the pandemic, particularly during the early stages. The number of referrals to Europol by the National Centre for Missing and Exploited Children (NCMEC) increased almost tenfold during March and April 2020, after which it began to revert to pre-pandemic levels.[88] Referrals specifically related to Ireland for March 2020 were approximately three times higher than March 2019, while referrals for April 2020 were approximately six times higher than April 2019.[89] The level of activity on the dark web forums connected with child sexual abuse material increased significantly, with an increase in messaging between users and the numbers of images being shared.[90] The figures levelled off over the remainder of 2020, but there was nevertheless a 4.5% increase in referrals by the NCMEC to An Garda Síochána in 2020 compared to 2019.[91]

The UN Special Rapporteur has expressed concern about an increase in sexual exploitation and abuse facilitated by information and communications technologies, including the live streaming of abuse, grooming, and so-called "sexting".[92] Her report cites Save the Children as observing that the COVID-19 crisis has "changed the pattern of sexual exploitation, which is now operating less on the streets and more 'indoors' or 'online'", and "jeopardised escape routes that would usually be available to many survivors".[93] Similarly, EPCAT note that "[w]hen it becomes more difficult for offenders to operate where they normally do, some tend to migrate elsewhere, often online".[94]

In addition to the increased circulation of child sexual abuse material, the pandemic also increased the risk of children encountering child abusers in the digital environment. During lockdown, children were spending significantly more time than usual engaged in unsupervised online activities; 60% of 12-year-old participants in the *Growing Up in Ireland* study reported an increase in their informal screen time.[95] Europol documented that online forums designed to facilitate the exchange of child sexual abuse material contained "enthusiastic messages about the opportunities provided when children will be online more than before".[96] EPCAT noted an increase in reports of online child sexual abuse to their hotline in Sweden, and received tips of webpages "where perpetrators are discussing how the situation we are in now can be exploited."[97] The UN Special Rapporteur noted that online abuses including sexual harassment, sex trolling and sextortion were reported to be on the rise during lockdown.[98]

88. Europol, *Exploiting Isolation: Offenders and victims of online child sexual abuse during the COVID-19 pandemic* (19 June 2020) at p 6, available at https://www.europol.europa.eu/publications-documents/exploiting-isolation-offenders-and-victims-of-online-child-sexual-abuse-during-covid-19-pandemic.

89. *Ibid* at p 7.

90. *Ibid* at p 10.

91. C Gallagher, "The US centre behind most of Ireland's online child sex abuse prosecutions", *Irish Times*, 13 March 2021.

92. UN Special Rapporteur (n 1 above) at [48].

93. Save the Children, "Covid-19 Pushed Victims of Child Trafficking and Exploitation into Further Isolation: Save the Children", 29 July 2020, available at https://www.savethechildren.net/news/covid-19-pushed-victims-child-trafficking-and-exploitation-further-isolation-save-children.

94. ECPAT, "Why children are at risk of sexual abuse and exploitation during COVID-19", 7 April 2020, available at https://www.ecpat.org/news/covid-19-sexual-abuse/.

95. ESRI (n 8 above) at p 4.

96. Europol (n 88 above) at p 12.

97. ECPAT (n 94 above).

98. UN Special Rapporteur (n 1 above) at [47].

2.3.5 Cyberbullying

The increased amount of unsupervised time spent online also exposed children to a heightened risk of cyberbullying. International analysis of social media posts during lockdown has documented "a significant increase in abusive content generated during the stay-at-home restrictions" and "evidence of the potential for children to be exposed to increasingly abusive content while online".[99] In Australia, in response to the rise in the incidence of cyberbullying during lockdown, a range of measures were implemented. These included tools for schools to support the development of effective online safety policies and procedures, as well as guidelines for responding to online safety incidents.[100]

In November 2020, Dr Tijana Milosevic from the DCU National Anti-Bullying Centre informed the Oireachtas Education Committee that there had been a 20% increase in cyberbullying in Ireland during lockdown, and that Ireland had one of the highest incidences of cyberbullying in Europe.[101] In a survey of over 500 Irish children conducted by researchers from the Centre, 28% reported having been the target of cyberbullying at some point during the first lockdown, while 50% reported having seen others being cyberbullied.[102] 34% of the children who admitted to being mean or hurtful to others online said it happened more frequently or much more frequently since the lockdown, while children also reported witnessing an increasing frequency of hateful messages targeted at members of specific groups.[103]

2.3.6 Access and Family Reunification

Lockdown measures created significant challenges in maintaining contact between children in care and their parents, and a common response in many jurisdictions was to cancel face-to-face contact, especially in the early stages of the pandemic.[104] The trend in Ireland was similar; access visits were at first "in the main replaced with remote technology",[105] before Tusla subsequently implemented a risk assessment process aimed at assessing on a case-by-case basis whether access could take the form of face-to-face contact. This process was kept under review in line with changing public health guidance.[106] The risk assessment examined various factors including the health of the participants, the views of the foster family and the child, transport arrangements and the location for the access; a decision on face-to-face contact would be made based on this assessment, and it was to be reviewed before each visit. Separate guidance was issued on access to residential centres.[107]

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99. P Babvey, F Capela, C Cappa, C Lipizzi, N Petrowski and J Ramirez-Marquez, "Using social media data for assessing children's exposure to violence during the COVID-19 pandemic" (2021) 116 *Child Abuse and Neglect* 104747.

100. H Hore, "Violence against children in the time of COVID-19: What we have learned, what remains unknown and the opportunities that lie ahead" (2021) 116 *Child Abuse and Neglect* 104776 at p 2.

101. S Bowers, "Cyberbullying rates for Irish children among highest in EU—expert", *Irish Times*, 6 November 2020.

102. Milosevic *et al* (n 7 above) at p 4.

103. *Ibid* at pp 7-8.

104. See, eg, K Pisani-Jacques, "A Crisis for a System in Crisis: Forecasting from the Short- and Long-Term Impacts of Covid-19 on the Child Welfare System" (2020) 58 *Family Court Review* 955.

105. B Gloster, Joint Oireachtas Committee on Children, Disability, Equality and Integration, 24 November 2020.

106. See, eg, *Covid 19: Updated Advisory Notice relating to Family Contact (access) for Children in Care* (18 March 2020), available at https://www.tusla.ie/uploads/content/CMT-AD-003-2020_-_Updated_Access_Guidance_COVID_19_-_2020-03-18.pdf and *Access Risk Assessment for face to face Family Contact (Access) for Children in Care during COVID-19* (19 May 2020), available at https://www.tusla.ie/uploads/content/CMT-AD-003a-2020_Access_Risk_Assessment_COVID_19.pdf.

107. *COVID-19: Restriction on Access to Residential Centres* (6 May 2020), available at https://www.tusla.ie/uploads/content/CMT-AD-48-2020_COVID-19_Restriction_on_Access_to_Residential_Centres_2020-05-06.pdf.

Inevitably, the impact of COVID restrictions resulted in significant disruption to access arrangements. A survey of residential centres carried out by EPIC found that in April 2020, "[a]ccess has been curtailed and, in most places, completely stopped so young people are missing their family".[108] Similarly, children in Oberstown Children Detention Campus were limited to Zoom calls rather than face-to-face visits for significant periods.[109] In relation to foster care, the Child Care Law Reporting Project documented a number of cases in which access difficulties had arisen. In several of these cases, issues arose because a member of the household in the foster home had a medical condition which made them vulnerable to a severe case of COVID-19. The outcomes of these cases were somewhat inconsistent; in some, the judge emphasised the importance of access and the need to do what was necessary to facilitate it, while in others, the judge was more deferential to concerns regarding mitigating the risks associated with COVID-19.

In one case, a foster family was unwilling to run the risk of infection caused by facilitating access; the issue came to a head when the mother removed her mask during access and kissed her child goodbye. The judge in this case stated that "[t]here is something disproportionate and unequal about children not having contact during the interim care order as the children could come back to their parents", and he ordered Tusla to come up with a plan for access before the next hearing date.[110] In another case, a judge noted that while the COVID-19 restrictions had created a great deal of difficulty for the implementation of access, there was no reasonable end to the pandemic in sight and the best interest of the children dictated that the difficulties had to be overcome.[111]

These cases can be contrasted with a case in which court-ordered access was reduced without a court order to that effect. The social workers later informed the court that the parent had consented to the reduction in access; but although questions were raised as to whether the mother (who had cognitive difficulties) had adequately understood what she was consenting to, the court left the agreement in place and discharged the previous access order.[112] A further case involved the father of the child who refused to wear a mask during access as he felt it would bring about a panic attack due to his asthma, anxiety and ADHD; as a result, face-to-face access was suspended, and it was suggested that he could "watch his child play at a playground".[113]

Even in cases where access was granted, issues could arise in relation to the impact of social distancing measures. A case was documented in which a baby had been taken into care due to drug abuse by the mother. Access was granted, but subject to the condition that the mother not have "any unnecessary close contact with her child". The solicitor for

108. Eurochild, *Growing up in lockdown: Europe's children in the age of COVID-19* (November 2020) at p 96, available at https://www.eurochild.org/resource/growing-up-in-lockdown-europes-children-in-the-age-of-covid-19/.

109. C Gallagher, "Coronavirus: Nearly all visits to children in detention suspended", *Irish Times*, 6 April 2020.

110. Child Care Law Reporting Project, "Court heard of foster carer's fears of Covid arising from access", available at https://www.childlawproject.ie/publications/court-heard-of-foster-carers-fears-of-covid-arising-from-access/.

111. Child Care Law Reporting Project, "District Court refuses to order face-to-face access following its suspension during Level 5 Covid restrictions", available at https://www.childlawproject.ie/publications/district-court-refuses-to-order-face-to-face-access-following-its-suspension-during-level-5-covid-restrictions/.

112. Child Care Law Reporting Project, "Care order extended and access reduced where assessments delayed and access disrupted by Covid-19", available at https://www.childlawproject.ie/publications/care-order-extended-and-access-reduced-where-assessments-delayed-and-access-disrupted-by-covid-19/ and "Parents concerned at reduction of access due to Covid-19", available at https://www.childlawproject.ie/publications/parents-concerned-at-reduction-of-access-due-to-covid-19/.

113. Child Care Law Reporting Project, "Novel issues in child care proceedings raised by Covid crisis", available at https://www.childlawproject.ie/publications/novel-issues-in-child-care-proceedings-raised-by-covid-crisis/.

the mother said she would like to hug her child and pick her up, but the social worker replied that access could only be looked at further once the mother was in residential treatment. The judge in the case commented that "it is a very difficult time for these children and for the mother. This nightmare that we are living through is a particular nightmare for parents of children in care".[114] In another case, concerning a child who had consistently stated that she wished to return home, access was restricted to Zoom calls for a period, before later being resumed outdoors in a park; the mother complained that everyone was required to wear masks and gloves and her daughter was not permitted to eat the food she had brought.[115]

The impact of restrictions on access runs deeper than a temporary reduction in contact between parents and children. It is firmly established in the case law of both the European Court of Human Rights[116] and the Irish courts[117] that placing a child in care is intended to be a temporary measure, the ultimate aim of which should be the reunification of the child with his or her parents. Maintaining meaningful access is seen as essential to achieving this aim. As such, temporary restrictions on access risk causing longer term damage to the relationship between children in care and their parents that may reduce the prospect of successful family reunification.

This risk is exacerbated by other impacts of the pandemic. Several cases documented by the Child Care Law Reporting Project involved delays to assessments being carried out.[118] Assessments are often a crucial part of providing the evidence base that would satisfy a court that it is in the best interests of a child to discharge a care order and allow the child to return home. A further barrier to family reunification posed by the impact of COVID-19 is that parents of children in care are struggling to overcome the challenges that led to their children entering care. This may be due to the stress of lockdown, the difficulty in accessing supports due to COVID-19 restrictions, or a combination of these factors. The Child Care Law Reporting Project documented a case in which a child had been in care for two years and was progressing towards family reunification; however, "the Covid-19 pandemic placed the child's mother under unexpected stress, causing her to relapse in her alcohol misuse." The unexpected removal of supports as a result left the mother finding it very difficult to cope.[119] An interim care order was extended in another case in which the father had continued his therapeutic intervention on Zoom, but the mother had not engaged in therapeutic interventions since the beginning of the pandemic.[120] These effects can be exacerbated by restrictions on access, since access

114. Child Care Law Reporting Project, "No "unnecessary" contact between mother and baby during pandemic", available at https://www.childlawproject.ie/publications/no-unnecessary-contact-between-mother-and-baby-during-pandemic/.

115. Child Care Law Reporting Project, "Covid crisis gives rise to access dispute", available at https://www.childlawproject.ie/publications/covid-crisis-gives-rise-to-access-dispute/.

116. See, eg, *Olsson v Sweden (No. 1)* (10465/83, 24 March 1988) at [81] and *Johansen v Norway* (17383/90, 7 August 1996) at [78].

117. See McMenamin J in *Health Service Executive (Southern Area) v SS (a minor)* [2007] IEHC 189 at [94].

118. See, eg, Child Care Law Reporting Project, "District Court concerned about delays in assessments due to Covid-19", available at https://www.childlawproject.ie/publications/district-court-concerned-about-delays-in-assessments-due-to-covid-19/ and "Care order extended and access reduced where assessments delayed and access disrupted by Covid-19", available at https://www.childlawproject.ie/publications/care-order-extended-and-access-reduced-where-assessments-delayed-and-access-disrupted-by-covid-19/.

119. Child Care Law Reporting Project, "Interim care order when mother's alcohol abuse relapses due to Covid 19", available at https://www.childlawproject.ie/publications/interim-care-order-when-mothers-alcohol-abuse-relapses-due-to-covid-19/.

120. Child Care Law Reporting Project, "Covid-19 causes problems for therapy and access as interim care orders extended", available at https://www.childlawproject.ie/publications/covid-19-causes-problems-for-therapy-and-access-as-interim-care-orders-extended/.

motivates parents to work towards treatment goals, while restrictions on access can have a negative impact on parental engagement.[121]

2.3.7 Delays in Court Hearings

In addition to delays in assessments, COVID-19 restrictions have—as in other jurisdictions[122]—caused delays in court hearings in child care cases. In some instances, it was possible to hold remote hearings;[123] but in other cases, hearings have been postponed for various reasons, including the need to make arrangements for a sufficiently large courtroom to accommodate the number of witnesses who would be in attendance.[124] In one documented instance, a District Court adjourned 21 out of 25 child care cases on its list to a later date.[125]

The 2020 Annual Report of the Special Rapporteur on Child Protection documented concerns expressed by various parties about the already limited capacity of the courts to afford child care cases sufficient time and attention within a reasonable timeframe.[126] This pre-existing pressure point is likely to have been exacerbated by the delays and other restrictions experienced by the Courts Service since the beginning of the pandemic.

2.3.8 Access to Therapeutic and Family Support Services

Similarly, the 2020 Annual Report of the Special Rapporteur on Child Protection had highlighted pre-existing capacity issues and lengthy waiting lists for therapeutic services for children who have experienced sexual abuse.[127] Again, this has been exacerbated by the COVID-19 pandemic. The UN Special Rapporteur has noted that "measures to contain the virus have affected delivery of vital support and treatment services as well as contact with informal support networks", and "forced institutions and NGOs to deal with greater difficulties in prevention and support activities for victims."[128] International research has shown that even where therapeutic work was able to continue, the focus shifted from dealing with abuse to family maintenance/stabilization.[129] Various organisations in Ireland including One in Four,[130] the CARI Foundation[131] and Barnardos,[132] have indicated that their work became considerably more challenging during the pandemic through a combination of increased demand and waiting list for services, and the challenges associated with moving therapeutic services online.

121. Pisani-Jacques (n 104 above) at p 956.

122. *Ibid* at p 958.

123. Child Care Law Reporting Project, "Interim care order granted in first ever virtual hearing", available at https://www.childlawproject.ie/publications/interim-care-order-granted-in-first-ever-virtual-hearing/.

124. Child Care Law Reporting Project, "District Court extends interim care order for a young girl of primary school age, full hearing delayed by Covid-19", available at https://www.childlawproject.ie/publications/district-court-extends-interim-care-order-for-a-young-girl-of-primary-school-age-full-hearing-delayed-by-covid-19/.

125. Child Care Law Reporting Project, "25 matters listed before District Court on one day during Covid-19 Pandemic", available at https://www.childlawproject.ie/publications/25-matters-listed-before-district-court-on-one-day-during-covid-19-pandemic/.

126. C O'Mahony, *Annual Report of the Special Rapporteur on Child Protection* (2020), sections 1.3.2, 1.5.1 and 1.8.3, available at https://www.gov.ie/en/publication/cfbc8-special-rapporteur-on-child-protection-13th-report/.

127. *Ibid* at 1.5.1 and 1.8.3.

128. UN Special Rapporteur (n 1 above) at [19] and [42].

129. D Tener *et al*, "How does COVID-19 impact intrafamilial child sexual abuse? Comparison analysis of reports by practitioners in Israel and the US" (2021) 116 *Child Abuse and Neglect* 104779.

130. See https://www.oneinfour.ie/blog/one-in-four-and-covid-19.

131. See https://www.cari.ie/2020/03/13/cari-covid-19-announcement/.

132. See https://www.barnardos.ie/news/cracks-press-release.

2.4 CHANGES IN CHILD PROTECTION PRACTICE DURING COVID-19

Child protection practice had to change during COVID-19 in order to adapt to the extraordinary circumstances that were faced by children, families and practitioners. It is important to consider what worked well and what worked less well in order to determine how best to respond to the remainder of the crisis, as well as to future emergencies. It also provided a laboratory in which practices were tested that may have considerable value even in normal circumstances. Pisani-Jacques has observed: "During COVID-19, the child welfare system embraced creativity and innovation because it had to. Now the best innovations should continue because they work."[133] This section will set out some examples of changes in child protection practices implemented in Ireland and internationally.

2.4.1 Use of Technology

As in other areas of society, the COVID-19 pandemic forced a new reliance on technology by staff working in all parts of the child protection system. It was noted in section 2.3.3 above that video or phone calls are often an inadequate substitute for face-to-face contact in child protection work. Nonetheless, advantages have been seen in certain circumstances. Youth organisations in Ireland adapted a range of online programmes and supports, including mental health supports, leadership training and e-mentoring, and reported that increased reliance on technology has resulted in a greater geographic reach in their engagement with young people.[134] Pisani-Jacques has argued that video calls can enhance the level of contact between children in care and family members:

> Virtual family time, although not a substitute for in-person contact, has the potential to allow children to have *more* contact with their parents, siblings, and extended family members. It enables parents to be part of children's daily routines, such as doing homework, reading bedtime stories, and even family meals. The child welfare system has more than endorsed that virtual family time can be successful; it has insisted in many places that this was the best response to ensure family contact during the pandemic. It would be difficult to argue that this type of contact, unless harmful to a specific child, should end after the pandemic does ...[135]

Technology has also been used in innovative ways in the provision of therapeutic services. It was reported in December 2020 that Childline is developing a video therapy service which it has been piloting in two areas of the country in collaboration with Tusla, and that early feedback on the pilot had been very positive.[136]

Virtual engagement also created a space within which measures could be implemented to mitigate the disruption of the flow of referrals to child protection services discussed in section 2.3.2 above. Rapoport *et al* argue that "[e]ducators, the single most common

133. Pisani-Jacques (n 104 above) at p 961.

134. National Youth Council of Ireland (n 50 above) at p 7.

135. Pisani-Jacques (n 104 above) at p 961.

136. N Baker, "Childline developing new video therapy service as it prepares for 'busier Christmas' than last year", *Irish Examiner*, 18 December 2020.

source of child maltreatment reports, must continue to be vigilant for signs of child abuse or neglect, even when using virtual platforms to engage with children".[137] The authors note that the Maine Department of Education issued guidance for educators on recognising signs of child abuse or neglect when engaging with children online, such as looking for marks of abuse; listening for background noises such as yelling; and ensuring that children and their family members have the ability to have private conversations with the educator.[138] In Serbia, a specific emoticon was designated as a "quick message to teachers and peers that children need protection."[139] Humphreys *et al* have set out similar guidance for health professionals who are conducting virtual consultations. Their advice includes looking for signs of parental stress, irritability, and depression; specifically asking about stress levels in the home and coping strategies; inquiring about substance use; and being attentive for children who appear overly fearful and parents who are unduly harsh or over-controlling.[140]

2.4.2 Social Work Practice

As discussed above, the inability of social workers to conduct normal home visits was a significant drawback of lockdown measures. However, some social workers reported that being forced to engage with children outside of the family home had an upside. Ferguson *et al* report:

> A consistent finding is that workers have gone on walks with young people and sometimes parents and used parks and other open spaces near family homes to walk, play or just be together in. When home visits are tense, using these other environments provides new opportunities for reflection and discussion … Walking alongside children and other family members is felt to offer a form of 'side-by-side' rather than 'face-to-face' communication that is highly productive, since people accessing services often disclose more when on the move …[141]

Social workers found that young people were "more relaxed in that open space rather than sitting in a home" and "were able to share a lot more".[142] This finding is noteworthy from a practice perspective, and also provides support for proposed legal reforms in respect of the scope of supervision orders (discussed in section 1.2.1 of this Report).

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137. Rapoport *et al* (n 72 above) at p 6.

138. *Ibid*.

139. Larkins *et al* (n 58 above) at p 14.

140. K Humphreys, M Myint and C Zeanah, "Increased Risk for Family Violence During the COVID-19 Pandemic" (2020) 146 *Pedeatrics* e20200982.

141. H Ferguson, S Pink and L Kelly, "How social work and child protection are being creative and helping children and families during COVID-19 and can do so beyond it", *Research in Practice*, 26 August 2020, available at https://www.researchinpractice.org.uk/children/news-views/2020/august/how-social-work-and-child-protection-are-being-creative-and-helping-children-and-families-during-covid-19-and-can-do-so-beyond-it/.

142. *Ibid*.

2.4.3 Policing

In response to the evident spike in incidents of domestic abuse during the pandemic, An Garda Síochána launched Operation Faoiseamh as a dedicated response aimed at that victims of domestic abuse were supported and protected during the pandemic.[143] The operation involved two phases: Phase I involved the utilisation of Garda Victim Liaison Offices, Divisional Protective Service Units (DPSUs) and other appropriate resources to reach out and make contact with victims of domestic abuse to ascertain issues of concern, to offer support and reassurance and to ensure that any issues identified were dealt with. Phase II concentrated on the execution of arrests and the commencement of prosecutions for offences relating to breaches of court orders obtained pursuant to relevant provisions of the Domestic Violence Act 2018.

The Policing Authority gave a positive assessment of policing performance during the COVID-19 pandemic:

> Fears expressed early in the pandemic regarding the likely resilience of the policing effort in this area have been allayed. There is a sense that the progress made is such that there can be confidence that the changes in understanding, culture and approach to the policing of domestic abuse are being, and continue to be, bedded in and unlikely to regress.[144]

The Authority described DPSUs "as offering an experienced, expert and victim centred service to those who come forward to report. Early outcomes are described as positive and the units are seen to be working well".[145] In particular, the Authority highlighted that the experience of people coming forward to make reports is much more positive when first contact is with a specialist unit rather than with a "front desk", which can be "entirely unconducive to such moments" due to the "visibility and sense of exposure which can be experienced while in a queue within a busy public environment".[146] The Authority also referenced the "strengthened relationships" that have developed between An Garda Síochána and groups and organisations working in the area of domestic abuse, including joint training and cooperation on domestic abuse initiatives. The Authority commented that "women are more trusting of the Gardaí as a result of the positive experiences they have had and that Gardaí are increasingly applying soft skills gained from this type of joint training."[147]

While all of the above is very positive, it must now be placed in the context of the more recent revelations about the cancellation by Gardaí of a large number of 999 calls relating to domestic abuse during 2019 and 2020 (as discussed in section 1.3.7 of this Report). These revelations risk undermining progress made and goodwill developed through the establishment of DPSUs and the implementation of Operation Faoiseamh.

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143. See details at https://www.garda.ie/en/about-us/our-departments/office-of-corporate-communications/press-releases/2020/june/operation%20faoiseamh%20-%20domestic%20abuse%209th%20june%202020.html.

144. Policing Authority, *Report on Policing Performance by the Garda Síochána during the Covid-19 Health Crisis* (April 2021) at p 10, available at https://www.policingauthority.ie/assets/uploads/documents/2021_04_19_Report_13_on_policing_performance_during_Covid-19_Final.pdf.

145. *Ibid* at p 10.

146. *Ibid.*

147. *Ibid* at p 11.

2.4.4 Helplines

Amid all the focus on the use of the latest video technology during the pandemic, it is interesting to note that international evidence suggests that a very effective measure aimed at identifying and responding to child abuse during lockdowns was targeted investment in traditional telephone helplines, or variations of these involving text or online chat functions. It was noted in section 2.3.1 above that calls to child helplines increased significantly in many countries during COVID-19 lockdowns. In some countries, the volume of calls to helplines was such that systems had to be developed for screening and prioritising calls.[148] Petrowski *et al* note that while lockdown measures disrupted many referral and reporting mechanisms, child helplines are one of the least affected of the child protective services, and remain operational even in situations where services based on physical interactions are restrained.[149] The authors note that "[c]hild helplines are relatively easy and cost-effective to establish", and "provide a confidential channel for children to speak openly and receive advice without confronting the formalities of a child protection system"; they are especially suited to capturing cases of violence from particularly vulnerable populations of children who have limited access to (or are afraid to utilise) formal reporting mechanisms.[150]

Petrowski *et al* argue that international evidence indicates an increase in usage of child helplines in recent years, which suggests that "such services are a critical lifeline for many children and women during times of crisis".[151] The authors conclude that "[e]fforts should also be made to raise public awareness of the existence and continued availability of helpline services even during times of crisis", and that "child helplines should be strengthened and equipped with sufficient resources and staff to handle increased demand and need of services during an emergency and make necessary referrals."[152] They cite guidance on what child helplines can do during a pandemic to continue supporting children and families prepared by the Alliance for Child Protection in Humanitarian Action.[153]

2.4.5 Targeted Resourcing

The UN Special Rapporteur has highlighted the use of targeted resourcing measures adopted in at least 60 countries to enhance or scale-up child protection services in response to the impact of the pandemic. These include social protection measures such as new child grant programmes or increasing the value of existing child grants to mitigate the risk of child poverty, and increased funding for organisations providing support to victims and survivors of child sexual abuse.[154] In Ireland, there were examples of similar measures. At an early point in the pandemic, Tusla adopted guidelines on the provision of aftercare supports which extended the dates on which young people would be due

148. Hore (n 100 above) at p 2.

149. Petrowski *et al* (n 58 above) at p 2.

150. *Ibid* at p 3.

151. *Ibid* at p 11.

152. Petrowski *et al* (n 58 above) at p 12.

153. *Ibid* at p 11, citing The Alliance for Child Protection in Humanitarian Action—Child Helpline International—CP AoR—UNICEF, *Technical Note: Child Helplines and the Protection of Children During the Covid-19 Pandemic* (May 2020), available at https://www.alliancecpha.org/en/child-protection-online-library/technical-note-child-helplines-and-protection-children-during-covid.

154. UN Special Rapporteur [n 1 above] at [59] to [63].

to leave care or exit formal aftercare with the aim of supporting young adults to ensure that they were not disadvantaged during the pandemic.[155] The Government made an additional budgetary allocation of 8 million to Tusla to cover additional costs arising from the pandemic.[156] Additional funds were also made available to An Garda Síochána and the Courts Service.[157]

2.4.6 Public Awareness Campaigns

In response to the Covid-19 pandemic, the Department of Justice launched a public awareness campaign on domestic abuse, detailing the available supports from An Garda Síochána, the Courts Service, and a range of organisations such as Women's Aid and Dublin Rape Crisis Centre.[158] Information on specific supports available to people under 18 years of age, as well as to people with disabilities and older persons was also provided.[159] The public messaging adopted by An Garda Síochána was praised by the Policing Authority as being "consistently victim centred and clearly offering reassurance that the Gardaí are 'still here' and that domestic abuse against women and men will not be tolerated;" this "gave confidence that there is 'an institutional understanding' of domestic abuse, and it was remarked that the significance of these moments for victims should not be underestimated".[160]

2.5 DISCUSSION AND RECOMMENDATIONS

The evidence discussed in this Chapter illustrates beyond doubt that the COVID-19 pandemic had an extremely negative impact on children and young people, with the most negative impacts falling disproportionately on the most disadvantaged and marginalised children. This general trend played itself out in Ireland in a manner broadly in line with international trends. Children and young people missed out on education and opportunities for social interactions and leisure/play for lengthy periods. Child poverty increased, while many children and young people experienced negative impacts on their physical and especially their mental health. Many children were forced to stay at home in unsafe environments during an enormous spike in levels of domestic abuse; some exceptionally serious cases of neglect presented themselves in the courts; and risks of exposure to cyberbullying or other online harms increased. At the same time, the flow of referrals to child protection services was seriously disrupted for several periods, making it more difficult to identify children at risk. Social work intervention with families and access visits became extremely challenging due to social distancing requirements, while delays were experienced in assessments, court hearings and access to therapeutic and other support services. From a child protection standpoint, COVID-19 was a perfect storm.

155. Tusla, *Guidelines for COVID-19 for young adults in receipt of an aftercare service* (CMT-AD-28-2020, Updated 29 September 2020), available at https://www.tusla.ie/uploads/content/CMT-AD-28-2020_Guidelines_for_COVID-19_for_young_adults_who_are_in_receipt_of_an_Aftercare_Service_V4.0_29-09-2020_.pdf.

156. Minister Roderic O'Gorman TD, Select Committee on Children, Disability, Equality and Integration, 6 October 2020.

157. C Lally, "Funds to recruit 600 new gardaí next year", *Irish Times*, 13 October 2020.

158. See https://www.stillhere.ie/.

159. *Ibid.*

160. Policing Authority (n 144 above) at p 11.

The additional burdens faced by everyone involved in the child protection system (whether as frontline workers or behind the scenes; in State agencies, Government departments or NGOs; or in law firms, the Courts Service, or elsewhere) must be acknowledged, as must the resilience and creativity shown in responding to them. No one was unaffected, and more was demanded of everyone. Extraordinary efforts were made by some, often involving personal risk of infection.

Nevertheless, the lives of many children have clearly disimproved during the pandemic, and considerable numbers of children experienced significant abuse, neglect, trauma or other ill-effects that might not have occurred if the pandemic had not happened. While many good things were done to protect children and children's rights, there were also failures and lost opportunities along the way. In particular, there was a tendency internationally for Governments to view children as passive objects during the crisis rather than autonomous agents; and their interests were not always prioritised amid the many difficult decisions that needed to be made. Lundy *et al* state that their study provides "ample evidence" that children "were not aware or indeed convinced that their governments had paid attention to children's interests or had given them sufficient weight when making key decisions such as the closure of their schools and play and leisure facilities. That in itself is a powerful indicator of a lack of a child-rights based response to the crisis."[161] Only 20 per cent of children (out of 26,258 respondents in 137 countries, including Ireland) who participated in the study felt that their governments were listening to children when making policy decisions about how to manage the crisis; children also felt that insufficient efforts were made to communicate with them directly, and to disseminate child-friendly information about the pandemic and its effect on children's everyday lives.[162] Although various research surveys were conducted in Ireland during the pandemic (some of which were supported by Government),[163] meaningful consultation with children on key decisions affecting them such as the cancellation of State examinations or the re-opening of schools was less evident. Lundy *et al* conclude:

> … children, right across the world, felt that their governments were not considering children as a priority and were definitely not seeking their views when crucial policy responses to the pandemic were formulated and implemented. The effects of this on their right to development, as reported by participants, were, are and will continue to be profound … Had states engaged with children, and bearing in mind the precautionary principle (that states have an obligation to take steps to reduce or eliminate threats to the protection of fundamental human rights even if the degree of threat is uncertain), some of the profound adverse consequences might have been mitigated or avoided.[164]

Perhaps the biggest failure seen in Ireland was the length of the school closures, as well as their indiscriminate nature for the majority of the period in question. As discussed throughout this Chapter, school closures were at the root of many of the negative impacts

161. Lundy *et al* (n 2 above) at p 274.

162. *Ibid* at pp 277-278.

163. See, eg, SpunOut (n 24 above).

164. Lundy *et al* (n 2 above) at pp 281-282.

of lockdown measures on children; they impacted on their education, their physical and mental health, and left many children in unsafe home environments and out of sight of mandated reporters. An editorial in the *British Medical Journal* by Lewis *et al* argues that "[c]hildren have least to gain and most to lose from school closures", and that the pandemic "has seen an unprecedented intergenerational transfer of harm and costs from elderly socioeconomically privileged people to disadvantaged children."[165] The first round of school closures in 2020 was probably a justifiable application of the precautionary principle, given the absence of reliable data on the virus at that point. However, by 2021, clear evidence was available that "[t]he overall risk to children and young people from covid-19 is very small", while "accumulating evidence shows that teachers and school staff are not at higher risk of hospital admission or death from covid-19 compared with other workers."[166] As such, Lewis *et al* argue that "[i]n the absence of strong evidence for benefits of school closures, the precautionary principle would be to keep schools open to prevent catastrophic harms to children."[167]

However, Ireland took the opposite approach: schools were closed for longer and for more children than was the case in most comparable countries. Children's interests did not receive the level of priority that they might have received in decision-making in early 2021 in particular. The Programme for Government adopted in 2020 committed to developing contingency plans for further potential school closures.[168] However, while contingency plans for school closures have their place, sole reliance on such plans is the wrong starting point because it places school closures too high on the menu of public health measures. It is recommended that a more important measure would be to develop and implement plans aimed at avoiding lengthy and indiscriminate school closures in future pandemics. The aim should be to keep schools open for all children; or, if this proves impossible, to keep them open at least for children from disadvantaged communities and children with special educational needs. The Department of Education, in conjunction with the HSE and other partners, should proactively develop a pandemic response plan that is future-proofed so far as possible and kept under regular review in light of the latest public health research. Infrastructural issues such as the provision of proper ventilation in school buildings should be worked on now so that they will be in place in the event of another pandemic (and would provide other benefits in the meantime). A huge body of evidence has been accumulated on the impact of school closures and the measures needed to keep schools open. It is imperative that we do not fall into the trap of forgetting all about this evidence as soon as the pandemic ends, because keeping schools open would serve to avoid or greatly mitigate many of the harms experienced by children during a pandemic.

The IASW survey referenced earlier found that during the pandemic, social workers "demonstrated leadership, adaptability and creativity"; however, "despite ever increasing levels of need, social workers are not always provided with the basic tools and supports to do their job. In fact, there was very little improvement in the levels of resources provided".[169] This indicates that notwithstanding the additional resources allocated by

165. S Lewis *et al*, "Closing schools is not evidence based and harms children" (2021) 372 *British Medical Journal*, doi: 10.1136/bmj.n521, at p 1.

166. *Ibid.*

167. *Ibid.*

168. Department of the Taoiseach, *Programme for Government: Our Shared Future* (October 2020) at p 97, available at https://www.gov.ie/en/publication/7e05d-programme-for-government-our-shared-future/.

169. Murphy and McGarry (n 84 above) at p 17.

Government to cover COVID-related costs, the level of demand on services is such that a shortfall remains. Given some of the evidence discussed in Chapter 1 of this Report about pressure on child protection services even before the pandemic, this is not entirely surprising. The IASW states that social workers who completed the survey provided clear messages as to the supports they needed from their employers: 1) increased access to technology; 2) adequate support and guidance, and 3) to be valued and acknowledged.[170] All of these points merit a careful response, particularly in light of the known challenges faced by Tusla in social worker retention (discussed further in section 4.4.9 of this Report).

The issue of resources is not only applicable in a social work context. Chapter 1 of this Report identified significant pressure on CAMHS before the pandemic, and the evidence in this Chapter has suggested that this pressure will build significantly in years to come due to the fallout of the pandemic. Further issues are likely to flow from the economic, social and health impacts of lockdown measures that were documented above. As such, it is essential that Government puts in place measures designed to forecast increased demand on services and make advance provision for it, so that children who need services in the years to come can access them without undue delay. Failure to adequately plan and resource now will lead to children suffering avoidable harm in the future.

170. *Ibid.*

Chapter 3

The Final Report of the Commission of Investigation into Mother and Baby Homes — A Human Rights Analysis

3.1 INTRODUCTION

The publication of the Final Report of the Commission of Investigation into Mother and Baby Homes[1] ("the Commission Report") in January 2021 was the culmination of over five and half years of work. It was much anticipated, and has generated considerable fallout. Following its publication, the Taoiseach issued a State apology in the Dáil to survivors, and the Government committed to implementing a response based on four pillars of Recognition, Remembrance, Records and Restorative Recognition.[2] Nonetheless, the Report has attracted considerable criticism and controversy. At the time of writing, multiple court proceedings are in train in which survivors of Mother and Baby Homes are seeking to quash findings made in the Report.[3] One law firm has petitioned the International Criminal Court to investigate the legacy of the Mother and Baby Homes.[4]

1. The Report can be accessed in full at https://www.gov.ie/en/publication/d4b3d-final-report-of-the-commission-of-investigation-into-mother-and-baby-homes/. All references in this chapter labelled "Commission Report" or "Confidential Committee" refer to documents available on this website.

2. The full statement can be viewed at https://www.gov.ie/en/speech/86f24-statement-of-an-taoiseach-report-of-commission-of-investigation-into-mother-and-baby-homes-and-certain-related-matters/.

3. See, eg, S Phelan, "Survivor's bid to quash mother and baby home finding on vaccine trials", *Irish Independent*, 3 April 2021; M Carolan, "Philomena Lee among five given leave to challenge mother and baby homes report", *Irish Times*, 12 April 2021; A O'Faoláin, "Woman who gave birth at Bessborough Mother and Baby Home sues over Commission's finding", *Irish Examiner*, 21 May 2021.

4. See M Fagan, "ICC asked to investigate mother and baby homes and Magdalene Laundries", *Irish Examiner*, 18 May 2021.

It is beyond the scope of this Report to address all of these issues. Instead, this Chapter aims only to consider the extent to which the Commission Report provides evidence of violations of human rights in the broad sphere of child protection. Notably, although it contains a chapter entitled "Human Rights", the Commission Report makes little or no effort to connect this chapter with the remainder of the Report. The evidence available to the Commission regarding the treatment of women and children in Mother and Baby Homes, County Homes and foster homes is not explicitly and consistently measured against the international human rights law standards to which Ireland was committed from 1953 onwards. This chapter aims to fill that gap in the Commission's analysis.

In doing so, the treatment of both mothers and children will be considered. From the perspective of the remit of the Special Rapporteur on Child Protection, it is significant that a considerable number of the mothers who spent time in Mother and Baby Homes were under the age of 18 when they entered the Homes (and thus were legally children). It is not possible to quantify these numbers, or to disentangle evidence relating to mothers who were above or below the age of majority. For this reason, the experiences of all mothers and children will be included in this analysis. (As a shorthand, to avoid confusion between mothers and their children, mothers will be referred to throughout this Chapter as "women", notwithstanding the fact that many of them were under 18 at the time.)

3.1.1 Applicable Human Rights Standards

This chapter will focus in particular on the standards set down in the European Convention on Human Rights (ECHR), which was ratified by Ireland in 1953, and accordingly was legally binding on Ireland from this date onwards. This is significant, since the Commission Report notes that the greatest number of admissions to Mother and Baby Homes was during the 1960s and early 1970s[5]—well after the ratification of the ECHR. The proportion of births outside of marriage which were associated with Mother and Baby Homes was consistently above 30% and at times above 50% in the years from the early 1950s to the mid-1970s.[6] As such, the standards set down in the ECHR were applicable during two decades of particularly intensive activity in Mother and Baby Homes. They were also applicable for the latter years of the operation of County Homes and of "boarded out" and "at nurse" foster placements, although the numbers in these systems declined from the early 1960s onwards.[7] To account for the fact that the ECHR was not binding on Ireland prior to 1953, evidence in the Commission Report which is clearly labelled as relating to the period prior to its ratification has been excluded, save in cases where it helps to shed light on post-1953 events which were the continuation of a pattern from pre-1953.

In establishing the nature and scope of ECHR standards, it is necessary to engage with the case law of the European Court of Human Rights (ECtHR) interpreting the various Articles of the Convention and applying them to the facts of individual cases. It is important to note that the process of interpreting the ECHR often involves applying judgments to factual scenarios that arose before the judgment in question was delivered. However, the text of the Convention has remained unchanged since it was originally drafted. Judgments

5. Commission Report, Executive Summary at p 2.

6. *Ibid* at p 19.

7. Commission Report, Executive Summary, p 2 and [11.24] to [11.35].

are interpretations of the meaning of the Convention and its application in a specific context; they are clarifications of the law that already existed, and are not considered to make new law. For example, in *O'Keeffe v Ireland*, the ECtHR held in 2014 that Ireland had violated Article 3 of the ECHR by failing to provide adequate protection from sexual abuse in National Schools in 1973.[8] In reaching this conclusion, the ECtHR cited and relied on case law from as recently as 2012, noting that while it was "true that the Court has further elucidated the breadth and nature of the positive obligations on States" in its more recent case law, "this is considered to be mere clarification of case-law which remains applicable to earlier facts without any question of retroactivity arising".[9]

3.1.2 Evidence Available to the Commission

Human rights are held on an individual basis; findings of violations of rights are not dependent on "critical mass" or a minimum quantity of people or of violations. The violation of the rights of some individuals is not cancelled out by the fact that the rights of others were not violated. For the same reason, ill-treatment of some individuals is not made good by kindness shown to others. Accordingly, the analysis in the chapter will focus entirely on evidence that is indicative of potential rights violations. It will not engage in a "balancing" of this evidence against evidence of better treatment or more positive experiences, since the latter cannot inform the analysis of the former.

That being said, the numbers of women and children involved and the weight of the testimony on certain points is worth highlighting. First, there is corroborative value to the fact that multiple witnesses provided substantially similar testimony on key points. Second, where the evidence is indicative of a consistent pattern rather than a collection of egregious instances, this makes claims that the State was not aware of the pattern less credible. Where large numbers of violations occur over a lengthy period of time, it becomes more arguable that even if State authorities were not aware, they ought to have been. As will be seen below, the issue of State knowledge is a key factor in determining whether violations of the ECHR occurred in several important instances.

The Commission relied primarily on documentary evidence in the form of contemporaneous records and affidavits as well as on oral testimony. The latter took two forms. An Investigative Committee received evidence from 195 individuals, including 64 former residents of Homes, as well as members of congregations, social workers, workers in the Homes, Gardaí and local authority officials. This evidence was given under oath or affirmation, and was subject to questioning by members of the Committee receiving the evidence.[10] Meanwhile, the terms of reference for the Commission required it to establish a Confidential Committee "to provide a forum for persons who were formerly resident in the homes … to provide accounts of their experience in these institutions in writing or orally as informally as is possible in the circumstances", and to "produce a report of a general nature on the experiences of the single women and children which the Commission may, to the extent it considers appropriate, rely upon to inform" its investigations.[11]

8. 35810/09, 28 January 2014.

9. *Ibid* at [147].

10. Commission Report, Part 5 (Archives) at p 94.

11. Commission of Investigation (Mother and Baby Homes and certain related Matters) Order 2015 (SI No 57/2015), Schedule, (3) and (4).

The Confidential Committee received evidence from 550 individuals; all but five of these gave evidence relating to the 1950s or later, with the "vast majority" relating to the period between 1960 and 1989.[12] Evidence given to the Confidential Committee was not given on oath and was not subject to challenge, either by the person receiving the evidence or anyone else.[13] The Confidential Committee report was published as a separate volume alongside the main Commission Report.

The main body of the Commission Report relied on various documentary sources, and included excerpts of witness testimony provided to the Investigative Committee (identifying the institution in which the witness had been resident). The Chair of the Commission stated in a letter to the Joint Oireachtas Committee on Children, Disability, Equality and Integration that testimony given to the Confidential Committee "was reviewed by the Commission and informed its investigations in accordance with the remainder of the Terms of Reference."[14] However, no oral evidence given to the Confidential Committee appears in the main body of the Report, and there is no visible evidence of the manner or extent of the reliance placed on it by the Commission in reaching its conclusions. Speaking at a seminar some months after the publication of the Report, one of the Commission members gave two reasons for confining this evidence to the Confidential Committee report: first, the fact that the evidence had not been given on oath and was not subject to challenge, and second, the workload that would have been involved in cross-checking this evidence against other sources and integrating it into the main body (described as "hundreds of hours").[15]

This reasoning is open to question. First, although the Commissions of Investigations Act 2004 allows for evidence to be given to Commissions on oath, it does not require this.[16] Second, a few hundred hours of additional work does not seem like a significant obstacle to a Commission that worked for well over five years and spent only half of its allocated budget of €23 million.[17] Third, the terms of reference of the Commission made it clear that the purpose of the Confidential Committee report was to produce a report of a general nature. The evidence produced in the Confidential Committee Report was anonymised and would not have led to the identification of either individuals or institutions; therefore, as Máiréad Enright has correctly observed, the need to provide for fair procedures such as a right to challenge the evidence did not arise.[18] While the Confidential Committee Report notes that some evidence given to the Committee was "clearly incorrect",[19] its report (which surely did not include among the selected excerpts

12. Confidential Committee at p 10.

13. *Ibid* at pp 7 and 11.

14. See https://www.irishtimes.com/news/social-affairs/full-letter-sent-to-oireachtas-by-former-members-of-mother-and-baby-homes-commission-1.4590705.

15. See E Loughlin, "Mother & Baby Homes inquiry discounted hundreds of survivors' testimonies", *Irish Examiner*, 2 June 2021 and O Ryan, "'Yet another blow to survivors': Women get few answers as Commissioner defends report", *TheJournal.ie*, 2 June 2021. A full transcript of the Commissioner's comments is available at http://clannproject.org/wp-content/uploads/Oxford-University-Seminar_Prof-Mary-Daly_02-06-2021.pdf; the relevant passages are at pp 3-5, 11-13 and 22.

16. Commissions of Investigations Act 2004, s 14(3) and 16(1)(c).

17. Commission Report, Introduction at p 15.

18. M Enright, "Flawed Mother and Baby report cannot be allowed to stand", *Irish Examiner*, 4 June 2021. In the event that any information from the Confidential Committee had led to a person being identifiable, the Commissions of Investigations Act 2004, s 34 would have required the Commission to send a draft of the report to that individual, who would be entitled by s 35 to seek to have the draft amended if fair procedures had not been observed. Enright states that since these procedures were utilised in respect of the main body of the Commission Report, the exclusion of anonymised testimony provided to the Confidential Committee was "overkill".

19. Confidential Committee at pp 7 and 11.

of testimony any evidence which the Committee knew to be incorrect) nevertheless has evidential value due to the number of witnesses involved and the consistency of the testimony provided. The Confidential Committee noted that witnesses (of whom almost ten times as many former residents testified to the Confidential Committee compared to the Investigative Committee) "related similar, sometimes identical stories from time spent in institutions where the type of work and living conditions, although based throughout the country in widely spaced geographical locations, seemed to be the same,"[20] and went on to say:

> No matter what congregation or religious order was in charge, or where its institutions were located, a remarkable similarity of regimes in most homes was described by the stream of individual witnesses of all ages and from all parts of the country who came to the Confidential Committee.[21]

Finally, as will become clear below, much of the evidence presented to the Confidential Committee that is indicative of human rights abuses is substantially similar to evidence that was given to the Investigative Committee and relied on by the Commission in the main body of its report. The difference between the two is quantitative rather than qualitative, and there appears to be a strong degree of mutual corroboration.[22] For all of these reasons, the analysis in this Chapter will draw on relevant evidence from both the Investigative Committee and the Confidential Committee, clearly labelling each.

3.1.3 Limitations

This chapter does not claim to be a comprehensive or definitive analysis of human rights issues arising from the matters considered in the Commission Report, and a number of important limitations must be noted. First, it draws only on evidence reproduced in the Commission Report itself. The author did not have access to archives of documentary evidence or oral testimony that were available to the Commission. As such, editorial decisions made by the Commission and by the Confidential Committee have already determined what material was available for review; and any errors that may have been made in the reproduction of witness testimony would not have been corrected.[23] Second, for the reasons given in section 3.1.1 above, it only examines human rights standards set down in the ECHR, and does not examine other international human rights law instruments that may be of relevance. Third, it examines issues of particular relevance to child protection; there are other human rights issues that might also be raised and that have not been considered here. Finally, it is acknowledged that there is a range of other

20. *Ibid* at p 42.

21. *Ibid* at p 52.

22. As noted by Enright (n 18 above): "In many places, the main report discloses 'limited' evidence of serious abuse, based on the small number of oral and written statements given to the investigative committee. Where this evidence is corroborated by hundreds of similar statements to the confidential committee, there is a good case for taking it into account. 'Limited' evidence might then become 'significant' evidence; a finding that certain abuses may have occurred can become a finding that they probably did …" Similarly, D Ferriter, "Mother and baby homes inquiry falls short of the mark", *Irish Times*, 11 June 2021, argues that testimony given to the Confidential Committee "would bridge the gap between the documentary records and 'what it felt like' for the women who spent time in these homes".

23. On the issue of errors in the reproduction of witness testimony, see C Crowe, "The Commission and the Survivors, *The Dublin Review*, Summer 2021, available at https://thedublinreview.com/article/the-commission-and-the-survivors/.

theoretical and methodological perspectives that might be brought to bear on a human rights analysis of the Commission Report. This chapter represents just one possible approach.

3.1.4 Outline of Chapter

Having laid out the rationale and aims of this Chapter, the analysis will proceed to examine a number of discrete issues that were addressed in the Commission Report which give rise to concerns regarding potential violations of a number of rights with a child protection dimension protected by the ECHR. These will be examined as follows: infant deaths (right to life—Article 2); ill-treatment of women and children (right to freedom from inhuman and degrading treatment—Article 3); forced labour (right to freedom from forced labour—Article 4); deprivation of liberty (right to liberty—Article 5); consent to adoption (right to family life—Article 8); and vaccine trials (right to private life—Article 8). In each case, evidence provided in the Commission Report will be measured against the standards set down in the relevant provision of the ECHR and the associated case law of the ECtHR with a view to establishing, in broad terms, whether the evidence suggests that rights violations were likely to have occurred.

3.2 INFANT DEATHS

3.2.1 Article 2 ECHR

Article 2 of the ECHR protects the right to life.[24] The Court has confirmed that this Article "ranks as one of the most fundamental provisions in the Convention" and "the Court must subject to the most careful scrutiny complaints about deprivation of life".[25] This Article "enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction".[26] The Court has held that:

> For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time, of the existence of a real and immediate risk to the life of an identified individual and, if so, that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk.[27]

Case law to date has shown that "the State's duty to safeguard the right to life is also applicable to school authorities, who carry an obligation to protect the health and well-being of pupils, in particular young children who are especially vulnerable and are under

24. Article 2 provides as follows: "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection".

25. *Velikova v Bulgaria* (41488/98, 18 May 2000) at [68].

26. *Centre for Legal Resources on behalf of Valentin Cámpeanu v Romania* (47848/08, 17 July 2014) at [130]. See also *LCB v United Kingdom* (23413/94, 9 June 1998) at [36].

27. *Kemaloglu v Turkey* (19986/06, 10 Aril 2012) at [36].

the exclusive control of the authorities".[28] Equally, it has been confirmed that children in a care home require protection for their right to life. In *Nencheva v Bulgaria*, the Court found a violation of the right to life in circumstances where 15 children died over a period of three months in a children's home in the Winter of 1996-1997.[29] Evidence before the Court showed that State officials were aware of the poor conditions and the risk to the children's lives. The "children had been subjected to extremely poor conditions: they had had insufficient quantities of food, medicines, clothes and bed linen and lived in rooms that were inadequately heated in the winter".[30] The applicant parents of seven of the children who died in the home argued "that the State had failed in its positive obligations to protect the lives of the persons in its care, in circumstances which created an imminent threat to their lives and well-being, and to conduct an investigation aimed at identifying those responsible for the deaths".[31] According to the Court, "a crucial factor" was that "the tragic events had not occurred in a sudden, one-off and unforeseen manner. There had been a series of deaths and the tragedy at the home had thus been spread over time".[32] The Court held that there was a violation of Article 2 as the State failed to protect the children's lives and to effectively investigate the deaths.

3.2.2 Mother and Baby Homes and County Homes

As the Commission has acknowledged, "[h]igh rates of infant and child mortality are a marked feature of the mother and baby homes under investigation".[33] Some 9,000 babies and children died in the Mother and Baby homes within the Commission's remit. According to the Commission, this was "about 15% of all the children who were in the institutions" during the time period under consideration.[34] The Commission notes that in some years during the 1930s and 1940s, over 40% of children in the Homes died before their first birthday,[35] while in 1945-46, the death rate among infants in the Homes was almost twice that of the national average for children born outside of marriage.[36] In particular, "a large number of deaths" occurred in Pelletstown, Bessborough, Castlepollard, Sean Ross, Tuam, and Bethany.[37] In Bessborough, for example, "three out of every four children" born there in 1943 died, while in Sean Ross, "1,090 of the 6,079 babies, who were born or admitted died".[38] This appalling rate of infant deaths improved over time, and by the 1960s, infant mortality in Mother and Baby homes was broadly in line with the national mortality rate for children born outside of marriage.[39]

The peak of infant and child deaths in Mother and Baby Homes appears to have occurred in the 1930s and 1940s. This section will focus mainly on infant deaths from the 1950s onwards, following the ratification of the ECHR by Ireland; but reference will

28. *Ibid* at [35].
29. 48609/06, 18 June 2013.
30. *Ibid*.
31. *Ibid*.
32. *Ibid*.
33. Commission Report at [33.1]. While the high rate of maternal deaths is also discussed in the Report, this section will focus on infant and child deaths.
34. Commission Report, Executive Summary at p 4.
35. *Ibid* at p 15.
36. *Ibid* at p 4.
37. Commission Report at [33.1].
38. Commission Report, Executive Summary at pp 29-30.
39. *Ibid* at p 64.

be made to earlier deaths to illustrate that infant deaths in Mother and Baby Homes after 1953 were a continuation of an established pattern. Drawing on the *Nencheva* case outlined above, it is important to emphasise that these deaths were not "sudden, one-off and unforeseen".[40] There was an excessive number of deaths that were "spread over time"—indeed over many months, years and decades.[41] The Commission Report provided some detail as to the causes of death, and it will be seen below that causes of deaths in the 1950s and 1960s were similar to those recorded in the 1930s. It is also evident that in some cases there were multiple causes of death, or "some of the causes given were quite non-specific".[42] Indeed, some deaths appear to be unexplained.[43] As will be see in the next section, it appears that many of the deaths were readily preventable.

3.2.1.1 Preventable deaths

The Commission Report details numerous examples of deaths which could have been prevented if appropriate infection control measures were in place, as well as proper sanitary facilities, heating and adequate space provided for the number of people in the institutions. Many diseases were recorded as causing deaths including measles, influenza, diphtheria, gastro-enteritis, pneumonia, bronchitis and typhoid.[44] Some of these diseases were highly infectious and could spread easily due to overcrowding. Indeed, "[d]uring the 1930s, 1940s and 1950s all the mother and baby homes—with the exception of Denny House—were overcrowded on numerous occasions".[45] According to the Commission, "the large infant nurseries, with cots crammed together—sometimes only one foot apart—served to spread infection. There was an absence of infection control … The risks of infection were exceptionally high in Tuam, which admitted older children, who might be homeless".[46] Further, Tuam had "inadequate sanitary facilities and [a] lack of running water and hot water".[47] In Cork County Home, the Commission commented that "[i]nfection control would have been extremely difficult in an overcrowded institution, with poor sanitary facilities, that admitted children of various ages".[48] In Sean Ross, mothers working in a local fever hospital as unpaid nurses "transmitted infection to their child", directly causing "the loss of children's lives".[49]

Meanwhile, in Denny House, where the number of infant deaths "was consistently lower than other mother and baby homes", the Commission reported that "[t]he small numbers resident was a factor in the low mortality; women were screened before admission and breast-feeding was almost universal".[50] In Castlepollard, the Commission commented that "[t]he peaks in infant mortality occurred when the home was most overcrowded",[51] but infant mortality "was consistently lower than the other homes run by the Sacred

40. *Nencheva v Bulgaria* (48609/06, 18 June 2013).
41. *Ibid*.
42. Commission Report at [33.4] and [33.6].
43. P McGarry, "Call for inquiry into deaths at Tuam mother-and-baby home", *Irish Times*, 4 June 2014.
44. Commission Report at [33.4] to [33.6].
45. Commission Report, Executive Summary at p 67.
46. *Ibid*.
47. *Ibid*.
48. *Ibid* at p 40
49. *Ibid* at p 65.
50. *Ibid* at p 37.
51. *Ibid* at p 31.

Hearts congregation" possibly because "much of the accommodation was in a modern purpose-built hospital".[52] Indeed, the Commission commented that "[t]he wide disparity in infant mortality between the Bessborough and Castlepollard, which were run by the same religious congregation, and with a similar profile of mothers, suggests that some deaths could have been prevented".[53] The Commission also commented that an "absence of professional staff, combined with what must be acknowledged as a general indifference to the fate of the children who were born in mother and baby homes, contributed to the appalling levels of infant mortality".[54]

"Resident A", a woman in Bessborough in the early 1960s, gave evidence to the Investigative Committee that "she received no medical care during her pregnancy in Bessborough and never saw a doctor or a nurse".[55] She described how when she screamed in pain during labour for three days, she was verbally abused, and was largely left alone, locked in a room. Her baby subsequently died and she stated that: "[o]n my second day in labour I was given an injection … To this day I do not know what the injection was but I believe that this was what caused my baby's death and almost caused my own".[56] Resident A also stated that "Bessborough was always cold and that she was forced to feed her infant in a cold passageway outside the nursery … After two or three days the child 'would not eat, would not drink his bottle and would not swallow'".[57] The baby was taken off her and died soon after in St. Finbarr's Hospital, due to "renal failure and septicaemia".[58]

The lack of medical care was reiterated by other women about their time in Bessborough in the 1960s and 1970s.[59] Further, Resident A gave evidence that she only received "some" medical information about her labour and her child's death from Bessborough in the 1990s, when she requested it.[60] While the rate of infant mortality dropped significantly in the 1950s, 1960s and 1970s in Bessborough, the Southern Health Board confirmed that it "was twice the national average" in 1981.[61] An investigation carried out by the Director of Community Care for Cork concluded that "'little could have been done in any of these cases'".[62] Nonetheless, the Southern Health Board "advised the department that it was considering the future of obstetrical services at Bessborough", and these were phased out in 1985.[63]

The Confidential Committee report contains further witness accounts about infant and child deaths in the homes. For example, two witnesses stated that their mother "blamed the nuns" for the death of her two-year-old son in a home in the 1940s "because the place was wet and she believed that her son got TB from being on wet ground. She also told the witnesses that one of the nuns had 'knocked the baby out of my arms'".[64] A separate

52. *Ibid* at p 65.
53. *Ibid*.
54. *Ibid* at p 67.
55. Commission Report at [18.298].
56. Commission Report at [18.299].
57. Commission Report at [18.303].
58. Commission Report at [18.304].
59. See for example, evidence of "Resident I" in a sworn affidavit in the early 1960s (Commission Report at [18.368]); "Resident E" in the early 1970s (Commission Report at [18.336]); and "Resident G" in the mid 1970s (Commission Report at [18.344]).
60. Commission Report at [18.309].
61. Commission Report at [18.197].
62. *Ibid*.
63. *Ibid*.
64. Confidential Committee at p 48.

witness account detailed "a child being beaten up" by a nun and never seen again, while other witnesses said that "deaths of babies were covered up".[65]

3.2.1.2 State knowledge of deaths or risk of death

The Commission Report confirms that the State was aware of the poor living conditions within institutions and commented that "[t]he very high mortality rates were known to local and national authorities at the time and were recorded in official publications".[66] The Commission explained that the "Registration of Maternity Homes Act 1934 provided for inspections of registered maternity homes by authorised local authority or departmental officials".[67] In the 1940s and 1950s, for example, Miss Alice Litster was one such inspector. Miss Litster produced many highly critical reports about living conditions and infant deaths in Bessborough and Dunscombe, including one in 1951 where she stated that "the society (Catholic Women's Aid Society) must have been aware of the infant deaths at Dunscombe but took no action. She recommended that the owner should be prosecuted for the neglect of infants in her care but thought it unlikely that the Cork local authority would press the case".[68]

Similarly, reports from the DLGPH in the 1930s and 1940s from Sean Ross recorded that "infant mortality was a problem".[69] A report by the county medical officer outlined that "the known neo-natal death rate for 1951 was very high" in Sean Ross.[70] Multiple reports in the early 1950s recorded that cots were not adequately spaced apart and did not meet the department's standards,[71] while "ante-natal patients were housed in converted coach houses which were low, damp, poorly lit and ventilated and were in close proximity to a farmyard on one side and an open sewer on the other".[72] Repeated requests for funding to build modern maternity facilities were rejected by the Department.[73] During this time, infant deaths remained high, and a report from 1958 showed that an inspector, Miss Reidy, "expressed alarm that the infant death rate at Sean Ross had increased since 1954 and had remained high during 1958".[74] As the Report outlined:

> … it appeared that seven in every ten deaths during this period were due to viral pneumonia. When questioned, the congregation told her that the affected children had been given every medical care available but stated that the facilities available were "inadequate to provide proper care for critically ill infants". The Reverend Mother also drew attention to the high levels of morbidity which prevailed among infants who survived viral pneumonia and the difficulty in finding foster homes for them. Miss Reidy concluded that the continued high infant death rate warranted medical investigation

65. *Ibid* at p 51.
66. Commission Report, Executive Summary at p 4.
67. Commission Report at [18.65].
68. Commission Report at [18.158].
69. Commission Report at [19.24].
70. Commission Report at [19.99].
71. See, eg, Commission Report at [19.109].
72. Commission Report at [19.116]
73. Commission Report at [19.117].
74. Commission Report at [19.132].

> and advised the Department of Health to refer the matter to its chief medical advisor to identify measures which would reduce infant deaths.[75]

The facts recorded here are strikingly similar to those outlined in the *Nencheva* case, described above. Government departments were repeatedly warned about the substandard facilities in Sean Ross, which resulted in a significantly high infant mortality rate. Despite this, funding was not provided to build modern facilities. This can be strongly argued to have been a violation of Article 2 of the ECHR. Multiple infant deaths were also recorded throughout the 1960s, before the closure in 1968.

In a similar vein, a report on conditions in Tuam by officials from the Department of Health in 1959 outlined that:

> A visit to the institution is the only way one can get an accurate impression of this poorly maintained, uncomfortable, badly heated and totally unsuitable building in which upwards of 140 children ranging from infancy to six years are accommodated ... Throughout the years since the adoption of the building for its present purpose maintenance appears to have been minimal.[76]

Infant deaths were high throughout the 1950s in Tuam. For example, "29 babies were born between 20 July 1956 and 26 August 1957; there was one stillbirth and six infants died".[77] The Report outlined the causes as follows:

> One was described as "delicate and difficult from birth"; another as "delicate from birth and very poor weight gain"; one had a congenital heart disorder; the mother of one of the children was in a sanatorium both before and after the birth. Three children died from pneumonia or respiratory infections.[78]

It is important to note the parallels between the evidence described above and the *Nencheva* case, where the Court held that Bulgarian authorities could have prevented deaths and they were aware of the risk to life several months before the first child died there.

3.2.3 Comment

The Commission Report concluded that "[t]he Commission considers it unlikely that deaths in hospitals and family homes were due to wilful neglect".[79] Nonetheless, it is evident throughout the Report that many infant deaths were directly attributed to overcrowding, inadequate sanitary facilities, cold and wet living conditions, a lack of professional staff and a lack of medical care for women and children in some homes. It is also evident that State authorities were well aware of these failings, which persisted over a period of decades. Although the rate of infant deaths in Mother and Baby Homes and County Homes declined over time, conditions similar to those seen in *Nencheva* existed in some

75. Commission Report at [19.132].
76. Commission Report at [15.38].
77. Commission Report at [15.73].
78. Commission Report at [15.73].
79. Commission Report at [33.5].

institutions during the 1950s and even into part of the 1960s. As such, it seems likely that violations of the right to life under Article 2 of the ECHR occurred during this period.

3.3 INHUMAN AND DEGRADING TREATMENT OF WOMEN AND CHILDREN

3.3.1 Article 3 ECHR

Under Article 3 of the ECHR, everyone has the right to freedom from inhuman and degrading treatment. The Court has noted that "the prohibition of torture and inhuman or degrading treatment or punishment is a value of civilisation closely bound up with respect for human dignity".[80] As a legal principle, human dignity conveys the idea that every human being is worthy of equal treatment and respect by virtue of their humanity, irrespective of external characteristics such as sex, marital status, race or religion.[81]

In *Ireland v United Kingdom*, the ECtHR noted that:

> … ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3 (art. 3). The assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim …[82]

Inhuman and degrading treatment "usually involves actual bodily injury or intense physical or mental suffering", while degrading treatment "humiliates or debases an individual, showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance".[83]

Article 3 imposes a negative obligation on the State to refrain from inflicting such harm on people under State control (e.g. in State institutions such as residential care, schools or hospitals).[84] It also extends to ill-treatment at the hands of private actors. By reading Article 3 together with Article 1 of the ECHR (which obliges States Parties to secure to everyone within their jurisdiction the rights and freedoms defined in the Convention), it will be seen below that the ECtHR has repeatedly held that States have a positive obligation to protect people from ill-treatment at the hands of private actors that amounts to inhuman and degrading treatment. Thus, direct State responsibility for ill-treatment is not a pre-requisite to a finding of a violation.

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80. *Muršić v Croatia* (7334/13, 20 October 2016) at [98].

81. For example, the Universal Declaration of Human Rights refers in its preamble to "the inherent dignity … of all members of the human family [as] the foundation of freedom, justice and peace in the world", and provides in Article 1 that "[a]ll human beings are born free and equal in dignity and rights". In *Quinn's Supermarkets v Attorney* [1972] IR 1 at 13-14, the Supreme Court stated that Article 40.1 of the Irish Constitution "is a guarantee related to their dignity as human beings and a guarantee against any inequalities grounded upon an assumption, or indeed a belief, that some individual or individuals or classes of individuals, by reason of their human attributes or their ethnic or racial, social or religious background, are to be treated as the inferior or superior of other individuals in the community." See further C McCrudden, "Human Dignity and Judicial Interpretation of Human Rights" (2008) 19 *European Journal of International Law* 655.

82. 5310/71, 18 January 1978 at [162].

83. See, eg, *Muršić v Croatia* (7334/13, 20 October 2016) at [98].

84. See, eg, *VK v Russia* (68059/13, 7 March 2017) (in which a violation of Article 3 was found in respect of ill-treatment of a child in a public nursery school).

The positive obligation to protect against ill-treatment at the hands of private actors is quite extensive. Where ill-treatment is occurring and the State either is aware or ought to be aware of it, the State is obliged to take steps to put a stop to that ill-treatment and prevent it from recurring.[85] However, it is not necessary for ill-treatment to occur before the Article 3 obligations are triggered; the State also has obligations to prevent ill-treatment from occurring in the first place. These include the obligation to enact laws to deter ill-treatment,[86] and the obligation to take reasonable preventive measures to mitigate foreseeable risks. The latter obligation includes protecting both identified individuals from specific risks[87] and unidentified individuals from general risks.[88] Once State authorities either are aware, or ought to be aware, that a risk of ill-treatment arises in a specific context, the State is obliged to take reasonable measures to mitigate that risk.

3.3.2 Mother and Baby Homes and County Homes

The Executive Summary of the Commission Report notes that "there is no evidence of the sort of gross abuse that occurred in industrial schools" having taken place in Mother and Baby Homes, and just "a small number of complaints of physical abuse"; however, it does accept that "[m]any of the women did suffer emotional abuse and were often subject to denigration and derogatory remarks".[89] This opening comment minimises the severity of the ill-treatment experienced by women in Mother and Baby Homes and County Homes. It will be seen below that there was an established pattern of sustained and serious verbal and emotional abuse which would in many cases have constituted degrading treatment contrary to Article 3 of the ECHR. In a smaller (but still significant) number of cases, women would have experienced more severe treatment that would have constituted inhuman treatment contrary to Article 3. This particularly includes the treatment of women during childbirth (including lack of medical attention and denial of pain relief) as well as sub-standard living conditions in County Homes involving a denial of adequate warmth, food, sanitation and proper bedding. There is also evidence of the cumulative impact of these factors in some cases—for example, serious verbal abuse during childbirth, combined with inadequate medical attention; or women being forced to engage in physical labour while heavily pregnant or before they had recovered from giving birth. It is arguable that the cumulative effect of such factors may bring them within the meaning of inhuman treatment.

The sections below will provide examples of specific forms of ill-treatment which were documented in the report and which would appear to reach the threshold of severity that would bring them within the meaning of "inhuman and degrading treatment" contrary to Article 3 of the ECHR.

85. See, eg, *Z v United Kingdom* (29392/95, 10 May 2001); Đorđević v Croatia (41526/10, 24 July 2012), and *TM and CM v Moldova* (26608/11, 28 January 2014).

86. See, eg, *A v United Kingdom* (25599/94, 23 September 1998) and *MC v Bulgaria* (39272/98, 4 December 2003).

87. See, eg, *Kontrová v Slovakia* (7510/04, 31 May 2007) and *E v United Kingdom* (33218/96, 26 November 2002).

88. *O'Keeffe v Ireland* (35810/09, 28 January 2014).

89. Commission Report, Executive Summary at p 5.

3.3.2.1 Verbal and Emotional Abuse of Women

The Commission Report provides extensive evidence of women being subject to a serious and sustained level of verbal and emotional abuse. The following examples of testimony given to the Investigative Committee are indicative:

> She felt that she was stripped of all her human rights and dignity when she entered Bessborough … She was subject to "psychological abuse" in Bessborough; the nuns "constantly" told her that she was "evil" and that no one would ever want to marry her … She considers that she suffered "severe trauma" at Bessborough and that she continues to have panic attacks because of her time there.[90]

> She stated that on one occasion she was forced to "go down on my knees" to publicly apologise to a nun. This was "just another part of the humiliation and shame" she was subjected to every day. The nuns constantly reminded her that she had "committed a mortal sin" and that 'her shame would be eternal'. She was given a "house name". Women did not discuss their family or their backgrounds. This was all part of the "shame" she was made to feel every day of her time at Sean Ross.[91]

Similar testimony was provided to the Confidential Committee:

> "I was told by a nun: 'God doesn't want you … 'You're dirt'."[92]

> Some witnesses described that while working on their hands and knees, they were verbally abused about their status as 'fallen women'. Witnesses reported being called "sinners" "dirt" "spawn of Satan" or worse.[93]

> Another man born in a home came to the Committee—again to bear witness on behalf of his birthmother who had been 17 years old when she became pregnant and went into a mother and baby home. She told him that she had been 'degraded' from the moment she went in, being called "a dirty woman", "a fallen woman" and "a scarlet woman"—while having to bear "constant verbal abuse about sin and shame".[94]

Women spoke to both Committees of a "culture of fear" in the institutions brought about by emotional abuse;[95] one witness recounted that his mother had described it as "an atmosphere of fear and terror the whole time, hardship and humiliation".[96] The nature of the work that women were required to carry out appeared to be part of the pattern of emotional abuse. Scrubbing floors for long hours features prominently; one witness told the Confidential Committee that her mother "spent the majority of the day on her hands

90. Commission Report at [18.372].
91. Commission Report at [19.197].
92. Confidential Committee at p 53.
93. *Ibid* at p 42.
94. *Ibid* at p 62.
95. Commission Report at [20.155].
96. Confidential Committee at p 49.

and knees scrubbing stone floors. She told me it was a very emotionally traumatic time and that it impacted her mental health severely."[97] The Confidential Committee report notes:

> Some referenced scrubbing as an inescapable part of their lives in the homes—saying that, while working, they were frequently and very closely supervised by a nun, some of whom would slap or punch them if they were judged not to be working hard or fast enough. Several witnesses from separate mother and baby homes told the Committee that the nun would deliberately 're-dirty' the cleaned surfaces. One related how she had just finished mopping a long corridor when the nun upended her bucket of dirty water and ordered: "now clean it again!"[98]

As noted above, the definition of degrading treatment refers to treatment that "humiliates or debases an individual, showing a lack of respect for or diminishing his or her human dignity, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance". It is evident that the pattern of sustained verbal and emotional abuse described in these passages was designed to humiliate and debase the women who experienced it; to arouse feelings of fear, anguish and inferiority; to diminish their human dignity by suggesting they were less worthy of respect than other women; and to break their resistance to their circumstances and the regime in the Homes. As such, it meets the definition of degrading treatment contrary to Article 3 ECHR.

3.3.2.2 Physical Abuse of Women

The Recommendations section of the Commission Report states that "there is very little evidence of physical abuse".[99] Again, this minimises the nature and extent of such abuse, which—while less common than verbal and emotional abuse—does not appear to have been uncommon in Mother and Baby Homes. The Investigative Committee received evidence of physical abuse:

> She said that she worked in the front hall of the home during this period. On one occasion she was physically attacked by one of the nuns which left her with "scratches on her arms and covered in flour". This nun also verbally abused her and told her that all she was good for was "lying under men".[100]

The Confidential Committee notes that "the abuse described was not just verbal; some witnesses told of being slapped, beaten and punched, with nuns shouting at them that this was their penance for sinful behaviour",[101] and cites numerous examples of testimony:

> A witness told the Committee that when she was born, her birthmother was told by the nuns that her baby would be "taken" and that she herself could "work off her sin for the next three years". The witness learned that her mother's response to this information

97. Commission Report at [20.169].
98. Confidential Committee at p 41.
99. Commission Report, Recommendations at p 8.
100. Commission Report at [20.165].
101. Confidential Committee at p 42.

> was that if that happened she would "go to the top of the building with my child and commit suicide" the response to this being that she was "badly" beaten by one of the nuns.[102]
>
> "When I was having my baby", said one mother, "the medical professionals knew that I had had a previous baby and one of the nurses gave me a clatter".[103]
>
> … she was put to work on the farm, milking cows and feeding chickens and was "hit" by the nuns for not doing this work correctly.[104]

The incidents described above would have amounted to assault and battery, which was a criminal offence under section 42 of the Offences Against the Person Act 1861. Thus, they were unacceptable under the domestic law standards applicable at the time. The context in which the incidents took place is essentially identical to the verbal and emotional abuse described in the previous section, and so the physical abuse described would have amounted to degrading treatment contrary to Article 3 of the ECHR for the same reasons. More serious incidents involving "actual bodily injury or intense physical or mental suffering" could potentially have amounted to inhuman treatment.

3.3.2.3 Physical Work Shortly Before or After Childbirth

As noted above, physical work, and scrubbing of floors in particular, was a constant feature of life in the Mother and Baby Homes. The evidence in the Report suggests that this was often the case even in the days immediately before or immediately after childbirth. Heavily pregnant women "on the verge of giving birth", or women who had very recently given birth (as little as two or three days previously), were often required to undertake physically demanding work. The following witness told the Investigative Committee:

> I arrived in Bessborough in mid-July and during the summer months my job was cutting the lawn with scissors. I did this every day in a line with a group of other women. We were not allowed to stop when we felt tired. In the winter months I had to polish and scrub the corridors. Other women were sent to work in the laundries. The work was especially difficult given that I and the other women were pregnant. I worked seven days a week until I went into labour.[105]

The Confidential Committee report documents what the Committee described as "physically exhausting work":[106]

> … one new mother gave an account of being shouted at and taunted while she was cleaning, post-birth stitches bursting, the cold stone of floor and staircase she had already cleaned now flooding with her blood.[107]

102. *Ibid* at p 50.
103. *Ibid* at p 49.
104. *Ibid* at p 54.
105. Commission Report at [18.373].
106. Confidential Committee at p 41.
107. *Ibid*.

> … very many said, they were quickly put back to work, some of it exceptionally heavy, as in scrubbing stone floors on hands and knees, or working on the land, and being verbally abused while at it.[108]

In another case, a pregnant woman reported that she was "forced to climb a ladder to clean windows", despite suffering from vertigo.[109]

Forcing women to undertake physical labour for which they were quite clearly medically unfit was an extension of the emotional and physical abuse described in the previous two sections. At the least, it would have amounted to degrading treatment for the same reasons, and to inhuman treatment in more serious cases which resulted in physical injuries.

3.3.2.4 Treatment during Childbirth

The evidence provided of how some women in Mother and Baby Homes were treated during childbirth makes for distressing reading. The denial of pain relief appears to have been commonplace, seemingly linked with the belief that unmarried mothers should suffer to atone for their sins. This issue features in testimony of several women received by the Investigative Committee:

> She said that there was no doctor present during her labour and that "there was no formal medical care or any kind of pain relief" made available to her. Her labour was "agonising in accordance with the principle that we had to suffer for our sins".[110]

> She said she was attended at the birth by a nurse/midwife who came in for this purpose. She got no pain relief.[111]

> He woke me up and stitched me in cold blood with not even a local anaesthetic. I will never forget the pain. I later found out that he had cut right through my rectum and I had six stitches. I couldn't go to the toilet properly for years after that.[112]

The Confidential Committee Report provides further examples:

> … what was additionally dreadful for them, they said, was the complete absence of pain medication. This, some alleged, had been deliberate since their birth pains were represented by some nuns (and nurses) as "punishment"—retribution by God for becoming pregnant out of wedlock. One interviewee, screaming for relief, said she was told to look at the crucifix on the wall.[113]

> The witness was 14 years old when she became pregnant, knew nothing of what was happening to her body or about childbirth and although in serious pain from the onset

108. *Ibid* at p 67.
109. *Ibid* at p 49.
110. Commission Report at [19.198].
111. Commission Report at [15.135].
112. Commission Report at [20.160].
113. Confidential Committee at p 66.

> of labour, was given no pain relief. The nun with her during the process told her: "You've had your fun, this is payment". The baby weighed nearly 10 pounds.[114]

One witness who gave birth as late as the 1970s "was given no pain relief when giving birth, because this gynaecologist said to her that they 'wanted me to feel every pain'":

> While a younger colleague of this gynaecologist observed that the witness needed a C-section … the response of the older one was: "she's from (the named) home, she's an unmarried mother. She can have it this way, she'll remember it and she won't ever do it again".[115]

The Commission Report states that "[p]ainkillers were not widely used either in home or hospital births", and that "[t]here is no evidence that the women who gave birth in mother and baby homes were denied pain relief or other medical interventions that were available to a public patient who gave birth in a Dublin or Cork maternity unit."[116] However, the Report also makes reference to pain relief being provided in the Homes for some births,[117] which indicates that it was potentially available.

Whether or not the availability of pain relief in the Homes compared unfavourably to hospitals, other aspects of the medical care provided to women during childbirth in Mother and Baby Homes seem likely to have fallen short of the standards expected at the time. Evidence was provided to both the Investigative Committee and the Confidential Committee of women being locked in rooms alone, "without qualified nursing care",[118] for extended periods while in labour:

> Labour was "horrendous"; she was left alone for most of the time. She was not given any pain relief or medical treatment.[119]

> I went into labour while polishing the corridors. Later that evening, as the pain progressed, I was locked in what I can only describe as a cell. There was a single bed in it and a commode and the door had a small window in it, like a prison cell. I was left there all night with no attention. In the morning a nun came into the cell to check on me. My baby's head was presenting …[120]

> In 1967, a witness who was 19 years old went into labour while polishing floors in a home, but was "instructed" by the nun to continue. When the pain got worse she was moved to a small room and, still in labour, was "locked in, alone, for the night". By the time someone came to check on her, she told the Committee, her baby was crowning and she was "barely able to walk".[121]

114. *Ibid* at p 68.
115. *Ibid* at pp 77-78.
116. Commission Report, Executive Summary at p 69.
117. Commission Report, Executive Summary at p 69; [13.438]; [18.316]; and Confidential Committee at p 66.
118. Commission Report, Executive Summary at p 69.
119. Commission Report at [13.458].
120. Commission Report at [18.375].
121. Confidential Committee at p 71.

This was compounded by "unkindness" which in some cases elevated to the level of subjecting women to significant verbal abuse or even physical abuse while giving birth. One witness told the Investigative Committee:

> … when she went into labour, she was locked in a room alone for 72 hours. She was afraid and in terrible pain and when she screamed or called for help she was "abused". "I was screaming with the pain, three days screaming with the pain and all you got was, 'Oh you should have thought about this nine months ago.' 'You have got to suffer for your sins and you have got to put up with it.' And the more you screamed the more she abused you …"[122]

The Confidential Committee report documents numerous similar cases:

> … she was spoken to "derogatorily", with the nurse telling her… "It's good enough for you; you tasted the sweet, now taste the sour! Christ suffered on the cross for you".[123]
>
> One nun's comment made to a 16-year old going through the throes of labour and birth was: "You didn't feel it going in, but you'll feel it coming out!"[124]
>
> … she was told she was now "paying" for her "five minutes of pleasure". In the same harsh spirit, "You're paying for your fun" was what was thrown at a 16-year old going through a difficult labour.[125]
>
> … one witness vividly described how "her insides were nearly dragged out of her" during delivery—with no pain relief—and how nurses, as well as nuns were "rough"—and liberal with the insults they cast on her and the names they called her.[126]
>
> She told the Committee that the nuns in this home referred to the women in their care as "unclean". (During childbirth, this witness was attended by a midwife who "slapped her across the face" when she screamed, said she was an "an unclean bitch" and told her to: "Get on with it".)[127]

It should be recalled that the emotional distress experienced by women in such circumstances was heightened by the fact that in almost every case, they would be giving up their baby for adoption, and some were not even given the opportunity to hold their baby before he or she was taken away.[128] Moreover, some of the women had no knowledge of what to expect during childbirth.[129] The cumulative effect of the various factors described in some of the examples above is particularly egregious. There is no doubt that treatment

122. Commission Report at [18.299].
123. Confidential Committee at p 69.
124. *Ibid.*
125. *Ibid* at p 70.
126. *Ibid* at p 66.
127. *Ibid* at p 71.
128. *Ibid* at pp 66-85.
129. *Ibid.*

of this nature amounted to degrading treatment. The Confidential Committee report notes that for some witnesses, the overall experience of birth was "so traumatic that there were lifelong physical repercussions, while others were traumatised psychologically".[130] Lasting physical and psychological injuries resulting from a combination of inadequate medical care and emotional abuse during child birth arguably fall within the definition of inhuman treatment since they involve "actual bodily injury or intense physical or mental suffering".

3.3.2.5 Living Conditions in County Homes

While the Commission Report at various points plays down the level of ill-treatment experienced by women in Mother and Baby Homes, it is far less circumspect about the conditions in County Homes and the experiences of women who resided in them. It describes conditions in Mother and Baby Homes as "greatly superior to the county homes where, until the 1960s, many unmarried mothers and their children were resident":

> Conditions in the county homes were generally very poor … The women in county homes have been largely forgotten. They included women on a second or subsequent pregnancy and women from the poorest families. County homes admitted women with special needs, mental health problems, venereal disease or a criminal conviction, who would be rejected by a number of mother and baby homes. They also accommodated children who had special needs, including the children of married families. The accommodation and care given to these children in county homes was grossly inadequate; some of the descriptions are extremely distressing.[131]

The Report notes that while improvements were carried out to mother and baby homes in the 1920s and 1930s, there is "no evidence of significant investment in county homes during these years—other than installing electric lights, and perhaps connecting the home to a town's water and sewerage system. Most county homes continued to lack adequate sanitary facilities, running water, hot water on tap and heating other than open fires until the 1950s—sometimes the end of that decade.[132] It also notes evidence that "contractors often supplied county homes with spoiled meat and low quality bread and milk with little nutritional value."[133]

As will be further elaborated in sections 3.4 and 3.5 below, the situation of women living in County Homes was closely analogous to that of prisoners given the absence of any realistic free choice to leave. Women who sought to leave were threatened with being left with financial (and in some cases physical) responsibility for their children—a burden they could not possibly discharge. Elsewhere in the Commission Report, reference is made to children being "detained in county homes, as quasi-hostages, to prevent their mothers being freed".[134] As such, given the State's role in forcing women to stay in County Homes, the State's responsibility to maintain reasonable living conditions in those Homes

130. *Ibid* at p 66.

131. Commission Report, Executive Summary at p 6.

132. *Ibid* at p 60. See further Commission Report at [10.27] to [10.39].

133. Commission Report, Executive Summary at p 62. See further Commission Report at [10.40] to [10.45].

134. Commission Report at [9.93].

was engaged. (Indeed, this was the case under Irish law from as early as 1924.)[135] It is notable that the ECtHR has in many cases found that living conditions in various forms of detention (including prisons and immigration facilities) has amounted to inhuman and degrading treatment by virtue of overcrowding and failings with respect to hygiene and quality of food.[136] The findings made in the Commission Report in respect of the living conditions in County Homes bear a strong resemblance to this line of case law.

3.3.2.6 Ill-Treatment of Children in Mother and Baby Homes and County Homes

Ill-treatment in Mother and Baby Homes and County Homes was not restricted to women; it was also inflicted on children who resided there. The Commission Report stated that it "considers that there is evidence of some abuse of children in a number of the institutions", with the abuse being physical and emotional in nature.[137] Conditions in County Homes were considered by the Commission to have been "utterly unsuitable for children".[138]

As with the ill-treatment of women, some testimony spoke of physical abuse,[139] but the evidence of emotional abuse is more extensive. A considerable volume of testimony provided to the Investigative Committee strongly suggests that neglect of children, through denial of comfort and adequate food and clothing, also appears to have been a feature of the Homes:

> A former resident told the Commission that he vaguely remembers putting his hands through railings in a cot asking to be picked up—he was about two at the time. He alleges that he suffered various forms of abuse including systematic neglect leading to malnutrition and severe emotional damage.[140]

> One, who was born in 1949, said that her mother told her that mothers were allowed contact with their babies only when breastfeeding. Babies in the nurseries were left to cry "without being given any attention". The babies' nappies were made of a rough material and caused them to suffer from nappy rash.[141]

> I vividly remember one day going to the nursery to pick up my son as he was screaming because he was very wet and dirty. He was clearly distressed and I believe that it was because he had been in that wet and dirty nappy for some time. As far as I am aware the nuns did not go in between feeding times to comfort the children if they were distressed or crying.[142]

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135. The County Boards of Health (General Regulations) Order 1924 required Boards of Health to "keep in good and substantial repair the premises constituting any County Institution, and shall from time to time remedy without delay any such defect in the repair of such institution, its drainage warmth or ventilation, or in the furniture or fixtures thereof, as may tend to injure the health of the inmates."

136. See, eg, *Rahimi v Greece* (8687/08, 5 April 2011); *Canali v France* (40119/09, 25 April 2013); *Vasilescu v Belgium* (64682/12, 25 November 2014); *Rezmiveș v Romania* (61467/12, 25 April 2017); *ShD and Others v Greece, Austria, Croatia, Hungary, North Macedonia, Serbia and Slovenia* (14165/16, 13 June 2019).

137. Commission Report, Recommendations at p 5.

138. Commission Report at [10.83].

139. See, eg, Confidential Committee at p 51: "Another witness from this decade [ie the 1960s] recalled watching a child being beaten up: 'The child was kicked, and she fell, and the blood was pouring out of her head; the nun was hitting her, swiping her… she was unconscious and was carried off'."

140. Commission Report at [13.429].

141. Commission Report at [18.395].

142. Commission Report at [18.376].

> She said that sometimes the children of women who were unable to breastfeed did not get fed. She said "they were hungry; screaming, hungry". She stated that bottle-fed babies were given the "bare minimum".[143]

> [The inspector found that the] other children were in a Dayroom [in a County Home] which looked equally unkempt and neglected, a "bad" low-grade (female) mental defective was eating bread which was being shared by the toddlers from the floor which was far from clean and which had been "abused" by the toddlers. Altogether, it was a very distressing sight.[144]

One witness told the Confidential Committee that "[a]s punishment for having a row over a toy on Christmas Day, I was put into a room with a corpse in the corner … for six hours".[145]

As with the women in the Homes, the impact on children would also in some cases have involved a cumulative effect of multiple forms of ill-treatment. The following examples from the Confidential Committee are illustrative:

> A man, born in the same year, recalled having been quarantined with other children, all suffering from chicken pox. He needed a drink of water and asked for it; but because "they" told him he would have to wait until dinnertime, he went to the toilet and drank from that. Evidence from this man continued to be graphic. It included being "let out into a field to play" and when out there with others, using (little balls of) "pig shit" with which to play marbles; when they got back inside, "the smell on your hands would be bad", he said, but "they" wouldn't countenance cleaning them before dinner. There was no sense in the home, he went on, of being "wanted" because "you were the product of an evil union and being made suffer for the sins of your parents." He recounted the backs of his hands being hit with sticks … He said that he was "always" hungry and that he suffered very badly on "bath night" (held on one night a week) because "they" would lace the bathwater with Jeyes Fluid, which caused him great pain: "My scrotum would be burning".[146]

> She was born in one of these mother and baby homes during the 1950s, spent the first five years of her life there, and described conditions as "horrific", saying that she had never had shoes, had slept in a bed with five other girls without pillows, sheets or blankets, (their bedding being old coats) and had been slapped by a nun for the crime of spilling milk from its container. She told the Committee that she had been sent to the gate of the institution to fetch it from a milkman but it had been snowing and her clothing was light. She was shivering so hard that some of it had spilled.[147]

Evidence of this nature shows that children who lived in Mother and Baby Homes and in County Homes were subjected to neglect and to physical and emotional abuse, as well as to entirely unsuitable living conditions. Case law of the ECtHR has repeatedly found that

143. Commission Report at [18.377].
144. Commission Report at [10.77].
145. Confidential Committee at p 53.
146. Confidential Committee at pp 46-47.
147. Confidential Committee at p 41.

similar treatment of children constitutes inhuman and degrading treatment contrary to Article 3 of the ECHR.[148]

3.3.2.7 State Responsibility for or Knowledge of Ill-Treatment

County Homes were run by local authorities; staff were employed by local authorities, and the Homes were regulated and subject to inspection by the Department of Health.[149] Thus, by definition, the State was either directly responsible for the conditions in these homes and the resultant ill-treatment of women and children, or was at the very least aware of it. Thus, State responsibility under the ECHR for ill-treatment in County Homes was engaged. Some of the Mother and Baby Homes (namely Pelletstown, Kilrush, Tuam and Dunboyne) were owned and under the control of local authorities, and so the same position would apply for such Homes.[150] Other Mother and Baby Homes were run by private actors, and so State responsibility under the ECHR would only be engaged if there was evidence that the State either was aware, or ought to have been aware, of the risk of ill-treatment.

In this respect it is noteworthy that there was a legally mandated inspection regime in place for Mother and Baby Homes:

> The Registration of Maternity Homes Act 1934 gave the DLGPH/Department of Health the authority to inspect all places where women gave birth, or received nursing care following a birth. All maternity homes were required to register, and registration was the responsibility of the local authority. The inspections conducted under the 1934 Act enabled the DLGPH/Department of Health to visit the private mother and baby homes and to recommend improvements.[151]

The Executive Summary notes that "department inspectors were thorough in carrying out inspections and were constantly seeking improvements",[152] and that "[i]n practice, the departmental inspectors inspected all aspects of the homes."[153] In the early 1940s, "successive inspections carried out by the DLGPH revealed major shortcomings in Bessborough".[154]

As established in *O'Keeffe v Ireland*, it is not necessary that the State was aware of specific instances of abuse in specific locations.[155] Once the State has enough information to know that a mere *risk* exists that ill-treatment will occur in a specific context, it is obliged to take reasonable measures to mitigate that risk. While the Commission Report contains few specific examples of evidence that State authorities were aware of the ill-treatment of women in Mother and Baby Homes, there is evidence that suggests that State authorities at the very least ought to have been aware of the general risk of ill-treatment, even if they did not have knowledge of the majority of the specific instances

148. See, eg, *A v United Kingdom* (25599/94, 23 September 1998) and *Z v United Kingdom* (29392/95, 10 May 2001).
149. Commission Report, Executive Summary at p 6.
150. *Ibid* at pp 6-7.
151. *Ibid* at p 8.
152. *Ibid*.
153. *Ibid* at p 9.
154. *Ibid*.
155. 35810/09, 28 January 2014.

of it. The Report cites evidence of a matron who was prosecuted and convicted of ill-treatment of girls in Marfield House in Wexford in 1943.[156] Separately, it quotes the Mother Superior of Bessborough as saying to a journalist that "she was aware that Bessborough had 'an unpleasant reputation' and that 'many girls from the country still feel that it is a prison'."[157] Such evidence can also be found outside of the Commission Report; for example, Conneelly recounts a story of a Priest arriving at Cork train station, not wearing his collar. When he hired a taxi driver to take him to Bessborough, the driver commented: "You're either a priest or your mad."[158] These vignettes speak to a level of public knowledge of the harshness of the regime in Mother and Baby Homes, as a result of which State authorities—who had legal responsibility for inspecting the Homes—at the very least ought to have been aware that there was a risk that women and children in the Homes would be ill-treated. On the standard applied by the ECtHR in *O'Keeffe v Ireland*, this is sufficient to engage State responsibility to take reasonable measures to mitigate this risk. The fact that ill-treatment was experienced by so many women in so many different Homes over such a long period of time strongly suggests that the State failed to discharge this obligation.

3.3.3 Children in Foster Homes

The Commission Report leaves little doubt that a considerable number of children in foster homes (whether "boarded out" by a local authority, or placed "at nurse" by a private individual or a charitable organisation)[159] experienced ill-treatment amounting to inhuman and degrading treatment contrary to Article 3 of the ECHR. Chapter 11 of the Report cites extensive evidence of physical abuse and neglect of children in foster homes; it states that "[t]here is evidence of foster children who were grossly neglected … and some experienced appalling living and sleeping arrangements."[160] Multiple distressing cases are detailed by reference to contemporaneous documentation, including a case where an inspector visited a foster home to find that the mother had left the child alone in the house, tied into a bed, while the foster mother visited her sister; the inspector commented that "[i]t is difficult however to estimate the terror a child may feel in being thus left alone".[161] A case from Galway is referenced in which a teacher and the local priest had confirmed that it was "common knowledge" that a boy was "severely beaten" by his foster father.[162] In another case from the 1950s, a 15-month-old child was "found sitting on a stone flour [*sic*] with a sack under him; his only clothes a thin vest which half covered him". He was "thin and white" and his feet were "blue with cold".[163] In Monaghan, a three-year-old boy was described as being unable to walk properly, "dressed in a cotton overall, many sizes too big and two woollen jerseys. He wore no vest and no other clothing was produced for him … [he] slept in a box, 'a large one containing a layer of straw and obviously used

156. Commission Report at [22.100].

157. Commission Report at [18.175].

158. A Conneelly, "Mother-and-baby homes: A dark story with a lasting impact", *RTE*, 31 May 2021, available at https://www.rte.ie/eile/truth-matters/2021/0526/1224086-mother-and-baby-homes-dark-story-with-a-lasting-impact/.

159. See Commission Report at [11.8] to [11.12] for an explanation of the differences between these groups of children.

160. Commission Report at [11.2].

161. Commission Report at [11.64].

162. Commission Report at [11.67].

163. Commission Report at [11.70].

for nesting fowl'."[164] The Report refers to a case in 1957 in which one boarded-out child in Wexford was sleeping in an outhouse used to store potatoes,[165] and notes that "[b]edclothes were inadequate, sometimes non-existent", and "some sleeping arrangements raise serious concerns about child protection".[166]

One witness who was boarded out by the local authority with an elderly woman and her 50-year-old bachelor son told the Investigative Committee that he "had a horrendous life there" and suffered physical abuse.[167] Others spoke to the Confidential Committee:

> … a witness born in 1948 recounted that as a "boarded out" child in early life, she suffered "horrific" sexual and physical abuse until the age of 12 and was then sent to an industrial school.[168]

> She too was brought by horsepower to a mother and baby home to give birth and had remained with him in the home, he said, until she was 16 years old, to be placed then in another institution while he was "boarded out", sadly to suffer (along with another "boarder") many beatings and sexual abuse at the hands of their "boarded-out father".[169]

Equally, there is little doubt that the State was aware of this treatment in many cases, and ought to have been aware of it in others. The Children Act 1908 imposed an obligation on local authorities to inspect placements, and further provision for the inspection regime was made in the County Boards of Health (Assistance) Order 1924; the Children Act 1934; and the Boarding out of Children Regulations 1954. Concerns were raised in official reports about the conditions in these placements as early as 1925, when "the Commission on the Relief of the Sick and Destitute Poor heard testimony from a number of witnesses who were highly critical of boarding out", with reasons including that the children "are not sent to school or properly fed".[170] However, where inspections did take place and recorded concerns about the welfare of children, local authorities sometimes did not move the children, and in some cases placed subsequent children with the same foster parents. For example:

> One foster mother in Kildare informed an inspector that she intended to send her two foster children, boys aged five and ten, back to the county home. "She appeared to have no affection for them whatsoever". She already had had three others, one taken by family, two sent back to the county home. The fact that a succession of foster children had been placed with this woman suggests that council officials ignored her record of rejecting previous foster children, and gave no consideration to the children's welfare.[171]

164. Commission Report at [11.76].
165. Commission Report at [11.83].
166. Commission Report at [11.83].
167. Commission Report at [11.145].
168. Confidential Committee at p 13.
169. *Ibid* at pp 14-15.
170. Commission Report at [11.22].
171. Commission Report at [11.64].

> The inspector reported that a nine-month old boy, who had been placed at nurse from Bethany two weeks previously, "appeared to me to be in a dying condition … It was dirty and neglected and sore and inflamed from a filthy napkin which cannot have been changed for a very long time". The Gardaí had informed her that they had already "received unfavourable reports" about this particular foster mother, who had fostered another infant from Bethany "some time ago [who] … wasted away and died within a month of being sent to her".[172]

Another case is mentioned in which a county medical officer supported a nurse's recommendation that a boy be removed from a foster home. "The local authority appealed to the department to determine whether the boy should be removed, but the department demurred."[173]

In addition to failures to respond to inspection reports that raised concern about the treatment of children in foster homes, the evidence clearly indicates that the inspection regime itself was grossly defective and would have been incapable of identifying a considerable amount of ill-treatment of boarded out children. Concerns about the adequacy of inspections were raised throughout the 1940s and 1950s (including in the media),[174] but the evidence indicates that this failing persisted. A deliberate policy of sending boarded out children to the countryside, often considerable distances away from the local authority placing them, hindered adequate inspections.[175] Thus, even by the standards applicable at the time, inspections were inadequate, which would have resulted in abuse and neglect going undetected in many cases. In spite of the clear legal obligation to carry out inspections, the Report notes:

> Many local authorities adopted a careless, even negligent attitude to their responsibilities to inspect children and foster homes. The department's inspectors frequently criticised local authority inspections and their general oversight of boarded-out children. A report on Clare in 1953, which was broadly positive, noted that the assistance officers lacked the capacity to report on children's health or inspect girls' clothing. The department's inspectors criticised the lack of record-keeping, inspections not carried out … The assistance officers were required to pay monthly visits to foster homes—checking on the child, their school attendance and health, while handing over the monthly fee to the foster parent, and recording details of each visit in an inspection register, but these regulations were widely flouted.[176]

The Report also notes that "local officials appear to have been lax in documenting foster children's health".[177] Reference is made to a 1946 report on Leitrim, which noted that "[t]here is every reason to believe that the Assistance Officers' visits of inspection to the

172. Commission Report at [22.90].

173. Commission Report at [11.67].

174. The Report notes an editorial in the *Irish Times* in 1946 which called for "[a] searching attention to the credentials of would-be foster parents and a system of frequent inspection". (Commission Report at [9.116].)

175. See Commission Report at [11.40] to [11.42]: "Miss Murray noted that 'The Board of Assistance is at a disadvantage in dealing with foster parents so far removed from the home county, since the removal of a child is a matter of difficulty and inconvenience. Foster parents are well aware of this situation and take advantage."

176. Commission Report at [11.50].

177. Commission Report at [11.85].

foster homes are extremely irregular. The condition of many of the homes is ample proof that the foster parents do not anticipate visits of inspection."[178] It also refers to a case in Limerick where two successive matrons of the City Hospital had reported favourably on a foster home from which three boys subsequently had to be removed following allegations of cruelty.[179] A 1967 report on Louth noted that the situation in the County was "very unsatisfactory and has shown no improvement over the years; in fact it has deteriorated steadily … The CMO [chief medical officer] knows little of the work, his staff are antagonistic or indifferent and the Public Health nurses confine their interest to spasmodic visits to the foster home."[180]

3.3.4 Comment

The above analysis shows that the Commission Report details clear evidence of considerable ill-treatment of women and children in Mother and Baby Homes and County Homes, and of children in foster homes, that would reach the threshold of severity to bring within the meaning of inhuman and degrading treatment under Article 3 of the ECHR. This took a variety of forms, including emotional and sometimes physical abuse of women and children; forcing women to engage in hard physical labour shortly before or after childbirth; the treatment of women during childbirth; physical and sometimes sexual abuse of children in foster homes; and living conditions in County Homes and foster homes. This ill-treatment in some instances was directly attributable to the State (in County Homes or Mother and Baby Homes controlled by local authorities). In other instances, it was perpetrated by private actors in Mother and Baby Homes or foster homes; but it is evident that the State either was aware of it (through its inspection regimes), or it ought to have been aware of it (had it been adequately discharging the inspection obligations which existed in law at the time). As such, the ECHR case law establishes that the State was obliged to take steps both to respond to individual cases of ill-treatment of identified individuals, and to mitigate the general risk that other, unidentified individuals within the system might experience similar ill-treatment. In respect of the former, the cases cited in the report suggest that while some children were removed from foster homes where they experienced abuse and neglect, others were not, even in situations where the ill-treatment had been identified by inspectors. In respect of the latter, the fact that ill-treatment in Mother and Baby Homes, County Homes and foster homes was allowed to continue for many decades, with no evidence of more effective measures being put in place to mitigate the risk of ill-treatment, suggests that the State fell short of discharging its human rights obligations.

178. *Ibid.*

179. Commission Report at [11.54].

180. Commission Report at [11.53].

3.4 FORCED LABOUR

3.4.1 Article 4 ECHR

Article 4(2) of the ECHR provides that "[n]o one shall be required to perform forced or compulsory labour." As with Article 3, the State's obligations under Article 4 are not limited to refraining from directly subjecting people to forced labour, but extend to protecting people against being subjected to forced labour at the hands of private actors;[181] indeed, the Court has noted that cases under Article 4 "typically" fall into the latter category.[182] This positive obligation includes an obligation to penalise and prosecute effectively any act aimed at maintaining a person in a situation of forced or compulsory labour.[183] The State may also be required to take operational measures to protect victims, or potential victims, of forced labour in cases where State authorities were aware, or ought to have been aware, of circumstances giving rise to a credible suspicion that an identified individual had been, or was at real and immediate risk of being subjected to such treatment.[184]

The ECtHR has noted that Article 4 does not define the concept of forced labour,[185] but the case law of the Court has adopted a definition based on the 1956 Convention to Suppress the Slave Trade and Slavery and the International Labour Organisation's 1930 Forced Labour Convention. "Forced or compulsory labour" is defined as all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered him or herself voluntarily.[186] The concept of "penalty" is a broad one, which may go as far as physical violence or restraint, but it can also take subtler forms of a psychological nature.[187] In *Chowdury v Greece*, the Court held that where an employer "abuses his power or takes advantage of the vulnerability of his workers in order to exploit them, they do not offer themselves for work voluntarily. The prior consent of the victim is not sufficient to exclude the characterisation of work as forced labour." The question of whether an individual offers himself for work voluntarily is a factual question which must be examined in the light of all the relevant circumstances of a case.[188]

A good example of a violation of Article 4 can be seen in *Siliadin v France*.[189] The applicant was a 15-year-old girl who was brought to France without immigration permission. The woman who brought her to France "lent" her to Mr and Mrs B to carry out domestic duties; Mr and Mrs B later decided to "keep" her. The applicant lived at their house, where she worked from 7.30 am to 10.30 pm, 7 days a week, for over three years. Tasks included cooking, cleaning, washing, ironing and looking after children. She was not paid, and her passport was withheld.

The Court found that the applicant had worked for Mr and Mrs B "without respite and against her will" and had received no remuneration.[190] Although the applicant was not threatened by a "penalty":

181. See, eg, *Siliadin v France*, 73316/01, 26 July 2005.
182. *SM v Croatia*, 60561/14, 25 June 2020 at [304].
183. See, eg, *Siliadin v France*, 73316/01, 26 July 2005 at [89] and [112].
184. See, eg, *CN v United Kingdom*, 4239/08, 13 November 2012 at [67] and *SM v Croatia*, 60561/14, 25 June 2020 at [286].
185. *SM v Croatia*, 60561/14, 25 June 2020 at [279].
186. *Ibid* at [281].
187. *CN and V v France*, 67724/09, 11 October 2012 at [77].
188. 21884/15, 30 March 2017 at [96].
189. 73316/01, 26 July 2005.
190. Ibid at [114].

> … the fact remains that she was in an equivalent situation in terms of the perceived seriousness of the threat. She was an adolescent girl in a foreign land, unlawfully present on French territory and in fear of arrest by the police. Indeed, Mr and Mrs B. nurtured that fear … Accordingly, the Court considers that the first criterion was met, especially since the applicant was a minor at the relevant time, a point which the Court emphasises.[191]

Thus, on the basis that it was evident that the applicant was not given any choice, the Court found that she was subjected to forced labour.[192]

The Court further noted that "[a]s she had not been sent to school … the applicant could not hope that her situation would improve and was completely dependent on Mr and Mrs B,"[193] and that her vulnerability was partly attributable to the fact that "she had no resources and was vulnerable and isolated, and had no means of living elsewhere than in the home of Mr and Mrs B. … She was entirely at Mr and Mrs B.'s mercy".[194] The applicant was not permitted to leave the house, except to take the children to school or activities, and "had no freedom of movement and no free time".[195] On this basis, the Court found that she had also been subjected to servitude, which the Court describes as "in addition to the obligation to perform certain services for others … the obligation for the "serf" to live on another person's property and the impossibility of altering his condition".[196] (It should be noted that these factors did not contribute to the finding that the applicant had been subjected to forced labour and are not part of the definition of that concept. The analysis in this section focuses on forced labour rather than servitude, which the ECtHR has described as an "aggravated" form of forced labour.)[197]

Crucially, the applicant in *Siliadin* "was not able to see those responsible for the wrongdoing convicted under the criminal law" because the legal regime at the time did not afford her "practical and effective protection against the actions of which she was a victim". Accordingly, France had not discharged its obligations under Article 4 of the Convention and the Court found a violation had occurred.[198]

Having laid out the key elements of violations of Article 4 of the ECHR due to forced labour, the next section will consider evidence from the Commission Report which gives rise to potential concerns of violations of Article 4 having occurred in Mother and Baby Homes, in County Homes and in boarded-out foster homes.

3.4.2 Mother and Baby Homes

The Commission Report makes the following opening observation about labour carried out by women in Mother and Baby Homes:

> Most women in mother and baby homes were not required to do commercial work. They were expected to work but this was generally work which they would have had

191. *Ibid* at [118].
192. *Ibid* at [119] to [120].
193. *Ibid* at [128].
194. *Ibid* at [126].
195. *Ibid* at [127].
196. *Ibid* at [123] and [129].
197. *CN and V v France*, 67724/09, 11 October 2012 at [91].
198. *Siliadin v France*, 73316/01, 26 July 2005 at [145] to [149].

> to do if they were living at home, for example, cleaning their living quarters, doing their own laundry, cooking, carrying out farm work. It is probably the case that more intensive and more frequent cleaning was required in the institutions than would be required in a normal home. Some mother and baby homes had farms attached and the women worked on the farms. This work was no different from that carried out by women on farms all over the country. There is some evidence of women being required to carry out work that would be considered unsuitable for women, for example, there is evidence that women in Castlepollard may have been required to chop wood and a witness has said that he saw women in Sean Ross chopping wood. There were groups of unmarried mothers who did carry out what might be termed "commercial work".[199]

This passage focuses on three points: first, whether the work was "commercial" in nature; second, whether it was "suitable" for women; and third, whether it was any different to the work that women would have carried out in homes or on farms at the time. This approach bears no resemblance to the approach taken by the ECtHR to defining forced labour which, as seen above, relies on none of these factors. In *Siliadin*, the work was not commercial in nature; it was not suggested to be unsuitable for a woman or indeed even for a teenage girl; and it was no different to what many women or teenage girls would do in many homes. Nonetheless, the ECtHR found that it amounted to forced labour, on the basis that the applicant had worked "without respite and against her will" and had received no remuneration.[200] It will be seen below that the Commission Report cites evidence from a number of witnesses that corresponds very closely to these elements of the *Siliadin* case.

First, it is clear that women were not paid for their work in Mother and Baby Homes. Far from being rewarded for work, there was a strong penal element to it; for example, the Confidential Committee notes that "[a] witness told the Committee that when she was born, her birthmother was told by the nuns that her baby would be 'taken' and that she herself could 'work off her sin for the next three years'."[201] Second, the hours that they worked were clearly extremely long, and women worked 7 days a week, even while heavily pregnant or shortly after giving birth. One witness told the Investigative Committee:

> I arrived in Bessborough in mid-July and during the summer months my job was cutting the lawn with scissors. I did this every day in a line with a group of other women. We were not allowed to stop when we felt tired. In the winter months I had to polish and scrub the corridors. Other women were sent to work in the laundries … I worked seven days a week until I went into labour.[202]

Many others related similar stories to the Confidential Committee:

> … a girl, only 14 years of age when she was raped and became pregnant, described the home to which she was sent as: "Horrible"; she had to "feed babies, morning and evening, clean and scrub floors, we were like slaves".[203]

199. Commission Report, Recommendations at p 8.
200. *Siliadin v France*, 73316/01, 26 July 2005 at [114].
201. Confidential Committee at p 50.
202. Commission Report at [18.373].
203. Confidential Committee at p 59.

> Witnesses reported that scrubbing of floors, stairs and steps (both as work task and punishment) had been imposed on residents from the 1950s into the 1970s in some mother and baby homes. Some mothers reported having to do physically exhausting work up to the verge of giving birth, or very soon (as little as two or three days) immediately afterwards … Some referenced scrubbing as an inescapable part of their lives in the homes—saying that, while working, they were frequently and very closely supervised by a nun, some of whom would slap or punch them if they were judged not to be working hard or fast enough.[204]

> … a week after giving birth, despite coming from a city background and with no knowledge of farming, she was put to work on the farm, milking cows and feeding chickens and was 'hit' by the nuns for not doing this work correctly.[205]

> On the day of arrival in the home, in the 1970s, at 24 years of age, this next witness had her hair cut off and was allocated the task of handwashing sheets, thick towels and other clothes, under the supervision of a nun who would "shout at us to go faster".[206]

Indeed, as will be elaborated on in section 3.5 below, conditions in the Mother and Baby Homes went beyond the definition of forced labour and included some (though not all) elements of the definition of servitude—for example, the absence of freedom of movement.

The key issue is the absence of free choice and fear of "penalty", which is closely linked (as in *Siliadin*) to the vulnerability of the women and their dependence on the Homes. In this respect, pregnant unmarried women in Ireland in the mid-Twentieth Century—many of whom were as young as the applicant in *Siliadin*, and some of whom were victims of rape or incest—were in a highly vulnerable situation. They lacked resources or any meaningful support from the State or from their families; they were seen as a problem to be hidden away; and the only realistic alternative to remaining in a Mother and Baby Home was a County Home. As noted in section 3.3 above when discussing inhuman and degrading treatment under Article 3, the conditions in County Homes were even worse than in Mother and Baby Homes; and it will be seen in section 3.4.3 below that the same can be said in respect of forced labour. Women who did not wish to remain in either a Mother and Baby Home or a County Home faced destitution. For at least some women in Mother and Baby Homes, the combination of vulnerability, absence of free choice and absence of pay is likely to have amounted to forced labour within the meaning of Article 4 of the ECHR.

Although the Commission Report does not provide direct evidence of State knowledge of the extent to which women were compelled to work in Mother and Baby Homes, it does cite evidence that inspectors raised concerns about this issue in County Homes.[207] As such, it could be argued that even if the State was not actually aware of forced labour taking place in Mother and Baby Homes, it ought to have been aware (given the similarities between the institutions) of the risk of same, and failed to take steps to mitigate that risk.

204. *Ibid* at p 41.
205. *Ibid* at p 54.
206. *Ibid* at p 56.
207. Commission Report at [10.55].

By analogy with case law interpreting Article 3 of the ECHR (discussed above—particularly *O'Keeffe v Ireland*), this is sufficient to trigger State responsibility under the ECHR.

3.4.3 County Homes

As discussed in section 3.3 above, the Commission Report takes the view that women in County Homes experienced more serious ill-treatment than women in Mother and Baby Homes. It takes the same view in respect of labour practices in County Homes. The Report states that "[t]here appears to have been no effort to conceal the extent of unpaid work carried out by unmarried mothers in county homes".[208] It notes that "[m]ost of the work [in County Homes] was carried out by the unmarried mothers, who were unpaid",[209] and that "[t]here are many contemporary statements by local officials or matrons insisting that unmarried mothers could not be removed from the county home, because there would be nobody to carry out this work."[210] Women continued to carry out unpaid work in some county homes until the early 1960s, despite a statement by the Minister of Health in 1952 that this was prohibited.[211]

The language of the Report is strikingly more critical of work practices in County Homes than in Mother and Baby Homes. It notes that "[t]he type of work that was required of unmarried mothers in county homes was far in excess of the work that was expected of women in mother and baby homes",[212] and continues:

> Generations of single mothers in county homes, institutions which were owned and run by local authorities, carried out onerous and often degrading unpaid labour, and some were effectively held hostage in these homes, threatened with having to take on responsibility for maintaining their child(ren) if they attempted to leave. This is yet another instance of a gulf between the regulations laid down by central government, and their implementation by the local authorities.[213]

It concludes that "[l]ocal authorities acquiesced, indeed probably connived at the retention of single mothers, because they valued their unpaid work".[214] For example, the Report notes that "[i]In Wicklow, mothers whose children were boarded out were 'expected to remain in the home until two years have elapsed from the date of confinement', working without pay."[215]

The coercive element of the practices in County Homes is evident in the threat that women who left would become financially responsible for maintaining their children, when clearly the women had no resources to discharge their responsibility. A specific example can be seen in this description of Wexford County Home:

> In 1953 one woman wrote to the Minister for Health complaining that mothers whose children were boarded out were required to remain in the Wexford county home,

208. Commission Report at [10.48].
209. Commission Report, Executive Summary at p 41.
210. *Ibid* at p 63.
211. *Ibid.*
212. Commission Report at [10.82].
213. Commission Report at [10.84].
214. Commission Report at [10.82].
215. Commission Report at [10.81].

> as unpaid workers, sometimes until their child was 15 years old. If a mother insisted on leaving the county home her child(ren) were removed from foster homes and the mother was made responsible for their maintenance. When Miss Litster checked with the Wexford authorities she was informed that this rule still applied though Matron has assured me on several occasions that although she must leave mothers under the impression that it will be enforced, she will not in fact remove children from their foster homes if their mothers leave the County Home. It is thought to be in their interests to subject them to the discipline of the institution as long as possible.[216]

Some County Homes took this even further and physically returned children to mothers who sought to leave:

> In 1943 Miss Litster reported that if a mother left the Meath county home any children that had been boarded out were "handed to her"; [she] believed that Meath was the only county to follow 'this short-sighted policy'. In 1950 the Department of Health, noted that one child who had been in a 'very satisfactory foster home' was returned to her mother in such circumstances …[217]

The Commission Report's description of practices in County Homes includes all the elements which led to a finding of a violation of Article 4 in *Siliadin*. Vulnerable women were forced to undertake relentless labour for no pay in circumstances where they were entirely dependent on the institutions, and under the threat (in some cases carried through) that if they left, they would be fixed with financial and/or physical responsibility for a child who they could not possibly care for. All of this occurred in institutions which were State-run, and in respect of which there is evidence that Government Departments were made aware of the conditions in question. In *Chowdury v Greece*, the Court held that Greece had failed in its positive obligations under Article 4 because a number of State authorities had been alerted to the situation but provided only a sporadic response that failed to provide a general solution to the problems encountered by the workers in that case.[218] It seems difficult not to conclude that labour practices in County Homes amounted to forced labour within the meaning of Article 4 of the ECHR, and that the Irish State failed to discharge its obligations to protect women from these practices.

3.4.4 Children in Foster Homes

Forced labour was not limited to unmarried mothers. The evidence in the Commission Report regarding the treatment of children in foster homes would appear to strongly indicate that many of these children were also subjected to conditions and practices which would amount to a violation of Article 4. The primary motivation of a considerable number of foster parents who took in boarded-out children or children at nurse appeared to have been to put them to work, particularly on farms. A Department of Health report cited by the Commission in relation to Mayo stated:

216. Commission Report at [10.79].
217. Commission Report at [10.79].
218. 21884/15, 30 March 2017 at [110] to [115].

> … the principles which appear to determine the selection of foster homes in Co Mayo give cause for grave concern … Owing to a high emigration rate there is a dearth of domestic and agricultural workers in the country and, as a consequence, boarded-out children have come to be regarded as a substitute for the normal labour supply. When an older child is available for boarding out—usually as a result of removal [from another foster home]—there is a spate of applications from middle class householders which require domestic or agricultural help. Generally speaking this type of home does not extend to the child that affection which is the first requirement for successful boarding-out. There is no question of the child becoming a member of the family or of having that feeling of belonging which is essential for normal development. I found that children who had been placed in this type of home were under no illusion as to the reasons for their being there.[219]

Several witnesses who spoke to the Investigative Committee "described being required to carry out very heavy farm chores, before and after going to school, which left them with little time for homework and a poor attendance record".[220] The Commission Report states that "[f]oster children were commonly viewed as a source of unpaid labour", and provides a number of telling examples:

> In 1931 an inspection in North Tipperary noted that "Mrs C admitted that she did not take the boy to foster but as help. This is in reality paying her his maintenance to have her own work done, for which a servant boy should be paid". The inspector recommended that this boy should be moved "to a genuine home with genuine foster parents" and no children should be placed with that foster mother in the future. A 12-year-old girl in another labourer's cottage, which was occupied by a widow and her elderly brothers, was very poorly clad. She appeared "to be there really as a help for general work with no home attention to her". She was only in third class at school. The inspector suggested that her lack of progress was because of her work duties. A 12-year-old boy boarded out nearby was "here for work. Going to the creamery and anything else that he can do. Appears hardworking and industrious but walks with a stoop such as children acquire from carrying loads of heavy buckets". A 14-year-old boy was described as extremely unhappy in a foster home, where he was expected to do a man's work unpaid. Another family wanted to foster a child to help on the farm; they would not take a child under nine years and would prefer a 12-year old. A Donegal foster mother claimed that she got so little money for keeping a boy that her husband had a right to keep him from school to work on the farm whenever he needed help.[221]

The frequent references in contemporary inspection reports to the use of foster children for forced labour indicates that State authorities were clearly aware that this was a widespread problem at the time. There is evidence that some children were moved from foster homes, particularly if they were kept out of school to work; but there is also evidence that this did not always occur. For example, the Report documents a case of a 14-year-old boy who the county medical officer described as appearing "to be in fear and

219. Commission Report at [11.66].

220. Commission Report at [11.145].

221. Commission Report at [11.65].

was evidently used to slave labour". Both the public health nurse and the county medical officer recommended that the child be moved, but the Department of Health demurred.[222] In addition, given the extensive evidence (discussed in section 3.3.3 above) of the weak and inadequate inspection regime operated in relation to boarded-out children, it seems highly likely that many instances of the use of children for forced labour in foster homes would have gone undetected.

In some instances, children were removed from foster homes by local authorities at the age of 14 or 15 and placed in a convent for the purposes of "training". The Report states that Department of Health officials acknowledged in 1949 that "'training' means little more than working in a public laundry for no wages" and that "work in a public laundry is considered unsuitable—children should not be sent there in future".[223] Notwithstanding this finding, the practice continued at least into the 1950s.

The treatment of children who were compelled to undertake excessive labour in foster homes, often unsuited to their age and at the expense of their education, appears likely to have amounted in many cases to forced labour contrary to Article 4 of the ECHR. They were placed by State authorities in full-time foster placements on which they were entirely dependent for their care. Leaving was simply not an option. Payment or free choice were never even considered, and while the hours worked by these children may not have been quite as lengthy as those seen in the *Siliadin* case, the children were in many cases much younger and even more vulnerable. Like the applicant in *Siliadin*, the children were often denied proper schooling as a result of being forced to work. The contemporary inspection reports make it clear that even by the standards of the time, the treatment of these children was considered to be tantamount to slavery. The nature of these arrangements, and the extent to which the State either was aware of them or ought to have been aware of them (had an adequate inspection regime been in operation) is such that violations of Article 4 seem highly likely to have occurred in a significant number of foster homes. Notably, specific concerns on this point were expressed by the UN Special Rapporteur on the sale and sexual exploitation of children in her 2019 report following her visit to Ireland.[224]

3.5 DEPRIVATION OF LIBERTY

Much of the commentary on Mother and Baby Homes describes women in the Homes as having been "incarcerated".[225] The "offence" was to have become pregnant outside of wedlock. As one survivor noted in a recent interview: "We were incarcerated. We were recorded by our offence. I was down as my first offence. The only difference is we didn't get a court of law or a trial to find us guilty of anything."[226] There was no legal basis for keeping women in Mother and Baby Homes; their presence there was supposedly on a voluntary basis. As such, if they were kept there against their will, this would potentially amount to a violation of the right to liberty.

222. Commission Report at [11.67].

223. Commission Report at [11.96].

224. *Visit to Ireland: Report of the Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material*, UN Doc No A/HRC/40/51/Add.2, 15 November 2019 at [17], available at https://undocs.org/A/HRC/40/51/Add.2.

225. See, eg, A Conneelly, "Mother-and-baby homes: A dark story with a lasting impact", *RTE*, 31 May 2021, available at https://www.rte.ie/eile/truth-matters/2021/0526/1224086-mother-and-baby-homes-dark-story-with-a-lasting-impact/.

226. M Fagan, "Bessborough survivor: 'The shame belongs with them'", *Irish Examiner*, 30 May 2021.

3.5.1 Article 5 ECHR

Article 5(1) of the ECHR provides: "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law …" Article 5(2) goes on to list a number of specific instances in which deprivation of liberty may be permitted, including for criminal offences; non-compliance with court orders; educational supervision; preventing the spread of disease; persons of unsound mind; or enforcement of immigration controls. In every case, it is required that the detention be "lawful" (ie have a basis in national law). Since there was no legal basis for keeping women in Mother and Baby Homes, the question of whether Article 5 was violated turns on two points: first, whether the circumstances in the Homes amounted to a deprivation of liberty within the meaning of Article 5; and second, if it did amount to a deprivation of liberty, the level of State involvement in or knowledge of this. As was shown above in respect of Articles 3 and 4 of the ECHR, the State's obligations under Article 5 are not merely negative obligations to refrain from unlawfully or arbitrarily detaining individuals. States also have positive obligations to protect individuals from unlawful detention at the hands of private actors of which State authorities have or ought to have knowledge.[227] States may also violate Article 5 if they acquiesce in, or fail to put an end to, a person's detention.[228]

A finding of a deprivation of liberty within the meaning of Article 5 depends on both objective factors (ie confinement to a restricted space for more than a negligible period of time) and subjective factors (ie that the person who has been confined has not validly consented to the confinement).[229] The assessment of the former is a holistic one that may depend on a variety of factors. In *Guzzardi v Italy*, the ECtHR made the following observation:

> In order to determine whether someone has been "deprived of his liberty" within the meaning of Article 5 (art. 5), the starting point must be his concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure in question …[230]

A deprivation of liberty was found to have occurred in *Guzzardi* on the basis that the applicant was confined for 16 months to a small area on an island in the buildings of a former medical establishment which were in a state of disrepair or even dilapidation. He lived there principally in the company of other persons subjected to the same measure, and there were few opportunities for social contacts available to the applicant other than with his near family, his fellow "residents" and the supervisory staff. Supervision was carried out strictly and on an almost constant basis. The ECtHR held that "[i]t is admittedly not possible to speak of 'deprivation of liberty' on the strength of any one of these factors taken individually, but cumulatively and in combination they certainly raise an issue of categorisation from the viewpoint of Article 5 … In certain respects the treatment complained of resembles detention in an 'open prison'".[231]

227. See, eg, *Storck v Germany* (61603/00, 16 June 2005) and *El-Masri v The Former Yugoslav Republic Of Macedonia* (39630/09, 13 December 2012).

228. *Rantsev v Cyprus and Russia* (25965/04, 7 January 2010).

229. See, eg, *Storck v Germany* (61603/00, 16 June 2005) at [74].

230. 7367/76, 6 November 1980 at [92].

231. *Ibid* at [95].

3.5.2 Evidence of Deprivation of Liberty in Mother and Baby Homes and County Homes

The Commission Report draws the following conclusion in respect of whether women in Mother and Baby Homes were "incarcerated":

> The women in mother and baby homes should not have been there. They should have been at home with their families. However, the reality is that most had no choice—they were, or expected to be, rejected by their families and they needed a place to stay. Most were unable to provide for the baby. They were not "incarcerated" in the strict meaning of the word but, in the earlier years at least, with some justification, they thought they were. They were always free to leave if they took their child; some did leave before the child was born and some left without their child. Most had no money and nowhere to go.[232]

This conclusion is open to criticism on two grounds. First, it contradicts itself by stating that the women were not incarcerated, but were justified in thinking that they were; and by going on to state that "[i]t could be argued that women who had to stay for two years or more because alternative arrangements had not been made for their children could be regarded as 'incarcerated'".[233] Second, it applies a narrow and literal definition of the term "incarcerated" and fails to engage in a human rights-based analysis of whether women were deprived of their liberty in Mother and Baby Homes and County Homes. As seen above, Article 5 of the ECHR envisages that a person can be lawfully incarcerated without any violation of their right to liberty; and conversely, that a person can be deprived of liberty without being incarcerated in the narrow sense applied by the Commission. The latter scenario is what the Commission failed to consider. The analysis below will apply the standards set down in Article 5 of the ECHR and associated case law to the evidence cited in the Commission Report with a view to establishing whether circumstances in Mother and Baby Homes would have amounted to a deprivation of liberty within the meaning of Article 5.

3.5.2.1 Objective Element: Confinement to a Restricted Space

The Commission Report contains extensive evidence that women in Mother and Baby Homes and County Homes were confined to a restricted space for more than a negligible period of time. Chapter 3 of the Report describes the "template" for Mother and Baby Homes:

> They were generally located behind high walls; isolated from the community; visitors were restricted, and women were required to stay for a specified period—at least six months after giving birth in order to 'benefit' from the discipline and rehabilitation that the home claimed to provide. The regime was also designed to act as a deterrent against becoming pregnant outside marriage.[234]

232. Commission Report, Recommendations at pp 7-8.
233. *Ibid* at p 8.
234. Commission Report at [3.28].

This passage identifies three factors that were relied on by the ECtHR in finding a deprivation of liberty in *Guzzardi*—namely, the high boundary walls (beyond which movement was not permitted); close supervision; and living "principally in the company of other persons subjected to the same measure". Other witness testimony provided to the Investigative Committee is illustrative of the absence of contact with the outside world, which was another factor relied on in *Guzzardi*:

> She said that, on her admission to Bessborough, she was told that she was not allowed to have contact with the outside world …[235]

> She said that there was a rule of silence in the institution; no visitors were allowed; she was not allowed to send or receive letters; and she was not allowed to listen to the radio.[236]

> She never saw anyone from the outside and she was not allowed to maintain contact with family and friends. She wrote letters to her mother which were sent to London first and then posted to her mother in Ireland. The nuns supervised and censored her letters and coerced her to write positive things about the home while she and her baby were ill.[237]

The restrictions on visitors described above are more pronounced than those seen in *Guzzardi*, or indeed in most prisons. Thus, it might be said of Mother and Baby Homes (as was found in *Guzzardi*) that "cumulatively and in combination", these factors amount to a deprivation of liberty, and that "[i]n certain respects the treatment complained of resembles detention in an 'open prison'".[238]

People responsible for running Mother and Baby Homes used the word "detention" to describe the women's stay in the Homes; for example, the Report cites the Mother General of the Congregation of the Sacred Hearts of Jesus and Mary as stating that mothers "ought to be detained until their child's life is out of danger".[239] The Report cites a Garda report of a visit to Dunboyne in 1966, in which the Garda stated that a woman who had made a complaint about being pressured into adoption was "due for release in January 1963" in accordance with "normal practice".[240] The Commission noted (in a footnote) that "[t]he use of the word 'release' suggests that the Garda thought the woman was incarcerated."

As will be developed in more detail below, the Commission Report contains multiple references to so-called "escape attempts"—some thwarted in advance, and some successful, following which women were returned to the Homes. The following testimony was provided to the Investigative Committee by a woman who had been in Bessborough:

235. Commission Report at [18.370].
236. Commission Report at [18.372].
237. Commission Report at [18.294].
238. 7367/76, 6 November 1980 at [95].
239. Commission Report at [17.3].
240. Commission Report at [24.94].

> Most girls "towed the line" and learned how to stay out of trouble. Some tried to "escape" but were "captured, brought back and punished". Women were "routinely denied contact with their children" as punishment.[241]

The cumulative impact of conditions in at least some of the Mother and Baby Homes would have contained sufficient objective factors to justify a conclusion that the women were confined to a restricted space for a period of months or even years. In such cases, the first element of a deprivation of liberty would have been present. (The Commission Report contains comparatively little evidence in relation to County Homes regarding factors such as physical limitations on movement or restrictions on contact with the outside world, and so it is not possible to draw conclusions in that respect.) This leads to the second element—namely, whether the women validly consented to their presence in the Homes.

3.5.2.2 Subjective Element: Absence of Consent

As noted above, women who spent time in the Mother and Baby Homes often used the word "incarceration" to describe their time there—the following are some examples from witness testimony provided to the Investigative Committee:

> In a separate statement Resident J said: I was incarcerated in Bessborough Mother and Baby Home in Cork from [for approximately a year and a half].[242]

> Although the doors were not locked, it felt like incarceration. They were technically free to leave but they had nowhere to go.[243]

> … why am I here, I am a prisoner in my head, you know, and sort of thinking I might escape and go to Dublin …[244]

Statements such as these cannot be reconciled with any concept of a valid consent to the women's presence in the Homes.

Women who entered Mother and Baby Homes and County Homes often did so at the insistence of parents and/or members of the clergy. Several passages in the Confidential Committee report provide grounds to question the voluntariness of the entry of many women into the Homes:

> A witness who went into a Home in 1964 at the age of 23, told the Committee that she had been abused by her father for many years after her mother had died. She then met a boy, and thought if she could have a baby with someone, she "would have her own life". However, when her father discovered she was pregnant, he gave her "the hiding of her life", wrapped cardboard around her stomach and forbade her to be 'seen outside'. A local priest made arrangements with this father for his daughter to go into the mother and baby home.[245]

241. Commission Report at [18.297].
242. Commission Report at [18.381].
243. Commission Report at [24.156].
244. Commission Report at [20.129].
245. Confidential Committee at pp 18-19

> A witness (24 years old but like so many others of that era, not having much knowledge of sex) went to see her GP to find out what was going on in her body. He phoned the parish priest from his surgery and she was taken straight to the mother and baby home as she would be a "dreadful example to her siblings".[246]
>
> She became pregnant at 19 with a man from her town who was seven years older than she was. The local doctor who had made this discovery, informed the witness's mother, saying: "You'll have to shift her out of here", so the parish priest was telephoned and it was he who summoned an ambulance to bring her to the mother and baby home.[247]
>
> She and her boyfriend intended to marry, but one night when she was due to meet him, a social worker turned up instead, and brought her directly to a Magdalen laundry … [She] went with this social worker because she assumed that because she had been raised in foster care, there was an entitlement by this state official, as she saw it, to move her involuntarily. The next day she was transferred from the laundry to a mother and baby home …[248]

Even if a woman entered Mother and Baby Homes or County Home voluntarily at first, she would still have been subjected to deprivation of liberty if she later changed her mind, but was not allowed to leave. Again, the Confidential Committee report cites witness testimony of measures being taken to prevent women from leaving:

> One Christmas I was going to go home. I had packed my bags. My sister and partner had come to collect me. Five nuns stood in my way and wouldn't let me leave. They said they would get the Gardaí to come and arrest my sister and partner if they attempted to take me.[249]

Contemporaneous records show that authority figures at the time accepted that women in the Homes did not want to be there, but needed to be contained. The Archbishop of Tuam is quoted as having stated in the 1950s that "[m]any of these unmarried mothers are anxious to get off without delay. The only thing that prevents their leaving is the strict supervision and boundary walls".[250] For this reason, he opposed moving the Tuam Home to the outskirts of Galway City, as "such a Home must be in a place that is quiet, remote and surrounded by high boundary walls".[251]

The evidence just discussed appears to indicate that the second element of deprivation of liberty under Article 5 of the ECHR—ie a subjective absence of consent to their presence in the Home—was also met for a considerable number of women in Mother and Baby Homes. This leads to the final point determining whether the right to liberty was violated—namely, whether State authorities were actively involved in, or acquiesced in, or had or ought to have had knowledge of, the deprivation of liberty.

246. *Ibid* at p 20.
247. *Ibid*.
248. *Ibid* at p 18.
249. *Ibid* at p 56.
250. Commission Report, Executive Summary at p 11.
251. *Ibid* at p 10

3.5.3 State Responsibility for or Knowledge of Deprivation of Liberty

As explained in section 3.5.1 above, the ECHR case law does not require any active involvement on the part of State authorities in deprivation of liberty in order to ground a violation of Article 5; it is sufficient that the State acquiesced in the deprivation of liberty; or had knowledge of it but failed to bring it to an end. The Commission Report provides evidence that State authorities were at least aware that women in Mother and Baby Homes were being deprived of their liberty, and may also have actively contributed to the deprivation of their liberty through returning women who escaped.

The Commission Report cites evidence of letters being held on file by the Department of Health seeking "release" of women from Mother and Baby Homes or complaining about the length of time for which women were forced to stay in the Homes after childbirth.[252] It cites a 1964 memorandum which noted that "nothing in the Health Act 1953 or the 1954 regulations empowered the mother and baby homes to detain a woman".[253] However, the regulations required that women who intended to leave should give reasonable notice of that intention; the memorandum stated that despite the absence of any legal powers of detention, the Sisters running these homes were "understandably reluctant to consent to the immediate departure of an unmarried mother after her confinement".[254] It was agreed that the Departmental inspector would examine length of stay during the next round of visits.[255]

In addition to the above evidence which is strongly suggestive of State knowledge of women being kept in Mother and Baby Homes against their will, the Commission Report cites multiple examples of the Gardaí having been contacted and requested to apprehend women who had escaped from Mother and Baby Homes. In some instances, the evidence provided to the Investigative Committee suggests that this was accomplished:

> In general, it would appear that many of the women stayed [in Kilrush] for two years unless taken out by their family and then only with the permission of the board. There were a number of 'escape' attempts. In May 1924, the matron reported that three women had "scaled the wall" but had been arrested and brought back by the Gardaí. In October of that year, she reported that two women escaped over the wall leaving behind their two children, one aged three weeks and the other five months. The matter was reported to the Gardaí.[256]

> She said that some girls "ran away" [from Seán Ross] but were "brought back by the Garda".[257]

> She said that she witnessed one woman who left the institution and was returned by the Garda.[258]

252. Commission Report at [6.64].
253. *Ibid.*
254. *Ibid.*
255. *Ibid.*
256. Commission Report at [16.56].
257. Commission Report at [19.197].
258. Commission Report at [18.371].

In other cases, the evidence suggests that the Gardaí were contacted, but the women were not returned:

> In September 1932, two women left Bessborough leaving their children who were then aged 18 months and 22 months, unaccompanied in the institution. The Gardaí were notified but did not locate the women. One woman was subsequently brought back to Bessborough by her father and the other was never seen again.[259]

It is suggested that "[t]he Gardaí did not pursue women who 'absconded' from Bessborough with any great vigour as they seem to have considered that the children were in a safe environment and often a better environment than a woman's family home."[260] Nonetheless, women were told on their arrival that if they attempted to leave without permission, they would be brought back by the Gardaí.[261] Women who left the Home while their child was still there were threatened with prosecution for child abandonment.[262]

Whether the Gardaí actually returned women to the Mother and Baby Homes is less important than the fact that the Gardaí were notified on many occasions about women "escaping" and asked to return them. This is sufficient to demonstrate that the State was aware or ought to have been aware that women were being kept in the Homes against their will, and that efforts were made to prevent them from leaving notwithstanding the absence of any legal basis for keeping them there. The quotation given above from a Garda who referred to a woman as being "due for release" in accordance with "normal practice"[263] is telling in this respect. Once State authorities were aware or ought to have been aware of the deprivation of liberty, they were obliged to bring it to an end. The continued existence of Mother and Baby Homes for a period of several decades is sufficient evidence that this did not occur. Tellingly, the Department of Health memorandum quoted above concluded: "In general, the arrangements for coping with the difficult and delicate problem of unmarried mothers appear to be working well; and it seems certain that any attempt by the Department to interfere with the existing machinery would involve exchanges with the higher ecclesiastical authorities."[264]

It was noted in section 3.3 above that County Homes were State-run, and therefore direct State responsibility is engaged for the treatment of women in these institutions. On the question of the deprivation of liberty, section 3.4.3 above detailed how women were (in the words of the Commission) "effectively held hostage in these homes, threatened with having to take on responsibility for maintaining their child(ren) if they attempted to leave".[265] The Report makes multiple references to requests being made to the Gardaí to apprehend women who "escaped" or "absconded" from County Homes.[266]

In summary, the evidence discussed above suggests that a significant number of women were confined in restricted spaces in Mother and Baby Homes for periods of

259. Commission Report at [18.62].
260. *Ibid.*
261. Commission Report at [18.370].
262. Commission Report at [18.62].
263. Commission Report at [24.94].
264. *Ibid.*
265. Commission Report at [10.84].
266. See, eg, Commission Report, Executive Summary at p 40; [10.81]; and [28.38]

months or even years. In many cases, the women would not have consented to this confinement, and steps were taken to prevent them from leaving. There was no legal basis for the confinement. In some cases, the State actively contributed to or acquiesced in the confinement (through the return of women by the Gardaí to Mother and Baby Homes, and potentially also by forcing women to remain in State-run County Homes). At the very least, State authorities were aware or ought to have been aware that women were being deprived of their liberty in Mother and Baby Homes, but failed to put an end to this state of affairs. Applying the standards established under Article 5 of the ECHR (as discussed in section 3.5.1 above), it seems likely that a violation of the right to liberty occurred in a substantial number of cases.

3.6 CONSENT TO ADOPTION

One of the issues that has generated considerable controversy in respect of Mother and Baby Homes is the allegation that some mothers were forced to place their baby for adoption, and did not provide free and informed consent. As such, the Commission's terms of reference required it to examine:

> … the extent of participation of mothers in relevant decisions, including
>
> (i) the procedures that were in place to obtain consent from mothers in respect of adoption, and
>
> (ii) whether these procedures were adequate for the purpose of ensuring such consent was full, free and informed …

The Commission Report did not conduct a comprehensive examination of adoption, but it did collect evidence on the specific issue of the consent given by women in Mother and Baby Homes to adoptions. This raises issues regarding the protection of the right to family life under Article 8 of the ECHR.

3.6.1 Article 8 ECHR

Article 8 of the ECHR provides:

> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

While the discussion of rights violations in this Chapter has thus far focused on the State's obligation to protect individuals from violations at the hands of private actors, adoption is in a different category due to the fact that every adoption involves a degree of

State involvement. Although Ireland's adoption system relied heavily on private adoption societies, the grant of an adoption order by the State was always required in order to effect a valid adoption. Within this process, the State's positive obligation to secure the right to family life to the parties involved is engaged. In *Kearns v France*, the ECtHR held that although the object of Article 8 is essentially that of protecting the individual against arbitrary interference by the public authorities, "it does not merely compel the State to abstain from such interference: in addition to this primarily negative undertaking, there may be positive obligations inherent in effective respect for family life. These obligations may involve the adoption of measures designed to secure respect for private life even in the sphere of the relations of individuals between themselves."[267]

A considerable body of case law concerning Article 8 of the ECHR has established that the placement of a child for adoption without the consent of the parent(s) constitutes an interference with the right to family life of the parent(s).[268] However, this case law has almost all arisen in the context of children being placed for adoption following a legal process in which a child has been removed from the care of his or her parent(s) due to child protection concerns, and which subsequently determines that it is in the child's best interests to be adopted by foster parents who are caring for the child. The focus of this case law has been on whether this interference is prescribed by law, pursues a legitimate aim, and is proportionate to the legitimate aim being pursued.

To date, the ECtHR has addressed just a small number of cases concerning the question of whether a mother who signed a consent form to adoption was fully informed,[269] and has not addressed any cases concerning allegations that consent to adoption was not freely given.[270] Nonetheless, it can safely be extrapolated from the case law that such an adoption would certainly constitute a restriction of the right to family life under Article 8, since the mother would be denied custody of her child in the absence of genuine consent on her part. Unlike adoptions resulting from a legal process based on the child's best interests, the adoption in such cases would not be "prescribed by law". The questions of whether the interference pursues a legitimate aim and is proportionate do not arise if the interference does not have a legal basis. Accordingly, the adoption would violate the right to family life if no remedy were provided.

On the question of remedy, the ECHR operates on the principle of subsidiarity, under which it is up to the State Party in the first instance to provide a remedy; the ECtHR will only intervene where no adequate domestic remedy is available.[271] Therefore, in the absence of ECHR case law specifically addressing the circumstances in which consent to adoption that was not freely given would constitute a violation of Article 8, it is appropriate to look to the domestic legal framework.

267. 35991/04, 10 January 2008 at [74].

268. See, eg, *Johansen v Norway* (17383/90, 7 August 1996); *Aune v Norway* (52502/07, 18 October 2010); *R and H v United Kingdom* (35348/06, 31 May 2011); *YC v United Kingdom* (4547/10, 13 March 2012); *AK and L v Croatia* (37956/11, 8 January 2013); *Strand Lobben v Norway* (37283/13, 10 September 2019); *AS v Norway* (60371/15, 17 December 2019); and *Abdi Ibrahim v Norway* (15379/16, 17 December 2019).

269. The decision most directly on point is *Todorova v Italy* (33932/06, 13 January 2009) at [82], where the Court stated that the Italian State failed to ensure that the applicant's consent to giving up her children had been given in full knowledge of the implications and had been attended by the appropriate guarantees, and this led to a violation of Article 8. See also *Kearns v France* (35991/04, 10 January 2008).

270. The absence of free consent was alleged in the domestic proceedings in *IS v Germany* (31021/08, 5 June 2014), but did not form part of the complaint to the ECtHR.

271. See, eg, *Kudla v Poland* (30210/96, 26 October 2000) at [152]: "The object of Article 13 [ie the right to an effective remedy], as emerges from the *travaux preparatoires*, is to provide a means whereby individuals can obtain relief at a national level for violations of their Convention rights before having to set in motion the international machinery of complaint before the Court." See further *Selmouni v France* (25803/94, 28 July 1999) at [74].

In Ireland, the Adoption Acts 1952-1974 provided a legal framework during the time period covered by the Commission Report which governed the consent process for adoption, and a significant body of case law was generated which elaborated on the circumstances which would vitiate consent. The key authority defining the circumstances in which a mother's consent to adoption is not legally valid is the decision of Laffoy J in the High Court in *DG and MG v An Bord Uchtála*:

> Fear, anxiety, stress, economic deprivation and other deprivations are frequently ingredients of the factual situations which give rise to an enquiry whether agreement by a mother to place a child for adoption was freely made in order to determine the applicability of Section 3 of the 1974 Act. In my view, the presence of one or more of these features does not necessarily vitiate a mother's consent. The true test is whether, in the circumstances which prevail at the time she makes her decision, that decision reflects her will or the will of somebody else.[272]

In that case, the mother's consent was found not to have been freely given because her parents, with whom she resided at the time at which she placed the child for adoption, had made it clear that they wished the child to be adopted and that the existence of the child should be concealed, and forbade her from bringing the child home. The mother "subordinated her own will to that of her parents because of fear which was a product of her upbringing, stress, anxiety, lack of maturity and deprivation of emotional support."[273]

The analysis below will measure the evidence contained in the Commission Report against this definition to assess the extent to which the Report raises concerns around adoptions having taken place without the free and informed consent of the mother. It will also consider the availability, and—more pertinently—the accessibility of a remedy to mothers whose consents were not freely given.

3.6.2 Evidence in the Commission Report

Chapter 32 of the Commission Report provides the following summation of the evidence provided by witnesses who provided testimony to the Commission in relation to consent to adoption:

> Some witnesses told the Commission that they consented to adoption because they considered that it would provide the best outcome for their children; in general, these women regarded their consents as free and informed. Others said that they consented because they were not in a position, economically or socially, to care for the child in the absence of family support; their decision was informed but some considered that it was not free as they had no real choice. Some said that they did not give free and informed consent to the placement of their children for adoption or to the subsequent adoption orders. A number of women said that they had had no choice but to sign the adoption papers; that they had been 'forced' to do so by, for example, parents, adoption societies, mother and baby home staff, social workers or priests. A number

272. High Court, Laffoy J, 23 May 1996; [1996] 1 FLR 263 at [61].
273. *Ibid* at [67].

> had no memory of ever signing any adoption papers but accepted that they probably had; some who had no memory of signing recognised their signature on the adoption papers when they viewed them later. Some stated adamantly that they had not actually signed any adoption papers. A few said that they had subsequently seen the forms in the adoption society files and they asserted that the signatures were not theirs.[274]

If this passage is broken down and compared to Laffoy J's test for free and informed consent in *DG and MG*, it can be seen that there are a number of different categories of cases. The first two categories do not provide any issue with respect to the legal standard—namely, women who raised no concern about the validity of their consent,[275] and women who felt compelled to consent by social and economic circumstances, but who were not subjected to other direct pressure. Applying Laffoy J's test, consents given in the latter cases were valid, as the presence of "[f]ear, anxiety, stress, economic deprivation and other deprivations … does not necessarily vitiate a mother's consent".[276] The categories that merit closer scrutiny are the women who say that they were forced to consent, and the women who say that they did not sign a consent form at all. These two categories will be examined in turn.

3.6.2.1 Absence of free consent

The Commission Report acknowledges that some women who provided testimony to the Commission claimed that their consent was not free and informed; but concludes that "with the exception of a small number of legal cases, there is no evidence that this was their view at the time of the adoption."[277] This conclusion is difficult to reconcile with some of the evidence and analysis produced in the Report, which strongly suggests that many women were pressured into concealing their pregnancy and placing their child for adoption in the manner described in *DG and MG*. Multiple witnesses who provided testimony to both the Investigative Committee and the Confidential Committee Report said that they were forced to sign adoption papers by parents, adoption societies, Mother and Baby home staff, social workers or priests. Determining whether an individual woman's consent reflected "her will or the will of somebody else" would require a case-by-case assessment of the circumstances of each individual case. Nonetheless, there are clearly significant concerns that a considerable number of cases would reach this threshold if subjected to such an examination.

In *DG and MG*, the threshold was met because the mother's consent was given in circumstances where her parents, with whom she resided at the time at which she placed the child for adoption, had made it clear that they wished the child to be adopted and that the existence of the child should be concealed, and forbade her from bringing the child home. There is a striking similarity between this finding and the following passage from Chapter 32 of the main body of the Commission Report:

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274. Commission Report at [32.161].

275. The Confidential Committee notes at p 88: "Some women who came to the Confidential Committee testified that they willingly gave up their babies for adoption, signed all papers necessary and got on with their lives. This, they told the Committee, had been the definite plan from the time they discovered they were pregnant and residency in a mother and baby home had been merely a necessary stop along the way."

276. See further *McF v G* [1983] ILRM 228.

277. Commission Report, Executive Summary at p 72.

> For much of the period under investigation, social attitudes were such that unmarried pregnant women were expected go away quietly, have the baby and place it for fostering or adoption and then resume life as if nothing had happened. Little consideration was given to how the mother felt about it. One commentator observed "the mother who has given birth was expected to do the decent thing and disappear".[278]

If this is an accurate description of the prevailing social landscape (and there is every reason to believe that it is), then a considerable number of women who entered Mother and Baby Homes and signed consent forms in respect of the adoption of their babies would have done so in circumstances directly analogous to *DG and MG*.

Testimony received by the Investigative Committee from multiple women spoke to a consistent theme of pressure being applied by parents and other actors in the adoption process. The Commission Report notes:

> Parental pressure was a big factor with seven women stating they felt categorically that this pressure was so intense that they "did not feel responsible for making the adoption decision". Adoption societies were also considered to be a source of pressure. Sixteen of the women described them as unhelpful saying they colluded "in compelling them towards adoption".[279]

> A witness who was involved with the Irish First Mothers group told the Commission "that there was a lot of emotional pressure put on mothers". She said that, in her case, her father was standing over her when she was asked to sign the adoption consent at the office of a commissioner for oaths. "I don't remember getting a chance to read the document because of the trauma I was feeling … we were never told what choices we had". Others who gave evidence also complained of strong parental pressures.[280]

The Report cites a 2005 study by Ruth Kelly of unmarried mothers who placed their children for adoption between the 1950s and 1970s in which none of the mothers who participated in the study "considered they had any real choice when it came to signing adoption consents".[281] It also details a case in which a woman in Dunboyne made a complaint to the Gardaí that she had been pressured into signing an adoption consent form.[282] The Confidential Committee Report provides more detail on the specifics of the types of pressure exerted on mothers by parents, priests and nuns:

> This next witness gave birth to her son in 1970 when she was 21 years old. When she was back in the family home, the parish priest put pressure on her to give the baby up for adoption, warning her that "no bastard child will enter my school". Subsequently,

278. Commission Report at [32.162].

279. Commission Report at [32.236].

280. Commission Report at [32.193].

281. R Kelly, *Motherhood Silenced: Reflections of Natural Mothers on Adoption Reunion* (Liffey Press, 2005), cited at Commission Report at [32.235].

282. Commission Report at [24.94] to [24.96]. The Garda Report states that the mother "was told that an illegitimate child grew up to hate its parents and in her case it would be the mother". Remarkably, the Garda concluded that "[o]ther than that point no pressure was placed on her to part with the child". The nuns informed that Garda that women were "encouraged to part with their babies for the reasons set out earlier and nothing irregular occurred in this instance".

"one day, some women carrying documents" arrived at her home—she had no idea who they were. "They gave her no choice" she said but forced her to sign the documents. This witness told the Committee that she had no idea where her child is and "no one would tell her".[283]

Another witness told the Committee that she gave birth in a mother and baby home in the late 1960s and described the following. Having said to a nun in the home that her plan was to go to England with her baby to stay with her sister, the response to the witness was: "That doesn't happen here. You'll do what we tell you and that's it. You're not keeping that baby. You're going nowhere with that baby. You're going home and the baby is going somewhere else". The witness told the Committee that after that conversation, the nun contacted the sister of the witness to tell her that the witness had decided to have her baby adopted. "This", the interviewee said, "was not true". She was then, she said, "brought to a room with a chair and a desk where I was told to sign the piece of paper put in front of me" and when she refused to comply, she said, she was "dragged down the corridor by the nun to an office where I was made to sign the paper". After this, she and another mother from the home were brought to what she thinks was a solicitor's office where she "swore an oath and signed another document and paid the solicitor half a crown".[284]

This next witness claims she was blackmailed. One day, in the early 1960s when she was 16 years old and having given birth to a baby in a mother and baby home, she was told by the nuns that her grandmother was dying and that she should go and visit her. When she arrived home, she found that her grandmother was not dying. She also found that it had been her mother, in concert with the nuns in the home, who had arranged for her to be absent so that her baby could be taken quietly. "I think of my baby as having been kidnapped", she said to the Confidential Committee. Later, her parents wrote to her in the UK, where she and her boyfriend, her child's birthfather, were "trying to get things together" so they could get the baby back and set up home. In that letter, her parents wrote that she had "one week" to sign adoption papers or the baby will end up in an orphanage. "That", she said, "was blackmail".[285]

Then there was the witness, 15 years old in 1972, when she gave birth to her child; "one day", she said, "one of the nuns sat me down for lunch" and by the time she got back to the nursery her baby was gone. When she left the home, "a priest visited her, put papers in front of her and told her to 'shut her mouth and sign'."[286]

The similarity between the circumstances described here and Laffoy J's test for free informed consent from *DG and MG* is evident. The testimony on this point did not only come from the women themselves. The Confidential Committee cites testimony from social workers to very similar effect:

283. Confidential Committee at p 102.
284. *Ibid* at p 95.
285. *Ibid* at p 96.
286. *Ibid* at p 102.

> They voiced the opinion that this culture was "systemic" and "a belief system", in that adoption was promoted as the "better option" and that in any event, by having come into a mother and baby home in the first place, the expectation was thereby that women would see this "better option" as the only realistic one and therefore would select it. In addition, these professionals said, this pressure to adopt was strengthened by default because in the mother and baby homes there was "no talk around pressure on the women to keep their babies".[287]
>
> From the time pregnancy was discovered, or was about to "show", many women and girls were banished from view, staying out of it all the way through giving birth and its immediate aftermath. Customarily at the behest of families (or, rarely, on their own initiative if they were more mature) they were sequestered behind the walls of mother and baby homes, coming home—if they were allowed home—with no baby to be seen or even mentioned, the story for neighbours and wider family carefully prepared. As already mentioned, these daughters were "going to or returning from boarding school" or from "work experience" in distant towns; from "working in England"—or from "living with an aunt and uncle for a few months in London"—or elsewhere, remote from her home.[288]
>
> The professionals who came to the Committee indicated that some of those who had rowed back on their original decision to choose adoption and had attempted to keep their children, were the ones who were subject to the greatest pressure. These pressures became intolerable because they were not just from the nuns in the homes, but from what was, in practice, an alliance of authorities, including their families (in many cases assisted by priests) all members of which were angry at the change of heart and adamant that adoption had been the first and was now the only choice. In some cases, this pressure was couched morally: ("You're being selfish; your baby will have a great life with a lovely family and will get a great education. What can someone like you offer?")[289]

In order to fully appreciate how vulnerable and disempowered these women were, it is essential to place the interactions during the consent process described above in the broader context of the women's circumstances and their treatment in the Mother and Baby Homes. As we know, these women were facing the stress and trauma of a crisis pregnancy (in some cases as a result of rape or incest) in a society where this was considered shameful. Furthermore, as shown throughout this Chapter, this trauma was likely compounded in many cases through multiple rights violations in the time period between becoming pregnant and signing the consent form (including inhuman and degrading treatment, forced labour and deprivation of liberty)—all at the hands of the same people who were administering the adoption process (including the signing of the consent forms). Representatives of the Council of Irish Adoption Agencies gave evidence to the Commission that it was their view that "considering that the mother was virtually incarcerated

287. *Ibid* at p 86.
288. *Ibid* at p 87.
289. *Ibid* at p 88.

in the Home the question of her consent being 'full, free and informed' was rendered moot".[290] Indeed, it might be questioned whether some women who were extremely traumatised and who lacked any support had the functional capacity to consent to the adoption of their child, since their vulnerability, maturity and the extreme stress of the situation may have compromised their ability to understand the information being presented at the relevant time; their ability to comprehend the consequences of the decision being made; and their ability to reason and consider options.[291]

The above material shows that notwithstanding the statement to the contrary in its Executive Summary, the Commission Report does in fact contain a range of evidence that would corroborate the witness testimony provided by women who say that they felt at the time that they were forced into signing consent forms to adoption. Pressure was exerted on them by parents and other actors in the adoption process; and there was a clear expectation that adoption was the only option, and that the pregnancy and adoption were to be concealed. This is directly analogous with the circumstances that led the High Court to declare the consent to adoption invalid in *DG and MG*. The passage of time makes it unlikely that any other or better evidence would be available, as in the majority of cases, other individuals present at the time will be deceased by now. While it is not possible to say definitively here whether consent to adoption was valid in individual cases, it is possible to say that on balance, the Commission Report provides sufficient evidence to say that it is likely that a considerable number of adoptions arranged in Mother and Baby Homes were based on consents which did not meet the legal test for free consent. This raises the question of whether an accessible and effective remedy was available to women in such cases; this point will be discussed in section 3.6.3 below. Before coming to that point, it is necessary to consider other ways in which the Report includes evidence regarding defective or absent consents.

3.6.2.2 Mothers with no memory of consenting

Aside from the issue of women being forced to consent to adoptions, the Report repeatedly touches on a different theme: women who have no memory of signing a consent form. For example, one witness told the Investigative Committee:

> … I have no recollection of signing papers. It is possibly something that I did but it doesn't stand out for me. I don't have this memory of signing away my baby … But I obviously did, I'm sure I did otherwise it wouldn't have happened. I don't know if I knew the full implication of it, but I did, I knew that I had no choice I think, so that was it.[292]

Others gave similar testimony to the Confidential Committee:

> This next witness, who gave birth to a baby boy in 1965, was told from the start that her baby would be going to the USA and was never allowed to touch him or speak

291. On capacity to consent and the impact of vulnerability and stress, see further PS Applebaum, "Assessment of patients competence to consent to treatment" (2007) 357 *The New England Journal of Medicine* 1834; JP Spike, "Informed consent is the essence of capacity assessment" (2017) 45 *The Journal of Law, Medicine & Ethics* 95; C Seth Landefeld *et al*, "Use of a modified informed consent process among vulnerable patients" (2008) 21 *Journal of Internal General Medicine* 867; P Morgado, N Sousa and JJ Cerquiera, "The impact of stress in decision-making in the context of uncertainty" (2015) 93 *Journal of Neuroscience Research* 839, and S Pabst, M Brand and OT Wolf, "Stress effects on framed decisions: there are differences for gains and losses" (2013) 7 *Frontiers in Behavioural Neuroscience* 142.

292. Commission Report at [20.133].

about him. Like many others, she has no memory of ever signing anything, nor was anything explained and as the years passed, she "sometimes questioned whether she had even had a child".[293]

One witness was 19 years old when she gave birth in 1967 in a home. She had had no idea her child would be taken—and certainly not in the way he was. Three weeks after he was born, a nun came into the nursery and "snatched" him from her. Another nun came to talk to her because she was "totally distraught" but the witness "punched her and tried to yank her veil off". Her mother collected her from the home two weeks after that, took her to the airport to send her to an aunt and uncle in the UK and told her "not to come back". The witness insists she never signed an adoption consent form.[294]

It is possible that accounts like this might be attributable to the suppression of traumatic memories, although it should be noted that the scientific debate on the existence of this phenomenon has not reached a consensus.[295] An alternative explanation might be that in at least some cases, the mother actually did not sign a consent form; someone else involved in the process forged her signature. The Commission Report states in Chapter 32 that while some women "who had no memory of signing recognised their signature on the adoption papers when they viewed them later", others "said that they had subsequently seen the forms in the adoption society files and they asserted that the signatures were not theirs".[296] One passage from the Confidential Committee Report gives rise to a distinct suspicion that a signature may have been forged in that case:

Earlier in the 1950s, a 16 year old girl became pregnant, she said, having been raped by a priest. She too went into a home and had her baby there, and then: "A nun took my baby away", she said to the Committee, "and that was the last I saw of him. It was terrible the way they took the child away without telling you (this was going to happen)." As in previous stories, this witness said she later saw an adoption record which appeared to have her signature on it. "I couldn't have signed it", she told the Committee "because at the time, I didn't know how to read or write". She acquired these skills she said, only after leaving the home.[297]

Another passage speaks to the falsification of numerous details on adoption documentation:

A witness had to ask for assistance, when she was unable to spell the Christian name, when she was "told" to write it on the document she was given to sign. Having become pregnant at the age of 15, she told the Committee that her baby was registered for

293. Confidential Committee at p 96.

294. *Ibid* at pp 98-99.

295. For a brief summary, see L Newman, "Do trauma victims really repress memories and can therapy induce false memories?", *The Conversation*, 9 October 2017. Some recent literature includes IM Englehard *et al*, "Retrieving and Modifying Traumatic Memories: Recent Research Relevant to Three Controversies" (2019) 28 *Current Directions in Psychological Science* 91; H Otgaar *et al*, "The Return of the Repressed: The Persistent and Problematic Claims of Long-Forgotten Trauma" (2019) 14 *Perspectives on Psychological Science* 1072; and A Mary *et al*, "Resilience after trauma: The role of memory suppression" (2020) 367 *Science* 756.

296. Commission Report at [32.161].

297. Confidential Committee at pp 91-92.

> adoption under false names, both Christian and surname, her name also inserted incorrectly, none having any connection to the real names. These "made-up names" were used, she was told at the time, so that she could not be traceable as having had a child, a subterfuge, she said, that had been at the behest of her mother and aunt … This witness concluded this section of her evidence by saying to the Committee: "there was a crime committed by the nuns because they registered me and my baby in another name" adding that she had also reported the matter to the Gardaí.[298]

It is now well documented that in at least one adoption agency, birth certificates were falsified in the course of children being placed for adoption.[299] In a similar vein, a detailed investigation in the *Irish Examiner* by Conall Ó Fátharta has documented a case of a mother being instructed by a nun to sign a false name on an adoption consent form.[300] Forging a signature on a consent form is not a big leap from either of these documented practices. Given the overall context detailed above, and the "belief system" referenced in the Commission Report that adoption was the "better option" for children of unmarried parents, the possibility that signatures were forged on consent forms in lieu of obtaining consent from the mother is very real. In such a case, the question of whether a consent was freely given or not does not arise, because there was no consent of any sort, whether given freely or under coercion. Having said that, on the evidence available in the report, it is not possible to say anything more than that there was a risk of such forgery occurring. Further investigation would be required to make any stronger comment on this point.

3.6.3 Availability of Effective Remedy for Defective Consent

It is clear from records of the Dáil Debates leading up to the enactment of the Adoption Act 1952 that members of the Oireachtas were aware of the risk that consent to adoption might not always be freely given and/or fully informed; indeed, amendments to the legislation were proposed as a response to this risk.[301] Following its enactment, section 14(1) of the Act provided that "[a]n adoption order shall not be made without the consent of every person being the child's mother or guardian or having charge of or control over the child". Section 15(3) of the Act required the Adoption Board to "satisfy itself that every person whose consent is necessary and has not been dispensed with has given consent and understands the nature and effect of the consent and of the adoption order."

Section 39 made it an offence for adoption societies (as well as for every person who took part in their management or control and every person concerned in the acceptance of the child on behalf of the society) to accept a child for placement for adoption without furnishing the mother or guardian with a statement in writing in the prescribed form explaining clearly the effect of an adoption order upon their rights, and the provisions of the 1952 Act relating to consent to the making of an adoption order. Adoption societies were required to ensure that the mother or guardian understood the statement and that they signed a document to that effect. Forgery of signatures on consent forms would have

298. *Ibid* at p 99.

299. See Commission Report, [32.390] to [32.419].

300. C Ó Fátharta, "Special Report: Women forced to give up babies for adoption still failed by State bodies", *Irish Examiner*, 3 December 2018.

301. Commission Report at [32.91] to [32.92].

been a criminal offence under section 43 of the Act, which made it an offence to knowingly make any false statement or furnish any false information to the Adoption Board.

A birth mother who felt that her consent to an adoption had not been freely given and/or fully informed could challenge the validity of the adoption order by way of High Court proceedings. Thus, in theory at least, Irish law provided a remedy to women who signed a consent form to adoption as a result of pressure applied by parents or other actors in the adoption process. However, the reality would in all likelihood have been very different for many women who placed children for adoption in Mother and Baby Homes. High Court litigation was at all times an extremely expensive undertaking. Civil legal aid was not introduced in Ireland until 1979; prior to this, the vast majority of women affected would have had no realistic possibility of instituting such proceedings. (It is significant in this respect that in *Airey v Ireland* in 1979, the ECtHR ruled that the absence of civil legal aid in family law proceedings in Ireland violated the right to a fair trial under Article 6 and the right to family life under Article 8 of the ECHR).[302] Women who had given birth in a Mother and Baby Home would have had no access to the resources necessary to fund such proceedings for years after the event; and parents who pressured them into the adoption would not have been minded to provide the necessary support. Moreover, many women were traumatised by their experience and had been shamed and conditioned into keeping the whole matter secret. The Confidential Committee Report details witnesses who were, when testifying to the Committee, speaking about their experiences for the first time;[303] one woman used the word "shame" nearly 20 times in her interview.[304] The shaming experienced by these women would have acted as a further impediment to bringing court proceedings.

In *Selmouni v France*, the ECtHR, when explaining an exception to the rule that normally requires that all domestic remedies must be exhausted before making an application to the Court, described the characteristics of an effective remedy within the meaning of the ECHR:

> … the only remedies which Article 35 of the Convention requires to be exhausted are those that relate to the breaches alleged and at the same time are available and sufficient. The existence of such remedies must be sufficiently certain not only in theory but also in practice, failing which they will lack the requisite accessibility and effectiveness; it falls to the respondent State to establish that these various conditions are satisfied …[305]

302. 6289/73, 9 October 1979 at [24]: "In Ireland, a decree of judicial separation is not obtainable in a District Court, where the procedure is relatively simple, but only in the High Court. A specialist in Irish family law, Mr. Alan J. Shatter, regards the High Court as the least accessible court not only because 'fees payable for representation before it are very high' but also by reason of the fact that 'the procedure for instituting proceedings ... is complex' … Furthermore, litigation of this kind, in addition to involving complicated points of law, necessitates proof … to establish the facts, expert evidence may have to be tendered and witnesses may have to be found, called and examined. What is more, marital disputes often entail an emotional involvement that is scarcely compatible with the degree of objectivity required by advocacy in court. For these reasons, the Court considers it most improbable that a person in Mrs. Airey's position … can effectively present his or her own case." See also [33]: "In Ireland, many aspects of private or family life are regulated by law … Effective respect for private or family life obliges Ireland to make this means of protection effectively accessible, when appropriate, to anyone who may wish to have recourse thereto. However, it was not effectively accessible to the applicant … [s]he has therefore been the victim of a violation of Article 8 (art. 8)."

303. Confidential Committee at p 98.

304. *Ibid* at p 99.

305. 25803/94, 28 July 1999 at [75].

In light of the contextual factors described above, it is strongly arguable that for many women who were pressured into placing children for adoption in Mother and Baby Homes, High Court proceedings were not a remedy which was "sufficiently certain not only in theory but also in practice". They were therefore not an effective remedy within the meaning of Article 13 of the Convention. In any case in which a woman's consent represented the will of someone else rather than her own, and in which High Court proceedings to challenge the adoption order were not a realistic and accessible avenue, it can be strongly argued that the right to family life under Article 8 was violated by the adoption.

3.7 VACCINE TRIALS

3.7.1 Article 8 ECHR

As noted in section 3.6.1 above, Article 8(1) of the ECHR protects the right to private life while Article 8(2) provides that any interference with this right must be "in accordance with the law". The ECtHR has delivered numerous judgments recognising that the right to "physical integrity" falls within the scope of the right to private life under Article 8, and emphasised the importance of obtaining "free, express and informed" consent to medical treatment.[306] When considering the right to private life under Article 8, the former European Commission on Human Rights (since subsumed into the ECtHR) stated in *X v Austria* in 1979 that "[a] compulsory medical intervention, even if it is of minor importance, must be considered as an interference with this right".[307] This statement has been repeated by the Commission and the Court in several judgments since then.

In *X and Y v Netherlands*, the Court held in 1985 that the right to private life under Article 8 encompasses a right to physical integrity.[308] This was reiterated by the Court in the case of *Pretty v United Kingdom* in 2002[309] where it was held that "the imposition of medical treatment, without the consent of a mentally competent adult patient, would interfere with a person's physical integrity in a manner capable of engaging the rights protected under Article 8 § 1 of the Convention".[310] In *YF v Turkey*, which concerned the right to physical integrity, the Court reiterated the Commission's position in *X v Austria* and held that "a person's body concerns the most intimate aspect of private life. Thus, a compulsory medical intervention, even if it is of minor importance, constitutes an interference with this right".[311]

Specifically in relation to children's rights in the sphere of medical intervention without consent, there are a number of cases of interest. For example, the case of *Glass v United Kingdom* in 2004 concerned diamorphine treatment given to a severely sick child at a hospital against his mother's wishes. The ECtHR held that the mother's "objections were overridden" and "that the decision to impose treatment" on the child "in defiance" of his mother's objections gave rise to an interference with the child's "right to respect for his

306. See, eg, *Glass v United Kingdom* (61827/00, 9 March 2004) at [70] and [82].
307. *X v Austria* (8278/78, 13 December 1979) at p 156.
308. *X and Y v Netherlands* (8978/80, 26 March 1985) at [22].
309. *Pretty v United Kingdom* (2346/02, 29 April 2002) at [61].
310. *Pretty v United Kingdom* (2346/02, 29 April 2002) at [63].
311. *YF v Turkey* (24209/94, 22 July 2003) at [33].

private life, and in particular his right to physical integrity".[312] The Court found that "it cannot be stated with certainty that any consent given was free, express and informed",[313] and held that "the decision of the authorities to override the … [mother's] objection to the proposed treatment in the absence of authorisation by a court resulted in a breach of Article 8 of the Convention".[314]

Further, in *MAK and RK v United Kingdom* in 2010, the Court considered circumstances where a blood test and photographs were taken of a nine-year-old child in a hospital without the consent of her parents. The child's father expressly stated that the hospital should wait until the child's mother was present to obtain her consent for any medical interventions, and this was repeated by the child's mother on a telephone call with the hospital. The photographs were taken of the girl's thighs as she had a number of bruises and the doctor suspected that they were as a result of sexual abuse. Citing UK domestic law as well as the Council of Europe's Convention on Human Rights and Biomedicine,[315] the Court stated that "[w]here the patient is a minor, the person with appropriate authorisation is the person with parental responsibility".[316] It continued that "[i]n view of her parent's express instructions, the only possible justification for the decision to proceed with the blood test and photographs was that they were required as a matter of urgency", and found that no such circumstances existed in this case.[317] The Court held that "the decision to take a blood test and photograph the [child] against her parents' *express instructions gave rise to an interference with her right to respect for her private life and, in particular, her right to physical integrity*".[318]

Two other cases address children's rights in the context of medical interventions without consent but it is important to note that these cases concern legally mandated childhood screening and immunisation programmes rather than physical interventions without either consent or a legislative basis. In 1984, the Commission delivered judgment in the case of *Acmanne v Belgium*, which concerned a refusal by parents of "under age children" and secondary school teachers to "to undergo, or let their children undergo, compulsory screening for tuberculosis by tuberculin skin-reaction test or by chest x-ray".[319] The Commission reiterated that "even minor medical treatment against the patient's will must be regarded as an interference with the right to respect for private life".[320] However, as per Article 8(2), this interference must be "in accordance with the law" and "necessary in a democratic society … for the protection of health". On the facts of this case, the Commission held that the compulsory screening was in accordance with the law, as set out in specific Belgian legislation in the "School Medical Inspection Act of 21 March 1964" and the accompanying Royal Order, as amended.[321] Further, the Commission held that "the

312. *Glass v United Kingdom* (61827/00, 9 March 2004) at [70].

313. *Ibid* at [82].

314. *Ibid* at [83].

315. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Council of Europe, Oviedo, 4 April 1997), available at https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168007cf98.

316. *MAK and RK v United Kingdom* (45901/05 and 40146/06, 23 March 2010) at [77].

317. *Ibid* at [79].

318. *Ibid* at [75].

319. *Acmanne v Belgium* (10435/83, 10 December 1984) at p 254.

320. *Ibid* at p 255.

321. *Ibid*.

interference was justified to protect both public health and the applicants' health".[322] The Commission cited the Court of Appeal in Liége which noted "that the applicants had not produced evidence of disadvantages comparable to the former ravages of tuberculosis, particularly among the deprived" and that "the individual had a social duty to defer to the general interest and not endanger the health of others where his life was not in danger".[323] It was held that the interference was "proportionate to the aim pursued" and "necessary to protect health in a democratic society within the meaning of Article 8 para. 2 of the Convention".[324] This case underlines the need for a concrete legislative basis in domestic law for any measures which interfere with the right to physical integrity as encompassed in the scope of the right to private life under Article 8.

Judgment in the case of *Vavricka v Czech Republic* was delivered in April 2021, and concerned parents' refusal for their children to take vaccinations as part of a childhood vaccination programme in the Czech Republic.[325] While the Court's case law has established that "compulsory vaccination, as an involuntary medical intervention, represents an interference with the right to respect for private life within the meaning of Article 8 of the Convention", the Court must consider whether this interference "was 'in accordance with the law', pursued one or more of the legitimate aims specified therein, and to that end was 'necessary in a democratic society'".[326] The Court found that the interference was in accordance with the law. (This judgment is discussed in detail in section 4.2.2.1 of this report.)

3.7.2 Vaccine Trials within the Commission's Remit

It has been well documented over a number of decades that many babies and children in the care of religious orders and the State were involved in vaccine trials.[327] These trials have raised multiple legal and ethical issues with specific, known, contraventions of domestic Irish legislation such as the Therapeutic Substances Act 1932, as well as international ethical standards such as the Declaration of Helsinki.[328] These trials were extremely invasive involving many blood samples being taken from babies and children; babies and children "being bled"; repeat injections, and rectal temperatures being taken in some trials for fourteen days in a row following an injection.[329] It is clear that these procedures amount to an interference with the right to private life and in particular, the right to physical integrity. Vaccine trials involved babies as young as three months old. In

322. *Ibid*.

323. *Ibid*.

324. *Ibid* at p 257.

325. *Vavricka v Czech Republic* (47621/13, 8 April 2021).

326. *Ibid* at [263] and [265].

327. See, eg, J Kiely, *Report on Three Clinical Trials involving babies and children in institutional settings 1960/61, 1970 and 1973* (Department of Health, 1997), available at https://www.lenus.ie/handle/10147/249856. See also details of work on vaccine trials undertaken by the Commission to Inquire into Child Abuse until such point as it was declared *ultra vires* the Commission, available at http://www.childabusecommission.ie/vaccinetrials/index.html.

328. Reports prepared by Dr James Kiely and Thomas McGuinn are cited by the Commission, confirming that some trials were not in compliance with the relevant law in place in Ireland at the time, namely the Therapeutic Substances Act 1932; see Commission Report at [34.58] to [34.61]. See also [34.95], which outlines that the Wellcome's MV27 measles vaccine trial was in contravention of the Declaration of Helsinki which requires "results of all clinical trials involving human subjects" be published. The results of this trial were not published.

329. Rectal temperatures were taken every day for fourteen days after vaccination for two measles trials, as reported at Commission Report at [34.83] and [34.104]. Reports of children "being bled" is described in respect to the Glaxo Laboratories measles vaccine; see Commission Report at [34.121].

one trial, which took place in 1973, testing Wellcome Diphtheria, Tetanus and Pertussis (DTP), "[t]wo of the children were recorded as having Downs' Syndrome; another had Crouzon Syndrome (Facial Deformity); another had Congenital Talipes Equino-Varus (Club Foot) and another had Congenital Heart Disease". Many trials referred to babies and children as being "'mixed race'".[330] In a "suspected oral polio vaccine trial" in 1965, "[e]ight of these children were described as 'mentally retarded', 'backward' or 'of low intelligence'. Others had physical disabilities and associated notes which read 'child won't walk', 'not lifting head', 'underdeveloped child', 'enlarged heart and partially deaf' and 'no teeth, large head'".[331]

Many of the vaccine trials were not licenced under the Therapeutic Substances Act 1932. An import licence was not held for four of the seven vaccine trials examined by the Commission Report.[332] In addition, research licences had not been issued for four of the seven trials.[333] There are also no records of import licences for the infant milk trials but the Commission was unclear as to whether one was necessary under the Act of 1932.[334]

It is evident that consent was not sought or obtained from parents or guardians in respect of some of the vaccine trials.[335] In the case of one trial, an article published in the British Medical Journal "thanked five medical officers who they stated 'had granted them permission to carry out this investigation on infants under their care'".[336] Babies and children in Mother and Baby Homes were treated differently to those in the "general population", where it was routine to obtain parental consent. For example, in respect to the trials carried out by Dr Denis Hanley on Wellcome's APT anti-diphtheria vaccine in 1934-1935, the Commission Report noted that "... health authorities insisted on obtaining written parental consent before inoculating children. This applied to children treated in the city schools and to children treated in municipal public health clinics". Further, Dr Hanley's published report "emphasised the importance of obtaining written consent prior to treatment and provided a breakdown of the number of consent forms returned in each school. No child was immunised unless a written parental consent form was produced". Notably, "Dr Hanley made no mention of consent, written or otherwise, in respect of institutional children".[337]

At one point, the Commission Report states that:

> The decision to undertake initial tests of the vaccine among vulnerable institutional children before rolling it out to the general population would not be regarded as acceptable practice today. However, even a cursory perusal of the most respected medical journals demonstrates that such practices were accepted in all jurisdictions in the early twentieth century and predated any codification of ethical standards pertaining to clinical research in human subjects.[338]

330. Commission Report at [34.143].
331. Commission Report at [34.162].
332. Commission Report at [34.57] to [34.59], [34.115] and [34.150].
333. Commission Report at [34.57]; [34.60] to [34.61]; [34.116]; [34.124], and [34.152] to [34.154].
334. Commission Report at [34.188].
335. Commission Report at [34.62] to [34.72]. This was confirmed in respect of the Quadrivax trial and the Wellcome MV27 measles vaccine.
336. Commission Report at [34.65].
337. Commission Report at [34.38].
338. Commission Report at [34.39].

This conclusion is difficult to reconcile with a later passage in the Report which cites Dr Hanley in an article entitled 'Anti-diphtheria immunization', published in the Irish Journal of Medical Science, in 1937:

> It was accepted best practice in general immunisation schemes at the time in Ireland that the consent of the relevant person should be in writing. Written parental consent was a prerequisite for children receiving immunisation under a local authority immunisation scheme since at least 1935. School children who did not produce a written consent form were not eligible for immunisation.[339]

Further, children in Irish institutions were also treated differently to children in institutions in the UK. Indeed, according to the Commission, "[t]he requirement to get consent for vaccine trials was very well known and respected in the conduct of such trials in the UK".[340] The Commission cited two published articles in the British Medical Journal in 1961 which discussed the requirement to obtain consent from parents for vaccine trials with children. One of these articles, for example, involved a Wellcome Foundation "measles vaccine trial involving 85 institutional British children". As the Commission reported, the researchers "explicitly stated that 'parental consent for the vaccination of these children was obtained'".[341] Further, parental consent was always obtained for children from the general population in the UK.[342]

Although parental consent was sought for some vaccine trials, capacity to consent was an issue in some cases involving mothers who were reported as having "mental health issues".[343] This was the case for the (4 in 1) vaccine 'Quadrivax'" carried out in 1960-1961 by Professor Meenan and Dr Hillery involving 68 young babies and children. The Commission reported that records in Bessborough, Pelletstown, Dunboyne and Castlepollard showed that "[t]here is no evidence that consent was properly sought or received" for Quadrivax.[344] Three of the mothers of the babies in the "Wellcome's MV27 measles vaccine" trial in Sean Ross in 1964 were under 18 years old and one mother "was described as 'mentally retarded' by a family member".[345] No consent from parents or guardians appears to have been sought or obtained. In the Quintuple 5 in 1 trial, two of the mothers were under the age of 18 years, one had a "'very low mentality' and another had suffered a 'nervous breakdown'".[346] There is no evidence of consent being sought or obtained by parents or guardians. In the 1973 trial of DTP, "at least seven of the mothers had psychiatric disorders or were recorded as being 'mentally handicapped'" while one mother was just 15 years old.[347]

339. Commission Report at [34.63].
340. Commission Report at [34.62].
341. Commission Report at [34.62].
342. Commission Report at [34.97] to [34.99].
343. Commission Report at [34.52].
344. Commission Report at [34.57].
345. Commission Report at [34.86].
346. Commission Report at [34.113].
347. Commission Report at [34.143].

3.7.3 "Adverse consequences"

The Commission reported on a large cohort of babies and children getting sick after a second inoculation in the Quadrivax trial, but insufficient evidence saw the trial lead state that "he suspected that the second inoculation had coincided with an outbreak of influenza in the institution".[348] Meanwhile, the Commission found no evidence of "adverse consequences" in respect to the measles vaccine trial in Sean Ross[349], while "one child died of cardiac and respiratory failure two weeks after receiving the first injection" in the Quintuple 5 in 1 vaccine administered in 1965. The Commission concluded in that case that "available medical records do not suggest that this child's death was in any way linked to the vaccine".[350] It stated that it was unable to conclude as to whether there were any adverse consequences in respect to the Glaxo Laboratories measles vaccine as it had not identified the babies and children involved.[351] Meanwhile, "[a] significant number of adverse reactions were reported among children" who were given "Wellcome's commercial 'off the shelf' Trivax and Trivax AD vaccines" in 1973 and two children were hospitalised with "'infantile spasms'".[352]

Some very negative reactions were recorded in relation to the infant milk trials in Bessborough and Pelletstown in 1968-1969. Babies were recorded as suffering from "moderate to severe vomiting, moderate to severe wind, loose stools and green stools".[353] In one of the trials, it was reported that "all infants in this group suffered continuous slight vomiting and regurgitation, that stools were undigested and that vomits contained large curds"[354], while in another trial, two babies "experienced 'violent vomiting' in reaction to the feed".[355] The Commission was unable to identify the babies and children involved in these. It is evident from considering the Commission's report that some trials made some young babies and children very sick. These trials inevitably raise questions for survivors, meaning that access to their medical information is crucial.

3.7.4 Access to Information

The Commission has outlined the trials in which it has identified the babies and children involved but it has been unable to do so in every trial.[356] A significant amount of information in relation to these vaccine trials appears to be missing, either because it was not recorded, or where it was recorded, it has not been shared with the relevant parties. Most importantly, many former residents of Mother and Baby Homes (or their relatives where they are deceased) do not have access to information about whether or not they were involved in vaccine trials. Indeed, some former residents have stated that they know that they were given vaccines when they were babies or children and despite

348. Commission Report at [34.75].
349. Commission Report at [34.96].
350. Commission Report at [34.118].
351. Commission Report at [34.125].
352. Commission Report at [34.137].
353. Commission Report at [34.175] and [34.177].
354. Commission Report at [34.175].
355. Commission Report at [34.185].
356. The Commission has not identified the babies and children involved in the Glaxo Laboratories measles vaccine; see Commission Report at [34.123].

this, they still cannot access information about which vaccines, and how many vaccines, they received.[357]

The right to access health and medical information is protected under Article 8 ECHR. In *Gaskin v United Kingdom*, the Court stated that persons "have a vital interest, protected by the Convention, in receiving the information necessary to know and to understand their childhood and early development".[358] While the Court confirmed the importance of confidentiality in respect of third parties in that case, it nevertheless held that "the interests of the individual seeking access to records relating to his private and family life must be secured when a contributor to the records either is not available or improperly refuses consent".[359]

In *McGinley and Egan v United Kingdom*, the applicants complained that their "Article 8 rights to respect for their private and family lives had been violated by the withholding of documents which would have assisted them in ascertaining whether there was any link between their health problems and exposure to radiation".[360] This case concerned atmospheric tests of nuclear weapons by the United Kingdom in the Pacific Ocean and at Maralinga, Australia, between 1952 and 1967. The Court stated that "the issue of access to information which could either have allayed the applicants' fears … or enabled them to assess the danger to which they had been exposed, was sufficiently closely linked to their private and family lives within the meaning of Article 8 as to raise an issue under that provision".[361] While the Court found that there was no violation of Article 8, this was based on the fact that there was a procedure available in the United Kingdom for the applicants to request such information and they had failed to do this. In *Roche v United Kingdom*, the Court held that the State has a "positive obligation to provide an effective and accessible procedure enabling the applicant to have access to all relevant and appropriate information that would allow him to assess any risk to which he had been exposed during his participation in the tests".[362]

3.7.5 Comment

As outlined in section 3.7.1 above, the case law of the ECtHR establishes that medical interventions which are not urgent, no matter how minor, require either legal authorisation or the consent of the patient. Where the patient is a child, the consent of the parent(s) is required. Consent to medical treatment, where given, must be given by a mentally competent adult.[363] The Commission Report provides clear evidence that vaccine trials took place in Mother and Baby Homes which had no basis in domestic law (and in fact contravened aspects of domestic law applicable at the time), and in which parental consent was either entirely absent or arguably invalid due to issues relating to mental capacity and competence. These trials were not conducted in secret; in fact, they were documented

357. Prime Time, "Anatomy of a Scandal", 9 June 2014, available at https://www.rte.ie/news/primetime/2014/0609/622696-prime-time-anatomy-of-a-scandal/.

358. *Gaskin v United Kingdom* (10454/83, 7 July 1989) at [49].

359. *Ibid.*

360. *McGinley and Egan v United Kingdom* (21825/93 and 23414/94, 9 June 1998) at [67].

361. *Ibid* at [97].

362. *Roche v United Kingdom* (32555/96, 19 October 2005) at [167].

363. *Pretty v United Kingdom* (2346/02, 29 April 2002) at [63].

in contemporaneous articles published in medical journals (which acknowledged that consent to participation by the infants had not been given by their parents). For this reason, it can be argued that even if the State was not aware of them, it ought to have been. The continuation of the trials over a period of several decades illustrates that no steps were taken to enforce existing laws or to put an end to the trials. Inadequacies in records of the trials make it impossible for people involved in them to establish the nature and extent of their involvement. The combined effect of these factors, when weighed against the case law of the ECtHR, suggests that most if not all of the vaccine trials considered in the Commission Report involved violations of Article 8 of the ECHR. Other vaccine trials outside of the remit of the Commission may also have done so.

3.8 DISCUSSION AND RECOMMENDATIONS

The purpose of this analysis has been to consider the extent to which the evidence produced in the Commission Report indicates that rights with a child protection dimension protected by the ECHR may have been violated in Mother and Baby Homes, County Homes and foster homes. This analysis is important because the Commission did not apply an explicit international human rights framework in its approach to assessing the relevant evidence. As a result, the conclusions that follow depart from the Commission Report to varying degrees. At times, they are a different way of expressing a conclusion that is similar to that reached by the Commission. At other times, they address a point not considered by the Commission. In several important respects, the conclusions of this Chapter are materially different to the conclusions reached in the Commission Report, for the reason that although they consider the same evidence, they assess that evidence by reference to different principles and reasoning to those relied on by the Commission.

In summary, all of the themes considered in this Chapter disclose substantial evidence cited in the Commission Report that is indicative of violations of provisions of the ECHR. This evidence includes witness testimony given on oath to the Investigative Committee and documentary evidence cited in the main volume of the Report, and it is corroborated by a substantial volume of testimony cited in the Confidential Committee report. The main points to highlight are as follows:

3.8.1 Right to Life (Article 2 ECHR)

The Commission Report provides evidence that a significant number of infants died in Mother and Baby Homes and County Homes due to poor living conditions, overcrowding, and inadequate medical care. Many of these deaths were readily preventable. State Authorities were aware of the high rate of deaths in the 1930s and 1940s, but failed to implement effective measures to mitigate the risk of death faced by infants in the Homes. As a result, the high death rate continued through the 1950s and into the 1960s. The evidence produced in the Commission Report on infant deaths is indicative of multiple violations of the right to life under Article 2 of the ECHR.

3.8.2 Right to Freedom from Inhuman and Degrading Treatment (Article 3 ECHR)

The Commission Report provides extensive evidence that women in Mother and Baby Homes were subjected to emotional abuse that reached the threshold of degrading treatment, as defined in the case law of the ECtHR. There is evidence that some women were subjected to physical abuse, and that a considerable number of women were denied adequate medical care during childbirth, or forced to engage in physical labour while heavily pregnant or shortly after childbirth. This treatment would also have reached the threshold of degrading treatment, and would potentially have reached the threshold of inhuman treatment in cases where physical injuries resulted. Women in County Homes in particular endured living conditions (including inadequate nutrition and sanitation) that were extremely similar to conditions that have been found to violate Article 3 of the ECHR in multiple judgments. Children who were resident in Mother and Baby Homes and in County Homes experienced neglect and emotional abuse, while children who were placed in foster homes experienced serious neglect and physical abuse. The State bore direct responsibility for ill-treatment that occurred in County Homes and in a number of Mother and Baby Homes that were managed by local authorities. In the case of ill-treatment perpetrated by private individuals, the evidence suggests that the State was either aware of the ill-treatment or the risk of same (through contemporaneous inspection reports), or ought to have been aware (since some inspection regimes were known to be defective, and the evidence indicates a general level of societal awareness of the harshness of the regime in the Homes). This triggered the State's obligation to take reasonable measures to mitigate the risk of ill-treatment. The fact that the ill-treatment continued to occur in so many locations for such a lengthy period of time strongly suggests that the State failed in its positive obligations, and that this would have amounted to a violation of Article 3 of the ECHR in a considerable number of cases.

3.8.3 Forced Labour (Article 4 ECHR)

A considerable volume of evidence in the Commission Report demonstrates that women in Mother and Baby Homes undertook unremitting labour against their will and without pay for a period of months or years. Women who sought to leave were threatened with penalties such as prosecution for child abandonment, or being left with physical and financial responsibility for a child which the women could not possibly discharge. Children in foster homes were often fostered for the sole purpose of providing a source of free labour and made to undertake work that was wholly unsuited to their age. The manner in which the vulnerability of these women and children was exploited, and the absence of any realistic free choice on their part, makes their treatment extremely similar to treatment that the ECtHR has found to fall within the definition of forced labour. The State was directly responsible for forced labour practices in County Homes, and aware (through inspection reports raising concerns) of the reality or at least the risk of forced labour in Mother and Baby Homes and in foster homes. The persistence of these practices over many years indicates that the State's response failed to effectively mitigate this risk, and is suggestive of violations of Article 4 of the ECHR.

3.8.4 Deprivation of Liberty (Article 5 ECHR)

The case law of the ECtHR indicates that deprivation of liberty involves both objective factors (ie confinement to a restricted space for more than a negligible period of time) and subjective factors (ie that the person who has been confined has not validly consented to the confinement). The Commission Report provided an abundance of evidence of each of these factors in respect of women in Mother and Baby Homes. Religious authority figures at the time accepted that many of the women did not wish to be in the Homes. Nonetheless, residents were forbidden from leaving or from having contact with the outside world. The Homes were physically designed and located to ensure this. Women were told on arrival that they would be returned by the Gardaí if they left. In at least some cases, this actually occurred; in others, the Gardaí were contacted, although they may not have returned the women. There is ample evidence in the Commission Report that State authorities were aware that large numbers of women were being kept in Mother and Baby Homes and County Homes against their will, but either acquiesced in the deprivation of their liberty, or failed to put an end to it. On the principles set down in the case law of the ECtHR, this would have amounted to a violation of Article 5 of the ECHR in many cases.

3.8.5 Consent to Adoption (Article 8 ECHR)

The Commission Report demonstrates that some women in Mother and Baby Homes claimed that their consent was not free and informed. The legal test for free consent to adoption is to consider whether the consent to adoption represented the will of the birth mother or of someone else. Free consent has been found to be absent in circumstances where parents instructed their daughter to place her child for adoption, and to conceal her pregnancy and the adoption; and forbade her from bringing the baby home, such that the birth mother "subordinated her own will to that of her parents because of fear which was a product of her upbringing, stress, anxiety, lack of maturity and deprivation of emotional support." The evidence produced in the Commission Report (both of the prevailing social conditions and the testimony of those women who claimed that their consent was not freely given) strongly suggests that in many cases, circumstances were such that this test would have been met. This raises the question of whether an accessible and effective remedy was available to women whose consent to adoption was not freely given. Although in theory, High Court proceedings could have been instituted to challenge the validity of consent, in reality such proceedings were far out of reach for vulnerable and traumatised women who lacked any financial resources or family support; did not have access to legal aid; and who had been systematically shamed into concealing their pregnancy and the resulting adoption. Consequently, these High Court proceedings were not "sufficiently certain not only in theory but also in practice", and did not amount to an effective remedy within the meaning of Article 13 of the ECHR. In turn, this suggests that cases documented in the Commission Report in which women gave consent to adoption under pressure from parents, adoption societies, Mother and Baby Home staff, social workers or priests involved a violation of the right to family life under Article 8 of the ECHR.

3.8.6 Vaccine Trials (Article 8 ECHR)

An extensive body of evidence in the Commission Report details how babies and infants in Mother and Baby Homes were subjected to vaccine trials (including administration of the vaccine drug itself, as well as invasive medical examinations and side-effects) without parental consent. Case law interpreting the ECHR clearly establishes that medical interventions without either consent or a legal basis are an interference with the right to physical integrity, which is protected by the right to private life under Article 8 of the ECHR. The vaccine trials detailed in the report featured neither parental consent nor a legal basis; on the contrary, they were in contravention of numerous provisions of the law applicable in Ireland at the time. Since the trials were conducted in relatively plain sight and documented in contemporaneous articles published in medical journals (which acknowledged that consent to participation by the infants had not been given by their parents), it can be argued that even if the State was not aware of them, it ought to have been; yet no steps were taken to enforce existing laws or to put an end to the trials. Inadequacies in records of the trials make it impossible for people involved in them to establish the nature and extent of their involvement. All of this is suggestive of multiple violations of the right to private life under Article 8 of the ECHR.

3.8.7 Recommendations

The conclusions that are set out above are offered primarily to enhance our understanding of violations of children's rights in Mother and Baby Homes, in County Homes and in foster homes, and of the actions and omissions of State authorities that allowed these violations to occur on such a large scale and over such a lengthy period. They demonstrate what can happen when the State cedes such extensive power over people's lives to private institutions, and either supports those institutions in the maintenance of abusive regimes; or actively turns a blind eye to those regimes; or merely fails to mitigate the risk that regimes may become abusive. Many of the issues discussed above echo what has been found in other contexts, including residential institutions and industrial schools[364] and National Schools.[365] The degree of direct State involvement in the care of children in these settings varied; but in all cases, the common thread is that the State knew or ought to have known that children were at risk of being abused, but failed to take reasonable steps to mitigate that abuse.

Child protection is always the State's responsibility, irrespective of the setting. Although the material under review is historical in nature, the implications for the present day are clear. The State continues to rely heavily on private actors in the education system, in

364. S Ryan, *Report of the Commission to Enquire into Child Abuse* (2006) at [6.03] and [6.06], available at http://www.childabusecommission.ie/rpt/04-06.php: "The deferential and submissive attitude of the Department of Education towards the Congregations compromised its ability to carry out its statutory duty of inspection and monitoring of the schools. The Reformatory and Industrial Schools Section of the Department was accorded a low status within the Department and generally saw itself as facilitating the Congregations and the Resident Managers … The system of inspection by the Department of Education was fundamentally flawed and incapable of being effective."

365. *O'Keeffe v Ireland* (35810/09, 28 January 2014) at [168]: "The Court has found that it was an inherent positive obligation of government in the 1970s to protect children from ill-treatment. It was, moreover, an obligation of acute importance in a primary education context. That obligation was not fulfilled when the Irish State, which must be considered to have been aware of the sexual abuse of children by adults through, *inter alia*, its prosecution of such crimes at a significant rate, nevertheless continued to entrust the management of the primary education of the vast majority of young Irish children to non-State actors (National Schools), without putting in place any mechanism of effective State control against the risks of such abuse occurring."

healthcare, in the provision of residential care in the care system, and in Direct Provision and other accommodation centres for asylum seekers (as discussed in Chapter 1 of this report). The risk that children may be abused or neglected in any of these settings is evident, and State authorities have a responsibility to maintain a vigilant and proactive stance in the supervision and regulation of these services.

Aside from the lessons for the future, the Commission Report also gives rise to obligations to deal with the past. Since the analysis in this Chapter indicates that it is likely that a considerable number of women and children experienced violations of rights protected by the ECHR, the right to an effective remedy under Article 13 of the Convention becomes relevant. As noted in section 3.6.1 above, the ECHR operates on the principle of subsidiarity, under which it is up to the State Party in the first instance to provide a remedy for violations of Convention rights. The ECtHR clearly stated this principle in *Kudla v Poland*:

> … Article 13, giving direct expression to the States' obligation to protect human rights first and foremost within their own legal system, establishes an additional guarantee for an individual in order to ensure that he or she effectively enjoys those rights. The object of Article 13, as emerges from the *travaux preparatoires*, is to provide a means whereby individuals can obtain relief at a national level for violations of their Convention rights before having to set in motion the international machinery of complaint before the Court.[366]

As such, where violations of ECHR rights are considered to have occurred, Ireland should seek to provide a remedy for those violations in domestic law before the individuals affected seek to make an application to the ECtHR. If States fail to provide effective remedies, "individuals will systematically be forced to refer to the Court in Strasbourg complaints that would otherwise, and in the Court's opinion more appropriately, have to be addressed in the first place within the national legal system. In the long term the effective functioning, on both the national and international level, of the scheme of human rights protection set up by the Convention is liable to be weakened".[367]

It was noted in the introduction to this Chapter that the Government has committed to implementing a response to the Commission Report based on four pillars of Recognition, Remembrance, Records and Restorative Recognition. In relation to records, the General Scheme of the Birth Information and Tracing Bill was published in May 2021. This is a welcome and long-overdue Bill that would give adopted persons a right to access records on their birth and early life. The core provisions of the Bill are strong, but there remains some scope for improvement on the edges. The Special Rapporteur on Child Protection was invited by the Select Committee on Children, Disability, Equality and Integration to participate in pre-legislative scrutiny of the Bill; a copy of the opening statement provided to the Committee is reproduced in Appendix D of this Report.[368]

In relation to redress, two main points will be highlighted here. First, the Commission Report recommends that women should only be provided redress if they spent longer than 6 months in a Mother and Baby Home, and that women who entered Mother and

366. See, eg, *Kudla v Poland* (30210/96, 26 October 2000) at [152].

367. *Ibid* at [155].

368. Video of the Committee hearing can be viewed at https://www.oireachtas.ie/en/oireachtas-tv/video-archive/committees/4348.

Baby Homes after 1973 (when the Unmarried Mother's Allowance was introduced) do not have a case for financial redress.[369] Other recommendations for redress were based on unpaid labour in specific institutions.[370] This approach to designing a redress scheme risks repeating the mistakes that have dogged past redress schemes related to Magdalene Laundries, symphysiotomies, and sexual abuse in primary schools: namely, the creation of "bright lines" which have the effect of entirely excluding some (or perhaps many) potential applicants from being considered for redress. The Commission Report accepts that "the State does have an obligation not to discriminate between people in similar situations."[371] A rigid rule based on date of entry to a Home, or length of time spent in a Home, risks doing exactly that. If a stay of six months and one week in a Home is deemed worthy of redress, it would be discriminatory to deny redress to someone who spent five months and three weeks in the same Home; or to someone who spent a shorter period in one where conditions were worse. Whatever criteria are relied on to determine eligibility for redress, it is essential that they are devised and applied with a degree of flexibility that allows for recognition of the similarities in people's experiences, instead of highlighting their differences to justify refusing applications.

Second, the Commission Report recommends that redress be offered to children who were resident in Mother and Baby Homes without their mother,[372] and the establishment of an *ex gratia* payment to compensate foster children who inherited farms and had to pay taxes for which birth children and adopted children were not liable.[373] It makes no recommendations for redress for the ill-treatment of children who were resident in Mother and Baby Homes, in County Homes or in foster homes—a position which is difficult to reconcile with the many passages in the Report which document the ill-treatment of children in these settings and State knowledge of this ill-treatment. Any redress scheme which excludes children who were subjected to inhuman and degrading treatment, forced labour and medical experimentation in the form of non-consensual vaccine trials would be inherently defective and a denial of the right to an effective remedy. Moreover, redress for rights violations in foster homes should not be confined to children who were placed in foster homes as an exit pathway from Mother and Baby Homes or County Homes, but should encompass all children who experienced ill-treatment or forced labour in foster homes.

369. Commission Report, Recommendations at pp 8-9.
370. *Ibid* at p 9.
371. *Ibid* at p 4.
372. *Ibid* at p 5.
373. *Ibid* at p 11.

Chapter 4

Legal Developments and Research Update

4.1 INTRODUCTION

This chapter will review legal developments and research of relevance to the broad area of child protection, covering the period of January 2020 to June 2021. It is primarily intended as a resource to update policymakers and practitioners; but it also includes discussion of implications for future law, policy and practice. The chapter is divided into three main sections. Section 4.2 will consider developments in international law, including a new General Comment by the UN Committee on the Rights of the Child on children's rights in relation to the digital environment, and a number of significant judgments of the European Court of Human Rights (ECtHR) on issues including compulsory vaccination; the obligation to protect children from harm; and the obligation to investigate allegations of abuse. At domestic level, Section 4.3 will discuss decisions of the Irish courts, which included a landmark Supreme Court decision on the interpretation of the constitutional rights of children and the State's power to intervene in family life following the 2012 referendum on Article 42A, as well as decisions on investigations of child sexual abuse, juvenile justice and other miscellaneous issues. Finally, Section 4.4 will outline a range of academic research on child protection issues, before Section 4.5 concludes with discussion and recommendations.

4.2 INTERNATIONAL LAW DEVELOPMENTS

4.2.1 General Comment No 25 (2021) on children's rights in relation to the digital environment

The Committee on the Rights of the Child published General Comment No 25 (2021) on children's rights in relation to the digital environment in March 2021.[1] The Committee acknowledged that "[c]rises, such as pandemics, may lead to an increased risk of harm online, given that children spend more time on virtual platforms in those circumstances".[2] The General Comment incorporates material from the Day of General Discussion on "Digital media and children's rights" which was held on 12 September 2014. Importantly, this General Comment is also informed by the views of "709 children living in a wide variety of circumstances in 28 countries in several regions", as well as other experts.[3] The General Comment emphasises that the four general principles of the UN Convention on the Rights of the Child (CRC) must be considered: non-discrimination, best interests of the child, right to life, survival and development and the views of the child. The evolving capacities of the child are also given special attention: "The risks and opportunities associated with children's engagement in the digital environment change depending on their age and stage of development".[4]

General Comment No 25 calls on States parties to ensure that domestic legislation "remain[s] relevant, in the context of technological advances and emerging practices".[5] States parties are also required to "ensure the operation of effective child protection mechanisms online and safeguarding policies, while also respecting children's other rights, in all settings where children access the digital environment, which includes the home, educational settings, cybercafés, youth centres, libraries and health and alternative care settings".[6] In addition, "States parties should identify a government body that is mandated to coordinate policies, guidelines and programmes relating to children's rights among central government departments and the various levels of government".[7] Attention is also given to the impact of the business sector, as well as advertising and marketing in the digital environment, and States parties are required to ensure that children's rights are respected in this regard.

The General Comment pays special attention to remedies and requires States to ensure that complaint mechanisms are available and "free of charge, safe, confidential, responsive, child-friendly and available in accessible formats".[8] It also calls for independent monitoring whereby complaints from children and their representatives are investigated and addressed.[9] As well as protecting children, the General Comment is also heavily focused on allowing children to exercise their rights in the digital environment, including the rights to access information, freedom of expression, freedom of thought, conscience

1. Committee on the Rights of the Child, *General Comment No. 25 (2021) on children's rights in relation to the digital environment*, UN Doc No CRC/C/GC25, 2 March 2021.
2. *Ibid* at [80].
3. *Ibid* at [5].
4. *Ibid* at [19].
5. *Ibid* at [23].
6. *Ibid* at [26].
7. *Ibid* at [27].
8. *Ibid* at [44].
9. *Ibid* at [31].

and religion, freedom of association and peaceful assembly, privacy, identity, education, culture, leisure and play. Overall, this General Comment requires States parties to ensure that legislation, policies and strategies are up-to-date and effective, and that children's parents and caregivers are well equipped to support children's rights in the digital environment.

General Comment No 25 has direct implications for domestic legislation regulating the digital environment. The Online Safety and Media Regulation Bill was published in January 2021. An invitation was issued to the Special Rapporteur on Child Protection to make written observations on the Bill, and to appear before the Oireachtas Committee on Media, Tourism, Arts, Culture, Sport and the Gaeltacht during pre-legislative scrutiny of the Bill on 12 May 2021.[10] These written observations are reproduced in Appendix C of this Report. Although they pre-date the publication of General Comment No 25, they drew on the report of the Day of General Discussion which informed the General Comment and are broadly in line with the terms of the latter.

4.2.2 European Convention on Human Rights (ECHR) Case Law

4.2.2.1 Vavricka v Czech Republic (Compulsory vaccination)

Vavricka v Czech Republic[11] concerned parents' refusal for their children to take vaccinations as part of a childhood vaccination programme in the Czech Republic. The applicant father claimed a violation of his right to private life under Article 8 ECHR as he was fined for failing to have his children vaccinated; while the child applicants claimed a similar violation as they were refused admission to preschool for not having taken the statutorily required vaccinations.[12] The Court's case law has established that "compulsory vaccination, as an involuntary medical intervention, represents an interference with the right to respect for private life within the meaning of Article 8 of the Convention"; as such, in determining the legitimacy of this interference, the Court must consider whether this interference "was 'in accordance with the law', pursued one or more of the legitimate aims specified therein, and to that end was 'necessary in a democratic society'".[13] Having quickly found that the interference was in accordance with the law, and pursued a legitimate aim, the Court considered at length whether the interference was necessary in a democratic society.

While noting that States have a wide margin of appreciation in respect to compulsory childhood vaccinations, the Court stated that "in the Czech Republic the vaccination duty represents the answer of the domestic authorities to the pressing social need to protect individual and public health against the diseases in question and to guard against any downward trend in the rate of vaccination among children".[14] In relation to the best interests of the child, the Court concentrated on children's rights to be protected from serious diseases and said that "where the view is taken that a policy of voluntary vaccination is not sufficient … domestic authorities may reasonably introduce a compulsory vaccination

10. Video of this Committee hearing can be viewed at https://www.oireachtas.ie/en/committees/33/media-tourism-arts-culture-sport-and-the-gaeltacht/videos/.

11. 47621/13, 8 April 2021.

12. The Grand Chamber considered six applications together because of the "similar subject matter" wherein the applicants refused vaccinations; see *ibid* at [159].

13. *Ibid* at [263] and [265].

14. *Ibid* at [284].

policy in order to achieve an appropriate level of protection against serious diseases".[15] The Court paid special attention to the proportionality of the interference, noting that the vaccinations are deemed "effective and safe by the scientific community" and that the compulsory vaccination in the Czech Republic "is not an absolute duty".[16] Further, the consequences for non-compliance were "relatively moderate" as the fine imposed on the father was low and the children, while denied admission to preschool, were permitted to attend primary school.[17] The Court held that the law in the Czech Republic was "supported by relevant and sufficient reasons",[18] and found no violation of Article 8.

The decision is noteworthy in laying out the framework under which the legitimacy of any potential future legal or policy measures aimed at securing vaccine take-up would be determined. Such measures could also be challenged under the Irish Constitution, and the principles and case law applicable in such a challenge would be somewhat different to a challenge based on the ECHR (whether in the Irish courts under the European Convention on Human Rights Act 2003, or in the ECtHR).[19] Nonetheless, in either context, the issue of proportionality and the scale of any consequences flowing from a decision not to vaccinate children would be a key consideration on which the outcome of any challenge would turn. *Vavricka* suggests that State authorities have some scope to apply measures that nudge parents towards the vaccination of their children, provided that the measures in question are moderate in impact and allow scope for parents to decline to vaccinate children without being faced with serious consequences for themselves or their children.

4.2.2.2 Association Innocence En Danger c France (Protection from abuse and neglect)

The applicants in this case[20] were two child protection organisations and the case concerned the State's failure "to take necessary and appropriate measures to protect a child from ill-treatment by her parents leading to her death" in August 2009.[21] The child, M, was eight years old and repeatedly subjected to "barbaric acts by her parents".[22] In June 2008, teachers reported that M had wounds on her face and body. This was investigated by police but the case was closed in October 2008 by the public prosecutor's office. The complaint relied on Articles 2 and 3 of the ECHR to argue that the French authorities failed "to fulfil their positive obligations to protect the child from parental abuse",[23] and on Article 13 of the Convention to argue that there had been no effective domestic remedy "on account of the need to prove "gross negligence' ("*faute loured*") in order for the State to be found liable".[24]

15. *Ibid* at [288].

16. *Ibid* at [291].

17. *Ibid* at [293] to [294].

18. *Ibid* at [289].

19. For a discussion of the relevant constitutional principles, see C O'Mahony, "Could the State introduce compulsory vaccination laws?", *RTE Brainstorm*, 1 October 2020, available at https://www.rte.ie/brainstorm/2019/0423/1045277-could-the-state-introduce-compulsory-vaccination-laws/.

20. 15343/15 and 16806/15, 4 June 2020. The judgment was delivered in French; there is no official English language version available yet. However, it was summarised in the Council of Europe, *Annual Report 2020 of the European Court of Human Rights* (2021) at pp 54-56 and pp 105-106, available at https://www.echr.coe.int/Documents/Annual_report_2020_ENG.pdf.

21. Council of Europe (n 20 above) at p 54.

22. *Ibid* at p 54.

23. *Ibid* at p 55.

24. *Ibid* at p 55.

The Court held that there had been a violation of Article 3 "as the domestic system had failed to protect M from the severe abuse to which she had been subjected by her parents",[25] but that there had been no violation of Article 13. The Court reiterated its case-law on the State's positive obligation under Article 3 to take specific measures to protect children from criminal abuse perpetrated by third parties, and "emphasised in this connection the need to secure rights that were practical and effective, and the need for the authorities' response to be adapted to the situation in order to fulfil that obligation …"[26] In addition, the Court pointed out that:

> … while the public prosecutor's office had reacted immediately (on the very day of the report), the case had only been entrusted to a police investigator thirteen days later; no inquiries had been conducted with the specific aim of shedding light on M's family environment (especially in view of the family's frequent relocations) and the teachers who had reported their suspicions had not been interviewed; and, while not mandatory, the participation of a psychologist when M was examined would have been appropriate. The Court further found that the combination of the total discontinuance of the case (in 2008) and the lack of any mechanism to centralise information had seriously reduced the chances of special monitoring of the child and prevented any useful exchange of information between the justice system and the social services. Moreover, while those services had certainly taken some steps (home visits), they had not engaged in any really meaningful action to establish the child's actual condition.[27]

Thus, ineffective inter-agency collaboration was found to have contributed to the child's death and to the finding of a violation of Article 3 of the ECHR. Challenges arising in respect of inter-agency collaboration in Irish child protection practice were discussed in sections 1.5 and 1.9 of this Report;[28] this ECtHR judgment provides further evidence of the need to work to make improvements in this area.

4.2.2.3 RB v Estonia (Effective investigation of abuse)

RB v Estonia[29] concerned the conduct of an effective investigation into child sexual abuse allegations. In this case, the applicant (who was four and a half years old) gave evidence that her father had sexually abused her. The Supreme Court in Estonia held that the lower courts had relied on evidence which had not complied with Estonian procedural law. In particular, the applicant's statements, which were central to her father's conviction, did not comply with procedural law as "she had not been made aware of the obligation to speak the truth … and had not been advised that she could refuse to give testimony against her father".[30] According to the Supreme Court, procedural law applied equally to minors and adults alike and it was the legislators' role to amend the law if it was deemed necessary to take account of a child's age. The Supreme Court held that "[s]tatements

25. *Ibid* at p 55.

26. *Ibid* at p 55.

27. *Ibid* at pp 55-56.

28. C O'Mahony, Annual Report of the Special Rapporteur on Child Protection 2020 at section 1.8.2, available at https://www.gov.ie/en/collection/51fc67-special-rapporteur-on-child-protection-reports/.

29. 22597/16, 22 June 2021.

30. *Ibid* at [24].

obtained from the victim without informing her of her rights and obligations could not be considered lawful evidence, as they had been obtained by materially breaching the procedural law".[31] Accordingly, the father was acquitted.

The applicant claimed that her rights under Articles 3 and 8 of the ECHR were violated as the relevant investigators failed to comply with requirements under Estonian procedural law, thereby depriving her of an effective investigation. The ECtHR stated that "for the effective protection of children's rights in line with international standards, it is essential to safeguard their testimony both during the pre-trial investigation and trial".[32] In particular, the ECtHR took note of the *Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice*.[33] The ECtHR found that there was a violation of both Articles 3 and 8, commenting that "there were significant flaws in the domestic authorities' procedural response to the applicant's allegation … which did not sufficiently take into account her particular vulnerability and corresponding needs as a young child …".[34] The ECtHR was critical of "the manner in which the criminal-law mechanisms as a whole were implemented … resulting in the disposal of the case on procedural grounds".[35]

4.2.2.4 X v Bulgaria (Effective Investigation of abuse and neglect)

In *X v Bulgaria*,[36] the applicants, three siblings, complained that they were subjected to sexual abuse in an orphanage in Bulgaria and that this was not effectively investigated. The siblings were adopted by an Italian couple in 2012 when they were 12, 10 and 9 years old. While the Court was satisfied with the "promptness and expedition" of the Bulgarian authorities' investigation,[37] it was critical of the lack of information and support which the parents and the children received from the Bulgarian authorities, in the light of requirements under the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse (the Lanzarote Convention) and the UN Convention on the Rights of the Child (CRC). The Court was also critical of the interviews which were conducted with other children in the orphanage as they were not adapted to take into account the children's age and maturity; the interviews were not videoed; and one child was interviewed twice, while other children who were named by the applicants, but who had left the orphanage, were not questioned.[38]

Further, the Court criticised the fact that the Bulgarian authorities did not appear to consider interviewing the applicants in their capacity as victims and witnesses, or request to view videos of their conversations with psychologists in Italy, or request a medical examination of the children to gain clarity around allegations of rape.[39] The Court also stated that "covert" investigations should have been considered, such as tapping telephone calls and recruiting undercover agents, as provided for under the Lanzarote Convention. Public criticism of the allegations and the applicants' parents by members of parliament and the head of the State Agency for Child Protection in Bulgaria also

31. *Ibid*.
32. *Ibid* at [102].
33. *Ibid*.
34. *Ibid* at [103].
35. *Ibid*.
36. 22457/16, 2 February 2021.
37. *Ibid* at [206].
38. *Ibid* at [211] and [220].
39. *Ibid* at [216] to [219].

"undermine[d] the objectivity—and hence the credibility—of the inquiries".[40] The Court held that the "omissions observed appear sufficiently serious for it to be considered that the investigation carried out was not effective for the purposes of Article 3 of the Convention", in the light of the Lanzarote Convention.[41] Criticism of this decision, from a children's rights perspective, has been put forward by Liefaard *et al*, who note the absence of an engagement with the substantive limbs of Article 3 which is required in respect of children in institutions who "require additional safeguards to ensure they can make complaints".[42]

4.2.2.5 Kurt v Austria (Right to life, children and domestic abuse)

The case of *Kurt v Austria*[43] concerned domestic abuse which culminated in the father, E, shooting and killing his son at school. Evidence before the Grand Chamber detailed that while "the applicant's children had been subjected to slaps by their father and to the mental strain of having to witness violence against their mother … the children had not been the main target of E.'s violence or threats".[44] Instead, the applicant, who is the child's mother, was the main target, and the authorities issued barring and protection orders. The mother claimed that there were breaches of Articles 2, 3 and 8 of the ECHR as the relevant authorities "had failed to protect her and her children from her violent husband" and that "the legal framework for the protection of children in the context of domestic violence" was insufficient.[45] The Chamber of the ECtHR focused on the right to life under Article 2 ECHR and unanimously held that there was no violation of Article 2 "under its substantive limb".[46] The case then came before the Grand Chamber which considered, amongst other factors, "whether the authorities knew or ought to have known that there was a real and immediate risk to the life of the applicant's son".[47] The Grand Chamber noted that the Austrian authorities' assessment "identified a certain level of non-lethal risk to the children in the context of the domestic violence perpetrated by the father"[48] and that the "measures ordered by the authorities appear, in the light of the result of the risk assessment, to have been adequate to contain any risk of further violence against the children".[49] According to the Grand Chamber, there was "[n]o real and immediate risk of an attack on the children's lives".[50] This meant that the authorities were not obliged "to take further preventive operational measures specifically with regard to the applicant's children, whether in private or public spaces, such as issuing a barring order for the children's school".[51] The Grand Chamber held that there was no violation of Article 2 under its substantive limb.

40. *Ibid* at [224].
41. *Ibid* at [228].
42. T Liefaard, J Valentine and L van Dijck, "Victims of 'vulnerability': Balancing protection, privacy and participation of child victims in X and Others v. Bulgaria", *Strasbourg Observers*, 26 April, 2021, available at https://strasbourgobservers.com/2021/04/26/victims-of-vulnerability-balancing-protection-privacy-and-participation-of-child-victims-in-x-and-others-v-bulgaria/.
43. 62903/15, 15 June 2021
44. *Ibid* at [206].
45. *Ibid* at [102] and [103].
46. *Ibid* at [110].
47. *Ibid* at [203] to [210].
48. *Ibid* at [209].
49. *Ibid*.
50. *Ibid*.
51. *Ibid*.

The joint dissenting opinion of Judges Turkovíc, Lemmens, Harutyunyan, Elósegui, Felici, Pavli and Yúksel provides some noteworthy comments, particularly regarding the conduct of a comprehensive lethality risk assessment with respect to children in domestic abuse situations.[52] The judges commented that no separate risk assessment was "explicitly carried out in relation to the children" and that "the children's specific situation received little attention".[53] The judges stated that this is "particularly problematic given that … children who are victims of domestic violence are particularly vulnerable individuals and entitled to State protection against serious breaches of personal integrity".[54] The judges highlighted the fact that the children gave evidence of physical abuse perpetrated by their father and also that the father made threats that he would kill the children. The dissenting opinion notes that "attacks on the children may be intended, by an unstable and violent father facing the sudden prospect of separation and perceived social humiliation, as the ultimate form of punishment for their mother".[55] It is also important to note, as is highlighted in both the judgment and the dissenting opinion, that since the incident in this case took place, "Austrian legislation was amended … to provide for the extension of police barring orders to schools as well as the immediate notification of the child protection authorities, and most recently for the prohibition or regulation of contact in any form and of attempts to approach the protected person".[56] Conscious of the "benefit of hindsight", the judges noted in the dissenting opinion that, "it is at the same time difficult not to see the multiple amendments undertaken since as implicit recognition at the national level of the flaws of the protective legal framework as it existed at the relevant time".[57] The judges concluded that there was a violation of the substantive element of Article 2 and that "the risk to the children was underestimated".[58]

4.2.2.6 Kotilainen v Finland (Firearms—Duty to mitigate a potential risk to life)

This case[59] concerned a shooting at a school in Finland in September 2008, in which ten people were killed before the perpetrator committed suicide. The perpetrator was granted a licence for a weapon just a few weeks prior to the shooting following an interview with a Detective Chief Inspector. A few weeks before this, the perpetrator was prescribed medication for panic attacks and severe depression. Four days before the shooting, the police were made aware of three video recordings of the perpetrator shooting his weapon and texts about war and dying. The perpetrator was also a member of a "community called 'Zero Hour: Massacre at Columbine High', where he commented that it was 'entertainment as its best'".[60] As a result of this, "several police officers had started to suspect that the perpetrator might commit a school killing since he seemed to imitate, with his way of dressing and gestures, the perpetrator of the previous school killing which took place in Finland less than a year earlier".[61] The police were granted permission to

52. *Ibid*; joint dissenting opinion of Judges Turkovíc, Lemmens, Harutyunyan, Elósegui, Felici, Pavli and Yúksel.
53. *Ibid* at [12].
54. *Ibid*.
55. *Ibid* at [13].
56. *Ibid* at [34]. See also majority judgment at [60].
57. *Ibid*; joint dissenting opinion of Judges Turkovíc, Lemmens, Harutyunyan, Elósegui, Felici, Pavli and Yúksel, at [34].
58. *Ibid* at [42] and [43].
59. 62439/12, 17 September 2020.
60. *Ibid* at [13].
61. *Ibid*.

seize the perpetrator's weapon but he was not at home or at school. On 22 September, the Detective Chief Inspector questioned the perpetrator about the video clips and gave him a verbal warning, but refrained from seizing his gun. That same day, police officers gave the Detective more internet material about the perpetrator. The school killings took place the next morning.

Relatives of those who were killed brought a case to the ECtHR under Article 2 of the ECHR (the right to life), complaining about "the lack of any measures on the part of the police to prevent the school shooting"[62] and the fact that "the perpetrator of the fatal attack was permitted to possess a firearm and that, in particular, his licensed weapon was not seized before the attack".[63] According to the Court, "the use of firearms is a form of dangerous activity which must engage the States' positive obligation to adopt and implement measures designed to ensure public safety".[64]

The Court held that it was "unable to conclude that there was a real and immediate risk to life directed at identifiable individuals of which the authorities knew or ought to have known at the relevant time". [65] It further stated that "it cannot be held that the circumstances in the present case gave rise to a duty of personal protection toward the victims of the subsequent killing, or toward the other pupils or staff of the school concerned".[66] However, the Court also considered "whether the authorities of the respondent State have complied with their duty of diligence in the protection of public safety, taking into account the context of the case, namely the use of firearms, where a particularly high level of risk to life is inherent".[67] In this case, the Court noted that the "authorities are responsible for determining and upholding the requirements for the lawful possession of firearms".[68] In the Court's opinion, the "crucial question is whether there were measures which the domestic authorities might reasonably have been expected to take to avoid the risk to life arising from the potential danger of which the perpetrator's known behaviour, displayed by the Internet postings, gave indications".[69] The Court held that there was a violation of Article 2 on the basis that:

> … the seizure of the perpetrator's weapon was a reasonable measure of precaution to take under circumstances where doubts had arisen, on the basis of information that had come to the attention of the competent authority, as to whether the perpetrator was fit to possess a dangerous firearm. The Court therefore considers that the domestic authorities have not observed the special duty of diligence incumbent on them because of the particularly high level of risk to life inherent in any misconduct involving the use of firearms.[70]

62. *Ibid* at [46].
63. *Ibid* at [74].
64. *Ibid* at [75].
65. *Ibid* at [81].
66. *Ibid*.
67. *Ibid* at [84].
68. *Ibid* at [85].
69. *Ibid* at [87].
70. *Ibid* at [89].

4.2.2.7 VCL and AN v United Kingdom (Human trafficking)

The ECtHR observed that *VCL and AN v United Kingdom* was the first case wherein it was required to "consider if and when" the "prosecution of a victim, or a potential victim, of trafficking … may raise an issue under Article 4 of the Convention" (which protects the right to freedom from slavery, forced labour and servitude).[71] The applicants, who were minors, were charged with the production of cannabis, a Class B drug in the United Kingdom. They were Vietnamese nationals who had been trafficked into the United Kingdom. The competent authority in the United Kingdom found credible evidence that they were victims of trafficking; but the Crown Prosecution Service (CPS) did not, and this was accepted by the courts in the UK. Citing Article 4 ECHR, the applicants claimed that the CPS had failed to identify them as victims of trafficking prior to the criminal conviction. The Court found a violation of Article 4. Reciting the facts of the case, the Court stated that "[a]t the time, there appears to have been clear evidence to indicate that the cultivation of cannabis plants was an activity commonly carried out by child trafficking victims".[72] The Court held that there is "a positive obligation to take operational measures to protect the applicants as potential victims of trafficking".[73] According to the Court, this obligation arises "shortly after they were discovered".[74] The Court described "the general framework of positive obligations under Article 4" as including: "(1) the duty to put in place a legislative and administrative framework to prohibit and punish trafficking; (2) the duty, in certain circumstances, to take operational measures to protect victims, or potential victims, of trafficking; and (3) a procedural obligation to investigate situations of potential trafficking".[75] It was held that the State "cannot be said to have fulfilled its duty under Article 4 of the Convention" to take operational measures to protect the applicants "either initially, as a potential victim of trafficking, and subsequently, as a person recognised by the Competent Authority to be the victim of trafficking".[76]

The applicants also claimed that their right to a fair trial under Article 6 was violated. The Court stated that a number of questions must be addressed under this claim: "did the failure to assess whether the applicants were the victims of trafficking before they were charged and convicted of drugs-related offences raise any issue under Article 6 § 1 of the Convention … did the applicants waive their rights under that Article by pleading guilty … and … were the proceedings as a whole fair?".[77] Having found a violation of Article 4, the Court held that "the lack of such an assessment prevented them from securing evidence which may have constituted a fundamental aspect of their defence".[78] The Court also found a violation of the right to a fair trial under Article 6 of the ECHR, holding that the applicants did not waive their rights and that "the proceedings as a whole could not be considered 'fair'".[79]

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71. *VCL and AN v United Kingdom* (74603/12 and 77587/12, 16 February 2021) at [157].
72. *Ibid* at [117].
73. *Ibid* at [120].
74. *Ibid* at [120].
75. *Ibid* at [156].
76. *Ibid* at [173] and [182].
77. *Ibid* at [194].
79. *Ibid* at [200].
79. *Ibid* at [203], [209]-[210].

4.3 IRISH COURT DECISIONS

4.3.1 *In Re JJ* (Constitutional Rights of Children)

In January 2021, the Supreme Court delivered judgment in *In Re JJ*,[80] which is the first judgment since the enactment of Article 42A of the Constitution (which was approved in a referendum in November 2012) to conduct a detailed examination of whether and how the children amendment impacted on the threshold for authorising State intervention to protect children. The case concerned a young boy (referred to in the judgment as "John") who suffered catastrophic brain injuries, as well as extensive other injuries, in an accident. Although his condition had stabilised to the point where the use of a ventilator was no longer required, he remained dependent on intensive medical interventions to keep him alive. The Court noted that "[i]t is not expected that John will ever walk, talk, develop any meaningful awareness of his surroundings, be able to communicate or process information, nor will he ever be capable of performing any voluntary movements."[81]

John's brain injuries caused him to develop a severe case of dystonia, a hyperkinetic movement disorder which causes abnormal electrical signals to trigger painful, prolonged, and involuntary contractions of muscles. He would frequently suffer dystonic episodes lasting hours. While the medical team had succeeded to a degree in bringing the dystonia under control, they were of the opinion that further episodes would occur in the future. When that arose, invasive ICU measures would be necessary to save his life, but these interventions would in themselves carry a risk of death, as well as of triggering further painful dystonic episodes.

The dispute in the case arose from the fact that the medical team were of the opinion that the interventions in question would cause unjustifiable pain and suffering for John, and that he would inevitably suffer a fatal dystonic episode at some point regardless. As such, their view was that it would be in his best interests not to administer any intensive or aggressive intervention in such circumstances. John's parents, on the other hand, maintained that John's preference would be for his life to be continued for as long as possible by whatever means necessary, and they refused to consent to the hospital's treatment plan.[82] On application of the hospital, John was declared a ward of court and various orders were sought by the hospital authorising such treatment as they determined medically necessary to manage his pain.

The central question in the case was whether the circumstances were such as to authorise the Court to override the parents' decisions in respect of their son's medical treatment. This involved a detailed consideration of whether the parents had failed in their duty within the meaning of Article 42A.2.1°, which in turn raised the question of the extent to which the amendment approved in 2012 had altered the test for State intervention that existed under the old Article 42.5, as interpreted in cases like *Re JH (an infant)*,[83] the *PKU case*,[84] the *Baby Ann case*[85] and *Re Baby AB*.[86] In each of these cases, it had

80. [2021] IESC 1.
81. *Ibid* at [4].
82. *Ibid* at [8] and [94] to [95].
83. [1985] IR 375.
84. [2001] 3 IR 635.
85. [2006] 4 IR 374.
86. [2011] 1 IR 665.

been held that State intervention could only occur in "exceptional cases" where parents failed in their duties towards their children or where there were other compelling reasons authorising intervention. "Exceptional cases" were broadly defined as cases involving an immediate risk of death or serious injury to the child.

In deciding the case, the Court clarified that the term "exceptional cases" refers to cases where parental failure of duty is established. Counsel for the parents had argued that it was necessary to prove both that the parents had failed in their duty and that the case was an exceptional one in order to justify intervention; but the Court rejected this argument and clarified that once parental failure of duty has been established, the case is an exceptional one within the meaning of Article 42A.2.1°.[87]

In turn, the Court made clear that parental failure of duty is established by "clear and convincing evidence that the decision of the parents is one which prejudicially affects the safety or welfare of a child".[88] This raises the question of what sort of evidence will suffice for this purpose. The Court stated that it "requires something more than a determination that a child would be better off if a different decision were made."[89] It is not a purely objective test:

> The Constitution requires, however, that a significant space be maintained between the views of families and particular parents and the point at which the State is obliged to intervene. If an official determination of the best interests of the child was to be the sole determinant, then the only decision which parents could ... make would be one which would receive the approval of the representatives of the State. That is not what the Constitution requires.[90]

Accordingly, the mere fact that all of the medical or scientific evidence in a case indicates that a particular outcome is in the best interests of a child will not suffice in itself to authorise State intervention. The Court commented that "the issue cannot be treated solely as a medical issue even when sensitively and carefully evaluated by the treating clinicians"; if medical consensus were always determinative, "the process of court adjudication could all too readily become reduced to elaborate hearings which lead, inevitably, to the same result and an overriding of deeply held parental views."[91] Before overriding parental authority, the Courts "must give full value and effect to the genuine, heartfelt, and honest response of the family here, even if it runs counter to the entirety of the medical consensus."[92] There are strong parallels here with the *PKU case*, in which the scientific evidence clearly favoured administering the heel prick test, but the majority of the Supreme Court held that refusing it did not constitute a failure by the parents in duties to their child.[93] *In Re JJ* seems clear in holding that Article 42A, like Article 42.5 before it, permits and even requires a similar deference to parental decisions that might expose

87. [2021] IESC 1 at [177(xii)].
88. *Ibid* at [176].
89. *Ibid* at [143].
90. *Ibid*.
91. *Ibid* at [148].
92. *Ibid* at [150].
93. [2001] 3 IR 635.

children to objective risk of harm, provided that the risk or the harm in question is below a certain threshold.

The Court described the parents' conduct since the accident as "exemplary and humbling", and noted that "[t]he care, concern, and love displayed by his family for John are exactly the values recognised by the philosophical approach embodied in Article 41 which declares the Family to be the natural primary and fundamental unit group in society possessing rights antecedent to positive law."[94] However, the Court clarified that blameworthiness is not a requirement of the concept of parental failure. Parents may make a decision in good faith which they fervently believe to be in the best interests of their children, and for which no blame can be ascribed; but if this decision prejudicially affects the child's safety and welfare, then the test for intervention is met.[95] Applying this to the facts of the case at hand, the Court concluded that the refusal of the parents to consent to the hospital treatment plan constituted parental failure of duty within the meaning of Article 42A, as it:

> … was a decision which could not be said to be in John's best interests … it is a decision which was prejudicial to his welfare since it was a decision that, if implemented, would be likely on the evidence to cause him extreme and avoidable pain and suffering … It is obviously the duty of parents to seek to ward off such avoidable suffering for their children and, accordingly, we must conclude that, notwithstanding the exemplary care and love shown by parents faced with a dreadful crisis, their decision in this single regard can properly be described as constituting a failure of duty …[96]

Thus, the level of pain and suffering that John would face, and the high degree of likelihood that it could not be avoided, took this case beyond the zone of autonomy that should be afforded to families to make decisions for their children that run contrary to medical consensus.

The broader significance of the judgment arises from the analysis contained therein regarding the effect of the enactment of Article 42A on the test for State intervention in family life. Finn Keyes has argued that the decision in *In Re JJ* clarifies that "a significant change in the law has been effected" and that "the replacement of Article 42.5 with Article 42A.2.1 has lowered the threshold for intervention."[97] This analysis reflects a number of passages of the judgment in which the Court suggests that Article 42A has impacted on the test for intervention; indeed, the Court expressly rejected the suggestion to the contrary contained in the 5th edition of *Kelly: The Irish Constitution*.[98] There are two main aspects to this discussion. First, the Court in *In Re JJ* held that Article 42A.2.1° differs from the old Article 42.5 in that the shift in focus from parental failure of duty "for physical or moral reasons" to parental failure of duty "to such extent that the safety or welfare of any of their children is likely to be prejudicially affected" removes a previous requirement of

94. [2021] IESC 1 at [149].

95. [2021] IESC 1 at [134].

96. *Ibid* at [152] to [153].

97. F Keyes, "Children's Rights and End of Life Decision-Making: *In the Matter of JJ*" (2021) *Irish Judicial Studies Journal* 58 at 70.

98. [2021] IESC 1 at [126], referring to GW Hogan, GF Whyte, D Kenny and R Walsh, *Kelly: The Irish Constitution*: (5th Edition, Bloomsbury, 2018) at [7.7.273].

blameworthiness on the part of parents before a finding of parental failure can be made.[99] Second, the Court held that "[i]t is necessary to place Article 42A.2.1° in the context of Article 42A generally",[100] and that when this is done, the reference to parental duties must be read as the duty of the parents to uphold and vindicate the rights of the child.[101] The Court characterised this as a shift in emphasis towards a more child-centred approach to the assessment of parental failure of duty than had previously existed under Article 42.5, and stated that the "direction of travel" of Article 42A was clear.[102]

On its face, therefore, *In Re JJ* can be read as a re-calibration of the threshold for State intervention that might make it somewhat easier for the State to override parental authority in order to protect the rights of the child. However, closer analysis suggests that it may be less clear-cut than this. While the requirement of blameworthiness was mentioned in a number of previous cases, all of these had turned on the "moral" reasons aspect of Article 42.5.[103] Other case law had relied on the "physical" reasons element of Article 42.5 to make findings of parental failure of duty in cases involving circumstances outside of the parents' control giving rise to the State's duty to intervene, in which there was no apparent finding by the Court that the parents were in any way blameworthy.[104] Indeed, many children are taken into care under the Child Care Act 1991 due to circumstances for which a parent could not be deemed culpable, such as mental health or cognitive issues. Since the Child Care Act 1991 depended (until Article 42A came into effect) on Article 42.5 for its constitutionality, such care orders could not be reconciled with an interpretation of Article 42.5 that made a finding of blameworthiness a pre-requisite to a finding of parental failure of duty. Thus, physical and blameless factors relating to the parents were capable of justifying an intervention in family life even before the enactment of Article 42A, and the suggestion by the Supreme Court in *In Re JJ* that its enactment has brought about a change in the law in this respect appears overstated.

A similar point can be made in relation to the Supreme Court's suggestion that Article 42A has changed the law by refocusing the concept of parental duties on the vindication of the rights of the child. Article 42.5 had already recognised the "natural and imprescriptible rights of the child", and case law interpreting Article 42.5 had already recognised that parents had a duty to vindicate these rights. The most significant decision in this respect was *Re Article 26 and the Adoption (No 2) Bill, 1987*, in which Finlay CJ, delivering the judgment of the Court, stated that:

> Article 42, s. 5 of the Constitution should not, in the view of the Court, be construed as being confined, in its reference to the duty of parents towards their children, to the duty of providing education for them. In the exceptional cases envisaged by that section where a failure in duty has occurred, the State by appropriate means shall endeavour to supply the place of the parents. This must necessarily involve supplying

99. *Ibid* at [133] to [134].

100. *Ibid* at [126].

101. *Ibid* at [131].

102. *Ibid* at [131] and [137].

103. See, eg, the *Baby Ann case* [2006] 4 IR 374 at 528, 560 and 581, and *State (Doyle) v Minister for Education* (1955) [1989] ILRM 277 at 280.

104. See, eg, *FN v Minister for Education* [1995] 1 IR 409 at 416 and *Re Baby AB* [2011] 1 IR 665 at 675 and 668-669.

> not only the parental duty to educate but also the parental duty to cater for the other personal rights of the child.[105]

In interpreting the phrase "the natural and imprescriptible rights of the child" in Article 42.5, the Supreme Court stated that these rights "are not confined to those identified in Articles 41 and 42 but are also rights referred to in Articles 40, 43 and 44."[106] It is quite difficult to see the difference between this decision and the comments of the Supreme Court in *In Re JJ*.

In summary, therefore, the Supreme Court judgment in *In Re JJ* suggested that the enactment of Article 42A has altered (and most probably lowered) the threshold for intervention at least a little. However, the two ways identified by the Court in which this change manifests itself (the removal of the requirement of blameworthiness, and the fact that parental failure of duty is now defined in terms of a failure of the parents to vindicate the rights of the child) both appear to have changed less about pre-existing law than the judgment suggests. What we are left with is a series of passages in which the Supreme Court describes Article 42A as a "wide-ranging, though subtle, change to the posture of the Constitution in relation to child and family matters"[107] whose "direction is clearly discernible".[108] It may be that this change proves to be very subtle indeed, and we will have to wait for future judgments to see more concrete evidence of whether and how the enactment of Article 42A might change the outcome of specific cases.

4.3.2 *CD v Child and Family Agency* (Investigation of Allegation of Child Sexual Abuse)

In this case,[109] Humphreys J considered whether Tusla has "jurisdiction to make a finding that an allegation of child sexual abuse is founded or unfounded, as opposed to simply finding that a future risk of child abuse exists in a particular case".[110] In considering the scope of section 3 of the Child Care Act 1991, the judge stated that this section "does provide a sufficient statutory basis for such findings".[111] He emphasised, however, that this "is not to take away from either the need for safeguards, the extent of which may need to be explored further in future caselaw, or the desirability of the Oireachtas at least considering whether a more explicit statutory basis for that jurisdiction should be provided".[112] In particular, having considered the case of *MQ v Gleeson*,[113] Humphreys J stated:

> ... the duty to promote the welfare of children in need of protection is a foundation for a wide-ranging power to investigate and make findings of child abuse against potentially anybody against whom an allegation is made, because any child abuser could in future

105. [1989] IR 656 at 663.
106. [1989] IR 656 at 662.
107. [2021] IESC 1 at [130].
108. *Ibid* at [133].
109. [2020] IEHC 452.
110. *Ibid* at [1].
111. *Ibid* at [30].
112. *Ibid*.
113. [1998] 4 IR 85.

> abuse children in need of protection. That logic is a very slender and wobbly basis for an entire statutory jurisdiction to conduct child sexual abuse inquiries and findings or indeed findings as to any other form of child abuse or neglect. One can only suggest that perhaps the Oireachtas might consider that this particular area warrants a more explicit statutory underpinning for the procedures of investigation of child harm.[114]

The comments made by Humphreys J in this case reinforce the need for reform of the law governing the investigation of child sexual abuse. The 2020 Annual Report of the Special Rapporteur on Child Protection covered this issue at length and made detailed proposals for reform in this regard.[115] As noted in section 1.2.1.1 of this Report, reform proposals on this issue are progressing, but the details of those proposals are yet to emerge.

4.3.3 *J (A Person subject to an allegation of abuse) v Child and Family Agency* (Investigation of Allegation of Child Sexual Abuse)

This case[116] concerned a judicial review of the handling of an allegation of historical child sexual abuse by Tusla. While Tusla had conceded that its "provisional conclusion" should be set aside, the applicant sought orders restraining any further inquiry by Tusla into the alleged abuse.[117] Citing Order 84, rule 27(4) of the Rules of the Superior Courts (as amended in 2011), Simons J stated that:

> In cases involving alleged child sexual abuse, the court's discretion under Order 84 is one which will almost always be exercised in favour of remittal. This is because the best interests of the child must be the paramount consideration in proceedings which have the purpose of preventing the safety and welfare of any child from being prejudicially affected. An order which restrained the Agency from fulfilling its obligations under section 3 of the Child Care Act 1991 would be inconsistent with that paramount consideration.[118]

In making this decision, Simons J commented that "[g]iven the breadth of the discretion afforded to the Agency under section 3 of the Child Care Act 1991, I am satisfied that, as a matter of law, it is open to the Agency to commence a fresh investigation of the complaint".[119] However, the judge stated that "[t]he legislation does not require the Agency to endlessly investigate and reinvestigate complaints of historical child sexual abuse. The decision to close the file in September 2016 represented a reasonable and proportionate response to the peculiar circumstances of the complaint".[120] Simons J quashed the decision of Tusla without a remittal order, commenting that "it is a matter for the Agency to decide whether to commence a further investigation".[121]

114. [2020] IEHC 452 at [17].
115. O'Mahony (n 28 above), Chapter 2.
116. [2020] IEHC 464.
117. *Ibid* at [5] to [6].
118. *Ibid* at [57].
119. *Ibid* at [66].
120. *Ibid* at [75].
121. *Ibid* at [76].

4.3.4 *DPP v SA* (Rape and sexual assault of minors—cross-examination—sentencing)

The case of *DPP v SA*[122] concerned an appeal regarding the sentence imposed on the appellant, SA, for multiple counts of rape and sexual assault of two sisters, CE (aged 10) and JE (aged 12). The appellant was sentenced to imprisonment for 14 years, with the final two years suspended pending his participation in the "Better Lives Programme for Sexual Offenders while in Prison".[123] SA appealed this sentence on grounds that the sentencing judge "erred in law and in principle", first, by imposing an "excessive and disproportionate" sentence; second, by "failing to have due regard to the mitigating factors and/or failing to correctly balance the mitigating factors against the severity of the offences"; third, by "attributing the background evidence to be an aggravating factor", and fourth, by "characterising a legitimate defence point as an aggravating factor".[124]

The main focus of this judgment was on the appellant's fourth ground of appeal.[125] Birmingham P noted that "[i]t is readily understandable that the judge took exception to the suggestion that a twelve year old girl made false allegations against the appellant and conspired with her younger sister in order to do so".[126] He commented that "[o]n one reading … it could be said that the reference to a particular aspect of the cross-examination was given by the sentencing judge in order to provide a further example of the appellant's manipulative conduct".[127] Nonetheless, Birmingham P held that the sentencing judge erred on this ground, citing the cases of *People (DPP) v Gillane*[128] and *People (DPP) v Daly*[129] which underline "the fact that an individual contests his trial should not add one day to the sentence. This of course also includes the manner in which an individual contests the trial, subject of course to that caveat that irrelevant or vexatious cross-examination should be prohibited by the trial judge".[130] He concluded that the Court was "not persuaded that this was an error of substance justifying intervention by this Court".[131] The Court of Appeal did not find issues with the remaining grounds of appeal, noting that the headline sentence was proportionate.[132] The Court did, however, observe the appellant's opposition to attending the Better Lives programme in prison, which was central to the mitigating factors underlying the suspended part of his sentence. The Court of Appeal replaced this aspect of the sentence, in accordance with section 99 of the Criminal Justice Act 2006.[133]

122. [2020] IECA 311.
123. *Ibid* at [15].
124. *Ibid* at [19].
125. *Ibid* at [53].
126. *Ibid* at [62].
127. *Ibid* at [64].
128. Court of Criminal Appeal, unreported, 21 December 1998.
129. [2012] 1 IR 476.
130. [2020] IECA 311 at [65].
131. *Ibid* at [66].
132. *Ibid* at [83].
133. *Ibid* at [96] to [99].

4.3.5 *McDonald v Conroy and Gorey Community School* (Tort of Grooming—Consent)

This decision[134] concerned two appeals from a judgment by Eager J in the High Court granting Ms McDonald an order for damages against the defendants. Ms McDonald claimed that "she was physically and sexually assaulted, falsely imprisoned and sexually abused by Fr Conroy", a teacher at her school, between 2004 and 2007.[135] The High Court judge upheld these claims and found Fr Conroy to be "guilty of the tort of 'grooming'".[136] The judge also held that the school was vicariously liable. Collins J in the Court of Appeal identified four issues: first, the trial judge's findings of fact; second, consent; third, the legal basis for the "tort of grooming", and fourth, the Statute of Limitations.[137]

On the first issue, Collins J held that there was a "conflict of evidence" regarding trips to the Gambia and Cologne and that this "should have been resolved clearly by" Eager J in the High Court.[138] Equally, Collins J held that the evidence of Elizabeth Kenny (Fr Conroy's sister) should have been considered by the trial judge regarding the plaintiff's alleged visits to Fr Conroy's house.[139] Collins J also criticised the psychiatric evidence in this case. Accordingly, Collins J stated that "the High Court Judgment must be set aside on this ground".[140]

In relation to the issue of consent, Collins J observed that Eager J was required "to make a finding whether, as a matter of law, Ms McDonald had capacity to consent to the sexual activity she had described and (if so) whether, in all the circumstances, she had, in fact, effectively consented. The Judge should also have addressed the issue of the onus of proof".[141] Collins J concluded, however, that "the Judge failed to address these questions in his Judgment. Strikingly, nowhere in his Judgment is there any reference to the issue of consent".[142] He held that this "leads inevitably to the conclusion that the findings of assault and abuse in paragraph 88 of his Judgment must be set aside".[143]

The third issue identified by Collins J concerned "the tort of grooming". This issue was not pleaded by the plaintiff but was included "on the hoof".[144] The case of *Walsh v Byrne*[145] was cited by all parties as the sole authority for this tort. Collins J concluded that: "The appeals here give rise to significant questions about whether there is a stand-alone tort of grooming and, if so, what its constituent elements are and how it relates to established torts such as sexual assault. Issues of consent also arise on the facts here. In my opinion, it would not be appropriate to attempt to resolve these difficult issues in these appeals".[146] Collins J noted that the plaintiff must "seek leave to amend her Statement of Claim" if she wishes to include a claim concerning the tort of grooming.[147] By way of final decision in this case, Collins J directed a re-hearing in the High Court.

134. [2020] IECA 239.
135. *Ibid* at [4].
136. *Ibid* at [4].
137. *Ibid* at [13].
138. *Ibid* at [62] and [72].
139. *Ibid* at [75] to [79].
140. *Ibid* at [98].
141. *Ibid* at [113].
142. *Ibid*.
143. *Ibid* at [118].
144. *Ibid* at [163].
145. [2015] IEHC 414.
146. [2020] IECA 239 at [176].
147. *Ibid*.

4.3.6 *JV v QI* (International Child Abduction—Grave Risk of Harm—COVID-19)

This case, before the Court of Appeal,[148] concerned a High Court order returning two children, E (aged 11) and O (aged eight), to Belgium under Article 12 of the Hague Convention and Article 11 of the Revised Brussels II *bis* Regulation. The father, JV, and the mother, QI are Belgian nationals and their children were born in Belgium. The parents' relationship broke down in 2016 and a court order in 2018 prohibited the removal of the children from Belgium. The mother moved to Ireland in September 2019, and the children remained in Belgium with their father. In July 2020, during scheduled access, the mother brought the children to Ireland. In August 2020, the father sought an order for the return of the children to Belgium. The appeal focused on the grounds of consent, the views of the children and grave risk of physical harm due to the COVID-19 pandemic. Whelan J's judgment in relation to the latter ground is noteworthy.

In relation to the claim of grave risk of returning the children to Belgium due to the pandemic, Whelan J held that "the trial judge was correct and that the high threshold has not been met in this case to establish grave risk of physical harm".[149] In this regard, Whelan J observed that "[o]ne factor to be considered, where relevant, is whether the return would involve a child being returned to a 'zone of disease' in light of the *Friedrich v Friedrich* jurisprudence derived from the decision of the US Court of Appeals for the Sixth Circuit".[150] In considering this, Whelan J stated that "regard must be had to the fact that children are in general acknowledged by experts to be at low risk of contracting Covid-19 and where contracted they normally suffer minor symptoms".[151] Further, Whelan J noted that "schools are open for children … both in Belgium and in Ireland".[152] In relation to international travel, Whelan J cited Rees J in the case of *In Re PT (A Child)*,[153] stating: "I can infer from the continuation of international flights between the two States that 'the risk of infection posed by air travel, whilst no doubt significantly greater than normal, is not so high that either government has felt necessary to end flights altogether'".[154] An order was made to return the children to Belgium.

4.3.7 *B v Director of Oberstown Children Detention Centre* (Juvenile Justice—Prison Rules—Remission)

In this case,[155] the Supreme Court was required to consider "whether children serving sentences of detention under the Children Act 2001 are entitled, on the basis of the equality guarantee in Article 40.1 of the Constitution, to be treated in the same manner as adult prisoners in respect of all aspects of the rules regarding remission of sentences".[156] Describing the law in the area, O'Malley J noted that the Minister for Justice has "power to regulate remission for prisoners serving sentences" under section 35 of the Prisons

148. [2020] IECA 302.
149. *Ibid* at [97].
150. *Ibid* at [94].
151. *Ibid* at [95].
152. *Ibid* at [97].
153. [2020] EWHC 834 (Fam).
154, [2020] IECA 302 at [91].
155. [2020] IESC 18.
156. *Ibid* at [1].

Act 2007. Regulations under the section expressly refer to St Patrick's Institution, which closed down in 2017. No reference is made to Oberstown.[157] According to prison rules, "[a] prisoner who has engaged in authorised structured activity may apply to the Minister for Justice and Equality for enhanced remission. Such remission may be up to one third of the sentence".[158] O'Malley J noted that "the Prison Rules do not apply to children detention schools".[159] The main question for the Court in this case was whether "the penal regime that applies to all children should be compared with that established for adults".[160] Referencing the Children Act 2001, O'Malley J held that "[t]he presumption of the legislature, that the differences between children and adults calls for different regimes, has not been shown to be factually incorrect or unfair in principle".[161]

4.3.8 *M v Director of Oberstown Children Detention Centre* (Juvenile Justice—Single Separation)

This case[162] concerned separation measures imposed on M following three incidents involving "challenging behaviour".[163] Simons J, citing *SF (a minor) v Director of Oberstown Children Detention Centre*,[164] noted that "the determination of whether separation measures represent a breach of a child's constitutional rights necessitates a fact-specific inquiry as to the precise nature of the separation."[165] The High Court found "that the threshold for a finding of a breach of a substantive constitutional right had not been met".[166] M put forward five issues on appeal to the Court of Appeal, including whether his separation constituted punishment; whether child detainees and adult prisoners are "appropriate comparators for the purpose of Article 40.1"; and whether their "differential treatment" serves "a legitimate legislative purpose".[167]

In making a decision, Whelan J stated that "the appellant was placed in single separation first and foremost in the interests of his own welfare and safety"[168] and that this "did not amount to punishment".[169] Discussing "the nuanced, child-oriented remit of the Children Acts 2001 to 2015", Whelan J commented that "[t]he process adopted was proportionate, appropriate and involved direct personal engagement aimed at addressing serious negative behavioural issues and incentivising personal improvements".[170] Whelan J also stated that the Single Separation Policy "had been carefully developed" and that the facts of this case had to be distinguished from those in *SF* (cited above).[171] In relation to

157. *Ibid* at [18].

158. Rule 59(2) as substituted by the Prison (Amendment) (No 2) Rules 2014 (SI No 385/2014). See [2020] IESC 18 at [19] to [20].

159. [2020] IESC 18 at [22].

160. *Ibid* at [76].

161. *Ibid* at [76].

162. [2020] IECA 249.

163. *Ibid* at [9].

164. [2017] IEHC 829.

165. [2020] IECA 249 at [16].

166. *Ibid* at [20].

167. *Ibid* at [46]. See also [44].

168. *Ibid* at [115].

169. *Ibid* at [119].

170. *Ibid* at [116].

171. *Ibid* at [123].

Article 40.1 of the Constitution, Whelan J noted that "there are fundamentally different challenges and objectives arising in a child detention centre such as render comparisons with the rules and regimes in adult prisons of the kind being raised in this case wholly misplaced".[172] For these reasons, the Court dismissed the appeal.

4.3.9 *DPP v EC* (Children Act 2001—Child Homicide—Identification of Victim in Media Reports)

DPP v EC[173] concerned the interpretation of section 252 of the Children Act 2001, and in particular, whether a child homicide victim can be identified and whether the person charged with that homicide can also be identified if that would identify the child. The relevant part of the section read as follows:

> (1) Subject to subsection (2), in relation to any proceedings for an offence against a child or where a child is a witness in any such proceedings—
>
> (a) no report which reveals the name, address or school of the child or includes any particulars likely to lead to his or her identification, and
>
> (b) no picture which purports to be or include a picture of the child or which is likely to lead to his or her identification, shall be published or included in a broadcast.

Birmingham P noted that "what is really in issue is the phrase 'in relation to any proceedings for an offence against a child'".[174] The judge noted that: "In my view, it is not possible to interpret this section as not including a deceased person who was a child at the time of death. Neither, in my view, is it possible to exclude proceedings relating to offences committed against a child, as a child, if they come on for hearing after the child has attained his or her majority".[175] According to Birmingham P, "If change is required and if it is desired to return to previous practice where it was possible to report cases involving the deaths of children, then it is a matter requiring intervention by the Oireachtas".[176]

The impact of this decision generated some disquiet. Families of victims expressed a feeling of being "silenced" and "gagged" by the ruling, which they felt undermined their children's right to be remembered.[177] An editorial in the Irish Times, while accepting that the wording of the Act was "very clear" and that "it is difficult to see how the Court of Appeal could have ruled otherwise," argued that the decision "overturns decades of practice and opens up a plethora of anomalies":

> … child murderers cannot, in the majority of cases, be identified, while those who murder adults can. It is hard to believe that this was the intention of the drafters of Section 252 of the Children Act 2001. The anomalies are glaring: if a whole family falls

172. *Ibid* at [130].

173. [2020] IECA 292.

174. *Ibid* at [7] and [5].

175. *Ibid* at [13].

176. *Ibid* at [14].

177. See, eg, L Dunphy, "Child murder victims will be 'forgotten children' under new interpretation", *Irish Examiner*, 5 February 2021 and V Clarke and C Gallagher, "Kathleen Chada welcomes lifting of ban on naming child victims of homicide", *Irish Times*, 7 May 2021.

> victim to a murder-suicide, and the murdering parent kills him or herself, there will be no trial and all the victims can be named. However, if the perpetrator survives and there is a trial they cannot. The ruling also deprives a surviving parent of murdered children of the opportunity to express publicly their grief if there is a trial.[178]

In response to this decision, the Oireachtas passed the Children (Amendment) Act 2021. This Act inserted new paragraphs into section 252 which disapply the section in cases where the proceedings concerned relate to the death of the child, and clarified that section 252 does not prohibit the publication or inclusion in a broadcast of a report or picture relating to the person against whom the offence concerned is alleged to have been committed where the person has attained the age of 18 years on or before the date on which the proceedings commence. In either case, the proviso is included that such publication or inclusion in a broadcast must not result in a contravention of section 252 in respect of a child who is alive, or of section 93 of the Children Act 2001 (which imposes restriction on the reporting of juvenile justice proceedings under Part 9 of the Act). The 2021 Act also amended subsection (2) of section 252 to impose a similar proviso on the power of the Court to dispense with the requirements of section 252.

4.4 RESEARCH UPDATE

The following is a selection of academic research in the broad area of child protection published between January 2020 and June 2021.

4.4.1 Child Welfare Removals

Several new studies have been published discussing issues relating to the removal of newborn children. Luhamaa *et al* discussed the extent to which services and support are available to mothers and their newborns in child protection cases in eight jurisdictions, including Ireland.[179] The research was based on 216 judgments from "eight high-income European countries (Austria, England, Estonia, Finland, Germany (one region), Ireland, Norway and Spain (one region)) that have slightly different child protection systems".[180] The judgments were delivered between 2012-2018, but "the base year was 2016".[181] The mothers in the judgments presented with "problems such as substance misuse, mental health problems, learning difficulties and physical disabilities".[182] Some 88% of cases mention service provision. The authors concentrated on "four hypotheses".[183] The first hypothesis was that "[a]ll states provide services to vulnerable families".[184] This was "partially supported" by the research; the authors found that "in some countries, all or

178. "The Irish Times view on reporting on child killings: an amendment must be enacted", *Irish Times*, 1 November 2020.

179. K Luhamaa, A McEwan-Strand, B Ruiken, M Skivenes and F Wingens, "Services and support for mothers and newborn babies in vulnerable situations: A study of eight European jurisdictions" (2021) 120 *Children and Youth Services Review* 1-10.

180. *Ibid* at p 1.

181. *Ibid* at p 4.

182. *Ibid* at p 5.

183. *Ibid* at p 4.

184. *Ibid* at p 4.

almost all cases include this information (England, Finland, Ireland and Norway), whereas in others (Austria, Estonia, Germany and Spain) we learn less about service provision by the welfare state or the child protection system".[185] The second hypothesis was that "[t]here will be differences in service provision due to the type of problems faced by the families/ parents (e.g., parents with substance abuse problems, learning disabilities or mental health problems)".[186] The authors noted that this is not supported by their research: "[w]e are unable to detect a pattern based on parental problems, as the countries with a large number of welfare services … do this across the board regardless of parental problem type".[187] The third hypothesis was that "[t]here will be country differences due to the type of child protection system in place (risk or family-service oriented)".[188] This was "partially confirmed, as we find differences between countries, but these differences do not accord directly with types of child protection systems".[189] The fourth and final hypothesis was that "[r]isks to a newborn are similar across countries and provoke similar responses across countries and problems".[190] The authors noted that this "is not confirmed as we have shown clear differences".[191] This research highlights that "[t]here are knowledge gaps in terms of the proven effects of services and what is actually provided to the child and the parents".[192]

Krutzinna and Skivenes published a comparative analysis of the assessment of mothers' parenting capacities in newborn removals, focussing on Germany, Norway and England.[193] The authors analysed 117 judgments: 27 from Germany (2015-2017), 76 from Norway (2016) and 14 from England (2015-2017). They observed three notable issues: "First, risk-increasing factors are much more evident in the cases than risk-reducing factors. Second, there are cross-country differences as to which factors are most often mentioned and which ones are rarely mentioned. Third, there is a lack of balancing act of risk-increasing versus risk-reducing factors in their justifications for decisions".[194] The authors found five recurring "risk-increasing" factors: "lack of empathy for child (61%) and poor parenting capacity (59%) … mother's abuse in childhood (53%); lack of compliance (50%); and denial of problems (47%)".[195] Regarding "cross-country differences", the authors observed that Norway provided a "far more comprehensive" consideration of risk factors than England or Germany.[196] Finally, as regards "balancing risk-increasing and risk-reducing factors", they observed that courts pay more attention to risk-increasing factors, and indeed neglected to consider risk-reducing factors in 25% of cases. An example put forward was that "in cases of mental disorder, the responsiveness to treatment was not systematically considered".[197] By way of conclusion, the authors comment that "given the severity of

185. *Ibid* at p 7.
186. *Ibid* at p 4.
187. *Ibid* at p 8.
188. *Ibid* at p 4.
189. *Ibid* at p 8.
190. *Ibid* at p 4.
191. *Ibid* at p 8.
192. *Ibid* at p 9.
193. J Krutzinna and M Skivenes, "Judging parental competence: A cross-country analysis of judicial decision makers' written assessment of mothers' parenting capacities in newborn removal cases" (2021) 26 *Child and Family Social Work* 50.
194. *Ibid* at p 57.
195. *Ibid* at p 56.
196. *Ibid* at p 57.
197. *Ibid* at p 58.

problems our analysis reveals, it is perhaps unsurprising that no full balancing exercise is undertaken. The requirement to act immediately to avert risk to the child will thus outweigh any risk-reducing factors in the short term in these most serious cases".[198]

Juhasz presented the results of a Norwegian study focused on the role of discretion in decision-making by the Norwegian County Social Welfare Board in child welfare removals of newborns.[199] The study involved an analysis of all of the child welfare removals that took place in respect of newborns removed from hospital in 2016. There were 46 such removals and Juhasz concentrated on 19 of these in which it was the parents' first time having a child removed. According to Juhasz, "[t]his is a sample in which decision-makers' assessment of, and predictions about, parenting capacities are not based on information about previous actual parenting, but rather take the form of hypothetical assessments about parenting".[200] The study showed that "personality/social functioning issues" were problematic in 16 of the 19 cases.[201] It was also evident that newborns are removed in circumstances where the parents have multiple problems. For example, the parents had mental health issues in 10 of the cases, they faced issues in their own upbringing in eight of the cases, and had intellectual disabilities in six of the cases.

Parents' capacity to change was assessed in all cases, and in 13 of these, "the parents … were not expected to change their problem behavior or functioning in the near future".[202] The problems were viewed as "permanent"; all six of the cases involving parents with intellectual disabilities fell into that category, and accordingly, the newborn was placed in long term care. It was noted in 13 cases that regardless of parental assistance, the problems were "somewhat 'fixed' or impossible to overcome in the foreseeable future".[203] In contrast, change was noted to be possible in four of the 19 cases, but this would be "slow-moving".[204] Juhasz noted that "[s]tability and time" was necessary in these cases for the parents who had drug problems. There were also two "transient" cases which included "personality/social functioning issues, as well as mental health problems".[205] According to Juhasz, while there were "no clear patterns … as to the amount of problems and the degree of change expected … it is evident that the two transient cases 'only' included two problem areas each", while the other cases had three or four problems.[206]

Regarding the duration of the parents' problems, a general conclusion drawn by Juhasz was that "where the problems had lasted the longest, since childhood, the County Board saw the least potential for change".[207] For example, nine of the parents had "lived in either foster homes or residential units" themselves as children.[208] Having considered all 19 cases, Juhasz remarked that the Norwegian County Social Welfare Board uses its discretion by focusing on "past and current parental risk factors and behavior, and making inferences

198. *Ibid.*

199. IB Juhasz, "Child welfare and future assessments—An analysis of discretionary decision-making in newborn removals in Norway" (2020) 116 *Children and Youth Services Review* 105137.

200. *Ibid* at pp 1-2.

201. *Ibid* at p 5.

202. *Ibid.*

203. *Ibid.*

204. *Ibid.*

205. *Ibid* at p 6.

206. *Ibid.*

207. *Ibid.*

208. *Ibid* at p 7.

from these observations to hypothetical future parenting".[209] The number of sources used in each case when assessing the parents can vary considerably, and this was viewed as problematic by the author, who concluded that there is "a need for more instructions and guidelines towards future assessments, to further improve predictions about parenting and assessing risk of future harm".[210]

Strömpl and Luhamaa published a study of children's participation in child welfare removals proceedings in Estonia.[211] They analysed 20 transcripts of interviews with children who were involved in the child removal process and 107 questionnaires distributed to relevant child protection practitioners. The authors used the Lundy model of child participation as the conceptual framework in analysing this empirical research. This research showed that children's and practitioners' understanding of participation in child welfare removals was not aligned. For example, the authors commented that "[t]he concept of child participation as a right and not an obligation was poorly understood by the professionals".[212] Meanwhile, "[c]hildren's preferences … depended mostly on their relations with the process and professionals".[213] The importance of the right to information (Article 13 CRC), as well as children's evolving capacities (Article 5 CRC) and the right to be safe (Article 19 CRC) were identified as "directly connected" with children's participation rights under Article 12 CRC, and the Lundy model of child participation.[214] The authors also found that "professionals need more sensitivity when hearing children so that they would not handle them only as a source of information, as this can cause further misuse and victimization".[215]

Strömpl and Luhamaa are critical of the approach to children's participation in Estonia, noting that despite legislative change, "children, especially children in vulnerable situations, are seen mostly as objects of adults' protection and care rather than as subjects of laws with their own personal agency".[216] The authors concluded that practitioners "need more awareness, skills, and knowledge to be responsible while at the same time engaging the child in decision making".[217] In particular, they commented that "shifting the focus of training from formal knowledge to practical implementation would be a welcome development in Estonia".[218]

4.4.2 Care-Leaver Mothers

Krutzinna discussed mothers in child protection cases who were in care themselves, and the role of the State in preparing these mothers to be parents, thus breaking the "continuous chain of mothers who lose their children to social services after having been

209. *Ibid.*

210. *Ibid* at p 9.

211. J Strömpl and K Luhamaa, "Child participation in child welfare removals through the looking glass: Estonian children's and professionals' perspectives compared" (2020) 118 *Children and Youth Services Review* 105421.

212. *Ibid* at p 9.

213. *Ibid.*

214. *Ibid.*

215. *Ibid* at pp 9-10.

216. *Ibid* at p 10.

217. *Ibid.*

218. *Ibid.*

in public care as children themselves".[219] The author focused on the role of "solidarity", defined by Prainsack and Buyx as "shared practices reflecting a collective commitment to carry 'costs' (financial, social, emotional, or otherwise) to assist others".[220] Applying this to the welfare state and child protection, Krutzina states that there "is a duty to assist in breaking the cycle and to prepare children in care for their potential future as parents".[221] This obligation is further emboldened by "children's rights, which emphasise a right to have their interests protected, including the option to be parents, if they so choose".[222] Krutzinna refers to both the CRC and the ECHR, and in respect of the latter, notes that the right to respect for family life should include "the right to respect for *future* family life and a right to safeguarding of parenting prospects".[223] Krutzinna notes that "we need to reflect on our failures towards the mothers and perceive children currently in care as future mothers (and fathers) who require assistance in developing adequate parenting capacities".[224] The dearth of research in this area is also flagged throughout by the author as it inhibits effective interventions by the State. The author concluded that "the welfare state ought to treat mothers whose children are removed from their care like other groups that experience grief and loss. Psychosocial support to work through the experience and to adjust the sense of self and identity would be a starting point".[225] In addition, "the state should begin to conceptualise children in care as future parents".[226]

4.4.3 ECHR Child Protection Cases

An article by Rittossa analysed ten cases before the European Court of Human Rights (ECtHR) concerning child sexual abuse (CSA), focusing on the standards for protection of sexually abused children's rights set by the Court.[227] In particular, this article addressed the boundaries of Articles 3 and 8 of the European Convention on Human Rights, and judicial interpretation of these. Ritossa noted that the ECtHR "has developed a clear evolutive line of human rights standards": "The Court's judicial review methodology in CSA cases has developed gradually starting from almost incidental enumeration of guiding principles in its early case law and concluding with the comprehensive standards tailored within the context of child friendly justice".[228] In making this finding, Ritossa discussed *O'Keeffe v Ireland*,[229] noting that the extension of State responsibility to include a general risk of harm to children as well as specific risks to identified children went further than previous case law, while "the causation standard is broader than the one in the context of protective positive obligations from earlier Court's practice".[230] Ritossa also discussed *A and B v*

219. J Krutzinna, "Breaking the cycle: Solidarity with care-leaver mothers" (2021) 7 *DiGeSt Journal of Diversity and Gender Studies* 82 at p 83.

220. *Ibid* at p 87.

221. *Ibid* at p 86.

222. *Ibid* at p 87.

223. *Ibid* at p 89.

224. *Ibid* at p 88.

225. *Ibid* at p 90.

226. *Ibid*.

227. D Rittossa, "Strengthening the Rights of Sexually Abused Children in front of the European Court for Human Rights—A Tale of Justice, Fairness and Constant Normative Evolution" (2020) 4 *EU and Comparative Law Issues and Challenges Series* 529 at 532.

228. *Ibid* at p 551.

229. 35810/09, 28 January 2014.

230. Ritossa (n 227 above) at p 548.

Croatia,[231] which she argues "stands out as potentially the most coherent Court's decision [*sic*] that illuminates a substantive nature of sexually abused children's rights under the Convention and their reach and practical recognition in regard to positive obligations of the state parties and the Court itself".[232] The author notes that this was the first case in which the ECtHR "issued a request to the Bar Association of a member country for appointment of a separate representative to overcome a strong risk of invoking the rights of the applicant child in an instrumental way by her parents who were in a mutual conflict and incompetent to protect the best interest of their child. The representative was trusted with the task to duly present child's views and interests due to the fact that the alleged abuser of a 4 year old girl was her father."[233] Ritossa emphasised some unresolved difficulties with CSA cases before the ECtHR including that "[i]t is still ambiguous under which circumstances the CSA amounts to torture, inhuman or degrading treatment or only constitutes a violation of the right to respect for private life under Article 8".[234] She also criticised the "level of discretion" afforded to States as well as the "absence of precise guidelines" for effective investigations.[235]

4.4.4 Disclosures of Sexual Abuse

Marchant, Carter and Fairhurst presented practical guidance for medical professionals, teachers and any professionals working with children in circumstances where children may talk about abuse.[236] This guidance is based on experience garnered from Triangle's day-to-day work with children. Triangle "is an independent organisation enabling children and young people (up to age 30) to communicate about important things, especially in legal proceedings".[237] This article demonstrated current inadequacies in guidance regarding children's sharing of abuse with professionals, which "focuses on reporting concerns rather than responding to the child".[238] The authors commented that this approach "could accidentally silence children, by creating anxiety, hesitancy or confusion".[239] Instead, this article proposed an "'opening doors' framework" which "draws on what is known about children's memory and children's testimony … about the impact of trauma … and on a set of ideas about non-directive communication".[240] The "opening doors" approach offers practical tips such as not expecting the child to maintain eye contact while they speak, as well as repeating exactly what the child said, "without expanding or amending or asking questions".[241] A "real-life scenario" is also presented involving a six-year-old's attendance at a doctor, demonstrating a series of questions which a doctor can ask that may encourage a child to tell a little more about abuse they have experienced, as opposed to discouraging them from talking. The authors also made a case for replacing use of the

231. 7144/15, 4 November 2019.

232. Ritossa (n 227 above) at p 549.

233. *Ibid* at p 549.

234. *Ibid* at p 552.

235. *Ibid*.

236. R Marchant, J Carter J and C Fairhurst, "Opening doors: suggested practice for medical professionals for when a child might be close to telling about abuse" (2021) 106 *Archives of Disease in Childhood* 108.

237. See www.triangle.org.uk.

238. Marchant *et al* (n 236 above) at p 108.

239. *Ibid*.

240. *Ibid* at pp 108-109.

241. *Ibid* at p 109.

word "disclosure" in the context of child abuse with "a two-way interaction … for example, 'She has told the doctor something'; 'He has made an allegation'; 'She has shown very concerning behaviours'; 'He has made worrying comments'".[242]

Practitioners who are interested in Triangle's work on communicating with young children may be interested in a practice tool developed as a collaboration between Triangle and the IDEA Child Rights Project at UCC, which provides practical guidance on use of language when communicating with young children, and which is free to download and share.[243]

Brennan and McElvaney considered twenty studies over a twenty year period from 1998-2008 regarding what helps children to disclose experiences of child sexual abuse.[244] According to the authors, there were two main themes: "'Needing to tell' and 'Opportunity to tell'" and they commented that "it is the combination" of these two factors "that help children tell".[245] They further identified subthemes under these main themes. For example, under "Needing to tell", they identified the following subthemes: "realising it's not normal; unable to cope with emotional distress; wanting something done about it; and being asked".[246] Meanwhile, under "Opportunity to tell", they identified the following subthemes: "access to someone you can trust; expecting to be believed; and being asked".[247] It was noted that "'Access to someone you can trust' was the most prominent subtheme identified in this data, underscoring the importance of the availability of a trusted other for the child and supporting the idea of disclosure as a dialogical process".[248] In the context of "realising it's not normal", which the authors identified as the "second most prominent subtheme in this data", it was commented that the research "highlights the importance of psychoeducational programmes … for children of all ages in helping them understand good and bad touches, human rights, and healthy and unhealthy relationships".[249]

Meanwhile, Mooney detailed research concerning adults' experiences of disclosing retrospective child abuse to child protection social workers in Ireland.[250] Four males and one female took part in this research and the "approximate average delay to disclosure" was 23 years.[251] Mooney identified six main themes: "the adult; disclosure; interaction; information; engagement with social work; and reflection"[252] and grouped findings under three distinct headings: "the system as a barrier; issues of power; and the system as a facilitator".[253] Regarding the system as a barrier, the author noted that study participants highlighted "what they perceived as a lack of expertise, competency and professionalism on the part of the social worker with whom they met".[254] This was "compounded by wider

242. *Ibid.*

243. See K Burns, C O'Mahony, C McAuley, F Ó Súilleabháin and E O'Callaghan, *Communicating with Children in Court* (2019), available at https://ideachildrights.ucc.ie/resources/Children-print.pdf.

244. E Brennan and R McElvaney, "What Helps Children Tell? A Qualitative Meta-Analysis of Child Sexual Abuse Disclosure" (2020) 29 *Child Abuse Review* 97.

245. *Ibid* at pp 101 and 109.

246. *Ibid* at p 102.

247. *Ibid.*

248. *Ibid* at p 110.

249. *Ibid* at p 109.

250. J Mooney, "How Adults Tell: A Study of Adults' Experiences of Disclosure to Child Protection Social Work Services" (2021) 30 *Child Abuse Review*, 193-209

251. *Ibid* at p 196

252. *Ibid* at p 198.

253. *Ibid* at p 203.

254. *Ibid.*

systemic issues, including a complex Irish legal context where there is an absence of a specific legislative framework underpinning assessment in this area".[255] In relation to issues of power, it was commented that "routine processes, for example, receiving an initial letter from social work services and preparing for an interview, may have a higher significance for an adult owing to the trauma that he or she has experienced".[256] Any delays in responses from social workers also impacted the participants. Finally, with regard to the system as a facilitator, Mooney commented that "[t]he narratives provided by the participants in this study present examples of how the current Irish child protection system of receiving and assessing adult disclosures has a potential to re-traumatise".[257] For example, one participant stated that their social worker "did not turn up to his appointment".[258] Participants in the study stated that they expected "clear communication, being kept up to date, and having a support plan and a more robust legal or statutory framework".[259] The author recommends further research with child protection social workers, further training and wider systemic reform with a focus on the EU Victims Directive. Mooney's findings are of relevance to the reform of section 3 of the Child Care Act 1991 and the law governing the investigation of allegations of child sexual abuse (as discussed in sections 1.2.1.1 and 4.3.2 above).

4.4.5 Corporal Punishment

Burns *et al* carried out a study of population responses to a survey vignette in 2016 in five European countries (Austria, Estonia, Ireland, Spain and Norway) on the subject of corporal punishment (CP).[260] The purpose of their article "was to provide baseline knowledge about population attitudes towards corporal punishment and reporting it to public child protection authorities".[261] The study showed that the "majority of citizens (73.8 per cent) do not accept" corporal punishment and "a majority—57.3 per cent of all the individuals in our sample—think that the school should report the case to the child protection authorities".[262] The study highlights two "mismatch groups"; first, "the group of respondents that reject CP and do not want to report it, and secondly the group of respondents that accept CP and do want it to be reported".[263] The authors suggest possible reasons for the mismatch groups and suggest further research "of whether there is a correlation between confidence in government/child protection system, and citizens' willingness to report child maltreatment".[264] This research is notable as one of the first studies to explore attitudes to corporal punishment in Ireland since the abolition of the defence of reasonable chastisement by the Children First Act 2015, as well as the introduction of mandatory reporting by the same Act.

255. *Ibid.*

256. *Ibid* at p 204.

257. *Ibid* at p 205.

258. *Ibid.*

259. *Ibid.*

260. K Burns, H Stein Helland, K Križ, S Sanchez-Cabezudo, M Skivenes and J Strompl, "Corporal punishment and reporting to child protection authorities: An empirical study of population attitudes in five European countries" (2021) 120 *Children and Youth Services Review* 105749.

261. *Ibid* at p 5.

262. *Ibid.*

263. *Ibid.*

264. *Ibid* at p 7.

4.4.6 Sexuality Education

An article by Daly and O'Sullivan explored the idea of sexuality education as a right of the child.[265] They point to the importance of education for children regarding sexual health, relationships and consent and note that failure to educate children in this respect can mean that they are unprotected and also cause harm to others. On this basis, the authors make the case that sexuality education has a role to play in combatting sexual violence. The authors discuss case law from the ECtHR, Canada and the European Committee of Social Rights and note that judgments have emphasised the importance of sexuality education as a public health benefit, rather than as a right of the child.[266] They also discuss parents' roles in sexuality education and comment that legislation and court decisions enabling parents to provide this education instead of in school is problematic as it can leave gaps in children's understanding.[267] This article also addresses the #MeToo movement, observing that legislative change as a result of this movement in some states in the United States can contribute to helping children "from becoming both victims and perpetrators of sexual crimes".[268] Daly and O'Sullivan discuss the role of lawyers in grounding their arguments in children's rights, which will have a knock-on effect for judgments delivered by courts. They note that "[l]awyers who are tasked with defending state sexuality education in relevant cases must therefore emphasize that such education is crucial for each individual child—they simply will not be adequately prepared for life without it".[269] They also call on NGOS and other bodies "to identify where states are failing to provide sexuality education. Connections must be drawn between these failures, high rates of child abuse and exploitation, and the criminalization of children and young people for unknowingly engaging in child sexual offences".[270]

Daly and O'Sullivan's article is timely given ongoing debates in Ireland regarding the overhaul of the current curriculum on sexuality education. Article 19 of the CRC obliges Ireland to take "all appropriate … social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse". The Committee on the Rights of the Child has called upon State Parties to implement educational measures for children which are "directed to improve their pro-social attitudes, competencies and behaviours",[271] and has specifically called upon Ireland to "[a]dopt a comprehensive sexual and reproductive health policy for adolescents and ensure that sexual and reproductive health education is part of the mandatory school curriculum and targeted at adolescent girls and boys."[272]

A 2021 report by Ofsted in England has documented the "normalisation" of sexual harassment and online sexual abuse in schools,[273] and early indicators give rise to concern

265. A Daly and C O'Sullivan, "Sexuality Education and International Standards: Insisting upon Children's Rights" (2020) 42(4) *Human Rights Quarterly* 835.

266. *Ibid* at pp 849-855.

267. *Ibid* at p 847.

268. *Ibid* at p 843.

269. *Ibid* at p 856.

270. *Ibid* at p 857.

271. Committee on the Rights of the Child, *General comment No 13 (2011): The right of the child to freedom from all forms of violence*, UN Doc No CRC/C/GC/13, 18 April 2011 at [52].

272. Committee on the Rights of the Child, *Concluding observations on the combined third and fourth periodic reports of Ireland*, UN Doc No CRC/C/IRL/CO/3-4, 1 March 2016 at [58].

273. Ofsted, *Review of sexual abuse in schools and colleges* (June 2021), available at https://www.gov.uk/government/publications/review-of-sexual-abuse-in-schools-and-colleges.

that this trend will emerge or may already be emerging in Ireland. Recent statistics indicate that 20% of detected sexual violence in Ireland involves children as both victims and offenders.[274] Doctoral research completed by Michelle Walsh in 2020 found that 83% of Irish adolescents who participated in her study reported having witnessed "mild to extreme instances of physical sexual harassment within their peer groups".[275] In a detailed report in 2019, the National Council for Curriculum and Assessment (NCCA) concluded that "[f]or most students their experience of RSE [relationships and sexuality education] can be summed up as too little, too late and too biological":

> … the dominant approach is concerned almost exclusively with the risks and dangers associated with relationships and sexuality and does not allow for sufficient discussion of the positive, healthy and enjoyable aspects of relationships as well as the challenges. Most people agreed that moving towards a more holistic and positive approach is desirable. In addition, there is agreement that RSE should be developmentally-appropriate, culturally and contextually relevant, and scientifically accurate.[276]

The NCCA recommended that the curriculum be redeveloped to address issues including the effects of the internet and social media on relationships; self-identity and self-esteem; consent and its relevance to all interpersonal relationships; LGBTQ+ matters; healthy positive sexual expression, and developments in contraception.[277]

When placed in this context, it is concerning that in the "Flourish" programme recently developed by the Catholic Bishops as a basis for relationships and sexuality education in Catholic primary schools (which account for almost 90% of primary schools in Ireland), the sections on "staying safe" focus on issues like crossing the road and the dangers of smoking.[278] The NCCA has established two development groups (one for primary and one for post-primary) to oversee development work arising from its 2019 report. The groups began meeting in October 2020 and aim to publish interim guidance by December 2021, with a view to finalising a revised Junior Cycle curriculum by 2022 and a revised Senior Cycle curriculum by 2023.[279] The importance of this work is clear. This report endorses the NCCA's 2019 conclusions, and calls on all parties concerned to work together to ensure that the timeline for the review of the curriculum on sexuality education is met, and that children's rights are at the heart of the revised curriculum in all Irish schools.

4.4.7 Children in Care

In the latest publication from the *Voluntary Care in Ireland Study*, Burns, O'Mahony and Brennan discussed the under-researched area of "private family arrangements" (PFAs) for

274. J Casey, "Students have their say on overhaul of sex education", *Irish Examiner*, 4 May 2021.

275. M Walsh, *An Exploration of Sexual Harassment among Irish Adolescents: Experience and Understanding* (PhD Thesis, National University of Ireland Galway, 2020) at p 241.

276. National Council for Curriculum and Assessment, *Report on the Review of Relationships and Sexuality Education (RSE) in primary and post-primary schools* (December 2019) at p 71, available at https://ncca.ie/media/4462/report-on-the-review-of-relationships-and-sexuality-education-rse-in-primary-and-post-primary-school.pdf.

277. *Ibid* at pp 73-74.

278. The full programme can be viewed at https://www.cpsma.ie/rse-primary-programme-flourish/.

279. See details at https://ncca.ie/en/primary/primary-developments/social-personal-and-health-education-sphe-relationships-and-sexuality-education-rse/.

the care of children in Ireland.[280] The authors described PFAs as "arrangements where children are cared for full-time by kinship carers (family/relative) who are not parents or legal guardians. The child is not in state care under the Child Care Act 1991".[281] The article discussed the strengths and weaknesses of PFAs, with the latter demonstrated by reference to the judgment delivered in the case of *PG v Child and Family Agency*.[282] Importantly, the article presented "the first empirical data collected on PFAs in Ireland".[283] This empirical research involved quantitative and qualitative research, including a survey as well as semi-structured interviews and focus groups with social workers, solicitors and children's advocates. The research showed that PFAs are increasingly being used in some counties in Ireland and a "significant number of participants in the study expressed positive views in support of the use of PFAs".[284] However, others "expressed reservations about the use of PFAs", and these included concerns about "accessing resources; lack of oversight; ineligibility for aftercare supports; the need to use assessed and vetted placements; a lack of a stable platform to make decisions …; … lack of 'status'; 'drift'; and payments to carers being insufficient to cover costs".[285]

The authors commented that "revocation of consent, parental access or family reunification" can be problematic in practice, given the absence of a formal legal structure underpinning PFAs,[286] and stated their view "that the existing *ad hoc* approach to PFAs raises considerable concerns".[287] As a result of this, and "notwithstanding the support amongst some practitioners for the use of PFAs", the authors conclude that "the better solution is … to discontinue reliance on *ad hoc*, unregulated PFAs".[288] A specific issue to emerge in this research was the impact of vetting requirements; the blanket requirement of Garda vetting for all foster placements can work to preclude formal foster placements in emergency situations with relatives who have not been vetted. The authors suggest that "the solution to this difficulty is not to circumvent the law by placing children in an informal and unregulated foster placement: it is to adapt the law so that the vetting requirements can allow for formal foster placements with relatives in emergency cases, with some level of interim checks put in place whilst an expedited vetting process is concluded."[289]

Daly presented the results of empirical research carried out with 21 professionals in Liverpool regarding "how and whether human rights relate to kinship care".[290] Kinship carers are defined as "family or friends who take on the care of children who cannot be cared for by parents".[291] This research took place between November 2018 and May 2019. The professionals who participated in the study confirmed the importance of

280. K Burns, C O'Mahony and R Brennan, "'Private Family Arrangements' for Children in Ireland: The Informal Grey Space In-Between State Care and the Family Home" (2021) 51 *British Journal of Social Work* 1203.

281. *Ibid* at p 3.

282. [2018] IEHC 812.

283. Burns *et al* (n 280 above) at p 8.

284. *Ibid* at p 9.

285. *Ibid* at pp 9-11.

286. *Ibid* at p 11.

287. *Ibid* at p 15.

288. *Ibid* at p 16.

289. *Ibid* at pp 12 and 16.

290. A Daly, "How Human Rights Apply to Kinship Care in Liverpool—the Views of Professionals" (2020) 30(4) *Seen and Heard* 1 at p.2.

291. *Ibid* at p 1.

human rights, particularly "1) fairness and equality 2) working together and being heard 3) information and access to justice 4) children's rights and the right to family life 5) the right to an adequate standard of living".[292] Daly outlined a number of core recommendations including that a kinship care allowance should be available; strategic litigation could be utilised to bring about change for these carers; kinship carers should have access to free legal aid, if required; and the need for kinship care advocacy with a focus on human rights, as well as training for professionals regarding the use of human rights. Daly also noted that "[m]ore work is needed to examine what would make more rights language more useful for those working on the ground for kinship care families".[293]

A paper by Van Breda *et al* discussed policy, practice and research around extended care (ie beyond the age of 18) in ten countries, including Ireland.[294] The article commenced by demonstrating "strong evidence for the value of extended care" while also highlighting potential differences in care in different regions.[295] The article then considered secondary data, aimed at providing "insight across a range of countries into how extended care is conceptualised and operationalised".[296] Ten national experts from Argentina, Canada, England, Ireland, Israel, the Netherlands, Norway, Romania, South Africa and Switzerland reported their national experiences around extended care, and considered the other national experiences focussing on two questions: "1. What stood out as significant to you, based on your reading of the country summaries? 2. How is your context similar to or different from the others?".[297] Comparison of the approach to extended care in these ten countries showed "that there is no universal construction of extended care, nor consensus on what measures are included under this umbrella term".[298] In addition, "[t]here is considerable diversity in how extended care arrangements are administered and funded".[299] Further, while most countries had formal systems in place, Ireland and Canada had "'organic' or 'bottom up' arrangements" for extended care.[300] The authors also noted that there is a lack of research on the subject of extended care and its role in improving outcomes for eligible young people.

A research project carried out by McGregor, Devaney and Moran entitled "Outcomes for Permanence and Stability for Children in Care" (2014-2017) showed that "the discourse of power regularly featured" in their findings.[301] Taking this on board, the authors collaborated on an article in *Child Care in Practice*, focusing "on power as perceived by the young people and their carers based on interviews with them".[302] The authors noted that some young people felt "'subjected' to being in care and not having power … not having access to a lot of information about their circumstances".[303] Parents also highlighted "the

292. *Ibid* at p 2.

293. *Ibid* at p 8.

294. AD Van Breda *et al*, "Extended care: Global dialogue on policy, practice and research" (2020) 119 *Children and Youth Services Review* 105596.

295. *Ibid* at p 2.

296. *Ibid*.

297. *Ibid* at p 3.

298. *Ibid* at p 9.

299. *Ibid* at p 11.

300. *Ibid* at p 11.

301. C McGregor, C Devaney and L Moran, "A Critical Overview of the Significance of Power and Power Relations in Practice with Children in Foster Care: Evidence from an Irish Study" (2021) 27 *Child Care in Practice* 4 at 5.

302. *Ibid* at p 6.

303. *Ibid* at p 10.

power of removal of the child and the feeling of having no say in the matter".[304] The authors described "the damage and power of language and words", giving some persuasive examples from young people: "The social worker said to my foster parents at one stage, 'you must manage the child's expectations about what they can do in life'".[305] The positive contribution which power can make was also highlighted: "They are there if you need anything like. Last year I asked for counselling and they got it straight away; I only went once or twice but they got it for me straight away".[306] While acknowledging that power can be both good and bad, the authors stated that "a thorough recognition of the range of power factors, looking at the power within each level of the ecological system is essential (e.g. power of worker, legislation, procedure)".[307] The authors noted "the necessity for practitioners and policymakers to appreciate the level of powerlessness a young person in care can experience", as well as "the external power of a system charged with their basic right of survival in terms of a home, shelter and basic care and support".[308] Future research with children in care should include a focus on power: "we must talk about power, apply in in our care and work planning, discuss it in supervision and interrogate it daily as part of our core critical reflection on practices and procedures that have such a powerful impact on young people who are in care and their families".[309]

4.4.8 Adoptions from Care

In the 2020 Annual Report of the Special Rapporteur on Child Protection, it was noted that the Adoption (Amendment) Act 2017 has lowered the threshold that must be reached before adoptions can be authorised without parental consent, which will likely make such adoptions a more common occurrence in Ireland; but meanwhile, the ECtHR has been dealing with an increasing number of cases concerning adoptions without parental consent, and finding violations of the right to family life in several recent instances.[310] Against this backdrop, 2020-21 saw the publication of a number of studies that have relevance to the development of social work and adoption practice in Ireland following the enactment of the 2017 Act.

Adoption from Care: International Perspectives on Children's Rights, Family Preservation and State Intervention, edited by Pösö, Skivenes and Thoburn, is a collection of essays on this under researched area (and significantly, this collection is available to read on an open access basis).[311] The collection is divided into three parts, with the first two parts focusing on adoption from care in "risk-oriented child protection systems" and in "family service-oriented child protection systems", while the last part focuses on "[h]uman rights platform and ways of belonging". A review of all chapters in the collection is outside of the scope of the present discussion, which will highlight one chapter of particular note. Burns and McCaughren contributed a chapter on the experience of adoption from care

304. *Ibid.*

305. *Ibid* at p 12.

306. *Ibid.*

307. *Ibid* at p 13.

308. *Ibid* at p 14.

309. *Ibid* at p 15.

310. O'Mahony (n 28 above) at sections 5.2.1 and 5.5.1.

311. T Pösö, M Skivenes and J Thoburn, *Adoption from Care: International Perspectives on Children's Rights, Family Preservation and State Intervention* (Policy Press, 2021), available at https://library.oapen.org/handle/20.500.12657/47833.

in Ireland that mapped out developments in Irish law and policy, noting that "Ireland has not traditionally used the care system as a pathway to adoption".[312] They discussed the changes outlined in the Adoption (Amendment) Act 2017 regarding the adoption of children from state care "where there are no reasonable prospects that the birth parents will be able to care for the child".[313] While the authors commented that "[i]t is unclear if there is a consensus about whether adoption will be, or ought to be, prioritised over other forms of care, such as long-term fostering", they noted that specific guidance on this issue is anticipated shortly in the forthcoming *Pathways to Permanency Handbook*, which will be published by the Child and Family Agency.[314] Crucially, they highlighted the importance of developing "a dedicated post-adoption support unit", available to all parties.[315]

Breen, Krutzinna, Luhamaa and Skivenes presented an important analysis of case law from the ECtHR on adoptions from care without parental consent.[316] The authors examined 20 cases from the Court from 1959-2018. In particular, they considered the child's right to respect for family life and their best interests as well as parents' rights. At the outset, the authors discussed the concept of "the family" in theory, as well as in both the CRC and the ECHR. On the case law from the ECtHR, half of the cases concerned procedural rights under Articles 6 and 8 ECHR, while half concerned the "material scope of Article 8, including themes such as the justifications provided for restrictions to/termination of contact, considerations of alternatives to a permanent severing of ties with the biological family or the appropriate balancing of parental rights against the best interests of the child".[317] The authors note that the Court's jurisprudence is increasingly becoming "child centric"[318] and that the importance of the "de facto family" is also being recognised.[319] It was observed that "[t]he status and respect of the child's de facto family life is changing. This resonates with a view that children do not only have formal rights but that they are recognised as individuals within the family unit that states and courts must address directly".[320] Importantly, this research shows "changes … in the Court's view on and understanding of family for children" and this "entails a recognition and stronger protection of children's non-biological and de facto family life".[321]

Helland, meanwhile, discussed the role of discretion in decision-making for judges, child welfare workers and experts on children in adoptions from care in Norway.[322] The study involved an analysis of nearly 500 responses to a vignette, and focused on 3 questions: "Which factors are important when child welfare decision-makers decide on adoption? How are different considerations balanced against each other? Are there similarities or

312. *Ibid* at p 58.

313. *Ibid* at p 59.

314. *Ibid* at p 61.

315. *Ibid* at p 62.

316. C Breen, J Krutzinna, K Luhamaa and M. Skivenes, "Family Life for Children in State Care: An Analysis of the European Court of Human Rights' Reasoning on Adoption Without Consent" (2020) 28 *International Journal of Children's Rights* 715.

317. *Ibid* at p 725.

318. *Ibid* at p 736.

319. *Ibid* at p 738.

320. *Ibid* at p 741.

321. *Ibid* at p 741.

322. HS Helland, "Tipping the scales: The power of parental commitment in decisions on adoption from care" (2020) 119 *Children and Youth Services Review* 105693.

differences within and between decision-maker groups and decision-making levels?".[323] Helland noted that "the similarities between groups in the discretionary application of the law in terms of weighting imply that child welfare context and wider societal norms contribute to shape the exercise of discretion".[324] She observed that the following considerations were important for the decision-makers when choosing adoption for the child: "the child's attachment to his foster family, his parents' inability to change and to provide adequate care and the child's age, as well as the time and length of placement".[325] However, the author pointed out that "when collating the findings … it is evident that the decisive factors are parental capabilities and the quality of visitation between the child and his parents".[326] Helland noted that:

> The findings reveal that though attachment, isolated, is the most important factor in a decision, it is *not* in fact a pivotal reason for adoption. While the rationales behind the justifications for adoption were varied and largely child-centered, the considerations that embodied the power to transform a decision was mainly parent-oriented and focused entirely on the parents and/or the relationship the child has or could have with his parents.[327]

Helland was critical of this approach, noting that it "discloses a paradox within the discretionary process where foster family attachment and the permanence of the placement, deemed as the most important considerations in a decision on adoption, essentially become redundant in the occasion where changes in parental behaviour and the quality of visitation occurs or has the potential to occur".[328] In conclusion, Helland called for further research "that 1) explores the attitudes and practices of decision-makers and aims to unbox the mechanisms that allow for and guide discretionary practices in decisions on adoption and 2) that address professional decision-makers [*sic*] interpretations of the law and the best interest of the child and how this coincides with popular opinion and policy".[329]

4.4.9 Social Worker Retention

Burns, Christie and O'Sullivan published an important analysis of qualitative research on the retention of social workers in child protection in Ireland.[330] Their research considered the experience "of social workers who have worked in child protection for 10 years" and concentrated on the following questions: "(i) What can we learn about retention from social workers with 10 years' experience of child protection? (ii) Does job embeddedness theory help explain their retention? (iii) Did the 'career preference typology' help explain social workers' retention?".[331] The data used in this research was gathered first, between

323. *Ibid* at p 1.

324. *Ibid* at pp 7-8.

325. *Ibid* at p 8.

326. *Ibid*.

327. *Ibid*.

328. *Ibid*.

329. *Ibid* at pp 9-10.

330. K Burns, A Christie and S O'Sullivan, "Findings from a Longitudinal Qualitative Study of Child Protection Social Workers' Retention: Job Embeddedness, Professional Confidence and Staying Narratives" (2020) 50 *British Journal of Social Work* 1363.

331. *Ibid* at p 1365.

2005 and 2007, and second, between 2014 and 2015. 35 social workers and senior social workers, and ten social workers who had left, were interviewed between 2005 and 2007. In 2014 to 2015, "twenty-two participants from the original dataset were eligible to contribute to the study as they were still working in frontline child protection; all were invited to participate and 19 (86%) agreed to be re-interviewed".[332]

The authors discussed job embeddedness theory, noting that it "is organised around three dimensions: 'fit', sacrifice' and 'links'".[333] They "examine how social workers with between 10 and 30 years of experience of child protection social work on five teams in Ireland describe their decisions to stay in terms of 'fit', 'sacrifice' and 'links'".[334] The authors' findings regarding "fit", for example, included "the level of autonomy and flexibility in the role" and that "making a decision to stay or leave involved a mix of fit with sacrifice decisions".[335] The value of being a public sector employee as a child protection social worker role was also important. Regarding "sacrifice", leaving their role to begin a new role was discussed. As "Sophia" commented, for example, "there's an ease in my job now because I'm experienced. So I'm not going to … go off somewhere else and change things".[336]

In addition, "personal and professional links and networks" including "strong peer support" as well as "family links" are important.[337] The authors also included "representative quotations of three staying narratives used by social workers both in their first and second interviews: the importance of being part of a team; working with people and seeing positive change; and strong job variety and autonomy".[338] Regarding the importance of a team and peer support, "Jenna" stated in their first interview: "I still like coming to work every morning. A big factor I think is the support with the team. We all get along well. We support each other... We take time to support each other. Even if we are busy".[339] In their second interview, Jenna said: "'I think with regards the job, I stay because of the team. There have always been a good group of people to work with, very supportive".[340] As the authors noted, the "social workers had constructed staying narratives that helped them explain their long-standing commitment to working in child protection and welfare social work. These narratives did not change much over the decade between interviews. This may suggest that these narratives are actively reproduced as a central part of their professional identities".[341]

The study found that "fifteen of nineteen study participants at interview two wanted to stay working in child protection and welfare".[342] It was noted that "the social workers in this sample enjoy this field of social work practice and find this work meaningful … it tests their skills, the variety of tasks are high, the work provides ongoing positive professional challenges, and the work 'fits' with their ongoing professional commitment to children and their families".[343] The authors suggest ways in which "the profession and educators"

332. *Ibid* at p 1370.
333. *Ibid* at p 1368.
334. *Ibid* at p 1369.
335. *Ibid* at p 1373.
336. *Ibid* at p 1374.
337. *Ibid.*
338. *Ibid* at p 1375.
339. *Ibid.*
340. *Ibid* at p 1376.
341. *Ibid* at p 1376.
342. *Ibid* at p 1377.
343. *Ibid.*

can collaborate to improve retention of child protection social workers, for example, by working "with employers to improve the work and support environment, help to address the structural causes that bring families into contact with the child protection system, highlight and publicise the positive contribution of this sector to the public and resist pressure to produce 'work-ready' graduates".[344]

However, it was observed that excessive workloads, a lack of induction policies and a lack of "creative and well-resourced practical and emotion-focused supports" for social workers are problematic in practice.[345] The authors detailed Tusla's role to date in addressing social workers' retention, including internal surveys with staff on the subject of retention, a new workforce strategy, an increased number of senior social workers, discussion around salary increases, collaboration with educators, a commitment to addressing excessive case-loads, a new employee welfare section and "the adoption of Signs of Safety as its national practice framework".[346] The authors also found "that if you can retain child protection and welfare social workers beyond the 5-year point, their retention narratives often remain constant and appear to become a more central focus of their professional identities".[347] In turn, "their embeddedness in the organisation and community intensifies and they have a stronger sense of professional confidence as they move from the novice professional to the experienced professional and expert practitioner stage".[348]

4.4.10 Family Support

O'Connor, McGregor and Devaney analysed newspaper content from 2014-2017 reporting on family support provided by Tusla.[349] This analysis was "part of a larger body of research which evaluated Tusla—Child and Family Agency's (Tusla) Prevention, Partnership and Family Support programme (PPFS)".[350] According to the authors, the aims of the analysis were to "(1) Explore if there is a change in frequency and reporting about PPFS. (2) Examine change in nature of reporting about PPFS. (3) Establish whether there is any evidence of greater awareness of Tusla family support services. (4) Ascertain the nature of regional and national reporting".[351] Some 1,497 newspaper articles were analysed in this study, stemming from national and regional sources. The study found that "the reports about family support have been more often 'framed' within the context of child protection".[352] According to the authors, this demonstrates "that those who research and write for newspapers in Ireland" are "unclear" about child protection and family support.[353] The impact of this is significant, as for example, "the way child protection and welfare is reported in the media impacts negatively on public opinion and understanding".[354]

344. *Ibid* at p 1378.

345. *Ibid*.

346. *Ibid* at pp 1378-1379.

347. *Ibid* at p 1379.

348. *Ibid*.

349. P O'Connor, C McGregor and C Devaney, "Family Support and the Media in Ireland: Newspaper Content Analysis 2014-2017" (2021) *Child Care in Practice*, https://doi.org/10.1080/13575279.2020.1860905.

350. *Ibid* at p 1.

351. *Ibid* at p 3.

352. *Ibid* at p 10.

353. *Ibid*.

354. *Ibid*.

In contrast, less attention is given to family support. According to the authors, "[c]hild protection and family support services need to be clearly understood and known by both the public and the media. This awareness could encourage families in need to seek help earlier".[355] The research also showed that more positive newspaper reports were emerging over the period in which the study took place. The authors noted in their conclusions that there is a "need for greater partnership with the local and national media, in order to give a more in-depth understanding of the nature and diversity of family support and child protection in practice".[356]

4.5 DISCUSSION AND RECOMMENDATIONS

4.5.1 International Law Developments

At international level, General Comment No 25 (2021) of the Committee on the Rights of the Child on children's rights in relation to the digital environment is timely in light of ongoing work on the Online Safety and Media Regulation Bill. Detailed analysis of this Bill can be seen in Appendix C of this Report, which emphasises that compliance with international standards requires the provision of accessible and effective remedies to victims of online harm (including an individual complaints mechanism which allows for harmful content to be removed). A further point that is highlighted is the importance of requiring service providers to carry out due diligence on risks to children's rights arising in the course of their service provision. It is recommended that the Online Safety and Media Regulation Bill be amended to address these issues and ensure compliance of Irish law with our international human rights law obligations.

4.5.2 Court Decisions

The 18 month period under review from January 2020 to June 2021 saw something of a reduction in the volume of significant judgments issuing from the Irish courts on matters related to child protection. This is unsurprising given the challenges posed to the operation of the Courts Service by the COVID-19 pandemic. While the courts facilitated over 2,000 virtual hearings from April to December 2020 in all areas of law,[357] the Child Care Law Reporting Project identified a number of challenges in respect to child protection cases, which included delays in obtaining assessments due to Covid-19 and the likelihood that child care cases will encounter further delays in what was an already overburdened system.[358] At the same time, the period saw the Supreme Court deliver a landmark judgment on the constitutional rights of children with a direct focus of the impact of the 2012 referendum on the threshold for State intervention in cases where parents make decisions that are detrimental to their children. Section 4.3.1 above considered

355. *Ibid.*

356. *Ibid* at p 11.

357. Courts Service, *Courts Service News* (Issue 4 December 2020) at p 5, available at https://www.courts.ie/acc/alfresco/8b21c2bf-4d7f-453f-8703-80a91aa063d2/CourtsServiceNewsDec20.pdf/pdf#view=fitH.

358. Child Care Law Reporting Project, "Observations on Concerns for Vulnerable Children Arising from the Covid-19 Pandemic", 3 April, 2020; "Case Report 7: Care order extended and access reduced where assessments delayed and access disrupted by Covid-19", and "Case Report 9: District Court concerned about delays in assessments due to Covid-19", all available at https://www.childlawproject.ie/covid-19/.

this judgment in detail, and argued that a careful comparison with pre-2012 case law makes it difficult to pin down any significant change effected by the enactment of Article 42A—for now, at least. Whether future judgments will take on board the Supreme Court's comments on the "shift of emphasis" and "direction of travel" embodied by Article 42A and develop the relevant law in a new direction remains to be seen.

Other judgments of the Irish Courts and indeed of the ECtHR were on a range of topics, and no clear themes emerged. The judgment that attracted most attention was the decision of the Court of Appeal in relation to reporting restrictions in cases involving child homicide (discussed in section 4.3.9 above). The enactment of the Children (Amendment) Act 2021 is to be welcomed as a prompt and appropriate resolution of the difficulties arising from this judgment. Another notable point (discussed in section 4.3.2 above) was the comments made by the High Court about the need for a more robust statutory basis for the investigation of allegations of child sexual abuse. This issue was discussed at length in the 2020 Annual Report of the Special Rapporteur on Child Protection, and the recommendations made in Chapter 2 of that Report are re-iterated here.

4.5.3 Issues Emerging from Academic Research

A number of points stand out in the academic research that have been published in the past 18 months. These include the importance to children's rights and child protection of reform of the curriculum on sexuality education. It is recommended that all interested parties work together to support the ongoing work of the NCCA on this topic and to ensure that a revised curriculum is delivered on schedule and in compliance with children's rights standards. It was seen in section 4.4.7 that a specific issue highlighted in respect of private family arrangements was the blanket requirement of Garda vetting for all foster placements, which precludes formal foster placements in emergency situations with relatives who have not been vetted. It is recommended that consideration be given to modifying the vetting requirements to allow for formal foster placements with relatives in emergency cases, with interim checks put in place whilst an expedited vetting process is concluded. Research on social worker retention discussed in section 4.4.9 above suggests that the first five years of a social worker's career is the key period during which measures designed to improve retention can have a positive impact; this important finding should be taken on board by Tusla in its work in this space, which is a crucial component in addressing workforce and recruitment challenges faced by the Agency in recent years. Finally, the need for further research in an Irish context to inform policy, practice and law reform is evident on a number of topics: these include child welfare removals of newborns; adoptions from care; kinship care, and the use of private family arrangements.

Appendices

APPENDIX A: SUBMISSION ON GENERAL SCHEME OF FAMILY COURT BILL 2020

Joint Committee on Justice, 15 February 2021

Introduction

The proposal to establish a specialised family court is most welcome. There have been multiple calls over the past two decades for the establishment of a specialist court in Ireland dealing with child and family law. Among the first was a report by the Law Reform Commission in 1996, when the approach of the Irish courts to family law matters was described as a 'system in crisis'.[1] The Report identified numerous problems, including inadequate physical facilities, an absence of specially trained judges, inconsistency between courts and judges in decision-making and excessive caseloads.[2] The Commission made a series of recommendations, including the establishment of a system of regional family courts with unified jurisdiction over family matters, dedicated physical facilities tailored to the needs of family law, integrated support services and dedicated judges with suitable experience and training.[3]

Few of the Report's recommendations (and none of those just mentioned) were implemented. Several research projects have produced evidence that the problems identified by the Commission in 1996 remain in existence.[3] In 2014, the Law Society of Ireland commented that 'little has changed' since the LRC's 1996 Report, and called for the implementation of all of the reforms mentioned above, as well as for efforts to make proceedings less adversarial.[5] This position has been echoed by my predecessor as Special Rapporteur on Child Protection, Dr Geoffrey Shannon;[6] by Dr Carol Coulter of the Child Care Law Reporting Project;[7] and by the UCC Child Care Proceedings research group.[8] More broadly, specialisation in the area of family law is now commonplace among judges and courts across Europe.[9]

The establishment of a separate court or court division dedicated to cases concerning families or children will not, in itself, rectify the difficulties identified above unless it is properly designed and resourced. Specialisation, rather than mere separation, is what really matters in this context. In Australia, research has documented many of the same

1. Law Reform Commission, *Report on Family Courts*, LRC 52–1996 (Dublin: Law Reform Commission, 1996), p.ii, available at http://www.lawreform.ie/_fileupload/Reports/rFamilyCourts.htm.

2. *Ibid* at pp.9-17.

3. Law Reform Commission, *Report on Family Courts*, LRC 52–1996 (Dublin: Law Reform Commission, 1996) at pp.22-46.

4. See C O'Mahony, K Burns, A Parkes and C Shore, "Child Care Proceedings in Non-Specialist Courts: The Experience in Ireland" (2016) 30 *International Journal of Law, Policy and the Family* 131-157; C Coulter, *Second Interim Report: Child Care Law Reporting Project* (2014), available at http://www.childlawproject.ie/wp-content/uploads/2014/10/Interim-report-2-Web.pdf; and C O'Mahony, A Parkes, C Shore and K Burns, "Child Care Proceedings and Family-Friendly Justice: The Problem with Court Facilities" (2016) 19(4) *Irish Journal of Family Law* 75-81.

5. Law Society of Ireland, *Submission to the Department of Justice, Equality and Defence: Family Law – The Future* (2014) at p.37, available at https://www.lawsociety.ie/globalassets/documents/committees/family/familylawsubmission2014.pdf.

6. G Shannon, *Seventh Report of the Special Rapporteur on Child Protection: A Report Submitted to the Oireachtas* (2014) at p.98, available at https://assets.gov.ie/27440/b9e888545a484e3baaa13a8572894acf.pdf.

7. C Coulter, *Second Interim Report: Child Care Law Reporting Project* (2014) at p.27, available at http://www.childlawproject.ie/wp-content/uploads/2014/10/Interim-report-2-Web.pdf

8. C *O'Mahony*, K Burns, A Parkes and C Shore, "Child Care Proceedings in Non-Specialist Courts: The Experience in Ireland" (2016) 30 *International Journal of Law, Policy and the Family* 131 at pp.150-153.

9. Council of Europe Consultative Council of European Judges (2012) *Opinion No. 15 of the Consultative Council of European Judges on the Specialisation of Judges*, available at https://www.coe.int/en/web/ccje/opinion-n-15-2012-on-the-specialisation-of-judges.

difficulties that have been documented in Ireland, notwithstanding the fact that specialist children's courts exist at State level. Similar findings have been made in each of Victoria,[10] Queensland[11] and New South Wales.[12] A common finding was that even though a dedicated children's court exists, cases outside of major metropolitan centres are often heard by a generalist judge who does not specialise in child law.

The General Scheme of the Family Court Bill is an important step towards the establishment of specialist family courts. Legislation is a necessary part of this process, although it will not be sufficient in itself – it is imperative that it is supported by policy and practice measures, resources, facilities and training to ensure that the family courts are genuinely specialist and not merely an administrative division of the general courts. At present, other than the provisions on specialist judges and judicial training, the Bill is silent on the ancillary measures that will be taken to ensure genuine specialisation. The Australian Law Reform Commission emphasised in 2019 "the importance of ancillary staff within the family courts in protecting the rights of children and promoting their welfare, in ensuring protection from family violence, and in assisting parties to improve their relationship to each other and to their children", and recommended that this be recognised in the legislation governing the family courts.[13] This recommendation is endorsed here. A number of other aspects of the text of the General Scheme of the Bill that merit further attention are set out below.

Best Interests and Views of the Child

Article 42A.4 of the Constitution provides as follows:

> 1° Provision shall be made by law that in the resolution of all proceedings—
>
> i. brought by the State, as guardian of the common good, for the purpose of preventing the safety and welfare of any child from being prejudicially affected, or
>
> ii. concerning the adoption, guardianship or custody of, or access to, any child,
>
> the best interests of the child shall be the paramount consideration.

In contrast, Head 5(3)(d)(i) states that rules for family law proceedings shall give effect, as far as practicable, in any family law proceedings in which a child is involved or likely to be affected by the outcome, to the principle of "ensuring that the best interests of each such child are a primary consideration in those proceedings". This Head uses the wording of Article 3 of the United Nations Convention on the Rights of the Child in referring to best interests as "primary consideration", in contrast to Article 42A.4 of the Constitution, which requires that it be the "paramount consideration" in both public and private family

10. R Sheehan and A Borowski, "Australia's Children's Courts: An assessment of the status of and challenges facing the child welfare jurisdiction in Victoria" (2014) 36(2) *Journal of Social Welfare and Family Law* 95-110.

11. Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (2013) at pp.464-474, available at http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0017/202625/QCPCI-FINAL-REPORT-web-version.pdf.

12. J Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (2008) at pp.528-543.

13. Australian Law Reform Commission, *Family Law for the Future — An Inquiry into the Family Law System* (2019) at p.359, available at https://www.alrc.gov.au/publication/family-law-report/.

law cases. The language of the Bill should reflect this constitutional obligation by using the term "paramount" rather than "primary".

Head 5(3)(d)(ii) makes similar reference to the principle of ensuring, in respect of any such child who is capable of forming his or her own views, ensuring as far as practicable that the views of the child are ascertained and given due weight having regard to the age and maturity of the child. Here, the language of Article 42A.4 of the Constitution is replicated; however, two issues arise. First, Head 5(5) disapplies Head 5(3)(d)(ii) in any proceedings in which legislative provision is already made for ascertaining the views of the child. Unfortunately, such legislation – including the Guardianship of Infants Act 1964 and the Child Care Act 1991 – often makes provision for ascertaining the views of children that is deficient and fails to adequately discharge the constitutional obligation.[14] This highlights the need to make amendments to these enactments to ensure that they provide for ascertaining and giving due weight to the views of all children capable of forming them. The General Scheme of the Family Court Bill cannot rely on these enactments in their current form to ensure that the right of children to be heard is vindicated.

The second issue that arises here relates to the use of judicial interviews with children as a means of ascertaining the views of the child. The UN Committee on the Rights of the Child has stated that "wherever possible, the child must be given the opportunity to be directly heard in any proceedings."[15] For some children, the opportunity to see at least some of the process that will lead to life-changing decisions about where and with whom they will live, and to meet and speak with the person charged with making that decision, is a hugely valuable part of coming to terms with their circumstances and can have beneficial effects on their well-being.[16] International research has found that "[m]ore than anything, they want to speak directly to those who take decisions about them".[17]

However, while there have been many calls for enhanced opportunities for children to meet with judges, these have been accompanied by calls for the provision of specific guidelines governing such meetings, as well as specialised training for judges.[18] Some District Court judges in Ireland have developed a practice of meeting with children in chambers or in an empty courtroom and gained significant experience of doing so. However, this has been on a largely *ad hoc* basis, with no rules governing the practice and no consistency as between judges with respect to whether or how this is done. Some judges are strongly against the practice on the basis that they do not have the requisite

14. See further Joint Oireachtas Committee on Justice and Equality, *Report on Reform of the Family Law System* (October 2019) at p.32, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2019/2019-10-24_report-on-reform-of-the-family-law-system_en.pdf and C O'Mahony, *Annual Report of the Special Rapporteur on Child Protection* (2020), Chapter 4, available at https://www.gov.ie/en/publication/cfbc8-special-rapporteur-on-child-protection-13th-report/.

15. UN Committee on the Rights of the Child, *General Comment No 12 (2009): The Right of the Child to be Heard*, UN Doc No CRC/C/GC/12, 20 July 2009 at [35].

16. See further A Daly, "The Judicial Interview in Cases on Children's Best Interests—Lessons for Ireland" (2017) 20(3) *Irish Journal of Family Law* 66 and E O'Callaghan, C O'Mahony and K Burns "'There is nothing as effective as hearing the lived experience of the child': Practitioners' Views on Children's Participation in Child Care Cases in Ireland" (2019) 22(1) *Irish Journal of Family Law* 2.

17. U Kilkelly, Listening to Children about Justice: Report of the Council of Europe's Consultation with Children on Child-Friendly Justice (Council of Europe, 2010) at p.39, available at https://rm.coe.int/168045f81d. Similar findings were reported by P Parkinson, J Cashmore, and J Single, "Parents' and Children's Views on Talking to Judges in Parenting Disputes in Australia" (2007) 21 *International Journal of Law, Policy and the Family* 84.

18. See, eg, P Case, "When the judge met P: the rules of engagement in the Court of Protection and the parallel universe of children meeting judges in the Family Court" (2019) 39(2) *Legal Studies* 302-320.

skills and training to speak directly with children, and other professionals involved in child care proceedings have expressed concern that the suitability of judges to meet with children varies widely.[19]

There is clearly an important place for direct participation of children in child care proceedings; but this needs to be underpinned by a firm statutory basis, and provision needs to be made to ensure that judges who interview children have the necessary skills and follow established guidelines. As such, the Family Court Bill should expressly recognise the judicial interview as a means of ascertaining the views of children, and require that guidelines be developed to assist judges in conducting such interviews. This task could (for example) be assigned to the Family Law Rules Committee envisaged under Head 18, and could draw on the experience already accumulated by some judges.

A further issue that needs to be addressed is how the rules of evidence should apply to the information gleaned in judicial interviews so as to ensure fair procedures for all parties. While concerns have been expressed about this point,[20] experience in jurisdictions such as New Zealand illustrates how rules and guidelines can be put in place that can balance the child's right to directly participate in the proceedings with the procedural rights of the other parties.[21] Some previous guidance has been provided by the Irish High Court on the conduct of judicial interviews which might provide a starting point;[22] however, it has been observed that these guidelines "focus on adult-centric concerns about securing the agreement of parents and compliance with principles of fairness. There is little emphasis on ensuring that children are comfortable …, that children's consent is given at all times, and that children later receive feedback on how their views were weighed in the decision-making process."[23] Thus, a more comprehensive framework governing judicial interviews should be incorporated into the Family Court Bill.

A related point that is omitted from the Bill, but which could be considered for inclusion, would be to give a statutory basis to the principle that was set down by the Supreme Court in *Southern Health Board v CH* – namely, that child care proceedings should be "in essence an *inquiry* as to what is best to be done for the child in the particular circumstances pertaining", and should not therefore follow a strictly adversarial model.[24] The same principle could be applied to any family court proceedings in which a child is involved or likely to be affected by the outcome. For example, in New South Wales, section 93(1) of the Children and Young Persons (Care and Protection) Act 1998 provides that proceedings before the Children's Court "are not to be conducted in an adversarial manner".

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19. Parkes *et al*. (n 12 above) at pp 432-437. See further Joint Oireachtas Committee on Justice and Equality *Report on Reform of the Family Law System* (October 2019) at p.36, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2019/2019-10-24_report-on-reform-of-the-family-law-system_en.pdf. For evidence from other jurisdictions on this point, see FE Raitt, "Hearing children in family law proceedings: can judges make a difference?" (2007) 19 *Child and Family Law Quarterly* 151 at p.156.

20. See I Clissman and P Hutchinson, "The Right of the Child to be heard in Guardianship, Custody and Access Cases (II)" (2006) 9(2) *Irish Journal of Family Law* 2.

21. See A Daly, "The Judicial Interview in Cases on Children's Best Interests—Lessons for Ireland" (2017) 20(3) *Irish Journal of Family Law* 66 at p.67.

22. See *O'D v O'D* [2008] IEHC 468.

23. A Daly, "The Judicial Interview in Cases on Children's Best Interests—Lessons for Ireland" (2017) 20(3) *Irish Journal of Family Law* 66 at p.69.

24. [1996] 1 IR 219 at 237 (emphasis in original).

Judges

Appointment

Head 6(4)(b) of the General Scheme provides that a person shall not be assigned to be a judge of the District Family Court unless "he or she is, by reason of his or her training or experience and temperament, a suitable person to deal with matters of family law." This provision is replicated at Head 11 for the Circuit Family Court and at Head 16 for the Family High Court. In principle, this stipulation is a good idea, but it raises the question of how a "suitable person to deal with matters of family law" will be defined or determined, and by whom?

While specific provision is made in Heads 6(3), 11(3) and 16(3) regarding the process leading to the appointment of the Principal Judge of the various Family Courts, no provision is made regarding the process of appointing ordinary judges. Thus, it is unclear what constitutes a judge who is "by reason of his or her training or experience and temperament, a suitable person to deal with matters of family law". Given the significance of this determination, it would be desirable that the Bill make at least some provision defining this standard, whether directly in the text of the Bill or indirectly by reference to regulations or guidelines that are to be drafted subsequently.

Even if the standard is defined, the related question is who determines whether it has been met. Is it a matter to be determined during the judicial appointments process before someone becomes a judge (ie can a person be appointed directly to the District Family Court?) Or is it determined afterwards – ie when a person who is already a District Court judge is then moved to the Family Court? Or could either process occur, in which case different individuals or bodies might make the appraisal and the decision in each case? At present, none of this is clear, and the Bill should provide some certainty and clarity (insofar as to do so is compatible with separate legislation governing judicial appointments).

Term of Office

Heads 6(5), 11(5) and 16(5) provide that every judge appointed to one of the family courts shall hold that assignment for so long as he or she holds office as a judge of the court of that level. However, Head 6(6) allows a judge to leave the family court and return to the general court at the same level with the prior agreement of the Principal Judge of the relevant family court and the President of the relevant court. In short, judges can remain as a family court judge for as long as they wish, but can request to opt-out after 3 years. This seems like a reasonable balance; it allows judges who are suited to the role to stay and to develop a deep level of experience and expertise in family matters, but avoids forcing judges to stay in one of the family courts against their will. Some judges will be suited to a long career in family law (and there are examples of judges who have done so successfully in numerous courts in the past), and it is important to allow them to stay in their role if they are content to do so. At the same time, the element of human tragedy inherent in family cases (and child care cases in particular) is such that there is a risk of burnout, and not every judge will be suited to remaining in such a position long-term. Past research has highlighted the fact that some District Court judges lack interest in this area of law. In the words of one judge, "there are too many judges doing this kind of work who

don't want to be doing it. And that is dynamite. They are making orders to get rid of it."[25] While this risk would be lessened by the criteria for appointing a judge to a family court, the risk remains that a judge who burns out might lose interest in family law cases, and the possibility of opting out after 3 years appropriately mitigates this risk.

Judicial Training

Heads 6(8) and 11(8) provide that a judge of the District Family Court or Circuit Family Court shall take such course or courses of training or education, or both, as may be required by the Judicial Studies Committee established by the Judicial Council. This is welcome, although a significant omission arises in that Head 16 does not replicate this requirement for the Family High Court. This omission should be rectified.

The importance of specialised training for family court judges was mentioned above in the context of judicial interviews of children, but it extends beyond that context. Judges and other professionals who spend the clear majority of their time on other issues are not incentivised to significantly upskill in the area of child and family law. By contrast, in a specialist family court, cases would not have to compete with criminal law and other matters for attention and resources, and it would be easier to ensure that staff involved in such proceedings had an appropriate level of interest, experience and specialist training.

This was among the reasons cited by the Family Justice Review in England and Wales when recommending the establishment of a Single Family Court (even though family divisions had existed within the general courts for over a decade). The Report encouraged that this court be staffed by judges who specialise in family law and professionals who receive specialist, inter-disciplinary training.[26] Similarly, The Australian Law Reform Commission has emphasised the importance of the criteria for judicial appointments and has recommended a specific reference to family violence, stating that "[f]amily violence is the most commonly raised factual issue in family law proceedings … In recognition of this prevalence, the ALRC recommends a legislative requirement that judicial officers presiding over family law matters in the family courts be competent in dealing with both family law and family violence".[27]

Moreover, the necessity for specialised training applies not only to judges, but also to lawyers working in family courts. A survey of Irish child protection practitioners carried out by the IDEA project confirmed multiple gaps in knowledge and a strong need for interdisciplinary training for solicitors, barristers, judges, social workers and Gardaí. Specific training needs identified include communicating with children, updates on recent developments in Irish and international law and self-care to help minimise stress and prevent burnout.[28] Consideration should be given to including a provision in the General

25. *C O'Mahony*, K Burns A Parkes and C Shore, "Child Care Proceedings in Non-Specialist Courts: The Experience in Ireland" (2016) 30 *International Journal of Law, Policy and the Family* 131 at p.151.

26. D Norgrove, *Family Justice Review: Final Report* (2011), pp.68-77 and 81-89, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/217343/family-justice-review-final-report.pdf.

27. Australian Law Reform Commission, *Family Law for the Future – An Inquiry into the Family Law System, Final Report* (2019) at p.400, available at https://www.alrc.gov.au/publication/family-law-report/. At p.405, the Commission made the same recommendation in respect of lawyers practicing in the family court.

28. The IDEA Project was a five-country project (Ireland, Hungary, Finland, Sweden, and Estonia), which was funded by the Rights Equality and Citizenship Programme of DG Justice. See: https://ideachildrights.ucc.ie/. Training was provided on each of these subjects to child protection practitioners throughout 2018.

Scheme of the Family Court Bill requiring lawyers who are practicing in the family courts to undergo a minimum level of continuous professional development specifically directed towards issues of relevance to family law.

Court Proceedings

Heads 9(3), 14(3) and 17(3) provide that the family courts shall sit to hear and determine family law proceedings in a different building or room from that in which sittings of any other court are held or on different days or at different times from those on, or at, which sittings of any such other court are held. This echoes the current provision made in section 29(3) of the Child Care Act 1991. However, two points are important to note. First, studies clearly show that this provision is routinely flouted, and child proceedings are often held in close proximity to criminal proceedings, so that families end up sharing the public spaces in the courthouse with people in handcuffs or people who are behaving in a disorderly manner.[29] Therefore, resourcing and provision of adequate facilities is essential if this provision is to be implemented in practice.

Second, and probably related to the last point, these Heads in the Bill depart from the wording of section 29(3) of the Child Care Act 1991 by referring not only to a different place, time or day, but also to a different "room". This would appear to be a watering down of the terms of section 29, in that it could be claimed that the obligation has been discharged as long as the actual court hearing is in a different room to other court proceedings taking place at the same time. This would invariably be the case in any event due to the *in camera* rule, and so the relevant Heads of the Bill would be essentially redundant if the word "room" is retained. More importantly, they would sanction the continued sharing of waiting areas, consultation rooms and other ancillary services between family cases and other cases such as criminal proceedings. This would undermine the spirit and effectiveness of a provision that is intended, as Geoffrey Shannon has observed, "to set the child care process apart from the normal court process, both physically and symbolically".[30]

Ineffective provision for the separation of family cases from other court proceedings creates an environment that is unfriendly to families. It exacerbates an already stressful situation for the parties; undermines the *in camera* rule by limiting the opportunity for privacy in crowded waiting areas, and risks making professionals in a gatekeeping role reluctant to consider bringing children to court. As a social worker commented in one study:

> I didn't think it was really conducive for a family going in because it felt like a … cattle mart because there was so many people going in and out and people being called over and it was very, very dysfunctional for a family … People get very frustrated in these venues. If a child came into them then you know I think it would be wholly inappropriate unless there was another designated area they come in. It's very, very hard … Everyone is handcuffs. Everyone is battened down.[31]

29. *C O'Mahony*, K Burns A Parkes and C Shore, "Child Care Proceedings in Non-Specialist Courts: The Experience in Ireland" (2016) 30 *International Journal of Law, Policy and the Family* 131 at pp.140-141.

30. G Shannon, *Child Law* (Thomson Round Hall, 2010) at p.227.

31. *C O'Mahony*, K Burns A Parkes and C Shore, "Child Care Proceedings in Non-Specialist Courts: The Experience in Ireland" (2016) 30 *International Journal of Law, Policy and the Family* 131 at pp.140-141.

A final point is that Heads 10(4) and 15(4) provide that proceedings in the District Family Court and Circuit Family Court shall, having regard to the proper and effective administration of justice and the need to follow orderly procedures, be as informal as is practicable. Unlike other provisions of the Bill, this is not replicated in respect of the Family High Court. It is recommended that it should be.

Privacy

Head 36 of the Bill deals with the hearing of family court proceedings otherwise than in public. While it is to be welcomed that a number of exceptions to the *in camera* rule are explicitly defined in the Bill, two points remain notable. First, the precise scope of the *in camera* rule and what is prohibited by the rule is not clearly defined. This is a cause of some confusion at present, and invites breaches of the rule due to a lack of clarity.[32] The opportunity should be taken to specify what types of communications concerning court proceedings are specifically prohibited by the rule unless expressly covered by one of the exceptions. Secondly, the exceptions included in Head 36 do not include an exception that would allow parties to family cases to participate in anonymised qualitative or quantitative research. This has a significant chilling effect on research in this area; researchers can speak to professional participants, or can apply to sit in court and observe, but are not currently permitted to directly seek the views of the people most impacted by family court proceedings in interviews, focus groups or surveys. This limits the scope and depth of research on family law proceedings, which hinders reform processes and teaching and training activities, and undermines transparency. The Joint Oireachtas Committee on Justice and Equality's 2019 *Report on Reform of the Family Law System* recommended that such an exception be enacted, and this recommendation is endorsed here.[33]

Finally, Head 37 of the General Scheme proposes to prohibit the broadcasting or publication of information about a matter which would be likely to lead members of the public to identify the parties to proceedings to which a relevant enactment relates or any child to whom those proceedings relate. This largely reflects existing provision in section 31 of the Child Care Act 1991, but with one significant difference: Head 37 does not replicate the provision in section 31(2) of the Child Care Act, which allows a court, if satisfied that it is appropriate to do so in the interests of the child, to dispense with the prohibition.

Since the best interests of the child is required by the Constitution to be the first and paramount consideration in family court proceedings, it is important to include this exception. The UN Committee on the Rights of the Child has emphasised that the best interests of the child include maximising the child's opportunity to exercise his or her other rights, one of which is freedom of expression.[34] The absolutist position taken by Head 37

32. Joint Oireachtas Committee on Justice and Equality *Report on Reform of the Family Law System* (October 2019) at p.25, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2019/2019-10-24_report-on-reform-of-the-family-law-system_en.pdf.

33. *Ibid* at pp.25-27 and p.46.

34. Committee on the Rights of the Child, *General Comment No 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*, UN Doc No CRC/C/GC/14, 29 May 2013 at [52] to [79]. See also T Hammarberg, "The Principle of the Best Interests of the Child—What it Means and What it Demands from Adults", Lecture by Thomas Hammarberg, Commissioner for Human Rights, Council of Europe (Warsaw, 30 May 2008, available at https://rm.coe.int/16806da95d.

on this point would lead to a situation where a criminal offence would be committed if (for example) a teenager created a social media post mentioning that they were in foster care (thus identifying themselves as a child who has been the subject of proceedings for a care order). If a post of this nature contained no details regarding the child's birth parents or the reasons for the child being in foster care, such a position would appear to be an unnecessary and disproportionate interference with a mature child's freedom of expression. It is recommended that the exception contained in section 31(2) of the Child Care Act 1991 be incorporated into Head 37 of the General Scheme of the Family Courts Bill, so as to allow family court judges the discretion to lift the prohibition in cases where it is in the child's best interests to do so.

Summary of Recommendations

1. Make specific provision in the Bill that obliges the provision of the ancillary services that are necessary to a successful and genuinely specialised family court.

2. Change the wording of Head 5(3)(d)(i) to refer to the child's best interests as the "paramount" consideration rather than the "primary" consideration.

3. Make specific provision recognising judicial interviews of children as a means of ascertaining the views of the child, and provide for the formulation of guidelines by the Family Court Rules Committee governing such interviews.

4. Make provision clarifying the application of the rules of evidence in family court proceedings.

5. Include a provision stipulating that in any family court proceedings in which a child is involved or likely to be affected by the outcome, the hearings shall not be adversarial in nature.

6. Clarify in the text of the Bill what constitutes a judge who is "by reason of his or her training or experience and temperament, a suitable person to deal with matters of family law".

7. Clarify when, and by whom, the determination is made of whether a candidate judge of a family court meets this standard.

8. Head 16 should replicate, in respect of the Family High Court, the stipulation in Heads 6(8) and 11(8) that a judge of the District Family Court or Circuit Family Court shall take such course or courses of training or education, or both, as may be required by the Judicial Studies Committee established by the Judicial Council.

9. Consider including a provision requiring lawyers who are practicing in the family courts to undergo a minimum level of continuous professional development specifically directed towards issues of relevance to family law.

10. Remove the reference to "room" in Heads 9(3), 14(3) and 17(3), so as to ensure a genuine separation between family court proceedings and other court proceedings in waiting areas, consultation rooms and other ancillary services.

11. The provision made in Heads 10(4) and 15(4) that proceedings in the District Family Court and Circuit Family Court shall, having regard to the proper and effective administration of justice and the need to follow orderly procedures, be as informal as is practicable, should be replicated in respect of the Family High Court.

12. Include a clear definition in Head 36 of the scope of the *in camera* rule, specifying the types of communications which are prohibited unless specifically covered by an exception.

13. Include an exception to the *in camera* rule allowing participants in family court proceedings to participate in anonymised qualitative and quantitative research projects.

14. Include an exception to the prohibition in Head 37 similar to section 31(2) of the Child Care Act under which a court may, in any case if satisfied that it is appropriate to do so in the best interests of the child, by order dispense with the prohibitions of that subsection in relation to him to such extent as may be specified in the order.

APPENDIX B: SUBMISSION TO FAMILY JUSTICE OVERSIGHT GROUP

24 February 2021

Introduction

The proposal to establish a specialist family court in Ireland is most welcome. Specialisation in the area of family law is now commonplace among judges and courts across Europe,[1]and has been recommended by multiple bodies in Ireland, most recently the Joint Oireachtas Committee on Justice and Equality.[2] However, the establishment of a separate court or court division dedicated to cases concerning families or children will not, in itself, rectify the difficulties that led to the above recommendations unless it is properly designed and resourced. The devil is in the detail, and it has been observed that "there are as many models of a family court as there are proponents of it".[3]

International research indicates that specialisation of staff, facilities, procedures and resourcing is what really matters: mere separation from general court proceedings will not suffice. For example, in Australia, research in Victoria,[4] Queensland[5] and New South Wales[6] has documented many of the same difficulties that have been documented in family law proceedings in Ireland continued to exist there following the establishment of specialist children's courts at State level. This was largely attributed to a lack of specialisation and training, particularly among the judiciary (with many cases outside of metropolitan areas being heard by judges who do not specialise in child or family law). However, more recent developments in Australia have seen their family courts being reimagined as genuinely specialist and multidisciplinary service, with much improved results. These developments will be discussed further below.

The imbalanced distribution of population in Ireland means that there is a limit to the number of specialist family court facilities that could feasibly be developed; each centre would require a critical population mass to justify the investment of dedicated judges and buildings. Regional centralisation of child and family law cases, which has already been possible to a degree in Dublin due to spatial density and a large population, would present challenges if families have to travel a significant distance to attend proceedings in these dedicated courts instead of in their local District Court. However, a balance could

1. Council of Europe Consultative Council of European Judges (2012) *Opinion No. 15 of the Consultative Council of European Judges on the Specialisation of Judges*, available at https://rm.coe.int/16807477d9#P53_1776.

2. Joint Oireachtas Committee on Justice and Equality *Report on Reform of the Family Law System* (October 2019), available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2019/2019-10-24_report-on-reform-of-the-family-law-system_en.pdf.

3. B Hoggett, "Family courts or family law reform—which should come first?" (1986) 6 *Legal Studies* 1–17.

4. R Sheehan and A Borowski, "Australia's Children's Courts: An assessment of the status of and challenges facing the child welfare jurisdiction in Victoria" (2014) 36(2) *Journal of Social Welfare and Family Law* 95-110.

5. Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (2013) at pp.464-474, available at http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0017/202625/QCPCI-FINAL-REPORT-web-version.pdf.

6. J Wood, *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (2008) at pp.528-543, available at https://www.dpc.nsw.gov.au/publications/special-commissions-of-inquiry/special-commission-of-inquiry-into-child-protection-services-in-new-south-wales/.

be struck through combining specialist regional facilities in some areas with travelling specialist judges and refurbished facilities in existing court buildings in other areas.[7]

I have made a separate submission to the Joint Oireachtas Committee on Justice in respect of the General Scheme of the Family Court Bill. This submission is targeted at the consultation exercise being conducted by the Family Justice Oversight Group, and will briefly address the following questions posed as part of that consultation:

1. The provision of facilities and supports in the family justice locations
2. How best to incorporate the voice of the child?
3. How can the proposed new system of family justice be made more child friendly?
4. How can we keep children informed in the family court system?

1. The provision of facilities and supports in the family justice locations

An effective specialised family court needs to be more than just a court. Geoffrey Shannon, the previous Special Rapporteur on Child Protection, called in 2018 for an "integrated Family Court structure that is properly resourced to meet the particular needs of people at a vulnerable time in their lives."[8] Shannon recommended that this should "recognise and actively promote an interdisciplinary system":

> "Restructuring of the family law court without the involvement and promotion of an interdisciplinary system would not achieve the objective of meeting the particular needs of the users of the family court structure. The interdisciplinary system involves an acceptance that simply making a court order is not sufficient, that further work needs to be undertaken by specialists with a range of non-legal skills to ensure that the needs of clients are met. Without this, any new system remains as flawed as the current one."[9]

Shannon stated that key ancillary services relating to parenting plans, domestic violence, supervised access and family therapy are an essential part of any new family law court system and recommended that they should be located in the new family law courthouses and linked into the welfare system.[10]

These recommendations are supported by international standards and by experience in other jurisdictions. The United Nations Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime recommend the use of "interdisciplinary services for child victims integrated in the same location."[11] In Australia, a pilot programme called the Family

7. For example, in Queensland, the recommended solution was the appointment of additional specialist judges in key locations where the greatest case load arises; this was to be achieved in part by appointing generalist judges as magistrates of the Children's Court where they had already developed a *de facto* degree of specialisation by managing child protection lists. See Queensland Child Protection Commission of Inquiry, *Taking Responsibility: A Roadmap for Queensland Child Protection* (2013) at pp. 464-466, available at http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0017/202625/QCPCI-FINAL-REPORT-web-version.pdf.

8. G Shannon, *Eleventh Report of the Special Rapporteur on Child Protection* (2018) at p.22, available at https://assets.gov.ie/27444/92175b78d19a47abb4d500f8da2d90b7.pdf.

9. *Ibid*.

10. *Ibid* at p.23.

11. United Nations Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime (ECOSOC Resolution 2005/20, 22 July 2005) at [30], available at https://www.un.org/en/ecosoc/docs/2005/resolution%202005-20.pdf.

Advocacy and Support Services (FASS) has been favourably received. This "enhanced integrated service recognises that people coming to the Family Court of Australia or the Federal Circuit Court of Australia have more than just legal needs", and aims to meet these needs by having services co-located at the court and working in collaboration with the court based duty lawyers.[12] It has been described as follows by the Australian Law Reform Commission:

> "[FASS] takes a team-based warm referral approach to delivering both legal and non-legal support services to families affected by family violence. While the service is based within the family courts, it aims to address jurisdictional fragmentation by providing clients with information and advice in relation to state and territory family violence and child protection matters, as well as family law matters, and the interactions between them … the FASS model provides an initial risk assessment, safety planning and warm referrals to relevant support services, such as counselling and/or drug and alcohol services, as well as the duty lawyer service."[13]

An evaluation of this model by the office of the Attorney General for Australia found that "FASS was an effective and important program that fills a gap in legal and social service provision to family law clients", and that "[p]lacement of social support workers alongside duty lawyers in the family law courts was found to have clear benefits".[14] In 2019, the Australian Law Reform Commission recommended the expansion of the FASS.[15] The Commission also emphasised "the importance of ancillary staff within the family courts in protecting the rights of children and promoting their welfare, in ensuring protection from family violence, and in assisting parties to improve their relationship to each other and to their children", and recommended that this be recognised in the legislation governing the family courts.[16] The experience in Australia of the FASS provides solid evidence in support of the recommendations made by Shannon for the integration of a wide range of non-legal support services in the same location as specialised family court facilities.

2. How best to incorporate the voice of the child?

In 2012, the Irish Constitution was amended by the insertion of Article 42A, which requires that in a wide range of court cases concerning children, provision shall be made by law that the views of any child who is capable of forming his or her own views shall be ascertained and given due weight having regard to the age and maturity of the child. Article 42A is mandatory. It requires that in every case where the child is capable of forming his

12. "New integrated services to help address family violence start 1 May in Dandenong and Melbourne", 26 April 2017, available at https://www.legalaid.vic.gov.au/about-us/news/new-integrated-services-to-help-address-family-violence-start-1-may-in-dandenong-and-melbourne.

13. Australian Law Reform Commission, *Review of the Family Law System – Issues Paper* (March 2018) at [234], available at https://www.alrc.gov.au/wp-content/uploads/2019/08/issues_paer_48_19_march_2018_.pdf.

14. Australian Government Attorney-General's Department, *An Evaluation of the Family Advocacy and Support Services Final Report* (18 October 2018), at pp.4-5, available at https://www.ag.gov.au/sites/default/files/2020-03/fass-final-evaluation-report.pdf.

15. Australian Law Reform Commission, *Family Law for the Future — An Inquiry into the Family Law System* (2019) at p.458-463, available at https://www.alrc.gov.au/publication/family-law-report/.

16. *Ibid* at p.359.

or her own views, those views shall be ascertained. Age and maturity are relevant to the question of how much weight to place on those views, but do not relieve the court of the obligation to ascertain the views of the child unless it is deemed that the child is incapable of forming their own views.

Article 42A does not specify the medium through which the views of children shall be ascertained in court proceedings, and as such, different mechanisms involving either direct participation by children, or indirect participation via a representative such as a guardian *ad litem* (GAL) or a solicitor, might fulfil the obligation imposed by Article 42A. I have provided a detailed analysis of the proposals for the reform of the GAL service in my most recent Annual Report, and reform of the relevant provisions of the Child Care Act 1991 are an essential part of vindicating the child's right to be heard.[17] Separately, there is a need to address shortcomings in the provision made in the Children and Family Relationships Act 2015 for ascertaining the views of children in private family law proceedings.

Leaving aside the question of indirect participation through a representative, it is important to note that the UN Committee on the Rights of the Child has stated that "wherever possible, the child must be given the opportunity to be directly heard in any proceedings."[18] For some children, the opportunity to see at least some of the process that will lead to life-changing decisions about where and with whom they will live, and to meet and speak with the person charged with making that decision, is a hugely valuable part of coming to terms with their circumstances and can have beneficial effects on their well-being.[19] International research by Kilkelly has found that "[m]ore than anything, they want to speak directly to those who take decisions about them".[20] Indirect participation through a GAL and/or solicitor will not achieve this. As such, the development of a family court system must make allowances not only for the provision of representatives who can communicate the child's views to the court, but also for the possibility of direct participation of children who are able to and wish to participate directly.

While there have been many calls for enhanced opportunities for children to meet with judges, these have been accompanied by calls for the provision of specific guidelines governing such meetings, as well as specialised training for judges.[21] Some District Court judges in Ireland have developed a practice of meeting with children in chambers or in an empty courtroom and gained significant experience of doing so. However, this has been on a largely *ad hoc* basis, with no rules governing the practice and no consistency as between judges with respect to whether or how this is done. Some judges are strongly against the practice on the basis that they do not have the requisite skills and training to

17. C O'Mahony, *Annual Report of the Special Rapporteur on Child Protection* (2020), Chapter 4, available at https://www.gov.ie/en/publication/cfbc8-special-rapporteur-on-child-protection-13th-report/.

18. UN Committee on the Rights of the Child, *General Comment No 12 (2009): The Right of the Child to be Heard*, UN Doc No CRC/C/GC/12, 20 July 2009 at [35].

19. See further A Daly, "The Judicial Interview in Cases on Children's Best Interests—Lessons for Ireland" (2017) 20(3) *Irish Journal of Family Law* 66 and E O'Callaghan, C O'Mahony and K Burns "'There is nothing as effective as hearing the lived experience of the child': Practitioners' Views on Children's Participation in Child Care Cases in Ireland" (2019) 22(1) *Irish Journal of Family Law* 2.

20. U Kilkelly, Listening to Children about Justice: Report of the Council of Europe's Consultation with Children on Child-Friendly Justice (Council of Europe, 2010) at p 39, available at https://rm.coe.int/168045f81d. Similar findings were reported by P Parkinson, J Cashmore, and J Single, "Parents' and Children's Views on Talking to Judges in Parenting Disputes in Australia" (2007) 21 *International Journal of Law, Policy and the Family* 84.

21. See, eg, P Case, "When the judge met P: the rules of engagement in the Court of Protection and the parallel universe of children meeting judges in the Family Court" (2019) 39(2) *Legal Studies* 302-320.

speak directly with children, and other professionals involved in child care proceedings have expressed concern that the suitability of judges to meet with children varies widely.[22]

There is clearly an important place for direct participation of children in family court proceedings; but this needs to be underpinned by a firm statutory basis, and provision needs to be made to ensure that judges who interview children have the necessary skills and follow established guidelines. The UN Committee on the Rights of the Child has stated that "adults need preparation, skills and support to facilitate children's participation effectively, to provide them, for example, with skills in listening, working jointly with children and engaging children effectively in accordance with their evolving capacities".[23] Moreover, the Family Court Bill should expressly recognise the judicial interview as a means of ascertaining the views of children, and require that guidelines be developed to assist judges in conducting such interviews. This task could (for example) be assigned to the Family Law Rules Committee envisaged under Head 18 of the Bill, and could draw on the experience already accumulated by some judges.

3. How can the proposed new system of family justice be made more child friendly?

Legislative reform, while a necessary step, is not sufficient to ensure effective direct participation by children. All of the evidence indicates that at present, our courts are an adversarial forum, with facilities that are unsuitable for direct child participation and staff who often have not been provided with the training necessary to facilitate child participation in an effective and appropriate manner. Research on District Court child care proceedings in Ireland suggests that it is the absence of an appropriate environment that currently acts as the biggest barrier to direct participation by children.[24] In a survey of legal practitioners conducted in 2017, 48% stated that "the lack of a child friendly environment" was an obstacle to communicating with children, while a further 29% identified "education about talking with children" as an obstacle.[25] As such, it is necessary to implement measures aimed at making the courts a more child friendly place.

This section will set out the relevant international standards, before identifying a number of key elements of achieving a child friendly environment – namely:

- Scheduling
- Facilities
- Mitigating the adversarial model
- Training of professionals

22. A Parkes, C Shore, C O'Mahony and K Burns, "The Right of the Child to be Heard? Professional Experiences of Child Care Proceedings in the Irish District Court" (2015) 27 *Child and Family Law Quarterly* 423 at pp 432-437. See further Joint Oireachtas Committee on Justice and Equality *Report on Reform of the Family Law System* (October 2019) at p.36, available at https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2019/2019-10-24_report-on-reform-of-the-family-law-system_en.pdf. For evidence from other jurisdictions on this point, see FE Raitt, "Hearing children in family law proceedings: can judges make a difference?" (2007) 19 *Child and Family Law Quarterly* 151 at p.156.

23. UN Committee on the Rights of the Child, *General Comment No 12 (2009): The Right of the Child to be Heard*, UN Doc No CRC/C/GC/12, 20 July 2009 at [134(g)].

24. See generally A Parkes, C Shore, C O'Mahony and K Burns, "The Right of the Child to be Heard? Professional Experiences of Child Care Proceedings in the Irish District Court" (2015) 27 *Child and Family Law Quarterly* 423 and E O'Callaghan, C O'Mahony and K Burns "'There is nothing as effective as hearing the lived experience of the child': Practitioners' Views on Children's Participation in Child Care Cases in Ireland" (2019) 22(1) *Irish Journal of Family Law* 2.

25. E O'Callaghan, C O'Mahony and K Burns "'There is nothing as effective as hearing the lived experience of the child': Practitioners' Views on Children's Participation in Child Care Cases in Ireland" (2019) 22(1) *Irish Journal of Family Law* 2.

3.1 International Standards

According to the Committee on the Rights of the Child, children must have a safe space within which to contribute their views where they are not subject to fear or intimidation in the surrounding environment.[26] Adequate time and resources should be made available to ensure that children are adequately prepared and have the confidence and opportunity to contribute their views.[27] Similarly, the Council of Europe Child Friendly Justice Guidelines emphasise that "[c]ases involving children should be dealt with in non-intimidating and child-sensitive settings".[28] Specific components of this approach should include:

- Before proceedings begin, children should be familiarised with the layout of the court or other facilities and the roles and identities of the officials involved.
- Language appropriate to children's age and level of understanding should be used.
- Court sessions involving children should be adapted to the child's pace and attention span: regular breaks should be planned and hearings should not last too long.
- As far as appropriate and possible, interviewing and waiting rooms should be arranged for children in a child friendly environment.[29]

3.2 Scheduling

Family court proceedings are often scheduled in close proximity to criminal proceedings, so that families end up sharing the public spaces in the courthouse with people in handcuffs or people who are behaving in a disorderly manner.[30] The requirement in section 29(3) of the Child Care Act 1991 that child care proceedings are held at a different time and in a different place to other court proceedings is routinely flouted. Heads 9(3), 14(3) and 17(3) of the Family Courts Bill risk watering down the existing obligation by providing merely that family law proceedings be held in a different room to other proceedings (which would have to be the case in any event due to the requirements of the *in camera* rule). A basic first step in making family court proceedings more child friendly would be to secure meaningful separation between those proceedings and other court proceedings.

A second scheduling issue relates to the overload of family law lists in many venues. As noted above, the international standards emphasise the importance of allowing sufficient time to allow children to participate; that court hearings involving children should be adapted to the child's pace and attention span, and that regular breaks should be allowed. However, research by the Child Care Law Reporting Project has found evidence of single judges having well in excess of 100 cases listed in a single day, and has described the courts as "severely over-worked".[31] This situation has multiple negative impacts, one of which is that it makes it essentially impossible to slow down proceedings to allow for meaningful child participation.

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26. UN Committee on the Rights of the Child, *General Comment No 12 (2009): The Right of the Child to be Heard*, UN Doc No CRC/C/GC/12, 20 July 2009 at [41].

27. *Ibid* at [134(e)].

28. Council of Europe, Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice (17 November 2010) at IV(54), available at https://rm.coe.int/16804b2cf3.

29. *Ibid* at IV(55), (56), (61) and (62).

30. *C O'Mahony*, K Burns A Parkes and C Shore, "Child Care Proceedings in Non-Specialist Courts: The Experience in Ireland" (2016) 30 *International Journal of Law, Policy and the Family* 131 at pp.140-141.

31. C Coulter, *District Court Child Care Proceedings: A National Overview (March 2019)* at pp.1 and 38, available at https://www.childlawproject.ie/wp-content/uploads/2019/03/CCLRP-regional-report-2019_FINAL.pdf.

3.3 Court Facilities

A further significant barrier to a child friendly environment in family court proceedings in Ireland is the state of the physical facilities in which they are held. This is a particular concern in more rural areas, but can also arise in larger urban courthouses. Research has indicated that the majority of District Court proceedings "take place in physical facilities ranging from somewhat to utterly inadequate, irrespective of the county in which they are located", and that the lack of adequate facilities has "a marked negative impact on the conduct of the proceedings and on both the professionals and the families involved".[32] The following table from the same study provides a selection of descriptions of District Court used by different professionals working in child care proceedings across three counties, including a mix or urban and rural areas:

Profession	County 1	County 2	County 3
Judge	"Dickensian"	"tinderbox" "not a suitable place for anyone"	
Solicitor	"disastrous" "humiliating"	"brutal" "highly unsuitable"	"terrible" "disaster" "horrendous" "a shed"
Social Worker	"unsafe" "appalling"	"horrendous" "dreadful" "extremely poor"	"cattle mart" "old bunk" "absolutely terrible"
Guardian *ad litem*	"huge safety issues" "very poor"	"dangerous"	"inhospitable" "very uncomfortable"

Thus, even if scheduling issues are addressed, it will remain the case that many family court proceedings will take place in facilities which are undersized and overcrowded, with inadequate facilities for private consultation and limited or no facilities which are specifically designed with the needs of children in mind. The result is that privacy is undermined, and parties to proceedings suffer significant stress and anxiety. The presence in overcrowded courts of some parents who may experience mental health or addiction issues, and who are further stressed by the experience of participating in an adversarial court hearing, can lead to safety concerns.[33] The combined effect of these defects is that the physical environment in the majority of District Court venues is the antithesis of child friendly.

32. C O'Mahony, A Parkes, C Shore and K Burns, "Child Care Proceedings and Family-Friendly Justice: The Problem with Court Facilities" (2016) 19(4) *Irish Journal of Family Law* 75-81.

33. *Ibid*. See also C Coulter, *District Court Child Care Proceedings: A National Overview* (March 2019) at pp.2-3, available at https://www.childlawproject.ie/wp-content/uploads/2019/03/CCLRP-regional-report-2019_FINAL.pdf.

3.4 Mitigating the Adversarial Model

Repeated calls have been made for the implementation of measures aimed at making child law proceedings less adversarial.[34] Research has indicated that professionals believe that an adversarial approach leads to court proceedings becoming a "battle" in which the focus is on "who wins and who loses", with the result that the "child gets lost".[35] The result of this is to increase the stress levels of participants and to create an acrimonious atmosphere which is not child friendly. As such, if family court proceedings are to give full effect to the principle that the welfare of the child is paramount, and to be a safe space with a child-sensitive atmosphere (as required by the international guidelines), steps must be taken to mitigate the tendency of family law proceedings to descend into highly contentious disputes.

Coulter has observed that the adversarial model has "deep roots" in Ireland and will not be easily displaced.[36] In her research, professionals state that different judges take very different approaches in the extent to which they modify the adversarial model and treat child care cases as inquiries into the welfare of the child rather than adversarial hearings (as the Supreme Court has suggested they should do).[37] As such, the appointment of specialist judges and the provision of judicial training is one element of addressing this inconsistency. Additional measures to be considered include clarifying the application of the rules of evidence in family court proceedings and the adoption of more intensive case management techniques aimed at early identification of issues and confining evidence to such issues in order to keep the focus on the best interests of the child rather than on parental grievances (as seen in the "Less Adversarial Trial" model applied in the Australian Family Court, for example).[38]

3.5 Training of Professionals

It has already been noted that achieving effective child participation and reducing adversarialism will require specialist training for judges. However, the need for specialist training in a child friendly court is not limited to judges. The UN Committee on the Rights of the Child has stated that the provision of training on Article 12 of the CRC for all

34. See, eg, Law Society of Ireland, *Submission to the Department of Justice, Equality and Defence: Family Law – The Future* (2014) at p.37, available at https://www.lawsociety.ie/globalassets/documents/committees/family/familylawsubmission2014.pdf; G Shannon, *Seventh Report of the Special Rapporteur on Child Protection: A Report Submitted to the Oireachtas* (2014) at p.98, available at https://assets.gov.ie/27440/b9e888545a484e3baaa13a8572894acf.pdf; C Coulter, *Second Interim Report: Child Care Law Reporting Project* (2014) at p.27, available at http://www.childlawproject.ie/wp-content/uploads/2014/10/Interim-report-2-Web.pdf.

35. C O'Mahony, K Burns, A Parkes and C Shore, "Child Care Proceedings in Non-Specialist Courts: The Experience in Ireland" (2016) 30 *International Journal of Law, Policy and the Family* 131. See further C Coulter, An Examination of Lengthy, Contested And Complex Child Protection Cases In the District Court (2018) at p 40, available at https://www.childlawproject.ie/wp-content/uploads/2018/06/CCLRP-Examination-of-Complex-Child-Protection-Cases-March-2018.pdf.

36. C Coulter, An Examination of Lengthy, Contested And Complex Child Protection Cases In the District Court (2018) at p 14, available at https://www.childlawproject.ie/wp-content/uploads/2018/06/CCLRP-Examination-of-Complex-Child-Protection-Cases-March-2018.pdf. See further *ibid* at pp.73-74.

37. *Ibid* at pp.92-93. The relevant Supreme Court decision is *Southern Health Board v CH* [1996] 1 IR 219 at 237, in which the Court stated that child care proceedings are "in essence an *inquiry* as to what is best to be done for the child in the particular circumstances pertaining" (emphasis in original).

38. J McIntosh, D Bryant and K Murray, "Evidence of a Different Nature: The Child-Responsive and Less Adversarial Initiatives of the Family Court of Australia" (2008) 46 *Family Court Review* 125-136, available at https://www.researchgate.net/publication/227852646_Evidence_of_a_different_nature_The_child-responsive_and_less_adversarial_initiatives_of_the_Family_Court_of_Australia.

professionals working with and for children is a "core obligation" of States Parties.[39] The Council of Europe Child Friendly Justice Guidelines recommend that all professionals working with and for children should receive necessary interdisciplinary training on the rights and needs of children of different age groups, as well as on proceedings that are adapted to them; this should include training in communicating with children at all ages and stages of development, as well as with children in situations of particular vulnerability.[40] Close co-operation between different professionals should be encouraged in order to obtain a comprehensive understanding of the child, as well as an assessment of his/her legal, psychological, social, emotional, physical and cognitive situation.[41] The Guidelines specifically recommend that lawyers representing children "be trained in and knowledgeable on children's rights and related issues, receive ongoing and indepth training and be capable of communicating with children at their level of understanding".[42]

4. How can we keep children informed in the family court system?

The Committee on the Rights of the Child has stressed that information concerning the decision must be provided to the child in advance of the decision-making process; this is an essential pre-requisite to children and young people being effectively heard in court proceedings. This information must be child-appropriate and must be provided all the way throughout the proceedings.[43] As such, it is not enough that children be asked for their views; they must be kept informed at all points of the process. The Council of Europe Child Friendly Justice Guidelines identify the provision of information and advice as the first element of child friendly justice; this should include information on:

- the specific rights children have in proceedings and the procedures involved;
- the support mechanisms for the child when participating in the proceedings;
- the general progress and outcome of the proceedings or intervention;
- the mechanisms for review of decisions affecting the child;
- the availability of services (health, psychological, social, interpretation and translation, and other) or organisations which can provide support as well as the means of accessing such services along with emergency financial support, where applicable.[44]

The Guidelines also emphasise that information and advice "should be provided to children in a manner adapted to their age and maturity, in a language which they can understand and which is gender- and culture-sensitive",[45] and that "both the child and parents or legal

39. UN Committee on the Rights of the Child, *General Comment No 12 (2009): The Right of the Child to be Heard*, UN Doc No CRC/C/GC/12, 20 July 2009 at [49].

40. Council of Europe, Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice (17 November 2010) at IV(14) and (15), available at https://rm.coe.int/16804b2cf3.

41. *Ibid* at IV(16).

42. *Ibid* at IV(39).

43. UN Committee on the Rights of the Child, *General Comment No 12 (2009): The Right of the Child to be Heard*, UN Doc No CRC/C/GC/12, 20 July 2009 at [34].

44. Council of Europe, Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice (17 November 2010) at IV(1), available at https://rm.coe.int/16804b2cf3.

45. *Ibid* at IV(2).

representatives should directly receive the information. Provision of the information to the parents should not be an alternative to communicating the information to the child."[46] To this end, "[c]hild-friendly materials containing relevant legal information should be made available and widely distributed, and special information services for children such as specialised websites and helplines established."[47]

It must be acknowledged that communicating the purpose and outcomes of complex legal proceedings in child friendly language is challenging, and will require judges, lawyers and other staff to acquire new skills. However, it is quite achievable with the correct training and supports. Multiple resources are already freely available that can assist with this work – for example:

- Project TALE provides a free online training course designed to support legal practitioners in making the legal process more sensitive to the rights and needs of child clients.[48]
- The IDEA project has published an open-access practice tool that provides practical guidance on how to communicate effectively with children in court.[49]

There are also examples available of effective use of plain language by members of the judiciary. One highly regarded example is the judgment of Mr Justice Jackson of the English High Court in *Re A: Letter to a Young Person* in 2017.[50] Jackson J wrote his judgment in the form of a letter to the 14-year-old boy at the centre of the proceedings. The boy had expressed a wish to accompany his father in relocating to Scandinavia, but the judge ruled that this was not in his best interests. In a four page judgment written in plain language, the judge effectively communicated both the reasons for his decision and the legal framework within which it was made. It is an exemplar of how legal professionals can provide accessible information to children while remaining legally accurate. And while it might not work in every case (depending on the age of the child or the complexity of the proceedings), the general approach could be adapted. For example, a traditional legal judgment could be accompanied by a letter giving a child friendly explanation, or by an oral explanation by the judge (accompanied if necessary by a specialist in communicating with children). An example of the former approach (albeit addressed to adult parties rather than children) can be seen in the judgment of Mr Justice Barrett of the Irish High Court in *X Executrix of the Estate of Y (Deceased) v Y* in 2020.[51]

46. *Ibid* at IV(3).
47. *Ibid* at IV(4).
48. See http://www.project-tale.org/online-training.
49. See https://ideachildrights.ucc.ie/resources/Children-print.pdf.
50. [2017] EWFC 48, available at https://www.bailii.org/ew/cases/EWFC/HCJ/2017/48.html.
51. [2020] IEHC 492, available at https://www.courts.ie/acc/alfresco/730ad020-bcd6-4437-af2a-42ea5451306f/2020_IEHC_492-1.pdf/pdf#view=fitH.

APPENDIX C: SUBMISSION ON THE GENERAL SCHEME OF THE ONLINE SAFETY AND MEDIA REGULATION BILL

Committee on Media, Tourism, Arts, Culture, Sport and the Gaeltacht, 12 May 2021

(Video of the Committee hearing can be viewed at https://www.oireachtas.ie/en/committees/33/media-tourism-arts-culture-sport-and-the-gaeltacht/videos/)

Introduction

Children increasingly have access to smart phones, tablets and computers at a young age, and are spending more and more time online for entertainment such as gaming and watching programmes. This has been increased further by the Covid-19 pandemic as children and young people are reliant on digital media for school work and for contact with extended family and friends. It is estimated that one-third of all internet users are under the age of 18 years.[1]

However, it is well documented that engagement in online activities exposes children to risks of harm, including access harmful or age-inappropriate material and cyberbullying. A study of young people aged 9 to 16 years, involving seven countries (including Ireland), found that "a quarter of 13-14 year olds and 37% of 15-16 year olds say they have experienced something that bothered them or wished they hadn't seen" and that 26% of girls and 17% of boys have experienced bullying online.[2] Further, "35% of girls aged 13-16 have encountered content such as hate messages, anorexic or bulimic content (14%), self-harm sites (9%); sites discussing suicide 8% and sites where people share their experiences with drugs (7%)". It was also reported that "47% of older teenagers have seen sexual images in the past 12 months compared to 11% of younger children. About half of older teenagers who had seen sexual images said they were upset by the experience".[3] The enactment of legislation targeted at addressing the risk of harm suffered on the digital environment is thus timely and welcome.

At the same time, it is important to be cognisant of an increasingly clear body of principles and recommendations related to children's rights in the digital environment that have emerged at international level, several of which have either already crystallised or are about to crystallise as international human rights law obligations that are binding on Ireland as a State Party to the Convention on the Rights of the Child (CRC). Key sources in this respect include:

- The Council of Europe in 2018 published its *Guidelines to respect, protect and fulfil the rights of the child in the digital environment* (referred to below at the Council of Europe Guidelines).[4]

1. S Livingstone, J Carr and J Byrne, *One in Three: Internet Governance and Children's Rights*, Office of Research – Innocenti Discussion Paper 2016-01 at p 7, available at https://www.unicef-irc.org/publications/795-one-in-three-internet-governance-and-childrens-rights.html.

2. B O'Neill and T Dinh (2015). Net Children Go Mobile: Full findings from Ireland. Dublin: Technological University Dublin, at pp 4-6, available at https://arrow.tudublin.ie/cserrep/55/.

3. B O'Neill and T Dinh (2015). Net Children Go Mobile: Full findings from Ireland. Dublin: Technological University Dublin, at pp 4-6, available at https://arrow.tudublin.ie/cserrep/55/. See also S Livingstone and PK Smith, "Annual Research Review: Harms experienced by child users of online and mobile technologies: the nature, prevalence and management of sexual and aggressive risks in the digital age" https://acamh.onlinelibrary.wiley.com/doi/10.1111/jcpp.12197.

4. Council of Europe, Recommendation CM/Rec(2018)7 of the Committee of Ministers, *Guidelines to respect, protect and fulfil the rights of the child in the digital environment*, available at https://rm.coe.int/guidelines-to-respect-protect-and-fulfil-the-rights-of-the-child-in-th/16808d881a.

- The UN Special Rapporteur on the promotion and protection of the right to freedom of opinion and expression published a report on *The right of the child to freedom of expression*, with significant references to online resources.[5]

- The Committee on the Rights of the Child published its General Comment No. 16 on *State obligations regarding the impact of the business sector on children's rights* in 2013.[6]

- The Committee on the Rights of the Child held a Day of General Discussion in 2014 on "Digital media and children's rights", at which it made numerous recommendations.[7] The Committee is currently completing a *General Comment on Children's rights in relation to the digital environment*, detailing an analysis of the relevant children's rights under the UN Convention on the Rights of the Child. This will publish shortly and will constitute the key standard by which Ireland's compliance with its CRC obligations will be measured.[8]

Geoffrey Shannon, in his 12th Report as the Special Rapporteur on Child Protection, sets out the approach adopted by the Council of Europe and by the Irish government to children's rights in the digital environment in recent years.[9]

The Council of Europe Guidelines state that "(l)aws and policies related to the digital environment should be assessed, at their drafting stage, with regard to the impact that their implementation may have on children's enjoyment of human rights and fundamental freedoms".[10] In this regard, there are a number of key principles that can be extrapolated from the international guidance that will form the basis of this submission and that aim to support the assessment of the impact of the General Scheme of the Online Safety and Media Regulation Bill on children's rights:

- Laws should provide protection for children online without unduly restricting the exercise of their other rights in a digital environment (eg expression, participation, education, development).

- Measures which restrict children's rights in the name of child protection must be prescribed by law and be necessary and proportionate.

- States must provide legislative, regulatory and remedial measures that provide for a clear and predictable legal environment (including definitions of concepts such as "harmful content").

- Laws must require businesses to meet their responsibility to respect children's rights in the digital environment.

5. A/69/335, (2014) available at https://www.ohchr.org/EN/Issues/FreedomOpinion/Pages/Annual.aspx.

6. Committee on the Rights of the Child, *General Comment No. 16 (2013) on State obligations regarding the impact of the business sector on children's rights*, CRC/C/GC/16 (April 2013), available at https://www.refworld.org/docid/51ef9cd24.html.

7. Committee on the Rights of the Child, *Report of the 2014 Day of General Discussion "Digital media and children's rights"* (September 2014), available at https://www.ohchr.org/Documents/HRBodies/CRC/Discussions/2014/DGD_report.pdf.

8. See further https://www.ohchr.org/EN/HRBodies/CRC/Pages/GCChildrensRightsRelationDigitalEnvironment.aspx.

9. G Shannon, *Twelfth Report of the Special Rapporteur on Child Protection, A Report Submitted to the Oireachtas* (2019) at pp 7-9 and 57, available at https://assets.gov.ie/45418/612999d7993449c780ecfdf4392b323e.pdf.

10. Council of Europe, Recommendation CM/Rec(2018)7 of the Committee of Ministers, *Guidelines to respect, protect and fulfil the rights of the child in the digital environment*, p 23, available at https://rm.coe.int/guidelines-to-respect-protect-and-fulfil-the-rights-of-the-child-in-th/16808d881a.

- Laws must provide for accessible non-judicial remedies and grievance mechanisms, while ensuring that judicial remedies remain available.

The General Data Protection Regulation (GDPR) is also an important consideration when drafting legislation regulating the digital environment. Recital 38 of the GDPR recognises children as requiring "specific protection with regard to their personal data, as they may be less aware of the risks, consequences and safeguards concerned and their rights in relation to the processing of personal data". The Data Protection Commission in Ireland has discussed the age of digital consent, age verification, direct marketing, profiling and advertising, and stated that "the DPC's position is that child protection/ welfare measures should always take precedence over data protection considerations affecting an individual. The GDPR, and data protection in general, should not be used as an excuse, blocker or obstacle to sharing information where doing so is necessary to protect the vital interests of a child or children".[11]

This submission will identify some points of discussion arising from two Heads in the General Scheme of the Online Safety and Media Regulation Bill – in particular, categories of harmful online content, and the definition of age inappropriate content. It will also identify two significant gaps in the current version of the Bill – namely, the requirement to remove harmful material and provide effective remedies, and the imposition of children's rights due diligence requirements on service providers. Finally, it will raise the issue of child participation in the process leading to the enactment of the legislation.

Head 49A – Categories of harmful online content

Head 49A provides proposed definition of categories of online harm. These include cyberbullying and material which promotes of eating disorders and promotion of self-harm). However, the current definitions do not include financial harm. The Children's Commissioner for England has recommended that "(f)inancial harm should be specifically listed as within *(sic)* scope of forthcoming online harms legislation".[12] This recommendation is made within the context of gambling. Gambling online is identified as a risk of harm for children in the Council of Europe Guidelines,[13] while the Data Protection Commissioner in Ireland has also referenced "financial harm" in respect of children.[14] The College of Psychiatrists of Ireland have stated that children have been "shown to be particularly vulnerable to gambling advertising", and cited evidence that "about three quarters of

11. Data Protection Commission, *Children Front and Centre* (December 2020) at p 23, available at https://www.dataprotection.ie/sites/default/files/uploads/2020-12/Fundamentals%20for%20a%20Child-Oriented%20Approach%20to%20Data%20Processing_Draft%20Version%20for%20Consultation_EN.pdf.

12. Children's Commissioner, *Gaming the system* (October 2019) at p 4, available at https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/10/CCO-Gaming-the-System-2019.pdf.

13. Council of Europe, Recommendation CM/Rec(2018)7 of the Committee of Ministers, *Guidelines to respect, protect and fulfil the rights of the child in the digital environment* at [51], available at https://rm.coe.int/guidelines-to-respect-protect-and-fulfil-the-rights-of-the-child-in-th/16808d881a.

14. Data Protection Commission, *Children Front and Centre* (December 2020) at p 58, available at https://www.dataprotection.ie/sites/default/files/uploads/2020-12/Fundamentals%20for%20a%20Child-Oriented%20Approach%20to%20Data%20Processing_Draft%20Version%20for%20Consultation_EN.pdf.

teenagers between years 12 and 17 gamble annually, higher than any other age group".[15] While "gaming" is referenced in the Explanatory Note to Head 56 – Designation of relevant online services, this does not sufficiently protect children from the risk of harm from online gambling. It is recommended that financial harm be added to the categories of harmful online content currently listed in Head 49A.

Head 49C – Definition of age inappropriate online content

First, there is room for improvement here by way of clarifying the definitions of some of these categories of material. The definition of pornography is notoriously subjective.[16] Leaving the term undefined will invite disputes at to what type of material is or is not captured by the Bill, and raise questions about the basis on which such disputes are to be resolved. The same point could be made in relation to material comprising "gross or gratuitous violence".

Second, the reference in Head 49C to "best interests" appears to be the only reference to this principle in the entire Bill. In the Council of Europe Guidelines, the best interests of the child are described as one of the "fundamental principles and rights":

> "In all actions concerning children in the digital environment, the best interests of the child shall be a primary consideration. In assessing the best interests of a child, States should make every effort to balance, and wherever possible, reconcile a child's right to protection with other rights, in particular the right to freedom of expression and information as well as participation rights".[17]

This echoes the phrasing of the best interests principle in Article 3 of the CRC, which is binding on Ireland. As such, the Bill should be re-drafted so that the best interests of children are not merely a factor to take "into account" in Head 49C, but are a primary consideration for regulatory agencies and service providers in all aspects of online regulation.

A specific consequence of making the best interests of the child a primary consideration in all aspects of online regulation is that the principle should be built into processes that service providers are obliged to carry out. For example, the Data Protection Commission in Ireland has stated that:

> "The DPC considers that the principle of the best interests of the child … requires that organisations whose services are directed at/ intended for children, or likely to be accessed by children, should carry out a DPIA in respect of the different types of processing operations which are carried out on the personal data of child users … Such risk assessments should take account of varying ages, capacities and developmental

15. College of Psychiatrists of Ireland, *Gambling Disorder*, Position Paper, EAP/01/20 (April 2020) at pp 6-7, available at https://www.irishpsychiatry.ie/wp-content/uploads/2020/10/Gambling-Disorder.pdf.

16. See further T Arthur, "The Problems with Pornography Regulation: Lessons from History" (2019) 68 *Emory Law Journal* 867, available at https://scholarlycommons.law.emory.edu/cgi/viewcontent.cgi?article=1021&context=elj.

17. Council of Europe, Recommendation CM/Rec(2018)7 of the Committee of Ministers, *Guidelines to respect, protect and fulfil the rights of the child in the digital environment* at [1], available at https://rm.coe.int/guidelines-to-respect-protect-and-fulfil-the-rights-of-the-child-in-th/16808d881a.

> needs of child users as well as considering both actual and potential risks arising from data processing to the health, well-being and general best interests of the child, including social, mental, physical and financial harm. The best interests of the child principle must be one of the primary risk evaluation tools when carrying out a DPIA concerning the processing of children's personal data".[18]

Further, while it is welcome that the "evolving capacities" of the child are referenced in this section, further consideration should be given to how this concept can be fleshed out in a meaningful way in the legislation and in surrounding policy. The Council of Europe Guidelines describe evolving capacities as one of the "fundamental principles and rights":

> "The capacities of a child develop gradually from birth to the age of 18. Moreover, individual children reach different levels of maturity at different ages. States and other relevant stakeholders should recognise the evolving capacities of children, including those of children with disabilities or in vulnerable situations, and ensure that policies and practices are adopted to respond to their respective needs in relation to the digital environment. This also means, for example, that policies adopted to fulfil the rights of adolescents may differ significantly from those adopted for younger children".[19]

In summary, the current references to best interests and evolving capacities are too narrow and opaque, and it is recommended that the Bill be revised so as to impose specific obligations on service providers and give effect to these principles in a meaningful way.

Removal of harmful content, individual complaints mechanism and remedies

Although Head 52B of the Bill makes provision for systemic complaints, the Online Safety and Media Regulation Bill makes no provision for a system of individual complaints that can lead to the removal of harmful content. This is by far the biggest gap in the Bill as it stands, and is clearly out of line with the international guidance on the requirements of children's rights law. The CEO of CyberSafeIreland has commented:

> *"Too often we have seen individuals reach out to us because there are glaring gaps in the system: most recently we had a case of a parent who tried unsuccessfully for more than two years to have videos removed from a platform, which were the source of a serious cyberbullying campaign against her son. The lack of support available to her and the feeling of 'utter helplessness' she described is simply unacceptable".*[20]

In its General Comment No. 16, the Committee on the Rights of the Child stated:

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18. Data Protection Commission, *Children Front and Centre* (December 2020) at p 58, available at https://www.dataprotection.ie/sites/default/files/uploads/2020-12/Fundamentals%20for%20a%20Child-Oriented%20Approach%20to%20Data%20Processing_Draft%20Version%20for%20Consultation_EN.pdf.

19. Council of Europe, Recommendation CM/Rec(2018)7 of the Committee of Ministers, *Guidelines to respect, protect and fulfil the rights of the child in the digital environment* at [2], available at https://rm.coe.int/guidelines-to-respect-protect-and-fulfil-the-rights-of-the-child-in-th/16808d881a.

20. Press Release: Children's and Youth Charities call for Online Child Safety to be a Priority in new Programme for Government, 4 June 2020, available at https://www.oneinfour.ie/news/press-release-june-4th-2020.

> "States have an obligation to provide effective remedies and reparations for violations of the rights of the child, including by third parties such as business enterprises … Several provisions in the Convention call for penalties, compensation, judicial action and measures to promote recovery after harm caused or contributed to by third parties. Meeting this obligation entails having in place child-sensitive mechanisms – criminal, civil or administrative – that are known by children and their representatives, that are prompt, genuinely available and accessible and that provide adequate reparation for harm suffered … In all cases, children should have recourse to independent and impartial justice, or judicial review of administrative proceedings."[21]

At its Day of General Discussion in 2014, the Committee elaborated on how this obligation applies in the specific context of protecting the rights of children in the digital environment:

> "States should empower and provide adequate resources to national institutions responsible for guaranteeing human rights (such as national human rights institutions, ombudspersons or equality bodies) to allow them to play a key role in monitoring compliance with the Convention and its Optional Protocols. Such an institution should have a specific mandate to address the rights of children in relation to digital media and ICTs, and be able to receive, investigate and address complaints by children in a child-sensitive manner, ensure the privacy and protection of victims, and undertake monitoring, follow-up and verification activities for child victims …
>
> States should also establish monitoring mechanisms for the investigation and redress of children's rights violations, with a view to improving accountability of ICT and other relevant companies, as well as strengthen regulatory agencies' responsibility for the development of standards relevant to children's rights and ICTs."[22]

To address the risks posed by digital media and ICTs to the safety of children, the Committee stated that States should "[p]rovide fast and effective procedures for removal of prejudicial or harmful material involving children" and "ensure access to effective remedies for child victims, including assistance to seek prompt and appropriate reparation for the harm suffered, through State compensation where appropriate."

The Council of Europe Guidelines have echoed this point, calling on States "to fulfil a child's right to an effective remedy when their human rights and fundamental freedoms have been infringed in the digital environment":

> "This entails the provision of available, known, accessible, affordable, and child-friendly avenues through which children, as well as their parents or legal representatives, may submit complaints and seek remedies. Effective remedies can include, depending on the violation in question, inquiry, explanation, reply, correction, proceedings,

21. Committee on the Rights of the Child, *General Comment No. 16 (2013) on State obligations regarding the impact of the business sector on children's rights*, CRC/C/GC/16 (April 2013) at [30], available at https://www.refworld.org/docid/51ef9cd24.html.

22. Committee on the Rights of the Child, *Report of the 2014 Day of General Discussion "Digital media and children's rights"* (September 2014) at [92] and [96], available at https://www.ohchr.org/Documents/HRBodies/CRC/Discussions/2014/DGD_report.pdf.

> immediate removal of unlawful content, apology, reinstatement, reconnection and compensation."[23]

The Guidelines specifically state that States should require that business enterprises make available, on their platform or within their service, easily accessible ways for any person, and in particular children, to report any material or activity which causes them concern and that reports received are dealt with efficiently and within reasonable timescales.

The Online Harms White Paper in the UK cites examples of international approaches in this area:

> "Germany adopted its Network Enforcement Act ('NetzDG') in 2017. This law requires online platforms with more than two million registered users in Germany to remove 'manifestly unlawful' content, which contravenes specific elements of the German criminal code, such as holocaust denial and hate speech, within 24 hours of receiving a notification or complaint, and to remove all other 'unlawful' content within seven days of notification. Non-compliance risks a fine of up to €50 million. This law also seeks to increase platform responsibility through imposing greater transparency and significant reporting obligations …
>
> Australia established an eSafety Commissioner through its Enhancing Online Safety for Children Act in 2015. The eSafety Commissioner is responsible for promoting online safety for all Australians. As well as offering a complaints service for young people who experience serious cyber bullying, its remit includes identifying and removing illegal online content and tackling image-based abuse".[24]

It is recommended that the Bill be revised to make provision for a clear legal obligation to remove harmful content identified on foot of complaints. In order to trigger this obligation, the Bill should make provision obliging service providers to establish procedures for receiving and investigating complaints, and for removing harmful material identified on foot of complaints. Further provision should be made for mechanisms through which complaints could be made to an independent agency with power to compel service providers to act where they fail to respond to direct complaints. The Bill should also provide for remedies and other supports for children experiencing harm.

Children's Rights Due Diligence Obligations

International children's rights law and guidelines are clear in stipulating that service providers should be subject to specific obligations requiring them to conduct due diligence aimed at ensuring that children's rights are respected by their businesses. In its General Comment No. 16, the Committee on the Rights of the Child stated:

23. Council of Europe, Recommendation CM/Rec(2018)7 of the Committee of Ministers, *Guidelines to respect, protect and fulfil the rights of the child in the digital environment* at [67], available at https://rm.coe.int/guidelines-to-respect-protect-and-fulfil-the-rights-of-the-child-in-th/16808d881a.

24. HM Government, *Online Harms White Paper* (April 2019) at p 66, available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793360/Online_Harms_White_Paper.pdf.

> "To meet their obligation to adopt measures to ensure that business enterprises respect children's rights, States should require businesses to undertake child-rights due diligence. This will ensure that business enterprises identify, prevent and mitigate their impact on children's rights including across their business relationships and within global operations. Where there is a high risk of business enterprises being involved in violations of children's rights because of the nature of their operations or their operating contexts, States should require a stricter process of due diligence and an effective monitoring system."[25]

The Committee continued by stating that large businesses should be required to make public their efforts to address child-rights impacts and to publish the actions taken to ensure that their services do not involve serious violations of children's rights. At its Day of General Discussion in 2014, the Committee reiterated these points specifically in the context of online services.[26] It seems highly likely that the forthcoming *General Comment on Children's rights in relation to the digital environment* will elaborate on this obligation, and that future periodic reporting by Ireland to the Committee will require Ireland to account for actions being taken in this regard.

Head 50A the General Scheme of the Online Safety and Media Regulation Bill provides that the Media Commission shall prepare, and from time to time revise, online safety codes that may provide for matters including risk and impact assessments that [may] be taken by designated online services or categories thereof in relation to the availability of harmful online content on their services. This is too weak to discharge the obligation set out above, in that it does not specifically refer to the impact of harmful content on children or on children's rights, nor does it impose a clearly legally binding obligation on service providers to conduct such an assessment or to publish the results. It is recommended that Head 50A be revised accordingly.

Child Participation in Legislative Process

Finally, the international guidance has repeatedly emphasised the importance of incorporating an element of child participation into the process leading to the enactment of laws regulating the digital environment. The Committee of the Rights of the Child has called upon States:

> "… to promote and facilitate regular public debates and the active involvement of all stakeholders, in particular children, parents and other caretakers, professionals working with or for children, including in the educational field, civil society and ICT and other relevant industries, before adopting draft laws, policies, strategies and programmes and when setting up services for child victims."[27]

25. Committee on the Rights of the Child, *General Comment No. 16 (2013) on State obligations regarding the impact of the business sector on children's rights*, CRC/C/GC/16 (April 2013) at [62], available at https://www.refworld.org/docid/51ef9cd24.html.

26. Committee on the Rights of the Child, *Report of the 2014 Day of General Discussion "Digital media and children's rights"* (September 2014) at [97], available at https://www.ohchr.org/Documents/HRBodies/CRC/Discussions/2014/DGD_report.pdf.

27. Committee on the Rights of the Child, *Report of the 2014 Day of General Discussion "Digital media and children's rights"* (September 2014) at [87], available at https://www.ohchr.org/Documents/HRBodies/CRC/Discussions/2014/DGD_report.pdf.

The Committee has also stated that "States should ensure that children are consulted in order to take into account their views and experiences in developing laws, policies, programmes, and in the setting up of services, and other measures relating to digital media and ICTs. This should include girls as well as boys, and children in vulnerable or marginalized situations."[28]

Similarly, the Council of Europe Guidelines state that "States should take measures to ensure that children are able to participate effectively in local, national and global public-policy and political debates and to support the development of online civic and social platforms to facilitate their participation and their enjoyment of the right to assembly and association, strengthening their capacity for democratic citizenship and political awareness."[29] Academic research has argued that although "[t]he task of balancing children's digital participation with their protection is enormously complex … it must not be overlooked that children themselves are an enormous resource in rising to this challenge".[30]

For these reasons, it is recommended that a specific process be put in place that allows for consultation with children in advance of the enactment of the Online Safety and Media Regulation Bill, and for meaningful consideration of the results of this consultation.

Summary of Recommendations

1. Include financial harm among the categories of harmful online content.

2. Provide clearer definitions of age inappropriate online content.

3. Oblige service providers and agencies with a regulatory role in relation to online series to make the best interests of children a primary consideration in all actions concerning children.

4. Clarify the specific obligations flowing from the evolving capacities of children.

5. Make provision for a clear legal obligation to remove harmful content identified on foot of complaints.

6. Make provision for complaints mechanisms (including both requiring service providers to establish procedures for receiving and investigating direct complaints, and a mechanism for complaints to an independent agency with power to compel service providers to act where they fail to respond to direct complaints).

7. Make provision for remedies and other supports for children experiencing harm.

8. Impose specified children's rights due diligence obligations on service providers

28. Committee on the Rights of the Child, *Report of the 2014 Day of General Discussion "Digital media and children's rights"* (September 2014) at [99], available at https://www.ohchr.org/Documents/HRBodies/CRC/Discussions/2014/DGD_report.pdf.

29. Council of Europe, Recommendation CM/Rec(2018)7 of the Committee of Ministers, *Guidelines to respect, protect and fulfil the rights of the child in the digital environment* at [24], available at https://rm.coe.int/guidelines-to-respect-protect-and-fulfil-the-rights-of-the-child-in-th/16808d881a.

30. A Third, D Bellerose, U Dawkins, E Keltie and K Pihl, *Children's Rights in the Digital Age: A Download from Children Around the World* (2014) at p 13, available at http://www.uws.edu.au/__data/assets/pdf_file/0003/753447/Childrens-rights-in-the-digital-age.pdf.

requiring them to identify, prevent and mitigate the impact of their services on children's rights and to publish the actions taken to ensure that their services do not involve serious violations of children's rights.

9. Incorporate an element of consultation with children into the process leading to the enactment of the Bill.

APPENDIX D: OBSERVATIONS ON BIRTH INFORMATION AND TRACING BILL

Committee Children, Disability, Equality and Integration, 15 June 2021

(Video of the Committee hearing can be viewed https://www.oireachtas.ie/en/oireachtas-tv/video-archive/committees/4348)

A Chairde,

I warmly welcome the General Scheme of the Birth Information and Tracing Bill. Ireland is currently one of only two countries in the European Union that does not permit adopted persons to access their birth information,[1] and the continuation of this approach is at odds with our obligations under international human rights law.[2] The enactment of legislation giving adopted persons the right to access their birth certificates and other crucial documentation to allow them to exercise their right to identity is long overdue.

The Bill delivers on important requirements of vindicating the right to identity, including:

- Unconditional access to birth certificates and other early life information;
- A legal basis for information sharing for the purposes of tracing;
- A contact preference register allowing parties to proactively indicate whether they are willing to be contacted following tracing; and
- Provision for the rectification of the register of births where details of a birth were falsified, as well as for a Register of Acknowledged Identity to address any issues arising from a person continuing to use an identity which they have used all of their life following an illegal registration of which they were unaware.

The core of the Bill is generally strong and the Minister and Department of Children are to be commended for the policy goals informing the legislation.

At the same time, there are some issues on the edges of the Bill that might benefit from further consideration. The main issue I would like to highlight is the proposal in Part 6 of the Bill that records would, for the most part, remain where they are currently kept. While some provision is made in Heads 24 and 25 for the transfer of records to the Adoption Authority of Ireland (AAI), it will nonetheless remain the case that **adoption records will be dispersed and fragmented between agencies and geographic locations**. A key concern of adopted persons seeking to trace their identity is the length of time that this process takes and the elimination of avoidable delays. Notwithstanding the fact that the legislation will smooth over data protection law concerns regarding the sharing of information, the physical fragmentation of records **is likely to contribute to ongoing delays** in this area. I would submit that it would be preferable if all records were held by

1. See European Union Agency for Fundamental Rights, "Accessing adoption files and information on the biological family" (2017), available at https://fra.europa.eu/en/publication/2017/mapping-minimum-age-requirements/accessing-adoption-files.

2. Article 8(1) of the Convention on the Rights of the Child (CRC) provides: "States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference." The right has been recognised as being a part of the child's right to private life under Article 8 of the European Convention on Human Rights (ECHR); see, eg, *Jäggi v Switzerland* (58757/00, 13 July 2006) at [37] to [38]. In *Godelli v Italy* (33783/09, 25 September 2012), a violation of Article 8 was found due to the inability of adopted persons in Italy to access their birth information.

a single agency and ideally digitised to allow for maximum searchability. If the transfer of some staff with special knowledge of particular archives is necessary to make this work, then it should be facilitated.

Some additional issues I would like to highlight include:

- **False dates of birth:** The definition of "incorrect birth registration" in Head 2 (and the related definition of "affected person" in Head 29) only covers the falsification of the identity of parents. It does not cover the falsification of the date of birth of children, which has been documented as a historic practice in some agencies as a means of hindering efforts at tracing. The narrow definition has the effect that falsification of date of birth is not covered by Head 31 allowing for the amendment of register of births. This should be rectified.
- **Information meetings:** The provision made in Head 3 for an information meeting with a social worker only applies when a no contact preference has been registered. Adopted persons who are about to contact a birth parent would also benefit from the information and support provided at such a meeting, and as such, I submit that this should apply in all cases.
- **Counselling supports:** Similarly, the provision in Head 4 for a right of birth parents to access counselling services only applies where the birth parent has registered a no contact preference. I would submit that all birth parents would benefit from this provision, as initiating contact may prove just as challenging as declining it.
- **Minimum age for right of access:** Heads 5 and 6 provide that the right to apply to access information only arises from the age of 16. International human rights law is clear in providing that the right to identity is a right of the child, and is held while a child; it is not the case that the right only crystallises upon turning 18 (albeit that parents have a key role in guiding the exercise of this right in a manner consistent with the evolving capacities of the child).[3] In line with recommendations I have made elsewhere in respect of the right to identity of children born pursuant to donor-assisted human reproduction or surrogacy, I submit that birth and early life information should be available to an adopted child's parents on behalf of the child at any point after birth, and directly to the child from the age of 12.
- **Compliance with requests for information:** Finally, I note that Head 13 (which requires a person from whom the AAI or Tusla requests information to comply with that request) lacks any enforcement mechanism. Failure to comply with a request under Head 13 is not included among the offences listed in Head 37. If Head 13 is to be effective, this should be rectified.

I am grateful for your time and attention, and I look forward to further discussion at the pre-legislative scrutiny hearing.

3. By definition, all rights recognised by the CRC apply to children. In respect of the ECHR, the ECtHR held in *Odièvre v France* (42326/98, 13 February 2003) at [29] that "[b]irth, and in particular the circumstances in which a child is born, forms part of a child's, and subsequently the adult's, private life guaranteed by Article 8 of the Convention." A 16 year-old applicant successfully asserted the right to identity in *Mikulić v Croatia* (53176/99, 7 February 2002). Article 5 of the CRC requires States Parties to respect the responsibilities, rights and duties of parents or legal guardians to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of their rights.

APPENDIX E: SUBMISSION TO THE CHILD MAINTENANCE REVIEW GROUP

26 March 2021

Introduction

Ensuring payment of child maintenance, where agreement is lacking, has long been a difficult issue to resolve in many jurisdictions, including Ireland.[1] Non-payment of child maintenance "can be very damaging"[2] to children and their families, placing them at risk of poverty.[3] Further, the requirement for parents who are receiving One-Parent Family Payment (OFP) and the Jobseeker's Transition (JST) to make "efforts to seek maintenance" has been recognised as a "cause for concern" by the Joint Committee on Social Protection.[4] As the Joint Committee has noted, seeking payment from a former partner can "exacerbate an already emotionally fraught situation".[5] This is especially complicated where there is domestic violence.[6] Data from the CSO indicates that the vast majority of one parent families with children are headed by mothers in Ireland.[7] Research has shown "that when a relationship ends, men withholding or limiting … child maintenance … may be perpetrating economic abuse".[8] The pursuit of payment of maintenance in Ireland, often through the courts, can further fracture familial relationships and prolong harm. At the same time, recourse to the court may prove ineffective as practice shows that some parties continually defy court orders.

It is important at the outset to note that "child support payments are related to the noncustodial parent's ability and willingness to pay support, and to the enforcement system".[9] As Meyer *et al* comment:

> A substantial amount of research has shown that payments are related to ability to pay: those with more resources or income pay more… some have concluded that the

1. See, for example, ED Katz, "Criminal Law in a Civil Guise: The Evolution of Family Courts and Support Laws", (2019) 86 *University of Chicago Law Review* 1241, which chronicles the development of the law regarding child maintenance in the United States. It is submitted here that the experience in the United States resonates with the experience in Ireland.

2. Joint Committee on Social Protection, *Report on the Position of Lone Parents in Ireland* (June 2017) at p 27, available at http://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_social_protection/reports/2017/2017-06-15_report-on-the-position-of-lone-parents-in-ireland_en.pdf.

3. DR Meyer, M Cancian and MK Waring, "Use of child support enforcement actions and their relationship to payments" (2020) 108 *Children and Youth Services Review* 104672 at p 1.

4. Joint Committee on Social Protection (n 2 above) at p 17.

5. *Ibid* at p 27.

6. As the Joint Committee has observed *ibid* at p 30, "[d]espite assurance from the Department that they will not require a lone parent to seek maintenance where there has been an abusive relationship in the past … an abusive relationship may exist without having been proved to exist and so the area is clearly problematic".

7. According to the Census in 2016, there are 189,112 one parent families with children headed by mothers in Ireland and 29,705 one parent families headed by fathers. See Census of Population 2016—Profile 4 Households and Families, available at https://www.cso.ie/en/releasesandpublications/ep/p-cp4hf/cp4hf/fmls/.

8. K Natalier, "State Facilitated Economic Abuse: A Structural Analysis of Men Deliberately Withholding Child Support" (2018) 26 *Feminist Legal Studies* 121 at p 122. See also TL Brito, "Fathers behind Bars: Rethinking Child Support Policy toward Low-Income Noncustodial Fathers and Their Families" (2012) 15 *Journal of Gender, Race & Justice* 617 at p 618, fn 8, where it is acknowledged that non-custodial mothers are also not compliant with the payment of maintenance, albeit in the minority of cases. For further consideration of father's rights in this area, see S Mayeri, "Foundling Fathers: (Non-) Marriage and Parental Rights in the Age of Equality" (2016) 125 *Yale Law Journal* 2292; D Dinner, "The Divorce Bargain: The Fathers' Rights Movement and Family Inequalities" (2016) 102 *Virginia Law Review* 79; and DL Hatcher, "Forgotten Fathers" (2013) 93 *Boston University Law Review* 897.

9. Meyer *et al* (n 3 above) at p 2.

> problem of nonpayment is primarily a problem of a lack of ability to pay. … There is also evidence that willingness to pay is related to payments. For example, those with stronger relationships to the custodial parent or to their children may pay more. … Noncustodial parents who think their obligation is fair pay more. … A third category of factors related to payments concerns the characteristics of the enforcement system. … noncustodial parents take into consideration the likelihood of an enforcement action, as well as its severity, when deciding whether to pay. … even if a noncustodial father does not have much willingness to pay support, he may still pay if the child support system is automatic.[10]

It is necessary, therefore, to concentrate on these aspects when reforming the child maintenance system: namely, the ability and willingness to pay maintenance, and the enforcement system itself. Accordingly, Part 2 of this submission outlines the current use of imprisonment as a sanction for the non-payment of child maintenance in Ireland, while Part 3 details the need for a State Child Maintenance Agency. In establishing such an Agency in Ireland, it is vital that legislators consider the lessons that can be learned from the experience of other jurisdictions which already use such agencies. This paper concentrates on the experience in the United States; research from that jurisdiction indicates that current practice in Ireland resembles the child support system that was in place there some fifty years ago.[11] While many difficulties remain across states in the United States regarding the non-payment of child maintenance, it is nevertheless possible to distil some key learnings. This submission argues that investment is necessary to support the non-custodial parent's ability and willingness to pay child maintenance, in addition to introducing more enforcement powers.

2. Imprisonment as a sanction for the non-payment of child maintenance

Recovering payment of child maintenance poses many challenges, given the delicate balance which must be considered when ensuring payment while seeking to avoid imposing imprisonment as a sanction on the non-compliant party. As Katz has observed, "[b]ecause of the particularly counterproductive consequences of incarcerating parents who owe child support, the better approach would be to decriminalize most child support proceedings through elimination of incarceration".[12]

The Irish judiciary has consistently expressed caution regarding the use of imprisonment as a sanction in intractable private family law matters. This is evident in high conflict custody and access cases, as well as in maintenance cases.[13] There is a fundamental understanding that imprisoning parents is generally not in the best interests of the child. There have been some cases, however, where fathers have been imprisoned

10. *Ibid* at p 2.

11. *Ibid*.

12. Katz (n 1 above) at p 1297; Brito (n 8 above).

13. The recent case of *PM v EM* [2020] IEHC 700 provides an example of a high conflict custody and access case, wherein the court concluded that committal would not be in the child's best interests, despite a flagrant and repeated disregard by one of the parties of the court's orders.

for the non-payment of maintenance in Ireland.[14] The case of *KB v District Judge David Kennedy*[15] illustrates the court's approach to imposing imprisonment in circumstances where child maintenance has repeatedly not been paid. In that case, O'Malley J stated that "[t]he judge should remember that imprisonment is to be seen as a last resort, and should not be imposed if there is any doubt as to the maintenance creditor's ability to pay".[16] The judge further commented that:

> There will be cases … where a District Judge forms a view that the nature of the default is such as to merit punishment, in order that the authority of the court be upheld. This might be the case where, for example, a maintenance debtor had sufficient assets to comply with the order but deliberately dissipates those assets in order to render himself or herself unable to comply. Another example might be where a debtor establishes a pattern of only paying when served with a summons … thus depriving the maintenance creditor of the regular income required for the maintenance of children. These are examples only – they are not intended to be binding or exhaustive, but to illustrate a type of behaviour calling for the vindication of the court's authority in the public interest. A finding of criminal contempt requires that the court be satisfied beyond reasonable doubt of the facts alleged, and, again, should be used as a last resort.[17]

Brito has remarked that "[i]t seems a pointless expenditure of state resources to repeatedly arrest poor fathers, jail them for nonpayment of child support, then later release them (when either the law requires their release or the court eventually concludes that civil incarceration is not succeeding in coercing compliance with child support orders), and repeat the cycle all over again".[18] Irish case law regarding the non-payment of child maintenance shows an understanding of this as imprisonment is used as a last resort. Imprisonment is an important sanction, and the Irish judiciary have demonstrated their careful use of this sanction in private family law matters. It is evident, however, that alternatives to imprisonment are necessary, and that a State Child Maintenance Agency can play an important role in resolving maintenance issues in practice, outside of the courts. The next section will consider the establishment of a State Child Maintenance Agency, and, importantly, the potential powers which such an Agency should have.

3. State Child Maintenance Agency

The Committee on the Elimination of Discrimination Against Women recommended in 2017 that the Irish State "[c]onsider establishing a statutory maintenance authority and prescribing amounts for child maintenance in order to reduce the burden on women of having to litigate to seek child maintenance orders".[19] The Joint Committee on Social

14. See, eg, Marques v Judge John Brophy of Trim District Court [2010] IEHC 339; LC v Judge Hugh O'Donnell [2013] IEHC 268; KB v District Judge David Kennedy [2015] IEHC 745; and Mr B v Governor of the Midlands Prison [2015] IEHC 781.

15. [2015] IEHC 745.

16. *Ibid* at [59].

17. *Ibid* at [61].

18. Brito (n 8 above) at p 618.

19. Committee on the Elimination of Discrimination against Women, *Concluding observations on the combined sixth and*

Protection has also recommended that a "state body, similar to that in other countries, should be put in place to appropriately seek and pursue maintenance payments".[20] These recommendations are endorsed here. While it is inevitable that some parties will have to attend court in order to seek enforcement of child maintenance payments, the establishment of a State Child Maintenance Agency, *if properly resourced and equipped with necessary enforcement powers*, should significantly reduce recourse to the courts. Further, from a child's point of view, it is more appropriate that their parents and caregivers are attending a specialised Agency, rather than court, to resolve maintenance issues. Indeed, recourse to a designated Agency may be less likely to exacerbate matters within the family. Because of the possibility of abuse, however, it is important that a State Child Maintenance Agency can effectively safeguard the rights of the parties involved.[21]

3.1 Segregation of maintenance from other private family law matters

A State Child Maintenance Agency can ensure proper segregation of the payment of maintenance from other issues. In practice, child maintenance is very often tied in with custody and access applications. The result of this is that in high conflict proceedings, where maintenance is withheld by one party, custody and access arrangements can be affected as access may be blocked by the other party.[22] As a result, the child's right to contact with one of their parents may be seriously curtailed. Separation of these issues is crucial, in order to ensure that parents and other caregivers do not continue to associate maintenance with other private family law matters. Maintenance should always be viewed as quite distinct from custody and access, and other issues. It is worth recalling the judgment of Finlay-Geoghegan J in *MJT v CC*,[23] wherein the court was considering whether the applicant was exercising rights of custody in child abduction proceedings. According to Finlay-Geoghegan J, the payment of maintenance, in itself, does not adequately establish that a party is exercising custody rights. The judge observed that the applicant was required to demonstrate "… that he kept or sought to keep regular contact or a relationship with his child ... In circumstances where the applicant was living in the same country as [the child], the payment of maintenance through CSA does not in my judgment suffice".[24] In practice, too often, parties assume that paying maintenance equals custody and access rights. A State Child Maintenance Agency can effectively remove maintenance from the litigation of other private family law matters, and establish maintenance as a separate obligation for parents and caregivers.[25]

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20. Joint Committee on Social Protection (n 2 above) at p 41.

21. Natalier (n 8 above) at p 137.

22. For a discussion of "divorce bargaining" in the United States, "in which fathers received custody rights in exchange for fulfilling child support obligations", see Mayeri (n 8 above) at p 2352 and Dinner (n 8 above).

23. [2014] IEHC 196.

24. *Ibid* at [29].

25. See also SR Gunter, "Child support wage withholding and father-child contact: parental bargaining and salience effects" (2018) 16 *Review of Economics of the Household* 427.

3.2 Enforcement powers

Brito's research demonstrates that "[r]ather than succeeding in reducing child poverty, aggressive enforcement practices directed at poor families instead produce large unpaid child support debts".[26] The Joint Committee on Social Protection has briefly outlined the approach taken in other jurisdictions, such as the UK, Sweden, Australia, New Zealand and Canada.[27] In some of these jurisdictions, "the state is involved in facilitating the transfer of maintenance to parents".[28] It is noted that in Sweden, for example, "if the parent fails to or cannot pay maintenance, the state provides the payment and recoups the money from the liable parent subject to their ability to pay".[29] These examples are useful. Intervention from the State, particularly in ensuring that where maintenance has not been paid, the State would instead cover the payment, can vastly improve the lives of children, ensuring consistency in income for the family. In addition, giving the State the role of recouping payment from the non-compliant party would provide relief, especially in circumstances where there is abuse or high conflict. In the next section, an example of the approach taken in the United States will be presented.

3.3 Child Support Agencies in the United States

The Office of Child Support Enforcement (OCSE) "is the federal government agency that oversees the national child support program".[30] While the OCSE does not work directly with families, it helps "child support agencies in states and tribes develop, manage, and operate their programs according to federal law using effective child support enforcement tools".[31] States and tribes may vary in how they operate but they provide families with the following services: "Locate noncustodial parents; Establish paternity; Establish and enforce support orders; Modify orders when appropriate; Collect and disburse child support payments".[32] Data from 2019 indicates that "75% of child support was collected by income withholding from an employee's paycheck".[33] Further, "[c]hild support is also secured from able nonpayers through a range of alternative mechanisms, such as intercepting federal and state income tax refunds, seizing bank account balances, restricting or revoking drivers', occupational, and professional licences, and placing liens on properties".[34] According to Brito, the result of these measures is that "an employed father is very likely to pay child support whether he chooses to or not".[35] It is recommended that consideration should be given to the use of these measures by a State Child Maintenance Agency in Ireland.[36]

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26. Brito (n 8 above) at p 649.
27. Joint Committee on Social Protection (n 2 above) at pp 27-29.
28. *Ibid* at p 27. See also pp 28-29.
29. *Ibid* at p 27.
30. See https://www.acf.hhs.gov/css/about.
31. *Ibid*.
32. *Ibid*.
33. See https://www.acf.hhs.gov/sites/default/files/documents/ocse/2019_infographic_national.pdf. A breakdown of individual state's and tribe's performances are also available in the OCSE's Annual Report to Congress: Office of Child Support Enforcement, *Annual Report to Congress FY 2016*, available at https://www.acf.hhs.gov/sites/default/files/documents/ocse/fy_2016_annual_report.pdf.
34. Brito (n 8 above) at p 650.
35. *Ibid* at p 650. Meyer *et al* (n 3 above) at p 3 discuss the literature analysing these enforcement tools.
36. It is important to note, however, that "in some circumstances, child support enforcement may hinder collections rather than enhance them". See Brito (n 8 above) at p 656.

Indeed, recent research by Meyer *et al*, in a qualitative study in Wisconsin which focused on the enforcement system, has shown that:

> "... about three-quarters of nonpaying fathers have an enforcement action; thus only a minority of fathers begin to pay before an action occurs. All the enforcement tools we test, whether letters, notices of intent to suspend a license, the actual license suspension, a court hearing, or being found in contempt, are associated with beginning to pay in at least one model. In our first analysis, looking at whether tools have immediate relationships with beginning to pay, or whether there are lags, three tools (letters, hearings, and contempt) are linked to beginning to pay not just in the month they occur, i.e. if no payment was received in that month, payment is also more likely in the next few months. However, the notice of intent to suspend a license is linked to payments only in the month it occurs, with no later changes in likelihood of payment. The lack of an ongoing relationship may reflect Beron (1988) notion that threatened actions are only effective if they seem likely to occur".[37]

This research has also shown, however, that "suspending licenses does not consistently show a positive relationship with payments, and is sometimes statistically related to a lower likelihood of beginning to pay".[38]

Those who are unemployed, or "low-income" are most susceptible to imprisonment for non-payment of maintenance.[39] Research cited by Brito details the role which individual case-workers can play within a child support agency, regarding the use of imprisonment as an enforcement option. It was observed that "some [case]workers are more willing than others to invest the time to work with a delinquent payer prior to the beginning civil contempt proceedings".[40] The lesson for a State Child Maintenance Agency in Ireland is that staff should be guided by the same principles as judges follow, namely that imprisonment should be used as a last resort in cases where non-payment of maintenance continues. Meyer *et al* note that research with staff in Wisconsin indicates that they use "punitive actions infrequently, as many workers do not believe these are effective".[41]

Dissatisfied with the high proportion of unemployed and low income fathers who are imprisoned for the non-payment of child maintenance, Brito suggests that the OCSE and individual state child support agencies must "mandate ... and implement ... realistic and appropriate child support policies in cases involving low- and no-income noncustodial parents".[42] In practice, this means that staff at the child support agency must "assess the noncustodial parent's ability and willingness to pay".[43] Brito also notes that there is a need to focus on "capacity building to enhance poor noncustodial parents' labor market prospects so that they are better able to meet their economic duties to their children".[44]

37. Meyer *et al* (n 3 above) at p 7.

38. *Ibid* at p 8. The research of Meyer *et al* is necessarily limited, and accordingly, research from other jurisdictions should also be considered.

39. Brito (n 8 above) at pp 650-651.

40. *Ibid* at p 654.

41. Meyer *et al* (n 3 above) at p 3.

42. Brito (n 8 above) at p 664.

43. *Ibid*.

44. *Ibid*.

4. Conclusion

Reform of child maintenance in Ireland must focus on the ability and willingness of the non-custodial parent to pay maintenance, and the enforcement system itself. Irish case law regarding the enforcement of maintenance payments demonstrates that some fathers have refused to include an attachment of earnings for the court, or consistently denied that they have income and/or assets, despite the other parent asserting to the contrary, and the judge concluding that they do have means to pay. It is vital, therefore, that a State Child Maintenance Agency has enforcement tools. The Agency must also have capacity to assist those parents who are genuinely unemployed or low-income to boost their ability to pay child maintenance, as detailed above. As Brito has observed, while "there is strong reason to be skeptical regarding the likely efficacy (and sufficiency) of such measures", they must be considered.[45] While this may take considerable investment and resources, children will benefit. Cost-savings may also be made as fewer court applications, supported by legal aid, may be instituted and fewer arrests and terms of imprisonment may be imposed. The State has an important duty to ensure that where maintenance has not been paid, children and their families will nevertheless be supported financially. The State must take the onus off parents to make "efforts to seek maintenance", and instead take on this role itself, recovering payment from the non-compliant party, with appropriate enforcement, and support, as the circumstances require.

45. *Ibid* at p 668. Brito provides a thorough analysis of the need for such an approach at pp 666-673.