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The History of Foster Care

Supplemented Kinship

Ireland has a long tradition in the area of foster care. The "fosterage" of early Irish society appears to have been a custom practised by all classes. It was not confined to orphans or non-marital children, and it did not sever the links between the child and the birth family. Ginnell in describing the effect of fosterage pointed out that:

"Quite apart from law, the relations arising from fosterage were in popular estimation the most sacred of the whole social system, and a stronger affection oftentimes sprang up between persons standing in those relations than that between immediate relatives by birth."

This custom continued in Ireland until the eighteenth century. It is likely that the popularity of the custom was in part due to Gaelic tradition but also because it relieved the pressure upon space in households where children were born with almost annual regularity. Daniel O’Connell, the Catholic emancipation advocate of the 1820’s, was fostered out in infancy and did not return to the care of his birth parents until he was four years old. MacDonagh in his biography of Daniel O’Connell pointed out that:
"Yet there is no suggestion that such an early childhood had the traumatic consequences which the present century would predict. O'Connell became deeply attached to his true mother and father. The bond with his foster-parents-to-be rewarded, according to the conventions of the day, by subsequent favours and support-remained strong; but this implied no division of loyalty or psychological confusion. So far from resenting his own early exile, O'Connell subjected his two eldest sons, Maurice and Morgan, and some at least of his younger children, to the same experience. It was after all the social norm, from which no one anticipated-and perhaps therefore everyone escaped-injurious results."

By the close of the eighteenth century, the process of de-Gaelicization of Ireland was complete. The Brehon Law concept of 'family' and tolerance of plurality of 'family ties' was gone. In the face of the transformation from a loose Gaelic society to a tight monarchical one, the characteristics of 'the family' also changed and the Gaelic tradition of fosterage was lost. It was ultimately replaced by the repressive and controlling Poor Law system.

**Out of the Poor Law**

The workhouse became the most feared and dreaded manifestation of the Poor Law system. The Irish Poor Relief Act of 1838 introduced into Ireland this system which was established in England by the English Poor Relief Act of 1834. The latter Act changed the English system by uniting a number of parishes to provide a larger area of administration to be known as "Unions". In each union a workhouse was established to accommodate the destitute poor of the District. A Board of Guardians governed each union and was in turn supervised and controlled by Poor Law Commissioners. The concept behind the Poor Law system was simple enough- to make reliance on the system as unpalatable and rigid as possible so as to ensure that the service would be one of last resort. The barbarity and institutional cruelty of the workhouse regime has been documented in numerous official reports in England and Ireland, as well as in popular literature of the time. Dickens' depiction of the workhouse innocent Oliver Twist and Mr Bumble the exemplar of workhouse injustice is still portrayed on stage and televisions.

The steadfast refusal to allow "outdoor relief" forcing people to enter the workhouse if they needed assistance was designed to ensure that parish charity would only be sought as a very last resort. The sad consequences of this policy were set to rhyme in the recitation "In The Workhouse: Christmas Day" which was written by a journalist and appeared under the pseudonym of 'Dagonet'.
"I came to the parish craving
Bread for a starving wife,
Bread for the woman who loved me
Through fifty years of life;
And what do you think they told me,
Mocking my awful grief,
That 'The House' was open to us,
But they wouldn't give 'out relief'."

The introduction of a system of ‘boarding out’ in 1862 was the slow beginning of a more benign regime for children aimed at keeping every ‘pauper child’ outside the workhouse. In 1872 the Local Government Board for Ireland replaced the Poor Law Commissioners and this body took over the general supervision of, inter alia, the Board of Guardians. In 1878 the addition to their duties to supervise the workhouse in their Union or District they now became responsible for additional duties, for example dispensing medical relief, public health, water supply, sewage, housing and public lighting. The Local government Act of 1898 placed the administration of Local Government in Ireland in the hands of County Councils, and Urban and Rural District Councils. Boards of Guardians were given the exclusive task of administering the Poor Law once again. The County Council was the rating authority and financed the Board of Guardians to run the workhouses and dispensary system and outdoor relief.

Reforms Introduced by the Irish State - Health Boards

The Local Government Act of 1923 which was the first local government legislative undertaking by the Irish Government abolished the Board of Guardians and organised the administration of the poor law under Boards of Public Assistance with the County as the unit of administration. The Local Government Act of 1925 abolished Rural District Councils and transferred their functions concerning public health and housing to Boards of Health elected by the County Councils. The Health Act of 1953 empowered the Health Boards to have a child cared for either by boarding him out (foster care), by sending him to an approved school, or if the child was over fourteen years old, by placing him in employment.

Foster Care

The Act itself provided for a contractual relationship between the Board and the foster parents defining the obligations of each party to the contract. In consideration of a monthly sum in respect of the maintenance, clothing and education of the child the foster parent undertook to bring up the child being fostered in the same way they would a
natural child. The contract obliged them to promote the proper development of the child, and to observe and keep specific basic defined conditions. These included the obligation to provide the child being fostered with proper and sufficient nourishment, and suitable accommodation, to ensure religious observance, to provide proper health care, to ensure regular school attendance, to notify the Health Board of any serious occurrence affecting the child, or of any proposed change of address, and to make the child, themselves and their home available for a Health Board inspection as required. The contract obliged the foster parents to return the child to the care of the Health Board at any time where the Health Board, with the consent of the Minister for Health so decided, or where the Minister for Health required the Health Board to remove the child. It was specifically provided that the foster parent should not insure, or attempt to insure, directly or indirectly, the life of the child or to obtain any interest in any insurance policy on the life of the child.

The Boarding out of Children Regulations of 1954 set out the obligations of the Health Board in terms of the ‘boarding out’ of children

- Foster care should be the first option, and a Health Board should not choose an approved school over foster care, unless a suitable foster placement was unavailable;

- Health Boards should properly assess potential foster parents in terms of their suitability and the suitability of their homes;

- The Health Board should ensure that ‘available history’ of the child matched the chosen foster placement thereby indicating the suitability of the placement to the welfare of the child;

- The Health Board should ensure that the religion of the chosen foster placement matched the religious persuasion of the child, unless the consent of the parent (s) or guardian was available to a cross religious placement, or where there is no parent or guardian to give consent, on the basis that the foster carers undertake in writing to raise the child within his or her own religion;

- The Health Board should inspect the child and the home within one month of the placement and thereafter at least every six months, the Health Board should also maintain adequate case records and a register of all children which it has boarded out
• The Health Board should provide reasonable funds necessary for the maintenance, clothing and education of a child and for other needs.

Under the Health Act, 1953 this assistance was only available until the child boarded out reached sixteen years of age or until the completion of the child’s education, with the consent of the Minister for Health. Should the child be adopted by the foster family, discretion remained with the Health Board to continue the contribution to the maintenance of the child as if he continued to be boarded out.

The Health Boards that we know today, were established by the Health Act of 1970 and they have inherited many of the functions carried on by the Boards of Guardians. The Children Act 1908 continued to be the legislative cornerstone for the compulsory reception of children into the care of a ‘Fit Person’ until the Child Care Act, 1991. Section 39 of the latter Act obliged the Minister to make regulations governing both the placement of children in foster care and for securing, generally, the welfare of children in foster care. Such regulations are now contained in the Child Care (Placement of Children in Foster Care) Regulations, 1995.

Foster care today and ghosts of foster care past

The Foster care is the most likely option when a child comes into the “care system” either voluntarily or as a result of a Court Order. A crisis or breakdown in the child’s family of origin therefore precedes it. The official reasons for the reception of children into care are many and varied ranging from sad to bad and including parent or parents unable to cope, neglect, parental illness, sexual abuse, emotional abuse, physical abuse, domestic violence, homelessness, child out of control, child awaiting adoption, or other family crisis. It is clear therefore that reception into foster care can be precipitous or to some extent planned for. It is also clear from the Department of Health and Children statistics that the most numerous category of primary reason for admission into care is ‘parents unable to cope’ followed by ‘neglect’. The other matter of note is that roughly half of the children received into care each year do so on a ‘voluntary basis’.

The processes of legal compulsion, which generally precedes many admissions, have undoubtedly reinforced the negative image of the care system. Even voluntary admissions can sometimes have a coercive quality about them. Residential care has received very bad press in recent years and has to some extent at least become linked in the public mind with child abuse and ‘failure’. Foster care aims to provide an alternative ‘family environment’ for children coming into the care system and is therefore preferred over residential care. Foster care also suffers from the prevailing stereotype of transience. Frequent changes of foster placement, and multiple family placements have
become the stuff of urban legend.  

The Task Force on Child Care Services Reports in 1975 and 1980 lamented the absence of research into foster care breakdown in Ireland. It noted that fostering at that time was almost exclusively used for younger children because of the evidence from England that fostering breakdown was more likely in the case of older children. The task force recommended project fostering for older or troubled children and felt that fostering should be one of the options for every child regardless of age, health or behaviour. The Report identified four factors, which it felt had impeded the development of foster-care:

- The absence of integration in child care services;
- Social attitudes to foster-care;
- The complexity of foster care and the diversity of responsibilities which different types entail;
- Insufficient resources for foster-care services within child care agencies and insufficient commitment to the principal of family placement.

It would seem that what is lacking at present in Ireland is a network of services which differ in their purpose, and are linked to the needs of the children coming into the care system. A review of research on residential care in the United Kingdom in 1988 noted that:

"Residential homes can provide short-term care to relieve relatives or to shelter children at risk, or give a holiday to a disabled person who needs one. They can provide long-term shelter for a variety of groups, but in doing so they may be aiming to allow for ordinary development in the case of the young or to give older groups the opportunity to live as normal a life as possible. They may set out to assess, treat, train or educate the young, teach skills to the mentally handicapped, provide care, attention and even nursing care for the frail elderly, prepare children for foster care or adolescents for independence and make sure that those in care do not lose touch with their families and roots. Less benignly perhaps, they may 'control the disruptive and punish the recalcitrant'."

The term 'residential care' does not appear to have such a wide currency in this country. Since the Task Force Reports the pervasive assumption is that really good care for children is only to be found in foster care. However it is now acknowledged that many
children require therapeutic treatment, sometimes in a secure residential setting. Unfortunately, residential units offering secure accommodation have had to be forced into existence through legal compulsion. The quality of ‘caring’ available in some of the secure facilities hastily provided to meet Court requirements have in turn become the cause for concern. The Social Services Inspectorate Report on the Newtown House High Support Unit, reported that the building was unsuitable for use as a specialised group home for children. There was an unacceptably high level of staff turnover and an absence of professional supervision for all staff coupled with stressful conditions for staff. The report described practices employed there as putting young people at risk in the centre. Residential care like foster care has to be seen as part of a network of services. The precise relationship between residential care and foster care in Ireland needs to be researched. Different residential regimes and/ or specialised foster care may be necessary to achieve the continuum of care required by some children. Children coming into the care system often have a variety of complex needs, which require in turn a multifaceted response. The continuum of care necessary to meet these needs is only now being constructed in response to the legal proceedings being taken by and on behalf of the children in the Courts.

Lessons Learned?

It must be acknowledged that the modern legislative framework for child protection has been radically improved over the last decade. The Child Care Act, 1991 which was fully implemented in 1996, the Child Care Regulations 1995, the Children Act 1997, the Protection of Persons Reporting Child Abuse Act, 1998 and the Children Act, 2001 represent a quantum leap forward on the previous legislative position. Irish child law remains fragmented nonetheless. Moreover there are still lamentable gaps in the integration and indeed availability of child care services on a practical level. The position of the child with ‘special needs’ being an obvious area of deficit. It is quite extraordinary that the provision of services must be forced by legal action taken by the parents/ foster parents of such children.

In 1992 Ireland ratified the United Nations Convention on the Rights of the Child, 1989 without any reservations or declarations. Our legislation and service provision must therefore comply with the minimum threshold standards for children’s rights embodied in the Convention. Each ratifying country’s compliance with the Convention is monitored by the specially designated UN Committee on the Rights of the Child. Each country must report on the measures adopted to give effect to the rights recognised in the Convention within two years of the entry into force of the Convention in that country. Thereafter they must report every five years. The Department of Foreign Affairs prepared the first National Compliance Report in 1996 in somewhat optimistic
mood, having regard to the achievements in having the 1991 Act fully implemented. Non-Governmental Organisations under the umbrella group Children’s Rights Alliance (formed in 1993 to promote awareness of the Convention) gave a more sanguine view to the UN Committee. The UN Committee on the Rights of the Child, evaluating Ireland’s compliance was critical of the absence or inadequacy of Irish governmental policies and programmes designed to give effect to the rights recognised in the Convention, as being ‘devoid of a national strategy’.

There have been Policy developments, strategy statements by the Department of Health and Children, pilot projects and national guidelines since this critical Report. The Social Services Inspectorate (SSI) was established on an administrative basis in 1999 to monitor the organisation, operation and management of child care services from a consumer perspective as well as from a service provider perspective. A ten-year plan entitled “The National Children’s Strategy” was launched in November 2000 and maps out policy goals to improve the quality of all children’s lives, as well as strategies designed to realise those goals in a strategic manner. The aim is to have a specific Cabinet committee for children chaired by the Taoiseach and to have a Minister for State with Special Responsibility for Children to oversee the co-ordination of all government policies for children. The National Children’s Office has been established on an administrative basis to operate on a cross-departmental basis and support the new role of the Minister for Children. In the specific area of foster care, The Report of the Working Group on Foster Care “Foster Care - A Child Centred Partnership” was published in May of this year. This Report provides a blueprint for the support and development of foster care in context as part of the continuum of care designed to promote the wellbeing of children who are not receiving adequate care and protection in their own families. It proposes a strategic management initiative to the delivery of the service with the objective of delivering a comprehensive and integrated service at community care level.

The next compliance report is due this year and one wonders whether through all of these developments Ireland can avoid censure in the follow up evaluation report of the UN Committee. The extensive consultative processes involving Non-Governmental Organisations in shaping the National Strategy is likely to deflect some criticism this time around, however there is still a palpable gap between aspirational and actual compliance with the tenets and principles of the Convention.

**Coming into Care**

Voluntary Care is necessary for roughly half of the children coming into the care of Health Boards each year. The numbers of children coming into care are increasing. Irish
society itself is changing. Families are getting smaller and fewer children are being born. The rate of marriage has declined and there has been a growth in lone parenthood. There has been an increase in the number of children born to unmarried parents and an increase in marital separation and divorce. Long term unemployment in families with children make them more vulnerable to problems associated with poverty, ill health, drug abuse, homelessness and social exclusion. But are children coming into care unnecessarily? Section 3 of the Child Care Act 1991 obliges Health Boards to provide child care and family support services. Why then are there not more in-home care workers, housekeepers, day care facilities, emergency housing and respite and shelter care centres? Precisely why are parents ‘unable to cope’?

The position of parents who place their children in voluntary care is also uncharted. How much access do they really retain to their children? Access is generally inflexible and based on agency rather than parental exigencies. The needs of the child for access to parents and siblings also tend to be tempered by agency exigencies rather than what is the optimum level of access from the perspective of the child. How are parents involved in the decision making process regarding their children’s lives when in care? They are generally left to liaise with the social worker assigned to the child but are not assigned a social worker themselves to work with them towards achieving rehabilitation of their family unit. Even where there are Care Plans they are usually light on the specifics in that regard. In practical terms one must ask how children themselves are given a voice in the voluntary admission process. It is quite clear that all of the international research points towards more positive fostering outcomes where foster parents are inclusive of the family of origin and generally where the Goddess OTA (openness, transparency and accountability) reigns. This proposition was also supported by a study by the South Eastern Health Board in 1995 aimed to analyse the response by that Board to child care concerns which were reported to it. The research showed that the majority of families referred were experiencing a number of adversities, which required a range of interventions but the child protection system was geared towards a one-dimensional response.

When children come into care though the Courts, Health Boards put resources into achieving the Care Order and concentrating on collating the evidence necessary to obtain the order ahead of all else. This is, of course, necessary in a child protection situation and a statutory responsibility, however it is not the only statutory responsibility. Care Plans are an essential part of the successful foster placement of a child taken into care and this is well recognised as a matter of best practice. It is also required by the Regulations. However the Social Services Inspectorate in their ‘Report of Findings Relating to the Inspection of Children’s Residential Centres’ in October 2000,
expressed concerns that care plans were only completed before admission in a minority of cases. The Report of the Working Group on Foster Care in May 2001 noted the same deficit in relation to children in foster care. In the case of *The Eastern Health Board v- District Judge James Paul McDonnell and CK and NW and Anor.*, the right of the District Court to impose conditions on making a Care Order (one of which obliged the completion of a comprehensive Care Plan within three months) was upheld by the High Court. Therefore, whilst child care professionals bemoan the fact that they operate within a very adversarial and legalistic framework, children, parents and foster parents must rely on that framework to ensure their legal rights are upheld and that ‘best practice’ is in fact applied.

**The Practical Realities**

As of 31 December 1999 there were 4,216 children in the care of Health Boards in Ireland. 3.35% of these were being supervised at home and the remainder either in foster care, relative foster care or residential/other care.

Robbie Gilligan, writing in 1990, examined the figures for children in foster care since 1925 and noted that there was a considerable drop in the numbers of children fostered in the mid and late 1940’s. Gilligan ascribes this reduction as being attributable to more rigorous screening of foster parents. The 1970’s heralded the revival in the use of foster care leading to its dominance as a form of placement for children in care in the 1980’s. Gilligan attributes the revival to the 1983 Foster Care Regulations, which were in turn informed by the Task Force Reports, which in effect promoted foster care as the best form of care. There was also an increased public awareness of fostering, and Gilligan also cites the establishment of the Irish Foster Care Association as a reason for the revival of foster care as the main form of care. The number of children in foster care has continued to increase reaching 1,986 children in 1989 and 3,289 ten years later in 1999. This increase is due to a combination of the social and demographic changes in Irish society in recent years, and to the impact of the child protection provisions of the Child Care Act, 1991.

The position of ‘adoption’ as an option for the child in long term foster care is not assisted by the current adoption legislation. The 1988 Act, only permits the ‘freeing’ of a child for adoption in the most extreme situations and where it can be established that there has been a total abandonment of all parental rights. As Abramson pointed out in 1984 however, adoption provides supplanted kinship and removes all links with the family of origin, whereas fosterage under the old Brehon Law system provided supplemented kinship. The same might be said today of inclusive fostering where strong links are maintained with the family of origin. The Report of the Working Group
on Foster Care argue that Health Boards should consider adoption as an option for children in long term foster care. One wonders however whether this form of adoption is appropriate, or whether a ‘simple’ form of adoption which did not sever the links with the birth family would be a more acceptable solution for all concerned.

Table 1: CHILDREN BOARDED OUT FOR SELECTED YEARS

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<th>Years 1925-1999</th>
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When we look for information on children in foster care the information must be gleaned from a number of sources. The Social Services Inspectorate Report 2000 for example tells us that in their examination of twelve residential care units in accordance with Section 69(2) of the Child Care Act, 1991 the centres had places for sixty-one children. There were 56 children in residence when the inspections took place. The ages of the children in these centres ranged from 4 to 18 years, with most of the children falling in the 11 to 17 year age range. Only three of the children were less than 10 years of age (4, 8 and 9 years). The Report acknowledged that normally, younger children in the care of the Health Boards are placed with foster carers in the community wherever possible unless there is a plan to avoid breaking up a sibling group who have been received into care together. The Report acknowledged that some of the young children in the residential units were there because of a lack of foster homes and were placed in centres catering for teenagers. Well over half the children (57%) had previously been placed in a foster care situation, which had not worked out. A significant number (49%) had previously been placed in another residential child care centre or in supported lodgings (some had been fostered and subsequently placed in another residential centre.
before coming to the centre in which they were residing at the time of the inspection. Only about 17% of the children had not previously been placed in some form of residential or foster care arrangement. These children generally came straight into care from a troubled family situation, often as emergency admissions.

Anecdotal evidence therefore suggests that there are not enough foster placements available to meet the needs of the children coming into the care system and some of these children end up in residential care. Failure to adequately match the needs of the child or children to the abilities and resources of the foster family also result in children ending up in residential care on the breakdown of their foster placement. Complex family circumstances may mean that the child requires a mix of services to support the child, the foster family and the natural family. This flexibility of service provision does not currently exist.

Where do we go now?

The Report of the Working Group on Foster Care acknowledged the critically important position of foster care in the child protection and welfare system. The Report examined the developments in foster care since the Task Force Reports and examined the issues facing foster care from three main perspectives: firstly, the need to provide a quality foster care service meeting national and international standards, secondly, to meet the needs of all children in foster care, and thirdly, to acknowledge and meet the needs of the foster carers.

The working group noted that there is very little published work on the operation of foster care services in Ireland to assist them in their deliberations. International studies, though obviously helpful, do not relate to the Irish context. It might also be noted however, that the nature of the statistical information gathered by the Department of Health and Children is incomplete. The statistics published by the Department of Health and Children for example do not provide the information to analyse the length of time children spend in care, the number of changes of foster placement and the reasons for the change, what level of contact remains with the birth family, etc.

The Report certainly provides a road map for a much improved foster care service over a three year period if, as is recommended, The Social Services Inspectorate, in consultation with all the stakeholders in the fostering process, draw up National Standards on Practice and Procedure. The Report acknowledges that the provision of a more strategic service based on assessing the child’s needs through care planning and review must be linked and co-ordinated with the availability and ability of foster carers to meet the
defined needs. The Health Board must manage the complex relationships involved by having a social worker for the child and family, and the foster family and promote the development of a relationship of trust in the best interests of the child. Gaps in service provision need to be identified and filled and the service itself needs to be monitored and evaluated. Progress is linked in the Report to a ‘partnership approach’ in the establishment and delivery of a quality service.

Issues under the current Act and Regulations
Section 39 of the 1991 Act obliged the Minister for Health and Children to make regulations pertaining to foster care. The Child Care (Placement of Children in Foster Care) Regulations 1995 obliged Health Boards to establish and maintain one or more panels of persons who will act as ‘foster parents’. However the Act defines ‘foster parent’ in a restrictive way, and only referring to non-relative placements.

The screening process stipulated by the Regulations represent the current minimal national standard. The process of assessment is very time consuming and rigorous. There is no provision for rapid response to meet the needs of the emergency placement.

When a child is in the care of a Health Board, the Board also has the option of making other suitable arrangements including placing the child with a relative. The placement of children with relatives also requires assessment in accordance with the Child Care (Placement of Children with Relatives) Regulations, 1996.

Clearly, one of the main tenets of the Child Care Act, 1991 is that the child should be supported within the family where this is possible. The Regulations governing the placement of children with relatives do provide for emergency placement with relatives prior to assessments or the completion of assessments where this is in the interests of the child. Placement before assessment with a relative does not obviate the need for assessment. The regulations provide for the assessment of relatives as carers but legislatively, they are not defined as ‘foster parents’ and ‘foster care’ is confined to children fostered by ‘foster parents’ as statutorily defined. One wonders whether relative foster care will supplant ordinary foster care, as it did in the case of adoption, where family adoptions are now far more numerous than stranger adoptions.

The Finance Act, 2001 has widened the category of ‘child’ for the purposes of computing capital acquisition tax to include a foster child if certain conditions are met. Firstly, the child must have been placed in the foster care of the deceased foster parent under the Child Care (Placement of Children in Foster Care) Regulations 1995. Alternatively, the foster child must have resided with the deceased foster parent for a
period of five years before he or she reached eighteen years and must have been under the care or maintained by the foster parent at the foster parent’s own expense. Identical rules apply in respect of the placement of children with relatives under the Child Care (Placement of Children with Relatives) Regulations 1995.

In order to qualify under the first category, an independent witness must corroborate the foster child’s claim for group one status. The Regulations themselves provide for a formal Contract in the form laid out in the First Schedule to the Regulations which should be accompanied by a copy of the Regulations themselves. One wonders whether current practice in this regard mirrors that on Care Plans. If it does, then a child seeking to claim the tax concession under the Finance Act 2001 may encounter some difficulties.

The question of screening and safe placement is of pivotal importance to the child regardless of whether the alternative family placement is with a relative or with another non-relative family. The real issue appears to be the obligation to provide a rapid, but thorough, assessment of all foster carers to meet the needs of the child coming into care in a crisis or emergency situation. There is little doubt that a child injured or damaged through placement in care in an inappropriate foster placement that was not screened in accordance with the Regulations would have a right of action against the Health Board concerned. The European Court has made it abundantly clear that National Authorities must display special diligence in expediting family law proceedings, which have a particular quality of irreversibility. In Glaser v United Kingdom, although the Court did not find a violation of the father’s human rights under the ECHR the Court emphasised the need for court cases to be dealt with speedily. There is little doubt that they would apply the same analogy to foster carer suitability assessments.

It is a matter for the Health Board to ensure that children are ‘safe from abuse’ whilst in foster care. However, a duty of care is also owed to foster parents. The recent English case of W v Essex County Council related to proceedings taken by foster parents whose children were abused by a child abuser placed in their care by the Local Authority. The foster parents sought and were given oral assurances by representatives of the council that no child who was a known or suspected sexual abuser would be placed with them, as they had their own four children for whom they had concerns. The Court determined that a social worker placing a child with foster parents had a duty of care to provide the foster parents with such information as a reasonable social worker would provide, and that the local authority was vicariously liable for the conduct of its social workers in that respect. A claim by the foster parents for misfeasance of public office was struck out. The claim for breach of contract was also struck out when it was established that the fostering contract did not contain an implied term that the authority
would inform the foster parents of any relevant knowledge or suspicion of the child. Before a child is placed in foster care, the Health Board must carry out an assessment of the child’s circumstances. In emergency situations this assessment may be postponed until after the placement occurs however it must thereafter be completed as soon as is practically possible. Article 9 of the Regulations provide that before the child is placed with foster parents, they must be furnished with basic information regarding the child and his or her family background and previous care admissions (if any) including the reason why the child was admitted to the care of the Health Board. A Care Plan outlining the aims and objectives for the placement must also be prepared in advance of placement, or in emergency situations as soon as practically possible thereafter. The Plan should contain details of the support to be provided by the Health Board to the child, the foster parents and the natural parents. In practice however, the Care Plan is sometimes a standard Word Processor document which is vague in its content and provision. In many cases it is not furnished until very well into the placement.

What then of the position of foster parents themselves? Once the foster placement is made, of course, they have lawful custody of the child until the placement is ended. They may have the child for a very short time, or indeed for its entire childhood and adolescence. They may see themselves as caretakers, or in an exclusive fostering situation, they may see themselves as substitute parents. Clearly the purpose of the placement and the likely length of stay are important matters to be stated at the outset and reviewed from time to time in order to avoid role ambiguity and confusion. It is very difficult to maintain a detached professional role when the placement has continued for a long time and there is little or no contact with the natural parents. Frequently, parents or foster parents are the only ones who can in fact seek to vindicate the constitutional rights of the children in their care as evidenced in the case of F.N v Minister for Education. This child who suffered from a hyperkinetic conduct disorder needed containment with treatment and the Health Board and Department of Health and Children had no such services available to meet his needs. Even if they did there was no statutory power given to the Court under the 1991 Act to direct his detention there. The High Court (Geoghegan J.), determined that:

‘where there is a child with very special needs which cannot be provided by his parents or guardian there is a constitutional obligation in the state under Article 412.5 of the Constitution to cater for those needs in order to vindicate the constitutional rights of the child’.

The Court made an order declaring that FN had a constitutional right to secure accommodation with treatment designed to meet his needs and vindicate his
Constitutional rights. The Department advised the Court that it would provide a secure unit to meet the needs of F.N and others like him. In fact those services were not in fact provided in time for F.N, or within the time scale mooted. When other similar applications for relief came before the High Court later, it transpired that the plans for the construction of the secure unit outlined in the F.N case did not progress due to what the Court (Kelly J.) described as ‘unseemly and wasteful wrangles going on for months between various departments as to who would have responsibility for the care of the children in question’\(^{27}\). Ultimately in the case of T.D v Minister for Education\(^{38}\) the High Court, by injunction, ordered the completion of the secure facilities within a specified time frame noting that it would be fully seven years before the decision in F.N before the facilities were in operation.

It is perhaps of note that many of the children applying to the High Court to uphold their Constitutional rights to special services have in fact been in the care system for a considerable number of years. It is also interesting that most of the applications are made on behalf of teenagers.

The duties of foster parents are specified in Article 16 of the Regulations and are both general and specific in nature. In a disputed situation foster parents can have recourse to Section 47 of the Child Care Act, 1991 and seek directions from the Court which are central to the welfare of the child. The Health Board can apply to remove the child from the placement under Section 34(2) but again the Court retains a discretion and will only make the order where it considers that it is in the best interests of the child to do so. It is, ultimately, for the Courts and not the Health Boards to ensure that the Constitutional rights of children are upheld.

Conclusion:
Foster carers have a ‘Cinderella status’ in many ways. For example, where parents apply under Section 47 seeking directions with regard to their child in care, foster parents are neither present nor represented at the proceedings. The child is rarely represented either. The Health Board and the parents are the only ‘voices’ heard by the Court even though the Court will hear vicariously about both the foster care arrangements and the child. However social parenting through fostering is given legal recognition if of a certain quality and duration. In the case of JO’T v B. and M.H. v. Rev. G.D\(^{44}\) The Supreme Court noted that in considering whether to make identifying information available to an adult natural child, the Court had to balance the competing Constitutional rights of privacy of the natural mother with the right of the child to know the identity of its natural mother. To do this the Court was entitled to consider a variety of factors including the view of the foster parents, if alive. A Circuit Court decision
recently resulted in two brothers who were fostered by a childless Donegal couple being awarded the family home and farm where they grew up under the doctrine of 'legitimate expectation' on the partial intestacy of their late foster father. The judge described the relationship between the boys and the deceased father as being a complete family unit. The judge said "It is fair to say that there should be some distinction in relation to people in long-term fostering arrangements that transcends just a year or two. This went far beyond such an arrangement". However, this decision does not have fundamental implications for the status of foster children generally. Being based on the doctrine of "legitimate expectation" it relates only to circumstances in which a person acts against their own immediate interest in the reasonable expectation of a positive outcome. The facts of that particular case were quite unique.

Having lived for many years in a foster family, possibly from a very early age, there is little doubt that children become part of that family. Having lived for a short period in a foster family they may still have some positive links with that family although they retain their own family identity. Fostering therefore has a very wide currency both for the children being fostered and for foster parents. The Report of the Working Group on Foster care proposes a child centred partnership. It is the first in depth look at Fostering since the Task Force Report in 1980. By embracing the views of all of the stakeholders in the fostering process, it is likely that if fully implemented the Report will pave the way for considerable improvements.

The world will not change. Parents will continue to fail to cope, to neglect and to desert their children for a myriad of reasons. The challenge is for the State to provide an appropriate and timely response to the children of this vulnerable group of children which respects their rights to a childhood in a secure family environment so that they may reach their potential in adulthood.
References


4 Sims G.R (1847-1922)


6 See Regulation 5.

7 See Regulation 7

8 See Regulation 8

9 See Regulations 11-14.

10 Regulation, 15.

11 Section 55(9)(c) Health Act, 1953


14 Department of Health and Children, Provisional Child Care Statistics.

15 Different Health Boards have different categories, the Department of Health and Children hopes to introduce a harmonised list agreed with all of the Health Boards by 2002.

16 See Department of Health Survey of Children in the Care of Health Boards 1992, and Department of Health and Children Provisional Figures for 1999, showing that in 1992 there were 3090 children in care as at 31 December 1992. 73.9% of those children were in foster care, 24.8% were in residential care. 50.5% of the children were in care on a voluntary basis and 49.5% were in care under Court Orders. ‘Parents unable to cope’ was the most frequent reason for admission at 30.6% and the next largest category was neglect at 19.6%. Provisional figures for 1999 show that at 31 December 1999 there were 4216 children in care, 60.13% of these were in foster care, 16.91% in relative foster care, and 14.11% were in residential care. 50.71% of the children were in care on a voluntary basis and 49.29% were in care under Court Orders. ‘Parents unable to cope’ at 29.7% continued to be the most frequent admission even though this category is now combined with the category parental illness which was a separate category in 1992 and ‘neglect’ remained the next most frequent admission at 25.43%.
17 The Boarding out of Children Regulations, 1983 (SI No. 67 of 1983) provided that a Health Board should not send a child to residential school “unless such a child cannot be suitably and adequately assisted by being boarded out”. Under Section 36 of the Child Care Act, 1991 a Health Board may place a child in foster care or in a residential centre, or for adoption where he or she is eligible for adoption, or it may make other suitable arrangements, which may include placing the child with a relative.

18 See Ferguson & O’Reilly (2001), Keeping Children Safe (A.&A. Farmar) where at page 124 the point is made that in 13 out of 36 cases (36.11%) surveyed, children experienced a change in foster placement during the surveyed period. This included some who returned home, while others went into other forms of care. See also Ferguson & Kenny (eds.) 1995, On behalf of the Child (A.&A. Farmar). Chapter 6, Gogarty H. The Implications of the Child Care Act 1991 For Working with Children in Care citing the origins of the Donegal treatment team set up in 1989 in response to a crisis in the fostering service, where it was found that approximately 30% of the children in care there needed a more in-depth service than could be offered in a general fostering context. National figures for foster placement breakdown are unavailable.


24 Article 43.

25 Article 44.


29 The Integrated Services Process in the area of preventative family support services, Young People at Risk programme providing a formal collaborative structure for public agencies, the voluntary sector and local community.


Triseliotis J. (1989). Foster care outcomes: a review of key research findings


See Section 36 (2).
SI 261 of 1996.

Sections 221 and 222 Finance Act, 2001 [No.7 of 2001]

[2001] 1 FLR 157

[1997] 2 FLR 535

Article 6 of the Regulations.


T.D v. Minister for Education [2000] 2 ILRM 321

[1998] 2 I.R 321

See; Breaking News, Irish Times, Friday, February 18, 2000 “Brothers awarded their foster parents’ farm”.