Sunday Business Post Opinion Piece - 17 May 2009
Ombudsman for Children – Emily Logan

On Tuesday last the report into the deaths of four year old Lean Dunne, her three year old sister Shania and their parents at Monageer in April 2006 was published.

This report follows a pattern of ad hoc inquiries by individuals and teams appointed by the Government in response to single instances of child death over recent years. In many instances, the outcomes of these inquiries have not been made public.

This ad hoc response has persisted in the absence of a standing mechanism to review child death. Just after the deaths in Monageer in April 2006, I commenced an initiative aimed at exploring the possibility of establishing a standing child death review team in Ireland. I will return to what we have done about this initiative later, but first some reflection is needed on the difficulties which appear to have arisen in the course of the Monageer inquiry and the heavily edited report finally produced.

While I appreciate that inquiries and investigations can take time to complete if they are to be thorough and accurate, a considerable period of time elapsed between the events in Monageer and the publication of the report. The then Minster for Children set up the Inquiry in June 2007 but it did not commence until January 2008. Although the Terms of Reference for the Inquiry required that a report be prepared within three months, it was not until October 2008 that the report was submitted to the relevant Ministers. By the time the report was redacted and published, over two years had passed since the death of the Dunne family. This contrasts with the seven months which elapsed between the November 2007 house fire in Omagh in which a family of seven died in suspicious circumstances and the publication in full of the independent inquiry relating to the deaths.

The deletion of certain passages from the Monageer report has been attributed to legal concerns raised regarding their content. The specific nature

of those concerns has not, however, been clarified. The omission of such information is in itself questionable, given that there are means open to the Minister to publish the report in a manner that would address the most obvious bases upon which a legal challenge could be raised. But even if one accepted that such a redaction was necessary, it would still be essential to provide a detailed explanation setting out the nature of the information and specific legal concerns raised.

A matter which has provoked widespread criticism is the fact that seven of the 26 recommendations set out at the end of the report were blacked out. The deletion of these recommendations is qualitatively different from the deletion of the other material set out in the report. One of the stated aims of the report is to inform and improve practice and, presumably, the deleted recommendations relate to this objective. It is difficult to see how these recommendations can be effectively actioned. It is not sufficient that the public bodies in question are aware of them as to accept this would be tantamount to accepting that public accountability in implementing such recommendations is unimportant. Establishing who is responsible for carrying out the recommendations of the report and monitoring implementation are key considerations.

The redaction of this report serves to undermine the difficult work of the Inquiry Team and more importantly lays bare a family in need, cruelly stripped of their dignity. The result of redaction is an unbalanced account of events with an over reporting of unnecessary and intimate details regarding the background and family life of the Dunne family.

The principal criteria governing the inclusion of information in a report such as this should be what is needed to support the report's conclusions and what is in the public interest. I would question whether certain of the personal information regarding the Dunne family should have been included in the report in view of the need to respect the individuals in question.

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This is not the first report into a terrible tragedy which has included the deaths of children. What is clear about the Monageer Inquiry and others that have gone before it is that we have not adopted a consistent approach to the examination of such incidents. Questions relating to how such an inquiry is undertaken, who should carry it out, how much information should be disclosed and who has responsibility for acting on the findings are revisited every time a new inquiry commences. There have also been incidents involving the deaths of children where no such inquiry has taken place. A number of cases of child death have been brought directly to the attention of my Office in respect of which the process to review those deaths was unclear.

These cases underscore the need for a mechanism in Ireland which guarantees that child deaths are reviewed consistently, both in terms of the instigation of the review and the manner in which the review is conducted.

These are the reasons that my Office launched an initiative looking at the possible establishment of a child death review mechanism in Ireland. A child death review mechanism would have a standard approach to such occurrences which would be to the advantage of family members, statutory agencies, the Government and the general public.

It is time that the authorities turn their minds to tackling the hard questions and making decisions in principle about how child death inquiries should function. Decisions need to made and agreements reached on a range of issues including: how information is to be shared and placed in the public domain; what is expected of State agencies in terms of their accountability to the public; the time frame for inquiries and the involvement of family members.

We have become complacent, developing a new language around explaining why children have been damaged by the actions of adults rather than expressing any new ambition to reduce the occurrence of such events.

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The tragic deaths of the Dunne family highlight the necessity for an independent, statutory and consistent child death review mechanism.

The purpose of such a review mechanism should be to develop a deeper understanding of why children die, in an effort to reduce the number of preventable deaths.

It is clear that not all child deaths are preventable and that unusual circumstances can lead to tragic outcomes in spite of timely and considered interventions on the part of State agencies. However, some deaths are preventable and can provide an opportunity to assess policy and practice relating to how we protect vulnerable children.