Ombudsman for Children - Child Death Review mechanism initiative

Background and Process

On Monday 28 April, the Ombudsman for Children convened a high level seminar on child death review. The seminar was the next step in the Ombudsman for Children's initiative to look at the possible establishment of a child death review mechanism in Ireland.

The Ombudsman for Children started this initiative in April 2007 when she contacted Minister Harney. Since then, the Ombudsman for Children's Office has conducted an initial round of consultations with relevant agencies. The seminar on 28 April brought these agencies together to discuss the possible development of a child death review mechanism and to identify a process for bringing this initiative forward.

This initiative is being conducted under the Ombudsman for Children's statutory mandate to advise on the development and co-ordination of policy relating to children. It aims to examine how best agencies could work together in establishing a mechanism and capitalising on what we already have in Ireland.

The need for a child death review mechanism

A number of cases of child death have been brought directly to the attention of the Ombudsman for Children in respect of which the process to review those deaths was unclear. These cases have underscored 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. The aim of the initiative is to prevent 'preventable' deaths.

In September 2006, the UN Committee on the Rights of the Child raised questions about child death review procedures in Ireland when it examined Ireland's second report to it. The UN Committee requests that all States inform it of their procedures to review child deaths in line with the obligation on States under the Convention to protect the right to life of children.

What can a child death review mechanism offer?

The impetus for this initiative stems from the belief that the establishment of a system to consistently examine child deaths in the State would lead to a deeper understanding of the factors which render children vulnerable. It would also be a great asset in our efforts to reduce the number of preventable child deaths. The scope of its work would leave it uniquely placed to make concrete and informed recommendations across a wide range of practice and policy areas which it could then monitor over time.

Learning from international best practice

The Ombudsman for Children's Office (OCO) has conducted a scoping exercise of best international practice regarding the review of child deaths.

Child death review mechanisms have been established in many countries and, while their functions and natures vary, their basic aim is to reduce the number of preventable child deaths. These mechanisms are geared towards achieving a better understanding of the factors and vulnerabilities that contribute to child death so that they can be tackled in a more effective way.

One of the first such mechanisms was established in California in 1978 as a result of concern on the part of parents, health care workers and other professionals over the increasing number of children who were dying from abuse, neglect or other preventable deaths. Since that time, child death review mechanisms have been established in every State in the USA, and in New Zealand, Australia and Canada. In addition, new child death review procedures will became mandatory in England and Wales from April 2008, while the Department of Health, Social Service and Public Safety in Northern Ireland has undertaken a consultation process on the establishment of a regional child death review protocol. The Scottish Executive has also established a Child Death and Significant Case Review Group to examine the possibility of introducing a child death review mechanism in Scotland.

Although the typology of review mechanisms is extensive, there are generally speaking two main approaches to child death review: one which focuses on the individual and one which looks at broader trends. The first is the examination of individual cases which can bring to light systemic problems that place children at risk and from which lessons can be learned aimed at preventing situations arising in future such as those which led to the child's death. The second is a more statistical exercise which looks at the total number of child deaths and identifies among other things what the leading causes of preventable deaths are and which groups of children and young people are most affected.

Practice in other jurisdictions is very instructive when considering how these approaches might be adapted for Ireland. The main questions which have emerged in relation to child death review in general over the last 30 years are: the scope of review; having mandatory or discretionary reviews; having standing or ad-hoc review groups; the composition of the group; the relationship with the coronial process; the relationship with other agencies; access to information; the involvement of family members; recommendations and findings; and effectiveness.

Human Rights Aspects of Child Death Review

Article 6 of the UN Convention on the Rights of the Child requires States Parties to recognise the inherent right to life of every child and ensure to the maximum extent possible the survival and development of the child.

In its General Guidelines for periodic reports, the UN Committee on the Rights of the Child has indicated that States Parties should include information on the registration of the deaths of children, the causes of death and, where appropriate, the investigation of and reporting on such deaths. The Committee views such a system of reporting and investigation as having a preventive purpose and regards it as an element of children's right to life under Article 6 of the UN Convention on the Rights of the Child. Indeed, when Ireland's most recent periodic report was examined by the UN Committee in September 2006, the State's delegation was specifically asked to provide information on Ireland's

policy for investigating the deaths of children, and on provisions to monitor the State's direct or indirect responsibility for such deaths[1].

[1] CRC/C/SR.1182 Summary record of the 1182nd meeting (Chamber B) of the UN Committee on the Rights of the Child, para. 65