



ombudsman
for children : do leanaí

Child Death Review

Options Paper

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I. Introduction

1. Under section 7.1 (a) of the Ombudsman for Children Act 2002, the Ombudsman for Children has a statutory responsibility to advise the Minister for Health and Children or any other Minister of the Government, as may be appropriate, on the development and co-ordination of policy relating to children.
2. In April 2007, the Ombudsman for Children contacted the Minister for Health and Children and, pursuant to section 7.1 (a) of the 2002 Act, recommended that consideration be given to the establishment of a mechanism to review systematically child deaths in the State. The purpose of such a review mechanism would be to develop a deeper understanding of why children die in an effort to reduce the number of preventable deaths.
3. The impetus for this initiative came from a number of cases being brought directly to the attention of the Ombudsman for Children relating to child deaths in respect of which the review process appeared unclear, in addition to an awareness that child death review mechanisms are common in other jurisdictions. 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 became mandatory in England and Wales in 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 then Scottish Executive also established a Child Death and Significant Case Review Group to examine the possibility of introducing a child death review mechanism in Scotland in 2005.
4. Following an initial meeting with the Minister for Health and Children's office, the Ombudsman for Children's Office engaged in a scoping exercise looking at international best practice in this area with a view to seeing how Ireland could learn from the experience of other jurisdictions. In order to get a sense of how the different facets of child death are examined at present in Ireland, the Ombudsman for Children's Office also consulted with a range of bodies that have a role in this area.
5. To facilitate a more focused discussion on this issue among statutory bodies that already examine certain aspects of child death in Ireland or that have mandates relevant to child death review, the Ombudsman for Children hosted a high-level seminar in April 2008. Preparing an inventory which captured existing practice and relevant mandates was identified by participants at the seminar as an essential pre-requisite for

advancing the consideration of establishing a child death review mechanism in Ireland (a copy of the inventory is attached at Annex 1). It is clear that there is already a great deal of work being undertaken in Ireland in the area of death review and many examples of good practice in developing prevention strategies.

6. 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.
7. 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 (of which there were 395 in Ireland in 2006¹) and identifies among other things what the leading causes of preventable deaths are and which groups of children and young people are most affected.
8. This paper discusses some key elements of both of these approaches and sets out options regarding each of them. In addition, it contains a brief examination of the human rights considerations relevant to child death review. It is hoped that, in addition to the inventory of current practice found at Annex 1, this paper will stimulate further discussion about how existing practice could be harnessed and improved and how a child death review mechanism might operate in Ireland. It also sets out questions for the consideration of stakeholders and the Government which focus on possible next steps in this process.
9. This paper has been circulated to those who attended the high-level seminar, the Minister for Children and Youth Affairs and other key stakeholders for their consideration.

¹ *State of the Nation's Children Report 2008*, Office of the Minister for Children and Youth Affairs (2008), p. 15

II. Human Rights Considerations

10. Ireland's international human rights obligations must be taken into account when considering how we approach the question of child death review. The provisions of the UN Convention on the Rights of the Child (UNCRC) and the European Convention on Human Rights (ECHR) are of particular importance in this regard.
11. Article 6 of the UNCRC 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 – the body that periodically examines the implementation of the Convention in States Parties – 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.
12. Although the UNCRC is not prescriptive about the manner in which child deaths are monitored and reviewed, the UN Committee on the Rights of the Child regards it as an important facet of a State's obligations under Article 6 of the UNCRC and the issue was raised with Ireland during the course of the examination of its most recent State Party report². It may once again be raised by the UN Committee during the course of the examination of Ireland's next periodic report.
13. Section 3 of the European Convention on Human Rights Act, 2003 requires every organ of State to perform its functions in a manner that is compatible with the State's obligations under the ECHR. The jurisprudence of the European Court of Human Rights relating to the procedural obligation under Article 2 of the Convention (the right to life) to investigate certain deaths is therefore a key consideration.
14. Two strains of jurisprudence around Article 2 are of particular importance in the context of child death review: the indirect responsibility of the State for death and the procedural obligation on the State to investigate cases in which the State's responsibilities under the Convention might have been engaged.
15. The European Court of Human Rights has held that, in certain circumstances, Article 2 of the Convention may entail positive obligations to take preventive measures to protect an individual whose life is at risk. It has concluded that for a State's responsibilities to be engaged, the authorities must have known or ought to have known of the existence of a real and immediate risk to life and they must have failed to take measures within the scope of their powers which, judged reasonably, might have avoided that risk. While the Court has indicated

² CRC/C/SR.1182 Summary record of the 1182nd meeting (Chamber B) of the UN Committee on the Rights of the Child, para. 65

that this obligation will not apply in every case, in *Osman v. UK* the Court rejected the UK Government's contention that the failure to act must be tantamount to gross negligence for the State's responsibility to be engaged, finding that such a standard would be inconsistent with the obligation under the Convention to ensure practical and effective protection of Convention rights³.

16. The Court has also held that the obligation to protect the right to life under Article 2 of the Convention, read in conjunction with the State's general duty under Article 1 of the Convention to "secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention", requires by implication that there should be some form of effective official investigation when someone's right to life under Article 2 has been violated. In *Edwards v UK*, the Court held that a State must investigate deaths not only where its agents are directly responsible for deaths but also where the State is indirectly responsible by failing to discharge its duties⁴. In an interesting comment on the possibility of distinguishing between the procedural requirement to investigate deaths where the State was directly as opposed to indirectly responsible, the House of Lords rejected the view that a lower level of scrutiny was required for the latter. The Lords adjudged that to be directly contrary to the decision of the European Court of Human Rights in *Edwards v UK* and held that systemic failures leading to deaths called for even greater scrutiny⁵.

17. Although the European Court of Human Rights has not been prescriptive about the form an Article 2 compliant investigation should take, it has laid out the general principles which should underpin any such investigation. The Court has held that it must:

- be on the State's own initiative (i.e. not civil proceedings);
- be independent, both institutionally and in practice;
- be capable of leading to a determination of responsibility⁶;
- be prompt;
- allow for a sufficient element of public scrutiny of the investigation or its results to ensure accountability; and
- allow the next of kin to participate to the extent necessary to safeguard his or her legitimate interests⁷.

³ *Osman v UK* (1998) 29 E.H.R.R. 245

⁴ *Edwards v UK* (2002) 35 E.H.R.R. 19

⁵ *R (on the application of Amin) v Secretary of State for the Home Department* [2003] UKHL 51, [2004] HRLR 3

⁶ The European Court of Human Rights has made it clear that this is not an obligation of result, but rather an obligation of means. Thus an investigation may lead to but not necessarily make a determination of responsibility. Where a violation of Article 2 attracts criminal liability, the procedural obligation of the State may be discharged by holding a criminal trial. In situations where the indirect responsibility of the State is engaged and no criminal act has taken place, the investigation would not need to mete out punishment but would nonetheless need to be able to make it clear who or what caused the death.

⁷ *Edwards v UK*, para. 69-73

18. Systemic problems may, however, contribute to deaths in situations where the State's responsibilities under Article 2 are neither directly nor indirectly engaged. While the State would not be obliged to carry out an Article 2 compliant investigation in such circumstances, the principle of learning from a death in order to prevent another one taking place in similar circumstances still holds. Against this background, consideration should be given to moving beyond the minimum requirements of the ECHR and applying more generally the principle of death review with a preventive focus. This would be in keeping not only with the spirit of the ECHR but also with that of the UNCRC.

III. Individual review of child death

19. It is clear that not all 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.
20. International experience differs on the relative value of individual case review as opposed to an approach to child death which examines broader trends at a demographic level. The success of each can depend on a wide range of factors such as the relationship between the different organisations involved, the nature of the recommendations produced and the extent to which the process is geared towards practice learning. The experience of New South Wales, for example, highlights the strengths of a robust system of research into child death and the uses to which a rich dataset can be put, as well as suggesting that individual case review may not be as effective as the more research oriented approach⁸. On the other hand, the recent Confidential Enquiry into Maternal and Child Health (CEMACH) pilot project on child death review in the United Kingdom concluded that multidisciplinary case reviews undertaken during the course of its work identified areas of concern which were not discernible from the broader dataset collected on all deaths⁹.
21. It may be that in certain instances child deaths do not give rise to wider systemic concerns and reviewing them will therefore not enhance our understanding of what renders children vulnerable. This cannot, however, be known in advance. In addition, the importance of supporting a culture of accountability and appropriate auditing should be borne in mind. That is not to say that a child death review mechanism should focus on the attribution of blame rather than learning lessons – it is merely to point out that there can be different reasons for establishing mechanisms to examine individual deaths.
22. There have been a number of cases of child death in Ireland over the last number of years that have necessitated independent reviews, though the approach taken has not always been consistent. One of the benefits of having a child death review mechanism is that there would be a standard approach to such occurrences which would be to the advantage of family members, statutory agencies, the Government and the general public.
23. What follows is an examination of the principal issues which arise in relation to the individual examination of child death. The elements for consideration are:

⁸ Presentation by the New South Wales Commissioner for Children and Young People, Gillian Calvert, at the high-level seminar hosted by the Ombudsman for Children's Office on 28 April 2008.

⁹ Confidential Enquiry into Maternal and Child Health, *Why Children Die: A Pilot Study* May 2008, p.3

- Scope
- Composition
- Standing or ad-hoc body
- Independence
- Confidentiality, data protection and information sharing
- Interaction with other investigations
- Involvement of family members
- Pathway for recommendations

Scope

24. In some jurisdictions, neo-natal deaths are not examined by general child death review mechanisms and remain largely hospital based, reflecting the fact that particular problems present for that age-group. This is the case with, for example, the Child and Youth Mortality Review Committee in New Zealand which does not examine deaths of children under the age of 28 days. Deaths of young people beyond the age of 18 are also sometimes included in reviews because some of the same problems present in the late teenage years/early twenties as in early adolescence¹⁰.

25. The question hinges on what added value an independent multidisciplinary review could bring to the examination of deaths among particular cohorts of children. If there are already review processes examining those groups and the difficulties which present are sufficiently specialised, then there may be no need to duplicate that examination with a general child death review mechanism, though information sharing between the different review structures could be beneficial.

26. Consideration should be given to the range of ages covered by the review mechanism, with due regard to the need for non-duplication and practical limitations on the number of cases which can be examined in depth by a child death review mechanism.

27. International practice varies on the issue of whether all deaths should be investigated or whether it should be limited to certain types of deaths. Research in this area indicates that regardless of what categories of death a mechanism examines, those categories must be clearly defined¹¹. In some jurisdictions such as California, it is only deaths resulting from abuse, neglect or which present other child protection concerns that are investigated. Child death review mechanisms with a restricted scope also sometimes include violent deaths, deaths of children in care, cases of suicide and drug abuse.

¹⁰ For further information on current practice in Ireland, particularly regarding the SIDS Register, see the inventory at Annex 1.

¹¹ Axford and Bullock, *Child Death and Significant Case Reviews: International Approaches*, Dartington Social Research Unit (2005), p. 58

28. This is the approach adopted in many other jurisdictions and it is based on the idea that, given the fact that individual reviews can be resource intensive, they should be carried out on cases in which one is more likely to be able to learn lessons and possibly improve systems for the protection of vulnerable children. A recent review of the new child death review structures in England and Wales found that the requirement to review all child deaths meant that it was not possible to go into great depth for many of them. Local child protection structures charged with carrying out those reviews were developing a system of selection for cases requiring a greater level of examination, including a notification system and some form of categorisation of all deaths¹². This was being done in order to avoid diminishing the effectiveness of the review process by having too many cases to examine.
29. It is possible, however, that useful information and practice learning could be lost from failing to examine all cases which do not involve abuse, neglect or other child protection concerns. During the consultations undertaken by the Ombudsman for Children's Office, the possibility of having some form of filtering mechanism was raised on a number of occasions. This would allow the child death review mechanism to remain flexible in selecting which cases to examine and how deeply each is reviewed.
30. A related question is that of whether the review mechanism should be able to examine serious incidents which do not end in death. This is the model which became mandatory in England and Wales from April 2008. The logic behind such an approach is that many of the same lessons can be learned from incidents which were serious but did not end in the death of a child. The argument against including such reviews within the same mechanism is that it would give the review body too wide a focus. It might also be more difficult to get as rich a dataset in relation to serious incidents as is available in cases of death.
31. **Consideration should be given to what categories of death are examined and the flexibility given to the review mechanism to select certain cases for more in-depth review. The different approaches adopted by other jurisdictions outlined above are instructive in this regard.**

Composition

32. The international practice is unequivocal in pointing to the importance of a multidisciplinary group to undertake child death review, the advantages of which are evident. In general, there are a number of core members whose numbers can be increased when required.

¹² Sidebotham et al, *Preventing Childhood Deaths: a study of 'early starter' Child Death Overview Panels in England*, Department for Children, Schools and Families, Research Report No. DCSF – RR036, p. 7

33. In the United States, child death review teams typically have representatives from the coroner service, law enforcement, social services, and the health services. British Columbia's child death review mechanism is integrated into the Coroner Service and has flexibility in relation to the composition of the review group by providing for the establishment of a Multidisciplinary Child Death Review Committee when issues which emerge in the course of a review would benefit from examination by other professionals.
34. **Consideration should be given to what the composition of the child death review mechanism should be, with particular emphasis on the need for an appropriate range of expertise and the flexibility to convene a larger group if necessary.**

Standing or ad-hoc body

35. The question of having a standing or an ad-hoc review mechanism will depend to an extent on the number of cases that have to be examined. The existence of a standing group to instigate and undertake child death review has the advantage that the body can accumulate knowledge and expertise. Research indicates that child death review mechanisms with a high turnover of staff are weaker than ones which are standing in nature¹³. A standing body would also be in a position to monitor the implementation of its recommendations over time.
36. The alternative of more ad-hoc groupings could be seen as more immediately practicable in relation to individual cases, as it could be set up in the manner of a protocol to bring together key professionals in the event of a child's death. Members of the review mechanism could potentially be drawn from a pool of qualified professionals who could bring the required expertise to bear on the examination of case.
37. **Consideration should be given to whether the child death review mechanism would involve a standing body or ad-hoc groups, possibly convened by means of a child death review protocol. Factors to be taken into account in this regard include the volume of cases (determined by the scope of the review mechanism), the value of continuity of membership and the value of flexibility.**

Independence

38. Independence is an essential characteristic of a child death review mechanism. This does not mean, however, that representatives from State bodies should not be members of such a mechanism – indeed, the presence and cooperation of professionals working for State bodies can have a great impact on the extent to which recommendations from a child death review mechanism are taken on board.

¹³ Ibid., p. 62

39. During the course of the OCO's consultations on the possible establishment of a child death review mechanism in Ireland, it was suggested that independence could be assured if the convening or chairing role of the body were assumed by an independent organisation or individual. The question of who leads the process is clearly important and international practice in this regard is quite varied. The range of bodies which can lead child death review mechanisms includes the Attorney General's Office (California), the Coroner Service (British Columbia), the National Public Health Service (Wales) and Commissioner for Children and Young People (New South Wales). It was also suggested that an independent legal professional could take on this role.
40. **Consideration should be given to the manner in which the independence of a child death review could be guaranteed, while recognising the importance of maintaining a close link with state agencies and service providers.**

Confidentiality, data protection and information sharing

41. One of the issues discussed at some length at the high-level seminar was that of data protection and information sharing. The extent to which bodies with relevant information might be bound by confidentiality rules not to disclose or share information with other bodies could raise significant but not insuperable legal barriers to the effective operation of a child death review mechanism.
42. It would be important to first of all establish what the remit of the child death review body would be before then examining how feasible it would be to use existing legislation and information sharing arrangements to operate effectively. If following such an examination it appeared that current arrangements were not sufficient to allow the requisite information to be shared, legislative changes might be required.
43. While any child death review mechanism would of course attempt to work amicably with agencies involved in the investigation, the question of the body's power to receive and/or compel information would also have to be addressed.
44. Another issue that arose during the course of consultations was that of confidentiality, in particular for those who might be contributing information directly to a child death review body. International experience would suggest that guaranteeing confidentiality in this respect can enhance the quality of the process because in the absence of such confidentiality, the information gathering process can be inhibited.

45. **Consideration should be given to the impact that confidentiality, data protection and information sharing arrangements could have on the operation of a child death review mechanism. Particular attention should be given to current legal provisions relevant to this area and to the possible need to amend them in order to ensure that the child death review mechanism can operate effectively.**

Interaction with other investigations

46. Given the work already undertaken by coroners, the risk of duplication with a child death review team is clear and the question of where the coronial process ends and where a child death review team begins must be considered in detail. Specific aspects of this question include the manner in which information is passed from the coroner service to the child death review team and whether the coroner could have a role in referring specific cases to a child death review team. Consideration might also be given to how a child death review team might monitor the implementation of recommendations issued by coroners over time.
47. In some instances, An Garda Síochána may also be undertaking an investigation into the death of a child. The possibility of a criminal investigation happening in parallel with or prior to the examination of the case by a child death review mechanism must be considered, with due regard to the evidence-related issues which could arise in this context.
48. It is also possible that other bodies – including independent statutory bodies and state agencies providing services – will be carrying out their own reviews in line with their own mandates and procedures. In such a situation, it is vital that a child death review team be constituted in such a way as to bring a perspective that is different from the other bodies and adds value. It is also important that the details of how parallel investigations proceed be established.
49. **Consideration should be given to how a child death review team would interact with other agencies investigating particular aspects of a child’s death. Child death review procedures should respect the integrity of those processes and avoid unnecessary duplication.**

Involvement of family members

50. Some child death review teams – particularly those in the United States - stress the need to deal sensitively with family members and with those grieving the loss of a child. Seeking further information for the purposes of child death review at such a time can be difficult, though many families in other jurisdictions where such reviews take place demonstrate a willingness to take part in the process and contribute information. In addition, families can be instrumental in raising

awareness about problems that may have contributed to the death of a child and in inspiring prevention programmes. It should also be borne in mind that an investigation into a death under Article 2 of the ECHR requires that next of kin be allowed participate to the extent necessary to safeguard their legitimate interests.

51. There can, however, be difficulties with the involvement of family members in the process, particularly where they might be implicated in some way in the death. Flexibility in when and how to engage with family members is therefore essential.

52. Consideration should be given to what principles should underpin the involvement of family members in the process of child death review, with due regard to the need to deal very sensitively with those who are grieving the loss of a child.

Pathway for recommendations

53. International practice strongly suggests that the recommendations emanating from a child death review team need to be realistic, practical and useful to frontline practitioners. In particular, the working definition of preventability underpinning the work of the body must be carefully thought out so that its analysis of systemic failings (should they exist) is fair¹⁴.

54. It is important to identify where the most useful place for recommendations emanating from the child death review team to be sent is. In some jurisdictions, reports are submitted to Parliament while in others it is to particular Ministers. In addition to establishing a clear relationship with State agencies and commenting on law and practice for which the State is responsible, it is also important to link in with community based organisations and research/advocacy organisations that work on preventing injury or death in areas such as road safety and public health. Recommendations for change should not be made in isolation and should be mindful of other initiatives being undertaken to achieve objectives similar to those of the child death review team, albeit in specific areas.

55. Consideration should be given to where recommendations made by the child death mechanism would be sent and how implementation could be monitored.

¹⁴ Durfee, M et al. 'Child Fatality review: an international movement', *Child Abuse and Neglect*, XXVI (2002) pp. 619-636

IV. Research on trends in child death

56. Many of the issues discussed above in relation to the individual examination of child death are relevant to a consideration of how a child death review mechanism looking at trends and patterns in child death would operate. There are, however, a number of distinct issues which arise in the areas of:

- Scope
- Composition
- Standing or ad-hoc body

Scope

57. In relation to research on trends in child death, the main issue is what sort of dataset is being sought and what difficulties arise in relation to gathering such information. For example, the child death review dataset examined recently by the Confidential Enquiry into Maternal and Child Health (CEMACH) for five regions of the UK in 2006 consists of: demographic and death certificate information; previous medical/developmental history; social circumstances; and other relevant information.

58. It is clear that the nature of the dataset which can be obtained by a child death review team in any given situation is heavily dependent on the structures and protocols already in place for recording and sharing information concerning death (coronial investigations, death certificates, public health data etc). As a great deal of very useful information is already being gathered, shared and analysed, it is important that any child death review mechanism build on this current practice.

59. After identifying what information is required for the purposes of undertaking a review of child death in Ireland, it would then be necessary to undertake an evaluation of how accessible that information is and, where gaps in information gathering/sharing are identified, how feasible it is to address them.

60. Consideration should be given to what information should be obtained in order to generate as rich and useful a dataset as possible, building on the large amount of information already available. In addition, the sources of that information and the manner in which that information is shared should be examined to see if it is possible to improve them.

Composition

61. International practice would suggest that, like the review of individual cases of child death, a group looking at larger trends and patterns in

relation to child death should be multidisciplinary. In addition to the 'core group' of professionals mentioned above in the context of individual case review, the group should also contain members with a specific background in child health research and epidemiology.

- 62. Consideration should be given to what additional expertise would be required for a child death review mechanism looking at broader trends and patterns in child death, in particular in the areas of child health research and epidemiology.**

Standing or ad-hoc group

63. In some jurisdictions, bodies looking at broader trends in child death meet at regular intervals during the year, unlike groups that examine individual deaths as they occur. It is possible that the collation and initial analysis of data could be undertaken by designated research and administrative staff, with the child death review body examining findings, providing direction to the work of the body and making recommendations.

- 64. Consideration should be given to the frequency of meetings and administrative/research support received by the child death review mechanism.**

V. Conclusion

65. Ultimately, 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.
66. It can be difficult to determine how effective a preventive mechanism actually is but there is clear evidence that child death review teams have had an impact. A review of recommendations made by the British Columbia coroner service child death review unit in 2002 for which a response from another body was requested, found that there was an 88% response rate and all of them were positive. The recommendations in question related to a number of different areas including hospital procedures, child protection, motor vehicle safety and suicide assessments¹⁵. An examination of child death review teams in the United States undertaken in the same year highlighted a number of instances of positive change brought about by child death review teams including: the introduction of standardised investigative protocols for unexpected infant death; a revision of the information included on death certificates; revised policies on home visitation; motor vehicle safety; and HIV testing for pregnant women¹⁶.
67. In addition, there is a great deal of work already being undertaken in Ireland relevant to the examination and prevention of child death, as outlined in the inventory at Annex 1. If a child death review mechanism were established in Ireland, it could build on these strong foundations.

¹⁵ British Columbia Coroner Service, *Overview of Child Death Review* (2004), pp. 9-13
<http://www.pssg.gov.bc.ca/coroners/child-death-review/docs/CDR-2004Report-Overview.pdf>

¹⁶ *Supra*, n. 13

ANNEX 1

Child Death Review – Inventory of bodies with mandates and functions relevant to child death review

Organisation	General Information	Functions and powers relevant to death review	Specific publications/work relevant to death review	Forthcoming changes
<p>Central Statistics Office</p>	<p>The CSO is responsible for the collection, compilation, extraction and dissemination for statistical purposes of information relating to economic, social and general activities and conditions in the State.</p> <p>It is also responsible for co-ordinating official statistics of other public authorities and for developing the statistical potential of administrative records</p> <p>Under the terms of the Statistics Act</p>	<p>The CSO compiles the quarterly and annual statistics relating to births, deaths and marriages.</p> <p>Death certificates provided by the General Register Office are the primary source of information for the CSO relating to deaths in Ireland (see below for information on the registration of deaths and the role of the General Register Office).</p> <p>The physical and external causes of death are both coded for every death in the State using the standard World Health Organisation International Classification of Diseases, Injuries and Causes of Death.</p> <p>In addition to death certificates, the CSO gathers information from a confidential statistical return known as a Form 104 which is filled in by a member of An Garda Síochána following an inquest. The Form 104 contains supplementary information not included on the death certificate (such as details of the deceased's family situation, whether the death was a suicide and details of any drug or alcohol dependency).</p> <p>Depending on the circumstances and the nature of the request, the CSO can also produce a particular</p>		

	<p>1993, the CSO is an independent Office established on a statutory basis under the aegis of the Department of An Taoiseach.</p>	<p>dataset from the information already in its possession which focuses on details that are not highlighted in the published vital statistics.</p>		
<p>Coroner Service</p>	<p>A coroner is an official with legal responsibility for the investigation of unnatural, sudden and unexplained deaths.</p> <p>Although the coroner system is subject to the general supervision of the Minister for Justice, Equality and Law Reform, a coroner is independent in his/her function acting in the name of, or on behalf of the State in the public interest.</p> <p>The principal pieces of legislation that established the role and responsibilities of</p>	<p>All sudden, unexplained, violent and unnatural deaths must by law be reported to a Coroner. If death is due to unnatural causes then an inquest must be held by law. An inquest must also be held for all deaths of children in care.</p> <p>An inquest is an inquiry in public by a coroner, sitting with or without a jury, into the circumstances surrounding a death. The inquest will establish the identity of the deceased, when, where and how death occurred and the particulars required for death registration.</p> <p>Questions of civil or criminal liability cannot be considered or investigated at an inquest and no person can be exonerated. The purpose of the inquest is to establish the facts surrounding the death and to place those facts on the public record and to make findings on the identification of the deceased, the date and place of death and the cause of death.</p> <p>Copies of the post-mortem report and depositions taken at inquest including a copy of the verdict are available from the coroner's office on payment of the statutory fee, once the inquest has concluded. The Freedom of Information Act 1997 does not apply to coroners' inquests and inquiries.</p>		<p>The new Coroners Bill may provide for individual examination of deaths in a manner that complies with Article 2 of the European Convention on Human Rights. This would mean, inter alia, that the examination of "how" a person died would go beyond the proximate cause of death and look at the wider circumstances.</p> <p>The Coroners Bill provides for the conclusion of protocols between the Coroner Service and other statutory bodies with mandates to investigate accidents, incidents or diseases which result in death. The protocols will relate to the sharing of information and the conduct of any such investigation.</p>

	<p>Coroners in Ireland were the Coroners Act, 1962 and the Coroners (Amendment) Act, 2005.</p>	<p>A general recommendation (rider) designed to prevent a similar death occurring may be made by the coroner or jury.</p>		<p>The Coroners Bill also provides that coroners may make recommendations and that Departments of State and public bodies will be obliged to respond to those recommendations within particular timeframes</p>
<p>Economic and Social Research Institute</p>	<p>The principal function of the ESRI is to produce high-quality research that contributes to understanding economic and social change and that informs public policymaking and civil society in Ireland and throughout the European Union.</p> <p>The ESRI is a not-for-profit organisation and is registered as a charity. The Institute enjoys full academic independence.</p>	<p>The ESRI, in association with the Department of Health and Children and the Health Service Executive, is engaged in the collection, processing and analysis of data for the Hospital In-Patient Enquiry Scheme (HIPE) which operates in all acute hospitals nationally.</p> <p>HIPE is a computer-based discharge abstracting system designed to collect demographic, clinical and administrative data on discharges and deaths from acute general hospitals nationally. Each HIPE discharge record represents one episode of care and patients may have been admitted to more than one hospital with the same or different diagnoses. The records therefore facilitate analyses of hospital activity rather than incidence of disease.</p> <p>A national database of all HIPE discharges is maintained by the HIPE Unit for each year since its inception. Since 2005, HIPE collects a principal diagnosis and up to 19 secondary diagnoses and, if surgery is performed, a principal surgical procedure and up to 19 secondary procedures. From the 1st of January 2009 all discharges will be coded using the ICD-10-AM/ACHI/ACS (The Australian Modification of ICD-10 incorporating the Australian Classification of Health Interventions (ACHI) and the Australian Coding</p>		

		<p>Standard (ACS) 6th Edition. Between 1st of January 2005 and 31st December 2008 all discharges were coded using ICD-10-AM, (The Australian Modification of ICD-10 incorporating the Australian Classification of Health Interventions) 4th Edition (July 2004).</p> <p>The coding scheme used to code diagnoses and surgical procedures prior to 2005 was the International Classification of Diseases, 9th Revision, Clinical Modification known as ICD-9-CM. Between 2002 and 2004 HIPE collected a principal diagnosis and up to 9 secondary diagnoses and, if surgery was performed, a principal surgical procedure and up to 9 secondary procedures. Prior to 2002 a principal diagnosis and up to 5 secondary Diagnoses were collected and, if surgery was performed, a principal surgical Procedure and up to 3 secondary procedures was collected. HIPE does not collect casualty or out-patient data.</p> <p>The source document for the HIPE system is the patient medical record or chart. In each hospital a coder translates the medical terminology into numeric codes and keys the data. All the data collected are coded in a standardised format for computer input and for subsequent analysis of the data.</p> <p>National Perinatal Reporting System (NPRS)</p> <p>The ESRI also manages the National Perinatal Reporting System (NPRS). The NPRS is the principal source of national data on perinatal events. The Health Research and Information Division at the Economic and Social Research Institute is responsible for the administration of all aspects of the NPRS since being contracted to do so by the Department of Health</p>		
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		<p>and Children in 1999.</p> <p>Information on every birth in the Republic of Ireland is submitted to the NPRS by hospital administrative staff and all practicing independent midwives. The information collected includes data on pregnancy outcomes (with particular reference to perinatal mortality and important aspects of perinatal care), as well as descriptive social and biological characteristics of mother's giving birth.</p> <p>The time frame to which the information relates is from 22 weeks gestation to the first week of life. Since 1 January 2005, the coding scheme used to code mortality is The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10). Prior to 2005 the coding system used was the International Classification of Diseases, 9th Revision (ICD-9).</p> <p>Where a perinatal death occurs the following data are collected:</p> <ul style="list-style-type: none"> • Type of Death; • Autopsy (Post Mortem); • Age at Death; • Place of death; • If Stillbirth, when did Death occur?; and • Cause of Death <p>(NPRS Instruction Manual)</p> <p>Further information on HIPE and NPRS including Instruction Manuals detailing the variables collected, reports and the HIPE On-line Data Reporter can be accessed from www.esri.ie/health_information/.</p>		
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<p>An Garda Síochána</p>	<p>As the national police force, An Garda Síochána is responsible for carrying out all policing functions in the areas of criminal and traffic law enforcement, as well as State security.</p> <p>The functions of An Garda Síochána have been set out in a number of Acts dating from 1923 and most recently in the Garda Síochána Act, 2005.</p>	<p>An Garda Síochána investigates many but not all child deaths in Ireland, though the nature of the investigation varies between criminal and non-criminal investigations. In general, the level of recorded information differs significantly between the two types of investigation – information for criminal investigations (e.g. homicide) is very complete whereas information for non-criminal investigations (e.g. suicide, sudden death, fatal collisions) is less complete.</p> <p>An Garda will investigate a child's death when:</p> <ul style="list-style-type: none"> • It may have resulted from an accident, suicide or homicide; • It occurs in suspicious circumstances; • It is an unexpected or unexplained death; • A dead body is found; or • There is no doctor who can certify a cause. <p>In carrying out such an investigation, the Gardaí interact with the Coroner, the HSE, voluntary bodies (e.g. bereavement counsellors, victim support) and the DPP's Office.</p>		
<p>Garda Síochána Ombudsman Commission</p>	<p>The Garda Ombudsman Commission is responsible for receiving and dealing with all admissible complaints made by members of the</p>	<p>The Garda Síochána Ombudsman Commission's functions are to:</p> <ul style="list-style-type: none"> • Directly and independently investigate complaints against members of the Garda Síochána; • Investigate any matter, even where no complaint has been made, where it appears 		

	<p>public concerning the conduct of members of the Garda Síochána.</p> <p>GSOC is an independent statutory body established under the Garda Síochána Act, 2005</p>	<p>that a Garda may have committed an offence or behaved in a way that would justify disciplinary proceedings;</p> <ul style="list-style-type: none"> Investigate any practice, policy or procedure of the Garda Síochána with a view to reducing the incidence of related complaints. <p>If a complaint concerns the death of, or serious harm to, a person as a result of Garda operations or while in the custody or care of An Garda Síochána, GSOC is obliged to immediately direct a designated officer to examine the complaint for the purpose of recommending whether it should be investigated.</p>		
General Register Office	<p>The General Register Office is the central civil repository for records relating to births, deaths and marriages in Ireland.</p> <p>The civil registration system was reorganised and modernised by the Civil Registration Act, 2004. The Act provides for the appointment of the Registrar General by the Minister for Health and Children from among his or her Officers.</p>	<p>Records of deaths are held in the General Register Office, which is the central civil repository for records relating to births, marriages and deaths in Ireland.</p> <p>Deaths may be registered in any Registrars office. A doctor must be satisfied about the cause of death before he/she can certify it. If he/she didn't see the deceased in the 28 days leading up to the death, or if he/she isn't satisfied about the cause of death, he/she must inform a coroner who will decide if a post mortem is necessary. If the deceased died as the result of an accident, or in violent or unexplained circumstances the coroner must be informed. There may be a delay in registering a death where a postmortem is carried out.</p> <p>The death is automatically registered where an inquest or postmortem is held at the request of the coroner. The coroner issues a certificate to the Registrar containing all the details to be registered.</p>		

		<p>The details required for registration of a death include:</p> <ul style="list-style-type: none"> • Date and place of death; • Place of birth of deceased; • Sex of deceased; • Forename(s), surname, birth surname and address of deceased; • Date of birth or age last birthday of deceased; • If deceased was less than 18 years of age on date of death, occupation(s) of his or her parent(s) or guardian(s); • Certificated cause of death, duration of illness and date of certificate; and • If an inquest in relation to the death or a post-mortem examination of the body of deceased was held, the forename, surname and place of business of the coroner concerned. 		
Health Information and Quality Authority	<p>The aim of the Authority is to promote safety and quality in the provision of health and personal social services for the benefit of the health and welfare of the public.</p> <p>HIQA is an independent body established under the Health Act 2007.</p>	<p>One of the Health Information and Quality Authority's main roles is to set national standards for the provision of health and social care services (except mental health services) in Ireland. These standards incorporate minimum standards for quality and safety for a given service and are developed based on evidence and best practice within Ireland and internationally.</p> <p>The Health Act 2007 also placed the Social Services Inspectorate within the Health Information and Quality Authority on a statutory basis as the Office of the Chief Inspector of Social Services. The Inspectorate currently inspects all HSE residential services for children in care, foster care and detention schools. When the 2007 Act is fully commenced, it will also inspect private children's residential services and</p>		

		<p>register all residential services.</p> <p>In addition to its work on children in care the Inspectorate's remit has been expanded to include the inspection and registration of residential services in the public, private and voluntary sectors for older people and people with a disability. The inspection of day facilities delivered by the HSE and special care units also falls within the remit of the Inspectorate.</p> <p>Like the other directorates of HIQA, the SSI may set standards and undertake investigations into systems errors or other serious incidents at the request of the Minister or on its own initiative.</p> <p>Under its health care quality function, HIQA aims to:</p> <ul style="list-style-type: none"> • Set standards for the delivery of care; • Implement a programme of quality assurance reviews for hospitals, primary care, general practice and the provision of ambulance services; • Monitor to ensure these standards are being met; • Provide programmes of accreditation for independent healthcare providers; and • Perform a National Hygiene Services Quality Review. <p>The Health Information and Quality Authority also has a health information function focussed on:</p> <ul style="list-style-type: none"> • Developing the standards for the collection and sharing of information across the health and social services; 		
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Health Research Board	<p>The Health Research supports and funds health research in Ireland. It provides funding, maintains health information systems and conducts research linked to national health priorities.</p> <p>The HRB's aim is to improve people's health, build health research capacity and make a</p>	<p>The specific functions of the Health Research Board include:</p> <ul style="list-style-type: none"> • to promote, assist, commission or conduct health research; • to promote, assist, commission or conduct such epidemiological research as may appropriately or necessarily be conducted at national level and to assist and support other health agencies in the promotion or conduct of such research; • to liaise and co-operate with other research bodies in Ireland or elsewhere in the promotion, commissioning or conduct of relevant research. 	<p>The child health epidemiology unit's current work programme includes the issues of congenital malformations, health inequalities in childhood and childhood accidents.</p> <p>The HRB has prepared a paper entitled <i>Absolute and socioeconomically stratified trends in birth rate and infant mortality</i></p>	

	<p>significant contribution to Ireland's knowledge economy.</p> <p>The Health Research Board was established under the Health (Corporate Bodies Act) 1961 by SI 279 of 1986.</p>	<p>The child health epidemiology unit in the HRB carries out research in pregnancy and child health.</p> <p>The alcohol and drug research unit is a multidisciplinary team of research and information specialists who provide objective reliable and comparable information on the alcohol and drug situation, its consequences and responses in Ireland.</p>	<p><i>rate in Ireland 1984 – 2005</i> and has also received funding from the OMCYA to undertake a mapping exercise called <i>Mapping Research on Children in Ireland</i>. In addition, the HRB is collaborating with Dublin City University in seeking European funding for a project examining the diversity and fragmentation of child health research in Europe.</p> <p>In November 2008, the Health Research Board published a paper on trends in drug-related deaths among drug users in Ireland from 1998-2005. The data was drawn from coroners' records, the Hospital In-Patient Enquiry Scheme, the Central Treatment List, the General Register Office, and the Family Support Network.</p>	
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<p>Health Service Executive</p>	<p>The Health Service Executive (HSE) is responsible for providing health and personal social services for everyone living in Ireland.</p> <p>The HSE was set up under the Health Act, 2004. Prior to its establishment, services were delivered by ten regional Health Boards, the Eastern Regional Health Authority and a number of other different agencies and organisations.</p>	<p>Primary, Continuing and Community Care</p> <p>Two processes that are especially relevant to the examination of child death are the Serious Incident Management Interim Policy and Procedures of March 2008 and the Case Management Review Policy under the Children First National Guidelines for the Protection and Welfare of Children, published in 1999.</p> <p>The purpose of the serious incident management policy is to ensure an urgent, appropriate and proportionate response to all serious incidents, defined as those which involved or are likely to cause extreme harm or is likely to become a matter of significant concern to service users, employees or the public.</p> <p>The responsibilities of the Serious Incident Management Team and the principles underpinning the process include:</p> <ul style="list-style-type: none"> • Ensuring that learning gained from the incident is shared throughout the system in order to prevent its repetition anywhere within the organisation; • Ensuring the necessary care is provided to the person or people affected; • Ensuring that the serious incident is appropriately managed in line with best practice, including the immediate reassignment of resources as appropriate; • Meeting statutory obligations, particularly as regards notification to relevant bodies; and • Accommodating independent audit and oversight. 		
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		<p>promote and protect the health of the population, with particular emphasis on reducing health inequalities. It acts as a unifying influence for the entire health service, and works to ensure that a Population Health approach supports and informs the planning and delivery of health services in Ireland.</p> <p>Expert Advisory Group on Children</p> <p>The purpose of the Expert Advisory Group is to bring the expertise of the clinical and health community as well as the voice of patients and clients into a more influential role within the HSE. Its specific functions include:</p> <ul style="list-style-type: none"> • Providing opportunities for front line professionals to use their knowledge and experience to influence operational policy development within the HSE; • Enabling recognised leaders to apply their expertise and, where possible, bring an international perspective to the health transformation programme; • Ensuring that the highest international standards of care and best practice are integral to the HSE planning process; and • Playing a key role in driving integration and promoting national consistency across the HSE's service delivery units. <p>The EAG is centrally located within the HSE as part of the Office of the CEO and the Chairperson meets with the CEO on a quarterly basis to discuss their work.</p> <p>Reports and recommendations developed by the EAG</p>		
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		<p>are firstly presented to the HSE's Strategic Planning and Reform Implementation (SPRI) Steering Group for initial consideration and review and are then presented to the CEO and Management Team for their consideration.</p> <p>Out of Hospital Cardiac Arrest Register</p> <p>An Out-of-Hospital Cardiac Arrest (OHCA) Register was established in November 2007 in accordance with the recommendations contained in "The Report of the Task Force on Sudden Cardiac Death" (2006).</p> <p>The purpose of the Register is to systematically gather information on the cardiac arrests that have occurred in the community that were attended by the Emergency Medical Services in which resuscitation was considered or attempted. The information obtained will enable:</p> <ul style="list-style-type: none"> • Investigation of the determinations of survival/death from OHCA; • Investigation of the effect of interventions on survival/death; and • Monitoring of survival from OHCA and subsequent quality of life. <p>It is envisaged that this will be a National Register. To date, information has been collected since November 2007 on cases in the North West. Reports are in the Utstein-style international standard format. National expansion is in progress, with the Midlands Area soon to be included.</p>		
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<p>Irish Human Rights Commission</p>	<p>To promote and protect human rights as defined both in international agreements to which Ireland is a party and in the Constitution.</p> <p>The Irish Human Rights Commission is an independent statutory body established under the Human Rights Commission Acts 2000 and 2001.</p>	<p>The functions of the Commission include the following:</p> <ul style="list-style-type: none"> • to keep under review the adequacy and effectiveness of law and practice in the State relating to the protection of human rights; • to make recommendations to Government on measures to strengthen, protect and uphold human rights in the State; • to conduct enquiries. For this purpose the Commission will have the means to obtain information, with recourse to the courts if necessary; • to offer its expertise in human rights law to the courts in suitable cases as amicus curiae, or friend of the court, in cases involving human rights issues; and • to take legal proceedings to vindicate human rights in the State or provide legal assistance to persons in this regard. 	<p>In September 2006, the IHRC published its Observations on the General Scheme of the Coroners Bill, 2005. One of the main issues it examined was the nature of the procedural obligation on the State under Article 2 of the European Convention on Human Rights to examine deaths and how that affects the coronial process in Ireland.</p>	
<p>National Sudden Infant Death Register</p>	<p>The purpose of the National SIDS Register is to obtain accurate, up-to-date information on sudden, unexpected and unexplained deaths in infants and young children in Ireland and to promote and support research into the</p>	<p>The major objectives of the Register are to:</p> <ul style="list-style-type: none"> • Identify and categorise all deaths in children from birth to 2 years of age in the Republic of Ireland; • Establish the incidence and causes of mortality from birth to 2 years of age; • Provide a National Register of all sudden, unexpected deaths for which cause of death is not identifiable following a post-mortem examination, in the infant population; • Collect comprehensive epidemiological data 	<p>The annual reports of the National Sudden Infant Death Register contain information on mortality figures; socio-demographic factors and SIDS; perinatal factors; and the impact of risk reduction guidelines.</p> <p>In addition to the</p>	<p>As regards future work of the SIDS register, its main objectives are:</p> <p>1) Expansion of the SIDS register reporting system to establish a Paediatric Mortality Register to compile an accurate database of all paediatric deaths in Ireland in order to monitor and develop a</p>

	<p>causes and prevention of sudden infant death syndrome.</p> <p>The National Sudden Infant Death Register was established by the Irish Sudden Infant Death Association in 1992. It is based in the Children's University Hospital in Temple Street and is funded by the Department of Health and Children.</p>	<p>on all the cases of sudden unexpected deaths in infancy (SUDI);</p> <ul style="list-style-type: none"> • Conduct a nation-wide case control study on all sudden, unexpected infant deaths; and • Conduct comprehensive analysis of the ongoing nation-wide SIDS case control study. <p>Each quarter, the Central Statistics Office (CSO), by special arrangement, issues to the Register details of deaths in children from birth to two years. Postmortem reports were also forwarded to the Register by the coroners.</p> <p>A system of notification ensures that the appropriate professionals report suspected cases of SIDS to the Register within 48 hours. For each reported case, the Register obtains the following information:</p> <ul style="list-style-type: none"> • Birth details; • Post-mortem report; • Medical certificate of the cause of death; • Central Statistics Office Form 102; • Medical histories (baby's, mother's and related family histories); • Medical report from the General Practitioner. <p>Parents are invited to participate in home interviews and a questionnaire is also used which collects the following information:</p> <ul style="list-style-type: none"> • socio-demographic data; • information relating to the pregnancy and birth; • infant's medical history; • environmental characteristics; • current child care and parenting practices, 	<p>annual reports, a number of information booklets have been produced such as those on reducing the risk of cot death and on the model of care for professionals who work in this area.</p> <p>The SIDS register has established links with the pathology department in the Children's University Hospital and via this link has conducted an assessment of the quality and thoroughness of post-mortems carried out in cases of sudden unexpected death in infancy in Ireland (SUDI). This work has highlighted the inconsistency and lack of standardisation in the current system of investigation of cases of SUDI, leading to potential misclassification of these deaths and the urgent necessity for a review of current</p>	<p>system for categorising paediatric deaths and the associated causes.</p> <p>2) Conduct further investigation of all sudden, unexplained and unexpected paediatric deaths by examining the epidemiological profiles in order to identify the risk factors and to develop prevention and intervention strategies (with particular emphasis on the investigation of deaths from accidents and injuries).</p> <p>3) Enhancement and analysis of the SIDS register's control database to examine characteristics relating to paediatric health in Ireland.</p> <p>4) Establish recommendations for the standardisation of a protocol for the investigation of all sudden, unexplained and unexpected paediatric deaths.</p>
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		<p>lifestyle practices, details of events in the 48 hours preceding the infant's death and in the immediate period afterwards.</p> <p>The information collected by the Register provides comprehensive data on all sudden, unexpected deaths amongst the infant population in Ireland for which a cause of death is not identifiable and enables the trend of SIDS in Ireland to be monitored over time.</p>	<p>protocols.</p> <p>The SIDS register has also noted that in recent years there has been a significant increase in the number of deaths diagnosed as SIDS which are older than 52 weeks of age (age range 53 weeks to 3 years), increasing from 3.8% of all SIDS cases in the period from 1994-2000 to 7.5% of cases in 2001-2007. There is currently no information in the scientific literature regarding cases of unexplained death in older infants, more commonly referred to as SUDC (sudden unexplained death in children). The register's ongoing monitoring system has allowed it to generate sufficient numbers with which to conduct further investigation and statistical analysis of these cases. Preliminary results indicate that these</p>	
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			deaths show some similarities as well as key differences from classic SIDS cases. This information will assist in correctly identifying cases of SUDI due to cardiac mechanisms, disorders of fatty acid metabolism and other causes which can be misdiagnosed as SIDS.	
National Suicide Research Foundation	The main aims of the NSRF are to produce a nationally and internationally recognised body of reliable knowledge from a multidisciplinary perspective on the risk and protective factors associated with suicidal behaviour; and to provide a solid evidence base for policy development and intervention in the prevention of suicide and the management of patients presenting with deliberate self	<p>The NSRF consists of a multi-disciplinary team with contributions from a broad range of disciplines, including epidemiology, psychology, psychiatry and biostatistics. The foundation has been recognised by the Department of Health and Children as an official research unit to contribute to the prevention of suicidal behaviour in Ireland.</p> <p>The NSRF has been recognised as the centre of excellence and the Irish focal point for information regarding suicide and its prevention by the World Health Organisation</p>	<p>In December 2007, a report entitled <i>Inquested deaths in Ireland: a study of routine data and recording procedures</i> was published. The report was prepared by the National Suicide Research Foundation and commissioned by the HSE National Office for Suicide Prevention.</p> <p>The study's aim was to analyse the data recorded on Form 104 documents for inquested deaths which took place in 2002. This was done with a view to seeing if the</p>	<p>The HSE National Office for Suicide Prevention has commissioned the NSRF to establish, on a pilot basis, a suicide support and information system (SSIS). The SSIS is being piloted in Cork and aims to facilitate and improve the provision of bereavement support to the families of persons whose deaths resulted in an inquest and to collect and report information relating to those who died, and in particular those who may have died by suicide.</p> <p>The SSIS involves collaboration with the three Cork coroners and with Console, the suicide</p>

	harm.		mechanism in place performed well in collecting socio-demographic and psychosocial data on the individuals in question, particularly those who died by suicide. The study also examined other facets of the death registration and cause of death determination system.	bereavement support organisation.
Office of the Director of Public Prosecutions	<p>The DPP is responsible for enforcing the criminal law in the courts on behalf of the people.</p> <p>The Office of the Director of Public Prosecutions was established by the Prosecution of Offences Act, 1974. Subject to the courts, the DPP is independent of all other bodies and institutions, including both the Government and the Garda Síochána.</p>	<p>The main functions of the DPP are to direct and supervise public prosecutions on indictment in the courts and to give general direction and advice to the Garda Síochána in relation to summary cases and specific direction in such cases where requested.</p> <p>The Chief Prosecution Solicitor provides a solicitor service, within the Office of the Director of Public Prosecutions, to act on behalf of the Director.</p>		

<p>Office of the Minister for Children and Youth Affairs</p>	<p>The role of the Office of the Minister for Children and Youth Affairs (OMCYA) is to improve the lives of children under the National Children's Strategy and bring greater coherence to policy-making for children.</p> <p>The OMCYA was set up by the Government in December 2005. The Minister for Children and Youth Affairs is a Minister of State at the Departments of Health and Children, Education and Science, and Justice, Equality and Law Reform. The Minister also attends Cabinet Meetings.</p>	<p>The co-location of units from three different Departments within the OMCYA is aimed at providing a joined-up Government approach to the development of policy and delivery of services for children and young people.</p> <p>The key role of the OMCYA is to support the Minister in:</p> <ul style="list-style-type: none"> • implementing the National Children's Strategy (2000 – 2010); • implementing the National Childcare Investment Programme (2006 – 2010); • developing policy and legislation on child welfare and child protection; • implementing the Children Act 2001; and • implementing Towards 2016 commitments in relation to children's services. 		
<p>Ombudsman for Children's Office</p>	<p>To promote the rights and welfare of children through its three main functions which are : participation and communication;</p>	<p>The functions of the OCO relevant to child death review are to:</p> <ul style="list-style-type: none"> • Advise the Minister for Health and Children or any other Minister of Governments on the development and coordination of policy 		

	<p>complaints and investigations; policy and research.</p> <p>The OCO is an independent statutory body established under the Ombudsman for Children Act, 2002.</p>	<p>relating to children;</p> <ul style="list-style-type: none"> • Encourage public bodies, schools and voluntary hospitals to develop policies, practices and procedures designed to promote the rights and welfare of children; • Give advice on any matter (including the probable effect on children of the implementation of any proposals for legislation) relating to the rights and welfare of children; • Investigate any action taken by/on behalf of a public body, school or voluntary hospital where the action may have adversely affected a child and may have been the result of maladministration. 		
<p>Royal College of Physicians of Ireland– Faculty of Paediatrics</p>	<p>The Royal College of Physicians of Ireland (RCPI) is Ireland’s largest postgraduate medical institution and its aim is to develop and maintain high professional standards in doctors who practice specialist medicine.</p> <p>The Faculty of Paediatrics was established in 1981 to advance the practice of paediatric medicine in Ireland and to promote</p>	<p>The Faculty of Paediatrics monitors neonatal mortality in Ireland on a non-statutory, voluntary basis. It seeks information on the primary causes of death among children aged 0-28 days from hospital units in which such deaths occur. The survey of neonatal deaths is based on a questionnaire and the response rate is nearly 100%.</p> <p>The results of the survey are drawn together on an annual basis for the purposes of presenting the findings to members of the College.</p>		

	education, training and research in paediatrics.			
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