ombudsman
do leanaí
for children

Child Death Review

The Case for a National Statutory Review Mechanism for the Deaths of Children in Ireland

April 2025

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Summary

About the Ombudsman for Children

The Ombudsman for Children's Office (OCO) is an independent human rights institution that promotes the rights and welfare of young people under 18 years of age living in Ireland. The OCO investigates complaints about services provided to children by public organisations. The service is free and independent.

Dedication

This report is dedicated to all the families in Ireland who experienced difficulties in trying to get answers after their children died.

Why this report?

For many years families whose children have died have come to the OCO looking for help to access information about what led to their child's death. The OCO knows about the struggles that some families face in trying to get answers when their child dies of unnatural causes such as suicide, homicide, drug overdoses, familicide or filicide, in accidents or suddenly from other causes.

Ireland does not have an independent statutory child death review mechanism, despite this issue being highlighted by the OCO and other stakeholders for many years. The National Review Panel (NRP) was established in August 2010 as part of the Implementation Plan associated with the Report of the Commission to Inquire into Child Abuse (Ryan Report) to review deaths and serious incidents of children in care. However, it did not and still does not have any statutory powers. In 2018, the Minister for Children, Equality, Disability, Integration and Youth intended to put it on a statutory footing. However, this has not happened. Though there is no comprehensive collection of data on the number of children that die of unnatural causes each year, the National Office of Clinical Audit (NOCA) indicates that 1,490 children and young people aged 18 and younger died between 2019 and 2023.

The recurring themes we hear are that the existing review mechanisms are ad-hoc, have no legislative or statutory basis and have no compellability or enforcement powers. Families have also told us that there are no consistent timelines for reviews which can further compound their grief, as they may be waiting years for answers.

For many families, they simply want lessons to be learned from the tragic death of their child to prevent other families experiencing their pain. However, through our work we have found that there is not even an agreed mechanism to share learnings derived from the various reviews which could help to prevent further deaths.

This is a key children's rights issue for the OCO, as the State has an obligation under Article 6 of the UN Convention on the Rights of the Child (UNCRC) to uphold children's right to life, survival and development by ensuring that deaths of children are reviewed with a view to identifying lessons to develop preventive strategies and ultimately save lives.

Experiences of families

Pseudonyms have been used unless requested. The report includes cases histories of six children who have died to highlight the experiences of families who have been in contact with the OCO in recent years.

Jake (his real name as requested by his family) died when he was 14 years of age from self-inflicted gun wounds while under the care of the Health Service Executive's (HSE's) Child and Adolescent Mental Health Services (CAMHS). Jake's parents spent the following decade looking for answers. They were eventually provided with the review report, over 10 years after Jake's death, that still did not provide them with answers.

Tori* was a child who suffered with scoliosis and severe epilepsy and had been on the waiting list for spinal fusion surgery for several years. She experienced multiple delays and was left on the waiting list until, eventually, in 2021, her parents were told by Children's Hospital Ireland that it was too late. Tori was now too high risk for spinal fusion surgery and efforts to manage her pain was the only intervention that was available to her. Tori tragically died the following year. She was nine years old. Tori died more than two years ago yet her parents are still without answers. No review has been conducted and they have had no response to their questions.

Bobby* was a 15-year-old teenager who died by suicide in 2021. Bobby had been known to CAMHS and to Tusla's Child Protection and Welfare Services for several years. The NRP conducted a review, which did involve the family, and after two years furnished a report on the death. Bobby's parents were not given a copy of the report and were only allowed to read the NRP report once while in the presence of Tusla staff. The CAMHS team had conducted an internal review, but Bobby's parents were told that they would not be provided with feedback on this review, or, as with the NRP, a copy of it.

Paul* died by suicide in 2021, aged 16 years. In March 2023, the OCO received a complaint on behalf of Paul. As Paul was in state care at the time of his death, his case was reviewed internally by Tulsa and referred to the NRP. Paul's mother is still anxiously awaiting the outcome of the NRP review nearly four years after his death.

Aoife (her real name as requested by her family) was 14 years old when she tragically died in 2015 following a drowning incident whilst on a residential trip with a youth service during Storm Desmond. Aoife's mother told us that she received limited communication from the youth service following Aoife's death and no acknowledgement or apology. Aoife's mother was eventually forced to take a civil case until finally, more than eight years after Aoife's death, the youth service admitted liability. Again, via the legal route in 2025 Aoife's family received a copy of the report commissioned by the organisation in 2020, as well as an offer to meet to apologise for the tragic loss of Aoife. Aoife's family remain unhappy with the report.

Baby James* and his twin were born in June 2022. James was born with Down Syndrome and a heart defect but otherwise was a healthy little boy. Unfortunately, in the days following his birth his health deteriorated and sadly he died three months later. His mother made numerous complaints to the HSE. However, she has been unable to get the answers around the circumstances that led to James' death.

Watch our video where two parents share their experiences here.

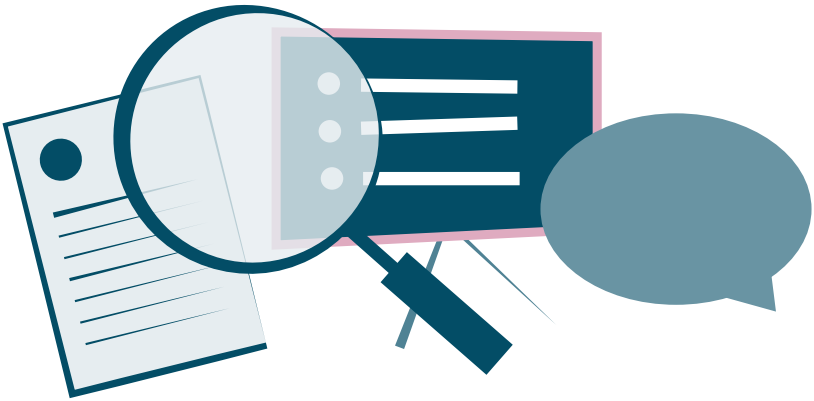
Children's rights standards

Child death reviews must be viewed in the context of children's right to life, survival and development under Article 6 of the UNCRC.

In its review of how countries implement the UNCRC, the Committee on the Rights of the Child has urged countries to establish statutory, automatic, independent, inter-agency child death reviews with the aim of strengthening preventative measures.

The European Court of Human Rights jurisprudence on the right to life under Article 2 of the European Convention on Human Rights (ECHR), particularly the procedural duty to investigate certain deaths, is also relevant to Ireland's obligations to establish a child death review mechanism.

To align with the spirit of the ECHR and UNCRC, Ireland must consider expanding death review practices by adopting a more preventive approach.



International practices

The OCO surveyed members of the European Network of Ombudspersons for Children (ENOC) and conducted a desk-based review of literature on mechanisms in Europe and in other jurisdictions. Of the 44 ENOC members, 12 responded to the OCO's survey and only 3 (England, Wales and Norway) reported that there is a child death review mechanism in place. The report provides information on the responses received from ENOC members as well as on the status of mechanisms in Australia, New Zealand and Scotland obtained from desk-based research.

The experiences of other jurisdictions demonstrate the critical importance of establishing a statutory, comprehensive child death review system in Ireland. By learning from the systems in countries like England and New Zealand, where reviews are broad in scope and supported by statutory powers, Ireland can ensure that all child deaths are examined for preventable factors.

- **Australia** - statutory reviews in some States
- **England** - statutory review in place
- **New Zealand** - statutory review in place
- **Norway** - voluntary model in place
- **Scotland** - review, but not full statutory powers
- **Wales** - review, but no statutory footing
- **Ireland** - no statutory review in place but Programme for Government commitment
- **Northern Ireland** - no delivery on legislation

Themes from stakeholder meetings

The information gathered from research conducted and engagement with government departments and public bodies show that there is a strong consensus that current mechanisms are not fit for purpose. The absence of a statutory basis for reviews creates a situation where there is a lack of accountability and independence. Challenges for the effective operation were also identified and include:

- A lack of sufficient and reliable data on child deaths in Ireland.
- A lack of interagency cooperation and data sharing.
- No shared understanding of requirement or obligations in relation to review processes.
- Limited scope for family support or involvement of families in reviews.

Conclusion

In response to our engagement on this issue the new Programme for Government 2025-2030 includes a commitment to establish a statutory child death review mechanism. This is very much to be welcomed.

This report identifies serious gaps in current structures and the impact this has on bereaved families and children's rights. In line with the State's obligations under the UNCRC, the Irish Government has a duty to respect, protect and fulfil children's right to life, survival and development. A child death review mechanism is a key part of fulfilling this right by ensuring that deaths of children are are reviewed to identify lessons to inform preventative strategies. It is not acceptable that, when a child unexpectedly passes away, Ireland currently does not have a consistent, and rights-based review process that is completed in a timely and transparent manner and involves the families at all stages.

Summary Recommendations

Read in full

Planning for the future	
1.	A statutory review mechanism for child deaths should be set up in Ireland. This should be informed by the views of families that have experienced reviews under the current system.
2.	The lead Department should set up a cross departmental working group without delay to progress the introduction of the child death review mechanism.
Interim measures pending introduction of a statutory mechanism	
3.	The interdepartmental working group should immediately develop interim national guidance on best practice in conducting child death reviews.
4.	Services must actively engage with and provide a liaison person for the families of children who have died unexpectedly and facilitate them to access any support they may need.
5.	The DCEDIY must immediately engage with the Ombudsman for Children's Office to find a resolution to limitations with the NRP in accessing information, engaging with other agencies and fundamental governance pending the establishment of the new statutory child death review mechanism.
6.	Tusla must take steps to be assured that all current and pending child deaths have been reviewed in accordance with their policies and notified to the NRP. Reports from the NRP should be shared should be shared with families and every effort must be made to remove barriers.

7.	Tusla should develop a framework to support the implementation of recommendations from NRP reports and that any findings and recommendations are shared with families. The Quality and Regulation Directorate should ensure the NRP receivesall necessary information within specific timelines
8.	The HSE must ensure that all active and pending child death reviews are completed in accordance with their policies, and all outcomes shared with families.
9.	The HSE should immediately address the current shortcomings in how they review unexpected deaths of children known to their services.
10.	The Department of Education should issue procedures for schools to follow upon the death of a child in circumstances where there may be learning for the school. These procedures should be informed by experiences of families.
11.	All child death review reports should be submitted to the relevant Government Department, and shared with other Departments if a recommendation is relevant. A joint working group should be established to analyse these reports to identify areas for improvement.
12.	Relevant Government Departments and public bodies should engage with the Data Protection Commission to ensure that all necessary information can be shared and agree a mechanism to address any barriers
13.	The Departments of Social Protection and Health should establish a national child death register without delay. The relevant sections of the Civil Registration (Electronic Registration) Act 2024 should be commenced to ensure that all deaths of children and young people are notified to the new central national database.

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