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northern ireland commissioner
for children and young people

patricia lewsley
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Mr George Russell
DHSSPS
Standards and Guidelines Unit
Room C3.21
Castle Buildings
Stormont Estate
Belfast
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11 March 2011.

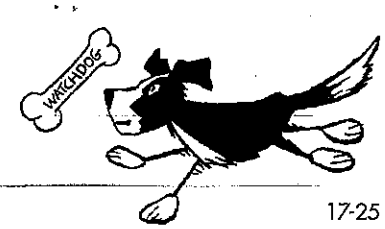
Dear Mr Russell

Consultation on the Review of Death Certification in Northern Ireland

We welcome the opportunity to provide comment on the Review of Death Certification. This response is not intended to be comprehensive and does not focus on the detail of options suggested but instead highlights key issues in relation to the deaths of children and young people.

NICCY is supportive of developments to improve the death certification process in Northern Ireland and hopes that the Review will build on the findings of research and inquiries, such as, the Luce Review, the Shipman Inquiry and the Confidential Enquiry into Maternal and Child Health (CEMACH). We remain disappointed that following consultation in 2006, a Regional Multi-Agency Procedure for Sudden or Unexpected Child Deaths has not been implemented across Northern Ireland and are of the view that this should be urgently addressed. Death certification processes must take account of and be responsive to the Procedure as it is developed and implemented.

The right to life is enshrined in the 1998 Human Rights Act and the United Nations Convention on the Rights of the Child requires government to take all measures to support children's right to life and development and protect them from violence, abuse and neglect. In meeting these obligations, government must ensure there is appropriate oversight and investigation of child deaths, including monitoring the extent of violence and abuse against children and ensuring that evidence based prevention programmes are developed.



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The death certification process which the tragic death of any child or young person is subject to must therefore be robust in ensuring that investigation, where this is appropriate, is carried out and that learning which can inform prevention and public health strategies is maximised. This process must, of course, be conducted sensitively, having regard to needs of those who have been bereaved and seeking to minimise any further distress that may be caused.

The death certification process has a central role in ensuring that accurate information is available to allow thorough statistical analysis of the deaths of those under 18 years of age. This includes identifying trends in child deaths, deaths where abuse and neglect is a factor and deaths where there have been preventable factors. We note that the 2008 CEMACH report highlights the need to improve death certification information and working between children's services bodies, such as Local Safeguarding Children Boards in England and Wales and coronial services. It is important that all work in this area takes cognisance of the duties of the Safeguarding Board for Northern Ireland in relation to child deaths and that the coronial service and others develop an effective working relationship with the Board when it is established.

The CEMACH report also sets out the importance of ensuring accurate and root cause of death information is recorded and that incorrect classification and coding of deaths which will impact on subsequent analysis of data is reduced. The importance of multi agency working and information sharing to understand causes of deaths and minimise misidentification or misclassification was also noted in the 2003 Luce Review.

While the consultation proposals outlined in option one strengthen local arrangements we note that these do not replicate the measures in other UK jurisdictions and would highlight the importance of a UK wide approach in certifying and recording information relating to deaths. Again, this is important to ensure that effective learning takes place and informs strategies for the reduction and prevention of child deaths. If option 1 is adopted this should be as a transitional measure towards the introduction of a more comprehensive system. If option 2 is taken forward we note that this must be adequately resourced with a clear transition process in place to ensure it can properly fulfil its functions.

Please do not hesitate to contact me if you require any further information.

Yours sincerely,

Alex Tennant

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Head of Policy and Research