



Equality and Human Rights Screening Template

The Safeguarding Board NI is required to address the 4 questions below in relation to all its policies. This template sets out a proforma to document consideration of each question.

What is the likely impact on equality of opportunity for those affected by this policy, for each of the Section 75 equality categories? (minor/major/none)

Are there opportunities to better promote equality of opportunity for people within the Section 75 equality categories?

To what extent is the policy likely to impact on good relations between people of a different religious belief, political opinion or racial group? (minor/major/none)

Are there opportunities to better promote good relations between people of a different religious belief, political opinion or racial group?

SCREENING TEMPLATE

See [Guidance Notes](#) for further information on the 'why' 'what' 'when', and 'who' in relation to screening, for background information on the relevant legislation and for help in answering the questions on this template.

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Child Death Review – Proposals for Development of a child death review process

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

The core purpose of the NI Child Death Overview Panel (CDOP) will be to collect, analyse and review information on the deaths of all children with a view to:

- Highlight matters of concern affecting the safety and welfare of children in Northern Ireland;
- Identify any wider public health or safety concerns arising from a particular death or pattern of deaths in Northern Ireland in order to inform regional learning, training, service provision and support development of policy aimed at a reduction in childhood mortality and;
- Identify any death which requires a case management review.

CDOP NI will review the deaths of **all children** (from birth up to 18th birthday) resident or temporarily resident in Northern Ireland, regardless of nationality or

immigration status. Stillborn babies are currently not included under the CDOP proposal.¹

The CDOP process will not focus on finding fault with individual practice but rather focus on prevention through the identification of learning through review.

Governance processes related to safety and quality of services will remain the responsibility of individual service providers and professional bodies.

The CDOP does not have an investigative role. CDOP will not replace existing internal child death policies and procedures of the SBNI or other partner agencies including; Case Management Review (CMR) processes, Sudden or Unexpected Infant Death (SUDI) processes, investigation of Serious Adverse Incidents (SAIs) or Critical Incidents. CDOP will collate and build on the information provided from these processes placing them in the context of a 'joined up' multiagency approach.

SBNI and partner organisations will work together to promote and facilitate multidisciplinary and interagency working to achieve consistency of approach in reporting, investigation and review of child deaths to assist in regional learning and reduce the risk of future preventable deaths of children in Northern Ireland.

The responsibility for determining the cause of death rests with the coroner or the doctor who completes and signs the medical death certificate.

All child deaths will be reviewed by CDOP. However, CDOP reports and recommendations will not identify or relate to individual deaths in line with Northern Ireland policy on confidentiality and data protection.

Currently there is no umbrella system which collects a standardised dataset for all child deaths in Northern Ireland.

Information is collected via by a number of different notification and data collection processes with some overlap and duplication

Regional and National work aimed at understanding different causes of child death, has led to the development of a range of data collection methods and processes depending on the population group under consideration.

Variation in practice across organisations exists in the processes for notification

¹ Understanding and prevention of Stillbirth is a key focus of the Clinical Outcome Review for Maternal, Newborn and Infant Programme which is commissioned by Health Care Quality Improvement Partnership (HQIP) on behalf of all 4 UK countries.

The implications of a recent determination (Sept 2013) by the Court of Appeal on the Coroner's role in investigation of Stillbirth are currently under consideration.

of child death to support service response, investigation and on-going service delivery related to child death.

Robust interagency working policies will be required for a CDOP to fulfil its obligations in the identification of learning from preventable child deaths. A framework to support liaison and effective cross agency working during the response to and investigation of unexpected death is provided by a Memorandum of Understanding developed jointly between Health and Social Care, Health and Safety, Police and Courts services

In Northern Ireland the response to child death is guided by a series of regional, professional and organisational policies and, many of which are also embedded in statute. Currently there is no overarching cross agency framework for the investigation and review of child death in Northern Ireland. There is no regionally implemented policy on the response to and investigation of sudden unexpected death in infancy or childhood.

All professionals responding to a child death are required to work in accordance with their individual codes of practice, statutory duties and obligations.

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

- Bereaved Parents and Families
- Public Health Agency (PHA);
- Health and Social Care Board (HSCB)
- The Coroner's Office;
- State Pathologist Department;
- Children's social care;
- Health & Social Care Trusts
- Education
- Primary Care
- Voluntary Sector – National Children's Bureau, NSPCC, SANDS
- Police Service for Northern Ireland;

- Northern Ireland Ambulance Service (NIAS);
- Northern Ireland Fire and Rescue Service (NIFRS)
- Children's Commissioner
- DHSSPSNI
- Professional Bodies – RCPCH, RCN, RCM
- User Groups
- Privacy Advisory Committee
- Patient Client Council
- Regulation Quality Improvement Authority (RQIA) for NI
- Health and Safety Executive (HSENI)
- Courts Services

1.4 Other policies or decisions with a bearing on this policy or decision

- **what are they?**
- **who owns them?**
 - Serious Adverse Incident – owned by the Health and Social Care Board / Public Health Agency
 - memorandum of understanding between DHSSPS, PSNI, Corner's office and HSENI which outlines interagency working in the investigation of sudden unexpected deaths (of all ages).
 - Neonatal reviews owned by PHA to link to CDOP
 - Safeguarding Board Regulations – CDOP requires a legislative basis before proceeding

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data gathering

What information did you use to inform this equality screening? For example previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

Information provided by the PHA in the review of child deaths in under 18 year old in Northern Ireland Jan 2013 (updated May 2013)

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

Category	<i>What is the makeup of the affected group? (%) Are there any issues or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?</i>
Gender	<p>General Population Data NI Population Statistics (2011 Census Data) Population of Northern Ireland in 2011 was 1,810,863 Male = 49% Female = 51%</p> <p>Children (Aged 0-17) : 430,763 (24%) Adults (Aged 18-64) : 1,116,380 (62%) Older People: (Aged 65+): 263,720 (14%)</p> <p>Northern Ireland has a higher level of deaths of children than other regions in the United Kingdom particularly in the perinatal period. In children under one year the cause of death if dominated by perinatal conditions (627 deaths) or congenital abnormalities (385) with 'undefined causes' as the third most common code used.</p> <p>Over the last decade some two hundred children under eighteen died each year in Northern Ireland. In every age group male</p>

	<p>deaths outnumbered females with the highest imbalance in the 15-17 years age group. 2011 Figures highlight the number of deaths in males under were 1,220 and females 852 (PHA Health Intelligence Briefing – Deaths in under 18s May 13).</p>
Age	<p>NI Population Statistics Children Less than 1 = 25,250 (6%) 1 - 4 = 99,132 (23%) 5 - 11 = 156,740 (36%) 12 – 15 = 98,201 (23%) 16-17 = 51,440 (12.%)</p> <p>Total children (0 – 17) = 430,763 (24% of the population)</p> <p>Over the last decade some two hundred children under eighteen died each year in Northern Ireland. In every age group male deaths outnumbered females with the highest imbalance in the 15-17 years age group.</p> <p>In 2011 the breakdown by age was as follows:</p> <p>Age 0 = 1,230 deaths (684 Male, 546 Female) Age 1 – 4 = 210 deaths(130 Male, 80 Female) Age 5 – 9 = 141 deaths (81 Male, 60 Female) Age 10 – 14 = 177 deaths (109 Male, 68 Female) Age 15 – 17 = 314 deaths (216 Male, 98 Female) (PHA Health Intelligence Briefing – Deaths in under 18s May 13).</p> <p>UK Statistics Over 5,000 children under the age of 19 years died in the UK, in 2012. 1.6% of deaths occurred before the age of one year and 18% between the ages of 15 and 19 years. Mortality rates are lower in early childhood from one to four years, and are lowest for five to nine year olds and the early adolescents, 10 to 14 year olds (why children die: deaths in infants, children and young people in the UK Royal College of Paediatrics and Child Health, National Children’s Bureau May 2014).</p>
Religion	<p>NI Population Statistics (2011 Census Data)</p> <p>Bringing together the information on Religion and Religion Brought up in, 45% of the population were either Catholic or brought up as</p>

	<p>Catholic, while 48% belonged to or were brought up in Protestant, Other Christian or Christian-related denominations. A further 0.9% belonged to or had been brought up in Other Religions and Philosophies, while 5.6% neither belonged to, nor had been brought up in, a religion.</p>
Political Opinion	N/A
Marital Status	N/A
Dependent Status	<p>NI Population Statistics</p> <p>Out of a total of 703,275 households the following break-down was found on Census Day 2011:</p> <p>Married or in a registered same-sex civil partnership: With no children = 10.28% With dependent children = 19.72% Children non-dependent = 8.31%</p> <p>Co-habiting couple: With no children = 2.92% With dependent children = 2.3% All children non-dependent = 0.26%</p> <p>Lone Parent: With dependent children = 9.13% All children non-dependent = 5.12%</p> <p>Other household types: With dependent children = 2.7%</p> <p>In summary, in 2011, one-third (34%) of households contained dependent children, down from 36% in 2001.</p> <p>A dependent child is a person in a household aged 0-15 (whether or not in a family) or a person aged 16-18 who is a full-time student and in a family with parent(s).</p> <p>Breakdown of child deaths in this group is not known</p>
Disability	<p>NI Population Statistics</p> <p>Just over one in five of the usually resident population (21%) had a long-term health problem or disability which limited their day-to-day</p>

	<p>activities. In response to a similar question in 2001, 20% had a long term illness, health problem or disability which limited their daily activities or the work they can do.</p> <p>In children under one year majority of deaths dominated by perinatal conditions or congenital abnormalities. For children aged 1-4 the majority of deaths over the last 10 years were classified as Nervous system disorders (15%) which primarily related to cerebral palsy and hydrocephalus.</p>
Ethnicity	Not known
Sexual Orientation	Not known

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	Needs and Experiences
Gender	<p>It is not known why more deaths occur in males than females however this is not unique to Northern Ireland and similar picture occurs in the rest of the UK.</p> <p>A report in the US indicates that 41 percent of transgender people have attempted to commit suicide (US National Center for Transgender Equality and the National Gay and Lesbian Task Force, October 2010). Some transgender people feel clear about their gender identity from a young age.</p>
Age	<p>Causes of death vary by age group. After year one road traffic accidents and cancers are the most common causes. In older teenagers suicide and self-inflicted injury accounts for one in five deaths. Even allowing for the higher numbers of children in the more deprived areas there is a disproportionate number of deaths from the more deprived areas. The most deprived areas have a two thirds higher death rate in children under fifteen than the least deprived areas. It is likely that the inclusion of 15-17 years data would increase the gradient given the numbers and distribution of deaths in this age group. Overall in the period 2002-2011 South Eastern and Belfast had the highest rates of</p>

childhood deaths however this is very prone to variation per age group and time period. In children under one year cause of death is dominated by perinatal conditions or congenital abnormalities with 'undefined causes' as the third most common code. For children aged 1-4 there are a multiplicity of causes. Nervous system disorders primarily relates to cerebral palsy and hydrocephalus representing the highest category for child deaths in this age group. For children aged 5-9 years cancer and road traffic accidents now overtake nervous systems disorders as the most common causes of death. The most common cancers being remain brain cancer and leukaemia. For children 10-14 years road traffic accidents accounted for almost one quarter of deaths. Cancers drops back to the second most common cause. 'Other accidents' remains about 8-10% irrespective of age groups. There are now instances classed as suicide or self-inflicted injury. For children 15-17 years the numbers of deaths begin to increase and road traffic accidents and suicide and self-inflicted injury now represent more than 50% of deaths. There are a small number of mental disorders which refer to children identified with behaviour disorders related to solvent miss-use, psychoactive drug use or developmental disorders.

UK Picture

The highest death rates are in infancy and adolescence and the main cause of death vary by age group too, so to understand better and to think about how to prevent deaths from happening, it is important to look in more detail at narrower age groups. Furthermore, specific causes merit special consideration. For example, injuries, many of which are highly amenable to prevention, cause a substantial proportion of deaths. This tells us we could do better.

From one to four years the three most common causes of death are injuries and poisoning (external causes), cancer and congenital causes. There is evidence that preterm birth impacts not only on infant mortality but has appreciable effects on mortality during later childhood. In later childhood, from five to nine years old, the most common causes of death in the UK are injuries and poisoning, cancer and congenital causes. The proportion of children who died with a chronic condition increased significantly in England in the decade to 2010, however no such increase was found in Scotland or Wales.

	<p>After infancy, late adolescence is the second riskiest time for death under the age of 19 years. Whilst we have made huge advances in reducing mortality among infants and young children in the past 40 years, death rates amongst adolescents have fallen little across the same period. As a result mortality amongst 15 to 19 year olds is still higher than any time in early childhood after the first 12 months. From 10 to 19 years, the most common causes of death in the UK are injuries and poisoning and cancer. In early adolescence, from 10 to 14 years, these two categories contribute to around half of all deaths. The proportion of young adolescents in England who dies with one or more chronic conditions increased significantly between 2000 and 2010.</p> <p>In later adolescence, from 15 to 19 years, the causes of mortality are largely split between injuries and poisoning (and risks and behaviours), and non-communicable diseases; the most common cause is cancer. Over half of deaths in this age group can be attributed to external causes, including injuries and poisoning, risks and behaviours, with major causes being transport injuries; intentional injuries, including suicide and violent deaths; and non-intentional injuries, such as drowning or fires. Injuries are a common cause of death among adolescents who have chronic conditions including mental and behavioural disorders, accounting for approximately a third of deaths among 15 to 18 year olds in England who had a long term condition.</p> <p>Adolescence is a time of increasing freedom and personal autonomy, and exploratory behaviours, often involving risk, are part of normal development. However, injuries are non-random preventable events, amenable to public health and public policy initiatives. This is true for suicide and violent deaths as well as other injuries. Unfortunately there is evidence from a national case audit of children's deaths suggesting that many children who died from suicide had not had any contact with mental health services, and there were reportedly problems with services failing to follow up patients who had been referred but not turned up for appointment.</p> <p>(why children die: deaths in infants, children and young people in the UK Royal College of Paediatrics and Child Health, National Children's Bureau May 2014).</p>
Religion	Not known

Political Opinion	Not Known																				
Marital Status	<p>Maternal unmarried status is associated with an increased risk of low birth weight, pre-term birth and small for gestational age (SGA) births (Shah, Zao and Ali, 2011). (Restricted growth is an important risk factor for perinatal mortality in normally formed babies.)</p> <p>For babies born in 2011, the percentage of pre-term births was highest for births that were solely registered by the mother (9.1%) and those registered jointly by parents living at different addresses (8.2%). In comparison, 7.0% births registered by unmarried parents living at the same address and 6.7% of births registered by married parents were born pre-term. (Office of National Statistics report: Gestation-specific Infant Mortality in England and Wales, 2011)</p>																				
Dependent Status	Not known																				
Disability	<p>Nervous system disorders, primarily cerebral palsy and hydrocephalus, are the highest causes of death in 1-4 age group. Cancer is one of the top causes of death in children aged 5-9, and the second most common cause in the 10-14 age group.</p> <p>For children aged 15-17 years, more than 50% of deaths are caused by road traffic accidents and suicide or self-inflicted injury. Research in the UK has shown that many people who die by suicide have a mental illness, most commonly depression.</p>																				
Ethnicity	<p>The All Ireland Traveller Health Study 2010 showed that infant mortality in the travelling community is 3.6 times higher than the settled community (based on Republic of Ireland results). The report further indicates the following (figures for 2008 only):</p> <table border="1" data-bbox="354 1563 1077 1957"> <thead> <tr> <th>Age group (Years)</th> <th>Traveller Deaths (Number)</th> <th>Traveller Deaths (%)</th> <th>General Population Deaths (%)</th> </tr> </thead> <tbody> <tr> <td>< 1</td> <td>12</td> <td>6.59</td> <td>1.03</td> </tr> <tr> <td>1 - 4</td> <td>0</td> <td>0</td> <td>0.16</td> </tr> <tr> <td>5 - 14</td> <td>3</td> <td>1.65</td> <td>0.26</td> </tr> <tr> <td>15 - 24</td> <td>12</td> <td>6.59</td> <td>1.18</td> </tr> </tbody> </table> <p>Mortality rates are higher in all age categories apart from 1 -4.</p>	Age group (Years)	Traveller Deaths (Number)	Traveller Deaths (%)	General Population Deaths (%)	< 1	12	6.59	1.03	1 - 4	0	0	0.16	5 - 14	3	1.65	0.26	15 - 24	12	6.59	1.18
Age group (Years)	Traveller Deaths (Number)	Traveller Deaths (%)	General Population Deaths (%)																		
< 1	12	6.59	1.03																		
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5 - 14	3	1.65	0.26																		
15 - 24	12	6.59	1.18																		

An Office of National Statistics report: Gestation-specific Infant Mortality in England and Wales, 2011 reports that Infant mortality rates were highest in the Pakistani (8.5 deaths per 1,000 live births), Black Caribbean (7.4 deaths per 1,000 live births) and Black African (6.8 deaths per 1,000 live births) groups. They were lowest in the White Other and White British groups (3.1 and 3.7 deaths per 1,000 live births respectively).

UK Picture

Infant mortality is an indicator of the overall health status of a population. Infant deaths are also a reflection of the quality of midwifery, obstetric and new-born care. Maternal health and the development of the foetus and baby are strongly influenced by the social, economic and environmental circumstances that surround them. These factors can also affect their chances of death. Infant mortality for England and Wales and for the UK as a whole has been declining steadily for many years, with occasional exceptions. Because rates for Northern Ireland and Scotland are based on smaller numbers, they fluctuate from year to year, although rates for Scotland tend to be below those for England and Wales and those for Northern Ireland tend to be higher. As in most high-income countries, the majority of infant deaths occur in the neonatal period and in the countries of the UK they account for around 70% of infant deaths, except in Northern Ireland where they account for nearly 80%. Just over three-quarters of neonatal deaths occur in the early neonatal period, although the proportion is higher, over four fifths in Northern Ireland. Not surprisingly, neonatal mortality rates show the same downward trends as infant mortality, although the higher rates in Northern Ireland and the lower rates in Scotland are more marked. Looking at the European picture Nordic countries, Sweden, Finland, and Iceland, are among those with the lowest neonatal mortality rates. Although stillbirths are not part of this proposal it is important to highlight that the UK appears to have the highest stillbirth rate of 12 high-income countries. The UK rate is 3.8 stillbirths per 1,000 births, contrasted with 2.2 per 1,000 in Norway. Exploring differences between countries helps point towards possible actions that could be taken at practice or policy level. Important modifiable factors contributing to risk of stillbirth include smoking in pregnancy, and overweight or obesity and social inequalities. Unexplained deaths in infancy are another important problem

	<p>that requires urgent attention. In 2010 there were 254 unexplained infant deaths in England and Wales. 80% of unexplained deaths happen in the post-natal period, they are more likely among socially disadvantaged families, among those who smoke and mothers who are very young. Infant mortality has a particular social relevance, as it is widely used as a marker of the overall health status of a population. As such, the UK has concern. In 1970 the infant mortality rate in the UK was similar to the median rate for comparable countries. However, trend data over three decades shows that UK infant mortality is now above the 75th centile among European countries. The causes, associations and risk factors for infant mortality highlight that social disadvantage is important, this and many other problems contributing to deaths in early life are amenable to interventions in practice and policy.</p> <p>(why children die: deaths in infants, children and young people in the UK Royal College of Paediatrics and Child Health, National Children’s Bureau May 2014).</p>
Sexual Orientation	<p>Young LGB people are 3 times more likely to attempt suicide than their heterosexual counterparts (SHOUT, The needs of young people in Northern Ireland who identify as lesbian, gay, bisexual and or transgender; Youth Net, December 2003).</p>

2.4 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example; disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

As per 2.3.

2.5 Making Changes

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

<i>In developing the policy or decision what did you do or change to address the equality issues you identified?</i>	<i>What do you intend to do in future to address the equality issues you identified?</i>
<p>Understanding why children die, and taking action to prevent deaths in childhood is the purpose of the child death overview process. Since children’s lives, their health, illnesses and chances of deaths are influenced by a wider variety of factors, it is important to understand where the CDOP process should focus its attention. Avoidable mortality in the adult population has been defined as premature and unnecessary deaths but since all childhood deaths are premature by definition, are they all avoidable. Setting aside biological factors that operate for all children regardless of which country they live in, there are three broad domains to consider, the role of government and civil society; health systems and organisations; healthcare and public health services.</p> <p>The CDOP process will identify trends in childhood deaths and lead to learning and potential public health messages.</p> <p>The purpose of the Child Death Overview panel will be to collect, analyse and review information on the deaths of all children with a view to :</p> <ul style="list-style-type: none"> • Reduce the number of preventable child deaths in NI 	<p>Through the CDOP process, SBNI will identify any particular trends/themes in relation to childhood deaths and work with the PHA and other partners in developing key learning and public health messages to address issues that arise.</p> <p>CDOP cannot address these inequalities. The key principles are:</p> <p>The CDOP process will not focus on finding fault with individual practice but rather focus on prevention through the identification of learning though review.</p> <p>Governance processes related to safety and quality of services will remain the responsibility of individual service providers and professional bodies.</p> <p>The CDOP does not have an investigative role. CDOP will not replace existing internal child death policies and procedures of the SBNI or other partner agencies including; Case Management Review (CMR) processes, Sudden or Unexpected Infant Death (SUDI) processes, investigation of Serious Adverse Incidents (SAIs) or Critical Incidents. CDOP will collate and build on the information provided from these processes placing them in the context</p>

<ul style="list-style-type: none"> • Highlight matters of concern affecting the safety and welfare of children in NI; • Identify any wider public health or safety concerns arising from a particular death or pattern of deaths in Northern Ireland in order to inform regional learning, training, service provision and support development of policy aimed at a reduction in childhood mortality and; • Identify any death which requires a case management review. <p>Northern Ireland could in theory change the same mortality rate as countries where children have a greater chance of surviving but how we might go about this is not clear. There is no single cause for the disparities between countries and equally there are no simple solutions. Child mortality is highly complex; however the CDOP can make policy and practice recommendations to help achieve this.</p> <p>The inequalities identified include:</p> <ul style="list-style-type: none"> • Infant deaths – the highest mortality rates occur in the first year of life, therefore has the greatest scope for improvement • Acute illness – it is important that measure are taken to improve recognition and management of serious illness across the health service 	<p>of a ‘joined up’ multiagency approach.</p> <p>SBNI and partner organisations will work together to promote and facilitate multidisciplinary and interagency working to achieve consistency of approach in reporting, investigation and review of child deaths to assist in regional learning and reduce the risk of future preventable deaths of children in Northern Ireland.</p> <p>The responsibility for determining the cause of death rests with the coroner or the doctor who completes and signs the medical death certificate.</p> <p>All child deaths will be reviewed by CDOP. Each death will be anonymised and CDOP reports and recommendations will not identify or relate to individual deaths in line with Northern Ireland policy on confidentiality and data protection.</p> <p>While CDOP will review all deaths its role will not extend to working directly with bereaved families.</p> <p>CDOP will review the deaths of all children (from birth up to 18th birthday) resident or temporarily resident in Northern Ireland, regardless of nationality or immigration status.</p> <p>The CDOP process will also include the death of any child here visiting and may, as far as possible, be implemented in respect of deaths of children who are normally resident in Northern Ireland but who die during a stay elsewhere e.g. on holiday abroad.</p>
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<ul style="list-style-type: none"> • Injuries and poisoning – these causes of death are highly preventable, with effective policies for most common causes of death from accidents and injuries. However, legislation, implementation and enforcement are crucial. A concerted and sustained policy response to self-harm, violence and suicide is required. • The number of children with chronic diseases are increasing and there is more evidence of comparatively poor outcomes for example in asthma, epilepsy and diabetes. Moreover the UK has failed to match the health gains for children and young people with chronic conditions made by other comparable countries, with particular concern regarding non communicable disease mortality in young people. Policy responses are needed from public health and healthcare. • Role of government – children’s lives can be protected through supportive social policy and redistributive fiscal measures. The messages are stark. Poverty kills children. Equity saves lives. Social protection is required. Children in Northern Ireland need the same standards of health, wellbeing and chances to fulfil their potential in life as our European counterparts. <p>As part of the development proposals of the Child Death Overview Panel, the</p>	<p>This may involve liaison with relevant foreign authorities.</p> <p>The CDOP process will be underpinned by a culture of continuous and supportive learning and improvement across the SBNI stakeholder organisations which will work together with the aim of reducing childhood mortality.</p> <p>Understanding and analysis of the ‘Root Cause’ of death will be central to identification of preventable factors.</p> <p>Recognition of the significance of ‘human factors’ associated with all aspects of child death (including investigative processes).</p> <p>Whilst SBNI has a role in coordinating and ensuring the effectiveness of the work of its member agencies to safeguard and promote the welfare of children, it is not accountable for their day to day operational work. The Statutory roles and functions of represented bodies engaged in the CDOP process should not be compromised by the requirements of the SBNI legislation.</p> <p>Promotion of interagency and multidisciplinary working and sharing of expertise in meeting the aims of CDOP should underpin working processes.</p> <p>Legal and statutory duties relating to data confidentiality will be adhered to at all times.</p> <p>Where possible CDOP will collect S75 data on children who have died which will provide a greater understanding of</p>
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<p>SBNI have identified these inequalities taken from research and will make them available to the Department who will be responsible for implementing the legislation to take forward this process. The SBNI will also take into consideration these inequalities once the CDOP process is up and running and in the development of detailed procedures. These detailed procedures will be screened as they are developed.</p>	<p>needs and issues associated with particular groups and whether specific interventions are required.</p>
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2.6 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

<i>Group</i>	<i>Impact</i>	<i>Suggestions</i>
Religion	N/A	
Political Opinion	N/A	
Ethnicity	N/A	

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

**How would you categorise the impacts of this decision or policy?
(refer to guidance notes for guidance on impact)**

Please tick:

Major impact	
Minor impact	
No further impact	x

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	x

Please give reasons for your decisions.

This paper is a discussion paper at this stage and to be presented to the Department of Health who may review process. The equality screening should be reviewed upon direction taken by the Department. The policy itself is positive action to promote an identified equality need: closer review of child deaths.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

<i>How does the policy or decision currently encourage disabled people to participate in public life?</i>	<i>What else could you do to encourage disabled people to participate in public life?</i>
N/A	N/A

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

<i>How does the policy or decision currently promote positive attitudes towards disabled people?</i>	<i>What else could you do to promote positive attitudes towards disabled people?</i>
N/A	N/A

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights?

Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	No
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	No
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	No
Article 5 – Right to liberty & security of person	No
Article 6 – Right to a fair & public trial within a reasonable time	No
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	No
Article 8 – Right to respect for private & family life, home and correspondence.	No
Article 9 – Right to freedom of thought, conscience & religion	No
Article 10 – Right to freedom of expression	No
Article 11 – Right to freedom of assembly & association	NO
Article 12 – Right to marry & found a family	NO
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	No
1 st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	No
1 st protocol Article 2 – Right of access to education	No

*If you have answered no to all of the above please move on to **Question 6** on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Does this raise legal issues?*
			Yes/No

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights)?

Equality & Good Relations	Disability Duties	Human Rights
Once CDOP is in place SBNI will collect data against all S75 categories were applicable	Once CDOP is in place SBNI will collect data on specific causes of death and will potential identity any themes in relation to specific disabilities that could require a focused public health message	CDOP process will be about learning and try and reduce where possible child deaths through the identification of themes. Article 2 right to life comes into play

Approved Lead Officer: Sharon Beattie

Position: Director of Operations

Date: 16th July 2014

Policy/Decision Screened by: Sharon Beattie

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