AGAINST CHILD ABUSE
Responding to the Legislative Council Panel on Welfare Services
On Child Fatality Review and Child Protection
14 May, 2007

This paper is compiled to present the position of the Against Child Abuse to the Legislative Council Panel on Welfare Services on Child Fatality Review and Child Protection based on the government paper LC Paper No. CB(2)1762/06-07(05). Part A of this paper focuses on Child fatality Review and Part B on child protection which had already been submitted for last session dated 12 April, 2007 For both issues, this agency has over the years presented papers and made submissions to the Panel.

a. Paper No. CB(2)1523/06-07(04) written submission on the need for a child commission and governments provision on Comprehensive Child Development Service and Child Protection Policies: presented with verbal submission on 12 April, 2007. (Appendix I)

b. Paper No. CB(2)2210/03-04(02): Prevention and Management of Domestic Violence, para 7 Against Child Abuse

c. Paper No. CB(2)2131/03-04(10): Reflections on the Tin Shui Wai Family Tragedy Appendix II, Child Death Review, 16 April, 2004. (Appendix II)

Part A: Child Fatality Review

The need of a Child Fatality Review Committee has been raised by child advocates on different occasions, particularly after the Tin Shui Wai Family Tragedy of Kim Shuk Ying. The Review Panel on Family Services in Tin Shui Wai also recommended, in November 2004, to explore the feasibility of setting up such a mechanism.

It took the Health, Welfare and Food Bureau, Social Welfare Department over two and a half years to come up with this paper LC Paper No. CB(2)1762/06-07(05) which is very brief and lacks thoroughness on the status, terms of reference and

composition of the mechanism.

The Objectives of the review as listed in SWD's paper appeared narrow and service focused, without a coherent policy base. The primary objective of the Review should be to prevent child deaths and injuries/harm through improved policy, legislation, education, services and through improved inter agency collaboration in effective case management and prevention. The review should also identify and characterize high risk groups and factors for child deaths/injuries/harm and to make all relevant recommendations accordingly.

SWD appeared passive and reactive when it stated in the Operation Mechanism (b) that the mechanism would only review cases that "have aroused public concern and have implication on social welfare services …. by the Review Panel" We believe that Hong Kong should be reviewing all cases. In view of resource constraints, we could start with unnatural death cases but eventually also serious child abuse/domestic violence cases, with various implications not only limited to social welfare services and certainly not only those that have aroused public concerns.

We are particularly concerned about the fact that this Review Mechanism will be under the SWD as many of the past tragic child abuse and domestic violence cases indicated that we have to look seriously into various aspects, education, medical and health, traffic, housing etc. A Review Mechanism under the SWD may limit its scope and we therfore propose that the Mechanism should be independent and supported by law and an ordinance with the needed resources.

SWD's proposal did not discuss in detail the necessary composition and jurisdiction of the Review Panel and left the discretion to the panel, without guidelines and principles, for the selection of cases for review.

We agree that the Review Mechanism shoulders succinct function different from the Coroner's and we have to be extra careful, respecting confidentiality and privacy. But we do have a concern for the review to be conducted only upon the completion of criminal investigation and judicial processes as sometimes such may involve a very lengthy process and could be delaying prompt improvements for other children and families.

We propose that there should be annual hearing by the Legislative Council on the Annual Report of cases reviewed and recommendations derived. Such review and recommendations should be properly monitored so that we are not merely paying lip service but actually working together to improve the situation.

Last but not the least, we look forward to a well monitored implementation with a thorough operational plan for the Review Committee with the appointment of experienced and dedicated multidisciplinary professionals/community leaders as its members and hope that this will become an on going Mechanism to benefit children and our community.

Part B: Child Protection
(Already submitted on 12 April, 2007 CB(2)1523/06-07(04))

Submitted by: Priscilla Lui (Mrs)
Director of Against Child Abuse, Ltd.

Against Child Abuse
防止虐待兒童會

Appendix I

爭取成立兒童事務的平台和機制

回應

政府提供的兒童身心全面發展服務及保護兒童政策

(一) 引言

保護兒童，維護兒童權利在任何社會本來就是困難重重。不過，在香港面對的困難和挑戰更加多！

香港保護兒童、維護兒童權利不但起步緩慢，更缺乏鮮明、前瞻性、預防與治療並重及衡切的政策。缺乏以兒童權利爲機制，以兒童最大利益爲依歸的決心，不但不願意像海外地方，一而再地大幅度檢討保護兒童的相關法例，投以資源建立有效的代表兒童跨專業獨立的平台，委任有經驗、有見地的兒童專員。還常以爲香港保護兒童的服務完善、多元化、機制健全。對傷害孩子及社會的制度及行爲視而不見。這種自滿和消極的心態，影響優質的兒童政策和體制的完善。直接間接影響香港的未來！

(二) 制訂政策，調配資源

- 起步緩慢並非致命的障礙，遲起步的有先驅者成功和失敗的經驗可以借鏡。本地的社會穩定，加上在資訊科技各方的發展，並且有優質和委身的專業人士，是可以迎頭趕上，建立有本地特質的制度，絕對有香港的條件。

- 可惜過往廿多年（大概從國際兒童年兒童的保護在香港獲得較多的關注說起), 缺乏一分決心，缺乏對一套整全的兒童政策的認識和重視，把大部份人力資源和討論投放在經濟和政制事宜上。

- 經濟和政制固然對社會發展生活穩定有十二分重大的影響，但同樣重要的兒童、家庭等民生問題在香港實在不如英國、加拿大、澳洲等國家，不但制定

兒童政策、委任兒童事務專員，他們更願意配合資源去訂定指標，量度成效，而所撥出的預算，較針對性和明確地使用在預防虐兒的服務上，而非像香港往往廣義地計算在醫療、教育、家庭服務上，或單一、兩個電視廣告，一、兩張海報、橫額，數個培訓項目，而是有長線策略，針對不同對象、階層而在社會不同時段廣泛推行。

(三) 訂定兒童發展的指標及兒童權利落實的指標

- 聯合國兒童權利公約從一九九四年延伸至港，香港進行了兩次匯報如何落實公約精神。相信政府花了相當多的時間準備相當詳細的報告。不過香港的報告以服務爲主。至今仍未訂定兒童發展指標和如何對兒童生存、發展、保護和參與權落實的議程和方針。再者政府對民間團體的智慧和努力重視不足。如香港社會服務聯會悉心制定的福利藍圖(２００６年)和家庭、社會發展指標(２０００、２００４、２００６年)，小童群益會最近公佈的兒童發展指標(２００６年)並未獲得政府任何回應和支持。

(四) 成立兒童事務的平台和機制

- 爲了認真落實維護兒童生存、發展、保護和參與權利，成立有效的機制，代表和倡議兒童有關的事務已經有國際共悉。不少國家先後成立不同形式的兒童事務委員會或兒童申訴署（附錄一），有些委任兒童事務專員或兒童事務申訴專員，使兒童各方面的需要在社會中廣泛被尊重和認同，有關兒童的公共政策在審慎評估對兒的影響下才修訂或訂定。

- 我們倡議香港馬上成立有效的兒童事務委員會，並撥出適當的預算，採取預防與治療並重的模式，充份代表兒童權利的落實。不但作爲一個諮詢的架構，或一個討論兒童事務的平台，亦不能單存在於一個部門底下。而必須發揮積極代表及落實兒童利益最大化的功能。本會大力支持成立「兒童事務委員會聯盟的聲明」(附錄二)

- 本會出席曾特首 2007 年施政佈告其中一個諮詢會議時，同時出席的有青年事務委員會、婦女事務委員會及安老事務委員會代表，爲他們代表的組群作出爭取和反映，可惜當日本會乃唯一爲兒童而爭取的倡議者，時至今日政府仍未設立有效代表兒童機制。

- 特首委任的專家小組正探討成立家庭事務委員會的方案。本會及兒童倡議者熱切期盼這家庭事務的機制，不會成爲設立兒童事務機制的障礙。而倡議設立兒童事務機制的主要目的是理解兒童的事務必須獲得專一的平台才能有足的時間、資源和人力去發展和處理，否則在眾多的問題和議題中，兒童又會成爲隱蔽的一群，總是在等待！

(五) 預防勝於治療，這理念必須落實

- 在過往廿多年，香港花了時間在個案的調查和處理守則上，在預防虐兒上所付出的時間和資源卻不足夠。在二零零五年施政報告中提到零至五歲發展的重要，使兒童發展先導計劃在四個區域展開，而政府文件 LC Paper No. CB(2)1470/06-07(04)中，更指出將於二零零七至零八年把計劃在東涌實施，而於二零一二年在全港推行，不失爲積極和值得鼓舞的做法。不過如果計劃不單以診所/中心形式，針對面對危機和有問題的人士，而能外展並盡量使每一個新生嬰兒家庭獲得家庭探訪，在更掌握家庭需要的情況下提供支援，將更徹底和有效。

- **政府必須公佈爲每一位新生嬰兒家庭全面提供此項服務的時間表**

  政府採用的兒童發展先導計劃以診所/辦公室爲基地，希望及早發現有需要的兒童及家庭，提供適切的跟進服務。這種做法比海外發展國家來得保守和短暫。香港並未採用「家庭探訪式」的先導計劃，使每一戶有新生嬰兒的家庭及早獲支援，得以強化家庭功能及凝聚力，掌握關懷及非暴力的照顧及管教，學習處理情緒及紛爭的方法，建立社區網絡及支援。

  目前政府推展的計劃固然可及早發現有困擾的家庭，使他們前往已建立的綜合家庭或醫療衛生服務機制求助，但提供服務的前線人員不少已經疲於奔命，甚至有公務員表示在不健全的制度下的無奈和痛苦，政府必須正視，加以舒緩！

- **海外可取的經驗**

  在美國及其他發展的國家都已先後定期全面提供家庭探訪先導計劃。不但重視使每一個家庭參與計劃，亦十分重視每位提供服務的人員的素質和培訓。

而針對的對象固然以懷孕婦女、配偶及新生嬰兒爲主，但亦相當重視支援強化其他相關的家庭成員及社會網絡，務求在新家庭成立時協助建立健康的根基及人際關係，亦重視社會網絡鞏固的安全網的安排，希望日後有困難的家庭及早獲得幫助。

- **本港經驗亦有可取的地方**

本港非政府機構已採取訓練義工支援探訪懷孕家庭，並嘗試建立有效的探訪機制，政府可以考慮如何適當地推動社會人士，協助探訪及支援新生嬰兒家庭，加強凝聚力和歸屬感，以達到市民較長期獲得支援的效果。目前港人所生的嬰兒數目有下降的趨勢，正是加強支援的好時機。

- **中港合作機制急不容緩**

在近年所新生的嬰兒中，約三份一爲內地父母所生，孩子乃屬本港合法居民，而數目亦有增加的趨勢，引起各界的關注。加上中港家庭的數目龐大問題繁雜，爲這些家庭必須馬上設立中港機制，兩地共同溝通，策劃和合作。

(六) 兒童法例有待全面檢討，符合公約標準

- 香港兒童相關的法例在不同階段，按社會不同發展和需要而訂定。有些甚至訂定於一百多年前。香港社會有如海外的國家走過不同的里程碑，也需要更全面地檢討修訂，使兒童權利的原則充份落實。

甲、 侵害人身罪條例有待檢討

- 過去香港因應一些嚴重虐兒案事件及社會壓力，在一些法例上作出修訂，例如保護婦孺條例便因應郭亞女事件或其他問題而修訂爲保護兒童及少年條例。不過侵害人身條例及其他條例卻並未全面檢討和修訂定以作相關配合。

乙、 立法禁止體罰應該是國際趨勢

- 近年討論激烈的有：立法禁止體罰兒童，因爲體罰是暴力其中重要的根源，再者體罰干擾兒童的人權。

- 政府雖然就防止虐待兒童會二零零五年四月三十日因應世界没有巴掌日而制訂的宣言(附錄三)，而香港特區政府委派社會福利署署長鄧國威先生爲代表作爲聯署者之一。卻未積極帶動如何立法禁止體罰兒童，採用體罰以外的有效方法。

- 政府表示未在法例中清楚說明體罰犯法，但使孩子受傷的個案會按侵害人身罪條例而被起訴。這種說法模稜兩可，使香港的家長誤以爲體罰是合情、合理和合法。在這方面政府必須採取更果斷和明確的立場，並在政策和法例上加以修改。使香港加入起碼有十八個國家的行列(附錄四)，他們率先全面立法，維護兒童受保護，不被體罰的權利。

丙、 性侵犯相關的條例：兒童性罪犯資料庫

- 兒童性侵犯的情況嚴重，舉報率增加的程度已引起社會迴響，何況舉報率已有數據多方證實爲冰山一角。使問題刑事化亦爲社會國際趨勢。使法例作爲社會底線，清楚指明對那類行爲的指責和懲治，並使有效的治療方案建立，幫助犯事者康復重新做人。

- 兒童性罪犯和其他罪犯有著獨特的差異，而兒童性罪犯有年輕的趨勢。研究的國家都成立了兒童性罪犯資料庫。以保障兒童和社會爲大前題，希望盡一切努力減少犯事者，由於重犯率高，完全康復的機會較微，躋身接觸兒童機會高的行業，例如幼兒工作和教學服務。

- 可惜當倡議者在接二連三發現兒童被性侵犯，而侵犯者確有前科的情況下，建議成立兒童性罪犯資料庫卻未獲政府優先處理。有關人士考慮似乎是犯事人的權利比兒童及社會利益優先。這些態度和社會發展階段在研究中的國家已遠遠超越。

- 爲對相關的前犯事者作出保障，香港其實可採用非公開式的資料庫，由政府部門仔細監管，而幼兒及學童工作者可親身取得証明保障資料不外洩的情況下，向僱主証明身份，這樣不但保障兒童得到較安全及優質的服務，更進一步保障犯事人的私隱。

- 再者政府可設定除去檔案的時限，在適當專業評估後，使康復者脫離檔案記錄。

- 當然設立資料庫不等於性侵犯問題的消失，但確實爲預防個案中積極的一步。

丁、 判刑選擇必須更寬

- 目前香港判刑選擇相對研究的國家較狹窄。要達到及早預防和徹底治療的政策，初犯者必須獲得支援和治療，單靠守行爲或社會服務令未必足夠，而法定經成效品質鑑訂的課程/治療計劃目前缺乏。必須配合資源和訓練而立法成立。

- 政府必須檢視向來的判刑邏輯和做法，以回答市民認爲往往判刑過輕和缺乏一致性的批評。

戊、 兒童法律代表這機制並未充份發揮

- 今次保護兒童海外做法文件顯示，香港兒童可以享有在法庭的法律代表，有倡議者認爲如今使兒童獲得法律代表的主動權掌握在法官及撿控人員之手，如各方人員不爲兒童提出則無法充份代表。希望政府提供數據，証明獲得法律代表的兒童，在全部相關的個案中的人數及百份率，並提供兒童獲得法律代表的情況和兒童參與的實況。

- 再者，政府必須按部就班增加公民教育，使兒童、家庭及市民了解自己有獲得法律代表的權利的安排。

- 在過往跨部門專業交流及培訓中缺少了司法界的人士，希望他們也能成爲經常交流和工作的伙伴，在問題的預防和治療上，在不妨礙司法公正的情況下，有更實際的問題探討！

(七) 保護兒童有專門化的必要

- 從八零年至今本港建立了專門化的制度，防止虐待兒童會爲專門處理各種虐兒個案及提供預防的非政府機構，在社會福利署、醫院、警方都先後成立了專責小組或協調人員，使個案處理更奏效，兒童及家庭獲得更適切的照顧和支援。

甲、 幼兒及學校協調人員

- 在未來政府帶動關注學前及幼兒發展的同期，本會建議在學校、幼兒院及相關的院舍亦設立指定的人員，這些協調人員未必需要全職處理懷疑虐兒的事件，不過加以適當培訓，協調有關懷疑虐兒個案的安排，使經驗整合下處事更有效率和人性化。

乙、 虐兒個案上訴機制

- 目前虐兒個案在個案會議中介定後如有異議，可向同一個會議的主席及人員求助或投訴，此舉有欠客觀性，並不適當。本會建議成立上訴/投訴的客觀機制，使有關兒童及家庭獲得跟進。當然，如香港委任兒童事務委員及委員會，這類個案便投訴有門！

(八) 死亡及嚴重個案檢討的機制

- 本會重申對成立死亡及嚴重個案檢討的跨部門獨立機制的訴求。這個機制使社會了解問題的結晶、特式和趨勢，作出切合時宜的建議和修訂，預防慘劇重演。這個建議已獲倡議者包括醫療保護兒童協調委員會大力支持，並曾向特首反映，無奈仍未見任何行動。雖然在社會福利署署長主持的虐兒委員會上，署上答允成立檢討機制，

卻只能停留在社會福利署屬下，未發揮跨部門獨立和全面的功效，而他答允檢討的範圍亦較爲狹隘。

(九) 研究和數據的整合成爲策劃及服務設計的基礎

- 直至目前香港尚未**設立一個中央資料庫，記錄兒童及相關的數據和統計資料。一個整合資料庫，不但使香港掌握兒童各方面的情況、趨勢及特式，更可以針對性地成爲策劃及服務設計的基礎。**

- 過往香港使用了不少金錢進行研究和調查。可惜有時比較保守和過份謹慎，或許因擔心某些數據被錯誤理解或運用，擔心研究的方法或方向受到批評，而不公開一些重要的數據及研究。是可惜、不必要、和浪費資源的做法。

- **本會建議政府撥款整合過往及善用將來各部門重要的調查研究。**例如過去在家庭生活教育方面，在兒童健康成長方面，虐待兒童各方面，政府及非政府機構的調查研究，並馬上成立中央資料庫。

- 倡議者在兒童權利論壇上爭取成立兒童中央資料庫時，指出聯合國於審議報告中詢問的一連串議題，是資料庫要考慮包括的項目。而目前政府統計處所提供的資料，在滿足策劃和預防虐兒問題上有一定的局限。

雷張慎佳撰寫
防止虐待兒童會總幹事
二零零七年三月廿九日

Against Child Abuse
防止虐待兒童會

Reflections on the Tin Shui Wai Family Tragedy

1. **It is agreed globally that protecting family and children is a collective responsibility**

   It is wrong to let the women, the children, the elderly and the vulnerable ones shoulder the responsibility all by themselves

   All departments, professionals and law-enforcers should try their best to communicate and collaborate

2. **Children are being neglected in family violence**

   Mothers and other vulnerable members are being neglected in child abuse cases

   The tolerance of violence is rather high at present

   Underestimate the risk and the severity of the problem

   Require clear definition and consensus

   Should include psychological and emotional safety

3. **Actualize zero tolerance to bullying and violence, should protect family and children strategically**

   (a) Current and new policies and legislations

   (b) A reliable, effective and acceptable service and law enforcement mechanism

   (c) Experience, competent and committed professionals and law-enforcers

   (d) An open and active participating community

   (e) Integrate research and resource and evidence based

4. **Mechanism to review child death and serious cases**

   (a) An on-going, independent, multidisciplinary forum with resource and manpower support

   (b) Aims:

   Investigate child death trend and characteristics

   Suggest policy, execution, law reform, strengthen professional and community education and participation

   Monitor governmental and non-governmental organizations and community to follow these policies & practices

5. **Review cross border mechanism to enhance collaboration in preventing family violence**

6. **Should invest resources and manpower to preventive work**

22 April 2004

Against Child Abuse
防止虐待兒童會

Strategies Plan for Family / Child Protection

Do Away with Bullying & Violence

Whose responsibilities ?

Focus		Suggestion
Government	Policies and legislations (update and practical)	(1) A mechanism for fatal/ serious Case review (Refer to Appendix I) (2) Amendment on Family Violence Ordinance (Refer to Appendix II) (3) Prevention – early and extensive preventive measures (4) Cross border co-operation
Governmental & Non-governmental Organizations	Service Delivery System (reliable, effective and receptive)	(1) Retaining high quality, specialized teams (handling procedure and guide) (2) Tools and Mechanism for risk assessment (3) Definition of the problem ✧ Psychological abuse ✧ Physical abuse ✧ Sexual abuse ✧ Gross neglect (4) Mechanism for monitoring and appeal
Social Workers Psychologists Medical Personel Teachers Police Religious Bodies Mass Media District Councilors	Professionals & law enforcement (high quality, witty, humanistic & accountable)	(1) Value system ✧ Towards bullying ✧ Towards new immigrant women and children ✧ Towards new immigrants and vulnerable groups ✧ Towards ones own roles in protection

		(2) Mentality ✧ Caring and concerned ✧ Sensitive and insightful * sensitive towards interpersonal relationship, the needs of others, and to response promptly ✧ Serious and thorough (3) Knowledge and belief (4) Skills ✧ Process handling and problem solving skill ✧ In-depth multi-professional collaboration
Parents Public Children & Youth Mass Media	Community Participation (active, prompt & persistent)	(1) An Open and Well Informed Community ✧ Serious, accountable, respect to human life and human right (2) Rights and responsibilities, participation ✧ A culture of zero bullying and zero violence (3) Valuable supportive network
Government Tertiary Institutes	Research & Resources Consolidation (in-depth, comprehensive)	(1) Central Data System on Family & Child Matters (2) Study on the problem assessment (3) Research, analysis and implementation of service effectiveness (4) Share Resource & Information - for prevention - for effective program design & implementation ✧ Public, professional, for policy making

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Appendix I

Against Child Abuse
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Responding to
Tin Shui Wai, Tin Heng Estate, Family Tragedy

1. Distinct Areas of Concerns

1.1 Some families are gravely at risk
- what is the prevalence
- what is the extent of risk
- how do we strengthen
- how do we identify

1.2 How competent are our professionals: social workers, police, medical personnel etc. in the forefront? Are various parties competently prepared and equipped with the necessary Knowledge, Skills and Attitude?

1.3 Are various parties provided with support in supervision, network of services to back up?

1.4 Are professionals provided with realistic workload and adequate manpower?

1.5 How do professionals and agencies work together effectively to help and Prevent Family Tragedies?

1.6 How do we monitor our work and measure success?

1.7 Is the community ready to contribute to the protection of children? Are we willing to give up some of our privilege (parental rights, domesai privacy)?

2. Recommendations

2.1 The Set Up of An Independent Fatality and Serious Cases Review Standing Committee

The Committee should be independent and with multidisciplinary representation.

2.2 Research prevalence and extent and demands as perceived by children, families and professionals. Ensure analysis of findings and recommendations carried through.

2.3 Community Mobilization

a. Strategic Prevention Program with the community and through training community leaders, youth and adults, to spread the message, support and strengthen others

b. To enable each family with newborn to join head start home visiting programs with a strong capacity building, networking and prevention element.

c. To enable each citizen seeking Labor Department assistance to look for jobs to receive some degree (e.g. 2 hours) of social service public education.

d. To enable each family receiving Comprehensive Social Security Assistance to receive some degree (e.g. 2 hours) of public education.

e. To reach each and every one non-Chinese speaking domestic helpers when they arrived at Hong Kong airport. Provide them with relevant basic information and a designated number of hours training.

f. Advocate Mandatory Treatment for abusers, victims and family members.

2.4 Thorough and On-going Empowerment of Professionals in the Early Identification and Handling of Domestic Violence Should be Strengthened

a. An assessment tool worked out and professionals trained periodically to use it more effectively.

b. Specialized child abuse and domestic violence intervention approach must be retained.
Some degree of specialization in the existing three tier Integrated Family Service Centre Model much be encouraged.
The law-enforcer is lacking experience and support in domestic violence. Even the CAIU is much into crime-investigation than child protection.

c. Monitoring mechanism establish to take audit and monitor cases' handling and measure success.

d. On going Multidisciplinary Training be strategically planned and implemented to enable competent intervention and services.

e. Local and Overseas experience be consolidated to help our professionals through literature review, research, workshop, sharing forum, Congress and Conferences.

2.5 The Service Delivery System be Improved

a. Handling Guidelines and Procedures be worked out and reviewed either annually or two yearly.

b. A mechanism assigned to be responsible for such review.

c. Professionals to be ensured to know the system and to follow through.

d. To ensure adequate channel for difficulties and concerns to be reflected to the review mechanism.

2.6 A Clear Written Policy Document Must be Prepared to ensure:

a. Family and Child Impact Assessment in identified current and new policies.

b. Emphasis and funding support in pro-active Prevention Services and quality remedial protective services must be the policy.

c. Built in measurement of success must be reinforced.

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Appendix II

Against Child Abuse
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Child Death Review

What is Child Death (Fatality) Review (CDR)

Review of deaths of children by a multidisciplinary team

Purpose: improve understanding of why children die and take action to prevent child deaths

- detect trends and patterns in child deaths
- recommend policies, practices, legislative changes, professional and community education to prevent child deaths
- monitor the implementation of such policies and practices by government and non-government agencies and in the community

Focus:

- the responsibility for responding to and preventing child deaths lies with the community and the entire government, not with any single department or agency
- the understanding of the circumstances surrounding the death, without attempting to establish whether criminal proceedings are required
- the improvement of interagency co-ordination, communication and co-operation in the provision of family services
- the improvement and standardization of data collection and the accurate identification of the incidence of childhood fatalities
- the development of prompt and comprehensive reporting systems
- the assessment of the extent to which the death was preventable
- the development of community education and other prevention strategies

In what way is CDR different from Coroner's inquest and internal reviews

The primary aim of Coroner's inquest is to determine the manner and cause of death. The coroner has the power to make recommendations on prevention but usually based on the specific case only. If in the course of the inquest, there is criminal concern, the process will be terminated and the case referred to the Director of Public Prosecution.

CDR does not focus on the criminality of the alleged offender. Investigation of child deaths is the responsibility of the Police and the Coroner.
CDR aims to identify system failures and deficiencies.
CDR does not comment on individual responsibility or performance.
CDR is multidisciplinary but does not replace internal reviews initiated by agencies.

History of development of CDR in other countries

The first CDR committee was established in Los Angeles in 1978 involving professionals from criminal justice, health and human services. The work of these teams "demonstrated the educational benefits of a systemic review of deaths as a way to improve services to the living" (Dr MJ Durfee)
At present 49 states in USA, most provinces in Canada, and two states in Australia have CDR programmes with others being developed.

Accomplishments of some CDR

Investigation protocols e.g. death scene investigation, autopsy
More accurate identification of the causes of child death
Better understanding, communication and co-operation between different disciplines/agencies
Advocacy and development of programmes addressing problems e.g. abandoned infants, Sudden Infant Death Syndrome, Abusive head trauma, accidental ingestion of methadone, daycare licensure, smoke detectors, child passenger, sporting safety, truancy and youth homicide, grief and mourning services.

Why Hong Kong should conduct CDR

The present Child Protection Register of SWD which is to reflect the situation of child abuse and neglect in Hong Kong does not even document the most serious outcome - child death.
The establishment of CDR is an international movement.
The life of every child is precious but especially when the number of children born in Hong Kong is decreasing. CDR is an effective way of preventing child deaths.
Although in most countries, the focus started with deaths from child abuse and neglect, soon attention was paid to deaths from other injuries. Even deaths from 'natural causes' during the perinatal period are often found to be related to antenatal and perinatal care.

For Hong Kong, from 1997-2001, there were on average 46 deaths from 0-14 years due to external causes including 7 per year from self-inflicted harm and 9 per year from assault/violence.

For every death from injuries, there are many more hospital admissions and even more visits to emergency departments and doctor consultations. The prevention of childhood injuries/deaths is a public health issue.

What needs to be done to establish CDR in Hong Kong

Establish terms of reference for the CDR team

Appoint a CDR team - Community and Departmental and agency representatives

Supported by a secretariat

Legislative change: to allow access to confidential information from police, doctors, social services, schools

System of annual report to Legislative Council

Information capable of identification of individual children, family members and worker will not appear in the reports.

Funding (In NSW, various government departments share the cost.)

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16 April 2004