Hong Kong College of Paediatricians
Submission to Panel on Welfare Services of the
Legislative Council
Child Fatality Review and Child Protection
14th May 2007

The Hong Kong College of Paediatricians welcomes the Panel on Welfare Services of the Legislative Council's review of the status of Child Fatality Review and Child Protection in Hong Kong, especially its research on systems of child protection in England, Ontario of Canada and New South Wales of Australia.

Child Fatality Review

Our College has long recognized the importance of introducing Child Fatality (Death) Reviews to Hong Kong. We have written a number of times to Dr EK Yeoh, ex-Secretary of Health, Welfare and Food and Mr Donald Tsang, Chief Executive of HKSAR since the Tin Shui Wai incident in 2004 on the matter. The attached Appendix stated our rationale for such a system in Hong Kong which has already been in place in the United States for nearly 30 years. We were informed then that the Director of Social Welfare was studying the subject. Three years on, with the Director having moved to another posting, we do not see such a system functioning in Hong Kong yet.

Children continue to die of unnatural causes. From the Coroner's Report, just in the two years 2004 and 2005, there were at least 85 deaths between 0 to 19 years from homicides, suicides and accidents (see Table below) – Hong Kong does not yet have a central database for children from 0 to below 18 years. We have already missed many valuable opportunities to learn from and prevent such deaths.

Coroner's Report

	2004		2005	
	0-9 years	10-19 years	0-9 years	10-19 years
Homicides	3	0	8	3
Suicides	1	29	0	13
Accidents	6	10	8	4
Sub-total	10	39	16	20
Total	85			

After prolonged “consultation” in the Committee on Child Abuse chaired by the Director of Social Welfare, the proposed Child Fatality Review system to be piloted in Hong Kong is of very limited scope, limited in the nature of cases to be included and the panel members who are to review the cases. The proposal is not at all like the longstanding, proven to be effective systems in other countries like the United States and Australia, nor the system mandated by the Children Act 2004 in UK with an on-going independent multidisciplinary and multisectoral team instead of ad hoc reviews by a few selected members.

The major reason of the limited scope of the proposal, as we understand it, is that the Director of Social Welfare has no authority over other government bureaux. The limitation is tied in with Hong Kong not having a Child Commission that oversees matters related to children with their best interest as the focus. Hence the proposal is that only cases recommended by the secretariat “that have aroused public concern and have implication on social welfare services” are to be reviewed. This is a very narrow focus indeed. Few Hong Kong children do not have some contact with professionals from their birth in hospitals, attendance in Maternal and Child Health Centres or other medical facilities, their education at kindergarten, primary and secondary schools, to of course social workers and law enforcement officers when there are concerns with child maltreatment. Encounters with every single group of such professionals are potential intervention points for prevention of future tragedies. Reviews should not be conducted merely to appease public concern either but to prevent future deaths.

To make the Child Fatality Review system effective, we need legislative changes to ensure access to relevant information from different parties and confidentiality during the review process. There also needs to be ongoing monitoring of the implementation of recommendations and trends. Otherwise reports can remain as such. For example, the Child Death Review Team in NSW established under the Children (Care and Protection) Amendment Act 1995 has a system of reporting findings and recommendations to their parliament. In Hong Kong, it could be our Legislative Council or Child Commission. Appropriate funding should be accorded to a secretariat to support the review team in order to avoid undue delay in the process.

Child Protection

Our College has submitted comments on Child Protection issues in Hong Kong a

number of times covering universal to selected to indicated preventive measures. On this occasion we will focus on the research done by the Legislative Council Secretariat on Child Protection systems in England, Ontario, Canada and New South Wales (NSW), Australia.

Guiding principles and policy framework

All the three areas studied have guiding principles for child protection policies specified by law. Hong Kong lacks a Child Policy to ensure the best interests of the child are to be of paramount importance in all matters related to children. Without this being clearly stated, being "child centered" has little meaning. With the current emphasis on family harmony, which is of course important, should there be conflicts between the rights of the parents versus that of the child, the "family focus" can be overpowering. This was also the concern when the "Family" was added to the "Child Protective Service Unit". It is not surprising that relatively few child abuse situations have been registered in families with domestic violence.

Legislative framework

It is quite clear that in all these jurisdictions, there is a legislative frame work specifically for children - England: Children Act 2004; Ontario: Child and Family Services Act; NSW: Children and Young Persons (Care and Protection) Act.

Times are changing. England has moved from Children Act 1989 to Children Act 2004 in view of practice experiences and evolving circumstances over the years. Hong Kong lacks a thorough review of ordinances related to children especially to ensure the ordinances comply with the spirit of the Convention of the Rights of the Children since its extension to Hong Kong. There is no law that explicitly prohibits all forms of violence towards children within the family as called for in the Concluding Observations of the Second Periodic Report of China Mainland, Hong Kong and Macau from the United Nations Committee on the Rights of the Child. With the increasing awareness of the detrimental effect of domestic violence on children whether harmed directly or as witnesses, we need to review if our children are being adequately protected legally under such circumstances as in other countries. When does children left unattended at home constitutes neglect is unclear. Mandatory reporting of child abuse by professionals needs serious debate. Although children at risk of abuse can be put under a Care and Protection Order, we have no means to require parents who are putting their children at risk to undergo counselling or treatment. Repeat sex offenses against children have raised much community

concern especially when such persons are in positions with easy access to children. We need to look at the feasibility of instituting a Sex Offenders' Registry and mandated programmes for offenders and the resources required for such programmes. Deprivation of liberty per se only temporarily controls such offenders' risk to children.

Training is essential for all professionals involved with child protection work, not the least the judiciary. Hong Kong has laws against child pornography but how these laws are to be interpreted and used to protect the best interests of the child is another matter.

Policy Implementation and Monitoring

England has a Children's Commissioner and a Minster for Children. NSW has a Commissioner for Children and Young People. Ontario has a Ministry of Children and Youth Services and is in the process of establishing the Provincial Advocate for Children and Youth accountable to the Ontario Parliament. The children of Hong Kong have an urgent need of a Children Commission to ensure the rights of the child to protection, survival, development and participation are respected, an independent Commission that has the power to investigate when there are public and policy implications.

Conclusion

"Zero tolerance of Violence Against Children" is an attractive slogan but will remain as such if Hong Kong does not have a **Child Policy,** a comprehensive updated set of **Child Ordinance** and a **Children Commission** vested with the power to ensure policy implementation. To upkeep Hong Kong's role in the international arena, she should not lag behind in her system of protection of children already in place in many countries.

Appendix

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 inter-agency 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 educational 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 / multi-agency but does not replace internal agency reviews.

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.

Accomplishment of some CDR

Investigation protocols for e.g. death scene investigation, autopsy of children
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 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 sometimes found to be related to antenatal and perinatal care.
For Hong Kong, from 1997-2001, there were on average 46 deaths per year 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 workers will not appear in the reports.

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

Scope of review: could screen all child deaths but review in the first instance, unexpected deaths / deaths reported to the Coroner

With maturation of the CDR team, reviews can extend to not only deaths but severe child abuse / injuries.

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