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For information on
14 February 2011

Legislative Council Panel on Welfare Services
Pilot Project on Child Fatality Review

Purpose

This paper briefs Members on the findings and recommendations made by the Review Panel of the Pilot Project on Child Fatality Review (the Pilot Project) upon completion of its review of child death cases which occurred in 2006 and 2007, as well as its evaluation of the Pilot Project detailed in its Final Report released in late January 2011.

Background

2. Despite the continuous efforts of the Administration and all parties concerned, tragic child death cases have still occurred and aroused great public concern. Committed to preventing the occurrence of these tragic incidents and safeguarding the welfare of our children, the Social Welfare Department (SWD) launched the two-year Pilot Project in February 2008, taking into account the views of relevant stakeholders.

3. The Administration last updated Members on the progress of the Pilot Project at the meeting held on 12 July 2010 [LC Paper No.: CB(2)1984/09-10(03)]. At that time, the Review Panel had completed the review of child death cases which occurred in 2006 and 2007. The evaluation of the Pilot Project and the preparation of the Final Report were then in progress. At the meeting, the Administration was requested to provide further information when the subject was to be discussed again by Members including statistics on child death cases by different age

groups and cases concerning child suicide. The requested information is set out at Annex A for Members' information.

Completion of the Pilot Project

4. The Review Panel has reviewed a total of **209** child death cases which occurred in 2006 and 2007. Of these, **121** died of natural causes and **88** of non-natural causes. In putting forward a total of 65 recommendations, the Review Panel has collected responses on its recommendations from the concerned government bureaux / departments and service organizations. Upon completion of the review of the 209 death cases, the Review Panel has also conducted an evaluation of the Pilot Project between March and August 2010.

The Review Panel's Reports

5. The Review Panel published its First Report in January 2010 on the findings of the review on 107 cases that occurred in 2006 and had been reported to the Coroner. Two other cases reported to the Coroner had not yet been reviewed at that time as litigation was still going on[1]. The First Report was uploaded onto the SWD Homepage for public access (http://www.swd.gov.hk/doc/whatsnew/201001/PPCFR1R.pdf). The number of child death cases reported to the Coroner in 2006 was subsequently revised from 109 to 118 after taking into account the updated information provided by the Coroner which included the stillbirth cases.

6. The Review Panel's Final Report (Annex B[2]) was released on 25 January 2011. An executive summary is at Annex C. The Final Report summarizes the work of the Review Panel over the pilot period, the findings of all the cases reviewed, the 65 recommendations put forward by the Review Panel, as well as the responses given and the

[1] Litigation for one of these cases was not completed by the end of the pilot project and was therefore not included in the review. The other case was subsequently reviewed and included upon completion of the legal proceedings.

[2] Published copy of the Final Report was provided to Members through the Legislative Council Secretariat on 31 January 2011.

improvement measures taken by relevant government bureaux / departments and service organizations concerned. The Report also contains the evaluation conducted by the Review Panel on the Pilot Project, including its methodology, findings and recommendations.

7. Media briefings were held on 12 January 2010 and 25 January 2011 during which the Review Panel shared its findings and the recommendations in the First and Final Reports respectively. The Final Report is now being distributed to concerned service organizations, government bureaux / departments and other stakeholders. It has also been uploaded onto SWD's Homepage (http://www.swd.gov.hk/doc/whatsnew/201101/PPCFRFR.pdf).

8. The recommendations in the First and Final Reports were generally supported by the concerned government bureaux / departments, service organizations and stakeholders. A statistical summary of the reviewed cases, with more detailed analysis of the 88 cases of children who died of non-natural causes, is at Annex D. The key recommendations of the Review Panel, the circumstances of the death cases, and the related improvement measures taken and their progress are at Annex E.

Evaluation of the Pilot Project

9. From March to August 2010, the Review Panel had conducted five sub-group meetings and two panel meetings and consulted stakeholders through a questionnaire for the purpose of evaluating different aspects of the review mechanism of the Pilot Project. Details of the evaluation are set out in Chapter 8 of the Final Report (pp. 123 – 141 of Annex B).

10. Respondents of the evaluation questionnaire, the majority of whom had participated in the review one way or another, generally found the scope, timing, means and level of confidentiality of the review appropriate. They were also satisfied with the neutrality and multi-disciplinary representation of the Review Panel. Overall speaking, they considered the recommendations of the Review Panel sound and proper, and the Pilot Project had met its objectives. In addition,

members of the Review Panel generally agreed that the Review Panel had performed its function in facilitating inter-sectoral and multi-disciplinary exchange and collaboration in the prevention of avoidable child deaths.

11. In view of the successful experience and positive feedback received, the Review Panel recommends that a standing child fatality review mechanism should be introduced and its modus operandi should largely follow that of the Pilot Project.

Way Forward

12. The Administration highly appreciates the effort of the Review Panel and acknowledges the value of the child fatality review in facilitating improvement in the current child protection work and child welfare service systems for the prevention of avoidable child deaths. The Administration accepts in principle the recommendations of the Review Panel, including the use of focus group meetings in addition to documentation review, and referring the recommendations made by the Review Panel to the relevant government advisory bodies / committees for higher-level consideration, etc.. We will map out the way forward accordingly, including the setting up of a standing child fatality review mechanism under SWD.

Advice Sought

13. Members are invited to note the content of the paper.

Social Welfare Department
February 2011

Annex A

Information on the Pilot Project on Child Fatality Review
Requested at the LegCo Welfare Services Panel Meeting on 12 July 2010

(a) Statistics compiled by the Census and Statistics Department (C&SD) on child death cases by different age groups, if available:

Tables A1 and A2 below set out the number of child deaths and total child population (aged below 18) in 2006 and 2007 obtained from C&SD by the Review Panel for review purpose:

Table A1 : No. of child deaths and total child population (aged below 18) in 2006[1]

Age group	No. of child deaths			Mid-year child population	
	Male	Female		Male	Female
0 – 4	87	67		110 400	102 600
5 – 11	28	26		245 300	229 100
12 – 17	40	21		265 300	251 400

Table A2 : No. of child deaths and total child population (aged below 18) in 2007[3]

Age group	No. of child deaths			Mid-year child population	
	Male	Female		Male	Female
0 – 4	80	72		111 400	103 200
5 – 11	23	21		234 900	219 400
12 – 17	36	15		263 400	248 600

Source: Census and Statistics Department

[3] The number of child death cases captured by C&SD is different from the number of cases reviewed by the Review Panel because the former includes cases not referred to the Coroner.

(b) The number of attempted and successful cases of child suicide occurred between 2006 and 2010:

We do not have information on the number of attempted child suicides in Hong Kong. The number of known child suicide deaths (aged below 18) is set out in Table A3 below:

Table A3 : known child suicide deaths (aged below 18) by sex (2006 – 2009)

Year	No. of Suicide Deaths		
	Male	Female	Overall
2006	7	7	14
2007	7	3	10
2008	7	6	13
2009	5	6	11

Source: Census and Statistics Department

(c) The number of meetings held by the Review Panel of the Pilot Project on Children Fatality Review and the progress made in respect of the 47 recommendations made by the Review Panel:

From February 2008 to December 2010, the Review Panel held 47 meetings, including 13 panel meetings and 34 sub-group meetings.

Further update / progress of the 47 recommendations made by the Review Panel in the First Report are presented as "Further Response / Updating (as at 31.10.2010)" in the Final Report.

Annex C

Executive Summary of the Final Report of the Review Panel of the Pilot Project on Child Fatality Review

I. Background

This is the second and final report of the Review Panel of the Pilot Project on Child Fatality Review (Review Panel) which is an independent multi-disciplinary non-statutory body with members appointed by the Director of Social Welfare. Its first annual report on review findings of child death cases occurring in the year 2006 was released to the public in January 2010. The Review Panel considers its report a very important forum for sharing review findings and promoting inter-sectoral and multi-disciplinary exchange of what have been or can be done to improve the service systems to prevent child death.

This report contains the review findings of 209 death cases involving children aged below 18 occurring in the years 2006 and 2007 reported to the Coroner, good practice identified and lessons learnt as well as evaluation of the Pilot Project by the Review Panel and its recommendations on the way forward.

II. Overview of Child Death Cases Reviewed

Compared with other countries, the age-specific child death rate of Hong Kong is relatively low. The major demographics of the 209 cases reviewed are as follows:

(i) 121 children (57.9%) died of natural causes, 32 (15.3%) died of accidents, 24 (11.5%) died of suicide, 11 (5.3%) died of assault and 21 (10.1%) died of miscellaneous causes;

(ii) The highest number of death occurs for children aged below 1 (N=69, 33.0%), and 53 of them died of natural causes. This is

followed by the age group 15 – 17 (N=41, 19.6%), and 17 of them died of suicide;

(iii) The majority of the deceased children were Chinese (N=189, 90.4%); only 18 (8.6%) were non-Chinese. The nationality of two (1.0%) children was unknown;

(iv) Of the deceased children, there were more male (N=119, 56.9%) than female (N=90, 43.1%);

(v) 91 (43.5%) children, either being too young or because of their health problems, were not attending school or work. 89 (42.6%) children were full-time students while 19 (9.1%) were neither studying nor working;

(vi) Yuen Long District had the highest number of child death (N=19, 9.1%), closely followed by Kwai Tsing and Sai Kung Districts (both N=18, 8.6%); and

(vii) Most fatal incidents occurred in the homes of the deceased children (N=90, 43.1%), followed by hospitals (N=70, 33.5%). 17 fatal incidents occurred on road or streets and these were mainly traffic accidents.

III. Main Themes and Issues

(i) Many child deaths were related to lack of proper child care, ineffective parental guidance, emotional trauma or depressive mood. Positive parenting, close supervision or concern and support from parents might have prevented such child deaths;

(ii) Home safety was a recurrent issue for cases with small children who died of accidental falls, which should not have happened if proper home safety device or measure had been in place;

(iii) Service providers generally found it difficult to motivate families or parents-at-risk lacking understanding on their own limited child care ability to seek or receive service at an early stage; and

(iv) Concealment and mishandling of unwanted pregnancy were observed in the review of many newborn and stillbirth cases. More thoughts should be given on how to encourage mothers, especially teenagers with unwanted pregnancy to voice their problems and seek assistance early.

IV. Highlights of Recommendations by the Review Panel

The Review Panel has made a total of 65 recommendations pointing to preventive strategies and systems improvement for cases involving death owing to classified causes.

For prevention of children who died of natural causes, proper and quality care arrangement for children with special needs at home or in residential care units, or during their home leaves from these units is recommended. Support for families looking after chronically-ill or disabled children requiring special care at home is also important.

For prevention of children who died of accidents, public education on the possible fatal risk of leaving children unattended and the importance of home safety measures and devices for small children is recommended. It is also crucial for parents to seek assistance from reliable child minders and to maintain good and clear communication with them on the needs of children. Public education on prevention of drug or medicine-related accidents to children, stepping up law enforcement on the use of vehicle safety devices and targeted road safety campaigns for professional drivers and cyclists are recommended.

For prevention of children who died of suicide, the professionals involved should bear in mind that children with serious suicidal intent may deny such intent in front of them. Management of cases with suicidal risk should focus on proper risk assessment with active follow-up and close liaison among the parties concerned. Public education are also

recommended to encourage children with suicidal tendencies, their peers and families to seek help from the professionals and to advise young people to take necessary precautions against possible tragedies arising from breaking up with their boyfriends or girlfriends.

For prevention of children who died of assault, the professionals involved should be sensitive and aware of the mental condition, mood, cultural background of the parents concerned, and other family risk factors which may have implications on the intervention required. Strengthening the mechanism of decisive and timely removal of children-at-risk under repeated threat of domestic violence and very close supervision for children living with suspected abusers can ensure their well-being. Close collaboration and information sharing among parties involved in child protection cases is also necessary.

V. Good Practice and Lessons Learnt

Good practice of and lessons learnt by service organisations identified in the review are shared for catalyzing improvement of service systems. The good practices include:

(i) A school immediately conducted an internal review after a student committed suicide, resulting in swift improvement in service mechanism;

(ii) The school personnel had taken prompt and coordination action to connect a student exhibiting abnormal and self-harming behaviour to needed services;

(iii) Concerted effort and regular liaison between an outreaching social worker and a school social worker in handling a school drop-out case; and

(iv) Some schools conducted comprehensive follow-up work after the occurrence of fatal incidents to their students, with support from the Education Bureau.

Important lessons were learnt by different service organizations which provided services to children who lost their lives. After going through in-depth internal reviews, these organizations have identified the improvement needs in some areas, including assessment and handling of cases with suicidal risk, helping adolescents to build up resilience, providing support for those children with mental problems and early and decisive intervention for child protection.

VI. Evaluation of the Pilot Project

The evaluation was conducted between March and August 2010. During this period, the Review Panel had held sub-group and panel meetings and collected views from parties having participated in the review and other stakeholders mainly through an evaluation questionnaire. Altogether 36 completed evaluation questionnaires were received.

The majority of respondents found the review appropriate in aspects of scope, means, sources of information, confidentiality of review, recommendations made by the Review Panel. The respondents considered that the review had facilitated inter-sectoral and multi-disciplinary exchanges. Over half of the respondents found the review appropriate in its timing and multi-disciplinary representation and that the review had met its objectives.

VII. Recommendations on Way Forward of the Review Mechanism

In view of the confirmation of the value of the review, the Review Panel has recommended that a standing child fatality review mechanism should be established. A statutory review mechanism is not considered necessary at this stage but may be considered in the future as and when necessary.

The proposed standing review mechanism will model on the Pilot Project with modifications. The scope of review should include but not limited to cases reported to the Coroner. Other than documentation review, other means of review such as focus group meeting and co-opting experts

can be employed. Involvement of forensic pathologist and police can further enhance the multi-disciplinary representation of the review body. More sharing on the findings can facilitate better implementation of the recommendations for improvement of service systems. The outcome of the evaluation or impact assessment for the review can be considered over time when sufficient experience and data are accumulated.

Annex D

Statistical Analysis of Cases Reviewed by the Review Panel of the Pilot Project on Child Fatality Review

Table D1 : No. of all reviewed cases by case nature

Case Nature	No. of Cases (%)
Natural	121 (57.9%)
Non-natural	88 (42.1%)
Total :	**209 (100.0%)**

Table D2 : No. of non-natural deaths by death cause

Non-natural Death Cause	No. of Cases (%)
Accidents	32 (36.4%)
Suicide	24 (27.3%)
Unknown	16 (18.2%)
Assault	11 (12.5%)
Medical Complications	5 (5.7%)
Total :	**88 (100.0%)**

Table D3 : No. of non-natural deaths by age group

Age Group	No. of Cases (%)
< 1	16 (18.2%)
1 – 2	3 (3.4%)
3 – 5	4 (4.5%)
6 – 8	11 (12.5%)
9 – 11	10 (11.4%)
12 – 14	16 (18.2%)
15 – 17	28 (31.8%)
Total :	**88 (100.0%)**

Table D4 : No. of accident cases by age group and type of accident

Age Group	Type of Accident (%)						No. of Cases (%)
	Traffic	Fall	Drowning	Poisoning	Drug overdose	Choking	
< 1	2	0	0	1	0	0	3 (9.4%)
1 – 2	0	1	0	0	0	0	1 (3.1%)
3 – 5	0	2	0	0	0	0	2 (6.3%)
6 – 8	5	3	1	0	0	0	9 (28.1%)
9 – 11	4	0	0	1	0	0	5 (15.6%)
12 – 14	4	0	1	0	1	1	7 (21.9%)
15 – 17	3	1	1	0	0	0	5 (15.6%)
Total :	**18**	**7**	**3**	**2**	**1**	**1**	**32 (100.0%)**

Table D5 : No. of suicide cases by age group and sex

Age Group	Sex		No. of Cases (%)
	Female	Male	
< 1	0	0	0 (0.0%)
1 – 2	0	0	0 (0.0%)
3 – 5	0	0	0 (0.0%)
6 – 8	0	0	0 (0.0%)
9 – 11	1	1	2 (8.3%)
12 – 14	3	2	5 (20.8%)
15 – 17	6	11	17 (70.8%)
Total :	**10**	**14**	**24 (100.0%)**

Table D6 : No. of assault cases by age group and sex

Age Group	Sex		Total (%)
	Female	**Male**	
< 1	1	1	2 (18.2%)
1 – 2	0	0	0 (0.0%)
3 – 5	1	0	1 (9.1%)
6 – 8	1	1	2 (18.2%)
9 – 11	2	1	3 (27.3%)
12 – 14	1	0	1 (9.1%)
15 – 17	0	2	2 (18.2%)
Total :	**6**	**5**	**11 (100.0%)**

Annex E

Key Recommendations of the Review Panel and
Improvement Measures Taken by the Administration and their Progress

Type **/ Circumstances**	**Key Recommendations**	**Improvement Measures Taken and Progresses**
For Fall Accident Cases: Five out of the seven fall cases reviewed occurred at home, with four of the deceased children left unattended.	A total of four recommendations were made by the Review Panel: 1. Public education to remind parents of the possible fatal risk of leaving children unattended; 2. Importance of home safety measures and devices when young children are present; 3. Parents to seek assistance from reliable child carers; and 4. Parents to give clear instructions to child carers to	Social Welfare Department (SWD) ◆ In addition to regular child care services, SWD has launched the three-year pilot Neighbourhood Support Child Care Project (NSCCP) since 2008 to provide flexible child care services to needy families. ◆ NSCCP will be regularized and extended to all the 18 districts in 2010-11. ◆ SWD continues to launch publicity and public education on the themes of 'not leaving children unattended' and 'taking proper care of children'. The messages of 'neglect once, regret forever' and 'child neglect is a criminal offence' have been put on regular television and radio broadcast since November 2009 to

Type / Circumstances	Key Recommendations	Improvement Measures Taken and Progresses
	ensure child safety.	remind families of the serious consequences of leaving children unattended. Department of Health (DH) ◆ Parenting programme of the Integrated Child Health and Development Programme of DH has included specifically the topic of home safety for children of different age groups. Hong Kong Housing Authority (HKHA) ◆ HKHA has taken child safety into consideration when planning and designing new public housing estates.
For Suicide Cases: Among the 24 child suicide cases reviewed, 22 jumped from height to their death were	A total of 16 recommendations were made by the Review Panel, the key ones include- 1. Thorough professional risk assessment and follow-up	SWD ◆ SWD has allocated resources to publicize anti-suicidal messages, promote positive life values and encourage persons with suicidal intent to seek professional help.

Type / Circumstances	Key Recommendations	Improvement Measures Taken and Progresses
adolescents aged 12 – 17. Two other deceased children were 11 years old.	services for children with suicidal intent; 2. Educating the public to encourage people with suicidal intent, their friends and relatives to seek help from professionals instead of covering it up from helping parties; and 3. Public education on the "when" and "how", and the precautions to be taken to initiate separation between young lovers.	◆ Since 2007, SWD has widely publicized the theme of suicide prevention through different channels of the mass media. ◆ SWD has also joined hands with the Education Bureau and five universities to support non-governmental organizations rendering school social work service to implement the "Positive Adolescent Training through Holistic Social Programmes to Adulthood: A Jockey Club Youth Enhancement Scheme" with a view to promoting students' positive values and enhancing their resilience and ability to cope with adversities and life stresses. ◆ SWD has provided additional resources to the Suicide Crisis Intervention Centre of the Samaritan Befrienders of Hong Kong to provide services for suicide survivors and search for suicide messages of bloggers since November 2009, and to launch a new web-engagement programme in August 2010.

Type / Circumstances	Key Recommendations	Improvement Measures Taken and Progresses
		<u>Education Bureau</u> (EDB) EDB has updated the information on prevention of student suicide on EDB website and held a seminar in October 2010 to enhance teachers' awareness in positive development of students and prevention of suicide.
For Assault Cases: 11 children who died of assault. Perpetrators of nine of these cases were parents of the deceased children.	A total of 13 recommendations were made to prevent such tragedies, the key ones include- 1. Step up collaboration and information sharing between the Police and SWD for improvement of risk assessment procedures; 2. To enhance professional training on risk assessment on child abuse for pre-school	<u>SWD</u> ◆ Various mechanisms among the Police, non-governmental organizations (NGOs) and SWD have been set up at the central, district and case levels to enhance service collaboration and coordination in tackling domestic violence issues and cases. ◆ SWD regularly offers comprehensive and systematic training to enhance the professional competencies of social workers and related professionals in handling child abuse cases. Apart from providing specific knowledge and skills in case handling, the training

Type / Circumstances	Key Recommendations	Improvement Measures Taken and Progresses
	children; and 3. Public education to assist children to learn how to protect themselves and build up their resilience towards domestic violence.	also focuses on age-specific concerns and skills in risk assessment and post-trauma care of victims so as to equip the frontline practitioners with the capabilities in working with children at all ages, including pre-school children. ◆ SWD will continue to promote concerted efforts among its service units and the NGOs concerned to protect children and to identify children-at-risk early through various means, such as life skills training for those children. ◆ SWD produced the booklet "What can I do? – For children who have witnessed domestic violence" in February 2008 to educate children how to protect themselves and seek help when domestic violence occurs. Hong Kong Police Force (the Police) ◆ The Police has enhanced sharing of information and

Type / Circumstances	Key Recommendations	Improvement Measures Taken and Progresses
		problems encountered in case handling in the District Liaison Groups on Family Violence chaired by District Social Welfare Officers of SWD, which is set up to strengthen liaison and cooperation at frontline working level between the Police and social workers from SWD or NGOs. ◆ The Police has enhanced training through close partnership with SWD in joint training programmes on child protection and domestic violence related issues for different professionals. ◆ The Police has introduced in 2008 a protocol of Victim Management for victims of domestic violence cases handled by Crime units to strengthen the support and safety assurance to victims and to enhance inter-disciplinary communication and collaboration.