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**Panel on Welfare Services**

**Background brief prepared by Legislative Council Secretariat for the meeting on 14 February 2011**

**Child Fatality Review**

## Purpose

This paper summarises the discussions by the Panel on Welfare Services ("the Panel") and its Subcommittee on Strategies and Measures to Tackle Family Violence ("the Subcommittee") on the Pilot Project on Child Fatality Review ("the Pilot Project").

## Background

2. Following the occurrence of the Tin Shui Wai family tragedy on 11 April 2004 in which two young children and their mother were killed (and the father also passed away on 23 April 2004), the Director of Social Welfare ("DSW") set up a three-member Review Panel on Family Services in Tin Shui Wai to review the provision and service delivery process of family services in Tin Shui Wai and to see what improvements could be made. The Review Panel recommended, inter alia, in its report released in November 2004 that the Social Welfare Department ("SWD") should explore the feasibility of setting up a mechanism for convening an independent review committee to examine fatal and serious injury cases to identify ways to prevent recurrence of similar tragedies.

3. The Administration subsequently launched a two-year pilot review project in February 2008. The purpose of the review was to facilitate the examination of and improvement to the current system in respect of child protection and child welfare. It was not intended to be the mechanism to identify the causes leading to the child's death nor to attribute responsibility to individuals. An

evaluation of the review would be conducted at the end of the two-year pilot with a view to throwing light on how the review mechanism could be improved.

**Deliberations of the Panel and the Subcommittee**

Scope of the proposed review mechanism

4. Members were advised that the proposed review mechanism for child fatal cases would cover all cases of children aged under 18 who died of non-natural causes during the 18-month period prior to the inception date of the project. Instead of conducting an in-depth review on cases which had aroused public concern and had implications on social welfare services only, some members considered that the scope of the review mechanism should be expanded to cover different categories of child death cases, given that cases of children who died of non-natural causes were not necessarily related to welfare services. A suggestion was also made that the Review Panel should study serious injuries in addition to child fatal cases.

5. The Administration advised that the Secretariat of the Review Panel would obtain the demographic and social information about all cases of children who died of non-natural causes within a specified period for the Review Panel's general review. Among these cases, those which had aroused public concern and had implications on social welfare services would be recommended for the consideration of in-depth review by the Review Panel. The Review Panel would refer specific cases to the relevant departments for follow-up as and when necessary.

Operation mechanism

6. In early February 2008, DSW appointed 14 members from different professions and sectors to form the Review Panel on the Pilot Project. The Administration announced on 4 March 2008 that the two-year Pilot Project had begun to examine cases of children who died of non-natural causes. At the Subcommittee meeting on 12 June 2008, members were further advised that the Review Panel would endeavour to review all cases involving children aged below 18 who died of non-natural causes in 2006 and 2007.

7. Members of the Subcommittee considered that the Review Panel should have statutory backing and its scope of work should be expanded in the long run to cover all domestic violence cases which had caused deaths or serious injuries. The Administration advised that subject to the experience gained and outcome

of the evaluation of the child fatality review mechanism after the two-year pilot period, it would not rule out the possibility of making it a statutory mechanism and expanding its scope of work in the long run to cover all domestic violence cases which had caused deaths or serious injuries.

8. Some members were of the view that the operation of the Review Panel should be put under the purview of the Family Council chaired by the Chief Secretary for Administration, in order to ensure that the recommendations made by the Review Panel would be followed up by relevant parties and organisations.

9. The Administration advised that similar to other non-statutory bodies set up by the Administration, the Review Panel operated independently from the Government, albeit with secretariat support from SWD. There was no reason to doubt that the recommendations made by the Review Panel would not be followed up by relevant parties and organisations where practicable, as the review findings and recommendations would be published in annual reports for public scrutiny.

10. Concern was also raised that placing the Review Panel under SWD might confine the selection of cases for review to those relating to the social welfare system. The Administration advised that the Secretariat of the Review Panel would, based on the list of cases obtained from the Coroner's Court, prepare a list of children who died of non-natural causes for general review by the Review Panel. As the child fatality review mechanism sought to examine the practice and service issues pertaining to child death cases for more effective prevention of such cases and protection of children, the Labour and Welfare Bureau and SWD were in the best position to oversee its operation.

11. Some members suggested that the Review Panel should preferably be chaired by the Secretary for Justice and that people from law enforcement agencies and with legal background should also be appointed as members of the Review Panel, as were practised in many overseas jurisdictions, having regard to the fact that investigation of child's death was an important element of the review. The Administration advised that the review mechanism was not intended to identify causes leading to the child's death nor to attribute responsibility to individuals. Instead, the objectives of the review were to examine the practice and service issues pertaining to the child death cases; identify feasible and practical improvements in these areas; identify patterns and trends for formulation of prevention strategies; and promote multi-disciplinary and inter-agency cooperation for prevention of child death. The Administration also pointed out that SWD had consulted stakeholders from

various sectors, such as the Hospital Authority, the then Education and Manpower Bureau (now the Education Bureau) and non-governmental organisations, on the scheme details before setting up the child fatality review mechanism.

Procedures of the review

12. The Subcommittee noted with concern that review of the cases would only be conducted upon completion of all criminal and judicial processes to avoid prejudicing such processes. Members considered such an arrangement undesirable, as the sooner the Review Panel could conduct its review, the better it could identify gaps and deficiencies in the delivery of services prior to the child's death. They considered that reviewing the child fatality cases when the criminal and judicial processes were still ongoing should not prejudice such legal proceedings, as meetings of the Review Panel were held closed-door.

13. Members were advised that in identifying cases to be reviewed under the Pilot Project, operationally and procedurally speaking, there was a need to wait until the Police had finished investigation into the cases and the Coroner's Court had defined whether the causes of death were "natural", before commencement of the review. The Administration's legal advice was that if the Review Panel were to conduct the review in parallel with the Police investigation, there could be concerns from the prosecution's perspective, including -

(a) whether the information gathered by the Review Panel was consistent with the evidence collected by the Police thus affecting, one way or the other, the prosecution case; and

(b) the duty to disclose to the defence all relevant evidence including any evidence which might adversely affect the prosecution case or assist the defence case.

As the duty of disclosure was continuous, the Review Panel must disclose all information gathered, albeit the information concerned might not be relevant to the criminal investigation or judicial proceedings, to the Police officer-in-charge of the investigation so that the matter of disclosure could be properly considered. If the trial was on-going, this passing on of information had to be done on at least a daily basis so that the prosecutor could discharge its duty of disclosure in time.

14. The Police had also pointed out that records of Review Panel members' discussions and views on specific case(s) could also be subject to disclosure as

there was no legal privilege or public interest immunity was involved. This might inhibit information collection and free discussion amongst members of the Review Panel. In addition, under the rule of sub-judice, the Police would not be able to provide the Review Panel with the investigation details of cases before conclusion of criminal proceedings, i.e. those cases where the suspects concerned had been identified and put through the criminal justice system, and cases pending death inquest by the Coroner's Court.

15. Members were further advised that the decision to conduct the review after completion of all criminal proceedings and death inquiry procedures had addressed the concerns of the stakeholders and professionals concerned regarding the confidentiality, neutrality independence and effectiveness of the review. There were also concerns as to whether some parties involved in the case might choose not to provide information, or withhold information for the review, thus defeating the purpose of the review in identifying areas of improvements in multi-disciplinary collaboration.

Confidentiality of the information provided to the Review Panel

16. Some members of the Subcommittee expressed concern about the confidentiality of the review and considered it necessary to provide legal support and protection from being sued to those organisations which had rendered services to the deceased child and/or his/her family, in particular if the information they provided to the Review Panel varied from that provided to the Court. For instance, the Administration could consider providing these organisations with free legal advice service as well as an undertaking similar to that of the legal professional privilege to ensure that the communications between the organisations and the Review Panel would be privileged from disclosure unless the Court so directed.

17. The Administration advised that the purpose of the review, which focused on inter-sector collaboration and multi-disciplinary cooperation, was quite different from criminal investigation. The Administration also pointed out that the review was primarily documentary in nature and the organisations concerned had thus far been very co-operative in providing information to the Review Panel. To ensure strict confidentiality, no individual case details or personal particulars of persons or agencies concerned would be included in the annual report of the Review Panel. The information collected would be destroyed upon completion of review. The Administration further advised that as a matter of principle, it would not be appropriate to provide legal immunity to the organisations concerned in the event of their having provided false or incomplete information in preceding legal proceedings as such acts might be in

breach of the law and liable to criminal sanction.

18. The Administration subsequently advised that to address members' concern, the Secretariat of the Review Panel would include a statement in the information sheet and relevant guidelines of the Pilot Project when collecting information, that "Information furnished by organisation(s) will be used by the Secretariat for the purpose of conducting child fatality review only. Such information will be kept strictly confidential and will not be disclosed without the prior consent of the organisation(s) concerned unless its disclosure is authorised or required by law."

The need to set up a statutory children's commission

19. Most members considered that the subject of child protection straddled different policy areas, it should not be taken up solely by SWD. These members took the view that the best way to safeguard the rights and well-being of children was for the Government to set up a statutory children's commission. Pointing out that the subject had been raised time and again and a consensus had been reached among members, members strongly called upon the Government to expeditiously establish a children's commission to facilitate cross-sectoral collaboration on protection of children and to monitor the operation of the Review Panel.

20. The Administration advised that the establishment of a statutory children's commission to look into child fatality cases would involve legislative changes which should be studied carefully. The experience of the Pilot Project would also provide useful information for the Administration to formulate policies and measures to better protect the well-being of children. The matter would also be considered in the context of how the Family Council would better protect the interests of different social groups, including children.

21. Members expressed disappointment at the Administration's response. A motion urging the Government to establish an independent statutory Commission on Children and make various improvements to the Pilot Project was moved by Dr Fernando CHEUNG and passed by all members present at the Panel meeting on 14 May 2007.

First Report of the Review Panel of the Pilot Project

22. At the Panel meeting on 12 July 2010, members were briefed on the major findings of the First Report of the Review Panel, which was published in January 2010, on the review of 107 child death cases which took place in 2006.

According to the Administration, the Report summarised the work of the Review Panel including its 47 recommendations as well as the responses given and improvement measures implemented by various government departments and concerned service organisations. Members were advised that with the completion of the initial review on the child fatal cases, the Review Panel had commenced evaluation of the Pilot Project in consultation with concerned stakeholders. It was expected that the final report with the evaluation of the Pilot Project would be available in early 2011 and a report would be made to the Panel.

23. Noting that 14 adolescents had committed suicide in 2006, members were gravely concerned about the suicide cases and whether the Review Panel had analysed the root causes of each case with a view to formulating specific preventive strategies. The Administration advised that the purpose of the review aimed to prevent child deaths through identifying good practices and possible areas for improvement, and promoting inter-sectoral collaboration and multi-disciplinary cooperation. It was the conscious decision of the Review Panel that details of individual cases would not be discussed in the report. Members, however, considered that in the absence of information on the background of deceased children, it was unable to examine in-depth the causes of child deaths, not to mention formulating preventive strategies. In the light of members' views, the Administration would invite the Review Panel to consider the presentation of the final report so as to facilitate the public in understanding the causes of the reviewed cases through the aggregate data received. As the review report had not analysed the causes of death cases and the respective family background of the deceased children, members agreed to request the Research Division of the Legislative Council Secretariat to prepare an information note on the major causes of death cases involving children died of non-natural causes and their family background in other places. An information note prepared by the Research Division (IN05/10-11) was issued to members vide LC Paper No. CB(2)940/10-11.

24. On the implementation progress of the 47 recommendations made by the Review Panel, members were advised that the Review Panel had distributed these recommendations to the related service organisations and/or government departments concerned. The various government departments and concerned service organisations expressed general support of the recommendations and had already introduced or incorporated the relevant measures into their existing practices as appropriate, notwithstanding that the final report had yet to be published. Members were further advised that the Secretariat of the Review Panel was collecting feedback and comments from concerned stakeholders on the Pilot Project and aimed to complete the evaluation around end 2010.

25. Some members pointed out that it was unduly long for the Review Panel to take four years to review 107 child death cases which took place in 2006. They took the view that the sooner the Review Panel could conduct its review, the better it could identify gaps and deficiencies in the delivery of services prior to the child's death, and formulate improvement measures to prevent child death.

26. According to the Administration, to avoid prejudicing any criminal or judicial processes, review on child death cases would be conducted after completion of all such processes. Operationally and procedurally speaking, there was a need to wait until the Police had finished investigation into the cases and the Coroner's Court had defined as to whether the causes of death were "natural", before commencement of the review. Therefore, the review of child deaths which occurred in 2006 began in May 2008. The Review Panel fully understood that the recommendations made, which were based on information at the time of the incidents, might not be most timely and improvement measures as well as policies might have already been put in place. This explained why the process of inviting responses on the recommendations, including updating and reporting on current service provisions, became an integral part of the review to promote inter-disciplinary sharing of experiences in improvement measures and lessons learnt.

27. To expedite the evaluation, some members considered that it was unnecessary to conduct the review of suicide cases after the completion of all criminal proceedings, since such cases did not necessarily involve inquiry by the Coroner's Court. As the Review Panel had embarked on the review of child death cases in 2007 and would issue its final report in early 2011, members agreed that the Panel should follow up with the evaluation of the Pilot Project in the 2010-2011 session.

**Relevant papers**

28. Members are invited to access the Legislative Council website at http://www.legco.gov.hk to view the Administration's papers and relevant minutes of the meetings of the Panel and the Subcommittee.

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