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For information on
14 December 2015

Legislative Council Panel on Welfare Services
Child Fatality Review Report

Purpose

This paper briefs Members on the findings and recommendations made by the Child Fatality Review Panel (the Panel) as contained in its first and second reports released in May 2013 and July 2015 respectively.

Background

2. To facilitate inter-sectoral collaboration and multi-disciplinary cooperation for prevention of occurrence of avoidable child death cases, the Social Welfare Department (SWD) launched the Pilot Project on Child Fatality Review (the Pilot Project) in February 2008 to review the child death cases involving children aged below 18, of both natural and non-natural death causes which occurred in the years of 2006 and 2007, with a view to identifying good practices and areas for improvement in the existing service system and providing recommendations. SWD had subsequently reported to 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)] and the findings and recommendations made by the Review Panel of 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 at the meeting held on 14 February 2011 [LC Paper No.: CB(2)972/10-11(06)].

3. In May 2011, SWD set up the standing Panel, with its terms of reference set out at Annex A, comprising professionals from different disciplines, including medical, education, social welfare and legal, etc., and a parent representative. The review aims at facilitating the enhancement of social service systems pertaining to child welfare with focus on inter-sectoral

collaboration and multi-disciplinary co-operation for prevention of occurrence of avoidable child deaths. It is not intended to ascertain death causes or attribute responsibility to any party. The scope of review is confined to child death cases involving children aged below 18, including but not limited to cases reported to the Coroner's Court. The review is conducted by studying the papers and documents filed to the Coroner's Court and supplemented by service reports from service organisations or government departments having provided services to the deceased children.

Reports of the Panel

4. The Panel commenced operation in June 2011, and after completing the review of 238 child death cases that occurred in 2008 and 2009, has published its First Report in May 2013, giving 21 recommendations on prevention of avoidable child death incidents. The report is available at the website of SWD: http://www.swd.gov.hk/doc/whatsnew/201312/CFRP First Report-201312E.pdf. Thereafter, the Panel continued its review work, and upon completing review of 238 child death cases that occurred in 2010 and 2011, it has published its Second Report in July 2015, giving 47 recommendations. The report is also available at the website of SWD: http://www.swd.gov.hk/doc/whatsnew/201511/CFRP Second Report Eng Rev.pdf.

Contents of the Two Reports

5. The First Report covered 238 child death cases, of both natural causes (156 cases) and non-natural causes (82 cases), that occurred in 2008 and 2009. The Second Report covered 238 child death cases that occurred in 2010 and 2011, including 151 cases died of natural causes and 87 non-natural causes. All of the reviewed cases were reported to the Coroner’s Court.

6. The Panel made a number of recommendations for preventing child/youth suicide, including educating the children to take positive attitude towards life and be resilient facing possible adversities/failures and encouraging them to seek help from reliable adults or helping professionals promptly when they face difficulties or experience distress or when their peers express suicidal idea; educating parents to equip them with effective parenting skills for improving family members' communication and

relationship and for handling adolescents' courtship problem and relationship breakup, as well as to nurture their children according to their capabilities and accept their limitations; enhancing school curriculum in life education and life skills training to strengthen students' coping ability and resilience; providing training to enhance professionals' awareness of the emotional expressions of the children as well as competency in conducting accurate assessment on the psycho-social needs of the children and their families, and detecting suicidal ideas of the children; and enhancing multi-disciplinary communication and cooperation for ensuring that children in need could receive appropriate treatments and support services. As regard to the public, enhancing the awareness of individuals, families and the general public to enable them to attend to and detect any suicidal signs for early intervention with those in need is required.

7. For cases with children died of traffic accidents, the Panel made a number of recommendations on the prevention of fatal traffic accidents, including organising road safety campaigns to strengthen awareness of road safety by the pedestrians, especially for pre-school children, cross-boundary students and children newly arrived from the Mainland, and reminding carers to take extra care when accompanying preschool children on the road.

8. The Panel has also made a number of recommendations relating to home safety, including public education to raise carers' awareness of various home safety issues such as keeping poisonous substances out of reach from the children, being aware of the symptoms of head injury in children and the immediate handling, never leaving children unattended/alone at home, monitoring children closely to prevent them from falling from height or bed/sofa, and installing home safety devices and ensuring their proper use and security.

9. Concerning cases with children who lost their lives as a result of assault, the Panel put forward a number of recommendations to prevent such tragedies, including public education to remind parents that they had the responsibility to take good care of their children and no right to take away their lives under any circumstances, to raise the awareness of the public to capture the signs and verbal threats of suicide and homicide of parents seriously, to enhance the awareness of new/prospective parents of postpartum depression and encourage them to seek help when such symptoms were noted in the mothers, and to encourage the public to seek help when facing individual/family problems especially involving child care.

10. In its Second Report, the Panel also made recommendations applicable to preventing child deaths of different causes. In addition to public education to encourage families to seek professional assistance and to raise carers' awareness of various home safety issues, the Panel proposed to enhance comprehensive gender relations and sex education for secondary school students, and to raise awareness of the possible fatal consequences of concealing pregnancy. The Panel also reiterated the fatal risk of co-sleeping with babies.

11. Apart from the highlights of recommendations given above, the main contents of the two reports are also summarised at Annex B and Annex C for Members' reference.

Follow-up on Panel's Recommendations

12. Upon reviewing the cases that occurred in every two years, the Panel would pass the recommendations to the relevant government bureaux/departments and organisations concerned for comments and responses. The Panel would continue to keep in view the implementation of the recommendations, and for those recommendations for which similar ones were made in previous reports, the Panel would initiate enquiries with concerned parties for updating of implementation of improvement measures. The recommendations made by the Panel, together with the comments, responses and updates on the improvement measures, by different death natures, are detailed in the reports.

Advice Sought

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

Social Welfare Department
December 2015

Annex A

Terms of Reference of the Child Fatality Review Panel

(i) To examine the circumstances and service delivery process of organisations/departments concerned (if any), preceding child's death through review of child death cases;

(ii) To identify good practice and lessons learnt relating to service delivery process, systems and multi-disciplinary collaborative efforts in the cases reviewed and to recommend improvements;

(iii) To keep in view the implementation of the recommendations made by the Child Fatality Review Panel in service enhancement;

(iv) To identify patterns and trends of child death cases for formulation of preventive strategies; and

(v) To promote inter-sector and inter-disciplinary collaboration in the delivery of child welfare services to prevent child death.

Annex B

Main Contents of the First Report of Child Fatality Review Panel

Main Themes and Issues

After reviewing the cases occurring in 2008 and 2009, the following main themes and issues are drawn up by the Panel:

(i) Proper child care and close supervision by parents and carers remains the most important factor in preventing most of the child deaths;

(ii) Public education to raise the awareness of the carers on home safety issues and equip them with the appropriate knowledge and child care skills is deemed necessary;

(iii) Education to children on road and home safety issues can help prevent fatal traffic accidents and accidents at home in children;

(iv) The public, carers and professionals working with or coming across any child could be more sensitive to any risks the child is facing, thus giving more timely assistance or intervention to the child; and

(v) Life education to children for treasuring life and being resilient could help them overcome various life challenges. Also, life education to parents for treasuring and respecting the lives of their own and their children could prevent fatal assaults to children.

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Annex C

Main Contents of the Second Report of Child Fatality Review Panel

Key Messages to Parents, Children and Concerned Parties

Based on the review of child death cases which occurred in 2010 and 2011, the Panel has the following key messages to parents, children and the parties concerned:

Parents and Carers

Suicide cases

- Your children may be facing various life stresses and difficulties. Be supportive to your children and maintain constructive communication to understand their needs and difficulties that they may be encountering.
- Be attentive and vigilant to your children's emotional/violent acts and expression/threatening of suicidal intention, either verbally or made through messages and notes. Past history of suicidal attempts is also an important sign of being at risk of suicide again.
- Your children need your assistance though they may not voice out their difficulties. Be ready to offer your helping hands. When you cannot handle the issues, seek help from helping professionals such as social workers of welfare service units and schools through direct contacts or various hotline services.

Accident cases

- Road is full of danger and hazards especially for children. Refrain from letting children at tender age to cross the streets/roads alone. When accompanying your children, hold their hands tightly.
- Your children would follow what you have done. Therefore, always set good role models and behave yourselves by following the road traffic regulations, such as following the traffic light signals and using

subways/footbridges for crossing streets/roads safely.

- Be aware of various potential risks and threats in the home environment. Remove these potential threats and install safety devices to prevent household accident and always check that the safety devices are properly installed and secured.

Assault cases

- When you are facing stresses and problems, talk to other family members, friends and if necessary seek help from professionals. There are always people available to help.
- Be vigilant to other family members susceptible to various risk factors and provide support to them or to link them with helping professionals.

Across child deaths of different natures

- Be aware of the fatal risk of co-sleeping with babies. Always make appropriate arrangement to ensure the safety of baby's sleep.

Children and Youth

Suicide cases

- Children and youth at different developmental stages may be facing various life stresses and difficulties. You can be assured that there are always family members, peers and friends who are willing to listen to and understand your feelings and problems.
- You can also seek help from helping professionals including teachers, student guidance personnel, doctors and social workers, etc. Various hotline services are also in place.
- When you know that your peers have suicidal intentions, tell a trustworthy adult and other helping professional who can offer prompt help to your peers in need.
- You can attend training on problem-solving skills and expose yourselves to more positive life experiences. You will then know there are always solutions to problems.

Accident cases

- Keep vigilance to the potential risks and threats in various environments, such as in the street/road, at home or when participating in high-risk sports and activities such as swimming, cycling and playing with high-risk amusement rides/games, etc.
- Be more aware of your own physical strengths/limitations and the potential risks of any illness you suffer and refrain from participating in activities that demand the skills and strength beyond your own. Never over-estimate your own physical strengths and capabilities.

Schools

Suicide cases

- School personnel can show understanding to the students who might be facing various stress and difficulties. They can express their concern and offer timely assistance to the students. Where necessary, collaboration with the parents and other helping professionals will be effective in helping students in need.
- School personnel can always be sensitive to the students especially those with special needs. They should be vigilant to the students' emotional/violent acts and expression/threatening of suicidal intention, either verbally or made through messages and notes. History of suicidal attempts is also an important sign of being at risk of future suicidal behaviour.
- School personnel should be sensitive to any bullying that might occur among students and intervene promptly or offer timely support/counselling to prevent the problem from getting worse.
- School personnel can teach students problem-solving skills and help them build up more resilience to face life difficulties.

Accident cases

- Through appropriate means, school personnel can teach students on raising their self-awareness and understanding of their own physical strengths and limitations.

- School personnel can also teach students on assessing the environmental risks and remind them of taking safety and precautionary measures before taking part in high-risk sports and activities.

Assault cases

- School personnel can teach students to be more sensitive and vigilant to potential risks in various situations. They can remind students on ways of self-protection facing with risks and threats and to seek help from trustworthy adults such as family members, relatives, teachers and other helping professionals.

Other Concerned Parties

- The Panel has put up a number of recommendations concerning public education to the children, the parents and the public. Relevant government bureaux/departments and organisations can continue to strengthen their public education work to arouse the public's awareness to prevent various natures of death.
- Also, government bureaux/departments, authorities and organisations should strictly enforce rules and regulations especially those concerning safety issues, including traffic safety, home safety, product safety and drug and food safety, etc. Where appropriate, the standards should be reviewed to see if upgrading is necessary to ensure that a safe environment with improving safety standards continuously is provided for our children.
- Social service providers can also provide education to their service users through their programmes and activities. These include education to parents/carers and children on raising their awareness of various risks, hazards and threats, as well as encouraging them to seek help when they encounter any difficulties and problems.
- Also, social service providers should ensure adequate provision and availability of social services to individual and families in need, including those of the ethnic minority groups.
- Helping professionals should also collaborate with different par ties and professionals to ensure that social services and support be provided to needy individuals and families promptly.

- Medical practitioners can continue their effective communication with patients and their families on the best treatment as well as necessary referrals for further investigation and medical follow-up when undiagnosed hereditary disease is revealed after death of a family member.

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