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**Panel on Welfare Services**

**Updated background brief prepared by Legislative Council Secretariat for the meeting on 14 December 2015**

**Child Fatality Review**

## Purpose

This paper summarizes the discussions by the Council and the relevant committees on the Child Fatality Review ("CFR").

## Background

2. According to the Administration, the Social Welfare Department ("SWD") launched a two-year Pilot Project on CFR ("Pilot Project") in February 2008 to review cases of children who died of natural or non-natural causes. The objective of the review was to examine the relevant child death cases with a view to identifying patterns and trends for formulation of prevention strategies and promoting multi-disciplinary and inter-agency cooperation in the prevention of avoidable child death. A review panel of the Pilot Project ("RPPP") was set up by SWD to review child death cases which occurred in 2006 and 2007. After reviewing those cases that occurred in 2006, RPPP published its first report in early 2010 with initial findings and recommendations.

3. Subsequently, the Pilot Project was completed in 2010 and RPPP released its final report in January 2011. RPPP also conducted evaluation of the Pilot Project, and concluded that the Pilot Project had met its objectives and was effective in facilitating inter-sectoral and multi-disciplinary exchange and collaboration in the prevention of avoidable child deaths. In view of the successful experience and positive feedback received, SWD has set up a standing Child Fatality Review Panel ("CFRP") in June 2011 to continue reviewing child death cases.

**Deliberations by Members**

Scope of the review mechanism and membership of RPPP

4. According to the Administration, RPPP had set the review mechanism of the Pilot Project to cover all cases of children aged below 18 who died of natural or non-natural causes in 2006 and 2007 and had been reported to the Coroner's Court. Some Members considered that the review mechanism should be expanded to cover all serious injuries cases. The Administration advised that research studies showed that it was difficult to provide a universal definition of serious injuries cases. The standing CFRP, however, would first look into child fatality cases and consider whether the scope of the review mechanism should be expanded when such needs arose.

5. Noting that RPPP comprised non-official members, including healthcare professionals, parents, academia, lawyers and social services providers, some Members took the view that the Police and forensic pathologist should be involved in the review mechanism to further enhancing the multi-disciplinary representation of the review body. Some other Members considered that suitable youth members should be appointed to RPPP to facilitate a better understanding of problems of the younger generation and the drawing up of recommendations to prevent such child deaths. According to the Administration, RPPP recommended that involvement of forensic pathologists and the Police could further enhance the multi-disciplinary perspective in case review. The Administration would actively consider the recommendation.

Operation mechanism of RPPP

6. Some Members were concerned that placing RPPP 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 RPPP would, based on the list of cases obtained from the Coroner's Court, prepare a list of child fatality cases for general review by RPPP. As the CFR 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.

7. Some Members were of the view that the operation of RPPP should be put under the purview of the Family Council chaired by the Chief Secretary for Administration, in order to ensure that recommendations made by RPPP would be followed up by relevant parties and organizations. The Administration advised that similar to other non-statutory bodies, RPPP operated independently from the Administration, albeit with secretariat support from SWD. There was

no reason to doubt that recommendations made by RPPP would not be followed up by relevant parties and organizations where practicable, as the review findings and recommendations would be published in annual reports for public scrutiny.

Procedures of review conducted by RPPP

8. Some Members noted with concern that review of child fatality cases would only be conducted upon completion of all criminal and judicial processes to avoid prejudicing such processes. These Members considered such an arrangement undesirable, as the sooner RPPP 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 child fatality cases when the criminal and judicial processes were still ongoing would not prejudice such legal proceedings, as meetings of RPPP were held closed-door.

9. The Administration 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 the causes of death, before commencement of the review. The Administration's legal advice was that if RPPP 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 RPPP 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, RPPP 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.

10. The Police advised that records of discussions and views of RPPP members 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 RPPP. In

addition, under the rule of sub-judice, the Police would not be able to provide RPPP 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.

11. The Administration further advised that the decision to conduct the review after completion of all criminal proceedings and death inquiry procedures had addressed concerns of the stakeholders and professionals concerned regarding the confidentiality, neutrality independence and effectiveness of the review. There was also concern 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 information provided for RPPP

12. Some Members expressed concern about the confidentiality of the review, and considered it necessary to provide legal support and protection from being sued for those organizations which had rendered services to the deceased child and/or his/her family, in particular if the information they provided for RPPP varied from that provided for the Court. For instance, the Administration could consider providing these organizations 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 organizations and RPPP would be privileged from disclosure unless the Court so directed.

13. The Administration advised that the purpose of the review, which focused on inter-sectoral collaboration and multi-disciplinary cooperation, was quite different from criminal investigation. The review was primarily documentary in nature and the organizations concerned had thus far been very co-operative in providing information for RPPP. To ensure strict confidentiality, no individual case details or personal particulars of the persons or agencies concerned would be included in the annual report of RPPP. The information collected would be destroyed upon completion of the review. The Administration further advised that as a matter of principle, it would not be appropriate to provide legal immunity for the organizations 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.

14. The Administration subsequently advised that to address Members' concern, the Secretariat of RPPP would include a statement in the information sheet and relevant guidelines of the Pilot Project when collecting information, that "Information furnished by organization(s) will be used by the Secretariat for the purpose of conducting CFR only. Such information will be kept strictly

confidential and will not be disclosed without the prior consent of the organization(s) concerned unless its disclosure is authorised or required by law."

The need to set up a statutory children's commission

15. Some Members considered that the subject of child protection straddled different policy areas. They had time and again called on the Administration to expeditiously establish a children's commission to facilitate cross-sectoral collaboration on protection of children and to monitor the operation of RPPP. 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.

16. Some Members expressed disappointment at the Administration's response. At its meeting on 14 May 2007, the Panel on Welfare Services ("Panel") passed a motion urging the Administration to establish an independent statutory Commission on Children to monitor and assist in formulating and implementing legislation and policies on child protection.

First and Final Reports of RPPP

17. At its meetings on 12 July 2010 and 14 February 2011, the Panel was briefed on the major findings of the First and Final Reports of RPPP respectively. According to the Administration, the First Report was published in January 2010 on the findings of the review on 107 child death cases which occurred in 2006 and had been reported to the Coroner's Court. In January 2011, RPPP published the Final Report which summarized the work of RPPP over the pilot period, the review findings of 209 child death cases occurring in 2006 and 2007, recommendations put forward by RPPP, as well as responses given and the improvement measures taken by relevant bureaux/departments ("B/Ds") and the service organizations concerned. The Final Report also contained the evaluation conducted by RPPP on the Pilot Project, including its methodology, findings and recommendations.

18. Noting from the First Report that 14 adolescents had committed suicide in 2006, some Members were gravely concerned about the suicide cases and whether RPPP had analyzed 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 RPPP that details of individual cases would not be discussed in the report.

19. Some Members noted from the Final Report that of the seven cases of children died of accidental fall, five cases occurred at home and four of them were left unattended. They urged the Administration to strengthen child care services with a view to providing more assistance for grass-root families to take care of their young children when both parents had gone to work. The Administration advised that it was mindful of home safety and prevention of child deaths. SWD would continue to launch publicity and public education on the themes of not leaving children unattended at home and provide child care services for needy families.

20. Some Members 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 this connection, RPPP should collect family background of the deceased children, such as the household income, working pattern of the parents and whether the children belonged to single parent families. The Administration advised that the view would be conveyed to RPPP for consideration.

21. Some Members held the view that it was unduly long for RPPP to take four years to review 107 child death cases which took place in 2006. They considered that the sooner RPPP 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. The Administration advised that having regard to the procedures of the review mentioned in paragraph 9 above, the review of child deaths which occurred in 2006 began in May 2008. The Administration further advised that RPPP 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.

22. Some Members were concerned about the follow-up on the recommendations and the implementation of improvement measures taken by relevant B/Ds and service organizations. The Administration advised that the recommendations in the review report were generally supported by the relevant B/Ds, service organizations and stakeholders. The related improvement measures taken and their progress were detailed in the Final Report of RPPP.

Further report on the progress made on the recommendations by CFRP would be provided in future as appropriate.

Recent development

23. According to the Administration, SWD has accepted the recommendation of RPPP and set up a standing CFRP in June 2011 to review child death cases which occurred in 2008 and beyond. The purpose of CFR is to facilitate the enhancement of social service systems pertaining to child welfare with focus on inter-sectoral collaboration and multi-disciplinary cooperation for prevention of occurrence of avoidable child death cases. Further to its first report published in May 2013, CFRP released its second report in July 2015 covering the review findings of the 238 child death cases which occurred in 2010 and 2011. Including the cases reviewed in the Pilot Project, a total of 685 child death cases occurred from 2006 to 2011 were reviewed.

24. Noting that CFRP took a few years to complete the review of child death cases which occurred in 2010 and 2011, some Members considered that the review findings of the CFRP's second report were outdated and unable to meet the fast-changing needs of the community. In view of the aforesaid shortcomings and the exclusion of serious injuries cases from the CFR mechanism, these Members called on the Administration to review the CFR mechanism. They also urged the Administration to examine the policy on children education and the provision of family support and emotional support services for children with an aim to strengthen protection of children and prevent occurrence of avoidable child death. The Panel agreed to discuss issues relating to the CFR mechanism at its meeting on 14 December 2015. The Administration will brief the Panel on the CFR report at that meeting.

**Relevant papers**

25. A list of the relevant papers on the Legislative Council website is in the **Appendix**.

Council Business Division 2
Legislative council Secretariat
10 December 2015

**Appendix**

## Relevant papers on child fatality review

| Committee | Date of meeting | Paper |
|---|---|---|
| Panel on Welfare Services | 14 May 2007 (Item V) | Agenda<br>Minutes |
| Subcommittee on Strategy and Measures to Tackle Family Violence | 12 June 2008 (Item II) | Agenda<br>Minutes |
| Panel on Welfare Services | 12 July 2010 (Item IV) | Agenda<br>Minutes |
| Panel on Welfare Services | 20 October 2010 (Item I) | Agenda<br>Minutes |
| Panel on Welfare Services | 14 February 2011 (Item VI) | Agenda<br>Minutes |
| Panel on Welfare Services | 21 October 2011 (Item I) | Agenda<br>Minutes |
| Legislative Council | 11 January 2012 | Official Record of Proceedings<br>Pages 63 to 73 |

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