LC Paper No. CB(2)1588/15-16(01)

For discussion
on 28 May 2016

Legislative Council Panel on Welfare Services

Follow-up on Child Fatality Review Report

Purpose

This paper addresses issues on child fatality review report raised by Members at the meeting of the Legislative Council Panel on Welfare Services held on 14 December 2015.

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 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. In May 2011, SWD set up the standing Child Fatality Review Panel (CFRP) which commenced operation in June 2011. After completing the review of 238 child death cases that occurred in 2008 and 2009, CFRP 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. Thereafter, upon completing review of 238 child death cases that occurred in 2010 and 2011, CFRP has published its Second Report in July 2015, giving 47 recommendations. The report is also available at the website of SWD.

3. SWD had reported to Members on the contents of the two reports at the meeting held on 14 December 2015 [LC Paper No.: CB(2)421/15-16(06)] and Members requested the Administration to follow up on the following five issues:

(a) provision of contact phone numbers of social workers and refuge centres for families at risk;
(b) enhancement of the 24-hour hotline service which provides crisis intervention and emotional support for people facing family crisis;
(c) follow-up visits by medical social workers to families at risk with members suffering from serious mental illness;
(d) provision of guidelines for schools to handle students suffering from mental illness; and
(e) provision of responses to the recommendations made in the first and second Child Fatality Review Reports and the actions taken by the Administration in response to the recommendations.

Follow-up Work

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

Concerning the Request for Strengthening the Telephone and Hotline Services

5. SWD has been providing a wide range of services for victims of domestic violence and individuals/families in crisis to facilitate them to seek advice and assistance. If immediate intervention is needed in urgent cases, SWD will provide counselling, support and advice by social workers to individuals/families in need and arrange appropriate follow-up

services through its hotline services (2343 2255) round-the-clock. Outreaching services will be conducted to offer timely intervention (including at odd hours) as deemed necessary.

6. At present, the five refuge centres for women, the Multi-purpose Crisis Intervention and Support Centre (CEASE Crisis Centre) and the Family Crisis Support Centre provide 24-hour hotline services for victims of domestic violence as well as individuals/families in crisis or distress. Individuals and families in need of urgent accommodation service at odd hours can be admitted upon referral by the police and social workers or they can approach the relevant services centres direct.

7. To facilitate the Police to seek immediate professional advice and/or social worker's support in handling urgent and high-risk domestic violence cases, a 24-hour direct referral line was set up in October 2006 between the Police and SWD. Through the direct referral line, the Police can seek advice, enlist assistance or refer urgent cases to social workers for follow-up round the clock.

Follow-up Visits to Families at risk

8. Medical social workers have close collaboration with medical and para-medical staff during ward rounds and multi-disciplinary case conferences for early identification of families at risk. Comprehensive follow-up services are provided by medical social workers to patients with serious mental illness and their families, including participation in the Case Management Programmes and Crisis Intervention Teams set up by the Hospital Authority for supporting patients with severe mental illness living in the community, and through inter-disciplinary collaboration and different means, such as home visits, office interviews and telephone contacts, etc. to assess their family condition so as to provide intensive support and appropriate welfare services to them. Medical social workers also co-organise mental health promotion activities with the Integrated Family Service Centres and Integrated Community Centres for Mental Wellness to enhance the awareness and knowledge of mental health by the local community.

Guidelines for Handling Students Suffering from Mental Illness

9. To assist schools in supporting students with mental health problems, the Education Bureau has laid down in its School Administration Guide with a guideline entitled "How Schools can Help Students with Mental Health Problems" for schools' reference. The topics cover early identification of students with mental health problems who are in need of support, reaching out to students with mental health problems proactively, enhancing mechanism to follow up and review support, establishing mechanism for collaboration with stakeholders concerned, enhancing communication between home and school, formulating appropriate and effective support strategies and adopting a whole school approach to promote students' mental health.

Responses to the Recommendations Made in the Child Fatality Review Reports

10. During the review of child fatality cases, CFRP would formulate recommendations and enquire with the related Government bureaux/departments and organisations in writing for the progress of implementing the improvement measures. The departments and organisations concerned have responded positively. The recommendations of CFRP, together with the concerned parties' comments, responses and progress of implementing the improvement measures, were set out in the CFRP's reports for public reference and discussion. Some examples of the follow-up actions by the relevant Government departments on the recommendations of CFRP are set out in Annex for reference.

11. Should CFRP consider that there are issues requiring immediate attention, it will share its observations and suggestions with the stakeholders immediately and seek their responses and improvement at an early instance, without waiting until the release of its reports. CFRP has recently shared its concern of the fatalities of neonates in postnatal wards during breastfeeding with the relevant departments/ organisations. It was noted that the relevant organisations have taken immediate preventive measures including adopting a practice guideline for skin-to-skin care for labour and postnatal wards; enhancing the education of healthcare personnel and family members regarding the appropriate positioning and monitoring of skin-to-skin contact during breastfeeding; and using pulse oximeters for monitoring babies during skin-to-skin care

when necessary. The relevant professional body also suggested adopting the management approach suggested in a latest article published in an academic journal to prevent sudden unexpected postnatal collapse.

Advice Sought

12. Members are invited to note the content of this paper.

Education Bureau
Social Welfare Department

May 2016

Annex

Examples of the Follow-up actions on the recommendations of CFRP by Government departments

Examples	*Recommendations of CFRP*	*Responses of the Relevant Departments*
(1)	On completion of the review of the child fatality cases occurring in 2006 and 2007, the Review Panel of the Pilot Project on Child Fatality Review has recommended in its Final Report published in December 2012 that "**Applying special restrictions for young and inexperienced drivers to minimise their risk of traffic accidents**."	The "Probationary Driving Licence Scheme" was extended to include novice drivers of private cars and light goods vehicles from 9 February 2009 to enhance road safety. The holder of a probationary driving licence is required by law to undergo a 12-month probationary driving period before a full driving licence can be issued and is subject to additional driving restrictions on top of the existing ones applicable to ordinary motorists. The Road Traffic Legislation (Amendment) Ordinance 2008 gazetted in July 2008 has stipulated a package of measures to combat drink driving and dangerous driving among other inappropriate driving behaviour. In addition, the Road Traffic (Amendment) Bill 2010 under consideration at that time will also tighten the laws on drink driving and dangerous driving. All these measures are also applicable to young and inexperienced drivers giving

Examples	*Recommendations of CFRP*	***Responses of the Relevant Departments***
		greater deterrent effects to improper driving behaviour and hence improving road safety.
	On completion of the review of the child fatality cases occurring in 2008 and 2009, CFRP has recommended in its First Report published in May 2013 "**To restrict drivers with probationary license from driving high performance cars (including sports car, high cylinder capacity (c.c.) car and modified car) may help prevent traffic accidents**."	The probationary driving licence scheme on private cars and light goods vehicles was put in place since 9 February 2009. The Road Traffic (Amendment) Ordinance 2010 was enacted on 17 December 2010 to increase the penalties for drink driving and dangerous driving offences which is applicable to all drivers, including young and inexperienced drivers, giving greater deterrent effects to improper driving behaviour and hence improving road safety. For drink driving, a 3-tier penalty system with a sliding scale was introduced, and the more a driver exceeds the prescribed limit for alcohol, the longer will be his driving disqualification. For dangerous driving, a new offence "causing grievous bodily harm by dangerous driving" was introduced. In addition, the Road Traffic (Amendment) Ordinance 2011 was enacted on 15 March 2012 which is applicable to all drivers, including young and inexperienced drivers. The purpose of the Ordinance is to

Examples	*Recommendations of CFRP*	*Responses of the Relevant Departments*
		impose a stricter control over drug driving and empower the Police to enforce drug driving offences more effectively by carrying out preliminary drug tests on suspected drug drivers.
(2)	On completion of the review of the child fatality cases occurring in 2006 and 2007, the Review Panel of the Pilot Project on Child Fatality Review has recommended in its Final Report published in December 2012 "**To set up a mechanism for pathologist to give feedback to family members of deceased children who, after post-mortem, confirmed to have hereditary diseases and refer them for medical examination, follow-up and genetic counselling**."	In connection with setting up mechanism for pathologist to give feedback, a practice has already been adopted by concerned department that: (i) In any case, forensic pathologist will explain autopsy findings and cause of death to the family upon their request; and (ii) In any case, where undiagnosed hereditary disease is found during autopsy, forensic pathologists will call the family proactively to explain the findings and give advice and / or refer the parents and surviving siblings for appropriate medical follow-up accordingly, including genetic counselling if indicated.
	On completion of the review of the child fatality cases occurring in 2008 and 2009, CFRP has recommended in its First Report published in May 2013 "**To set up feedback system between forensic**	The above responses are still valid.

Examples	*Recommendations of CFRP*	*Responses of the Relevant Departments*
	pathologist and family doctor for arranging family screening, follow up treatment and genetic counselling for family members of deceased child confirmed to have hereditary disease after post-mortem for preventive purposes."	
	On completion of the review of the child fatality cases occurring in 2010 and 2011, CFRP further recommended in its Second Report published in July 2013 that "**Newborn screening for inborn errors of metabolism will help identify and prevent re-occurrence of death related to these hereditary diseases. Medical teams coming across such cases should encourage family members to receive genetic counselling**."	The relevant department and organisation have set up a working group to study the feasibility of trying out in the public healthcare system a screening programme for newborn babies in relation to inborn errors of metabolism.