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Submission from the Hong Kong Paediatric Society to the Legco Welfare Penal on Child Fatality Review

"Speaking for the dead to protect the living"

The Hong Kong Paediatric Society supports to establish a regular mechanism to review Child Deaths in Hong Kong. By reviewing deaths in a timely manner and focusing on the underlying reasons and circumstances leading to the occurrence, the review aims to:

- ✓ Identify significant risk factors and monitor trends in child deaths.
- ✓ Identify specific barriers and system issues involved in the deaths of the children
- ✓ Identify needed changes in legislation, policy and practices, and expanded efforts in child health and safety to prevent child deaths.
- ✓ Facilitate communications and coordination among agencies especially concerning child death investigations and child protection strategies
- ✓ Improve agency responses to child deaths
- ✓ Improve agency response to protect siblings of deceased children
- ✓ Improve communication, linkages and enhanced coordination of efforts
- ✓ Provide access to available information to facilitate child death investigations
- ✓ Increase public awareness of the issues that impinge on the health and safety of children.

With a dedicated reporting system, data would be systematically analysis and local trends and issues would be identified to review child deaths, public would be appropriately alerted and educated. By having a pre-defined protocol of investigation as well as robust reporting and evaluation, effective strategies could be developed to prevent further death.

Child Fatality Review would maintain a register of the deaths of all children and young people (with potential extension to include severely injured or near-missed). It would focus on unexpected or unnatural deaths but there should also be mechanism to screen through the expected or natural deaths

in order not to miss cases of public interest. It should have the power to review the causes and patterns of deaths and to conduct broad research in relation to child deaths.

Child Fatality Review would complement the existing Coroner Court System by adopting a multidisciplinary and non public inquiry approach. The recommendations from the review would determine problems or failings with systems or processes and recommend improvement in laws, policies, procedures and practices to prevent child death.

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