Hong Kong College of Paediatricians
Submission to
Panel on Welfare Services of the Legislative Council
Subcommittee on Strategy and Measures to Tackle Family Violence
Child Fatality Review Mechanism
12th June 2008

The Hong Kong College of Paediatricians is pleased that after prolonged discussion a pilot project on Child Fatality Review was finally launched in February 2008, that a review panel has been appointed, the scope includes all cases involving children aged below 18 who died of unnatural causes and there will be a Child Death Register. Yet many of our concerns on this subject raised in the meeting of the Panel on Welfare Services on 14 May 2007 still remain to be addressed.

Selection of cases to be reviewed

It is unclear from the information provided by the Administration whether all unnatural deaths of children below 18 years are screened by the Panel members and then selected cases considered for in-depth review, or all cases are screened by the secretariat and selected cases considered by the Panel members with further selection for in-depth review. It is unclear also if only cases that have undergone a Coroner's inquest are being reviewed and whether there are potential unnatural child deaths that did not go through such an inquest. It is preferable that the net is cast wide till experience is gained.

Definition of cases to be reported to the Panel by concerned parties

Although the review covers all children who died of unnatural causes, before an investigation / review, professionals may not know whether the death is natural or unnatural in the first instance. The UK practice laid out in "Working together to safeguard children" 2006 recommends reporting all unexpected deaths in the first instance using the definition of "the death of a child that was not anticipated as a significant possibility 24 hours before the death, or when there was a similarly unexpected collapse leading to or precipitating the events that led to the death." If the Panel can clarify the definition for reporting in Hong Kong, there is less of a chance for omissions.

Composition of Panel members

Child death / death scene investigation is an important element in the identification of unnatural deaths in the first place. Enhanced protocols for investigation and autopsy are positive outcomes of some overseas child fatality review teams. There does not appear to be any member from law enforcement whose expertise would complement that of the rest of the Panel members.

Who to report cases to the Panel

For the healthcare sector, medical practitioners who encounter child deaths may be from different specialties e.g. paediatricians, doctors at the Accident and Emergency Departments, surgeons, neurosurgeons, orthopaedic surgeons. Currently other than paediatricians and medical social workers in public hospitals, there is probably little awareness of the pilot project within the healthcare sector, especially the private sector. There needs to be wider dissemination of the existence of the pilot project.

Legal liability and legislation

Our College has recommended legislative changes to ensure access to information, in whatever format, from different parties and confidentiality of information during the review process. It is unfortunate that the Review Panel is non-statutory and the current proposal is voluntary submission of reports by service agencies or reports of internal review within three months after the death of the child. This would usually be before the coroner's inquest is held or police investigations are generally made known. Without the legal protection of colleagues for this exercise, the reports may not be as thorough as it would be otherwise. While the focus of the Review Panel may be on the improvement of systems to protect children, parents or guardians may question professional management – be it medical or allied health care. Hong Kong is a relatively small community and cases of public interest are not many compared with other countries. Despite efforts to conceal identities, child deaths with certain characteristics may still be identified. Under such circumstances, it awaits to be seen how much information is or can be obtained through goodwill alone.

Ability of Panel / Secretariat to screen for appropriate cases for review

While it is appreciated that the Review Panel has decided to include all unnatural child deaths under the age of 18, whether appropriate cases will be identified for more thorough review depends very much on the information available on which to base the selection. With the difficulties mentioned under "Legal liability and legislation" above, the Panel / Secretariat may lack the basic information to make the appropriate selection of cases for review and even after selection to have the appropriate information to make recommendations.

Report and monitoring of implementation of recommendations

Reports of review findings and recommendations if only distributed to relevant parties / organizations for consideration and follow-up action may not maximize the value of the exercise. Our College recommends that the report should be submitted to the Legislative Council as recommendations may involve legislative and policy changes, service provision and interagency / department co-ordination. There needs to be also a mechanism to monitor whether recommendations are followed and if not, the reason(s) for failure of implementation.

Timing and scope of reviews

Starting with cases in 2006, the Review Panel will probably have a fair number of cases for review. In time, when the backlog is cleared, the requirement that all judicial processes have been completed prior to the review may have to be re-visited to avoid delays in identifying preventable causes of child deaths. As Hong Kong's legal system is based much on the British system, we do well to learn from the UK's Child Death Review process where apart from a multidisciplinary "rapid response" to unexpected child deaths, a "serious case review" is conducted within one month of being made known to the Local Safeguarding Children Board Chair and completed within four months. It is thought that serious case reviews "should not be delayed as a matter of course because of outstanding criminal proceedings or an outstanding decision whether or not to prosecute…" so as not to "prevent early lessons learnt from being implemented."

Lack of overall independent body to oversee the interest of children in Hong Kong

Despite repeated government consultations, the power of the Review Panel of the pilot projected is still relatively limited because the project is under the Director of Social Welfare who has no authority over other Government Bureaux. Hong Kong is in need of a Children's Commission that has overall responsibility to see that the best interest of children is served whichever government bureau is involved. The current exercise can then start and continue on firmer grounds with better and speedier outcome for the benefit of children.