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Review Panel of the Pilot Project on Child Fatality Review

Final Report

December 2010

FOREWORD

It is my honour to present this final report of the Review Panel of the Pilot Project on Child Fatality Review to you. We would like to share the findings of the review with all of you who are interested and committed in the welfare and well-being of children. This report is a synthesis of views and ideas of what can be done to prevent child death, in particular those of non-natural causes.

For members of the Review Panel, looking into the preventable and unpreventable child deaths in the past two years has been painful but meaningful. It is our mission to facilitate improvement of service systems pertaining to child welfare through promoting inter-sectoral and multi-disciplinary collaboration. We very much hope to see improvement in service systems, strengthening of collaboration of related professionals and an integrative approach in delivery of services pertaining to child welfare and prevention of child fatality.

With our deepest sympathy for the parents and families who lost their dear and beloved children, we hope that their suffering can be comforted by the very thought that the review on their children's death will help prevent similar sorrowful loss in future.

During the review process, members of the Review Panel highly appreciated the strenuous and meticulous efforts of many frontline personnel from different disciplines in helping the deceased children and their families. With the aim of prevention and striving for betterment, members of the Review Panel considers that there are times when services could have been better delivered to achieve preventive effects. Nevertheless, with the benefit of hindsight and the availability of more information we enjoy, we do not deem it fair to pass any judgement on the practice of those persons or organisations at particular moments under specific circumstances.

The willing and active participation of many parties, including government and non-governmental organisations, service providers, professional bodies have made the review an inter-sectoral and multi-disciplinary sharing forum. On behalf of the Review Panel, I must take this opportunity to extend our sincere and hearty thanks to all of them. They have shared their invaluable experience of good practice and lessons learnt with us where appropriate. Their support, cooperation, input and valuable views have supplied essential elements and substance for the newly born review mechanism to grow. We hope that the review has been a good learning and sharing experience for all who have participated.

Leung Nai Kong
Chairman
Review Panel of the Pilot Project on Child Fatality Review

ACKNOWLEDGEMENT

The Review Panel would like to extend our thanks to the Coroners, staff of the Coroner's Court, the concerned service organisations, and relevant government bureaux or departments. This Pilot Project would not have been so smooth without their continuous and active support.

Our hearty thanks to all frontline workers, professionals, and managerial personnel of organisations, bodies, and government bureaux or departments, who have provided information of different kinds to support the review. Their feedback and responses to the recommendations distributed to them have facilitated inter-sectoral and multi-disciplinary collaboration and sharing, which is the main purpose of the review. This review would not have been possible without their cooperation and participation.

Personnel from different disciplines, organisations, interested bodies and government bureaux or departments who gave suggestions and advice on the Pilot Project during its planning, implementation and way forward have demonstrated their strong commitment towards bettering child welfare. Their valuable views and advice on the future development of child fatality review have made them active partners working together to better child welfare service systems.

EXECUTIVE SUMMARY

I Background

This is the second and final report of the Review Panel of the Pilot Project on Child Fatality Review (Review Panel) which is an independent multi-disciplinary non-statutory body with members appointed by the Director of Social Welfare. Its first annual report on review findings of child death cases occurring in the year 2006 was released to the public in January 2010. The Review Panel considers its report a very important forum for sharing review findings and promoting inter-sectoral and multi-disciplinary exchange of what have been or can be done to improve the service systems to prevent child death.

This report contains the review findings of 209 death cases involving children aged below 18, occurring in the years 2006 and 2007 reported to the Coroner, good practice identified and lessons learnt as well as evaluation of the Pilot Project by the Review Panel and its recommendations on the way forward.

II Overview of Child Death Cases Reviewed

Compared with other countries, the age-specific child death rate of Hong Kong is relatively low. Major demographics of the 209 cases reviewed are as follows:

(i) 121 children (57.9%) died of natural causes, 32 (15.3%) died of accidents, 24 (11.5%) died of suicide, 11 (5.3%) died of assault and 21 (10.1%) died of miscellaneous causes;

(ii) The highest number of death occurs for children aged below 1 (N=69, 33.0%) with 53 of them died of natural causes. This is followed by the age group 15 – 17 (N=41, 19.6%) with 17 of them died of suicide;

(iii) The majority of the deceased children are Chinese (N=189, 90.4%), only 18 (8.6%) are non-Chinese. Nationality of two (1.0%) children is unknown;

(iv) There are more male (N=119, 56.9%) than female (N=90, 43.1%) children;

(v) Occupation of 91 (43.5%) children is not applicable either because they are too small or because their health problems prevented them from attending school or work. 89 (42.6%) children are full-time students while 19 (9.1%) are neither studying nor working;

(vi) Yuen Long District has the highest number of child death (N=19, 9.1%), closely followed by Kwai Tsing and Sai Kung Districts (both N=18, 8.6%); and

(vii) Most fatal incidents occurred in the homes of the deceased children (N=90, 43.1%), with hospital (N=70, 33.5%) as the second most common place. 17 fatal incidents occurred on road or streets and these were mainly traffic accidents.

III Main Themes and Issues

(i) Many child deaths are related to lack of proper child care, ineffective parental guidance, emotional trauma or depressive mood. Positive parenting, close supervision or concern and support from parents may have prevented such child deaths;

(ii) Home safety is a recurrent issue for cases with small children died of accidental falls, which would not happen if proper home safety device or measure had been in place;

(iii) Service providers generally find it difficult to motivate families or parents-at-risk lacking understanding on their own limited child care ability to seek or receive service at an early stage; and

(iv) Concealment and mishandling of unwanted pregnancy are observed in the review of many newborn and stillbirth cases. More thoughts should be given on how to encourage mothers, especially teenagers with unwanted pregnancy to voice their problems and seek assistance early.

IV Highlights of Recommendations by the Review Panel

The Review Panel has made a total of 65 recommendations pointing to preventive strategies and systems improvement for cases died of classified causes.

For prevention of children died of natural causes, proper and quality care arrangement for children with special needs at home or in residential care units, or during their home leaves from these units is recommended. Support for families looking after chronically-ill or disabled children requiring special care at home is also important.

For prevention of children died of accidents, public education on the possible fatal risk of leaving children unattended and the importance of home safety measures and devices for small children is recommended. It is also crucial for parents to seek assistance from reliable child minders and to maintain good and clear communication with them on the needs of children. Public education on prevention of drug or medicine-related accidents to children, stepping up law enforcement on the use of vehicle safety devices and targeted road safety campaigns for professional drivers and cyclists are also recommended.

For prevention of children died of suicide, helping professionals should bear in mind that children with serious suicidal intent may deny such intent in front of them. Management of cases with suicidal risk should focus on proper risk assessment with active follow-up and close liaison among the working parties concerned. Public education are also recommended to encourage suicidal children, their peers and families to seek help from helping professionals and to alert young people to take necessary precautions against possible tragedies arising from breaking up with their boyfriends or girlfriends.

For prevention of children died of assault, helping professionals should be sensitive and aware of the mental condition, mood, cultural background of the parents concerned, and other family risk factors which may have implication on the intervention required. Strengthening of the mechanism of decisive and timely removal of children-at-risk under repeated threat of domestic violence and very close supervision for children living with suspected abusers can ensure their well-being. Close collaboration and information sharing between parties involved in child protection cases is also necessary.

V Good Practice and Lessons Learnt

Good practice of and lessons learnt by service organisations identified in the review are shared for catalysing improvement of service systems. The good practice include:

(i) A school immediately conducted a reflective internal review after a student committed suicide resulting in quickly improved service mechanism;

(ii) The school personnel had taken prompt and collaborated actions to connect a student exhibiting abnormal and self-harming behaviour to needed services;

(iii) Concerted effort and regular liaison between an outreaching social worker and a school social worker in handling a school drop-out case; and

(iv) Some schools conducted comprehensive aftermath work subsequent to occurrence of fatal incidents to their students with support from the Education Bureau.

Important lessons were learnt by different service organisations having provided services to children who lost their lives due to different causes. After going through in-depth internal reviews, these organisations have identified the improvement needs in some areas, including assessment and handling of cases with suicidal risk, helping adolescents to build up resilience, providing support for those children with mental problems and early and decisive intervention for child protection.

VI Evaluation of the Pilot Project

The evaluation was conducted between March and August 2010. During this period, the Review Panel had held sub-group and panel meetings and collected views from parties having participated in the review and other stakeholders mainly through an evaluation questionnaire. 36 completed evaluation questionnaires were received.

The majority respondents found the review appropriate in aspects of scope, means, source of information, confidentiality of review, recommendations made by the Review Panel and they considered the review facilitative towards inter-sectoral and multi-disciplinary exchange. Over half of the respondents found the review appropriate in its timing and multi-disciplinary representation as well as considered the review having met its objectives.

VII Recommendations on Way Forward of the Review Mechanism

In view of the confirmation of the value of the review, the Review Panel recommends for a standing child fatality review mechanism. Meanwhile legislation is not necessary at this stage but may be considered in the future as and when necessary.

The standing review proposed will model on the Pilot Project with modifications. The scope of review should include but not limited to cases reported to the Coroner. Other than document study, other means of review such as focus group meeting and co-opting experts can be employed. Involvement of forensic pathologist and police can further enhance the multi-disciplinary representation of the review body. More sharing on the findings can facilitate better implementation of the recommendations for improvement of service systems. Outcome evaluation or impact assessment for the review can be considered over time when sufficient experience and data are accumulated.

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1 INTRODUCTION

Our society cannot bear the loss of our children.

Despite continuous efforts of the government and non-governmental service organisations, tragic child death cases of great public concern still arise occasionally. Committed to preventing reoccurrence of similar tragic incidents, and safeguarding the welfare of our children, the Social Welfare Department has implemented the two-year Pilot Project on Child Fatality Review since 15 February 2008.

An independent Review Panel was set up under this Pilot Project. Its mission is to help professionals and organisations serving children and their families to better understand the underlying causes of death of children and in what ways different parties could join hands to prevent similar incidents in the future. The purpose of the review is to identify and share good practice and lessons learnt in child welfare service delivery systems among professionals from different disciplines across sectors. It is not meant to examine individual practice or attribute responsibilities.

The trial review began with a scope of review on cases involving children aged below 18, died of non-natural causes and reported to the Coroner. Among the 20 categories of deaths reportable to the Coroner, as seen at ***Appendix I***, there are cases of public concern worth examining for lessons to learn. For this Pilot Project, "non-natural causes" refers to all causes other than "natural causes". Taking a prudent approach, the review put "unknown cause" ruled by the Coroner into the category of "non-natural cause" lest there were suspicious circumstances surrounding the death of those children.

The background, purpose and objectives, scope of review and the review mechanism of the Pilot Project are summarised in an Information Brief at ***Appendix II***.

Shortly after commencement of the Pilot Project, in pursuance of a more comprehensive review, the Review Panel widened the scope to cover child death cases with natural causes reported to the Coroner. Cases from other sources, such as reports from concerned service organisations and mass media, had also been identified and included if they were found suitable for review.

Despite the main source of cases and review information is from the Coroner's Court, the review is meant to complement, rather than duplicate what the Coroner's Court has been doing. While not all child death cases would go through death inquest with recommendations made in the Coroner's Court, the Review Panel examined every case within the scope of review in details to look for possible prevention strategies.

To avoid prejudicing any criminal or legal procedures, review on child death cases begins only after such procedures have been completed. As two years after the occurrence of the child fatal incident is considered a reasonable period for the completion of such processes, the trial review covers child death cases occurring between 1 January 2006 and 31 December 2007. After a period of information collection, the Review Panel started review on cases in May 2008.

In January 2010, the Review Panel released its First Report on the findings and recommendations for cases occurring in 2006 to the public. The Report is also uploaded onto the website of the Social Welfare Department at: **http://www.swd.gov.hk/doc/whatsnew/201001/PPCFR1R.pdf** for easy access by the public.

This is the second and final report of the Review Panel which includes all findings and recommendations made and responses received from all concerned parties during the pilot period, and the evaluation of the Pilot Project. It is designed to cater for readers who may or may not have read the First Report or prior knowledge of the Pilot Project. Chinese version of this report is also available.

The content of this Report is structured as follows:

In pursuance of the principle of strict confidentiality and to protect the privacy of persons and parties concerned, no identifying information of cases reviewed, related individual or non-governmental organisation will be revealed in this report. Taking care not to recall or arouse any traumatic feelings of the parents and parties concerned, and in pursuance of free and neutral discussion, the Review Panel is obliged to maintain an anonymous and aggregate style of reporting as pledged to all information providers.

2 THE REVIEW PANEL

To take forward the Pilot Project commencing on 15 February 2008, the Director of Social Welfare appointed 14 individuals from different disciplines for two years to form the Review Panel.

The appointment of the members of the Review Panel was based on the expertise, commitment, knowledge or experience in child welfare of these individuals. Special care has been taken during the appointment process to ensure that the Review Panel was multi-disciplinary, neutral and independent. The Social Welfare Department provided secretarial support for the Review Panel.

The terms of reference of the Review Panel are:

(i) To examine the service delivery process of organisations / departments concerned, if any, prior to the child's death;

(ii) To identify good practice, gaps and deficiency in related services, systems and multi-disciplinary collaboration that may be involved in the cases reviewed and to suggest improvements;

(iii) To identify patterns and trends through reviewing cases of children died of non-natural causes in the direction of formulating preventive strategies; and

(iv) To promote inter-disciplinary and inter-agency cooperation to prevent child death.

Soon after the commencement of the Pilot Project, the Review Panel decided to extend the scope of review to cover cases died of natural causes to make the review more comprehensive. To support the Review Panel's decision and in view that most natural death causes were related to health or medical conditions of the deceased, the Director of Social Welfare appointed four paediatricians as co-opted members of the Review Panel in February 2009 for one year to tap their medical expertise to facilitate the review.

The tasks of the co-opted members (medical experts) are:

(i) To conduct a general review on cases of children who died of natural causes;

(ii) To report the findings of this general review on cases of children who died of natural causes to the Review Panel;

(iii) To propose suitable cases, if any, for in-depth review for consideration by the Review Panel, and;

(iv) To participate in in-depth review of cases of children who died of natural causes.

For efficient and effective review, members of the Review Panel divided themselves into 5 sub-groups to look into cases of different nature according to their expertise. A convenor was selected for each group to lead the discussion and to report the findings of review at the quarterly panel meeting.

Members of the Review Panel are listed in the following:

A. Chairman and Convenors:

	Name	**Discipline**
1.	Prof LEUNG Nai-kong (Chairman)	Medical (Paediatrics)
2.	Prof SHEK Tan-lei, Daniel (Convenor of Group A – Suicide)	Academia
3.	Ms WONG Yu-pok, Marina (Convenor of Group B – Traffic Accidents)	Accounting
4.	Dr LEE Lai-wan, Maria (Convenor of Group C – Other Accidents)	Child Education
5.	Mr HUI Chung-shing, Herman (Convenor of Group D – Assault & Miscellaneous)	Legal
6.*	Dr YU Chak-man (Convenor of Medical Group – Natural Causes)	Medical (Paediatrics)

B. Other Members:

	Name	Discipline
7.	Ms CHAN Kit-bing, Sumee	Clinical Psychology
8.	Miss CHAN Mei-lan, Anna May	Legal
9.	Miss CHAN Mi-har, Grace	Social Welfare
10.*	Dr CHEUNG Chi-hung, Patrick	Medical (Paediatrics)
11.	Miss HUNG Wing-chee, Anna	Education
12.	Dr LAM CHAN Lan-tak, Gladys	Academia
13.	Ms LAM Wai-ling, Leona	Education
14.*	Prof Albert Martin LI	Medical (Paediatrics)
15.	Miss TSANG Lan-see, Nancy	Social Welfare
16.*	Dr TSANG Man-ching, Anita	Medical (Paediatrics)
17.	Dr YIU Gar-chung, Michael	Medical (Psychiatry)
18.	Mr YU Wing-fai, Christopher	Parent Representative

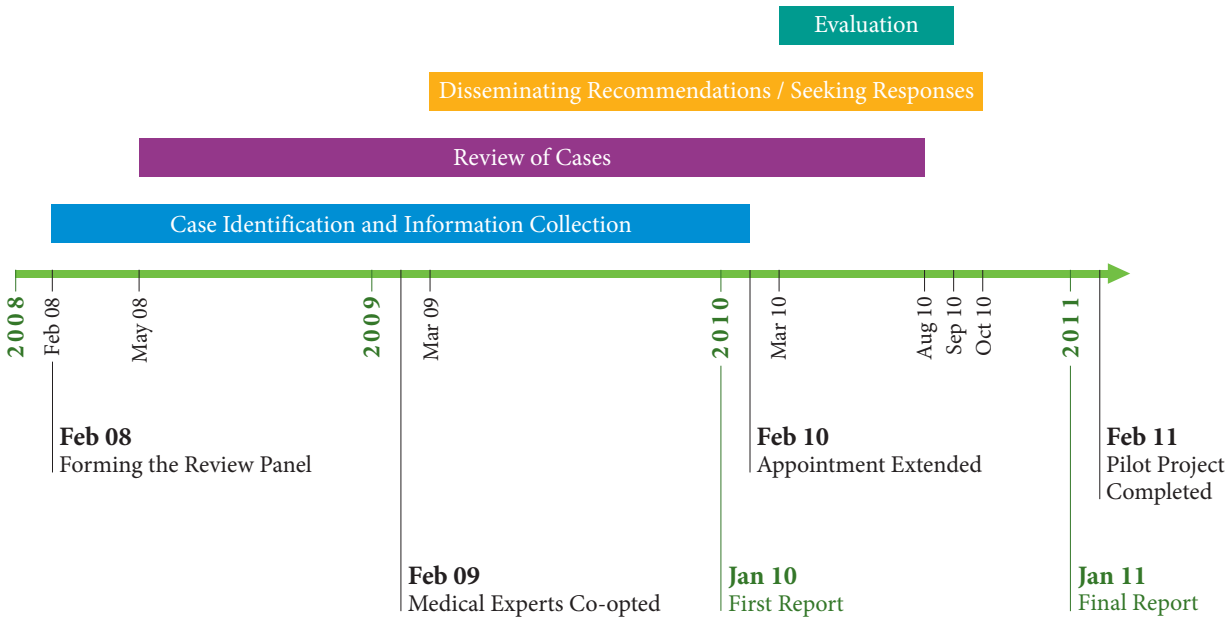
* *Co-opted members*

The appointment of the members and co-opted members of the Review Panel who were all volunteers expired on 15 February 2010. As there were still outstanding tasks including the evaluation of the Pilot Project and the production of the Final Report, the Director of Social Welfare extended the appointment of all members, including the co-opted members, for one year to February 2011.

From February 2008 to December 2010, the Review Panel had held 47 meetings, including 13 panel meetings and 34 sub-group meetings.

During the appointment period, when possible, the Review Panel has taken the opportunity to exchange view on the review and share the findings with interested parties to promote inter-disciplinary collaboration. Figure 2.1 below shows the timeline of the work of the Review Panel:

Figure 2.1: Timeline of the Review Panel



3 REVIEW METHODOLOGY

The methods and tools used in the Pilot Project are chosen or designed with the assumption that the concerned service providers have commitment and capability of reflective internal and external reviews. It is also believed that parties concerned are ready to share good practice identified and lessons learnt with the focus on or purpose of improving service systems to enhance child protection. Therefore, all procedures set for the review are geared towards multi-disciplinary and inter-sectoral collaborative efforts to systems improvement.

The following is a description of methods and tools used to facilitate the review:

3.1 Identifying Cases

As the 20 categories of deaths to be reported to the Coroner as required by law ***(Appendix I)*** already covered type of cases with greatest public concern, the original scope of review of the Pilot Project was set at cases reported to the Coroner. With approval sought from the Coroner's Court, the Secretariat of the Review Panel obtained the list of child death cases aged below 18 and reported to the Coroner for the years 2006 and 2007 for review.

Apart from cases reported to the Coroner, the Review Panel encouraged reporting of child death cases from all relevant service providers. The Secretariat of the Pilot Project had received a few reports from service organisations / departments. However, as these child deaths occurred later than 2007, they were not included in the review. The Secretariat also identified child death cases from media reports for the Review Panel's consideration of review.

3.2 Collecting Information

Approval from the Coroner was obtained for collecting information of child death cases reported to the Coroner's Court. Therefore, the Review Panel had access to papers and documents filed there. The Education Bureau also regularly provided brief information on student suicide cases to the Secretariat. Through information from the Coroner's Court and the Education Bureau, the Secretariat could trace the service organisations or government departments having provided services to the deceased children to request information on services provided to the deceased children.

The basic tools designed for collecting information was a Data Input Form ***(Appendix III)*** and a Service Report ***(Appendix IV)***. The Data Input Form was for initial reporting of basic information while the Service Report provided details of case information, professional input and internal review results of the service provider.

After parties having provided service to the deceased child were identified, the Secretariat sent written request to all related organisations, government bureaux or departments for submission of service report. Follow-up written or phone enquiries were made to service providers if clarification, further information or information on specific areas of concern was required for review.

The Secretariat also, where necessary, requested information on service guidelines, regulations or handling procedures etc. from concerned organisations / government bureaux or departments as background information to facilitate the review.

3.3 Ensuring Confidentiality

During the process of review, prudent measures were taken to ensure that the review was strictly confidential and anonymous.

In respect to privacy of personal data, no names or other personal identifiers of individuals related to the cases, including family members and staff of the service organisation were required to be entered in the Service Report or Data Input Form. Only the name and identity of the deceased child were quoted on the form for referring purpose. Names and contacts of those who completed the reports were required solely for the purpose of facilitating subsequent clarification of information when necessary.

Every member of the Review Panel signed a statement of confidentiality to undertake that they would keep all information they had accessed confidential after they accepted the appointment to the Review Panel. It was also a standard procedure for the Chairman and Convenors to remind all members to keep all review information confidential and within the Review Panel at all review meetings.

The Secretariat removed all names of persons (including those of the deceased children) and organisations and their identifiers which appeared in the information collected for review purpose before passing the information to members of the Review Panel. To prevent any leakage of review information, members of the Review Panel usually arrived before the review meeting early enough to go through all the review documents, and would not take away any of them after the meeting. In other words, these documents were all along kept in confidential storage in the office of the Secretariat and were destroyed upon completion of review.

3.4 Ensuring Neutrality

There were also standard procedures for members of the Review Panel to declare interest before review meetings started. They were required to indicate if they were in any way related to any case, person or organisation. In case there appeared possibility of conflict of interest for a member of the Review Panel, he/she would abstain from discussion. While shortlisting cases for review by different sub-groups within the Review Panel, the Secretariat also arranged to avoid distributing cases to members who might be related to them.

3.5 Reviewing Cases

The method of reviewing child death cases was primarily documentary in nature. Written information collected from various sources on the case background, death circumstances, services provided and related service systems were consolidated, organised and presented to the Review Panel for screening, examination and discussion.

The Review Panel remained open in employing the method of interviewing the concerned parties to collect information for review. Interviews with concerned parties could be arranged when necessary and provided it would not arouse traumatic feelings.

Review of cases was conducted through sub-group and panel meetings. Panel meetings, which were attended by all members of the Review Panel, were held quarterly to discuss issues relating to the implementation of the Pilot Project, to receive and discuss reports from sub-groups, and to conduct in-depth review. Members of the Review Panel were divided into five sub-groups according to their expertise to hold meetings in-between the panel meetings to conduct review on cases with different causes of death:

Group A	:	Suicide
Group B	:	Traffic Accidents
Group C	:	Other Accidents
Group D	:	Assault & Miscellaneous
Medical Group	:	Natural Causes

All related review documents for each case were examined in details in the sub-group review meetings. The Convenor of each sub-group regularly reported the findings and recommendations of his / her sub-group to the Review Panel at the quarterly panel meeting. The Review Panel discussed the findings, endorsed, amended or added on the recommendations as and when necessary. Upon recommendations from members, cases with good lessons to learn were scheduled for review by all members at panel meetings.

Under the Pilot Project, a computerised database was set up for keeping demographic data and death information of cases reviewed. It was hoped that data collected and stored in this database could contribute to statistical and future study purposes of the Review Panel.

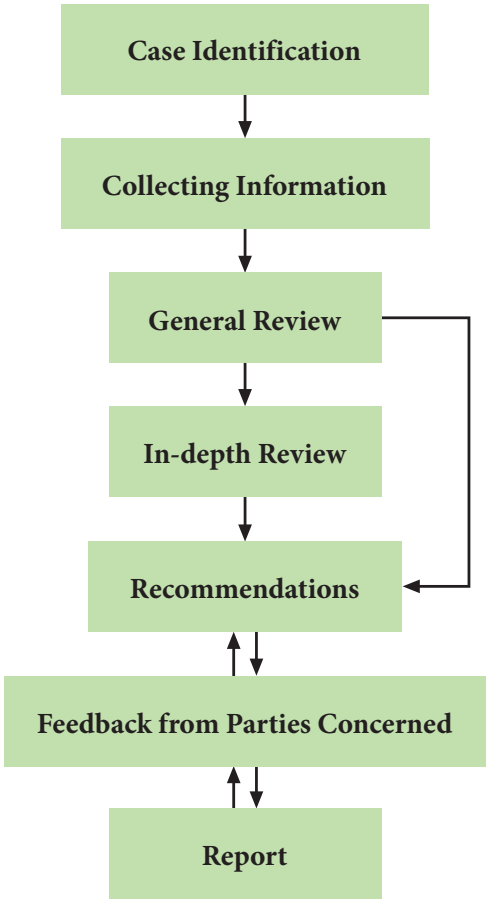
3.6 Handling of Findings

After review, observations and recommendations made on individual or group of cases by the Review Panel were distributed to parties concerned for consideration of follow-up. These parties included those who had provided services to the deceased children's families, government bureaux / departments or non-governmental organisations / bodies which might have an interest in, or could join hands to implement the improvement measures suggested.

All recipients of the recommendations were invited to give their comments, feedback and updating of service improvements for sharing with others. This was another very important process of the review for promotion of inter-sectoral and inter-disciplinary collaboration to better the child welfare service system. It had also become an integral part of the review as it served to catalyse multi-disciplinary exchange of views and cooperation for strengthening of service improvement measures.

The Review Panel of the Pilot Project published its First Report in January 2010. This Final Report was also meant to be an important means of documentation and sharing of this kind of inter-sectoral and multi-disciplinary exchange. Figure 3.1 summarises the review procedures and the exchange process:

Figure 3.1 Flowchart of the Review Process



4 STRENGTHS AND LIMITATIONS OF THE REVIEW

4.1 Strengths

(1) This Pilot Project was an unprecedented attempt to introduce a child fatality review mechanism in the Hong Kong context for improving local child welfare service systems. It has the strength of a clear and sound objective signifying the society's putting child welfare as paramount, and a call for concerted efforts to promote quality child welfare services;

(2) The planning and implementation of the Pilot Project was based on the result of examination of pros and cons of existing types of child fatality review mechanisms in different countries, including the United States, the United Kingdom, Australia and Canada, with consideration of applicability to the local context;

(3) The Review Panel has also made reference to reports on child fatality review from these countries in order to ensure that the methodology was on par with the international standard used in existing review methods;

(4) The review of this Pilot Project adopts a multi-disciplinary approach, pooling expertise from professionals of different fields and disciplines. This approach was reflected in the different background of the members appointed to the Review Panel, including medical (paediatrics and psychiatric), clinical psychology, social welfare, education, legal, accounting, academic and parent representative. It was hoped that multi-faceted perspective would lead to recommendations useful and feasible for service improvements;

(5) This review also placed high value in the process of inter-sectoral and inter-disciplinary exchange and sharing of good practice or improvement measures taken. In fact, one of the objectives of the review was to promote multi-disciplinary collaboration to achieve improvement of our child welfare service systems; and

(6) The findings of the review were based on detailed case-by-case study of child deaths with different causes.

4.2 Limitations

(1) The review was primarily documentary in nature based on available information. The Review Panel was well aware that the information collected might not be able to reflect the entire sequence of events that had occurred, all actions that had been taken or all efforts made to help the families of the deceased children;

(2) The review of child deaths that occurred in 2006 began in May 2008. With the lapse of time, the Review Panel fully understood that the recommendations made, which were based on information at the time of the incidents, might not be 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;

(3) Owing to limited or insufficient information available for some of the cases (for instance, death of natural causes with autopsy waived due to request by family members), the Review Panel was mindful of not passing any comment on such cases;

(4) Two organisations had reservations in disclosing the case details and provided very basic information despite the assurance of confidentiality. On the other hand, the Review Panel appreciated that many organisations provided very detailed reports with recommendations for future improvement;

(5) Some of the recommendations made by the Review Panel stemmed from the review of just one single case. With due respect to the uniqueness of every case and every family, the Review Panel understood that it might not be appropriate to generalise such recommendations to all cases. Likewise, the recommendations on improvement measures should not be considered as panacea to child fatality;

(6) With due respect for different missions, functions or service scope of different government departments or non-governmental organisations, and to allow concerned parties' autonomy in service delivery, the recommendations were directional rather than specific in nature. However, it was hoped that they could help prevent child fatality when similar circumstances occurred in the future; and

(7) Owing to the variations in the comprehensiveness and depth of the information submitted to the Coroner's Court or provided by organisations concerned to the Review Panel, and that not all deceased children had attended school or received services from social welfare organisations from where their family background could be traced, this report could not provide comprehensive or detailed statistical data reflecting the social profiles of all the deceased children.

The limitations mentioned above are in fact faced by nearly all known fatality review mechanisms elsewhere in the world. With close reference to overseas practices and judging from the feedback from stakeholders, the present review mechanism in Hong Kong is actually on par with international standards and is considered to have performed its functions well.

5 OVERVIEW OF ALL CASES REVIEWED

In the year 2006, among the mid-year child population of 1,204,100[1], a total of 269[2] children aged under 18 died and in the year 2007, among the mid-year child population of 1,180,900[3], a total of 247[4] children died.

Table 5.1: Facts and Figures of Child Death in Hong Kong (2006 – 2007)

Type of Figure	Year	
	2006	2007
Child population[5]	1,204,100	1,180,900
No. of child death	269	247
Child death rate[6]	0.2	0.2
No. of child death reported to Coroner	118*	91
(–) No. of outstanding cases with litigation process going on	1	0
(+) No. of reviewed cases not reported to Coroner	0	1
No. of cases reviewed	117	92

**In the First Report of the Review Panel of the Pilot Project on Child Fatality Review, the number of child death reported to Coroner for the year 2006 was 109. The figure has been revised to 118 after taking into account updated figure including the stillbirth data.*

[1] Source: Census and Statistics Department.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Child population: refers to the mid-year population of children aged under 18.
Source: Census and Statistics Department.

[6] Child death rate: refers to the number of child deaths per 1,000 child population.
Source: Census and Statistics Department.

Table 5.1 above shows some facts and figures concerning child death in Hong Kong for the years 2006 and 2007. The child death rate for both 2006 and 2007 is 0.2 per 1,000 child population.

As litigation process was still going on for one case reported to the Coroner in 2006 when the pilot review ended, this case was not included in the review. On the other hand, the Review Panel had included in the review a case which had aroused public concern in 2007 but not reported to the Coroner. Consequently, the total number of cases reviewed is the same as the total number of cases reported to the Coroner as at 31 October 2010, i.e. 209 cases.

In this Report, cases reviewed are classified into five main categories, namely: natural causes, accidents, suicide, assault and miscellaneous causes. The category of "miscellaneous" includes cases died of unknown cause and medical complications. These two types of cases are grouped together for presentation in this report because of their being small in number or low relevance to child welfare service systems.

For this Chapter:

- Section 5.1 is an overview of the demographic data of the 209 cases reviewed during the pilot review. These data are based on available information gathered or reported for review from various sources.

- Section 5.2 is an overview of those 209 cases reviewed by year.

- Section 5.3 is an account of the general observations of the Review Panel on the cases reviewed.

In the presentation of percentage of figures in tables in this report, there may be a slight discrepancy between the percentage of individual items and the total percentage as shown in the tables owing to rounding.

5.1 Overview of All Child Death Cases

Table 5.1.1: No. of Cases by Case Nature

Case Nature	No. of Cases (%)
Natural	121 (57.9%)
Non-natural	88 (42.1%)
Total:	209 (100.0%)

Table 5.1.2: No. of Cases by Age Group and Sex

Age Group	Sex		No. of Cases (%)
	Female (%)	Male (%)	
< 1	35 (16.8%)	34 (16.3%)	69 (33.0%)
1 – 2	5 (2.4%)	10 (4.8%)	15 (7.2%)
3 – 5	4 (1.9%)	8 (3.8%)	12 (5.7%)
6 – 8	6 (2.9%)	12 (5.7%)	18 (8.6%)
9 – 11	14 (6.7%)	11 (5.3%)	25 (12.0%)
12 – 14	11 (5.3%)	18 (8.6%)	29 (13.9%)
15 – 17	15 (7.2%)	26 (12.4%)	41 (19.6%)
Total (%):	90 (43.1%)	119 (56.9%)	209 (100.0%)

Table 5.1.3: No. of Cases by Nationality

Nationality	No. of Cases (%)
Chinese	189 (90.4%)
Non-Chinese	18 (8.6%)
Unknown	2 (1.0%)
Total:	209 (100.0%)

Table 5.1.4: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	89 (42.6%)
Full-time Work	3 (1.4%)
Part-time Work	1 (0.5%)
Not Studying & Not Working	19 (9.1%)
Not Applicable*	91 (43.5%)
Unknown	6 (2.9%)
Total:	209 (100.0%)

Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

Table 5.1.5: No. of Cases by Cause of Death

Cause of Death	No. of Cases (%)
Natural Causes	121 (57.9%)
Accidents	32 (15.3%)
Suicide	24 (11.5%)
Assault	11 (5.3%)
Miscellaneous*	21 (10.1%)
Total:	209 (100.0%)

Miscellaneous: includes Unknown and Medical Complications.*

Table 5.1.6: No. of Cases by Cause of Death and Sex

Cause of Death	Sex		No. of Cases (%)
	Female (%)	Male (%)	
Natural Causes	54 (25.8%)	67 (32.1%)	121 (57.9%)
Accidents	11 (5.3%)	21 (10.1%)	32 (15.3%)
Suicide	10 (4.8%)	14 (6.7%)	24 (11.5%)
Assault	6 (2.9%)	5 (2.4%)	11 (5.3%)
Miscellaneous*	9 (4.3%)	12 (5.7%)	21 (10.1%)
Total (%):	90 (43.1%)	119 (56.9%)	209 (100.0%)

Miscellaneous: includes Unknown and Medical Complications.*

Table 5.1.7: No. of Cases by Age Group and Cause of Death

Age Group	Cause of Death					No of Cases (%)
	Natural Causes	Accidents	Suicide	Assault	Miscellaneous*	
< 1	53	3	0	2	11	69 (33.0%)
1 – 2	12	1	0	0	2	15 (7.2%)
3 – 5	8	2	0	1	1	12 (5.7%)
6 – 8	7	9	0	2	0	18 (8.6%)
9 – 11	15	5	2	3	0	25 (12.0%)
12 – 14	13	7	5	1	3	29 (13.9%)
15 – 17	13	5	17	2	4	41 (19.6%)
Total:	121	32	24	11	21	209 (100.0%)

Miscellaneous: includes Unknown and Medical Complications.*

Table 5.1.8: No. of Cases by Residential District

Residential District	No. of Cases (%)
HONG KONG ISLAND	
Central and Western	8 (3.8%)
Wan Chai	1 (0.5%)
Eastern	11 (5.3%)
Southern	9 (4.3%)
KOWLOON	
Yau Tsim Mong	1 (0.5%)
Sham Shui Po	14 (6.7%)
Kowloon City	9 (4.3%)
Wong Tai Sin	14 (6.7%)
Kwun Tong	15 (7.2%)
NEW TERRITORIES	
Kwai Tsing	18 (8.6%)
Tsuen Wan	9 (4.3%)
Tuen Mun	15 (7.2%)
Yuen Long	19 (9.1%)
North	8 (3.8%)
Tai Po	7 (3.3%)
Sha Tin	10 (4.8%)
Sai Kung	18 (8.6%)
Islands	5 (2.4%)
OTHERS	
Not residing in HK	15 (7.2%)
Unknown	3 (1.4%)
Total:	209 (100.0%)

Classification of the residential districts above is according to the 18 districts in District Council / Constituency Area.

Table 5.1.9: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	90 (43.1%)
Hospital	70 (33.5%)
School	2 (1.0%)
Indoor (Not Home)	8 (3.8%)
Outdoor	13 (6.2%)
Street/Road	17 (8.1%)
Water/Sea	5 (2.4%)
Others*	1 (0.5%)
Unknown	3 (1.4%)
Total:	209 (100.0%)

Others: inside the lift in a building.*

5.1.1 General Observations

Table 5.1.1 shows that of the 209 reviewed cases, 57.9% (N=121) died of natural causes while 42.1% (N=88) died of non-natural causes.

Table 5.1.2 shows that the highest number of death occurred for children aged below 1 (N=69, 33.0%). The age group 15 – 17 came second (N=41, 19.6%), followed by the age group 12 – 14 (N=29, 13.9%).

Table 5.1.3 shows that among all child death cases reviewed, the vast majority, amounting to 90.4% (N=189) of the children were Chinese and only 8.6% (N=18) were non-Chinese.

Table 5.1.4 shows that the majority of the deceased children in the cases reviewed were students (N=89, 42.6%). Occupation was not applicable to 91 (43.5%) children who were small or had health problems which rendered them unable to attend school or work.

Table 5.1.5 shows that over half of the cases reviewed died of natural causes (N=121, 57.9%). The second highest number of child death was caused by accidents (N=32, 15.3%). There were 24 (11.5%) children who committed suicide.

Table 5.1.6 shows that more male (N=119, 56.9%) than female (N=90, 43.1%) died. It is only for the death cause of assault that more female (N=6, 2.9%) than male children (N=5, 2.4%) died but the difference is slight.

Table 5.1.7 shows the number of cases by age group and cause of death. The highest number of child death occurs for children aged below 1 died of natural causes (N=53, 25.4%), followed by the aged group 15 – 17 died of suicide (N=17, 8.1%). Meanwhile, the largest number of children died of accidents appears in the age group 6 – 8 (N=9, 4.3%).

Table 5.1.8 shows the distribution of the cases according to the residential districts of the deceased children. Yuen Long District has the highest number of child death (N=19, 9.1%) followed by Kwai Tsing and Sai Kung Districts with the same number of child death (N=18, 8.6%). The smallest number of child death (N=1, 0.5%) appeared in both Wan Chai and Yau Tsim Mong Districts. However, it should be noted that the child death rates[7] for the five districts mentioned above are about the same (around 0.2 child death per 1,000 child population).

Table 5.1.9 shows that home is the most common place for occurrence of fatal incidents (N=90, 43.1%), with hospital comes second (N=70, 33.5%). 17 (8.1%) fatal incidents occurred on road or in streets mainly owing to traffic accidents.

[7] Child death rate : refers to the number of child deaths per 1,000 child population.
Source: Planning Department, Census and Statistics Department.

5.2 Overview of All Child Death Cases by Year – a Comparison

Table 5.2.1: No. of Cases by Year

Year	No. of Cases (%)
2006	117 (56.0%)
2007	92 (44.0%)
Total:	209 (100.0%)

Table 5.2.2: No. of Cases by Case Nature and Year

Case Nature	Year		No. of Cases (%)
	2006 (%)	2007 (%)	
Natural	69 (50.0%)	52 (56.5%)	121 (57.9%)
Non-natural	48 (41.0%)	40 (43.5%)	88 (42.1%)
Total (%):	117 (100.0%)	92 (100.0%)	209 (100.0%)

Table 5.2.3: No. of Non-natural Deaths by Age Group and Year

Age Group	Year		No. of Cases (%)
	2006 (%)	2007 (%)	
< 1	6 (12.5%)	10 (25.0%)	16 (18.2%)
1 – 2	2 (4.2%)	1 (2.5%)	3 (3.4%)
3 – 5	1 (2.1%)	3 (7.5%)	4 (4.5%)
6 – 8	7 (14.6%)	4 (10.0%)	11 (12.5%)
9 – 11	5 (10.4%)	5 (12.5%)	10 (11.4%)
12 – 14	7 (14.6%)	9 (22.5%)	16 (18.2%)
15 – 17	20 (41.7%)	8 (20.0%)	28 (31.8%)
Total (%):	48 (100.0%)	40 (100.0%)	88 (100.0%)

Table 5.2.4: No. of Natural Deaths by Age Group and Year

Age Group	Year		No. of Cases (%)
	2006 (%)	2007 (%)	
< 1	26 (37.7%)	27 (51.9%)	53 (43.8%)
1 – 2	8 (11.6%)	4 (7.7%)	12 (9.9%)
3 – 5	6 (8.7%)	2 (3.8%)	8 (6.6%)
6 – 8	3 (4.3%)	4 (7.7%)	7 (5.8%)
9 – 11	10 (14.5%)	5 (9.6%)	15 (12.4%)
12 – 14	11 (15.9%)	2 (3.8%)	13 (10.7%)
15 – 17	5 (7.2%)	8 (15.4%)	13 (10.7%)
Total (%):	69 (100.0%)	52 (100.0%)	121 (100.0%)

Table 5.2.5: No. of Cases by Age Group,Year and Sex

Age Group	Year and Sex				No. of Cases (%)
	2006		2007		
	Female	Male	Female	Male	
< 1	18	14	17	20	69 (33.0%)
1 – 2	3	7	2	3	15 (7.2%)
3 – 5	1	6	3	2	12 (5.7%)
6 – 8	3	7	3	5	18 (8.6%)
9 – 11	8	7	6	4	25 (12.0%)
12 – 14	6	12	5	6	29 (13.9%)
15 – 17	11	14	4	12	41 (19.6%)
Total:	50	67	40	52	209 (100.0%)

Table 5.2.6: No. of Cases by Nationality and Year

Nationality	Year		No. of Cases (%)
	2006 (%)	2007 (%)	
Chinese	105 (89.7.%)	84 (91.3%)	189 (90.4%)
Non-Chinese	12 (10.3%)	6 (6.5%)	18 (8.6%)
Unknown	0 (0.0%)	2 (2.2%)	2 (1.0%)
Total (%):	117 (100.0%)	92 (100.0%)	209 (100.0%)

Table 5.2.7: No. of Cases by Occupation and Year

Occupation	Year		No. of Cases (%)
	2006 (%)	2007 (%)	
Full-time Student	49 (41.9%)	40 (43.5%)	89 (42.6%)
Full-time Work	2 (1.7%)	1 (1.1%)	3 (1.4%)
Part-time Work	0 (0.0%)	1 (1.1%)	1 (0.5%)
Not Studying & Not Working	14 (12.0%)	5 (5.4%)	19 (9.1%)
Not Applicable*	47 (40.2%)	44 (47.8%)	91 (43.5%)
Unknown	5 (4.3%)	1 (1.1%)	6 (2.9%)
Total (%):	117 (100.0%)	92 (100.0%)	209 (100.0%)

Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

Table 5.2.8: No. of Cases by Cause of Death and Year

Cause of Death	Year		No. of Cases (%)
	2006 (%)	2007 (%)	
Natural Causes	69 (59.0%)	52 (56.5%)	121 (57.9%)
Accidents	20 (17.1%)	12 (13.0%)	32 (15.3%)
Suicide	14 (12.0%)	10 (10.9%)	24 (11.5%)
Assault	5 (4.3%)	6 (6.5%)	11 (5.3%)
Miscellaneous*	9 (7.7%)	12 (13.0%)	21 (10.1%)
Total (%):	117 (100.0%)	92 (100.0%)	209 (100.0%)

Miscellaneous: includes Unknown and Medical Complications.*

Table 5.2.9: No. of Cases by Cause of Death, Year and Sex

Cause of Death	Year & Sex				No. of Cases (%)
	2006		2007		
	Female	Male	Female	Male	
Natural Causes	30	39	24	28	121 (57.9%)
Accidents	8	12	3	9	32 (15.3%)
Suicide	7	7	3	7	24 (11.5%)
Assault	3	2	3	3	11 (5.3%)
Miscellaneous*	2	7	7	5	21 (10.1%)
Total:	50	67	40	52	209 (100.0%)

Miscellaneous: includes Unknown and Medical Complications.*

Table 5.2.10: No. of Cases by Residential District and Year

Residential District	Year		No. of Cases (%)
	2006	2007	
HONG KONG ISLAND			
Central and Western	7	1	8 (3.8%)
Wan Chai	1	0	1 (0.5%)
Eastern	4	7	11 (5.3%)
Southern	4	5	9 (4.3%)
KOWLOON			
Yau Tsim Mong	1	0	1 (0.5%)
Sham Shui Po	8	6	14 (6.7%)
Kowloon City	5	4	9 (4.3%)
Wong Tai Sin	7	7	14 (6.7%)
Kwun Tong	7	8	15 (7.2%)
NEW TERRITORIES			
Kwai Tsing	10	8	18 (8.6%)
Tsuen Wan	4	5	9 (4.3%)
Tuen Mun	8	7	15 (7.2%)
Yuen Long	10	9	19 (9.1%)
North	6	2	8 (3.8%)
Tai Po	5	2	7 (3.3%)
Sha Tin	7	3	10 (4.8%)
Sai Kung	11	7	18 (8.6%)
Islands	3	2	5 (2.4%)
OTHERS			
Not residing in HK	9	6	15 (7.2%)
Unknown	0	3	3 (1.4%)
Total:	117	92	209 (100.0%)

Classification of the residential districts above is according to the 18 districts in District Council / Constituency Area.

Table 5.2.11: No. of Cases by Place of Fatal Incident and Year

Place of Fatal Incident	Year		No. of Cases (%)
	2006 (%)	2007 (%)	
Home	52 (44.4%)	38 (41.3%)	90 (43.1%)
Hospital	37 (31.6%)	33 (35.9%)	70 (33.5%)
School	0 (0.0%)	2 (2.2%)	2 (1.0%)
Indoor (Not Home)	6 (5.1%)	2 (2.2%)	8 (3.8%)
Outdoor	7 (6.0%)	6 (6.5%)	13 (6.2%)
Street/Road	10 (8.5%)	7 (7.6%)	17 (8.1%)
Water/Sea	4 (3.4%)	1 (1.1%)	5 (2.4%)
Others*	1 (0.9%)	0 (0.0%)	1 (0.5%)
Unknown	0 (0.0%)	3 (3.3%)	3 (1.4%)
Total (%):	117 (100.0%)	92 (100.0%)	209 (100.0%)

Others: inside the lift of a building.*

5.2.1 General Observations

As shown in Table 5.2.1, among the cases reviewed, the number of cases occurring in 2006 (N=117, 56.0%) is more than 2007 (N=92, 44.0%).

Table 5.2.2 shows the number of cases for natural and non-natural deaths for the years 2006 and 2007. In both years, the number of cases of natural causes is higher than the number of non-natural causes. The proportions of natural death (N=69, 59.0% for 2006 and N=52, 56.5% for 2007) to non-natural death (N=48, 41.0% for 2006 and N=40, 43.5% for 2007) are quite similar.

Table 5.2.3 shows the number of children died of non-natural causes in different age groups in the years 2006 and 2007. For the year 2006, the age group of 15 – 17 has the largest number of cases (N=20, 41.7%) due to the larger number of suicide cases within this age group in that year as compared to 2007. The age groups with the second highest number of child death were 6 – 8 and 12 – 14 (both N=7, 14.6%). For the year 2007, the highest number occurred for children aged below 1 (N=10, 25.0%), followed by the age groups of 12 – 14 (N=9, 22.5%) and 15 – 17 (N=8, 20.0%).

Table 5.2.4 shows the number of children died of natural causes in different age groups for the years 2006 and 2007. For both years, the children aged below 1 (N=26, 37.7% for 2006 and N=27, 51.9% for 2007) has significantly higher number of child death as compared with other age groups. For the year 2006, the age group of 12 – 14 has the second highest number of cases (N=11, 15.9%). For the year 2007, the age group of 15 – 17 has the second highest number of cases (N=8, 15.4%).

Table 5.2.5 shows the number of female and male deceased children in different age groups in the years 2006 and 2007. Total number of male children (N=119) is higher than the total number of female children (N=90). For the year 2006, except for those aged below 1 and aged 9 – 11, there are more male than female children in all other age groups. For the year 2007, except for age groups 3 – 5 and 9 – 11, there are more male than female children in all other age groups. In both years, the numbers of male children in four age groups (1 – 2, 6 – 8, 12 – 14 and 15 – 17) are consistently higher than female children.

Table 5.2.6 shows the number of cases by nationality for the years 2006 and 2007. In both years, the percentages of Chinese children (N=105, 89.7% for 2006, and N=84, 91.3% for 2007) are consistently much higher than non-Chinese children (N=12, 10.3% for 2006 and N=6, 6.5% for 2007).

Table 5.2.7 shows the occupation of the deceased children of the years 2006 and 2007. For both years, the category "full-time student" has the highest number of cases and percentage (N=49, 41.9% for 2006 and N=40, 43.5% for 2007). Occupation is not applicable to a great portion of deceased children in both years (N=47, 40.2% for 2006 and N=44, 47.8% for 2007) mainly because these children are either too small or their physical and health conditions made them unable to attend school or work.

Table 5.2.8 shows the number of cases died of different causes in 2006 and 2007. There is a general decrease in percentage in the categories of: natural causes, accidents and suicide.

Table 5.2.9 shows the number of deceased children by cause of death and sex in the years 2006 and 2007. For both years, more male children (N=39 in 2006 and N=28 for 2007) died of natural causes than female children (N=30 for 2006 and N=24 for 2007).

Table 5.2.10 shows the number of child deaths according to their residential districts in the years 2006 and 2007. The total number of cases for Yuen Long District (N=10 for 2006 and N=9 for 2007) is highest, followed by Kwai Tsing District (N=10 for 2006 and N=8 for 2007), and Sai Kung District (N=11 for 2006 and N=7 for 2007).

Table 5.2.11 shows the number of cases according to places where the fatal incidents occurred in the years 2006 and 2007. The numbers of cases occurring in home of the deceased children (N=52, 44.4% for 2006 and N=38, 41.3% for 2007) are consistently highest in both years, while hospital (N=37, 31.6% for 2006 and N=33, 35.9% for 2007) is the second most common place of fatal incidents.

5.3 Overall Observations of the Review Panel on Cases Reviewed

In both 2006 and 2007, the child death rate of Hong Kong is 0.2 per 1,000[8] child population. Although no official overseas child death rates for children aged below 18 could be traced so far, a broad comparison of age-specific death rates with other countries[9] revealed that child death rates in Hong Kong are relatively low.

After reviewing 209 child death cases occuring in 2006 and 2007, the Review Panel has the following overall observations. Other observations of the Review Panel on cases died of classified causes will be listed in Chapter 6 under those causes.

[8] Source: Census and Statistics Department.

[9] Comparison of age-specific death rates

Age Group & Year / Country / Place	Age: 0		Age: 1-4		Age: 5-9		Age: 10-14		Age: 15-19	
	2006	2007	2006	2007	2006	2007	2006	2007	2006	2007
HKSAR	2.8	3.0	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2
Australia	4.7	4.4	0.2	0.2	0.1	0.1	0.1	0.1	0.4	0.4
Canada	5.0*	5.1*	0.2	0.2	0.1	0.1	0.1	0.1	0.5	0.4
Japan	2.6*	2.6*	–	–	0.1	0.1	0.1	0.1	0.3	0.3
UK	5.1	4.9	0.2	0.2	0.1	0.1	0.1	0.1	0.4	0.3
USA	6.9	6.8	0.3	0.3	0.1	0.1	0.2	0.2	0.6	0.6

Notes:
Unless otherwise specified, death rate refers to the number of deaths per 1,000 population.
* Infant deaths per 1,000 live births.

Sources:

Hong Kong SAR	Census and Statistics Department.
Australia	Website of Australian Bureau of Statistics (www.abs.gov.au).
Canada	Website of Statistics Canada (www.statcan.gc.ca).
Japan	Website of Ministry of Health, Labour and Welfare (www.mhlw.go.jp), Demographic Yearbook, United Nations Statistics Division (unstats.un.org/unsd).
U K	Websites of Office for National Statistics (www.statistics.gov.uk), General Register Office for Scotland (www.gro-scotland.gov.uk) and Northern Ireland Statistics & Research Agency (www.nisra.gov.uk).
U S A	Website of National Center for Health Statistics (www.cdc.gov/nchs).

5.3.1 Specific Issues

(a) Many of the child deaths reviewed could have been avoided if the deceased children had received positive parenting or adequate supervision from their parents. Love, care and attention from parents are of paramount importance to the growth and healthy development of children;

(b) It is always the responsibility of parents to assess the risk and to ensure that proper safety measures are taken in any outdoor activity for their children;

(c) Good family relationship is the key to effective coping of hardships. Parents' care and concern for their children were of paramount importance in encouraging children to voice their problems and seek help during crisis;

(d) High unpredictability in the development of cases involving divorce and domestic violence causing child death is observed;

(e) Concealment and mishandling of teenage or unwanted pregnancy can cost lives;

(f) Issue of adjustment and adaptation of new arrivals to Hong Kong has emerged in child death cases with different types of death causes, including suicide, accidents and assault cases;

(g) Issue of home safety has been recurrent in families with small children;

(h) Mainstream or normal schooling seems unable to meet the need of over-aged new arrival students with limited intelligence. Cultural difference and lack of positive engagement after dropping out from school had aggravated their adjustment problem;

(i) The need to promote acceptance of schools and peers for students with special educational needs under the present policy of Integrated Education;

5.3.2 The Children

(j) Unresolved trauma caused by divorce of parents may affect children's coping skills negatively;

(k) Children's indulgence in computer games affect their schooling and family relationships negatively;

(l) Children, particularly teenagers, tend to over-estimate their own ability and under-estimate the risk of their actions;

(m) The risk of depressive mood or suicidal thoughts of quiet children often escapes the notice of parents and school personnel;

(n) Child victims of traffic accidents have weak awareness towards road safety;

5.3.3 The Parents

(o) Parents' level of awareness, alertness and motivation to protect their children from risks are crucial elements for effective prevention of child death;

(p) Parents tend to over-estimate the self-care ability of their young children with special needs and under-estimate the risk of letting them go to school without adult supervision;

(q) Caring and concerned parents may choose wrong and destructive means of child discipline;

(r) While there is differences in individual potentials, sibling comparison may be a risk factor to children's growth and development which has implication on parenting education;

5.3.4 The Service Providers

(s) Strengthening family support and family-based intervention can help ensure positive development of children;

(t) Motivating families-at-risk with parents lacking insight or self-awareness on their own limitation in child care ability to seek or receive service at an early stage is a great challenge to service providers;

(u) The professionals' sensitivity towards cultural differences in child care practice of families is crucial for effective intervention; and

(v) More thought should be given to developing an integrative approach to service provision by different systems for better child welfare services.

6 THE FINDINGS AND RESPONSES

6.1 Introduction

This Chapter summarises the findings of the Review Panel for cases occurring in the years 2006 and 2007 according to classified death causes. It also contains valuable responses and updating of related improvement measures contributed by concerned parties from different sectors and disciplines. This part of the report is meant to be a platform for inter-sectoral and multi-disciplinary sharing and exchange.

Considering that services related to prevention of child death might have development over time, the Review Panel had requested further updating of service improvement from the concerned parties related to the recommendations at different time points. These updating are also included in this Report. The Review Panel is of the view that it is very important for improvement initiatives and their development to be respected, acknowledged, shared and sustained.

A summary of all recommendations made by the Review Panel is at ***Appendix V.***

6.1.1 Making of Recommendations

The recommendations of the Review Panel are meant to improve the system rather than operation-oriented, such that the concerned organisation / department is left to decide on actual measures of improvement appropriate to their function. Therefore, the recommendations are directional in nature pointing to strategies of prevention of child death.

It should be noted that the observations and recommendations made by the Review Panel are primarily suggestions on possibly missed opportunities and what could be done to enhance measures or services to protect our children or to ensure their safety, without full knowledge of the actual environment or circumstances under which services had been rendered by different service providers. It is hoped that stepping up these enhancement could prevent reoccurrence of similar tragic events but they should not be interpreted as panacea which, if applied, could stop the fatal incidents absolutely.

The findings of the review are presented in aggregate with the following reasons:

(1) A commitment to protect personal data and privacy;
(2) To encourage free flow discussion among concerned parties;
(3) To honour the pledge of keeping review information confidential within the Review Panel to various information providers; and
(4) To avoid arousing sentiment or traumatic feelings of the family members of the deceased children relating to the deaths of their beloved children.

6.1.2 Process of Dissemination, Updating and Responding

Recommendations of the Review Panel on individual cases reviewed were distributed to related service organisations and government bureaux / departments either because they had provided information to facilitate the review, or it was believed that they could contribute towards improving the service systems by following-up on the recommendations. The organisations and government bureaux / departments were invited to comment on the recommendations and provide update information on improvement measures taken / would be taken, if any, as well as relevant service development for prevention of child death for reference of the Review Panel. It was based on the belief that valuable lessons might have already been learnt and improved measures already in place even before the review or recommendations made and if such were the case, recognition and credit should be given to those parties.

The concerned parties were prepared that relevant responses would be included in the Review Panel's reports for sharing with the public to promote inter-sectoral and inter-disciplinary collaboration. It was hoped that sharing of such kind can further facilitate enhancement of our child welfare service systems.

The process of dissemination, updating service information, seeking views and obtaining of responses from different service organisations and departments has become a valuable and integral part of the review. As the review is conducted nearly two years after the occurrence of child deaths, such process can ensure fairness to and participation of organisations or departments that have taken initiatives to make improvement to prevent similar incidents of child fatality.

Not all service organisations have given responses to the recommendations distributed to them. Some feel it not necessary to respond while others may not feel easy to comment without grasping the full picture of how the review is conducted, given that the Pilot Project is a new initiative.

The related parties responding to the Review Panel's recommendations for cases that occurred in 2006 had been invited to provide any further updating on the improvement measures or services they mentioned in the First Report for sharing in this Final Report. The Review Panel believes that this can help ensure continuous enhancement of our child welfare service systems.

6.1.3 Responding to Responses

Even though some of the respondents may not agree with the recommendations, their comments help enhance our understanding towards their handling of the cases or their services. The Review Panel feels obliged to share different views and appeals for open discussion on such issues. Such an approach will contribute to a fair, reasonable and feasible manner to examine or improve the existing service systems.

Although it is highly appreciated that many service organisations or departments concerned have given detailed updating of improvement measures that have taken place since occurrence of child fatal incidents, the Review Panel notes that not all the details of the responses will be included in the following parts of this Chapter due to its specific scope and function, and the need to maintain confidentiality in case inclusion of such details will enable reader to identify a particular case.

Sections 6.2 through 6.6 are findings and recommendations of the Review Panel on child death cases of both 2006 and 2007. They are grouped under five classes of death causes, namely: natural causes, accidents, suicide, assault and miscellaneous causes. The recommendations under each type of death cause are sequenced in a way such that those considered deserving more attention and concern are ahead of others.

For easy identification, boxes which contain *recommendations for 2007 are shaded in darker colour* as compared to those recommendations made for 2006 cases in each section. Further updating of improvement measures mentioned in the First Report provided by concerned government bureaux / departments and service organisations are put in a green box titled "Further Response / Updating (as at 31.10.2010)" under the respective recommendation where applicable.

It should be noted that the Review Panel has made 18 recommendations for child death cases occurring in 2007, being much lesser than the number of 47 recommendations made for cases occurring in 2006 which have already been published in the First Report. This is largely due to the similarity of case circumstances with common themes and issues observed and the Review Panel does not wish to repeat recommendations already made.

6.2 Cases Died of Natural Causes

Table 6.2.1: No. of Cases by Age Group and Sex

Age Group	Sex		No. of Cases (%)
	Female (%)	Male (%)	
< 1	28 (23.1%)	25 (20.7%)	53 (43.8%)
1 – 2	4 (3.3%)	8 (6.6%)	12 (9.9%)
3 – 5	2 (1.7%)	6 (5.0%)	8 (6.6%)
6 – 8	2 (1.7%)	5 (4.1%)	7 (5.8%)
9 – 11	10 (8.3%)	5 (4.1%)	15 (12.4%)
12 – 14	3 (2.5%)	10 (8.3%)	13 (10.7%)
15 – 17	5 (4.1%)	8 (6.6%)	13 (10.7%)
Total (%):	54 (44.6%)	67 (55.4%)	121 (100.0%)

Table 6.2.2: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	32 (26.5%)
Full-time Work	0 (0.0%)
Part-time Work	0 (0.0%)
Not Studying & Not Working	14 (11.6%)
Not Applicable*	71 (58.7%)
Unknown	4 (3.3%)
Total:	121 (100.0%)

Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

Table 6.2.3: No. of Cases by Type of Health Problem According to ICD10[10] Chapter Level Classification

ICD Code	Type of Health Problem	No. of Cases (%)
A00-B99	Certain infectious and parasitic diseases	17 (14.0%)
C00-D48	Neoplasms	5 (4.1%)
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	3 (2.5%)
E70-E99	Metabolic disorders	4 (3.3%)
G00-G99	Diseases of the nervous system	9 (7.4%)
I00-I99	Diseases of the circulatory system	16 (13.2%)
J00-J99	Diseases of the respiratory system	12 (9.9%)
K00-K93	Diseases of the digestive system	7 (5.8%)
M00-M99	Diseases of the musculoskeletal system and connective tissue	1 (0.8%)
N00-N99	Diseases of the genitourinary system	1 (0.8%)
O00-O99	Pregnancy, childbirth and the puerperium	2 (1.7%)
P00-P96	Certain conditions originating in the perinatal period	15 (12.4%)
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	28 (23.1%)
T15-T19	Effects of foreign body entering through natural orifice	1 (0.8%)
	Total:	121 (100.0%)

[10] ICD10: the International Classification of Diseases, Version 10 which is developed by the World Health Organisation. The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality and guidelines.

Table 6.2.4: No. of Cases by Age Group and Category*

Age Group	Category*					No. of Cases (%)
	A (%)	B (%)		C (%)	D (%)	
		B1 (%)	B2 (%)			
< 1	29 (24.0%)	0 (0.0%)	8 (6.6%)	7 (5.8%)	9 (7.4%)	53 (43.8%)
1 – 2	0 (0.0%)	4 (3.3%)	4 (3.3%)	4 (3.3%)	0 (0.0%)	12 (9.9%)
3 – 5	0 (0.0%)	3 (2.5%)	2 (1.7%)	3 (2.5%)	0 (0.0%)	8 (6.6%)
6 – 8	0 (0.0%)	2 (1.7%)	2 (1.7%)	3 (2.5%)	0 (0.0%)	7 (5.8%)
9 – 11	0 (0.0%)	5 (4.1%)	4 (3.3%)	6 (5.0%)	0 (0.0%)	15 (12.4%)
12 – 14	0 (0.0%)	4 (3.3%)	2 (1.7%)	7 (5.8%)	0 (0.0%)	13 (10.7%)
15 – 17	0 (0.0%)	5 (4.1%)	2 (1.7%)	6 (5.0%)	0 (0.0%)	13 (10.7%)
Total (%)	29 (24.0%)	23 (19.0%)	24 (19.8%)	36 (29.8%)	9 (7.4%)	121 (100.0%)
		47 (38.8%)				

* *These categories of death, with content listed below, are designed by the medical experts of the Review Panel for review purpose:*

***A** - Neo-natal Conditions*
***B** - Chronic Medical Conditions*
* ***B1** - with mental or physical disabilities*
* ***B2** - without mental or physical disabilities*
***C** - Acute Medical Conditions*
***D** - Others: all stillbirths*

Table 6.2.5: No. of Cases with Autopsy Done or Waived

Autopsy	No. of Cases (%)
Done	73 (60.3%)
Waived	48 (39.7%)
Total:	121 (100.0%)

* *Source: according to information search at the Coroner's Court.*

Table 6.2.6: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	41 (33.9%)
Hospital	61 (50.4%)
School	2 (1.7%)
Indoor (Not Home)	8 (6.6%)
Outdoor	5 (4.1%)
Street/Road	1 (0.8%)
Water/Sea	0 (0.0%)
Others*	1 (0.8%)
Unknown	2 (1.7%)
Total:	121 (100.0%)

Others: inside the lift of a building.*

6.2.1 General Observations:

In the years 2006 and 2007, a total of 121 cases ruled by the Coroner to have natural death causes have been reviewed by the Review Panel.

Table 6.2.1 shows the number of deceased children by age group and sex. More male (N=67, 55.4%) than female children (N=54, 44.6%) died of natural causes. The age group with the highest number of natural child death occurred for children aged below 1 (N=53, 43.8%) in which more female (N=28, 23.1%) than male children (N=25, 20.7%) died. The age group of 9 – 11 has the second highest number of natural child death (N=15, 12.4%) with also more female (N=10, 8.3%) than male children (N=5, 4.1%).

Table 6.2.2 shows the occupation of the deceased children. Occupation is not applicable to the majority of the children died of natural causes (N=71, 58.7%). This indicates that either these children are too small for schooling or work, or their physical and health conditions make them unable to attend school or work.

Table 6.2.3 shows the number of cases by type of health problem according to the coding of the International Classification of Disease, Version 10 (ICD10) developed by the World Health Organisation and adopted worldwide. The highest number of child death (N=28, 23.1%) falls within the class of *congenital malformations, deformations and chromosomal abnormalities* (ICD code: Q00-Q99). The class of *certain infectious and parasitic diseases* (ICD code: A00-B99) comes second (N=17, 14.0%) in case number, closely followed by the class of *diseases of the circulatory system* (N=16, 13.2%).

Table 6.2.4 shows the number of cases by age group and category. These four categories (from A to D) are developed by the Medical Experts of the Review Panel during the review of cases died of natural causes for examination of possible patterns and trends of cases with similar problems. These four categories are as follows:

Category	**Description**
A	Neo-natal Conditions
B	Chronic Medical Conditions:
B1	*with mental or physical disabilities*
B2	*without mental or physical disabilities*
C	Acute Medical Conditions
D	Others

As shown in Table 6.2.4, Category B (chronic medical conditions) has the greatest number of child death cases (N=47, 38.8%). Under this category, there are two sub-categories including cases with mental or physical disabilities (N=23, 19.0%) and cases without mental or physical disabilities (N=24, 19.8%). Category C (acute medical conditions) has the second highest number of child deaths (N=36, 29.8%). For Category D (others), all cases under this category in the pilot review are stillbirth cases (N=9, 7.4%) which the Review Panel considers worthy of examining in view of the possible preventability of some of these cases.

Table 6.2.4 also shows that the majority of the children died of natural causes (N=53, 43.8%) are aged below 1 among which 29 (24.0%) of them died of neo-natal conditions. Of the nine stillbirth cases (7.4%) reviewed, the dead bodies of five of them were unlawfully handled or disposed. Being uncertain whether these children were born alive or not, the Review Panel has concern over if concealment and mishandling of unwanted pregnancy have taken these children's lives.

Table 6.2.5 shows the number of cases with autopsy done or waived. Of all child death cases reviewed, autopsy for 39.7% (N=48) of them had been waived.

Table 6.2.6 shows the number of cases by place of fatal incident. Half of the fatal incidents (N=61, 50.4%) occurred in hospital, indicating that the death causes of these deceased children are closely related to health or medical conditions. It should be noted that a significant number of fatal incidents occurred at home (N=41, 33.9%), many of these children fell ill and collapsed at home. This led to the Review Panel's concern over the care for children chronically-ill or with special needs and support required for their families.

6.2.2 Recommendations

Recommendation N1

(i) It is observed that there is service gap in the home leave care arrangement for disabled children under residential care during which child fatality had occurred. Support for their families, particularly single parents can help prevent such incidents;

(ii) To cater for the special need of some children who do not have appropriate care-giver to look after them during home leave, residential care units can consider providing respite care service with minimal staff so that the needy children can stay in an environment they are familiar with; and

(iii) Children with severe disability should not be put under the care of young siblings who are not capable of such task.

Updating / Responses

Social Welfare Department:
Under the existing special education policy, children with disabilities aged 6 to 15 are provided with boarding service at special schools under the schedule of the Education Bureau. To meet the temporary residential care needs of special school children, the Department, with support from non-governmental organisations operating subvented residential care service units for adult persons with disabilities, extended the residential respite service to children with disabilities below the age of 15 since April 2008. The Department agrees that the arrangement may not be to the best interest of these children with disabilities but consider it an option to release the caring burden for the parents / carers. To provide support for parents / carers of children with disabilities, the Department also provides a wide range of centre-based or home-based occasional care services at the 16 District Support Centre for Persons with Disabilities set up and located throughout the territory in January 2009.

Recommendation N2

Support for families looking after chronically-ill or disabled children with medical condition requiring special care at home is necessary.

Updating / Responses

Social Welfare Department:
Parents / Relatives Resource Centres provide a wide range of support services to parents and relatives of children with disabilities. Seminars, workshops, groups, talks are organised from time to time for parents / relatives of children with disabilities to help them better understand their children's disabilities and ways to provide care for them.

Recommendation N3

As occurrence of incidents of collapsing at home could be quite shocking and traumatic for family members (particularly young siblings) of the deceased children, it would be necessary to ensure that these families could receive needed counselling and support.

Updating / Responses

Social Welfare Department:
Medical social workers of the Department will be reminded to provide emotional support or counselling services to affected families where necessary. In handling cases involving death in the family, social workers of Integrated Family Service Centres / Integrated Services Centres will take note of the need of surviving family members and provide support services as appropriate.

Recommendation N4

To ensure that staff on duty in special schools and care / training centres for disabled children have received update first aid training.

Updating / Responses

Social Welfare Department:
Under the Funding and Service Agreement between the Department and the operating non-governmental organisations, provision of nurse is an essential staff requirement for special child care centres. That being so, the care / training centres will be reminded to ensure staff on duty has first-aid training.

Education Bureau:
To address the needs of the boarders in special schools for children with severe intellectual disability or physical disability, the boarding section of these schools is provided with one nurse for 25 boarders for weekdays, and an additional 0.6 nurse for 25 boarders at weekend and on Sunday if they operate at weekends and on Sundays. The minimum provision is one nurse at any one time during the operational hours of the boarding section irrespective of its size. This provision ensures that the boarders are provided with first aid and other essential nursing support in case of emergency.

Recommendation N5

To work out procedures to ensure every newborn should have physical examination by a paediatrician before discharge from hospital.

Updating / Responses

Hospital Authority:
Under the current practice of the Hospital Authority, which is not dissimilar to those in other developed countries, newborns are attended by doctors and will be seen by doctors of relevant discipline when clinically indicated.

Recommendation N6

General education to urge parents of children with asthma to help their children seek medical treatment whenever in need, particularly in the night-time.

Updating / Responses

Department of Health:

(1) It is usual practice for doctors to explain to parents / caretakers the causes of the illness, possible triggers or aggravating factors, possible complications, prognosis, available treatment options and individualised treatment plan for the child, possible side effects of treatment prescribed, symptoms & signs of non-response to treatment which warrant immediate medical intervention, etc. Education provided to parent / caretaker by the doctor managing the children with asthma is considered to be more effective and targeted approach, while education targeting general public would be less effective as most of the general population do not have asthma and may not consider the advice relevant; and

(2) Treatment and follow-up for acute / chronic illness such as asthma for general public / children is not provided by the Department. Nevertheless, medical and nursing staff of the Department will address parents' or caretakers' concerns and offer health advice during encounters.

Social Welfare Department:

The Department of Health and the Hospital Authority are in the best position to provide general education in this aspect. Medical social workers of the Department will also advise the parents to bring their children with asthma to seek medical treatment when necessary, particularly in the night time.

Recommendation N7

To ensure the presence of on-site personnel trained in resuscitation of children in every private or public hospital treating paediatric patient.

Updating / Responses

Department of Health:
All nurses in private hospitals and nursing homes have already been undergoing annual cardiopulmonary resuscitation (CPR) courses and drills.

***Further Response / Updating (as at 31.10.2010):**

Department of Health:
The Department has required that all private hospitals where children are admitted as in-patients, resident medical practitioners should have an accredited Paediatric Advance Life Support (PALS) certificate which should be updated regularly.

Recommendation N8

Provision of trained first aiders and equipment like automated defibrillator in sports venues for handling sudden collapse cases during sports events.

Updating / Responses

Leisure and Cultural Services Department:

(1) According to the Department's policy, basic first aid equipment are provided at major recreation and sports venues under its schedule to enable its staff to carry out immediate first aid treatment in case of injuries or accidents. Organisers of events held at the Department's venues are required to engage qualified first aiders. Moreover, the Department is now studying the feasibility of providing automated external defibrillator at major sports venues; and

(2) It is an established requirement stipulated in the "General Conditions of Use of Leisure and Cultural Services Department Sports Grounds for Athletics Meets and Other Sports Activities" that schools, as hirers of the sports grounds, should provide first-aid service and the necessary precautions and care for ensuring the safety of the athletes, spectators and all other persons using the sports ground during the event period. The Department will remind schools that they should comply with the conditions of use when conducting athletic activities at sports grounds under the Department's schedule.

Education Bureau:
Under the "Guidelines on Outdoor Activities", schools are advised that at least one member of the outdoor activity group should have received first aid training if the activity is conducted in a natural environment and is exploratory, challenging and physically demanding.

Recommendation N9

For some cases, autopsy may help enlighten the cause of death for prevention purpose.

Updating / Responses

Department of Health:
The Forensic Pathologists of the Department handle reportable deaths under the Coroner's Ordinance (Cap. 504) and the authority to order an autopsy to be conducted or waived comes under the jurisdiction of the Coroner. When an autopsy is ordered by the Coroner, the primary objective of the forensic pathologist's role is to assist the Coroner in ascertaining a cause of death and one of the purposes of Coroner's death enquiry is to prevent similar fatality in the future.

Coroner's Court:
Noted the recommendation.

Recommendation N10

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.

Updating / Responses

Department of Health:
In connection with setting up mechanism for pathologist to give feedback, it is already a practice adopted by the Forensic Pathology Service of the Department that:

(1) In any case, forensic pathologist will explain autopsy findings and cause of death to the family upon their request, and

(2) 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.

Hospital Authority:
If autopsy reveals an inheritable disease that could affect siblings or relatives of the deceased, the pathologist should notify the referring clinical departments to trace and advise the family accordingly.

Coroner's Court:
Noted the recommendation.

Recommendation N11

The use of cough suppressants containing codeine is not generally recommended in children and should be avoided altogether in those under one year old.

Updating / Responses

Department of Health:
The medical and nursing staff of Family Health Service of the Department would advise the parents or the caretakers to give the medications to their children according to the instructions given by their doctors.

Hospital Authority:
Agrees with the recommendation.

HK College of Paediatricans:
Supports the recommendation.

HK Doctors Union:
Agrees with the recommendations.

HK Medical Association:
Agrees that the use of cough suppressants containing codeine is not generally recommended in children and should be avoided in those under one year old.

6.3 Cases Died of Accidents

Table 6.3.1: No. of Cases by Age Group and Sex

Age Group	Sex		No. of Cases (%)
	Female	Male	
< 1	2	1	3 (9.4%)
1 – 2	1	0	1 (3.1%)
3 – 5	1	1	2 (6.3%)
6 – 8	3	6	9 (28.1%)
9 – 11	1	4	5 (15.6%)
12 – 14	2	5	7 (21.9%)
15 – 17	1	4	5 (15.6%)
Total (%):	11 (34.4%)	21 (65.6%)	32 (100.0%)

Table 6.3.2: No. of Cases by Type of Accident

Type of Accident	No. of Cases (%)
Traffic	18 (56.3%)
Fall	7 (21.9%)
Drowning	3 (9.4%)
Poisoning	2 (6.3%)
Drug overdose	1 (3.1%)
Choking	1 (3.1%)
Total:	32 (100.0%)

Table 6.3.3: No. of Cases by Age Group and Type of Accident

Age Group	Type of Accident (%)						No. of Cases (%)
	Traffic	Fall	Drowning	Poisoning	Drug overdose	Choking	
< 1	2	0	0	1	0	0	3 (9.4%)
1 – 2	0	1	0	0	0	0	1 (3.1%)
3 – 5	0	2	0	0	0	0	2 (6.3%)
6 – 8	5	3	1	0	0	0	9 (28.1%)
9 – 11	4	0	0	1	0	0	5 (15.6%)
12 – 14	4	0	1	0	1	1	7 (21.9%)
15 – 17	3	1	1	0	0	0	5 (15.6%)
Total (%):	18 (56.3%)	7 (21.9%)	3 (9.4%)	2 (3.1%)	1 (3.1%)	1 (6.3%)	32 (100.0%)

Table 6.3.4: No. of Cases by Age Group and Type of Traffic Victim

Age Group	Type of Traffic Victim (%)			No. of Cases (%)
	Cyclist	Pedestrian	Passenger	
< 1	0	1	1	2 (11.1%)
1 – 2	0	0	0	0 (0.0%)
3 – 5	0	0	0	0 (0.0%)
6 – 8	2	2	1	5 (27.8%)
9 – 11	0	3	1	4 (22.2%)
12 – 14	2	2	0	4 (22.2%)
15 – 17	2	0	1	3 (16.7%)
Total (%):	6 (33.3%)	8 (44.4%)	4 (22.2%)	18 (100.0%)

Table 6.3.5: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	8 (25.0%)
Hospital	0 (0.0%)
School	0 (0.0%)
Indoor (Not Home)	0 (0.0%)
Outdoor	5 (15.6%)
Street/Road	15 (46.9%)
Water/Sea	4 (12.5%)
Others	0 (0.0%)
Unknown	0 (0.0%)
Total:	32 (100.0%)

Table 6.3.6: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	24 (75.0%)
Full-time Work	1 (3.1%)
Part-time Work	0 (0.0%)
Not Studying & Not Working	2 (6.3%)
Not Applicable*	4 (12.5%)
Unknown	1 (3.1%)
Total:	32 (100.0%)

Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

6.3.1 General Observations

Table 6.3.1 shows the number of cases by age group and sex. The number of male (N=21, 65.6%) is significantly higher than the number of female children (N=11, 34.4%). The age group 6 – 8 has the highest number of child death (N=9, 28.1%), followed by the age group 12 – 14 (N=7, 21.9%). Both age groups of 9 – 11 and 15 – 17 have the same number of child death (N=5, 15.6%) coming third.

Table 6.3.2 shows the number of cases by type of accident. Over half of the cases died of traffic accident (N=18, 56.3%). Fall accident has the second highest number of child death (N=7, 21.9%).

Table 6.3.3 shows the number of cases by age group and type of accident. For traffic accident, the highest number of child death occurs in the age group 6 – 8 (N=5, 15.6%), followed by the age groups of 9 – 11 and 12 – 14 (both N=4, 12.5%) and then 15 – 17 (N=3, 9.4%). For fall accident, child death occurs in the younger age groups with the highest number of child death comes from the age group 6 – 8 (N=3, 9.4%), followed by the age group 3 – 5 (N=2, 6.3%). The youngest child fell from height and died was in the age group 1 – 2 (N=1, 3.1%).

Table 6.3.4 shows the number of cases by age group and type of traffic victim. Six (33.3%) children were cyclists, eight (44.4%) pedestrians and four (22.2%) passengers on board traffic vehicles when they lost their lives in traffic accidents. Four cyclists were adolescents aged from 12 – 17. Seven out of the eight pedestrians were aged from 6 – 14. This led to the Review Panel's concern over the awareness on road safety of school age children, in particular adolescents.

Table 6.3.5 shows the number of cases by place of fatal incidents. About half of the incidents occurred on street or in road (N=15, 46.9%) and these were all traffic accidents. Fatal incidents of eight (25.0%) cases occurred at home, including five fall accidents. Thus, the Review Panel observes that there are issues of the quality of care and home safety for children staying at home, attended or unattended.

Table 6.3.6 shows the number of cases by occupation. Most of the children died of accidents were full-time students (N=24, 75.0%). Occupation was not applicable to four (12.5%) children who were in infancy or whose health conditions prevented them from attending school or work.

During review on the accident cases, the Review Panel has the following observations:

(1) Seven out of the 18 "traffic accident" cases occurred because of carelessness of pedestrians and / or undesirable conduct of drivers;

(2) Five out of the six cycling accidents occurred on roads with running traffic;

(3) Five out of the seven "fall accident" cases could have been avoided if proper home safety design or devices were in place;

(4) Five out of the seven "fall accident" cases and seven out of the eighteen "traffic accident" cases reviewed occurred when the children, either left alone or with peers, lacked close or proper parental care or supervision; and

(5) Two out of three drowning cases occurred because the deceased children swam in places not suitable for swimming and had over-estimated their swimming ability.

6.3.2 Recommendations

Recommendation A1

To strengthen public education on:

(i) the possible fatal risk of leaving children unattended; and

(ii) the importance of home safety measures and devices when small children are present.

Updating / Responses

Department of Health:

(1) The Maternal and Child Health Centres (MCHCs) of the Department provide a comprehensive range of health promotion and disease prevention service for children from birth to five years through the Integrated Child Health and Development Programme (ICHDP). Parenting programme is one of the core service components of the ICHDP. Parents-to-be and parents of young children are provided with anticipatory guidance on childcare, child development and parenting issues through information leaflets, audiovisual resources, workshop and individual counselling. In particular, the topic of home safety specific for children of different age groups is covered in various Happy Parenting Workshops. Participants are able to discuss and view video footage on various traps and samples of safety measures / devices they can use at home;

(2) The Family Health Service (FHS) has also published leaflets to promote home safety for children of different ages. These leaflets are distributed to clients when they attend MCHCs. General public can also access these leaflets and video footage from FHS website (www.fhs.gov.hk); and

(3) Information on different child care service is also introduced to parents-to-be and parents to increase their awareness and use of these services to avoid leaving children unattended at home. Information leaflets on various child care services produced by the Social Welfare Department are also available in MCHCs.

Social Welfare Department:

Apart from publicity on the themes of 'not leaving children unattended' and 'taking proper care of children' as well as the different child care services through various media, the television and radio announcement in the public interest has been put on regular broadcast since November 2009 to warn families against leaving children unattended, high-lighting such messages as 'neglect once, regret forever' and 'child neglect is a criminal offence'. On-going publicity measures will be taken by the Department.

Recommendation A2

(i) Public awareness, in particular that of the parents and the care-givers, should be raised on the importance of home safety and the use of safety devices, including window grilles all the time for families with small children;

(ii) Education and promotion of household safety and related measures for families with children;

(iii) When planning and designing buildings, particularly public housing estates, the issues of child safety should be considered e.g. installation of grilles on windows and in corridors; and

(iv) Parents should be educated to communicate with child minders on the needs of their children effectively to ensure proper care for their children.

Updating / Responses

Social Welfare Department:
Proper sense of responsibility and parenting attitude to ensure safety of children has been included as one of the themes for publicity campaign on strengthening family harmony and prevention of domestic violence. Reference materials on home safety for children are available in the Department's Family Life and Education Resource Centre (Website: flerc.swd.gov.hk).

Hong Kong Housing Authority:
Supports the recommendations on taking child safety into consideration when planning and designing new public housing estates and shares the following views:

(1) The installation of window grilles should be extended to all common areas including staircases, landings and lift lobbies in addition to corridors except for fixed windows 1.1m above floor level; and

(2) Additional reminder should be promulgated in internal design guides on the design and planning of parapets and railings at roofs and at podiums where children may abuse to climb over adjacent pipes, planters or seats.

Since the incidents in 2006, the Authority has further improved the safety measures against risk of falling from height in new public rental housing projects by providing window grilles to all openings in staircases and landings in addition to statutory requirements.

Hong Kong Housing Society:

(1) Always advocates good practice and look into areas for improvements in planning and designing of buildings, including rehabilitation works in its rental estates. From time to time, safety measures and device at public areas, e.g. fencings, fall arrestors etc. are incorporated;

(2) Enhances residents' awareness on home safety by posting up notices, posters and arranging safety talks regularly in estates; and

(3) Supports in principle the installation of grilles on windows and in corridors subject to approval from authorities and compliance of relevant legislations for new projects.

***Further Response / Updating (as at 31.10.2010):**

Hong Kong Housing Authority:

Has promulgated in Public Rental Housing projects standard detailed drawings in January 2007 on provision of window grilles to all openable windows in common areas including staircases, landings and lift lobbies in addition to corridors. These provisions in fact outclass the relevant statutory requirements. Our Model Client Brief for new public housing projects has been further updated in October 2009 incorporating additional reminder on fall protection by provision of guard-rails to floor edges, and the provision of railings or other safety barriers at appropriate locations and routing of services.

Recommendation A3

(i) Parenting education on the role, skills and responsibility of parents should start right at the beginning when a child is born to a family; and

(ii) Strengthening the role and responsibility of the father would better protect the children.

Updating / Responses

Social Welfare Department:

Service units of the Department and non-governmental organisations, including Integrated Family Service Centres, Integrated Services Centres and Family Life Education Units, have been organising parenting education programmes of different themes for parents-to-be, parents and grandparents.

Department of Health:

(1) The Family Health Service of the Department offers a parenting programme through 31 Maternal and Child Health Centres in Hong Kong to equip parents / care-givers with the necessary parenting knowledge and skills; and

(2) Fathers are always encouraged and welcomed to attend parenting workshops. In case they cannot attend, the mothers are advised to share the written information with them or encourage them to visit the Department's website (www.dh.gov.hk).

Recommendation A4

Education for parents:

(i) To seek assistance from reliable child minders, and

(ii) To give clear instructions to child minders to ensure child safety.

Updating / Responses

Social Welfare Department:

In addition to normal child care services provided by child care centres, the Department has introduced the Neighbourhood Support Child Care Project since October 2008. It provides childminding service to needy families to prevent them from leaving their children unattended. Proper training in childminding is also provided to child minders by operators of this Project. On the other hand, relevant messages will be included in the Department's programmes for parents, such as programmes organised in Integrated Family Service Centres as well as publicity material prepared by its Family Life Education Resource Centre (Website: flerc.swd.gov.hk).

Recommendation A5

Schools or welfare organisations to provide education and support for grass-root parents, especially for those having children with special educational needs, to raise their awareness and ability to take care of their young children.

Updating / Responses

Education Bureau:
With resource provision and support from the Bureau, primary schools are encouraged to organise parent-child activities and conduct seminars / workshops to help parents enhance parenting skills under the Bureau's Comprehensive Student Guidance Service. In collaboration with teachers in secondary schools, school social workers provide support service to parents.

Social Welfare Department:
Parents / Relatives Resource Centres (PRC) provide a wide range of support services to parents and relatives of children with disabilities through various means. Groups for enhancing parenting skills are organised in various service units including Integrated Family Service Centres and reference materials are maintained in the Department's Family Life Education Resource Centre (Website:flerc.swd.gov.hk) to support frontline workers in conducting education programmes for parents.

Recommendation A6

(i) Education for family members / care-givers of children with disability or chronic illness to be alert of the special needs of these children and the type of care they need; and

(ii) Providing first aid training for family members / care-givers of children with physical disability or chronic illness may help prevent accidental choking at home.

Updating / Responses

Social Welfare Department:
Social workers of the Department and non-governmental organisations will advise family members / carers of children with physical disability or chronic illness to be more alert to their special needs and care required, and to receive first aid training as far as possible.

Hospital Authority:
Agrees with the recommendation in principle. Medical and nursing staff will educate care-givers to take care of those children with a disability or a chronic illness according to their special needs and the type of care they need. First aid training is part of the education given to the care-givers, especially for those high risk cases.

Recommendation A7

To strengthen survival training and drills for students of special schools to escape from fire or other household accidents.

Updating / Responses

Education Bureau:

(1) To enhance the awareness of possible household accidents and handling skills of students with intellectual disabilities (ID students), they study an adapted curriculum in special schools. Related topics on self protection, survival skills and crisis management are taught in subjects / programmes such as General Studies, Self Care, Daily Living Skills, Survival Skills Training, etc. Schools will also make use of the morning assembly, class teacher lessons, whole school activities, etc. to discuss current news such as fire cases with students with an aim to help them understand the possibility and danger of household accidents. Relevant resource teaching programme in special schools for ID students may also further enhance students' survival skills and teach them proper ways of escape; and

(2) Education Regulation 38 stipulates that "The principal of every school shall draw up a practical scheme for the evacuation of the school premises in case of fire, shall ensure that fire drill including the use of all exits from the school premises is carried out by the teachers and pupils at least once in every 6 months, and shall keep a written record of all such drills in a school log book." The Education Regulations are also applicable to special schools.

Recommendation A8

(i) Regulation and periodic refresher training for security guards to raise their alertness on child safety issues and handling of emergency situations; and

(ii) Management of public housing estate to ensure that guidelines on handling accidents are developed and to arrange for regular emergency drills for security guards of the estate to learn or refresh skills involved.

Updating / Responses

Hong Kong Housing Authority:

(1) Under the existing security services contracts, the contractors are obliged to provide training / seminars to security guards on safety issues, in particular, fire safety, public security and handling of emergency situations. In this connection, a Handbook of Procedures for handling emergency situations within estates has been prepared in consultation with the estate management and the security guards are required to follow the procedures as laid down;

(2) An occurrence book is maintained by the security contractor for recording incidents occurred. The estate management would check the occurrence book periodically to closely monitor the quality of service provided by the security guards;

(3) Refresher training and drills are arranged for security guards on a regular basis. Guidelines and instructions are in place and issued to contractors periodically to remind / refresh them of their obligations;

(4) Following the fatal incident, has stepped up improvement measures to enhance the safety of recreational facilities through various means in our public housing estates with planned improvement works and design; and

(5) On the aspect of public education for parents to take care of their children during outdoor activities, our estate management has promulgated the theme of "Promotion of Child Care" through meetings with the Tenants' Estate Management Advisory Committees (EMACs). The message has clearly got across through newsletters, notices and the rolling text in the lift lobbies. Furthermore, 'Child Care' is one of our partnering community building activities to be organised by EMACs and non-government organisations.

Security and Guarding Services Industry Authority:

For Recommendation (i):

(1) Currently, all security guards joining a security company must undergo and pass an initial basic training course of not less than 16 hours before performing operational duties regardless of their working experience, unless they can produce a valid certificate issued to them in respect of a training course accepted by the Authority within three years;

(2) Has established a Quality Assurance Scheme for the basic training course, which has included "handling of emergencies" as one of the syllabus items; and

(3) Has published a "Manual for Security Personnel Providing Guarding Services in Buildings" which aims to provide guidance and useful tips for security personnel to perform their duties. The Authority has reviewed the content of the Manual and will include in the Manual suitable paragraphs to raise the security guards' alertness and preparedness of security guards to handle emergency situations including child safety issues.

For Recommendation (ii):

Deems it more appropriate for the housing estate management to provide the relevant guidelines and training which are specific to the workplace and to familiarise their guards with the emergency procedures.

Recommendation A9

(i) To derive more effective ways to reach out to juveniles with drug abuse problem; and

(ii) Public education for all age groups on the negative effects of drug abuse through ways such as: use of life-coaching, promotion of positive life-style, strengthening coping strategies and resilience to life stresses etc.

Updating / Responses

Narcotics Division / Security Bureau:
Tasked with coordinating anti-drug policies and measures across the public sector, non-government organisations (NGOs) and society at large to combat the problem of drug abuse with a five-pronged approach covering (1) preventive education and publicity, (2) treatment and rehabilitation, (3) legislation and law enforcement, (4) external cooperation and (5) research.

To combat the youth drug abuse problem, the Chief Executive announced in his 2007 Policy Address the appointment of the Secretary for Justice, as Deputy Chairman of the Fight Crime Committee, to lead a high-level inter-departmental task force to consolidate anti-drug strategies in a holistic manner. The Task Force on Youth Drug Abuse (Task Force) concluded its work and published a Report on 11 November 2008, with over 70 recommendations spanning the five prongs of the anti-drug policy. The recommendations of the Task Force also include the promotion of a community culture of care for young people through the *Path Builders* initiative.

The Task Force has come up with focused, holistic and sustainable strategies to tackle the youth abuse problem with enhanced collaboration within the government (among bureaux, departments and agencies) and engagement of the anti-drug sector (comprising the many non-governmental organisations and others) and various stakeholders (e.g. schools, parents, teachers, social workers, legislators etc.) to ensure ownership and support for the anti-drug cause.

In July 2009, the Chief Executive announced the further stepping up of the anti-drug campaign along five directions, namely community awareness and mobilisation, community support, drug testing, treatment and rehabilitation, and law enforcement.

For recommendation (i):

Given the hidden nature of psychotropic substance abuse, the Task Force recommends stepping up efforts in identifying young drug abusers for early intervention as soon as possible. Drug testing at three levels were recommended, i.e. (a) compulsory drug testing with backup of legislation: the Division plan to consult the public in 2010 on a detailed proposal; (b) voluntary school-based drug testing: a trial scheme with participation of all secondary schools in Tai Po District launching in December 2009; and (c) voluntary drug testing service in Counselling Centres for Psychotropic Substance Abusers. (CCPSAs): the service has been provided in CCPSAs since October 2009 as part of the elementary medical support for young drug abusers to enhance the engagement and counselling process.

In addition to drug testing, the Task Force recommends schools to play a proactive role in early identification of at-risk students through other means and provides necessary assistance. A resource kit for schools now under preparation would provide useful checklists for school personnel including school management staff, guidance and discipline teachers, school social workers, class and subject teachers to identify at-risk students and make referrals where necessary. Training is now being provided to teachers and school social workers to help them deliver drug education and to handle student drug abuse cases. Schools are encouraged to develop and institutionalise a health school policy with an anti-drug element.

For recommendation (ii):

The Task Force recommends that, for future preventive education and publicity purposes, the generic reference to drug abuse should be "吸毒" or "吸食毒品" , and the use of such Chinese terms as "濫藥" or "濫用藥物" should be avoided as far as possible. In this context, drugs should be referred to as "毒品" , but not the more neutral term of "藥物" . In the case of psychotropic substances (not "soft drugs" any more), they should be referred to as "危害精神毒品" , or, for more colloquial usage, "丸仔毒品" , "K仔毒品" or the like, instead

of "精神藥物". Accordingly, a two-year territory-wide campaign with the theme "No Drugs, No Regrets. Not Now, Not Ever" and "不可一，不可再。向毒品說不，向遺憾說不。" was launched on 28 June 2008. A series of programmes followed, including seven Announcements in the Public Interest featuring real life stories of different sectors in the society, a theme song plus a music video, massive publicity drive as well as online promotion on popular websites.

School is a key institution on the path to adulthood. The Task Force attaches great importance to the school sector in preventive efforts. To cultivate positive values among students and help them acquire the skills to keep themselves away from drugs, the Education Bureau will enhance its efforts to promote students' participation in uniformed group activities and other youth development programmes such as the Positive Adolescent Training through Holistic Social Programmes to Adulthood (Project PATHS), Understanding Adolescent Programme, Smart Teen Programme, Adolescent Health Programme, Junior Health Pioneer Workshop and by Exploring further collaboration with other parties. Schools should arrange these specific education programmes to enhance students' knowledge on drug and other health issues. Through non-governmental organisations, the Division and Social Welfare Department will also strengthen anti-drug talks and programmes to senior primary students and secondary students to help them acquire knowledge about the dire consequences of drug abuse and skills to refuse drugs.

As youth drug abuse is often a manifestation of more deep-rooted problems in family, growth, study and employment, the Division and the Action Committee Against Narcotics have launched the *Path Builders* initiative to foster a caring culture for youth for their healthy development. Path Builders serves as a platform for different sectors of the community to help the younger generation through many different ways. For instance, companies may offer internships, visits, vocational training or job opportunities for young people or to help disseminate anti-drug messages to staff. Professionals may share their professional knowledge and life experience. Individuals may contribute their talent, reach out as Anti-drug Ambassadors or provide sponsorship or donations for the anti-drug cause. With the launch of *Path Builders* in September 2008, appropriate promotion of the cultivation of a culture of community care for young people may also underpin the anti-drug cause.

To steer, coordinate and monitor the implementation of the recommendations of the Task Force, an inter-departmental working group chaired by the Commissioner for Narcotics was set up in early 2009 and is working in full swing.

Social Welfare Department:

For recommendation (i):

In order to achieve early identification and timely rehabilitation for juveniles with drug abuse problem, additional manpower has been injected for the District Youth Outreaching Social Work Teams and Overnight Outreaching Teams for Young Night Drifters since October 2008. These outreaching teams would always collaborate with school social workers as well as Counselling Centres for Psychotropic Substance Abusers, which are all serving the whole territory, to reach out and engage target drug abusers and at-risk youths in counselling services, including referrals for appropriate medical treatment as and when required.

For recommendation (ii):

All along, the Administration has made great cross bureaux / departments efforts on public education including preventive education and publicity on the negative effects of drug abuse in various venues. The Hong Kong Jockey Club Drug InfoCentre has been the central executive arm of Narcotics Division / Security Bureau to serve as a platform for providing drug education to students, parents and the general public.

Under the youth services portfolio, the Department has secured a funding of $750 million from the Hong Kong Jockey Club Charities Trust to implement "Positive Adolescent Training through Holistic Social Programmes to Adulthood: A Jockey Club Youth Enhancement Scheme" (Project PATHS) in secondary schools from 2005-6 to 2011-12 school years. The Project PATHS is jointly organised by the Department, Education Bureau and five universities. It aims to provide comprehensive training programmes / activities for promoting students' positive values, enhancing their resilience against adversities and life stresses as well as strengthening their coping strategies. The Project PATHS could promote their healthy development and thus helping them develop positive life perspective as well as a sense of right and wrong, thus helping them resist the temptations of drugs and other undesirable behaviours.

Committing to the common goal of preventing unnatural child death, the Department would continue to collaborate with relevant welfare service units / stakeholders in the community under the policy coordination of the Narcotics Division of the Security Bureau to tackle the youth drug abuse problems and render timely assistance to avert tragedy.

Meanwhile, professionals should strike the balance between disciplining and protecting children, especially those who have been overly-protected as their resilience to adversity is low.

Education Bureau:
To help students adopt a healthy lifestyle is one of the aims of school education. The Bureau is taking the lead to promote the institutionalisation of a Healthy School Policy with anti-drug element in all schools to build up positive values and attitudes among students. As support measures for schools, a Resource Kit for Parents has been distributed to schools and a Resource Kit for Schools to strengthen anti-drug education and is expected to be ready for distribution by the Narcotics Division of Security Bureau in the fourth quarter of 2009. On going efforts will be made to enhance teachers' competence in delivering anti-drug education and supporting at risk students who may have drug abuse problems.

School Concerned:
Various measures had been taken since 2006 to develop positive self-esteem, sense of responsibility and enhancement in students' resilience from depression and frustration and the temptation of drug abuse. The means used are summarised as follows:

- Curricula about the value of life for F.1 – 3 students.
- Class discussions and debates on drug abuse matters.
- Psychological health programme for F.1 – 4 students.
- Project "PATHS" for F.1 – 3 students.
- Creating atmosphere of "Love and Care" through implementing education project emphasising respect, trust, optimism and intentionality.
- Preventive and educational programmes and activities by the school guidance and counselling team.
- Workshops for teachers on knowledge of drugs and drug abuse.
- A system of mentor teachers for showing love and concern to students, allowing closer supervision to cater students' special needs, detection and dealing with their personal problems.
- Involving and working closely with the Parent-Teacher Association to join the school in implementation of project on staying healthy in school and at home.

***Further Response / Updating (as at 31.10.2010):**

Education Bureau:
The Bureau issued a circular on 'Healthy School Policy' in February 2010 to encourage all secondary and primary schools to formulate a school-based Healthy School Policy with an anti-drug element starting from the 2010/2011 school year. The focus is on developing students' healthy lifestyles, positive attitudes and values, practical life skills and refusal skills to resist temptation. A Resource Kit for Parents and a Resource Kit for Schools were produced and distributed to schools in June 2009 and March 2010 respectively.

Narcotics Division / Security Bureau:

For Recommendation (i):

The Trial Scheme on School Drug Testing in Tai Po District (school year 2009/10) completed smoothly in June 2010. Twenty three secondary schools in Tai Po had participated in the scheme. A professional research organisation was commissioned to undertake a parallel comprehensive assessment of the design, implementation and effectiveness of the Scheme, also to study other local and overseas experiences in school drug testing and to suggest refinements and revisions to the Scheme. The study found that the Scheme has had a positive impact on enhancing students' resolve to stay away from drugs, building an anti-drug culture in schools and triggering the motivation of those in need to seek help.

In light of the positive results revealed in the research, the Scheme will be continued in the school year 2010/11 to reinforce the ground gained last school year, and to further cultivate the anti-drug culture which is beginning to take root. The Administration will gather more experience and data during this school year to continue the assessment of its effectiveness.

On the further development of drug testing in other schools and districts, the study made a series of recommendations regarding the grouping of schools, participation of stakeholders, implementation arrangements, drug testing methods, supporting services, resource support and the Government's role.

The Government will play a facilitating and promotional role, and would encourage schools to pursue drug testing as part of the Healthy School Policy and provide support to interested schools and organisations including offering advice and sponsoring school drug testing schemes through the Beat Drug Fund (BDF).

A Resource Kit for Schools was produced in March 2010 to provide useful checklists for school personnel including school management staff, guidance and discipline teachers, school social workers, class and subject teachers to identify at-risk students and make referrals where necessary.

For Recommendation (ii)

Following the two-year territory-wide campaign with the theme "No Drugs, No Regrets. Not Now, Not Ever" and "不可一，不可再。向毒品說不，向遺憾說不。" , a new series of publicity work carrying a slogan of "Stand Firm Knock Drugs Out" "企硬 唔take嘢", was launched in July 2010.

Recommendation A10

(i) To widely publicise the adverse, and possibly fatal effect of salicylic acid, methyl salicylate, menthol, camphor and thymol on children;

(ii) All Chinese or Western medicines containing these chemicals should carry the label of "Poison – to be kept away from children" to warn the public to use them with care and to keep them away from children; and

(iii) Public education to raise awareness that medicinal oil of different brands may contain similar poisonous chemicals such that concurrent application of more than one brand over a period of time may lead to chronic poisoning.

Updating / Responses

Department of Health:

For Recommendations (i) & (iii) –

(1) Has been continuously educating the public on the safe use of medication via various means such as pamphlets and on-line bulletin (Poisoning Watch on precautionary measures for childhood poisoning related to household products including medicinal products);

(2) It is the usual practice for medical and nursing staff of Maternal and Child Health Centres (MCHCs) of the Department to alert the parents and caretakers about the prevention of unintentional injury including poisoning to their children through individual interview, workshops, audio-visual resources and the website. The leaflets 'Prevention of childhood poisoning' and 'Prevention of Accidental Paracetamol Poisoning in Children' published by Hong Kong Poison Control Network are distributed to parents when they attend MCHC, and uploaded to Family Health Service website (www.fhs.gov.hk) for the public to access; and

(3) According to the literature, toxic effects may occur when significant amount of chemicals, most commonly salicylic acid, is ingested. Systemic effects may occur following large or chronic application of methyl salicylate products to the skin, especially in infants or when the skin is abraded and that can be lethal. Toxicity from camphor containing products is uncommon and severe toxicity is rare. Contact with it may cause burns to skin and eyes. Regarding menthol and thymol, there is no evidence of toxicity and adverse effects on humans via dermatological exposure.

For Recommendation (ii):

(1) Under the Chinese Medicine Ordinance, Cap. 549, the Chinese Medicines Board (the Board) approves the application of proprietary Chinese medicines registration subject to compliance of the requirements including label and package insert. The guidelines for label and package insert as set out by the Board requires that all Chinese medicines containing the chemical of methyl salicylate should bear the statement "Parents or guardians of children should consult healthcare professionals before using this product" on the label and "Children having flu, chicken-pox or fever should avoid using this product" on the package insert to warn the public to use them with care and to keep them away from children;

(2) According to the Pharmacy and Poisons Ordinance, Cap.138, all western medicines containing these concerned chemicals should bear the statement "For external use only"; and

(3) Currently, a warning message "Keep out of reach of children 小心放置，以免兒童誤服 " is included in all drug labels issued by the Department.

Hospital Authority:

(1) Currently, a warning message 'KEEP OUT OF REACH OF CHILDREN' is included in all drug labels issued for outpatients and discharged patients, and advice on the proper usage of drugs will be given to patients; and

(2) Has been educating the public on the safe use of medications via various means, such as the 'Tips on Proper Drug Storage' pamphlet. In addition, there is communication channel within the Hospital Authority to enhance the awareness of healthcare professionals on potential risks of drugs.

Recommendation A11

To incorporate in the education for teenagers on self-awareness of one's own physical ability and risk assessment of the environment.

Updating / Responses

Social Welfare Department:
The recommendation will be considered in the Department's planning of relevant programmes or public education for teenagers.

Recommendation A12

Government to oversee different ethnic groups have equal opportunity on access to information and social services in their language through different media to facilitate their adjustment.

Updating / Responses

Social Welfare Department:
To facilitate ethnic minorities-in-need with difficulties accessing social welfare services because of language barrier, leaflets on major welfare services are translated into six languages commonly used among ethnic minority groups to facilitate their understanding of available services. Interpretation service is in place for those who cannot communicate in Chinese or English while seeking social welfare services and when assistance from relatives, friends or clansmen is not available. The Support Service Centre for Ethnic Minorities funded by the Constitutional and Mainland Affairs Bureau also provides interpretation service to support the Department in service delivery.

Recommendation A13

(i) Public education for parents to assert their responsibility to take care of or supervise their children in outdoor activities involving traffic safety, and to act as good models for their children in observing rules and regulations pertaining to road safety; and

(ii) Relevant government departments to strictly enforce rules and regulations to ensure safe cycling for children.

Updating / Responses

Hong Kong Housing Authority:

For Recommendation (i):

On the aspect of public education for parents to assert their responsibility to take care of or supervise their children in outdoor activities involving traffic safety, Estate Management of the Authority has promulgated the theme of "Promotion of Child Care" through meetings with the Estate Management Advisory Committees (EMACs). The message has been clearly delivered through newsletters, notices and rolling text in lift lobbies. Furthermore, "Child Care" is one of our partnering community building activities to be organised by EMACs and non-governmental organisations.

For Recommendation (ii):

Cycling is normally prohibited in the pedestrian and common areas in our public rental housing estates, though this prohibition is not applicable to young children's cycling if they are accompanied by adults.

Hong Kong Police Force:

(1) In 2009, a total of 7,008 summonses / arrests were made against cycling offence and 11,268 verbal warnings were issued to cyclists. The Police will continue to take enforcement actions in order to enhance safe cycling; and

(2) By adopting a multi-agency approach, the Police work with the Road Safety Council, government departments and non-governmental organisations to promote safe cycling through education, publicity and enforcement. Seminars are conducted at schools and community centres while training courses are arranged for members of the public to raise their awareness on safe cycling.

Recommendation A14

In view that cycling is becoming a trendy sport in Hong Kong, targeted public education and campaigns should be organised to promote safe cycling and alertness of vehicles drivers to observe cyclists on road.

Updating / Responses

Transport Department:
The Road Safety Council, with the support of the Hong Kong Police Force, the Transport and Housing Bureau, this and other relevant departments will carry out various promotion and public education activities to enhance road safety in Hong Kong. They include television and radio announcements, outdoor advertising e.g. billboards and banners, campaigns and events on various road safety topics, seminars and visits to schools and communities. In the meantime, cycling safety is one of our major topics in recent years.

Hong Kong Police Force:
(1) Road safety is one of the Commissioner's Operational Priorities in 2010 and safe cycling is always one of the Police's concerns. Through publicity, education and enforcement actions, the Police aims at enhancing the road safety level. Territory-wide safe cycling campaigns to remind cyclists their legal responsibilities are conducted regularly. The campaigns consist of the education and publicity phases to educate cyclists on their legal responsibilities, and the enforcement phase to take strict enforcement action on cycling offences. Besides, publicity campaigns and educational activities are conducted along cycling tracks, cycling hot spots and schools to promote safe cycling and the importance of wearing protective gears; and

(2) The Police also work in close partnership with the Road Safety Council (RSC), government departments and non-governmental organisations in promoting safe cycling. Drivers are reminded to keep a safe distance from cyclists on roads by means of road safety campaigns, electronic media, publicity materials such as posters and banners and messages carried on moving vehicles. The RSC also engages local cycling associations to provide cycling training programmes to young students and teenagers. 'Safe Cycling' is also promoted through television and radio under the theme of 'Cycling Safety Gear'.

Recommendation A15

To strengthen the regulations, their enforcement and publicity on the use of proper safety seat for ensuring safety of infant passengers in vehicles.

Updating / Responses

Transport Department:

(1) To educate the public about the use of the best restraints for children, the Department has put up relevant information on the website: **http://td.gov.hk/filemanager/en/content_174/seatbelt_leaflet.pdf**; and

(2) To offer better protection for children passengers, drivers are suggested to arrange children to take the rear seats. In addition, it is also recommended to provide children with appropriate restraint devices in cars according to their body sizes and ages, including carrycot, child safety seats and boosters. The Department will continue to promote and encourage drivers to use suitable child restraint devices for children where appropriate.

Hong Kong Police Force:

Territory-wide road safety campaigns are conducted on selected themes. These campaigns consist of education / publicity and enforcement phases to enhance the road safety awareness of road users. The safety measure for passengers will be promoted continuously.

Recommendation A16

Legislation for installation of devices alerting pedestrian for reversing vehicles.

Updating / Responses

Transport Department:

Regulation 38 (1A) of Road Traffic (Construction and Maintenance of Vehicles) Regulations (Cap. 374A) requires that "every goods vehicle shall be fitted with an automatic device capable of giving audible and sufficient warning when it is reversing and is about to reverse." Since 2006, the Department has taken joint effort with relevant parties on various measures to enhance safety of reversing vehicles, including publicity and education efforts / campaigns and review of road environment. "A Guide for the Installation of Devices to Assist Reversing of Goods Vehicles" was issued for reference by the goods vehicle trade. Since August 2007, the Department had conducted consultation meetings with operators and driver associations of different types of goods vehicles on installation of more advanced reversing aids to enhance safety and will continue to encourage the goods vehicle trade to install various reversing aids while study on legislative amendments to make the installation of reversing video device a mandatory requirement on goods vehicles is under way.

Recommendation A17

To revisit the definition of "Light Goods Vehicle".

Updating / Responses

Transport Department:

(1) The vehicle classifications for goods vehicles, which are clearly defined in the Road Traffic Ordinance (Cap. 374) has been adopted for years and working properly and is well received by drivers and the driving industry. The need to review this classification system may not have been arisen at present;

(2) The Department has been implementing an effective driving test system to ensure that candidates who pass the tests have adequate knowledge, skills and capability in the safe and full manoeuvring and control of the vehicles before they are granted probationary driving licences; and

(3) The "Probationary Driving Licence Scheme" has been extended to include novice drivers of light goods vehicles before full driving licences are issued to them. In addition, the Road Traffic Legislation (Amendment) Ordinance 2008 gazetted in July 2008 has also stipulated a package of measures to combat drink driving, dangerous driving among other inappropriate driving behaviours which are also applicable to novice drivers of light goods vehicles.

Recommendation A18

Applying special restrictions for young and inexperienced drivers to minimise their risk of traffic accidents.

Updating / Responses

Transport Department:

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.

***Further Response / Updating (as at 31.10.2010):**

Transport Department:
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 currently under consideration will also tighten the laws on drink driving and dangerous driving. All these measures are also applicable to young and inexperience drivers giving greater deterrent effects to improper driving behaviour and hence improving road safety.

Recommendation A19

(i) Promotion of proper attitude and manner in driving; and

(ii) Regular reinforcement of public education for children and the public on the importance of road safety.

Updating / Responses

Transport Department:
From time to time, the Road Safety Council, with the support of the Hong Kong Police Force, the Department and other relevant departments carries out various promotion and public education activities to enhance road safety in Hong Kong, including: television and radio announcements, outdoor advertising such as billboards, banners; printed materials; campaigns and events on various topics like Smart Driving with Courtesy, Crossing the road with Care, etc. In addition, the Road Safety Vision "Zero Accidents on the Road, Hong Kong's Goal" was developed together with a distinctive symbol to raise public interest and support for road safety improvement.

Recommendation A20

To strengthen training for professional drivers and to organise targeted publicity campaigns on proper driving manner for them.

Updating / Responses

Transport Department:

A For Public Light Bus Drivers

(1) Has issued letters to the Green Mini-bus (GMB) operators and the Red Mini-bus (RMB) trade associations in March 2007 to reinforce the safety precautionary measures to be taken by all GMB and RMB drivers during boarding and alighting of passengers;

(2) Has distributed a set of guidelines on Public Light Bus (PLB) Boarding and Alighting Safety to the GMB operators and RMB trade associations for their compliance;

(3) Has obtained the consent of the suppliers of PLBs to modify the design of new PLBs to enhance safety for boarding and alighting passengers;

(4) Will continue to organise PLB safety workshops for GMB and RMB operators; and PLB drivers to educate and remind them of safe driving. In addition, the Vocational Training Council offers Advanced PLB Driver Training Course under the Skill Upgrading Scheme to interested PLB drivers at a subsidised course fee. PLB drivers can attend the Driving Improvement Course on a voluntary or mandatory basis to refresh proper driving behaviour and attitude;

(5) In March 2008, the Department and the Police jointly launched a Safe-Ride Project in Kowloon East which was later extended to cover the whole territory; and

(6) In addition to reminding PLB drivers and operators of the importance of safe driving through our regular publications (PLB Net), the Department continues to appeal to the GMB operators and RMB trade associations on safety matters in our regular GMB and RMB trade conferences.

B For Franchised Buses and Non Franchised Buses Drivers

(1) The Department and the Police jointly arrange seven Road Safety Seminars every year for both franchised bus captains and non-franchised bus captains to enhance their road safety awareness and update them on the latest road safety requirements, new legislation relating to traffic offences and road safety, and occupational health information;

(2) Franchised Bus companies arrange training programmes for their bus captains, including:

(a) Training courses for the new recruits –
Subject to the driving qualifications of the individuals, such courses last for three to four weeks. Unless they possess public bus driving licences, trainee bus captains must pass the driving tests of the Transport Department before they are allowed to serve on buses with passengers;

(b) Enhancement / refresher training for serving bus captains –
Such training aims at enhancing bus captainsí road safety awareness, driving skills and attitudes, including defensive driving techniques. Bus captains receive enhancement training about once every one to three years, depending on the operational arrangements of individual franchised bus companies. Refresher training will be arranged for bus captains when necessary, taking into consideration their driving performance, such as involvement in traffic accidents or upon the advice of the driving instructors;

(c) Special / remedial training –
Such training lasts for a few days. It will be arranged for bus captains who are found to have improper driving behaviours or who have been away from driving duties for a long period because of sickness or other reasons;

(3) In January 2008, KMB introduced a new driving simulator to strengthen the training on driving skills of their bus captains;

(4) Professional drivers, including the Non-Franchised Bus (NFB) drivers, would be granted subsidies of 70% of the course fee if they take training courses under the Skill Upgrading Scheme. Safe driving behaviour, proper driving attitudes and occupational health tips are included as key components of these courses; and

(5) NFB Newsletters are issued quarterly with a view to promoting road safety and improving driving manner among NFB drivers.

C. For Taxi Drivers

(1) Encourages taxi drivers to enrol in training courses / programmes in order to enhance their driving safety and service quality; and

(2) Road safety messages are disseminated to taxi trade through "Taxi Newsletters" and taxi conferences.

Recommendation A21

To set up sufficient safe leisure and sports facilities in newly developed residential areas.

Updating / Responses

Leisure and Cultural Services Department:

(1) Has all along been providing various types of recreational and sports facilities which are up to international safety standards to serve the needs of the citizens; and

(2) Will continue to implement projects for the provision of recreational and sports facilities in newly developed residential areas having regard to the factors including the population growth and the needs of the community, the views of the District Councils, the level of the existing provision of recreational and sports facilities and their utilisation.

Planning Department:

In planning for newly developed areas, land would be reserved for community and recreational facilities according to the Hong Kong Planning Standards and Guidelines. The Department also helps identify sites upon requests from the client departments who had obtained policy support for provision of free standing facilities in consultation with relevant departments regarding the access to the site and the availability of infrastructure facilities. As regards the safety of the facility, it would have to rely on the architects or engineers concerned, and also on how the user department manages the facility.

Recommendation A22

To ensure that proper warning signs and notices are erected at places unsafe for swimming to remind the public the danger of swimming in such places.

Updating / Responses

Leisure and Cultural Services Department:

(1) Has fenced off rock outcrops and erected floating signage to warn swimmers in bathing beaches with rock outcrops which may endanger swimmers particularly during the high tide when these rock outcrops are submerged under water;

(2) For public swimming pools, water depth indicators are marked on the sides of swimming pools to remind swimmers of the pool depth and children under the age of 12 are not allowed to enter or use any public swimming pools unless accompanied by adults with posters and large banners posted at conspicuous locations to draw the swimmers' attention of this rule. Gate attendants will ensure children under age of 12 are accompanied by an adult on admission;

(3) To prevent accidents, water features are designed in such a way that it deters people from entering. For the promenades, the Department normally provides railing or low retaining walls along the harbourfront to prevent members of the public to have access to the sea for swimming; and

(4) Appropriate signs and notices are also erected to warn visitors not to get into the water features or the sea along the harbourfront for swimming as it is not safe.

Recommendation A23

To raise public awareness on the importance of swimming in a safe place under safe environment through publicity campaigns targeting children of different age groups.

Updating / Responses

Leisure and Cultural Services Department:
Water safety messages are displayed at conspicuous locations of public swimming pools and bathing beaches as well as in the website of the Department (http://www.lcsd.gov.hk). Each year, the Department launches publicity campaigns and organises promotional activities to promote water safety. Means like announcement in the public interest on water safety, distribution of swimmers' handbook are employed to the public to arouse their awareness to prevent swimming accidents. To further enhance students' awareness of water safety, students from primary and secondary schools have been invited to participate in the Department's annual events with themes of water sports safety.

6.4 Cases Died of Suicide

Table 6.4.1: No. of Cases by Age Group and Sex

Age Group	Sex		No. of Cases (%)
	Female	Male	
< 1	0	0	0 (0.0%)
1 – 2	0	0	0 (0.0%)
3 – 5	0	0	0 (0.0%)
6 – 8	0	0	0 (0.0%)
9 – 11	1	1	2 (8.3%)
12 – 14	3	2	5 (20.8%)
15 – 17	6	11	17 (70.8%)
Total:	10	14	24 (100.0%)

Table 6.4.2: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	17 (70.8%)
Full-time Worker	2 (8.3%)
Part-time Worker	1 (4.2%)
Not Studying & Not Working	3 (12.5%)
Not Applicable	0 (0.0%)
Unknown	1 (4.2%)
Total:	24 (100.0%)

Table 6.4.3: Reasons of Committing Suicide

*Reason of Committing Suicide	No. of Cases
Family relationship problem	11
School work problem	7
Relationship problem with boyfriend / girlfriend	5
Mental problem	4
Past trauma	3
Health problem	2
Drug abuse problem	1
Unknown	2
Total:	24

** Multiple reasons were allowed.*
(The reasons were identified in the police death investigation reports of the reviewed cases).

Table 6.4.4: Means of Committing Suicide

Means of Committing Suicide	No. of Cases (%)
Jumping from height	22 (91.7%)
Hanging	1 (4.2%)
Gas poisoning	1 (4.2%)
Total:	24 (100.0%)

Table 6.4.5: No. of Cases with Identified Suicidal Signs

Presence of Suicidal Signs*	No. of Cases (%)
With suicidal signs	16 (66.7%)
Without suicidal signs	7 (29.2%)
Unknown	1 (4.2%)
Total:	24 (100.0%)

Signs: include leaving suicidal notes; emotional / violent acts; verbal expression / threatening of suicidal intention and past history of suicidal attempts. (The signs were identified through police investigation reports.)*

6.4.1 General Observations

In the years 2006 and 2007, a total of 24 children took their own lives.

Table 6.4.1 shows the number of cases by age group and sex. More male (N=14, 58.3%) committed suicide than female (N=10, 41.7%) children. Except for two children who were in the age group 9–11, all other children were aged 12–17, with the majority in the adolescent age group 15–17 (N=17, 70.8%).

Table 6.4.2 shows the number of cases by occupation. The majority (N=17, 70.8%) of the children who committed suicide are students. Three of them were neither studying nor working and two were engaged in full-time work when the fatal incidents happened.

Table 6.4.3 shows the reasons of committing suicide for the cases reviewed as identified through the police investigation reports. The most common reason leading the deceased children to commit suicide was family relationship problem (N=11), and school work problem ranked second (N=7). Relationship problem with boyfriend / girlfriend is the third most common cause (N=5).

Table 6.4.4 shows the means of committing suicide employed by the deceased children. Most of them committed suicide by jumping from height (N=22, 91.7%), which was the most convenient and all-time available means in a densely populated city with high rise buildings. One child chose hanging while another one chose gas poisoning as their means of suicide.

Table 6.4.5 shows the number of cases with identified suicidal signs. Over half of the children who committed suicide (N=16, 66.7%) had expressed their suicidal thoughts in one way or another before actual attempts. This has implication on the timing and approach of early intervention for prevention of youth suicide.

During review on suicide cases, the Review Panel has the following observations:

(1) All the five cases with relationship problem with boyfriend / girlfriend as the main reason for committing suicide occurred around festive seasons. Such seasons include Christmas, New Year, Valentine's Day and Mid-Autumn Festival;

(2) Before or during the happening of seven suicide cases, the peers or family members of the deceased children were present or aware of the fatal incidents and such experience could be traumatic for them;

(3) Sibling comparison on academic performance and parenting style in reaction to children's misbehaviour may be risk factors of child suicide; and

(4) Children of parents with psychiatric problems or suicidal history require special attention.

6.4.2 Recommendations

Recommendation S1

(i) Helping professionals should take note of possible denial of suicidal ideation by suicidal person and connect them with professional counsellors immediately through available means as far as possible once they are identified to have suicidal threat;

(ii) To explore ways to support school social workers to handle resistant adolescent youths with uncooperative parents; and

(iii) To enhance education to the public to encourage people with suicidal intent and their friends and relatives to seek help from professionals instead of covering up such intent in front of the helping parties.

Updating / Responses

Hong Kong Police Force:

(1) Has provided relevant training and procedural instructions to frontline officers for handling attempted suicide reports;

(2) Will remind police officers of possible denial of suicidal ideation; and

(3) Will explore better detection techniques on identifying false denial in future training.

Concerned School Social Work Service of NGO:

(1) Has prepared and uploaded checklists on stress, depression, suicidal risk and crisis intervention manual to intranet for staff's reference;

(2) Has enhanced risk assessment and referral for clinical psychological service for cases;

(3) Has enhanced peer support system; and

(4) Suggested more life education programmes and announcement in the public interest to encourage people to seek help through various sources.

Social Welfare Department:

(1) School social workers would closely collaborate with school / supporting personnel and other professions to mobilise various welfare and community resources to render timely and appropriate assistance to needy students;

(2) Has allotted resources for publicising anti-suicidal messages, promoting positive life values and encouraging seeking professional help; and

(3) Has supported non-governmental organisations rendering school social work service to implement the "Positive Adolescent Training through Holistic Social Programmes to Adulthood: A Jockey Club Youth Enhancement Scheme" jointly organised with the Education Bureau and five universities promoting students' positive values, enhancing their resilience / coping against adversities and life stresses.

Education Bureau:

(1) Has been promoting the Whole School Approach to Guidance under which all teachers and school social workers should collaborate in helping students with problems; and

(2) Attaches great importance to enhancing students' ability to cope with adversity and respect for life through life education with different means.

***Further Response / Updating (as at 31.10.2010)**

Education Bureau:

Has updated the information on prevention of student suicide on EDB website. A seminar on the prevention of suicide was held in Oct 2010 to enhance teachers' awareness in student positive development and prevention of student suicide.

Recommendation S2

(i) Helping professionals to keep in mind that any suicidal ideation from children should always be taken seriously;

(ii) Giving follow-up appointment to children who express suicidal thoughts with no immediate or concrete plan of suicide by helping professionals may help prevent suicide; and

(iii) The focus on suicidal case management should be on proper risk assessment. Proper and evidence-based application of "no-suicide contract" with follow-up services by helping professionals should be noted.

Updating / Responses

Concerned School Social Work Service of NGO:

For Recommendation (i) :

Case was taken seriously ever since the client was being assessed to have self-destructive tendency. The responsible school social worker had carried several measures to prevent the tragic incident:

(1) An interview was conducted with the deceased child on the day he revealed his suicidal ideation. Moreover a "no-suicide" contract was drafted and signed by the client during the session;

(2) With the consent of the deceased child, a joint interview had been arranged with the father, the class teacher and Guidance Master for discussion of the safety measures on the same date; and

(3) Referrals were made to an organisation providing suicide prevention service and our Clinical Psychology Service on the same date. The school social worker had escorted the child to the first session with clinical psychologist.

For Recommendation (ii):

The stationing school social worker had arranged a follow-up interview appointment to the child. It is also our team standard procedure to have follow-up sessions with those students with self-destructive tendency.

For Recommendation (iii):

It is our standard procedure to apply "no-suicide" contract and discuss safety agreement with student having suicidal ideation.

Education Bureau:

(1) Recommendations (i) to (iii) are the prevailing practices of Educational Psychologists (EPs), student guidance personnel in primary schools and school social workers in secondary schools. Such ongoing practices are further reinforced through regular meetings, sharing and various coordination platforms among EPs and the student guidance personnel;

(2) Resources, such as tools for assessment of internet habit and suicide risk, recommended support measures, helpline and community resources, etc. have been uploaded on the EDB homepage in December 2009 for easy access by school personnel, support professionals and parents in December 2009;

(3) A circular memorandum on "Suicide Prevention" was issued to heads and teachers of all primary and secondary schools in December 2009 to alert schools of the need to enhance early identification and intervention of students at risk of involving in cybersuicide pact, together with a sample letter to enlist parents' support in this regard;

(4) The two existing Resource Packages on Student Suicide, for secondary and primary schools respectively are being updated and will be modified into an electronic format to be put on the Bureau's website; and

(5) A seminar on the prevention of suicide was held in Oct 2010 to enhance teachers' awareness in positive development of students and prevention of suicide.

Social Welfare Department:

Since November 2009, the Department has provided additional funding to the Suicide Crisis Intervention Centre for searching blogs with suicidal ideation. Since March 2010, further funding has been provided to the same Centre for a new web-engagement programme which commenced in August 2010.

Hospital Authority:

For children with suicidal ideation, if assessed to be in need of specialist service of the Hospital Authority, they could be referred to Child and Adolescent Psychiatric Service. These children will be rendered timely and comprehensive suicide risk assessment or hospitalisation if they have such need.

Recommendation S3

To consider improvement measures to ensure timely referral between medical unit and medical social service unit within hospital.

Updating / Responses

Hospital concerned / Social Welfare Department:
Both reported that the intra-hospital referral mechanism had been improved in the concerned hospital since September 2008 so that timely service could be rendered to needy clients.

Hospital Authority:
Reported that all Accident and Emergency Departments of the Hospital Authority hospitals will ensure timely referral to relevant clinical specialties and/or medical social services unit so that timely service could be rendered to needy patients.

Recommendation S4

For students who experienced academic failure in schools with good average result, more parental support and supportive service to facilitate their adjustment are required.

Updating / Responses

Education Bureau:
Has reminded schools through guidelines and seminar to refer students with learning and emotional difficulties to the school guidance team or the school social workers for counselling service to support under-performed students.

School Concerned:
(1) Had conducted a review immediately after the suicide incident in 2006;

(2) Has taken improvement measures in providing service and assistance to under-performed students who have to repeat class in an early stage since September 2006; and

(3) Enhancement of service system within school from remedial to preventive approach including early detection of students at-risk; support by peers with specific attention given to 'quiet' students; promotion of students' positive attitude towards life and building up their resilience towards adversities and referral to school social worker for needed services.

Recommendation S5

(i) Public education on acceptance of individual difference in learning ability and potentials of students. Given stimulation and training, students with unsatisfactory academic performance could achieve high in areas where their potentials rest; and

(ii) Strengthening elements of life skills and resilience in school curriculum, and assisting students to enhance their coping ability can help prevent student suicide.

Updating / Responses

Education Bureau:

For Recommendation (i):

(1) Has organised various activities to raise public awareness and understanding of individual differences;

(2) A set of leaflets on various special educational needs and the support services available have been published and uploaded on the Bureau's website. "An Inclusive School-It All Begins with Our Hearts" publicity drive was organised and a series of ten television episodes titled 'Parenting' was produced in 2009. They aim to enhance public understanding and acceptance of students with special educational needs. Resource packages with suggested extended activities and teaching materials were provided to schools in 2010 for further promoting an inclusive culture among students and parents; and

(3) Regularly publishes a web-newsletter on the Bureau's website to provide parents and the public with updated special education information and promote inclusive practices.

For Recommendation (ii):

(1) Relevant learning elements have been included in the school curricula;

(2) Related professional development programmes are organised and learning and teaching resources are prepared for school reference; and

(3) Has been encouraging schools to provide students with ample opportunities in developing competences, helping them set life goals and build an optimistic and positive attitude in face of life changes. To this end, the Understanding Adolescent Project has been conducted in primary schools since the 2004/05 school year to enhance students' resilience by instilling into them a sense of competence, belonging and optimism. Relevant activities for secondary schools have also been organised from time to time, including the Enhanced Smart Teen Project conducted in collaboration with the disciplinary forces and the "Positive Adolescent Training through Holistic Social Programmes to Adulthood: A Jockey Club Youth Enhancement Scheme" (Project PATHS) funded by the Hong Kong Jockey Club Charities Trust and co-organised by the Bureau and the Social Welfare Department.

Recommendation S6

To strengthen professional training for school personnel in aspects of raising their awareness on the emotional expressions and feelings of students with behaviour problems, and enhancing their skills of handling such students.

Updating / Responses

Education Bureau:
Regularly conducts seminars to raise teachers' awareness on the needs of students with behavioural and emotional difficulties and strengthen teachers' skills to help the students in need. In the Certificate Course on Student Guidance and Discipline for Teachers of Primary / Secondary Schools commissioned by the Bureau, the topic "Understanding and Managing students with emotional and behavioural difficulties" has been included.

Social Welfare Department:
To echo the recommendation of the Review Panel, the Department will organise training course / workshop for school social workers:

(a) To strengthen their awareness and skills in handling students with emotional / behavioural problems; and

(b) To provide parents with training programmes on effective parenting skills.

Recommendation S7

Proactive and early intervention, including prompt and accurate assessment for new arrival children suspected to have limited intelligence or special educational needs, and intensive counselling for families with such children.

Updating / Responses

Education Bureau:

(1) Full-time Initiation Programme is offered to newly arrived children. Those entering mainstream school direct are provided with a 60-hour Induction Programme. Public sector schools admitting these children will be given a School-based Support Scheme Grant for integration programmes;

(2) Has reminded schools to optimise the use of available resources in catering for students with learning and / or behaviour difficulties regularly; and

(3) Has established an Early Identification and Intervention mechanism to prevent deterioration of students with special educational needs and to support them. Should the case warrant further assessment, follow-up service will be provided by specialist such as educational psychologists.

Social Welfare Department:

(1) The 61 Integrated Family Service Centres and two Integrated Services Centres over the territory provide preventive, supportive and therapeutic services for individuals and families in need, including new arrival youths and their families, through different activities. These centres also organise groups or programmes specifically for new arrivals to facilitate their adjustment and integration into the community;

(2) Has been funding the International Social Service Hong Kong Branch (ISS) to operate the Cross-boundary and Inter-country Casework Service to help new arrival individuals / families and network those having difficulties to mainstream / community services for early identification of problems and timely intervention; and

(3) Has linked up its Departmental Hotline and the 'New Arrivals Connect Service' of ISS in July 2009 for tailor-made, targeted advice / services to enhance services for new arrivals.

***Further Response / Updating (as at 31.10.2010):**

Education Bureau:
To further enhance home-school cooperation, schools are requested to establish a structured mechanism to enlist parents' support and involvement in supporting students with special educational needs. Schools should explain to parents the inclusive policy, support measures and the communication channels with teachers. Schools are also advised to involve parents in formulating and reviewing the support plans for their children. Guidelines on improving the communication mechanism have been incorporated into the latest version of the Operation Guide on Integrated Education for schools' reference.

Social Welfare Department:
Additional recurrent resources have been allocated to ISS since July 2010 to operate a service counter at the Lo Wu Checkpoint so as to reach out to new arrivals and identify those who are in need of assistance right upon their entry into the territory.

Recommendation S8

Flexible means to be made available in the education system to cater for new arrival children with special educational needs or maladjustment to mainstream schooling.

Updating / Responses

Education Bureau:
Advocates the adoption of the Whole School Approach to catering for student diversity through a 3-tier support model as differentiated by the needs of the students regardless of whether they are local students or newly arrived children:

Tier-1 - Quality teaching in the regular classroom to prevent deterioration of the learning difficulties of the students at-risk.

Tier-2 - Add-on intervention for students with persistent learning difficulties.

Tier-3 - Support for students who need intensive individualized support and special accommodations in the light of their severe difficulties identified.

At present, schools are providing a wide range of support services for these students. If a student is found to have adjustment difficulties in the ordinary school, school would provide school-based guidance or support programme to help him / her adjust to the school routine. On-site advisory service is provided by educational psychologists, inspectors or relevant staff of the Bureau.

Recommendation S9

Positive engagement of adolescent school drop-outs for developing their potentials and building up their self-confidence was crucial for prevention of developmental risks for them.

Updating / Responses

Education Bureau:

(1) Schools are required to step up measures for assuring students' regular attendance and to follow strictly the requirements of reporting to the Bureau on the seventh day of the student's continuous absence in order to ensure timely intervention and provision of appropriate assistance by the relevant parties. If the student's absence is assessed to be related to behaviour difficulties, the at-risk student must be referred immediately to school social workers in secondary schools or student guidance personnel in primary schools for early intervention; and

(2) With the consent of their parents, the Bureau will refer school dropouts to short-term programme / social development programme run by non-government organisations to prepare them for resumption of normal schooling.

Recommendation S10

Public education on the when and how, and the precautions to be taken to initiate separation between young lovers.

Updating / Responses

Social Welfare Department:

Will consider the recommendation in organising future public education programmes under purview where appropriate.

Recommendation S11

To revisit the policy of Integrated Education for students with special educational needs with consideration of aspects including overall need assessment for students transferring from special to ordinary school; guidance to students and parents involved in decision-making on transfer; continuous school work and emotional support for the students; and strengthening of co-intervention and collaboration among involved professionals for students decided on transfer.

Updating / Responses

Education Bureau:

(1) It has been the prevailing practice that teachers, specialists (i.e. speech therapists, educational psychologists) and school social workers of special schools would assess the educational and social needs of students before recommending a particular student for transfer. In the assessment process, the students and their parents should have been consulted and their concerns taken into consideration before making the recommendation or endorsing the parents' choice;

(2) Teachers and social workers in special schools have the expertise in assessing the communication, educational and psycho-social needs of the students for consideration of transfer to ordinary schools. Whenever appropriate, they could also seek advice from the school-based psychologist and / or relevant audiologists / speech therapists / inspectors of the Bureau. They are the most suitable persons to continue to carry out the "overall assessment";

(3) Will remind special schools and relevant specialists / inspectors of the Bureau to conduct interviews with parents to go through assessment findings and help them make an informed decision through careful and detailed considerations;

(4) As a standing practice, when students with special educational needs are transferring out, ordinary and special schools should (after obtaining parental consent) send relevant background information (including professional assessment reports and student progress reports) to the next school and liaise with the other school to facilitate follow-up support for the student. The specialists / inspectors of the Bureau will provide back-end support to the ordinary schools;

(5) The "Operation Guide for Schools on Whole School approach to Integrated Education (2008)" advises schools to adopt a Whole School Approach to catering for students with special educational needs and spells out that ordinary schools are to set up a Student Support Team to plan, coordinate and review the student support measures;

(6) In supporting schools in implementing Integrated Education, government provides additional resources for schools. There are also comprehensive services embracing identification, assessment, intervention and support, such as teacher training, professional support and production of resource materials;

(7) Hearing impaired students in ordinary schools are also supported under the Enhanced Support Service, resource teachers provide school visits and advise ordinary school teachers on the effective use of the amplification system, differentiated teaching strategies, social skills training and communication strategies to support the students. They also organise school-based or district-based training for the ordinary school personnel on need basis;

(8) Has published the "Catering for Student Differences – Indicators for Inclusion" since 2004 to assist schools to conduct systematic planning and self-evaluation of the school policy, culture and practices in catering for student differences; and

(9) A 5-year teacher professional development framework on Integrated Education was launched in the 2007/2008 school year to build up teachers' capacity in catering for students with special educational needs and to enhance staff collaboration in supporting such students.

Social Welfare Department:
Will remind school social workers to closely collaborate with the personnel / supporting personnel from the Education Bureau to support students with special educational needs and their family members to enhance their adjustment and facilitate their better integration into ordinary schools.

Recommendation S12

Public education on the following aspects:

(i) To remind parents that it was their duty and responsibility to bring up, support and protect their children;

(ii) To arouse public awareness on the negative impact of casual or unlawful sexual intercourse for young children; and

(iii) To arouse public awareness on the importance of providing true and accurate personal information of their new arrival children (including age and special needs) to concerned government departments / service organisations to ensure that education or social services provided would be commensurate with their needs.

Updating / Responses

Education Bureau:

(1) Has published a set of leaflets on special education informing the general public of the support services available to children with special educational needs. The leaflets can be accessed on the Bureau's website (www.edb.gov.hk);

(2) Will continue to promote public understanding / acceptance of students with special educational needs and home-school collaboration in supporting students with diverse learning needs through seminars organised by the Bureau or jointly with non-governmental organisations; and

(3) Details such as address and enquiry hotline of respective Regional Education Offices are clearly indicated in the comprehensive guide on services provided by various government departments for parents' reference.

Social Welfare Department:

Proper parenting attitude to ensure safety of children is one of the themes for publicity in the publicity campaign for strengthening of family harmony and prevention of domestic violence.

Recommendation S13

To provide co-parenting counselling to divorcing parents with focus on knowledge and skills in helping children to handle their own emotions to minimise the trauma caused to their children.

Updating / Responses

Social Welfare Department:

(1) Integrated Family Service Centres and Integrated Services Centres of the Department or non-governmental organisations have been taking care of the needs of and providing support services to divorcing parents and their children to help minimise the trauma for the children; and

(2) Family and Child Protective Services Units of the Department also provide counselling service to divorced / divorcing couples with promotion of co-parenting and enhancement of parents' understanding of the children's emotions as one of the work foci.

Recommendation S14

Debriefing and counselling to the surviving siblings, peers, helpers or witnesses of the deceased children should be provided to help them recover from the trauma and resume normal functioning.

Updating / Responses

Social Welfare Department:

(1) Individual or group crisis intervention may be more appropriate for helping peers and helpers of the deceased child or those who have witnessed the death to help them recover from the trauma and resume normal functioning. When needs are indicated, they will be provided with further counselling or psychotherapy;

(2) Will remind frontline social workers to provide welfare services and assistance to persons affected by traumatic incidents where necessary;

(3) Integrated Family Service Centres and Integrated Services Centres have been taking care of the needs of and providing support services to surviving family members; and

(4) Additional funding has been provided to Suicide Crisis Intervention Centre to provide crisis intervention to survivors in November 2009.

Education Bureau:

(1) Has prevailing practice to provide school-based aftermath support to affected schools, with debriefing and counselling being an important and standard procedure to mitigate stress reactions, reduce psychological harm and reinforce group cohesiveness of survivors such as peers, school personnel, parents, witness and helpers;

(2) Debriefing can be conducted individually or in groups by teachers, guidance personnel, school social workers and Educational Psychologists, depending on the need of the survivors. Those identified to be adversely affected will be referred for more in-depth follow-up services, such as psychotherapy etc.;

(3) Ready-to-use materials are in the Resource Package on Student Suicide (published in 1992 and revised in 1997) to facilitate school personnel and helping professionals in addressing the needs of survivors. These have been enriched and updated in the Bureau's e-Book on School Crisis Management, published in 2005. The e-Book has been distributed to all schools and is accessible to the public at the Bureau's website (www.edb.gov.hk); and

(4) Supports schools to conduct crisis management drills to better prepare school personnel to identify and address the emotional needs of survivors.

Recommendation S15

The Education Bureau may consider keeping statistics of student suicide for review and research purposes.

Updating / Responses

Education Bureau:
Has been assisting the Administration in collecting relevant data on suicide cases involving primary and secondary school students, regardless of their age and will continue to keep track of the statistics of student suicide for review if and when necessary.

Recommendation S16

Clear documentation of services rendered to students (especially for those from families with high risk factors or history of psychiatric problems) by school and retention of such records would be helpful for review and service improvement purposes.

Updating / Responses

Education Bureau:
In the School Administration Guide, which has been uploaded on the Bureau's website, schools are reminded to keep proper records of its students, which should be maintained regularly and retrieved easily.

6.5 Cases Died of Assault

Table 6.5.1: No. of Cases by Age Group and Sex

Age Group	Sex		Total (%)
	Female	Male	
< 1	1	1	2 (18.2%)
1 – 2	0	0	0 (0.0%)
3 – 5	1	0	1 (9.1%)
6 – 8	1	1	2 (18.2%)
9 – 11	2	1	3 (27.3%)
12 – 14	1	0	1 (9.1%)
15 – 17	0	2	2 (18.2%)
Total (%):	6 (54.5%)	5 (45.5%)	11 (100.0%)

Table 6.5.2: Perpetrator's Relationship with the Deceased Child

Relationship	No. of Cases (%)
Parent	9 (81.8%)
Stranger	2 (18.2%)
Total:	11 (100.0%)

Table 6.5.3: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	9 (81.8%)
Hospital	0 (0.0%)
School	0 (0.0%)
Indoor (Not Home)	0 (0.0%)
Outdoor	1 (9.1%)
Street/Road	1 (9.1%)
Water/Sea	0 (0.0%)
Others	0 (0.0%)
Unknown	0 (0.0%)
Total:	11 (100.0%)

6.5.1 General Observations

Eleven children died of assault in the years 2006 and 2007.

Table 6.5.1 shows the number of cases by age group and sex. More female (N=6, 54.5%) than male (N=5, 45.5%) died of assault. They are scattered in different age groups except for 1–2. The age group 9–11 has the highest number of cases (N=3, 27.3%).

Table 6.5.2 shows that nine (81.8%) out of the 11 perpetrators are parents of the deceased children. The other two (18.2%) perpetrators are strangers to the children.

Table 6.5.3 shows that nine (81.8%) out of the 11 fatal incidents occurred at home. One incident occurred outdoor while another one occurred on street.

During review of cases died of assault, the Review Panel has the following observations:

(1) Most perpetrators causing the death of the children were their parents;

(2) Four out of the nine parent perpetrators also killed themselves after assaulting their children;

(3) Two deceased newborns were unwanted children whose mothers tried to conceal their birth;

(4) Three out of the 11 deceased children were victims of parental disputes; and

(5) The two victims of the cases died of stranger assault were teenagers who had involved in gang fights.

6.5.2 Recommendations

Recommendation AS1

Professionals working on parenting issues should be sensitive and aware of the cultural difference in child discipline in each case.

Updating / Responses

Social Welfare Department:

(1) Supports that awareness and providing assistance or counselling to clients of different backgrounds based on their individual needs, including cultural variations in parenting, should be part of the foundation training for social workers;

(2) The Department has been providing training programmes on parenting concerns for social workers on regular basis with awareness / sensitivity on cultural variation in child discipline as one of the features covered which will continually be included in related training courses; and

(3) Social workers working on parenting issues in different service units have been advised to take note of the cultural background of service users in handling cases and conducting groups / programmes, including those relating to parental education.

Recommendation AS2

Frontline social workers should stay alert to clients' mental condition and depressive mood right at initial contacts to facilitate prompt intervention to meet their immediate needs.

Updating / Responses

Social Welfare Department:

Generally agrees with the recommendation.

Recommendation AS3

To work out a mechanism to help social workers to make decisive action on protection of children, such as early removal of the children from their families, even without consent of their abusive parents in case of serious domestic violence in order to prevent them from being harmed.

Updating / Responses

Social Welfare Department:

(1) There is existing legal provision under the Protection of Children and Juveniles Ordinance (Cap. 213) for the Director of Social Welfare or any person authorised by the Director of Social Welfare as well as the Police to apply for an order on a child or juvenile in need of care or protection, including removal of the child or juvenile from his / her family. However, this provision is not applicable for the reviewed case as there was no evidence or indication that the child's safety was in jeopardy before the death incident; and

(2) The "Procedural Guide for Handling of Child Abuse Cases" provides guidance for different professionals on handling cases involving child abuse. The fundamental objective of child protection work is to remove the risk and protect the child from risk. Nonetheless, child protection professionals, including social workers, are reminded to assess the risk level that might necessitate the removal of a child from his / her family for his / her own protection.

Recommendation AS4

(i) Where a child is under statutory supervision and put under the care of parents who are suspected to be abusers, very close supervision by the caseworker will be required. For such cases, careful consideration should be made before deciding on case closure, change of caseworker or service unit; and

(ii) To enhance professional training on assessment on child abuse risk for pre-school children.

Updating / Responses

Social Welfare Department:

For Recommendation (i) :

Agrees that caseworkers should render close supervision to child abuse case, particularly those with high risk and living with abuser(s) / suspected abuser(s). Case should only be closed if the risk of child abuse has subsided.

For Recommendation (ii) :

Regularly runs a set of comprehensive and systematic training package to enhance the professional competencies of social workers and related professionals in handling child abuse cases. Apart from providing specific knowledge and skills in case handling, the training also focuses on age-specific concerns and skills in risk assessment and post-trauma care of victims so as to equip the frontline practitioners with the capabilities in working with children of all ages, including pre-school children.

Recommendation AS5

Apart from referring to past history of domestic violence, on-going risk assessment, and alertness of social workers to critical periods during divorce are important for effective intervention for cases with such elements.

Updating / Responses

Social Welfare Department:

(1) The "Procedural Guide for Handling of Child Abuse Cases" providing guidance for different professionals on handling cases involving child abuse reminds them that risk assessment begins at the time of case intake and continues throughout the process of case assessment and planning, provision of service and termination of the case;

(2) The Department runs various training programmes for social workers and related professionals, including teachers, child care professionals, medical and allied health professionals, and the Police on handling family violence cases; and

(3) The Department will continue to provide training on the knowledge and skills in handling high-conflict families, especially complicated cases with custody disputes to social workers to strengthen their sensitivity on risk assessment.

Recommendation AS6

For victims of domestic violence in high risk but refusing to follow suggested safety plans for any reason, issue of written reminders with warning and description of previous fatal incidents by social worker might help them realise the risk and change their minds.

Updating / Responses

Social Welfare Department:

Notes the recommendation, yet has the following concerns:

(1) In divorce case with custody dispute, the party receiving the written reminder may use it as an evidence to fight for child custody in the Family Court; and

(2) The party not receiving the written reminder may complain of social worker's bias and presumption of the occurrence of extreme violence between the couple.

Recommendation AS7

Training for frontline social workers working with domestic violence should emphasise on child-focused assessment and intervention, with consideration of the subjective experience of the child.

Updating / Responses

Social Welfare Department:
Agrees that while training for frontline social workers on child protection should be child-focused, it should also be put in a family context.

Recommendation AS8

More collaboration and information sharing between the Police and the Social Welfare Department, including cross referencing of risk criteria of the two Departments for reaching a common understanding of the levels of risk, may improve the risk assessment procedures.

Updating / Responses

Social Welfare Department:
Various mechanisms for regular communication and liaison among the Police, non-governmental organisations and the Department have been set up at the central, district and case level to enhance service collaboration and coordination in tackling domestic violence issues.

Hong Kong Police Force:
Since November 2006, enhancement measures have been taken for strengthening the collaboration and information sharing between the Police and the Social Welfare Department (SWD) especially in the areas of risk assessment and training with the following details:

(1) Enhanced risk assessment through Introduction of an Emergency Referral Questionnaire to assist frontline police officers in identifying risk factors of domestic violence cases and deciding on emergency referral to SWD;

(2) Established a referral mechanism for domestic violence related cases, including immediate arrangement for temporary accommodation; immediate crisis intervention by social workers; 24-hour direct referral hotline to facilitate handling of urgent requests for needed social services; acknowledgement and non-consensual referral systems;

(3) Enhanced sharing of information and problems encountered in case handling in the District Liaison Groups on Family Violence chaired by District Social Welfare Officers of SWD which aims at strengthening liaison and cooperation at frontline working level amongst the Police and social workers from the SWD or non-governmental organisations;

(4) Enhanced training through close partnership with the SWD in joint training programmes on child protection and domestic violence related issues to different professionals;

(5) Introduced a protocol of Victim Management for victims of domestic violence cases handled by Crime units in 2008 to strengthen the support and safety assurance to victims and to enhance inter-disciplinary communication and collaboration; and

(6) Will maintain close liaison and cooperation with SWD in seeking continuous improvement in the child protection and combating of violence.

Recommendation AS9

(i) While working with divorcing couples in high conflicts, professionals should stay highly alert to high risk moments during the divorce proceedings, the impact on the children and their safety;

(ii) Legal professional to liaise with the case social worker to alert him / her of the possible risk after discussion on sensitive issue, such as property right, with parties involved in domestic violence;

(iii) School personnel should keep watch and be aware of the predicament of children with divorcing parents and they should coordinate with other professionals when safety of these children is at stake; and

(iv) Service organisations may consider requesting clients to give consent for sharing of information by different professionals when they first received the service.

Updating / Responses

Social Welfare Department:

(1) Emphasises the importance of collaboration among different professionals in handling domestic violence cases. While professionals should protect the confidentiality of the personal data of their clients obtained in the course of duties, for cases without client's consent, Data Protection Principle 3 under Section 58 of the Personal Data (Privacy) Ordinance (Cap. 486) may be invoked if the data were to be used and shared for the purpose of child abuse investigation or related child protection work; and

(2) Agrees that professionals concerned should pay more attention to the high risk moments.

Education Bureau:

(1) Has advised school personnel to be sensitive to the needs and the impact on students who are affected by family violence through seminars and circulars; and

(2) Has reminded schools to observe the Procedural Guidelines for Handling Battered Spouse Cases published by the Social Welfare Department and take prompt actions by making referrals and arranging for follow-up support.

The Law Society of Hong Kong:

There is a common theme that all organisations involved with the process need a system in place to enable vital information to be shared. Professionals involved with divorcing parents face difficulties gaining access to information which the frontline social workers have on the high risk cases unless the client volunteers this. Social workers should be provided with the power to release up to date information on high risk children to appropriate parties, including solicitors, to enable all relevant stakeholders to be effective in the effort to prevent child fatalities.

In this regard, the exemption under Section 59 of the Personal Data (Privacy) Ordinance (Cap. 486) which covers *"serious harm to the physical or mental health of the data subject or any other individual"* could be highlighted to frontline social workers in order to ease fears on possible breach of the Ordinance and the privacy of their clients.

Recommendation AS10

In pursuance of bias-free intervention, social worker should consult his / her supervisor in case of great difficulty in serving both the batterer and the victim for support and / or consideration of assigning another social worker to work with one of the parties.

Updating / Responses

Social Welfare Department:

It is common practice for the Department's social workers to report to their supervisors for support and advice whenever in need. Depending on individual case merit and circumstances, the supervisor will arrange for change of social worker or assignment of an additional social worker to work with the parties to promote the effectiveness and quality of the intervention.

Recommendation AS11

(i) To raise the alertness and awareness of children from families with problems on the necessary practical steps to protect themselves in face of immediate violent threats at home; and

(ii) To enhance professional training on early risk detection and welfare planning for children with parents suffering from psychiatric illness to ensure their safety and well-being.

Updating / Responses

Concerned School Social Work Service of NGO:

(1) Had reviewed the procedures of case handling and supervision and professional training for staff after the incident. A briefing session on the incident as well as regular individual supervision sessions have been arranged for our professional staff to raise their alertness and awareness on needs of children from problematic families on the necessary practical steps for self-protection in the face of immediate violent threats at home; and

(2) Caseworkers and other professional staff are supported to join in-service training like Critical Incident Stress Management training. Active participation to district-based training is encouraged so as to facilitate early risk detection and welfare planning for children with parents suffering from psychiatric illness to ensure their safety and well-being.

Education Bureau:

(1) Has produced various teaching resources for prevention of domestic violence such as "Lesson Plans on prevention and support to students affected by domestic violence" and teaching materials on the topic of "self protection". Schools can make use of the resources to encourage the students to seek help and help them develop the skills to protect themselves against immediate violent threats at home; and

(2) Has conducted seminars and workshops for teachers to enhance their skills in working with difficult parents and helping the children with emotional and behavioural difficulties. The topics of "home-school collaboration" and "collaboration with different professionals" in the Certificate Course on Student Guidance and Discipline for Teachers of Primary/Secondary Schools commissioned by the Bureau can also enhance teachers' skills to detect the risk of children with problematic parents, including those with mental illness.

Social Welfare Department:

For Recommendation (i) :

(1) Will continue to promote concerted efforts among its service units and with non governmental-orgnisations to protect children and to early identify children-at-risk through various means, such as life skills training for those children;

(2) Caseworkers of different service units of the concerned District Social Welfare Offices of the Department have been reminded by their supervisors of the importance of detecting problems and risks of children with mentally ill family members. Frontline staff will be encouraged continuously to attend training to enhance their professional competence for such kind of work; and

(3) Has launched a Family Support Programme (Psychiatric) [FSP(Psy)] in eight Medical Social Services Units (Psychiatric) since 2007 for reaching out to vulnerable psychiatric patients and their families, and strengthening social support to them through community support and psycho-educational services and programmes. Mentally-ill persons with dependent children aged 15 or below with records of suicidal attempts; substance abuse, violent acts against others, etc. are accorded priority for admission to the FSP(Psy), through which more intensive services will be provided.

For Recommendation (ii) :

Professional training for medical social workers and school social workers on risk assessment and management of children with parents suffering from mental illness, in particular those parents with suicidal ideation or violent history will be enhanced.

Recommendation AS12

Public education for children to help them learn how to protect themselves and build up their resilience towards domestic violence.

Updating / Responses

Social Welfare Department:

(1) Agrees that public education for children to help them learn how to protect themselves is very important;

(2) Has produced the booklet "What can I do? - *For children who have witnessed domestic violence*" in February 2008 to educate children to protect themselves when domestic violence occurs; and

(3) Will consider further promoting the awareness and skills of self-protection for children experiencing domestic violence in future publicity campaigns.

Education Bureau:

(1) Has produced various teaching resources on the prevention of domestic violence, such as "Lesson plans on prevention and support to students affected by domestic violence", teaching resources for Personal Growth Education in primary schools on the topics of "self protection" and "problem-solving skills". Schools can make reference to the resources when educating students to protect themselves against domestic violence; and

(2) Has implemented the Understanding Adolescent Project (UAP) which aims at enhancing students' resilience to adversities.

The Law Society of Hong Kong:

Procedures should be put in place so that children-at-risk will know where they can seek assistance including but not limited to where and how they can contact their social worker in emergency situations.

Recommendation AS13

Pre-marriage counselling for couple involved in cross-border marriage might help improve mutual understanding between the couple and easier adjustment to such kind of marriage.

Updating / Responses

Concerned Integrated Family Service Centre of NGO:

(1) Strongly supports this recommendation. With over twenty years of experience providing pre-marital counselling, we are thoroughly convinced of its effectiveness in facilitating mutual understanding and easier adjustment to marriage life. However, it is difficult to reach parties involved in cross-border marriage, especially for those who reside in the Mainland. The collaboration among relevant government departments and non-governmental organisations on both sides of the border with a view to making provisions for such service will be necessary:

(2) As a stopgap, we have sent pamphlets on our pre-marital counselling service to some of the Civil Celebrants of Marriage hoping that the information can reach cross-border couples who have plans to have their marriage registered in Hong Kong. A pilot project providing social work service to cross-border kindergarten children and their families was started in the summer of 2010; and

(3) Will try every effort within our capacity to implement the recommendations for the ultimate goal of prevention of child death.

Social Welfare Department:

Service units of the Department and non-governmental organisations, including Integrated Family Service Centres, Integrated Services Centres and Family Life Education Units, have been organising pre-marriage education programmes for couples-to-be. These service units will continue to provide appropriate counselling and support services including organising appropriate education programmes / groups for individuals involved in cross-border marriage to help improve mutual understanding and adjustment of the couple concerned.

6.6 Cases Died of Miscellaneous Causes

Table 6.6.1: No. of Cases by Age Group and Cause of Death

Age Group	Cause of Death		Total (%)
	Medical Complications	Unknown*	
< 1	2	9	11 (52.4%)
1 – 2	0	2	2 (9.5%)
3 – 5	0	1	1 (4.8%)
6 – 8	0	0	0 (0.0%)
9 – 11	0	0	0 (0.0%)
12 – 14	1	2	3 (14.3%)
15 – 17	2	2	4 (19.1%)
Total (%):	5 (23.8%)	16 (76.2%)	21 (100.0%)

Unknown: 15 out of 16 of these cases are ruled by the Coroner's Court to have unknown death cause.*

Table 6.6.2: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	10 (47.6%)
Hospital	9 (42.9%)
School	0 (0.0%)
Indoor (Not Home)	0 (0.0%)
Outdoor	0 (0.0%)
Street/Road	0 (0.0%)
Water/Sea	1 (4.8%)
Others	0 (0.0%)
Unknown	1 (4.8%)
Total:	21 (100.0%)

6.6.1 General Observations

Table 6.6.1 shows the number of cases with miscellaneous causes which include medical complications and unknown. Five (23.8%) children died of complicated medical problems with two of them aged below 1, and the other three (14.3%) were aged between 12–17. 16 (76.2%) children have unknown death cause. Nine (42.9%) of them were aged below 1.

Table 6.6.2 shows the number of cases by place of fatal incident. Most fatal incidents (N=10, 47.6%) occurred at home, closely followed by hospital (N=9, 42.9%). One (4.8%) child was found in sea water while the place of one (4.8%) fatal incident was unknown.

During review of cases died of miscellaneous causes, the Review Panel has the following observations:

(1) Of the 16 cases with unknown death causes, the deaths of 13 children were related to health problems according to police investigation reports at the Coroner's Court;

(2) Nine out of these 16 children collapsed at home; and

(3) Two newborns died of unknown causes were given birth at home.

6.6.2 Recommendations

Recommendation M1

Public education on "Shaken Baby Syndrome" to inform parents and care-givers the possible serious harm of shaking baby through local media and preferably to be broadcast in the Mainland.

Updating / Responses

Department of Health:

(1) The Maternal and Child Health Centres (MCHCs) provide a comprehensive range of health promotion and disease prevention service for children from birth to five years through the Integrated Child Health and Development Programme (ICHDP). Parenting programme is one of the core service components of the ICHDP. Parents-to-be and parents of young children are provided with anticipatory guidance on childcare, child development and parenting issues through information leaflets, audiovisual resources, workshops and individual counselling;

(2) The topic of "Shaken Baby Syndrome" is being covered in one of the parenting leaflets on handling crying baby by the Department;

(3) A video footage on "Shaken Baby Syndrome" produced by the United Christian Hospital is also shown in the Happy Parenting Workshop (0–2 months) to alert the participants on this issue; and

(4) Will explore the possibility to upload the information and video on this topic in the Department's website in order to allow access to the above information by parents residing in the Mainland.

Social Welfare Department:

While the topic of "Shaken Baby Syndrome" is covered by education programmes for parents provided by the Department of Health, the Department will take note of the recommendation and advise welfare service units to consider it in organising public education programmes where appropriate.

***Further Response / Updating (as at 31.10.2010):**

Department of Health:

The video footage on "Shaken Baby Syndrome" produced by the United Christian Hospital has been uploaded on Family Health Service Website (www.fhs.gov.hk) to allow access by parents residing in Mainland.

Recommendation M2

Special attention and support for single parents with multiple risk factors (e.g. young parent, broken marriage / relationship with partner, post-partum depression, history of suicidal attempts) could help reduce risk of improper child care and enhance protection for their children.

Updating / Responses

Department of Health:
To address the needs of children and families with special needs like those from socially or economically disadvantaged families, a targeted intervention programme – the Comprehensive Child Development Service (CCDS) has been implemented in phases in the Department's Maternal Child Health Centres (MCHCs) since 2005. Using the MCHCs and other service units as a platform, the CCDS aims to identify at an early stage at-risk pregnant women, mothers with postnatal depression, families with psychosocial needs, as well as pre-primary children with health, developmental and behavioural problems. Children and their families in need are referred to appropriate health and welfare service units for follow-up. With MCHC as a non-stigmatising platform, CCDS has strengthened the inter-sectoral partnership of the health, social, and education sectors. Apart from direct communication between workers, ad hoc case conference involving service providers are conducted to discuss on the management plan for those families requiring special attention. With CCDS, single parents with multiple risk factors can be identified by the Department's staff at several contact points, including antenatal visits, routine screening of postnatal depression and psychosocial needs at postnatal visit and when the parents and child attend the Department's child health service. In addition, training has been provided to nursing and medical staff of the Department to raise their awareness and sensitivity on the psychosocial needs of families during the delivery of routine health care service.

Social Welfare Department:
For early identification and timely intervention, children and their families who have been identified to have psychosocial needs by the Maternal and Child Health Centres of the Department of Health under the Comprehensive Child Development Service will be referred to Integrated Family Services Centres / Integrated Services Centres for follow-up services as appropriate. The centres provide a continuum of preventive, supportive and remedial welfare services including counselling service, supportive / mutual help groups, developmental programmes, family aide service, family life education, parent-child activities, referral for supportive community services (e.g. financial assistance) and child care services etc. to needy families, including single-parents.

7 GOOD PRACTICE AND LESSONS LEARNT

7.1 Introduction

This chapter is for sharing of good practice and lessons learnt during the pilot review. The Review Panel considers this a very important task in catalysing improvement of our child welfare service systems.

Despite the fact that all cases reviewed by the Review Panel involve deaths of children, the sad ending of these children's lives does not necessarily signify that the services and intervention rendered to them and their families have been ineffective or in vain. The Review Panel deems that there may be times when services could have been better or more promptly delivered. However, in many cases, unforeseeable family or environmental circumstances, and the strong self-destructive impulse or intention of the deceased children have diminished the effect of the support and services delivered to them.

In fact, the Review Panel observes that many of the service mechanisms, intervention models or individual practices for helping those children and their families in the cases reviewed are good, desirable and worth adopting. Important and reflective lessons learnt from review and the suggestions given by related service providers can also serve as good and sound reference helping us to work through difficulties and avoid practice pitfalls.

This Chapter is dedicated to all those who wish to spend more thoughts on improvement in services and service systems.

7.2 Good Practice:

During the Pilot Project, many good practices were observed in service delivery for the cases reviewed which the Review Panel highly appreciated. Some examples are selected to be shared in this section. The Review Panel notes that some of the practices mentioned below might have already been adopted by many service organisations. Nevertheless, it is hoped that such kind of sharing can stimulate more discussion and wider adoption of the good practice to better safeguard our children's well-being.

7.2.1 Reflective internal review resulting in improved service mechanism for students repeating class in a school

Brief Circumstances
The deceased child had poor academic performance and studied in a school with good average academic results. He committed suicide at the beginning of the new school year because he did not want to repeat class.
Good Practice Identified
The school concerned had conducted an internal review immediately after the incident achieving the following: (1) Tracing the risk factors with reference to the deceased child's academic performance, behaviour, family background and services rendered to him; (2) Improving the mechanism for handling students who are required to repeat; (3) Switching from remedial to preventive approach with emphasis on early detection of students at risk; and (4) Pooling concerted efforts of related parties, including assistant principal, school counselor, discipline master, careers mistress and form teacher, school social worker and parents in providing support for students who have to repeat class.
Review Panel's Remarks
The Review Panel appreciated the reflective attitude of the school concerned. The promptness, width and depth of the internal review conducted had led to immediate improvement measures for the school's mechanism of helping students repeating class.

7.2.2 Prompt and collaborative service delivery for a student with mental health problem by school personnel

Brief Circumstances

The deceased child was absent from school and found having abnormal and self-harming behaviour. The class teacher and school social worker quickly intervened and connected her to medical treatment after which she was later diagnosed suffering from early psychosis. She committed suicide during home leave from hospital.

Good Practice Identified

The school personnel had taken the following prompt and collaborated actions to render needed services to the deceased child:

(1) The class teacher paid home visit to the deceased child who was absent from the first day of school in the new school term on that same day and immediately referred her to receive service from the school social worker after observing her normal behaviour;

(2) The school social worker promptly interviewed the deceased child and the mother in school on the following day. As the deceased child exhibited behaviour harmful to herself, she was escorted to hospital for treatment;

(3) The class teacher and the school social worker closely liaised with each other and had frequent phone contacts with the parents of the deceased child. They also visited the deceased child during her hospitalisation; and

(4) The school social worker had also made contacts with concerned medical staff to keep in view the service need of the deceased child and had advised the parents and family members to keep close watch on the deceased child during home leave.

Review Panel's Remarks

It was only 23 days from case became known to the school to the child's death. During this short period, the school teachers and the school social worker had done all they could to help the deceased child and her family. The school social worker was also well aware of the service needs of the deceased child. The intensive intervention and close liaison of the school personnel had demonstrated a good collaborative model of service delivery for children with mental health problems. It was a pity that the deceased child committed suicide during home leave from hospital due to psychiatric problem and her strong suicidal intention, despite the school social worker had reminded the family to play caution and the family members tried hard to keep close watch on her.

7.2.3 Good inter-organisational collaboration and clear division of the work focus for a shared case

Brief Circumstances

The deceased child was associated with undesirable peers and gradually dropped out from school. He had received service from an outreaching social worker who made good efforts to engage the deceased child and his peers. He was also known to his school social worker. Upon intervention of both social workers, the deceased child showed marked improvement in his behaviour with prospect of resuming schooling. Nevertheless, after a period of stable behaviour, the deceased child could not stand the strong provocation from others and lost his life in a gang fight.

Good Practice Identified

(1) The outreaching social worker and the school social worker had good collaboration and they shared information regularly for appropriate and complementary intervention;

(2) The outreaching social worker worked meticulously with the deceased child to lead him back to right track and had built up very good rapport with him, his family and his peers; and

(3) The social workers worked out a clear division of the work focus for this shared case. The outreaching social worker focused on helping the deceased child to detach from association with undesirable peers and involvement in high risk activities. The school social worker mainly focused on facilitating the deceased child's adjustment in school and empowering the parents in child-disciplining.

Review Panel's Remarks

The Review Panel appreciated the services rendered by the concerned social workers and was particularly impressed by the wide spectrum of information on the family background and in-depth case assessment of the outreaching social worker. This case illustrated the significant role which outreaching social work service could play in cases involving runaway youths and school drop-outs.

7.2.4 Comprehensive crisis management and aftermath work in a school

Brief Circumstances

In the review of the case of a deceased child who died in a traffic accident, the concerned school had supplied a very informative report on the crisis management and aftermath work done upon the request of the Review Panel. It included a list of actions taken by related school personnel.

Good Practice Identified

(1) The school kept a very detailed account of the aftermath work upon occurrence of fatal incident to the deceased child, including the services rendered, with details of who, when, what, why and how. This would serve as very important documentation for future reference of personnel for that school;

(2) The school had paid special attention to identify and take care of the needs of potential at-risk students, including sibling and classmates of the deceased child, which might have emotional reaction towards the incident; and

(3) The Education Bureau has been providing guideline on school crisis management in form of an electronic book on the internet, and given appropriate support to schools' crisis management team.

Review Panel's Remarks

Out of the concern for surviving family members and peers of the deceased children, the Review Panel had, on many occasions, requested schools or other service organisations to supply information on services rendered to these survivors. All those concerned service organisations were able and willing to give information on their services rendered in aftermath. It was very encouraging to observe that school crisis management in Hong Kong was quite well-established and widely adopted as a standard procedure.

While the good practices quoted above are some of the significant learning identified by the Review Panel during the review, it is believed that they are not uncommon in the social service field. They also stem from lessons learnt from past experiences of handling of cases pertaining to child welfare. The Review Panel hopes that more and more good practice will be identified and shared in the future.

7.3 Lessons Learnt

This section contains identified rooms for improvement raised by different concerned service organisations subsequent to the happening of child deaths. Providers of these lessons learnt are speaking from their own experiences after going through in-depth internal reviews. They are directions or practices which have implication on practices which frontline professionals may consider for making our service systems work better.

7.3.1 In the assessment of suicidal cases, apart from basing on the client's alleged concern and information, more observation, third parties' information, such as peers and family members as well as continual assessment on client's situation is essential for thorough judgement on determining suitable intervention plan. Continual and close liaison and further discussion with collaborating professionals on the case progress are also very important for handling such cases.

7.3.2 Helping adolescents to develop healthy lifestyle and creating supportive environment for them are important for developing their self-image and resilience. On the other hand, more parenting work to help parents to acquire better understanding towards their adolescent children will also be necessary.

7.3.3 Preventive programmes enhancing students' self confidence, sense of belongingness to school and positive interest can help develop healthy social life and prevent them associate with undesirable peers.

7.3.4 School personnel to be more alert to the mood and service needs of different types of students. Special attention should be given to quiet students who may have suicidal risk but do not express their unhappy thoughts.

7.3.5 In working with students with behaviour problems, it will be very important for school personnel to maintain frequent and good communication with parents and to advise them to employ a calm attitude to discipline their children.

7.3.6 There is a felt need to keep on enhancing professional skills in assessment and management of cases involving resistant and or evasive clients.

7.3.7 Adopting different ways to build up rapport with resistant children is necessary and peers should be mobilised to give support to those children in the helping process.

7.3.8 School social workers should step in early and employ different means to help students suspected to have mental problems through various means, and to initiate liaison with other working parties to provide intensive and needed follow-up services to the children's families.

7.3.9 Where a young child is under statutory supervision, the case social worker should closely liaise with the school personnel for assessment of need in school.

7.3.10 For review of family cases with child care issues, face-to-face contact with the tender-aged children who may not yet have the ability to express themselves well is necessary to ensure their well-being.

8 EVALUATION OF THE PILOT PROJECT

8.1 Introduction

The Review Panel accords great significance to the evaluation of the pilot review which was unprecedented in Hong Kong. After two years' concerted and focused effort on reviewing child death cases during the pilot period from February 2008 to February 2010, the Review Panel began the evaluation of the Pilot Project in March 2010, and completed in August 2010.

The following part of this Chapter describes how the evaluation was carried out and the results, including views collected from stakeholders, remarks and recommendations of the Review Panel on the review mechanism.

8.2 Limitations

The Review Panel is well aware that the following analysis is based on the return of a relatively small number of questionnaires only (N=36). However, it is believed that the respondents are parties with advocacy or participant roles having better knowledge or experience of the child fatality review.

8.3 Means

To increase the objectivity and validity of the evaluation, the Review Panel deemed it crucial to seek the views of different stakeholders, including concerned organisations / departments having provided information to facilitate the review, those responding to the Review Panel's recommendations, those having updated the Review Panel with service improvements, and interested bodies advocating for a review mechanism on child death cases. The Review Panel had sought their views on the Pilot Project through the following means.

Evaluation Questionnaire

An evaluation questionnaire (Chinese version only at ***Appendix VI***) was designed and distributed to different stakeholders as a structured tool to collect their views on the Pilot Project. These stakeholders included those service providers who had supplied information to facilitate the review, those who had responded to the Review Panel's recommendations, and those professional bodies with interest in or advocating for such a review. From March to April 2010, a total of 51 questionnaires were distributed to different stakeholders. A total of 36 completed questionnaires were returned. The return rate was 70.6%.

Sent-in Comments

From time to time, concerned parties or bodies sent in written comments which were discussed in sub-group and panel meetings. Members of the Review Panel also collected views during their meetings or sharing with professionals on the review. The opinions gathered were also included in this report.

Evaluation Meetings of the Review Panel

From March to June 2010, members of the Review Panel, who were the only persons in Hong Kong having two years' actual experience in reviewing child fatality death cases with different death causes, held five sub-group meetings and two panel meetings for detailed evaluation of different aspects of the Pilot Project.

8.4 Results

8.4.1 The evaluation questionnaire

Below is the statistical analysis of returned evaluation questionnaires, with the comments and views of the respondents collected laid out according to the structure of the evaluation questionnaire in which different aspects of the Pilot Project were put under different questions. The part and question numbers quoted below are in accordance to those as set in the evaluation questionnaire. For questions 3 to 13, the responses with highest number of response are highlighted for easy reference of the readers.

As some of the views collected from the questionnaire may stem from lack of detailed information of the review process of the Pilot Project, the actual practice and clarifications of the Review Panel are put as remarks after the views collected.

Part One of Questionnaire : Information on respondents

Questions 1 & 2 – Name and Nature of Responding Organisation

To upkeep the principle of confidentiality, names of individual organisations / bodies / departments having responded or not responded to the questionnaire will not be disclosed.

Type of Organisation		No. of Respondents	Has Also Responded to Recommendations
Information Providers	School	10	2
	*NGOs	7	3
	**GB/Ds	6	6
Concerned Parties	*NGOs	7	0
	**GB/Ds	1	1
Professional Bodies		5	2
Total:		36	14

*NGOs – *non-governmental organisations include service providers of integrated family service, school social work service, clinical psychological service, residential care service, outreaching social service.*

**GB/Ds – *government bureaux / departments.*

The Respondents

Of the 36 respondents, 23 of them (ten schools, seven NGOs and six GB/Ds) have provided information to facilitate the review of child death cases, with 11 of them having responded to the recommendations made by the Review Panel and distributed to them after review of the child death cases.

Eight concerned parties (seven NGOs and one GB/D) and five professional bodies were not directly involved in the cases reviewed but they were included either because they were committed advocates of child fatality review, or it was believed that their professional services were related to the recommendations made by the Review Panel and are essential partners to join hands with others to enhance the child welfare service systems.

Part Two of Questionnaire: Views on Pilot Project
(Questions 2 – 13 of questionnaire)

Question 3 – How do you find the scope of review?

Present scope: cases with children aged below 18, died of natural or non-natural causes and reported to the Coroner.

Response	No. of Respondents (%)
Too narrow	3 (8.3%)
Appropriate	29 (80.6%)
Too Wide	1 (2.8%)
Does not express view	3 (8.3%)
Total:	36 (100.0%)

Views Collected

The majority (80.6%) of the respondents rated the scope of review as appropriate. One respondent considered the scope too wide and there was no need to include cases with natural death causes. Three respondents deemed that the scope should be expanded to cover unexpected child deaths or cases with serious injury.

Review Panel's Remarks

Shortly after commencement of the Pilot Project, the Review Panel has actually extended the scope from non-natural child deaths to cover natural child deaths to make the review more comprehensive. The present scope of review already covered unexpected child deaths. As for cases with serious injury, it was outside the scope of a child death review mechanism. It will also be very difficult to define serious injury and there is strong concern over privacy of personal data in reviewing cases involving living individuals.

Question 4 – How do you find the timing of the review?

Present timing: two years after child's death and upon completion of all legal procedures to avoid prejudicing such procedures.

Response	No. of Respondents (%)
Too early	0 (0.0%)
Appropriate	21 (58.3%)
Too late	8 (22.2%)
Does not express view	6 (16.7%)
No answer	1 (2.8%)
Total:	36 (100.0%)

Views Collected

Over half (58.3%) of the respondents have rated the timing of the review as appropriate. However, there were views that it was not necessary to wait for two years and that review should start as soon as possible after child's death or even before completion of all legal proceedings to avoid information loss or difficulty in recall if long time lag was involved. Also, effective preventive improvement strategies or measures, which should start as early as possible, might also be delayed with the present timing of review.

Review Panel's Remarks

The Review Panel respected the legal and judicial systems and deemed that the review should avoid any interference of or prejudicing criminal and legal proceedings. The Review Panel also found earlier review desirable but the experience of reviewing a case not yet reported to the Coroner revealed that information available for review at such timing would be limited. Nevertheless, the Review Panel also strove to speed up the review process. During the pilot review, once all information of a case was available, the Review Panel reviewed the case without waiting. In fact, of the 209 cases reviewed, 55 cases were reviewed at a time gap of less than two years since the occurrence of the child deaths. The Review Panel thus opined that with the review focus on system improvement, present timing of review was acceptable and the practice of reviewing the case when all information was available should be maintained.

Question 5 – How adequate do you find the source of information for review?

Present source of information: Coroner's Court, mass media, reports and information from concerned service organisations, written or phone enquiries with concerned parties.

Response	No. of Respondents (%)
Very inadequate	0 (0.0%)
Inadequate	5 (13.9%)
Adequate	26 (72.2%)
Very Adequate	1 (2.8%)
Does not express view	4 (11.1%)
Total:	36 (100.0%)

Views Collected

The majority [75.0% (72.2% + 2.8%)] of respondents rated the present source of information as adequate / very adequate. There were suggestions that access to case records or first hand information could minimise the subjectivity and selectivity of providers of information for review. Interview with concerned parties was considered a useful means in understanding why children died.

Review Panel's Remarks

The Review Panel found the width and depth of information collected for review generally satisfactory and sufficient. Though there had been strong concerns from two service organisations in disclosing case details limiting the information they supplied, the response rate to request of information for review was 95.0%. For the means of interview, the Review Panel had tried to arrange for an interview with a parent of a deceased child for collection of information but later deterred from such action due to strong ethical concern.

Question 6 – How adequate do you find the level of confidentiality of the information for review?

Present level of confidentiality: all review information was anonymous. Related information for review was classified as confidential documents. Members could only access review documents before the meeting at the meeting venue and were not allowed to take away any review documents after meeting.

Response	No. of Respondents (%)
Very inadequate	0 (0.0%)
Inadequate	2 (5.6%)
Adequate	29 (80.6%)
Very Adequate	3 (8.3%)
Does not express view	2 (5.6%)
Total:	36 (100.0%)

Views Collected

The majority [88.9% (80.6% + 8.3%)] of respondents rated the confidentiality level as adequate / very adequate. There were suggestions that members of the Review Panel should declare that they would not disclose the review information in any way, and the information should be stored and disposed according to guideline.

Review Panel's Remarks

All members of the Review Panel have signed an undertaking to keep review information confidential at the beginning of the Pilot Project. The Chairman and Convenors would remind all members to keep all review information confidential and within the Review Panel at all review meetings.

The Secretariat of the Review Panel adhered strictly to guideline for storage and disposal of review materials. Readers may also wish to refer to paragraph 3.3 on page 8 on measures taken to ensure confidentiality.

Question 7 – How appropriate do you find the recommendations of the Review Panel?

Recommendations of the Review Panel were set out in Chapter 6 of the First Report. Some examples are: educating young lovers how to separate in peace; educating parents how to choose suitable child minders and keeping clear and good communication with them.

Response	No. of Respondents (%)
Very Inappropriate	0 (0.0%)
Inappropriate	6 (16.7%)
Appropriate	26 (72.2%)
Very Appropriate	1 (2.8%)
Does not express view	3 (8.3%)
Total:	36 (100.0%)

Views Collected

The majority [75.0% (72.2% + 2.8%)] of respondents rated the recommendations made by the Review Panel as appropriate / very approriate. There were views that the recommendations were general and superficial. Some suggested that it might be helpful for the Review Panel to better integrate or prioritise the recommendations for easy follow-up by the concerned service organisations or government departments.

Review Panel's Remarks

As different service organisations, government bureaux / departments have different missions, objectives, service scope and management structure, the Review Panel deemed it more appropriate to make the recommendations directional in nature so that concerned organisations or departments could determine how to take forward the recommendations, including implementation of improvement measures under their organisational and service context.

Question 8 – How adequate do you find the multi-disciplinary representation of the Review Panel?

Present disciplines include: medical, legal, accounting, academic, clinical psychology, education, social welfare and parent representative.

Response	No. of Respondents (%)
Very Inappropriate	0 (0.0%)
Inappropriate	6 (16.7%)
Appropriate	24 (66.7%)
Very Appropriate	3 (8.3%)
Does not express view	2 (5.6%)
No answer	1 (2.8%)
Total:	36 (100.0%)

Views Collected

The majority [75.0% (66.7% + 8.3%)] of respondents rated the representation of multi-disciplines in the Review Panel as adequate / very adequate. There was suggestion for involving police and forensic pathologist and youth or disadvantaged groups in the Review Panel.

Review Panel's Remarks

The Review Panel found the present representation of members from various disciplines appropriate and complementary, yet opined that involvement of forensic pathologist and police in the review process would enhance the multi-faceted perspective of the review. The Review Panel considered that other than appointing them as members of the Review Panel, there were alternatives to collect their views, e.g. interview, focus meeting, or inviting them to be resource persons.

Question 9 – How adequate do you find the neutrality of the review?

Present way to ensure neutrality: declaration of interest from members before each review meeting is a standard procedure for the Review Panel to avoid conflict of interest.

Response	No. of Respondents (%)
Very Inappropriate	0 (0.0%)
Inappropriate	3 (8.3%)
Appropriate	29 (80.6%)
Very Appropriate	2 (5.6%)
Does not express view	2 (5.6%)
Total:	36 (100.0%)

Views Collected

The majority [86.2% (80.6% + 5.6%)] of respondents rated the neutrality of the review as adequate / very adequate. There were suggestions that all panel members involved in reviewing a case should be totally unrelated to that case and to replace those members being related to the cases to be reviewed.

Review Panel's Remarks

It was a standard procedure for members of the Review Panel to declare interest before each review meeting. Should they have any kind of involvement in any case, they would not participate in the review of that particular case. The Review Panel deemed that the review had high degree of neutrality. Members were observed to be objective, impartial and open-minded during review.

Question 10 – Do you find the means of review appropriate?

Present means: primarily documentary and interview with concerned parties when necessary.

Response	No. of Respondents (%)
Yes	28 (77.8%)
No	5 (13.9%)
Does not express view	3 (8.3%)
Total:	36 (100.0%)

Views Collected

The majority (77.8%) of respondents rated the means employed for review as appropriate. Those who deemed it inadequate suggested that interviewing concerned parties, with prior preparation and counselling, would be an important step to obtain first hand information for review. It would also be important to get the parents' perspective through interview.

Review Panel's Remarks

The basically documentary nature of the review, supplemented by interview with concerned parties when necessary, was assessed to be sufficient in facilitating the review by the Review Panel. There had been an attempt of arranging an interview with a parent who had caused the death of a child. This was later given up because the Review Panel was concerned about the ethical and practical issues involved in the case. While understanding that it was difficult to judge whether information obtained through an interview was accurate or objective, the Review Panel deemed that interviewing the parent might not worth the consequence of awakening the traumatic feeling of a parent who had lost his/her child some time ago.

Question 11 – Do you think the review process could facilitate inter-sectoral and multi-disciplinary exchange?

Present review process: disseminating the recommendations and review findings to concerned organisations / bureaux / departments; inviting them to give response and urging them to share good practices and updating of implemented improvement measures.

Response	No. of Respondents (%)
Yes	32 (88.9%)
No	2 (5.6%)
Does not express view	2 (5.6%)
Total:	36 (100.0%)

Views Collected

The majority (88.9%) of respondents rated the review process as facilitative to inter-sectoral and multi-disciplinary exchange. It was suggested that inter-disciplinary meetings or conferences could better facilitate such exchange. It would be desirable to set up a mechanism to assess the effectiveness of improvement measures reported to find out why systems have failed to prevent child death and who should be responsible for coordinating the service systems.

Review Panel's Remarks

The Review Panel took the task of facilitating inter-sectoral and multi-disciplinary exchange an integral part of the review process and agreed that more sharing among professionals in different ways could add impetus to the positive effects. Though the follow-up or monitoring of improvement measures was outside the terms of reference of the Review Panel, members have ventured to pursue this by initiating periodic enquiries with concerned parties for updating of implementation of improvement measures.

Question 12 – Do you think the Pilot Project has met its objectives?

Objectives of the Pilot Project: to identify good practice and possible areas for improvement, patterns and trends for formulation of prevention strategies and promote multi-disciplinary and inter-agency cooperation.

Response	No. of Respondents (%)
Yes	21 (58.3%)
No	6 (16.7%)
Does not express view	8 (22.2%)
No answer	1 (2.8%)
Total:	36 (100.0%)

Views Collected

Over half (58.3%) of the respondents deemed that the Pilot Project had met its objectives. It is noticeable that a considerable number (22.2%) of respondents have chosen not to express their views on this question with reason unknown. Six respondents (16.7%) deemed that the Pilot Project could not meet its objectives. It is noted that the same respondents have considered the scope, timing or means of the review inadequate, or expressed the lack of a mechanism to follow-up the implementation of the recommendations made.

Review Panel's Remarks

Making reference to public responses upon the release of the First Report, their terms of reference and conclusions of their evaluation meetings, members of the Review Panel considered that the stipulated purpose and objectives of the Pilot Project were generally met within a set time span. Nevertheless, the Review Panel deemed that more efforts could be made on identifying good practice and sharing with the public to promote such good practice and recommendations by the Review Panel.

Question 13 – Do you find it difficult to follow-up with the recommendations of the Review Panel?

Recommendations made by the Review Panel were distributed to concerned service organisations, government bureaux / departments for consideration of follow-up and implementation of improvement measures.

Response	No. of Respondents (%)
With Difficulty	2 (8%)
Without Difficulty	12 (48.0%)
Does not express view	3 (12.0%)
No answer	8 (32.0%)
Total:	*25 (100.0%)

** This question is not applicable to all respondents. Among the 36 respondents, 25 of them have been requested to consider and follow-up the Review Panel's recommendations and therefore, there is 25 respondents for this question.*

Views Collected

Some respondents deemed that the recommendations were not directly related to their services. This might explain why three respondents (12.0%) had not expressed any view and eight of them (32.0%) gave no response at all to this question. Twelve respondents (48.0%) claimed to have no difficulty in following up with the recommendations while two (8.0%) expressed difficulty in this issue. The difficulties mentioned included difficulty in applying the recommendation to improvement measures without knowing details of the cases reviewed; and different organisations might differ in views on what could or should be done on the same recommendation.

Review Panel's Remarks

The Review Panel distributed recommendations made to all concerned parties, including those service organisations and government departments having provided information or services to the deceased children' families, and those parties which the Review Panel believed to have concern over the improvement measures required. It was not surprising that some organisations did not find the recommendations directly related to their services, but it was hoped that they could join hands to plan, work or monitor implementation of recommendations sent to them in ways applicable and practicable to them.

Part Three of Questionnaire : Other views

The following are other views collected in Part Three of the questionnaire:

(i) The Pilot Project was a good initiative with positive effects on prevention of child death;

(ii) There should be a standing review mechanism with representatives from all related professionals;

(iii) The Review Panel should have statutory power and legal back up;

(iv) The recommendations of the Review Panel could be better integrated or prioritised for easy follow-up by the concerned organisations; and

(v) There should be a mechanism to follow-up implementation of recommendations made by the Review Panel.

8.4.3 Other Views on the Pilot Project

The following comments on the Pilot Project were obtained through written comments other than the evaluation questionnaire, and views gathered during sharing or meeting between members of the Review Panel and other professionals.

(i) The good intention of the government and the Review Panel to prevent all types of non-natural deaths of children was generally welcomed and supported and there was obvious need to prevent all types of child abuse;

(ii) The Pilot Project was a new innovation focusing and specialising on review of child fatality and should be continued;

(iii) While some suggested that cases with children seriously injured, which was also worth examining and should be included in the review, others opined that as the handling of death and injury cases were different, including cases other than child death would lead the review to lose its focus. This would result in findings and recommendations becoming too general and building up of expertise in reviewing child death cases easily lost. Concerns over the difficulty in defining serious injury and collection of information for cases of living individuals were also raised;

(iv) Some remarked that after studying the First Report of the Review Panel published in January 2010 and having participated in a professional sharing session concerning the Pilot Project, they found the process of review far more serious and objective than they had imagined. Steps taken to ensure confidentiality during the review process also sounded very rigorous to them;

(v) Some appreciated the Review Panel's effort of seeking responses to the recommendations made as it allowed them a chance to see all parties' updated improvement measures or comments, which might contain very good practice for them to follow or lessons to learn;

(vi) More extensive sharing between the Review Panel and related professionals could enhance the effect of the review;

(vii) Child fatality review could be very meaningful and effective if all concerned parties, including non-governmental organisations, could stay reflective and strive for continuous service improvement by implementing the recommendations of the Review Panel in areas applicable to their services; and

(viii) Despite members of the Review Panel were only volunteers, the work done illustrated their enthusiasm and commitment towards the promotion of inter-disciplinary collaboration and child welfare.

8.5 Recommendations of the Review Panel on Way Forward of the Review Mechanism

8.5.1 On Scope of review

The Review Panel recommends that the scope of review be confined to child death cases (under 18) died of natural or non-natural causes, including but not limited to cases reported to the Coroner's court. In fact, during the pilot period, the Secretariat of the Review Panel had received reports or enquiries of reporting procedures from different sources like medical social workers, outreaching social workers and school personnel. Referrals from any other sources, though unpredictable in a voluntary review, should be encouraged by promoting the review through different means.

8.5.2 On Timing of Review

The Review Panel considers the timing of review in the Pilot Project acceptable. Earlier review on some particular cases, especially those child deaths arousing great public concern and with imminent need for prevention measures to be taken to avoid reoccurrence should be attempted as far as legal proceedings would not be prejudiced.

8.5.3 On Information Collection

During the pilot period, service organisations and government departments have been generally cooperative in providing needed information to facilitate the review. It is recommended that more publicity on the review objectives and procedures through different means, such as the internet, may help encourage supply of information and reporting of cases to widen the scope and depth of information collection.

Considering the willing cooperation from concerned parties, especially the service providers during the pilot review, and to avoid possible adverse effects of arousing sentiment and defensiveness from concerned parties when they are bound by legal obligation to participate in the review, the Review Panel is of the view that legislative backup for the review was not necessary at this stage. Need for legislation can be revisited as and when necessary.

8.5.4 On Methodology

The Review Panel considers that the basically documentary nature of the review, supplemented by interview with concerned parties when necessary, is effective in facilitating the review though no interview had been necessary so far. General and in-depth reviews by sub-group and panel meetings are fruitful processes in developing members' expertise in their sub-groups while allowing them exposure and chances to participate in review of cases of different natures in panel meetings. To widen the perspective of the review, means such as focus group meeting and co-opting expert resource persons from other fields when necessary are recommended.

8.5.5 On Tools

Though it is always desirable to look for adequacy and accuracy of information to be collected, it will be difficult for any form to be exhaustive and include all information needed. Therefore, the Review Panel considers the data input form and service report format used for collecting information from concerned parties appropriate in content and length. Nevertheless, the user-friendliness of these forms can be further enhanced.

The database containing demographic, social and review data of the cases reviewed is recommended to be maintained and used continuously in future review for statistical and research purpose. With the accumulation of more data, it is hoped that patterns and trends of child death cases could be plotted and themes could be compared over time.

8.5.6 On Membership of the Review Panel

The knowledge and expertise of the medical experts have proven to be very facilitative in conducting review for cases died of either natural or non-natural death causes. In view of this and the relatively larger number of cases died of natural or health causes, the Review Panel recommends that medical experts should be included as regular, instead of co-opted, members in the Review Panel.

The Review Panel also recommends that input from forensic pathologist and police for better understanding of the death circumstances would be useful.

8.5.7 On Purpose and Function of the Review Panel

The Review Panel recommends more efforts on identifying good practice and inter-disciplinary collaboration for sharing with the public. It also recommends that the present purpose and objectives of the review and similar function of the Review Panel should be maintained.

8.5.8 On Handling and Release of Findings

The Review Panel is always concerned about possible arousal of sentiment and defensive responses during the process of dissemination of review findings and inter-sectoral exchange of responses, which it strives hard to avoid. This is essential for a fair and open review.

The Review Panel also recommends for anonymity of cases reviewed and information providers, the presentation of review findings in aggregate and the focus on improvement of service systems to be maintained for strict confidentiality and avoidance of sentiment arousal.

The Review Panel recommends for more interaction among different disciplines to discuss the findings, and to pursue community education on the recommendations through different means. Supervisors of non-governmental organisations should also be encouraged to share the findings of the review with frontline professionals who may be unfamiliar with child fatality review. This in turn, may raise their awareness and help prevent child death.

8.5.9 On Way Forward

The Review Panel has the following recommendations on the way forward of the child fatality review mechanism:

(1) The value of the review is confirmed and setting up of a standing child fatality review mechanism is highly recommended;

(2) Ways will have to be explored to shorten the time gap between review and report;

(3) Legislative backup for the review should only be considered when voluntary review fails to meet the objectives and when cooperation from concerned parties cannot be obtained continuously, and when society reaches consensus on legislation;

(4) To increase their impact and chances of implementation, the review findings and recommendations could be distributed to the relevant advisory committees or bodies for higher level consideration and follow-up; and

(5) To measure the impact of the review mechanism, outcome evaluation or impact assessment for the review could be considered after the standing review mechanism has been in operation for a sufficiently long period for accumulation of experience and data as well as with the necessary resource secured. Details of the study could be worked out then.

Appendix I : The 20 Categories of Deaths Reportable to the Coroner

The 20 Categories of Deaths Reportable to the Coroner

1 Death the medical cause of which is uncertain
2 Sudden / unattended death, except where a person has been diagnosed before death with a terminal illness
3 Death caused by an accident or injury
4 Death caused by crime
5 Death caused by an anaesthetic or under the influence of a general anaesthetic or which occurred within 24 hours of the administering of anaesthetic
6 Death caused by a surgical operation or within 48 hours after a surgical operation
7 Death caused by an occupational disease or directly / indirectly connected with present or previous occupation
8 Still birth
9 Maternal death
10 Deaths caused by septicaemia with unknown primary cause
11 Suicide
12 Death in official custody
13 Where death occurred during discharge of duty of an officer having statutory powers of arrest or detention
14 Death in the premises of a government department any public officer of which has statutory powers of arrest or detention
15 Death of certain mental patients (as defined by law) in a hospital or in a mental hospital
16 Death in a private care home
17 Death caused by homicide
18 Death caused by a drug or poison
19 Death caused by ill-treatment, starvation or neglect
20 Death which occurred outside Hong Kong where the body of the person is brought into Hong Kong

Source: http://www.judiciary.gov.hk/en/crt_services/pphlt/html/cor.htm

Appendix II: Information Brief of the Pilot Project on Child Fatality Review

Pilot Project on Child Fatality Review

Background

Despite concerted efforts of the Government and Non-governmental Organisations in the provision of child welfare services, occasional child deaths have aroused public concerns. In consultation with the Committee on Child Abuse and with reference to overseas experience, the Social Welfare Department (SWD) has launched a 2-year Pilot Project on Child Fatality Review with effect from 15 February 2008.

Purpose

1. To facilitate the improvement / enhancement of the current child protection and child welfare service systems.
2. With focus on inter-sectoral collaboration and multi-disciplinary cooperation, it is neither intended to identify causes leading to the child's death nor to attribute responsibility to individuals.

Objectives

1. To examine the practice and service issues pertaining to the child death cases;
2. To identify good practice and possible areas for improvement;
3. To identify patterns and trends for formulation of prevention strategies; and
4. To promote multi-disciplinary and inter-agency cooperation for prevention of child death.

Levels and Scope

1. General Review for *all children under 18 who died of non-natural causes on or after 1 January 2006* upon completion of all criminal and judicial processes to avoid prejudicing such processes.
2. In-depth Review for cases arousing public concern and with implication on the welfare services system.

The Review Mechanism

1. A non-statutory Review Panel (RP), with members appointed by the Director of Social Welfare will conduct review with secretariat support from the SWD;
2. The Secretariat will prepare the lists of cases within specified periods for General and In-depth Reviews, and obtain their information for review by the RP. The review is primarily documentary in nature. However, the RP may consider interviews with concerned parties when necessary;
3. Organisation(s) that had rendered service(s) to the deceased child or his/her family could facilitate the review by providing available information to the secretariat;
4. A child death register will be set up to facilitate the review, and for future statistical or research purpose;
5. The review findings and recommendations of the RP will be published in annual reports. Recommendations will be distributed to relevant parties/organisations for consideration and follow-up action; and
6. No individual case details or personal particulars of persons or agencies concerned will be included in the annual report to ensure ***strict confidentiality***. Information furnished by organisation(s) will be used by the Secretariat for the purpose of conducting child fatality review only. Such information will be kept strictly confidential and will not be disclosed without the prior consent of the organisation(s) concerned unless its disclosure is authorised or required by law. The information collected will be destroyed upon completion of review.

Enquiries

Secretariat / Pilot Project on Child Fatality Review
Room 721, Wu Chung House, 213 Queen's Road East, Wanchai, Hong Kong
Tel: 2892 5670 E-mail: srp@swd.gov.hk

Appendix III: Data Input Form for Reporting Child Died of Non-natural Cause

Pilot Project on Child Fatality Review
Data Input Form for Reporting Child Died of Non-natural Cause

Please read this Guiding Notes before completing this Data Input Form:

1. This Data Input Form is to facilitate the implementation of the Pilot Project on Child Fatality Review.

2. Your assistance in completing this Data Input Form will help facilitate the review on children died of non-natural causes which aims at improving child protection and welfare services and preventing child death.

3. If more than one unit is involved in the same case within the same organisation, the management concerned may consider submitting one consolidated Data Input Form incorporating information from all units concerned, or alternatively, submitting all Data Input Forms completed by different units to the Secretariat.

4. Please complete this Data Input Form according to information and record available to you and all you know about the deceased child and/or his/her family **up till the child's death**.

5. No identifying personal data of the surviving family members of the deceased child should be entered in this Form. You are free to decide what data should be included in case you have strong concern about privacy of any party concerned.

6. In case you deem it necessary to obtain consent from the concerned parties before you release their data, care should be given to possible arousal of their traumatic feelings. If such being the case, appropriate counselling is required.

7. Please use one Data Input Form for each deceased child.

8. If there is not enough space provided in this Form or if you want to provide relevant information which falls outside the scope of the items or parts provided in this Form, please supply such information on separate sheet(s).

9. Information furnished by organisation(s) will be used by the Secretariat for the purpose of conducting child fatality review only. Such information will be kept strictly confidential and will not be disclosed without the prior consent of the organisation(s) concerned unless its disclosure is authorised or required by law.

10. This Data Input Form will be destroyed upon completion of review.

11. Please put the completed Data Input Form into a sealed envelope marked confidential and send it to: (For schools, the Form should also be copied to CSDOs of their respective districts as requested by EDB)

Secretary (Review Panel)
Pilot Project on Child Fatality Review
Room 721, Wu Chung House
No. 213 Queen's Road East
Wanchai, Hong Kong

(Tel. No. for Enquiries : 2892 5670)

For Official Use Only:

CDR No.: ☐☐☐☐ / ☐☐☐☐ Date Form Received: ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

CPR No.: ☐☐☐☐ *(if applicable)*

Data Input Form for Reporting Child Died of Non-natural Cause

I. PARTICULARS OF THE DECEASED CHILD

(Please fill in the blanks or put a ☑ in relevant boxes as appropriate.)

(1) **Name:** _____ (English) _____ (Chinese)
(Surname/FamilyNameFirst)

(2) **Sex:** ☐ M ☐ F

(3) **Date of Birth:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(4) **Date of Death:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(5) **HK*BC/IC No.:** ☐☐ ☐☐☐☐☐☐ (☐)

(6) **Identification Document** *(only when HKBC/IC is not available)*:
i) Type of Identification Document: *(e.g. Passport)* _____
ii) Identification Document Number: _____

(7) **Year arrived in HK:** _____ ☐ Since Birth ☐ Unknown

(8) **Nationality:** ☐ Chinese ☐ Non-Chinese *(Please specify)* _____

(9) **Marital Status:** ☐ Never Married ☐ Cohabited ☐ Married ☐ Separated ☐ Divorced

(10) **Occupation:**
☐ 01 Full-time student ☐ 02 Part-time student
☐ 03 Full-time work ☐ 04 Part-time work
☐ 05 Not applicable ☐ 06 Not studying & not working
☐ 07 Unknown

(11) **District of Residence:** *(according to District Council districts)*

☐ CW	Central/Western	☐ TW	Tsuen Wan
☐ S	Southern	☐ KWT	Kwai Tsing
☐ WC	Wan Chai	☐ TM	Tuen Mun
☐ E	Eastern	☐ YL	Yuen Long
☐ IS	Islands	☐ ST	Sha Tin
☐ YTM	Yau Tsim Mong	☐ TP	Tai Po
☐ SSP	Sham Shui Po	☐ N	North
☐ KC	Kowloon City	☐ PRC	Residing in People's Republic of China
☐ WTS	Wong Tai Sin	☐ NHK	Not residing in Hong Kong
☐ SK	Sai Kung	☐ U	Unknown
☐ KT	Kwun Tong	☐ OTH	Others *(Please specify)* _____

(12) **Type of Residence:**

- ☐ 01 Public/Interim Housing
- ☐ 02 Bedspace/Squatter Area/Rooftop Structure
- ☐ 03 Rented Room/ Suite
- ☐ 04 Rented Cubicle
- ☐ 05 Self-owned Cubicle
- ☐ 06 Residential Care Unit/ Foster Home
- ☐ 07 No fixed abode
- ☐ 08 Street sleeping
- ☐ 09 Others *(Please specify)* _____

(13) **Educational Level of Deceased Child and Parents/Guardian:**

Deceased Child:

- ☐ PSC Pre-school
- ☐ PRI Primary
- ☐ SEC Secondary
- ☐ VCT Vocational Training
- ☐ TER Tertiary or above
- ☐ NYS Not Yet Studying
- ☐ U Unknown

Name of school last attended by the deceased child with period:

_____

_____ (From: To:) Class: _____

Father	***Mother***	***Guardian***
☐ ILT Illiterate	☐ ILT Illiterate	☐ ILT Illiterate
☐ PRI Primary	☐ PRI Primary	☐ PRI Primary
☐ SEC Secondary	☐ SEC Secondary	☐ SEC Secondary
☐ VCT Vocational Training	☐ VCT Vocational Training	☐ VCT Vocational Training
☐ TER Tertiary or above	☐ TER Tertiary or above	☐ TER Tertiary or above
☐ U Unknown	☐ U Unknown	☐ U Unknown

(14) **Persons Living with the Deceased Child at the Time of Death:** *(Please ☑ all that are applicable.)*

☐ FA Father	☐ REL Relative(s)
☐ MO Mother	☐ CO Cohabiting with Boyfriend/Girlfriend
☐ BP Both Parents	☐ FR Friend(s)
☐ SIB Sibling(s)	☐ SW Sworn Parent(s)
☐ PG Paternal Grandparent(s)	☐ AL Alone
☐ MG Maternal Grandparent(s)	☐ INS In Institution
☐ STP Step-parent(s)	☐ FP Foster Parents
☐ STS Step-sibling(s)	☐ OTH Others (Please Specify)
☐ CG Care-giver	☐ U Unknown

Total no. of sibling in deceased child's family: *(excluding the deceased child)* _____

(15) **Health Condition of the Deceased Child:**

*(Please ☑ all types of problems that are applicable and *delete as appropriate.)*

☐ a. Generally healthy

☐ b. Had suffered from:

Type of problem	Diagnosis	Received Treatment	Name of Hospital/ Clinic/Treatment Centre
☐ Physical chronic illness	_____	*Yes/No	_____
☐ Psychiatric illness	_____	*Yes/No	_____
☐ Disability	_____	*Yes/No	_____
☐ Developmental delay	_____	*Yes/No	_____
☐ Others *(Please Specify)*	_____	*Yes/No	_____

☐ c. Unknown

(16) **Deceased Child being Recipient of Disability Allowance:**

☐ Yes, SSA Ref. No.:

☐ No

(17) **Family Income:**

☐ 01 On CSSA CSSA Ref. No.: _____

☐ 02 Below $10,000

☐ 03 $10,000 – $19,999

☐ 04 $20,000 – $29,999

☐ 05 $30,000 – $39,999

☐ 06 $40,000 – $49,999

☐ 07 $50,000 or above

☐ 08 Unknown

II. INFORMATION ABOUT CHILD'S DEATH

(18) **Information about Child's Death:**

(i) Date when Reporting Office came to know child's death:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(ii) Date of Reporting Office's last contact with deceased child:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iii) Date of Reporting Office's last contact with deceased child's family:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iv) Cause of death :

☐ ACC(D)	Accident - Drowning	☐ SUI(DO)	Suicide - Drug Overdose
☐ ACC(DO)	Accident - Drug overdose	☐ SUI(G)	Suicide - Gas
☐ ACC(F)	Accident - Fall	☐ SUI(H)	Suicide - Hanging
☐ ACC(HH)	Accident - Household	☐ SUI(J)	Suicide - Jumping
☐ ACC(T/C)	Accident - Traffic (Cycling)		
☐ SUI(OTH)	Suicide - Others *(Please specify)* _____		
☐ ACC(T/O)	Accident - Traffic (Other than Cycling)		
☐ MC	Complications of medical treatment/procedures		
☐ ACC(OTH)	Accident - Others *(Please specify)* _____		
☐ HOM	Homicide	☐ P	Pending Investigation
☐ U	Unknown		

(v) Place where the fatal incident occurred: _____

(vi) Any suspicion of child abuse element leading to child's death:

☐ No ☐ Uncertain

☐ Yes, please elaborate: _____

_____

(vii) Apart from this child's death, any other child death(s) involved in the same family or in the same event?

☐ No

☐ Yes, please give name(s) of the other deceased child(ren): _____

[Please fill in a separate Data Input Form for each named deceased child]

(19) **How the Reporting Office/Organisation came to know about the child's death:**

(20) **Significant circumstances or event(s) that had occurred to the deceased child and/or his/her family prior to child's death, particularly those related with the child's death:**

(21) **Other significant information or observation on the deceased child and his/her family:**

III. INFORMATION ON SERVICES RECIEVED

(22) **Service(s) received from the Reporting Office:**

(i) Had the deceased child and/or his/her family received service from the Reporting Office:
☐ Yes: please complete (ii) to (viii) below ☐ No

(ii) Type of service(s) received: _____

(iii) Service period(s): _____

(iv) File reference number at the Reporting Office (if any): _____

(v) Source of referral: _____
☐ Self-referral

(vi) Presenting problem(s)/Need(s) when the case was last known: _____

(vii) Identified problem(s)/Need(s) when the case was last known: _____

(viii) Assistance requested by client/referrer: _____

(23) **Information about contacts between the deceased child and his/her family with other professionals within 6 months before the child's death:**
*(Please ☑ all that are applicable, give details and *delete as appropriate.)*

Professionals	**Principal Client (e.g. child, father)**	**Service Unit/ Agency**	**Contact Phone No.**
☐ a. Psychiatrist			
☐ b. Medical Practitioner			
☐ c. Psychologist (*Clinical/Educational)			
☐ d. Social Worker (including Medical Social Worker)			
☐ e. School Helping Professionals (*SGP/SSW/SGO/SGT/Teacher)			
☐ f. Therapist (*OT/PT/ST)			
☐ g. Community Psychiatric Nurse			
☐ h. Police			
☐ i. Staff of Social Security Field Unit			
☐ j. Others *(please specify)*			

(24) **Information about service delivery and collaborative contacts on deceased child and/or his/her family:**

(i) Professionals/agencies mentioned in item (23) above whom you had had contact(s) with concerning the deceased child and/or his/her family in the past:

(ii) Agreed intervention plan among different professionals (if any) and progress of implementation:

(Please include good practice identified and difficulties encountered in inter-disciplinary or inter-sectoral collaboration.)

(iii) Other Remarks:

Please use additional sheets for any part if required.

IV. PARTICULARS OF THE REPORTING OFFICE

(25) **Date of Reporting:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(26) **Reporting Office/Organisation:** _____

(27) **Reporting Officer (Name/Post):** _____

(28) **Reporting Officer's Contact Tel. No.:** _____
(for contact only when clarification or further information is required)

July 2008

Appendix IV: Service Report for Review of Child Died of Non-natural Cause

Pilot Project on Child Fatality Review
Service Report for Review of Child Died of Non-natural Cause

Please read this Guiding Notes before completing this Service Report:

1. This Service Report is to facilitate the implementation of the Pilot Project on Child Fatality Review.

2. In case you have previously submitted the Data Input Form on this same case before, please note that Parts I to III of this Service Report are identical to those in the Data Input Form.

3. Your assistance in completing this Service Report will help facilitate the review on children died of non-natural causes which aims at improving child protection and welfare services and preventing child death.

4. Please complete this Service Report according to information and record available to you and all you know about the deceased child and/or his/her family **up till the child's death**.

5. The Reporting Organisation can decide on the appropriate person(s) to be the Reporting Officer(s) on any part of the Service Report. But it is advised that Part VI should be completed by management staff of the Reporting Organisation.

6. If more than one unit is involved in the same case within the same organisation, the management concerned may consider submitting one consolidated Service Report incorporating information from all units concerned, or alternatively, submitting all Service Reports with Part I to Part V completed by different units and with the consolidated Part VI completed by the management to the Secretariat.

7. **No identifying personal data of the surviving family members** of the deceased child should be entered in this Service Report. You are free to decide what data should be included in case you have strong concern about privacy of any party concerned.

8. In case you deem it necessary to obtain consent from the concerned parties before you release their data, care should be given to possible arousal of their traumatic feelings. If such being the case, appropriate counselling is required.

9. For protection of personal privacy, please remove any personal identifiers of the living family members of the deceased child and the worker(s) and supervisor(s) concerned in the Service Report before submission to the Secretariat.

10. Involved parties, such as the caseworker or his/her immediate supervisor, are invited and encouraged to give their views on the case.

11. This report format serves only as a guide for provision of information essential for a thorough child fatality review. Depending on the service nature, duration and the degree of involvement, the Reporting Office is advised to complete the Report according to the format as similar as possible though not all items may be applicable.

12. If there is not enough space provided in this report format or if you want to provide relevant information which falls outside the scope of the items or parts provided in this Report Format, please supply such information on separate sheet(s).

13. The Service Report should preferably be completed within three months after the child's death while memory is still fresh and records are readily available. The Secretariat will advise the concerned agency on the proper time of submission of the Report.

14. Information furnished by organisation(s) will be used by the Secretariat for the purpose of conducting child fatality review only. Such information will be kept strictly confidential and will not be disclosed without the prior consent of the organisation(s) concerned unless its disclosure is authorised or required by law.

15. This Service Report will be destroyed upon completion of review.

16. Please put the completed Service Report into a sealed envelope marked confidential and send it to: (For schools, the Report should also be copied to CSDOs of their respective districts as requested by EDB)

    Secretary (Review Panel)
    Pilot Project on Child Fatality Review
    Room 721, Wu Chung House
    No. 213 Queen's Road East
    Wanchai, Hong Kong

    (Tel. No. for Enquiries : 2892 5670)

For Official Use Only:

CDR No.: ☐☐☐☐ / ☐☐☐☐ Date Form Received: ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

CPR No.: ☐☐☐☐ *(if applicable)*

Service Report for Review Child Died of Non-natural Cause

I. PARTICULARS OF THE DECEASED CHILD

(Please fill in the blanks or put a ☑ in relevant boxes as appropriate.)

(1) **Name:** _____ (English) _____ (Chinese)
(Surname/FamilyNameFirst)

(2) **Sex:** ☐ M ☐ F

(3) **Date of Birth:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(4) **Date of Death:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(5) **HK*BC/IC No.:** ☐☐ ☐☐☐☐☐☐ (☐)

(6) **Identification Document** *(only when HKBC/IC is not available)*:
i) Type of Identification Document: *(e.g. Passport)* _____
ii) Identification Document Number: _____

(7) **Year arrived in HK:** _____ ☐ Since Birth ☐ Unknown

(8) **Nationality:** ☐ Chinese ☐ Non-Chinese *(Please specify)* _____

(9) **Marital Status:** ☐ Never Married ☐ Cohabited ☐ Married ☐ Separated ☐ Divorced

(10) **Occupation:**
☐ 01 Full-time student ☐ 02 Part-time student
☐ 03 Full-time work ☐ 04 Part-time work
☐ 05 Not applicable ☐ 06 Not studying & not working
☐ 07 Unknown

(11) **District of Residence:** *(according to District Council districts)*

☐ CW	Central/Western	☐ TW	Tsuen Wan
☐ S	Southern	☐ KWT	Kwai Tsing
☐ WC	Wan Chai	☐ TM	Tuen Mun
☐ E	Eastern	☐ YL	Yuen Long
☐ IS	Islands	☐ ST	Sha Tin
☐ YTM	Yau Tsim Mong	☐ TP	Tai Po
☐ SSP	Sham Shui Po	☐ N	North
☐ KC	Kowloon City	☐ PRC	Residing in People's Republic of China
☐ WTS	Wong Tai Sin	☐ NHK	Not residing in Hong Kong
☐ SK	Sai Kung	☐ U	Unknown
☐ KT	Kwun Tong	☐ OTH	Others *(Please specify)* _____

(12) **Type of Residence:**

- ☐ 01 Public/Interim Housing
- ☐ 02 Bedspace/Squatter Area/Rooftop Structure
- ☐ 03 Rented Room/ Suite
- ☐ 04 Rented Cubicle
- ☐ 05 Self-owned Cubicle
- ☐ 06 Residential Care Unit/ Foster Home
- ☐ 07 No fixed abode
- ☐ 08 Street sleeping
- ☐ 09 Others *(Please specify)* _____

(13) **Educational Level of Deceased Child and Parents/Guardian:**

Deceased Child:

- ☐ PSC Pre-school
- ☐ PRI Primary
- ☐ SEC Secondary
- ☐ VCT Vocational Training
- ☐ TER Tertiary or above
- ☐ NYS Not Yet Studying
- ☐ U Unknown

Name of school last attended by the deceased child with period:

_____

_____ (From: To:) Class: _____

Father	***Mother***	***Guardian***
☐ ILT Illiterate	☐ ILT Illiterate	☐ ILT Illiterate
☐ PRI Primary	☐ PRI Primary	☐ PRI Primary
☐ SEC Secondary	☐ SEC Secondary	☐ SEC Secondary
☐ VCT Vocational Training	☐ VCT Vocational Training	☐ VCT Vocational Training
☐ TER Tertiary or above	☐ TER Tertiary or above	☐ TER Tertiary or above
☐ U Unknown	☐ U Unknown	☐ U Unknown

(14) **Persons Living with the Deceased Child at the Time of Death:** *(Please ☑ all that are applicable.)*

☐ FA Father	☐ REL Relative(s)
☐ MO Mother	☐ CO Cohabiting with Boyfriend/Girlfriend
☐ BP Both Parents	☐ FR Friend(s)
☐ SIB Sibling(s)	☐ SW Sworn Parent(s)
☐ PG Paternal Grandparent(s)	☐ AL Alone
☐ MG Maternal Grandparent(s)	☐ INS In Institution
☐ STP Step-parent(s)	☐ FP Foster Parents
☐ STS Step-sibling(s)	☐ OTH Others (Please Specify)
☐ CG Care-giver	☐ U Unknown

Total no. of sibling in deceased child's family: *(excluding the deceased child)* _____

(15) **Health Condition of the Deceased Child:**

*(Please ☑ all types of problems that are applicable and *delete as appropriate.)*

☐ a. Generally healthy

☐ b. Had suffered from:

Type of problem	Diagnosis	Received Treatment	Name of Hospital/ Clinic/Treatment Centre
☐ Physical chronic illness	_____	*Yes/No	_____
☐ Psychiatric illness	_____	*Yes/No	_____
☐ Disability	_____	*Yes/No	_____
☐ Developmental delay	_____	*Yes/No	_____
☐ Others *(Please Specify)*	_____	*Yes/No	_____

☐ c. Unknown

(16) **Deceased Child being Recipient of Disability Allowance:**

☐ Yes, SSA Ref. No.: _____

☐ No

(17) **Family Income:**

☐ 01 On CSSA CSSA Ref. No.: _____

☐ 02 Below $10,000

☐ 03 $10,000 – $19,999

☐ 04 $20,000 – $29,999

☐ 05 $30,000 – $39,999

☐ 06 $40,000 – $49,999

☐ 07 $50,000 or above

☐ 08 Unknown

II. INFORMATION ABOUT CHILD'S DEATH

(18) **Information about Child's Death:**

(i) Date when Reporting Office came to know child's death:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(ii) Date of Reporting Office's last contact with deceased child:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iii) Date of Reporting Office's last contact with deceased child's family:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iv) Cause of death :

☐ ACC(D)	Accident - Drowning	☐ SUI(DO)	Suicide - Drug Overdose
☐ ACC(DO)	Accident - Drug overdose	☐ SUI(G)	Suicide - Gas
☐ ACC(F)	Accident - Fall	☐ SUI(H)	Suicide - Hanging
☐ ACC(HH)	Accident - Household	☐ SUI(J)	Suicide - Jumping
☐ ACC(T/C)	Accident - Traffic (Cycling)		
☐ SUI(OTH)	Suicide - Others *(Please specify)* _____		
☐ ACC(T/O)	Accident - Traffic (Other than Cycling)		
☐ MC	Complications of medical treatment/procedures		
☐ ACC(OTH)	Accident - Others *(Please specify)* _____		
☐ HOM	Homicide	☐ P	Pending Investigation
☐ U	Unknown		

(v) Place where the fatal incident occurred: _____

(vi) Any suspicion of child abuse element leading to child's death:

☐ No ☐ Uncertain

☐ Yes, please elaborate: _____

_____

(vii) Apart from this child's death, any other child death(s) involved in the same family or in the same event?

☐ No

☐ Yes, please give name(s) of the other deceased child(ren): _____

[Please fill in a separate Service Report for each named deceased child]

(19) **How the Reporting Office/Organisation came to know about the child's death:**

(20) **Significant circumstances or event(s) that had occurred to the deceased child and/or his/her family prior to child's death, particularly those related with the child's death:**

(21) **Other significant information or observation on the deceased child and his/her family:**

III. INFORMATION ON SERVICES RECIEVED

(22) **Service(s) received from the Reporting Office:**

(i) Had the deceased child and/or his/her family received service from the Reporting Office:
☐ Yes: please complete (ii) to (viii) below ☐ No

(ii) Type of service(s) received: _____

(iii) Service period(s): _____

(iv) File reference number at the Reporting Office (if any): _____

(v) Source of referral: _____
☐ Self-referral

(vi) Presenting problem(s)/Need(s) when the case was last known: _____

(vii) Identified problem(s)/Need(s) when the case was last known: _____

(viii) Assistance requested by client/referrer: _____

(23) **Information about contacts between the deceased child and his/her family with other professionals within 6 months before the child's death:**
*(Please ☑ all that are applicable, give details and *delete as appropriate.)*

Professionals	**Principal Client (e.g. child, father)**	**Service Unit/ Agency**	**Contact Phone No.**
☐ a. Psychiatrist			
☐ b. Medical Practitioner			
☐ c. Psychologist (*Clinical/Educational)			
☐ d. Social Worker (including Medical Social Worker)			
☐ e. School Helping Professionals (*SGP/SSW/SGO/SGT/Teacher)			
☐ f. Therapist (*OT/PT/ST)			
☐ g. Community Psychiatric Nurse			
☐ h. Police			
☐ i. Staff of Social Security Field Unit			
☐ j. Others *(please specify)*			

(24) **Information about service delivery and collaborative contacts on deceased child and/or his/her family:**

(i) Professionals/agencies mentioned in item (23) above whom you had had contact(s) with concerning the deceased child and/or his/her family in the past:

(ii) Agreed intervention plan among different professionals (if any) and progress of implementation:

(Please include good practice identified and difficulties encountered in inter-disciplinary or inter-sectoral collaboration.)

(iii) Other Remarks:

IV. INFORMATION ON DECEASED CHILD'S FAMILY

(25) **Family composition:**

Relationship	**Sex**	**Age**	**Educational Level**	**Occupation**	**Monthly Income**	**Remarks** *(Please specify if any disability/illness or living apart)*
1. Deceased Child						
2.						
3.						
4.						
5.						

(26) **Family background:**

(27) **Family relationship:**

(28) **History of residential placement of deceased child (if any):** *(in chronological order)*

Name of Residential Unit	Supervising Agency	Admission Period	Reasons for Out-of-home Care
		to	
		to	
		to	
		to	

(29) **Significant family issues:** *(Please ☑ all that are applicable, fill in the blanks and *delete where appropriate)*

☐ Marital Problem of Parents

☐ Relationship Problem
Type: _____ Persons Involved: _____

☐ Financial Problem
Person(s) Involved: _____

☐ Domestic Violence
Type: _____ Victim: _____
Abuser: _____ *Abuser prosecuted (result:)/not prosecuted

☐ Child Abuse
Type: _____ Victim: _____
Abuser: _____ * Abuser prosecuted (result:)/not prosecuted

☐ Gambling Problem
Person(s) Involved: _____

☐ Mental Problem(s)
Type: _____ Patient(s): _____

☐ Suicidal Attempt
Type: _____ Person(s) attempted: _____
No. of Attempts: _____ *Successful/Not Successful

☐ Substance Abuse (including alcohol)
Abused Substance: _____ Abuser: _____

☐ Statutory Supervision for Members in the Family *(Samples below in Italics)*

Person Involved	**Type of Court Order**	**Content**	**Period**	**Reason for Statutory Supervision**
Deceased Child	*C or P Order*	*Ward of DSW*	*01/01/2005 – 21 year olds*	*Inadequate parents with child abuse history*
Father	*Probation Order*	*12-month Supervision*	*02/02/06 – 01/02/07*	*Violence against mother*

☐ Other Risk Factors within the Family *(please specify)* _____
Person(s) Involved: _____

V. PROFESSIONAL INVOLVEMENT

(30) **Chronological list of workers and supervisors (no actual names required) involved in the Reporting Agency:** *(Sample below in Italics)*

Worker	Supervisor	Serving Period
Worker 1	*Supervisor A*	*09/06 – 01/07*
Worker 2	*Supervisor B*	*01/07 till case closed*

(31) **Circumstances leading to Reporting Office's involvement with the case:**

(Please state how the deceased child and/or his/her family became connected with the Reporting Office, the kind of programmes, activities, casework intervention or counselling they had participated in.)

(32) **Case assessment, intervention progress and response from client(s):**

(Please include in chronological order: assessment on the needs of the deceased child and his/her family; intervention plan and efforts made; means and frequency of contact; referrals made for services and client's response to intervention.)

(33) **Any other comments or remarks :**

(Involved professionals of different levels may express their views here.)

Prepared by: _____ (Signature)

Name/Post: _____

Name of Reporting Office/ Organisation: _____

Date: _____

VI. REVIEW BY MANAGEMENT OF SERVICE ORGANISATION/DEPARTMENT

(To be completed by Management of Service Organisation/Department Concerned)

(34) **Views and observations:**

(Please state any difficulties encountered, views and observations at all levels during service provision and delivery in this case, particularly in the aspect of inter-disciplinary or inter-sectoral collaboration.)

(35) **Good practice observed in the service provision and service systems in this case:**

(36) **Lesson learnt and recommendations for service improvement:**

(If any, please state any improvement measures undertaken after the incident.)

(37) **Any other remarks:**

(Please provide relevant guidelines and training provided for staff handling such type of cases, if applicable.)

Prepared by: _____ (Signature)

Name/Post: _____

Name of Reporting Office/
Organisation: _____

Date: _____

July 2008

Appendix V: Summary of All Recommendations Made by the Review Panel

For Cases Died of Natural Causes :

N1 (i) It is observed that there is service gap in the home leave care arrangement for disabled children under residential care during which child fatality had occurred. Support for their families, particularly single parents can help prevent such incidents;

(ii) To cater for the special need of some children who do not have appropriate care-giver to look after them during home leave, residential care units can consider providing respite care service with minimal staff so that the needy children can stay in an environment they are familiar with; and

(iii) Children with severe disability should not be put under the care of young siblings who are not capable of such task.

N2 Support for families looking after chronically-ill or disabled children with medical condition requiring special care at home is necessary.

N3 As occurrence of incidents of collapsing at home could be quite shocking and traumatic for family members (particularly young siblings) of the deceased children, it would be necessary to ensure that these families could receive needed counselling and support.

N4 To ensure that staff on duty in special schools and care / training centres for disabled children have received update first aid training.

N5 To work out procedures to ensure every newborn should have physical examination by a paediatrician before discharge from hospital.

N6 General education to urge parents of children with asthma to help their children seek medical treatment whenever in need, particularly in the night-time.

N7 To ensure the presence of on-site personnel trained in resuscitation of children in every private or public hospital treating paediatric patient.

N8 Provision of trained first aiders and equipment like automated defibrillator in sports venues for handling sudden collapse cases during sports events.

N9 For some cases, autopsy may help enlighten the cause of death for prevention purpose.

N10 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.

N11 The use of cough suppressants containing codeine is not generally recommended in children and should be avoided altogether in those under one year old.

For Cases Died of Accidents :

A1 To strengthen public education on:

(i) the possible fatal risk of leaving children unattended; and

(ii) the importance of home safety measures and devices when small children are present.

A2 (i) Public awareness, in particular that of the parents and the care-givers, should be raised on the importance of home safety and the use of safety devices, including window grilles all the time for families with small children;

(ii) Education and promotion of household safety and related measures for families with children;

(iii) When planning and designing buildings, particularly public housing estates, the issues of child safety should be considered e.g. installation of grilles on windows and in corridors; and

(iv) Parents should be educated to communicate with child minders on the needs of their children effectively to ensure proper care for their children.

A3 (i) Parenting education on the role, skills and responsibility of parents should start right at the beginning when a child is born to a family; and

(ii) Strengthening the role and responsibility of the father would better protect the children.

A4 Education for parents:

(i) To seek assistance from reliable child minders, and

(ii) To give clear instructions to child minders to ensure child safety.

A5 Schools or welfare organisations to provide education and support for grass-root parents, especially for those having children with special educational needs, to raise their awareness and ability to take care of their young children.

A6 (i) Education for family members / care-givers of children with disability or chronic illness to be alert of the special needs of these children and the type of care they need; and

(ii) Providing first aid training for family members / care-givers of children with physical disability or chronic illness may help prevent accidental choking at home.

A7 To strengthen survival training and drills for students of special schools to escape from fire or other household accidents.

A8 (i) Regulation and periodic refresher training for security guards to raise their alertness on child safety issues and handling of emergency situations; and

(ii) Management of public housing estate to ensure that guidelines on handling accidents are developed and to arrange for regular emergency drills for security guards of the estate to learn or refresh skills involved.

A9 (i) To derive more effective ways to reach out to juveniles with drug abuse problem; and

(ii) Public education for all age groups on the negative effects of drug abuse through ways such as: use of life-coaching, promotion of positive life-style, strengthening coping strategies and resilience to life stresses etc.

A10 (i) To widely publicise the adverse, and possibly fatal effect of salicylic acid, methyl salicylate, menthol, camphor and thymol on children;

(ii) All Chinese or Western medicines containing these chemicals should carry the label of "Poison – to be kept away from children" to warn the public to use them with care and to keep them away from children; and

(iii) Public education to raise awareness that medicinal oil of different brands may contain similar poisonous chemicals such that concurrent application of more than one brand over a period of time may lead to chronic poisoning.

A11 To incorporate in the education for teenagers on self-awareness of one's own physical ability and risk assessment of the environment.

A12 Government to oversee different ethnic groups have equal opportunity on access to information and social services in their language through different media to facilitate their adjustment.

A13 (i) Public education for parents to assert their responsibility to take care of or supervise their children in outdoor activities involving traffic safety, and to act as good models for their children in observing rules and regulations pertaining to road safety; and

(ii) Relevant government departments to strictly enforce rules and regulations to ensure safe cycling for children.

A14 In view that cycling is becoming a trendy sport in Hong Kong, targeted public education and campaigns should be organised to promote safe cycling and alertness of vehicles drivers to observe cyclists on road.

A15 To strengthen the regulations, their enforcement and publicity on the use of proper safety seat for ensuring safety of infant passengers in vehicles.

A16 Legislation for installation of devices alerting pedestrian for reversing vehicles.

A17 To revisit the definition of "Light Goods Vehicle".

A18 Applying special restrictions for young and inexperienced drivers to minimise their risk of traffic accidents.

A19 (i) Promotion of proper attitude and manner in driving; and

(ii) Regular reinforcement of public education for children and the public on the importance of road safety.

A20 To strengthen training for professional drivers and to organise targeted publicity campaigns on proper driving manner for them.

A21 To set up sufficient safe leisure and sports facilities in newly developed residential areas.

A22 To ensure that proper warning signs and notices are erected at places unsafe for swimming to remind the public the danger of swimming in such places.

A23 To raise public awareness on the importance of swimming in a safe place under safe environment through publicity campaigns targeting children of different age groups.

For Cases Died of Suicide :

S1 (i) Helping professionals should take note of possible denial of suicidal ideation by suicidal person and connect them with professional counsellors immediately through available means as far as possible once they are identified to have suicidal threat;

(ii) To explore ways to support school social workers to handle resistant adolescent youths with uncooperative parents; and

(iii) To enhance education to the public to encourage people with suicidal intent and their friends and relatives to seek help from professionals instead of covering up such intent in front of the helping parties.

S2 (i) Helping professionals to keep in mind that any suicidal ideation from children should always be taken seriously;

(ii) Giving follow-up appointment to children who express suicidal thoughts with no immediate or concrete plan of suicide by helping professionals may help prevent suicide; and

(iii) The focus on suicidal case management should be on proper risk assessment. Proper and evidence-based application of 'no-suicide contract' with follow-up services by helping professionals should be noted.

S3 To consider improvement measures to ensure timely referral between medical unit and medical social service unit within hospital.

S4 For students who experienced academic failure in schools with good average result, more parental support and supportive service to facilitate their adjustment are required.

S5 (i) Public education on acceptance of individual difference in learning ability and potentials of students. Given stimulation and training, students with unsatisfactory academic performance could achieve high in areas where their potentials rest; and

(ii) Strengthening elements of life skills and resilience in school curriculum, and assisting students to enhance their coping ability can help prevent student suicide.

S6 To strengthen professional training for school personnel in aspects of raising their awareness on the emotional expressions and feelings of students with behaviour problems, and enhancing their skills of handling such students.

S7 Proactive and early intervention, including prompt and accurate assessment for new arrival children suspected to have limited intelligence or special educational needs, and intensive counselling for families with such children.

S8 Flexible means to be made available in the education system to cater for new arrival children with special educational needs or maladjustment to mainstream schooling.

S9 Positive engagement of adolescent school drop-outs for developing their potentials and building up their self-confidence was crucial for prevention of developmental risks for them.

S10 Public education on the when and how, and the precautions to be taken to initiate separation between young lovers.

S11 To revisit the policy of Integrated Education for students with special educational needs with consideration of aspects including overall need assessment for students transferring from special to ordinary school; guidance to students and parents involved in decision-making on transfer; continuous school work and emotional support for the students; and strengthening of co-intervention and collaboration among involved professionals for students decided on transfer.

S12 Public education on the following aspects:

(i) To remind parents that it was their duty and responsibility to bring up, support and protect their children;

(ii) To arouse public awareness on the negative impact of casual or unlawful sexual intercourse for young children; and

(iii) To arouse public awareness on the importance of providing true and accurate personal information of their new arrival children (including age and special needs) to concerned government departments / service organisations to ensure that education or social services provided would be commensurate with their needs.

S13 To provide co-parenting counselling to divorcing parents with focus on knowledge and skills in helping children to handle their own emotions to minimise the trauma caused to their children.

S14 Debriefing and counselling to the surviving siblings, peers, helpers or witnesses of the deceased children should be provided to help them recover from the trauma and resume normal functioning.

S15 The Education Bureau may consider keeping statistics of student suicide for review and research purposes.

S16 Clear documentation of services rendered to students (especially for those from families with high risk factors or history of psychiatric problems) by school and retention of such records would be helpful for review and service improvement purposes.

For Cases Died of Assault :

AS1 Professionals working on parenting issues should be sensitive and aware of the cultural difference in child discipline in each case.

AS2 Frontline social workers should stay alert to clients' mental condition and depressive mood right at initial contacts to facilitate prompt intervention to meet their immediate needs.

AS3 To work out a mechanism to help social workers to make decisive action on protection of children, such as early removal of the children from their families, even without consent of their abusive parents in case of serious domestic violence in order to prevent them from being harmed.

AS4 (i) Where a child is under statutory supervision and put under the care of parents who are suspected to be abusers, very close supervision by the caseworker will be required. For such cases, careful consideration should be made before deciding on case closure, change of caseworker or service unit; and

(ii) To enhance professional training on assessment on child abuse risk for pre-school children.

AS5 Apart from referring to past history of domestic violence, on-going risk assessment, and alertness of social workers to critical periods during divorce are important for effective intervention for cases with such elements.

AS6 For victims of domestic violence in high risk but refusing to follow suggested safety plans for any reason, issue of written reminders with warning and description of previous fatal incidents by social worker might help them realise the risk and change their minds.

AS7 Training for frontline social workers working with domestic violence should emphasise on child-focused assessment and intervention, with consideration of the subjective experience of the child.

AS8 More collaboration and information sharing between the Police and the Social Welfare Department, including cross referencing of risk criteria of the two Departments for reaching a common understanding of the levels of risk, may improve the risk assessment procedures.

AS9 (i) While working with divorcing couples in high conflicts, professionals should stay highly alert to high risk moments during the divorce proceedings, the impact on the children and their safety;

(ii) Legal professional to liaise with the case social worker to alert him / her of the possible risk after discussion on sensitive issue, such as property right, with parties involved in domestic violence;

(iii) School personnel should keep watch and be aware of the predicament of children with divorcing parents and they should coordinate with other professionals when safety of these children is at stake; and

(iv) Service organisations may consider requesting clients to give consent for sharing of information by different professionals when they first received the service.

AS10 In pursuance of bias-free intervention, social worker should consult his / her supervisor in case of great difficulty in serving both the batterer and the victim for support and / or consideration of assigning another social worker to work with one of the parties.

AS11 (i) To raise the alertness and awareness of children from families with problems on the necessary practical steps to protect themselves in face of immediate violent threats at home; and

(ii) To enhance professional training on early risk detection and welfare planning for children with parents suffering from psychiatric illness to ensure their safety and well-being.

AS12 Public education for children to help them learn how to protect themselves and build up their resilience towards domestic violence.

AS13 Pre-marriage counselling for couple involved in cross-border marriage might help improve mutual understanding between the couple and easier adjustment to such kind of marriage.

For Cases Died of Miscellaneous Causes :

M1 Public education on "Shaken Baby Syndrome" to inform parents and care-givers the possible serious harm of shaking baby through local media and preferably to be broadcast in the Mainland.

M2 Special attention and support for single parents with multiple risk factors (e.g. young parent, broken marriage / relationship with partner, post-partum depression, history of suicidal attempts) could help reduce risk of improper child care and enhance protection for their children.

Remarks:

Recommendations made for 2006 cases

Recommendations made for 2007 cases

Appendix VI: Evaluation Questionnaire of the Pilot Project on Child Fatality Review (Chinese Version Only)

「檢討兒童死亡個案先導計劃」檢討問卷

此問卷的目的，是向相關的機構／部門／團體收集對「檢討兒童死亡個案先導計劃」各方面的意見作檢討該計劃之用。你的意見將令檢討兒童死亡個案的機制更為完善。填妥問卷後請寄回：

香港灣仔皇后大道東213號胡忠大廈7樓721室
「檢討兒童死亡個案先導計劃」檢討委員會秘書處

(一) *機構／部門／團體資料：（*請刪去不適用者）

1. 名稱：_____

2. 貴*機構／部門／團體（可選多項）

   □曾提供資料協助檢討進行
   □曾就檢討委員會之觀察或建議作出回應
   □屬於關注團體

(二) 對「先導計劃」的意見： _____

_____

3. 檢討範圍包括所有18歲以下，死於各種自然及非自然因素，並曾向死因庭呈報的兒童死亡個案。你認為**檢討涵蓋範圍**：

   太窄 1 □　合適 2 □　太闊 3 □　不表意見 □

   若選「太窄」/「太闊」，請提出你的建議給檢討委員會作參考：

   _____

4. 檢討委員會於兒童死亡個案發生後兩年及所有法律程序完結後進行檢討，以免妨礙任何司法程序。你認為**進行檢討的時間**：

   太早 1 □　合適 2 □　太遲 3 □　不表意見 □

   若選「太早」/「太遲」，請提出你的建議給檢討委員會作參考：

   _____

5. 檢討的資料來源包括死因庭、報章報導、相關機構／部門提交的資料輸入表、服務報告、電話或書面查詢等。你認為**資料的來源**：

極不足夠 1 □　不足夠 2 □　足夠 3 □　極足夠 4 □　不表意見 □

若選「極不足夠」/「不足夠」，請提出你的建議給檢討委員會作參考：

_____

6. 秘書處準備相關文件交檢討委員會作檢討前，會先去除所有個人資料。為免資料外洩，檢討前後所有檢討文件均以加密形式儲存於秘書處，委員會成員在檢討會議後亦不得將文件帶走。你認為**檢討資料的保密程度**：

極不足夠 1 □　不足夠 2 □　足夠 3 □　極足夠 4 □　不表意見 □

若選「極不足夠」/「不足夠」，請提出你的建議給檢討委員會作參考：

_____

7. 檢討委員會為預防兒童死亡而提出各項建議（見檢討委員會發表的首份報告第六章），如教育年輕情侶如何心平氣和地分手、教育家長謹慎地為子女選擇可靠的褓母，並與褓母保持清楚及良好的溝通等。一般來說，你認為檢討委員會的**建議：**

極不適切 1 □　不適切 2 □　適切 3 □　極適切 4 □　不表意見 □

若選「極不適切」/「不適切」，請提出你的建議給檢討委員會作參考：

_____

8. 為確保檢討的全面性，檢討委員會成員來自不同界別（包括醫學、法律、會計、學術、心理學、教育、社福和家長）。你認為**不同專業的參與程度**：

極不足夠 1 □　不足夠 2 □　足夠 3 □　極足夠 4 □　不表意見 □

若選「極不足夠」/「不足夠」，請提出你的建議給檢討委員會作參考：

_____

9. 檢討乃由獨立的委員會進行，檢討過程中，如成員與個案有任何關連，均須申報以避免利益衝突。你認為**檢討過程的中立程度**：

極不足夠 1 □　不足夠 2 □　足夠 3 □　極足夠 4 □　不表意見 □

若選「極不足夠」/「不足夠」，請提出你的建議給檢討委員會作參考：

_____

10. 為免觸及家人或相關人士的傷痛，檢討是以查閱相關資料及文件為主，有需要時才與相關人士會面。你認為此**檢討形式**是否適合?

是 □　否 □　不表意見 □

若選「否」，請提出你的建議給檢討委員會作參考：

_____

11. 檢討委員會向各相關機構／部門傳達檢討結果及建議，促請他們回應、分享良好做法及作出改善措施。你認為以上工作流程是否能**促進跨專業及跨界別交流**？

是 □　否 □　不表意見 □

若選「否」，請提出你的建議給檢討委員會作參考：

_____

12. 先導計劃的目標是找出相關服務系統的優良、不足及可改善之處，提出建議及預防策略，並促進跨專業及跨機構的合作，以預防兒童死亡。你認為此先導計劃是否能**達致目標**？

是 □ 否 □ 不表意見 □

若選「否」，請提出你的建議給檢討委員會作參考：

_____

13. （此題只適用於曾收到檢討委員會要求對其觀察及建議作出考慮及跟進之機構）貴機構在**跟進建議**上有沒有遇上任何困難？

有 □ 沒有 □ 不表意見 □

若選「有」，請略述你的困難給檢討委員會作參考：

_____

(三)其他意見：

_____

_____

_____

問卷完，多謝您的寶貴意見！

填表者資料（只在有需要聯絡填表者澄清資料時用，所有個人資料均絕對保密。）

姓名：_____

職位：_____

聯絡電話：_____