立法會 CB(2)1040/10-11(01)號文件
LC Paper No. CB(2)1040/10-11(01)

The Against Child Abuse
Responding to
Legislative Council Panel on Welfare Services
Pilot Project on Child Fatality Review
14 February, 2011

INTRODUCTION

A Child Fatality Review (CFR) is long overdue. The efforts of the pilot project panel deserve recognition as many important observations and recommendations were made.

We would like to comment on the scope of review, pinpoint certain areas of inadequacy and emphasise the importance of effective implementation of the Panel's rather worthy recommendations.

SCOPE

The review reflected our children at grave risks and "early prevention" at various levels is essential but not yet properly put in place.

The deterioration of family solidarity, the increase in family break down, the inadequacy of positive parenting, the increase in domestic violence, the frequent cases of children being left unattended and/or abused have been affecting an enormous number of children.

It would be dangerous if we limit our review only to those who died and in this case the 209 children and consider our prevalence rate low as compared with other countries. This may not only be misleading but may contribute to complacency that Hong Kong can ill afford.

We call for A Permanent Child Fatality and Serious Cases Review Mechanism (CFR) with the terms of reference to review not only fatal but also serious cases so as to ensure genuine prevention including early identification, proper intervention by an

adequate system with well trained and sensitive professionals. This approach may ensure help rendered early to a larger group of children and families.

There is hesitation that it would be hard to define what serious cases means and to include all such cases would be labour intensive and further delay findings from being found. It was thus believed that this would be undesirable. Nevertheless no administrative or technical difficulties should deter the will and determination for early prevention in the formulation of policy and practices.

When the panel reviewed suicide cases, the panel should have reviewed also children's self mutilating cases as there are children who harmed themselves and suffered physical and emotional trauma and professional attention and guidance must be strengthened. We also recommend more resources and attention given to support parents with teenage children. Such support should be given on a person to person in depth basis and the mentoring approach may be considered an effective way of rendering help to teenagers and their parents.

Reviewing cases with children seriously injured, physically, socially and/or psychologically, helps to unravel patterns and characteristics in order to better formulate proactive policy and practices and to involve necessary stakeholders early. The sexual abuse case in the hospital ward with a boy sexually abusing a younger girl was one example in hand that should be promptly reviewed.

We should continue to honour the conviction that every child matters and his best interests command top priority.

AREAS OF INADEQUACIES

Child neglect and children left unattended has been an area of concern since the eighties. There were at least 160 young children killed while left unattended since 1989 (the year that the Coroner's Report started to reflect whether the child was unattended in the time of the incident), and every year there were a large number of children injured and admitted in Accident and Emergency Wards due to home safety and accidents. There were extensive media coverage and debate on the problem and its resolution. Nevertheless our government refused a more proactive approach by putting adequate law in place to protect children from being left unattended. This position regretfully remained the same as the recommendation list did not include such item.

The report indicated 7 fall cases with four of the deceased left unattended but did not go further to explain contributing factors or reasons for children being left unattended. Whether children are left unattended because of financial problems, inadequate safety concepts, over estimating a child's ability for self care or mere convenience of carers should be properly identified. These reasons if found may contribute to recommendations for improvements. Moreover a base line study on the extent and characteristics of children left unattended should be commissioned.

Head Start home based support found effective elsewhere should be made available for every new born families. To ensure new couple properly supported and adequate caring and parenting and home safety being reminded, the Department of Health Integrated Child Health and development Program of DH must include home visitation for all new born families, especially for new arrivals and ethnic minorities, to ensure capacity building, home safety, positive parenting and couples communication.

We welcome the recommendation that the Hong Kong Housing Authority to take child safety into consideration when planning and designing new public housing estates and welcome the HKHA to inform how such promise would be actualized.

The lack of in-depth positive life education, sex education and proper handling of emotions and affect must be carefully addressed. The increasing usage of the internet, internet addiction, sex traps online calls for prompt strategic action and support for children and their parents.

In addition, there should be improvement in the heavy loaded psychiatric and clinical psychological services to follow up with the depressed and those attempted suicide. The current follow up service is in at extremely stressful condition. Clients would have to queue up for long hours for consultation and wounded souls require expert time and advice promptly. Any delay may kill and the situation must be swiftly addre**ssed.**

Furthermore, the relevant recommendations should be included in the handling procedures of child abuse and domestic violence to ensure multidisciplinary collaboration and coordination and these should also be channeled to relevant stakeholders through their training and practices.

IMPLEMENTATION

A Fatality Review Panel with mandatory authority may help to ensure information swiftly provided and recommendations implementation monitored.
The piloted FRP has no mandatory power to require provision of relevant documents and information for review. Those organizations who had reservations in disclosing the details, the necessary documents and information had adversely affected the findings. Furthermore, the current Fatality Review Panel being ad hoc and advisory had no role to perform in the monitoring of the proper implementation of the list of recommendations.

A beyond documentary review should be considered to obtain better understanding of case sequence and details. The documentary review in nature affected the depth and the detail profiles obtained and such limitations must be addressed.

The role of the Family Council has a significant role to play ensuring proactive child safe and friendly policy and practices and on the monitoring of these recommendations.

A Child Commission is long over due and must be promptly appointed as children's advocate. In addition to the support of the Legislative Council on 14 May, 2007 urging for the set up of a Child Commission, there are more and more advocates calling for such a high power, independent platform for children and to ensure a strong child perspective in Hong Kong. A Child Commission, set up in Norway since 1981 and in almost thirty countries, could be the body to take up the monitoring role of overseeing the recommendations being enforced. There would be no duplication but unique roles shouldered to coordinate multidisciplinary collaboration. Furthermore, Child Impact Assessments for policy, legislation, education and services would thus be obtained and analyzed.

CONCLUSION

It is only when these proactive recommendations are put into practice can Hong Kong claim to have tried her best to put children out of harm's way.

Priscilla Lui,

Director
Against Child Abuse
9 February, 2011