INFORMATION NOTE

Children's unnatural death cases

1. Background

1.1 At its meeting held on 12 July 2010, the Panel on Welfare Services was briefed on the findings of the First Report of the Pilot Project on Child Fatality Review. During the meeting, some members of the Panel were of the view that additional information was needed in order to capture the full picture of the issue. In this connection, the Research Division was requested to provide information on major causes of death cases involving children died of non-natural causes and their family background in other places.

1.2 In order to facilitate further discussion on the issue, this information note provides information on unnatural death of children in selected places, particularly on two aspects:

(a) child death review mechanisms; and

(b) statistics on unnatural death of children.

1.3 The preliminary research has revealed the non-existence of a child death review mechanism in most of the Asian places comparable to Hong Kong. As such, the child death review mechanisms in Australia, Canada, England of the United Kingdom (UK) and the United States (US) are examined in this information note.

1.4 As to statistics on unnatural death of children, this information note studies Japan, Taiwan, England and Wales of the UK, as well as cases reported to the Coroner's Court in Hong Kong. Information on major causes of death is extracted from the vital statistics released by the respective statistics department. However, it is noted that the non-natural causes of child death are not commonly specified in the statistics. Meanwhile, information on family background of the deceased children is not available in all the selected places studied.

2. Child death review mechanisms

2.1 In general, child death reviews focus on "unexpected, suspicious and accidental" deaths of children (and sometimes covering youth as well). Nevertheless, reviews in some jurisdictions include all child deaths.[1] The major purpose of child death reviews is to prevent future deaths and improve systems providing services to children.[2]

2.2 Child death reviews often involve experts from various fields. The first multi-disciplinary and multi-agency child death review team was established in Los Angeles of the US in 1978. Multi-agency and multi-disciplinary reviews aim to reduce misclassification of deaths, identify specific interventions for surviving family members, develop public policies to address the prevention of child deaths from abuse, and prevent future deaths.[3]

2.3 During child death reviews, both individual and aggregated cases are assessed. In particular, a study of aggregated cases enables the review team to identify trends and causes of death as well as to develop recommendations to prevent similar deaths from occurring in the future. Increasingly, child death reviews focus on preventing child deaths at an aggregate level as opposed to individual investigations.[4]

Australia

Purpose of review

2.4 In Australia, the primary aim of child death reviews is to identify whether the child protection system has any failings which in some way contribute to a child's death. Based on the lessons learned from individual deaths, the child death review body is able to make recommendations to improve departmental practice, policies and legislation so as to reduce the likelihood of deaths occurring in similar circumstances and to provide better protection for children.[5]

1 Taylor (2006) p.2.
2 Frederick (2007) p.2.
3 Webster et al. (2003) p.59; and Frederick (2007) p.2.
4 Taylor (2006) p.3.
5 Tasmania Department of Health and Human Services (2010).

Review mechanism

2.5 Most states and territories in Australia have child death review processes. Although these processes vary considerably, they generally involve experts from various fields and focus on two aspects:[6]

(a) conducting reviews into the circumstances of individual child deaths, with the aim of identifying shortcomings of the child protection system and making relevant recommendations to reduce the risks of future child deaths; and

(b) analysing child deaths from different causes and conducting further research into child mortality and morbidity, in order to better understand the causes of child deaths and to prevent or reduce child deaths.

Scope of review

2.6 The scope of review varies among the states and territories. For instance, New South Wales (NSW) has a broad scope of reviewable cases, which covers deaths of all children who were usually residents in NSW. In contrast, Queensland only conducts review on a child who was known to the child safety service system (i.e. under service or had received service) in the three years prior to death.[7] Meanwhile, work of the Child Death and Serious Injury Review Committee of South Australia is unique in Australia in that in addition to review of death cases, it also conducts in-depth review of cases where a child has been seriously injured and survived.[8]

6 Frederick (2007) p.2; New South Wales Commission for Children and Young People (2010); and Queensland Child Death Case Review Committee (2010).

7 New South Wales Commission for Children and Young People (2010); and Queensland Child Death Case Review Committee (2010).

8 Child Death & Serious Injury Review Committee (2009) pp.20-21.

Canada

Purpose of review

2.7 In Canada, the first multi-disciplinary child death review team was created in 1992 in Manitoba. The original focus of the Manitoba team was to advise the Chief Medical Examiner whether an inquest was necessary, but it has later moved beyond this role to review all aspects of children's deaths and conduct individual studies on specific cases.[9] The purpose is to identify ways in which the programmes and services may be improved to enhance the safety and well-being of children and reduce the likelihood of children's deaths in similar circumstances.[10]

Review mechanism

2.8 Within each province and territory, a mechanism is in place to review deaths of children receiving services from the child serving agency or in care.[11] In addition to reviewing the manner and cause of death, the review committee set up under the mechanism will evaluate relevant protocols, policies and procedures, standards and legislation as to whether they are followed and as to their adequacy. The committee will also comment on the efficiency and effectiveness of linkages and coordination of services with relevant parties such as social workers and child serving agencies, and make recommendations aiming at preventing future deaths or improving services to children.[12]

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9 Taylor (2006) p.6.
10 Office of the Children's Advocate (2010).
11 Taylor (2006) p.8.
12 Child Death Review Committee (1997).

Scope of review

2.9 There is no consistent way of collecting information on child deaths across the country, nor are the results of child death reviews posted or shared amongst the Directors of Child Welfare in the provinces and territories.[13] In some provinces like Ontario and Alberta, a review is conducted when a child dies unexpectedly in suspicious or unusual circumstances; while in some provinces such as British Columbia and New Brunswick, deaths of all children who have been known to the child protection system are examined.

England

Purpose of review

2.10 In England, Local Safeguarding Children Boards (LSCBs) are responsible for developing policies and procedures for safeguarding and promoting the welfare of children in their Local Authority area. From 1 April 2008, all LSCBs have taken up a statutory responsibility to review the deaths of all children up to 18 years old, who are normally resident within their area. Child Death Overview Panels (CDOPs) have been set up to review child deaths on behalf of one or several LSCBs. The main purpose of the child death review process is to learn how to prevent future deaths.

[13] Taylor (2006) p.8.

Review mechanism

2.11 The duties of LSCBs regarding the child death review process are set out in Chapter 7 of the government's framework document, *Working Together to Safeguard Children*.[14] A CDOP meets several times a year to review child deaths in a particular Local Authority area. It comprises of representatives from public health, local child health and social care services, as well as the police. The steps involved in reviewing child deaths includes collecting information about the circumstances of the fatality, assessing if the death was preventable and determining lessons learned to reduce future child deaths. The CDOP makes recommendations and reports to the corresponding LSCB, which will make sure that such recommendations are sent to those with responsibility for taking them forward.[15]

Scope of review

2.12 It is statutorily required that deaths of all children under the age of 18 must be reviewed by a CDOP on behalf of a LSCB. The review mainly assesses if the death was preventable and determines the lessons learned, but is not an investigation into why a child has died. Nevertheless, in a small number of child deaths, LSCB may conclude that it is necessary to conduct a more detailed investigation. A "Serious Case Review", as it is known, is a detailed review of a child who died where there are serious concerns about the cause of death.[16]

[14] *Working Together to Safeguard Children (2010)* provides a national framework under which agencies and professionals at the local level, individually and jointly, draw up and agree on their own ways of working together to safeguard and promote the welfare of children.

[15] *The child death review: A guide for parents and carers*, p.12.

[16] Department for Education (2010); *The child death review: A guide for parents and carers*, pp.13-15.

United States

Purpose of review

2.13 In the US, child death reviews focused initially on cases with suspicious or unknown causes of death. The intent of the investigation was to determine if child abuse or neglect had been committed. Increasingly, child death reviews have put more emphasis on preventing child and youth deaths at the aggregate level[17] so as to improve the health and safety of children and to prevent other children from dying.[18]

Review mechanism

2.14 A child death review team normally consists of representatives from law enforcement, child protective services, prosecutor/district attorney, medical examiner/coroner, public health, paediatrician or other family health provider, and emergency medical services. The implementation of child death review programmes typically follows one of four different models:[19]

(a) local reviews of individual cases, state reviews of local findings, and state and local responses to findings;

(b) state and local reviews of individual cases, and state and local responses to findings;

(c) state reviews of individual cases, and state responses to findings; and

(d) local reviews of individual cases, and local responses to findings.

17 Taylor (2006) p.3.
18 National Center for Child Death Review (2005).
19 Ibid.

Scope of review

2.15 The criteria for review are set at the state or local level. Child death review teams review either all deaths or deaths due to certain causes. While many professional organizations have endorsed child death reviews, including the American Academy of Pediatrics and the American Bar Association, there are no standardized criteria for child death review and no national guidelines for child death programmes.[20] Instead, the National Center on Child Fatality Review (NCFR)[21] serves as a national resource provider for anyone involved in child death reviews. It provides training and technical assistance to child death review teams throughout the US and other parts of the world as well.[22] The NCFR website[23] provides a clearinghouse for the collection and dissemination of information and resources related to child deaths.

3. Statistics on unnatural death of children

3.1 Despite the fact that statistics on the leading causes of deaths in the selected places and Hong Kong are expressed in different terms, in general, deaths caused by illnesses such as cancer and heart attacks are regarded as natural; while deaths resulted from external causes like injury or poisoning are unnatural. Unnatural deaths therefore include deaths due to intentional injury such as homicide or suicide, and deaths caused by unintentional injury in accidents. In Japan, Taiwan, England and Wales as well as Hong Kong, the leading causes of deaths which can be classified as unnatural mainly comprise "suicide" and "accidents" (though expressed in slightly different terms), with other causes being also included in England and Wales and Hong Kong. Only deaths due to suicide and accidents are covered in the following presentation.

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20 Webster et al. (2003) p.59.

21 In 1978, the Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN) formed the first Child Death Review Team. In 1996, ICAN received a grant from the US Department of Justice to establish the ICAN National Center on Child Fatality Review (NCFR). The mission of NCFR is to develop and promote a nationwide system of Child Fatality Review Teams to improve the health, safety and well being of children and reduce preventable child fatalities and severe injuries. As a centralized agency, NCFR enables local, state, regional, and national entities to communicate and learn from one another about programmes and activities aimed at decreasing preventable child injuries and fatalities.

22 Taylor (2006) p.3.

23 http://ican-ncfr.org

3.2 The grouping of age groups in presenting the vital statistics is also different among the selected places and Hong Kong. In most of them, data is grouped in age groups with an interval of five years (i.e. 0-4, 5-9, 10-14, and 15-19). The exceptions are Japan and Hong Kong in that the age groups are with an interval of 10 years. As such, the grouping of age groups cannot be fitted perfectly with the definition of "children", i.e. under the age of 18.

Japan

3.3 The leading causes of death listed on the *Japan Statistical Yearbook* include various kinds of diseases, accidents and suicide. **Tables 1** and **2** show the number of death cases and death rate per 100 000 population in the specified age group caused by accidents and suicide respectively.

Table 1 – Children's deaths caused by accidents in Japan

Year	0-4 years old		5-14 years old	
	Number	Rate per 100 000	Number	Rate per 100 000
2001	543	9.20	391	3.16
2002	460	7.83	451	3.69
2003	382	6.59	369	3.05
2004	427	7.44	356	2.97
2005	410	7.35	380	3.18
2006	356	6.47	275	2.31
2007	304	5.59	274	2.31

Table 2 – Children's deaths caused by suicide in Japan

Year	0-4 years old		5-14 years old	
	Number	Rate per 100 000	Number	Rate per 100 000
2001	0	0.00	61	0.49
2002	0	0.00	37	0.30
2003	0	0.00	65	0.54
2004	0	0.00	49	0.41
2005	0	0.00	45	0.38
2006	0	0.00	77	0.65
2007	0	0.00	47	0.40

Taiwan

3.4 Similarly, the leading causes of death listed on the *Statistical Yearbook of the Republic of China* include various kinds of diseases, accidents and adverse effects, as well as suicide and self-inflicted injury. **Tables 3** and **4** present the number of death cases and death rate per 100 000 population in the specified age group caused by accidents and adverse effects and suicide and self-inflicted injury respectively.

Table 3 – Children's deaths caused by accidents and adverse effects in Taiwan

Year	0-4 years old		5-9 years old		10-14 years old		15-19 years old	
	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000
2001	288	20.19	131	8.09	128	7.92	668	37.78
2002	256	18.95	83	5.13	100	6.15	522	31.05
2003	236	18.02	115	7.37	100	6.21	482	29.28
2004	194	15.60	86	5.65	92	5.67	512	32.15
2005	161	14.07	76	5.06	100	6.20	519	32.64
2006	150	13.72	72	5.01	89	5.51	450	27.97
2007	123	11.69	62	4.56	65	4.02	361	22.28
2008	124	12.08	50	3.79	59	3.78	339	21.11

Table 4 – Children's deaths caused by suicide and self-inflicted injury in Taiwan

Year	0-4 years old		5-9 years old		10-14 years old		15-19 years old	
	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000
2001	0	0.00	0	0.00	8	0.50	52	2.94
2002	0	0.00	0	0.00	4	0.25	55	3.27
2003	0	0.00	1	0.06	6	0.37	54	3.28
2004	0	0.00	0	0.00	4	0.25	57	3.58
2005	0	0.00	0	0.00	8	0.50	60	3.77
2006	0	0.00	1	0.07	8	0.50	46	2.86
2007	0	0.00	0	0.00	5	0.31	53	3.27
2008	0	0.00	1	0.08	8	0.51	45	2.80

England and Wales

3.5 In the *Mortality Statistics* published by the Office for National Statistics, the classification of underlying causes of deaths is based on the International Statistical Classification of Diseases and Related Heath Problems. The category "external causes of morbidity and mortality" depicts unnatural causes of deaths. There are various sub-divisions under this category. **Tables 5** and **6** show the number of death cases and death rate per 100 000 population in the specified age group caused by accidents and intentional self-harm in England and Wales respectively.

Table 5 – Children's deaths caused by accidents in England and Wales

Year	0-4 years old		5-9 years old		10-14 years old		15-19 years old	
	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000
2001	115	3.72	62	1.88	110	3.20	457	14.15
2002	102	3.36	57	1.75	102	2.95	416	12.58
2003	113	3.76	47	1.45	88	2.55	428	12.58
2004	95	3.15	32	1.00	103	3.01	434	12.54
2005	84	2.75	38	1.21	91	2.70	443	12.66
2006	105	3.37	49	1.59	92	2.77	493	13.94
2007	88	2.75	44	1.45	91	2.78	455	12.79
2008	91	2.76	36	1.20	81	2.50	445	12.60

Table 6 – Children's deaths caused by intentional self-harm in England and Wales

Year	0-4 years old		5-9 years old		10-14 years old		15-19 years old	
	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000	Number	Rate per 100 000
2001	0	0.00	0	0.00	5	0.15	77	2.38
2002	0	0.00	0	0.00	5	0.14	87	2.63
2003	0	0.00	0	0.00	3	0.09	66	1.94
2004	0	0.00	0	0.00	5	0.15	64	1.85
2005	0	0.00	0	0.00	1	0.03	66	1.89
2006	0	0.00	0	0.00	3	0.09	80	2.26
2007	0	0.00	0	0.00	7	0.21	77	2.16
2008	0	0.00	0	0.00	8	0.25	80	2.26

3.6 Meanwhile, the Child Death Review Process has been in place in England since April 2008. Data on child deaths has been accumulated for two years. However, because of implementation issues encountered by CDOPs like delay of some reviews due to criminal proceedings and different definitions of "preventability" adopted by various CDOPs, there may be inconsistency of the data presented in those two years.[24]

3.7 According to the *Preventable Child Deaths in England: Year Ending 31 March 2010*, in England, 150 (4% of the total) child death cases were assessed as preventable.[25] The majority of such preventable deaths in 2009-2010 were due to trauma and other external factors (54%), which included drowning, road traffic accidents and deaths due to fires. A further 15% were due to deliberately inflicted injury, abuse or neglect.[26]

Hong Kong

3.8 In Hong Kong, the statistics released by the Census and Statistics Department do not provide details of the causes of deaths. Hence, data published by the Coroner's Court is used instead. However, it should be noted that not all deaths occurred in Hong Kong are reported to the Coroner's Court.

3.9 In the *Coroner's Report*, deaths are classified by causes of death. **Tables 7** and **8** are the number of death cases and death rate per 100 000 population in the specified age group caused by accidents (including both accidental deaths and vehicular accidents) and suicide respectively.

[24] Department for Education (2010) p.4.

[25] A preventable child death is defined as "events, actions or omissions contributing to the death of a child or to substandard care of a child who died, and which, by means of national or locally achievable interventions, can be modified".

[26] Department for Education (2010) p.6.

Table 7 – Children's deaths caused by accidents in Hong Kong (Coroner's Court)

Year	0-9 years old		10-19 years old	
	Number	Rate per 100 000	Number	Rate per 100 000
2003	15	2.50	16	1.87
2004	7	1.24	12	1.41
2005	8	1.49	17	2.00
2006	10	1.91	18	2.11
2007	5	0.99	15	1.76
2008	7	1.41	12	1.45
2009	5	1.02	10	1.25

Table 8 – Children's deaths caused by suicide in Hong Kong (Coroner's Court)

Year	0-9 years old		10-19 years old	
	Number	Rate per 100 000	Number	Rate per 100 000
2003	0	0.00	30	3.50
2004	1	0.18	40	4.69
2005	3	0.56	19	2.24
2006	1	0.19	32	3.74
2007	0	0.00	22	2.58
2008	1	0.20	24	2.90
2009	1	0.20	28	3.49

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