For discussion on
20 February 2014

Paper FC 4/2014

Family Council

First Report of the Child Fatality Review Panel

Purpose

This paper introduces the First Report of the standing Child Fatality Review Panel.

Background

2. To enhance multi-disciplinary and cross-sectoral collaboration in preventing avoidable child deaths, the Social Welfare Department (SWD) has implemented the Pilot Project on Child Fatality Review (the Pilot Project) since February 2008. With its members appointed by the Director of Social Welfare, the Review Panel of the Pilot Project has reviewed the child death cases with natural and non-natural causes occurred in 2006 and 2007, with a view to identifying good practice and lessons learnt for service improvement as well as making recommendations.

3. The successful experience of the Pilot Project and the positive feedback received by it confirmed the value of child fatality review. The Review Panel of the Pilot Project thus recommended and the Administration accepted to set up a standing child fatality review mechanism. In May 2011, the Director of Social Welfare has appointed 20 members including professionals from different disciplines and a parent representative to form the Child Fatality Review Panel (CFRP).

Completion of the Review of Child Death Cases Occurred in 2008 and 2009 and Release of the First Report

4. Since the commencement of its work in June 2011, the standing CFRP has completed reviewing 238 child death cases occurred in 2008 and 2009. The CFRP has put forth 21 recommendations which were sent to the concerned organisations / government departments for consideration, follow-up and responses, for enhancing multi-disciplinary and cross-sectoral sharing.

5. The CFRP held a press briefing on 28 May 2013 to release the First Report. The Report has been published and uploaded onto the SWD Homepage:

English version:

http://www.swd.gov.hk/doc/whatsnew/201312/CFRP First Report-201312E.pdf

Chinese version:

http://www.swd.gov.hk/doc/whatsnew/201312/CFRP First Report-201312C.pdf

Highlights of the First Report and Overview of Child Death Cases Reviewed

6. Compared with other countries, the age-specific death rate of Hong Kong remained to be low. The present review covered the deaths of 238 children, aged below 18, who died in 2008 and 2009 of both natural (156 cases) and non-natural (82 cases) causes. They were all reported to the Coroner's Court. Major demographics of the 238 cases reviewed are as follows:

(i) 156 cases (65.5%) died of natural causes, 26 (10.9%) died of suicide, 23 (9.7%) died of accidents, 18 (7.6%) died of assault and 15 (6.3%) died of miscellaneous causes;

(ii) The highest number of child deaths occurred for children aged below 1 died of natural causes (80 cases, 33.6%). The second highest number of child deaths occurred for children aged 1 – 2 died of natural causes and also for children aged 15 – 17 died of suicide (both 18 cases, 7.6%);

(iii) The majority of the deceased children were Chinese (218 cases, 91.6%), and the remaining 20 (8.4%) were non-Chinese;

(iv) There were more male (128 cases, 53.8%) than female (110 cases, 46.2%);

(v) Occupation was not applicable to 134 (56.3%) children who were too young or because their health problems prevented them from attending school or work. 90 (37.8%) children were full-time students while 5 (2.1%) were neither studying nor working;

(vi) Kwai Tsing District and Tuen Mun District had the highest rate of child death per 1 000 child population in 2008 and 2009 respectively (0.175 for Kwai Tsing District in 2008 and 0.162 for Tuen Mun District in 2009); and

(vii) The most common place for fatal incidents occurred is the homes of the deceased children (99 cases, 41.6%), with hospital (84 cases,

35.3%) as the second most common place. 13 fatal incidents occurred on road or streets and these were mainly traffic accidents.

7. Among the 26 child/youth suicide cases, 19 jumped from height to their death. The youngest child who committed suicide was aged 9. Seven recommendations were made by the CFRP for the prevention of child/youth suicide, including public education for children to encourage them to seek help when their peers expressed suicidal thoughts; public education for parents to nurture their children according to their capabilities and help their children build up resilience in the face of failure, as well as enhancement of school curriculum in life education and life skills training to strengthen students' coping ability and resilience.

8. Of the 23 fatal child accident cases, 12 children died in traffic incidents. The CFRP has made three recommendations on the prevention of fatal traffic accidents, including campaigns to strengthen road safety awareness of pedestrians, particularly pre-school children, cross-boundary students and those who have newly arrived from the Mainland. Regarding other fatal accident cases, the CFRP has recommended the use of public education to raise parents' awareness of keeping poisonous substances away from children as well as their alertness of symptoms caused by serious head injury sustained by children and immediate intervention required.

9. On the other hand, 18 children lost their lives as a result of assault, in which 13 perpetrators were their parents. Five recommendations were made to prevent such tragedies, including public education to remind parents that they have the responsibility to take good care of their children and no right to take away their lives under any circumstances as well as to raise

public awareness of paying serious attention to suicidal and homicidal signs and verbal threats of parents.

Conclusion

10. Members are invited to note the content of the paper.

Secretariat of the Child Fatality Review Panel
February 2014