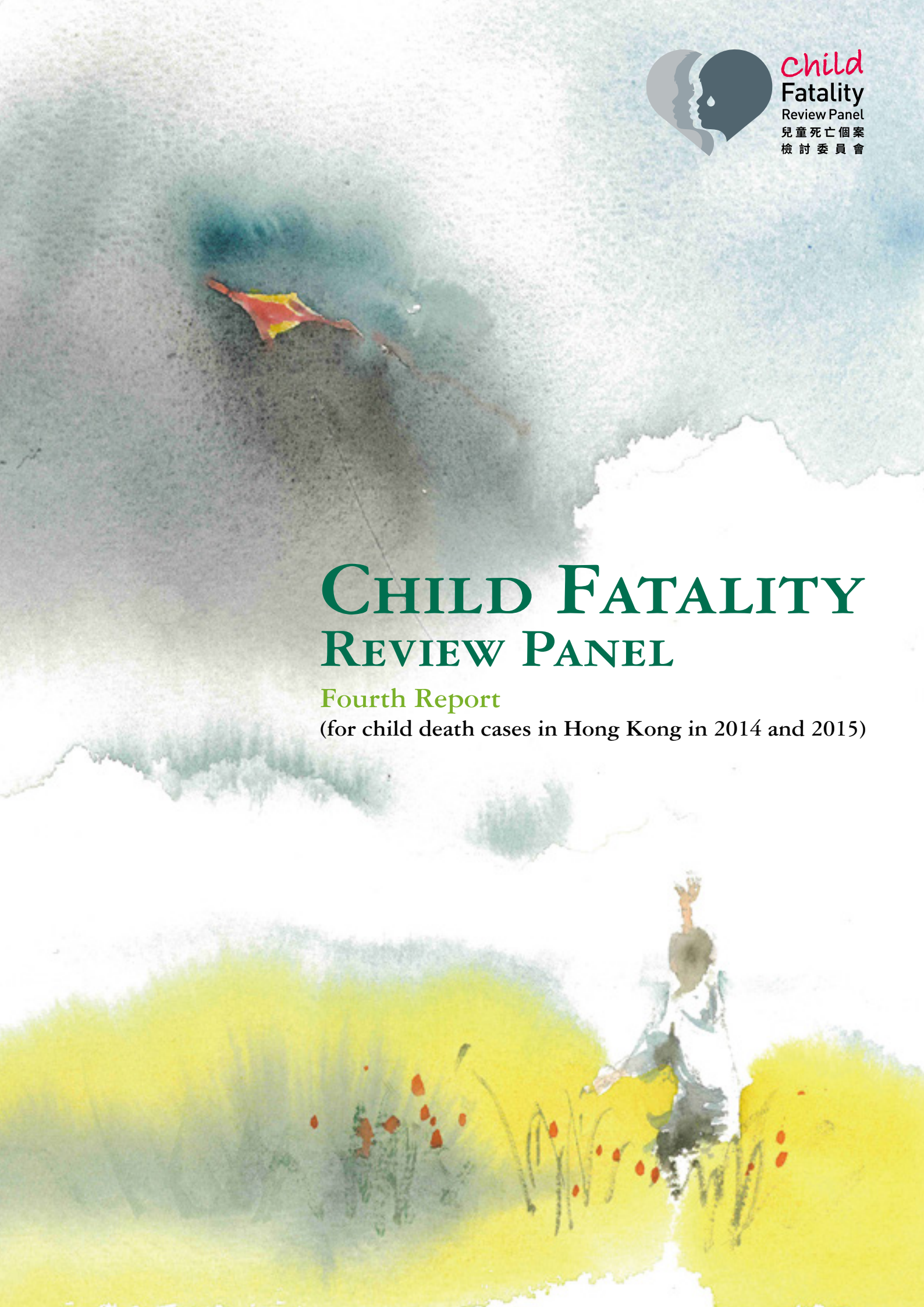
Child Fatality Review Panel
兒童死亡個案檢討委員會



Child Fatality Review Panel

Fourth Report

(for child death cases in Hong Kong in 2014 and 2015)

Table of Contents

List of Tables and Charts

01 Foreword

Children are our future and they should be protected and kept healthy and safe. Every child's death is a tragic loss for the family, as well as the society. It is particularly indignant that child death could have been avoided. It is important that having regard to the circumstances of these fatality cases, measures are being taken to enhance the protection of children in future and the prevention of child death. On behalf of the Child Fatality Review Panel (Review Panel), I extend my deepest condolences to the families that have suffered the loss of their children.

By systematically and thoroughly reviewing the death of children, the Review Panel aims to get a better understanding of what leads to child death and what can be done to prevent the tragedies. The circumstances involved in most of the child death cases are complex and multi-dimensional, making it unfair to rest the responsibility on any individual or agency. The Review Panel hopes, by sharing our observations and recommendations, to enhance the awareness of the public, professionals and agencies on the circumstances leading to and causing these fatal deaths and on the risk factors that could be eliminated to prevent avoidable child death in future.

This is the fourth report of the Review Panel, covering a review of child death cases which occurred in 2014 and 2015. A total of 53 recommendations on preventive strategies and system improvement for child death cases have come up and have been passed to the relevant government bureaux/departments and organisations concerned for comments and responses. With repeated child death identified in relation to co-sleeping with adults or other sleeping safety, concealment of pregnancy and accidental falls, continued thematic review has been conducted on these topics. Though the Review Panel still encounters limitations such as the lapse of time in the review and the recommendations made were subjected to the information collected from the Coroner's Court, we hope our findings and recommendations can still raise the public awareness and call for collaborations from different parties in protecting the health and lives of our children.

Hui Chung-shing, Herman, S.B.S., M.H., J.P.
Chairman
Child Fatality Review Panel
May 2019

02 Executive Summary

2.1 Review of Child Death Cases in 2014 and 2015

In this report, 166* child death cases that occurred in 2014 and 2015 and reported to the Coroner's Court were reviewed. The following table shows the case distribution by year and by death cause.

Cause of Death	Year in which the case occurred		Total
	2014	2015	
Natural Causes	50	57	107
Non-natural Causes	33	26	59
Suicide	*9*	*9*	*18*
Accident	*6*	*6*	*12*
Assault	*3*	*6*	*9*
Unascertained #	*15*	*5*	*20*
Total	**83**	**83**	**166**

* *4 natural-cause cases and 2 assault/unascertained cases in 2015 are not covered in this report because legal proceedings were still underway when the review was done. Review findings for these cases, if any, will be included in the next report.*

\# *Cases with non-natural unascertained causes of death.*

Major demographics of the 166 cases reviewed are as follows:

- A total of 107 cases (64.5%) died of natural causes, 18 cases (10.8%) died of suicides, 12 cases (7.2%) died of accidents, 9 cases (5.4%) died of assaults and 20 cases (12.0%) died of non-natural unascertained causes. *(Charts 5.2.1 and 5.2.6)*

- There were more male (N=90, 54.1%) than female (N=76, 45.8%). *(Table 5.2.2)*

- The highest number of child deaths occurred for children aged below 1 (N=72, 43.4%), followed by the age groups of 15 – 17 (N=28, 16.9%) and 1 – 2 (N=24, 14.4%). *(Table 5.2.2 and Chart 5.2.3)*

- The majority of the deceased children were Chinese (N=144, 86.7%), and 20 (12.0%) were non-Chinese while the remaining 2 (1.2%) were of unknown ethnicity. *(Chart 5.2.4)*

- Occupation was not applicable to 103 children (62.0%) who were too young or whose health problems had prevented them from attending school or work. 59 children (35.5%) were full-time students, 2 (1.2%) were unknown while 1 (0.6%) was having part-time work and 1 (0.6%) was neither studying nor working. *(Chart 5.2.5)*

- There were more male than female in the death cause groups of natural causes and assault but the other way round for accident. Male and female were equal for the death cause groups of suicides and non-natural unascertained causes. *(Chart 5.2.7)*

- The highest number of child deaths occurred for children aged below 1 who died of natural causes (N=49, 29.5%). The second and third highest numbers of child deaths occurred for children aged 1-2 who died of natural causes (N=17, 10.2%) and those aged below 1 who died of unascertained causes (N=16, 9.6%). *(Chart 5.2.8)*

- Most fatal incidents occurred at home (N=84, 50.6%) while hospital is the second most common place where 60 (36.1%) fatal incidents occurred. *(Chart 5.2.10)*

For more details of the case profile by death cause, please refer to **Chapter 5**.

2.2 Observations by the Nature of Death in 2014 and 2015

Based on the review of child death cases which occurred in 2014 and 2015, the Review Panel has a number of observations per death nature. Please see **Chapter 6** for more details.

2.3 Recommendations Arising from Review of Child Death Cases in 2014 and 2015

After reviewing the child death cases which occurred in 2014 and 2015, the Review Panel has come up with 53 recommendations on preventive strategies and system improvement for child fatal cases. In summary, the numbers of recommendations by death cause are listed below:

Cause of Death	Reference Number	Number of Recommendations
Natural Causes	N1-N3	3
Suicide	S1 – S18	18
Accident	A1-A12	12
Assault and Non-natural Unascertained Causes	AS1-AS20	20
Total	**-**	**53**

These recommendations have been passed to the relevant government bureaux/departments and organisations (B/D/Os) concerned for comments and responses. **Chapter 7** tabulates these recommendations together with the comments/responses by the B/D/Os by category of causes. A summary of the recommendations is also given in **Appendix 9.5**.

2.4 Profile of Child Death Cases Reviewed from 2006 to 2015

Taking account of the child death cases which occurred from 2006 to 2015, thematic review on co-sleeping, other sleeping safety, concealment of pregnancy and accidental falls has been completed. Besides, tables and charts are prepared to show the changes over time by case nature.

Please refer to **Chapter 8** for more details.

03 Acknowledgement

The Child Fatality Review Panel extends its appreciation to the Coroners and staff members of the Coroner's Court who have been supportive of the work relating to the prevention of avoidable child death.

We also appreciate the contribution of information from all professionals of service organisations and units involved in the review process. We would also like to acknowledge government bureaux/departments, professional bodies and service organisations for their professional comments, responses, updates and feedback on the preliminary views of the Child Fatality Review Panel.

Our work would not have been possible without all parties' participation and contribution. We look forward to continuous cooperation with all the parties concerned in promoting child welfare and child protection.

04 About the Review

4.1 History

The three-year Pilot Project on Child Fatality Review (Pilot Project) commenced in February 2008 to review child death cases which involved children aged below 18 and were reported to the Coroners. The review covered child fatality cases of natural or non-natural causes. The evaluation of the Pilot Project in 2010 confirmed the value of the review. The Review Panel of the Pilot Project recommended and the Administration accepted to set up a standing child fatality review mechanism.

While Panel Members of the Pilot Project continued their contribution, a number of new experts and professionals joined the standing mechanism to contribute their invaluable experience. The standing Child Fatality Review Panel (Review Panel) began its services in June 2011. In May 2013, July 2015 and August 2017, the Review Panel published its First Report, Second Report and Third Report respectively, sharing the findings, observations and recommendations after reviewing the child death cases which occurred from 2008 to 2013.

4.2 Purpose

The review aims at facilitating the enhancement of social service systems pertaining to child welfare with focus on inter-sectoral collaboration and multi-disciplinary cooperation to prevent the occurrence of avoidable child death. It is not intended to ascertain death causes or attribute responsibility to any party.

4.3 The Review Panel

The Review Panel comprises 17 members including professionals from different disciplines and a parent representative. For efficient and effective review, members of the Review Panel formed 4 sub-groups to look into cases of different natures according to their expertise. A convener was selected for each sub-group to lead the discussion and to report the findings of the review at the quarterly panel meeting. From June 2017 to May 2019, the Review Panel held 19 meetings, including 8 panel meetings and 11 sub-group meetings.

The membership list and terms of reference of the Review Panel are at **Appendices 9.1** and **9.2** respectively.

4.4 Scope

The scope of review is confined to child death cases involving children aged below 18, including but not limited to cases reported to the Coroner's Court. Referrals from any other sources would be welcomed.

4.5 Timing

Since its formation in June 2011, the Review Panel has completed serveral rounds of review of child death cases from 2008 to 2013. The Review Panel published its First report in May 2013 with 21 recommendations, Second Report in July 2015 with 47 recommendations and Third Report in August 2017 with 45 recommendations. Over the subsequent two years, a review of child death cases that occurred in 2014 and 2015 has been completed. The time lag in the review often gives rise to the query of not conducting the review and coming up with recommendations in a timely manner. Yet, as almost all of the child fatality cases have to go through legal proceedings in the Coroner's Court and some may even involve criminal and civil legal actions, review of the cases can only be started after the completion of the proceedings in Court so as to avoid prejudicing the legal proceedings. Notwithstanding this, the Review Panel has been proactive in exchanging views and recommendations with stakeholders to put forth observations and concerns immediately after the review in a timely manner without waiting for the publication of biennial reports.

4.6 Means

The review methodology is by and large adopted from that used in the Pilot Project. In gist, the review is basically documentary by nature, and is conducted by accessing the papers and documents filed to the Coroner's Court, supplemented by the reports from service organisations or government departments having provided services for the children before their death.

For more details of the review methodology, please refer to the Final Report of the Pilot Project on Child Fatality Review at the following websites:

English Version:
http://www.swd.gov.hk/doc/fcw/PPCFRFR-Eng.pdf

Chinese Version:
http://www.swd.gov.hk/doc/fcw/PPCFRFR-Chi.pdf

The Child Fatality Review Panel has completed reviews of child death cases that occurred from 2008 to 2013, with its First Report, Second Report and Third Report published in May 2013, July 2015 and August 2017 respectively. The reports are available at the following websites:

First Report

English Version:
http://www.swd.gov.hk/doc/fcw/CFRP1R-Eng.pdf

Chinese Version:
http://www.swd.gov.hk/doc/fcw/CFRP1R-Chi.pdf

Second Report

English Version:
http://www.swd.gov.hk/doc/fcw/CFRP2R-Eng.pdf

Chinese Version:
http://www.swd.gov.hk/doc/fcw/CFRP2R-Chi.pdf

Third Report

English Version:
https://www.swd.gov.hk/storage/asset/section/2867/en/CFRP_Third_Report_Aug2017_Eng.pdf

Chinese Version:
https://www.swd.gov.hk/storage/asset/section/2867/tc/CFRP_Third_Report_Chinese.pdf

05 Overview of Child Death Cases Covered by this Report

5.1 Figures of Child Population and Child Death in Hong Kong in 2014 and 2015

Note on rounding of figures: Owing to rounding, percentage may not add up to 100 as shown in the following tables/charts.

Table 5.1.1: Facts and Figures of Child Death in Hong Kong (2014 and 2015)

Type of Figure	Year	
	2014	2015
Child Population*	1 014 800	1 020 000
No. of Child Deaths	216	171
Child Death Rate@	0.2	0.2
No. of Cases Reviewed	83	83

** Child population: refers to the mid-year population of children aged under 18.*
@ Child death rate: refers to the number of known child deaths per 1 000 child population.
(Source: Census and Statistics Department)

Table 5.1.2: Comparison of Age-specific Death Rates*

Age group		Age: 0		Age: 1-4		Age: 5-9		Age: 10-14		Age: 15-19	
Year		2014	2015	2014	2015	2014	2015	2014	2015	2014	2015
Country/ Place@	Hong Kong#	2.1	1.5	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.1
	Australia^	3.3	3.2	0.1	0.2	0.1	0.1	0.1	0.1	0.3	0.3
	Canada&	4.7	4.9	0.2	0.2	0.1	0.1	0.1	0.1	0.3	0.3
	Japan~	2.1	2.0	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2
	Singapore~	2.1	1.9	0.1	0.1	0.0	0.0	0.0	0.1	0.2	0.2
	United Kingdom~	3.9	3.9	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2

** Age-specific Death Rate: refers to the number of known deaths per 1 000 persons of the same age group, unless otherwise specified.*
@ Only information of the selected countries/places could be obtained from the relevant sources.
 # Source: Census and Statistics Department
^ Source: Australian Bureau of Statistics (http://stat.data.abs.gov.au/Index.aspx?Queryid=458)
& Source: Statistics Canada (Table 13-10-0710-01) (https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071001)
~ Source: World Health Organization (WHO) Mortality Database (http://www.who.int/healthinfo/mortality_data/en/)

5.2 Statistics of Child Death Cases Reviewed in 2014 and 2015

Chart 5.2.1: No. of Cases by Case Nature

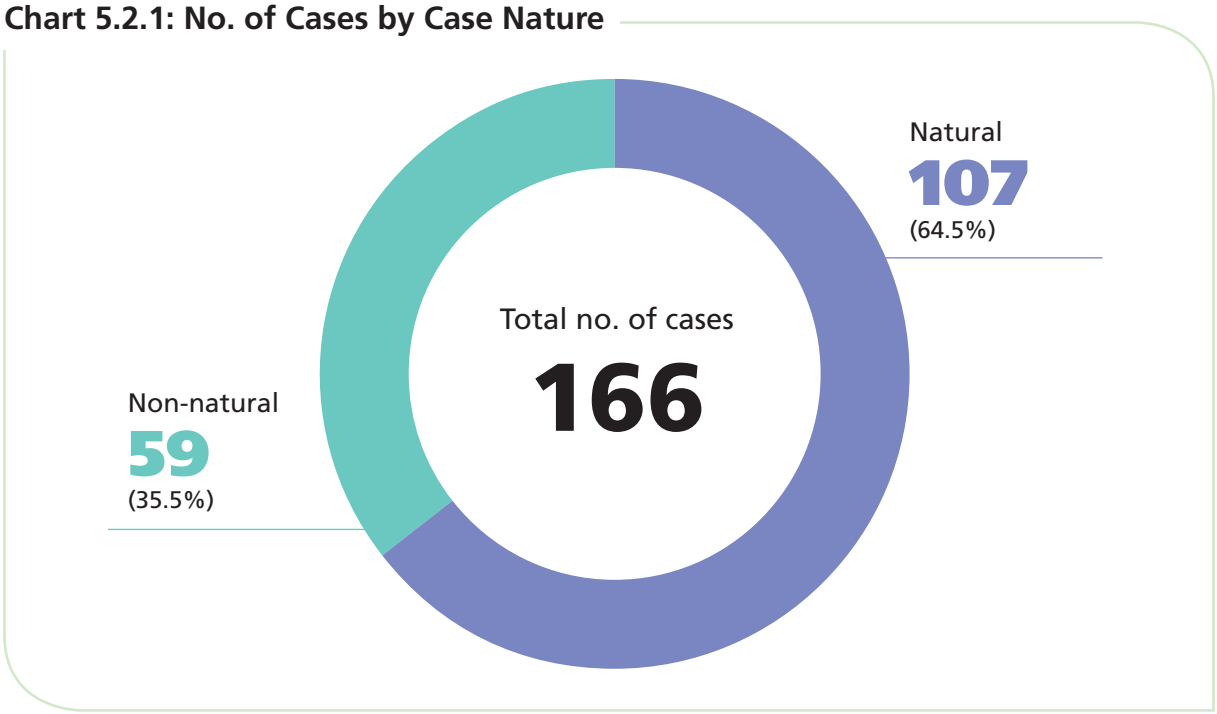


Table 5.2.2: No. of Cases by Age Group and Sex

Age Group	Sex		No. of Cases (%)
	Female (%)	Male (%)	
< 1	36 (21.7%)	36 (21.7%)	72 (43.4%)
1-2	12 (7.2%)	12 (7.2%)	24 (14.4%)
3-5	5 (3.0%)	8 (4.8%)	13 (7.8%)
6-8	2 (1.2%)	4 (2.4%)	6 (3.6%)
9-11	0 (0%)	5 (3.0%)	5 (3.0%)
12-14	8 (4.8%)	10 (6.0%)	18 (10.8%)
15-17	13 (7.8%)	15 (9.0%)	28 (16.9%)
Total	**76 (45.8%)**	**90 (54.1%)**	**166 (100.0%)**

The highest case numbers among different age groups are highlighted.

Chart 5.2.3: No. of Cases by Age Group and Sex

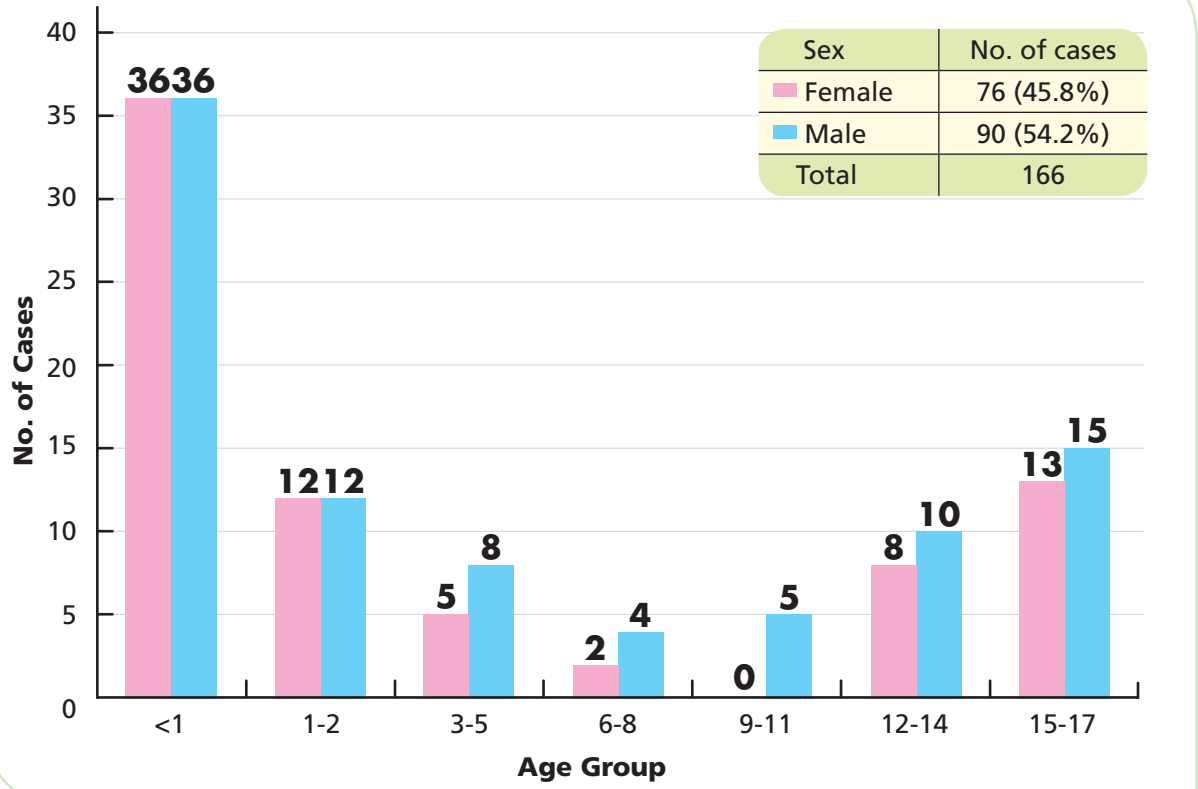


Chart 5.2.4: No. of Cases by Ethnicity

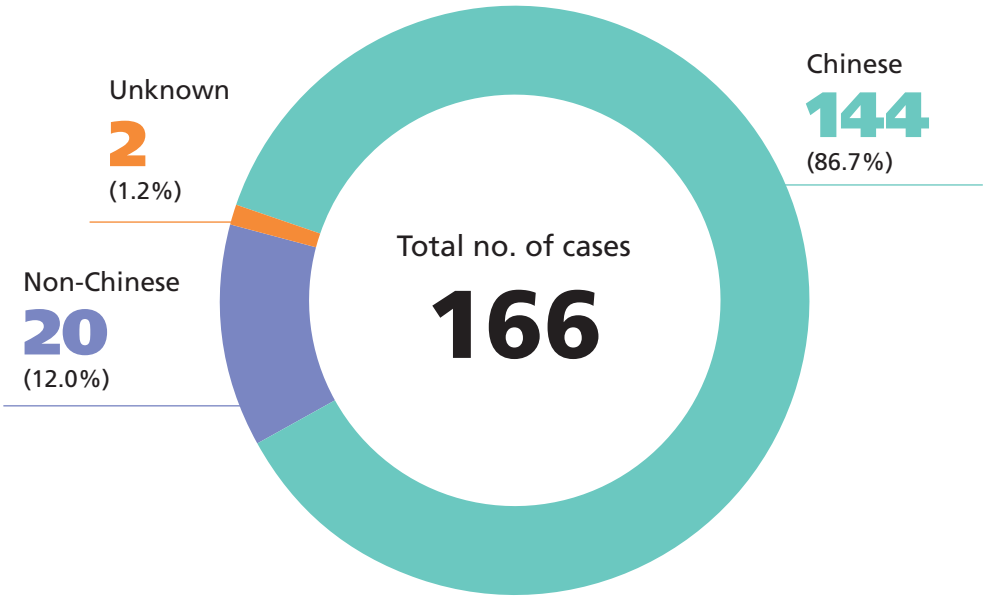
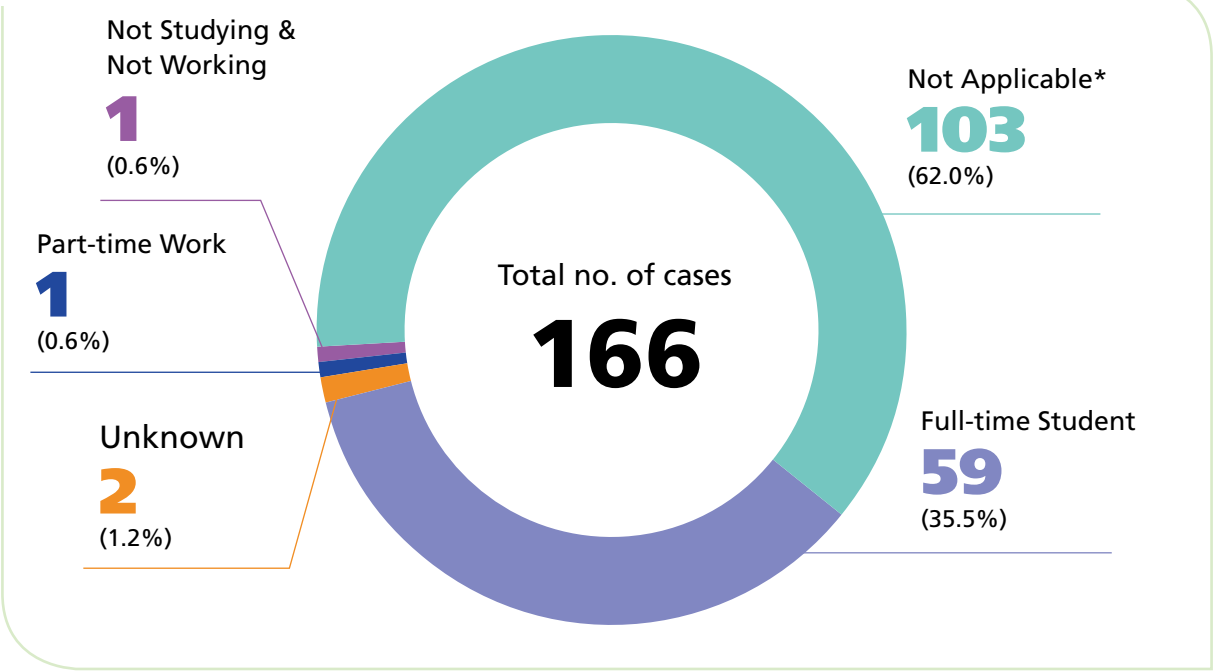


Chart 5.2.5: No. of Cases by Occupation



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

Chart 5.2.6: No. of Cases by Cause of Death

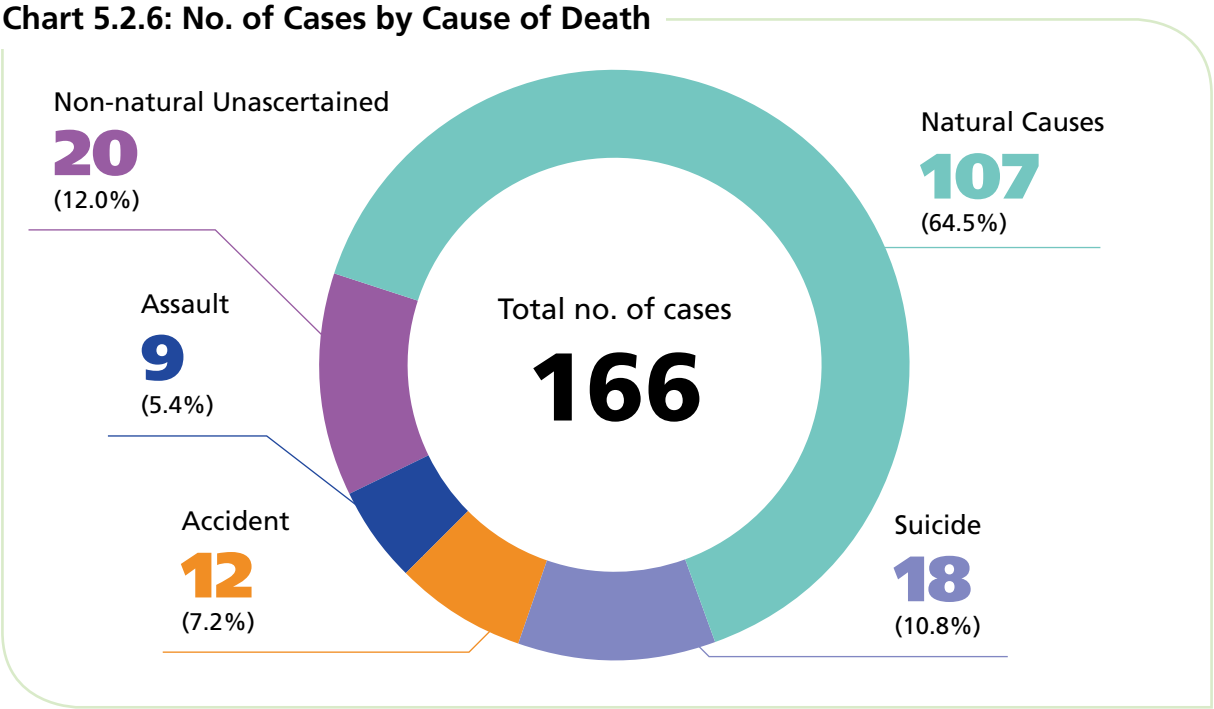


Chart 5.2.7: No. of Cases by Cause of Death and Sex

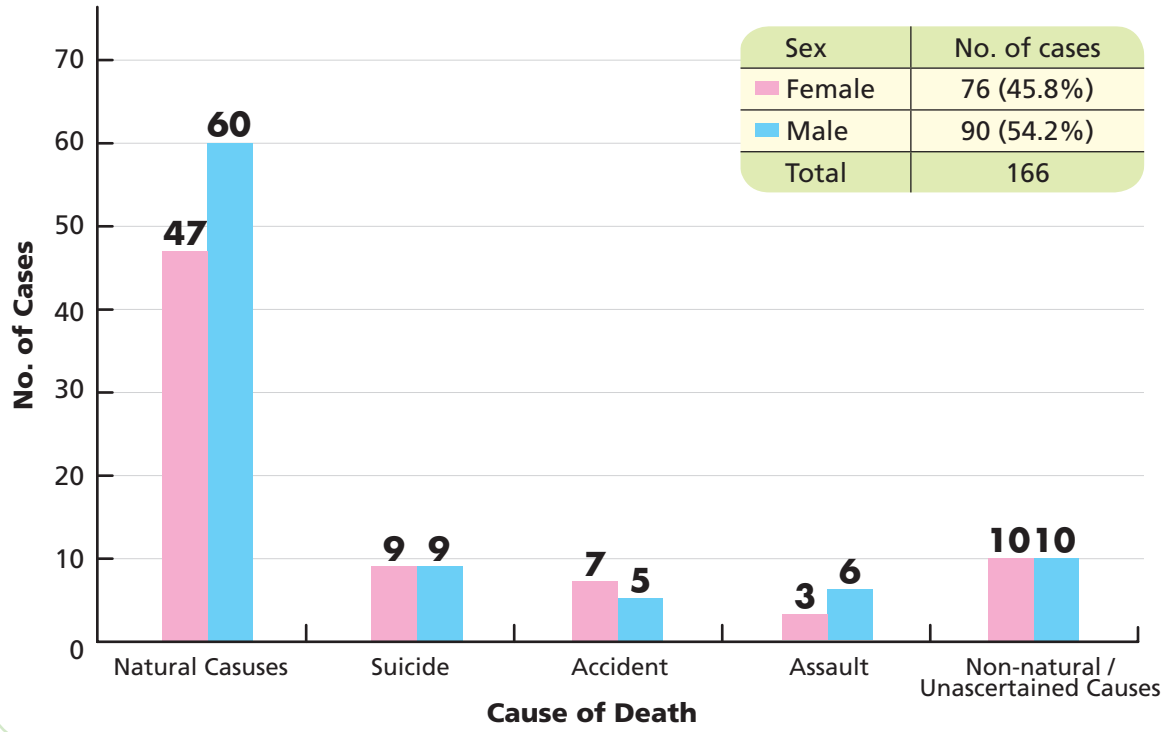


Chart 5.2.8: No. of Cases by Age Group and Cause of Death

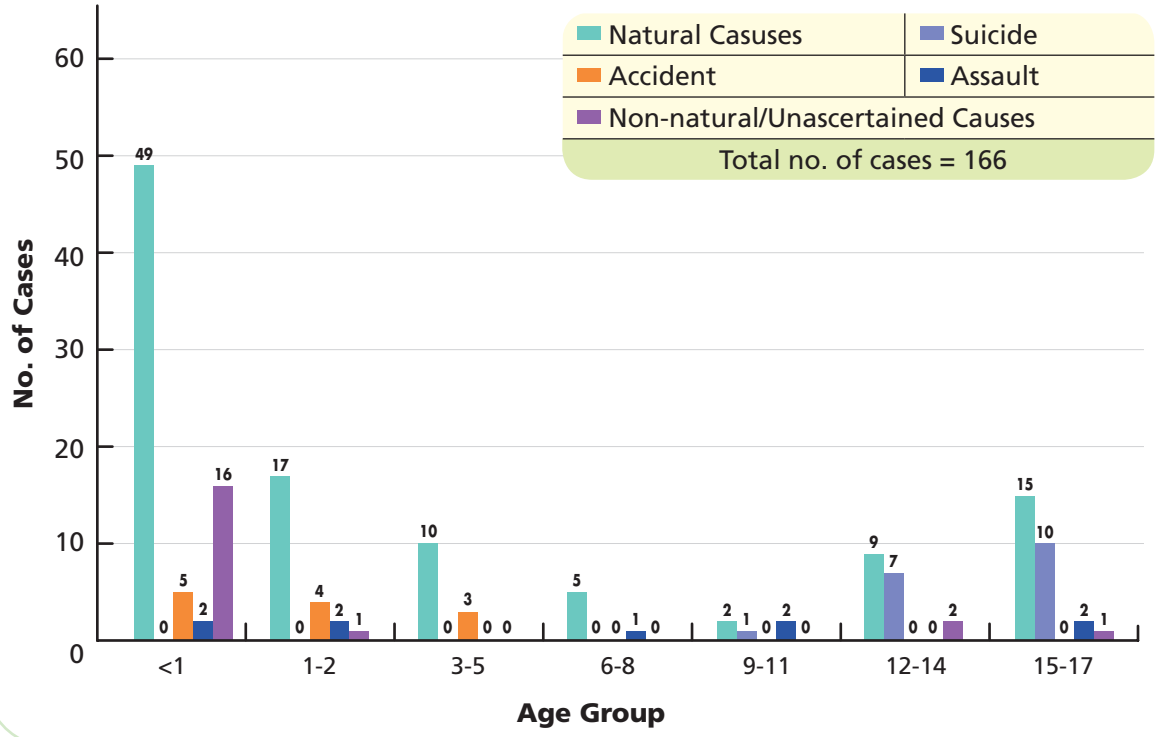


Table 5.2.9: No. of Cases by Residential District and Year

Residential District	2014			2015		
	No. of cases	*Population	#Death rate	No. of cases	*Population	#Death rate
HONG KONG ISLAND						
Central & Western	3	34 500	0.087	2	38 100	0.052
Wan Chai	1	19 700	0.051	0	20 200	0
Eastern	8	75 100	0.107	6	73 600	0.082
Southern	2	37 500	0.053	6	35 300	0.170
KOWLOON						
Yau Tsim Mong	4	48 000	0.083	3	49 900	0.060
Sham Shui Po	2	55 900	0.036	3	55 900	0.054
Kowloon City	3	58 100	0.052	6	57 600	0.104
Wong Tai Sin	5	55 000	0.091	4	53 100	0.075
Kwun Tong	8	90 800	0.088	7	90 800	0.077
NEW TERRITORIES						
Kwai Tsing	8	67 800	0.118	3	69 600	0.043
Tsuen Wan	4	46 500	0.086	2	46 600	0.043
Tuen Mun	6	69 300	0.087	4	70 000	0.057
Yuen Long	9	94 900	0.095	10	94 500	0.106
North	3	44 700	0.067	4	47 200	0.085
Tai Po	2	38 100	0.052	5	39 900	0.125
Sha Tin	7	86 900	0.081	7	88 700	0.079
Sai Kung	3	68 300	0.044	6	66 900	0.090
Islands	2	25 900	0.077	4	26 600	0.150
OTHERS						
Not residing in HK	2	-	-	1	-	-
Unknown	1	-	-	0	-	-
Total	**83**	**-**	**-**	**83**	**-**	**-**

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

The top 3 highest case numbers or death rates among the 18 districts are highlighted.

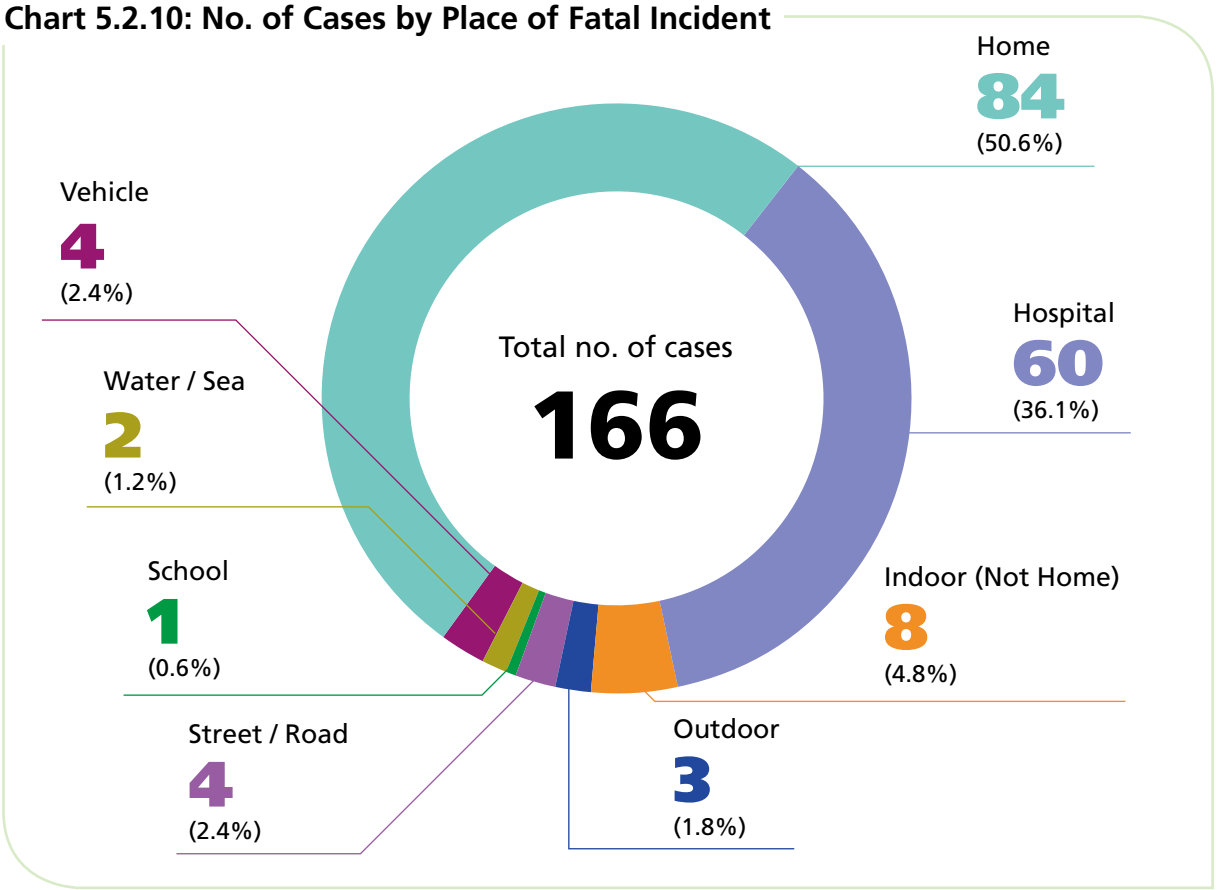
** denotes land-based non-institutional population aged 0-17 in respective district. Source: General Household Survey, Census and Statistics Department.*

 # denotes district-specific child death rate, i.e. child death cases reviewed per 1 000 land-based non-institutional child population in respective district.

In 2014, the highest number of child deaths was recorded in Yuen Long District (N=9), followed by Eastern District, Kwun Tong District and Kwai Tsing District (all N=8). However, taking account of the child population in respective districts, the highest child death rate, i.e. child death cases reviewed per 1 000 land-based non-institutional child population in respective districts, came from Kwai Tsing District (0.118), followed by Eastern District (0.107) and Yuen Long District (0.095). Kwai Tsing District, Eastern District and Yuen Long District were the districts with relatively higher number of child deaths and child death rate.

In 2015, the highest number of child deaths was recorded in Yuen Long District (N=10), followed by Kwun Tong District and Sha Tin District (all N=7). The highest child death rate came from Southern District (0.170), followed by Islands District (0.150) and Tai Po District (0.125). Yuen Long District, Sha Tin District and Kwun Tong District were the districts with relatively higher number of child deaths and child death rate.

Chart 5.2.10: No. of Cases by Place of Fatal Incident



5.3 Statistics of Child Death Cases According to Death Causes

5.3.1 Cases Died of Natural Causes

Chart 5.3.1.1: No. of Cases by Age Group and Sex

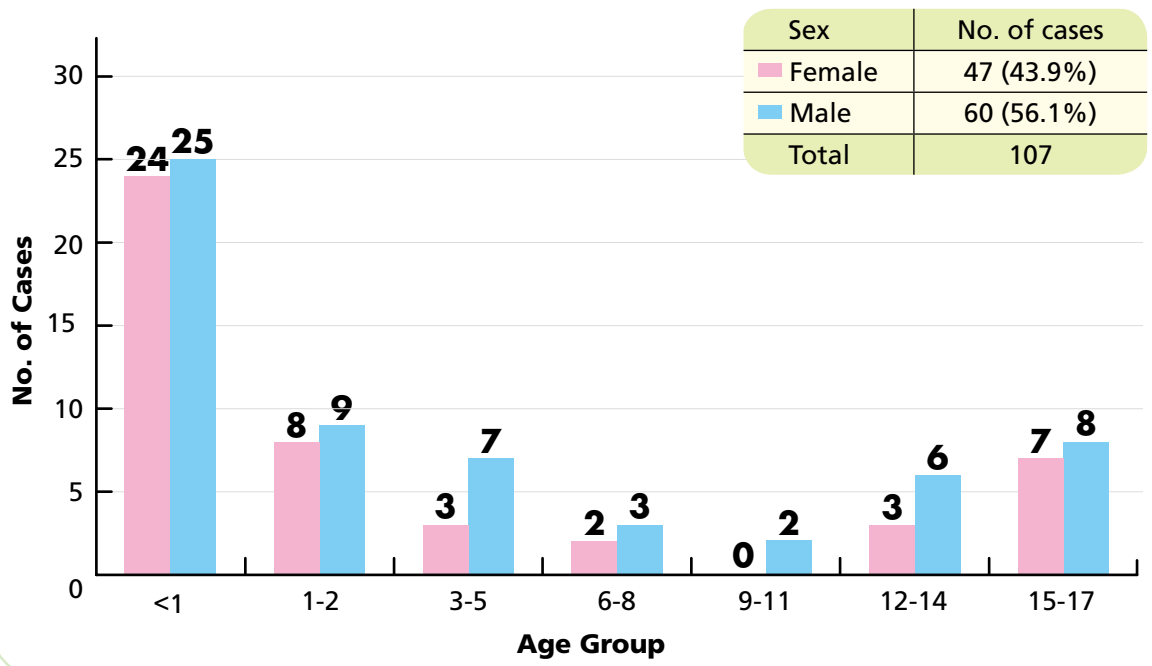
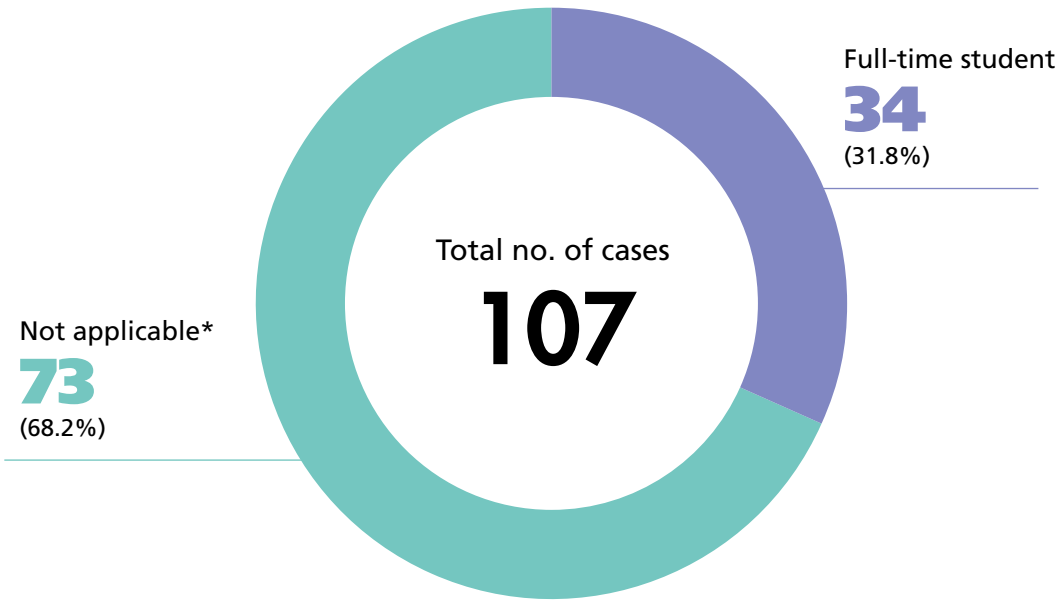


Chart 5.3.1.2: No. of Cases by Occupation



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

Table 5.3.1.3: No. of Cases by Type of Health Problem According to ICD10 Classification

ICD Code	Type of Health Problem	No. of Cases (%)
A00-B99	Certain infectious and parasitic diseases	10 (9.3%)
C00-D48	Neoplasms	3 (2.8%)
E00-E90	Endocrine, nutritional and metabolic diseases	3 (2.8%)
G00-G99	Diseases of the nervous system	10 (9.3%)
I00-I99	Diseases of the circulatory system	14 (13.1%)
J00-J99	Diseases of the respiratory system	13 (12.1%)
K00-K93	Diseases of the digestive system	5 (4.7%)
M00-M99	Disease of the musculoskeletal system and connective tissue	1 (0.9%)
N00-N99	Diseases of the genitourinary system	1 (0.9%)
P00-P96	Certain conditions originating in the perinatal period	25 (23.4%)
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	11 (10.3%)
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (mainly sudden infant death or sudden unexplained death for the reviewed cases)	11 (10.3%)
	Total	**107 (100.0%)**

ICD10: The International Classification of Diseases, Version 10 is developed by the World Health Organisation. The ICD is the international standard diagnostic classification for epidemiology, health management and clinical purposes. 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.

The top 3 highest case numbers among the ICD codes are highlighted.

Table 5.3.1.4: No. of Cases by Age Group and Death Category

Age Group	Category*					No. of Cases (%)
	A (%)	B (%)		C (%)	D# (%)	
		B1 (%)	B2 (%)			
< 1	18 (16.8%)	1 (0.9%)	4 (3.7%)	6 (5.6%)	20 (18.7%)	49 (45.8%)
1-2	0	7 (6.5%)	3 (2.8%)	6 (5.6%)	1 (0.9%)	17 (15.9%)
3-5	0	3 (2.8%)	1 (0.9%)	3 (2.8%)	3 (2.8%)	10 (9.3%)
6-8	0	4 (3.7%)	1 (0.9%)	0	0	5 (4.7%)
9-11	0	1 (0.9%)	1 (0.9%)	0	0	2 (1.9%)
12-14	0	3 (2.8%)	4 (3.7%)	2 (1.9%)	0	9 (8.4%)
15-17	0	5 (4.7%)	5 (4.7%)	3 (2.8%)	2 (1.9%)	15 (14.0%)
Total (%)	**18 (16.8%)**	**24 (22.4%)**	**19 (17.8%)**	**20 (18.7%)**	**26 (24.3%)**	**107 (100.0%)**
		43 (40.2%)				

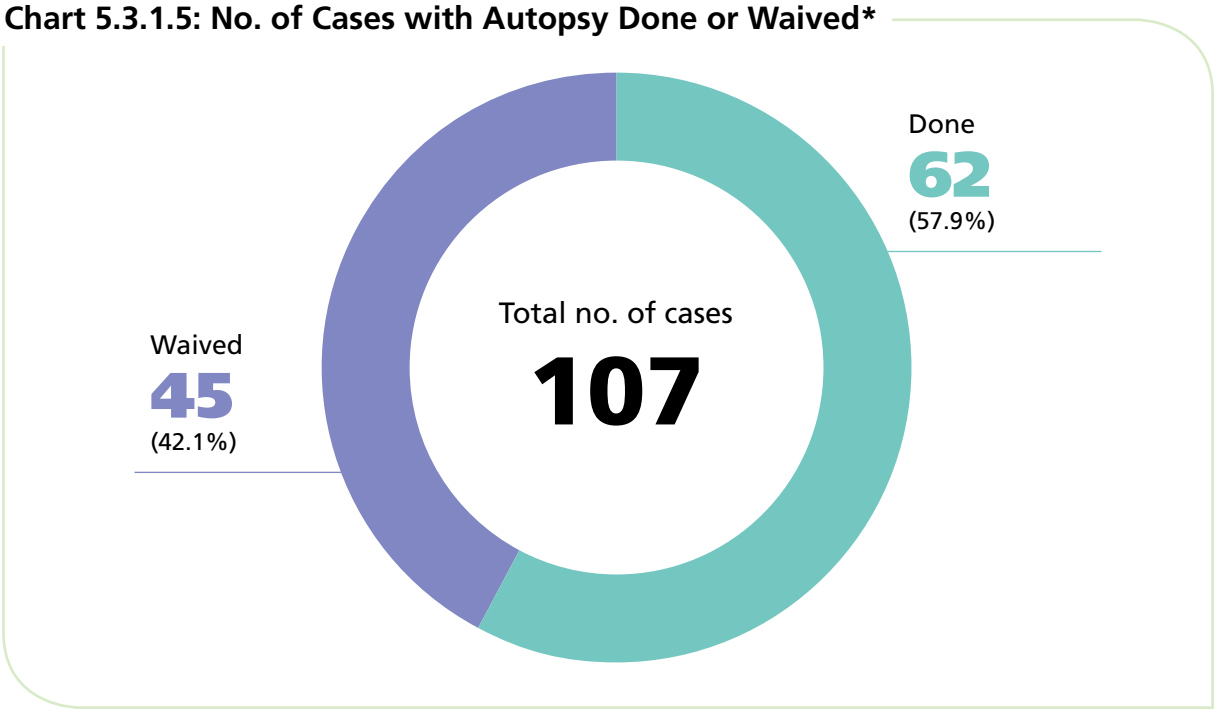
* *These categories of death, with content listed below, are designed by the medical experts of the Review Panel for review purpose:*

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, including:*
Unidentifiable Aetiology
SUDI (Sudden and Unexpected Death in Infancy)
Stillbirth

For cases under Category D, further breakdowns are: Stillbirth cases (N=16, 15.0%); SUDI cases (N=1, 0.9%) & Cases with unidentifiable aetiology (N=9; 8.4%).

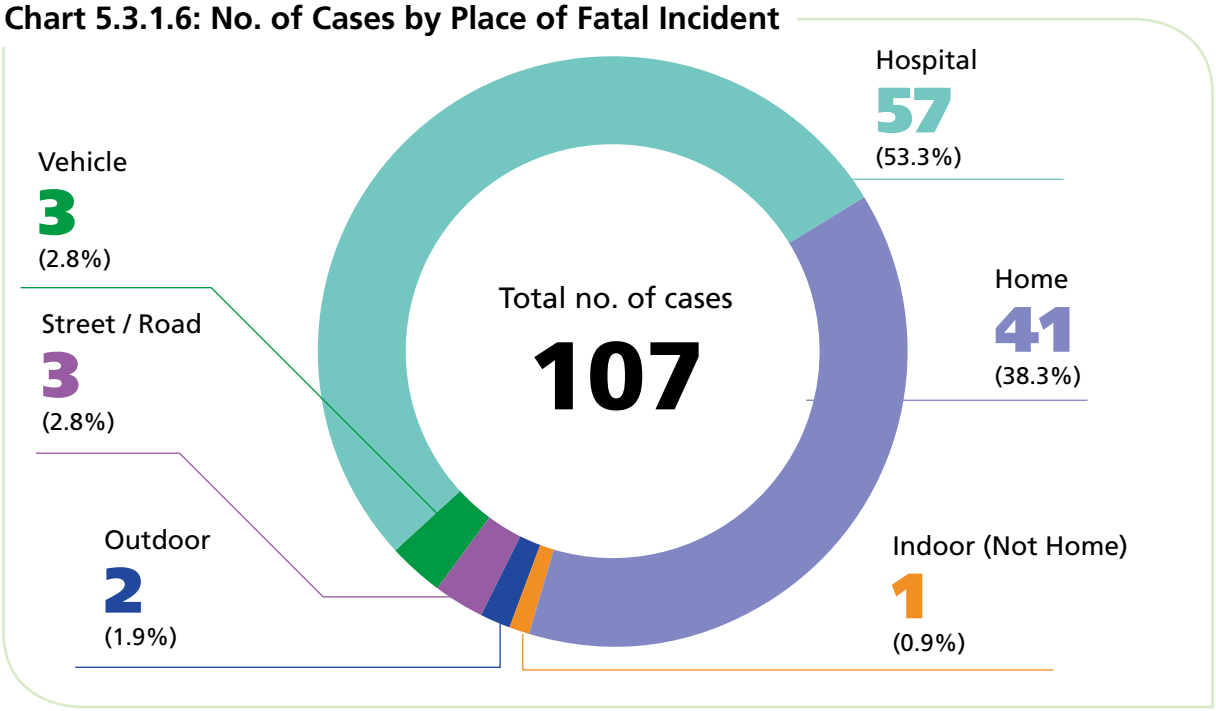
The highest case numbers among different categories are highlighted.

Chart 5.3.1.5: No. of Cases with Autopsy Done or Waived*



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

Chart 5.3.1.6: No. of Cases by Place of Fatal Incident



5.3.2 Cases Died of Suicide

Chart 5.3.2.1: No. of Cases by Age Group and Sex

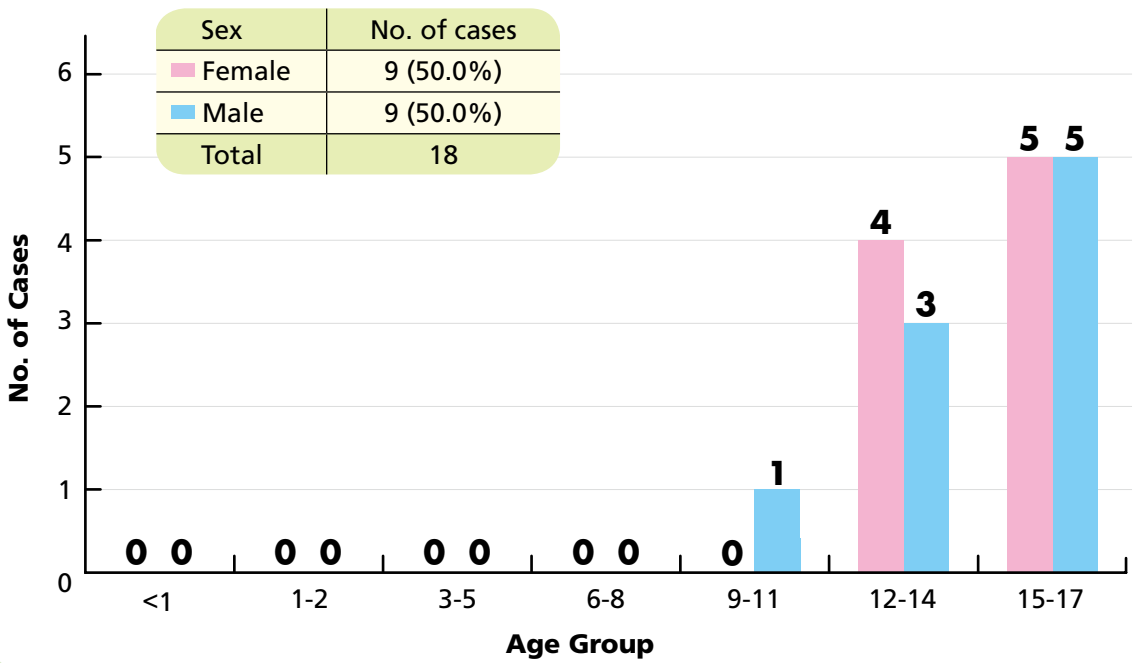


Chart 5.3.2.2: No. of Cases by Occupation

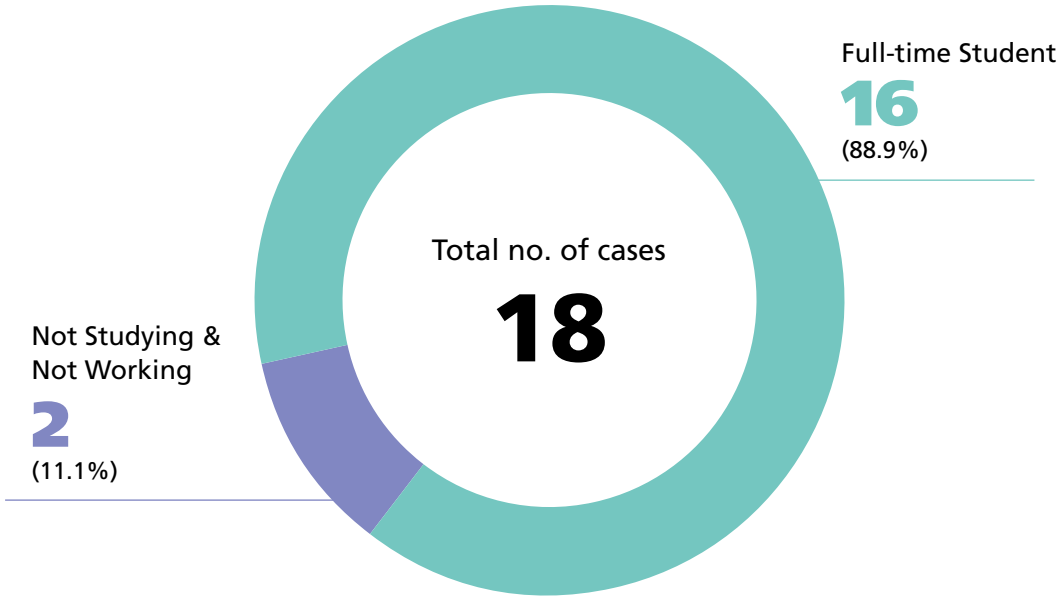
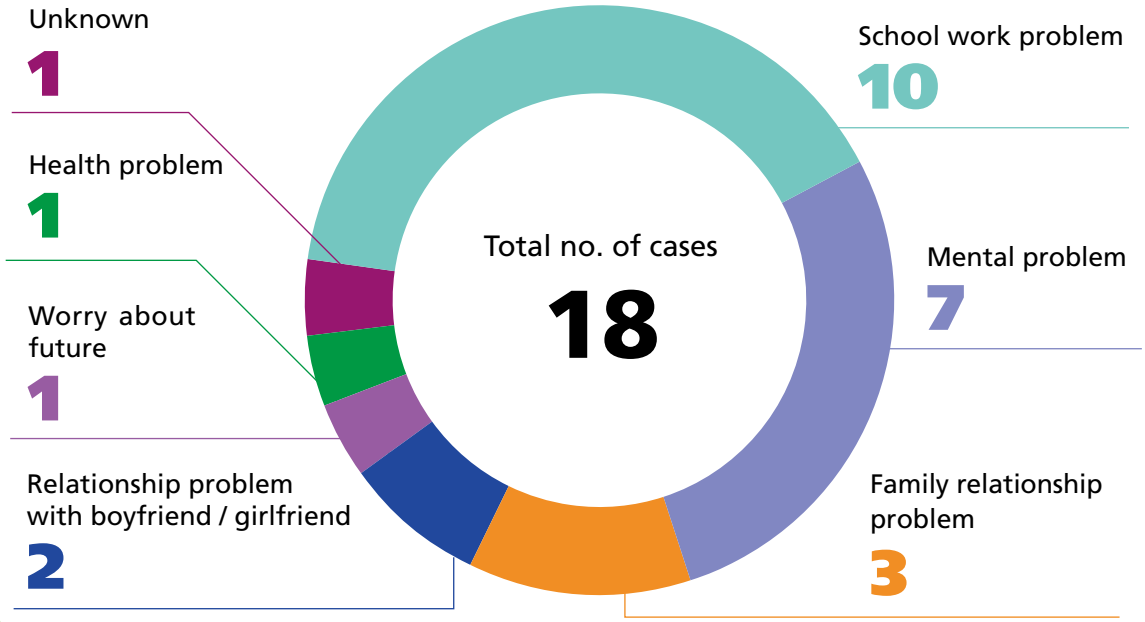


Chart 5.3.2.3: *Reasons of Committing Suicide



* *Note: Multiple reasons are allowed.*
(The reasons were identified in the police death investigation reports and/or service reports of the reviewed cases.)

Chart 5.3.2.4: Means of Committing Suicide

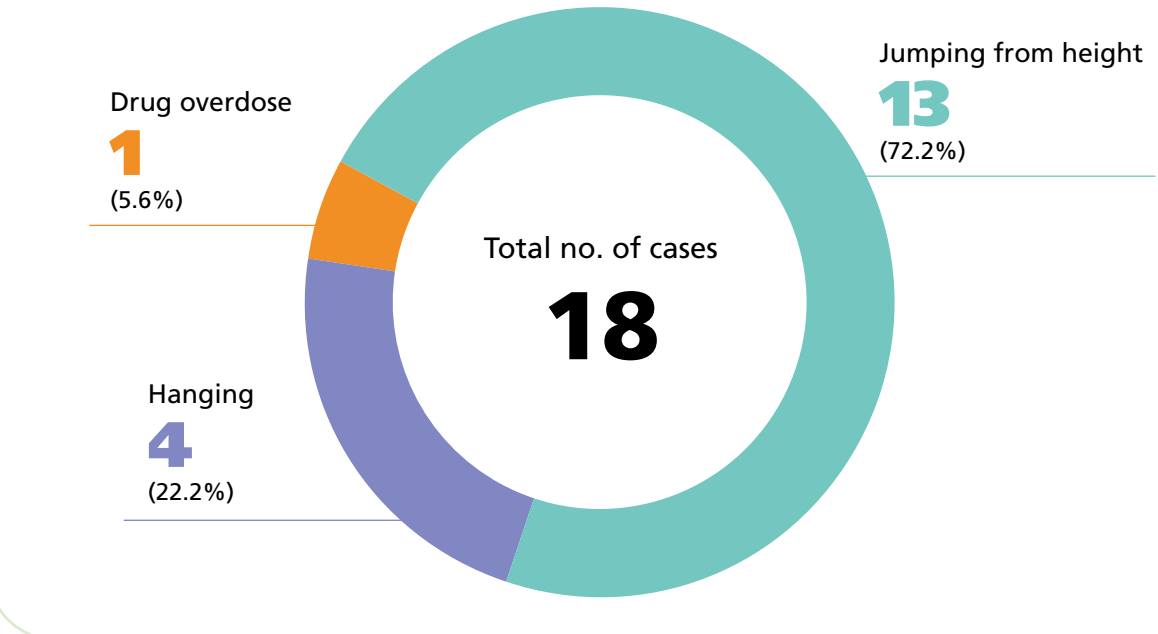
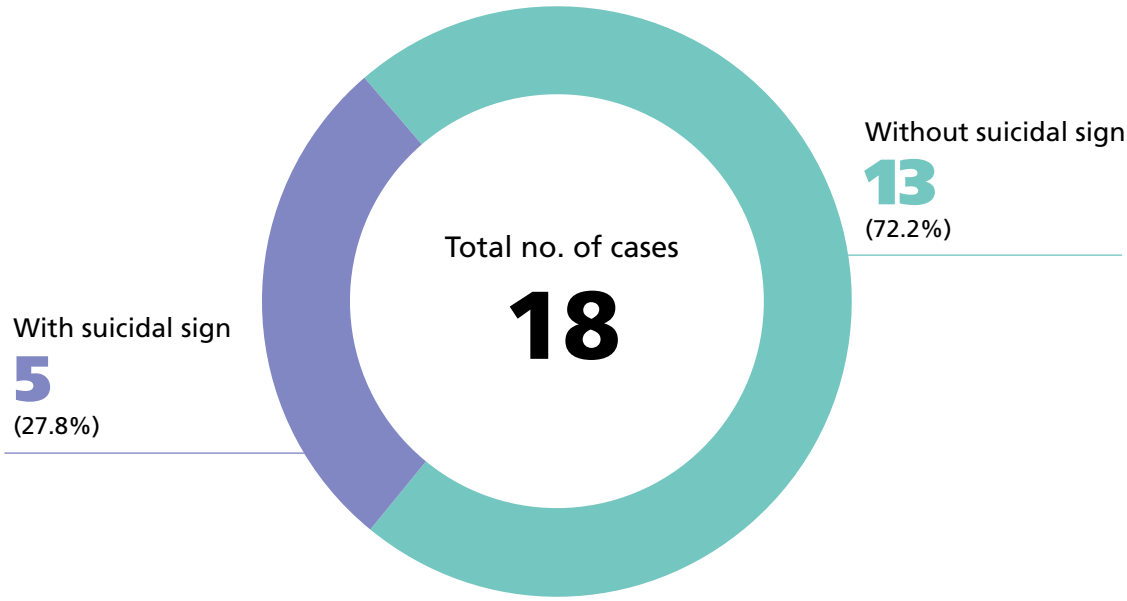


Chart 5.3.2.5: Cases with Identified Suicidal Signs*



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

5.3.3 Cases Died of Accident

Chart 5.3.3.1: No. of Cases by Age Group and Sex

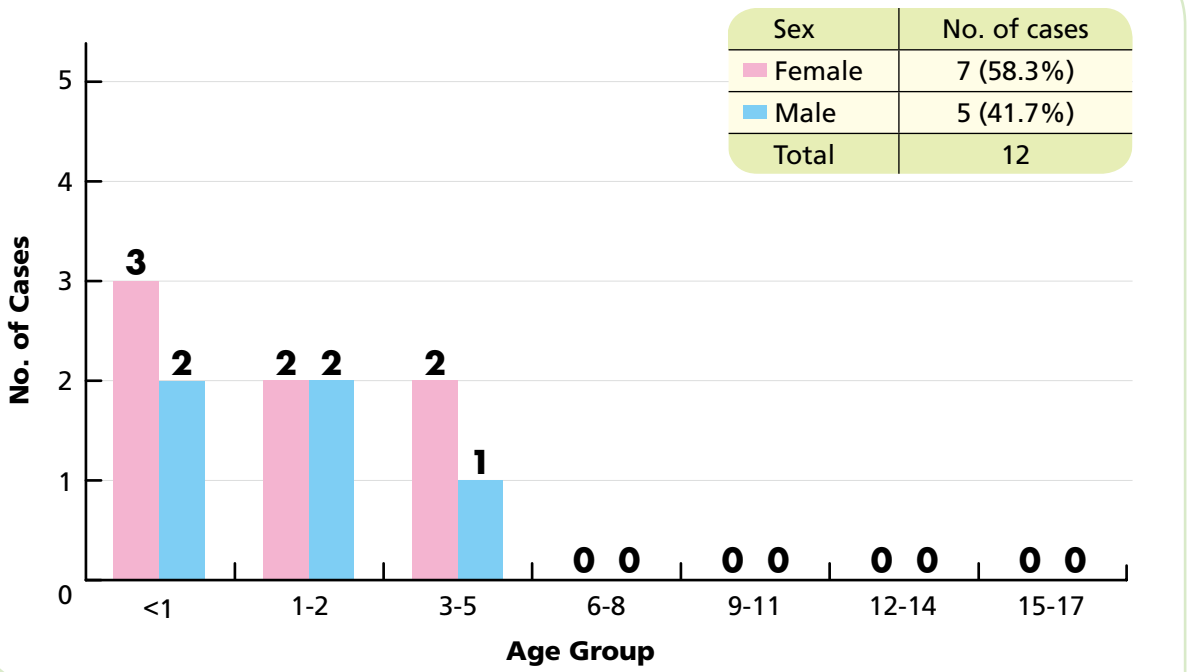


Chart 5.3.3.2: No. of Cases by Type of Accident and Sex

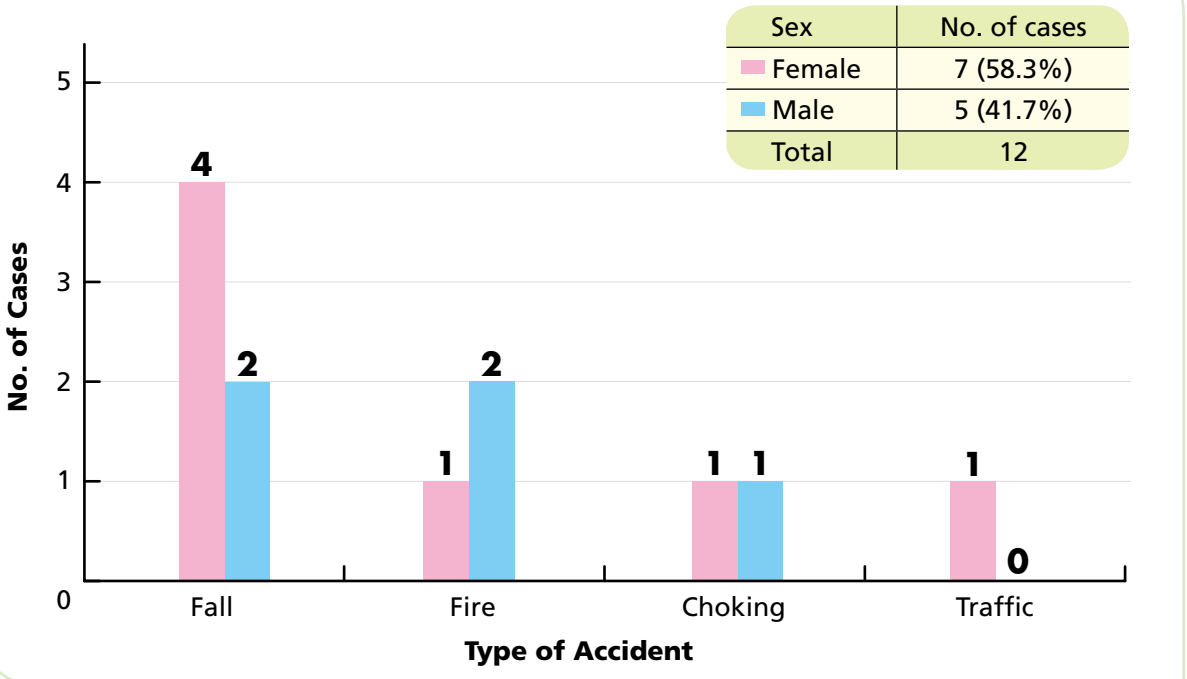


Chart 5.3.3.3: No. of Cases by Age Group and Type of Accident

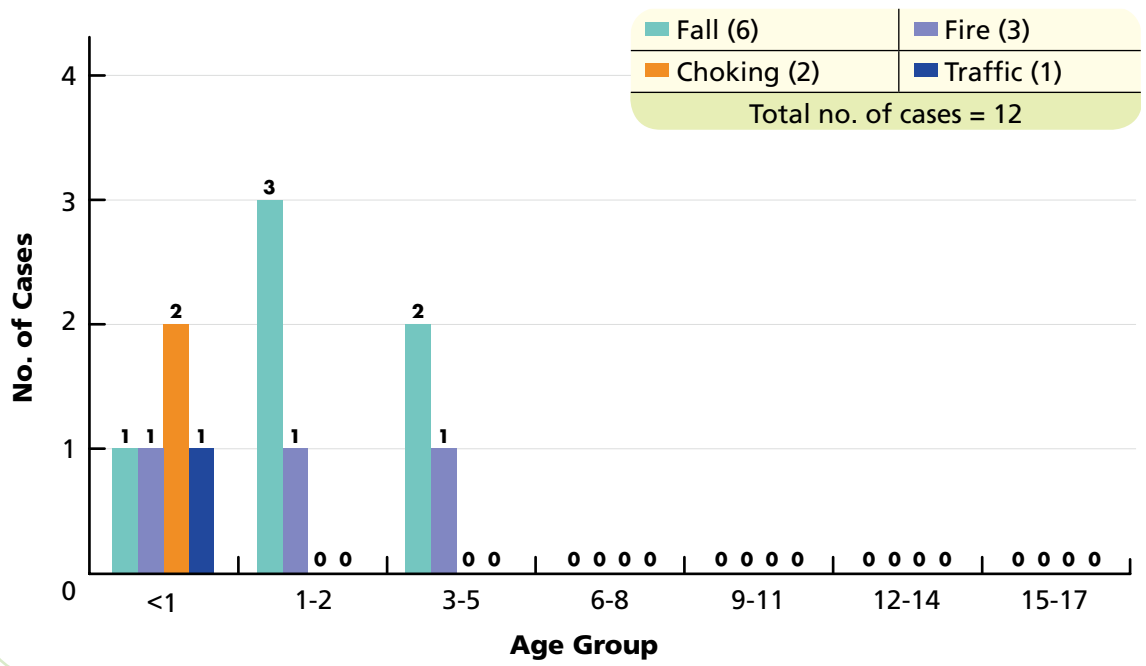


Chart 5.3.3.4: No. of Cases by Age Group and Type of Traffic Victim

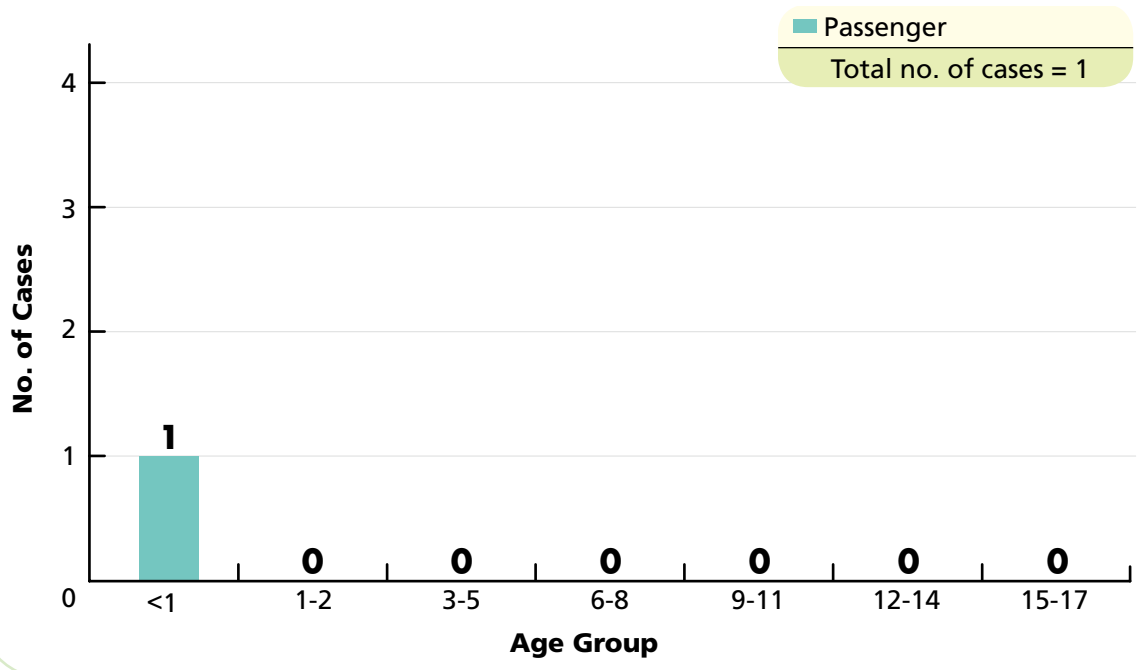


Chart 5.3.3.5: No. of Cases by Place of Fatal Incident

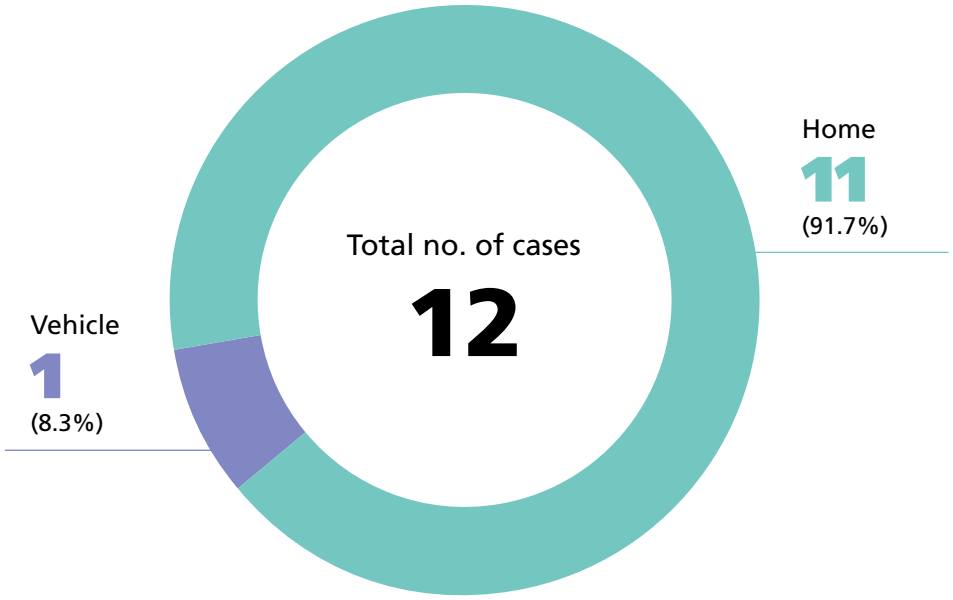
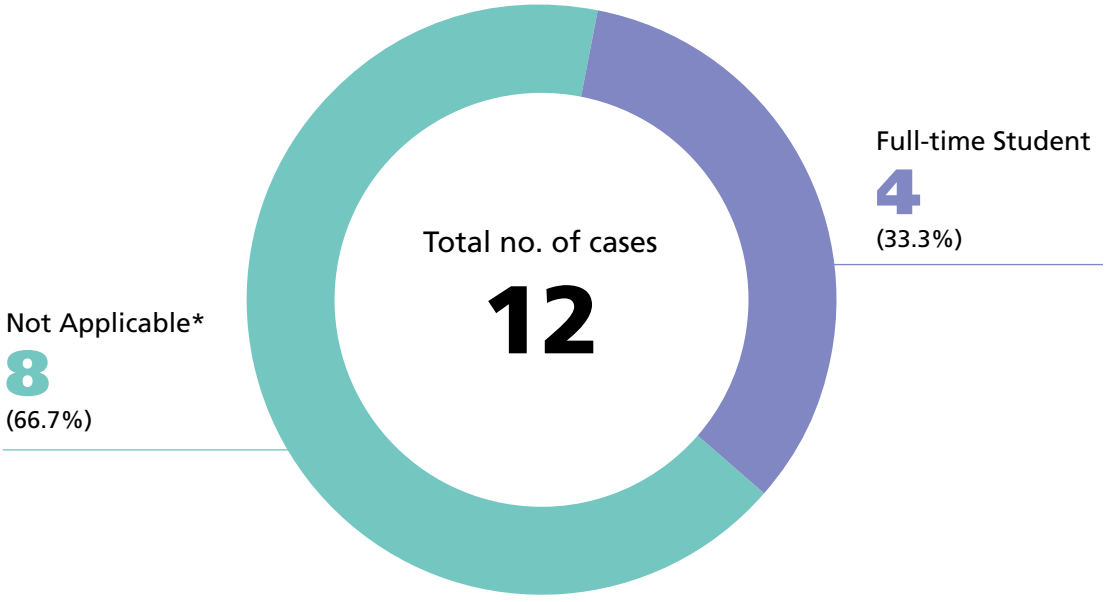


Chart 5.3.3.6: No. of Cases by Occupation



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

5.3.4 Cases Died of Assault

Chart 5.3.4.1: No. of Cases by Age Group and Sex

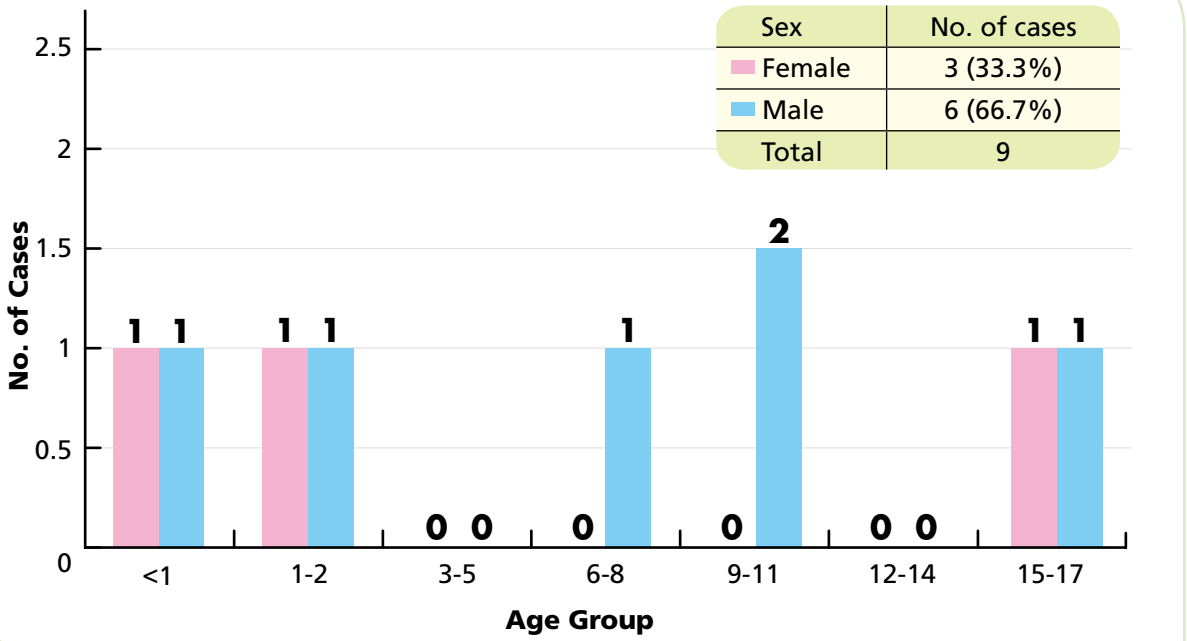
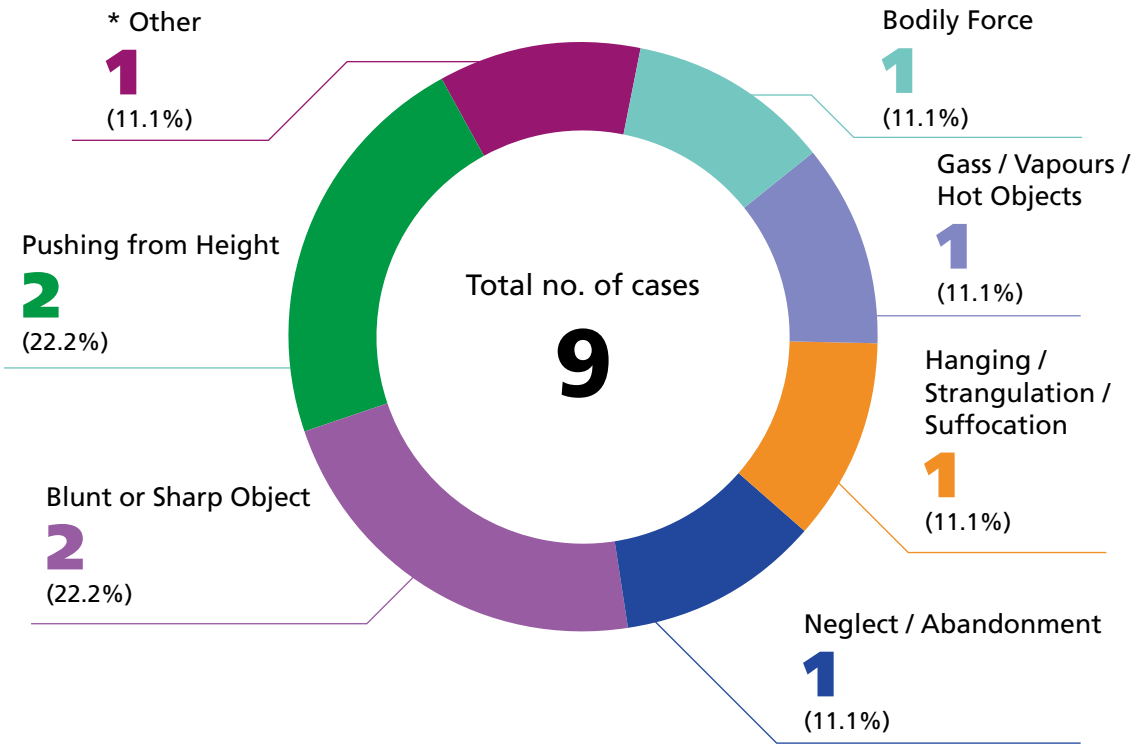


Chart 5.3.4.2: Types of Assault



**Other: Unascertained due to decomposition of the dead body.*

Chart 5.3.4.3: Perpetrator's Relationship with the Deceased Child

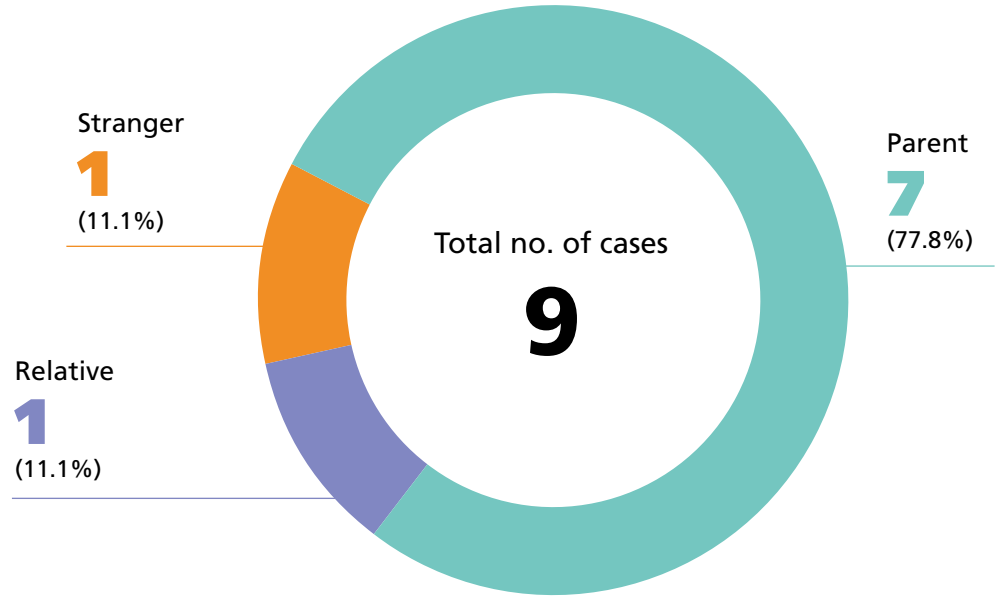
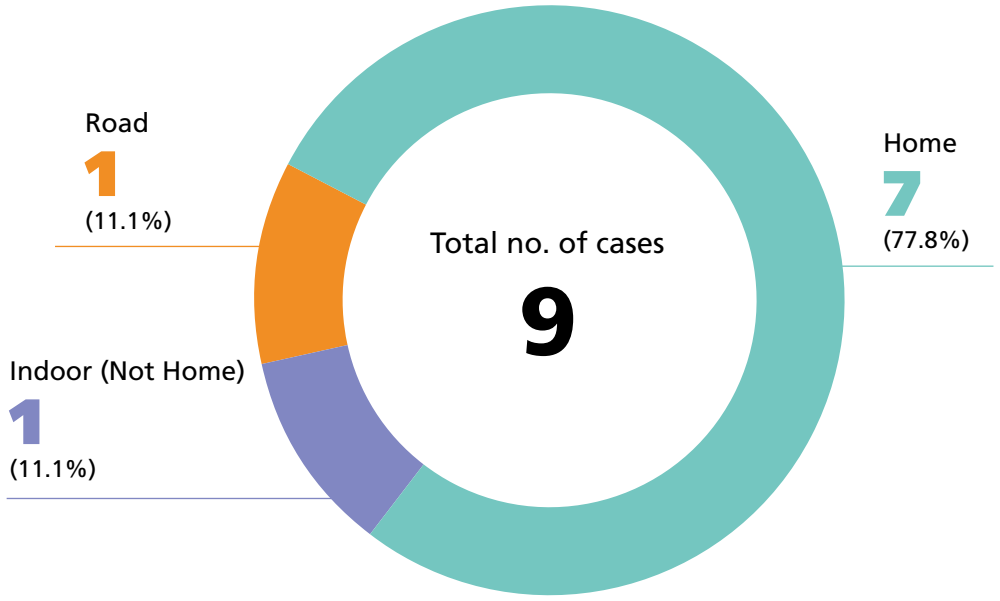


Chart 5.3.4.4: No. of Cases by Place of Fatal Incident



5.3.5 Cases Died of Non-natural Unascertained Causes

Chart 5.3.5.1: No. of Cases by Age Group and Sex

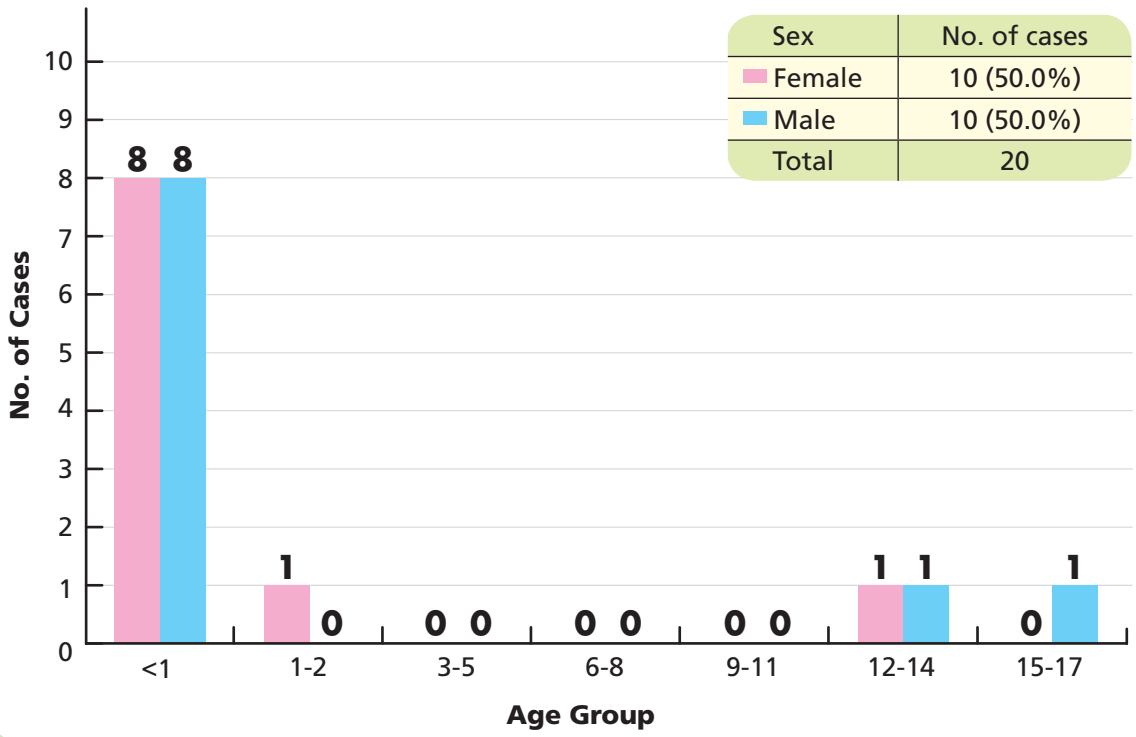
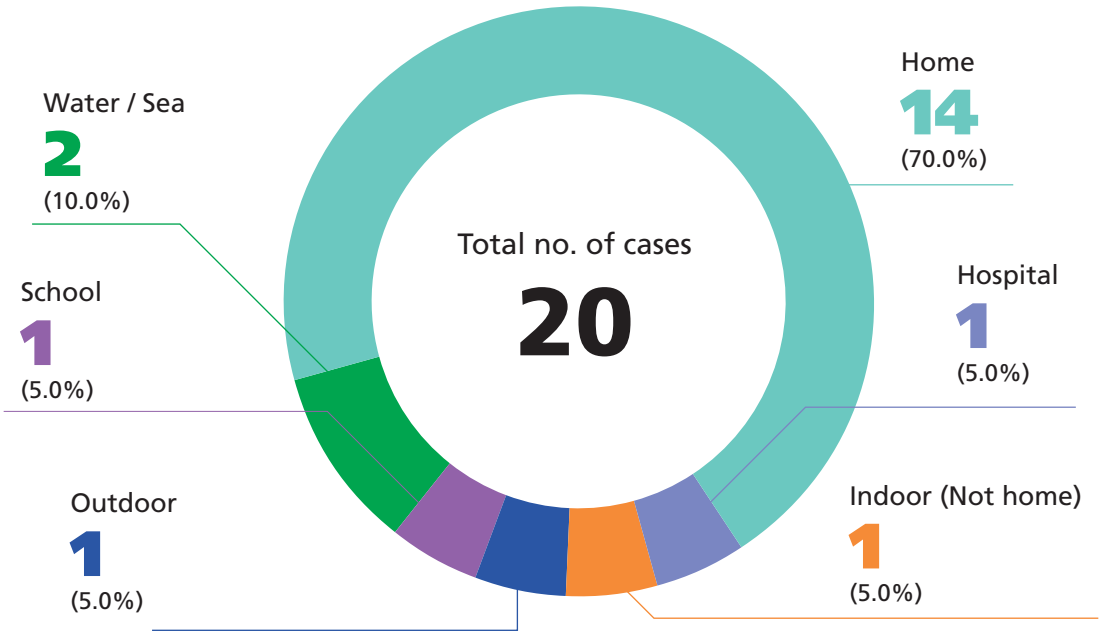


Chart 5.3.5.2: No. of Cases by Place of Fatal Incident



06 Observations on Review of Child Death Cases in 2014 and 2015

After reviewing the child death cases which occurred in 2014 and 2015, the Review Panel has come up with the following observations and 53 recommendations on preventive strategies and system improvement for child fatal cases. The observations by death cause are listed below.

6.1 Observations by Different Death Nature

6.1.1 Natural-cause Cases

- Despite request for waiving the autopsy by the deceased children's families (some due to religious reasons), in unclear circumstances with respect to the cause of death, Panel Members viewed that autopsy might help to provide more information on the cause(s) of death for prevention purpose. **(Recommendation N1)**

- The Review Panel reviewed some natural-cause cases in which the deaths were suspected to be related to concealment of pregnancy (N=8). Panel Members viewed that public education on "safe sex" and "proper management of pregnancy" should be continued so as to prevent child death out of "concealment of pregnancy". **(Recommendation N2)** Observations on cases related to concealment of pregnancy and the recommendations will be discussed under the thematic topic in Chapter 8.

- Among the 107 cases with children dying of natural cause, 5 deaths were suspected to be related to metabolic diseases or genetic abnormalities. Panel Members viewed that if genetic abnormality was found on the deceased child, genetic screening for family members should be conducted. Under the current practice, paediatricians would refer parents and/or surviving siblings of deceased children dying of suspected hereditary disease in paediatric wards for genetic counselling. There was however no standard protocol for forensic pathologists to request for genetic testing on deceased children dying of sudden or unexpected death when the children were certified dead upon arrival at the Accident & Emergency Department. Panel Members viewed that forensic pathologist should be encouraged to refer the case to clinical genetic service (CGS) to conduct molecular or genetic testing if the deceased child's cause of death was unascertained, related to genetic disorder or inborn errors of metabolism. **(Recommendation N3)**

6.1.2 Suicide Cases

(I) Handling of Suicidal Threats Received from Peers

- Consistent with previous years, the Panel reviews identified that young people often told their friends about their thoughts of self-harm or intent to commit suicide before they took actions. The messages were often conveyed electronically via social media.

- Among the 18 child suicide cases, three children (16.7%) had sent suicidal messages to their friends via social media, such as WhatsApp and Instagram prior to their suicidal acts. For example, one of them had revealed her suicidal ideation on preferred methods of suicide during casual talks with classmates and said goodbye to them on the last school day. However, the suicidal message was not taken seriously by the classmates and thus there was no intervention. In another case, a girl posted photos of her sitting on the edge of the rooftop with suicidal message posted on Instagram. Her friend had successfully reached her by WhatsApp and located her with an immediate report made to the Police despite that the girl could not be saved finally. Panel Members suggested enhancing children's management of death threats received from their peers. **(Recommendation S1)**

(II) Children with Mental Illness/Suspected Mental Health Problem/ Special Educational Needs

- In reviewing the 18 suicide cases in 2014 and 2015, "Diagnosed/Suspected mental illness" stood out as the most frequent circumstance for death by suicide with 7 (38.9%) out of 18 suicide cases, followed by "Adaptation to Form One schooling", "Parent-Child Conflict" and "Relationship Breakup". Among these 7 cases, 5 children had been diagnosed with mental illness while 2 with suspected mental health problem.

- A boy was observed to have very bad temper and aggressive acts by his school-mates. He was suspected to be suffering from psychosis but his signs of early psychosis were not detected by his family members, school-mates or teachers before he committed suicide. It seemed that the public lacked the general knowledge of early psychosis.

- In another case, a girl suspected herself to be suffering from mental illness for some time. However, her family members were unaware of that despite the girl had made repeated complaints of headache. Instead of seeking professional help, the girl searched information on the internet to self-diagnose her mental problem. She finally committed suicide, leaving a will note expressing her pain and hopelessness by having to live with mental illness.

- Panel Members considered that early detection of signs of depression with timely professional intervention might have helped prevent the suicide of children with suspected mental illness. Prompt intervention was viewed as crucial for youth experiencing stress, depression or suicidal thoughts. **(Recommendations S2 and S3)**

- As for the 5 children who had been diagnosed with mental health problems, they had been receiving regular psychiatric follow-up. A girl with limited intelligence had attended regular psychiatric follow-up for her mental illness. Ever since her primary schooling, the girl had encountered much academic pressure as she could not catch up with her study and had a strong wish to quit school. The prolonged academic stress was a vulnerable factor behind her suicide.

- Panel Members considered that schools should be more accommodating to children with special educational needs or mental health problems. Parents should accept their children's limitations and develop their potentials in other aspects. **(Recommendations S4 to S6)**

- In other cases, a youth had made multiple suicidal attempts with various means before and finally committed suicide while another youth committed suicide by taking excessive psychiatric drugs before going to bed at night. Parents or family members should be reminded to closely monitor the mental conditions of children diagnosed with mental illness and to keep proper storage of their psychiatric drugs. **(Recommendations S7 and S8)**

(III) Adaptation to Form One Schooling

- 3 (16.7%) out of 18 suicide cases involving students who were just promoted to Form One and jumped from height within the month of September when school term had just begun. It was observed that "stress" was common for students during the transitional period of schooling, especially when they got promotion to Form One, prepared for the Hong Kong Diploma of Secondary Education Examination (HKDSE) or just started university study.

- One of the cases involving a boy, who refused to return school and requested to study overseas when he was just promoted to Form One, jumped after three weeks of the new school term. Another Form One boy with an aloof and socially withdrawn character jumped on the second day of the new school term.

- Members opined that Form One was a critical stage in which students needed great adaptation to the new school environment with new school-mates. Parents should be alert when their children refused to attend school. The school personnel should also keep in view the adjustment needs of Form One students. **(Recommendations S9 to S11)** Furthermore, it was observed that some children in general did not know how to handle when they received bullying messages from their school-mates via social media. **(Recommendation S12)**

- In one of the suicide cases, a boy, who used to have favourable academic performance in his primary schooling, turned to be very upset when being allocated to the second lowest competent class of Form One.

- Panel Members opined that special attention should be given to those Form One students who were allocated to Band 1 secondary schools with good achievement in their primary schooling as these students might easily get a "sense of failure" when not being allocated to the best class in Form One. Apart from aligning the academic level of Form One students, the Education Bureau (EDB) should remind secondary schools, especially those of top school banding, not to overlook the social and emotional adjustment needs of the Form One students.

- In addition, Panel Members concerned about the pros and cons of competence-based class grouping in Form One, which without adopting a positive view, might generate labeling effect or negative self-image from students' perspectives. As such, teachers should help both the parents and students to understand the rationale behind the competence-based class grouping that a favourable teacher-student manning ratio in less competent classes might be conducive to students' better learning. **(Recommendations S13 to S14)**

(IV) Parent-Child Conflict

- 3 (16.7%) out of 18 cases involved direct parent-child conflict just prior to the child suicidal act.

- It was observed that some children committed suicide out of their impulsive act after having heated conflicts with their parents. A boy committed suicide after being stopped by his parents to play on-line game with his laptop being confiscated while a girl jumped from height after being scolded by her parent for staying out with her friends late at night and getting drunk. Panel Members viewed that communication between parents and children seemed to be inadequate and ineffective in hasty living nowadays.

- Though many children were active in sharing with their peers via Facebook, Snapchat or WhatsApp, parents had no idea of their children's personal life at all. Sometimes, parents might mishandle or intensify the conflicts with their children. It was suggested that parenting skills should be further enhanced in improving the parent-child communication, particularly in handling the rebellious behaviour of teenagers. **(Recommendations S15 to S17)**

(V) Handling of Breakup and Loss

- A secondary school girl committed suicide just after a recent breakup with her boyfriend who was her classmate. Panel Members viewed that "break-up" was a common risk factor behind suicide but it seemed that parents and schools seldom taught children how to handle "break-up". In addition, many parents failed to be aware of their children's personal affairs and disturbed emotions. Panel Members would like to reiterate that education for children in coping with breaking up of relationship was important in preventing youth suicide. **(Recommendation S18)**

6.1.3 Accident Cases

(I) Falls from Height (no installation of or unlocked window grilles)

- The Child Fatality Review Panel examined 12 accident cases which occurred in 2014 and 2015.

- Out of these 6 fatal fall cases, 3 were related to "falls from height" in which 2 cases involved children being left unattended at home and there was either no installation of window grilles or the window grilles found to be unlocked.

- An infant girl, who was left alone at home by the domestic helper, was believed to have climbed to an open window with no window grilles, where she lost her balance and fell down from it. Another case involved an infant girl, who was asleep and left unattended at home by the grandmother, who went to the rooftop for hanging laundry. Just within ten minutes, the girl fell off from the louver window without window grilles when she climbed up from the bed after waking up. Another infant locked herself inside her bedroom after a dispute with her sibling. Although window grilles were installed in the bedroom, one of the window grilles was not locked, leaving a gap between the central divider frame and the grille. It was believed that girl accidentally fell out of the window when she opened it and looked outside out of curiosity.

- Fatal fall accidents could have been avoided if proper home safety designs or devices had been in place and infants had not been left unattended. Panel Members would like to remind that safety measures should be the first priority for protection of children at home. Apart from installation of window grilles to prevent children from falling out of the window, including those living in rental flats, the public should consider different safety measures, such as invisible protective net (隱形防護網) for balcony or limit safety lock for aluminium windows (鋁窗限位安全鎖).

- In addition, training for foreign domestic helpers, in the aspect of safety for children, needed to be strengthened. The importance of home safety measures could further be promoted at district level through the Community Affairs Committee of District Councils so as to heighten the public awareness. **(Recommendations A1 to A3)**

(II) Falls on Floor with Head Injuries

- There were 3 fall cases at home which resulted in head injuries of infants with 2 involving falls from the bed and 1 from a chair. The parents failed to take the infants for immediate medical consultation.

- A child was left to sleep alone on a 3-foot-high bed without a fence. He was found lying prone unconsciously on the floor of his bedroom and was believed to have fallen down from his bed with his head hitting on the floor. Although he sustained head injuries on the incident day with bruises on his forehead, the parents seemed to have under-estimated his head injuries and failed to bring him to seek medical consultation at once before he fell from the bed again in the evening.

- Another case involved an accidental fall of a girl from a chair at home. Instead of taking the girl for medical consultation at once, the parent put her to sleep. When she was later found collapsed by the parent, the parent did not call the ambulance at once to send the girl for immediate medical treatment but tried to wake her up by slapping and shaking her. The last case involved an infant not being sent to hospital at once by the parent when he was found falling off from the bed onto the floor without bleeding.

- Panel Members observed that parents seemed to have overlooked the possible fatal consequences of children's fall and failed to escort them for immediate medical check-up. **(Recommendations A4 to A6)**

- In view of repeated child deaths in relation to falls in the past years, a thematic review on accidental falls would be further discussed in **Chapter 8**.

(III) Choking/Suffocation (related to Unsafe Sleeping Arrangement)

- Two cases of choking/suffocation were related to unsafe sleeping arrangement.

- A baby, together with her parents stayed in the relatives' home one night. She was placed to sleep in a portable baby cot with four cushions and a mattress at night. However, she was found wedged between the mattress and cot side in an upside down position in the next morning with the cause of death as "positional asphyxia". Another case involved a baby who used to sleep with the mother and a sibling on a double bed. He was put to sleep alone on the double-bed after being fed but was later found lying facing down without any response. Investigation revealed that the baby had been learning how to turn over and it was believed that he had accidentally turned his head onto the pillow during sleep which led to his suffocation.

- In view of the above two cases, Panel Members observed that it was not uncommon to have sudden death of babies when they slept in places other than their own homes and parents seemed to have easily overlooked the risk of suffocation when babies rolled over on a bed being placed with excessive soft objects. Thus, the public should be aware of a safe sleeping environment for babies. **(Recommendations A7 to A9)**

(IV) Fire Incident

- In the course of reviewing a child fatality case which involved the death of a parent with three infant children in an accidental fire incident, it came to the Review Panel's attention that the public seemed to have inadequate knowledge on fire escape, such as whether to stay or to leave when a fire broke out inside a residential unit. In reviewing the case, the parents failed to escape with their children from the unit at the initial stage of the fire. Instead, one of the parents tried to tackle the fire and a report was made to the Police only after the parent failed to put out the fire.

- The Review Panel intended to alert the public on what one should do in case of a fire breaking out inside one's own residential unit. Expert advice was sought from the Fire Services Department (FSD) as to the appropriateness for one to try to put out a fire breaking out in the sitting room when one's family members, particularly some being at tender age, kept themselves inside the bedrooms of the residential unit. In addition, the Review Panel hoped the FSD would further strengthen public education on fire safety and fire prevention in order to prevent the tragic loss of lives in similar scenarios. **(Recommendations A10 to A12)**

- The Review Panel was pleased to have received reply from the FSD, sharing their expert advice on what one should do in case of fire breaking out in one's unit as follows:

  If a fire breaks out in one's own unit:

  - He or she should stay calm and tell everyone to leave immediately;
  - do not try to retrieve one's belongings, except the three useful items for fire escape, namely mobile phone, keys and wet towel;
  - he or she should escape via the nearest staircase/corridor and break the breakglass unit to activate the fire alarm;
  - if there is smoke in the nearest staircase, escape via another staircase;
  - if there is no safe passage, try to enter another unit, until you find a safe place to take shelter; and
  - one should report the fire by calling "999" when he or she is safe.

  If one decides not to or cannot leave the affected unit:

  - Call "999" and inform the fire personnel where one is trapped;
  - move to a room which is free from smoke;
  - close the door and seal any gaps with duct tapes and wet towels; and
  - show his/her location by hanging a bed sheet or waving a towel at the balcony or by the window.

  The appropriateness for the public to try to put out a fire:

  - All individuals in the affected unit should stay calm and evacuate at once;
  - putting out the fire by the public is never the first priority and it should be done only when he or she is safe, as well as the escape route is secured;
  - one can use fire service installations (FSIs) of the building, such as hose reel system, portable fire extinguisher to put out the fire if he or she is safe and confident to do so;
  - the use of FSIs should not in any way delay anyone's escape; and

- be vigilant of the fire situation at the unit as it may change abruptly and become out of control. Leaving the unit as quickly as possible is the top priority if the situation permits.

6.1.4 Assault and Non-natural Unascertained Causes

(I) Distress of Carers of Special Need Children:

- The Child Fatality Review Panel examined 9 assault cases which occurred in 2014 and 2015. 7 children (including one sibling case) were assaulted by their parents, 1 by the relative and 1 by a stranger. For the perpetrators who were parents/relatives, three of them being male and being the main the carers of the deceased children. The Panel would like to raise public's awareness on the carers' mental well-being, especially for male carers and strongly encourage those with emotional distress to seek help from the professionals.

- Out of the 3 male carers, one involved a father, who suffered from burnt-out and great emotional distress, killed his child with multiple disabilities. Panel Members observed that it was quite common for parents, who have taken care of their disabled children for years, to have developed mental health problem due to great childcare stress. In some cases, these parents might have neglected or overlooked the needs of their normal children, too.

- In addition, Panel Members observed that as compared with females, males appeared to be less ready to share their feelings or to seek help when they encountered difficulties in taking care of children with special needs. At the same time, Panel Members viewed that it might be difficult for the social workers of special schools to cater the needs and handle the behaviour of children with different kinds of mental deficiency problems where nearly every student required intervention from the school social workers though at different levels.

- In view of the heavy workload for social workers serving in special schools, it might be an appropriate time to review the manning ratio of school social worker to students as well as that of other disciplines, such as physiotherapist, occupational therapist or speech therapist. **(Recommendations AS1 to AS4)** Panel Members also concerned about the adequacy of respite care or hostel service for needy families with disabled children.

- In another case, a child was killed by the grandfather, who was suspected to be suffering from depression with suicidal ideation. The Panel observed that in general, men suffering from depression might be easily ignored as males were relatively less expressive than females. They were less willing to seek help when in face of problems but their determination to commit suicide was usually higher.

- In addition, it was not uncommon for grandparents to be entrusted with the care of their grandchildren nowadays. In view that elderly depression was on a rising trend, the Panel was concerned about the mental health conditions and child care stress of those elders who were carers of their grandchildren. **(Recommendations AS5 & AS6)**

(II) Youth Exposed to Cyber Risks:

- A young girl was assaulted by a male stranger whom she knew through the social media, WeChat, for private photo shooting at an agreed fee. Like many youngsters nowadays, the deceased girl liked using social media, including "Facebook", "Instagram" and "WeChat" for communication. However, given her young age and inexperience, the girl had little if not without alertness of the perils of meeting up with and engagement in activities with strangers which resulted in her tragic death.

- Cybercrimes were common nowadays. In view of increasing sex crimes involving underage girls making acquaintances through the Internet, young people should be educated to be alert of the dangers of such and to protect themselves when using the Internet. **(Recommendations AS7 & AS8)**

(III) Distress of Children of Separated/Divorcing/Divorced Couples

- There would be risk for children, having parents undergoing divorce with high conflicts, as in the tragic death of two children being killed by a father, who experienced great distress in face of the broken marriage, loss of the children's custody and various family problems. Both of the separated parents failed to seek help from the professionals with the father keeping himself isolated and the mother's being denied access to the children by the father.

- Panel Members observed that divorcing couples and their children were usually in great distress during and after the divorce process. Many of these children suffered a lot in face of their parents' fight for the custody and access.

- Co-parenting and supportive services for separated/divorcing/divorced couples should be strengthened so that these parents could learn how to minimise the conflicts and to safeguard the interests of their children so as to strive for an everlasting parenthood for their children despite the parents' separation. **(Recommendations AS9 to AS11)**

(IV) Co-sleeping and Other Sleeping Safety

- 11 child deaths under non-natural unascertained cause were found to be related to co-sleeping or other unsafe sleeping arrangement. Appropriate sleeping arrangement for babies might have prevented these tragic deaths. Sleep safety issues for children and the recommendations will be discussed under the thematic topic of Co-sleeping and Other Sleeping Safety in **Chapter 8**. **(Recommendations AS12 to AS16)**

(V) Drug-abusing Parents:

- The death of a baby was found to be related to drug-taking behaviour of his mother. The baby, who was placed under the sole care of his drug-addicted mother, was found dead after he was left alone at home. It was observed that the mother, with long history of drug-abuse and delinquent behaviour, adopted a carefree attitude in child care. Given the mother's unruly behaviour and poor sense of responsibility under the adverse effects of drugs, she failed to have adequate vigilance on raising a baby by leaving him alone at home. Despite that the cause of child death in this case was unascertained, Panel Members viewed that the abuse of drugs by parents/carers had weakened their child care ability and the contaminated living environment was hazardous to the health of children. **(Recommendations AS17 to AS19)**

(VI) Concealment of Pregnancy:

- 3 fatal cases under non-natural unascertained cause were found to be related to concealment of pregnancy. Observations on cases related to concealment of pregnancy and the recommendations will be discussed under the thematic topic of concealment of pregnancy in **Chapter 8**. **(Recommendation AS20)**

07 Recommendations Made and Responses from Concerned Parties

7.1 Concerning Child Death Cases by Natural Causes

Recommendation N1

To reiterate previous recommendation that autopsy may help provide more information on the cause(s) of death for prevention purpose.

Responses/Updates to Recommendation N1

Department of Health (DH)

Forensic pathologists of DH handle reportable deaths under the Coroners Ordinance (Cap.504) and the authority to order an autopsy to be conducted or waived comes under the jurisdiction of the Coroner. If the circumstances with respect to the cause of death are unclear, forensic pathologist would normally recommend an autopsy to the Coroner despite request for a waiver by the family.

Coroner's Court

The Coroners are not in a position to comment on the judicial decision made in individual cases.

Recommendation N2

Public education on "safe sex" and "proper management of pregnancy" should be continued so as to prevent child death out of concealment of pregnancy.

Responses/Updates to Recommendation N2

Department of Health (DH)

Maternal and Child Health Centres (MCHCs) under Family Health Service of DH provide family planning service for women of childbearing age. Contraceptives including emergency contraception are prescribed according to individual needs. Counselling and referral will be offered to women with unwanted pregnancy. Concerning sexual health education, safer sex is emphasized to reduce the chance of contracting sexually transmitted diseases and developing cervical cancer. Health educational materials are also translated into languages of ethnic minorities.

Recommendation N3

A standard protocol with clear referral mechanism should be set up by the government requiring forensic pathologist to refer the case to clinical genetic service (CGS) to conduct molecular or genetic testing if deceased child's cause of death was unascertained, related to genetic disorder or inborn errors of metabolism.

Responses/Updates to Recommendation N3

Department of Health (DH)

Starting from October 2017, forensic pathologists of the DH would refer deaths suspected of suffering from inheritable cardiac conditions or deaths with obscure autopsy findings to the Clinical Genetic Service (CGS) of the DH for post-mortem molecular testing using Next Generation Sequencing. If a genetic cause is identified in the deceased, the CGS will provide genetic counselling for family members and perform family cascade screening if indicated.

Hospital Authority (HA)

HA agrees with the view of the CFRP on setting up a standard protocol with a clear referral mechanism to conduct molecular or genetic testing and subsequent referral if the deceased child's cause of death was unascertained or related to genetic disorder or inborn errors of metabolism.

7.2 Concerning Child Death Cases by Suicide

Recommendation S1

To enhance children/youths' alertness and response skills when they identify or receive distress messages or suicidal threats from their peers/schoolmates, such as via instant message in mobile phone or social media, like notifying the school social workers or trustworthy adults promptly so that the latter can report to the Police at once in critical situation.

Responses/Updates to Recommendation S1

Education Bureau (EDB)

The Education Bureau (EDB) has been educating students about mental wellness, signs of mental distress and help seeking behaviour through talks/workshops and various programmes. The Department of Health (DH) and EDB jointly launched the "Joyful@School" Campaign in the 2016/17 school year which has been continuously delivered in the 2017/18 and 2018/19 school years to enhance students' awareness and understanding of mental health, willingness of help-seeking and reduce the stigma associated with help-seeking behaviour. Schools (or in collaboration with non-governmental organisations (NGOs)) can submit proposals to the Quality Education Fund for funding not exceeding $200,000 through simplified application procedures to organise related activities.

Department of Health (DH)

DH launched an infotainment website "YouthCan.hk" in August 2017 (www.youthcan.hk). Focused around school life, it supports teenagers to meet the challenges and handle problems during adolescence by providing health knowledge, basic life skills, and community resources presented in entertaining ways.

Enrolled primary and secondary school students at the Student Health Service Centre will be given an annual appointment for health screening including screening for psycho-social health, self-esteem and behavioural problems. Counselling and advice are provided according to the screening results and concerns raised by students /parents.

Besides, Adolescent Health Programme provides outreaching service to secondary schools aiming to improve the psychosocial health of adolescents by enhancing their self-understanding and acceptance, emotions and stress management as well as harmonious interpersonal and problem-solving skills. In 2016, a pilot Booster Programme was launched for Secondary Three students to further strengthen their psychosocial health and resilience so as to empower them to solve the problems and meet the challenges that they encountered.

Recommendation S2

To enhance the public's sensitivity and knowledge on symptoms of "early psychosis" and "depression" and relevant treatment required.

Responses/Updates to Recommendation S2

Education Bureau (EDB)

Learning elements related to emotions management, ways to cope with negative emotions and enhance the understanding of oneself, etc. are incorporated into the curricula of different Key Learning Areas/subjects, such as General Studies at the primary level, Life and Society at the junior secondary level and Liberal Studies at the senior secondary level, as well as Moral and Civic Education in primary and secondary schools.

EDB also developed different resources to help schools identify and support students with mental health needs, including those with suicidal risk. EDB published "A Resource Handbook for Schools: Detecting, Supporting and Making Referral for Students with Suicidal Behaviour" and launched a webpage of "Prevention of Student Suicide" in March 2017. In August 2017, EDB also published in collaboration with the Hospital Authority the "Teacher's Resource Handbook on Understanding and Supporting Students with Mental Illness" to facilitate schools to identify and support students with mental illness, including depression, anxiety disorders and psychosis.

Recommendation S3

To strengthen mental health education to the public by delivering the message that mental illness is "highly treatable" and to encourage those who suspect themselves to be suffering from mental illness to seek professional help at once.

Responses/Updates to Recommendation S3

Education Bureau (EDB)

Through dissemination of the resources as mentioned above in the Response/ Updates to Recommendation S2 and organising various talks/seminars in collaboration with medical professionals, EDB has been conveying the messages to students, teachers and parents that mental illness is treatable and seeking help is encouraged.

In particular, EDB has invited the University of Hong Kong to collaborate with 15 secondary schools to conduct "Mindshift + Educational Programme" (9/2017 – 3/2019) to strengthen students' understanding of "early psychosis" and other mental illnesses through talks, skills training and community service. The programme is further enhanced as "Mindshift Educational Networking Programme" to be launched in the 2019/20 school year.

Responses/Updates to Recommendations S2 and S3

Department of Health (DH)

Adolescent Health Programme provides out-reaching health promotion service for secondary school students, their parents and teachers in the school setting. The aim is to improve the psycho-social health of adolescents by empowering them with necessary basic life skills including stress management and problem solving. Students are encouraged to seek early professional help if they have emotional or depressive symptoms. There is also a programme for enhancing teachers and parents' awareness and handling of susceptible adolescents for the prevention of adolescent suicide.

Enrolled primary and secondary school students at the Student Health Service Centre will be given an annual appointment for health screening including screening for psycho-social health, self-esteem and behavioural problems. Counselling and advice are provided according to the screening results and concerns raised by students/parents. Students may be referred to clinical psychologists of Student Health Service, school social workers, Social Welfare Department, non-governmental organisations or Hospital Authority's psychiatric specialists for further assessment and follow up as appropriate.

Moreover, as announced in the 2018 Policy Address, the Government has earmarked an annual funding of $50 million to embark on an on-going mental health promotion and public education initiative. The first phase of the new initiative will commence in the first half of 2019, which aims to enhance public understanding on mental health, thereby reducing stigmatisation towards persons with mental health needs, with a view to building a mental-health friendly society in the long run.

Hospital Authority (HA)

HA has implemented the EASY Programme since 2001. Targeting people aged between 15 and 64 with first episode psychosis, the Programme offers one-stop, phase-specific and ongoing support for the first three critical years of illness. Public education and promotional programmes are also organised under the Programme to enhance awareness of mental health in the community.

HA has implemented the Child and Adolescent Mental Health Community Support Project ("CAMcom") providing children and adolescents aged between 6 and 18 with anxiety or depression problems with appropriate assistance to help them overcome their emotional problems and prevent their problems from getting worse so that they can resume their normal learning, social and family life.

In addition, the Food and Health Bureau, in collaboration with the Education Bureau, HA and the Social Welfare Department, has launched a two-year pilot scheme of "Student Mental Health Support Scheme" (SMHSS), based on a medical-education-social collaboration model, in the 2016/17 and 2017/18 school years in 17 schools to establish school-based multi-disciplinary platforms for providing better support for students with mental health needs. In the 2018/19 school year, HA has rolled out SMHSS to support a total of around 40 schools and enhanced the multi-disciplinary teams for child and adolescent psychiatric service in the five clusters to provide better support for the school-based multi-disciplinary platform under SMHSS. Also, at the same school year, service elements of CAMcom have been incorporated into SMHSS to assist in the early identification of suspected cases of children and adolescents with mental health needs. HA has planned to further roll out SMHSS to more schools in the 2019/20 school year.

Social Welfare Department (SWD)

The 24 Integrated Community Centres for Mental Wellness (ICCMWs) subvented by the SWD provide one-stop, district-based community mental health support service ranging from prevention to risk management for ex-mentally ill persons and persons with suspected mental health problems aged 15 or above, their family members/carers and the residents living in the serving district.

In 2019-20, ICCMWs will extend their support service to cover all secondary school students with mental health problems. By scaling up professional intervention for those adolescents with mental health problems and their parents/carers, SWD aims to step up early intervention, prevent their mental problems from further deterioration, as well as enhancing collaboration among various sectors in working with adolescents in need. SWD will also deploy five mobile publicity vans in five regions over the territory, through roadshow, mini talks, simple consultations, etc. to step up community education for early prevention of mental illness and promotion of mental health.

Recommendation S4

To enhance parents' understanding of the needs of their children with Special Educational Needs (SEN) and advise parents to set appropriate expectations on these children.

Responses/Updates to Recommendation S4

Education Bureau (EDB)

The Committee on Home-school Co-operation has been conducting talks for parents with SEN children to enhance parents' understanding of the needs of their children in learning, as well as to assist parents to support children through daily life, home-school co-operation and community resources.

To help parents understand how to support their children with SEN, EDB has produced the "Parent Guide on the Whole School Approach to Integrated Education", various information leaflets and resource packages as well as conducting talks/seminars. Schools are also requested to closely communicate with parents.

Social Welfare Department (SWD)

Please refer to the above Responses/Updates to Recommendations S2 and S3.

Recommendation S5

Schools should accommodate the needs of SEN children as well as those with mental illness in early recovery stage so that they could learn happily and not being hard pressed by the requirement of following the school syllabus. These children need more support and allowance through cross-disciplinary collaboration. Emphasis should be placed on individual educational plan (IEP), particularly for those students having limited intelligence and suffering from mental illness.

Responses/Updates to Recommendation S5

Education Bureau (EDB)

Schools are encouraged to adopt a Three-tier Support Model to detect and support students with SEN, including students with mental illness. Students with severe learning and/or adjustment difficulties would be given intensive individualized support, such as IEP.

Since the 2017/18 school year, the Learning Support Grant that EDB provides for public sector ordinary schools has covered students with mental illness so that schools will have additional resources to enhance their support to cater for these students' learning, social, emotional and behavioural needs. Besides, FHB launched in collaboration with EDB, HA and SWD the "Student Mental Health Support Scheme" since the 2016/17 school year to provide appropriate support services to students with mental health needs and their carers through the multi-disciplinary teams at the school-based platform. 41 schools participated by the 2018/19 school year. This Scheme will include more schools for support in the 2019/20 school year.

Recommendations S6

The Education Bureau is advised to provide training for teachers to have more understanding on needs of SEN children by inviting mental health professionals and educational psychologists to deliver talks to teachers preferably using case studies.

Responses/Updates to Recommendation S6

Education Bureau (EDB)

EDB has been providing serving teachers with structured training courses on supporting students with SEN pitched at Basic, Advanced and Thematic levels. Since the 2017/18 school year, EDB has also conducted the "Professional Development Programme for Mental Health" delivered by different disciplines, including psychiatrists, psychologists, using various teaching modes, such as lectures, discussions, case studies, etc.

EDB also arranges professional training for Special Educational Needs Coordinators to enhance their professional capacity.

Recommendations S7 and S8

Recommendation S7

Children with underlying mental illness would be at higher risk of suicide. Family members should be alert of that and escort their children to seek assessment and/or management by mental health professionals at once when they are found to be mentally unstable.

Recommendation S8

To advise parents to keep proper storage of psychiatric medication for their children, who suffer from depression with suicidal intent, so as to prevent them from easy access for drug overdose.

Responses/Updates to Recommendations S7 and S8

Department of Health (DH)

Enrolled primary and secondary school students at the Student Health Service Centre will be given an annual appointment for health screening including screening for psycho-social health, self-esteem and behavioural problems. Counselling and advice are provided according to the screening results and concerns raised by students/parents. Students may be referred to clinical psychologists of Student Health Service, school social workers, Social Welfare Department, non-governmental organisations or Hospital Authority's psychiatric specialists for further assessment and follow up as appropriate.

Besides, Adolescent Health Programme has a programme for enhancing teachers and parents' awareness and handling of susceptible adolescents for the prevention of adolescent suicide.

Hospital Authority (HA)

The Child and Adolescent Psychiatric Service of HA comprising healthcare practitioners in various disciplines provides early identification, assessment and treatment services for children and adolescents in need. The multi-disciplinary professional team, including doctors, clinical psychologists, nurses, speech therapists, occupational therapists and medical social workers, provides a range of appropriate treatment and follow-up for children and adolescents, including in-patient service, specialist out-patient service, day rehabilitation training and community support service according to their clinical conditions, with a view to enhancing their speech and communication, social, emotions management, problem solving, learning and life skills.

The multi-disciplinary professional team also provides parents and carers of the children and adolescents in need with information on the respective illnesses (including psychiatric medication) so as to enhance their understanding of the symptoms and treatment needs of their children. The professional team also maintains close communication with related organisations, such as early training centres and schools, to provide support according to the developmental needs of the children and adolescents.

Recommendation S9

Parents should be equipped with the knowledge of the possible subtle signs of depression of their children, such as "school refusal", especially when their children have just been promoted to Form One.

Responses/Updates to Recommendation S9

Educational Bureau (EDB)

EDB launched a parent education website called "Smart Parent Net" in February 2018 which enables parents of kindergarten, primary and secondary school levels to easily access useful information on supporting the physical and mental development of students (including parent-child relationship, character development, discipline of children, managing children's emotional and psychiatric problems, etc.

The Committee on Home-school Co-operation has also been conducting parent talks on enhancing parents' understanding and skills to handle their children's emotional and behavioural problems.

Recommendation S10

School refusal is a warning sign of teenagers' unstable emotions which requires attention and intervention by the helping professionals. For those with suicidal threats, clinical psychologist or psychiatrist should be involved.

Responses/Updates to Recommendation S10

Educational Bureau (EDB)

EDB has stated clearly the relevant policy in the circular on "Upholding Students' Right to Education" issued in January 2009 and schools are reminded to step up measures for upholding students' right to education. Schools should put in place a mechanism for timely and proper intervention from teachers in collaboration with guidance and discipline personnel, school social workers, school-based educational psychologists or youth work organisations in the community so that appropriate support can be provided to at-risk students or marginal non-attendance students. If symptoms of school refusal are found in non-attendance students, EDB would refer these cases, depending on their needs, to Social Welfare Department or relevant social services agencies for appropriate professional services. Schools should also develop their attendance policies with a view to promoting students' regular attendance, harmonious teacher-student relationship, a caring school atmosphere and close home-school partnership.

Recommendation S11

To help students build up resilience in face of adversity and academic challenges when promoted to Form One by incorporating the components of "stress inoculation", "mental wellness" and "how to seek help" into the bridging or adjustment class, especially for those who used to have good academic result with high self-expectation but without experiencing failure in their primary schooling.

Responses/Updates to Recommendation S11

Educational Bureau (EDB)

EDB encourages schools to strengthen the element of enhancing students' mental well-being in the bridging programmes for Secondary One and Secondary Four students. EDB has conducted seminars for teachers and student guidance personnel to share good practices on Secondary One bridging programmes and on supporting Primary Six students for smooth transition to secondary schools. EDB will continue encouraging schools to make use of the case referral mechanism to enable students in need to receive continuous support after promoting or transferring to other schools.

Helping our students to lead a healthy lifestyle is one of the seven learning goals of the school curriculum. Besides providing training sessions for school personnel, EDB encourages schools to enhance students' resilience and help them take care of their own overall wellness including mental/psychological health through whole-school curriculum planning. Schools are also encouraged to provide a greater variety of life-wide learning opportunities to broaden students' horizons and enrich their learning experience which help nurture perseverance, resilience and empathy for others in students.

Responses/Updates to Recommendations S9 to S11

Department of Health (DH)

Enrolled primary and secondary school students at the Student Health Service Centre will be given an annual appointment for health screening including screening for psycho-social health, self-esteem and behavioural problems. Counselling and advice are provided according to the screening results and concerns raised by students/parents. Students may be referred to clinical psychologists of Student Health Service, school social workers, Social Welfare Department, non-governmental organisations or Hospital Authority's psychiatric specialists for further assessment and follow-up as appropriate.

Adolescent Health Programme provides outreaching health promotion service to secondary school students, their parents and teachers in the school setting. The aim is to improve the psycho-social health of adolescents by empowering them with necessary basic life skills including stress management and problem solving. Students are encouraged to seek early professional help if they have emotional or depressive symptoms. There is also a programme for enhancing teachers and parents' awareness and handling of susceptible adolescents for the prevention of adolescent suicide.

Besides, DH launched an infotainment website "YouthCan.hk" (www.youthcan.hk) in August 2017. Focused around school life, it supports teenagers to meet the challenges and handle problems during adolescence by providing health knowledge, basic life skills, and community resources presented in entertaining ways.

Recommendation S12

In order to tackle peer bullying, especially via social media, such as: WhatsApp, snapchat, etc., students should be taught to have "empathy" for one another. Students being bullied are to be advised to seek help from teachers or school social worker at once. The bullies may also suffer from psychopathologies and so may need attention and help.

Responses/Updates to Recommendation S12

Education Bureau (EDB)

EDB attaches great importance to the whole-person development and the cultivation of positive values and attitudes among students. Schools are required to incorporate life education into the school curriculum to help students learn to respect each other, acquire communication/social skills, resolve conflicts and nurture a sense of empathy among them so as to minimise the occurrence of bullying incidents.

EDB has launched the Harmonious School Net and the Wise NET School Recognition Scheme for inter-school sharing of information and organising mass programmes so as to assist schools to cultivate a harmonious and caring school culture.

We also advise schools that through parent education and promotion, parents are encouraged to listen patiently to their children's bullying problems, support them to face the problems with a caring attitude, maintain communication with their schools, and seek help from teachers, guidance personnel and social workers whenever necessary.

Department of Health (DH)

Enrolled primary and secondary school students at the Student Health Service Centre will be given an annual appointment for health screening including screening for psycho-social health, self-esteem and behavioural problems. Counselling and advice are provided according to the screening results and concerns raised by students/parents. Students may be referred to clinical psychologists of Student Health Service, school social workers, Social Welfare Department, non-governmental organisations or Hospital Authority's psychiatric specialists for further assessment and follow-up as appropriate.

Adolescent Health Programme provides out-reaching health promotion service to secondary school students, their parents and teachers in the school setting. The aim is to improve the psycho-social health of adolescents by empowering them with necessary basic life skills including stress management and problem solving. Students are encouraged to seek early professional help if they have emotional or depressive symptoms.

Recommendation S13

To promote a "Caring and Loving" culture at school in order to strengthen mutual care among students and to teach them how to respond to their peers' expression of emotional distress or suicidal thoughts at the Life Education Class.

Responses/Updates to Recommendation S13

Education Bureau (EDB)

The learning elements of life education, such as "understand life", "cherish life", "respect life" and "explore life", have already been incorporated into different learning themes under the school curriculum. For example, topics on "respect and value life" have been included in General Studies at the primary level and Life and Society Curriculum at the junior secondary level. The meaning of "life and death" can be explored in Ethics and Religious Studies at the senior secondary level. In the learning of Liberal Studies at the senior secondary level, students can understand their personal strengths and weaknesses, and learn how to manage stress and frustration and how to make decisions under the pressure of challenges for a positive and meaningful life.

Over the past years, EDB has organised the Caring School Award Scheme in close collaboration with non-governmental organisations/associations, to award schools with good efforts in promoting "Life Education", "Home-school Cooperation", "Caring Staff Team", etc. so as to encourage more schools in the building of a caring school culture.

Recommendation S14

Schools could consider renaming the "remedial class" as "enhancing class" so as to get rid of its negative connotation.

Responses/Updates to Recommendation S14

Education Bureau (EDB)

Other than considering naming activities/classes in a positive manner, schools should use appropriate strategies to embrace learner diversity, help students improve through identifying and building on their strengths. For example, planning for a whole-school curriculum that caters for students' abilities, interests and learning needs, offering a wide range of life-wide learning activities and Other Learning Experience, adopting different modes of assessment to understand students' performance and needs so as to provide feedback and improve learning and teaching. Teachers can provide an inviting and secure learning environment that embraces and respects learner differences, engages students in setting and reviewing learning targets, promotes peer support and assessment, and encourages active learning, risk-taking, student collaboration and reflection. They can vary the teaching approach and questioning technique, adopt multiple means of presentation, use a variety of e-learning tools and resources, use flexible grouping arrangements and assign different tasks in accordance with the students' abilities and interests, etc.

Recommendation S15

Parents should spend more time and make more effort to communicate with their children at an "emotional level" so that they can get more in touch with their children's feelings or emotions and help their children ventilate the distress.

Responses/Updates to Recommendation S15

Education Bureau (EDB)

A Task Force on Home-school Co-operation and Parent Education (Task Force) was set up under the Education Commission in December 2017 to review the existing approach and formulate the directions and strategies for fostering home-school co-operation and promoting parent education. It aims to assist parents to help their children grow up happily and healthily and learn effectively through promotion of correct understanding of developmental needs of children. The Task Force completed the review and submitted the report to EDB in April 2019. The Task Force has proposed a number of comprehensive measures to promote universal, diversified and innovative home-school co-operation and parent education activities with a view to facilitating parents' comprehensive understanding of their children's development needs and strengthen their ability, knowledge, skills and attitude in parenting so as to create an enjoyable and healthy learning and living environment for students.

Please also refer to the above Responses/Updates to Recommendation S9.

Recommendation S16

To strengthen parent education in handling teenagers' conduct problems. Parents should control their emotions when confronting the misbehaviour of their children and beware of their use of words which might easily trigger the children's impulsive reaction.

Responses/Updates to Recommendation S16

Education Bureau (EDB)

The Committee on Home-school Co-operation has been conducting parent talks on parenting skills, nurturing "positive kids", parent-child communication with a view to enhancing parents' understanding and skills to handle their children's emotional and behavioural problems.

Responses/Updates to Recommendations S15 and S16

Social Welfare Department (SWD)

Family life education provided by Family Life Education Units, Integrated Family Service Centres and Integrated Services Centres includes groups and programmes on equipping parents with effective parenting, positive communication and conflict resolution, as well as teaching parents how to interact with their children for maintaining harmonious relationship. These service units collaborate with schools to offer targeted programmes for students and their parents in order to enhance their understanding of the developmental needs of children and equip them with effective communication and parenting skills. Related articles and pamphlets promoting effective parenting skills are also uploaded to SWD Homepage for easy access by the public.

Under a preventive approach, SWD will continue to work closely with relevant partners and stakeholders in providing a comprehensive network of welfare services to preserve and strengthen the family as a unit for developing a caring family relationship.

Recommendation S17

Teenagers should be taught the harmful effects of alcohol at school.

Responses/Updates to Recommendation S17

Education Bureau (EDB)

Learning elements related to the health hazards of alcohol, smoking and drug abuse are included in the curricula of Key Learning Areas/subjects and related school-based learning activities of primary and secondary schools. Through various programmes for promotion of students' health awareness and good habits for healthy living, students learn to face challenges in personal growth with a proactive attitude, develop independent thinking and problem solving skills, be able to make reasonable judgements and decisions, thereby enhancing their resilience against substances such as alcohol, drugs and tobacco. Since 1995, EDB has commissioned the Life Education Activity Programme (LEAP) for delivering health-based education programmes to primary school students to help prevent substance abuse.

Department of Health (DH)

The Student Health Service of the DH organises health promotion activities on alcohol prevention, including regular "Junior Health Pioneer Workshop" for P.3 students and the outreach classroom talk "Refusal Skills" for S.1 students. Through interactive talks and games, these activities aim to increase students' knowledge on harmful effects of alcohol consumption, smoking, drug abuse and excessive use of internet and electronic screen products, and teach students about refusal skills. Another talk "Psychological Health of Adolescents" also touches on the harmful effects of alcohol and discourages young people from consuming alcohol in order to reduce stress. Doctors and nurses conduct personal counselling for students with alcohol problems. Pamphlets on healthy living, refusal skills on alcohol consumption and healthy use of internet and electronic screen products are distributed to students attending the Student Health Service Centres.

Further to the full implementation of the Action Plan to reduce alcohol-related harm, DH launched the "Young and Alcohol Free" campaign in late 2016 targeting young people and their significant others. Youth-specific education materials, audio-visual resources, social media publicity, educational activities and student workshops have been organised to prevent underage drinking. In May 2018, the Government launched the "Towards 2025: Strategy and Action Plan to Prevent and Control Non-communicable Diseases in Hong Kong" which had set a target on reducing harmful use of alcohol, among its 9 NCD targets.

The Dutiable Commodities (Amendment) Ordinance 2018 commenced on 30 November 2018. It prohibits the sale or supply of alcohol to minors in the course of business. With this new legislation in effect, alcohol access should be reduced among youth in Hong Kong, in turn reducing the effects of alcohol related harm among youth.

Recommendation S18

To strengthen courtship education for students with emphasis on how to handle "breakup" and cope with "loss".

Responses/Updates to Recommendation S18

Education Bureau (EDB)

Learning elements related to sex education such as personal development, making friends and dating are included in the curricula of Key Learning Areas/ subjects and related school-based learning activities of primary and secondary schools. EDB has been producing and updating learning and teaching resources to support schools to foster students' positive values and attitude towards sex-related issues, encourage them to build healthy interpersonal relationships (including how to handle relationship breakup rationally), as well as make reasonable judgement and responsible choices based on rational and objective analyses.

EDB has also been organising seminars regularly for teachers and social workers of primary and secondary schools to facilitate their understanding of the recent trends of teenagers' concepts of love and sex, modes of love and relationship and possible threats. Teachers are also equipped to counsel and support students in facing challenges arising from their love relationships, including problems on break-up, sexual harassment and sexual violence, etc.

Social Welfare Department (SWD)

SWD continues to provide a range of services, including Integrated Children and Youth Services Centres and School Social Work Service for secondary schools to counsel and support young persons to handle courtship problems and relationship breakups.

7.3 Concerning Child Death Cases by Accident

Recommendations A1 to A3

Recommendation A1

To reiterate the previous recommendations that young children should never be left alone or unattended at home, even for a very short period of time and especially when they were asleep.

Recommendation A2

To make every safety measure to prevent falls of children, parents should install proper window grilles (including grilles for louver windows as well) and ensure the window grilles are designed with adequate protection for children and are properly locked at all times.

Recommendation A3

To disseminate the message and to enhance training on child safety for foreign domestic helpers through their employment agencies, Consulates-General or labour unions.

Responses/Updates to Recommendations A1 and A2

Department of Health (DH)

The Maternal and Child Health Centres (MCHCs) of DH provide a comprehensive range of health promotion and disease prevention service for children from birth to five years. Parents-to-be and parents of young children are provided with anticipatory guidance on childcare (including home safety), child development and parenting issues through various channels.

Ensuring a safe home environment is a key role of parents, MCHC has strengthened its health advice on home safety for carers. Parents first attending MCHCs will be provided with home safety information and they are asked to complete a home safety check list and then reviewed by nurses. Relevant advice and follow-up will be arranged as necessary. For families identified to have specific risk conditions and need extra support, they will be referred to relevant social services for further management.

Apart from individual advice, parents/carers and the public can also access to different printed and audio-visual home safety health education resources (including prevention of falls) for children of different age groups through the Family Health Service website, telephone hotline, e-newsletters, workshops and talks.

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.

In addition, an e-book to highlight potential hazards and safety precautions in relation to common household items is under preparation. Safety recommendations related to the safe use of bed and window frame are included. Parents are the key target audience.

Social Welfare Department (SWD)

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, highlighting such messages as 'neglect once, regret forever' and 'child neglect is a criminal offence'. On-going publicity measures will be taken by the Department.

Proper sense of responsibility and parenting attitude to ensure the 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).

Recommendations A4 to A6

Recommendation A4

To reiterate the previous recommendation of raising parents and caregivers' awareness of appropriate sleeping arrangement for young children, such as not to arrange for them to sleep alone on a high bed without a fence or having a gap between the bed and the wall.

Recommendation A5

To reiterate the previous recommendation of reminding parents and caregivers to seek immediate medical attention at once when children sustained/were suspected to have sustained head injuries, especially from a fall even without any obvious/observable injuries.

Recommendation A6

To enhance parents' knowledge on home safety for infants and to consider placing slip resistant rubber mats on the floor so as to prevent infants from slipping at home.

Responses/Updates to Recommendations A4 to A6

Department of Health (DH)

Please refer to the above Responses/Updates to Recommendations A1 and A2.

Recommendations A7 to A9

Recommendation A7

To enhance parents' awareness of the risk of suffocation for very young babies when they roll over to a face-down position on a bed being placed with soft objects, such as pillows, cushions, bumpers, blankets and stuffed toys, etc. as babies could easily be smothered by these objects.

Recommendation A8

To remind parents to pay special attention to the sleeping arrangement for their babies when they have to sleep at a place other than their familiar home environment.

Recommendation A9

The Department of Health should further promote "sleeping safety for babies" to parents-to-be during the pre-natal and post-natal check-up through audio-visual means or delivery of information kits.

Responses/Updates to Recommendations A7 to A9

Department of Health (DH)

Baby's sleep safety is an important home safety issue. Maternal and Child Health Centres (MCHCs) of the DH provide parents-to-be, parents and carers with health education on sleep safety and the risk of co-sleeping with the baby through individual counselling, education booklets, website, parenting workshop and audio-visual resources.

A new health education video "Baby's safe sleeping position and environment--you are the one to care" covering important key messages of sleep safety in infants was produced in early 2018. Apart from broadcasting in MCHCs, the video is also uploaded to FHS website and YouTube channel. Periodic public broadcasting in mass transit system has also been arranged to increase public awareness of this issue.

The leaflet on "Protect Baby from Sudden Infant Death Syndrome (SIDS)" and factsheet "Providing a safe environment for your baby" with specific items on sleep safety are being given to parents-to-be and new parents. These can also be accessed through the Family Health Service website.

Parents of young babies attending MCHC are routinely asked to complete a checklist on "Is Your Baby Safe at Home?" and then reviewed by the nurses. Relevant advice and follow up will be arranged as necessary. For families identified to have specific risk conditions and need extra support, they will be referred to relevant social services for further management.

Recommendations A10 to A12

Recommendation A10

To remind the public to call '999' at once when witnessing the breakout of a fire.

Recommendation A11

To continue strengthening public education on fire prevention and safety issues such as ways of escape from a fire, whether to stay or leave the household unit and whether it is appropriate to put out the fire by oneself.

Recommendation A12

To continue strengthening public education on the proper use of electrical home appliances and installations.

Responses/Updates to Recommendations A10 to A12

Fire Services Department (FSD)

The FSD integrated the Community Relations Section of the Fire Safety Command and the Community Relation Unit of the Ambulance Command into a new Community Emergency Preparedness Division ("CEPD") in October 2018.

The CEPD reaches out to different age and community groups through platforms such as social media (Facebook and YouTube), conventional training courses, publicity campaigns, advertisements and exhibitions, in a bid to raise the public's awareness of emergency preparedness as well as their response capabilities in case of danger or emergencies, which include the proper usage and maintenance of fire service installations and equipment, the response skills and survival methods in case of fire.

To further promote people's awareness of accident prevention at home, FSD will devise a "Checklist for Safe Home" in 2019 to facilitate the general public to carry out self-inspection for identifying the potential risks at home and rectifying the irregularities identified.

Responses/Updates to Recommendation A12

Electrical and Mechanical Services Department (EMSD)

Proper use and maintenance of electrical appliances is an important household electrical safety issue. EMSD has continued to strengthen the publicity works to remind the users on proper use and maintenance of electrical appliances such as to consider switching off the electrical appliances if not in use and no more than one adaptor or one extension unit to be inserted into a socket outlet to prevent circuit overload through various channels, e.g. TV API, radio broadcast, elderly and school visits, etc.

The leaflets on "Use Household Electrical Appliances Properly" and "Regular Maintenance on Electrical Appliances" were produced by EMSD. They can be read or downloaded from the EMSD website (http://www.emsd.gov.hk).

7.4 Concerning Child Death Cases by Assault and Non-natural Unascertained Causes

Recommendation AS1

To enhance carer support service in special schools for parents in taking care of students with a wide range of disabilities.

Responses/Updates to Recommendation AS1

Education Bureau (EDB)

All along, EDB has been providing special schools with various resources for improving the quality of education. Schools are advised to deploy the resources in a holistic manner to support the diverse learning needs of students, and may promote home-school co-operation through organising a variety of activities and parent education programmes etc. Schools would also help and advise parents to take care of their children in consistence with the school practices so as to enhance the learning effectiveness.

Recommendation AS2

To advise the Education Bureau to review the current manning ratio of school social workers serving in special schools with a view to enhancing the manpower of school social workers in Special Schools.

Responses/Updates to Recommendation AS2

Education Bureau (EDB)

With effect from the 2018/19 school year, the provision of special school social workers to students has been enhanced to 0.5:30 to better support the needs of students. Special schools with approved capacity of 60 or below are also provided with one school social worker. Furthermore, special schools are provided with the Consultation Service Grant to enhance the support and supervision for their school social workers.

The provision of other specialists has also been enhanced in recent years in different types of special schools. For example, in the 2017/18 school year, occupational therapists are provided for schools with children with mild intellectual disability (ID), schools with children with moderate ID, schools with children with visual impairment (VI) and schools with children with hearing impairment. A speech therapist is also provided for schools for social development and schools with children with VI.

Recommendation AS3 and AS4

Recommendation AS3

To empower parents/carers in taking care of their disabled children by enhancing their knowledge of different available training or resources in the community.

Recommendation AS4

To encourage carers, especially male carers to seek help whenever in need and to join carer support groups/programmes for sharing and alleviating their distress.

Responses/Updates to Recommendations AS3 and AS4

Social Welfare Department (SWD)

Parents/Relatives Resource Centre (PRC) provides a focal point for parents and relatives/carers of persons with disabilities with similar problems to share their experience and seek mutual support with assistance from the staff. The services provided include casework counselling, therapeutic groups, supportive, social and recreational groups and mass programmes, resource materials, community education programmes, etc.

There is currently a total of six subvented PRCs, including one centre serving parents or carers of ex-mentally ill persons exclusively. The Government will set up additional 13 PRCs from 2018-19 to 2019-20 to strengthen the support for parents and relatives/carers of persons with disabilities.

Recommendations AS5 and AS6

Recommendation AS5

Family members should keep in view the caregivers' mental health, including those elderly persons who are entrusted with child care and be alert to any suicidal signs or depressive mood manifested by them so as to help them seek professional assistance promptly.

Recommendation AS6

To further enhance public knowledge of "depression" (including its symptoms and treatment) and encourage help-seeking through TV Announcements in the Public Interest (TVAPIs).

Responses/Updates to Recommendations AS5 and AS6

Social Welfare Department (SWD)

SWD provides subvention for 24 Integrated Community Centres for Mental Wellness (ICCMWs) over the territory to provide one-stop, district-based community mental health support services ranging from prevention to risk management for ex-mentally ill persons and persons with suspected mental health problem aged 15 or above, their family members/carers and the residents living in the respective serving district.

In 2019-20, SWD will also deploy five mobile publicity vans in five regions over the territory, through roadshow, mini talks, simple consultations, etc. to step up community education for early prevention of mental illness and promotion in mental health.

Department of Health (DH)

To enhance the elders' awareness, DH's Elderly Health Service (EHS) promotes psychosocial health to the elderly through various channels like media interviews, published books, news articles, and videos, etc. Health talks delivered to the elderly by EHS include depression, stress management, life and death education, and social isolation. Pilot project has also been initiated with the HK Red Cross training up volunteers to detect early mental signs during their home visits to the elders.

To support early detection and management of elderly mood problems, the Hong Kong Reference Framework for Preventive Care for Older Adults in Primary Care Settings recommends primary care doctors to conduct opportunistic screening of depression for older adults.

As announced in the 2018 Policy Address, the Government has earmarked an annual funding of $50 million to embark on an on-going mental health promotion and public education initiative. The first phase of the new initiative will commence in the first half of 2019, which aims to enhance public understanding on mental health, thereby reducing stigmatisation towards persons with mental health needs, with a view to building a mental-health friendly society in the long run.

Hospital Authority (HA)

HA has established a 24-hour mental health advisory hotline, namely the Mental Health Direct Hotline (Tel: 2466 7350) since 2012. The hotline is manned by psychiatric nurses to provide professional advice to patients, their carers and persons in need (including children and adolescents with mental health needs and their parents) on mental health issues.

Recommendations AS7 and AS8

Recommendation AS7

To alert youth to the importance of "self-protection" when using social media, such as "Facebook", "Instagram" and "WeChat" for making friends.

Recommendation AS8

To educate youth on the potential risks of making "fast and easy money", particularly by engaging in social activities which involved financial transactions under the name of "compensated dating", "private photo model" or "part-time girlfriend", etc.

Responses/Updates to Recommendations AS7 and AS8

Education Bureau (EDB)

The framework on "Information Literacy for Hong Kong Students", updated in 2016, enables schools to incorporate information literacy into their curriculum so as to foster students' ability and correct attitude to use information, including evaluating the reliability of information sources and guarding against dangers on the Internet. EDB also organised relevant professional development programmes for teachers. EDB has provided an information kit on e-learning for reference by schools in undertaking relevant parent education, and has organised seminars for parents to help develop proper attitude of their children in using information technology in daily life and study, in order to avoid internet addiction or access to undesirable information. Besides, a telephone hotline has been set up to provide individual support for parents, teachers and students in need. To further support teachers in developing students' information literacy and proper attitude on using information technology, EDB also produced the "Smart e-Master" Information Kit on e-learning for students in 2018.

EDB has been organising seminars regularly for teachers and social workers of primary and secondary schools, and published thematic articles through e-periodicals, to help them understand the issue of students' involvement in compensated dating and possible threats faced. Teachers are also equipped with prevention, intervention and supporting strategies as well as community resources with an aim to strengthen students' awareness of self-protection and avoid avoidance from dangers against material temptations.

Hong Kong Police Force (HKPF)

The Police is very concerned about sex crimes arising from making acquaintances on the Internet and adopts a four-pronged approach, namely (1) education and prevention, (2) intelligence gathering, (3) enforcement actions, and (4) multi-agency cooperation in combating relevant crimes.

(1) Education and Prevention

The Police places strong emphasis on educating the youth regarding the pitfalls of engaging in social activities which involved financial transactions. Seminars and workshops are regularly conducted to disseminate pertinent information to parents, teachers, students and other stakeholders of the community.

Regular liaison is maintained with Internet Service Providers to explore opportunities to post e-banner warnings on websites popular among the youths.

(2) Intelligence Gathering

Cyber patrol is conducted and cooperation with Internet Service Providers is maintained to monitor the trend and gather pertinent intelligence on crimes in relation to social networking on the Internet.

(3) Enforcement Actions

'Cyber Security and Technology Crime' has remained one of the Police's operational priorities. A dedicated unit from Crime KW has been established to coordinate the investigations of Compensated Dating related illegal activities and conduct intelligence-led enforcement actions under Operation WHALEDIVER.

Other Regions/ Districts will take proactive enforcement actions against illegal activities associated with Compensated Dating in their respective Regions/Districts.

The Cyber Security and Technology Crime Bureau (CSTCB) has increased manpower to enhance and expand the Police's capability and roles in combating technology crimes. CSTCB will provide technical support and training to investigators, secure evidence for prosecutions through computer forensic examination, seek mutual legal assistance from overseas jurisdictions, and collaborate with stakeholders including law enforcement agencies, Internet Service Providers and Internet Content Providers with a view to securing evidence for prosecutions.

(4) Multi-agency Approach

The Police will continue to work with stakeholders including the Social Welfare Department, Education Bureau as well as other NGOs to tackle crimes in relation to social networking on the Internet. Where appropriate, referrals will be made to these stakeholders with a view to making concerted efforts in combating relevant crimes.

Social Welfare Department (SWD)

To address the changing welfare needs of youth, the SWD has secured resources to set up five Cyber Youth Support Teams (CYSTs) in 2018-19. CYSTs will search for and engage at-risk and hidden youths, who may not prefer the conventional mainstream services, and provide timely social work intervention and support services.

Using internet as the platform, CYSTs will proactively search and engage high risk and hidden youth manifesting at-risk behaviour through online channels popular among the youth such as social media website and instant messaging software on mobile phones/computers, and provide them with on-line and off-line counselling services and intervention as well as referral services to relevant mainstream services.

Recommendations AS9 to AS11

Recommendation AS9

To reiterate the message that children have their own rights to survival which no one, including their parents, should take away.

Recommendation AS10

To strengthen co-parenting support services for separated/divorcing/divorced families.

Recommendation AS11

To further promote counselling service on peaceful separation and co-parenting for divorced couples, as well as, child-focused service for their children by delivering relevant pamphlets to them at the Family Court or through their representing lawyers.

Responses/Updates to Recommendation AS9

Social Welfare Department (SWD)

SWD has conveyed the recommendation to the Samaritan Befrienders Hong Kong (SBHK). Through its subvented service project, the Suicide Crisis Intervention Centre, SBHK provides dedicated services for persons in great distress and/or disturbed by suicide problem. In conducting public education, it also conveys positive life attitude, promotes messages on treasuring their lives and those of their children and enhances the general public's awareness on prevention of suicide. A video clip entitled "可唔可以唔死呀?" with the theme on treasuring children's life was produced and uploaded to social media and the Agency's Homepage for browsing by the general public (https://www.youtube.com/watch?v=D5hRsL7Jp_w).

Responses/Updates to Recommendations AS10 and AS11

Social Welfare Department (SWD)

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

The SWD launched a Pilot Project on Children Contact Service operated by NGO in September 2016 to assist separated/divorcing/divorced parents to maintain contact with their children in a safe and conflict-free environment.

The SWD had enhanced support measures for separated/divorcing/divorced families. The measures include :

- Additional manpower resources will be allocated to FCPSUs in 2018/19 to provide a range of early intervention services, co-parenting service as well as timely support for the children of families with history of domestic violence and on the verge of separation/divorce so as to reduce the negative impact of divorce on them.
- Five specialised co-parenting support centres, to be operated by NGOs, will be set up in 2019/20 to provide one-stop support services to the separated/divorcing/divorced parents and their children. Services to be provided include co-parenting counselling, child-focused counselling, groups or programmes as well as children contact services.
- The SWD had also produced a set of handbooks for parents and children respectively to provide information on co-parenting and to help children understand the issue of divorce. The handbooks had been distributed to government departments, NGOs concerned, service units, lawyers, etc. In addition, the SWD has launched a thematic website under the SWD homepage to promote the concept of parental responsibility, and to disseminate information on the relevant groups/programmes available in different districts. Two short animation videos have been produced and uploaded to the thematic website to further promote parental responsibility and co-parenting.
- The SWD supports districts to organise activities on family life education, marriage enrichment and anti-domestic violence to promote family harmony.
- SWD will continue to enhance the separated/divorcing/divorced parents' understanding on their children's emotions through organising psycho-educational programmes at the district level and to promote the concept of child-focused co-parenting through public education and publicity effort.

Responses/Updates to Recommendation AS11

The Law Society of Hong Kong

The Law Society could certainly plan and hold forums, seminars, workshops to alert the public on possible legal routes to protect our children. The relevant welfare authorities should be doing more to make all stakeholders aware of the paramount safety of children at all times.

Recommendations AS12 to AS16

Recommendation AS12

To reiterate the risk of co-sleeping with babies and raise the awareness of parents and caregivers not to arrange for baby sharing a bed with siblings or other children.

Recommendation AS13

To arouse parents' awareness of the threat of "wedging" between the bed and the wall and that very young babies are not totally immobile as commonly perceived to be.

Recommendation AS14

To remind parents and caregivers that babies should wear light and comfortable clothing at bedtime as too much clothing is unfavourable.

Recommendation AS15

To remind parents and carers that they will not be suitable to take care of babies when they are very tired or sick, after drinking alcohol or taking medicines with drowsy effect as their alertness will be reduced under such circumstances.

Recommendation AS16

To reiterate the message that parents and caregivers should conduct regular checking on babies while alseep or to install appropriate monitoring devices when the latter was sleeping alone.

Responses/Updates to Recommendations AS12 to AS16

Department of Health (DH)

Please refer to the above Responses/Updates to Recommendations A7 to A9.

Recommendations AS17 to AS19

Recommendation AS17

To further raise the public's awareness, especially for teenagers, of the harmful effects of drug abuse and the importance of staying away from illicit drugs.

Recommendation AS18

To provide education and support programmes for drug-abusing parents so as to raise their awareness of the harmful effects of illicit drugs on their children and to enhance their parental capacity.

Recommendation AS19

To alert and encourage family members of drug-abusing parents to render necessary child care assistance to the latter who are in definite need of child care and social support.

Responses/Updates to Recommendations AS17 and AS18

Social Welfare Department (SWD)

The SWD has been subsidizing NGOs to provide residential and community-based drug services to meet drug abusers' various needs.

Counselling centres for drug abusers collaborate with relevant social service units in the community and other professionals (e.g. medical practitioners and nurses) to provide appropriate follow-up and support for drug abusers and their families.

The NGOs also provide preventive education services to the at-risk youth and the public to enhance their awareness of drug harms and encourage them to seek early assistance.

Narcotics Division, Security Bureau

The Narcotics Division (ND) of the Security Bureau in collaboration with the Action Committee Against Narcotics (ACAN) will continue preventive education and publicity on the harmful effects of prevalent drugs, through different platforms, for different target groups including young persons.

The Beat Drugs Fund will continue to support worthwhile anti-drug projects on preventive education and publicity and on treatment and rehabilitation services for persons with drug abuse problems, including drug-abusing parents. Many funded projects have highlighted the harmful effects of drug abuse and the importance of staying away from illicit drugs. Other funded projects with drug-abusing parents as the target service recipients have included support services to stengthen their parental capacity and to enhance their motivation to quit drugs.

ND will continue to implement anti-drug initiatives for different target groups, including activities and programmes held at the Drug InfoCentre for young persons, parents and members of the public; anti-drug school education programmes for students, teachers and school personnel; and the Healthy School Programme and Participate in Sports, Stay Away from Drugs Programme for secondary schools.

Responses/Updates to Recommendation AS19

Social Welfare Department (SWD)

Multi-disciplinary collaboration is emphasised for early identification and intervention and enhance the case management for high risk cases (including young children with drug-abusing parents) under Comprehensive Child Development Service (CCDS). SWD will continue to work closely with relevant partners and stakeholders in providing a comprehensive network of welfare services to preserve and strengthen the family as a unit for developing a caring family relationship of these drug-abusing parents so as to alert and encourage their family members to render necessary child care assistance to the latter who are in definite need of child care and social support.

Recommendation AS20

To reiterate the previous recommendation of arousing awareness of the possible fatal consequence of concealment of pregnancy and the importance of seeking medical attention and social service support after getting pregnant or when giving birth to a baby.

Responses/Updates to Recommendation AS20

Education Bureau (EDB)

Learning elements related to sex education such as making friends, dating and protecting one's own body are included in the curricula of Key Learning Areas, subjects and related school-based learning activities of primary and secondary schools. EDB has been producing and updating learning and teaching resources to support schools to foster students' positive values and attitudes towards sex-related issues, enhance students' self-protection awareness, their ability to make reasonable judgement and responsible choices based on rational and objective analyses.

Social Welfare Department (SWD)

SWD will continue to arouse awareness of the possible fatal consequence of concealment of pregnancy, with emphasis on the consequence of unwanted pregnancy and the appropriate ways of handling through public education. SWD will deliver the message via educational leaflet encouraging women with unplanned pregnancy to seek help which has been uploaded to SWD homepage and the website of SWD FLERC. Integrated Children and Youth Services Centres provide a wide range of preventive, developmental and remedial services for children and youth; early identify children and young people in need as well as render timely counselling and support to them.

School social workers organise preventive and supportive groups/programmes for students in schools so as to support and arouse their awareness of the possible fatal consequence of concealment of pregnancy and the appropriate ways of handling unwanted pregnancy.

The "Positive Adolescent Training through Holistic Social Programme (P.A.T.H.S.) to Adulthood: A Jockey Club Community-Based Youth Enhancement Programme" provided by NGOs and coordinated by SWD with funding support from the Hong Kong Jockey Club Charities Trust also aims at instilling in students proper value as well as promoting an optimistic attitude in facing life adversities.

08 Child Death Cases Reviewed from 2006 to 2015

8.1 Observations by Thematic Topic

8.1.1 Co-sleeping and Other Sleeping Safety

8.1.1.1 Statistical Information on Co-sleeping

Total no. of cases = 37 (35 cases aged below 1; and 2 cases aged 1). 3 cases were also related to other sleep safety.

Table 8.1.1.1.1: No. of Cases by Year and Sex

Year	Female	Male	Total
2006	0	2	**2**
2007	1	0	**1**
2008	1	1	**2**
2009	2	2	**4**
2010	1	2	**3**
2011	2	5	**7**
2012	5	1	**6**
2013	1	4	**5**
2014	2	2	**4**
2015	1	2	**3**
Total	**16**	**21**	**37**

Table 8.1.1.1.2: No. of Cases by Nature of Death and Sex

Case nature	Type	Female	Male	Total
Natural	Chronic medical conditions with disabilities	0	1	**1**
Natural	Chronic medical conditions without disabilities	0	1	**1**
Natural	Acute medical conditions	3	2	**5**
Natural	Sudden and Unexpected Death in Infancy (SUDI)	3	10	**13**
Natural	Unidentifiable aetiology	4	1	**5**
Non-natural	Unascertained cause	6	6	**12**
	Total	**16**	**21**	**37**

Table 8.1.1.1.3: No. of Cases by Place of Fatal Incident

Place of fatal incident	Total
Home	**29 (78.4%)**
Hospital	**4 (10.8%)**
Indoor (not home)	**4 (10.8%)**
Total	**37**

8.1.1.2 Statistical Information on Other Sleeping Safety

Total no. of cases = 36 (35 cases aged below 1; and 1 case aged 7 having special needs). 3 cases were also related to co-sleeping.

Table 8.1.1.2.1: No. of Cases by Year and Sex

Year	Female	Male	Total
2006	0	0	**0**
2007	0	0	**0**
2008	0	0	**0**
2009	2	1	**3**
2010	1	2	**3**
2011	1	1	**2**
2012	8	5	**13**
2013	0	7	**7**
2014	4	0	**4**
2015	2	2	**4**
Total	**18**	**18**	**36**

Table 8.1.1.2.2: No. of Cases by Nature of Death and Sex

Case nature	Type	Female	Male	Total
Natural	Neonatal conditions	1	0	**1**
Natural	Chronic medical condition with disabilities	2	0	**2**
Natural	Acute medical conditions	2	1	**3**
Natural	Sudden and Unexpected Death in Infancy (SUDI)	1	11	**12**
Natural	Unidentifiable aetiology	2	2	**4**
Non-natural	Accident	2	4	**6**
Non-natural	Unascertained	8	0	**8**
	Total	**18**	**18**	**36**

Table 8.1.1.2.3: Table of Cases by Place of Fatal Incident

Place of fatal incident	Total
Home	**26 (72.2%)**
Hospital	**5 (13.9%)**
Indoor (not home)	**5 (13.9%)**
Total	**36**

8.1.1.3 Observations on Co-sleeping and Other Sleeping Safety

- For the cases reviewed from 2006 to 2015, 37 cases involved children whose deaths might be related to co-sleeping with adults or with siblings/other children while 36 cases involved children whose deaths might be related to sleep safety issues, such as being found sleeping in prone position, nose and mouth covered by objects including pillows and blankets, being trapped in the gap between the bed and the wall and being covered by soft objects on the bed, etc. Majority of these cases were babies aged below one.

- Although the nature of death for majority of the cases was considered natural, most of them were cases of Sudden and Unexpected Death in Infancy (SUDI) or without clear aetiology that could explain the death, or cause of death could not be ascertained.

- For cases where the cause of death could not be ascertained, investigation revealed that accidental suffocation or strangulation could occur when an infant's airway becomes blocked by a soft mattress, sleep surface, or an object in their sleep area such as a blanket, pillow, quilt, bumper pads, toys or accidental compression by a sleeping adult or child during co-sleep. It seemed that the general public was not fully aware of the dangers of suffocation, entrapment or compression injuries that could occur when sharing an adult bed with an infant. Furthermore, when parents and infants were away from home, there might not be a crib available so infants might be placed to sleep in an unsafe environment such as a stroller, sofa or an adult bed.

- Parents might have the common belief that infants were safe on bed because of their immobility as compared to older children. However, medical experts pointed out that very young baby could roll over at the age of 2 months or even younger. Accidental suffocation due to wedging was potentially avoidable. Wedging as a cause of infant injury and death had been well reported in the West. In view of the space constraint in most households in Hong Kong, there was often a need to place the infants' bed or crib close to the wall, making wedging a particular threat to infants' safety. Thus, the Panel viewed that public education on safe sleeping environment for infants should be promoted to arouse public awareness of such a threat and no infant should be left unattended lying on high surfaces.

- To reduce the risk of all sleep-related deaths, there was a necessity to improve public awareness about infant sleep safety. Social workers, doctors or nurses should be encouraged to provide knowledge to parents with an infant, or who were expecting a baby, about an infant's sleep environment and offered information and guidance about safe sleep. The Review Panel recognised the efforts already in place to spread safe sleep awareness to the public and recommended the Department of Health to continue educating parents about safe sleep and to warn parents about the dangers of suffocation or entrapment of an infant while sleeping in an adult bed, on couches or in a crib filled with excessive soft objects, such as pillows, blankets, quilts, cushions stuffed toys, etc. **(Recommendations A7 to A9 and AS12 to AS16)**

8.1.1.4 Recommendations for Co-sleeping

Year	Case nature	Ref.	Recommendations
2008-2009	Natural	N1	Through public education, to remind parents the possible fatal risk of sleeping together with infants on the same bed.
2010-2011	Various	G6	Through public education, to reiterate the fatal risk of co-sleeping with babies.
2012-2013	Natural	N1	To raise caregivers' awareness of sleep safety for children: Never co-sleep or co-bed with infants; Never place unnecessary objects on the chest of infants while sleeping or to ensure any object so placed would not be moved to cover the mouth and nose of the infants; Infants should sleep on flat surface and not with soft beddings; and Caregivers should closely monitor children's safety during sleep.
2012-2013	Non-natural Unascertained Cause	AS8	To reiterate the fatal consequence of co-sleeping with babies.
2014-2015	Non-natural Unascertained Cause	AS12	To reiterate the risk of co-sleeping with babies and raise the awareness of parents and caregivers not to arrange baby sharing a bed with siblings or other children.

8.1.1.5 Recommendations for Other Sleeping Safety

Year	Case nature	Ref.	Recommendations
2012-2013	Natural	N1	To raise caregivers' awareness of sleep safety for children: Never co-sleep or co-bed with infants; Never place unnecessary objects on the chest of infants while sleeping or to ensure any object so placed would not cover the mouth and nose of the infants; • Infants should sleep on flat surface and not with soft beddings; and • Caregivers should closely monitor children's safety during sleep.
2012-2013	Non-natural Unascertained Cause	AS7	To provide education to parents especially those with children under 1 year old for close monitoring of the babies' safety through more frequent checking on the babies or installing appropriate monitoring devices while the latter was sleeping alone.

Year	Case nature	Ref.	Recommendations
2014-2015	Non-natural Unascertained Cause	AS13	To arouse parents' awareness of the threat of "wedging" between the bed and the wall and that very young babies are not totally immobile as commonly perceived to be.
2014-2015	Non-natural Unascertained Cause	AS14	To remind parents and caregivers that baby should wear light and comfortable clothing at bedtime as too much clothing is unfavourable.
2014-2015	Non-natural Unascertained Cause	AS15	To remind parents and carers that they will not be suitable to take care of babies when they are very tired or sick, after drinking alcohol or taking medicines with drowsy effect as their alertness will be reduced under such circumstances.
2014-2015	Non-natural Unascertained Cause	AS16	To reiterate the message that parents and caregivers should conduct regular checking on babies while asleep or to install appropriate monitoring devices when the latter was sleeping alone.
2014-2015	Accident	A7	To enhance parents' awareness of the risk of suffocation for very young babies when they roll over to a face-down position on a bed being placed with soft objects, such as pillows, cushions, bumpers, blankets and stuffed toys, etc. as babies could be smothered easily when these objects covered them.
2014-2015	Accident	A8	To remind parents to pay special attention to the sleeping arrangement for their babies when they have to sleep overnight at place other than their familiar home environment.
2014-2015	Accident	A9	The hospital should further promote "sleeping safety for babies" to parents-to-be during the pre-natal and post-natal check-up through audio-visual means or delivery of information kits.

8.1.1.6 Responses/Updates on Co-sleeping and Other Sleeping Safety

From Department of Health (DH)

Please refer to the Responses/Updates to Recommendations A7 to A9 and AS12 to AS16 provided by the Department of Health in Chapter 7.

8.1.2 Concealment of Pregnancy

8.1.2.1 Statistical Information

Total no. of cases = 37 (all were aged below 1).

Table 8.1.2.1.1: No. of Cases by Year and Sex

Year	Female	Male	Total
2006	2	1	**3**
2007	0	1	**1**
2008	2	3	**5**
2009	0	3	**3**
2010	2	2	**4**
2011	0	1	**1**
2012	2	0	**2**
2013	3	3	**6**
2014	6	3	**9**
2015	1	2	**3**
Total	**18**	**19**	**37**

Table 8.1.2.1.2: No. of Cases by Nature of Death and Sex

Case nature	Type	Female	Male	Total
Natural	Neonatal conditions	1	0	**1**
Natural	Sudden and Unexpected Death in Infancy (SUDI)	0	1	**1**
Natural	Stillbirth	10	10	**20**
Non-natural	Accident	1	0	**1**
Non-natural	Assault	2	4	**6**
Non-natural	Unascertained	4	4	**8**
	Total	**18**	**19**	**37**

Table 8.1.2.1.3: No. of Cases by Foreign Domestic Helper Mothers

Foreign domestic helper	Total
Yes	16 (43.2%)
No	21 (56.8%)
Total	**37**

Table 8.1.2.1.4: No. of Cases by Age Distribution of the Non-Foreign Domestic Helper Mothers

Age	Total
14	**1 (4.8%)**
15	**3 (14.3%)**
17	**5 (23.8%)**
18	**2 (9.5%)**
19	**3 (14.3%)**
28	**1 (4.8%)**
32	**1 (4.8%)**
33	**1 (4.8%)**
37	**1 (4.8%)**
Unknown	**3 (14.3%)**
Total	**21**

Table 8.1.2.1.5: No. of Cases by Place of Fatal Incident

Place of fatal incident	Total
Home	**24 (64.9%)**
Indoor (not home)	**3 (8.1%)**
Hospital	**3 (8.1%)**
Vehicle	**2 (5.4%)**
Outdoor	**1 (2.7%)**
Street/Road	**3 (8.1%)**
Water/Sea	**1 (2.7%)**
Total	**37**

8.1.2.2 Observations

- For the cases reviewed from 2006 to 2015, 37 cases involved children whose deaths might be related to concealment of pregnancy by their mother. Most of the deaths related to concealment of pregnancy resulted in stillbirths. A significant number of these cases (N=16, 43.2%) involved mothers who were foreign domestic helpers (FDHs) while 9 were girls under the age of 18 with the youngest being 14.

- There seemed to have an increase of concealment of pregnancy cases which involved mothers who were FDHs. It was understood that with various reasons, the FDHs might be afraid to inform their employers or others about their pregnancies, many of which were unplanned or out of unprotected sex. Without seeking help, the FDHs might resort to terminate the pregnancies by their own means and some even resulted in dumping of the fetus in public places.

- To prevent child deaths related to concealment of pregnancy by FDHs, the Review Panel opined that FDHs should be helped enhance their knowledge on preventing unplanned pregnancy and possible child care options if they decide to deliver their babies. Meanwhile, the Review Panel had liaised with the Labour Department (LD) that an educational leaflet, namely "Having an Unplanned Pregnancy, what can I do?" in English, Chinese, Thai, Tagalog and Indonesia languages produced by the Social Welfare Department had been uploaded on the webpage of the LD under the heading of "Foreign Domestic Helper Corner" and "Links" of the LD's webpage.

- Furthermore, it came to the Panel's understanding that the Family Planning Association of Hong Kong (FPAHK) had organised Sexual and Reproductive Health Education Programme for Marginalised Women's Group, which include FDHs, to enhance their knowledge on contraceptive measures so as to prevent unplanned pregnancy. Information on contraceptive methods (including birth control methods and emergency contraception pills) and unplanned pregnancy was also placed on the webpage of the FPAHK in Bahasa Indonesia language.

- Besides, the Review Panel had also appealed to the assistance of organisations serving FDHs in raising the awareness of FDHs the "risk of concealment of pregnancy and the importance of seeking help early."

8.1.2.3 Recommedations

Year	Case nature	Ref.	English
2008-2009	Assault & Miscellaneous	AS4	To raise the awareness of foreign domestic helpers and their employers on the risk of concealing pregnancy and the importance of seeking help early.
2010-2011	Various	G4	Access to comprehensive sexual and reproductive health information is important in the prevention of unintended pregnancies. Schools play an important role in this regard. To enhance a comprehensive Sex & Relationship Education in secondary schools with substantiation on: (i) helping students learn proper sexual knowledge and establish their analytical ability for development of personal attitude, morals and values towards sex; (ii) the adverse consequences of teenage pregnancy; (iii) the undesirability and possible fatal consequence of concealing pregnancy, and; (iv) appropriate help-seeking behaviour in handling unintended pregnancy; as well as educating parents on the handling of unintended pregnancy of their adolescent children.
2012-2013	Assault	AS2	To repeat the previous recommendation of arousing awareness of the possible fatal consequence of concealment of pregnancy.
2012-2013	Assault	AS3	Through public education, to reiterate the importance of seeking medical attention and social service support after getting pregnant or when giving birth to a baby.
2014-2015	Natural	N2	Public education on "safe sex" and "proper management of pregnancy" should be continued so as to prevent child death out of concealment of pregnancy.
2014-2015	Assault	AS20	To reiterate the previous recommendation of arousing awareness of the possible fatal consequence of concealment of pregnancy and the importance of seeking medical attention and social service support after getting pregnant or when giving birth to a baby.

8.1.2.4 Responses/Updates on Concealment of Pregnancy

Please refer to the Responses/Updates to Recommendation N2 provided by the Department of Health and AS20 provided by the Education Bureau and the Social Welfare Department in Chapter 7.

8.1.3 Accidental Fall

8.1.3.1 Statistical Information

Total no. of cases = 30

Table 8.1.3.1.1: No. of Cases by Year and Sex

Year	Female	Male	Total
2006	2	3	**5**
2007	1	1	**2**
2008	0	1	**1**
2009	1	0	**1**
2010	1	2	**3**
2011	2	5	**7**
2012	2	1	**3**
2013	2	0	**2**
2014	2	1	**3**
2015	2	1	**3**
Total	**15**	**15**	**30**

Table 8.1.3.1.2: No. of Cases by Nature of Fall

Year	Falls from height	Falls on floor	Total
2006	5	0	**5**
2007	1	1	**2**
2008	0	1	**1**
2009	1	0	**1**
2010	3	0	**3**
2011	5	2	**7**
2012	2	1	**3**
2013	2	0	**2**
2014	2	1	**3**
2015	1	2	**3**
Total	**22**	**8**	**30**

Table 8.1.3.1.3: No. of Cases by Place of Fatal Incident

Place of fatal incident	Total
Home	**24 (80.0%)**
Indoor (not home)	**5 (16.7%)**
Outdoor	**1 (3.3%)**
Total	**30**

Table 8.1.3.1.4: No. of Cases by Year and Age Group

	Age Group							Total
Year	<1	1-2	3-5	6-8	9-11	12-14	15-17	
2006	0	0	1	3	0	0	1	**5**
2007	0	1	1	0	0	0	0	**2**
2008	0	0	0	1	0	0	0	**1**
2009	0	1	0	0	0	0	0	**1**
2010	0	0	2	1	0	0	0	**3**
2011	1	1	0	0	2	1	2	**7**
2012	0	1	0	1	0	1	0	**3**
2013	0	1	1	0	0	0	0	**2**
2014	0	2	1	0	0	0	0	**3**
2015	1	1	1	0	0	0	0	**3**
Total	**2**	**8**	**7**	**6**	**2**	**2**	**3**	**30**

8.1.3.2 Observations

- For the accident cases reviewed from 2006 to 2015, fatal fall is the second leading cause of accidental death with a total of 30 children dying from accidental falls. Out of these 30 cases, 22 were related to falls from height while 8 were related to falls on floor. There were equal numbers of male and female children dying from fatal fall(both N=15). The highest number of fatal fall incidents occurred for children aged between 1-2 (N=8), followed by the age groups of 3-5 (N=7) and 6-8 (N=6).
- Physical hazards, such as lack of window guards, unlocked window guards in high-rise buildings and inadequate adult supervision were major contributors to fatal falls of children. These fatal fall incidents could have been avoided if the parents or carers had asserted their responsibility to provide constant supervision to their children by not leaving them unattended at home. In addition, parents should clear any hidden "hazards" at home and make sure that home safety devices are in place and secured. Furthermore, parents should seek immediate medical advice promptly when their children sustain head injuries from a fall at home.

8.1.3.3 Recommendations

Year	Ref.	Recommendations
2008-2009	A1	Through public education, to educate parents on the symptoms of serious head injury in children and the immediate handling.
2010-2011	A7	Through public education, to encourage families with parent-child communication/relationship problem to seek professional assistance early to facilitate family functioning.
2010-2011	A11	To promote basic home safety knowledge and first aid skills which are useful for parents and carers in taking care of the children, especially those with special needs. For example, to conduct training courses on first aid and home safety knowledge by special schools for students and their parents/carers.
2012-2013	A7	The message of never leaving young children alone or unattended at home should continue to be promoted.
2012-2013	A8	To reiterate the previous recommendation of raising caregivers' awareness of the home safety issues such as appropriate sleeping arrangements, close monitoring of children's safety during sleep and installation of window grilles.
2012-2013	A9	Parents and caregivers should be reminded to take special care when children sustain injuries, especially head injuries, and to seek immediate medical attention.
2014-2015	A1	To reiterate the previous recommendations that young children should never be left alone or unattended at home, even for a very short period of time and especially when they were asleep.
2014-2015	A2	To make every safety measure to prevent falls of children, parents should install proper window grilles (including grilles for louver windows as well) and ensure the design of the window grilles are secured with adequate protection for children and are properly locked at all times.
2014-2015	A3	To disseminate the message and to enhance training on child safety for foreign domestic helpers through their employment agencies, Consulate-Generals or labour unions.
2014-2015	A5	To reiterate the previous recommendation of reminding parents and caregivers to seek immediate medical attention at once when children sustained/were suspected to have sustained head injuries, especially from a fall even without any obvious/observable injuries.
2014-2015	A6	To enhance parents' knowledge on home safety for infants and to consider placing slip resistant rubber mats on the floor so as to prevent infants from slipping at home.

8.1.3.4 Responses/Updates on Accidental Fall

From Department of Health (DH)

Please refer to the Responses/Updates to Recommendations A1 and A2 provided by the Department of Health in Chapter 7.

8.2 Statistics of Child Death Cases Reviewed from 2006 to 2015

Taking account of the child death cases reviewed from 2006 to 2015, tables and charts are prepared as follows to show the changes over time by various natures of cases.

Table 8.2.1: No. of Cases by Cause of Death and Year

Cause of Death	Year in which the cases occurred										Total
	2006[@]	2007[@]	2008	2009	2010	2011	2012[^]	2013[~]	2014	2015[&]	
Natural Causes	74 [69]	60 [52]	70	86	79	72	72	62	50	57	**682 [669]**
Non-natural Causes-	43 [48]	32 [40]	49	33	49	38	41	36	33	26	**380 [393]**
Suicide	*14*	*10*	*14*	*12*	*21*	*14*	*10*	*10*	*9*	*9*	***123***
Accident	*20*	*12*	*13*	*10*	*15*	*13*	*19*	*11*	*6*	*6*	***125***
Assault	*5*	*6*	*9*	*9*	*8*	*4*	*2*	*6*	*3*	*6*	***58***
[#]Unascertained	*1 [6]*	*2 [10]*	*9*	*1*	*5*	*7*	*10*	*8*	*15*	*5*	***63 [76]***
**Medical Complication*	*3*	*2*	*4*	*1*	*0*	*0*	*0*	*1*	*0*	*0*	***11***
Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**98**	**83**	**83**	**1 062**

[#] *Unascertained cases include cases with unknown/unascertained/other death causes.*

* *Medical Complications refer to (i) Complications of Medical or Surgical Care; or (ii) Complications of Medical Treatment/Procedures.*

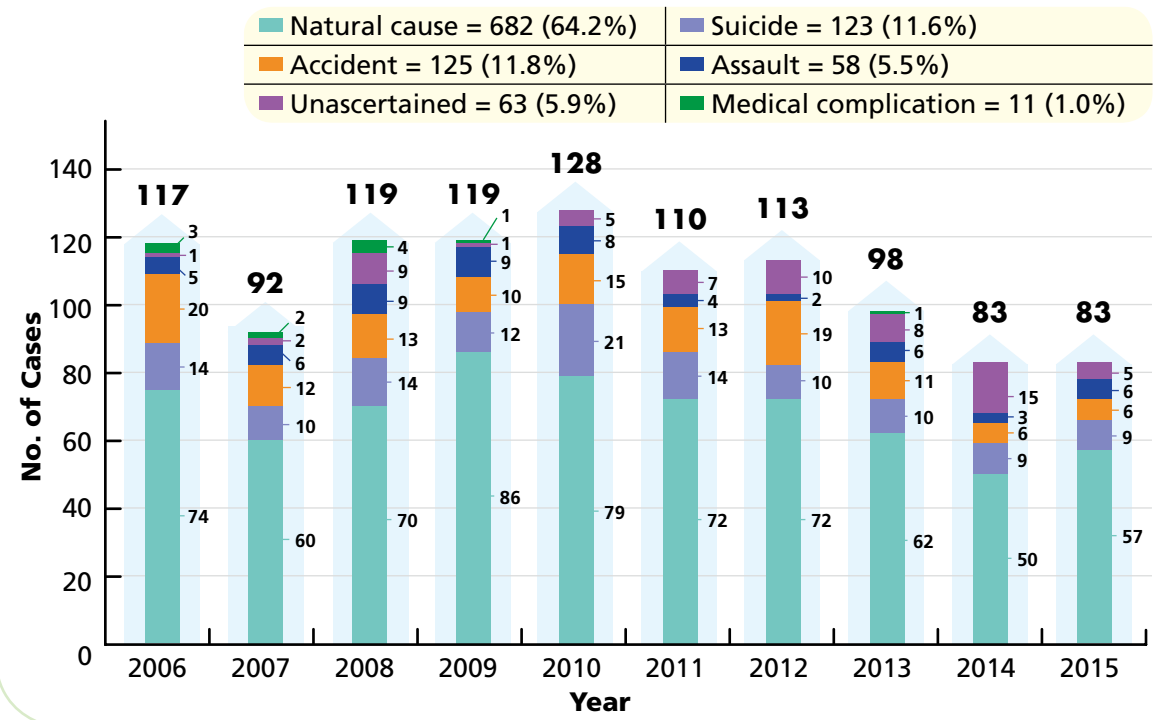
[@] *For years 2006 and 2007, figures previously published are given in the square brackets [ ] for reference purpose. The discrepancies between the previously published figures and the revised figures are due to inclusion of the natural cause cases with unidentifiable aetiology in the "Unascertained" category in the previously published figures. From year 2008 and beyond, these cases have been grouped under "Natural Causes" with a sub-category of "Unidentifiable Aetiology", while the "Unascertained" category refers to non-natural cause cases with unascertained/unknown/other death causes. For consistency purpose, the following analysis is based on the revised figures.*

[^] *2 natural-cause cases and 2 accident cases of 2012 are added after review while 8 accident cases of 2012 are still not covered in this report.*

[~] *1 natural-cause case of 2013 is added after review while 1 natural-cause case is still not covered in this report.*

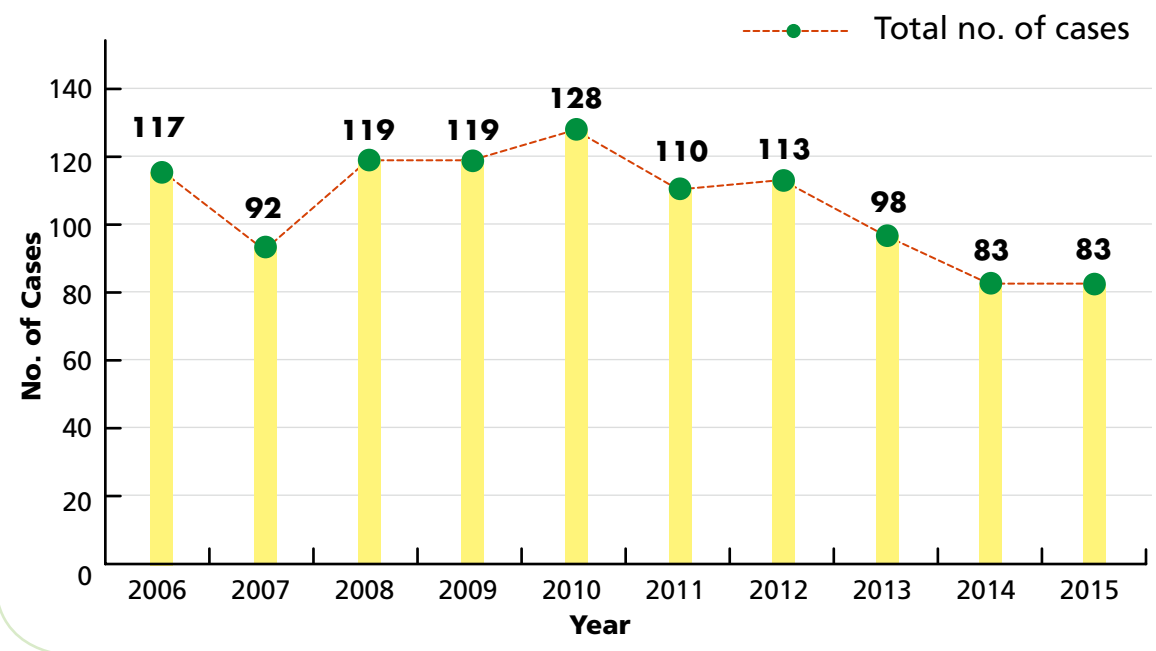
[&] *4 natural-cause cases and 2 assault/unascertained cause cases of 2015 are not covered in this report because legal proceedings were still underway when this report was prepared. Review findings of these cases, if any, will be included in the next report.*

Chart 8.2.1.1: No. of Cases by Cause of Death and Year



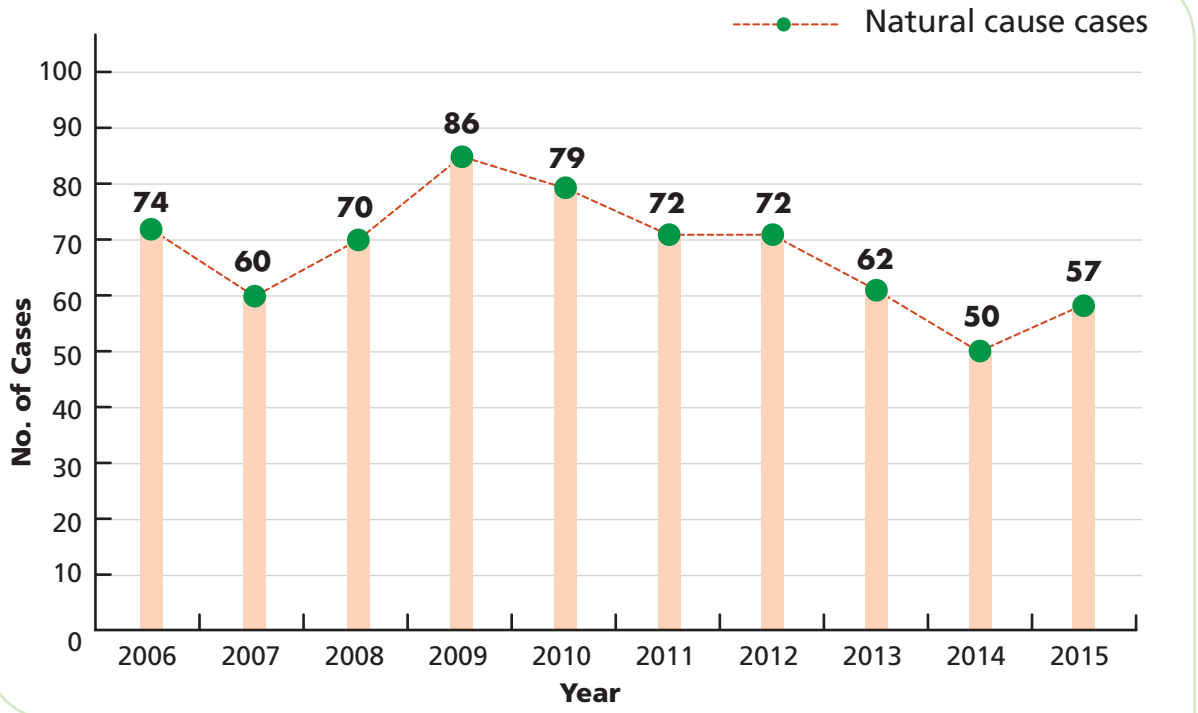
The leading cause of death was natural cause (N=682, 64.2%), followed by accident (N=125, 11.8%) and suicide (N=123, 11.6%).

Chart 8.2.1.2: No. of Overall Cases by Year



There was a decline of child death cases since 2010.

Chart 8.2.1.3: No. of Natural Cause Cases by Year

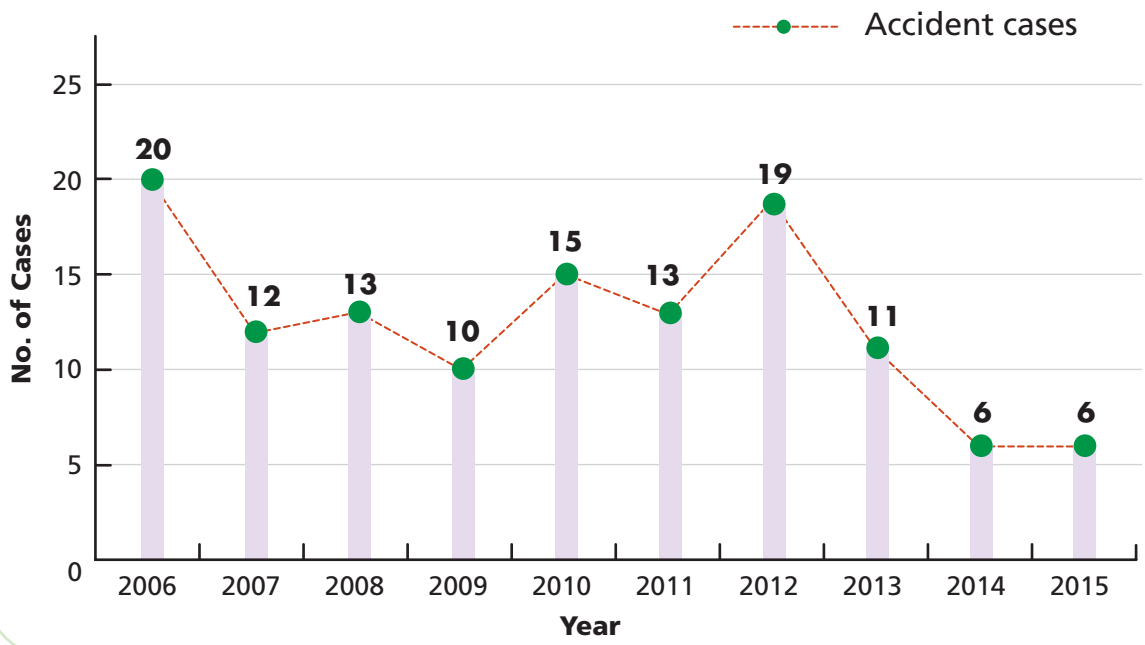


There was a decline of natural cause cases since 2009 though with a very slight increase in 2015.

Chart 8.2.1.4: No. of Suicide Cases by Year

There was a decline of suicide cases since 2010 and the number of cases kept at around 9 to 10 from 2012 to 2015.

Chart 8.2.1.5: No. of Accident Cases by Year

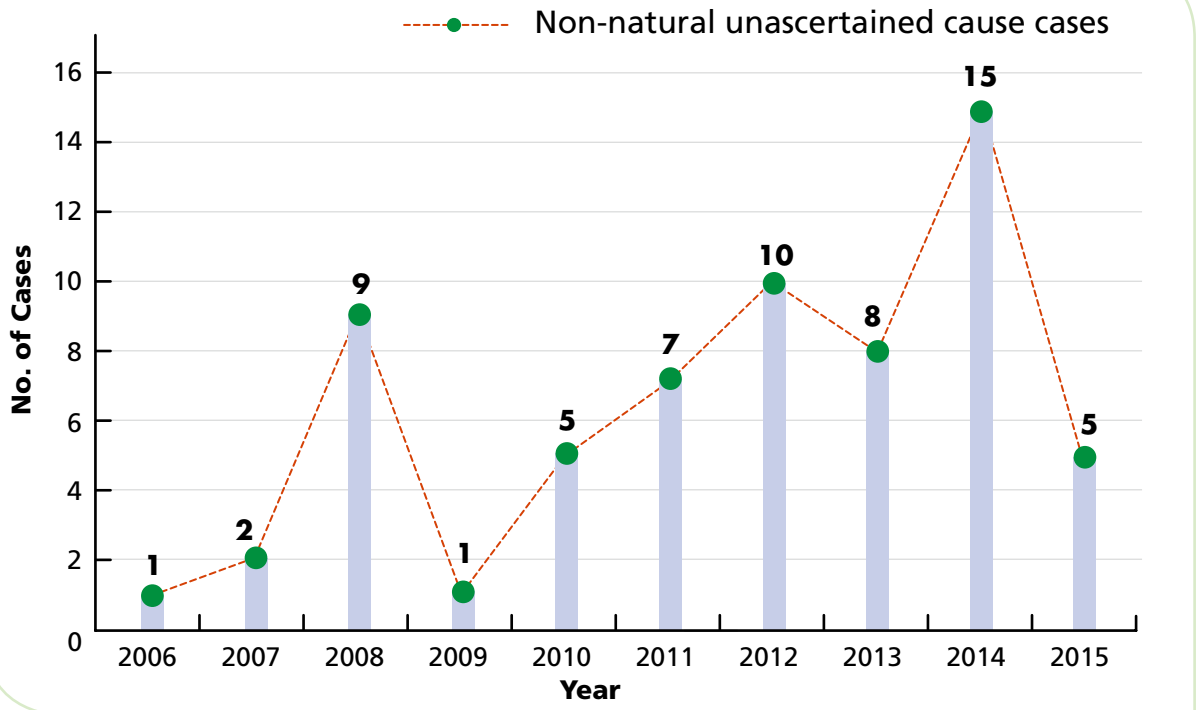


There was a great decline of accident cases since 2012.

Chart 8.2.1.6: No. of Assault Cases by Year

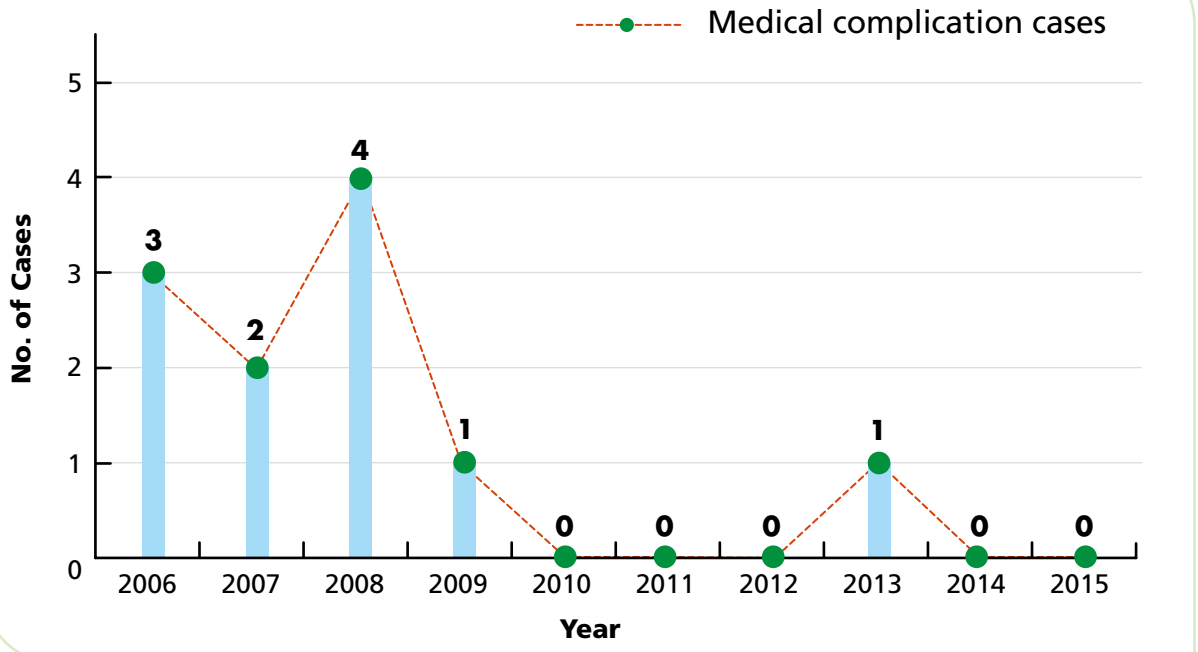
There was a decline of assault cases since 2010 but the number of cases fluctuated for the years from 2012 to 2015.

Chart 8.2.1.7: No. of Non-natural Unascertained Cause Cases by Year



There was an increase for non-natural unascertained cause cases since 2009 but the cases dropped much in 2015.

Chart 8.2.1.8: No. of Medical Complication Cases by Year



There was a decline of medical complication cases since 2008 and the number of cases kept at 1 or 0.

Table 8.2.2: No. of Cases by Age Group, Sex and Year

Age Group and Sex		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	No. of Cases (%)
< 1	F	18	17	16	23	17	24	27	14	24	12	192
	M	14	20	27	25	40	25	28	27	16	20	242
	Sub-total	**32**	**37**	**43**	**48**	**57**	**49**	**55**	**41**	**40**	**32**	**434 (41.0%)**
1-2	F	3	2	8	7	3	3	3	4	6	6	45
	M	7	3	3	7	2	8	5	7	5	7	54
	Sub-total	**10**	**5**	**11**	**14**	**5**	**11**	**8**	**11**	**11**	**13**	**99 (9.3%)**
3-5	F	1	3	5	4	2	5	1	4	4	1	30
	M	6	2	5	7	9	1	5	5	1	7	48
	Sub-total	**7**	**5**	**10**	**11**	**11**	**6**	**6**	**9**	**5**	**8**	**78 (7.3%)**
6-8	F	3	3	2	2	2	2	4	2	0	2	22
	M	7	5	3	3	4	3	5	4	2	2	38
	Sub-total	**10**	**8**	**5**	**5**	**6**	**5**	**9**	**6**	**2**	**4**	**60 (5.6%)**
9 -11	F	8	6	3	4	1	1	1	5	0	0	29
	M	7	4	6	3	2	5	4	2	1	4	38
	Sub-total	**15**	**10**	**9**	**7**	**3**	**6**	**5**	**7**	**1**	**4**	**67 (6.3%)**
12-14	F	6	5	8	8	7	5	7	3	6	2	57
	M	12	6	6	6	11	6	2	10	5	5	69
	Sub-total	**18**	**11**	**14**	**14**	**18**	**11**	**9**	**13**	**11**	**7**	**126 (11.9%)**
15-17	F	11	4	12	8	8	8	4	8	6	7	76
	M	14	12	15	12	20	14	17	3	7	8	122
	Sub-total	**25**	**16**	**27**	**20**	**28**	**22**	**21**	**11**	**13**	**15**	**198 (18.6%)**
Total (%):	F	50	40	54	56	40	48	47	40	46	30	451 (42.5%)
	M	67	52	65	63	88	62	66	58	37	53	611 (57.5%)
	Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**98**	**83**	**83**	**1 062 (100%)**

The top 3 highest case numbers among different years are highlighted.

The highest number of child deaths occurred for children aged below 1 (N=434, 41.0%), followed by the age groups of 15-17 (N=198, 18.6%) and 12-14 (N=126, 11.9%).

Chart 8.2.2.1: No. of Cases by Year and Age Group

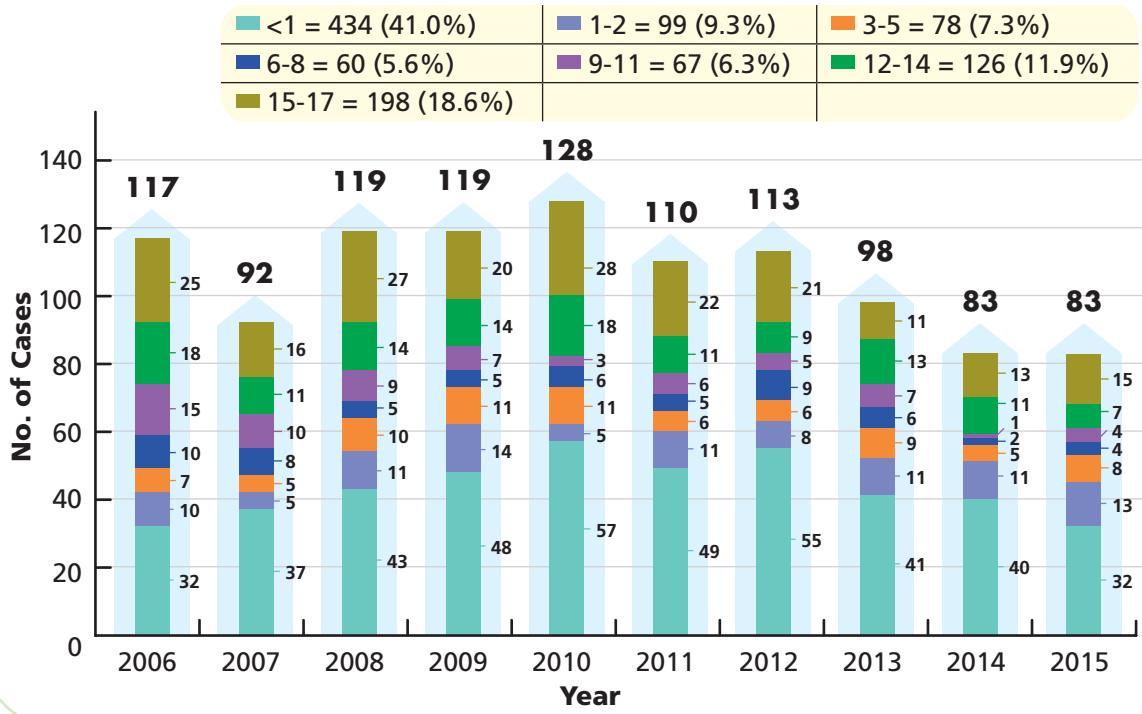
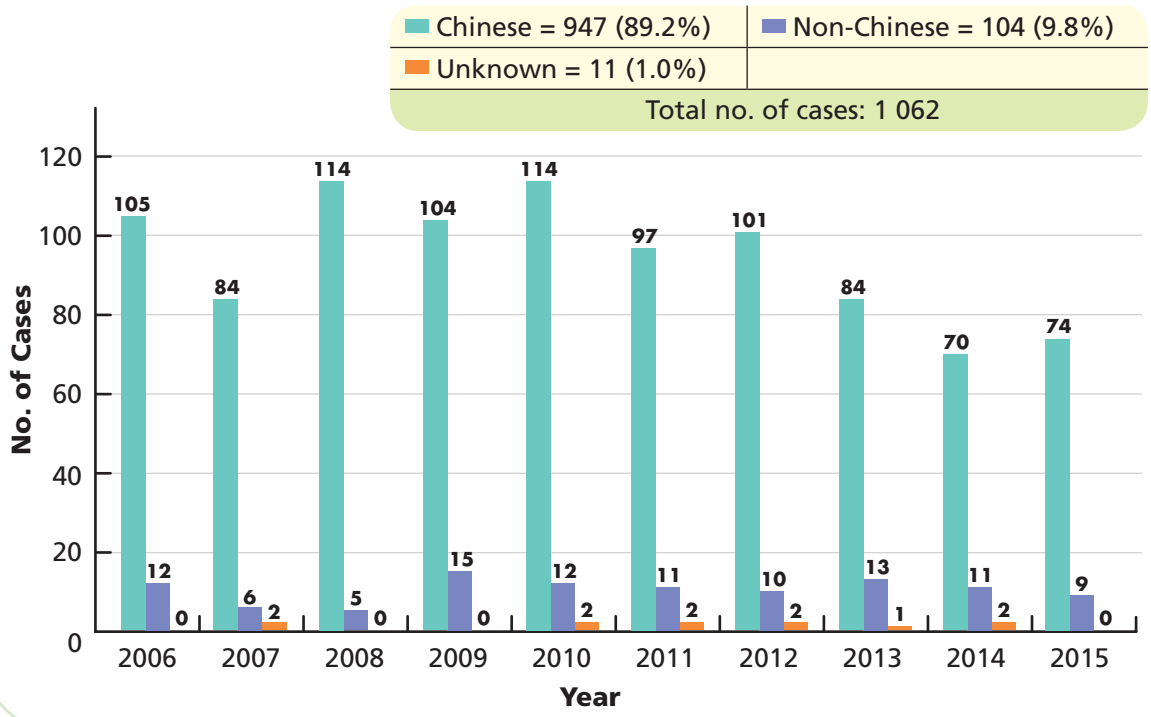


Chart 8.2.2.2: No. of Cases by Year and Ethnicity



The majority of the deceased children were Chinese (N=947, 89.2%) and there were 104 (9.8%) non-Chinese children.

Table 8.2.3: No. of Cases by Cause of Death, Year and Sex

Cause of Death		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	No. of Cases (%)
Natural Causes	F	31	29	32	39	24	35	33	20	27	20	290
	M	43	31	38	47	55	37	39	42	23	37	392
	Sub-total	**74**	**60**	**70**	**86**	**79**	**72**	**72**	**62**	**50**	**57**	**682 (64.2%)**
Suicide	F	7	3	6	6	6	6	5	6	5	4	54
	M	7	7	8	6	15	8	5	4	4	5	69
	Sub-total	**14**	**10**	**14**	**12**	**21**	**14**	**10**	**10**	**9**	**9**	**123 (11.6%)**
Accident	F	8	3	3	4	6	2	4	6	3	4	43
	M	12	9	10	6	9	11	15	5	3	2	82
	Sub-total	**20**	**12**	**13**	**10**	**15**	**13**	**19**	**11**	**6**	**6**	**125 (11.8%)**
Assault	F	3	3	5	6	4	1	1	1	2	1	27
	M	2	3	4	3	4	3	1	5	1	5	31
	Sub-total	**5**	**6**	**9**	**9**	**8**	**4**	**2**	**6**	**3**	**6**	**58 (5.5%)**
Unascertained	F	0	1	7	1	0	4	4	6	9	1	33
	M	1	1	2	0	5	3	6	2	6	4	30
	Sub-total	**1**	**2**	**9**	**1**	**5**	**7**	**10**	**8**	**15**	**5**	**63 (5.9%)**
Medical Complication	F	1	1	1	0	0	0	0	1	0	0	4
	M	2	1	3	1	0	0	0	0	0	0	7
	Sub-total	**3**	**2**	**4**	**1**	**0**	**0**	**0**	**1**	**0**	**0**	**11 (1.0%)**
Total (%):	F	50	40	54	56	40	48	47	40	46	30	451 (42.5%)
	M	67	52	65	63	88	62	66	58	37	53	611 (57.5%)
	Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**98**	**83**	**83**	**1 062 (100%)**

The highest case numbers among different years are highlighted.

There were more male (N=611, 57.5%) than female (N=451, 42.5%) for the deceased child cases reviewed. This was also the same in the death cause groups of natural causes, suicide, accident, assault and medical complication. However, there were more female than male in the death cause group of unascertained causes.

Chart 8.2.3.1: No. of Overall Cases by Year and Sex

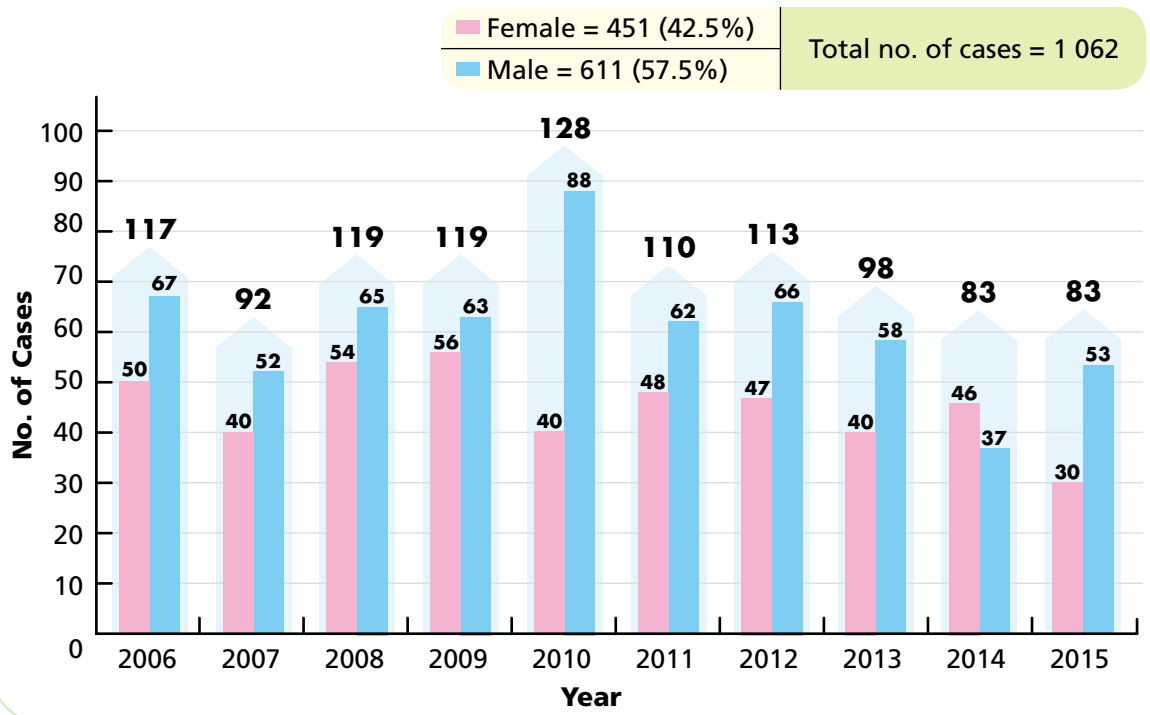


Chart 8.2.3.2: No. of Natural Cause Cases by Year and Sex

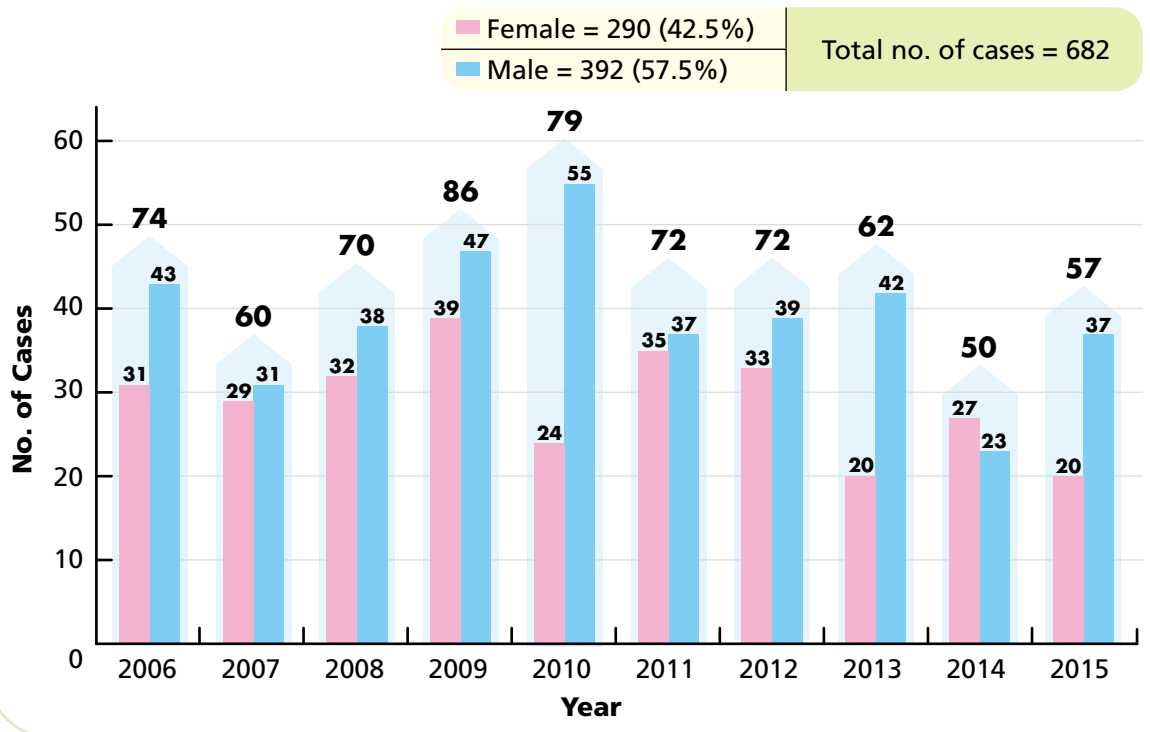


Chart 8.2.3.3: No. of Suicide Cases by Year and Sex

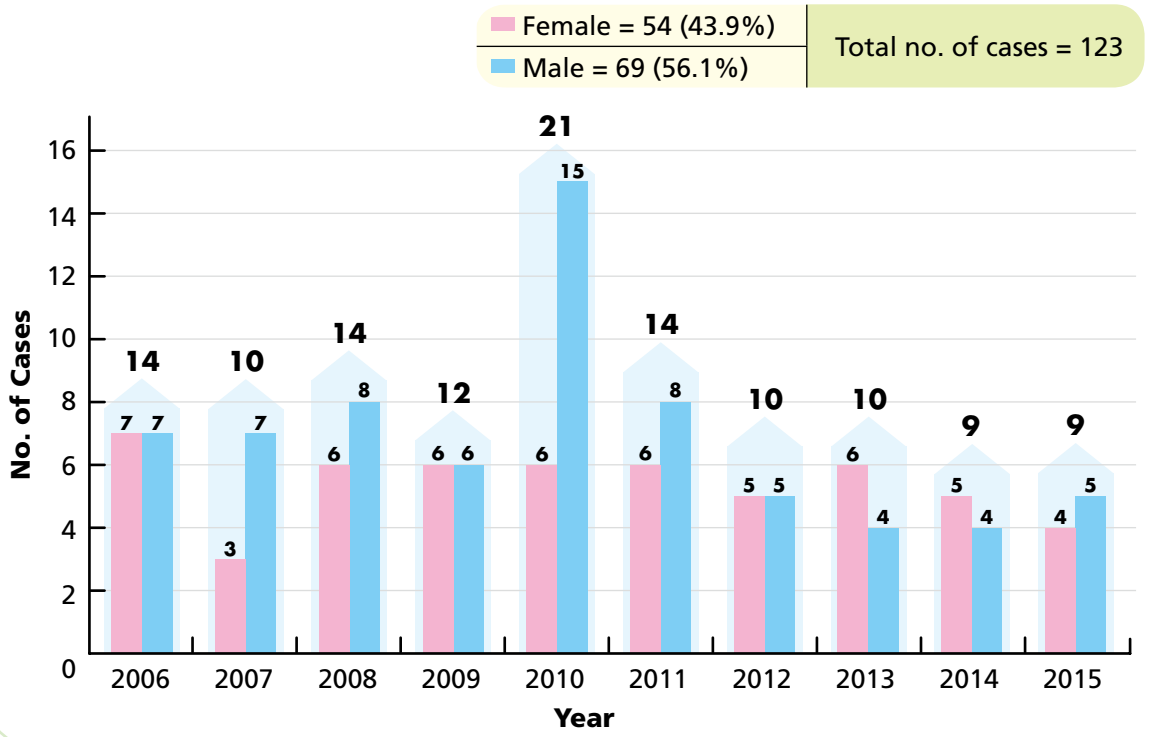


Chart 8.2.3.4: No. of Accident Cases by Year and Sex

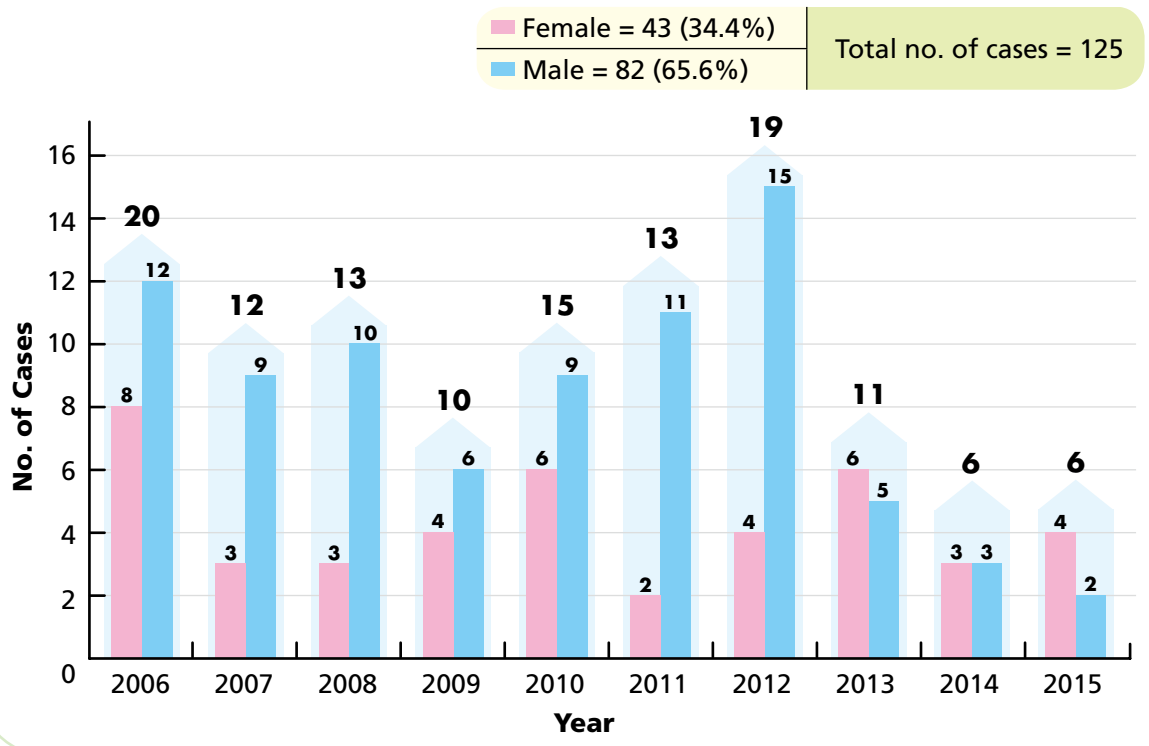


Chart 8.2.3.5: No. of Assault Cases by Year and Sex

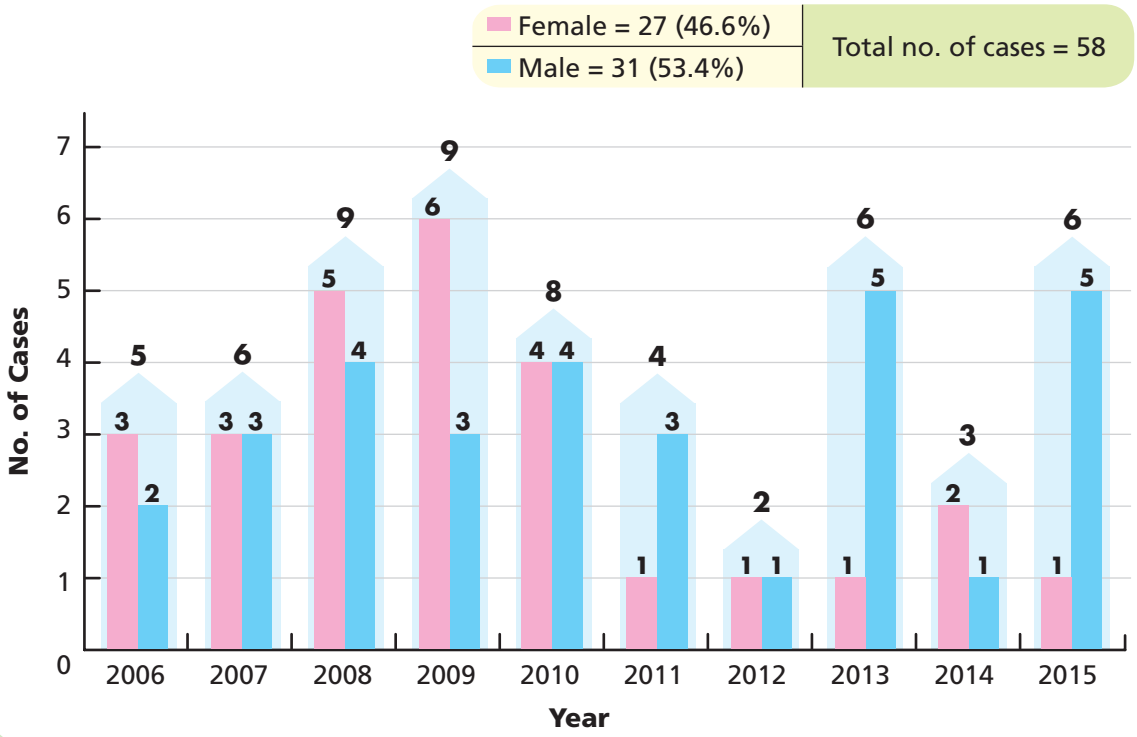


Chart 8.2.3.6: No. of Non-natural Unascertained Cause Cases by Year and Sex

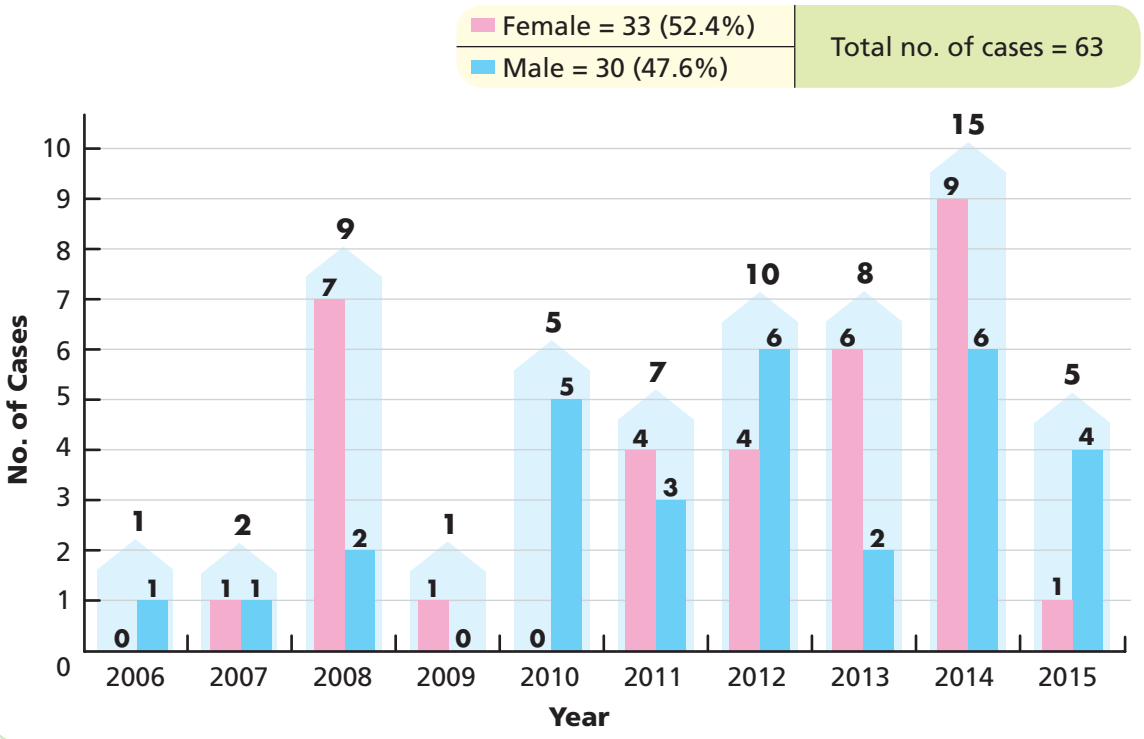


Chart 8.2.3.7: No. of Medical Complication Cases by Year and Sex

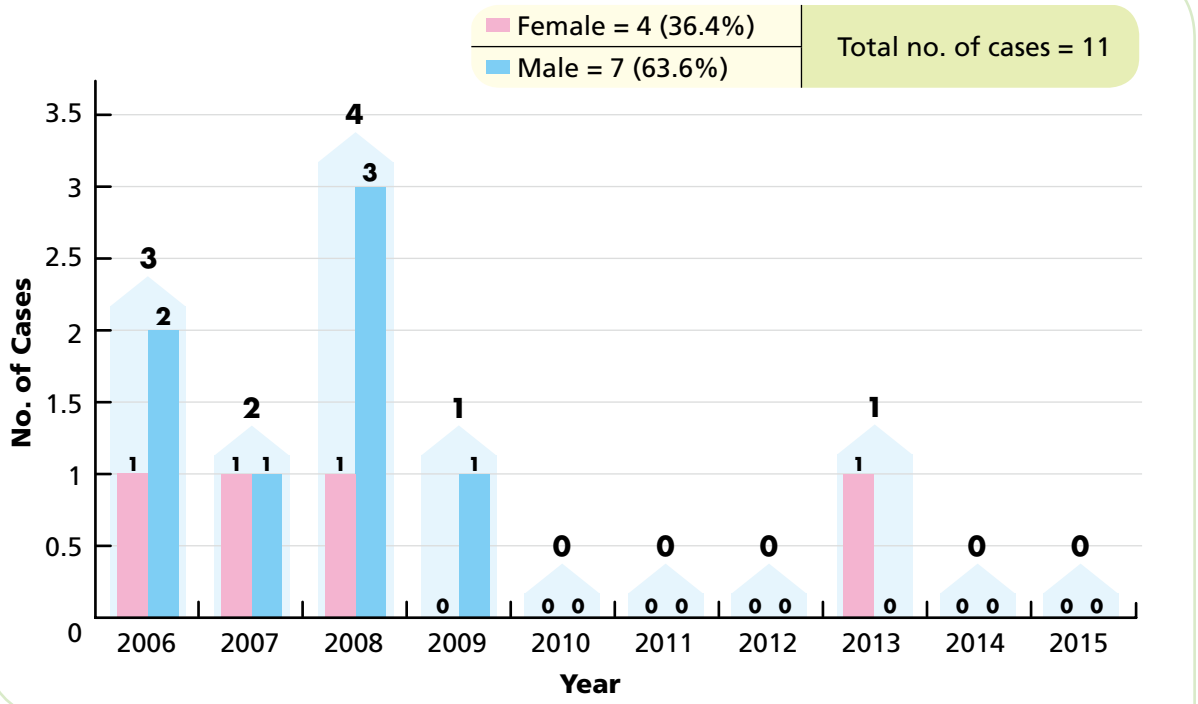


Table 8.2.4: No. of Cases by Residential District

Residential District	No. of Cases / Death Rate*										
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total (%)
HONG KONG ISLAND											
Central & Western	7	1	4	6	2	5	6	1	3	2	**37 (3.5%)**
	0.185	0.026	0.102	0.157	0.051	0.144	0.172	0.029	0.087	0.052	
Wan Chai	1	0	1	0	2	0	2	2	1	0	**9 (0.8%)**
	0.045	0.000	0.047	0.000	0.099	0.000	0.105	0.109	0.051	0.000	
Eastern	4	7	9	5	2	6	11	6	8	6	**64 (6.0%)**
	0.043	0.076	0.100	0.058	0.024	0.074	0.140	0.079	0.107	0.082	
Southern	4	5	6	3	7	3	2	5	2	6	**43 (4.0%)**
	0.085	0.111	0.132	0.069	0.165	0.071	0.050	0.134	0.053	0.170	
KOWLOON											
Yau Tsim Mong	1	0	2	7	4	5	7	5	4	3	**38 (3.6%)**
	0.025	0.000	0.046	0.160	0.088	0.107	0.148	0.104	0.083	0.060	
Sham Shui Po	8	6	2	9	5	7	6	6	2	3	**54 (5.1%)**
	0.134	0.106	0.035	0.158	0.090	0.120	0.105	0.108	0.036	0.054	
Kowloon City	5	4	1	1	7	7	2	3	3	6	**39 (3.7%)**
	0.088	0.070	0.018	0.018	0.128	0.126	0.036	0.057	0.052	0.104	
Wong Tai Sin	7	7	6	4	11	6	5	7	5	4	**62 (5.8%)**
	0.102	0.103	0.093	0.065	0.187	0.103	0.087	0.122	0.091	0.075	
Kwun Tong	7	8	9	7	9	4	10	6	8	7	**75 (7.1%)**
	0.073	0.083	0.095	0.074	0.095	0.042	0.104	0.064	0.088	0.077	
NEW TERRITORIES											
Kwai Tsing	10	8	15	7	8	6	2	5	8	3	**72 (6.8%)**
	0.115	0.092	0.175	0.086	0.102	0.079	0.027	0.069	0.118	0.043	
Tsuen Wan	4	5	0	3	6	1	4	2	4	2	**31 (2.9%)**
	0.083	0.095	0.000	0.058	0.119	0.020	0.085	0.042	0.086	0.043	
Tuen Mun	8	7	13	13	8	11	7	3	6	4	**80 (7.5%)**
	0.083	0.079	0.153	0.162	0.104	0.150	0.099	0.044	0.087	0.057	

Residential District	No. of Cases / Death Rate*										
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Total (%)
Yuen Long	10	9	12	15	14	10	13	14	9	10	**116 (10.9%)**
	0.083	0.077	0.105	0.135	0.130	0.096	0.128	0.142	0.095	0.106	
North	6	2	6	6	10	6	2	7	3	4	**52 (4.9%)**
	0.104	0.035	0.108	0.109	0.191	0.122	0.041	0.153	0.067	0.085	
Tai Po	5	2	6	7	2	3	4	5	2	5	**41 (3.9%)**
	0.091	0.041	0.128	0.161	0.048	0.074	0.100	0.132	0.052	0.125	
Sha Tin	7	3	11	6	9	9	6	7	7	7	**72 (6.8%)**
	0.069	0.030	0.113	0.064	0.099	0.100	0.068	0.080	0.081	0.079	
Sai Kung	11	7	3	9	4	6	10	3	3	6	**62 (5.8%)**
	0.139	0.090	0.039	0.122	0.055	0.084	0.140	0.044	0.044	0.090	
Islands	3	2	1	4	5	2	3	2	2	4	**28 (2.6%)**
	0.094	0.065	0.032	0.131	0.164	0.075	0.111	0.078	0.077	0.150	
OTHERS											
Not residing in HK	9	6	7	6	9	11	10	7	2	1	**68 (6.4%)**
Unknown	0	3	5	1	4	2	1	2	1	0	**19 (1.8%)**
Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**98**	**83**	**83**	**1062 (100.0%)**

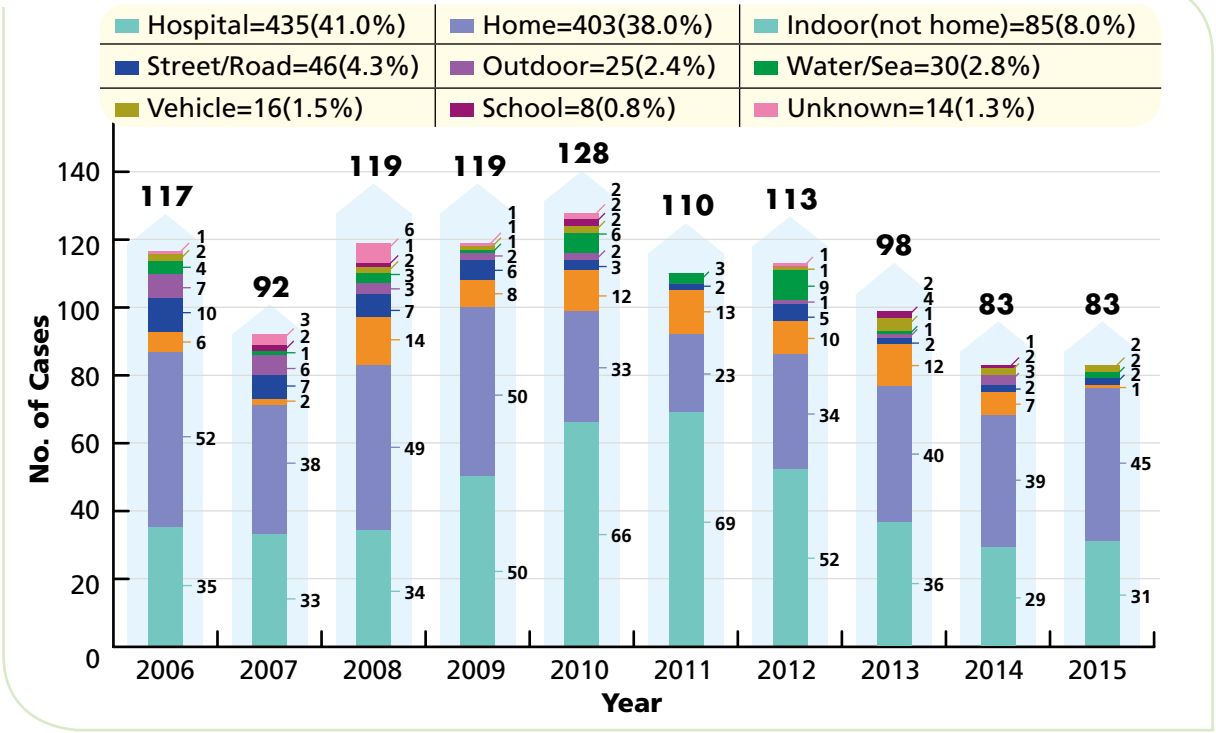
** denotes district-specific child death rate, i.e. child death cases reviewed per 1 000 land-based non-institutional child population in respective district.*

The highest case numbers or death rates among the 18 districts of different years are highlighted.

Yuen Long District had the highest number of child deaths (N=116, 10.9%), followed by Tuen Mun District (N=80, 7.5%) and Kwun Tong District (N=75, 7.1%)

The lowest number of child deaths (N=9, 0.8%) was in Wan Chai District. Families of 68 deceased children (6.4%) were not residing in Hong Kong or taking Hong Kong as their usual place of residence.

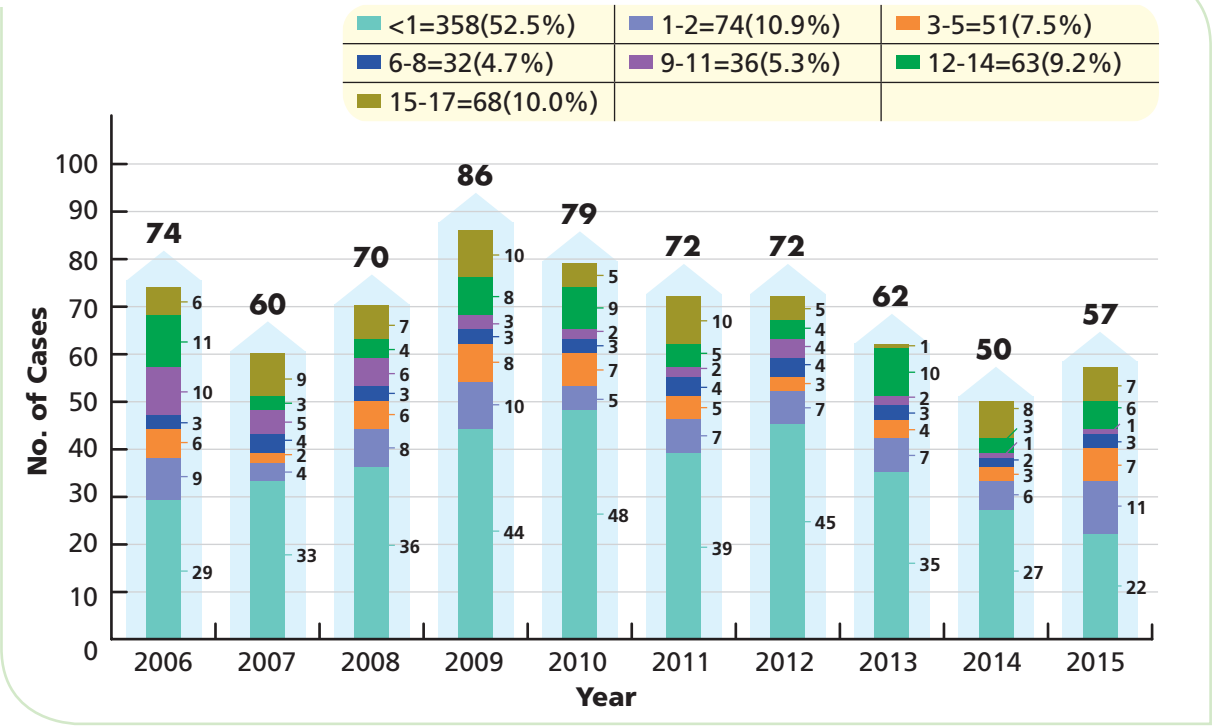
Chart 8.2.5: No. of Cases by Place of Fatal Incident



Hospital was the most common place for the occurrence of fatal incidents (N=345, 41.0%), followed by Home (N=403, 38.0%) and Indoor (not home) (N=85, 8.0%)

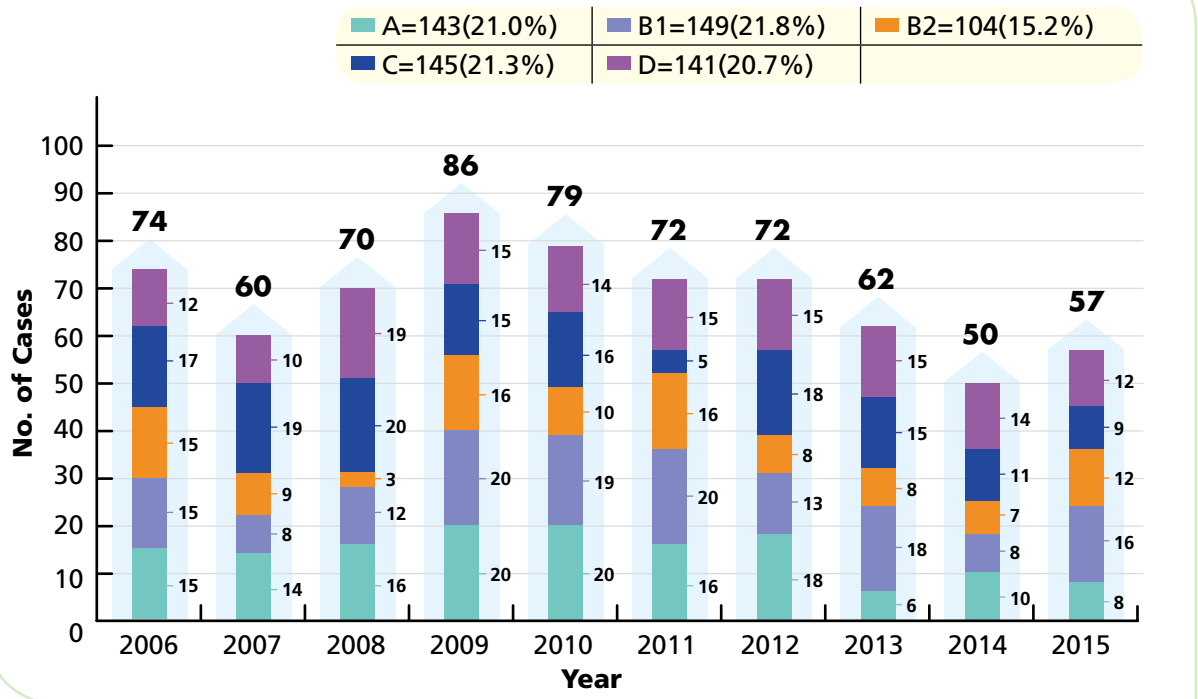
8.3 Statistics of Cases Died of Natural Causes

Chart 8.3.1: No. of Cases by Year and Age Group



The highest number of natural child deaths occurred in children aged below 1 (N=358, 52.5%), followed by the age groups of 1-2 (N=74, 10.9%) and 15-17 (N=68, 10.0%).

Chart 8.3.2: No. of Cases by Year and Death Category*

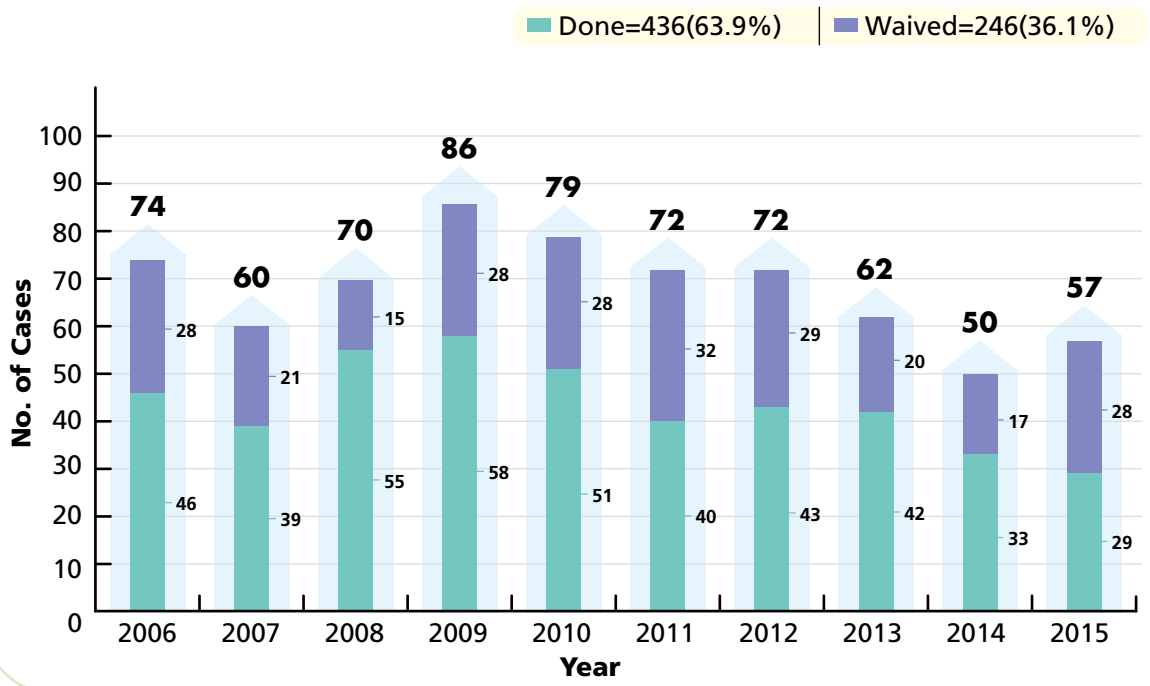


* *These categories of death, with content listed below, are designed by the medical experts of the Review Panel for review purpose:*

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, including:*
Unidentifiable Aetiology
SUDI (Sudden and Unexpected Death in Infancy)
Stillbirth

Category B (chronic medical conditions) had the highest number of child deaths (N=253, 37%). Under this category, there were two sub-categories including cases with mental or physical disabilities (N=149, 21.8%) and cases without mental or physical disabilities (N=104, 15.2%). Category C (acute medical conditions) had the second highest number of child deaths (N=145, 21.3%) while Category A (neo-natal conditions) had the third highest number of child deaths (N=143, 21.0%).

Chart 8.3.3: No. of Cases by Year and with Autopsy Done or Waived*

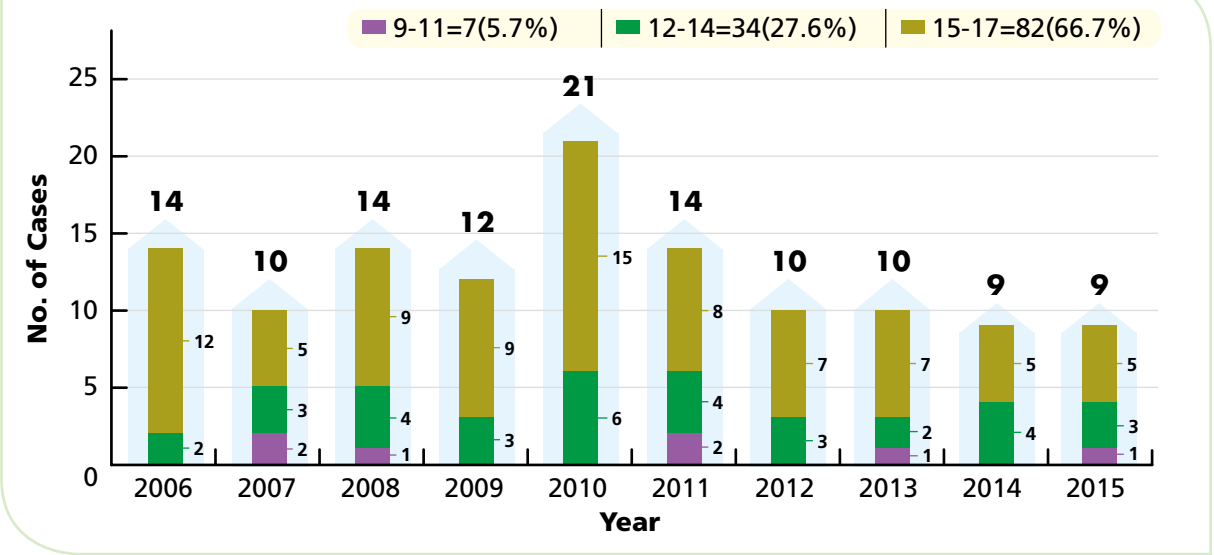


* *Source: According to information search at the Coroner's Court.*

Autopsy had been done for 436 cases (63.9%) and waived for 246 cases (36.1%).

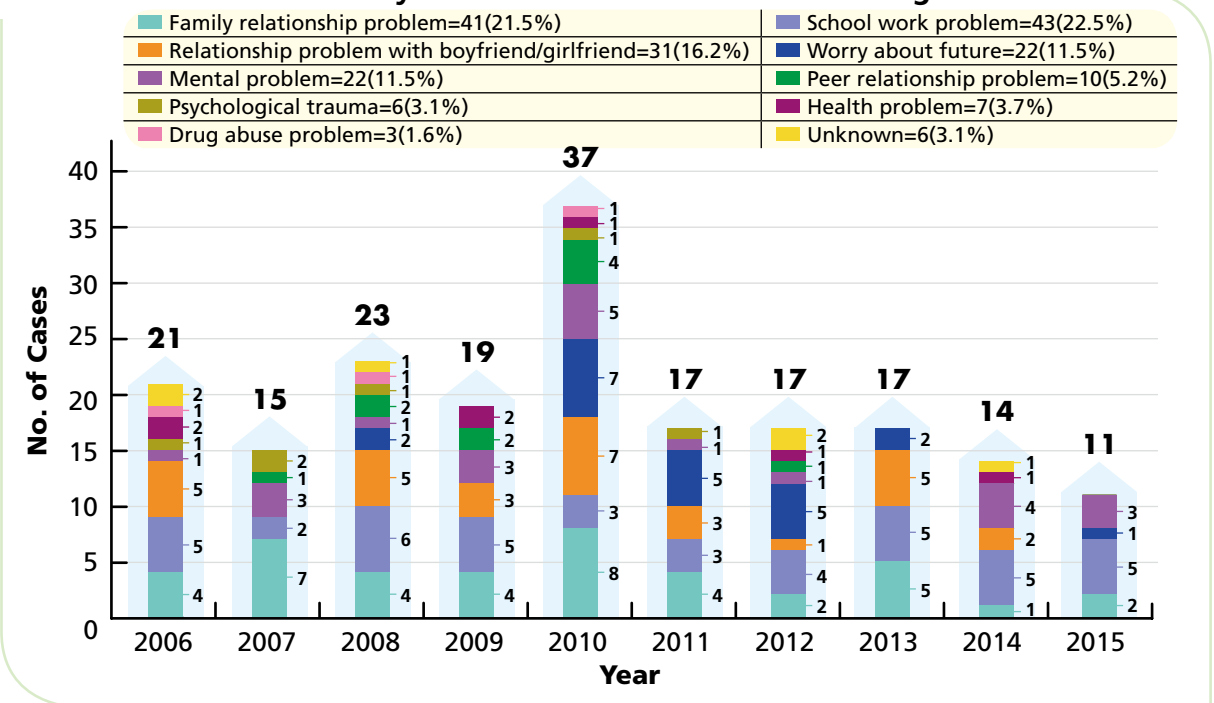
8.4 Statistics of Cases Died of Suicide

Chart 8.4.1: No. of Cases by Year and Age Group



The highest number of suicide deaths occurred in children aged 15-17 (N=82, 66.7%), followed by the age group of 12-14 (N=34, 27.6%) and 9-11 (N=7, 5.7%).

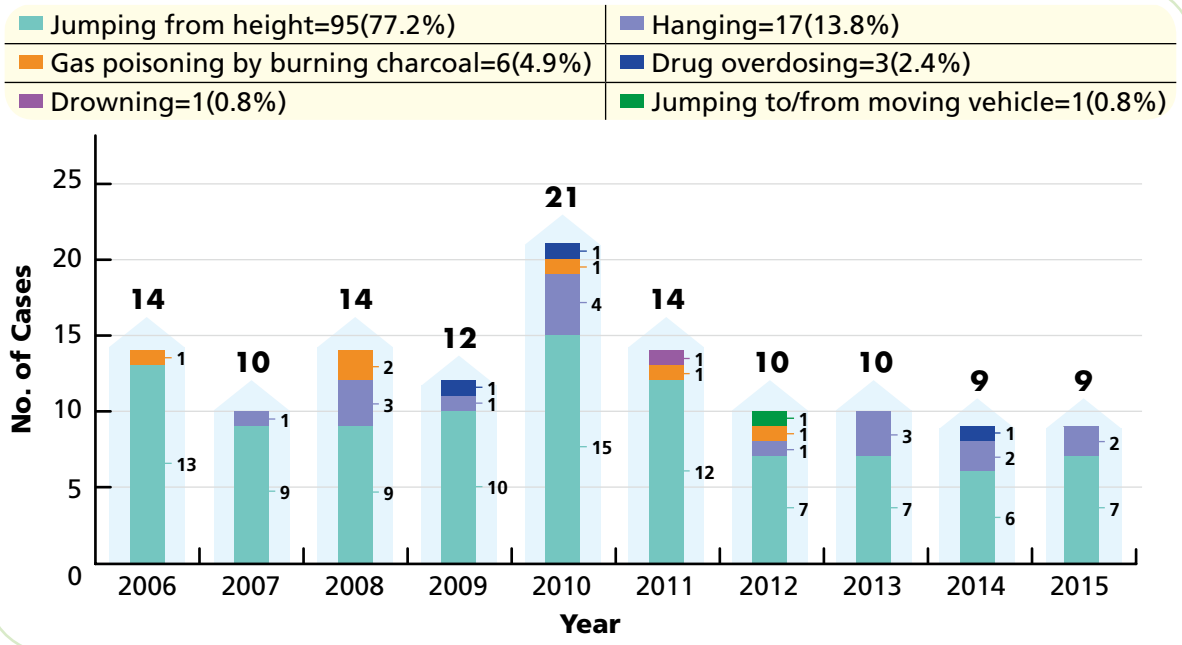
Chart 8.4.2: No. of Cases by Year and Reasons* of Committing Suicide



* *Note: Multiple reasons are allowed. The reasons were identified in the police death investigation reports of the reviewed cases.*

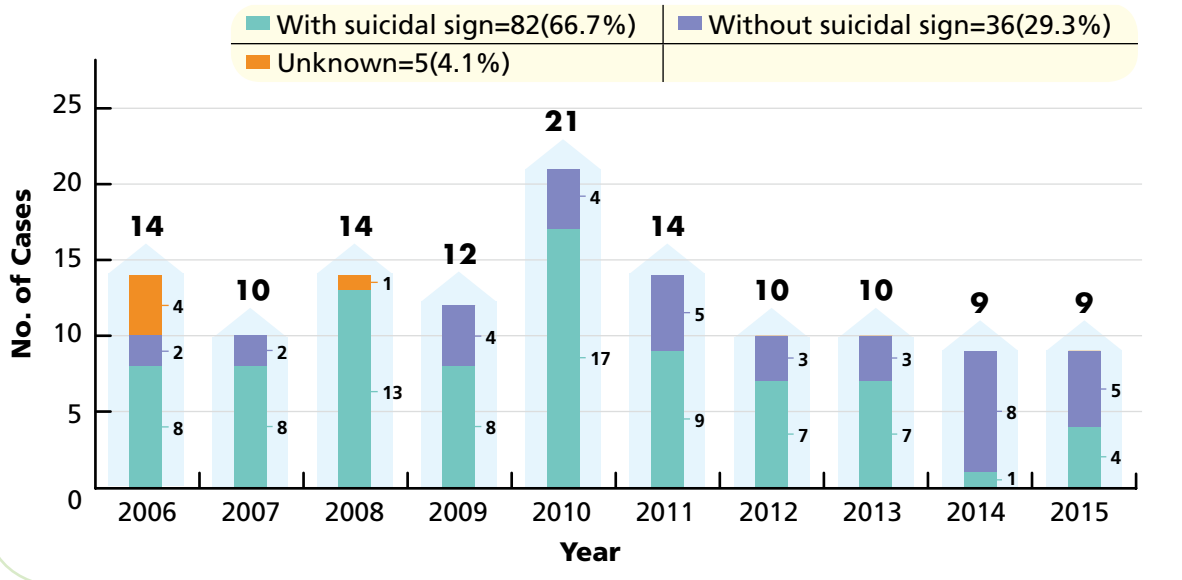
The most common reasons leading to children's suicide were school work problem (N=43, 22.5%), followed by family relationship problem (N=41, 21.5%) and relationship problem with boyfriend/girlfriend (N=31, 16.2%).

Chart 8.4.3: No. of Cases by Year and Means of Committing Suicide



Most of the deceased children committed suicide by jumping from height (N=95, 77.2%), followed by Hanging (N=17, 13.8%) and gas poisoning by burning charcoal (N=6, 4.9%).

Chart 8.4.4: No. of Cases by Year and Identified Suicidal Signs*

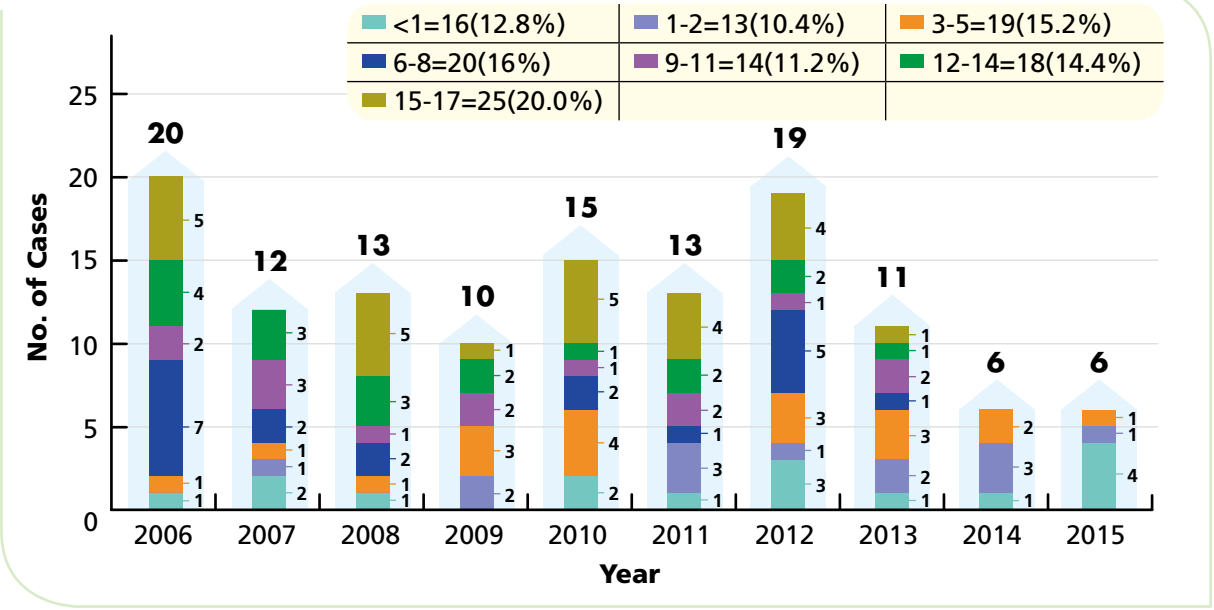


* *Signs: Include leaving suicidal notes; emotional / violent acts; verbal expression / threatening of suicidal intention and past history of suicidal attempts. (The signs were identified through police investigation reports.)*

The majority of children who committed suicide (N=82, 66.7%) had expressed their suicidal thoughts in one way or another before actual attempts.

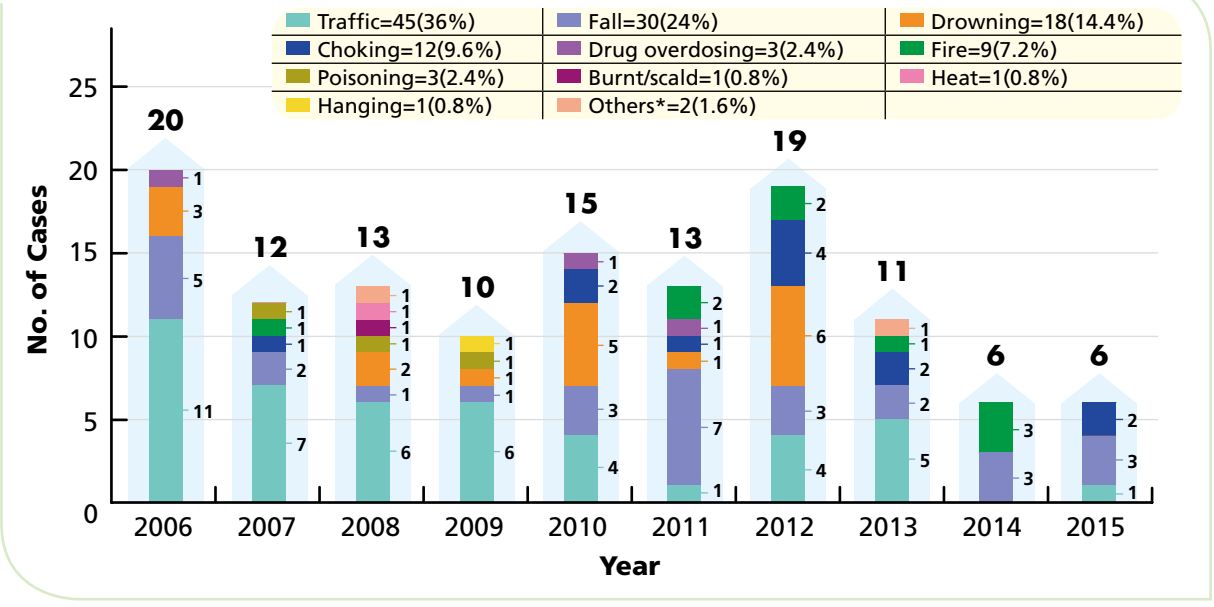
8.5 Statistics of Cases Died of Accident

Chart 8.5.1: No. of Cases by Year and Age Group



The highest number of child deaths occurred in the age group of 15-17 (N=25, 20.0%), followed by the age group of 6-8 (N=20, 16%) and 3-5 (N=19, 15.2%).

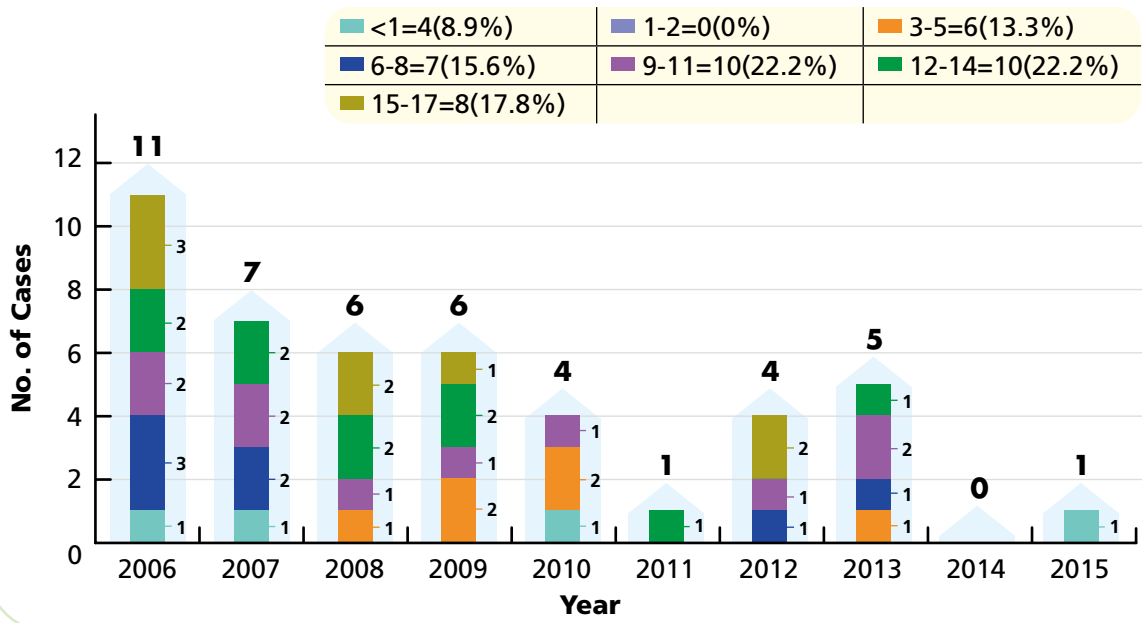
Chart 8.5.2: No. of Cases by Year and Type of Accident



** The case in 2008 was a newborn who died a few hours after birth due to complication during birth. The Coroner's Court ruled that the death cause was "Other accidental threats to breathing". The case in 2013 was a child struck by an object causing head injury.*

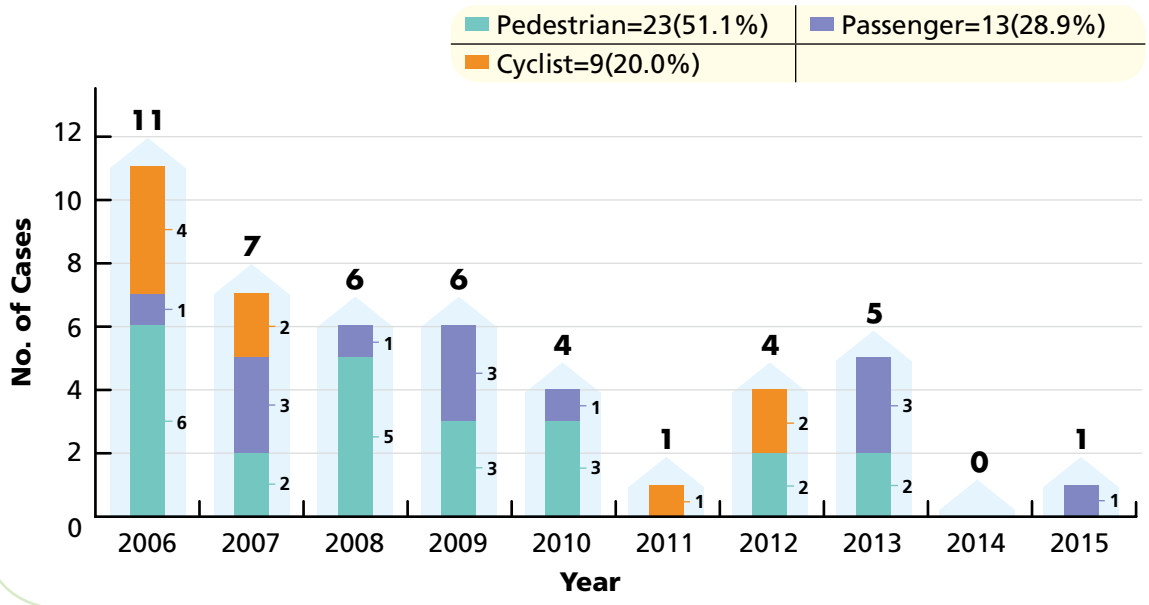
Traffic accident (N=45, 36%) was the leading cause of accident death, followed by fall (N=30, 24%) and drowning (N=18, 14.4%).

Chart 8.5.3: No. of Traffic Accident Cases by Year and Age Group



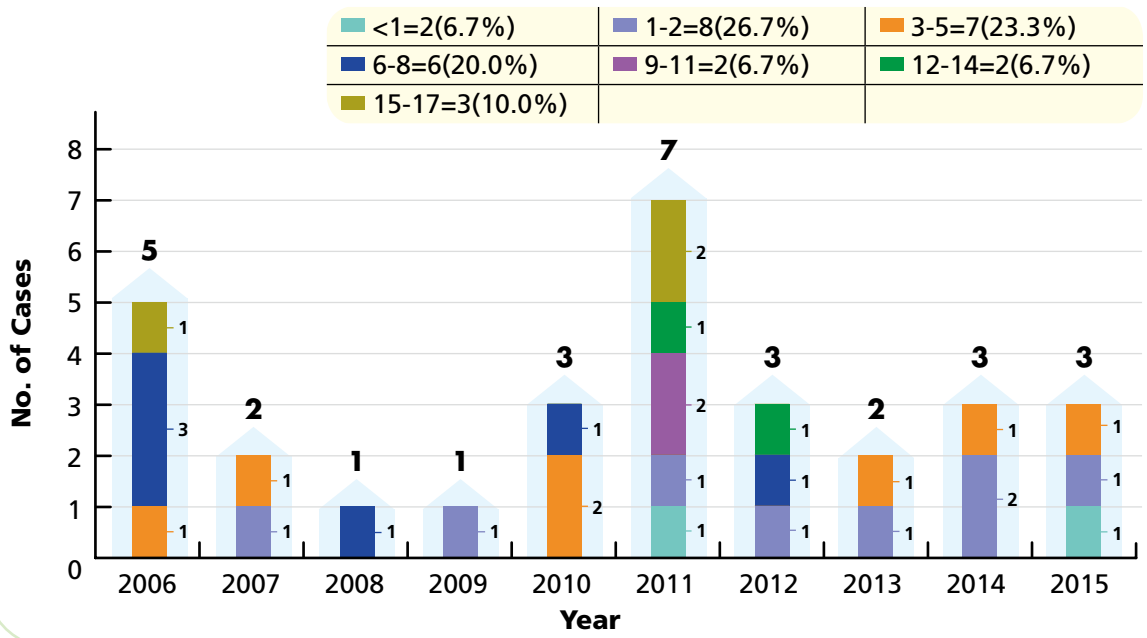
The highest number of child deaths out of traffic accident occurred in both the age group of 9- 11 (N=10, 22.2%) and 12-14 (N=10, 22.2%), followed by the age group of 15-17 (N=8, 17.8%).

Chart 8.5.4: No. of Cases by Year and Type of Traffic Victim



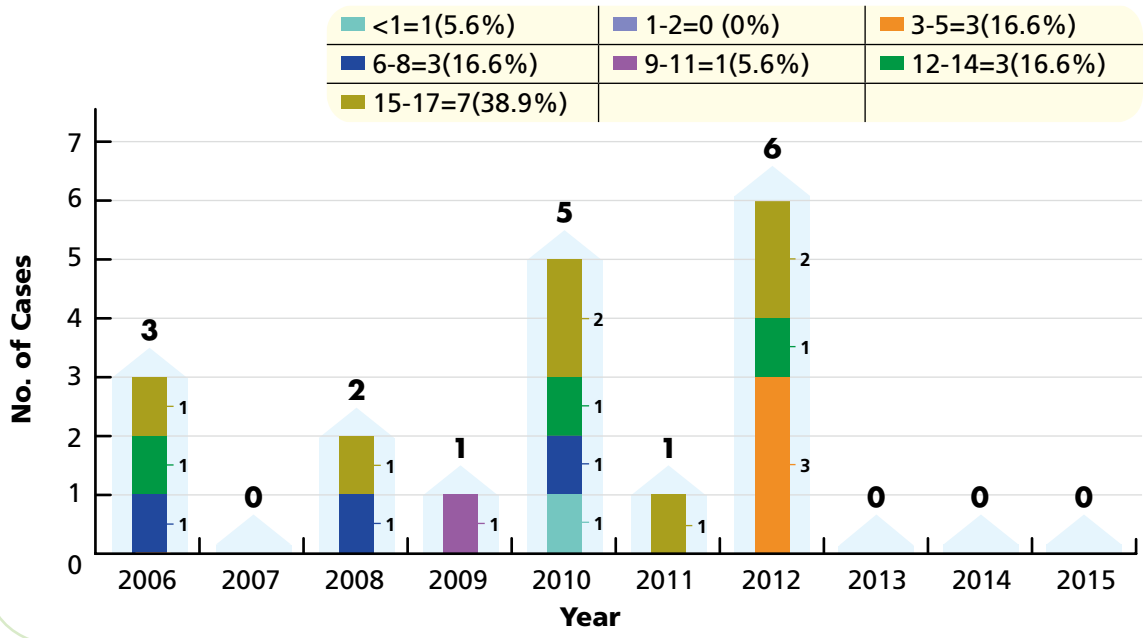
The highest number of traffic victims were pedestrian (N=23, 51.1%), followed by passenger (N=13, 28.9%) and cyclist (N=9, 20.0%).

Chart 8.5.5: No. of Fall Accident Cases by Year and Age Group



The highest number of child deaths by fall accident occurred in the age group of 1-2 (N=8, 26.7%), followed by the age group of 3-4 (N=7, 23.3%) and 6-8 (N=6, 20.0%).

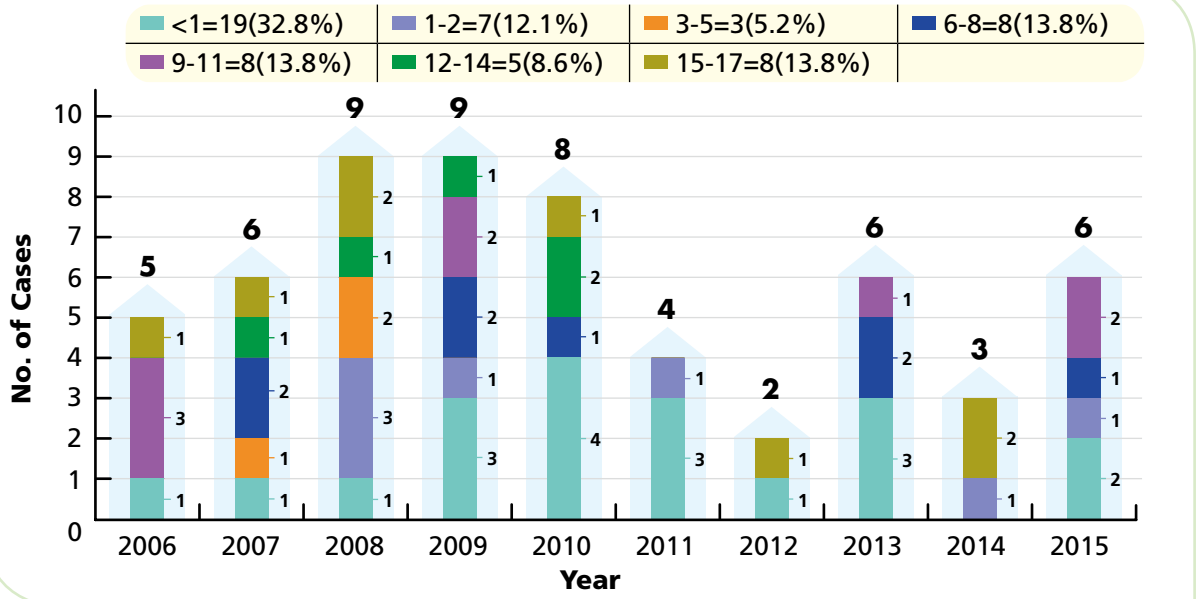
Chart 8.5.6: No. of Drowning Accident Cases by Year and Age Group



The highest number of child deaths by drowning occurred in the age group of 15-17 (N=7, 38.9%) while three age group of 3-5, 6-8 and 12-14 had the same number of deaths (N=3, 16.6%).

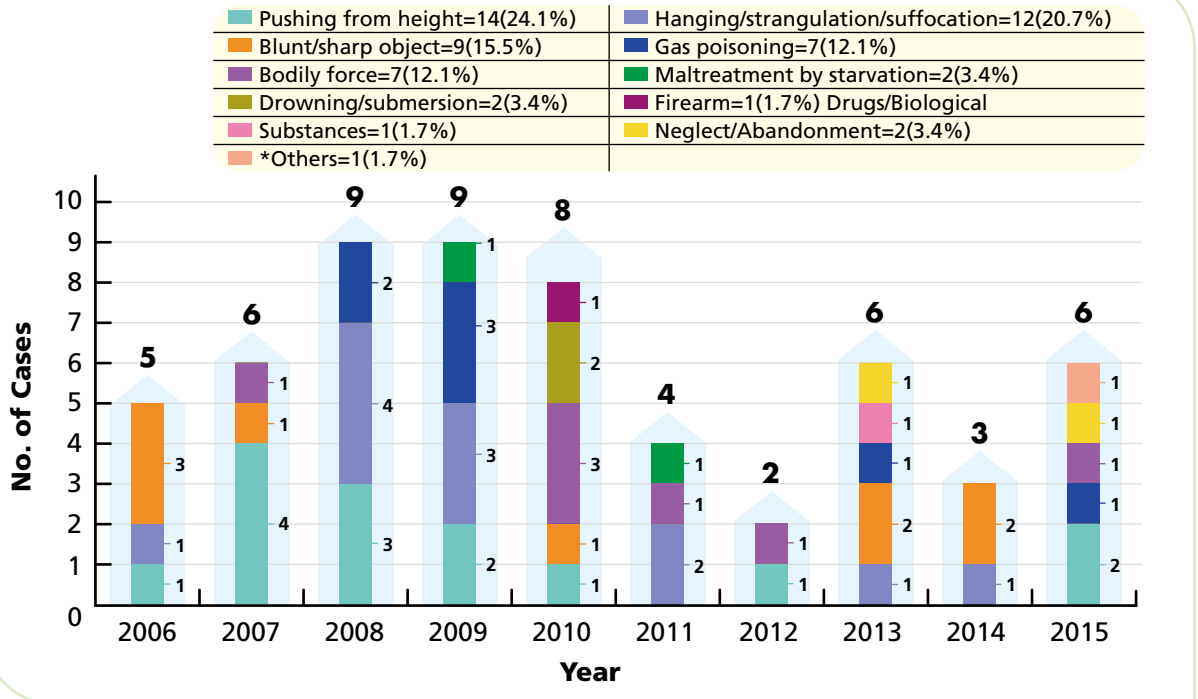
8.6 Statistics of Cases Died of Assault

Chart 8.6.1: No. of Cases by Year and Age Group



The highest number of child deaths by assault occurred in the age group of <1 (N=19, 32.8%) while three age groups of 6-8, 9-11 and 15-17 had the same number of deaths (N=8, 13.8%).

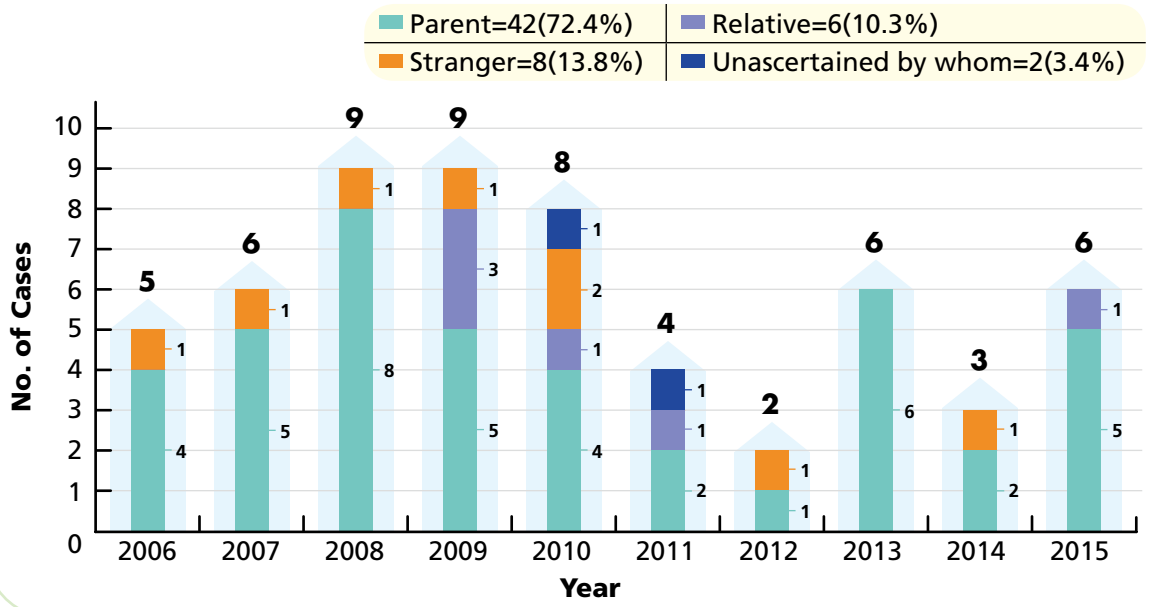
Chart 8.6.2: No. of Cases by Year and Type of Assault



* *Others: Unascertained due to decomposition of dead body*

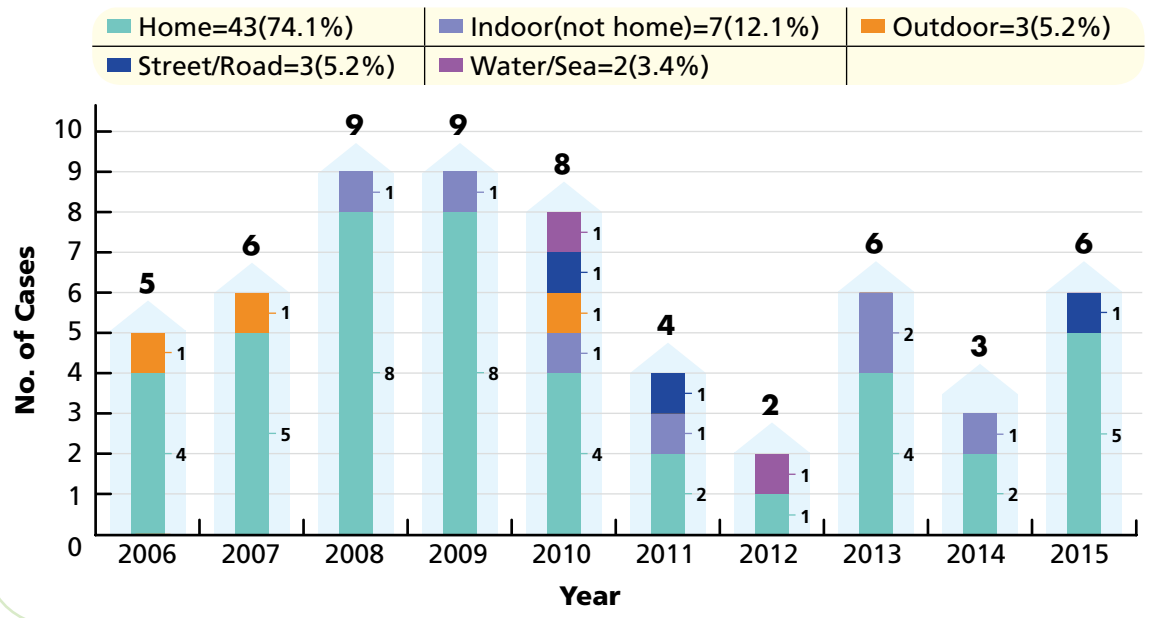
The highest number of types of assault was pushing from height (N=14, 24.1%), followed by hanging/strangulation/suffocation (N=12, 20.7%) and killed by blunt/sharp object (N=9, 15.5%).

Chart 8.6.3: No. of Cases by Year and Perpetrator's Relationship with the Deceased Child



Most of the perpetrator were parent (N=42, 72.4%), followed by stranger (N=8, 13.8%) and relative (N=6, 10.3%).

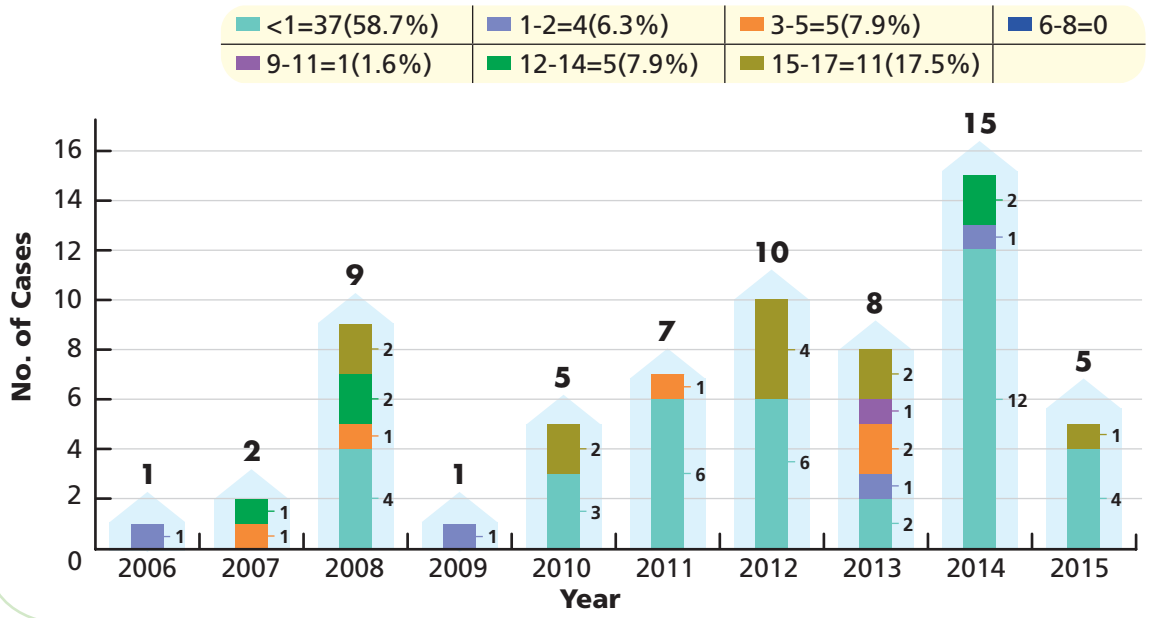
Chart 8.6.4: No. of Cases by Year and Place of Incident



Most of the assault incident occurred at home (N=43, 74.1%), followed by indoor (not home) (N=7, 12.1%) and both outdoor (N=3, 5.2%) and street/road (N=3, 5.2%).

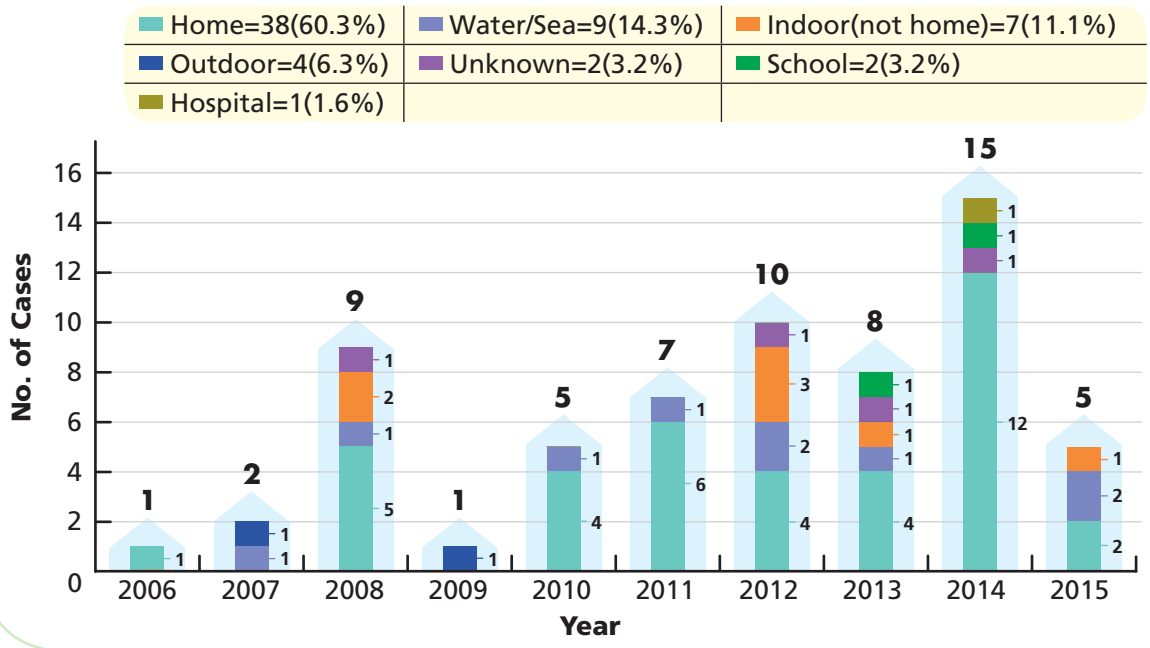
8.7 Statistics of Cases Died of Non-natural/ Unascertained Causes

Chart 8.7.1: No. of Cases by Year and Age Group



The highest number of child deaths occurred in the age group of <1 (N=37, 58.7%), followed by the age group of 15-17 (N=11, 17.5%) and both age group of 3-5 (N=5, 7.9%) and 12-14 (N=5, 7.9%).

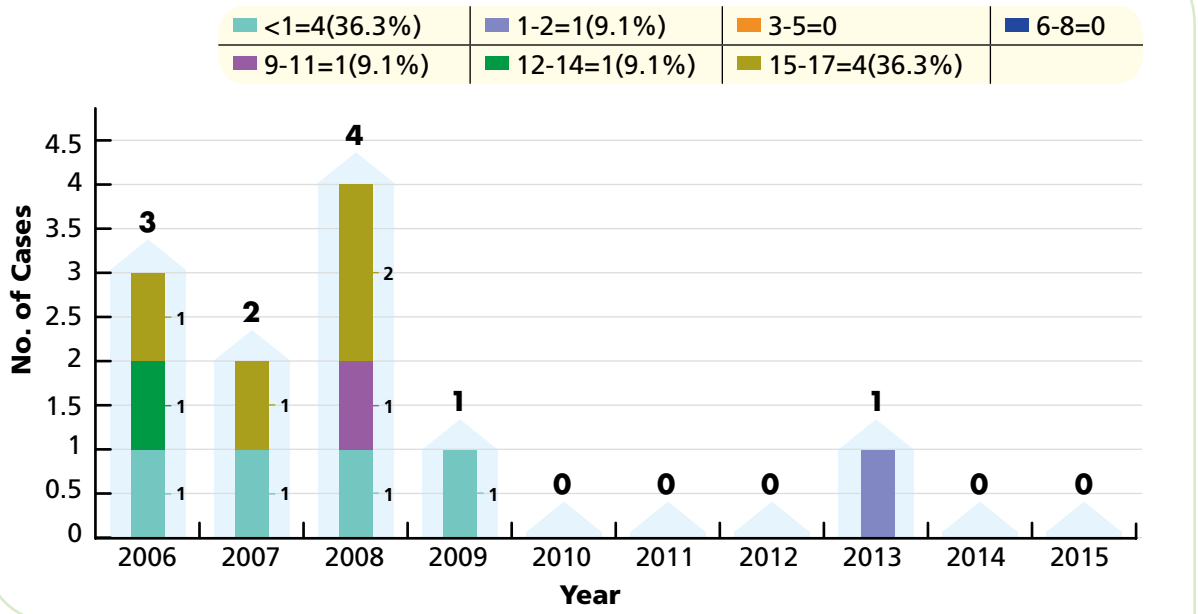
Chart 8.7.2: No. of Cases by Year and Place of Fatal Incident



Home was the most common place with the occurrence of unascertained death (N=38, 60.3%), followed by Water/Sea (N=9, 14.3%) and Indoor (not home) (N=7, 11.1%).

8.8 Statistics of Cases with Causes Related to Medical Complication

Chart 8.8.1: No. of Cases by Year and Age Group



The highest number of child deaths occurred in both the age group of <1 (N=4, 36.3%) and 15-17 (N=4, 36.3%), followed by the age groups of 1-2, 9-11 and 12-14 (N=1, 9.1%).

09 Appendices

Appendix 9.1 List of Child Fatality Review Panel Members

Members of the Child Fatality Review Panel (since June 2011) are listed in the following:

Name	Profession/ Discipline	Position	Service Term
1. * Professor Leung Nai-kong, S.B.S., MBE, J.P.	Medical (Paediatrics)	Chairman	June 2011 to May 2015
2. @ Mr Hui Chung-shing, Herman, S.B.S., M.H., J.P.	Legal	Chairman	June 2015 to present
		Member	June 2011 to May 2015
3. Dr Hung Se-fong, B.B.S., CEs COM	Medical (Child Psychiatry)	Group Convenor of Suicide Cases	June 2011 to May 2017
4. @ Ms Wong Yu-pok, Marina, J.P.	Accounting	Group Convenor of Traffic Accident Cases	June 2011 to May 2013
5. @ Dr Lee Lai-wan, Maria	Child Education	Group Convenor of Other Accident Cases	June 2011 to May 2013
6. @ Ms Lam Wai-ling, Leona, J.P., B of H	Education	Group Convenor of Accident Cases	June 2013 to May 2016
		Member	June 2011 to May 2013
7. Dr Yeung Ka-ching	Academia	Group Convenor of Accident Cases	June 2016 to May 2018
		Member	June 2012 to May 2016
8. Mr Fong Cheung-fat, J.P.	Social Welfare	Group Convenor of Assault and Miscellaneous Cases	June 2015 to May 2018
		Member	June 2012 to May 2015

Name	Profession/ Discipline	Position	Service Term
9. # Dr Yu Chak-man	Medical (Paediatrics)	Group Convenor of Medical Cases	June 2011 to May 2013
10. # Dr Cheung Chi-hung, Patrick	Medical (Paediatrics)	Group Convenor of Medical Cases	June 2013 to May 2017
		Member	June 2011 to May 2013
11. Dr Dunn Lai-wah, Eva	Medical (Psychiatry)	Group Convenor of Suicide Cases	June 2017 to May 2018
		Member	June 2012 to May 2017
12. Dr Lau Ka-fai, Tony	Medical (Paediatrics)	Group Convenor of Medical Cases	June 2017 to present
		Member	June 2013 to May 2017
13. Dr Tang Chun-pan	Medical (Psychiatry)	Group Convenor of Suicide Cases	June 2018 to present
		Member	June 2017 to May 2018
14. Ms Lee Shuk-yee, Charrix	Social Welfare	Group Convenor of Assault and Miscellaneous Cases	June 2018 to present
		Member	June 2013 to May 2018
15. Mr Tang Chee-ho, Alric	Legal	Group Convenor of Accident Cases	June 2018 to present
		Member	June 2016 to May 2018
16. Dr Beh Swan-lip, Philip	Medical (Forensic Pathology)	Member	June 2011 to present
17. @ Ms Chan Kit-bing, Sumee, CEs COM	Clinical Psychology	Member	June 2011 to May 2016

Name	Profession/ Discipline	Position	Service Term
18. @ Ms Chan Mei-lan, Anna May, M.H.	Legal	Member	June 2011 to May 2012
19. @ Ms Chan Mi-har, Grace	Social Welfare	Member	June 2011 to May 2013
20. Ms Chan Siu-lai	Social Welfare	Member	June 2018 to present
21. Dr Chui Mo-ching, Eileena	Medical (Psychiatry)	Member	June 2018 to present
22. Dr Fung Lai-chu, Annis	Academia	Member	June 2018 to present
23. Ms Ho Wai-ling	Education	Member	June 2018 to present
24. @ Ms Hung Wing-chee, Anna	Education	Member	June 2011 to May 2012
25. Mr Jao Ming, Raymond	Parent Representative	Member	June 2018 to present
26. @ Dr Lam Chan Lan-tak, Gladys	Academia	Member	June 2011 to May 2012

Name	Profession/ Discipline	Position	Service Term
27. Ms Lam Tze-yan	Legal	Member	June 2012 to May 2016
28. Dr Lee Lai-ping	Medical (Paediatrics)	Member	June 2015 to present
29. # Professor Albert Martin Li	Medical (Paediatrics)	Member	June 2011 to May 2015
30. Dr Li Chak-ho, Rever	Medical (Paediatrics)	Member	June 2016 to present
31. @ Professor Shek Tan-lei, Daniel, S.B.S, J.P.	Academia	Member	June 2011 to May 2013
32. Professor Sin Kuen-fung, Kenneth	Child Education	Member	June 2013 to present
33. Dr Sze Mei-lun, Angela	Clinical Psychology	Member	June 2016 to present
34. Ms Tao Chee-ying, Theresa, J.P.	Education	Member	June 2012 to May 2018
35. Mr Tong Siu-hon, David	Parent Representative	Member	June 2012 to May 2018

Name	Profession/ Discipline	Position	Service Term
36. @ Ms Tsang Lan-see, Nancy	Social Welfare	Member	June 2011 to May 2012
37. # Dr Tsang Man-ching, Anita	Medical (Paediatrics)	Member	June 2011 to present
38. Dr Wong Suet-na, Sheila	Medical (Paediatrics)	Member	May 2017 to present
39. Ms Wong Shuk-fan, Luparker	Education	Member	June 2016 to present
40. @ Dr Yiu Gar-chung, Michael	Medical (Psychiatry)	Member	June 2011 to May 2012
41. @ Mr Yu Wing-fai, Christopher, M.H.	Parent Representative	Member	June 2011 to May 2012

* *Professor Leung was also the Chairman of the Review Panel of the Pilot Project on Child Fatality Review implemented from February 2008 to February 2011.*

@ *Also as a Member of the Review Panel of the Pilot Project on Child Fatality Review implemented from February 2008 to February 2011.*

\# *Also as a Co-opted Member of the Review Panel of the Pilot Project on Child Fatality Review from February 2009 to February 2011.*

Appendix 9.2 Terms of Reference

The Terms of Reference of the Child Fatality Review Panel are:

(i) To examine the circumstances and service delivery process of the organisations/ departments concerned (if any) preceding the death of children through a review of child death cases;

(ii) To identify good practice and lessons to learn on the service delivery process, systems and multi-disciplinary collaborative efforts through the cases reviewed and to recommend improvements;

(iii) To keep in view the implementation of the recommendations made by the Child Fatality Review Panel on service enhancement;

(iv) To identify the patterns and trends of child death cases for formulation of preventive strategies; and

(v) To promote inter-sectoral and inter-disciplinary collaboration in the delivery of child welfare services to prevent child death.

Appendix 9.3 Information Brief on Child Fatality Review

Background

The Social Welfare Department (SWD) launched the Pilot Project on Child Fatality Review (Pilot Project) from 15 February 2008 to 14 February 2011. The findings of the Pilot Project have confirmed the value and worth of child fatality review in facilitating the improvement of social service systems to enhance child welfare (details of the Pilot Project can be found in the Final Report of its Review Panel at website: http://www.swd.gov.hk/doc/fcw/PPCFRFR-Eng.pdf). This leads to setting up of the standing child fatality review mechanism on 1 June 2011.

Purpose

The review aims at facilitating the enhancement of social service systems pertaining to child welfare with focus on inter-sectoral collaboration and multi-disciplinary cooperation for prevention of occurrence of avoidable child death cases. It is not intended to identify death causes or attribute responsibility to any party.

Objectives

1. To examine the practice and service issues in relation to the child death cases under review;
2. To identify and share good practice and lessons to learn for service improvement;
3. To keep in view the implementation of recommendations made after review for service enhancement;
4. To identify patterns and trends in relation to the reviewed child death cases for formulation of preventive strategies; and
5. To promote inter-sectoral collaboration and inter-disciplinary cooperation for prevention of occurrence of avoidable child death cases.

Levels and Scope

1. All cases with children aged under 18 who died on or after 1 January 2008 and were reported to the Coroner with all criminal and judicial processes completed so as to avoid prejudicing such processes.
2. Cases not reported to the Coroner but worthy of examination.

The Standing Review Mechanism

1. A non-statutory Child Fatality Review Panel (CFRP), with members appointed by the Director of Social Welfare will conduct review with secretariat support from the SWD.
2. The Secretariat will obtain the list of cases and relevant information from different sources for review by the CFRP. The review is primarily documentary in nature, supplemented by use of other means such as focus group or interview with concerned parties where necessary.
3. Organisation(s) that had rendered service(s) to the deceased child or his/her family could facilitate the review by reporting child death or providing service reports to the CFRP. Relevant forms can be obtained from the Secretariat upon request.
4. A database of child death cases is set up to facilitate the review and for future statistical or research purpose of the CFRP.
5. The review findings and recommendations of the CFRP will be released to the public through integrative reports. Recommendations will be distributed to relevant parties/organisations for feedback, consideration and follow-up action.
6. Where appropriate, the CFRP will request the organisations concerned to provide update of the progress of implementation of improvement measures.
7. No details of individual cases or particulars of persons or agencies concerned will be included in CFRP's report to ensure strict confidentiality. Information furnished by organisation(s) to the Secretariat will be used 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.

Reports of the Child Fatality Review Panel

The Child Fatality Review Panel has completed the review of child death cases which occurred from 2008 to 2013 and published its First Report, Second Report and Third Report in May 2013 and July 2015 and August 2017, respectively. The reports are available at websites:

http://www.swd.gov.hk/doc/fcw/CFRP1R-Eng.pdf,

http://www.swd.gov.hk/doc/fcw/CFRP2R-Eng.pdf and

https://www.swd.gov.hk/storage/asset/section/2867/en/CFRP_Third_Report_Aug2017_Eng.pdf

Enquiries

Secretariat / Child Fatality Review Panel

Room 721, Wu Chung House, 213 Queen's Road East, Wan Chai, Hong Kong

Tel. No.: 3468 2140 E-mail: srp@swd.gov.hk

Appendix 9.4 20 Categories of Deaths Reportable to the Coroners

20 Categories of Reportable Deaths

- Death the medical cause of which is uncertain
- Medically unattended within 14 days prior to the death, except where the person was diagnosed as having a terminal illness before his/her death
- Death caused by an accident or injury
- Death caused by a crime or suspected crime
- Death caused by an anaesthetic or the deceased was under the influence of a general anaesthetic or which occurred within 24 hours after the administering of a general anaesthetic
- Death caused by an operation or which occurred within 48 hours after a major operation
- Death caused by an occupational disease or which is directly/indirectly connected with the person's present/previous occupation
- Still birth
- Death of a woman which occurred within 30 days after the birth of her child/ an abortion/a miscarriage
- Death caused by septicaemia with unknown primary cause
- Suicide
- Death in official custody
- Death occurred during discharge of duty of an officer having statutory powers of arrest or detention
- Death in the premises of a Government department, any public officer of which has statutory powers of arrest or detention
- Death of certain mental patients (as defined by law) in a hospital or in a mental hospital
- Death in private care premises
- Death caused by homicide
- Death caused by administering of a drug or a poison
- Death caused by ill-treatment, starvation or neglect
- Death which occurred outside Hong Kong where the body of the person is brought into Hong Kong

Source: The Judiciary (Website: http://www.judiciary.hk/en/court_services_facilities/cor.html)

Appendix 9.5 Recommendations for Child Death Cases in 2014 and 2015

For Children Died of Natural Causes:

N1	To reiterate previous recommendation that autopsy may help provide more information on the cause(s) of death for prevention purpose.
N2	Public education on "safe sex" and "proper management of pregnancy" should be continued so as to prevent child death out of concealment of pregnancy.
N3	A standard protocol with clear referral mechanism should be set up by the government requiring forensic pathologist to refer the case to clinical genetic service (CGS) to conduct molecular or genetic testing if deceased child's cause of death was unascertained, related to genetic disorder or inborn errors of metabolism.

For Children Died of Suicide:

S1	To enhance children/youth's alertness and response skills when they identify or receive distress messages or suicidal threats from their peers/ schoolmates, such as via instant message in mobile phone or social media, like notifying the school social workers or trustworthy adults promptly so that the latter can report to the Police at once in critical situation.
S2	To enhance the public's sensitivity and knowledge on symptoms of "early psychosis" and "depression" and relevant treatment required.
S3	To strengthen mental health education to the public by delivering the message that mental illness is "highly treatable" and to encourage those who suspect themselves to be suffering from mental illness to seek professional help at once.
S4	To enhance parents' understanding of the needs of their children with Special Educational Needs (SEN) and advise parents to set appropriate expectations on these children.
S5	Schools should accommodate the needs of SEN children as well as those with mental illness in early recovery stage so that they could learn happily and not being hard pressed by the requirement of following the school syllabus. These children need more support and allowance through cross-disciplinary collaboration. Emphasis should be placed on individual educational plan (IEP), particularly for those students having limited intelligence and suffering from mental illness.

S6	The Education Bureau is advised to provide training for teachers to have more understanding on needs of SEN children by inviting mental health professionals and educational psychologists to deliver talks to teachers preferably using case studies.
S7	Children with underlying mental illness would be at higher risk of suicide. Family members should be alert of that and escort their children to seek assessment and/or management by mental health professionals at once when they are found to be mentally unstable.
S8	To advise parents to keep proper storage of psychiatric medication for their children, who suffer from depression with suicidal intent, so as to prevent them from easy access for drug overdose.
S9	Parents should be equipped with the knowledge of the possible subtle signs of depression of their children, such as "school refusal", especially when their children have just been promoted to Form One.
S10	School refusal is a warning sign of teenagers' unstable emotions which requires attention and intervention by the helping professionals. For those with suicidal threats, clinical psychologist or psychiatrist should be involved.
S11	To help students build up resilience in face of adversity and academic challenges when promoted to Form One by incorporating the components of "stress inoculation", "mental wellness" and "how to seek help" into the bridging or adjustment class, especially for those who used to have good academic result with high self-expectation but without experiencing failure in their primary schooling.
S12	In order to tackle peer bullying, especially via social media, such as: WhatsApp, snapchat, etc., students should be taught to have "empathy" for one another. Students being bullied are to be advised to seek help from teachers or school social worker at once. The bullies may also suffer from psychopathologies and so may need attention and help.
S13	To promote a "Caring and Loving" culture at school in order to strengthen mutual care among students and to teach them how to respond to their peers' expression of emotional distress or suicidal thoughts at the Life Education Class.
S14	Schools could consider renaming the "remedial class" as "enhancing class" so as to get rid of its negative connotation.
S15	Parents should spend more time and make more effort to communicate with their children at an "emotional level" so that they can get more in touch with their children's feelings or emotions and help their children ventilate the distress.

S16	To strengthen parent education in handling teenagers' conduct problems. Parents should control their emotions when confronting the misbehaviour of their children and beware of their use of words which might easily trigger the children's impulsive reaction.
S17	Teenages should be taught the harmful effects of alcohol at school.
S18	To strengthen courtship education for students with emphasis on how to handle "breakup" and cope with "loss".

For Children Died of Accidents:

A1	To reiterate the previous recommendations that young children should never be left alone or unattended at home, even for a very short period of time and especially when they were asleep.
A2	To make every safety measure to prevent falls of children, parents should install proper window grilles (including grilles for louver windows as well) and ensure the window grilles are designed with adequate protection for children and are properly locked at all times.
A3	To disseminate the message and to enhance training on child safety for foreign domestic helpers through their employment agencies, Consulates-General or labour unions.
A4	To reiterate the previous recommendation of raising parents and caregivers' awareness of appropriate sleeping arrangement for young children, such as not to arrange for them to sleep alone on a high bed without a fence or having a gap between the bed and the wall.
A5	To reiterate the previous recommendation of reminding parents and caregivers to seek immediate medical attention at once when children sustained/were suspected to have sustained head injuries, especially from a fall even without any obvious/observable injuries.
A6	To enhance parents' knowledge on home safety for infants and to consider placing slip resistant rubber mats on the floor so as to prevent infants from slipping at home.
A7	To enhance parents' awareness of the risk of suffocation for very young babies when they roll over to a face-down position on a bed being placed with soft objects, such as pillows, cushions, bumpers, blankets and stuffed toys, etc. as babies could easily be smothered by these objects.

A8	To remind parents to pay special attention to the sleeping arrangement for their babies when they have to sleep at a place other than their familiar home environment.
A9	The Department of Health should further promote "sleeping safety for babies" to parents-to-be during the pre-natal and post-natal check-up through audio-visual means or delivery of information kits.
A10	To remind the public to call '999' at once when witnessing the breakout of a fire.
A11	To continue strengthening public education on fire prevention and safety issues such as ways of escape from a fire, whether to stay or leave the household unit and whether it is appropriate to put out the fire by oneself.
A12	To continue strengthening public education on the proper use of electrical home appliances and installations.

For Children Died of Assault and Non-natural Unascertained Causes:

AS1	To enhance carer support service in special schools for parents in taking care of students with a wide range of disabilities.
AS2	To advise the Education Bureau to review the current manning ratio of school social workers serving in special schools with a view to enhancing the manpower of school social workers in special schools.
AS3	To empower parents/carers in taking care of their disabled children by enhancing their knowledge of different available training or resources in the community.
AS4	To encourage carers, especially male carers to seek help whenever in need and to join carer support groups/programmes for sharing and alleviating their distress.
AS5	Family members should keep in view the caregivers' mental health, including those elderly persons who are entrusted with child care and be alert to any suicidal signs or depressive mood manifested by them so as to help them seek professional assistance promptly.
AS6	To further enhance public knowledge of "depression" (including its symptoms and treatment) and encourage help-seeking through TV Announcements in the Public Interest (TVAPIs).

AS7	To alert youth to the importance of "self-protection" when using social media, such as "Facebook", "Instagram" and "WeChat" for making friends.
AS8	To educate youth on the potential risks of making "fast and easy money", particularly by engaging in social activities which involved financial transactions under the name of "compensated dating", "private photo model" or "part-time girlfriend", etc.
AS9	To reiterate the message that children have their own rights to survival which no one, including their parents, should take away.
AS10	To strengthen co-parenting support services for separated/divorcing/ divorced families.
AS11	To further promote counselling service on peaceful separation and co-parenting for divorced couples, as well as, child-focused service for their children by delivering relevant pamphlets to them at the Family Court or through their representing lawyers.
AS12	To reiterate the risk of co-sleeping with babies and raise the awareness of parents and caregivers not to arrange for baby sharing a bed with siblings or other children.
AS13	To arouse parents' awareness of the threat of "wedging" between the bed and the wall and that very young babies are not totally immobile as commonly perceived to be.
AS14	To remind parents and caregivers that babies should wear light and comfortable clothing at bedtime as too much clothing is unfavourable.
AS15	To remind parents and carers that they will not be suitable to take care of babies when they are very tired or sick, after drinking alcohol or taking medicines with drowsy effect as their alertness will be reduced under such circumstances.
AS16	To reiterate the message that parents and caregivers should conduct regular checking on babies while alseep or to install appropriate monitoring devices when the latter was sleeping alone.
AS17	To further raise the public's awareness, especially for teenager, of the harmful effects of drug abuse and the importance of staying away from illicit drugs.
AS18	To provide education and support programmes for drug-abusing parents so as to raise their awareness of the harmful effects of illicit drugs on their children and to enhance their parental capacity.

AS19	To alert and encourage family members of drug-abusing parents to render necessary child care assistance to the latter who are in definite need of child care and social support.
AS20	To reiterate the previous recommendation of arousing awareness of the possible fatal consequence of concealment of pregnancy and the importance of seeking medical attention and social service support after getting pregnant or when giving birth to a baby.

Amendments had been made in the Fourth Report of the Child Fatality Review Panel (May 2019) as highlighted in red (for English version only):

Page 2

The highest number of child deaths occurred for children aged below 1 (N=**72**, **43.4%**), followed by the age groups of 15-17 (N=28, 16.9%) and 1-**2** (N=24, 14.4%).

Page 10 - Table 5.2.2

For Age Group <1 Male = **36 (21.7%)** and No. of Cases = **72 (43.4%)**

For Age Group 9-11 Male = **5 (3.0%)** and No. of Cases = **5 (3.0%)**

Page 11 - Chart 5.2.3

For the bar, age group <1, Male = **36** and age group 9-11, Male = **5**

Page 13 - Chart 5.2.8

For the bar, age group <1, Assault= **2** and age group 9-11, Assault = **2**

Page 28 - Chart 5.3.5.1

For the index of chart, Female = **10 (50.0%)** and Male = **10 (50.0%)**

For the bar, age group <1, Female = **8** and age group 15-17, Male = 1

Page 90 - Chart 8.2.1.4

For the index of chart, Suicuide cases should be **Suicide** cases

Page 93 - Table 8.2.2

For year 2012, age group 1-2, M = **5**, Sub-total = **8**

age group 3-5, M = **5**, Sub-total = **6**

age group 6-8, M = **5**, Sub-total = **9**

age group 9-11, M = **4**, Sub-total = **5**

For year 2015, age group <1, M = **20**, Sub-total = **32**

age group 9-11, M = **4**, Sub-total = **4**

For No. of Cases (%), age group <1 M = **242**, Sub-total = **434** (41.0%)

age group 1-2 M = **54**, Sub-total = **99 (9.3%)**

age group 3-5 M = **48**, Sub-total = **78 (7.3%)**

age group 6-8 M = **38**, Sub-total = **60 (5.6%)**

age group 9-11 M = **38**, Sub-total = **67 (6.3%)**

The highest number of child deaths occurred for children aged below 1 (N =**434**, 41.0%), followed by……

Page 94 - Chart 8.2.2.1

For the index of chart, age <1= **434** (41.0%) and age 9-11 = **67 (6.3%)**

For the bar 2015, age <1 = **32** and age 9-11 = **4**

Page 98 - Chart 8.2.3.6

For the index of chart, Female = **33 (52.4%)** and Male = **30 (47.6%)**

For the bar 2015, Female = **1**, Male = **4**

Page 100 & 101 - Table 8.2.4

For 2015, the highlighted number should be **0.170** instead of 0.150

Page 103 - Chart 8.3.1

The highest number of natural child deaths occurred in children aged below 1 (N=358, 52.5%), followed by the age groups of 1-2 (N=74, 10.9%) and 15-17 (N=**68**, 10.0%).

Page 113 - Chart 8.7.1

For the index of chart, age <1 = **37 (58.7%)** and age 15-17 = **11 (17.5%)**

For the bar 2015, age <1 = **4** and age 15-17 = **1**

The highest number of child deaths occurred in the age group of <1 (N=**37, 58.7%**), followed by the age group of 15-17 (N=**11, 17.5%**) and both age group of 3-5 (N=5, 7.9%) and 12-14 (N=5, 7.9%).

Page 124 - Appendix 9.4

Source: The Judiciary

*(Website:**https//www.judiciary.hk/en/court_services_facilities/cor.html**)*

Secretariat

Child Fatality Review Panel

November 2019

Special thanks to Mr Derek Yeung for the report cover design