Child Fatality Review Panel

Third Report **for child death cases in Hong Kong in 2012 and 2013**

Table of Contents

Table of Contents

List of Tables and Charts

List of Tables and Charts

List of Tables and Charts

1 Foreword

Every child has the right to live, and to grow to be a healthy individual with love, joy and fulfilment. There are potentials, creativities and possibilities to be unveiled and developed from our children. They will bring happiness to their families and others as well as contributing to our society. The loss of every child saddens his/her family and causes much pain and grief to them. The Child Fatality Review Panel (Review Panel) extends our deepest condolences to the families that have suffered the loss of their children.

The Review Panel believes that, through the concerted efforts of all parties, including parents, school personnel, social workers and those having a role in the service systems and their delivery, our children can be better nurtured and protected to develop fully and healthily.

This is the third report of the Review Panel, covering the review of child death cases which occurred in 2012 and 2013. Having witnessed a rising trend over child deaths in relation to co-sleeping with adults or other sleeping safety and with quite a number of child deaths found to be related to concealment of pregnancy, the Review Panel has completed a thematic review of these two topics with feedback received from concerned stakeholders. With the understanding of the public concern over the lapse of time in our review, the Review Panel has been proactive in exchanging our views and recommendations with stakeholders by sending our observations and recommendations in writing to the stakeholders concerned when we encounter issues which warrant attention. So far, the stakeholders concerned have been responsive to our observations. Yet, the Review Panel encounters limitation in its review. Having mainly relied on the documents obtained from the Coroner's Court, the recommendations made in the Review Panel will be subject to the useful information collected at the Coroner's Court. Nonetheless, we hope that our findings and observations may facilitate the public to understand the circumstances leading to and causing these fatalities and the risk factors that may be mitigated to prevent similar tragic incidents. Let us join hands to better protect our children by preventing avoidable child deaths.

Hui Chung Shing, Herman, S.B.S., MH., J.P.
Chairman
Child Fatality Review Panel
August 2017

2 Executive Summary

2.1 Review of Child Death Cases in 2012 and 2013

In this report, 206* child death cases that occurred in 2012 and 2013 and were 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
	2012	2013	
Natural Causes	70	61	131
Non-natural Causes	39	36	75
Suicide	10	10	20
Accident	17	11	28
Assault	2	6	8
Unascertained#	10	8	18
Medical Complications@	0	1	1
Total:	109	97	206

* *2 natural-cause cases and 10 accident cases in 2012 and 2 natural-cause cases in 2013 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.*

@ *Complications of medical/surgical care or complications of medical treatment/procedures.*

Major demographics of the 206 cases reviewed are as follows:

- A total of 131 cases (63.6%) died of natural causes, 20 cases (9.7%) died of suicides, 28 cases (13.6%) died of accidents, 8 cases (3.9%) died of assaults and 18 cases (8.7%) died of non-natural unascertained causes. *(Charts 5.2.1 and 5.2.6)*
- There were more male (N=119, 57.8%) than female (N=87, 42.2%). *(Table 5.2.2)*
- The highest number of child deaths occurred for children aged below 1 (N=96, 46.6%), followed by the age groups of 15 – 17 (N=32, 15.5%) and 12 – 14 (N=22, 10.7%). *(Table 5.2.2 and Chart 5.2.3)*
- The majority of the deceased children were Chinese (N=182, 88.3%), and 21 (10.2%) were non-Chinese while the remaining 3 (1.5%) were of unknown ethnicity. *(Chart 5.2.4)*

- Occupation was not applicable to 116 (56.3%) children who were too young or whose health problems had prevented them from attending school or work. Seventy-nine (79) (38.3%) children were full-time students while 8 (3.9%) were neither studying nor working. *(Chart 5.2.5)*
- There were more male than female in the death cause groups of natural causes, accident and assault but the other way round in the groups of suicides, non-natural unascertained causes and medical complications. *(Chart 5.2.7)*
- The highest number of child deaths occurred for children aged below 1 who died of natural causes (N=80, 38.8%). The second and third highest numbers of child deaths occurred for children aged 12-14 who died of natural causes and those aged 15-17 who died of suicide (both N=14, 6.8%). *(Chart 5.2.8)*
- Most fatal incidents occurred in hospitals (N=86, 41.7%) due to natural deaths. Home is the second most common place where 71 (34.5%) 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 Nature of Deaths in 2012 and 2013

Based on the review of child death cases which occurred in 2012 and 2013, the Review Panel has a number of observations as per death nature. Please see **Chapter 6** for more details.

2.3 Recommendations Arising from Review of Child Death Cases in 2012 and 2013

After reviewing the child death cases which occurred in 2012 and 2013, the Review Panel has come up with 45 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 Nos.	No. of Recommendations
Natural Causes	N1 – N5	5
Suicide	S1 – S15	15
Accident	A1 – A11	11
Assault and Non-natural Unascertained Causes	AS1 – AS11	11
Medical Complications	MP1 – MP3	3
Total:	–	45

The recommendations are tabulated in **Chapter 6** for reference.

2.4 Profile of Child Death Cases Reviewed from 2006 to 2013

Taking account of the child death cases which occurred from 2006 to 2013, thematic review on co-sleeping, other sleeping safety and concealment of pregnancy has been completed. Besides, tables and charts are prepared to show the changes over time by case nature. While these tables and charts may be used for interpretation of trends and patterns, it is considered that when more data is gathered from subsequent reviews, a more significant representation of the trends and patterns may be available.

Please refer to **Chapter 7** for more details.

3 Acknowledgement

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

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 continuing the cooperation with all the parties concerned in promoting child welfare and child protection.

4 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 involving children aged below 18 and 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 and July 2015, the Review Panel published its First and Second Reports respectively, sharing the findings, observations and recommendations after reviewing the child death cases which occurred from 2008 to 2011.

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 deaths. It is not intended to ascertain death causes or attribute responsibility to any party.

4.3 The Review Panel

The Review Panel comprises 18 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 convenor was selected for each sub-group to lead the discussion and to report the findings of review at the quarterly panel meeting. From June 2015 to May 2017, the Review Panel held 25 meetings, including 8 panel meetings and 17 sub-group meetings.

The membership list and terms of reference of the Review Panel are at **Appendices 8.1** and **8.2** 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

Upon its formation in June 2011, the Review Panel began to review child death cases that occurred in 2008. The Review Panel completed the review of child death cases that occurred in 2008 and 2009 and released its first report in May 2013. After completing the review of child death cases that occurred in 2010 and 2011, the Review Panel also released its second report in July 2015. Over the subsequent two years, the Review Panel also completed the review of child death cases that occurred in 2012 and 2013. 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 fatal 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 the 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 in 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 deceased children.

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 2011 and published its First Report and Second Report in May 2013 and July 2015 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

5 Overview of Child Death Cases Covered by this Report

5.1 Figures of Child Population and Child Death in Hong Kong in 2012 and 2013

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 (2012 and 2013)

Type of Figure	Year	
	2012	2013
Child Population*	1 057 900	1 028 000
No. of Child Death	261	221
Child Death Rate@	0.2	0.2
No. of Cases Reviewed	109	97

** 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		2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
Country/ Place@	Hong Kong#	2.7	2.3	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2
	Australia^	3.4	3.5	0.2	0.2	0.1	0.1	0.1	0.1	0.3	0.3
	Canada&	4.8	4.9	0.2	0.2	0.1	0.1	0.1	0.1	0.4	0.3
	Japan~	2.2	2.1	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2
	Singapore~	2.1	2.1	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2
	United Kingdom~	4.1	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 102-0504) (http://www5.statcan.gc.ca/cansim/a01?lang=eng&p2=1)
~ Source: World Health Organization (WHO) Mortality Database (http://www.who.int/healthinfo/mortality_data/en/)

5.2 Statistics of Child Death Cases Reviewed in 2012 and 2013

Chart 5.2.1: No. of Cases by Case Nature

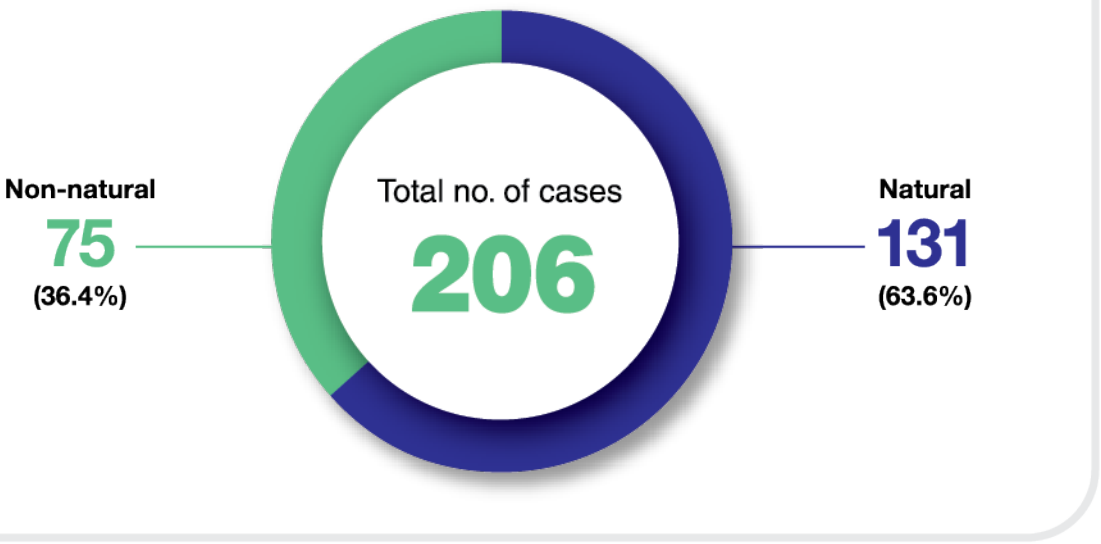


Table 5.2.2: No. of Cases by Age Group and Sex

Age Group	Sex		No. of Cases (%)
	Female (%)	Male (%)	
< 1	41 (19.9%)	55 (26.7%)	96 (46.6%)
1 – 2	7 (3.4%)	11 (5.3%)	18 (8.7%)
3 – 5	5 (2.4%)	8 (3.9%)	13 (6.3%)
6 – 8	6 (2.9%)	7 (3.4%)	13 (6.3%)
9 – 11	6 (2.9%)	6 (2.9%)	12 (5.8%)
12 – 14	10 (4.9%)	12 (5.8%)	22 (10.7%)
15 – 17	12 (5.8%)	20 (9.7%)	32 (15.5%)
Total (%) :	87 (42.2%)	119 (57.8%)	206 (100.0%)

The highest case numbers among different age groups are highlighted.

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

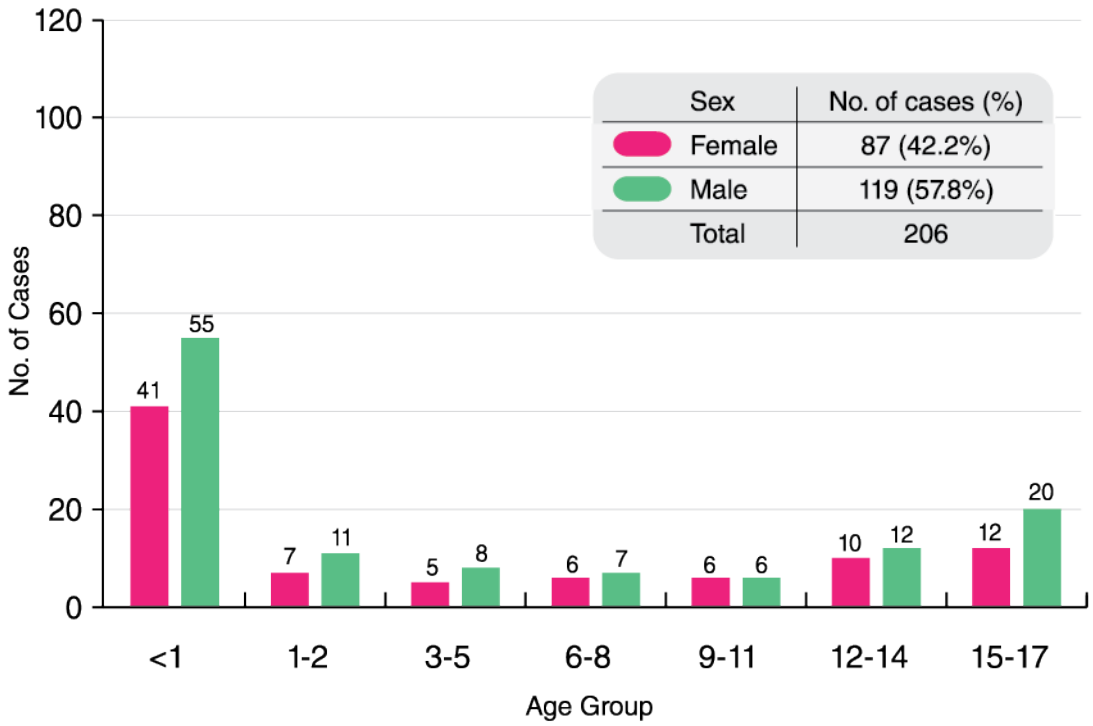


Chart 5.2.4: No. of Cases by Ethnicity

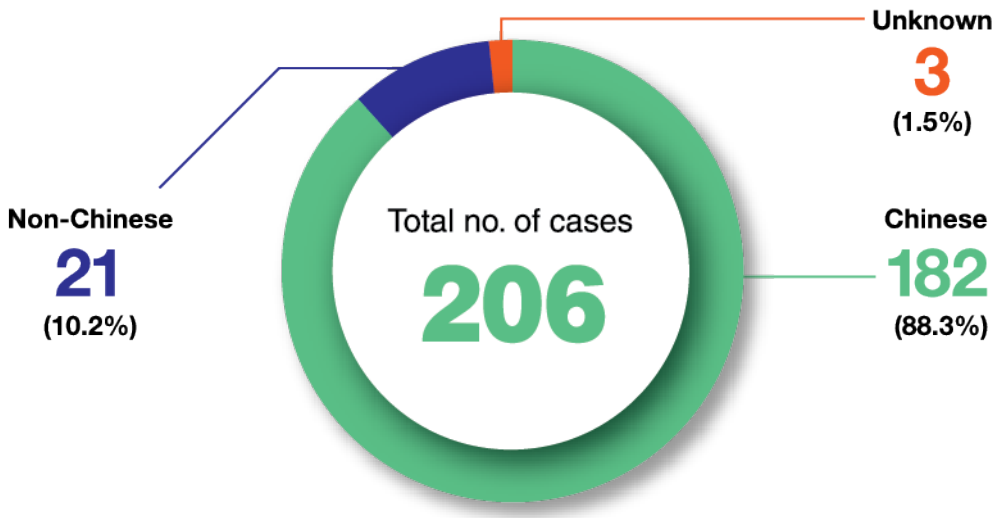
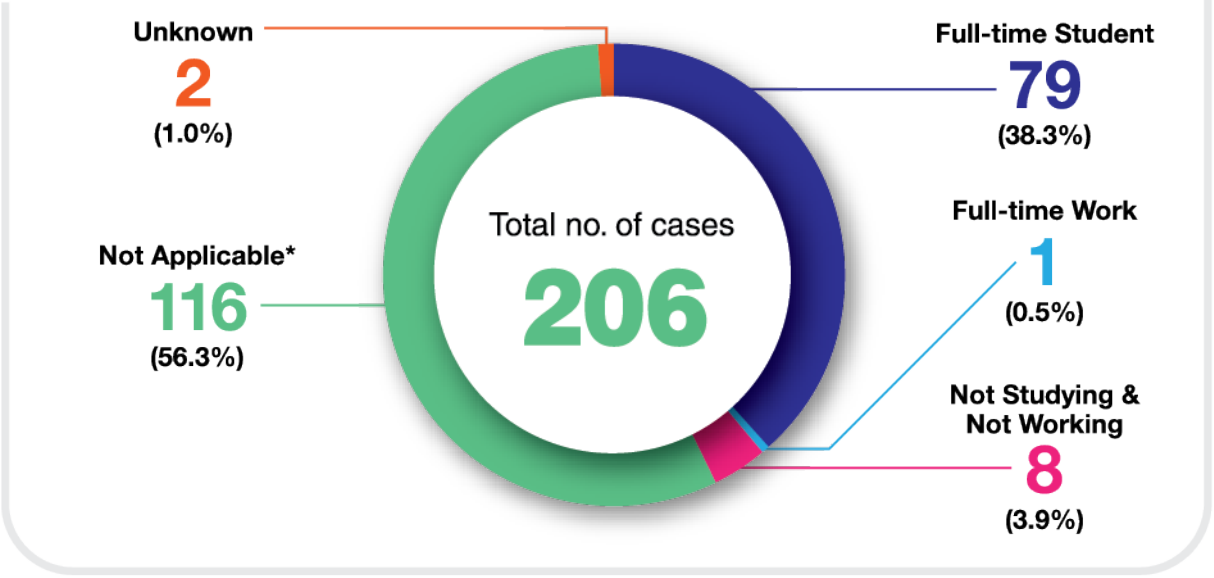


Chart 5.2.5: No. of Cases by Occupation



**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

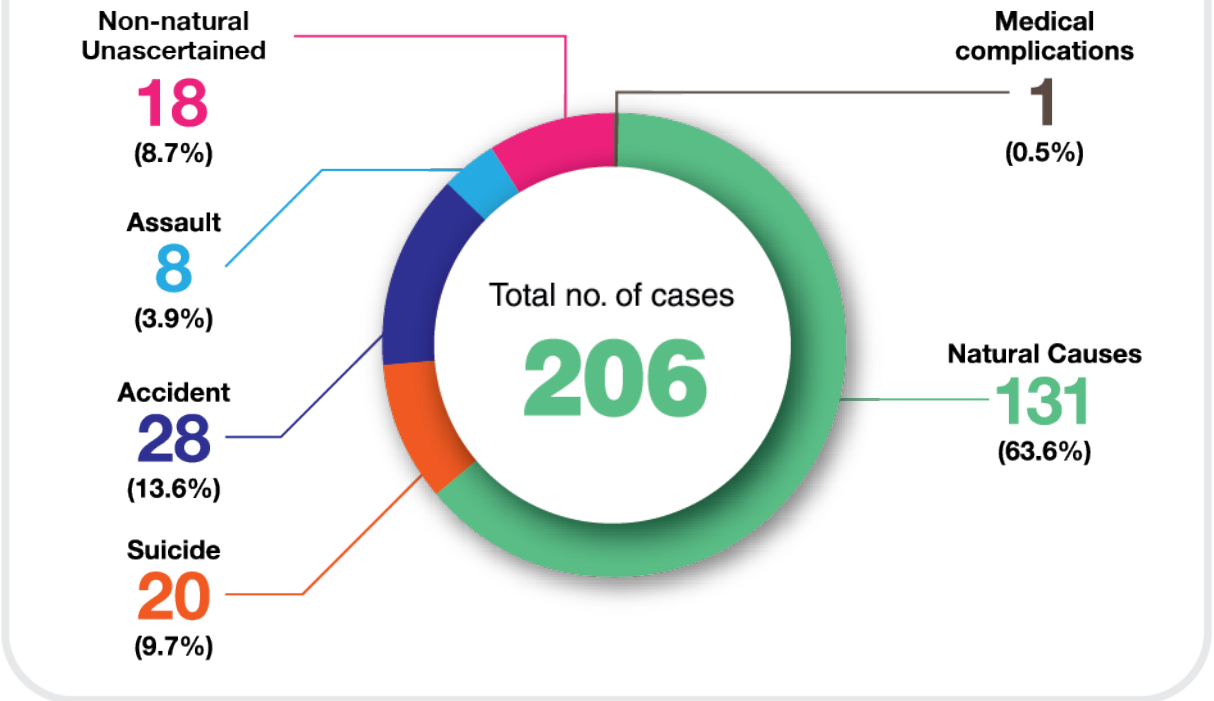


Chart 5.2.7: No. of Cases by Cause of Death and Sex

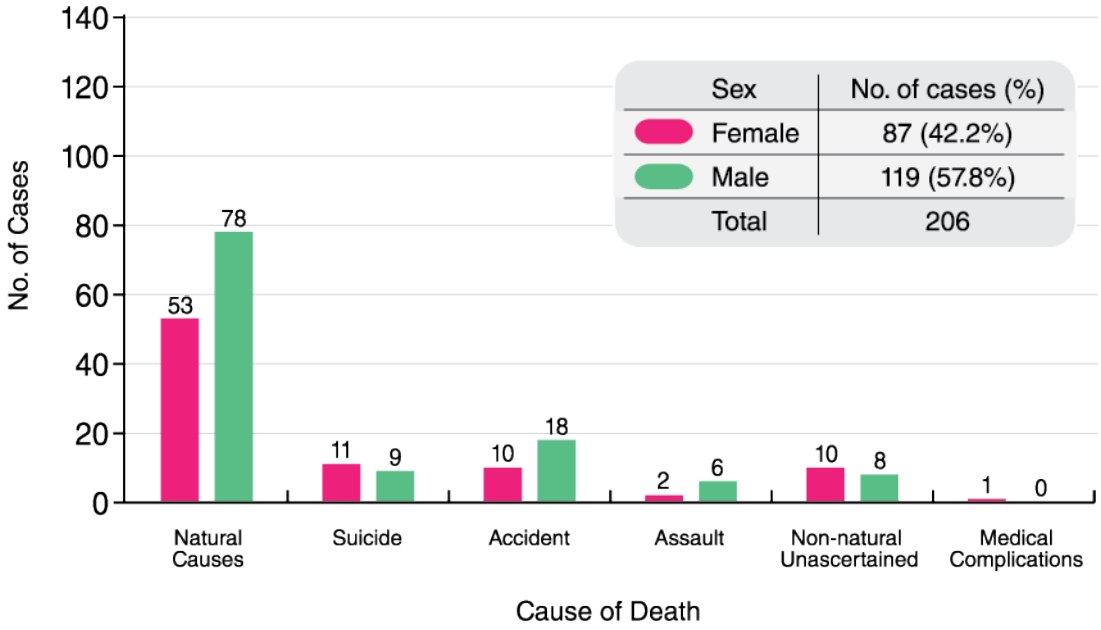


Chart 5.2.8: No. of Cases by Age Group and Cause of Death

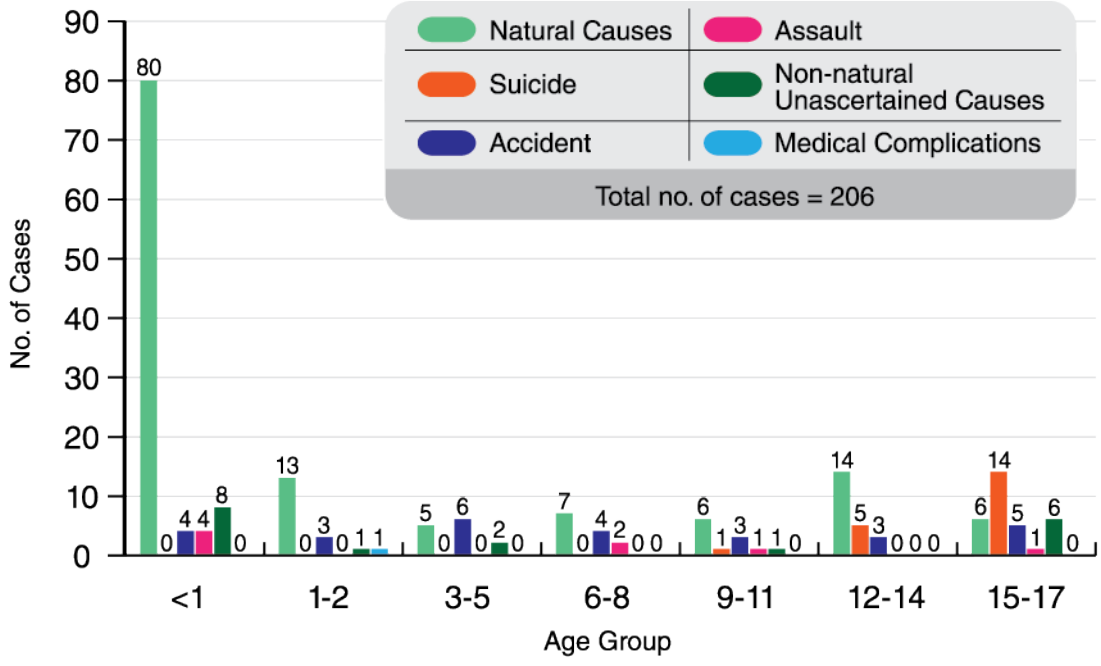


Table 5.2.9: No. of Cases by Residential District and Year

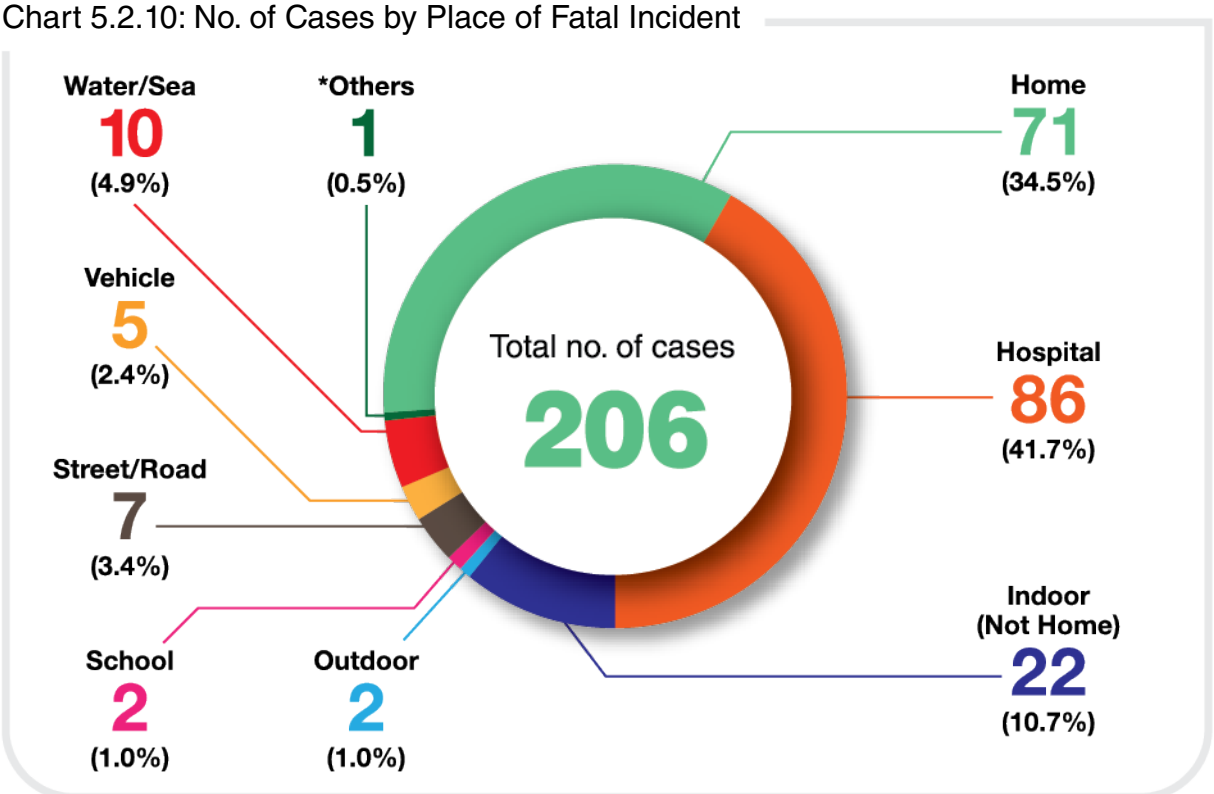
Residential District	2012			2013		
	No. of cases	*Population	#Death rate	No. of cases	*Population	#Death rate
HONG KONG ISLAND						
Central & Western	6	34 900	0.172	1	34 800	0.029
Wan Chai	2	19 100	0.105	2	18 300	0.109
Eastern	11	78 600	0.140	6	76 300	0.079
Southern	2	39 700	0.050	5	37 400	0.134
KOWLOON						
Yau Tsim Mong	7	47 400	0.148	5	48 100	0.104
Sham Shui Po	6	56 900	0.105	6	55 700	0.108
Kowloon City	2	55 200	0.036	3	52 600	0.057
Wong Tai Sin	5	57 800	0.087	7	57 400	0.122
Kwun Tong	9	96 200	0.094	6	93 900	0.064
NEW TERRITORIES						
Kwai Tsing	2	73 600	0.027	5	72 600	0.069
Tsuen Wan	4	47 300	0.085	2	47 400	0.042
Tuen Mun	6	70 600	0.085	3	68 900	0.044
Yuen Long	11	101 600	0.108	14	98 500	0.142
North	2	48 500	0.041	7	45 700	0.153
Tai Po	4	40 200	0.100	4	37 800	0.106
Sha Tin	6	88 600	0.068	7	87 900	0.080
Sai Kung	10	71 200	0.140	3	68 300	0.044
Islands	3	27 000	0.111	2	25 700	0.078
OTHERS						
Not residing in HK	10	-	-	7	-	-
Unknown	1	-	-	2	-	-
Total :	109	-	-	97	-	-

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 2012, the highest number of child deaths was recorded in Eastern District and Yuen Long District (both N=11), followed by Sai Kung District (N=10). 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 Central & Western District (0.172), followed by Yau Tsim Mong District (0.148) as well as Eastern and Sai Kung Districts (both 0.140). Eastern District and Sai Kung District were the districts with relatively higher number of child deaths and child death rate.

In 2013, the highest number of child deaths was recorded in Yuen Long District (N=14), followed by Wong Tai Sin District, North District and Sha Tin District (all N=7). The highest child death rate came from North District (0.153), followed by Yuen Long District (0.142) and Southern District (0.134). Yuen Long District and North 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



*Others: 1 fatal case occurred on a flight to Hong Kong.

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

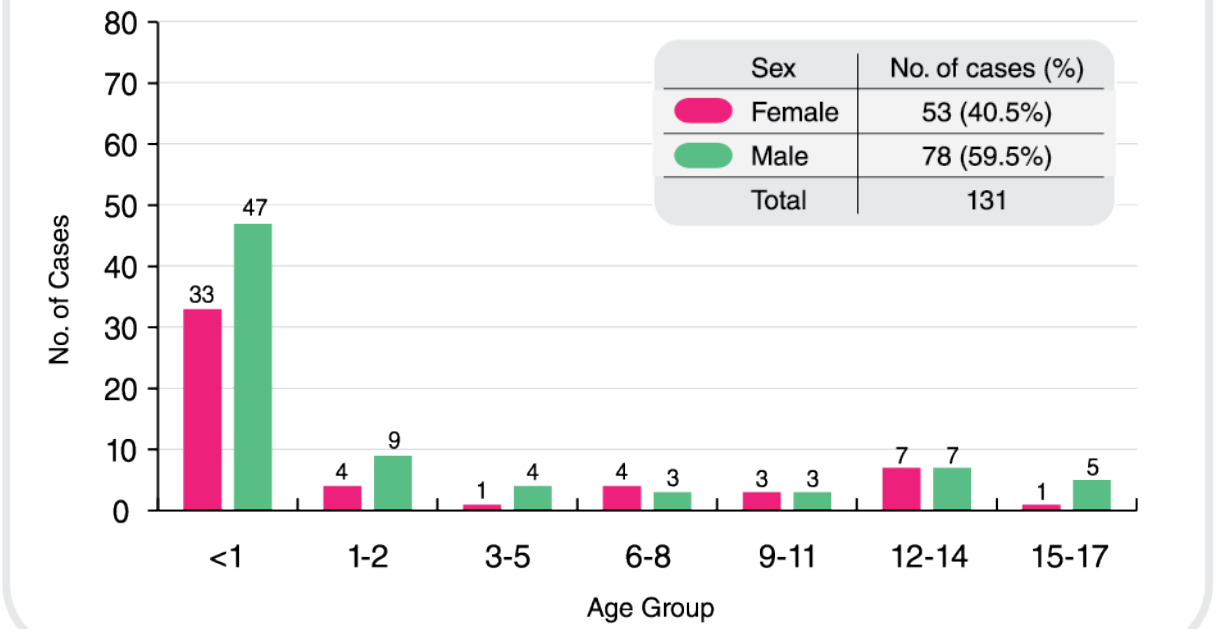
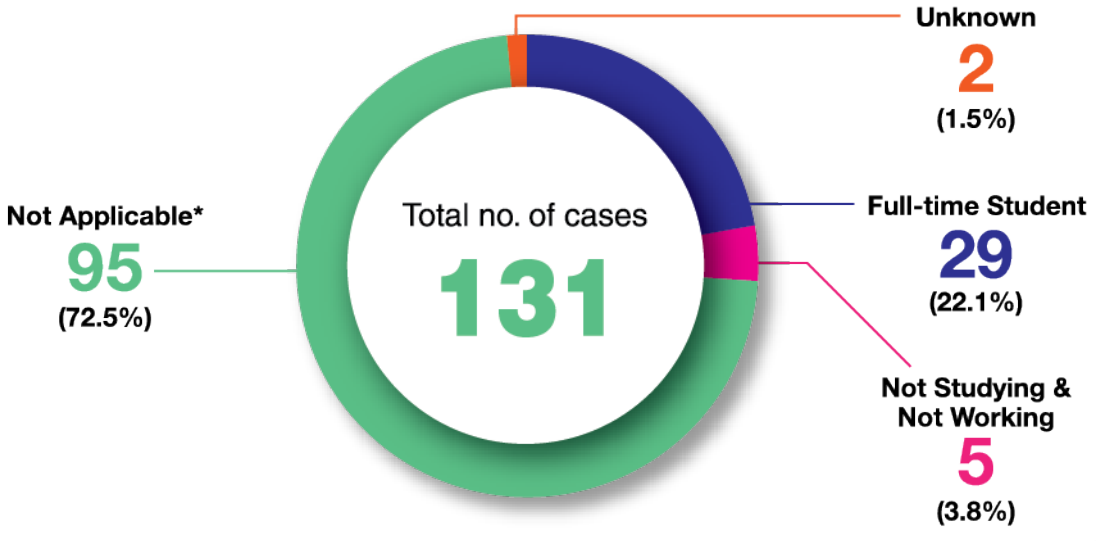


Chart 5.3.1.2: No. of Cases by Occupation



**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	14 (10.7%)
C00-D48	Neoplasms	3 (2.3%)
E00-E90	Endocrine, nutritional and metabolic diseases	2 (1.5%)
G00-G99	Diseases of the nervous system	4 (3.1%)
I00-I99	Diseases of the circulatory system	18 (13.7%)
J00-J99	Diseases of the respiratory system	22 (16.8%)
K00-K93	Diseases of the digestive system	6 (4.6%)
N00-N99	Diseases of the genitourinary system	1 (0.8%)
O00-O99	Pregnancy, childbirth and the puerperium	1 (0.8%)
P00-P96	Certain conditions originating in the perinatal period	20 (15.3%)
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	19 (14.5%)
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)	18 (13.7%)
Not available	-	3 (2.3%)@
	Total :	131 (100.0%)

ICD10: The International Classification of Diseases, Version 10 is developed by the World Health Organization. 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.

@ICD classification has not been assigned for 3 stillbirth cases.

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	24 (18.3%)	9 (6.9%)	9 (6.9%)	9 (6.9%)	29 (22.1%)	80 (61.1%)
1 – 2	0	6 (4.6%)	1 (0.8%)	5 (3.8%)	1 (0.8%)	13 (9.9%)
3 – 5	0	1 (0.8%)	1 (0.8%)	3 (2.3%)	0	5 (3.8%)
6 – 8	0	5 (3.8%)	0	2 (1.5%)	0	7 (5.3%)
9 – 11	0	2 (1.5%)	1 (0.8%)	3 (2.3%)	0	6 (4.6%)
12 – 14	0	7 (5.3%)	3 (2.3%)	4 (3.1%)	0	14 (10.7%)
15 – 17	0	1 (0.8%)	1 (0.8%)	4 (3.1%)	0	6 (4.6%)
Total (%):	24 (18.3%)	31 (23.7%)	16 (12.2%)	30 (22.9%)	30 (22.9%)	131 (100.0%)
		47 (35.9%)				

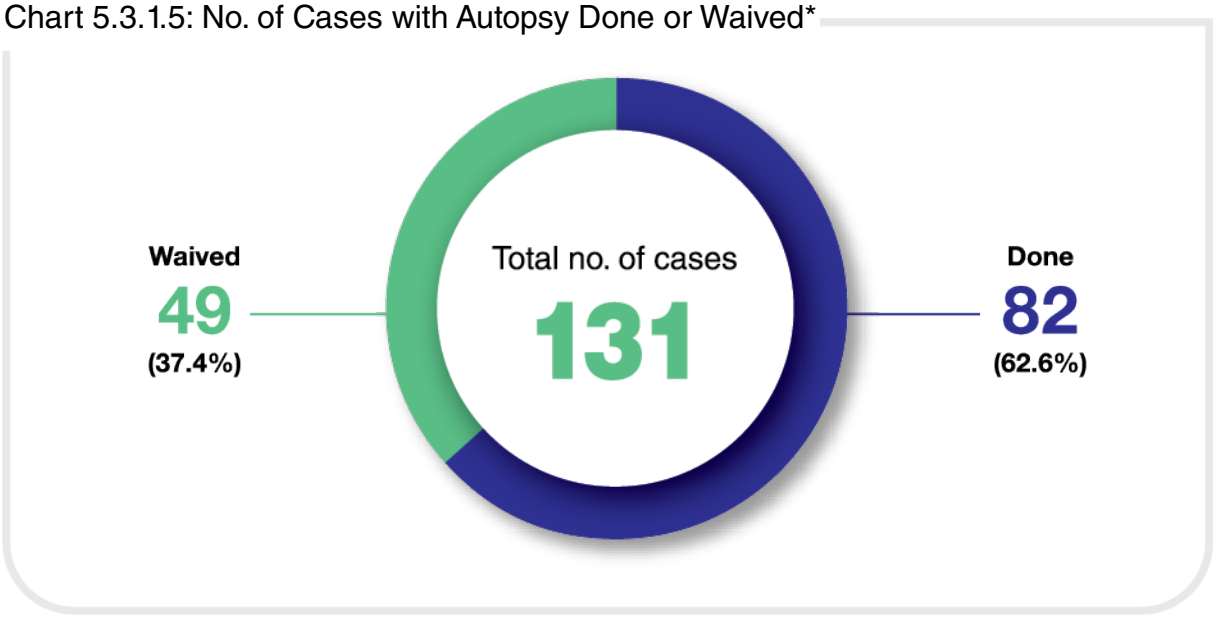
**These categories of death, with content listed below, are designed by the medical experts of the Review Panel for review purpose:*

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=13, 9.9%); SUDI cases (N=12, 9.2%) & Cases with unidentifiable aetiology (N=5; 3.8%).

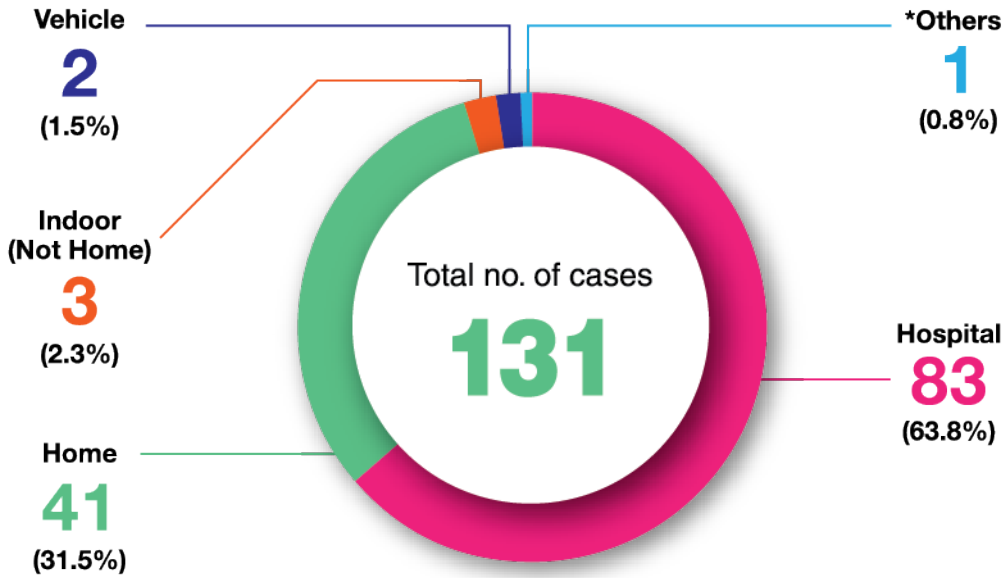
The highest case numbers among different categories are highlighted.

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



Others: 1 fatal case occurred on a flight to Hong Kong.

5.3.2 Cases Died of Suicides

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

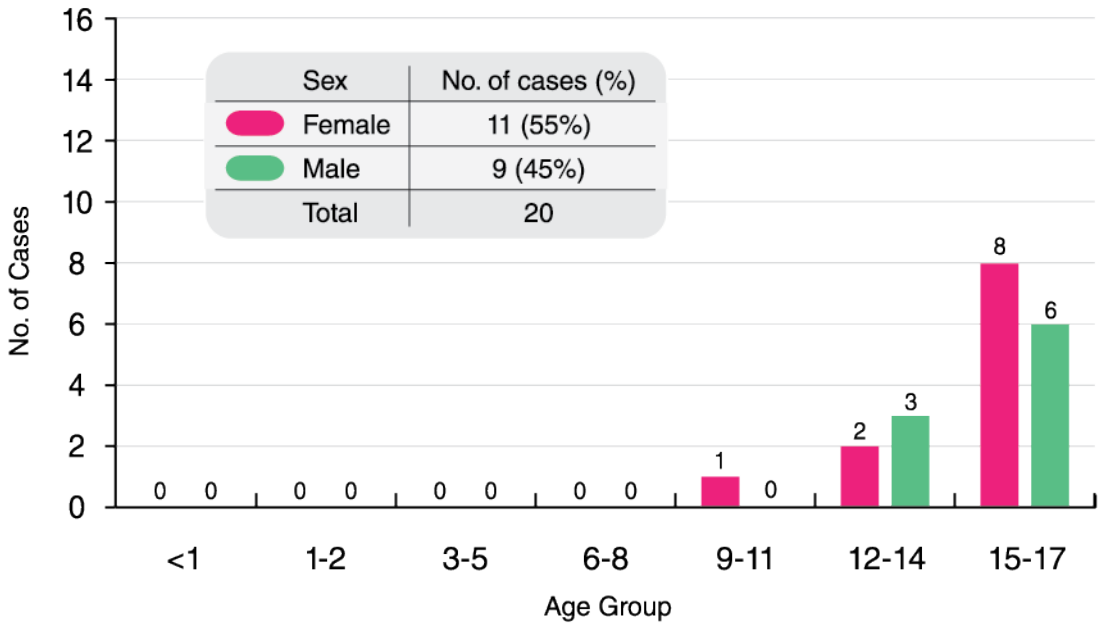


Chart 5.3.2.2: No. of Cases by Occupation

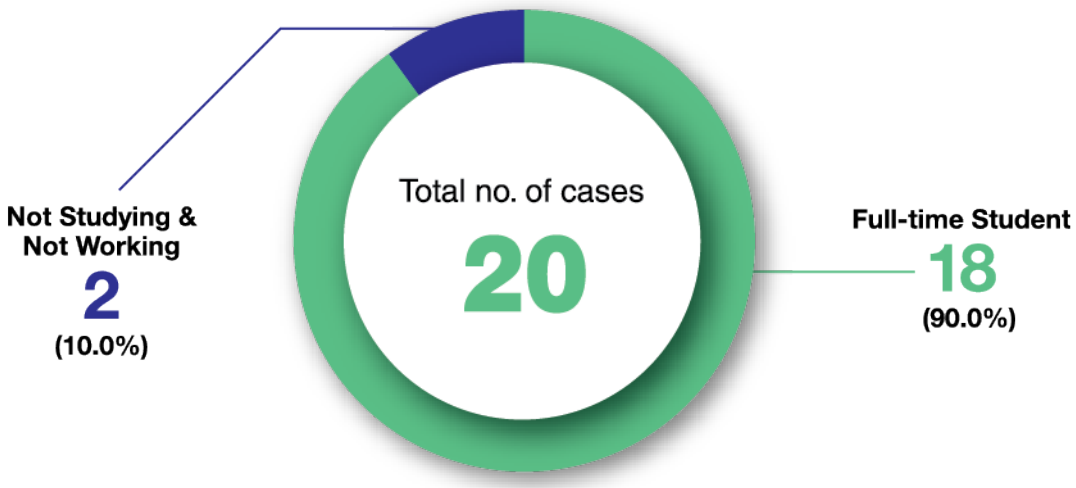
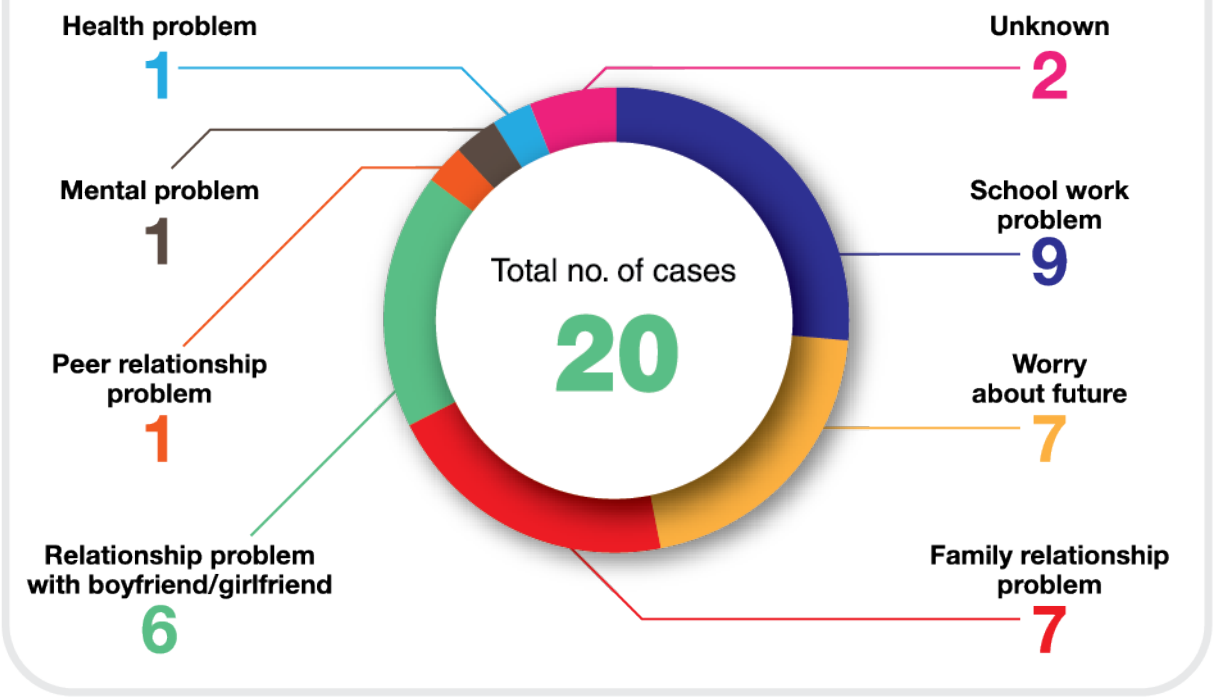


Chart 5.3.2.3: Reasons* of Committing Suicide



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

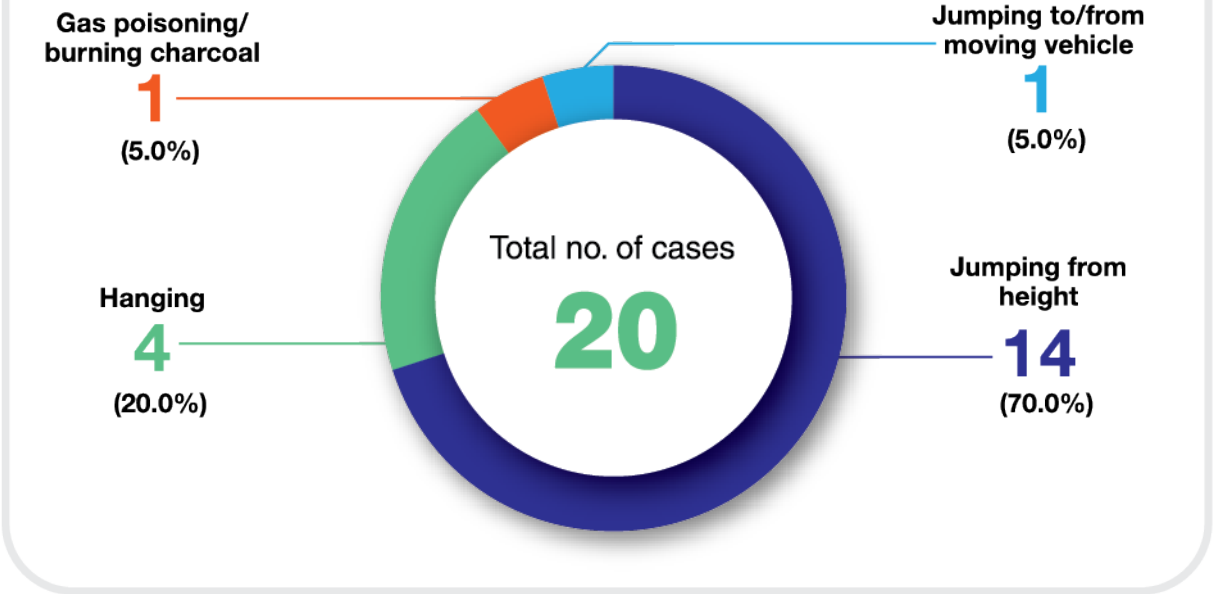


Chart 5.3.2.5: Cases with Identified Suicidal Signs*

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 Accidents

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

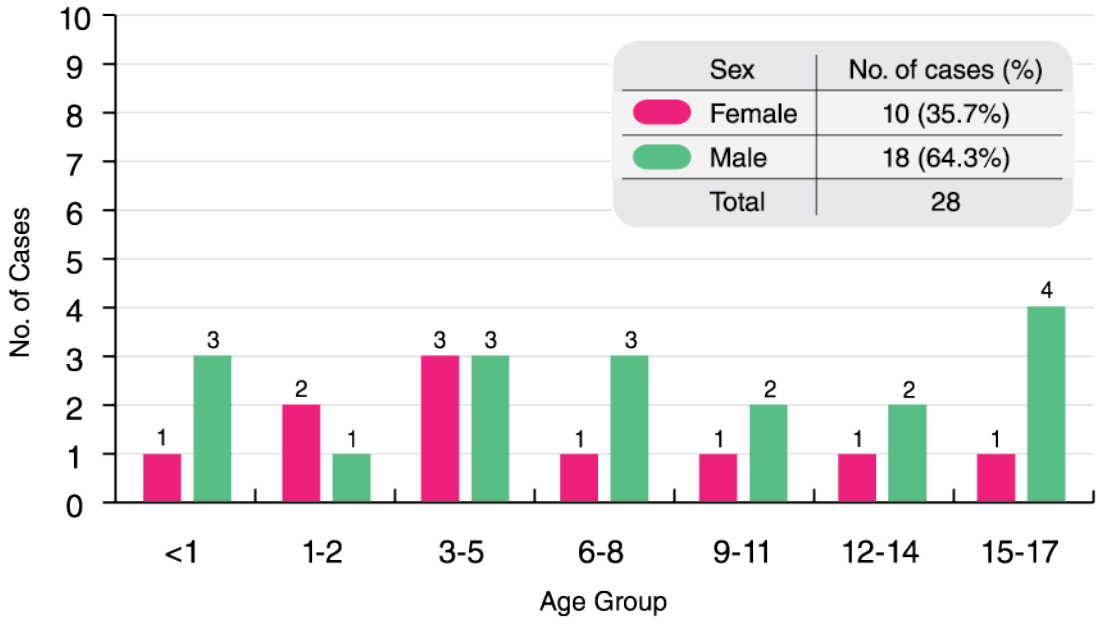


Chart 5.3.3.2: No. of Cases by Type of Accident and Sex

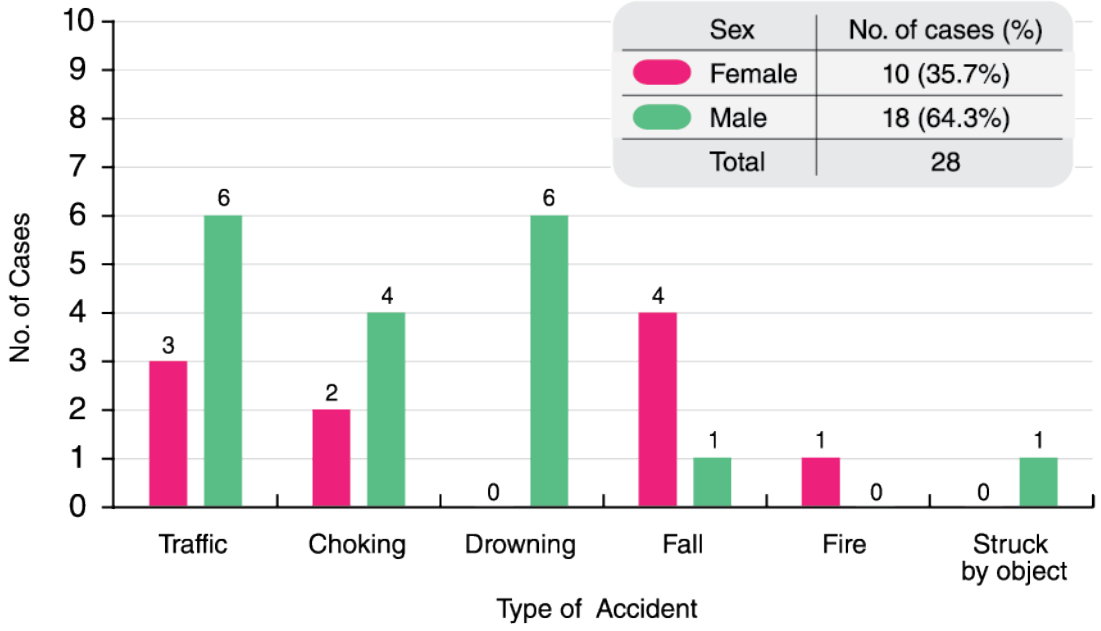


Chart 5.3.3.3: No. of Cases by Age Group and Type of Accident

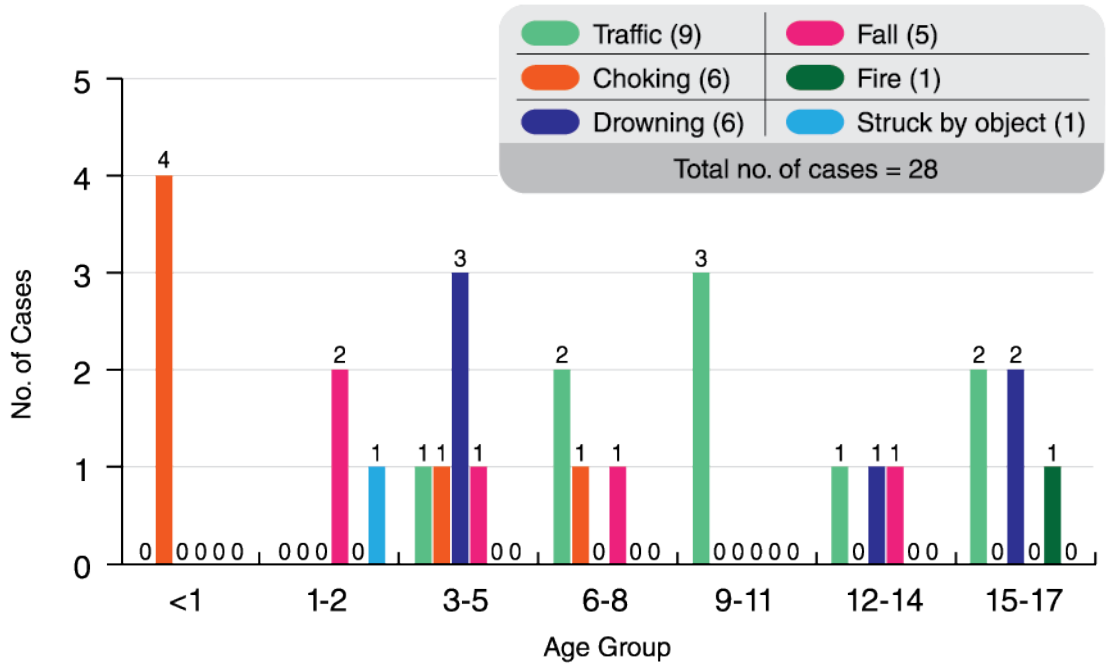


Chart 5.3.3.4: No. of Cases by Age Group and Type of Traffic Victim

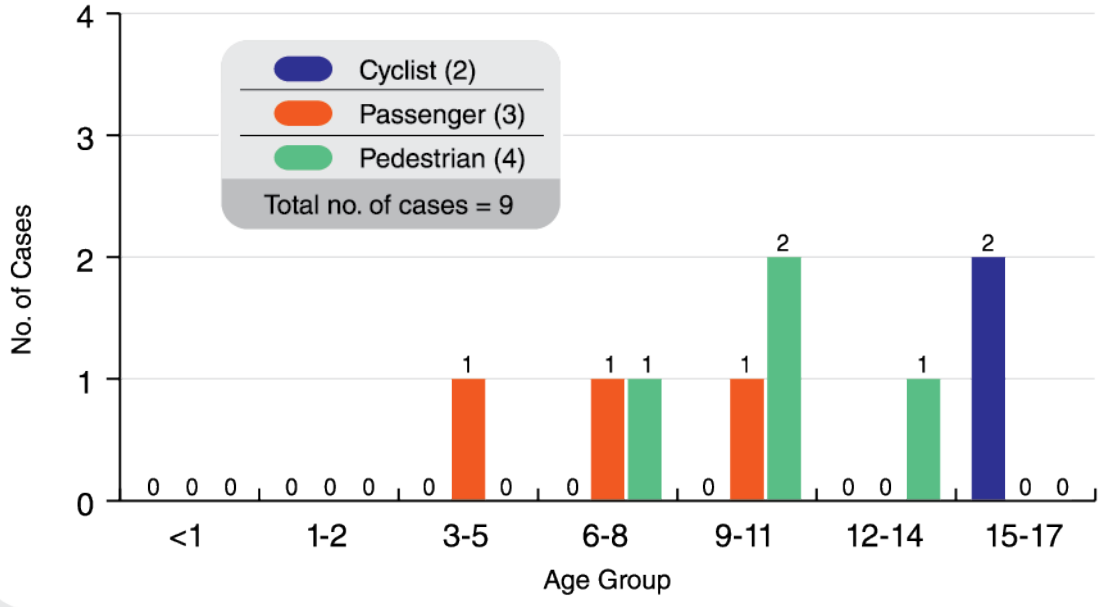


Chart 5.3.3.5: No. of Cases by Place of Fatal Incident

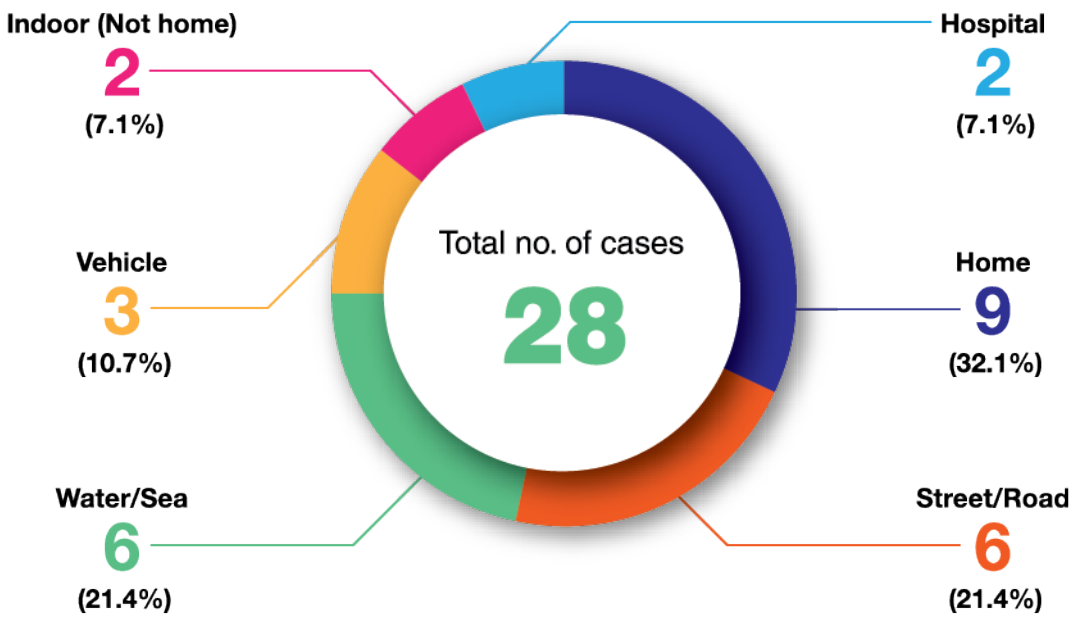
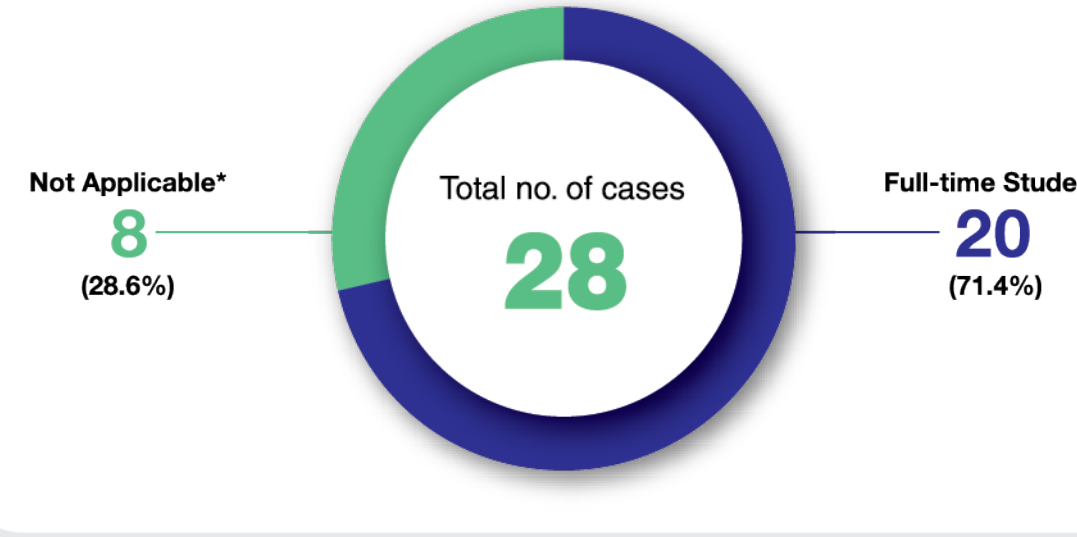


Chart 5.3.3.6: No. of Cases by Occupation



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

5.3.4 Cases Died of Assaults

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

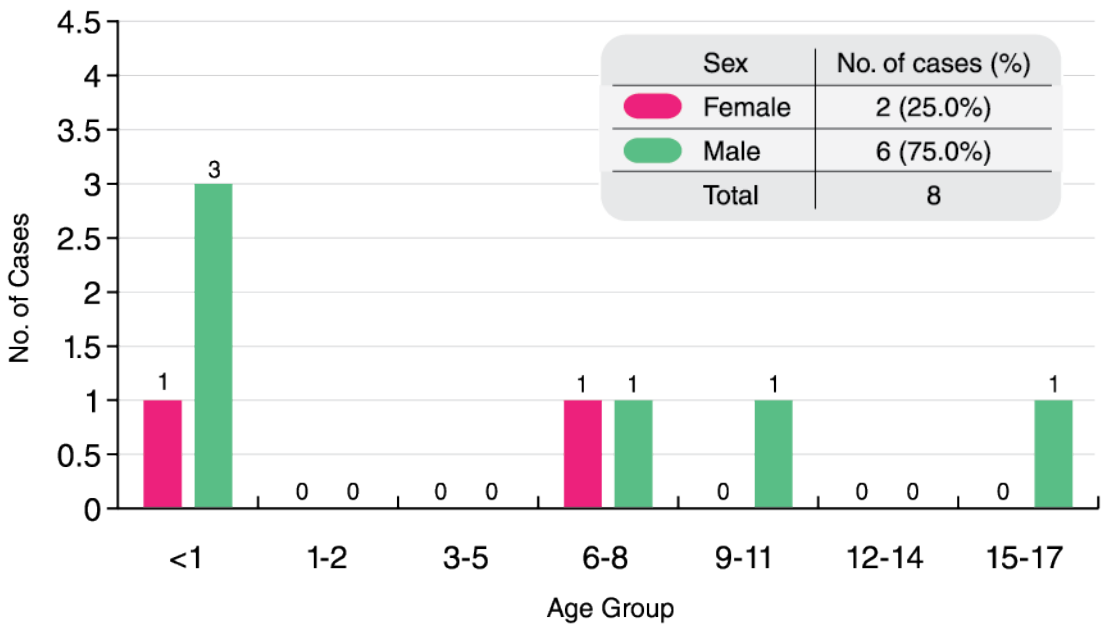


Chart 5.3.4.2: Types of Assault

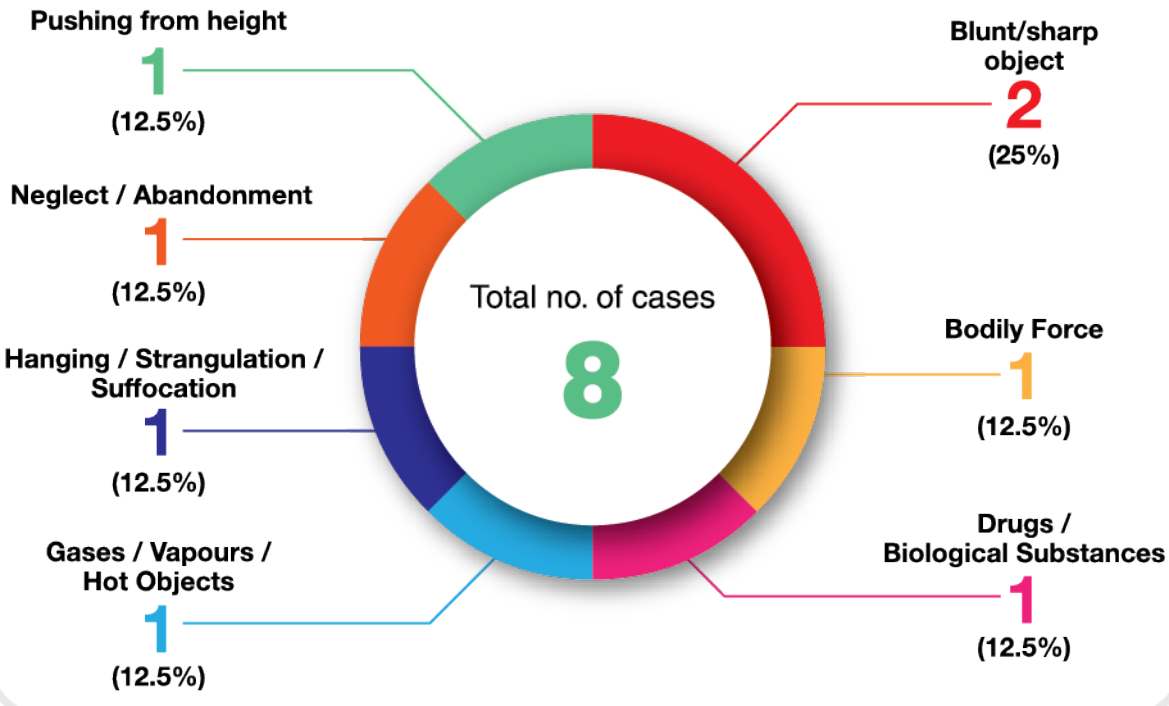


Chart 5.3.4.3: Perpetrator's Relationship with the Deceased Child

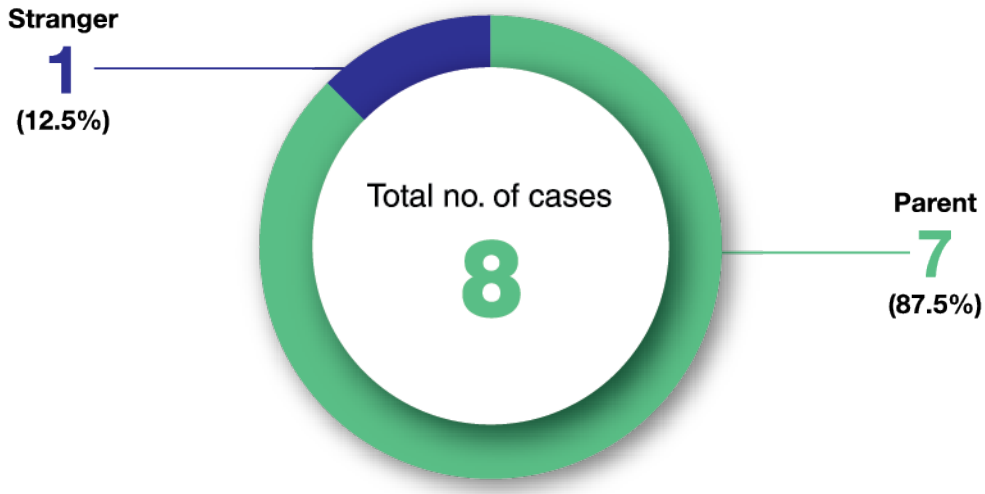
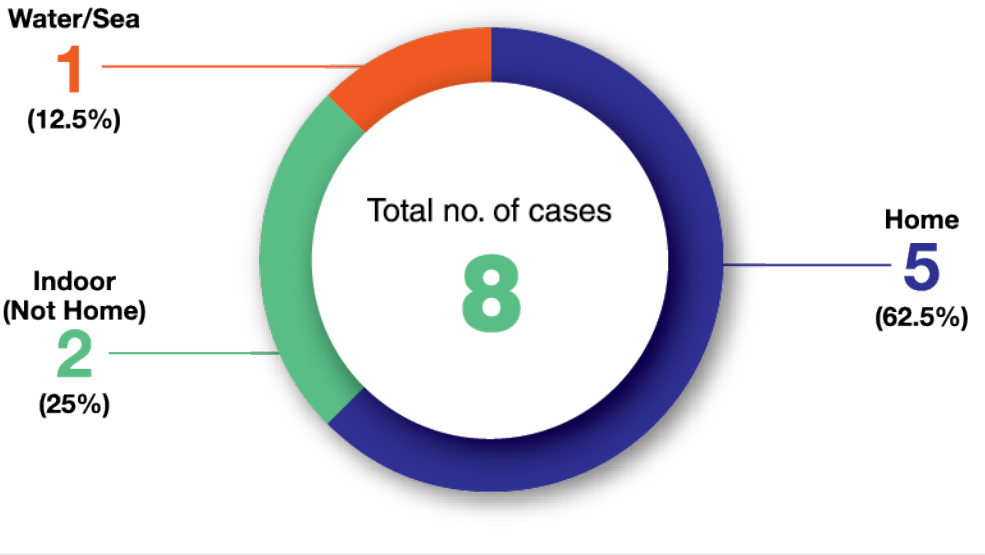


Chart 5.3.4.4: No. of Cases by Place of Fatal Incident



5.3.5 Cases Died of Non-natural Unascertained Causes

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

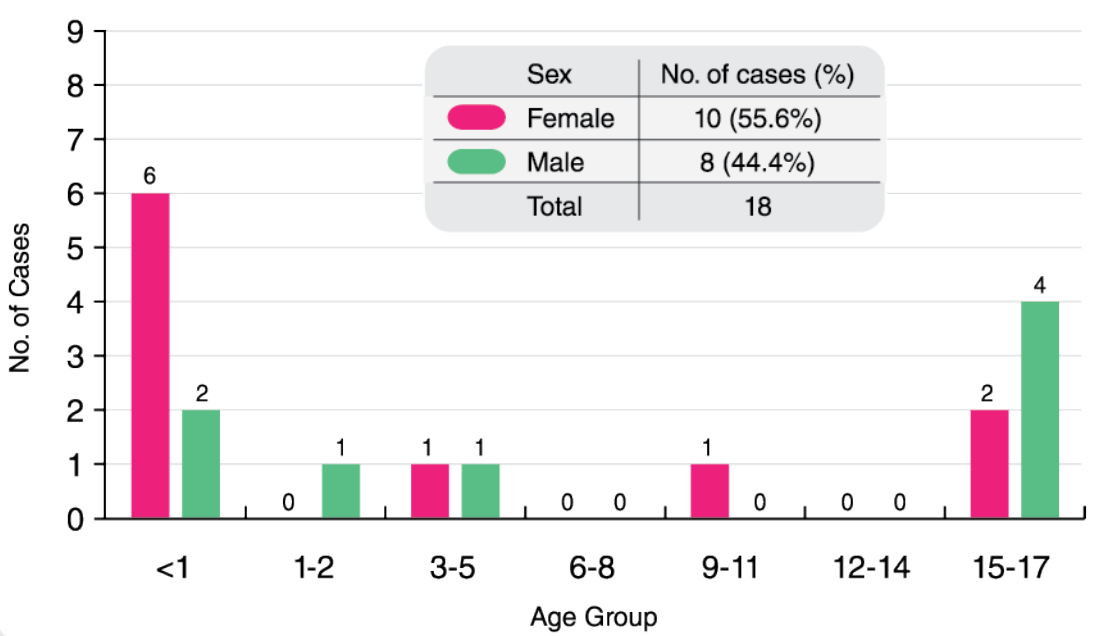
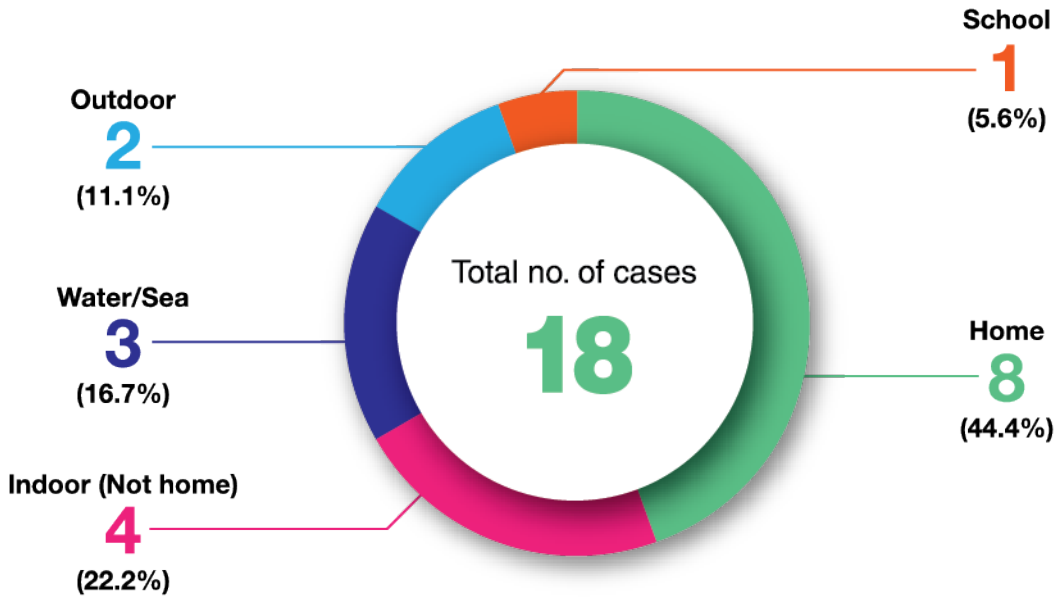


Chart 5.3.5.2: No. of Cases by Place of Fatal Incident



6 Observations and Recommendations Arising from Review of Child Death Cases in 2012 and 2013

After reviewing the child death cases which occurred in 2012 and 2013, the Review Panel has come up with the following observations and 45 recommendations on preventive strategies and system improvement for child fatal cases. The observations and recommendations by death cause are listed below.

6.1 Observations and Recommendations by Death Nature

6.1.1 Observations on Natural-cause Cases

- The Review Panel reviewed some natural-cause cases in which the deaths were related to various sleep safety issues. **(Recommendation N1)** Together with cases of other natures, observations on cases with sleep safety issues and the recommendations will be further discussed in Chapter 7.

- A new born girl was found to have neither breath nor heartbeat after her mother had fallen asleep when trying to breast-feed the baby in left lateral position on bed in a post-natal ward. **(Recommendation N2)**. The Review Panel also shared the observations on the unexpected fatality of neonates in post-natal wards with the stakeholders who had shared their suggestions of management approach and improvement measures*.

- An adolescent who had chronic illnesses requiring various medical supports. When he started having difficulty in breathing after admission to hospital, the medical doctor recommended to use invasive assisted ventilation but was refused by him. He succumbed after his condition got deteriorated. **(Recommendation N3)**.

- An adolescent was found to be died of bronchial asthma with an autopsy showing anatomical findings that were consistent with chronic asthma. **(Recommendation N4)**.

- A mother who was a known drug abuser passed out a fetus in which methamphetamine was found in its liver and the mother was living with another child. **(Recommendation N5)**.

6.1.2 Recommendations for Natural-cause Cases

No.	Recommendations
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.
N2	To enhance the education of mothers of newborn babies on the various risks during feeding including breastfeeding. Close supervision and monitoring of the conditions of babies and mothers in the postnatal wards is deemed essential.
N3	To reiterate previous recommendation of raising children's self-awareness of own strengths/limitations and the potential risks arising from the illness they suffer and reminding them to adhere to medical advices.
N4	To reiterate previous recommendation of educating parents to help children with asthma seek medical treatment.
N5	Forensic pathologists having suspicion or evidence that the deceased child has been affected by drugs should consider making referrals to social workers for risk assessment if the deceased child has siblings who may also be exposed to the same kind of risk.

**The Review Panel has shared our observations on neonates who died unexpectedly in postnatal ward of public hospitals and invited stakeholders' expert sharing of experience in Sudden Unexpected Postnatal Collapse (SUPC) and management approach by writing to the Hospital Authority's Director (Quality & Safety), the respective Chairmen of the Co-ordinating Committees for Paediatrics and Obsterics & Gynaecology and the Family Health Service of the Department of Health.*

The Review Panel is pleased to have received replies from the Hospital Authority and the Hong Kong College of Paediatricians, sharing their expert experience, views and comments in managing babies having SUPC. In gist, the Hospital Authority has taken immediate measures to prevent unexpected fatality of neonates, including adopting a practice guideline for skin-to-skin care for labour and postnatal wards, enhancing the education of healthcare personnel and family members regarding the appropriate positioning and monitoring of skin-to-skin contact during breastfeeding and using pulse oximeters for monitoring babies during skin-to-skin care when necessary.

The positive responses of the Hospital Authority reflected the Review Panel's effective work of promoting inter-sectoral collaboration and inter-disciplinary cooperation. Furthermore, with the kind permission of the Hospital Authority and the Hong Kong College of Paediatricians, the Review Panel has also shared their expert experience, views and comments in managing babies with SUPC with concerned parties for promoting inter-sectoral and multi-disciplinary collaboration.

To alert parents of the safety measures during breastfeeding so as to ensure their infants' safety, the Review Panel has also shared our observations and views on promoting safety measures associating with breastfeeding by writing to the Committee on Promotion of Breastfeeding with the hope that the Committee can help remind the parents/parents-to-be on the good practices in taking proper care of babies during and after breastfeeding so as to minimise risk factors with regard to breastfeeding.

6.1.3 Observations on Suicide Cases

- Though some children were found to have suicidal signs before their suicidal acts, parents, school personnel or helping professionals working with these children failed to take note of these suicidal signs. **(Recommendations S1 and S2)**.

- Some children were observed to have manifested behavioural changes such as becoming quieter or more easily irritable when they experienced stresses or crisis, some also showed signs of emotional disturbance. However, these signs of crisis were usually not picked up by their family members. **(Recommendation S3)**.

- Parents and caregivers failed to know available resources and to encourage their children to seek help from helping professionals. **(Recommendation S4)**.

- Children might turn to be fragile and distress in face of impending punishment or disciplinary actions. They would easily have adverse emotions when receiving punishment by their parents or caregivers. **(Recommendations S5 and S6)**.

- Some children suffering from chronic illness might have emotional distress and frustration, particularly in face of coping with their study. **(Recommendation S7)**.

- Some children would disclose their suicidal intention or ideation to their peers before actual attempt. **(Recommendation S8)**.

- Some students were observed to be sensitive towards their teachers' words or discipline and were afraid of being blamed. **(Recommendation S9)**.

- For children requiring institutional or statutory supervision to reform, they might encounter difficulties and were in need of guidance even after the expiry of the supervision period. **(Recommendation S10)**.

- Risk or vulnerability factors such as inadequate family support, physical or mental illness by the children or their family members, drug/alcohol abuse problems by the children and their family members were identified to be in relation to children's suicide. **(Recommendation S11)**.

- Many children did not know how to cope with possible life challenges and failures and they usually failed to ask for help. **(Recommendation S12)**.

- For those under-achievers in schools, they usually carried a failure role as they did not recognise their own strengths or potentials and was unaware of different academic or career paths for advancements that they might also achieve high in areas where their potentials rest. **(Recommendation S13)**. The Review Panel shared the observations with the Education Bureau who shared support measures provided to students*.

- Despite the Review Panel's appeal for information from stakeholders to provide details on the suicide cases for review, there was often insufficient information to allow the panel members to understand the underlying factors leading to the children's suicide. **(Recommendation S14)**.

- A youth jumped from a platform to an approaching train with his body trapped under the train. The incident was captured by the CCTV of the train station. **(Recommendation S15)**.

6.1.4 Recommendations for Suicide Cases

No.	Recommendations
S1	To strengthen the ability of family members, school personnel and youths in detecting suicidal signs and ideations with a view to providing prompt help to the needy children and youths.
S2	Parents, school personnel and professionals working with children should take note of any suicidal signs so that timely assistance could be provided to help the children at risk of suicide.
S3	Family members should be reminded to be more alert to any signs of crisis experienced by children and adolescents. They should seek help when noticing any emotional disturbance of the family members.
S4	To let parents know the existence of various resources from helping professionals including teachers, student guidance personnel, school social workers and educational psychologists to support the students, and encourage them to seek help if needed.

No.	Recommendations
S5	Parents and caregivers should be educated to be more aware of the possible adverse emotions caused to the children when punishing them. Equipping parents with effective parenting skills would be useful for parents' understanding of the needs and feelings of their children and for better parent-child relationship.
S6	To reiterate the previous recommendation of having strategic planning when handling children/adolescents facing impending disciplinary action/punishment. Their condition should also be closely monitored so that timely support could be provided for meeting their emotional needs.
S7	Family members and medical practitioners should be alert of the children's perception of the difficulties they encounter and the frustration they have arising from their chronic physical illness so that timely emotional support could be rendered to them.
S8	To encourage students to seek help when there is communication about feeling depressed or expression of suicidal ideations by their peers.
S9	Discipline and guidance are equally important in schools for helping students. Students should be led to understand that teachers and school personnel are there to help and would not put the blame on them.
S10	High risk cases should deserve more intensive support from Social Welfare Department or Correctional Services Department even after discharge from an institution or completion of statutory supervision. If needed, case referral to appropriate welfare/counselling services units should be made for better support for them.
S11	Cases with much vulnerability should warrant more intensive intervention and follow-up. Helping professionals should look beyond the presenting problems such as poor school attendance and focus on the various vulnerability factors.

No.	Recommendations
S12	Parents and children must be helped to see the strengths of the children. Children's resilience of facing possible life challenges and failures should be strengthened. Adults should support the children who are experiencing failure and help them rebuild their self-confidence.
S13	For under-achievers in schools, alternative arrangements such as vocational training might help them develop their other potentials. The schools could be more proactive in helping students who could not cope with the school curriculum/requirements, such as guiding them in understanding their strengths, coping with stresses and accepting changes.
S14	Social workers and school personnel having information of the child death cases as well as police officers investigating the child deaths should have more systematic data collection by uncovering the psychological vulnerability and other underlying factors, in addition to the immediate precipitants or acute stressors, to facilitate the post-mortem review for prevention purpose.
S15	Installation of platform screen doors as suicide barriers would be effective in preventing suicide in railway stations.

**Upon review of a child fatality case that a senior secondary school student committed suicide after receiving the result of not being able to be admitted into the university programme under the Joint University Programmes Admissions System (JUPAS), the Review Panel noticed that substantial supportive services were available to students when the HKDSE results were released but students might not have ready access to guidance and support when the JUPAS results were announced during summer vacation. In view of that, a letter had been issued by the Review Panel to the Education Bureau (EDB) for soliciting school's assistance in providing support to student applicants of JUPAS.*

In its reply, EDB shared their efforts in collaborating with different sectors to provide support for students upon the release of the results of both HKDSE and JUPAS by issuing circular memorandum which summarised support measures to assist schools to prepare students for the result release. To help students realise their aspirations for further studies and/or work, schools were also advised to support students prior to, on and after the release of HKDSE results with multiple pathways provided. Besides, articles were published at the Guidance Digest and the Parents' Bulletin to remind school personnel and parents purposefully to offer timely counselling and assistance to students on the release of the results of both HKDSE and JUPAS.

6.1.5 Observations on Accident Cases

- Some of the fatal traffic accident occurred due to low awareness of road safety of both drivers and pedestrians which involved child not being put on car seat, cycling without wearing a helmet, caregiver talking over mobile phone when accompanying child crossing the road and drivers failed to observe the traffic signal, etc. **(Recommendations A1 to A4)**.

- Five fatal incidents took place when children were swimming. Parents and caregivers sometimes overlook the importance of safe swimming. **(Recommendation A5)**.

- Electrical home appliances and portable electrical/electronic devices such as mobile phones, tablets and rechargeable batteries, etc. are getting more popular but the public seemed to be not fully aware of their safety use. **(Recommendation A6)**.

- Caregivers were unaware of various home safety issues such as never leaving young children alone or unattended as well as sleep safety for their children and installation of safety devices at home. **(Recommendations A7 and A8)**.

- Children sustaining injuries especially head injuries used to be under-estimated and were not brought for medical attention immediately. Also, parents and caregivers were found to have inadequacy in adhering to medical advice in taking care of their children especially for those with special needs. **(Recommendations A9 and A10)**.

- Some families employed foreign domestic helpers (FDHs) in supporting them in child care but without closely monitoring the quality of care provided by FDHs, which resulted in some cases having babies being shaken and children with injuries were not promptly reported to their parents. **(Recommendation A11)**.

6.1.6 Recommendations for Accident Cases

No.	Recommendations
A1	Motor drivers should adopt a careful and considerate driving attitude to improve road safety and prevent traffic accidents.
A2	Relevant government department should consider legislation on using suitable restraining devices for children in vehicles for safeguarding their safety more effectively.
A3	Parents and caregivers should be reminded not to use mobile phones when crossing the road, especially when they are accompanying children.
A4	To further promote cycling safety such as wearing a safety helmet, cycling on appropriate cycling tracks, and attaining adequate skills in controlling the bicycles under different road conditions by the cyclists.
A5	To reiterate the recommendation that children should only swim in beaches/ swimming pools where life guards are on duty. Parents and caregivers should closely supervise their children who are swimming.
A6	Public education on proper use of electrical home appliances and installations should be continued.
A7	The message of never leaving young children alone or unattended at home should continue to be promoted.
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.
A9	Parents and caregivers should be reminded to take special care when children sustain injuries, especially head injuries, and to seek immediate medical attention.
A10	More education could be provided to the parents and caregivers of children with special needs especially on adhering to medical advice.

A11	Foreign Domestic Helpers (FDHs) newly arriving at the immigration counters may be provided with leaflets on the important safety issues in child care such as never shaking the babies/children and reporting promptly to their employer and seeking immediate medical attention whenever children under their care have sustained any injuries. Concern groups formed by employers of FDHs may also be provided with similar safety information.

6.1.7 Observations on Assault and Non-natural Unascertained Causes

- Three children were assaulted by their parents out of their marital/relationship problems with their spouses/ex-spouses. **(Recommendation AS1)**.

- Concealment of pregnancy can result in child fatality. **(Recommendations AS2 and AS3)** Observations on cases related to concealment of pregnancy and the recommendations will be discussed in section 6.2.

- New/prospective parents and their family members were found to be unaware of postpartum depression and failed to seek help. **(Recommendation AS4).**

- Family members of mental patients did not understand the illness that the patients are suffering. They failed to provide support for the patients to face the illnesses positively as well as to seek professional help as soon as it is needed. **(Recommendation AS5)**.

- An adolescent without much motivation in schooling mingled with undesirable peers and was assaulted in a fatal incident. Training on life planning seemed to be inadequate at school. **(Recommendation AS6)**.

- Fatal incidents were found to be involved with co-sleeping and other sleeping arrangement. **(Recommendations AS7 and AS8)**. Sleep safety issues for children and the recommendations will be discussed in Chapter 7.

- Some death of children was found to be related to drug-taking and consumption of alcohol. **(Recommendations AS9 and AS10)**.

- The Review Panel has deliberated thoroughly on a case involving a 5-year-old boy who was poisoned by methamphetamine when he was under the care of his family and has come up with a number of suggestions to prevent the re-occurrence of similar cases. **(Recommendation AS11)**.

6.1.8 Recommendations for Assault and Non-natural Unascertained Causes

No.	Recommendations
AS1	To reiterate the message that children have their own rights of survival which no one, including their parents, should take away. Parents should also be reminded not to use their children as bargaining chips in handling parental relationship problems/conflicts.
AS2	To repeat the previous recommendation of arousing awareness of the possible fatal consequence of concealment of pregnancy.
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.
AS4	To reiterate the previous recommendation of enhancing new/prospective parents' awareness of postpartum depression and encourage them to seek help through various preventive measures.
AS5	To provide public education to enhance family members' understanding of mental illnesses and encourage them to support the mental patients to face the illnesses positively. It is particularly high risk for those vulnerable groups such as the mentally ill mothers who are deemed to be in need of multi-disciplinary support from psycho-social and medical experts, etc. It would be necessary for experts involved in helping these families to collaborate and work closely in helping these families.
AS6	Students with low motivation to continue schooling might be assisted with training on life planning to facilitate their understanding of their own interests, abilities for their planning of subject and career choices.

No.	Recommendations
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 of the babies or installing appropriate monitoring devices while the latter was sleeping alone.
AS8	To reiterate the fatal consequence of co-sleeping with babies.
AS9	To continue providing education to children and adolescents on never trying or using illicit drugs.
AS10	Through public education, to remind adolescents not to drink wine even in social context with emphasis on the adverse effects of alcohol which could affect our judgement and reaction time and could result in fatality.
AS11	(i) To provide training to enhance helping professionals' sensitivity to various risk elements as well as the skills in collecting relevant information relating to the risk elements especially with special alertness to any drug-abuse problems in the family and their potential adverse effects to the children. (ii) The "Procedural Guide for Handling Child Abuse Cases" could be further enhanced on the aspect of risk assessment to facilitate the professionals to serve the best interests of children and provide protection to them. (iii) Drug testing for medical purpose is an important part of such risk assessment. (iv) In view of the great demand for residential child care services in general, more resources to increase the provision of residential care services for children would be required. (v) For cases pending long-term placement and be restored home during the interim, there should be thorough assessment on the risk factors especially on the caregivers' capability in providing proper child care including child abuse, drug abuse, mental illness, violence, serious offences and dubious means of earning a living, etc. (vi) Multi-disciplinary collaboration should be further enhanced to facilitate sharing of essential information by different disciplines, e.g. medical staff, police, social workers, etc. especially on the related high risks factors as mentioned above at Multi-disciplinary Case Conferences.

6.1.9 Observations on Medical Complications Cases

- A 17-month-old baby girl had cold and runny nose and was attended by several private medical practitioners. She was suddenly found unresponsive during a routine afternoon nap in a nursery. She used to enjoy satisfactory health and the cause of death could not be ascertained. Yet, toxicology examination result found the blood Chlorpheniramine level was much higher than the reference therapeutic level and one medical practitioner later realised that Codeine was an ingredient in the Actifed syrup preparation prescribed and dispensed while another bottle prescribed and dispensed also contained Codeine. **(Recommendations MP1 to MP3)**. The Review Panel shared the observations with the Department of Health who then provided information on the provision of guidelines for registered medical practitioners on drug dispensing and administering*.

6.1.10 Recommendations for Medical Complications Cases

No.	Recommendations
MP1	Forensic pathologists should be encouraged to request for work-up on possible inborn errors of metabolism more readily in cases where the autopsy reveals little evidence of a cause of death.
MP2	To reiterate that cough suppressants containing codeine should not be used for children under 12 years old.
MP3	It is not a good practice to prescribe multiple medications containing essentially the same active compounds such as anti-histamine.

**The Review Panel shared with the Department of Health (DH) on our observation of the sub-optimal prescribing practice arising from this case and invited its sharing of any official directives/guidelines governing the production or mixing of medication preparations, the clear labelling of concentrations and quantities of active ingredients in medications and of such in medications known only by their brand names.*

DH responded that the Medical Council of Hong Kong has promulgated the Code of Professional Conduct which provides guidelines to registered medical practitioners on prescription and labelling of dispensed medicines. The relevant clauses from the Code of Professional Conduct are extracted for reference as follows:

Clause 9.2

A doctor who dispenses medicine to patients has the personal responsibility to ensure that the drugs are dispensed strictly in accordance with the prescription and are properly labelled before they are handed over to the patients. The doctor should establish suitable procedures for ensuring that drugs are properly labelled and dispensed. Doctors are advised to observe the provisions of the Good Dispensing Practice Manual issued by the Hong Kong Medical Association.

Clause 9.4

All medications dispensed to patients directly or indirectly by a doctor should be properly and separately labelled with all the following information:-

(a) name of prescribing doctor or proper means of identifying him;
(b) full name of the patient, except where the full name is unusually long (in which case the family name and such part of the given name or initials sufficient to identify the patient should be written);
(c) date of dispensing;
(d) name of medicine, which can be either:-
(i) the name of the medicine as if is registered with the Pharmacy and Poisons Board of Hong Kong and shown in the Compendium of Pharmaceutical Products published by the Department of Health; or
(ii) the generic, chemical or pharmacological name of the medicine;
(e) method of administration;
(f) dosage to be administered;
(g) strength and/or concentration of the medicine where applicable; and
(h) precautions where applicable.

DH further explained that in respect of strength and/or concentration of the medicine, the Medical Council in its Newsletter Issue No. 21 of August 2014 has listed out specific situations under which medical practitioners should specify the strength and/or concentration of the medicine for reference by other medical practitioners subsequently taking care of the patient. The situations (which are not exhaustive) include:-

(i)when the doctor chooses to use the generic, chemical or pharmacological name of the medicine (e.g. for reason that the product name may not be familiar to others);
(ii) when the medicine (e.g. syrups) has been diluted even if the registered name is used; and
(iii) when different medicines have been mixed (e.g. mixture of syrups, compounding cream, etc.)

Furthermore, the Drug Office of DH provides health education on drug usage and information including list of active ingredients of all registered pharmaceutical products in Hong Kong on its website (http://www.drugoffice.gov.hk). Healthcare professionals or members of the public may access to this information through the dedicated search engine in the website and the website also provides information on medication safety and the latest alerts on safe use of medicines. Besides, the Maternal and Child Health Centres operated by the Family Health Service of DH also provides health education to parents attending their clinics on the prevention of accidental poisoning such as proper storage of medicine, seeking and following medical advice on using any medication for children.

DH has promulgated the Code of Practice for Clinics Registered under the Medical Clinics Ordinance (Cap. 343) ("Code of Practice") to govern those clinics to enhance patients' safety and the standard of good practice. The Code of Practice stipulates that medicines must be handled according to the requirements of the legislations in Hong Kong and all medicines shall be clearly labelled. Medicines should be dispensed and administered under the supervision of the medical in-charge of the clinic. Clinic staff should familiarise themselves with the procedures of administering medicines in the latest guidelines of "Good Dispensing Practice Manual" as promulgated by the Hong Kong Medical Association.

7 Child Death Cases Reviewed from 2006 to 2013

7.1 Observations by Thematic Topic

7.1.1 Co-sleeping

7.1.1.1 Statistical Information

Total no. of cases = 30 (29 were aged below 1; and 1 aged 1).
Two cases also related to other sleep safety.

Table 7.1.1.1.1: 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
Total	13	17	30

Table 7.1.1.1.2: No. of Cases by Nature of Death and Sex

Nature of death	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	3	2	5
Total		13	17	30

Table 7.1.1.1.3: No. of Cases by Place of Fatal Incident

Place of fatal incident	Total
Home	23 (76.7%)
Hospital	4 (13.3%)
Indoor (not home)	3 (10.0%)
Total	30

7.1.1.2 Recommendations

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.

7.1.1.3 Observations

- For the cases reviewed from 2006 to 2013, 30 cases involved children whose deaths might be related to co-sleeping with adults. Majority of the cases were babies aged below one. Also, as shown in Table 6.2.1.1, there seems to be an increase in the number of cases over the years.

- 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.

- Researches have shown that the sudden, unexpected and unexplained death of a baby or young child usually occurred during sleep and there was a link between co-sleeping with these sudden deaths.

- Home was the place where most fatalities arising from co-sleeping had occurred. Parents and caregivers should be reminded of the potential fatal consequence of co-sleeping with their babies.

- The Review Panel noted that the concerned department has provided health information on protecting babies from sudden infant deaths, it is hoped that the message of never co-sleeping with their babies, even for a very short moment, could continue to be emphasised for reaching all of the parents and families with new born babies.

7.1.2 Other Sleeping Safety

7.1.2.1 Statistical Information

Total no. of cases = 28 (27 were aged below 1; and 1 aged 7 child with special needs). Two cases also related to co-sleeping.

Table 7.1.2.1.1: 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
Total	12	16	28

Table 7.1.2.1.2: No. of Cases by Nature of Death and Sex

Case nature	Type	Female	Male	Total
Natural	Neonatal conditions	1	0	1
Natural	Chronic medical condition with disabilities	2	0	2
Natural	Acute medical conditions	2	1	3
Natural	Sudden and Unexpected Death in Infancy (SUDI)	1	10	11
Natural	Unidentifiable aetiology	2	2	4
Non-natural	Accident	1	3	4
Non-natural	Unascertained	3	0	3
Total		12	16	28

Table 7.1.2.1.3: Table of Cases by Place of Fatal Incident

Place of fatal incident	Total
Home	19 (67.9%)
Hospital	5 (17.9%)
Indoor (not home)	4 (14.3%)
Total	28

7.1.2.2 Recommendations

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 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	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 of the babies or installing appropriate monitoring devices while the latter was sleeping alone.

7.1.2.3 Observations

- For the cases reviewed from 2006 to 2013, 28 cases involved children whose deaths might be related to sleep safety issues such as being found sleeping in prone position or nose and mouth covered by objects including pillows and blankets or being trapped in the gap between the bed and the wall, etc.

- 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.

- Again, home was the place where most fatalities arising from other sleep safety issues had occurred. Parents and caregivers should keep vigilance in the sleep arrangement for their babies.

- Apart from taking note of the various safety issues such as arranging the babies to sleep on flat surface and not on soft beddings as well as not placing unnecessary objects on the baby's bed, parents and caregivers should closely supervise and monitor the sleeping condition of the babies by checking them more frequently.

- The Review Panel noted that the concerned department has provided health information on protecting babies from sudden infant deaths occurred mostly during their sleep, it is hoped that the message of various safety measure to ensure the sleep safety of the babies could continue to be emphasised for reaching all of the parents and families with new born babies.

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

From Department of Health (DH)

Baby's sleep safety is an important home safety issue. Maternal and Child Health Centres (MCHCs) of the DH provides 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, audio-visual resources, website and Parenting workshop. Leaflet on "Protect Baby from Sudden Infant Death Syndrome (SIDS)" and a checklist "Is Your Baby Safe at Home?" with specific questions on sleep safety have been included in the "Happy Parenting" booklet which is given to every parents or carers attending MCHCs. These can be accessed through the Family Health Service website (www.fhs.gov.hk), "Parent-Child e-Link" e-newsletters and "Parenting Made Easy" web page.

Sleep safety issues and breastfeeding measures is also strengthened in antenatal parent talks and the breastfeeding booklet to remind parents putting baby back to sleep in his cot for every sleep, especially after breastfeeding. Staff education on sleep safety and infant feeding is strengthened through training.

A new home safety checklist specific for babies under 1 year with emphasis on sleep safety is being developed by DH. It will be distributed to expectant parents during the antenatal visit, new parents attending MCHCs to remind them of the importance of safe sleep. Staff is reminded to discuss this issue with parents during interviews.

7.1.4 Concealment of Pregnancy

7.1.4.1 Statistical Information
Total no. of cases = 25 (all were aged below 1).

Table 7.1.4.1.1: 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
Total	11	14	25

Table 7.1.4.1.2: 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	5	7	12
Non-natural	Accident	1	0	1
Non-natural	Assault	1	4	5
Non-natural	Unascertained	3	2	5
Total		11	14	25

Table 7.1.4.1.3: No. of Cases by Foreign Domestic Helper Mothers

Foreign domestic helper	Total
Yes	10 (40.0%)
No	15 (60.0%)
Total	25

Table 7.1.4.1.4: No. of Cases by Age Distribution of the Non-Foreign Domestic Helper Mothers

Age	Total
14	1 (6.7%)
15	1 (6.7%)
17	4 (26.7%)
18	2 (13.3%)
19	3 (20.0%)
28	1 (6.7%)
32	1 (6.7%)
33	1 (6.7%)
37	1 (6.7%)
Total	15

Table 7.1.4.1.5: No. of Cases by Place of Fatal Incident

Place of fatal incident	Total
Home	19 (76.0%)
Indoor (not home)	3 (12.0%)
Hospital	2 (8.0%)
Vehicle	1 (4.0%)
Total	25

7.1.4.2 Recommendations

Year	Case nature	Ref.	Recommendations
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 behaviours in handling unintended pregnancy; as well as educating parents on the handling of unintended pregnancy of their adolescent children.
2010-2011	Various	G5	Through public education, to arouse awareness of the possible fatal consequence of concealment of pregnancy, with emphasis on the consequence of unintended pregnancy and the appropriate ways of handling it.
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.

7.1.4.3 Observations

- For the cases reviewed from 2006 to 2013, 25 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. Some cases resulted in assault as the mothers did not want the babies who were tragically left to die. In some cases, the cause of death could not be ascertained

but it was believed that had suitable medical attention or treatment been available, the chance of their survival could have been significantly increased.

- A significant portion of the cases (40%) involved mothers who were foreign domestic helpers. For those mothers who were not foreign domestic helpers, 6 of them were girls under the age of 18 with the lowest being 14.

- The awareness of the possible fatal consequence of concealment of pregnancy should be further strengthened through education to adolescents and publicity to the community of foreign domestic helpers.

- The availability of various professional services and community resources to support the pregnant women and their new born babies should also be widely publicised.

7.1.5 Responses/Updates on Concealment of Pregnancy

From Labour Department (LD)

Insofar as labour policy is concerned, Hong Kong is one of the few areas which grants equal and full statutory rights to migrant workers, including foreign domestic helper ("FDH"), like local workers. For instance, they enjoy the protection and benefits under the Employment Ordinance (Cap. 57), including maternity protection, as local workers.

To raise the awareness of labour right among FDHs and their employers, the Labour Department has been continually publicising the messages through various channels like television and radio commercials, distributing pamphlets, holding seminars and setting up information kiosks at popular FDH gathering locations etc. We understand that some FDH interest groups (e.g. PathFinders) are also working on this front, sometimes in collaboration with the relevant Consulate General.

The above said, all pregnant women, irrespective of their nationality and employment status, should be aware of the risk of concealing pregnancy and the importance of seeking help early.

From Education Bureau (EDB)

Topics related to sex and relationship education are covered in the existing school

curricula recommended by EDB. Schools are encouraged to cultivate positive values like perseverance, respect for others, responsibility in students and enhance their power of rational analysis and judgement and proper handling of sex-related issues, through the provision of various learning activities, such as class periods, assemblies, talks, etc. EDB will continue to review relevant curricula, update learning and teaching resources in a timely manner and provide professional development programmes for teachers.

Schools will also tap resources from the community, such as the Family Planning Association, the Mother's Choice, the Adolescent Health Programme of the Student Health Service of the Department of Health, etc. to organise sex education programmes in schools.

If students are found to be involved in sex-related problems, teachers should work closely with the student guidance personnel/school social workers and provide counseling to these students. According to the nature and seriousness of the problem, student cases should be referred to related organisations or departments for appropriate services and closely monitored through multidisciplinary collaboration. EDB organises thematic seminars for teachers as required to consolidate their related skills in supporting students facing difficulties in love relationship.

From Social Welfare Department (SWD)

SWD agrees to the views and observations of the Review Panel.

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 the 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.

7.2 Statistics of Child Death Cases Reviewed from 2006 to 2013

Taking account of the child death cases reviewed from 2006 to 2013, tables and charts are prepared to show the changes over time by various natures of cases. However, with limited data from our reviewed cases available for a short period of time, there might be fluctuations in the data and the data analysis might not yield very significant findings in presenting the trends and patterns.

Table 7.2.1: 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^	
Natural Causes	74 [69]	60 [52]	70	86	79	72	70	61	572 [559]
Non-natural Causes-	43 [48]	32 [40]	49	33	49	38	39	36	319 [332]
Suicide	14	10	14	12	21	14	10	10	105
Accident	20	12	13	10	15	13	17	11	111
Assault	5	6	9	9	8	4	2	6	49
#Unascertained	1 [6]	2 [10]	9	1	5	7	10	8	43 [56]
*Medical Complications	3	2	4	1	0	0	0	1	11
Total:	117	92	119	119	128	110	109	97	891

 # 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.

^ There are 2 natural-cause cases and 10 accident cases of 2012 and 2 natural-cause cases of 2013 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 7.2.1.1: No. of Cases by Cause of Death and Year

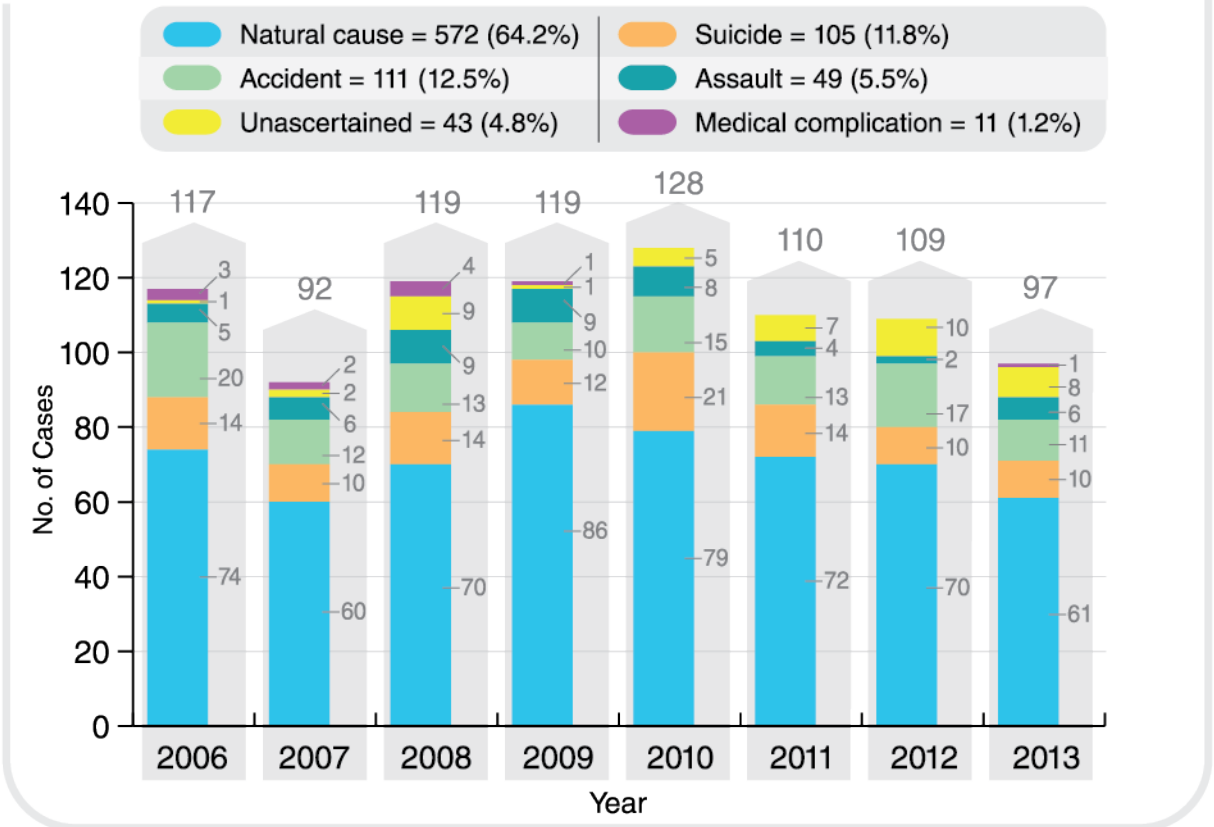


Chart 7.2.1.2: No. of Overall Cases by Year

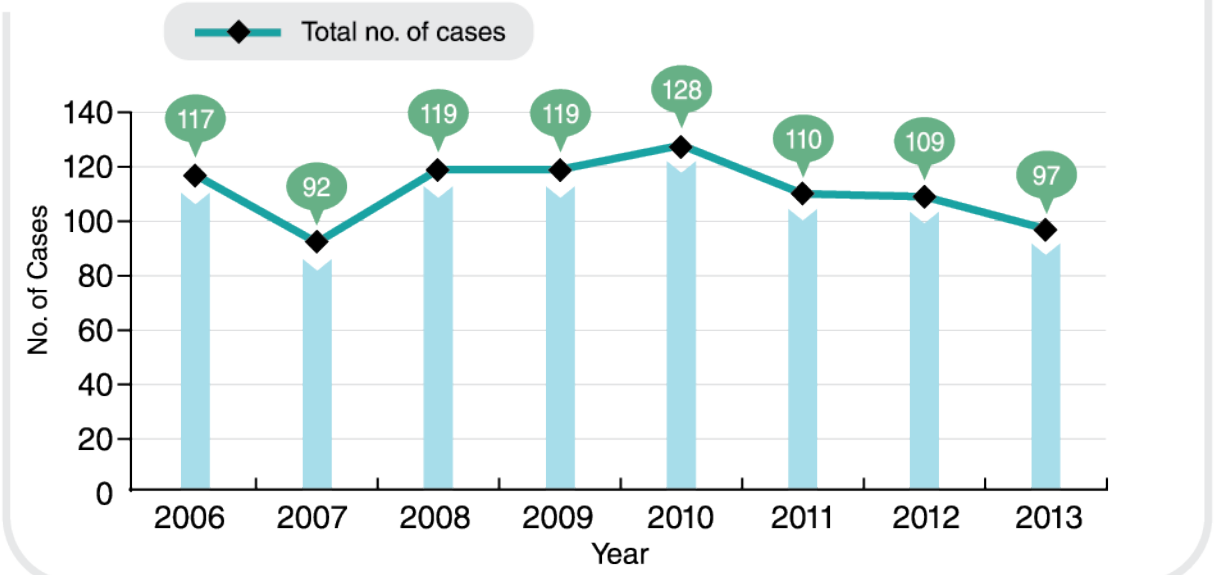


Chart 7.2.1.3: No. of Natural Cause Cases by Year

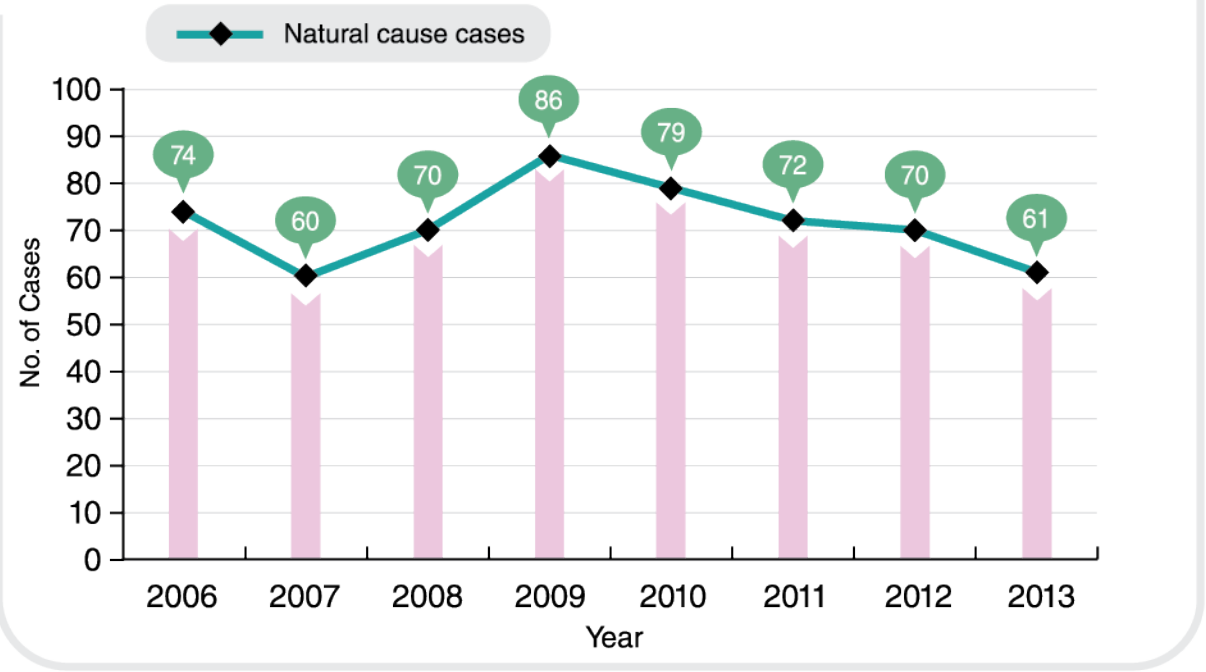


Chart 7.2.1.4: No. of Suicide Cases by Year

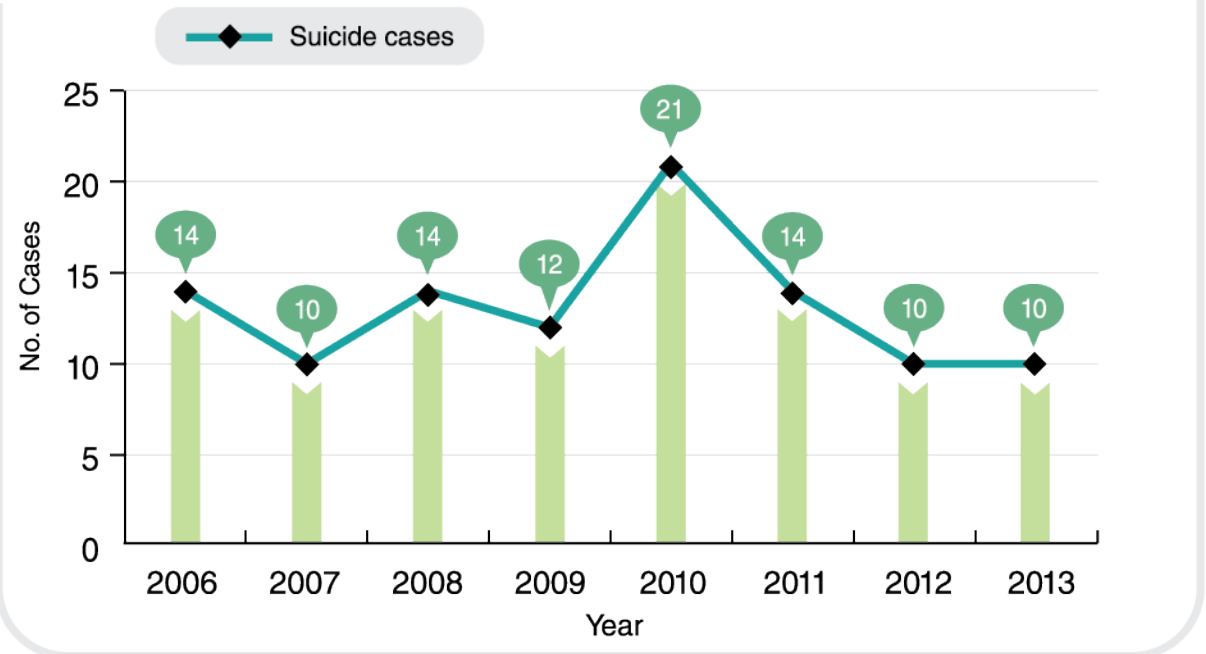


Chart 7.2.1.5: No. of Accident Cases by Year

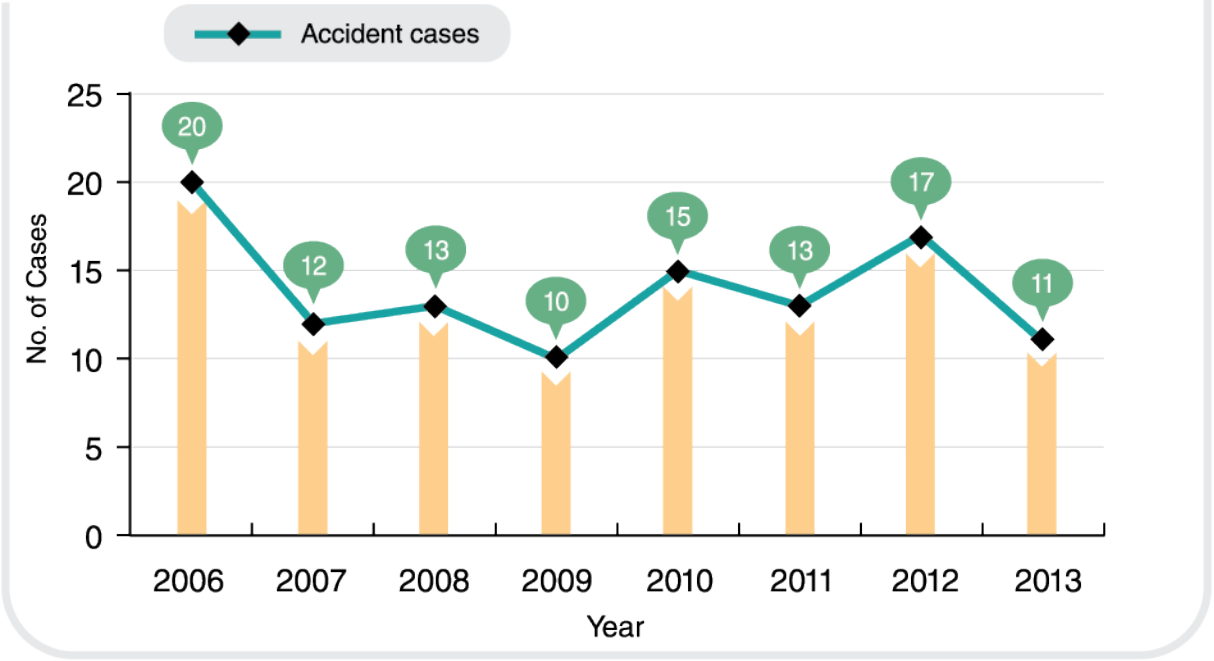


Chart 7.2.1.6: No. of Assault Cases by Year

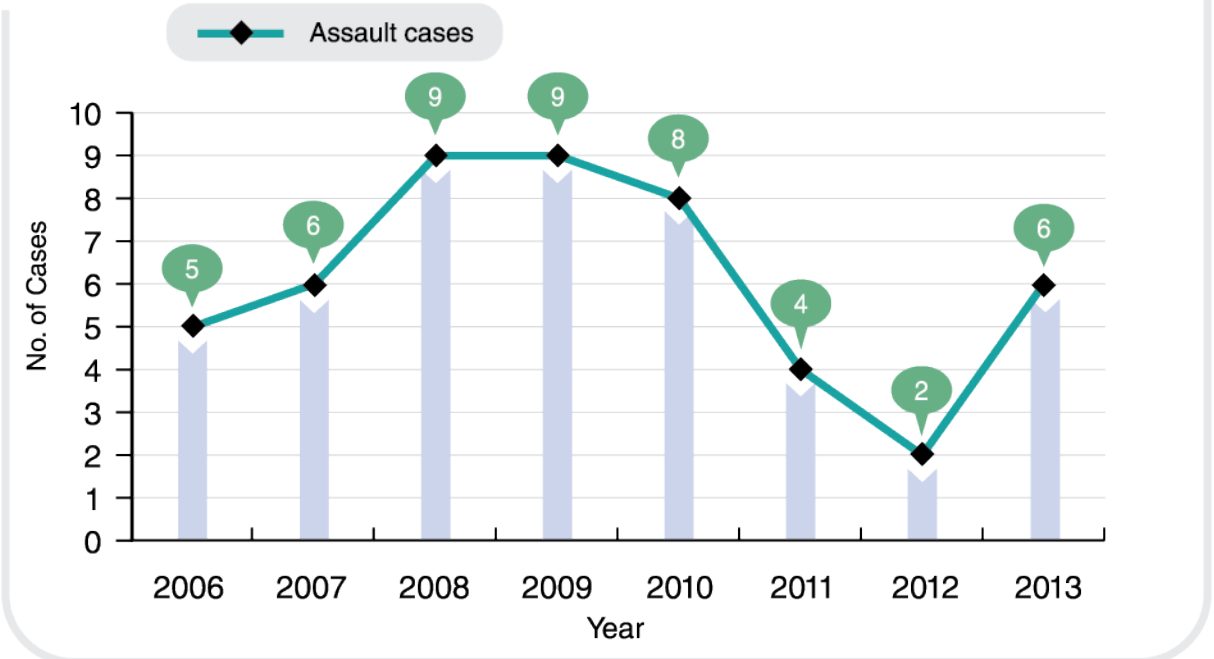


Chart 7.2.1.7: No. of Non-natural Unascertained Cause Cases by Year

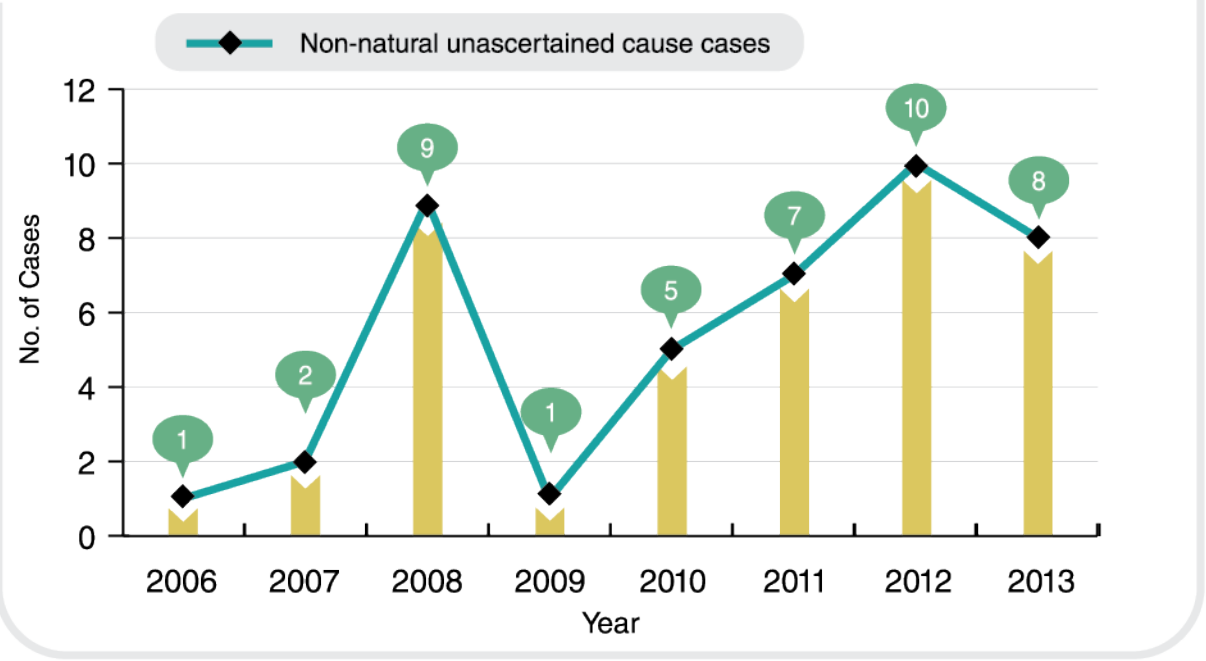


Chart 7.2.1.8: No. of Medical Complication Cases by Year

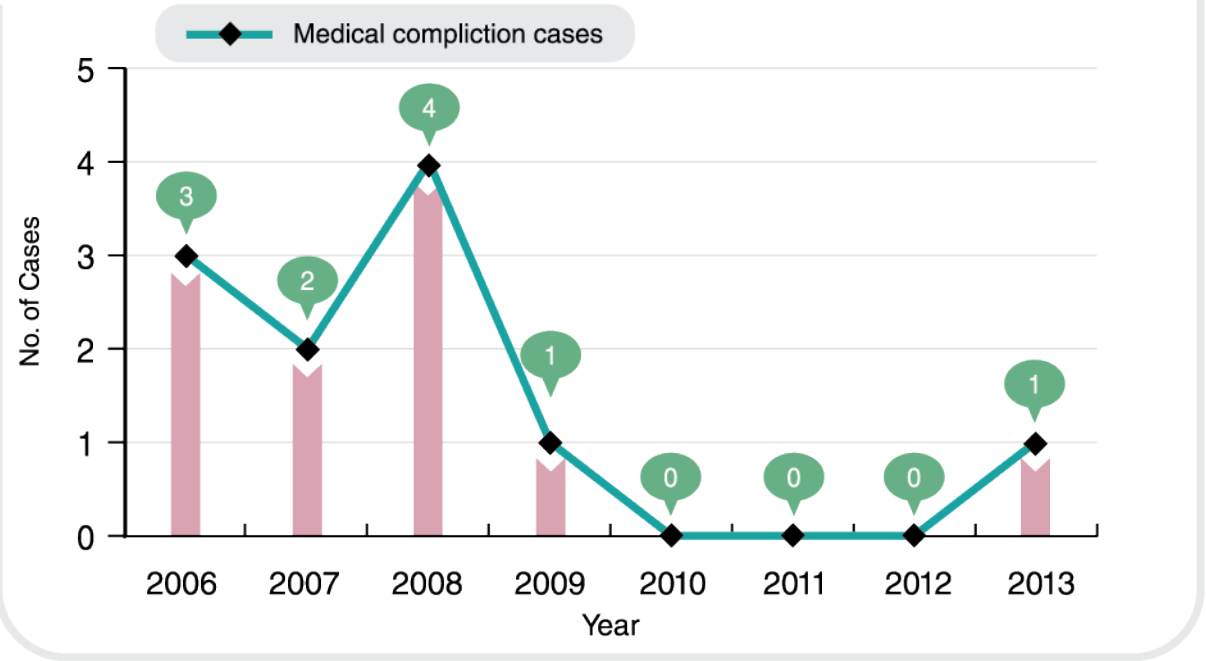


Table 7.2.2: No. of Cases by Age Group, Sex and Year

Age Group and Sex		2006	2007	2008	2009	2010	2011	2012	2013	No. of Cases (%)
<1	Female	18	17	16	23	17	24	27	14	156
	Male	14	20	27	25	40	25	28	27	206
	Sub-total	**32**	**37**	**43**	**48**	**57**	**49**	**55**	**41**	**362 (40.6%)**
1-2	Female	3	2	8	7	3	3	3	4	33
	Male	7	3	3	7	2	8	4	7	41
	Sub-total	**10**	**5**	**11**	**14**	**5**	**11**	**7**	**11**	**74 (8.3%)**
3-5	Female	1	3	5	4	2	5	1	4	25
	Male	6	2	5	7	9	1	4	4	38
	Sub-total	**7**	**5**	**10**	**11**	**11**	**6**	**5**	**8**	**63 (7.1%)**
6-8	Female	3	3	2	2	2	2	4	2	20
	Male	7	5	3	3	4	3	3	4	32
	Sub-total	**10**	**8**	**5**	**5**	**6**	**5**	**7**	**6**	**52 (5.8%)**
9-11	Female	8	6	3	4	1	1	1	5	29
	Male	7	4	6	3	2	5	4	2	33
	Sub-total	**15**	**10**	**9**	**7**	**3**	**6**	**5**	**7**	**62 (7.0%)**
12-14	Female	6	5	8	8	7	5	7	3	49
	Male	12	6	6	6	11	6	2	10	59
	Sub-total	**18**	**11**	**14**	**14**	**18**	**11**	**9**	**13**	**108 (12.1%)**
15-17	Female	11	4	12	8	8	8	4	8	63
	Male	14	12	15	12	20	14	17	3	107
	Sub-total	**25**	**16**	**27**	**20**	**28**	**22**	**21**	**11**	**170 (19.1%)**
Total (%)	Female	50	40	54	56	40	48	47	40	375 (42.1%)
	Male	67	52	65	63	88	62	62	57	516 (57.9%)
	Total	**117**	**92**	**119**	**119**	**128**	**110**	**109**	**97**	**891 (100%)**

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

Chart 7.2.2.1: No. of Cases by Year and Age Group

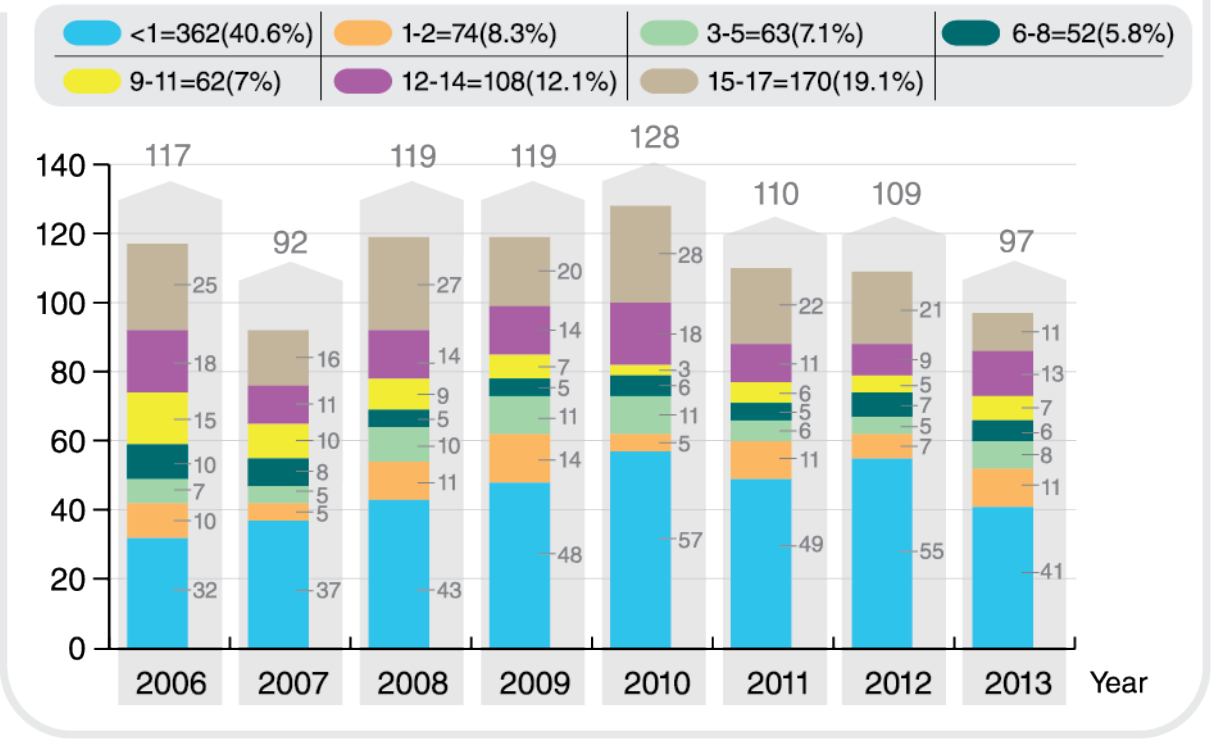


Chart 7.2.2.2: No. of Cases by Age Group and Year

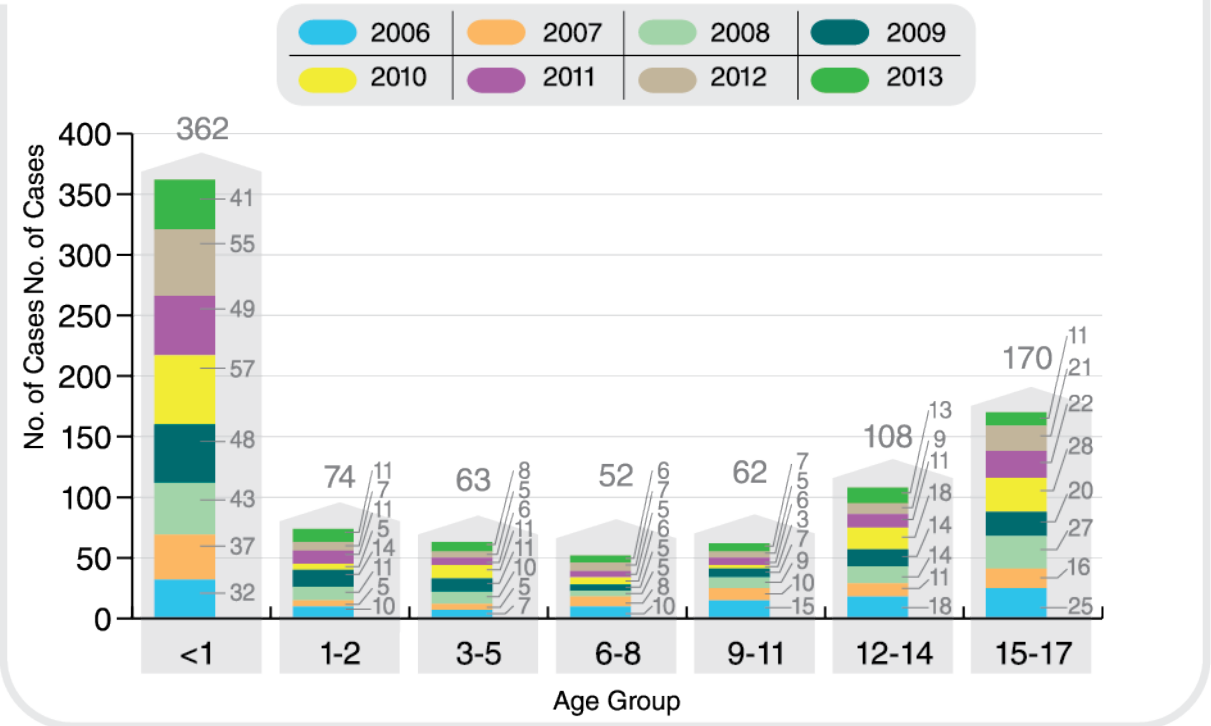


Chart 7.2.2.3: No. of Cases by Year and Ethnicity

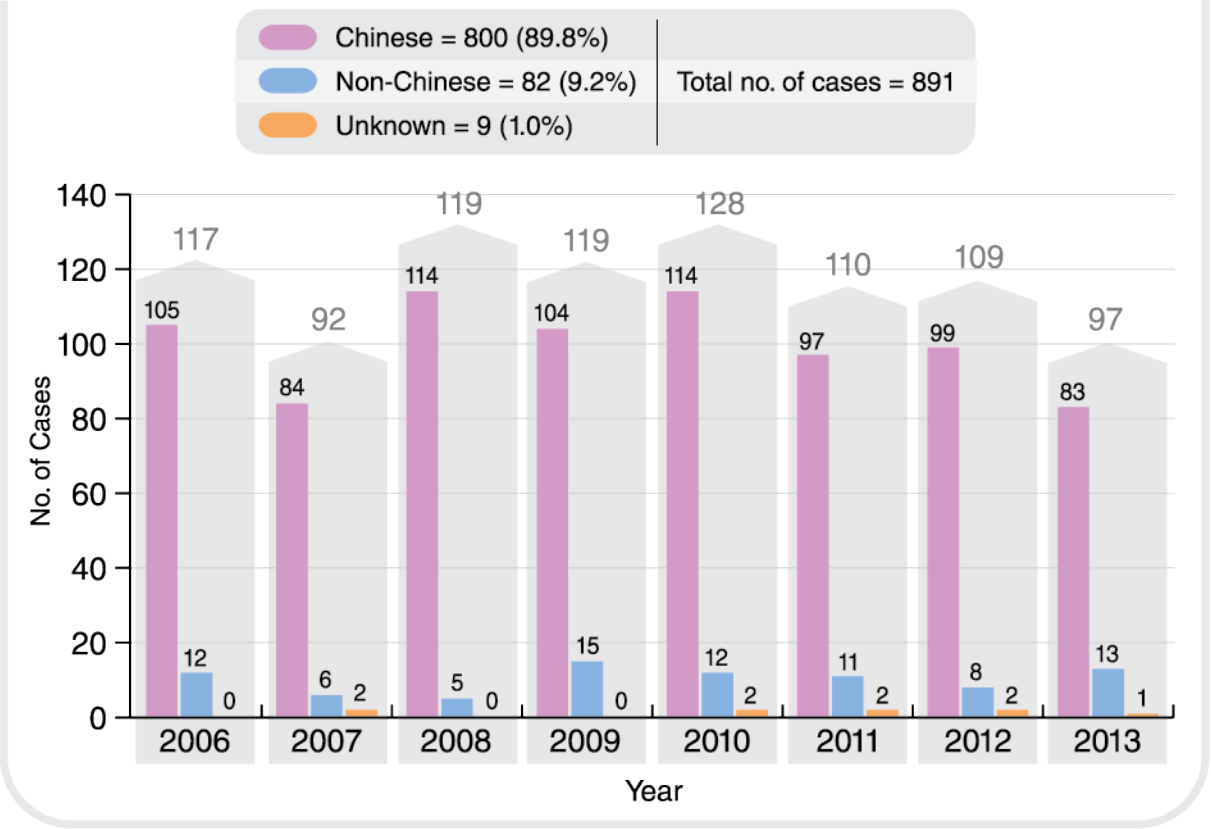


Table 7.2.4: No. of Cases by Cause of Death, Year and Sex

Cause of Death		2006	2007	2008	2009	2010	2011	2012	2013	No. of Cases (%)
Natural Causes	Female	31	29	32	39	24	35	33	20	243
	Male	43	31	38	47	55	37	37	41	329
	Sub-total	**74**	**60**	**70**	**86**	**79**	**72**	**70**	**61**	**572 (64.2%)**
Suicide	Female	7	3	6	6	6	6	5	6	45
	Male	7	7	8	6	15	8	5	4	60
	Sub-total	**14**	**10**	**14**	**12**	**21**	**14**	**10**	**10**	**105 (11.8%)**
Accident	Female	8	3	3	4	6	2	4	6	36
	Male	12	9	10	6	9	11	13	5	75
	Sub-total	**20**	**12**	**13**	**10**	**15**	**13**	**17**	**11**	**111 (12.5%)**
Assault	Female	3	3	5	6	4	1	1	1	24
	Male	2	3	4	3	4	3	1	5	25
	Sub-total	**5**	**6**	**9**	**9**	**8**	**4**	**2**	**6**	**49 (5.5%)**
Unascertained	Female	0	1	7	1	0	4	4	6	23
	Male	1	1	2	0	5	3	6	2	20
	Sub-total	**1**	**2**	**9**	**1**	**5**	**7**	**10**	**8**	**43 (4.8%)**
Medical Complication	Female	1	1	1	0	0	0	0	1	4
	Male	2	1	3	1	0	0	0	0	7
	Sub-total	**3**	**2**	**4**	**1**	**0**	**0**	**0**	**1**	**11 (1.2%)**
Total (%)	Female	50	40	54	56	40	48	47	40	375 (42.1%)
	Male	67	52	65	63	88	62	62	57	516 (57.9%)
	Total	**117**	**92**	**119**	**119**	**128**	**110**	**109**	**97**	**891 (100%)**

The highest case numbers among different years are highlighted.

Chart 7.2.4.1: No. of Overall Cases by Year and Sex

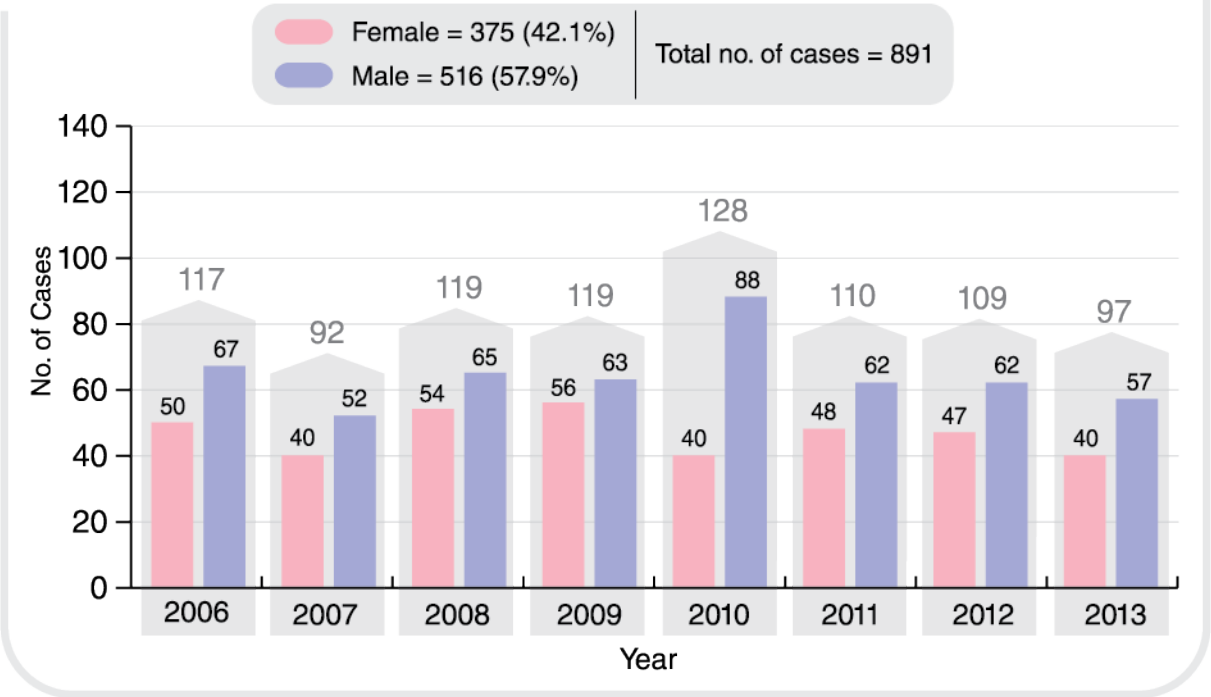


Chart 7.2.4.2: No. of Natural Cause Cases by Year and Sex

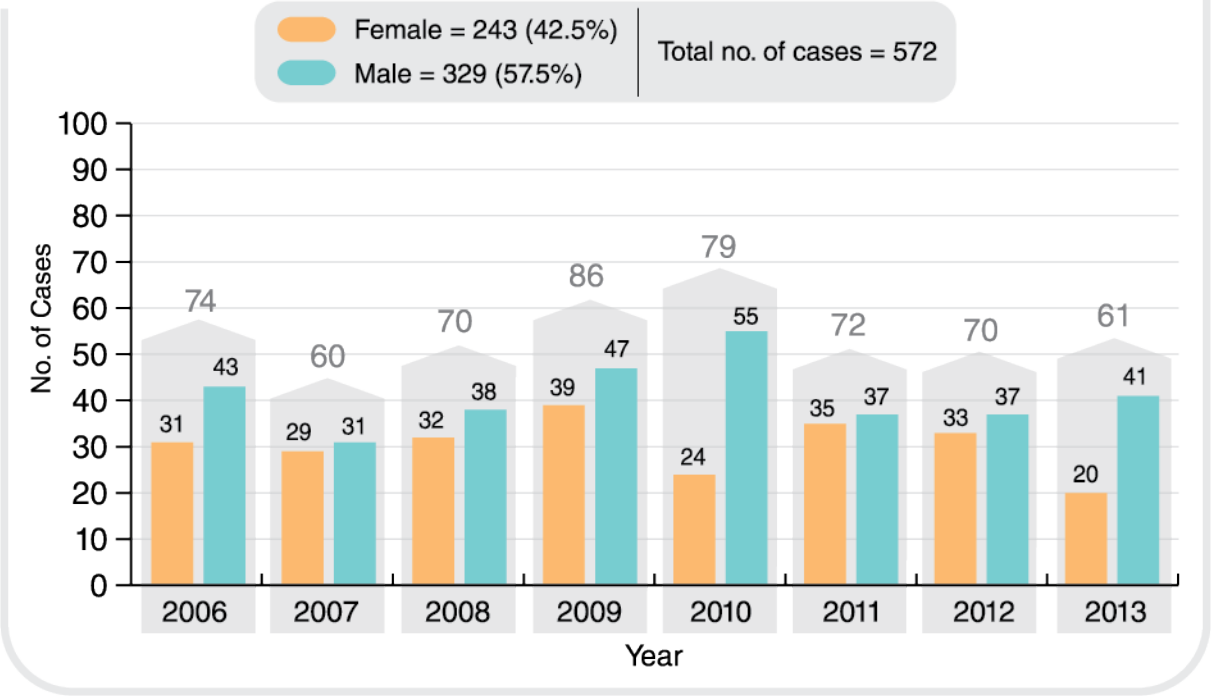


Chart 7.2.4.3: No. of Suicide Cases by Year and Sex

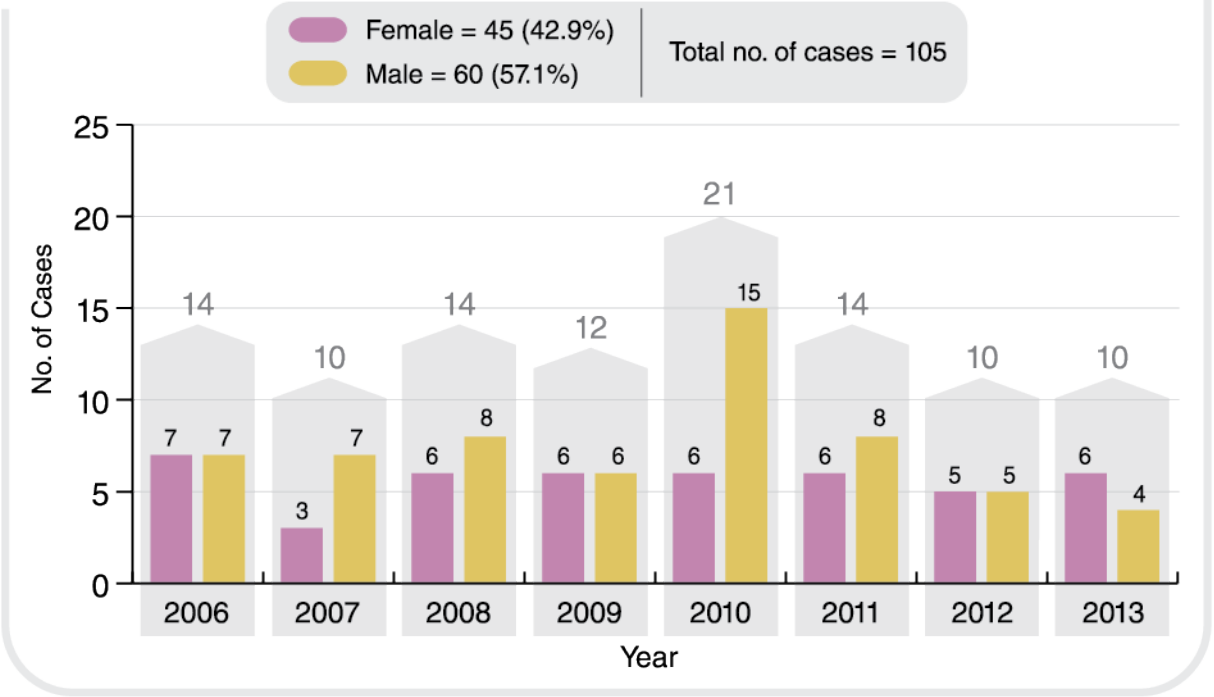


Chart 7.2.4.4: No. of Accident Cases by Year and Sex

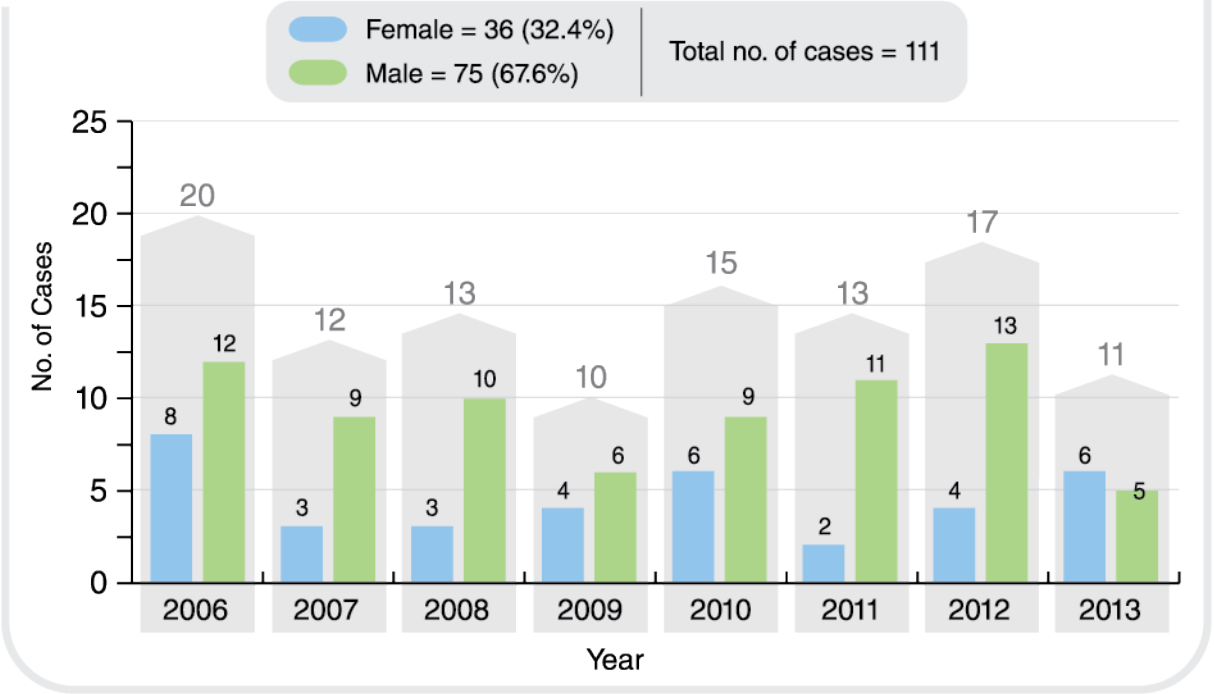


Chart 7.2.4.5: No. of Assault Cases by Year and Sex

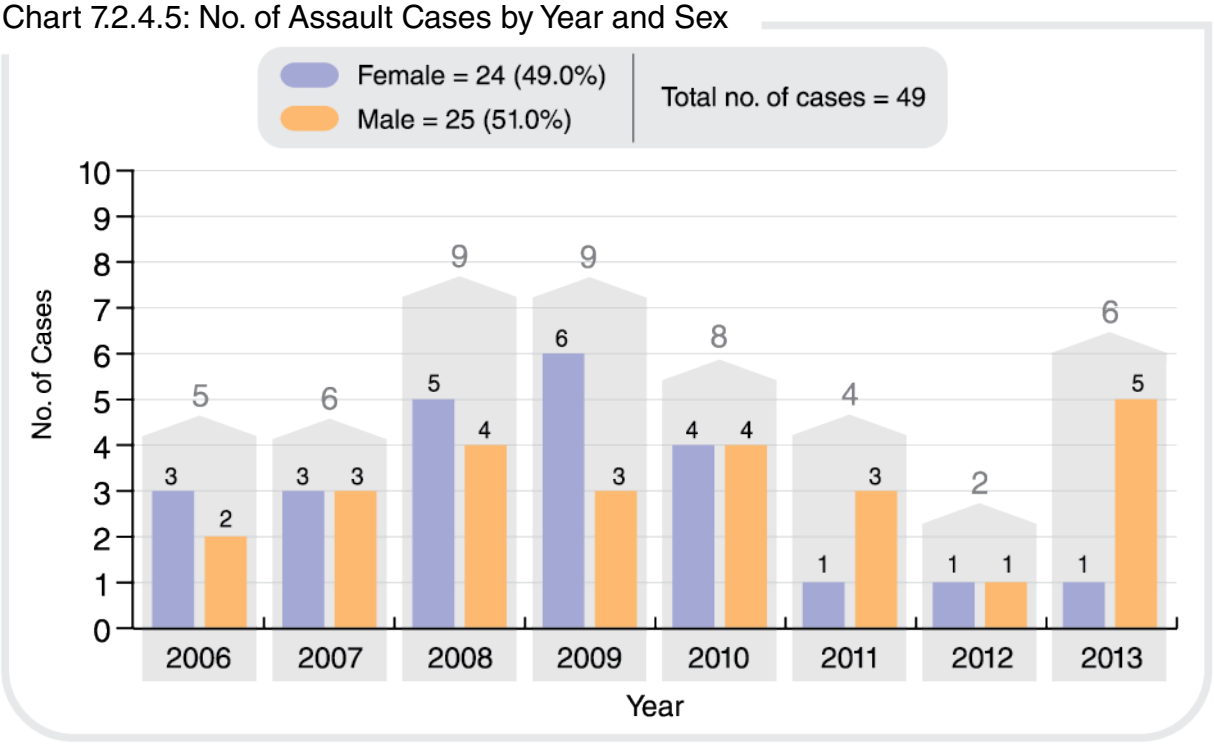


Chart 7.2.4.6: No. of Non-natural Unascertained Cause Cases by Year and Sex

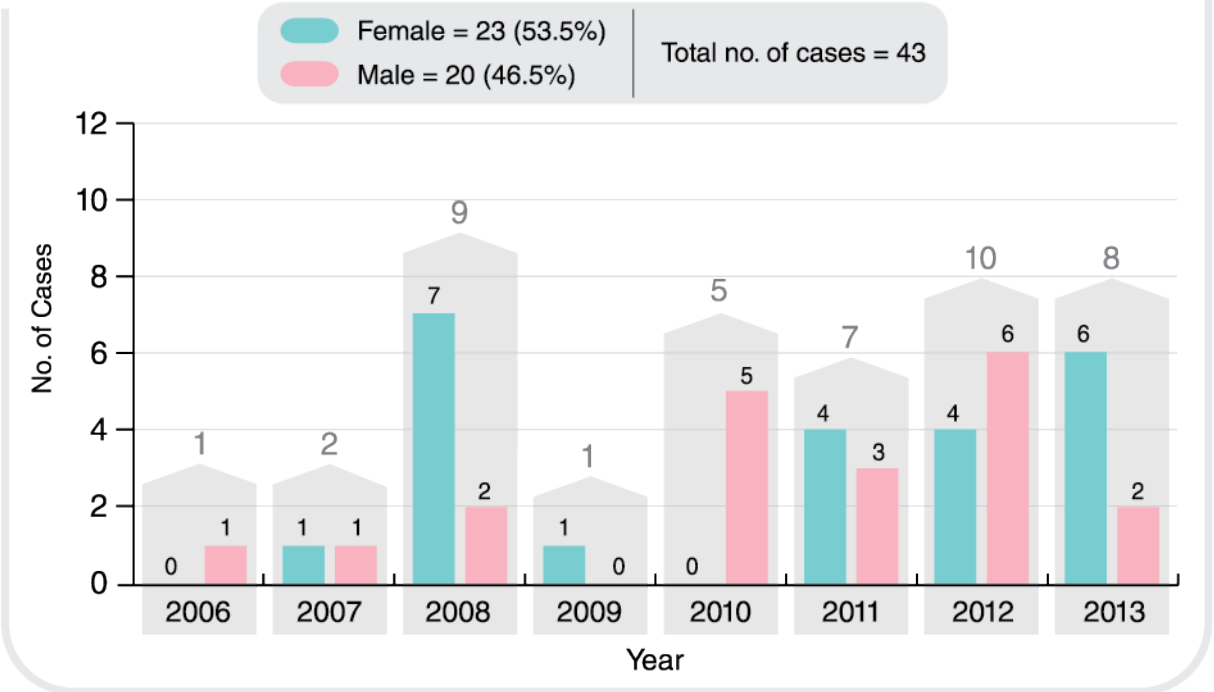


Chart 7.2.4.7: No. of Medical Complication Cases by Year and Sex

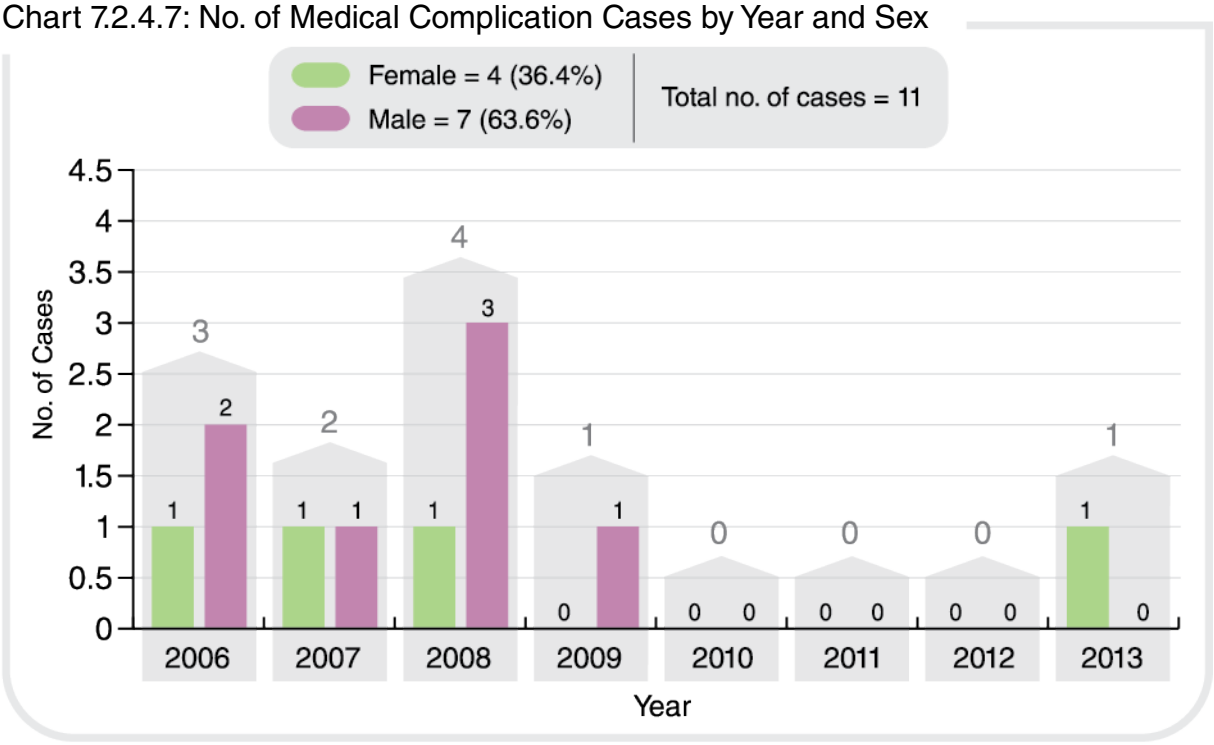


Table 7.2.5: No. of Cases by Residential District

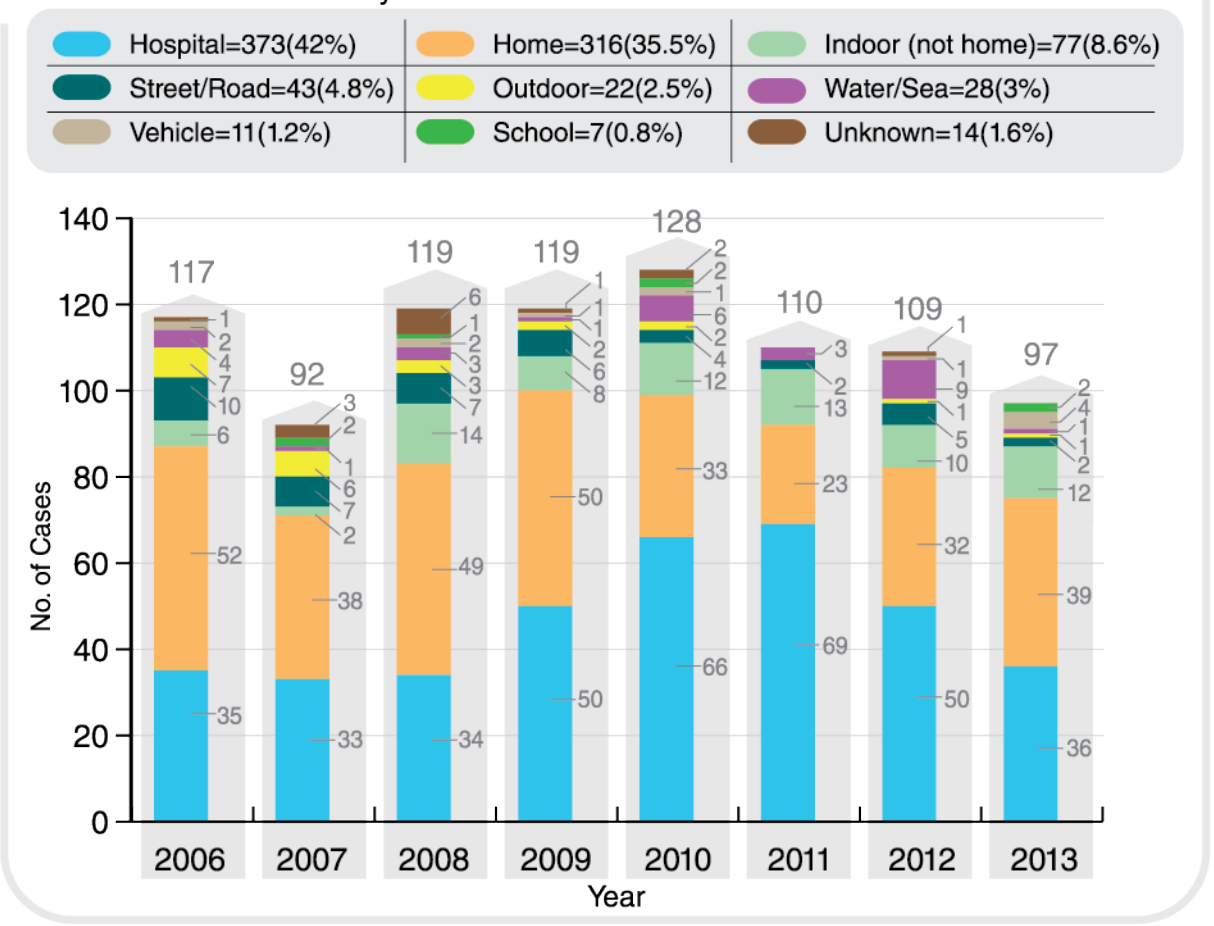
Residential District	No. of Cases / Death Rate*								
	2006	2007	2008	2009	2010	2011	2012	2013	Total (%)
HONG KONG ISLAND									
Central & Western	7	1	4	6	2	5	6	1	32 (3.6%)
	0.185	0.026	0.102	0.157	0.051	0.144	0.172	0.029	
Wan Chai	1	0	1	0	2	0	2	2	8 (0.9%)
	0.045	0.000	0.047	0.000	0.099	0.000	0.105	0.109	
Eastern	4	7	9	5	2	6	11	6	50 (5.6%)
	0.043	0.076	0.100	0.058	0.024	0.074	0.140	0.079	
Southern	4	5	6	3	7	3	2	5	35 (3.9%)
	0.085	0.111	0.132	0.069	0.165	0.071	0.050	0.134	
KOWLOON									
Yau Tsim Mong	1	0	2	7	4	5	7	5	31 (3.5%)
	0.025	0.000	0.046	0.160	0.088	0.107	0.148	0.104	
Sham Shui Po	8	6	2	9	5	7	6	6	49 (5.5%)
	0.134	0.106	0.035	0.158	0.090	0.120	0.105	0.108	
Kowloon City	5	4	1	1	7	7	2	3	30 (3.4%)
	0.088	0.070	0.018	0.018	0.128	0.126	0.036	0.057	
Wong Tai Sin	7	7	6	4	11	6	5	7	53 (5.9%)
	0.102	0.103	0.093	0.065	0.187	0.103	0.087	0.122	
Kwun Tong	7	8	9	7	9	4	9	6	59 (6.6%)
	0.073	0.083	0.095	0.074	0.095	0.042	0.094	0.064	
NEW TERRITORIES									
Kwai Tsing	10	8	15	7	8	6	2	5	61 (6.8%)
	0.115	0.092	0.175	0.086	0.102	0.079	0.027	0.069	
Tsuen Wan	4	5	0	3	6	1	4	2	25 (2.8%)
	0.083	0.095	0.000	0.058	0.119	0.020	0.085	0.042	
Tuen Mun	8	7	13	13	8	11	6	3	69 (7.7%)
	0.083	0.079	0.153	0.162	0.104	0.150	0.085	0.044	
Yuen Long	10	9	12	15	14	10	11	14	95 (10.7%)
	0.083	0.077	0.105	0.135	0.130	0.096	0.108	0.142	

Residential District	No. of Cases / Death Rate*								
	2006	2007	2008	2009	2010	2011	2012	2013	Total (%)
NEW TERRITORIES									
North	6	2	6	6	10	6	2	7	45 (5.1%)
	0.104	0.035	0.108	0.109	0.19	0.122	0.041	0.153	
Tai Po	5	2	6	7	2	3	4	4	33 (3.7%)
	0.091	0.041	0.128	0.161	0.048	0.074	0.100	0.106	
Sha Tin	7	3	11	6	9	9	6	7	58 (6.5%)
	0.069	0.030	0.113	0.064	0.099	0.100	0.068	0.080	
Sai Kung	11	7	3	9	4	6	10	3	53 (5.9%)
	0.139	0.090	0.039	0.122	0.055	0.084	0.140	0.044	
Islands	3	2	1	4	5	2	3	2	22 (2.5%)
	0.094	0.065	0.032	0.131	0.164	0.075	0.111	0.078	
OTHERS									
Not residing in HK	9	6	7	6	9	11	10	7	65 (7.3%)
Unknown	0	3	5	1	4	2	1	2	18 (2.0%)
Total :	**117**	**92**	**119**	**119**	**128**	**110**	**109**	**97**	**891 (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.

Chart 7.2.6: No. of Cases by Place of Fatal Incident



Statistics of Cases Died of Natural Causes

Chart 7.3.1: No. of Cases by Year and Age Group

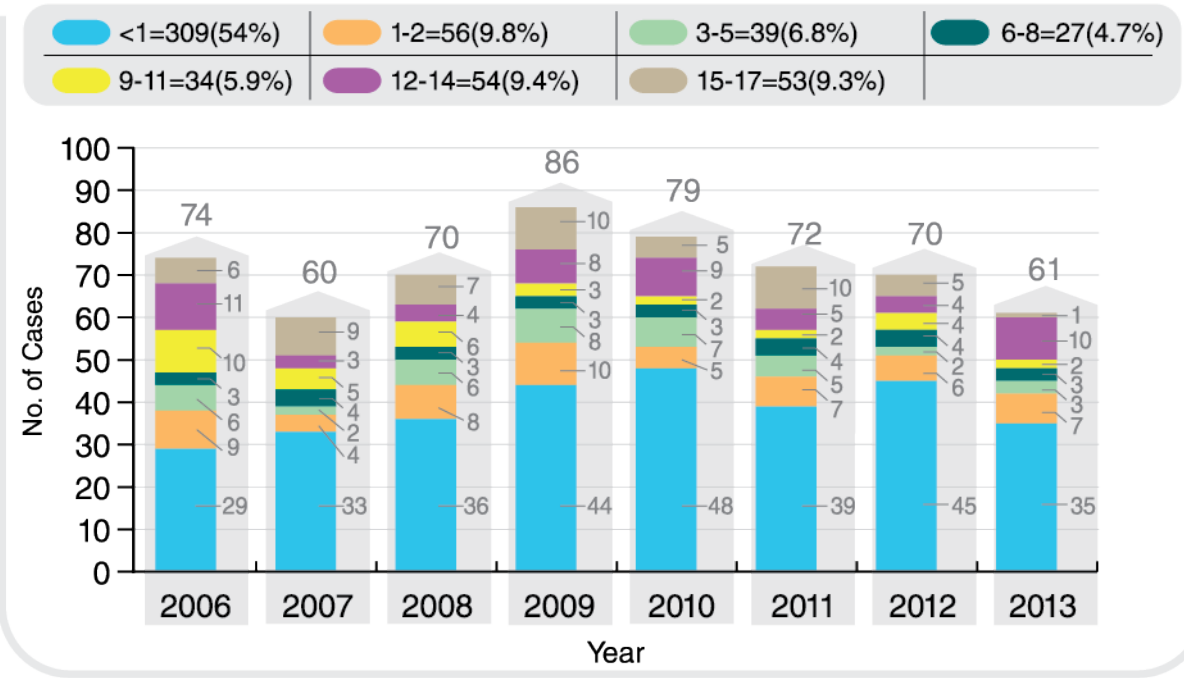
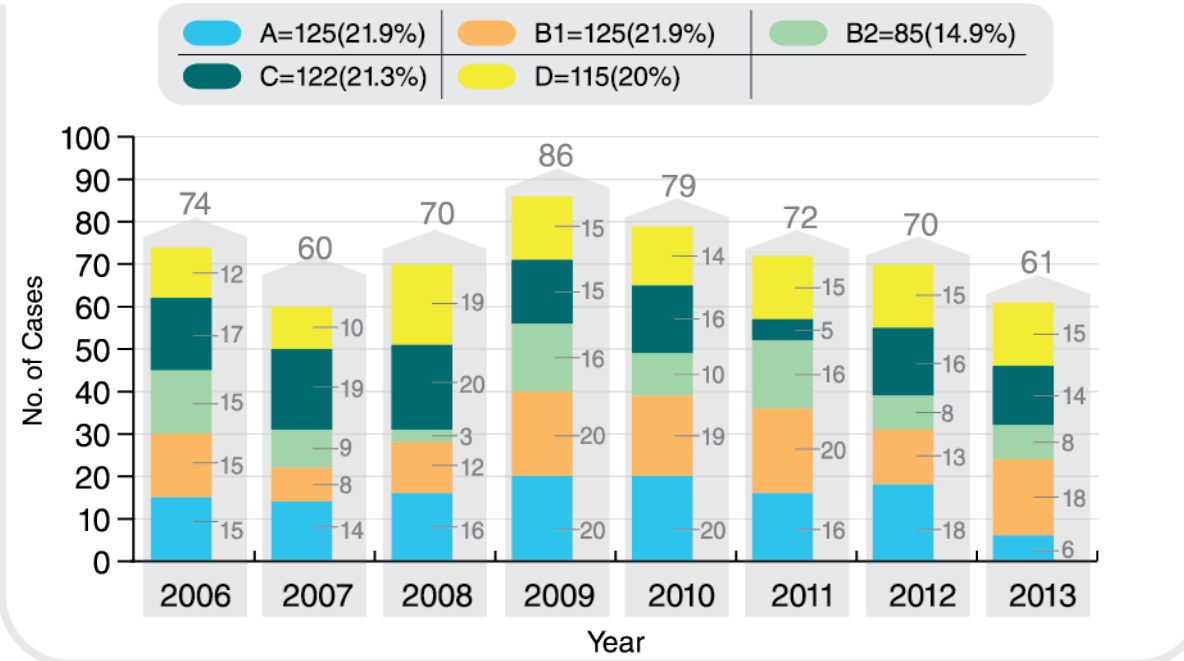


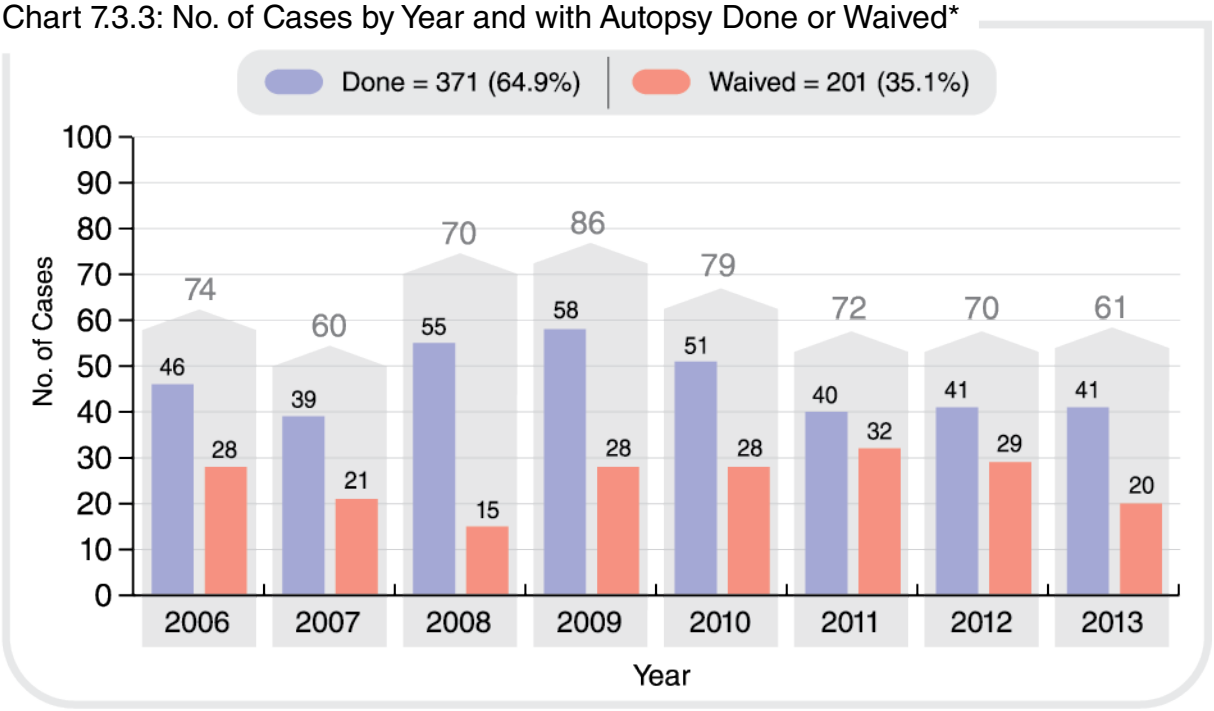
Chart 7.3.2: No. of Cases by Year and Death Category*



*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

Chart 7.3.3: No. of Cases by Year and with Autopsy Done or Waived*



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

7.4 Statistics of Cases Died of Suicides

Chart 7.4.1: No. of Cases by Year and Age Group

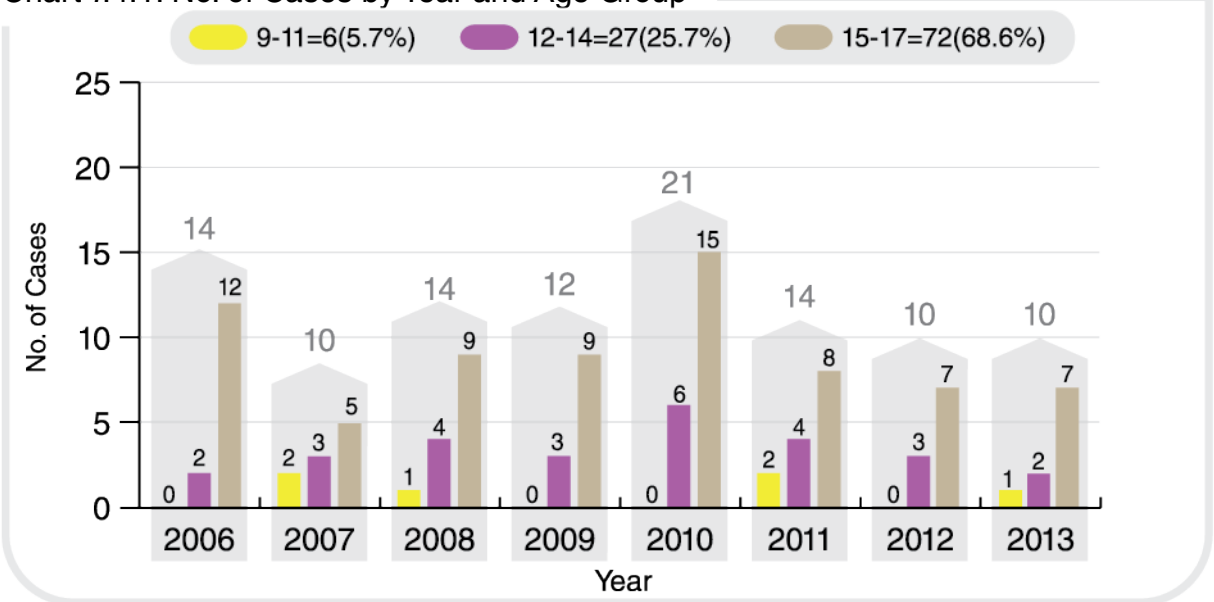
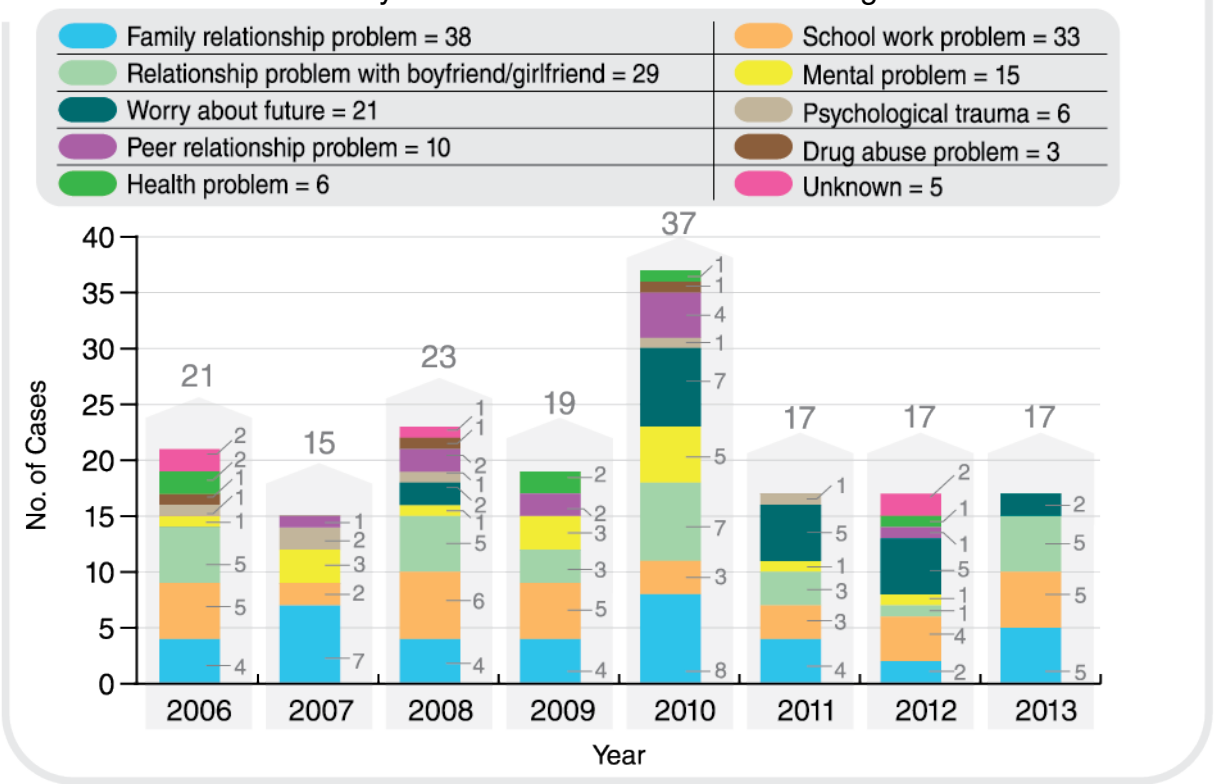


Chart 7.4.2: No. of Cases by Year and Reasons* of Committing Suicide



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

Chart 7.4.3: No. of Cases by Year and Means of Committing Suicide

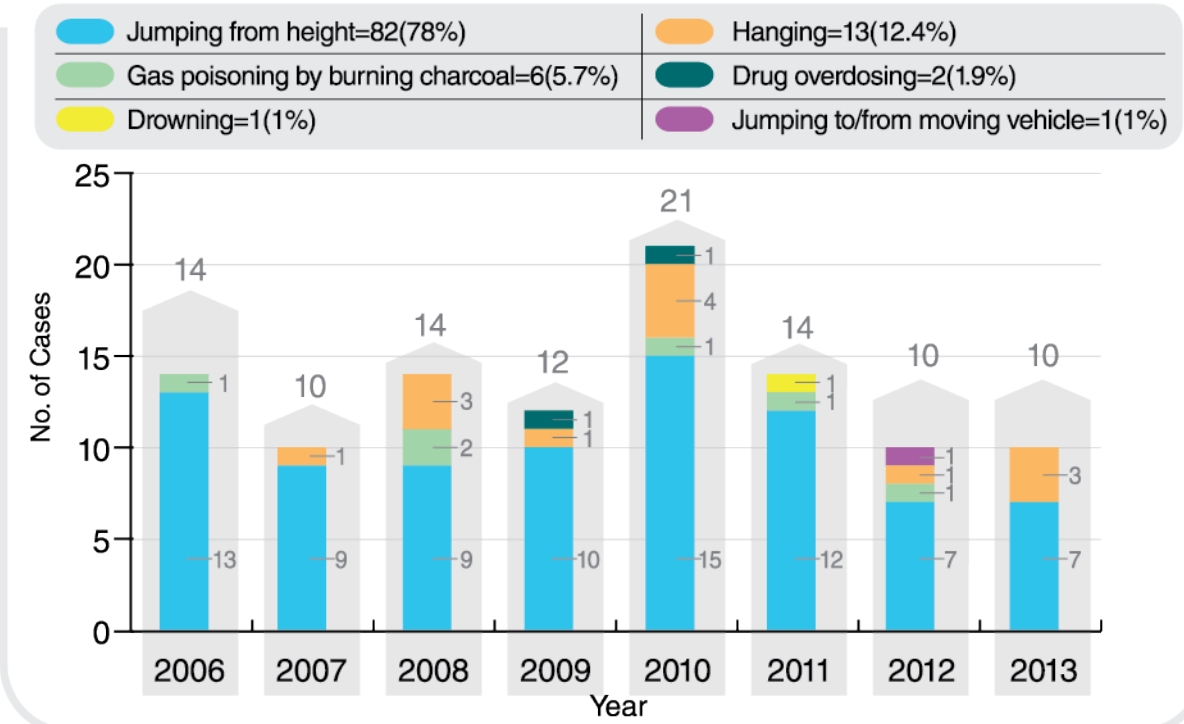
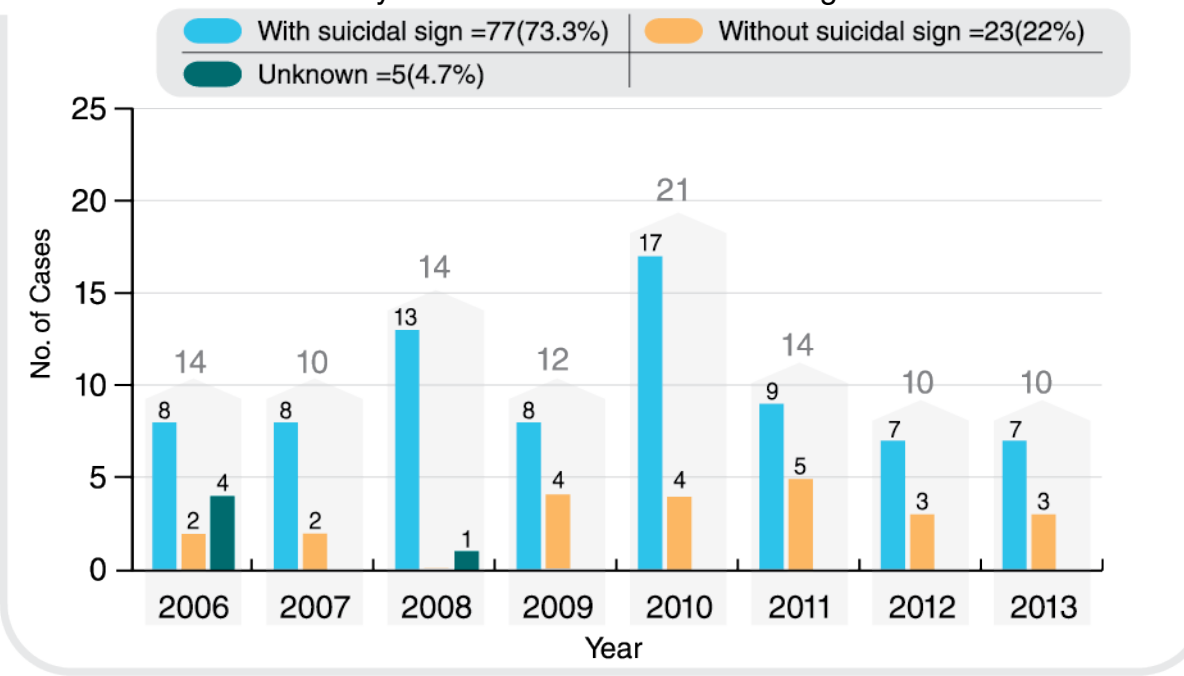


Chart 7.4.4: No. of Cases by Year and Identified Suicidal Signs*



*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.)

7.5 Statistics of Cases Died of Accidents

Chart 7.5.1: No. of Cases by Year and Age Group

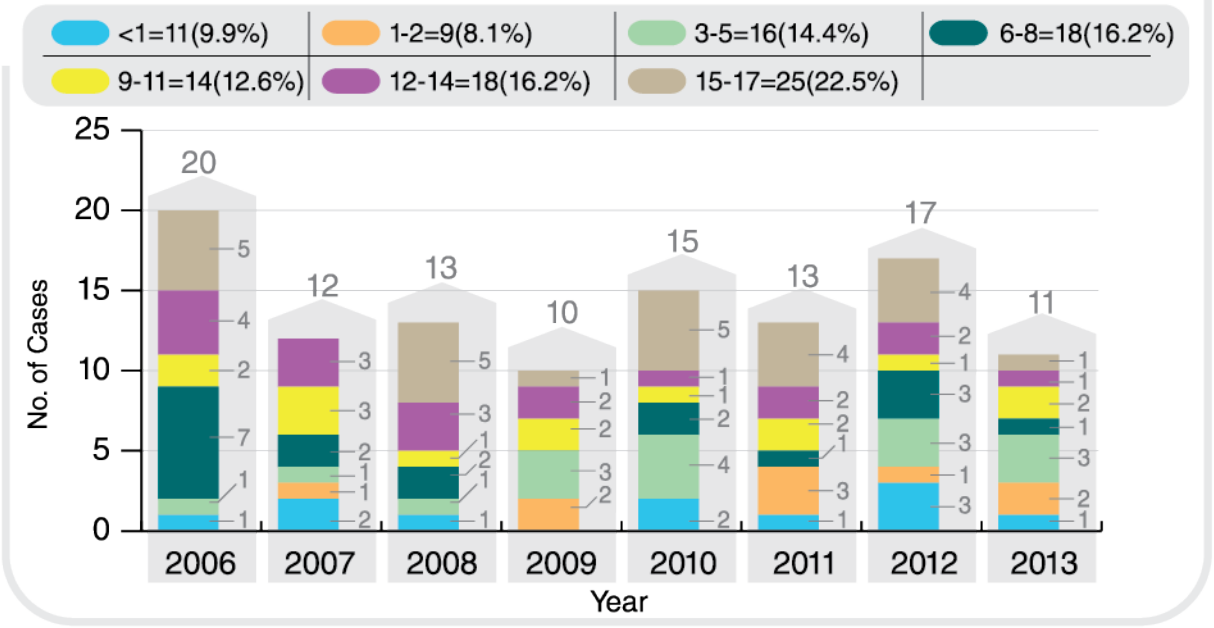
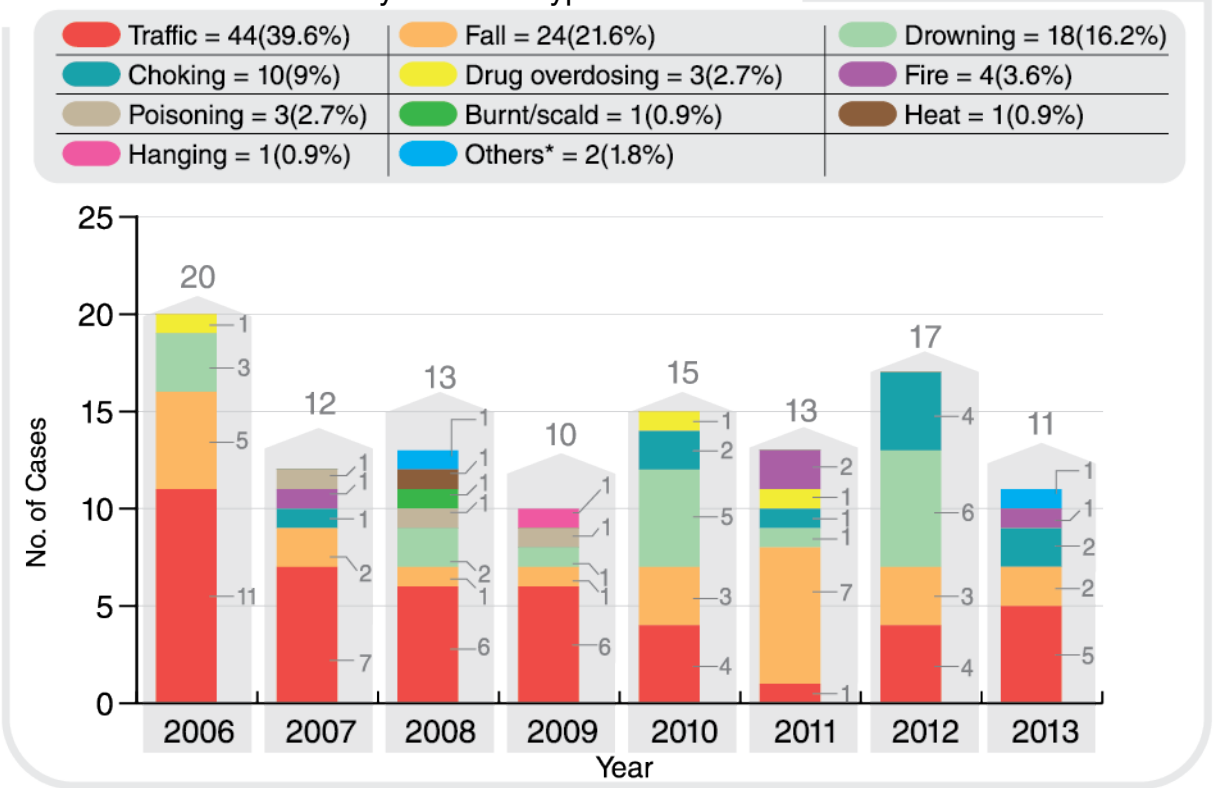


Chart 7.5.2: No. of Cases by Year and Type of Accident



** 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.*

Chart 7.5.3: No. of Traffic Accident Cases by Year and Age Group

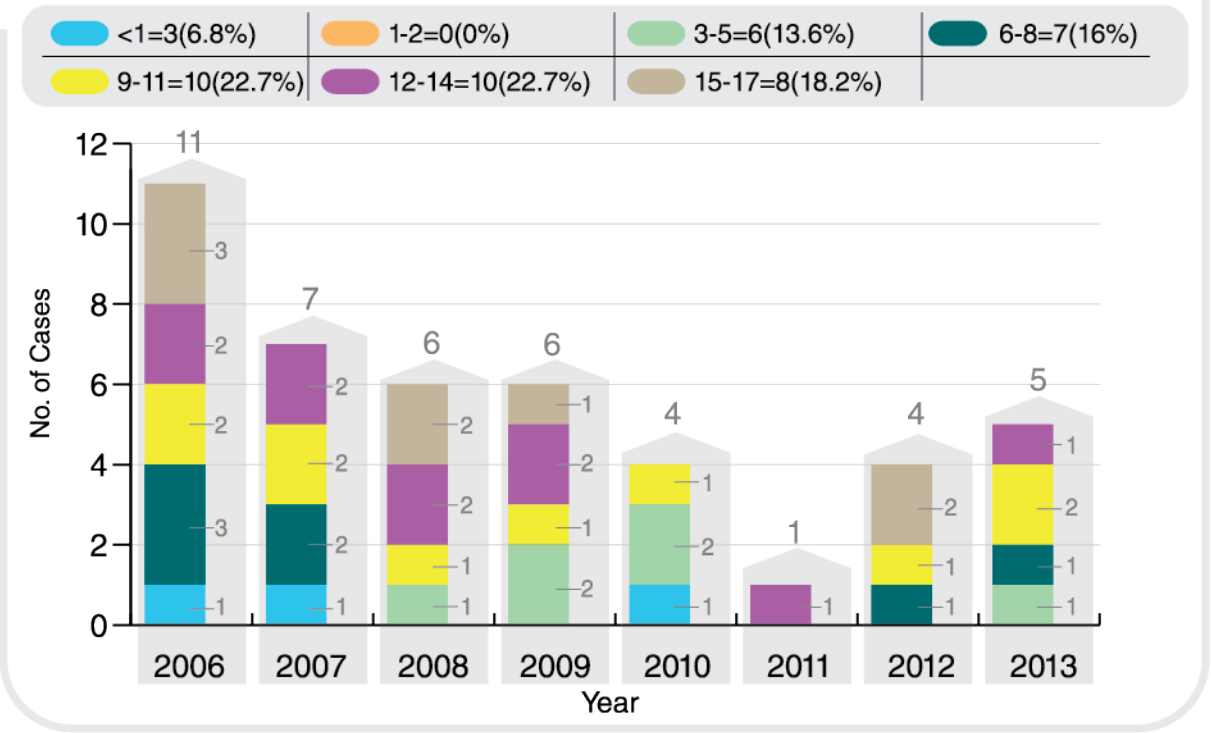


Chart 7.5.4: No. of Cases by Year and Type of Traffic Victim

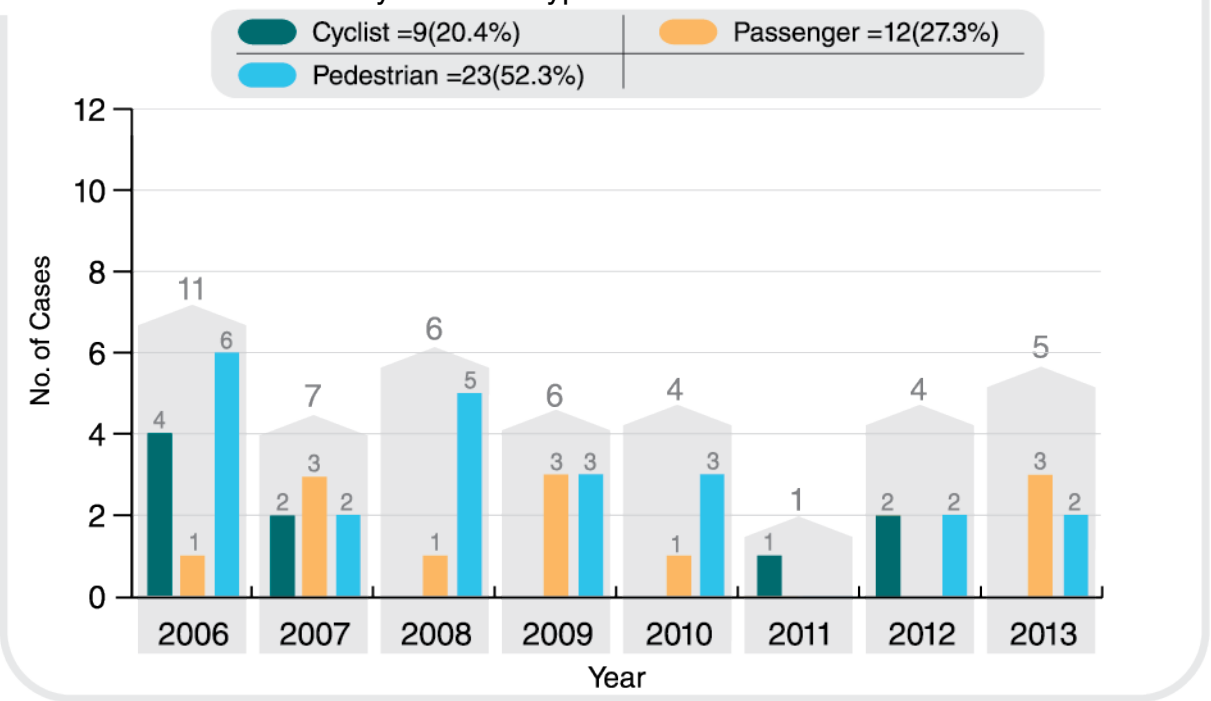


Chart 7.5.5: No. of Fall Accident Cases by Year and Age Group

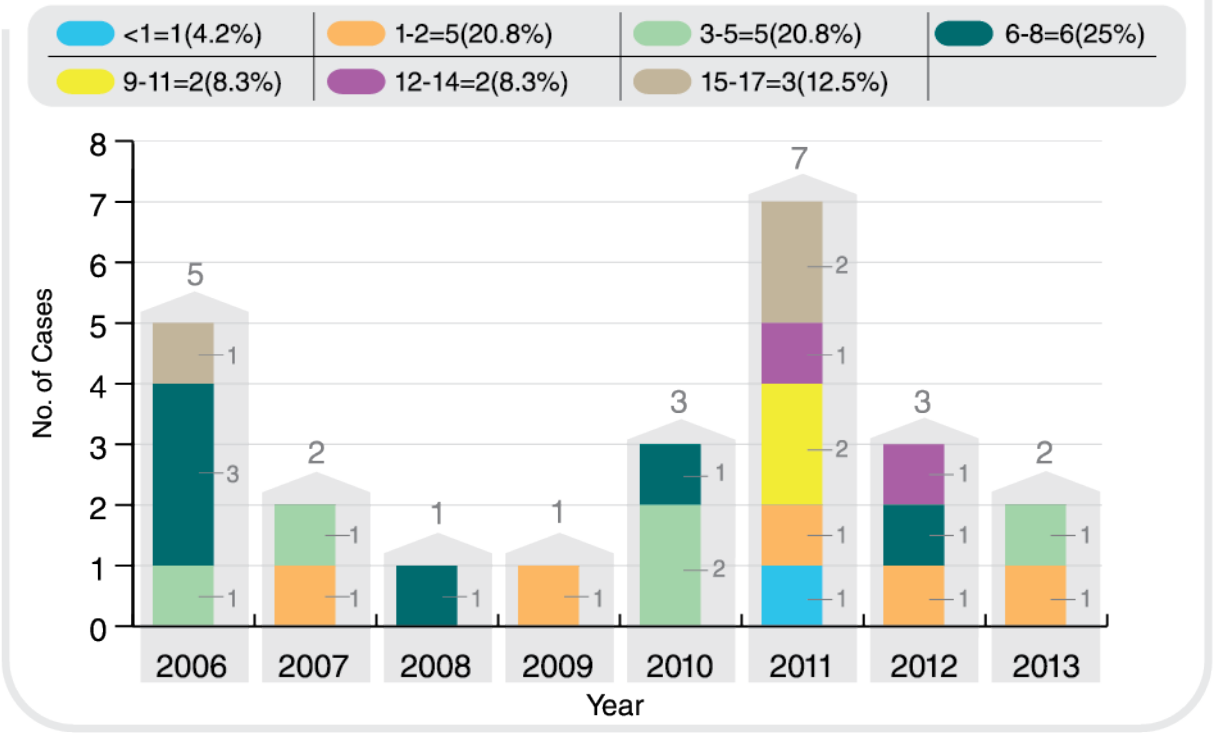
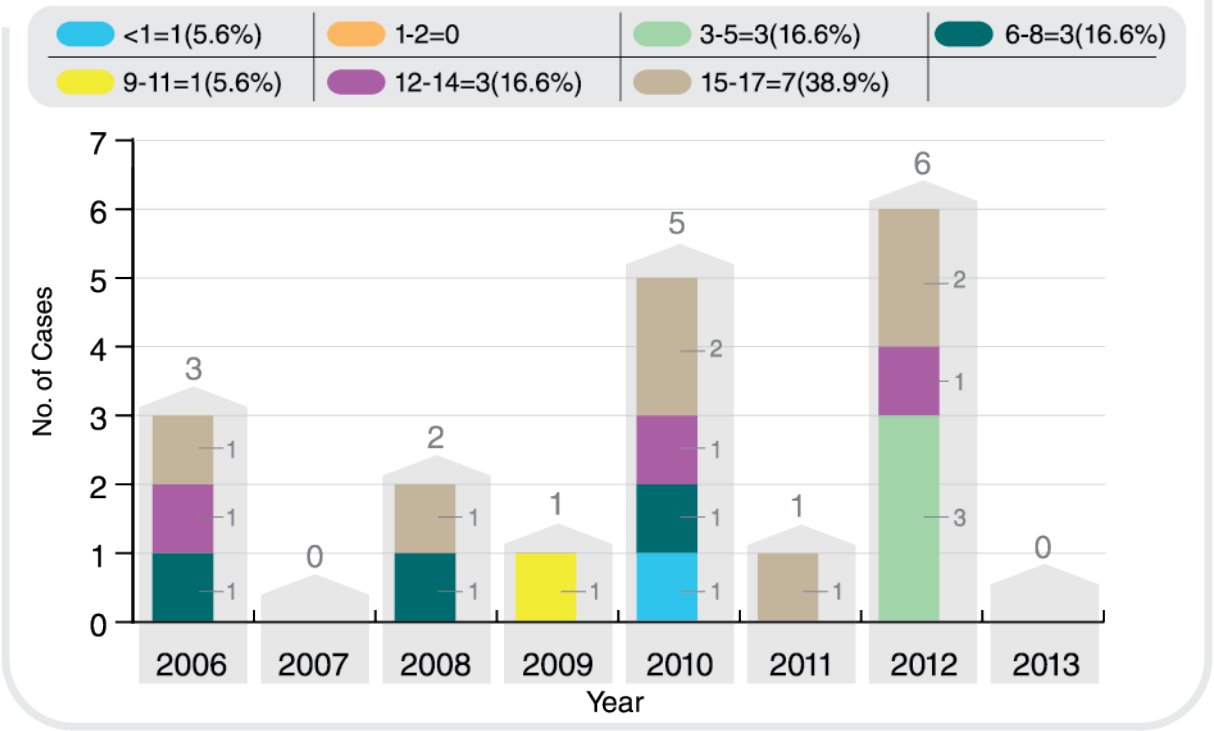


Chart 7.5.6: No. of Drowning Accident Cases by Year and Age Group



7.6 Statistics of Cases Died of Assaults

Chart 7.6.1: No. of Cases by Year and Age Group

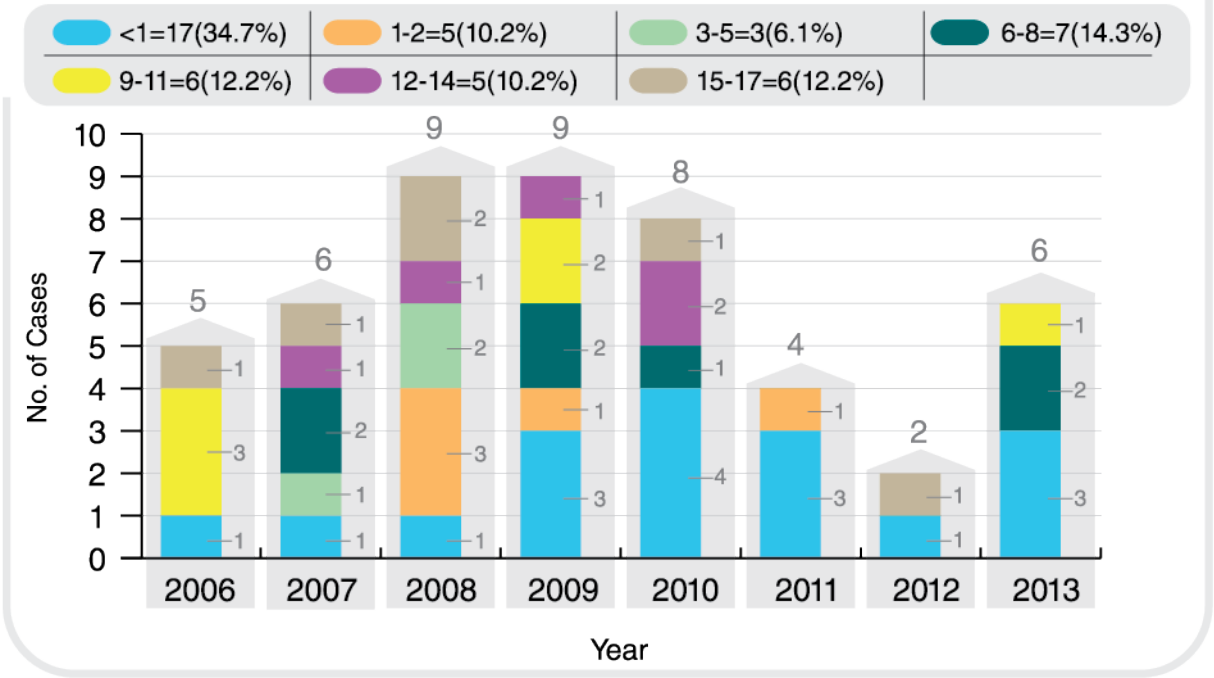


Chart 7.6.2: No. of Cases by Year and Type of Assault

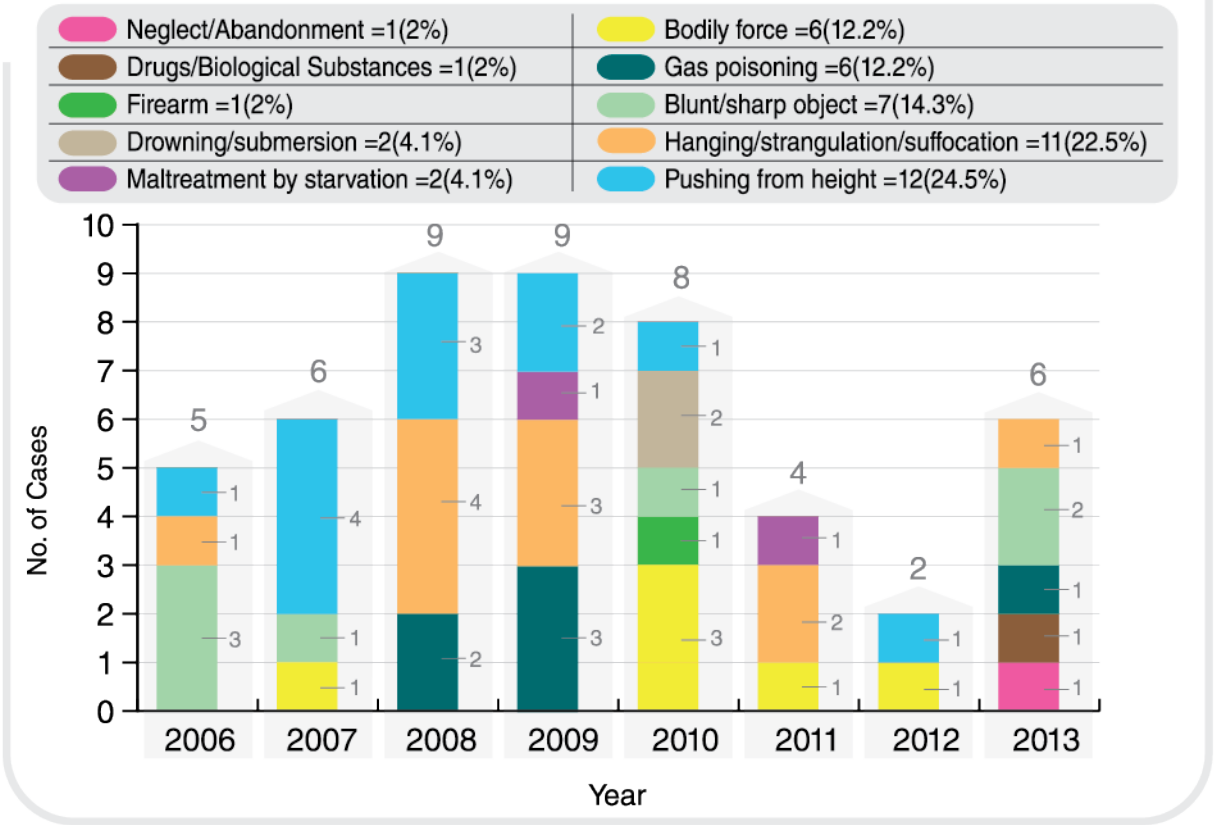


Chart 7.6.3: No. of Cases by Year and Perpetrator's Relationship with the Deceased Child

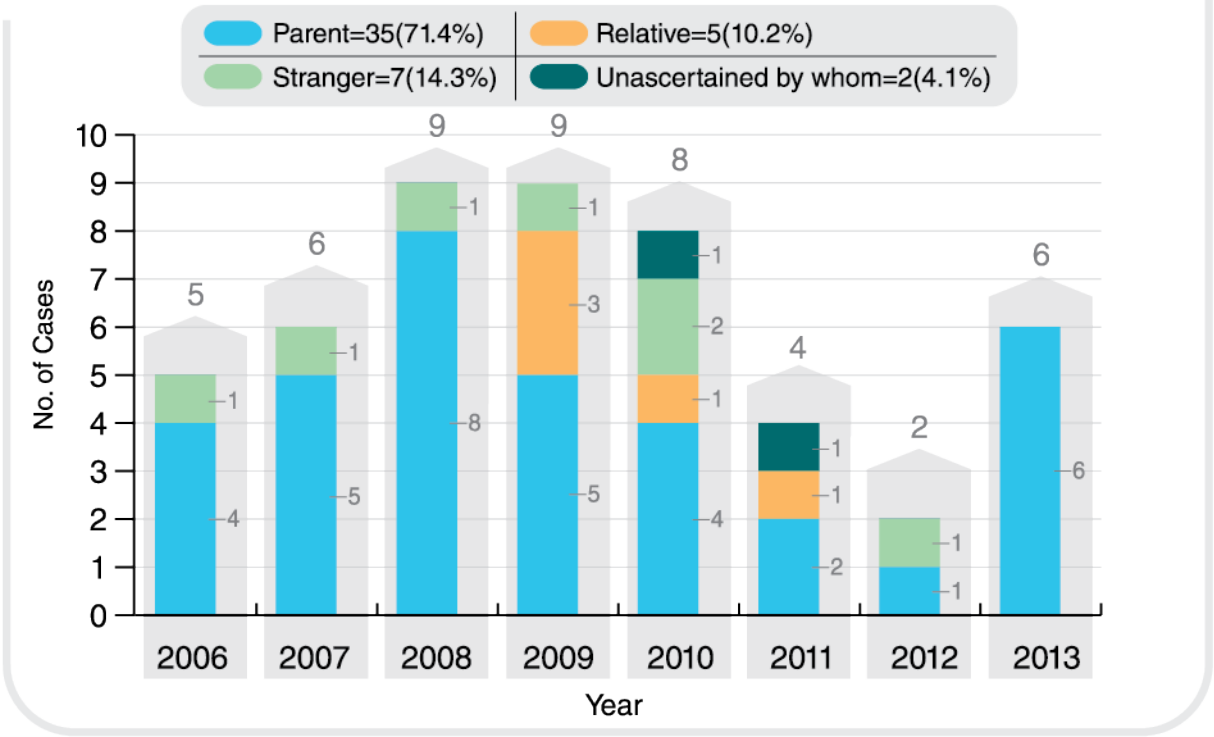
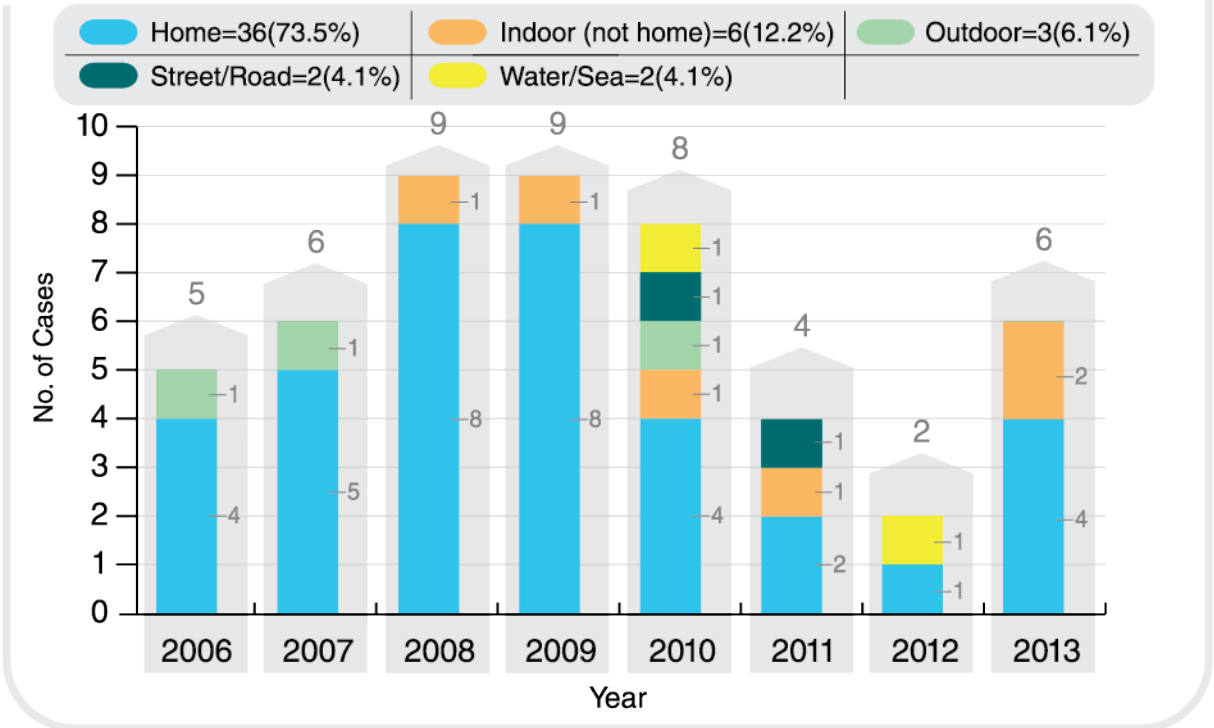


Chart 7.6.4: No. of Cases by Year and Place of Incident



7.7 Statistics of Cases with Non-natural Unascertained Causes of Death

Chart 7.7.1: No. of Cases by Year and Age Group

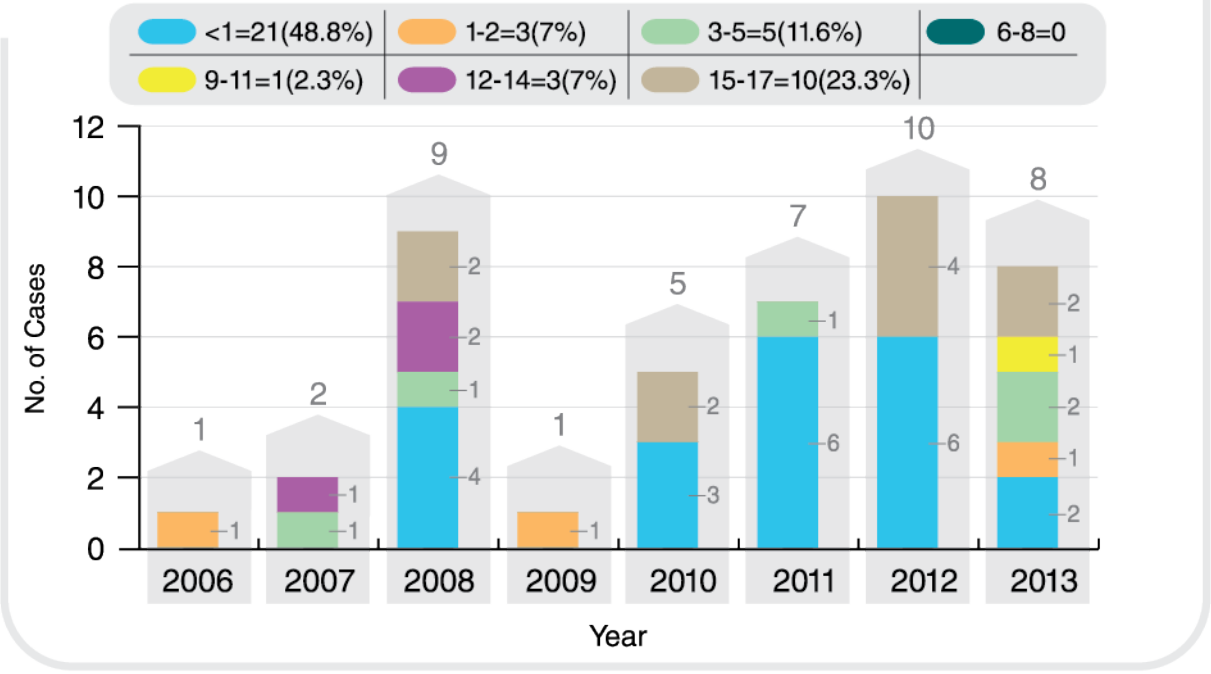
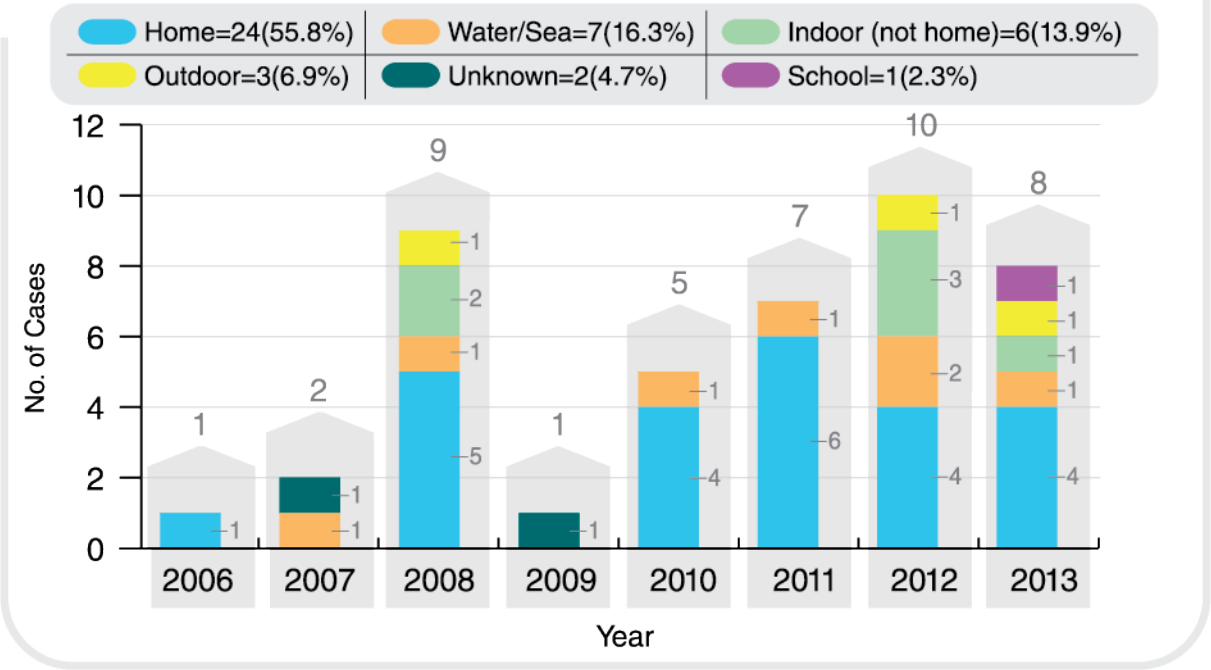
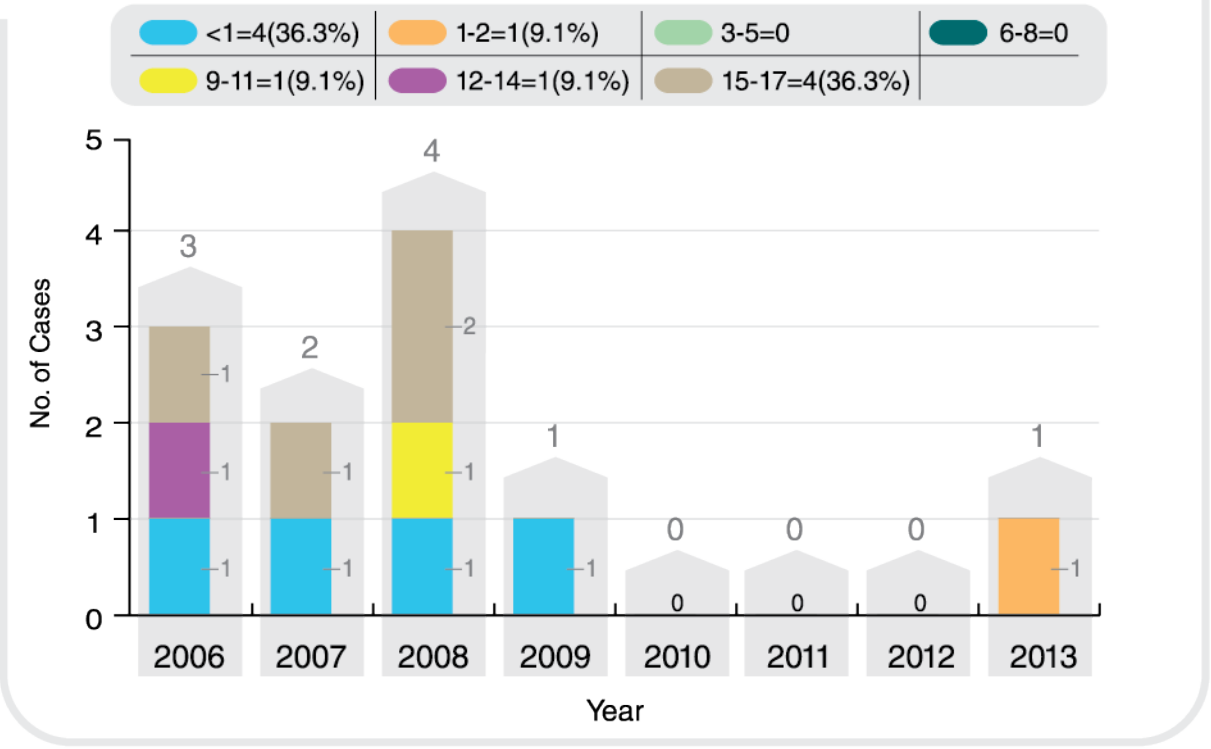


Chart 7.7.2: No. of Cases by Year and Place of Fatal Incident



7.8 Statistics of Cases with Causes Related to Medical Complication

Chart 7.8.1: No. of Cases by Year and Age Group



8 Appendices

Appendix 8.1 List of Child Fatality Review Panel Members

Members of the Child Fatality Review Panel (from June 2011 to May 2017) 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 Member	June 2015 to present 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 present
4. @Ms Wong Yu-pok, Marina, J.P.	Accounting	Group Convenor 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 Member	June 2013 to May 2016 June 2011 to May 2013
7. Dr Yeung Ka-ching	Academia	Group Convenor of Accident Cases Member	June 2016 to present June 2012 to May 2016

Name	Profession/ Discipline	Position	Service Term
8. Mr Fong Cheung-fat, J.P.	Social Welfare	Group Convenor of Assault and Miscellaneous Cases Member	June 2015 to present June 2012 to May 2015
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 Member	June 2013 to present June 2011 to May 2013
11. Dr Beh Swan-lip, Philip	Medical (Forensic Pathology)	Member	June 2011 to present
12.@Ms Chan Kit-bing, Sumee, CEs COM	Clinical Psychology	Member	June 2011 to May 2016
13.@Ms Chan Mei-lan, Anna May, M.H.	Legal	Member	June 2011 to May 2012
14.@Ms Chan Mi-har, Grace	Social Welfare	Member	June 2011 to May 2013
15.Dr Dunn Lai-wah, Eva	Medical (Psychiatry)	Member	June 2012 to present
16.@Ms Hung Wing-chee, Anna	Education	Member	June 2011 to May 2012

Name	Profession/ Discipline	Position	Service Term
17. @Dr Lam Chan Lan-tak, Gladys	Academia	Member	June 2011 to May 2012
18. Ms Lam Tze-yan	Legal	Member	June 2012 to May 2016
19. Dr Lau Ka-fai, Tony	Medical (Paediatrics)	Member	June 2013 to present
20. Dr Lee Lai-ping	Medical (Paediatrics)	Member	June 2015 to present
21. Ms Lee Shuk-yee, Charrix	Social Welfare	Member	June 2013 to present
22. #Professor Albert Martin Li	Medical (Paediatrics)	Member	June 2011 to May 2015
23. Dr Li Chak-ho, Rever	Medical (Paediatrics)	Member	June 2016 to present
24. @Professor Shek Tan-lei, Daniel, S.B.S, J.P.	Academia	Member	June 2011 to May 2013
25. Professor Sin Kuen-fung, Kenneth	Child Education	Member	June 2013 to present

Name	Profession/ Discipline	Position	Service Term
26. Dr Sze Mei-lun, Angela	Clinical Psychology	Member	June 2016 to present
27. Mr Tang Chee-ho, Alric	Legal	Member	June 2016 to present
28. Ms Tao Chee-ying, Theresa, J.P.	Education	Member	June 2012 to present
29. Mr Tong Siu-hon, David	Parent Representative	Member	June 2012 to present
30. @Ms Tsang Lan-see, Nancy	Social Welfare	Member	June 2011 to May 2012
31. #Dr Tsang Man-ching, Anita	Medical (Paediatrics)	Member	June 2011 to present
32. Ms Wong Shuk-fan, Luparker	Education	Member	June 2016 to present
33. @Dr Yiu Gar-chung, Michael	Medical (Psychiatry)	Member	June 2011 to May 2012
34. @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 8.2 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 8.3 Information Brief on Child Fatality Review

Background

The Social Welfare Department (SWD) has launched the Pilot Project on Child Fatality Review (Pilot Project) which lasted from 15 February 2008 to 14 February 2011. The findings of the Pilot Project confirm 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 learnt 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 died on or after 1 January 2008 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.
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 individual case details or personal 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 occurred from 2008 to 2011 and published its First Report and Second Report in May 2013 and July 2015 respectively. The reports are available at websites:
http://www.swd.gov.hk/doc/fcw/CFRP1R-Eng.pdf and
http://www.swd.gov.hk/doc/fcw/CFRP2R-Eng.pdf.

Enquiries

Secretariat / Child Fatality Review Panel
Room 721, Wu Chung House, 213 Queen's Road East, Wan Chai, Hong Kong
Tel. No.: 2892 5670 E-mail: srp@swd.gov.hk

Appendix 8.4 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/crt_services/pphlt/html/cor.htm)