Child Fatality Review Panel

First Report
(for child death cases in 2008 – 2009)

May 2013

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1 FOREWORD

"If there was anything in this world I could have done to save my child from death, I would have done it." *- An extract of 'Just for Today', a poem by Vicki Tushingham – from the internet*

The future of our society depends on our children and we cannot bear the loss of any of them. It is tragic for the death of children whose lives were too short and yet to blossom. To their parents and loved ones, the loss is very bitter and painful.

To the members of the Child Fatality Review Panel (the Review Panel), it has been very sad to review every of the child death cases. But we hope that the work of the Panel could help the prevention of similar unfortunate loss.

All members of the Review Panel shared the same mission and enthusiasm. They were devoted to the welfare of the children. They gave their views and recommendations according to their professional experience.

During the review, parties concerned were co-operative and their comments, updates and responses often reflected their prudence in delivering services to children.

I am pleased to present this first report of the Review Panel after its inception in June 2011. This report aims at sharing our observations and recommendations with a view to raising public awareness and encouraging concerted efforts in minimising child deaths, especially those avoidable ones.

I hope everyone of us who shares the same mission of promoting child welfare will find this report and the recommendations therein useful for reference in helping prevention of child fatality.

Leung Nai Kong
Chairman of the Child Fatality Review Panel

2 EXECUTIVE SUMMARY

2.1 Background

This was the first report of the Child Fatality Review Panel (the Review Panel) which was an independent multi-disciplinary non-statutory body with members appointed by the Director of Social Welfare (DSW).

Prior to this standing review mechanism, the Pilot Project on Child Fatality Review (the Pilot Project) with members appointed by DSW operated from February 2008 to February 2011 to review child death cases occurred in 2006 and 2007. The Review Panel of the Pilot Project published its First Report and Final Report in January 2010 and December 2010 respectively.

Please refer to the following websites for the reports of the Pilot Project:

First Report:
English Version only: http://www.swd.gov.hk/doc/whatsnew/201001/PPCFR1R.pdf

Final Report:
English Version: http://www.swd.gov.hk/doc/whatsnew/201101/PPCFRFR.pdf
Chinese Version: http://www.swd.gov.hk/doc/whatsnew/201103/PPCFRFR_Chi.pdf

Adopting similar review practice of the Pilot Project, the review of the child death cases covered by the report was also documentary in nature by referring to information gathered from Coroner's Court and service reports completed by concerned professionals. The recommendations of the Review Panel were sent to the related service organisations / departments and parties concerned. Together with their responses, the recommendations of the Review Panel were shared in this report.

2.2 Overview of Child Death Cases Reviewed

Compared with other countries, the age-specific death rate of Hong Kong remained to be low. In this report, 238 child death cases that occurred in 2008 and 2009 and reported to the Coroner's Court were reviewed. Major demographics of the 238 cases reviewed were as follows:

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

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

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

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

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

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

(vii) Most fatal incidents occurred in the homes of the deceased children (N=99, 41.6%), with hospital (N=84, 35.3%) as the second most common place. 13 fatal incidents occurred on road or streets and these were mainly traffic accidents.

2.3 Highlights of Recommendations by the Review Panel

2.3.1 Main Themes and Issues

(i) Proper child care and close supervision by parents and care-givers remains the most important factor in preventing most of the child deaths;

(ii) Public education to raise the awareness of the care-givers of home safety issues and equip them with the appropriate knowledge and child care skills is deemed necessary;

(iii) Education to children on road and home safety issues could help prevent fatal traffic accidents and accidents at home in children;

(iv) The public, care-givers and professionals working with or coming across any child could be more sensitive to any risks the child is facing, thus giving more timely assistance or intervention to the child; and

(v) Life education to children for treasuring life and being resilient could help them overcome various life challenges. Also, life education to parents for treasuring and respecting the lives of their own and their children could prevent fatal assaults to children.

2.3.2 Highlights of Recommendations

The Review Panel has made a total of 21 recommendations on preventive strategies and systems improvement for child fatal cases by categorised causes.

For prevention of children dying of natural causes, parents should be reminded of the possible fatal risk of sleeping with infants and to arrange children to receive influenza vaccination. Also, it is advisable to set up feedback system between forensic pathologist and family doctor for arranging family screening with children died of hereditary diseases.

For prevention of children dying of accidents, promotional campaigns to strengthen awareness of road safety for pre-school children and new arrival students from the Mainland or cross-boundary students attending schools close to the boundary is recommended. The importance of using safety belts and restricting drivers with probationary license from driving high performance cars are also emphasised for preventing traffic accidents. Also, care-givers may be educated on the symptoms and immediate handling of serious head injury in children and keeping poisonous substances away from children through public education.

For prevention of children dying of suicide, it is recommended to strengthen public education to parents to nurture their children according to their capabilities and accept their limitations and to help their children build up resilience as well as to encourage children with emotional problems and their families to seek professional assistance. Meanwhile, schools may set up mechanisms to early identify children facing multiple risks, prevent bullying in school and enhance school curriculum on life education and life skills training. Children should be educated to seek help when they come across any peers expressing suicidal idea.

For prevention of children dying of assault, it would be useful to raise public's awareness of capturing the signs and verbal threats of suicide and homicide of parents seriously, connecting children-in-risk to professional services at an early instance and reminding parents of their responsibility of taking good care of their children and having no right to take away their lives under any circumstances. The assessment mechanism for the discharge of mental patients with explicit ideas of homicide may also be enhanced. It is also suggested to raise the public's awareness of the potential danger of making acquaintance with strangers in the cyber world where many things and persons are faked or masked, the harm of concealing pregnancy and possible fatal risk of shaking babies.

Meanwhile, a good practice identified in a fatal accident case is that the deceased boy's parents donated the cornea of their son to help others in need. Also in the same case, the follow-up services by the Education Bureau and school concerned had alleviated the emotional disturbances of fellow students in face of the schoolmate's death.

3 ACKNOWLEDGEMENTS

The Review Panel would like to extend our heart-felt gratitude to the Coroners and staff members of the Coroner's Court. Without their unfailing support since the commencement of the Pilot Project in 2008, the Review Panel could not have worked so smoothly in carrying out its work.

The Review Panel would also like to thank all professionals and parties involved in the review process. Their co-operation by providing the information and input greatly facilitated the work of the Review Panel. Also, their professional comments, responses and feedback on the preliminary views of the Review Panel had telling on the existing protection to the children and the good practices being adopted, which shed light on going the extra mile for prevention of child fatality.

4 THE REVIEW

4.1 History

The three-year Pilot Project on Child Fatality Review (the Pilot Project) commenced in February 2008 to review child death cases involving children aged below 18 and reported to the Coroners. Though it was originally planned to review child fatality cases of non-natural causes, it soon expanded its scope to cover cases of natural causes. The evaluation of the Pilot Project in 2010 confirmed the value of the review. The Review Panel of the Pilot Project thus 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 (the Review Panel) began its services in June 2011.

4.2 Purpose

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

4.3 The Review Panel

The Review Panel comprised 20 members including professionals from different disciplines and a parent representative. For efficient and effective review, members of the Review Panel divided themselves into 5 sub-groups to look into cases of different nature 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 2011 to April 2013, the Review Panel had held 33 meetings, including 8 panel meetings and 25 sub-group meetings.

The membership list and terms of reference of the Review Panel are given in Appendices 7.1 and 7.2 respectively.

4.4 Scope

The scope of review was 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 and encouraged.

4.5 Timing

Upon the formation of the Review Panel in June 2011, it began to review child death cases that occurred in 2008. The lapse of time in the review often gave rise to the query of not conducting the review and coming up with timely recommendations. Yet, as almost all of the child fatal cases had to go through the legal proceedings in the Coroner's Court and some might even involve criminal and civil legal actions, it was necessary to start reviewing the cases only after the completion of the proceedings in Court so as to avoid prejudicing these legal proceedings.

4.6 Means

The review methodology was by and large adopted from that used in the Pilot Project. In gist, the review was basically documentary in nature, and was conducted by accessing to papers and documents filed to the Coroner's Court, supplemented by service reports from service organisations or government departments having provided services to 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/whatsnew/201101/PPCFRFR.pdf
Chinese Version: http://www.swd.gov.hk/doc/whatsnew/201103/PPCFRFR_Chi.pdf

5 OVERVIEW OF CHILD DEATH CASES REVIEWED

5.1 Figures of Child Population and Child Deaths in Hong Kong in 2008 and 2009

In the year 2008, among the mid-year child population of 1 152 512[1], a total of 293[2] children aged under 18 died and, in the year 2009, among the mid-year child population of 1 115 832[3], a total of 257[4] children died.

Table 5.1.1: Facts and Figures of Child Death in Hong Kong (2008 – 2009)

Type of Figure	Year	
	2008	2009
Child Population[5]	1 152 512	1 115 832
No. of Child Death	293	257
Child Death Rate[6]	0.3	0.2
No. of Cases Reviewed	119	119

The child death rate of Hong Kong decreased from 0.3 per 1 000 child population in 2008 to 0.2 per 1 000 child population in 2009. A broad comparison of age-specific death rates with some countries reveals that child death rates in Hong Kong remained relatively low.

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		2008	2009	2008	2009	2008	2009	2008	2009	2008	2009
Country/ Place	Hong Kong[7]	3.2	3.0	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2
	Australia[8]	4.3	4.3	0.2	0.2	0.1	0.1	0.1	0.1	0.4	0.4
	Canada[9]	5.1*	4.9*	0.2	0.2	0.1	0.1	0.1	0.1	0.4	0.4

Unless otherwise specified, death rate refers to the number of deaths per 1 000 population.
* Infant deaths per 1 000 live births.

1 Source: Census and Statistics Department.
2 Ibid.
3 Ibid.
4 Ibid.
5 Child population: refers to the mid-year population of children aged under 18.
Source: Census and Statistics Department.
6 Child death rate: refers to the number of child deaths per 1 000 child population.
Source: Census and Statistics Department.
7 Source: Census and Statistics Department.
8 Website of Australian Bureau of Statistics (http://www.abs.gov.au)
9 Website of Statistics Canada (http://www.statcan.gc.ca)

5.2 Statistics of Child Death Cases Reviewed

Table 5.2.1: No. of Cases by Case Nature

Case Nature	No. of Cases (%)
Natural	156 (65.5%)
Non-natural	82 (34.5%)
Total:	238 (100.0%)

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

Age Group	Sex		No. of Cases (%)
	Female (%)	Male (%)	
< 1	39 (16.4%)	52 (21.8%)	91 (38.2%)
1 – 2	15 (6.3%)	10 (4.2%)	25 (10.5%)
3 – 5	9 (3.8%)	12 (5.0%)	21 (8.8%)
6 – 8	4 (1.7%)	6 (2.5%)	10 (4.2%)
9 – 11	7 (2.9%)	9 (3.8%)	16 (6.7%)
12 – 14	16 (6.7%)	12 (5.0%)	28 (11.8%)
15 – 17	20 (8.4%)	27 (11.3%)	47 (19.7%)
Total:	110 (46.2%)	128 (53.8%)	238 (100.0%)

Table 5.2.3: No. of Cases by Ethnicity

Ethnicity	No. of Cases (%)
Chinese	218 (91.6%)
Non-Chinese	20 (8.4%)
Unknown	0 (0.0%)
Total:	238 (100.0%)

Table 5.2.4: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	90 (37.8%)
Full-time Work	5 (2.1%)
Part-time Work	0 (0.0%)
Not Studying & Not Working	5 (2.1%)
Not Applicable*	134 (56.3%)
Unknown	4 (1.7%)
Total:	238 (100.0%)

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

Table 5.2.5: No. of Cases by Cause of Death

Cause of Death	No. of Cases (%)
Natural Causes	156 (65.5%)
Accidents	23 (9.7%)
Suicide	26 (10.9%)
Assault	18 (7.6%)
Miscellaneous*	15 (6.3%)
Total:	238 (100.0%)

Miscellaneous: Includes Unknown and Medical Complications.*

Table 5.2.6: No. of Cases by Cause of Death and Sex

Cause of Death	Sex		No. of Cases (%)
	Female (%)	Male (%)	
Natural Causes	71 (29.8%)	85 (35.7%)	156 (65.5%)
Accidents	7 (2.9%)	16 (6.7%)	23 (9.7%)
Suicide	12 (5.0%)	14 (5.9%)	26 (10.9%)
Assault	11 (4.6%)	7 (2.9%)	18 (7.6%)
Miscellaneous*	9 (3.8%)	6 (2.5%)	15 (6.3%)
Total:	110 (46.2%)	128 (53.8%)	238 (100.0%)

Miscellaneous: Includes Unknown and Medical Complications.*

Table 5.2.7: No. of Cases by Age Group and Cause of Death

Age Group	Cause of Death					No of Cases (%)
	Natural Causes	Accidents	Suicide	Assault	Miscellaneous*	
< 1	80	1	0	4	6	91 (38.2%)
1 – 2	18	2	0	4	1	25 (10.5%)
3 – 5	14	4	0	2	1	21 (8.8%)
6 – 8	6	2	0	2	0	10 (4.2%)
9 – 11	9	3	1	2	1	16 (6.7%)
12 – 14	12	5	7	2	2	28 (11.8%)
15 – 17	17	6	18	2	4	47 (19.7%)
Total:	156	23	26	18	15	238 (100.0%)

Miscellaneous: Includes Unknown and Medical Complications.*

Table 5.2.8: No. of Cases by Residential District

Residential District	No. of Cases (%)
HONG KONG ISLAND	
Central & Western	10 (4.2%)
Wan Chai	1 (0.4%)
Eastern	14 (5.9%)
Southern	9 (3.8%)
KOWLOON	
Yau Tsim Mong	9 (3.8%)
Sham Shui Po	11 (4.6%)
Kowloon City	2 (0.8%)
Wong Tai Sin	10 (4.2%)
Kwun Tong	16 (6.7%)
NEW TERRITORIES	
Kwai Tsing	22 (9.2%)
Tsuen Wan	3 (1.3%)
Tuen Mun	26 (10.9%)
Yuen Long	27 (11.3%)
North	12 (5.0%)
Tai Po	13 (5.5%)
Sha Tin	17 (7.1%)
Sai Kung	12 (5.0%)
Islands	5 (2.1%)

Residential District	No. of Cases (%)
OTHERS	
Not Residing in HK	13 (5.5%)
Unknown	6 (2.5%)
Total:	238 (100.0%)

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

Table 5.2.9: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	99 (41.6%)
Hospital	84 (35.3%)
Indoor (Not Home)	22 (9.2%)
Outdoor	5 (2.1%)
School	1 (0.4%)
Street / Road	13 (5.5%)
Vehicle	3 (1.3%)
Water / Sea	4 (1.7%)
Unknown	7 (2.9%)
Total:	238 (100.0%)

5.2.1 Summary Findings

238 child death cases occurred in the years 2008 and 2009 were reviewed.

Table 5.2.1 shows that of the 238 reviewed cases, 65.5% (N=156) died of natural causes while 34.5% (N=82) died of non-natural causes.

Table 5.2.2 shows that the highest number of child deaths occurred for children aged below 1 (N=91, 38.2%), followed by the age groups of 15 – 17 (N=47, 19.7%) and 12 – 14 (N=28, 11.8%).

Table 5.2.3 shows that among all child death cases reviewed, the vast majority, amounting to 91.6% (N=218) of the children were Chinese and only 8.4% (N=20) were non-Chinese.

Table 5.2.4 shows that occupation was not applicable to over half of the children (N=134, 56.3%) who were small or had health problems which rendered them unable to attend school or work. 90 (37.8%) of the cases reviewed were full-time students.

Table 5.2.5 shows that 65.5% the cases reviewed died of natural causes (N=156). The second highest number of child deaths was caused by suicide (N=26, 10.9%). There were 23 (9.7%) children died of accidents.

Table 5.2.6 shows that more male (N=128, 53.8%) than female (N=110, 46.2%) died. It was only for the death causes of assault (female N=11, 4.6%; male N=7, 2.9%) and of miscellaneous (female N=9, 3.8%; male N=6, 2.5%) that there were relatively more female than male children died.

Table 5.2.7 shows that the highest number of child deaths occurred for children aged below 1 died of natural causes (N=80, 33.6%). The second highest number of child deaths occurred for children aged 1 – 2 died of natural causes and also for children aged 15 – 17 died of suicide (both N=18, 7.6%).

Table 5.2.8 shows that Yuen Long District had the highest number of child deaths (N=27, 11.3%) followed by Tuen Mun District (N=26, 10.9%) and Kwai Tsing District (N=22, 9.2%). The smallest number of child deaths (N=1, 0.4%) happened in Wan Chai District. However, taking account of the child population in respective districts, Yuen Long District did not have the highest rate of child death.

Table 5.2.9 shows that home was the most common place for occurrence of fatal incidents (N=99, 41.6%), with hospital came second (N=84, 35.3%). While 22 (9.2%) fatal incidents occurred indoor (not home) mainly due to death of natural causes and suicide, another 13 (5.5%) fatal incidents occurred on road or in streets mainly due to traffic accidents.

5.3 Statistics of Child Death Cases Reviewed by Year – A Comparison

Table 5.3.1: No. of Cases by Year

Year	No. of Cases (%)
2008	119 (50.0%)
2009	119 (50.0%)
Total:	238 (100.0%)

Table 5.3.2: No. of Cases by Case Nature and Year

Case Nature	No. of Cases (%)		
	2008	2009	Total
Natural	70 (58.8%)	86 (72.3%)	156 (65.5%)
Non-natural	49 (41.2%)	33 (27.7%)	82 (34.5%)
Total:	119 (100.0%)	119 (100.0%)	238 (100.0%)

Table 5.3.3: No. of Natural Deaths by Age Group and Year

Age Group	No. of Cases (%)		
	2008	2009	Total
< 1	36 (51.4%)	44 (51.2%)	80 (51.3%)
1 – 2	8 (11.4%)	10 (11.6%)	18 (11.5%)
3 – 5	6 (8.6%)	8 (9.3%)	14 (9.0%)
6 – 8	3 (4.3%)	3 (3.5%)	6 (3.8%)
9 – 11	6 (8.6%)	3 (3.5%)	9 (5.8%)
12 – 14	4 (5.7%)	8 (9.3%)	12 (7.7%)
15 – 17	7 (10.0%)	10 (11.6%)	17 (10.9%)
Total:	70 (100.0%)	86 (100.0%)	156 (100.0%)

Table 5.3.4: No. of Non-natural Deaths by Age Group and Year

Age Group	No. of Cases (%)		
	2008	2009	Total
< 1	7 (14.3%)	4 (12.1%)	11 (13.4%)
1 – 2	3 (6.1%)	4 (12.1%)	7 (8.5%)
3 – 5	4 (8.2%)	3 (9.1%)	7 (8.5%)
6 – 8	2 (4.1%)	2 (6.1%)	4 (4.9%)
9 – 11	3 (6.1%)	4 (12.1%)	7 (8.5%)
12 – 14	10 (20.4%)	6 (18.2%)	16 (19.5%)
15 – 17	20 (40.8%)	10 (30.3%)	30 (36.6%)
Total:	49 (100.0%)	33 (100.0%)	82 (100.0%)

Table 5.3.5: No. of Cases by Age Group, Year and Sex

Age Group	No. of Cases (%)				
	2008		2009		Total
	Female	Male	Female	Male	
< 1	16	27	23	25	91 (38.2%)
1 – 2	8	3	7	7	25 (10.5%)
3 – 5	5	5	4	7	21 (8.8%)
6 – 8	2	3	2	3	10 (4.2%)
9 – 11	3	6	4	3	16 (6.7%)
12 – 14	8	6	8	6	28 (11.8%)
15 – 17	12	15	8	12	47 (19.7%)
Total:	54	65	56	63	238 (100.0%)

Table 5.3.6: No. of Cases by Ethnicity and Year

Ethnicity	No. of Cases (%)		
	2008	2009	Total
Chinese	114 (95.8%)	104 (87.4%)	218 (91.6%)
Non-Chinese	5 (4.2%)	15 (12.6%)	20 (8.4%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total:	119 (100.0%)	119 (100.0%)	238 (100.0%)

Table 5.3.7: No. of Cases by Occupation and Year

Occupation	No. of Cases (%)		
	2008	2009	Total
Full-time Student	46 (38.7%)	44 (37.0%)	90 (37.8%)
Full-time Work	5 (4.2%)	0 (0.0%)	5 (2.1%)
Part-time Work	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not Studying & Not Working	2 (1.7%)	3 (2.5%)	5 (2.1%)
Not Applicable*	63 (52.9%)	71 (59.7%)	134 (56.3%)
Unknown	3 (2.5%)	1 (0.8%)	4 (1.7%)
Total:	119 (100.0%)	119 (100.0%)	238 (100.0%)

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

Table 5.3.8: No. of Cases by Cause of Death and Year

Cause of Death	No. of Cases (%)		
	2008	2009	Total
Natural Causes	70 (58.8%)	86 (72.3%)	156 (65.5%)
Accidents	13 (10.9%)	10 (8.4%)	23 (9.7%)
Suicide	14 (11.8%)	12 (10.1%)	26 (10.9%)
Assault	9 (7.6%)	9 (7.6%)	18 (7.6%)
Miscellaneous*	13 (10.9%)	2 (1.7%)	15 (6.3%)
Total:	119 (100.0%)	119 (100.0%)	238 (100.0%)

Miscellaneous: Includes Unknown and Medical Complications.*

Table 5.3.9: No. of Cases by Cause of Death, Year and Sex

Cause of Death	No. of Cases (%)				
	2008		2009		Total
	Female	Male	Female	Male	
Natural Causes	32	38	39	47	156 (65.5%)
Accidents	3	10	4	6	23 (9.7%)
Suicide	6	8	6	6	26 (10.9%)
Assault	5	4	6	3	18 (7.6%)
Miscellaneous*	8	5	1	1	15 (6.3%)
Total:	54	65	56	63	238 (100.0%)

Miscellaneous: Includes Unknown and Medical Complications.*

Table 5.3.10: No. of Cases by Residential District and Year

Residential District	2008			2009		
	No.	*Population	#Death Rate	No.	*Population	#Death Rate
HONG KONG ISLAND						
Central & Western	4	39 400	0.100	6	38 200	0.157
Wan Chai	1	21 300	0.047	0	19 700	0.000
Eastern	9	89 700	0.100	5	86 000	0.058
Southern	6	45 600	0.132	3	43 600	0.069
KOWLOON						
Yau Tsim Mong	2	43 500	0.046	7	43 800	0.160
Sham Shui Po	2	57 400	0.035	9	57 100	0.158
Kowloon City	1	56 800	0.018	1	55 300	0.018
Wong Tai Sin	6	64 500	0.093	4	61 500	0.065
Kwun Tong	9	94 300	0.095	7	94 900	0.074
NEW TERRITORIES						
Kwai Tsing	15	85 800	0.175	7	81 600	0.086
Tsuen Wan	0	52 800	0.000	3	51 600	0.058
Tuen Mun	13	85 200	0.153	13	80 100	0.162
Yuen Long	12	114 300	0.105	15	111 000	0.135
North	6	55 400	0.108	6	54 800	0.110
Tai Po	6	46 900	0.128	7	43 500	0.161
Sha Tin	11	97 000	0.113	6	93 700	0.064
Sai Kung	3	76 100	0.039	9	73 700	0.122
Islands	1	31 300	0.032	4	30 500	0.131

Residential District	2008			2009		
	No.	*Population	#Death Rate	No.	*Population	#Death Rate
OTHERS						
Not Residing in HK	7	–	–	6	–	–
Unknown	5	–	–	1	–	–
Total:	119	–	–	119	–	–

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

** 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.

Table 5.3.11: No. of Cases by Place of Fatal Incident and Year

Place of Fatal Incident	No. of Cases (%)		
	2008	2009	Total
Home	49 (41.2%)	50 (42.0%)	99 (41.6%)
Hospital	34 (28.6%)	50 (42.0%)	84 (35.3%)
Indoor (Not Home)	14 (11.8%)	8 (6.7%)	22 (9.2%)
Outdoor	3 (2.5%)	2 (1.7%)	5 (2.1%)
School	1 (0.8%)	0 (0.0%)	1 (0.4%)
Street / Road	7 (5.9%)	6 (5.0%)	13 (5.5%)
Vehicle	2 (1.7%)	1 (0.8%)	3 (1.3%)
Water / Sea	3 (2.5%)	1 (0.8%)	4 (1.7%)
Unknown	6 (5.0%)	1 (0.8%)	7 (2.9%)
Total:	119 (100.0%)	119 (100.0%)	238 (100.0%)

5.3.1 Summary Findings

238 child death cases occurred in the years 2008 and 2009 were reviewed.

Table 5.3.1 shows that, among the child death cases reviewed, the number of cases occurring in 2008 and 2009 were the same (both N=119, 50.0%).

Table 5.3.2 shows that for both 2008 and 2009, the number of cases of natural causes (N=70, 58.8% for 2008 and N=86, 72.3% for 2009) was higher than that of non-natural causes (N=49, 41.2% for 2008 and N=33, 27.7% for 2009). There was an increase in the ratio of natural death to non-natural death from 2008 (1.4: 1) to 2009 (2.6: 1).

Table 5.3.3 shows that for cases died of natural causes in both 2008 and 2009, the children aged below 1 (N=36, 51.4% for 2008 and N=44, 51.2% for 2009) had the highest number of child deaths among all age groups. For the year 2008, the age group of 1 – 2 had the second highest number of child deaths (N=8, 11.4%). For the year 2009, both the age groups of 1 – 2 and 15 – 17 had the second highest number of child deaths (both N=10, 11.6%).

Table 5.3.4 shows that for cases died of non-natural causes in both 2008 and 2009, the age group of 15 – 17 had the highest number of child deaths (N=20, 40.8% for 2008 and N=10, 30.3% for 2009) due to the higher number of suicide cases within this age group in both years. Also, for both years, the age groups with the second highest number of child deaths were 12 – 14 (N=10, 20.4% for 2008 and N=6, 18.2% for 2009).

Table 5.3.5 shows that the total number of male children (N=128) was higher than that of female children (N=110). For both 2008 and 2009, the numbers of male children in three age groups (i.e. below 1, 6 – 8 and 15 – 17) were consistently higher than that of female children.

Table 5.3.6 shows that for both 2008 and 2009, the percentages of Chinese children (N=114, 95.8% for 2008, and N=104, 87.4% for 2009) were relatively much higher than that of non-Chinese children (N=5, 4.2% for 2008 and N=15, 12.6% for 2009).

Table 5.3.7 shows that occupation was not applicable to over half of deceased children in both years (N=63, 52.9% for 2008 and N=71, 59.7% for 2009) mainly because these children were either too small or their physical and health conditions made them unable to attend school or work. Over one-third of the cases reviewed (N=46, 38.7% for 2008 and N=44, 37.0% for 2009) were classified in the category of "full-time student" for both years.

Table 5.3.8 shows that while there was an increase in number of child death cases and percentage in the category of "natural causes" from 2008 to 2009, a decrease was noted in number of child death cases and percentage in the categories of "accidents", "suicide" and "miscellaneous" during the same period.

Table 5.3.9 shows that for both 2008 and 2009, more male children died of natural causes (N=38 in 2008 and N=47 for 2009) and accidents (N=10 in 2008 and N=6 in 2009) than that of female children (natural causes: N=32 for 2008 and N=39 for 2009, accidents: N=3 in 2008 and N=4 in 2009). Yet, more female children died of assault (N=5 in 2008 and N=6 in 2009) than that of male children (N=4 in 2008 and N=3 in 2009) in both years.

Table 5.3.10 shows that in 2008, the highest number of child deaths was recorded in Kwai Tsing District (N=15), followed by Tuen Mun District (N=13) and Yuen Long District (N=12). However, taking account of the child population in respective districts, the highest child death rate, i.e. child death cases reviewed per 1 000 land-based non-institutional child population in respective districts, came from Kwai Tsing District (0.175), followed by Tuen Mun District (0.153) and Southern District (0.132). Kwai Tsing District and Tuen Mun District were the top two districts with relatively higher number of child deaths and child death rate. In 2009, the highest number of child deaths was recorded in Yuen Long District (N=15), followed by Tuen Mun District (N=13), Sham Shui Po District and Sai Kung District (both N=9). Yet, the highest child death rate came from Tuen Mun District (0.162), followed by Tai Po District (0.161) and Yau Tsim Mong District (0.160). Though Yuen Long District had the highest number of child deaths, its child death rate (0.135) only ranked the sixth among the districts.

Table 5.3.11 shows that in 2008, the number of child deaths occurring in home of the deceased children (N=49, 41.2%) was the highest, followed by those in hospital (N=34, 28.6%). In 2009, the number of child deaths occurring in home and in hospital (both N=50, 42.0%) constituted the vast majority of the fatal cases.

5.4 Statistics of Child Death Cases Reviewed According to Death Causes

5.4.1 Cases Died of Natural Causes

Table 5.4.1.1: No. of Cases by Age Group and Sex

Age Group	No. of Cases (%)		
	Female	Male	Total
< 1	35 (22.4%)	45 (28.8%)	80 (51.3%)
1 – 2	10 (6.4%)	8 (5.1%)	18 (11.5%)
3 – 5	7 (4.5%)	7 (4.5%)	14 (9.0%)
6 – 8	2 (1.3%)	4 (2.6%)	6 (3.8%)
9 – 11	4 (2.6%)	5 (3.2%)	9 (5.8%)
12 – 14	6 (3.8%)	6 (3.8%)	12 (7.7%)
15 – 17	7 (4.5%)	10 (6.4%)	17 (10.9%)
Total:	71 (45.5%)	85 (54.5%)	156 (100.0%)

Table 5.4.1.2: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	40 (25.6%)
Full-time Work	0 (0.0%)
Part-time Work	0 (0.0%)
Not Studying & Not Working	0 (0.0%)
Not Applicable*	114 (73.1%)
Unknown	2 (1.3%)
Total:	156 (100.0%)

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

Table 5.4.1.3: No. of Cases by Type of Health Problem According to ICD10[10] Chapter Level Classification

ICD Code	Type of Health Problem	No. of Cases (%)
A00-B99	Certain infectious and parasitic diseases	12 (7.7%)
C00-D48	Neoplasms	1 (0.6%)
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1 (0.6%)
E00-E90	Endocrine, nutritional and metabolic diseases	2 (1.3%)
F00-F99	Mental and behavioural disorders	2 (1.3%)
G00-G99	Diseases of the nervous system	13 (8.3%)
I00-I99	Diseases of the circulatory system	21 (13.5%)
J00-J99	Diseases of the respiratory system	26 (16.7%)
K00-K93	Diseases of the digestive system	3 (1.9%)
M00-M99	Diseases of the musculoskeletal system and connective tissue	1 (0.6%)
N00-N99	Diseases of the genitourinary system	2 (1.3%)
O00-O99	Pregnancy, childbirth and the puerperium	3 (1.9%)
P00-P96	Certain conditions originating in the perinatal period	22 (14.1%)
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	25 (16.0%)
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	21 (13.5%)
S00-T98	Injury, poisoning and certain other consequences of external causes	1 (0.6%)
Total:		156 (100.0%)

[10] *ICD10: The International Classification of Diseases, Version 10 is developed by the World Health Organisation. The ICD is the international standard diagnostic classification for epidemiology, health management and clinical purposes. These include the analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality and guidelines.*

Table 5.4.1.4: No. of Cases by Age Group and Category of Cause of Death*

Age Group	Category*					No. of Cases (%)
	A (%)	B (%)		C (%)	D (%)	
		B1 (%)	B2 (%)			
< 1	36 (23.1%)	4 (2.6%)	6 (3.8%)	8 (5.1%)	26 (16.7%)	80 (51.3%)
1 – 2	0 (0.0%)	8 (5.1%)	3 (1.9%)	5 (3.2%)	2 (1.3%)	18 (11.5%)
3 – 5	0 (0.0%)	5 (3.2%)	1 (0.6%)	6 (3.8%)	2 (1.3%)	14 (9.0%)
6 – 8	0 (0.0%)	2 (1.3%)	0 (0.0%)	4 (2.6%)	0 (0.0%)	6 (3.8%)
9 – 11	0 (0.0%)	5 (3.2%)	0 (0.0%)	3 (1.9%)	1 (0.6%)	9 (5.8%)
12 – 14	0 (0.0%)	4 (2.6%)	3 (1.9%)	3 (1.9%)	2 (1.3%)	12 (7.7%)
15 – 17	1 (0.6%)	4 (2.6%)	6 (3.8%)	5 (3.2%)	1 (0.6%)	17 (10.9%)
Total:	37 (23.7%)	32 (20.5%)	19 (12.2%)	34 (21.8%)	34 (21.8%)	156 (100.0%)
		51 (32.7%)				

** The following categories of cause of death, 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*

Table 5.4.1.5: No. of Cases with Autopsy Done or Waived*

Autopsy	No. of Cases (%)
Done	113 (72.4%)
Waived	43 (27.6%)
Total:	156 (100.0%)

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

Table 5.4.1.6: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	55 (35.3%)
Hospital	78 (50.0%)
Indoor (Not Home)	9 (5.8%)
Outdoor	3 (1.9%)
School	1 (0.6%)
Street / Road	1 (0.6%)
Vehicle	3 (1.9%)
Water / Sea	0 (0.0%)
Unknown	6 (3.8%)
Total:	156 (100.0%)

5.4.1.1 Summary Findings

In the years 2008 and 2009, a total of 156 cases ruled by the Coroner's Court to have natural death causes had been reviewed by the Review Panel.

Table 5.4.1.1 shows that more male (N=85, 54.5%) than female children (N=71, 45.5%) died of natural causes. Analysed by age group, the highest number of natural child deaths occurred for children aged below 1 (N=80, 51.3%), followed by the age groups of 1 – 2 (N=18, 11.5%) and 15 – 17 (N=17, 10.9%)

Table 5.4.1.2 shows that occupation was not applicable to the majority of the children died of natural causes (N=114, 73.1%). This indicates that either these children were too small for schooling or work, or their physical and health conditions made them unable to attend school or work. 40 (25.6%) of the cases reviewed were full-time students.

Table 5.4.1.3 shows that the highest number of child deaths (N=26, 16.7%) fell within the class of diseases of the respiratory system (ICD code: J00-J99), followed by the classes of congenital malformations, deformations and chromosomal abnormalities (ICD code: Q00-Q99) (N=25, 16.0%) and certain conditions originating in the perinatal period (ICD code: P00-P96) (N=22, 14.1%).

Table 5.4.1.4 shows the number of child deaths by age group and the four categories (from A to D) of cause of death developed by the Medical Experts of the Review Panel during the review of cases died of natural causes for examination of possible patterns and trends of cases with similar problems. These four categories are as follows:

Category		**Description**
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

As shown in Table 5.4.1.4, Category B (chronic medical conditions) had the highest number of child deaths (N=51, 32.7%). Under this category, there were two sub-categories including cases with mental or physical disabilities (N=32, 20.5%) and cases without mental or physical disabilities (N=19, 12.2%). Category A (neo-natal conditions) had the second highest number of child deaths (N=37, 23.7%). For Category C (acute medical conditions) (N=34, 21.8%), the highest number of child deaths occurred for children aged below 1 (N=8, 5.1%). For Category D (others) (N=34, 21.8%), the highest number of child deaths under this category were stillbirth cases (N=13, 8.3%). Of these 13 stillbirth cases reviewed, 4 were related to concealment of pregnancy while 3 to illegal disposal of the dead bodies. The Review Panel has concern over the cases if concealment and mishandling of unwanted pregnancy had led to the death of these children.

Table 5.4.1.4 also shows that over half of the children died of natural causes were aged below 1 (N=80, 51.3%), among which 36 (23.1%) of them died of neo-natal conditions.

Table 5.4.1.5 shows that of the reviewed cases died of natural causes, autopsy for 27.6% (N=43) of them had been waived.

Table 5.4.1.6 shows that half of the fatal incidents (N=78, 50.0%) occurred in hospital, indicating that the death causes of these deceased children were closely related to health or medical conditions. It should be noted that a significant number of fatal incidents occurred at home (N=55, 35.3%), where many of these children fell ill and collapsed. There is concern over the care for children with chronic illness or special needs and support required for their families.

5.4.2 Cases Died of Accidents

Table 5.4.2.1: No. of Cases by Age Group and Sex

Age Group	No. of Cases (%)		
	Female	Male	Total
< 1	0 (0.0%)	1 (4.3%)	1 (4.3%)
1 – 2	1 (4.3%)	1 (4.3%)	2 (8.7%)
3 – 5	0 (0.0%)	4 (17.4%)	4 (17.4%)
6 – 8	0 (0.0%)	2 (8.7%)	2 (8.7%)
9 – 11	0 (0.0%)	3 (13.0%)	3 (13.0%)
12 – 14	3 (13.0%)	2 (8.7%)	5 (21.7%)
15 – 17	3 (13.0%)	3 (13.0%)	6 (26.1%)
Total:	7 (30.4%)	16 (69.6%)	23 (100.0%)

Table 5.4.2.2: No. of Cases by Type of Accident

Type of Accident	No. of Cases (%)
Traffic	12 (52.2%)
Drowning	3 (13.0%)
Fall	2 (8.7%)
Poisoning	2 (8.7%)
Burn	1 (4.3%)
Hanging	1 (4.3%)
Heat	1 (4.3%)
Others	*1 (4.3%)
Total:	23 (100.0%)

** The deceased child was a newborn who died a few hours after birth due to complications during birth. The Coroner's Court ruled that the death cause was "Other accidental threats to breathing".*

Table 5.4.2.3: No. of Cases by Age Group and Type of Accident

Age Group	Type of Accident (%)								No. of Cases (%)
	Traffic	Drown-ing	Fall	Poison-ing	Burn	Hanging	Heat	Others	
< 1	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.3%)	1 (4.3%)
1 – 2	0 (0.0%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	2 (8.7%)
3 – 5	3 (13.0%)	0 (0.0%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (17.4%)
6 – 8	0 (0.0%)	1 (4.3%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (8.7%)
9 – 11	2 (8.7%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (13.0%)
12 – 14	4 (17.4%)	0 (0.0%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (21.7%)
15 – 17	3 (13.0%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	6 (26.1%)
Total:	12 (52.5%)	3 (13.0%)	2 (8.7%)	2 (8.7%)	1 (4.3%)	1 (4.3%)	1 (4.3%)	1 (4.3%)	23 (100.0%)

Table 5.4.2.4: No. of Cases by Age Group and Type of Traffic Victim

Age Group	Type of Traffic Victim (%)		No. of Cases (%)
	Pedestrian	Passenger	
< 1	0 (0.0%)	0 (0.0%)	0 (0.0%)
1 – 2	0 (0.0%)	0 (0.0%)	0 (0.0%)
3 – 5	3 (25.0%)	0 (0.0%)	3 (25.0%)
6 – 8	0 (0.0%)	0 (0.0%)	0 (0.0%)
9 – 11	2 (16.7%)	0 (0.0%)	2 (16.7%)
12 – 14	1 (8.3%)	3 (25.0%)	4 (33.3%)
15 – 17	2 (16.7%)	1 (8.3%)	3 (25.0%)
Total:	8 (66.7%)	4 (33.3%)	12 (100.0%)

Table 5.4.2.5: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	4 (17.4%)
Hospital	1 (4.3%)
Indoor (Not Home)	2 (8.7%)
Outdoor	1 (4.3%)
School	0 (0.0%)
Street / Road	12 (52.2%)
Vehicle	0 (0.0%)
Water / Sea	3 (13.0%)
Unknown	0 (0.0%)
Total:	23 (100.0%)

Table 5.4.2.6: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	18 (78.3%)
Full-time Work	2 (8.7%)
Part-time Work	0 (0.0%)
Not Studying & Not Working	0 (0.0%)
Not Applicable*	3 (13.0%)
Unknown	0 (0.0%)
Total:	23 (100.0%)

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

5.4.2.1 Summary Findings

23 children died of accidents in the years 2008 and 2009.

Table 5.4.2.1 shows that the number of male children (N=16, 69.6%) was significantly higher than that of female children (N=7, 30.4%). The age group of 15 – 17 had the highest number of child deaths (N=6, 26.1%), followed by the age groups of 12 – 14 (N=5, 21.7%) and 3 – 5 (N=4, 17.4%).

Table 5.4.2.2 shows that over half of the cases died of traffic accidents (N=12, 52.2%). Drowning accidents had the second highest number of child deaths (N=3, 13.0%).

Table 5.4.2.3 shows that for traffic accidents, the highest number of child deaths occurred in the age group of 12 – 14 (N=4, 17.4%), followed by the age groups of 3 – 5 and 15 – 17 (both N=3, 13.0%) and then 9 – 11 (N=2, 8.7%). For the two fall accident cases, they came from the age groups of 1 – 2 and 6 – 8 (both N=1, 4.3%).

Table 5.4.2.4 shows that eight (66.7%) children were pedestrians and four (33.3%) passengers on board traffic vehicles when they lost their lives in traffic accidents. No fatal traffic accident case involved cyclists in these two years. Three out of the eight pedestrians were aged between 3 and 5, and the remaining five were between 9 and 17.

Table 5.4.2.5 shows that over half of the fatal incidents occurred on street or in road (N=12, 52.2%) and these were all traffic accidents. Fatal incidents of four (17.4%) cases occurred at home, with one case each for poisoning, hanging, burn and fall accidents. The issue of the quality of care and home safety for children staying at home, attended or unattended, remains to be an area of concern.

Table 5.4.2.6 shows that most of the children died of accidents were full-time students (N=18, 78.3%). Occupation was not applicable to three (13.0%) children who were in infancy or whose health conditions prevented them from attending school or work.

During review on the accident cases, the Review Panel has the following observations:

(1) All of the 12 "traffic accident" cases occurred because of carelessness of pedestrians and / or undesirable conduct of drivers;

(2) One of the two "fall accident" cases could have been avoided if proper home safety design or devices were in place;

(3) The two "poisoning accident" cases could have been avoided if the poisonous substance and medication (methadone) were kept out of reach from the children or clearly labeled; and

(4) All of the three "drowning accident" cases occurred when the children, either left alone or with peers, lacked close or proper care or supervision by adult.

5.4.3 Cases Died of Suicide

Table 5.4.3.1: No. of Cases by Age Group and Sex

Age Group	No. of Cases (%)		Total
	Female	Male	
< 1	0 (0.0%)	0 (0.0%)	0 (0.0%)
1 – 2	0 (0.0%)	0 (0.0%)	0 (0.0%)
3 – 5	0 (0.0%)	0 (0.0%)	0 (0.0%)
6 – 8	0 (0.0%)	0 (0.0%)	0 (0.0%)
9 – 11	1 (3.8%)	0 (0.0%)	1 (3.8%)
12 – 14	4 (15.4%)	3 (11.5%)	7 (26.9%)
15 – 17	7 (26.9%)	11 (42.3%)	18 (69.2%)
Total:	12 (46.2%)	14 (53.8%)	26 (100.0%)

Table 5.4.3.2: No. of Cases by Occupation

Occupation	No. of Cases (%)
Full-time Student	19 (73.1%)
Full-time Worker	1 (3.8%)
Part-time Worker	0 (0.0%)
Not Studying & Not Working	5 (19.2%)
Not Applicable	0 (0.0%)
Unknown	1 (3.8%)
Total:	26 (100.0%)

Table 5.4.3.3: Reasons of Committing Suicide

*Reasons of Committing Suicide	No. of Cases
School Work Problem	11
Family Relationship Problem	8
Relationship Problem With Boyfriend / Girlfriend	8
Peer Relationship Problem	4
Mental Problem	4
Health Problem	2
Worry About Future	2
Psychological Trauma	1
Drug Abuse Problem	1
Unknown	1
Total:	42

* *Multiple reasons were allowed.*
(The reasons were identified in the police death investigation reports of the reviewed cases.)

Table 5.4.3.4: Means of Committing Suicide

Means of Committing Suicide	No. of Cases (%)
Jumping From Height	19 (73.1%)
Hanging	4 (15.4%)
Gas Poisoning	2 (7.7%)
Drug Overdosing	1 (3.8%)
Total:	26 (100.0%)

Table 5.4.3.5: No. of Cases with Identified Suicidal Signs

Presence of Suicidal Signs*	No. of Cases (%)
With Suicidal Signs	21 (80.8%)
Without Suicidal Signs	4 (15.4%)
Unknown	1 (3.8%)
Total:	26 (100.0%)

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.)*

Summary Findings

In the years 2008 and 2009, a total of 26 children took their own lives.

Table 5.4.3.1 shows that more male children (N=14, 53.8%) committed suicide than that of female children (N=12, 46.2%). Except for one child who was in the age group of 9 – 11, all other children were aged 12 – 17, with the majority in the adolescent age group of 15 – 17 (N=18, 69.2%).

Table 5.4.3.2 shows that the majority (N=19, 73.1%) of the children who committed suicide were full-time students. Five (19.2%) were neither studying nor working and one (3.8%) was engaged in full-time work when the fatal incidents happened.

Table 5.4.3.3 shows that the most common reason leading the deceased children to commit suicide was school work problem (N=11), followed by family relationship problem and relationship problem with boyfriend / girlfriend (both N=8), and by peer relationship problem and mental problem (both N=4).

Table 5.4.3.4 shows that most of the deceased children committed suicide by jumping from height (N=19, 73.1%), which was very common in Hong Kong with high rise buildings. Four children (15.4%) chose hanging, two (7.7%) with gas poisoning and one (3.8%) by drug overdosing to end their lives.

Table 5.4.3.5 shows that majority of the children who committed suicide (N=21, 80.8%) had expressed their suicidal thoughts in one way or another before actual attempts. The early detection of such signs with timely professional intervention might have helped the prevention of child / youth suicide.

During review on suicide cases, the Review Panel also has the following observations:

(1) Before or during the happening of 10 suicide cases, the peers or family members of the deceased children were present or aware of the fatal incidents and such experience could be traumatic for them;

(2) School work problem and relationship problem with family or boyfriends / girlfriends were the main causes of the child / youth suicide;

(3) High expectation of academic performance from self or family and parenting style in reaction to children's misbehaviour might be risk factors of child / youth suicide; and

(4) Children of parents with psychiatric problems or suicidal history required special attention.

5.4.4 Cases Died of Assault

Table 5.4.4.1: No. of Cases by Age Group and Sex

Age Group	No. of Cases (%)		
	Female	Male	Total
< 1	1 (5.6%)	3 (16.7%)	4 (22.2%)
1 – 2	3 (16.7%)	1 (5.6%)	4 (22.2%)
3 – 5	1 (5.6%)	1 (5.6%)	2 (11.1%)
6 – 8	2 (11.1%)	0 (0.0%)	2 (11.1%)
9 – 11	2 (11.1%)	0 (0.0%)	2 (11.1%)
12 – 14	1 (5.6%)	1 (5.6%)	2 (11.1%)
15 – 17	1 (5.6%)	1 (5.6%)	2 (11.1%)
Total:	11 (61.1%)	7 (38.9%)	18 (100.0%)

Table 5.4.4.2: Perpetrator's Relationship with the Deceased Child

Relationship	No. of Cases (%)
Parent	13 (72.2%)
Relative	3 (16.7%)
Stranger	2 (11.1%)
Total:	18 (100.0%)

Table 5.4.4.3: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	16 (88.9%)
Hospital	0 (0.0%)
Indoor (Not Home)	2 (11.1%)
Outdoor	0 (0.0%)
School	0 (0.0%)
Street / Road	0 (0.0%)
Water / Sea	0 (0.0%)
Others	0 (0.0%)
Unknown	0 (0.0%)
Total:	18 (100.0%)

Summary Findings

18 children died of assault in the years 2008 and 2009.

Table 5.4.4.1 shows that more female children (N=11, 61.1%) than male children (N=7, 38.9%) died of assault. These cases were scattered in different age groups, with the highest number and percentage falling in the age groups of below 1 and 1 – 2 (both N=4, 22.2%).

Table 5.4.4.2 shows that 13 (72.2%) out of the 18 perpetrators were parents of the deceased children. Three (16.7%) were relatives of the children and the other two (11.1%) perpetrators were strangers to the children.

Table 5.4.4.3 shows that 16 (88.9%) out of the 18 fatal incidents occurred at home. The remaining two incidents (11.1%) occurred indoor other than home.

During review of cases died of assault, the Review Panel has the following observations:

(1) Most perpetrators causing the death of the children were their parents;

(2) Of the 13 child death cases with parent perpetrators, two mothers killed themselves after assaulting their children (involved total three children), six committed suicide together with the children but one managed to survive while her children died;

(3) Two deceased newborns were unwanted children whose mothers tried to conceal their birth; and

(4) One of the two victims of the cases died of stranger assault was a teenager who had got acquainted with the assailant through internet and was killed during compensated dating.

5.4.5 Cases Died of Miscellaneous Causes

Table 5.4.5.1: No. of Cases by Age Group and Cause of Death

Age Group	Cause of Death		Total (%)
	Medical Complications	Unknown*	
< 1	2 (13.3%)	4 (26.7%)	6 (40.0%)
1 – 2	0 (0.0%)	1 (6.7%)	1 (6.7%)
3 – 5	0 (0.0%)	1 (6.7%)	1 (6.7%)
6 – 8	0 (0.0%)	0 (0.0%)	0 (0.0%)
9 – 11	1 (6.7%)	0 (0.0%)	1 (6.7%)
12 – 14	0 (0.0%)	2 (13.3%)	2 (13.3%)
15 – 17	2 (13.3%)	2 (13.3%)	4 (26.7%)
Total:	5 (33.3%)	10 (66.7%)	15 (100.0%)

Unknown: 4 out of these 10 cases are ruled by the Coroner's Court to have unknown death cause.*

Table 5.4.5.2: No. of Cases by Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	5 (33.3%)
Hospital	5 (33.3%)
Indoor (Not Home)	2 (13.3%)
Outdoor	1 (6.7%)
School	0 (0.0%)
Street / Road	0 (0.0%)
Water / Sea	1 (6.7%)
Others	0 (0.0%)
Unknown	1 (6.7%)
Total:	15 (100.0%)

Summary Findings

15 children died of miscellaneous causes in the years 2008 and 2009.

Table 5.4.5.1 shows that five (33.3%) children died of medical complications with two (13.3%) of them aged below 1, one (6.7%) aged between 9 and 11 and the other two (13.3%) were aged between 15 and 17. 10 (66.7%) children had unknown death causes. Six (40.0%) of them were aged below 6 and four (26.7%) aged between 12 and 17.

Table 5.4.5.2 shows that most of the fatal incidents occurred at home and in hospitals (both N=5, 33.3%). Two (13.3%) occurred indoor (not home).

During review of cases died of miscellaneous causes, the Review Panel has the following observations:

(1) Of the 15 cases with unknown death causes, the deaths of 5 children might be related to health problems according to police investigation reports at the Coroner's Court;

(2) Two newborns died of unknown causes were related to concealment of pregnancy;

(3) Two children died of unknown causes with suspicion of abuse elements which could not be established during the investigation; and

(4) Four children died after falling from height had unknown death causes because it could not be ascertained if they had fallen by accidents or other reasons.

6 REVIEW FINDINGS, RESPONSES AND FOLLOW-UP WORK

6.1 General Observations on Cases Reviewed and Messages from Child Fatality Review Panel on Child Death Prevention

6.1.1 General Observations on Cases Reviewed

(i) A broad comparison of age-specific death rates with some countries revealed that child death rates (0.3 per 1 000 child population in 2008 and 0.2 per 1 000 child population in 2009, including all child deaths, both reviewed or not reviewed by the Review Panel) in Hong Kong remained relatively low;

(ii) Among the cases reviewed, more children died of natural causes (N=156, 65.5%) than non-natural causes (N=82, 34.5%);

(iii) Children aged below 1 constituted the highest number of death (N=91, 38.2%) among different age groups and the vast majority of these infants died of natural causes (N=80, 33.6%);

(iv) Vast majority of the child death cases reviewed were Chinese (91.6%). Non-Chinese child death cases (N=20) also accounted for 8.4% of the total child death cases reviewed;

(v) There were more male (N=128, 53.8%) than female (N=110, 46.2%);

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

(vii) Home was the most common place for occurrence of fatal incidents (N=99, 41.6%) with hospital came second (N=84, 35.3%).

6.1.2 Messages from the Child Fatality Review Panel on Child Death Prevention

(i) Majority (65.5%) of the fatal cases reviewed died of natural causes. Many of the unfortunate children had been suffering from chronic or acute illnesses which might be alleviated or cured only by advancement of medicines and treatment procedures. Notwithstanding this, the Review Panel still saw that there could be areas for improvement and made three recommendations on these fatal cases of natural causes;

(ii) The next highest group was "Suicide" (10.9%). It is most sad to see that children were determined to take their own lives. Though the factors causing these children to have such thoughts and behaviours were complex, the Review Panel recommended using public education to enhance care-givers' knowledge and awareness in giving more support to these children;

(iii) The third group was "Accident" (9.7%). It was equally regrettable as most of the children might not die if their carers were more careful in the child care arrangement. Public education to raise the awareness of both children and their carers of road and home safety issues was equally important;

(iv) For the assault cases, the assailants of vast majority (72.2%) of the cases were the parents. The loss of the innocent lives might have been avoided if timely help and intervention could have been provided to these parents facing various difficulties;

(v) Whether the causes of a child's death were due to health or other social reasons, sometimes they were complex and might be difficult to predict and avoid. Yet, through the review of the fatal cases, the Review Panel is appreciative to a lot of professionals who were paying much efforts in safeguarding the welfare and well-being of our children; and

(vi) It is undoubtedly that everyone would agree to the value of safeguarding the well-being of our children and walk the extra mile to better protect them.

6.2 Themes and Issues

After reviewing the cases occurring in 2008 and 2009, the following main themes and issues are drawn up:

(i) Proper child care and close supervision by parents and care-givers remains the most important factor in preventing most of the child deaths;

(ii) Public education to raise the awareness of the care-givers of home safety issues and equip them with the appropriate knowledge and child care skills is deemed necessary;

(iii) Education to children on road and home safety issues could help prevent fatal traffic accidents and accidents at home in children;

(iv) The public, care-givers and professionals working with or coming across any child could be more sensitive to any risks the child is facing, thus giving more timely assistance or intervention to the child; and

(v) Life education to children for treasuring life and being resilient could help them overcome various life challenges. Also, life education to parents for treasuring and respecting the lives of their own and their children could prevent fatal assaults to children.

6.3 Good Practices Identified in Service Reports Submitted to Child Fatality Review Panel

In relation to a case in which a 7 years' old boy slipped and fell, causing head injury and resulting in his death (recommendation A1), the following good practices are identified and worth sharing:

(i) Parents donated the cornea of their son who died accidentally to help others in need; and

(ii) Follow-up services by the Education Bureau and school concerned had alleviated the emotional disturbances of fellow students in face of a schoolmate's death.

6.4 Recommendations Made (by Death Causes) and Responses from Concerned Parties

Upon reviewing the child death cases that occurred in 2008 and 2009, the Review Panel has made a total of 21 recommendations on preventive strategies and systems improvement for child death cases by the categorised causes which are summarised in the following paragraphs. For those recommendations for which similar ones were made in the Final Report of the Review Panel of the Pilot Project, the Review Panel also took the opportunity of the present review to initiate enquiries with concerned parties for updating of implementation of improvement measures. The recommendations made in the Final Report of the Review Panel of the Pilot Project echoed by the current review, the views / comments given previously and the updates collected during current review are also highlighted in the following paragraphs.

6.4.1 Cases Died of Natural Causes

6.4.1.1 Recommendations and Responses

Recommendation N1
Through public education, to remind parents the possible fatal risk of sleeping together with infants on the same bed.
Updating / Responses
Department of Health Baby's sleep safety is an important home safety issue. Maternal and Child Health Centres (MCHCs) will alert parents-to-be, parents and carers on importance of sleep safety and the risk of co-sleeping with the baby through individual counselling, "Happy Parenting" workshop and booklet, audio-visual resources and website. A leaflet on "Protect Baby from Sudden Infant Death Syndrome (SIDS)" is produced by the Department of Health and is included in the "Happy Parenting" booklet which is given to every parent or carer attending MCHCs. It can also be viewed or downloaded from the Family Health Service (FHS) website (http://www.fhs.gov.hk), "Parent-Child e-Link" e-newsletters and "Parenting Made Easy" self-learning e-course. **Hospital Authority** The Hospital Authority agreed to the recommendation.

Recommendation N2

Through public education, to encourage parents and care-givers of children with disabilities and chronic illness to arrange annual influenza vaccination for these children to safeguard their health.

Updating / Responses

Department of Health

To encourage annual seasonal influenza vaccination among children with disabilities and chronic illness, the Government has put in place the followings:

Firstly, under the Residential Care Home Vaccination Programme, children residing in residential care homes for the disabled can receive free influenza vaccination annually.

Secondly, under the Government Vaccination Programme, children with chronic medical problems or on long-term aspirin, attending Paediatric out-patient clinics or are in-patients under the Hospital Authority can receive free influenza vaccination in public clinics / hospitals. Children (aged between 6 months and less than 6 years) from families on Comprehensive Social Security Assistance (CSSA) can receive the free vaccination in the Maternal and Child Health Centres.

Thirdly, the Childhood Influenza Vaccination Subsidy Scheme provides $130 per dose (maximum 2 doses) of influenza vaccine subsidy to children aged between 6 months and less than 6 years or children aged 6 years or above but attending a kindergarten or child care centre in Hong Kong. Eligible children can receive the vaccination provided by enrolled private doctors.

The Department of Health worked closely with the Social Welfare Department, Housing Society, Hospital Authority and other stakeholders, together with a series of publicity work, to inform the public and target groups about the arrangement.

Hospital Authority

Influenza vaccination is one of the effective means to prevent influenza and its complications.

The Hospital Authority (HA) provides annual influenza vaccination to eligible groups under the Government Vaccination Programme, including paediatric patients with chronic medical problems, in order to prevent influenza related complications and death.

The HA also provides a free influenza vaccination programme to all staff, including healthcare workers, in order to protect them from influenza infection and prevent secondary transmission to the patients. Various promotional programmes are implemented to boost the vaccine uptake rate, for example, by means of Mobile Vaccination Teams.

Recommendation N3

To set up feedback system between forensic pathologist and family doctor for arranging family screening for family members of deceased child confirmed to have hereditary disease after post-mortem for preventive purposes.

Similar recommendation made in the Final Report of the Pilot Project of Child Fatality Review

To set up a mechanism for pathologist to give feedback to family members of deceased children who, after post-mortem, confirmed to have hereditary diseases and refer them for medical examination, follow-up and genetic counselling.
(Recommendation N10, p.47 of Final Report)

Updating / Responses

Department of Health

Responses given in the Final Report of the Pilot Project of Child Fatality Review:

In connection with setting up mechanism for pathologist to give feedback, it is already a practice adopted by the Forensic Pathology Service of the Department that:

(i) In any case, forensic pathologist will explain autopsy findings and cause of death to the family upon their request, and

(ii) In any case, where undiagnosed hereditary disease is found during autopsy, forensic pathologists will call the family proactively to explain the findings and give advice and / or refer the parents and surviving siblings for appropriate medical follow-up accordingly, including genetic counselling if indicated.

(See p.47 of Final Report: Updating / Responses)

Update for the present Report:

The given responses are still valid.

Hospital Authority

If autopsy reveals an inheritable disease that could affect siblings or relatives of the deceased, the pathologist will notify the referring clinical departments to trace and advise the family accordingly.

6.4.2 Cases Died of Accidents

6.4.2.1 General Observations

During review on accident cases, the Review Panel has the following observations:

(i) Children of cross-boundary residence or newly arrived in Hong Kong might not be familiar with road and traffic conditions in Hong Kong and seemed to have weaker awareness on road safety; and

(ii) Television announcement is effective means to remind children the safety issues in crossing the road.

6.4.2.2 Recommendations and Responses

Recommendation TA1

To consider organising road safety campaigns targeting at cross-boundary students and students newly arrived from the Mainland in schools close to the boundary, so as to familiarise these students with pedestrian road safety regulations in Hong Kong.

Updating / Responses

Road Safety Council

The Road Safety Council (RSC) agreed with the initial findings of the Review Panel. The cross-boundary and newly arrived students are not familiar with road and traffic conditions in Hong Kong and might be vulnerable to traffic accidents.

The Council is delivering the road safety message to these students by means of education and promotion. Recently, the Council produced a series of 'Pedestrian Safety Rules' leaflets. The leaflets are portrayed with colourful cartoon and written in simplified Chinese for the cross-boundary and newly arrived students to learn about the road safety rules in Hong Kong.

The Council would also conduct road safety seminars and lectures to students, parents and teachers through different channels, including in Road Safety Towns and Road Safety Bus, or during visit by Police Road Safety Officers. Between January and October 2012, the Council and the Police conducted 358 seminars in the New Territories North area.

'Pedestrian Safety Rules' leaflets:

1. http://www.roadsafety.gov.hk/en/dnload/leaflets/pedestrian_02.html *(Simplified Chinese Version Only)*
2. http://www.roadsafety.gov.hk/images/en/dnload/leaflets/New%20Pedestrian%20Leaflet.jpg
3. http://www.roadsafety.gov.hk/doc/tc/dnload/Road%20Safety%20Rules%20for%20Pedestrians%20(chs).pdf

School Concerned

The proposal is feasible.

Recommendation TA2

To strengthen awareness of road safety for pre-school children through various means, such as organising periodic visit to Road Safety Towns, watching short films on road safety issues in schools, etc.

Updating / Responses

Transport Department

The Road Safety Council (RSC) coordinates education and publicity on road safety in Hong Kong. The Transport Department (TD) is a member of the RSC and its Road Safety Campaign Committee. We understand that the Police, on behalf of RSC, will continue to promote education and publicity on child road safety. For instance, the Police give road safety lectures to students and members of the public who visit the Road Safety Towns. Besides, the Police also arrange Road Safety Bus to visit schools and youth centres to promote road safety message. During the period from 2010 to 2012, there have been a yearly average of about 2 030 visits and 42 800 visitors to the Road Safety Towns and about 800 visits by the Police to schools and youth centres. In addition, RSC also arranges the broadcasting of radio and television announcements to promote road safety.

TD has also participated in education activities organised by organisations which promote child road safety. For example, TD presented a speech and participated in the discussion of "2012 Hong Kong Child Safety Conference". TD will continue to work in collaboration with RSC to enhance education and publicity on child road safety in order to disseminate road safety messages.

Road Safety Council

The Road Safety Council attached great importance to the education of pre-school children on road safety through mass media. Therefore, the Council has produced a series of announcement in television and radio, such as "Pay Attention, Cross the Road with Care" and "Road Safety Symbol and Vision" to promote the messages of pedestrian safety to pre-school children.

The Road Safety Towns provide a simulated road environment to enhance children's awareness of road safety. The Towns are open for visit by students of kindergartens and primary schools, and also community groups. On the other hand, the Road Safety Bus would visit schools and youth centres across the territory periodically. In 2011, the Towns and the Bus recorded over 43 800 and 60 000 visitors respectively.

Links to the television announcements:
1. http://www.isd.gov.hk/eng/tvapi/08_rs141.html
2. http://www.isd.gov.hk/eng/tvapi/06_rs139.html

Recommendation TA3

(i) To widely publicise the importance of using safety belts in vehicles.

Updating / Responses

Transport Department

The Transport Department (TD) has been exercising efforts in disseminating road safety messages. With respect to wearing seat belts, TD has produced a leaflet "Be Smart, Buckle Up". In addition, TD has also reminded passengers to wear seat belts in Road Safety Bulletin No. 23 published in February 2010. In December 2011, TD has distributed 180 000 copies of Road Safety Bulletin No. 27 on "Always Buckle Up" as the theme, describing how to use different child care seats in proper way. The relevant bulletins have been uploaded in TD's homepage and distributed to district offices, road tunnels, carparks, libraries, and TD's licensing offices for collection by the public.

To enhance safety of child passengers in private cars, TD proposes to amend the legislation to raise the current age ceiling for all front seat passengers under 3 years old in using child restraint devices (CRDs), and to extend the requirement to rear seat passengers. If the proposed amendments are enacted, TD will also strengthen relevant education and publicity on proper use of CRDs.

Road Safety Council

The Road Safety Council is committed to promoting the importance of wearing seat belt to the public, and has produced a public announcement "Wear Seat Belt on Public Light Buses" for broadcasting in television and radio.

The Council has also produced a leaflet "Please Buckle Up" for distribution across the territory. The public announcement and the leaflet can also be viewed on the websites of the Road Safety Council, the Information Services Department and the Transport Department. The Council will continue to explore more new platforms and channels to disseminate road safety messages.

Link to the television announcement:
http://www.isd.gov.hk/eng/tvapi/belt_e.html
'Please Buckle Up' leaflet:
http://www.roadsafety.gov.hk/doc/en/dnload/leaflets/PLB_Seat%20Belt.pdf

Recommendation TA3

(ii) To restrict drivers with probationary license from driving high performance cars (including sports car, high cylinder capacity (c.c.) car and modified car) may help prevent traffic accidents.

Similar recommendation made in the Final Report of the Pilot Project of Child Fatality Review

Applying special restrictions for young and inexperienced drivers to minimise their risk of traffic accidents.
(Recommendation A18, p.73 of Final Report)

Updating / Responses

Transport Department

Responses given in the Final Report of the Pilot Project of Child Fatality Review:

The "Probationary Driving Licence Scheme" was extended to include novice drivers of private cars and light goods vehicles from 9 February 2009 to enhance road safety. The holder of a probationary driving licence is required by law to undergo a 12-month probationary driving period before a full driving licence can be issued and is subject to additional driving restrictions on top of the existing ones applicable to ordinary motorists.

Further Response / Updating (as at 31 October 2010)

The Road Traffic Legislation (Amendment) Ordinance 2008 gazetted in July 2008 has stipulated a package of measures to combat drink driving and dangerous driving among other inappropriate driving behaviour. In addition, the Road Traffic (Amendment) Bill 2010 currently under consideration will also tighten the laws on drink driving and dangerous driving. All these measures are also applicable to young and inexperience drivers giving greater deterrent effects to improper driving behaviour and hence improving road safety.
(See p.73-74 of Final Report: Updating / Responses & Further Response / Updating)

Update for the present Report:
The probationary driving licence scheme on private cars and light goods vehicles was put in place since 9 February 2009.

The Road Traffic (Amendment) Ordinance 2010 was enacted on 17 December 2010 to increase the penalties for drink driving and dangerous driving offences which is applicable to all drivers, including young and inexperienced drivers, giving greater deterrent effects to improper driving behaviour and hence improving road safety. For drink driving, a 3-tier penalty system with a sliding scale was introduced, and the more a driver exceeds the prescribed limit for alcohol, the longer will be his driving disqualification. For dangerous driving, a new offence "causing grievous bodily harm by dangerous driving" was introduced.

In addition, the Road Traffic (Amendment) Ordinance 2011 was enacted on 15 March 2012 which is applicable to all drivers, including young and inexperienced drivers. The purpose of the Ordinance is to impose a stricter control over drug driving and empower the Police to enforce drug driving offences more effectively by carrying out preliminary drug tests on the suspected drug drivers.

Recommendation A1

Through public education, to educate parents on the symptoms of serious head injury in children and the immediate handling.

Updating / Responses

Department of Health

The Department of Health, with input from the Auxiliary Medical Service and Hong Kong College of Emergency Medicine, produced a booklet entitled "First Aid Made Easy". This publication is intended for members of the public who may encounter incidents (including head injury) at home or otherwise which require first-aid treatment. In addition, information on injury prevention is also available via the pre-recorded telephone hotline as well as website of the Department's Central Health Education Unit.

Hospital Authority

The Hospital Authority noted the recommendation.

Recommendation A2

To strengthen regular refresher training for life-guards of swimming pools to familiarise them with updated guidelines for handling suspected drowning.

Updating / Responses

Leisure and Cultural Services Department

To enhance the quality of lifesaving service and ensure that lifeguards are conversant with the rescue operations for drowning swimmers, the Leisure and Cultural Services Department (LCSD) provides a wide range of training for lifeguards on a regular basis, including induction training, qualification revalidation and skills enhancement training. In 2011-12, each lifeguard received an average of 3.9 days of training. These regular training programmes and qualification revalidation courses aim at ensuring that lifeguards are refreshed with the most up-to-date skills, such as preventive lifeguarding (including the handling of suspected drowning), emergency action plan, rescue techniques, aquatic first aid, etc. and possess valid qualifications in lifesaving. Mobilisation drills are also organised regularly at all LCSD swimming pools and beaches during the swimming season to get lifeguards prepared and ready for lifesaving operations at any time. The drills cover the areas of emergency action plan, resuscitation, aquatic first aid, pool lifesaving techniques, etc. Besides, lifeguards are arranged to take up different posts every half an hour on a rotational basis to maintain their alertness.

Meanwhile, to enhance the safety of children in the public swimming pools, the Department has already implemented the following measures:

(a) Children under the age of 12 should be accompanied by adults when they are admitted to public swimming pools. If a child under the age of 12 is not accompanied by an adult, he / she will be refused admission; and

(b) When a child under the age of 12 is found alone in a public swimming pool and it is confirmed that he / she is not accompanied by an adult, the staff of the pool will not allow the child to swim.

The Hong Kong Life Saving Society

(1) "To protect the safety of children, a child under 12 must be accompanied by an adult when entering the swimming pool." It is suggested to include this rule for the swimming pool users in both public and private swimming pools.

(2) "Adult is suggested to maintain supervision of his or her child in the pool precinct." This advisory message should be well delivered to the pool users.

Recommendation A3

To enhance public education on "Children must be kept away from poisonous substances".

Updating / Responses

Department of Health

The parenting programme in Maternal and Child Health Centres (MCHCs) of the Family Health Service (FHS) provides parents with a comprehensive range of anticipatory guidance on various child care and parenting issues. Home safety is one of the main topics covered. Nursing and medical staffs of MCHCs will remind parents and carers the importance of home safety, including prevention of poisoning, through individual counselling, "Happy Parenting" workshop and booklets, audio-visual resources and website. In addition, leaflets on "Prevention of childhood poisoning" and "Prevention of accidental paracetamol poisoning in children", produced by the Hong Kong Poison Control Network, are being given to parents attending MCHCs. These leaflets can also be downloaded from the Hong Kong Poison Control Network website (http://www.hkpcn.org.hk) and Family Health Service website (http://www.fhs.gov.hk). Moreover, FHS has also produced leaflets on home safety for parents targeting children of different age groups. These leaflets and audio-visual materials (with Chinese and English versions) can also be downloaded by public from the FHS website. The FHS has also launched two parenting e-learning platforms, the "Parent-Child e-Link" e-newsletters and "Parenting Made Easy" self-learning e-course since 2011-12. These allow parents, carers and public to obtain child care and parenting information via different channels. Information on home safety is also included in these new e-learning platforms.

6.4.3 Cases Died of Suicide

6.4.3.1 General Observations

During review on suicide cases, the Review Panel has the following observations:

(i) Parents and teachers should be aware of the resilience of perfectionist children;

(ii) It seemed that teachers were less alert of the emotional upset of students than their behavioural problems; and

(iii) Children with special educational needs or mental illness in mainstream school needed intensive social support and services.

6.4.3.2 Recommendations and Responses

Recommendation S1
Through public education, to educate parents on how to help their children build up resilience in face of failure.
Updating / Responses
Education Bureau The Education Bureau (EDB) publicises information from time to time through various channels such as the e-Bulletin and Education Update news column to remind parents and the public to help their children in facing adversities. In the EDB website, a document on "Managing Traumatic Incidents (Quick Reference)" is provided to remind parents and teachers to keep an eye on students' psychological states and marked emotions or behaviours when managing traumatic incidents. The EDB has launched the Understanding Adolescent Project (Primary) and the Enhanced Smart Teen Project (Secondary) since the 2004/05 and 2006/07 school years respectively to build up resilience among students. Parents are requested to actively participate in parent training, parent-child activities and passing out activities so as to help parents understand students' progress and collaborate with schools on student growth. **Social Welfare Department** 22 Family Life Education Units, 65 Integrated Family Service Centres and two Integrated Services Centres provide family life education to enhance public's resilience in adverse circumstances. These units / centres also organise groups or programmes specifically on equipping parents on how to help their children build up resilience in face of failure.

The Family Life Education Resources Centre has resources on educating parents in enhancing their children's resilience in face of failure.

Social Welfare Department (SWD) subvents non-governmental organisations (NGOs) to run integrated children and youth services centres (ICYSCs) in the community to provide a wide range of preventive, developmental and remedial services for children and youth; as well as parents' education and support.

The school social work service, subvented by SWD, not only helps early identification and provides timely support to needy students, but also engages the students' parents for building positive value and promoting healthy development of needed students. School social workers will be encouraged to conduct more programmes for parents so as to enhance their skills on helping their children build up resilience in face of failure.

SWD organises a variety of territory-wide and district-based publicity and public education programmes on strengthening families, prevention of domestic violence and positive thinking each year. To meet district's need, individual districts organise community activities to strengthen family cohesion and family harmony as well as to promote to the public an optimistic attitude in facing life adversities.

Recommendation S2

(i) To set up a mechanism in school for early identification of students facing multiple risks threatening their normal growth; and

(ii) Through public education, to publicise the message "Depression is curable" and to encourage children with depression or emotional distress as well as their families to seek professional assistance.

Updating / Responses

Education Bureau

For part (i):

The guidance and discipline teams in schools would plan and implement relevant programmes and curriculum for the prevention and intervention of students' emotional and stress management problems.

The EDB has progressively extended the provision of the School-based Educational Psychology Service to cover all public sector primary and secondary schools by the 2016/17 school year to enhance the support provided by educational psychologists to schools.

We recommend schools to adopt a Three-tier Support Model to detect and support students who are at risk of emotional distress and possibly at risk of suicidal behaviour. Tier 1 targets at the early detection of students who are vulnerable and requiring additional support through teaching, guidance and support activities mainly from teachers. Tier 2 targets at a smaller group of at-risk students referred to school guidance personnel or school social workers for risk assessment and 'add-on' support services, such as individual counselling and group work. Tier 3 focuses on the high-risk cases requiring in-depth assessment and intensive individualised support. School personnel need to solicit assistance from specialised helping professionals such as psychiatrist, clinical psychologist, educational psychologist, medical social worker, etc. where appropriate.

For part (ii):
Information on various mental illnesses (including depression) and EDB's guidelines entitled "How can schools help students with mental health problems?" have been uploaded to the EDB website. We have also produced an eBook on Student Suicide for Schools: Early Detection, Intervention and Postvention for teaching, counselling and risk assessment purposes.

Relevant training programmes are provided to teachers, including the Certificate Courses on Student Guidance and Discipline for primary and secondary teachers, the 120-hour thematic course on Psychological Approach to Effective Strategies in Handling Students' Challenging Behaviour. In the 2009/10, 2011/12 and 2012/13 school years, EDB has collaborated with the Hospital Authority to organise several regional seminars for teachers / guidance personnel to enhance their alertness to students' emotional difficulties.

Department of Health
Adolescent Health Programme (AHP) of the Student Health Service of Department of Health provides out-reaching health promotion services to secondary school students, their parents and teachers in the school setting. The aim is to improve the psycho-social health of adolescents by empowering them with necessary basic life skills which covers areas on stress management, problem solving etc. Such training serves to help adolescents establish a positive attitude and outlook so that they would be able to deal with changes and challenges with confidence during their development. Students are encouraged to seek early professional help if they have emotional or depressive symptoms. AHP also has a programme for enhancing teachers and parents' awareness and handling of susceptible adolescents for the prevention of adolescent suicide.

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

We believe that the concerted efforts of government and non-governmental organisations and the support of parents and teachers are essential in prevention of child and adolescent suicide. The Student Health Service will continue to work in collaboration with schools, parents and different sectors of the society to prevent suicide of students.

The Department of Health has also produced a comprehensive range of health educational resources and audio-visual aids on mental health, and set up a round-the-clock pre-recorded telephone information hotline and webpage to disseminate messages on mental health and to promote the psycho-social well-being of the public.

Social Welfare Department

The school social workers, subvented by SWD, collaborate with school personnel to early identify and provide timely support to needy students. Training courses on enhancing school social workers and youth services workers' skills in early identification of students' depression and emotional disturbance will continue to be organised by SWD in 2013-14.

Besides, SWD also subvents NGOs to run ICYSCs in the community to 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 support to them.

SWD organises a variety of territory-wide and district-based publicity and public education programmes on strengthening families, prevention of domestic violence and positive thinking each year. To meet district's need, individual districts organise community activities to strengthen family cohesion and family harmony as well as to promote to the public an optimistic attitude in facing life adversities.

Hospital Authority

For children or adolescents with suicidal ideation, if assessed to be in need of specialist service of the Hospital Authority, they could be referred to Child and Adolescent Psychiatric Service. They would be rendered with timely and comprehensive suicide risk assessment, and hospitalisation would be arranged if indicated.

School Concerned

- The school continues to develop students' positive values towards life through school-based curriculum and campaigns, etc.
- The school also implements mentorship scheme to enhance student-teacher relationship. Teachers and students have more chances of casual gathering and chat.

Recommendation S3

To take measures to prevent bullying in school.

Updating / Responses

Education Bureau

EDB has a very clear policy whereby we will not tolerate any act of bullying in schools. We have issued circulars and asked all schools to take the matter seriously and implement proactive measures to ensure the safety of students at school and create a harmonious school environment.

EDB has produced and uploaded on the EDB homepage resource packages, which provide guidelines and advice for schools with a view to enhancing teachers' awareness about school bullying and helping schools formulate school-based strategies to prevent, handle, follow up on this problem.

EDB regularly organises talks and workshops for schools to remind them to handle school bullying incidents according to the relevant guidelines, and adopt a whole school approach in formulating and implementing anti-bullying strategies.

EDB has organised a series of anti-bullying activities and launched a programme entitled "Anti-bullying Day / Week" since the 2011/12 school year to help schools promote anti-bullying messages and enhance students' awareness and ability to handle bullying behaviour. Schools are provided with a Resource Package and promotion materials.

School Concerned

A Pastoral Care Committee has been in operation to adopt a whole school Caring School Approach for students. The school has a harmonious school policy and being a caring school is one of the major concerns of the school. More support is especially provided for F.1 students to help them adapt to the new learning environment and to enhance their interpersonal skills.

Recommendation S4

Through public education, to encourage children to seek help from reliable adults or helping professionals promptly when their peers expressed suicidal idea.

Updating / Responses

Education Bureau

To help schools cater for student with special educational needs (SEN), EDB has been providing schools with additional resources, professional support and teacher training, and encouraging schools to provide appropriate support for their students with SEN through the Whole School Approach.

Students with mental illness require diagnostic treatment from medical professionals and usually they are followed up by psychiatrists, clinical psychologists or medical social workers. Professionals in schools, including student guidance personnel, school social workers and educational psychologists, can provide support to students with mental illness in their respective professions to complement their treatment / rehabilitation plan. If necessary, multi-disciplinary case conferences involving school professionals, psychiatrist, medical social worker, other school personnel and parents will be arranged to discuss support strategies.

For particularly difficult cases, a time-limited additional grant will be provided where appropriate for employing temporary teaching assistants to cater for the specific needs of individual students.

Social Welfare Department

SWD organises a variety of territory-wide and district-based publicity and public education programmes on strengthening families, prevention of domestic violence and positive thinking each year. In 2011-12, SWD produced a set of bilingual television and radio announcements as well as posters with the main theme on "Embrace Your Hopes, Cherish Your Love" to publicise the message of "Love your children. Treasure their lives as well as yours" to the public. To meet district's need, individual districts organise community activities to strengthen family cohesion and family harmony as well as to promote to the public an optimistic attitude in facing life adversities.

SWD encourages ICYSCs and school social workers to organise more preventive and supportive group activities for young people / students in Centres / schools so as to raise their awareness to those who want to seek help.

SWD has conveyed the recommendation to the Samaritan Befrienders Hong Kong (SBHK). Through its dedicated Suicide Crisis Intervention Centre, SBHK encourages children with suicidal idea to seek help from reliable adults or helping profession as soon as possible when it provides public education on suicide prevention.

School Social Work Service / Non-governmental Organisation Concerned

- Agree that public education for children to seek help is very important.
- Suggest to arrange mentors / volunteers for students with greater social needs.
- Has strengthened the school social workers' training on mental health such as attending workshops on "Suicide Crisis Assessment and Intervention", "Mental Health First Aid", "Personality Disorder" and "Psychosis".
- Has updated the information on prevention of student suicide on the Agency's website.
- Has initiated liaison with educational psychologist in handling cases with emotional problems as appropriate.

Schools Concerned

School No. 1:

Talks about treasuring life and thanksgiving are held. These messages are also brought out in lessons of different subjects.

School No. 2:

In response to the school-based evaluation of the incident, the following measures have been taken by the management:

(i) Stepped up the services of the school social worker by allocating more time on handling cases with suicidal risks;
(ii) Organised for students a series of thematic seminars on the topics of life goals and values, positive thinking and ways of handling emotional stress and daily pressure;
(iii) Integrated more visits or activities related to the suffering of the disadvantaged to strengthen the students' ability against adversity and hope for brighter life;
(iv) Raised the staff's awareness of identifying students with suicidal risks;
(v) Recruited a teaching assistant specifically for handling students with special educational needs or emotional problems; and
(vi) Revised the school's contingency plan to prioritise the handling of aftermath.

School No. 3:

For staff:

- Crisis management team reviewed the guideline and streamlined the procedures on handling crisis after the incident.

- Staff members were reminded to maintain high sensitivity on students' behaviour and emotions constantly. Staff members were well informed of the guidelines on handling crisis.
- Staff members, Guidance Teachers in particular, were invited to attend workshops on understanding and handling student suicidal ideas and mental problems.
- Professional advices from Educational Psychologists and other professional parties were sought on handling students with serious emotional and mental problems.

For students:

- Seminars and workshops on stress management, online addiction and cyber bullying had been organised for students at various levels.
- Elements concerning values of life had been incorporated into class teacher's period under the Moral and Life Education Theme.

School No. 4:

The school constantly follows up closely students with emotional disturbance or mental illness. With prior approval from parents, school will work together with concerned teachers and school social workers to follow up cases or make other professional referral basing on individual situation and needs of students.

School No. 5:

- The school has already actively reminded teachers during staff meeting to pay attention to students' day-to-day behaviour. In case students behave strangely, teachers should try to understand the situation and report to relevant departments for follow-up action.
- Since forming the Student Supporting Team, we have regularly held various activities to strengthen students' awareness of healthy living and resilience.

School No. 6:

- We agree with the findings and observations. It is our policy for case workers to report any expressed suicidal ideas from students and inform their parents as soon as possible. We also put a great deal of efforts to promote a caring culture in our school.
- A Learning Support Team was established to cater for the needs of SEN students. Regular Form Meetings with School Social Workers, Guidance and Discipline Teachers, were held with Form Masters to monitor emotional and behaviour problems of all students.

School No. 7:

Agreed to the opinions of the Review Panel. We have actually told our teachers and students not to neglect any single wording(s) related to suicide. We always remind our teachers to look out for students with emotional problems from time to time.

Recommendation S5

To enhance school personnel's knowledge on child mental illness and to strengthen support in school for students with mental problems.

Updating / Responses

Education Bureau

EDB's School Administration Guide calls for schools' proper care of students' health (including mental health). A Circular Memorandum was issued in April 2012 to all schools reminding them of matters on supporting students with mental health problems and web resources (including EDB's guideline entitled "How can schools help students with mental health problems?").

EDB has reached consensus with the seven district centres of The Early Assessment Service for Young People under the Hospital Authority (HA) that schools could contact the relevant district service centres to seek their expert advice and support when needed.

Relevant training programmes are provided to teachers, including the Certificate Courses on Student Guidance and Discipline for primary and secondary teachers, and the 120-hour thematic course on Psychological Approach to Effective Strategies in Handling Students' Challenging Behaviour. In the 2009/10, 2011/12 and 2012/13 school years, EDB has collaborated with HA to organise several regional seminars.

Department of Health

Adolescent Health Programme (AHP) of the Student Health Service of Department of Health provides out-reaching health promotion services to secondary school students, their parents and teachers in the school setting. The aim is to improve the psycho-social health of adolescents by empowering them with necessary basic life skills which covers areas on stress management, problem solving etc. Such training serves to help adolescents establish a positive attitude and outlook so that they would be able to deal with changes and challenges with confidence during their development. Students are encouraged to seek early professional help if they have emotional or depressive symptoms. AHP also has a programme for enhancing teachers and parents' awareness and handling of susceptible adolescents for the prevention of adolescent suicide.

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

We believe that the concerted efforts of government and non-governmental organisations and the support of parents and teachers are essential in prevention of child and adolescent suicide. The Student Health Service will continue to work in collaboration with schools, parents and different sectors of the society to prevent suicide of students.

The Department of Health has also produced a comprehensive range of health educational resources and audio-visual aids on mental health, and set up a round-the-clock pre-recorded telephone information hotline and webpage to disseminate messages on mental health and to promote the psycho-social well-being of the public.

Social Welfare Department

Agreed to the recommendation so that the child's emotional condition could be comprehensively assessed routinely by various disciplines in school. Communication among school personnel and other helping professionals could facilitate the responsible social worker to know more about the child's current mental conditions and to enhance the treatment effectiveness. Multi-disciplinary case management approach could also bring in more supportive services to help lower the risk of recurrent self-harming behaviour. In case the child needs psychiatric or psychological treatment, concerned social worker could take appropriate response promptly and obtain the required collateral support to avoid tragedy. In addition, we believe it is equally important to enhance the awareness of parents of early signals of suicidal tendency in children with psychiatric problem and seeking help for early intervention through parent education.

Therefore, SWD has organised relevant course in 2011-12, to enrich school social workers and youth services workers' knowledge on child psychiatry and related handling skills.

School Social Work Service (SSWS) /
Non-governmental Organisations Concerned

SSWS No. 1:

Agreed to the Review Panel's views, especially for those child mental illness with higher suicidal risk, such as psychosis.

SSWS No. 2:

- Suggest to conduct case conference which involves psychiatrist, psychologist, social worker, teacher and parents to work out support measures and treatment plan in an early stage in handling students with mental illness.
- Suggest to continue to promote understanding and acceptance of students with special needs / mental illness in school.
- Four case conferences were conducted to increase school personnel's understanding on the needs of students with mental illness.

- Has produced a year planner to promote positive values and happiness and distributed to all students and teachers.
- Has conducted a review immediately after the incident to share assessment and handling of cases with suicidal risk.

Schools Concerned

School No. 1:

To equip teachers with knowledge in students' special needs, more teachers are encouraged to join related courses so as to enhance their awareness in how to support students with different needs. So far there are two teachers finished the advanced course and both of them are frontline teachers belong to discipline and guidance team. With the joint effort by educational psychologist, school social workers, teachers of SEN unit, a group of students were recruited to promote message of acceptance and integration. Sessions about knowing more SEN and emotions were conducted and will be run in the future. On top of that, a workshop was arranged and will be arranged to convey message of positive thinking. It is hoped that having educational psychologist stationed at school, teachers will find it a helpful channel to refer students with potential emotional / mental problems.

School No. 2:

On a regular basis, the school Counselling Committee will exchange relevant information on mental health of young people with concerned teachers and school social workers as well as sharing with them relevant cases. Educational Psychologist will, when necessary, be consulted, so as to enhance understanding and skill of intervention when dealing with students with emotional disturbances or mental illness. Immediate special staff meeting will also be called and Educational Psychologist will be invited for support whenever necessary. Moreover, with prior approval obtained from parents, school social workers or concerned teachers will also attend meetings the school conducted with psychiatry doctors or clinical psychologists in order to jointly follow up with students' needs.

Recommendation S6

Through public education, to remind parents that they should nurture their children according to their capabilities and accept their limitations.

Similar recommendation made in the Final Report of the Pilot Project of Child Fatality Review

Public education on acceptance of individual difference in learning ability and potentials of students. Given stimulation and training, students with unsatisfactory academic performance could achieve high in areas where their potentials rest.
(Recommendation S5(i), p.83 of Final Report)

Updating / Responses

Education Bureau

Responses given in the Final Report of the Pilot Project of Child Fatality Review:

(i) Has organised various activities to raise public awareness and understanding of individual differences;

(ii) A set of leaflets on various special educational needs and the support services available have been published and uploaded on the Bureau's website: "An Inclusive School – It All Begins with Our Hearts" publicity drive was organised and a series of ten television episodes titled 'Parenting' was produced in 2009. They aim to enhance public understanding and acceptance of students with special educational needs. Resource packages with suggested extended activities and teaching materials were provided to schools in 2010 for further promoting an inclusive culture among students and parents; and

(iii) Regularly publishes a web-newsletter on the Bureau's website to provide parents and the public with updated special education information and promote inclusive practices.

(See p.88 of Final Report: Updating / Responses)

Update for the present Report:

In the Learning and Teaching Expo organised by the Hong Kong Education City in June 2011 and Nov 2012, the Education Bureau (EDB) introduced to teachers, the sector, parents groups and the general public the support strategies adopted by ordinary schools in implementing integrated education and the characteristics of learning and teaching in special schools through booth display, talks and school visits, as well as the services, teaching materials and ancillary equipment, etc. for supporting students with special educational needs (SEN).

EDB also organised the Visual Arts Contest on Inclusion activities and exhibitions in mid-2012, to promote the inclusive school culture.

EDB will continue to organise various activities and publish regularly a web-newsletter on the Bureau's website to raise public awareness and understanding of individual differences, provide updated special education information and promote inclusive policy and practices.

School Social Work Service / Non-governmental Organisation Concerned

- Suggest to organise more parent education workshops to equip parents with knowledge of and methods in communication with their children in particular respecting individual differences and uniqueness.
- Has run life education talks and activities for whole school in order to enhance students' coping skills on negative emotions and learning to treasure life.

Recommendation S7

To enhance the school curriculum in respect of life education and life skills training to strengthen the coping ability and resilience of students.

Similar recommendation made in the Final Report of the Pilot Project of Child Fatality Review

Strengthening elements of life skills and resilience in school curriculum, and assisting students to enhance their coping ability can help prevent student suicide.
(Recommendation S5(ii), p.83 of Final Report)

Updating / Responses

Education Bureau

Responses given in the Final Report of the Pilot Project of Child Fatality Review:

(i) Relevant learning elements have been included in the school curricula;

(ii) Related professional development programmes are organised and learning and teaching resources are prepared for school reference; and

(iii) Has been encouraging schools to provide students with ample opportunities in developing competences, helping them set life goals and build an optimistic and positive attitude in face of life changes. To this end, the Understanding Adolescent Project has been conducted in primary schools since the 2004/05 school year to enhance students' resilience by instilling into them a sense of competence, belonging and optimism. Relevant activities for secondary schools have also been organised from time to time, including the Enhanced Smart Teen Project conducted in collaboration with the disciplinary forces and the "Positive Adolescent Training through Holistic Social Programmes to Adulthood: A Jockey Club Youth Enhancement Scheme" (Project PATHS) funded by the Hong Kong Jockey Club Charities Trust and co-organised by the Bureau and the Social Welfare Department.

(See p.88 of Final Report: Updating / Responses)

Update for the present Report:

Related professional development programmes are organised by EDB annually. Learning and teaching resources are prepared and updated regularly for school reference.

Life education related learning elements and core values have been included in the existing school curricula. In addition, life education related elements are enhanced through the implementation of Life and Society curriculum at junior secondary level since the 2012/13 school year. Topics like emotion management and ways to cope with negative emotions, coping with adversities, developing potentials and self-identity, etc. aim at strengthening students' resilience and necessary coping skills.

In the 2012/13 school year, over 380 primary schools have joined the Understanding Adolescent Project while over 2 000 secondary students are participating in the Enhanced Smart Teen Project. About 290 primary and secondary schools have joined the Caring Schools Awards Scheme to show their commitment and actions in nurturing a caring school culture.

Schools Concerned

School No. 1:

Some counselling groups are held to support students in need.

School No. 2:

For staff:

- Crisis management team reviewed on the guideline and streamlined the procedures on handling crisis after the incident.
- Staff members were reminded to maintain high sensitivity on students' behaviour and emotions constantly. Staff members were well informed of the guidelines on handling crisis.
- Staff members, Guidance Teachers in particular, were invited to attend workshops on understanding and handling student suicidal ideas and mental problems.
- Professional advices from Educational Psychologists and other professional parties were sought on handling students with serious emotional and mental problems.

For students:

- Seminars and workshops on stress management, online addiction and cyber bullying had been organised for students at various levels.
- Elements concerning values of life had been incorporated into class teacher's period under the Moral and Life Education Theme.

School No. 3:

To foster students' stamina and positive attitude, one of the major concerns of the school's three-year School Development Plan is to develop students' resilience and healthy lifestyles. Through various activities such as thematic programmes organised by subjects, healthy school plan, assembly talks, extra-curricular activities, peer mentoring scheme, etc., the school aims at cultivating a positive attitude and improving problem solving skills among students, as well as fostering a friendly and supportive atmosphere among peers.

School No. 4:

We have a comprehensive guidance programme and use the whole school approach to equip our students with the life skills to face everyday challenges in the course of their personal growth.

School No. 5:

We have accommodated knowledge and life skills in dealing with courtship affairs, dating and separation in our life education curriculum. Teachers act as the mentors of students, facilitate students to face and tackle all sorts of growth problems.

School Social Work Service / Non-governmental Organisation Concerned

- Has implemented multifarious activities including adventure-based training, stress management workshop, art activities and career planning to strengthen students' problem solving ability and resilience.
- Has conducted reflective internal sharing among school social workers to share good practices in suicide prevention.
- Has arranged school social workers to attend various staff development training for further enhancing the knowledge and skills such as stress management and positive psychology.

6.4.4 Cases Died of Assault and Miscellaneous Causes

6.4.4.1 General Observations

During review on assault and miscellaneous cases, the Review Panel has the following observations:

(i) Television announcement or docu-drama are effective means to spread the message of preventing child assault to the public;

(ii) Supported the recommendation made by the jury after death inquest: "To enhance the assessment mechanism for the discharge of mental patients by, for instance, requiring the examination and approval of more than one doctor or a senior doctor.";

(iii) There is concern over the non-vigilant attitude of children in acquainting themselves to strangers through the internet and even using it for compensated dating; and

(iv) Concealment of pregnancy and delivery threatens the life of the baby.

6.4.4.2 Recommendations and Responses

Recommendation AS1
(i) To raise the awareness of the public to capture the signs and verbal threats of suicide and homicide of parents seriously and to connect those children-at-risk to professional services as early as possible; and
(ii) Through public education, to remind parents that they have the responsibility to take good care of their children and no right to take away their lives under any circumstances.
Updating / Responses
Social Welfare Department SWD organises a variety of territory-wide and district-based publicity and public education programmes on strengthening families, prevention of domestic violence and positive thinking each year. In 2011-12, SWD produced a set of bilingual television and radio announcements as well as posters with the main theme on "Embrace Your Hopes, Cherish Your Love" to publicise the message of "Love your children. Treasure their lives as well as yours." to the public. To meet district's need, individual districts organise community activities to strengthen family cohesion and family harmony as well as to promote to the public an optimistic attitude in facing life adversities.

SWD has conveyed the recommendation to the Samaritan Befrienders Hong Kong (SBHK). Through its dedicated Suicide Crisis Intervention Centre, SBHK conveys positive life attitude to the public, message on treasuring their lives and those of their children and strengthening awareness of public on prevention of suicide when it provides public education on suicide prevention.

Special Child Care Service Organisation Concerned

- Apart from providing parent training to enhance their knowledge and skills in taking care of children with special needs, we also organise sharing and support groups to relieve parents' stress.
- Recently, the Society has actively promoted positive thinking among parents to encourage them to appreciate the strength of their children and be thankful to the care and concern from their family members.
- When teachers discover parents with emotional distress, they will refer to the social worker to follow up. Psychologist's support will be sought when necessary.
- Staff training is organised to enhance their awareness of parental stress and skills in identifying and supporting parents with mental health problem or at risk of other family crisis such as financial difficulty and substance abuse, etc.

School Concerned

Agreed to the recommendation.

Recommendation AS2

To enhance the assessment mechanism for the discharge of mental patients, especially those patients with explicit ideas of homicide, may help ensure the safety of their children.

Updating / Responses

Social Welfare Department

According to the existing mechanism, multi-disciplinary medical team would conduct pre-discharge risk assessment and formulate discharge plan before the discharge of patient, including seeking views from patient's family members and providing supportive community services according to patients' treatment and rehabilitation needs. Support services for children with parents suffering from mental problems would also be strengthened upon the discharge of their parents from institutions. The implementation of Personalised Care Programme and Integrated Community Centre for Mental Wellness has strengthened community support services for discharged patients.

A series of community education programmes to enhance the public's understanding on mental health and mental rehabilitation services, to eliminate misunderstanding and prejudice against mental patients as well as to help release stress of carers have been organised in the Districts.

SWD will assign complicated or high risk cases to Medical Social Workers (MSWs) of Social Work Officer rank such that more intensive input could be rendered to these types of cases.

MSWs, upon receiving referrals from hospitals, will maintain close collaboration with medical and health care professionals as well as relevant parties and service providers in the community on need assessment and formulation of discharge plans for the patients, in particular those with suicidal or homicidal risk. SWD will update the procedures for handling suicide / child abuse / domestic violence cases as needed.

Clinical supervision to enhance social workers' sensitivity and risk assessment for mental patients with explicit ideas of homicide will continuously be rendered.

Hospital Authority

The Hospital Authority (HA) has a mechanism in place to ensure psychiatric in-patients are clinically suitable for discharge. Appropriate risk and needs assessment would be conducted, and a post-discharge follow-up plan would be worked out prior to a patient's discharge.

For patients with complexity needs, a senior or supervisor of the case doctor would be involved for making the discharge decision. Furthermore, for patients in need of community support, appropriate community psychiatric services would be arranged. For example, the HA will arrange home visits by community psychiatric nurses.

School Concerned

Agreed to the recommendation.

Recommendation AS3

To remind the public to raise vigilance and caution towards making acquaintance in the cyber world where things and persons may be faked or masked.

Updating / Responses

Social Welfare Department

Since August 2011, SWD funded three Pilot Cyber Youth Outreaching Projects for three years to proactively search and outreach at-risk / hidden youths, including those not actively receiving traditional youth service, through the communication means commonly adopted by young people, e.g. via email, SMS, chatroom, web game etc. The projects also provide cyber preventive, developmental and remedial services, including the development of web-based education, counselling and mutual help groups to help youths enhance their sense of safety when making acquaintance in the cyber world and to build up proper attitude and resistance towards the temptation of compensated dating.

In addition, SWD organises a variety of territory-wide and district-based publicity and public education programmes on strengthening families and prevention of domestic violence each year. SWD has produced an episode of short publicity video to remind parents to pay attention to children's internet surfing behaviour. This episode has been broadcasted on buses through Roadshow and uploaded on SWD's YouTube webpage. In 2012-13, SWD has launched a shortfilm cum storyboard creation competition through the internet to raise the public awareness towards the traps of sexual abuse in the internet and to explore how to prevent children and youth from being victims of sexual abuse.

Education Bureau

For cyber safety among students, EDB has commissioned an NGO to provide a hotline service for parents, teachers and students to encourage healthy use of Internet, such as avoiding Internet addiction, dealing with cyber-bullying, recognising correct information. For the 2011/12 school year, a total of 18 talks have been arranged for parents, teachers and students. EDB also maintains an Internet Safety Information Channel for public access to relevant information. 10 movie clips to further promote Internet Safety will be launched in the second quarter of 2013.

EDB has collaborated with IBM and the Hong Kong Association of Careers Masters and Guidance Masters to launch an "Internet Safety Best Practice Award Scheme" during the period of September 2011 to December 2012. The scheme encourages schools to develop policies and implementation strategies to promote Internet safety.

Recommendation 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.

Updating / Responses

Labour Department

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.

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.

Social Welfare Department

A leaflet was produced to encourage women with unplanned pregnancy to seek help when they encountered difficulty. Apart from distributing the leaflet to the public through related social services units, it was also distributed to the Immigration Department, Labour Department and Education Bureau. The leaflet has also been uploaded to the websites of SWD and the Family Life Education Resource Centre. The leaflet has been translated into languages of the ethnic minorities to facilitate ethnic minorities to understand the contents of the leaflet.

Immigration Department

No updated information / comments.

Recommendation AS5

To strengthen public education to remind parents and care-givers on the possible fatal risk of shaking babies.

Similar recommendation made in the Final Report of the Pilot Project of Child Fatality Review

Public education on "Shaken Baby Syndrome" to inform parents and care-givers the possible serious harm of shaking baby through local media and preferably to be broadcast in the Mainland.
(Recommendation M1, p.114 of Final Report)

Updating / Responses

Department of Health

Responses given in the Final Report of the Pilot Project of Child Fatality Review:

(i) The Maternal and Child Health Centres (MCHCs) provide a comprehensive range of health promotion and disease prevention service for children from birth to five years through the Integrated Child Health and Development Programme (ICHDP). Parenting programme is one of the core service components of the ICHDP. Parents-to-be and parents of young children are provided with anticipatory guidance on childcare, child development and parenting issues through information leaflets, audio-visual resources, workshops and individual counselling;

(ii) The topic of "Shaken Baby Syndrome" is being covered in one of the parenting leaflets on handling crying baby by the Department;

(iii) A video footage on "Shaken Baby Syndrome" produced by the United Christian Hospital is also shown in the Happy Parenting Workshop (0 – 2 months) to alert the participants on this issue; and

(iv) Will explore the possibility to upload the information and video on this topic in the Department's website in order to allow access to the above information by parents residing in the Mainland.

Further Response / Updating (as at 31 October 2010)

The video footage on "Shaken Baby Syndrome" produced by the United Christian Hospital has been uploaded on Family Health Service Website (www.fhs.gov.hk) to allow access by parents residing in Mainland.

(See p.114 of Final Report: Updating / Responses & Further Response / Updating)

Update for the present Report:

Maternal and Child Health Centres have launched two new parenting e-learning platforms, the "Parent-Child e-Link" e-newsletters and "Parenting Made Easy" self-learning e-course since 2011-12. These allow parents, carers and public to obtain child care and parenting information via different channels. Information on "Shaken Baby Syndrome" is being included in these new e-learning platforms so as to publicise the message and remind the baby carers the potential fatal risk of shaking a baby.

7 APPENDICES

Appendix 7.1 List of Child Fatality Review Panel Members

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

A. Chairman and Convenors:

	Name	Profession / Discipline
1.	Prof Leung Nai-kong *(Chairman)*	Medical (Paediatrics)
2.	Dr Hung Se-fong *(Convenor of Group A – Suicide)*	Medical (Child Psychiatry)
3.	Ms Wong Yu-pok, Marina *(Convenor of Group B – Traffic Accidents)*	Accounting
4.	Dr Lee Lai-wan, Maria *(Convenor of Group C – Other Accidents)*	Child Education
5.	Mr Hui Chung-shing, Herman *(Convenor of Group D – Assault & Miscellaneous)*	Legal
6.	Dr Yu Chak-man *(Convenor of Medical Group – Natural Causes)*	Medical (Paediatrics)

B. Other Members:

	Name	Profession / Discipline
1.	Dr Beh Swan-lip, Philip	Medical (Forensic Pathology)
2.	Ms Chan Kit-bing, Sumee	Clinical Psychology
3.	Miss Chan Mei-lan, Anna May (up to May 2012)	Legal
4.	Miss Chan Mi-har, Grace	Social Welfare
5.	Dr Cheung Chi-hung, Patrick	Medical (Paediatrics)
6.	Dr Dunn Lai-wah, Eva (from June 2012)	Medical (Psychiatry)
7.	Mr Fong Cheung-fat (from June 2012)	Social Welfare
8.	Miss Hung Wing-chee, Anna (up to May 2012)	Education
9.	Dr Lam Chan Lan-tak, Gladys (up to May 2012)	Academia
10.	Miss Lam Tze-yan (from June 2012)	Legal

	Name	Profession / Discipline
11.	Ms Lam Wai-ling, Leona	Education
12.	Prof Li Albert Martin	Medical (Paediatrics)
13.	Prof Shek Tan-lei, Daniel	Academia
14.	Ms Tao Chee-ying, Theresa (from June 2012)	Education
15.	Mr Tong Siu-hon, David (from June 2012)	Parent Representative
16.	Miss Tsang Lan-see, Nancy (up to May 2012)	Social Welfare
17.	Dr Tsang Man-ching, Anita	Medical (Paediatrics)
18.	Dr Yeung Ka-ching (from June 2012)	Academia
19.	Dr Yiu Gar-chung, Michael (up to May 2012)	Medical (Psychiatry)
20.	Mr Yu Wing-fai, Christopher (up to May 2012)	Parent Representative

Appendix 7.2 Terms of Reference

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

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

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

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

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

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

Appendix 7.3 Information Brief on Child Fatality Review

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/whatsnew/201101/PPCFRFR.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 co-operation 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 co-operation 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, supplemented by use of other means such as focus group or interview with concerned parties where necessary.
3. Organisation(s) that had rendered service(s) to the deceased child or his / her family could facilitate the review by reporting child death or providing service reports to the CFRP. Relevant forms can be obtained from the Secretariat upon request.
4. A database of child death cases is set up to facilitate the review and for future statistical or research purpose of the CFRP.
5. The review findings and recommendations of the CFRP will be released to the public through integrative reports. Recommendations will be distributed to relevant parties / organisations for feedback, consideration and follow-up action.
6. Where appropriate, the CFRP will request the organisations concerned to provide update of the progress of implementation of improvement measures.
7. No 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.

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 7.4 The 20 Categories of Deaths Reportable To The Coroners

The 20 Categories of Reportable Deaths

1 Death the medical cause of which is uncertain
2 Sudden / unattended death, except where a person has been diagnosed before death with a terminal illness
3 Death caused by an accident or injury
4 Death caused by crime
5 Death caused by an anaesthetic or under the influence of a general anaesthetic or which occurred within 24 hours of the administering of anaesthetic
6 Death caused by a surgical operation or within 48 hours after a surgical operation
7 Death caused by an occupational disease or directly / indirectly connected with present or previous occupation
8 Still birth
9 Maternal death
10 Deaths caused by septicaemia with unknown primary cause
11 Suicide
12 Death in official custody
13 Where death occurred during discharge of duty of an officer having statutory powers of arrest or detention
14 Death in the premises of a Government department any public officer of which has statutory powers of arrest or detention
15 Death of certain mental patients (as defined by law) in a hospital or in a mental hospital
16 Death in a private care home
17 Death caused by homicide
18 Death caused by a drug or poison
19 Death caused by ill-treatment, starvation or neglect
20 Death which occurred outside Hong Kong where the body of the person is brought into Hong Kong

Source: The Judiciary (Website: http://www.judiciary.gov.hk/en/crt_services/pphlt/html/cor.htm)

Appendix 7.5 Recommendations of Child Fatality Review Panel for Child Death Cases in 2008 and 2009

Note: Highlighted recommendations are those made in the Final Report of the Review Panel of the Pilot Project echoed by the current review.

For Cases Died of Natural Causes:

N1	Through public education, to remind parents the possible fatal risk of sleeping together with infants on the same bed.
N2	Through public education, to encourage parents and care-givers of children with disabilities and chronic illness to arrange annual influenza vaccination for these children to safeguard their health.
N3	To set up feedback system between forensic pathologist and family doctor for arranging family screening for family members of deceased child confirmed to have hereditary disease after post-mortem for preventive purposes.

For Cases Died of Accidents:

TA1	To consider organising road safety campaigns targeting at cross-boundary students and students newly arrived from the Mainland in schools close to the boundary, so as to familiarise these students with pedestrian road safety regulations in Hong Kong.
TA2	To strengthen awareness of road safety for pre-school children through various means, such as organising periodic visit to Road Safety Towns, watching short films on road safety issues in schools, etc.
TA3	(i) To widely publicise the importance of using safety belts in vehicles; and (ii) To restrict drivers with probationary license from driving high performance cars (including sports car, high cylinder capacity (c.c.) car and modified car) may help prevent traffic accidents.
A1	Through public education, to educate parents on the symptoms of serious head injury in children and the immediate handling.
A2	To strengthen regular refresher training for life-guards of swimming pools to familiarise them with updated guidelines for handling suspected drowning.
A3	To enhance public education on "Children must be kept away from poisonous substances".

For Cases Died of Suicide:

S1	Through public education, to educate parents on how to help their children build up resilience in face of failure.
S2	(i) To set up a mechanism in school for early identification of students facing multiple risks threatening their normal growth; and (ii) Through public education, to publicise the message "Depression is curable" and to encourage children with depression or emotional distress as well as their families to seek professional assistance.
S3	To take measures to prevent bullying in school.
S4	Through public education, to encourage children to seek help from reliable adults or helping professionals promptly when their peers expressed suicidal idea.
S5	To enhance school personnel's knowledge on child mental illness and to strengthen support in school for students with mental problems.
S6	Through public education, to remind parents that they should nurture their children according to their capabilities and accept their limitations.
S7	To enhance the school curriculum in respect of life education and life skills training to strengthen the coping ability and resilience of students.

For Cases Died of Assault and Miscellaneous Causes:

AS1	(i) To raise the awareness of the public to capture the signs and verbal threats of suicide and homicide of parents seriously and to connect those children-at-risk to professional services as early as possible; and (ii) Through public education, to remind parents that they have the responsibility to take good care of their children and no right to take away their lives under any circumstances.
AS2	To enhance the assessment mechanism for the discharge of mental patients, especially those patients with explicit ideas of homicide, may help ensure the safety of their children.
AS3	To remind the public to raise vigilance and caution towards making acquaintance in the cyber world where things and persons may be faked or masked.
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.
AS5	To strengthen public education to remind parents and care-givers on the possible fatal risk of shaking babies.