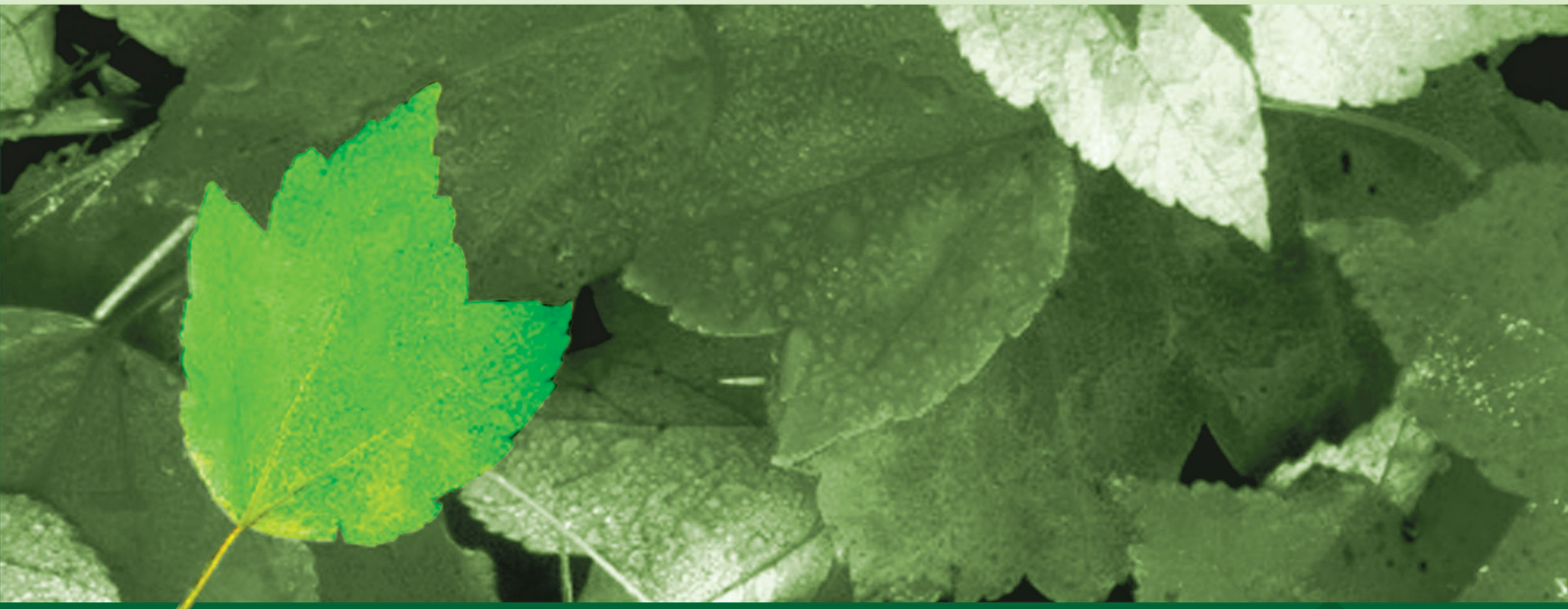


Review Panel of the Pilot Project on Child Fatality Review

First Report (on 2006 Cases Reviewed)

January 2010

FOREWORD

I am pleased to present this first report of the Review Panel of the Pilot Project on Child Fatality Review to all those concerned with or interested in child welfare. This report focuses on possible ways to improve the service systems to prevent child death.

Through the review, members of the Review Panel noted painstaking efforts of committed frontline professionals in helping the deceased children and their families in face of different risk factors and crises. With hindsight, we consider that there may be times when services could have been better delivered or coordinated. Yet, we note the high level of unpredictability in risky cases. We have reviewed cases of preventable and unpreventable child deaths.

Members of the Review Panel are well aware that we have the benefit of hindsight and the luxury of reviewing a case when more information is available and not under pressurized time frame. Therefore, we do not deem it fair for us to pass judgment on case management, least to say responsibilities. However, it is through this hindsight and post-mortem review that the Review Panel hopes to assist in contributing to foresight in the child welfare and child protection systems.

It is most encouraging for us to find that the processes of calling for information and dissemination of our recommendations for consideration turn out to be fruitful exchanges of ideas on service improvement across disciplines and sectors. Very often, we are impressed to find that reflective internal reviews have been conducted and service improvement measures implemented. We have received active responses to our findings and recommendations, with generous sharing of good practices and lessons to learn. We hope that the review can continue to play a part in stimulating and promoting inter-sectoral and inter-disciplinary exchange for the purpose of continuous service enhancement.

During the review, members of the Review Panel are deeply concerned with the pain suffered by the parents and the families of the deceased children. Our sympathy is always with them. We hope that the painful loss of their precious children can be reconciled by the thought that review of their children's death will throw light on how to prevent similar loss in future.

Leung Nai Kong
Chairman of the Review Panel of the Pilot Project on Child Fatality Review

ACKNOWLEDGEMENT

This Pilot Project would not be able to materialize without the continuous and active support from the Coroners and staff of the Coroner's Court.

Through giving their suggestions and advice on the Pilot Project during its planning and implementation, personnel of different disciplines, organisations and government departments have demonstrated their commitment towards better child welfare services.

The Review Panel would also like to express hearty thanks to those frontline workers, professionals and managerial personnel of organisations, bodies, and government departments, who have facilitated the review by providing information of different kinds, giving feedback or responses to recommendations, and offering suggestions to the running of the Pilot Project itself. This review would not have been possible without their cooperation. They also contribute valuable views and advice to the future development of child fatality review and how it can be more fruitful. Their participation has made the review a continuous process of inter-sectoral and inter-disciplinary exchange striving for better child protection.

EXECUTIVE SUMMARY

Background

The Pilot Project on Child Fatality Review (Pilot Project) commenced in February 2008 with the formation of a Review Panel with secretarial support from the Social Welfare Department to review child death cases involving children aged below 18 and reported to the Coroners to have died of non-natural causes. The Review Panel soon decided to extend the scope of review to cover those cases with natural causes of death and had been reported to the Coroners.

The purpose of the review is to facilitate the improvement / enhancement of the current child protection and child welfare service systems with focus on inter-sectoral collaboration and multi-disciplinary cooperation.

The Review

109 child death cases that ocurred in the year 2006 had been reported to the Coroner's Court. The Review Panel has reviewed 107 of these cases as at the end of April 2009 while two cases were then still pending for completion of legal proceedings and not yet ready for review. 46 cases died of non-natural causes while 61 cases died of natural causes.

During review, the child death cases were classified by causes of death, namely: suicide, accidents, others and natural causes. Basing on the case circumstances and information gathered, the review was documentary in nature. The Review Panel has made recommendations and distributed these to the related service organisations / departments and parties concerned with responses invited from them for sharing in this report.

Findings of Review on 2006 Cases

Chapter 5 of this report gives an overview on all cases reviewed while Chapter 6 gives overviews of cases died of different causes:

- *Cases Died of Suicide (Section 6.2)*

14 children died of suicide. Half of them were male and half female. Their age ranged between 12 – 17. Ten of them were full-time students while one worked full-time. Two of them were neither studying nor working while the occupation of one child was unknown. Eight deceased children were identified to have different signs of suicidal intent before they took their own lives. Relationship problem with boyfriend / girlfriend and school work problem were the main reasons accounting for suicidal attempts of these children.

- *Cases Died of Accidents (Section 6.3)*

20 children died of different types of accidents, namely: traffic, fall, drowning and drug overdose. 12 of them were male and eight of them were female. The age group with the highest number of accidental death is 6 – 8 (N=7), followed by the age group 15 – 17 (N=5). Traffic accident has the highest number of child death among all types of accident (N=11).

- *Cases Died of Other Causes (Section 6.4)*

Owing to their small numbers, cases died of causes other than suicide and accidents are grouped under "Other Causes". Six children died of unknown causes, four died of assault by others and two died of medical complications. Among these 12 children, four were aged below one and three were in the age range 9 – 11. Three deceased children were female while nine were male.

- *Cases Died of Natural Causes (Section 6.5)*

61 children died of natural causes of different kinds. 25 of them were female while 36 were male. 18 children were aged below one and 11 were in the age group 12 – 14. The class of diseases including congenital malformations, deformations and chromosomal abnormalities has the highest number of child death (N=14) while the class of circulatory system comes second (N=12). During review, the Review Panel has grouped the cases into four categories according to their death causes to see if there was any implication on service systems. These categories are: neo-natal conditions (N=14); chronic medical conditions (N=30); acute medical conditions (N=17) and others (N=0).

The Recommendations & Responses

The recommendations made by the Review Panel were summarized in ***Appendix VI***. These recommendations have been distributed to service organisations / departments and parties concerned and they were invited to give comments, response and updating of improvement measures taken for sharing with others in this report. The recommendations, responses and updating of improvement measures are also set out in Chapter 6 after overviews of cases died of different causes.

The Way Forward

The Review Panel will review child death cases that occurred in 2007 and publish the findings in the next report. The Review Panel may contact the concerned organisations or departments to whom the recommendations have been distributed in this report to inquire if further action has been taken regarding the recommendations. There will be an evaluation on the Pilot Project after its end.

TABLE OF CONTENT

LIST OF TABLES AND FIGURES

1 INTRODUCTION

The death of a child is always unfortunate and a grave loss both for the child's family and for society. Besides, from time to time, there occurred cases of child death which aroused our great concern. To safeguard the welfare of our children and to avoid such incidents, there is a propelling need for all those involved in providing care and services for children and their families to better understand why children died and how this can be prevented. It is under such circumstances that the call for a child fatality review emerges.

In response to the call for a review mechanism, the Social Welfare Department initiated and implemented the Pilot Project on Child Fatality Review in February 2008. The purpose of review is for identifying and sharing lessons learnt and good practices among professionals from different disciplines and sectors without attributing responsibilities. As a trial, it was decided that the review would focus on all deaths of children aged below 18 due to non-natural causes which had been reported to the Coroners. The review is meant to complement, rather than duplicate what the Coroner's Court has been doing for the prevention of child death. The types of death reportable to the Coroners are at ***Appendix I***. For this Pilot Project, "non-natural causes" refers to all causes other than "natural causes" as ruled by the Coroners. The Review Panel also decided that cases with "unknown" causes of death should also be included in the "non-natural causes" group for review as it could not be ruled out that the "unknown" causes might be related to child abuse or neglect.

To avoid prejudicing any criminal or legal procedures, review on child death cases will begin only after such procedures have been completed, and two years is considered to be a reasonable period for the completion of such processes. Consequently, the trial review begins with cases in which the children died on or after 1 January 2006. Details of the background, purpose and objectives, scope of review and the review mechanism of the Pilot Project are at ***Appendix II***.

To widen the coverage and to make the review more comprehensive, the Review Panel extended the scope of review from examining child deaths with non-natural causes to cover those cases of natural causes that had been reported to the Coroners.

This report provides an overview of the review mechanism, the findings and recommendations made by the Review Panel on cases that occurred from 1 January to 31 December in the year 2006, as well as the responses and improvement measures or policies put in place by government departments or non-governmental organisations involved, including schools, hospitals and social welfare organisations.

To observe the principle of confidentiality and to protect the privacy of persons and parties concerned, no identifying information of any individual of the reviewed cases is included in this report.

2 THE REVIEW PANEL

To take forward the Pilot Project, the Director of Social Welfare has appointed 14 individuals from different disciplines to form the Review Panel with the terms of reference as follows:

(i) To examine the service delivery process of organisations / departments concerned, if any, prior to the child's death;

(ii) To identify good practice, gaps and deficiency in related services, systems and multi-disciplinary collaboration that may be involved in the cases reviewed and to suggest improvements;

(iii) To identify patterns and trends through reviewing cases of children died of non-natural causes in the direction of formulating preventive strategies; and

(iv) To promote inter-disciplinary and inter-agency cooperation to prevent child death.

While the main source of cases for review is from the Coroner's Court, the functions and focuses of the Review Panel are different from those of the Coroner's Court and, therefore, will not duplicate the efforts and work of the latter.

With the extension of the scope of review to cover cases of death due to natural causes, the Director of Social Welfare appointed four paediatricians as co-opted members to tap their medical expertise to facilitate the review. The tasks of the co-opted members (medical experts) are:

(i) To conduct a general review on cases of children who died of natural causes;

(ii) To report the findings of this general review on cases of children who died of natural causes to the Review Panel;

(iii) To propose suitable cases, if any, for in-depth review for consideration by the Review Panel, and;

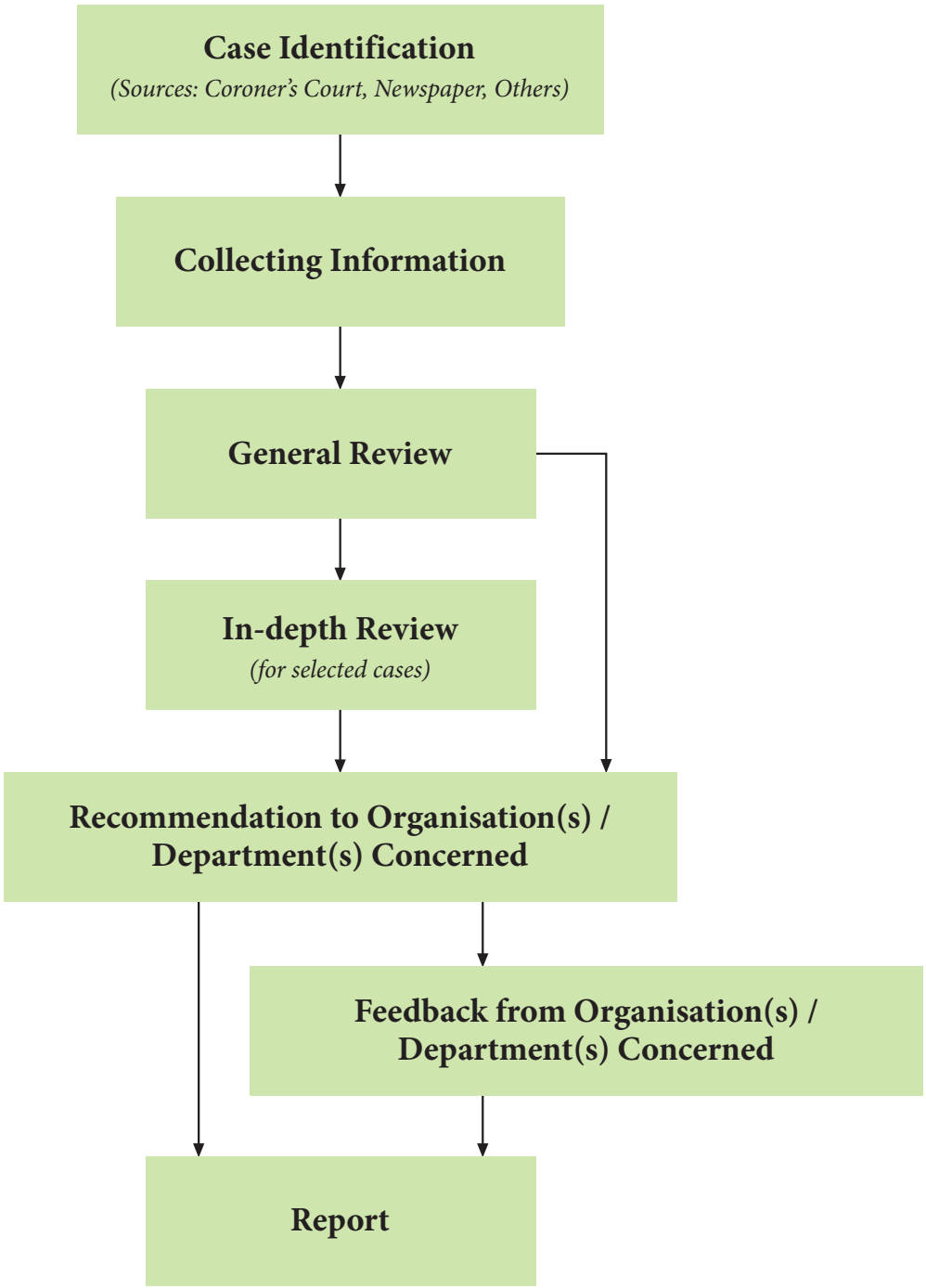
(iv) To participate in in-depth review of cases of children who died of natural causes.

Special care has been taken during the appointment process to ensure that the Review Panel is multi-disciplinary and independent in nature. The Social Welfare Department provides secretarial support for the Review Panel.

The list of members of the Review Panel is at ***Appendix III***.

3 THE REVIEW PROCEDURES

3.1 Flow Chart of the Review Procedures



3.2 Description of the Review Procedures

3.2.1 Case Identification

The Review Panel has obtained the Coroners' approval to obtain the list of child death cases reported to the Coroner's Court and to collect information on these cases on a regular basis. Other than that, the Secretariat of the Review Panel receives reports of child death cases from service organisations and identifies such cases from press reports. The Education Bureau also regularly provides brief information on student suicide cases on their record to the Secretariat.

3.2.2 Collecting Information

If a deceased child is known to any school or social service organisation, the Secretariat will approach the parties concerned for case information and make enquiries into the services provided as well as handling procedures to facilitate the review. The organisations provide information mainly through completing a Data Input Form (***Appendix IV***) or a Service Report (***Appendix V***), depending on the stage of information collection. The Secretariat may also make written enquiry on specific areas of concern or contact the service providers direct for clarification of information.

Information collected are consolidated, organised and presented to the Review Panel for examination and consideration. Such information will be destroyed after the review with the relevant data to be stored in a computerised Child Death Register for statistical and future research purposes.

3.2.3 Confidentiality

No names or personal identifiers of persons related to the cases are required in the Service Report or Data Input Form apart from the names and identities of the deceased children for referring purpose, and the names and posts of those who complete the reports to facilitate subsequent clarification of information if needed. All personal identifiers appearing in the information collected will be removed before they are presented to the Review Panel.

All members of the Review Panel have signed statements of confidentiality to undertake that they will keep all information they have access to during the review procedures confidential.

3.2.4 Review of Cases

The Review Panel meets quarterly to conduct review and to discuss issues relating to the implementation of the Pilot Project.

Members of the Review Panel are divided into five sub-groups to hold meetings in-between the quarterly meeting of the Review Panel to conduct review on cases with different causes of death:

Group A : Suicide
Group B : Traffic Accidents
Group C : Other Accidents
Group D : Other Causes
Medical Group : Natural Causes

Cases are reviewed in meetings of sub-groups and Panel meetings. After conducting a general review, the Convenor of each sub-group reports the findings and recommendations of his / her sub-group to the Review Panel at the quarterly meeting and recommends suitable cases for in-depth review. The Review Panel discusses the findings, endorses, amends or adds on the recommendations as and when necessary. In-depth review is conducted by all members at quarterly meeting.

3.2.5 Declaration of Interest

To avoid conflict of interest, members of the Review Panel are requested and reminded to declare interest in the cases for review if they have any kind of involvement with the persons or organisations concerned at the beginning of every review meeting.

3.2.6 Handling of Findings

Recommendations of the Review Panel on individual or group of cases reviewed are distributed to related service organisations and government departments either because they have provided information to facilitate the review, or it is believed that they can contribute towards improving the service systems by following-up on the recommendations. The organisations and government departments are invited to comment on the recommendations and provide information on improvement measures taken / will be taken, if any, as well as relevant service development for prevention of child death for reference of the Review Panel.

4 STRENGTHS AND LIMITATIONS

During the planning of the Pilot Project and prior to its implementation, studies on existing child fatality review mechanisms of different countries, including those in the United States, the United Kingdom, Australia and Canada have been made. The Review Panel has also made reference to reports on child fatality review from these countries in order to ensure that the methodology is on par with the international standard used in existing review methods.

The review of this Pilot Project adopts a multi-disciplinary approach, pooling expertise from professionals of different fields and disciplines. This approach is reflected in the different background of the members appointed to the Review Panel as listed in ***Appendix III***. It is hoped that diverging multi-faceted views will lead to positive recommendations that will be useful and feasible for service improvements.

This Pilot Project is an unprecedented pioneering attempt to introduce and apply a child fatality review mechanism in the Hong Kong context with the objective of improving local child welfare service systems.

Nevertheless, it is important for readers to note the following limitations of the review and the present report:

4.1 The review was primarily documentary in nature based on available information which might not be comprehensive for various reasons. The Review Panel was well aware that the information collected might not be able to reflect the entire sequence of events that had occurred, all actions that had been taken or all efforts made to help the families of the deceased children.

4.2 The review of child deaths that occurred in 2006 began in May 2008. With the lapse of time, the Review Panel fully understood that the recommendations made, which were based on information at the time of the incidents, might not be timely and improvement measures as well as policies might have already been put in place. This explains why the process of inviting responses on the recommendations, including updating and reporting on current service provisions, becomes an integral part of the review to promoting inter-disciplinary sharing of experiences in improvement measures and lessons learnt.

4.3 Owing to limited or insufficient information available for some of the cases (for instance, death of natural causes with autopsy waived due to request by family members), the Review Panel was mindful of not passing any comment on such cases.

4.4 Some service organisations had reservations in disclosing the case details and provided very basic information despite the assurance of confidentiality. On the other hand, the Review Panel appreciated that some organisations provided very detailed reports with recommendations for future improvement.

4.5 Some of the recommendations made by the Review Panel stemmed from the review of just one single case. With due respect to the uniqueness of every case and every family, the Review Panel understood that it might not be appropriate to generalise such recommendations to all cases. Likewise, the recommendations on improvement measures should not be considered as panacea to child fatality. However, it is hoped that they can help prevent child fatality when similar circumstances occurred in the future.

4.6 Owing to the variations in the comprehensiveness and depth of the information submitted to the Coroner's Court or provided by organisations concerned to the Review Panel, and that not all deceased children have attended school or received services from social welfare organisations from where their family background could be traced, this report is unable to provide comprehensive or detailed statistical data reflecting the social profiles of the deceased children.

5 OVERVIEW OF ALL CASES REVIEWED

As mentioned earlier in Chapter 3, Members of the Review Panel have divided themselves into sub-groups to review cases of different nature for specialisation and evening out of workload. Four groups review cases died of non-natural causes namely: suicide, traffic accidents, other accidents and other causes. The medical group reviews cases died of natural causes.

The readers will find that in this report, findings of cases died of traffic and other accidents are presented in aggregate under the same umbrella cause of "Accident". The overviews of review findings are presented in the following structure:

Section 5.1	All cases reviewed
Section 6.1	Cases died of non-natural causes
Section 6.2	Cases died of suicide
Section 6.3	Cases died of accidents
Section 6.4	Cases died of other causes
Section 6.5	Cases died of natural causes

5.1 Overview of All Child Death Cases

In the year 2006, among the mid-year population of 1,204,100, a total of 269 children aged under 18 died[1]. 109 child deaths had been reported to the Coroners[2]. The Review Panel has completed reviewing 107 of these cases while two cases were still pending completion of legal proceedings and not yet ready for review as at 30 April 2009. An overview of these 107 cases is in the below.

Total number of cases reviewed as at 30 April 2009:	**107**
Cases died of Non-natural causes:	46
Cases died of Natural causes:	61
Total number of cases still pending for review:	**2**

For this Chapter, Section 5.1 is an overview of the demographic data of the 107 cases reviewed by the Review Panel as at 30 April 2009. These data are based on available information gathered or reported for review from various sources. Section 5.2 is an account of the general observations of the Review Panel on the cases reviewed.

In the presentation of percentage of figures in tables in this report, there may be a slight discrepancy between the percentage of individual items and the total percentage as shown in the tables owing to rounding.

[1] Figures are from the Census and Statistics Department.
[2] Figure as confirmed with the Coroner's Court.

Table 5.1.1: No. of Cases by Cause of Death

Cause of Death	No. of Cases (%)
Non-natural Causes	46 (43.0%)
Natural Causes	61 (57.0%)
Total:	107 (100.0%)

Figure 5.1.1: No. of Cases by Cause of Death

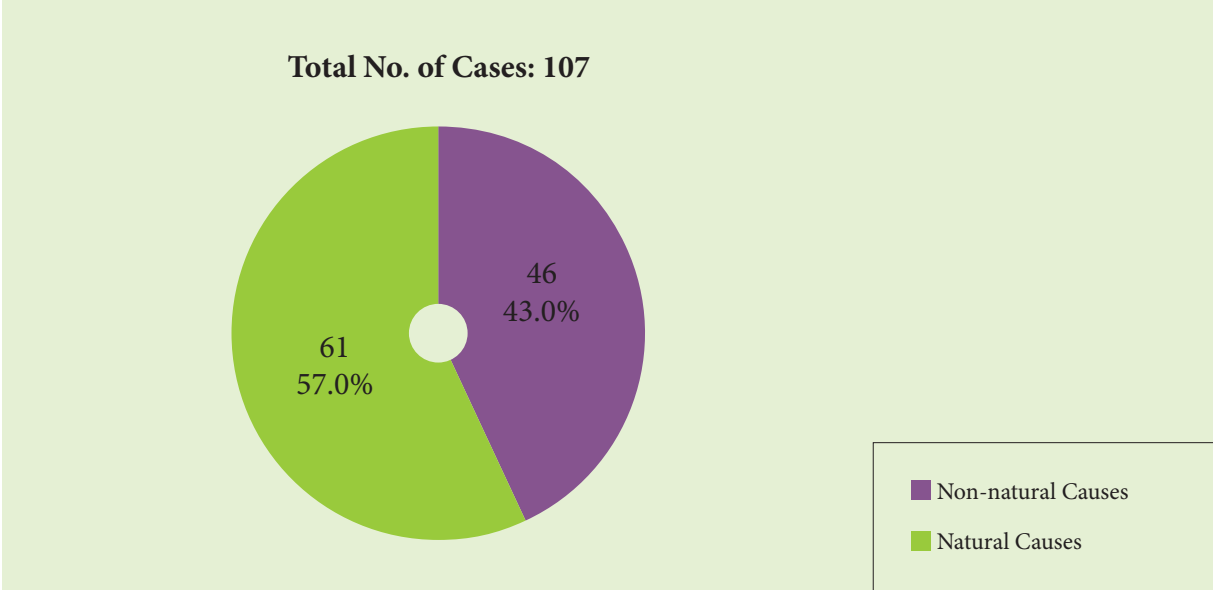


Table 5.1.2: No. of Cases by Cause of Death and Sex

Cause of Death	Sex (%)		Total (%)
	Female	Male	
Non-natural	18 (16.8%)	28 (26.2%)	46 (43.0%)
Natural	27 (25.2%)	34 (31.8%)	61 (57.0%)
Total:	45 (42.1%)	62 (57.9%)	107 (100.0%)

Figure 5.1.2: No. of Cases by Cause of Death and Sex

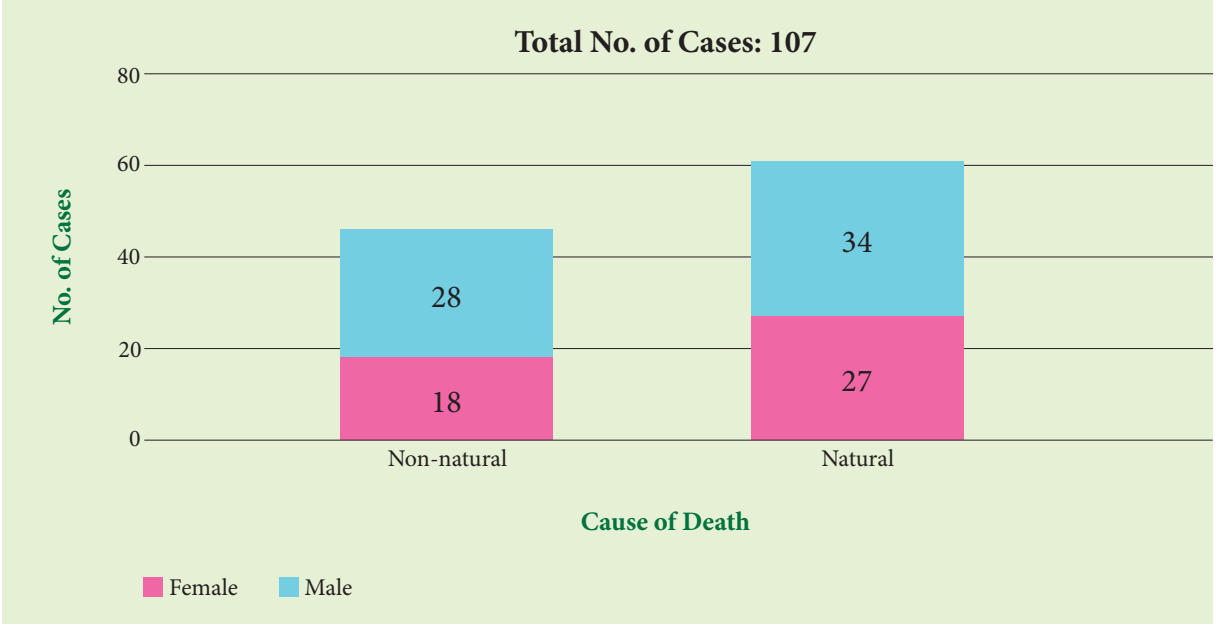


Table 5.1.3: No. of Cases by Age Group and Cause of Death

Age Group	Cause of Death (%)		Total (%)
	Non-natural	Natural	
< 1	5 (4.7%)	18 (16.8%)	23 (21.5%)
1 – 2	2 (1.9%)	8 (7.5%)	10 (9.4%)
3 – 5	1 (0.9%)	6 (5.6%)	7 (6.5%)
6 – 8	7 (6.5%)	3 (2.8%)	10 (9.4%)
9 – 11	5 (4.7%)	10 (9.4%)	15 (14.0%)
12 – 14	7 (6.5%)	11 (10.3%)	18 (16.8%)
15 – 17	19 (17.8%)	5 (4.7%)	24 (22.5%)
Total:	46 (43.0%)	61 (57.0%)	107 (100.0%)

Figure 5.1.3: No. of Cases by Age Group and Cause of Death

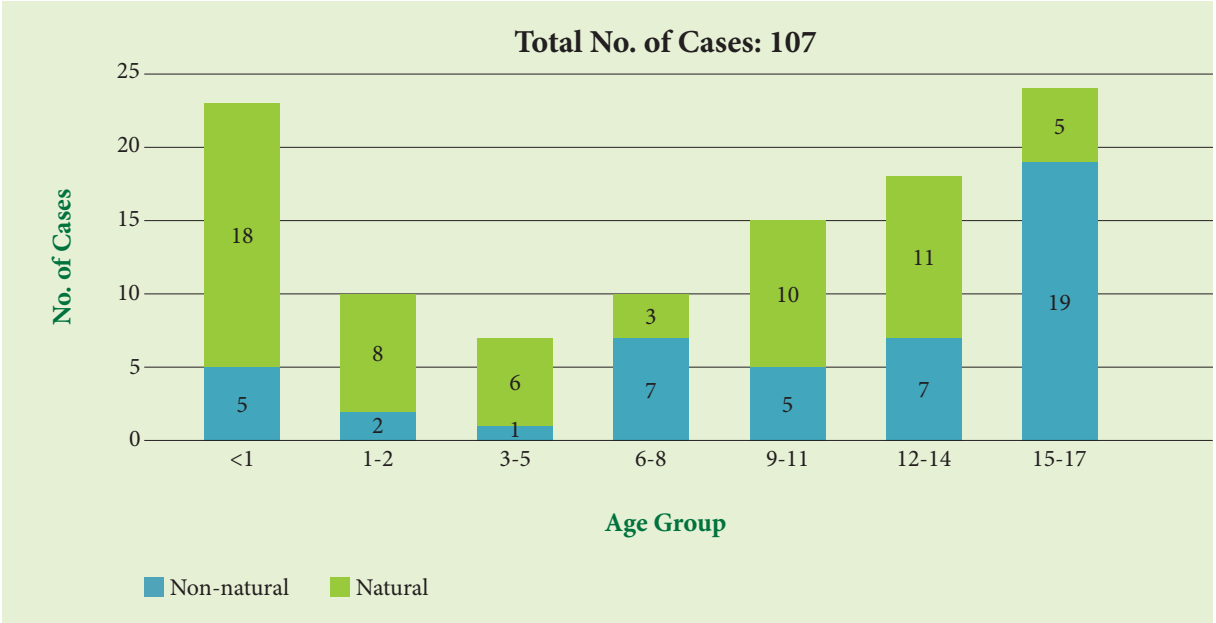


Table 5.1.4: No. of Cases by Age Group and Sex

Age Group	Sex (%)		Total (%)
	Female	Male	
< 1	13 (12.1%)	10 (9.4%)	23 (21.5%)
1 – 2	3 (2.8%)	7 (6.5%)	10 (9.4%)
3 – 5	3 (2.8%)	4 (3.7%)	7 (6.5%)
6 – 8	2 (1.9%)	8 (7.5%)	10 (9.4%)
9 – 11	7 (6.5%)	8 (7.5%)	15 (14.0%)
12 – 14	7 (6.5%)	11 (10.3%)	18 (16.8%)
15 – 17	10 (9.4%)	14 (13.1%)	24 (22.5%)
Total:	45 (42.1%)	62 (57.9%)	107 (100.0%)

Figure 5.1.4: No. of Cases by Age Group and Sex

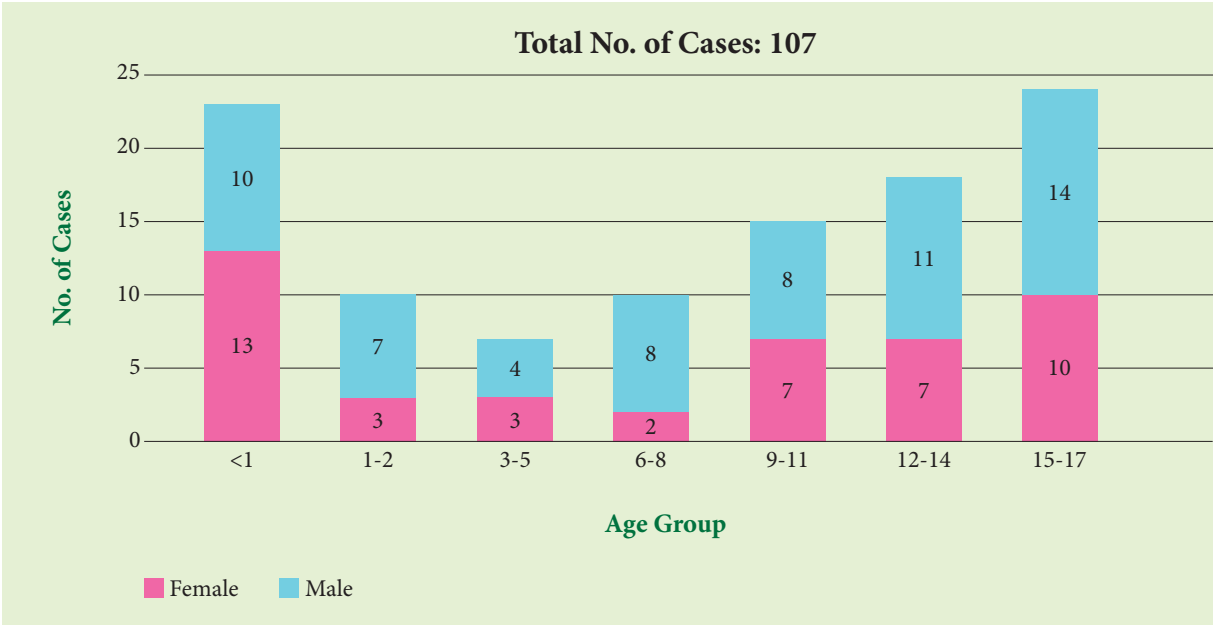


Table 5.1.5: No. of Cases by Nationality

Nationality	No. of Cases (%)
Chinese	99 (92.5%)
Non-Chinese	8 (7.5%)
Total:	107 (100.0%)

Figure 5.1.5: No. of Cases by Nationality

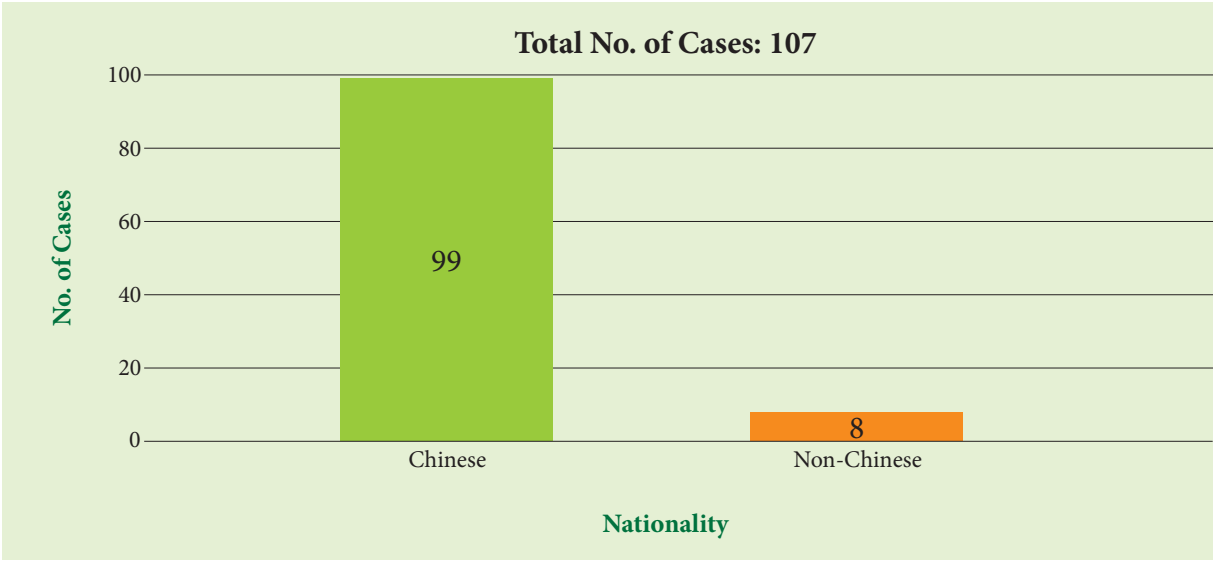
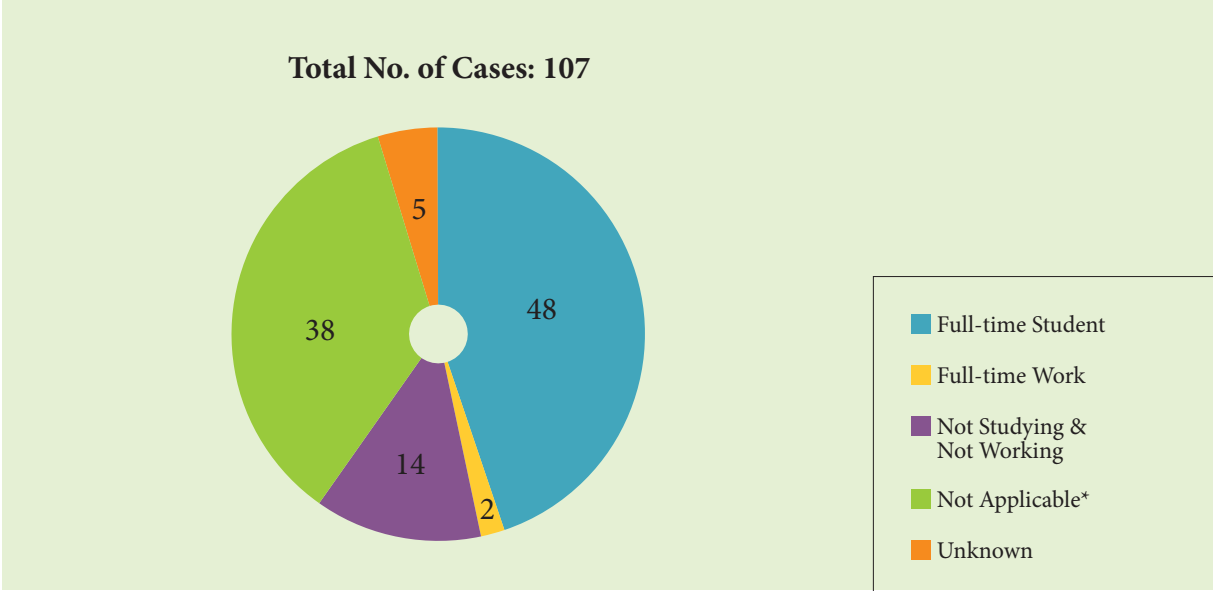


Table 5.1.6: Occupation of the Deceased Children

Occupation	No. of Cases (%)
Full-time Student	48 (44.9%)
Full-time Work	2 (1.9%)
Not Studying & Not Working	14 (13.1%)
Not Applicable*	38 (35.5%)
Unknown	5 (4.7%)
Total:	107 (100.0%)

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

Figure 5.1.6: Occupation of the Deceased Children



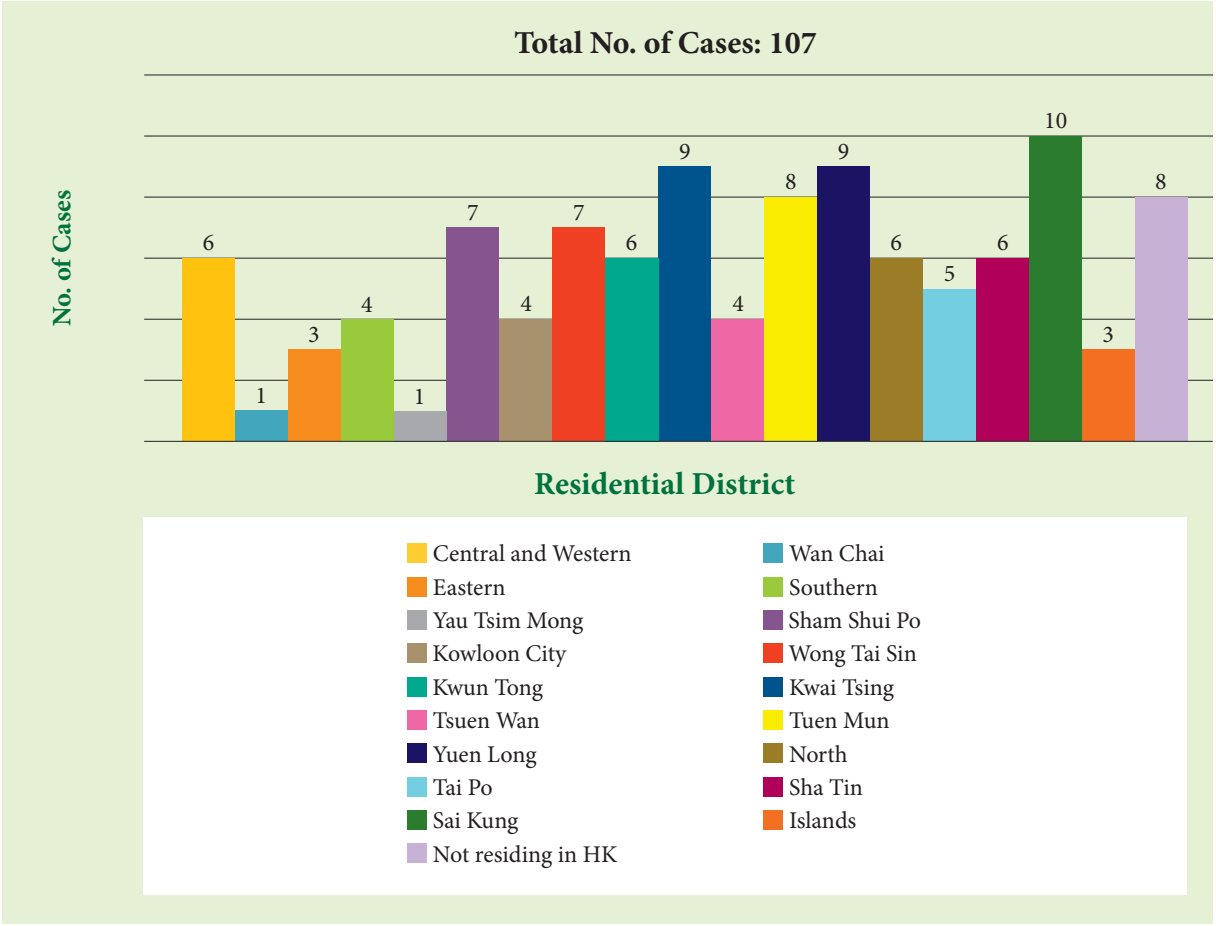
Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

Table 5.1.7: Residential District of the Deceased Children

Residential District	No. of Cases (%)
HONG KONG ISLAND	
Central and Western	6 (5.6%)
Wan Chai	1 (0.9%)
Eastern	3 (2.8%)
Southern	4 (3.7%)
KOWLOON	
Yau Tsim Mong	1 (0.9%)
Sham Shui Po	7 (6.5%)
Kowloon City	4 (3.7%)
Wong Tai Sin	7 (6.5%)
Kwun Tong	6 (5.6%)
NEW TERRITORIES	
Kwai Tsing	9 (8.4%)
Tsuen Wan	4 (3.7%)
Tuen Mun	8 (7.5%)
Yuen Long	9 (8.4%)
North	6 (5.6%)
Tai Po	5 (4.7%)
Sha Tin	6 (5.6%)
Sai Kung	10 (9.4%)
Islands	3 (2.8%)
OTHERS	
Not residing in HK	8 (7.5%)
Total:	107 (100.0%)

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

Figure 5.1.7: Residential District of the Deceased Children



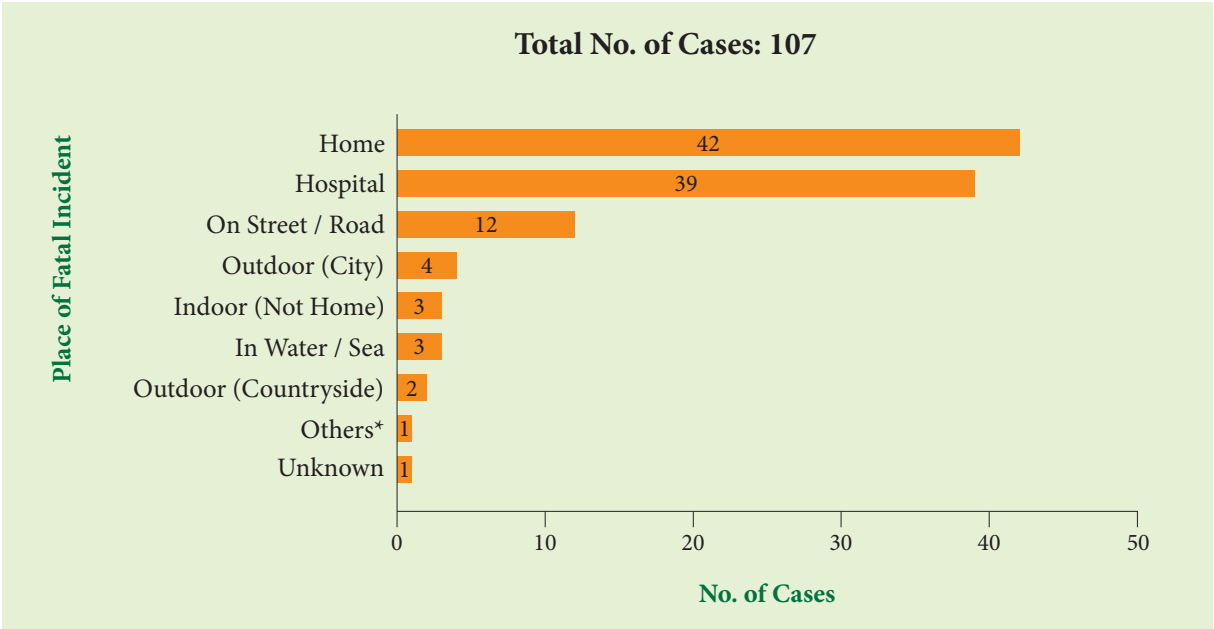
Classification of the residential districts above is according to the 18 districts in District Council / Constituency Area.

Table 5.1.8: Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	42 (39.3%)
Hospital	39 (36.4%)
On Street / Road	12 (11.2%)
Outdoor (City)	4 (3.7%)
Indoor (Not Home)	3 (2.8%)
In Water / Sea	3 (2.8%)
Outdoor (Countryside)	2 (1.9%)
Others*	1 (0.9%)
Unknown	1 (0.9%)
Total:	107 (100.0%)

Others: inside the lift in a building.*

Figure 5.1.8: Place of Fatal Incident



Others: inside the lift in a building.*

5.2 General Observations of the Review Panel

During review of the 107 child death cases occurring in 2006, the Review Panel has the following observations:

(a) In the year 2006, the child death rate of Hong Kong was 0.2 per 1000 population[3]. Compared with some foreign countries, the age-specific child death rates in Hong Kong were relatively low. No obvious difference in the child death rates among various districts in Hong Kong was observed;

(b) Love, care and attention from parents were of paramount importance to the growth and healthy development of children;

(c) High unpredictability of cases involving divorce and domestic violence;

(d) Caring and concerned parents may choose wrong and destructive means of child discipline;

(e) Importance of strengthening multi-disciplinary referral system within the same organisation to enhance service delivery for suicide cases;

(f) Strengthening of family support and family-based intervention was crucial for positive development of children;

(g) Importance of sensitivity on cultural differences in child care practice;

(h) Issue of adjustment and adaptation of new arrivals to Hong Kong has emerged in child death cases with different types of death causes, including suicide, accidents and assault cases;

(i) Mainstream or normal schooling seemed unable to meet the need of over-aged new arrival students with limited intelligence. Cultural difference and lack of positive engagement after dropping out from school had aggravated their maladjustment problems;

(j) The need to promote acceptance of schools and peers for students with special educational needs under the present policy of Integrated Education;

(k) Children's indulgence in computer games affected their schooling and family relationship negatively;

(l) Parents tend to over-estimate the self-care ability of their young children with special needs and under-estimate the risk of letting them go to school without supervision of an adult;

(m) Children, particularly teenagers, tend to over-estimate their own ability and under-estimate the risk of their actions; and

(n) The children died as pedestrians in traffic accidents have weak awareness towards road safety.

[3] Source: the Census and Statistics Department.

6 REVIEW FINDINGS, RECOMMENDATIONS AND RESPONSES

Introduction

This Chapter summarizes the findings, observations and recommendations made by the Review Panel after review and responses received from concerned organisations or departments.

The Review Panel has the following consideration in mind before recommendations were made according to gathered and available information:

(i) The recommendations are meant to improve the system rather than operation-oriented, such that the concerned organisation / department is left to decide on actual improvement measures appropriate to their function;

(ii) The observations and recommendations made by the Review Panel are suggestions on possibly missed opportunities and what could be done to enhance measures or services to protect our children or to ensure their safety. They should not be interpreted as panacea which, if applied, could stop the fatal incidents absolutely;

(iii) It is decided that the recommendations made are to be distributed to the involved or concerned organisations / departments and responses to be invited from them. This is based on the belief that lessons might have already been learnt and improved measures already in place even before the review or recommendations made and if such is the case, recognition and credit should be given to those organisations / departments;

(iv) It is also believed that sharing of recommendations made by the Review Panel, good practices identified, lessons learnt and services improved will help enhance child protection service systems. The Review Panel hoped to promote such kind of sharing and extend it to the public through its report to reinforce good practices and stimulate further multi-disciplinary collaboration and innovations; and

(v) The recommendations made and responses collected from concerned organisations / departments are grouped under different types of death in this report.

After recommendations have been made, they were distributed to the organisations or government departments concerned. The latter were invited to give responses, including updating of service improvement that have taken place since the occurrence of the fatal incidents and comments on the recommendations. These organisations and departments have been prepared that their responses, where appropriate, might be included in this report.

The Review Panel finds this process of updating service information, seeking views and obtaining of responses from different service organisations and departments very important because the review was conducted nearly two years after the occurrence of child deaths. This process could ensure fairness to the organisations or departments that have taken initiatives to make improvement to prevent similar incidents of child fatality. This process also turned out to have the effect of stimulating the practice of internal review and promoting inter-disciplinary and cross-sectoral exchange of views, which is in line with the objectives of the Pilot Project.

It is also very encouraging for the Review Panel to see that many of the updating or responses returned from organisations or departments concerned are accepting and positive towards the recommendations made and many improvement measures are already in place. Most of the respondents are committed in working together to better the child protection service system and welcomed the recommendations distributed to them and agreed to consider the suggestions of improvement not yet implemented in their future planning of services and training for helping professionals.

Even though some of the respondents may not agree with the recommendations, their comments help enhance our understanding towards their handling of the cases or their services. The Review Panel feels obliged to share different views and appeals for open discussion on such issues. Such an approach will contribute to a fair, reasonable and feasible manner to examine or improve the existing service systems.

Not all service organisations have given responses to the recommendations distributed to them. Some feel it not necessary to respond while others may not feel easy to comment without grasping the full picture of how the review is conducted, given that the Pilot Project is a new initiative.

In the following part of this Chapter, the recommendations of the Review Panel made and responses from different parties are presented under different types of death. Section 6.1 is an overview of all reviewed cases with non-natural death causes. Sections 6.2 through 6.4 describe findings of different non-natural causes, namely: suicide, accidents and other causes. Finally, Section 6.5 is an overview of cases died of natural causes.

Committed to protect personal data and privacy, and taking care not to arouse sentiment or traumatic feelings relating to the deaths of beloved children, the findings and recommendations are presented in aggregate and no details of any individual case will be described.

Although it is highly appreciated that many service organisations or departments concerned have given detailed updating of improvement measures that have taken place since occurrence of child fatal incidents, the Review Panel regrets that not all the details of the responses will be included due to the specific scope of this report, and the need to maintain confidentiality in case inclusion of the details will enable reader to identify a particular case.

6.1 Overview of Cases died of Non-natural Causes

Table 6.1.1: No. of Cases by Age Group and Sex

Age Group	Sex (%)		Total (%)
	Female	Male	
< 1	2 (4.4%)	3 (6.5%)	5 (10.9%)
1 – 2	0 (0.0%)	2 (4.4%)	2 (4.3%)
3 – 5	1 (2.2%)	0 (0.0%)	1 (2.2%)
6 – 8	2 (4.4%)	5 (10.9%)	7 (15.2%)
9 – 11	3 (6.5%)	2 (4.4%)	5 (10.9%)
12 – 14	4 (8.7%)	3 (6.5%)	7 (15.2%)
15 – 17	6 (13.0%)	13 (28.3%)	19 (41.3%)
Total:	18 (39.1%)	28 (60.9%)	46 (100.0%)

Figure 6.1.1: No. of Cases by Age Group and Sex

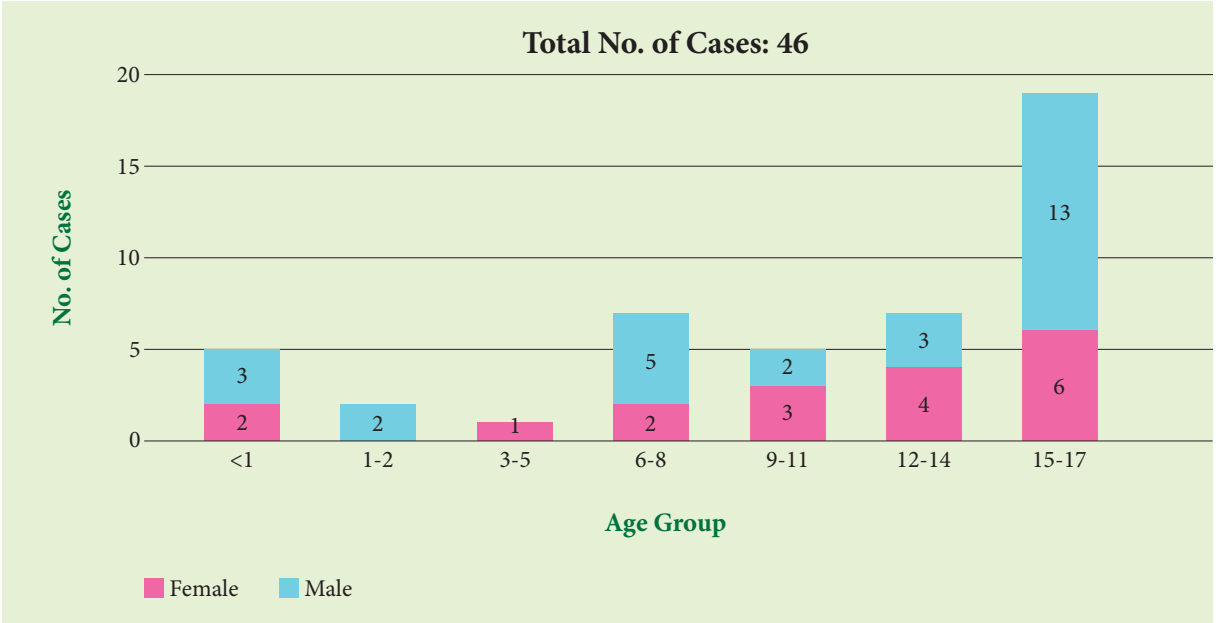
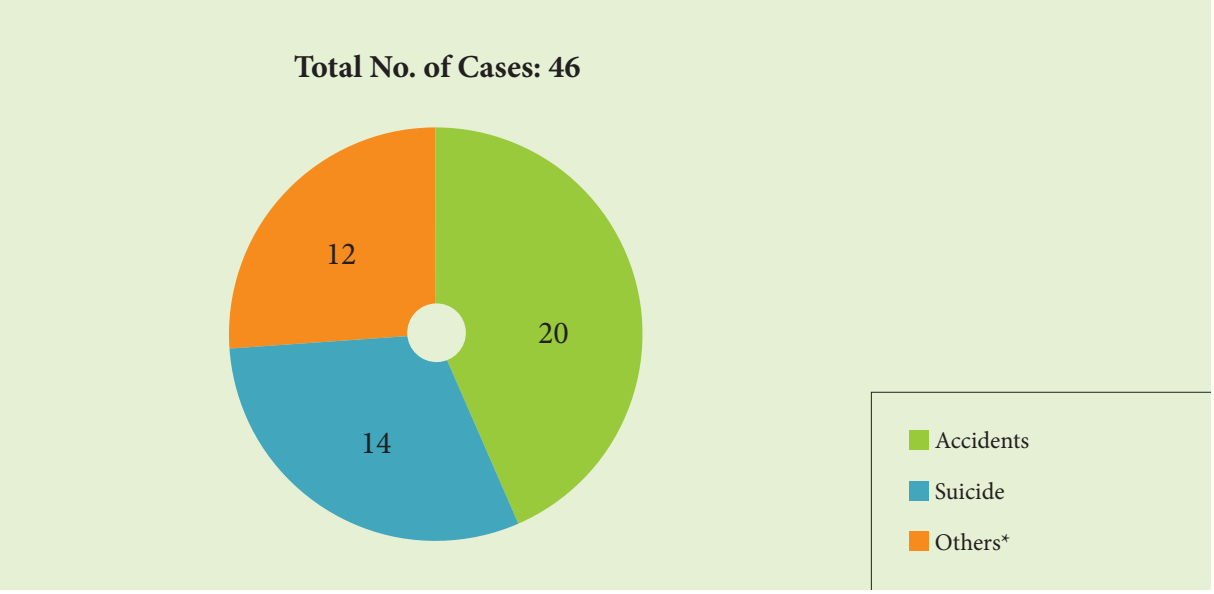


Table 6.1.2: No. of Cases by Cause of Death

Cause of Death	No. of Cases (%)
Accidents	20 (43.5%)
Suicide	14 (30.4%)
Others*	12 (26.1%)
Total:	46 (100.0%)

Others: include Assault, Medical Complications and Unknown.*

Figure 6.1.2: No. of Cases by Cause of Death



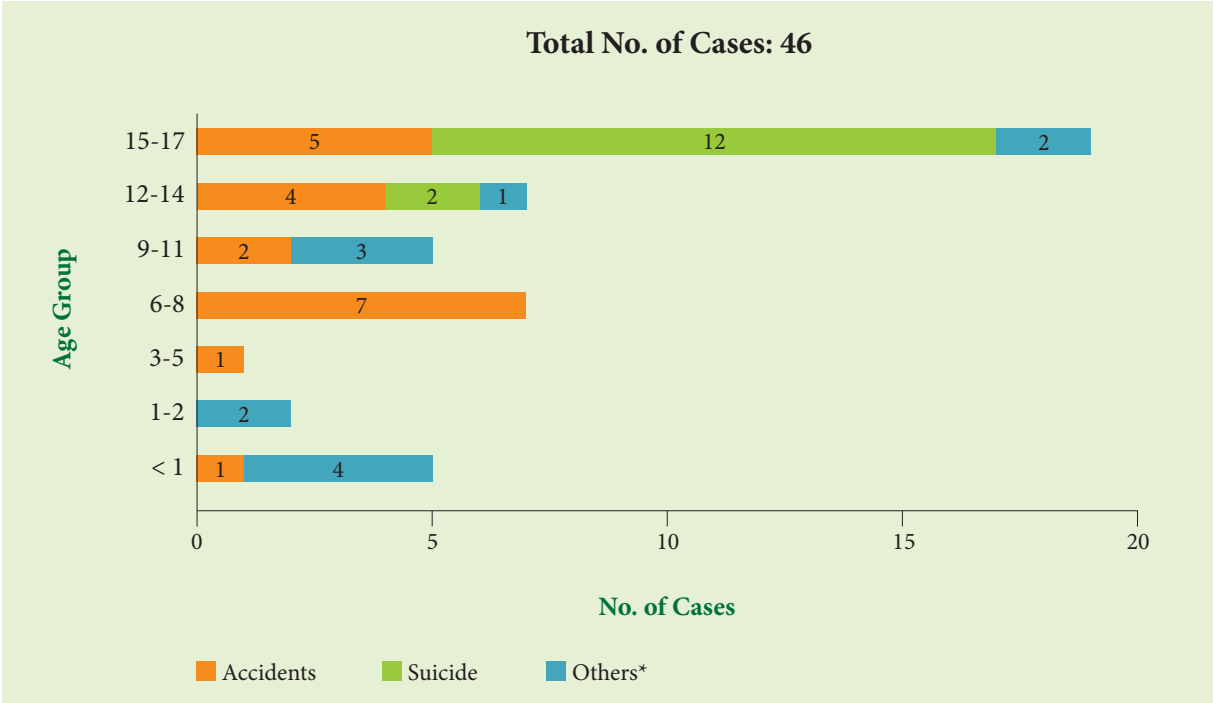
Others: include Assault, Medical Complications and Unknown.*

Table 6.1.3: No. of Cases by Age Group and Cause of Death

Age Group	Cause of Death			Total (%)
	Accident	Suicide	Others*	
< 1	1	0	4	5 (10.9%)
1 – 2	0	0	2	2 (4.3%)
3 – 5	1	0	0	1 (2.2%)
6 – 8	7	0	0	7 (15.2%)
9 – 11	2	0	3	5 (10.9%)
12 – 14	4	2	1	7 (15.2%)
15 – 17	5	12	2	19 (41.3%)
Total (%):	20 (43.5%)	14 (30.4%)	12 (26.1%)	46 (100.0%)

Others: include Assault, Medical Complications and Unknown.*

Figure 6.1.3: No. of Cases by Age Group and Cause of Death



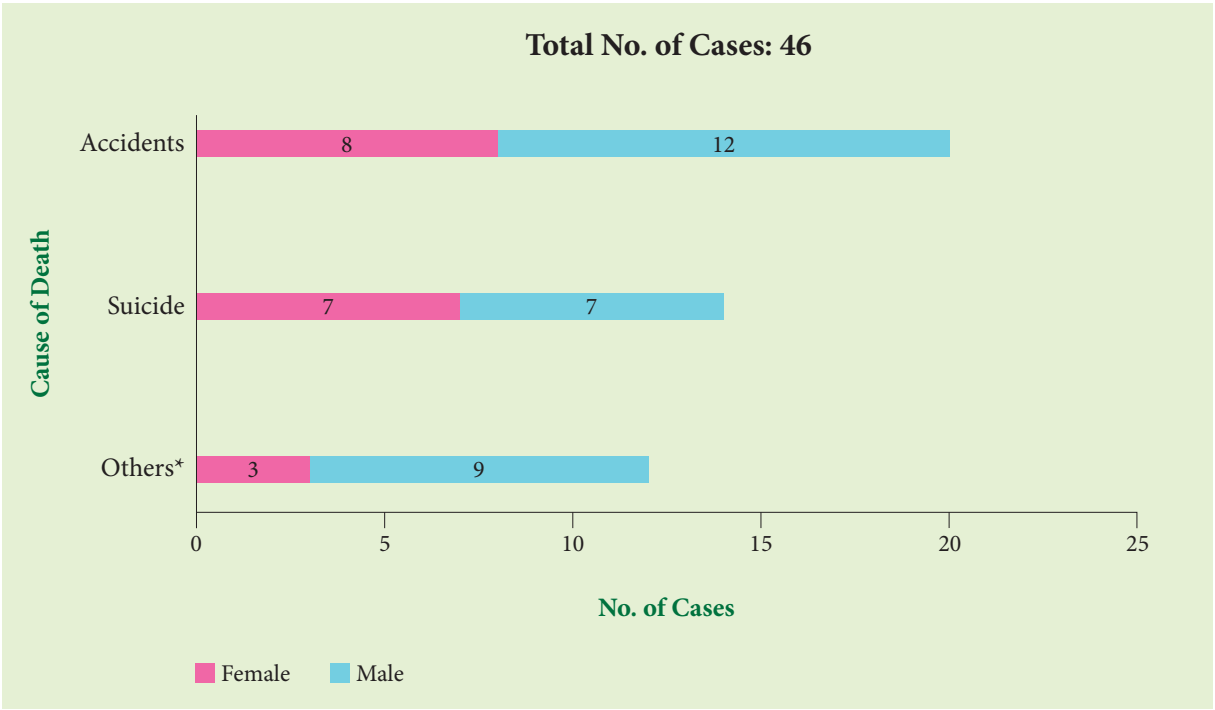
Others: include Assault, Medical Complications and Unknown.*

Table 6.1.4: No. of Cases by Cause of Death and Sex

Cause of Death	Sex (%)		Total (%)
	Female	Male	
Accidents	8 (17.4%)	12 (26.1%)	20 (43.5%)
Suicide	7 (15.2%)	7 (15.2%)	14 (30.4%)
Others*	3 (6.5%)	9 (19.6%)	12 (26.1%)
Total:	18 (39.1%)	28 (60.9%)	46 (100.0%)

Others: include Assault, Medical Complications and Unknown.*

Figure 6.1.4: No. of Cases by Cause of Death and Sex



Others: include Assault, Medical Complications and Unknown.*

Table 6.1.5: No. of Cases by Nationality

Nationality	No. of Cases (%)
Chinese	41 (89.1%)
Non-Chinese	5 (10.9%)
Total:	46 (100.0%)

Figure 6.1.5: No. of Cases by Nationality

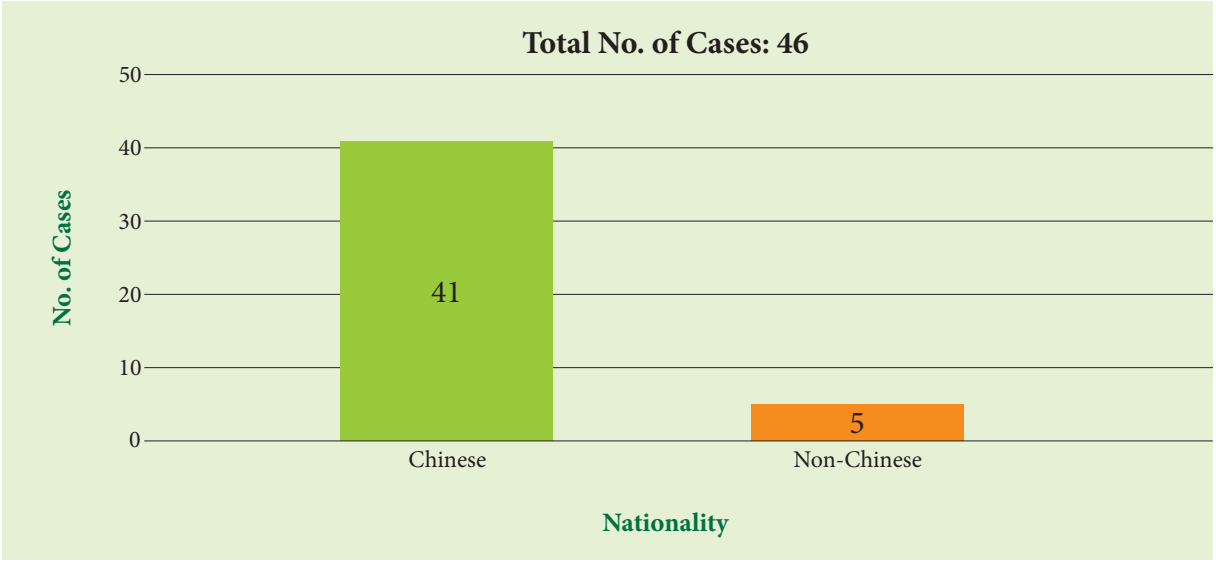
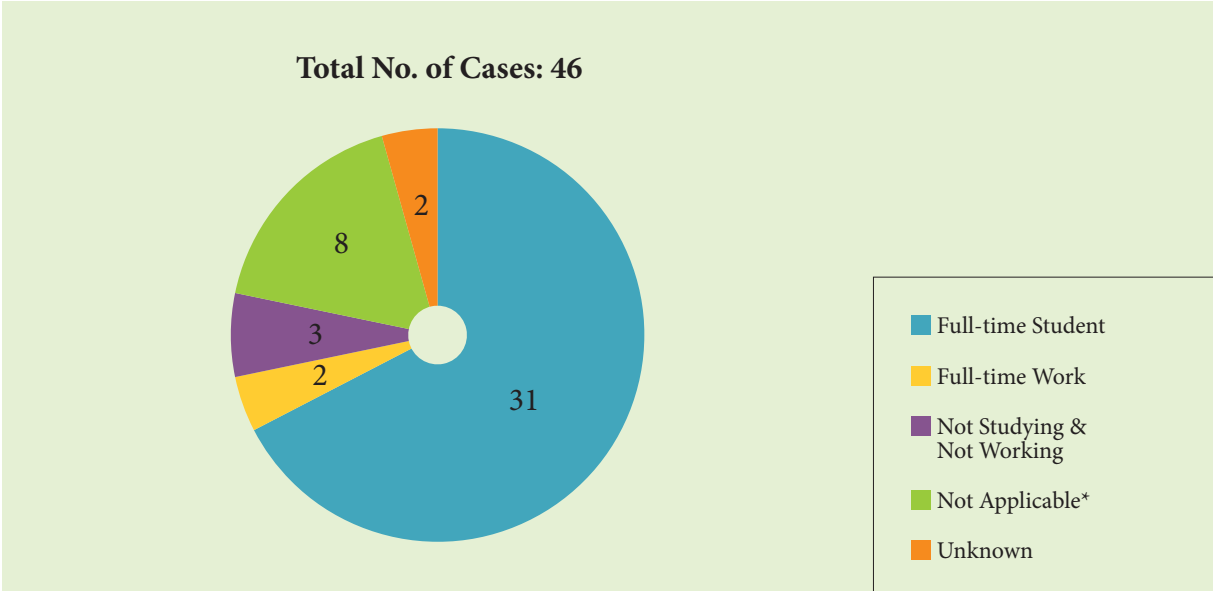


Table 6.1.6: Occupation of the Deceased Children

Occupation	No. of Cases (%)
Full-time Student	31 (67.4%)
Full-time Work	2 (4.3%)
Not Studying & Not Working	3 (6.5%)
Not Applicable*	8 (17.4%)
Unknown	2 (4.3%)
Total:	46 (100.0%)

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

Figure 6.1.6: Occupation of the Deceased Children



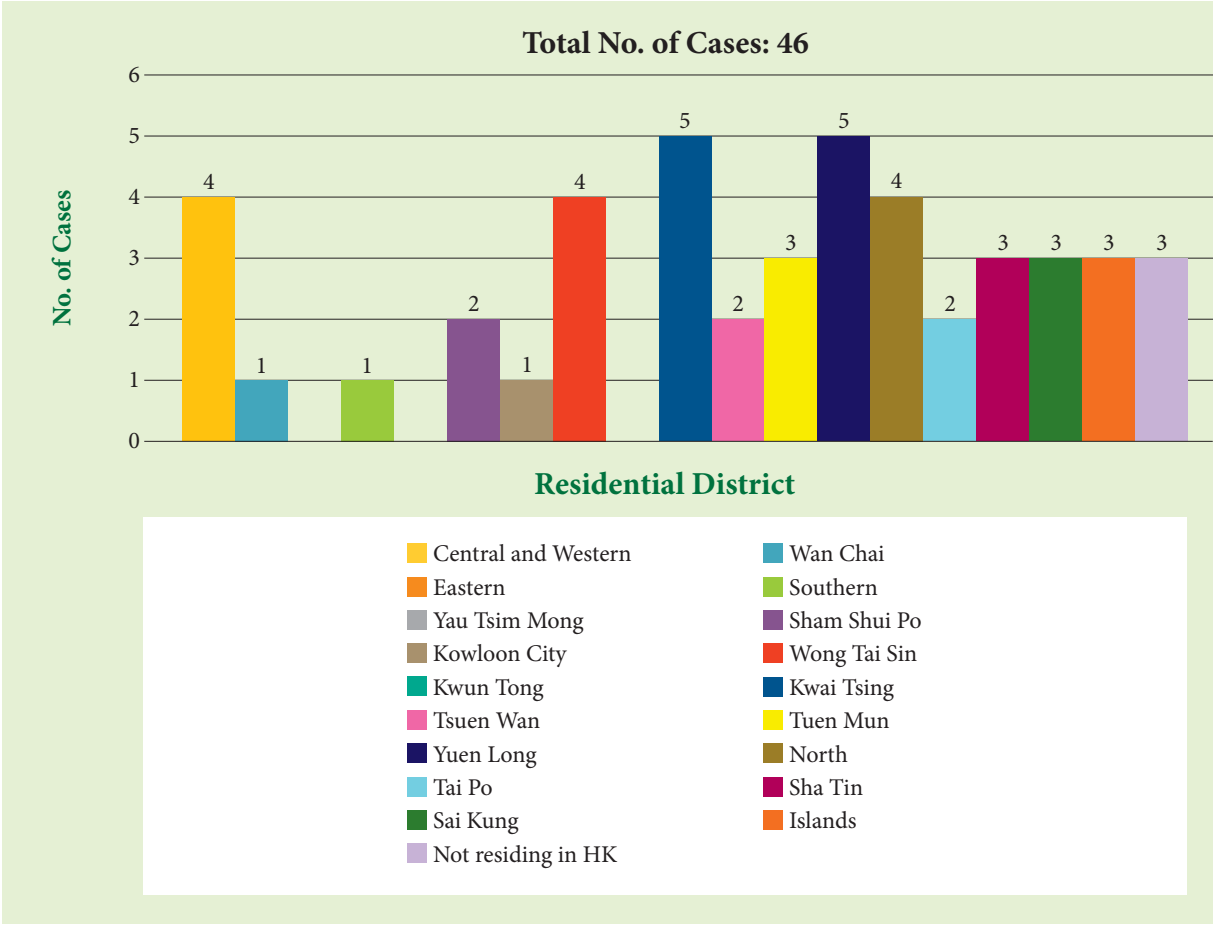
Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

Table 6.1.7: Residential District of the Deceased Children

Residential District	No. of Cases (%)
HONG KONG ISLAND	
Central and Western	4 (8.7%)
Wan Chai	1 (2.2%)
Eastern	0 (0.0%)
Southern	1 (2.2%)
KOWLOON	
Yau Tsim Mong	0 (0.0%)
Sham Shui Po	2 (4.3%)
Kowloon City	1 (2.2%)
Wong Tai Sin	4 (8.7%)
Kwun Tong	0 (0.0%)
NEW TERRITORIES	
Kwai Tsing	5 (10.9%)
Tsuen Wan	2 (4.3%)
Tuen Mun	3 (6.5%)
Yuen Long	5 (10.9%)
North	4 (8.7%)
Tai Po	2 (4.3%)
Sha Tin	3 (6.5%)
Sai Kung	3 (6.5%)
Islands	3 (6.5%)
OTHERS	
Not residing in HK	3 (6.5%)
Total:	46 (100.0%)

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

Figure 6.1.7: Residential District of the Deceased Children



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

Table 6.1.8: Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Home	23 (50.0%)
On Street / Road	12 (26.1%)
Hospital	3 (6.5%)
In Water / Sea	3 (6.5%)
Outdoor (City)	3 (6.5%)
Outdoor (Countryside)	1 (2.2%)
Indoor (Not Home)	0 (0.0%)
Others	0 (0.0%)
Unknown	1 (2.2%)
Total:	46 (100.0%)

Figure 6.1.8: Place of Fatal Incident

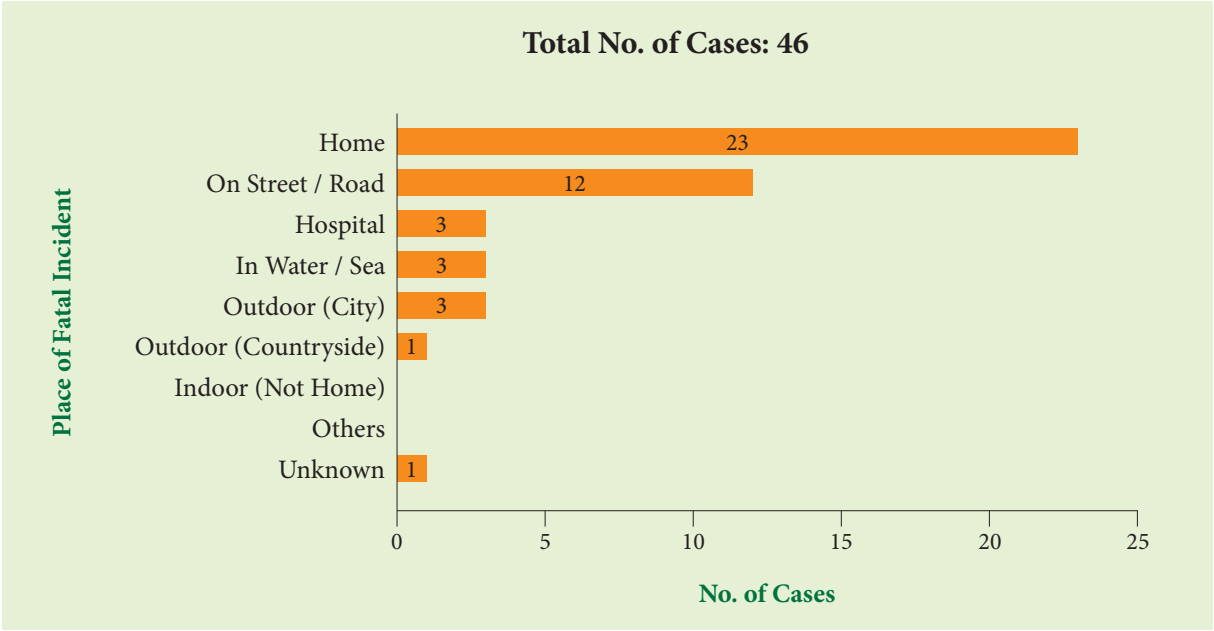
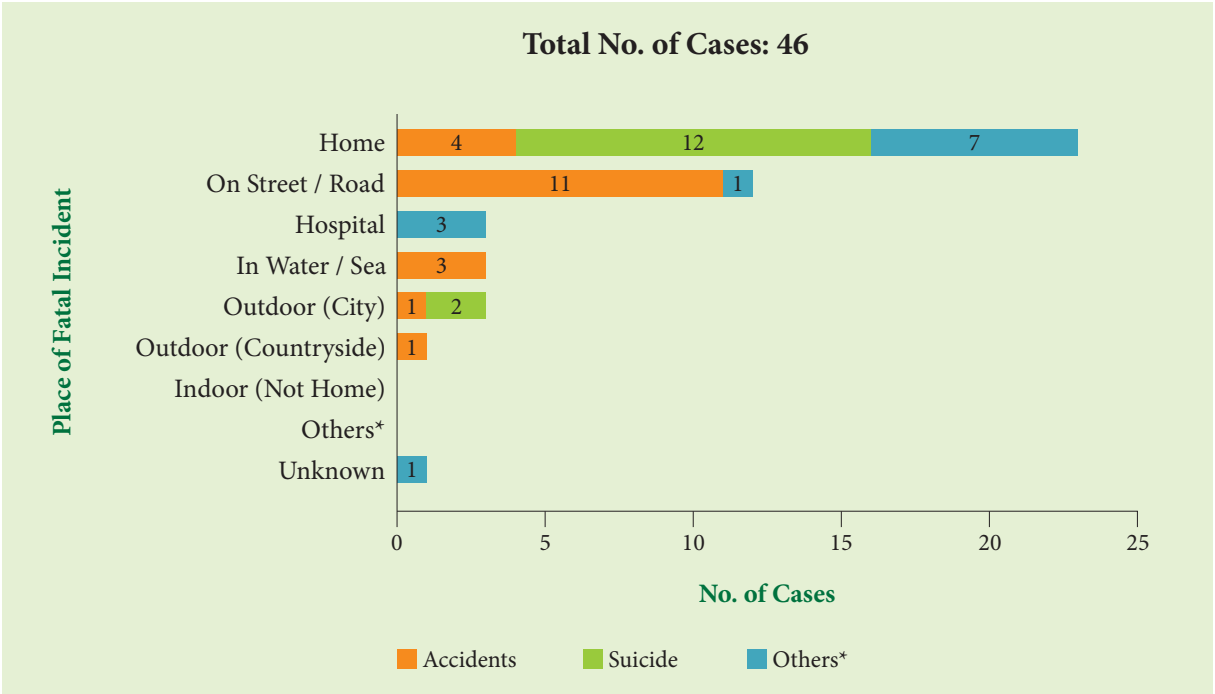


Table 6.1.9: No. of Cases by Place of Fatal Incident and Cause of Death

Place of Fatal Incident	Cause of Death			Total (%)
	Accident	Suicide	Others*	
Home	4	12	7	23 (50.0%)
On Street / Road	11	0	1	12 (26.1%)
Hospital	0	0	3	3 (6.5%)
In Water / Sea	3	0	0	3 (6.5%)
Outdoor (City)	1	2	0	3 (6.5%)
Outdoor (Countryside)	1	0	0	1 (2.2%)
Indoor (Not Home)	0	0	0	0 (0.0%)
Others*	0	0	0	0 (0.0%)
Unknown	0	0	1	1 (2.2%)
Total:	20	14	12	46 (100.0%)

Others: include Assault, Medical Complications and Unknown.*

Figure 6.1.9: No. of Cases by Place of Fatal Incident and Cause of Death



Others: include Assault, Medical Complications and Unknown.*

6.2 Overview of Cases Died of Suicide

Table 6.2.1: No. of Cases by Age Group and Sex

Age Group	Sex (%)		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	0 (0.0%)	0 (0.0%)	0 (0.0%)
12 – 14	2 (14.3%)	0 (0.0%)	2 (14.3%)
15 – 17	5 (35.7%)	7 (50.0%)	12 (85.7%)
Total:	7 (50.0%)	7 (50.0%)	14 (100.0%)

Figure 6.2.1: No. of Cases by Age Group and Sex

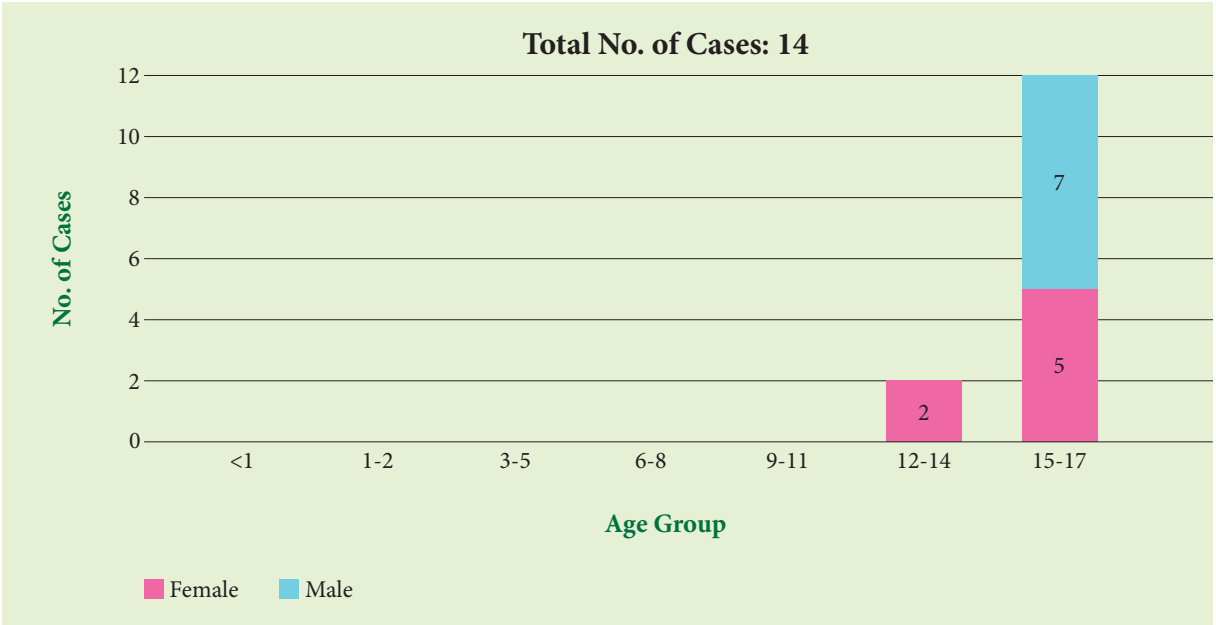


Table 6.2.2: Occupation of the Deceased Children

Occupation	No. of Cases (%)
Full-time Student	10 (71.4%)
Full-time Work	1 (7.1%)
Not Studying & Not Working	2 (14.3%)
Not Applicable*	0 (0.0%)
Unknown	1 (7.1%)
Total:	14 (100.0%)

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

Figure 6.2.2: Occupation of the Deceased Children

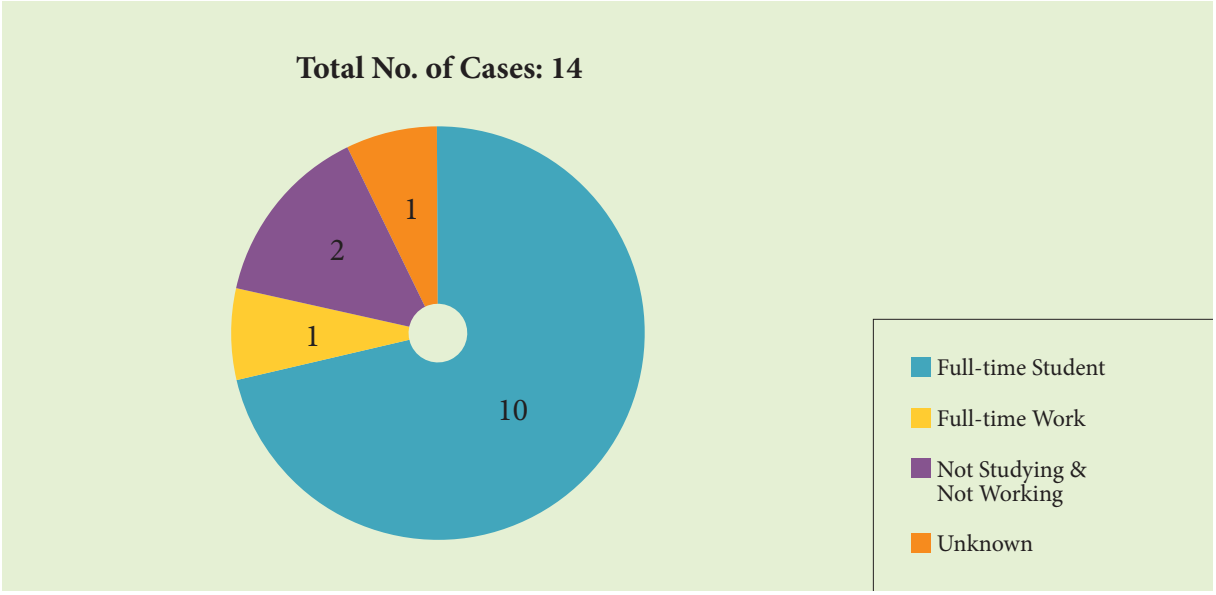


Table 6.2.3: Means of Suicide

Means of Committing Suicide	No. of Cases (%)
Jumping from height	13 (92.9%)
Gas poisoning	1 (7.1%)
Total:	14 (100.0%)

Figure 6.2.3: Means of Suicide

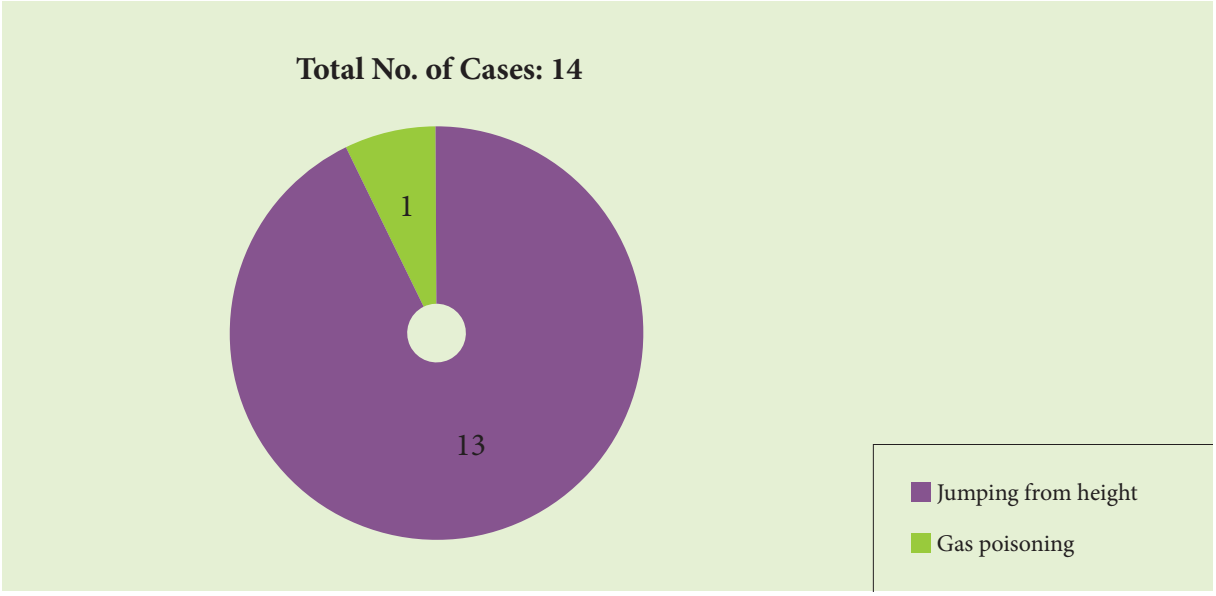
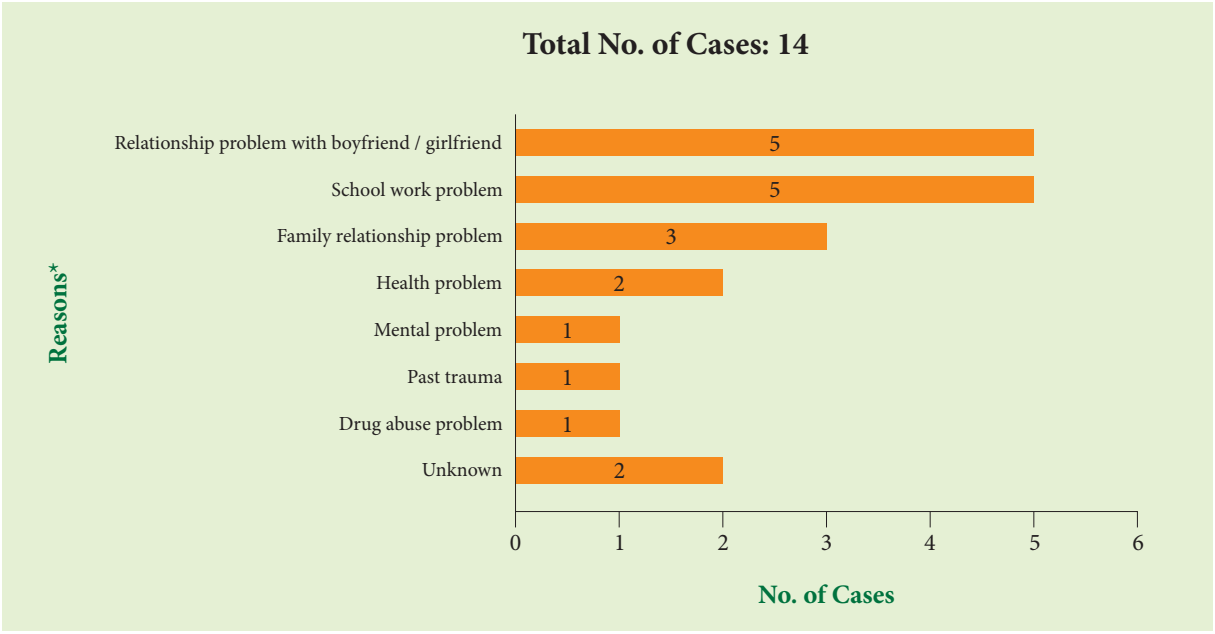


Table 6.2.4: Reasons of Committing Suicide

Reasons* of Committing Suicide	No. of Cases (%)
Relationship problem with boyfriend / girlfriend	5 (35.7%)
School work problem	5 (35.7%)
Family relationship problem	3 (21.4%)
Health problem	2 (14.3%)
Mental problem	1 (7.1%)
Past trauma	1 (7.1%)
Drug abuse problem	1 (7.1%)
Unknown	2 (14.3%)
Total:	14

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

Figure 6.2.4: Reasons of Committing Suicide



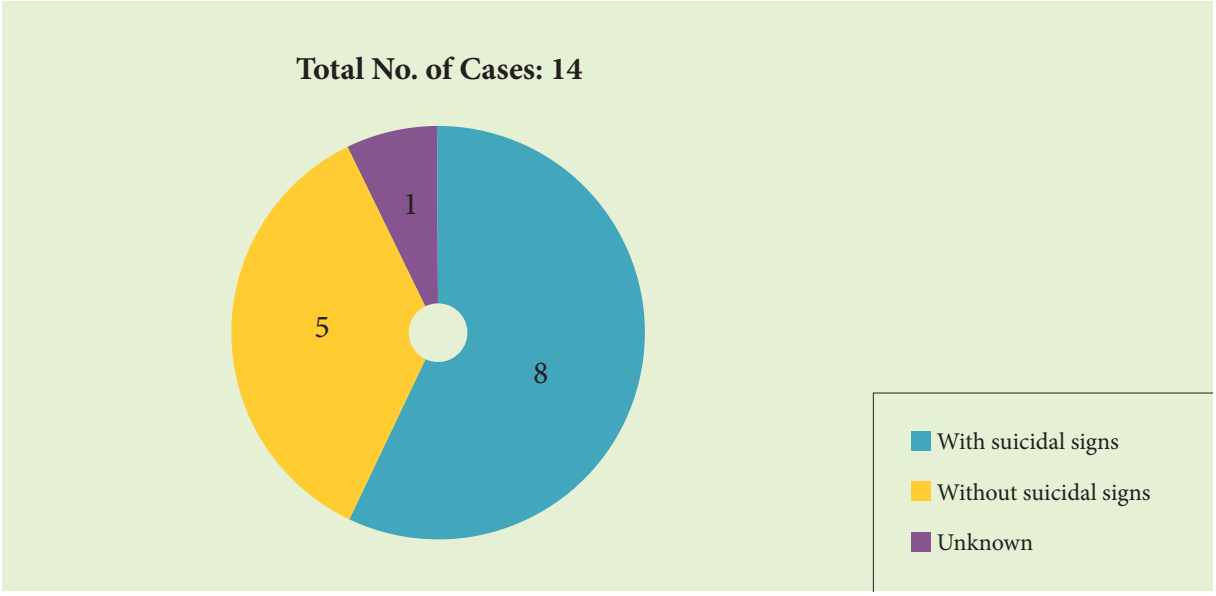
* *Multiple reasons were allowed.*
(The reasons were identified in the police death investigation reports of these cases.)

Table 6.2.5: No. of Cases with Identified Suicidal Signs

Presence of Suicidal Signs*	No. of Cases (%)
With suicidal signs	8 (57.1%)
Without suicidal signs	5 (35.7%)
Unknown	1 (7.1%)
Total:	14 (100.0%)

Signs: include leaving suicidal notes; verbal expression / threatening of suicidal intention and past history of suicidal attempts. (The signs were identified through police investigation report.)*

Figure 6.2.5: No. of Cases with Identified Suicidal Signs



Signs: include leaving suicidal notes; verbal expression / threatening of suicidal intention and past history of suicidal attempts. (The signs were identified through police investigation report.)*

6.2.1 General Observations

Fourteen children gave up their lives by committing suicide in the year 2006.

Table and Figure 6.2.1 show that out of the 14 cases, the number of male (N=7) and the number of female (N=7) are the same and no sex difference is observed. All the suicide child death cases fall into the age range between 12 to 17 years old which belongs to the adolescence stage of development. The age group 15 – 17 has the higher number of child deaths of suicide (N=12) while the other two cases were aged 12 – 14.

Table and Figure 6.2.2 show that before they died, 10 out of these 14 children were full-time students; one worked full-time; two were neither studying nor working while the occupation of one child was unknown.

Table and Figure 6.2.3 show that jumping from height was the dominant means of committing suicide and 13 out of the 14 deceased children had chosen this means to end their lives.

Table and Figure 6.2.4 show that both relationship problem with boyfriend or girlfriend (N=5) and problems in school work (N=5) were main reasons accounting for suicidal ideation and attempts of these 14 deceased children.

Table and Figure 6.2.5 show that out of the 14 suicide cases, eight cases were identified to have different signs of suicidal intent before the deceased children ended their lives.

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

(i) Four out of 14 deceased children committed suicide around festive seasons, such as New Year and Valentine's Day;

(ii) Currently, there is no official statistics on student suicide under the age of 18; and

(iii) Before or during the occurrence of four out of these 14 suicide cases, and in 10 out of the 20 accident cases reviewed, the peer or siblings of the deceased children were present or aware of the fatal incidents and such experience could be traumatic for them.

6.2.2 Recommendations and Responses for Cases Died of Suicide

Recommendation 1

To consider improvement measures to ensure timely referral between medical unit and medical social service unit within hospital.

Updating / Responses

Hospital concerned
Social Welfare Department:
Both reported that the intra-hospital referral mechanism had been improved in the concerned hospital since September 2008 so that timely service could be rendered to needy clients.

The Hospital Authority:
Reported that all Accident and Emergency Departments of Hospital Authority hospitals will ensure timely referral to relevant clinical specialties and/or medical social services unit so that timely service could be rendered to needy patients.

Recommendation 2

(i) Helping professionals should take note of possible denial of suicidal ideation by suicidal person and connect them with professional counsellors immediately through available means as far as possible once they are identified to have suicidal threat;

(ii) To explore ways to support school social workers to handle resistant adolescent youths with uncooperative parents; and

(iii) To enhance education to the public to encourage people with suicidal intent and their friends and relatives to seek help from professionals instead of covering up such intent in front of the helping parties.

Updating / Responses

The Hong Kong Police Force:

(i) Has provided relevant training and procedural instructions to frontline officers for handling attempted suicide reports;

(ii) Will remind police officers of possible denial of suicidal ideation; and

(iii) Will explore better detection techniques on identifying false denial in future training.

School Social Work Service Organisation Concerned:

(i) Has prepared and uploaded checklists on stress, depression, suicidal risk and crisis intervention manual to intranet for staff's reference;

(ii) Has enhanced risk assessment and referral for clinical psychological service for cases;

(iii) Has enhanced peer support system; and

(iv) Suggested more life education programmes and announcement in the public interest to encourage people to seek help through various sources.

Social Welfare Department:

(i) School social workers would closely collaborate with school / supporting personnel and other professions to mobilize various welfare and community resources to render timely and appropriate assistance to needy student;

(ii) Has allotted resources for publicizing anti-suicidal messages, promoting positive life values and encouraging seeking professional help; and

(iii) Has supported non-governmental organisations rendering school social work service to implement the "Positive Adolescent Training through Holistic Social Programmes to Adulthood: A Jockey Club Youth Enhancement Scheme" jointly organised with the Education Bureau and five universities promoting students' positive values, enhancing their resilience / coping against adversities and life stresses.

Education Bureau:

(i) Has been promoting the Whole School Approach under which all teachers and school social workers should collaborate in helping students with problems; and

(ii) Attaches great importance to enhancing students' ability to cope with adversity and respect for life through life education with different means.

Recommendation 3

To revisit the policy of Integrated Education for students with special educational needs with consideration of aspects including overall need assessment for students transferring from special to ordinary school; guidance to students and parents involved in decision-making on transfer; continuous school work and emotional support for the students and strengthening of co-intervention and collaboration among involved professionals for students decided on transfer.

Updating / Responses

Education Bureau:

(i) It has been the prevailing practice that teachers, specialists (i.e. speech therapists, educational psychologists) and school social workers of special schools would assess the educational and social needs of students before recommending a particular student for transfer. In the assessment process, the student and the parents should have been consulted and their concerns taken into consideration before making the recommendation or endorsing the parents' choice;

(ii) Teachers and social workers in special schools have the expertise in assessing the communication, educational and psycho-social needs of the students for consideration of transfer to ordinary schools. Whenever appropriate, they could also seek advice from the school-based psychologist and / or relevant audiologists / speech therapists / inspectors of the Bureau. They are the most suitable persons to continue to carry out the "overall assessment";

(iii) Will remind special schools and relevant specialists / inspectors of the Bureau to conduct interviews with parents to go through assessment findings and help them make an informed decision through careful and detailed considerations;

(iv) As a standing practice, when students with special educational needs are transferring out, ordinary and special schools should (after obtaining parent consent) send relevant background information (including professional assessment reports and student progress reports) to the next school and liaise with the other school to facilitate follow-up support for the student. The specialists / inspectors of the Bureau will provide back-end support to the ordinary schools;

(v) The "Operation Guide for Schools on Whole School Approach to Integrated Education (2008)" advises schools to adopt a Whole School Approach to catering for students with special educational needs and spells out that ordinary schools are to set up a Student Support Team to plan, coordinate and review the student support measures;

(vi) In supporting schools in implementing Integrated Education, government provides additional resources for schools. There are also comprehensive services embracing identification, assessment, intervention and support, such as teacher training, professional support and production of resource materials;

(vii) Hearing impaired students in ordinary schools are also supported under the Enhanced Support Service, resource teachers provide school visits and advise ordinary school teachers on the effective use of the amplification system, differentiated teaching strategies, social skills training and communication strategies to support the students. They also organise school-based or district-based training for the ordinary school personnel on need basis;

(viii) Has published the "Catering for Student Differences – Indicators for Inclusion" since 2004 to assist schools to conduct systematic planning and self-evaluation of the school policy, culture and practices in catering for student differences; and

(ix) A 5-year teacher professional development framework on Integrated Education was launched in the 2007/2008 school year to build up teachers' capacity in catering for students with special educational needs and to enhance staff collaboration in supporting such students.

Social Welfare Department:
Will remind school social workers to closely collaborate with the personnel / supporting personnel from the Education Bureau to support students with special educational needs and their family members to enhance their adjustment and facilitate their better integration into ordinary schools.

Recommendation 4

Proactive and early intervention, including prompt and accurate assessment for new arrival children suspected to have limited intelligence or special educational needs and intensive counselling for families with such children.

Updating / Responses

Education Bureau:
(i) Full-time Initiation Programme is offered to newly arrived children. Those entering mainstream school direct are provided with a 60-hour Induction Programme. Public sector schools admitting these children will be given a School-based Support Scheme Grant for integration programmes;

(ii) Has reminded schools to optimize the use of available resources in catering for students with learning and / or behaviour difficulties regularly; and

(iii) Has established an Early Identification and Intervention Mechanism to prevent deterioration of students with special educational needs and to support them. Should the case warrant further assessment, follow-up service will be provided by specialist such as educational psychologists.

Social Welfare Department:

(i) The 61 Integrated Family Service Centres and two Integrated Services Centres over the territory provide preventive, supportive and therapeutic services for individuals and families in need, including new arrival youths and their families, through different activities. These centres also organise groups or programmes specifically for new arrivals to facilitate their adjustment and integration to the community;

(ii) Has been funding the International Social Service Hong Kong Branch (ISS) to operate the Cross-boundary and Inter-country Casework Service to help new arrival individuals / families and network those having difficulties to mainstream / community services for early identification of problems and timely intervention; and

(iii) Has linked up its Departmental Hotline and the 'New Arrivals Connect Service' of ISS in July 2009 for tailor-made, targeted advice / services to enhance services for new arrivals.

Recommendation 5

For students who experienced academic failure in schools with good average result, more parental support and supportive service to facilitate their adjustment are required.

Updating / Responses

Education Bureau:

Has reminded schools through guidelines and seminar to refer students with learning and emotional difficulties to the school guidance team or the school social workers for counselling service to support under-performed students.

School Concerned:

(i) Had conducted a review immediately after the suicide incident in 2006;

(ii) Has taken improvement measures in providing service and assistance to under-performed students who have to repeat class in an early stage since September 2006; and

(iii) Enhancement of service system within school from remedial to preventive approach including early detection of students at-risk; support by peers with specific attention given to 'quiet' students; promotion of students' positive attitude towards life and building up their resilience towards adversities and referral to school social worker to needed services.

The Review Panel appreciated the reflective attitude of the school concerned and the promptness, width and depth of the interview review conducted. This good practice is highlighted for sharing among professionals working with students.

Recommendation 6

Flexible means to be made available in the education system to cater for new arrival children with special educational needs or maladjustment to mainstream schooling.

Updating / Responses

Education Bureau:

Advocates the adoption of the Whole School Approach to catering for student diversity through a 3-tier support model as differentiated by the needs of the students regardless of whether they are local students or newly arrived children:

Tier 1 - Quality teaching in the regular classroom to prevent deterioration of the learning difficulties of the students at-risk.
Tier 2 - Add-on intervention for students with persistent learning difficulties.
Tier 3 - Support for students who need intensive individualized support and special accommodations in the light of their severe difficulties identified.

At present, schools are providing a wide range of support services for these students. If a student is found to have adjustment difficulties in the ordinary school, school would provide school-based guidance or support programme to help him / her adjust to the school routine. On-site advisory service is provided by educational psychologists, inspectors or relevant staff of the Bureau.

Recommendation 7

Positive engagement of adolescent school drop-outs for developing their potentials and building up their self-confidence was crucial for prevention of developmental risks for them.

Updating / Responses

Education Bureau:

(i) Schools are required to step up measures for assuring students' regular attendance and to follow strictly the requirements of reporting to the Bureau on the seventh day of the student's continuous absence in order to assure timely intervention and provision of appropriate assistance by the relevant parties. If the student's absence is assessed to be related to behaviour difficulties, the at-risk student must be referred immediately to school social workers in secondary schools or student guidance personnel in primary schools for early intervention; and

(ii) With the consent of their parents, the Bureau will refer school dropouts to short-term programme / social development programme run by non-government organisations to prepare them for resumption of normal schooling.

Recommendation 8

Public education on the following aspects:

(1) To remind the parents that it was their duty and responsibility to bring up, support and protect their children;

(2) To arouse the public's awareness on the negative impact of casual or unlawful sexual intercourse for young children; and

(3) To arouse the awareness of new arrivals the importance of providing true and accurate information on the personal information of their children (including age and special needs) to the concerned government departments / service organisations upon arrival to ensure that education or social services provided would be commensurate with their needs.

Updating / Responses

Education Bureau:

(i) Has published a set of leaflets on special education informing the general public of the support services available to children with special educational needs. The leaflets can be accessed on the Bureau's website (www.edb.gov.hk);

(ii) Will continue to promote public understanding / acceptance of students with special educational needs and home-school collaboration in supporting students with diverse learning needs through seminars organised by the Bureau or jointly with non-governmental organisations; and

(iii) Details such as address and enquiry hotline of respective Regional Education Offices are clearly indicated in the comprehensive guide on services provided by various government departments for parent's reference.

Social Welfare Department:

Proper parenting attitude to ensure safety of the children is one of the themes for publicity in the publicity campaign for prevention of domestic violence.

Recommendation 9

Public education on the when and how, and the precautions to be taken to initiate separation between young lovers.

Updating / Responses

Social Welfare Department:

Will consider the recommendation in organising future public education programmes under purview where appropriate.

Recommendation 10

Debriefing and counselling to the surviving siblings, peers, helpers or witnesses of the deceased children should be provided to help them recover from the trauma and resume normal functioning.

Updating / Responses

Social Welfare Department:

(i) Individual or group crisis intervention may be more appropriate for helping peers and helpers of the deceased child or those who have witnessed the death to help them recover from the trauma and resume normal functioning. When the needs are indicated, these will be provided with further counselling or psychotherapy;

(ii) Will remind frontline social workers to provide welfare services and assistance to persons affected by traumatic incidents where necessary;

(iii) Integrated Family Service Centres and Integrated Services Centres have been taking care of the needs of and providing support services to surviving family members; and

(iv) Additional funding has been provided to Suicide Crisis Intervention Centre to provide crisis intervention to survivors in November 2009.

Education Bureau:

(i) Has prevailing practice to provide school-based aftermath support to affected schools, with debriefing and counselling being an important and standard procedure to mitigate stress reactions, reduce psychological harm and reinforce group cohesiveness of survivors such as peers, school personnel, parents, witness and helpers;

(ii) Debriefing can be conducted individually or in groups by teachers, guidance personnel, school social workers and Educational Psychologists, depending on the need of the survivors. Those identified to be adversely affected will be referred for more in-depth follow-up services, such as psychotherapy, etc;

(iii) Ready-to-use materials are in the Resource Package on Student Suicide (published in 1992 and revised in 1997) to facilitate school personnel and helping professionals in addressing the needs of survivors. These have been enriched and updated in the Bureau's e-Book on School Crisis Management, published in 2005. The e-Book has been distributed to all schools and is accessible to the public at the Bureau's website (www.edb.gov.hk); and

(iv) Supports schools to conduct crisis management drills to better prepare school personnel to identify and address the emotional needs of survivors.

Recommendation 11

The Education Bureau may consider keeping statistics of student suicide for review and research purposes.

Updating / Responses

Education Bureau:
Has been assisting the Administration in collecting relevant data on suicide cases involving primary and secondary school students, regardless of their age and will continue to keep track of the statistics of student suicide for review if and when necessary.

6.3 Overview of Cases Died of Accidents

Table 6.3.1: No. of Cases by Age Group and Sex

Age Group	Sex (%)		Total (%)
	Female	Male	
< 1	1 (5.0%)	0 (0.0%)	1 (5.0%)
1 – 2	0 (0.0%)	0 (0.0%)	0 (0.0%)
3 – 5	1 (5.0%)	0 (0.0%)	1 (5.0%)
6 – 8	2 (10.0%)	5 (25.0%)	7 (35.0%)
9 – 11	1 (5.0%)	1 (5.0%)	2 (10.0%)
12 – 14	2 (10.0%)	2 (10.0%)	4 (20.0%)
15 – 17	1 (5.0%)	4 (20.0%)	5 (25.0%)
Total:	8 (40.0%)	12 (60.0%)	20 (100.0%)

Figure 6.3.1: No. of Cases by Age Group and Sex

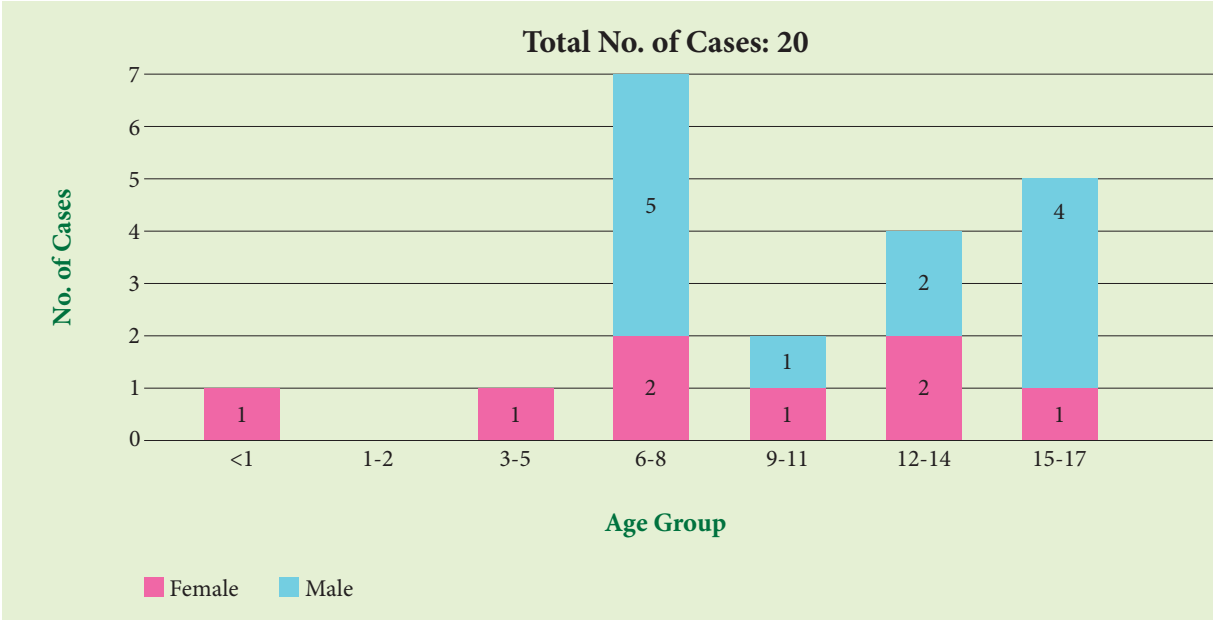


Table 6.3.2: No. of Cases by Type of Accident

Type of Accident	No. of Cases (%)
Traffic	11 (55.0%)
Fall	5 (25.0%)
Drowning	3 (15.0%)
Drug Overdose	1 (5.0%)
Total:	20 (100.0%)

Figure 6.3.2: No. of Cases by Type of Accident

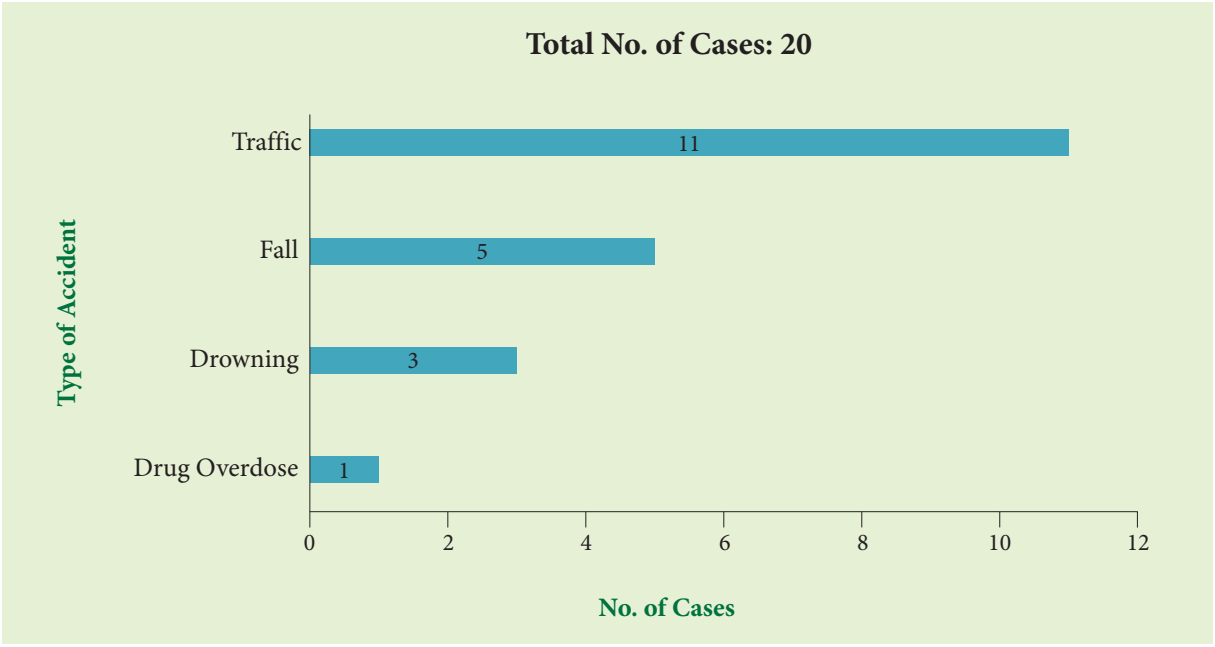


Table 6.3.3: No. of Cases by Age Group and Type of Accident

Age Group	Type of Accident				Total (%)
	Traffic Accident	Fall	Drowning	Drug Overdose	
< 1	1	0	0	0	1 (5.0%)
1 - 2	0	0	0	0	0 (0.0%)
3 - 5	0	1	0	0	1 (5.0%)
6 - 8	3	3	1	0	7 (35.0%)
9 - 11	2	0	0	0	2 (10.0%)
12 - 14	2	0	1	1	4 (20.0%)
15 - 17	3	1	1	0	5 (25.0%)
Total (%):	11 (55.0%)	5 (25.0%)	3 (15.0%)	1 (5.0%)	20 (100.0%)

Figure 6.3.3: No. of Cases by Age Group and Type of Accident

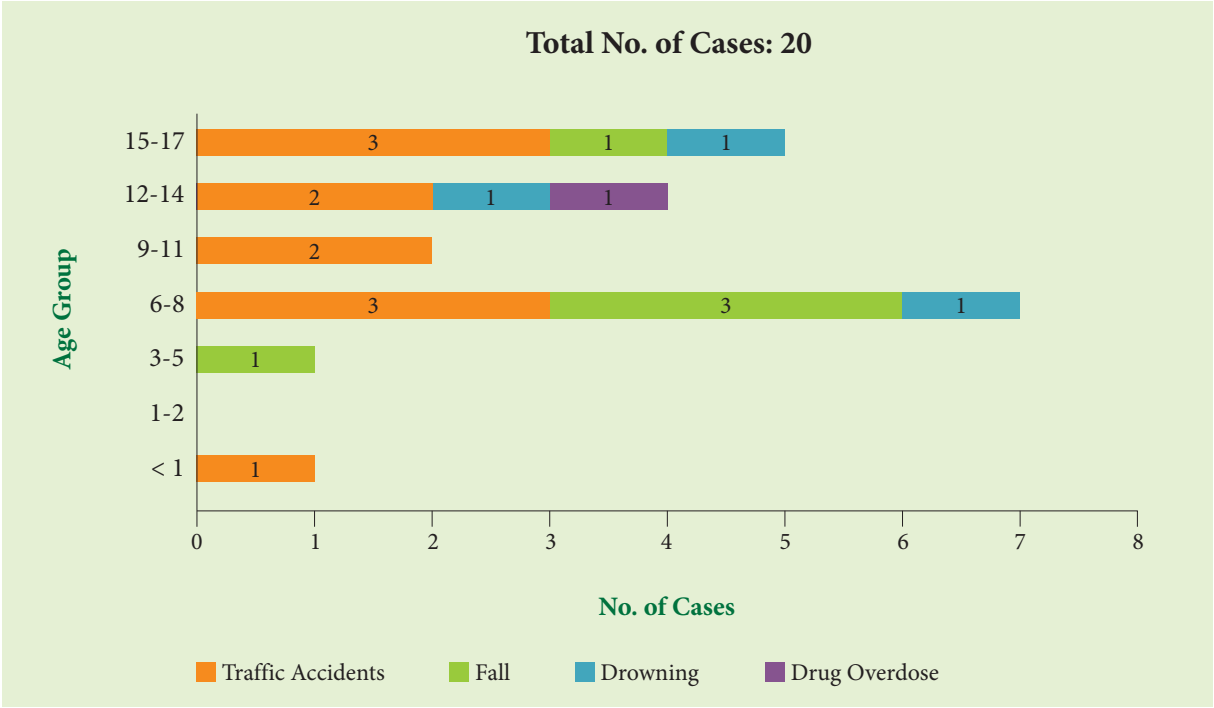
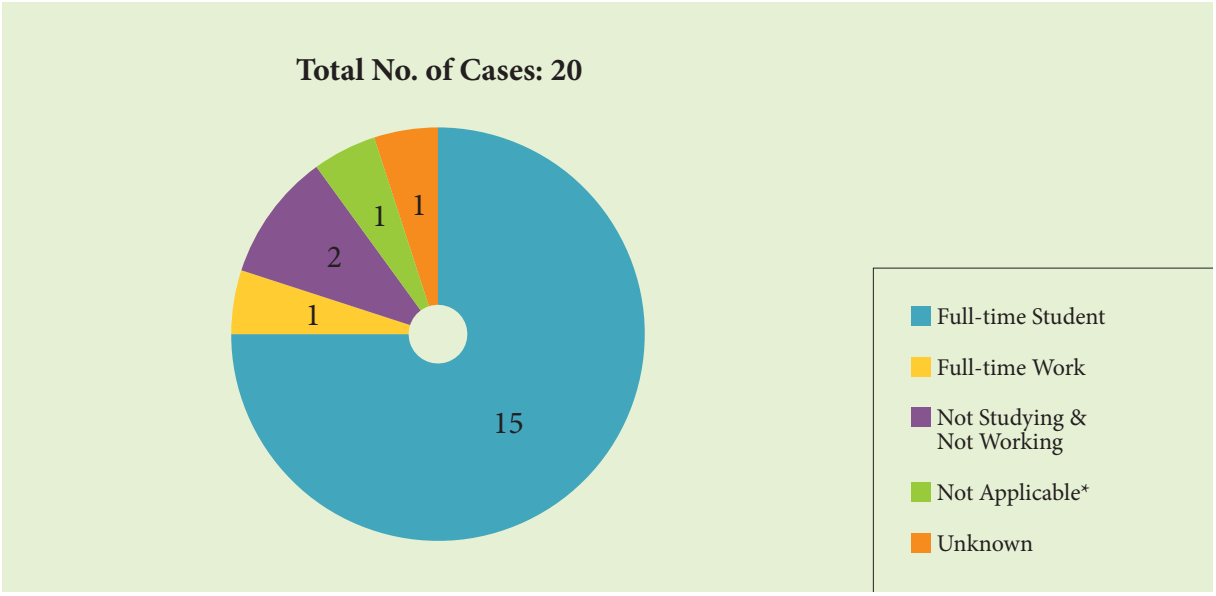


Table 6.3.4: Occupation of the Deceased Children

Occupation	No. of Cases (%)
Full-time Student	15 (75.0%)
Full-time Work	1 (5.0%)
Not Studying & Not Working	2 (10.0%)
Not Applicable*	1 (5.0%)
Unknown	1 (5.0%)
Total:	20 (100.0%)

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

Figure 6.3.4: Occupation of the Deceased Children

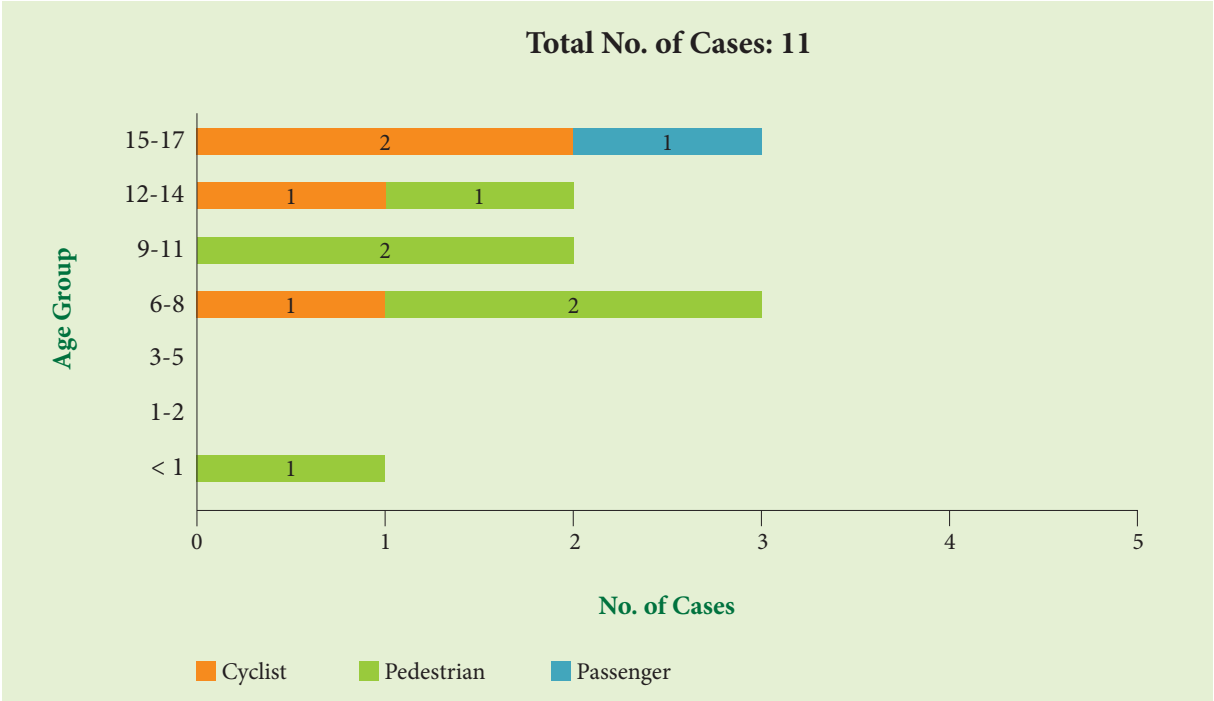


Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

Table 6.3.5: No. of Cases by Age Group and Type of Traffic Victim

Age Group	Type of Traffic Victim			Total (%)
	Cyclist	Pedestrian	Passenger	
< 1	0	1	0	1 (9.1%)
1 - 2	0	0	0	0 (0.0%)
3 - 5	0	0	0	0 (0.0%)
6 - 8	1	2	0	3 (27.3%)
9 - 11	0	2	0	2 (18.2%)
12 - 14	1	1	0	2 (18.2%)
15 - 17	2	0	1	3 (27.3%)
Total:	4	6	1	11 (100.0%)

Figure 6.3.5: No. of Cases by Age Group and Type of Traffic Victim



6.3.1 General Observation

In the year 2006, 20 children died of accidents of different kinds, namely traffic, drowning, fall and drug overdose.

Table and Figure 6.3.1 show the number of cases by age group and sex. More male children (N=12, 60.0%) than female (N=8, 40.0%) died in different kinds of accident. It also shows that the age group that has the highest number of child death is 6 – 8 (N=7, 35.0%), followed by the age group 15 – 17 (N=5, 25.0%).

Table and Figure 6.3.2 show that traffic accidents remains the major type of accident causing child death in 2006 (N=11, 55.0%).

Table and Figure 6.3.3 show the number of cases by age group and type of accident. Traffic accident has the highest number of child death (N=11, 55.0%) with falling from height comes second highest (N=5, 25.0%). Of the 11 children died in traffic accidents, 10 were aged 6 – 17 and only one deceased child was below one year of age. Of the five children who died of falling from height, four of them were aged 3 – 8 years old while the remaining one was in the age group 15 – 17.

Table and Figure 6.3.4 show that out of the 20 deceased children, 15 were students and only one was working. Two school-aged children were yet to attend school because they had just been brought to Hong Kong from other countries.

Table and Figure 6.3.5 show the age group distribution of the 11 traffic accidents by type of victim, which involved four cyclists, six pedestrians and one passenger on board a vehicle. Of the four cyclists died in accidents, two of them were in the age group 15 – 17.

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

(i) Five out of 11 "traffic accident" cases occurred due to carelessness of pedestrians and/or undesirable conduct of drivers;

(ii) Three out of five “accidental fall” cases and three out of eleven “traffic accident” cases reviewed occurred when the children, either left alone or with peers, lacked close or proper parental supervision;

(iii) Four out of five "fall" cases reviewed could have been avoided if proper home safety design or devices were in place; and

(iv) Two out of three drowning cases occurred because the deceased children swam in places not suitable for swimming and had over-estimated their own swimming ability.

6.3.2 Recommendations and Responses for Cases Died of Accidents

Recommendation 12

(i) Parenting education on the role, skills and responsibility of parents should start right at the beginning when a child is born to a family; and

(ii) Strengthening the role and responsibility of the father would better protect the children.

Updating / Responses

Social Welfare Department:
Service units of the Department and non-governmental organisations, including Integrated Family Service Centres, Integrated Services Centres and Family Life Education Units, have been organising parenting education programmes of different themes for parents-to-be, parents and grandparents.

Department of Health:
(i) The Family Health Service of the Department offers a parenting programme through 31 Maternal and Child Health Centres in Hong Kong to equip parents / caregivers with the necessary parenting knowledge and skills; and

(ii) Fathers are always encouraged and welcomed to attend parenting workshops. In case they cannot attend, the mothers are advised to share the written information with them or encourage them to visit the Department's website (www.dh.gov.hk).

Recommendation 13

Schools or welfare organisations to provide education and support for grass-root parents, especially for those having children with special educational needs, to raise their awareness and ability to take care of their young children.

Updating / Responses

Education Bureau:
With resource provision and support from the Bureau, primary schools are encouraged to organise parent-child activities and conduct seminars / workshops to help parents enhance parenting skills under the Bureau's Comprehensive Student Guidance Service. In collaboration with teachers in secondary schools, school social workers provide support service to parents.

Social Welfare Department:
Parents / Relatives Resource Centres (PRC) provide a wide range of support services to parents and relatives of children with disabilities through various means. Groups for enhancing parenting skills are organised in various service units including Integrated Family Service Centres and reference materials are maintained in the Department's Family Life Education Resource Centre (Website: flerc.swd.gov.hk) to support frontline workers in conducting education programmes for parents.

Recommendation 14

(i) To derive more effective ways to reach out to juveniles with drug abuse problem; and

(ii) Public education for all age groups on the negative effects of drug abuse through ways such as: use of life-coaching, promotion of positive life-style, strengthening coping strategies and resilience to life stresses etc.

Updating / Responses

Narcotics Division / Security Bureau:
Tasked with coordinating anti-drug policies and measures across the public sector, non-government organisations (NGOs) and society at large to combat the problem of drug abuse with a five-pronged approach covering (1) preventive education and publicity, (2) treatment and rehabilitation, (3) legislation and law enforcement, (4) external cooperation and (5) research.

To combat the youth drug abuse problem, the Chief Executive announced in his 2007 Policy Address the appointment of the Secretary for Justice, as Deputy Chairman of the Fight Crime Committee, to lead a high-level inter-departmental task force to consolidate anti-drug strategies in a holistic manner. The Task Force on Youth Drug Abuse (Task Force) concluded its work and published a Report on 11 November 2008, with over 70 recommendations spanning the five prongs of the anti-drug policy. The recommendations of the Task Force also include the promotion of a community culture of care for young people through the Path Builders initiative.

The Task Force has come up with focused, holistic and sustainable strategies to tackle the youth abuse problem with enhanced collaboration within the government (among bureaux, departments and agencies) and engagement of the anti-drug sector (comprising the many NGOs and others) and various stakeholders (e.g. schools, parents, teachers, social workers, legislators' etc.) to ensure ownership and support for the anti-drug cause.

In July 2009, the Chief Executive announced the further stepping up of the anti-drug campaign along five directions, namely community awareness and mobilization, community support, drug testing, treatment and rehabilitation and law enforcement.

*For recommendation (i):

Given the hidden nature of psychotropic substance abuse, the Task Force recommends stepping up efforts in identifying young drug abusers for early intervention as soon as possible. Drug testing at three levels were recommended, i.e. (a) compulsory drug testing with backup of legislation: the Division plan to consult the public in 2010 on a detailed proposal; (b) voluntary school-based drug testing: a trial scheme with participation of all secondary schools in Tai Po District launching in December 2009; and (c) voluntary drug testing service in Counselling Centres for Psychotropic Substance Abusers. (CCPSAs): the service has been provided in CCPSAs since October 2009 as part of the elementary medical support for young drug abusers to enhance the engagement and counselling process.

In addition to drug testing, the Task Force recommends schools to play a proactive role in early identification of at-risk students through other means and provides necessary assistance. A resource kit for schools now under preparation would provide useful checklists for school personnel including school management staff, guidance and discipline teachers, school social workers, class and subject teachers to identify at-risk students and make referrals where necessary. Training is now being provided to teachers and school social workers to help them deliver drug education and to handle student drug abuse cases. Schools are encouraged to develop and institutionalise a health school policy with an anti-drug element.

*For recommendation (ii)

The Task Force recommends that, for future preventive education and publicity purposes, the generic reference to drug abuse should be "吸毒" or "吸食毒品" and the use of such Chinese terms as "濫藥" or "濫用藥物" should be avoided as far as possible. In this context, drugs should be referred to as "毒品" , but not the more neutral term of "藥物" . In the case of psychotropic substances (not "soft drugs" any more), they should be referred to as "危害精神毒品", or, for more colloquial usage, "丸仔毒品" , "K仔毒品" or the like, instead of "精神藥物" . Accordingly, a two-year territory-wide campaign with the theme "No Drugs, No Regrets. Not Now, Not Ever" and "不可一，不可再。向毒品說不，向遺憾說不。" was launched on 28 June 2008. A series of programmes followed, including seven Announcements in the Public Interest featuring real life stories of different sectors in the society, a theme song plus a music video, massive publicity drive as well as online promotion on popular websites.

School is a key institution on the path to adulthood. The Task Force attaches great importance to the school sector in preventive efforts. To cultivate positive values among students and help them acquire the skills to keep themselves away from drugs, the Education Bureau will enhance its efforts to promote students' participation in uniformed group activities and other youth development programmes such as the Positive Adolescent Training through Holistic Social Programmes to Adulthood (Project PATHS), Understanding Adolescent Programme, Smart Teen Programme, Adolescent Health Programme, Junior Health Pioneer Workshop and by exploring further collaboration with other parties. Schools should arrange these specific education programmes to enhance students' knowledge on drug and other health issues. Through NGOs, the Division and the Social Welfare Department will also strengthen anti-drug talks and programmes to senior primary students and secondary students to help them acquire knowledge about the dire consequences of drug abuse and skills to refuse drugs.

As youth drug abuse is often a manifestation of more deep-rooted problems in family, growth, study and employment, the Division and the Action Committee Against Narcotics have launched the *Path Builders* initiative to foster a caring culture for youth for their healthy development. *Path Builders* serves as a platform for different sectors of the community to help the younger generation through many different ways. For instance, companies may offer internships, visits, vocational training or job opportunities for young people or to help disseminate anti-drug messages to staff. Professionals may share their professional knowledge and life experience. Individuals may contribute their talent, reach out as Anti-drug Ambassadors or provide sponsorship or donations for the anti-drug cause. With the launch of *Path Builders* in September 2008, appropriate promotion of the cultivation of a culture of community care for young people may also underpin the anti-drug cause.

To steer, coordinate and monitor the implementation of the recommendations of the Task Force, an inter-departmental working group chaired by the Commissioner for Narcotics was set up in early 2009 and is working in full swing.

Social Welfare Department:

*For recommendation (i):

In order to achieve early identification and timely rehabilitation for juveniles with drug abuse problem, additional manpower has been injected for the District Youth Outreaching Social Work Teams and Overnight Outreaching Teams for Young Night Drifters since October 2008. These outreaching teams would always collaborate with school social workers as well as Counselling Centres for Psychotropic Substance Abusers, which are all serving the whole territory, to reach out and engage target drug abusers and at-risk youths in counselling services, including referrals for appropriate medical treatment as and when required.

*For recommendation (ii):

All along, the Administration has made great cross bureaux / departments efforts on public education including preventive education and publicity on the negative effects of drug abuse in various venues. The Hong Kong Jockey Club Drug InfoCentre has been the central executive arm of Narcotics Division / Security Bureau to serve as a platform for providing drug education to students, parents and the general public.

Under the youth services portfolio, the Department has secured a funding of $750 million from the Hong Kong Jockey Club Charities Trust to implement "Positive Adolescent Training through Holistic Social Programmes to Adulthood: A Jockey Club Youth Enhancement Scheme" (Project PATHS) in secondary schools from 2005-6 to 2011-12 school years. The Project PATHS is jointly organised by the Department, Education Bureau and five universities. It aims to provide comprehensive training programmes / activities for promoting students' positive values, enhancing their resilience against adversities and life stresses as well as strengthening their coping strategies. The Project PATHS could promote their healthy development and thus helping them develop positive life perspective as well as a sense of right and wrong, thus helping them resist the temptations of drugs and other undesirable behaviours.

Committing to the common goal of preventing unnatural child death, the Department would continue to collaborate with relevant welfare service units / stakeholders in the community under the policy coordination of the Narcotics Division of the Security Bureau to tackle the youth drug abuse problems and render timely assistance to avert tragedy.

Meanwhile, professionals should strike the balance between disciplining and protecting children, especially those who have been overly-protected as their resilience to adversity is low.

Education Bureau:
To help students adopt a healthy lifestyle is one of the aims of school education. The Bureau is taking the lead to promote the institutionalisation of a Healthy School Policy with anti-drug element in all schools to build up positive values and attitudes among students. As support measures for schools, a Resource Kit for Parents has been distributed to schools and a Resource Kit for Schools to strengthen anti-drug education was expected to be ready for distribution by the Narcotics Division of the Security Bureau in the fourth quarter of 2009. On-going efforts will be made to enhance teachers' competence in delivering anti-drug education and supporting at-risk students who may have drug abuse problems.

School Concerned:
Various measures had been taken since 2006 to develop positive self-esteem, sense of responsibility and enhancement in students' resilience to depression and frustration and the temptation of drug abuse. The means used are summarized as follows:

- Curricula about the value of life for F.1 – 3 students.
- Class discussions and debates on drug abuse matters.
- Psychological health programme for F.1 – 4 students.
- Project "PATHS" for F.1 – 3 students.
- Creating atmosphere of "Love and Care" through implementing education project emphasizing respect, trust, optimism and intentionality.
- Preventive and educational programmes and activities by the school guidance and counselling team.
- Workshops for teachers on knowledge of drugs and drug abuse.
- A system of mentor teachers for showing love and concern to students, allowing closer supervision to cater students' special needs, detection and dealing with their personal problems.
- Involving and working closely with the Parent-Teacher Association to join the school in implementation of project on staying healthy in school and at home.

Recommendation 15

To incorporate in the education for teenagers on self-awareness of one's own physical ability and risk assessment of the environment.

Updating / Responses

Social Welfare Department:
The recommendation will be considered in the Department's planning of relevant programmes or public education for teenagers.

Recommendation 16

Government to oversee that different ethnic groups have equal opportunity on access to information and social services in their language through different media to facilitate their adjustment.

Updating / Responses

Social Welfare Department:
To facilitate ethnic minorities-in-need with difficulties accessing social welfare services because of language barrier, leaflets on major welfare services are translated into six languages commonly used among ethnic minority groups to facilitate their understanding of available services. Interpretation service is in place for those who cannot communicate in Chinese or English while seeking social welfare services and when assistance from relatives, friends or clansmen is not available. The Support Service Centre for Ethnic Minorities funded by the Constitutional and Mainland Affairs Bureau also provides interpretation service to support the Department in service delivery.

Recommendation 17

Legislation for installation of devices alerting pedestrian for reversing vehicles.

Updating / Responses

Transport Department:
Regulation 38 (1A) of Road Traffic (Construction and Maintenance of Vehicles) Regulations (Cap. 374A) requires that "every goods vehicle shall be fitted with an automatic device capable of giving audible and sufficient warning when it is reversing and is about to reverse." Since 2006, the Department has taken joint effort with relevant parties on various measures to enhance safety of reversing vehicles, including publicity and education efforts / campaigns and review of road environment. "A Guide for the Installation of Devices to Assist Reversing of Goods Vehicles" was issued for reference by the goods vehicle trade. Since August 2007, the Department had conducted consultation meetings with operators and driver associations of different types of goods vehicles on installation of more advanced reversing aids to enhance safety and will continue to encourage the goods vehicle trade to install various reversing aids while study on legislative amendments to make the installation of reversing video device a mandatory requirement on goods vehicles is under way.

Recommendation 18

To revisit the definition of "Light Goods Vehicle".

Updating / Responses

Transport Department:

(i) The vehicle classifications for goods vehicles, which are clearly defined in the Road Traffic Ordinance (Cap. 374) has been adopted for years and working properly and is well received by drivers and the driving industry. The need to review this classification system may not have been arisen at present;

(ii) The Department has been implementing an effective driving test system to ensure that candidates who pass the tests have adequate knowledge, skills and capability in the safe and full manoeuvring and control of the vehicles before they are granted probationary driving licences; and

(iii) The "Probationary Driving Licence Scheme" has been extended to include novice drivers of light goods vehicles before full driving licences are issued to them. In addition, the Road Traffic Legislation (Amendment) Ordinance 2008 gazetted in July 2008 has also stipulated a package of measures to combat drink driving, dangerous driving among other inappropriate driving behaviours which are also applicable to novice drivers of light goods vehicles.

Recommendation 19

Applying special restrictions for young and inexperienced drivers to minimize their risk of traffic accidents.

Updating / Responses

Transport Department:

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.

Recommendation 20

(i) Promotion of proper attitude and manner in driving; and

(ii) Regular reinforcement of public education for children and the public on the importance of road safety.

Updating / Responses

Transport Department:
From time to time, the Road Safety Council, with the support of the Hong Kong Police Force, the Department and other relevant departments carries out various promotion and public education activities to enhance road safety in Hong Kong, including: television and radio announcements, outdoor advertising such as billboards, banners; printed materials; campaigns and events on various topics like Smart Driving with Courtesy, Crossing the road with Care, etc. In addition, the Road Safety Vision "Zero Accidents on the Road, Hong Kong's Goal" was developed together with a distinctive symbol to raise public interest and support for road safety improvement.

Recommendation 21

Education for parents:

(i) To seek assistance from reliable child minders; and

(ii) To give clear instructions to child minders to ensure child safety.

Updating / Responses

Social Welfare Department:
In addition to normal child care services provided by child care centres, the Department has introduced the Neighbourhood Support Child Care Project since October 2008. It provides childminding service to needy families to prevent them from leaving their children unattended. Proper training in childminding is also provided to child minders by operators of this Project. On the other hand, relevant messages will be included in the Department's programmes for parents, such as programmes organised in Integrated Family Service Centres as well as publicity material prepared by its Family Life Education Resource Centre (Website: flerc.swd.gov.hk).

Recommendation 22

(i) Public awareness, in particular that of the parents and the care-givers, should be raised on the importance of home safety and the use of safety devices, including window grilles all the time for families with small children;

(ii) Education and promotion of household safety and related measures for families with children;

(iii) When planning and designing buildings, particularly public housing estates, the issues of child safety should be considered e.g. installation of grilles on windows and in corridors; and

(iv) Parents should be educated to communicate with child minders on the needs of their children effectively to ensure proper care for their children.

Updating / Responses

Social Welfare Department:
Proper sense of responsibility and parenting attitude to ensure safety of children has been included as one of the themes for publicity campaign on prevention of domestic violence. Reference materials on home safety for children are available in the Department's Family Life and Education Resource Centre (Website: flerc. swd.gov.hk).

Hong Kong Housing Authority:
Supports the recommendations on taking child safety into consideration when planning and designing new public housing estates and shares the following views:

(a) The installation of window grilles should be extended to all common areas including staircases, landings and lift lobbies in addition to corridors except for fixed windows 1.1m above floor level; and

(b) Additional reminder should be promulgated in internal design guides on the design and planning of parapets and railings at roofs and at podiums where children may abuse to climb over adjacent pipes, planters or scats.

Since the incidents in 2006, the Authority has further improved the safety measures against risk of falling from height in new public rental housing projects by providing window grilles to all openings in staircases and landings in addition to statutory requirements.

Hong Kong Housing Society:

(i) Always advocates good practice and look into areas for improvements in planning and designing of buildings, including rehabilitation works in its rental estates. From time to time, safety measures and device at public areas, e.g. fencings, fall arrestors etc. are incorporated;

(ii) Enhances residents' awareness on home safety by posting up notices, posters and arranging safety talks regularly in estates; and

(iii) Supports in principle the installation of grilles on windows and in corridors subject to approval from authorities and compliance of relevant legislations for new projects.

Recommendation 23

To set up sufficient safe leisure and sports facilities in newly developed residential areas.

Updating / Responses

Leisure and Cultural Services Department:

(i) Has all along been providing various types of recreational and sports facilities which are up to international safety standards to serve the needs of the citizens; and

(ii) Will continue to implement projects for the provision of recreational and sports facilities in newly developed residential areas having regard to the factors including the population growth and the needs of the community, the views of the District Councils, the level of the existing provision of recreational and sports facilities and their utilization.

Planning Department:

In planning for newly developed areas, land would be reserved for community and recreational facilities according to the "Hong Kong Planning Standards and Guidelines". The Department also helps identify sites upon requests from the client departments who had obtained policy support for provision of free standing facilities in consultation with relevant departments regarding the access to the site and the availability of infrastructure facilities. As regards the safety of the facility, it would have to rely on the architects or engineers concerned, and also on how the user department manages the facility.

Recommendation 24

To ensure that proper warning signs and notices are erected at places unsafe for swimming to remind the public the danger of swimming in such places.

Updating / Responses

Leisure and Cultural Services Department:

(i) Has fenced off rock outcrops and erected floating signage to warn swimmers in bathing beaches with rock outcrops which may endanger swimmers particularly during the high tide when these rock outcrops are submerged under water;

(ii) For public swimming pools, water depth indicators are marked on the sides of swimming pools to remind swimmers of the pool depth and children under the age of 12 are not allowed to enter or use any public swimming pools unless accompanied by adults with posters and large banners posted at conspicuous locations to draw the swimmers' attention of this rule. Gate attendants will ensure children under age of 12 are accompanied by an adult on admission;

(iii) To prevent accidents, water features are designed in such a way that it deters people from entering. For the promenades, the Department normally provides railing or low retaining walls along the harbourfront to prevent members of the public to have access to the sea for swimming; and

(iv) Appropriate signs and notices are also erected to warn visitors not to get into the water features or the sea along the harbourfront for swimming as it is not safe.

Recommendation 25

To raise public awareness on the importance of swimming in a safe place under safe environment through publicity campaigns targeting children of different age groups.

Updating / Responses

Leisure and Cultural Services Department:
Water safety messages are displayed at conspicuous locations of public swimming pools and bathing beaches as well as in the website of the Department (http://www.lcsd.gov.hk). Each year, the Department launches publicity campaigns and organises promotional activities to promote water safety. Means like announcement in the public interest on water safety, distribution of swimmers' handbook are employed to the public to arouse their awareness to prevent swimming accidents. To further enhance students' awareness of water safety, students from primary and secondary schools have been invited to participate in the Department's annual events with themes of water sports safety.

6.4 Overview of Cases Died of Other Causes

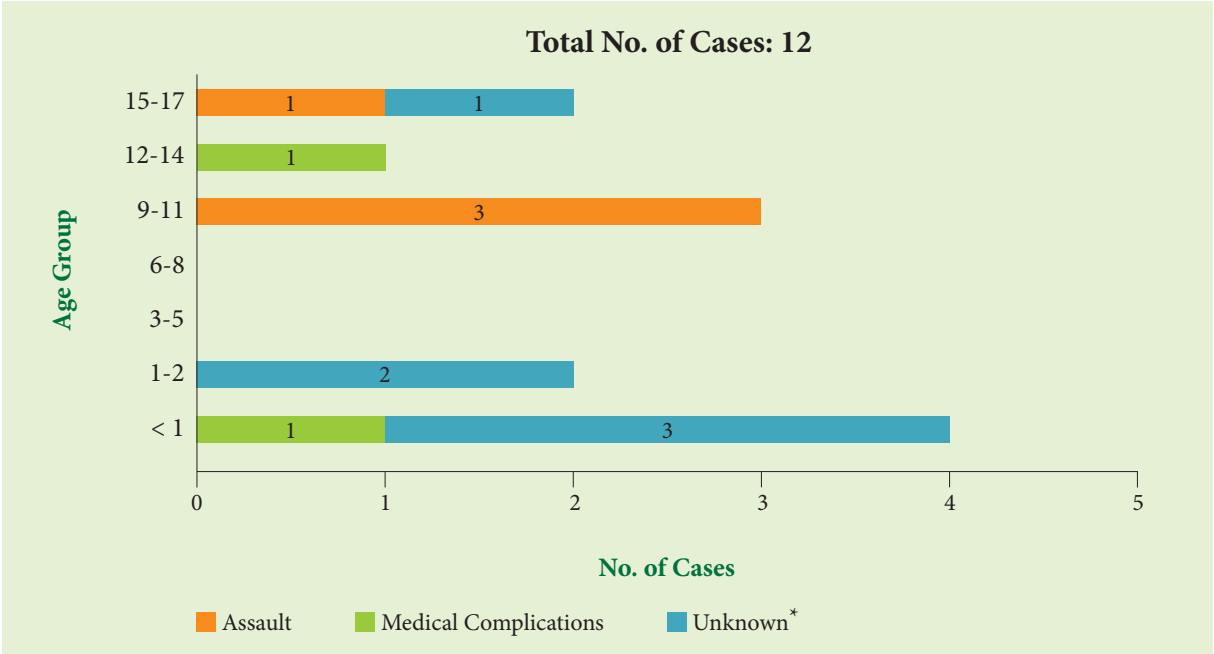
Due to their small numbers, the findings, recommendations and responses of reviewed cases with death causes other than suicide and accidents are all grouped under this section.

Table 6.4.1: No. of Cases by Age Group and Cause of Death

Age Group	Cause of Death			Total (%)
	Assault	Medical Complications	Unknown*	
< 1	0	1	3	4 (33.3%)
1 - 2	0	0	2	2 (16.7%)
3 - 5	0	0	0	0 (0.0%)
6 - 8	0	0	0	0 (0.0%)
9 - 11	3	0	0	3 (25.0%)
12 - 14	0	1	0	1 (8.3%)
15 - 17	1	0	1	2 (16.7%)
Total:	4 (33.3%)	2 (16.7%)	6 (50.0%)	12 (100.0%)

Unknown: ruled by the Coroner's Court to have unknown death cause.*

Figure 6.4.1: No. of Cases by Age Group and Cause of Death

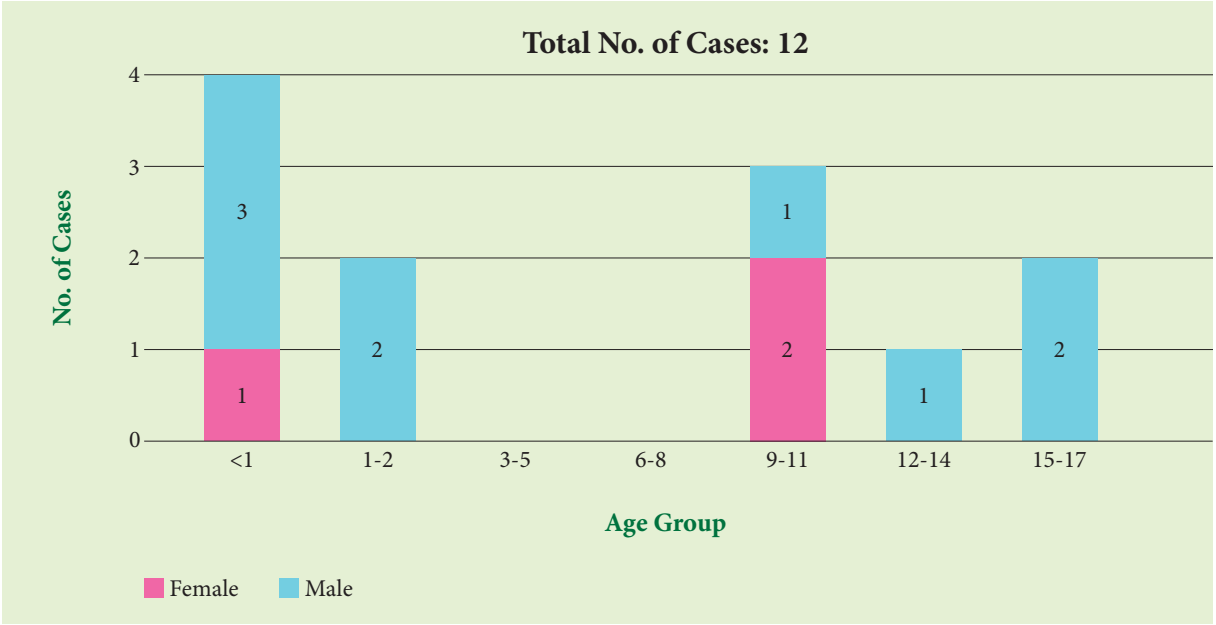


Unknown: ruled by the Coroner's Court to have unknown death cause.*

Table 6.4.2: No. of Cases by Age Group and Sex

Age Group	Sex		Total (%)
	Female	Male	
< 1	1	3	4 (33.3%)
1 – 2	0	2	2 (16.7%)
3 – 5	0	0	0 (0.0%)
6 – 8	0	0	0 (0.0%)
9 – 11	2	1	3 (25.0%)
12 – 14	0	1	1 (8.3%)
15 – 17	0	2	2 (16.7%)
Total:	3	9	12 (100.0%)

Figure 6.4.2: No. of Cases by Age Group and Sex



6.4.1 General Observations

Table and Figure 6.4.1 show the number of cases with death causes other than suicide and accidents. These other causes include assault, medical complications and unknown.

Four children died of assault in the year 2006. Three out of the four deceased children were in the age group 9 – 11 while the other one was aged 15 – 17. Two of them were male and two of them were female. The perpetrators of three deceased children were their parents while the remaining deceased child died of stranger assault.

Two children died of medical complications in the year 2006. One of them was aged below one while the other was in the age group 12 – 14.

Six cases have been classified to have "Unknown" death causes by the Coroners in the year 2006. They died of undetermined and unknown causes of mortality. Among these six deceased children, two were infants in the age group <1, two were in the age group 1 – 2 and one was in the age group 15 – 17. Only one deceased child was female and the other five were male. Five out of six of these deceased children collapsed at home and one died in hospital shortly after birth there.

Table and Figure 6.4.2 show the number of children by age group and sex. Three deceased children were female while nine were male. The age group <1 has the greatest number (N=4) of child death.

6.4.2 Recommendations and Responses for Cases Died of Other Causes

Recommendation 26

Professionals working on parenting issues should be sensitive and aware of the cultural difference in child discipline in each case.

Updating / Responses

Social Welfare Department:

(i) Supports that awareness and providing assistance or counselling to clients of different backgrounds based on their individual needs, including cultural variations in parenting, should be part of the foundation training for social workers;

(ii) The Department has been providing training programmes on parenting concerns for social workers on regular basis with awareness / sensitivity on cultural variation in child discipline as one of the features covered which will continually be included in related training courses; and

(iii) Social workers working on parenting issues in different service units have been advised to take note of the cultural background of service users in handling cases and conducting groups / programmes, including those relating to parental education.

Recommendation 27

Special attention and support for single parents with multiple risk factors (e.g. young parent, broken marriage / relationship with partner, post-partum depression, history of suicidal attempts) could help reduce risk of improper child care and enhance protection for their children.

Updating / Responses

Department of Health:
To address the needs of children and families with special needs like those from socially or economically disadvantaged families, a targeted intervention programme – the Comprehensive Child Development Service (CCDS) has been implemented in phases in the Department's Maternal Child Health Centres (MCHCs) since 2005. Using the MCHCs and other service units as a platform, the CCDS aims to identify at an early stage at-risk pregnant women, mothers with postnatal depression, families with psychosocial needs, as well as pre-primary children with health, developmental and behavioural problems. Children and their families in need are referred to appropriate health and welfare service units for follow-up. With MCHC as a non-stigmatising platform, CCDS has strengthened the inter-sectoral partnership of the health, social, and education sectors. Apart from direct communication between workers, ad hoc case conference involving service providers are conducted to discuss on the management plan for those families requiring special attention. With CCDS, single parents with multiple risk factors can be identified by the Department's staff at several contact points, including antenatal visits, routine screening of postnatal depression and psychosocial needs at postnatal visit and when the parents and child attend the Department's child health service. In addition, training has been provided to nursing and medical staff of the Department to raise their awareness and sensitivity on the psychosocial needs of families during the delivery of routine health care service.

Social Welfare Department:
For early identification and timely intervention, children and their families who have been identified to have psychosocial needs by the Maternal and Child Health Centres of the Department of Health under the Comprehensive Child Development Service will be referred to Integrated Family Services Centres / Integrated Services Centres for follow-up services as appropriate. The centres provide a continuum of preventive, supportive and remedial welfare services including counselling service, supportive / mutual help groups, developmental programmes, family aide service, family life education, parent-child activities, referral for supportive community services (e.g. financial assistance) and child care services, etc. to needy families, including single-parents.

Recommendation 28

Frontline social workers should stay alert to clients' mental condition and depressive mood right at initial contacts to facilitate prompt intervention to meet their immediate needs.

Updating / Responses

Social Welfare Department:
Generally agrees with the recommendation.

Recommendation 29

To work out a mechanism to help social workers to make decisive action on protection of children, such as early removal of the children from their families, even without consent of their abusive parents in case of serious domestic violence in order to prevent them from being harmed.

Updating / Responses

Social Welfare Department:

(i) There is existing legal provision under the Protection of Children and Juveniles Ordinance (Cap. 213) for the Director of Social Welfare or any person authorized by the Director of Social Welfare as well as the Police to apply for an order on a child or juvenile in need of care or protection, including removal of the child or juvenile from his / her family. However, this provision is not applicable for the reviewed case as there was no evidence or indication that the child's safety was in jeopardy before the death incident; and

(ii) The "Procedural Guide for Handling of Child Abuse Cases" provides guidance for different professionals on handling cases involving child abuse. The fundamental objective of child protection work is to remove the risk and protect the child from risk. Nonetheless, child protection professionals, including social workers, are reminded to assess the risk level that might necessitate the removal of a child from his / her family for his / her own protection.

Recommendation 30

Apart from referring to past history of domestic violence, on-going risk assessment and alertness of social workers to critical periods during divorce are important for effective intervention for cases with such elements.

Updating / Responses

Social Welfare Department:

(i) The "Procedural Guide for Handling of Child Abuse Cases" providing guidance for different professionals on handling cases involving child abuse reminds them that risk assessment begins at the time of case intake and continues throughout the process of case assessment and planning, provision of service and termination of the case;

(ii) The Department runs various training programmes for social workers and related professionals, including teachers, child care professionals, medical and allied health professionals, and the Police on handling family violence cases; and

(iii) The Department will continue to provide training on the knowledge and skills in handling high-conflict families, especially complicated cases with custody disputes to social workers to strengthen their sensitivity on risk assessment.

Recommendation 31

For victims of domestic violence in high risk but refusing to follow suggested safety plans for any reason, issue of written reminders with warning and description of previous fatal incidents by social worker might help them realize the risk and change their minds.

Updating / Responses

Social Welfare Department:

Notes the recommendation, yet has the following concerns:

(i) In divorce case with custody dispute, the party receiving the written reminder may use it as an evidence to fight for child custody in the Family Court; and

(ii) The party not receiving the written reminder may complain of social worker's bias and presumption of the occurrence of extreme violence between the couple.

Recommendation 32

Training for frontline social workers working with domestic violence should emphasize on child-focused assessment and intervention, with consideration of the subjective experience of the child.

Updating / Responses

Social Welfare Department:
Agrees that while training for frontline social workers on child protection should be child-focused, it should also be put in a family context.

Recommendation 33

More collaboration and information sharing between the Police and the Social Welfare Department, including cross referencing of risk criteria of the two Departments for reaching a common understanding of the levels of risk, may improve the risk assessment procedures.

Updating / Responses

Social Welfare Department:
Various mechanisms for regular communication and liaison among the Police, non-governmental organisations and the Department have been set up at the central, district and case level to enhance service collaboration and coordination in tackling domestic violence issues.

Hong Kong Police Force:
Since November 2006, enhancement measures have been taken for strengthening the collaboration and information sharing between the Police and the Social Welfare Department (SWD) especially in the areas of risk assessment and training with the following details:

(i) Enhanced risk assessment through Introduction of an Emergency Referral Questionnaire to assist frontline police officers in identifying risk factors of domestic violence cases and deciding on emergency referral to SWD;

(ii) Established a referral mechanism for domestic violence related cases, including immediate arrangement for temporary accommodation; immediate crisis intervention by social workers; 24-hour direct referral hotline to facilitate handling of urgent requests for needed social services; acknowledgement and non-consensual referral systems;

(iii) Enhanced sharing of information and problems encountered in case handling in the District Liaison Groups on Family Violence chaired by District Social Welfare Officers of SWD which aims at strengthening liaison and cooperation at frontline working level amongst the Police and social workers from the SWD or non-governmental organisations;

(iv) Enhanced training through close partnership with the SWD in joint training programmes on child protection and domestic violence related issues to different professionals;

(v) Introduced a protocol of Victim Management for victims of domestic violence cases handled by Crime units in 2008 to strengthen the support and safety assurance to victims and to enhance inter-disciplinary communication and collaboration; and

(vi) Will maintain close liaison and cooperation with SWD in seeking continuous improvement in the child protection and combating of violence.

Recommendation 34

(i) While working with divorcing couples in high conflicts, professionals should stay highly alert to high risk moments during the divorce proceedings, the impact on the children and their safety;

(ii) Legal professional to liaise with the case social worker to alert him / her of the possible risk after discussion on sensitive issue, such as property right, with parties involved in domestic violence;

(iii) School personnel should keep watch and be aware of the predicament of children with divorcing parents and they should coordinate with other professionals when safety of these children is at stake; and

(iv) Service organisations may consider requesting clients to give consent for sharing of information by different professionals when they first received the service.

Updating / Responses

Social Welfare Department:

(i) Emphasizes the importance of collaboration among different professionals in handling domestic violence cases. While professionals should protect the confidentiality of the personal data of their clients obtained in the course of duties, for cases without client's consent, Data Protection Principle 3 under Section 58 of the Personal Data (Privacy) Ordinance (Cap. 486) may be invoked if the data were to be used and shared for the purpose of child abuse investigation or related child protection work; and

(ii) Agrees that professionals concerned should pay more attention to the high risk moments.

Education Bureau:

(i) Has advised school personnel to be sensitive to the needs and the impact on students who are affected by family violence through seminars and circulars; and

(ii) Has reminded schools to observe the "Procedural Guidelines for Handling Battered Spouse Cases" published by the Social Welfare Department and take prompt actions by making referrals and arranging for follow-up support.

The Law Society of Hong Kong:

There is a common theme that all organisations involved with the process need a system in place to enable vital information to be shared. Professionals involved with divorcing parents face difficulties gaining access to information which the frontline social workers have on the high risk cases unless the client volunteers this. Social workers should be provided with the power to release up to date information on high risk children to appropriate parties, including solicitors, to enable all relevant stakeholders to be effective in the effort to prevent child fatalities.

In this regard, the exemption under Section 59 of the Personal Data (Privacy) Ordinance (Cap. 486) which covers "*serious harm to the physical or mental health of the data subject or any other individual*" could be highlighted to frontline social workers in order to ease fears on possible breach of the Ordinance and the privacy of their clients.

Recommendation 35

In pursuance of bias-free intervention, social worker should consult his / her supervisor in case of great difficulty in serving both the batterer and the victim for support and / or consideration of assigning another social worker to work with one of the parties.

Updating / Responses

Social Welfare Department:
It is common practice for the Department's social workers to report to their supervisors for support and advice whenever in need. Depending on individual case merit and circumstances, the supervisor will arrange for change of social worker or assignment of an additional social worker to work with the parties to promote the effectiveness and quality of the intervention.

Recommendation 36

Public education for children to help them learn how to protect themselves and build up their resilience towards domestic violence.

Updating / Responses

Social Welfare Department:

(i) Agrees that public education for children to help them learn how to protect themselves is very important;

(ii) Has produced the leaflet "What can I do? - *For children who have witnessed domestic violence*" in February 2008 to educate children to protect themselves when domestic violence occurs; and

(iii) Will consider further promoting the awareness and skills of self-protection for children experiencing domestic violence in future publicity campaigns.

Education Bureau:

(i) Has produced various teaching resources on the prevention of domestic violence, such as "Lesson plans on prevention and support to students affected by domestic violence", teaching resources for Personal Growth Education in primary schools on the topics of "self protection" and "problem-solving skills". Schools can make reference to the resources when educating students to protect themselves against domestic violence; and

(ii) Has implemented the Understanding Adolescent Project (UAP) which aims at enhancing students' resilience to adversities.

The Law Society of Hong Kong:

Procedures should be put in place so that children at-risk will know where they can seek assistance including but not limited to where and how they can contact their social worker in emergency situations.

Recommendation 37

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.

Updating / Responses

Department of Health:

(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, audiovisual 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.

Social Welfare Department:
While the topic of "Shaken Baby Syndrome" is covered by education programmes for parents provided by the Department of Health, the Department will take note of the recommendation and advise welfare service units to consider it in organising public education programmes where appropriate.

6.5 Overview of Cases Died of Natural Causes

Table 6.5.1: No. of Cases by Age Group and Sex

Age Group	Sex (%)		Total (%)
	Female	Male	
< 1	10 (16.4%)	8 (13.1%)	18 (29.5%)
1 – 2	3 (4.9%)	5 (8.2%)	8 (13.1%)
3 – 5	0 (0.0%)	6 (9.8%)	6 (9.8%)
6 – 8	1 (1.6%)	2 (3.3%)	3 (4.9%)
9 – 11	5 (8.2%)	5 (8.2%)	10 (16.4%)
12 – 14	2 (3.3%)	9 (14.8%)	11 (18.0%)
15 – 17	4 (6.6%)	1 (1.6%)	5 (8.2%)
Total:	25 (41.0%)	36 (59.0%)	61 (100.0%)

Figure 6.5.1: No. of Cases by Age Group and Sex

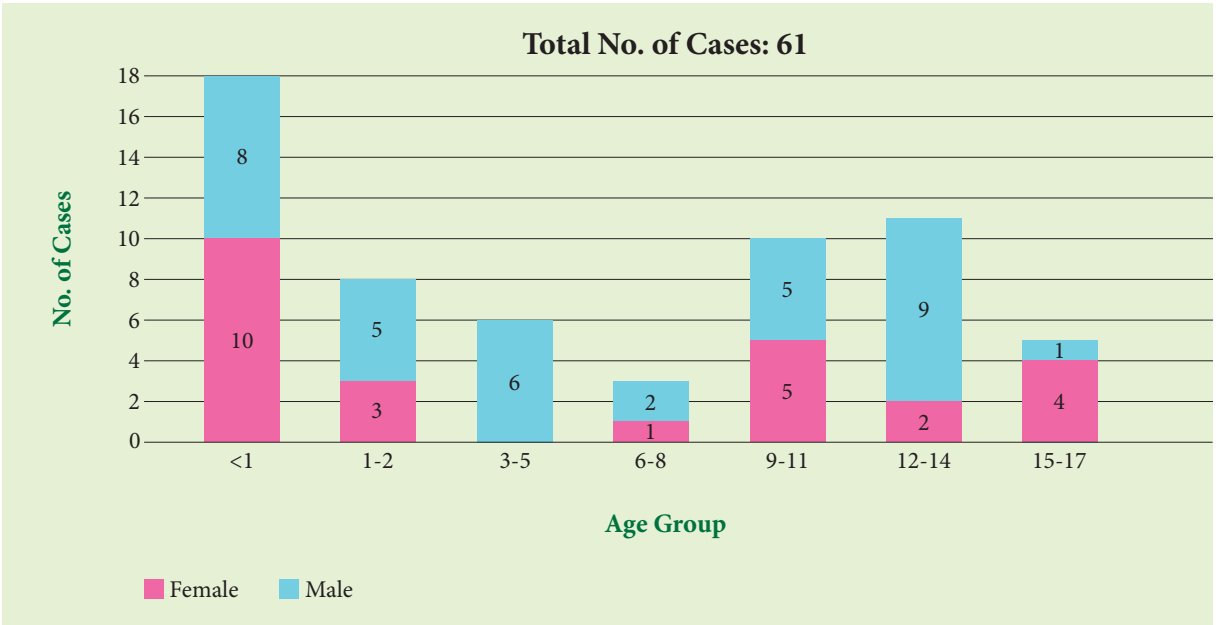
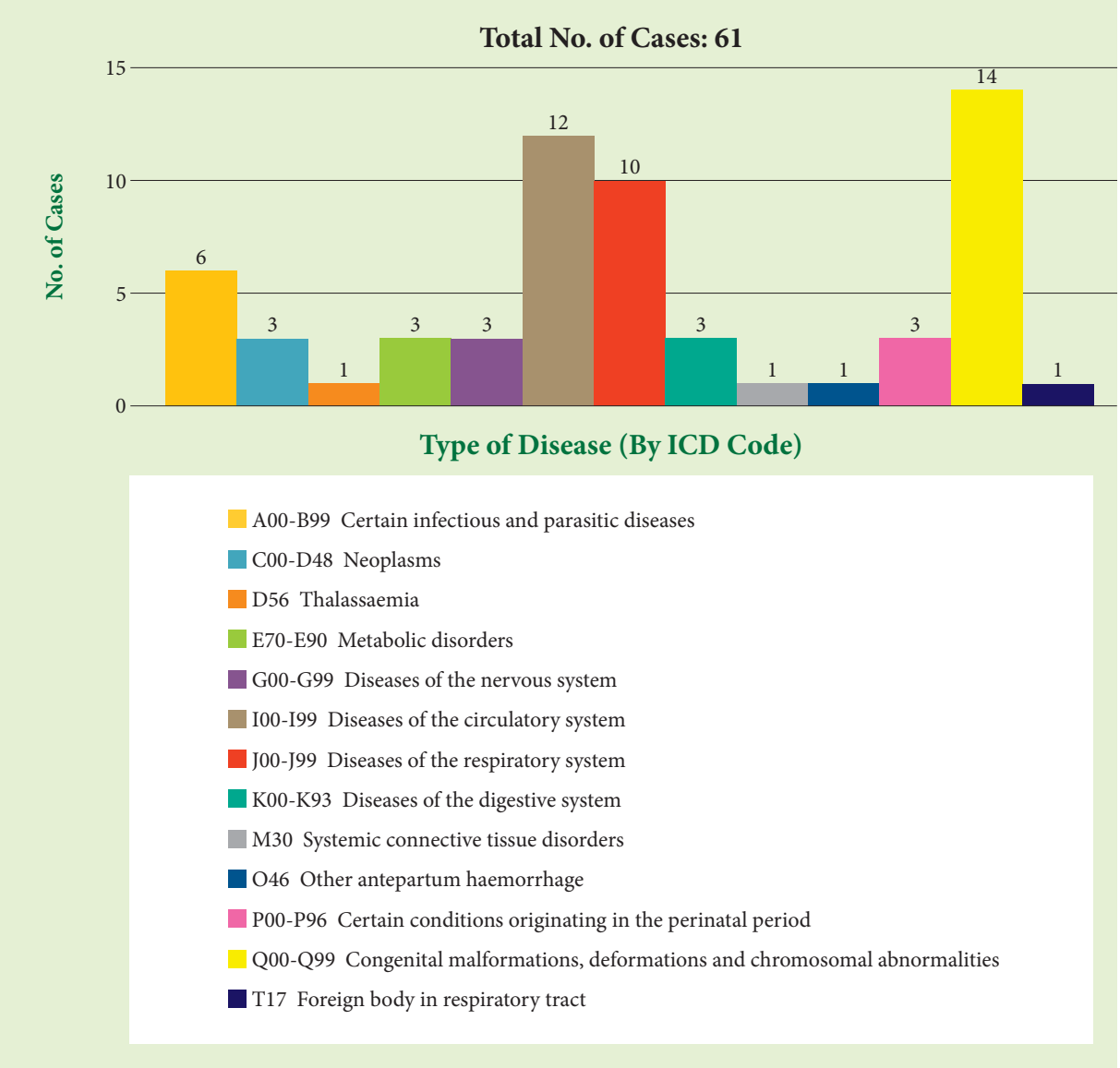


Table 6.5.2: No. of Cases by Type of Disease According to ICD10[4] Chapter Level Classification

ICD Code	Type of Disease	No. of Cases (%)
A00-B99	Certain infectious and parasitic diseases	6 (9.8%)
C00-D48	Neoplasms	3 (4.9%)
D56	Thalassaemia	1 (1.6%)
E70-E90	Metabolic disorders	3 (4.9%)
G00-G99	Diseases of the nervous system	3 (4.9%)
I00-I99	Diseases of the circulatory system	12 (19.7%)
J00-J99	Diseases of the respiratory system	10 (16.4%)
K00-K93	Diseases of the digestive system	3 (4.9%)
M30	Systemic connective tissue disorders	1 (1.6%)
O46	Other antepartum haemorrhage	1 (1.6%)
P00-P96	Certain conditions originating in the perinatal period	3 (4.9%)
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	14 (23.0%)
T17	Foreign body in respiratory tract	1 (1.6%)
	Total:	61 (100.0%)

[4] ICD10: the International Classification of Diseases, Version 10 which is developed by the World Health Organisation. The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. 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.

Figure 6.5.2: No. of Cases by Type of Disease According to ICD10[5] Chapter Level Classification



[5] ICD10: same as Note 4 (p.81)

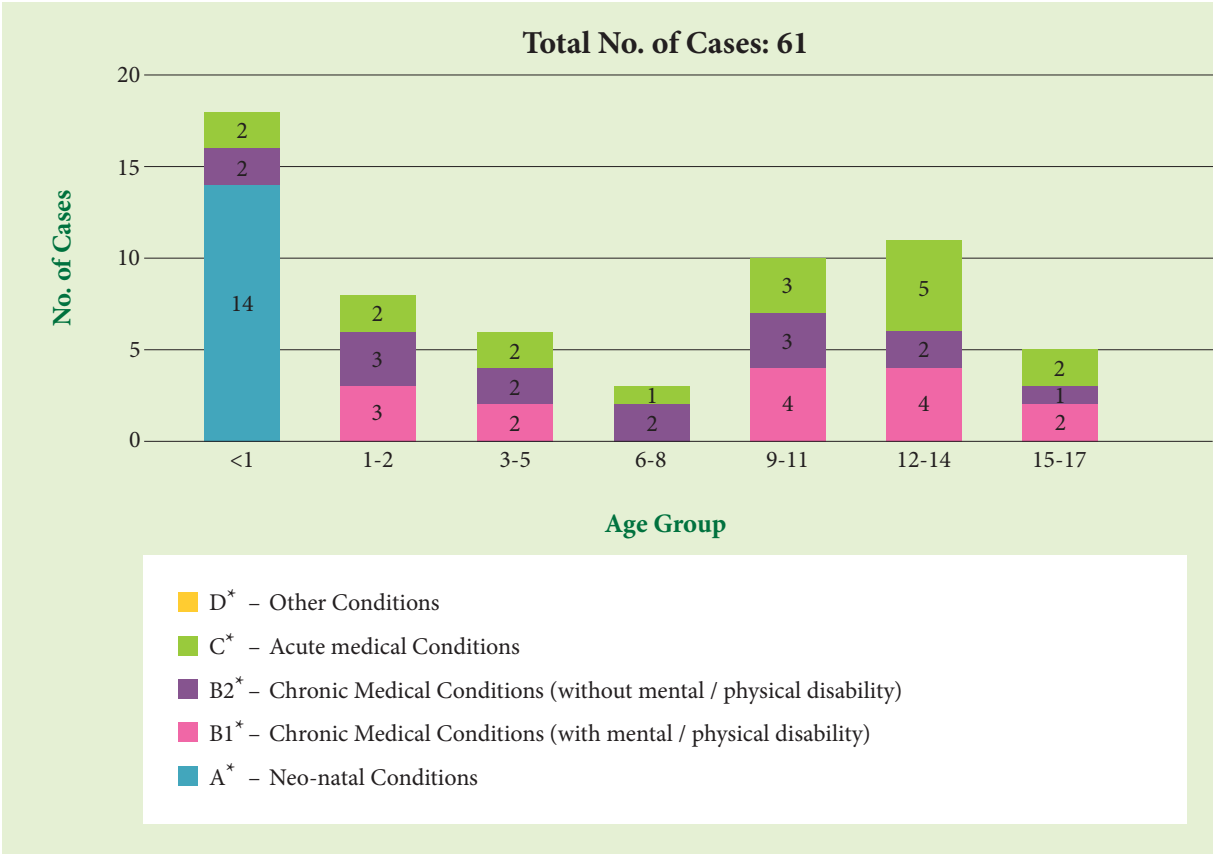
Table 6.5.3: No. of Cases by Age Group and Category

Age Group	Category*					Total (%)
	A	B		C	D	
		B1	B2			
< 1	14	0	2	2	0	18 (29.5%)
1-2	0	3	3	2	0	8 (13.1%)
3-5	0	2	2	2	0	6 (9.8%)
6-8	0	0	2	1	0	3 (4.9%)
9-11	0	4	3	3	0	10 (16.4%)
12-14	0	4	2	5	0	11 (18.0%)
15-17	0	2	1	2	0	5 (8.2%)
Total (%)	14 (23.0%)	15 (24.6%)	15 (24.6%)	17 (27.9%)	0 (0.0%)	61 (100.0%)

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

A - Neo-natal Conditions
B - Chronic Medical Conditions
B1 - with mental or physical disabilities
B2 - without mental or physical disabilities
C - Acute Medical Conditions
D - Others

Figure 6.5.3: No. of Cases by Age Group and Category



* *These categories of death are designed by the medical experts of the Review Panel for review purpose.*

Table 6.5.4: No. of Cases by Nationality

Nationality	No. of Cases (%)
Chinese	58 (95.1%)
Non-Chinese	3 (4.9%)
Total:	61 (100.0%)

Figure 6.5.4: No. of Cases by Nationality

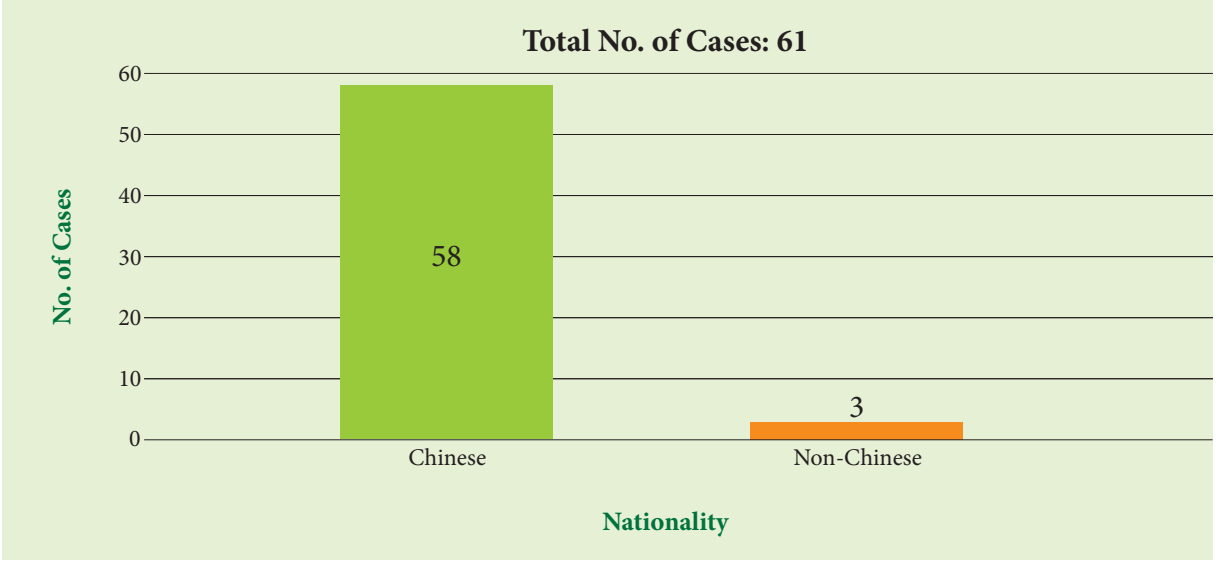
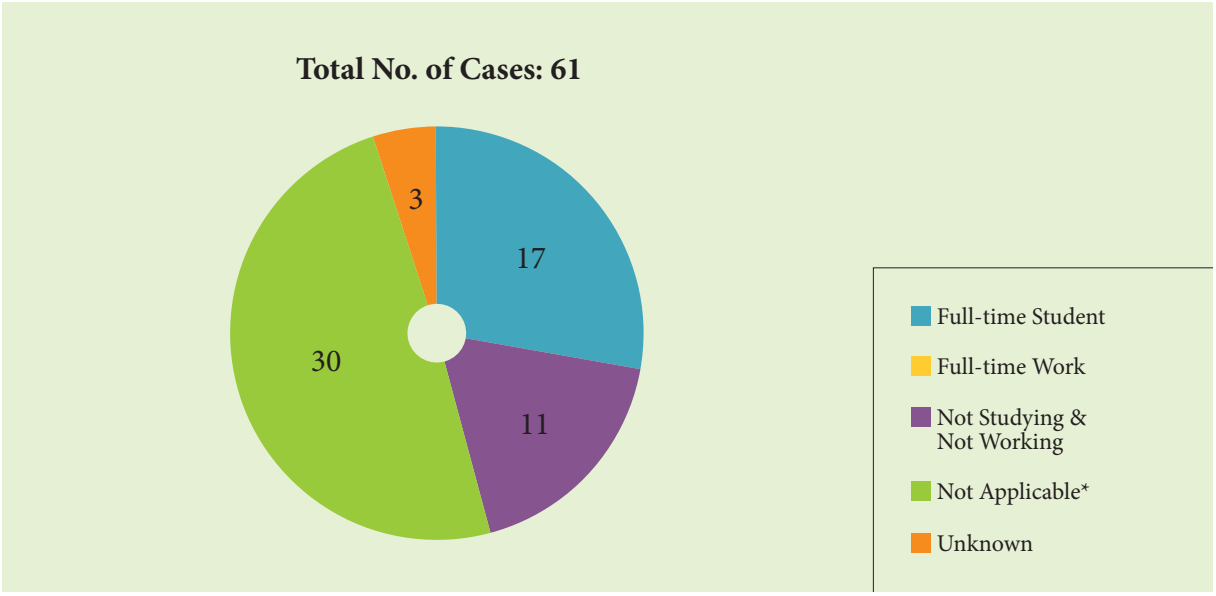


Table 6.5.5: Occupation of the Deceased Children

Occupation	No. of Cases (%)
Full-time Student	17 (27.9%)
Full-time Work	0 (0.0%)
Not Studying & Not Working	11 (18.0%)
Not Applicable*	30 (49.2%)
Unknown	3 (4.9%)
Total:	61 (100.0%)

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

Figure 6.5.5: Occupation of the Deceased Children



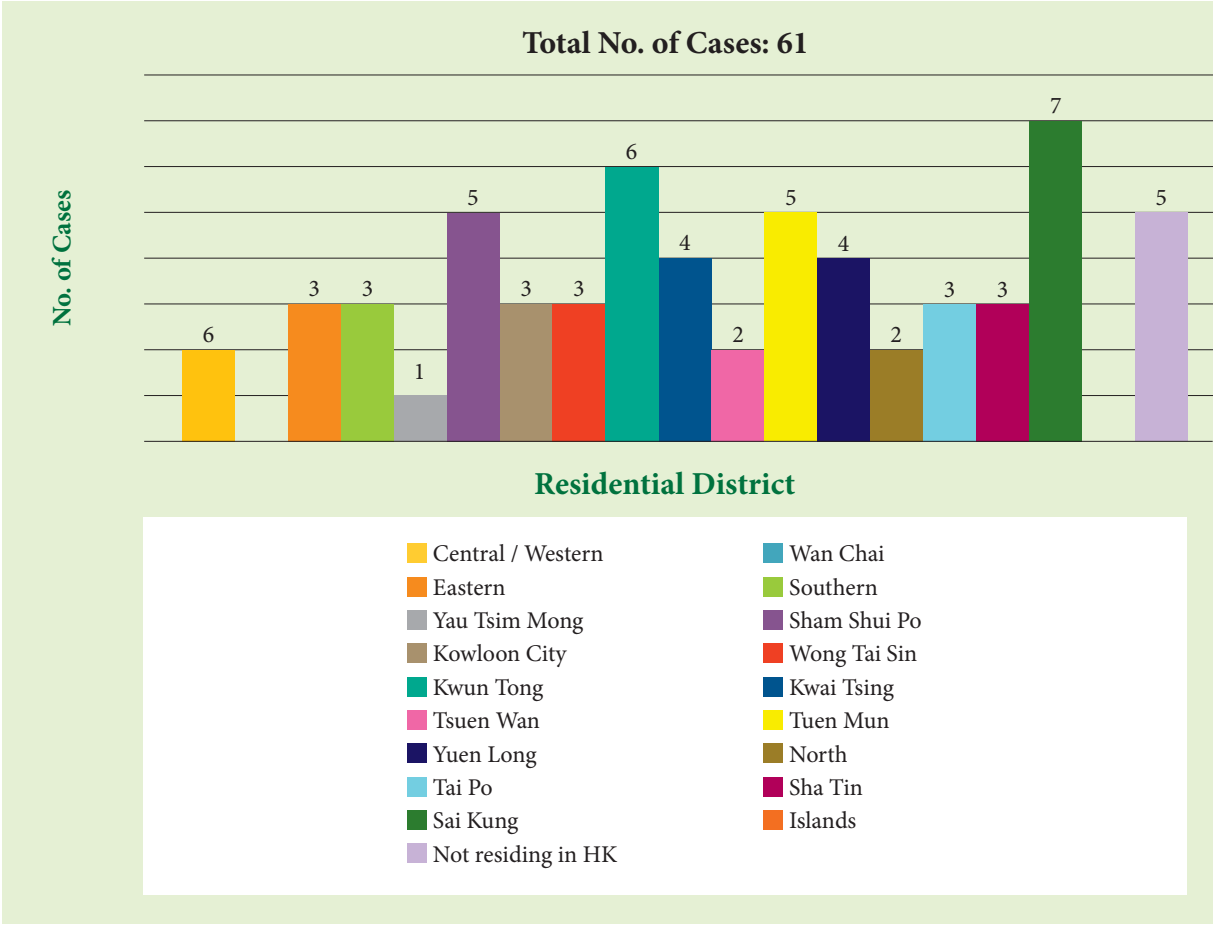
Not Applicable: includes those children in infancy or with health problems preventing them from attending school or work.*

Table 6.5.6: Residential District of the Deceased Children

Residential District	No. of Cases (%)
HONG KONG ISLAND	
Central and Western	2 (3.3%)
Wan Chai	0 (0.0%)
Eastern	3 (4.9%)
Southern	3 (4.9%)
KOWLOON	
Yau Tsim Mong	1 (1.6%)
Sham Shui Po	5 (8.2%)
Kowloon City	3 (4.9%)
Wong Tai Sin	3 (4.9%)
Kwun Tong	6 (9.8%)
NEW TERRITORIES	
Kwai Tsing	4 (6.6%)
Tsuen Wan	2 (3.3%)
Tuen Mun	5 (8.2%)
Yuen Long	4 (6.6%)
North	2 (3.3%)
Tai Po	3 (4.9%)
Sha Tin	3 (4.9%)
Sai Kung	7 (11.5%)
Islands	0 (0.0%)
OTHERS	
Not residing in HK	5 (8.2%)
Total:	61 (100.0%)

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

Figure 6.5.6: Residential District of the Deceased Children



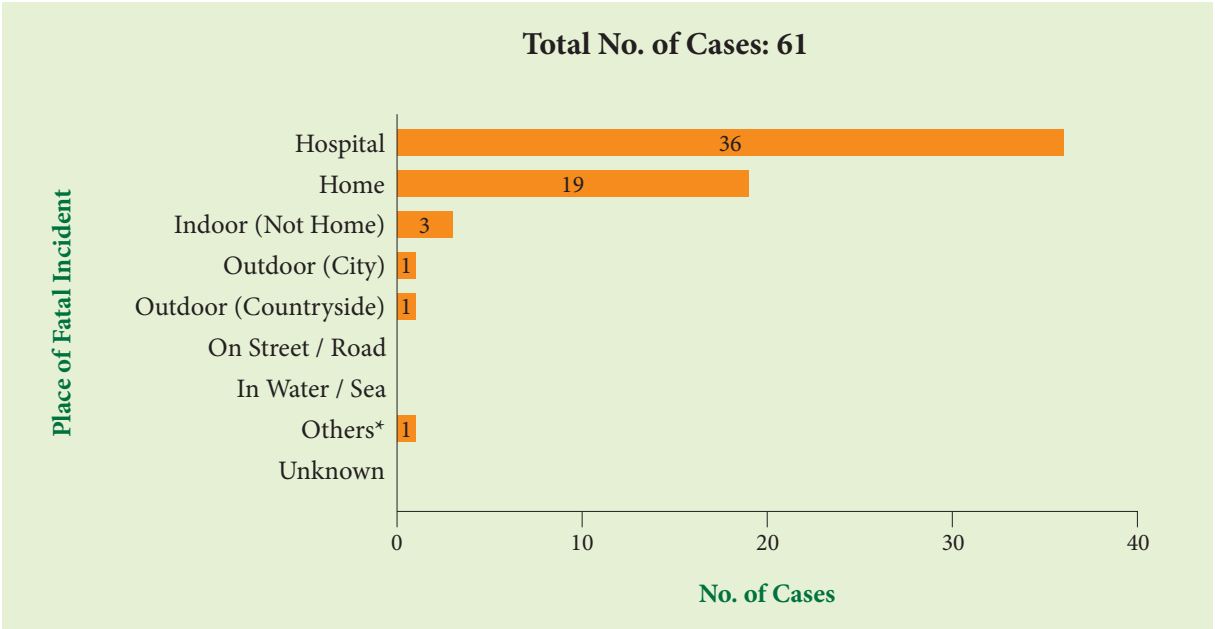
Classification of the residential districts above is according to the 18 districts in District Council / Constituency Area.

Table 6.5.7: Place of Fatal Incident

Place of Fatal Incident	No. of Cases (%)
Hospital	36.1 (59.0%)
Home	19 (31.1%)
Indoor (Not Home)	3 (4.9%)
Outdoor (City)	1 (1.7%)
Outdoor (Countryside)	1 (1.7%)
On Street / Road	0 (0.0%)
In Water / Sea	0 (0.0%)
Others*	1 (1.7%)
Unknown	0 (0.0%)
Total:	61 (100.0%)

Others: inside the lift in a building.*

Figure 6.5.7: Place of Fatal Incident



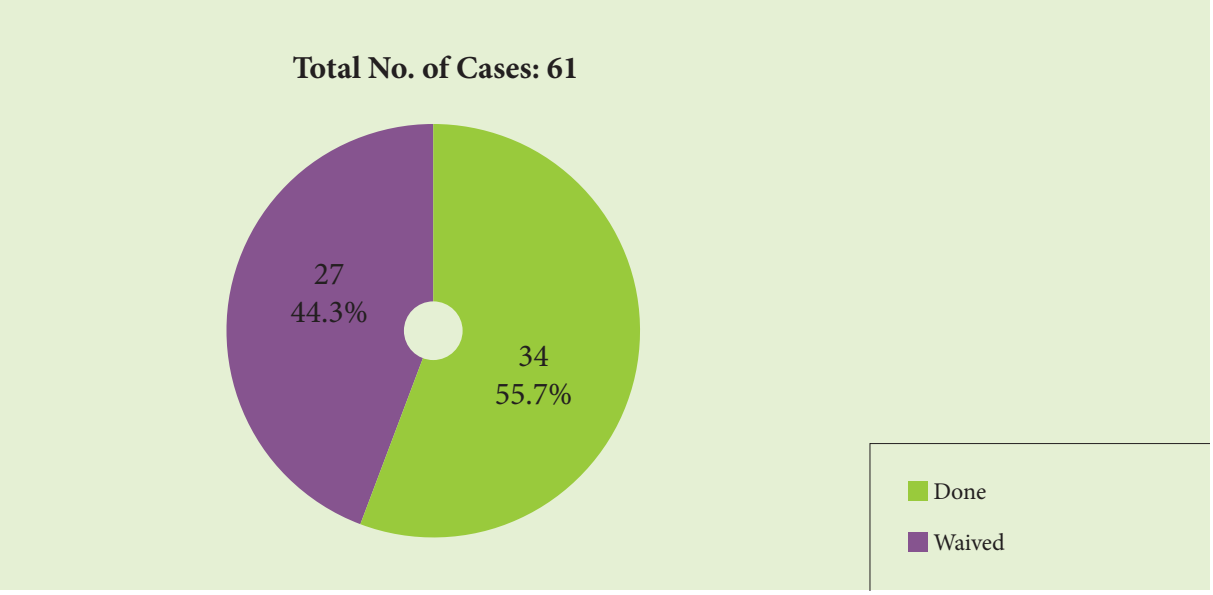
Others: inside the lift in a building.*

Table 6.5.8: No. of Cases with Autopsy Done or Waived

Autopsy	No. of Cases (%)
Done	34 (55.7%)
Waived	27 (44.3%)
Total:	61 (100.0%)

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

Figure 6.5.8: No. of Cases with Autopsy Done or Waived



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

6.5.1 General Observation

In the year 2006, 61 cases were reported to the Coroners and concluded to have died of natural causes. It should be noted that for some cases, there were insufficient information on different aspects, such as the family conditions and medical history of the deceased children for review. The Review Panel hence had difficulty to pass any comment on these cases.

Table and Figure 6.5.1 show the number of deceased children by age group and sex. The age group <1 has the highest number of child death (N=18, 29.5%) while the age group 12 – 14 comes second (N=11, 18.0%). The number of male (N=36, 59.0%) is higher than the number of female (N=25, 41.0%).

Table and Figure 6.5.2 show the number of child death by different categories according to the coding of the International Classification of Disease, Version 10 (ICD10) developed by the World Health Organisation and adopted worldwide. The death cause with the highest number of children (N=14, 23.0%) falls within the class of congenital malformations, deformations and chromosomal abnormalities (ICD code: Q00-Q99). The second class of disease with highest number of death (N=12, 19.7%) is diseases of the circulatory system (ICD Code: I00-I99). This includes pulmonary and other heart diseases. The class that comes third highest in number of child deaths (N=10, 16.4%) is diseases of the respiratory system (ICD Code: J00-J99). This category includes health problems like pneumonia and bronchopneumonia.

The Medical Experts of the Review Panel has grouped the 61 cases into four different categories for review purpose. These categories reflect the dominant nature of the death causes and their classification is as follows:

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 and Figure 6.5.3 show the number of child deaths under each of these four categories and the age group of the deceased. 14 children (23.0%) died of neo-natal conditions shortly after birth. 30 children (49.2%) died of chronic medical conditions among which 15 of them were with disability of some kind and the other 15 without. 17 children (27.9%) died of acute medical conditions.

After reviewing the cases died of natural causes, the medical experts of the Review Panel suggested that for some cases, more elaboration on the death causes within the ICD classification can help achieve better understanding towards the death causes for prevention purposes.

Table and Figure 6.5.4 show the number of child deaths by nationality. The majority of the children died of natural causes were of Chinese nationality. Only three (4.9%) out of the 61 children were non-Chinese.

Table and Figure 6.5.5 show the occupation of the deceased children. Occupation is not applicable to nearly half of the deceased children (N=30, 49.2%). This is because they were either too small or their health problems made it not possible for them to attend school. On the other hand, 17 (27.9%) of these children were full-time students and 11 (18.0%) were neither studying nor working despite they were at school or working age.

Table and Figure 6.5.7 show the place where the fatal incidents occurred. Over half of the incidents (N=36, 59.0%) occurred in hospitals, indicating that the death causes of these deceased children are closely related to health or medical problems. A significant number of these incidents (N=19, 31.1%) also occurred at the homes of the deceased children, including those who fell ill and collapsed at home.

Table and Figure 6.5.8 show the number of cases with autopsy done or waived according to the record at the Coroner's Court. Among the 61 cases that died of natural causes in 2006, 55.7% (N=34) of them had undergone autopsy for ascertaining the causes of death while 44.3% (N=27) had not.

6.5.2 Recommendations and Responses for Cases Died of Natural Causes

Recommendation 38

(i) It is observed that there is service gap in the home leave care arrangement for disabled children under residential care during which child fatality had occurred. Support for their families, particularly single parents can help prevent such incidents;

(ii) To cater for the special need of some children who do not have appropriate care-giver to look after them during home leave, residential care units can consider providing respite care service with minimal staff so that the needy children can stay in an environment they are familiar with; and

(iii) Children with severe disability should not be put under the care of young siblings who are not capable of such task.

Updating / Responses

Social Welfare Department:
Under the existing special education policy, children with disabilities aged 6 to 15 are provided with boarding service at special schools under the schedule of Education Bureau. To meet the temporary residential care needs of special school children, the Department, with support from non-governmental organisations operating subvented residential care service units for adult persons with disabilities, extended the residential respite service to children with disabilities below the age of 15 since April 2008. The Department agrees that the arrangement may not be to the best interest of these children with disabilities but consider it an option to release the caring burden for the parents / carers. To provide support for parents / carers of children with disabilities, the Department also provides a wide range of centre-based or home-based occasional care services at the 16 District Support Centre for Persons with Disabilities set up and located throughout the territory in January 2009.

Recommendation 39

Support for families looking after chronically-ill or disabled children with medical condition requiring special care at home is necessary.

Updating / Responses

Social Welfare Department:
Parents / Relatives Resource Centres provide a wide range of support services to parents and relatives of children with disabilities. Seminars, workshops, groups, talks are organised from time to time for parents / relatives of children with disabilities to help them better understand their children's disabilities and ways to provide care for them.

Recommendation 40

As occurrence of incidents of collapsing at home could be quite shocking and traumatic for family members (particularly young siblings) of the deceased children, it would be necessary to ensure that these families could receive needed counselling and support.

Updating / Responses

Social Welfare Department:
Medical social workers of the Department will be reminded to provide emotional support or counselling services to affected families where necessary. In handling cases involving death in the family, social workers of Integrated Family Service Centres / Integrated Services Centres will take note of the need of surviving family members and provide support services as appropriate.

Recommendation 41

To work out procedures to ensure every newborn should have physical examination by a paediatrician before discharge from hospital.

Updating / Responses

Hospital Authority:
Under the current practice of the Hospital Authority, which is not dissimilar to those in other developed countries, newborns are attended by doctors and will be seen by doctors of relevant discipline when clinically indicated.

Recommendation 42

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.

Updating / Responses

Department of Health:
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:

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

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

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

Coroner's Court:
Noted the recommendation.

Recommendation 43

To ensure that staff on duty in special schools and care / training centres for disabled children have received update first aid training.

Updating / Responses

Social Welfare Department:
Under the Funding and Service Agreement between the Department and the operating non-governmental organisations, provision of nurse is an essential staff requirement for special child care centres. That being so, the care / training centres will be reminded to ensure staff on duty have first-aid training.

Education Bureau:
To address the needs of the boarders in special schools for children with severe intellectual disability or physical disability, the boarding section of these schools is provided with one nurse for 25 boarders for weekdays, and an additional 0.6 nurse for 25 boarders at weekend and on Sunday if they operate at weekends and on Sundays. The minimum provision is one nurse at any one time during the operational hours of the boarding section irrespective of its size. This provision ensures that the boarders are provided with first aid and other essential nursing support in case of emergency.

Recommendation 44

To ensure the presence of on-site personnel trained in resuscitation of children in every private or public hospital treating paediatric patient.

Updating / Responses

Department of Health:
All nurses in private hospitals and nursing homes have already been undergoing annual cardiopulmonary resuscitation (CPR) courses and drills.

Recommendation 45

Provision of trained first aiders and equipment like automated defibrillator in sports venues for handling sudden collapse cases during sports events.

Updating / Responses

Leisure and Cultural Services Department:

(i) According to the Department's policy, basic first aid equipment are provided at major recreation and sports venues under its schedule to enable its staff to carry out immediate first aid treatment in case of injuries or accidents. Organisers of events held at the Department's venues are required to engage qualified first aiders. Moreover, the Department is now studying the feasibility of providing automated external defibrillator at major sports venues; and

(ii) It is an established requirement stipulated in the "General Conditions of Use of Leisure and Cultural Services Department Sports Grounds for Athletics Meets and Other Sports Activities" that schools, as hirers of the sports grounds, should provide first aid service and the necessary precautions and care for ensuring the safety of the athletes, spectators and all other persons using the sports ground during the event period. The Department will remind schools that they should comply with the conditions of use when conducting athletic activities at sports grounds under the Department's schedule.

Education Bureau:

Under the "Guidelines on Outdoor Activities", schools are advised that at least one member of the outdoor activity group should have received first aid training if the activity is conducted in a natural environment and is exploratory, challenging and physically demanding.

Recommendation 46

For some cases, autopsy may help to enlighten the cause of death for prevention purpose.

Updating / Responses

Department of Health
The Forensic Pathologists of the Department handle reportable deaths under the Coroner's Ordinance (Cap. 504) and the authority to order an autopsy to be conducted or waived comes under the jurisdiction of the Coroner. When an autopsy is ordered by the Coroner, the primary objective of the forensic pathologist's role is to assist the Coroner in ascertaining a cause of death and one of the purposes of Coroner's death enquiry is to prevent similar fatality in the future.

Coroner's Court:
Noted the recommendation.

Recommendation 47

General education to urge parents of children with asthma to seek medical treatment whenever in need, particularly in the night-time.

Updating / Responses

Department of Health:

(i) It is usual practice for doctors to explain to parents / caretakers the causes of the illness, possible triggers or aggravating factors, possible complications, prognosis, available treatment options and individualized treatment plan for the child, possible side effects of treatment prescribed, symptoms & signs of non-response to treatment which warrant immediate medical intervention, etc. Education provided to parent / caretaker by the doctor managing the children with asthma is considered to be more effective and targeted approach, while education targeting general public would be less effective as most of general population do not have asthma and may not consider the advice relevant; and

(ii) Treatment and follow-up for acute / chronic illness such as asthma for general public / children is not provided by the Department. Nevertheless, medical and nursing staff of the Department will address parents' or caretakers' concerns and offer health advice during encounters.

Social Welfare Department:

The Department of Health and the Hospital Authority are in the best position to provide general education in this aspect. Medical social workers of the Department will also advise the parents to bring their children with asthma to seek medical treatment when necessary, particularly in the night time.

7 WAY FORWARD

Building on the experience gained in reviewing child death cases occurring in 2006, members of the Review Panel will review cases that had occurred in 2007 with improved efficiency. The Review Panel hopes that findings of the review of child death cases may throw light on how existing services or systems can be improved to prevent child death. Such findings will be included in the next report of the Pilot Project to be published upon completion of review on cases occurring in 2006 and 2007.

At a later stage, the Review Panel may contact the concerned organisations / departments to whom the recommendations listed in Chapter 6 of this Report were distributed to inquire if further action has been taken regarding the recommendations for further sharing and updating in future report.

When the Pilot Project comes to its end, an evaluation examining different aspects of the review mechanism will take place. Information on the evaluation will also be published.

Appendix I : The 20 Categories of Deaths Reportable to the Coroner

The 20 Categories of Deaths Reportable to the Coroner

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

Source: http://www.judiciary.gov.hk/en/crt_services/pphlt/html/cor.htm

Appendix II: Bilingual Information Brief of the Pilot Project on Child Fatality Review

Pilot Project on Child Fatality Review

Background

Despite concerted efforts of the Government and Non-governmental Organisations in the provision of child welfare services, occasional child deaths have aroused public concerns. In consultation with the Committee on Child Abuse and with reference to overseas experience, the Social Welfare Department (SWD) has launched a 2-year Pilot Project on Child Fatality Review with effect from 15 February 2008.

Purpose

1. To facilitate the improvement / enhancement of the current child protection and child welfare service systems; and
2. With focus on inter-sectoral collaboration and multi-disciplinary cooperation, it is neither intended to identify causes leading to the child's death nor to attribute responsibility to individuals.

Objectives

1. To examine the practice and service issues pertaining to the child death cases;
2. To identify good practice and possible areas for improvement;
3. To identify patterns and trends for formulation of prevention strategies; and
4. To promote multi-disciplinary and inter-agency cooperation for prevention of child death.

Levels and Scope

1. General Review for *all children under 18 who died of non-natural causes on or after 1 January 2006* upon completion of all criminal and judicial processes to avoid prejudicing such processes.
2. In-depth Review for cases arousing public concern and with implication on the welfare services system.

The Review Mechanism

1. A non-statutory Review Panel (RP), with members appointed by the Director of Social Welfare will conduct review with secretariat support from the SWD;
2. The Secretariat will prepare the lists of cases within specified periods for General and In-depth Reviews, and obtain their information for review by the RP. The review is primarily documentary in nature. However, the RP may consider interviews with concerned parties when necessary;
3. Organisation(s) that had rendered service(s) to the deceased child or his/her family could facilitate the review by providing available information to the secretariat;
4. A child death register will be set up to facilitate the review, and for future statistical or research purpose;

5. The review findings and recommendations of the RP will be published in annual reports. Recommendations will be distributed to relevant parties/organisations for consideration and follow-up action; and
6. No individual case details or personal particulars of persons or agencies concerned will be included in the annual report to ensure ***strict confidentiality***. Information furnished by organisation(s) will be used by the Secretariat 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 / Pilot Project on Child Fatality Review
Room 721, Wu Chung House
213 Queenís Road East
Wanchai, Hong Kong

Tel. No.: 2892 5670
E-mail: srp@swd.gov.hk
July 2008

「檢討兒童死亡個案先導計劃」

背景

儘管政府與非政府機構一直協力提供有關服務以維護兒童的福祉，兒童死亡個案仍時有發生並引起公眾關注。在諮詢過防止虐待兒童委員會及參考外國經驗後，社會福利署(下稱社署) 已於二零零八年二月十五日開始推行一項為期兩年的「檢討兒童死亡個案先導計劃」。

目的

1. 促進改善及強化現行保護兒童及兒童福利服務制度；及
2. 重點在於跨界別和跨專業的協作情況，而非為調查導致兒童死亡的原因或追究個人責任。

目標

1. 研究涉及兒童死亡個案的工作及服務事宜；
2. 找出服務及制度上優良或可改善之處；
3. 識別有關模式及趨勢以制訂預防兒童死亡之策略；及
4. 促進跨專業及跨機構的合作以預防兒童死亡。

層次及範疇

1. 對所有自二零零六年一月一日或以後死於非自然因素的18歲以下兒童死亡個案作總體檢討。檢討只會在有關個案的所有刑事及司法程序完成後才會進行，以免影響該等程序。
2. 對那些引起公眾關注並會對社會福利服務有所影響的個案再另作深入檢討。

檢討機制

1. 由非法定的檢討委員會進行檢討。其成員由社署署長委任，並由社署成立秘書處向檢討委員會提供文書支援；
2. 秘書處會按時段擬備死於非自然因素的兒童個案名單，並收集相關資料供檢討委員會作總體及深入檢討。檢討形式基本上是以閱覽相關資料及文件為主。如認為有需要，檢討委員會亦會約見有關人士；
3. 曾為已故兒童或其家庭提供服務的機構可透過向秘書處提供有關個案的資料協助進行檢討；
4. 設立兒童死亡名冊及資料庫以協助檢討的進行，其資料亦可作統計及研究用途；
5. 檢討的結果及建議將刊載於檢討委員會出版的綜合年報。檢討委員會所提出的建議會交相關團體及機構考慮及跟進；及
6. 基於保密原則，個別個案的詳情及任何個人或機構的資料將不予公開。機構向秘書處提供的資料，只會作檢討兒童死亡個案之用。除因法律授權或規定外，否則所有資料絕對保密，並且不會在未經有關機構事先同意下向第三者披露。從各方面搜集得有關死亡兒童個案的資料會於檢討完成後銷毀。

查詢

「檢討兒童死亡個案先導計劃」檢討委員會秘書處
香港灣仔皇后大道東213號
胡忠大廈7樓721室

電話：2892 5670
電郵：srp@swd.gov.hk

二零零八年七月

Appendix III: List of Members of the Review Panel

A. Members :

	Name	*Field*
1.	Prof LEUNG Nai-kong (Chairman)	Medical (Paediatrics)
2.	Ms CHAN Kit-bing, Sumee	Clinical Psychology
3.	Miss CHAN Mi-har, Grace	Social Welfare
4.	Miss CHAN Mei-lan, Anna May	Legal
5.	Mr HUI Chung-shing, Herman	Legal
6.	Miss HUNG Wing-chee, Anna	Education
7.	Dr LAM CHAN Lan-tak, Gladys	Academia
8.	Ms LAM Wai-ling, Leona	Education
9.	Dr LEE Lai-wan, Maria	Child Education
10.	Prof SHEK Tan-lee, Daniel	Academia
11.	Miss TSANG Lan-see, Nancy	Social Welfare
12.	Ms WONG Yu-pok, Marina	Accounting
13.	Dr YIU Gar-chung, Michael	Medical (Psychiatry)
14.	Mr YU Wing-fai, Christopher	Parent

B. Co-opted Members: (since 9.2.2009)

	Name	*Field*
15.	Dr CHEUNG Chi-hung, Patrick	Medical (Paediatrics)
16.	Prof Albert Martin LI	Medical (Paediatrics)
17.	Dr TSANG Man-ching, Anita	Medical (Paediatrics)
18.	Dr YU Chak-man	Medical (Paediatrics)

Appendix IV: Data Input Form for Reporting Child Died of Non-natural Cause

Pilot Project on Child Fatality Review
Data Input Form for Reporting Child Died of Non-natural Cause

Please read this Guiding Notes before completing this Data Input Form:

1. This Data Input Form is to facilitate the implementation of the Pilot Project on Child Fatality Review.

2. Your assistance in completing this Data Input Form will help facilitate the review on children died of non-natural causes which aims at improving child protection and welfare services and preventing child death.

3. If more than one unit is involved in the same case within the same organisation, the management concerned may consider submitting one consolidated Data Input Form incorporating information from all units concerned, or alternatively, submitting all Data Input Forms completed by different units to the Secretariat.

4. Please complete this Data Input Form according to information and record available to you and all you know about the deceased child and/or his/her family up **till the child's death**.

5. **No identifying personal data of the surviving family members** of the deceased child should be entered in this Form. You are free to decide what data should be included in case you have strong concern about privacy of any party concerned.

6. In case you deem it necessary to obtain consent from the concerned parties before you release their data, care should be given to possible arousal of their traumatic feelings. If such being the case, appropriate counselling is required.

7. Please use one Data Input Form for each deceased child.

8. If there is not enough space provided in this Form or if you want to provide relevant information which falls outside the scope of the items or parts provided in this Form, please supply such information on separate sheet(s).

9. Information furnished by organisation(s) will be used by the Secretariat 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.

10. This Data Input Form will be destroyed upon completion of review.

11. Please put the completed Data Input Form into a sealed envelope marked confidential and send it to: (For schools, the Form should also be copied to CSDOs of their respective districts as requested by EDB)

Secretary (Review Panel)
Pilot Project on Child Fatality Review
Room 721, Wu Chung House
No. 213 Queen's Road East
Wanchai, Hong Kong

(Tel. No. for Enquiries : 2892 5670)

For Official Use Only:

CDR No.: ☐☐☐☐ / ☐☐☐☐ Date Form Received: ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

CPR No.: ☐☐☐☐ *(if applicable)*

Data Input Form for Reporting Child Died of Non-natural Cause

I. PARTICULARS OF THE DECEASED CHILD

(Please fill in the blanks or put a ☑ in relevant boxes as appropriate.)

(1) **Name:** _____ (English) _____ (Chinese)
(Surname/FamilyNameFirst)

(2) **Sex:** ☐ M ☐ F

(3) **Date of Birth:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(4) **Date of Death:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(5) **HK*BC/IC No.:** ☐☐ ☐☐☐☐☐☐ (☐)

(6) **Identification Document** *(only when HKBC/IC is not available)*:
i) Type of Identification Document: *(e.g. Passport)* _____
ii) Identification Document Number: _____

(7) **Year arrived in HK:** _____ ☐ Since Birth ☐ Unknown

(8) **Nationality:** ☐ Chinese ☐ Non-Chinese *(Please specify)* _____

(9) **Marital Status:** ☐ Never Married ☐ Cohabited ☐ Married ☐ Separated ☐ Divorced

(10) **Occupation:**
☐ 01 Full-time student ☐ 02 Part-time student
☐ 03 Full-time work ☐ 04 Part-time work
☐ 05 Not applicable ☐ 06 Not studying & not working
☐ 07 Unknown

(11) **District of Residence:** *(according to District Council districts)*

☐ CW	Central/Western	☐ TW	Tsuen Wan
☐ S	Southern	☐ KWT	Kwai Tsing
☐ WC	Wan Chai	☐ TM	Tuen Mun
☐ E	Eastern	☐ YL	Yuen Long
☐ IS	Islands	☐ ST	Sha Tin
☐ YTM	Yau Tsim Mong	☐ TP	Tai Po
☐ SSP	Sham Shui Po	☐ N	North
☐ KC	Kowloon City	☐ PRC	Residing in People's Republic of China
☐ WTS	Wong Tai Sin	☐ NHK	Not residing in Hong Kong
☐ SK	Sai Kung	☐ U	Unknown
☐ KT	Kwun Tong	☐ OTH	Others *(Please specify)* _____

(12) **Type of Residence:**

- ☐ 01 Public/Interim Housing
- ☐ 02 Bedspace/Squatter Area/Rooftop Structure
- ☐ 03 Rented Room/ Suite
- ☐ 04 Rented Cubicle
- ☐ 05 Self-owned Cubicle
- ☐ 06 Residential Care Unit/ Foster Home
- ☐ 07 No fixed abode
- ☐ 08 Street sleeping
- ☐ 09 Others *(Please specify)* _____

(13) **Educational Level of Deceased Child and Parents/Guardian:**

Deceased Child:

- ☐ PSC Pre-school
- ☐ PRI Primary
- ☐ SEC Secondary
- ☐ VCT Vocational Training
- ☐ TER Tertiary or above
- ☐ NYS Not Yet Studying
- ☐ U Unknown

Name of school last attended by the deceased child with period:

_____

_____ (From: To:) Class: _____

Father	***Mother***	***Guardian***
☐ ILT Illiterate	☐ ILT Illiterate	☐ ILT Illiterate
☐ PRI Primary	☐ PRI Primary	☐ PRI Primary
☐ SEC Secondary	☐ SEC Secondary	☐ SEC Secondary
☐ VCT Vocational Training	☐ VCT Vocational Training	☐ VCT Vocational Training
☐ TER Tertiary or above	☐ TER Tertiary or above	☐ TER Tertiary or above
☐ U Unknown	☐ U Unknown	☐ U Unknown

(14) **Persons Living with the Deceased Child at the Time of Death:** *(Please ☑ all that are applicable.)*

☐ FA Father	☐ REL Relative(s)
☐ MO Mother	☐ CO Cohabiting with Boyfriend/Girlfriend
☐ BP Both Parents	☐ FR Friend(s)
☐ SIB Sibling(s)	☐ SW Sworn Parent(s)
☐ PG Paternal Grandparent(s)	☐ AL Alone
☐ MG Maternal Grandparent(s)	☐ INS In Institution
☐ STP Step-parent(s)	☐ FP Foster Parents
☐ STS Step-sibling(s)	☐ OTH Others (Please Specify)
☐ CG Care-giver	☐ U Unknown

Total no. of sibling in deceased child's family: *(excluding the deceased child)* _____

(15) **Health Condition of the Deceased Child:**

*(Please ☑ all types of problems that are applicable and *delete as appropriate.)*

☐ a. Generally healthy

☐ b. Had suffered from:

Type of problem	Diagnosis	Received Treatment	Name of Hospital/ Clinic/Treatment Centre
☐ Physical chronic illness	_____	*Yes/No	_____
☐ Psychiatric illness	_____	*Yes/No	_____
☐ Disability	_____	*Yes/No	_____
☐ Developmental delay	_____	*Yes/No	_____
☐ Others *(Please Specify)*	_____	*Yes/No	_____

☐ c. Unknown

(16) **Deceased Child being Recipient of Disability Allowance:**

☐ Yes, SSA Ref. No.:

☐ No

(17) **Family Income:**

☐ 01 On CSSA CSSA Ref. No.: _____

☐ 02 Below $10,000

☐ 03 $10,000 – $19,999

☐ 04 $20,000 – $29,999

☐ 05 $30,000 – $39,999

☐ 06 $40,000 – $49,999

☐ 07 $50,000 or above

☐ 08 Unknown

II. INFORMATION ABOUT CHILD'S DEATH

(18) **Information about Child's Death:**

(i) Date when Reporting Office came to know child's death:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(ii) Date of Reporting Office's last contact with deceased child:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iii) Date of Reporting Office's last contact with deceased child's family:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iv) Cause of death :

☐ ACC(D)	Accident - Drowning	☐ SUI(DO)	Suicide - Drug Overdose
☐ ACC(DO)	Accident - Drug overdose	☐ SUI(G)	Suicide - Gas
☐ ACC(F)	Accident - Fall	☐ SUI(H)	Suicide - Hanging
☐ ACC(HH)	Accident - Household	☐ SUI(J)	Suicide - Jumping
☐ ACC(T/C)	Accident - Traffic (Cycling)		
☐ SUI(OTH)	Suicide - Others *(Please specify)* _____		
☐ ACC(T/O)	Accident - Traffic (Other than Cycling)		
☐ MC	Complications of medical treatment/procedures		
☐ ACC(OTH)	Accident - Others *(Please specify)* _____		
☐ HOM	Homicide	☐ P	Pending Investigation
☐ U	Unknown		

(v) Place where the fatal incident occurred: _____

(vi) Any suspicion of child abuse element leading to child's death:

☐ No ☐ Uncertain

☐ Yes, please elaborate: _____

_____

(vii) Apart from this childís death, any other child death(s) involved in the same family or in the same event?

☐ No

☐ Yes, please give name(s) of the other deceased child(ren): _____

[Please fill in a separate Data Input Form for each named deceased child]

(19) **How the Reporting Office/Organisation came to know about the child's death:**

(20) **Significant circumstances or event(s) that had occurred to the deceased child and/or his/her family prior to child's death, particularly those related with the child's death:**

(21) **Other significant information or observation on the deceased child and his/her family:**

III. INFORMATION ON SERVICES RECIEVED

(22) **Service(s) received from the Reporting Office:**

(i) Had the deceased child and/or his/her family received service from the Reporting Office:
☐ Yes: please complete (ii) to (viii) below ☐ No

(ii) Type of service(s) received: _____

(iii) Service period(s): _____

(iv) File reference number at the Reporting Office (if any): _____

(v) Source of referral: _____
☐ Self-referral

(vi) Presenting problem(s)/Need(s) when the case was last known: _____

(vii) Identified problem(s)/Need(s) when the case was last known: _____

(viii) Assistance requested by client/referrer: _____

(23) **Information about contacts between the deceased child and his/her family with other professionals within 6 months before the child's death:**
*(Please ☑ all that are applicable, give details and *delete as appropriate.)*

Professionals	**Principal Client (e.g. child, father)**	**Service Unit/ Agency**	**Contact Phone No.**
☐ a. Psychiatrist			
☐ b. Medical Practitioner			
☐ c. Psychologist (*Clinical/Educational)			
☐ d. Social Worker (including Medical Social Worker)			
☐ e. School Helping Professionals (*SGP/SSW/SGO/SGT/Teacher)			
☐ f. Therapist (*OT/PT/ST)			
☐ g. Community Psychiatric Nurse			
☐ h. Police			
☐ i. Staff of Social Security Field Unit			
☐ j. Others *(please specify)*			

(24) **Information about service delivery and collaborative contacts on deceased child and/or his/her family:**

(i) Professionals/agencies mentioned in item (23) above whom you had had contact(s) with concerning the deceased child and/or his/her family in the past:

(ii) Agreed intervention plan among different professionals (if any) and progress of implementation:

(Please include good practice identified and difficulties encountered in inter-disciplinary or inter-sectoral collaboration.)

(iii) Other Remarks:

Please use additional sheets for any part if required.

IV. PARTICULARS OF THE REPORTING OFFICE

(25) **Date of Reporting:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(26) **Reporting Office/Organisation:** _____

(27) **Reporting Officer (Name/Post):** _____

(28) **Reporting Officer's Contact Tel. No.:** _____
(for contact only when clarification or further information is required)

July 2008

Appendix V: Service Report for Review of Child Died of Non-natural Cause

Pilot Project on Child Fatality Review
Service Report for Review of Child Died of Non-natural Cause

Please read this Guiding Notes before completing this Service Report:

1. This Service Report is to facilitate the implementation of the Pilot Project on Child Fatality Review.

2. In case you have previously submitted the Data Input Form on this same case before, please note that Parts I to III of this Service Report are identical to those in the Data Input Form.

3. Your assistance in completing this Service Report will help facilitate the review on children died of non-natural causes which aims at improving child protection and welfare services and preventing child death.

4. Please complete this Service Report according to information and record available to you and all you know about the deceased child and/or his/her family up **till the child's death**.

5. The Reporting Organisation can decide on the appropriate person(s) to be the Reporting Officer(s) on any part of the Service Report. But it is advised that Part VI should be completed by management staff of the Reporting Organisation.

6. If more than one unit is involved in the same case within the same organisation, the management concerned may consider submitting one consolidated Service Report incorporating information from all units concerned, or alternatively, submitting all Service Reports with Part I to Part V completed by different units and with the consolidated Part VI completed by the management to the Secretariat.

7. **No identifying personal data of the surviving family members** of the deceased child should be entered in this Service Report. You are free to decide what data should be included in case you have strong concern about privacy of any party concerned.

8. In case you deem it necessary to obtain consent from the concerned parties before you release their data, care should be given to possible arousal of their traumatic feelings. If such being the case, appropriate counselling is required.

9. For protection of personal privacy, please remove any personal identifiers of the living family members of the deceased child and the worker(s) and supervisor(s) concerned in the Service Report before submission to the Secretariat.

10. Involved parties, such as the caseworker or his/her immediate supervisor, are invited and encouraged to give their views on the case.

11. This report format serves only as a guide for provision of information essential for a thorough child fatality review. Depending on the service nature, duration and the degree of involvement, the Reporting Office is advised to complete the Report according to the format as similar as possible though not all items may be applicable.

12. If there is not enough space provided in this report format or if you want to provide relevant information which falls outside the scope of the items or parts provided in this Report Format, please supply such information on separate sheet(s).

13. The Service Report should preferably be completed within three months after the childís death while memory is still fresh and records are readily available. The Secretariat will advise the concerned agency on the proper time of submission of the Report.

14. Information furnished by organisation(s) will be used by the Secretariat 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.

15. This Service Report will be destroyed upon completion of review.

16. Please put the completed Service Report into a sealed envelope marked confidential and send it to: (For schools, the Report should also be copied to CSDOs of their respective districts as requested by EDB)

    Secretary (Review Panel)
    Pilot Project on Child Fatality Review
    Room 721, Wu Chung House
    No. 213 Queen's Road East
    Wanchai, Hong Kong

    (Tel. No. for Enquiries : 2892 5670)

For Official Use Only:

CDR No.: ☐☐☐☐ / ☐☐☐☐ Date Form Received: ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

CPR No.: ☐☐☐☐ *(if applicable)*

Service Report for Review Child Died of Non-natural Cause

I. PARTICULARS OF THE DECEASED CHILD

(Please fill in the blanks or put a ☑ in relevant boxes as appropriate.)

(1) **Name:** _____ (English) _____ (Chinese)
(Surname/FamilyNameFirst)

(2) **Sex:** ☐ M ☐ F

(3) **Date of Birth:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(4) **Date of Death:** ☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(5) **HK*BC/IC No.:** ☐☐ ☐☐☐☐☐☐ (☐)

(6) **Identification Document** *(only when HKBC/IC is not available)*:
i) Type of Identification Document: *(e.g. Passport)* _____
ii) Identification Document Number: _____

(7) **Year arrived in HK:** _____ ☐ Since Birth ☐ Unknown

(8) **Nationality:** ☐ Chinese ☐ Non-Chinese *(Please specify)* _____

(9) **Marital Status:** ☐ Never Married ☐ Cohabited ☐ Married ☐ Separated ☐ Divorced

(10) **Occupation:**
☐ 01 Full-time student ☐ 02 Part-time student
☐ 03 Full-time work ☐ 04 Part-time work
☐ 05 Not applicable ☐ 06 Not studying & not working
☐ 07 Unknown

(11) **District of Residence:** *(according to District Council districts)*

☐ CW	Central/Western	☐ TW	Tsuen Wan
☐ S	Southern	☐ KWT	Kwai Tsing
☐ WC	Wan Chai	☐ TM	Tuen Mun
☐ E	Eastern	☐ YL	Yuen Long
☐ IS	Islands	☐ ST	Sha Tin
☐ YTM	Yau Tsim Mong	☐ TP	Tai Po
☐ SSP	Sham Shui Po	☐ N	North
☐ KC	Kowloon City	☐ PRC	Residing in People's Republic of China
☐ WTS	Wong Tai Sin	☐ NHK	Not residing in Hong Kong
☐ SK	Sai Kung	☐ U	Unknown
☐ KT	Kwun Tong	☐ OTH	Others *(Please specify)* _____

(12) **Type of Residence:**

- ☐ 01 Public/Interim Housing
- ☐ 02 Bedspace/Squatter Area/Rooftop Structure
- ☐ 03 Rented Room/ Suite
- ☐ 04 Rented Cubicle
- ☐ 05 Self-owned Cubicle
- ☐ 06 Residential Care Unit/ Foster Home
- ☐ 07 No fixed abode
- ☐ 08 Street sleeping
- ☐ 09 Others *(Please specify)* _____

(13) **Educational Level of Deceased Child and Parents/Guardian:**

Deceased Child:

- ☐ PSC Pre-school
- ☐ PRI Primary
- ☐ SEC Secondary
- ☐ VCT Vocational Training
- ☐ TER Tertiary or above
- ☐ NYS Not Yet Studying
- ☐ U Unknown

Name of school last attended by the deceased child with period:

_____

_____ (From: To:) Class: _____

Father	***Mother***	***Guardian***
☐ ILT Illiterate	☐ ILT Illiterate	☐ ILT Illiterate
☐ PRI Primary	☐ PRI Primary	☐ PRI Primary
☐ SEC Secondary	☐ SEC Secondary	☐ SEC Secondary
☐ VCT Vocational Training	☐ VCT Vocational Training	☐ VCT Vocational Training
☐ TER Tertiary or above	☐ TER Tertiary or above	☐ TER Tertiary or above
☐ U Unknown	☐ U Unknown	☐ U Unknown

(14) **Persons Living with the Deceased Child at the Time of Death:** *(Please ☑ all that are applicable.)*

☐ FA Father	☐ REL Relative(s)
☐ MO Mother	☐ CO Cohabiting with Boyfriend/Girlfriend
☐ BP Both Parents	☐ FR Friend(s)
☐ SIB Sibling(s)	☐ SW Sworn Parent(s)
☐ PG Paternal Grandparent(s)	☐ AL Alone
☐ MG Maternal Grandparent(s)	☐ INS In Institution
☐ STP Step-parent(s)	☐ FP Foster Parents
☐ STS Step-sibling(s)	☐ OTH Others (Please Specify)
☐ CG Care-giver	☐ U Unknown

Total no. of sibling in deceased child's family: *(excluding the deceased child)* _____

(15) **Health Condition of the Deceased Child:**

*(Please ☑ all types of problems that are applicable and *delete as appropriate.)*

☐ a. Generally healthy

☐ b. Had suffered from:

Type of problem	Diagnosis	Received Treatment	Name of Hospital/ Clinic/Treatment Centre
☐ Physical chronic illness	_____	*Yes/No	_____
☐ Psychiatric illness	_____	*Yes/No	_____
☐ Disability	_____	*Yes/No	_____
☐ Developmental delay	_____	*Yes/No	_____
☐ Others *(Please Specify)*	_____	*Yes/No	_____

☐ c. Unknown

(16) **Deceased Child being Recipient of Disability Allowance:**

☐ Yes, SSA Ref. No.:

☐ No

(17) **Family Income:**

☐ 01 On CSSA CSSA Ref. No.: _____

☐ 02 Below $10,000

☐ 03 $10,000 – $19,999

☐ 04 $20,000 – $29,999

☐ 05 $30,000 – $39,999

☐ 06 $40,000 – $49,999

☐ 07 $50,000 or above

☐ 08 Unknown

II. INFORMATION ABOUT CHILD'S DEATH

(18) **Information about Child's Death:**

(i) Date when Reporting Office came to know child's death:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(ii) Date of Reporting Office's last contact with deceased child:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iii) Date of Reporting Office's last contact with deceased child's family:
☐☐ / ☐☐ / ☐☐☐☐ (DD / MM / YYYY)

(iv) Cause of death :

☐ ACC(D)	Accident - Drowning	☐ SUI(DO)	Suicide - Drug Overdose
☐ ACC(DO)	Accident - Drug overdose	☐ SUI(G)	Suicide - Gas
☐ ACC(F)	Accident - Fall	☐ SUI(H)	Suicide - Hanging
☐ ACC(HH)	Accident - Household	☐ SUI(J)	Suicide - Jumping
☐ ACC(T/C)	Accident - Traffic (Cycling)		
☐ SUI(OTH)	Suicide - Others *(Please specify)* _____		
☐ ACC(T/O)	Accident - Traffic (Other than Cycling)		
☐ MC	Complications of medical treatment/procedures		
☐ ACC(OTH)	Accident - Others *(Please specify)* _____		
☐ HOM	Homicide	☐ P	Pending Investigation
☐ U	Unknown		

(v) Place where the fatal incident occurred: _____

(vi) Any suspicion of child abuse element leading to child's death:

☐ No ☐ Uncertain

☐ Yes, please elaborate: _____

_____

(vii) Apart from this child's death, any other child death(s) involved in the same family or in the same event?

☐ No

☐ Yes, please give name(s) of the other deceased child(ren): _____

[Please fill in a separate Data Input Form for each named deceased child]

(19) **How the Reporting Office/Organisation came to know about the child's death:**

(20) **Significant circumstances or event(s) that had occurred to the deceased child and/or his/her family prior to child's death, particularly those related with the child's death:**

(21) **Other significant information or observation on the deceased child and his/her family:**

III. INFORMATION ON SERVICES RECIEVED

(22) **Service(s) received from the Reporting Office:**

(i) Had the deceased child and/or his/her family received service from the Reporting Office:
☐ Yes: please complete (ii) to (viii) below ☐ No

(ii) Type of service(s) received: _____

(iii) Service period(s): _____

(iv) File reference number at the Reporting Office (if any): _____

(v) Source of referral: _____
☐ Self-referral

(vi) Presenting problem(s)/Need(s) when the case was last known: _____

(vii) Identified problem(s)/Need(s) when the case was last known: _____

(viii) Assistance requested by client/referrer: _____

(23) **Information about contacts between the deceased child and his/her family with other professionals within 6 months before the child's death:**
*(Please ☑ all that are applicable, give details and *delete as appropriate.)*

Professionals	**Principal Client (e.g. child, father)**	**Service Unit/ Agency**	**Contact Phone No.**
☐ a. Psychiatrist			
☐ b. Medical Practitioner			
☐ c. Psychologist (*Clinical/Educational)			
☐ d. Social Worker (including Medical Social Worker)			
☐ e. School Helping Professionals (*SGP/SSW/SGO/SGT/Teacher)			
☐ f. Therapist (*OT/PT/ST)			
☐ g. Community Psychiatric Nurse			
☐ h. Police			
☐ i. Staff of Social Security Field Unit			
☐ j. Others *(please specify)*			

(24) **Information about service delivery and collaborative contacts on deceased child and/or his/her family:**

(i) Professionals/agencies mentioned in item (23) above whom you had had contact(s) with concerning the deceased child and/or his/her family in the past:

(ii) Agreed intervention plan among different professionals (if any) and progress of implementation:

(Please include good practice identified and difficulties encountered in inter-disciplinary or inter-sectoral collaboration.)

(iii) Other Remarks:

Please use additional sheets for any part if required.

IV. INFORMATION ON DECEASED CHILDíS FAMILY

(25) **Family composition:**

Relationship	**Sex**	**Age**	**Educational Level**	**Occupation**	**Monthly Income**	**Remarks** *(Please specify if any disability/illness or living apart)*
1. Deceased Child						
2.						
3.						
4.						
5.						

(26) **Family background:**

(27) **Family relationship:**

(28) **History of residential placement of deceased child (if any):** *(in chronological order)*

Name of Residential Unit	Supervising Agency	Admission Period	Reasons for Out-of-home Care
		to	
		to	
		to	
		to	

(29) **Significant family issues:** *(Please ☑ all that are applicable, fill in the blanks and *delete where appropriate)*

☐ Marital Problem of Parents

☐ Relationship Problem
Type: _____ Persons Involved: _____

☐ Financial Problem
Person(s) Involved: _____

☐ Domestic Violence
Type: _____ Victim: _____
Abuser: _____ *Abuser prosecuted (result:)/not prosecuted

☐ Child Abuse
Type: _____ Victim: _____
Abuser: _____ * Abuser prosecuted (result:)/not prosecuted

☐ Gambling Problem
Person(s) Involved: _____

☐ Mental Problem(s)
Type: _____ Patient(s): _____

☐ Suicidal Attempt
Type: _____ Person(s) attempted: _____
No. of Attempts: _____ *Successful/Not Successful

☐ Substance Abuse (including alcohol)
Abused Substance: _____ Abuser: _____

☐ Statutory Supervision for Members in the Family *(examples)*

Person Involved	**Type of Court Order**	**Content**	**Period**	**Reason for Statutory Supervision**
Deceased Child	*C or P Order*	*Ward of DSW*	*01/01/2005 – 21 year olds*	*Inadequate parents with child abuse history*
Father	*Probation Order*	*12-month Supervision*	*02/02/06 – 01/02/07*	*Violence against mother*

☐ Other Risk Factors within the Family *(please specify)* _____
Person(s) Involved: _____

V. PROFESSIONAL INVOLVEMENT

(30) **Chronological list of workers and supervisors (no actual names required) involved in the Reporting Agency:** *(Sample below in Italics)*

Worker	Supervisor	Serving Period
Worker 1	*Supervisor A*	*09/06 – 01/07*
Worker 2	*Supervisor B*	*01/07 till case closed*

(31) **Circumstances leading to Reporting Office's involvement with the case:**

(Please state how the deceased child and/or his/her family became connected with the Reporting Office, the kind of programmes, activities, casework intervention or counselling they had participated in.)

(32) **Case assessment, intervention progress and response from client(s):**

(Please include in chronological order: assessment on the needs of the deceased child and his/her family; intervention plan and efforts made; means and frequency of contact; referrals made for services and clientís response to intervention.)

(33) **Any other comments or remarks :**

(Involved professionals of different levels may express their views here.)

Prepared by: _____ (Signature)

Name/Post: _____

Name of Reporting Office/ Organisation: _____

Date: _____

VI. REVIEW BY MANAGEMENT OF SERVICE ORGANISATION/DEPARTMENT

(To be completed by Management of Service Organisation/Department Concerned)

(34) **Views and observations:**

(Please state any difficulties encountered, views and observations at all levels during service provision and delivery in this case, particularly in the aspect of inter-disciplinary or inter-sectoral collaboration.)

(35) **Good practice observed in the service provision and service systems in this case:**

(36) **Lesson learnt and recommendations for service improvement:**

(If any, please state any improvement measures undertaken after the incident.)

(37) **Any other remarks:**

(Please provide relevant guidelines and training provided for staff handling such type of cases, if applicable.)

Prepared by: _____ (Signature)

Name/Post: _____

Name of Reporting Office/
Organisation: _____

Date: _____

July 2008

Appendix VI: Summary of Recommendations Made by the Review Panel for Cases Reviewed

For Cases Died of Suicide:

1. To consider improvement measures to ensure timely referral between medical unit and medical social service unit within hospital.

2. (i) Helping professionals should take note of possible denial of suicidal ideation by suicidal person and connect them with professional counsellors immediately through available means as far as possible once they are identified to have suicidal threat;

   (ii) To explore ways to support school social workers to handle resistant adolescent youths with uncooperative parents; and

   (iii) To enhance education to the public to encourage people with suicidal intent and their friends and relatives to seek help from professionals instead of covering up such intent in front of the helping parties.

3. To revisit the policy of Integrated Education for students with special educational needs with consideration of aspects including overall need assessment for students transferring from special to ordinary school; guidance to students and parents involved in decision-making on transfer; continuous school work and emotional support for the students and strengthening of co-intervention and collaboration among involved professionals for students decided on transfer.

4. Proactive and early intervention, including prompt and accurate assessment for new arrival children suspected to have limited intelligence or special educational needs, and intensive counselling for families with such children.

5. For students who experienced academic failure in schools with good average result, more parental support and supportive service to facilitate their adjustment are required.

6. Flexible means to be made available in the education system to cater for new arrival children with special educational needs or maladjustment to mainstream schooling.

7. Positive engagement of adolescent school drop-outs for developing their potentials and building up their self-confidence was crucial for prevention of developmental risks for them.

8. Public education on the following aspects:
   (i) To remind the parents that it was their duty and responsibility to bring up, support and protect their children;

   (ii) To arouse the public's awareness on the negative impact of casual or unlawful sexual intercourse for young children; and

   (iii) To arouse the awareness of new arrivals the importance of providing true and accurate information on the personal information of their children (including age and special needs) to the concerned government departments/service organisations upon arrival to ensure that education or social services provided would be commensurate with their needs.

9. Public education on the when and how, and the precautions to be taken to initiate separation between young lovers.

10. Debriefing and counselling to the surviving siblings, peers, helpers or witnesses of the deceased children should be provided to help them recover from the trauma and resume normal functioning.

11. The Education Bureau may consider keeping statistics of student suicide for review and research purposes.

For Cases Died of Accidents:

12. (i) Parenting education on the role, skills and responsibility of parents should start right at the beginning when a child is born to a family; and

    (ii) Strengthening the role and responsibility of the father would better protect the children.

13. Schools or welfare organisations to provide education and support for grass-root parents, especially for those having children with special educational needs, to raise their awareness and ability to take care of their young children.

14. (i) To derive more effective ways to reach out to juveniles with drug abuse problem; and

    (ii) Public education for all age groups on the negative effects of drug abuse through ways such as: use of life-coaching, promotion of positive life-style, strengthening coping strategies and resilience to life stresses etc.

15. To incorporate in the education for teenagers on self-awareness of one's own physical ability and risk assessment of the environment.

16. Government to oversee that different ethnic groups have equal opportunity on access to information and social services in their language through different media to facilitate their adjustment.

17. Legislation for installation of devices alerting pedestrian for reversing vehicles.

18. To revisit the definition of "Light Goods Vehicle".

19. Applying special restrictions for young and inexperienced drivers to minimize their risk of traffic accidents.

20. (i) Promotion of proper attitude and manner in driving; and

    (ii) Regular reinforcement of public education for children and the public on the importance of road safety.

21. Education for parents:
    (i) to seek assistance from reliable child minders, and

    (ii) to give clear instructions to child minders to ensure child safety.

22. (i) Public awareness, in particular that of the parents and the care-givers, should be raised on the importance of home safety and the use of safety devices, including window grilles all the time for families with small children;

    (ii) Education and promotion of household safety and related measures for families with children;

    (iii) When planning and designing buildings, particularly public housing estates, the issues of child safety should be considered e.g. installation of grilles on windows and in corridors; and

    (iv) Parents should be educated to communicate with child minders on the needs of their children effectively to ensure proper care for their children.

23. To set up sufficient safe leisure and sports facilities in newly developed residential areas.

24. To ensure that proper warning signs and notices are erected at places unsafe for swimming to remind the public the danger of swimming in such places.

25. To raise public awareness on the importance of swimming in a safe place under safe environment through publicity campaigns targeting children of different age groups.

For Cases Died of Other Causes:

26. Professionals working on parenting issues should be sensitive and aware of the cultural difference in child discipline in each case.

27. Special attention and support for single parents with multiple risk factors (e.g. young parent, broken marriage/relationship with partner, post-partum depression, history of suicidal attempts) could help reduce risk of improper child care and enhance protection for their children.

28. Frontline social workers should stay alert to clients' mental condition and depressive mood right at initial contacts to facilitate prompt intervention to meet their immediate needs.

29. To work out a mechanism to help social workers to make decisive action on protection of children, such as early removal of the children from their families, even without consent of their abusive parents in case of serious domestic violence in order to prevent them from being harmed.

30. Apart from referring to past history of domestic violence, on-going risk assessment, and alertness of social workers to critical periods during divorce are important for effective intervention for cases with such elements.

31. For victims of domestic violence in high risk but refusing to follow suggested safety plans for any reason, issue of written reminders with warning and description of previous fatal incidents by social worker might help them realize the risk and change their minds.

32. Training for frontline social workers working with domestic violence should emphasize on child-focused assessment and intervention, with consideration of the subjective experience of the child.

33. More collaboration and information sharing between the Police and the Social Welfare Department, including cross referencing of risk criteria of the two Departments for reaching a common understanding of the levels of risk, may improve the risk assessment procedures.

34. (i) While working with divorcing couples in high conflicts, professionals should stay highly alert to high risk moments during the divorce proceedings, the impact on the children and their safety;

(ii) Legal professional to liaise with the case social worker to alert him/her of the possible risk after discussion on sensitive issue, such as property right, with parties involved in domestic violence;

(iii) School personnel should keep watch and be aware of the predicament of children with divorcing parents and they should coordinate with other professionals when safety of these children is at stake; and

(iv) Service organisations may consider requesting clients to give consent for sharing of information by different professionals when they first received the service.

35. In pursuance of bias-free intervention, social worker should consult his/her supervisor in case of great difficulty in serving both the batterer and the victim for support and/or consideration of assigning another social worker to work with one of the parties.

36. Public education for children to help them learn how to protect themselves and build up their resilience towards domestic violence.

37. 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.

For Cases Died of Natural Causes:

38. (i) It is observed that there is service gap in the home leave care arrangement for disabled children under residential care during which child fatality had occurred. Support for their families, particularly single parents can help prevent such incidents;

(ii) To cater for the special need of some children who do not have appropriate care-giver to look after them during home leave, residential care units can consider providing respite care service with minimal staff so that the needy children can stay in an environment they are familiar with; and

(iii) Children with severe disability should not be put under the care of young siblings who are not capable of such task.

39. Support for families looking after chronically-ill or disabled children with medical condition requiring special care at home is necessary.

40. As occurrence of incidents of collapsing at home could be quite shocking and traumatic for family members (particularly young siblings) of the deceased children, it would be necessary to ensure that these families could receive needed counselling and support.

41. To work out procedures to ensure every newborn should have physical examination by a paediatrician before discharge from hospital.

42. 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.

43. To ensure that staff on duty in special schools and care/training centres for disabled children have received update first aid training.

44. To ensure the presence of on-site personnel trained in resuscitation of children in every private or public hospital treating paediatric patient.

45. Provision of trained first aiders and equipment like automated defibrillator in sports venues for handling sudden collapse cases during sports events.

46. For some cases, autopsy may help to enlighten the cause of death for prevention purpose.

47. General education to urge parents of children with asthma to seek medical treatment whenever in need, particularly in the night time.