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Submission to Panel on Welfare Services of Legislative Council on

The Final Report of the Review Panel of the Pilot Project on Child Fatality Review

The Hong Kong College of Paediatricians welcomes the Final Report of the Review Panel of the Pilot Project on Child Fatality Review. The time and effort of the Review Panel in analyzing over 200 child deaths in a project that involves voluntary participation of multiple sectors and disciplines is much appreciated. This is indeed a significant milestone of child protection in Hong Kong and an opportune time to move forward, building on the experience over the past three years.

Our College has the following comments on the Report.

1. Representation of the Review Panel

It is good to note that the future Review Panel will include law enforcement professionals and forensic pathologists. This may provide better insight into child death investigations (a significant outcome of some overseas child fatality review is a standardised sudden unexpected infant death investigation protocol)[1] and a more transparent system of performing or waiving of autopsies in child deaths. As discussed in the "Timing of Review" section (see below) that there should not be undue delay of child fatality reviews, representation from the Department of Justice may be considered when there are potential legal proceedings.

The input from paediatricians should not be confined to "natural" deaths but should extend to include in-depth review of "unnatural" deaths, as paediatricians are well versed in the overall care of children and their families with a multidisciplinary approach.

2. Scope

The extension of the scope of review from "unnatural" to "natural" deaths reported to the Coroner and those from other sources does make the review more embracive.

Now that the Child Fatality Review has started, the scope should extend to Serious Case Review, i.e., not only deaths but serious injuries when child abuse or neglect is known or suspected. Such a mechanism is already in place in England for a number of years[2]. The British experience should help address any concerns regarding the definition of seriousness, privacy and the process.

3. Timing of Review

It is encouraging to know that the Review Panel had started review on some child death cases once the information was available and with a time gap of less than 2 years. However, to have a review report in 2010 for deaths concerning 2006 or in 2011 for deaths concerning 2007 is far too long. Thus, the next Review Panel will now have a backlog of child death cases for over 3 years. As a comparison, NSW, Australia published in October 2010 the review of child deaths in 2009[3]. In England, Serious Case Review has to be completed within 6 months of the decision to conduct such a review (i.e., within a few months of the event)[2].

Undoubtedly, the legal and judicial systems have to be respected. However, in the interest of learning early lesions to prevent future deaths, it is not impossible to review child deaths even when there is a possibility of legal proceedings. There may be concerns from different parties e.g., police. That is why we need a legal mandate for the review mechanism so that information is used solely for the review. Reference can be taken again from the British experience.

Should parents wish to be involved, memory will be fresh for an early review and there will be less of a concern of reviving traumatic experience long ago. If managed well, this can be part of the healing process as parents are able to contribute information for preventing death of other children.

When there are good practices to share and if the review has been performed earlier, such good practices can also be disseminated much earlier.

4. Source of Information

It is unfortunate that the Child Fatality Review is not a statutory mechanism backed by legislation so that information can be accessed for the specific purpose of the review, confidentiality ensured and potential legal liability attended to. Such legislation supports the system in Australia[4], New Zealand[5], and England[2], California of USA[6], British Columbia of Canada[7], just to name a few.

The Report mentioned that two organisations refused to give additional information to the Review Panel despite reassurance of confidentiality. Although this constituted 5% of all the organisations from whom information was sought, should it be an organisation that could provide important services to children territory-wide, the impact of such lack of information might not be proportional to the small percentage. It could be a critical factor in failing to conduct a thorough and fair review.

When information is provided on a voluntary basis, this is bound to be subjective or biased whether intentional or not. The Review Panel also noted "variations in the comprehensiveness and depth of the information submitted to the Coroner's Court or provided by organisations." Without access or comparison with information that could be acquired as necessary, it would not

be difficult to understand that three quarters of the respondents to the Evaluation Questionnaire considered the information for the review adequate or very adequate.

The Review Panel encouraged report of child death from service providers as they occurred, presumably when the event was still fresh in the mind. It was noted that "a few reports from service organisation / departments" were received. These were not reviewed as they occurred before 2007. This lack of self-reporting could also mean that voluntary report was not a reliable channel of information and a statutory mechanism would be required (as in other countries).

5. Statistical Findings

One child death is one too many. Before we are complacent with our relatively low child death rate in Hong Kong, it is worth comparing the statistics with similar cities e.g., Singapore, rather than countries with vast stretches of land.

For non-Chinese child deaths, 8.6% are ethnic minorities among the total child deaths. We need to know whether non-Chinese children are over-represented in the statistics when compared with their percentage in the childhood population of Hong Kong.

6. Database

It is an excellent idea to set up a computerized database to collect the demographic data and child death information for monitoring the trend.

7. Nomenclature

The nomenclature for the various categories of child deaths is worth revisiting. "Accident" conveys an impression that the incident is not preventable. In Chinese, the meaning is even clearer - "意外" or "out of expectation". Even deaths from "natural" causes e.g., asthma and pneumonia, may not be totally unpreventable. The Review Panel may like to consider terms used in NSW, Australia[3].

- Deaths due to external causes (e.g. Fatal assault, Transport deaths, Drowning deaths, Suicide deaths)

- Deaths due to disease and morbid conditions

8. Recommendations and Responses

Although the "missions, functions or service scope of different government departments or NGOs" are to be respected, too broad "directional" recommendations may not be too meaningful or able to prevent similar future child deaths.

There were some concrete and useful recommendations made especially for deaths due to diseases and morbid conditions e.g., staff caring for disabled children should receive updated first aid training or hospital personnel caring for children should be trained in cardiopulmonary resuscitation. These responses were positive.

However, there were many general recommendations and it was not surprising that half of the respondents to the Evaluation Questionnaire thought that there was no difficulty in following-up and implementation. A recommendation to "strengthen" public education might not necessarily imply that better outcomes would automatically follow.

An example is child death that occurs while the child is not being attended. In 1991, in response to a spat of child deaths, a government consultation paper on preventive measures concerning education, support and legislation, was issued. The government conclusion was more education and support, but not legislation. The latter could have conveyed a clearer educational message and prevented violation of an agreed community norm. There was more sporadic public education, and 'occasional' child care centres being established. The children centers being non-user friendly were underutilized. Deaths and reports of children having to be rescued continued. The Review Panel's recommendation in 2011 is still on the subject of "strengthen public education." Admittedly, Social Welfare Department (SWD)'s Neighbourhood Support Child Care Project may have a role in relieving some parents of childcare responsibilities but whether the parents who use such a service are those that would have left their children unattended remain to be researched. In the meantime, child neglect on the Child Protection Registry continues to rise.

With other aspects of child safety, it is unclear why recommendations on home safety are for "new" housing plans and designs, and leisure and sports facilities in "newly" developed residential areas. What are the implications on home safety of children who are living in existing residences?

For parental education to start when a child is born is a good gesture, but will all the existing services enumerated be able to reach families most in need or most at risk? Are at risk families identified through the commendable Comprehensive Child Development Service provided with the support they need? Are Integrated Family Service Centers the answer to all family problems especially for unmotivated clients? Recommendations can be more solid and innovative like those of the Los Angeles Child Death Review Team Report of 2009[8] which stated that "universal neonatal home visitation by a public health nurse" for first time parents or at a minimum for families at risks. Recommendations if not yet adopted as practice, could be further researched or explored in detail, taking into experience of other countries.

9. Follow-up and Monitoring

Although some responses to recommendations are concrete and positive, many departments and organisations list existing practices and services without much information on their accessibility, efficacy and user-friendliness. If these measures are effective as they claimed, there should not be any preventable child deaths (though it could be argued that if these measures were absent, there might be more deaths). Others "note" the Review Panel's recommendations with no commitment of any action. The Review Panel may be bound by its terms of reference that do not include follow-up or monitoring of implementation. An attempt of setting indicators and making recommendations that are specific, measureable, achievable, realistic and time bound may facilitate the monitoring process even if it is not done by the Panel.

10. Systemic Issues

Child fatality reviews overseas were sometimes thought to have spent too much time on what had happened instead of asking why it happened, focused excessively on individual performance and not enough on how to enable workers to perform their tasks, and on what child caretakers did and not enough on caretakers' needs. Having reviewed child deaths from a variety of causes, the Review Panel should be in a good position to identify root causes and systemic issues that need to be addressed.

Many preventable child deaths are complex and often beyond the jurisdiction of a single department or bureau. For example drug abuse cases, it is rightly pointed out that it is often a "manifestation of more deep-rooted problems in family, growth, study and employment". For parents to be able to assert their responsibility to take care of and supervise their children or to be interacting appropriately with them or to be aware of their mental health status, parents need to be working reasonable hours and earning livable wages in order to have the time and energy to perform their parenting role. Why does the child who succumb to gang violence finds school life unattractive? Public acceptance of individual difference in learning ability and potentials of students may start with parents' perception of schools' acceptance of their children and also their teachers being equipped with the knowledge, skill and time to attend students of a wide range of abilities. Adopting the Law Reform Commission's recommendations in 2005 on Custody and Access that "ownership" of children be replaced by the concept of "parental responsibility" is a strong message to parents that they are expected to "co-parent". Will the stress of cross-border families be minimised in a systematic manner through high-level liaison between Hong Kong and the Mainland? All these scenarios illustrate that our society needs to explore other parameters such as policies, legislations, resource allocation and priority setting for making an impact on the child so that our society can be child-focused, child friendly and child right based. These issues are definitely beyond the capability of individual departments and bureaux to address, not the least that of SWD which is overseeing the Child Fatality Review.

11. Concluding Comments

Hong Kong started the Child Fatality Review three decades late, as such team was already in place overseas in 1978. We should take advantage of the vast experience of good practices formulated ahead of us in many countries. Although the Child Fatality Review will not prevent all child deaths, an effective review mechanism brings children a step closer to enjoying the basic right of survival and the ability to grow and develop to their full potentials in a caring environment. To enhance its effectiveness, our College strongly recommends that the Review be a statutory body based on relevant legislation. A Children Commission should be established as soon as possible with one of its functions to oversee the monitoring and implementation of the recommendations of Child Fatality Reviews.

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