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

CHILD FATALITY REVIEW PANEL

FIFTH REPORT
(FOR CHILD DEATH CASES IN HONG KONG IN 2016, 2017 AND 2018)

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1 Foreword

Children have the right to live in a safe environment and be protected in their vulnerable age. The death of any child is heartbreaking and a tragedy for the family and community. On behalf of the Child Fatality Review Panel (the Review Panel), I extend my deepest condolences to those families who have had to face the death of their children. The Review Panel hopes to give a broad picture of the child fatality cases presented in a biennial report to facilitate more understanding of the factors leading to child death and further exploration of what can be done to prevent avoidable child deaths in future.

Through a thorough review of the child death cases reportable to the Coroners, the Review Panel hopes to learn from the circumstances surrounding the death of a child and to identify risk factors for that death. Panel Members endeavour to identify measures to help prevent or reduce similar deaths from occurring in future. We have shared our observations and recommendations with related service organisations or government bureaux/departments so that they could review their services regularly and explore areas in which improvements can be made so as to keep our children healthy, safe and protected. All the concerned departments/organisations have been co-operative and positive in providing feedback and updating measures on improvement which are included in the Report. It is also encouraging that the Review Panel has gained the support of the Commission on Children in publicising the key recommendations related to child safety alerts through various media platforms.

The Fifth Report of the Review Panel covers the child death cases for three years occurred in 2016, 2017 and 2018. A total of 59 recommendations on preventive strategies have been made and passed to the relevant government bureaux/departments and organisations concerned for comment and response. In view that suicide is the second leading cause of death for children and youth over the past 10 years from 2009 to 2018, a thematic review has been conducted to examine the trend of children suicide death. Despite the limitation of the Review Panel in reviewing the cases and the recommendations made were subjected to the information collected from the Coroner's Court and Service Reports, I trust our findings and recommendations can still raise the public awareness and call for collaborations among different parties in preventing future child deaths. By working together, I hope we can provide a better environment for our children and nurture their healthy development in a safe and supportive community.

Dr DUNN Lai-wah, Eva M.H.
Chairman
Child Fatality Review Panel
November 2021

2 Executive Summary

2.1 Review of Child Death Cases from 2016 to 2018

In this report, 259* child death cases that occurred from 2016 to 2018 and reported to the Coroner's Court were reviewed. The following table shows the case distribution by year and by death cause.

Cause of Death	Year in which the case occurred			Total
	2016	2017	2018	
Natural Causes	69	54	36	159
Non-natural Causes	37	36	27	100
Suicide	*21*	*24*	*14*	*59*
Accident	*11*	*7*	*4*	*22*
Assault	*2*	*2*	*3*	*7*
Unascertained #	*1*	*3*	*4*	*8*
Medical Complications@	*2*	*0*	*2*	*4*
Total	**106**	**90**	**63**	**259**

* *3 natural-cause cases and 1 accident case in 2016; 4 natural-cause cases and 1 non-natural case in 2017 and 5 natural-cause cases, 1 non-natural case and 3 assault cases in 2018 are not covered in this report because legal proceedings were still underway when the review was done. Review findings for these cases, if any, will be included in the next report.*

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

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

Major demographics of the 259 cases reviewed are as follows:

- A total of 159 cases (61.4%) died of natural causes, 59 cases (22.8%) died of suicide, 22 cases (8.5%) died of accident, 7 cases (2.7%) died of assault, 8 cases (3.1%) died of non-natural unascertained causes and 4 cases (1.5%) died of medical complication. *(Charts 5.2.1 and 5.2.6)*

- There were more male (N=144, 55.6%) than female (N=115, 44.4%). *(Table 5.2.2)*

- The highest number of child deaths occurred among children aged below 1 (N=103, 39.8%), followed by the age group of 15-17 (N=51, 19.7%) and both age groups of 3-5 and 12-14 (both N=27, 10.4%). *(Table 5.2.2 and Chart 5.2.3)*

- The majority of the deceased children were Chinese (N=226, 87.3%), and 33 (12.7%) were non-Chinese. *(Chart 5.2.4)*

- Occupation was not applicable to 132 (51.0%) children who were too young or whose health problems had prevented them from attending school or work. 121 (46.7%) children were full-time students, 4 (1.5%) were neither studying nor working while 1 (0.4%) was unknown and 1 (0.4%) was having part-time work. *(Chart 5.2.5)*

- There were more male than female died of natural causes and suicide but vice versa for accident, assault and medical complications. The number of male and female died of non-natural unascertained cause was equal. *(Chart 5.2.7)*

- The highest number of child deaths occurred among children aged below 1 who died of natural causes (N=90, 34.7%). The second and third highest numbers of child deaths occurred among children aged 15-17 who died of suicide (N=39, 15.1%) and those aged 1-2 who died of natural causes (N=19, 7.3%). *(Chart 5.2.8)*

- Almost half of the fatal incidents occurred at home (N=119, 45.9%). *(Chart 5.2.10)*

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

2.2 Observations by the Nature of Deaths from 2016 to 2018

Based on the review of child death cases which occurred in 2016, 2017 and 2018, the Review Panel has a number of observations as per death nature. Please see **Chapter 6** for more details.

2.3 Recommendations Arising from Review of Child Death Cases from 2016 to 2018

The Review Panel has come up with 59 recommendations on preventive strategies and system improvement after reviewing the child death cases which occurred in 2016, 2017 and 2018. In summary, the number of recommendations by death cause are listed below:

Cause of Death	Reference Number	Number of Recommendations
Natural Causes	N1 – N12	12
Suicide	S1 – S22	22
Accident	A1 – A11	11
Assault and Non-natural Unascertained Causes	AS1 – AS14	14
Total	**-**	**59**

These recommendations have been passed to the relevant government bureaux/ departments and organisations concerned for comment and response. **Chapter 7** tabulates these recommendations while the responses/updates given by the concerned parties under different nature of death are shown in **Chapter 8**.

2.4 Profile of Child Death Cases Reviewed from 2006 to 2018

In view that suicide is the second leading cause of death for children and youth over the past 10 years from 2009 to 2018, a thematic review has been conducted to examine the trend and significant findings of children suicide death. Besides, taking account of the child death cases reviewed from 2006 to 2018, tables and charts are prepared to show the changes over time under different nature of death.

Please refer to **Chapter 9** and **Chapter 10** for more details.

3 Acknowledgement

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

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

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

4 About the Review

4.1 History

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

While Panel Members of the Pilot Project continued their contribution, a number of new experts and professionals joined the standing mechanism to contribute their invaluable experience. The standing Child Fatality Review Panel began its review work in June 2011. In May 2013, July 2015, August 2017 and May 2019, the Review Panel published its First Report, Second Report, Third Report and Fourth Report respectively, sharing the findings, observations and recommendations after reviewing the child death cases which occurred from 2008 to 2015.

4.2 Purpose

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

4.3 The Review Panel

The Review Panel comprises 18 members including professionals from different disciplines and a parent representative. For efficient and effective review, members of the Review Panel formed 4 sub-groups to look into cases of different nature according to their expertise. A convenor was selected for each sub-group to lead the discussion and to report the findings of the review at the quarterly panel meeting. From June 2019 to May 2021, the Review Panel held 25 meetings, including 7 panel meetings and 18 sub-group meetings.

The membership list and terms of reference of the Review Panel are at **Appendices 11.1** and **11.2** respectively.

4.4 Scope

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

4.5 Timing

Since its formation in June 2011, the Review Panel has completed the review child death cases from 2008 to 2015 and published its First report in May 2013 with 21 recommendations, Second Report in July 2015 with 47 recommendations, Third Report in August 2017 with 45 recommendations and Fourth Report in May 2019 with 53 recommendations. In the past two years, the Review Panel also completed the review of child death cases that occurred in 2016, 2017 and 2018. The time lag in the review often gives rise to the concern of not conducting the review and coming up with recommendations in a timely manner. Yet, as almost all of the child fatal cases have to go through legal proceedings in the Coroner's Court and some may even involve criminal and civil legal actions, review of the cases can only be started after the completion of the proceedings in Court so as to avoid prejudicing the legal proceedings. Notwithstanding this, the Review Panel has been proactive in exchanging views and recommendations with stakeholders to put forth observations and concerns immediately after the review was completed in a timely manner without waiting for the publication of the biennial reports.

4.6 Review Methodology

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

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

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

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

The published reports are available at the following websites:

First Report (May 2013)

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

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

Second Report (July 2015)

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

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

Third Report (August 2017)

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

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

Fourth Report (May 2019)

English Version:
https://www.swd.gov.hk/storage/asset/section/2867/en/CFRP_Fourth_Report_en_Nov2019.pdf

Chinese Version:
https://www.swd.gov.hk/storage/asset/section/2867/tc/CFRP_Fourth_Report_cn_Nov2019.pdf

5 Overview of Child Death Cases Covered by this Report

5.1 Figures of Child Population and Child Death in Hong Kong in 2016, 2017 and 2018

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

Table 5.1.1: Facts and Figures of Child Death in Hong Kong (2016, 2017 and 2018)

Type of Figure	Year		
	2016	2017	2018
Child Population*	1 015 800	1 019 900	1 029 300
Number of Child Deaths	217	202	176
Child Death Rate@	0.2	0.2	0.2
Number of Cases Reviewed	106	90	63

** Child population: refers to the mid-year population of children aged under 18.*

@ Child death rate: refers to the number of known child deaths per 1 000 child population.

(Source: Census and Statistics Department)

Table 5.1.2: Comparison of Age-specific Death Rates*

Age group		<1			1-4			5-9			10-14			15-19		
Year		2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Country/ Place@	Hong Kong#	2.0	1.8	1.6	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2
	Australia^	3.0	3.4	3.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.3
	Canada&	4.5	4.4	4.5	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.4	0.3
	Japan~	2.0	1.9	1.9	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2
	Singapore+	2.4	2.2	2.1	0.1	0.1	0.1	0.1	-	0.1	0.1	0.1	0.1	0.2	0.2	0.2
	United Kingdom>	3.5	3.5	3.4	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2

** Age-specific Death Rate: refers to the number of known deaths per 1 000 persons of the same age group, unless otherwise specified.*

@ Only information of the selected countries/places could be obtained from the relevant sources.

 # Source: Census and Statistics Department

^ Source: Australian Bureau of Statistics (http://stat.data.abs.gov.au/Index.aspx?Queryid=458)

& Source: Statistics Canada (Table 13-10-0710-01) (https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071001)

~ Statistics of Japan (https://www.e-stat.go.jp/en/stat-search/files?page=1&query=general%20mortality%)

+ Source: Department of Statistics – Singapore (https://www.tablebuilder.singstat.gov.sg/publicfacing/backToMainMenu.action)

> Source: Office for National Statistics of the United Kingdom (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsregisteredinenglandandwalesseriesdrreferencetables)

5.2 Statistics of Child Death Cases Reviewed from 2016 to 2018

Chart 5.2.1: Number of Cases by Nature of Death Cause

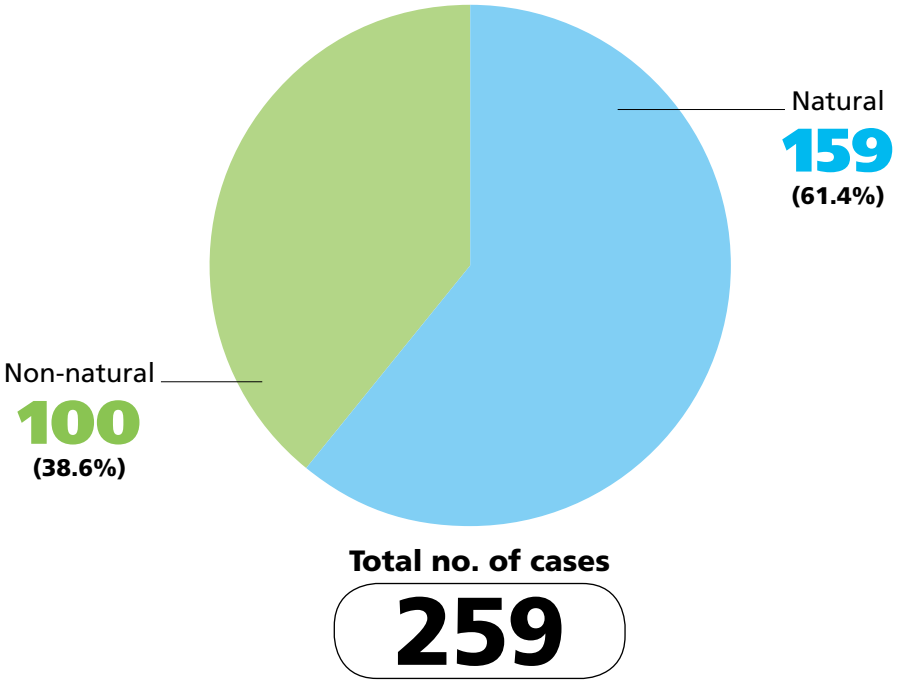
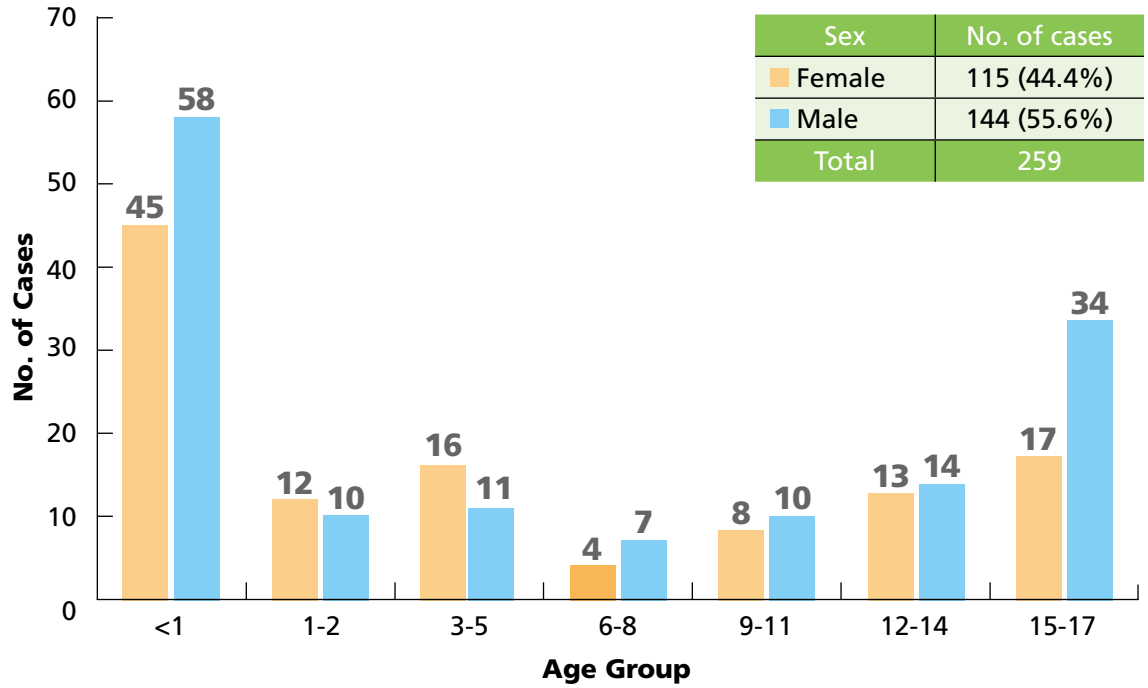


Table 5.2.2: Number of Cases by Age Group and Gender

Age Group	Gender		Number of Cases (%)
	Female (%)	Male (%)	
< 1	45 (17.4%)	58 (22.4%)	103 (39.8%)
1-2	12 (4.6%)	10 (3.9%)	22 (8.5%)
3-5	16 (6.2%)	11 (4.2%)	27 (10.4%)
6-8	4 (1.5%)	7 (2.7%)	11 (4.2%)
9-11	8 (3.1%)	10 (3.9%)	18 (7.0%)
12-14	13 (5.0%)	14 (5.4%)	27 (10.4%)
15-17	17 (6.6%)	34 (13.1%)	51 (19.7%)
Total (%)	**115 (44.4%)**	**144 (55.6%)**	**259 (100.0%)**

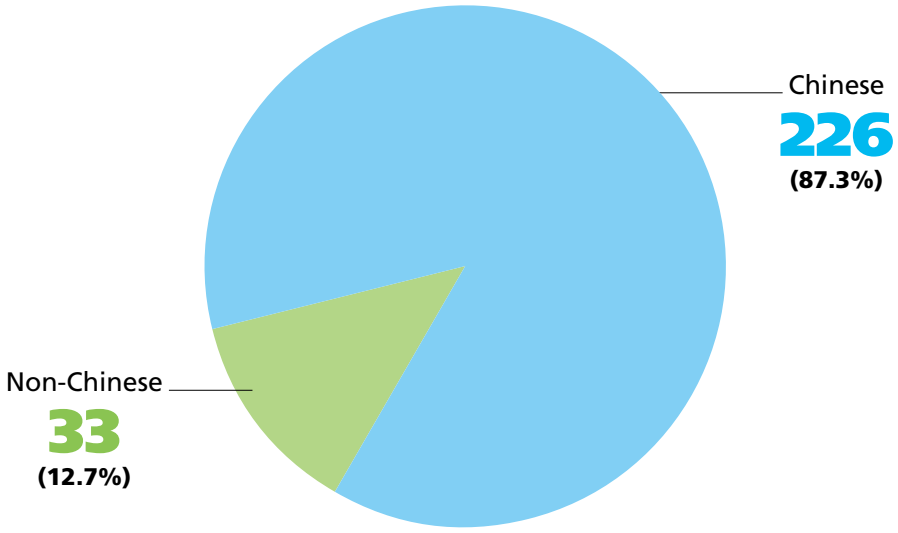
The age group with highest case numbers is highlighted.

Chart 5.2.3: Number of Cases by Age Group and Gender



Sex	No. of cases
Female	115 (44.4%)
Male	144 (55.6%)
Total	259

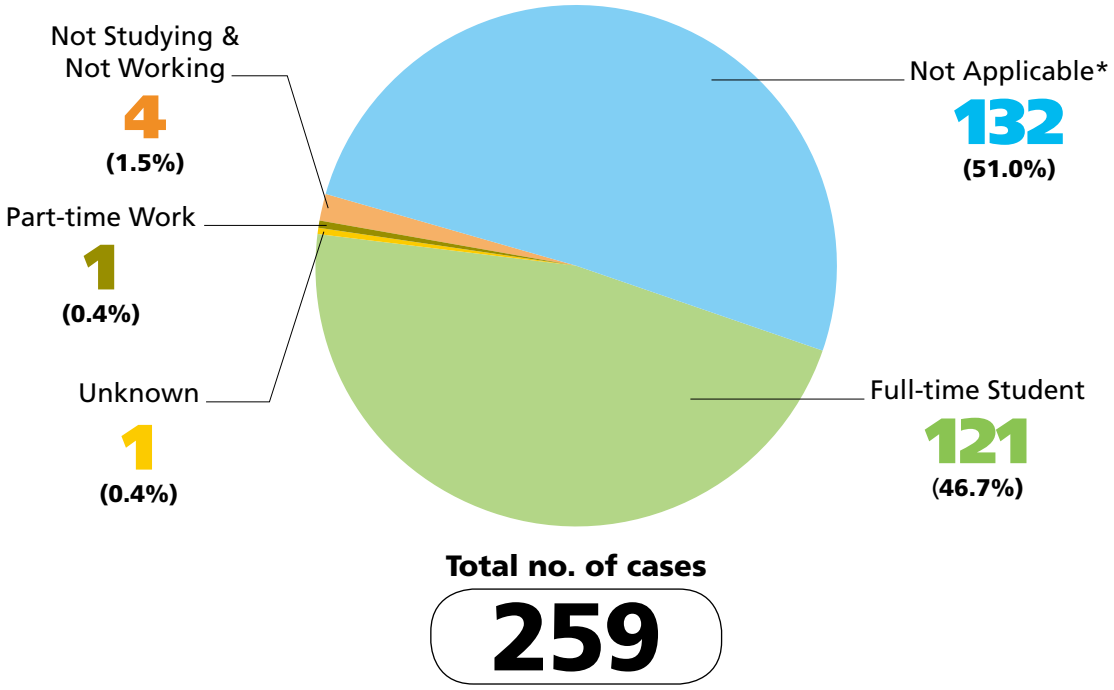
Chart 5.2.4: Number of Cases by Ethnicity



Total no. of cases

259

Chart 5.2.5: Number of Cases by Education/Occupation



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

Chart 5.2.6: Number of Cases by Cause of Death

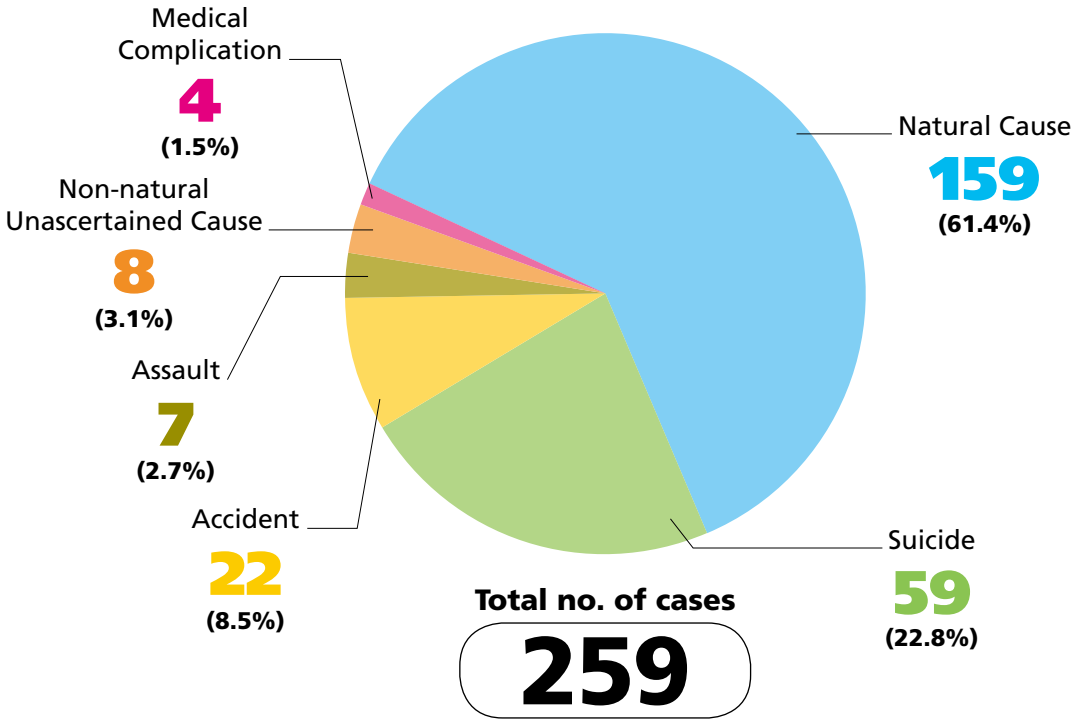
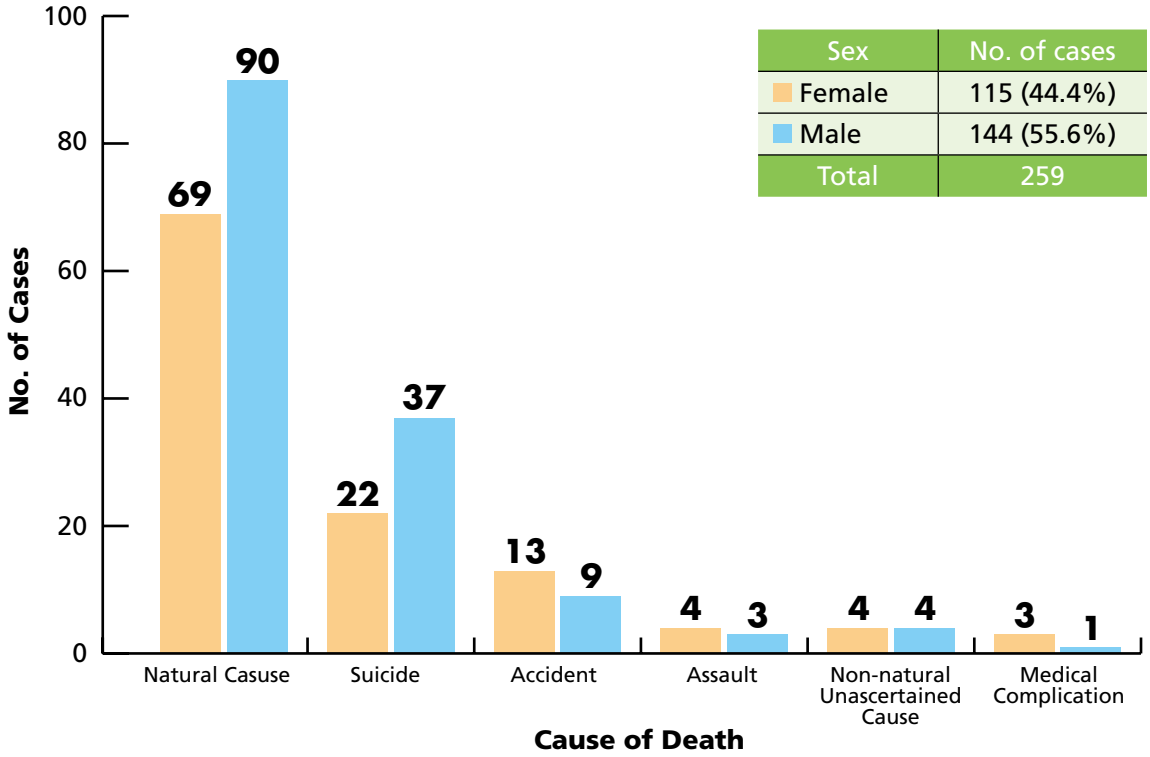


Chart 5.2.7: Number of Cases by Cause of Death and Gender



Sex	No. of cases
Female	115 (44.4%)
Male	144 (55.6%)
Total	259

Chart 5.2.8: Number of Cases by Age Group and Cause of Death

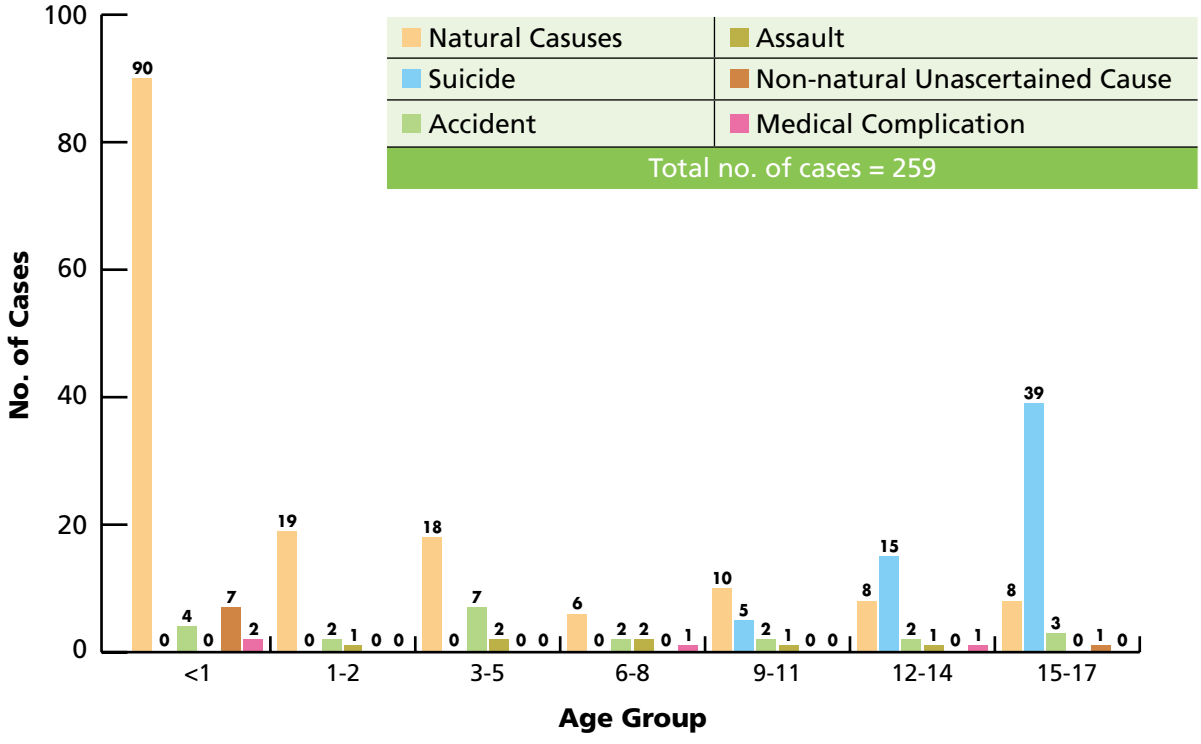


Table 5.2.9: Number of Cases by Residential District and Year

Residential District	2016			2017			2018		
	No. of cases	*Population	#Death rate	No. of cases	*Population	#Death rate	No. of cases	*Population	#Death rate
HONG KONG ISLAND									
Central & Western	1	29 600	0.034	4	29 900	0.134	2	30 300	0.066
Wan Chai @	0	21 500	0	2	21 600	0.093	0	21 700	0
Eastern @	5	73 600	0.068	4	77 100	0.052	7	74 600	0.094
Southern	2	37 400	0.053	3	36 200	0.083	1	37 500	0.027
KOWLOON									
Yau Tsim Mong	7	44 300	0.158	6	45 900	0.131	4	45 400	0.088
Sham Shui Po	8	56 900	0.141	6	58 300	0.103	3	58 100	0.052
Kowloon City	9	59 100	0.152	3	57 100	0.053	2	59 500	0.034
Wong Tai Sin	3	55 300	0.054	3	55 700	0.054	6	55 100	0.109
Kwun Tong	8	93 300	0.086	9	95 100	0.095	2	97 000	0.021
NEW TERRITORIES									
Kwai Tsing	5	73 900	0.068	8	71 800	0.111	6	70 600	0.085
Tsuen Wan	7	43 900	0.159	2	43 200	0.046	1	42 900	0.023
Tuen Mun	7	66 800	0.105	5	68 000	0.074	9	69 000	0.130
Yuen Long	19	89 100	0.213	13	91 600	0.142	2	92 400	0.022
North	4	48 300	0.083	4	48 500	0.082	2	47 800	0.042
Tai Po	2	43 000	0.047	2	43 000	0.047	2	43 300	0.046
Sha Tin	7	91 900	0.076	6	94 000	0.064	4	93 400	0.043
Sai Kung	4	64 400	0.062	6	64 200	0.093	6	63 200	0.095
Islands	5	22 400	0.223	1	22 300	0.045	0	25 400	0
OTHERS									
Not residing in HK	3	-	-	3	-	-	3	-	-
Unknown	0	-	-	0	-	-	1	-	-
Total	**106**	**-**	**-**	**90**	**-**	**-**	**63**	**-**	**-**

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

The Top 3 highest case numbers among the 18 districts are highlighted.

The Top 3 highest death rates among the 18 districts are highlighted.

** denotes land-based non-institutional population aged 0-17 in respective district.*

Source: General Household Survey, Census and Statistics Department.

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

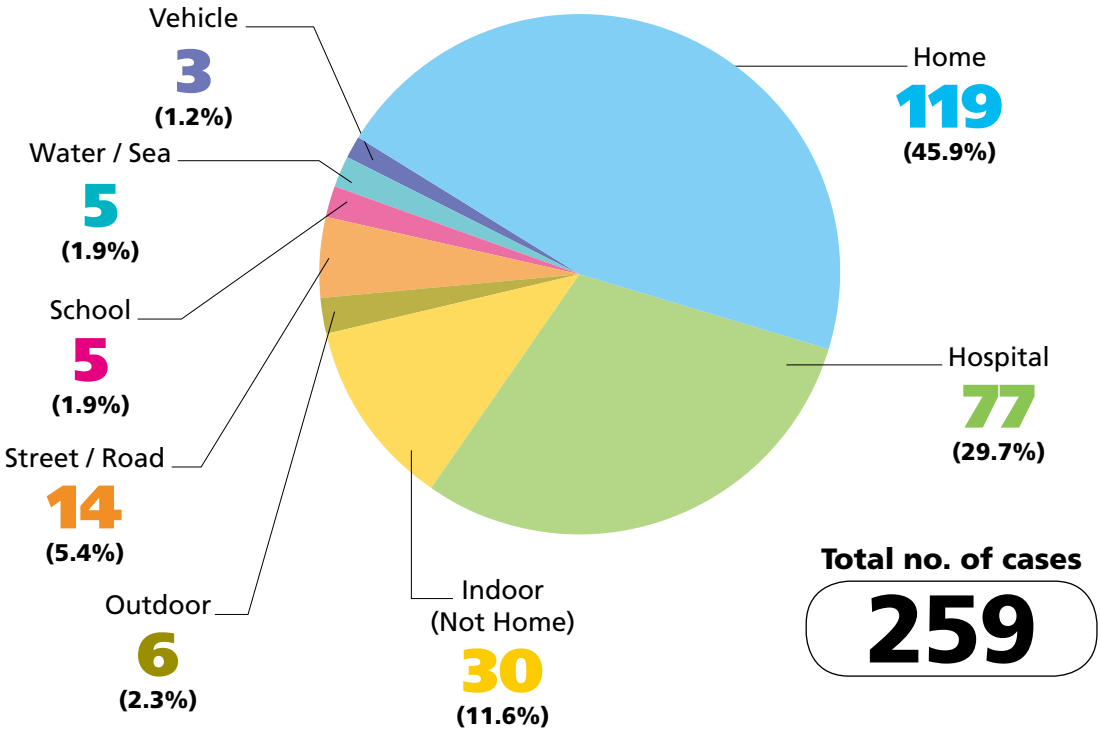
@ The boundaries of the Wan Chai district and Eastern district adopted since 2016 are different from those adopted in 2015 and earlier years. Therefore, figures of the Wan Chai and Eastern districts for 2016 and thereafter are not strictly comparable with those for 2015 and earlier years in this table.

In 2016, the highest number of child deaths was recorded in Yuen Long District (N=19), followed by Kowloon City District (N=9), Sham Shui Po District and Kwun Tong District (both N=8). However, taking account of the child population in respective districts, the highest child death rate, i.e. child death cases reviewed per 1 000 land-based non-institutional child population in respective districts, came from Islands District (0.223), followed by Yuen Long District (0.213) and Tsuen Wan District (0.159).

In 2017, the highest number of child deaths was recorded in Yuen Long District (N=13), followed by Kwun Tong District (N=9) and Kwai Tsing District (N=8). The highest child death rate came from Yuen Long District (0.142), followed by Central and Western District (0.134) and Yau Tsim Mong District (0.131).

In 2018, the highest number of child deaths was recorded in Tuen Mun District (N=9), followed by Eastern District (N=7) and Wong Tai Sin, Kwai Tsing and Sai Kung District (all N=6). However, taking account of the child population in respective districts, the highest child death rate, came from Tuen Mun District (0.130), followed by Wong Tai Sin District (0.109) and Sai Kung District (0.095).

Chart 5.2.10: Number of Cases by Place of Fatal Incident



* *Note: Fatal-incidents occurred in hospitals are natural cause cases*

Chart 5.2.11: Number of Cases by Type of Residence

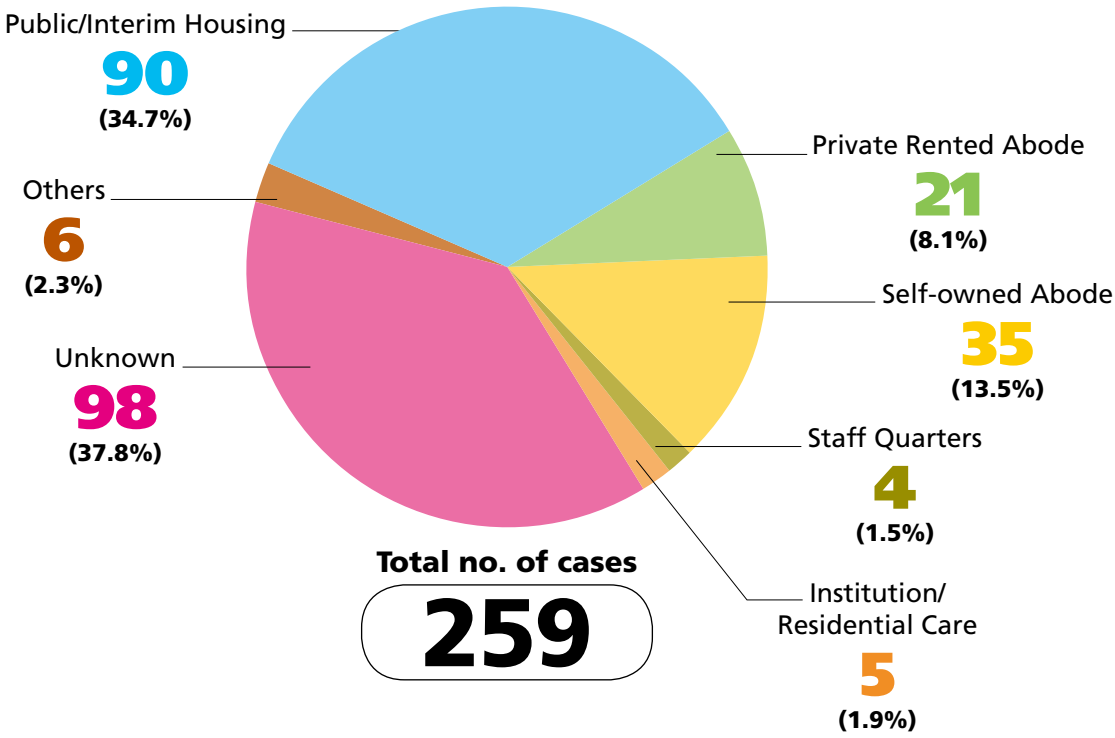


Table 5.2.12: Number of Cases by Family Income

Family Income	Number of Cases (%)
On CSSA	13 (5.0%)
Below $10,000	4 (1.5%)
$10,000 - $19,999	11 (4.2%)
$20,000 - $29,999	1 (0.4%)
$30,000 - $39,999	2 (0.8%)
$40,000 - $49,999	0 (0.0%)
$50,000 or Above	6 (2.3%)
Unknown	222 (85.7%)
Total (%)	**259 (100%)**

Table 5.2.13: Number of Cases by Parental Status

Parental Status	Number of Cases (%)
Both-parent	187 (72.2%)
Separated / Divorced Parents	23 (8.9%)
Unmarried Parents	20 (7.7%)
Single-parent	10 (3.9%)
One Parent Residing in Mainland	2 (0.8%)
Remarried Parent(s)	1 (0.4%)
*Large Age Gap Parents	1 (0.4%)
#Aged Parent(s)	1 (0.4%)
Unknown	14 (5.4%)
Total (%)	**259 (100%)**

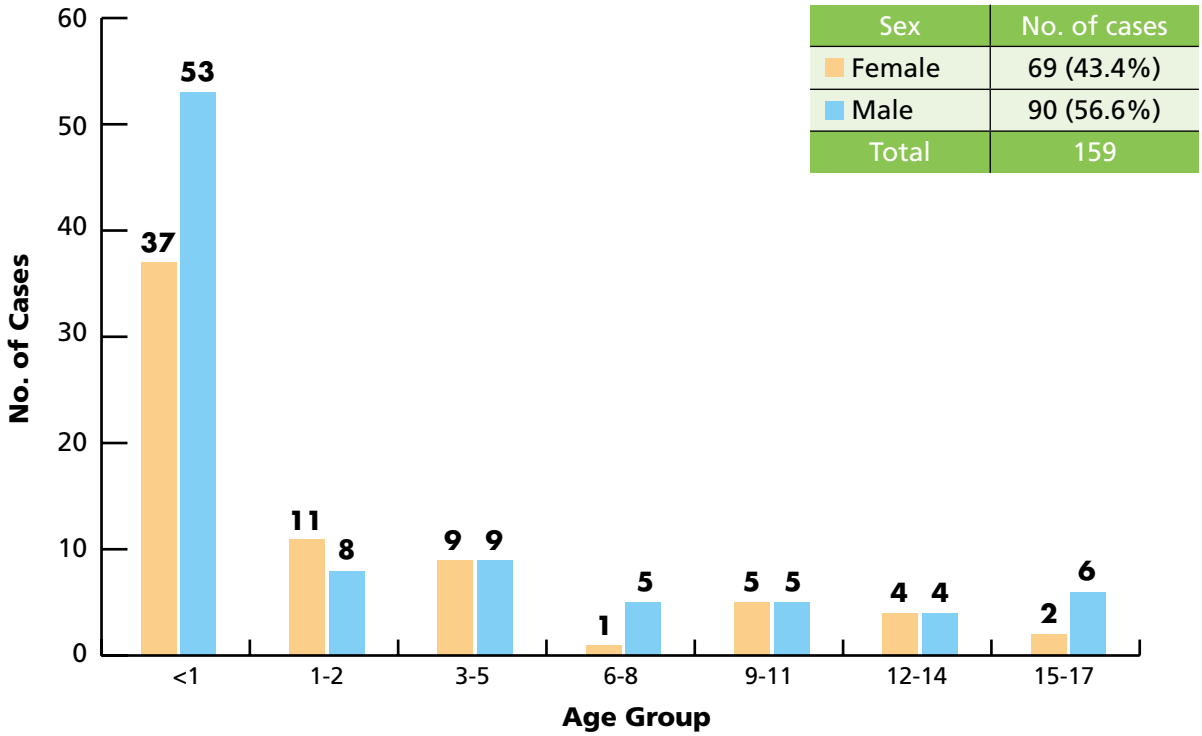
** Large Age Gap Parents: ≥15 years age gap*

 # Aged Parent(s): ≥60 years old

5.3 Statistics of Child Death Cases According to Death Causes

5.3.1 Natural Cause Cases

Chart 5.3.1.1: Number of Cases by Age Group and Gender



Sex	No. of cases
Female	69 (43.4%)
Male	90 (56.6%)
Total	159

Table 5.3.1.2: Number of Cases by Type of Health Problem According to ICD10 Classification

ICD Code	Type of Health Problem	No. of Cases (%)
A00-B99	Certain infectious and parasitic diseases	8 (5.0%)
C00-D48	Neoplasms	7 (4.4%)
D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1 (0.6%)
E00-E90	Endocrine, nutritional and metabolic diseases	4 (2.5%)
G00-G99	Diseases of the nervous system	14 (8.8%)
I00-I99	Diseases of the circulatory system	21 (13.2%)
J00-J99	Diseases of the respiratory system	18 (11.3%)
K00-K93	Diseases of the digestive system	7 (4.4%)
M00-M99	Disease of the musculoskeletal system and connective tissue	3 (1.9%)
N00-N99	Diseases of the genitourinary system	1 (0.6%)
P00-P96	Certain conditions originating in the perinatal period	26 (16.4%)
Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities	23 (14.5%)
R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (mainly sudden infant death or sudden unexplained death for the reviewed cases)	26 (16.4%)
	Total (%)	**159 (100.0%)**

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

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

Table 5.3.1.3: Number of Cases by Age Group and Death Category

Age Group	Category*					No. of Cases (%)
	A (%)	B (%)		C (%)	D# (%)	
		B1 (%)	B2 (%)			
< 1	27 (17.0%)	10 (6.3%)	7 (4.4%)	9 (5.7%)	37 (23.3%)	90 (56.6%)
1-2	0	10 (6.3%)	1 (0.6%)	7(4.4%)	1 (0.6%)	19 (11.9%)
3-5	0	10 (6.3%)	2 (1.3%)	6 (3.8%)	0	18 (11.3%)
6-8	0	0	1 (0.6%)	5 (3.1%)	0	6 (3.8%)
9-11	0	4 (2.5%)	1 (0.6%)	5 (3.1%)	0	10 (6.3%)
12-14	0	2 (1.3%)	1 (0.6%)	4 (2.5%)	1 (0.6%)	8 (5.0%)
15-17	0	2 (1.3%)	2 (1.3%)	4 (2.5%)	0	8 (5.0%)
Total (%)	**27 (17.0%)**	**38 (23.9%)**	**15 (9.4%)**	**40 (25.2%)**	**39 (24.5%)**	**159 (100.0%)**
		53 (33.3%)				

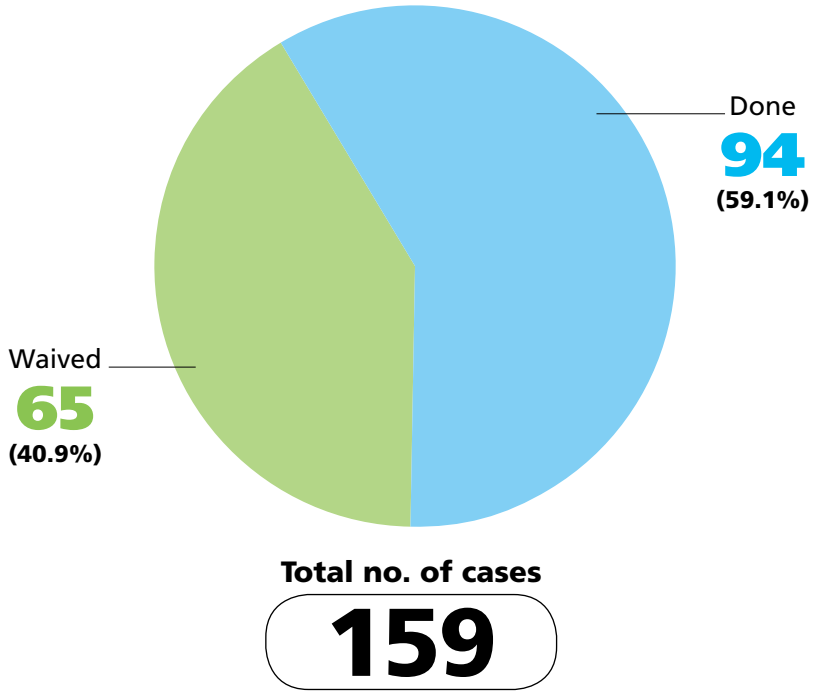
* *These categories of death, with content listed below, are designed by the medical experts of the Review Panel for review purpose:*

A – *Neo-natal Conditions*
B – *Chronic Medical Conditions*
B1 – *with mental or physical disabilities*
B2 – *without mental or physical disabilities*
C – *Acute Medical Conditions*
D – *Others, including:*
Unidentifiable Aetiology
SUDI (Sudden and Unexpected Death in Infancy)
Stillbirth

For cases under Category D, further breakdown is: Stillbirth cases (N=18, 11.3%); SUDI cases (N=13, 8.2%) & Cases with unidentifiable aetiology (N=8; 5.0%).

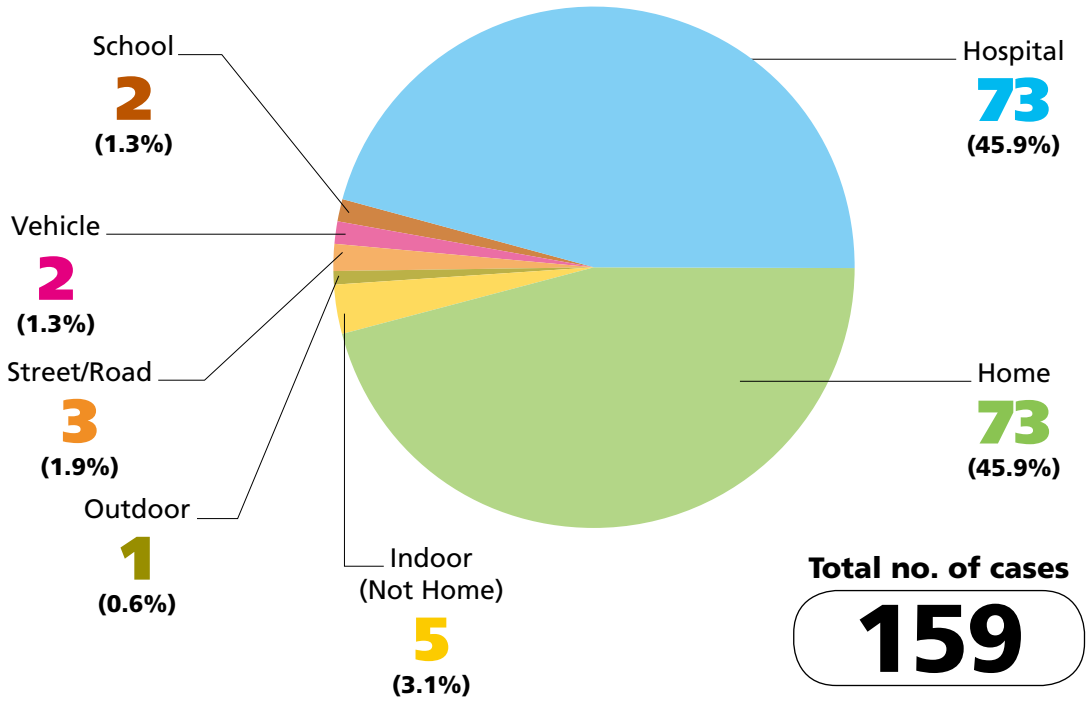
The highest number of case among different categories are highlighted.

Chart 5.3.1.4: Number of Cases with Autopsy Done or Waived*



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

Chart 5.3.1.5: Number of Cases by Place of Fatal Incident



Note: Fatal-incidents occurred in hospitals are natural cause cases

Table 5.3.1.6: Number of Cases by Ethnicity

Ethnicity	Number of Cases (%)
Chinese:	139 (87.4%)
Non-Chinese:	20 (12.6%)
Pakistani	6 (3.8%)
Filipino	3 (1.9%)
Indonesian	3 (1.9%)
Indian	2 (1.3%)
Nepalese	2 (1.3%)
American	2 (1.3%)
Taiwanese	1 (0.6%)
Vietnamese	1 (0.6%)
Total (%)	**159 (100%)**

5.3.2 Suicide Cases

Chart 5.3.2.1: Number of Cases by Age Group and Gender

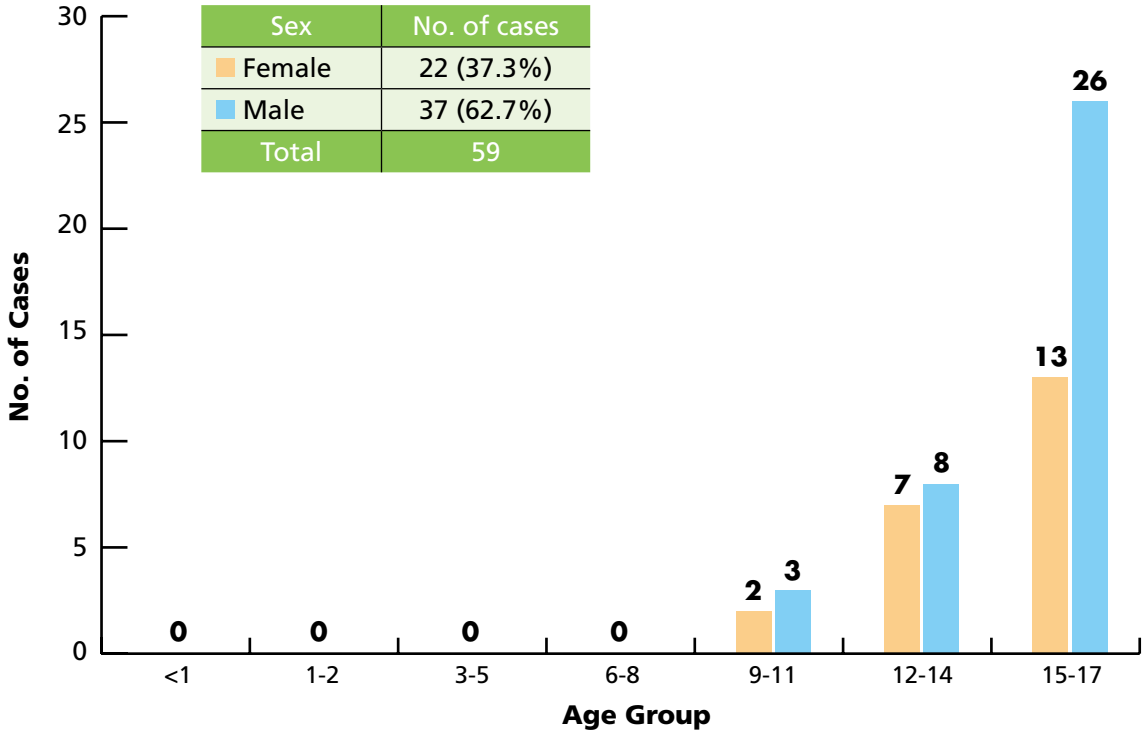


Chart 5.3.2.2: Number of Cases by Education/Occupation

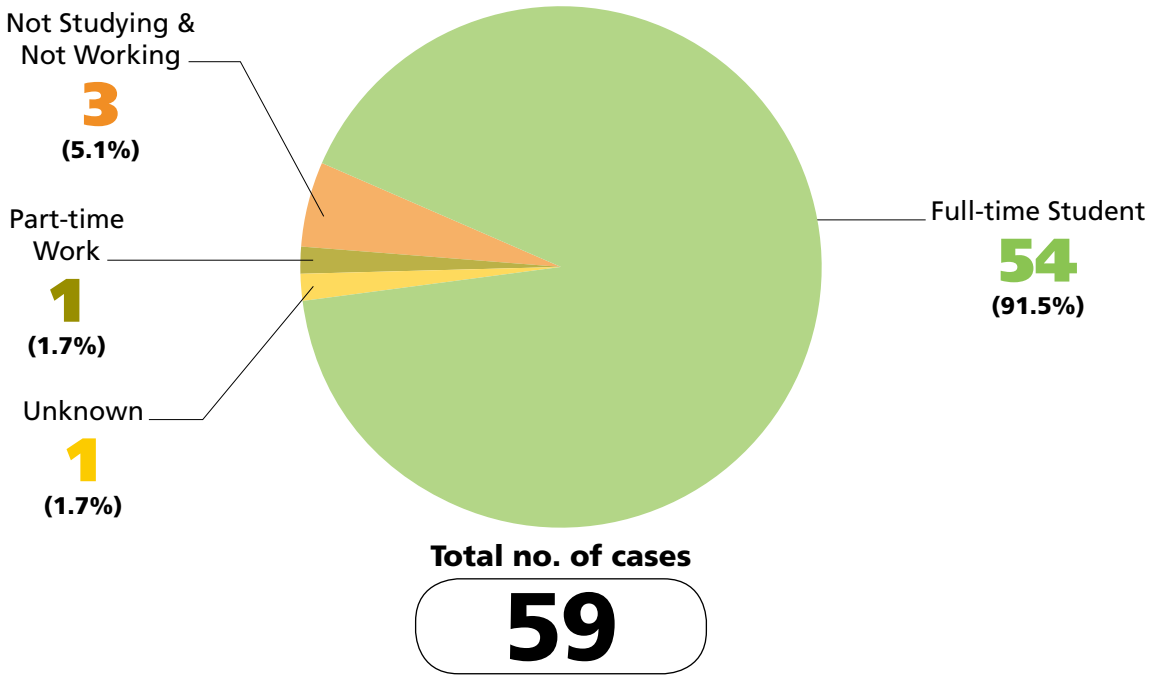
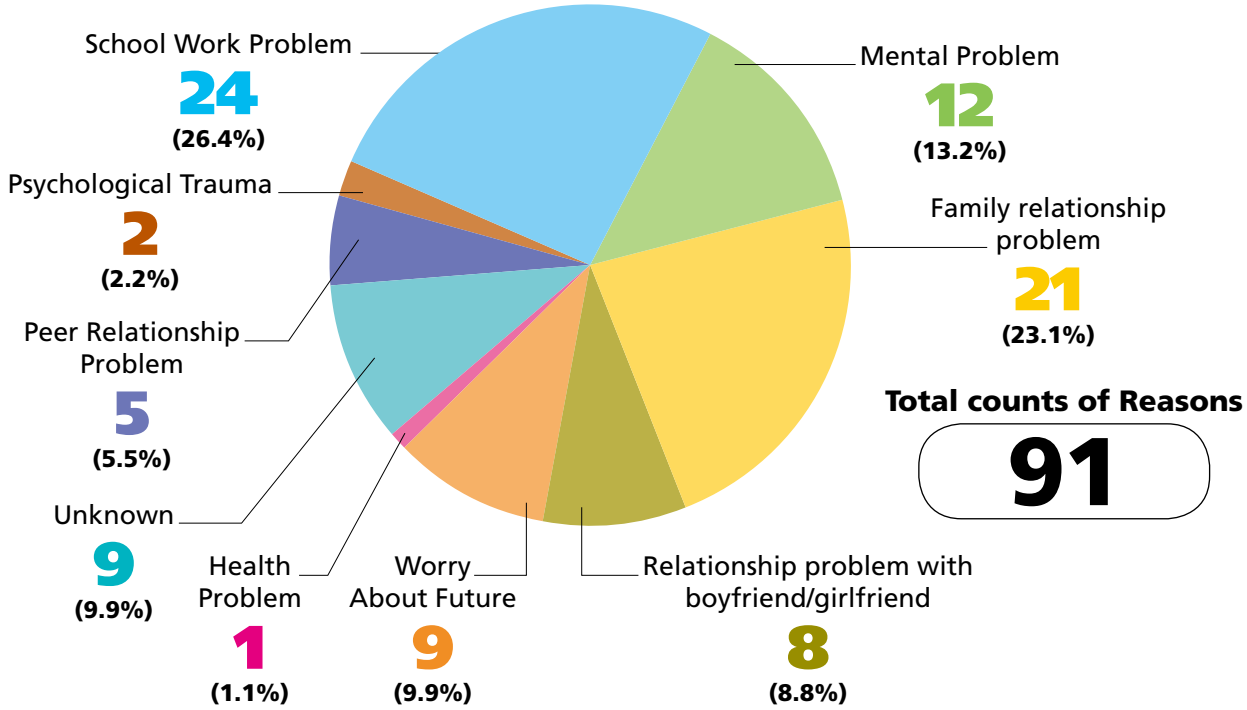


Chart 5.3.2.3: Reasons for Committing Suicide*



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

Chart 5.3.2.4: Means of Committing Suicide

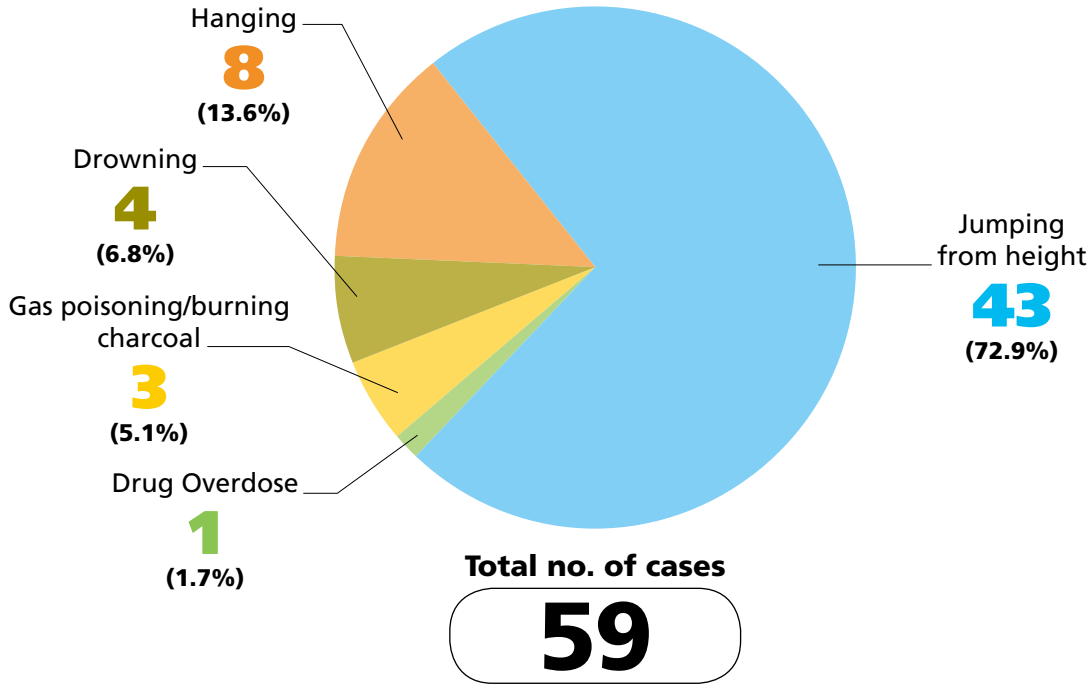
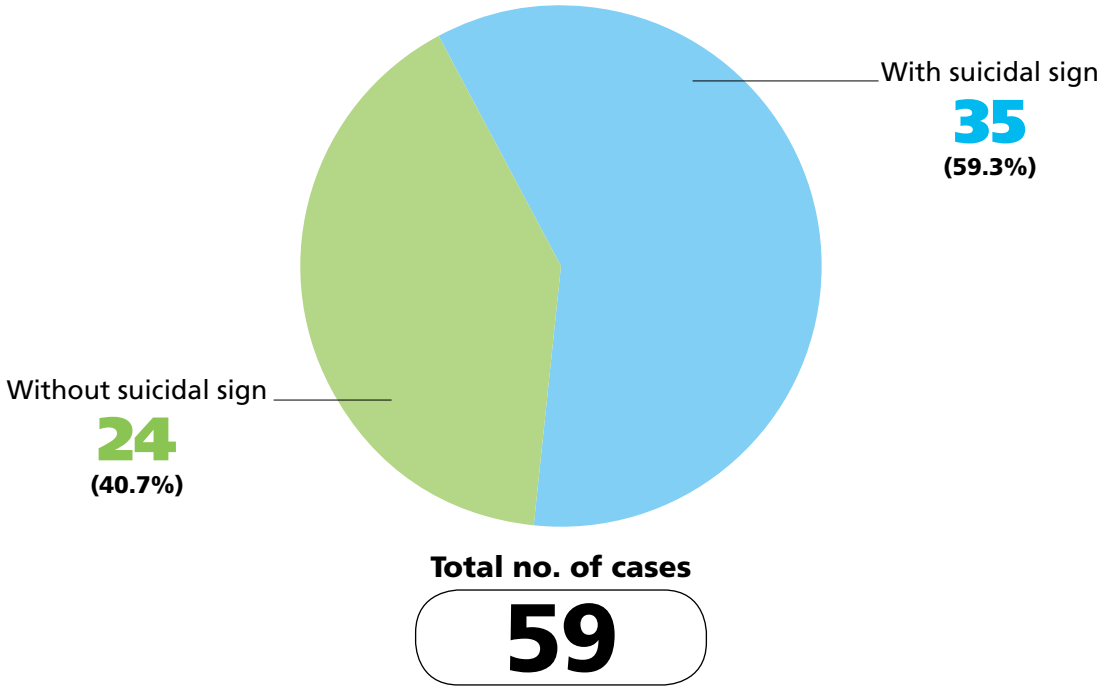


Chart 5.3.2.5: Cases with Identified Suicidal Signs*



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

Chart 5.3.2.6: Number of Cases by Parental Status

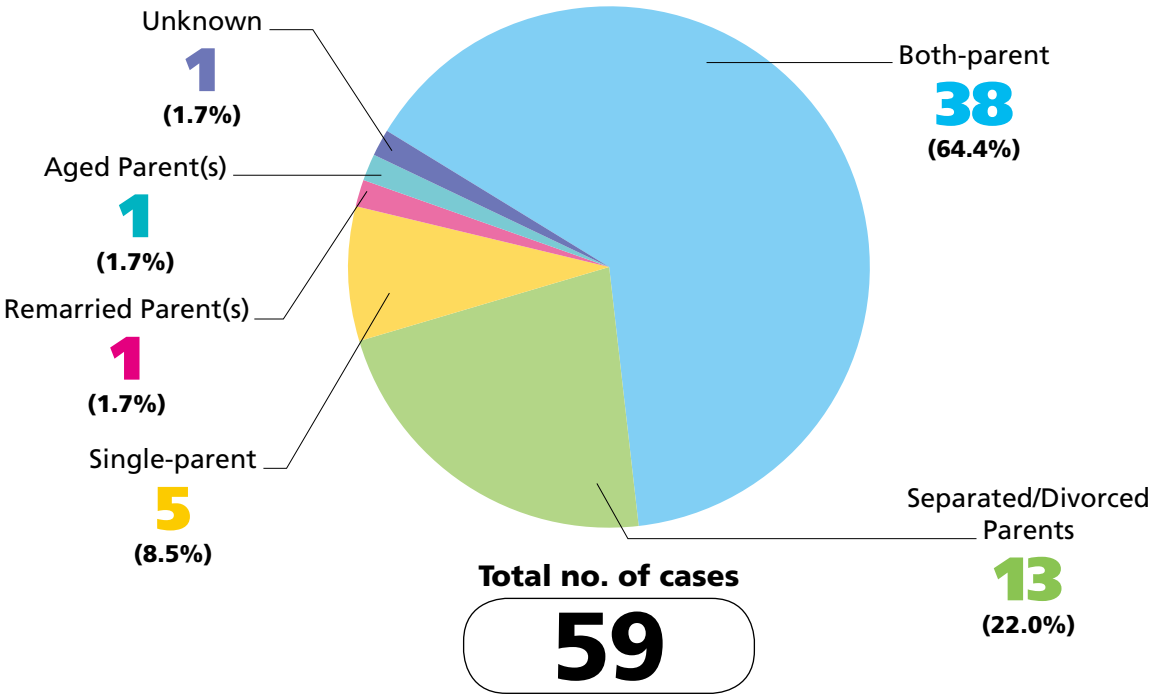


Table 5.3.2.7: Number of Cases by Family Income

Family Income	Number of Cases (%)
On CSSA	6 (10.2%)
Below $10,000	2 (3.4%)
$10,000 - $19,999	6 (10.2%)
$20,000 - $29,999	1 (1.7%)
$30,000 - $39,999	2 (3.4%)
$40,000 - $49,999	0 (0.0%)
$50,000 or Above	5 (8.5%)
Unknown	37 (62.7%)
Total (%):	**59 (100%)**

Table 5.3.2.8: Number of Cases by Education/Occupation

Education/Occupation	Number of Cases (%)	
Primary 5	3	Primary = 5 (8.5%)
Primary 6	2	
Form 1	3	Junior Secondary = 21 (35.6%)
Form 2	10	
Form 3	8	
Form 4	9	Senior Secondary = 27 (45.8 %)
Form 5	11	
Form 6	7	
Vocational Training after Form 3	1	
Not Studying & Not Working	2	
Working	1	
Unknown	2	
Total	**59**	

Table 5.3.2.9: Number of Cases by Month of each Year

Months	2016	2017	2018	Total (%)
January	1	0	**4**	5 (8.5%)
February	2	**6**	1	9 (15.3%)
March	**4**	2	0	6 (10.2%)
April	2	2	0	4 (6.8%)
May	0	0	2	2 (3.4%)
June	3	1	1	5 (8.5%)
July	0	2	0	2 (3.4%)
August	1	3	1	5 (8.5%)
September	1	2	0	3 (5.1%)
October	2	3	3	8 (13.6%)
November	2	2	1	5 (8.5%)
December	3	1	1	5 (8.5%)
Total (%)	**21**	**24**	**14**	**59 (100%)**

5.3.3 Accident Cases

Chart 5.3.3.1: Number of Cases by Age Group and Gender

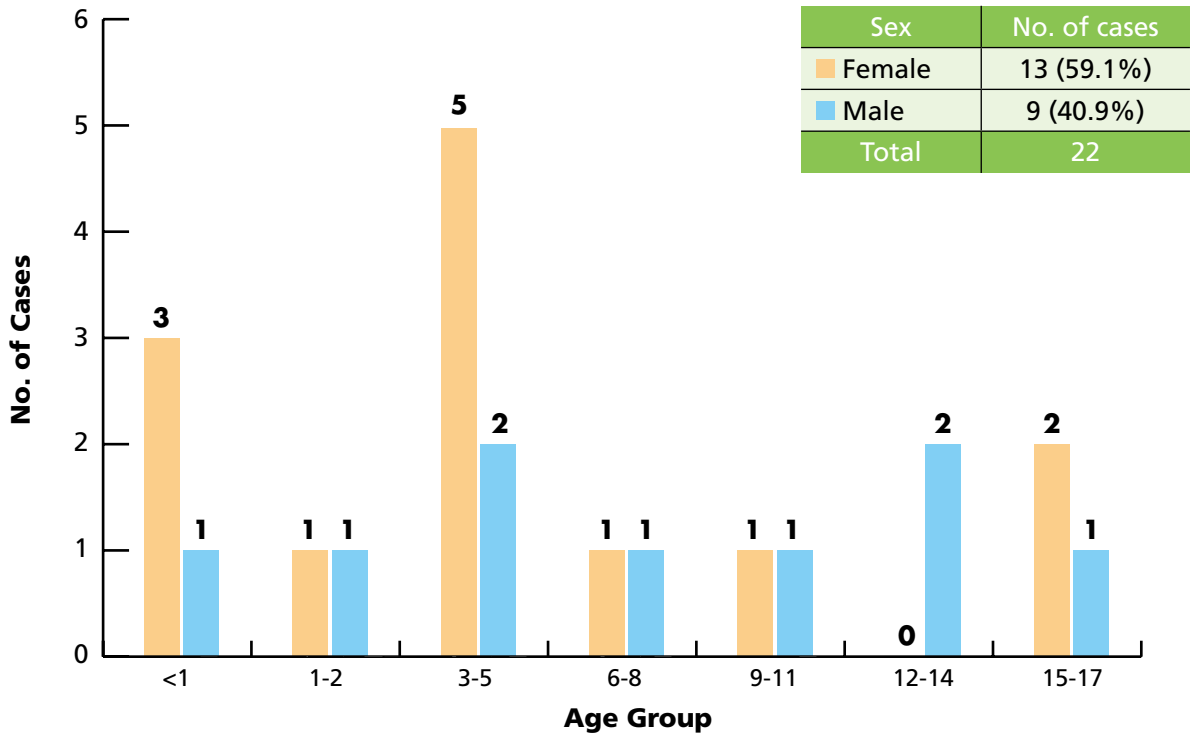


Chart 5.3.3.2: Number of Cases by Type of Accident and Gender

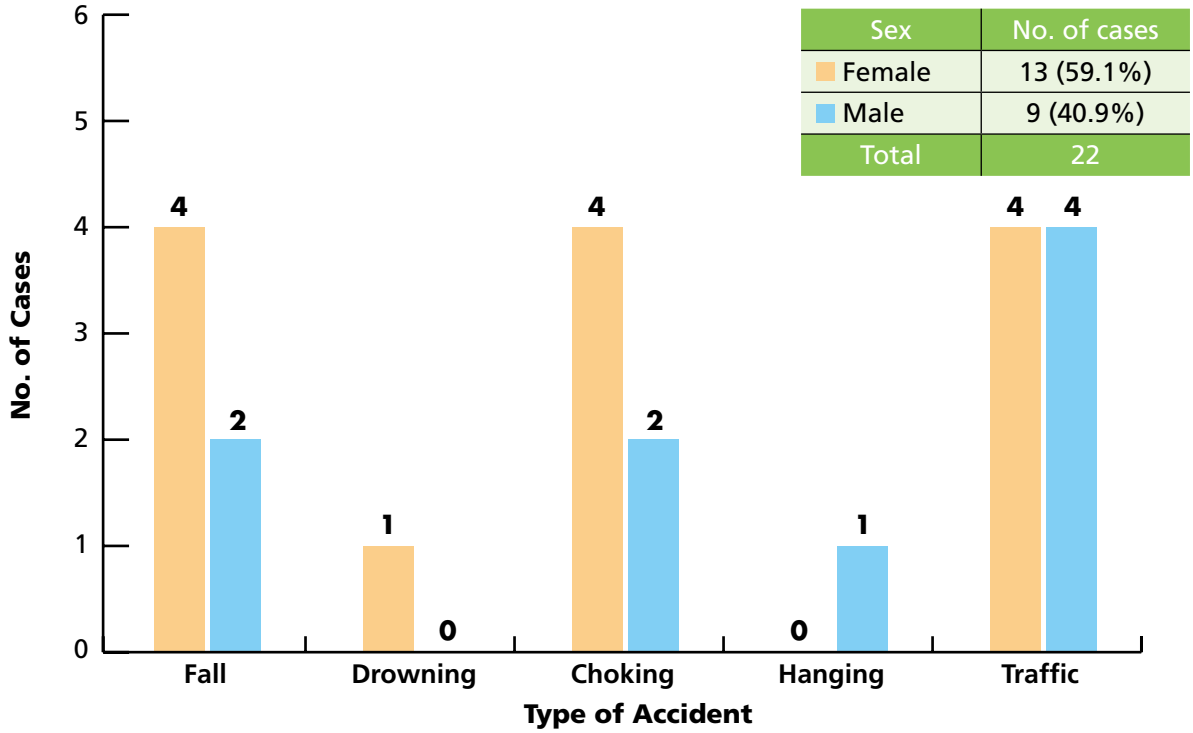


Chart 5.3.3.3: Number of Cases by Age Group and Type of Accident

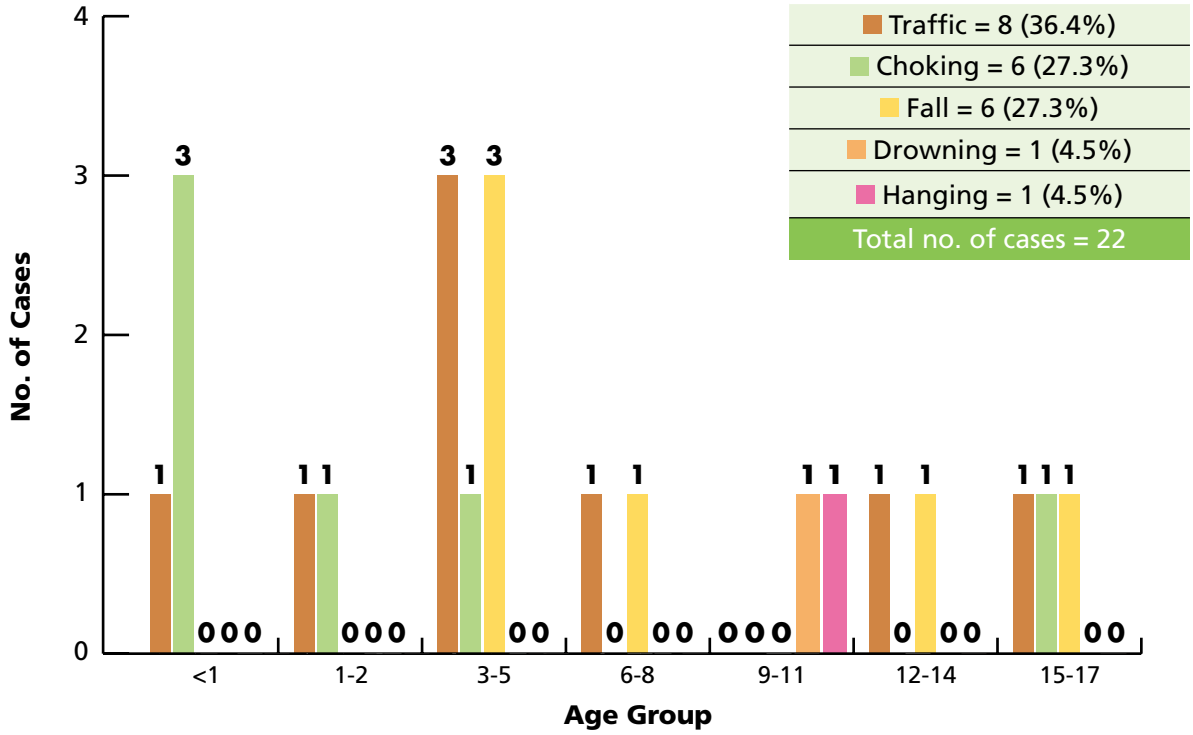


Chart 5.3.3.4: Number of Cases by Age Group and Type of Traffic Victim

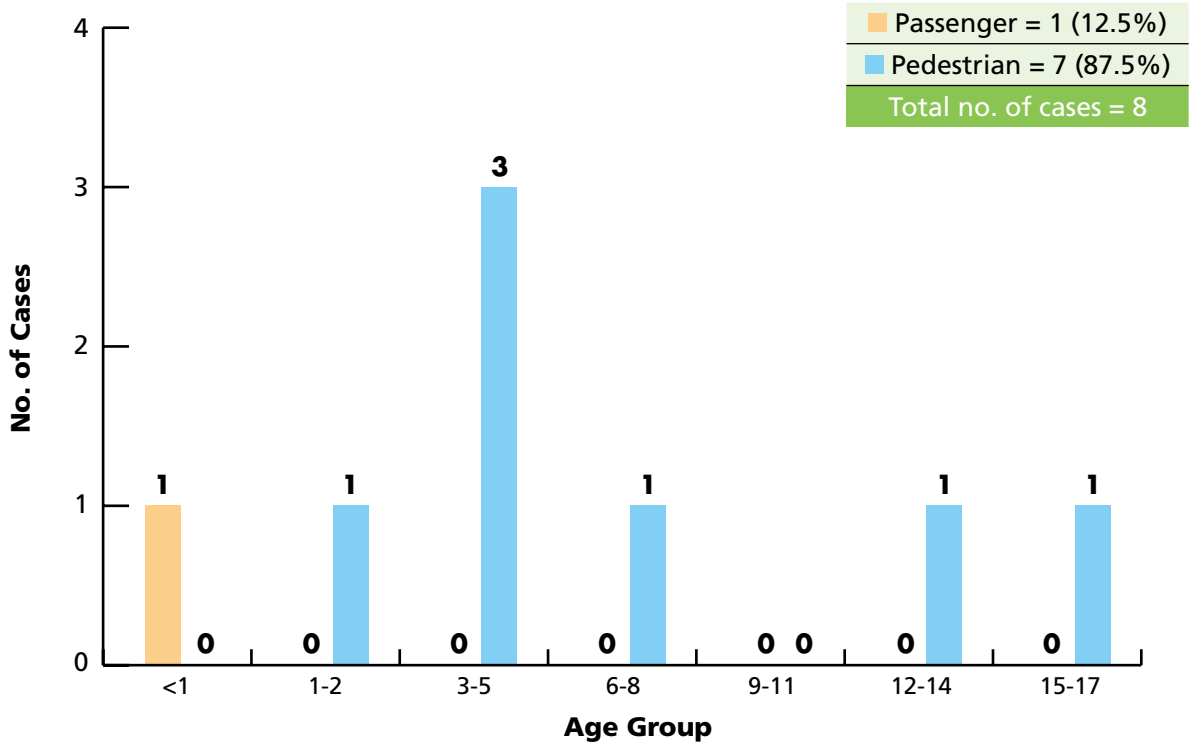


Chart 5.3.3.5: Number of Cases by Place of Fatal Incident

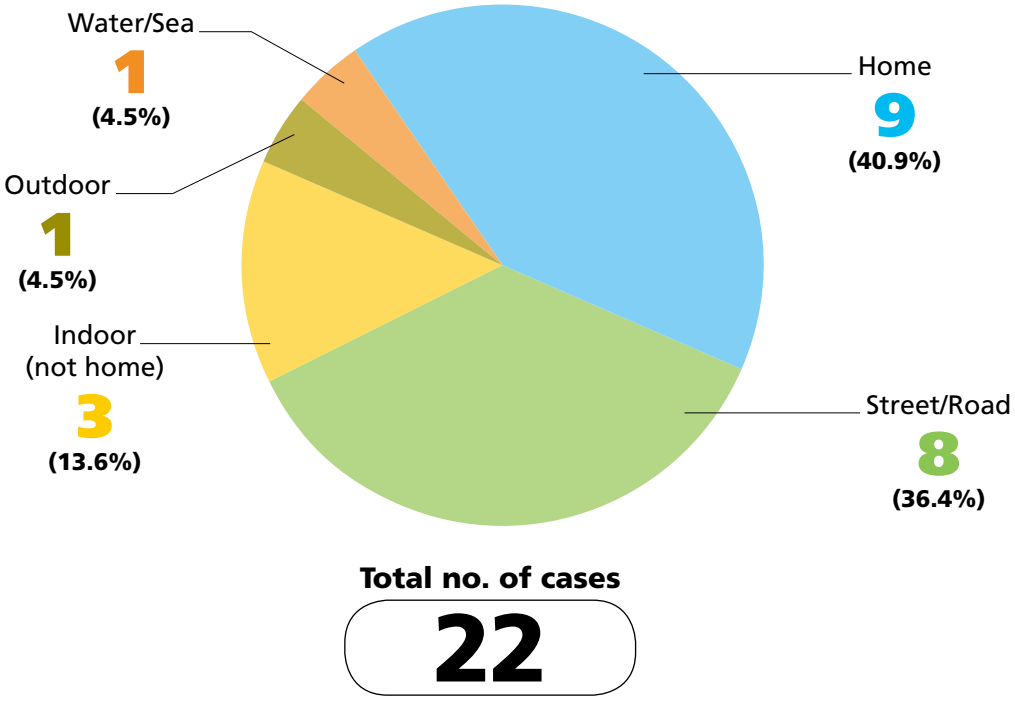
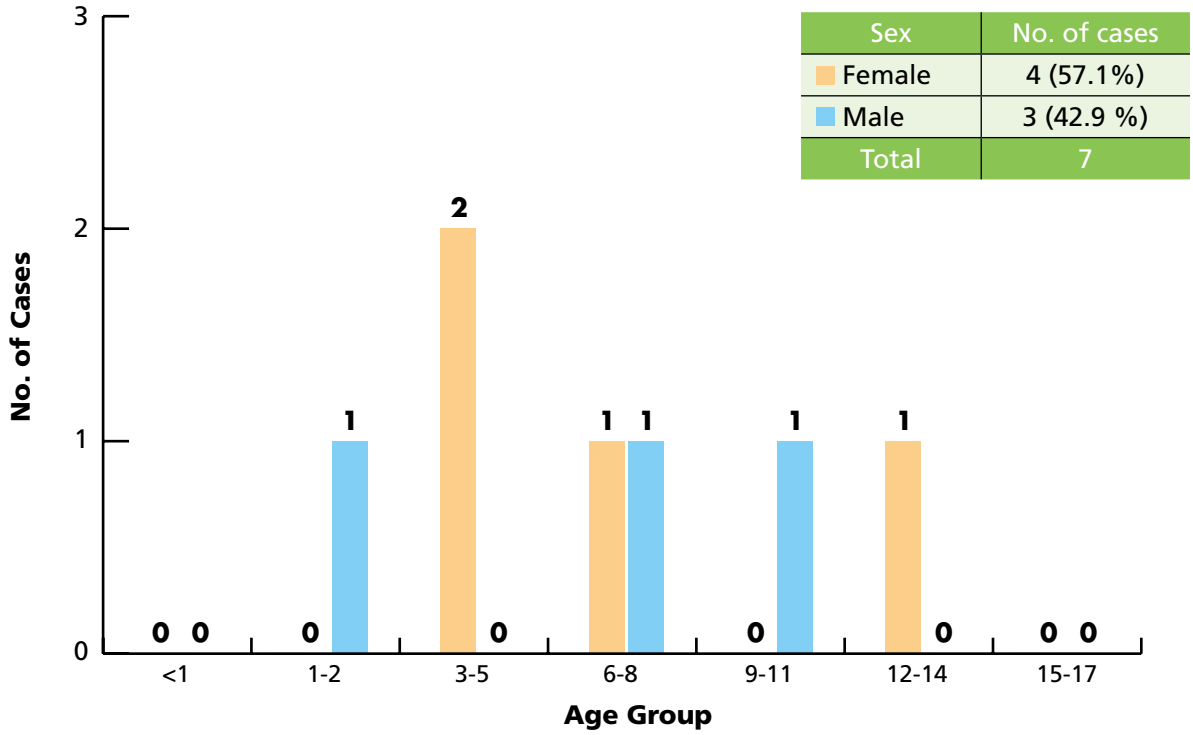


Table 5.3.3.6: Number of Cases by Ethnicity

Ethnicity	Number of Cases (%)
Chinese:	17 (77.3%)
Non-Chinese:	5 (22.7%)
Indian	1 (4.5%)
Indonesian	1 (4.5%)
Filipino	1 (4.5%)
Nepalese	1 (4.5%)
American	1 (4.5%)
Total (%)	**22 (100%)**

5.3.4 Assault Cases

Chart 5.3.4.1: Number of Cases by Age Group and Gender



Sex	No. of cases
Female	4 (57.1%)
Male	3 (42.9 %)
Total	7

Chart 5.3.4.2: Types of Assault

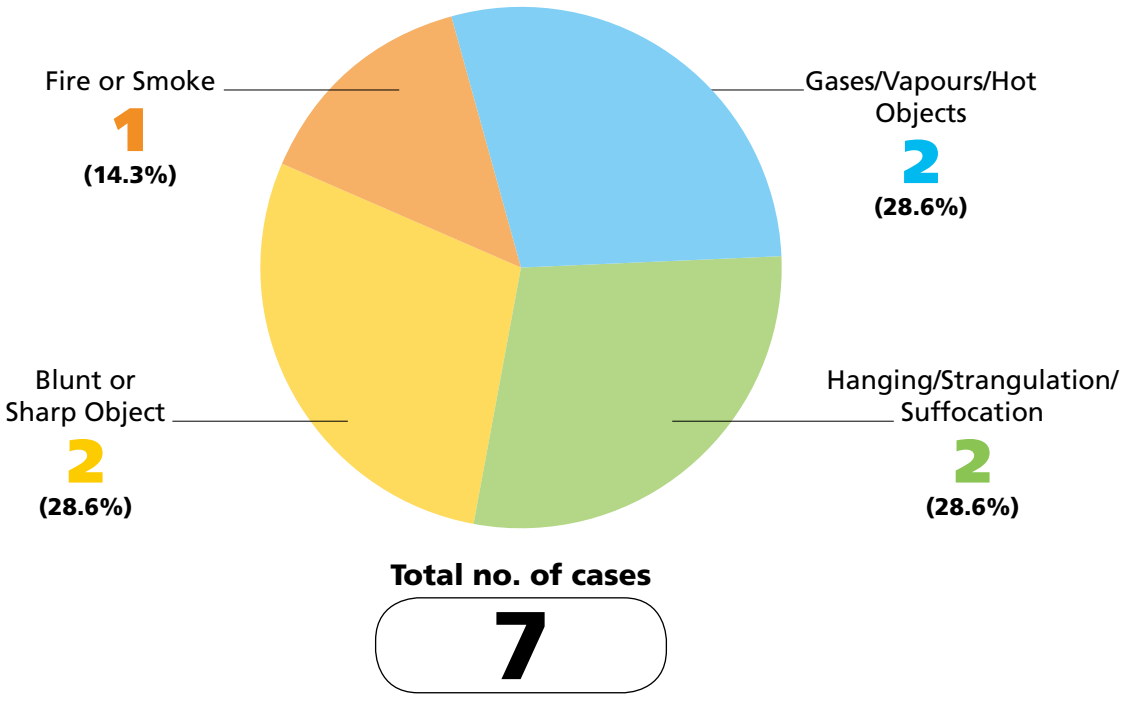
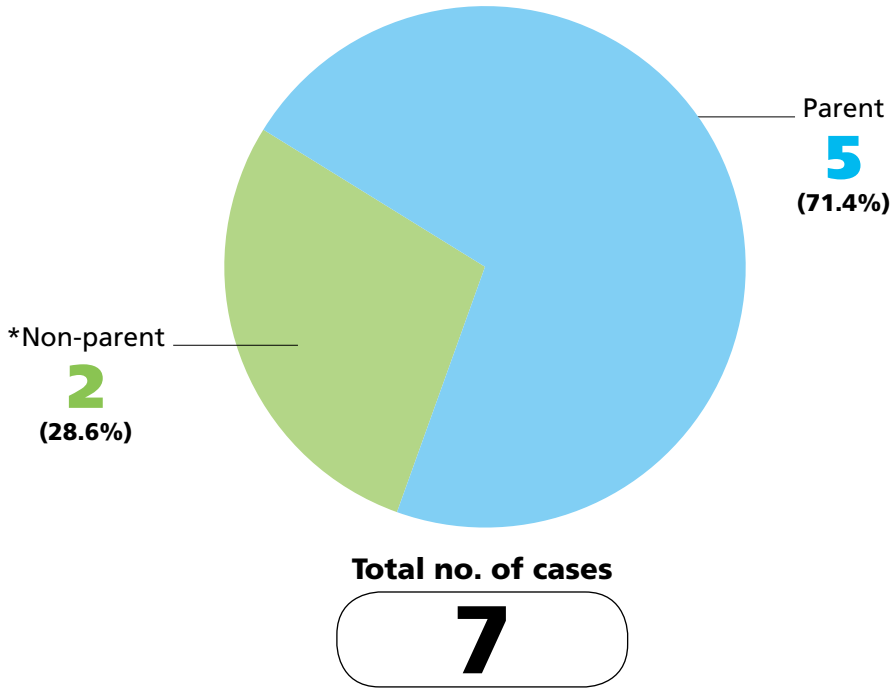


Chart 5.3.4.3: Perpetrator's Relationship with the Deceased Child



* *Non-parent: includes 1 neighbour and 1 foreign domestic helper*

Chart 5.3.4.4: Major contributing factors leading to Assault

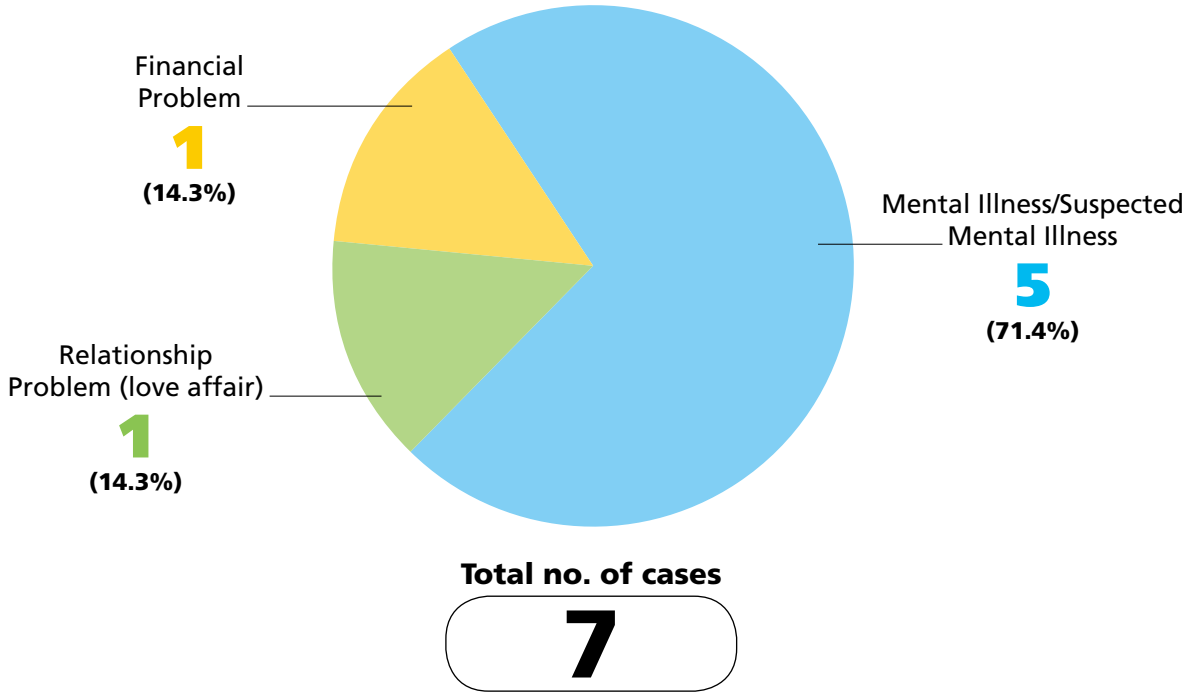


Chart 5.3.4.5: Number of Cases by Place of Fatal Incident

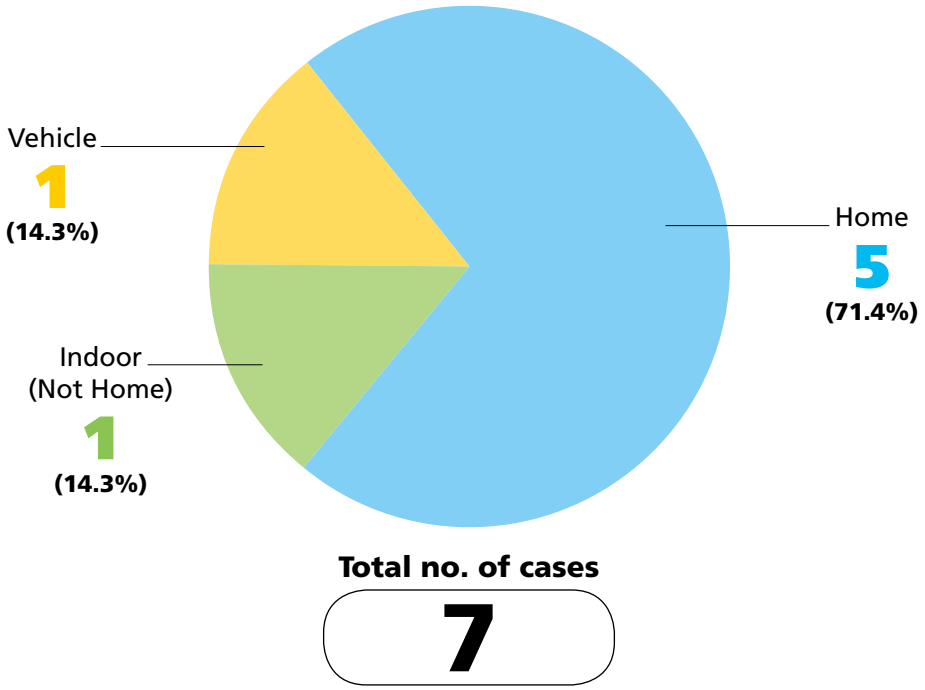


Chart 5.3.4.6: Number of Cases by Parental Status

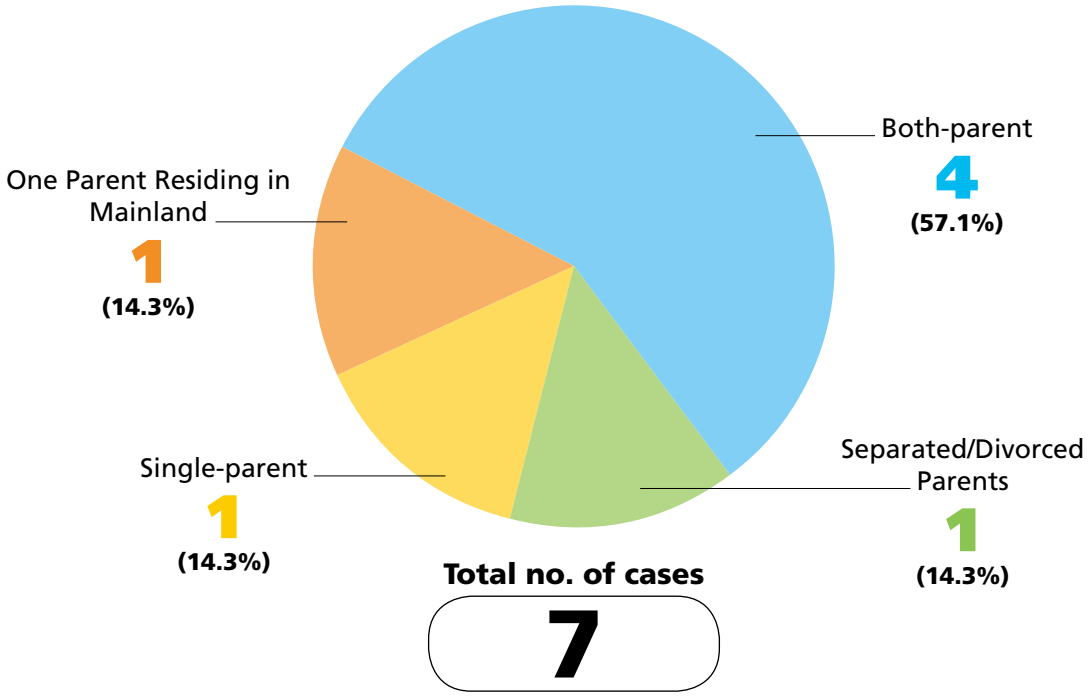


Chart 5.3.4.7: Number of Cases by Type of Residence

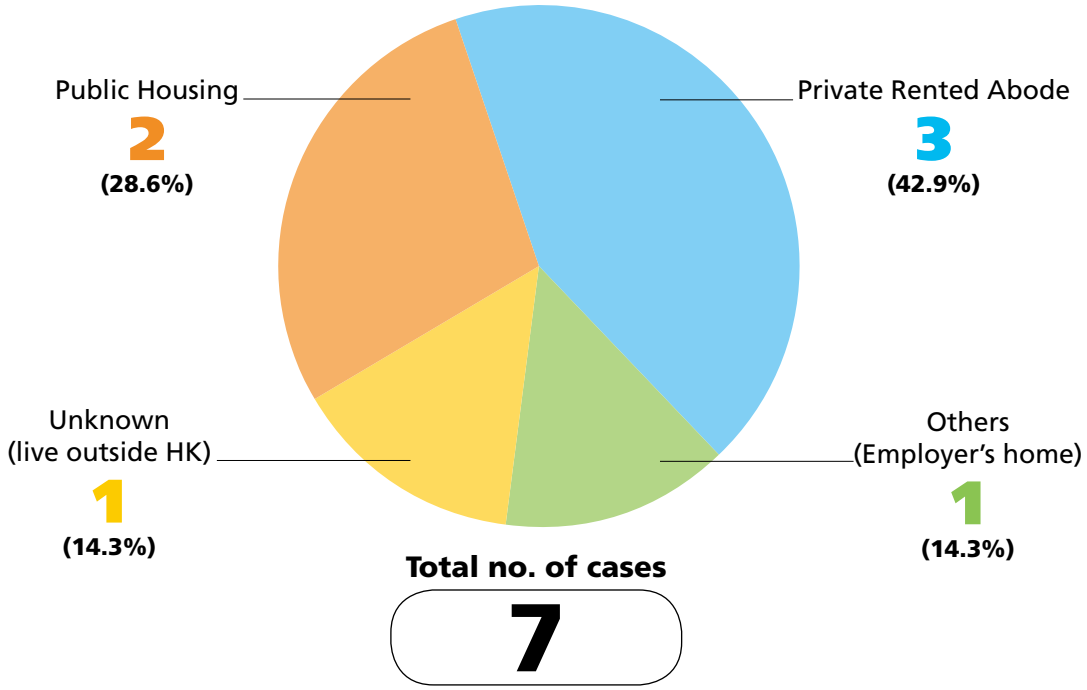


Table 5.3.4.8: Number of Cases by Ethnicity

Ethnicity	Number of Cases (%)
Chinese:	4 (57.1%)
Non-Chinese:	3 (42.9%)
Indian	2 (28.6%)
Korean	1 (14.3%)
Total (%)	**7 (100%)**

5.3.5 Non-natural Unascertained Cause Cases

Chart 5.3.5.1: Number of Cases by Age Group and Gender

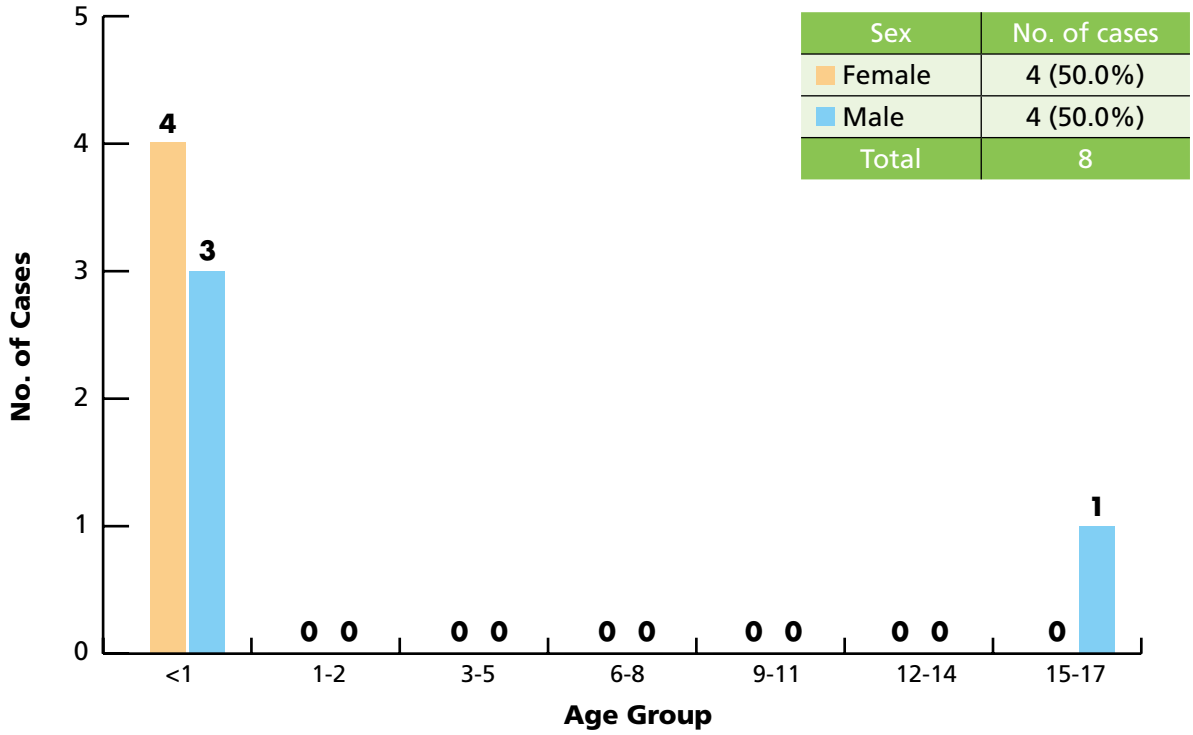


Table 5.3.5.2: Nature of Death under the Unascertained Causes

Nature of Death	Year			Total (%)
	2016	2017	2018	
Co-sleeping/unsafe sleeping arrangement	0	1	2	3 (37.5%)
Concealment of pregnancy (by a foreign domestic helper and a foreigner)	1	1	0	2 (25.0%)
At-risk pregnant women without prenatal check-up	0	0	2	2 (25.0%)
Unknown (decomposed body of a 15-year-old boy)	0	1	0	1 (12.5%)
Total (%)	**1**	**3**	**4**	**8 (100%)**

Chart 5.3.5.3: Number of Cases by Place of Fatal Incident

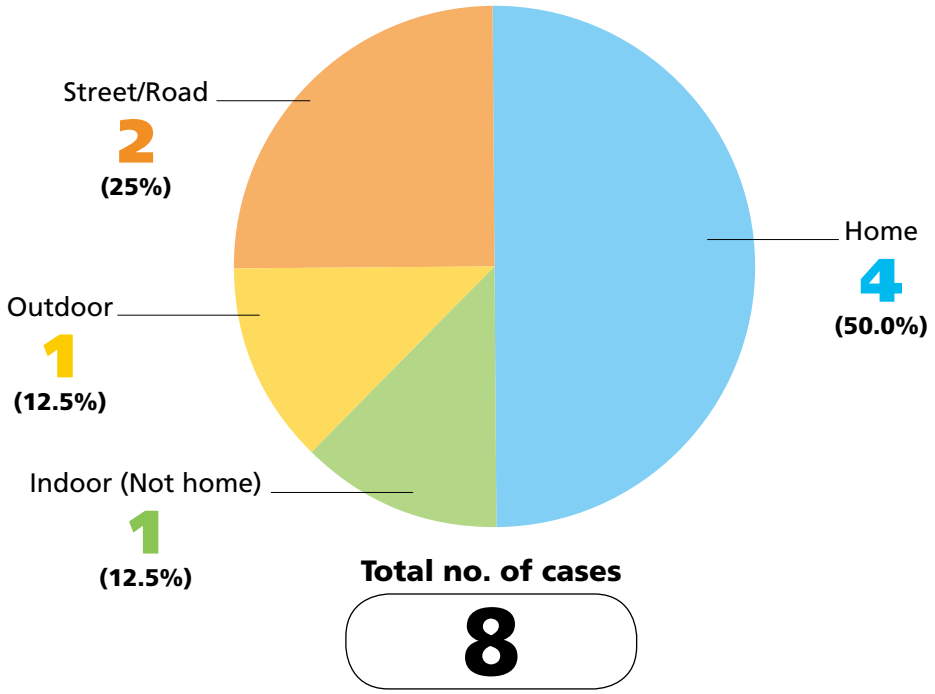


Chart 5.3.5.4: Number of Cases by Parental Status

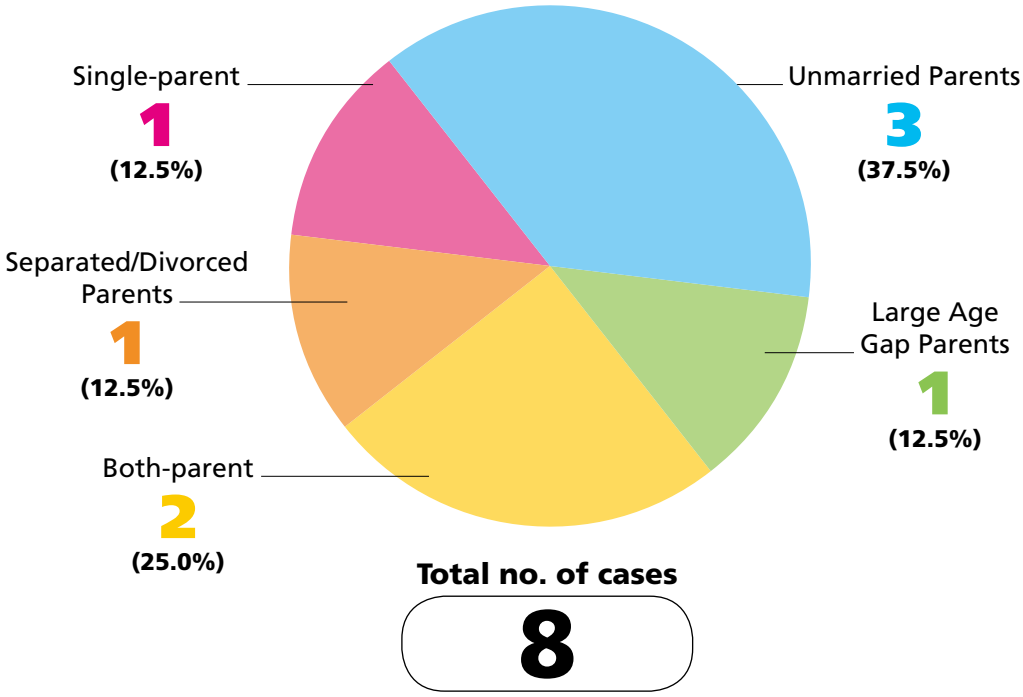


Chart 5.3.5.5: Number of Cases by Type of Residence

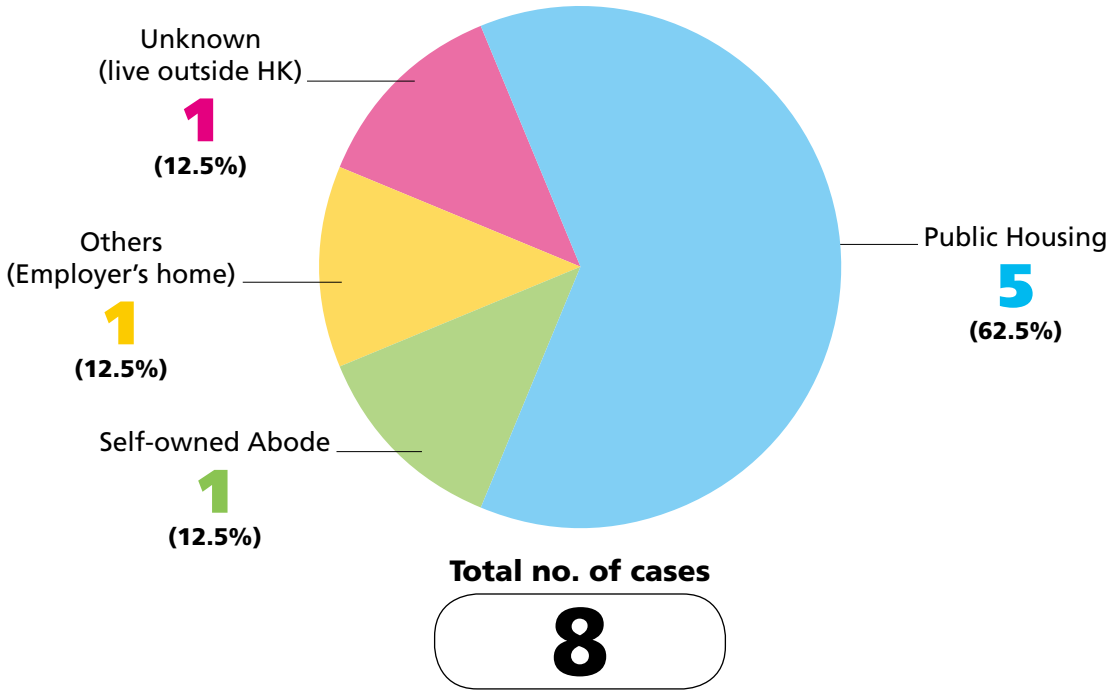


Table 5.3.5.6: Number of Cases by Ethnicity

Ethnicity	Number of Cases (%)
Chinese:	6 (75.0%)
Non-Chinese:	2 (25.0%)
Filipino	1 (12.5%)
Zambian	1 (12.5%)
Total (%)	**8 (100%)**

6 Observations on Review of Child Death Cases in 2016, 2017 and 2018

After reviewing the child death cases which occurred in 2016, 2017 and 2018, the Review Panel has come up with the following observations and 59 recommendations on preventive strategies and system improvement for child fatal cases. The observations by death cause are listed below.

6.1 Observations by Different Death Nature

6.1.1 Natural Cause Cases

- The Review Panel reviewed 5 child death cases which involved at-risk pregnant women and mothers who were single-mothers or young mothers with inadequate social support, limited child care knowledge, history of substance-abuse, limited intelligence, rejected intervention by social workers or defaulted antenatal care. **(Recommendation N1)**
- Among the cases, there were two infants, step siblings born out of wedlock of their mother, died under the Category of SUDI (Sudden and Unexpected Death in Infancy). The single-mother, who had history of substance abuse, rejected intervention by social worker after the birth of her elder child and did not follow the child care arrangement as agreed in the multi-disciplinary case conference before the discharge of her younger child. Panel Members opined that regular multi-disciplinary case meeting, especially when there is significant change of the family circumstances, can help monitor the child care condition. **(Recommendation N2)**
- Two cases were found died of influenza infection. **(Recommendation N3)**
- Among the 159 cases with children dying of natural cause, 16 cases involved ethnic minorities (EMs). Panel Members noticed that there was a number of EM child fatality cases involving the mothers' failure to receive regular antenatal check-up and medical care while labouring which had increased the risk of complications for the new born babies. **(Recommendation N4)**
- There is limited understanding with respect to the cause of death of cases with autopsy waived as requested by the deceased children's families (some due to religious reasons). The Review Panel thus encountered difficulties to make recommendations for prevention of similar child death. **(Recommendation N5)**

- There were 4 reviewed cases suspected to be related to metabolic diseases or genetic abnormalities. Panel Members noted that the Hong Kong Children's Hospital and Department of Health is now promulgating a territory wide new born screening for inborn errors of metabolism according to the government policy. Under the current practice, paediatricians would refer parents and/or surviving siblings of child died of suspected hereditary disease in paediatric ward for genetic counselling. However, there is no standard protocol for forensic pathologist to conduct genetic testing on child died of sudden or unexpected death when the child was certified dead upon arrival at the Accident and Emergency Department. For those unexpected sudden child death cases, protocol for peri-mortem investigations might help delineate the underlying possible medical causes. If genetic abnormality is found on the deceased child, genetic screening for family members should be conducted so as to prevent heredity disease in the family. **(Recommendation N6)**

- There were 9 death cases under natural cause and 3 under accident were related to co-sleeping and improper sleeping arrangement, including prone sleeping, leaving babies to sleep alone on adult's beds out of sight and arranging babies to sleep on a bed placed with soft objects. **(Recommendations N7-N9)**

- The Review Panel reviewed 3 natural cause death cases which were suspected to be related to concealment of pregnancy of foreign domestic helpers. Panel Members viewed that foreign domestic helpers might conceal their pregnancy for fear of losing the job as the employers might not accept their pregnancy. **(Recommendation N10)**

- There were 6 natural cause death cases suspected to be related to concealment of pregnancy without antenatal care. Among which, 2 involved teenagers' concealment of pregnancy. It was probably due to their ignorance of proper handling of unwed pregnancy and worry of being rejected by their parents. **(Recommendation N11)**

- Autopsy reports of 2 cases dying of natural cause revealed that pholcodine, a cough suppressant, was detected in the blood of the deceased child. Panel Members shared the expert's view of possible serious side effects of codeine, including slowed or difficult breathing and even death which are at higher risks of occurrence in children younger than 12 years of age. It is advised that codeine should not be prescribed for children below 12 years of age which is in accordance with the recommendation and warning statement from U.S. Food and Drug Administration (FDA). **(Recommendation N12)**

6.1.2 Suicide Cases

(1) To Education Bureau/Schools/Teachers:

- In one of the suicide cases, a student committed suicide upon his promotion to Form One. Although he had suicidal thoughts ever since his primary school years, the parents refused to arrange him to receive psychiatric consultation. Panel Members viewed that Form One is an important transition in which students need great adaptation to the new school environment and curriculum. If the information of students with known suicidal thoughts or high-risk elements can be transferred from the primary schools to the secondary schools, the secondary school personnel can have better follow-up on helping at-risk students cope with the changes in secondary schooling. Parents should also be encouraged to give their consent for the transfer of information. **(Recommendation S1)**

- Heavy workload of teachers might hinder them from spending more time for better understanding of the students. In a suicide case, though a student had expressed "to die" and "reborn" in the year plan worksheet, such cues had not been taken seriously and handled timely by the teachers. Besides, a student's frequent absence from school was also an "alarm" for teachers to dig into the underlying causes, which might be related to a child's mood problem and warranted timely intervention. Mere punishment according to school regulations might not be helpful. In addition, Panel Members opined that it is undesirable to deliver a message of punishment directly to a student through telephone without conducting face-to-face joint interview with the student and the parents as the emotional reaction and non-verbal cues of the student can hardly be assessed via phone call. **(Recommendation S2)**

- Children coming from complicated families with high risk factors, such as having separated/divorced parents, with family history of mental illness/ suicide, with history of self-harm, mood problem, being bullied, etc. might be more prone to suicide. A standard mechanism for identifying the at-risk students for early intervention is important in preventing suicides. **(Recommendation S3)**

- As reflected from the suicidal notes left by the three children who have committed suicide, they seemed to have a distorted conception of death, which induced them to look forward to "reborn" and uphold a myth of a continuation of life after death. Some suicidal notes were written in a rather naive and casual tone. Panel Members opined that there is prevailing influence of media on youth, which tends to beautify life after death and some portrayed that one can gain more power of control after death. As such, the youth might believe in the myth of a happier life after death. **(Recommendation S4)**

- Form One students who encounter drastic deterioration in their academic performance when compared with their primary studies are found to be at-risk. It was observed that a mismatch of Form One school placement allocation would be a setback to those Form One students who used to have favourable academic results in their primary schools. Schools could help these Form One students have better adjustment and strengthen their support network by developing positive relationship with upper form students. In addition, for those introvert students without peer support, they usually refuse helping professionals' intervention through individual counselling. Engagement through mentorship programme may avoid the labelling effect. A balance should be strived between the needs of enhancing academic achievement and fostering a healthy whole person development. **(Recommendation S5)**

- Youngsters nowadays are under huge pressure out of study and peer relationship. Coupled with weak social support network, they would become very vulnerable and may easily feel hopeless when facing life's challenges or adversity. A few youngsters who committed suicide were perfectionists with high self-expectation but low resilience. In face of the developmental stage of "identify-crisis", youngsters do care much about their self-image. They need to strengthen their self-esteem to accept one's imperfection and cope with negative comments. **(Recommendation S6)**

- Some students might express their problems through their written composition or artwork. For example, a boy expressed his dissatisfaction towards his parents twice in his composition with one containing some "bloody and dark" content in his composition. Panel Members opined that once teachers come across the gloomy, bloody or death expressions in the students' composition or artwork, they should initiate dialogue with the students for better understanding of their thoughts as well as personal and family condition. If the students' situation warrants further exploration and intervention, they should be referred to the school social workers for counselling or other relevant professionals for follow-up as appropriate. **(Recommendation S7)**

- Some children who committed suicide were observed to have "aggressive or disruptive behaviour and poor relationship with school-mates". They used to be accused of bullying their school-mates. However, Panel Members observed that their disruptive behaviour at school might reflect their inner insecurity, sense of inferiority and emotional disturbances. These children actually belonged to the type of "reactive aggressors" who were emotionally-driven and bullied others out of their inner anger and impulsivity. They had poor emotional regulation and would easily be provoked by others. For example, a boy retaliated after being provoked by his schoolmates and was subsequently charged for an offence of wounding. He viewed that the school personnel was unfair to him as he was the only one being punished despite he was being teased and bullied. Panel Members viewed that apart from physical and verbal bullying, cyber-bullying is also common among students nowadays. Bullying, coupled with other risk factors or negative events, might increase the vulnerability of a child and the risk of suicide. **(Recommendations S8 & S9)**

(II) To Service Providers/Helping Professionals:

- A total of 25 (42.4%) out of the 59 reviewed suicide cases were known to social services (ie. school social workers, school guidance teachers, medical social workers, social workers of the Integrated Family Service Centre, etc.) or psychiatric services prior to their suicide. Out of these 25 cases, 10 (16.9%) cases with high risk factors were known to more than one helping professionals. Though multi-disciplinary intervention had already been in place, the services were fragmented with little coordination among different disciplines. Collaboration among different disciplines is important for monitoring the risk of suicidal cases. **(Recommendation S10)**

- Seven suicide cases were found to have family members with history of mental illness or suicide. If there is family history of mental illness, a child would be more vulnerable and susceptible to develop emotional or mental health problems, which warrants due attention as he or she is at higher risk of self-destructive behaviour. Helping professionals should be alert of the risk factors. Besides, the emotional needs of children in face of parents' separation or divorce would easily be overlooked by the helping professionals who tend to focus on handling the marital problem of the parents. A "systemic perspective" should be advocated in handling family cases. **(Recommendations S11 & S12)**

- Seven suicide cases had been diagnosed with mental illness, such as obsessive-compulsive disorder, depression, eating disorder, etc. and had received psychiatric treatment. The intervention could be more effective if collaboration could be enhanced further among psychiatrists and other helping professionals, such as social workers or clinical psychologists, in monitoring these cases with suicidal tendency and to educate the parents on how to identify and manage the suicidal thought or attempt of their children. **(Recommendation S13)**

- It is observed that many introvert youths were not easy to be engaged and they preferred text-based or on-line counselling. Many youths nowadays are in favour of social media platforms. Panel Members viewed that the development of on-line counselling and inviting YouTubers to disseminate positive life attitudes and mental health promotion would be helpful in the prevention of children suicide. **(Recommendation S14)**

(III) To Parents: Not to over-emphasise on children's academic achievement

- Among the 59 reviewed suicide cases, 5 (8.5%) were "Primary Students"; 21 (35.6%) were junior secondary (Form 1 to Form 3); 27 (45.8%) were senior secondary (Form 4 to Form 6). There are 6 children who were studying Form 6 had expressed great anxiety and immense pressure in face of the Hong Kong Diploma of Secondary Education (HKDSE).

- With the increase of university placements, more youth can attain university study nowadays. However, this in turn has brought immense pressure and sense of failure to those who cannot get good results in public examination. Despite the government's promotion on multiple and flexible pathways for students to pursue post-secondary education or vocational training, many parents still uphold the traditional belief that university study is the only pathway to success through taking the HKDSE. Panel Members believed that it would take time to change the mindset of both parents and the youth. As such, education and counselling on career and life planning should start at an earlier stage for both parents and their children, e.g. in Form One, so that parents can have a better understanding that children should be nurtured according to their different potentials and there are multiple pathways to success while to university study is not the only means. **(Recommendation S15)**

- Many school children have developed their own hobbies and some of them are good at computer, sports, playing musical instruments and debate, etc. However, some parents accorded high priority on study and would discourage their children from developing their hobbies or even threaten not to allow them to continue participating in the extra-curricular activities or developing their hobbies if they fail to attain good examination results. This created much frustration to the children. Panel Members viewed that parents should recognise and appreciate the non-academic achievements of their children so as to encourage an all-rounded development and help alleviate their undue pressure for high academic performance. **(Recommendation S16)**

- It is observed that the parent-child relationship was distant in some of the suicide cases and family relationship problem was the second prominent risk factor leading to children suicide. Some parents did express regret for not spending adequate time with their adolescent children. Panel Members opined that parents should spend more quality time to understand their children and address their changing needs at different stages of development through more positive communication and interaction. They should also serve as good role models for their children in coping with different life challenges and adversities. **(Recommendation S17)**

To Parents: Handling children's addiction to online games

- Four suicide cases involved conflicts between children and their parents over the children's indulgence in playing with mobile or online games. These children's suicidal acts were the result of impulsivity triggered by the parents who stopped their playing by deleting the mobile games, taking away the SIM cards or even confiscated the mobile phones. Playing computer or on-line games is a very common phenomenon among youngsters nowadays from which they can attain great satisfaction in the virtual reality. Online game is accessible, rewarding, fulfilling social function and allows children to escape from the reality and frustration. Children's indulgence in playing computer or online games may reflect their emotional disturbance and avoidance of stress which can be a signal to cry for help.

- Playing computer or online games appears to be a more visible problem to the parents which might undermine some underlying problems, such as high expectation of parents, unsatisfactory peer relationship, lack of communication and mutual understanding between parents and their children, etc. However, most parents fail to handle children's addiction to online game properly. As such, parent education should aim at promoting quality parent-child interaction instead of just forbidding children from playing online games. Self-control ability is still developing in children. It is the responsibility of the adult carers of young children to monitor their screen activities, exercising effective parental control and at the same time spend quality time with them fostering and cultivating interests and hobbies. Parents should also keep themselves abreast of the internet world and befriend with their children by knowing their pastime. A good parent-child relationship and communication with empathy is important so that parents can get more in touch with their children's feelings or thoughts. **(Recommendation S18)**

To Parents: Mental health of children

- Three children revealed to have suffered from prolonged insomnia or psychosomatic complaints prior to their suicide, which reflected that they might have been suffering from mood problem for a certain period of time. However, the parents failed to recognise the seriousness and seek medical or psychiatric consultation for the children at the early stage. Panel Members opined that parents should be alert to the children's repeated emotional disturbances and seek immediate psychiatric consultation for assessment and intervention as soon as possible. **(Recommendation S19)** Furthermore, in a suicide case died of drug overdose, the deceased child who was diagnosed with depression was prescribed with anti-depressant. Panel Members would like to further remind parents to supervise the intake of psychotropic medication of their children and keep proper storage of the medicine. **(Recommendation S20)**

To Parents: Separation or Divorce of parents

- Family is an important source of support in children's development. Failing to establish emotional connection with parents in childhood or having conflicts with parents are significant risk factors leading to children suicide. A total of 19 (32.2%) out of the 59 reviewed suicide cases were found to come from families with single (N=5), remarried (N=1) or separated/divorced parents (N=13). Parents should be aware that family changes, such as separation/divorce of parents, could bring tremendous negative impact on a child. They should address the emotion and feeling of their children and well prepare them for the parents' divorce and seek early professional help to handle their own emotions and adjustment arising from the change in family circumstances. Furthermore, co-parenting education for parents and support services for children of divorced families should be strengthened. There should be more publicity through TV Announcements in the Public Interest (APIs) on good divorce and co-parenting for those divorced / divorcing / separated parents. **(Recommendation S21)**

(IV) To Students: Enhance awareness of peer's suicidal expression and gate-keeper training

- Adolescents might disclose their suicidal thoughts to their peers before they put it to action. Though some had sent WhatsApp messages to their peers shortly before their suicidal act, revealed their suicidal plan some days before or expressed their suicidal thoughts every now and then, however, their peers usually did not take it seriously or did not know how to respond properly. In two of the suicide cases, a close friend had received a personal letter, as well as letters addressing to other school-mates from the deceased child but was asked not to open the letter or to deliver the letters to others until they were told to do so. The close friend acted accordingly and missed the chance of discovering the suicidal plan of the deceased child thus failing to seek early intervention by the helping professionals. Adolescents should be educated on how to respond to the peers' suicidal indicators or messages and seek help from teachers, school social workers or trustworthy adults as quickly as possible. **(Recommendation S22)**

6.1.3 Accident Cases

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

- There were 6 fatal fall cases reviewed. Among which, 3 fall incidents were related to accidental fall from height in residential buildings/commercial buildings where there was no window grilles or the window grilles with moving padlocks were not locked properly after use. **(Recommendation A1)**

- There were 2 fatal fall cases related to accidental fall from the rooftop when the children played there without any adult supervision. In one of the fatal fall cases, a girl fell from the rooftop of a "three-nil" tenement building during her play there. Rooftop of the three-nil tenement building was easily accessible. To prevent accident, entrance of the rooftop should be properly guarded, for example, by installation of an emergency exit device not easily opened by children or installed with an alarm when being pushed. Panel Members observed that it was common that families living in sub-divided units with very limited space at home would allow their children to play outdoors without adult supervision. Playing around on the rooftops without adult supervision is full of potential fall hazards for children. The fall accidents were somehow due to the negligence of the carers, who failed to keep a close eye on the children. **(Recommendation A2)**

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

- There were 6 fatal cases related to choking/suffocation. One case involved a 4-month-old baby dying of suffocation due to sleeping on a pillow wrapped up with a plastic garbage bag. Panel Members viewed that babies at the age of four months were able to move and roll over with the risk of suffocation. More education should be rendered to the young parents and carers that pillows are not suggested for babies under one year of age. **(Recommendation A3)**

  (Remarks: 3 suffocation cases in relation to unsafe sleeping arrangement were discussed under the "Co-sleeping and Unsafe Sleeping Arrangement" topic of the Natural Cause cases).

- The Review Panel reviewed a fatal case which involved a 2-year-old child being choked when being fed with grapes. Panel Members highlighted that parents and caregivers should be educated about the common choking hazards for babies and infants and should learn how to prevent them from choking during meals. **(Recommendation A4)**

(III) Traffic Incident

- There were 8 fatal cases related to traffic incidents, among which 4 fatal cases were due to the parents/carers' low awareness of road safety without holding tight the young children's hands on the street or failing to keep close supervision on their toddlers and young children. Panel Members viewed that small children, particular toddlers, would be at risk of being hit by moving vehicles in low speed 'off road' locations such as car parks or driveways as there is "blind zone" that drivers may not be able to notice the toddlers. **(Recommendation A5)**

- A fatal case involved a toddler being knocked down by a 7-seat vehicle with tinted films covering the window glass of the vehicle which might have blocked the light transmission and affected the driver's visibility. **(Recommendation A6)**

- There was a fatal case involving EM and another one involving new immigrant from the Mainland whose parents seemed to be carefree in child care with low awareness of road safety. **(Recommendation A7)**

- A fatal case involved a teenager, who dashed out between the gaps of parked vehicles when the "Red Man" pedestrian traffic signal was on, being knocked down by a mini-bus. The incident could probably be avoided if the driver could be more alert during driving. Panel Members highlighted that in some foreign countries, a signage of "School Zone" would be put up near school area so as to alert drivers to drive slowly and look out for children crossing the road, or getting on or off vehicles. (**Recommendation A8)**

- A fatal case involved a mother carrying her 3-month-old baby on her chest and fastened up with a seat belt but not using a baby car carrycot, which resulted in the baby's head bumping against the back of the front passenger seat under strong collision. Panel Members noted that there was no mandatory requirement for children passengers to use child restraint device such as baby car carrycots or child safety car seats when travelling in the rear seat of private car in Hong Kong. **(Recommendation A9)**

(IV) Drowning Accident

- A case of drowning incident involved a child being left to swim alone at the beach without adult supervision. When the adults were aware of the missing of the child, they did not seek early assistance from the lifeguards nor make a report to the Police but only conducted search at the beach by themselves instead. **(Recommendation A10)**

(V) Hanging Accident

- A fatal case was related to hanging accident, in which the child accidentally strangled himself to death when practising "rope escape" skill by tying his neck with a scout rope to the bedside railing of the upper bunk bed inside his bedroom. Prior to the incident, the child had watched YouTube video on "rope escape" and practised the said skill in his bedroom alone. Panel Members opined that children should be reminded not to imitate those dangerous acts being performed on the social media and parents should be educated on how to use scan software to prevent children from viewing those high-risk or inappropriate videos which might endanger their lives. **(Recommendation A11)**

6.1.4 Assault and Non-natural Unascertained Cause Cases

(I) Mental Illness/Suspected Mental Illness of the perpetrators who are parents

- Among the 7 assault cases which occurred between 2016 and 2018, 5 children were assaulted by their parents and 2 by non-parents, which included a neighbour and a foreign domestic helper. For the perpetrators who were parents, 4 of them were mothers who were the main carers of the deceased children while 1 was the father. Among the parents, 2 mothers and 1 father also committed suicide at the same time or after assaulting their children to death.
- Perpetrators with "Diagnosed mental illness" or "Suspected mental illness" was identified to be the major contributing factor leading to 5 out of the 7 assault cases. Out of these 5 assault cases, 3 perpetrators were the mothers of the deceased children while the other 2 were a neighbour and a foreign domestic helper respectively.
- Among the 3 perpetrators who were mothers, an EM mother who suffered from a replapse of her mental illness with poor drug compliance killed her child under psychotic influence. It was observed that despite some mental health patients had been regularly attending psychiatric follow-up, they might lack insight of their mental illness and have poor drug compliance. Sometimes, these patients might cover up their irregular drug compliance from their psychiatrists. They might adjust or even stop taking medication on their own accord without consulting their psychiatrists. Their family members might be kept in the dark or they might fail to notice the early signs of mental relapse. Children would be endangered if being placed under the sole care of parents who have unstable mental health conditions and poor drug compliance. For the EMs with mental health issues and facing child care difficulty or other family problems, it might be difficult for them to take initiative to seek help due to cultural and language barriers. **(Recommendations AS1 & AS2)**
- In another case, a mother killed her daughter under the influence of substance-induced psychosis. This single-parent family was not known to any social services and the school was not aware of any unusual behaviour of the mother. Support network is observed to be weak for those underprivileged families living in sub-divided units. Different community systems, such as 'school', 'management office' of the housing estates or 'neighbours' need to be mobilised for proactive detection, early identification and intervention for those hidden families. Children can be encouraged to seek help if they witnessed drug-taking or mental health problem of their carers or family members. **(Recommendations AS3 & AS4)**

- Some parents were found to have been suffering from distress arising from financial problem, marital/relationship problem with their spouses/partners, tragic loss of the beloved ones or child care difficulties, etc. They might be depressed with suicidal ideation. However, they might have hidden their suicidal thoughts. Instead of seeking assistance from helping professionals, they chose to end their lives together with their children with a belief that children should not be left behind. Parents should be educated that they should not treat their children as their subsidiary and deprive their children's survival right. **(Recommendation AS5)**

- Panel Members opined that bereavement counselling is necessary to help children go through the grief upon the death of parents or family members, especially for those who had committed suicide. **(Recommendations AS6-AS9)**

(II) Mental Illness/Suspected Mental Illness of the perpetrators who are non-parents

- Out of the 2 assault cases by non-parents, a child was assaulted by a neighbour with mental illness, who had repeatedly lodged complaints of noises made by the child and requested for housing transfer. It was observed that mental patients might have psychiatric symptoms, such as paranoid thoughts and could be over-sensitive to noises, they might have problem in getting along with neighbours. Even if these patients regularly attended psychiatric follow-up, they might conceal their symptoms making it difficult for their psychiatrists to assess their mental states. As such, for mental patients who request for housing transfer, medical social workers or community psychiatric nurses could assist in understanding the reasons behind their request, in particular to assess whether their complaints were owing to their unstable mental state or due to some external factors.

- Panel Members opined that the request for housing transfer by tenants with mental illness or suspected mental health problems would be a good entry point to engage them for intervention and support from social services such as Integrated Community Centre for Mental Wellness. Even after successful housing transfer, follow up service from the social services and Estate Office was necessary to review the tenants' adjustment to the new living environment. There should be a platform to facilitate regular and close communication and collaboration amongst the parties concerned especially the Estate Office and social services handling the tenants with mental illness or suspected mental health problems, so that timely referral can be made to the Community Psychiatric Service of the Hospital Authority for early intervention when in need. **(Recommendations AS10 & AS11)**

- In another case, a child was killed by an Indian foreign domestic helper with suspected mental health problem. The Review Panel observed that the existing requirement of medical check-up for foreign domestic helpers in Hong Kong only covers physical but not mental health condition. Even with mental health check-up, acute psychosis is not easily diagnosed. As the population of Indian domestic helpers in Hong Kong is much smaller than those of the Filipino and the Indonesian, their social support network in Hong Kong is relatively weak. The mental wellness and emotional needs of foreign domestic helpers seem to have been overlooked by the employers. **(Recommendation AS12)**

- An unascertained cause case involved a teenage boy and his mother who were found dead inside their home. Due to decomposition of their dead bodies, the cause of death remained unascertained. The boy had been absent from school for years. Though the family had been known to different systems, including school, Non-attendance Case Team of the Education Bureau (EDB), Integrated Family Service Centre, Social Security Field Unit and Housing Estate Office, all of them failed to connect with the family for timely intervention. Though Panel Members noticed that some enhanced measures had been taken by EDB in handling non-attendance cases, training for frontline staff should be enhanced to strengthen their sensitivity and skills in identifying and handling non-attendance cases for child protection.

- Panel Members opined that since most of the reviewed assault cases involved parents with psychiatric illness, drug abuse problem or emotional distress who lived in public rental housing units or sub-divided units, community care project would be helpful for promotion of neighbourhood mutual help to early identify the at-risk hidden families and provide timely intervention, thus preventing avoidable child deaths. **(Recommendations AS13 & AS14)**

- There are 7 out of 8 child deaths classified under non-natural unascertained cause were found to be related to "co-sleeping or other unsafe sleeping arrangement" (3 cases), "concealment of pregnancy" by a foreign domestic helper and a foreigner (2 cases) and "at-risk pregnant mothers without prenatal check-up" (2 cases). Observations made for these 7 unascertained cause cases were similar to those made under natural cause deaths which have been discussed in the previous paragraphs under the Natural Cause Cases.

7 Recommendations for Child Death Cases in 2016, 2017 and 2018

7.1 Natural Cause Cases

N1	(i) To strengthen multi-disciplinary collaboration and intervention for those at-risk pregnant women with limited intelligence, psychosocial needs and defaulted antenatal care despite repeated reminders. Inter-disciplinary communication and more effort is required to engage these high-risk pregnant women for timely intervention. (ii) To develop a linkage of the computer systems for sharing clinical information between Maternal and Child Health Centres (MCHCs) and Hospital Authority (HA) to enhance tracking of antenatal and post-natal check-up records of at-risk pregnant women. (iii) To enhance young parents' knowledge and abilities in child care, particularly in handling emergency situations and to further promote the child care support services for families in crisis or with urgent need for child care, especially those underprivileged parents whose support network is weak and unreliable.
N2	(i) To conduct regular multi-disciplinary case meetings to share information among professionals for formulating an updated strategic and intervention plan for the at-risk mother lacking social support, especially single-mother with history of substance abuse and with elder child died with Sudden and Unexpected Death in Infancy (SUDI)/unascertained cause. (ii) To build in an alert system in the Client Management System (CMS) under HA for child protection so as to alert medical professionals of the previous assessment on the mother's capability and competence for baby care.
N3	To enhance public education to encourage parents and care-givers to arrange seasonal influenza vaccination for children.
N4	(i) More attention and support should be given to EMs in need of medical care, especially those pregnant women with inadequate social support. (ii) More health education in multi languages should be provided for EMs so as to enhance their knowledge on pregnancy and different diseases and the management. (iii) To enhance the interpretation and translation services for EMs in public hospitals or clinics, and the arrangement of interpreters of the same gender to encourage communication with EM women on pregnancy issues.

N5	To encourage pathologist to print out more relevant clinical medical records about the interview with family members to the Coroner's Court in particular when there is application for waiver of autopsy. The records can help provide more background information for the child fatality review.
N6	(i) To further encourage metabolic or DNA screening for those unexpected sudden child death cases so as to find out the possible medical causes of death. (ii) A standard protocol with clear referral mechanism should be set up by the government for forensic pathologist to conduct metabolic or DNA screening if the deceased child's cause of death was found to be related to genetic disorder or unascertained so as to prevent heredity disease in the family.
N7	(i) To reiterate the fatal risk of co-sleeping with babies and raise the awareness of parents and caregivers not to arrange baby sharing a bed with siblings, other children or adult. (ii) To further educate parents and caregivers to place babies to sleep on their back to prevent suffocation. (iii) More education to parents and caregivers not to place soft objects on the baby cot to avoid possible risk of suffocation.
N8	(i) To promote home visitation programme by nurses of MCHCs or social workers of Integrated Family Services Centres (IFSCs) to conduct home visit to new parents, particularly to those young parents, so as to enhance education for the parents on safe sleeping for babies. (ii) More publicity on family-aide service provided by IFSCs while MCHCs should be encouraged to refer parents with inadequate child care abilities for family-aide training in child care.
N9	(i) More promotion on safe sleeping arrangement for babies at MCHCs so that parents can easily obtain such information when they bring the new-born babies for vaccination. (ii) To promote safe sleep arrangement for babies through promotional video during the mothers' prenatal and postnatal check-up or by means of publicity on public transports, such as advertisement inside MTR compartments.

N10	(i) To reiterate the awareness of foreign domestic helpers and their employers on possible fatal consequence of concealing pregnancy and the importance of antenatal care. (ii) More effort to disseminate information on community resources and social services for the pregnant foreign domestic helpers in need through various channels including social media, employment agencies and setting up a hotline so as to enhance the support for the pregnant foreign domestic helpers and their employers.
N11	(i) Public education on "safe sex", "proper handling of pregnancy" and the importance of antenatal care should be strengthened so as to prevent child death out of concealment of pregnancy. (ii) To educate parents on the handling of unintended pregnancy of their adolescent children.
N12	(i) To reiterate that cough suppressants containing codeine should not be used for children under 12 years old. (ii) To provide health education on proper use of drugs for parents by the Department of Health so as to alert parents or child carers the possible adverse effects of codeine for children under the age of 12. The message should also be clearly conveyed to parents through MCHCs and the Student Health Service Centres.

7.2 Suicide Cases

To Education Bureau/Schools/Teachers

S1	The EDB should consider strengthening the existing mechanism for primary schools to transfer information of students with identified suicidal thoughts or high risk elements to the secondary schools for better follow-up.
S2	EDB should review the current manning ratio of teachers to students so that the form teachers can spend more time taking care of those at-risk students. Training for teachers should be strengthened with practicum in identifying and supporting students with expressed suicidal threats and to remind them that any clues of suicidal ideation or behaviour from children should always be taken seriously. On-the-job training should also be enhanced for disciplinary teachers to strengthen their counselling skills, particularly in the application of discipline strategies.
S3	To facilitate early identification of at-risk students, a mechanism to monitor student mental health to be set up in schools to assess and identify any students with emotional problems or suicidal risk with a view to referring them for counselling or other appropriate services if needed.
S4	To strengthen life and death education in school, especially to explore students' conception of death, so as to help students develop healthy and positive life values and attitudes.
S5	To support students (especially at Form One with adjustment difficulty or introvert students) for better adjustment at school and strengthen their support network, schools are encouraged to help students build up a trustful and positive relationship with upper form students or graduates through the "Big Brother and Big Sister Scheme" or "Mentor-mentee Scheme" (pairing up of alumni with students).
S6	To provide training to youngsters to build up their resilience and adversity coping skills and to advocate "experiential learning in daily living" for those with perfectionist disposition to cope with failure and imperfection.
S7	Teachers should be more alert and sensitive to students' disclosure of their problems through their composition writing or artwork, especially for those who have gloomy/bloody/violent/death expressions in their composition or artwork.

S8	To enhance the awareness of teachers that most children with aggressive or disruptive behaviour may suffer from psychopathological problems which warrant external help and treatment, especially for those coupled with psychosocial stressors. They should not focus on the apparent behavioural symptoms of these children and the punishment on them but look into their emotional distress and engage them for professional intervention.
S9	Schools should nurture mutual care and a loving atmosphere to deal with bullying behaviour and should formulate prevention or intervention programme to address bullying problem. Teachers should be more sensitive to students who have expressed or experienced bullying at school and its negative impact on students' mental health.

To Service Providers/Helping Professionals

S10	To strengthen multi-disciplinary collaboration in handling complicated cases with high-risk factors even with no immediate crisis for intervention and in monitoring children with high suicidal risk through regular case review meeting, so as to share updated information among helping professionals and to formulate welfare plan to ensure the child safety and well-being.
S11	Helping professionals should be more sensitive in working with children with high-risk factors, such as having family members with history of mental illness or suicide, parents undergoing separation or divorce. Social workers should be alerted to the emotional needs of children though they might appear to be fine in face of the parents' conflict or separation.
S12	Taken into consideration the possible impact of the parents' marital problem on the children, social workers are encouraged to adopt a "systemic perspective" in case assessment and management so as to assess the family dynamic and address to the needs of children in the family.
S13	Doctors should be alert to refer youths with suicidal tendency to the medical social workers or clinical psychologists for follow-up if deemed suitable. When making prescriptions, doctors should be alert to the possibilities of drug overdose by young patients themselves and therefore should exercise caution to watch out for any accumulation of un-used drugs. They should also educate parents on how to identify and manage "psychiatric emergency" such as suicidal thought/attempt of their children.
S14	To further promote instant online text platforms to engage youngsters with suicidal ideation for immediate intervention by helping professionals and to promote the message of "positive life attitudes and values" by influential YouTubers via popular social media platforms.

To Parents

S15	Parents should support their children's career and life planning in accordance with their potentials and aspirations but not just to focus on fulfilling the parents' expectation. They should not dictate their children's future but to respect the choices of their children in study and career planning.
S16	To encourage an all-rounded personal development. Parents should not over-emphasise the academic performance of their children but look for the strengths of their children and recognise the importance of developing other personal interests as protective factor for children.
S17	As positive parenting is conducive to the development of secure parent-child bonding and attachment, family life and parent education, therefore positive parenting and understanding the changing need of and communication with children entering into adolescence, should be more widely promoted and provided.
S18	To strengthen parent education on how to handle the children's addiction to internet and online games starting from their early childhood.
S19	Mental health education for parents should be strengthened, particularly on the knowledge and treatment of mood disorder, such as depression. Parents should be alert of their children's repeated emotional disturbance, including having low or disturbed mood, insomnia, and should escort them to seek immediate psychiatric consultation as soon as possible.
S20	Parents should supervise their children in taking psychotropic drugs and keep proper storage of the medications so as to prevent their drug overdose.
S21	To strengthen co-parenting service for both divorced parents and their children in particular to help the children cope with the changes in family circumstances.

To Students

S22	To advise students to take all signs of suicidal clues of their schoolmates seriously, such as expression of health problem/emotional distress/ psycho-somatic complaints/self-harm behaviour or suicidal threats or messages from them. They should be educated on how to respond to the suicidal indicators and to seek help from teachers, school social workers or trustworthy adults as quickly as possible.

7.3 Accident Cases

A1	To reiterate the importance of the installation of window grilles and raise public awareness on the safety use of window grilles with movable padlocks which should be re-locked properly immediately after use, especially for those commercial buildings with public access and those designed for hanging laundry.
A2	(i) To remind parents to keep close supervision on their children at all time, especially when they were not at home, and not to allow children to play alone in inappropriate places, such as rooftops of residential buildings. (ii) To promote mutual help and care among neighbours in the community and to further promote the "Neighbourhood Support Child Care Project" (NSCCP) so as to provide temporary child care support for families in need.
A3	Not to cover an infant's pillow or lining with a plastic bag as the infant may roll over and get suffocated.
A4	To educate parents and caregivers that grapes and similar round-shape food are common choking hazard for babies and young children. To avoid choking, grapes should be cut vertically into quarters with seeds removed prior to serving.
A5	(i) To further promote road safety through reminding pedestrians to cross the road with extreme caution by using zebra crossing, strictly follow the pedestrian traffic signals and not to start crossing under a flashing "Green Man" light and remind parents to render close supervision on their children by holding their hands tightly when crossing the road and walking near moving vehicles such as in car parks or near driveways. (ii) To educate parents to set good role models for their children and train up their children to strictly follow the pedestrian traffic signals.
A6	To remind drivers to keep the window glass of their vehicles clear with no stickers which may obstruct the vision and not to add reflective material or film to the glass which may block the light transmission. Drivers should strictly observe the speed limit and pay full attention to all traffic signs and road markings while driving.
A7	To enhance EMs' awareness of road safety for children through the District Council and Non-governmental Organisations serving EMs and more parent education with case illustration for new immigrants with different cultural backgrounds on road safety, home safety and proper supervision on children.

A8	(i) To remind children to use zebra crossing, follow the pedestrian traffic signals strictly, not to cross the road between gaps of parked vehicles and avoid using mobile phones or other electronic devices or listening to music via earphones when crossing the road as it will easily distract them from observing the road conditions and the movement of vehicles around them. (ii) To set up "School Zone" warning signs for traffic control in areas with a number of schools so as to alert drivers to drive slowly and look out for children crossing the road or getting on or off vehicles. (iii) To further convey road safety messages to student pedestrians through TV Announcements in the Public Interest (APIs) and other electronic platforms.
A9	(i) To promote the knowledge and use of appropriate baby car carrycots or child safety car seats to parents at the Maternal and Child Health Centres. (ii) The government should consider legislation for mandatory use of appropriate car seats for children in private cars for enhanced protection for child passengers. (iii) Transport Department should have more promulgation of TV Announcements in the Public Interest (APIs) to promote child safety in cars, in particular on the use of baby car carrycots and child safety car seats.
A10	Parents and caregivers should accompany and closely supervise their children when they swim at beaches or in swimming pools and should seek immediate assistance from the lifeguards and report to the Police simultaneously when a child is found missing at beaches.
A11	A warning message should be posted by YouTube that potentially dangerous videos should only be watched by children under proper parental guidance and to encourage the public to report videos with inappropriate content for children to YouTube for proper management.

7.4 Assault and Non-natural Unascertained Cause Cases

AS1	To establish a standard protocol for psychiatrists to refer psychotic parents with pre-school children for medical social services, so as to assess their child care capacity and appropriate follow-up on their psycho-social needs.
AS2	To enhance mental health education for EMs including the impact of poor drug compliance in EM languages.
AS3	To promote public education on enhancing children's awareness to seek help when they witness the carers or family members with drug-taking behaviour or mental health problem.
AS4	To further promote the hotline service on mental health to the public, including the Hospital Authority Psychiatric Hotline – "Mental Health Direct" as well as the hotlines of the Social Welfare Department and Non-governmental Organisations.
AS5	To reiterate the message that children have their own rights of survival which no one, including their parents, should take away. There should be more promulgation of APIs to promote the message on treasuring children's life and positive thinking, particularly in times of economic downturn and adversities.
AS6	To advise the Police to make referral to the Integrated Family Service Centre (IFSCs) for intervention proactively if they come across the suicidal death of a parent with children under the age of 18 being left behind.
AS7	To advise school to show concern and render bereavement counselling to students who are going through the grief upon the death of parents or family members.
AS8	To promote grief and bereavement counselling service for children and their parents and to encourage them to seek help to cope with the grief and loss of family members.
AS9	To distribute pamphlets on acute grief handling with information on bereavement support services at the Accident and Emergency Department of the Hospital Authority.
AS10	To advise the Hong Kong Housing Authority and Hong Kong Housing Society to consider setting up a "Housing Transfer Concern Group" (調遷關顧小組) with designated staff of the Estate Office and social workers to work out strategies for engaging and rendering support services for public rental housing tenants with or suspected to have mental problem, who request housing transfer on grounds of distress by noises or disputes with neighbours.

AS11	To provide training to frontline staff (including security guards) of the Estate Office to increase their awareness and enhance their knowledge in handling tenants with mental illness or suspected mental health problems and in identifying hidden families in need.
AS12	To appeal to agencies serving foreign domestic helpers for rendering more support to them, and to encourage the employers to show more support to their foreign domestic helpers and be more alert to their mental health.
AS13	To strengthen cross-sectoral and inter-departmental collaboration for early identification and intervention for those at-risk hidden families.
AS14	To promote neighbourhood support in the housing estate or community aiming at building a neighbourhood mutual support network to identify families in need or those with suspected mental health problems and to connect them w ith community resources, such as referring them to the IFSCs or Integrated Community Centre for Mental Wellness for early intervention.

8 Responses and Updated Measures from Concerned Parties

8.1 Natural Cause Cases

Multi-disciplinary collaboration and intervention for at-risk pregnant women and parents

(Response to Recommendations N1 & N2)

- Family Health Service (FHS) of the Department of Health (DH) provides a comprehensive range of health promotion and disease prevention services for children from birth to 5 years through a network of Maternal and Child Health Centres (MCHCs) in Hong Kong. Through the Integrated Child Health and Development Programme, children attend MCHCs at different ages to receive immunisation, health and developmental surveillance (HDS) and parenting service to promote the holistic health of preschool children. Parents are provided with anticipatory guidance on parenting through various means so as to equip them with the necessary knowledge and skills to bring up healthy children through positive parenting practices.

- Under the Comprehensive Child Development Service (CCDS), MCHCs act as one of the platforms to identify at an early stage at-risk pregnant women, children and their families so that appropriate service will be timely provided to facilitate children's healthy development. Depending on their needs, families will be referred to relevant health and social services.

- For pregnant women joining Electronic Health Record Sharing system (eHealth), the antenatal initial assessment and obstetric progress will be shared between the Hospital Authority (HA) and the MCHCs.

- DH, HA and Social Welfare Department (SWD) have also jointly developed a Parenting Capacity Assessment Framework (PCAF) (0-3 years) for staff of social and health sectors to facilitate them to assess the capacity of the families in protecting the children from risk and enhancing their children's developmental experience, as well as to formulate feasible parenting support and welfare plans for the families according to their needs.

- MCHCs have also implemented a strengthened HDS for children from very high risk families, e.g. substance abuse parents, families with poor compliance to health/social services, or parents with unsatisfactory parenting capacity. These children are subjected to more stringent surveillance so that potential health and developmental problems can be identified as early as possible for timely intervention and support.

More frequent and comprehensive HDS interviews are arranged from newborn to 4 to 5 years. Defaulter tracing system is in place and there is close communication and collaboration with CCDS working partners e.g. case social workers, HA CCDS professionals, etc., in case management. Psychosocial and parenting capacity assessment is performed routinely as well as on need basis. In case there is suspicion of child abuse/neglect, the necessary procedure of child protection with health and social service partners will be activated to ensure safety of the child. Alert system in the Clinical Management System under HA is in place too.

- Multi-disciplinary collaboration is emphasised for early identification and intervention for high risk cases (including at-risk pregnant women and parents) under CCDS, to enhance the case management. SWD will continue to work closely with relevant partners and stakeholders, in providing a comprehensive network of welfare services to preserve and strengthen the family as a unit for developing a caring family relationship. SWD will also alert and encourage the family members of these at-risk parents to render necessary child care assistance, including child care support and family aide service provided by Integrated Family Service Centres (IFSCs)/Integrated Family Centres (ISCs), etc.

- SWD, together with DH, HA, Education Bureau (EDB) and non-governmental organisations (NGOs), will set up/strengthen the designated collaboration platform on CCDS at district level in 2021. District Social Welfare Offices, considering individual district needs, will invite the participation of concerned units or members, such as MCHCs, IFSCs/ISCs, Family and Child Protective Services Units (FCPSUs), Counselling Centre for Psychotropic Substance Abusers (CCPSA), NGOs operating children and youth services, and school personnel, etc. Multi-disciplinary case meetings are conducted for reviewing high risk cases.

Seasonal influenza vaccination for children

(Response to Recommendation N3)

- Vaccination is one of the most effective ways to prevent seasonal influenza and its complications. In order to increase the coverage of seasonal influenza vaccination (SIV) among school children, the DH has actively assisted schools and private doctors in organising outreach SIV activities in schools through Seasonal Influenza Vaccination School Outreach (Free of Charge) Programme (SIVSOP) and Vaccination Subsidy Scheme (VSS). These programmes have covered interested primary schools, kindergartens, kindergarten-cum-child care centres, and child care centres.

- The DH and other relevant departments organise health education activities and provide health advice on influenza prevention, personal hygiene and environmental hygiene, targeting the general public as well as specific sectors (e.g. schools) of the community. The DH also issues letters to kindergartens, child care centres, primary and secondary schools to alert them about the latest influenza situation from time to time.

- In addition, extensive promotion on SIV has been made through multiple channels, including press conferences, press releases, television/radio, expert interviews/videos, videos by key opinion leaders (KOL), health talks, advertisements, social media, online information, hotlines, posters and leaflets.

- The DH will continue to take proactive measures to encourage more people in the target groups to receive SIV through enhancing the awareness of the public on the need for vaccination and improving the availability of vaccination service to young school students.

- To dovetail with the Government Vaccination Programme for 2020-21, public hospitals and out-patient clinics of the HA has started to provide seasonal influenza vaccination services to persons belonging to eligible groups as set out by the Centre for Health Protection since 22 October 2020.

Health education and support for ethnic minority service users

(Response to Recommendation N4)

- FHS of the DH provides a comprehensive antenatal shared-care programme to pregnant women, in collaboration with the Obstetrics Department of public hospitals, to monitor the whole pregnancy and delivery process. Suitable assistance is provided to ethnic minority service users according to their practical needs, including interpretation services. Antenatal health information is provided by FHS in seven ethnic minority languages which include knowledge on pregnancy and common problems encountered during pregnancy. The information can be accessed through the Family Health Service Website. (*https://www.fhs.gov.hk/english/other_languages*)

- 24-hour interpretation service is available in the HA to provide adequate support for the pregnant ethnic minorities. Besides, breastfeeding booklet with different languages will also be used for teaching breastfeeding mothers.

Collection of medical information

(Response to Recommendation N5)

- The identification interviews with families of deceased children aim to gather relevant background information including medical history to assist in medicolegal death investigations. At the time of identification interviews, family members often do not possess detailed medical records of deceased children, and therefore forensic pathologists of the Forensic Pathology Service of the DH may not be able to provide such information, which would be more readily available through the HA or e-Health.

- HA's hospitals, on a case-by-case basis, would facilitate and provide relevant information for evaluation of child death if necessary, on the request of the Coroner for Coroner cases, in particular when the case concerns an application for waiver of autopsy.

Referral mechanism for metabolic/DNA screening

(Response to Recommendation N6)

- In cases of sudden unexpected child death, forensic pathologists of Forensic Pathology Service of the DH would collect samples including blood and urine, which would be sent to the Department of Pathology of the Hong Kong Children's Hospital for metabolic screening and DNA analyses. In cases of sudden death suspected to be caused by inheritable heart diseases, the Forensic Pathologists would also send samples of blood to the Clinical Genetic Service (CGS) for DNA analysis.

- The referral mechanism from forensic pathologists to the CGS is applicable, mainly but not limited to cases of sudden cardiac deaths. If the cause of death after the conclusion of autopsy appears to be related to potentially inheritable diseases, the forensic pathologist in charge of the case would contact the family and refer them to the CGS for assessment and genetic counselling. Referral pathway has been established for the CGS to receive referral from the Forensic Pathology Service.

Education on safe sleeping arrangement for babies

(Response to Recommendations N7-N9 & A3)

- Baby's sleep safety is an important home safety issue. MCHCs of the DH provide parents-to-be, parents and carers with health education on sleep safety and the risk of co-sleeping with the baby through various means like individual counselling, education booklets and video, website, e-newsletters and parenting workshops, etc.

- Different health education resources on sleep safety have been developed and made available to parents and public at MCHCs or the FHS website:

  (i) Video on "Baby's safe sleeping position and environment - you are the one to care" (*http://s.fhs.gov.hk/9uun7*). This video covers important key messages on sleep safety of infants, e.g. babies should be put to sleep on their back in their own cot, no co-sleeping with babies and no other objects, including pillow, on babies' bed, etc. Apart from broadcasting in MCHCs, the video is also uploaded to FHS website and YouTube channel. Periodic public broadcasting in public transport system is being arranged every now and then to increase public awareness of this issue.

  (ii) The leaflet "Safe Sleep Sweet Dream" (*http://s.fhs.gov.hk/086ly*) is a revised version of the previous "Protect Baby from Sudden Infant Death Syndrome (SIDS)" leaflet based on the latest recommendation on sleep safety, with further highlights on the importance of safe sleep environment and common FAQs on baby's sleep safety.

  (iii) Factsheet "Providing a safe environment for your baby" (*http://s.fhs.gov.hk/tdjz4*) with specific items on sleep safety are being given to parents-to-be and new parents.

  (iv) A series of Cue Cards developed for parents with important health messages and QR code to relevant leaflets including reminders on home and sleep safety, are given out to parents after nurse interview. The attending nurses will go through and highlight relevant salient points with the parents.

- Parents of newborn babies attending MCHCs are routinely asked to complete a checklist on "Is Your Baby Safe at Home?" (*http://s.fhs.gov.hk/uoghe*) which includes several questions on sleep arrangement of their newborn babies and then reviewed by nurses. Relevant advice and follow up will be arranged as necessary. For families identified to have specific risk conditions needing extra supports, nurses in MCHCs will

perform a parenting capacity assessment, in which home safety is one key areas, to identify any possible risk factors. Needy families will be referred to relevant social services for further management.

- In order to enhance frontline social service providers on knowledge of parenting and support for needy families, DH, HA and SWD have also jointly developed a Parenting Capacity Assessment Framework (PCAF) (0-3 years) which covers different child care areas (including home safety) for the staff of social service sectors to facilitate them to assess the capacity of the families in protecting the children from risk and enhancing their developmental experience, as well as to formulate feasible parenting support and welfare plans for the families according to their needs. Training on the PCAF have also been provided to these workers accordingly by DH, HA and SWD.

Support services for pregnant foreign domestic helpers

(Response to Recommendation N10)

- Hong Kong is one of the few places that grant foreign domestic helpers (FDHs) statutory labour rights and protection, including maternity protection, that are on par with those enjoyed by local workers.

- According to the provisions on maternity protection under the Employment Ordinance, unless the pregnant employee is summarily dismissed due to her serious misconduct, it is an offence for an employer to dismiss a pregnant employee (including an FDH). A female employee employed under a continuous contract immediately before the commencement of her maternity leave, and having given notice of pregnancy and her intention to take maternity leave to the employer is entitled to a continuous period of 14 weeks' maternity leave.

- The Labour Department (LD) set up in September 2020 a dedicated FDH Division to ensure effective coordination and implementation of measures to enhance protection of FDHs, and to provide better support for FDHs and their employers. Pregnant FDHs can call the LD's dedicated 24-hour FDH hotline (2157 9537) for one-stop support services if necessary. Interpretation service for the hotline is provided in seven languages.

- LD has been enhancing FDHs' awareness of their rights and benefits and channels for seeking assistance through a series of publicity and education work, including providing FDHs directly or through employment agencies (EAs) with information relating to maternity protection, antenatal care, and non-governmental organisations providing assistance and counselling to pregnant migrant workers.

- All pregnant women, irrespective of their nationality and employment status, should be aware of the risks of concealing pregnancy and the importance of seeking help early. LD has uploaded the leaflet "Having an Unplanned Pregnancy, what can I do?" produced by the SWD in eight languages, including Chinese, English, Tagalog, Bahasa Indonesia, Thai, Hindi, Nepali and Urdu, on the LD's dedicated FDH Portal (*https://www.fdh.labour.gov.hk/*) and EA Portal. (*www.eaa.labour.gov.hk*)

Education on safe sex

(Response to Recommendation N11)

- MCHCs under FHS of the DH provide family planning service for women of childbearing age. Contraceptives including emergency contraception are prescribed according to individual needs. Counselling and referral will be offered to women with unwanted pregnancy. Concerning sexual health education, safe sex is emphasised to reduce the chance of contracting sexually transmitted diseases and developing cervical cancer. Health education materials are also translated into seven ethnic minority languages. (*http://s.fhs.gov.hk/uwsdv*)

- The Family Planning Association of Hong Kong offers school sexuality education programmes to help young people acquire accurate information, clarify their own sexual attitudes, learn about communications and negotiation skills, promote practice of safer sex and continuous contraceptive measures. It also develops multi-media resources, and through its Resource Centre, Mobile Classroom, website, social media platforms and youth volunteer team, reaches young people to disseminate messages of protecting their own sexual and reproductive health. Its three Youth Health Care Centres provide youths with integrated medical and counselling service in sexual and reproductive health. Through providing various services to youths, the Centre staff help increase client's sex knowledge as well as their awareness of sexual right and responsible sex for self-protection. For those youths facing with unwanted pregnancy, the Centre staff provide medical assessment,

counselling and relevant medical and legal information to enable the youths to make an informed choice. Referral for relevant service will be provided according to youth's decision.

- Parents and students can access health information related to puberty, sex education at home, dating and love, etc. at Student Health Service website.

- 21 Family Life Education Units, 65 IFSCs and two ISCs continue to provide family life education including groups and programmes, to encourage parents with adolescent children with unplanned pregnancy to seek help. The concerned educational leaflet produced by SWD has been distributed to the public through various service units and uploaded to SWD homepage.

Education on safe use of medicine (codeine)

(Response to Recommendation N12)

- In December 2017, the Pharmacy and Poisons Board ("the Board") considered the latest warnings on oral preparations containing codeine imposed by overseas drug regulatory authorities, and decided that the requirements on sales packs and/or package inserts of registered pharmaceutical products containing codeine should be updated by including the statement "Codeine is contraindicated for all children younger than 12 years of age". Since December 2017, this additional requirement has been updated in the **"Guidelines on the Labelling of Pharmaceutical Products"**[1] and promulgated through different channels, including through letters to certificate holders of pharmaceutical products[2] and via the website of the Drug Office of the DH".

- In January 2018, letters to healthcare professionals[3] including registered medical practitioners and relevant medical associations (e.g. Hong Kong Medical Association, Hong Kong College of Family Physicians, the Association of Licentiates of Medical Council of HK, and Hong Kong Doctors Union etc.) were issued by the Drug Office of DH to draw their attention to the associated health risks of codeine-containing preparations and also to remind them of the Board's decision of regarding codeine as contraindicated for all children younger than 12 years of age.

- To enhance public awareness, the Drug Office has produced health education materials on the use of medicines for public information. Information on the safe use of cough and cold medicines is available from the webpage: *https://www.drugoffice.gov.hk/eps/do/en/consumer/news_informations/dm_06.html*

- The Medical Council of Hong Kong (MCHK) has promulgated the Code of Professional Conduct ("the Code") which provides guidelines to registered medical practitioners on prescription and labelling of dispensed medicines and proper prescription of dangerous drugs. Relevant sections, including "sections 9.2, 9.4, 10.1 and Appendix E", are extracted at Appendix 11.5 for reference.

- In respect of strength and/or concentration of the medicine in section 9.4(g) of the Code, the MCHK has listed out in its Newsletter Issue No. 21 of August 2014 specific situations under which medical practitioners should specify the strength and/or concentration of the medicine for reference by other medical practitioners taking care of the patient. The situations (which are not exhaustive) include:

  (i) when the doctor chooses to use the generic, chemical or pharmacological name of the medicine (e.g. for reason that others may not be familiar with the product name);

  (ii) when the medicine (e.g. syrups) has been diluted even if the registered name is used; and

  (iii) when different medicines have been mixed (e.g. mixture of syrups, compounding cream, etc.)

- FHS of the DH has produced a fact sheet called 'Tips for Smart Parents - Drug Safety', which categorically states that cold and cough medicines are not indicated for children under 6 years old, and codeine medications are contraindicated for all children under 12 years old. This fact sheet is provided to parents attending MCHCs. Parents can also access the information on the FHS website: *https://www.fhs.gov.hk/english/health_info/child/30152.html*

- Student Health Service provides health promoting and screening services to primary and secondary school students. No cough suppressant would be prescribed by doctors in Student Health Service Centres.

[1] *https://www.drugoffice.gov.hk/eps/do/en/doc/guidelines_forms/Label_GI_e.pdf?v=pqsqtln*

[2] *https://www.drugoffice.gov.hk/eps/upload/eps_news/prc_ing/280/PRC%20letter%2012.12.2017_codeine,%20dihydrocodeine%20&%20tramadol.pdf*

[3] *https://www.drugoffice.gov.hk/eps/upload/eps_news/30038/ZH/1/FDA%20requires%20labeling%20changes%20for%20prescription%20opioid%20cough%20and%20cold%20medicines%20to%20limit%20their%20use%20to%20adults%2018%20years%20and%20older.pdf*

8.2 Suicide Cases

Mechanism of transfer information to secondary schools

(Response to Recommendation S1)

- EDB has put in place a mechanism to assist schools in transferring information of students with special education needs (SEN) (including students with mental illness (MI)) at different stages to facilitate early identification of and intervention for these students. Before Primary Six students with SEN proceed to Secondary One, primary schools would seek parents' consent for transferring the SEN information of the students concerned to their recipient secondary schools. After the release of the results for Secondary School Places Allocation and with parental consent, EDB will transfer information on the students' SEN type, tier of support required, etc., to the recipient secondary schools via the Special Education Management Information System. At the same time, primary schools will pass the respective information of the students concerned (e.g. medical reports, assessment reports, summary of the support rendered, succinct learning records and teaching strategy suggestions) to the recipient secondary schools so that the secondary schools can timely understand the students' SEN and arrange appropriate support.

Manning ratio of teachers

(Response to Recommendation S2)

- The Government has all along been committed to enhancing the quality of education in Hong Kong, and has allocated additional manpower and resources to support teachers' work continuously. Starting from the 2017/18 school year, the teacher-to-class (T/C) ratio for public sector schools has been increased by 0.1 across-the-board. This measure has provided around 2 200 additional regular teaching posts for schools to enhance their teaching manpower to take forward various education initiatives and the quality of education for the benefit of students. Apart from the regular teacher establishment calculated according to T/C ratio, EDB has also provided schools with additional regular teaching posts under various initiatives as well as cash grants featured by their deployment flexibility for meeting specific policy objectives. Schools can utilise the grants to hire additional teaching and non-teaching staff and/or procure services according to their own needs. To strengthen school administrative support and at the same time reduce the administrative

work of teachers, thereby, creating room for them to focus more on core education tasks and to take care of student development, EDB has implemented the "One Executive Officer for Each School" policy starting from the 2019/20 school year to provide schools with resources for hiring additional administrative manpower. EDB will continue to review the manpower and resources provided to schools in consideration of school development and students' needs.

Training for teachers to identify suicidal threats/clues

- To enhance the professional capabilities of teachers to support students with SEN, EDB has been organising structured training programmes pitched at basic, advanced and thematic levels (BAT Courses) for them starting from the 2007/08 school year. Some modules of the BAT Courses cover mental illness. From the 2017/18 school year onwards, EDB has also provided primary and secondary school teachers with the "Professional Development Programme for Mental Health" with a view to raising their awareness of mental health and enhancing their professional knowledge and skills in identifying and supporting students with mental health needs (including those with suicidal risk).

- To strengthen teachers' detecting warning signs of suicide of students, a PowerPoint with highlights of the "A Resource Handbook for Schools: Detecting, Supporting and Making Referral for Students with Suicidal Behaviour" was compiled by EDB and provided to all school-based educational psychologists for sharing with the teachers of their serving schools.

Enhance disciplinary teachers' counselling skills

- EDB has commissioned tertiary institutions to provide "Certificate Courses on Student Guidance and Discipline for Teachers of Primary/Secondary Schools" and "Course on Management and Leadership for Heads of Guidance and Discipline Teams in Primary and Secondary Schools" annually, aiming at equipping teachers with necessary knowledge and skills to integrate guidance and discipline work into the school system and developing their capacity on case management, group work and collaboration with multi-disciplinary professionals. The contents cover modules such as "Contemporary Approaches to Student Guidance and Discipline", "Intervention Approaches and Skills Practice for Guidance and Discipline Teachers" and "Case Intervention and Management of Incidents Related to Schools with Skills Practice", etc. In addition, EDB regularly conducts seminars, sharing sessions and workshops on guidance

and discipline work for teachers. Topics include positive discipline, helping students get back on the right track, handling of emotional and behavioral problems, etc. Experts/academics, relevant institutions and school personnel with successful experience are invited to share their insight and facilitate professional exchange so as to enhance the capability of school personnel in preventing and handling improper behaviour.

Mechanism to monitor student mental health at school

(Response to Recommendation S3)

- For students who have been diagnosed with mental illness and students who have been identified as having mental health issues, the EDB requests that the collaboration between the guidance team and the student support team of public sector schools should be strengthened to jointly decide the tier of support and strategies for them. The Learning Support Grant has also been provided to schools so as to strengthen their support for these students in the learning, social, emotional and behavioural aspects, and organise school-based training, such as training teachers, parents and students to become "gatekeepers" in order to raise their awareness of mental health/mental illness and equip them with the skills to identify and respond to students who require additional support (including those with suicidal risk).

Life and death education

(Response to Recommendation S4)

- The EDB has always attached high importance to values education in which life education is an essential part. The Task Force on Review of School Curriculum Final Report (2020) recommended according higher priority to education of values in schools, including strengthening life education. The learning elements of life education, such as "understanding life", "cherishing life", "respecting life", and "exploring life", have already been incorporated into different learning themes under the school curriculum. Topics on "respecting and cherishing life" have been included in General Studies at the primary level and Life and Society Curriculum at the junior secondary level. In the learning of Ethics and Religion Studies, students can explore and reflect on issues related to "life and death".

These learning elements help deepen students' understanding of life and death-related issues and, more importantly, cultivate positive values such as perseverance, cherishing life, and a positive attitude towards life.

- EDB also develops learning and teaching resources related to life education and organises teacher professional development courses. The "Programme on Planning Life Education in Primary/Secondary Schools" has also been commissioned to a local university to support schools in whole-school planning for life education. The territory-wide annual school campaign "My Pledge to Act" organised by EDB has set the theme as "Be Grateful and Treasure What We Have, Stay Positive and Optimistic" for three consecutive school years starting from the 2019/20 school year. It supports schools to implement life education and cultivate students' positive outlook on life. EDB also organises a series of teacher professional development programmes, for instance, "Building Resilience in Students", "Learning and Teaching Strategies for Life Education and Life Planning Education", "Using Picture Books to Develop Students' Positive Values and Attitudes" in supporting teachers in conducting life education.

Adjustment at Secondary One

(Response to Recommendation S5)

- EDB encourages schools to adopt a Whole School Approach to provide remedial, preventive and developmental guidance programmes, such as induction/adjustment programme and peer support scheme (e.g. Big Brother and Big Sister Programme and Mentorship Scheme) to enhance students' adjustment upon transition.

- In order to strengthen the effectiveness of schools in implementing the bridging programme for Secondary One and Four students, EDB issued a letter to all schools in July 2019 to recommend the elements in good bridging programmes. In addition to understanding school life and academic requirements, the contents of the bridging programmes should be diversified and enriched with mental health and stress management (e.g. understanding the importance of mental health, stress relief methods and handling mental health problems), self-help and help-seeking method, etc. Schools were recommended to create opportunities for students to establish support networks to strengthen their sense of belonging and connectedness in school, such as arranging sharing, interaction and collaboration with schoolmates of different levels, and

strengthening their interpersonal relationship skills.

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

Resilience and adversity coping skills for those with perfectionist disposition

(Response to Recommendation S6)

- All public sector primary schools are required to design and implement Personal Growth Education to nurture students' knowledge, skills and attitudes in the four domains of personal, social, academic and career development and apply what they have learnt in their daily life. In the area of personal development, students learn to understand themselves and accept their individuality as well as strengths and weaknesses. They also learn about problem-solving and decision-making skills as well as developing a positive attitude in face of adversity.

- EDB has been actively promoting diversified student development programmes, such as the "Understanding Adolescent Project" for primary schools, "Enhanced Smart Teen Project" for secondary schools and "Pupil Ambassador Scheme on Positive Living", to enhance students' resilience, self-respect, self-discipline, sense of responsibility and courage to embrace changes in facing challenges through self-awareness, adventure-based, team-building and problem-solving training.

Teachers be sensitive to disclosure of problems in composition/artwork

(Response to Recommendation S7)

- To assist school personnel in early detection and supporting students with suicidal behaviour, EDB published "A Resource Handbook for Schools: Detecting, Supporting and Making Referral for Students with Suicidal Behaviour" in March 2017. The content includes introducing different types of suicidal behaviour, how to timely detect different types of warning signs of suicide, practical skills in responding to suicidal behaviour with different degrees of risk, and case illustration.

Awareness of teachers on students with aggressive or disruptive behaviour

(Response to Recommendation S8)

- If teachers find that students have serious behavioural problems, they can discuss with school social workers, conduct case analysis, understand the needs of students and provide counselling as appropriate. If further support is needed, they can refer the students to the school-based Educational Psychologist (EP). School-based EPs will also conduct talks and workshops for teachers according to the situation of a school. For example, EPs will conduct teacher training on how to support students with emotional and behavioural problems so as to help teachers understand the psychological needs of students and the appropriate methods and skills to deal with students' behavioural problems.

Mutual care and love atmosphere to deal with bullying

(Response to Recommendation S9)

- School is a place where care, concern, support and mutual respect are practised. EDB adopts a multi-pronged approach to implement the policy of prevention and handling of school bullying through different aspects. These include further nurturing students' positive values and empathy for others through the school curriculum, learning and teaching resources and diversified student learning activities, as well as cultivating in students a sense of mutual trust, inclusion and friendship through various student guidance programmes/activities. For example, it is aimed

to enable students to get familiar with peer mediation skills through the Peer Mediation Project, so that they can assist in resolving campus conflicts. EDB has also organised the Harmonious School Net to enable students to help promote a harmonious school culture, and the Wise NET School Recognition Scheme for inter-school sharing of successful experience, with a view to minimising the occurrence of incidents involving discrimination, bullying and violence.

- In handling school bullying incidents, EDB has reminded schools to arrange guidance personnel to offer assistance to the bullied or further enlist the help of professionals, such as social workers and psychologists, to provide support and mediation services, if necessary, or even refer the students to the necessary professional service (e.g. support for those who suffer from post-traumatic stress disorder), so as to safeguard their psychological well-being while preventing them from being hurt again. When dealing with students who bullied others, schools should help them understand the mistakes they have made and the moral values involved. Schools should also work with parents to help the students involved rectify their misbehaviour. If necessary, arrangements should be made for guidance personnel to take up the cases for thorough follow-up by providing individual/group counselling or referring the students to relevant professional service outside school.

Multi-disciplinary collaboration for children with high suicidal risk and mental health education for parents

(Response to Recommendations S10 - S13 & S20)

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

- The multi-disciplinary professional team also provides parents and carers of the children and adolescents in need with information on the

respective diseases and medications so as to enhance their understanding of the symptoms and treatment needs of their children. The professional team also maintains close communication with related organisations, such as early education and training centres and schools, to provide support according to the developmental needs of the children and adolescents.

- The Food and Health Bureau, in collaboration with EDB, HA and Social Welfare Department, has launched the Student Mental Health Support Scheme (SMHSS) since the 2016/17 school year based on a medical-educational-social collaboration model. Under the SMHSS, a multi-disciplinary team, comprising a psychiatric nurse of HA, a designated teacher and a school social worker, is formed in each participating school and works closely with the psychiatric team of HA, the school-based educational psychologist, relevant teachers and social workers from relevant social service units to provide support to students with mental health needs in the school setting.

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

Intervention through online and web-based services

(Response to Recommendation S14)

- To address the changing welfare needs of young people, five Cyber Youth Support Teams (CYSTs) set up by NGOs under SWD subventions have commenced service in December 2018. CYSTs search for and engage at-risk and hidden youths, who may not prefer the conventional mainstream services, and provide social work intervention through online services.

- CYSTs have developed a website with relevant web-based services. Through online platforms popular among youths and instant messaging software on mobile phones and computers, social workers of CYSTs proactively search and approach those at-risk and hidden youths who are manifesting various deviant or high risk behaviour, including emotional disturbance and suicidal ideation, and provide intervention and counselling service as well as referral services to relevant mainstream services for follow up.

- Adopting a total person and community approach and in collaboration with other sectors and departments in the community, Integrated Children and Youth Services Centres (ICYSCs) formulate work plans, setting service priorities and flexibly deploying resources to provide preventive, developmental, supportive and remedial services for children and youth (C&Y). Particular attention is given to C&Y at risk or in disadvantaged circumstances including those with emotional disturbance. ICYSCs would also make use of information technology (wherever appropriate) to provide programmes for C&Y including on-line groups, etc.

Parents should respect children's choices of study and career planning

(Response to Recommendation S15)

- Since the 2014/15 school year, EDB has strengthened the support for schools to implement Life Planning Education (LPE) with a view to helping students, through LPE and career exploration activities, identify their interests, abilities and orientations at an earlier stage as well as enhance their readiness for further studies and career pursuits by equipping them with career information and multiple pathways. In this connection, EDB has implemented a series of support measures, including encouraging parents to support their children in life planning. For example, EDB has launched the brand-new Life Planning Information Website to provide students, teachers and parents with more comprehensive information on life planning education and career guidance. Moreover, EDB conveys the message of "every trade has its master" to the public including parents through videos, mini-movies and media, and encourages partners of the "Business-School Partnership Programme" to offer career exploration activities of respective industries for parents, in the hope that parents will support and encourage their children to pursue their life goals based on their interests and abilities.

Parents should not over-emphasise academic performance

(Response to Recommendation S16)

- EDB has launched the Positive Parent Campaign (the Campaign) and organised different activities to promote positive parent education as well as the proper ways and attitudes of raising their children. It is hoped to enhance the positive mindset among parents in nurturing their children, and gradually change the present culture of excessive competition among some of the parents, with a view to helping their children learn effectively and grow up happily.

Positive parenting

(Response to Recommendation S17)

- EDB has launched the Campaign and organised different activities to promote positive parent education in order to raise parents' awareness on the importance of happy and healthy development of children and strengthen the positive mindset among parents in nurturing their children. The Campaign has been launched through various publicity channels, including Announcements of Public Interest on television and radio, competitions, etc. The objective is to promote proper ways and attitudes of raising children. In addition, EDB has launched a one-stop parent education website called "Smart Parent Net" in 2018 to provide parents with information on supporting the physical and psychological development of students, which includes parent-child relationship, parenting skills and emotional management of parents.

- The Committee on Home-School Co-operation (CHSC) has been conducting different theme-based parent talks covering areas of parenting skills, nurturing positive kids, parent-child communication, children's developmental needs and caring children's mental and psychological well-being, etc., with a view to enhancing parents' understanding and skills to handle their children's emotional and behavioural problems.

- 21 Family Life Education Units, 65 IFSCs and two ISCs continue to provide family life education including groups and programmes, specifically on equipping parents with effective parenting, positive communication and conflict resolution. The families are encouraged to seek professional assistance early to facilitate family functioning.

- These service units have collaborations with schools to offer tailor-made programmes for students and their parents in order to enhance their understanding on the developmental needs of adolescents, effective communication and parenting.

Parent education on handling children's addiction to internet and online games

(Response to Recommendation S18)

- EDB provides teachers with relevant professional development programmes and e-learning resource kits, and collaborate with different government departments and NGOs to produce videos and teaching materials to assist schools in conducting relevant parent education in nurturing their children's ability and attitude to use information and communication technology effectively and ethically, including healthy use of the Internet. In addition, EDB also organises seminars to help parents cultivate good habits of their children in using information technology in daily life and study, refraining from Internet addiction. Besides, a telephone hotline has been set up to provide individual support for parents, teachers and students in need. A list of relevant resources produced by different government departments, including EDB and NGOs, has been uploaded onto the website of EDB for easy reference by teachers, parents and students.

- Since the 2017/18 school year, EDB, Hong Kong Education City and CHSC have jointly organised a series of parent talks each year engaging professionals and social workers to brief parents on effective parenting for Net Generation, information literacy, youth online culture, online risks and tips for handling internet addiction of children and ways for protecting their children from cyberbullying.

Mental health education

(Response to Recommendation S19)

- The Government attaches great importance to the mental well-being of the public. DH has been promoting mental health by enhancing public awareness through education and publicity and by using a life-course and setting-based approach.

- DH launched a three-year territory-wide mental health promotion campaign named Joyful@HK Campaign in January 2016. In addition to public engagement in promoting mental well-being, the Campaign also aimed to increase public understanding about mental health. In the Policy Address in October 2018, the Government has reserved an annual funding of $50 million to embark on an on-going mental health promotion and public education initiative. The first phase of the initiative aims to sustain the efforts of the Joyful@HK Campaign and increase public knowledge on mental health.

- The initiative named "Shall We Talk 陪我講 " was launched in July 2020. The initiative has established a one-stop thematic website to provide information on mental well-being, common mental health problems, treatment, help seeking, community support, activities, stories and different resources and health education materials (including posters, leaflets, brochures and infographics). The initiative also sets up social media pages (including Facebook and Instagram) and launches KOL social media campaigns, television programmes and interactive art activities. Series of other online and offline advertisement and publicity on various platforms have also been carried out.

- The second phase was launched in 2021 and the target groups extend from youth to their parents and families, and more emphasis is put on the theme of seeking help timely. The initiative makes use of both traditional channels and new social media platforms in order to reach out to all walks of life in the society. In addition to KOL social media campaigns and production of television programmes, more media pitching as well as workplace and school activities will be implemented, and there will be production of more multimedia resources for schools and enhancement of website functions and experience.

- The initiative will continue to promote positive messages on mental health, with a view to enhancing public knowledge and awareness of the importance of maintaining their own mental health, paying attention to the mental health condition of people around them, and seeking help from professionals in a timely and prompt manner.

- FHS of the DH has developed extensive positive parenting education resources to support parents with guidance on child development and positive parenting during the antenatal period and the pre-school years of their children. Parents can access these resources through individual counselling, printed and audiovisual resources, website and social media, workshops as well as virtual/face-to-face public talks. It aims to equip parents with the necessary knowledge and skills for bringing up

healthy and well-adjusted children through positive parenting practices. Education resources on promoting the psychological well-being of parents, e.g. relieving the stress of parenting are also available. In 2021, a series of leaflets (*http://s.fhs.gov.hk/d75pz*) and videos (*http://s.fhs.gov.hk/e0lm6*) on social emotional development as well as emotion coaching for young children have been developed. These resources have been made available to clients attending MCHCs and FHS website since the second quarter of 2021.

- Under the HDS conducted at MCHCs, health care professionals work in partnership with parents/caregivers in the continual monitoring of children, with the aim to achieve timely identification of children with health, behavioural or developmental problems. Referral to specialist outpatient departments of the HA or the Child Assessment Service of DH will be made as appropriate. Apart from the scheduled visits, parents can also approach MCHC in case they notice any problem with their children's behaviour and development.

- Student Health Service promotes mental health of students through annual health assessment in Student Health Service Centres and outreach service in secondary schools by Adolescent Health Programme. Students who are found to have mental and/or psychosocial problem will be referred to appropriate organisation for management and follow-up. Parents and students can also access health information related to emotional and mental health at Student Health Service website.

Support services for divorced/separated parents and their children

(Response to Recommendation S21)

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

- Following the completion of the 3-year Pilot Project on Children Contact Services (from September 2016 to September 2019), SWD set up five specialised co-parenting support centres (SCSCs) operated by NGOs in October 2019 to provide one-stop service to assist the divorced/separated parents to fulfil their parental responsibilities under the child-focused principles, strengthen parent-child connection and provide support for children affected by the family change to promote their healthy growth and development.

- With a view to introducing the concept of co-parenting and parental responsibility at an early stage, IFSCs operated by the SWD have been allocated additional supervisory manpower resources for enhancing parents' capability to cope with separation/divorce and strengthening family functioning, through district-based co-ordination. They also arrange related training/sharing for professionals in the districts

- Additional manpower resources have been allocated to 11 FCPSUs of SWD to strengthen co-parenting support for separated/divorced parents and child focused service for their children. The additional manpower resources would also enable FCPSUs to provide a range of early intervention services, co-parenting services, as well as timely support for children with parents on the verge of separation/divorce. Besides, FCPSUs would also provide professional intervention and support services, including psycho-educational programmes, to the children placed under the statutory supervision by the Family Court, as well as their parents for enhancing the parents' cooperation, improve their communication and carry out their parental responsibility more effectively.

- SWD has enhanced the content of the thematic website "Parenthood Goes On" to promote the concept of parental responsibility and to disseminate information on the relevant groups/programmes available in different districts for separated/divorced parents and children. Besides, the set of handbooks, which provide useful information for divorced parents on co-parenting and help children understand the issue of divorce, has been updated in 2019 for distribution to target users through frontline service units. In 2019-20, SWD produced a short film with slogan "For your child's happiness, don't fight, please talk". The film aims to enhance the public's understanding of the impact of family conflict on children, encourage separated parents to nurture their children in their best interest and to promote co-parenting for ensuring children's healthy development. In addition, publicity vehicles are also arranged to travel around the territory, and the concept of "parental responsibility" is further promoted through games and short videos.

- SWD and the SCSCs will continue the efforts through different publicity measures such as Facebook fanpage and Instgram to enhance the separated/divorced/divorcing parent's understanding on their children's emotions and promote the concept of child-focused co-parenting through public education and publicity effort.

Signs of suicidal clues

(Response to Recommendation S22)

- In order to strengthen students' knowledge in detecting their peers in need, and the effective ways of responding to peers' emotional distress or suicidal thoughts, EDB has collaborated with a non-governmental organisation in implementing a student gatekeeper training programme starting from the 2019/20 school year. The programme trains secondary school students to become "gatekeepers", enhance their awareness in mental health and skills in managing stress and emotions, equips them for detecting and responding to peers in needs, and promotes a positive and help-seeking culture in schools.

8.3 Accident Cases

Health advice on safe home equipment and environment (installation of window grilles)

(Response to Recommendations A1 & A2)

- An e-book called "Domestic Safety Handbook" was published by DH in 2019, in consultation with the Electrical and Mechanical Services Department, Coroner's Court and Consumer Council, to highlight injury hazards and safety precautions in relation to furniture, electronic appliances and general equipment which can easily be found in the domestic setting in Hong Kong. Safety recommendations related to common home equipment such as window frame is included in this e-book. Parents are one of the major target audience of this handbook.

- DH conducted "Unintentional Injury Survey 2018" in 2018-19 to collect pertinent information about the characteristics and burden of unintentional injuries (commonly known as "accidents") in Hong Kong. The survey covered whether households adopted domestic injury prevention measures such as installing window frames (locking window frames if they can be opened). The survey results will be announced within 2021.

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

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

- A series of Cue Card for parents with important health messages and QR code to access to relevant leaflets, including reminders on home safety, are given out to parents after each nurse interview. The attending nurses will go through and highlight the relevant salient points with the parents.

- Apart from individual advice, parents/carers and the public can also access different printed and audiovisual home safety health education resources (including prevention of falls by not leaving young child alone at home, always keeping an eye on children at home and during outdoor play, installing window guards and fences or wire meshes around balconies etc) for children of different age groups through FHS website. (*http://s.fhs.gov.hk/74rnt* and *http://s.fhs.gov.hk/mdowt*)

- Information on different child care services has also been introduced to parents-to-be and parents to increase their awareness and use of these services to avoid leaving children unattended at home. Information leaflets on various child care services produced by SWD are also available in MCHCs.

Education on safe sleeping arrangement for babies

(Response to Recommendation A3)

- Please refer to Response to Recommendations N7 to N9 for Natural Cause Cases

Education on choking hazard for children

(Response to Recommendation A4)

- FHS of the DH has developed a series of health information resources on infant and young child feeding. Avoiding foods that have risk of choking are highlighted to parents and caregivers in the series of health education booklets "Healthy Eating for 6 to 24 month old children" and webpages as well as at the public talks.

Parents are warned:

- Do not give babies any food that is small and hard, like sweets, corn, whole nuts or peanut, or any food that is sticky, such as glutinous rice dumplings and marshmellow; or roundish springy-texture foods such as meatballs (fish balls, etc.), mini-jelly, sausages and "siu mai".

- The booklet "Healthy Eating for 6 to 24 month old Children (2) Moving On (6 – 12 months)" includes the specific advice to parents and caregivers

that small roundish fruit should be cut into small pieces when giving to children. In the booklet, the messages are illustrated with pictures.

https://www.fhs.gov.hk/english/health_info/child/14722.pdf

https://www.fhs.gov.hk/english/health_info/child/14722.html

Healthy Eating for 6 to 24 month old Children (1) Getting Started (6 – 12 months)

https://www.fhs.gov.hk/english/health_info/child/14727.pdf

https://www.fhs.gov.hk/english/health_info/child/14727.html

Healthy Eating for 6 to 24 month old Children (2) Moving On (6 – 12 months)

https://www.fhs.gov.hk/english/health_info/child/14722.pdf

https://www.fhs.gov.hk/english/health_info/child/14722.html

Healthy Eating for 6 to 24 month old Children (3) Ready to Go (12 – 24 months)

https://www.fhs.gov.hk/english/health_info/child/16301.pdf

https://www.fhs.gov.hk/english/health_info/child/16301.html

Road safety messages to caregivers and road users

(Response to Recommendation A5)

- The Government has attached great importance to road safety.
- The Transport Department (TD) published an updated version of the Road Users' Code (RUC) in June 2020, providing rules and advice on using pavements and roads and on crossing roads in different places such as near parked vehicles, at or near a junction without traffic lights, at zebra crossings and "Green man" crossings, etc. The RUC reminds parents to take care of their children, such as always going with the children and holding the children's hands, as well as to set a good example to the children by following the RUC so that the children will learn the correct and safe way to use the road. The RUC is available on TD's website at *https://www.td.gov.hk/en/road_safety/road_users_code/index.html* for viewing by the public.
- Moreover, TD has been collaborating with the Road Safety Council (RSC) and the Police in launching publicity and educational activities through various means and channels to promote road safety to pedestrians (including those taking children to the roads). For example, TD published

the 50th Issue of the Road Safety Bulletin in March 2020 (*https://www.td.gov.hk/filemanager/en/content_182/rs_bulletin_50.pdf*) which provided the safety tips for crossing the road, using "Green man" crossings and zebra crossings. The RSC has also carried out publicity campaigns to enhance public awareness of pedestrian safety. These include launching posts and short movies on social media platform (*https://www.facebook.com/mr.safegg*), distributing leaflets, posters, etc. to enhance pedestrians' road safety awareness, remind them to follow traffic rules and traffic signals and always hold their children's hands. TD will continue to work with the RSC and the Police to promote safety of pedestrians when crossing the roads.

- The RSC is concerned about children's road safety, and has been delivering road safety message to the caregivers and children by means of education and promotional activities. Road Safety Towns located in North Point, Sau Mau Ping, Sha Tin and Tuen Mun provide children with simulated road environment such as traffic light, subway, footbridge, zebra crossing and road marking, etc. There is also a Road Safety Bus which provides a mobile exhibition platform for promoting road safety through visits to schools, housing estates and youth centres across the territory. Furthermore, the Council has produced a series of Road Safety Virtual Reality (VR) Games, named "Running Saves Lives" and "Stop and Go", which provide a virtual environment to participants to experience various road situations, whereby educating them to make appropriate judgement and reactions that can be applied in real life. The Road Safety VR Game is available for the public at Road Safety Towns and on Road Safety Bus.

Education on road safety to drivers

(Response to Recommendation A6)

- Safety specifications of motor vehicle glass are governed by regulation 28 of the Road Traffic (Construction and Maintenance of Vehicles) Regulations (Cap. 374A). Regulations 28(1)(a) and (b) provide that the glass or transparent material used in all windscreens, windows and partitions of a motor vehicle shall be safety glass or safety glazing approved by the Commissioner for Transport, and that the material shall be of such transparency that it does not obscure the view of the interior of the motor vehicle. Moreover, Regulation 28(2) stipulates that no alteration or addition shall be made to any windscreen or window

whereby the reflecting effect of the safety glass or safety glazing is increased, or whereby the ability of such safety glass or safety glazing to transmit light is decreased.

- Besides, the Road Traffic Ordinance (Cap. 374) and the Road Traffic (Traffic Control) Regulations (Cap. 374G) stipulate that drivers must observe traffic rules, including compliance with traffic signals, traffic signs, road markings and speed limits.

- TD has been collaborating with the RSC and the Police in launching road safety publicity and educational campaigns to remind drivers to always keep a safe and courteous driving attitude through different channels like social media platforms, publicity video clips and leaflets. In the second quarter of 2019, the Government launched an announcement in the public interest (API) on the theme of "one good turn deserves another", reminding motorists of the importance of safe and courteous driving. Relevant road safety messages (including the legal requirements on car window glass and reminders to observe speed limit, traffic sign and road marking) have also been publicised in Road Safety Bulletins, transport trades' newsletters and variable message signs on strategic roads. These publicity leaflets, newsletters and Road Safety Bulletins are available on TD's and the RSC's homepages. TD will continue to work with the RSC and the Police to promote road safety and safe and courteous driving.

- To remind drivers to maintain good driving behaviour and attitude, the RSC regularly publishes Road Safety Bulletins to enhance road safety awareness of drivers. In October 2020, the Council also launched a new series of APIs on TV and radio featuring renowned Hong Kong car racing driver Mr Darryl O'Young. Drivers were reminded of proper driving practice and attitude at roundabouts, zebra-crossings, etc., so as to achieve "driving excellence: mutual respect, safe arrival."

Advice on road safety for the ethnic minorities and new arrivals

(Response to Recommendation A7)

- To facilitate early integration of ethnic minorities and new arrivals into the local community, the Home Affairs Department (HAD) publishes and updates annually the "Your Guide to Services in Hong Kong" and the "Service Handbook for New Arrivals", which introduce the services related to the daily life of citizens. "Your Guide to Services in Hong Kong" is currently available in seven languages, namely English, Bahasa Indonesia, Hindi, Nepali, Tagalog, Thai and Urdu, while the "Service Handbook for New Arrivals" is printed in both traditional and simplified Chinese. In the Guide and Handbook, TD provides advice and information on road safety, including proper use of crossing facilities, cycling safety tips and safe driving rules and advices. TD noted the Panel's suggestion, and will provide advice and information on road safety of children in the next update of the Guide and Handbook for HAD's consideration.

Publicity and educational activities for children and students

(Response to Recommendation A8)

- For publicity and educational activities on general crossing safety, please refer to the response to Recommendation A5. Moreover, the RUC reminds children not to carry out any other activities when crossing the road, such as eating, drinking, playing mobile games, using a mobile phone, listening to any audio device or talking.

- TD has been collaborating with the RSC and the Police in launching publicity and educational activities through various means and channels to promote road safety to children. For example, the four existing "Road Safety Towns", which provide a simulated road environment to enhance children's awareness of road safety, turn road safety education into a fun engaging atmosphere for small children. The "Road Safety Bus" acts as a mobile exhibition platform and visits schools, housing estates as well as youth centres so as to promote road safety themes to the students, residents and children. The bus was revamped in 2018 with multi-media facilities installed to enhance visitors' enjoyment in learning road safety knowledge. In addition, TD also publishes Road Safety Bulletins for distributing to the public and uploading on the internet, and the RSC uses social media platforms to disseminate road safety advice and

messages to students to raise their road safety awareness (such as avoid using portable electronic devices when crossing the road and not to cross the road by emerging from gaps of slow-moving or stationary vehicles), and to enhance their understanding of traffic regulations and rules.

- The following traffic sign has been installed in some school areas, e.g. Ho Tung Road in Kowloon Tong and High Street in Pok Fu Lam, to alert drivers of children going to and from school ahead. They should drive slowly and look out for children on the road.

- Moreover, the RSC has produced a number of announcements in public interest (API) on both television and radio, such as "Driving attentively and pedestrians' attentive use of roads" and "Be a Responsible Road User" to promote the messages of pedestrian safety. The Council has also used the social media page, "Mr Safegg" to disseminate road safety messages in an interesting manner. Furthermore, the Council has organised online campaigns to promote road safety in the midst of the COVID-19 pandemic. For example, "Road Safety Miniature Photography Competition" held between February and April 2021 has attracted an overwhelming response and spread out the message of road safety effectively via social media.

Child safety in cars and health advice on use of car carriers/car seats

(Response to Recommendation A9)

- Under the existing regulation, children under the age of 3 must be restrained by an approved child restraint device when travelling at the front seats of a private car, private light bus or goods vehicle. The requirement also applies to those children travelling at the rear seats of a private car when such device is available for use.

- In conjunction with the TD, the Road Safety Council provides a wide range of publications and leaflets including the "Road Users' Code" and "Be Smart, Buckle up" leaflet. These publications advise the public on how to ensure child safety in cars and the proper use of child restraint devices such as carrycot, infant carrier, child safety seat and booster seat together with the ordinary seat belt.

- The government is considering to amend the legislation to require the use of child restraint device in private cars by children no matter they are seated at the front or back seats. Upon formulation of the detailed arrangements, TD will consult the Legislative Council and stakeholders in due course.

- Meanwhile, TD will continue to work closely with RSC and the Police to further strengthen the education and publicity efforts in promoting child safety in cars. For example, TD published an updated version of the RUC in June 2020, which sets out the prevailing statutory requirements, instructions and rules concerning the use of child restraint device (CRD). For example, CRD must be fitted to the vehicle in accordance with the manufacturer's instructions, and children should be seated at the rear seats, etc.

- Ensuring a safe environment is the key responsibility of parents. MCHC has strengthened its health advice on child safety for carers. Apart from the information on usual home safety measures, FHS has prepared a specific leaflet "Safety notes on using baby carriers, pushchairs, high chairs and car seats" (*http://s.fhs.gov.hk/d6s7x*). Proper selection and use of baby products as well as related product safety are listed for parent's reference. Apart from individual advice, parents/carers and the public can also access these health education resources through FHS website.

Education and publicity on water safety of children

(Response to Recommendation A10)

- The Leisure and Cultural Services Department (LCSD) attaches great importance to the water safety of children and requires that children under the age of 12 must be accompanied by adults for entry to any public swimming pools. LCSD's lifeguards on duty will from time to time pay close attention to unaccompanied children at poolside or shorelines of gazetted beaches and will ask the adults to swim alongside their young children. Whenever there is a report of suspected missing swimmer at a gazetted beach, the lifeguards will carry out rescue operation at the beach immediately and call the Police for assistance.

- On publicity and education, LCSD reminds swimmers to take care of their children through putting up notices and broadcasting public announcement messages at its public swimming pools and gazetted beaches. The Swimmers' Handbook is produced every year and uploaded

onto the LCSD's webpage. The Water Safety Campaign, water safety slogan competition and poster design competition are organised to disseminate messages on water safety to the public through different means. To boost publicity, LCSD launched a new APIs this swimming season to further promote the importance of water safety to the public.

Warning message on YouTube

(Response to Recommendation A11)

- EDB provides a framework on "Information Literacy for Hong Kong Students" for schools to enhance students' ability and attitude to use information and communication technology effectively and ethically, including guarding against possible dangers on the Internet. EDB also collaborates with different government departments and NGOs to organise related student activities.

8.4 Assault and Non-natural Unascertained Cause Cases

Multi-disciplinary community support services for patients and their carers

(Response to Recommendations AS1, AS2 & AS3)

HA Community Psychiatric Services

- The multi-disciplinary teams of the community psychiatric service (CPS) of HA, involving doctors, nurses, clinical psychologists, occupational therapists, medical social workers and peer support workers' etc., provide appropriate community support services to patients with mental health problems residing in the community, having regard to the severity of their mental condition and clinical needs. The healthcare professionals in CPS mainly provide necessary community support services, including, among others, mental health assessment, disease management, training and crisis intervention, to facilitate patients' re-integration into the community. They also offer support and advice to patients' carers and families as appropriate and promote mental health in the community.

- Since 2010-11, HA has launched the Case Management Programme by phases to provide intensive, continuous and personalised support for patients with severe mental illness. Under this Programme, case managers will also work closely with various service providers, particularly the Integrated Community Centres for Mental Wellness (ICCMWs) subvented by SWD, in providing coordinated support to needy patients in the community. By 2014-15, the Programme was extended to cover all 18 districts.

Medical-social collaboration

- Following the implementation of the Case Management Programme, a three-tier collaboration platform has been instituted by HA and SWD since 2010 to facilitate cross-sectoral communication at the central, district and service delivery levels.

- At the central level, HA Head Office and SWD headquarters as well as NGOs meet regularly to discuss service strategies and explore models of collaboration. At the district level, HA's cluster representatives of psychiatric services and SWD's District Social Welfare Officers liaise regularly with service providers in the district and relevant government agencies to coordinate the community support and consider necessary adjustment to

service models having regard to district-specific demographics and service demand. At the service delivery level, HA case managers maintain close communication with other service providers, including the ICCMWs, for case referral and arrangement of rehabilitation services.

Hotline service on mental health

(Response to Recommendation AS4)

- The HA has established a mental health advisory hotline, namely Mental Health Direct Hotline (Tel: 2466 7350), to provide support for ex-mentally ill persons and their carers (including children and adolescents with mental health needs and their parents). Manned by professional psychiatric nurses, the hotline provides professional advice on mental health issues for patients with mental illness, their carers, the relevant stakeholders and members of the public. The hotline operates round-the-clock so that people in need may call and seek assistance at their convenience.

Publicity on child protection and positive thinking

(Response to Recommendation AS5)

- Amidst the prolonged battle against COVID-19 and at time of economic downturn and adversities, tensions are likely to run high among families in Hong Kong. In view of this, SWD has produced a 6-episode series of publicity videos, namely「北斗同行」. Through case studies and sharing by social workers and clinical psychologists, the videos aimed to shed light on child protection, prevention of domestic violence and support for families in need, while appealing to the public to seek early assistance from social service agencies when facing the adversity. The videos have been broadcast on TVB News Channel and TVB Finance and Information Channel from 10 to 16 May 2021 (7 consecutive days). The 6 episodes were also uploaded to the YouTube channel of SWD (*https://www.youtube.com/swdipru*) for viewing by the public.

Protocols of case referral for welfare services

(Response to Recommendation AS6)

- The Police has established protocols governing the referral of any members of the public whom they find to be in need of welfare services (including counselling), including persons involved in a suicidal incident, in the course of their duty to SWD.
- The Police will observe the provisions of Personal Data (Privacy) Ordinance ("PDPO") and obtain consent from the data subjects or their parents/ guardians before a referral is made to SWD.
- In circumstances where no consent is obtained, Police will exercise professional judgment and consider invoking the relevant exemptions under PDPO before referring the data subject to SWD.

Bereavement counselling to students

(Response to Recommendation AS7)

- Schools are staffed with professionals, including guidance personnel, school social workers and school-based EPs, etc., to provide students in need (including those who have lost their relatives) with necessary support and mediation.
- EDB is developing a picture book for junior primary students / students with SEN on bereavement. The picture book can be used as a tool for caretakers to explain death, the emotions that accompany with loss, the grieving process and appropriate coping strategies to their children according to their developmental stage.

Bereavement counselling service

(Response to Recommendation AS8)

- To assist families to cope with various life stresses including the death of parents or family members, the 67 IFSCs/ISCs have been providing a spectrum of services to individuals and families, including bereavement counselling, positive parenting, therapeutic and support groups, and referring the needy families to appropriate services, such as clinical psychological service.

Bereavement support services at the Accident & Emergency Department

(Response to Recommendation AS9)

- The Accident & Emergency Departments under HA have prepared relevant pamphlets and information for distribution to the bereaved as necessary.

Mechanism of housing transfer (tenants with suspected mental illness)

(Response to Recommendation AS10)

- The Housing Department (HD) and SWD have regular meetings with each other at the headquarters and district levels to enhance communication and collaboration. Various mechanisms have been set up for effective handling of problems encountered by the public rental housing (PRH) residents. For instance, there is a mechanism for case referral and mutual cooperation when dealing with cases requesting for housing transfer. Under this mechanism, workflow and conditions for referring cases will be reviewed regularly and problems of the PRH residents will be solved effectively with appropriate assistance. Meeting notes and highlights of the said meetings will be issued to frontline staff to facilitate them to render appropriate support and follow-up actions to PRH residents.

- HD will maintain close liaison and cooperation with SWD in providing continuous support to PRH residents.

- Hong Kong Housing Society (HKHS) has employed in-house registered social workers as "Community Services Manager" stationing in all of its public rental estates to render social support to tenants in need. There is a mechanism for HKHS Estate Office to refer tenants with mental illness or suspected mental health problems suffering from noise nuisance or having disputes with neighbours to the social workers. After assessing their needs, the social workers will refer them, if deemed necessary, to the appropriate social services providers like the ICCMWs, CPS and Medical Social Service units for further assessment and service provision. To maintain effective communication with the abovementioned mental health service providers, HKHS has assigned representatives to attend the "District Task Group on Community Mental Health Support Services" convened by SWD in various districts.

- Housing transfer application is open to eligible tenants all the time, and special priority will be granted to needy tenants to speed up the transfer process. For very special cases, HKHS will proactively offer flats for tenants to transfer despite no request from them. After their transfer to a new flat in the same estate or to another estate, the social worker will follow up to facilitate tenants' adjustment to the new living environment.

Training for frontline staff on handling tenants with suspected mental illness

(Response to Recommendation AS11)

- To enrich frontline staff's knowledge on the characteristics and handling skills of mentally ill persons during their daily operation, in the past few years, HD had invited psychiatric specialists and medical staff to deliver training programmes on identification and handling of suspected mental persons, communication skills with suspected mentally ill persons and effective way to make referrals to ICCMW, etc.

- Under the existing security services contracts, the contractors are obliged to provide regular trainings and drills for security guards which aim at strengthening their knowledge on public safety and ability to handle emergency.

- To increase frontline colleagues' awareness and enhance their knowledge in handling tenants with mental illness or suspected mental health problems, HKHS has developed crisis management manuals on "Handling of people who suddenly lose emotional control" and "Handling of psychosis patients" for their staff and security guards. Various trainings on mental health have also been arranged from time to time, e.g. "Mental Health in Post-Pandemic Period", "Talk on Decoding of Mental Health: Depression and Anxiety", "Management of Conflict", "Overcoming Adversity - Enhancement of AQ and Resilience", "Clapping Hand Action - Contemporary Management of Stress", "Mindfulness Workshop", etc. HKHS will continue to arrange related training to frontline staff.

Measures to enhance protection of foreign domestic helpers

(Response to Recommendation AS12)

- Labour Department (LD) set up in September 2020 a dedicated FDH (Foreign Domestic Helper) Division to ensure effective coordination and implementation of measures to enhance protection of FDHs, and to provide better support for FDHs and their employers. LD will hold seminars or briefings for FDHs, employers and EAs respectively, and organise other exchange activities, such as sharing sessions, to answer enquiries of FDHs and employers on the spot. LD has also been disseminating information relating to mental health and stress management to FDHs and encourages them to seek help when necessary. FDHs can call the LD's dedicated 24-hour FDH hotline (2157 9537) for one-stop support services if necessary. Also, LD will maintain liaison with the consulates-general of major FDH-sending countries in Hong Kong to ensure provision of timely assistance to FDHs and employers in need.

Cross-sectoral and inter-departmental collaboration to identify at-risk hidden families

(Response to Recommendation AS13)

- IFSCs/ISCs have close collaboration with non-governmental organisations and community bodies in the locality, including District Council members, women's associations, local networks, etc. In addition, to increase connection with vulnerable families which are unmotivated to seek help to address their problems at an early stage, IFSCs/ISCs proactively reach out to those unmotivated families through outreaching and service promotion in public housing estates or at those spots with more people, aiming at introducing the needy families to various support services available and motivating them to receive appropriate services.

Mental health community support services and publicity on mental wellness

(Response to Recommendation AS14)

- To enhance the social support and re-integration of the ex-mentally ill persons into the community, SWD has implemented the ICCMW service in all the districts across the territory since October 2010. Through the one-stop and integrated service mode, 24 ICCMWs provide mental health community support services ranging from early prevention to risk management for ex-mentally ill persons, persons with suspected mental health problems, their families/carers and residents living in the serving district. SWD has also provided additional resources to strengthen professional support for children of ex-mentally ill persons since October 2018 and expanded the service targets of ICCMWs to secondary school students with mental health needs and strengthen professional support for them and their family members/carers since October 2019.

- Since July 2019, SWD has set up the Mobile Van for Publicity Service on Mental Wellness in five designated regions over the territories, i.e. Hong Kong Island, Kowloon East, Kowloon West, New Territories East and New Territories West, through mobile exhibitions, mini talks, experimental activities, simple on-site screening, etc., to step up community education, promote the public's awareness on mental wellness and develop positive help-seeking attitude/behaviour in order to achieve the objective of early prevention, early identification and early intervention.

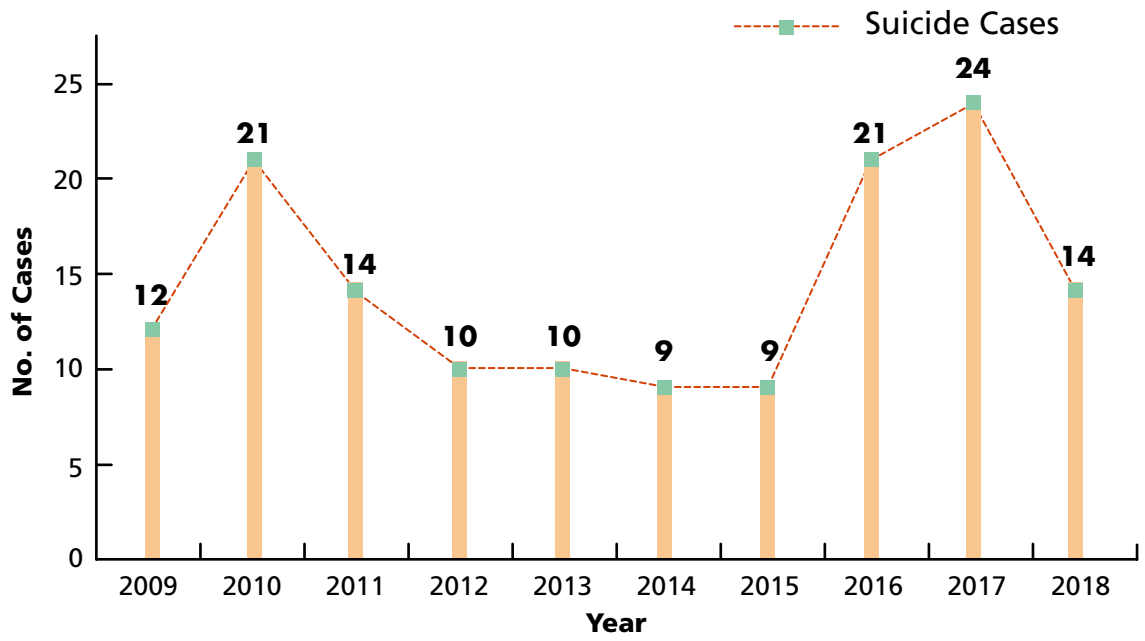
9 Thematic Review on Children and Youth Suicide Deaths

(a 10-year review from 2009 to 2018)

- Suicide deaths of children or youth cause great distress to their families, teachers, school-mates, friends, helping professionals and the community at large. The impact may last for a long time. Despite the fact that suicide is complicated and is due to a complex interplay of risk factors, circumstances and adverse experience, suicide is potentially preventable. To have a better understanding of the trend of suicide deaths among children and youth and the identified reasons leading to their suicide, the Review Panel has conducted a 10-year thematic review on deaths of children and youth by suicide from 2009 to 2018.

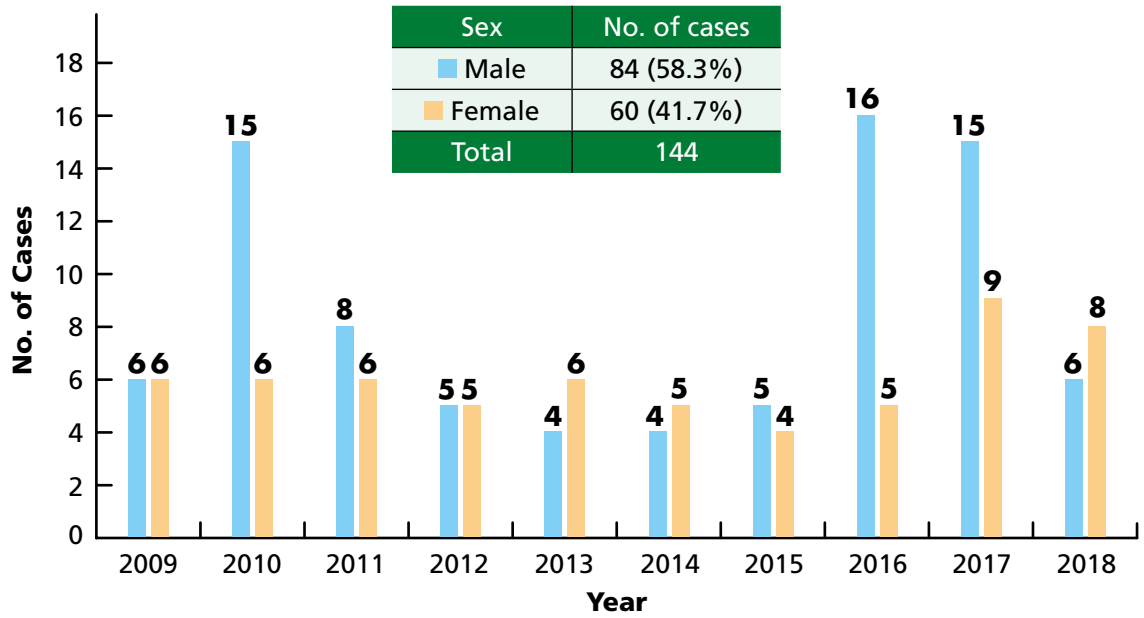
9.1 Summary Findings on Suicide Deaths from 2009 to 2018

Chart 9.1.1: Number of Suicide Deaths by Year



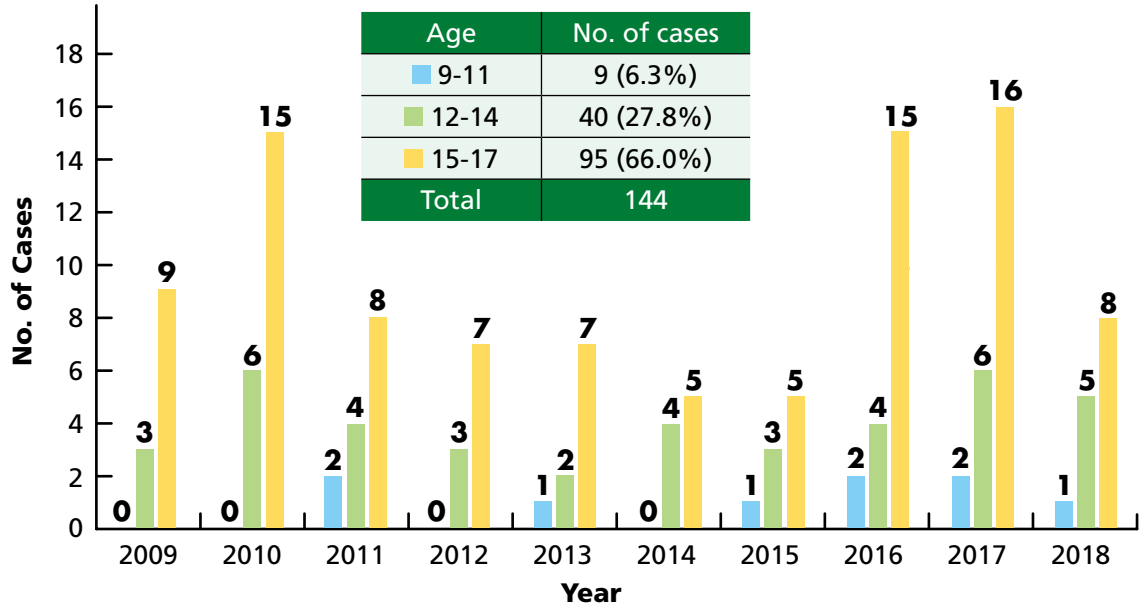
- Over the 10-year period from 2009 to 2018, there were 144 reviewed cases, which involved children and youth who committed suicide with an average of 14.4 suicide deaths per year. Taking into account the reviewed child death cases from 2009 to 2018, suicide is the second leading cause of child deaths (i.e. 14.4% out of the 998 reviewed child death cases). As seen from the chart, there is a marked increase of suicide deaths in 2010 (an increase of 75% from 12 cases in 2009 to 21 cases in 2010). Since then, the number of cases has dropped continuously to the lowest at 9 in 2014 and 2015. However, there was a sharp rise to 21 cases in 2016 (an increase of 133.3% from 9 cases in 2015 to 21 cases in 2016), reaching a record high to 24 cases in 2017 and then dropped to 14 cases in 2018.

Chart 9.1.2: Number of Suicide Deaths by Year and Gender



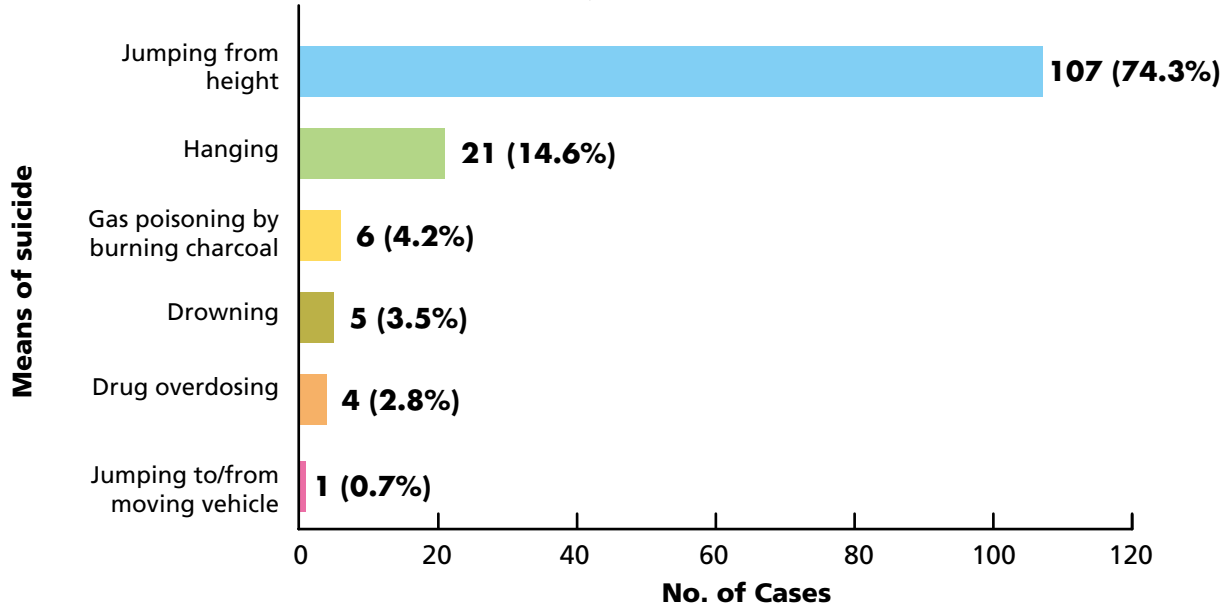
- Of the 144 children who committed suicide from 2009 to 2018, 58.3% (N=84) were male and 41.7% (N=60) were female. The gender ratio was similar except for the years 2010, 2016 and 2017 in which male greatly outnumbered female.

Chart 9.1.3: Number of Suicide Deaths by Year and Age Group



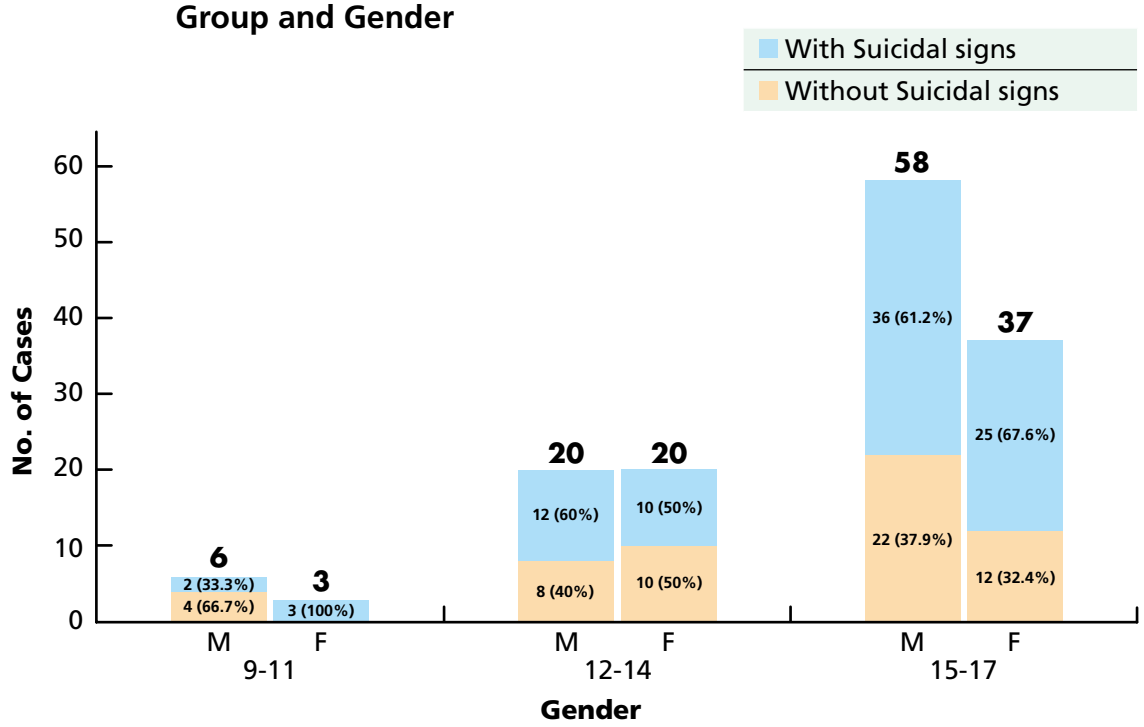
- The majority of suicide deaths occurred in the age group of 15-17, accounting for 66% of suicide deaths (N=95), while children aged 12-14 made up 27.8% of suicide deaths (N=40) and those aged 9-11 made up the remaining 6.3% of suicide deaths (N=9). The rate of suicide increases with the older age group. Though the number of suicide deaths for the age group of 9 to 11 was comparatively small with 9 cases, it is noticeable that 5 cases were at the age of 10 while 4 were at the age of 11.

Chart 9.1.4: Number of Suicide Deaths by Means



- The three highest means of suicide adopted by children were jumping from height (N=107, 74.3%), followed by hanging (N=21, 14.6%) and gas poisoning by burning charcoal (N=6, 4.2%). Throughout the 10-year-period, "jumping from height" is the most common means of suicide adopted by children which is also the most common method of suicide given the abundant number of high rise buildings in Hong Kong, which makes jumping from height a relatively "easy" method.

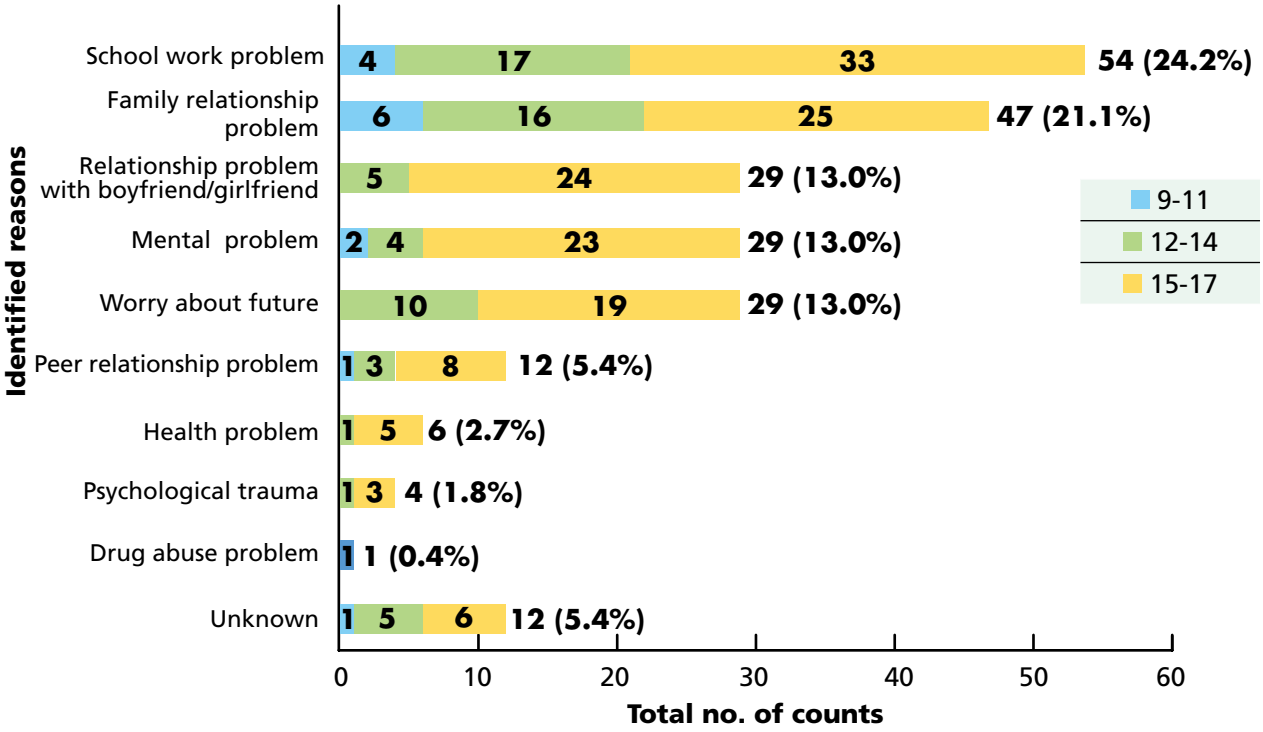
Chart 9.1.5: Number of Suicide Deaths with Identified Suicidal Signs* by Age Group and Gender



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

- Majority of the children (N=88, 61.1%) who committed suicide had expressed their suicidal thoughts in one way or another before actual attempts. Out of these 88 children with identified suicidal signs, 50 (56.8%) were male and 38 (43.2%) were female. Among the three age groups, the eldest age group of 15-17 (64.2%) had shown suicidal signs more than that of the younger age groups of 9-11 (55.6%) and 12-14 (55%). It was common that these children expressed their distress to their peers online via social media sites or text messages, such as WhatsApp or Instagram. This reflected the importance and need for timely intervention and support for children who expressed suicide ideation and plan.

Chart 9.1.6: Identified *Reasons for Committing Suicide by Age Group



** More than one reasons are allowed. The reasons were identified in the police death investigation reports and/or service reports of the reviewed cases.*

- Suicide is a complicated social problem with multifactorial causes. It cannot be sufficiently explained by a single event or stressor. As identified from the police investigation reports and/or service reports of the 144 reviewed cases, school work problem (N=54, 24.2%) had the highest number of counts, followed by family relationship problem (N=47, 21.1%) and relationship problem with boyfriend/girlfriend, mental problem and worry about future (all N=29, 13.0%)

- In Hong Kong, the prevailing belief that "academic results determine one's future" and the "examination-oriented" culture has created much pressure to students to pursue for academic excellence. It is not surprising that school work problem was a prominent reason behind the children's suicide for the age group of 12-14 and 15-17. As observed from the reviewed cases, children expressed to have "study pressure such as worries about impending school examination", especially for the age group of 15-17, who have to prepare or sit for the HKDSE examination, which was perceived as the only means to pursue for a degree at the university. For the age group of 12-14, "adjustment to new school life upon promotion to Form One" and "having difficulty to catch up with the study with drastic setback in examination results" when promoted to senior forms, particularly for those who used to have

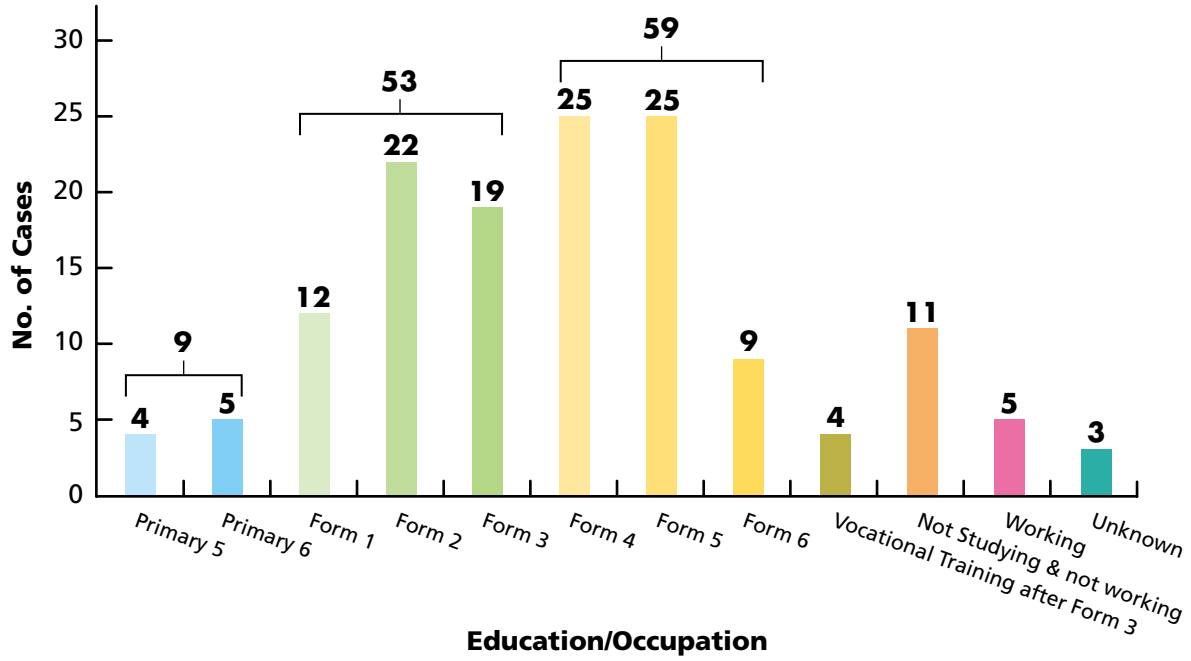
favourable academic results in their junior forms, were the reported academic stressors. Children facing changes such as moving on to secondary school and adaptation to new social circles were more susceptible to emotional distress. As for the age group of 9-11, "facing the school examinations for the Secondary School Places Allocation" had induced much stress on them. Apart from that, tension was aroused easily between children and parents when the children's "academic result did not meet with the parents' expectations" and some children were unhappy when being asked by the parents to give up their interests for revision.

- Family relationship problem had the second highest counts for the age group of 12-14 and 15-17. These children were found having conflicts with their parents or siblings, lacking family communication and support, being upset by the parents' marital problems or having arguments with parents over the use of mobile phone and playing on-line games. Among these cases, there were 5 cases having their mobile phones or laptop being confiscated just before their suicide. A total of 42 children (29.2%) out of the 144 reviewed cases came from families with single, divorced or remarried parents. As we mentioned before, family changes could bring tremendous negative impact on children.

- Out of the 29 counts of mental problem, 7 children were found to have suspected mental health problem, while 22 had been diagnosed with mental illness, such as early psychosis, obsessive-compulsive disorder, depression, anxiety disorder, etc. and have received psychiatric treatment. Eight out of these 22 children had attempted suicide before. It was noted that mental problem had the third highest count for the age group of 9-11, among which two children were diagnosed with Attention Deficit Hyperactivity Disorder and Asperger respectively. More attention should be paid to the mental health condition of young children, especially those with mental health problems and there is a need to enhance the parents' knowledge and skills in addressing their emotional needs.

- Relationship problem with boyfriend/girlfriend had the third highest count for the age group of 15-17. As this age group of children just started dating, they might encounter stress in handling conflicts and break-ups. It was observed that children did not know how to cope with breaking up or rejection after making proposal of love. Some children committed suicide out of impulsivity after quarrels with their boyfriends/girlfriends or being turned down after asking for reconciliation. Being emotionally attached to each other, children lovers sharing negative thoughts might mutually influence or reinforce each other to end their lives together, which reflected in a case involving two youths who entered into a suicide pact. Courtship education needs to be strengthened in helping children cope with break-ups, rejection and develop a healthy dating relationship.

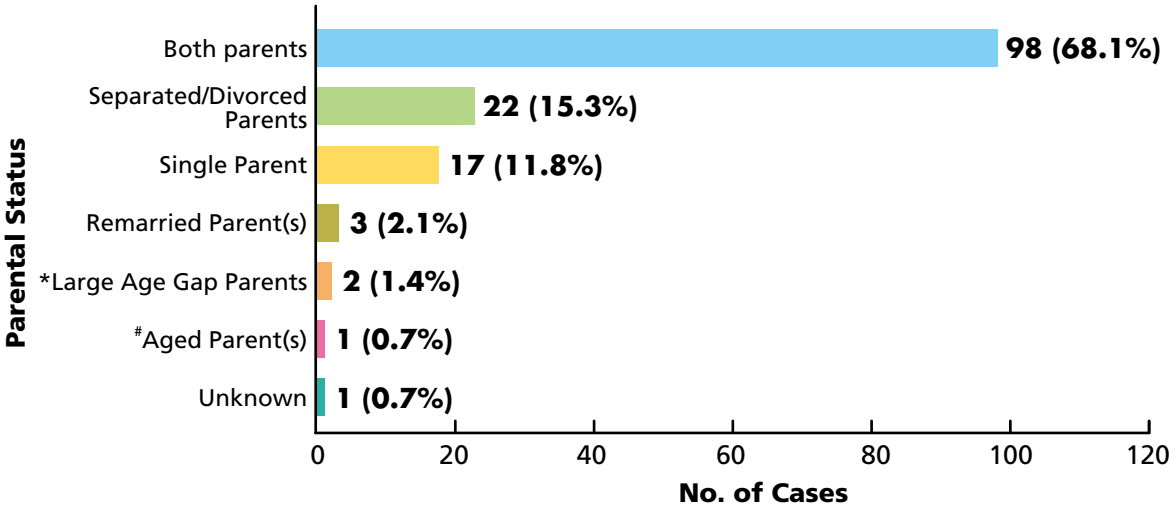
Chart 9.1.7: Number of Suicide Deaths by Education/Occupation



- Out of the 144 children suicide cases, 86.8% (N=125) children were studying, 7.6% (N=11) were not studying and not working while 3.5% (N=5) were engaged in full-time or part-time work. Among those who were studying, 7.2% (N=9) were studying in primary schools, 42.4% (N=53) were at junior secondary level (Form 1 to Form 3), 47.2% (N=59) were in senior secondary schooling (From 4 to Form 6). Relatively more children studying at senior secondary level committed suicide which reflected the anxiety and pressure in coping with advanced school work and starting to prepare for HKDSE.

- Attention should be paid to those children who are neither studying nor working, especially for those school drop-outs. Though without any presenting problems identified, students who dropped out from school needed to have continuous support. There were multiple pathways for school dropouts nowadays. Teachers and school social workers should introduce alternate options with them. The drop-out students may be referred to the Integrated Children and Youth Services Centres (ICYSCs) for continuous support service. However, early bridging to the follow-up unit is necessary as it is not easy to engage those school drop-outs to receive service and develop a trustful relationship with the other helping professionals. School social worker may also refer case with psychiatric problem to receive service from the Integrated Community Centre for Mental Wellness (ICCMW) as appropriate.

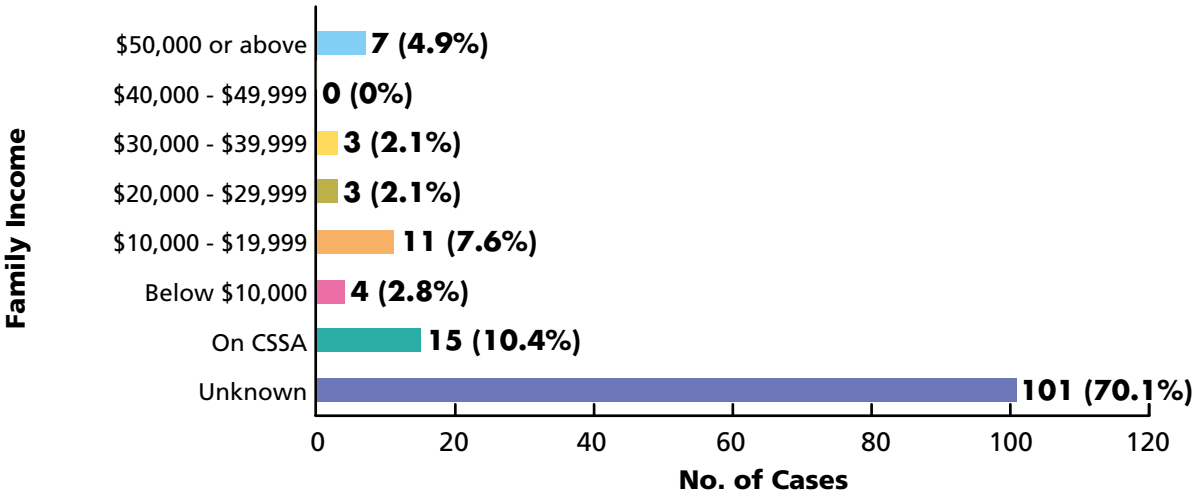
Chart 9.1.8: Number of Suicide Deaths by Parental Status



** Large Age Gap Parents: ≥ 15 years age gap*
 # Aged Parents(s): ≥ 60 years old

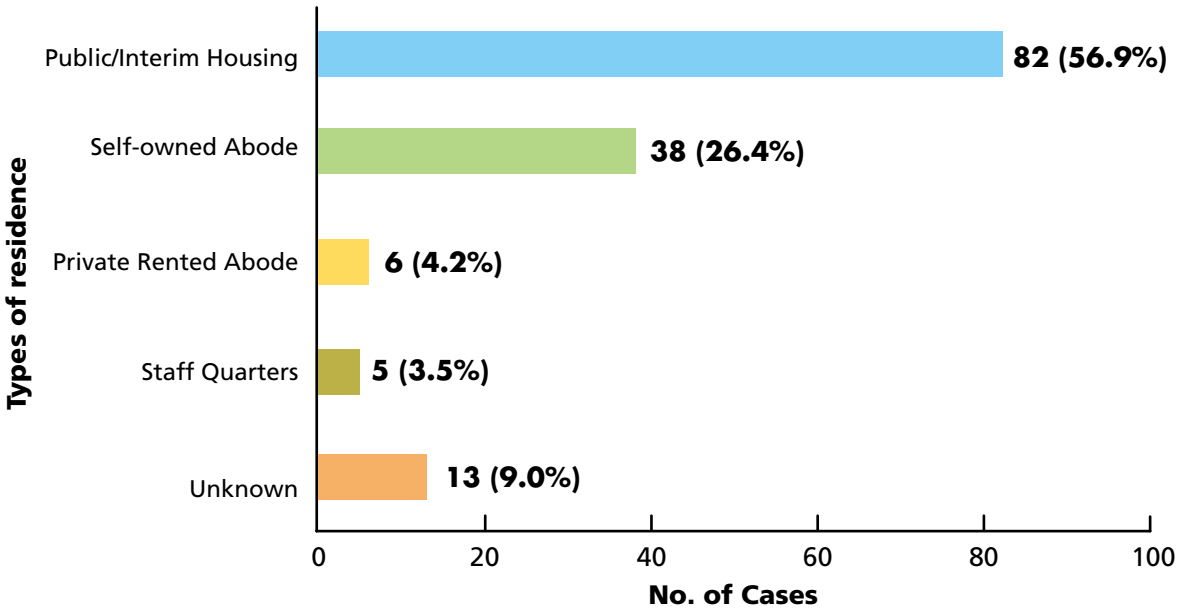
- There were 98 children (68.1%) who committed suicide came from intact families with both parents. 22 children (15.3%) came from families with separated/divorced parents, while 17 children (11.8%) came from single parent families and 3 children (2.1%) came from families with parents having remarried.

Chart 9.1.9: Number of Suicide Deaths by Family Income



- 10.4% children who committed suicide lived on CSSA. However, since the family income of the children who committed suicide was not captured in the police investigation reports or Service Reports provided by the schools and welfare service units, the family income of 70.1% cases was unknown.

Chart 9.1.10: Number of Suicide Deaths by Type of Residence



- 56.9% of the children who committed suicide lived in public/interim housing whereas 26.4% lived in self-owned abode and 4.2% lived in private rented abode.

Chart 9.1.11: Number of Suicide Deaths by Month

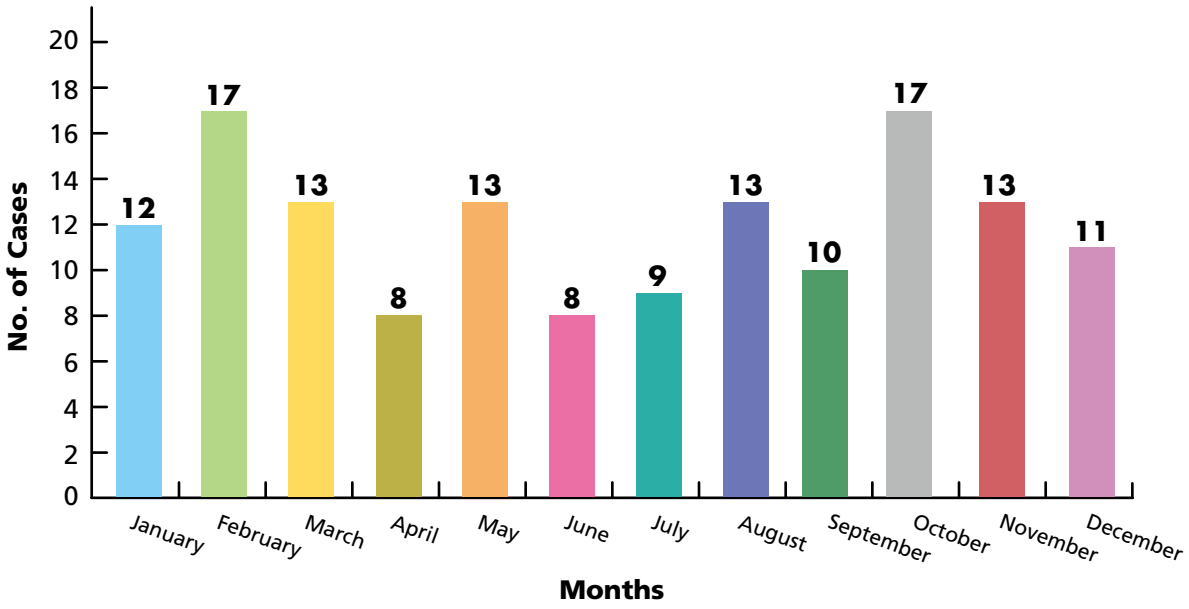
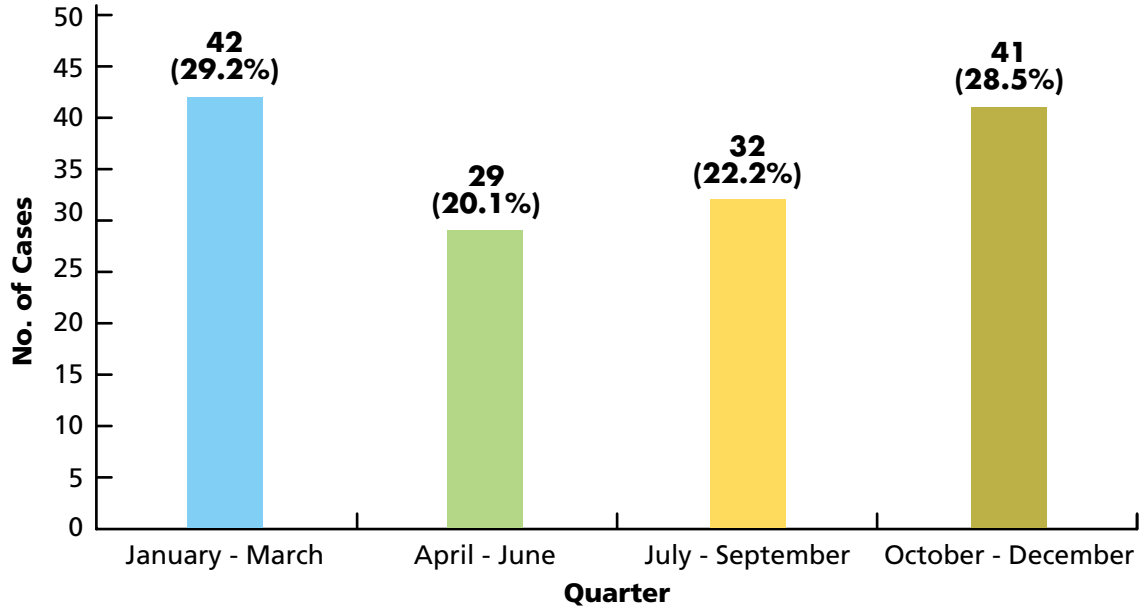


Chart 9.1.12: Number of Suicide Deaths by Quarter



- Though children suicides happened every month throughout the year, the number of children suicide cases was relatively higher in February and October. As observed from the quarterly basis, up to 57.7% of children suicides took place in the first quarter (January to March) and last quarter (October to December) within a year. Normally, students encountered more stress in face of tests and assessment in October and November, examination in January and release of school examination results and the issue of school reports at the Parents' Day in February.

- In view of the above, teachers, parents and school social workers should pay special attention to students during the critical periods, such as the examination period, before and after the school report release day, school resumption after long holidays, at the beginning of new school term, upon release of results of HKDSE and Joint University Programmes Admissions System (JUPAS) as well as the adjustment period of Form One students newly promoted to secondary schools.

- During the release of school reports, teachers should remind parents not to put too much emphasis on their children's academic achievement, but to identify their potentials and strengths and to attend more to their need for psycho-social development. Teachers should also pay attention to those students with setback in academic performance, so as to enhance their resilience. For example, sending out "caring cards" to students before the release of school reports.

Suicide Clusters:

- The highest number of suicide deaths occurred in the years 2010 (N= 21), 2016 (N= 21) and 2017 (N= 24). Suicide clusters were found in these years with four suicide cases occurring within the same month in May 2010 (on 19/5, 19/5, 22/5 and 24/5), in July 2010 (on 9/7, 11/7, 12/7 and 14/7) and March 2016 (on 7/3, 8/3, 12/3 and 28/3), while six suicide cases took place within the same month in February 2017 (on 5/2, 6/2, 12/2, 17/2, 20/2 and 21/2).

- It was observed that some of the deaths of these children and youths were widely reported in the media. Under sensational reports by the media, suicide can be contagious and intensify copycat effect. This has been reported in the local studies conducted by the Centre for Suicide Research and Prevention (CSRP) that suicide spates often coincide with extensive and sensational media coverage.

- Responsible reporting of suicide deaths would minimise negative effects on vulnerable youths or further distress to their families and friends. To support and promote appropriate media coverage on suicide cases in the public interest, the CSRP has paid concerted effort to draw up principles and recommendations on suicide reporting. The Review Panel observed that the media has included suicide prevention hotline as well as contact information of organisations of suicide prevention, mental health and social services when reporting suicide cases which is a good practice.

Schools with more than one suicide case:

- The Review Panel observed that a few schools had repeated suicide cases. Nine schools were found to have more than one suicide cases with the maximum of two. Two schools were found to have two students having committed suicide within the same year, while two students knew each other though studying in different forms as they joined the same interest class.

- Suicidal deaths of students would bring considerable distress to the whole school. Aftermath follow-up and debriefing for all students after a student's suicide is considered necessary as the suicide incident would have negative impact and might trigger imitative suicidal behaviour among students of the same school. Access to bereavement support following a suicidal case is also deemed important.

- In addition, professional support and intervention in response to a student's suicide should not be carried out only for the immediate crisis, but also for the aftermath follow-up and support for the family members and significant

persons in connection with the deceased child. Helping professionals should be aware of the long-term impact and monitor those students impacted by the death, such as those studying in the same class, same form or in other ways connected with the deceased or the suicide incident. A Handbook on School Crisis Management: Intervention and Psychological Support in the Aftermath of Crisis, published by the Education Bureau in June 2021, provides guidance to schools in handling crisis incidents, including suicidal deaths of students. The Handbook provides guidance to schools to match the needs of students, staff and parents with appropriate crisis management and psychological support. Schools are advised to evaluate the extent of impacts on students and formulate different tiers of support measures for them according to their level of needs. For example, to refer individual students with intense emotional or behavioural reaction to receive counselling from the school social workers and to refer those who are seriously affected to receive mental health services.

- Schools are also advised to be cautious when arranging memorial activities that involve suicide. Some students may regard committing suicide as a means to draw attention from others or even imitate the suicidal behaviour. Schools are advised to avoid any activities that may glorify suicide act, such as holding large-scale memorial activities at school.

Conclusion:

- Suicide prevention is a shared responsibility among government, organisations and various systems in contact with children as well as the children's families and community network, including schools, social, public health and mental health services. To reduce the risk of suicide for children, we need to help children build up resilience and acquire positive experience in face of adversity, while continued measures should also be taken to enhance the protective factors such as strengthening the support services for those having high-risk factors (e.g. suffering from mental illness or from dysfunctional families), facilitating students' school adjustment, encouraging youth to play an active role in improving their mental well-being, enhancing teachers and helping professional's sensitivity and responsiveness to students in distress, strengthening collaboration among different disciplines for early intervention; parent education on effective parenting skills and most importantly listening to our children and giving them hope in their upbringing.

10 Summary of Statistics on Child Death Cases Reviewed from 2006 to 2018

Taking account of the child death cases reviewed from 2006 to 2018, the following tables and charts are prepared to show the changes over time by various nature of cases.

10.1 Statistics of Child Death Cases Reviewed

Table 10.1.1: Number of Cases by Cause of Death and Year

Cause of Death	Year in which the cases occurred													Total
	2006@	2007@	2008	2009	2010	2011	2012^	2013~	2014	2015&	2016<	2017>	2018+	
Natural Causes	74 [69]	60 [52]	70	86	79	72	72	62	50	60	69	54	36	**844 [831]**
Non-natural Causes-	43 [48]	32 [40]	49	33	49	38	41	37	33	27	37	36	27	**482 [495]**
Suicide	*14*	*10*	*14*	*12*	*21*	*14*	*10*	*10*	*9*	*9*	*21*	*24*	*14*	***182***
Accident	*20*	*12*	*13*	*10*	*15*	*13*	*19*	*11*	*6*	*6*	*11*	*7*	*4*	***147***
Assault	*5*	*6*	*9*	*9*	*8*	*4*	*2*	*6*	*3*	*7*	*2*	*2*	*3*	***66***
#Unascertained	*1 [6]*	*2 [10]*	*9*	*1*	*5*	*7*	*10*	*8*	*15*	*5*	*1*	*3*	*4*	***71 [84]***
**Medical Complication*	*3*	*2*	*4*	*1*	*0*	*0*	*0*	*2*	*0*	*0*	*2*	*0*	*2*	***16***
Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**99**	**83**	**87**	**106**	**90**	**63**	**1 326**

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

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

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

^ 8 accident cases of 2012 are still not covered in this report.

~ 1 medical complication case of 2013 is added after review.

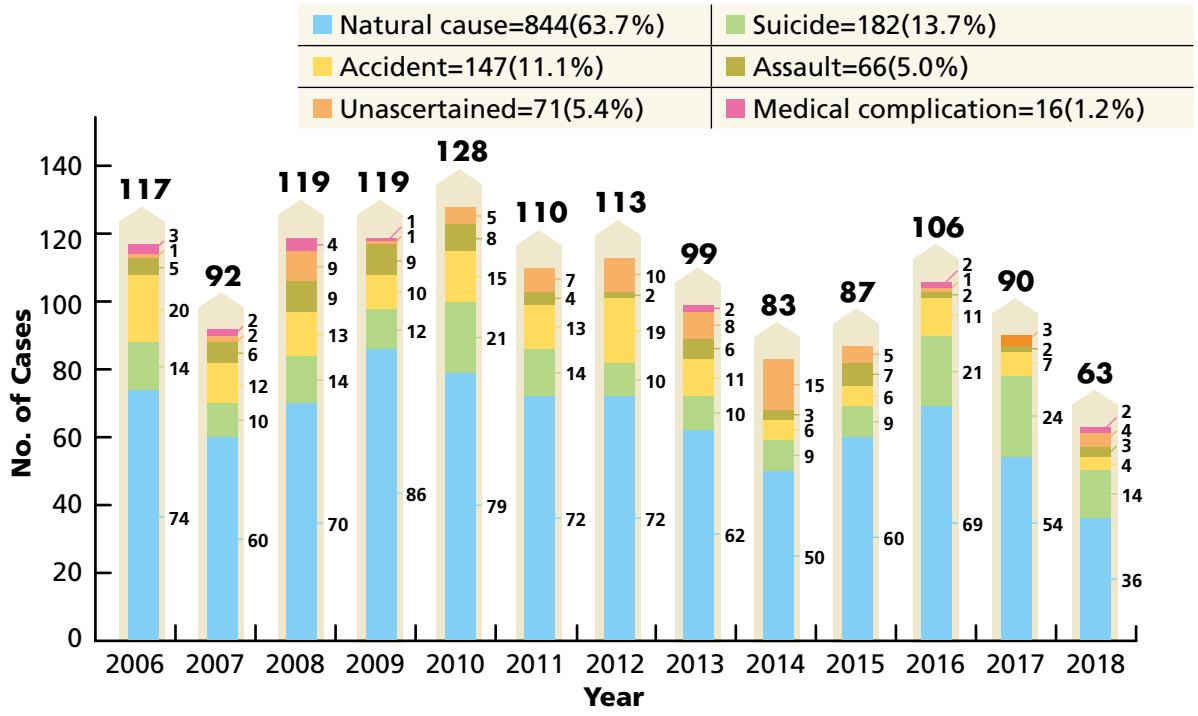
& 3 natural-cause cases and 1 assault case of 2015 are added after review while 2 natural-cause cases are still not covered in this report.

< 3 natural cause cases and 1 accident case of 2016 are not covered in this report.

> 4 natural cause cases, 1 non-natural cause case of 2017 are not covered in this report.

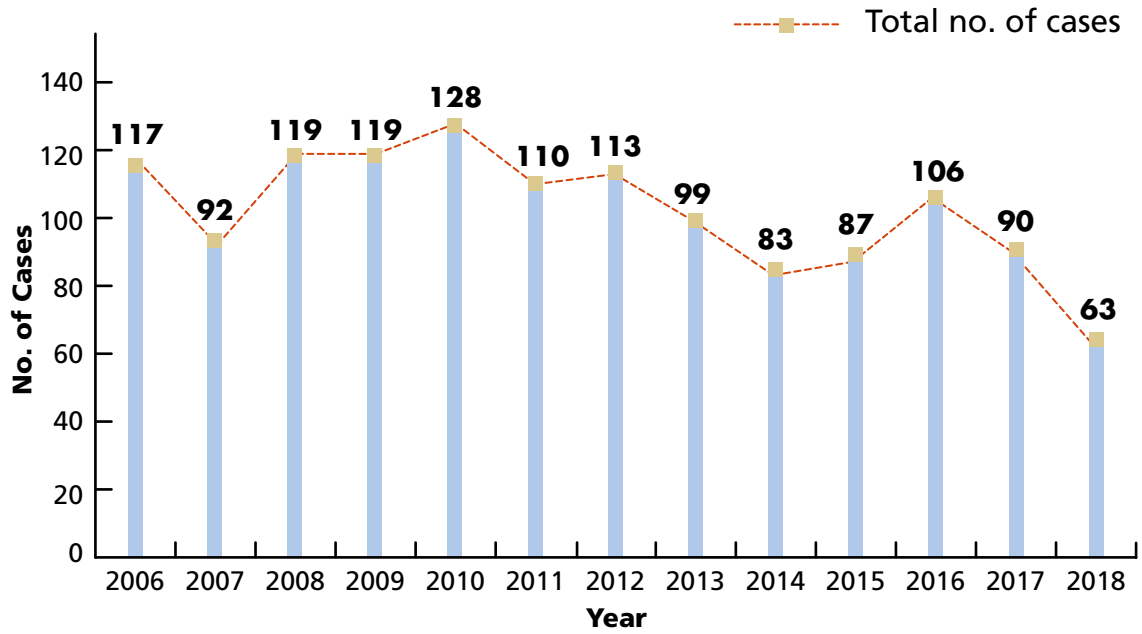
+ 5 natural cause cases, 1 non-natural cause case and 3 assault cases of 2018 are not covered in this report.

Chart 10.1.1.1: Number of Cases by Cause of Death and Year



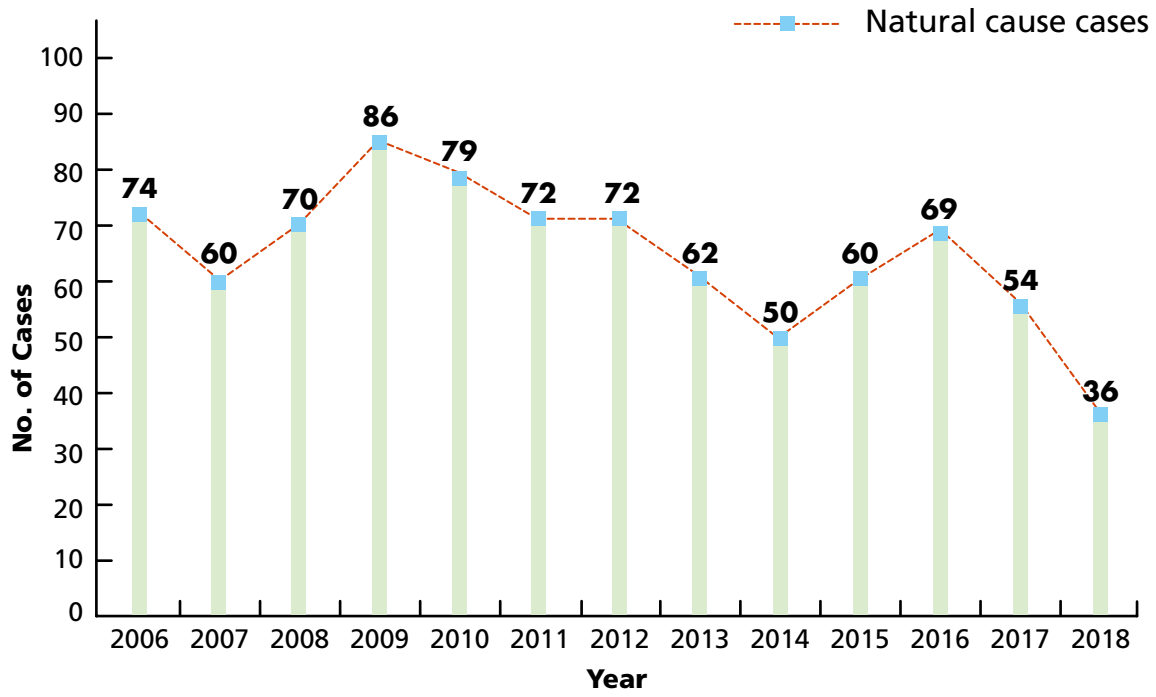
The leading cause of death was natural cause (N=844, 63.7%), followed by suicide (N=182, 13.7%) and accident (N=147, 11.1%).

Chart 10.1.1.2: Number of Overall Cases by Year



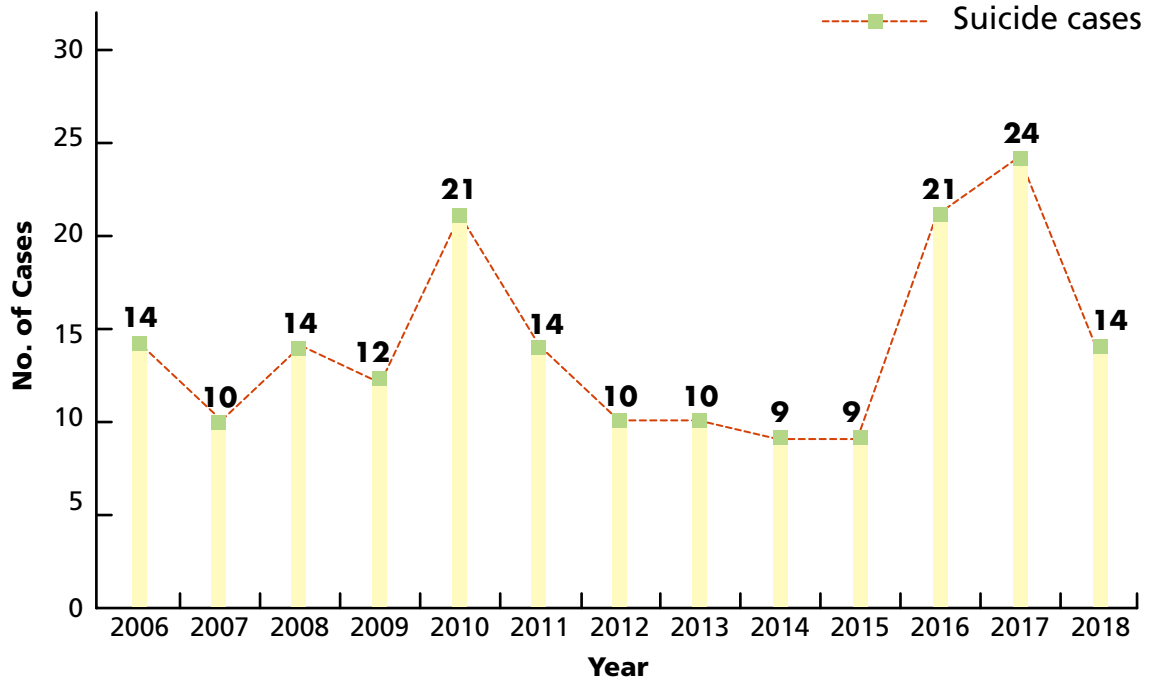
Since 2008, the overall number of reviewed cases started to rise to the highest at 128 in 2010. It then started to drop till 2014 to 83 with a rise again up to 106 in 2016. Since then, there was a significant drop to 63 in 2018.

Chart 10.1.1.3: Number of Natural Cause Cases by Year



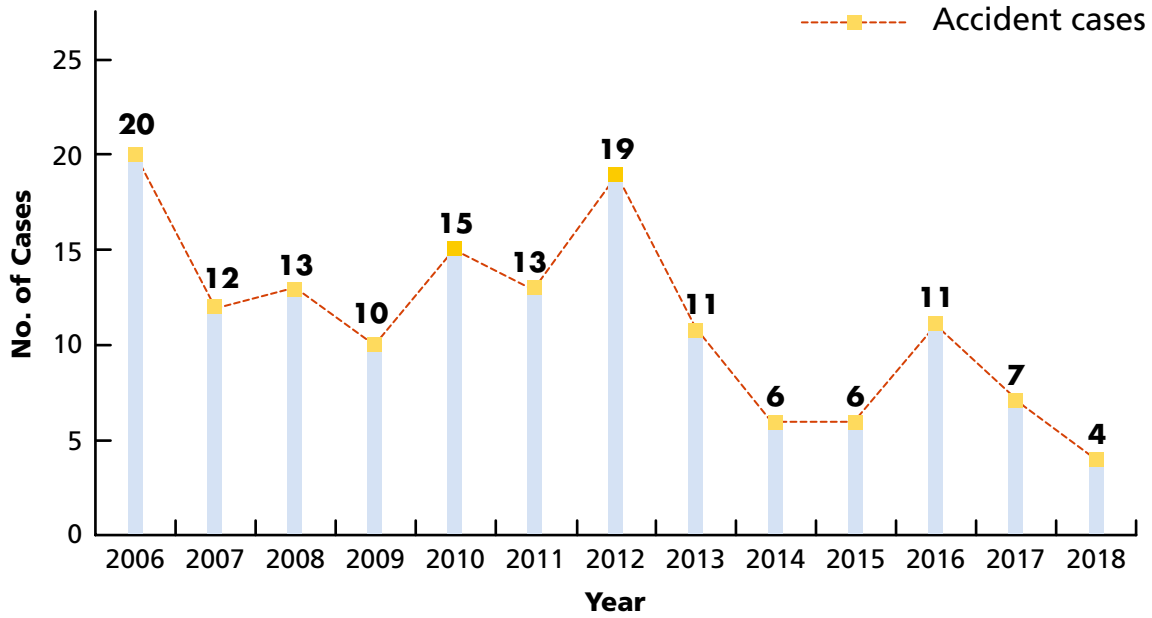
The highest number of reviewed natural cause cases was at 86 in 2009. Since then, there was a gradual decline to 50 cases in 2014. It started to rise again to 69 in 2016 but then a drop to 36 in 2018.

Chart 10.1.1.4: Number of Suicide Cases by Year



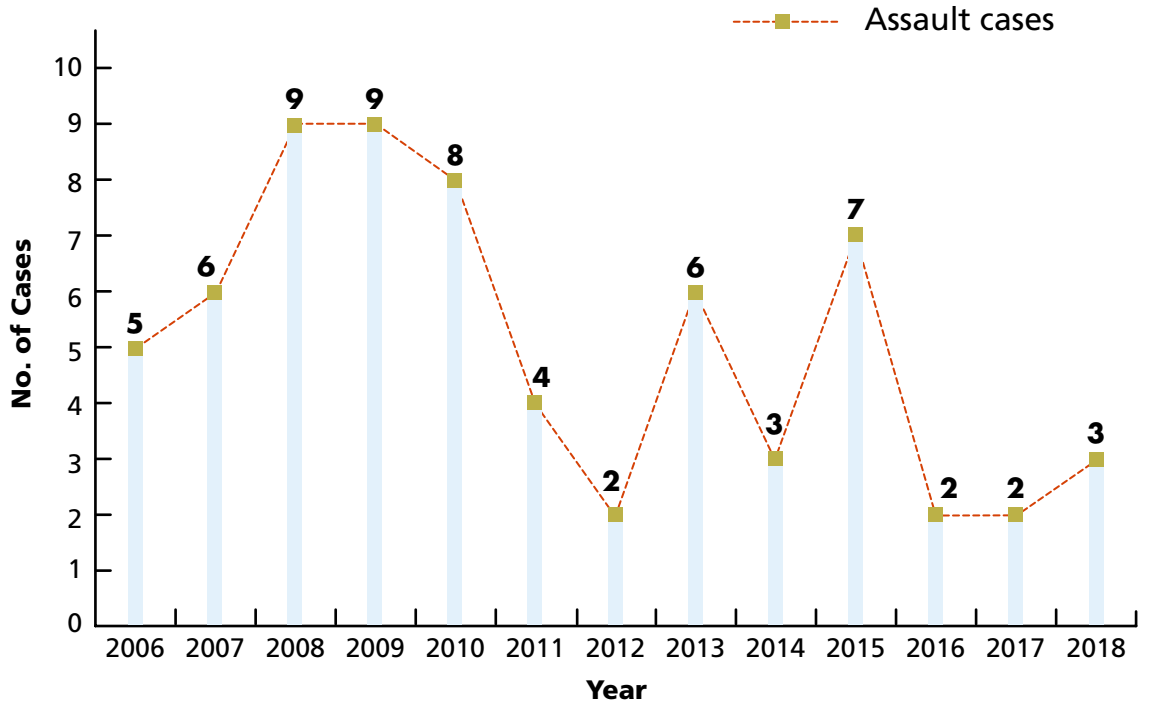
There was a marked increase of suicide in 2010 with 21 cases but the number of cases has dropped continuously to its lowest at 9 in 2014 and 2015. However, there was a sharp rise to 21 cases in 2016, reaching a record high to 24 cases in 2017 and then dropped to 14 cases in 2018.

Chart 10.1.1.5: Number of Accident Cases by Year



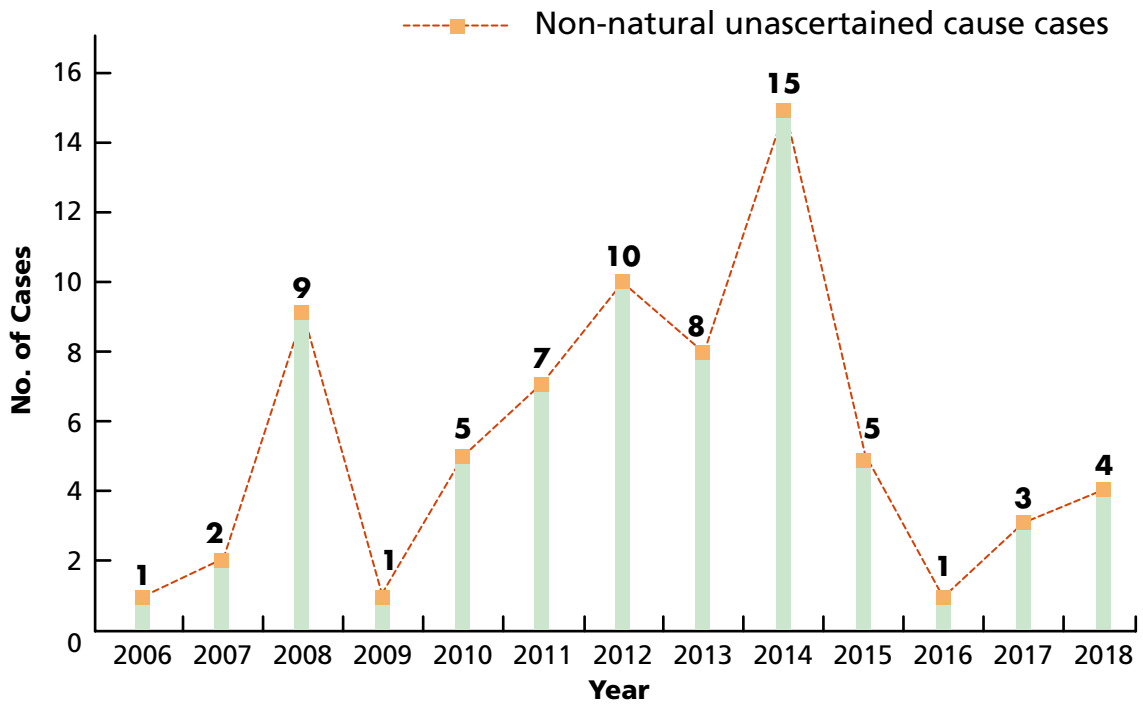
The number of accident cases went up and down from 2006 to 2012. A great decline started after 2012 till 2015 to 6 cases with an upward bounce to 11 cases in 2016. Since then, the number of cases dropped continuously to its lowest at 4 in 2018.

Chart 10.1.1.6: Number of Assault Cases by Year



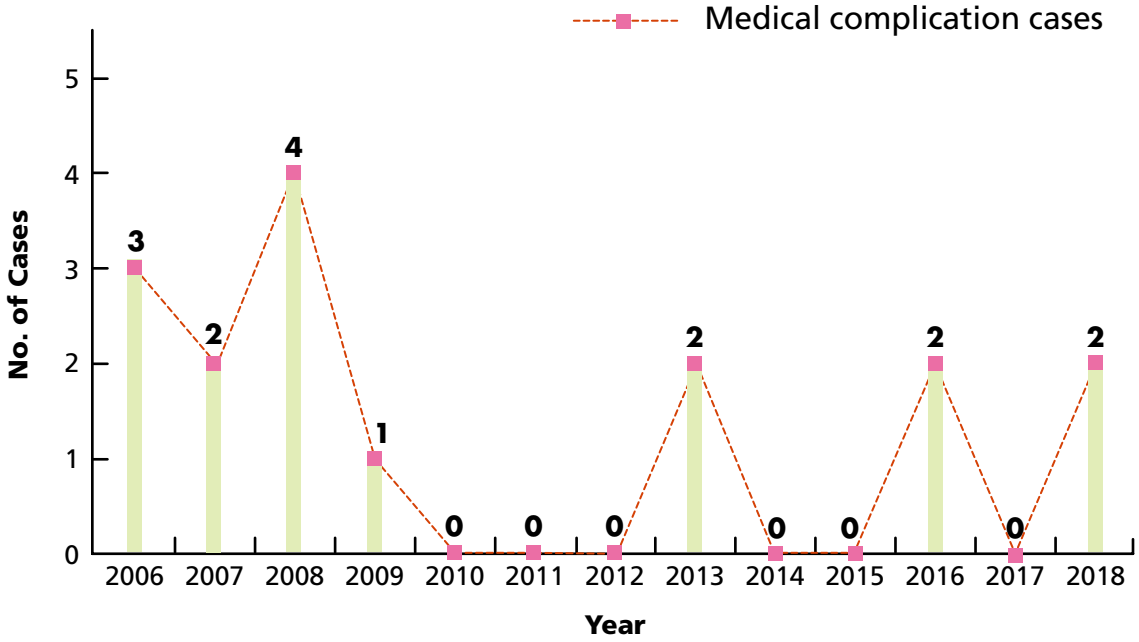
The number of assault cases rose from 5 in 2006 to the highest at 9 in 2008 and 2009. A decline started after 2010 with cases dropped to 2 in 2012. Since then, the number of cases fluctuated from 2012 to 2015 with a drop to 2 in 2016 and 2017.

Chart 10.1.1.7: Number of Non-natural Unascertained Cause Cases by Year



The number of unascertained cases rose from 1 in 2006 to the highest at 9 in 2008 and then dropoed to its lowest at 1 in 2009. A rise started in 2010 till 2012 to the highest at 15 in 2014 though there had been a drop to 8 cases in 2013. After 2014, cases dropped down to its lowest at 1 in 2016 with a rise again in 2017 and 2018.

Chart 10.1.1.8: Number of Medical Complication Cases by Year



There was a decline for medical complication cases after 2008 to 0 in 2010. Since then, the number of cases kept at either 0 or 2.

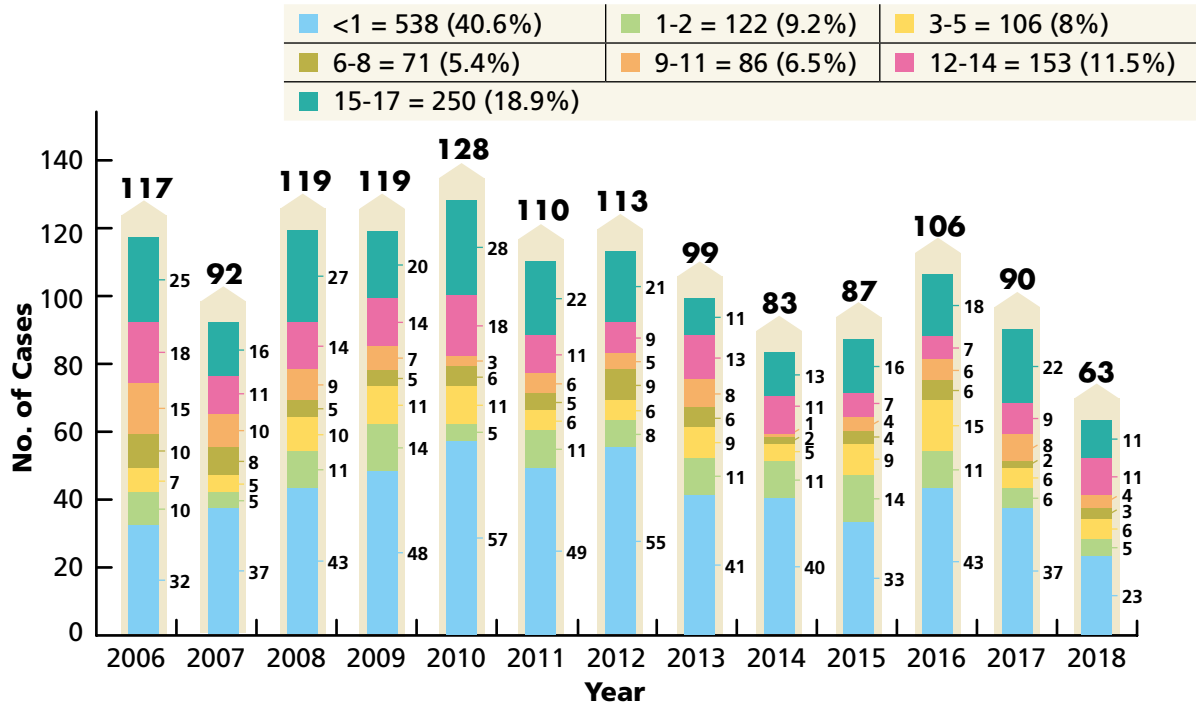
Table 10.1.2: Number of Cases by Age Group, Gender and Year

Age Group and Gender		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	No. of Cases (%)
< 1	F	18	17	16	23	17	24	27	14	24	13	19	15	11	238
	M	14	20	27	25	40	25	28	27	16	20	24	22	12	300
	Sub-total	**32**	**37**	**43**	**48**	**57**	**49**	**55**	**41**	**40**	**33**	**43**	**37**	**23**	**538 (40.6%)**
1-2	F	3	2	8	7	3	3	3	4	6	6	5	4	3	57
	M	7	3	3	7	2	8	5	7	5	8	6	2	2	65
	Sub-total	**10**	**5**	**11**	**14**	**5**	**11**	**8**	**11**	**11**	**14**	**11**	**6**	**5**	**122 (9.2%)**
3-5	F	1	3	5	4	2	5	1	4	4	1	7	5	4	46
	M	6	2	5	7	9	1	5	5	1	8	8	1	2	60
	Sub-total	**7**	**5**	**10**	**11**	**11**	**6**	**6**	**9**	**5**	**9**	**15**	**6**	**6**	**106 (8%)**
6-8	F	3	3	2	2	2	2	4	2	0	2	2	0	2	26
	M	7	5	3	3	4	3	5	4	2	2	4	2	1	45
	Sub-total	**10**	**8**	**5**	**5**	**6**	**5**	**9**	**6**	**2**	**4**	**6**	**2**	**3**	**71 (5.4%)**
9 -11	F	8	6	3	4	1	1	1	5	0	0	5	3	0	37
	M	7	4	6	3	2	5	4	3	1	4	1	5	4	49
	Sub-total	**15**	**10**	**9**	**7**	**3**	**6**	**5**	**8**	**1**	**4**	**6**	**8**	**4**	**86 (6.5%)**
12-14	F	6	5	8	8	7	5	7	3	6	2	4	4	5	70
	M	12	6	6	6	11	6	2	10	5	5	3	5	6	83
	Sub-total	**18**	**11**	**14**	**14**	**18**	**11**	**9**	**13**	**11**	**7**	**7**	**9**	**11**	**153 (11.5%)**
15-17	F	11	4	12	8	8	8	4	8	6	8	4	8	5	94
	M	14	12	15	12	20	14	17	3	7	8	14	14	6	156
	Sub-total	**25**	**16**	**27**	**20**	**28**	**22**	**21**	**11**	**13**	**16**	**18**	**22**	**11**	**250 (18.9%)**
Total (%):	F	50	40	54	56	40	48	47	40	46	32	46	39	30	568 (42.8%)
	M	67	52	65	63	88	62	66	59	37	53	60	51	33	758 (57.2%)
	Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**99**	**83**	**87**	**106**	**90**	**63**	**1 326 (100%)**

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

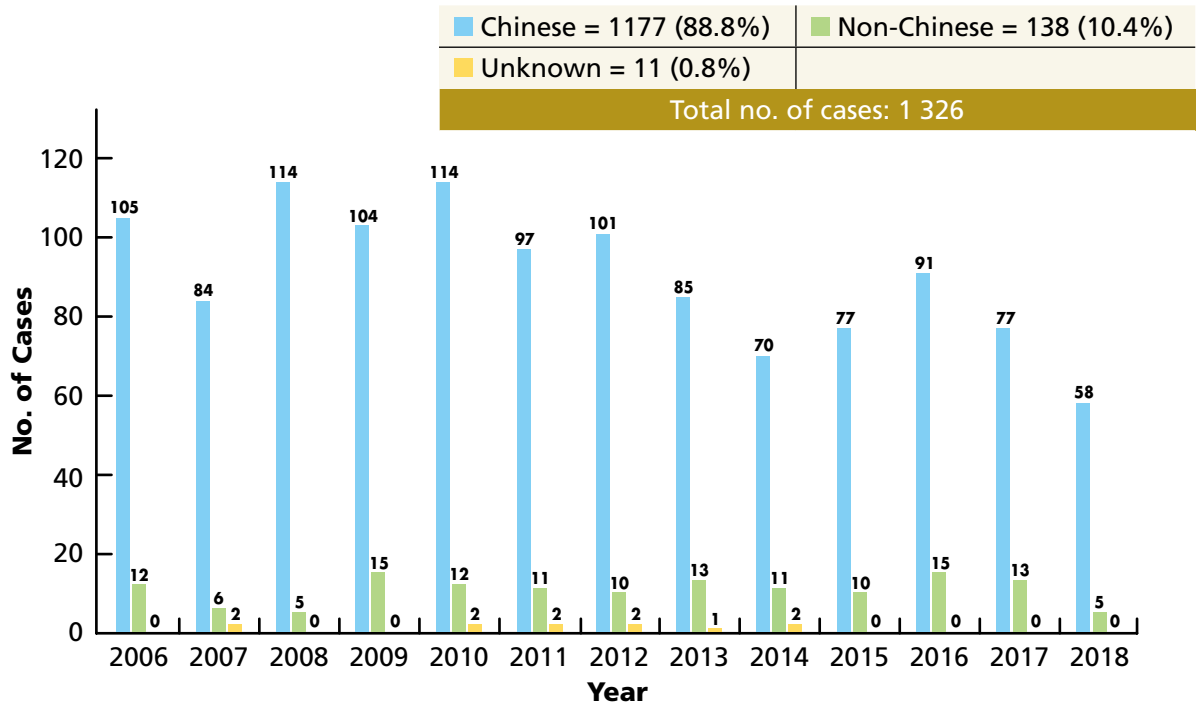
The highest number of child deaths occurred among children aged below 1 (N=538, 40.6%), followed by the age groups of 15-17 (N=250, 18.9%) and 12-14 (N=153, 11.5%).

Chart 10.1.2:1: Number of Cases by Year and Age Group



The highest number of child deaths occurred among children aged below 1 (N=538, 40.6%), followed by the age groups of 15-17 (N=250, 18.9%) and 12-14 (N=153, 11.5%).

Chart10.1.2.2: Number of Cases by Year and Ethnicity



The majority of the deceased children were Chinese (N=1177, 88.8%) and there were 138 (10.4%) non-Chinese children.

Table 10.1.3: Number of Cases by Cause of Death, Year and Gender

Cause of Death		2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	No. of Cases (%)
Natural Causes	F	31	29	32	39	24	35	33	20	27	21	33	21	15	360
	M	43	31	38	47	55	37	39	42	23	39	36	33	21	484
	Sub-total	**74**	**60**	**70**	**86**	**79**	**72**	**72**	**62**	**50**	**60**	**69**	**54**	**36**	**844 (63.7%)**
Suicide	F	7	3	6	6	6	6	5	6	5	4	5	9	8	76
	M	7	7	8	6	15	8	5	4	4	5	16	15	6	106
	Sub-total	**14**	**10**	**14**	**12**	**21**	**14**	**10**	**10**	**9**	**9**	**21**	**24**	**14**	**182 (13.7%)**
Accident	F	8	3	3	4	6	2	4	6	3	4	5	6	2	56
	M	12	9	10	6	9	11	15	5	3	2	6	1	2	91
	Sub-total	**20**	**12**	**13**	**10**	**15**	**13**	**19**	**11**	**6**	**6**	**11**	**7**	**4**	**147 (11.1%)**
Assault	F	3	3	5	6	4	1	1	1	2	2	1	2	1	32
	M	2	3	4	3	4	3	1	5	1	5	1	0	2	34
	Sub-total	**5**	**6**	**9**	**9**	**8**	**4**	**2**	**6**	**3**	**7**	**2**	**2**	**3**	**66 (5.0%)**
Unascertained	F	0	1	7	1	0	4	4	6	9	1	0	1	3	37
	M	1	1	2	0	5	3	6	2	6	4	1	2	1	34
	Sub-total	**1**	**2**	**9**	**1**	**5**	**7**	**10**	**8**	**15**	**5**	**1**	**3**	**4**	**71 (5.4%)**
Medical Complication	F	1	1	1	0	0	0	0	1	0	0	2	0	1	7
	M	2	1	3	1	0	0	0	1	0	0	0	0	1	9
	Sub-total	**3**	**2**	**4**	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**2**	**0**	**2**	**16 (1.2%)**
Total (%):	F	50	40	54	56	40	48	47	40	46	32	46	39	30	568 (42.8%)
	M	67	52	65	63	88	62	66	59	37	55	60	51	33	758 (57.2%)
	Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**99**	**83**	**87**	**106**	**90**	**63**	**1 326 (100%)**

There were more male (N=758, 57.2%) than female (N=568, 42.8%) among the deceased child cases reviewed. This phenomenon applied to the death cause groups of natural causes, suicide, accident, assault and medical complication. There were more female than male only among the death cause group of unascertained causes.

Chart 10.1.4.1: Number of Overall Cases by Year and Gender

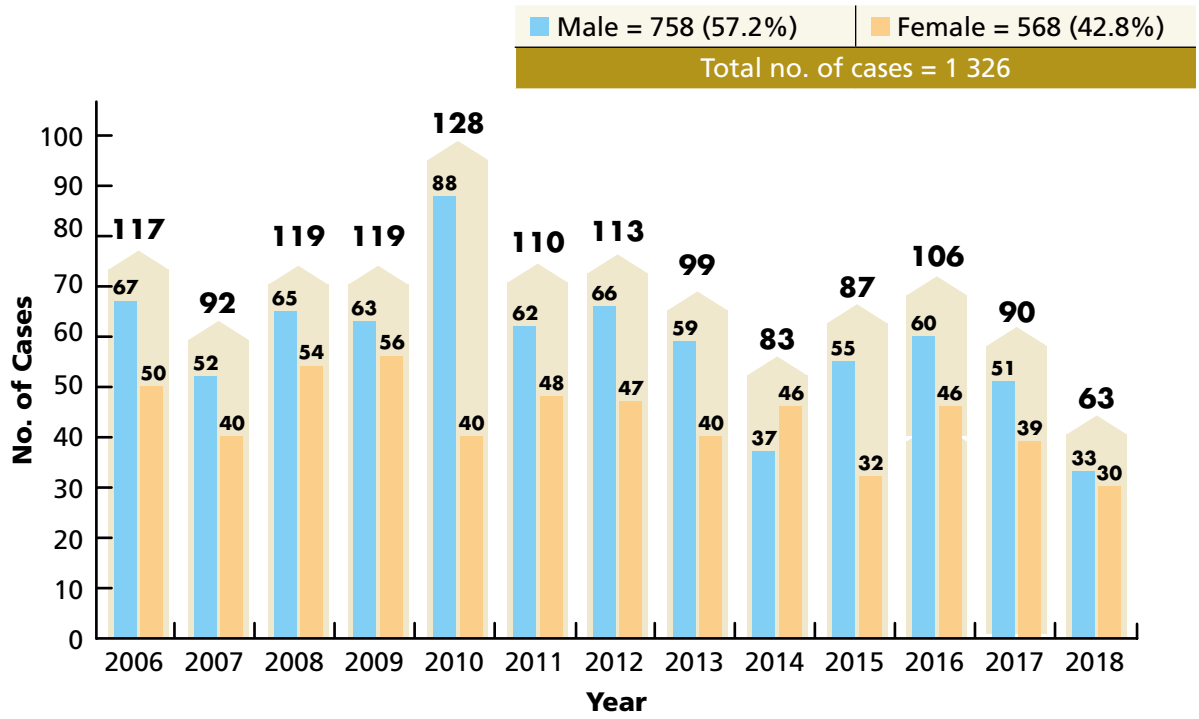


Chart 10.1.4.2: Number of Natural Cause Cases by Year and Gender

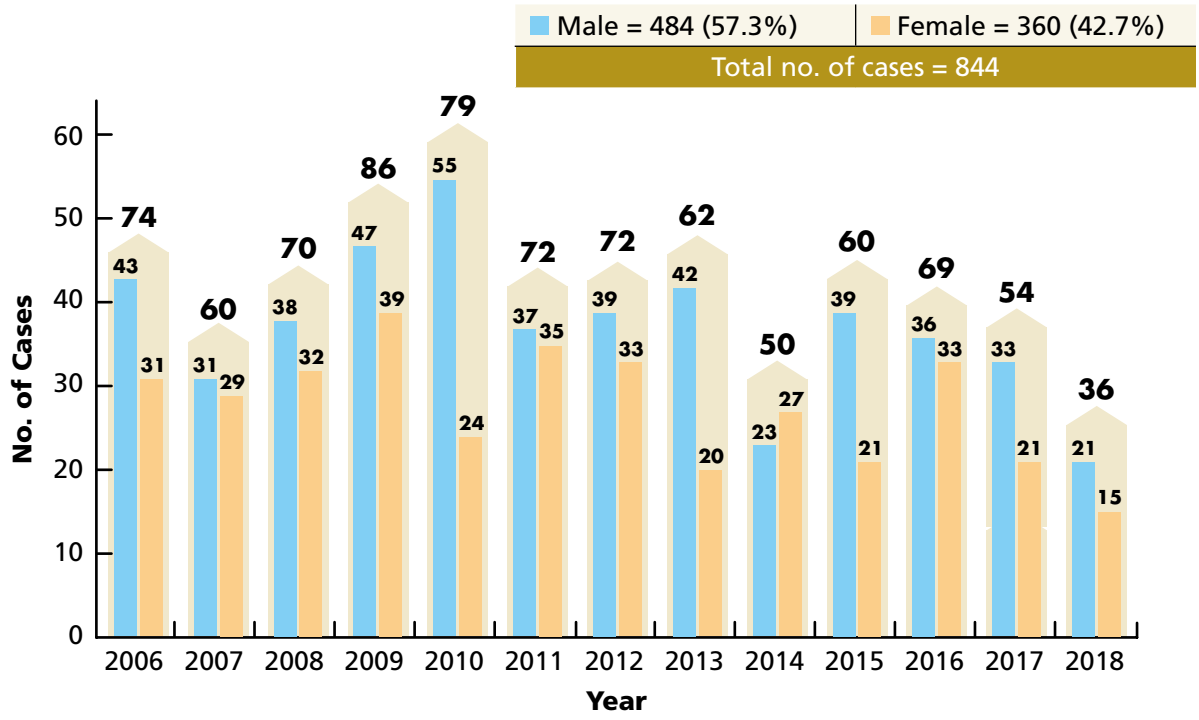


Chart 10.1.4.3: Number of Suicide Cases by Year and Gender

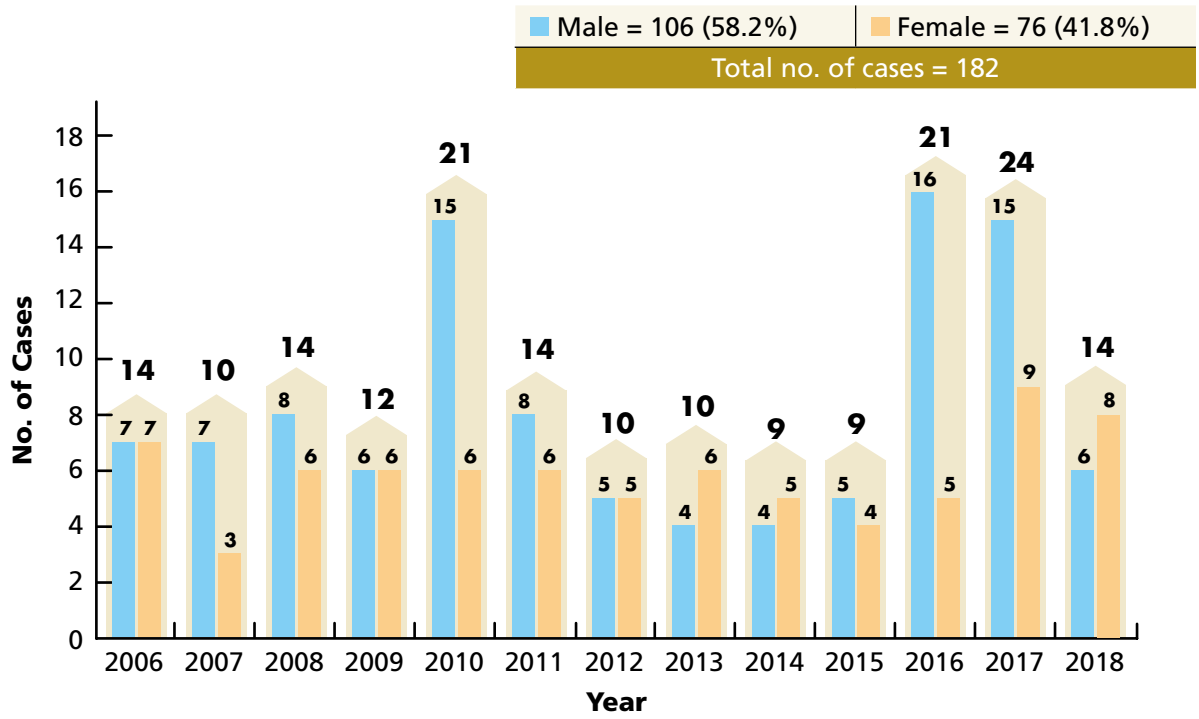


Chart 10.1.4.4: Number of Accident Cases by Year and Gender

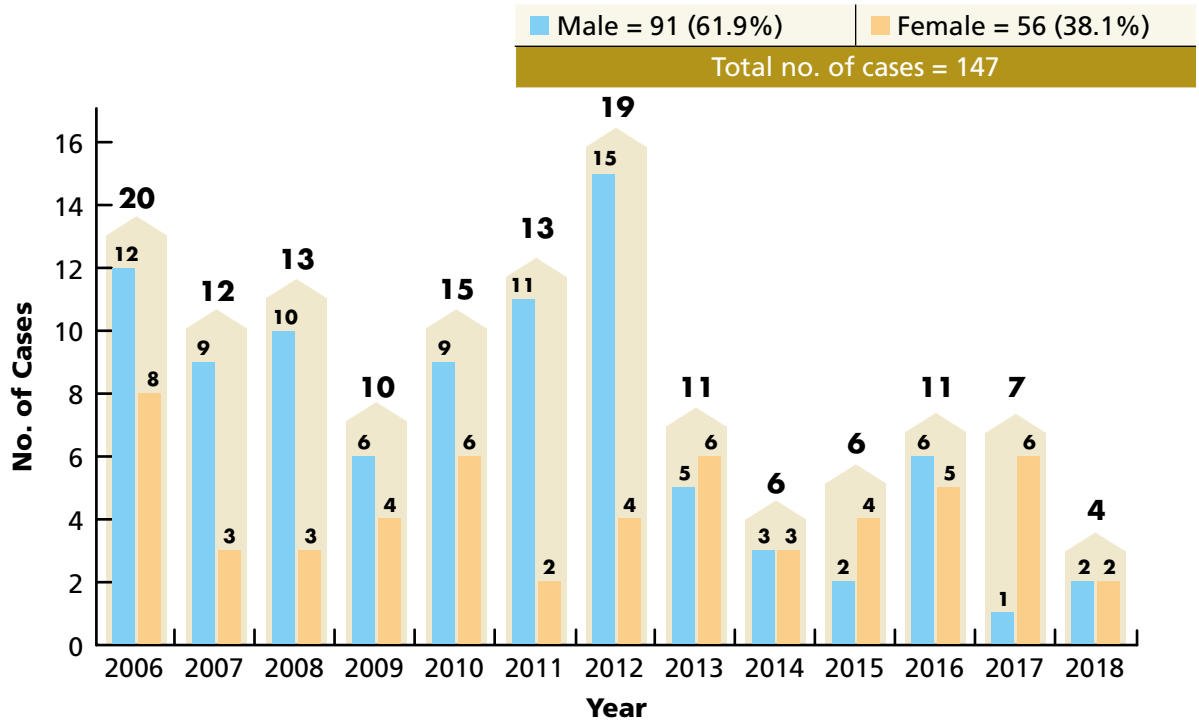


Chart 10.1.4.5: Number of Assault Cases by Year and Gender

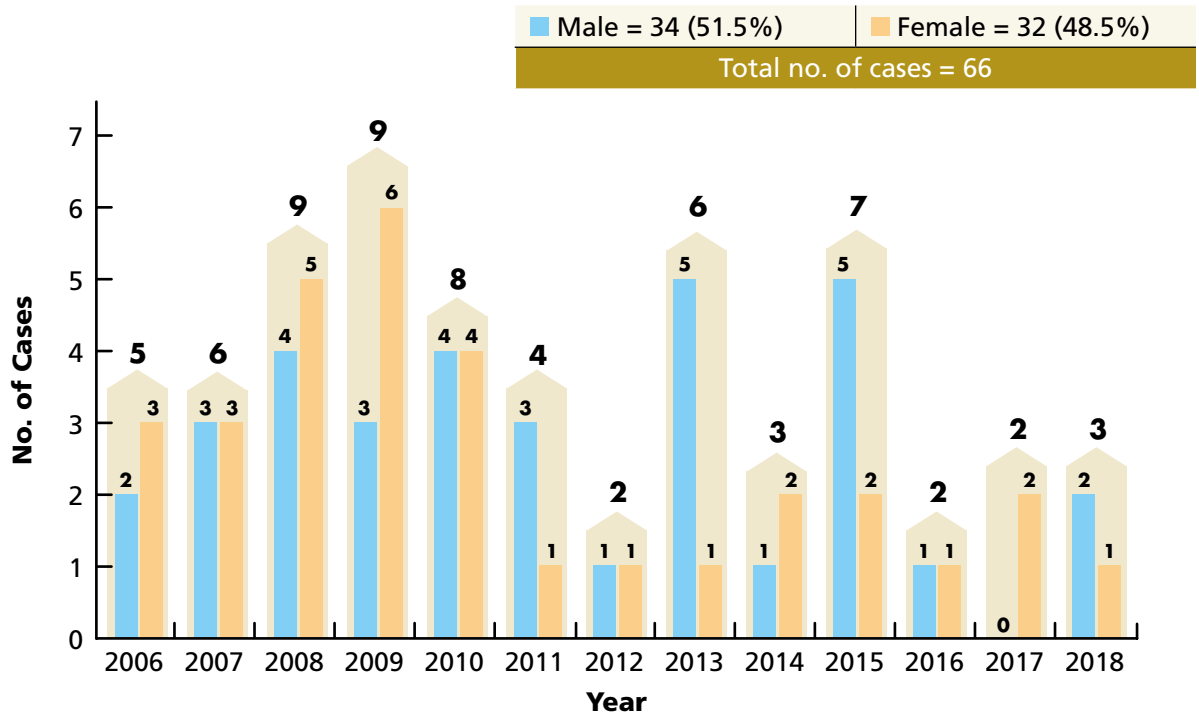


Chart 10.1.4.6: Number of Non-natural Unascertained Cause Cases by Year and Gender

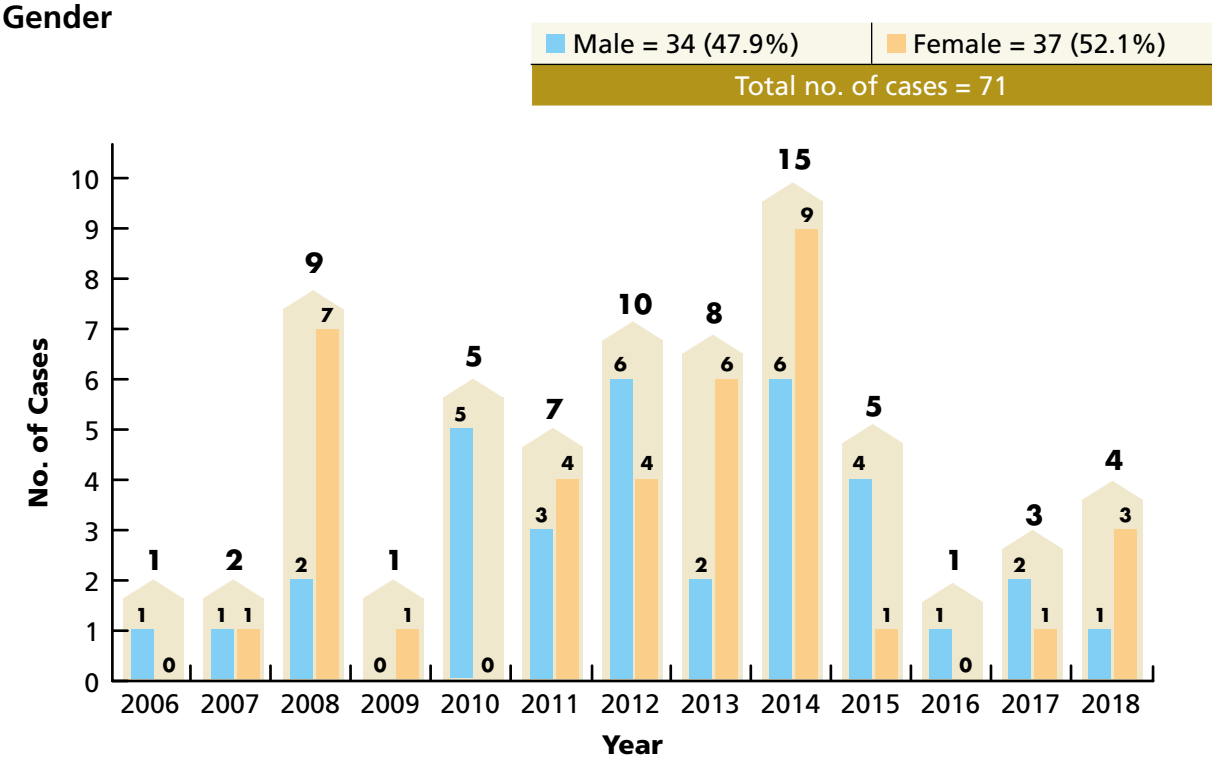


Chart 10.1.4.7: Number of Medical Complication Cases by Year and Gender

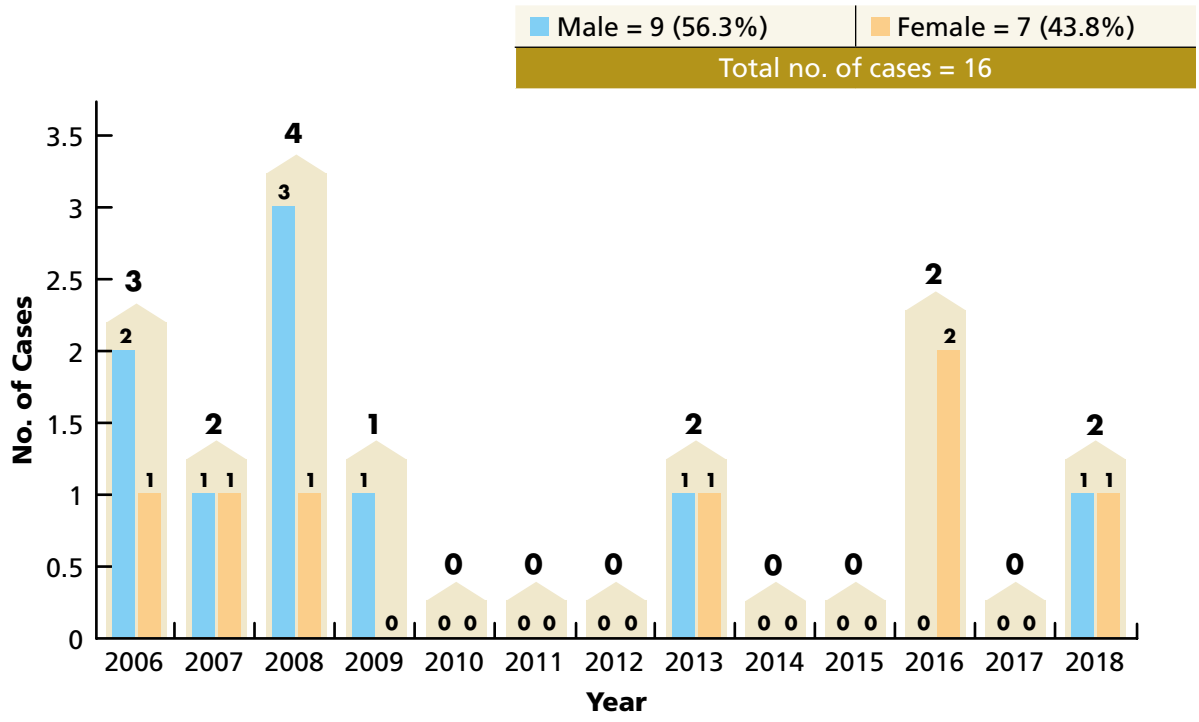


Table 10.1.5: Number of Cases by Residential District

Residential District	No. of Cases / Death Rate*													
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total (%)
HONG KONG ISLAND														
Central & Western	7	1	4	6	2	5	6	1	3	2	1	4	2	**44 (3.3%)**
	0.185	0.026	0.102	0.157	0.051	0.144	0.172	0.029	0.087	0.052	0.034	0.134	0.066	
Wan Chai	1	0	1	0	2	0	2	2	1	0	0	2	0	**11 (0.8%)**
	0.045	0.000	0.047	0.000	0.099	0.000	0.105	0.109	0.051	0.000	0.000	0.093	0.000	
Eastern	4	7	9	5	2	6	11	7	8	6	5	4	7	**81 (6.1%)**
	0.043	0.076	0.100	0.058	0.024	0.074	0.140	0.092	0.107	0.082	0.068	0.052	0.094	
Southern	4	5	6	3	7	3	2	5	2	6	2	3	1	**49 (3.7%)**
	0.085	0.111	0.132	0.069	0.165	0.071	0.050	0.134	0.053	0.170	0.053	0.083	0.027	
KOWLOON														
Yau Tsim Mong	1	0	2	7	4	5	7	5	4	3	7	6	4	**55 (4.1%)**
	0.025	0.000	0.046	0.160	0.088	0.107	0.148	0.104	0.083	0.060	0.158	0.131	0.088	
Sham Shui Po	8	6	2	9	5	7	6	6	2	4	8	6	3	**72 (5.4%)**
	0.134	0.106	0.035	0.158	0.090	0.120	0.105	0.108	0.036	0.072	0.141	0.103	0.052	
Kowloon City	5	4	1	1	7	7	2	3	3	6	9	3	2	**53 (4.0%)**
	0.088	0.070	0.018	0.018	0.128	0.126	0.036	0.057	0.052	0.104	0.152	0.053	0.034	
Wong Tai Sin	7	7	6	4	11	6	5	7	5	4	3	3	6	**74 (5.6%)**
	0.102	0.103	0.093	0.065	0.187	0.103	0.087	0.122	0.091	0.075	0.054	0.054	0.109	
Kwun Tong	7	8	9	7	9	4	10	6	8	7	8	9	2	**94 (7.1%)**
	0.073	0.083	0.095	0.074	0.095	0.042	0.104	0.064	0.088	0.077	0.086	0.095	0.021	
NEW TERRITORIES														
Kwai Tsing	10	8	15	7	8	6	2	5	8	4	5	8	6	**92 (6.9%)**
	0.115	0.092	0.175	0.086	0.102	0.079	0.027	0.069	0.118	0.057	0.068	0.111	0.085	
Tsuen Wan	4	5	0	3	6	1	4	2	4	2	7	2	1	**41 (3.1%)**
	0.083	0.095	0.000	0.058	0.119	0.020	0.085	0.042	0.086	0.043	0.159	0.046	0.023	
Tuen Mun	8	7	13	13	8	11	7	3	6	4	7	5	9	**101 (7.6%)**
	0.083	0.079	0.153	0.162	0.104	0.150	0.099	0.044	0.087	0.057	0.105	0.074	0.130	

Residential District	No. of Cases / Death Rate*													
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total (%)
Yuen Long	10	9	12	15	14	10	13	14	9	10	19	13	2	**150 (11.3%)**
	0.083	0.077	0.105	0.135	0.130	0.096	0.128	0.142	0.095	0.106	0.213	0.142	0.022	
North	6	2	6	6	10	6	2	7	3	4	4	4	2	**62 (4.7%)**
	0.104	0.035	0.108	0.109	0.191	0.122	0.041	0.153	0.067	0.085	0.083	0.083	0.042	
Tai Po	5	2	6	7	2	3	4	5	2	5	2	2	2	**47 (3.5%)**
	0.091	0.041	0.128	0.161	0.048	0.074	0.100	0.132	0.052	0.125	0.047	0.047	0.046	
Sha Tin	7	3	11	6	9	9	6	7	7	8	7	6	4	**90 (6.8%)**
	0.069	0.030	0.113	0.064	0.099	0.100	0.068	0.080	0.081	0.090	0.076	0.064	0.043	
Sai Kung	11	7	3	9	4	6	10	3	3	6	4	6	6	**78 (5.9%)**
	0.139	0.090	0.039	0.122	0.055	0.084	0.140	0.044	0.044	0.090	0.062	0.093	0.095	
Islands	3	2	1	4	5	2	3	2	2	5	5	1	0	**35 (2.6%)**
	0.094	0.065	0.032	0.131	0.164	0.075	0.111	0.078	0.077	0.188	0.223	0.045	0.000	
OTHERS														
Not residing in HK	9	6	7	6	9	11	10	7	2	1	3	3	3	**77 (5.8%)**
Unknown	0	3	5	1	4	2	1	2	1	0	0	0	1	**20 (1.5%)**
Total	**117**	**92**	**119**	**119**	**128**	**110**	**113**	**99**	**83**	**87**	**106**	**90**	**63**	**1 326 (100.0%)**

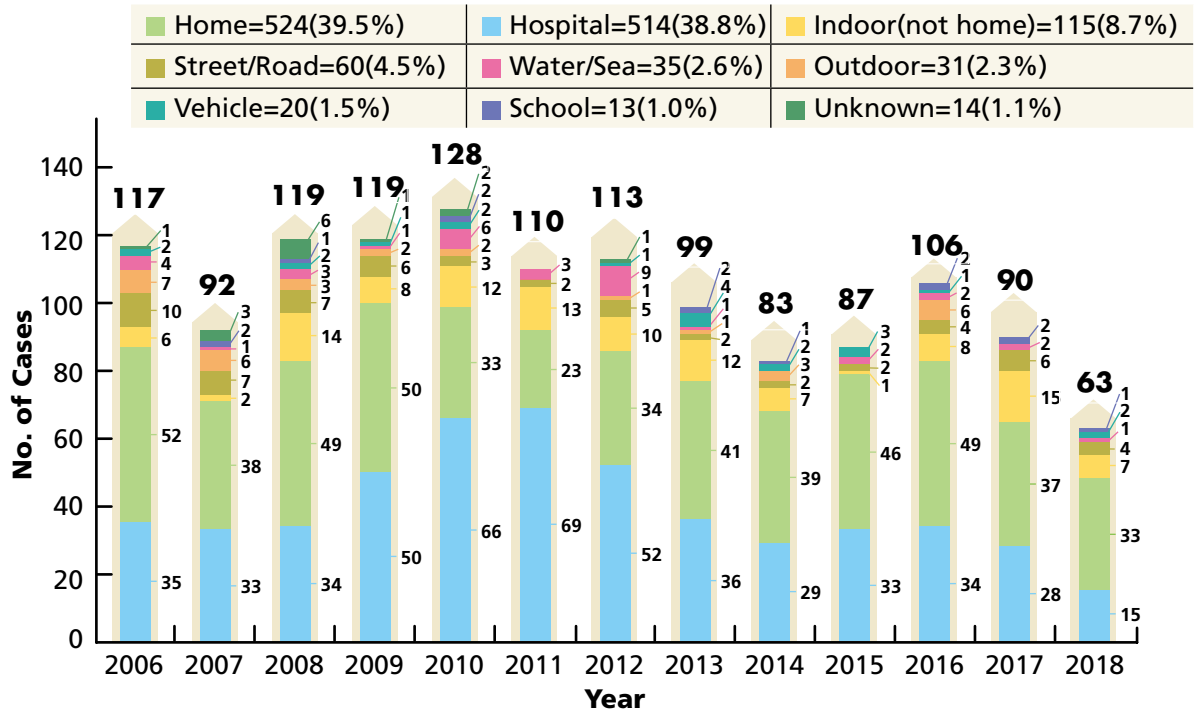
** denotes district-specific child death rate, i.e. child death cases reviewed per 1 000 land-based non-institutional child population in respective district.*

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

Yuen Long District recorded the highest number of child deaths (N=150, 11.3%), followed by Tuen Mun District (N=101, 7.6%) and Kwun Tong District (N=94, 7.1%)

The lowest number of child deaths (N=11, 0.8%) was in Wan Chai District. Families of 77 deceased children (5.8%) were not residing in Hong Kong or taking Hong Kong as their usual place of residence.

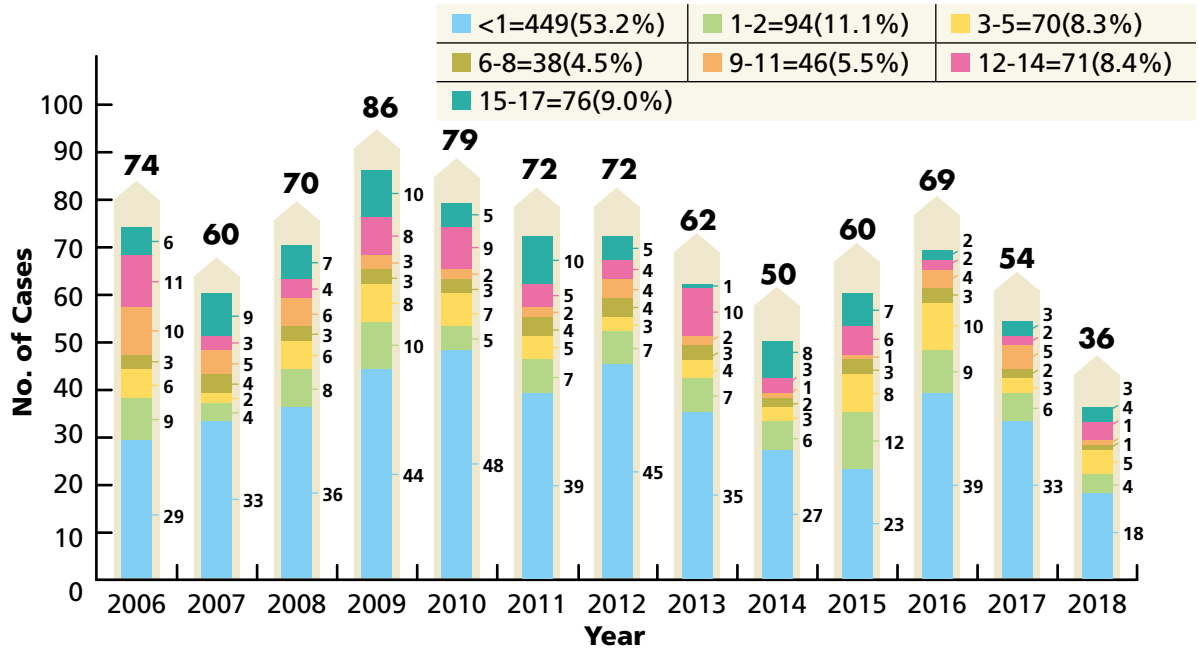
Chart 10.1.6: Number of Cases by Place of Fatal Incident



Home was the most common place for the occurrence of fatal incidents (N=524, 39.5%), followed by Hospital (N=514, 38.8%) due to natural causes and Indoor (not home) (N=115, 8.7%)

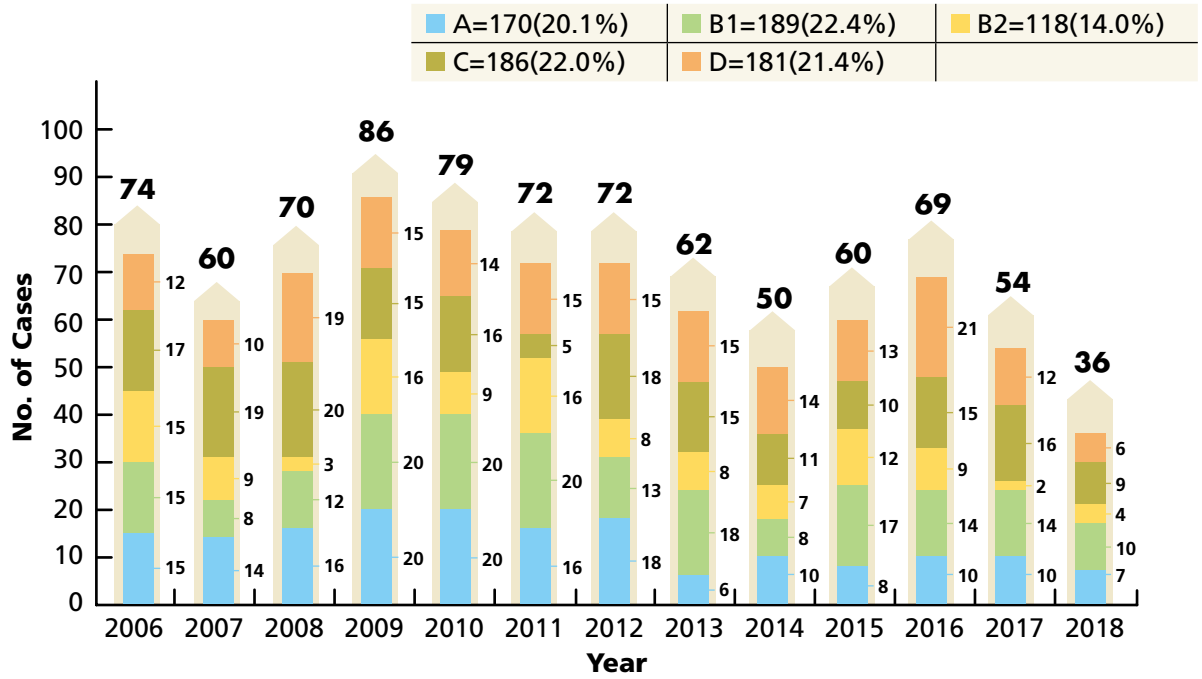
10.2 Statistics of Natural Cause Cases

Chart 10.2.1: Number of Cases by Year and Age Group



The highest number of natural child deaths occurred among children aged below 1 (N=449, 53.2%), followed by the age groups of 1-2 (N=94, 11.1%) and 15-17 (N=76, 9.0%).

Chart 10.2.2: Number of Cases by Year and Death Category*

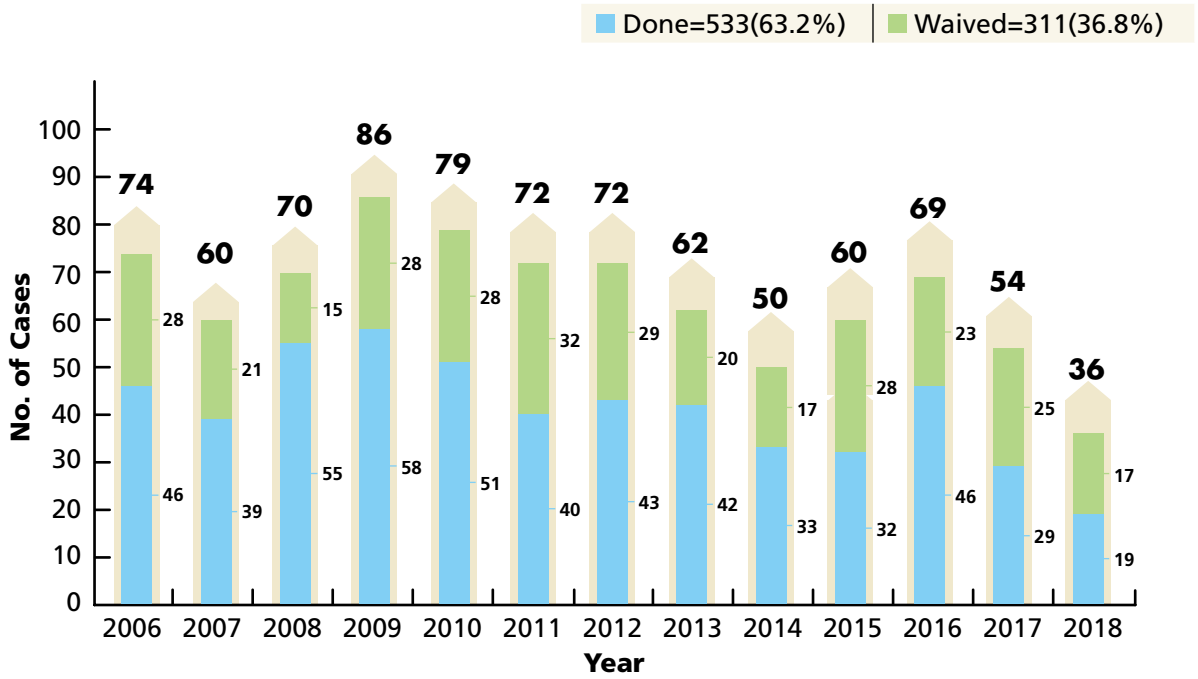


* *These categories of death, with content listed below, are designed by the medical experts of the Review Panel for review purpose:*

A – *Neo-natal Conditions*
B – *Chronic Medical Conditions*
B1 – *with mental or physical disabilities*
B2 – *without mental or physical disabilities*
C – *Acute Medical Conditions*
D – *Others, including:*
Unidentifiable Aetiology
SUDI (Sudden and Unexpected Death in Infancy)
Stillbirth

Category B (chronic medical conditions) constituted the highest number of child deaths (N=307, 36.4%). Under this category, there were two sub-categories including cases with mental or physical disabilities (N=189, 22.4%) and cases without mental or physical disabilities (N=118, 14.0%). Category C (acute medical conditions) constituted the second highest number of child deaths (N=186, 22.0%) while Category D (Others) constituted the third highest number of child deaths (N=181, 21.4%).

Chart 10.2.3: Number of Cases by Year and with Autopsy Done or Waived*

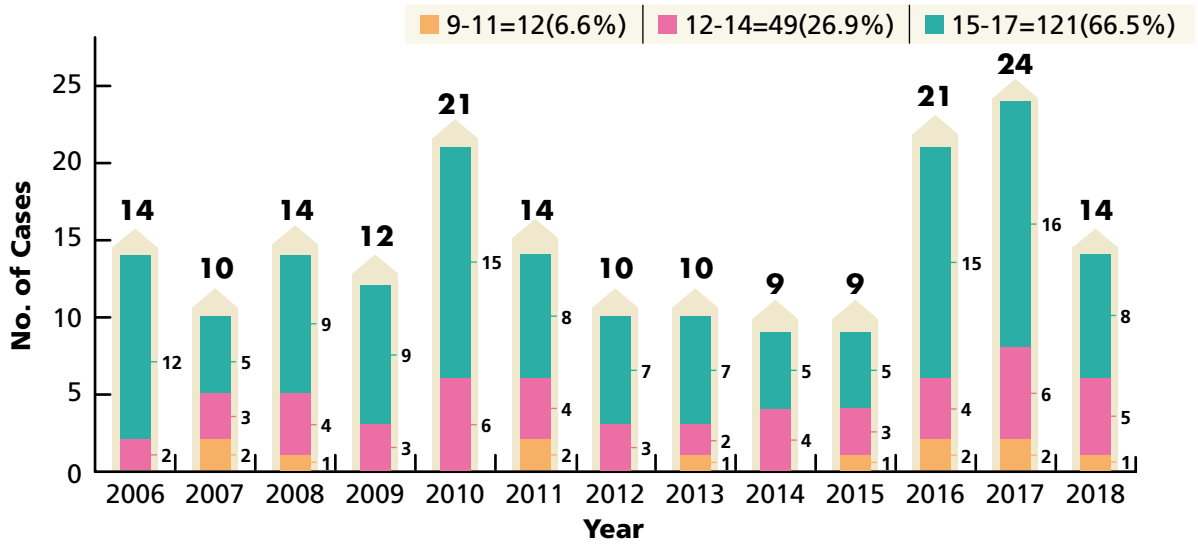


* *Source: According to information search at the Coroner's Court.*

Autopsy had been done for 533 cases (63.2%) and waived for 311 cases (36.8%).

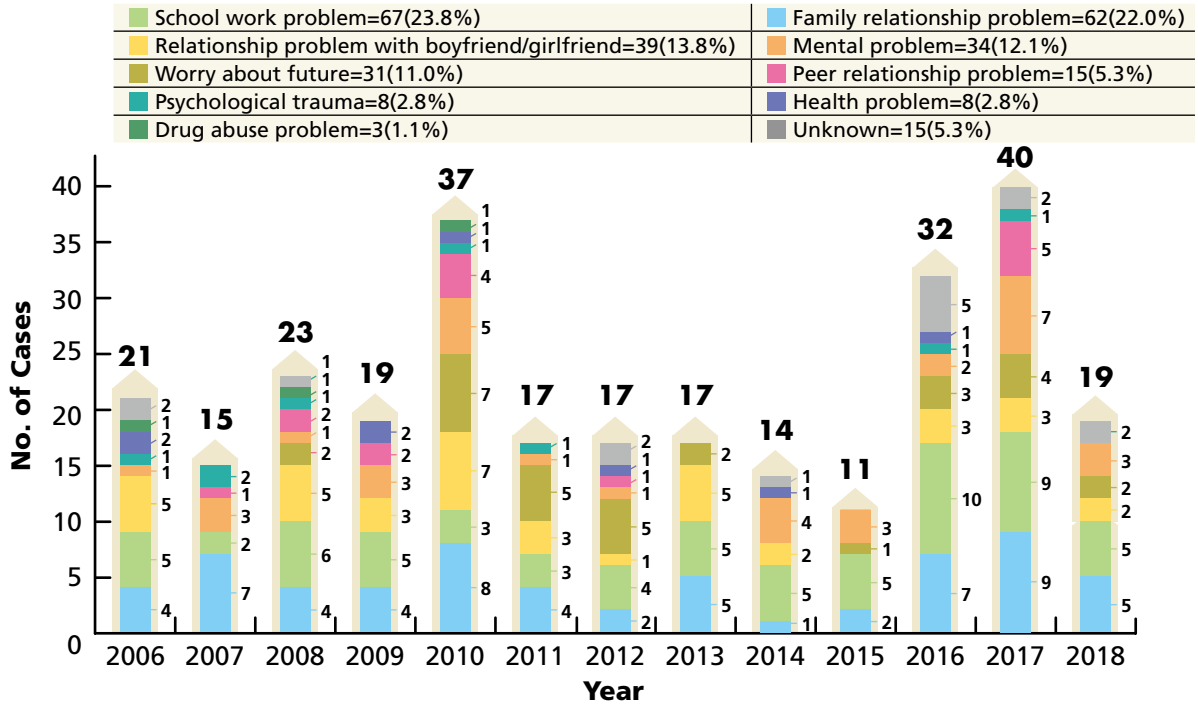
10.3 Statistics of Suicide Cases

Chart 10.3.1: Number of Cases by Year and Age Group



The highest number of suicide deaths occurred among children aged 15-17 (N=121, 66.5%), followed by the age group of 12-14 (N=49, 26.9%) and 9-11 (N=12, 6.6%).

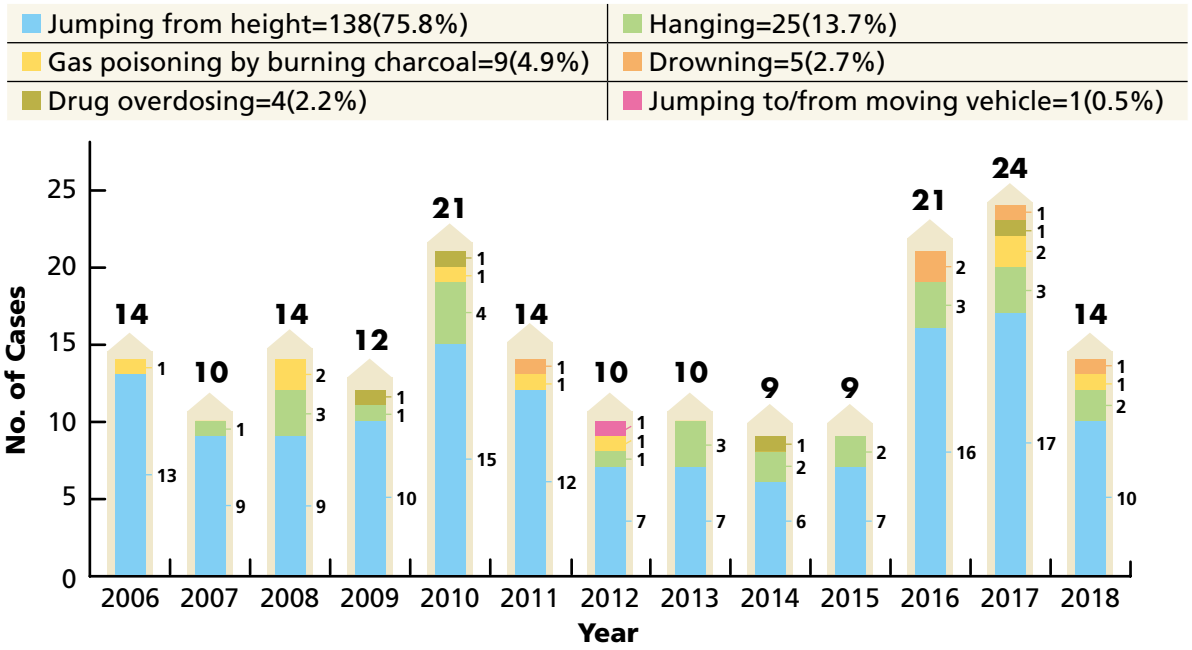
Chart 10.3.2: Number of Cases by Year and Reasons* for Committing Suicide



* *Note: More than one reason is allowed. The reasons were identified in the police death investigation reports of the reviewed cases.*

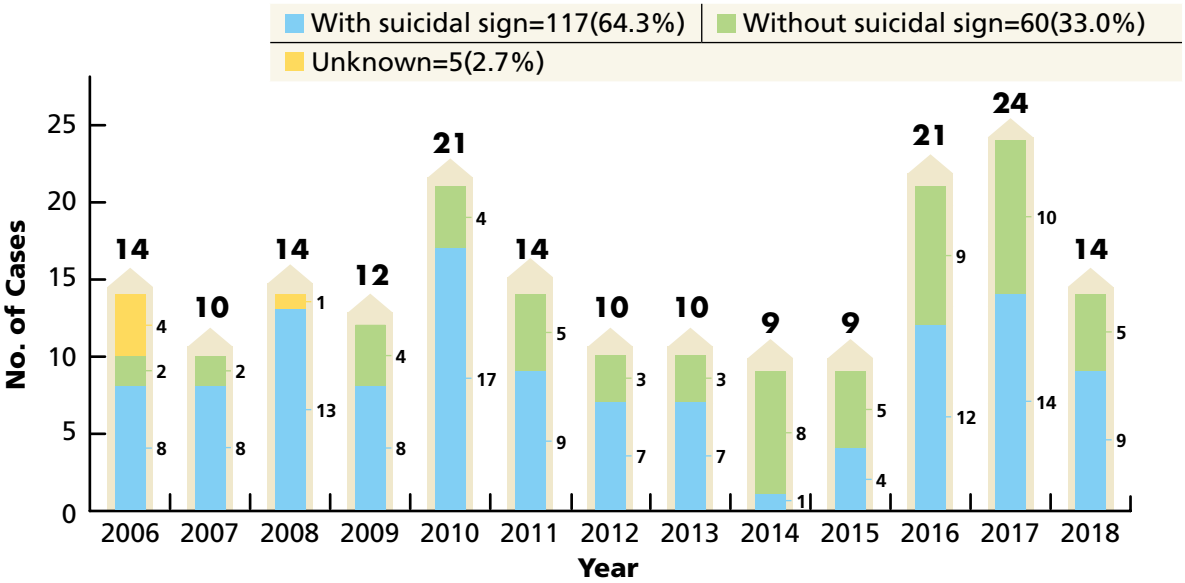
The most common reasons for the deceased children to commit suicide were school work problem (N=67, 23.8%), followed by family relationship problem (N=62, 22.0%) and relationship problem with boyfriend/girlfriend (N=39, 13.8%).

Chart 10.3.3: Number of Cases by Year and Means of Committing Suicide



Most of the deceased children committed suicide by jumping from height (N=138, 75.8%), followed by hanging (N=25, 13.7%) and gas poisoning by burning charcoal (N=9, 4.9%).

Chart 10.3.4: Number of Cases by Year and Identified Suicidal Signs*

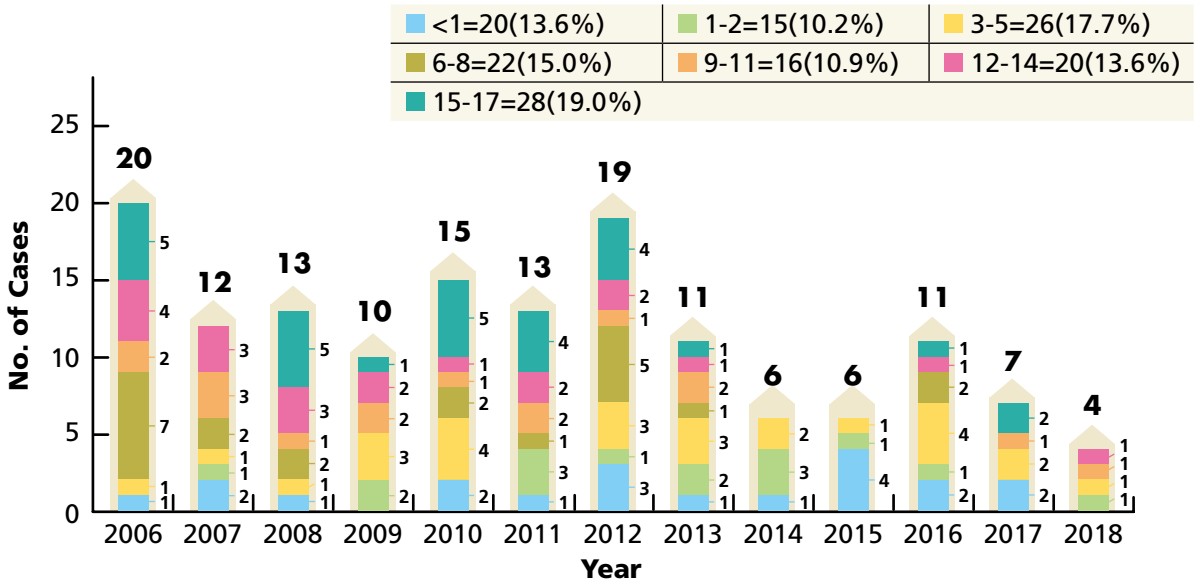


* *Signs: Include leaving suicidal notes; emotional / violent acts; verbal expression / threatening of suicidal intention and past history of suicidal attempts. (The signs were identified through police investigation reports.)*

The majority of children who committed suicide (N=117, 64.3%) had expressed their suicidal thoughts in one way or other before actual attempts.

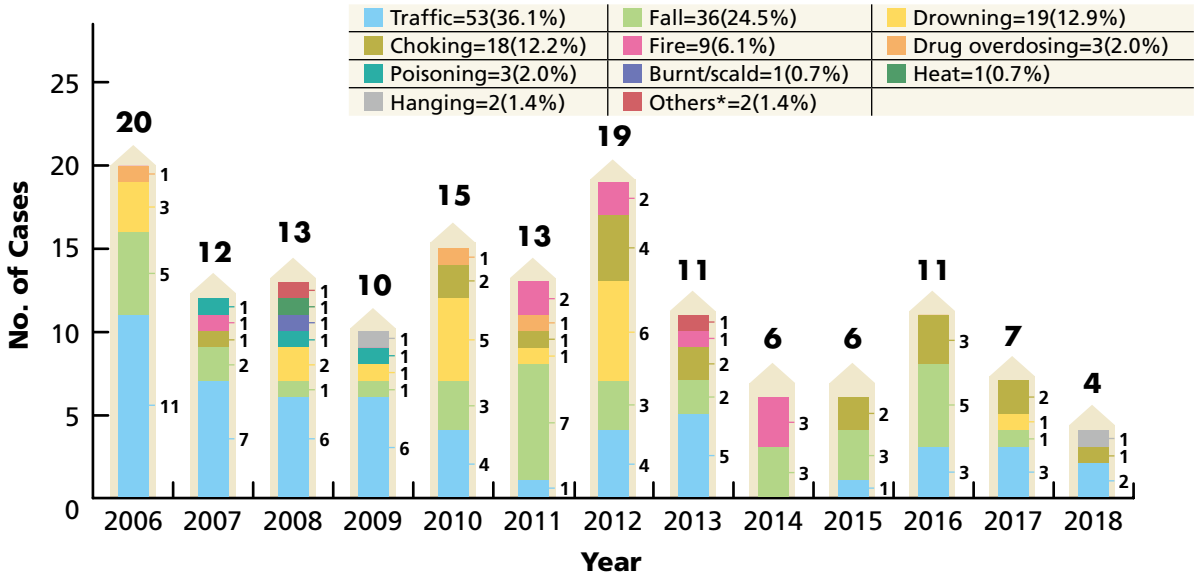
10.4 Statistics of Accident Cases

Chart 10.4.1: Number of Cases by Year and Age Group



The highest number of child deaths occurred in the age group of 15-17 (N=28, 19.0%), followed by the age groups of 3-5 (N=26, 17.7%) and 6-8(N=22, 15.0%).

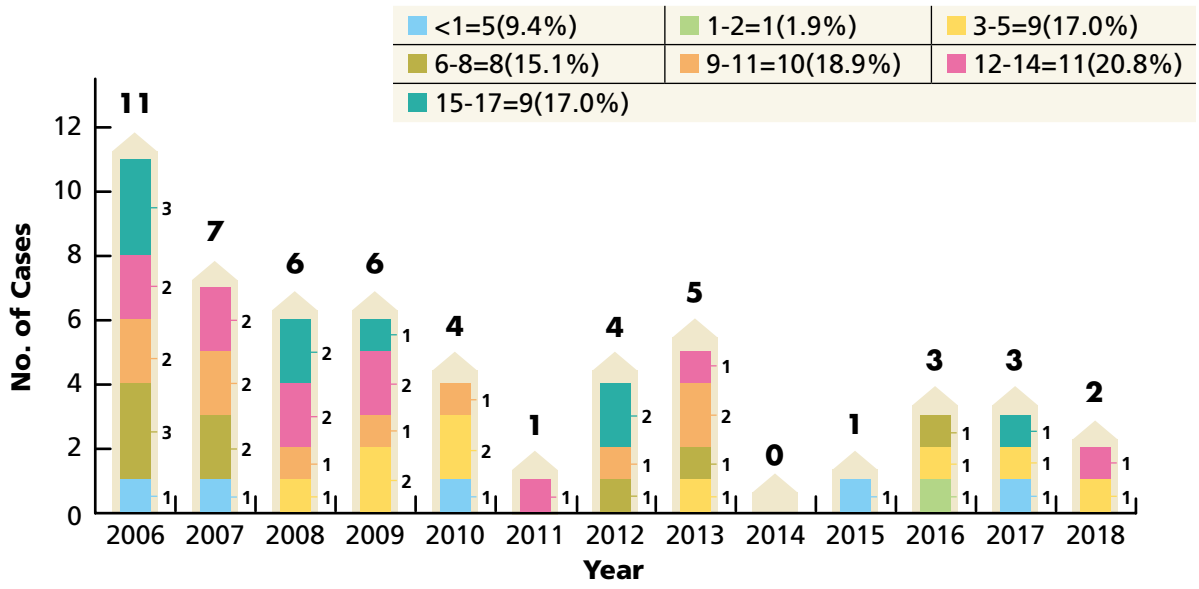
Chart 10.4.2: Number of Cases by Year and Type of Accident



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

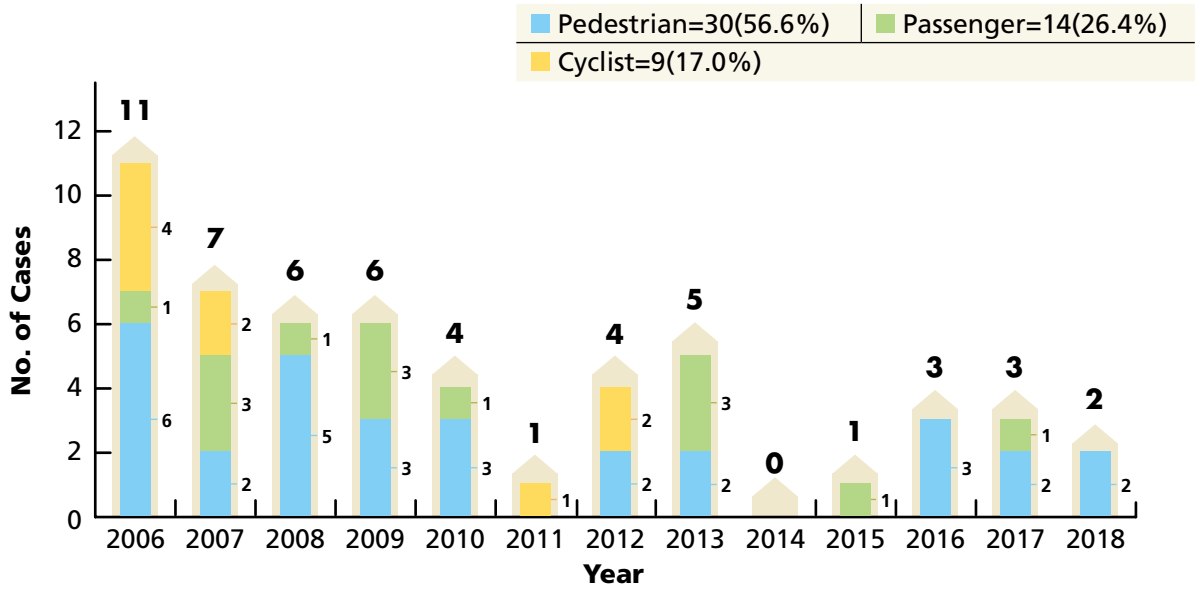
Traffic accident (N=53, 36.1%) was the leading cause of accident death, followed by fall (N=36, 24.5%) and drowning (N=19, 12.9%).

Chart 10.4.3: Number of Traffic Accident Cases by Year and Age Group



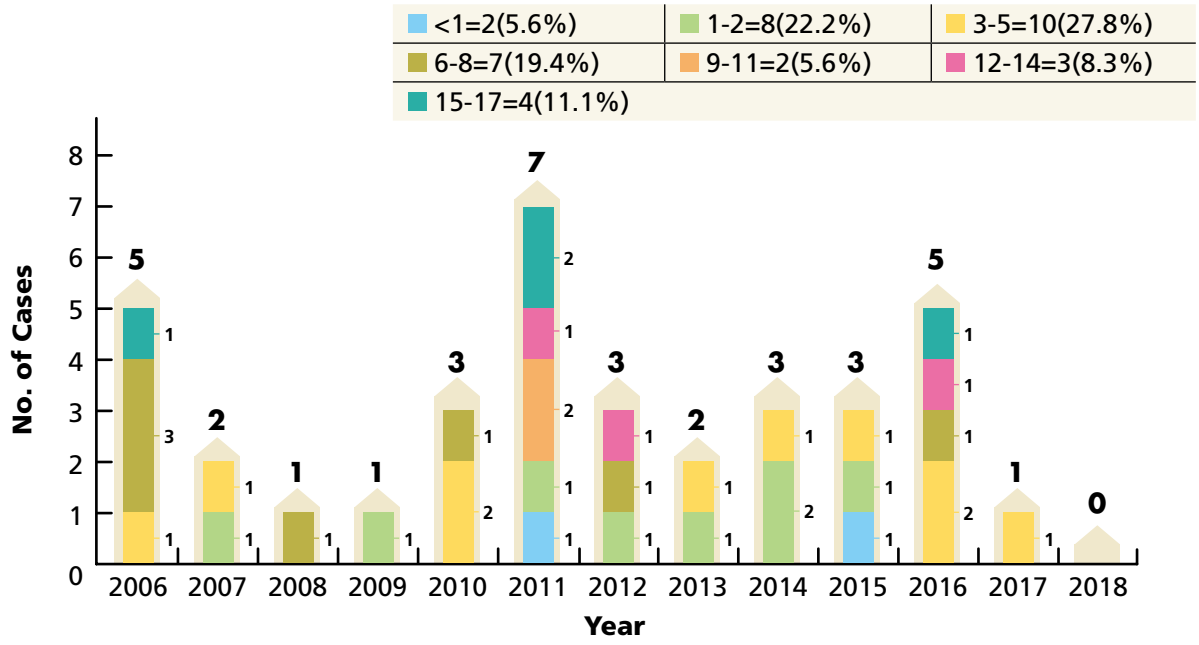
The highest number of child deaths caused by traffic accident occurred in the age group of 12-14 (N=11, 20.8%), followed by the age group of 9-11(N=10, 18.9 %) and both the age group of 15-17 (N=9, 17.0%) and the age group of 3-5 (N=9, 17.0%).

Chart 10.4.4: Number of Cases by Year and Type of Traffic Victim



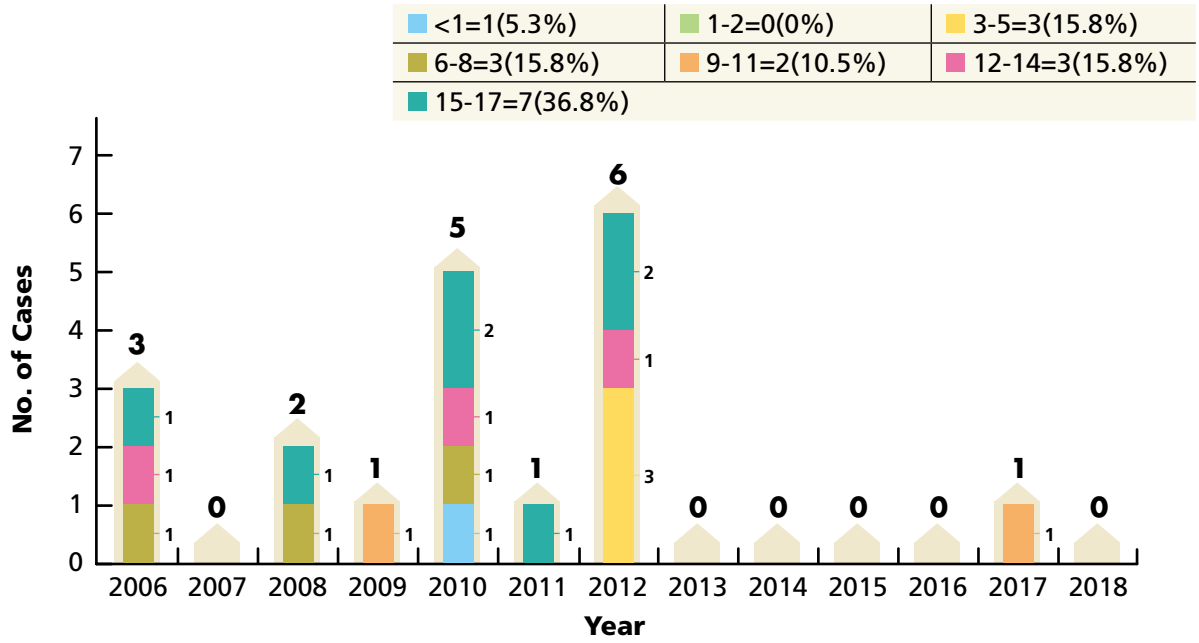
The highest number of traffic victims were pedestrian (N=30, 56.6%), followed by passenger (N=14, 26.4%) and cyclist (N=9, 17.0%).

Chart 10.4.5: Number of Fall Accident Cases by Year and Age Group



The highest number of child deaths caused by fall accident occurred in the age group of 3-4 (N=10, 27.8%), followed by the age groups of 1-2 (N=8, 22.2%) and 6-8(N=7, 19.4%).

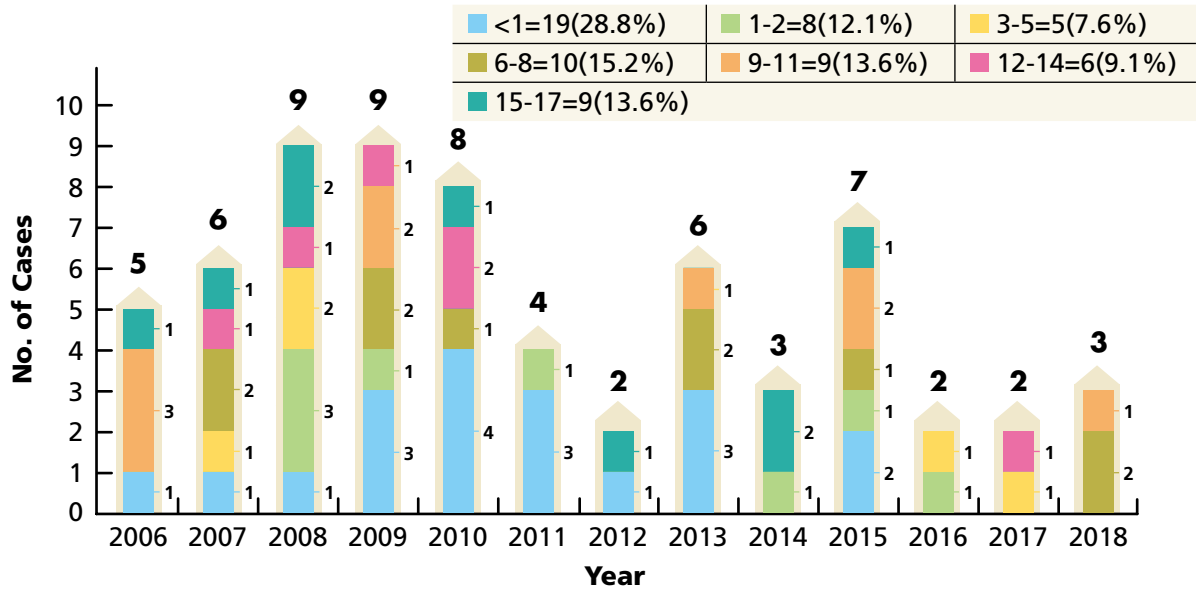
Chart 10.4.6: Number of Drowning Accident Cases by Year and Age Group



The highest number of child deaths caused by drowning occurred in the age group of 15-17 (N=7, 36.8%) while three age groups of 3-5, 6-8 and 12-14 recorded the same number of deaths (N=3, 15.8%).

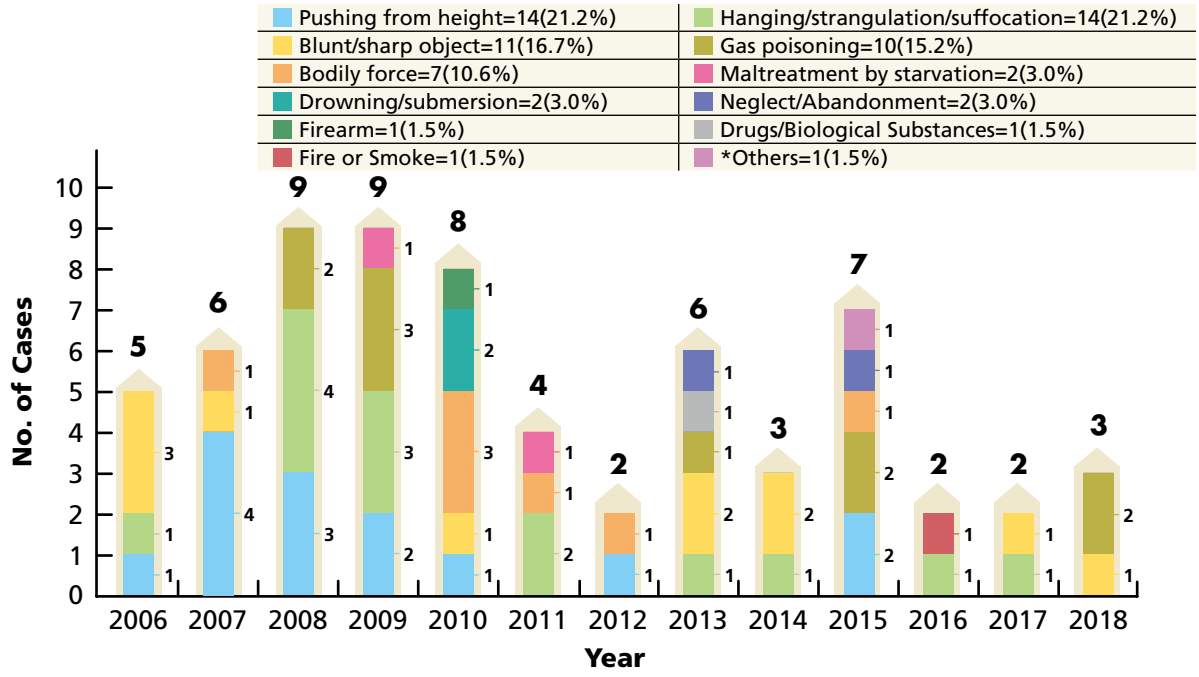
10.5 Statistics of Assault Cases

Chart 10.5.1: Number of Cases by Year and Age Group



The highest number of child deaths caused by assault occurred in the age group of <1 (N=19, 28.8%), followed by the age group of 6-8 (N=10, 15.2%) and then both the age groups of 9-11 and 15-17 with the same number of deaths (N=9, 13.6%).

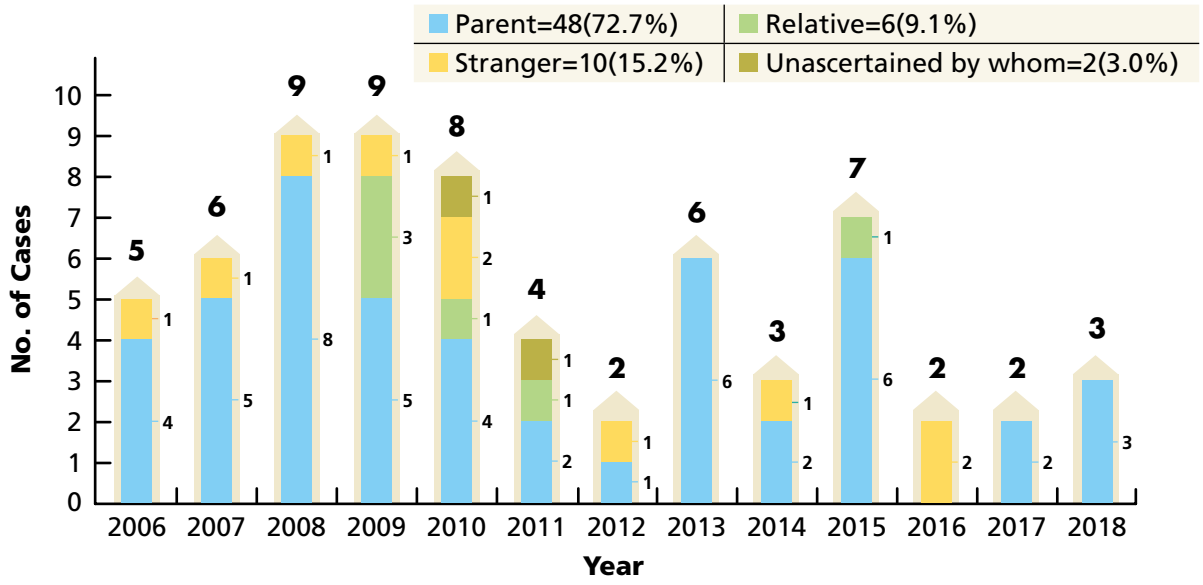
Chart 10.5.2: Number of Cases by Year and Type of Assault



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

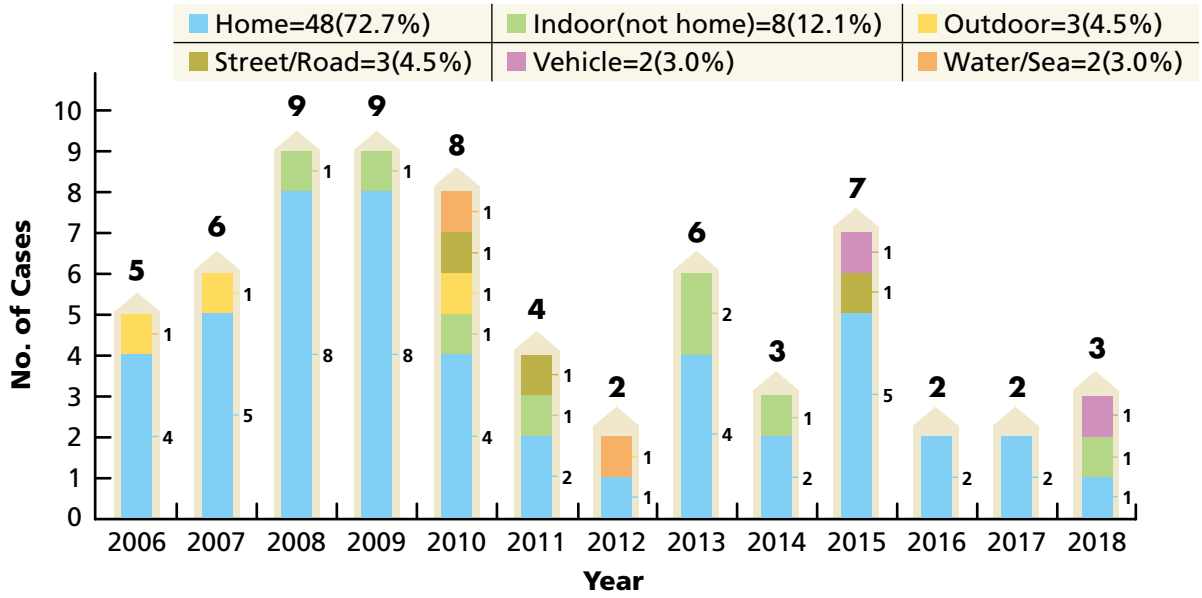
The highest number of types of assault was pushing from height and hanging/strangulation/suffocation (both N=14, 21.2%), followed by blunt/sharp object (N=11, 16.7%) and by gas poisoning (N=10, 15.2%).

Chart 10.5.3: Number of Cases by Year and Perpetrator's Relationship with the Deceased Child



Most of the perpetrator were parent (N=48, 72.7%), followed by stranger (N=10, 15.2%) and relative (N=6, 9.1%).

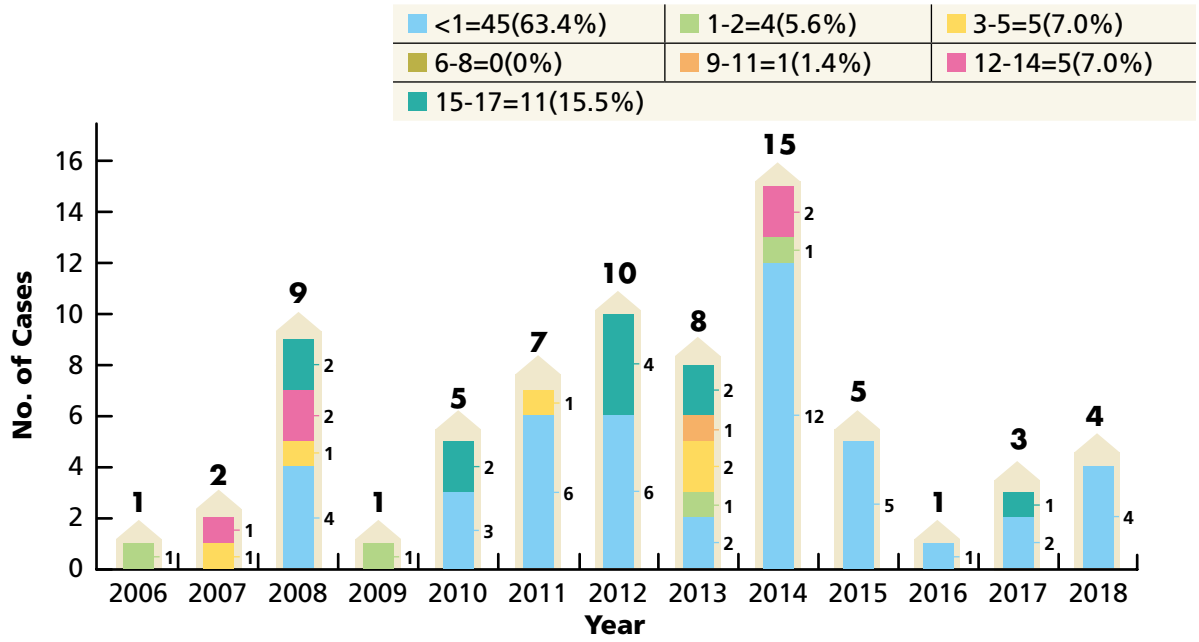
Chart 10.5.4: Number of Cases by Year and Place of Incident



Most of the assault incidents occurred at home (N=48, 72.7%), followed by indoor (not home) (N=8, 12.1%) and both outdoor (N=3, 4.5%) and street/road (N=3, 4.5%).

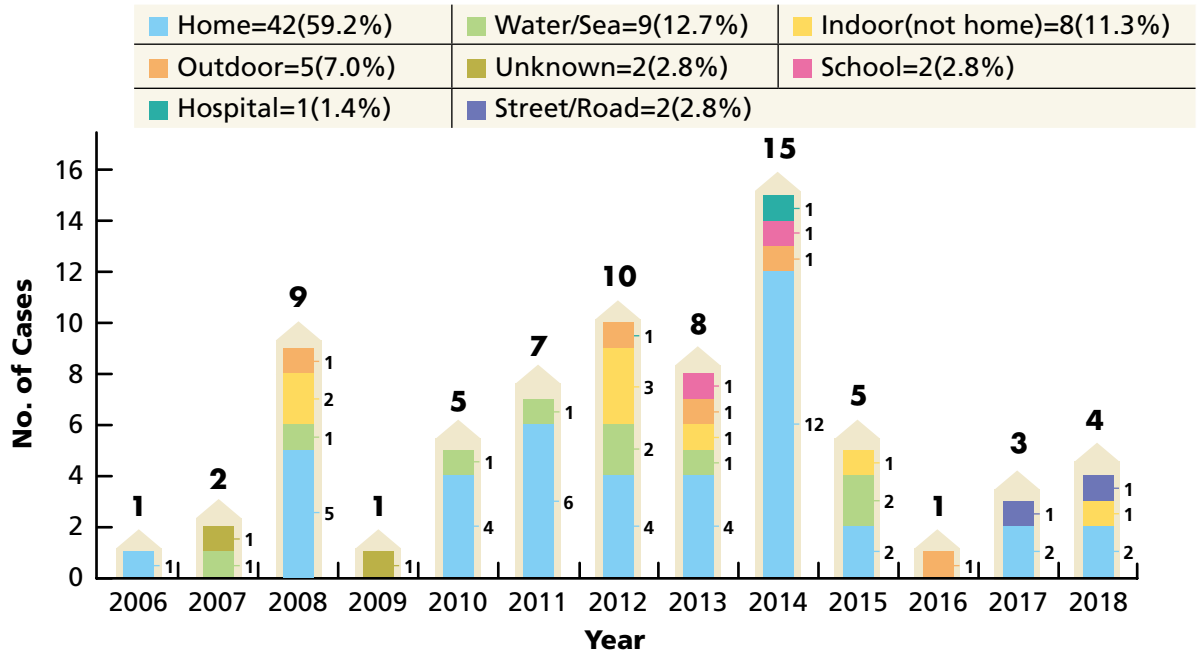
10.6 Statistics of Non-natural Unascertained Cause Cases

Chart 10.6.1: Number of Cases by Year and Age Group



The highest number of child deaths occurred in the age group of <1 (N=45, 63.4%), followed by the age group of 15-17 (N=11, 15.5%) and both age groups of 3-5 (N=5, 7.0%) and 12-14(N=5, 7.0%).

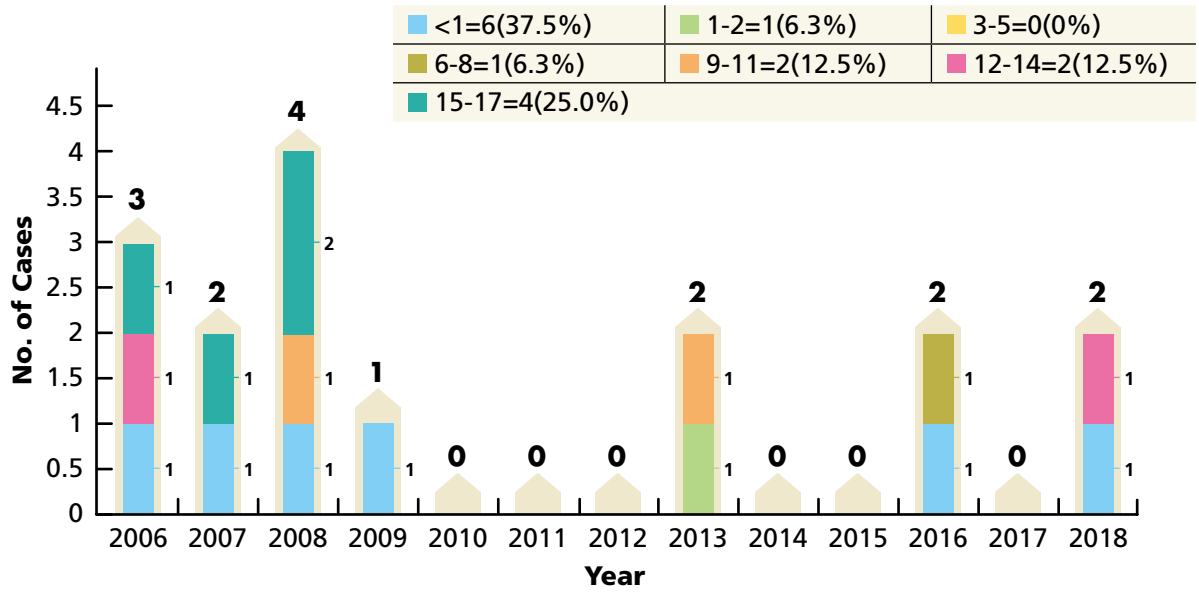
Chart 10.6.2: Number of Cases by Year and Place of Fatal Incident



Home was the most common place for the occurrence of unascertained death (N=42, 59.2%), followed by Water/Sea (N=9, 12.7%) and Indoor (not home) (N=8, 11.3%).

10.7 Statistics of Cases with Causes Related to Medical Complication

Chart 10.7.1: Number of Cases by Year and Age Group



The highest number of child deaths occurred in the age group of <1 (N=6, 37.5%), followed by the age group of 15-17 (N=4, 25.0%) and both the age groups of 9-11 (N=2, 12.5%) and 12-14 (N=2, 12.5%).

11 APPENDICES

Appendix 11.1 List of Child Fatality Review Panel Members

The current Chairman of the Review Panel is Dr DUNN Lai-wah, Eva[1], M.H. who succeeded Mr HUI Chung-shing, Herman[2], S.B.S., M.H., J.P., while the current Group Convenor of Medical cases is Dr LI Chak-ho, Rever, who succeeded Dr LEE Lai-ping[3]. The current members of the Review Panel are:

	Name	Profession/ Discipline	Position
1	Dr DUNN Lai-wah, Eva, M.H.	Medical (Psychiatry)	Chairman
2	Dr LI Chak-ho, Rever	Medical (Paediatrics)	Group Convenor of Medical Cases
3	Dr TANG Chun-pan	Medical (Psychiatry)	Group Convenor of Suicide Cases
4	Mr TANG Chee-ho, Alric	Legal	Group Convenor of Accident Cases
5	Dr SZE Mei-lun, Angela	Clinical Psychology	Group Convenor of Assault and Miscellaneous Cases
6	Dr BEH Swan-lip, Philip	Medical (Forensic Pathology)	Member
7	Ms CHAN Siu-lai	Social Welfare	Member
8	Dr CHENG Wai-fun, Anna	Medical (Paediatrics)	Member
9	Dr CHUI Mo-ching, Eileena	Medical (Psychiatry)	Member
10	Dr FUNG Lai-chu, Annis	Academia	Member
11	Ms HO Wai-ling	Education	Member
12	Ms HSU Siu-man	Social Welfare	Member
13	Mr JAO Ming, Raymond	Parent Representative	Member
14	Mr LEUNG Shek-lim, Steven	Legal	Member
15	Dr SHIU Yiu-keung	Medical (Paediatrics)	Member
16	Prof SIU Fung-ying, Angela	Academia	Member
17	Ms WONG Shuk-fan, Luparker	Education	Member
18	Dr WONG Suet-na, Sheila	Medical (Paediatrics)	Member

[1] *Dr DUNN has been the Chairman since June 2021, and was a Group Convenor of Suicide Cases from June 2017 to May 2018 and a member from June 2012 to May 2017.*

[2] *Mr HUI chaired the Review Panel from June 2015 to May 2021, and was a member from June 2011 to May 2015. He was also a member of the Pilot Project on Child Fatality Review implemented from February 2008 to February 2011.*

[3] *Dr LEE was a Group Convenor of Medical Cases from June 2019 to May 2021, and a member from June 2015 to May 2019.*

Appendix 11.2 Terms of Reference

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

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

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

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

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

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

Appendix 11.3 Information Brief on Child Fatality Review

Background

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

Purpose

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

Objectives

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

Levels and Scope

1. All cases with children aged under 18 who died on or after 1 January 2008 and were reported to the Coroner with all criminal and judicial processes completed so as to avoid prejudicing such processes.

2. Cases not reported to the Coroner but worthy of examination.

The Standing Review Mechanism

1. A non-statutory Child Fatality Review Panel (CFRP), with members appointed by the Director of Social Welfare will conduct review with secretariat support from the SWD.

2. The Secretariat will obtain the list of cases and relevant information from different sources for review by the CFRP. The review is primarily documentary in nature, supplemented by use of other means such as focus group or interview with concerned parties where necessary.

3. Organisation(s) that had rendered service(s) to the deceased child or his / her family could facilitate the review by reporting child death or providing service reports to the CFRP. Relevant forms can be obtained from the Secretariat upon request.

4. A database of child death cases is set up to facilitate the review and for future statistical or research purpose of the CFRP.

5. The review findings and recommendations of the CFRP will be released to the public through integrative reports. Recommendations will be distributed to relevant parties / organisations for feedback, consideration and follow-up action.

6. Where appropriate, the CFRP will request the organisations concerned to provide update of the progress of implementation of improvement measures.

7. No details of individual cases or particulars of persons or agencies concerned will be included in CFRP's report to ensure strict confidentiality. Information furnished by organisation(s) to the Secretariat will be used for the purpose of conducting child fatality review only. Such information will be kept strictly confidential and will not be disclosed without the prior consent of the organisation(s) concerned unless its disclosure is authorised or required by law. The information collected will be destroyed upon completion of review.

Reports of the Child Fatality Review Panel

The Child Fatality Review Panel has completed the review of child death cases which occurred from 2008 to 2013 and published its First Report, Second Report and Third Report and Fourth Report in May 2013 and July 2015, August 2017 and May 2019 respectively. The reports are available at websites:

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

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

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

https://www.swd.gov.hk/storage/asset/section/2867/en/CFRP_Fourth_Report_en_Nov2019.pdf

Enquiries

Secretariat / Child Fatality Review Panel
Room 721, Wu Chung House, 213 Queen's Road East, Wan Chai, Hong Kong
Tel. No.: 3468 2140 E-mail: *srp@swd.gov.hk*

Appendix 11.4 20 Categories of Deaths Reportable to the Coroners

20 Categories of Reportable Deaths

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

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

Appendix 11.5 Extract of the Code of Professional Conduct promulgated by the Medical Council of Hong Kong

Code of Professional Conduct
For the Guidance of Registered Medical Practitioners

9. Prescription and labelling of dispensed medicines

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

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

(a) name of prescribing doctor or proper means of identifying him;

(b) full name of the patient, except where the full name is unusually long (in which case the family name and such part of the given name or initials sufficient to identify the patient should be written);

(c) date of dispensing;

(d) name of medicine, which can be either:-

(i) the name of the medicine as it is registered with the Pharmacy and Poisons Board of Hong Kong and shown in the Compendium of Pharmaceutical Products published by the Department of Health; or

(ii) the generic, chemical or pharmacological name of the medicine;

(e) method of administration;

(f) dosage to be administered;

(g) strength and/or concentration of the medicine where applicable; and

(h) precautions where applicable.

10. Supply of dangerous or scheduled drugs

10.1 Doctors are advised to acquaint themselves with the Guidelines on Proper Prescription and Dispensing of Dangerous Drugs at Appendix E.

Guidelines on Proper Prescription and Dispensing of Dangerous Drugs

A. Application of Guidelines

1. This set of guidelines applies to the use of psychoactive substances with known potential for abuse as set out in Schedule 1 to the Dangerous Drugs Ordinance ("Dangerous Drugs"), for example, opioids like methadone (Physeptone), dipipanone (Wellconal), fentanyl (Durogesic, Fentanyl); benzodiazepines like diazepam (Diazemuls, Valium), triazolam (Halcion), flunitrazepam (Rohypnol), midazolam (Dormicum); and other psychoactive agents like phentermine (Duromine), ketamine (Ketalar) or methylphenidate (Ritalin or Concerta).

2. These guidelines reflect currently accepted professional standards on the use of Dangerous Drugs in the local context, and are intended to provide general guidance to medical practitioners for the promotion of good clinical practice.

3. The Practice Directions at the Annex below should be followed. Breach of these directions may be construed as improper use of Dangerous Drugs.

B. General Principles

1. The medical practitioner should be familiar with updated knowledge and guidelines on the use of Dangerous Drugs.

2. The medical practitioner should abstain from prescribing at the sole request of the patient Dangerous Drugs that are not medically justified by his condition.

3. Dangerous Drugs should be prescribed with due caution in order to avoid misuse and/or iatrogenic dependence.

4. Dangerous Drugs should only be prescribed after proper clinical assessment and diagnosis.

5. Dangerous Drugs should be prescribed within the range of therapeutic dosage and for such duration as necessary for the clinical condition being treated.

6. Simultaneous use of multiple Dangerous Drugs should be properly assessed and justified. Justification should be clearly documented.

7. The prescription, dispensing and/or administration of Dangerous Drugs should be carefully organized so as to avoid stock piling, resale or other inappropriate use by the patient.

8. An adequate and proper medical record should always be kept concerning the treatment of the patient with Dangerous Drugs.

9. Special clinical problems deserve expert advice. Appropriate referral to specialists or programmes should always be considered.

10. All medical practitioners should comply with all the provisions in the Dangerous Drugs Ordinance and Regulations.

C. Handling of Dangerous Drugs Dependence

Doctors who use Dangerous Drugs for the management of patients who have become dependent on such drugs ("Dependents on Dangerous Drugs") should ensure the following:-

1. They should have relevant training or experience in the management of drug dependence.

2. They should keep themselves updated with relevant guidelines/information published by appropriate professional bodies.

3. Appropriate referral should be made to substance abuse clinics, drug addiction counselling centres, and other available services or facilities in the community with resources and support for a comprehensive care (including physical, psychological, and social aspects) for Dependents on Dangerous Drugs. More information can be found in the website of Narcotics Division of the Security Bureau.

4. Dependents on Dangerous Drugs should be ensured attentive and conscientious care by the attending medical practitioner. Medical practitioners must know their limitations.

5. In every case, the attending doctor should assess the patient thoroughly, formulate a suitable management plan, keep an adequate medical record concerning the treatment of the patient with Dangerous Drugs and monitor the outcome.

D. High-Volume Consumption

Significant social harm can be caused by misuse of Dangerous Drugs supplied by medical practitioners or the inadvertent flow of such drugs into the "black market". These are especially prone to occur, when Dangerous Drugs are used in large quantities on out-patient basis in non-programme settings. To fulfill our social obligation and to avoid disrepute to our profession, the following measures are considered essential for all medical practitioners regularly prescribing large quantities of Dangerous Drugs:-

1. The use of Dangerous Drugs should be reviewed regularly to ensure that their use meets the standards as stipulated in sections B and C. In every case, the use or continued use of Dangerous Drugs should be adequately accounted for. Dangerous Drugs should be withdrawn appropriately wherever their use is considered ineffective, inappropriate, or unnecessary.

2. Careful measures should be taken to guard against misuse of Dangerous Drugs so supplied. Examples of such measures may include:-

   (a) the dosage should be within therapeutic range. Strong justification should be properly documented if it exceeds the therapeutic range.

   (b) regular follow-up assessment, preferably monthly. Exceptions with appropriate justification could be allowed.

   (c) minimize the quantity of Dangerous Drugs dispensed per visit, bearing in mind that the practitioner has the responsibility to decide the proper medication with appropriate duration and justification.

   (d) detailed record of justification and prescription.

   (e) direct supervision of drug-taking where possible.

   (f) random urine checking.

   (g) notification to Central Registry of Drug Abuse with patient's consent.

   (h) other measures as appropriate, e.g. referral to appropriate specialists (e.g. to pain clinic for patients in chronic pain), regular checking of unfinished drugs.

3. If a medical practitioner is not satisfied with the measures he has taken in relation to sections D.1 and D.2, he should seek advice and assistance from the "Advisory Committee on the Use of Psychoactive Agents" of the Hong Kong Medical Association. Continued use of large quantities of Dangerous Drugs cannot be accepted as proper medical practice, unless reasonable measures have been taken against possible misuse.

Annex – Practice Directions for the Use of Dangerous Drugs

The following Practice Directions for selected Dangerous Drugs should be followed.

1. Practice Directions for use of benzodiazepines

   (a) Initial assessment of the patient should include:-

      (i) proper history and examination

      (ii) appropriate investigation

      (iii) proper diagnosis and/or diagnostic formulation

      (iv) education and counselling

   (b) Patients on benzodiazepines should be informed of the following:-

      (i) Drugs are only part of the management plan;

      (ii) Drug dependence is likely to occur with improper use;

      (iii) Various adverse effects, which include impairment of the performance of skilled tasks and driving;

      (iv) Interactions with drugs and alcohol are potentially dangerous.

   (c) The lowest effective dose with therapeutic range which can control the symptoms should be used.

   (d) In general, initial prescription and/or dispensing of benzodiazepines should be kept to the minimum appropriate dosage and duration.

   (e) For repeated and/or prolonged prescription, there should be a properly documented management plan.

   (f) If the duration of initial treatment is likely to be prolonged, the patient should be properly reassessed periodically. Alternative methods of therapy, if any, may be offered. In case of clinical problems which cannot be adequately dealt with, expert advice should be sought, or patients be referred to appropriate specialists or programmes.

   (g) Benzodiazepines should be prescribed with caution especially to patients under 18 and the elderly in which cases the prescribing doctor should fully justify the use. Such justification should be properly documented.

   (h) Caution should be exercised in the use of benzodiazepines in the treatment of major depression.

(i) Caution should be exercised in prescribing benzodiazepines for patients where there is a history or evidence of alcohol abuse or substance misuse (particularly sedative-hypnotic drugs).

(j) Caution should be exercised in the use of benzodiazepines for bereavement-related problems. A tapering-off regime should be used to minimize benzodiazepine withdrawal symptoms.

(k) Simultaneous use of multiple benzodiazepines should be prescribed with caution and its justification should be documented.

(l) The patient should be regularly monitored. An adequate and proper medical record should be kept concerning the treatment provided to the patient and the outcome.

(m) In addition, the medical practitioner shall comply with all the provisions in the Dangerous Drugs Ordinance and Regulations.

2. Practice Directions on the use of substitute drugs for opioid dependence

(a) Initial assessment of the patient should include:-

(i) proper history and examination

(ii) appropriate investigation

(iii) proper diagnosis and/or diagnostic formulation

(iv) education and counselling

(v) promotion of detoxification programmes

(b) The medical practitioner should inform patients of other treatment modalities available in the community before putting them on long-term maintenance therapy.

(c) Treatment of opioid dependence should be prescribed only after accurate diagnosis. There should be a properly documented management plan given to the patient and accordingly recorded. In the management plan for the use of substitute drugs for opioid dependence, holistic care is important and success of therapy is highly dependent on the trust between the physician and the patient.

(d) The attending doctor should ensure that he is fully competent to provide proper care of patients under his care. Specific training in the management of drug dependence is strongly encouraged for all doctors involved in such work.

(e) The patient should be informed that drugs are only part of the management plan, and should be put in touch with available support for proper social and psychological management.

(f) The patient should be warned of risks of concurrent heroin/drug use. He should be informed of the need for random urine checking.

(g) The prescription, dispensing and/or administration of substitute drugs should be organized in such a way as to avoid stock piling by the patient, resale or other illicit usage. The minimum amount of such substitute drugs as necessary should be supplied.

(h) The patient should be regularly monitored. An adequate and proper medical record should be kept concerning the treatment provided to the patient and the outcome.

(i) Simultaneous use of other Dangerous Drugs should be justified and used with caution. Adequate and proper documentation for the justification is required.

(j) In addition, the medical practitioner shall comply with all the provisions in the Dangerous Drugs Ordinance and Regulations.