FOREWORD

To tie in with the new service development including the re-structuring of the former Child Protective Service Units, the formation of Integrated Children and Youth Services Centres, the re-engineering of family services, and the provision of Student Guidance Service in primary schools, the guidelines on handling child abuse cases by workers of related sectors have to be updated.

The Multi-disciplinary Case Conference on Child Abuse (MDCC) is an important mechanism for handling suspected child abuse cases. In the ‘Procedures for Handling Child Abuse Cases (revised 1998)’ (the Procedures), the ‘Guide to Participants of the Multi-disciplinary Case Conference on Child Abuse’ (the Guide) is provided in Appendix XIX. As there have been concerns raised by parents about the function of the MDCC, the decision-making process, as well as the role and participation of parents, the Guide was revised and put into practice in July 2002 after endorsement by Members of the Task Group on Handling Procedures on Child Sexual Abuse Cases. Subsequently, a Reference Kit was also produced in June 2003 to supplement the Guide and to provide reference for the Chairperson to facilitate him/her to steer the MDCC effectively. When the revised Guide was implemented, Members agreed that it should be further reviewed after the concerned professionals had gained experience after its implementation.

On the other hand, there has been other development in various services for children in the recent years. To further strengthen the effort and collaboration of the different professionals in handling the problem of child abuse, there is a need to revise the Procedures other than those relating to the MDCC. As proposed by the Social Welfare Department, Members of the Committee on Child Abuse (CCA) agreed in the meeting held on 27 January 2004 to review the Procedures. A Task Group was subsequently nominated with representatives from various professions. The Task Group met on 24 occasions and prepared the revised version ‘Procedural Guide for Handling Child Abuse Cases (revised 2007)’ (the Procedural Guide) as follows. The revised version was endorsed by the CCA at its meeting on 20 December 2007.

Making use of advanced technology, this Procedural Guide will be uploaded to the SWD Homepage for reference of all professionals. In the future, updating of any change in factual information will be done by the Social Welfare Department with input from the professionals concerned.
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<td>Accident and Emergency Department</td>
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<tr>
<td>CAIU</td>
<td>Child Abuse Investigation Unit</td>
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<tr>
<td>CCTV</td>
<td>Closed Circuit Television</td>
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<tr>
<td>CP</td>
<td>Clinical psychologist</td>
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<tr>
<td>CP</td>
<td>Clinical Psychologist</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<td>Director of Social Welfare</td>
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<td>DVO</td>
<td>Domestic Violence Ordinance</td>
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<td>EDB</td>
<td>Education Bureau</td>
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<td>FCPSU</td>
<td>Family and Child Protective Services Unit</td>
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<td>FPM</td>
<td>Force Procedures Manual</td>
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<td>FAQ</td>
<td>Frequently asked questions</td>
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<td>Hospital Authority</td>
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<td>ICYSC</td>
<td>Integrated Children and Youth Services Centre</td>
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<td>Integrated Family Service Centre</td>
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<td>ISC</td>
<td>Integrated Services Centre</td>
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SECTION I

INTRODUCTION
CHAPTER 1

AIM, BELIEFS AND PRINCIPLES

AIM

1.1 The aim of this Procedural Guide is to provide guidance on the way government departments, non-governmental organisations and other concerned sectors should work together to serve the best interest of children and to provide protection to the children suspected to be abused or having been abused. This Procedural Guide is to provide reference to professionals or personnel engaged in social service, health service, educational services, law enforcement and those whose work brings them into close contact with children. This Procedural Guide recognizes that the key to effective action is built on the multi-disciplinary approach of WORKING TOGETHER, TRUSTING EACH OTHER and FOR THE WELFARE OF CHILDREN.

BELIEFS

1.2 All children have the right to:

(a) grow and develop as physically, emotionally and mentally healthy as possible before as well as after birth;
(b) live in a safe environment and be protected from harm;
(c) be loved and valued, and be supported by a network of reliable and affectionate relationships;
(d) become competent in looking after themselves and coping with everyday living;
(e) have a positive image of themselves, and a secure sense of identity;
(f) receive proper education;
(g) develop adequate inter-personal skills and confidence in social situations; and
(h) receive medical and health assessment and treatment.

1.3 All children have physical, psychological and social needs that should be met by their parents / guardians, carers and society at large.

GOVERNING PRINCIPLES OF CHILD PROTECTION

1.4 All children have the right to be protected against harm and exploitation regardless of their:

(a) race, language or religion;
(b) political or immigration status;
(c) gender;
(d) age;
(e) health or ability; and
(f) behaviour.

1.5 The safety, needs, welfare and rights of the children should always come first and should be the primary concern in working with children and families.

1.6 All relevant parties should collaborate and share the responsibility for protection of children at relevant stages of case development with the involvement of the children and significant others.

1.7 Any symptom or report of suspected child abuse must be taken seriously and investigation should be conducted as soon as possible.

1.8 To avoid requiring the children to describe the suspected abuse incident(s) repeatedly, the number of investigative / assessment interview on the suspected abuse incident(s) should be kept to a minimum. Face-to-face contacts with the children should be conducted and relevant information should be collected from sources other than the suspected abusers wherever applicable to ascertain the condition of the children.

1.9 Where necessary, the information collected with regard to the suspected abuse incident(s) should be shared with other concerned parties as soon as possible to ensure effective protection of the children. The Personal Data (Privacy) Ordinance, Cap 486 provides specific exemption for collection of data and transfer of information under Part VIII of the Ordinance (refer to Personal Data (Privacy) Ordinance, Cap 486 for details).

1.10 The children’s participation should be encouraged and their voices should be heard at different stages including investigation and assessment. Their wishes and feelings must be explored and attended to in formulating welfare plans. However, care must be exercised to strike a balance between safety and the preference of the children.

1.11 While serving the best interest of children, consideration should be given to assist the families and the children’s significant others to protect the children. In the formulation of welfare plans for the children, the views of the parents / guardians / significant others should be sought and should be taken into account. The parents / carers’ co-operation and capability to protect the children should also be considered. However, risk assessment has to be conducted irrespective of the severity of the abuse. Statutory protection under the Protection of Children and Juveniles Ordinance, Cap 213 should be sought whenever situation warrants, including removal of the children to a place of safety.
CHAPTER 2

UNDERSTANDING OF CHILD ABUSE

DEFINITION

2.1 In a broad sense, child abuse is defined as any act of commission or omission that endangers or impairs the physical / psychological health and development of an individual under the age of 18. Such act is judged on the basis of a combination of community standards and professional expertise. It is committed by individuals, singly or collectively, who by their characteristics (e.g. age, status, knowledge, organisational form) are in a position of differential power that renders a child vulnerable. Child abuse is not limited to a child-parent / guardian situation, but includes anyone who is entrusted with the care and control of a child, e.g. child-minders, relatives, teacher, etc. For child sexual abuse, the acts may also be committed by strangers to the child.

2.2 The definition of child abuse set out in this Procedural Guide is provided to facilitate relevant professionals or personnel to safeguard the welfare of children being abused or at risk of abuse. It is not a legal definition. When prosecution against an abuser is required, reference should be made to the relevant Ordinances in force. It should also be noted that cases involving child welfare but not defined as child abuse in this Procedural Guide should also be handled with care and appropriate services should be rendered to ensure the best interest of children.

2.3 In determining whether a case should be defined as a child abuse case, the responsible professionals should make assessment based on individual case merits and take into consideration various factors (e.g. the child’s age, the act, the consequences of the act on the child, etc.) instead of just focusing on the frequency and nature of incident that has occurred.

2.4 Child abuse includes the following:

Physical Abuse is a physical injury or physical suffering to a child (including non-accidental use of force, deliberate poisoning, suffocation, burning, Munchausen’s Syndrome by Proxy\(^1\), etc.), where there is a definite knowledge, or a reasonable suspicion that the injury has been inflicted non-accidentally;

Sexual Abuse is the involvement of a child in sexual activity (e.g. rape, oral sex) which is unlawful, or to which a child is unable to give informed consent\(^2\).

\(^1\) Munchausen’s Syndrome by Proxy occurs when a parent or guardian falsifies a child’s medical history or alters a child’s laboratory test or actually causes an illness or injury to a child in order to gain medical attention for the child which may result in innumerable harmful hospital procedures. (Ref: Zumwalt R. E. & Kirsch C.S., “Pathology of Fatal Child Abuse and Neglect” in R. E. Helfer & R.S. Kempe (Eds.), The Battered Child (4th ed.), pp. 247-285, Chicago: University of Chicago Press, 1987.)

\(^2\) In consultation with the then Attorney General's Chambers, any dependent, developmentally immature children and adolescents involved in sexual activities that they do not fully comprehend are considered unable to give “informed consent”. For instance, when a child is involved in a sexual act for snacks or money, though the child may say “yes” to the perpetrator, this should not be regarded as an
This includes direct or indirect sexual exploitation and abuse of a child (e.g. production of pornographic material). It may be committed by individuals whether inside the home or outside. It may be committed by parents, or carers or other adults singly or acting in an organised way, or children. It includes acts which may be rewarded or apparently attractive to the child. It may be committed by individuals either known or strangers to the child; (Child sexual abuse differentiates from casual sexual relationship that does not include any sexual exploitation e.g. between a boy and a girl, though the boy can be liable for offences like indecent assault or unlawful sexual intercourse with an underaged girl.)

**Neglect** is severe or a repeated pattern of lacking of attention to a child’s basic needs that endangers or impairs the child’s health or development. Neglect may be:

- Physical (e.g. failure to provide necessary food, clothing or shelter, failure to prevent physical injury or suffering, lack of appropriate supervision or left unattended)
- Medical (e.g. failure to provide necessary medical or mental health treatment)
- Educational (e.g. failure to provide education or ignoring educational needs arising from a child's disability)
- Emotional (e.g. ignoring a child's emotional needs, failure to provide psychological care);

**Psychological Abuse** is the repeated pattern of behaviour and attitudes towards a child or extreme incident that endangers or impairs the child’s emotional or intellectual development. Examples include acts of spurning, terrorizing, isolating, exploiting / corrupting, denying emotional responsiveness, conveying to a child that he/she is worthless, flawed, unwanted or unloved (refer to Major Types of Psychological Abuse at Annex 1 to Chapter 2 for details). Such act damages immediately or ultimately the behavioural, cognitive, affective, or physical functioning of the child.

**INDICATORS OF POSSIBLE CHILD ABUSE**

2.5 In conducting investigation into any suspected child abuse case, the responsible professionals should make reference to indicators manifested by the child, the parents and the family. Physical indicators are indicators which are usually readily observable and may be mild or severe. The child's behaviour can sometimes be a clue to the presence of child abuse. Behavioural indicators may exist alone, or in combination with physical indicators. They may be subtle or they may be graphic statements by the child. The behaviour and attitudes of the parents, their own life histories, or even the conditions of their

---

“informed consent” by the child.

3 According to the Disability Discrimination Ordinance Code of Practice on Education, the provisions of the Disability Discrimination Ordinance apply to a wide range of persons, including those usually referred to as persons with intellectual disability or mental handicap, autism, specific learning disabilities, hearing impairment, visual impairment, physical disability or handicap, mental illness and various other chronic illnesses, and persons who are infected with the human immunodeficiency virus (commonly known as “HIV-positive”) or who have acquired immune deficiency syndrome (commonly known as “AIDS”).
home, can also offer valuable clues to the presence of child abuse.

2.6 The list of indicators presented in this Chapter is not intended to be exhaustive. Neither does the presence of a single or even several indicators necessarily prove that child abuse exists. However, the possibility of child abuse should be seriously considered in case of repeated occurrence of an indicator, presence of several indicators in combination, or presence of serious injury. The behavioural indicators in different categories of child abuse might be interchangeable and should be applied as appropriate.

2.7 These indicators are only useful for professionals with training and experience in dealing with children and families. They are an aid to assessment by professionals and should be used with caution. Some sections will have more relevance to certain professions than others. (It is not expected, for example, that non-medical professionals should be conversant with or attempt to interpret the different forms of fracture or internal injury specified in this Chapter).

CHECKLIST FOR IDENTIFYING POSSIBLE CHILD ABUSE

2.8 The following checklist aims to help concerned professionals and parties for identifying possible child abuse and is listed for reference only. It is not exhaustive and due consideration should be taken according to the age appropriateness of the child and his/her ability.

Physical Abuse

2.9 If there is doubt about the nature or severity of the physical signs of injury, the child concerned should be brought to medical attention as soon as possible.

(a) Bruises and Welts
   - Should be interpreted with reference to the developmental age (e.g. whether the child is able to walk), number, size and distribution of the bruises, and whether they form a specific pattern that suggests direct impact with an object, punching, grasping, and/or bites.
   - Bruises that are unlikely to be accidental, e.g. large bruises, bruises at unusual locations, multiple bruises of different ages, or injuries around the genitalia are suspicious.
   - Bite marks are specific signs of injuries. If identified early, the injury itself may contain sufficient information to help identify the perpetrator.

(b) Lacerations and Abrasions
   - Lacerations over the hands, arms or feet that damage the underlying tendons may be potentially crippling.
   - Laceration to the fraenulum, the piece of tissue that connects the upper lip to the upper gum in the middle, may be indicative of
forced feeding.

(c) Burns and Scalds
- Burns / scalds from unintentional and intentional origin may be
difficult to differentiate.
- Some inflicted burns may assume the shape or pattern of the
burning objects, e.g. heated plate, cigarette.
- “Glove and/or stocking” distribution is indicative of dunking
(immersion) scald of a limb or buttock.

(d) Fractures
- These should be interpreted / handled individually.

(e) Internal Injuries
- Brain / head injuries
  ➢ May be due to direct impact, shaking or penetrating
  injuries.
  ➢ The “Shaken Baby Syndrome” is the most common cause
  of death in physical child abuse.
- Abdominal injuries
  ➢ Perforation of internal organs may lead to abdominal pain
    and vomiting.
  ➢ Serious injuries or even death may occur without any
    external signs of injuries. Hence, a high degree of
    suspicion is required if abdominal injury is not to be
    missed.

(f) Others
- Fabricated or induced illnesses, including Munchausen’s
  Syndrome by Proxy
- Poisoning
- Hair loss by pulling or burning
- Drowning
- Cot death
  ➢ Conclusion should not be made until a formal Coroner’s
    examination has been completed.

Sexual Abuse (Both sexes)

(a) Physical Indicators
- Torn, stained or bloody underclothing
- Complaints of pain, swelling or itching in the genital area
- Complaints of pain on urination
- Bruises, bleeding, or lacerations in external genitalia, vaginal or
  anal area, mouth or throat
- Vaginal / penile discharge
- Sexually transmitted disease
- Early adolescent pregnancy
(b) Behavioural Indicators
- Appetite disturbance
- Sexual exploitation of young children
- Poor peer relationship
- Unwilling to participate in physical activities
- Behaviour disturbance (anorexia nervosa, obesity, self-mutilation, run away, suicide, promiscuity, drug abuse)
- Sexual knowledge or behaviour that is abnormally advanced for the respective age of the child
- Marked change in academic performance
- Sleep disturbance
- Excessive masturbation
- Excessive reaction to being touched
- Intensive dislike for being left somewhere or with someone

Neglect

(a) Physical Indicators
- Malnutrition, under-weight, or lacking sufficient quantity and/or quality of food
- Delayed development
- Severe rash or skin disorder
- Left in care of inappropriate carer (e.g. young child)
- Inadequately supervised for long periods or when engaged in dangerous activities
- Unattended physical problems or unmet medical / dental needs
- Chronically dirty / unkempt
- Habitual absence from school or deprivation of schooling
- Spoiled food found at home
- Insanitary living conditions (garbage, excretion, dirt, etc)
- Young child unattended for long periods
- Abandoned : totally or for long periods of time
- Child confined at home

(b) Behavioural Indicators
- Persistent complaints of hunger or rummaging for food, overtly aggressive eating habit or begs for / steals food
- Assumes responsibilities inappropriate to age
- Addiction
- Delinquency
- Complaints of inadequate care, supervision or nurturing
- Being made to work excessive hours / beyond physical ability
- Poor peer relationship
- Responds to questions in monosyllables
- Extreme apprehension
- Sexual activity caused by inadequate supervision
- Reluctant to return home
- Runs away from home
Psychological Abuse

(a) Physical Indicators
- Failure to thrive
- Developmental delay e.g. speech disorder
- Anorexia nervosa

(b) Behavioural Indicators
- Indicators in Child
  ➢ Alienation
  ➢ Habit disorder
  ➢ Wetting / soiling
  ➢ Learning disorder e.g. marked deterioration in academic performance
  ➢ Lags in mental, emotional, social development
  ➢ Self harm or suicidal thoughts / attempts
  ➢ Disruptive behaviour or conduct problems
  ➢ Sleep disturbance
  ➢ Appetite disturbance
  ➢ Speech impediment

- Indicators in Family
  ➢ Rejection
  ➢ Constant scolding
  ➢ Humiliating criticism
  ➢ Inducing fear
  ➢ Encouraging deviant behaviour
  ➢ Bizarre punishment

CHARACTERISTICS COMMONLY ASSOCIATED WITH CHILD ABUSE

2.10 Child abuse may occur in any family and the background of families with problem of child abuse may be different. The following characteristics which are often found in child abuse cases are listed for reference only and should not be taken as evidence of child abuse. On the other hand, child abuse may occur in families without any of the following identifiable features.

The Family

(a) Chaotic or obsessively organized home
(b) Social isolation
(c) Crisis or tension in family e.g. pregnancy, eviction, divorce / desertion / separation, in-law conflict
(d) Cultural / superstitious beliefs
(e) Domestic violence e.g. spouse battering
The Parents

(a) **Biography**
- History of childhood abuse
- History of unhappy or being rejected in childhood; serious physical / emotional deprivation
- History / Experience of domestic or other violence
- History of serious recurrent illness and/or psychiatric disorder
- Alcoholism / Drug abuse / Gambling

(b) **Attitude and Behaviour**
- Rigid or unreasonable expectation on the child
- Strong belief in harsh discipline / corporal punishment
- Overtly critical of or aloof to the child
- Immaturity of parents
- Low self-esteem
- Passiveness
- Low intelligence of one or both parents
- Low tolerance to stress
- Deficiency in anger control
- Diffusion and confusion in family roles
- Sexual problems
- Unconvincing or inconsistent explanations of the child’s injury
- Failure or delay in seeking medical advice
- Inadequate parenting

The Child

(a) Premature birth
(b) Unwanted child
(c) Illegitimate child
(d) Baby with feeding or sleeping problem
(e) Non-thriving baby
(f) Early separation from parents
(g) Complicated birth delivery
(h) Child exposed to conflicting child care rearing practices e.g. child reared away from home
(i) Child with physical or mental disability
(j) Child associated with family misfortune
(k) The female gender

GUIDE TO RISK ASSESSMENT

Functions

(a) To assess the level of risk to a child who is reported to be the victim of the alleged abuse;
(b) to measure and organize factors present in abuse situation, which are considered as important in describing the current safety and in predicting future safety of the child. These factors include the characteristics of the reported abuse, the child and his/her family involved, and the environment in which the child and his/her family exist; and

(c) to facilitate planning of action, case management and service delivery such that the child can receive sufficient care required to sustain growth, health and safety.

**Governing Principles in Risk Assessment**

(a) Risk assessment should begin at the time of case intake and continue throughout the process of case management, provision of service and termination of the case. It should take into consideration the likelihood of recurrence of maltreatment, neglect, physical or sexual abuse AND not only the severity of the child’s injuries. It is a continuous and future oriented process.

(b) The child and his/her family members (including siblings and abusers) should be involved in risk assessment in identifying problems and developing service plans. However, decision to remove or allow the child to remain with the family must be made carefully.

(c) Risk assessment has to be made with professional skills and judgement of various disciplines on individual case situation.

**Guide to Decision Making in Risk Assessment Process**

(a) Whether the child is in immediate danger or future risk of abuse.

(b) What social services, actions, or support system are necessary to protect the child during the investigation.

(c) Whether or not the child must be removed from home for his/her protection.

(d) What initial action plan is needed to address the factors that are placing the child at risk.

(e) What modifications, if any, must be made to the action plan to further reduce risk and enhance safety of the child.

(f) When it is safe to return a child home, if the child has been removed.

(g) When sufficient care is being provided that would support case closure.
Skills in Risk Assessment

(a) Identify the concern for risk as reflected in the available reports or information. Assess all areas of risk.

(b) Ascertain the immediacy of risk.

(c) Assess the origin, type and extent of risk. Be alert especially for serious risk factors.

(d) Examine the duration, severity and controllability of the risk factors. Be aware of risk factors that may interact in a dangerous manner.

(e) Assess family strengths and resources.

(f) Examine the overall level of risk to the child within the context of risk factors, family strengths, and agency resources.

(g) Determine the child’s capabilities to face / manage the risk and to protect himself/herself, and the degree of safety.

(h) Gather direct and genuine evidence whenever possible.

(i) Use risk assessment as the foundation of the action plan, subsequent modifications of the plan, and case referral to Family and Child Protective Services Units, Child Protection Special Investigation Team or case transfer.

(j) Consider action plan and develop strategies to respond to and reduce risk.

(k) Mobilize service resources to reduce risk.

(l) Conduct case review when action plan changes and consider alternatives to reduce risk.

(m) Identify conditions which suggest risk is being reduced or has been sufficiently reduced to warrant closure of the case.

Risk Factors

Risk factors may interact with one another in a dynamic way in child abuse. The risk factors and their variables can be summarized as follows:

<table>
<thead>
<tr>
<th>Factors</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Precipitating incident</td>
<td>(a) Severity and/or frequency of abuse</td>
</tr>
<tr>
<td></td>
<td>(b) Location of injury on body</td>
</tr>
<tr>
<td></td>
<td>(c) History of abuse</td>
</tr>
</tbody>
</table>
### Factors

<table>
<thead>
<tr>
<th>Assessment on</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>child</td>
<td></td>
</tr>
<tr>
<td>(2) Assessment on child</td>
<td>(a) Child’s age, physical and/or mental abilities</td>
</tr>
<tr>
<td></td>
<td>(b) Perpetrator’s access to child</td>
</tr>
<tr>
<td></td>
<td>(c) Child’s behaviour and mental well being</td>
</tr>
<tr>
<td></td>
<td>(d) Interaction between child and carer</td>
</tr>
<tr>
<td></td>
<td>(e) Child’s interaction with siblings, peers and others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment on</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>carer</td>
<td></td>
</tr>
<tr>
<td>(3) Assessment on carer</td>
<td>(a) Carer’s capacity for child care</td>
</tr>
<tr>
<td></td>
<td>(b) Interaction between child and carer</td>
</tr>
<tr>
<td></td>
<td>(c) Interaction between carers</td>
</tr>
<tr>
<td></td>
<td>(d) Carer’s parenting skills / knowledge</td>
</tr>
<tr>
<td></td>
<td>(e) Carer’s substance / alcohol abuse</td>
</tr>
<tr>
<td></td>
<td>(f) Carer’s criminal behaviour</td>
</tr>
<tr>
<td></td>
<td>(g) Carer’s emotional and mental health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family assessment</th>
<th>Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) Family assessment</td>
<td>(a) Family interactions / relationship</td>
</tr>
<tr>
<td></td>
<td>(b) Strength of family / support systems</td>
</tr>
<tr>
<td></td>
<td>(c) History of abuse / neglect in family</td>
</tr>
<tr>
<td></td>
<td>(d) Presence of a parent substitute in the home</td>
</tr>
<tr>
<td></td>
<td>(e) Progress of child / family in treatment</td>
</tr>
</tbody>
</table>

**Assessment Matrix**

Risk Assessment Guidelines with an Assessment Matrix is at Annex II to Chapter 2 for quick reference in assessing child abuse cases.
MAJOR TYPES OF PSYCHOLOGICAL ABUSE

FIVE MAJOR TYPES OF PSYCHOLOGICAL ABUSE ARE DESCRIBED BELOW AND FURTHER CLARIFIED BY IDENTIFICATION OF SUB-CATEGORIES

A repeated pattern or extreme incident(s) of the conditions described in this table constitute psychological maltreatment. Such conditions convey the message that the child is worthless, flawed, unloved, endangered, or only valuable in meeting someone else's needs.

<table>
<thead>
<tr>
<th>SPURNING (Hostile Rejecting / Degrading)</th>
<th>Includes verbal and non-verbal caregiver acts that reject and degrade a child. SPURNING includes the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- Belittling, degrading, and other non-physical forms of overtly hostile or rejecting treatment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Shaming and/or ridiculing the child for showing normal emotions such as affection, grief, or sorrow</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Consistently singling out one child to criticize and punish, to perform most of the household chores, or to receive fewer rewards</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Public humiliation</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TERRORIZING</th>
<th>Includes caregiver behaviour that threatens or is likely to physically hurt, kill, abandon, or place the child or child's loved ones or objects in recognizably dangerous situations. TERRORIZING includes the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- Placing a child in unpredictable or chaotic circumstances</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Placing a child in recognizably dangerous situations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Setting rigid or unrealistic expectations with the threat of loss, or danger if they are not met</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Threatening or perpetrating violence against the child</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Threatening or perpetrating violence against the child's loved ones or objects</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISOLATING</th>
<th>Includes caregiver acts that consistently deny the child opportunities to meet needs for interacting or communicating with peers or adults inside or outside the home. ISOLATING includes the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- Confining the child or placing unreasonable limitations on the child’s freedom of movement within his or her environment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Placing unreasonable limitations or restrictions on social interactions with peers or adults in the community</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPLOITING / CORRUPTING</th>
<th>Includes caregiver acts that encourage the child to develop inappropriate behaviour (self-destructive, anti-social, criminal, deviant, or other maladaptive behaviour). EXPLOITING / CORRUPTING includes the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- Modeling, permitting, or encouraging anti-social behaviour (e.g. prostitution, performance in pornographic media, initiation of criminal activities, substance abuse, violence to or corruption of others)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Modeling, permitting, or encouraging developmentally inappropriate behaviour (e.g. parentification, infantilization, living the parent’s unfulfilled dreams)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Encouraging or coercing abandonment of developmentally appropriate autonomy through extreme over-involvement, intrusiveness, and/or dominance (e.g. allowing little or no opportunity or support for child's views, feelings, and wishes; micro-managing child's life)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Restricting or interfering with cognitive development</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DENYING EMOTIONAL RESPONSIVENESS (Ignoring)</th>
<th>Includes caregiver acts that ignore the child’s attempts and needs to interact (failing to express affection, caring, and love for the child) and show no emotion in interactions with the child. DENYING EMOTIONAL RESPONSIVENESS includes the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- Being detached and uninvolved through either incapacity or lack of motivation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Interacting only when absolutely necessary</strong></td>
<td></td>
</tr>
<tr>
<td><strong>- Failing to express affection, caring, and love for the child</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Office for the Study of the Psychological Rights of the Child, Indiana University, Purdue University at Indianapolis.
### ASSESSMENT MATRIX

<table>
<thead>
<tr>
<th>ACTION</th>
<th>A. LOW RISK</th>
<th>B. INTERMEDIATE RISK</th>
<th>C. HIGH RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Child's age, physical and mental abilities</td>
<td>10 years and over and cares for and protects self without or with limited adult assistance, no physical or mental handicaps / limitations</td>
<td>5 through 9 years of age, any age requiring adult assistance to care for and protect self, emotionally withdrawn; minor physical illness / mental handicap; mild to moderately impaired development</td>
</tr>
<tr>
<td>2.</td>
<td>Severity and / or frequency of abuse, physical or sexual</td>
<td>No injury or minor injury; not requiring medical attention; no discernible effect on child; isolated incident</td>
<td>Minor physical injury or unexplained injury requiring some form of medical treatment / diagnosis; history or pattern of punishment / discipline; mild sexual confrontation</td>
</tr>
<tr>
<td>3.</td>
<td>Severity and / or frequency of neglect and recentness</td>
<td>No discernible effect on child; isolated incident</td>
<td>Caretaker suspected of failing to meet minimum medical, food and/or shelter needs of child; unconfirmed history or pattern of leaving child unsupervised</td>
</tr>
<tr>
<td>4.</td>
<td>Location of injury</td>
<td>Bony body parts; knee, elbows, buttocks</td>
<td>Torso</td>
</tr>
<tr>
<td>5.</td>
<td>School problems</td>
<td>Regular attendance; no reported school problems</td>
<td>Frequent absence; some behavioural problems; child comes unkempt and hungry</td>
</tr>
<tr>
<td>6.</td>
<td>Caretaker's physical, intellectual, or emotional abilities</td>
<td>No intellectual / physical limitations, realistic expectations of child; in full control of mental faculties</td>
<td>May be physically / emotionally handicapped; moderate intellectual limitations; past criminal / mental health record / history, poor reasoning abilities; needs planning and assistance to protect child</td>
</tr>
<tr>
<td>7.</td>
<td>Caretaker's level of cooperation</td>
<td>Willingness and ability to work with agency to resolve problem and protect child</td>
<td>Overtly compliant with investigator; presence / ability of non-offending adult to assure minimal cooperation with agency</td>
</tr>
<tr>
<td>ACTION</td>
<td>A. LOW RISK</td>
<td>B. INTERMEDIATE RISK</td>
<td>C. HIGH RISK</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>----------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>8. Caretaker's parenting skills and/or knowledge</td>
<td>Caretaker exhibits appropriate parenting skills and knowledge pertaining to child-rearing techniques or responsibilities</td>
<td>Inconsistent display of the necessary parenting skills and/or knowledge required to provide a minimal level of child care</td>
<td>Caretaker is unwilling / incapable of exercising the necessary parenting skills and/or lacks minimal knowledge needed to assure a minimal level of child care</td>
</tr>
<tr>
<td>9. Presence of a parent substitute in the home</td>
<td>Parent substitute in the home is viewed as supportive / stabilizing influence</td>
<td>Parent substitute is in the home on an infrequent basis and/or assumes only minimal caretaker responsibility for the child</td>
<td>Parent substitute resides with the family and is the alleged offender</td>
</tr>
<tr>
<td>10. Previous history of abuse / neglect</td>
<td>No previous reported history of abuse / neglect</td>
<td>Previous indicated report of abuse / neglect; or protective services provided to the child, family or offender</td>
<td>Pending child abuse / neglect investigation; previous indicated abuse / neglect report of a serious nature; multiple reports of abuse / neglect involving the child, family or offender; prior dependency</td>
</tr>
<tr>
<td>11. Strength of family support systems</td>
<td>Family, neighbours, or friends available and committed to help; participation in church, community, or social group</td>
<td>Family supportive but not in geographic area; some support from friends and neighbours; limited community services available</td>
<td>Relatives or friends unavailable / uncommitted or subversive; geographically isolated from community services, no phone or means of transportation available</td>
</tr>
<tr>
<td>12. Perpetrator's access to child</td>
<td>Out of home, no access to child</td>
<td>In home, access to child is difficult; child is under constant supervision of other adult in the home</td>
<td>In home, complete access to child; uncertainty if other adult can protect child</td>
</tr>
<tr>
<td>13. Environmental condition of the home</td>
<td>Home in relatively clean with no apparent safety or health hazards; functional utilities</td>
<td>Trash and garbage not disposed and hazardous water and/or electricity inoperative; infestation of ants, roaches or other vermin.</td>
<td>Living in condemned and/or structurally unsound residence; exposed wiring and/or other potential fire / safety hazards present</td>
</tr>
<tr>
<td>14. Stresses / crises</td>
<td>Stable family, steady employment or income; means of transportation available; strong relationship with relatives</td>
<td>Pregnancy or recent birth of a child; insufficient income and/or food; inadequate home management skills / knowledge; relationship with relatives characterized by mutual hostility</td>
<td>Death of spouse; recent change in marital or relationship status; acute psychiatric episodes; spouse abuse / marital conflict; drug / alcohol dependency; chaotic life-style; criminal activity; frequent arrests</td>
</tr>
<tr>
<td>15. Substance abuse drug / alcohol</td>
<td>No drug / alcohol use; caretaker's drug / alcohol use does not influence parenting</td>
<td>Drug / alcohol use impairs caretaker's functioning; connected to major presenting problem</td>
<td>Regular heavy use of drug / alcohol resulting in chronic endangerment to child; prevents working on case plan</td>
</tr>
</tbody>
</table>

CHAPTER 3
LEGAL ASPECTS

GOVERNING PRINCIPLES

3.1 Relevant statutory provisions serve as the baselines for care and protection of children. Various legislative provisions are in place to protect the welfare of children and set out the responsibility of parents and carers. Relevant Ordinances should be referred to as and when necessary and appropriate.

3.2 Care and judgment should be exercised when considering the need to initiate legal proceedings. The responsible professionals should bear in mind that the procedures and interventions intended to protect the child should not in themselves be abusive by causing further damage or distress. Related factors (e.g. safety of the child, severity of the abusive act, etc.) should be taken into account.

3.3 The definition of “child abuse” in paragraph 2.1 of Chapter 2 is not a legal definition. Child abuse is a general term to describe different acts of abuse committed against children. Specific abusive acts are dealt with under a number of Ordinances including Crimes Ordinance, Cap 200, Offences Against the Person Ordinance, Cap 212, etc. If the responsible professionals believe that a criminal abusive act has been or is about to be committed against a child, they should report to the Police as soon as possible.

3.4 The decision to prosecute lies with the Counsel who needs to consider:

(a) sufficiency of evidence;
(b) interests of the child; and
(c) public interest
(d) paragraphs 7 to 9 of the Statement of Prosecution Policy and Practice issued by the Department of Justice in 2002

RELEVANT ORDINANCES RELATED TO CHILD PROTECTION AND CHILD ABUSE IN HONG KONG

3.5 Relevant Ordinances related to child protection and child abuse include:

(a) Protection of Children and Juveniles Ordinance, Cap 213
(b) Evidence Ordinance, Cap 8
(c) Employment Ordinance, Cap 57 (Employment of Children Regulations Cap 57B, Employment of Young Persons Regulations Cap 57C)
(d) Criminal Procedure Ordinance, Cap 221
(e) Live Television Link and Video Recorded Evidence, Cap 221J
(f) Education Ordinance, Cap 279
(g) Adoption Ordinance, Cap 290
(h) Child Abduction and Custody Ordinance, Cap 512
(i) Crimes Ordinance, Cap 200
(j) Offences Against the Person Ordinance, Cap 212
(k) Prevention of Child Pornography Ordinance, Cap 579

(Refer to Annex I to Chapter 3 for the full list of the related sections under these Ordinances. Some frequently asked questions about the application of these Ordinances are listed at Annex II to Chapter 3.)

DEFINITION OF THE AGE OF CHILD AND JUVENILE

3.6 While children involved in child abuse cases covered in this Procedural Guide refer to children and juveniles under the age of 18, the definitions of child and juvenile vary under different legislations as set out at Annex III to Chapter 3.

PROTECTION OF CHILDREN AND JUVENILES ORDINANCE (PCJO), CAP 213

3.7 Statutory duties under the PCJO, Cap 213 should be discharged by police officer or social worker as authorized by the Director of Social Welfare whenever situation warrants, to protect a child or juvenile in need of care or protection. As stipulated under Section 34 (2) of the PCJO, Cap 213, a child or juvenile in need of care or protection means a child or juvenile -

(a) who has been or is being assaulted, ill-treated, neglected or sexually abused; or
(b) whose health, development or welfare has been or is being neglected or avoidably impaired; or
(c) whose health, development or welfare appears likely to be neglected or avoidably impaired; or
(d) who is beyond control, to the extent that harm may be caused to him or others,

and who requires care or protection.

3.8 It should be noted that not every suspected child abuse or child abuse case warrants the application for a Care or Protection Order under the PCJO. Such application should be considered on a case-by-case basis taking into account the attitude of the parents’/carers’ towards professional intervention, safety, psychological state and behaviour of the child, etc. In light of the possible adverse effects (e.g. distress to the child) caused by the legal proceedings, soliciting co-operation of the parents/carers in the intervention process should first be considered before resorting to statutory action to protect the child.

EVIDENCE ORDINANCE, CAP 8

3.9 Following the amendment of Section 4 of the Evidence Ordinance, Cap 8 in 1995,
(a) a child's evidence in criminal proceedings shall be given unsworn and shall be capable of corroborating the evidence, sworn or unsworn, given by any other person; and
(b) a deposition of a child’s unsworn evidence may be taken for the purpose of criminal proceedings as if that evidence had been given on oath.

**CRIMINAL PROCEDURE ORDINANCE, CAP 221**

3.10 Sections 79C and 79D of the Criminal Procedure Ordinance, Cap 221, allow a video recording of an interview with a child witness of certain sexual or violent offences to be used, where it relates to any matter in issue in the criminal proceedings, in trials at the High Court, District Court or Magistrates Court. The video recording may, with leave of the Court, be given in evidence. Under Section 79C, a video recording is admissible only where:-
(a) the child is not the accused;
(b) the child is available for cross-examination (assuming the proceedings get that far); and rules of the Court requiring disclosure of the circumstances in which the recording was made have been properly complied with.

3.11 Bearing the above criteria in mind, the use of video-recorded interview should be restricted to those cases where a child has made specific allegations or there is suspicion of sexual abuse, or physical abuse.

3.12 In deciding if video is the appropriate medium on which to record the evidence, other factors should also be considered. They may include the nature of the allegation, age and competence of the child and where appropriate, wishes of the child (older children may wish to provide a statement and appear in Court). Consideration should also be given as to the likelihood of the matter going to Court.

3.13 Section 79(B) of the Criminal Procedure Ordinance, Cap 221, allows child abuse victims to testify in Court through a live television video link (CCTV) system and admission of video recorded evidence as evidence-in-chief.

3.14 Under the Live Television Link and Video Recorded Evidence, Cap 221J, there is a provision for child witnesses to be accompanied by a ‘Support Person’ in giving evidence through CCTV system after obtaining the Court’s permission. The Support Person should not be a witness in the case or have been involved in the investigation of the case. SWD in co-operation with the Police has established a Witness Support Programme to provide Support Persons for child witnesses.
Annex I to Chapter 3

ORDINANCES AND OFFENCES RELATED TO
CHILD PROTECTION AND CHILD ABUSE IN HONG KONG

A. LIST OF ORDINANCES RELATED TO CHILD PROTECTION

Protection of Children and Juveniles Ordinance, Cap 213

Evidence Ordinance, Cap 8
Section 4 Evidence given by children

Employment Ordinance, Cap 57

Criminal Procedure Ordinance, Cap 221
Section 79B Evidence by live television link
Section 79C Video recorded evidence
Section 79D Chief Justice to make rules

Live Television Link and Video Recorded Evidence Rules, Cap 221J
Rule 3 Evidence through live television link where witness is a vulnerable witness or is to be cross-examined after admission of a video recording

Education Ordinance, Cap 279
Section 74 Power of Permanent Secretary to order attendance at primary school or secondary school
Section 78 Enforcement of order

Adoption Ordinance, Cap 290
Section 22 Prohibition of certain payments
Section 23 Restriction upon Advertisements
Section 23A Restriction on arranging adoption and placing of infant for adoption

Child Abduction and Custody Ordinance, Cap 512
B. LIST OF ORDINANCES AND OFFENCES RELATED TO CHILD ABUSE

I. Offences of Sexual Abuse

An offence of sexual abuse refers to one of the following Sections of the Crimes Ordinance, Cap 200 and the Prevention of Child Pornography Ordinance, Cap 579.

**Crimes Ordinance, Cap 200**

**Part VI Incest**

Section 47 Incest by men
Section 48 Incest by women of or over 16

**Part XII Sexual and Related Offences**

Section 118 Rape
Section 118A Non-consensual buggery
Section 118B Assault with intent to commit buggery
Section 118C Homosexual buggery with or by man under 21
Section 118D Buggery with girl under 21
Section 118E Buggery with mentally incapacitated person
Section 118F Homosexual buggery committed otherwise than in private
Section 118G Procuring others to commit homosexual buggery
Section 118H Gross indecency with or by man under 21
Section 118I Gross indecency by man with male mentally incapacitated person
Section 118J Gross indecency by man with man otherwise than in private
Section 118K Procuring gross indecency by man with man
Section 119 Procurement by threats
Section 120 Procurement by false pretences
Section 121 Administering drugs to obtain or facilitate unlawful sexual act
Section 122 Indecent assault
Section 123 Intercourse with girl under 13
Section 124 Intercourse with girl under 16
Section 125 Intercourse with mentally incapacitated person
Section 126 Abduction of unmarried girl under 16
Section 127 Abduction of unmarried girl under 18 for sexual intercourse
Section 128  Abduction of mentally incapacitated person from parent or guardian for sexual act
Section 129  Trafficking in persons to or from Hong Kong
Section 130  Control over persons for purpose of unlawful sexual intercourse or prostitution
Section 131  Causing prostitution
Section 132  Procurement of girl under 21
Section 133  Procurement of mentally incapacitated person
Section 134  Detention for intercourse or in vice establishment
Section 135  Causing or encouraging prostitution of, intercourse with, or indecent assault on, girl or boy under 16
Section 136  Causing or encouraging prostitution of mentally incapacitated person
Section 137  Living on earnings of prostitution of others
Section 138A Use, procurement or offer of persons under 18 for making pornography or for live pornographic performances
Section 140  Permitting girl or boy under 13 to resort to or be on premises or vessel for intercourse
Section 141  Permitting young person to resort to or be on premises or vessel for intercourse, prostitution, buggery or homosexual act
Section 142  Permitting mentally incapacitated person to resort to or be on premises or vessel for intercourse, prostitution or homosexual act
Section 146  Indecent conduct towards child under 16
Section 147  Soliciting for an immoral purpose
Section 148  Indecency in public

Prevention of Child Pornography Ordinance, Cap 579
Section 3(1) Printing child pornography; making child pornography; producing child pornography; reproducing child pornography; importing child pornography; exporting child pornography
Section 3(2) Publishing child pornography
Section 3(3) Possession of child pornography
Section 3(4) Advertising child pornography
II. Offences of Cruelty

An offence of cruelty refers to Section 26 or 27 of the Offences Against the Person Ordinance, Cap 212.

*Offences Against the Person Ordinance, Cap 212*

Section 26 Exposing child whereby life is endangered
Section 27 Ill-treatment or neglect by those in charge of child or young person

III. Offences Involving an Assault on, or Injury or a Threat of Injury to, a Child

An offence involves an assault on, or injury or a threat of injury to, a child and the offence is triable on indictment or either summarily or on indictment refers to one of the following Sections of the Offences Against the Person Ordinance, Cap 212.

*Offences Against the Person Ordinance, Cap 212*

Section 17 Shooting or attempting to shoot, or wounding or striking with intent to do grievous bodily harm
Section 19 Wounding or inflicting grievous bodily harm
Section 39 Assault occasioning actual bodily harm
Section 40 Common assault
Section 42 Forcible taking or detention of person, with intent to sell him
Section 43 Stealing child under 14 years
Annex II to Chapter 3

Frequently Asked Questions about the Application of the Ordinances Relating to Child Protection and Child Abuse

1. **What charges can be brought against child abuse perpetrators under the existing law?**

Child abuse can be committed in many different forms. There is no specific Ordinance on child abuse. Depending on the act and circumstances, a child abuse perpetrator can be prosecuted under the Crimes Ordinance (Cap 200) for incest, rape, indecent assault, unlawful sexual intercourse, etc.; or under the Offences Against the Person Ordinance (Cap 212) for exposing child whereby life is endangered, ill-treatment or neglect, assault occasioning actual bodily harm, common assault, etc.

2. **Who can apply for Care or Protection Order for victim of suspected child abuse?**

In accordance with Section 34(1) of the Protection of Children and Juveniles Ordinance (PCJO), Cap 213, a Juvenile Court, on its own motion or upon the application of the Director of Social Welfare (DSW) or of any person authorized by the DSW in writing or of any police officer upon being satisfied that a child or juvenile is a child or juvenile in need of care or protection as stipulated under Section 34(2) of the PCJO, Cap 213, may make a Care or Protection Order in respect of the child or juvenile.

3. **What are the possible outcomes set out in the court order granted under the Protection of Children and Juveniles Ordinance (PCJO), Cap 213?**

The outcome set out in the court order may vary from case to case, depending on the nature of protection required by the child and the specific provision under which the court order is granted. In many cases, the court order is granted in accordance with Section 34(1) of the PCJO, Cap 213. Under this provision, a Juvenile Court, upon being satisfied that any child or juvenile is a child or juvenile in need of care or protection, may specify in the court order any or all of the followings:

(a) appoint the DSW to be the legal guardian of such child or juvenile; or

(b) commit him/her to the care of any person whether a relative or not, who is willing to undertake the care of him/her, or of any institution which is so willing; or

(c) order his/her parent or guardian to enter into recognizance to exercise proper care and guardianship; or
(d) make an order placing him/her for a specified period, not exceeding three years under the supervision of a person appointed for the purpose by the court.

4. What can be done if a child attends a clinic and is suspected to be a victim of child abuse while the parents refuse to take him/her to hospital for further examination or refuse to be referred to social worker for further management?

In accordance with Section 34E and Section 34F of the Protection of Children and Juveniles Ordinance (PCJO), Cap 213, any person authorized in writing by the DSW or any police officer of the rank of Station Sergeant or above is of the opinion that any child or juvenile who appears to be in need of care or protection is in need of urgent medical or surgical attention or treatment may take the child or juvenile to a hospital.

5. What can be done if the parent refuses to give consent for a victim of child abuse to stay in hospital for examination?

Upon admitting the child / juvenile to hospital in accordance with the procedure stated in Q4 above, authorized social workers of Social Welfare Department (SWD) may invoke Section 34F of the PCJO, Cap 213 which states that “a child who is admitted to a hospital may be detained by the Director of Social Welfare in that hospital for so long as the attendance of the child at that hospital is necessary for the purpose of medical or surgical attention or treatment”.

6. What can be done, after hospitalization of the child victim, his/her parent refuses to give history or refuses to give consent for examination?

- There is no statutory provision compelling any person, including a parent, to give his/her history or that of the child.

- Generally speaking, in the case where an abused child is in need of urgent medical treatment but his/her parents / guardians do not consent to his/her admission to hospital for examination, police officers in the rank of Station Sergeant or above, or any other person authorised in writing by the DSW, may take the child to a hospital pursuant to Section 34F of the PCJO, Cap 213. The child may be kept by the DSW in that hospital for so long as the attendance of the child at that hospital is necessary for the purpose of medical attention or treatment.

- If the abused child is in life-threatening situation or in critical condition and must receive immediate medical examination or treatment, the attending doctor may carry out treatment without first obtaining consent...
from the parties concerned if the doctor considers that as a matter of urgency that treatment is necessary and is in the best interest of the child.

- If the suspect is the father / mother / guardian of the victim and he/she insists on not allowing the medical officer or forensic pathologist to examine the victim, and while the victim is not capable of giving his/her consent, then the concerned staff (such as a social worker) will continue to explain to the non-offending parent / guardian the importance of arranging the victim to receive physical examination, so as to obtain his/her consent for the child to be examined.

- Under exceptional circumstances where in the end the parents / guardians still refuse to allow the child to undergo medical examination, the social worker of the Social Welfare Department (SWD) may, in exercise of the power conferred by Section 34(1) of the PCJO, Cap 213, apply to the court for assumption of legal guardianship of the child by the DSW, having regard to the thorough considerations given to the needs of the case by the relevant medical practitioner (including the forensic pathologist), the social worker of the SWD and the Police. Upon approval of the application, the Director of Social Welfare may authorise arrangement for a forensic pathologist to perform the necessary examination of the child. Alternatively, the DSW may cause a notice to be served on the person having custody or control of the child requiring that person to produce the child for an assessment by a medical practitioner of the way in which he/she has been treated under Section 45A (1) of the PCJO, Cap 213.

7. **What can be done if the parent(s) insists / insist to take the child victim away from the hospital after completion of medical management but before the Multi-disciplinary Case Conference (MDCC)?**

The parent(s) has/have the right to take the child victim away from the hospital after completion of medical management. However, the investigating social worker should carefully assess the suitability and feasibility of discharging the child home prior to the MDCC. In case the child is considered not suitable to be restored home and the parent(s) refuses / refuse to co-operate, PCJO may be invoked to retain the child in hospital or remove him/her to a place of refuge.

8. **The Police sometimes would need to take a child out of hospital for video recorded interview (VRI) in relation to the suspected child abuse incident. If the child's guardian does not sign the undertaking form for home leave, what should the hospital staff do?**

- Under Criminal Procedure Ordinance, Cap 221, a video recording of an interview between an adult (i.e. a police officer, a social worker or a clinical psychologist who is employed by the Government) and a child relating to an offence of assault or sexual abuse is admissible evidence
in court. It is primarily the responsibilities of the Police or the SWD to comply with any rules or regulations, including the need to obtain consent from the guardians, if any, when a decision is made to take a minor out of hospital for VRI.

- The first and primary concern of the hospital should be whether the child is medically suitable to leave the hospital temporarily for interview on clinical grounds. If the child is not yet suitable for temporary discharge for interview, the doctor has to clearly express his/her opinions to the Police. If the Police still insist to take the child out of hospital, the hospital staff need to record all the discussions with the Police on the matter.

- Under normal circumstances, the guardian’s consent is necessary for any matter in respect of a child staying in hospital including temporary discharge. This must be the position of the hospital. The hospital should explain to the Police the aforesaid position. However, it is not for the hospital staff to assess whether the Police’s particular action in any particular case is necessary and/or legal. If the Police still insist to take the minor out of hospital without parents’ consent, the hospital staff need to record all the discussions with the Police on the matter.

- If there is doubt as to whether the parents may not know the Police’s action, the hospital is obliged to contact the child’s parents. The hospital staff should explain to the Police their duty and intention to do so and may request the Police to inform either of the parents of the action forthwith (unless it is on record expressly forbidden by the Police). It is again necessary to record all the discussions with the Police and the parents and the actions taken by the hospital.

9. **In reporting suspected child abuse, would the informants be liable if the allegation is not substantiated subsequently?**

   No.
DEFINITION OF CHILD AND JUVENILE UNDER DIFFERENT LEGISLATIONS

- **Evidence Ordinance, Cap 8:**
a ‘child’ means a person under 14 years of age.

- **Employment Ordinance, Cap 57:**
a ‘child’ means a person under the age of 15 years.

- **Protection of Children and Juveniles Ordinance, Cap 213:**
a ‘child’ means a person who is, in the opinion of the Court having cognizance of any case in relation to such person, under the age of 14 years, while a ‘juvenile’ means a person who is, in the opinion of a Court or a person exercising any power under this Ordinance, 14 years of age or upwards and under the age of 18 years.

- **Criminal Procedure Ordinance, Cap 221:**
a ‘child’ means a person, who

  (a) in the case of an offence of sexual abuse -
      i. is under 17 years of age; or
      ii. for the purpose of Section 79C of the Ordinance, if the person was under that age when a video recording to which Section 79C applies was made in respect of him/her, is under 18 years of age; or

  (b) in the case of an offence to which the Ordinance applies, other than an offence of sexual abuse -
      i. is under 14 years of age; or
      ii. for the purpose of Section 79C of the Ordinance, if the person was under that age when a video recording to which Section 79C applies was made in respect of him/her, is under 15 years of age.

- **Prevention of Child Pornography Ordinance, Cap 579:**
a ‘child’ means a person under the age of 16.

- **Adoption Ordinance, Cap 290:**
an ‘infant’ means a person under 18 years of age but does not include a person who is or has been married.
CHAPTER 4

INFORMATION SHARING AND CONFIDENTIALITY

GOVERNING PRINCIPLES

4.1 Professionals should protect the confidentiality of the personal data of their clients obtained in the course of their duties because privacy is protected both legally and ethically – Article 14 of the Hong Kong Bill of Rights, Personal Data (Privacy) Ordinance, the Common Law and the professionals code of ethics. However, in exceptional cases, depending on the circumstances, disclosure may be justified when disclosure of information is necessary to prevent foreseeable harm to a child.

The Common law duty of confidentiality

4.2 The courts recognize that professionals such as social workers and lawyers owe a duty to those who consult them to keep information they have learned about them confidential. If they breach such duty without justification, the court can interfere by making an award for damages or an injunction prohibiting disclosure of the relevant information. Whilst the starting point is that the source of a social worker’s information is confidential, there may be circumstances which justify disclosure. The role of the social workers is to balance the interest in maintaining confidentiality and the interest in breaching confidentiality. Such circumstances includes where disclosure is in the interest of the client or the person who gave the information – the “need to know” exception.

4.3 To protect a child from being abused, sharing of information among relevant professionals on a need-to-know basis is essential to facilitate risk assessment and timely and appropriate intervention.

4.4 Relevant information relating to child protection may include:
   (a) health and development of a child and his/her exposure to possible harm;
   (b) child care ability of a parent / carer that may pose danger to the child under his/her care;
   (c) act that may cause harm to a child; and
   (d) actual harm to the child.

4.5 The Personal Data (Privacy) Ordinance, Cap 486, should be complied with in sharing information.

4.6 The principles that a medical practitioner is required to observe with regard to patient confidentiality and disclosure of medical information are at Annex I to Chapter 4.

4.7 The principles that a clinical psychologist, who is a member of the Hong Kong
Psychological Society, is required to observe in regard to communication of information on clients are at Annex II to Chapter 4.

4.8 The principles that a social worker is required to observe under the Code of Practice for Registered Social Workers are at Annex III to Chapter 4.

PERSONAL DATA (PRIVACY) ORDINANCE, CAP 486

4.9 The sharing of personal data is governed by the Personal Data (Privacy) Ordinance, Cap 486 [PD(P)O] which controls the collection, holding, processing and use of personal data by data users and enables an individual to request access to and correction of any personal data relating to him/her. In collecting data and sharing information, professionals should observe the data protection principles as stipulated in Schedule 1 of the PD(P)O:

Principle 1 - Purpose and Manner of Collection of Personal Data
Principle 2 - Accuracy and Duration of Retention of Personal Data
Principle 3 - Use of Personal Data
Principle 4 - Security of Personal Data
Principle 5 - Information to be Generally Available
Principle 6 - Access to Personal Data

(Details of the Data Protection Principles are at Annex IV to Chapter 4.)

PRINCIPLES OF SHARING OF INFORMATION

4.10 According to Data Protection Principle 3, data user should not use (including disclose or transfer) personal data for any purpose other than the purpose for which the data were to be used at the time of collection or a directly related purpose unless the data subject’s prescribed consent is obtained.

4.11 The PD(P)O allows use, disclosure or transfer for a different purpose and without the data subject’s consent where the use, disclosure or transfer is exempted from the provision of Principle 3 by virtue of Part VIII of the Ordinance - Exemptions.

4.12 Section 58 of the PD(P)O provides an exemption from Principle 3 where the observance of the provisions of Principle 3 would be likely to prejudice the detection or prevention of crime or the prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct. As such, Principle 3 may be invoked if the data are to be used and shared for the purpose of child abuse investigation or related child protection work.

4.13 According to Section 59 of the PD(P)O, personal data relating to the physical or mental health of the data subject may be exempted from Principle 3 if application of this Principle would likely cause serious harm to the physical or mental health of the data subject or any other individuals. Claiming this
exemption, professionals (e.g. medical practitioners, residential child care staff) may share health record of service users, including suspected abusers and victims of child abuse, with other concerned professionals on a need-to-know basis for the purpose of protecting a child from serious physical and/or mental harm.

4.14 In handling request for access to personal data under Data Protection Principle 6, as stipulated in Section 58(1)(a), (b) & (d), Section 59(a) of the PD(O), exemption from access and correction may be invoked provided the data user has reasonable grounds for believing that release of the personal data (which were held for child abuse investigation and related child protection work) would likely prejudice the investigation and any possible proceedings on a suspected child abuse case and protection for the child.

4.15 If any person (including a child victim) makes a disclosure of a suspected child abuse incident and asks for it to be kept secret, it should be explained to the person that it is in the best interest of the concerned child that such a promise cannot be made.

MEASURES TO PRESERVE CONFIDENTIALITY

4.16 While exemption from Data Protection Principle 3 on the use of data may be invoked in circumstances as mentioned in paragraphs 4.9 to 4.10 above, in all circumstances, professionals should disclose the least amount of confidential information necessary to achieve the desired purpose and only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

4.17 Confidential information should not be discussed in any setting unless confidentiality can be ensured. Hence, discussion in public or semi-public areas such as hallways, waiting rooms, elevators and restaurants should be avoided.

4.18 All professionals should take precautions to ensure and maintain confidentiality of information transmitted to other parties through the use of computers, electronic mail, telephones and telephone answering machines, and other electronic or computer technology such as message left through pager service. Disclosure of identifiable information should be avoided whenever possible.

4.19 All professionals should not disclose identifiable information of any service user in the course of discussion for teaching or training purposes or seeking advice from a third party outside their organisation unless the service user has consented to the disclosure of confidential information.

4.20 All professionals should protect the confidentiality of service user(s) according to the preceding principles even after the case has been closed.
CHILD PROTECTION REGISTRY (CPR)

4.21 The CPR is a computerized record system which carries the function of case registration, case checking as well as facilitating statistical research. The main objectives of the CPR are:

(a) to facilitate better communication among government departments and NGOs, which are registered users handling child abuse cases, through an easy checking mechanism to ascertain whether a case is a known case of any department / organisation;

(b) to collect and compile statistical information on the abused children and their abusers in known and/or at risk cases of child abuse for the purpose of ascertaining the magnitude of the problem, including identification of the general profile and characteristics of child abuse;

(c) to monitor regular updating and review of significant data to ensure accuracy of the statistical information as far as possible; and

(d) to facilitate planning and development of services which prevent child abuse, including planning of public education programmes to prevent child abuse.

(Reference can be made to Appendix VI for information on CPR.)

4.22 All SWD & NGO service units providing casework service including Integrated Family Service Centres, Integrated Services Centre, Family and Child Protective Services Units, Medical Social Services Units, Probation Offices, School Social Work Units, Outreaching Social Work Units, Integrated Children and Youth Services Centres, etc. are requested to report child abuse cases and children at risk of abuse to the CPR. Through the checking mechanism, registered users (including Officers-in-charge / Supervisors / Social Work Officers of service units from both SWD and NGOs as listed in this paragraph, senior medical officers / medical officers-in-charge, as well as designated police officers of the Child Abuse Investigation Units (CAIUs) of Hong Kong Police Force) may check whether a case is a known case of any department / organisation.

4.23 Apart from keeping record of the reported cases and providing case checking function, annual statistical report to provide information on the general profile of the newly reported child abuse cases is produced.

4.24 Although it is a good practice to inform the data subject of the transfer of his/her personal data to the CPR arguably, his/her prescribed consent is not required because:

(a) if the purpose for which personal data of the victim and other individuals were collected by the reporting NGOs include the handling and investigation of, and the planning of services to prevent child abuse, and,
then it may be argued that the transfer of data to the CPR for use for the purposes as mentioned in paragraph 4.21 (a)-(d) is a purpose directly related to the purpose for which the data were collected; or

(b) even if the purpose of disclosure of the data by the social workers of the NGOs to the CPR constitutes a purpose different from the purpose for which the data were collected by them, exemption from Principle 3 provided under Section 58 may be invoked by the NGOs if they have reasonable grounds for believing that investigation, detection or prevention of child abuse would be likely to be prejudiced if the data concerned were not reported to the CPR.

A list of frequently asked questions is at Annex V to Chapter 4 for reference.
Annex I to Chapter 4

Medical Practitioners and Confidentiality Issues

Under *Duties of Doctors to the Sick* of the International Code of Medical Ethics (World Medical Assembly, 1983),

“[a] doctor shall preserve absolute confidentiality except where others are endangered on all he knows about his patient even after the patient has died.”

Under Section A, part III, of the Professional Code and Conduct for the Guidance of Registered Medical Practitioners (Medical Council of Hong Kong, 2000), a medical practitioner is required to observe the following principles in regard to patient confidentiality and disclosure of medical information:

1.4 *Disclosure of medical information to third parties*

1.4.1 A doctor should obtain consent from a patient before disclosure of medical information to a third party not involved in the medical referral.

1.4.2 In exceptional circumstances medical information about a patient may be disclosed to a third party without the patient's consent. Examples are: (i) where disclosure in the public interest or in the interests of an individual is justified because the failure to disclose the appropriate information would expose the patient, or someone else, to a risk of death or serious harm; (ii) when required by law to do so.

1.4.3 However, before making such a disclosure, a doctor must weigh carefully the arguments for and against disclosure and be prepared to justify the decision. If in doubt, it would be wise to discuss the matter with an experienced colleague or to seek help from a medical defence society, a professional association or an ethics committee.

In addition,

1.1.4 Doctors should be aware of the provisions of the Personal Data (Privacy) Ordinance (Cap 486), and have due regard to their responsibilities and liabilities under that Ordinance. In particular they should be aware of the patient's rights of access to and correction of the information in the medical record and the circumstances when these rights may be refused.
Clinical Psychologists and Confidentiality Issues

Under Chapter 8 of the Code of Professional Conduct (Hong Kong Psychological Society, 1998), a member of the Hong Kong Psychological Society is required to observe the following principles in regard to communication of information on clients:

8.1 Members who, in preparing a report, draw substantially upon the work of other professionals shall seek their consent to include such material and shall acknowledge its source in the report.

8.2 Test scores, like test materials, are released only to persons who are qualified to interpret and use them properly. Usually, an interpretation of the test results rather than test scores, is communicated.

8.3 The reporting of data obtained from test materials which are designed for self-appraisal purposes in schools, social agencies, or industry shall be closely supervised by Members, and provisions should be made for referring and counselling individuals when needed.

8.4 All psychological reports, whether oral or written, shall be directly concerned with the problems at issue and shall be expressed as simply and unequivocally as possible, with due regard for the understanding and qualifications of the recipient.

8.5 If an organisation employing a Member wishes to obtain psychological data about a client from another professional or another organisation, Members shall endeavour to establish the principle that they are the proper persons to obtain such information and to relay it to other workers within the organisation.

8.6 Confidential materials about clients or subjects, which might lead to their identification, shall not be released without their permission.
Social Workers and Confidentiality Issues

As stipulated in the “Principles of Practice Related to Clients” under the Code of Practice for Registered Social Workers (Social Workers Registration Board 1998),

“3. The social worker should inform clients fully, as far as possible, about the limits of confidentiality in a given situation, and the purpose for which information is obtained, and how it may be used. In publication of case material, the social worker should make necessary and responsible efforts to remove all identification information and to seek consent, as far as possible from client and the employing agency.”

The following sections are extracted from the Guidelines on the Code of Practice for Registered Social Workers (Social Workers Registration Board, 2000) for reference:

Guidelines:

3.5 Informed consent has to be obtained from the clients and the employing agency for the release of client’s information. If the social workers are of the view that the clients are not capable of making an appropriate decision, informed consent from the client’s guardians should be obtained. Social workers should make reasonable efforts to remove any information contained in the case material that may reveal the identity of the clients to someone who is casually related to the clients (e.g. neighbours, workmates, school teachers, etc.). If personal information of clients should be disclosed, the social workers should obtain the clients’ prior consent and assess whether the clients might have the ability to estimate the consequences of making such a decision.

3.6 In circumstances where there is sufficient evidence to raise serious concern about the safety or interests of clients or of others who may be affected by the clients’ behaviour, social workers should take such steps as are judged necessary to inform appropriate third parties even without the prior consent of the clients. Whether the social workers should alert the clients about going beyond the limits of confidentiality depends on the judgement of any reasonable person that the serious concern under consideration may exacerbate or transform into something even worse.

3.8 The clients have the right to know about the information relating to themselves that are being stored in their own case files and to access to the information that is provided by them or consequential to the information provided by them (e.g. opinions of the social workers, diagnosis, treatment plans, etc.). Information obtained from other sources, or their consequentials, should also be accessible to the clients and consent of the clients have to be sought before the relevant contacts are made, except when the clients have given up such a right prior to the social workers’ action to obtain such information. The access of the clients to such information may only be limited in the circumstances where there is sufficient evidence to raise serious concern that the safety or interests of clients or concerned persons will be jeopardized. If the guardians of the
clients wish to obtain information about the clients, they must first seek the consent of the clients. At the same time, the social workers must make a judgement as to whether or not the clients have the capability to make an appropriate decision and whether or not the decision so made is in the interests of the clients.

3.10 Should the social workers receive a request from the Police to provide personal information about their clients, the social workers should first seek the consent of the clients. When necessary, the social workers should make a professional judgment, after considering whether or not provision of the information would cause damage to the personal safety or interests of the clients or other people. If the Police hold a search warrant, the social workers should cooperate with the Police and provide information that is basic and necessary.
1. **Principle 1 – Purpose and Manner of Collection of Personal Data**

   (1) Personal data shall not be collected unless -
   (a) the data are collected for a lawful purpose directly related to a function or activity of the data user who is to use the data;
   (b) subject to paragraph (c), the collection of the data is necessary for or directly related to that purpose; and
   (c) the data are adequate but not excessive in relation to that purpose.

   (2) Personal data shall be collected by means which are –
   (a) lawful; and
   (b) fair in the circumstances of the case.

   (3) Where the person from whom personal data are or are to be collected is the data subject, all practicable steps shall be taken to ensure that –
   (a) He is explicitly or implicitly informed, on or before collecting the data, of –
      (i) whether it is obligatory or voluntary for him to supply the data; and
      (ii) where it is obligatory for him to supply the data, the consequences for him if he fails to supply the data; and
   (b) He is explicitly informed –
      (i) on or before collecting the data, of –
         (A) the purpose (in general or specific terms) for which the data are to be used; and
         (B) the classes of persons to whom the data may be transferred; and
      (ii) on or before first use of the data for the purpose for which they were collected, or –
         (A) his rights to request access to and to request the correction of the data; and
         (B) the name and the address of the individual to whom any such request may be made,

   Unless to comply with the provisions of this subsection would be likely to prejudice the purpose for which the data were collected and that purpose is specified in Part VIII of this Ordinance as a purpose in relation to which personal data are exempt from the provisions of data protection principle 6.

2. **Principle 2 – Accuracy and Duration of Retention of Personal Data**

   (1) All practicable steps shall be taken to ensure that –
(a) personal data are accurate having regard to the purpose (including any directly related purpose) for which the personal data are or are to be used;

(b) Where there are reasonable grounds for believing that personal data are inaccurate having regard to the purpose (including any directly related purpose) for which the data are or are to be used –
   (i) the data are not used for that purpose unless and until those grounds cease to be applicable to the data, whether by the rectification of the data or otherwise; or
   (ii) the data are erased;

(c) Where it is practicable in all the circumstances of the case to know that -
   (i) personal data disclosed on or after the appointed day to a third party are materially inaccurate having regard to the purpose (including any directly related purpose) for which the data are or are to be used by the third party; and
   (ii) that data were inaccurate at the time of such disclosure, that the third party –
       (A) is informed that the data are inaccurate; and
       (B) is provided with such particulars as will enable the third party to rectify the data having regard to that purpose.

(2) Personal data shall not be kept longer than is necessary for the fulfillment of the purpose (including any directly related purpose) for which the data are or are to be used.

3. **Principle 3 – Use of Personal Data**

   Personal data shall not, without the prescribed consent of the data subject, be used for any purpose other than –

   (1) the purpose for which the data were to be used at the time of the collection of the data; or

   (2) a purpose directly related to the purpose referred to in paragraph (1).

4. **Principle 4 – Security of Personal Data**

   All practicable steps shall be taken to ensure that personal data (including data in a form in which access to or processing of the data is not practicable) held by a data user are protected against unauthorized or accidental access, processing, erasure or other use having particular regard to –

   (1) the kind of data and the harm that could result if any of those things should occur;

   (2) the physical location where the data are stored;
(3) any security measures incorporated (whether by automated means or otherwise) into any equipment in which the data are stored;
(4) any measures taken for ensuring the integrity, prudence and competence to persons having access to the data; and
(5) any measures taken for ensuring the secure transmission of the data.

5. **Principle 5 – Information to be Generally Available**

All practicable steps shall be taken to ensure that a person can –
(1) ascertain a data user’s policies and practices in relation to personal data;
(2) be informed of the kind of personal data held by a data user; and
(3) be informed of the main purposed for which personal data held by a data user are or are to be used.

6. **Principle 6 – Access to Personal Data**

A data subject shall be entitled to –
(1) ascertain whether a data user holds personal data of which he is the data subject;
(2) request access to personal data –
   (a) within a reasonable time;
   (b) at a fee, if any, that is not excessive,
   (c) in a reasonable manner; and
   (d) in a form that is intelligible;
(3) be given reasons if a request referred to in paragraph (2) is refused;
(4) object to a refusal referred to in paragraph (3);
(5) request the correction of personal data;
(6) be given reasons if a request referred to in paragraph (5) is refused; and
(7) object to a refusal to in paragraph (6).
Frequently Asked Questions about Information Sharing and Confidentiality Issues

1. If a child has disclosed child abuse incident(s) to a professional (e.g. a teacher, a child care worker, etc.) and requested the professional to keep the information confidential and not to disclose the case to a third party, what should the professional do?

It should be explained to the child that it is in his/her best interests that such a promise cannot be made although the child’s concerns should be addressed. Instead, the professional should assure the child that the prime objective of any follow up actions is for his/her best interests. Moreover, timely risk assessment has to be made to secure prompt supportive service for the child.

2. Would verbal disclosure of relevant information of the child victims to other professionals relating to child protection violate the Personal Data (Privacy) Ordinance?

- According to Data Protection Principle 3, data user should not use (including disclose or transfer) personal data for any purpose other than the purpose for which the data were to be used at the time of collection or a directly related purpose unless the data subject’s prescribed consent is obtained.

- The Ordinance allows use including disclosure or transfer of personal data for a different purpose and without the data subject’s consent where such use, disclosure or transfer is exempted from the provision of Principle 3 by virtue of Part VIII of the Ordinance - Exemptions.

- Section 58 of the Ordinance provides an exemption from Principle 3 where the observance of the provisions of Principle 3 would be likely to prejudice the detection or prevention of crime or the prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct. As such, Principle 3 may be invoked if the data were to be used and shared for the purpose of child abuse investigation or related child protection work.

3. How can the medical officer-in-charge get access to the CPR?

Medical officer / medical officer-in-charge can register as “user” of the CPR to gain access to the CPR checking system. They should forward the particulars of the office and the authorized officer to the CPR by completing the Record Form for Access at Annex 1 to Appendix VI. Whenever there are changes, updating is required.
4. Can the medical officer-in-charge, with reasonable suspicion, check the CPR before initiation of child protection mechanism?

Yes, provided that the medical officer-in-charge is a registered user of CPR.

5. What kind of information should be provided in giving statement to the Police?

In handling reports of child abuse, the paramount concern of the Police is to protect the safety and best interest of children, especially the abusers are often their close relatives or caregivers. To this end, the Police would conduct thorough investigation to gather evidence including the testimonies of victims and witnesses, case exhibits, medical/forensic evidence as well as any other circumstantial evidence, so as to establish the authenticity of the allegation. Where there is evidence of an offence, the abuser would be arrested. For the Police to initiate prosecution actions against the abuser, it is crucial to have sufficient evidence and the testimonies are of particularly importance.

Since any first-hand information or direct knowledge of the alleged crime, the victim, the witness, the alleged abuser and even other related incidents, etc. would be of relevance to the investigation, the Police will ask the professional involved to give a detailed statement of these facts. As victims may tend to disclose certain information, which may be of material assistance to the investigation or the prosecution, to the professional at some stage during interviews or contacts, whether in person, by phone, in writing or otherwise, full particulars of these communications would be essential. The professional should provide the full records of such interviews / contacts, whether in the form of a written report, audio / video recordings or otherwise, including date, time, location, persons involved, purpose of the communications, process of the events, and personal observations, etc.

Part VIII of the Personal Data (Privacy) Ordinance (Cap 486) provides specific exemptions for collection and transfer of information. It is exempted from the data protection principle 3 under section 58(2) of the Ordinance to disclose to the Police the personal data of the victim, and any other persons relevant to the investigation, if the disclosure of information is related to the prevention / detection of crime, the arrest / prosecution of the offender or the preclusion / remedying of unlawful conduct, etc.
SECTION III

MULTI-DISCIPLINARY COLLABORATION
CHAPTER 5
CASE MANAGER AND
MULTI-DISCIPLINARY COLLABORATION

GOVERNING PRINCIPLES

5.1 Protecting a child from abuse is the joint responsibility of different professionals who may come into contact with the child.

5.2 Priority should be given to ensuring immediate safety of the child.

5.3 While it is appreciated that different professionals may have different views at different stages of intervention, consensus should be reached among the professionals as far as practicable, bearing in mind that the safety and welfare of the child should be the paramount concern.

5.4 Making reference to the guidelines set out in Chapter 4 “Information Sharing and Confidentiality”, relevant information about the child and/or the child’s family should be shared among professionals involved in the helping process on a need-to-know basis.

5.5 The child should not be required to repeat the abuse incident(s) except when necessary.

CASE MANAGER

5.6 To facilitate coordination of the services rendered by different professionals and reduce the child’s stress and trauma of repeating the abusive experience, the case manager approach should be adopted so that the child only needs to interact with the case manager for most of the time whenever situation allows. Under most circumstances, the key social worker handling the case would normally take up the role of a case manager. However, other professionals involved should also cooperate with the case manager as appropriate in order to ensure coordinated intervention among different personnel.

5.7 The role of case manager includes:

(a) to prepare the child and his/her parents / guardians / carers for the steps / tasks involved in the intervention process so as to reduce their anxiety and enlist their cooperation;

(b) to collect relevant information from other professionals / personnel involved;

(c) to share relevant information with other professionals / personnel involved on a need-to-know basis;
(d) to take necessary actions, including the application for Court Orders, to safeguard the immediate well-being of the child; and

(e) to ensure that actions taken by the responsible parties are well coordinated.

GOOD PRACTICE

5.8 To enhance the effectiveness of multi-disciplinary collaboration in protecting the child, the following good practice should be promoted:

(a) to render timely assistance and support to the child and his/her family members;

(b) to have knowledge of the assistance other professionals can provide and where necessary and appropriate, make referrals to the concerned service unit(s) at the earliest possible time;

(c) to be aware of the assistance being rendered to the child and his/her family members by other professionals / personnel;

(d) to have access throughout the course of investigation to the supervision and advice from a senior colleague / supervisor who has the proper training and experience in handling child abuse;

(e) to consult other professionals in case of any difficulty encountered; and

(f) to provide advice / assistance to other professionals as and when necessary.
CHAPTER 6

INITIAL HANDLING OF REPORTS / REFERRALS

GOVERNING PRINCIPLES

6.1 A child suspected of being abused may be brought to the attention of any welfare service unit, clinic / hospital, school, police station or other service unit of various government departments as well as non-governmental organisations (NGOs) by an informant\(^1\) or a referrer\(^2\). Each service unit should handle the report / referral according to the following principles:

(a) Each report / referral should be taken seriously regardless of the source or recency. Even if there is insufficient details of the incident, due consideration should also be given to the case if the informant or referrer has reasons to believe that something harmful has happened to the child.

(b) Priority should be given to the immediate safety of the child.

(c) The child suspected of being abused should not be required to describe the abuse incident(s) to different parties or on different occasions unnecessarily.

(d) Sometimes the informant may wish to be treated in confidence. The informant should be assured that his/her identity and personal data will not be disclosed unless such disclosure is essential to protect the child or other persons or in court proceedings.

(e) If the suspected abuse incident(s) is/are disclosed by the child himself / herself and asks for his/her disclosure to be kept secret, it should be explained to the child that it is in his/her best interests that such a promise cannot be made.

(f) If the unit is not responsible for conducting social investigation of the suspected child abuse case, the unit should refer the case to the appropriate unit and/or make a report to the Police for investigation / assistance as soon as possible according to the procedures set out in the subsequent Chapters.

GENERAL GUIDE TO RESPONDING TO A REPORT / REFERRAL

6.2 The informant / referrer should be told that the report / referral would be taken seriously and looked into even though the allegation of abuse may turn out to

\(^1\) An informant is a member of the public (e.g. neighbour, relative of the child concerned) who provides information on a suspected child abuse case.

\(^2\) A referrer is a staff member of a government department, NGO, HA or other organisation who comes across the suspected child abuse case in the course of performing his/her duties.
be mistaken or unsubstantiated.

6.3 If the informant / referrer is not the person who first identified the suspected child abuse incident(s), an attempt should be made to contact that person directly.

6.4 In order to avoid confusion and duplication, the informant / referrer should be asked whether he/she has contacted other departments or organisations.

6.5 If the unit is not responsible for conducting investigation of the suspected child abuse case, it is not necessary for the unit to probe into the details of the abuse incident(s).

**UNITS RESPONSIBLE FOR INVESTIGATION**

6.6 The Police are responsible for conducting investigation of suspected child abuse cases involving criminal elements. The following welfare units of SWD, NGOs and Hospital Authority (HA) providing casework service will carry out social enquiry / investigation and render follow up service to the concerned child and his/her family:

(a) Family and Child Protective Services Units (FCPSUs)
(b) Integrated Family Service Centres (IFSCs)
(c) Integrated Services Centres (ISCs)
(d) Medical Social Services Units (MSSUs)
(e) Probation Offices (POs)
(f) Adoption Unit (AU)
(g) Integrated Children and Youth Services Centres (ICYSCs)
(h) School Social Work Units (SSWUs) serving in secondary schools
(i) Student Guidance Personnel (SGP) serving in primary schools
(j) District Youth Outreaching Social Work Teams (YOTs)
(k) Overnight Outreaching Service for Young Night Drifters (YND)
(l) Community Support Service Scheme (CSSS)
(m) Other casework units

6.7 FCPSUs would carry out social enquiry of new suspected child abuse cases. For known cases, the responsible unit would conduct the social enquiry. If the concerned social worker is not available to take up the case timely, the responsible unit has to develop a back-up mechanism. Definition of known cases of welfare organisations is given at Appendix I.

6.8 In respect of sexual abuse case where the victim is a child under 17 years of age or serious physical abuse case where the victim is a child under 14 years of age, the Child Abuse Investigation Unit (CAIU) of the Police is responsible for investigating allegations of the following nature according to the CAIU

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3 If the SGP is a registered social worker and employed by an NGO, he/she may take up the role of case manager subject to mutual agreement of the school, NGO and SWD.
Charter:
(a) intra-familial sexual abuse (including the extended family e.g. mother, father, aunt, uncle);
(b) sexual abuse where the perpetrator is known to the child or is entrusted with the care of the victim (e.g. baby-sitter, school teacher, youth worker);
(c) serious physical abuse case at the discretion of the respective Senior Superintendent of Crime Region; and
(d) organised child abuse. (Organised child abuse is defined as abuse which may involve a number of abusers, a number of abused children and juveniles and often encompasses different forms of abuse. It will also involve to a greater or lesser extent an element of organisation e.g. paedophile or pornography rings.)

6.9 For cases falling within the CAIU Charter as described in paragraph 6.8 above, the Child Protection Special Investigation Team (CPSIT), comprising the Police, as well as social workers or clinical psychologists from SWD with special training, will provide consultation and/or conduct joint investigation of suspected child abuse cases upon referral. It will work closely with the pathologists and Medical Coordinators on Child Abuse (MCCAs) of the HA. Meanwhile, referrals for social enquiries should be made to social workers of FCPSUs or other units of SWD or NGOs according to the criteria set out in paragraph 6.7 above. The charts at Appendix IIA and Appendix IIB provide easy reference on referrals to FCPSU or CAIU and the handling procedures of those cases for which CPSIT will be formed.

6.10 For other forms of suspected child abuse cases, in circumstances suggesting that a criminal offence may have been committed, the cases should be reported to CAIU or other police units as appropriate. The charts at Appendix IIIA and Appendix IIIB provide quick reference on referrals and the handling procedures of these cases.

6.11 Apart from the Police and social workers, medical personnel, clinical psychologists and other related professionals have respective roles to play in the process of enquiry/investigation of suspected child abuse cases.

6.12 Guidelines on conducting enquiry/investigation by different professionals are provided in Chapter 8.

REFERENCES FOR MAKING REFERRALS

6.13 Professionals or relevant personnel may draw reference to the following appendices when making referrals of suspected child abuse cases:

(a) Charts on Referrals and Handling Procedures - Appendix IIA, IIB, IIIA, IIIB
(b) Guide to People Working with Children Who Disclose Sexual Abuse - Appendix IV
CHAPTER 7
INITIAL ASSESSMENT AND REFERRAL PROCEDURES

GOVERNING PRINCIPLES

7.1 In handling child abuse cases, the paramount concern is the welfare of the child.

7.2 To avoid requiring the child to describe the abuse incident(s) repeatedly, it is preferable to keep the number of investigative / assessment interview on the suspected abuse incident(s) to a minimum, say one interview. The interviewer may be the responsible social worker, the professional to whom the child has established trust for disclosure, the representative from the Police, or jointly by the professionals concerned. For video-recorded interview to be used in court proceedings, the interview should be conducted by police officer, social worker or clinical psychologist employed by the Government with special training. The information collected with regard to the suspected abuse incident(s) shall be shared with relevant parties concerned as soon as possible and on a need-to-know basis.

REFERRALS

7.3 Suspected child abuse cases may be identified:

(a) through direct approach in person or by telephone call from the child, the family or the public;

(b) by teachers, personnel of kindergartens / schools / child care centres / residential child care centres, Student Guidance Officers / Teachers / Personnel serving in primary schools, school social workers serving in secondary or special schools, children and youth centre workers, medical officers or private practitioners, nursing staff of hospitals / clinics, personnel of government departments or non-governmental organisations, etc.;

(c) through information from hotlines.

The following sections provide a guide for social workers in various settings who may come across a suspected child abuse case.

INTAKE PROCEDURES

7.4 The social worker who comes across the suspected child abuse case should intake the case. For sexual abuse and serious physical abuse cases falling within the Charter of Child Abuse Investigation Units (CAIU), reports can be
made to the Family and Child Protective Services Units (FCPSU) of SWD or Child Abuse Investigation Units (CAIU) of Police for follow up actions. Professionals or relevant personnel may draw reference to the Key to Making Referrals to Child Protection Special Investigation Team at Appendix V. For other forms of new child abuse cases, referrals / reports can be made to the Family and Child Protective Services Units (FCPSUs). In intaking the case or prior to making referral, the social worker should collect the following basic information from the informant / referrer if available:

(a) request the informant / referrer to give his/her name, address, telephone number and, if possible, HKIC number. Anonymous referrals are also accepted, but contact telephone number is preferred to be recorded in order to obtain further information on the case;

(b) collect all details of identifiable data of the child / family, e.g.
   i) the nature, date and frequency of the abuse or concern;
   ii) the name, date of birth (if unavailable - age), and any disability or special needs of the child;
   iii) the child’s whereabouts;
   iv) whether the child is in immediate danger;
   v) names and HKIC number of parents / carers and others involved;
   vi) names of other children in the household and whether the children are at risk or potentially at risk;
   vii) name of school / child care centre, if known;
   viii) how the informant / referrer is aware of the information;
   ix) names of other witnesses and other agencies.

7.5 For suspected sexual abuse cases, if the child is seen during intake interview and accompanied by the informant / referrer or during visits, the social worker should refer to the Guide to People Working with Children Who Disclose Sexual Abuse at Appendix IV.

7.6 The social worker will check with the Child Protection Registry (CPR) (reference on CPR is given at Appendix VI) and with the respective SWD / NGO unit to see if it is a new case or a known case. Whenever necessary, the assistance of his/her supervisor should be sought. It is important that checking of record from the CPR or concerned agencies should not pose any delay to the assessment process.

7.7 The intake social worker or the responsible social worker should, based on the initial information available or observation from the intake interview or home visit, assess the situation if there is:

(A) reason(s) to believe that the child has been or is being abused;
(B) urgency for medical attention;
(C) a cause for concern that child abuse might have occurred.

(Note: For all forms of abuse cases, refer to Understanding of Child Abuse in Chapter 2. For sexual abuse cases in particular, refer also to Key to Making
Referrals to Child Protection Special Investigation Team at Appendix V.)

(A) For cases with reason(s) to believe that the child has been or is being abused

7.8 For child sexual abuse cases or serious physical abuse cases (refer to cases falling within the CAIU Charter)

The intake social worker or the responsible social worker should:

(a) seek advice from Social Work Officer / Family and Child Protective Services Units (FCPSUs) (Appendix VII) in consultation with Police Officer / Child Abuse Investigation Units (CAIUs) (Appendix VIII) to decide whether or not to form Child Protection Special Investigation Team (CPSIT);

(b) prepare Report Form (Appendix IX) and Written Dated Notes on the case (Appendix X) which may be required as documents in court proceedings in the event that statutory intervention is involved in future;

(c) forward the completed Report Form and the Written Dated Notes to FCPSU or CAIU for making a report for investigation;

(d) be prepared for consultation by FCPSU/CPSIT or CAIU/CPSIT after the referral is made; and

(e) clarify with the family at an early stage what his/her role will be during the course of investigation by CPSIT.

7.9 For cases where CPSIT is formed, CPSIT will be responsible for strategy planning, investigative interview by means of video-recorded interview or taking of written statement, arrangement of medical examination, as necessary, and immediate case assessment. FCPSU/CPSIT or CAIU/CPSIT will share information obtained on the abuse incident(s) and the result of the immediate case assessment with relevant parties concerned as necessary. For a new case, a FCPSU worker will be assigned to take up the case and conduct social enquiry and provide casework services. The FCPSU worker should prepare the social enquiry report and arrange the Multi-disciplinary Case Conference (MDCC) to formulate the welfare plan for the child and his/her family. For known case of concerned welfare unit, the responsible worker of the concerned welfare unit will be involved throughout the handling procedures of CPSIT, including strategy planning and immediate case assessment. The responsible worker should continue to provide casework service to the child and his/her family, including implementation of the child protection plan upon immediate case assessment. He/she should also prepare the social enquiry report and arrange the MDCC to formulate the welfare plan for the child and his/her family.

7.10 For cases where CPSIT is not formed, the case will be transferred by the
CAIU to the relevant police unit for action if necessary. The police unit will then contact the responsible worker to conduct further enquiries as soon as possible. For a new case, a FCPSU worker will be assigned to take up the case and conduct social enquiry and provide casework service. The FCPSU worker should prepare social enquiry report and arrange the MDCC to formulate the welfare plan for the child and his/her family. For known case of a concerned welfare unit, the responsible worker should provide casework service to the child and the family, including immediate protection for the child. He/she should conduct the social enquiry, prepare report and arrange the MDCC to formulate the welfare plan for the child and his/her family. He/she will also share information obtained on the abuse incident(s) with relevant parties concerned as necessary. In the course of collecting information from the child on the abuse incident(s), the responsible worker should follow the governing principle in paragraph 2 above as far as possible.

7.11 For other forms of abuse cases

For a new case, a FCPSU worker will be assigned to take up the case and conduct social enquiry and provide casework service. The FCPSU worker should prepare social enquiry report and arrange the MDCC to formulate the welfare plan for the child and his/her family. For known case of a concerned welfare unit, the responsible worker should conduct social enquiry and provide casework service to the child and his/her family, including immediate protection for the child. In circumstances that suggest a criminal offence may have been committed, the case should be reported to CAIU or police unit as appropriate. The responsible worker should prepare the social enquiry report and arrange the MDCC to formulate the welfare plan for the child and his/her family. He/she will also share information obtained on the abuse incident(s) with relevant parties concerned as necessary. In the course of collecting information from the child on the abuse incident(s), the responsible worker should follow the governing principle in paragraph 7.2 above as far as possible.

(B) For cases requiring urgent medical attention

7.12 The intake / responsible worker should arrange the child to attend the Accident and Emergency Department of a public hospital designated for medical examination / treatment (with help from the Police, if necessary) and/or contact the Medical Coordinator on Child Abuse (MCCA) of the Hospital Authority for direct admission of the child victim to the Paediatric Ward as required (refer to Appendix XI). If the parent(s) / guardian(s) does / do not consent, the FCPSU worker and other SWD worker as necessary can invoke Section 34F(1) & (2) of the PCJO, Cap 213 and make an order for taking the child to the hospital and detaining the child in that hospital for the purpose of medical or surgical attention or treatment.

7.13 The social worker should follow up the case as described in paragraphs 7.8 to 7.11 above as appropriate.
(C) **For cases with a cause for concern that child abuse might have occurred**

7.14 **For child sexual abuse cases**

The social worker should explore further information on areas of concern by:

(a) contacting the informant / referrer, and/or parents / carers / teachers, etc., if necessary;

(b) seeking advice from SWO/FCPSU or Police/CAIU who will assist to assess the case with the social worker at what stage the case should be reported to Police for investigation and what further information is required;

(c) contacting the alleged victim with special caution not to use leading questions to probe into the area of sexual abuse if further exploration is required;

(d) making written dated notes of the social worker's observations on the case which may be required as documents in court proceedings in the event that statutory intervention is involved;

(e) reporting the case to FCPSU or CAIU and following up the case as described in paragraphs 7.8 to 7.10 above as appropriate, if there is reason to believe that sexual abuse has occurred upon further exploration.

7.15 **For other forms of abuse cases**

The social worker should explore further information. For cases where there is reasonable cause of concern over the health or development or welfare of the child, the responsible worker should directly observe the child in person and collect adequate information and data to substantiate the suspicion. If there is reason to believe that child abuse has occurred upon further exploration, the responsible worker should follow the steps described in paragraph 7.11.

**COLLABORATION WITH OTHER PARTIES**

7.16 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
SECTION IV

HANDLING OF REFERRALS / EQUIRY / INVESTIGATION
CHAPTER 8
SOCIAL ENQUIRY / INVESTIGATION

GOVERNMENT PRINCIPLES

8.1 In handling child abuse cases, the paramount concern is the welfare of the child.

8.2 To avoid requiring the child to describe the abuse incident(s) repeatedly, it is preferable to keep the number of investigative / assessment interview on the suspected abuse incident(s) to a minimum, say one interview. For video-recorded interview to be used in court proceedings, the interview should be conducted by police officer, social worker or clinical psychologist employed by the Government with special training. The information collected with regard to the suspected abuse incident(s) shall be shared with relevant parties concerned as soon as possible and on a need-to-know basis.

PURPOSE OF SOCIAL ENQUIRY

8.3 The purpose of the initial enquiry / investigation is to gather and analyze information in response to referral on suspected child abuse incident(s). Social workers providing casework service are responsible for conducting the social enquiry / investigation to decide whether there is reason to believe that the child has been or is being abused. Immediate action should be taken where there is a need for immediate protection and medical attention for the child. An important part of social enquiry / investigation should include determining whether there is a risk or likelihood of maltreatment in the future. Social enquiry / investigation should take place upon receipt of referral and/or alongside joint investigation and medical / forensic examination as appropriate. The results of the social enquiry / investigation will form a base of the welfare plan for the child.

RISK ASSESSMENT

8.4 The fundamental objective of child protection service is to remove risk from the child. Risk assessment is a process used to assess the level of risk to a child who is reported to have been abused and/or neglected. As child protection professionals, social workers should assess the risk level that might necessitate the removal of a child from his/her family for his/her own protection. Risk assessment should begin at the time of case intake and continue throughout the process of case assessment and planning, provision of service and termination of the case (refer to Guide to Risk Assessment in Chapter 2).
Information to be Collected

8.5 Based on the information gathered from intake, outreaching or joint investigation, the caseworker taking up the case should plan the interview process and conduct social enquiry / investigation on the victim of suspected child abuse ("the child") and his/her family. The following information has to be collected during the social enquiry / investigation:

(a) family composition of the child;

(b) living environment (including observation from home visit);

(c) schooling and employment of the child if applicable (including adjustment and social relationship in school and at work);

(d) family background (including parents' upbringing, any physical or mental health problems, criminal history if applicable, family financial status and support network, etc.);

(e) family relationship (including pattern of communication, level of affection, roles and functions of family members in the family, relationship among parents and other family members, violent behaviour of family members, etc.);

(f) characteristics and behaviour of the child;

(g) history of child care, child discipline and suspected abuse (including approach / pattern of parenting, expectations on children and sensitivity to children, etc.);

(h) precipitating incident(s) (including severity, frequency, location and description of injury);

(i) attitudes and feelings of the parent(s) / suspected abuser(s) / significant others towards the incident(s) and the welfare plan (including the possibility of further harm to the child and the willingness to accept help, etc.);

(j) capacity of the parent(s) / carer(s) to protect the child (including parents' resources and approach in solving problem and dealing with stress, use of drugs or alcohol, perception of self and coping capability, etc.);

(k) attitudes and feelings of the child (towards the parents, siblings, incident(s) and welfare plan, etc.);

(l) any other factors that may induce stress.

8.6 The caseworker may consider to interview the child and each of his/her family members individually in the following sequence as appropriate:
(a) the child;
(b) siblings and other children in the home;
(c) non-maltreating parent(s) / carer(s);
(d) suspected abuser(s);
(e) other family members, relatives and concerned professionals.

8.7 Joint interview may be conducted if necessary to assess the family dynamics, family relationship and communication patterns.

Analysis of Information and Immediate Child Protection Plan

8.8 With the information collected, caseworkers should analyze the information in a timely manner to make appropriate decision for child protection and to minimize any unnecessary anxiety affecting the family during the assessment process. A social enquiry report should be prepared with recommendation for the welfare planning of the child and his/her family (refer to Social Enquiry Report on Suspected Child Abuse Case for Multi-disciplinary Case Conference at Annex to Chapter 8). The caseworkers should prepare the child and the parents for possible alternatives to the welfare planning to protect the child, such as arrangement of residential child care service, application for Care or Protection Order, where necessary. In assessing the risk for the child, reference can be made to Guide to Risk Assessment in Chapter 2. Risk assessment helps caseworkers analyse information and guides decision making but does not replace their professional judgement.

8.9 Prompt action should be taken to address the emergency needs of the child and his/her family. For example, action relating to immediate medical attention for the child and removal of the child to a place of safety should be taken promptly. If the child is assessed to be in need of statutory protection in the course of enquiry, application should be made by the responsible social worker of SWD or by the Police under the provision of Section 34(1) / Section 34E(1) / Section 34F(1) / Section 35(1) / Section 44(1) / Section 45(A) of the Protection of Children and Juveniles Ordinance, Cap 213, as appropriate. For known case of an NGO, the responsible worker may consult the intake worker of the Family and Child Protective Services Unit (FCPSU) whenever necessary. If urgent statutory care proceedings on the child / children are required for the case during the course of enquiry, application should be either made by respective IFSC of SWD according to the latest residential address of the child’s parent / guardian or by the Police.

REFERRAL FOR PSYCHOLOGICAL ASSESSMENT / TREATMENT AND CASEWORK SERVICE

8.10 Social workers should be sensitive to the emotional needs of the child and his/her family throughout the social enquiry / investigation process. Where the need for psychological assessment / treatment is indicated, referral for psychological service should be arranged. At the same time, the social worker
taking up the case should provide casework service to the child and his/her family, which include counselling and other support service.

8.11 When psychological abuse is suspected, clinical psychologist could be involved.

**COLLABORATION WITH OTHER PARTIES**

8.12 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service for the family.
Annex to Chapter 8

Social Enquiry Report on Suspected Child Abuse Case
for Multi-disciplinary Case Conference

Reference No. :
Name of the Child :
Sex / Age :
Address :
School :

Family Composition of the Child (the Suspected Victim)

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<th>Name</th>
<th>Sex / Age</th>
<th>Employment</th>
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<td>Mother</td>
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<td>Siblings* (including boy / girl-in-question)</td>
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Living Environment (including observation from home visit)

Education (including adjustment and social relationship in school)

Employment (including adjustment and social relationship at work)

Family Background (including parents’ upbringing, any physical or mental health problems, criminal history if applicable, family financial status and support network, etc.)

Family Relationship (including pattern of communication, level of affection, roles and functions of family members in the family, relationship among parents and other family members, violent behaviour of family members, etc.)

Characteristics and Behaviour of the Child

History of Child Care, Child Discipline and Suspected Abuse (including approach / pattern of parenting, expectations on children and sensitivity to children, etc.)

Precipitating Incident(s) (including severity, frequency, location and description of injury)

Risk of Child Abuse to Other Child(ren) in the Family
Attitudes and Feelings of Parent(s) / Suspected Abuser(s) / Significant Others towards the Incident(s) and Welfare Plan (including the possibility of further harm to the child and the willingness to accept help, etc.)

Capability of the Parent(s) / Carer(s) to Protect the Child (including parents’ resources and approach in solving problems and dealing with stress, use of drugs or alcohol, perception of self and coping capability, etc.)

Attitude and Feelings of the Child (towards the parents, siblings, incident(s) and welfare plan, etc.)

Any Other Factors that may Induce Stress

Recommendation on Welfare Planning

Signature : _____________________
Name : _________________________
Rank : _________________________
Office : _________________________
Tel. No. : _________________________
Date : _________________________
CHAPTER 9
MEDICAL EXAMINATION

GOVERNING PRINCIPLES

9.1 In any medical examination, the child's health and welfare must always be of paramount concern. Requiring the child to describe the abuse incident(s) repeatedly should be avoided as far as possible and the number of examination should be kept to the minimum.

9.2 The examination should be conducted in a child-oriented reception and examination room to avoid additional emotional trauma.

9.3 The examination should be performed by staff with the ability to establish rapport with children and respond to their anxiety and discomfort, and by well trained medical examiners in a gentle and sensitive manner.

9.4 The child should be given full explanation about the examination, taking into account the child’s age and capability, and which should be conducted in the presence of a supportive adult who is not suspected to be party of the abuse.

9.5 There should be regular peer review on the findings and chartings.

9.6 Ideally all children suspected of being sexually abused should receive a medical examination by a well-trained medical examiner to achieve the following objectives:

(a) to identify injuries or conditions requiring medical attention;

(b) to assess the possibility of sexual abuse and to collect evidence of abuse;

(c) to have a general assessment on the physical, developmental, social, psychological and psychiatric status of the child;

(d) to minimize possible trauma to the child or carers in the examination process; and

(e) to interpret findings preferably by trained personnel making use of equipment of photographic capability with a colposcopic or macro lens camera.

9.7 Medical Co-ordinators on Child Abuse (MCCA) are designated by the Paediatric Departments in hospitals under the Hospital Authority for handling child abuse cases. For cases that the Child Protection Special Investigation Team (CPSIT) has been formed, the MCCA can be consulted at the strategy planning stage to determine the need for medical examination.
PLANNING AND MEDICAL EXAMINATION IN HOSPITAL

9.8 All children suspected to have been abused should be given a comprehensive examination, including assessment of physical, developmental, behavioural and emotional status. If necessary, referrals to clinical psychologists, psychiatrists and doctors of other relevant disciplines may be made. Special attention should be paid to the growth parameters and sexual development of the child.

For Suspected Child Sexual Abuse Cases

9.9 Doctor conducting initial examination should confine to a routine observation of the genital area unless indicated, e.g. heavy bleeding. Detailed examination of the genital area should be deferred until the planning by the MCCA to decide whether full assessment is needed.

9.10 Planning by the MCCA should be performed as soon as possible (preferably within 24 hours) in all suspected child sexual abuse cases with all relevant professionals concerned after gathering information on the child’s medical, family and educational background. The purpose of the planning is to decide on the plan and need for further assessment:

(a) consultation of welfare / crime-related issues can be made to the Family and Child Protective Services Unit (FCPSU) or Child Abuse Investigation Unit (CAIU) or Police Station as appropriate;

(b) multi-disciplinary interview;

(c) full genital examination;

(d) forensic examination for collection of medical and physical evidence;

(e) full developmental and mental health assessment;

(f) Detention Order in Hospital under Section 34F of the Protection of Children and Juveniles Ordinance, Cap 213;

(g) informing parents, etc.

9.11 For direct disclosure and suspected child sexual abuse cases, referrals to FCPSU or reports to CAIU should be made as early as possible. The process should be repeated when additional or new information is available.

9.12 For child sexual abuse cases and serious physical abuse cases falling under the Charter of CAIUs, medical officers (MO) can join the CPSIT for a particular case. However, the MO cannot participate in the investigatory process other than the medical examination of the child. As the child should not be required to describe the abuse incident repeatedly but the information might be of great significance to the MO in carrying out medical examination of the child, the MO working with the CPSIT can observe the video-recorded interview of some
special cases from a viewing room. In doing so, the MO who has viewed the interview will be required to provide a statement as to their action and conduct of the interview and will be liable to be required by the Court to give evidence on the matter.

**Consent to Medical Examination**

9.13 Generally a doctor administering treatment or carrying out an examination must satisfy himself that the child is of sufficient understanding and has the capacity to give consent and the views of the child and parent / carer on consenting to a medical examination should be considered. Where the life or physical well-being of the child is at risk, and medical examination and treatment must be carried out promptly especially in situation of life and death, doctors may depart from the general rule and proceed without either the child's or his parents' consent. This would cover situations where the child is brought to the Accident and Emergency Department (AED) in the aftermath of an accident or as a result of suspected child abuse. The medical examination is undertaken for diagnosis and treatment purpose. The requirement for consent is dispensed with as a matter of necessity.

9.14 In cases where medical examination is carried out by the forensic pathologists for the purpose of gathering evidence in relation to the criminal investigation into the child abuse incident, the Department of Justice has advised that the normal requirement for consent (from the child's parent / guardian or the child if he/she is competent and of sufficient understanding to give consent) should be adhered to.

9.15 In the absence of consent, the provisions of the Protection of Children and Juveniles Ordinance, Cap 213 to facilitate such forensic examination should only be invoked under **exceptional circumstances**, and only after full and careful consultation with the examining doctor, the respective forensic pathologist and immediate supervisory officers of SWD and Police. Under Section 34(1), care proceedings may be instituted so that the Juvenile Court can commit the child into the legal guardianship of the Director of Social Welfare (DSW) who may then give consent to such forensic examination. Or alternatively, the DSW may cause a notice to be served on any person having custody or control of the child (whom DSW has reasonable cause to suspect to be in need of care or protection) to produce the child for an assessment by a medical practitioner of the way in which the child has been treated [Section 45A(1)(a)], failing which the DSW may remove the child for an assessment [Section 45A(4)] though the DSW's entry into any premises for the purpose of effecting a removal shall not be by force unless a warrant has been obtained from a Magistrate, Juvenile Court or District Court [Section 45A(8)].

**Medical Investigation**

9.16 Appropriate investigation should be performed as indicated by the history of the case or examination.
9.17 Routine screening for sexually transmitted diseases is not required for all sexual abuse cases.

**Documentation and Evidence Collection**

9.18 Careful documentation of the history, examination and investigation is essential. Photographs, X-rays, culture results, specimens taken for investigation, site, time and date, and person(s) who took the specimens are to be recorded. Chain of evidence needs to be properly kept. MOs conducting the examination will be required to be asked in Court on their findings, conversations and contacts with the child.

**ROLE OF FORENSIC PATHOLOGIST**

9.19 **For child sexual abuse cases,** forensic pathologist will be involved upon request of the Police (OC Case) to conduct the forensic examination or when the hospital doctors, during their clinical management of the child, wish to seek a second opinion.

9.20 For child sexual abuse cases that have been reported to Police, the forensic pathologist will conduct forensic examination upon request of the Police as follows:

(a) In **non-hospitalised cases,** the forensic pathologist will conduct the examination in the designated suites.

(b) In **hospitalised cases,** the forensic pathologist will see the child as a member of the medical examination team when indicated. The forensic pathologist will attend the hospital whilst the child is still hospitalized. The examination can also be conducted at the police suites. Case discussion between the hospital doctors and the forensic pathologists is encouraged as it may not be possible / necessary for the forensic pathologist to be present for every suspicious case.

9.21 For child sexual abuse cases in which the incidents happened recently, the forensic pathologist will conduct the forensic examination as soon as practicable. The forensic pathologist should be notified and the escorting officer should inform the doctor of AED whether the forensic pathologist will personally attend the hospital to carry out the examination in respect of the alleged offence. This is to avoid the victim being examined twice. In the event that the victim is hospitalized, the responsible police officer (OC Case) will inform the Ward Manager / MO once the decision of conducting forensic examination is determined. However, if the victim requires urgent medical treatment, immediate medical examination and management by the hospital doctor should not be deferred.

9.22 If the hospital doctor who has examined the child during his clinical management of the child can provide adequate evidence, which is also
admissible in court, separate forensic examination by a forensic pathologist is not required so as to minimize the trauma to the child.

9.23 For child sexual abuse cases in which the abuse happened some time before, forensic examination can be arranged at a time convenient to all parties concerned.

9.24 For child sexual abuse cases that have not been reported to the Police, forensic examination by forensic pathologist will not normally be performed. However, the Consultant Forensic Pathologist will be available to provide specialist advice when necessary.

9.25 For non-contact child sexual abuse cases, there is normally no indication for forensic examination by forensic pathologist on top of the general medical examination by clinicians. However, the Consultant Forensic Pathologist or his/her delegate will be available to provide specialist advice when necessary.

9.26 For child sexual abuse cases, CAIU/CPSIT should liaise with the MOs concerned for details of the examination findings and any forensic evidence. CAIU/CPSIT will, in consultation with a forensic pathologist and FCPSU/CPSIT where CPSIT is formed, determine whether a further examination of the child is required.

9.27 For other forms of child abuse cases, there is normally no indication for forensic examination by forensic pathologist on top of the general medical examinations by clinicians. However, the Consultant Forensic Pathologist will be available to provide specialist advice for serious / complicated cases when necessary.

9.28 Forensic pathologists are on call 24 hours a day and can be contacted through the Duty Officer, HQCCC, Police Headquarters.

STRATEGY PLANNING

9.29 The CPSIT will be responsible for conducting strategy planning, video-recorded interview and immediate case assessment, irrespective of the need of the child for hospitalization. The MCCA and relevant personnel attending the cases will be closely involved throughout the handling process by CPSIT to contribute their professional views and information gathered on the child's medical, family and education background. They will also be involved in formulating the immediate protection plan of the child as necessary.

MULTI-DISCIPLINARY CASE CONFERENCE

9.30 The MO(s) attending the case should attend the Multi-disciplinary Case Conference to formulate the welfare planning of the child and his/her family and prepare preferably written report(s) on the child's condition for reference of
the Conference. When subsequent case conferences are called by the key worker, MOs concerned will be invited to attend.

**FOLLOW UP**

9.31 For cases requiring medical follow up in ward or Specialist Outpatient Clinic (SOPC), etc., the case should be followed up by the MCCA, medical social worker, clinical psychologist, psychiatrist or other professionals as appropriate.

**COLLABORATION WITH OTHER PARTIES**

9.32 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
CHAPTER 10

JOINT INVESTIGATION –
EARLY CONSULTATION, STRATEGY PLANNING,
INVESTIGATIVE INTERVIEW AND
IMMEDIATE CASE ASSESSMENT

GOVERNING PRINCIPLES

10.1 In any child protection intervention, the child's welfare must always be paramount concern and take precedence over:-

(a) the rights of parents; and

(b) the criminal prosecution of any alleged perpetrator.

10.2 A proper balance must be struck between protecting children and respecting the rights and needs of parents and families; but where there is a conflict, the child’s interests must always come first. A thoroughly considered approach to intervention in the family is essential. Procedures and interventions intended to protect the child should not in themselves be abusive by causing further damage or distress.

10.3 During investigation into allegation of child abuse, there will be situations where the Police and social workers of the Government will work together in a joint investigation. In the process of collecting evidence, a decision may be made to record a child’s account of an abuse on video tape. The decision to record the interview with a child on video or not will be made with the above welfare principle in mind. In order to safeguard the “welfare principle”, it is essential to take steps to ensure that this process is applicable to all children, if appropriate.

10.4 Professionals involved in joint investigation should be sensitive to the emotional needs of the child and his/her family members, including the offending parent, throughout the process of joint investigation.

AIM OF THIS CHAPTER

10.5 The aim of this Chapter is to provide guidance to officers of the Regional Child Abuse Investigation Units (CAIUs) of Police, the Family and Child Protective Services Units (FCPSUs) and clinical psychologists (CP) of SWD who will form Child Protection Special Investigation Team (CPSIT) in handling allegation or suspicion of child abuse.
10.6 To handle allegation or suspicion of child abuse with a view to collecting evidence which will be admissible in criminal proceedings, and to prevent further trauma to the child by having to repeat details of the allegation to different persons, the Police and SWD will form a CPSIT to conduct joint investigation into cases of suspected child abuse. The reasons for this are:

(a) SWD have a statutory responsibility to investigate all allegations of child abuse to determine whether the child concerned is in need of care or protection under the Protection of Children and Juveniles Ordinance Cap 213;

(b) Police have the responsibility to investigate reports of offences against children; and

(c) both SWD and Police have specialist and complementary skills in terms of investigating allegations of child abuse. In appropriate cases, it is necessary for these skills to be combined to provide maximum protection to the children who have been abused or at risk.

10.7 CAIUs will investigate cases of:

(a) child sexual abuse occurring within the family or extended family (e.g. mother, father, aunt, uncle) where the victim is under the age of 17 years;

(b) child sexual abuse where the victim is under the age of 17 years and, the alleged offender is known to the child or is entrusted with the care of the child (e.g. baby-sitter, school teacher, youth worker);

(c) serious physical abuse where the victim is under the age of 14 years (at the discretion of the respective Senior Superintendent of Crime Region); and

(d) organised child abuse. (Organised child abuse is defined as abuse which may involve a number of abusers, a number of abused children and juveniles and often encompasses different forms of abuse. It will also involve to a greater or lesser extent an element of organisation e.g. paedophile or pornography rings.)

10.8 In respect of cases falling outside the Charter, cases involving mentally handicapped victims and witnesses and child witnesses to crime, where appropriate, the CAIUs will be responsible for:
(a) assisting in intaking / recording their statements on video tape; and

(b) advising investigation units in relation to giving evidence in criminal proceedings.

10.9 Cases falling outside the above Charter (such as sexual assaults by strangers) will be handled by the appropriate police units. Procedures for handling suspected child abuse cases by CAIUs and other police units are provided at Appendix XII.

10.10 Cases of child sexual abuse referred to in this Chapter are those specified in the CAIU Charter in paragraph 10.7 above.

10.11 The Police have established five Regional CAIUs in Hong Kong Island, Kowloon East, Kowloon West, New Territories North and New Territories South respectively. Correspondingly, SWD have divided the work among FCPSUs to match with each of the regional CAIUs. These CAIUs and FCPSUs will work together as the Child Protection Special Investigation Teams (CPSIT) for cases described in paragraph 10.7 above. The respective lists of contact phone numbers are at Appendix VII and VIII.

10.12 Each CPSIT will be formed and begin to function when a report of case described in paragraph 10.7 above is received, either by CAIU or FCPSU. The CPSIT member (CAIU/CPSIT and FCPSU/CPSIT) will contact each other by phone / pager to conduct joint investigation as appropriate in accordance with the procedures described in the following paragraphs.

10.13 When a video-recorded interview of a child is to be conducted, the CPSIT member (CAIU/CPSIT and FCPSU/CPSIT) or clinical psychologist of SWD will conduct the investigation together in police interviewing suites according to Section 79C of the Criminal Procedure Ordinance, Cap 221.

10.14 In discharging their statutory duties, it is important for staff of both SWD and Police to be conscious that a lack of necessary intervention may have an adverse effect on the child, or conversely, that unnecessary intervention may adversely affect both the child and the family. They should ensure that children at risk are protected.

10.15 In conducting video-recorded interviews, reference should be made to the procedures laid down in the Memorandum of Good Practice (MOGP) (Appendix XIV).

REFERRALS

10.16 Consultation of welfare / crime-related issues in relation to allegation / suspicion of child abuse cases can be made to FCPSU/CAIU as appropriate. Joint investigation will be conducted on cases described in paragraph 10.7 above.
10.17 Referrals to FCPSU / Reports to CAIU will broadly fall into two groups:

(a) allegation / suspicion which requires joint investigation from the outset; and

(b) allegation / suspicion which requires consultation with FCPSU/CAIU to consider if joint investigation by the CPSIT is necessary.

10.18 All referrals / reports will be taken seriously and considered with an open mind.

10.19 Members of the CPSIT, i.e. CAIU/CPSIT or FCPSU/CPSIT, receiving referrals must be aware that it is not necessary to have incontrovertible evidence before initiating joint investigation. Circumstances where the information is assessed to have indicated a reasonable probability that the child is suffering from abuse should be subject to such investigation.

Sources of Referral

10.20 Referrals may originate from:

(a) the child;

(b) any member of the public;

(c) staff working with children and families who are not directly involved in child protection work, e.g. teachers, child care workers, youth workers, etc.; and

(d) other professionals who are regularly engaged in child protection work, e.g. family caseworkers, medical practitioners, police, clinical psychologists, etc.

Handling of Referral

10.21 CAIU has a call out list and is available on a 24-hour basis. FCPSU and clinical psychologist can also be contacted according to the list at Appendix VII. On receipt of a referral of case which falls in the Charter of CAIU (paragraph 10.7 above), the CPSIT will be formed and the members on duty will collect the following information from the informant / referrer:

(a) request the informant / referrer to give his/her name, address, telephone number and if possible, HKIC number. Anonymous referrals are also accepted, but contact telephone numbers are preferred to be recorded in order to obtain further information on the case;

(b) collect all details of identifiable data of the child / family, e.g.

(i) the nature, date and frequency of the abuse or concern;
(ii) the name, date of birth (if unavailable - age), and any disability or special needs of the child;

(iii) the child’s whereabouts;

(iv) whether the child is in immediate danger;

(v) names and HKIC numbers of parents / carers and others involved;

(vi) names of other children in the household and whether the children are at risk or potentially at risk;

(vii) name of school / child care centre, if known;

(viii) how the informant / referrer is aware of the information; and

(ix) names of other witnesses and other agencies / government departments involved.

10.22 Sample Report Forms and Written Dated Notes are at Appendix IX & X respectively.

10.23 In order to avoid confusion or duplication, it should be established whether the informant / referrer has contacted other government departments or agencies. If the informant is the child himself/herself and asks for the allegation to be kept secret, explanation should be made to the child that it is in his/her best interests that such a promise cannot be made.

10.24 Sometimes informants may wish to be treated in confidence. The informant should be assured that his/her identity and personal data will not be disclosed unless such disclosure is essential to protect the child or other persons or required in court proceedings.

10.25 On receipt of a referral or when in direct contact with a child who wishes to make an allegation of abuse, the following principles should be adopted:

(a) listen to the child, rather than directly question him/her;

(b) never stop a child who is recalling significant events at will;

(c) make a note of the discussion, with due care in recording the time, setting and personnel present at the time of the discussion, as well as what has been said (this may be required as a court exhibit); and

(d) record all subsequent events up to the time of the investigative interview.

10.26 The court may be interested in hearing evidence from those who have had direct contact with the child prior to the investigative interview.

10.27 The FCPSU/CPSIT will check the Child Protection Registry following which both CAIU/CPSIT and FCPSU/CPSIT will make initial assessment of the referral.
JOINT INVESTIGATION

10.28 Goals of the Investigation:

(a) to protect the child;

(b) not to traumatise the child any further; and

(c) to collect evidence on the allegation or suspicion in a friendly environment for the child.

10.29 The process of joint investigation generally consists of the following stages:
- Stage I - Early Consultation
- Stage II - Strategy Planning
- Stage III - Investigative Interview
- Stage IV - Immediate Case Assessment

Stage I - Early Consultation

10.30 Early consultation should begin as soon as a referral is received. Based on the data collected, CPSIT should consider whether further action is required. Some allegation/suspicion may warrant joint investigation while some may not. The informant/referrer will be kept informed of the decision or if necessary will be involved in strategy planning. The referrer is advised to initiate contacts with FCPSU/CAIU for their views/results of their enquiry. For cases which require further exploration, the referrers will be kept informed by the CPSIT as soon as possible. A written record of early consultation will be kept by the CPSIT.

Stage II - Strategy Planning

10.31 All joint investigation undertaken by the CPSIT should involve a strategy planning meeting, or consultation over the phone preferably within 24 hours. The social worker from the referring agency/department and other concerned professionals (medical officer/practitioner, psychiatrist, psychologist, school personnel as appropriate) should attend. If it is not possible to establish a joint investigation plan within 24 hours of referral, then it may be appropriate for the Police or social worker to conduct initial investigation singly to assess the protection needs of the child.

10.32 The purpose of Strategy Planning is:

(a) to share relevant information about the child, the family and the allegation;

(b) to plan the extent of and how to conduct the investigation;

(c) to decide if there is a need to interview the child and the most appropriate time and method;
(d) to decide if there is a need to record the interview on video or to take a written statement from the child; and

(e) to plan the tasks of each agency involved.

10.33 It is essential for the safety of the child that no precipitous action is taken and that the investigation is carried out in a carefully planned way. An assessment of the immediate risk to the child should be undertaken preferably within 24 hours upon receipt of information.

10.34 An immediate response is required if the child:

(a) is making an allegation and asking for help;

(b) needs urgent medical treatment, or is otherwise in danger or has suffered significant harm;

(c) is threatening suicide;

(d) alleges to have recently been abused and forensic evidence is likely to be available; or

(e) is living / staying with the alleged offender.

10.35 The CPSIT should consider immediately specific actions to be taken. This will include:

(a) what action if any to immediately protect the child or other children in the household;

(b) who will be responsible for the removal of the abuser or the removal of the child from home;

(c) who to interview

(i) the person making the allegation;
(ii) the parents or other carers;
(iii) the child;
(iv) other children in the family;
(v) other family members or people who may have information relevant to the enquiry; and
(vi) the suspected abuser.

(d) who to conduct the interview which has been agreed to be necessary;

(e) careful consideration on the appropriateness of the interviews to be conducted jointly by the social worker and police officer;

(f) timing of the interviews;
(g) where to conduct the interviews;

(h) appropriateness of medical examination at this stage (in respect of consent to a medical examination see paragraphs 9.13 to 9.15 above);

(i) whether the interviews are to be video-recorded;

(j) arrangements for reporting back;

(k) there will not normally be a joint interview of the alleged perpetrator for the purpose of a criminal investigation. This will be conducted by the Police alone;

(l) if urgent action needs to be taken, only in the following circumstances will the interview with the child start while no other party but only the Police/CPSIT is present:

   (i) to protect the child;
   (ii) to preserve the evidence;
   (iii) to detain the alleged perpetrator; or
   (iv) if the other agency is unable to attend within a reasonable time.

10.36 The result of the Strategy Planning must be recorded properly by completing the “Record of Strategy Planning” contemporaneously (Appendix XIII).

10.37 Adequate planning is essential for the efficient conduct of any interview with a child. The strategy agreed should reflect the skills and experience represented by CPSIT.

10.38 Where there is uncertainty or disagreement on whether the interview should be video-recorded or otherwise, advice should be sought immediately from the supervisors of the respective CAIU and FCPSU who will direct appropriate action having due regard to all the circumstances.

10.39 For cases not meeting the criteria for video-recorded interview, a decision has to be made on how to take the written statement from the child with due consideration to the welfare of the child.

**Gaining Access to the Child and Removal of the Child**

10.40 Whenever necessary, immediate action to protect the child should be taken. For a child in need of care or protection under Section 34(2)(a) of the Protection of Children and Juveniles Ordinance, Cap 213, CPSIT will visit and gain access to the child and bring the child to a suitable location with transportation provided by the Police/CAIU.
Protection of Other Children

10.41 The SWO/FCPSU should also consider protecting other children in the household who may be at risk and if necessary, initiating enquiry by the CPSIT (see paragraph 10.91 below).

Stage III - Investigative Interview

Criteria for Video-recorded Interview

10.42 Section 79C of the Criminal Procedure Ordinance, Cap 221 allows video recording of an interview with a child witness of certain sexual or violent offences to be used, where it relates to any matter in issue in the proceedings, in trials at the High Court, District Court or Magistracy. Under Section 79C, video recording is admissible only where:

(a) the child is not the accused;
(b) the child is available for cross-examination (assuming the proceedings get that far); and
(c) the rules of Court requiring disclosure of the circumstances in which the recording was made have been properly complied with.

10.43 Bearing this in mind, the use of the video-recorded interview should be restricted to those cases where a child or young person has made specific allegation or there is a suspicion of sexual abuse, or physical abuse.

10.44 In deciding if video taping is the appropriate medium on which to record the evidence, other factors should also be considered. They may include the nature of the allegation, age and competence of the child and where appropriate, and wishes of the child (older children may prefer to provide a statement and appear in Court). Consideration should also be given as to the likelihood of the matter going to Court.

10.45 With regard to very young children (i.e. under the age of 5), it must be considered whether the child will be able to give a coherent account of the events under investigation. This should not necessarily be age limited. Each child should be considered as an individual in respect of the criteria on competence and suitability.

10.46 Under the Evidence Ordinance, Cap 8, it is no longer a requirement in law for the Court to examine the child’s competency before the trial. It may be the case, as with some adult witnesses, when a particular child proves to be unable to give an understandable account of the event under investigation. If this happens, the child’s evidence will not form part of the case for the prosecution or defence. The CPSIT should assume that the Court will be willing to listen to the evidence of any child who is able to communicate in a way the team as a whole can understand. This would include communication which has been
aided by the use of communication tools such as dolls or drawings.

10.47 This is only an advice and each case must always be judged on its merits. In light of this advice, the following criteria should still apply.

10.48 Interviews with children who may be victims may be video-recorded where there is:

(a) an allegation or suspicion of an offence involving assault, or injury, or a threat of assault or injury, or cruelty, and the witness may be a victim under 14 years of age;

OR

(b) an allegation or suspicion of a sexual offence where the witness may be a victim under 17 years of age;

AND

the child appears to be capable of giving evidence in Court.

10.49 However, there will be occasions when child witnesses to offences of violence who may not be victims of child abuse require interviewing and there is neither a child protection issue nor statutory duty for the FCPSU/CPSIT to investigate. In these cases, the Police will interview with SWD personnel only when there is a valid reason for the interview to be conducted jointly and consent has been obtained from an officer supervising the respective CAIU. According to good practice, welfare principle and special working policies, it is suggested that in certain cases, e.g. where a child has witnessed the murder or serious assault of a family member, SWD should be informed and should consider whether their involvement will be in the best interest of the child.

10.50 Interviews with child witnesses who are not victims may be video-recorded where:

(a) they are under 14 years of age and are material witnesses in any offence involving assault or injury, or a threat of injury or cruelty;

OR

(b) they are under 17 years of age and are material witnesses in any sexual offence;

AND

the child appears to be capable of giving evidence in Court.

10.51 A full list of offences is given at Annex I to Chapter 3.
**When to Interview**

10.52 All allegations should be investigated without delay. However, a premature interview of an investigation may not be in the child’s best interest. Equally, a delay may be prejudicial to the child’s welfare where this is specifically due to the lack of resources, whether this be access to a suite, equipment or personnel. In such case, other means to conduct the interview may need to be considered.

10.53 Once it becomes clear that a criminal offence may have been committed, and it has been agreed to interview the child through video recording, an interview should be arranged as soon as practicable.

10.54 This will minimise the stress on the child and reduce the chance of him/her forgetting important or relevant details or being influenced by others. Consideration will be given to:

(a) the needs of the child;
(b) the child’s physical, social and sexual development;
(c) the child’s memory;
(d) the child’s concept of time;
(e) the child’s understanding and trust of the interviewer(s);
(f) the use of age-appropriate language; and
(g) legal aspects.

**Care to be taken when Transporting Children to and from Interviews**

10.55 Care must be taken that the CPSIT does not stay with the child without the presence of independent adult(s). This is especially so, where children in police protection are conveyed to the police suites from police stations. It will be subject to query if no independent adult is present. If such situation is unavoidable, a brief record of any conversation with the child should be made as soon as possible after it takes place. This record should be retained for production in Court if required.

**Consent**

10.56 Written consent to be video-recorded needs not be obtained. However, in the interest of good practice, parents should be fully informed and their permission should be sought in writing using the consent forms provided unless the action to do so would affect the safety and welfare of the child. This will depend on the age of the child, the circumstances and nature of the allegation (i.e. whether the parent / carer is a suspected abuser and whether there is the likelihood of
collusion with the parent / carer).

10.57 In exceptional circumstances when the child is interviewed without informing the parents / carers, the reasons for this should be clearly recorded. Generally in such circumstances, legal advice should be sought. Where a child is mature enough to understand the concept, he/she should be given an explanation of the purpose of the video recording so that the child is fully informed to a level appropriate to his/her own age and understanding and freely consents to be interviewed and video recorded.

10.58 Where a child is of sufficient understanding to indicate his/her willingness to make a video-recorded statement against the wishes of his/her parents, he/she should be permitted to do so, where such a statement is to facilitate a criminal investigation / prosecution. However, there is no legal authority to prevent parents of an abused child from observing the interview through a Close Circuit Television in the viewing room.

10.59 In cases of child abuse, if the parent(s) are suspected of the abuse or if it is believed that by viewing the video recording from a separate room, the parents would be in a position to affect or prejudice the child’s subsequent testimony in the criminal proceedings, and if the child is unable to give consent and the parents refuse or, are suspected to have involvement in the abuse, neither the child's nor the parents’ consent is required to conduct any procedures in respect of the child for the purpose of police investigation. The Police Force Procedures Manual (FPM) 21-35 details the situations where it may be necessary to interview a child or young person under the age of 16 years old with the presence of a parent or guardian.

10.60 In circumstances where the child is a witness or victim, a parent or guardian has no legal right to demand to be present during the interview, however, in accordance with paragraph 10.58 above, he/she cannot be denied access to view the interview in the viewing room.

10.61 Officers conducting interviews in scenarios outlined in the paragraphs above should differentiate between a parent or guardian “being present” as opposed to “viewing” or “monitoring”. Presence implies physical proximity (i.e. in the interview room), "view" and "monitor" do not require physical proximity as the parents can be accommodated in the viewing room.

Explanation to Child

10.62 Children, parents or accompanying adults should always be given clear information regarding the format and nature of the interview. The child can be informed about the investigative interview as soon as it is planned. It will be important to avoid coaching the child, but answering his/her questions about the reasons for the interview would be helpful and would provide an opportunity to assess the child’s willingness to be video-recorded.
10.63 It should be explained to the child that video recording will be used to record his/her conversation with the interviewer instead of a written statement. It should also be explained that this video recording may be viewed by other professionals but will not be shown to the child’s friends and that the Police will ensure security of the video tape. The child should be advised that after the video recording has been made, he/she will be given an explanation of what will happen next and this will depend on what was said during the interview.

10.64 Where a child is too young to understand fully, the team should listen to the views of the parents or carers. (Care should be taken regarding the possibility of anyone, implicated in abuse of the child, exerting pressure on a child not to give his/her account.)

**Location of Interviews**

10.65 Interviews must be conducted in sympathetically designed suites which are equipped with video / audio equipment.

10.66 There are five such suites: one each in HKI, KW, KE, NTS and NTN (all suitable for people with disabilities - including children and accompanying adults) operated by the Police.

10.67 To comply with the **Memorandum of Good Practice** and the general welfare principle, a portable video recording system will be used to conduct interviews in hospitals, witnesses’ homes, or other appropriate locations. The use of this equipment is designed for occasions when witnesses are unable to attend the above suites. This equipment is available from the Child Protection Policy Unit of Hong Kong Police.

**Video-recorded Interviews**

10.68 The basic aim of the interview is to obtain a truthful account from the child, in a way which is fair and in the child’s interests, acceptable to the Court and can reduce the trauma of the child having to repeat details of the incident(s).

10.69 In conducting the interview, it is important to **listen** to what the child has to say. It is not a “therapeutic” interview. However, each child is unique and an effective interview will be one which is tailored to the child’s particular needs and circumstances.

10.70 It must be understood that front-line practitioners, therapeutic interviewers, and CPSIT members may be required to be witnesses in Court.

10.71 Interviews should be conducted using the phased approach as recommended in the **Memorandum of Good Practice** (*Appendix XIV*).

**Who should Interview**

10.72 Interviews should only be conducted by police officers, social workers and
clinical psychologists of SWD trained in joint investigation and video-recorded interviews. It is an essential pre-requisite that they are fully conversant with the Memorandum of Good Practice. The interviewers should consult their supervisors for any difficulties encountered in arranging the video-recorded interviews, case assessment and decision making.

10.73 The CPSIT should consider, in the light of the issues known, who is best qualified to conduct the interview. The interviewer, be he/she the CAIU/CPSIT, FCPSU/CPSIT or clinical psychologist, should be the person who has or is likely to be able to establish rapport with the child, who understands how to communicate effectively with him/her, including during disturbed periods, and who also has a proper grasp of both the basic rules of evidence and the elements of criminal offences. Wherever possible, the child’s wish should be taken into account. Some compromise may be necessary.

10.74 In circumstances when a child refuses to talk, the CPSIT may decide to temporarily suspend the investigation and refer the suspected victim to a clinical psychologist for assessment/treatment where necessary. If the child has psychiatric symptoms or has records of mental illness, a child psychiatrist should be invited to assess the mental state of the child before the video-recorded interview is conducted.

10.75 In the event that a video-recorded interview has to be terminated because the child refuses to talk and there is a need to conduct a second video-recorded interview, legal advice shall be sought prior to the second interview, and a full record of the reason for the second interview shall be recorded.

10.76 Having regard to paragraphs 10.48 to 10.50 above, a video-recorded interview may be conducted by:

(a) the CAIU/CPSIT, assisted by the FCPSU/CPSIT and/or clinical psychologist in the monitoring room;

(b) the FCPSU/CPSIT, assisted by the CAIU/CPSIT and/or clinical psychologist in the monitoring room;

(c) the clinical psychologist, assisted by the FCPSU/CPSIT and/or CAIU/CPSIT in the monitoring room.

10.77 A rigid definition of the roles of Police and social service professionals in the joint investigation on the child and his/her family is not likely to be possible or desirable and a high degree of flexibility and responsiveness within the CPSIT is essential.

10.78 In exceptional cases, it may be in the interests of the child to be interviewed by an adult whom he/she confides in, but who is not a member of the CPSIT. Provided that such a person is a police officer, social worker or clinical psychologist working for the Government and is prepared to co-operate fully
with appropriately trained interviewers and accept adequate briefing, this possibility should not be precluded. The covert earpiece / induction loop system should be used in these circumstances and the interview should be controlled by a member of the CPSIT.

10.79 In the event of criminal proceedings, any formal or informal notes relating to the investigation, preparation and conduct of any interview must be retained and passed to CAIU/CPSIT for disclosure to the Department of Justice (Prosecution Division).

Observer of Interview

10.80 People other than the interviewer and the child should not normally be in the interview room. A suspected offender must never be present. The presence of excessive number of people in the interview room may overwhelm the child. Persons who accompany the child, i.e. to provide support, may view the interview in the viewing room via the CCTV.

10.81 When the CAIU/CPSIT is the interviewer, the FCPSU/CPSIT partner will monitor the interview in the monitoring room and vice versa. The monitor can communicate with the interviewer through the induction loop ear piece. A supervisor may also be present to monitor the interview.

10.82 Where appropriate, e.g. in rape cases, the investigating officer who may not be a member of CPSIT, may also observe the interview of the victim in the viewing room through the CCTV.

10.83 Consideration should be given to the fact that the accompanying adult(s) may become distressed or obstructive or the victim is not ready to disclose the incident in the presence of the accompanying adult. Where the strategy meeting has predicted such a reaction, proper arrangement should be made to facilitate the smooth conduction of the interview e.g. there should be someone available to sit with the accompanying adult, in addition to the practitioner monitoring the interview.

10.84 Subject to the decision of the CPSIT, the person with whom the child has a good rapport and is accompanying the child, the responsible worker of the concerned SWD / NGO units and/or parent may be allowed to observe the interview in the viewing room. It must be made clear that he/she will take no part in the interview. The responsible worker will not normally be allowed to communicate directly with the interviewer but may pass written messages to the member of the CPSIT in the monitoring room, but preferably, the communication should take place prior to the interview. Any person who has observed the interview will be requested to make a statement and must be prepared to give evidence in Court.

Communication Difficulties

10.85 Assessment of the child’s ability to communicate will take into account the first language and any physical or learning difficulties which might impede
effective communication with the child. The clinical psychologist may, where necessary, be involved in assessing the competence of a child with communication difficulties or mental handicap.

10.86 Should difficulties in communication arise, someone who can facilitate the communication will be needed to assist the CPSIT. The CPSIT should also consider whether there are any special factors, arising from the child’s cultural or religious background, which are relevant to the planning of an effective interview. In some cases, it will be necessary for the team to seek advice in advance about particular ethnic customs. Consideration of ethnicity, language, and gender may influence the choice of interviewer.

10.87 The above should form part of the planning process and should be carefully considered, despite giving rise to some delay if necessary. It is important that the interview is not prejudiced by failing to give the proper weight to, or obtain appropriate advice and help for the interview process.

10.88 A list of suitable and qualified interpreters, including sign language interpreters, is maintained by the Police and readily accessible (via CAIU).

10.89 It must be borne in mind, for the purpose of giving evidence, that a different interpreter will be required for the trial.

10.90 The induction loop system to prompt the interviewer should be appropriately used.

**Interviewing Other Children of the Family**

10.91 It is important for the CPSIT to obtain additional information and to assess the risk factors of other children in the family. The children will always be interviewed separately. If there is suspicion of child abuse within the family, video-recorded interviews with other child(ren) may be necessary.

**Interviewing Parents / Significant Others** (e.g. relatives / carers but not the perpetrator)

10.92 The CPSIT will :-

(a) explain to the parents / carers the purpose of their investigation; and

(b) interview the parents / carers as appropriate to understand the family circumstances and to assess the welfare needs of the family.

**Video-recorded Interview conducted Outside Office Hours**

10.93 When a referral is received outside office hours (taking into account such consultation and planning), the CPSIT may consider in the interests of the child whether to delay the interview until the next day. The age of the child, his/her needs and normal bedtime should always be taken into consideration.
10.94 There are occasions outside office hours when it will be necessary to interview the child immediately, i.e.:

(a) where the deferment will occasion serious risk to the child;

(b) the alleged abuser has been detained by the Police; or

(c) medical or forensic evidence is required due to the nature and recent commission of the offence.

10.95 In these cases, the police officer on the call out list will respond. If a delay is likely to be prejudicial to the child, other means to record the interview may be considered. The welfare principle should determine the outcome.

**Handling of Video-recorded Interview Tapes**

10.96 The Police have guidelines for the handling and disposal of the video-recorded interview tapes.

**Supervision / De-briefing**

10.97 There are obvious benefits for workers involved in the work to have de-briefing sessions after the interview. Attempts should be made wherever possible for the social worker and police officer involved to spend some time together after the interview for the purpose of de-briefing and identifying any themes which have emerged during the process. In addition, supervisory officers need to be sensitive to the needs of the staff involved in this process and where possible allocate time for specific supervision / de-briefing as soon as possible after the interview.

**Cases not Suitable for Video-recorded Interview**

10.98 If a decision is made not to have video-recorded interview but to use other means for taking evidence from a child, it is vital that the same care in relation to early consultation, strategy planning, immediate case assessment, and effective communication and planning should be taken. All children have a right to the highest standard of investigation as far as possible. The principles of good practice laid down in the Memorandum of Good Practice should apply regardless of the medium used.

**Stage IV - Immediate Case Assessment after Investigation**

10.99 Following the investigative interview with the child, the CPSIT will meet and discuss with the social worker of the referring agency / department and other concerned professionals to assess whether there is adequate evidence to substantiate this as a child abuse case and whether immediate protection for the child is necessary. If the multi-disciplinary assessment indicates that the child’s health, development or welfare is at risk, the following action will be considered and taken by the FCPSU/CPSIT as appropriate (Appendix XV):
(a) to arrange the child to return home if the suspected abuser has been removed and / or no other risk in the family will occur. Regular visits to the child and his/her family should be paid to ensure safety and well-being of the child and regular consultation be maintained with the police officers, psychologists and other concerned professionals on the well-being of the child; and

(b) to arrange for the child to be removed
   (i) to a suitable place with consent from parent(s) / guardian(s); or
   (ii) if consent from parent(s) / guardian(s) is not available, to remove the child to a place of refuge or such other place as appropriate by exercising Section 34E of the Protection of Children and Juveniles Ordinance, Cap 213. Care proceedings should be initiated within 48 hours after the child’s removal from his/her home by exercising Section 34E(3) / Section 35(1A) / Section 44(4A) of the Protection of Children and Juveniles Ordinance, Cap 213.

10.100 All parties involved in the strategy planning and case assessment process will be informed of the result (Appendix XV) and debriefing service for the abused child and his/her family will be arranged as appropriate.

10.101 In the light of the information gathered, the CPSIT will decide whether it is in the best interest of the child to proceed with prosecution of the alleged offence.

10.102 If no sign of abuse is detected or the multi-disciplinary immediate case assessment result does not suggest that the child has been abused, but where problems in the family are identified, this should be treated as an ordinary family case and assistance / service, as required, should be provided by the respective IFSC / ISC if the case is not known to other service unit providing casework service. All other parties concerned who have been involved in the case should be informed of the result of the immediate case assessment. A Multi-disciplinary Case Conference on the welfare planning of the child can also be arranged if necessary.

CRIMINAL INVESTIGATION

10.103 Conducting any interview with an alleged perpetrator under caution is the sole responsibility of CAIU/CPSIT. The CAIU/CPSIT may consult the FCPSU/CPSIT and/or social worker of the referring agency in respect of the child’s family problem and history. In such circumstances, the latter may be called as a witness in any subsequent criminal proceedings.
CHAPTER 11
MULTI-DISCIPLINARY CASE CONFERENCE
ON CHILD ABUSE

11.1 Within 10 working days after receipt of referral, the Multi-disciplinary Case Conference (MDCC) on child abuse has to be conducted. The MDCC provides a forum for professionals to share their professional knowledge, information and concern, and most importantly, to formulate a welfare plan for the child suspected to have been abused and his/her family.

11.2 A “Guide to Participants of Multi-disciplinary Case Conference on Child Abuse” is provided in Annex I to Chapter 11 to facilitate the professionals in taking part in the MDCC. As the Chairperson of the MDCC plays a vital role in leading the discussion and achieving the objective of protecting the best interest of the child in the forum, a “Reference Kit for Chairperson of Multi-disciplinary Case Conference on Child Abuse” is provided in Annex II to Chapter 11 to supplement the Guide and serve as reference for the Chairperson in steering the MDCC effectively. Some frequently asked questions about MDCC are also listed at Annex III to Chapter 11 for reference.
A. Objectives of Multi-disciplinary Case Conference (MDCC)

(1) The MDCC is a forum by which professionals having a major role in the handling and investigation of a suspected child abuse case can share their professional knowledge, information and concern on the child health, development, functioning and his/her parents’/carers’ ability to ensure safety of the child.

(2) The focus of the MDCC is on protection and welfare of the child and not prosecution of the abuser. Family perspective should be adopted in reviewing safety of all the children and other members (e.g. parents) in the household even if concerns are only being expressed about one child. Unless action under the Protection of Children and Juveniles Ordinance, Cap 213, is involved, participants should be bound by the collective decision of the MDCC.

(3) The MDCC analyzes risks and recommends actions to be taken in relation to the welfare planning of the child and his/her family, respecting the statutory obligations of individual members for the case. The MDCC should consider the following:

(a) the nature of the incident;

(b) the level and nature of risk to the child and, if any, other children of the family;

(c) risk of recurrence of the incident;

(d) welfare planning to protect the child upon multi-disciplinary collaboration, including post abuse therapeutic counselling service at pre-trial stage;

(e) parent(s)’/guardian(s)’ attitude on the welfare plan of the child; and

(f) where necessary, the welfare need of other family members related to the protection and well-being of the child victim.

B. Personal Data (Privacy) Ordinance, Cap 486

(1) Information given in a MDCC is confidential and should not be used for purposes other than that of child protection, nor should it be disclosed to any other agency or individual without the permission of the contributor.
The Personal Data (Privacy) Ordinance (PD(P)O), Cap 486 provides exemption under Data Protection Principle 3, the use limitation principle, in respect of sharing of information at the MDCC under Part VIII of the Ordinance.

According to the PD(P)O, a person with parental responsibility for a minor may make request on behalf of the minor to access to the personal data of a minor (i.e. a person below 18 years old). However, personal data collected from the minor (or from other parties concerning the minor) on a confidential basis may be withheld from the parents’ request. It is important that the social worker has to ascertain and discuss the wish of a minor at the stage of collecting the personal data from the minor as to whether he/she will agree to provide the data to his/her parent(s) if they make the request. The reply should be recorded in the file to facilitate a decision if an access request from his/her parent is received. In the context of a MDCC, the personal data of the minor should be treated in the same manner.

C. Responsibility to convene MDCC

(1) The officer-in-charge / supervisor / co-ordinator of the concerned units providing casework service (including medical social services units of Social Welfare Department and Hospital Authority) will assume the chairmanship and the related responsibilities.

(2) The Chairperson should be experienced in family service or paediatric service and have good knowledge on child protection and family work.

(3) If two or more service units share the case, the unit that has the main responsibility for the family should chair the MDCC or arrange a Chairperson as appropriate. The unit to take up the chairmanship may or may not be the one that first discovered the child abuse incident. In case of uncertainties or difficulties, the units should discuss among themselves to decide who to chair the MDCC.

(4) The Chairperson should not directly handle the child abuse case.

D. Timing

(1) The MDCC should be held at the earliest available date. It should take place within 10 working days after receipt of referral by the investigating social welfare unit. Moreover, the investigating social worker should explain to all invited participants why a case conference must be held within 10 working days and indicate the date and event from which this is to be counted.

(2) The MDCC may be postponed when:

(a) the child’s critical medical condition precludes necessary
investigation;

(b) essential clinical findings / diagnosis is not yet concluded; or

(c) the necessary investigation is not yet adequately completed due to complication of the case (e.g. the parents refuse to co-operate or cannot be located).

Under such circumstances, parties concerned should be informed of the deferment of the MDCC.

E. Membership of MDCC

(1) The Chairperson, in consultation with the investigating social worker, should decide on the membership of the conference.

(2) Those professionals who have direct knowledge on the child and his/her family and have a major role in the handling and investigation of the suspected child abuse case, as well as those not involved in the investigation but will give particular information or advice on the case for determining whether abuse has occurred and formulation of welfare plan should be invited as members of the MDCC.

(3) The Police may request members attending the MDCC who are potential witnesses\textsuperscript{Note} to be interviewed, with a statement taken or to provide documentary evidence, e.g. medical chits / reports, chemist certificates, etc., prior to the MDCC so as to avoid the possible contamination of evidence during discussion at the MDCC.

F. Tasks to be performed by MDCC

The major functions and tasks to be performed by the MDCC are:

(1) to examine the cause for concern, analyze information available, and decide from the \textit{child welfare point of view} whether this is a child abuse case, or the child is at risk of being abused, and the nature of abuse by making reference to the definition of child abuse as listed in Chapter 2;

(2) to share, if available, the result of joint investigation and the decision of immediate case assessment, in relation to the protection and welfare of the child, if Child Protection Special Investigation Team (CPSIT) is formed;

(3) to assess the level of risk and whether the name of the child and the siblings should be placed into the Child Protection Registry and the category of registration;

(4) to make recommendation for the welfare planning of the child;

\textsuperscript{Note} Generally speaking, potential witnesses are those persons who possess relevant information on the abuse incident and may be required to give evidence in the subsequent court proceedings, if any.
(5) to assess the degree of risk and make recommendation for the welfare planning of other children in the family, if any;

(6) to consider the situation of the whole family and re-classify or re-define the case (if necessary) but not just focusing on the presenting problem;

(7) to agree upon an inter-agency plan to protect the child;

(8) to identify the key social worker and the roles of other helping professionals in the follow up welfare plan for the child;

(9) to decide how the child and parents will be informed of the outcome and decisions of the conference, if they are not present in the MDCC;

(10) to consider the need, if any, for statutory action to protect the child or to ensure the child’s welfare;

(11) to consider the need for subsequent MDCCs with reference to:

   (a) the need for further information;
   (b) the need to review any follow up action; and
   (c) any important decision of the MDCC that cannot be implemented because of circumstantial changes and which may jeopardize the well-being of the child.

(12) to consider the need and timing to issue progress report to related parties involved in the follow up of the case. (See also paragraph O(3) below)

G. Roles and Responsibilities of the Chairperson

(1) Personal Data (Privacy) Ordinance, (PD(P)O), Cap 486

The Chairperson of the MDCC should remind participants of the conference the confidentiality of the proceeding and clarify with them their wish on the control and prohibition of data in accordance with the PD(P)O (see also paragraph B above and Annex IIA to Chapter 11). The notes of the MDCC will also contain a reminder to this effect.

(2) Necessary Arrangements

   (a) Before the MDCC, the Chairperson, with assistance of the investigating social worker, should work out the following:

   (i) date and venue of the MDCC;

   (ii) membership of the MDCC and invitation (see paragraph E above) including assessment of the suitability for family participation (see paragraph H below);
(iii) distribution of available written reports in a confidential manner preferably prior to the MDCC;

(iv) attendance of the parent(s) / guardian(s) of the child at the appropriate session and lining up of pre-conference preparation (see paragraph L below) for the family and professionals where appropriate; and

(v) minutes / notes taking during the MDCC.

(b) **During the MDCC**, the Chairperson has to ensure that the focus and objective of the MDCC are for the **welfare and protection of the child**, and not to determine whether the acts of the alleged perpetrator have constituted criminal acts. The Chairperson also has to ensure that the objectives of the MDCC have been achieved and contributions are relevant and concise. Lengthy and unnecessary elaboration of the social investigation or medical consultation should be avoided.

(c) The Chairperson should alert members who are potential witnesses the danger of contamination of evidence, e.g. by revealing details given in their police statements, during the MDCC. Similarly discussion among potential witnesses on the details of the abusive acts should be avoided until the conclusion of subsequent court proceedings, if any.

(d) In formulating the welfare plan of the child, the following should be considered to ensure the child’s safety (see also “Guide to Risk Assessment” in Chapter 2):

(i) the level and nature of all risk factors;

(ii) the views of the child in relation to the protection and welfare plan;

(iii) the degree of co-operation from the family and parental attitude in implementing the welfare plan;

(iv) the degree of support and supervision required for implementing the welfare plan; and

(v) availability of service required to implement the welfare plan.

(e) **During the MDCC**, the Chairperson has to lead members to analyze all the facts and opinions and come to a decision regarding the welfare plan of the child through consensus.

(f) Any decisions made in the MDCC should have consensus among
H. Family Participation in MDCC

(1) Family participation in the whole MDCC should as far as practicable be promoted and be adopted as a standing practice for those cases in which the parents are not the abusers.

(2) Family participation aims to enhance parents’ understanding of the issues of concern, tap their contribution to the formulation of the welfare plan, and enlist their involvement in the implementation of the welfare plan. It is also an empowering process. However, members of the MDCC have to find effective measures to protect the child and take into full account the wish of the child when formulating the welfare plan. The welfare and rights of the child should always be the paramount concern of the MDCC.

(3) Parent(s) and/or the child to be invited to participate in the MDCC is/are not member(s). The Chairperson has to ensure pre-conference preparation for the parent(s) and/or the child with reference to paragraph L below.

(4) Subject to the consent of the parent(s) and members of the MDCC, significant family members and relatives who have sound knowledge of the child and would be contributive to the welfare plan can also be invited as appropriate.

(5) Parents and/or the child can be invited to attend:

(a) the whole MDCC, or
(b) at the time of formulating welfare plan, or
(c) at the time when initial recommendation on the welfare plan is made.

(6) Upon careful consideration and on balancing different views from all members, parents who are the suspected abusers can be invited to participate in the MDCC, especially on the part of formulating welfare plan.

(7) In case the parent(s) is/are suspected abusers and the child being the victim has been taken away from their custody due to the suspected child abuse incident, careful consideration should be taken as to whether it would be appropriate to invite the child to attend the same session with his/her parent(s) (see also paragraph I below). The suspected abuser should not be given any opportunity, during the MDCC, to influence, interfere with and/or exert pressure on the child directly or indirectly such that the child might change or withdraw his/her previous version of the events.

(8) In case the parent(s) who attend(s) the MDCC is/are suspected abusers,
members should be cautious not to ask them questions such as whether they are related to and/or responsible for the abuse of the child, or make such accusations against them. The Chairperson should remind all members of the MDCC that any admission of guilt made during the MDCC by the suspected abuser(s) may be adduced as evidence in subsequent criminal trial and all others present at the MDCC may become prosecution witnesses should there be any charges laid against the suspected abuser(s).

I. Arrangement for Family Participation in MDCC

(1) The decision of inviting parents to participate in the MDCC should be made by the Chairperson in consultation with the investigating social worker and all members of the MDCC.

(2) All members of the MDCC should be informed beforehand of the parents’ and/or child’s participation.

(3) Any members who feel that the participation of parents and/or the child will not be appropriate for a particular part or the whole session of the MDCC can discuss the matter with the Chairperson before the MDCC or suggest to the Chairperson to arrange the parents and/or child to withdraw from the MDCC and wait at a comfortable sitting area, preferably with privacy, for a while.

(4) The Chairperson can also exercise professional judgment to invite the family to withdraw from the MDCC temporarily if there is a need for the professionals to discuss among themselves on a particular issue. The Chairperson has to explain to the family the reasons clearly for this arrangement and brief them the outcome of the discussion afterwards.

(5) If the parent(s), being the suspected abuser(s), and the child have been asked to withdraw from the MDCC and wait somewhere for a while, special arrangement should be made to make sure that the suspected abuser(s) would not be given any opportunity to influence, interfere with and/or exert pressure on the child directly or indirectly such that the child might change or withdraw his/her previous version of the events.

(6) In case the parents are unable or considered not suitable to participate in the MDCC, their views should be made known to the investigating social worker or other members of the MDCC who should undertake to ensure that the MDCC is aware of the parents’ views. The investigating social worker should also inform the parents that they can give their views to the case conference in writing if they are unable to attend.

Child Participation in MDCC
In some cases, the child can be invited to attend part of or the whole MDCC to contribute in the formulation and implementation of the welfare plan. The decision to involve child victim in the MDCC should take into consideration the child’s age, level of understanding, maturity and emotional state. The Chairperson has to ensure that the child would benefit from attending the MDCC.

The investigating social worker who is more familiar with the child should brief and prepare the child in person prior to the MDCC.

If the child is to attend the MDCC, the Chairperson has to plan the MDCC very carefully and assess if the child can attend the same session with the parent (see also (5) and (7) of paragraph H and (5) of paragraph I above).

In case the child is unable to attend the MDCC or is not invited, the child should be told that a meeting is being held and the child’s views and wishes will be conveyed to the MDCC by the investigating social worker or other members of the MDCC. The investigating social worker should also inform the child that he/she can give his/her views to the case conference in writing if he/she is unable to attend. The Chairperson should appoint a member to convey the decision and recommendation of the MDCC to the child after the MDCC as soon as possible.

J. Roles of Parents in MDCC

The roles of parents in the MDCC are to supplement background information of the family, participate and contribute in the discussion on formulation of the welfare plan and its implementation.

The Chairperson should facilitate exchange and discussion between the parents and other members as appropriate.

K. Roles and Responsibilities of Members of MDCC

All members should give priority to attend the MDCC and contribute from their professional point of view to safeguard the welfare of the child victims during the MDCC. The investigating social worker should also inform all those being invited that they can give their views to the case conference in writing if they are unable to attend.

In case of enquiry about the conference proceeding, members should seek clarification from the Chairperson.

Members should attend the whole MDCC to share their findings of the incident / allegation, contribute their professional knowledge,
experience and represent their Department / agency’s views. Individual members may share, preferably prior to the MDCC, useful published reports and articles (e.g. medical reports and researches) relevant to the case to facilitate mutual understanding on the case nature and facilitate formulation of welfare plan.

(4) Each member should prepare a written report / notes on the child for reference of the MDCC as far as possible. The report can be brief, with relevant information on the child and family such as the child’s risk, protection and welfare plan. For the investigating social worker, the report must be in written form.

(5) Members should share openly their professional views; make decisions on whether the case is a child abuse case and its case nature. As the Police may be involved in the criminal investigation of the case, the police officer attending the MDCC would remain neutral during the discussion on case nature in order to avoid being accused of showing prejudice in the criminal investigation. The Police, however, will inform the MDCC the progress, but not the details of the investigation, i.e. the case is still being investigated, legal advice is being sought, no charge has been laid or a charge has been laid against the suspected child abuser(s).

(6) Members who follow up the case should assist in carrying out the decisions made in the MDCC. They should inform the key worker if the actions as decided in the MDCC cannot be implemented. The key social worker has to ensure that the post-conference management and multi-disciplinary collaboration in intervention are in place (see paragraphs M, N and O below).

(7) Members should report to the key social worker any changes in the circumstances and independent action taken concerning the child and his/her family.

(8) Members should attend subsequent case conference if they are involved in the follow up of the case.

L. Pre-conference Preparation

For the family

(1) If family member(s) is/are invited to participate in the MDCC whether in full or in part, the Chairperson or his/her delegate should hold a pre-conference briefing with the family members concerned to reiterate the following issues:

(a) purpose, focus and ambit of the MDCC;
(b) proceeding of the MDCC, issues to be discussed;
(c) participants of the MDCC and their respective roles; and
(d) how they can contribute in the MDCC and their rights.

(2) The pre-conference briefing between the Chairperson and the family, if required, should preferably be held in the form of a meeting and the discussion at the pre-conference briefing should be noted in the case record.

**For the professionals**

(3) The Chairperson, in consultation with the investigating social worker, or any members can initiate pre-conference meeting on a need basis to sort out any incongruent findings, clarify the progress of criminal investigation from the Police, i.e. the case is still being investigated, legal advice is being sought, no charge has been laid or charge has been laid against the suspected child abuser(s), and any other points that may require further investigation, thrash out issues relating to the personal details of the suspected abuser and anything that should not be discussed during the MDCC.

(4) Given the time constraint to conduct the MDCC (i.e. within 10 working days), the Chairperson would consult concerned members about the appropriate timing to conduct the pre-conference meeting.

(5) As the pre-conference meeting and the MDCC serve different purposes, the Chairperson should ensure that the discussion in the pre-conference meeting will not pre-empt and distort the decision to be made in the MDCC by all members.

**M. Post-conference Management**

(1) Debriefing for parents and the child who have participated in the MDCC should be provided so as to address their possible emotions after the MDCC and, clarify any areas they may raise on the MDCC.

(2) Debriefing after the MDCC also enables the family to recapitulate their roles and contribution in the entire process of child protection.

(3) The Chairperson and the key social worker (see paragraph N below) should decide among themselves who and when to conduct debriefing, preferably within 10 days after the MDCC.

**N. Roles and Responsibility of “Key Social Worker”**

The MDCC should appoint a key social worker to follow up the case. The responsibilities of the key social worker are:

(1) to implement the decisions of the MDCC. If action under the Protection of Children and Juveniles Ordinance, Cap 213, is required, the case will be taken over by the Social Welfare Department;
(2) to line up multi-disciplinary collaboration in implementing the welfare plan concerning the child and his/her family and ensure that actions taken by the responsible parties are in line with the decisions of the MDCC;

(3) to inform members as soon as possible consideration of reconvening the MDCC if the decision of the MDCC cannot be implemented by the key social worker or other responsible parties; and

(4) to ensure that if a change of the key social worker is agreed upon in the MDCC, all relevant information and documents are to be transferred to the incoming key social worker. If the case cannot be transferred out to the incoming key social worker within one month after the MDCC, communication between the outgoing key social worker and the incoming key social worker is required.

O. Multi-disciplinary Collaboration in Post-conference Stage

*Case review*

(1) If there is new information coming up or any follow up action is required to be reviewed, the key social worker, in consultation with all members of the MDCC, will decide whether to convene a review conference. Membership of the review conference should be confined to those professionals who have direct involvement in the case.

(2) Other than the review conference, the key social worker and professionals involved to follow up the case should maintain regular contacts with one another to ensure implementation of the welfare plan.

*Progress report*

(3) Subject to the agreement in the MDCC, the key social worker will inform members of the MDCC in writing the progress on the implementation of the welfare plan in an agreed period of time, say 6 months after the MDCC, or a period to be decided by the MDCC. The progress report should be concise and precise, capturing only the most recent and essential development of the case.

P. Minutes of MDCC

(1) The minutes of the MDCC should include the following:

(a) the persons invited with attendance or absence;
(b) the family members invited, and if not, the reasons;
(c) points discussed;
(d) decisions made;
(e) reasons for such decisions; and
(f) dissenting views.

(2) Where application for Care or Protection Order or other statutory power is required, the Magistrate or District Court Judge should be informed of the decisions and recommendations of the MDCC through the Social Welfare Officer’s Report to the court.

(3) The draft minutes of the MDCC will be sent to members for confirmation preferably within two weeks after the MDCC.

(4) Members of the MDCC should read and check the draft minutes to ensure if their views are correctly and appropriately documented. Requests for amendments, if any, should be made to the Chairperson preferably within one week after receiving the draft minutes of the MDCC.

(5) The Chairman should issue the confirmed minutes to all members and, on a need-to-know basis, to other professionals who would follow up the case no later than one month after the MDCC.

(6) The investigating social worker should send a letter to the parent(s), whether they have attended the MDCC or not, stating the decisions of the MDCC, highlighting the welfare plan for the child, and restating that the decision of the MDCC has no binding effect on the decision of the Police whether to institute criminal proceedings against the abuser(s) or not.
Reference Kit for
Chairperson of Multi-disciplinary Case Conference on Child Abuse

I. INTRODUCTION

This Reference Kit (Kit) is provided for social workers who may chair the Multi-Disciplinary Case Conference (MDCC) on Child Abuse. It is intended to supplement the “Guide to Participants of Multi-Disciplinary Case Conference on Child Abuse” (Guide) by sharing information on the basic principles for conducting meetings, highlighting significant issues that need to be considered in chairing the MDCC, elaborating some of the points stipulated in the Guide and providing examples to illustrate various situations.

2. It should be noted that the Kit should be read together with the Guide. Besides, in handling special situations where the Guide and the Kit are not applicable, the Chairperson should make appropriate arrangements based on professional judgment, bearing in mind that the welfare of the child should be the paramount concern.

II. BASIC PRINCIPLES

An Effective Meeting

3. The essential elements of an effective MDCC are similar to those contributing to the effectiveness of a meeting of other nature. Generally speaking, a meeting is considered effective when it achieves its objectives within minimal time. An effective meeting should be:

(a) purposeful;
(b) well-structured;
(c) open;
(d) efficient; and
(e) with focus on key issues to facilitate decision-making.

Common Problems of a Meeting

4. The following common problems would render a meeting ineffective:

(a) poor preparation;
(b) drifting off the subject;
(c) lack of listening;
(d) lack of participation;
(e) verbosity / side-tracking; and
(f) unnecessary length.
A Competent Chairperson

5. To ensure the effectiveness of a meeting, a competent Chairperson should:

   (a) be very clear about the objectives of the meeting and the desired outcome;

   (b) know the different roles and concerns of the participants;

   (c) examine the agenda with reference to the significant issues that need to be covered and the composition of the participants;

   (d) make sure that participants are well-prepared for the meeting;

   (e) facilitate communication among participants;

   (f) make sure that the atmosphere is open and positive;

   (g) clarify viewpoints and avoid subjective judgment;

   (h) accommodate the varying needs and sentiments of the participants;

   (i) stay neutral;

   (j) keep the discussion in control and focused;

   (k) guide the meeting towards the desired outcomes;

   (l) regularly summarize what has been achieved and agreed; and

   (m) avoid jumping to conclusions.

Checklist of Steps

6. Below is a checklist of steps for planning and conducting effective meetings.

   Before the Meeting

   (a) Plan the meeting carefully: who, what, when, where, why, how many?
   (b) Prepare and send out an agenda in advance.
   (c) Come early and set up the meeting room.

   At the Beginning of the Meeting

   (d) Start on time.
   (e) Get participants to introduce themselves.
   (f) Explain the objectives of the meeting.
(g) Give the participants the opportunity to raise their views / questions, if any, on the agenda.
(h) Review action items from the previous meeting, if any.
(i) Set clear time limits.

During the Meeting

(j) Follow the agenda for discussion.
(k) Ask questions if in doubt.
(l) Listen patiently.
(m) Clarify issues and identify underlying interests.
(n) Develop multiple options.

At the End of the Meeting

(o) Identify additional data needed for making decisions.
(p) Summarize agreements.
(q) Establish action items: who? what? when?
(r) Set the date and place of the next meeting and develop a preliminary agenda, if necessary.
(s) Close the meeting crisply and positively.

After the Meeting

(t) The Chairperson is responsible for following up and monitoring action items. In case the Chairperson and the key social worker are not working in the same unit, supervisor of the key social worker should play the role to follow up and monitor action items as agreed.

III. PREPARATION FOR THE MDCC
Essential Information the Chairperson should Know

7. The Chairperson should acquaint himself/herself with the following guidelines and ordinances and make reference to the relevant chapters and appendices, wherever necessary:

   (a) Procedures for Handling Child Abuse Cases
   (b) Guide to Participants of the MDCC
   (c) Protection of Children and Juveniles Ordinance, Cap 213
   (d) Personal Data (Privacy) Ordinance, Cap 486

8. The Chairperson should also get familiar with services for children so as to facilitate discussion in the MDCC.

9. The Chairperson should fully understand the Social Enquiry Report prepared by the investigating social worker and any relevant reports prepared by other professionals.
10. The Chairperson should take note of any new case development not covered in the written reports / notes prepared by the members prior to the MDCC.

Should MDCC be required for this case

11. MDCC is required when there is suspected child abuse incident(s) with investigation conducted by social worker and other professionals. As a general practice, MDCC should be conducted as far as possible unless under exceptional situations such as:

(a) the intended welfare plan is straight-forward and agreed among concerned parties; and

(b) less than three parties are involved in the investigation of the case, e.g. child sexual abuse cases involving only Child Protection Special Investigation Team (CPSIT).

12. The decision for not conducting a MDCC should be agreed by all parties involved including the possible key social worker to follow up the case. A brief or telephone conference may be considered as an alternative if appropriate.

Who to Conduct MDCC

13. As stipulated in (1)-(4) of paragraph C in the “Guide to Participants of MDCC”, the chairperson of a MDCC should:

(a) be the officer-in-charge / supervisor / co-ordinator of unit providing casework service conducting the social enquiry;

(b) be experienced in family or paediatric service;

(c) have good knowledge on child protection and family work; and

(d) not directly handle the child abuse case.

14. If necessary, Family and Child Protective Services Units (FCPSUs) of SWD will provide support and assistance to the Chairperson who is not experienced in conducting MDCC. For cases handled by units without a social worker as the supervisor, e.g. school social work unit of special school in which the principal is the supervisor, social workers of FCPSUs may assume the role of Chairperson in the MDCCs.

15. For cases shared by more than one units providing casework service, the concerned units should discuss among themselves on the chairmanship. Usually the responsible officer-in-charge / supervisor / co-ordinator of the unit which knows the family and the child(ren) more and better will take up the chairperson role.

When to Conduct MDCC
16. The MDCC should be held at the earliest available date. It should take place within 10 working days after receipt of referral by the investigation social welfare unit. Moreover, the investigating social worker should explain to all invited participants why a case conference must be held within 10 working days and indicate the date and event from which this is to be counted. The MDCC may be postponed when:

(a) the child’s critical medical condition precludes necessary investigation;

(b) essential clinical findings / diagnosis is not yet concluded; or

(c) the necessary investigation is not yet adequately completed due to complication of the case (e.g. the parents refuse to co-operate or cannot be located).

17. If the MDCC cannot be held within 10 working days, the Chairperson should inform parties concerned of the deferment and effort should still be made to ensure that the MDCC will be conducted in time. The Chairperson should also explain the reason(s) in the “Introduction” of the MDCC and the reason(s) should be recorded in the minutes.

Membership

18. In deciding the membership, the Chairperson should include the professionals who have direct knowledge on the child and his/her family and have a major role in the handling and investigation of the suspected child abuse case, as well as those not involved in the investigation but will give particular information or advice on the case for determining whether abuse has occurred and formulation of welfare plan to be discussed in the MDCC. In addition to the social worker responsible for the investigation of the suspected child abuse case, members of MDCC may include, as appropriate:

(a) police officer;

(b) school personnel e.g. teacher, counsellor, school social worker, principal, etc.;

(c) medical personnel e.g. doctors, nurses, etc.;

(d) medical social worker;

(e) clinical psychologist; and

(f) social worker who may follow up the case, if different from the investigating social worker.

19. To facilitate discussion and ensure the best welfare plan is formulated, only relevant personnel should be involved in the meeting. However, at times it is suggested that members may attend the MDCC with their supervisors, or their
colleagues may like to sit in the MDCC for learning purpose. In the latter case, the consent of all other members of the MDCC, the parent(s) and the child(ren) (where appropriate) should be obtained prior to the meeting.

20. Although it is a good practice to explain to the parent(s) and the child(ren) (where appropriate) about the membership of the MDCC, the views of the parent(s) / child(ren) should have no bearing regarding the decision of the membership which should be made by the Chairperson in consultation with the investigating social worker and based on professional judgment.

21. No parties should be excluded from the MDCC because of parent(s)’ or child(ren)’s objection. If the parent(s) / child(ren) object to the participation of a particular member, the Chairperson should find out the reasons for such an objection and explain to them the role of the member. Any misunderstanding between the parent(s) / child(ren) and the particular member should best be dealt with prior to the MDCC.

22. The Chairperson should be alert of the issue of conflict of interest in cases where the suspected abusers are staff of an institution such as school and residential care facilities for children. The suspected abusers in these cases should not attend the MDCC, but other staff of the institution may attend provided they are involved in the handling of the case, or can provide relevant information on the child / family / incident to facilitate discussion at the MDCC.

23. Though participation in the MDCC is voluntary, the Chairperson should encourage all relevant professionals to attend the MDCC. Those being invited should also be informed that they can give their views to the case conference in writing if they are unable to attend. If for any reason a member being invited could not be available, he/she should be requested to prepare a written report / notes on the child(ren) for reference of the MDCC as far as possible.

Family and Child Participation

24. Parent(s), family members, relatives and/or child(ren) attending the MDCC are not members of the MDCC. Their roles are to supplement background information and contribute in the formulation of welfare plan. Hence, they will not be provided with reports and minutes of the MDCC. They may make a data access request for a copy of their own personal data as contained in the reports and/or minutes of the MDCC according to Section 18(1) of the Personal Data (Privacy) Ordinance (PD(P)O), Cap 486.

25. The decision of inviting parent(s) to participate in the MDCC should be made by the Chairperson in consultation with the investigating social worker and all members of the MDCC. If necessary, a pre-conference meeting can be held among members to decide on family participation. If family participation in the whole MDCC is deemed not suitable, the parent(s) concerned should be so informed before the MDCC.

26. The participation of the parent(s) who are suspected abusers is not the
standing practice of MDCC. However, subject to the views of the members, they (e.g. those who are co-operative in the investigation process and show motivation to accept the professionals’ intervention) may be invited to attend the whole or part of the MDCC if their participation is considered beneficial to the welfare of the child(ren) after careful assessment.

27. The parent(s) and/or child(ren) should be informed that they can give their views to the case conference in writing if they are unable to attend.

**Logistics and Venue Arrangement**

28. The Chairperson should confirm with the investigating social worker the logistic arrangement of the MDCC including:

   (a) membership list;
   
   (b) agenda;
   
   (c) issue of invitation letter with agenda and feedback form on family participation (a sample is at Annex IIB to Chapter 11 for reference);
   
   (d) distribution of available written reports to all members preferably prior to the MDCC and as far as possible, in a confidential manner (details of the abuse incident should not be mentioned in the report);
   
   (e) minutes taking;
   
   (f) arrangement of pre-conference briefing to the child(ren) and family members if they are to be invited to attend the MDCC; and
   
   (g) the need to conduct pre-conference meeting with the professionals.

29. If the suspected abused child is hospitalized, the MDCC should preferably be held in the hospital and medical social worker’s assistance can be solicited in arranging the venue.

30. If family members have to wait for their turn to attend the MDCC or be requested to withdraw from part of the MDCC pending the discussion among members, the Chairperson has to arrange a comfortable place with chairs, preferably with privacy, for the family. If the parent(s) who is/are the suspected abuser(s) and the child(ren) are invited to attend the MDCC, separate waiting areas for the parent(s) and the child(ren) will be required to prevent the parent(s) from influencing, interfering with and/or exerting pressure on the child(ren) directly or indirectly such that the child(ren) may change/withdraw his/her previous version of the events.

**Pre-conference Briefing for Family Members**

31. The Chairperson or his/her delegate should conduct the pre-conference
briefing for the family prior to the MDCC. For the purposes and contents of the pre-conference briefing, reference should be made to paragraph L in the “Guide to Participants of MDCC” (Annex II to Chapter 11).

32. The pre-conference briefing should preferably be held in the form of a meeting. If for any reason the pre-conference briefing cannot be held, the Chairperson or his/her delegate should brief the family members over phone clearly and with adequate details.

33. Minute-taking is not required as pre-conference briefing is not a formal meeting. Nevertheless, the discussion at pre-conference briefing should be noted in the case record.

**Pre-conference Meeting for Professionals**

34. The Chairperson, in consultation with the investigating social worker or any members, may initiate a pre-conference meeting on a need basis. Reference could be made to paragraph L in the “Guide to Participants of MDCC” for the functions of the pre-conference meeting.

35. Pre-conference meeting among members is not a must and, if so required, it can be done in a simple form (e.g. brief discussion immediately before the MDCC).

36. In general, minute-taking in such informal pre-conference is not required, but, if deemed necessary, discussions should be recorded in the form of minutes for future reference and record purpose.

**IV. DURING THE MDCC**

**To Start the MDCC**

37. The Chairperson should arrive at the venue earlier to ensure that appropriate seating and other logistic arrangements have been made. To start the MDCC, the Chairperson should:

   (a) welcome members and introduce himself/herself;
   (b) explain the objectives of the MDCC;
   (c) confirm the name(s) of the child(ren);
   (d) re-confirm the membership;
   (e) invite members to introduce themselves;
   (f) inform members of absentee and reasons behind, if any;
(g) stress the importance of confidentiality and explain concerns relating to the PD(P)O (see paragraph 38 below);

(h) explain briefly how the meeting will run, i.e. the agenda items and any special issues relating to the case that members should be aware of;

(i) explain the arrangement of family participation in the MDCC (e.g. who attends, reason for family participation, etc.);

(j) remind members of the need to share information on a need-to-know basis, including the use of relevant reports for court proceedings or follow up services;

(k) remind members who are potential witnesses the danger of contamination of evidence (see (2)(c) of paragraph G in the “Guide to Participants of MDCC” for details);

(l) explain that the Police would remain neutral during the discussion on the nature of the case in order to avoid being accused of showing prejudice in the criminal investigation (see (5) of paragraph K in the “Guide to Participants of MDCC” for details);

(m) emphasize that the decision of the MDCC on the case nature has no binding effect on the prosecution of the abuser; and

(n) seek members’ consent if tape recording is necessary to facilitate minute-taking (any recording tape should be destroyed once minute-taking is completed).

**Concerns Relating to Confidentiality and Personal Data (Privacy) Ordinance**

38. The Chairperson should state the “Introductory Remarks in Relation to Personal Data (Privacy) Ordinance, Cap 486” at the Annex IIA to Chapter 11 and invite members to confirm whether they wish to retain control of the use of the data provided by them during the MDCC. Members should also be reminded of the importance of confidentiality and that the information given in the MDCC should not be disclosed to other agencies without the permission of the contributor in any context other than that of child protection.

**Family Participation**

39. The Chairperson may make reference to the following **DOs** and **DON’Ts** if the parent(s) and/or the child(ren) are present in the MDCC:

**DOs**

(a) Attend to the parent(s)’/child(ren)’s reaction to members’ views.
(b) Facilitate exchange and discussion between parent(s) and members as appropriate.

(c) Ensure that the parent(s) / child(ren) understands members’ views.

(d) Enlist the parent(s) / child(ren)’s co-operation in implementing the welfare plan agreed by members.

DON’Ts

(a) Use jargons and technical terms.

(b) Give lecture to parents or conduct therapy in the MDCC.

(c) Ask questions relating to the admission of guilt by the parent(s) who is/are suspected abusers.

Sharing of Reports and Findings

40. To facilitate discussion and ensure the best welfare plan is formulated, it would be advisable for members to highlight the key points already mentioned in their written reports which have been distributed prior to the meeting instead of presenting the whole report in the MDCC.

41. Detailed description of the abusive acts which may cause contamination of evidence and divert the focus of the MDCC should be avoided. In case of doubt on whether certain information about the abusive act should be disclosed, the advice of the Police can be sought prior to the MDCC.

42. Clarification should be made in case of inconsistency in the information provided by different members.

Discussion on Case Nature

43. The decision on whether the case is a child abuse case helps facilitate the formulation of appropriate welfare plan for the child(ren). The decision of the MDCC has no binding effect on the prosecution of the abuser.

44. For cases to be registered in the Child Protection Registry (CPR), reference should be made to the “Case Nature” of the CPR Data Input Form regarding the category of case nature.

45. Members are expected to make decision on the case nature in the MDCC. However, if they find it difficult to make decision, they should not be compelled to do so.

46. The participants of the MDCC should review and consider the situation of the whole family and classify or re-define the case (if necessary) but not just focusing on the presenting problem.
Risk Assessment

47. In conducting risk assessment, the likelihood of recurrence of maltreatment, neglect, physical or sexual abuse, and not just the severity of the child(ren)’s injuries should be taken into consideration.


49. The considerations made in the risk assessment should form the foundation of the welfare plan for the child victim.

Formulation of Welfare Plan

50. The welfare plan should address all the risk factors that the child(ren) would be facing for the protection of the child(ren). It should also be targeted for the healthy physical, social, and psychological development of the child(ren).

51. The welfare needs of the child(ren)’s family members including the parents and siblings should also be attended to where necessary.

52. As the co-operation of the parents (or the significant family members) and the child(ren) is very important to the implementation of welfare plan, their views should be considered and addressed carefully on the basis that the child(ren)’s safety and well-being should be the paramount concern.

53. Multi-disciplinary collaboration in the implementation of the welfare plan should be fostered.

Conflict Resolution and Decision-making

54. As the nature of the case (i.e. whether the case is considered a child abuse case) and the welfare plan for the child are very delicate issues, related decisions should be made by consensus in the MDCC as far as possible rather than by simple voting. If there are divergent views, the Chairperson should guide the discussion from the perspective of child protection.

55. The Chairperson has to handle the disagreement among members with an open mind. The use of the following skills may help members reach consensus:

   (a) highlighting common concerns;
   (b) clarifying the conflict and disagreement;
   (c) positive reframing of disagreement and conflict;
   (d) adopting objective criteria;
   (e) refocusing the discussion on the best interest of the child(ren); and
   (f) exploring additional information that will facilitate decision-making.

56. If a consensus cannot be reached after using the suggested skills, the Chairperson may consider concluding the discussion following the views of majority and record divergent views in the minutes.
Appointment of Key Social Worker

57. The Chairperson should confirm the appointment of key social worker or unit to follow up the case upon members’ agreement on the nature of the case and the welfare plan for the child. FCPSU of SWD will take up the case when members at the MDCC agree that it is a child abuse case / a case with high risk of child abuse. Otherwise, the case will be referred to other welfare service unit / agency for follow up when the case is not classified as child abuse but is still in need of welfare service. Case transfer, if required, should be carefully planned, taking into consideration the emotional reaction of the child(ren) and family members involved.

Need for Progress Report

58. The Chairperson should lead the MDCC to discuss the need for progress report (e.g. to review the feasibility / suitability of the agreed welfare plan for cases in which the parent(s) does not / do not agree to the plan).

Need for Review Conference

59. The Chairperson should seek the views of members on the need to convene review conference if there is new information coming up (e.g. family members’ change in attitude towards restoring the child(ren) home) or any follow-up action (e.g. the welfare plan has yet to be confirmed pending the exploration of suitable residential placement for the child(ren)) is required to be reviewed. In case the Chairperson and the key social worker are not working in the same unit, supervisor of the key social worker should play the role to monitor action items as agreed and assess the need for convening review conference.

To End the MDCC

60. The Chairperson should summarize the decisions of the MDCC in the following areas:

(a) whether the case is established as a child abuse or at-risk case;
(b) welfare plan for the child(ren) and if necessary, for family members;
(c) key social worker responsible for following up the case;
(d) respective roles of members in implementing the welfare plan; and
(e) date of review conference, if necessary.

Transfer of Information

61. The investigating social worker should complete immediate welfare services as agreed in MDCC, e.g. waitlisting of residential care services before transferring the case to the follow-up unit. To facilitate smooth case transfer, the investigating social worker should prepare relevant documents including case summary, confirmed minutes of the MDCC, register of CPR if required and inform the child and his/her family about the case transfer to the follow up unit. The incoming social worker should also take active steps to facilitate the case transfer.
V. POST CONFERENCE MANAGEMENT

De-briefing for Family

62. If the key social worker responsible for following up the case is not the investigating social worker, the Chairperson and the investigating social worker should arrange debriefing for the parents and the child who have participated in the MDCC and prepare them adequately for the transfer of the case. Discussion during debriefing should be noted in the case record.

63. In case the parent(s) is/are not satisfied with the decision made by the MDCC, he/she/they can lodge any complaint to the Chairperson who has to explain to the parent(s) the reasons for the decision. Nevertheless, the welfare plan should still be carried out as far as practicable even when the parent(s) has/have lodged a complaint against the welfare plan. If there is new information provided by the parent(s), upon consultation with all members, a review conference may be considered.

64. If the complaint is against a particular member of the MDCC, the complaint should be channeled to the respective organisation of that member for handling.

Minutes of MDCC and Notification Letter to Family

65. The Chairperson should clear the minutes of the MDCC prepared by the investigating social worker and issue to members for amendments preferably within two weeks after the MDCC. A sample format of the minutes of the MDCC is at Annex IIC to Chapter 11 for reference. The confirmed minutes should also be sent to members no later than one month after the MDCC.

66. Parent(s) and the child(ren) having attended the MDCC will not be provided with minutes of the MDCC as they are not members.

67. Regardless whether the parent(s) has/have attended the MDCC, a notification letter to the parent(s) stating the decisions of the MDCC, highlighting the welfare plan for the child and restating that the decision of the MDCC has no binding effect on the decision of the Police whether to institute criminal proceedings against the abuser(s) or not, may be issued by the Chairperson. A sample of the notification letter is at Annex IID to Chapter 11 for reference. The letter may need to be translated into the appropriate language to facilitate communication with the service user.

VI. LEGAL CONCERNS

Prosecution and Protection
68. Child abuse may be a criminal offence. Prosecution of the abuser is part of child protection work although it may not be initiated for every child abuse case. However, the definition of child abuse as set out in Chapter 2 has neither legal effect nor legal implications. It only provides operational guidelines in dealing with child abuse cases. Besides, the focus of the discussion at the MDCC should be on the welfare of the child(ren). Therefore the decision of the MDCC regarding the nature of the case has no binding effect on prosecution of the abuser(s) while members may give views on the implications of prosecution on the welfare of the child(ren).

69. The Chairperson should take note of the measures as stipulated in paragraphs E(3), G(2)(c), H(7)&(8), I(5) and K(5) in the “Guide to Participants of MDCC”, to avoid contamination of evidence during discussion at the MDCC.

Role of Police

70. The police officer in charge of the investigation of the suspected child abuse case should attend the whole MDCC as member to inform the MDCC the progress, but not the details of the investigation of the incident(s), i.e. the case is still being investigated, legal advice is being sought, no charge has been laid or a charge has been laid against the suspected child abuser(s) and contribute his/her professional knowledge as far as possible.

71. The police officer attending the MDCC should remain neutral during the discussion on the nature of the case in order to avoid being accused of showing prejudice in the criminal investigation (see (5) of paragraph K in the “Guide to Participants of MDCC” for details).

72. The police officer may also advise members on the progress of criminal investigation and to provide relevant information on the abusive incident(s) which is deemed essential for the formulation of a suitable welfare plan for the child(ren) concerned.
References:


Conducting Effective Meetings (2002). http://www.resolv.org/articles/meetings.htm


Introductory Remarks in Relation to Personal Data (Privacy) Ordinance, Cap 486
by the Chairperson of Multi-disciplinary Case Conference (MDCC)

English Version:

“In accordance with Section 18(1) of the Personal Data (Privacy) Ordinance, Cap 486, the parents may make a data access request for a copy of their own and/or the child’s personal data as contained in the reports and/or minutes of the MDCC. Please clarify whether you wish the information to be provided by you during this MDCC to be kept confidential in which case you would be regarded as the data user in relation to such information even though the information is held in our record. This is because Section 2 of the Personal Data (Privacy) Ordinance provides that a person who does not hold the data but control use of the data may nevertheless be regarded as a data user. Under Section 20(3)(d) of the Ordinance, a data user who is the data holder is permitted to refuse a data access request made by the data subject where any other data user controls the use of the data in such a way as to prohibit the non-controlling data user from complying, either in whole or part, with such request. If the data access is refused by us under this provision, the Ordinance requires us to inform the requestor of the name and address of the data user retaining control of the use of the data. Unless any of the exemptions provided in Part VIII of the Ordinance is applicable, the data user who retains control of the use of data is obliged to comply with the request”.  

中文本：

根據《個人資料(私隱)條例》(以下簡稱《條例》)第18(1)條，家長可提出查閱資料要求，取得一份會議報告及／或記錄所載有關其本人及／或子女的個人資料複本。請各位表明是否希望把各位在會議中所提供的資料保密。如當作保密資料處理，則即使這些資料是由我們的記錄備存，各位仍會被視為這些資料的資料使用者。《條例》第2條訂明，任何並無持有資料但控制資料的使用的人士，均會被視為資料使用者。根據《條例》第20(3)(d)條，如有另一資料使用者控制該等資料的使用，而控制的方式禁止非控制該等資料的資料使用者依從（完全依從或部分依從）查閱資料要求，則該持有資料的資料使用者可拒絕依從資料當事人的查閱資料要求。《條例》訂明，如我們根據這項條文拒絕查閱資料要求，我們須告知提出要求者控制資料使用的資料使用者的姓名（或名稱）及地址。除非可援引《條例》第VIII部所訂的豁免，否則，控制資料使用的資料使用者必須依從查閱資料要求。
Our Ref : 
Address : 
Tel. No. : 
Fax No. : 
E-mail : 

Dear Sir / Madam,

**Multi-disciplinary Case Conference on Suspected Child Abuse Case**

Name : 
Sex / Age : 

You are cordially invited to attend a case conference on a suspected child abuse case concerning the above-named child with detailed as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>:</td>
</tr>
<tr>
<td>Venue</td>
<td>:</td>
</tr>
</tbody>
</table>


To facilitate fruitful and productive sharing on the case nature and the welfare plan of the child(ren) and his/her family, would all members please prepare **written report** on the child(ren) for the reference of the case conference as far as possible.

Attached please find the Agenda of the Conference and the Feedback Form for Family Participation. Please fill in the form and return to me by fax on or before ____________. If you have any views on the membership or agenda, please feel free to contact me or the investigating social worker, (name) ____________ at (tel. no.) ____________.

I look forward to seeing you in the conference.

Yours faithfully,

(                                        )

*Delete as appropriate

Encl.
Distribution *(The list of members should be worked out on case-by-case basis. The membership list below is for reference only.)*

Dr xxx, Senior Medical Officer / xxxxxx Hospital (Your Ref:  )
Miss xxx, Nursing Officer / xxxxxx Hospital (Your Ref:  )
Mr xxx, Medical Social Worker / xxxxxx Hospital (Your Ref:  )
Mr xxx, Senior Inspector / xxxxx Police Station (Your Ref:  )
Miss xxx, teacher / xxxxx Primary School (Your Ref:  )
Ms xxx, Social Work Officer / Family and Child Protective Services Unit (xx)
Conference on Suspected Child Abuse Case

Name : 
Sex / Age : 
Date : 
Time : 
Venue : 

AGENDA

I. Introduction

II. Information sharing
   1. Report by investigating social worker
   2. Report by medical officer
   3. Report by medical social worker
   4. Report by nursing officer
   5. Report by police officer
   6. Report by school teacher

(Order of sharing to be arranged on a case-by-case basis)

III. Discussion
   1. The case nature
   2. The welfare plan for the child and the family

IV. Any other business

(e.g. arrangement of case transfer, need for review conference, progress report, debriefing to family, etc.)
Feedback Form for Family Participation in Case Conference on Suspected Child Abuse Case

Dear Sir / Madam,

Name of child : 
Sex / Age : 
Date of Conference : 

I propose to invite ___________________________ (suspected abuser*) who is (relationship) of the victim

☐ to attend the whole case conference.
☐ to attend the second part of the case conference at the time of welfare plan formulation.
☐ to be present at the time when initial recommendation on welfare plan is made.

Please give your opinion regarding the above arrangement by filling and returning the reply slip below to me by fax at your earliest convenience.

( )

Reply Slip
(Fax No.: )

To : 
From : 
Date : 

Name of Child : 
Date of Conference : 

☐ I agree to the proposed arrangement of family participation in the case conference.
☐ I do not agree / have reservation* to the proposed arrangement because

☐ I propose the following alternative arrangement (with reasons):

________________________________________

Signature : ____________________
Name : ____________________
Post : ____________________
Tel. No. : ____________________

* Delete as appropriate
Minutes of Multi-disciplinary Case Conference on Suspected Child Abuse Case

Re : Name of child : xx
Sex / Age : xx

Date :
Time :
Venue :

Present :
Absent with apology :

1. Introduction

2. Sharing of information
   2.1 Report from Investigating Social Worker
   2.2 Report from Medical Officer
   2.3 Report from Medical Social Worker
   2.4 Report from Ward Nurse
   2.5 Report from Police
   2.6 Report from Class Teacher and Student Guidance Teacher

(Order of sharing to be arranged on case-by-case basis)

3. Discussion
   3.1 Nature of the case
(The participants of MDCC should review and consider the whole situation and re-classify or re-define the case (if necessary) but not just focusing on the suspected child abuse incident.)

- risk
- violence within the family
- strength within the family
- support outside the family

3.2 Welfare Plan for the Family
- Monitoring, progress report, review meeting

4. Any Other Business
XXX 先生／女士，

懷疑虐待兒童多專業個案會議

兒童姓名：
性別／年齡：

多謝你／你們於____________(日期)參與有關上述兒童的個案會議。

(如家長未有出席會議，一個由____________(與會機構)組成的多專業個案會議已於_______________(日期)召開，以商討上述兒童的福利事宜。)

各與會人士在當日的會議中對上述兒童的狀況均表示十分關注；而有關事件亦已在會議中被界定為_________________________個案。個案會議亦決定該名兒童的福利計劃如下：

___________________________________________________
_________________________________________________

__________先生／姑娘將會由____________(日期)開始跟進本個案，並會與你商討落實多專業個案會議為該名兒童制定的福利計劃。__________先生／姑娘的聯絡電話及地址為____________________。

本人希望你／你們能夠與有關人士共同努力，確保上述兒童能得到最適當的照顧。

請留意，個案會議的決定，不會對警方在有關案件的調查及決定會否刑事起訴有關的違法人士方面，具有任何約束力。

如你有任何疑問，請與我聯絡，電話__________。

( )
姓名

註：信件內容可因應個別個案作出修訂
Annex III to Chapter 11

Frequently Asked Questions about
Multi-disciplinary Case Conference (MDCC) on Child Abuse

1. **What factors should be taken into consideration when determining whether a case is a child abuse or not in MDCC?**

   In determining whether a case should be defined as a child abuse case, the responsible professionals should make assessment based on individual case merits and taking into consideration various factors (e.g. the child’s age, the act, the consequences of the act on the child, etc.) instead of just focusing on the frequency and nature of incident that has occurred.

2. **Can the MDCC make decision by voting rather than by consensus as stated in (2)(e) of paragraph G in the Guide to Participants of MDCC?**

   By consensus each member is given the opportunity to express and exchange his/her views with others. This is the basis of multi-disciplinary cooperation. This is particularly important as child abuse and the welfare plan for the victims are very delicate issues that should not be dealt with simply by voting.

3. **Can the parent(s) appeal against the decision made by the MDCC?**

   The parent(s) can lodge any complaint to the Chairperson who has to explain to the parent(s) the reasons for the decision. If there is new information that has not been fully addressed in the first MDCC, the Chairperson, upon consultation with all members, can consider holding a second MDCC.

   If the complaint is against a particular member of the MDCC, the complaint should be channeled to the respective agency of that member for handling.

4. **Can the alleged perpetrator attend the MDCC?**

   The focus of the MDCC is on protection and welfare of the child but not prosecution of the abuser. The welfare and rights of the child should always be the paramount concern. In case the parent(s) is/are suspected abuser(s), careful consideration and balancing of different views from all members should be rendered to determine whether to invite the parent(s) to attend the MDCC. The parent(s) who is/are suspected abuser(s) can attend the MDCC if it is assessed by the Chairperson and all members, including the Police, to be suitable.

5. **Can the alleged perpetrator send his/her legal representative to attend the MDCC?**

   As the focus of MDCC is not on prosecution of the abuser and it is a forum by which professionals having a major role in the handling and investigation of a suspected child abuse case to share their information and concern on the child,
there is no ground for the alleged abuser to send his/her legal representative to attend the MDCC.

6. Can the parent(s) or the child victim(s) ask their friends or relatives to accompany them during the MDCC?

Subject to the consent of members of the MDCC, significant family members and relatives who have sound knowledge of the child victim(s) and would be contributive to the welfare planning of the child victim(s) can also be invited to attend the MDCC.

7. Can the parent(s) or the child victim(s) attend the MDCC if they have special communication needs?

Measures should be taken to facilitate effective communication for parent(s) or child victim(s) who participate in MDCC. If the parent(s) or child victim(s) have special communication needs, accredited interpreters, sign language interpreters or others with special communication skills should be made available to facilitate family participation in MDCC. Updated list of accredited interpreters can be obtained from the Senior Court Interpreter of the High Court. Family members, relatives or friends of the service users should not be regarded as formal interpreters during MDCCs.

8. Does class teacher need to attend MDCC?

The class teacher may be included in MDCC as he/she possesses relevant knowledge regarding the child and his/her family. Such information provides good reference materials for the MDCC in working out a welfare plan to the best interest of the child. However, if the class teacher cannot attend the MDCC, a suitable representative, who has sufficient understanding of the case, can report on the child’s family situation, school performance, conduct and emotional condition in school.

9. Can the case been transferred to the follow-up unit before confirmation of minutues?

In principle, the investigating social worker should prepare relevant documents including case summary and confirmed minutes of the MDCC before transferring the case to the follow-up unit. If there is a dispute on confirmation of the minutues, the Chairperson / the supervisor of the investigating social worker should help to settle the dispute and issue the confirmed minutes as soon as possible.
CHAPTER 12

FOLLOW UP SERVICE

REGISTRATION AT THE CHILD PROTECTION REGISTRY

12.1 The social worker who conducts social enquiry into the child abuse incident should send the particulars of the child to the Child Protection Registry (CPR) for registration in accordance with the recommendation of the Multi-disciplinary Case Conference (MDCC) on child abuse (see Appendix VI for information on CPR).

CARE PROCEEDINGS

12.2 If the child is assessed to be in need of statutory protection during the MDCC, application for a court order under Section 34(1) / Section 34E(1) / Section 34F(1) / Section 35(1) / Section 44(1) / Section 45(A) of the Protection of Children and Juveniles Ordinance (PCJO), Cap 213 should be made by the responsible social worker of SWD. For new cases, Family and Child Protective Services Unit (FCPSU) will take up the care proceedings and provide follow up service. For known cases of IFSC / Probation Office / Medical Social Services Unit / Adoption Unit / Tuen Mun Children and Juvenile Home, the social worker of the concerned unit will take up the responsibility for the care proceedings and refer the case to FCPSU for follow-up service after the Care or Protection Order is granted. For known cases of MSSUs, the medical social worker will focus on the patient’s rehabilitation and act as a coordinator between the medical and allied health professionals and social workers of FCPSUs. For known cases of Family and Child Protective Services Unit / High Court Probation Office, the social worker of the unit concerned will take up the care proceedings and provide follow-up service.

12.3 Relevant information, e.g. medical / psychological report, social enquiry report and conclusions of the MDCC, should be compiled for the information of the Magistrate at the Juvenile Court.

12.4 Article 37(d) of the United Nations Convention on the Rights of the Child states that, among others, “Every child deprived of his/her liberty shall have the right to prompt access to legal and other appropriate assistance”. To this end, the Duty Lawyer Service (DLS) has been commissioned to run the Legal Representation Scheme (the Scheme) for children or juveniles involved in care or protection proceedings. The Scheme will provide legal assistance to any child or juvenile in need of care or protection and who is:

(a) deprived of his/her liberty and detained in a gazetted place of refuge under Section 34E of the PCJO, Cap 213; or
(b) taken to the Juvenile Court directly by the Police for the application of Care or Protection Order, without any period of detention at a gazetted place of refuge before court hearing; or

(c) likely to be detained in a gazetted place of refuge on the recommendation of a social worker of SWD.

12.5 A placement in a small group home / foster home / children’s home, etc., if needed, should be secured as soon as possible.

12.6 Parties providing follow up service to the child and his/her family should share information on the significant development of the case (e.g. when the order is made, terms of the order, placement of child, etc.).

DOMESTIC VIOLENCE INJUNCTION ORDER

12.7 Under the Domestic and Cohabitation Relationships Violence Ordinance (DCRVO), Cap 189, where a party (i.e. spouse/ former spouse/ partner / former partner) to a marriage / cohabitation relationship, who is of opposite sex, makes an application to the District Court or the Court of First Instance, the Court may grant an injunction which either :

(a) restrains the other party from using violence against the applicant or a child living with the applicant; or

(b) excludes the other party from the residence or from a specified part of the residence or from a specified area.

VOLUNTARY CARE

12.8 If the case is assessed to be a child abuse case but considered not in need of invoking PCJO or DCRVO as decided by the MDCC, voluntary care should be provided. The key social worker appointed by the MDCC should follow up the case as follows:

(a) if out-of-home care for a child is necessary and agreed by parent(s) / guardian(s), suitable placement in a small group home / foster home / children's home, etc. should be secured as soon as possible;

(b) voluntary supervision should be rendered to the child and his/her family;

(c) parties providing follow-up services to the child and his/her family should share information on the significant development of the case (e.g. placement of child, etc.);

(d) continued services should be provided to the child and his/her family, as required.
FOLLOW UP ACTION AFTER CARE PROCEEDINGS / CASE CONFERENCE

12.9 Depending on the terms of the Care or Protection Order and recommendations of the MDCC, the key social worker will continue to provide counselling and appropriate assistance to the child and his/her family. Other rehabilitative service including therapeutic treatment should be arranged as necessary. Home visits and personal contacts with the child and his/her family should continue to be made as frequently as required. The key social worker should, where applicable, also work closely with staff of the residential home where the child is placed.

FAMILY REUNION

12.10 The following areas have to be observed in considering the re-union of the child with his/her family:

(a) Positive parent / child / siblings relationship is necessary before a child is returned to the family.

(b) The reaction of parties concerned must be carefully monitored and studied.

(c) Reunion should be tried out in stages: more visits by parent(s) / siblings to the child, the child staying with parent(s) overnight, on weekends, etc. Where applicable, before actual return of the child to the family, opinion from the clinical psychologist / child psychiatrist may be sought.

(d) Regular visits and contacts by the social worker should be maintained even if initial reaction from the parties concerned is satisfactory after the return of the child.

(e) Consultation with the officers-in-charge / supervisor and other parties involved or related to the family should be maintained throughout.

(f) Parties which are still actively involved should be informed on the discharge / amendment / expiry of Care or Protection Order / reunion of child to family.

PERMANENCY PLAN FOR THE CHILD

12.11 Continued attention must also be given to a child receiving out-of-home care, especially for those cases where reunion with the family is not advisable. A permanency plan for the child is required for those children living away from
home.
CHAPTER 13

VICTIM MANAGEMENT BEFORE COURT HEARING
AND POST ABUSE THERAPEUTIC SERVICE

GOVERNING PRINCIPLES

13.1 It is most important that in the period following a video-recorded interview, and prior to any Court hearing, continued contact is maintained with the child and the family by the Child Protection Special Investigation Team (CPSIT), so as to keep them informed of the progress of the case investigation, and to prepare the child witness for attendance in Court. Full use of the Child Witness Pack available at the Social Welfare Department (SWD) and Child Abuse Investigation Units (CAIUs) of the Police should be made in this task. A pre-trial visit to the Court will also be arranged for the child to familiarize him/her with the Court setting.

13.2 Details of any visits and any relevant conversations should be recorded and retained.

13.3 The following areas are to be avoided in any therapeutic work carried out to the child before the trial:

(a) details of the investigative interview;

(b) the abuse
   - what happened?
   - who did it?
   - when?
   - where?

(c) the use of any materials which suggest or presume that abuse has taken place.

PRE-TRIAL COUNSELLING SERVICE

13.4 Why is Therapeutic Work Necessary

It is recognized that all forms of child abuse may have long term harmful consequences for the emotional development and mental health of the victims. Once video-recorded interview is completed, it should be necessary for appropriate counselling and therapy to take place to reduce these harmful effects.
13.5 **Definition of Pre-trial Counselling Service**

Pre-trial counselling service should be defined as intervention which is focused on the needs of the individual child having experience of abuse. It aims at addressing the following areas of the child at the pre-trial stage:

(a) **Child’s feelings and reactions** in the aftermath of the investigation - fear, anger, insecurity, guilt, shame or confusion.

(b) **Sex education and sexuality** including information about physical and sexual development, contraception, sexual orientation, and generalised self-protection (good and bad touching).

(c) **Social skills and peer relationships** to overcome possible isolation, establish support and form normal alliances and friendships.

(d) **Rebuilding of self-esteem** including improvement of self-image and integrity.

13.6 **Who to Conduct Post Abuse Therapeutic Counselling Service at Pre-trial Stage**

(a) Subsequent to the video-recorded interview, members of the MDCC are responsible for assessing the need for post abuse therapeutic counselling to the child on individual case basis at the pre-trial stage. They should establish the cause of the child's distress, and must not presume that the abuse itself is the source. They must also make a clear distinction between investigative interviews and therapeutic interviews.

(b) In providing counselling service, the follow up social worker should work with both the abused child and his/her family with emphasis on the child's relationship with the parents and other family members, his/her needs for proper care and attention, his/her health and development, behaviour and emotion, and schooling problems. Family support service will be mobilized in the process of counselling to improve parenting skills, the family's living environment, financial status and to provide substitute care for the child on need basis. Statutory supervision will also be enforced by the FCPSU social worker under Section 34(1) of Protection of Children and Juveniles Ordinance, Cap 213, to protect the child.

(c) In circumstances when the child cannot resolve his/her inner feelings or overcome his/her fears or distress, helplessness, shame or distrust after the abuse incident(s), thus causing serious harm or damage to his/her emotional and mental equilibrium, counselling or therapeutic treatment may need to be provided to the child by a clinical psychologist or child psychiatrist.
13.7 **Areas for Special Attention regarding Pre-trial Counselling Service**

(a) The child’s need must take precedence.

(b) All therapeutic work undertaken should have clear objectives and be reviewed to ensure continuous improvement in practice.

(c) Efforts should be made to avoid direct contact between the suspected abuser and the child.

(d) The follow up social worker or clinical psychologist or child psychiatrist should inform the Officer-in-charge of the Case (OC Case) / CAIU of the need for pre-trial counselling service for the child and shall consult the trial preparation counsel of the Department of Justice, preferably prior to the therapy / counselling taking place. The consultation should be done in written form and should include the areas to be covered, methods to be used and reasons for wishing to offer therapeutic help at that time. The Department of Justice will then offer comments on the proposal.

(e) Where the Police are undertaking a parallel investigation which may lead to prosecution of an alleged abuser, there are important issues to be considered about the need for the child to receive appropriate counselling and support and the need for the child to appear as a credible witness in Court.

(f) Care should be taken to avoid counselling from adversely affecting the criminal proceedings.

(g) Where the child is to give evidence in the prosecution, it is essential to avoid discussion of any matters which might discredit the child as a witness or permit allegations of coaching by the follow up social worker or clinical psychologist or child psychiatrist.

(h) Anybody involved in the joint investigation is not preferred to take part in the counselling or psychological or psychiatric therapeutic treatment.

(i) Anyone who does counselling or therapeutic treatment must realise they might have to give evidence in court themselves.

(j) Where there is more than one victim, each should be counselled or treated separately.

(k) If, during the counselling or therapeutic treatment, inconsistent comments are made, the follow up social worker, clinical psychologist, or child psychiatrist should be reminded of the following:

- remind the child the need to tell the truth;
- encourage the child to disclose the information to the Police;
- observe the rules regarding confidentiality in their own professionals’ Code of Practice; and
- seek advice from their supervisors and consider taking various appropriate action to safeguard the child’s welfare and interest if affected.

(l) Records of the counselling provided to the child must be kept in order as the Court or defence may justifiably wish to know about both the nature and content of the counselling that has taken place before the child gives evidence in cross-examination and such records may be subject to disclosure to the defence as unused material. Video-taped interview is allowed in therapeutic counselling but the tape has to be kept under locked.

(m) At all stages, the follow up social worker or clinical psychologist or child psychiatrist should use games books or play materials in counselling with confidence, proper records and description of any game books, or apparatus, etc. used should be kept as these records may be subject to disclosure to the defence as unused material. Any exercise or materials which presume that abuse has actually taken place, or abusive scenarios for discussion should be avoided.

(n) The follow up social worker or clinical psychologist or child psychiatrist engaged in the pre-trial counselling service should attend to the case review meeting, if needed, to contribute to the prompt development of a package of support services to the child, his/her siblings and carers. As a follow up worker of the case, he or she should be responsible for the coordination and review of post abuse work.

(o) The follow up social worker will prepare the child witness for court hearing on areas like:

(i) the physical setting of the Court;
(ii) roles of the personnel involved;
(iii) telling the truth;
(iv) the use of the live TV link or screens; and
(v) introduction of the support person, etc.

(p) In the event that the clinical psychologist or child psychiatrist finds it unavoidable to go through the abuse incident(s) with the child again in order to offer effective therapeutic treatment to the child who is seriously at risk mentally or psychologically, the clinical psychologist or child psychiatrist should inform the follow up social worker, the OC Case / CAIU and seek advice from the trial preparation counsel of the Department of Justice. Consideration should then be made by the Department of Justice in striking a balance between prosecution and dropping the case in the best interest of the child. The follow up social worker, clinical psychologist or child psychiatrist should be informed by the Department of Justice of their decision.
VIDEO-RECORDED THERAPEUTIC INTERVIEWS

13.8 Some practitioners regularly record on video their therapeutic work with the children. It enables them to review the content of each session, reflect on their own contributions and plan subsequent sessions more carefully. This may aid professional development, and can be used with a consultant to improve practice further. A young person may appreciate having a record of these sessions to monitor their own change or perhaps to show to a trusted carer. Video-recording can be of value in student training, but should only be used after obtaining consent of the child and his/her parent concerned.

13.9 Practitioners who use video recording for the above reasons should be aware that such records may be subject to disclosure to the defence as unused material and / or called by the defence in a prosecution. Materials may be used to discredit the witness by finding inconsistencies in the child's evidence. A video-recording of a therapeutic interview is usually undertaken on the understanding that the record will remain confidential, and be kept securely. The child or young person may also be dismayed to find the contents of their video recording being used against them.

13.10 The decision to make a video recording of the therapeutic work should be left to the individual social worker, clinical psychologist and child psychiatrist having weighed the considerations above. It is preferable that only equipment which has the facility to record the date and time should be used. If such equipment is not available, then the date and time of the recording should be properly and accurately recorded at the start and end of the recording. Then care should be taken to label and store securely the video recording. Informed consent should be secured in every case, and arrangements should be made for secure storage and subsequent destruction of recordings.

13.11 Written records of counselling work should also be retained by social workers, clinical psychologists, or child psychiatrists providing service to the victim in line with normal practice on case records.

WRITTEN RECORDS OF THERAPEUTIC INTERVIEWS

13.12 In a prosecution, the defence may request access to some or all records kept about a child witness. Work undertaken with the child prior to the trial of the alleged abuser will be subject to scrutiny. Materials contained in a case file may suggest lines of cross examination, and again may be used to discredit the child’s evidence. Records may also lay open the therapeutic process to accusations of coaching the child.

13.13 Good standard of case recording should be applied at all times, and extra caution should be exercised in these circumstances. Recorded comments should be soundly based on facts and susceptible to proof. Professional judgements should be backed by reasoning and concrete evidence.
Practitioner musings or speculative interpretations of the child’s behaviour, play or drawings should be recorded accurately and not withheld.

13.14 Social workers, clinical psychologists or child psychiatrists undertaking the pre-trial counselling work with a child who is not involved in a prosecution should be aware that counselling work often enables a child to reveal further incident(s) or information about the abuse which may result in a subsequent prosecution. All pre-trial counselling work should therefore be supported by case recording in the light of the above guidance.

POST-TRIAL STAGE

13.15 After the trial, there are no constraints on the nature of counselling service. The follow up social worker should continue to look after the child and his/her family carers through counselling service and mobilization of family support service while the clinical psychologist or child psychiatrist should carry on their therapeutic treatment as needed by the child.

13.16 Apart from the follow up social worker, clinical psychologist and child psychiatrist, any other persons including staff of the residential homes who are providing pre-trial counselling service or care service to the child are also advised not to probe into the abuse incident(s) of the child.
SECTION V

ROLES OF RELEVANT DEPARTMENTS / ORGANISATIONS
Roles of

Social Service Units
CHAPTER 14

FAMILY AND CHILD PROTECTIVE SERVICES UNITS
(SOCIAL WELFARE DEPARTMENT)

HANDLING OF INTAKE / REFERRALS

14.1 Family and Child Protective Services Unit (FCPSU) shall take up initial enquiry into all newly reported suspected child abuse cases during office hours. For reports on suspected child abuse cases received after office hours, the SWD Outreaching Team (after office hours) through information from the SWD Departmental Hotline Service, hotline service of Family Crisis Support Centre and CEASE Crisis Line should respond to the report (refer to paragraphs 14.9 to 14.11 below).

For New Cases of Suspected Child Abuse

14.2 Upon receiving a referral or when handling an intake, the FCPSU intake worker should conduct initial social assessment in accordance with the governing principles, general guide and procedures as set out in Chapter 6 and Chapter 7. The FCPSU intake worker should follow the intake procedures as stipulated in paragraphs 7.4 to 7.15 of Chapter 7 to collect available information and based on the initial information available or the observation from the intake interview or home visit, to conduct initial social assessment if there is:

(a) reason(s) to believe that the child has been or is being abused;

(b) urgency for medical attention;

(c) a cause for concern that child abuse might have occurred.

Note: For all forms of abuse cases, refer to Understanding of Child Abuse in Chapter 2. For sexual abuse cases in particular, refer also to Key to Making Referrals to Child Protection Special Investigation Team (CPSIT) at Appendix V.

14.3 In making an initial social assessment, the intake worker is required to assess preliminarily from the welfare point of view if a child is left unattended, neglected or in any form of abuse or risk situation. For children being left unattended at home or abandoned children, IFSCs / ISCs should perform the outreaching duties for initial assessment unless there are further indicators or evidence of child abuse.

14.4 For newly reported suspected child abuse cases received during office hours (i.e. from 8:45 a.m. to 5:00 p.m. for Monday to Friday and from 9:00 a.m. to
12:00 noon for Saturday) with the need for outreaching visit, the SWO/FCPSU (i.e. the team leader) should pair up with a social worker from the respective IFSC of SWD to reach out to the case for investigation. The team leader should collect information from the informant / referrer, conduct initial social assessment and take appropriate action following the intake procedures as stipulated in paragraphs 7.4 to 7.15 in Chapter 7. If the case is suggestive of child sexual abuse or serious physical abuse cases falling within the Charter of Child Abuse Investigation Units (CAIU), based on information collected on the phone, referral can be made to SWO/FCPSU or Police/CAIU directly for investigation in accordance with paragraph 7.4 in Chapter 7. The right of entry into premises is provided under Section 34E (6) / Section 44 (1) / Section 45A (8) of the Protection of Children and Juveniles Ordinance, Cap 213. Assistance from the Police, Fire Services Department, or others as appropriate may be enlisted if the parent(s) / guardian(s) are unco-operative. An order of removal of the child to a place of refuge or such other place / hospital is provided under Section 34E (1) / Section 34F (1) & (2) / Section 35 (1)(a) of the Ordinance. The application for care proceedings should be initiated within 48 hours after the child is so removed to a place of refuge or such other place.

14.5 If the information collected indicates suspected child abuse incident(s) and the case is not a known case of any welfare organisations\(^1\), a FCPSU worker will be assigned to take up the case and conduct the social enquiry and provide casework service. The FCPSU worker should prepare the social enquiry report and arrange the Multi-disciplinary Case Conference to formulate the welfare plan for the child and his/her family. For cases where no evidence of abuse is identified but are assessed to be in need of IFSC services such as counselling, child care, etc. after investigation, they can be referred to the IFSCs / ISCs of SWD or non-governmental organisations for follow up according to place of residence of the child’s parent / guardian with their consent.

**For Known Cases of FCPSU**

14.6 The responsible FCPSU worker should take up the case and follow the steps described in paragraphs 7.7 to 7.15 of Chapter 7 as appropriate and to conduct the social enquiry.

**For Known Cases of other SWD / NGO Units**

14.7 For known cases of other SWD / NGO units, the FCPSU intake worker should inform the responsible social worker or the responsible unit to provide initial social assessment. The responsible social worker or the responsible unit should assess the situation and follow the steps described in paragraphs 7.7 to 7.15 of Chapter 7 as appropriate and to conduct the social enquiry. The responsible social worker of the NGO units should handle the case as described in the respective Chapter of Social Service Units in Section V of this

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\(^1\) Refer to Appendix I for Definition of Known Cases of Welfare Organisations.
14.8 For urgent cases requiring immediate action but the responsible unit cannot be contacted immediately, the FCPSU intake worker should provide initial social assessment and assist to make referral to the CPSIT as necessary. The responsible caseworker of SWD / NGO units will then be informed to follow up the case.

Referrals Received by SWD Outreaching Team After Office Hours

14.9 For reports on suspected child abuse cases received after office hours, the SWD outreaching team (after office hours), comprising a SWO/FCPSU or Oi/c IFSC or SWO/IFSC and a caseworker of FCPSU or IFSC, should respond to the report and reach out to investigate the case if necessary.

14.10 If upon outreaching to the case and child abuse is suspected, the team leader should collect information from the informant / referrer, conduct initial social assessment and take appropriate action following the intake procedures as stipulated in paragraphs 7.4 to 7.15 of Chapter 7. If the case is suggestive of child sexual abuse based on information collected on the phone, referral can be made to the CPSIT directly for consultation and necessary action. The team leader should check with the CPR and respective SWD / NGO unit on the following working day and prepare an intake report.

14.11 To follow up the outreached cases, the new case can be referred to the respective FCPSU for follow up service. For known suspected sexual abuse cases, the team leader should inform the respective SWD / NGO unit to take up the case after referral has been made to CPSIT in situations (a) and (b) as stipulated in paragraph 14.2 above, or to inform that unit to conduct further exploration for the case in situation (c). For other forms of known suspected abuse cases, the responsible worker of the concerned unit should be informed for follow-up service after the outreach. (refer to Appendix I for Definition of Known Cases). The responsible worker of the concerned unit should continue to provide casework service for the family. He/she should conduct the social enquiry, prepare report and arrange the Multi-disciplinary Case Conference to formulate the welfare plan for the child and his/her family.

CHILD ASSESSMENT PROCEDURE

14.12 Where there is reasonable cause to suspect that the child is or is likely to be in need of care or protection regarding the state of the child’s health, development or welfare or there is suspicion that the child’s health, development or welfare is neglected or avoidably impaired, but the necessary assessment procedure cannot be carried out, the FCPSU worker should consult his/her senior officer(s) on the need to serve a Child Assessment Notice to the parent(s) / guardian(s) under Section 45A of Protection of Children and Juveniles Ordinance, Cap 213, requiring the child to be produced for an assessment by a medical practitioner, clinical psychologist or an approved social worker. [For
details of the Child Assessment Order, refer to the Guidelines on Handling Cases of Children and Juveniles in need of Care or Protection (1993).]

14.13 In situation where there is a cause for concern that child abuse might have occurred but no abuse element is detected after investigation, the case can be closed at FCPSU or referred to the respective IFSC / ISCs for appropriate service.

COLLABORATION WITH OTHER PARTIES

14.14 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
CHAPTER 15
INTEGRATED FAMILY SERVICE CENTRES / INTEGRATED SERVICES CENTRES

HANDLING OF INTAKE / REFERRALS

15.1 Social worker of Integrated Family Service Centres (IFSC) / Integrated Services Centres (ISC) who comes across a suspected child abuse case should conduct initial social assessment during enquiry / intake interview in accordance with the governing principles, general guide and procedures as set out in Chapter 6 and Chapter 7.

For New Cases of Suspected Child Abuse

15.2 If the information collected in the telephone contact indicates suspected child abuse incident(s) and the case is not a known case of any welfare organisations\(^1\), the intake worker of IFSC / ISC should refer the case to the appropriate Family and Child Protective Services Unit (FCPSU) as soon as possible after obtaining the contact means of the informant who has called the IFSC / ISC. If there is a referral which indicates suspected child abuse incident(s) and the case is not a known case of any welfare organisations, the IFSC / ISC should follow the general guide as stipulated at paragraphs 6.2 to 6.5 of Chapter 6 and pass the referral to the appropriate FCPSU for follow up after initial screening.

15.3 If the informant and/or the child approach the IFSC / ISC in person, the intake worker of IFSC / ISC should follow the intake procedures as stipulated at paragraphs 7.4 to 7.15 of Chapter 7 to collect available information, conduct initial social assessment and consult FCPSU before referring the case to the appropriate FCPSU for follow up.

15.4 In making an initial social assessment, the intake worker of IFSC / ISC is required to assess preliminarily from the welfare point of view if a child is left unattended, neglected or in any form of abuse or risk situation. For children being left unattended at home or abandoned, IFSC / ISC should perform the outreaching duties for initial assessment unless there are further indicators or evidence of child abuse.

15.5 For newly reported suspected child abuse cases received during office hours (i.e. from 8:45 a.m. to 5:00 p.m. for Monday to Friday and from 9:00 a.m. to 12:00 noon for Saturday) with the need for outreaching visit, the SWO/FCPSU (i.e. the team leader) should pair up with a social worker from the respective IFSC of SWD to reach out to the case for investigation. The team leader should collect information from the informant / referrer, conduct initial social

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\(^1\) Refer to Appendix I for Definition of Known Cases of Welfare Organisations.
assessment and take appropriate action following the intake procedures as stipulated in paragraphs 7.4 to 7.15 in Chapter 7. If the case is suggestive of child sexual abuse based on information collected on the phone, report can be made to FCPSU or CAIU directly for investigation in accordance with paragraph 7.4 in Chapter 7.

15.6 The new case of suspected child abuse outreached will be taken up by the appropriate FCPSU for follow up service including conducting social enquiry, arranging Multi-disciplinary Case Conference and providing support service as required. For cases where no evidence of abuse is identified but are assessed to be in need of IFSC service such as counselling and child care, etc. after investigation, they can be referred to the IFSCs / ISCs of SWD or NGO for follow-up according to place of residence of the child’s parent / guardian with their consent.

For Known Cases of IFSC / ISC

15.7 Social worker of the IFSC / ISC concerned should take up the case and follow the steps described in paragraphs 7.7 to 7.15 of Chapter 7 as appropriate and to conduct the social enquiry. If urgent statutory care proceedings on the child / children are required other than known case of SWD Units during the course of enquiry, application should be either made by respective IFSC of SWD according to the latest residential address of the child’s parent / guardian or by the Police.

For Known Cases of other SWD / NGO Units

15.8 For known cases of other SWD / NGO units, the IFSC / ISC intake worker should inform the responsible social worker to provide initial social assessment. The responsible social worker should assess the situation and follow the steps described in paragraphs 7.7 to 7.15 in Chapter 7 as appropriate and to conduct the social enquiry.

CHILD ASSESSMENT PROCEDURE

15.9 Where there is reasonable cause to suspect that the child is or is likely to be in need of care or protection having regard to the state of the child’s health, development or welfare or there is suspicion that the child’s health, development or welfare is neglected or avoidably impaired, the responsible worker should consult his/her senior officer(s) on the need to serve a Child Assessment Notice to the parent(s) / guardian(s) under Section 45A of the Protection of Children and Juveniles Ordinance, Cap 213, requiring the child to be produced for an assessment by a medical practitioner, clinical psychologist or an approved social worker. [For details of the Child Assessment Order, refer to the Guidelines on Handling Cases of Children and Juveniles in need of Care or Protection (1993).]
15.10 In situation if there is a cause for concern that child abuse might have occurred but no abuse element is detected after investigation / assessment, the case can be closed at IFSC / ISC as appropriate if the child and his/her family members has/have no welfare needs.

COLLABORATION WITH OTHER PARTIES

15.11 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
CHAPTER 16

MEDICAL SOCIAL SERVICES UNITS
(SOCIAL WELFARE DEPARTMENT / HOSPITAL AUTHORITY)

SOURCE OF REFERRALS

16.1 Suspected child abuse cases may come to the notice of the Medical Social Services Units (MSSUs) in hospitals, specialist out-patient clinics and child assessment centres under Social Welfare Department (SWD) / Hospital Authority (HA) through:

(a) hospital personnel or Medical Coordinator on Child Abuse (MCCA) of the HA;
(b) social workers, police and other organisations, etc;
(c) direct approach by patients or their families.

ROLES OF MEDICAL SOCIAL WORKER

Handling of Intake / Referrals

16.2 The medical social worker (MSW) who comes across the suspected child abuse case should intake the case and conduct initial social assessment during enquiry / intake interview in accordance with the governing principles, general guide and procedures as set out in Chapter 6 and Chapter 7.

For New Cases of Suspected Child Abuse

16.3 Upon receiving a referral or when handling an intake, the MSW should follow the intake procedures as stipulated in paragraphs 7.4 to 7.15 of Chapter 7 to collect available information, confirm with the Medical Officers (MO) the result of their examination of the child if appropriate and conduct initial social assessment.

16.4 If the information collected / referral indicates suspected child abuse incident(s) and the case is not a known case of any welfare organisations, for suspected child sexual abuse and serious physical abuse cases which fall in the Charter of CAIU, the MSW should refer the case to FCPSU or CAIU for consultation as far as possible. For other forms of abuse cases, the MSW should consult / refer the case to the appropriate Family and Child Protective Services Unit (FCPSU) as soon as possible. Casework service will be provided by the FCPSU worker assigned, including immediate protection for the child.

16.5 For cases under the attention of hospital / clinic, the MSW attached in hospital should provide support service for the child and/or his/her family while the

1 Refer to Appendix I for Definition of Known Cases of Welfare Organisations
child is in hospital and the MSW will be consulted throughout the handling process, including the welfare planning of the child. The MSW should assist the Medical Coordinator on Child Abuse (MCCA) and Consultant / Senior Medical Officer (SMO) / MO concerned to co-ordinate and facilitate intra-agency and inter-agency communication, investigate and plan for further handling of the case. The MSW should be prepared to attend and report at the Multi-disciplinary Case Conference as well as to assist the FCPSU worker whenever necessary.

16.6 Whether or not the child is to be warded in hospital, the MSW should make sure that the suspected child abuse case is brought to the attention of the appropriate FCPSU.

16.7 If no abuse element is detected, the case can be closed. If other problems in the family are identified, this should be treated as an ordinary family case and be referred to IFSC / ISC of SWD / NGO for non-hospitalized case or to the responsible MSW for hospitalized case.

**For Known Cases of MSSUs of SWD / HA**

16.8 The responsible MSW concerned should take up the case and follow the steps described in paragraphs 7.7 to 7.15 of Chapter 7 as appropriate and to conduct the social enquiry.

16.9 The responsible MSW should provide casework service to the child and/or his/her family, including implementation of the child protection plan. He/she should also prepare the social enquiry report and arrange the Multi-disciplinary Case Conference to formulate the welfare plan for the child and his/her family. For cases where CPSIT is formed, the responsible MSW will be involved throughout the handling procedures of CPSIT, including strategy planning and immediate case assessment. The SWO/FCPSU or Police/CAIU will share information obtained on the abuse incident(s) and the result of the immediate case assessment with relevant parties concerned as necessary. If urgent statutory care proceedings on the child / children are required for the case other than known case of SWD Units during the course of enquiry, application should be either made by respective IFSC of SWD according to the latest residential address of the child’s parent / guardian or by the Police.

16.10 The MSW attached in hospital will continue to observe the child’s condition while the child is in hospital, be prepared to attend and report at the Multi-disciplinary Case Conference as well as to assist the responsible MSW whenever necessary.

**For Known Cases of other SWD / NGO Units**

16.11 For known cases of other SWD / NGO units, the intake MSW should inform the responsible social worker of concerned SWD or NGO unit to take immediate action. The responsible social worker should assess the situation and follow the steps described in paragraphs 7.7 to 7.15 of Chapter 7 as
appropriate and to conduct the social enquiry. The responsible social worker of the NGO unit should handle the case as described in the respective Chapter of Social Service Unit in **Section V** of this Procedural Guide.

16.12 The MSW attached in hospital will continue to observe the child’s condition while the child is in hospital, be prepared to attend and report at the Multi-disciplinary Case Conference as well as to assist the responsible social worker whenever necessary.

**CHILD ASSESSMENT PROCEDURE (only applicable to MSSUs/SWD)**

16.13 Where there is reasonable cause to suspect that the child is or is likely to be in need of care or protection having regard to the state of the child’s health, development or welfare or there is suspicion that the child’s health, development or welfare is neglected or avoidably impaired, the responsible worker should consult his/her senior officer(s) on the need to serve a Child Assessment Notice to the parent(s) / guardian(s) under Section 45A of the Protection of Children and Juveniles Ordinance, Cap 213, requiring the child to be produced for an assessment by a medical practitioner, clinical psychologist or an approved social worker. [For details of the Child Assessment Order, refer to the Guidelines on Handling Cases of Children and Juveniles in need of Care or Protection (1993).]

16.14 In situation if there is a cause for concern that child abuse might have occurred but no abuse element is detected after investigation / assessment, the case can be closed at IFSC / ISC as appropriate if the child and his/her family members has/have no welfare needs.

**COLLABORATION WITH OTHER PARTIES**

16.15 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare services to the family.
CHAPTER 17

CHILDREN AND YOUTH SERVICES
(NON-GOVERNMENTAL ORGANISATION)

SERVICES COVERAGE

17.1 Children and youth services in this chapter refer to the following subvented service units:

(a) Integrated Children and Youth Services Centres (ICYSCs);
(b) School Social Work Units (SSWUs) serving students in secondary schools;
(c) District Youth Outreaching Social Work Teams (YOTs).
(d) Overnight Outreaching Service for Young Night Drifters (YND); and
(e) Community Support Service Scheme (CSSS)

REFERRALS

17.2 Suspected child abuse cases may come to the notice of social worker of the above centre / team / unit:

(a) through direct approach by the child / student, or the family, or the public;
(b) referred by teachers, other school personnel, social workers, other organisations, etc.

HANDLING OF INTAKE / REFERRALS

17.3 The social worker of the centre / team / unit who comes across a suspected child abuse case should intake the case and conduct initial social assessment during enquiry / intake interview in accordance with the governing principles, general guide and procedures as set out in Chapter 6 and Chapter 7.

17.4 For cases involving student in the serving school, the school social worker should intake the case and conduct initial social assessment during enquiry / intake interview in accordance with the governing principles, general guide and procedures as set out in Chapter 6 and Chapter 7.

17.5 For suspected child abuse cases involving sibling of student not attending the serving school, the school social worker after intaking the case should refer the
For New Cases of Suspected Child Abuse

17.6 Upon receipt of telephone enquiries, if the information collected indicates suspected child abuse incident(s) and the case is not a known case of any welfare organisations, the social worker of the centre / team / unit should refer the case to the appropriate FCPSU as soon as possible after taking down the available information on the case to facilitate further contact by the FCPSU.

17.7 When handling a new suspected child abuse case at intake in which the informant and/or the child approaches in person and the case is not a known case of any welfare organisations, the social worker of the centre / team / unit should follow the intake procedures as stipulated in paragraphs 7.4 to 7.15 in Chapter 7 to collect available information and conduct initial social assessment and consult FCPSU before referring the case to the appropriate FCPSU for follow up. Casework service will be provided by the FCPSU worker assigned, including immediate protection for the child. The social worker of the centre / team / unit will continue to observe the condition of the child during contacts and will be consulted throughout the handling process. The FCPSU worker who takes up the case should prepare the social enquiry report and arrange the Multi-disciplinary Case Conference to formulate the welfare plan for the child and his/her family. The social worker of the centre / team / unit should be prepared to attend and report at the Multi-disciplinary Case Conference.

17.8 If no abuse element is detected, the case can be closed or referred to / followed up by relevant service unit as appropriate.

For Known Case of the Centre / Team / Unit

17.9 If the suspected child abuse case is a known case of the centre / team / unit, the responsible social worker should take up the case and follow the steps described in paragraphs 7.7 to 7.15 in Chapter 7 as appropriate and to conduct the social enquiry.

17.10 The social worker concerned should provide casework service to the child and/or his/her family, including implementation of the child protection plan. He/she should prepare the social enquiry report and arrange the Multi-disciplinary Case Conference to formulate the welfare plan for the child and his/her family. For cases where CPSIT is formed, the social worker

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1 Refer to Appendix I for Definition of Known Cases of Welfare Organisations.

2 Definition of known cases of centre / team / unit refer to the suspected child abuse victim being an active case (opened case with treatment plan and case record) handled by ICYSC / SSWU / YOT / YND / CSSS.
concerned will be involved throughout the handling procedures of the CPSIT, including strategy planning and immediate case assessment. The FCPSU/CPSIT or CAIU/CPSIT will share information obtained on the abuse incident(s) and the result of the immediate case assessment with relevant parties concerned as necessary. If urgent statutory care proceedings on the child / children are required for the case during the course of enquiry, application should be either made by respective IFSC of SWD according to the latest residential address of the child’s parent / guardian or by the Police.

**For Known Cases of Other SWD / NGO Units**

17.11 For known cases of other SWD or NGO units, the social worker of the centre / team / unit should inform the responsible SWD / NGO social worker to take immediate action. The concerned NGO / SWD unit should follow the steps described in the respective Chapter of Social Service Unit in Section V of this Procedural Guide.

**COLLABORATION WITH OTHER PARTIES**

17.12 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
CHAPTER 18

CLINICAL PSYCHOLOGICAL SERVICE

GOVERNING PRINCIPLES

18.1 In handling child abuse cases, the paramount concern is the welfare of the child.

18.2 To avoid requiring the child to describe the abuse incident(s) repeatedly, it is preferable to keep the number of investigative / assessment interview on the suspected abuse incident(s) to a minimum, say one interview. For video-recorded interview to be used in court proceedings, the interview should be conducted by police officer, social worker or clinical psychologist employed by the Government. The information collected with regard to the suspected abuse incident(s) shall be shared with relevant parties concerned as soon as possible.

CHILD SEXUAL ABUSE

Hospital / Clinic Settings

18.3 Clinical Psychologists (CPs) working in hospitals or clinics under either the Hospital Authority (HA) or the Department of Health (DH), like their counterparts in social welfare settings should handle the suspected child sexual abuse cases as described in one of the following situations:

(a) During the course of treatment or assessment of patients not originally suspected to be victims of child sexual abuse

CPs working in hospitals and clinics may sometimes come across young patients who are referred for treatment and/or assessment because of their behaviour and emotional problems. While working with these patients, the CP may encounter spontaneous revelation of previous incident(s) of sexual abuse or information that will arouse concern that sexual abuse might have happened. The CP should refer to the Guide to People Working with Children who Disclose Sexual Abuse and Key to Making Referrals to Child Protection Special Investigation Team (CPSIT) at Appendix IV and V. Consultation of welfare / crime related issues can be made to FCPSU / CAIU (Appendix VII & VIII) as appropriate and the CP should inform the Medical Coordinator on Child Abuse (MCCA) or Chief-of-service as well as the medical social worker (MSW) of his/her action. However, when the case is reported to either one of them, the referral should contain the following details:

(i) the nature, date and frequency of the abuse or concern;
(ii) the name, date of birth (if unavailable - age), and any disability or
special needs of the child;
(iii) the child’s whereabouts;
(iv) whether the child is in immediate danger;
(v) names and HKIC No. of parents / carers and others involved;
(vi) names of other children in the household and whether the children are at risk or potentially at risk;
(vii) name of school / child care centre, if known;
(viii) how the informant / referrer is aware of the information;
(ix) names of other witnesses and other agencies / government departments involved.

(b) When a child admitted to a hospital or referred to a clinic is suspected to be a victim of sexual abuse

The responsible medical staff can refer the child for CP assessment after consultation with social worker of FCPSU or police officer of CAIU. The CP, upon request, will perform an investigatory role by conducting a general assessment and interview regarding the suspected sexual abuse. The CP should refer to *Indicator of Possible Child Abuse* and *Guide to Risk Assessment* in Chapter 2. Based on the information gathered during the assessment, the CP will share his/her opinions with other professionals within the hospital and decide whether further action is warranted, such as, referring the child to FCPSU or CAIU for further action. If the child makes a spontaneous revelation, the same procedures as in paragraph 3(a) above should follow.

(c) When the victim of suspected sexual abuse cannot provide sufficient information to FCPSU worker or police officer of CAIU:

When the victim of suspected sexual abuse cannot provide sufficient information, the FCPSU worker and police officer of CAIU may decide to temporarily suspend the investigation. In the meantime, if the child has manifested distressful feelings or disturbing behaviors that may cause harm to his/her emotional and mental equilibrium, the responsible medical staff can consider referring him/her for psychological assessment and treatment. For exceptional cases of serious nature, these children can also be referred to CP for consideration of facilitative interview on a case-by-case basis. The purpose is to provide an opportunity to the victim of suspected abuse to make a full disclosure through building up a trusting relationship and helping the child to work through any fear or emotional blockage that may be present. The CP will usually review the progress after a few sessions to decide on further action. Once the victim has decided to tell, the CP should follow the procedures as stated in paragraph 3(a) above.

(d) After forensic investigation

After investigation by the FCPSU/CPSIT or CAIU/CPSIT, the victim of suspected child sexual abuse may require urgent psychological treatment
to help the child cope with the psychological crisis. In the best interest of the child, the CP of HA / DH will provide such service. If it is foreseeable that the case might go to court, Chapter 13 on Victim Management Before Court Hearing and Post Abuse Therapeutic Service should be adhered to.

Social Welfare Setting

18.4 CPs employed by either the government or non-governmental organisations (NGOs) in social welfare settings should handle the suspected child sexual abuse cases as described in one of the following situations:

(a) During the course of treatment or assessment of cases not originally suspected to be victims of child sexual abuse

CPs working in social welfare settings often come across children who are referred for treatment and/or assessment because of their behaviour and emotional problems. These may include running away from home, inappropriate sexual behaviour, relationship problem with parents or peers, promiscuity in adolescents, etc. While working on these problems with the CP, the children may sometimes spontaneously reveal previous incident(s) of sexual abuse or give information that will arouse concern that sexual abuse might have happened. The CP should refer to the Guide to People Working with Children who Disclose Sexual Abuse and Key to Making Referrals to Child Protection Special Investigation Team (CPSIT) at Appendix IV and V. Consultation of welfare / crime-related issues can be made to FCPSU / CAIU as appropriate and inform the referring social worker of his action. However, when the case is reported to either one of them, the referral should contain the following details:

(i) the nature, date and frequency of the abuse or concern;
(ii) the name, date of birth (if unavailable - age), and any disability or special needs of the child;
(iii) the child’s whereabouts;
(iv) whether the child is in immediate danger;
(v) names and HKIC No. of parents / carers and others involved;
(vi) names of other children in the household and whether the children are at risk or potentially at risk;
(vii) name of school / child care centre, if known;
(viii) how the informant / referrer is aware of the information;
(ix) names of other witnesses and other agencies / government departments involved.

(b) When the child is suspected to be a victim of sexual abuse

The responsible social worker can refer the child for CP assessment after consultation with social worker of FCPSU or making report to CAIU. The CP, upon request, will perform an investigatory role by conducting
a general assessment and interview regarding the suspected sexual abuse. The CP should refer to **Indicator of Possible Child Abuse** and **Guide to Risk Assessment** in Chapter 2. Based on the information gathered during the assessment, the CP will share his/her opinions with the referrer / referring social worker to decide whether further action is warranted, such as, referring the child to FCPSU or making report to CAIU for further action. If the child makes a spontaneous revelation, the same procedures as in paragraph 18.4 (a) above should follow.

(c) **When the victim of suspected sexual abuse cannot provide sufficient information to the FCPSU worker or police officer of CAIU**

When the victim of suspected sexual abuse cannot provide sufficient information, the FCPSU worker and police officer of CAIU may decide to temporarily suspend the investigation. In the meantime, if the child has manifested distressful feelings or disturbing behaviors that may cause harm to his/her emotional and mental equilibrium, the responsible social worker can consider referring him/her for psychological assessment and treatment. For exceptional cases of serious nature, these children can also be referred to CP for consideration of facilitative interview on a case-by-case basis. The purpose is to provide an opportunity to the victim of suspected abuse to make a full disclosure through building up a trusting relationship and helping the child to work through any fear or emotional blockage that may be present. The CP will usually review the progress after a few sessions to decide on further action. Once the victim has decided to tell, the CP should follow the procedures as stated in paragraph 18.4(a) above.

(d) **After forensic investigation**

After investigation by the FCPSU worker or police officer of CAIU, the victim of suspected child sexual abuse may require urgent psychological treatment to help the child cope with the psychological crisis. In the best interest of the child, the CP of SWD or NGO should provide such service. If it is foreseeable that the case might go to court, Chapter 13 on **Victim Management Before Court Hearing and Post Abuse Therapeutic Service** should be adhered to.

**INVolVEMENT OF CLINICAL PSYCHOLOGIST IN INVESTIGATION PROCESS**

18.5 Depending on case nature and need, the CP attending to the case will be involved in strategy planning, immediate case assessment and the Multi-disciplinary Case Conference in the handling process. He/she may be summoned to give evidence in court. CP of the government will also be responsible for joint investigation through video-recorded interview as necessary.
Other Forms of Abuse

18.6 CPs may receive referrals on suspected child abuse cases or he/she may come across such cases in the course of treatment or assessment.

(a) If a child reveals information from which physical abuse or other forms of child abuse is suspected, the CP should inform the respective social worker, i.e. the medical social worker (MSW) (for CP in Hospital Authority), intake worker in relevant Integrated Family Service Centre (IFSC) / Integrated Services Centre / Family and Child Protective Services Unit (FCPSU) (for CP in SWD) or referring social worker (for CP in NGOs). The CP will work closely with the responsible social worker in the investigation process and continue to provide treatment service to the child and his/her family as appropriate. The CP should also follow the procedures stated as paragraph 18.3(a) or paragraph 18.4(a) above.

(b) For children who are suspected to have been suffering from psychological abuse, upon the responsible social worker’s request, the CP should perform an investigatory role by arranging an urgent appointment to conduct the necessary assessment interview, so as to provide information to members of the multi-disciplinary case conference about the child’s psychological functioning, and facilitate members’ discussion about the case nature and formulate the welfare plan. However, a completed psychological assessment is not a prerequisite for establishing a case as suffering from psychological abuse.

DIVISION OF WORK BETWEEN CLINICAL PSYCHOLOGISTS IN MEDICAL AND SOCIAL WELFARE SETTINGS

18.7 The division of work between CPs in medical and social welfare settings in providing psychological assessment and treatment are decided by the SCPs of HA and SWD, and CPs of NGOs. The agreement has been stated clearly on the related papers which are also uploaded on the SWD intranet for quick reference. As a general rule, the following guiding principles would apply:

(a) when the victim of suspected abuse is an in-patient of the hospital and consultation has been made with the social worker or police officer of CAIU concerned, the CP of HA will provide psychological service as needed;

(b) for hospitals or clinics or NGO with no clinical psychologist, the client should be referred to SWD for service;

(c) for victim of suspected abuse who has been receiving regular

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1 The two papers are: “Guideline on Provision of Clinical Psychological Service between HA and SWD” and “Summary of Agreements on Clinical Psychological Support for IFSCs”.
psychological follow up service from the CP of HA / DH / SWD / NGO before disclosure of the abuse, it is preferable for him/her to continue to receive psychological service from the CP concerned;

(d) the client’s wish should be considered when considering where to refer.

18.8 As stated in the Criminal Procedure Ordinance, Cap 221, only clinical psychologists of the government should be involved in the following activities which are directly related to the function of CPSIT:

(a) conducting video-recorded interview;

(b) acting as the monitor in the monitor room during the investigative interview.

COLLABORATION WITH OTHER PARTIES

18.9 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
Roles of

Health Service
CHAPTER 19

CLINICS
(DEPARTMENT OF HEALTH)

19.1 Medical Officers (MOs), nurses and para-medical staff should familiarize themselves with the procedures of handling suspected child abuse. They should be alert to the signs of child abuse by making reference to Indicator of Possible Child Abuse & Guide to Risk Assessment in Chapter 2. If a child has symptoms or signs which indicate that sexual abuse may have taken place, the MOs, nurses and para-medical staff should follow the Guide to People Working with Children Who Disclose Sexual Abuse at Appendix IV.

GOVERNING PRINCIPLES

19.2 The most important governing principle is to protect the best interest of the child. The emotional well-being of the child must be protected and all those involved must be sensitive to the social and psychological needs of the child and his/her family.

19.3 The child must not be further traumatized by the investigative process.

19.4 History is the keystone in establishing a diagnosis of child abuse. However, the clinical interview can be very distressing to the child. At initial contact, the MO should focus on obtaining information from the child and the carer in order to establish the suspicion of child abuse and to determine whom to refer for further action, with special attention to the injuries or trauma and to factors that may determine any continuing risk to the child. The in-depth interview of the traumatic abuse incident can be left to a multi-disciplinary team of specialists on interviews of suspected child abuse.

19.5 For cases in need of full medical / forensic examination, the child should be referred to the medical professionals with expertise in child abuse examination and the number of examination must be kept to a minimum. For suspected sexual abuse cases, the initial assessment should be limited to a general examination with visual inspection of the genital area depending on the history, age and distress of the child. Advanced training and experience are needed for the proper recognition and examination of child sexual abuse cases. A comprehensive record should be made. Normal physical findings do not exclude the diagnosis of child sexual abuse. Reference can be made to Chapter 9 for the procedures and principles for medical / forensic examination.

CONFIDENTIALITY ISSUES

19.6 The principles that a medical practitioner is required to observe with regard to patient confidentiality and disclosure of medical information are given at
Annex I to Chapter 4.

19.7 Schedule 1 of the Personal Data (Privacy) Ordinance, Cap 486 stipulates the data protection principles that professionals should observe in collecting and sharing of information. Sections 58 & 59 of the Ordinance provide an exemption from Principle 3 (Use of Personal Data) with regard to the use and sharing of personal data for the purpose of child abuse investigation or related child protection work (refer to paragraphs 4.11 & 4.12 of Chapter 4).

19.8 Some frequently asked questions about information sharing and confidentiality issues are given in Annex V to Chapter 4.

INTAKE PROCEDURES

19.9 If child abuse is suspected from history and upon examination, the MO should inform:

(a) the doctor-in-charge of the clinic and regional / cluster / service SMO;

(b) (i) clinics with Medical Social Worker (MSW) attached:
   ➢ inform MSW and MSW will take further action (refer to paragraphs 19.10 & 19.11 below).

   (ii) clinics without MSW:
   ➢ inform the SWD / NGO unit concerned if the child is a known case under their care. The SWD / NGO unit concerned will take further action according to the procedures in Chapter 14 to 17. Chapter 6 and 7 append the details on handling of referrals by SWD / NGO units.

   (iii) clinics without MSW and child is not receiving service from any SWD / NGO unit:
   ➢ the MO can consult Social Work Officer of Family and Child Protective Services Unit (SWO/FCPSU) (List of FCPSUs at Appendix VII) for advice. If formal referral to FCPSU or report to CAIU is necessary after consultation, the MO should refer to Key to Making Referrals to CPSIT at Appendix V for details.

(c) In circumstances that suggest a criminal offence may have been committed (refer to Annex I to Chapter 3 for list of offences related to child abuse), the case should be reported to the Police to safeguard the welfare of the child (refer to paragraph 24.23 of Chapter 24 for the procedures in making report to the police).

19.10 The MSW of SWD / NGO would initiate the child protection mechanism including checking with the Child Protection Registry (Appendix VI), contacting other SWD / NGO units if necessary to see whether the case is
known to them, or conducting initial social assessment. The MSW of SWD / NGO can consult / refer the case to FCPSU as appropriate.

19.11 The MSW of SWD / NGO or FCPSU worker will then assess the case, liaise with other parties and decide on the appropriate action to be taken. The MO should provide necessary assistance as far as possible.

19.12 Reporting / referral of suspected child abuse cases to FCPSU do not require consent of the concerned service users i.e. parents, carers, significant others, etc. (see paragraph 19.7 above), but they should be informed by the MO about the referral.

19.13 If professional advice from paediatricians is required, the MO can consult the respective Medical Coordinator on Child Abuse (MCCA) appointed in each of Paediatric Department in the Hospital Authority hospitals (List of MCCA at Appendix XI).

19.14 Where hospitalization is necessary, the MO should contact the MCCA of the designated Paediatric Departments of Hospital Authority hospitals for appropriate action as described in Chapter 20. If there is no MCCA in the nearby hospital, the case should be sent to the AED but the MO should liaise with the Consultant / SMO of the AED prior to the referral.

19.15 If the parent(s) / guardian(s) refuse to go to hospital or to be referred to social worker for further management, the doctor-in-charge should try to persuade the parent(s) / carer(s) to stay whilst contact is made with the responsible social worker of the known case or SWO/FCPSU or IFSC/SWD or SWOs/MSSU/SWD for assistance or consideration who is relevant for invoking powers under Section 34F / Section 35(1) of the Protection of Children and Juveniles Ordinance, Cap 213. The MSW of the clinic, if any, should assist whenever situation warrants (see FAQ 5 in Annex II to Chapter 3). If assistance from the Police is deemed necessary, the MSW should contact the nearest police station directly. Upon invoking powers under Section 34F, the responsible social worker of the known case or SWO/FCPSU or IFSC/SWD as appropriate will provide follow-up service if further care proceeding is necessary.

MULTI-DISCIPLINARY CASE CONFERENCE ON CHILD ABUSE

19.16 The MO attending the case would be invited to attend the Multi-disciplinary Case Conference to formulate the welfare planning of the child. A written report on the child’s condition should be prepared for reference of the Conference [paragraph K of Annex I to Chapter 11].
COLLABORATION WITH OTHER PARTIES

19.17 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
CHAPTER 20

HOSPITALS / CLINICS
(HOSPITAL AUTHORITY)

20.1 Medical Officers (MOs), nurses and para-medical staff of hospital / clinic of the Hospital Authority should familiarize themselves with the procedures of handling suspected child abuse. They should be alert to the signs of child abuse by making reference to the *Indicator of Possible Child Abuse & Guide to Risk Assessment* in Chapter 2. If a child has symptoms or signs which indicate that sexual abuse may have taken place, the MOs, nurses and para-medical staff should follow the *Guide to People Working with Children Who Disclose Sexual Abuse* at Appendix IV and *Guidance for Paediatric Wards, A&E and Staff involved with Child Abuse* at Appendix XVI.

GOVERNING PRINCIPLES

20.2 The primary objectives in managing victim of suspected child abuse or neglect are:

(a) to protect the child;

(b) to plan and provide a healthier environment for the child; and

(c) to facilitate criminal investigation and subsequent prosecution.

20.3 Principles:

(a) The child must not be further traumatized by the investigative process.

(b) The best interest of the child must be accorded top priority. The emotional well-being of the child must be protected and all those involved must be sensitive to the social and psychological needs of the child and the family. The clinical interview should be conducted in private to minimize further distress to the child.

(c) History is the keystone in establishing a diagnosis of child abuse. A detailed medical history from the child, as far as possible, and from the carer should follow the format of a thorough paediatric health assessment with special attention to the injuries and to factors that may determine any continuing risk. However, the clinical interview can be very distressing for the child and should be carefully planned. **At the initial contact, it is probably the best to keep the number of interview to a minimum.**

(d) The number of investigative / assessment interview on the suspected abuse incident(s) should be kept to a minimum, say one interview. The
interviewer may be the responsible caseworker, the professional to whom the child has established trust for disclosure, the representative from the Police, or jointly by these professionals. For video-recorded interview to be used in court proceedings, the interview should be conducted by police officer, social worker or clinical psychologist employed by the Government. The information collected with regard to the suspected abuse incident(s) shall be shared with relevant parties concerned as soon as possible.

(e) Advanced training and experience are needed for the proper recognition and examination of child sexual abuse cases. The initial assessment should be limited to a general examination with visual inspection of the genital area depending on the history, and the age and level of distress of the child. A careful and comprehensive record should be made. Normal physical findings do not exclude the diagnosis of child sexual abuse.

(f) For child sexual abuse cases in need of full medical / forensic examination, the child should be examined by medical professionals with expertise in child abuse examination. Should the child indicates the preference for a female medical officer, this should be entertained if a female expertise is available.

(g) The number of examination must be kept to a minimum.

**ROLE OF MEDICAL CO-ORDINATOR ON CHILD ABUSE (MCCA)**

20.4 Medical Co-ordinators on Child Abuse (MCCA) are designated in the Paediatric Departments within the Hospital Authority Hospitals (*List of MCCA at Appendix XI*) for handling child abuse cases. Working closely with medical social workers (MSW), nurses, clinical psychologists, psychiatrists and other related personnel through their expertise in child protection, the MCCA provide support to the suspected child victims by making their physical, emotional and developmental needs understood.

20.5 The duties of a MCCA include:

(a) acting as a source of referral and providing medical service to child abuse cases;

(b) assisting to arrange direct admission for the child to Paediatric Ward upon receiving a referral as appropriate;

(c) providing expert medical advice to colleagues and other professionals;

(d) co-ordinating and facilitating intra-agency and inter-agency communication, investigation and planning for further handling of the case, through the assistance of MSW.
INTAKE PROCEDURES

20.6 **For child sexual abuse cases**, the handling procedures for medical officer are outlined at Appendix XVII. Such cases will be managed according to the index of suspicion at Appendix XVIII and the need for urgent medical treatment. When handling these cases, all medical officers are advised to read the following procedures together with Appendix XVII & XVIII.

Referral received by Accident & Emergency Department (AED) and Specialist Outpatient Clinic (SOPC)

20.7 **(a)** **If child sexual abuse or serious physical abuse is suspected**, the doctor should:

(i) inform the Consultant / Senior Medical Officer (SMO) in charge of the case who may in turn consult the MCCA of the hospital or nearby hospital or the Social Work Officer of Family and Child Protective Services Unit (SWO/FCPSU) at Appendix VII or seeking advice from Child Abuse Investigation Unit (Police/CAIU) on crime-related issues at Appendix VIII; or

(ii) admit or refer the child to a paediatric in-patient unit.

**(b)** **If other form(s) of child abuse is/are suspected**, the doctor should inform:

(i) the Consultant / SMO in charge of the case who may in turn consult the MCCA of the hospital or nearby hospital; and

(ii) the MSW who would initiate the child protection mechanism including checking with Child Protection Registry (CPR) via his/her supervisor (reference on CPR at Appendix VI), contacting the respective SWD / NGO staff if the case is known to the SWD / NGO unit, or consult / refer the case to FCPSU as appropriate if the case is not known to other SWD / NGO unit.

**(c)** **For cases in need of urgent intervention / investigation**, the doctor should inform the Police (the nearest Hospital Police Post or Police Station) or social worker (SWD hotline / FCPSU or Hospital MSW) as appropriate, and keep the Consultant / SMO in charge of the case and MSW informed of the case for assistance as soon as possible.

**(d)** **For cases where child abuse is suspected and the child concerned is not going to be warded in hospital** before the child leaves the AED or SOPC, the doctor or MSW concerned who has first-hand information on the suspected abuse incident(s) should make a report to the Hospital Police Post if police investigation and management is considered helpful. The concerned police unit will then contact the doctor or MSW concerned for further enquiries as soon as possible. The MSW should
make sure that the case is reported to the Police as soon as possible. For known cases of SWD / NGO unit, the MSW will keep the SWD / NGO staff informed of the case for follow-up. For new cases, the MSW will refer the case to FCPSU for follow-up actions.

(e) For suspected child abuse cases where hospitalization for observation or treatment is necessary, the child can be admitted to the Department of Paediatrics or other appropriate Department of the Hospital or nearby Hospital.

(i) The MCCA and other relevant staff will as far as possible ensure that appropriate assessment to the child be completed. These will include both physical and mental aspects.

(ii) If parent(s) / guardian(s) resist hospital admission, the doctor-in-charge should try to persuade the parent(s) / guardian(s) to stay whilst contact is made with the responsible social worker of known case or SWO/FCPSU or IFSC / SWD for assistance or consideration who is relevant for invoking powers under Section 34F(2) / Section 35(1)(a) of the Protection of Children and Juveniles Ordinance, Cap 213. The MSW in hospital should assist whenever situation warrants in office hours. Assistance could also be obtained through the SWD hotline (Tel. no.: 2343 2255).

(iii) If the child’s life and safety is endangered and/or the parent is in breach of peace, police officers may intervene. Once an order for removal and detention under Section 34F(2) / Section 35(1)(a) is made by the relevant public officers, the Police will, as far as possible, assist to ensure enforcement of the order.

(f) For doubtful cases where in-patient treatment is not required and the level of suspicion of child abuse is not high, Consultant / SMO in charge of the case or MCCA or FCPSU can be consulted. The child should be referred to the MCCA or relevant welfare organisation for follow-up, or be followed up by the MO in-charge of the AED for review as soon as possible.

(g) For cases where in-patient treatment is not required and there is not enough evidence to substantiate the suspicion of child abuse but the child or the family has other welfare needs, the doctor of AED / SOPC is advised to ensure that the case is referred to the relevant welfare organisation for follow up e.g. MSW / IFSC / ISC.
Referral received by Paediatric Ward

20.8 (a) If child abuse is suspected, the doctor should inform :

(i) the Consultant / SMO in charge of the case who may in turn consult the MCCA of the hospital or nearby hospital or SWO/FCPSU or seeking advice from Police / CAIU on crime-related issues; or

(ii) the MSW who would initiate the child protection mechanism including checking with Child Protection Registry (CPR) via his/her supervisor (reference on CPR at Appendix VI), contacting the respective SWD / NGO staff if the case is known to the SWD / NGO unit, or consult / refer the case to the FCPSU as appropriate if the case is not known to SWD / NGO unit.

Referral received by Orthopaedic / Gynaecological / Medical / Surgical Ward, etc.

20.9 (a) If child abuse is suspected, the doctor should :

(i) inform the Consultant / SMO in charge of the case who may in turn consult the MCCA of the hospital or nearby hospital or SWO/FCPSU or seeking advice from Police / CAIU on crime-related issues; or

(ii) refer the child to a paediatric in-patient unit.

MEDICAL AND FORENSIC EXAMINATION

20.10 Reference can be made to Chapter 9 for the procedures for medical / forensic examination.

MULTI-DISCIPLINARY CASE CONFERENCE ON CHILD ABUSE

20.11 The MO attending the case would be invited to attend the Multi-disciplinary Case Conference to formulate the welfare planning of the child. A written report on the child’s condition should be prepared for reference of the Conference (paragraph K of Annex I to Chapter 11).

COLLABORATION WITH OTHER PARTIES

20.12 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
CHAPTER 21

CHILD PSYCHIATRY SERVICE

REFERRALS

21.1 Suspected child abuse cases come to the notice of child psychiatry service:

(a) through consultations from other departments in the hospital;
(b) through referrals to child psychiatry out-patient clinics;
(c) during the course of treatment and assessment of patients not originally suspected to be child abuse victims.

Child Sexual Abuse Cases

(a) Through Consultations from Other Departments in the Hospital

21.2 Psychiatrists working in hospital settings may receive consultations from other departments of the hospital for treatment and/or assessment of suspected child sexual abuse and/or associated psychiatric disorders. On offering consultation service to these suspected child sexual abuse cases, the psychiatrists should refer to the Guide to People Working with Children Who Disclose Sexual Abuse at Appendix IV and Key to Making Referrals to Child Protection Special Investigation Team (CPSIT) at Appendix V.

21.3 For cases where CPSIT is formed, the investigation of the suspected sexual abuse incident(s) will be taken up by the CPSIT. The psychiatrist attending to the case will be involved in strategy planning, immediate case assessment and the Multi-disciplinary Case Conference as necessary in the handling process of the case. The psychiatrist shall proceed on psychiatric assessment / treatment as clinically indicated.

21.4 For cases where CPSIT is not formed, the case will be transferred by the Child Abuse Investigation Unit (CAIU) to the relevant police unit for action if necessary. The police unit will then contact the referrer / referring social worker concerned to conduct further enquiries as soon as possible. The investigation of the suspected sexual abuse incident(s) should adopt the multi-disciplinary approach. To avoid requiring the child to describe the abuse incident(s) repeatedly, it is preferable to keep the number of investigative / assessment interview on the suspected abuse incident(s) to a minimum, say one interview. The interviewer may be the responsible caseworker, the professional to whom the child has established trust for disclosure, the representative from the Police, or jointly by the professionals concerned. For video-recorded interview to be used in court proceedings, the interview should be conducted by police officer, social worker or clinical psychologist employed by the Government. The information collected with regard to the suspected abuse incident(s) shall be shared with relevant parties.
concerned as soon as possible. The psychiatrist attending the case will be involved throughout the handling process of the case, including the Multi-disciplinary Case Conference. He can also liaise with the responsible worker or other professionals involved in this regard and can proceed on the psychiatric assessment / treatment as clinically indicated.

(b) Through Referrals to Child Psychiatry Out-patient Clinics

21.5 Suspected child sexual abuse cases may be referred to a child psychiatric out-patient clinic for assessment and/or treatment of suspected sexual abuse and/or associated psychiatric disorders. The referral may come from doctor, social worker, clinical psychologist, teacher, other child care professionals, or sometimes parent(s) / guardian(s) of the child. It is the responsibility of the referrer to ensure the suspected victim and their parent(s) / guardian(s) agree to the referral.

21.6 A referral letter shall, at least, contain the following: name and age of the child, corresponding address and contact telephone number of the family and the referrer, and the relevant details of the present complaint.

21.7 On offering psychiatric service to these suspected child sexual abuse cases, the psychiatrist should refer to the Guide to People Working with Children Who Disclose Sexual Abuse at Appendix IV and Key to Making Referrals to Child Protection Special Investigation Team (CPSIT) at Appendix V.

21.8 For cases where CPSIT is formed, the steps as described in paragraph 21.3 above should be followed.

21.9 For cases where CPSIT is not formed, the steps as described in paragraph 21.4 above should be followed.

(c) During the Course of Treatment and Assessment of Patients not Originally Suspected to be Child Abuse Victims

21.10 Psychiatrist working in hospital and out-patient clinic settings may sometimes come across patients who are referred for treatment and/or assessment because of behavioural, emotional and other psychiatric problems. While working with these patients, the psychiatrist may encounter situations that sexual abuse may have happened.

21.11 On offering psychiatric service to these patients, the psychiatrist should refer to the Guide to People Working with Children Who Disclose Sexual Abuse at Appendix IV and Key to Making Referrals to Child Protection Special Investigation Team (CPSIT) at Appendix V.

21.12 The psychiatrist shall inform Social Work Officer / Family and Child Protective Services Unit (SWO/FCPSU), Police / Child Abuse Investigation Unit (Police/CAIU), MCCA or MSW as clinically indicated.
21.13 For cases where CPSIT is formed, the steps as described in paragraph 21.3 above should be followed.

21.14 For cases where CPSIT is not formed, the steps as described in paragraph 21.4 above should be followed. If necessary, the psychiatrist can proceed to perform the assessment of the suspected sexual abuse case and then share information collected from the child with the FCPSU concerned and in the MDCC where appropriate.

**Other Forms of Abuse Cases**

21.15 Child psychiatrists may receive referrals on suspected child abuse cases or he may come across such cases in the course of treatment or assessment. For cases other than sexual abuse cases, the child psychiatrist should inform the MCCA or respective MSW / caseworker as appropriate. The child psychiatrist will work closely with concerned parties in the investigation process and continue to provide treatment service to the child and his/her family as appropriate.

**CHILD PSYCHIATRY SERVICE FOR CHILD ABUSE CASES**

21.16 Staff in the child psychiatry service should be alert to the possible signs of child abuse and should make reference to the *Indicator of Possible Child Abuse & Guide to Risk Assessment* in Chapter 2.

21.17 A comprehensive assessment of a suspected child abuse victim requires attention to the physical health and social circumstances as well as mental well-being of the child, his/her family members, and the relationship among themselves. The mental health of these concerned parties can have a direct reference to the investigation process and the welfare plan.

21.18 Psychiatric examination should be arranged as soon as possible to determine, if any, the nature and extent of psychiatric disturbances, and the form of psychiatric treatment required in the overall management of the child, his/her family, and/or occasionally the perpetrator.

21.19 Psychiatric examination should be coordinated with the physical, social and forensic assessment / management and should act in the best interest of the child. This will require a close collaboration of the professionals from different disciplines.

21.20 Representatives of the child psychiatry service should be called upon:

(i) to conduct a comprehensive psychiatric assessment on the suspected victim as soon as possible;

(ii) to screen psychiatric problems in the relevant family members if there is a cause for concern;
(iii) to liaise with the responsible social worker and other professionals to share information of the suspected abuse incident(s) when CPSIT is not formed and the investigation process is not undertaken by CPSIT;

(iv) to participate in the Multi-disciplinary Case Conference and contribute to the welfare plan and management of the suspected victim and his/her family (refer to Guide to Participants of Multi-disciplinary Case Conferences on Child Abuse at Annex I to Chapter 11); and

(v) to provide psychiatric treatment to the suspected victim and assessment to his/her family when necessary. On offering psychiatric treatment to the suspected victim and if it is foreseeable that the case may go to court, Chapter 13 on Victim Management Before Court Hearing and Post Abuse Therapeutic Service should be adhered to.

21.21 The List of Child Psychiatry Teams is at Appendix XIX.

21.22 Child psychiatrists can refer to the respective Chapters in this Procedural Guide of other professionals in Section V for their procedures in handling referrals.

**COLLABORATION WITH OTHER PARTIES**

21.23 All parties concerned should maintain communication about the case progress as appropriate for the protection of the child and provision of welfare service to the family.
Roles of

Other Departments / Organisations
CHAPTER 22

RESIDENTIAL CHILD CARE SERVICE AND SPECIAL CHILD CARE SERVICE

22.1 Residential homes / hostels / centres and special child care service refer to those serving children aged below 18 years old.

GOVERNING PRINCIPLES

22.2 In handling child abuse cases, the paramount concern is the welfare of the child.

22.3 Children should not be required to describe the child abuse incident(s) to different parties and agencies unnecessarily.

CONFIDENTIALITY ISSUES

22.4 It is crucial to involve only the relevant staff in the process of handling a suspected child abuse case in order to avoid unnecessary repeated description of the abuse incident(s) by the child victim and spread of information. Residential child care service and special child care service units are encouraged to assign designated personnel (e.g. supervisor, superintendent, assigned caseworker) to handle suspected child abuse cases. The designated personnel involved should adhere strictly to the principle of confidentiality in the course of handling the suspected child abuse cases.

REFERRALS

22.5 Staff of residential homes / hostels / centres and special child care service should be alert to signs and symptoms of child abuse for children under their care by making reference to the Indicator of Possible Child Abuse & Guide to Risk Assessment in Chapter 2. Where abuse is suspected, they should report immediately to the Supervisor / Superintendent / assigned / designated personnel of the residential home / hostel / centre and special child care service.

22.6 In handling suspected child abuse cases, staff of residential homes / hostels / centres and special child care service, if necessary, may consult Social Work Officer / Family and Child Protective Services Unit (SWO/FCPSU).

22.7 For a case that is being followed-up in parallel by SWD / NGO service units, the social worker concerned should be informed in the first instance and follow up the case as appropriate according to the respective chapters on roles of relevant departments / organisations.
22.8 In informing the parents of suspected child abuse cases, staff of residential homes / hostels / centres and special child care service may consult SWO/FCPSU or the responsible caseworker as appropriate on how to handle the case and by whom it should be handled. Special attention has to be paid when parent(s) / guardian(s) is/are suspected to be involved in the abuse.

22.9 When making case referrals, the supervisor / superintendent / assigned caseworker of the residential home / hostel / centre and special child care service should provide the relevant data of the child, with written dated notes (refer to paragraph 7.4 of Chapter 7 and Appendix IX & X).

22.10 In circumstances that suggest a criminal offence may have been committed, the case should be reported to the Police to safeguard the welfare of the child (refer to paragraph 24.23 of Chapter 24 for the procedures in making report to the Police).

22.11 For suspected child sexual abuse cases, if the child is seen in the home / hostel / centre, the staff of the home / hostel / centre should refer to the Guide to People Working with Children Who Disclose Sexual Abuse at Appendix IV. Where necessary, assistance from his/her supervisor / superintendent should be sought.

22.12 Staff of the concerned residential home / hostel / centre and special child care service should attend to the safety and emotional needs of the child at the centre.

MULTI-DISCIPLINARY CASE CONFERENCE ON CHILD ABUSE

22.13 The supervisor / superintendent / caseworker of the residential home / hostel / centre and special child care service should attend the Multi-disciplinary Case Conference to formulate the welfare plan whenever necessary and prepare preferably a written report for reference of the Conference. It may include the child's behaviour and emotional state in the home / hostel / centre, parental attitude and any previous incident(s) of suspected abuse, etc. (Annex I to Chapter 11).

COLLABORATION WITH OTHER PARTIES

22.14 Staff of the residential child care service and special child care service, particularly the assigned / designated personnel of the residential settings, should maintain close communication with the responsible social worker of SWD / NGO units on the case progress for the protection of the child and provision of welfare service to the family.
22.15 When a case is categorized as an established or suspicious child abuse case and the child continues to reside in the residential facility, the social worker of the home / hostel / centre should keep keen observation on the child’s progress and liaise with the key social worker from time to time.
CHAPTER 23

EDUCATIONAL SERVICES

(Kindergartens, Kindergarten-cum-Child Care Centres, Primary Schools, Secondary Schools and Special Schools)

23.1 To safeguard the welfare of children, all school personnel in kindergartens, kindergarten-cum-child care centres, primary schools, secondary schools and special schools are reminded to familiarize themselves with the details of this chapter and to observe the following principles and procedures in handling suspected child abuse cases. For those secondary schools with school social work service provided by NGOs, reference can also be made to Chapter 17.

GOVERNING PRINCIPLES

23.2 In handling suspected child abuse cases in schools, the paramount concern is the welfare of the child. School personnel have an obligation to safeguard the best interest of the child. Early identification and intervention at the initial stage are vital. Failure to recognize abuse cases may lead to further abusive injuries or even death of a child. School personnel should be sensitive to the emotional needs of the child throughout the investigation process, and should render every possible assistance to help the child to re-integrate and adjust to the school life after investigation.

23.3 Reporting child abuse incident(s) in schools may bring about the “positive effect” that the school is concerned about the child’s welfare and will handle it properly without ignoring the welfare of the pupils or covering up the abuse incident(s). Delay in making reports of child abuse cases may affect the child’s safety.

23.4 It is crucial to only involve the relevant staff in the process of handling suspected child abuse case in order to avoid requiring the child to describe the incident(s) repeatedly.

23.5 Schools should activate the Crisis Management Team and assign designated personnel (e.g. principal, senior teacher, named teacher, Student Guidance Officers (SGO) / Student Guidance Teachers (SGT) / Student Guidance Personnel (SGP) in primary schools / school social workers (SSW) in secondary schools and special schools) to handle suspected child abuse cases.

23.6 For kindergartens, kindergarten-cum-child care centres and schools without Crisis Management Team or school guidance personnel (e.g. SGO / SGT / SGP / SSW), the principal should assign designated personnel (e.g. principal, senior teacher, or named teacher) to handle suspected child abuse cases.
CONFIDENTIALITY

23.7 The designated personnel involved should have close communication among themselves and adhere strictly to the principle of confidentiality in the course of handling the suspected child abuse cases. The information collected with regard to the suspected abuse incidents should be shared on a need-to-know basis with relevant parties concerned such as the principal, the responsible social worker, the Police, etc, as soon as possible.

23.8 All records must be kept centrally by the principal / SGO / SGT / SGP / SSW. Access to these records within the school must be restricted and recorded. On no account should these records be kept with the child's general records. Records, letters or information supplied by other agencies should not be shown to the parents by the school without expressed permission.

PREVENTIVE WORK

23.9 Schools should help children develop appropriate values, attitudes and knowledge of respect for others and self-protection through preventive and developmental programmes in moral and civic education, sex education, life skills and the curriculum (e.g. learning areas of Self and Society in kindergartens / kindergarten-cum-child care centres, Personal Growth Education and General Studies in primary schools, Life Education, Integrated Science and Liberal Studies in secondary schools, etc.), where appropriate.

23.10 Schools should facilitate parents as co-working partners with the school in the prevention of child abuse by providing parents education in child protection and building harmonious family relationship for the healthy development of children.

23.11 Schools have the responsibility to provide appropriate educational service for all children including those with disabilities. Principals and teachers should ensure that the children's right to education is properly protected. They should be on the alert for symptoms of educational neglect. When children are absent from school, they should take appropriate action and if necessary, report to the Education Bureau (EDB) according to the procedures laid down in the circular relating to upholding students’ right to education.

23.12 School personnel should have the knowledge and skills in identifying and handling child abuse cases. They should familiarize themselves with the procedures in handling suspected child abuse cases and follow through such procedures when signs and symptoms of child abuse (refer to Chapter 2 on Indicator of Possible Child Abuse & Guide to Risk Assessment) among students are first observed and reported. The principal and the school guidance personnel (e.g. SGO / SGT / SGP / SSW) should ensure that all teachers are alert to signs and symptoms of child abuse for early identification by providing them with relevant training.
EARLY IDENTIFICATION

23.13 School personnel may encounter suspected child abuse cases through direct contact with students in the delivery of lessons or school activities, disclosure in students’ school work, direct approach in person from students / parents / guardians / carers, etc. School personnel should be alert to signs and symptoms of child abuse among their students. Their sensitivity in early identification of suspected abused students is important in saving the child victim from being further abused (refer to Chapter 2 on Checklist for Identifying Possible Child Abuse).

REFERRALS

23.14 When a suspected case of child abuse comes to the attention of the school, the first person in contact of the child should inform the principal and consult the principal / SGO / SGT / SGP / SSW / designated personnel. The principal / SGO / SGT / SGP / SSW / designated personnel should render full support to the school personnel in handling the suspected child abuse cases.

23.15 In handling suspected child abuse cases, the principal may, if necessary, consult Social Work Officer / Family and Child Protective Services Unit (SWO/FCPSU) (List of offices of FCPSUs at Appendix VII) during office hours. For reports on suspected child abuse cases received after office hours, the SWD Outreaching Team (after office hours) through contact by the SWD hotline (Tel. No. : 2343 2255) should respond to the report.

23.16 When making a referral of the suspected child abuse case to FCPSU or the responsible social worker to solicit multi-disciplinary support / investigation and follow up welfare plan, the principal / SGO / SGT / SGP / SSW / designated personnel should inform the parent(s) / guardian(s). Special attention has to be paid when parent(s) / guardian(s) is/are suspected to be involved in the abuse.

23.17 When making referrals to FCPSU or reports to CAIU for cases falling into CAIU Charter, the principal / SGO / SGT / SGP / SSW / designated personnel should provide the relevant data of the child, with written dated notes for reporting cases (refer to paragraph 7.4 of Chapter 7 and Appendix IX & X).

23.18 In circumstances that suggest a criminal offence may have been committed, the case should be reported to the Police to safeguard the welfare of the child. (refer to paragraph 24.23 of Chapter 24 for the procedures in making report to the Police).

23.19 For suspected child sexual abuse cases, if the child is seen in the school, the staff of the school should refer to the Guide to People Working with Children who Disclose Sexual Abuse at Appendix IV.

23.20 In handling child sexual abuse cases when the alleged perpetrator is a staff member of the school, the principal of secondary, primary schools, special
schools and kindergartens should inform the School Development Officer of the respective Regional Education Office of EDB of the incident(s). For kindergarten-cum-child care centres, they should inform the Joint Office for Pre-primary Services of EDB (refer to the relevant EDB circular in use for the procedures in handling child sexual abuse cases involving school staff as suspected abusers). In consultation with relevant professionals as necessary, the principal should take appropriate follow up actions for the suspected abused child and step up measures to ensure safety of other students in the school.

23.21 School personnel / SSW / SGO / SGT / SGP should attend to the safety and emotional needs of the child in school.

23.22 If the SGP serving in primary school is a registered social worker and employed by an NGO, he/she may take up the role of case manager as stipulated at Chapter 6 and 7, subject to mutual agreement of the school, NGO and SWD.

MULTI-DISCIPLINARY CASE CONFERENCE ON CHILD ABUSE

23.23 Multi-disciplinary Case Conference (MDCC) will be conducted to formulate the welfare planning of the child. The relevant school personnel should attend the MDCC and prepare a written report for reference of the Conference. It may include the child’s school performance, conduct, emotional state in the school, parental attitude and any previous incident(s) of suspected abuse, etc. (refer to Guide to Participants of MDCC on Child Abuse at Annex I to Chapter 11).

COLLABORATION WITH OTHER PARTIES

23.24 When a case is categorized as an established or suspicious child abuse case and the child continues to attend school, the school should keep keen observation on the child’s progress and keep the concerned unit or key worker informed of the child's condition and development. Teachers play an important role in the follow up work by providing the child with continuous emotional support, opportunities for success and positive experience, and in the long run, facilitating a stable and caring learning environment for the child in school.
CHAPTER 24

POLICE

24.1 This Chapter should be read in conjunction with Chapter 10 which specifically relates to the investigation of child abuse cases by Child Abuse Investigation Units (CAIUs) / other Crime Units of the Police and the Family and Child Protective Services Units (FCPSU) of Social Welfare Department (SWD).

GOVERNING PRINCIPLES

24.2 The following should be observed in handling child abuse cases:

(a) The child must not be further traumatised by the investigation. The child should not be questioned or asked to describe the abuse incident(s) repeatedly.

(b) The best interest of the child must always be protected. The child and the family should be interviewed in privacy to minimize any distress to the child.

REPORTING

24.3 For the definition of child abuse, officers should refer to paragraph 2.1 & 2.4 of Chapter 2 and also make reference to Indicator of Possible Child Abuse & Guide to Risk Assessment in the same Chapter.

24.4 A report may be made in any manner by any person. Reports are usually made by referrals from medical practitioners, social workers and teachers. However, they may also be made by telephone through 999 or in person to a police station or officers on patrol. In all cases, the following procedures will be adopted.

INITIAL HANDLING

24.5 Initial actions by an officer receiving a complaint of child abuse are stipulated in the Force Procedures Manual 34-04 which specifically details actions to be taken by Duty Officers, officers on patrol, at reports rooms, hospital Police posts and crime units.

24.6 As a general guide, the following steps should be taken by the police officer receiving a report of child abuse either by phone or in person:

(a) request the informant to give his/her particulars. Anonymous referrals should also be accepted, but the referrer should be advised that the
Police may need further details and information and attempts should be made to obtain a contact number;

(b) record all details of identification of the family including:

(i) the name, date of birth / age and sex of the child;
(ii) HKIC / Birth Certificate No. of the child;
(iii) the nature, date, place and frequency of the suspected abuse;
(iv) any disability or special needs of the child;
(v) the child’s whereabouts; and
(vi) names and HKIC No. of the parents / carers / others involved.

(c) once the information referred to above has been obtained and the basis of the allegation established, the officer shall immediately notify his/her Duty Officer for further action.

24.7 On coming into direct contact with a child who wishes to make allegation of abuse, the following steps should be taken by the officer:

(a) arrange for medical treatment, if necessary;

(b) remove the child to a quiet place;

(c) relevant information should be obtained from the adult(s) accompanying the child, preferably not in the hearing of the child;

(d) listen to the child, rather than directly question him/her, and as far as possible do not ask leading questions;

(e) not to question the child any further once the basis of the allegation is established;

(f) make a note of the discussion, taking care to record the timing, setting and persons present, as well as what was said (this may be required to disclose in subsequent court proceedings); and

(g) record all subsequent events up to time of the investigative interview.

INVESTIGATION

24.8 Following the initial report, allegation of child abuse will be referred to either Divisional / District / Regional Crime Units or regional CAIUs for investigation as appropriate. The charter of regional CAIUs can be referred to paragraph 24.19 below (Inter-departmental referral and handling procedures are dealt with in the respective chapters in Section IV and V).

24.9 There are legal measures and procedures specifically set out for child witnesses in order to reduce their pressure in the process of investigation and subsequent
Video Recorded Interviews

24.10 Section 79C of the Criminal Procedure Ordinance (CPO), Cap 221, allows for a video recording of an interview with a child witness of specified sexual or violent offences to be tendered in evidence in criminal proceedings. These child witnesses should be interviewed on video unless they do not wish to do so.

24.11 Whenever there is a need to conduct a video-recorded interview with a child witness, the investigation officers shall contact their regional CAIU for assistance. Police officers should observe the handling procedures stipulated in the Force Procedures Manual Chapter 34-11.

Forensic Examination for Victims of Child Abuse Cases

24.12 In any medical and/or forensic examination, the child’s health and welfare must always be of paramount importance. The number of such examination on the child should be kept to the minimum. The governing principles for medical examination in Chapter 9 should be followed.

24.13 Children suspected of having been abused should receive medical / forensic examination with the following objectives:

(a) to identify injuries or conditions that require medical attention;
(b) to ascertain whether any abuse has taken place; and
(c) to collect evidence.

Identification of Suspects by Child Witnesses

24.14 OC Case should arrange for an identification parade room equipped with one-way viewers to conduct identification parade for child witnesses. Police officers should refer to the handling procedures stipulated in the Force Procedures Manual Chapter 34-11 and 46-17.

Evidence by Live Television Link

24.15 According to Section 79B of the CPO, the court may, on application or on its own motion, permit a child witness to give evidence by way of a live TV link in criminal proceedings in specified offences. OC Case may refer to the handling procedures stipulated in the Force Procedures Manual Chapter 34-13.

Witness Support Person

24.16 For child witnesses giving evidence in court is a very traumatic experience. As such, the Evidence Rule made under Section 79D of CPO provides that a child witness giving evidence through a live television link can be accompanied by a Support Person acceptable to the court. This is subject to
the proviso that the person is not a witness in the case and has not been directly involved in the investigation of the case.

24.17 The Social Welfare Department (SWD) in conjunction with the Police has established a Witness Support Programme (refer to Appendix XXI for details) to provide emotional support and practical assistance for child witness.

24.18 Once approval to use the live television link is granted, OC Case should submit request for support persons and make necessary arrangement with reference to the Force Procedures Manual Chapter 34-13.

CAIU CHARTER – DUTIES AND RESPONSIBILITIES

24.19 In respect of cases of sexual abuse where the victim is a child under 17 years of age or in cases of serious physical abuse where the victim is a child under 14 years of age, CAIU is responsible for investigating allegation of the following nature:

(a) intra-familial sexual abuse (including the extended family e.g. mother, father, aunt, uncle);

(b) sexual abuse where the perpetrator is known to the child or is entrusted with the care of the victim (e.g. baby-sitter, school teacher, youth worker);

(c) serious physical abuse at the discretion of the respective Senior Superintendent of Crime Region; and

(d) organised child abuse (organised child abuse is defined as abuse which may involve a number of abusers, a number of abused children and juveniles and often encompasses different forms of abuse. It will also involve to a greater or lesser extent an element of organisation e.g. paedophile or pornography rings).

24.20 On receipt of such a referral, CAIU will initiate investigation and will, where appropriate, in conjunction with FCPSU / SWD, form Child Protection Special Investigation Team (CPSIT). Actions to be taken by CPSIT will be governed by Chapter 10 to 13 of this Procedural Guide.

MENTALLY INCAPACITATED VICTIMS / WITNESSES AND OTHER CHILD VICTIMS / WITNESSES TO CRIME

24.21 In respect of mentally incapacitated victims and witnesses and other child victims of and witnesses to crime, where appropriate, CAIU will be responsible for:

(a) recording their statements either on video tape or in writing as
appropriate; and

(b) advising investigation units in relation to their giving evidence in criminal proceedings.

DIVISIONAL / DISTRICT CRIME UNITS DUTIES AND RESPONSIBILITIES

24.22 Divisional / District / Regional Crime Units will be responsible for the investigation of all complaints / allegations of child abuse which do not fall within the charter of regional CAIUs (see paragraph 24.19 above). Divisional / District / Regional Crime Units investigating allegations of child abuse should consider utilising the expertise of their regional CAIU in statement taking, particularly where the video taping of a vulnerable witness’ evidence in accordance with the Criminal Procedure Ordinance is required.

REFERRALS TO CAIU

24.23 CAIU of the Region is the Police point of contact in respect of handling procedures for child abuse cases. As regards reporting procedures, all child abuse cases including those not falling within the CAIU’s charter can be reported directly to the respective CAIUs during office hours (Report Form at Appendix IX and Written Dated Notes at Appendix X). For outside office hours, cases that fall within the CAIU’s charter can be reported directly to CAIU. For cases that do not fall within the CAIU’s charter, concerned professionals should report directly to the nearest police station (List of Police Stations at Appendix XXII). Upon receiving the report form, the police investigation unit should contact the referrer / referring social worker to conduct further enquiries as soon as possible.

REFERRALS TO CRIME UNITS (CRIME)

24.24 Cases that have initially been reported directly to CAIUs but do not fall within their charter will be transferred back to the appropriate police divisions normally where the incidents occurred under a referral memo. A specimen is at Annex I to this Chapter. The reply memo should also be copied to the concerned Family and Child Protective Services Unit of SWD or referrer / referring social worker as appropriate by fax. It is the responsibility of the police officer receiving the referral / report to contact the informant / referrer / referring social worker. Details of the information / referrer / referring social worker are provided in the same referral memo.

24.25 Police officers are reminded of the provisions of the Criminal Investigation Manual Chapter 5 in that any statements obtained should be done so in a manner which is most convenient to the statement giver and it may be necessary to go to the agency or the child’s home to take a statement.
TRANSFER OF CASES

24.26 There are also circumstances where police stations may receive reports directly from the referrer/referring social worker for cases falling outside the CAIU’s charter but requiring immediate police action. Initial action is to be taken by the Formation (police unit) to which the report is made. All subsequent action relating to the allegation is to be taken by the regional CAIU or by the Formation where the incident occurred as appropriate. All officers should be reminded of the content of the Force Procedures Manual Chapter 21-08 and 21-10 in this respect.

24.27 Accordingly, all investigating officers who determine that a case is to be transferred to another Formation will ensure that sufficient details of the informants/witness and details of the case are forwarded to allow the receiving Formation to initiate appropriate action and enquiries. Officers should ensure that the originating/referring agency or social worker is advised of the development of the case.

REFERRAL TO SOCIAL WELFARE DEPARTMENT FOR WELFARE SERVICE

24.28 Any cases in need of welfare service should be referred to relevant SWD units (Appendix XXIII) in writing, except for known case of NGOs. As a good practice, the welfare principle and special working policies also suggest that in certain cases, e.g. where a child has witnessed the murder of a parent, SWD should be informed for consideration of welfare assistance to the family. A specimen case information memo is at Annex II to this Chapter.

24.29 Regarding the referral procedures to regional CAIUs and other police units, a schematic diagram of the inter-relationship between CAIU, FCPSU and other crime units is at Appendix XII.
MEMO
From: OC CAIU
Ref.: in
Tel. No.: Your ref.: in
Fax. No.: dated
Date: Total No. of Pages:

Suspected Child Abuse Case Report

I refer to our telephone conversation today on the above subject. A case of ______________________________________ on (date) __________________ was reported to this office at (time) __________________ on (date) __________________.

2. As the case does not fall within the CAIU Charter, it is herewith referred to you for appropriate action. Please contact the referrer / referring social worker / informant as soon as possible to arrange for an interview with the victim at a place and time convenient to them.

(a) Particulars of the referrer / referring social worker / informant:

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<tr>
<th>Name:</th>
<th>I / D card no.:</th>
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<tbody>
<tr>
<td>Sex:</td>
<td>Age:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Tel. no.:</td>
<td>Fax. no.:</td>
</tr>
<tr>
<td>Relationship with victim:</td>
<td>Occupation:</td>
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<tr>
<td>Name of organisation: (if applicable)</td>
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(b) Particulars of the victim:

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<tr>
<th>Name:</th>
<th>I / D card no.:</th>
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<tbody>
<tr>
<td>Sex:</td>
<td>DOB / Age:</td>
</tr>
<tr>
<td>Name of parent</td>
<td>Relationship with the victim:</td>
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<tr>
<td>Address:</td>
<td></td>
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<tr>
<td>Tel. no.:</td>
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<tr>
<td>Whereabouts:</td>
<td>Relationship with suspect:</td>
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<td>Any special needs / disability:</td>
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</table>
(c) Particulars of the suspect:

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<th>Name:</th>
<th>I / D card no.:</th>
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<td>Age:</td>
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<td>Tel. no.:</td>
<td>Occupation:</td>
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(d) Brief description of the allegation:

3. Should you require our assistance in obtaining a statement from the victim, please do not hesitate to contact the undersigned.

4. Please acknowledge receipt of the referral by signing and returning the following to the undersigned **within 3 working days** from the date of this memo.

(                          )

OC CAIU

cc Director of Social Welfare (Attn: Family and Child Protective Services Unit) or Referrer* (*Delete whichever is inapplicable.)

==================================================================

Reply Memo

From: DVC                      To: OC CAIU
Ref.: in                      (Attn:
Tel. No.: in
Fax. No.: in
Date: Total No. of Pages:

Suspected Child Abuse Case Report
Re: (Name of Child)

I acknowledge receipt of the above referral. The case is being investigated by __________________ and may be contacted on telephone no. __________________.

(                          )

cc Director of Social Welfare (Attn: Family and Child Protective Services Unit) or Referrer*
Referrer / referring social worker (Attn:_______________________________)

(*Delete whichever is inapplicable.)
From: Commissioner of Police

To: Director of Social Welfare

Ref. in __________________________

Tel. No. __________________________

Fax. No. __________________________

Date __________________________

Referral for Family and Child Protective Services

☐ Child Abuse ☐ Domestic Violence (Spouse/Cohabitant Battering)

The following person has come to police attention of being in need of social services or assistance of your Department in a case of __________________________ (Case Nature) [Police Report No.: __________________________].

Name: __________________________ Sex/Age: ____________

Address: ______________________________________

__________________________________________ Tel. No.: __________________________

2. The Background Information sheet is attached for your reference and follow up.

3. Consent form is / is not attached.

4. Please acknowledge receipt of this referral by signing and returning the Reply Slip to me within seven working days from the date of this referral. Should you require any further information, please contact the following officer:

Name of Officer: __________________________

Post / Telephone: __________________________

Acknowledgement of Receipt of Referral

Re: (Name of Subject) / (RN: __________________________)

I acknowledge receipt of the above referral. Please be informed that * the case is being handled by / has been referred to the officer as follows:—

Name of Officer: __________________________

Unit of Department / Agency: __________________________

Telephone / E-mail: __________________________

☐ The person(s) referred has / have declined our services.

☐ (For DV only) The person(s) referred cannot be contacted within 7 days. Progress will be informed by the 2nd reply memo within one month.

for Commissioner of Police

for Director of Social Welfare
PERSONAL DATA

Background Information

Part A

(a) Particulars of the Subject/ Persons Living with the Subject: (please use the blank space provided at subsequent page if there is not enough space for inputting additional information)

<table>
<thead>
<tr>
<th>Name &amp; Sex</th>
<th>Relationship</th>
<th>HKID</th>
<th>Age</th>
<th>Workplace or School</th>
<th>Consent Given (Y/N)</th>
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<td>Address/ Phone no.</td>
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</table>

(b) Offence and Case Nature: (Police Report No.________________________)  
(c) Brief fact of the incident: (please include the date, place, persons involved in the incident, and if weapon used and any injury)

(d) Officer-in-charge/ Duty Officer and Contact Number:

(e) Case Has Been/To Be Taken (can (✓) tick more than one box):

- The alleged offender was/will be charged*. (Please specify offence(s)__________)
- The alleged offender was/will be* bound over.
- The alleged offender was/will be* cautioned under the Police Superintendents’ Discretion Scheme.
- Domestic Incident Notice (Pol. 915 Rev. 2008) was served.
- Investigation is still in progress.
- No further action will be taken.

Reasons:  
- Complainant did not wish to pursue and subsequently withdrew the complaint.
- Unruly child under 10
- Others. (please specify__________________________________________)

(f) Additional Information

- The subject person(s) is / are* currently admitted into Hospital / __________
- Domestic Violence: Persons / Children living with the complainant. (please specify number, relationship and age of the children ____________________________)
- Elder Abuse: Name of relative and contact details
- Other Information ________________________________

Remark: Subject to compliance with the Personal Data (Privacy) Ordinance, the above personal data shall not be used for the purpose(s) other than provision of social welfare service(s) other than stated at the consent form without the prescribed consent of the data subject, and not to be retained longer than is necessary for the fulfilment of the purpose(s) for which the data are to be used.

For Referral with Consent, Pol. 917 (Rev. 2008) or Consent form must be faxed together with the completed referral memo to SWD.

*Delete as appropriate
CHAPTER 25

HOUSING DEPARTMENT

25.1 Staff / Delegated personnel of Housing Department may encounter suspected child abuse cases through direct contact with tenants / residents, direct approach in person from child victims / parents / neighbours, or when the victims or their family members request for housing assistance.

GOVERNING PRINCIPLES

25.2 In handling child abuse cases, the paramount concern is the welfare of the child.

25.3 Children should not be required to describe the child abuse incident(s) to different parties and agencies unnecessarily.

25.4 To ensure that timely assistance can be rendered to the child, where suspected abuse incident is occurred, concerned staff should report immediately to the supervisor / designated personnel and refer the case to the intake Social Work Officer / Family and Child Protective Services Unit (SWO/FCPSU) (Appendix VII) immediately during office hours. For reports on suspected child abuse cases received after office hours, the SWD Outreaching Team (after office hours) through contact by the SWD hotline (Tel. No. : 2343 2255) should respond to the report.

CONFIDENTIALITY

25.5 It is crucial to involve only the relevant staff in the process of handling a suspected child abuse case in order to avoid unnecessary repeated description of the abuse incident(s) by the child victim and spread of information. The Housing Department are encouraged to assign designated personnel (e.g. Assistant Housing Manager, Housing Officer) to handle suspected child abuse cases. The designated personnel involved should adhere strictly to the principle of confidentiality in the course of handling the suspected child abuse cases.

REFERRALS

25.6 The designated personnel of the Housing Department should be alert to signs and symptoms of child abuse for children. Their sensitivity in early identification of suspected abused children is important in saving the children from being further abused (refer to Chapter 2 on Checklist for Identifying Possible Child Abuse).
25.7 In handling suspected child abuse cases, staff of Housing Department, if in doubt, may consult SWO/FCPSU. (List of Offices of FCPSUs at Appendix VII)

25.8 In informing the parents of suspected child abuse cases, staff of Housing Department, may consult SWO/FCPSU or the responsible social worker as appropriate on how to handle the case and by whom it should be handled. Special attention has to be paid when parent(s) / guardian(s) is/are suspected to be involved in the abuse.

25.9 When making case referrals, the designated personnel should provide the relevant data of the child and his/her family to the FCPSU or concerned unit.

25.10 In circumstances that suggest a criminal offence may have been committed, the case should be reported to the Police to safeguard the welfare of the child. (refer to paragraph 24.23 of Chapter 24 for the procedures in making report to the Police).

COLLABORATION WITH OTHER PARTIES

25.11 The staff of Housing Department might be invited to attend the Multi-disciplinary Case Conference to formulate the welfare plan if appropriate. (refer to Guide to Participants of MDCC on Child Abuse at Annex I to Chapter 11).
CHAPTER 26

OTHER DEPARTMENTS, ORGANISATIONS
AND INDIVIDUAL PRACTITIONER

26.1 Suspected child abuse cases or child abuse victims may come to the attention of different organisations, e.g. mutual help group, church organisations and various social service units, individual practitioners etc. in their daily activities or service delivery.

GOVERNING PRINCIPLES

26.2 In handling child abuse cases, the paramount concern is the welfare of the child.

26.3 Children should not be required to describe the child abuse incident(s) to different parties and agencies unnecessarily.

26.4 To ensure that timely assistance can be rendered to the victim, where suspected abuse incident is occurred, concerned staff should report immediately to the supervisor / designated personnel and refer the case to the intake Social Work Officer / Family and Child Protective Services Unit (SWO/FCPSU) (Appendix VII) immediately during office hours. For reports on suspected child abuse cases received after office hours, the SWD Outreaching Team (after office hours) through contact by the SWD hotline (Tel. No.: 2343 2255) should respond to the report.

REFERRALS

26.5 Staff of the organisation should be alert to signs and symptoms of child abuse for children. Their sensitivity in early identification of suspected abused students is important in saving the child victims from being further abused (refer to Chapter 2 on Checklist for Identifying Possible Child Abuse).

26.6 In handling suspected child abuse cases, staff of the organization, if in doubt, may consult SWO/FCPSU. (List of Offices of FCPSUs at Appendix VII)

26.7 In informing the parents of suspected child abuse cases, staff of the organisation may consult SWO/FCPSU or the responsible caseworker as appropriate on how to handle the case and by whom it should be handled. Special attention has to be paid when parent(s) / guardian(s) is/are suspected to be involved in the abuse.

26.8 When making case referrals, staff of the organisation should provide all the background information and the relevant data of the child and his/her family as far as possible.
26.9 In circumstances that suggest a criminal offence may have been committed, the case should be reported to the Police to safeguard the welfare of the child. (refer to paragraph 24.23 of Chapter 24 for the procedures in making report to the Police).

**COLLABORATION WITH OTHER PARTIES**

26.10 The staff personnel / referrer / informants may be invited to attend the Multi-disciplinary Case Conference to formulate the welfare plan if appropriate (refer to Guide to Participants of MDCC on Child Abuse at Annex I to Chapter 11).
SECTION VI

HANDLING OF

ALLEGATIONS AGAINST STAFF
CHAPTER 27

ALLEGATIONS AGAINST STAFF, CARERS AND VOLUNTEERS

SCOPE OF CONCERN

This Chapter touches upon the following situations:

- Where there is suspicion or allegation of abuse by a person who works with children in either a paid or unpaid capacity i.e. any employee, foster parent, child carer, or volunteer.

- When allegation or suspicion arises in connection to the individual’s work.

GENERAL PRINCIPLES IN HANDLING ALLEGATIONS OF CHILD ABUSE AGAINST STAFF, CARERS AND VOLUNTEERS

27.1 When a staff of an organisation suspects an incident of child abuse has occurred or has received allegation of such abuse, he/she must report this to the supervisory and management level.

27.2 The responsible organisation or agency must ensure that allegation is investigated and that any justifiable action is taken to ensure that the service is safe for child / children.

27.3 Upon receipt of an allegation of abuse by a staff, the supervisory management of the organisation should ensure that they follow the complaint procedures as set out by the organisation.

27.4 Any disciplinary process must be clearly separated from child protection enquiries.

27.5 Child protection enquiries take priority over any disciplinary investigations, and will determine whether the investigations can be carried out concurrently.

27.6 Enquiries must be conducted in the strictest confidence so that information can be given freely and without fear of victimization and in a way that protects the rights of the staff, employees, volunteers, foster carers and child carers concerned.

27.7 Information about an allegation must be restricted to those who have a need to know in order to:

- protect a child / children;
- facilitate enquiries;
- manage disciplinary / complaints aspects; and
- protect the rights of the alleged perpetrator.
27.8 In circumstances that suggest a criminal offence may have been committed, the case should be reported to the police unit as appropriate to safeguard the welfare of the child (refer to paragraph 24.23 of Chapter 24 for the procedures in making report to the Police).

27.9 Even when there is insufficient evidence to support a criminal offence with or without proceeding initiated, complaints, regulatory or disciplinary procedures may still be justified.

27.10 If, following the conclusion of protection process, further enquiries are pursued for the purpose of disciplinary, regulatory or complaint investigation, they should be arranged in a way that avoids repeated interviews of the children or other vulnerable witnesses.

27.11 The need for consultation with the Family and Child Protective Services Unit (FCPSU) on child protection investigation must not delay a referral, which should be in accordance with the procedures in as stipulated in respective Chapters.

HANDLING OF SUBSTANTIATED ALLEGATIONS

27.12 Where the allegations are substantiated, relevant information must be passed to the appropriate unit for follow up as stipulated in respective Chapters of this Procedural Guide.

HANDLING OF UNSUBSTANTIATED ALLEGATIONS

27.13 Where, following initial enquiries, there is insufficient evidence to determine whether the allegation is substantiated, the outcome of enquiries should be recorded.

27.14 The member of staff concerned must be notified of the outcome.

27.15 Consideration must be given to the support the staff member may need, particularly if returning to work following suspension, if any.

27.16 The child and his/her parents should also be informed of the outcome.

27.17 Consideration should be given to the provision of support or counselling for the child, and where appropriate, his/her parents, taking full account of a child’s needs particularly if a seemingly false or malicious allegation has been made.

27.18 Staff conducting disciplinary proceedings should also be informed of the findings of the investigation on allegation against the staff concerned upon its conclusion.
MEMBERSHIP LIST OF
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‘PROCEDURES FOR HANDLING CHILD ABUSE CASES – REVISED 1998’

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Ms PANG Kit-ling (9th to 24th meeting)
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Housing Department

Child Psychiatrist / Hospital Authority