

Protecting Children from Maltreatment Procedural Guide for Multi-disciplinary Co-operation (Annexes)

Revised 2020



Labour and Welfare
Bureau



社會福利署
Social Welfare Department

Education
Bureau



衛生署
Department of Health

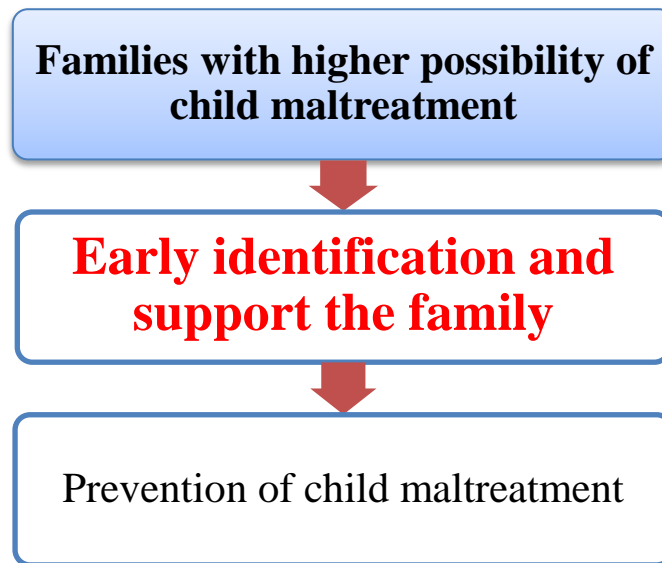


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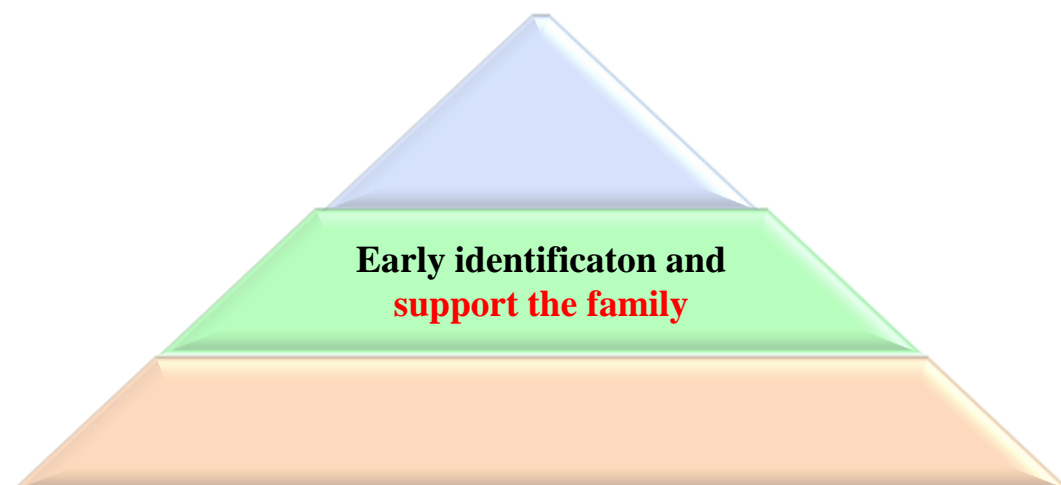
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Annex 1: Families with Higher Possibility of Child Maltreatment

Professionals with opportunities of contact with children and their families should identify families with higher possibility of child maltreatment as soon as possible to provide them with appropriate and substantial support, and gradually enhance the families' capability for child care and parenting, with a view to preventing the problem from continuing or worsening.



The following characteristics are often found in families with higher possibility of child maltreatment. Professionals in contact with these families are advised to be vigilant and explore the families' conditions in order to identify their needs at an early stage and provide assistance for prevention of child maltreatment.



(I) Parents/Carers

(a) Personal background/experiences

- History of maltreatment during childhood
- History of unhappy childhood or having been abandoned; serious deprivation (including such aspects as daily care and emotions)
- History of/experiencing domestic or other violence(s)
- Lower intelligence
- Chronic illness to a serious extent that affect one's own daily life
- Past/current history of mental/emotional illness, and history of suicidal attempt(s)
- Alcohol/drug abuse or other indulgent behaviours (e.g. sexual promiscuity, gambling, overspending, indulgence in the internet and electronic games, etc.)
- Teenage pregnancy

(b) Attitude and behaviour

- Rigid or unreasonable expectation on/vision of the child or the concept of childcare
- Strong belief in harsh/authoritarian discipline/corporal punishment
- Overtly critical or aloof to the child
- Immature handling of affairs or too simple in mind
- Low self-esteem
- Too passive in handling the child's problems or childcare matters
- Low tolerance threshold to stressors
- Poor control of negative emotions, e.g. anger management difficulties
- Unclear and confused family roles
- Sexual problems
- Inadequate parenting (reference may be made to the "Manual of Parenting Capacity Assessment Framework" jointly developed by the Department of Health, the Hospital Authority and the Social Welfare Department to assess the capacity of parents/carers in taking care of children aged 0 to 3)
- Resistant/hostile to external assistance

(II) Children

- (a) Unwanted by their parents
- (b) Infants/toddlers with caring difficulties (e.g. premature birth, multiple birth, having difficulties or complications during delivery, having feeding or sleeping problems, easily agitated, hyperactive or crying unceasingly)
- (c) Early separation from parents
- (d) Have been entrusted with different people adopting inconsistent/contradictory ways of parenting
- (e) Chronically ill, physically or mentally disabled, or have other special care/educational needs
- (f) Attitudes or behaviours showing frequent disrespect to their parents/carers, or having improper behaviours (e.g. frequent temper tantrums, manipulative behaviours, retorts, speaking foul languages, lies, thefts, playing truant, etc.)
- (g) Considered to be associated with some family misfortune
- (h) Of a sex disliked by their parents

(III) Family

- (a) Crisis or tension in family, e.g. pregnancy, eviction, unemployment, financial stringency, indebtedness, serious marital conflicts, divorce/desertion/separation or in-law conflict, etc.
- (b) Family facing complicated problems or multiple stressors for a long time/concurrently
- (c) Detach from others/being isolated/lack of support
- (d) Domestic violence
- (e) The living environment is poor, or is being chaotic or obsessively clean
- (f) Have a set of cultural beliefs that differs from local social norms
- (g) Superstitious

Annex 2: Information Sharing and Confidentiality

Governing Principles

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 of information may be justified when it is necessary to prevent foreseeable harm to a child.
2. To protect a child from being maltreated, sharing of information among relevant professionals on a need-to-know basis is essential to facilitate risk assessment and timely and appropriate intervention.
3. 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 capacity of a parent/carer that may pose danger to the child under his/her care;
 - (c) behaviour that may cause harm to a child; and
 - (d) actual harm to the child.
4. If any person (including the alleged perpetrator) makes a disclosure of a suspected child maltreatment incident and asks for it to be kept secret, the related professionals should explain to the person that it is in the best interests of the child concerned that such a promise cannot be made.

Personal Data (Privacy) Ordinance, Cap. 486

5. The sharing of personal data among professionals 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 his/her personal data. In collecting and sharing the data, professionals should observe the data protection principles as stipulated in Schedule 1 of the PD(P)O (please refer to https://www.elegislation.gov.hk/hk/cap486!en?INDEX_CS=N&xpid=ID_1438403261084_001 for details):

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

Principles of Sharing of Information

Use of Personal Data

6. In the course of investigation on a suspected child maltreatment case or discussion in the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC), professionals may need to share information of the child(ren) and his/her/their family member(s) with other parties or collect information from the latter. 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 prescribed consent¹ of the data subject or the data subject's relevant person² under specific circumstances is obtained.
7. Based on the merit of individual case, the PD(P)O, however, allows use, disclosure or transfer of personal data for a different purpose without the data subject's consent and/or the data subject's relevant person where the use, disclosure or transfer is exempt from the provisions of Data Protection Principle 3 by virtue of the exemptions in Part VIII of the Ordinance.
8. Section 58 of the PD(P)O provides an exemption from Data Protection Principle 3 where the use of the personal data is for the purpose of, inter alia, the detection or prevention of crime or the prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct, or

¹ Where under the PD(P)O, an act may be done with the prescribed consent of a person (and howsoever the person is described), such consent-

(a) means the express consent of the person given voluntarily;

(b) does not include any consent which has been withdrawn by notice in writing served on the person to whom the consent has been given (but without prejudice to so much of that act that has been done pursuant to the consent at any time before the notice is so served).

² According to Section 2 of the PD(P)O Cap 486, where the individual is a minor, relevant person in relation to an individual means a person who has parental responsibility for the minor.

dishonesty or malpractice, and the application of the provisions of Data Protection Principle 3 would be likely to prejudice the above-mentioned purposes. As such, if the personal data are to be used and shared for the purpose of suspected child maltreatment investigation or related child protection work, it may be exempt from Data Protection Principle 3 subject to the satisfaction of both conditions mentioned above (i.e. the use of the personal data is for the purpose of the detection or prevention of crime or the prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct, or dishonesty or malpractice, **and** the application of the provisions of Data Protection Principle 3 would be likely to prejudice the aforementioned purposes). Each case has to be decided on its own merit.

9. According to Section 59 of the PD(P)O, personal data relating to the physical or mental health of the data subject may be exempt from the Data Protection 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 individual. To invoke this exemption to share health records of service users (including the alleged perpetrators and victims of child maltreatment) with other related professionals on a need-to-know basis for the purpose of protecting a child from serious physical and/or mental harm, professionals (e.g. medical officers, personnel of residential child care services) have to, on the merit of each case, satisfy themselves that the application of the Data Protection Principle 3 would likely cause serious harm to the physical or mental health of the data subject or any other individual.
10. A sample request form is at [Appendix 1](#) to this Annex for reference and use by professionals when request for information is to be made by quoting the exemption from the provision of Data Protection Principle 3. Where the purpose of transfer of the information is for a purpose other than the purpose or a directly related purpose for which the data was to be used at time of the collection, the professional having received such request may disclose or transfer relevant data if he/she is satisfied that exemption from Data Protection Principle 3 of the PD(P)O can be invoked. All parties invoking the provisions of exemption are advised to properly document the grounds and decisions. Relevant paragraphs on quoting exemption have been added in the sample invitation letter to members of MDCC for the latter's consideration if needed (please refer to [Appendix 2 to Chapter 11](#)).
11. While exemption from Data Protection Principle 3 on the use of data may be invoked in circumstances as mentioned above, in all circumstances, professionals should disclose the least amount of personal data 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.

12. Apart from Section 58 and 59, according to Section 60B of the PD(P)O, personal data is exempt from the provisions of Data Protection Principle 3 if the use of the data is:
 - (a) required or authorised by or under any enactment, by any rule of law or by an order of a court in Hong Kong;
 - (b) required in connection with any legal proceedings in Hong Kong; or
 - (c) required for establishing, exercising or defending legal rights in Hong Kong.

Access to Personal Data

13. According to Section 18(1) and Data Protection Principle 6 of the PD(P)O, an individual, or a relevant person on behalf of an individual, may make a request –
 - (a) to be informed by a data user whether the data user holds personal data of which the individual is the data subject; and
 - (b) if the data user holds such data, to be supplied by the data user with a copy of such data.
14. Where the individual is a minor, a relevant person means a person who has parental responsibility for the minor. The provisions of the Ordinance however give no indication on under what kind of situation a data access request made by a relevant person is to be regarded as being so made “on behalf of” the individual. If a parent’s request cannot be regarded as a data access request on the ground that the data user is not satisfied that the requestor parent is acting on behalf of his/her child and therefore he/she is not entitled to the child’s data as of right, pursuant to Section 21 of the PD(P)O, the data user shall, as soon as practicable but, in any case, not later than 40 days after receiving the request, by notice in writing inform the requestor (a) of the refusal; and (b) the reasons for the refusal.
15. According to Section 2 of the PD(P)O, “data subject”, in relation to personal data, means the individual who is the subject of the data. Hence, allegations against the parent given by the minor are likely to be personal data of the parent, rather than the minor. The parent, as the data subject, arguably has the right to access to these allegations under Section 18(1) and Data Protection Principle 6

of the PD(P)O.

[Note: For the elaboration related to “making data access request by a relevant person on behalf of the individual”, reference may be made to the “Personal Data (Privacy) Law in Hong Kong – A Practical Guide on Compliance” jointly published by the Office of the Privacy Commissioner for Personal Data, Hong Kong and the City University of Hong Kong Press (<https://www.pcpd.org.hk/misc/booklets/e-lawbook/html/>).]

16. Even if a data user is not satisfied that the requestor is a relevant person in relation to the minor (i.e. a person with parental responsibility acting on behalf of the minor) and therefore he/she is not entitled to be supplied of the data of the minor, the requestor may simply request the data user to use (which as defined in Section 2 of the PD(P)O “includes disclose or transfer the data”) the data and hence release the minor’s data to him/her. For such request, Data Protection Principle 3 (use of personal data) is relevant. It is for the data user to decide whether to release the data having regard to the original purpose(s) of collection of the data.
17. In handling request for access to personal data under Data Protection Principle 6, as stipulated in Sections 58(1)(a), (b) & (d) and Section 59(1) of the PD(P)O, the relevant exemption provision may be invoked to refuse to comply with the data access request provided that:
 - (a) the personal data involved is held for the purposes of the prevention or detection of crime, or the apprehension, prosecution or detention of offenders, or the prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct, or dishonesty or malpractice, by persons; and to comply with the data access request would likely prejudice the aforementioned purposes; or
 - (b) the personal data involved is related to the physical or mental health of the data subject **and to comply with the data access request** would likely to cause serious harm to the physical or mental health of the data subject or any other individual.

Measures to Preserve Confidentiality

18. 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.

19. Professionals should take precautions to ensure and maintain confidentiality of information transmitted to other parties through the use of computers, electronic mails, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifiable information should be avoided whenever possible.

(Sample Letter)

(Consent from data subject for release of data is not available)

Our Ref :
Tel. No. :
Fax No. :
E-mail :

(Date)

Dear Sir/Madam,

Name: _____

**Request for Personal Data from Other Data Users
in Respect of Persons Subject / Relating to
a Suspected Child Maltreatment Case**

The *(organisation/department)* is conducting a child protection investigation into a suspected child maltreatment case. To assist in the *(investigation/and formulation of follow-up plan for the child concerned in the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment)*, we would like to request you for providing the personal data of the person(s) subject to this investigation, namely *(name and, if required, other particulars sufficient to identify the data subject)*. The request is detailed below.

The brief circumstances of the case and the request for information:

Note: The brief should cover

- (i) *brief account of the case (including how the data subject relates or may relate to what unlawful or seriously improper conduct, or dishonestly or malpractice);*
- (ii) *purpose for obtaining the information; and*
- (iii) *how the requested information relates to the purpose.*

The information sought is as below:

Consent

Consent from the data subject for the release of the required personal data is not available to the *(organisation/department)* due to the following reason:

- Consent has been sought but was refused by the data subject;
- Unable to contact the data subject – Reason: *(Please specify)*;
- Seeking consent from the data subject is likely to prejudice the purpose of the collection of the requested data – Reason: *(Please specify)*; or
- Other reasons *(please specify)*:

Certification

I confirm that the requested information is required for the purpose of *(please refer to the wording of the exemption at relevant Section(s) of Part VIII of the PD(P)O Cap. 486, e.g. S.58(1)(a) “prevention or detection of crime”, S.58(1)(b) “the apprehension, prosecution or detention of offenders”; S.58(1)(d) “prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct, or dishonesty or malpractice, by persons; or, S.59(1)(b) “application of those provisions to the data would be likely to cause serious harm to the physical or mental health of the data subject or any other individual.”)*

Failure to provide the requested information would be likely to prejudice the said purpose because *(how the purpose is likely to be prejudiced)*.

In view of the above, I consider that S.58(2) (as read with S.58(1)(a / b / d)/S.59(1)(b) of the Personal Data (Privacy) Ordinance, Cap 486) is the applicable exemption under the circumstances.

This request for personal data is submitted to you for your consideration as to whether the exemption quoted above is applicable under the circumstances relating to the *(investigation/formulation of follow-up plan for the child concerned in the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment)*. In doing so, you may also wish to consult your legal adviser.

I should be grateful if you could reply by *(date)*. Should you have any question in respect of this request, please feel free to contact me, *(Name/Rank/Post)* on *(Tel. No.)*.

()
for (head of organisation/department)

Annex 3: Ordinances on Criminal Offences Related to Child Maltreatment

1. Various legislative provisions are in place to protect children from maltreatment. This annex lists the Ordinances on criminal offences relating to child maltreatment and [Annex 15](#) lists the Ordinances related to Child Protection Work. The personnel may refer to relevant Ordinances when necessary.
2. The definition of “child maltreatment” in [Chapter 2](#) of this Guide is not a legal definition. On criminal offences, specific abusive acts are dealt with under a number of Ordinances including Crimes Ordinance, Cap 200, Offences Against the Person Ordinance, Cap 212, etc., of which the upper age limit of the child concerned varies according to the objectives of the respective legal provisions. If personnel believe that a criminal abusive act has been/is about to be committed against a child, they should report to the Police as soon as possible.
3. The decision to prosecute lies with the Counsel who needs to consider :
 - (a) sufficiency of evidence;
 - (b) interests of the child;
 - (c) public interest; and
 - (d) paragraphs 7 to 9 of “The Statement of Prosecution Policy and Practice” issued by the Department of Justice in 2002.
4. Below is the list of Ordinances related to child maltreatment:

(a) 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 man under 16
Section 118D	Buggery with girl under 21
Section 118E	Buggery with mentally incapacitated person
Section 118I	Gross indecency with mentally incapacitated person
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

(b) 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

(c) 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 4: Roles of Social Service Units

When a child is suspected to be maltreated, personnel of social services units should take up different roles to safeguard the child's safety and best interests.

(I) Family and Child Protective Services Unit of the Social Welfare Department (SWD)

(1) Receiving Initial Consultation

Family and Child Protective Services Unit (FCPSU) shall receive consultation on cases related to suspected child maltreatment within its office hour.

FCPSU may offer immediate assistance depending on the case circumstances, e.g. contact the Medical Co-ordinator on Child Abuse (MCCA) for admitting the child for medical examination, or liaise with a Child Abuse Investigation Unit (CAIU) of the Hong Kong Police Force and forward the Report form (see [Appendix 4 to Chapter 10](#) of this Guide) and Written Dated Notes (see [Appendix 5 to Chapter 10](#)) to CAIU.

(2) Receiving a Report, Conducting Initial Assessment and Taking Immediate Child Protection Action (if needed) (please refer to [Chapters 4 to 6](#) of this Guide)

FCPSU, during its office hours (i.e. from 8:45 a.m. to 5:00 p.m. for Monday to Friday and from 9:00a.m. to 12:00 noon for Saturday, excluding public holidays), shall receive report and conduct initial assessment for the following suspected child maltreatment cases (including, as necessary, conducting an outreaching visit jointly with the social worker of an Integrated Family Service Centre or the service unit concerned/school personnel):

- (a) The child suspected to be maltreated and his/her family is not a known case of other casework units³, or cannot ascertain if it is a known case of other casework units; or
- (b) Report made by kindergarten/child care centre, primary school, special school and international school (including the child concerned is a known case of the social worker of the school/unit concerned and the social worker is employed by a non-governmental organisation (NGO))

³ Please refer to Annex 5, Definition of "Known Cases" to Welfare Organisations.

or the school) and the child or his/her family is not a known case of other casework units, or

- (c) The suspected child maltreatment case falling within the Charter of CAIU may be handled in the form of joint investigation. If the case is a known case of other casework units, social worker of FCPSU will collaborate with the responsible social worker of the known case to take child protection actions as necessary (please refer to [Chapter 10](#) of this Guide).

- (3) Strategy Planning and Taking Statutory Protection Action (please refer to [Chapters 4 to 6](#) of this Guide)

For known case of casework unit of NGOs (not a shared case with SWD unit) of which the personnel suspects the child has been maltreated yet the parent(s) do(es) not co-operate so that medical examination/psychological assessment of the child cannot be conducted or caring arrangement for the child in a safe place cannot be made, etc., the personnel of the unit can contact FCPSU if he/she considers invoking the Protection of Children and Juveniles Ordinance (PCJO) may be needed in protecting the child. If FCPSU initially considers invocation of PCJO is necessary, the social worker will offer outreaching service, and has strategy planning as well as take necessary actions jointly with the responsible casework unit.

- (4) To Conduct Child Protection Investigation (please refer to [Chapter 8](#) of this Guide)

FCPSU will conduct child protection investigation for suspected child maltreatment cases after carrying out initial assessment and taking immediate child protection action(s).

- (5) To Chair Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) (please refer to [Chapter 11](#) of this Guide)

FCPSU will/may chair MDCC in the following cases/circumstances:

- (a) Cases with child protection investigation conducted by FCPSU; or
- (b) Supervisor/personnel of the service unit which conducts child protection investigation is not suitable to be the Chairperson of MDCC (e.g. parents of the child concerned is filing a complaint with the supervisor of the service unit against the social worker who is handling the case) or not experienced in conducting MDCC; or

- (c) Child protection investigation conducted by school social work service unit (excluding secondary school) or youth service unit of NGOs
- (6) To attend MDCC chaired by other service units subsequent to the child protection investigation and to give professional advice on issues being discussed and decided in the conference
- (7) To follow up child protection cases until the risk of child maltreatment is eradicated or reduced and the child's physical and psychological safety is safeguarded

(II) Outreaching Team of SWD

Outreaching team of SWD shall, within its office hours⁴, receive cases reported by the hotline service operated by the Tung Wah Group of Hospitals (TWGHs). Initial assessment will be conducted and immediate child protection actions will be taken as necessary (please refer to [Chapters 4 to 6](#) of this Guide).

(III) Casework Units Operated by SWD and Subvented NGOs and Medical Social Services Units under the Hospital Authority

(1) Known case

If the child concerned or his/her family is a known case of a casework unit operated by SWD or subvented NGOs (excluding cases of kindergarten/child care centre, primary school, special school and international school), the unit concerned should be responsible for:

- (a) Receiving report in relation to suspected child maltreatment of that case (please refer to [Chapter 4](#) of this Guide)
- (b) Conducting initial assessment and taking immediate child protection action (please refer to [Chapter 5 and 6](#) of this Guide)

While handling the case and invocation of the PCJO is considered for protecting the child, NGO can contact the FCPSU concerned according to the updated residential address of the child's parent(s)/guardian(s)

⁴ Office hours of Outreaching Team of SWD is as follows :

- Monday to Thursday: 5:00p.m. to 8:45a.m. on the next day;
- Friday: 5:00p.m. to 9:00a.m. on the next day;
- Saturday: 12:00noon to 8:45a.m. on the next day; and
- Sunday & Public holiday: 8:45a.m. to 8:45a.m. on the next day.

for joint strategy planning and rendering assistance in taking statutory protection action as necessary. NGO can also seek assistance from police (please refer to [Annex 15](#) of this Guide for matters of the PCJO).

- (c) Conducting child protection investigation (please refer to [Chapter 8](#) of this Guide)
- (d) Convening/chairing MDCC [MDCC convened by school social work service unit (excluding secondary school) and youth service unit can be chaired by FCPSU] (please refer to [Chapter 11](#) of this Guide)
- (e) If the case is being handled by casework units of both SWD and NGO and invocation of the PCJO for child protection is necessary, the unit of SWD should conduct the assessment and consider whether the invocation is necessary

(2) Not a Known Case

- (a) Interview is not conducted

If the child or his/her family member has not been interviewed directly but the social worker of the unit has, through tele-conversation or other means, collected information that a child is suspected to be harmed/maltreated, the social worker should report the case to the social service unit concerned (if it is a known case of that unit) or FCPSU (if the case is not known to any service units)

- (b) Interview is conducted

If the child or his/her family member has been interviewed directly, the social worker of the unit should collect information and report to a suitable unit for conducting initial assessment according to procedures as stipulated in [Chapter 4](#) of this Guide. The unit can also take action before reporting to the social service unit concerned if immediate child protection action is deemed appropriate and urgently needed, e.g. sending the injured child to hospital for examination/requesting immediate police intervention for protecting the child concerned. FCPSU can be consulted or solicited for assistance as necessary.

If the child concerned is a case being handled by the Hospital Authority or Department of Health, medical social worker (MSW) should help co-ordinate and facilitate intra-organisation and inter-organisation communication, e.g. collecting basic information, having initial discussion on case handling with medical officer

concerned, assisting in reporting the case to a suitable unit (please refer to [Chapter 4](#) of this Guide). MSW may also observe the child's/family members' condition while the child is in hospital as well as to render them assistance as needed.

- (3) If the unit responsible for conducting child protection investigation considers necessary to invite personnel of the unit concerned to attend MDCC, the said personnel should attend and prepare a written report for facilitating the discussion. The unit should render continuous assistance to the child or his/her family according to the follow-up plan formulated at MDCC (please refer to [Chapter 11 and 12](#) of this Guide).

(IV) Residential Child Care Services, Day Child Care Services and Special Child Care Centre

(1) Case Identification and Reporting

- Personnel of residential child care services, day child care services and special child care centre should be constantly alert to indicators of child maltreatment for children under their care by making reference to Possible Indicators of Child Maltreatment in [Chapter 4](#) of this Guide. Where a child is suspected to be maltreated, personnel should report immediately to the supervisor/superintendent/designated personnel and report the basic information collected to a suitable unit for conducting initial assessment so as to decide whether action or follow-up is necessary.
- The unit can also take action before reporting to the social service unit concerned if immediate child protection action is deemed appropriate and urgently needed, e.g. sending the injured child to hospital for examination/requesting immediate police intervention for protecting the child concerned. FCPSU can be consulted or solicited for assistance as necessary (please refer to [Chapter 4](#) of this Guide).
- In informing the parent(s) of the child suspected to be maltreated, personnel may consult the social worker of FCPSU or the responsible caseworker (if it is a known case of a casework unit) on how and who to contact the parents, etc. Case should be handled with care when parent(s)/guardian(s) of the child concerned is/are suspected to be involved in the child maltreatment.
- In circumstances that suggest a criminal offence may have been committed, the case should be reported to the Police to safeguard the

safety and interests of the child concerned (please refer to [Chapter 10](#) of this Guide).

- For suspected child sexual abuse cases, personnel should refer to [Annex 12](#), “Points to Note on Contacting Children Suspected to be Sexually Abused” and [Annex 13](#) “Guidance Notes on Reporting Suspected Sexual Abuse” to this Guide.
- Designated personnel of residential child care services, day child care services and special child care centre (e.g. supervisor, superintendent, social worker) should be assigned for handling the suspected child maltreatment case as far as practicable to avoid repeating the maltreatment incident(s) unnecessarily by the child concerned and spread of information.

(2) Protection of Other Children

For suspected child sexual abuse cases, personnel should report the case to supervisor/superintendent as soon as possible if the alleged perpetrator is also a child of the residential home/hostel/centre. In taking care of the needs of the child suspected to be sexually abused, personnel should also pay attention to the safety and emotional needs of other children of the home/hostel/centre.

(3) Attending MDCC and Case Follow-up

- The supervisor/superintendent/caseworker of the residential child care services, day child care services and special child care centre should attend MDCC and prepare a written report to facilitate the formulation of the follow-up plan of the child concerned. The report may include the child's behavioural and emotional state in the home/hostel/centre, parental attitude and any previous incident(s) of suspected child maltreatment, etc. (please refer to [Chapter 11](#) of this Guide).
- If the case is categorised as a child protection case and the child continues to reside in the home/hostel or receiving service from the centre, the social worker of the home/hostel/centre should render assistance to the child or his/her family according to the follow-up plan formulated at MDCC. He/she should also keep keen observation on the child's progress and liaise with the key worker and other personnel working on the same case from time to time.

(V) Other Social Services Units (Non-casework Unit)

(1) Case Identification and Reporting

Personnel of non-casework units should collect basic information and report to a suitable unit for conducting initial assessment when a child is suspected to be maltreated so as to decide whether action or follow-up is necessary. The unit can also take action before reporting to the social service unit concerned if immediate child protection action is deemed appropriate and urgently needed, e.g. sending the injured child to hospital for examination/requesting immediate police intervention for protecting the child concerned. FCPSU can be consulted or solicited for assistance as necessary (please refer to [Chapter 4](#) of this Guide).

(2) Attending MDCC and Case Follow-up

If the unit responsible for conducting child protection investigation considers necessary to invite reporting personnel to attend MDCC, the said personnel should attend and prepare a written report for facilitating the discussion. He/she should render continuous assistance to the child or his/her family according to the follow-up plan formulated at MDCC (please refer to [Chapter 11 and 12](#) of this Guide).

Annex 5: Definition of Known Cases to Welfare Organisations

For receiving reports and handling of suspected child maltreatment cases, “known cases” refer to the following categories of cases of different service units:

(I) Integrated Family Service Centres (IFSCs)/Family and Child Protective Services Units (FCPSUs) of SWD & IFSCs/Integrated Services Centres (ISCs) operated by NGO

1. Active cases of IFSCs/ISCs/FCPSUs⁵;
2. Closed cases of IFSCs/ISCs which have been closed for 3 months or less (irrespective of the family’s/service user’s current residential address);
3. Closed cases of FCPSUs, namely child protection and/or battered spouse cases and/or child custody cases with supervision order, which have been closed for 3 months or less (irrespective of the family’s/service user’s current residential address);
4. Any intake cases or outreaching cases of IFSCs/ISCs/FCPSUs for which interview or visit has been conducted with the individual/family and recommendation to open file for follow-up action has been endorsed;
5. Any intake cases or outreaching cases of IFSCs/ISCs/FCPSUs for which interview or visit has been conducted with the individual/family and the recommendation (excluding those cases with recommendation of having no need for follow-up) has not yet been endorsed after one month since enquiry/intake (irrespective of whether the presenting problem(s) is/are related to suspected child maltreatment or whether case file has been opened or not);

(II) Other SWD Casework Units

6. Active cases of casework units, such as Probation and Community Service Orders Office/Adoption Unit/Medical Social Services Unit (excluding cases being handled by Probation and Community Service Orders Office for social enquiry and welfare referrals);

⁵ For court referral case (if it is not an active case of any other units) that comes to the attention of FCPSU during the course of child custody social enquiry in which court disposals have not been concluded and have not been put away, the FCPSU will conduct the social enquiry if suspected child maltreatment incident occurs

7. Children who are residing at the reformatory school or receiving aftercare service from the Aftercare Officer of the reformatory school upon their discharge;
8. For medical social service (MSS), “known” cases mean the active cases of medical social services units in addition to one of the following conditions (but excluding new cases referred to MSS for child’s admission to hospital due to suspected child maltreatment):
 - (a) medically intensive cases of MSS where the alleged perpetrator or child being maltreated is an in-patient or a patient who is required to attend medical treatment at least once within 6 weeks (irrespective of patient’s residential address). (Medical social workers of child assessment centres would only handle patient’s training and educational arrangement);
 - (b) medically intensive cases of MSS where the family member of the child being maltreated is living in the same household as the child concerned. He/she is attending medical treatment at least once within 6 weeks and the patient’s residential address is within the same administrative district of the MSS unit; or
 - (c) medically active cases of MSS where the child being maltreated is a patient attending medical treatment at least once from 6 to 26 weeks and the residential address is within the same administrative district of the MSS unit.

(III) NGO Units (excluding IFSCs/ISCs)

9. For receiving reports and handling of child maltreatment cases, “known cases” of NGOs are defined as those active cases being handled by units with casework services which include the following:
 - (a) Medical Social Services Units under the Hospital Authority;
 - (b) Integrated Children and Youth Services Centres;
 - (c) School Social Work Units serving students in secondary schools;
 - (d) Student Guidance Personnel serving students in primary schools;
 - (e) School Social Work Units serving students in pre-primary Institutions;
 - (f) District Youth Outreaching Social Work Teams;

- (g) Overnight Outreaching Service for Young Night Drifters; and
- (h) Community Support Service Schemes.

Cases Known to More Than One Service Unit

10. Where a case is known to more than one service unit, or where a case with more than one child within a family is/are suspected to be maltreated and these children are active cases of different service units, the service unit to which the case is first known should be responsible for conducting child protection investigation and convening the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC).
11. In case of emergency, the service unit first identifies the suspected child maltreatment incident may conduct initial assessment and carry out immediate protection action.
12. The personnel concerned should apply flexibility and discuss among themselves for the benefit of the child and his/her family. For example, if the social worker of a service unit, to which the case is not first known, is more familiar with the child concerned and his/her family and can make a more comprehensive assessment on the family as well as handle the case more effectively, this service unit may conduct child protection investigation and convene MDCC.

Annex 6: Roles of Clinics under Department of Health

1. Medical officers, nurses and para-medical staff who may have chances to contact children possibly be maltreated and the latter's families should handle the cases making reference to the principles and procedures of this Guide.
2. Medical history is the keystone in establishing a diagnosis of child maltreatment. However, the clinical interview may be very distressing to the child. At initial contact, the medical officer should focus on obtaining information from the child concerned and his/her carer(s) in order to ascertain the suspicion of child maltreatment and to determine whether to report to the unit concerned for further action, with special attention to the injuries or psychological trauma and to factors that may pose any continuing risk to the child. The in-depth interview of the suspected maltreatment incident should be left to a designated multi-disciplinary team responsible for interviewing children suspected to be maltreated.
3. For cases in need of full medical/forensic examination, the child concerned should be referred to the medical professionals with expertise in child maltreatment examination and the number of examination must be kept to a minimum. For suspected 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, age and distress of the child. Advanced training and experience are needed for the proper identification and examination of child sexual abuse cases. A comprehensive record of the examination should be made. Normal physical findings do not exclude the possibility of child sexual abuse. Reference can be made to [Chapter 9](#) of this Guide for the procedures and principles for medical examination.
4. When a child is suspected to be harmed/maltreated, the social worker responsible for initial assessment or other professionals may contact respective clinic of the Department of Health (DH) for arrangement of an assessment on the state of the child's health or development or the way in which the child has been treated if considered necessary. If the parents(s) do(es) not co-operate but the social worker responsible for initial assessment (if the social worker is from the Social Welfare Department (SWD)) has reasonable cause to suspect the child is, or is likely to be in need of care and protection, Section 45A of the Protection of Children and Juveniles Ordinance, Cap 213 (PCJO) may be considered and invoked as needed. The social worker authorised by the Director of Social Welfare (DSW) may cause a notice to be served on any person having custody or control of such child or juvenile, requiring that person

to produce the child or juvenile for an assessment by a medical practitioner, clinical psychologist or an approved social worker⁶ of the state of his/her health or development or the way in which the child has been treated (Section 45A(1)(a) of the PCJO). Social workers of SWD will contact medical officer of the clinic concerned for necessary arrangement. Social worker of NGO who is responsible for initial assessment may contact Family and Child Protective Services Unit (FCPSU) for discussing the suitability in invoking the PCJO. Please refer to [Annex 15](#) to this Guide, “Ordinances Related to Child Protection Work” and Frequently Asked Questions in relation to the PCJO.

Confidentiality Issues

5. The principles that a medical practitioner is required to observe with regard to patient confidentiality and disclosure of medical information are given at “International Code of Medical Ethics” (please refer to Part I of the HK CODE OF PROFESSIONAL CONDUCT issued by the Medical Council of Hong Kong. The whole document is at https://www.mchk.org.hk/english/code/files/Code_of_Professional_Conduct_2016.pdf).
6. 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 maltreatment investigation or related child protection work (please refer to [Annex 2](#) to this Guide).

Reporting Procedures

7. If child maltreatment is suspected from medical history and upon examination, the medical officer/nurse and para-medical staff should inform:
 - (a) the Medical Officer-in-charge of the clinic and regional/cluster/service Senior Medical Officer;
 - (b)
 - (i) clinics with Medical Social Worker (MSW) attached:
 - inform MSW and MSW should assist in handling the case according to [Chapters 4 to 6](#) of this Guide.
 - (ii) clinics without MSW:

⁶ An approved social worker refers to the social worker approved by the DSW to discharge the duty under Section 45A of the PCJO.

- report to the service unit of SWD/NGO concerned according to [Chapter 4](#) of this Guide if the child is a known case of that unit so that it will take further action.
 - if the child is not receiving service from any service units of SWD/NGO or there is no information on whether a child is known to any of these units, the medical officer may report the case to FCPSU (Contact information of FCPSUs at [Appendix 1 to Chapter 4](#)). Consultation can be made first with FCPSU as needed.
- (c) In circumstances that suggest a criminal offence may have been committed (please refer to [Annex 3](#) to this Guide, “Ordinances on Criminal Offences related to Child Maltreatment”), the case should be reported to the Police to safeguard the safety and interests of the child. For the procedures and methods in making report to the Police, please make reference to [paragraphs 10.1 to 10.8 of Chapter 10](#) of this Guide.
- (d) For suspected sexual abuse cases, please refer to [Annex 12](#) “Points to Note on Contacting Children Suspected to be Sexually Abused” and [Annex 13](#) “Guidance Notes on Reporting Suspected Sexual Abuse” to this Guide.
8. When the responsible social worker of the known case or social worker of FCPSU conducts initial assessment on the case, the medical officer should provide necessary assistance as far as possible.
 9. Reporting of suspected child maltreatment cases to the responsible unit of the known case or FCPSU **do not require** consent of the service users concerned (i.e. parents, carers, significant others of the child concerned, etc.) if the situation stated in [paragraph 6](#) above warrants. However, they should be informed by the medical officer about the report. Please refer to [Annex 2](#) to this Guide for points to note on the information sharing among the personnel during the reporting process.
 10. If professional advice from paediatricians is required, the medical officer can consult the respective Medical Co-ordinator on Child Abuse (MCCA) appointed in each Paediatric Department in the hospitals of the Hospital Authority (HA) (List of MCCA at [Appendix 1 to Chapter 9](#) of this Guide).
 11. Where hospitalisation of the child concerned is necessary, the medical officer

should contact the MCCA of the designated Paediatric Departments/paediatrician on duty of HA hospitals for appropriate action (please refer to [Annex 7](#) to this Guide). If there is no MCCA in the nearby hospital, the medical officer should first liaise with the paediatrician on duty.

12. If the parent(s)/guardian(s) refuse to arrange the child concerned to go to hospital to receive medical examination and the child is considered in need of care or protection, the Medical Officer-in-charge should contact the responsible unit of the known case or FCPSU for assistance or consideration on the appropriateness for invoking powers under Section 34F of the Protection of Children and Juveniles Ordinance, Cap 213 (PCJO) whilst trying to persuade the parent(s)/guardian(s) to stay in the clinic. The MSW of the clinic, if any, should assist whenever situation warrants (please refer to Frequently Asked Questions at [Appendix 2 to Annex 15](#) to this Guide). If assistance from the Police is deemed necessary, the MSW/medical staff should contact the nearest police station directly. Upon invoking powers under Section 34F, the responsible social worker of the known case or social worker of FCPSU will provide follow-up service if further care proceeding is necessary.

Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) and Follow-up Services

13. The medical officer attending the case should attend MDCC to formulate the follow-up plan of the child. A written report on the child's condition should be prepared for facilitating discussion in MDCC (please refer to [Chapter 11](#) of this Guide). After MDCC, the medical officer should follow up the case in collaboration with other personnel according to the decision of MDCC and [Chapter 12](#) of this Guide if medical follow-up is required.

Annex 7: Roles of Hospitals/Out-patient Clinics of the Hospital Authority

1. Medical officers, nurses and para-medical staff of hospital/out-patient clinic of the Hospital Authority (HA) should familiarise themselves with the principles and procedures of handling suspected child maltreatment cases as stipulated in this Procedural Guide. They should also make reference to [Appendix 1](#) to this Annex, Guidance for Paediatric Wards, Accident and Emergency Department and Staff involved in Handling Child Maltreatment.

Guiding Principles

2. The primary **objectives** in managing child suspected to be abused or neglected 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.
3. **Handling Principles :**
 - (a) The child must not be further traumatised by the investigative process.
 - (b) The best interests of the child must be accorded top priority and the emotional well-being of the child must be protected. All those personnel 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 minimise further distress to the child.
 - (c) Medical history is the keystone in establishing a diagnosis of child maltreatment. A detailed medical history should be inquired from the child and his/her carer(s) as far as possible. Medical record should follow the format of a thorough paediatric health assessment with special attention to the injuries and to factors that may pose any continuing risk to the child. However, the clinical interview may be very distressing for the child and should be carefully planned. **At the initial contact with the child, the number of interview should be kept to the minimum.** 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.

- (d) Advanced training and experience are needed for the proper identification 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, age and level of distress of the child. A careful and comprehensive record should be made. Normal physical findings do not exclude the possibility of child sexual abuse.
- (e) For child sexual abuse cases in need of full medical/forensic examination, the child should be examined by medical professionals with expertise in child maltreatment examination.
- (f) The number of examination must be kept to a minimum.

Role of Medical Co-ordinator on Child Abuse (MCCA)

- 4. MCCAs are designated in the Paediatric Departments within HA for handling child maltreatment cases (List of MCCAs at [Appendix 1 to Chapter 9](#) of this Guide). Working closely with investigating social worker, medical social workers (MSW), nurses, clinical psychologists, psychiatrists and other related personnel, the MCCAs, through their expertise in child protection, provide support to these personnel to understand the physical, emotional and developmental needs of the child suspected to be maltreated to facilitate these personnel to support the child concerned.
- 5. The duties of a MCCA include:
 - (a) reporting the case and providing medical service to the child suspected to be maltreated;
 - (b) assisting to arrange direct admission for the child to Paediatric Ward as appropriate upon receiving a referral;
 - (c) providing expert medical advice to colleagues and other professionals; and
 - (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

- 6. For suspected child maltreatment cases, all medical officers should make reference to the following procedures. For child sexual abuse cases, the

handling procedures for medical officer are outlined at [Appendix 2](#) to this Annex. Medical officers can make reference to [Annex 12](#), “Points to Note on Contacting Children Suspected to be Sexually Abused” and [Annex 13](#) “Guidance Notes on Reporting Suspected Sexual Abuse” to this Guide.

Referral received by Accident and Emergency Department (AED) and Specialist Outpatient Clinic (SOPC)

7. (a) **If a child is suspected to be maltreated**, medical officer should:
- (i) inform the Senior Medical Officer (SMO)/Associate Consultant in charge of the case who may in turn consult the MCCA of the hospital or nearby hospital; and
 - (ii) inform the MSW concerned who would, according to the information collected, check with Child Protection Registry (CPR) via his/her supervisor (please refer to [Annex 14](#) to this Guide for CPR), report the case to respective personnel of the Social Welfare Department (SWD)/non-governmental organisation (NGO) (if the case is known to the service unit of SWD/NGO), or to Family and Child Protective Services Unit (FCPSU) (if the case is not known to the service unit of SWD/NGO). Please refer to [Appendix 1 to Chapter 4](#) of this Guide for the contact information of FCPSUs.
 - (iii) In circumstances that suggest a criminal offence may have been committed, the medical officer or MSW concerned can report to the Police by using the Report Form for Reporting Suspected Child Abuse Cases to Police and Written Dated Notes at [Appendix 4 and Appendix 5 to Chapter 10](#) (please make reference to [paragraphs 10.1 to 10.8 of Chapter 10](#) of this Guide for details). Making report to the Police is not a pre-requisite for conducting medical examination.
- (b) **For cases in need of urgent intervention/investigation**, the medical officer should inform the Police (the nearest Hospital Police Post or police station) or social worker (FCPSU/Hospital MSW or SWD Hotline) as appropriate, and keep the SMO/Associate Consultant in charge of the case and MSW informed of the updated case progress for assistance as soon as possible.

- (c) **For cases where child maltreatment is suspected and the child concerned is not going to be warded in hospital**, the medical officer or MSW concerned who has first-hand information on the suspected maltreatment incident(s) should make a report to the respective personnel of SWD/NGO staff (if the case is known to the service unit of SWD/NGO), or to FCPSU (if the case is not known to the service unit of SWD/NGO unit). Please refer to [Appendix 1 to Chapter 4](#) of this Guide for the contact information of FCPSUs. If police investigation is necessary before the child leaves the AED or SOPC, report should be made to the Hospital Police Post. Otherwise, report to the Police can be made by using the Report Form for Reporting Suspected Child Abuse Cases to Police and Written Dated Notes at [Appendix 4 and Appendix 5 to Chapter 10](#).
- (d) **For suspected child maltreatment cases where hospitalisation for observation or treatment is necessary**, the child can be admitted to the Paediatric Department or another appropriate department of the Hospital or nearby Hospital.
- (i) The MCCA and other relevant personnel will as far as possible ensure that appropriate assessment to the child be completed. These will include both physical and mental aspects.
- (ii) If the child or juvenile is brought to the hospital under 34F(1) of the Protection of Children and Juveniles Ordinance, Cap 213 (PCJO), yet parent(s)/guardian(s) resist hospital admission of the child or juvenile, the Medical Officer-in-charge should try to persuade the parent(s)/guardian(s) to stay whilst contact is made with the responsible social worker (if it is a known case) or social worker of FCPSU for discussing the need on invoking powers under Section 34F(2). If the child is not brought to the hospital under 34F, the Medical Officer-in-charge should handle the child according to Frequently Asked Questions 4 at [Appendix 2 to Annex 15](#) to this Guide. The MSW in hospital should assist whenever situation warrants in office hours. For outside office hours, the Medical Officer-in-charge can obtain assistance through SWD Hotline (Tel. no.: 2343 2255). Once an order for detention under Section 34F(2) is made by the relevant public officers, the Police will, as far as possible, assist to ensure enforcement of the order.

- (iii) If the child's life and safety is endangered and/or the parent is in breach of peace, police officers may intervene.
- (e) **For doubtful cases where in-patient treatment is not required and the level of suspicion of child maltreatment is not high,** SMO/Associate Consultant in charge of the case, 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 Medical Officer in-charge of the AED for review as soon as possible.
- (f) **For cases where in-patient treatment is not required and there is no sufficient information for substantiating the occurrence of a suspected child maltreatment case, yet the child concerned or his/her family has other welfare needs,** the medical officer of AED/SOPC should ensure the case be referred to the relevant welfare organisation for follow-up (e.g. MSW/Integrated Family Service Centre/Integrated Services Centre).

Referral received by Paediatric Ward

- 8. (a) If a child is suspected to be maltreated, medical officer should:
 - (i) inform the SMO/Associate Consultant in charge of the case who may in turn consult the MCCA of the hospital or nearby hospital; and
 - (ii) inform the MSW concerned who would, according to the information collected, check with Child Protection Registry (CPR) via his/her supervisor (please refer to [Annex 14](#) to this Guide for CPR), report the case to respective personnel of SWD/NGO (if the case is known to the service unit of SWD/NGO), or to FCPSU (if the case is not known to the service unit of SWD/NGO). The unit receiving the report will conduct initial assessment and decide/discuss with the medical officer concerned on the need for conducting investigation. Please refer to [Appendix 1 to Chapter 4](#) of this Guide for the contact information of FCPSUs.
 - (iii) In circumstances that suggest a criminal offence may have been committed, the medical officer or MSW concerned can report to the Police by using the Report Form for Reporting Suspected

Child Abuse Cases to Police and Written Dated Notes at [Appendix 4 and Appendix 5 to Chapter 10](#) (please make reference to [paragraphs 10.1 to 10.8 of Chapter 10](#) of this Guide for details). Making report to the Police is not a pre-requisite for conducting medical examination.

Referral received by Orthopaedic/Gynaecological /Medical /Surgical Ward, etc.

9. (a) If a child is suspected to be maltreated, medical officer should:
 - (i) inform the SMO/Associate Consultant in charge of the case who may in turn consult the MCCA of the hospital or nearby hospital;
 - (ii) refer the child to a paediatric in-patient unit; and
 - (iii) inform the MSW concerned who would, according to the information collected, check with Child Protection Registry (CPR) via his/her supervisor (please refer to [Annex 14](#) to this Guide for CPR), report the case to respective personnel of SWD/NGO (if the case is known to the service unit of SWD/NGO), or to FCPSU (if the case is not known to the service unit of SWD/NGO). The unit receiving the report will conduct initial assessment and decide/discuss with the medical officer concerned on the need for conducting investigation. Please refer to [Appendix 1 to Chapter 4](#) of this Guide for the contact information of FCPSUs.
 - (iv) In circumstances that suggest a criminal offence may have been committed, the medical officer or MSW concerned can report to the Police by using the Report Form for Reporting Suspected Child Abuse Cases to Police and Written Dated Notes at [Appendix 4 and Appendix 5 to Chapter 10](#) (please make reference to [paragraphs 10.1 to 10.8 of Chapter 10](#) of this Guide for details). Making report to the Police is not a pre-requisite for conducting medical examination.

Medical and Forensic Examination

10. For the procedures for medical/forensic examination, please refer to [Chapter 9](#) of this Guide.

11. When a child is suspected to be harmed/maltreated, the social worker responsible for initial assessment or child protection investigation may contact Hospital/Out-patient clinic of HA for arrangement of an assessment on the state of the child's health or development or the way in which the child has been treated if considered necessary. If the parents(s) do(es) not co-operate but the social worker responsible for initial assessment (if the social worker is from SWD) has reasonable cause to suspect the child is, or is likely to be in need of care and protection, Section 45A of the PCJO may be considered and invoked as needed. The social worker authorised by the Director of Social Welfare (DSW) may cause a notice to be served on any person having custody or control of such child or juvenile, requiring that person to produce the child or juvenile for an assessment by a medical practitioner, clinical psychologist or an approved social worker⁷ of the state of his/her health or development or the way in which the child has been treated (Section 45A(1)(a) of the PCJO). The social worker of SWD can contact the MCCA of the hospital concerned for necessary arrangement. Social worker of NGO who is responsible for initial assessment may contact FCPSU for discussing the suitability in invoking the PCJO (please refer to [Annex 15](#) to this Guide, "Ordinances Related to Child Protection Work" and Frequently Asked Questions in relation to the PCJO).

Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) and Follow-up Services

12. The medical officer attending the case should attend MDCC to formulate the follow-up plan of the child concerned. A written report on the child's condition should be prepared for facilitating discussion in MDCC (please refer to [Chapter 11](#) of this Guide). After MDCC, the medial officer should follow up the case in collaboration with other personnel according to the decision of MDCC and [Chapter 12](#) of this Guide.

⁷ An approved social worker refers to the social worker approved by the DSW to discharge the duty under Section 45A of the PCJO.

**Guidance For Paediatric Wards, Accident and Emergency Department
and Staff involved in Handling Child Maltreatment**

1. Inform Nursing Officer (NO)/Advanced Practice Nurse (APN).
2. Communicate with medical officer admitting the child suspected to be maltreated.
3. Check medical notes on what has been revealed to parents.
4. Record:
 - (a) Record as routine especially on emotional, behavioural and physical aspects of the child.
 - (b) Make careful note of all that is said to you by parents and carers.
 - (c) For suspected child sexual abuse cases:
 - (i) DO NOT examine the child on the area concerned.
 - (ii) DO NOT let the child's clothes be taken home.
 - (iii) DO NOT remove clothes when weighing, even if soiled.
5. Do not leave the child unattended at any time. The child must be accompanied by a member of the nursing staff.
6. Discuss with medical officer on future observations and care needed.
7. Check if MSW or the Police is informed.
8. Confidentiality and dignity of the child and his/her family must be addressed at all times.
9. Minimal questioning on the incident(s).
10. If the child is seen in the ward by the MSW or the Police, the child should be allowed to be accompanied by a family member or nurse he/she trusts.
11. Observe for any unusual behaviour and take note of what the child says. If there are any concerns or suspicions of any sort, report to NO/APN on-duty who will then bring it to the attention of the medical staff.

Members of Ward Team

Nurses, Ward Managers
Ward Stewards
Physiotherapists
Occupational Therapists

Teachers
Play Therapists
Ward Attendants
Health Care Assistants

Summary of Handling Procedures of Child Sexual Abuse Cases for Medical Officers

Initial encounter	Suspicion on Disclosed Incident	High suspicion	Medium suspicion	Low suspicion
Medical Officer				
Need immediate treatment	Consult MCCA or Refer hospital, AED or ward	Consult MCCA or Refer hospital, AED or ward	Consult MCCA or Refer hospital, AED or Ward	Consult MCCA or Refer hospital, AED or Ward
Immediate treatment not needed	Consult MCCA or Report to known case social worker/FCPSU/ or CAIU/ hospital	Consult MCCA or Report to known case social worker/FCPSU or CAIU/ hospital	Consult MCCA or FCPSU	Consult MCCA only

Always inform the most senior staff available immediately should there be any suspicion of sexual abuse so that they may in turn decide to consult the specialists on child maltreatment (MCCA).

AED

Need immediate treatment	Consult MCCA or Admit ward, then Consult MCCA and Report to known case social worker/FCPSU or CAIU	Consult MCCA or Admit ward, then Consult MCCA/ FCPSU or CAIU and Report to known case social worker/FCPSU or CAIU	Consult MCCA or Admit ward, then Consult MCCA and Report to known case social worker/FCPSU or CAIU if needed	Consult MCCA or FU after treatment, Consult MCCA as needed
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Initial encounter	Suspicion on Disclosed Incident	High suspicion	Medium suspicion	Low suspicion
Immediate treatment not needed	Consult senior, MSW, MCCA and Report to known case social worker/FCPSU or CAIU	Consult senior, MSW, MCCA and Report to known case social worker/FCPSU or CAIU FU in 2 week and Consult MCCA as needed	Consult senior, MSW, MCCA and Report to known case social worker/FCPSU or CAIU as needed FU in 2 weeks and Consult MCCA as needed	Consult senior, MSW, MCCA FU in 2 weeks and Consult MCCA as needed
SOPC				
Need immediate treatment	Consult MCCA or Admit ward, then Consult MCCA and Report to known case social worker/FCPSU or CAIU	Consult MCCA or Admit ward, then Consult MCCA and Report to known case social worker/FCPSU or CAIU	Consult MCCA or Admit ward, then Consult MCCA	Consult MCCA or Admit ward, then Consult MCCA
Immediate treatment not needed	Consult MCCA, Inform MSW and Report to known case social worker/FCPSU or CAIU	Consult senior, MSW and MCCA, Admit or FU in 2 weeks	Consult senior, MSW & MCCA, FU in 2 weeks or admit	Consult senior, MSW & MCCA, FU in 2 weeks

MCCA = Medical Co-ordinator on Child Abuse
AED = Accident and Emergency Department
FCPSU = Family and Child Protective Services Unit
CAIU = Child Abuse Investigation Unit

FU = Follow-up
MSW = Medical Social Worker
SOPC = Specialist Out-Patient Clinic

Annex 8: Roles of Child Psychiatry Service of the Hospital Authority

1. Suspected child maltreatment cases come to the notice of child psychiatry service through the following ways:
 - (a) consultations from other departments in the hospital;
 - (b) referrals to child psychiatry out-patient clinics; and
 - (c) during the course of treatment and assessment of patients not originally suspected to be victim of child maltreatment.

Child Psychiatry Service for Child Suspected to be Maltreated/Having Been Maltreated

2. Personnel in the child psychiatry service should be alert to the possible indicators of child maltreatment and should make reference to the “Possible Indicators of Child Maltreatment” in [Chapter 4](#) and “Risk Assessment and Decision Making on Protecting the Safety of Children” in [Chapter 7](#) of this Guide in handling these cases.
3. A comprehensive assessment of a suspected child maltreatment victim requires attention to the physical health and social circumstances as well as mental well-being of the child and 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 formulation of follow-up plan.
4. 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, on case merits, the alleged perpetrator.
5. Psychiatric examination should be co-ordinated with the physical, social and forensic assessment/management and should act in the best interests of the child concerned. This will require a close collaboration of the professionals from different disciplines.
6. Representatives of the child psychiatry service should be called upon:
 - (a) to conduct a comprehensive psychiatric assessment as soon as possible on the child suspected of being maltreated;

- (b) to screen psychiatric problems in the related family members if there is a cause for concern;
 - (c) to liaise with the investigating social worker and other professionals to share information of the suspected maltreatment incident(s);
 - (d) to participate in the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) and contribute to the formulation of follow-up plan and related arrangements for the child suspected of being maltreated and his/her family (please refer to [Chapter 11](#) of this Guide); and
 - (e) to provide psychiatric treatment to the child suspected of being maltreated and conduct assessment for his/her family when necessary. On offering psychiatric treatment to the child concerned and if it is foreseeable that the case may go to court, [Chapter 12](#) on “Follow-up Services for Child Protection Case” and [Annex 21](#) on “Counselling/Therapeutic Treatment before Court Hearing and after Maltreatment” should be adhered to.
7. Psychiatrist 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 child maltreatment may have happened. If the incident involves suspected sexual abuse, the psychiatrists should refer to [Annex 12](#), “Points to Note on Contacting Children Suspected to be Sexually Abused” and [Annex 13](#) “Guidance Notes on Reporting Suspected Sexual Abuse” to this Guide.
 8. Psychiatrist should share the result of clinical assessment and information regarding to the child concerned with the investigating social worker, police officer and Medical Co-ordinator on Child Abuse or medical social worker, and report in MDCC. Psychiatrist should proceed to the psychiatric treatment to the child and his/her family as clinically indicated.
 9. The List of Child Psychiatry Teams is at [Appendix 1](#) to this Annex.

Consent to Psychiatric Assessment

10. Psychiatrist working in hospital and out-patient clinic settings may receive enquiry or referral for treatment and/or assessment of suspected child maltreatment and/or associated psychiatric disorders. It is the responsibility of the referrer to ensure the child suspected of being maltreated and his/her parent(s)/guardian(s) agreed to the referral.

11. If the parents(s) does not co-operate but the social worker responsible for initial assessment or child protection investigation (if the social worker is from SWD) has reasonable cause to suspect the child to be or likely to be in need of care and protection, Section 45A of the PCJO can be invoked. The social worker as authorised by the Director of Social Welfare (DSW) may cause a notice to be served on any person having custody or control of such child or juvenile, requiring that person to produce the child or juvenile for an assessment by a medical practitioner, clinical psychologist or an approved social worker⁸ of the state of his/her health or development or the way in which the child has been treated (Section 45A(1)(a) of the PCJO). The social worker of SWD can contact the psychiatrist of the hospital/out-patient clinic concerned for necessary arrangement. Social worker of NGO who is responsible for initial assessment or child protection investigation can contact FCPSU for discussing the suitability in invoking the PCJO (please refer to [Annex 15](#) to this Guide, “Ordinances Related to Child Protection Work” and Frequently Asked Questions in relation to the PCJO).

⁸ An approved social worker refers to the social worker approved by the DSW to discharge the duty under Section 45A of the PCJO.

☎ List of Child and Adolescent Psychiatry Teams

Hospital	Corresponding Psychiatrists	Tel. No.
1. Tuen Mun Hospital	Dr S.M. Lam	2468 6411
2. Alice Ho Miu Ling Nethersole Hospital	Dr Flora Mo	2689 2544
3. Queen Mary Hospital	Dr Chan Kwok-ling, Phyllis	2255 3656
4. Kwai Chung Hospital	Dr Tang Chun-pan	2384 9774
5. United Christian Hospital	Dr Lam Wai-chung	3949 4888

Annex 9: Roles of Clinical Psychological Service

Suspected Child Sexual Abuse

1. Clinical Psychologists (CPs) working in hospitals or clinics under either the Hospital Authority (HA) or the Department of Health (DH) and those working in the Social Welfare Department (SWD)/non-governmental organisations (NGOs) should handle the suspected child sexual abuse cases as described in the following situations :

- (a) Suspected sexual abuse is disclosed by the child during the course of treatment and/or assessment

CPs may sometimes come across children who are referred for treatment and/or assessment because of their behaviour and emotional problems. While working with these children, 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 [Chapter 4](#) of this Guide on “Possible Indicators of Child Maltreatment”, as well as [Annex 12](#), “Points to Note on Contacting Children Suspected to be Sexually Abused” and [Annex 13](#) “Guidance Notes on Reporting Suspected Sexual Abuse” to this Guide under such situations. Subject to the child’s situation, the CP should inform the Medical Co-ordinator on Child Abuse (MCCA)/medical officer, doctor-in-charge of the clinic as well as the medical social worker (MSW)/referring social worker concerned.

The CP or personnel of hospital/clinic or referring social worker should follow procedures as set out in [Chapter 4](#) of this Guide to collect basic information in order to report the case to responsible social worker of the known case (if any) or Family and Child Protective Services Unit (FCPSU) of SWD. Please refer to [Annex 2](#) to this Guide for points to note on the information sharing among the personnel during information collection and the reporting process.

- (b) When a child suspected to be sexually abused has emotional distress

If the child suspected to be sexually abused is found to have serious emotional distress during the investigation process and is in need of

urgent support, medical officer or investigating social worker may refer the child to CP for psychological assessment.

- (c) When the child suspected to be sexually abused cannot provide information/details of the incident(s) to the investigating personnel

When the child suspected to be sexually abused cannot provide information/details of the incident(s) to the investigating personnel but shows emotional distress, the medical staff/investigating social worker may consider referring the child for psychological assessment and treatment. If the child is ready to disclose the information/details of the incident(s) in later stage, the CP concerned should follow the procedures as stipulated in [paragraph 1\(a\)](#) above.

Other Forms of Suspected Maltreatment

2. If a child is suspected to have other forms of maltreatment during the course of psychological assessment and/or treatment, the CP should, subject to the child's situation, inform the MCCA/medical officer, doctor-in-charge of the clinic as well as the MSW/referring social worker concerned. The CP or personnel of hospital/clinic or referring social worker should follow procedures as set out in [Chapter 4](#) of this Guide to collect basic information for reporting the case to responsible social worker of the known case (if any) or FCPSU. Please refer to [Annex 2](#) to this Guide for points to note on the information sharing among the personnel during information collection and the reporting process. The CP should work closely with the investigating social worker in the course of investigation and continue to provide treatment service to the child and his/her family as appropriate.

Involvement of Clinical Psychologist in Investigation Process and Follow-up Services

3. Depending on case nature and need, the CP concerned may be asked to provide case information to facilitate the strategy planning in the course of investigation. Government CP will also be involved in video-recorded interview (VRI) with the child witness, immediate case assessment and Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC).
4. If the CP has direct knowledge on the child and his/her family and has a major role in the service provision for and investigation of the suspected child maltreatment case, he/she will be invited to attend MDCC. Under certain

circumstances that psychological harm/abuse is suspected, CP may be invited to attend MDCC to provide professional views in order to facilitate discussion of the nature of incident, risk and need assessments, category of case and formulation of follow-up plan, despite that no CP service is involved in the investigation or handling of the case. The roles of CP and arrangement of CP service are in accordance with [Chapter 11](#) of this Guide.

5. After conducting VRI with the child concerned and MDCC, the investigating social worker/key worker will, subject to the need/recommendation of MDCC, arrange the maltreated child/child suspected to be maltreated to receive psychological assessment and/or treatment. CP should, in accordance to [Chapter 12](#) of this Guide, collaborate with other personnel involved in the case follow-up. If it is foreseeable that the case may go to court, [Chapter 12](#), “Follow-up Services on Child Protection Cases” and [Annex 21](#), “Counselling/Therapeutic Treatment before Court Hearing and after Maltreatment” should be adhered to.
6. When a child is suspected to be harmed/maltreated, the social worker responsible for initial assessment or child protection investigation may contact CP for arrangement of an assessment on the child’s health, development or the way in which the child has been treated, if he/she considers that necessary. If the parent(s) do(es) not co-operate but the social worker responsible for initial assessment (if the social worker is from SWD) has reasonable cause to suspect that the child is or likely to be in need of care and protection, Section 45A of Protection of Children and Juveniles Ordinance, Cap 213 (PCJO) can be invoked. The social worker authorised by the Director of Social Welfare (DSW) may cause a notice to be served on any person having custody or control of such child or juvenile, requiring that person to produce the child or juvenile for an assessment by a medical practitioner, clinical psychologist, or an approved social worker⁹ of the state of his/her health or development or the way in which the child has been treated (Section 45A(1)(a) of the PCJO). Social workers of SWD can contact CP of hospital/clinic/SWD/NGO concerned for necessary arrangement. Social workers of NGO who is responsible for initial assessment can contact FCPSU for discussion on the suitability in invoking the PCJO (please refer to [Annex 15](#) to this Guide, “Ordinances Related to Child Protection Work” and Frequently Asked Questions in relation to the PCJO).

⁹ An approved social worker refers to the social worker approved by the DSW to discharge the duty under Section 45A of the PCJO.

Division of Work Between Clinical Psychologists in Medical and Social Welfare Settings

7. The division of work between CPs in medical and social welfare settings in providing psychological assessment and treatment is generally according to the following guiding principles¹⁰ :
 - (a) when the child suspected to be maltreated is an in-patient of the hospital, the CP of HA will provide psychological service as needed during the child's hospitalisation;
 - (b) for hospitals or clinics or NGOs with no clinical psychologist, the child should be referred to SWD for service;
 - (c) if a child who is suspected to be maltreated is attending regular psychological follow up service from the CP of HA/DH/SWD/NGO before disclosure of the maltreatment, it is preferable for him/her to continue to receive psychological service from the CP concerned; and
 - (d) the child's wish should be considered when considering where to refer.

8. As stated in the Criminal Procedure Ordinance, Cap 221, only government CPs can be involved in the VRI with child witnesses.

¹⁰ The division of work between CPs in medical and social welfare settings in providing psychological assessment and treatment is decided by the Senior Clinical Psychologists of HA and SWD, and CPs of NGOs. The agreement has been stated clearly on two related papers, "Guideline on Provision of Clinical Psychological Service between HA and SWD" and "Summary of Agreements on Clinical Psychological Support for IFSCs".

Annex 10: Role of Educational Services

(Kindergartens, Kindergarten-cum Child Care Centres, Primary Schools, Secondary Schools and Special Schools)

Governing Principles

1. To protect the safety and best interests of children (students), all kindergartens (KGs), kindergarten-cum-child care centres (KG-cum-CCCs), primary schools, secondary schools and special schools should observe this Guide and the relevant guidelines/circulars/codes of practice issued by the Education Bureau (EDB)/the Social Welfare Department (SWD) in establishing or enhancing schools' internal mechanism, procedures and measures, so as to prevent child maltreatment incidents and handle suspected child maltreatment cases properly and provide appropriate assistance to the children and their families in need. The school should ensure that the mechanism and procedures are transparent and recognised, so that they can be implemented effectively in future.
2. In handling suspected child maltreatment cases, the paramount concern is the safety and best interests of the child. School personnel (e.g. principal, teachers, Student Guidance Officers/Personnel, School Social Workers (SSWs), etc.) should be constantly alert to possible indicators of maltreatment of the students for early identification and immediate intervention so as to avoid further harm or even death of the students. During or after investigation, school personnel should pay attention to the safety and emotional needs of the student concerned in the school and render necessary assistance to help him/her resume normal school life.
3. School personnel may refer to [Chapter 2](#) "Definition and Types of Child Maltreatment" and [Chapter 4](#) of this Guide on "Possible Indicators of Child Maltreatment" to identify children who may have been maltreated. Attention should also be paid to the relevant procedures as set out in the EDB Circular "Handling Suspected Cases of Child Maltreatment and Domestic Violence" (the circular can be found using the following link: <https://applications.edb.gov.hk/circular/circular.aspx?langno=2>). KGs and KG-cum-CCCs participating in SWD Pilot Scheme on Social Work Service for Pre-primary Institutions should also refer to the relevant procedures as set out in the "Reference Guide on Operational Matters related to the Pilot Scheme on Social Work Service for Pre-primary Institutions" issued by SWD on the Scheme.

4. In gist, if school personnel have reasons to believe that a student has been maltreated or is at risk of maltreatment, the first personnel in contact with the student should inform the principal and consult Student Guidance Officer(s)/Teacher(s)/Personnel and SSW(s). In handling suspected child maltreatment cases, school personnel must not conceal the incident or delay its report.
5. The school should activate its school-based contingency mechanism/Crisis Management Team and assign SSW (if any) and designated personnel (e.g. principal, senior teacher, designated teacher, Student Guidance Officer/Teacher/Personnel) to handle suspected child maltreatment cases. During the handling process, care should be taken to avoid having the child repeated description of the maltreatment incident.
6. For KGs, KG-cum-CCCs and schools without a Crisis Management Team or school guidance personnel/SSWs, the principal should assign designated personnel (e.g. principal, senior teacher or designated teacher) to handle suspected child maltreatment cases.

Confidentiality

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 maltreatment cases. The information collected with regard to the suspected maltreatment incidents should be shared on a need-to-know basis with relevant parties concerned (e.g. principal, the responsible social worker and the Police) as soon as possible.
8. All records should be kept centrally by the principal/designated personnel. Access to these records within the school must be restricted and recorded. On no account should these records be kept with the general records of the student concerned. Should the parent(s) of the student request for access to information, it should be handled in accordance with the Personal Data (Privacy) Ordinance (please refer to [Annex 2](#) to this Guide).

Reporting and Investigation

9. When a student is suspected to have been maltreated, designated personnel can make a preliminary enquiry of the conditions of the student (please refer to [Annex 11](#), “Points to Note on Initial Contact with Children Who may have been Harmed/Maltreated or Their Parents”). If the case of the student is not one

followed up by SSWs but designated personnel know that the student or his/her family is a “known case” of SWD or a non-governmental organisation (NGO), the school should inform the responsible social worker of the unit concerned as soon as possible for an initial assessment.

10. If the student or his/her family is not a “known case” of SSWs, SWD or NGOs, report should be made to the Family and Child Protective Services Unit (FCPSU) of SWD in office hours (contact information of FCPSUs is listed in [Appendix 1 to Chapter 4](#)). Schools should provide information of the student for the social worker of FCPSU to conduct an initial assessment. For reports on suspected child maltreatment cases outside office hours, they could be made through SWD Hotline¹¹(Tel. No. 2343 2255). The personnel on duty will contact Outreaching Team of SWD for conducting an initial assessment.
11. The SSWs of individual secondary schools should follow through the procedures as set out in [Chapters 4 to 10](#) of this Guide when handling their “known cases” of which child maltreatment is suspected. Social workers of non-secondary schools, if necessary, may also report their “known cases” to FCPSU for conducting initial assessment (please refer to [Chapter 4](#) of this Guide for details). School designated personnel may also, as necessary, consult the social worker of FCPSU first.
12. If the Student Guidance Personnel of KGs, KG-cum-CCCs and primary schools is a registered social worker employed by an NGO, he/she may also take up the role of conducting initial assessment and child protection investigation for their “known cases” as set out in [Chapters 4 to 8](#) of this Guide, subject to mutual agreement of the school, the NGO and SWD.
13. While a report of a suspected child maltreatment case is made by the school to a unit responsible for the “known case”/FCPSU/ Outreaching Team of SWD, the school should also discuss with the social worker of the unit/FCPSU/ Outreaching Team of SWD on whether immediate actions are to be taken to protect the child. Designated personnel should also inform the parent(s)/guardian(s) about the report. However, if the parent(s)/guardian(s) is/are involved in the child maltreatment, the school does not have to obtain the prescribed consent of the student’s parent(s)/guardian(s) to making the report. For the use of the personal data (including invoking **special exemption provisions** on information disclosure and transfer), please refer to [Annex 2](#) to

¹¹ Departmental Hotline Service operates 24-hours a day. The hotline service is manned by Departmental Hotline Service Unit of SWD from 9:00 a.m. to 5:00 p.m. for Monday to Friday and 9:00 a.m. to 12:00noon on Saturday (excluding Public holidays). Calls received outside the above operating hours are handled by the Hotline and Outreaching Service Team operated by the Tung Wah Group of Hospitals.

this Guide. If it is necessary for the school to contact the parent(s)/guardian(s) during the assessment, advice or assistance may first be sought from the social worker of the unit concerned/FCPSU regarding the handling approach (please also refer to [Annex 11](#), “Points to Note on Initial Contact with Children Who may have been Harmed/Maltreated or Their Parents”).

14. If the school considers that the student is likely to be in urgent need of medical service, arrangement should be made for the student to undergo medical examination/treatment in a public hospital. FCPSU may also assist in contacting Medical Co-ordinator on Child Abuse of the Hospital Authority so as to arrange for admission of the child into a hospital for medical examination. Please refer to [Chapter 6](#) of this Guide for details. If necessary, police assistance may be sought.
15. In circumstances that suggest a criminal offence may have been committed, the case should be reported to the Police to protect the safety and interests of the student concerned. Under no circumstances should the student suspected to have been maltreated be required to make a report in person at a police station. In non-urgent cases, the school may complete a Report Form (see [Appendix 4 to Chapter 10](#) of this Guide) and Written Dated Notes (see [Appendix 5 to Chapter 10](#)) for reporting the case to the Child Abuse Investigation Unit (CAIU) and for the Police to arrange for investigation by a suitable unit. FCPSU may assist in forwarding the Report Form to CAIU. (Regarding the procedures of reporting to the Police, please refer to the [paragraphs 10.2 to 10.8 in Chapter 10](#) of this Guide).
16. If the case is serious, or if the personal safety/life of the student is under immediate threat and instant action has to be taken (e.g. serious physical abuse), the school has to call the Police for reporting the case as soon as possible. Concealing the incident or delayed report may pose safety threat to the child concerned or other people.

Handling of Child Sexual Abuse Cases

17. For suspected child sexual abuse cases, whether or not the student attends school as normal, school personnel should handle the cases with reference to [Annex 12](#) “Points to Note on Contacting Children Suspected to be Sexually Abused” and [Annex 13](#) “Guidance Notes on Reporting Suspected Sexual Abuse” to this Guide.

18. Given the relative complexity and sensitive nature of cases where the alleged perpetrator is a family/extended family member of the child, or a person being entrusted to take care of the child, or if a number of child victims are involved, the school should call FCPSU before contacting the parent(s) for discussing the appropriate handling approach. Social worker of FCPSU will contact CAIU of the Police for a joint investigation. If in doubt, the school may seek advice or assistance from the School Liaison Officer of the Police or social workers of FCPSU.
19. In handling child sexual abuse cases where the alleged perpetrator is a staff member of the school, principals of the secondary schools, primary schools, special schools and kindergartens should inform the School Development Officer of the respective Regional Education Office of the EDB of the incident(s). For KG-cum-CCCs, their principals should inform the Joint Office for Kindergartens and Child Care Centres of the EDB (please refer to the relevant EDB circular in use for the procedures in handling child sexual abuse cases involving school staff as alleged perpetrators) .
20. Apart from taking appropriate protective actions for the student suspected to be maltreated, the principal should also step up measures to ensure the safety of other students in the school. For implementation of the relevant procedures, please also refer to [Chapter 13](#) of this Guide, “Handling of Child Maltreatment Allegations against Staff, Carers and Volunteers of Organisations”.

Multi-Disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC)

21. An MDCC will be convened by the unit responsible for child protection investigation so as to formulate a follow-up plan for the student concerned. The school personnel concerned should attend MDCC and prepare a written report for facilitating discussion in the conference. The report may include the student’s academic and behavioural performance, emotional state in the school, parental attitude and any previous incident(s) of suspected maltreatment. If members of MDCC consider it necessary, school personnel may be invited to join the core group for a joint follow-up of the case (please refer to [Chapter 11](#) of this Guide).

Collaboration with Other Parties Involved in Handling the Cases

22. If a case is categorised as a child protection one and the student concerned continues to attend school, the school should keep keen observation on the

student's academic/behavioural performance and emotional state, and keep the key worker or other follow-up personnel informed of the student's condition and development. Collaboration should be continued to provide assistance to the student and his/her family (please refer to [Chapter 12](#) of this Guide).

Annex 11: Points to Note on Initial Contact with Children Who may have been Harmed/Maltreated or Their Parents

If it is suspected that a child may have been harmed/maltreated, for example because of the discovery of such bodily/behavioural/emotional/environmental indicators as mentioned in [Chapter 4](#) of this Guide, or that the incident is disclosed by the child himself/herself, or by others (e.g. the family member of the child or a member of the public), personnel have to collect the information necessary for understanding the case and making initial assessment.

Initial assessment is usually made by social workers. However, if other professionals have to contact the child who may have been harmed/maltreated or his/her parents, this annex may also serve as a reference.

When making an initial assessment, apart from meeting/contacting the child and his/her family members directly, personnel may have to observe the care and development of the young child or his/her home condition as well. Different cases will warrant different handling in considering the way to collect information and the amount of information to be collected. The following are the points to note.

If the incident involves suspected sexual abuse of a child or is of a special nature, special attention should be given to posing questions to the child and contacting the parent not being involved in the suspected abuse/harm to the child.

If necessary, consultation can be made with the Family and Child Protective Services Unit of the Social Welfare Department (SWD) for discussing a better arrangement.

(1) Meeting with or contacting the child

Unless the incident is first disclosed by the parent(s), personnel should make every effort to meet with or contact with the child who may have been harmed/maltreated so as to collect the necessary information before discussing the incident with the parent(s). When talking to the child, attention should be paid in making the child feel safe and being respected.

To avoid the need for the child to give an account of similar matter to different personnel, once the child has disclosed an incident of being harmed/maltreatment to a personnel, it would be better for the same personnel to collect other relevant information from the child. Personnel responsible for initial assessment should ask those who know about the case and, if not necessary, should not question the child repeatedly.

- (a) Objectives (may include all or part of the following)
 - (i) Find out whether the child has been harmed/maltreated and his/her conditions
 - (ii) Find out the relation between the child and his/her family members, and between the child and the alleged perpetrator, including whether family members know the incident, and who in the family can protect and help the child
 - (iii) Observe and understand the emotions and behaviours of the child
 - (iv) Make an initial assessment of the severity and urgency of the incident, risk level of further harm/maltreatment to the child, and the assistance the child and his/her family members may currently need
 - (v) If subsequent action will be taken in protecting the child or in investigation, especially if such an arrangement may affect the daily living of the child or induce anxiety/insecurity to the child, personnel should explain to the child and seek his/her views before taking actions to show respect for him/her, and reduce the child's worries about the unknown
- (b) Arrangements
 - (i) Talk to the child in a safe and an undisturbed environment, perhaps in the presence of an adult whom the child trusts and knows well for supporting the child
 - (ii) If the child is disabled/has special needs/uses a different language or has a different cultural background, etc., proper arrangements should be made to facilitate the child to express himself/herself. Special attention has to be paid if interpretation service is arranged. An appropriate person should be arranged for providing interpretation service (including sign language). It is inappropriate to arrange a family member, relative, friend or an acquaintance of the child to act as the interpreter
 - (iii) Taking into account of the relation between the child and the alleged perpetrator, and the sensitive nature of the incident (e.g. intra-familial sexual abuse), advance planning should be made as to the mode of meeting/contact with the child to avoid the child's refusal of disclosing the incident for whatever reasons
 - (iv) Even if the child requests not to disclose the incident to other people,

personnel should, instead of giving any promise to the child, explain that the case need to be handled jointly with other personnel for the protection of his/her safety. However, it can be made clear to the child that except when disclosure is necessary, information will be kept confidential as far as practicable

- (v) The child having been harmed/maltreated may worry about the consequences of disclosing the incident, such as facing even more serious violence or psychological harm, criminal investigations of his/her family members, etc., and conceal it instead. Some children of ethnic minorities may also appear withdrawn or reluctant in disclosing the incident as being influenced by their cultural background. Personnel therefore have to remain sensitive. If the child expresses any worries or anxieties, assistance should be given to him/her as far as possible to ease his/her worries. The child should also be encouraged to disclose the incident by helping him/her understand the importance of disclosure in preventing him/her from further harm. If it is observed that the child may be concealing facts or found that the explanation of the causes/course of injury is unconvincing/contradictory to or inconsistent with the injuries sustained, personnel should probe into the incident by using appropriate skills or they may also explore the child's situation through persons who have more contact with the child (e.g. other family members, classmates, etc.)
- (vi) If the child says that he/she has a physical injury but the situation appears not urgent or consent has been obtained from the parents or/and the child (e.g. consent has been given by the parents for child care worker to conduct a physical examination of the child, or the child agrees to roll up his/her sleeves to show the injury to the personnel), it will be appropriate for medical staff to conduct an examination of the child
- (vii) If the child denies any information he/she disclosed about the incident, personnel should clarify with the child and find out the reason(s). If there are reasons to believe/suspect that the incident did happen, personnel should continue with the necessary assessment and action in child protection

(c) Questioning

- (i) When trying to find out more about the incident from the child, attention should be paid as to how a question is put and how much detail is asked for. As the child may have to undergo a formal interview for statement-taking later arranged by the Police, personnel should avoid requiring the child to repeat the process of harm
- (ii) At the stage of initial assessment, **it is not necessary to ask for the details of the incident, especially when it involves sexual abuse.** However, if the child discloses the details of his/her own accord, he/she should not be stopped from doing so
- (iii) Use words and ask questions that are comprehensible to the child. Keep the questions as simple and clear as possible

- (iv) Ask open questions and let the child disclose the incident using his/her own words at his/her own pace. For examples, “Tell me what happened.” or “Tell me the incident from beginning to end.” If necessary, say “What’s next?” to encourage the child to continue disclosing the incident. Do not ask questions hastily

- (v) When the child says he/she has finished telling the incident but the personnel needs to clarify or ask more questions about the basic information of the incident, the personnel could, according to the ability and comprehension capability of the child, ask the following open questions:
 - What happened?
 - When did it happen?
 - Where did it happen?
 - Who was involved?
 - How did it happen?

- (vi) When personnel clarify or ask more questions, attention should be paid to the following:
 - Do not ask any leading questions (i.e. questions containing information that the child has never mentioned and that is assumed or guessed by the personnel)
 - Although some children may not be able to express themselves clearly in speech, personnel should not at this stage take the initiative to use any tool/pictures/toys, etc. to help the children express themselves because these things are suggestible. Even if the child draws a picture or uses other tools for expression on his/her own initiative, caution should be taken to clarify and interpret the meaning of the picture/behaviour of the child
 - Do not comment on or blame the child or his/her family member(s)/the alleged perpetrator lest the child becomes reluctant to further disclose the incident or co-operate with the personnel. Personnel should note that the child and his/her family member(s)/the alleged perpetrator may all along have a good relationship
 - Do not ask questions with “why?” so that the child will not feel being blamed
 - Do not change the words used by the child, especially those used in describing the incident, so that the child will not be confused
 - Do not repeat the same question. Young children may think their answers are not considered correct and change them subsequently leading to inaccurate information given instead. If clarification is to be made, personnel can ask questions in another manner, or tell the child that there are parts of information the personnel does not understand/hear clearly, to invite the child to describe in detail

(d) Record

Record exactly what the child says and what the personnel has said in response, mark the date on the record and have it properly kept.

(2) Observe the care and development of young children

If the child is young or not good at verbal expression, personnel shall observe the growth and development of the child and the subtle childcare skills of the parents during home visits or other occasions for initial assessment. Personnel may ask parents to let them get in touch with the child and to describe the details of their care of the child, including the following in particular:

- (a) Daily care and arrangement of the child by the parents/carers, e.g. diet arrangement, sleep arrangement, healthcare/medical care, personal care, home safety, etc.
- (b) Motor ability and development of the child
- (c) Emotions and behaviours of the child
- (d) Relationship and interaction between the parents/carers and the child
- (e) How the parents/carers handle the emotional and behavioural problems of the child

Reference may be made to the “Manual of Parenting Capacity Assessment Framework” (for aged 0 to 3) jointly developed by the Department of Health, the Hospital Authority and the Social Welfare Department.

(3) Observe the home conditions

If personnel have the opportunity or need to pay a home visit, they should observe the home environment for collecting the following information:

- (a) Home sanitary conditions
- (b) Home safety, such as whether window grilles have been installed and locked, sharp objects are properly stored, electrical appliances and sockets are safely positioned, etc.

(c) If carers or other family members are drug abusers, special attention has to be paid to the place of storage of suspected dangerous drugs or drug-taking equipment, the methods by which the carers abuse the drugs, etc.

(4) Contact with the parents

If it is the child who first disclosed the incident to the personnel or if the personnel learnt it from inquiring the child, advice may better be sought from the personnel responsible for initial assessment or investigation when considering the time to and way of contacting the parents so that such contact can be made properly.

If the incident disclosed by the child involves **sexual abuse between family members/relatives**, considering the complexity and sensitive nature of the incident and the possible impact and stress arising response of family members on the child being abused, personnel should **contact FCPSU of SWD as soon as possible** and discuss the case handling approach before contacting the parents, including when to contact the Police, which family member should be contacted first for supporting the child, how and when to contact the parent(s) who is/are believed not to have been involved in the sexual abuse, etc.

(a) Objectives

- (i) Find out whether the child has been harmed/maltreated and his/her conditions
- (ii) Obtain a preliminary understanding of the conditions and needs of the family
- (iii) Explain to the parents the concern of the personnel and learn about the views of the parents on the incident
- (iv) If it is believed that a child may have been harmed, assessment should be made as to the severity, urgency, risk level of further harm on the child, and the assistance the child and his/her family members may currently need
- (v) Explain to the parents the results of initial assessment, the actions or follow-up work to be taken, and discuss with them about the ways of handling the case

(b) Arrangements

- (i) To safeguard the best interests of the child, consideration should be given as to which parent is more suitable to contact first according to the circumstances of individual cases (e.g. the parent not being involved in harming the child, the parent

with custody or care of the child in a separated/divorced family, the parent who is the first to disclose the incident, etc.). With regard to the child of a separated/divorced family, contact should be made as far as possible with the parent having custody of the child when making a decision about the care arrangement of the child

- (ii) Discussion with the parent(s) alone should be considered. If the parents and the child are to be interviewed jointly, assessment should first be made as to the impact it might have on the child
- (iii) Depending on the circumstances of the case, personnel should show concern and understanding of the difficulties of parents in parenting/taking care of the child. Personnel should explain to the parents that they need to co-operate with the personnel who will assist them in making use of their own strengths and resources to handle the problems properly without delay in order to ensure the physical and psychological safety of the child and to avoid recurrence of similar problems or more serious consequences
- (iv) If there are reasons to believe that the physical or psychological development of the child has been endangered or impaired because of the behaviour or neglect of the parent(s)/carer(s), personnel should explain to the parent(s) the actions to be taken and the procedures involved. Personnel should obtain as much co-operation from the parents as possible by emphasising that these actions are to protect the safety of the child and safeguard his/her interests, and are not intended for blaming the parent(s)/carer(s) or opposing them
- (v) If the parents disagree with the planned actions to be taken by the personnel, they should be explained about the personnel's responsibilities in child protection and the handling procedures of suspected child maltreatment cases. If the social worker of SWD consider it necessary to invoke "Protection of Children and Juveniles Ordinance", Cap 213, for child protection action, he/she should explain to the parents his/her scope of duties/authority and the related procedures
- (vi) If interpretation service for the parents is required, an appropriate person should be arranged for providing interpretation service (including sign language). It is not advisable to arrange a family member, relative, friend, an acquaintance or the child concerned to act as the interpreter

Annex 12: Points to Note on Contacting Children Suspected to be Sexually Abused

If a child talks about something which makes you believe/suspect that sexual abuse may have taken place, [Annex 11](#), “Points to Note on Initial Contact with Children Who may have been Harmed/Maltreated or Their Parents” should be referred to and attention should be paid to the following:

- (1) Listen to what the child says. Be comforting and sympathetic. Ensure that the child feels as little responsibility as possible for the incident. Tell the child that you appreciate that he/she has told you the incident and this should help you make him/her safe. (It will be helpful in supporting the child if another adult whom the child trusts is present).
- (2) Do not make the child tell anyone else because he/she may have to be formally interviewed for investigation later. It is important to minimise the number of times information is repeated.
- (3) Do not promise to keep the information secret. Make it clear to the child that you will have to refer the matter to the relevant professionals later on.
- (4) It is particularly important not to enquire the child about the process of the suspected sexual abuse incident using leading questions or make any suggestions to the child regarding the incident or comment on the incident. Personnel may ask in the following manner: “You said your uncle touched you. What do you mean?”, “You looked so worried when you told me your father slept in your bed. Please tell me more.”, “You said your grandfather peeped at you when you were in the bathroom. Please tell me the whole thing.” or “You behaved in a strange manner during the sex education class. Is there anything that is bothering you?” Do not question the child about the details of the incident except to clarify what they are saying and do not stop a child who is freely recalling significant events.
- (5) Personnel should collect information to ascertain if there are reasons to believe/suspect an occurrence of a sexual abuse incident and the identity of the alleged perpetrator yet exploration of the details of the incident is not necessary. Exploration of the identity of the alleged perpetrator is not a must at this stage if the child is unable or unwilling to disclose it.
- (6) Personnel need to enquire the child about the time that the incident occurred (the earliest and the most recent time), frequency of the incident and whether it

is likely for him/her to be in contact with the alleged perpetrator. If the incident happened recently or the child is in frequent contact with the alleged perpetrator, personnel are required to provide immediate intervention. If the incident concerns an event of some years ago or even longer, personnel may need to ask for more information, e.g. whether the child can identify the alleged perpetrator, whether the alleged perpetrator is still at large, any other person is aware of the incident and his/her response(s), etc.

- (7) Do not assume that the parent/carer of the child concerned is not involved in the suspected sexual abuse incident. Report to the social worker of Family and Child Protective Services Unit (FCPSU) or police officer of Child Abuse Investigation Unit (CAIU) who will advise you what steps they will take and what information, if needed, you may give to the parents at this stage. If the child has to return home (e.g. at the end of the school day) or is at risk of further abuse, social worker of FCPSU and/or police officer of CAIU should be informed as soon as possible for him/her/them to take necessary action.
- (8) Bear in mind that if the parent/carer of the child concerned is said to be involved in the suspected sexual abuse incident and knows that the child has told someone about the incident, he/she may threaten or put pressures on the child to prompt the child to recant.
- (9) Record exactly what the child says and what you have said in response. Sign and date what you have written

Annex 13: Guidance Notes on Reporting Suspected Sexual Abuse

1. The following are guidance notes on when the personnel should report a suspected child sexual abuse case and how much information is needed for the report. Some suspected child sexual abuse cases will be jointly investigated by Child Abuse Investigation Unit of the Hong Kong Police Force and Family and Child Protective Services Unit (FCPSU) of the Social Welfare Department. For the cases handled through joint investigation, please refer to [paragraphs 10.4 to 10.5 of Chapter 10](#) of this Guide. Extreme caution should be exercised when handling these cases which are complicated and serious in nature.
2. When a suspected child sexual abuse incident is disclosed by a reasonably credible source, personnel should handle the case according to [Chapter 4 and 5](#) of this Guide and note the following:
 - (a) To decide whether the source of information is reasonably credible, personnel may have to ask a little more about the suspected sexual abuse incident by clarifying who is the child suspected to be abused (when the child suspected to be abused is not the source of information), what has happened and when it happened. If the child is to be enquired about the above information, reference should be made to [Annex 11](#), “Points to Note on Initial Contact with Children Who may have been Harmed/Maltreated or Their Parents” and [Annex 12](#), “Points to Note on Contacting Children Suspected to be Sexually Abused”.
 - (b) It is preferable but not a must that the child suspected to be abused is ready to make a disclosure to social worker or the Police.
 - (c) While probing a suspected child sexual abuse incident, bear in mind whether a criminal offence might have been committed. A sexual crime such as rape, indecent assault, incest, etc. is commonly understood to be a criminal offence but there is behaviour which may be sexual abuse but not criminal in nature. Personnel are **not required** to determine if the act is criminal when deciding whether to make a report or not. Even if the Police will not follow up on a case, FCPSU or a social worker handling the child/family case will conduct the required child protection investigation.
3. In most circumstances, disclosures in child sexual abuse cases begin with a vague or non-specific complaint. In considering the course of action to be

taken to protect a child, it is important to assess the case situations brought to light by a disclosure.

- (a) The following situations indicate that there are reasons to believe/suspect an occurrence of a sexual abuse incident. Report to suitable unit is required after collecting basic information. For suspected sexual abuse incident between family members or involving multiple victims, considering the complexity and sensitive nature of the incident, and the possible impact and stress arising from the family members' responses on the child being abused, reporting personnel/social worker of the known case should contact FCSPU as soon as possible and discuss the case handling approach with the social worker of FCPSU, including when to contact the Police, which family member should be contacted first for supporting the child, how and when to contact the parent(s) who is/are believed not to have been involved in the sexual abuse incident, etc.
- (i) Any disclosure by a child to personnel that he/she has been sexually abused, such as:
- “My daddy fondled my breast/private part” or “indecently assaulted me”
 - “Uncle made me suck his dick” or “raped me”
 - “so-and-so put a finger into my pussy and it hurts”
- (ii) Presence of physical evidence of sexual abuse on children, such as sexually transmitted disease, pregnancy, swelling/bleeding of sexual organ, etc.
- (b) The following situations indicate that sexual abuse may have happened but more concrete information is needed. If the child/family is a known case of casework service unit of SWD or a subvented NGO, contact with the social worker of that unit may be considered to decide who and how will be suitable to collect the more concrete information. If the child/family is not a known case of casework unit of SWD or a subvented NGO, personnel in contact with the child/informant should collect basic information of the incident (please refer to [Annex 11 and 12](#)). If there are reasons to believe/suspect an occurrence of a sexual abuse incident, personnel should handle the case in accordance with [paragraph 3\(a\)](#) above. If difficulty is encountered in collecting the information, case may be first reported to FCPSU for initial assessment. Safeguarding the child's safety and best interests should be accorded priority in the course of case

handling. It is advised to avoid asking leading questions, asking details of the incident repeatedly and re-traumatising the child. If needed, personnel may consult FCPSU for advice.

(i) Child exhibiting sexualised behaviour including excessive masturbation, talking about sex with relatively older people or having sexual knowledge beyond what would be expected for his/her developmental stage, etc., such as:

- a 6-year-old girl drew a picture of a man with an erected penis
- a 5-year-old boy took off the panties of his playmate to play games of a sexual nature
- a 5-year-old girl invited playmate(s) who is/are the older boys in the play group to touch her genitalia
- a 6-year-old boy told his friends that his uncle got a long “dick” that can squirt

(ii) Any disclosures by a child to personnel, or through an individual, about an incident or incidents that may arouse suspicion that sexual abuse might have occurred, such as:

- a 13-year-old girl reported that “daddy slept in my bed last night”
- an 8-year-old girl said, “my private tutor kissed me after the lesson”
- a 10-year-old girl stated, “I saw daddy playing games with auntie”
- a 12-year-old girl disclosed to her classmate that her brother watched dirty movies at home
- a 11-year-old girl reported that her step-father peeped her at bath
- a student reported to the school social worker that a 13-year-old female classmate was spanked on her bare bottom by her father as a form of punishment

(iii) A child reporting a “story” or an incident or incidents of sexual abuse that happened to another child without revealing the identity of the child(ren) suspected to be abused, such as:

- “I know a girl who was indecently assaulted by her father”

- a teenage girl wrote a story describing an incident or incidents of sexual abuse but claiming it to be fictitious
 - a child seemed to get interested in the subject of sexual abuse and asked a lot of questions about it but without saying why
- (iv) A report of suspected sexual abuse making to an organisation by an informant who is not involved in the incident but the nature of the allegation is vague and non-specific, such as:
- a neighbour reported that the mother of the family living next door had deserted home, leaving behind the father and a teenage daughter. He/she suspected that something was going on between the father and the daughter
 - a domestic helper reported that her male employer took his 8-year-old daughter inside the toilet and stayed there for over half an hour. She suspected the father might have done something “bad” to the girl
 - a separated couple with the mother who has custody over their 2-year-old daughter complained that her husband molested the child during access but without any supporting evidence
- (v) Any individuals making a report to an organisation claiming that he/she has witnessed an incident or incidents of child sexual abuse
- (vi) Any individuals (including the perpetrator) revealed to have been involved in a child sexual abuse incident
- (vii) A child exhibiting unusual reaction to preventive programmes on sexual abuse, such as:
- a 8-year-old girl appeared distressed after watching a preventive programme on sexual abuse

Annex 14: Information Sheet on Child Protection Registry

1. Background

Through the joint efforts of the Social Welfare Department (SWD), the non-governmental Organisations (NGOs) and the Hong Kong Council of Social Service (HKCSS), a computerised record system for maintaining the Child Protection Registry (CPR) has been devised, which carries functions of case registration, case-checking as well as facilitating statistical research. Family and Child Welfare Branch of SWD have assumed full responsibility in implementing the computerised CPR since 1 July 1994. In 2016, a review on CPR was conducted with the contribution of a task group with representatives from SWD, NGOs, HKCSS, the Hong Kong Police Force and Hospital Authority (HA). The enhanced CPR rolled out on 1 July 2018.

2. Purpose

The main objectives of CPR are:

- (a) to facilitate better communication among casework units, which are registered users of CPR and are handling suspected child maltreatment cases/cases with risk of child maltreatment, through an easy checking mechanism to ascertain whether a case is/was registered in CPR and the last known service unit of SWD/NGO handling the case;
- (b) to collect and compile statistical information on the children who have been maltreated/might have been maltreated or are currently at risk of maltreatment and the perpetrators/alleged perpetrators/potential perpetrators for the purpose of ascertaining the magnitude of the problem, including identification of the general profile and characteristics of child maltreatment;
- (c) to monitor the regular updating and review of significant data to ensure accuracy of the statistical information as far as possible; and
- (d) to facilitate the planning and development of services which prevent child maltreatment, including the planning of public education programmes to prevent child maltreatment.

3. Reporting Organisation

All SWD & NGO service units providing casework service, including Integrated Family Service Centres, Integrated Services Centres, Family and Child Protective Services Units, Medical Social Services Units (including HA), Probation and Community Service Orders Offices, School Social Work Units, Outreaching Social Work Units, Integrated Children and Youth Services Centres, etc., are invited to report child maltreatment cases and children with risk of child maltreatment to the CPR.

4. Registration of Service Units as Users

4.1 Officers-in-charge/Supervisors/Social Work Officer (SWO) of casework service units from both SWD and NGOs as well as Senior Medical Officers/Medical Officers-in-charge of HA and Department of Health (DH) handling child maltreatment/suspected child maltreatment cases can register as ‘users’ of CPR to gain access to the checking system. They should forward the particulars of the office and the authorised officers to CPR by completing the Record Form for Access at [Appendix 1](#) to this Annex. Whenever there are changes, updating will be required.

4.2 If there is only one registered service unit within the organisation, one caseworker (in addition to the officer-in-charge/supervisor) can be named at the time of registration so that he/she may be authorised to make enquiries in the absence of the officer-in-charge/supervisor.

5. Registration of Cases

5.1 Consent from data subject and exemption

Prescribed consent has to be obtained from the data subject and/or the relevant person of the data subject for transferring his/her personal data to CPR, except in the following situations:

- (a) the purposes for which the personal data of the child and other individuals collected by the reporting NGOs include the handling and investigation of, and the planning of services to prevent child maltreatment, which are directly related to the purposes mentioned in [paragraphs 2\(i\) and 2\(ii\)](#) above; or

- (b) exemption from Data Protection Principle 3 can be invoked under Section 58 of the Personal Data (Privacy) Ordinance, e.g. the transfer of the personal data to CPR is for the purpose of the detection or prevention of crime or the prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct, or dishonesty or malpractice, and the application of the provisions of Data Protection Principle 3 would be likely to prejudice the above-mentioned purposes. Each case has to be decided on its own merit.

5.2 Registration of Cases and Categories

Service units of SWD are required to input data for the registration of children to CPR through the Client Information System. The Officer-in-charge/Supervisor/SWO of a casework service unit of NGOs/HA should send the data input form on the child concerned and the perpetrator/alleged perpetrator/potential perpetrator ([Appendix 2](#) to this Annex) to CPR (address at [paragraph 10](#) of this Annex) for registration. The cases are classified into 4 categories:

Category (a)

The incident was considered as *a harm/maltreatment to a child* in the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation.

Category (b)

A child was considered of *having a high risk of harm/maltreatment in future* though *the incident was not considered as a harm/maltreatment to a child* in a MDCC or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation.

Category (c)

A child who is not suspected to be harmed/maltreated but is considered *potentially at risk of harm/maltreatment* by virtue of risk factors of harming/maltreating a child identified, e.g. he/she is a younger sibling of a child being maltreated or a new born baby of a single parent with serious drug problem and being at risk of harm/maltreatment.

Category (d)

The incident was *not ascertained as a harm/maltreatment to a child who was also not considered of having a high risk of harm/maltreatment in future* in a MDCC or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation but with analysis on the concrete information available, professionals considered that the *harm/maltreatment incident was very likely to have happened*.

6. Access to Case Checking System

- 6.1 Telephone enquiries by registered users of CPR may be made to CPR (Tel. No.: 3468 2167) for case checking purpose during office hours from Monday to Friday (excluding public holidays).
- 6.2 The staff of CPR will ask for the registered user's name, office, telephone number and user code to check if the caller is a registered user of CPR. To ensure that the information will not be leaked to non-registered users, the staff will call back the caller after confirming that the latter is a registered user.
- 6.3 The staff of CPR will ask for the personal particulars of the child-in-question which include the name, sex, age, residential address and identification information (such as the number of HKIC or HKBC if available) of the child. The staff of the CPR will then check whether the child-in-question is registered in the CPR.
- 6.4 If the caller is a registered user, the staff of CPR will inform the caller whether the child-in-question is registered in CPR. If the child is registered in CPR, the information given by the staff of CPR will be restricted to confirmation of the following items:
 - (i) date(s) of registration;
 - (ii) whether it is an active or de-registered case; and
 - (iii) the name and telephone number of the service unit, reporting officer handling/last handled the case.
- 6.5 In case the caller needs to know whether the perpetrator/alleged perpetrator is a family member or relative of the child concerned in the previous registration(s) so as to plan for the strategy of intervention for a new suspected child maltreatment incident but the de-registered case of the child concerned is checked to have been closed in the service unit concerned, the caller may fill in [Appendix 6](#) to this Annex for the request

and fax to Child Protection Registry of Family and Child Welfare Branch supplemented with a phone call (fax no.: 3468 2510). A reply slip will be forwarded to the caller as soon as possible.

- 6.6 If the registered user of a unit is not available but there is urgency to check a case from CPR, assistance of another registered user of the same organisation/department may be enlisted.
- 6.7 For data protection, no information shall be released to caller who is a non-registered user.
- 6.8 Records regarding the enquiries will be kept by the staff of CPR for one year.

7. Operation of CPR

7.1 Case Checking and Enquiries

The staff of CPR will handle case checking enquired by registered users. In addition, they will deal with simple enquiries on procedures and practices regarding registration of children and organisations but they will not handle enquiries concerning the handling of suspected child maltreatment cases and policy matters which are outside the purview of CPR. (The subject officers of the Family and Child Welfare Branch at SWD Headquarters should be consulted on policy matters and the Family and Child Protective Services Units on the handling of suspected child maltreatment cases if necessary).

7.2 Quarterly & Annual Statistics

The CPR issues, on a quarterly and annual basis, statistical reports to indicate the general profile of the cases involving child maltreatment as registered in CPR.

7.3 Operational Procedures

To gain access to CPR's service and to ensure that accurate and relevant records are kept at CPR to reflect a realistic picture of the problem of child maltreatment in Hong Kong, reporting units should take note of the following procedures:

Registration

- 7.3.1 Staff of service units from SWD/NGOs and Senior Medical Officers/Medical Officers-in-charge of HA/DH who handle child maltreatment/suspected child maltreatment cases and wish to be registered as users of CPR are required to send in the completed Record Form for Access to the Child Protection Registry ([Appendix 1](#) to this Annex).
- 7.3.2 Units of SWD are required to input data for the registration of children to CPR through the Client Information System following MDCC or immediately after the investigation and formulation of follow-up services made by all professionals concerned (for cases where MDCC was dispensed with), or immediately after the child is identified to be at risk of maltreatment. NGOs providing casework service dealing with child maltreatment/suspected child maltreatment cases should send the completed data input form ([Appendix 2](#) to this Annex) in a **sealed envelope** marked “**Confidential**” for the registration of children to CPR (address at [paragraph 10](#)) at the time listed above. The unit handling the case at the time of the maltreatment or while the child is identified to be at risk of maltreatment should register the case. The follow up unit should undertake the updating after the case has been transferred in.
- 7.3.3 To confirm the registration of cases and users, CPR will send a completed return slip back to the NGO reporting unit concerned.

Updating Information

- 7.3.4 There may be information requiring updating as a result of the follow-up actions after the case has been registered, e.g. whether the child has been made a subject of a Care or Protection Order and whether residential placement has been arranged as recommended by MDCC, whether the perpetrator has been prosecuted and what the court’s disposal is, etc.
- 7.3.5 Units of SWD are required to update case information through the Client Information System. Units of NGOs handling the case should complete the Case Updating Form to report changes of case information ([Appendix 3](#) to this Annex) and return it to CPR in a **sealed envelope** marked “**Confidential**”.

- 7.3.6 If the case is transferred from an organisation/a service unit to another organisation/service unit, the follow-up social worker (including SWD service units) should complete the Reporting Transfer Form ([Appendix 4](#) to this Annex).
- 7.3.7 If there is any subsequent change in the category from Cat. (c) to other categories, a new set of Data Input Form ([Appendix 2](#) to this Annex) should be completed. Besides, a new Data Input Form ([Appendix 2](#) to this Annex) should be completed if there is a new child maltreatment incident identified.
- 7.3.8 The accuracy and effectiveness of CPR depends very much on the prompt updating of information by the service units concerned.

De-registration

- 7.3.9 The De-registration Form at [Appendix 5](#) to this Annex should be used for de-registration of cases.
- 7.3.10 Among the de-registered cases, data that can identify the child will be removed after the child reaches the age of 19, while other data (i.e. data that cannot identify the child) will be retained for the purpose of statistical research on child protection.

8. Security to Ensure No Leakage of Information

- 8.1 The clerical staff operating the registration, and the “call in” and “call back” systems of CPR will be given limited access to the information stored in the computer. The information which is permitted on the computer screen is restricted to the name, sex and age of the child-in-question plus the name of the supervisor, office, address and telephone number of the handling unit and the case file number.
- 8.2 The personal data of registered cases are being protected by appropriate safeguards (such as passwords known only to the authorised officers) against unauthorised access, alteration, disclosure or destruction. Besides, this computerised information system follows a number of basic data protection principles and guidelines issued for compliance by government departments.

- 8.3 Since the major functions of CPR are to facilitate case-checking by registered users and to compile aggregate data on clientele profiles for statistical research, any individual's personal data should not be disclosed.
- 8.4 The Data Input Form, the Case Updating Form and the Reporting Transfer Form are all confidential documents which will be kept in safe custody before they are properly destroyed after the data have been coded and recorded.
- 8.5 It is important that all participating organisations/service units should put all data input forms and related documents in **sealed envelopes marked "Confidential"** and address them to CPR directly.

9. Review of the Operation of CPR

The operation of CPR and other ad hoc operational difficulties will be reviewed and sorted out in consultation with the NGOs or among the parties concerned as need arises. The latest review of CPR was in 2016.

10. Address and Telephone Number of CPR

Child Protection Registry,
Family and Child Welfare Branch,
Social Welfare Department,
7/F, Wu Chung House,
213 Queen's Road East,
Wanchai,
Hong Kong.
(Tel. No. : 3468 2167)

11. Limitations of CPR

With its computerised database, CPR will be able to provide a comprehensive set of statistical information on the child maltreatment cases in Hong Kong and an easy checking mechanism on the known cases of child maltreatment/cases with risk of child maltreatment of SWD and NGOs. However, the system is basically reactive and limitations to the system include the following:

- 11.1 The CPR records only cases reported to CPR by the service units listed in [paragraph 3](#).

- 11.2 Statistical information generated by CPR will be confined to those contained in the data input form input/sent in by the service units concerned.
- 11.3 Case checking could only be made by using the name and particulars of the child-in-question. Case checking by using the particulars of the perpetrator/alleged perpetrator/potential perpetrator will not be possible because the names of the perpetrators/alleged perpetrators/potential perpetrator will not be recorded by CPR.

CONFIDENTIAL
CHILD PROTECTION REGISTRY
RECORD FORM FOR ACCESS
***(Initial Registration/Reporting Changes)**

Participating Unit

1. Name of Department/Organisation: _____
2. Name of Unit: _____
3. Office Address: _____

4. Telephone No.: _____
5. Name of Applicant of the Unit: _____
6. Designation/Post: _____
7. Name of a Caseworker Authorised to Gain Access to CPR
(Applicable to those NGOs having one registered unit only): _____

8. Reporting Changes (Please specify which of the above item(s) or other information is changed): _____

Specify which of the above item(s) (e.g. item 4, 5, 6):

Other Changes: _____

Signature of Applicant: _____

Date: _____

*Delete as appropriate

CONFIDENTIAL
CHILD PROTECTION REGISTRY
DATA INPUT FORM

Guidelines for completing the data input form

1. Please complete one form for each case. If there are more than one child or perpetrator/alleged perpetrator/potential perpetrator in the case, please provide information on these persons by filling out a separate form for each individual, using *Part B* for child and *Part C* for perpetrator/alleged perpetrator/potential perpetrator.
2. Please provide the information as requested or tick (✓) the box corresponding to the appropriate answer. Please ensure that the ticks are confined to the given boxes to facilitate data input.
3. Unless specified, please tick one choice only in each item.
4. Please send in your completed data input form in a sealed envelope marked “Confidential” to Child Protection Registry at the following address as soon as possible following the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) (if any) or immediately after the investigation and formulation of follow-up services (for cases where MDCC was dispensed with) by all professionals concerned, or immediately after the child is identified to be at risk of harm/maltreatment.

Child Protection Registry
Family and Child Welfare Branch
Social Welfare Department
7/F, Wu Chung House
213 Queen’s Road East
Wanchai
Hong Kong

Consent from Data Subject and Exemption

5. Please note that prescribed consent has to be obtained from the data subject and/or the relevant person¹² of the data subject for transferring his/her personal data to CPR, except in the following situations:
 - (a) the purposes for which the personal data of the child and other individuals collected by the reporting NGOs include the handling and investigation of, and the planning of services to prevent child maltreatment, which are directly related to the purposes mentioned in [paragraphs 2\(i\) and 2\(ii\)](#) of the Information Sheet on CPR at [Annex 14](#) to the “Protecting Children from Maltreatment--Procedural Guide for Multi-disciplinary Co-operation; or
 - (b) exemption from Data Protection Principle 3 can be invoked under Section 58 of the Personal Data (Privacy) Ordinance, e.g. the transfer of the personal data to CPR is for the purpose of the detection or prevention of crime or the prevention, preclusion or remedying (including punishment) of unlawful or seriously improper conduct, or dishonesty or malpractice, and the application of the provisions of Data Protection Principle 3 would be likely to prejudice the above-mentioned purposes. Each case has to be decided on its own merit.

¹² According to Section 2 of the Personal Data (Privacy) Ordinance Cap 486, where the individual is a minor, relevant person in relation to an individual means a person who has parental responsibility for the minor.

Part A - General Information

<p><u>For CPR coding only</u></p> <p>□□□□□-□□</p> <p>□□□</p>
--

- A1. Case file no.: _____
- A2. Name of the reporting organisation: _____
- A3. Name of the unit: _____
- A4. Office address: _____
- A5. Telephone no.: _____
- A6. Type of service, e.g. school social work

A7. Whether the maltreatment/suspected maltreatment incident of which the disclosure is initiated by the child concerned or by perpetrator(s)/alleged perpetrator(s)/potential perpetrator(s), or the incident is identified by others (i.e. the person who *first* identified the incident and made a report for follow-up service)?

- (1) self-disclosed (*Tick one only and go to item A8*)
 - (111) by child himself/herself
 - (112) by perpetrator(s)/alleged perpetrators(s)/potential perpetrator(s)
- (2) identified by (*Tick one only and go to item A9*)
 - (211) parent(s) or family member(s) (i.e. members within the nuclear family) of the child concerned
 - (212) parent(s) or family member(s) (i.e. members within the nuclear family) of the perpetrator/alleged perpetrator/potential perpetrator (if different from that of the child)
 - (213) other maltreated/potentially maltreated child(ren) of the maltreatment /suspected maltreatment incident
 - (214) social worker
 - (215) medical professional
 - (216) clinical psychologist/psychiatrist
 - (217) police
 - (218) school personnel (including kindergarten, kindergarten-cum-child care centre, child care centre)
 - (219) carer (other than parent or family member)
 - (220) relative
 - (221) schoolmate/friend/neighbour
 - (222) public/mass media
 - (223) other government department
 - (224) others, please specify _____

- A8. To whom the maltreatment was disclosed to? (*Tick one only*)
 - (1) parent(s) or family member(s) (i.e. members within the nuclear family) of the child concerned
 - (2) parent(s) or family member(s) (i.e. members within the nuclear family) of the perpetrator/alleged perpetrator/potential perpetrator (if different from that of the child victim)
 - (3) other maltreated/potentially maltreated child(ren) of the maltreatment incident

- (4) social worker
- (5) medical professional
- (6) clinical psychologist/psychiatrist
- (7) police
- (8) school personnel (including kindergarten, kindergarten-cum-child care centre, child care centre)
- (9) carer (other than parent or family member)
- (10) relative
- (11) classmate/friend/neighbour
- (12) public/mass media
- (13) other government department
- (14) hotlines
- (15) others, please specify _____

A9. Has this case ever been registered with CPR?

(Tick as appropriate)

- (0) Yes
- (1) No

Number of times of registration

(To be filled in by CPR)

Part B - Information on Maltreated Child/Child at Risk of Maltreatment

(Note: Use separate form of Part B for each child)

B1. CPR No. (If known)

(Not applicable for new cases)

CPR No.

(To be assigned by CPR)

B2. Name in English (surname first):

B3. Name in Chinese: _____

B4. Document of identity (✓Tick as appropriate)

- (1) Hong Kong Identity Card (HKIC No.: _____)
- (2) Hong Kong Birth Certificate (HKBC No.: _____)
- (3) Passport (Passport No.: _____)
- (4) Entry Permit (Permit No.: _____)
- (5) Others, please specify _____

B5. Date of birth: / / (DD/MM/YYYY)

B6. Approximate age: (Fill in if Date of Birth unknown, leave blank otherwise)

B7. Sex: Male Female

B8. In HK since birth? Yes

No, please give the year of arrival in HK

B9. Whether the child/family is on Comprehensive Social Security Assistance?

- Yes
- No
- Unknown

B10. Ethnicity:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Chinese | <input type="checkbox"/> German | <input type="checkbox"/> Pakistani |
| <input type="checkbox"/> African | <input type="checkbox"/> Indian | <input type="checkbox"/> Singaporean |
| <input type="checkbox"/> Australian | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Sri Lankan |
| <input type="checkbox"/> British | <input type="checkbox"/> Japanese | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Canadian | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Nepalese | <input type="checkbox"/> Others, please specify _____ |
| <input type="checkbox"/> French | <input type="checkbox"/> New Zealander | <input type="checkbox"/> Unknown |

B11. Residential status

- Hong Kong resident
- Conditional stay
- Illegal stay
- Unknown
- others, please specify _____

B12. Disability (*may choose more than one*)

- | | |
|---|---|
| <input type="checkbox"/> Attention Deficit/Hyperactivity Disorder | <input type="checkbox"/> Specific Learning Disabilities |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Speech impairment |
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Visceral disability |
| <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Physical disability | <input type="checkbox"/> Others, please specify _____ |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Not applicable |

B13. Nature of the incident: (*Tick one only*)

- (1) Cat.(a) The incident was considered as ***a harm/maltreatment to a child*** in the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation.
- (2) Cat.(b) A child was considered of ***having a high risk of harm/maltreatment in future*** though ***the incident was not considered as a harm/maltreatment to a child*** in a MDCC or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation.
- (3) Cat.(c) A child who is not suspected to be harmed/maltreated but is considered ***potentially at risk of harm/maltreatment*** by virtue of risk factors of harming/maltreating a child identified.
- (4) Cat.(d) The incident was ***not ascertained as a harm/maltreatment to a child who was also not considered of having a high risk of harm/maltreatment in future*** in a MDCC or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation but, with analysis on the concrete information available, professionals considered that the ***harm/maltreatment incident was very likely to have happened.***

B14. No. of MDCC(s) (including review conference) held:

(not applicable for Cat.(c) cases in item B13.)

a. Date of MDCC(s) or formulation of follow-up plan (if MDCC was dispensed with)

1st MDCC/Follow-up plan: _____

2nd MDCC/Follow-up plan: _____

3rd MDCC/Follow-up plan: _____

b. Was review conference considered necessary as agreed in the MDCC?

Yes No

B15. No. of MDCC(s) (including review conference) held with family participation:

(not applicable for Cat.(c) cases in item B13.)

B16. Relationship of family member(s) who participated

in the MDCC(s) [please “√” as appropriate]:

Number of MDCC(s) participated*

- (1) Father
- (2) Mother
- (3) Brother
- (4) Sister
- (5) Grandfather
- (6) Grandmother
- (7) Step-father (including mother's boy-friend/cohabitant)
- (8) Step-mother (including father's girl-friend/cohabitant)
- (9) Other relatives, please specify _____

(* Please fill in the number of MDCC participated in the by referring to item B.15, e.g. if the no. in item B.15 is 2 and the two MDCCs were participated by the father, “2” should be marked in the)

B17. Did the child concerned participate in the MDCC(s) ? Number of MDCC(s) participated*

Yes

No

(* Please fill in the number of MDCC(s) participated in the by referring to item B.15. e.g. if the no. in item B.15 is 2 and the two MDCCs were participated by the child, “2” should be marked in the)

B18. Location where maltreatment/suspected maltreatment incident happened

a. Type of location (may choose more than one if the incidents happened in various locations)

- (1) Child victim’s/Potential victim’s residential abode
- (2) Father’s/Mother’s home (if different from child’s residential abode)
- (3) Relative’s home (if different from child’s residential abode)
- (4) Foster home
- (5) Small group home

- (6) Residential institution/children's home/hostel
- (7) School
- (8) Boarding section of school
- (9) Tuition centre
- (10) Hospital/clinic
- (11) Perpetrator's/Alleged perpetrator's/Potential perpetrator's residential abode (if perpetrator is not family member/relative/foster parent)
- (12) Public place (e.g. street, restaurant, park, etc.)
- (13) Others, please specify _____

b. According to District Council districts (If there were more than one location, please give the district of the most serious or most frequent or most recent incident. For children classified under Cat.(c) at item B13, please give the child's usual place of residence.)

District Code

(To be filled in by CPR)

- | | | | |
|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Central/Western | <input type="checkbox"/> Southern | <input type="checkbox"/> Islands | <input type="checkbox"/> Eastern |
| <input type="checkbox"/> Wanchai | <input type="checkbox"/> Kowloon City | <input type="checkbox"/> Yau Tsim Mong | <input type="checkbox"/> Shamshuipo |
| <input type="checkbox"/> Wong Tai Sin | <input type="checkbox"/> Sai Kung | <input type="checkbox"/> Kwun Tong | <input type="checkbox"/> Sha Tin |
| <input type="checkbox"/> Tai Po | <input type="checkbox"/> North | <input type="checkbox"/> Yuen Long | <input type="checkbox"/> Tsuen Wan |
| <input type="checkbox"/> Kwai Tsing | <input type="checkbox"/> Tuen Mun | <input type="checkbox"/> Outside HK | <input type="checkbox"/> Unknown |

B19. Residential address of parent(s)/guardian(s)/carer(s) with whom the child used to live at the time when the maltreatment/suspected maltreatment incident occurred
(Please give full address and District Council districts)

District Code

(To be filled in by CPR)

- | | | | |
|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Central/Western | <input type="checkbox"/> Southern | <input type="checkbox"/> Islands | <input type="checkbox"/> Eastern |
| <input type="checkbox"/> Wanchai | <input type="checkbox"/> Kowloon City | <input type="checkbox"/> Yau Tsim Mong | <input type="checkbox"/> Shamshuipo |
| <input type="checkbox"/> Wong Tai Sin | <input type="checkbox"/> Sai Kung | <input type="checkbox"/> Kwun Tong | <input type="checkbox"/> Sha Tin |
| <input type="checkbox"/> Tai Po | <input type="checkbox"/> North | <input type="checkbox"/> Yuen Long | <input type="checkbox"/> Tsuen Wan |
| <input type="checkbox"/> Kwai Tsing | <input type="checkbox"/> Tuen Mun | <input type="checkbox"/> Outside HK | <input type="checkbox"/> Unknown |

B20. Type of housing of residential address of item B19.

- (1) Public housing estate
- (2) Interim housing
- (3) Home Ownership Scheme
- (4) Tenants Purchase Scheme
- (5) Private housing (rented)
- (6) Private housing (self-owned)
- (7) Staff quarters
- (8) Squatters/cottages/huts (rented)
- (9) Squatters/cottages/huts (self-owned)
- (10) Residential home for children
- (11) Others, please specify _____

B21. The child's abode at the time of the maltreatment /suspected maltreatment

- (1) Living with both parents
- (2) Living with father and step-mother/father's cohabitant
- (3) Living with mother and step-father/mother's cohabitant
- (4) Living with father
- (5) Living with mother
- (6) Living with grandparent(s)
- (7) Living with relative(s)
- (8) Living with childminder
- (9) Living in small group home/foster home
- (10) Living in residential institution/children's home/hostel
- (11) Living in boarding school
- (12) Living in hospital
- (13) Others, please specify _____

B22. Care arrangement recommended in MDCC/as agreed by all professionals after investigation

- Living with parent(s) *(please update Item 5(3) of [Appendix 3](#), CPR Form III, to this Annex if residential child care service is subsequently arranged within 6 months after the MDCC/formulation of follow-up plan as agreed by professionals) (Go to item B24)*
- Living with relative(s) *(please update Item 5(3) of [Appendix 3](#), CPR Form III, to this Annex if residential child care service is subsequently arranged within 6 months after the MDCC/formulation of follow-up plan as agreed by professionals) (Go to item B24)*
- Residential child care service *(Go to item B23)*
- Others, please specify _____

B23. If residential child care service was recommended in MDCC/agreed by all professionals after the investigation, has the arrangement been made yet?

- Not yet waitlisted *(please update item 5(2) of [Appendix 3](#), CPR Form III, to this Annex when admission has been arranged)*
- Waitlisted *(please update item 5(2) of [Appendix 3](#), CPR Form III, to this Annex when admission has been arranged)*
- Admitted into residential child care service

B24. Whether statutory supervision under Protection of Children and Juveniles Ordinance (PCJO) for a maltreatment/suspected maltreatment incident was required during investigation/as recommended by MDCC/as agreed by all professionals (or for case of Cat. (c) at item B13)

- (0) No
- Yes and the child was already a subject of statutory supervision at the time of maltreatment under the legal provisions of:
 - (1) Protection of Children and Juveniles Ordinance (PCJO)
 - (2) Juvenile Offenders Ordinance
 - (3) Guardianship of Minors Ordinance
 - (4) Matrimonial Causes Ordinance
 - (5) High Court Ordinance

- (6) Others, please specify _____
- (7) Yes (please answer question (a) below)
 - (a) Has application for statutory supervision been made?
 - Not yet (*please update item 5(1) of [Appendix 3](#), CPR Form III, to this Annex when application has been made*)
 - Yes

B25. Type of harm/maltreatment or suspected harm/maltreatment (Please refer to definitions stated in the “Protecting Children from Maltreatment--Procedural Guide for Multi-disciplinary Co-operation”) (*please select only one choice for type of harm/maltreatment but may choose more than one sub-item under the specific type*)

- (1) Physical harm/abuse
 - (11) Battering & non-accidental use of force (fisting, kicking, striking with an object, Shaking Baby Syndrome, etc.)
 - (12) Non-accidental injury by poison, acid or fire, etc.
 - (13) Forcing a child to undertake duties inappropriate to his/her physical strength or age
 - (14) Factitious Disorder Imposed on Another

- (2) Neglect
 - (21) Inadequate physical care (food, clothing, shelter, improper storage of dangerous drugs resulting in accidental ingestion by a child, etc.)
 - (22) Inadequate health care
 - (23) Deprivation of education/training
 - (24) Leaving a child habitually unattended

- (3) Sexual abuse (also answer 3a)
 - (31) Incest
 - (32) Sexual intercourse with relatives (other than parent(s)/sibling(s))
 - (33) Sexual intercourse with non-relative(s)
 - (34) Other forms of sexual activity (fondling, mutual sexual fondling, etc.)

(3)(a) Whether the sexual abuse involved the following:

 - (i) The Child acquainted with the perpetrator/alleged perpetrator through internet/software in mobile phone (0) No (1) Yes
 - (ii) compensated dating (0) No (1) Yes
 - (iii) cybersex (0) No (1) Yes
 - (iv) production of pornographic images of child (0) No (1) Yes

- (4) Psychological harm/abuse
 - (41) Persistent/severe verbal abuse
 - (42) Persistent resentment and rejection/indifference
 - (43) Persistent modelling, encouragement and permission of maladaptive behaviours
 - (44) An extreme incident of psychological harm/abuse

- (5) Multiple abuse
(when assessment by one major type is not possible, specify by a combination of major categories)

- (51) Physical harm/abuse
- (52) Neglect
- (53) Sexual abuse
- (54) Psychological harm/abuse

Not applicable (*for Cat (c) cases at item B13*)

B26. Did the child die of maltreatment/suspected maltreatment?

- (0) No (*Please update item 5(4) of [Appendix 3](#), CPR Form III, to this Annex if the child died of maltreatment for the same incident after registration*)
- (1) Yes (Date of death: _____)

B27. Risk factors of child maltreatment (at the time of identification/disclosure/investigation)

(*Select at most 3 factors from each subgroup if the subgroup is appropriate*)

Subgroup 1 Factors relating to maltreated child/child at risk of maltreatment

- (0) *This subgroup is not applicable*
- (1) School attendance/performance problem
- (2) Behavioural problem
- (3) Emotional/psychological problem
- (4) Mental illness like schizophrenia, major depression, anxiety disorders, etc.
- (5) Mental retardation including slow learning or developmental delay
- (6) Special educational needs like Autism, Attention Deficit/Hyperactivity Disorder, dyslexia, specific learning disabilities, etc.
- (7) Illness/physical disability
- (8) Unwanted child/pregnancy
- (9) Long period of separation from parents in early infancy
(i.e. separation for one year or over before the age of 5)
- (10) Others, please specify _____

Subgroup 2 Factors relating to perpetrator/alleged perpetrator/potential perpetrator (for case where parent(s) is/are perpetrator(s)/alleged perpetrator(s)/potential perpetrator(s)) (parent includes step parent and adoptive parent)

- (0) *This subgroup is not applicable*
- (1) Superstitious belief
- (2) Marital problem
- (3) In-law relationship problem
- (4) Emotional/psychological problem
- (5) Mental illness/retardation including slow learning or developmental delay
- (6) Illness/ physical disability
- (7) Immaturity/extreme self-centredness
- (8) Incompetence in child rearing/lack of parenting skills
- (9) High expectation on child-in-question
- (10) Undesirable habits (e.g. gambling, indulgence in internet surfing)
- (11) Heavy/chronic use of drug
- (12) Heavy/chronic use of alcohol
- (13) Intimate partner violence

- (14) Refuse to co-operate with professionals/evasive
- (15) Being perpetrator/alleged perpetrator/potential perpetrator of previous child maltreatment case/case with high risk of maltreatment
- (16) Others, please specify _____

Subgroup 3 Factors relating to environmental or social circumstances

- (0) *This subgroup is not applicable*
- (1) Financial difficulty/unemployment
- (2) Housing problem/poor living environment
- (3) Perpetrator/alleged perpetrator/potential perpetrator cannot cope with family crisis/stressors
- (4) Lack of support system (e.g. spouse, grandparents, relatives, friends, etc.)
- (5) Lack of community resources (e.g. day child care centre, neighbourhood support child care project, tutorial class, etc.)
- (6) Perpetrator/alleged perpetrator/potential perpetrator (non-family member) can easily access to the child
- (7) Others, please specify _____

Subgroup 4 Factors relating to the precipitating incident

- (0) *This subgroup is not applicable*
- (1) Incidence was severe and/or of high frequency
- (2) Location of injury on delicate and/or extensive body parts
- (3) Cause of injuries unknown
- (4) Others, please specify _____

*Not applicable (for **Cat (c)** cases at item **B13**)*

B28. Type of family

- (1) Nuclear family with both parents
- (2) Nuclear family with one parent
- (3) Extended family with both parents
- (4) Extended family with one parent
- (5) Extended family with absence of parent(s)
- (6) Others, please specify _____

<u>Relationship with perpetrator</u> (To be filled in by CPR)	
<u>Perpetrator Ref. No.</u>	<u>Relationship</u>
□□□□□	□
□□□□□	□

Part C - Information on perpetrator/alleged perpetrator/potential perpetrator

(Note: Use separate Part C for each perpetrator/alleged perpetrator/potential perpetrator)

C1. Year of birth: Unknown

C2. Sex: Male Female Unknown

C3. In HK since birth? (1) Yes

(2) No, please give the year of arrival at HK

(3) Unknown

Perpetrator Ref. No.

(To be assigned by CPR)

C4. Relationship with child-in-question

Name of child-in-question	Relationship of perpetrator (Please fill in the number according to codes given below)

CPR No.
(To be filled by CPR)

Code of relationship with child-in-question

- (1) Father
- (2) Mother
- (3) Brother
- (4) Sister
- (5) Grandfather
- (6) Grandmother
- (7) Step-father (including mother's boy-friend/cohabitant)
- (8) Step-mother (including father's girl-friend/cohabitant)
- (9) Step-brother
- (10) Step-sister
- (11) Relative
- (12) Family friend/parent of peer
- (13) Foster parent
- (14) House parent/staff of residential institution/children's home/hostel
- (15) Childminder
- (16) Domestic helper
- (17) Co-tenant/neighbour
- (18) School teacher/personnel
- (19) Staff of boarding section of school
- (20) Tutor/coach
- (21) Religious personnel
- (22) Schoolmate/friend/peer
- (23) Inmate of residential service/boarding section of school
- (24) Unrelated person/stranger
- (25) Unidentified person
- (26) Others, please specify _____

C5. Residential address of perpetrator/alleged perpetrator/potential perpetrator at the time of maltreatment (*Please fill in name of street, estate and district only. If information is not available, please fill in "unknown"*).

To be filled in by CPR □□□

- | | | | |
|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Central/Western | <input type="checkbox"/> Southern | <input type="checkbox"/> Islands | <input type="checkbox"/> Eastern |
| <input type="checkbox"/> Wanchai | <input type="checkbox"/> Kowloon City | <input type="checkbox"/> Yau Tsim Mong | <input type="checkbox"/> Shamshuipo |
| <input type="checkbox"/> Wong Tai Sin | <input type="checkbox"/> Sai Kung | <input type="checkbox"/> Kwun Tong | <input type="checkbox"/> Sha Tin |
| <input type="checkbox"/> Tai Po | <input type="checkbox"/> North | <input type="checkbox"/> Yuen Long | <input type="checkbox"/> Tsuen Wan |
| <input type="checkbox"/> Kwai Tsing | <input type="checkbox"/> Tuen Mun | <input type="checkbox"/> Outside HK | <input type="checkbox"/> Unknown |

C6. Whether living at the same residential address as child-in-question at time of incident

Name of child-in-question	Whether living at same residential address as child-in-question	CPR No. (To be filled by CPR)
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	□□□□□
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	□□□□□
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	□□□□□
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	□□□□□
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	□□□□□

C7. Marital Status

- (1) Single
- (2) Married
- (3) Cohabited
- (4) Separated/Divorced
- (5) Widowed
- (6) Unknown

C8. Highest educational level attained

- (1) No schooling/below primary
- (2) Primary (P.1 - P.6)
- (3) Lower secondary (F.1 - F.3)
- (4) Upper secondary (F.4 - F.7) or equivalent
- (5) Post-secondary/Tertiary
- (6) Unknown

C9. Occupation

- (1) Business/factory or company proprietor
- (2) Professional/administrative/managerial work
- (3) Clerical/secretarial work
- (4) Sales/shop-keeper/stall owner/hawker
- (5) Service/technical work (e.g. restaurant waiter, hair-dresser, driver, etc.)
- (6) Production work (e.g. factory hand, construction worker, cook, etc.)

- (7) Unemployed
- (8) Homemaker
- (9) Student
- (10) Retired
- (11) Unknown
- (12) Others, please specify _____

C10. Has the perpetrator/alleged perpetrator/potential perpetrator been maltreated in childhood?

- Yes No Unknown

C11. Ethnicity:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Chinese | <input type="checkbox"/> German | <input type="checkbox"/> Pakistani |
| <input type="checkbox"/> African | <input type="checkbox"/> Indian | <input type="checkbox"/> Singaporean |
| <input type="checkbox"/> Australian | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Sri Lankan |
| <input type="checkbox"/> British | <input type="checkbox"/> Japanese | <input type="checkbox"/> Thai |
| <input type="checkbox"/> Canadian | <input type="checkbox"/> Korean | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Nepalese | <input type="checkbox"/> Others, please specify _____ |
| <input type="checkbox"/> French | <input type="checkbox"/> New Zealander | <input type="checkbox"/> Unknown |

C12. Residential status

- Hong Kong resident
- Conditional stay
- Illegal stay
- Unknown
- Others, please specify _____

C13. Does the perpetrator/alleged perpetrator/potential perpetrator has the following situations?

- Alcoholism Drug abuse Unsustainable indebtedness
- Mental illness Indulgence in Gambling Mental handicap
- Physical handicap/illness
- Unknown
- Not applicable

C14. i) Has the case been reported to the Police?

- (0) No (1) Yes

ii) Any prosecution contemplated or made as a result of the incident of harm/maltreatment?

- (1) Not yet known pending police investigation
- (2) No prosecution contemplated or made
- (3) Yes, prosecution was made but court's disposal not yet known (*please update item 5(5) of [Appendix 3](#), CPR Form III, to this Annex when information is available*)
- (4) Yes, prosecution was made and the court's disposal is:
(*can ✓ tick more than one*)
 - (41) Fined
 - (42) Bound over
 - (43) Probation for ____ months
 - (44) Imprisonment for ____ months yet suspended for ____ months

- (45) Imprisonment for _____ months
- (46) Offence not established
- (47) Others, please specify _____

C15. In addition to information provided in this registration, please provide information, as far as possible, on other child(ren) who will be/have already been registered in CPR in relation to the incident perpetrated by the same perpetrator/alleged perpetrator/potential perpetrator.

Name	CPR No. *	<i>(Number of Identity Document)</i>
_____	□□□□□□	_____
_____	□□□□□□	_____
_____	□□□□□□	_____
_____	□□□□□□	_____
_____	□□□□□□	_____
_____	□□□□□□	_____

* If CPR No. is not available, please try to provide the number of identity document, e.g. HKIC, HKBC, of the child in the space provided as far as possible.

Part D - Information on additional form(s)

Additional form(s) for maltreated child/child at risk of maltreatment/perpetrator/alleged perpetrator/potential perpetrator

Have you attached additional forms for registration of new case?

- (0) No
- (1) Yes
 - Maltreated child/child at risk of maltreatment [indicate the number of
 - Perpetrator/alleged perpetrator/potential perpetrator additional form(s)attached]

Reporting Officer/Social Worker

Name: _____	Tel No.: _____
Rank: _____	Signature: _____
Post: _____	Date: _____

Countersigning Officer/Supervisor

Name: _____	Tel No.: _____
Rank: _____	Signature: _____
	Date: _____

To be completed by CPR staff

Date of entry to CPR: _____

Name of Officer: _____

Signature: _____

**CONFIDENTIAL
CHILD PROTECTION REGISTRY
CASE UPDATING FORM**

Note 1.This form is used for updating of case information. For reporting change of handling service unit and/or caseworker, please use **CPR Form IV**.

2.A new data input form (CPR Form II) should be completed when "a child with potential risk of maltreatment" becomes "a child being maltreated". Besides, a new data input form (CPR Form II) might be used if there are lots of items to be updated as a result of a new child maltreatment incident identified.

1. CPR No.:

2. Name of child (in English): _____

(in Chinese): _____

3. Document of identity: (*✓Tick as appropriate*)

(1) Hong Kong Identity Card (HKIC No.: _____)

(2) Hong Kong Birth Certificate (HKBC No.: _____)

(3) Passport (Passport No.: _____)

(4) Entry Permit (Permit No.: _____)

(5) Others, please specify _____

4. Date of birth: // (DD/MM/YYYY)

5. Updating on case information

(For items (1) to (5) below, please complete only those where changes have occurred)

(1) Whether the child has become a subject of statutory supervision as recommended by MDCC/agreed by all professionals after investigation as a result of maltreatment/suspected maltreatment

(0) No

The care plan has changed as risk of child maltreatment has been reduced/subsided as agreed by MDCC/related professionals

Application had been made but court order was not granted

Others, please specify _____

(1) Yes

(2) If residential child care service was recommended in MDCC/as agreed by all professionals after investigation, has the arrangement been made?

(0) No

The care plan has changed as risk of child maltreatment has been reduced/subsided as agreed by MDCC/related professionals

- Alternative child care arrangement has been worked out, e.g. taken care of by a relative or friend
- Others, please specify _____
- (1) Yes, the child was admitted into residential child care service

(3) The child care arrangement changed and residential child care service was subsequently arranged as agreed by professionals within 6 months after the MDCC/formulation of the original agreement.

(1) Yes

(4) Did the child die of maltreatment/suspected maltreatment for the same incident after registration?

(1) Yes (Date of death: _____)

(5) Whether the perpetrator(s) (including alleged perpetrators/potential perpetrators) has/have been prosecuted for the act of maltreatment (please fill in the same sequence of perpetrators as reported in the data input form):

(i) Perpetrator Ref. No. at CPR

(to be completed by CPR)

Relationship of perpetrator to the child-in-question _____

Whether the perpetrator has been prosecuted (✓ tick as appropriate)

- (0) No
- Yes: the court disposal is (✓ Can tick more than one)
 - (1) Fined
 - (2) Bound over
 - (3) Probation for _____ months
 - (4) Imprisonment for _____ months yet suspended for _____ months
 - (5) Imprisonment for _____ months
 - (6) Offence not established
 - (7) Others, please specify

(ii) Perpetrator Ref. No. at CPR

(to be completed by CPR)

Relationship of perpetrator to the child-in-question _____

Whether the perpetrator has been prosecuted (✓ tick as appropriate)

- (0) No
- Yes: the court disposal is (✓ Can tick more than one)
 - (1) Fined
 - (2) Bound over
 - (3) Probation for _____ months
 - (4) Imprisonment for _____ months yet suspended for _____ months
 - (5) Imprisonment for _____ months
 - (6) Offence not established
 - (7) Others, please specify

(iii) Perpetrator Ref. No. at CPR

(to be completed by CPR)

Relationship of perpetrator to the child-in-question _____

Whether the perpetrator has been prosecuted (✓ tick as appropriate)

(0) No

Yes: the court disposal is (✓ Can tick more than one)

(1) Fined

(2) Bound over

(3) Probation for _____ months

(4) Imprisonment for _____ months yet suspended
for _____ months

(5) Imprisonment for _____ months

(6) Offence not established

(7) Others, please specify

(6) Other changes not included in the above (please specify):

Reporting Unit (Department/organisation): _____

Signature: _____
Name: _____
Post: _____
Rank: _____
Tel No.: _____
Date: _____

Countersigned by: _____
Name: _____
Post: Officer-in-charge/Supervisor
Tel No.: _____
Date: _____

**CONFIDENTIAL
CHILD PROTECTION REGISTRY
REPORTING TRANSFER FORM**

- Note* 1. This form is used for reporting of change of handling service unit. For updating of case information, please use CPR Form III.
2. The follow-up caseworker is required to complete this form and provide a copy of this completed form to the transfer-out caseworker.

1. CPR No.:
2. Name of child (in English): _____
(in Chinese): _____

3. Document of identity (✓ *Tick as appropriate*)
- (1) Hong Kong Identity Card (HKIC No.: _____)
 - (2) Hong Kong Birth Certificate (HKBC No.: _____)
 - (3) Passport (Passport No.: _____)
 - (4) Entry Permit (Permit No.: _____)
 - (5) Others, please specify _____

4. Date of birth: / / (DD/MM/YYYY)

5. Particulars of new handling service units and caseworker:
- Name of responsible caseworker: _____
Post and rank of the caseworker: _____
Name of organisation: _____
Name of office/unit: _____
Office address: _____

Telephone number: _____
Type of service e.g. school social work: _____
Follow-up office's file reference of the case: _____

Signature: _____
Name: _____
Post: _____
Rank: _____
Tel No.: _____
Date: _____

Countersigned by: _____
Name: _____
Post: Officer-in-charge/Supervisor
Tel No.: _____
Date: _____

If same as item 5 above, only sign and fill in date in this column.

**CONFIDENTIAL
CHILD PROTECTION REGISTRY
DE-REGISTRATION**

Child Ref No. at CPR (as assigned by CPR at initial registration)

Name of child:

(in English): _____

(in Chinese): _____

Date of birth: // (DD/MM/YYYY)

Residential address of parent(s)/guardian(s)/carer(s) with whom the child used to live

Reasons for deregistration: (✓ tick only one item)

- (1) No further risk of maltreatment identified
- (2) Child reached age of 18
- (3) Migration of child/child leaving Hong Kong
- (4) Death of child
- (5) Client declined/refused further service
- (6) Others, please specify _____

Signature:

Name:

Post:

Officer-in-charge/Supervisor/SWO(FCPSU)

Unit (Department/Organisation):

Tel. No.:

Date:

**CONFIDENTIAL
CHILD PROTECTION REGISTRY
CASE ENQUIRY FORM**

Note This form is used for enquiring supplementary case information on those de-registered cases under Child Protection Registry (CPR). The enquirer should be a registered user of CPR.

1. CPR No.:
2. Name of child (in English): _____
(in Chinese): _____
3. HKBC/HKIC No. : _____
4. Date of birth: / / (DD/MM/YYYY)

Information enquired

- The relationship of the child-in-question and the perpetrator(s)/alleged perpetrator(s) of previous reported child maltreatment incident(s). (*please provide the previous reporting date(s) to CPR*)
(A) _____ (B) _____

Registered user of CPR

Name:	_____	Tel No.:	_____
Rank/Post:	_____	Fax No.:	_____
Organisation:	_____		_____
Date:	_____	Signature:	_____

Reply

- The relationship of the child-in-question and the perpetrator(s)/alleged perpetrator(s) of previous reported child maltreatment incident(s) is/are as follows:

(A) _____ Family member(s) Relative(s) Other(s)
(*Date of reporting*)

(B) _____ Family member(s) Relative(s) Other(s)
(*Date of reporting*)

Name:	_____	Tel No.:	_____
Post:	_____		_____
Date:	_____	Signature:	_____

Annex 15: Ordinances Related to Child Protection Work

1. Various legislative provisions are in place to protect children from maltreatment. This Annex lists the Ordinances related to child protection work and Annex 3 lists the Ordinances on criminal offences related to child maltreatment. The personnel may refer to relevant Ordinances when necessary.
2. Care and judgment should be exercised when considering the need to initiate legal proceedings and should take into account the related factors (e.g. safety of the child, severity of the maltreating behaviour, etc.). 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 trauma or distress to the child.

Relevant Ordinances Related to Child Protection Work

3. Relevant Ordinances related to child protection work include :
 - (a) Protection of Children and Juveniles Ordinance, Cap. 213
 - (b) Evidence Ordinance, Cap. 8
 - Section 4 Evidence given by children
 - (c) Employment Ordinance, Cap. 57
 - Employment of Children Regulations, Cap. 57B
 - Employment of Young Persons (Industry) Regulations, Cap. 57C
 - (d) Domestic and Cohabitation Relationships Violence Ordinance, Cap. 189
 - (e) Criminal Procedure Ordinance, Cap. 221
 - Section 79B Evidence by live television link
 - Section 79C Video recorded evidence
 - Section 79D Chief Judge to make rules
 - (f) 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
 - (g) Education Ordinance, Cap. 279

Section 74 Power of Permanent Secretary to order attendance at primary school or secondary school

Section 78 Enforcement of order

(h) Adoption Ordinance, Cap. 290

Section 22 Prohibition of certain payments

Section 23 Restrictions upon advertisements

Section 23A Restriction on arranging adoption and placing of infant for adoption

(i) Child Abduction and Custody Ordinance, Cap. 512

Definition on the Age of Child and Juvenile

4. While children involved in the definition of child maltreatment covered in this Guide refers to children and juveniles under the age of 18, the definitions of child and juvenile vary under different legislations because of different focuses of the Ordinances, considerations and objectives in legislation. Details are set out at [Appendix 1](#) to this Annex.

Protection of Children and Juveniles Ordinance, Cap. 213 (PCJO)

5. Statutory duties under the PCJO should be discharged by police officer or social worker as authorised by the Director of Social Welfare whenever situation warrants protecting a child or juvenile in need of care or protection. As stipulated under Section 34(2) of the PCJO, 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 to others,
and who requires care or protection.

6. It should be noted that not every suspected child maltreatment or child protection case warrants the application for an order under the PCJO. Such application should be considered on a case-by-case basis taking into account the parents'/carers' views and attitude towards professional intervention, the child's safety, psychological state, behaviour and views, and the seriousness of the incident(s), etc. In light of the possible adverse effects (e.g. distress to the child) caused by the legal proceedings, solicitation of the parents'/carers' co-operation in the intervention process should first be considered before resorting to statutory action to protect the child. Please refer to Appendix 2 to this Annex for the Frequently Asked Questions in relation to the PCJO.

Evidence Ordinance, Cap. 8

7. 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

8. 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' Courts. 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 defendant;
 - (b) the child is available for cross-examination (assuming the proceedings get that far); and any rules of the Court requiring disclosure of the circumstances in which the recording was made have been properly complied with.
9. Section 79B of the Criminal Procedure Ordinance, Cap. 221, allows child witnesses of certain sexual or violent offences to testify in Court through a live television video link (CCTV) system and admission of video recorded evidence as evidence-in-chief.

10. Under the Live Television Link and Video Recorded Evidence Rules, 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 Service to arrange Support Persons for child witnesses. For Child Witness Service, please refer to [Annex 20](#) to this Guide.

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, is under 18 years of age; or

(b) in the case of an offence to which Part IIIA of 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, 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.

**Frequently Asked Questions in relation to
the Protection of Children and Juveniles Ordinance (PCJO)**

1. Who can apply for an order under the PCJO for a child who has been maltreated/is suspected to be maltreated?

In accordance with Section 34(1) of the PCJO, a Juvenile Court, on its own motion or upon the application of the Director of Social Welfare (DSW) or of any person authorised by the DSW in writing or of any police officer upon being satisfied that a child or juvenile is in need of care or protection as stipulated under Section 34(2) of the PCJO, may make an order in respect of the child or juvenile.

2. What are the possible outcomes set out in the order granted under the PCJO?

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

- (a) appoint the DSW to be the legal guardian of such child or juvenile; or
- (b) commit him to the care of any person whether a relative or not, who is willing to undertake the care of him, or of any institution which is so willing; or
- (c) order his parent or guardian to enter into recognizance to exercise proper care and guardianship; or
- (d) without making such order or in addition to making an order of the above (b) or (c), make an order placing him for a specified period, not exceeding 3 years under the supervision of a person appointed for the purpose by the court.

3. What can be done if a child attends a clinic and is suspected to be a victim of child maltreatment while the parents refuse to take him/her to hospital for further examination?

In accordance with Section 34F(1) of the PCJO, any person authorised 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 instead of to a place of refuge.

Personnel of the clinic can report the case to the service unit handling the case (if the case is a known case of the unit) or to Family and Child Protective Services Unit (FCPSU) of the Social Welfare Department (SWD). The social worker of the unit concerned will assess if the PCJO should be invoked. The personnel of the clinic may also enlist the assistance of the Police to invoke the PCJO.

4. What can be done if the parents refuse to give consent for a child suspected to be maltreated to stay in hospital for examination/treatment?

- Section 34F(2) of the PCJO states that “A child or juvenile who is admitted to a hospital after being taken there under subsection (1) may be detained by the Director of Social Welfare in that hospital for so long as the attendance of the child or juvenile at that hospital is necessary for the purpose of medical or surgical attention or treatment”. If the authorised social worker of SWD or police officer has taken the child or juvenile to hospital in accordance with the procedures as set out in [Question 3](#) above, the authorised social worker of SWD may invoke Section 34F(2) of the PCJO.
- If the child is in life-threatening situation or in critical condition and must receive immediate medical examination or treatment, the attending medical officer may carry out treatment first without obtaining consent from the parties concerned if the medical officer considers that as a matter of urgency that treatment is necessary and is in the best interests of the child.
- If the alleged perpetrator is the father/mother/guardian of the child and he/she insists on not allowing the medical officer to examine the child who is not in a critical medical condition that warrants the medical officer to take immediate medical treatment, and while the child is not capable of giving his/her consent, then the related personnel (e.g. the social worker, nurse, medical officer, etc.) will continue to explain to the parent/guardian (including the alleged

perpetrator) the importance of arranging the child to receive physical examination, so as to obtain his/her consent for the child to be examined.

- The DSW may cause a notice to be served on the person having custody or control of the child or juvenile requiring that person to produce the child or juvenile for an assessment by a medical practitioner, clinical psychologist or an approved social worker¹³ of the state of his/her health or development or of the way in which he/she has been treated under Section 45A(1) of the PCJO.
- Under exceptional circumstances where in the end the parents/guardian(s) still refuse to allow the child or juvenile to undergo medical examination, the social worker of SWD may, in exercise of the power conferred by Section 34(1)(a) of the PCJO, apply to the court for an order appointing the DSW to be the legal guardian of the child or juvenile, having regard to the thorough considerations given to the needs of the case by the relevant medical practitioner, the social worker of SWD and the Police. Subject to approval of the application, the DSW may authorise arrangement for a medical officer to perform the necessary examination of the child.

5. What should be done when a child is considered in need of care or protection under Section 34(2)(b) or (c) and is to be taken to a place of refuge under Section 34E?

- Section 34E(1)(a) provides any persons authorised by DSW, or any police officer of the rank of station sergeant or above, to take any child or juvenile who appears to be in need of care or protection to a place of refuge/such other place. However, the power conferred by this subsection (1)(a) shall not be exercised in respect of a child or juvenile who appears to be in need of care or protection by virtue only of any matter referred to in section 34(2)(b) or (c), unless –
 - (a) the child or juvenile has within the preceding 2 weeks, been assessed by a medical practitioner, clinical psychologist or an approved social worker pursuant to section 45A;
 - (b) a notice issued and served under section 45A(1)(a) within the preceding one month in respect of the child or juvenile has not been complied with as regards the production of the child or juvenile for an assessment; or

¹³ An approved social worker refers to the social worker approved by the DSW to discharge the duty under Section 45A of the PCJO.

(c) the DSW is unable to ascertain the identity or whereabouts of any of the persons on whom notice may be served pursuant to section 45A(1)(a) for the purposes of an assessment of the child or juvenile.

- Whenever there are reasons to suspect or believe that the child's/juvenile's health, development or welfare has been/is being/appears likely to be neglected or avoidably impaired under Section 34(2)(b) or (c) of the PCJO to an extent that may require the removal of the child or juvenile to a place of refuge/such other place under Section 34E(1) and (1A), the social worker should consider, preferably with prior consultation with his/her senior officer(s) before taking action, serving a child assessment notice according to Section 45A(1). Social workers of non-governmental organisations (NGOs) can contact FCPSU of SWD for information and assistance, if appropriate.

6. When a child is considered in need of child assessment pursuant to Section 45A of the PCJO, what will be the procedure?

- Under Section 45A(1) of the PCJO, where the DSW has reasonable cause to suspect that a child or juvenile is, or is likely to be, in need of care or protection he may –
 - (a) cause a notice to be served on any person having custody or control of the child or juvenile requiring that person to produce the child or juvenile for an assessment by a medical practitioner, clinical psychologist or an approved social worker of the state of his health or development or of the way in which he/she has been treated; or
 - (b) require any person having the custody or control of the child or juvenile to allow the DSW to observe the condition of the child or juvenile.
- For cases requiring medical assessment under Section 45A, referrals should be made by the social workers of SWD to Hospital Authority (HA) or Department of Health (DH) as appropriate. For cases requiring psychological assessment, referrals should be made to the clinical psychologist of the hospital/clinic/SWD/NGO concerned. For cases requiring social assessment, referrals should be made to the approved social worker of SWD. The list of approved social workers is updated for circulation to the concerned colleagues of SWD regularly. Social workers of NGOs can contact FCPSU of SWD for information and assistance, if appropriate.

- Before serving the child assessment notice, the social worker of SWD should liaise with the relevant medical practitioner, clinical psychologist or approved social worker to make an appointment which should be within 2 weeks after serving the notice.
- The assessment notice shall be served or given to or left with the person intended to be served or to whom the notice is intended to be given to. If the person cannot be readily found, registered mail should be posted to, or left with the adult(s) at, his/her last known address of abode or business.
- According to Section 45A(2), any person who is served with a notice issued under subsection (1)(a) in respect of a child or juvenile shall take all reasonable steps to ensure that the child or juvenile is produced for assessment at the time and place specified in the notice.
- When a notice under Section 45A(1) of the PCJO is served, the social worker of SWD should follow up with the person having custody or control of the child or juvenile to produce the child or juvenile for an assessment. SWD social worker should make every possible means to facilitate the person having the custody or control of the child or juvenile to bring the latter for the assessment.
- Pursuant to Section 45A(3), the medical practitioner, clinical psychologist or approved social worker named in the notice or any person assisting him/her or acting on his/her behalf is to make an assessment and report his/her assessment to the DSW.
- Based on the assessment report, the observations and the data/information collected and other factors, the social worker of SWD should, preferably with prior consultation with his/her supervisor, make a decision within 2 weeks from the date of the assessment on whether or not removal of the child or juvenile is necessary pursuant to Section 34E or 34F of the PCJO.

7. What can be done if the parents refuse to give history of themselves or their child, who is hospitalised for suspected child maltreatment?

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

8. What can be done if the parent(s) insist(s) to take the child suspected to be maltreated away from the hospital after completion of medical management but before the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC)?

- Under normal circumstances, the investigating social worker should in consultation with the medical officer or other related professionals to carefully assess the suitability and feasibility of discharging the child home prior to MDCC. In case the child or juvenile is considered not suitable to be restored home, discussion may be made with the parent(s) on alternative living arrangement for the child to stay in relative's/friend's home. If the parent(s) refuse(s) to co-operate and risk of child maltreatment is considered high, Section 34E of the PCJO may be invoked to remove the child concerned to a place of refuge if the child was first brought to the hospital not under statutory power of Section 34(F)(1) of the PCJO.
- Under Section 34E of the PCJO, any person authorised in writing by the DSW or any police officer of the rank of station sergeant or above may take to a place of refuge or such other place as he/she may consider appropriate any child or juvenile -
 - (a) who appears to be in need of care or protection (under the situations specified in Section 34(2) of the PCJO as listed in [paragraph 5](#) of this Annex); or
 - (b) in relation to whom there is in force an order under Section 34(1) of the PCJO (as listed in [Question 2](#) above) and who is the subject of a motion or application for discharge or variation of the order.
- When the child or juvenile is still in the hospital, social worker of SWD and police officer can consider whether there is reasonable grounds to believe that the child or juvenile is “in need of care or protection” by virtue of any of the matters as set out in Section 34(2) and, if situation warrants, take the child or juvenile to a place of refuge. Within 48 hours, an application has to be made to a juvenile court. The parent(s) should be explained of the above arrangement. If the parent(s) change their mind and are willing to place the child or juvenile in the hospital voluntarily, the removal and application can be suspended.
- If the child or juvenile is taken to hospital by invoking Section 34F(1) of the PCJO as stated in [Question 3](#) above, authorised social workers of SWD may invoke Section 34F(2) of the PCJO which states that “a child or juvenile who

is admitted to a hospital may be detained by the DSW in that hospital for so long as the attendance of the child or juvenile at that hospital is necessary for the purpose of medical or surgical attention or treatment”.

9. What can be done if the investigating social worker is not allowed to enter into the premises while the child is believed staying in the premises and has been or is being assaulted, ill-treated, neglected or sexually abused?

The right of entry into premises is provided under various Sections of the PCJO for the purpose of –

- (i) removing any child or juvenile to a place of refuge or such other place as the DSW or authorised SWD officer or the police officer of the rank of station sergeant or above may consider appropriate [Section 34E(6)]; or
- (ii) ascertaining whether there is therein any child or juvenile who is or may be liable to be dealt with under the provisions of the Ordinance, or whether any offence under the Ordinance is being, or has been, committed, and may remove any such child or juvenile to a place of refuge, a hospital or such other places as the DSW or the authorised officer consider appropriate to be there detained [Section 44(1)]; or
- (iii) observing the condition of a child or juvenile or effecting a removal [Section 45A(8)],

and such entry shall not be effected by the use of force unless the DSW or authorised officer has first obtained a warrant issued by a Magistrate, Juvenile Court or District Court pursuant to the concerned provisions of the PCJO. Assistance from the Hong Kong Police Force, Fire Services Department, or other parties as appropriate may be enlisted as appropriate if the parent(s)/guardian(s) are uncooperative.

Annex 16: Family Assessment Risk Variables¹⁴

1. SEVERITY AND/OR FREQUENCY OF ABUSE

HIGH RISK	MODERATE RISK	LOW RISK
Severe physical injury (emergency medical treatment or hospitalization required); abuse of a sibling that resulted in death or permanent dysfunction of organ/limbs; weapon or instrument used; sadistic, violent patterns of behavior	Moderate physical injury	No physical injury or minor injury (nothing more than simple home treatment required)
Serious injuries at different stages of healing	Minor injuries/bruises at different stages of healing	No evidence of prior injury; most likely an isolated incident
Severe emotional harm/damage	Moderate emotional harm/damage	No discernable emotional harm/damage
Any evidence of sexual abuse		No evidence of sexual abuse, exploitation

¹⁴ Walker, P. J., & Tabbert, W. (1997). *Culturally sensitive risk assessment: An ethnographic approach*. Berkeley: University of California at Berkeley, California Social Work Education Center.

2. SEVERITY AND/OR FREQUENCY OF NEGLECT

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker is clearly not able to meet minimum food, shelter, hygiene, educational, and medical needs of child	There is some evidence that caretaker is failing to meet minimum food, shelter, hygiene, educational, and medical needs of child	Child's minimum food, shelter, hygiene, educational, and medical needs are being met
Child has suffered physical harm or illness from marginal health/safety/housekeeping standards of home	Child shows physical indications of trauma due to marginal health/safety/housekeeping standards of home	Child appears unaffected by marginal health/safety/housekeeping standards of home
Child is ignored, belittled, and/or shunned by caretaker	Child receives little attention, affection, or nurturing, but is not belittled or shunned by caretaker	Child's emotional needs are being met at a minimum level (receives attention, affection, praise, nurturing, etc., from caretaker)
Child has been frequently left unsupervised, resulting in injury/illness, or clear and present danger to the child	Child has been occasionally left unsupervised, in a potentially dangerous situation	Child has not been left unsupervised; there is no pattern of leaving child unsupervised

3. LOCATION OF INJURY

HIGH RISK	MODERATE RISK	LOW RISK
Head, face, neck, anus, genitals, abdomen, groin, evidence of internal injuries	Back, arms, thighs, feet	No injury, or injury on buttocks or bony body parts: knees, elbows, shins, hands, fingers

4. HISTORY OF REPORTED ABUSE OR NEGLECT

HIGH RISK	MODERATE RISK	LOW RISK
Pending child abuse/neglect investigation; previous report of serious abuse/neglect or multiple Child Protective Agency reports involving child, family, or perpetrator; report(s) substantiated	Previous report of abuse/neglect to Child Protective Agency unsubstantiated, but not unfounded	No previous reports of abuse/neglect to Child Protective Agency; unfounded report(s)

5. CHILD’S AGE, PHYSICAL, AND/OR MENTAL ABILITIES

HIGH RISK	MODERATE RISK	LOW RISK
Less than 5 years of age	5-9 years of age	10 years of age and over
Child has severe/chronic physical/mental handicap or disability that totally restricts his/her daily activities	Child has moderate physical/mental handicap or disability that restricts some daily activities	Child has no physical/mental handicap or disability
Child is severely/chronically ill, requiring specialized or continual medical care; medically fragile	Child has chronic illness that is not life threatening, but requires regular medical care	Child is generally healthy; any minor health problems are being addressed adequately
Child is significantly delayed in one or more developmental areas and may not recover even with treatment	Child is delayed in one or more developmental areas, requiring some treatment by specialist	Child exhibits no evidence of developmental delay
Child is moderately or severely mentally retarded	Child is mildly mentally retarded	Child is not mentally retarded
Child is totally unable to care for and protect self	Child needs frequent adult assistance to care for and protect self	Child is mature enough to care for and protect self

6. PERPETRATOR'S ACCESS TO CHILD

HIGH RISK	MODERATE RISK	LOW RISK
Perpetrator is in home, complete access to child; other adult will not predictably deny access; multiple perpetrators are present, perpetrator has unrestricted visitation rights and/or unsupervised visits	Perpetrator is in home, but access to child is limited; a nonperpetrating adult is in the house; nonabusing parent/other adult is able to protect child, but is ambivalent	Perpetrator is out of home, has either no access to child or access only during closely supervised visits; nonabusing parent/other adult is able and willing to protect

7. CHILD'S BEHAVIOR

HIGH RISK	MODERATE RISK	LOW RISK
Infant has severe colic; has extremely irregular eating/sleeping patterns; cries frequently and for prolonged periods of time	Infant is fussy; has irregular eating/sleeping pattern; cries frequently for no obvious reason	Infant is calm, easy to care for; has regular eating/ sleeping patterns; cries only for obvious reasons
Child's behavior is extremely violent, disruptive, or dangerous; child demonstrates chronic/severe hyperactivity or other serious behavioral problem	Child's behavior is disruptive or difficult to control; shows occasional pattern of mild hyperactive behavior; exhibits infantile behavior which negatively impacts interactions with others	Child's behavior appears age-appropriate; child shows no evidence of hyperactivity; minor behavior problems are being addressed adequately
Child has chronic diagnosed mental illness; history of suicide attempts; current suicidal ideation; self-destructive tendencies	Child has mental health condition which currently affects his/her ability to function adequately (i.e., mild symptoms of depression/ anxiety)	Child has no history of mental illness or psychiatric treatment, or current symptoms
Child has demonstrated chronic truancy; has run away frequently and for long periods of time (rarely returns voluntarily)	Child has history of periodic tardiness and/or truancy; has run away for short periods of time (returns voluntarily)	Child has record of normal school attendance; has made only verbal threats of running away
Child has admitted or diagnosed drug and/or alcohol dependency	Child has occasionally used mood-altering drugs and/or alcohol which impairs his/her decision-making abilities	Child has no known history of drug/alcohol misuse
Child has previous record of or current involvement in dangerous/violent criminal/delinquent behavior	Child has previous record of or current involvement in nonviolent criminal or delinquent behaviour	Child has no record of criminal/ delinquent behavior

8. CHILD/CARETAKER INTERACTION

HIGH RISK	MODERATE RISK	LOW RISK
<p>Child's interaction is extremely disruptive, violent, or unpredictable; child is unable/ unwilling to form more positive relationship with caretaker; child does not accept or respond to caretaker as an authority figure; infant does not appear bonded and is unresponsive to caretaker</p>	<p>Child's interaction with caretaker is occasionally disruptive, conflictual, or disrespectful; child does not appear highly motivated to change; child has some accumulation of resentment; infant appears marginally bonded and only occasionally responsive to caretaker</p>	<p>Child responds/relates to caretaker in age-appropriate manner; child engages in positive interaction with caretaker; child/caretaker minor conflicts are easily resolved, with no accumulation of resentment; infant appears highly bonded and very responsive to caretaker</p>
<p>Child is either extremely passive, fearful, or openly hostile and defiant toward caretaker; child never displays affection; child is extremely guarded toward caretaker</p>	<p>Child shows ambivalence, apprehensiveness, or suspicion toward caretaker; child only rarely displays affection; child is fearful or mistrustful at times; child is overly compliant</p>	<p>Child is able to develop trusting relationship with caretaker; child openly displays affection</p>
<p>Complete role reversal has occurred, with child assuming majority of caretaker functions and responsibilities</p>	<p>Some significant role reversal evident; child has assumed an inappropriate number of caretaker functions and responsibilities</p>	<p>Child/caretaker roles are age-appropriate</p>

9. CHILD'S INTERACTIONS WITH SIBLINGS, PEERS, OR OTHERS

HIGH RISK	MODERATE RISK	LOW RISK
<p>Child is abused or frequently exploited by siblings, peers, or others; child is ostracized or scapegoated; child engages in sibling rivalry of an aggressive or violent nature, requiring constant caretaker intervention</p>	<p>Child is victimized by or victimizes siblings, peers, or others to the point of being stressful, but not abusive; child's interactions are limited to siblings and peers somewhat younger than self</p>	<p>Child interacts with siblings, peers, or others in age-appropriate manner; sibling conflict or rivalry minor; child is too young to interact with others outside the family</p>
<p>Child has no friends; child's interactions are described as unpredictable and violent; peer interactions are nonexistent</p>	<p>Child's friendships are transient; relationships in general are problematic or stressful, with a negative impact on the family</p>	<p>Child is able to develop and maintain friendships easily</p>
<p>Child's interaction with siblings, peers, or others is largely negative due to current criminal activity, delinquency, drug abuse, truancy, or other socially unacceptable behavior</p>	<p>Child withdraws from interactions with siblings, peers, and others; displays frequent hostility or oppositional behavior toward most authority figures</p>	<p>Peer interactions have been negative in past, but there is no current indication of problems affecting the family; child interacts appropriately with siblings, although he/she may not relate as well to peers or others</p>

10. CARETAKER'S CAPACITY FOR CHILD CARE

HIGH RISK	MODERATE RISK	LOW RISK
<p>Caretaker has a diagnosed acute or chronic illness or disability that severely impairs his/her childcaring capacity, posing a serious risk to the child</p>	<p>Caretaker appears to have a physical or intellectual disability that interferes somewhat with his/her ability to provide adequate child care; illness or disability is untreated and/or caretaker's condition is deteriorating to the point that he/she requires supplementary services to maintain care role; caretaker has serious communicable disease that poses health threat to the child, although it does not impair childcaring capacity</p>	<p>Caretaker has no observable illness or disability which limits his/her ability to provide adequate child care; in spite of minor physical/intellectual limitation which impairs caretaker's ability to provide child care, with appropriate services he/she has been able to maintain childcare responsibilities and demonstrates a continued desire to do so</p>
<p>Caretaker has severe intellectual limitations that preclude him/her from providing minimal child care</p>	<p>Caretaker has a reported intellectual limitation which adversely affects his/her ability to provide minimal child care and protection, and no immediate improvement is expected, even with specialized treatment</p>	<p>Caretaker is viewed as competent; no intellectual impairment is evident</p>

11. CARETAKER/CHILD INTERACTION

HIGH RISK	MODERATE RISK	LOW RISK
<p>Caretaker demonstrates complete absence of behaviors indicating attachment, affection, or acceptance of child; exhibits no evident bonding, especially with infant; has extremely limited physical contact, if any at all</p>	<p>Caretaker only occasionally demonstrates attachment, affection, and acceptance of child; appears marginally bonded with child, especially infant; is uncomfortable with physical contact</p>	<p>Caretaker demonstrates appropriate attachment, affection, and acceptance of child; appears highly bonded with child, especially infant; exhibits frequent and appropriate physical contact; may be loving, without ability to be highly demonstrative</p>
<p>Caretaker views child as outsider in family; sees child as something evil and bad; actually hates child; constantly overemphasizes perceived faults of child; has adopted view of child as an appropriate target of exploitation; demands perfect behavior or total obedience to harsh and unreasonable rules; views child's presence as personal threat; states an inability to control child's behaviour</p>	<p>Caretaker blames child for family's problems; views child as a disruptive influence, or labels child in a derogatory manner which seriously undermines the caretaker-child interaction; expresses disapproval or criticism of child more often than necessary; speaks to and about child in resentful, vindictive, or angry manner; only occasionally expresses any acceptance of child</p>	<p>Caretaker speaks positively of child; expresses approval often and spontaneously; views child as unique individual requiring love and protection; may occasionally view child as disruptive, different, or bad, in response to child's behavior, but such perceptions are generally situation specific</p>

12. CARETAKER/CARETAKER INTERACTION

HIGH RISK	MODERATE RISK	LOW RISK
Caretakers demonstrate no positive affection or attachment and are openly hostile toward each other	Caretakers rarely display affection or have diminishing emotional ties, but are not openly hostile to one another	Only one caretaker is present; caretakers demonstrate positive affection and emotional support in their interactions
Violent arguments and threats of harm represent the only reported form of communication between caretakers; dominant caretaker uses authority/power to intimidate or verbally abuse the other caretaker, who is viewed as property or servant, or as unequal	Caretakers' communication is characterized by frequent periods of shouting, yelling, or extended arguments; one caretaker dominates the interaction, with the other assuming a submissive role; one caretaker has assumed all authority/power in childrearing practices	Caretakers communicate in positive manner with each other; caretakers verbalize and exhibit appropriate sharing of authority/power in childcaring responsibilities
Overly hostile custody/court proceedings have negatively affected the interaction of caretakers to the point of escalating physical violence or threat of violence; injuries may have occurred in these disputes	Caretakers are in direct competition for child's affection or are engaged in heated custody/court proceedings; caretakers rarely demonstrate support for each other in important matters or decisions concerning child	Caretakers indicate no ongoing custody conflicts or disputes; caretakers support each other in most important decisions and rarely engage in verbal conflict/arguments concerning child
The marital relationship is characterized by violence, with serious injuries inflicted by one or both caretakers; there are hostile separation/divorce proceedings with no possibility of reconciliation; primary caretaker displays pattern of entering into multiple short-lived or unstable primary relationships	Caretakers engage in frequent episodes of physical contact/fighting, but there are no documented reports of serious injuries or objects used; there is a mutually agreed upon separation, with reconciliation anticipated by both parties	Caretakers' communication occasionally is disrupted by episodes of verbal conflict; there are minor breakdowns in the authority/power structure related to childcare responsibilities; caretakers admit to rare instances of minor physical discord in marital disputes

13. CARETAKER'S PARENTING SKILLS/KNOWLEDGE

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker's level of care or supervision plan has repeatedly exposed child to danger, and harm has occurred; caretaker refuses to develop/implement corrective care or supervision plan	Caretaker's level of care or supervision plan places child at some risk, but child has never been actually injured as a result	Caretaker's level of care or supervision plan is adequate for child's age/special needs
Caretaker repeatedly administers discipline that is inappropriate, excessive, or harsh in relation to child's age or misconduct; physical discipline is caretaker's only response to misconduct; pattern of physical discipline is escalating in severity; violent/sadistic tendencies are evident	Caretaker's methods of verbal and physical discipline are administered inconsistently; some disciplinary forms are not appropriate to child's age or misconduct (e.g., verbal discipline that is used with a very young child or physical discipline that is applied for an involuntary physiological response)	Caretaker's methods of verbal and physical discipline are consistent with and appropriate to child's age and misconduct; sometimes caretaker is too rigid or permissive, but generally controls discipline
Caretaker demonstrates completely inadequate knowledge of age-appropriate child behaviors and does not recognize stages of child development; usually makes unrealistic demands of child; consistently sets expectations of child too high or too low (allowing child's behavior to become unmanageable); appears unlikely to acquire needed knowledge in this area or to be able to change expectations of child significantly	Caretaker demonstrates only minimal knowledge of age-appropriate child behaviors and only occasionally recognizes stages of child development; frequently makes unrealistic demands of child; seems capable of acquiring knowledge in this area and changing expectations of child with assistance	Caretaker demonstrates adequate knowledge of age-appropriate child behaviors and recognizes stages of child development; makes generally realistic demands of child; sets expectations for child that are neither too high nor too low
Caretaker demonstrates completely inadequate knowledge of child's basic needs, including nutrition, shelter, clothing, medical care, etc.; appears unlikely to acquire such knowledge	Caretaker demonstrates only minimal knowledge of child's basic needs including nutrition, shelter, clothing, medical care, etc.; appears capable of acquiring such knowledge with assistance	Caretaker demonstrates adequate knowledge of child's basic needs, including nutrition, shelter, clothing, medical care, etc.

14. CARETAKER'S SUBSTANCE/ALCOHOL MISUSE

HIGH RISK	MODERATE RISK	LOW RISK
Current drug/alcohol misuse or dependence has been admitted or verified and this dependence poses an immediate threat to the supervision of the child	Current drug/alcohol misuse or dependence has been admitted or verified, but does not constitute an immediate danger to child, although risk is present	No history of drug/alcohol dependency or misuse has been admitted or verified; former substance abuser has successfully completed a recognized treatment program (or has been actively involved in AA/NA); past or current alcohol abuse poses no risk to child
Caretaker's life revolves around the use or attainment of drugs or alcohol, endangering the child; substance misuse poses risk to family's financial resources and negatively affects caretaker's ability to meet basic needs of the child	Caretaker is currently experimenting with or using several substances; use tends to be episodic with no serious consequences or significantly reduced ability to parent; drug/ alcohol abuse is not physically/ psychologically addictive at this time, but pattern of misuse may be escalating	Alcohol is consumed only in moderation and caretaker is in control of his/her actions
Caretaker needs treatment in order to satisfactorily care for child and refuses treatment or is a chronic treatment dropout; maintains frequent contact and/or strong identification with suspected drug/alcohol abusers, which endangers the child	Caretaker admits to current substance abuse and is reluctant to seek treatment; caretaker is periodically incapable of caring for child due to drug/alcohol misuse; ability to make or assure adequate childcare arrangements is deteriorating	Caretaker has admitted to substance abuse, but is actively participating in recognized treatment program (or AA/NA); drug or alcohol misuse is present, but is not escalating and does not constitute any risk to the child

AA: Alcohol Anonymous (i.e. Alcohol Abuse Treatment Service)

NA: Narcotics Anonymous (i.e. Substance Abuse Treatment Service)

15. CARETAKER'S CRIMINAL BEHAVIOR

HIGH RISK	MODERATE RISK	LOW RISK
<p>Caretaker has a confirmed arrest record involving use of force or violence against children; has a previous history of violent crimes perpetrated against a member of immediate family; habitual criminal activity that severely impairs caretaker's current ability to provide minimal child care; habitual criminal and/or gang-related activity repeatedly exposes child to immediate danger from high-risk environment; child may have been actually harmed</p>	<p>Evidence of current participation in felonious criminal activity of a nonviolent nature; has a previous record of violent crimes perpetrated against non-related adult victims; is involved in habitual criminal activity that currently interferes with his/her ability to provide minimal child care; is involved in habitual criminal and/or gang-related activity that presents a risk to the child, although child has never actually been harmed</p>	<p>No evidence of any past or current caretaker involvement in criminal activities; previous criminal history poses no current risk to child <u>or</u> previous record of arrests is for nonviolent crimes that did not involve the child; caretaker is on probation and meeting all requirements of probation</p>

16. CARETAKER'S EMOTIONAL AND MENTAL HEALTH

HIGH RISK	MODERATE RISK	LOW RISK
Caretaker has a history of acute psychiatric episodes which have and/or are currently affecting his/her ability to provide minimal child care or supervision	Current indicators of psychological problems or mental illness appear to be present and if not monitored or evaluated, may pose risk to the child	There is no evidence or history of psychological disorder or mental illness; caretaker has no observable symptoms or indicators of mental illness; previous history of mental illness does not pose current risk to child
Caretaker's current psychological state appears to pose a high level of risk to the child; caretaker is unwilling and/or refuses to seek psychiatric treatment and/or evaluation; caretaker has a history of suicide attempts and/or makes current suicide gestures that place child at high risk and create high level of emotional distress for family; caretaker currently is making verbal threats of harm to child during episodes of psychiatric distress; caretaker has demonstrated inability to function independently due to a major mental disorder	Caretaker is currently exhibiting behaviors which may be a sign of deteriorating mental health, and treatment is not being sought; caretaker admits to current psychological or psychiatric problem, but is reluctant to seek treatment; caretaker exhibits difficulty in functioning in a child-caring capacity or in assuming tasks essential to family functioning	Current psychological disorder or mental illness is viewed by mental health professional as transitory and/or does not impair caretaker's ability to provide minimal child care; caretaker is receiving appropriate treatment which is proving successful
Caretaker shows extreme immaturity, self-absorption, low self-esteem, lack of empathy, impaired judgment, dependence, lack of impulse control, or irresponsibility which places child at substantial risk for abuse/neglect	Caretaker exhibits signs of self-absorption, impaired judgment, lack of impulse control, or irresponsibility which place child at increased risk for abuse/neglect	There is little evidence of personality traits which place child at risk for abuse/neglect

17. FAMILY INTERACTIONS/RELATIONSHIPS/STRESSORS

HIGH RISK	MODERATE RISK	LOW RISK
<p>Family members display hostility, aggression, and/or anger to each other in most interactions; almost no affection or attachment is observed among family members; constant disorganization in relation to household tasks is creating an atmosphere of chaos, confusion, and mistrust</p>	<p>Family is disorganized; frequent conflict is causing family problems or dysfunction; there is some isolation of family members, resulting in unsupportive interactions and indifference among family members; a minimal level of attachment and affection is observed; sharing of family responsibilities is problematic</p>	<p>Positive family interactions are observed; family appears close, supportive, and caring; family unit is currently stable; family conflicts are resolved without further incident; sharing of responsibilities among family members is age-appropriate; only occasional relationship problems or disorganization occurs</p>
<p>Family is totally overwhelmed by any form of stressors, regardless of how minor</p>	<p>Family copes adequately only with minor stressors, and shows some signs of deterioration in functioning</p>	<p>Family appears to cope well with stressors</p>
<p>Family structure is constantly in flux; family is totally overwhelmed by such transitions; primary caretaker's marriage or relationship with partner has completely deteriorated and consists of primarily negative interactions highly disruptive to family functioning</p>	<p>Family structure has recently changed or appears likely to change in the near future; family adapts poorly to such transitions; primary caretaker has unstable marriage or relationship with partner, but some interactions remain positive</p>	<p>Family structure is intact; primary caretaker has stable marriage or stable relationship with partner; if changes have occurred, family is adapting well</p>

18. STRENGTHS OF FAMILY SUPPORT SYSTEMS

HIGH RISK	MODERATE RISK	LOW RISK
<p>Family is isolated; few, if any, support systems are available in any form, or interactions are generally negative; no concrete assistance or emotional aid is available without professional intervention, which family is not likely to accept</p>	<p>Support systems such as extended family, neighbors, friends, and/or cultural, ethnic, or religious associations (formal and informal) are inconsistently available, or limited; support systems are only minimally committed to providing concrete assistance and emotional aid if needed to resolve intrafamilial stress and/or conflict</p>	<p>Support systems such as extended family, neighbors, friends, coworkers, and/or cultural, ethnic, or religious associations (formal and informal) are available; support systems are committed to providing concrete assistance and emotional aid, if needed, to resolve intrafamilial stress and/or conflict</p>
<p>Family is clearly in need of assistance from external support system, but intentionally avoids seeking any help and alienates anyone offering aid; family is isolated from ethnic group, and cultural/language differences appear as a significant barrier to family's receiving assistance</p>	<p>Family requires some assistance from external support systems, but is new to community and has not established viable support system as yet (or is not generally inclined to do so), but is likely to do so if required to meet child's basic needs; cultural/language differences of family present difficulty in acquiring assistance, but family is not totally isolated from ethnic group</p>	<p>Family requires no external support systems to resolve child protection issues or to cope with stress</p>
<p>Family lacks sufficient income and material resources to meet child's basic needs, and professional intervention is not likely to result in resolution of crisis due to family's extreme social isolation</p>	<p>Family lacks sufficient income and material resources to meet child's basic needs, but professional intervention is likely to result in resolution of crisis</p>	<p>Family has sufficient income and material resources to meet child's basic needs</p>

19. HISTORY OF ABUSE OR NEGLECT IN FAMILY

HIGH RISK	MODERATE RISK	LOW RISK
One or more previous incidents, both serious and frequent in nature, in which child sustained serious injury or substantial emotional trauma	Several previous incidents that are becoming increasingly serious in nature in terms of caretaker actions and potential harm to child; some emotional scars may be evident	No previous history of child protection intervention in this family or no current risk to child despite reports of minor concerns; previous incidents left no known emotional scars
Same child is repeatedly targeted for abuse/neglect by same caretaker(s)	At least one prior incident involving same caretaker/child or multiple child victims and/or multiple perpetrators	No previous history of abuse/neglect involving same caretaker/child
Abuse of sibling resulted in death or permanent dysfunction of organ/limbs	Minor to severe abuse of sibling past or present (no permanent damage)	No known abuse of sibling, past or present
Caretaker reports a personal history of serious, ongoing maltreatment as a child which resulted in severe injury and emotional scars; agency records or collaterals may confirm past CWS involvement with caretaker as a child	Caretaker reports a personal history of ongoing maltreatment by parents or other adult caretakers with only minor injuries or emotional trauma; agency records or collaterals may confirm past CWS involvement with caretaker as a child	Caretaker reports no more than minor incidents of abuse/neglect in his/her childhood history

20. PRESENCE OF A PARENT SUBSTITUTE IN THE HOME

HIGH RISK	MODERATE RISK	LOW RISK
<p>Parent substitute resides with the family and is the alleged perpetrator; parent substitute has an extremely detrimental influence on the primary caretaker's level of child care</p>	<p>Parent substitute is in the home on an infrequent basis and assumes only minimal caretaker responsibility for the child; or is in the home on a regular basis and has somewhat negative influence on primary caretaker's level of child care</p>	<p>Child's primary caretaker is biological parent(s); parent substitute in the home is supportive/stabilizing influence</p>

21. ENVIRONMENTAL CONDITION OF HOME

HIGH RISK	MODERATE RISK	LOW RISK
Home environment is hazardous, dilapidated, or poorly maintained and problems pose an immediate threat to child's well-being; home is dangerously unsafe, beyond repair, or condemned; living conditions are barely suitable for providing shelter; no functional utilities and no plan for reinstating them	Home environment has physical/structural problems, inoperable utilities, or sanitation problems, and requires immediate remediation; repairs are being accomplished or can be arranged; some utilities shut off but are currently unnecessary due to weather conditions or substitutes in place	Home environment is adequately maintained and structurally sound; utilities are available and functional
Home environment is filthy and/or hazardous to child, posing immediate and serious risk to child	Home environment presents minor housekeeping problems and/or safety hazards posing some risk to child	No serious housekeeping problems or safety defects observed in home environment
Home environment has serious overcrowding, necessitating adults--related or unrelated--and children of varying ages and opposite sex to occupy same bedroom space	Home environment is overcrowded and lacks some privacy for family members; children of varying ages and opposite sex may have to occupy same bedroom space	Home environment is no more than slightly overcrowded, but privacy is maintained for family members

**22. CARETAKER'S COOPERATION WITH AGENCY STAFF
AND/OR SERVICE PLAN**

HIGH RISK	MODERATE RISK	LOW RISK
<p>Client vehemently denies problems or responsibility for them; is evasive, verbally hostile, or physically assaultive/ threatening to agency staff and/or service provider</p>	<p>Client denies seriousness of problems, but is generally cooperative, not openly hostile</p>	<p>Caretaker recognizes problems, takes responsibility for actions, shows guilt or remorse, has made commitment to cooperate and/or is willing and able to protect child from abuse</p>
<p>Caretaker refuses to cooperate at every stage of service planning or treatment; caretaker actively or passively resists all service-related agency contact or involvement; caretaker actively sabotages service objectives/ treatment when coerced into using it</p>	<p>Caretaker accepts services verbally, passively resists cooperating or is argumentative at many stages of service planning/treatment; participation only obtained through prodding and constant intervention</p>	<p>Client accepts and adheres to most service objectives; any initial denial of problems has diminished; involvement with agency staff and outside service providers is generally voluntary, regardless of any court-ordered treatment plan</p>

23. PROGRESS OF CHILD/FAMILY IN TREATMENT

In this section, no rating is required. Rather, record progress in narrative form using the guidelines below.

In assessing this factor, caseworkers must rely on the assessments or opinions of outside professional staff involved in treating or providing services to the family. *Progress is defined as* the degree to which protection-related treatment goals and objectives have been achieved. The more problematic and conflictive the child's or family's conduct is in treatment, the higher the level of risk to the child. Staff must be cognizant of the fact that this assessment can have a significant bearing on the monitoring or future planning of treatment goals and objectives.

In determining whether there is a real and significant risk to the child, caseworkers should assess whether:

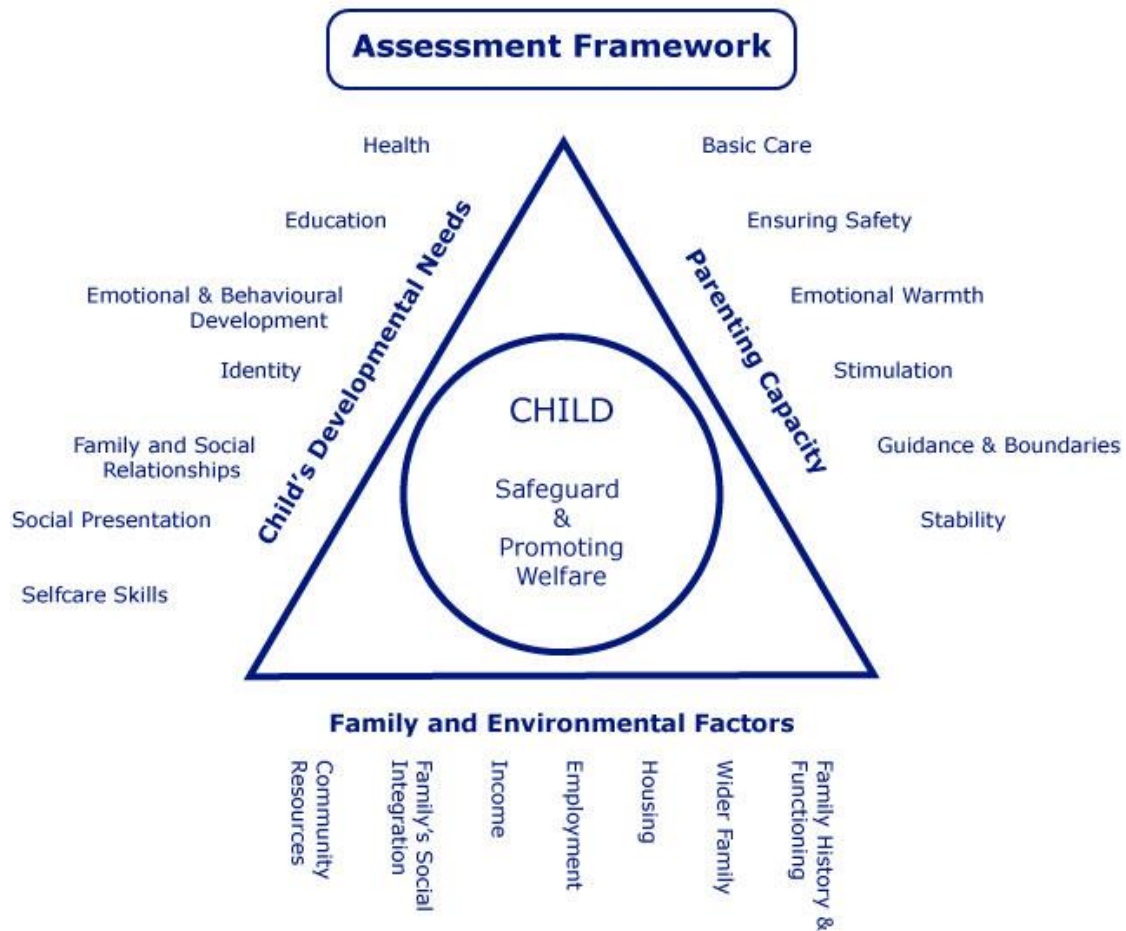
- The caretaker has demonstrated the commitment and ability to cooperate fully with the treatment plan.
- There is a history of stressful, conflictive, or unsuccessful participation in protection-related treatment plans.
- Clear evidence exists that the child's or family's conduct is directly responsible for the lack of progress in achieving treatment goals and objectives.
- The child or family has assumed inappropriate roles in his or her participation in the treatment plan.
- The child's or family's lack of progress in achieving treatment goals and objectives has created a real and significant risk to the child.

Annex 17: Signs of Safety® Assessment and Planning Framework¹⁵

What are we Worried About?	What's Working Well?	What Needs to Happen?
<p>HARM: Past hurt, injury or abuse to the child (likely) caused by adults. Also includes risk-taking behaviour by children/teens that indicates harm and/or is harmful to them.</p>	<p>Existing Strengths: People, plans and actions that contribute to a child's well-being and plans about how a child will be made safe when danger is present.</p>	<p>SAFETY GOALS: The behaviours and actions the child protection agency needs to see to be satisfied the child will be safe enough to close the case.</p>
<p>DANGER STATEMENTS: The harm or hurt that is believed likely to happen to the child(ren) if nothing in the family's situation changes.</p>	<p>EXISTING SAFETY: Actions taken by parents, caring adults and children to make sure the child is safe when the danger is present.</p>	<p>Next Steps: The immediate next actions that will be taken to build future safety.</p>
<p>Complicating Factors: Actions and behaviours in and around the family, the child and by professionals that make it more difficult to solve danger of future abuse.</p>		
<p>On a scale of 0–10 where 10 means everyone knows the children are safe enough for the child protection authorities to close the case and zero means things are so bad for the children that they can't live at home, where do we rate this situation? <i>Locate different people's judgments spatially on the two-way arrow.</i></p>		
<div style="display: flex; align-items: center; justify-content: center;"> 0 ← → 10 </div>		

¹⁵ Turnell, A and Murphy, T. (2017). Signs of Safety Comprehensive Briefing Paper, 4th edition

Annex 18: Assessment Framework¹⁶



The following elaboration on the Assessment Framework is copied from Appendix 4 of Part B4, London Child Protection Procedures, 5th Ed.

1. Dimensions of child's developmental needs

Health

- 1.1 Includes growth and development as well as physical and mental wellbeing. The impact of genetic factors and of any impairment need to be considered. Involves receiving appropriate health care when ill, an adequate and nutritious diet, exercise, immunisations where appropriate and developmental checks, dental and optical care and, for older children, appropriate advice and information on issues that have an impact on health, including sex education and substance misuse.

¹⁶ London Children Safeguarding Board. (2015). Triangle chart for the Assessment of Children in Need and their Families, *London Child Protection Procedures*, 5th Ed. Part B4, Appendix 4. (http://www.londoncp.co.uk/chapters/appendix_4.html)

Education

- 1.2 Covers all areas of a child's cognitive development which begins from birth. Includes opportunities: for play and interaction with other children to have access to books; to acquire a range of skills and interests; to experience success and achievement. Involves an adult interested in educational activities, progress and achievements, who takes account of the child's starting point and any special educational needs.

Emotional and behavioural development

- 1.3 Concerns the appropriateness of response demonstrated in feelings and actions by a child, initially to parents and caregivers and, as the child grows older, to others beyond the family. Includes nature and quality of early attachments, characteristics of temperament, adaptation to change, response to stress and degree of appropriate self control.

Identity

- 1.4 Concerns the child's growing sense of self as a separate and valued person. Includes the child's view of self and abilities, self image and self esteem, and having a positive sense of individuality. Race, religion, age, gender, sexuality and disability may all contribute to this. Feelings of belonging and acceptance by family, peer group and wider society, including other cultural groups.

Family and social relationships

- 1.5 Development of empathy and the capacity to place self in someone else's shoes. Includes a stable and affectionate relationship with parents or caregivers, good relationships with siblings, increasing importance of age appropriate friendships with peers and other significant persons in the child's life and response of family to these relationships.

Social presentation

- 1.6 Concerns child's growing understanding of the way in which appearance, behaviour, and any impairment are perceived by the outside world and the impression being created. Includes appropriateness of dress for age, gender, culture and religion; cleanliness and personal hygiene; and

availability of advice from parents or caregivers about presentation in different settings.

Self care skills

- 1.7 Concerns the acquisition by a child of practical, emotional and communication competencies required for increasing independence. Includes early practical skills of dressing and feeding, opportunities to gain confidence and practical skills to undertake activities away from the family and independent living skills as older children. Includes encouragement to acquire social problem solving approaches. Special attention should be given to the impact of a child's impairment and other vulnerabilities, and on social circumstances affecting these in the development of self care skills.

2. Dimensions of parenting capacity

Basic care

- 2.1 Providing for the child's physical needs, and appropriate medical and dental care. Includes provision of food, drink, warmth, shelter, clean and appropriate clothing and adequate personal hygiene.

Ensuring safety

- 2.2 Ensuring the child is adequately protected from harm or danger. Includes protection from significant harm or danger, and from contact with unsafe adults/other children and from self-harm. Recognition of hazards and danger both in the home and elsewhere.

Emotional warmth

- 2.3 Ensuring the child's emotional needs are met giving the child a sense of being specially valued and a positive sense of own racial and cultural identity. Includes ensuring the child's requirements for secure, stable and affectionate relationships with significant adults, with appropriate sensitivity and responsiveness to the child's needs. Appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement.

Stimulation

- 2.4 Promoting child's learning and intellectual development through encouragement and cognitive stimulation and promoting social opportunities. Includes facilitating the child's cognitive development and potential through interaction, communication, talking and responding to the child's language and questions, encouraging and joining the child's play, and promoting educational opportunities. Enabling the child to experience success and ensuring school attendance or equivalent opportunity. Facilitating child to meet challenges of life.

Guidance and boundaries

- 2.5 Enabling the child to regulate their own emotions and behaviour. The key parental tasks are demonstrating and modelling appropriate behaviour and control of emotions and interactions with others, and guidance which involves setting boundaries, so that the child is able to develop an internal model of moral values and conscience, and social behaviour appropriate for the society within which they will grow up. The aim is to enable the child to grow into an autonomous adult, holding their own values, and able to demonstrate appropriate behaviour with others rather than having to be dependent on rules outside themselves. This includes not over protecting children from exploratory and learning experiences. Includes social problem solving, anger management, consideration for others, and effective discipline and shaping of behaviour.

Stability

- 2.6 Providing a sufficiently stable family environment to enable a child to develop and maintain a secure attachment to the primary caregiver/s in order to ensure optimal development. Includes: ensuring secure attachments are not disrupted, providing consistency of emotional warmth over time and responding in a similar manner to the same behaviour. Parental responses change and develop according to child's developmental progress. In addition, ensuring children keep in contact with important family members and significant others.

3. Family and environmental factors

Family history and functioning

- 3.1 Family history includes both genetic and psycho-social factors. Family functioning is influenced by who is living in the household and how they are related to the child; significant changes in family / household composition; history of childhood experiences of parents; chronology of significant life events and their meaning to family members; nature of family functioning, including sibling relationships and its impact on the child; parental strengths and difficulties, including those of an absent parent; the relationship between separated parents.

Wider family

- 3.2 Who are considered to be members of the wider family by the child and the parents? This includes related and non-related persons and absent wider family. What is their role and importance to the child and parents and in precisely what way?

Housing

- 3.3 Does the accommodation have basic amenities and facilities appropriate to the age and development of the child and other resident members? Is the housing accessible and suitable to the needs of disabled family members? Includes the interior and exterior of the accommodation and immediate surroundings. Basic amenities include water, heating, sanitation, cooking facilities, sleeping arrangements and cleanliness, hygiene and safety and their impact on the child's upbringing.

Employment

- 3.4 Who is working in the household, their pattern of work and any changes? What impact does this have on the child? How is work or absence of work viewed by family members? How does it affect their relationship with the child? Includes children's experience of work and its impact on them.

Income

- 3.5 Income available over a sustained period of time. Is the family in receipt of all its benefit entitlements? Sufficiency of income to meet the family's needs. The way resources available to the family are used. Are there financial difficulties which affect the child?

Family's social integration

- 3.6 Exploration of the wider context of the local neighbourhood and community and its impact on the child and parents. Includes the degree of the family's integration or isolation, their peer groups, friendship and social networks and the importance attached to them.

Community resources

- 3.7 Describes all facilities and services in a neighbourhood, including universal services of primary health care, day care and schools, places of worship, transport, shops and leisure activities. Includes availability, accessibility and standard of resources and impact on the family, including disabled members.

Annex 19: Reference Kit for Chairperson of Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment

I. Introduction

This Reference Kit provides information and practice wisdom for the reference of social workers who may chair the Multi-Disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC). The Reference Kit includes information on the basic principles for conducting meetings, highlights significant issues that need to be considered in chairing MDCC, elaborates some of the points as stipulated in [Chapter 11](#) of the Guide and provides examples to illustrate various situations. In handling special situations, the Chairperson should make appropriate arrangements based on professional judgment, bearing in mind that the best interests of the child should be the paramount concern.

II. Basic Principles

An Effective Meeting

2. 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.

A Competent Chairperson

3. 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 summarise what has been achieved and agreed; and
- (m) avoid jumping to conclusions.

III. Tasks to be Performed and Good Practice

Checklist for Chairperson

4. A checklist for Chairperson on tasks to be performed before, during and after MDCC is at [Appendix 1](#) to this Annex. The checklist is for reference only and can be adjusted to fit individual case situation. Some good practice and suggestions in handling various situations are listed below for reference of chairpersons.

Before MDCC

Essential Information the Chairperson Should Know

5. The Chairperson should acquaint himself/herself with the following information:
 - (a) Guidelines and ordinances by making reference to the relevant chapters and appendices, wherever necessary:
 - (i) Protecting Children from Maltreatment – Procedural Guide for Multi-disciplinary Co-operation
 - (ii) Protection of Children and Juveniles Ordinance, Cap 213

- (iii) Personal Data (Privacy) Ordinance, Cap 486
- (b) Services for children
- (c) Child Protection Investigation Report prepared by the investigating social worker and any relevant reports prepared by other professionals
- (d) Any new case development not covered in the written reports/notes prepared by the members prior to MDCC.

Logistical and Venue Arrangement

6. The Chairperson should make proper arrangements on the logistical arrangements and venue with the investigating social worker:
 - (a) If the child suspected to be maltreated is hospitalised, MDCC should preferably be held in the hospital and medical social worker's assistance can be solicited in arranging the venue.
 - (b) 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.
 - (c) If the parent(s) who is/are the alleged perpetrator(s) and the child(ren) are invited to attend MDCC, the Chairperson has to assess whether separate waiting areas/sessions for the parent(s) and the child(ren) is required to prevent the parent(s) from influencing, interfering with and/or exerting pressure on the child(ren) directly or indirectly.
 - (d) The Chairperson should arrive at the venue earlier to ensure that appropriate seating and other logistical arrangements have been made.

Arrangement of Family Participation

7. Usually, both parents of the child concerned (including the alleged perpetrator) will be invited to attend the second part of MDCC. If there will be important decision affecting the child's life, the non-custodial parent will also be invited to attend MDCC. The Chairperson, in consultation with members as appropriate, will decide at which time point the family members will join the MDCC. Feedback from members is usually not required if the parents are invited to join MDCC at the same time when the initial follow-up plan is formulated. Under the following situations, members should be consulted before making the decision:

- (a) if any of the parent is considered not suitable to attend;
- (b) if the child or other family member is suggested attending MDCC; or
- (c) if separate session for the parents is suggested.

Record of the consultation and decision making should be made. The feedback form at [Appendix 3](#) to this Annex can be used as needed.

- 8. To facilitate the participation of family members in MDCC, child care support is to be provided as far as possible.

During MDCC

Introduction

- 9. To start a MDCC, the Chairperson should:
 - (a) stress the importance of confidentiality and explain concerns relating to the Personal Data (Privacy) Ordinance, Cap. 486 [PD(P)O] (please refer to [paragraphs 11.28 to 11.31 of Chapter 11](#) of this Guide). The Chairperson should state the “Introductory Remarks in Relation to Personal Data (Privacy) Ordinance, Cap 486” (please refer to the [Appendix 4](#) to this Annex) and invite members to confirm whether they wish to retain control of the use of the data provided by them during MDCC. Members should also be reminded that the information given in MDCC should not be disclosed to other organisations without the permission of the contributor in any context other than that of child protection;
 - (b) 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;
 - (c) explain and re-confirm the arrangement of family participation in the MDCC;
 - (d) 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;
 - (e) remind members who are potential witnesses the danger of contamination of evidence (please refer to paragraph 11.36 of Chapter 11 of this Guide);

- (f) explain that the Police would remain neutral during the discussion on the nature of the incident(s) in order to avoid being accused of showing prejudice in the criminal investigation (please refer to [paragraph 11.45 of Chapter 11](#) of this Guide);
- (g) emphasise that the decision of MDCC on the nature of the incident(s) is from the perspective of protecting child's safety and has no binding effect on the prosecution of the alleged perpetrator;
- (h) explain the reason if more than 10 working days is needed to conduct the MDCC;
- (i) explain the reason if the case has not been reported to the Police; and
- (j) seek members' consent if audio recording is necessary to facilitate notes-taking (any such record should be destroyed once the notes of the meeting is confirmed).

Information Sharing

10. To allocate more time for discussion and formulation of follow-up plan, the Chairperson may ask members to highlight only the key points especially when their written reports have already been distributed prior to the MDCC.
11. The Chairperson may remind members that detailed description of the maltreating behaviour which may cause contamination of evidence and divert the focus of MDCC should be avoided.
12. The police officer in charge of the investigation of the suspected child maltreatment case will inform MDCC of the progress, but not the details of the investigation of the incident(s). The Chairperson may however invite the Police to provide relevant information obtained from the investigation if it is considered essential for the discussion on the nature of the incident(s) and formulation of a suitable follow-up plan for the child(ren) concerned.
13. Clarification should be made in case of inconsistency in the information provided by different members.

Discussion

Nature of the Incident(s)

14. The decision on whether the incident(s) is/are child maltreatment is from the concern of protecting child's safety, the focus of which is on what has

already happened. The Chairperson may ask members to note the definition of child maltreatment as set out in [Chapter 2](#) of this Guide and the consideration when deciding whether an incident is child maltreatment or not. Besides, it only provides operational guidelines in dealing with cases involving child maltreatment and has neither legal effect nor legal implications. Therefore the decision of MDCC regarding the nature of the incident(s) has no binding effect on prosecution of the alleged perpetrator(s) while members may give views on the implications of prosecution on the best interests of the child(ren).

15. The Chairperson can lead members to review and consider the situation of the whole family and classify or re-classify the incident(s) (if necessary, to be discussed in the review conference). Nonetheless, the Chairperson may advise members that the discussion on the nature of the incident(s) should be confined to the child suspected to be maltreated where investigation has been conducted. If other children of the family are suspected to be maltreated, an investigation on those children should be conducted before MDCC is held. While leading members to reach a conclusion on the nature of the incident(s), the Chairperson may need to differentiate whether certain view given by member is a fact, a professional opinion, a personal opinion or an unfounded statement.
16. The police officer should remain neutral during the discussion on the nature of the incident(s) in order to avoid being accused of showing prejudice in the criminal investigation. All other members are expected to give views on the nature of the incident(s). However, if they have reservation to give views, they should not be compelled to do so. The Chairperson may ask them to explain the reason for not giving views. If the alleged perpetrator is a staff member or volunteer of an organisation, for possible conflict of interest, other staff of the same organisation attending the MDCC is not to be asked to give views on the nature of the incident(s). If more than one person of the same profession from the same organisation attend the MDCC, the Chairperson may advise these members to discuss among themselves and give a consensus view on the nature of the incident(s).
17. It will be useful if elaboration on the concerns relating to the nature of the incident(s) be made in the conclusion to facilitate accurate recording for reference of the professionals following up the case and for explaining to the parents/child who may have different interpretations on the nature of the incident(s) from members of MDCC. For example, the Chairperson may remark that “members considered the case as physical harm/abuse because

serious injuries have been inflicted on the child even though members recognised that the parent had no intention to harm the child when exerting physical punishment”.

18. Child maltreatment may be a criminal offence though prosecution of the alleged perpetrator may not be initiated for every child maltreatment case. If the case has not been reported to the police before the MDCC, there should be a discussion in the MDCC whether reporting to the police is required. If members recommend not reporting the case to police, reasons for considerations should be recorded. Individual members may seek endorsement from their organisations according to their internal guidelines as appropriate.

Risk Assessment

19. No matter whether an incident is considered a harm/maltreatment to a child or not, risk assessment should be conducted to consider the likelihood of occurrence/recurrence of harming/maltreating the child concerned as well as other children in the family. The potential perpetrator is to be identified if appropriate.
20. Reference should be made to “Risk Assessment and Decision Making on Protecting the Safety of Children” in [Chapter 7](#) of this Guide. While risk factors are to be identified, protective factors and family strengths should also be identified. The factors considered in the risk assessment should form the foundation of the follow-up plan to safeguard the safety for the child(ren).

Need Assessment

21. Assessment on the needs of the child and family is required for the formulation of a thorough follow-up plan for the child(ren) and family to safeguard the safety and interests of the child(ren). Reference can be made to the “Assessment Framework” in [Annex 18](#) to this Guide.

Case Category and Follow-up Plan

22. To conclude whether the case is a child protection case based on the nature of the incident(s) and the risk assessment (please refer to [paragraph 11.26 of Chapter 11](#) of this Guide). Child protection case refers to:

- (a) the incident(s) was/were considered by members as a harm/maltreatment to a child; or
- (b) the incident(s) was/were not considered by members as a harm/maltreatment to a child but the child was considered of having a high risk of harm/maltreatment in future; or
- (c) the incident(s) was/were not ascertained by members as a harm/maltreatment to a child who was also not considered of having a high risk of harm/maltreatment in future but, with analysis on the concrete information available, members considered that the harm/maltreatment incident was very likely to have happened;

that the child is in need of protection.

23. In regard of item (c) above, members should quote concrete examples or information to illustrate why they considered that the suspected maltreatment incident was very likely to have happened despite that they could not ascertain the incident as a harm/maltreatment to a child, such as *“Since (certain information) could not be validated, members consider that sexual abuse cannot be established. Risk of child maltreatment is not high (e.g. the alleged perpetrator does not have further chance to access to the child). However, considering that, members considered that the suspected sexual abuse incident(s) was very likely to have happened and protection for the child concerned is required.”* This case category is usually found in suspected sexual abuse incident. For example, a child initially disclosed to have been sexually abused by his/her carer with description of the abusive process yet he/she later changed his/her version/recanted. As the related information could not be validated, members could not conclude that there was a sexual abuse. On the other hand, risk of further harm to the child by that carer is low (e.g. the alleged perpetrator is a tutor or a coach and the child has withdrawn from that activity). Despite so, members believed that the child’s initial disclosure of the suspected sexual abuse incident was very likely to have happened that the child is considered to be in need of protection.
24. The objectives of the follow-up plan and actions for the child(ren) and the family are to reduce/eradicate the risk factors identified and to strengthen the protective factors so as to ensure the safety of child(ren) and welfare of the family. As the co-operation of the child(ren) and the parents (and/or the significant family members) is very important to the implementation of the follow-up plan, their views should be considered and addressed carefully on

the basis that the child(ren)'s safety and best interests should be the paramount concern.

Safety of the child concerned and other family members

25. For safeguarding the safety of the child concerned, the safety plan formulated for the child should address various risks of maltreatment faced by the child (including concrete short/long term objectives, concrete actions and steps that professionals as well as the parents should take) so as to reduce/eradicate the risk factors identified and to strengthen the protective factors. Discussion on the care arrangement of the child(ren) and the need for applying any statutory order for the child(ren) should be included.
26. The Chairperson may also suggest members considering voluntary follow-up to the child and family be tried but a statutory order be applied if the case progress is not satisfactory, e.g. the parents has not implemented the follow-up plan as promised within a certain period of time, and at that time point the child is considered in need of care or protection fulfilling the grounds of application.
27. The Chairperson should also advise members to note whether any actions are required to ensure the safety of other children and family members in the household, e.g. a parent might have been battered by his/her spouse, the perpetrator/alleged perpetrator might have attempted self-harm behaviour after the disclosure of the incident(s), etc.

Needs of the child concerned or his/her family

28. The Chairperson may invite members to consider the provision of the following services, which are not exhaustive, to meet the needs of the child and his/her family with reference to the result of need assessment:
 - (a) Medical service (e.g. specialised medical follow-up, psychiatric service)
 - (b) Clinical psychological service
 - (c) Child assessment service
 - (d) Counselling
 - (e) School support
 - (f) Child care service (day or residential)

- (g) Extra-curricular activities
 - (h) Parent education programme
 - (i) Specific treatment/assistance, e.g. drug/gambling/alcoholic treatment programme, housing assistance
29. The Chairperson may advise members to make recommendations on services/assistance in general such as housing assistance and financial assistance instead of suggesting a specific programme/scheme, like Compassionate Rehousing and Comprehensive Social Security Assistance, etc., where specific assessments on the family's eligibility of different schemes are required.
30. Though members may wish to make recommendations to meet the long term needs of the child/family, it is not always practicable in view of the changing situation of the family, e.g. the parents are applying for divorce and having dispute on the care arrangement. Hence, those services which may meet the immediate needs of the child/family should be accorded higher priority. The Chairperson should encourage members to adopt a multi-disciplinary approach in implementing the follow-up plan.

Conflict Resolution and Decision-making

31. As the nature of the incident(s) (i.e. whether the incident is considered as child maltreatment) and the follow-up plan for the child are very delicate issues, related decisions should be made by consensus in 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 protecting child's safety.
32. 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 interests of the child(ren); and

(f) exploring additional information that will facilitate decision-making.

33. 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 notes. If it is still difficult to make a final conclusion, the Chairperson may ask members to respect the views of the key worker, who will follow-up the case, first and discuss whether there is a need to review the implementation of the follow-up plan by preparing report(s) or convening a review conference.

Appointment of Key Worker and Core Group

34. Members should confirm the appointment of service unit of the key worker following up the case (please make reference to [paragraphs 11.69 to 11.71 of Chapter 11](#) of this Guide). The Chairperson should remind related social worker(s) that case transfer, if required, should be carefully planned, taking into consideration the emotional reaction of the child(ren) and family members involved.
35. The Chairperson should ask members to confirm the membership of the core group if a core group is considered necessary for follow-up the case. The membership includes professionals who will work with the child(ren) or parents/carers. Those who will provide follow-up services but have not attended the MDCC can also be invited to join the core group. The Chairperson may remind members that timely notification of any deviation from MDCC recommendations should be sent to the key worker prior to the actions to be taken as far as practicable, especially for the recommendations relating to protection measures such as child care arrangement and statutory action. The key social worker should inform members of MDCC and discuss the need to alter the original follow-up plan if the safety of child concerned will be affected due to the failure in implementing the follow-up plan or the changes in child's/family's situation.

Family Participation

36. Meeting with family is a part of the whole MDCC. The Chairperson should request all members to attend and to contribute relevant knowledge and views to facilitate the communication with the child(ren) concerned and/or his/her parents.

37. While the child(ren) concerned/parents will join the second part of MDCC, the Chairperson, in consultation with members as appropriate, will decide at which time point the child(ren)/parents will join the MDCC according to individual case merit but at least when the initial follow-up plan is formulated. The second part may start earlier while discussing other agenda items for the benefit of the individual case.
38. There may be cases where a parent appears to be uncooperative during the child protection investigation period. The Chairperson/investigating social worker will, prior to MDCC, brief the parent about the proceedings of MDCC and how he/she can express his/her views to members. The parent will also be required to follow the general rules of MDCC so that effective communication between him/her and members can be achieved. However, if there is a decision that the parent will not be invited after consulting all members, the parent should be informed of this decision and his/her views on the incident(s) and the follow-up plan should be obtained prior to MDCC (please refer to [paragraph 11.52 of Chapter 11](#) of this Guide on the consideration for decision). In MDCC, discussion should be made on the way of informing the parent of the decisions and recommendations of MDCC.
39. Before meeting with the child(ren)/parents, the Chairperson may have a brief discussion with members on the flow of discussion and which members will assist in explaining certain information.
40. When meeting with the child(ren)/parents, the Chairperson may remind them and members of the general rules of MDCC as needed. While explaining to the child(ren)/parents the decision of members on nature of the incident(s), the Chairperson should note that child(ren)/parents may have different interpretations on the nature of the incident(s) from members. Hence, the Chairperson and members are advised to elaborate the concerns considered and raised in MDCC in detail and highlight the nature of the incident(s) and category of case is decided from the perspective of protecting the child's safety. At the same time, child(ren)'s/parents' concerns and feelings should also be recognised and addressed as far as possible.
41. In the process of discussion, views of child(ren)/parents should be considered. In case there is a need for members to reconsider the recommendations of follow-up plan, the child(ren)/parents may be asked to withdraw from the MDCC for a short period of time.

42. The Chairperson may make reference to the following *DOs* and *DON'Ts* if the child(ren) and/or his/her/their parents are present in MDCC:

DOs

- (a) Attend to the child(ren)'s/parents' reaction to members' views.
- (b) Facilitate the exchange and discussion between the child(ren)/parents and members as appropriate, including the discussion on the risk factors and level of risk on further harm/maltreatment on child, protective factors to ensure child's safety, needs of the family, and goals and plan of the case follow-up, etc.
- (c) Ensure that the child(ren)/parents understands members' views and concerns.
- (d) Enlist the child(ren)'s/parents' co-operation in implementing the follow-up plan agreed in MDCC.

DON'Ts

- (a) Use jargons and technical terms.
- (b) Give lecture to parents or conduct counselling/therapeutic treatment in MDCC.
- (c) Ask questions relating to the admission of guilt by the parent(s) who is/are alleged perpetrator(s).

Registering Case in the Child Protection Registry (CPR)

43. For cases to be registered in the Child Protection Registry (CPR), reference should be made to the "Nature of the incident(s)" of CPR Data Input Form regarding the category of nature of the incident(s) and [Annex 2](#) of this Guide on the concern of data transfer. If the child concerned involved in the following categories, the information of the child should be registered in CPR.

- (a) the incident(s) was/were considered by members as a harm/maltreatment to a child; or
- (b) the incident(s) was/were not considered by members as a harm/maltreatment to a child but the child was considered having a high risk of harm/maltreatment in future; or

- (c) the incident(s) was/were not ascertained by members as a harm/maltreatment to a child who was also not considered of having a high risk of harm/maltreatment in future but, with analysis on the concrete information available, members considered that the harm/maltreatment incident was very likely to have happened
44. Besides, if the child concerned or his/her sibling(s) is/are not considered to be harmed/maltreated but is/are potentially at risk of harm/maltreatment by virtue of risk factors of harming/maltreating a child identified, the information of the child(ren) can also be registered in CPR.

Need for Report on Implementation of Follow-up plan

45. The Chairperson should lead the discussion on the need for the key worker or members of MDCC to report in writing the status of the implementation of the follow-up plan and to discuss the time frame for submitting the report. Members should be reminded that the report, if required, should only include information about whether the follow-up plan recommended by MDCC has been implemented as planned and if there is any difficulty/change making the follow-up plan not feasible and a review is required. Normally, such information should already been available within two to three months after the MDCC. Such information may also be added in the notes of MDCC as a post-meeting note if appropriate and these are available before issuance of the notes. Bearing in mind the principles as stipulated in PD(P)O, information regarding new development of the case should not be released to parties not following up the case.

Need for Review Conference

46. The Chairperson should seek views of members on the need to convene review conference if it is foreseeable that further information on the case will be coming up (e.g. new evidence on the suspected maltreatment incident(s) to be collected) or that any follow-up action is required to be reviewed (e.g. family members' change in attitude towards the child care plan, members need to review whether certain follow-up services for the child is/are still required by considering the progress of counselling/therapeutic treatment received by the parents). The Chairperson may also invite members to suggest the timing and format of case review by the core group.

Arrangement of the Written Reports and Notes of MDCC

47. The Chairperson needs to confirm with members on the arrangement about the written reports and notes of MDCC:
- (a) if any member wants to take back the written report from other members;
 - (b) if members give consent on sending relevant reports/notes of MDCC to the absent members who have asked for having a copy of such; and
 - (c) if members give consent on releasing the information/reports/notes of MDCC to other follow-up units or core group members-to-be as needed, such as clinical psychologist or social worker of residential service unit.

After MDCC

De-briefing for Family

48. If needed, the Chairperson and/or the investigating social worker should arrange debriefing for the child(ren) and the parents who have participated in MDCC, especially if the case will be transferred to another unit, for preparing them adequately. Discussion during debriefing should be noted in the case record.
49. In case the parent(s) is/are not satisfied with the decisions made by the MDCC, the Chairperson/investigating social worker should explain to them the reasons of the decisions. In case the parent(s) want(s) to lodge any complaint about the MDCC, they should be informed of the procedures for handling complaints (please refer to [paragraphs 11.86 to 11.89 of Chapter 11](#) of this Guide).

Notes of MDCC

50. The Chairperson should clear the notes of MDCC prepared by the investigating social worker before issuing to members for amendments (please make reference to the sample of Notes of MDCC at [Appendix 2](#) to this Annex). It should be noted that the terms “victim” and “perpetrator” are not to be used if the incident is not classified as child maltreatment.
51. In case certain members have taken back the written reports from other members after MDCC, record has to be made in the notes of MDCC.

Besides, a brief summary of the significant points of the report made by those members should be included in the notes.

52. The notes of MDCC should be transmitted in a secure manner to protect the personal data of the child(ren)/family.

Letter to Parents

53. Regardless whether the parent(s) has/have attended MDCC, the Chairperson/the supervisor of the unit convening the MDCC should issue a letter to the parent(s) after the MDCC. In view that separate letters may be required for divorced/separated parents, the letter can be sent to one parent with a remark in the letter as appropriate that a letter with the same content/purpose will also be sent to another parent (please make reference to sample letter at [Appendix 3](#) to this Annex).

**Checklist for Chairperson of Multi-disciplinary Case Conference on
Protection of Child with Suspected Maltreatment (MDCC)
(for Reference Only)**

I. Before MDCC

- 1. To decide membership and consider any conflicts of role/interest among individual members
- 2. To decide the arrangement of family participation (including the child) and to consult members if there is special consideration
- 3. To arrange briefing to the child and family members for MDCC arrangement including possible decision making
- 4. To prepare and issue the agenda in advance
- 5. To oversee the logistical arrangements, e.g. drinks and waiting area for family members, setting up of the meeting room
- 6. To confirm the attendance of members, and whether the absentee has prepared written reports and requested to get relevant reports/notes of MDCC

II. During MDCC

Professional Sharing and Discussion

Introduction

- 1. To introduce members, absentees and reasons
- 2. To state the purposes of MDCC
 - share information
 - discuss nature of the incident (police will remain neutral) (defining the nature of the incident has no binding effect on criminal investigation and prosecution)
 - risk and need assessment
 - discuss category of case and formulate follow-up plan
- 3. To inform members of the arrangement of family participation
- 4. To remind members to keep confidential the case information
- 5. To explain PD(P)O provisions
 - any members request to control data and prohibit other parties from complying with the data access request on their behalf
- 6. To explain if more than 10 working days is needed to conduct MDCC
- 7. To explain the reason if the case has not been reported to police

Information Sharing and Discussion

- 1. To invite members to share the information
 - to remind the need of sharing information on a need-to-know basis
 - to alert members who are potential witnesses to avoid contamination of evidence
- 2. Discussion on the nature of the incident(s) (should not compel members to give views if they have reservation to do so)
 - whether the incident is child maltreatment (if yes, type of harm/maltreatment)
 - elaboration of the nature of the incident(s)/further concerns to be noted (e.g. despite that a harm/maltreatment to a child cannot be ascertained, with analysis on the concrete information available, members consider that the suspected maltreatment incident was very likely to have happened)
 - identity of perpetrator (identified or unidentified) if the incident is considered child maltreatment
- 3. Need for reporting the case to the Police if not done so before
- 4. Risk assessment on child maltreatment (may refer to the Family Assessment Risk Variables at [Annex 16](#))
 - risk factors and level of risk on child concerned
 - risk factors and level of risk on other children of the family
 - protective factors of child/family and family strengths
 - potential perpetrator identified if needed
- 5. Discussion on category of case (whether it is a child protection case)
- 6. Need assessment on the child and family (may refer to the Assessment Framework at [Annex 18](#))
 - immediate needs significant to the child and family
 - other significant needs of the child and family
- 7. Discussion on the follow-up plan
 - for safety of child (including arrangement for alternative temporary placement and application of statutory order)
 - for needs of the child (e.g. arrangement for alternative temporary placement due to other concerns, medical follow-up, clinical psychological assessment, etc.)
 - for safety and needs of other family members
 - appointment of key worker/follow-up unit, core group and other professionals to follow up the case
- 8. Need for registering the information of the child concerned or his/her sibling(s) in Child Protection Registry

- 9. Need for review conference
- 10. Need for report on implementation of follow-up plan (if needed, which member(s) to prepare)
- 11. Handling of reports and notes of MDCC
 - any members need to take back reports from other members
 - to seek members' consent on giving relevant reports/notes to absent members
 - to seek members' consent on releasing the information/reports/notes to other follow-up unit(s) and core group member(s), if any, which/who has/have not attended the MDCC, as appropriate, such as clinical psychologist or social worker of residential service unit.
- 12. Arrangement of family participation
 - messages to convey to family and by which members
 - remind members not to ask family members questions such as whether they are related to and/or responsible for the maltreatment incident, or make such accusation against them
 - to discuss ways of informing family members the decision of MDCC if they do not attend the MDCC

Meeting with Family Members (at appropriate time during or after the above discussion)

- 1. Welcome the family and introduce members
- 2. To explain the purpose of family participation
- 3. To inform the family of the rules of MDCC as needed
- 4. To share with the family of views come up in the first part of MDCC and discuss with family on relevant issues
 - summary of reports shared by members in the first part of MDCC as appropriate
 - nature of the incident(s) (with elaboration) and concerns to be noted (e.g. sexual abuse incident(s) might very likely have happened)
 - risk factors of child maltreatment, family strengths and needs of the child/family (may ask family members to give views on analysis made by members)
 - follow-up plan for child/family (to invite the family to give views on the goals/follow-up plan on protecting child's safety, and how they can co-operate in the follow up process to achieve the goal of protecting child's safety)
- 5. To re-consider the follow-up plan as needed if the parents make alternative suggestions

III. After MDCC

- 1. To arrange debriefing to family members (if needed) if they have attended the MDCC/informing them decision of MDCC if they have not attended
- 2. To issue notes of MDCC to members (with post-meeting notes on family's feedback if they have not attended the MDCC and progress of implementation of the follow-up plan if appropriate)
- 3. To ensure members have received the draft notes before deadline for confirmation of notes
- 4. To notify members the confirmation of draft notes or issue confirmed notes to members and, if needed, the follow-up parties
- 5. To issue a letter to parents to list the follow-up plan recommended by MDCC

(Sample for Reference)

**Notes of Multi-disciplinary Case Conference
on Protection of Child with Suspected Maltreatment**

Re : Name of child : xx

Sex/Age : xx

Date :

Time :

Venue :

Present :

Absent with apology :

1. Introduction

1.1 The Chairperson introduced the major objectives of the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) as follows:

- i. to share case information among various professionals;
- ii. to discuss and determine the nature of the incident(s);
- iii. to assess risk of child maltreatment;
- iv. to discuss the category of case (whether it is a child protection case);
- v. to assess the needs of the child/family; and
- vi. to formulate follow-up plan for the family.

1.2 The Chairperson reminded members to keep confidential the case information and informed members of the relevant provisions of the Personal Data (Privacy) Ordinance. *He/she indicated that the (organisation) would control the use of data contained in the child protection investigation report and the notes of MDCC and prohibited other parties from complying with the data access request on their behalf. (Name of members) also indicated that they would control the use of data in their parts.*

1.3 *(As appropriate) The Chairperson informed members that more than 10 working days was needed to conduct the MDCC due to (the reason) _____.*

1.4 *(As appropriate) The Chairperson informed members that the case had not been reported to the Police due to (the reason) _____.*

1.5 The Chairperson informed members that *(family members)* had been invited to join the MDCC and they *would attend (at what time/stage)/(family members) had been invited to join the MDCC but they would not join due to (the reason)*.*

(Note: please state the reasons if certain family member was not invited to join or special arrangement would be made.)

2. Information Sharing

2.1 The following members had presented their reports

- Investigating social worker (with/without* written report)
- Medical officer (with/without* written report)
- Medical social worker (with/without* written report)
- Ward nurse (with/without* written report)
- Police (with/without* written report)
- School teacher (with/without* written report)
- School social worker (with/without* written report)
- Others, please specify:

(Note: Order of sharing according to the actual sequence in the MDCC)

2.2 Besides the information covered in the written reports that were distributed to all members, members also provided the following information:

(Note: Significant points are to be highlighted here if the written report has been taken back from individual member after MDCC.)

3. Discussion

(Note: please specify in related item(s) if individual member requested to record different views expressed in MDCC.)

3.1 Nature of the incident

3.1.1 With consensus among members where police officer remained neutral *(if there is other member remaining neutral, a record may be made as needed)*, the Chairperson concluded that, from the perspective of protecting child's safety, the incident was considered as child maltreatment/was not considered as child maltreatment*. *(As appropriate)* The Chairperson reminded that the decision of MDCC regarding the nature of the incident had no binding effect on prosecution of the alleged perpetrator(s).

3.1.2 *(For child maltreatment incident)* The type(s) of harming/maltreatment behaviour was/were*:

- physical harm/abuse
- neglect
- sexual abuse
- psychological harm/abuse

The perpetrator(s) was/were _____ *(if identified)/*
unidentified*.

- 3.1.3 *(As appropriate)* Members had the following consideration/concerns regarding the nature of the incident(s):
- (e.g. reasons for concluding the incident as child maltreatment or not child maltreatment, concerns/suspicions raised by members though the incident was not considered as child maltreatment.)*

3.2 Risk of child maltreatment

- 3.2.1 *(As appropriate)* Members identified the following risk factors of child maltreatment on the child concerned and the level of risk:

- i.
- ii.

(Note: it is suggested that risk factors with moderate and high risk that required follow up services be recorded)

- 3.2.2 *(As appropriate)* Members identified the following risk factors of child maltreatment on other child(ren) of the family and the level of risk:

- i.
- ii.

(Note: it is suggested that risk factors with moderate and high risk that required follow up services be recorded)

- 3.2.3 *(As appropriate)* Members identified the following strengths within the family which might contribute to child protection:

- i.
- ii.

- 3.2.4 *(As appropriate)* Members identified the following support and resources outside the family which might contribute to child protection:

- i.
- ii.

3.3 Category of the case

With discussion, members classified that this was/was not* a child protection case with the following situation (*as appropriate*):

- the incident(s) was/were considered by members as a harm/maltreatment to a child
- the incident(s) was/were not considered by members as a harm/maltreatment to a child but the child was considered of having a high risk of harm/maltreatment in future
- The incident(s) was/were not ascertained by members as a harm/maltreatment to a child who was also not considered of having a high risk of harm/maltreatment in future but, with analysis on the concrete information available, members considered that the harm/maltreatment incident was very likely to have happened;

that the child was in need of protection.

3.4 Needs of the child concerned and his/her family

(*As appropriate*) Members identified the following needs of the child and family related to the protection of and for the best interests of the child that required the following follow-up services:

- i.
- ii.

3.5 Follow-up plan for the Child and Family

3.5.1 Members discussed the following follow-up plan for the child and family:

3.5.1.1 (*As appropriate*) For protection of child's safety and/or to reduce risk of child maltreatment identified, the following follow-up plan was recommended:

- i. Child care arrangement:
- ii. Care or protection order was recommended/not required/might be considered if _____ *(please specify)
with the consideration that _____ *(please specify)
- iii. Other arrangements: (*e.g. contacts between child and the perpetrator/potential perpetrator, etc.*)

3.5.1.2 (*As appropriate*) To meet the identified needs of the child and family, the following service(s) was/were* recommended: (*e.g. psychological service, support services, tangible services, etc.*)

- i.
- ii.

(*Note: child care arrangement and statutory order may also be considered for protection of the best interests of the child*)

3.5.1.3 Social worker of (*Service Unit*) would follow up the case as the key worker. Core group consists of the following (*member/organisation/service unit/professional*) :

- i.
- ii.

4. Any Other Business

4.1 The information of child/and (*information of sibling*)* would be/would not be* placed into the Child Protection Registry (*If placed*) under the following category:

- Cat.(a) The incident was considered as a harm/maltreatment to a child in the MDCC or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation.

- Cat.(b) A child was considered of having a high risk of harm/maltreatment in future though the incident was not considered as a harm/maltreatment to a child in a MDCC or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation.
- Cat.(c) A child who is not suspected to be harmed/maltreated but is considered potentially at risk of harm/maltreatment by virtue of risk factors of harming/maltreating a child identified.
- Cat.(d) The incident was not ascertained as a harm/maltreatment to a child who was also not considered of having a high risk of harm/maltreatment in future in a MDCC or by all professionals concerned (for cases where MDCC was dispensed with) after the investigation but, with analysis on the concrete information available, professionals considered that the harm/maltreatment incident was very likely to have happened.

(As appropriate) For Cat.(a), (b) or (d), the type(s) of maltreatment was/were*:

- physical harm/abuse
- neglect
- sexual abuse
- psychological harm/abuse

4.2 Members considered that a review conference was needed/not needed*.

(If needed) The review conference would be held *(date or time frame)*.

4.3 Members considered that a report on the implementation of follow-up plan was/was not* needed. Report would be prepared by *(name of member)(date or time frame)*.

(If needed) The report would be included in the notes of MDCC as post-meeting notes/was to be forwarded to members in ___months*.

4.4 *(As appropriate)* Members agreed that the following arrangements would be made: *(e.g. arrangement of case transfer)*

i.

ii.

4.5 *(As appropriate)* The following member(s) had not kept the written report(s) prepared by member(s) after MDCC:

i. *(name of member)* had not kept any written reports prepared by other members

ii. *(name of member)* had not kept the written report prepared by *(name of member)*

4.6 *(As appropriate)* Members agreed to send the following reports/notes of MDCC to *(absent member/professional who will follow up the case /core group member)*:

i. *(with reason)*

ii.

5. Meeting with Family Members

Members met with *(family members)* at *(time)* during the (agenda item).

(Note: please give a summary of meeting with family members including their views on the recommended follow-up plan)

(Note: If family members had not attended the MDCC, please state how they would be informed of the conclusion and recommendations.)

(Post-meeting note:)

(e.g. feedback of parents on recommended follow-up plan if they have not attended the MDCC, report of status of implementation of the recommended follow-up plan)

** Delete as appropriate*

(Sample for Reference)

Letter to Parents After Multi-disciplinary Case Conference
(The content of the letter can be revised for individual case)

(Date)

Dear Mr YYY/Madam XXX,

Name of Child :

Sex/Age :

Thank you for your attendance at the above Multi-disciplinary Case Conference held on *(Date)* in respect of XX. *(If the parents have not attended the MDCC: A Multi-disciplinary Case Conference comprised of (the participating organisation(s)) was held on (Date) in respect of the above-named child.)*

During the conference, the participants were concerned about the child's condition. Considering your existing family situation *(or child disciplinary pattern/difficulties in child care, etc.)*, members of the conference have formulated the following follow-up plan:

- (1) Clinical psychological service will be arranged to assist XX in emotional regulation;
- (2) The caseworker will apply to XX Court for XX a care or protection order;
- (3) Residential child care service will be arranged for XX. If there is urgent need during the waiting time, the caseworker will arrange for XX to receive emergency residential child care service; and
- (4) Doctor XX of Paediatrics & Adolescent Medicine of XX Hospital will continue treatment for XX.

Miss/Mr XX will continue following up the case and will discuss with you in the implementation of the above follow-up plan. You may contact Miss/Mr XX on xxxx xxxx./*(If the case will be transferred to another unit) The case will be transferred to Family and Child Protective Services Unit/Integrated Family Service Centre/Integrated Services Centre (Name of the service unit) for follow-up. The contact telephone number of the unit is xxxx xxxx.*

We hope that you would co-operate with Miss/Mr XX and other follow-up parties (*name(s) of the unit and personnel may be listed if needed*) so as to ensure proper care of XX. For enquiries, please contact me on XXXX XXXX.

Yours sincerely,

()
Chairperson of the Multi-disciplinary
Case Conference/Supervisor of the
Investigating Unit

(If the same letter will be issued to another parent, a remark may be added as needed)

Note: a letter with the same content/purpose will be sent to XX's father/mother.

We hope that both parents can co-operate with the personnel to ensure proper care of XX.

Annex 20: Witness Support Service for Child Witnesses

Background

1. The Evidence Rules made under Section 79D of the Criminal Procedure Ordinance allow that where a child is a witness, with the permission of the Court, to be accompanied by a Support Person in the room from which the child is giving evidence over the live television link. This is subject to the provision that the person is not a witness in the case and has not been directly involved in the investigation of the case.
2. The Social Welfare Department (SWD) in co-operation with the Police has established the first "Witness Support Programme" in 1996 to provide Support Persons for child witnesses in case of need. At the initial stage, the service was mainly provided by a group of trained volunteers and staff of SWD.

Objective of the Service and Role of the Support Person

3. The objective of the service is to help reduce the fear and anxiety of child witnesses when giving evidence in Court by providing a "Support Person" to accompany the witness during the trial.
4. The role of Support Person is to assist child witnesses in the pre-trial preparation and to accompany the witness in giving evidence in Court through the CCTV system.
5. Pre-trial preparation means facilitating a child witness to familiarise with the court procedures in a way that does not prejudice the rights of the defendant. The Support Person or any personnel neither involves the child in discussing the evidence nor rehearsing or practising giving testimony in Court. The Support Person will not provide any advice on the case or prejudice the witness's testimony, and will not make any comments on or express any personal views about the case/persons involved in the case/trial.

Service Provision and Arrangement

6. A group of trained social workers and volunteers of non-governmental organisations (NGOs) subvented by SWD are available to be called upon as "Support Persons" for child witnesses.

7. Before the trial, the Support Person assigned to the case will meet the child witness and explain to the child about the trial process and the role as a witness in accordance with the Child Witness Pack so as to help the child witness build up confidence as a witness. The Support Person will accompany the witness for the pre-trial Court visit for familiarisation of the court procedures. The pre-trial Court visit will be arranged by the Police and Court staff. The Support Person will accompany the witness and help the latter calm down during the trial process.
8. If the Court permits a child, when giving evidence, be accompanied by a Support Person, the Family Conflict and Sexual Violence Policy Unit of the Police will liaise with the concerned NGO for the arrangement of a Support Person (for application procedures, police officers should refer to Force Procedure Manual 34-13).

Code of Practice

9. To ensure that Support Persons do not behave in any manner prejudicial to the trial process, they have undergone a training programme provided by SWD or NGOs and the Police and have to adhere to an agreed Code of Practice.
10. In order to avoid allegations of coaching made by the Defence, concerned parties should ensure that the Support Persons are not informed about details of the case but merely the nature of the alleged offences. They must not be shown any of the witness's statement(s) or transcripts of video-recorded statements. Where a video record of the child's allegation is to be introduced in evidence-in-chief, the Support Person **must not** accompany the child when the child views the record to refresh his/her memory prior to the trial.

Annex 21: Counselling/Therapeutic Treatment before Court Hearing and after Maltreatment

Pre-trial Counselling/Treatment Service

1. After the child protection investigation, members of the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) will, based on the individual needs of the child concerned, recommend whether there is a need to provide counselling service (including those before trial) to the child and his/her family members with a view to reducing the harm of incident on the child.
2. Pre-trial counselling service is focused on the individual needs of the child having experience of maltreatment. It aims at addressing the following aspects of the child at the pre-trial stage:
 - (a) Child's feelings and reactions after the investigation process – e.g. fear, anger, insecurity, guilt, shame or confusion
 - (b) Sex education and issues relating to sexuality, including giving information about physical and sexual development, contraception, sexual orientation and self-protection (e.g. good touch and bad touch), etc.
 - (c) Social skills and peer relationships, to help the child overcome the possible sense of isolation, establish support and develop normal connections and friendships
 - (d) Rebuilding of self-esteem, including improvement of self-image and enhancement of wholeness
3. In providing counselling service, the key worker should work with both the child concerned 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. Family support service may be mobilised in the course of counselling to improve the parenting skills, the family's living environment and financial status, and to provide service on substitute care for the child.
4. In circumstances where the child, after the maltreatment incident(s), cannot resolve his/her inner feelings or overcome feelings of fear, distress, helplessness, shame or distrust, etc. thus leading to emotional imbalance and

mental instability, counselling or therapeutic treatment may need to be provided to the child by a clinical psychologist or child psychiatrist.

5. When pre-trial counselling/therapeutic treatment is rendered, special attention should be paid to the following:
 - (a) The child's need(s) must take precedence.
 - (b) All therapeutic work undertaken should have clear objectives and be reviewed to ensure continuous improvement in practice.
 - (c) Depending on the case nature, efforts should be made to avoid direct contact between the alleged perpetrator and the child.
 - (d) Care should be taken to avoid having counselling/therapeutic treatment affects the criminal proceedings adversely.
 - (e) 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 social worker, clinical psychologist or child psychiatrist following-up the case.
 - (f) Anyone who provides counselling/therapeutic treatment (usually including key worker, clinical psychologist and child psychiatrist) must realise they might have to give evidence in court.
 - (g) Where there is more than one victim, counselling/treatment should be arranged for them individually.
 - (h) If inconsistent information is given by the child in the course of counselling, the social worker, clinical psychologist, or child psychiatrist following up the case should be reminded of the following:
 - (i) remind the child the need to tell the truth;
 - (ii) encourage the child to disclose the information to the Police;
 - (iii) observe the rules regarding confidentiality in their own professionals' Code of Practice; and
 - (iv) seek advice from their supervisors and consider taking various appropriate actions to safeguard the child's safety and interests .
 - (i) At all stages in the counselling process, the personnel providing counselling/therapeutic treatment should avoid using any exercises or materials which presume that maltreatment has actually taken place, or discussing with the child any scenarios of the maltreatment incident(s).

Records of description of any game books or apparatus, etc. used should be properly kept as these records may be subject to disclosure to the Defence as unused material.

- (j) The key worker, clinical psychologist or child psychiatrist providing pre-trial counselling service should attend the case review meeting, if needed, to contribute to the review/formulation of the follow-up plan for the child concerned, his/her siblings and carers. The key worker should be responsible for the co-ordination and review of follow-up on child protection.

Written Records of Counselling/Therapeutic Interviews

- 6. Written records should be properly kept and retained by the personnel providing counselling/therapeutic treatment to the child concerned. In a prosecution, the Defence may request access to some or all records kept about a child witness. These records may be subject to disclosure to the Defence as unused material.
- 7. Nature and content of counselling/therapeutic treatment undertaken with the child concerned prior to the trial will be subject to scrutiny by the Defence. Extra caution should therefore be exercised in keeping the case records. Records should be soundly based on facts and susceptible to proof. Professional judgements should be backed by reasonable reasoning and concrete evidence. Views or speculative interpretations of the child's behaviour, play or drawings by personnel providing treatment should be recorded accurately and not withheld.
- 8. Personnel providing counselling/therapeutic treatment to a child should be aware that counselling/treatment often enables a child to reveal further incident(s) or information about the maltreatment which may result in a subsequent prosecution. All pre-trial counselling service should therefore be supported by case recording in the light of the above guidance.

Video Records of Counselling/Therapeutic Interviews

- 9. Some personnel regularly record on video their counselling/therapeutic work with children. It enables them to review the content of each session, reflect on their own contributions and plan subsequent sessions more carefully. A video-recording of a counselling/therapeutic interview should remain confidential and be kept securely. Personnel providing

counselling/therapeutic treatment should be aware that such records may be subject to disclosure to the Defence as unused material. Materials contained in a case record may also suggest lines of cross examination.

10. For video-recording, it is preferable that only equipment which has the function 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. Prescribed consent should be secured in every case, and arrangements should be made for secure storage and subsequent destruction of recordings.

Post-trial Stage

11. After the trial, there will be no constraint on the nature of counselling /therapeutic treatment. The key worker should continue to assist the child and his/her family/carers through counselling service and family support services while the clinical psychologist or child psychiatrist should carry on the therapeutic treatment as needed by the child.
12. Apart from the personnel providing counselling/therapeutic treatment, other follow-up personnel, including personnel from the residential child care services, are not to probe into the maltreatment incident(s) of the child.