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

Revised 2020

Labour and Welfare Bureau
社會福利署 Social Welfare Department
Education Bureau
衞生署 Department of Health
HKCSS 社聯

"Protecting Children from Maltreatment —
Procedural Guide for Multi-disciplinary Co-operation"

With Co-ordination of
Social Welfare Department,
Hong Kong Special Administrative Region,

drawn up jointly by
Labour and Welfare Bureau
Education Bureau
Department of Health
Hong Kong Police Force
Hospital Authority
The Hong Kong Council of Social Service
and
Non-governmental Welfare Organisations

Foreword

Every child has a right to protection against any forms of harm and exploitation.

Anyone who comes into contact with a child in the course of his or her work, regardless of sector, must use his or her expertise to safeguard the best interests of the child. When children are harmed, people from different sectors should work together to ensure that children are properly protected and cared for.

The Social Welfare Department (SWD) has, in collaboration with relevant government departments, non-governmental organisations (NGOs) and professionals, drawn up a "Procedural Guide for Handling Child Abuse Cases" (Procedural Guide) for reference by different professionals in taking necessary actions for suspected child maltreatment cases. Revised versions of the Procedural Guide have been issued in 1993, 1998 and 2007 respectively. The revised version of 2015 mainly focused on the review of "Multi-disciplinary Case Conference" and the related parts.

Following the changes in the society and family circumstances, the problem of children being harmed/maltreated has become more complicated. A few serious child maltreatment cases occurred in Hong Kong in the past few years have also attracted much public attention. Therefore, stakeholders from various sectors consider it necessary to provide a clearer guidance and reference for frontline personnel so as to identify families having risk of child maltreatment at an early stage. Multi-disciplinary collaboration should also be strengthened to prevent occurrence of child maltreatment. For children who have been harmed, all professionals should work together in protecting the physical and psychological safety of the children and assisting them in dealing with the adverse consequences of their harm. Furthermore, they should assist the families of children holistically so that they could make good use of their resources and exert the family's functions to safeguard the safety and best interests of the children.

At its meeting held in October 2016, the Committee on Child Abuse (CCA), which is comprised of individuals from different sectors and professions, supported SWD to form a task group to conduct a comprehensive review of the Procedural Guide. The task group members include representatives from various government bureaux/departments and NGOs, including the Labour and Welfare Bureau, Education Bureau, Department of Health, Hong Kong Police Force, Hospital Authority, The Hong Kong Council of Social Service and NGOs under relevant service settings.

From November 2016 to November 2019, the task group and its six focus groups had conducted comprehensive and in-depth discussions on different aspects. References were also made to procedural guides overseas and views given by personnel in different sectors during the consultation process. With concerted effort, the following purposes of this review are achieved:

(i) to help various professionals keep a more consistent view on the definition and scope of child maltreatment;

(ii) to provide references for frontline personnel so as to facilitate their identification of families with higher risk of child maltreatment；

(iii) to provide a clearer guide for frontline personnel to handle and follow up cases of different types of suspected child maltreatment and protecting the children who have been harmed/maltreated；

(iv) to enhance the co-operation among the child, his/her family and professionals in order to formulate and implement the follow-up plans; and

(v) to define the roles and responsibilities of professionals from different disciplines in facilitating and enhancing their co-operation.

At the meeting of the CCA held on 20 December 2019, the newly revised "Protecting Children from Maltreatment – Procedural Guide for Multi-disciplinary Co-operation" ("Guide") was endorsed. The "Guide" is to be implemented on 1 April 2020.

The completion of the review of the "Guide" did rely on the efforts and contributions of task group members and personnel from various disciplines. Considering the large numbers of personnel involved, please excuse us from listing only the names of task group members but not the ones of other relevant personnel in detail.

After a comprehensive review and revision of the "Guide", its layout and content are quite different from the previous versions. Personnel are advised to read **Guide to the "Guide"** to take note of the matters that require attention when reading the "Guide".

Although the "Guide" has extended the content on the procedures, matters for attention and reference materials of child protection work and addressed many societal concerns in the recent years, it will still be updated from time to time as needed. The most important thing is that personnel can put the principles of "Child-focused, Safety First", "Family Participation" and "Multi-disciplinary Co-operation" into actual

practice and exert the spirit of co-operation with the attitude of collaborating in partnership based on “Working Together and Trusting Each Other” in order to achieve the common goal of “Protecting the Vulnerable and for the Welfare of Children”.

Social Welfare Department
January 2020

Membership of Task Group

Convenor

Social Welfare Department	Ms Lee Kam-yung, Dora (November 2018 to December 2019) Mrs Chang Lam Sook-yee (March to October 2018) Ms Ma Sau-ching, Annisa (November 2016 to February 2018)

Secretary

Social Welfare Department	Ms Lo Miu-han, Eve (April 2018 to December 2019) Mrs Chang Lam Sook-yee (November 2016 to February 2018) Ms Wong Man-si, Shirley (Assistant) (March to December 2019) Mrs Mak Lee Miu-ying (Assistant) (October 2018 to March 2019) Ms Cheng Mei-chi, Christine (Assistant) (February 2017 to October 2018) Mr Lau Hang-chi, Frederick (Assistant) (November 2016 to February 2017)

Members

Labour and Welfare Bureau	Mr Tang Hin-kuen, Huggin (March 2017 to December 2019) Ms Chan Chor-wing, Winnie (November 2016 to February 2017)
Education Bureau	Ms Tao Pui-ki, Kay (June to December 2019) Mr Cheung Wing-fat, Raymond (November 2016 to June 2019)
Department of Health	Dr Tso Ka-pik, Karen
Hong Kong Police Force	Ms Law Wan-yee, Fannie (September 2018 to December 2019) Ms Li Ka-wing, Ivy (November 2016 to September 2018)

Hospital Authority

United Christian Hospital	Dr Cheung Chi-hung, Patrick
Tuen Mun Hospital	Dr Lee Chak-ho, Rever
Hong Kong Children's Hospital	Ms Chung Ka-po, Karre (September 2018 to December 2019)
Kwong Wah Hospital	Mrs Ha Woo Yuen-ling (November 2016 to August 2018)

Non-governmental Social Service Organisations

The Hong Kong Council of Social Service	Mr Mui Wai-keung, Moses (Family and Community Service)
	Ms Yiu Kit-ling, Karen (Children and Youth Service)
Against Child Abuse	Ms Wong Chui-ling, Donna (October 2017 to December 2019)
	Dr Jessica Ho (November 2016 to October 2017)
Hong Kong Family Welfare Society	Ms Ng Wai-ngan, Shirley (Integrated Family Service)
	Mr Sin Kai-chi, Anthony (Children and Youth Service)
Yan Oi Tong	Ms Fong Wing-sze, Wincy (School Social Work Service)
Hong Kong Christian Service	Mrs Leung Li Chi-mei, Cross (Residential Child Care Service)
	Ms Hon Siu-wan, Wendy (Substance Abuse Treatment Service)

Social Welfare Department

Family and Child Protective Services	Mrs Chang Lam Sook-yee (January to December 2019)
	Ms Mok Yuen-nga, Monica (October 2018 to December 2019)
	Ms Lo Miu-han, Eve (November 2016 to April 2018)
Family Services	Ms Shea Ka-shuen (October to December 2019)
	Ms Chan Mei-yi (November 2016 to October 2019)
	Mr Chan Chau-sang (July to December 2019)
	Mr Kwong Lap-kuen (November 2016 to July 2019)
Medical Social Services	Ms Leung Po-ling
Youth Services	Ms Ding Shuk-wah, Alice (October 2017 to December 2019)
	Ms Chiu-Lai-chun, Kitty (November 2016 to October 2017)
Clinical Psychological Service	Ms Ma Yee-man, Ellen (January to December 2019)
	Ms Chew Po-ling, Linda (November 2016 to January 2019)

Table of Content

Guide to the "Guide"

After a comprehensive review and revision of the Guide, its layout and content are quite different from the previous versions. Personnel should pay attention to the following items when reading the "Guide"

Change in Work Direction

Firstly, the name of the "Guide" differs from the previous one which is now changed from "Procedural Guide for Handling Child Abuse Cases" to "Protecting Children from Maltreatment – Procedural Guide for Multi-disciplinary Co-operation". It emphasises the principle of "Child-focused" and expects personnel to shift their focus of work from previous "case handling" to "child protection" so as to replace the "task-centred" point of view with the one of "person-centred". At the same time, personnel should also shift their work direction from the need to determine whether a case is child maltreatment to the need for protecting children from harm/maltreatment, i.e. to move from a relatively passive perspective to a more proactive and forward-looking perspective. In addition, as child protection work requires joint efforts and co-operation of all sectors, the term "Multi-disciplinary Co-operation" is added on the name of the "Guide" in order to point out the importance of this work approach.

With regard to the English name of the "Guide", the word "abuse" is changed to "maltreatment" with the aim of reducing the negative connotation behind the term. Nevertheless, during the review and revision of the "Guide", the task group considered it necessary to retain the term "abuse" (虐待) in the Chinese version in order to reflect the seriousness of the matter. Therefore, the term "abuse" continues to be used in the Chinese version. Even so, Chapters 1 and 2 of the "Guide" have pointed out that personnel should communicate with the children and family members using terms which are easy to be understood. Considering that the children and their family members may have different understandings of the definition of the term "maltreatment" ("abuse" in Chinese version) adopted in the "Guide" and by the personnel, the task group recommended personnel, in communicating with the children and family members, may consider replacing the term "maltreatment" ("abuse" in Chinese version) with the term "harm" (傷害) taking into account of the impact(s) of the related incident on children.

The Layout of the "Guide"

Apart from stating a series of handling procedures in more detail, the "Guide" also enhances reference materials on various aspects. To facilitate personnel to make reference of the necessary information, the "Guide" is divided into the following two parts:

(i) Core procedures: explain the steps and focuses of the handling procedures and the content is for all personnel who may have access to the children suspected of being harmed/maltreated, have a duty to handle/investigate suspected child maltreatment case, and are involved in following up child protection cases; and

(ii) Annexes: details of practical information, handling skills, roles and points to note of relevant sectors in relation to the core procedures for reference by different disciplines

Core Procedures

Before reading the handling procedures and practical information as stipulated in the "Guide", all personnel **must first read Chapters 1 and 2** and pay attention to the following key points:

Number of Chapters	Content Highlights	Matters for Attention
Chapter 1	Strategies to ensure the safety of children, and the objectives and guiding principles of multi-disciplinary co-operation in child protection	● All personnel should be guided by the common objectives and principles in carrying out child protection work ● Personnel need to have early identification of families with higher possibility of child maltreatment and provide them with effective support so as to avoid occurrence of child maltreatment, with a view to protecting children from harm ● While various personnel may have different views on the way the case should be handled, they must still strive to reach consensus as far as practicable

Number of Chapters	Content Highlights	Matters for Attention
Chapter 2	Definition of child maltreatment and its scope of application in the "Guide"	● When considering defining whether a case is child maltreatment, personnel should be aware of the meanings of child maltreatment and the use of terms as set out in this Chapter ● Even if some cases are not defined as child maltreatment, personnel should, in accordance with the principles on child protection as stipulated in Chapter 1, adopt multi-disciplinary approach as far as practicable so as to provide appropriate support and assistance to the child and his/her family, with a view to enhancing the protection of the best interests of the children facing different crises

Chapters 3 to 13 of the "Guide" list the procedures and handling methods at different stages of work in detail. Please pay special attention to the following key points:

Number of Chapters	Content Highlights	Matters for Attention
Chapter 3	Overview of procedures in multi-disciplinary co-operation	● Roles and responsibilities of case manager and other personnel
Chapter 4	Identification of suspected child maltreatment cases and reporting	● "Behavioural/emotional indicators relating to various types of harm/maltreatment" are specifically added to the part of "Possible Indicators of Child Maltreatment", including some relatively common manifestations on infants/toddlers and carers ● When identifying a child with suspected maltreatment, personnel should consider thoroughly if the child may have been

Number of Chapters	Content Highlights	Matters for Attention
		harmed/maltreated by more than one type of harm/maltreatment and should not focus on a single category ● Points to note on making initial contact with children and families of ethnic minorities, including arrangement for interpretation, were added ● A new term, "Report", which differs from "Consult" and "Refer", was added so as to avoid misunderstandings among personnel (may refer to the Glossary) ● Personnel should report to appropriate unit as soon as possible for conducting initial assessment after collecting the required information
Chapters 5 to 7	Initial assessment, immediate child protection actions and risk assessment	● Separate chapters are set out to explain how to carry out initial assessment, immediate child protection actions and risk assessment ● Personnel receiving a report have to conduct initial assessment to ascertain if there are reasons to believe/suspect that a child has been harmed/maltreated. They should also avoid a child from experiencing unnecessary investigation(s), examination(s) and even hospitalisation, or prematurely rule out the possibility that a child has been harmed/maltreated ● In the Chapter on Risk Assessment, the principles, timing, purposes and focuses of the assessment are clearly stated
Chapters 8 to 10	Related to investigation work	● Replacing "Social Investigation" with "Child Protection Investigation" and enriching the content on information to be collected ● When residential child care service is arranged, personnel should make reference to Appendix 1

Number of Chapters	Content Highlights	Matters for Attention
		to Chapter 8 for considering a permanency plan for children as soon as possible ● Adding appropriate physical examination(s) and toxicology test(s) in the process of medical investigation for children who may have been affected by dangerous drugs
Chapter 11	Multi-disciplinary Case Conference (MDCC)	● The focus of MDCC is to protect the safety of the child concerned and to formulate a "Safety Plan" for the child as part of the "Follow-up Plan" in response to the various risk factors faced by the child ● Separate discussions in the MDCC on the nature of incident and whether the case is a "child protection case" ● Paying attention to the considerations on whether parent(s) with drug/alcohol abuse problem is/are able to take care of the child(ren) ● Discussing the formation of a "Core Group" to follow up on more complicated child protection cases
Chapter 12	Follow-up services	● All follow-up personnel should take into account the circumstances of the family as a whole, work closely, conduct ongoing risk assessment, and empower the family members and the child to take part in the implementation of child protection plan ● For children receiving residential child care services, points to note on considering the suitability for family reunion, especially when the parent(s)/carer(s) is/are having drug abuse problem, were added. Emphasis was also made on considering and implementing the child's permanency plan, including adoption, as soon as possible

Number of Chapters	Content Highlights	Matters for Attention
Chapter 13	Handling of child maltreatment allegations against staff, carers and volunteers of organisations	● Formulation of child protection policies, measures and handling procedures by organisation is emphasised ● Organisation should not reach any private agreement of compromise with the alleged perpetrator, otherwise the interests of the child concerned or other children cannot be safeguarded

Annexes

In addition to the updates of part of the information on the annexes, some annexes are newly added or reorganised. Personnel may pay attention to the following key points when drawing reference from the annexes:

Number of Annexes	Content Highlights	Matters for Attention
Annex 1	Families with higher possibility of child maltreatment	● Families with higher possibility of child maltreatment should be identified and supported as early as possible so as to prevent children from being harmed
Annex 2	Information sharing and confidentiality	● If the prescribed consent of the data subject and/or the relevant person of the data subject on behalf of the party concerned is not obtained, for protection of a child who may have been harmed/maltreated, consideration should be given to invoking special provisions of exemption at Part VIII of the Personal Data (Privacy) Ordinance, Cap. 486 on the use, disclosure or transfer of data so as to release the collected information to other relevant personnel

Number of Annexes	Content Highlights	Matters for Attention
Annex 4 to Annex 10	Roles of personnel from various sectors and the definition of "known cases"	● Family and Child Protective Services Units of SWD have enhanced their roles in receiving report, carrying out initial assessment and procedures at subsequent stages
Annex 11 to Annex 13	Practical knowledge on case handling	Personnel should pay attention to: ● Points to note on initial contact with children who may have been harmed/maltreated or their parents ● Points to note on contacting children suspected to be sexually abused ● Guidance notes on reporting suspected sexual abuse
Annex 15	Ordinances related to child protection work	Points to note on invocation of "Protection of Children and Juveniles Ordinance"
Annex 16 to Annex 18	Reference materials on assessment matrixes	These are the reference materials on risk and needs assessments, of which Annex 16 is the updated version of risk assessment matrix and Annex 17 is the newly added risk assessment framework

Glossary

The Guide	Protecting Children from Maltreatment—Procedural Guide for Multi-disciplinary Co-operation
Personnel	All personnel who work closely with children (may use alternatively with 'professionals')
Reporting personnel	Personnel who make a report of cases with suspicion on child being harmed/maltreated
FCPSU	Family and Child Protective Services Unit
SWD	Social Welfare Department
HA	Hospital Authority
Case manager	Social worker who is responsible for co-ordinating services provided when the case is being handled by different disciplines
Investigating social Worker	Social worker who is responsible for child protection investigation
Key worker	Social worker who is responsible in co-ordinating various follow-up services after child protection investigation/MDCC
MCCA	Medical Co-ordinator on Child Abuse
MDCC	Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment
Consult	To seek advice, no follow-up action is expected
Report	To provide case information, expecting the social worker receiving the report to take necessary actions, e.g. conducting initial assessment to assess whether the suspicion of child maltreatment is substantiated, taking immediate child protection actions, conducting child protection investigation, etc.
Refer	To request support services, professional assessments or follow-up services, etc.
PCJO	Protection of Children and Juveniles Ordinance
PD(P)O	Personal Data (Privacy) Ordinance
VRI	Video-recorded Interview
Child abuse	Equivalent to 'child maltreatment', will appear in the forms used by the Police in Chapter 10

Chapter 1 Aim, Beliefs and Principles

The Aim of this Guide

1.1 The aim of this Guide is to provide guidance on the way various sectors (including government departments, non-governmental organisations (NGOs) and other relevant organisations) should co-operate, and provide reference to personnel engaged in social services, health services, educational services, law enforcement and those who work closely with children, with a view to **protecting children suspected to have been or having been harmed/maltreated**. For the handling procedures and points to note as set out in this "Guide", references have been made to the "Declaration of the Rights of the Child" and the "Convention on the Rights of the Child" of the United Nations. Personnel, when helping a child who is being harmed/has possibly been harmed, should take into consideration of the child's need for growth and development and his/her vested rights.

1.2 Children may need protection in different circumstances and for various reasons. Child protection is a complicated task which may bring a certain level of stress and anxiety to the children, their families and even personnel involved in the process. To achieve effective child protection, the "**multi-disciplinary collaboration**" model should be adopted. Despite the fact that personnel from different disciplines have their own work focus and professional knowledge and may have different viewpoints or methods in handling cases, they should observe the following in the protection of children suspected to have been or having been harmed:

- collaborate in partnership based on **"Working Together"** and **"Trusting each Other";**
- achieve the common goal of **"Protecting the Vulnerable"** and **"For the Welfare of Children".**

Our Values – Protecting the Best Interests of Children

1.3 Children need sufficient care and attention. Before birth, foetuses need parental care for healthy growth. After birth, children depend on parents/carers to provide them with various daily necessities, education and healthcare, etc. according to their needs in each developmental stage. Children

also need to be loved and valued so that they can grow and develop safely and healthily in physical, psychological and social aspects. At the same time, it is also necessary for children to learn to look after themselves and cope with everyday life through diversified learning. Children should have the chance to express their own views, build up a positive self-image and confidence, have a sense of identity, and develop good interpersonal relationships.

1.4 These are the children's rights and also the responsibilities of their parents/guardians, carers and the society. Regardless of children's gender, age, race, language, religion, status of residence, health condition, capability or behaviour, parents and all sectors should strive for ensuring children's physical and psychological safety as well as their health.

1.5 Children may be influenced by different people and happenings they have encountered in their surroundings during their growth, and family plays an irreplaceable and extremely important role. Parents/carers provide material and emotional satisfaction to their children and gradually build up secure ties and attachment with them. This secure attachment is of paramount importance to the children's development of self-confidence, emotional regulation, resilience, and a positive and trusting interpersonal relationship in the future.

1.6 If children's physical and psychological safety/health is jeopardised or neglected by parents/carers, it will have adverse effects on the children. These effects will usually bring greater harm to the children than those brought about by other people. Physiologically, children being maltreated will suffer not only from physical injuries but also different degree of harm in body functions and intellectual development which may even result in death in serious cases. Psychologically and socially speaking, problems will arise with the children's behaviour, emotions, perceptions and interpersonal relationship. If these problems are not dealt with properly, they will affect the growth of the children and even lead to trauma. Such problems may also affect their parenting and child discipline mode posing potential problems to the next generation.

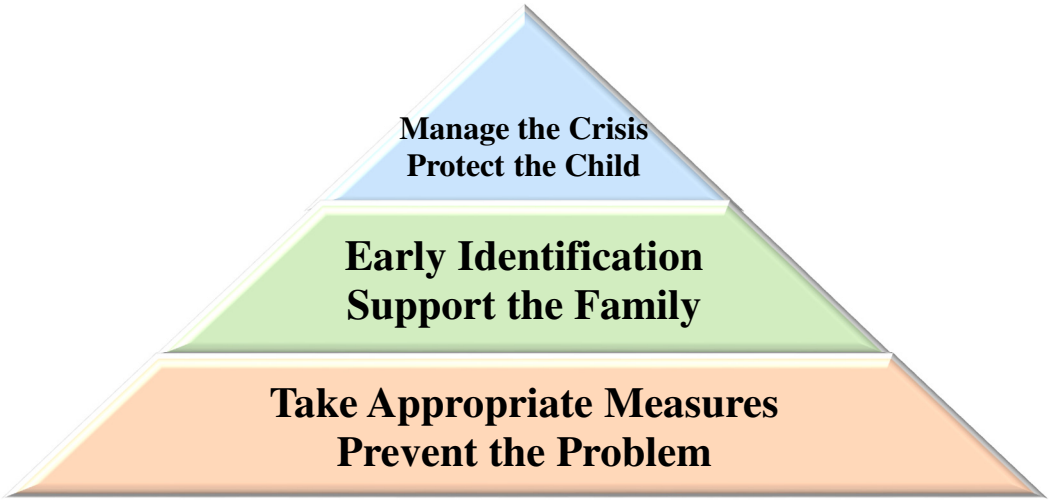
Strategies to Safeguard Children's Safety

1.7 To safeguard the physical and psychological safety of children, different sectors of the society should adopt the following 3-pronged strategies in aiding families and children so as to prevent the occurrence/recurrence of problems:

(1) Prevent the Problem: Implement various measures, education and activities to facilitate performance of family's functions so that the children can receive proper care and supervision in their families.

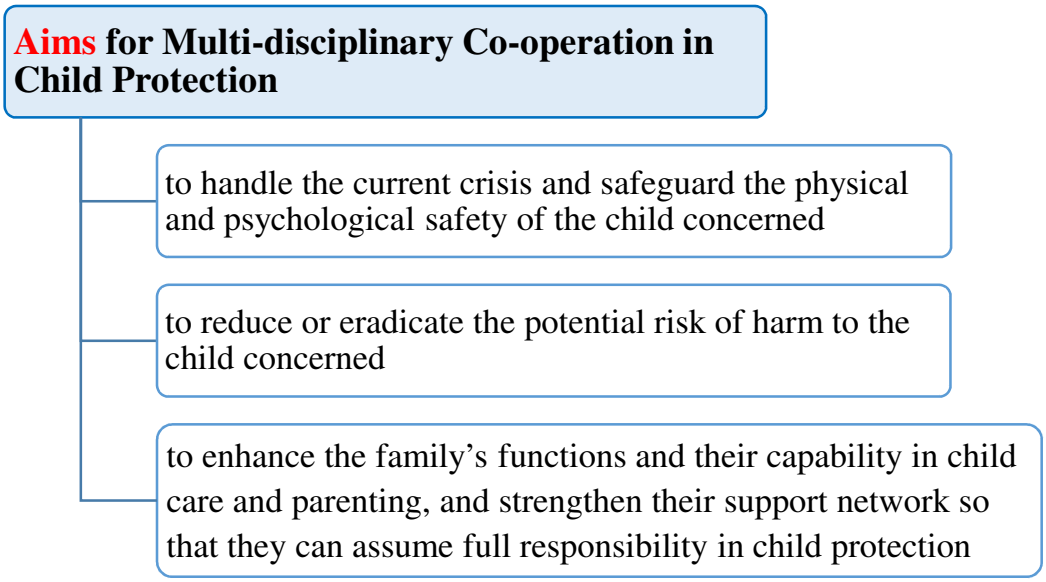
(2) Support the Family: When children could not receive proper care and supervision, or are even exposed to potential physical and psychological threats due to difficulties or problems of their families, professionals who are in contact with these needy families and children should identify them as soon as possible to provide them with appropriate and substantial support, and gradually enhance these families' capability for child care and parenting so as to prevent the continuation or worsening of the problem (please refer to "Families with Higher Possibility of Child Maltreatment" at Annex 1 to this Guide).

(3) Protect the Child: When children's physical or psychological safety is threatened or harmed, professionals should take appropriate actions promptly and co-ordinate with each other to handle the crisis being faced by the children so as to safeguard their physical and psychological safety. Professionals should also enhance families' capability of child protection in order to prevent children from further harm.



The Aims and Guiding Principles for Multi-disciplinary Co-operation in Child Protection

1.8 Where it is necessary to adopt the third strategy mentioned in Paragraph 1.7 above for handling cases under which **the physical and psychological safety of a child is suspected or believed to be threatened or harmed**, personnel of different disciplines should conduct appropriate assessment/investigation. Personnel should carry out suitable intervention, engage family members and the child concerned as far as practicable in the formulation of a safety plan for child protection, and make use of family resources, support network and community services, with a view to achieving the following work targets:



1.9 When handling child protection cases, personnel should follow the principles below:

(1) Always **focus on** and accord priority to **children's safety**, needs, welfare and rights.

(2) A child's best interests shall always top the priority in any intervention for child protection. Comparing with:

(a) parents' rights; and

(b) criminal prosecution against the alleged perpetrator,

the child's best interests is more important.

(3) When taking actions to protect the physical and psychological safety of a child, personnel should take into account those factors such as his/her family circumstances, gender, age, developmental stage, race, religion and culture, etc. Interventions should not deal with the child in isolation but have to be taken in comprehension and **consideration of the overall situation of the family**. Assistance should also be given to his/her families and significant others in maintaining the attachment between the child and his/her families/relatives for healthy growth of the child on the one hand, and in empowering the family to leverage on their own support

network or enhance their own capability for shouldering the responsibility to protect the physical and psychological safety of the child in the long run.

(4) Where it is suspected that a child's physical or psychological safety is threatened or harmed, or relevant report is received, it must be taken seriously by understanding the case situations, assessment of the risk being faced by the child and taking timely actions to safeguard the safety of the child (please refer to Chapters 5 to 7 of this Guide).

(5) Personnel should explore the situation through direct approach to the child concerned as far as practicable and collect relevant information from individuals who have knowledge of the child/family/incident so as to ascertain the child's condition. To prevent the child from describing the process of maltreatment repeatedly, interviews with the child for examination/investigation should be minimised. Similarly, the frequency of medical examinations should also be reduced as far as practicable (please refer to Chapters 8 to 10 of this Guide).

(6) At different stages of case handling (including initial assessment, investigation, formulation of a safety plan for child protection and follow-up of the case), the child(ren) should be explained in details of the actions to be taken and these should be conducted in languages intelligible and methods comprehensible to him/her/them. The child(ren)'s opinions should be heard and be taken seriously. Their feelings and impact of the actions on the child(ren) concerned should also be taken into account for minimising/dispelling their doubts and worries.

(7) Having regard to a child's age and comprehension capability, personnel should encourage the child to express his/her opinions or participate in discussions and decision-making on issues which may affect his/her daily life. However, personnel should be cautious about formulating plans for the child so as to ensure balance between a child's safety and his/her wishes.

(8) If intervention is necessary to ensure the safety of the child, such intervention should be minimised to avoid causing unnecessary frustration to the child and his/her family.

(9) Parents/guardians/significant others of the child concerned should be engaged in assessing the risk of further harm and formulating safety and follow-up plans of the child. Personnel should listen to and consider their opinions.

(10) Communication with the child's family members should be conducted in languages intelligible and methods comprehensible to them. Their feelings should also be taken care of. Personnel should solicit their co-operation, draw their attention to matters of concern and encourage them to propose as well as implement concrete plans so as to achieve the goal of protecting the child's safety.

(11) Resources and support network of the family should be leveraged where feasible and safe so that the child concerned can grow in the family and can be taken care of by appropriate family members/relatives as far as practicable. If temporary residential child care service is required, a long-term and stable care plan for the child should be formulated as early as possible. This includes consideration of whether and when to return the child concerned to his/her family/relative(s) for care.

(12) Personnel must act with caution and accord priority in ensuring safety and safeguarding the best interests of the child when considering the wishes of the child and the family. Where parents/carers are incapable of protecting their child(ren), or where their wishes are not in line with the goal of protecting the physical and psychological safety of the child, personnel should consider seeking/providing statutory protection pursuant to the "Protection of Children and Juveniles Ordinance", Cap. 213 for the child in need of care or protection as appropriate. This includes sending the child concerned to reside in a safe place or receive medical examination/treatment (please refer to Chapters 5 to 7 of this Guide).

(13) At different stages of case handling (including initial assessment, investigation, formulation of a safety plan for child protection and follow-up services), personnel involved should collaborate with each other and share the responsibility for protection of the child and provision of assistance to the family. While different professionals may have different views on the way the case should be handled, the primary concern remains

to be the child's safety and best interests and consensus should be reached as far as practicable.

(14) If necessary, the prescribed consent of the data subject and/or relevant person of the data subject[1] should be obtained as early as possible for the personal information[2] to be provided to other personnel for discussion on the case handling, with a view to ensuring effective protection of the child's safety. To protect a child who may have been harmed/maltreated, if the prescribed consent could not be obtained from the data subject and/or the relevant person of the data subject on behalf of the party concerned, consideration should be given to invoking special **provisions of exemption** at Part VIII of the Personal Data (Privacy) Ordinance, Cap. 486 (PD(P)O) on the use, disclosure or transfer of data, for the case to be reported/referred to relevant units for investigation or follow-up actions, or for information to be provided to other personnel for discussion on the case handling (e.g. **detection or prevention** of crime, or **the prevention, preclusion or remedying** (including punishment) of unlawful or seriously improper conduct, dishonesty or malpractice under Section 58; and protection of the data subject or any other individuals from serious physical and/or mental harm under Section 59) (please refer to Personal Data (Privacy) Ordinance, Cap. 486 and Annex 2 to this Guide for details).

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

[2] According to the PD(P)O, Cap. 486, personal data means any data—
(a) relating directly or indirectly to a living individual;
(b) from which it is practicable for the identity of the individual to be directly or indirectly ascertained; and
(c) in a form in which access to or processing of the data is practicable.

Chapter 2 Definition and Types of Child Maltreatment

Definition of Child Maltreatment

2.1 **In a broad sense, child maltreatment is defined as any act of commission or omission that endangers or impairs the physical/psychological health and development of an individual under the age of 18.**

2.2 Child maltreatment is committed by individuals, singly or collectively, who, by their characteristics (e.g. age, status, knowledge, organisational form), are in a position of **differential power** that renders a child vulnerable.

Purposes of Definition

2.3 The above broad definition of "child maltreatment" adopts the **perspective of safeguarding children's best interests** for the following purposes:

(1) Prevent the Problem: Educate the public with a clear message of preventing harm to children to safeguard their physical and psychological safety.

(2) Support the Family: Raise personnel's awareness for early identification of and support to families prone to child maltreatment to prevent children from being harmed.

(3) Protect the Child: Provide reference for personnel to take appropriate actions for protecting the safety of children having been maltreated or suspected to be maltreated and to assist the families concerned to prevent further harm to the children.

Scope of Definition in This Guide

2.4 Procedures set out in this Guide should be implemented when personnel suspect that the physical/psychological health and development of a child is endangered or impaired by any act of commission or omission by the following individuals who, by their characteristics, are in a position of differential power:

(1) Those who are responsible for the care or supervision of the child or play a role in the care or supervision of the child owing to their statuses/identities, including the following individuals:

(a) parents/guardians;

(b) persons entrusted with the care and supervision of the child (e.g. relatives, teachers, childminders, etc.);

(c) elders (e.g. relatives, elder siblings with relatively bigger age difference, close friends of the parents, etc.); or

(2) In child sexual abuse cases, the perpetrators also include other individuals who are in a position of differential power to the child and may be known or unknown to the child. These individuals can be either adults or children.

2.5 While some cases (such as children being bullied by peers/strangers and consensual sexual activities between an adolescent and his/her lover of similar age) are not defined as child maltreatment, caution must be taken in dealing with these cases. In accordance with the child protection principles specified in Chapter 1 of this Guide, the approach of multi-disciplinary co-operation, e.g. convening pre-birth conference/welfare meeting/case meeting, should be employed as far as possible to render appropriate support and assistance to the children concerned and their families to better safeguard the best interests of these children who are in face of different crises.

2.6 During the course of case handling, the personnel has to explain to the children or their family members specifically and clearly their concerns, in particular the harm of the "maltreatment" caused to the children and the risk of further harm to the children.

2.7 Considering that the children and their family members may have different understandings of the definition as well as the scope of the term "maltreatment" adopted in this Guide and by the personnel, in order to help them have a clear grasp of the personnel's concern, personnel should point out whether the child requires protection and is being harmed (i.e. the impacts of the incident on the child) but not whether the behaviour constitutes to "child maltreatment" when explaining their concerns and categories of the case to the children and their families.

2.8 This Guide recommends personnel to adopt an approach that is relatively comprehensible to the children and their family members when explaining the captioned concern. Personnel may, depending on the impacts of the incident on the child, consider using the term "harm" instead of "maltreatment". This is not to undermine the seriousness of the incident but to avoid another party's misunderstanding or miscommunication resulting from insistence of possible

different understanding of the term "maltreatment" (especially in relation to the intention or seriousness of the behaviour). Hence, there is no difference in meaning of the term "maltreatment" and "harm" in this Guide in which both terms will be used. However, some chapters will use "maltreatment" only to reduce cumbersome wording.

Types of Harm/Maltreatment

2.9 Under the scope of definition in this Guide, the types of harm/maltreatment are set out as follows:

(1) Physical harm/abuse;

(2) Sexual abuse;

(3) Neglect; and

(4) Psychological harm/abuse.

2.10 These behaviours may take the form of a repeated pattern, multiple incidents or a single but serious incident. An individual case may also involve more than one type of harm/maltreatment to the child.

(1) Physical harm/abuse

This refers to physical injury or suffering inflicted on a child by violent or other means (e.g. punching, kicking, striking with an object, poisoning, suffocation, burning, shaking an infant or Factitious Disorder Imposed on Another[3]), where there is a definite knowledge, or a reasonable suspicion that the injury has been inflicted non-accidentally.

(2) Sexual abuse

This refers to forcing or enticing a child to take part in any acts of sexual activity for sexual exploitation or abuse and the child does not consent to or fully understand or comprehend this sexual activity that occurs to him/her due to mental immaturity.

This sexual activity includes acts that have or do not have direct physical contact with children (e.g. rape, oral sex, procuring a child to masturbate

[3] Factitious Disorder Imposed on Another, formerly known as Munchausen's Syndrome by Proxy, occurs when a parent or guardian falsifies physical and psychological signs or symptoms of a child, or induction of injury or disease to a child, or causes a child to receive innumerable unnecessary hospital treatments through other deceitful conducts (e.g. alters a child's laboratory test report) (Ref.: American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th Edition).)

others/expose his/her sexual organs, or to pose in an obscene way/watch sexual activities of others, production of pornographic material, forcing a child to engage in prostitution, etc.).

Sexual abuse may be committed inside or outside the home or through social media on the internet by perpetrators acting individually or in an organised manner. It includes luring a child through rewards or other means for abuse, including sexual grooming which refers to designedly establish a relationship/an emotional connection with a child by various means for gaining his/her trust with an intent to sexually abuse him/her (e.g. communicating with a child through mobile phone or the Internet).

Consensual sexual activity between an adolescent and another person may also involve sexual exploitation by a person who, by his/her characteristics, is in a position of differential power to the adolescent. Cases where the adolescent is not mentally mature, too young (e.g. under the age of 13) or the sexual activity leads to sexually transmitted diseases ("STDs") or pregnancy may be considered and handled as suspected sexual abuse[4].

(3) Neglect

This refers to a severe or repeated pattern of lack of attention to a child's basic needs that endangers or impairs the child's health or development.

Neglect may be caused by the following forms[5]:

(a) Physical neglect includes failure to provide necessary food/clothing/shelter, failure to prevent physical injury/suffering, lack of appropriate supervision, leaving a young child unattended, improper storage of dangerous drugs resulting in accidental ingestion by a child or allowing a child to stay in a drug-taking environment resulting in inhalation of the dangerous drugs by a child.

Drug/alcohol abuse during pregnancy can affect the health and development of an infant. If a pregnant woman fails to receive

[4] The younger the age, the more vulnerable a juvenile is even he/she is involved in a consensual sexual activity (With reference made to Section 123 "Intercourse with Girl under 13" of "Crimes Ordinance", Cap 200, its maximum penalty is higher than the one of Section 124 "Intercourse with Girl under 16"). As STDs or pregnancy resulting from sexual activity will affect the juvenile physiologically and psychologically, personnel should first conduct an initial assessment to identify if there is a reason to believe or suspect the juvenile is harmed/maltreated where cases involved juvenile engaging in a consensual sexual activity being under the age of 13 or having STDs or pregnancy resulting from unsafe sex. Personnel should also take child protection and related investigation as appropriate.

[5] Emotional neglect will be put under the scope of psychological harm/abuse.

treatment for drug /alcohol abuse or make every effort to reduce her drug/alcohol use during pregnancy resulting in signs of poisoning (e.g. being tested positive for dangerous drugs or alcohol) of the newborn or withdrawal symptoms for dangerous drug or alcohol of the infant, these cases may be regarded and handled as suspected neglect; or

(b) Medical neglect includes failure to provide necessary medical or mental health treatment to a child; or

(c) Educational neglect includes failure to provide education or ignoring the educational/training needs arising from a child's disability[6].

(4) Psychological harm/abuse

This refers to a repeated pattern of behaviour and/or an interaction between carer and child, or an extreme incident that endanger(s) or impair(s) the child's physical and psychological health (including emotional, cognitive, social and physical development).

2.11 Physical harm/abuse, sexual abuse or neglect often leaves a certain degree of mental or psychological impact on a child. However, reference should be made to the above definition when determining whether a case is psychological harm/abuse.

In considering whether a case should be defined as child maltreatment, personnel should understand that:

(1) Each case has different circumstances and there are no absolute standards. Personnel should evaluate the merits of individual cases. The primary consideration is the harm and the potential impact caused to the child's physical/psychological health and development by the

6 According to the "Disability Discrimination Ordinance Code of Practice on Education", the provisions of the "Disability Discrimination Ordinance" apply to a wide range of persons, including those usually referred to as persons with intellectual disability or mental handicap, autism, specific learning disabilities, hearing impairment, visual impairment, physical disability or handicap, mental illness and various other chronic illnesses, and persons who are infected with the human immunodeficiency virus (commonly known as "HIV-positive") or who have acquired immune deficiency syndrome (commonly known as "AIDS") (please refer to the following website for details: https://www.eoc.org.hk/eoc/otherproject/eng/color/youthcorner/education/cop_edu/cop_edu_b.htm)34F

behaviour rather than whether the individual commits/omits the behaviour with an intent to harm the child.

(2) When a case is defined as child maltreatment, it is not to blame the parent/carer concerned nor label the parent/carer/child negatively but to make the family concerned aware of the seriousness of the matter and to motivate them to co-operate with personnel in making use of their own strengths and resources to resolve the problems properly as soon as possible in order to **ensure the physical and psychological safety of the child** and avoid recurrence of similar problems or more serious consequences.

(3) Criminal investigation by the Police is required in most incidents relating to children being harmed/maltreated in which commission of criminal offence is suspected. However, when defining a case as child maltreatment, the professionals should consider it from the perspective of child protection, which **bears no binding effect on the outcome of the Police's criminal investigation or whether any prosecution action is pursued**. Please refer to the relevant prevailing legislation on criminal offences (may draw reference from Annex 3, "Ordinances on Criminal Offences Related to Child Maltreatment", to this Guide).

(4) The definition of child maltreatment will change with time, culture, values and societal changes. What behaviour constitutes child maltreatment is assessed on the basis of a combination of social standards and professional expertise at the time.

(5) For Frequently Asked Questions relating to the definition of child maltreatment, reference can be drawn from Appendix 1.

Appendix 1 to Chapter 2

Frequently Asked Questions about the Definition of Child Maltreatment

Relating to Physical Harm/Abuse

1. Does corporal punishment be regarded as physical harm/abuse?

- Corporal punishment usually refers to hitting a child to make him/her suffer in order to change or control the child's behaviour. In most situations, corporal punishment is used by parents/carers on children for discipline without any intent to harm the children. However, corporal punishment is not an appropriate or effective way in child discipline. As parents/carers get agitated, the punishment may escalate or become excessive and turn into a channel for venting their emotions. It will not only fail to serve the purpose of child discipline but lead to many undesirable consequences. Apart from inflicting physical injury on the children, corporal punishment will also impair children's psychological development, e.g. impairing self-esteem or inducing the children's tendency to use violence in problem solving. Above all, the parent-child relationship will also be adversely affected.

- Many physical harm/abuse cases arise from corporal punishment by parents on their children. There is no absolute standard in defining what kind of corporal punishment constitutes physical harm/abuse. Personnel should evaluate the merits of individual cases. The primary consideration is the harm and the potential impact caused to the child's physical/psychological health and development by the behaviour rather than whether the parent/carer has any intent to harm the child.

- Even in some cases where corporal punishment is not defined as physical harm/abuse with the child's safety not being under threat, personnel should still provide appropriate and substantial support according to the needs of the child and the family and enhance their capacity of managing children's behaviour so as to prevent the problem from persisting or getting worse.

Relating to Sexual Abuse

2. How to distinguish children's behaviour of bullying involving sexual abuse from childhood sexual play?

- Childhood sexual play is usually found between children of the same age (including same or opposite sex) and does not involve differential power. It refers to activities engaged out of curiosity and matched the developmental stage in respect of age. Common childhood sexual play includes a child exposing his/her body parts to another child, touching the body of another child (including genitals) or mutual physical exploration and it is usually found between children with tender age. Bullying involving sexual abuse is different from childhood sexual play with the presence of differential power between the children involved that renders the abused child vulnerable.

3. Are consensual sexual activities between an adolescent and another person regarded as sexual abuse? Will the adolescent's age be taken into account?

- Consensual sexual activities with an adolescent who is mentally mature and without the presence of differential power that renders either party vulnerable will usually not be regarded as sexual abuse, even if the adolescent concerned may have committed such offences as indecent assault, intercourse with a girl under 16 or homosexual buggery with a boy under 16, etc., or if statutory care or protection is required under the circumstances where harm may be caused to him/her or others.

- Under the above principle, consensual sexual activities between teenage lovers of similar age will usually not be regarded as sexual abuse. However, in order to further protect the children's safety, if an adolescent under the age of 16 is found to have engaged in consensual sexual activities with another person (especially for sexual activities between an adolescent and a substantially older adult), an initial assessment may be conducted by the social worker to explore whether the adolescent might have been exploited sexually through differential power between him/her and the other party. The initial assessment includes understanding the adolescent's mental maturity and self-protection capacity, his/her feelings toward the incident, the relationship between the adolescent and the other party and the consequences of the incident, etc.

- Where the adolescent involved is not mentally mature enough to fully understand or comprehend these sexual activities that occur to him/her, or the adolescent is too young (e.g. under the age of 13), or the sexual activity leads to sexually transmitted diseases ("STDs") or pregnancy while the case is not a known case of any social service unit, child protection investigation will be conducted by the social worker of Family and Child Protective Services Unit to study the case in detail and a Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) will be convened to discuss the follow-up plan for the child. If the case is a known case, the responsible social worker should adopt multi-disciplinary collaboration approach to discuss the handling of the case with other personnel. If it is suspected that the incident involves sexual exploitation of an adolescent by a person who, by his/her characteristics, is in a position of differential power to the adolescent, child protection investigation should be conducted and MDCC should be convened for this suspected sexual abuse incident (please draw reference from paragraphs 8.3 and 8.4 of Chapter 8 and paragraphs 11.5 and 11.6 of Chapter 11 of this Guide for the handling procedures).

- Even if some cases are not regarded as sexual abuse following initial assessment, personnel should still help the adolescents involved and their families deal with the consequences of the sexual activities. Personnel should also protect the adolescents from undesirable impact and pay attention to whether the parents have difficulties or insufficient capacity in parenting. Social worker of the casework unit and/or other professionals should consider the circumstances of the case and arrange appropriate services, including medical follow-up or application for a supervision order for the adolescent under the Protection of Children and Juveniles Ordinance, Cap. 213. Where necessary, welfare meeting/case meeting or pre-birth conference (for pregnant adolescents) may be convened by the related professionals to discuss the follow-up plan for the adolescent/infant through multi-disciplinary collaboration.

- Notwithstanding initial consent, sexual activities with an adolescent (regardless of any romantic relationship between them) who is coerced into certain behaviours or withdraws his/her consent during the act should be regarded as sexual abuse.

Relating to Neglect

4. At what age of a child is considered neglect when being left unattended at home or elsewhere?

- In considering whether a child left unattended at home or elsewhere is being neglected, the actual age of the child is not the only factor for consideration. The primary consideration should be whether the physical/psychological health and development of the child is endangered or impaired while being left unattended with respect to the level of mental maturity of the child, and his/her capacity of self-care, problem solving and handling unexpected incidents.

- In general, infants and pre-school children should never be left unattended. For children studying in primary or secondary school, depending on their mental development, the following factors should be considered in determining whether their being left unattended at home or elsewhere constitutes neglect:

  (a) duration, location and frequency of being left unattended;
  (b) any prior arrangements on childcare made by the parents;
  (c) whether the children left unattended can contact their parents or other adults in a position to help;
  (d) whether and how assistance is available from others; and
  (e) feelings of the children left unattended.

- However, if more than one child is left unattended at the same time, consideration should be given to their respective circumstances. Even if the physical/psychological health and development of one of these children is not endangered or impaired while being left unattended, he/she does not necessarily have the capacity of being tasked with caring for another child.

5. Does school non-attendance of children/adolescents constitute neglect?

- According to the Education Ordinance, Cap. 279, parents have a legal responsibility to ensure that their children aged between 6 and 15 attend school regularly. Schools must comply strictly with the requirements of the Education Bureau ("EDB") by reporting non-attendance and dropouts among these children/adolescents to the EDB. Starting from March 2018, kindergartens, kindergarten-cum-child care centres and schools with kindergarten classes are also required to comply with the EDB's

requirements by reporting kindergarten students' absence to the EDB (please draw reference from the EDB Circular for details).

- Early identification of school non-attendance of children/adolescents, with a view to providing necessary support/services to them and their families and to assist/facilitate the children's/adolescents' return to school, can help prevent the problem of non-attendance from deteriorating and affecting the physical/psychological health and development of the children/adolescents.

- In considering whether school non-attendance of children/adolescents constitutes neglect, the personnel has to take into account the circumstances of the case, including the actual age of the children/adolescents, reasons/frequency/pattern of non-attendance and whether the parents have taken any action (successfully or otherwise) to assist or facilitate their return to school during the period of non-attendance.

- Should parents refuse to receive any support/services for handling the issue of school non-attendance and forbid their children to attend school or allow them to be absent from school without justifiable reasons that the physical/psychological health and development of the children is endangered or impaired, the social worker may conduct child protection investigation to study the case in detail and convene a Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment to discuss the follow-up plan for the children/adolescents.

6. Does it constitute neglect or psychological harm/abuse if parent(s) cannot fulfill a child's basic/psychological needs due to mental/emotional/intellectual problems or chronic illness, or reject the required training of a child due to inability in accepting the child's special needs?

- In general, family with parent(s) suffer(s) from mental/emotional/intellectual problems or chronic illness will have greater difficulty in childcare and may also be inadequate in fulfilling the basic/psychological needs of the children. In addition, some parents, even with professionals' advice, reject the recommended training for their children as they are unable to accept their children having special needs. Children raised up in these families may have higher possibility of neglect or other forms of harm/maltreatment.

- The professionals are advised to explore the families' conditions and identify their needs as soon as possible when making contacts with these families in order to render prompt and appropriate support before the child's physical/psychological health and development is endangered or impaired for preventing child maltreatment.

- When personnel identify the physical/behavioural/ emotional/environmental indicator(s) of possible child maltreatment when contacting these families, they should conduct initial assessment or report to appropriate units for initial assessment in order to determine whether child protection actions or follow-up are required by making reference to Chapter 4 to 7 of this Guide. Neglect or other type of harm/maltreatment may have been constituted if the child's physical/psychological health and development has been endangered or impaired.

- Professionals may draw reference from 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, "Family Assessment Risk Variables" at Annex 16 to this Guide, in particular the ones on the caretaker's capacity for child care, caretaker's parenting skills/knowledge and caretaker's emotional and mental health, to assess the level of risk on child maltreatment, and "Assessment Framework" at Annex 18 to this Guide to assess the needs of children and their families.

7. Does it constitute neglect if a pregnant woman is found to have abused drugs/alcohol during pregnancy or have suspected dangerous drugs/drug-taking equipment at home, or if a newborn's urine sample is tested positive for dangerous drugs, etc.?

- In considering whether these circumstances constitute neglect, personnel should evaluate the merits of individual cases. The primary concern is whether the behaviour has harmed/may harm the physical/psychological health and development of the infant/child. Appropriate support/services should also be provided to parents/pregnant women with drug/alcohol abuse, with a view to protecting the safety of the infant/child concerned.

- If the personnel have reasons to believe that the infant/child concerned is under harm/maltreatment, the social worker may first conduct child protection investigation to study the case in detail and convene a Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) to discuss the follow-up plan for the infant/child.

(a) Drug abuse during pregnancy

- As drug abuse during pregnancy can affect the health and development of the infant, personnel should encourage pregnant drug abusers to receive antenatal check-ups and deal with their drug abuse problems, with a view to reducing the health risk posed by drug abuse to themselves and their foetuses.

- Personnel may also suggest convening pre-birth conferences for pregnant women with drug abuse problems and their families. Relevant professionals (including social workers/medical and health professionals who provide drug treatment and rehabilitation services), the pregnant women and their families can be invited to the conference to formulate appropriate plan for support through multi-disciplinary collaboration so that the parents have sufficient knowledge, capacity and resources to protect their infants and reduce the impact of drugs on the latter's physical/psychological health and development.

- If the newborn's urine sample is tested negative for dangerous drugs and the newborn displays no drug withdrawal symptom, personnel need not conduct child protection investigation or convene MDCC but may convene welfare meeting/case meeting to discuss the follow-up plan for the case.

(b) Suspected dangerous drugs/drug-taking equipment found at home

- Where physical/behavioural symptoms related to suspected use of dangerous drugs are present or exposure to dangerous drugs is strongly suspected, the children concerned should be admitted to a hospital for appropriate health checks, toxicological examination, observation and treatment of drug toxicity/withdrawal symptoms.

(c) Newborn/child's urine sample tested positive for dangerous drugs

- In such situation, the personnel has reasons to believe that the infant/child concerned is under harm/maltreatment and should explain to the parents the risk of harm/potential harm caused by the dangerous drugs detected in the urine sample to the physical/psychological health and development of the infant/child. In accordance with the handling procedures of this Guide, it is obligatory to admit the infant

to Special Baby Care Unit for observation and treatment of drug toxicity/withdrawal symptoms and to convene a MDCC to discuss the follow-up plan for the infant/child.

- For pregnant women who are stable methadone users for detoxification treatment without abusing other dangerous drugs, if their newborn's urine sample is thus tested positive for methadone, personnel may consider convening a welfare meeting/case meeting to discuss the follow-up plan for the infant/child(ren) in the same family.

- The above measures for handling cases with drug abuse during pregnancy may also apply to cases with alcohol abuse during pregnancy.

8. For children with chronic/serious illness or in poor health, will it constitute medical neglect if the parents fail to comply with medical advice for their children to receive follow-up or treatment or if they make use of alternative therapy for their children?

Parents can choose the medical treatment for their children as they see fit. However, if they do not allow their children to receive follow-ups or treatments (including taking recommended medication as required) for a clearly serious health condition, where a layman would consider intervention or treatment by registered healthcare professionals necessary under the circumstances, or if the parents have arranged alternative therapy over a period of time yet without any improvement or the children's condition is turning worse while they still insist on not arranging recommended medication or treatment for diagnosed conditions of their children, even with the advice of registered healthcare professionals, it may be regarded as neglect for endangering or impairing the children's health or development.

Relating to Psychological Harm/Abuse

9. How do we determine if a child is under psychological harm/abuse?

- Psychological harm/abuse is usually not caused by a single incident but accumulated from undesirable behaviours from the carer toward the child and/or the interaction pattern between carer and child repeatedly over an extended period. As some children subjected to psychological harm/abuse may not immediately show clear signs of psychological stress, personnel should not base the judgment solely on the psychological and emotional response of the child when determining whether he/she is under

psychological harm/abuse. Instead, consideration should be focused on the long-term impact of the carer's behavioural pattern on the child.

- Such prolonged and repeated undesirable behaviour and/or interaction pattern includes but is not limited to the following[7]:

  (a) Neglect of the emotional need of the child, emotional unavailability in interactions with children, e.g. being detached and uninvolved, failing to express care and affection for the child, being emotionally detached and inattentive to the child's emotional needs and child's victimisation by others;

  (b) Spurning the child, refers to verbal or nonverbal acts that disdain, degrade, reject or dislike a child, e.g. shaming or ridiculing the child's physical, psychological or behavioural characteristics, singling out one child to criticise, punish and treat him/her badly, humiliating the child in public;

  (c) Terrorising the child, refers to behaviour that threatens to hurt, kill, abandon or place the child or the child's love ones or objects in recognisably dangerous situations, e.g. threatening to abandon the child or leave the child in dangerous or frightening situations, setting rigid or unrealistic expectations with threat of harm or danger if they are not met;

  (d) Developmentally inappropriate interaction with the child, refers to acts that encourage or let the child to develop inappropriate behaviours (e.g. adultification, parentification, infantilisation), encouraging the child to degrade or use other forms of hostile treatment to those in significant relationships with the child such as parents, siblings, etc.;

  (e) Unreasonably limit the child's opportunities to interacting with others (including inside or outside home), e.g. placing unreasonable limitations or restrictions on interactions with family members, peers or others in the community; and

  (f) Thwarting the child's socialisation and social development within the child's context by cultivating improper/deviated social and moral values, e.g. coercing the child's submission to extremely dominant parenting behaviours, manipulating or micromanaging

[7] Hart SN, Brassard MR, Baker AJL, Chiel ZA. Psychological maltreatment of children. In: Klika JB, Conte JR , editors. *The APSAC handbook on child maltreatment*. 4th ed. Los Angeles: Sage; 2017. p.145-162.

the child's life that disorientates the child's concept of right and wrong, induces guilt or fosters anxiety.

10. Does a child exposed to domestic violence constitute psychological harm/abuse?

- In general, domestic violence refers to actual/threatened use of violence among family members due to anger or conflicts, resulting in harm to and control over the other party. If parents/carers totally ignore the impacts of witnessing domestic violence on children by forcing them to witness and/or participate in the use of violence, or if they teach children to view violence as an appropriate way to handle disputes and disagreements, the children thus exposed to domestic violence may be subjected to psychological harm/abuse. If the above situation is confirmed, the social worker may conduct child protection investigation to study the case in detail and convene Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment to discuss the follow-up plan for the child.

- While children exposed to domestic violence are not necessarily subjected to psychological harm/abuse, these children are more prone to emotional distress. As such, social workers of casework units and/or other professionals are still required to help these children and their families understand the impacts of the domestic violence incidents and continuously assess the risk of domestic violence and child maltreatment in respect of the circumstances of the case, with a view to drawing up a safety plan to protect the children and their families from harm. The perpetrator should also be given assistance to stop the violent behaviour.

Chapter 3 Procedures of Multi-disciplinary Co-operation in Handling Suspected Child Maltreatment/Child Protection Cases

General Procedures

3.1 In order to protect the child facing imminent risk of being harmed/maltreated, the below description and flowcharts illustrate the steps which should be taken by personnel (including Government Departments, Non-governmental Organisations (NGOs), the Hospital Authority, schools or personnel of other organisations) when suspecting a child to have possibly been harmed/maltreated. These steps include:

(1) Identification of and reporting suspected child maltreatment case (please refer to Flowchart 1 of this Chapter and Chapter 4 of this Guide for details)

(2) Conducting initial assessment (please refer to Flowchart 2 of this Chapter and Chapter 5 of this Guide for details)

(3) Taking immediate child protection actions (if needed) (please refer to Flowchart 3 of this Chapter and Chapter 6 of this Guide for details)

(4) Investigating the suspected child maltreatment case (if the suspicion is substantiated) (please refer to Flowcharts 2 and 3 of this Chapter)

(a) Child protection investigation (please refer to Chapter 8 of this Guide for details)

(b) Medical examination (if needed) (please refer to Chapter 9 of this Guide for details)

(c) Criminal investigation (if needed) (please refer to Chapter 10 of this Guide for details)

(5) Conducting Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) (please refer to Flowchart 4 of this Chapter and Chapter 11 of this Guide for details)

(6) Follow-up the child protection case (please refer to Flowchart 4 of this Chapter and Chapter 12 of this Guide for details)

Roles of Personnel of Different Disciplines

3.2 With diverse work positions, service scopes and foci of intervention, personnel of different disciplines have different roles to be performed at various stages in handling suspected child maltreatment cases. Flowcharts in this Chapter show

the general procedures in case handling. Personnel of different disciplines should make reference to the annexes of this Guide and internal guidelines of their organisations (if any), and should work together with good co-ordination in order to assure the child and his/her family obtaining the help in need.

(1) For roles of social services unit, please refer to Annex 4 to this Guide (For definition of known cases of welfare organisations, please refer to Annex 5 to this Guide).

(2) For roles of clinics under the charge of Department of Health, please refer to Annex 6 to this Guide.

(3) For roles of hospitals/clinics under the charge of the Hospital Authority, please refer to Annex 7 to this Guide.

(4) For roles of child psychiatric services under the charge of the Hospital Authority, please refer to Annex 8 to this Guide.

(5) For roles of clinical psychological services of related departments/organisations, please refer to Annex 9 to this Guide.

(6) For roles of educational services, please refer to Annex 10 to this Guide.

Case Manager

3.3 To facilitate co-ordination of the services rendered by different professionals, the social worker who is responsible for conducting child protection investigation/following-up the child protection case will be the case manager in co-ordinating various tasks and **letting the child interact with the case manager only for most of the time whenever situation allows in order to reduce the child's stress and trauma in repeating the abusive experience**.

3.4 The duties of case manager include:

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

(2) to collect relevant information from other personnel involved;

(3) where necessary, make referrals of the child and his/her family members to the concerned service unit(s) at the earliest possible time;

(4) to share relevant information with other personnel involved on a need-to-know basis;

(5) to take necessary actions or liaise with relevant departments/personnel for taking those actions, including the application for Court Orders, to safeguard the immediate safety and well-being of the child; and

(6) to ensure that actions taken by personnel responsible for investigation/follow-up are well co-ordinated.

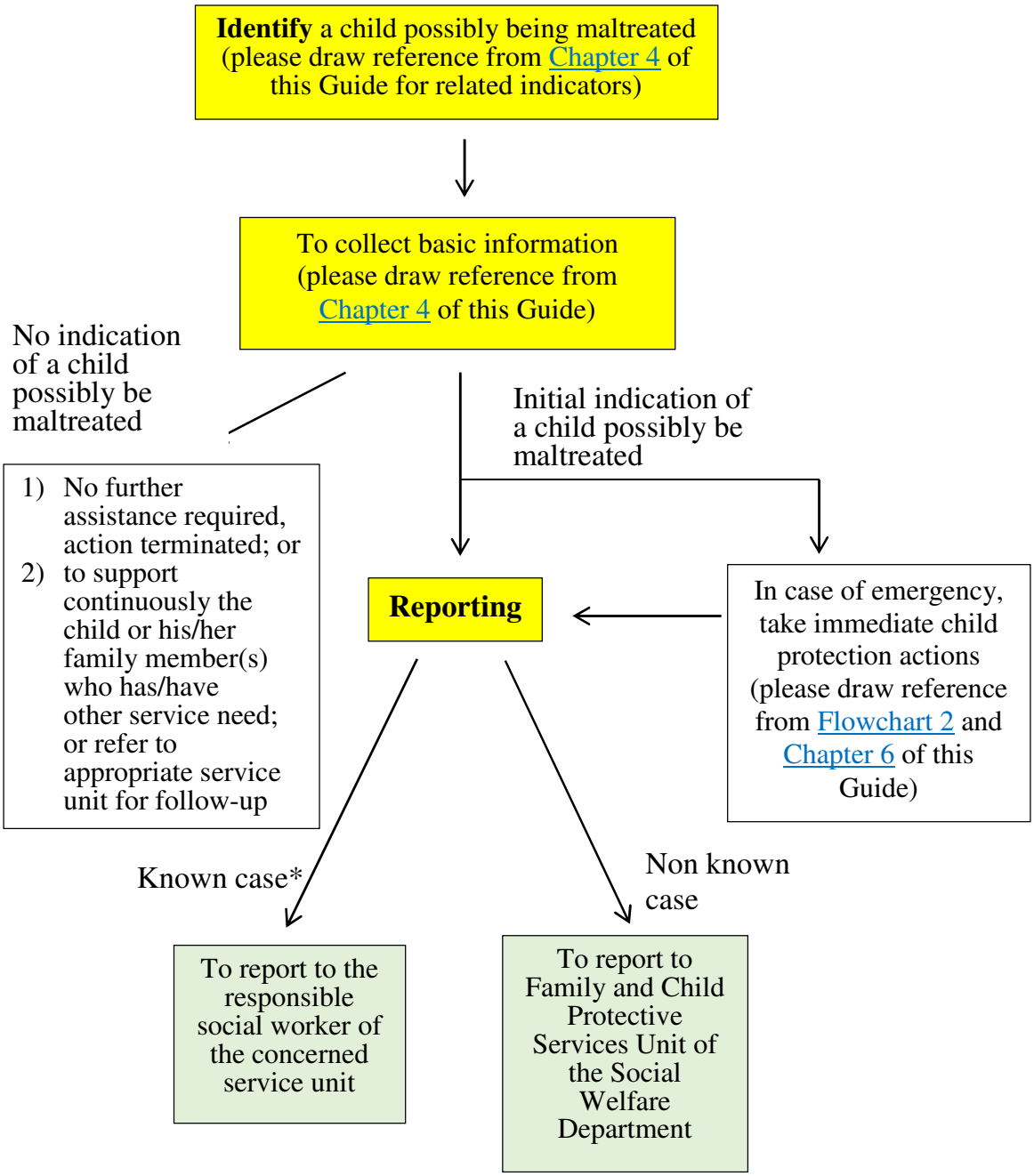
3.5 The duties of other professionals include:

(1) to report the case to appropriate social service unit for follow-up, where necessary, after contacting a child suspected of being harmed/maltreated (For reporting and initial assessment, please refer to Chapters 4 and 5 of this Guide);

(2) to share relevant information with the case manager and other personnel involved on a need-to-know basis so that the case manager could properly co-ordinate intervention rendered among different personnel; and

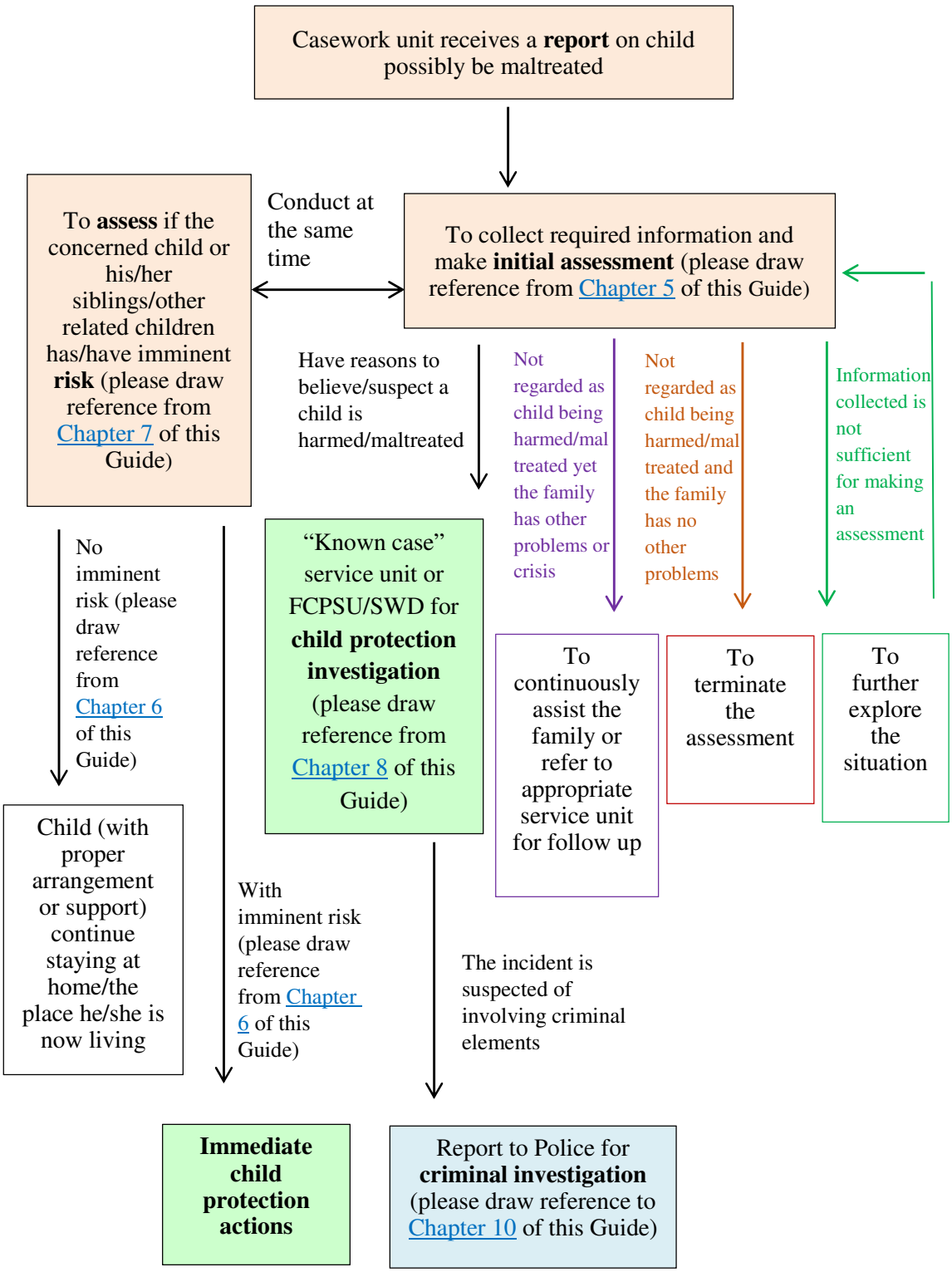
(3) during the course of case handling, to take initiative in revealing to case manager and other personnel the important observations or problems which need to be worked on and to discuss jointly the strategy and way of intervention in order to ensure the child and his/her family receive the assistance as required.

Flowchart 1: Identification and Reporting of a Suspected Child Maltreatment Case

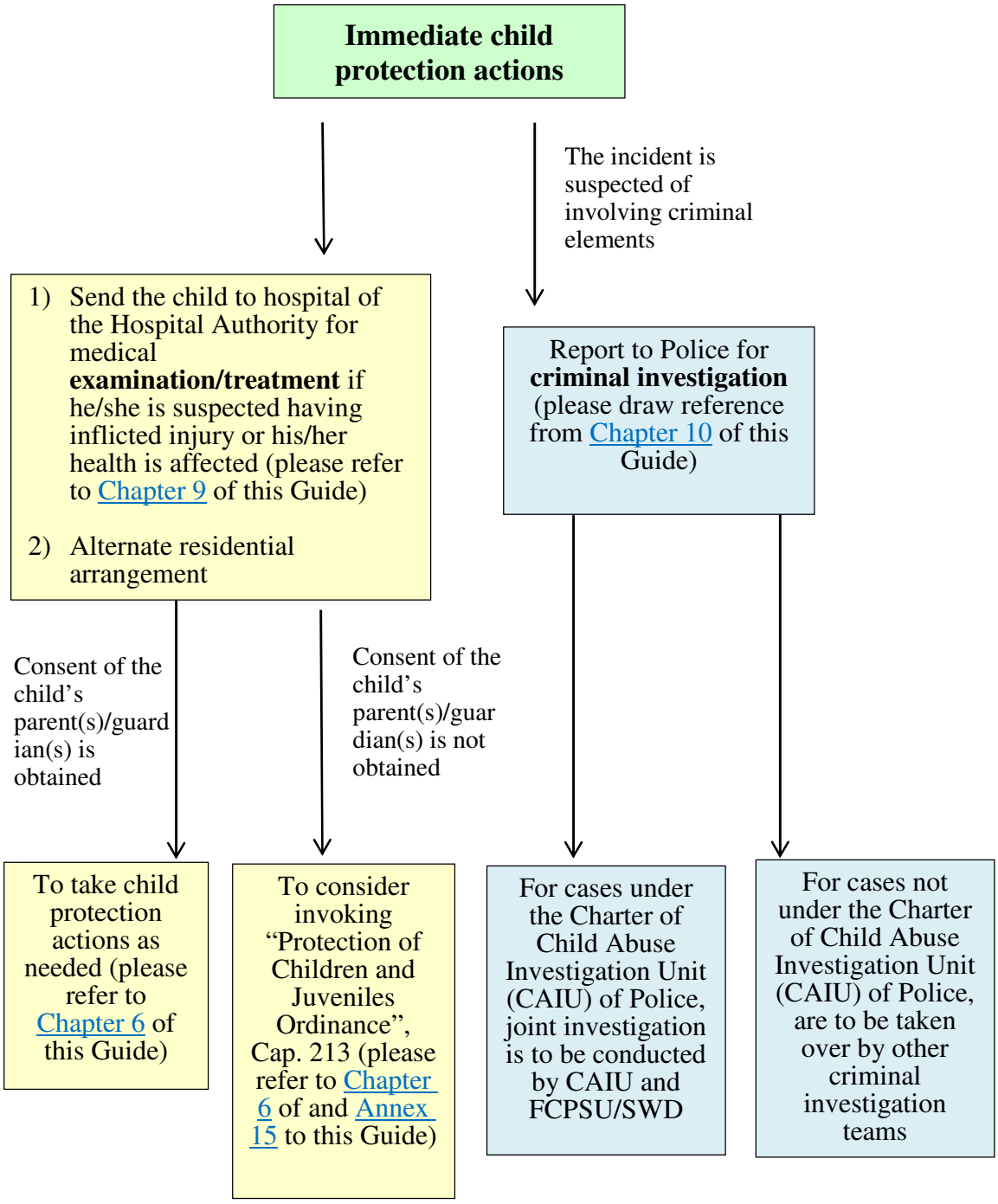


* Please refer to Annex 5 to this Guide for the definition of known case. Some of the known cases could also be reported to Family and Child Protective Services Unit (FCPSU) of the Social Welfare Department (SWD) for initial assessment, child protection investigation and convening/chairing the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment. Please refer to related chapters and Annex 4 for details.

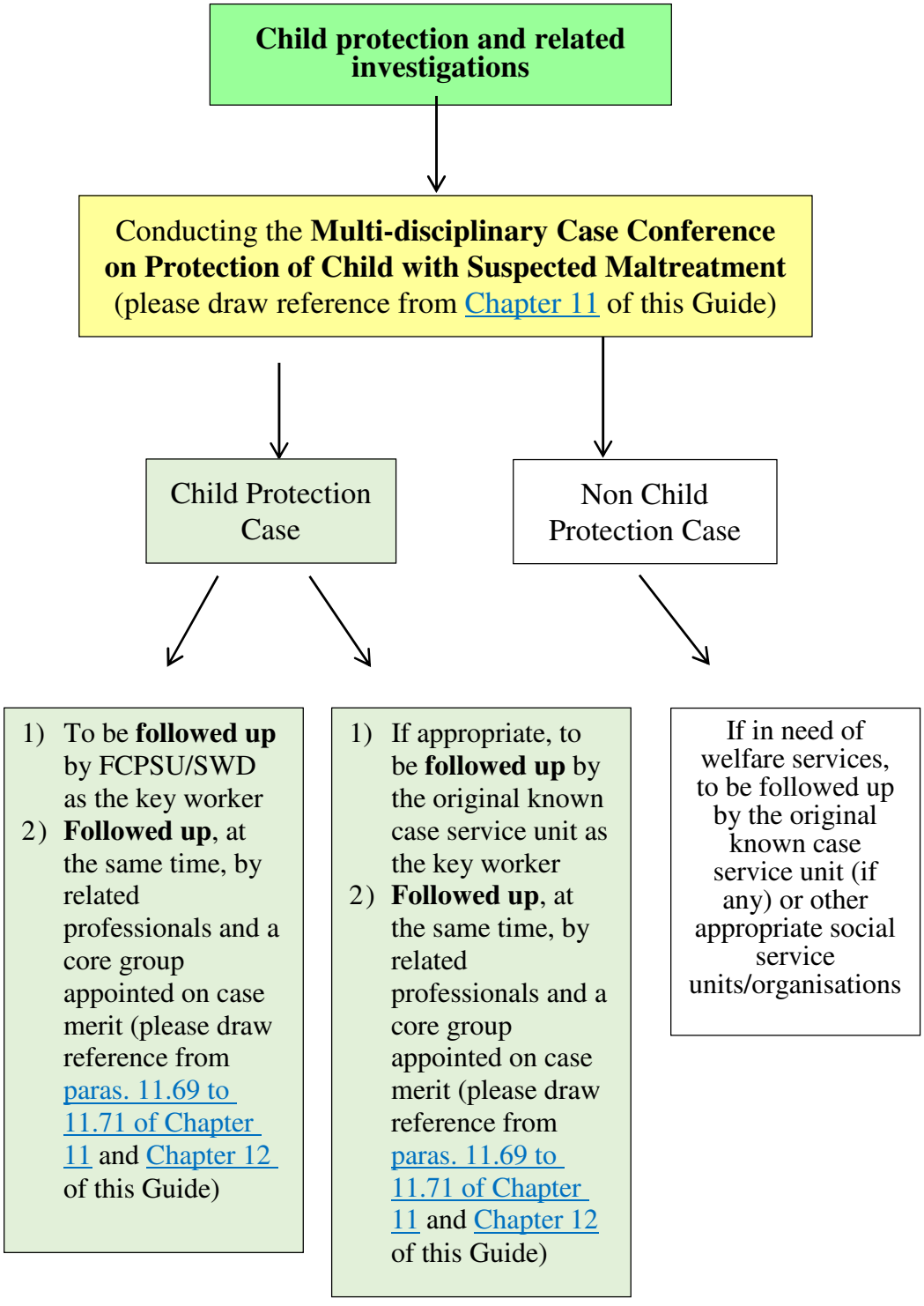
Flowchart 2: Conducting Initial Assessment and Immediate Child Protection Actions



Flowchart 3: Immediate Child Protection Actions and Investigations



Flowchart 4: Conducting the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment and Follow-up Services

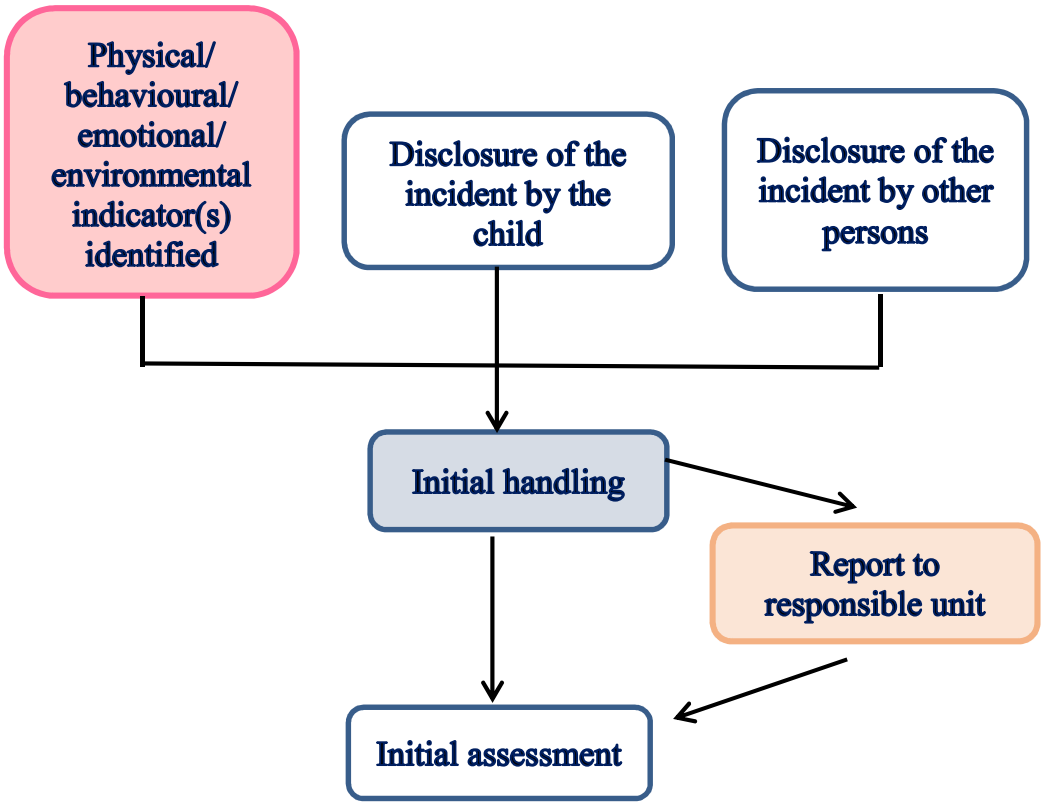


Chapter 4 Case Identification, Initial Handling and Reporting

Case Identification

4.1 Personnel from various sectors (including members of government departments, non-governmental organisations, the Hospital Authority (HA), schools or other organisations) may come across children having been harmed/maltreated or their family members in the course of their duties. When a child is suspected of having been maltreated, personnel should take preliminary actions (including collection of basic information) and, as per their respective roles (please refer to Chapter 3 of and Annexes 4 to 10 to this Guide), conduct initial assessment or report to an appropriate unit for conducting initial assessment in order to determine whether actions or follow-up work are required.

4.2 In some cases, the child may disclose the incident to the personnel on his/her own accord or through other persons (e.g. family members of the child or members of the public, etc.). However, in view of the close relationship between the child and the carer, it is normally not easy for the child to disclose the incident even he/she has been harmed/maltreated, especially in the case of sexual abuse where the child is even harder to tell because of the sensitive nature of the incident and a possible feeling of shame. As such, personnel approaching the child (especially very young child not yet go to school) or his/her family members (including interviews and family visits, etc.) should pay attention to whether the child or parent/carer concerned has manifested the following physical, behavioural, emotional and environmental indicators, showing that the child may have suffered from harm/maltreatment.



Possible Indicators of Child Maltreatment

4.3 Physical/behavioural/emotional/environmental indicators, which are usually manifested persistently, may be found on children being maltreated. Some behavioural/emotional indicators may appear in various types of harm/maltreatment to a child while some physical/behavioural/emotional/environmental indicators are more prevalent in specific types of harm/maltreatment. If personnel identify these indicators, please handle the case according to paragraphs 4.5 to 4.14 of this Chapter.

Regarding physical/behavioural/emotional/environmental indicators, please pay attention to the following:

1. Physical/behavioural/emotional/environmental indicators may manifest singly or in combination.
2. In serious situation, indicator(s) may appear only once even these indicators usually occur repeatedly.
3. Physical/environmental indicators are usually more readily observable while behavioural/emotional indicators (including the behaviour/emotion of the child or his/her parents/carers) are more subtle or concealed, which may be manifested by the child through drawings or play. Professionals have to be more sensitive and observant to identify these indicators.
4. Due consideration should be given to the age and capability of the child, and also to the behaviours, attitudes of parents/carers and family circumstances.
5. Personnel should consider thoroughly if the child may have been harmed/maltreated by different types of harm/maltreatment instead of focusing on one single type.
6. Some indicators can only be identified by professionals with relevant training (e.g. medical professionals may be required to determine whether the physical injury of a child is due to an accident). Please seek advice from professionals of relevant sectors as early as possible if there is any doubt about the indicator(s) identified.

4.4 As young children are particularly vulnerable, personnel have to be observant and make enquiries proactively with parents about their care of the child. Meanwhile, personnel may draw reference from the "Manual of Parenting Capacity Assessment Framework" jointly developed by the Department of Health, the Hospital Authority and the Social Welfare Department (SWD) in order to assess the capacity of parents/carers in taking care of children aged between 0 and 3 (including assessment of relevant risk factors).

Attention: Indicators listed below are not exhaustive. Neither does the presence of a single nor even several indicators point to the occurrence of child maltreatment. It however indicates that attention is required for the child. Personnel should first collect information, gain preliminary understanding and conduct initial assessment.

Personnel should not prematurely conclude that an incident is suspected child maltreatment in order to prevent the child from experiencing unnecessary investigations, examinations or hospitalisation. Personnel should also not exclude the possibility of a child being harmed/maltreated just because certain circumstances are not listed below.

(1) Behavioural/emotional indicators relating to various types of harm/maltreatment

(a) Child

(i) Infant/toddler being highly irritable/excessively quiet or sleepy

(ii) Infant/toddler refusing to be fed

(iii) Infant/toddler being unresponsive/reacting abnormally to external stimuli

(iv) Enacting/reproducing scenes of harm/maltreatment in play or daily behaviour

(v) Reluctant to speak/withdrawn

(vi) Extremely angry/short-tempered/aggressive in behaviour

(vii) Always in fear/excessive vigilance

(viii) Extremely rebellious/overtly compliant or pleasing

(ix) Over-sensitive to the carer's emotions/responses

(x) Exceptionally friendly towards strangers or persons other than the carer/being suspicious and difficult to build trust in people

(xi) Poor peer relationship

(xii) Presence of attention problems/marked change in academic performance

(xiii) Poor self-image

(xiv) Delayed development

(xv) Regressive or repetitive behaviour (e.g. bed-wetting, thumb-sucking, hair-pulling, head-banging, body-rocking, etc.)
(xvi) Sleep disturbance
(xvii) Psychosomatic symptoms[8]
(xviii) Reluctant to return home/running away from home
(xix) Absence/withdrawal from school without reason or sudden loss of contact
(xx) Child disclosing that he/she has been forced into marriage by parents (e.g. children of ethnic minorities)

(b) Parent/carer
(i) Parent/carer repeatedly refusing others from approaching the child or forbidding the child to communicate with personnel directly (e.g. the child is always absent or asleep during scheduled visits by personnel and cannot be reached by relatives and family friends)
(ii) Parent/carer forbidding the child to receive vaccination or health/medical follow-ups without sound reasons
(iii) Parent/carer not applying for birth certificate/identification documents for the child without sound reasons
(iv) Holding the infant with excessive force frequently
(v) Ignoring the cries of the infant frequently

(2) Indicators relating to physical harm/abuse

(a) Physical Indicators
(i) Bruises and Welts
- Should be interpreted with reference to various factors, including the developmental stage (e.g. whether the child is able to walk), the number, size and distribution of bruises and whether they form a specific shape that suggests direct impact with an object, punching, grasping or bites
- Bruises that are unlikely to be accidental, e.g. extensive bruises or bruises at unusual body parts, multiple bruises of different ages or injuries around the genitalia
- Bite marks

[8] Psychosomatic symptoms refer to physical discomfort or symptoms resulting from psychological or emotional disturbances, e.g. headache, tummy ache, diarrhea, vomiting, skin allergy, etc.

(ii) Lacerations and Abrasion

- Lacerations over the hands, arms or feet. Those that damage the underlying tendons may be potentially crippling
- Laceration to the frenulum (the piece of tissue in midline that connects the inside of upper lip to the upper gum) may be indicative of forced feeding

(iii) Burns and Scalds

- Some inflicted burns may assume the shape or pattern of the burning objects, e.g. a heated plate or cigarette
- Distribution of scalds on hands/feet or buttocks of the child in glove or stocking shape is indicative of immersion into hot water

(iv) Fractures

- Should be interpreted/handled individually based on case circumstances

(v) Internal Injuries

- Brain/head injuries
  - May be caused by direct impact, shaking or piercing
  - The "Shaken Baby Syndrome" is the most common cause of death in physical harm/abuse
- Abdominal injuries
  - Perforation of internal organs may lead to abdominal pain and vomiting
  - Child may have been seriously wounded or even die without any visible signs of injuries. Hence, a high degree of suspicion is required for the detection of abdominal injury

(vi) Others

- Fabricated or induced illness, Factitious Disorder Imposed on Another
- Poisoning (including a child being tested positive for dangerous drugs)
- Hair loss by pulling or burning
- Drowning
- Multiple injuries sustained at different times
- Ordered to carry out duties/activities that are beyond the child's physical ability for excessive hours

- Sudden death of the infant
  - Conclusion should not be made until a formal Coroner's investigation has been completed

(b) Behavioural Indicators

(i) The explanations of the causes/course of child's injury made by the parent/carer/child are unconvincing/contradictory to or inconsistent with the injuries sustained

(ii) Failure or delay in seeking medical advice

(iii) Excessive amount of clothes worn by the child to cover his/her body

(iv) Enacting/reproducing scenes of harm/maltreatment in play or daily behaviours by the child

(3) Indicators relating to sexual abuse (for both boys and girls)

(a) Physical Indicators

(i) Torn, stained or bloodstained underclothing

(ii) Complaints of pain, swelling or itching in the genital area

(iii) Complaints of pain during urination

(iv) Bruises, bleeding, or lacerations in external genitalia, vaginal area, anus, mouth or throat

(v) Vaginal/penile discharge

(vi) Bowel control or bladder control weakened despite toilet trained

(vii) Repeated urinary tract infection

(viii) Sexually transmitted disease

(ix) Pregnancy

(b) Behavioural Indicators

(i) Child showing particular interest in body parts of adults or touching adults' sensitive body parts repeatedly

(ii) Enacting/reproducing scenes of sexual abuse in play or daily behaviour

(iii) Child disclosing that his/her parent or other person has played secret games with him/her

(iv) Knowledge about sex or sexual behaviour that is beyond the expectation for the age of the child

(v) Marked change in attire

(vi) Sleep disturbance

(vii) Excessive masturbation

(viii) Hyper-sensitive to being touched

(ix) Highly resistant to stay at somewhere or with someone/a specific sex/individual(s) of a certain identity
(x) Child with adequate self-care abilities disclosing that the carer often takes care of his/her personal hygiene/care matters (e.g. bathing, cleaning after toileting, changing clothes, etc.)
(xi) Child of an older age disclosing that his/her parent of the opposite sex often shares the same bed with him/her
(xii) Having frequent contact with strangers through mobile phone or the internet and having been invited to meet outside
(xiii) Behavioural problems (including anorexia/bulimia, obesity, self-harm, running away from home, suicide, promiscuity, alcoholism and drug abuse)

(4) Indicators relating to neglect

(a) Physical Indicators
(i) Newborn showing symptoms of Neonatal Withdrawal Syndrome after birth
(ii) Newborn's urine sample is tested positive for dangerous drugs
(iii) Malnutrition, under-weight or frail
(iv) Though the weight of the infant is within the normal range, his/her weight gain slows down significantly/weight loss or abnormally increases within a period of time
(v) Delayed development (e.g. speech disorder, motor skills, intelligence, etc.)
(vi) Severe rash or other skin problems
(vii) Unattended physical problems or unmet medical/ dental needs
(viii) Lack of adequate diet/diet inappropriate for the child of that age group
(ix) Persistently dirty/shabby/lack of sufficient clothing/ inappropriately dressed for weather conditions
(x) Poisoning/accidental ingestion of dangerous drugs or hazardous substances
(xi) Frequent accidental injuries

(b) Environmental Indicators
(i) Infant/pre-school child being left unattended at home
(ii) Child inadequately supervised for long periods of time
(iii) Child being abandoned completely or for long periods of time
(iv) Left in the care of inappropriate carer (e.g. young child)
(v) Child being confined at home

(vi) School-aged child being persistently absent from school or deprived of schooling
(vii) Child with special care/educational needs being deprived of opportunities in receiving appropriate assessment, education or training
(viii) Inadequate supervision when the child is engaged in dangerous activities (e.g. no parental supervision when the child is playing at the beach)
(ix) Spoiled food at home left undealt with
(x) Frequent use of filthy utensils or items/feeding newborn with unsterilised utensils
(xi) Insanitary home conditions (e.g. with lots of garbage, excreta, dirt, etc.)
(xii) Unsafe living environment (e.g. with dangerous items/household drugs accessible to the child)
(xiii) Suspected dangerous drugs or drug-taking equipment found in the place of residence
(xiv) Infant/child being exposed to venues with suspected dangerous drugs or drug-taking equipment, carer/other persons suspected to be taking drugs in the presence of the child
(xv) No place of abode

(c) Behavioural Indicators
(i) Persistent complaints of hunger or constant rummaging for food, wolfing down meals or begging for/stealing food
(ii) Addiction
(iii) Delinquency
(iv) Involved in sexual activities because of inadequate supervision
(v) Complaints of inadequate care, supervision or nurturing

(5) Indicators relating to psychological harm/abuse

(a) Physical Indicators
(i) Underweight or frail
(ii) Developmental delay
(iii) Eating disorder (e.g. Anorexia nervosa)
(iv) Psychosomatic symptoms[9]

[9] Psychosomatic symptoms refer to physical discomfort or symptoms resulting from psychological or emotional disturbances, e.g. headache, tummy ache, diarrhea, vomiting, skin allergy, etc.

(b) Behavioural Indicators

(i) Child

- Resisting contact with others and the outside world
- Anxiety symptoms observed, e.g. habitual nail-biting, hair-pulling, thumb-sucking, head-banging and body-rocking, etc.
- Wetting/soiling
- Language delay
- Self-harm or suicidal thoughts/attempts

(ii) Carer

- Often emotionally unavailable/giving inappropriate emotional response
- Being detached or indifferent towards the child
- Often singling a particular child and treat him/her badly
- Rejection
- Constant scolding
- Humiliating criticism
- Terrorising the child
- Often requiring the child to bear responsibilities of an adult/that is inappropriate for his/her age
- Unreasonably limiting or restraining the child from interacting with peers or other persons
- Forbidding the child to express his/her opinions, feelings and wishes
- Encouraging deviant or criminal behaviour
- Bizarre punishment
- Unpredictable behaviour
- Repeatedly accusing others of harming/maltreating the child without factual evidence, subjecting the child to repeat unnecessary investigating procedures (this is more common in divorced/separated families with disputes)

Initial Handling and Reporting

4.5 When the above indicator(s) is/are identified, personnel should first conduct initial assessment to ascertain the possibility of a child maltreating behaviour/incident and decide whether any actions are to be taken. In general, initial assessment is conducted by the following units (please refer to paragraphs 4.6 to 4.8 of this Chapter at the same time):

(1) social worker of the service unit in charge of a case (i.e. the social worker responsible for a "known case"); or

(2) social worker from Family and Child Protective Services Unit (FCPSU) of SWD.

For definition of "known cases" of welfare organisations, please refer to Annex 5 to this Guide. As for the contact information of FCPSUs, please refer to Appendix 1 to this Chapter.

4.6 If personnel suspects a child is being maltreated but his/her respective service unit is not handling the case, he/she should report the case to the social worker/service unit in charge (if any) **as soon as possible** so that initial assessment can be conducted by the responsible caseworker to determine necessary actions. If there is no social worker in charge, report should be made to FCPSU of which the social worker will conduct initial assessment.

4.7 Social workers of Integrated Family Service Centres/Integrated Services Centres operated by NGOs, school social workers rendering services at various secondary schools and medical social workers of the HA should conduct initial assessment for their "known cases". Social workers of other NGO social service units and those employed by primary schools/pre-primary institutions may also report their "known cases" to FCPSUs for initial assessment (please refer to Appendix 1 to this Chapter for the contact information of FCPSUs).

4.8 For suspected sexual abuse cases between family members or involving multiple child victims, the case can also be reported to FCPSU even it is a "known case" of a casework unit. Social worker of FCPSU will discuss the handling strategy and collaborate with the reporting personnel or responsible social worker in taking necessary actions.

4.9 Reporting of suspected child maltreatment cases outside office hours can be made through SWD Hotline[10] (Telephone number: 2343 2255). Officer-on-duty will contact the outreaching team of SWD which is responsible for handling child maltreatment cases. The outreaching team will conduct initial assessment on the said report case and take immediate child protection actions as deemed necessary.

[10] Departmental Hotline Service operates 24-hours a day. The hotline service is manned by Departmental Hotline Service Unit of SWD from 9:00 am to 5:00 pm from Monday to Friday and 9:00 am to 12:00 noon on Saturday (excluding public holidays). Outside the above operation hours, the calls are handled by the Hotline and Outreaching Service Team operated by the Tung Wah Group of Hospitals.

4.10 Cases involving suspected child maltreatment should usually be dealt with as soon as possible. Hence, report may be made by phone. If the reporting unit wants to have a written report for record purpose, the reported information may subsequently be forwarded to the unit responsible for initial assessment. The report form and reply sample are set out in Appendix 2 to this Chapter for reference and use.

4.11 If the personnel considers the situation is urgent warranting immediate child protection actions, e.g. sending an injured child to the hospital for examination/requesting police intervention for protecting a child, actions may first be taken before reporting to the social service unit concerned.

4.12 When reporting a case or taking immediate child protection actions, the feelings of the child and the impact of such actions on the child should be taken into consideration. The child should be explained of the arrangements and procedures. In addition, the parent(s)/guardian(s) of the child, depending on circumstances, should also be explained of the arrangements and relevant procedures. Communications with the child/parent(s)/guardian(s) should be conducted in languages comprehensible to them. If interpretation is required, appropriate interpretation service (including sign language) should be arranged. It is not advisable to arrange family members/relatives/friends/acquaintances or child himself/herself to act as interpreters. Regarding immediate child protection actions, please refer to Chapter 6 of this Guide.

4.13 Reporting personnel should gather and provide basic information as per the needs of individual cases without having to enquire about the details of the incident. Basic information may include the following items:

(1) Regarding the incident of possible child harm/maltreatment
   (a) nature and brief account of the incident;
   (b) frequency of similar incident(s);
   (c) identity and number of the alleged perpetrator(s);
   (d) date/time of the incident, e.g. the earliest, the most recent and the most severe incident;
   (e) location of the incident; and
   (f) any other person present at the scene or aware of the incident; if yes, his/her/their response(s) and action(s) taken

(2) Regarding the child
   (a) name, date of birth/age;
   (b) any disability or special needs;

(c) current whereabouts;
(d) any physical injury currently sustained;
(e) behavioural/emotional conditions of the child;
(f) whether the child is in immediate danger; and
(g) name of school/child care centre

(3) Regarding the family
(a) name and Hong Kong Identity Card number of parents/carers and other relevant parties;
(b) name and age of other children in the same family, and whether they are at risk or potentially at risk of maltreatment;
(c) significant persons who can help the child or family concerned (e.g. family members, relatives) ; and
(d) whether the family concerned has previously been involved in or suspected of child maltreatment

(4) Regarding the reporting personnel
(a) affiliation, name and contact telephone number; and
(b) how the reporting personnel found out about the incident and actions taken

4.14 In respect of points to note on the sharing of information among personnel during collection of information and reporting, please refer to Annex 2 to this Guide.

4.15 When handling cases of suspected child maltreatment, personnel engaged in initial handling shall pay attention to the following:

(1) Each case shall be taken seriously regardless of the source or recency of the incident.

(2) Collection of information may take time yet priority shall be given to the immediate safety of the child.

(3) The child suspected of having been maltreated should not be required, where it is unnecessary, to repeatedly describe the incident(s) of maltreatment to different parties or on different occasions.

(4) If it is the child himself/herself who discloses the suspected maltreatment incident(s) and asks for confidentiality, it should be

explained to the child that such a promise cannot be made for safeguarding his/her best interests.

(5) If there is a need for the personnel to make an initial contact with a child who may have been harmed/maltreated or his/her parent (e.g. for making preliminary enquiries with the child on the suspected maltreatment incident, observing the care and development of young children, observing the home conditions and contacting parents), they may refer to "Points to Note on Initial Contact with Children Who may have been Harmed/Maltreated or their Parents" at Annex 11 to this Guide.

(6) For suspected sexual abuse cases, please refer to "Points to Note on Contacting Children Suspected to be Sexually Abused" at Annex 12 and "Guidance Notes on Reporting Suspected Sexual Abuse" at Annex 13 to this Guide.

(7) Sometimes the informant may wish to have his/her identity treated in confidence. The informant should be assured that his/her identity and personal data will not be disclosed to a third party unless such disclosure is essential in the litigation process or for the protection of the child or other persons.

Appendix 1 to Chapter 4

☎ List of Family and Child Protective Services Units of Social Welfare Department

SWD Hotline			2343 2255
Family and Child Protective Services Units (FCPSUs)			
1.	FCPSU (Central Western, Southern and Islands)	Room 2313, 23/F, Southorn Centre, 130 Hennessy Road, Wanchai, H.K.	2835 2733
2.	FCPSU (Eastern/Wanchai)	Room 229, 2/F, North Point Government Offices, 333 Java Road, North Point, H.K.	2231 5858
3.	FCPSU (Sham Shui Po)	G/F, Cheung Shan Wan Community Centre, 55 Fat Tseung Street, Kowloon	2247 5373
4.	FCPSU (Kowloon City/Yau Tsim Mong)	Room 803, 8/F, Kowloon Government Offices, 405 Nathan Road, Kowloon	3583 3254
5.	FCPSU (Kwun Tong)	Unit 2101, 21/F, Kwun Tong View, 410 Kwun Tong Road, Kowloon	3586 3741
6.	FCPSU (Wong Tai Sin/ Sai Kung)	3/F, Wong Tai Sin Community Centre, 104 Ching Tak Street, Wong Tai Sin, Kowloon	3188 3563
7.	FCPSU (Shatin)	Room 716, 7/F, Shatin Government Offices, 1 Sheung Wo Che Road, Shatin, New Territories	2158 6680
8.	FCPSU (Tai Po/North)	4/F, Tai Po Complex, 8 Heung Sze Wui Street, Tai Po Market, New Territories	3183 9323
9.	FCPSU (Tsuen Wan/Kwai Tsing)	21/F, Tsuen Wan Government Offices, 38 Sai Lau Kok Road, Tsuen Wan, New Territories	2940 7350

10. FCPSU (Tuen Mun)	4/F, On Ting/Yau Oi Community Centre, On Ting Estate, Tuen Mun, New Territories	2618 5614
11. FCPSU (Yuen Long)	G/F, Wah Yuet House, Tin Wah Estate, Tin Shui Wai, Yuen Long, New Territories	2445 4224

Appendix 2 to Chapter 4

Report Form (Sample for Reference)

Unit/Organisation responsible for initial assessment	Name and address of Organisation/School

Mr/Ms XX,

Reporting of Suspected Child Maltreatment Case

Our organisation/unit identified a suspected child maltreatment case on _____ (Date)_____(Month)_____(Year) and has reported to your Organisation/Unit via phone on _____(Date)_____(Month)_____(Year). Case information is hereby enclosed for your reference and record:

A. Information of the child suspected to be maltreated and the family

Name：_____ Sex：____Date of Birth/Age：_____

Birth certificate/HKID No.：_____ Current whereabouts：_____

Class：_____Language normally used：_____

Name of Father/Mother/Guardian：_____ Relationship：_____

Address：_____

Tel. No.：_____

Language normally used：_____

Whether preliminary information indicates immediate danger of the child：

1. Child has immediate danger of continual staying at home/the place he/she is now living：Yes/No
2. Child has immediate need for medical examination and treatment：Yes/No
3. Child has urgent need for statutory protection：Yes/No
4. Urgent report to Police for this suspected child maltreatment incident is needed：Yes/No

Any disability or special needs of the child：_____

The child and/or the family members concerned is/are known case(s) of social service unit(s)：

❑ Yes

[please specify：Name of the Unit：

Name of the responsible social worker：]

Contact means：

❑ No ❑ Unknown

B. Information of the Incident

1. Date/Time/Location of the incident：_____
2. Types of maltreatment suspected：❑ Physical harm/Abuse❑ Sexual Abuse ❑ Psychological harm/Abuse ❑ Neglect ❑ cannot be categorised
3. Name and HKID No. of the alleged perpetrator (if available)：_____
4. Relationship of the alleged perpetrator with the child：_____
5. Brief account of the incident：_____

_____

_____

For follow-up by your organsisation/unit please. For enquiry, please contact Mr/Ms_____(Name) on _____ (Tel. No.) at/during (time convenient for contact).

(Name)
(Reporting Organisation/School)
Date：_____

----------✂----------

Reply

From：(Organisation/Unit receiving the report （Fax No.： ）
To：(Reporting Organisation/School) （Fax No： ）
Date：(_____)

Reporting of Suspected Child Maltreatment Case

Our Oganisation/Unit has received the captioned report.

☐ Social worker has conducted/will conduct initial assessment.

☐ The captioned case is a known case of ___(Organisation/Unit) , please contact the responsible social worker_____（Tel. No.： _____）.

For enquiry, please contact____(Name)_____on_____.

(Name)
Post

Chapter 5 Initial Assessment

5.1 When the social service unit responsible for initial assessment receives a report that a child may have been maltreated, social worker of the unit shall perform the following actions:

(1) collect the necessary information; and

(2) conduct the following assessment and retain the relevant records:

(a) assess whether the suspicion of child maltreatment is substantiated and determine whether there are reasons to believe/suspect that the child has been harmed/maltreated;

(b) the level of imminent risk of harm to the child; and

(c) whether immediate child protection actions are necessary.

5.2 During assessment, social worker shall take into account the possible diverse views of families with different cultural backgrounds on the behaviour concerned. However, emphasis should be put on safeguarding the physical and psychological safety of the child.

5.3 If the social worker responsible for the "known case" is unable to perform the actions as stipulated in the paragraphs 5.1 and 5.2 above in a timely manner, his/her service unit should arrange for another social worker to handle the matter in order to avoid delay of initial assessment.

Collection of Information

5.4 Apart from collecting the required information as listed in Chapter 4 of this Guide, social worker responsible for initial assessment may also make enquiry to the "Child Protection Registry" (CPR) of SWD on the following information:

(1) whether the child/sibling(s) has/have been registered in the CPR;

(2) if so, whether the case is active or has been de-registered; and

(3) information of the service unit handling/last handled the case.

[The above information will only be released to registered users of the CPR. Telephone enquiries by registered users may be made to the CPR (Tel. no.: 3468 2167) during office hours from Monday to Friday (excluding public holidays).] (Please refer to Annex 14 to this Guide for information on the CPR.)

5.5 If the personnel making report of a case (the reporting personnel) is not the first person who suspected a child might have been maltreated, the social worker responsible for initial assessment should attempt to contact directly the first person who had such suspicion. In order to avoid confusion and duplication of work, the reporting personnel should be asked whether he/she has contacted other department(s) or organisation(s).

5.6 When collecting information and liaising with the reporting personnel, the social worker responsible for initial assessment is advised to meet with/contact the child in person and get in touch with his/her parent(s) in due course if the reported information is insufficient for him/her to make necessary decision(s). If interpretation is required, appropriate interpretation service (including sign language) should be arranged. It is not advisable to arrange family members/relatives/friends/acquaintances or child himself/herself to act as interpreters. For points to note on initial contact with children who may have been harmed/maltreated or their parents (including arrangements and questioning approach for meeting with the child, observing the care and development of young children, observing the home conditions and contacting parents), please refer to Annex 11 to this Guide.

5.7 The social worker responsible for initial assessment may need to request for supplementary information from the reporting personnel in order to facilitate the assessment. However, information required may vary due to the nature of individual cases. Unless necessary, the reporting personnel should not be requested to repeatedly question the child or collect excessive amount of information.

5.8 In respect of points to note on the sharing of information among personnel during initial assessment, please refer to Annex 2 to this Guide.

Scope of Initial Assessment

5.9 Based on the information collected, the social worker responsible for initial assessment shall carry out the following assessments and arrange for related follow-up actions.

(1) Assess whether the suspicion of child maltreatment is substantiated: whether there are reasons to believe/suspect that the child has been harmed/maltreated. The result of assessment generally falls under the five categories below:

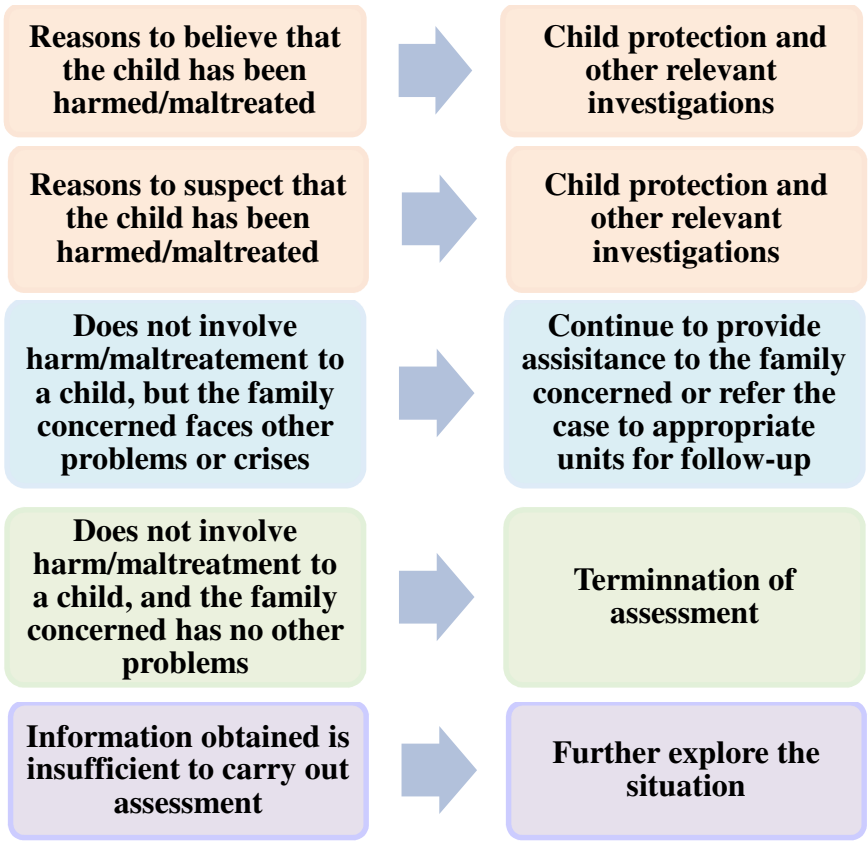
(a) There are reasons to believe that the child has been harmed/maltreated and there is a need to conduct child protection and other relevant investigations;

(b) There are reasons to suspect that the child has been harmed/maltreated, and there is a need to conduct child protection and other relevant investigations;

(c) The incident does not involve harm/maltreatment to a child but the family has difficulty in providing care/discipline to their children or faces other problems/crises that it requires assistance and follow-up (assistance to be rendered to the family concerned by the social worker responsible for the "known case" or referral(s) to be made to appropriate unit(s) for follow-up);

(d) The incident does not involve harm/maltreatment to a child and the family concerned has no other problems that require assistance (may terminate the assessment); and

(e) Information obtained is insufficient to carry out assessment. Social worker responsible for initial assessment should continue to explore the situation or refer the case to appropriate unit(s) for follow-up. If necessary, social worker responsible for initial assessment may consult Family and Child Protective Services Unit (FCPSU). If the cause of the injuries on the child is unclear or the physical/psychological condition(s) of the child is/are uncertain/worrying but there is not yet a reason to suspect that the child has been harmed/maltreated, the social worker may first consult medical staff/clinical psychologist or arrange for the child to receive medical examination/psychological assessment.



(2) If the incident falls under the category as stated in paragraph 5.9 (1)(a) or (b), the imminent risk of harm/maltreatment to the child should be assessed which generally involves the following aspects (please refer to "Risk Assessment and Decision Making on Protecting the Safety of Children" at Chapter 7 of this Guide for details):

(a) whether the child is currently safe;

(b) imminent/future risk of harm/maltreatment (e.g. whether the incident occurred recently, whether it is likely for the child to be in contact with the alleged perpetrator, degree of vulnerability/helplessness of the child);

(c) whether the child will refrain from telling the truth or accepting help due to pressure (e.g. whether the alleged perpetrator/family members of the child, etc. have a negative attitude or interfere with child protection actions); and

(d) imminent/future risk of harm/maltreatment to other children (e.g. whether the alleged perpetrator can harm other children).

(3) If the incident falls under the category as stated in paragraph 5.9 (1)(a) or (b), consideration should also be given to whether actions should be taken to ensure the safety of the child/other children (may refer to "Immediate Child Protection Actions" at Chapter 6 of this Guide). Arrangements

should be made having regard to the severity and urgency of the incident and may involve the following actions:

(a) whether the child requires medical examination/treatment if he/she has been/may be injured or his/her health is affected;

(b) whether the child requires protection, removal from the environment where the harm took place, or other residential care arrangements;

(c) whether it should be reported to the Police for criminal investigation or whether a joint investigation should be conducted by FCPSU and the Child Abuse Investigation Unit (CAIU) of the Police if a criminal offence may have been committed (please refer to "Criminal Investigation" and "Guidance Notes on Reporting Suspected Sexual Abuse at Chapter 10 of and Annex 13 to this Guide respectively); and

(d) whether relevant department(s)/organisation(s)/individual(s) should be contacted to ensure the safety of other children.

Below are some examples of situations where there are reasons to believe/suspect that a child has been harmed/maltreated and immediate actions should be taken to ensure the safety of the child/other children (the list below is not exhaustive):

(i) Child having suffered from severe physical injuries, being noticeably frail or behaving oddly

(ii) Carer(s)/family member(s) explicitly stating that he/she/they will harm the child or is/are worried that he/she/they may harm the child

(iii) Child having suffered from apparent physical injuries or is in poor health, but the explanation provided by him/her or his/her family member(s) is inconsistent with the injuries suffered or his/her health conditions, or such explanation is found to be unreasonable, and the child/family member(s) refuse(s) assistance of personnel

(iv) Home condition exceptionally poor

(v) Infant/pre-school child being left unattended

(vi) Infant/child being exposed to venue with suspected dangerous drugs or drug-taking equipment and is highly likely to inhale/gain access to such substances, or carer/other persons

suspected to be taking drugs in the presence of the child, which resulted in the child highly likely to inhale such substances

(vii) Sexual abuse occurred recently/persistently and the child has been in frequent contact with the perpetrator or will do so within a short period of time

5.10 If the incident falls under the category as stated in paragraph 5.9 (1)(a) or (b) but no immediate action is required to ensure the safety of the child/other children (e.g. the incident occurred a period of time ago, the child currently has no injuries and will not be in contact with the alleged perpetrator for the time being), social worker responsible for initial assessment may make arrangements for child protection investigation and other necessary investigations, such as medical examination and criminal investigation (please refer to Chapters 8 to 10 of this Guide for details).

5.11 If the incident involves the safety of other children and assistance of or handling by other unit(s)/department(s)/organisation(s) is required, the social worker responsible for initial assessment should contact the relevant unit(s)/department(s)/organisation(s) having regard to the circumstances of individual cases. For enquiries, please contact FCPSU.

5.12 If the incident falls under the category as stated in paragraph 5.9 (1) (e) and the social worker responsible for initial assessment considers it necessary for the child to undergo assessment on his/her health, development or the way in which he/she has been treated, appropriate arrangements should be made. If the parents are unwilling to co-operate, but the social worker responsible for initial assessment (if he/she is a social worker of SWD) has reasonable cause to suspect that the child to be or is likely to be in need of care or 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 workers[11] 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 will contact medical officer of the relevant hospital/clinic, clinical psychologist of the hospital/clinic/SWD/NGO or approved social worker of SWD to make the

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

necessary arrangements (please refer to Annex 15 to this Guide, "Ordinances Related to Child Protection Work" and Frequently Asked Questions in relation to the PCJO). If the social worker responsible for initial assessment is not from SWD, he/she may discuss with social worker of FCPSU to see if invocation of the PCJO is appropriate.

Continuous Assessment of Cases that do not Involve Harm/Maltreatment to the Child but Require Assistance

5.13 If the incident falls under the category as stated in paragraph 5.9 (1) (c), it implies that the incident does not involve harm/maltreatment to a child but the family has difficulty in providing care/discipline to their children or faces other problems/crises that it requires assistance and follow-up. Personnel engaged in follow-up should pay attention to the following:

(1) In view that the circumstances of a case will change from time to time, follow-up personnel shall remain sensitive and be at all times alert to any physical/behavioural/emotional/environmental indicators that reveal potential harm/maltreatment (please refer to Chapter 4 of this Guide). Further assessment is to be made if necessary.

(2) If the child has been harmed/maltreated afterwards, he/she may conceal the incident for fear of consequences of disclosure (e.g. facing aggravated violence or psychological harm, putting family members under criminal investigation, etc.). If the personnel is aware that the child may be concealing facts or finds that the explanation of the causes/course of the injury is unconvincing, contradictory or inconsistent with the injuries sustained, he/she shall probe into the incident by using appropriate skills. The personnel may also explore the child's situation through persons who have more contact with the child (e.g. other family members, classmates, etc.) to facilitate the assessment.

Chapter 6 Immediate Child Protection Actions

6.1 After conducting initial assessment, social worker may need to take the following actions immediately for child protection. In case of emergency, the personnel who found that a child may have been harmed/maltreated may also take the following actions:

(1) If the child is physically injured/suspected to have been physically injured or his/her health is affected that calls for urgent medical attention, he/she should be sent to a hospital under the Hospital Authority (HA) for examination/treatment. Arrangements are as follows:

(a) If the parent(s)/guardian(s) of the child can be reached, social worker may consult the Medical Co-ordinator on Child Abuse (MCCA) or the Medical Officer On-duty of the Paediatric Department of the HA (or contact them through the social worker of the Family and Child Protective Services Unit of SWD) in order to arrange direct admission of the child to paediatric ward for medical examination/treatment. In respect of medical examination, please refer to Chapter 9 of this Guide. Regarding information on MCCA or the Medical Officer On-duty of the Paediatric Department, please refer to Appendix 1 to Chapter 9.

(b) If the parent(s)/guardian(s) of the child cannot be reached, social worker may arrange for the child to receive medical examination/treatment at the Accident and Emergency Department of a public hospital (with the assistance of the Police if necessary).

(c) If the parent(s)/guardian(s) do(es) not consent to sending the child to a hospital for examination/treatment but the social worker responsible for initial assessment/the personnel who found that the child may have been harmed/maltreated considers it necessary, Sections 34F(1) and (2) of the Protection of Children and Juveniles Ordinance, Cap. 213 (PCJO) may be invoked. It is stipulated in the PCJO that any person authorised in writing by the Director of Social Welfare (DSW) or any police officer of the rank of station sergeant or above is of the opinion that that child or juvenile who appears to be in need of urgent medical or surgical attention or treatment may take the child or juvenile to a hospital. A child or juvenile who is admitted to a hospital after being taken there 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, and

thereafter the DSW may take him/her to a place of refuge (please refer to Annex 15 to this Guide, "Ordinances Related to Child Protection Work" and the Frequently Asked Questions in relation to the PCJO). Personnel other than those from SWD or the Police may contact Family and Child Protective Services Unit (FCPSU) of SWD for necessary assessment and arrangement.

(d) For complicated or urgent cases, the social worker/personnel taking immediate child protection actions should provide his/her emergency contact to facilitate liaison with the medical staff for discussion on the approach of case handling.

(2) If the child is in urgent need of residential care arrangement instead of medical service/hospitalisation, the following arrangements should be made:

(a) Consideration should first be given to arranging temporary accommodation of the child in the home of his/her relative or friend of the family, given that assessment should first be made as to whether the relative or the friend is capable of providing appropriate care.

(b) If temporary accommodation in the home of a relative or friend of the family cannot be arranged, consideration may be given to emergency residential child care services (please refer to https://sites.google.com/site/vperccs/ for information on vacancies of emergency residential child care services. As for emergency foster care service, please refer to the list on the following webpage https://www.swd.gov.hk/en/index/site_pubsvc/page_family/sub_listofserv/id_residchildcare/).

(c) If it is also necessary for other family member(s) to leave the home environment, the child together with the family member(s) can be admitted to appropriate emergency residential services, such as Refuge Centre for Women, etc.

(d) If the parent(s)/guardian(s) of the child do(es) not consent to the aforesaid arrangement but the social worker responsible for initial assessment/the personnel who found that the child may have been harmed/maltreated considers it unsuitable for the child to return home for the time being, in accordance with Section 34E(1) 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 the child or juvenile who appears to be in need of care or protection to a place of refuge or such other place as he/she may consider appropriate (please refer to

Annex 15 to this Guide, "Ordinances Related to Child Protection Work" and the Frequently Asked Questions in relation to the PCJO). Personnel other than those from SWD or the Police may contact FCPSU for necessary assessment and arrangement.

(3) If a criminal offence may have been committed that the incident should be reported to the Police as soon as possible or jointly investigated by an FCPSU and Child Abuse Investigation Unit (CAIU) of the Police, the following arrangements should be made:

(a) For child sexual abuse and serious physical abuse cases falling under the Charter of CAIU, personnel may call the respective FCPSU or CAIU to report the case for follow-up actions (please refer to Chapter 10 of this Guide for details).

(b) For cases beyond the Charter of CAIU, personnel may report the case to the Police under normal procedures. The social worker responsible for initial assessment or the personnel who found that the child may have been harmed/maltreated may also fill in the "Report Form for Reporting Suspected Child Maltreatment Cases to Police" (Appendix 4 to Chapter 10) and the "Written Dated Notes" (Appendix 5 to Chapter 10) and submit them to CAIU or to FCPSU for transfer to CAIU, which will subsequently refer the case to appropriate police units for further action (please refer to Chapter 10 of this Guide for details). (Please refer to Appendix 6 to Chapter 10 of this Guide for the Flowchart on Procedures for Handling Suspected Child Maltreatment Cases by Police Units.)

(c) The social worker responsible for initial assessment/the personnel who found that the child may have been harmed/maltreated should explain, as far as possible, to the parent(s) the importance of handing the case over to the Police for investigation. Even if it is against the wishes of the parent(s), it is still necessary for the social worker or the personnel to hand the case over to the Police for investigation.

(d) For urgent cases, the personnel who handed the case over to the Police for investigation should provide his/her emergency contact for facilitating liaison with police officers or social workers of FCPSUs in order to obtain necessary information for investigation or discussion on the approach of case handling.

6.2 If the social worker responsible for initial assessment/the personnel who found that the child may have been harmed/maltreated encounter difficulties in the process of taking immediate protection actions, he/she may contact FCPSU for

discussion of possible solutions. Social worker of FCPSU should maintain close contact with the personnel taking immediate protection actions so as to offer assistance as appropriate.

6.3 If the case has not been reported to the responsible social service unit/FCPSU concerned, the personnel should report to the unit concerned as soon as practicable after taking immediate child protection actions so that the social service unit/FCPSU receiving the report may follow up on other necessary actions or investigations (please refer to Chapter 4 of this Guide for means of reporting).

Chapter 7 Risk Assessment and Decision Making on Protecting the Safety of Children

Function of Risk Assessment

7.1 At different stages of case handling (including initial assessment, investigation, formulation of a safety plan for child protection and follow-up of the case), personnel have to make various decisions and arrangements relating to the protection of a child's physical and psychological safety. Before making an appropriate decision, related professionals (especially social workers responsible for initial assessment/investigation/follow-up of the case) have to conduct **risk assessment, i.e. to assess the current/future probability and the severity of harm/maltreatment to a child,** jointly with other professionals in due course. During the assessment, the following two aspects have to be identified and analysed:

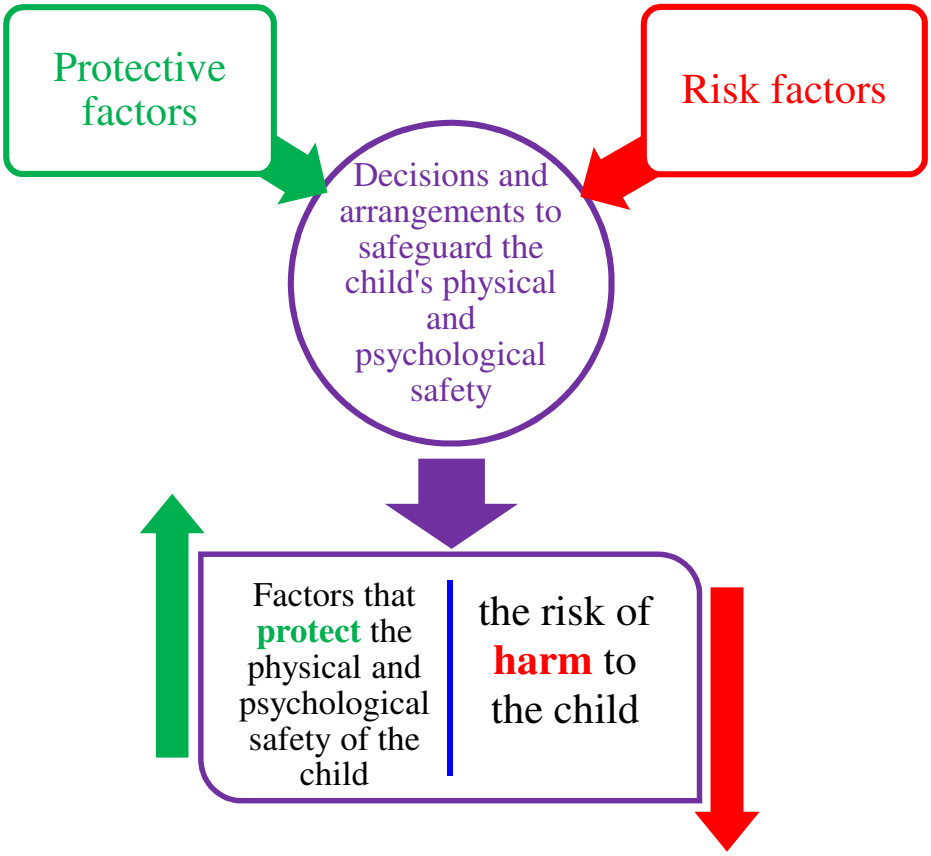
(1) Risk factors: factors that increase the child's risk of being harmed/maltreated. These normally include the precipitating incident and factors relating to the child, the carer and the family; and

(2) Protective factors: factors that can reduce the child's risk of being harmed/maltreated and increase his/her safety level, including the capabilities, strengths and resources of the child and his/her family (any factors that can reduce the influence of known risk factors can be regarded as protective factors).

7.2 The tools/matrixes of risk assessment are not perfect and may not ensure the non-occurrence of any child harm/maltreatment. However, they provide a framework for personnel to assess the case and assist them in exercising their professional judgment and skills to formulate and implement appropriate plans by balancing various risk and protective factors, and taking into account the needs of the child and his/her family, with a view to

(1) reducing or eradicating the risk of harm to the child; and

(2) enhancing factors that protect the physical and psychological safety of the child, in particular the capacity of the family in caring/parenting of the child and family's functions.



Time of Conducting Risk Assessment and Relevant Decision Making on Safety

7.3 Risk assessment is a continuous process. At different stages of case handling, personnel have to conduct risk assessment so as to make the following decisions on protecting the child having been harmed/maltreated and other children in the family.

(1) Initial assessment stage — protect the immediate safety of the child

During the initial assessment stage, it is of utmost importance to protect the immediate safety of the child (the same attention should be drawn to the safety issue where incident(s) of suspected harm/maltreatment to the child is identified again at other stages of the case handling). At this point, personnel should consider the following questions:

(a) Is the child safe at present?

(b) If not,

(i) what risks are the child facing?

(ii) how imminent are these risks?

(iii) how serious will the harm arising from these risks be to the child, considering the vulnerability of the child?

(iv) are parents/carers able to take appropriate measures to ensure the safety of the child?

(v) what immediate actions are to be taken by personnel to protect the safety of the child?

As regards whether immediate child protection actions are to be taken, personnel should consider the following questions:

(a) Whether it is possible for the child (perhaps under appropriate arrangements/support) to remain staying at home/in the place where he/she is living?

(b) Whether there is a pressing need to arrange for the child and others (including other children/the child's family member(s) and the alleged perpetrator) to leave the current environment/environment where the harm took place and remove them to a safe place (including homes of their relatives) temporarily?

(c) Whether immediate medical examination and treatment is needed for the child who sustains physical injury or whose health is affected?

(d) Whether the case is to be reported to the Police as soon as practicable so as to protect the safety of the child and others?

(e) Whether it is necessary to provide urgent statutory protection for the child by invoking the Protection of Children and Juveniles Ordinance (PCJO) (please refer to Annex 15 to this Guide, "Ordinances Related to Child Protection Work" and Frequently Asked Questions in relation to the PCJO)?

(2) Investigation stage — formulate a safety plan for child protection

(a) Whether the safety situation of the child is a cause of concerns that a safety plan has to be formulated for protecting the child and/or his/her sibling(s)/other related child(ren)?

(b) How the child and his/her family are to be assisted, if necessary, so as to reduce or eradicate the risk of harm to the child and enhance the factors that protect his/her physical and psychological safety?

(i) whether it is necessary for the child (and his/her family) to leave home for a period of time and have alternative residential care arrangements so as to protect the physical and psychological safety of the child?

(ii) whether it is necessary to apply for a care or protection order from the Juvenile Court so as to protect the physical and psychological safety of the child?

(iii) how the family conditions are to be improved so as to enhance the safety of the child, regardless of whether the child will remain to be taken care of by his/her family?

(3) Follow-up stage — review whether the safety situation of the child has improved

(a) Whether the risk of harm to the child has been reduced or eradicated and whether the factors that protect the physical and psychological safety of the child have been enhanced after the provision of necessary assistance?

(i) where the child has been taken care of by his/her family members (including the alleged perpetrator), whether his/her safety situation has improved continuously?

(ii) where residential child care service has been arranged for the child, whether his/her family conditions and the parenting capacity of his/her family members (including the alleged perpetrator) have been improved so that the child can be returned to the care of his/her family?

(iii) whether the child is safe and may continue to be taken care of by his/her family members (including the alleged perpetrator) after having returned to the care of the family?

(b) Whether it is necessary to change the safety plan for child protection and the way in helping the child or his/her family (including consideration as to whether the long-term care arrangement for the child has to be changed) if the risk of harm to the child has not been reduced or eradicated, or the protective factors have not been satisfactorily enhanced?

(4) Case closure stage — ensure continued protection of the safety of the child

(a) Under the care of his/her family members (including the alleged perpetrator), whether the child remains safe and the case can be closed/referred to other service unit(s) for handling other welfare matters of the family?

(b) If the child cannot be returned to the care of his/her family members (including the alleged perpetrator) on account of issues other than child safety, whether the case can be referred to other service unit(s) for handling other welfare matters of the family?

(c) Where it is difficult to return the child to the care of his/her family members (including the alleged perpetrator) for safety reasons and long-term care plan/arrangement has been made for the child, whether the case can be referred to other unit(s) for offering continuous assistance to the child and/or his/her family?

7.4 The following table outlines the objectives of risk assessment and decisions to be made on matters relating to child protection at various stages of the case handling:

Stage	Initial Assessment	Investigation	Follow-up	Case Closure
Objective	Protect the immediate safety of the child	Formulate a safety plan for child protection	Review whether the safety situation of the child has improved	Ensure continued protection of the safety of the child
Decision	-- whether it is possible for the child (perhaps under appropriate arrangements or support) to remain staying at home -- whether there is a pressing need to leave	-- whether formulation of a safety plan for child protection is required -- how to reduce or eradicate the risk of harm to the child	-- whether the child under the care of his/her family remains safe -- whether the child under residential child care service can be returned	-- whether the case can be closed -- whether the case can be referred to other unit(s)

Stage	Initial Assessment	Investigation	Follow-up	Case Closure
	the current environment/ environment where the harm took place -- whether immediate medical examination and treatment is needed -- whether urgent statutory protection is required -- whether the case is to be reported to the Police as soon as practicable	-- whether arrangement for residential child care service is required -- whether application for a care or protection order is required -- how to enhance factors that protect the physical and psychological safety of the child	to the care of his/her family -- whether the child having returned to the care of his/her family remains safe -- whether change of the safety plan for child protection and the way in helping the child/family is required	

Guiding Principles of Risk Assessment

7.5 To make an effective risk assessment, personnel have to follow the principles below:

(1) Information required should be collected by various means through different channels, including making reference to records, observation, interview, visit and contact with the related parties, etc.

(2) In assessing certain risk factors and their severity, elaborations should be made with specific examples/behaviours, instead of relying on simple impression or using general descriptions.

(3) The risk level of various factors and their dynamic interaction should be fully assessed, including whether such factors will increase or decrease the level of risk/protection. During the assessment, personnel should take into consideration the family's strengths as well as the concerns that are

worrying at the same time but not only count on the number of risk factors or high risk factors. For example, when the family has members who can undertake the role of parental care, this will not only reduce the risk of harm/maltreatment to the child but can also be regarded as a factor that can enhance the protection of the safety of the child which will reduce the overall risk level. On the other hand, where a family is facing with various stressors, children at a younger age/with lower mental abilities may have a higher risk of being harmed/maltreated.

(4) Apart from assessing the risk of harm/maltreatment to the child concerned, personnel should also assess the risk of harm/maltreatment to other children in the family.

(5) Personnel should discuss the issue with the child and his/her family (including siblings and the alleged perpetrator) or take into account their views, including their suggestions/views on how various factors can enhance or reduce the level of risk/protection.

(6) The yardstick for assessment is to consider the basic care that the child should receive and whether he/she is genuinely at risk. Especially when considering whether to remove the child from his/her family and make alternative care arrangements, focus should not be made merely on the parenting skills of the carer which, to personnel, are not satisfactory enough or are causes of concern. Unless there is a change in the need of the child, this yardstick should be adopted throughout the life of the case, including consideration as to whether the child receiving residential child care service can be returned to the care of his/her family.

(7) In identifying factors that protect the safety of the child, personnel should understand whether such factors can reduce certain risks in a specific and sustainable manner.

(8) All types of assessment matrixes have their limitations. It is impossible for them to include all possible risk factors and their dynamic interactions. There may also be special circumstances in individual cases. Therefore, professionals of various disciplines should exercise their professional judgment in making assessment.

(9) When the assessment is jointly conducted by various professionals, and may be also with family members, they may have different views on risk factors and their risk levels. Based on the available information, they should discuss the issue and express their views in words in an objective, clear and specific manner as far as practicable so as to achieve a consensus and formulate an effective plan to safeguard the safety of the child.

(10) The methods used to reduce/eradicate the risk should be targeted at risk factors and commensurate with the risk levels. They should be specific and feasible and cause minimal disturbance to the child/family.

Assessment Matrix

7.6 With reference to Family Assessment Risk Variables[12], the risk factors of child maltreatment can be broadly divided into the following categories (details are set out at Annex 16 to this Guide):

Categories of Risk Factors	Variables
I Precipitating incident	(1) Severity and/or frequency of abuse (2) Severity and/or frequency of neglect (3) Location of injury (4) History of reported abuse or neglect
II Child aspect	(5) Child's age, physical and/or mental abilities (6) Perpetrator's access to child (7) Child's behaviour (8) Child/Caretaker interaction (9) Child's interactions with siblings, peers, or others
III Caretaker aspect	(10) Caretaker's capacity for child care (11) Caretaker/Child interaction (12) Interaction among caretakers (13) Caretaker's parenting skills/knowledge (14) Caretaker's substance/alcohol misuse (15) Caretaker's criminal behaviour (16) Caretaker's emotional and mental health
IV Family aspect	(17) Family interactions/relationships/stressors (18) Strengths of family support systems

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

Categories of Risk Factors	Variables
	(19) History of abuse/neglect in family (20) Presence of a parent substitute in the home (21) Environmental condition of home
V Interaction between family and agency staff	(22) Caretaker's co-operation with agency staff and/or service plan (23) Progress of the child/family in treatment

Besides, assessment framework of Signs of Safety approach is set out at Annex 17 to this Guide.

Chapter 8 Child Protection Investigation

Purposes of Child Protection Investigation

8.1 Child protection investigation has to be conducted when there is a reason to believe/suspect that a child has been or is being maltreated during the course of initial assessment disregard of the need to take immediate child protection actions. The purposes of child protection investigation include:

(1) to gather and analyse information in response to suspected child maltreatment incident(s);

(2) to analyse the risk and protective factors of the child and other children in the family and to assess the risk level;

(3) to assess the need of the child concerned and his/her family; and

(4) to formulate the initial follow-up plan, with reference to the conditions and views of the child and his/her parents, for members of the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) to consider.

8.2 Some of the above listed purposes of child protection investigation and items to be carried out might have already been implementing at the stage of initial assessment. Actually, these two phases sometimes need not to be significantly divided.

8.3 In general, child protection investigation should be conducted by the social worker who is handling the case (i.e. the social worker of the "known case") or the social worker of the Family and Child Protective Services Unit (FCPSU) of SWD (if it is not a "known case").

8.4 According to the handling of reporting, Integrated Family Service Centre/Integrated Services Centre of NGO, School Social Work Unit (SSWU) serving students in secondary schools and Medical Social Services Unit (MSSU) of the Hospital Authority (HA) should conduct child protection investigation for their known cases. FCPSU could conduct child protection investigation for "known case" of other social service units of NGO or school social workers employed by the School (please refer to paragraphs 4.5 to 4.7 of Chapter 4 of this Guide).

Information to be Collected

8.5 The social worker who is responsible for conducting the child protection investigation (the investigating social worker) should collect information according to the nature of individual case, including the following:

(1) Background information of the child and family

(a) name, age and gender of the child and his/her family members;

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

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

(d) health and developmental conditions of the child (including any diagnosed/suspected illness, medical services being wait-listed, records of vaccination, medical/health records/certificates of diagnosis, etc. (if applicable));

(e) family background (including race, religion, culture, traditions, use of language, upbringing of parents/family members living under the same roof, physical or mental health status/record, marital status, criminal history, history/circumstances of use of drug/alcohol or any other form of addiction (if applicable), financial status and support network of the family, etc.);

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

(g) behaviour and emotional status of the child;

(h) history of child care/child discipline and any previous record of suspected child maltreatment (including approach/pattern of parenting of the parents/carers, expectations on child(ren) and sensitivity to/care of the needs of child(ren), etc.); and

(i) any other family stressors.

(2) The suspected child maltreatment incident

(a) details of the suspected child maltreatment incident (including the severity, frequency, location and description of the injury), precipitating circumstances and the process of disclosure;

(b) the present condition of the child; and

(c) consequences/impacts of the suspected child maltreatment incident on the child.

(3) Resources and capacities of the family in child protection

(a) attitudes and feelings of the parents (including the alleged perpetrator)/other significant others towards the incident(s) (including the possibility of further harm to the child and the willingness to accept help, etc.);

(b) capabilties of the parents/carers to protect the child (including parents' resources and approach in problem solving and stress coping, self-perception and adaptability, etc.);

(c) the concrete care arrangement/safety plan of the child proposed by the parents (including the alleged perpetrator)/other family members/relatives/individuals who can protect the child and/or help the family, and their views on the proposed plan made by personnel; and

(d) attitudes, feelings and suggestions of the child (towards the parents, siblings, incidents and the proposed childcare/safety/follow-up plan made by various parties, etc.).

8.6 The investigating social worker may collect information in the following approach as appropriate：

(1) Consider to interview the child, his/her family members and related person(s) individually in the following sequence:

(a) the child；

(b) siblings and other children in the family;

(c) parent(s)/carer(s) who is/are not the alleged perpetrator(s)；

(d) the family member(s)/relative(s) who is/are the alleged perpetrator(s)；

(e) other family members and relatives;

(f) concerned professionals (when sharing some information of the child(ren) and family with related professionals and to collect information from the latter, please draw reference from the concerned principles as stipulated in Annex 2 to this Guide); and

(g) relative(s)/carer(s) who will be responsible in childcare/supporting the child.

(2) If the case has been reported to the police and a video-recorded interview is to be arranged for the child, the investigating social worker is to liaise with the police officer and be arranged to observe the video-recorded interview in order to obtain details of the incident and avoid causing secondary trauma or distress to the child for repeating the maltreatment incidents in unnecessary circumstances.

(3) If needed and appropriate, joint interview with certain family members/individual(s) may be conducted to further explore/assess the family relationship, communication patterns and parenting capacity of the parent(s)/carer(s).

(4) If the child will be entrusted to the care of a relative or carer, home visit must be arranged first in observing the home environment to assess the suitability for a child to stay and the capacity of the carer for childcare.

8.7 If it is necessary to obtain the advice of other professionals, e.g. to explore the physical and mental health of the child and the capacity of the carer for childcare, the child/family member(s)/carer(s) should be referred for assessment made by other professionals, e.g. clinical psychologist, psychiatrist, etc.

8.8 The investigating social worker may need to contact other professionals to collect personal data and make the necessary assessments about the child concerned and his/her family members/carers. If the prescribed consent to disclose the data is unable to be obtained from the data subject and/or the relevant person of the data subject on behalf of the party concerned, the investigating social worker may draw reference from Annex 2 to this Guide in considering requesting the related professional(s) to provide the data by invoking the **special provisions of exemption** in using, disclosing or transferring the data as stipulated at Part VIII of the Personal Data (Privacy) Ordinance, Cap. 486. The investigating social worker may submit the form as at Appendix 1 to Annex 2 to the Medical Record Office of hospital under the charge of the Hospital Authority (HA) to obtain information on whether a person concerned is receiving treatment in the hospital/out-patient clinic of HA if he/she is informed/suspects that the carer is receiving treatment in hospital/out-patient clinic of HA and is to contact the medical officer concerned to see if the carer's physical/mental condition is suitable for the care of the child concerned, or is to invite the medical officer concerned to participate in Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) for discussing the follow-up plan for the child

concerned but the consent of the data subject (carer) to disclose the data is not obtained or it is not sure whether the data subject (carer) is receiving treatment in the hospital/out-patient clinic of HA. A copy of this form will also be handed over to the Medical Co-ordinator on Child Abuse (MCCA) of the hospital where the child is staying so that the MCCA can assist in contacting the hospital's Medical Record Office if necessary. If the investigating social worker is from non-governmental organisation where the case is being handled by a medical social worker or a SWD service unit at the same time, the medical social worker or the SWD service unit may also submit/pass the relevant document in requesting for information.

Analysis of Information and Immediate Child Protection Arrangements

8.9 When conducting child protection investigation, the investigating social worker should conduct risk assessment of the child concerned and other children in the family (e.g. siblings) with the information collected (please refer to Chapter 7 of this Guide "Risk Assessment and Decision Making on Protecting the Safety of Children"). If the information collected shows that changes in child protection arrangements have to be made or that appropriate action has to be taken to protect the safety of other children so as to take care of the urgent needs of the child concerned and his/her family, e.g. arrangement of medical services, residential care/shelters, statutory protection, etc., those actions should be carried out as early as possible. Liaison or contacts with related professionals should also be made as far as practicable throughout the process (please refer to Chapter 5 "Initial Assessment" and Chapter 6 "Immediate Child Protection Actions" for details).

8.10 The investigating social worker should assess the needs of the child concerned and his/her family. For needs assessments, please refer to Annex 18 to this Guide, "Assessment Framework".

8.11 In the course of investigation, the investigating social worker should provide/arrange related services to the child concerned and his/her family (including the alleged perpetrator) if they are identified to have a need for counselling or other services, e.g. referring them for psychological/psychiatric services.

Participation of Parents and Children

8.12 To safeguard the best interests of children and to provide protection to the children suspected to be maltreated or having been maltreated, it will be more effective if parents of the child concerned (including the alleged perpetrator) and significant others can be assisted as early and as far as possible to enhance their capabilities in caring and protecting the child. Hence, the investigating

social worker should inform the parents and carers of the child as early as possible of the concerns, unless to do so would place the child at risk of further harm or undermine a criminal investigation.

8.13 The investigating social worker should explain to the child concerned and his/her parents (including the alleged perpetrator) of the purposes and arrangement of the child protection investigation, related investigating procedures and the need of information sharing with related professionals during the course of child protection investigation and MDCC.

8.14 The investigating social worker should also explain to the parents of the child concerned that these procedures are neither intended to blame the parent/carer involved nor to label the parent/carer/child negatively, but rather to make the family concerned aware of the seriousness of the matter such that the family will co-operate with the related personnel in making use of their own strengths and resources to resolve the problem properly as soon as possible in order to **ensure the physical and psychological safety of the child** and avoid recurrence of similar situations or more serious consequences. The investigating social worker may give the leaflets of "Multi-disciplinary Case Conference on Protection of Children with Suspected Maltreatment" (for children/adolescents and parents respectively) to the child concerned and his/her family members for their reference. For content of the leaflets, please refer to the webpage of the Social Welfare Department (https://www.swd.gov.hk/tc/index/site_pubsvc/page_family/sub_fcwprocedure/id_1447/).

8.15 Some parents may appear to be uncooperative because of social, cultural, psychological and historical factors. The investigating social worker is advised to understand the background of the family, including the stress faced by the parents during the investigation, and to assess the risk of harm to the child. The investigating social worker should understand the reasons for such uncooperative responses, dispel the doubts of the parents and encourage the parents' participation. Nevertheless, if there is threat or actual violence from parent(s) in the course of investigation, the investigating social worker should plan for his/her personal safety and seek assistance from other professionals as appropriate.

8.16 The investigating social worker should contact the parent not being granted the custody of the child and have his/her views be heard in the course of child protection investigation if there will be important decision affecting the child's life unless it is justifiable that the non-custodial parent's involvement will jeopardise the best interests of the child. Nevertheless, the formulation/implementation of the follow-up plan for the child concerned

should not be delayed even if the non-custodial parent cannot be contacted before the MDCC. If the non-custodial parent is not contacted or untraceable, record is to be made and it should be reported in the MDCC.

8.17 When conducting child protection investigation, the investigating social worker needs to arrange interpretation service (including sign language) where the child concerned and his/her family are using language unfamiliar to the investigating social worker or having communication barriers (e.g. hearing impairment). Generally speaking, the social circle of ethnic minorities is relatively small and ethnic minorities are under great psychological pressure because they may worry if the incident is known to relatives/religious leaders/clans. To ensure that the investigating social worker, the child concerned and his/her family fully understand the exchanges of information/views, it is not advisable to arrange family members, relatives, friends/acquaintances or child himself/herself to act as interpreters. In addition, given the small population of some ethnic minority groups in Hong Kong that the interpreter may know the family concerned, the investigating social worker has to explain to the interpreter the purposes of the investigation and emphasise the principle of confidentiality, and to clarify that the interpreter's role is to fully and accurately translate direct communications between professionals and family members and exact words that were said. The investigating social worker may also require the interpreter to explain, at an appropriate time, any cultural or other issues that might need to be attended to or be overlooked. Interpretation services for ethnic minorities can be arranged through different means, e.g. court interpretation services, HA and the interpretation service provided by "Centre for Harmony and Enhancement of Ethnic Minority Residents (CHEER)", which is operated by the Hong Kong Christian Service and funded by Home Affairs Department. For information, please refer to the webpage of the Home Affairs Department: http://www.had.gov.hk/rru/tc_chi/programmes/programmes_comm_sscem.html.

Initial Formulation of Child Protection/Follow-up Plan

8.18 The investigating social worker should, with reference to the information collected in the child protection investigation, make initial analysis on the risk of child maltreatment on the child concerned and other children in the same family as well as the needs of the child and family in order to formulate an initial safety/follow-up plan for child protection for MDCC members' consideration.

8.19 While the views of the child concerned and his/her parents on the safety/follow-up plan for child protection will be considered, the investigating

social worker also needs to prepare them for possible alternatives that may be proposed in the MDCC for protection of child(ren) where necessary, e.g. arrangement of residential child care service or application for a care or protection order under the "Protection of Children and Juveniles Ordinance".

8.20 If residential child care service is likely to be arranged for the child(ren) concerned, the investigating social worker should provide the child(ren) and the parents with necessary information of relevant placements for earlier preparation. Exploration of availability and suitability of the alternative placement has to be made before the MDCC so that admission can be arranged as soon as practicable once decision is made in the MDCC. When considering residential child care service, long-term care plan (permanency plan) of the child should also be considered. Please refer to Appendix 1 of this Chapter for details.

8.21 To prepare for information sharing with related professionals in the MDCC, the investigating social worker should prepare a Child Protection Investigation Report with initial recommendation for the safety/follow-up plan for child protection (please refer to Appendix 2 of this Chapter for the Child Protection Investigation Report sample for use in the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment). The report should provide a brief and accurate account of the behaviour/incident of which the child concerned is suspected of being harmed/maltreated. In case of doubt on whether certain information of the behaviour/incident should be disclosed that may be related to the criminal investigation, advice of the Police should be sought prior to the MDCC.

Collaboration with Other Parties Involved in Case Handling

8.22 To reduce the disturbances caused to the child and family members during the investigation process, professionals should jointly interview the child/family members as far as possible.

8.23 Personnel involved in case handling should maintain communication and share significant information timely to protect the child concerned and provide necessary assistance to his/her family, or to alter the child protection/childcare arrangement during the investigation process. For example, after due physical examination/treatment and necessary investigation procedures be conducted, if the child is certified to be in good health and medically fit for discharge from the hospital and the risk of child being harmed/maltreated is assessed to be low by personnel involved in investigating/handling the case (including social worker, police officer and medical officer, etc.), the child can

be, after discussion among personnel, discharged home or stay at an alternate place before the MDCC.

8.24 If the suspected child maltreatment incident involves multiple children in the community/organisation, personnel conducting the investigation and their seniors (if appropriate) should be more proactive in communication and collaboration in strategy planning, investigation, risk assessment and intervention.

8.25 For suspected sexual abuse case where the alleged perpetrator is also a child/adolescent, personnel involved in investigating/handling the case should explore whether the alleged perpetrator may also be a victim of any sexual abuse cases. Appropriate protection actions to this child/adolescent should also be taken with procedures as stipulated in Chapters 6 and 7. If the investigating social worker is unable or fails to contact the child/adolescent alleged to have harmed a child or is in emergency situation, assistance from other professionals in rendering urgent intervention or making referral(s) should be solicited.

8.26 In the course of investigation, if the alleged perpetrator is identified to have emotional/welfare need and he/she is not the serving target of the service unit of the investigating social worker, with his/her consent, he/she can be referred to appropriate service unit for related counselling/support services. If the investigating social worker is unable or fails to contact the alleged perpetrator or is in emergency situation, assistance from other professionals in rendering urgent intervention or making referral(s) should be solicited. If the alleged perpetrator is a mentally incapacitated person, the investigating social worker should draw reference from "Procedural Guide for Social Workers on the Handling of Mentally Incapacitated Adults Arising from the New Provisions in the Criminal Procedure (Amendment) Ordinance 1995".

8.27 Even if the incident is not regarded as suspected child maltreatment upon initial assessment/physical examination or in the process of child protection investigation upon agreement among personnel involved in investigating/handling the case, a welfare meeting/case meeting/pre-birth conference can still be convened as appropriate to have a discussion on the follow-up plan by professionals, and may be also with family members.

Long-term Care Plan for Children Receiving Residential Child Care Services

(Reference made to Appendix I of the Central Referral System for Residential Child Care Services -- Manual of Procedures)

1. Decision-making in Childcare based on the "Permanency Planning Approach"

"Permanency planning" for a child under out-of-home care is a systematic, goal-directed and timely approach of care planning to maintain the child with his/her family of origin or live in safe and permanent environment, aiming at securing stability and continuity of nurturing relationships for the child. When professionals plan to refer a child for residential child care services, the best interests of the child are paramount. A comprehensive assessment and accurate information of the family's situation, in respect to the child's genuine need for out-of-home care, are very essential for formulation of a follow-up plan.

2. Assessment of Parents and Understanding of Children

Social workers, while making an assessment of parents and children within a permanency planning context, should be guided by principles and techniques that are basic to social work practice. Assessment of parents should include:

(a) exploration of family history, including marital relationship;

(b) assessment of the childcare capacity and level of functioning of family and parents;

(c) evaluations of parents' physical, mental and psychological well-being;

(d) understanding of parental response to children in different developmental stages;

(e) identification of parental strengths and weaknesses; and

(f) appreciation of the family's environment.

In understanding children, professionals need to pay attention to:

(a) history of child's growth and development (including developmental history, school, health and previous out-of-home placements);

(b) observation of the child's performance in different settings;

(c) child's current functioning; and

(d) psychological evaluations.

3. Permanency Planning Put into Practice

The responsibility of the key social worker does not END after the child is admitted into a residential setting. The key social worker as well as related professionals handling the case should adopt a "permanency planning approach" and observe the following key components:

(a) early consideration of a long-term plan for the child, beginning immediately upon the decision of making referral;

(b) identification of different options for averting out-of-home placement or temporary care, with priorities set for each option;

(c) creation of a time-specific service plan to achieve the most appropriate long-term care plan;

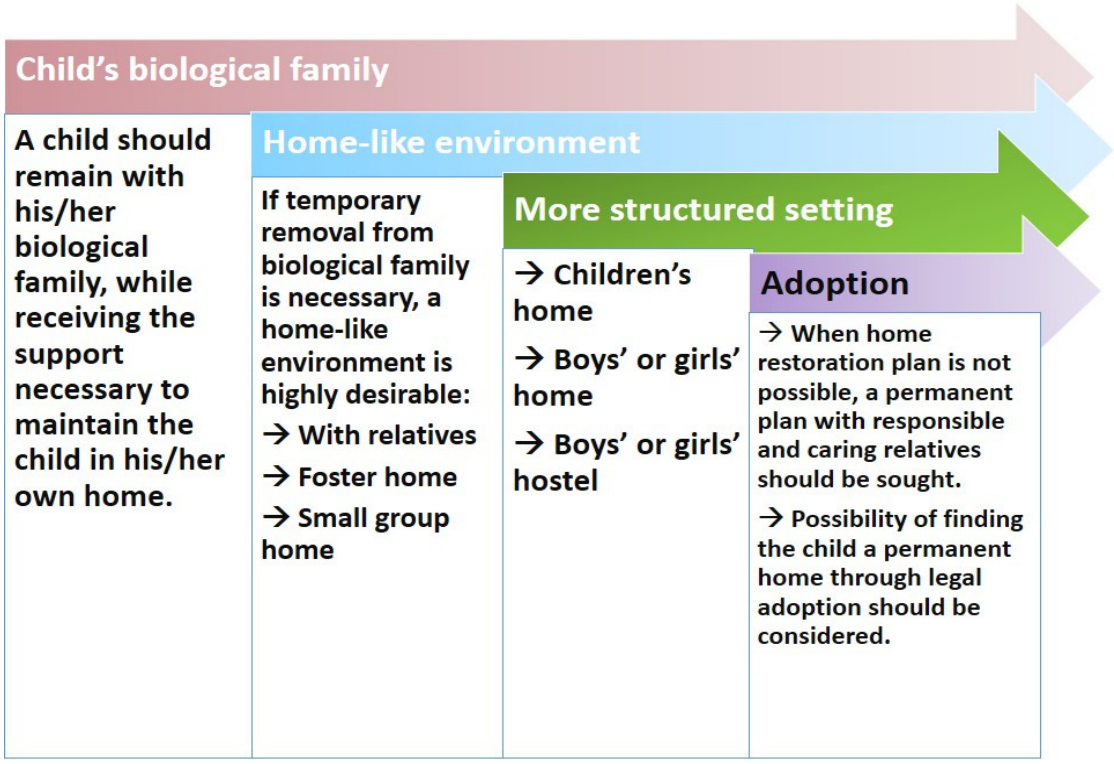
(d) keeping clear records that structures documentation and organisation of evidence for legal actions, if necessary (e.g. for termination of parental rights);

(e) regular and periodic case reviews to monitor progress in implementing the plan;

(f) collaboration with other community agencies to obtain the optimal assistance and support the family; and

(g) provision of comprehensive services to the biological family to support and maintain the long-term care plan of the child.

4. Permanency Planning Options



Salient points to note:

(a) The child should return to the parents at the earliest possible date, following intensive work with the family and the child.

(b) Social workers and related professionals should continue to review the placement regularly to ensure that the type of placement arranged for the child best meets his/her needs.

(c) The family should continue to receive the necessary support so that another removal of the child does not occur.

(d) For a child who cannot remain with the biological family or with relatives and who cannot be adopted, long-term substitute care, as a last resort, has to be planned very thoroughly and opportunities for ongoing contact with a family should be built into the care plan.

5. List of Factors to be Considered in Deciding Placement Choice

Placement choice for a child should be made after due consideration of the child's need and the arrangements that can be offered by different residential services. The following factors are listed to facilitate the referring worker in deciding which type of residential service is the most suitable placement for the child:

(a) age of child;

(b) physical, mental and emotional conditions of the child;

(c) behaviour of the child;

(d) developmental needs;

(e) last class level and educational needs of the child;

(f) status of the child – for legal guardian e.g. staying with family or ward of Director of Social Welfare/Court, and by occupation e.g. student or working youth;

(g) previous placement experience of the child;

(h) need to remove child from his/her community e.g. to sever relationship with undesirable peers;

(i) environment which best meets the child's need, e.g. family-like or more structured and restrictive milieu;

(j) continuity of care/relationship;

(k) needs for arranging siblings in same placement;

(l) parental/family resources;

(m) circumstances leading to need for placement;

(n) urgency of the placement;

(o) admission criteria, service characteristics and programmes offered by individual residential units;

(p) preference indicated by the child and the parent(s)/guardian(s); and

(q) vacancy available according to the gender and age range.

Note: The listing order has no implication of their relative importance. The placement choice for each child should be assessed and decided according to the circumstances and characteristics of individual case.

Appendix 2 to Chapter 8

(Sample for Reference)

Child Protection Investigation Report
for Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment

（*Name of Organisation** controls the use of data in this document）

(Note: The contents of the report should be adjusted according to the nature and needs of the case)

Reference No. :

Name of the Child :

Sex/Age :

Address :

School :

Reasons for Conducting Child Protection Investigation

Family Composition of the Child Suspected to be Maltreated (including the ones living together)

Name	Sex/Age	Employment	Education/Income
Father			
Mother			

Siblings* (including the child concerned)

1.

2.

Living Environment (including observation from home visit)

Education (including adjustment, academic performance and social relationship in school) (the details can be skipped if the school personnel will attend the MDCC and submit a report)

Employment (including adjustment, performance and social relationship at work)

Health Condition/Developmental Condition (including any diagnosed/suspected illness, medical services being wait-listed, records of vaccination, medical/health records/certificates of diagnosis, etc.) (if applicable) (the details can be skipped if the related professional will attend the MDCC and submit a report)

Family Background (including race/religion/culture/traditions/use of language, upbringing of parents/family members living under the same roof, physical or mental health status/record, marital status, criminal record/circumstances of use of drug/alcohol or any other form of addiction (if applicable), financial status and support network of the family, etc.)

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

Behaviour and Emotional Status of the Child Concerned

History of Childcare/Child Discipline and Previous Record of Suspected Maltreatment (including approach/pattern of parenting of the parents, expectations on children and sensitivity to/care of the needs of children, etc.)

Other Family Stressors

The Suspected Child Maltreatment Incident (including the severity/frequency, location/description of the injury, precipitating circumstances, the process of disclosure; the present condition of the child, consequences/impacts of the suspected child maltreatment incident on the child, etc.)

Attitudes and Feelings of the Parents (including the alleged perpetrator)/Other Significant Others towards the Incident(s) (including the possibility of further harm to the child and the willingness to accept help, etc.)

Capacities of Parents/Resources of the Family in Child Protection (including parents' resources and approach in problem solving and stress coping, self-perception and adaptability, etc.)

Concrete Care Arrangement/Safety Plan of the Child Proposed by the Parents (including the alleged perpetrator)/Other Family Members/Relatives/Individuals who Can Protect the Child and/Help the Family, and Their Views on the Proposed Plan Made by Personnel

Attitudes, Feelings and Suggestions of the Child (towards the parents, siblings, incidents and the proposed childcare/safety/follow-up plan made by various parties, etc.)

Risk of Child Maltreatment/Protective Factors and the Needs of the Child and Family Identified (please draw reference from Chapter 7 and Annexes 16 to 18)

- Related to the child concerned/other children in the same family
- Related to the parent(s)/carer(s)
- Related to the family/environment

Initial Recommendations on Child Protection/Follow-up Plan

- For safety of the child and reduction of risk on child maltreatment (including childcare arrangement, statutory supervision, contacts with the alleged perpetrator, etc.)
- Concrete recommendations for meeting the needs of child and the family (including psychological services, support services, tangible assistance, etc.)

Signature : _____

Name : _____

Rank : _____

Office : _____

Tel. No. : _____

Date : _____

Note: * to quote when the organisation wants to control the use of data in the report

Chapter 9 Medical Examination

9.1 When a child is suspected to have been harmed/maltreated leading to inflicted injury or his/her physical health is affected, the child should be arranged to receive medical examination. In some of the cases, the Police will co-ordinate forensic examination for the child in order to collect evidence for criminal investigation. In any medical examinations, medical staff should follow the principles as stipulated in Chapter 1 of this Guide, put the child's best interests as the paramount concern and take care of the emotional needs of the child and his/her family members.

Arrangement for Medical Examination

9.2 As a general practice, the medical examination will be conducted in the Paediatric Department of the Hospital Authority. Social worker, who is responsible for initial assessment or child protection investigation, is advised to consult the Medical Co-ordinator on Child Abuse (MCCA) for the need of medical examination for the child who is suspected to be harmed/maltreated (contact information is listed in Appendix 1 to this Chapter). To minimise the number of medical examination and to shorten the waiting time, the MCCA or the Medical Officer On-duty of the Paediatric Department can be contacted to arrange direct admission to paediatric ward or other appropriate department of the hospital, or to fix a designated time for the medical examination in the hospital as appropriate. Assistance from Family and Child Protective Services Unit (FCPSU) can be enlisted for consultation or liaison with the medical officer mentioned above. If the MCCA or Medical Officer On-duty cannot arrange direct admission for the child, professionals should, as appropriate, arrange the child to receive examination at the Accident and Emergency Department (AED) of the nearby hospital.

9.3 Under usual circumstances, it is preferably to have consent from the parent/guardian on the arrangement of medical examination. Please refer to Chapter 5 "Initial Assessment" and Chapter 6 "Immediate Child Protection Actions" for actions to be taken. If Protection of Children and Juveniles Ordinance, Cap. 213 (PCJO) has to be invoked, please refer to Annex 15 to this Guide for information.

Objectives of Medical Examination

9.4 The objectives of medical examination include the following:

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

(2) to assess the possibility of harm/maltreatment and to collect evidence; and

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

9.5 If necessary, medical officer of the Paediatric Department may refer the child to clinical psychologists, psychiatrists and medical officers of other relevant disciplines for follow-up. Special attention should be paid to the growth parameters and sexual development of the child.

Principles of Medical Examination

9.6 The following are the principles of medical examination:

(1) In any medical examinations, the child's health and best interests must always be of paramount concern. Requiring the child to repeatedly describe the incident(s) of being harmed/maltreated should be avoided as far as possible and the number of examinations should be kept to the minimum to minimise the possible trauma to the child in the examination process.

(2) The examination should be conducted in a child-oriented reception and examination room to avoid additional emotional trauma to the child.

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

(4) The child should be given full explanation about the examination, taking into account the child's age and comprehension capability, and the examination should as far as possible be conducted in the presence of a supportive adult who is not the alleged perpetrator.

(5) There should be regular peer review on the findings and chartings.

Suspected Child Sexual Abuse Cases

9.7 All children suspected of being sexually abused should receive a medical examination by a well-trained medical staff.

9.8 In all suspected child sexual abuse cases, the MCCA/Medial Officer On-duty should discuss with all relevant professionals concerned (such as the investigating social worker and the Police) as soon as possible (preferably within 24 hours) after gathering information on the child's medical, family and

educational background. The purpose of the discussion is to decide on the need for further assessment and actions as follows:

(1) arrange interview with the child to understand the details of the incident (e.g. conducting video-recorded investigative interview by officers from the Police and SWD);

(2) full genital examination;

(3) liaison with forensic pathologist for collection of medical and physical evidence (as appropriate);

(4) full developmental and mental health assessment;

(5) other arrangements for protecting the child's safety/best interests and facilitating the investigation; and

(6) informing parents.

9.9 Medical officer conducting initial examination should confine to a routine observation of the genital area unless indicated, e.g. heavy bleeding. Detailed examination of the genital area should be deferred until the liaison made by the MCCA and the Police/investigating social worker to decide whether full assessment is needed.

9.10 Case discussion between the medical officer of the hospital and the forensic pathologist is encouraged as it may not be possible/necessary for the forensic pathologist to be present for every suspected child sexual abuse case.

9.11 For direct disclosure by the child or if the medical professionals suspected that the child was sexually abused, report to FCPSU or the Police should be made as early as possible. The process should be repeated when additional or new information is available.

9.12 As the child should not be required to repeatedly describe the incident(s) of being harmed/maltreated yet the information might be of great significance to the medical officer in carrying out medical examination of the child, medical officer may therefore contact the investigating social worker for the required information.

Consent to Medical Examination

9.13 Generally, a medical officer administering treatment or carrying out an examination must satisfy himself/herself that the child is of sufficient understanding and has the capacity to give consent and the views of the child and parent/carer on consenting to a medical examination should be considered.

Where the life or physical health of the child is at risk, and medical examination and treatment must be carried out promptly especially in situation of life and death, medical officers may depart from the general rule and proceed without either the child's or his parents' consent. This would cover situations where the child is brought to the AED in the aftermath of an accident or as a result of suspected child maltreatment. The medical examination is undertaken for diagnosis and treatment purpose.

9.14 If the Director of Social Welfare (DSW) has reasonable cause to suspect the child or juvenile to be in need of care or protection, the 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 worker[13] 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). If the DSW is unable to ascertain the identity or whereabouts of any of the persons on whom notice may be served or a notice issued and served has not been complied with as regards the production of the child or juvenile at the time and place specified in the notice, the DSW may remove the child or juvenile for an assessment (Section 45A(4) of the PCJO) though the DSW's entry into any premises for the purpose of effecting a removal shall not be by force unless a warrant issued by a Magistrate, Juvenile Court or District Court (Section 45A(8) and (9) of the PCJO). Please refer to Annex 15 to this Guide for certain provisions of the PCJO.

9.15 In cases where forensic examination is carried out by the forensic pathologists for the purpose of gathering evidence in relation to the criminal investigation of the child maltreatment incident, the normal requirement for consent should be adhered to, that is to obtain consent from the child's parent/guardian or the child if he/she is competent and of sufficient understanding to give consent.

Medical Investigation

9.16 Appropriate investigation should be performed as indicated by the history of the case or medical examination.

9.17 Routine screening for sexually transmitted diseases is not required for all sexual abuse cases.

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

9.18 Routine blood tests (e.g. complete blood picture, clotting profile) and X-ray examination are not necessary for most physical abuse cases unless clinically indicated.

9.19 For newborns whose mothers are suspected to have abused dangerous drugs during pregnancy, urine for toxicology testing should be performed, especially when the history given by the mother is considered unreliable. The babies should be admitted to Special Baby Care Unit for observation and treatment of any symptoms or signs of drug intoxication/withdrawal.

9.20 Drug testing for medical purpose is an important part of risk assessment of suspected maltreatment cases with drug abuse problem in the family. Any child with physical/behavioural symptoms related to dangerous drug use or is highly suspected to have been exposed to dangerous drugs should be admitted to hospital for a proper physical examination, toxicology testing, observation and treatment of the signs and symptoms of drug intoxication/withdrawal.

Documentation and Evidence Collection

9.21 Careful documentation of the history, examination and investigation is essential. Photographs, X-rays, culture results, specimens taken for investigation, site, time and date, and person(s) who took the specimens are to be recorded. Guideline of Specimen Handling of individual medical facility should be followed to ensure patient identification and clear documentation of specimen collection and handling. This is especially important for the collection of urine for toxicology testing. Medical officers conducting the examination may be required to testify in Court on their findings, the details of the conversations and contacts with the child.

Role of Forensic Pathologist

<u>For Suspected Child Sexual Abuse Cases</u>

9.22 Forensic pathologist will be involved upon request by the Police (OC Case) for conducting the forensic examination or when the medical officer of the hospital, during their clinical management of the child, wish to seek a second opinion.

9.23 The forensic pathologist will conduct forensic examination upon request by the Police as follows:

(1) For <u>non-hospitalised cases</u>, the forensic pathologist will conduct the examination in the designated suite.

(2) For hospitalised cases, the forensic pathologist will interview the child as a member of the medical examination team and attend the hospital for examination when appropriate whilst the child is still hospitalised.

(3) The examination can also be conducted at the Police's interview suite.

9.24 For suspected child sexual abuse cases in which the incidents happened recently and forensic examination is necessary, the forensic pathologist will conduct the forensic examination as soon as practicable. To avoid the child being examined twice, the responsible police officer should inform the medical officer of AED/Ward Manager/the medical officer of Paediatric Department and state whether the forensic pathologist will personally attend the hospital to carry out the examination. However, if the child requires urgent medical treatment, immediate medical examination and management by the medical officer of the hospital should not be deferred.

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

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

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

9.28 For suspected child sexual abuse cases that have not been reported to the Police, forensic examination by forensic pathologist will not normally be performed. However, the Consultant Forensic Pathologist or his/her delegate will provide specialist advice when necessary.

For Other Forms of Suspected Child Maltreatment Cases

9.29 There is normally no indication for forensic examination by forensic pathologist on top of the general medical examinations by clinicians. However, the Consultant Forensic Pathologist or his/her delegate will provide specialist advice for serious/complicated cases when necessary.

9.30 Forensic pathologists are on call 24 hours a day and can be contacted through the Duty Officer, HQCCC, Police Headquarters (Tel. no. 3661 7100).

☎ List of Designated Paediatric Department within the Hospital Authority Hospitals

Hospital	Medical Coordinator(s) on Child Abuse	Telephone
Hong Kong East Cluster		
1. Pamela Youde Nethersole Eastern Hospital	Dr Tai Shuk-Mui Dr Wong Kwok-wan, Wendy	2595 6111
Hong Kong West Cluster		
2. Queen Mary Hospital	Dr Lam Lai-na, Almen Dr Ip Pak-keung, Patrick Dr Tsang Man-ching, Anita	2255 3111
Kowloon Central Cluster		
3. Queen Elizabeth Hospital	Dr Ho Po-Ki, Polly Dr Chiu Ka-Ho, Jackie Dr Wong Man-Yee, Shirley Dr Yu Wing-Sze, Margaret	3506 8887
4. Kwong Wah Hospital	Dr Lettie Leung Dr Sharon Fung Dr Kong Sum-yi Dr Chan Wing-shan	2332 2311
5. Hong Kong Children's Hospital	Dr Ku Tak-loi, Dennis	3513 6051
Kowloon East Cluster		
6. Tseung Kwan O Hospital	Dr Louis Chan Dr Ku Wai-hung	2208 0111

Hospital	Medical Coordinator(s) on Child Abuse	Telephone
7. United Christian Hospital	Dr Lam Ying-yin, Sam Dr Lo Wai-chee, Priscilla Dr Cheng Wai-fun, Anna Dr Ng Kwok-leung Dr Luk Chi-kong, David Dr Cheung Chi-hung, Patrick	3949 4000
Kowloon West Cluster		
8. Caritas Medical Centre	Dr Hui Wai-han	3408 7911
9. Princess Margaret Hospital	Dr Wong Guat-yuet Dr Lee Lai-ping Dr Shiu Yiu-keung (For direct admission, call Caritas Medical Centre)	2990 1111 3408 7911
10. Yan Chai Hospital	Associate consultant	2417 8383
New Territories East Cluster		
11. Alice Ho Miu Ling Nethersole Hospital	Dr Tong Chi-tak Dr Chan Tang-tat	2689 2000
12. Prince of Wales Hospital	Dr Chan Fung-ying, Dorothy	3505 2211
New Territories West Cluster		
13. Tuen Mun Hospital	Dr Chung Fung-shan Dr Lee Yuen-han, Tracy Dr Li Chak-ho Dr Wong Lap-ming	2468 5111

In case the Medical Coordinator(s) cannot be contacted, please contact the second call medical officer on duty.

Chapter 10 Criminal Investigation

10.1 In handling cases with a child suspected to be harmed/maltreated, professionals should report it to the Police for investigation when they consider that a case may involve criminal elements.

Reporting the Case

10.2 Professionals may report a suspected child maltreatment case to the Police through normal procedures, or alternatively, to a Child Abuse Investigation Unit (CAIU), which is a police unit designated to investigate child maltreatment cases. It also serves as a police contact point in respect of handling procedures for child maltreatment cases and advising other criminal investigation units on the investigation of such cases. Under no circumstances will the child being harmed/maltreated be obliged to report the case in person at a police station.

10.3 Apart from taking statements from the informant, the Police may, depending on the circumstances of the case, also have to take statements from the one who has first identified the suspected child maltreatment incident and those who have interviewed with the child about the incident to assist in police investigation.

Cases Handled by CAIU

10.4 The Police have set up CAIUs under 5 Regional Headquarters, namely Hong Kong Island, Kowloon East, Kowloon West, New Territories North and New Territories South. They are responsible for the investigation of the following types of cases (the Charter):

(1) Suspected child sexual abuse cases with the victim under the age of 17 and the suspect being a family/extended family member of the victim; or entrusted with the care of the victim;

(2) Suspected child sexual abuse cases involving multiple victims under the age of 17;

(3) Serious physical abuse cases with victims under the age of 14 (at the discretion of respective Senior Superintendent of the Police (Crime) (SSP(C)) of the Regional Headquarters); and

(4) All other cases assigned by the regional SSP(C).

10.5 Generally speaking, if a suspected child maltreatment case falls within the Charter of CAIU, a CAIU and a Family and Child Protective Services Unit (FCPSU) of the Social Welfare Department (SWD) will conduct a **joint investigation** into the case. As these cases are usually more urgent and complicated, professionals may first call CAIU or FCPSU for early consultation and/or report the case (please refer to Appendices 1 and 2 to this Chapter for the contact numbers and service districts of the units concerned). If it is outside office hours, professionals may first contact the social worker of FCPSU on duty responsible for the joint investigation via SWD hotline[14] (telephone no.: 2343 2255) or the district/divisional police station (please refer to Appendix 3 to this Chapter for the list of district/divisional police stations). The social worker of FCPSU and personnel of CAIU will contact each other as soon as practicable for a joint decision as to whether a Child Protection Special Investigation Team (CPSIT) should be formed to take over the case and conduct a joint investigation. Professionals may subsequently complete the Report Form (please refer to Appendix 4 to this Chapter) and the Written Dated Notes (please refer to Appendix 5 to this Chapter) and submit them to FCPSU/CAIU.

Cases Handled by Other Criminal Investigation Units

10.6 For cases not falling within the Charter of CAIU (e.g. cases in which children were sexually abused by strangers, or those of general physical abuse), professionals may complete the Report Form (please refer to Appendix 4 to this Chapter) and the Written Dated Notes (please refer to Appendix 5 to this Chapter), and report the case to CAIU concerned within office hours. FCPSU may also assist in passing the forms to CAIU (please refer to Appendix 6 to this Chapter for the Flowchart of the handling of suspected child maltreatment cases by police units).

10.7 CAIUs will normally transfer cases to police districts at where the incident occurred by a Referral Memo (please refer to Appendix 7 to this Chapter for a sample), which should be copied to the FCPSU concerned or the informant (as appropriate) by fax. Police officer(s) receiving the reports is/are responsible for contacting the informant. Details of the informant should be provided in the Referral Memo (to include means of contact outside office hours as far as possible) so as to facilitate the Police to communicate with the individual about the case.

[14] Departmental Hotline Service operates 24-hours a day. The hotline service is manned by Departmental Hotline Service Unit of SWD from 9:00 am to 5:00 pm from Monday to Friday and 9:00 am to 12:00 noon on Saturday (excluding public holidays). Outside the above operation hours, the calls are handled by the Hotline and Outreaching Service Team operated by the Tung Wah Group of Hospitals.

10.8 In an emergency outside office hours of CAIU, professionals should report the case directly to the nearest police station (please refer to Appendix 3 to this Chapter for a list of district/divisional police stations). After receiving the report, police investigation unit should contact the informant as soon as possible for further enquiries.

10.9 If the informant is not an SWD's social worker, criminal investigation unit other than CAIU should notify the FCPSU concerned as soon as they take over the case so that social worker of that FCPSU can verify if there is/are social worker(s) handling the case of that child/family, and arrange for responsible social worker to handle the welfare matters of the child.

Investigation

10.10 After receiving a report of a suspected child maltreatment case, police officer(s) will contact the informant for an initial enquiry into the incident and draw up investigation plans according to the circumstances and urgency of the case. He/She/They will ensure that children at risk of abuse are adequately protected under the principle of "Child-focused, Safety First".

Child Protection Special Investigation Team (CPSIT) — Joint Investigation

10.11 The following stages are normally involved when CAIU and FCPSU form a CPSIT for a joint investigation:

- Stage I - Early Consultation
- Stage II - Strategy Planning
- Stage III - Investigative Interview
- Stage IV - Immediate Case Assessment

Stage I - Early Consultation

10.12 After receiving a report, CAIU or FCPSU concerned shall collect information about the incident, the child, the suspect, the parent(s) and the informant (please refer to Chapter 4 of this Guide for the basic information required to be collected).

10.13 Personnel of CAIU or FCPSU may require the informant to provide more information on the case for considering whether they should take over the

case, or what action(s) should be taken. If it is necessary for the informant to ask the child or relevant person(s) for important information of the case, investigating personnel should remind them to pay attention to the questioning skills (please refer to Annex 11 to this Guide). If the informant has difficulty in questioning the child (especially for young children), personnel of CAIU or FCPSU should consider meeting with the child directly to obtain more accurate information.

10.14 When collecting information from the informant, personnel of CAIU or FCPSU should also remind the informant of the following:

(1) reduce the number of times of requiring the child to repeat the incident;

(2) tell the child that he/she needs not to repeat the incident to other people before his/her interview with the investigating personnel;

(3) do not ask the child about the incident in great detail, yet never stop a child who is recalling significant events at will;

(4) do not ask leading questions or make any suggestion to the child about the incident, and do not take initiative to use any tool/picture/toy to facilitate the child to express;

(5) record your conversation with the child;

(6) do not promise the child to keep the incident confidential or make any casual promise which you are not sure you can keep;

(7) assist in explaining to the child (if appropriate, also to the parent(s)) about the need to report the case to the Police and the relevant procedures; and

(8) if the child is a mentally incapacitated person or has other special needs, provide as much information as possible on the child's ability, e.g. assessment reports and records of rehabilitation services/medical follow-up, etc.

10.15 For cases falling within the Charter of CAIU, a joint investigation should be commenced with if the information is assessed to have indicated a reasonable probability that the child is suffering from maltreatment.

10.16 For suspected sexual abuse cases between family/extended family members, having regard to the possibility that the reaction of the parent(s) may affect the child or obstruct subsequent investigation, personnel of CAIU or FCPSU should confirm with the informant as to whether the child concerned and/or the parent(s) is/are informed that the case will be handed over to the Police for investigation, and their attitude (if they are informed), so as to facilitate

subsequent formulation of investigation strategies, including discussion on when and how the parent(s) should be contacted to minimise any negative impact on the child. CAIU/FCPSU can take over the case without obtaining consent of the parent(s) to report the case but they need to know the aforesaid information for careful planning of actions to be taken, and should invite the informant to provide as much information as possible on people, including relatives and friends who can provide support for the child or individuals whom the child trusts,.

10.17 The informant may sometimes request to keep his/her identity confidential. He/she should be assured that his/her identity and personal data will not be disclosed unless such disclosure is essential to protect the child or other individuals or required during the litigation process.

Stage II - Strategy Planning

10.18 As cases handled by CPSIT are more complicated (especially for cases involving family/extended family members or multiple victims), investigation should be planned carefully when a joint investigation commences, with a view to ensuring both the physical and psychological safety of the child. Personnel of CAIU and FCPSU should formulate investigation strategies jointly within 24 hours by way of discussion through meetings or telephone conversations and, depending on the circumstances of the case, discuss together with other relevant professionals (e.g. school personnel, medical officers, psychiatrists, clinical psychologists, etc.). If a joint investigation plan cannot be formulated within 24 hours upon the report, police officers or social workers should conduct initial investigation separately to assess if it is necessary to take child protection actions first.

10.19 When formulating investigation strategies, consideration should be given to the circumstances and ability of the child, the level of risk of further harm/maltreatment to the child, and the urgency of the case in the discussion of the following:

(1) scope and methods of investigation;

(2) actions for immediate protection to the child concerned or other children within the family;

(3) whether it is necessary to initiate an initial contact/meeting with the child suspected to have been maltreated, and (if necessary) how it should be conducted;

(4) whether it is necessary to initiate an initial contact/meeting with the parent who is not involved in the case and (if necessary) how it should be conducted;

(5) arrangements to take statement (including video-recorded interview) with the child concerned;

(6) arrangements to contact/meet with/take statement from other individuals, such as:

(a) the informant;

(b) parents or carer(s);

(c) other children in the family concerned;

(d) other family members or individuals who have the information required for the investigation; and

(e) the person suspected to have harmed the child; and

(7) other special arrangements, such as measures of confidentiality, medical/forensic examination, arrangements required to cater for the child's special needs/intellectual ability/mental condition and language used by the child, or the overall arrangement for investigation of cases involving multiple perpetrators or victims, etc.

10.20 When handling complicated cases, personnel of CAIU and FCPSU should maintain close contact with each other to discuss and adjust the investigation strategies as necessary.

Stage III - Investigative Interview

10.21 The basic aim of an investigative interview is to obtain a truthful account from the child, in a way which is fair and in the child's interests, acceptable to the Court and can reduce the trauma of the child without having him/her to repeat details of the incident(s).

10.22 In conducting the interview, it is important to listen to what the child has to say. It is not a "therapeutic" interview. However, as each child is unique, the interview should be tailored to the child's particular needs and circumstances.

Criteria for Video-recorded Interviews (VRIs)

10.23 Section 79C of the Criminal Procedure Ordinance, Cap. 221, allows video recording of an interview with a child witness of certain sexual or violent

offences to be used as a testimony, where it relates to any matter in issue in the proceedings, in trials at the High Court, District Court or Magistracy.

10.24 Under Section 79C of the aforesaid Ordinance, video recording is admissible only where:

(1) the child is not the defendant;

(2) the child is available for cross-examination (assuming the proceedings get that far); and

(3) the rules of Court requiring disclosure of the circumstances in which the recording was made have been properly complied with.

10.25 To avoid having the child repeat details of unpleasant incident(s), unless taking video-recorded statement will cause greater distress to the child (e.g. the child had been forced to shoot for child pornography and refused to give his/her statement by video-recorded means), interview(s) with **the child suspected to be the victim or child witness(es) related to the case** should be video-recorded as far as practicable where there is:

(1) an allegation or suspicion of a sexual offence where the witness is under the age of 17; or

(2) an allegation or suspicion of an offence involving assault, or injury, or a threat of assault or injury, or cruelty, where the witness is under the age of 14; or

(3) the witness involved in the aforesaid offences is a mentally incapacitated person (no specification on age)

The relevant offences are listed at Annex 3 to this Guide.

10.26 Bearing this in mind, the use of the VRI should be restricted to those cases where a child has made specific allegation or there is a reasonable suspicion of maltreatment.

10.27 With regard to very young children, each child should be considered as an individual in respect of the criteria on competence and suitability to take video-recorded statement. This should not necessarily be age limited.

Arrangements of Video-recorded Interviews (VRIs)

Timing of the Interview

10.28 All allegations should be investigated without delay. A delay may be prejudicial to the child's interests (e.g. the child may be under pressure and unwilling to reveal the incident(s) to investigating personnel or may forget important or relevant details). Therefore, once it becomes clear that a criminal offence may have been committed and the child is willing to give his/her statement through video-recording, a VRI should be arranged as soon as practicable. However, if the child is not prepared to reveal the details of the incident in a VRI, a premature interview as such may not safeguard the child's best interests.

10.29 The time for the interview should tie in as far as possible with the daily routine, school time and rest pattern of the child so that the child can give a more detailed and clear statement under an optimal physical and psychological condition.

10.30 However, arrangements should be made immediately to have an interview with the child concerned even if it is outside office hours, provided that the physical and psychological condition of the child permits, under the following emergency situations:

(1) the deferment may expose the child to serious risk;

(2) the alleged perpetrator has been detained by the Police; or

(3) collection of medical or forensic evidence is required because of the nature and recent commission of the offence.

10.31 If the child concerned has psychiatric symptoms or has records of mental illness and investigating personnel has doubts as to whether the child is mentally fit for giving his/her statement, a child psychiatrist should be invited to assess the mental state of the child before the VRI is conducted.

Location of Interviews and Transport Arrangement

10.32 Interviews must be conducted in sympathetically designed suites. There are five such suites managed by the Police in the territory. They are suitable for persons with disabilities, including children or accompanying adults.

10.33 The location of the suites is kept confidential to avoid disturbances to the child. All personnel, children and accompanying adults at the venue should comply with the confidentiality agreement.

10.34 Police officers are to arrange transport of the child and accompanying adult(s) to the suite. In avoidance of queries, police officers should not stay with the child concerned in the absence of independent adult(s). If such situation is unavoidable, a brief record of any conversation with the child concerned should be made as soon as possible after it takes place. This record should be duly maintained for production in Court if required.

Consent to Video-recorded Interviews (VRIs)

10.35 Written consent from parent/guardian is not required for VRIs. However, in the interests of good practice, parent(s)/guardian(s) of the child should be informed and their permission should be sought in writing using the "Consent from Parent/Guardian to Conduct a Video-recorded Interview with Witness" provided (this is available in the suites).

10.36 However, if asking for the permission of the child's parent(s) will affect the safety and best interests of the child concerned, such action should not be taken. This will depend on the age of the child, the circumstances and nature of the allegation (i.e. whether the parent/carer is the alleged perpetrator and whether there is the likelihood of collusion between the parent/carer and the alleged perpetrator). If the child concerned is not capable of giving consent and his/her parent(s)/guardian(s) do(es) not give consent, or is/are suspected of child maltreatment, **neither the child's nor the parent(s)'/guardian(s)' consent is required to conduct any procedures in respect of the child concerned for the purpose of police investigation.**

10.37 In exceptional circumstances where the child concerned is interviewed without informing his/her parent(s)/guardian(s)/carer(s), the reasons for this should be clearly recorded. Where the child concerned is mature enough to understand the concept of VRI, he/she should be given an explanation of the purposes of video-recording so that the child is fully informed to a level appropriate to his/her own age and understanding, and able to express whether or not he/she consents to be interviewed and video-recorded.

10.38 Where a child is of sufficient understanding to indicate his/her willingness to make a video-recorded statement against the wishes of his/her parent(s), he/she should be permitted to do so where such a statement is to facilitate a criminal investigation/prosecution.

Observing and Witnessing a Video-recorded Interview (VRI)

10.39 The Police will normally arrange the parent/guardian who is not involved in the case to accompany the child to the suite, where he/she can observe and witness the interview through a close circuit television system in a place other than the monitor room.

10.40 Regarding child maltreatment cases, if the parent(s) is/are the alleged perpetrator or if there are reasons to believe that the parent permitted to observe the video-recording from a separate room may affect or prejudice the child's subsequent testimony in criminal proceedings, police officers may consider interviewing the child or juvenile concerned under the age of 16 in the absence of the parent or guardian under the following arrangements:

(1) Arrange for another adult relative of the child, or an "appropriate adult" aged 18 or above who concerns about the child's welfare and is not employed by the Police to witness the video-recording process at the scene. The appropriate adult shall sign the form, "Appropriate Adult Present at the Video-recorded Interview with Witness" (this is available in the suite).

(2) The officer-in-charge of the case (OC Case) may authorise to conduct an interview with a child or juvenile under the age of 16 in the absence of the parent(s)/guardian or other appropriate adults. However, police officers should record the details of such interviews by explaining in detail that attempts have been made to find person(s) responsible for taking care of that child or juvenile and giving reasons for deciding to commence investigation work at that time.

10.41 When arranging for the child's parent/appropriate adult to be present to witness the VRI, investigating personnel should also consider whether the presence of such person will bring pressure or embarrassment to the child who may become unwilling to disclose the details of the incident. If necessary, discussion may be held with the parent(s) to arrange for a suitable person to witness the video-recording process.

10.42 If the social worker responsible for the child protection investigation is not involved in conducting the VRI, police officer should also notify and arrange for that social worker to be present so that the social worker can observe the VRI and know the details of the incident, provide information of the child concerned for facilitating the VRI, help support the child and the accompanying adult, and discuss with the police officers and personnel

participating in the VRI for a child protection plan after the interview. To obtain contact information of the social worker, police officer may contact social worker of FCPSU for assistance.

10.43 Any person who has observed/witnessed the VRI may be requested to make a statement and give evidence in Court. If that person has information about the case and need to give a statement to facilitate investigation, he/she should do so before observing/witnessing the VRI.

Personnel Responsible for the Interview

10.44 VRIs with the child concerned should only be conducted by police officers, SWD's social workers and SWD's/Police's clinical psychologists who have received relevant training. Generally, interviews are jointly conducted by personnel from the two professions, namely a police officer and a social worker/clinical psychologist, one being responsible for interviewing the child and the other for monitoring the video-recording.

10.45 In respect of the sex of the interviewer, an officer of the same sex as that of the child will normally be the interviewer, especially for sexual abuse cases. However, under exceptional circumstances and according to the professional judgment of the investigating personnel, consideration may be given to officer of the other sex to interview the child. For example, children abused by someone of the same sex may be particularly repulsive to reveal the details of the incident(s) in the presence of investigating personnel of the same sex.

10.46 For a child of a different race or who speaks a different language, arrangement should be made as far as practicable for trained personnel who can communicate directly with the child to conduct the interview (e.g. using the mother tongue of the child/the language he/she uses in daily communication or for fluent expression) so as to minimise the inconvenience interpretation may bring. If interpretation (including sign language interpretation) is required, early arrangement for an appropriate interpreter should be made. Investigating personnel should also learn more about the child's race, culture or religion so as to facilitate communication with the child.

Explanation to Child

10.47 Before the VRI, the child, parent(s) or the accompanying adult should be given clear information regarding the format and nature of the interview. It will be important to avoid coaching the child but to answer his/her questions

about the interview arrangement as far as practicable and assess the child's willingness to be video-recorded.

10.48 The child may feel anxious before a VRI, especially when it is conducted in an unfamiliar environment. This might affect his/her recollection of details of the incident(s). Therefore, the interviewer should help the child get psychologically prepared prior to the VRI, which should be conducted only when the child is ready and willing to do so. It should be explained to the child that his/her conversation with the interviewer will be video-recorded instead of being taken as a written statement, and that the Police will ensure the safekeeping of the video record and prohibit any unauthorised viewing of the video.

10.49 Where a child is too young to understand fully, investigating personnel should listen to the views of the parent(s) or carer(s), and engage the parent(s) or carer(s) to help the child prepare for the VRI by proper means (care should be taken regarding the possibility of anyone exerting pressure on the child not to reveal the truth).

Strategy Planning Meeting prior to the Video-recorded Interview (VRI)

10.50 Before the VRI, personnel should convene a strategy planning meeting to plan jointly for the interview so as to assist the child in giving a detailed and clear statement as required. The meeting should be hosted by the OC Case trained in VRI, and if the OC Case is not trained or unable to attend, it should be hosted by other trained personnel. The child concerned and his/her family members should not be allowed to participate. Attending personnel include:

(1) Police officers (including the OC Case and the officer responsible for video-recording);

(2) social worker of SWD or the clinical psychologist of SWD/Police responsible for the VRI;

(3) the social worker responsible for the child protection investigation; and

(4) other professionals (if any) who know the child well.

10.51 The following items will be discussed in a strategy planning meeting:

(1) brief facts of the reported case and the preliminary investigation conducted by the Police;

(2) offences that may have been committed and key points of the case which are the subjects of enquiry or clarification in the VRI;

(3) information known to investigating personnel and social workers on the family background and the child, his/her ability, communication pattern, cultural and religious background, etc., and particular questioning methods, techniques or tools that may come to be useful having regard to the child's ability;

(4) deciding the ones who will perform the role of the interviewer and the monitor;

(5) arrangement(s) for identification of exhibits (including child/other pornography items) (if necessary);

(6) special arrangement(s) of the interview (if necessary) that need(s) to be explained to the child and the witnessing adult prior to the VRI;

(7) special arrangement of interpretation (if interpretation is needed) that needs to be explained to the interpreter prior to the VRI;

(8) roles of each personnel during the VRI (e.g. monitoring or observing the VRI in the monitor room, or accompanying the parent to observe the interview in a separate room, etc.);

(9) communication methods among personnel during the VRI (e.g. between the interviewer and monitor, how and when the OC Case could raise questions for the interviewer to clarify); and

(10) ways to deal with special circumstances that may occur during the VRI (e.g. the accompanying adult may be emotionally disturbed or may obstruct the interview process).

Procedures of Video-recorded Interviews (VRIs)

10.52 The procedures and methods of conducting VRIs are based on the phased approach proposed by the "Achieving Best Evidence in Criminal Proceedings: Guidance for Interviewing Victims and Witnesses, and Guidance on Using Special Measurers" (2011 version), which includes 4 phases, namely establishing rapport, free narrative account, questioning and closing the interview.

Stage IV - Immediate Case Assessment

Case Assessment Meeting

10.53 Following the VRI with the child, personnel participating in the strategy planning meeting prior to the interview should immediately hold a case assessment meeting. The child concerned and his/her family member

should not be allowed to participate. The meeting will normally be hosted by the social worker of SWD having participated in the VRI. If the video-recorded interview does not involve any SWD's social worker, the meeting will be hosted by another trained personnel or SWD's social worker responsible for the child protection investigation. The following items will be discussed in the meeting:

(1) preliminary discussion on the nature of the case based on the information obtained;

(2) whether it is necessary to provide immediate protection to the child;

(3) whether there are other children who may have been harmed and need protection;

(4) other urgently needed services for the child and his/her family, such as clinical psychological services, schooling arrangement, medical services, etc.;

(5) other relevant investigation procedures and arrangements, e.g. forensic examination; and

(6) other issues requiring the co-operation of different professionals (e.g. assistance that the child's family members may need during and/or after the arrest of the alleged perpetrator, and the emotional management of the alleged perpetrator, etc.).

Welfare Arrangements for the Child and His/Her Family Members

10.54 Investigating social worker and/or investigating personnel responsible for child protection investigation should discuss with the child and his/her family member(s) on the proposed child protection plan and other arrangements as necessary, and assist them in handling their possible emotional responses after the interview.

<u>Cases Handled by Other Criminal Investigation Unit(s)</u>

10.55 If the case is handled by another criminal unit, care should equally be exercised that all procedures be followed under the above arrangements and principles. These procedures include making contact with the informant/other personnel, planning investigation strategies, arrangement for VRIs, holding strategy planning meetings before the VRI, discussing on the communication methods among personnel during the interview, building an initial relationship with the child and explaining the procedures of the VRI with the child, and holding a case assessment meeting immediately after the

VRI. All children should have the right to the highest standard of investigation.

10.56 In case of emergency where the VRI is conducted only by police officers without notifying a social worker to follow up, police officers should consider and arrange for appropriate follow-up services after the VRI, and notify FCPSU if the case involves a child believed/suspected to have been harmed/maltreated, so as to facilitate follow-up arrangements by the social worker.

Cases with Statement Taken by Non-video-recording Means

10.57 If investigating personnel, having regard to the wish and circumstances of the child, choose not to take video-recorded statement from the child, they should mindfully exercise equal care and follow the procedures under the above arrangements and principles.

Other Investigation Procedures

Identification of Suspects by Child Witnesses

10.58 If a child is required to identify the suspect, the OC Case should arrange for an identification parade room equipped with a one-way viewing facility to conduct identification parade for the child witness. If the child has given a video-recorded statement before, another VRI with the child should be arranged after the identification parade to confirm the result.

Conducting Another Investigative Interview

10.59 Depending on the complexity of the case, a second investigative interview with the child may be necessary for supplementary information or identification of exhibits, etc. Prior consultation should be made with the Department of Justice (DoJ) for further VRI(s) with the child and a detailed account of the reasons for further VRI(s) should be recorded (excluding the VRI on confirmation of results of identification parade). If the first interview was video-recorded, subsequent interview(s) with the same child should also be video-recorded. If it is deemed necessary to change the interview method with the same child witness, the OC case of the Police has to seek advice from DoJ.

10.60 The preparation work and the interviewing procedures of the second investigative interview (including confirmation of results of identification parade) are largely the same with those of the first one. As the child has built rapport with the personnel who met him/her in the first interview, arrangement should be made for the same personnel to conduct subsequent interview(s) as far as practicable.

Other Investigation Work and Referrals

10.61 Police officers will carry out other investigation work, including taking witness statement(s) from other parties, searching for exhibits, arresting suspects, etc. During the investigation, if the alleged perpetrator is found to have emotional or welfare needs, the investigating social worker should be notified for follow-up actions. If the alleged perpetrator is not known to any casework unit, police officers may, with the former's consent, refer him/her to an appropriate casework unit (e.g. Integrated Family Service Centre/Integrated Services Centre) for services with reference to his/her residential address. In case of emergency, urgent intervention should also be arranged.

Appendix 1 to Chapter 10

☎ List of Police Command and Control Centres and Child Abuse Investigation Units (CAIUs)

Region	Name/Post	Tel. No.	Fax No.
—	Police Duty Officer of Headquarters Command and Control Centre (HQCCC)	3661 7100	2529 0191
Hong Kong Island	Supervisor of Hong Kong Island Regional Command and Control Centre (RCCC)	3661 7001	—
	OC CAIU HKI	2860 7815 2860 7814	2860 7813
Kowloon	Supervisor of Kowloon East Regional Command and Control Centre (RCCC)	3661 7401	—
	Supervisor of Kowloon West Regional Command and Control Centre (RCCC)	3661 7403	—
	OC CAIU KE	2726 6297 2726 6298	2360 2296
	OC CAIU KW	3661 8259 3661 8375	2712 4296
New Territories	Supervisor of New Territories North Regional Command and Control Centre (RCCC)	3661 7203	—
	Supervisor of New Territories South Regional Command and Control Centre (RCCC)	3661 7201	—
	OC CAIU NTN	3661 3373 3661 3370	2667 4230
	OC CAIU NTS	3661 1234 3661 1239	2200 4669

Appendix 2 to Chapter 10

List of District Service Boundary of Child Abuse Investigation Units (CAIUs) and Family and Child Protection Services Units (FCPSUs)

CAIU Region	Service Boundary	FCPSU	*Office Tel. No.
Hong Kong Island	Central, Western, Southern, Outlying Islands (excluding Lantau Island and Peng Chau)	FCPSU(CW/S/I)	2835 2733
	Eastern, Wanchai, Causeway Bay, Quarry Bay, North Point, Siu Sai Wan, Chai Wan	FCPSU(E/W)	2231 5859
Kowloon East	Wong Tai Sin, Tsz Wan Shan, Sai Kung, Tseung Kwan O, Lok Fu, San Po Kong, Choi Hung	FCPSU(WTS/SK)	3188 3563
	Kwun Tong, Ngau Tau Kok, Sau Mau Ping, Lam Tin, Yau Tong, Lei Yue Mun, Shun Lee	FCPSU(KT)	3586 3741
Kowloon West	Kowloon City, Tsim Sha Tsui, Mongkok, Yaumatei	FCPSU(KC/YTM)	3583 3254
	Shamshuipo, Shek Kip Mei, Cheung Sha Wan, Mei Foo	FCPSU(SSP)	2247 5373
New Territories (North)	Sheung Shui, Fanling, Ta Kwu Ling, Sha Tau Kok, Tai Po, Border	FCPSU(TP/N)	3183 9323
	Siu Lam, Tuen Mun	FCPSU(TM)	2618 5710
	Yuen Long, Tin Shui Wai, Hung Shui Kiu, Lau Fau Shan	FCPSU(YL)	2445 4224
New Territories (South)	Shatin, Ma On Shan	FCPSU(ST)	2158 6680
	Tsuen Wan, Kwai Chung, Tsing Yi	FCPSU(TW/KwT)	2940 7350
	Lantau Island (including Tung Chung), Peng Chau	FCPSU(CW/S/I)	2835 2733

	Offices	*Office Tel. No.
Senior Social Work Officers / FCPSUs	SSWO/FCPSU(CW/S/I)	2835 2722
	SSWO/FCPSU(E/W)	2231 5899
	SSWO/FCPSU(KT)	3586 3740
	SSWO/FCPSU(WTS/SK)	3586 3500
	SSWO/FCPSU(SSP)	2247 5438
	SSWO/FCPSU(KC/YTM)	3583 3235
	SSWO/FCPSU(ST)	2158 6660
	SSWO/FCPSU(TP/N)	3183 9343
	SSWO/FCPSU(TM)	2618 5571
	SSWO/FCPSU(TW/KwT)	2940 7351
	SSWO/FCPSU(YL)	2445 3043

*Please call SWD Hotline at 2343 2255 outside office hours

Appendix 3 to Chapter 10

List of District/Divisional Police Stations

	Report Room	Tel. No.	Fax No.
	Hong Kong Island		
1.	Central District	3661 1600	2975 4392
2.	Peak Sub-Division	3661 1604	2849 5652
3.	Western Division	3661 1618	2858 9065
4.	Aberdeen Division	3661 1614	2552 9216
5.	Stanley Sub-Division	3661 1616	2813 6480
6.	Wan Chai Division	3661 1612	2511 8731
7.	Happy Valley Division	3661 1610	2575 8051
8.	North Point Division	3661 1608	2562 5546
9.	Chai Wan Division	3661 1606	2556 3406
	Kowloon East		
10.	Wong Tai Sin District	3661 1632	2752 9405
11.	Sai Kung Division	3661 1630	27915129
12.	Kwun Tong District	3661 1622	2348 0700
13.	Tseung Kwan O District	3661 1624	2706 1332
14.	Sau Mau Ping Division	3661 1628	2790 7017
15.	Ngau Tau Kok Division	3661 1626	2750 0642
	Kowloon West		
16.	Tsim Sha Tsui Division	3661 1650	2369 0793
17.	Yau Ma Tei Division	3661 1652	2332 8500
18.	Sham Shui Po Division	3661 1646	2958 1430
19.	Cheung Sha Wan Division	3661 1644	2742 7046
20.	Mong Kok District	3661 1642	2789 2123
21.	Kowloon City Division	3661 1640	2762 9789
22.	Hung Hom Division	3661 1638	2624 5367
	New Territories South		
23.	Kwai Chung Division	3661 1690	2410 0013
24.	Tsing Yi Division	3661 1692	2449 0351
25.	Tsuen Wan District	3661 1708	2405 3687
26.	Sha Tin Division	3661 1702	2601 2176
27.	Tin Sum Division	3661 1706	2601 5841
28.	Ma On Shan Division	3661 1700	2640 1904
29.	Lantau North Division	3661 1694	2988 1822

	Report Room	Tel. No.	Fax No.
30.	Lantau South (Mui Wo) Division	3661 1696	2984 1538
31.	Airport District	3661 1688	2769 4809
	New Territories North		
32.	Tai Po Division	3661 1674	2144 1271
33.	Sheung Shui Division	3661 1672	2676 7569
34.	Tuen Mun Division	3661 1670	2456 4105
35.	Castle Peak Division	3661 1668	2457 9507
36.	Yuen Long Division	3661 1680	2443 0590
37.	Tin Shui Wai Division	3661 1678	2446 6547
38.	Pat Heung Division	3661 1676	2488 0328
39.	Sha Tau Kok Division	3661 1664	2659 2339
40.	Lok Ma Chau Division	3661 1658	2482 4808
41.	Ta Kwu Ling Division	3661 1666	2659 8501
	Marine		
42.	Marine Harbour Division	3661 1720	2884 9242
43.	Marine East Division	3661 1718	2194 4542
44.	Maine South Division	3661 1724	2553 7165
45.	Marine West Division	3661 1726	2452 2759
46.	Marine North Division	3661 1722	2602 7353
47.	Cheung Chau Division	3661 1712	2986 9057
48.	Lamma Island Police Post	3661 1714	2982 1824
49.	Peng Chau Police Post	3661 1716	2983 1146
50.	Sok Kwu Wan Police Post	3661 1736	2982 8403

Appendix 4 to Chapter 10

(Confidential)

Report Form for Reporting Suspected Child Abuse Cases to Police

(to be completed by Informant and/or sent together with the Written Dated Notes (Appendix 5))

A. INFORMANT

Name:_____ Rank/Post:_____

Name of Agency:_____ Unit:_____

Address:_____

Tel. No:_____Fax No.:_____

Emergency contact Tel. No. outside office hours (for the use of this case only):

_____

B. CHILD VICTIM

Name:_____Sex:_____Date of Birth:_____

HK Birth Certificate/Identity Card No.:

Address:_____

Present Location:_____ Tel. No:_____

School:_____ Class:_____

Any Disability or Special Needs of the Child:_____

Language normally used: _____

C. PARENTS/CARER

Name:_____	Name:_____
H.K.I.D. No.:_____	H.K.I.D. No.:_____
Sex/Age:_____	Sex/Age:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
_____	
Tel. No.:_____ (Home/Mobile)	Tel. No.:_____ (Home/Mobile)
Language Normally Used: _____	Language Normally Used:_____

D. SIBLINGS

1._____ 2._____

(Name, Sex/Age)

3._____ 4._____

5._____ 6._____

E. INCIDENT INFORMATION

1. Date and Time of Incident:_____
2. Location of Incident:_____
3. Type of Abuse: ❑Physical ❑Sexual ❑Psychological ❑Neglect
   (tick one or more) ❑cannot be categorised
4. Narrative Description:_____

---

5. How the Informant is aware of the Information:_____

_____

6. Any Known History of Similar Incident for the child victim:_____

_____

7. Name/H.K.I.D. No. of Alleged Perpetrator:_____

---

8. Relationship of Alleged Perpetrator with Victim:_____

_____

9. Name of Other Witness(es):_____

_____

10. Other Agency/Government Department(s) Involved in Handling the Case of the child/family concerned:_____

_____

11. Result of Child Protection Registry Check:_____

(If there are more than one incident, please use a separate sheet to provide the information.)_____

Signature : _____
Name : _____
Agency/Department : _____
Unit : _____
Tel. No. : _____
Date : _____

Appendix 5 to Chapter 10

(Confidential)
Written Dated Notes

(This form is to be forwarded with the Report Form (Appendix 4) in making a report to Police)

1. File Reference: _____
2. Name of the Child:_____
3. Sex/Age of the Child (Date of Birth):_____
4. Family Members in brief:_____
5. Type of Abuse: ❑ Physical ❑ Sexual ❑Psychological ❑ Neglect
   ❑ Other ❑cannot be categorised
6. Information Collected:

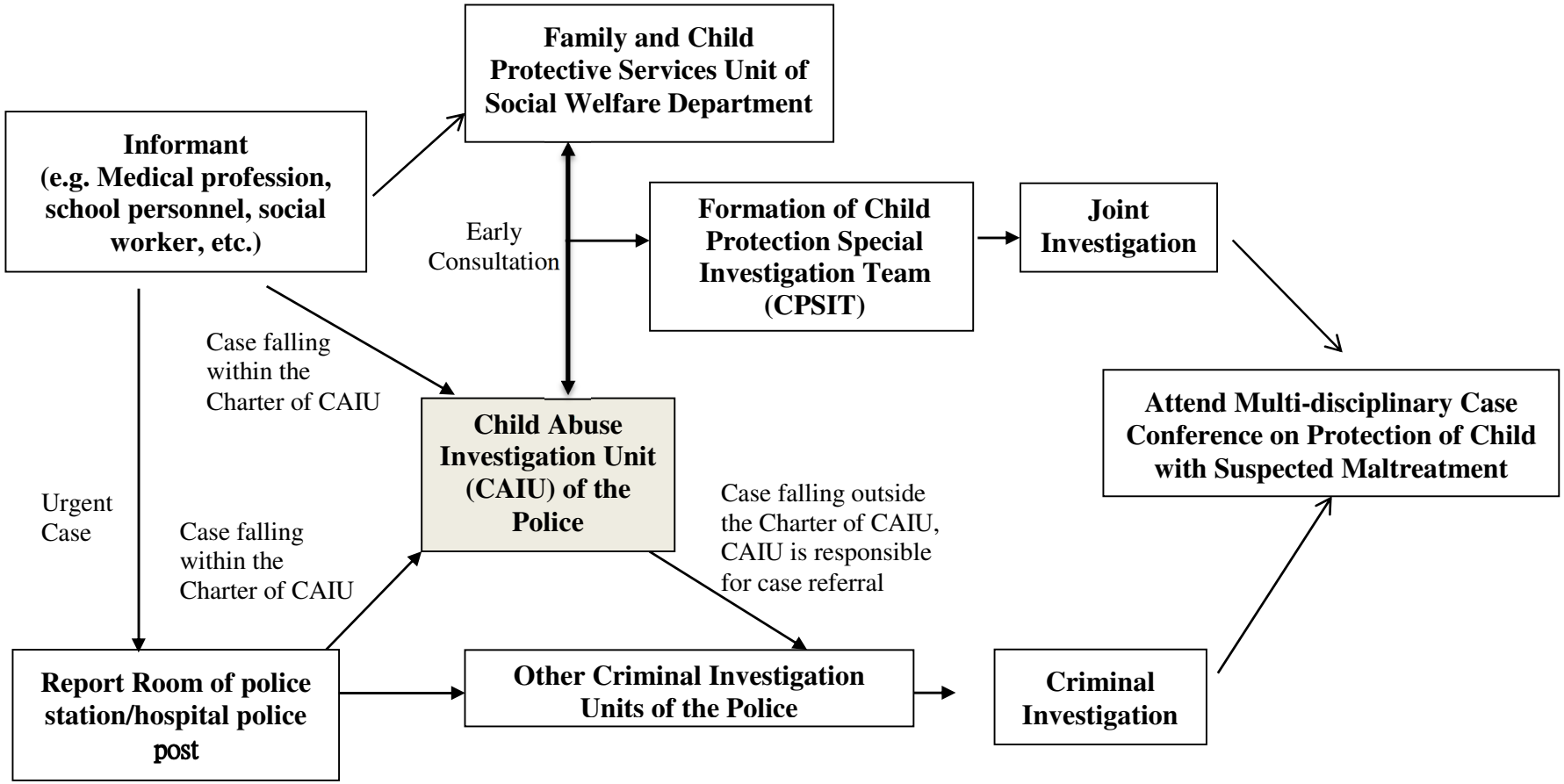
Date/Time	Details

Signature :_____
Name :_____
Agency/Department :_____
Unit :_____
Tel. No. :_____
Fax No. :_____
Date : _____

(This Document may be submitted to Court as legal evidence)

Appendix 6 to Chapter 10

Flowchart on Procedures for Handling Suspected Child Maltreatment Cases by Police Units



Appendix 7 to Chapter 10

This memo may be handwritten

MEMO

From: OC CAIU	To: DVC
Ref.:	(Attn:
Tel. No.:	Your ref.:
Fax. No.:	dated Fax. No.:
Date:	Total No. of Pages:

Suspected Child Abuse Case Report

I refer to our telephone conversation today on the above subject. A case of _____ was reported to this office at (time) _____on (date) _____.

2. As the case does not fall within the CAIU Charter, it is herewith referred to you for appropriate action. Please contact the referrer/referring social worker/informant as soon as possible to arrange for an interview with the victim at a place and time convenient to them.

(a) Particulars of the referrer/referring social worker/informant:

Name:	H.K.I.D. No.:
Sex:	Age:
Address:	
Tel. no.:	Fax. no.:
Relationship with victim:	Occupation:
Name of organisation: (if applicable)	

(b) Particulars of the victim:

Name:	H.K.I.D. No.:
Sex:	DOB / Age:
Name of parent:	Relationship with the victim:
Address:	

Tel. no.:	
Whereabouts:	Relationship with the suspect:
Any special needs/disability:	

(c) Particulars of the suspect:

Name:	H.K.I.D. No.:
Sex:	Age:
Tel. no.:	Occupation:
Address:	

(d) Brief description of the allegation:

3. Should you require our assistance in obtaining a statement from the victim, please do not hesitate to contact the undersigned.

4. Please acknowledge receipt of the referral by signing and returning the following to the undersigned **within 3 working days** from the date of this memo.

( )
OC CAIU

cc Director of Social Welfare (Attn: Family and Child Protective Services Unit) or Informant*
(* Delete whichever is inapplicable.)

==========

Reply Memo

From: DVC	To: OC CAIU
Ref.:	(Attn:)
Tel. No.:	our ref.:
Fax. No.:	Dated Fax. No.:
Date:	Total No. of Pages:

Suspected Child Abuse Case Report
Re: (Name of Child)

I acknowledge receipt of the above referral. The case is being investigated by _____ and may be contacted on telephone no. _____.

( )

cc Director of Social Welfare (Attn: Family and Child Protective Services Unit) or Referrer*
Referrer/referring social worker
(Attn:_____)

(* Delete whichever is inapplicable.)

Appendix 8 to Chapter 10

From	Commissioner of Police	***To***	Director of Social Welfare
Ref.	____ *in* _____	*(Attn.*:	SSWO of FCPSU( ))
Tel. No.	_____		
Fax. No.	_____		
Date	_____		

(Unit) / Fax. No.

(CW/S/I) 3107 0051 (E/W) 2164 1771 (KT) 2717 7453
(WTS/SK) 3421 2535 (KC/YTM) 3583 3137 (SSP) 2729 6613
(TW/KWT) 2940 6421 (TM) 2618 7976 (TP/N) 3104 1357
(ST) 2681 2557 (YL) 2445 9077

Referral for Family and Child Protective Services

☐ **Child Abuse** ☐ **Domestic Violence (Spouse/Cohabitant Battering)**

The following person has come to police attention of being in need of social services or assistance of your Department in a case of _____(Case Nature) [Police Report No. : _____].

Name : _____ Sex / Age: _____
Address : _____
_____ Tel. No. : _____

2. The Background Information sheet is attached for your reference and follow up.

3. Consent form is/is not attached.

4. Please acknowledge receipt of this referral by signing and returning the Reply Slip to me within **seven working days** from the date of this referral. Should you require any further information, please contact the following officer

Name of Officer : _____
Post / Telephone : _____

( )
for Commissioner of Police

Acknowledgement of Receipt of Referral

Re : (Name of Subject) / (RN :)

I acknowledge receipt of the above referral. Please be informed that * the case is being handled by/has been referred to the officer as follows :-

Name of Officer : _____

Unit of Department/ Agency : _____

Telephone/E-mail : _____

☐ The person(s) referred has/have declined our services.

☐ (For DV only) The person(s) referred cannot be contacted within 7 days. Progress will be informed by the 2nd reply memo within one month.

( )

for Director of Social Welfare

PERSONAL DATA

Background Information

Part A

(a) Particulars of the Subject/Persons Living with the Subject: (please use the blank space provided at subsequent page if there is not enough space for inputting additional information)

Name & Sex	Relationship	HKID	Age	Workplace or School.	Consent Given (Y/N)
(1)					
Address/ Phone no.					
(2)					
Address/ Phone no.					

(b) Offence and Case Nature: (Police Report No._____)

(c) Brief fact of the incident : (please include the date, place, persons involved in the incident, and if weapon used and any injury)

_____

(d) Officer-in-charge/Duty Officer and Contact Number:

_____

(e) Case Has Been/To Be Taken (can (✓) tick more than one box):

- ☐ The alleged offender was/will be charged*. (Please specify offence(s)_____)
- ☐ The alleged offender was/will be* bound over.
- ☐ The alleged offender was/will be* cautioned under the Police Superintendents' Discretion Scheme.
- ☐ Domestic Incident Notice (Pol. 1130a) was served.
- ☐ Investigation is still in progress.
- ☐ No further action will be taken.

Reasons:
- ☐ Complainant did not wish to pursue and subsequently withdrew the complaint.
- ☐ Unruly child under 10
- ☐ Others (please specify_____)

(f) Additional Information

- ☐ The subject person(s) is/are* currently admitted into Hospital / ____

☐ Domestic Violence: Persons/Children living with the complainant. (Please specify number, relationship and age of the children _____)

☐ Elder Abuse: Name of relative and contact details

☐ Other Information

_____

_____

Remark:Subject to compliance with the Personal Data (Privacy) Ordinance, the above personal data shall not be used for the purpose(s) other than provision of social welfare service (s) other than stated at the consent form without the prescribed consent of the data subject, and not to be retained longer than is necessary for the fulfilment of the purpose(s) for which the data are to be used.

For Referral with Consent, Pol. 1130b or Consent form must be faxed together with the completed referral memo to SWD.

*Delete as appropriate

Chapter 11 Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment

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

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

11.2 The focus of MDCC is on protecting the safety and best interests of the child and NOT prosecution of the alleged perpetrator. Even if concerns are only being expressed about one child, safety of all the children and other members (e.g. parents) in the family should also be reviewed by adopting a family perspective.

11.3 MDCC analyses risks and needs, and recommends actions to be taken in relation to the follow-up plan of the child and his/her family. MDCC should consider the following:

(1) the nature of the incident;

(2) the level and nature of risk of harm/maltreatment to the child and, if any, other children of the family;

(3) formulation of the safety/follow-up plan to protect the child upon multi-disciplinary collaboration;

(4) parent(s)'/guardian(s)' suggestions and attitude on the safety/follow-up plan on the protection of the child; and

(5) the needs and views of the child and other family members.

11.4 Members of MDCC should be bound by the collective decision of the MDCC unless there is any statutory order with different arrangement made under the Protection of Children and Juveniles Ordinance, Cap 213 (PCJO) or other ordinances relating to child issues (e.g. Matrimonial Causes Ordinance, Cap. 179). When statutory action is considered in MDCC, the statutory obligations of individual members for the case should be respected.

Circumstances Warranting Convening MDCC

11.5 MDCC is required when there is/are suspected child maltreatment incident(s) with investigation conducted by social worker and other professionals. MDCC should be conducted unless under the following **exceptional situations** where related professionals (including the service unit which will possibly follow up on the case) agree to have discussion in other means:

(1) (a) less than three parties are involved in the investigation of the case; or

(b) the alleged perpetrator is **not** a family member/relative of the child concerned or a staff/carer/volunteer of an organisation who works with children, and he/she will not have further chance to access to/harm the child concerned such that there will be lower risk of similar harm to the child;

and

(2) the nature of incident, risk/need assessment, category of case and intended follow-up plan are agreed among related professionals (including the service unit which will follow up on the case).

11.6 If MDCC is not conducted, the investigating social worker is still required to furnish a child protection investigation report with the nature of the incident, risk/need assessment and recommendations on follow-up plan to facilitate the discussion among the parties concerned. A covering letter to enclose the child protection investigation report and a reply slip to invite related professionals to give views on (i) not convening MDCC; and (ii) the proposed nature of the incident, risk/need assessment and follow-up plan for record purpose. The letter sample is at Appendix 1 to this Chapter for reference. Telephone communication among related professionals is also encouraged for a more effective communication. If agreement on whether or not to conduct MDCC cannot be made, related professional may raise the issue to the senior of the responsible party.

11.7 For cases where a child is found deceased possibly due to maltreatment, MDCC is to be conducted under the following two situations:

(1) the deceased child has sibling(s). In view of the seriousness of the incident, special attention is to be paid on the safety and needs of the surviving child(ren) in the same family;

(2) the child is deceased during the course of investigation conducted by related professionals. MDCC is to be conducted as part of the

investigation procedures, regardless whether there is/are surviving child(ren) in the family.

11.8 For certain cases with suspected child maltreatment, the parents have decided to relinquish their parental rights upon the birth of the baby and MDCC is therefore not convened for the child (e.g. the case where the newborn's urine sample is tested positive for dangerous drugs). If the parents subsequently change their mind and revert their decision on relinquishment of the parental rights, the social worker(s) working with the child/parents should arrange or inform suitable service unit to conduct child protection investigation and convene MDCC (please refer to paragraphs 8.3 and 8.4 of Chapter 8 and Annex 5 to this Guide for the arrangement).

Timing

11.9 MDCC should take place within 10 working days after receipt of the report by the unit responsible for child protection investigation so that the plan to protect the safety of the child can be formulated as early as possible.

11.10 MDCC may be postponed under the following circumstances:

(1) the child's critical medical condition precludes necessary investigation;

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

(3) due to complexity of the case, information is still being collected and hence the necessary investigation is not yet completed (e.g. the parents refuse to co-operate or cannot be located, the collection of significant evidence is still underway).

Under such circumstances, the related professionals should be informed of the deferment of the MDCC.

Chairperson

11.11 The officer-in-charge/supervisor/senior social worker of the units providing casework service and conducting the child protection investigation will normally assume the chairmanship and the related responsibilities.

11.12 The Chairperson should be experienced in family, children or youth services and have good knowledge on child protection and family work.

11.13 Family and Child Protective Services Unit (FCPSU) of SWD will provide support and assistance to the personnel who are not experienced in conducting MDCC or not appropriate to be the Chairperson (e.g. the officer-in-charge of the unit is handling a complaint lodged by the parent(s) of the child concerned about case handling). If necessary, social worker of FCPSU can help them chair the MDCC. The support and assistance of another colleague of the same organisation can also be enlisted. Social worker of FCPSU will also chair the MDCC if the child protection investigation is conducted by school social work service unit (excluding secondary schools) or youth service unit of non-governmental organisations.

Membership

11.14 The Chairperson, in consultation with the social worker conducting investigation (investigating social worker), should decide on the membership of MDCC, including the following professionals:

(1) who have direct knowledge on the child and his/her family and have a major role in the handling and investigation of the suspected child maltreatment case; or

(2) those not involved in the investigation but can give particular information on the child or his/her family or professional advice, or will soon follow up on the case, to facilitate the discussion of the nature of the incident, risk and need assessment and formulation of follow-up plan.

11.15 In addition to the investigating social worker, the Chairperson may invite the following professionals to be a member of MDCC, as appropriate:

(1) medical staff e.g. medical officers, nurses, etc.;

(2) school personnel e.g. teachers, principals, counsellors, etc.;

(3) social worker e.g. medical social workers, school social workers, social workers of residential service unit, social workers of FCPSU (if FCPSU has not been involved in the investigation), the social worker(s) who will possibly follow up on the case (if the case may not be followed up by the investigating social worker);

(4) police officer;

(5) clinical psychologist; and

(6) other professionals.

11.16 The chairperson may issue invitation to the responsible professionals or the head of the unit/section so that the latter can decide who will be more suitable to attend the MDCC. The professionals being invited can also discuss with the Chairperson on the membership if they consider certain professional should also be involved in the MDCC. All professionals should attend the MDCC as far as practicable including the part of meeting with the family.

11.17 For cases where more than one child in the same family are suspected to be maltreated, the Chairperson may consider the need to invite professionals working with individual child to attend the same MDCC to facilitate the formulation of follow-up plan for the family as a whole. Nonetheless, members should note the concern of data protection on individual family member and make appropriate arrangement as appropriate.

11.18 Since MDCC focuses on the concerns relating to the child suspected to be maltreated, if the alleged perpetrator is not a family member of the child, the professional(s) only working with the alleged perpetrator should not be invited to attend the MDCC unless the Chairperson considers his/her/their attendance is significant and beneficial to the follow-up plan of the child and appropriate arrangement in protecting the personal data of child and family can be made.

11.19 The Chairperson/investigating social worker may come with one more staff to provide secretariat work.

11.20 Sometimes, more than one person of the same profession in the same organisation may have different roles to play in the investigation or follow-up. If more than one person of the same profession from the same organisation is to attend the MDCC, the Chairperson should be informed beforehand and these members should discuss among themselves on their division of work in the MDCC.

11.21 Professional observers (e.g. newly posted staff, trainee, chairperson-to-be, etc.) can only sit in the MDCC with the prior consent of the Chairperson, all members of the MDCC, the parent(s) and the child(ren) (where appropriate). They must not take part in discussion or decision-making.

11.22 The social worker of FCPSU who is merely conducting social investigation on custody/access issue as ordered by the Court but is not handling the case may sit in the MDCC as appropriate for information collection to facilitate the formulation of the recommendation on these issues to Court with consideration of the need to protect the safety and best interests of the child concerned. This

social worker will not be a member of MDCC to maintain his/her neutrality in the investigation.

11.23 As there may be conflict of interest in cases where the alleged perpetrators are staff or volunteers of an organisation (e.g. school or residential child care service unit), these individuals should not attend the MDCC.

11.24 If staff of the organisation which is mentioned in paragraph 11.23 is required to provide relevant information on the child/family/incident to facilitate discussion at the MDCC, the Chairperson may invite other staff of the same organisation to attend the MDCC but will not request them to give views on the nature of incident/category of case. Such arrangement can be recorded in the notes of MDCC.

11.25 Although the parent(s) and the child(ren) (where appropriate) will be informed of the membership of the MDCC, their views should have no bearing regarding the decision on the membership. If the parent(s)/child(ren) object to the participation of a particular member, the Chairperson should find out the reasons and explain to them the role of the member. Any misunderstanding between the parent(s)/child(ren) and the particular member should best be dealt with prior to the MDCC. No member should be excluded from the MDCC because of parent(s)' or child(ren)'s objection.

Tasks to be Performed by MDCC

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

(1) to examine the cause(s) of incident, analyse information available, and decide from **the perspective of protecting child's safety** whether the incident involves a child being harmed/maltreated after drawing reference form the definition of child maltreatment as set out in Chapter 2 of this Guide;

(2) to assess the current/future risk level of maltreatment to the child(ren) concerned as well as other children in the family and their needs (please refer to Chapter 7 and Annexes 16 to 18 to this Guide);

(3) to decide whether it is a child protection case, which refers to cases in which:

(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;

(4) based on the assessment outcome of the child's risk of being maltreated and the child's and his/her family's needs to make recommendation and concrete arrangement in relation to their follow-up plan (including safety plan), including whether statutory action, arrangement for residential child care service and clinical psychological assessment, etc. is/are needed to protect the safety and best interests of the child(ren);

(5) to appoint the key worker and to delineate the roles and responsibilities of other professionals in the implementation of the follow-up plan for the child which involves inter-agency co-operation; and to appoint a core group to follow up on the case as appropriate (e.g. for cases where risk of child maltreatment is high and the child is in need of residential child care service, cases with complications and in need of close collaboration among various professionals) and decide membership of the core group;

(6) to discuss with family members and/or the child(ren) the issues which MDCC concerns when they attend the MDCC, and to inform them of the views/recommendations/decisions of MDCC as well as to consider their opinions; and if the child(ren) and parents are not present in the MDCC, to decide how the child(ren) and parents will be informed of the views/recommendations/decisions of MDCC and how their feedback can be conveyed to members;

(7) to consider the need to register the information of the child concerned and/or his/her sibling(s) in Child Protection Registry;

(8) if criminal offence may have been committed, to discuss the need to report the incident to the Police if it has not been done so before MDCC;

(9) to consider the need for a review conference with reference to:

(a) the need for further information to make necessary decisions/recommendations;

(b) the need to review any follow-up action (especially relating to child's safety) in the format of a meeting; and

(c) any important decisions of MDCC that may not be implemented because of foreseeable circumstantial changes and which may jeopardise the safety and best interests of the child.

(10) to consider the need and timing to issue a report/reports to related parties involved regarding the implementation of the follow-up plan. If a core group is to be set up, MDCC may make suggestion on the format of collaboration/follow-up of the core group, time for the first review and the format of conducting it;

(11) to suggest follow-up services be rendered by a social service unit/organisation as appropriate if the case is not classified as a child protection case but in need of welfare services; and

(12) to make recommendations and arrange an appropriate unit to follow up if the perpetrator is not a family member of the child and may need follow-up services, especially when he/she is also a child.

11.27 The Chairperson of MDCC may draw reference from Appendix 19 to this Guide, "Reference Kit for Chairperson of Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment", to enable him/her to effectively prepare for and steer the MDCC. It is desirable that members also refer to this information in order to clearly understand the proceedings of MDCC and to effectively achieve the objectives of MDCC.

Information Sharing

11.28 Information given in MDCC is confidential and should not be used for purposes other than that of child protection, nor should it be disclosed to any other organisation(s) or individual(s) without the permission of the information provider.

Use of Personal Data Collected during the Handling of Suspected Child Maltreatment Cases

11.29 According to Data Protection Principle 3 of the Personal Data (Privacy) Ordinance [PD(P)O], personal data shall not, without the prescribed consent of the data subject or a relevant person on behalf of the data subject, be used (including disclosure and transfer) for a new purpose, i.e. any purpose other than the purpose for which the data was to be used at the time of the collection of the data, or a directly related purpose. Disclosure of the minor's personal data to another individual (including parent(s)) for the purpose for which the data were originally collected or a directly related purpose is in compliance with Data Protection Principle 3 of the PD(P)O.

11.30 While there may be a duty of confidentiality, it does not necessarily render the disclosure of the minor's personal data to a parent for the above mentioned purpose a breach of Data Protection Principle 3.

11.31 For principles of sharing information and invoking exemption from the provisions of Data Protection Principle 3, please refer to Annex 2 to this Guide.

Before MDCC

11.32 The Chairperson, with assistance of the investigating social worker, should work out the following:

(1) date and venue of the MDCC;

(2) membership of the MDCC and invitation (a sample of invitation letter and agenda is at Appendix 2 to this Chapter for reference);

(3) arrangement for participation of family member(s) and/or the child(ren) concerned in the MDCC. If special arrangement is suggested, confirmation with members on the arrangement is to be made (a sample feedback form on family member(s)' and/the child(ren)'s participation is at Appendix 3 to this Chapter for reference);

(4) distribution of available written reports in a confidential manner preferably prior to the MDCC;

(5) arrangement for notes taking during the MDCC; and

(6) arrangement of pre-conference briefing to family member(s) and/or the child(ren) concerned who are to be invited to attend the MDCC.

11.33 If the Chairperson is not from the unit conducting the child protection investigation, the unit conducting child protection investigation should be responsible for making the above arrangements. Members of the MDCC and

the family members and/or the child(ren) concerned are to be informed of the name, post and affiliation of the Chairperson.

During MDCC

11.34 At the start of MDCC, the Chairperson should remind participants of the MDCC the confidentiality of the proceedings and clarify with them their wish on the control and prohibition of data in accordance with the PD(P)O (see also Annex 2 to this Guide and Appendix 4 to this Chapter). The notes of MDCC will also contain a reminder to this effect.

11.35 Members have to note that the focus and objectives of MDCC are for the protection of the safety of the child and safeguarding his/her best interests, and not to determine whether the acts of the alleged perpetrator have constituted criminal offence. Members should concisely report the significant points relating to the investigations.

11.36 The Chairperson should alert members who are potential witnesses[15] the danger of contamination of evidence, e.g. even when members need to reveal the information given in their police statements to facilitate the discussion during MDCC, they have to differentiate which part of the information they obtain is directly from the child concerned and which part is from other persons. Similarly, discussion among potential witnesses on the details of the abusive acts should be avoided even after the conference until the conclusion of subsequent court proceedings, if any.

11.37 In discussing the nature of the incident, risk/need assessment and follow-up plan, the Chairperson has to lead members to analyse all the facts and opinions and come to decisions through consensus as far as possible. However, if any members have reservation to give views, they should not be compelled to do so. If necessary, the reasons for not giving views by certain members can be included in the notes of MDCC.

11.38 In formulating the follow-up plan of the child concerned, the following should be considered to ensure the child's safety (please refer to Chapter 7 of this Guide, "Risk Assessment and Decision Making on Protecting the Safety of Children"):

[15] Generally speaking, potential witnesses are those persons who possess relevant information on the maltreatment incident and may be required to give evidence in the subsequent court proceedings, if any. The Police may request members attending the MDCC who are potential witnesses to be interviewed, with a statement taken or to provide documentary evidence, e.g. medical chits/reports, chemist certificates, etc., prior to the MDCC so as to avoid the possible contamination of evidence during discussion at the MDCC.

(1) how the follow-up plan targets at the risk factors and level of risk of child maltreatment to the child and/or other children of the family;

(2) how the follow-up plan targets at the needs of the child and his/her family, including the safety of other family members;

(3) the suggestions and views of the child in relation to the measures and follow-up plan for protecting his/her safety;

(4) strengths and resources of the family;

(5) parents' suggestions, views and attitude in implementing the follow-up plan;

(6) support and supervision required from external parties for implementing the follow-up plan; and

(7) availability of services required to implement the follow-up plan.

11.39 To safeguard the safety of the child concerned, a safety plan targeting various risk factors of child maltreatment should be formulated for the child (including concrete short/long term objectives, the concrete actions and steps that professionals as well as parents have to take) to reduce/eradicate the identified risk factors and to strengthen the protective factors.

11.40 Regarding the care arrangement of the child, the following areas should be considered:

(1) whether it is safe if the child is taken care of by his/her family;

(2) if the child will continue to be cared by his/her family, what actions the family members should take to safeguard the child's safety and what support the professionals should render to the family and the child;

(3) when considering whether the parent(s) having drug/alcohol abuse problem can take care of the child, members of MDCC should make sure that the child will at all times be taken care of by at least one adult carer who is not affected by any drug/alcohol and is capable of child care. At the same time, the carer should also ensure that the child will not be exposed to any suspected dangerous drugs or equipment for taking drugs. Such arrangement should be closely monitored and reviewed by the follow-up personnel (e.g. the core group);

(4) if it is necessary to separate the child from the perpetrator/alleged perpetrator, consider the possibility of arranging the perpetrator/alleged

perpetrator to move away so that the child can be taken care of by his/her family continuously;

(5) if members of MDCC consider that it is temporarily not suitable for the child to be taken care of by his/her family, caring by relatives should be considered as far as practicable. Residential child care service will be a last resort when all the above arrangements are infeasible (when considering residential child care arrangement, please consider the permanency planning for the child at the same time by referring to Appendix 1 to Chapter 8 of this Guide).

11.41 When discussing the need for application of a statutory order made to a Juvenile Court under the PCJO for the care and/or protection of the child concerned, it should be based on the risk assessment with substantiated grounds for making such decisions. Such application should be considered on a case-by-case basis taking into account the parents'/carers' views and attitudes towards professional intervention, the child's safety, psychological state, behaviour and views, and seriousness of the incident(s), etc. In the 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 Annex 15 to this Guide for certain provisions of the PCJO.

Roles and Responsibilities of Members of MDCC

11.42 All members have the responsibility to attend MDCC, assist in carrying out the tasks of MDCC mentioned above and contribute from their professional point of view during MDCC to safeguard the safety and best interests of the child. In case of enquiry about MDCC proceedings, members should seek clarification from the Chairperson.

11.43 Members should attend the whole MDCC (including the part for professional sharing and the part for meeting with family members). They are required to share their findings of the investigation on the incident, contribute their professional knowledge and experience, represent their department's/organisation's views, and to share relevant information and concerns with the family members.

11.44 Each member has the responsibility to prepare a written report/notes on the child for reference of MDCC. The report can be brief, with relevant information on the child and family such as the risks to the child, protection

required/available and follow-up plan. To save time on information sharing in MDCC, members are requested to distribute their reports to other members before MDCC as far as practicable. The transmission of the reports should be in a secure manner to protect the personal data of the child/family. Individual members may share (preferably prior to the MDCC) useful published reports and articles (e.g. medical reports and researches) relevant to the case to facilitate mutual understanding among the members on the nature of the incident and facilitate formulation of follow-up plan.

11.45 The police officer in charge/investigating officer responsible for the investigation of the suspected child maltreatment incident(s) should attend the whole MDCC as member to inform the MDCC the progress, but not the details of the investigation of the incident(s), and contribute his/her professional knowledge as far as possible. As the police officer may be involved in the criminal investigation of the case, he/she 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. The police officer may also provide relevant information obtained in the investigation if it is deemed essential for the formulation of a suitable follow-up plan for the child(ren) concerned.

11.46 While the Chairperson, investigating social worker and the key worker who will follow up on the case need to keep a full set of reports prepared by members for record, members may request to take back their reports from individual members if they consider that the latter has no need to keep the report. If the report has been distributed to members through electronic means, they may request individual members to delete it after the MDCC. For example, social workers from Integrated Family Service Centre/Integrated Services Centre or FCPSU who have not been involved in the case handling and will not follow up on the case after MDCC may not need to keep the reports.

11.47 Those members being invited but unable to attend are requested to provide information of the case in writing for reference of MDCC. The absentees who need to follow up on the case will be given relevant reports/notes of MDCC. For other absentees, they may request for a copy of relevant reports/notes of MDCC before the conference for members to discuss this request and decide in MDCC.

11.48 Members who follow up on the case should assist in carrying out the decisions made in MDCC. The key worker has to ensure that the post-conference management and multi-disciplinary collaboration in intervention are in place.

Member(s) should inform the key worker if certain actions as decided in MDCC cannot be implemented within the expected period of time, or there are any changes in the circumstances that subsequent action is to be/has been taken concerning the child and his/her family. Prior discussion with the key worker is to be made as far as practicable before actions are to be taken especially when the action is related to child protection measures (e.g. child care arrangement or statutory action). If the actions which cannot be implemented/changes in the circumstances may possibly affect the child's safety, the key worker should inform members of MDCC so as to discuss if the original follow-up plan formulated has to be changed.

11.49 Members should attend subsequent review/case conference (if applicable) and submit reports (according to the decisions of MDCC or core group) if they are involved in the follow-up of the case

Family Participation in MDCC

Objectives

11.50 Family participation aims to enhance those families' understanding of the issues of concern, allow them to give views on the formulation of the follow-up plan in protecting child's safety and assisting the family, and enlist their involvement in implementing the follow-up plan to achieve the common goal of protecting the safety of the child.

Arrangement

11.51 MDCC normally consists of two parts. The first part is for professional sharing and discussion while the family members will be invited to join the second part. The Chairperson, in consultation with members as appropriate, will decide at which time point the family members will join the MDCC according to individual case merit but at least the family should participate when the initial follow-up plan is formulated. All members should attend the part of meeting with the family members unless there is a specific reason, e.g. it is not appropriate for the social worker of a refuge centre, at where the mother and the child concerned are residing, to meet the father who is the alleged perpetrator.

11.52 Usually, parents (including the alleged perpetrator(s)) will be invited to participate in the second part of MDCC unless after informing the parent(s) of

the MDCC arrangement, including its proceedings and general rules, and having due discussion with the parent(s), it is considered that:

(1) his/her/their presence may seriously prejudice the best interests of the child;

(2) there is sufficient evidence that the parent(s) may behave in such a way as to interfere seriously with the work of the conference such as violence, threats of violence, etc.; or

(3) the parent(s) is/are in an unfit state (e.g. because of drug, alcohol consumption or acute mental health problem) making them unable to join the discussion effectively.

For parents having high conflict, separate sessions might be considered to meet with each of them. If there will be important decision affecting the child's life, the non-custodial parent will also be invited to attend the MDCC. Members' views have to be sought for the above arrangement which is different from the usual practice.

11.53 In some cases, the child can be invited if he/she would benefit from attending MDCC. The decision to involve child in MDCC should take into consideration the child's age, comprehension capability, maturity and emotional state. During MDCC, the child should be explained of all related matters using the ways that he/she can comprehend and be encouraged to express his/her views.

11.54 Careful consideration should be taken as to whether it would be appropriate to invite the child to attend the same session with his/her parent(s) if the latter is/are the alleged perpetrator(s). The alleged perpetrator(s) should not be given any opportunity, during the MDCC or the waiting period, to influence/interfere with and/or exert pressure on the child directly or indirectly such that the child might change or withdraw his/her previous account of the events or views on follow-up plan.

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

11.56 While parents will usually be invited to attend MDCC, if there is any different arrangement proposed by the Chairperson (e.g. one of the parents is not invited to attend, child concerned/relative is invited to attend, separate sessions for meeting with parents, etc.), he/she has to consult all members before making

the decision. If any member considers that the participation of parent(s) will not be appropriate, he/she can discuss the matter with the Chairperson before the MDCC.

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

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

11.59 Interpretation service (including sign language) may be required if the parent(s)/child use(s) foreign language or have communication barriers (e.g. hearing impairment). Generally speaking, the social circle of ethnic minorities is relatively small and ethnic minorities are under great psychological pressure because they may worry if the incident is known to relatives/religious leaders/clans. To ensure that members of MDCC, the parent(s) and/child fully understand the exchanges of information/views, it is not advisable to arrange family members, relatives, friends/acquaintances or child himself/herself to act as interpreters. In addition, given the small population of some ethnic minority groups in Hong Kong that the interpreters may know the family concerned, the Chairperson/investigating social worker has/have to explain to the interpreter the objectives of MDCC and the principle of confidentiality, and to clarify the latter's role is to fully and accurately translate direct communications between professionals and family members and exact words that are said. The interpreter may also be required to explain, at an appropriate time, any cultural or other issues that might need to be attended to or be overlooked. Interpretation services for the ethnic can be arranged through different means such as court interpretation services, the Hospital Authority and the interpretation service provide by “Centre for Harmony and Enhancement of Ethnic Minority Residents (CHEER), which is operated by the Hong Kong Christian Service and funded by Home Affairs Department. For information, please refer to the webpage of the Home

Affairs Department: https://www.had.gov.hk/rru/english/programmes/programmes_comm_sscem.html.

11.60 If members of MDCC and family members present cannot reach the consensus on the matters discussed, especially on the concrete objectives and actions to ensure the physical and psychological safety of the child, members should inform the family members how the matters will be handled, particularly on the arrangement on protecting the child's physical and psychological safety.

Absence of Family Members

11.61 In case the parents and/or child are unable or considered not suitable to participate in the MDCC, the investigating social worker should inform the parents and/or child that they can give their views to the investigating social worker or other members of the MDCC. The investigating social worker should undertake to ensure that the MDCC is aware of the parents'/child's views.

11.62 Members of MDCC should decide how the family will be informed of the outcome and decisions of the conference if they are not present in the MDCC. The feedback of family can be included in the post-meeting note in the notes of MDCC.

Roles of Parents/Child in MDCC

11.63 Parent(s) and/or the child to be invited to participate in MDCC is/are not member(s). Their roles in MDCC are to supplement background information of the family, participate and contribute in the discussion on risk/need assessment, formulation and/or implementation of the follow-up plan.

Pre-conference Preparation for the Family

11.64 When family member(s) is/are invited to participate in MDCC, the Chairperson or investigating social worker should brief them on the following issues:

(1) objectives, focus and ambit of MDCC;

(2) proceedings and discussion practice of MDCC, and issues to be discussed;

(3) participants of the MDCC and their respective roles; and

(4) the ways of giving their views and contribution in the MDCC.

11.65 The leaflets for children and parents uploaded onto the webpage of SWD with general information of the above can be given to them by the investigating social worker before MDCC. The discussion with family members should also be noted in the case record. Before the child joins the MDCC to meet with various professionals and/or his/her parent(s), the Chairperson or investigating social worker needs to help him/her prepare psychologically and encourage him/her to speak up.

Post-Conference Management

Debriefing for the Family

11.66 Debriefing for parents and/or the child who have participated in MDCC is to be provided, as needed, so as to address their possible emotions after the MDCC and clarify any queries they may raise on the MDCC.

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

11.68 The Chairperson and the investigating social worker should decide between themselves who and when to conduct debriefing (preferably within 10 days after the MDCC).

Roles and Responsibility of "Key Worker" and "Core Group"

11.69 MDCC should appoint a key worker to follow up on the child protection case if such classified. Normally, FCPSU will take up the child protection case. If the original service unit shows its readiness to continue following up the case and members of MDCC deem it appropriate, the unit can continue taking up the role of a key worker for the child protection case.

11.70 The core group is formed by professionals who have significant roles in following up the case (on assisting the child or parents/carers). If member(s) of the core group has/have not joined the MDCC but will involve in the follow-up of the case or will provide services to the child/family, the social service unit in charge of the investigation or the follow-up should be responsible for inviting those professionals to join the core group.

11.71 The responsibilities of the key worker and core group members are:

(1) to implement the decisions of MDCC;

(2) to line up multi-disciplinary collaboration in implementing the follow-up plan concerning the child and his/her family and ensure that actions taken by the related parties are in line with the decisions of the MDCC (please refer to Chapter 12 of this Guide on details of follow-up services);

(3) to inform members of MDCC as soon as possible for discussion on the need to convene a review conference when knowing that the follow-up plan recommended by the MDCC cannot be implemented; and

(4) to keep close contact with each other to review the case progress, conduct risk assessment and adjust the follow-up plan. Core group members should discuss among themselves and decide on the method and timing of liaison, e.g. convening regular conference of which the parent(s)/child is/are invited to join.

Notes of MDCC

11.72 The notes of MDCC should include the following:

(1) the persons invited with attendance or absence;

(2) the family members invited, and if not, the reasons;

(3) points discussed and views shared including dissenting ones if significant; and;

(4) decisions made and the reasons (if applicable).

11.73 A proforma for notes of MDCC is at Appendix 2 to Annex 19 to this Guide for reference. Where application for an order under the PCJO or other Ordinance is required, the Magistrate or Judge should be informed of the decisions and recommendations of the MDCC through the Social Welfare Officer's Report submitted to the court. On certain occasions, the notes of MDCC will be submitted to the Magistrate or Judge by the social worker of SWD as ordered by the Court by invoking exemption under Section 60(B) of PD(P)O.

11.74 The draft notes of MDCC is to be sent to members for confirmation preferably within two weeks after the MDCC. Members may take the initiative to contact the unit which convened the MDCC/the Chairperson if they have not received the draft notes two weeks after the MDCC.

11.75 Members of MDCC should read and check the draft notes to ensure if their views are correctly and appropriately documented. The investigating social worker is advised to contact members of MDCC either when the draft notes is issued to make sure members have received it or when no reply is heard upon the deadline (e.g. one week after the issuance of the draft) to ascertain if there is any request for amendments.

11.76 The Chairperson should notify members of the confirmation of the draft notes (if no amendment is required) or issue the confirmed notes to all members (if amendment is required) no later than one month after the MDCC.

11.77 Please refer to Annex 2 to this Guide for handling requests made by the parent(s) of the child concerned under the PD(P)O for access to materials of MDCC.

Letter to Parents after MDCC

11.78 The supervisor of the unit convening the MDCC/the Chairperson should send a letter to the parents, whether they have attended the MDCC or not, stating the follow-up plan for the child and the family. The letter may need to be translated into the appropriate language to facilitate the parents' comprehension of the content. A sample letter is at Appendix 3 to Annex 19 to this Guide for reference.

Transfer of Case and Information

11.79 If it is decided in MDCC that the investigating social worker will not be the key worker and the latter is from another service unit, the investigating social worker should render immediate follow-up services as agreed in MDCC (e.g. waitlisting for residential child care services) before transferring the case to the follow-up unit.

11.80 With prior consent given by members in MDCC and on a need-to-know basis, relevant reports and the notes of MDCC may be sent to related professionals who are not members of MDCC but will provide services to the child/family members for the purpose of child protection.

11.81 To facilitate smooth case transfer, the investigating social worker should prepare relevant documents, including case summary, confirmed notes of MDCC, data input form of Child Protection Registry (if required) and inform the child and his/her family about the case transfer to the follow-up unit. The

incoming social worker should also take active steps to facilitate the case transfer.

11.82 If the case cannot be transferred out to the incoming social worker within one month after the MDCC, the investigating social worker should liaise with the incoming social worker on this matter and inform the members of MDCC in due course.

Case Review

11.83 Apart from convening a review conference as decided in MDCC, if there is new information coming up that has not been fully addressed to in the MDCC but will possibly affect the decision made or there is any follow-up actions required to be reviewed (e.g. a statutory order is recommended by MDCC but the Juvenile Court has not issued such order; residential child care service is recommended by MDCC but the parents/child reject(s) afterwards; treatment/support services significant to the child's safety and best interests is recommended by MDCC but the family member/child concerned rejects subsequently), the Chairperson, in consultation with all members of the MDCC, will decide whether to convene a review conference. In case the Chairperson and the key worker are not working in the same service unit, the supervisor of the key worker should be responsible for monitoring the implementation of the agreed follow-up plan and assessing the need to convene the review conference.

11.84 While there will be different issues requiring a review conference, if the issue concerns the investigation of the case, the review conference is to be convened by the unit of the investigating social worker. If the issue concerns the implementation of follow-up plan, the review conference is to be convened by the unit handling the case. Membership of the review conference should be confined to those professionals who have direct involvement in the investigation/handling of the case.

Report on Implementation of Follow-up Plan

11.85 The progress of implementation of follow-up plan may be included in the notes of MDCC as post-meeting notes. Subject to the need and agreement in MDCC, the key worker and/or relevant members of MDCC will report in writing in an agreed period of time (e.g. 3 months after the MDCC) the status of the implementation of the follow-up plan. The report should be concise and precise capturing only whether the follow-up plan has been implemented as recommended by MDCC and if there is any difficulty/change making the

follow-up plan not feasible, and whether a review/refinement of the follow-up plan is required. The sample report at Appendix 5 to this chapter may be used as appropriate.

Handling Complaint

11.86 In case the parent(s) (or the child(ren)) want(s) to lodge any complaints about the MDCC, they should be informed of the complaint procedures. For issues relating to the decision(s) of MDCC, the complaint should be handled by the Chairperson. If the Chairperson is not a staff member of the unit conducting child protection investigation, the complaint should then be handled by the unit conducting child protection investigation. If the issue concerns the follow-up plan which is to be considered by the Court under an application for a statutory order, the parents should be explained that the issue will be handled by the Court and they can express their views during court hearing.

11.87 The follow-up plan should still be carried out as far as practicable even when the parent(s) has/have lodged a complaint about the follow-up plan.

11.88 If there is new information provided by the parent(s) that has not been fully addressed to in the MDCC but will possibly affect the decision made, the supervisor of the investigating unit/Chairperson, in consultation with all members, may consider convening a review conference.

11.89 If the complaint is against the Chairperson or a particular member of the MDCC, the complaint should be made to the Chairperson or the respective organisation of that member, or be channelled to the organisation of the Chairperson or that member for handling.

11.90 For frequently asked questions regarding MDCC, please refer to Appendix 6 to this chapter.

Appendix 1 to Chapter 11

(Sample Letter for Reference)
(For Cases with MDCC not Conducted)

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

Dear Sir/Madam,

Child Protection Investigation and Follow-up Plan on Protection of Child with Suspected Maltreatment

Name :
Sex/Age :

Child protection investigation on the above-named child suspected to be maltreated has been conducted by this unit. It is recommended that the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment be not conducted as

- ☐ the number of units involved in the investigation are less than three.
- ☐ the alleged perpetrator is not a family member/relative of the child concerned or staff/carer/volunteer of an organisation who works with children.

Enclosed please find the Child Protection Investigation Report and a Reply Slip. You may refer to the Child Protection Investigation Report on the proposed nature of incident, risk/need assessment, category of case and follow-up plan. Please complete the Reply Slip and return to me by fax or email on or before (date)_____.

You may refer to paragraphs 11.5 to 11.8 and relevant content of Chapter 11 of the "Protecting Children from Maltreatment -- Procedural Guide for Multi-disciplinary Co-operation" for information.

For discussion, please contact me or the investigating social worker, (name) _____ on (tel. no.) _____.

Yours faithfully,

( )

**Delete as appropriate*

Encl.

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

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

Reply Slip
for Follow-up Plan on Protection of Child with Suspected Maltreatment

To : _____ (Fax No.: _____)
From :
Date : _____

Name of child :
Sex/Age :

I agree/do not agree/have reservation* to the suggestion of not conducting the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment for the above-named child.

For recommendations based on information collected from investigation, I have the following views:

- ☐ I agree to the proposed
  - ☐ nature of incident (police officer is not required to fill in this item)
  - ☐ risk/need assessment
  - ☐ category of case
  - ☐ follow-up plan

- ☐ I have the additional views: _____
_____

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

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

* Delete as appropriate

Appendix 2 to Chapter 11

(Sample for Reference)

Invitation Letter

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

Dear Sir/Madam,

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

Name :
Sex/Age :

You are cordially invited to attend a case conference on the above-named child suspected to be maltreated with details as follows:

Date :
Time :
Venue :

Attached please find the Agenda of the Conference. *(For general cases) The child's parent(s) will be invited to attend the second part of the conference when the initial follow-up plan has been formulated. If you have any concern or other views for re-consideration, please inform me as soon as possible. (For other arrangement on family participation) Regarding the arrangement of family participation, please refer to the recommendation stated in the attached Feedback Form for Family Participation. Please fill in the form and return to me by fax on or before _____.*

To facilitate fruitful and productive sharing on the nature of incident, category of the case and the follow-up plan of the child(ren) and his/her family, would all members please prepare ***written report*** on the child(ren) for reference of the case conference as far as practicable. You are encouraged to forward the reports to other members prior to the conference, or if needed, through the investigating social worker.

You may refer to Chapter 11 of the "Protecting Children from Maltreatment -- Procedural Guide for Multi-disciplinary Co-operation" for information on the case conference and Annex 2 on information sharing. *(For general cases) For the concerned case, consent from the data subject for the release of the required personal data is available for all members.*

(For cases where consent from data subject for the release of the required personal data is not available for certain organisation) For the concerned case, 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 reason (please specify):*

_____

However, the requested information is required for the purpose of [(refer to the wording of the exemption at relevant section of Part VIII of PDPO Cap. 486, e.g. S.58(1)(a) prevention and 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 individuals."] 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, it is considered 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. Member from_____ (organisation/department) is requested to consider as to whether the exemption quoted above is applicable for the release of the required personal data under the circumstances surrounding the formulation of follow-up plan for the child concerned in this conference.

If you have any views on the membership or agenda, please feel free to contact me or the investigating social worker, (name) _____ on (tel. no.) _____.

I look forward to seeing you in the conference.

Yours faithfully,

( )

**Delete as appropriate*
Encl.

Distribution ***(The list of members should be worked out on a case-by-case basis. The membership list below is for reference only.)***
Dr xxx, Senior Medical Officer/xxxxxx Hospital (Your Ref:)
Miss xxx, Nursing Officer/xxxxxx Hospital (Your Ref:)
Mr xxx, Medical Social Worker/xxxxxx Hospital (Your Ref:)
Mr xxx, Senior Inspector/xxxxx Police Station (Your Ref:)
Miss xxx, Teacher/xxxxx Primary School (Your Ref:)
Ms xxx, Social Work Officer/Family and Child Protective Services Unit (xx)

(Note: the content in italic is to be included in the letter as appropriate)

(Sample Agenda for Reference)

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

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

AGENDA

1. Introduction

2. Information sharing *(Order of sharing to be arranged on a case-by-case basis)*

(a) Report by investigating social worker

(b) Report by medical officer

(c) Report by medical social worker

(d) Report by nursing officer

(e) Report by police officer

(f) Report by school personnel

(g) Report by other professionals (e.g. social worker of other service units, clinical psychologist, etc.)

3. Discussion

(a) Nature of incident

(b) Risk of child maltreatment
  (i) on child concerned
  (ii) on other children of the family

(c) Category of case (whether it is a child protection case)

(d) Need of child concerned and his/her family

(e) The follow-up plan for the child and the family (including the safety plan)
  (i) Key worker/core group
  (ii) Care arrangement
  (iii) Need for statutory order

(iv) Other services (e.g. professional support services)

4. Any other business

(a) Need to register information of child/sibling(s) into Child Protection Registry

(b) Need for review conference

(c) Need for report on implementation of follow-up plan

(d) Other arrangements (e.g. arrangement for case transfer, ways of informing family of decisions of case conference if they have not attended)

(Note: The Chairperson, in consultation with members as appropriate, will decide at which time point the family members will join the case conference. The arrangement for meeting with family members may be different for individual cases.)

Appendix 3 to Chapter 11

(Sample for Reference)

Feedback Form for Family Participation in Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (For Special Arrangement Only)

Dear Sir/Madam,

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

I propose to make the following arrangement for the family participation *(please add other scenarios/amend the following scenarios as needed)*:

- ☐ to invite the child and *[the family member(s)]* of the child to join the case conference at *(the time point/agenda item)*
- ☐ not to invite the child and *[the family member(s)]* of the child to attend the case conference
- ☐ to arrange separate sessions for the parents/the child and parent(s)

The reason is _____
_____

The proposed arrangement is as follows:

_____
_____

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

( )_

Reply Slip

To : _____ (Fax No.: _____)
From :
Date : _____

Name of Child :
Date of Conference :

☐ I agree to the proposed arrangement of family participation in the case conference.

☐ I do not agree/have reservation* to the proposed arrangement because

_____

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

_____

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

* Delete as appropriate

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

英文本：

- "In accordance with Section 18(1) of the Personal Data (Privacy) Ordinance, Cap 486, ("the Ordinance"), the data subject or his/her relevant person on behalf of him/her may make a data access request for a copy of the data subject's personal data as contained in the reports and/or notes of MDCC. According to the Ordinance, a person with parental responsibility for a minor is the relevant person of that minor.
- In Section 2 of the Ordinance, a data user means a person who, either alone or jointly or in common with other persons, controls the collection, holding, processing or use of the data. Hence, besides those members/their organisations who have prepared relevant reports and notes of MDCC, other members/their organisations who keep the reports and notes of MDCC will also be regarded as the data users.
- Under Section 20(3)(d) of the Ordinance, if any member or his/her organisation controls the use of the data in such a way as to prohibit other members/their organisations (i.e. the non-controlling data user) from complying, either in whole or part, with such request, the member/organisation holding the data is permitted to refuse a data access request made by the data subject.
- If the data access is refused by us under this provision, the Ordinance requires us to inform the requestor of the name and address of the data user retaining control of the use of the data.
- Would all members please state whether you wish to retain control of the use of the information, advice, the reports and documents you provided at and to the meeting in such a way as to prohibit other members from complying with the data access request made under the Ordinance.

中文本：

- 根據《個人資料（私隱）條例》（第 486 章）（以下簡稱《條例》）第 18(1)條，資料當事人或代表資料當事人的有關人士可提出查閱資料要求，取得一份會議報告及／或記錄所載有關該資料當事人的個人資料複本。根據《條例》，就一名未成年人來說對該未成年人負有作為父母親的責任的人就是該未成年人的有關人士。

- 《條例》第 2 條訂明，資料使用者指獨自或聯同其他人或與其他人共同控制該資料的收集、持有、處理或使用的人，因此，除了負責撰寫有關報告或會議紀錄的成員／其機構外，其他持有該報告或會議紀錄的成員／其機構亦會被視為資料使用者。

- 根據《條例》第 20(3)(d)條，如有會議成員／其機構控制該等資料的使用，而控制的方式是禁止其他會議成員／其機構（即非控制該等資料的資料使用者）依從（完全依從或部分依從）查閱資料要求，則該持有資料的會議成員／其機構可拒絕依從資料當事人的查閱資料要求。

- 《條例》訂明，如我們根據這項條文拒絕查閱資料要求，我們須告知提出要求者控制資料使用的資料使用者的姓名（或名稱）及地址。

- 請各位表明是否控制你在會議上提供的資料及意見，以及向會議上提供的報告及文件的使用，而控制的方式是禁止其他資料使用者依從根據《條例》提出的查閱資料要求。

Appendix 5 to Chapter 11

(Sample for Reference)

Multi-disciplinary Case Conference on
Protection of Child with Suspected Maltreatment
Report on Implementation of Follow-up plan

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

Dear Sir/Madam,

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

The Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment for the child concerned has been held on *(date)*. The follow-up plan recommended includes the following immediate actions. This is to report to members on the implementation of such recommended actions *(the actions listed below are just examples and can be revised as needed)*:

(1) Referring child for residential placement
- ☐ waitlisted on *(date)*
- ☐ child has been admitted into (nature of placement) on (date)
- ☐ child refused to admit into the residential service unit subsequently

(2) Referring child for *psychological service/psychiatric service/other services (please specify)*
- ☐ waitlisted on (date)
- ☐ child has been offered the first appointment on (date)
- ☐ parents objected to the referral subsequently

(3) Application of care or protection order for child concerned

☐ application has been made to court on *(date)* pending *(court disposal on residential placement*)*

☐ order granted on *(date)*

☐ order not granted *(please specify reason)*

(4) Medical follow-up/urine test for toxicology

☐ medical follow-up/urine test for toxicology has been conducted on *(date)*

☐ result of medical follow-up/urine test for toxicology

☐ medical follow-up/urine test for toxicology not arranged *(please specify reason)*

(If applicable) As the follow-up plan is hard to be implemented, the following arrangement on follow-up plan is recommended:

☐

☐

(If applicable) Please let me have your view on the above suggested arrangement on the follow-up plan *(please state the method of implementation).*

Yours faithfully,

( )

Distribution

List of Members

Frequently Asked Questions about Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC)

1. What factors should be taken into consideration when determining whether an incident is child maltreatment in MDCC?

In MDCC, discussion on the nature of incident is from the perspective of protecting child's safety and safeguarding child's best interests. In determining whether an incident is child maltreatment, the responsible professionals should make assessment based on the merits of individual case and take into consideration various factors (e.g. the child's age, the behaviour of suspected maltreatment and its impacts on the child, etc.). Please also refer to Chapter 2 of this Guide.

2. Can MDCC make decision by voting rather than by consensus?

By consensus each member is given the opportunity to express and exchange his/her views with others. This is the basis of multi-disciplinary co-operation. This is particularly important as handling of cases involving child maltreatment and formulation of follow-up plan for the child(ren) are very delicate issues that should not be dealt with simply by voting.

3. Can the alleged perpetrator send his/her legal representative to attend MDCC or attend MDCC with his/her legal representative?

As the focus of MDCC is not on prosecution of the alleged perpetrator but a forum for professionals having a major role in the handling and investigation of a suspected child maltreatment case to share their information and concern on the child from the perspective of protecting child's safety and safeguarding child's best interests, it is not appropriate for the alleged perpetrator to send his/her legal representative to attend MDCC or attend MDCC with his/her legal representative.

4. Can the parent(s) or the child(ren) suspected to be maltreated ask their friends or relatives to accompany them during MDCC?

Subject to the consent of members of MDCC, significant family members and relatives who have sound knowledge of the child(ren) and would be contributive to the formulation of follow-up plan of the child(ren) can also be invited to attend MDCC.

5. Can the parent(s) send a representative to attend MDCC if they cannot attend themselves?

A direct communication between parent(s) and members of MDCC is preferred. If the parent(s) is/are unable to attend MDCC, members of MDCC will discuss the ways to inform parent(s) of the decisions of MDCC and receive feedback from the latter. A representative of parent(s) will not be allowed to attend MDCC to protect the privacy of the child and other persons concerned.

6. Can the parent/family member/child concerned object the attendance of another parent in MDCC?

Parents (no matter whether any of them is the alleged perpetrator) will usually be invited to join the second part of MDCC to discuss the follow-up plan for the child and family. The purpose is to enhance their understanding of the issues of concern, allow them to give views on the formulation of the follow-up plan and enlist their involvement in the implementation of the follow-up plan. However, as the best interests of the child should always be the paramount concern of MDCC, if the parent's presence may seriously prejudice the best interests of the child, or there is sufficient evidence that a parent may behave in such a way as to interfere seriously with the work of the conference such as violence, threats of violence, etc. or the parent is in an unfit state (e.g. because of drug, alcohol consumption or acute mental health difficulty) making him/her unable to join the discussion effectively, this parent will not be invited to attend MDCC. Views of another parent (including the non-custodial parent)/family member/the child concerned will be considered based on the above principle.

7. Can prospective adoptive parents attend MDCC?

Prospective adoptive parents, who have been taking care of the child concerned, can also be invited to attend MDCC, if deemed appropriate.

8. Can the case been transferred to the follow-up unit before confirmation of notes of MDCC?

In principle, the investigating social worker should prepare relevant documents, including case summary and confirmed notes of MDCC, before transferring the case to the follow-up unit. As urgent actions may be required to be taken by the follow-up social worker in certain cases and for the benefit of the child/family, subject to decision in MDCC or mutual agreement between two service units, flexibility is to be allowed for earlier transfer of the case or for the

outgoing/incoming social workers to work jointly during the transitional period before the notes of MDCC is confirmed.

9. Can the parents request to tape-record MDCC during his/her participation in MDCC?

The focus of MDCC is on protecting the child's safety and safeguarding the child's best interests. It is also a forum for professionals to share their information and concern on the child. A direct communication between the parent(s) and members of MDCC is preferred to enhance their understanding of the issues of concern. Should the parent(s) initiate(s) request for tape-recording, it should be handled before the MDCC, including seeking the consent of members of the MDCC and significant family members.

While the PD(P)O does not contain any provision prohibiting members of MDCC from turning down or requiring members to turn down the parent's request for tape-recording MDCC, whether or not it is appropriate to allow the parent(s) to tape-recording MDCC is a matter for members to decide having regard to the best interests of the child. In this regard, members should find out the reasons for the parent's request and whether the request can be met by other alternative arrangements, such as providing the parent(s) with written information including listing the outcomes of MDCC.

Members should also note that the discussion in MDCC will possibly contain personal data of individuals other than the data subjects. Prescribed consent of these individuals must be obtained beforehand for disclosing their personal data at MDCC if the purpose of the parent's tape-recording does not fall within the original purpose of collection or its directly related purpose. If such prescribed consent cannot be obtained, members should not disclose the personal data of these individuals in MDCC, and the parent should be clearly informed of this before MDCC.

If the request for tape-recording by the parent(s) is to be acceded to, members should also consider whether there is a need to tape-record the meeting as a proof in case the parent(s) take(s) certain parts of the recordings out of context or tampers with the recordings.

Chapter 12 Follow-up Services on Child Protection Cases

12.1 After conducting investigations of a suspected child maltreatment incident, the key worker, core group members (if applicable) and other related professionals should implement the proposed follow-up plan according to the recommendations of the Multi-disciplinary Case Conference on Protection of Child with Suspected Maltreatment (MDCC) (or the outcome of discussions among professionals if MDCC is dispensed with). They shall also liaise with each other, take into account the circumstances of the family as a whole, make continuous assessment of the risk of harm to the child and the needs of the child/his/her family, with a view to protecting the child from being harmed while providing assistance to the family and the significant others of the child.

12.2 Family members and the child should be empowered to take part in the implementation of the child protection plan as far as possible and to make use of family resources and support from the community, with a view to achieving the following objectives:

(1) To reduce or eradicate the risk of harm to the child; and

(2) To enhance the family's functions and their capability in childcare and parenting so that the family can assume full responsibility to protect the physical and psychological safety of the child.

12.3 If the child needs temporary residential child care service, a permanency plan should be drawn up as early as possible, including consideration of whether and when the child is suitable for returning to the care of his/her family/relatives.

12.4 Besides the need to protecting the physical and psychological safety of the child, during the follow-up process, the follow-up personnel should facilitate the parents to understand and take care of the various needs of the child in respect of his/her developmental stages, so that the child can grow and develop safely and healthily in physical, psychological and social aspects.

Registration at the Child Protection Registry

12.5 The social worker who conducts child protection investigation into the suspected child maltreatment incident should send the particulars of the child and the case information to the Child Protection Registry (CPR) for registration in accordance with the recommendation of the MDCC (introductory remarks relating to the CPR, including consideration of invoking exemption to obtain the data subject's consent for transfer of case data, and the data input forms are at Annex 14 to this Guide). Prompt updates by the key worker are required if some information has to be inputted upon implementation of the follow-up plan (the Case Updating Form is at Annex 14 to this Guide).

Care Proceedings

12.6 If the child is assessed to be in need of statutory protection during MDCC or the case follow-up process, application for an order should be made by the social worker of SWD according to appropriate Section(s) of the Protection of Children and Juveniles Ordinance, Cap. 213 (PCJO). Please refer to Annex 15 to this Guide for relevant provisions of the PCJO. In general, if the application is made immediately after the MDCC and the child protection investigation is conducted by a service unit of SWD, the unit will undertake the application and handle the care proceedings. If the child protection investigation is conducted by a service unit of a non-governmental organisation, the service unit of SWD which is following up the case will apply for and execute the order of the Juvenile Court.

12.7 Apart from furnishing a child protection investigation report to the Juvenile Court, the social worker of SWD shall submit the reports or notes of the MDCC as may be required by the Magistrate.

12.8 Article 37(d) of the United Nations Convention on the Rights of the Child states that, among others, "Every child deprived of his/her liberty shall have the right to prompt access to legal and other appropriate assistance". To this end, the Duty Lawyer Service has been commissioned to run the Legal Representation Scheme for children or juveniles involved in care or protection proceedings. The Scheme will provide legal assistance to any child or juvenile in need of care or protection and who is:

(1) deprived of his/her liberty and detained in a gazetted place of refuge under Section 34E of the PCJO; or

(2) taken to the Juvenile Court directly by the Police for the application of Care or Protection Order, without any period of detention at a gazetted place of refuge before court hearing; or

(3) likely to be detained in a gazetted place of refuge on the recommendation of a social worker of SWD.

12.9 If the child in need of statutory protection is also in need of residential child care service, arrangement should be made as soon as possible with relevant order granted by the Juvenile Court.

12.10 Pursuant to the terms of the court order and other recommendations of the MDCC, the key worker shall continue to provide appropriate assistance to the child and his/her family, e.g. casework and/or group counselling, clinical psychological service, residential child care service, medical/rehabilitation service, education service and tangible/financial assistance, etc. Home visits and personal contacts with the child and his/her family should continue to be made.

Injunction Order in relation to Domestic Violence

12.11 Under the Domestic and Cohabitation Relationships Violence Ordinance (DCRVO), Cap. 189, where a party (i.e. spouse/former spouse/partner/former partner) to a marriage/cohabitation relationship makes an application to the District Court or the Court of First Instance, the Court may grant an injunction which either:

(1) restrains the other party from using violence against the applicant or a child living with the applicant; or

(2) excludes the other party from the residence or from a specified part of the residence or from a specified area.

Voluntary Follow-up Service Received

12.12 If the invocation of the PCJO or the DCRVO is considered not necessary for the case handling, the key worker and core group appointed by the MDCC member, and other professionals should follow up on the case according to the recommendations of the MDCC and the actual circumstances of the case to provide the child and his/her family with necessary services, e.g. casework and/or group counselling, clinical psychological service, residential care service, medical/rehabilitation service, education service and tangible/financial assistance, etc.

Close Collaboration among Follow-up Personnel

12.13 Parties providing follow-up services to the child and his/her family should work closely together and share information on the significant development of the case (e.g. when the court order is made/amended/expired, terms of the order, living arrangement of child, etc.).

12.14 Depending on the development of the case, core group members (if any) will be changed and updated regularly. Members may discuss among themselves the ways of jointly reviewing the case progress (e.g. whether regular conferences should be held and written reports be prepared to review the case progress). During the case follow-up process, the key worker may invite other professionals to join the core group as necessary. Original members may however withdraw from the group upon service termination. If any core group member has not participated in the MDCC but need to obtain documents and notes of MDCC, he/she may approach the key worker who will assist in consulting members of the MDCC whether they agree to provide the information to that member of the core group.

12.15 During the follow-up period, if parties providing follow-up services encounter any difficulties (e.g. inability to implement certain follow-up items, failure to reach the child or parents, etc.) and discover that the risk of harm/maltreatment to the child increases, they should inform other follow-up personnel as soon as possible and discuss the arrangements to be made.

12.16 If the case involved parent(s)/carer(s) having drug/alcohol abuse problem, and the key worker or any follow-up personnel suspects that the child might have been exposed to dangerous drug or equipment for taking drugs and might very likely have inhaled/been exposed to the suspected dangerous drug, the follow-up personnel may discuss with paediatrician the need to arrange the child to receive medical examination, including urine test on toxicology.

Victim Management before Court Hearing and Pre-trial Counselling Service

12.17 Upon completion of investigations on child maltreatment incidents, Department of Justice will bring prosecution against some cases and the child may be summoned to a court hearing. In the period following an investigation and prior to any court hearing, continued contacts should be maintained with the child and the family by the key worker and police investigators, so as to keep them informed of the progress of the investigation and to prepare the child witness for attendance in court. Information packages for the child witness

and his/her parents/carers may be used during the preparation. If permission is granted from the court, witness support service should be arranged for the child witness (please refer to Annex 20 to this Guide).

12.18 The following items should be avoided by the follow-up personnel before the trial:

(1) mentioning the details of the investigative interview;
(2) mentioning the details of the maltreatment incident
- what happened?
- who did it?
- when did it happen?
- where did it happen?
(3) the use of any materials which suggest or presume that maltreatment has taken place.

12.19 The personnel who provide counselling or therapeutic treatment may have to give evidence in court. All the records of interviews/visits/contacts should be kept properly.

12.20 Please refer to Annex 21 to this Guide when it is necessary to provide the child with counselling service or therapeutic treatment before the trial. During the counselling or therapeutic treatment, if the child gives inconsistent information on the maltreatment incident or need to provide supplementary information, the follow-up personnel should pay attention to the following:

(1) remind the child the need to tell the truth;
(2) encourage the child to disclose the information to the Police; and
(3) consider taking various appropriate actions to safeguard the child's best interests if affected.

Psychological Assessment and Counselling/Treatment

12.21 All forms of child maltreatment may have long-term negative impact on the emotional development and mental health of the child having been maltreated. Their family members (including the perpetrator) may also be distressed or in need of psychological services. For psychological treatment services after maltreatment, please refer to Annex 21 to this Guide.

12.22 Even if the incident does not appear to have great impact on the child and his/her family, the key worker may consider, upon completion of investigations, obtaining consent from the child and his/her parents and

referring them to receive assessment from clinical psychologist(s). The clinical psychologist should provide appropriate advice, and may be also with therapy, according to the needs of the cases so as to reduce the harmful effect(s) of the incident on the child and his/her family and assist them in rebuilding family relationship, etc.

12.23 Personnel should be aware that counselling/treatment often enables a child to reveal further incident(s) or related information about the maltreatment which may result in a subsequent prosecution. Therefore, the counselling/treatment records should be documented and kept properly.

Residential Child Care Service and Follow-up on Permanency Plan

12.24 Children have to grow up in a safe and stable relationship and environment. The follow-up personnel should make use of the resources and support network of the family members as long as it is feasible and safe to do so, so that the child will be placed under the care of appropriate family members/relatives as far as possible.

12.25 If the child needs temporary residential child care service (including cases ordered by the court or admitted voluntarily) on account of his/her high risk of being harmed/maltreated or particular difficulties faced by his/her family, the follow-up personnel should fully consider the physical and psychological health, development, behaviour and emotional status of the child (including the impact of the experience of being harmed/maltreated on the child, the experience of receiving residential child care service, etc.). They should also approach the organisations/units applied for providing residential child care service for details so as to ensure that the service nature, the care, support and treatment, etc. provided by the unit can meet the child's needs.

12.26 The children in need of residential child care services resulted from harm/maltreatment are usually negatively affected in their emotional development and psychological health. Besides making preparation and assisting the child and his/her parents to accept the related residential arrangement before admission, the key worker should, during the child's stay, keep continued contact with the child and his family and to render due support, especially on assisting the family in enhancing their capability in childcare and child discipline, so as to improve the family and parent-child relationships.

12.27 In general, the child should not receive residential child care service for an excessively long period of time or have frequent change of the residential care

service unit/carer. Personnel should draw up a permanency plan for the child as soon as possible (please refer to Appendix 1 to Chapter 8 of this Guide for details). If the risk of harm to the child has been reduced or eradicated and the capability of the family in the childcare and parenting has been enhanced (please refer to Chapter 7, "Risk Assessment and Decision Making on Protecting the Safety of Children", of this Guide), arrangement should be made gradually for the child to return to the care of his/her family/relatives.

12.28 Related professionals should communicate with each other and review the case progress. Review conferences should be held regularly for the child receiving residential child care service. If members of the MDCC or the core group have made recommendations on the case review arrangement, they should regularly communicate and share information on the case accordingly.

12.29 For cases where the child's parent(s)/carer(s) has/have drug/alcohol abuse problem, personnel should regularly review the progress of their drug/alcohol abstinence and assess their capability in childcare.

12.30 The following areas have to be observed in considering the reunion of the child receiving residential child care service with his/her family:

(1) The child's family members (especially the one who has harmed/is suspected of having harmed the child) understand the harm and consequences of their harmful/maltreating behaviour on the child and have made improvement in childcare, child discipline and interacting with the child. Risk of further harm/maltreatment on the child has been reduced. Positive and safe parent/child/siblings relationship has been established before a child is returned to the family.

(2) The preparation and level of acceptance of the family members towards the return of the child must be carefully monitored and observed.

(3) Family reunion should be tried out in stages: considering the physical and psychological safety of the child, arrangement should first be made for the parents/siblings to contact the child (including supervised and non-supervised contacts), such as by telephone, video calls, visits, spending holidays away from home with the child, then letting the child return home to spend the weekends and holidays with their parents, etc..

(4) Before arranging for contact between the child and his/her family members and his/her actual return to the family, discussions should be

held with core group members following up the case (if any) and opinions from related parties may be sought as appropriate. Parties which are still actively involved in the follow-up should also be informed of the progress on reunion of the child to the family.

(5) Even if the initial reaction from the family members is satisfactory after the return of the child, regular visits and contacts to the child by the key worker should be maintained. Continuous assessment on the adaptability of the child/family members and the risk of further harm/maltreatment to the child should also be made.

(6) Throughout the follow-up process, the key worker should regularly review the case progress and the permanency plan of the child with his/her supervisor, core group members (if any) and other relevant parties of the child or his/her family.

(7) For cases where the child's parent(s)/carer(s) has/have drug/alcohol abuse problem, before discharging the child from residential child care service, the follow-up personnel should make sure that the person who is responsible for taking care of the child does not have drug/alcohol abuse problem or has already abstained from drug/alcohol, or to make sure that the child will at all times be taken care of by at least one adult carer who is not affected by any drug/alcohol and is capable of child care. At the same time, the carer should also ensure that the child will not be exposed to any suspected dangerous drugs or equipment for taking drugs and should be able to safeguard that the child can obtain basic care.

12.31 The key worker and other follow-up personnel shall pay continuous attention to the child receiving residential child care service. If it is assessed that the child has a dim chance of family reunion in the long term, other appropriate permanency plans, including adoption, should be considered and arranged expeditiously (personnel should make reference to Appendix 1 to Chapter 8 of this Guide on Making Decisions in Child Care Based on the Permanency Planning Approach).

Recurrence of Suspected Child Maltreatment Incident(s)

12.32 If the personnel identifies that the child may be at risk of recurrent harm/maltreatment (regardless of whether the child is harmed by the same person) in the course of implementing the follow-up plan, he/she should notify the key worker as soon as possible. The key worker should conduct an

initial assessment as stipulated in the procedures of this Guide. If there are reasons to believe/suspect that the child has been harmed/maltreated, necessary investigations should be conducted and MDCC should be convened to review and assess the situation of the child and his/her family, adjust the follow-up plan, and enhance the protection of the child and the support for the child and his/her family.

Chapter 13 Handling of Child Maltreatment Allegations against Staff, Carers and Volunteers of Organisations

13.1 Organisations should formulate relevant child protection policies, measures and handling procedures according to the content as stipulated in this Guide so as to prevent child maltreatment incidents and for due handling of suspected child maltreatment cases, with a view to protecting the safety and best interests of children, including assigning designated personnel to handle suspected child maltreatment incidents, providing staff with relevant training, checking whether eligible applicants have any criminal conviction records against a specified list of sexual offences when making recruitment on child-related work and work relating to mentally incapacitated persons (MIPs).

13.2 Organisations are also responsible for ensuring that their staff, foster parents, child carers or volunteers comply with their codes of conduct in their service delivery to children.

Scope of Concern

13.3 This Chapter applies to the following situations:

(1) where there is suspicion or allegation of maltreatment by a person who works with children (in either a paid or unpaid capacity), including employee, foster parent, child carer, or volunteer (i.e. any person whose appointment is recognised by the organisation).

(2) when the allegation or suspicion of child maltreatment arises in connection with the encounter of the above person with the child.

Principles in Handling Child Maltreatment Allegations against Staff, Carers and Volunteers

13.4 When a staff member of an organisation suspects another staff member or a child carer/foster parent/volunteer under the purview of the same organisation maltreating a child, or receives child maltreatment allegations against the above person, he/she must report the incident to the supervisory/management personnel. A report should also be made to the governing institution of the organisation if it is so required.

13.5 If the organisation has reasons to believe/suspect that the child was/is under maltreatment, a report shall be made as soon as possible to the appropriate unit according to the procedures as set out in Chapter 4 of this Guide so as to

facilitate initial assessment and subsequent investigation procedures as necessary. If the responsible social worker handling the case of the child/family belongs to the same unit as that of the alleged perpetrator, it is not suitable for the social worker of the unit to conduct child protection investigation. If the child/family is a case known to another unit of the same organisation or another organisation, the social worker of the unit where the incident occurred should report the incident to the other unit/organisation and that unit/organisation will conduct child protection investigation. If the child/family has not received any casework service from other units, the social worker may report the case to a Family and Child Protective Services Unit of the Social Welfare Department.

13.6 Upon receipt of a report or allegation of the above suspected child maltreatment, the supervisory/management personnel of the organisation shall first take the appropriate actions/steps to ensure the immediate safety, health and well-being of the child and other children possibly affected, and also ensure that the child protection policies and procedures of the organisation have been complied with. If the physical and health conditions of the child require urgent attention, arrangements should be made for the child to receive medical examination/treatment in a hospital under the Hospital Authority (please refer to Chapter 6, "Immediate Child Protection Actions", of this Guide for details).

13.7 The organisation should assign suitable personnel to take the necessary child protection action(s) and should notify without delay the child's guardian(s)/parent(s)/family/relative(s) about the progress of such actions and the safety of the child under circumstances that will not pose further harm to the child.

13.8 In circumstances that suggest a criminal offence may have been committed, the case should be reported to the Police by the organisation, the unit responsible for child protection investigation or other persons having assisted the child during the process, so as to safeguard the safety and interests of the child concerned and other children as appropriate (please refer to paragraphs 10.2 to 10.8 of Chapter 10 for the procedures in making report to the Police). In the event of failure to obtain consent from the parent(s)/guardian(s) of the child suspected to have been maltreated, actions may be taken pursuant to stipulations in Section 58 of the Personal Data (Privacy) Ordinance, Cap. 486 (see Annex 2 to this Guide).

13.9 The organisation should appoint suitable personnel (designated personnel) to maintain close liaison with the investigating personnel concerned so as to facilitate investigations and take appropriate follow-up actions.

13.10 Any disciplinary proceedings must be clearly separated from child protection investigations. Child protection investigations should take priority over any disciplinary investigations.

13.11 During the investigation process, the organisation should maintain its impartiality and avoid any conflict in interests/roles. The organisation personnel should not reach any private agreement of compromise with the staff/carer/volunteer involved, such as agreeing to terminate relevant investigations if the staff involved agrees to resign.

13.12 During the process of disciplinary investigations, the organisation should avoid meeting with the child or other children concerned repeatedly. At the same time, the organisation should adopt suitable administrative measures to suspend any contact with or care for the child and other children (if applicable) by the staff/carer/volunteer involved, so as to facilitate investigations and prevent the child concerned and other children from harm.

13.13 Investigations must be conducted in the strictest confidence so that information can be given freely by staff/volunteer, etc. of the organisation without fear of punishment or revenge and in a way that ensure fair treatment of the staff/carer/volunteer alleged of child maltreatment.

13.14 Information about an allegation of child maltreatment must be restricted to those who have a need to know in order to:

(1) protect the child(ren);

(2) facilitate investigations;

(3) manage matters relating to discipline/complaints; and

(4) ensure that the alleged perpetrator obtain appropriate assistance and fair treatment from the relevant organisation/individual(s).

13.15 Even when there is insufficient evidence to support a criminal offence (with or without proceedings initiated), the organisation should still proceed with relevant complaint, regulatory or disciplinary procedures.

Handling of Unsubstantiated/Not Established Allegations

13.16 Where there is insufficient evidence following initial assessment to substantiate the allegation, or where the allegation is found to be not established following child protection investigation, the outcome of assessment/investigation should be recorded.

13.17 The organisation receiving the report/allegation of child maltreatment must notify the staff/carer/foster parent/volunteer alleged of child maltreatment of the outcome of investigations.

13.18 Consideration should be given to any support the staff/carer/foster parent/volunteer may need, particularly if returning to his/her work post after suspension (if any).

13.19 The organisation should take full account of the child's needs and provide support or counselling for the child and his/her guardian(s)/parent(s) (where appropriate) if the child maltreatment allegation is found to be not established. Suitable measures should also be taken regarding the circumstances of the organisation so as to prevent the occurrence of child maltreatment.

13.20 The designated personnel of the organisation should also inform the staff conducting disciplinary proceedings of the results of the investigations, so that the latter may follow it up according to the policies and procedures of complaints handling of the organisation.