

**立法會**  
***Legislative Council***

LC Paper No. CB(2)2054/15-16  
(These minutes have been  
seen by the Administration)

Ref : CB2/PL/WS

**Panel on Welfare Services**

**Minutes of special meeting  
held on Saturday, 28 May 2016, at 9:00 am  
in Conference Room 2 of the Legislative Council Complex**

**Members present** : Hon CHEUNG Kwok-che (Chairman)  
Hon CHAN Yuen-han, SBS, JP (Deputy Chairman)  
Hon LEUNG Yiu-chung  
Hon Alan LEONG Kah-kit, SC  
Hon LEUNG Kwok-hung  
Hon Frankie YICK Chi-ming, JP  
Hon Gary FAN Kwok-wai  
Hon CHAN Chi-chuen  
Dr Hon Fernando CHEUNG Chiu-hung  
Hon POON Siu-ping, BBS, MH  
Hon TANG Ka-piu, JP

**Members absent** : Hon Albert HO Chun-yan  
Hon Frederick FUNG Kin-kee, SBS, JP  
Dr Hon LEUNG Ka-lau  
Hon YIU Si-wing, BBS  
Hon LEUNG Che-cheung, BBS, MH, JP  
Dr Hon Helena WONG Pik-wan  
Hon CHUNG Kwok-pan  
Hon Alvin YEUNG Ngok-kiu

**Public Officers attending : Item I**

Mr FUNG Man-chung  
Assistant Director (Family and Child Welfare)  
Social Welfare Department

Ms Annisa MA Sau-ching  
Chief Social Work Officer (Domestic Violence)  
Social Welfare Department

Mr LAM Bing-chun  
Chief Social Work Officer (Rehabilitation and Medical  
Social Services)<sup>1</sup>  
Social Welfare Department

Mr Herman HUI Chung-shing, SBS, MH, JP  
Chairman  
Child Fatality Review Panel

Mr TANG Ping-ming  
Assistant Commissioner (Rehabilitation)  
Correctional Services Department

Ms CHIK Shun-kwan  
Head of Consumer Protection Bureau  
Customs and Excise Department

Ms Kitty HO Kit-wah  
Principal Inspector (Guidance & Discipline)  
Education Bureau

Mr CHENG Sui-on  
Senior Divisional Officer (Support)  
Fire Services Department

Dr Tina CHAN Siu-mui  
Assistant Director (Health Administration & Planning)  
Department of Health

Mr Fred CHAN Wai-cheung  
Senior Manager (Patient Safety & Risk Management)  
Hospital Authority Head Office

Mr George NGAN Siu-ming  
Chief Leisure Manager (Aquatic Venues)  
Leisure and Cultural Services Department

**Attendance by  
invitation** : Item I

PathFinders Limited

Ms Mabiriizi, Ruth  
Senior Social Worker

Save the Children Hong Kong

Ms Chine CHAN  
Program Manager

Hong Kong Committee on Children's Rights

Dr CHOW Chun-bong  
Chairman

Against Child Abuse

Ms HAU Yuet-king  
Assistant Director

Dr Patricia IP

The Hong Kong Council of Social Service

Ms Dora NGAN  
Officer (SVD, CY)

Ms WONG Wai-yuk

Gilt Chambers

Mr Azan Aziz Marwah  
Barrister-at-Law

Baskerville Chambers

Mr Shaphan Habib Marwah  
Barrister-at-Law

Civic Party

Mr Henry SIN

Miss Luna CHAN

Ms Angela LEE

Ms Priscilla TSANG

Ms Darcy Davison Roberts

**Clerk in attendance** : Mr Colin CHUI  
Chief Council Secretary (2) 4

**Staff in attendance** : Miss Kay CHU  
Council Secretary (2) 4

Miss Maggie CHIU  
Legislative Assistant (2) 4

Ms Ada TANG  
Clerical Assistant (2) 4

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- I. Discussions on mechanism for handling abuse cases relating to children from high risk families and follow-up to the Child Fatality Review Report**  
[LC Paper Nos. CB(2)421/15-16(07), CB(2)1276/15-16(01), CB(2)1556/15-16(01) to (09), CB(2)1557/15-16(01), CB(2)1588/15-16(01) to (03), CB(2)1612/15-16(01) and CB(2)1627/15-16(01) to (03)]

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At the invitation of the Chairman, Assistant Director (Family and Child Welfare) ("AD(Family and Child Welfare)") briefed members on the mechanism for handling abuse cases relating to children from high risk families ("the Mechanism") and various support services for abused children and their families.

2. The Chairman invited the deputations/individuals to present their views. A total of 14 deputations/individuals expressed their views which were summarized in the **Appendix**.

The Administration's response to deputations' views

3. AD(Family and Child Welfare) thanked the deputations/individuals for their views. He briefed members and deputations on the Administration's continuous efforts in enhancing the Mechanism as set out in its paper (i.e. paragraphs 14, 15, 21 and 26 to 28 of LC Paper No. CB(2)1556/15-16(01)). He added that the Administration had commenced the review of the Child Protection Registry ("CPR") since April 2016, and would invite the non-governmental organizations concerned and other stakeholders to give views in this regard. As to some members' concern about whether the Administration would review child serious injuries cases, he advised that the Administration had started a preliminary discussion with some stakeholders over the issue, and planned to set up a task group to follow up and collect more views from stakeholders. He reassured members and deputations that the Administration would continue to examine and enhance its work on child protection.

4. Mr Herman HUI, Chairman of the Child Fatality Review Panel ("CFRP"), said that CFRP was responsible for the review of child death cases, with a view to making recommendations to enhance the existing system instead of attributing responsibility to the parties concerned. Sharing some deputations' concern about child safety and welfare in Hong Kong, he advised that CFRP had grave concern about the death case of YEUNG Chi-wai (a five-year-old boy with intellectual disability who was poisoned by direct ingestion of crystal methamphetamine) ("the YEUNG's death case"). To facilitate the review of the YEUNG's death case, CFRP had already obtained relevant information from the Coroner's Court upon the completion of the death inquiry procedures, and had required the bureaux/departments ("B/Ds") and service organizations concerned to provide the necessary information under their respective purviews. CFRP, which comprised 17 non-official members from different sectors, would specially examine the YEUNG's death case in detail from various

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perspectives with an aim to identify improvement areas in the existing system and avoid recurrence of similar cases. The review findings and recommendations would be reported as appropriate.

Discussion

*Implementation of recommendations made by Child Fatality Review Panel*

5. Whilst appreciating that CFRP would specially examine the YEUNG's death case, Dr Fernando CHEUNG said that the findings of the review of child death cases conducted by CFRP were generally lagged behind by four to five years. He was also concerned that the recommendations made by CFRP, which rarely touched on how to reform the existing system for child protection, were not implemented by some B/Ds. Mr Herman HUI reiterated that CFRP was tasked to review child death cases and make recommendations for the prevention of avoidable child fatality. It would keep in view the implementation of its recommendations with the concerned B/Ds on the progress of any improvement measures and share these with the public in its reports for encouraging multi-disciplinary collaboration and continuous service improvement.

6. Mr TANG Ka-piu declared that his family members were carers of children from high risk families. He said that in some of their responses to the recommendations of CFRP, the relevant government departments had considered that the responsible parties should be regulated but had not suggested any improvements on their part. In his view, the Social Welfare Department ("SWD") should have arranged an accommodation for YEUNG Chi-wai when he was assessed to be unsuitable to live at home. He wondered why SWD had not taken any actions in this regard.

7. AD(Family and Child Welfare) responded that the YEUNG's death case had not yet been reviewed by CFRP. The Administration would actively follow up CFRP's recommendations to the YEUNG's death case on completion of the review. He further said that the YEUNG's case was handled by a non-governmental organization and a multi-disciplinary case conference on child abuse ("MDCC") was conducted arising from a suspected child abuse incident. The case was concluded as a child neglect at the MDCC and it was recommended to be followed up by the Family and Child Protective Services Unit ("FCPSU") under SWD. The case was transferred to FCPSU within one month after the MDCC. After taking up the case for two days by FCPSU, YEUNG Chi-wai was found dead. The FCPSU caseworker was actively following up the case of YEUNG Chi-wai's

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family.

*Inadequacies of mechanism for handling abuse cases relating to children from high risk families*

8. Mr Alan LEONG opined that children from high risk families were not adequately protected because of the poor governance of the Government, rigidity of the existing system and inadequate collaboration among B/Ds. Although the mechanism for reviewing child death cases had been in place for eight years, it failed to prevent the YEUNG's death case. He wondered whether the Administration's inability to forestall the occurrence of the YEUNG's death case was due to lack of commitment, obliviousness of the relevant B/Ds or inadequate resources.

9. AD(Family and Child Welfare) responded that the Administration had increased the resources for provision of social welfare services by several folds in the past eight years and the staffing provision for FCPSUs had almost doubled over the past 10 years. The Administration would continue its publicity campaign and public education to raise public awareness of the importance of family cohesion and prevention of domestic violence. Joint efforts from CFRP, the Administration and the community were necessary to give better results in preventing child death cases. Mr Alan LEONG was of the view that the aforesaid measures could not address the problem of child abuse in high risk families. The Chairman opined that relevant legislation should be made if public education was ineffective in preventing child abuse cases.

10. Expressing sadness over YEUNG's death, the Deputy Chairman said that inadequacies of the Mechanism and support services for victims of abuse cases had all along been the concern of the Legislative Council ("LegCo"), and several case conferences were convened to discuss individual cases. The Administration, however, did not take concrete measures to address the problems such as inadequate supply of residential child care services. To prevent the recurrence of tragedies, she urged the Administration to review the Mechanism. She also suggested that the Administration engage the community for providing safety shelters for children at risk of abuse. Mr TANG Ka-piu asked whether SWD had drawn up any plans in this regard.

11. Mr LEUNG Yiu-chung said that in responding to deputations' views, the Administration had given the impression that it had perceived child protection as welfare services for children rather than children's rights. He wondered whether the deficiencies in the existing system stemmed from the

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Administration's perspective on child protection. AD(Family and Child Welfare) responded that the Administration had always regarded rights of survival and equal rights for all the core values of society. In handling cases relating to children from high risk families, frontline caseworkers had due respect for children's rights and the best interests of the children were of paramount concern.

12. Mr POON Siu-ping enquired about the arrangements and target participants of the training courses on handling suspected child abuse cases and ways to identify and handle high risk child welfare cases in the light of observations from child death cases, which were mentioned in the Administration's paper (i.e. paragraph 28 of LC Paper No. CB(2)1556/15-16(01)). AD(Family and Child Welfare) responded that these training courses would mainly be provided for frontline caseworkers. An experienced member of CFRP would be invited to share his observations from child death cases with frontline caseworkers in due course.

13. Mr LEUNG Kwok-hung urged the Administration to strengthen the manpower of FCPSUs in view of its strong fiscal reserve. In addition, he said that the authority of MDCC should be enhanced and a high-level official should be accountable to MDCC, so as to ensure that the implementation of the welfare plans recommended by MDCC could be facilitated and appropriate services could be provided for the children concerned to protect their well-being. In response, AD(Family and Child Welfare) briefed members on how the decisions of MDCC in respect of individual child abuse cases would be followed up by the designated case managers as set out in the Administration's paper (i.e. paragraphs 20 and 21 of LC Paper No. CB(2)1556/15-16(01)).

14. In response to Mr LEUNG Yiu-chung's enquiry about the decision of MDCC on YEUNG Chi-wai's care arrangement before the tragedy occurred, AD(Family and Child Welfare) said that out-of-home arrangement was one of the options considered by MDCC. MDCC had also considered the risk factors and concluded that it was suitable for YEUNG Chi-wai to be restored home temporarily pending the arrangement of residential care.

15. Mr CHAN Chi-chuen said that MDCC had classified the YEUNG's case a high risk case and recommended that YEUNG Chi-wai should be admitted to a home for mentally handicapped children ("HMHC"). Unfortunately, there was no vacancy in these homes before the tragedy occurred. He enquired whether there were cases in which at-risk children had to stay home because no place was available in residential child care facilities and the Administration's follow-up to these cases. AD(Family and



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Child Welfare) responded that he was not aware of any such cases.

16. Mr LEUNG Yiu-chung said that the Administration should have made greater efforts to increase provision of residential care places for children from high risk families since implementation of the mechanism for reviewing child death cases if it had attached importance to protecting these children. Mr CHAN Chi-chuen and Mr LEUNG Yiu-chung sought information on the immediate actions taken and the improvement measures adopted by the Administration after the occurrence of the YEUNG's death case. AD(Family and Child Welfare) responded that where there was an urgent need of a child for residential care services, social workers might apply to the court for a care or protection order under the Protection of Children and Juveniles Ordinance (Cap. 213) and arrange for admission of the child to a place of refuge immediately.

17. Mr POON Siu-ping sought information on the number of HMHC places, the number of children who were recommended by SWD for admission to these homes but were still on the waiting list and the number of visits to these children conducted by caseworkers during the waiting period. He also enquired about the Administration's plan for deploying additional resources for provision of support services for children from high risk families.

18. AD(Family and Child Welfare) responded that SWD had all along been bidding for resources for enhancing measures on child protection. Residential care places for children with special needs, particularly those with urgent service needs, would be increased. An additional of about 40 such places would be provided and funds for additional staffing provision had been approved. SWD would keep in view the manpower requirements taking into account the situation of child abuse cases. Given that the average occupancy rate of HMHCs had reached over 90%, SWD would strive to secure resources to increase the provision of HMHC places.

19. Chief Social Work Officer (Rehabilitation and Medical Social Services)<sup>1</sup> supplemented that there were mainly two types of residential care services for children with special needs, namely residential special child care centres ("RSCCCs") and small group homes for mildly mentally handicapped children/integrated small group homes. As at 30 April 2016, there were 110 places in RSCCCs and 104 of which were occupied. In the 2016-2017 school year, 26 of these 104 residents were expected to leave RSCCCs for special schools or primary schools and the places vacated by them would be allocated to waitlistees. There were now 36 children on the waiting list and about 10 children were expected to remain on the waiting

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list after these 26 children left the service. According to the current practice, priority placement would be considered for children who were assessed by SWD as having urgent needs and they could also be committed to the care of a place of refuge by a care or protection order if they were assessed to be in need of immediate care or protection.

*(At 10:58 am, the Chairman extended the meeting for 15 minutes beyond the appointed ending time to allow sufficient time for discussion.)*

20. Dr Fernando CHEUNG was concerned about the undesirable arrangement for residential child care services, non-accountability of MDCC and the absence of information on new borns from high risk families. Expressing disappointment that the YEUNG's death case could not be avoided even though the neglect case was intervened under the Mechanism and studied at MDCC, he moved the following motion:

"五歲智障男童楊智維中冰毒死亡個案揭示，目前保護兒童的制度、法例，以至服務的不足及缺乏問責的情況極待改善，本委員會促請政府立即成立獨立調查委員會，檢討楊智維個案及整個保護兒童的制度、法例及服務模式，包括多專業個案會議、福利計劃的制訂、執行、跟進及監察等，並在一年內作出改善法例、制度及服務的建議；保護兒童是迫切的，我們絕不能讓下一個楊智維個案出現。"

(Translation)

" That, the death case of YEUNG Chi-wai, a five-year-old boy with intellectual disability who was poisoned by direct ingestion of crystal methamphetamine, has revealed that the existing system and legislation for child protection as well as inadequacy of services and lack of accountability are in dire need of improvement, this Panel urges the Administration to immediately set up an independent commission of inquiry to review YEUNG Chi-wai's case and the entire system and legislation for child protection as well as the mode of service delivery, including multi-disciplinary case conferences and the formulation, implementation, follow-up and monitoring of welfare plans, and make recommendations within a year for improvement of the legislation, system and services concerned; child protection is of great urgency, we should prevent recurrence of tragedies similar to YEUNG Chi-wai's case by all means."

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21. The Chairman put the motion to vote. All members present voted for the motion. The Chairman declared that the motion was carried.

22. The Chairman summarized the views given and concerns raised by the deputations/individuals and members, and called on the Administration to consider these suggestions from the perspective of humanity. He said that the Administration should consider making legislation on child protection, and providing a platform for children to make their voices heard. In addition, the Administration should make use of MDCC to strengthen multi-disciplinary collaboration and communication among the B/Ds concerned with a view to enhancing government policies and services on child protection. Noting that the Administration would conduct a review of CPR, he called on the Administration to consider expanding the coverage of CPR to the relevant information kept under the Narcotics Division of the Security Bureau, the Police, the Correctional Services Department and the Education Bureau. He also reiterated the Panel's request, by way of the carried motion, for the Administration to set up an independent commission of inquiry, which comprised representatives from different sectors, to review the YEUNG's death case, and make recommendations to enhance the policy on child protection with an aim to prevent the recurrence of similar cases. In addition, he asked CFRP to conduct a review of its operation and effectiveness.

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23. As requested by Dr Fernando CHEUNG, AD(Family and Child Welfare) undertook to provide a paper, before the end of the Fifth LegCo, setting out the Administration's response to:

- (a) the carried motion;
- (b) the Panel Chairman's letter (LC Paper No. CB(2)1556/15-16(02)) in respect of the Mechanism; and
- (c) the questions raised and views expressed by the deputations/individuals at this meeting and in their written submissions.

*(Post-meeting note: The Administration's response was issued to members vide LC Paper No. CB(2)1923/15-16(01) on 18 July 2016.)*

24. The Deputy Chairman suggested that the subject of the Mechanism should be revisited in the term of the Sixth LegCo.

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**II. Any other business**

25. There being no other business, the meeting ended at 11:27 am.

Council Business Division 2  
Legislative Council Secretariat  
19 September 2016

## Panel on Welfare Services

Special Meeting on Saturday, 28 May 2016 at 9:00 am

Discussions on mechanism for handling abuse cases relating to children from high risk families  
and follow-up to the Child Fatality Review Report

## Summary of views and concerns expressed by deputations/individuals

No.	Deputation/individual	Views
1.	PathFinders Limited	[LC Paper No. CB(2)1556/15-16(03)]
2.	Save the Children Hong Kong	[LC Paper No. CB(2)1627/15-16(01)]
3.	Hong Kong Committee on Children's Rights	[LC Paper No. CB(2)1556/15-16(04)]
4.	Against Child Abuse	[LC Paper No. CB(2)1556/15-16(05)]
5.	Dr Patricia IP	<ul style="list-style-type: none"> <li>Hong Kong did not have a policy on children which was drawn up on the basis of children rights, legislation on children or a Children's Commission.</li> <li>The support for high risk families by the Integrated Family Service Centres, multi-disciplinary case conferences on child abuse should be reviewed to enhance its effectiveness.</li> <li>The Administration should strive to overcome difficulties in the current mechanism for handling abuse cases relating to children from high risk families so as to avoid recurrence of cases similar to the death case of YEUNG Chi-wai ("the YEUNG's death case").</li> <li>The Administration should provide information on the circumstances in which individual child fatality cases, e.g. the YEUNG's death case, would be selected for review.</li> </ul>
6.	The Hong Kong Council of Social Service	[LC Paper No. CB(2)1627/15-16(02)]
7.	Ms WONG Wai-yuk	<ul style="list-style-type: none"> <li>An independent commission of inquiry should be set up to review the YEUNG's death case with a view to finding the truth about the case and avoiding recurrence of tragedies similar to that case. It was hoped that the inquiry could reveal the adverse impact of parents' drug abuse on their children.</li> <li>A multi-disciplinary and inter-departmental task force should be set up to review the mechanism for handling abuse cases relating to children from high risk families with reference to overseas legislation, mechanism and practice in this regard.</li> </ul>

No.	Deputation/individual	Views
8.	Gilt Chambers	<ul style="list-style-type: none"> <li>[LC Paper No. CB(2)1556/15-16(06)]</li> <li>There should be a comprehensive review of the child protection system.</li> </ul>
9.	Baskerville Chambers	[LC Paper No. CB(2)1556/15-16(06)]
10.	Civic Party	[LC Paper No. CB(2)1627/15-16(03)]
11.	Miss Luna CHAN	<ul style="list-style-type: none"> <li>A loophole in the present child protection system in Hong Kong was the absence of an implementation timeline.</li> <li>For all child abuse cases, consideration should be given at the very earliest stages to the development of a formal "permanency plan" with a view to finding a permanent, stable family and home environment as quickly as possible. The permanency plan and implementation timeline must be set out clearly and followed.</li> <li>Suggested that the Social Welfare Department ("SWD") adopt the practice of the United Kingdom which imposed a 26-week processing and determination timetable.</li> </ul>
12.	Ms Angela LEE	<ul style="list-style-type: none"> <li>The YEUNG's death case should be reinvestigated to find out the truth about it.</li> <li>Child neglect was equivalent to child abuse. SWD, YEUNG's mother and her boyfriend should be prosecuted for YEUNG's death.</li> <li>The Administration should make the voices of the children of problem drug users heard and listened to.</li> </ul>
13.	Ms Priscilla TSANG	[LC Paper No. CB(2)1556/15-16(08)]
14.	Ms Darcy Davison Roberts	[LC Paper No. CB(2)1556/15-16(06)]