Against Child Abuse
防止虐待兒童會

Reflections on the Tin Shui Wai Family Tragedy

1. **It is agreed globally that protecting family and children is a collective responsibility**

   It is wrong to let the women, the children, the elderly and the vulnerable ones shoulder the responsibility all by themselves

   All departments, professionals and law-enforcers should try their best to communicate and collaborate

2. **Children are being neglected in family violence**
   Mothers and other vulnerable members are being neglected in child abuse cases

   The tolerance of violence is rather high at present

   Underestimate the risk and the severity of the problem

   Require clear definition and consensus

   Should include psychological and emotional safety

3. **Actualize zero tolerance to bullying and violence, should protect family and children strategically**
   (a) Current and new policies and legislations
   (b) A reliable, effective and acceptable service and law enforcement mechanism
   (c) Experience, competent and committed professionals and law-enforcers
   (d) An open and active participating community
   (e) Integrate research and resource and evidence based

4. **Mechanism to review child death and serious cases**
   (a) An on-going, independent, multidisciplinary forum with resource and manpower support
   (b) Aims:

   Investigate child death trend and characteristics

   Suggest policy, execution, law reform, strengthen professional and community education and participation

   Monitor governmental and non-governmental organizations and community to follow these policies & practices

5. **Review cross border mechanism to enhance collaboration in preventing family violence**

6. **Should invest resources and manpower to preventive work**

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Strategies Plan for Family / Child Protection

Do Away with Bullying & Violence

Whose responsibilities ?

Focus		Suggestion
Government	Policies and legislations (update and practical)	(1) A mechanism for fatal/ serious Case review (Refer to Appendix I) (2) Amendment on Family Violence Ordinance (Refer to Appendix II) (3) Prevention – early and extensive preventive measures (4) Cross border co-operation
Governmental & Non-governmental Organizations	Service Delivery System (reliable, effective and receptive)	(1) Retaining high quality, specialized teams (handling procedure and guide) (2) Tools and Mechanism for risk assessment (3) Definition of the problem ✧ Psychological abuse ✧ Physical abuse ✧ Sexual abuse ✧ Gross neglect (4) Mechanism for monitoring and appeal
Social Workers Psychologists Medical Personel Teachers Police Religious Bodies Mass Media District Councilors	Professionals & law enforcement (high quality, witty, humanistic & accountable)	(1) Value system ✧ Towards bullying ✧ Towards new immigrant women and children ✧ Towards new immigrants and vulnerable groups ✧ Towards ones own roles in protection

		(2) Mentality ✧ Caring and concerned ✧ Sensitive and insightful * sensitive towards interpersonal relationship, the needs of others, and to response promptly ✧ Serious and thorough (3) Knowledge and belief (4) Skills ✧ Process handling and problem solving skill ✧ In-depth multi-professional collaboration
Parents Public Children & Youth Mass Media	Community Participation (active, prompt & persistent)	(1) An Open and Well Informed Community ✧ Serious, accountable, respect to human life and human right (2) Rights and responsibilities, participation ✧ A culture of zero bullying and zero violence (3) Valuable supportive network
Government Tertiary Institutes	Research & Resources Consolidation (in-depth, comprehensive)	(1) Central Data System on Family & Child Matters (2) Study on the problem assessment (3) Research, analysis and implementation of service effectiveness (4) Share Resource & Information - for prevention - for effective program design & implementation ✧ Public, professional, for policy making

Appendix I

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Responding to
Tin Shui Wai, Tin Heng Estate, Family Tragedy

1. Distinct Areas of Concerns

1.1 Some families are gravely at risk
- what is the prevalence
- what is the extent of risk
- how do we strengthen
- how do we identify

1.2 How competent are our professionals: social workers, police, medical personnel etc. in the forefront? Are various parties competently prepared and equipped with the necessary Knowledge, Skills and Attitude?

1.3 Are various parties provided with support in supervision, network of services to back up?

1.4 Are professionals provided with realistic workload and adequate manpower?

1.5 How do professionals and agencies work together effectively to help and Prevent Family Tragedies?

1.6 How do we monitor our work and measure success?

1.7 Is the community ready to contribute to the protection of children? Are we willing to give up some of our privilege (parental rights, domesai privacy)?

2. Recommendations

2.1 The Set Up of An Independent Fatality and Serious Cases Review Standing Committee

The Committee should be independent and with multidisciplinary representation.

2.2 Research prevalence and extent and demands as perceived by children, families and professionals. Ensure analysis of findings and recommendations carried through.

2.3 Community Mobilization

a. Strategic Prevention Program with the community and through training community leaders, youth and adults, to spread the message, support and strengthen others

b. To enable each family with newborn to join head start home visiting programs with a strong capacity building, networking and prevention element.

c. To enable each citizen seeking Labor Department assistance to look for jobs to receive some degree (e.g. 2 hours) of social service public education.

d. To enable each family receiving Comprehensive Social Security Assistance to receive some degree (e.g. 2 hours) of public education.

e. To reach each and every one non-Chinese speaking domestic helpers when they arrived at Hong Kong airport. Provide them with relevant basic information and a designated number of hours training.

f. Advocate Mandatory Treatment for abusers, victims and family members.

2.4 Thorough and On-going Empowerment of Professionals in the Early Identification and Handling of Domestic Violence Should be Strengthened

a. An assessment tool worked out and professionals trained periodically to use it more effectively.

b. Specialized child abuse and domestic violence intervention approach must be retained.
Some degree of specialization in the existing three tier Integrated Family Service Centre Model much be encouraged.
The law-enforcer is lacking experience and support in domestic violence. Even the CAIU is much into crime-investigation than child protection.

c. Monitoring mechanism establish to take audit and monitor cases' handling and measure success.

d. On going Multidisciplinary Training be strategically planned and implemented to enable competent intervention and services.

e. Local and Overseas experience be consolidated to help our professionals through literature review, research, workshop, sharing forum, Congress and Conferences.

2.5 The Service Delivery System be Improved

a. Handling Guidelines and Procedures be worked out and reviewed either annually or two yearly.

b. A mechanism assigned to be responsible for such review.

c. Professionals to be ensured to know the system and to follow through.

d. To ensure adequate channel for difficulties and concerns to be reflected to the review mechanism.

2.6 A Clear Written Policy Document Must be Prepared to ensure:

a. Family and Child Impact Assessment in identified current and new policies.

b. Emphasis and funding support in pro-active Prevention Services and quality remedial protective services must be the policy.

c. Built in measurement of success must be reinforced.

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Appendix II

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Child Death Review

What is Child Death (Fatality) Review (CDR)

Review of deaths of children by a multidisciplinary team

Purpose: improve understanding of why children die and take action to prevent child deaths

- detect trends and patterns in child deaths
- recommend policies, practices, legislative changes, professional and community education to prevent child deaths
- monitor the implementation of such policies and practices by government and non-government agencies and in the community

Focus:

- the responsibility for responding to and preventing child deaths lies with the community and the entire government, not with any single department or agency
- the understanding of the circumstances surrounding the death, without attempting to establish whether criminal proceedings are required
- the improvement of interagency co-ordination, communication and co-operation in the provision of family services
- the improvement and standardization of data collection and the accurate identification of the incidence of childhood fatalities
- the development of prompt and comprehensive reporting systems
- the assessment of the extent to which the death was preventable
- the development of community education and other prevention strategies

In what way is CDR different from Coroner's inquest and internal reviews

The primary aim of Coroner's inquest is to determine the manner and cause of death. The coroner has the power to make recommendations on prevention but usually based on the specific case only. If in the course of the inquest, there is criminal concern, the process will be terminated and the case referred to the Director of Public Prosecution.

CDR does not focus on the criminality of the alleged offender. Investigation of child deaths is the responsibility of the Police and the Coroner.
CDR aims to identify system failures and deficiencies.
CDR does not comment on individual responsibility or performance.
CDR is multidisciplinary but does not replace internal reviews initiated by agencies.

History of development of CDR in other countries

The first CDR committee was established in Los Angeles in 1978 involving professionals from criminal justice, health and human services. The work of these teams "demonstrated the educational benefits of a systemic review of deaths as a way to improve services to the living" (Dr MJ Durfee)
At present 49 states in USA, most provinces in Canada, and two states in Australia have CDR programmes with others being developed.

Accomplishments of some CDR

Investigation protocols e.g. death scene investigation, autopsy
More accurate identification of the causes of child death
Better understanding, communication and co-operation between different disciplines/agencies
Advocacy and development of programmes addressing problems e.g. abandoned infants, Sudden Infant Death Syndrome, Abusive head trauma, accidental ingestion of methadone, daycare licensure, smoke detectors, child passenger, sporting safety, truancy and youth homicide, grief and mourning services.

Why Hong Kong should conduct CDR

The present Child Protection Register of SWD which is to reflect the situation of child abuse and neglect in Hong Kong does not even document the most serious outcome - child death.
The establishment of CDR is an international movement.
The life of every child is precious but especially when the number of children born in Hong Kong is decreasing. CDR is an effective way of preventing child deaths.
Although in most countries, the focus started with deaths from child abuse and neglect, soon attention was paid to deaths from other injuries. Even deaths from 'natural causes' during the perinatal period are often found to be related to antenatal and perinatal care.

For Hong Kong, from 1997-2001, there were on average 46 deaths from 0-14 years due to external causes including 7 per year from self-inflicted harm and 9 per year from assault/violence.

For every death from injuries, there are many more hospital admissions and even more visits to emergency departments and doctor consultations. The prevention of childhood injuries/deaths is a public health issue.

What needs to be done to establish CDR in Hong Kong

Establish terms of reference for the CDR team

Appoint a CDR team - Community and Departmental and agency representatives

Supported by a secretariat

Legislative change: to allow access to confidential information from police, doctors, social services, schools

System of annual report to Legislative Council

Information capable of identification of individual children, family members and worker will not appear in the reports.

Funding (In NSW, various government departments share the cost.)

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