香港保護兒童會
Hong Kong Society for the Protection of Children

Independent Review Committee Report Submitted to SWD

HKSPC Accepts IRC Recommendations to Drive Reform

Since the first incident of alleged child abuse at the Children's Residential Home (CRH) of the Hong Kong Society for the Protection of Children (HKSPC) in mid-December, the Society immediately began an internal review of activity within CRH resulting in further reports to the SWD and the Hong Kong Police Force (HKPF) on 28 December as outlined in our previous statement.

HKPF have taken over review of the CCTV footage we have provided to them, and as reported, a number of arrests have been made, with those children involved sent to hospital. The Society is mortified.

To find out how and why these failings happened, on 3 January 2022 Executive Committee (Exco) invited Mr. Lester Garson HUANG, Managing Partner and Co-Chairman of P. C. Woo & Co., to chair an Independent Review Committee (IRC) with five other reputable experts, with support from Deloitte and Steve Vickers Associates (SVA). The IRC was asked, as Phase 1 of a broader review, to identify shortcomings in our CRH operations, and to recommend whatever actions it deemed appropriate that the Society should make to ensure the health and safety of the children in our care.

The IRC has worked extremely hard and very quickly to provide the First Interim Report (FIR) to Exco. We accept the IRC's findings in full, and have submitted the report to the Social Welfare Department (SWD) yesterday. The Society wishes to thank Mr. HUANG and all IRC members for their efforts in this difficult job.

The IRC has conducted site visits, CCTV footage review, interviews with former staff and staff in various roles as well as the Society's Chairman and Director, and a review of our processes has been undertaken by Deloitte.

The IRC report highlights the devastating fact that an apparent excessive focus on the physical safety of the children under our care, coupled with exceptionally high staff turnover among our child care workers (CCWs), poor supervision and management have in combination led to a deterioration in the culture and work practices amongst our CCWs. This is obviously unacceptable.

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The IRC report also identifies failings of Management and at committee level. We accept the criticism, and will act on the recommendations to the fullest extent possible to improve everything about the CRH.

An Executive Summary of the FIR is attached. In the spirit of full transparency, the full-version FIR (English only) should be made available for the public upon receiving full consent from relevant interviewees, which we are seeking.

The Society will adopt all IRC's recommendations subject to implementation feasibility. A listing of IRC's recommendations and HKSPC's corresponding remedial actions already introduced or planned for is attached.

'Once again and on behalf of the Society, I whole-heartedly apologise for our failures. I am particularly sorry for our service users and supporters of the Society, whose confidence in us, I understand, may have been shaken,' said Robin Hammond, Chairman, Exco, HKSPC.

'The HKSPC is dedicated to keeping children healthy, happy and safe through service and advocacy. For the past 95 years, the Society has contributed significantly to our community but the problems we have identified are clearly unacceptable. They reflect that our management, monitoring and supervision have failings, and that our governance structure and team need reform,' continued Robin.

The Society is determined to learn from the CRH incidents and reform along 3 major directions:

1. **Taking responsibility**
   - We have accepted the resignation of the Director and have started a search for her replacement. We have already interviewed a small number of candidates, and hope to start making offers to enhance our management capabilities soon. The Director has agreed to stay to ensure a smooth transition and to assist in the IRC Phase II review as the Society may deem appropriate but she has been removed from any business in relation to CRH. There are also a Deputy Director and a management team underpinning the Director in the current structure so management continuity can be assured.
   - We have also accepted the resignation of the Superintendent of CRH and appointed the Deputy Director to supervise and oversee CRH while identifying a suitable candidate as replacement Superintendent from other services in the Society within the week.

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- The IRC report has indicated that a number of staff may have involved in irregularities identified. The Exco will form an HR taskforce to follow up as part of the overall follow-up to the IRC recommendations.

2. **Increase budget from non-subvention resource to rebuild CRH**

   One of the issues emphasized by the IRC is that recruitment and staff workload in the CRH have been challenging and stressful. Since the CRH incident came to light, we have also lost CCWs through arrests and resignations. To cope, we have introduced a recruitment and retention drive including the provision of a 6-month retention Special Allowance which also applies to the CCWs we have redeployed from other operations within the Society. To date, we have interviewed 25, successfully recruited 3, and are in the process of recruiting 11 CCWs. Reference and medical checks make this process slower than we would wish. We have also reached out to the sector and are in preliminary discussion to engage CCWs from other agencies. We welcome any support they may offer and thank them for extending a helping hand at this critical time. Internally, we have so far secured 7 CCWs who have responded to our request to be redeployed to CRH for the next 6 months. At present, CRH's staffing level stands at 34 for 61 children so we can ensure that there is a renewed team with suitable continuity to prevent any adaptation issues on the part of our children. We will continue to build a new workforce at CRH with suitably expanded training and supervision. SWD has sent in a Designated Professional Team to help with supervision and improvement measures and they been working with us since 17 Jan. New training initiatives are already underway – with the first session, focusing specifically on protection of children, completed

3. **Immediately expand committees' responsibilities, training and counselling to ensure the safe protection of children under our care**

   We shall introduce board level audit/safeguarding & child protection committees to achieve adequate internal control, and strengthen Management capacity and capabilities, as well as staff training, morale and complaints handling. Two weeks ago, we introduced psychological support services offered by the HK Christian Service for our staff. This week we have expanded by engaging the Division of Clinical Psychology to provide broader counselling and review for children, parents and staff

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under the leadership of Dr. Rachel Poon. Dr. Poon will start the psychological assessment and support programme tomorrow.

'We shall work hard to earn the community's confidence and I sincerely ask that we be given the chance to build back CRH as a showcase of best practice. The IRC will conduct a thorough review of the entire Society as its Phase II assignment, including our governance, internal controls, checks and balances, training, reporting, and all else appropriate to ensure we operate on best practice principles. We expect the relevant work to take some months to complete but will share progress as appropriate with SWD and the public.' said Robin.

Hong Kong Society for the Protection of Children
26 January 2022

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Executive Summary

Introduction and Background

1. This executive summary of the First Interim Report gives :

   (a) The key observations and findings of the Independent Review Committee in connection with the recently discovered incidents of apparent unprofessional and abusive behaviour on the part of child care workers in the Children's Residential Home of the Society; and

   (b) The recommended actions that the Society should take into consideration to ensure that these incidents are not repeated in the future.

2. On 18 December 2021, a member of the public wrote to the Hong Kong Society for the Protection of Children claiming to have witnessed a member of staff using abusive conduct while looking after children in the Society's playground on the morning of 17 December 2021. This was investigated and reported to the Police.

3. On 3 January 2022, the Executive Committee of the Society resolved to establish an Independent Review Committee to identify the root cause of the incidents and to come up with recommendations for remedial action in accordance with its Terms of Reference.

4. The Independent Review Committee interviewed 21 individuals from the Society and the Children's Residential Home and some former staff of the Children's Residential Home. A summary of their accounts and observations are set out in the Full Report.

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5. In addition, Deloitte Advisory (Hong Kong) Limited conducted an internal control systems review of the Society, and Steve Vickers & Associates reviewed CCTV footage from the Children's Residential Home. Their work complemented the work of the Independent Review Committee.

6. In discharging the task, the Independent Review Committee adopted an evidence-based approach to examine the available facts to ensure an impartial and targeted investigation, and that conclusions and recommendations were made in an independent and objective manner.

Key Observations and Findings

7. Based on the Independent Review Committee's review of the CCTV footage excerpts identified by Steve Vickers & Associates, information provided by Deloitte Advisory (Hong Kong) Limited and the Independent Review Committee's independent and critical review of the information and documents provided by the Society, the Independent Review Committee has the following observations and findings :-

The Fine Line between Abuse and Rough Handling of Children

8. The Independent Review Committee finds that in general, the handling of children by the Child Care Workers in the Children's Residential Home was generally rough, lacking in care and without regard for the feelings, respect or dignity of the children.

9. Such rough handling did not always amount to abuse as such, but once a Child Care Worker went any further, as is likely, the conduct can constitute physical abuse. The rough conduct was such that physical injury may not be immediately apparent or detectable. However, there is little doubt that the children who are subject to the handling will have felt discomfort, unease or even pain. Even

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though there was no apparent physical injury, the emotional impact on the child may be lasting.

10. The rough conduct was because the Child Care Workers used expedient ways to keep the children out of harm, or to avoid risk. However, such conduct was uncaring to the children, thwarts their spontaneity and innate sense to explore and learn, and did not contribute to the emotional wellbeing of the children. One must question how this impacts the holistic development of the children.

Review of the Incidents from the CCTV Footage

11. The Independent Review Committee was satisfied that there were occasions when the conduct went further and amounted to abuse, including but not limited to :-

(a) A child being lifted by the collar and dumped to the mat;

(b) Another having her ears pulled;

(c) The use of slapping as corporal punishment;

(d) Pushing a standing child's head down with force to make him or her lie down in bed;

(e) One being shaken by the arms;

(f) A child being thrown against a padded wall;

(g) A Child Care Worker moving a child by using a leg in a kicking motion;

(h) After waking up and standing, a child having an ear pulled to make her lie down;

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(i) Another being heavily placed into an activity area, knocking other children in the course; and

(j) A child having her face poked with the fingers of a Child Care Worker.

Poor Supervision and Monitoring

12. The supervision and monitoring of day-to-day work of the Child Care Workers were unstructured, done only when time allows and was not recorded. Because the Superintendent and other senior staff said they trust the Child Care Workers as professionals, they did not sufficiently monitor their performance and give the necessary feedback.

13. The Independent Review Committee was satisfied that the Management of the Children's Residential Home must have been aware of the generally rough handling of the children, but must have considered this acceptable as there has been no intervention. Only mild reminders were given by supervisors from time to time, but the Child Care Workers were either perfunctory in their response or ignored the reminders.

14. When the more serious abusive conduct occurred, it is possible that the supervisors were not physically present as the Child Care Workers regularly prompt each other when supervisors enter their vicinity.

15. Therefore, the Independent Review Committee considers the quality and frequency of the supervision and monitoring to be considerably inadequate and practically ineffective.

16. The system of peer monitoring among Child Care Workers had also totally collapsed, and therefore staff never reported any irregularity to their superiors and as such questionable conduct was hardly ever challenged. In this way, bad conduct would breed more bad conduct, and the standard of care given to the children fell lower and lower over time.

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CCTV Coverage in the Children's Residential Home

17. Even though there is extensive CCTV coverage in the Children's Residential Home, there is no system in place to review the footage from time to time to identify any irregularity, and the Child Care Workers were aware that there was hardly any scrutiny. They therefore carried on with the unacceptable conduct reasonably expecting to not be caught. In any event, if and when poor conduct was reported, there was no serious reprimand or punishment.

The High Turnover Rate of Child Care Workers

18. The turnover rate of Child Care Workers was seriously high in the last three years, resulting in many Child Care Workers being new to the work. Over 70% had less than three years of experience. This may explain why the Management of the Children's Residential Home were not robust in reprimanding or punishing staff.

19. The Child Care Workers passed on their undesirable work practices to newcomers, and such included the practice of rough handling. In some cases, new Child Care Workers were even told not to adopt practices which may offer comfort and warmth, as this could attract the children to request more of such good conduct from the Child Care Workers concerned and even others. A newcomer was dissuaded from performing well because this would increase the workload of the Child Care Workers.

20. The high staff turnover rate also caused a loss of good practices and of a caring culture in the Children's Residential Home. Instead, a culture of poor conduct, mixed with an uncaring attitude and complicit oblivion had set in as a new norm.

Insufficient and Impractical Trainings

21. The loss of good practices was also contributed to by a lack of a structured and comprehensive training programme for the staff, and in particular for the newcomers. The last time a talk on child abuse was given to the staff was in 2015.

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22. Even though an external clinical psychologist came to the Children Residential Home to give ongoing trainings and to conduct clinical case reviews the focus of the training was not on child abuse.

23. The Management failed to regularly provide suitable training on safeguarding and child protection, and in particular the Social Welfare Department's procedural guide "Protecting Children from Maltreatment – Procedural Guide for Multi-Disciplinary Co-operation" (Revised 2020) to the staff of the Children's Residential Home to reduce the risk of child abuse. Furthermore, the Management ought to have assessed the impact of the staff's conduct on the emotional health and development of the children.

The High Workload of Staff in the Children's Residential Home

24. The workload in the Children's Residential Home was considerable for all, and overwhelming for most. The Child Care Workers have to mind the children, and have paper work to complete. The Chief Child Care Workers were expected to be all-rounded managers, overseeing the frontline operations while attending to all incidental requirements in the background, and a considerable amount of paperwork in between. The Superintendent and Assistant Superintendent also had to consider improvements and deal with manpower needs and report to the regulators and the Executive Committee of the Society. This left little, if any, room for reflective consideration of the quality of work, and the tendency to resort to expedient measures to meet work needs.

Poor Management

25. The Management of the Society had not put in place sufficient safeguards to protect the children from abuse. There was no institutional wide system of monitoring the performance of the Child Care Workers for conduct that could harm the children, no designated person to monitor and check on safeguarding practices. In fact, there was not even a staff handbook circulated to staff. The Management wrongly trusted that the staff of the Children's Residential Home know the right thing to do, without sufficiently checking this.

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26. The Management also failed to properly inform the Executive Committee about the situation in the Children's Residential Home, including the high turnover rate and the rough handling of the Child Care Workers. There was no regular written report to the Executive Committee on how the Children's Residential Home was performing, other than that it was difficult to recruit Child Care Workers. In fact, the Superintendent and the Service Director may have felt that the Children's Residential Home was doing well given that the Social Welfare Department did not express any concern.

27. The Management failed to assess and evaluate weaknesses in internal control. In particular, but not only, the Management failed to monitor the work of Child Care Workers through a regular review of CCTV footage, and to inform the staff of the Children's Residential Home that such monitoring would occur. The Management ought to have put in place a system of supervision at all levels, and given regular training on how to supervise staff to the Chief Child Care Workers, the Assistant Superintendent and the Superintendent, and monitored their performance in this regard.

28. The Management failed to appropriately address workload issues by properly assessing administrative and other work required of staff in the Children's Residential Home, and in particular that of the Chief Child Care Workers, resulting in their having less time to monitor and supervise the work of the Child Care Workers, and to work directly with the children.

Inadequacy of the Executive Committee

29. Even though the Executive Committee is devoted and dedicated to the well-being of the children in the care of the Society, and has properly delegated the task to Management and the front-line staff, the Executive Committee's supervision and monitoring of the performance of the Management and the front-line staff is lacking. The procedure and content of reports to the Executive Committee did not enable it to properly grasp the happenings of the Children's Residential Home in a timely manner. More robust questioning or queries to the

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Management should have given the Executive Committee members a better understanding or shed light on what is actually happening.

30. In particular, the Executive Committee failed to put in place sufficient means of monitoring the work in the Children's Residential Home, including :-

(a) Appointing a dedicated member of the Executive Committee or a committee to oversee safeguarding and child protection issues;

(b) Appointing one or more senior members of staff as an officer to conduct independent assessments of safeguarding measures, and to conduct surprise visits, such officer to report directly to the Director and the dedicated member of the Executive Committee or committee responsible for overseeing safeguarding and child protection;

(c) Calling for timely and frequent reports from Management on the Children's Residential Home on child safety and protection; and

(d) Establishing an Audit Committee to assess internal control systems, risk management mechanisms and processes.

31. Further, the Executive Committee failed to establish and operate a comprehensive and effective complaint handling mechanism, particularly relating to the Children's Residential Home. In particular, there was no requirement for the management of the Children's Residential Home to report whether any complaint had been lodged, and how it had been dealt with. The Executive Committee also failed to call for complaint related information and data regularly, or at all. The Management also failed to maintain a centralised complaint register to consolidate all complaints received, and to suitably reflect on and learn from the complaints.

32. The Executive Committee also failed to have Management set out and regularly review proper internal procedures, including :-

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(a) Establishing an Audit Committee to assess internal control systems, risk management mechanisms and processes.

(b) A safeguarding policy and procedure manual;

(c) Systems to deal with complaint handling and whistleblowing;

(d) A staff handbook, work guidelines, a code of conduct or other human-resource related stipulations;

(e) A comprehensive induction programme including on-site supervision for new staff joining the Children's Residential Home;

(f) A programme of continuing professional training for staff of the Children's Residential Home, and the monitoring of the emotional well-being of staff who work with the children so as to ascertain the risk of their taking abusive action on the children; and

(g) A system to assure achievement of control objectives and ongoing compliance with policies, procedures, and laws and regulations relating to child care.

Main Conclusion

33. The main conclusion in this First Interim Report is that there were errors, failures and omissions at practically all levels of the organisation. The Independent Review Committee therefore attributes culpability to all levels of the agency, including the Executive Committee, the Director and Management, and the Superintendent of the Children's Residential Home. They exposed the children in their care to unnecessary harm by failing to put in place the necessary systems to prevent and detect abuse, and to review its operations in the interests of the children.

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Recommendations

34. The following recommendations from the Independent Review Committee represent just one of the many considerations that the Society will need to take into account to ensure that these incidents of apparent unprofessional and abusive behaviour on the part of child care workers in the Children's Residential Home of the Society are not repeated in the future.

Recommendation 1

35. The Independent Review Committee considers it important that the interests of the children must be put first. They deserve to be in a safe and nurturing environment. To attain this, there has to be a practically wholesale change of staff.

36. We understand that the Child Care Workers who have been arrested on suspicion of criminal conduct have been suspended from work and are no longer in contact with the children. Nonetheless, the Independent Review Committee is concerned that existing staff may habitually adopt rough practices in handling the children and this could continue, constituting a recurring risk to the children. Therefore, subject to a caveat, the current Child Care Workers should be re-deployed to other units and be substituted with new Child Care Workers, preferably with some experience.

37. The caveat referred to above is this: because the children may only be familiar with the current Child Care Workers, a total replacement of such workers will put these children into the hands of strangers. This may cause them anxiety and adjustment problems.

38. A robust system of monitoring and supervision must be put in place, particularly if any current Child Care Workers are retained.

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39. It is imminent for the Society to gain back the trust of the families of the children and the community as a whole in its work at the Children's Residential Home.

Recommendation 2

40. The Executive Committee and the Management should undertake a major reform of the Society and the Children's Residential Home, which should include the following :-

(a) Appointing a dedicated member of the Executive Committee or a committee to oversee safeguarding and child protection issues;

(b) Appointing one or more senior members of staff as an officer to conduct independent assessments of safeguarding measures, and to conduct surprise visits, such officer to report directly to the Director and the dedicated member of the Executive Committee or committee responsible for overseeing safeguarding and child protection;

(c) Calling for timely and frequent reports from Management on the Children's Residential Home on child safety and protection;

(d) Establishing an Audit Committee which shall undertake regular assessments of internal control systems, risk management mechanisms and processes and regularly review and report to the Executive Committee on risks and steps to reduce such risks;

(e) Calling for regular reports on and reviewing the human resources position in the Children's Residential Home, including the staff turnover rate, vacancy and recruitment issues. The Executive Committee should ensure that the Management has in place a comprehensive program for the training of new staff joining and continuing training of all staff, including on child safety and protection, and all relevant changes of the law, policies and procedures, ensuring that such courses are relevant to the Child Care Workers;

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(f) Establishing a complaint handling and whistleblowing system and maintaining a centralised register to consolidate all complaints received and to report the same to the Executive Committee at regular intervals;

(g) Establishing a system to retrospectively review the CCTV footage and to inform staff of the Children's Residential Home that such monitoring would occur; using the CCTV footage for training as suitable. The Society should also promptly review its CCTV written policy. In this connection, it is the view of the members of the Independent Review Committee that the cameras in the children's bathrooms and toilets of the Children's Residential Home should be removed in the interests of maintaining the privacy of the children. There must be adequate monitoring of staff performance; and

(h) Establishing a system to review exit interviews and to reflect the considered views to the Executive Committee from time to time.

Recommendation 3

41. Given the catalogue of errors, failures and omissions as detailed in this Report, a robust scheme of accountability calls for senior leaders in the Society to offer their resignation.

Recommendation 4

42. As to the Children's Residential Home, the Management is recommended to :-

(a) Arrange for the children to attend regular classes as pupils in kindergartens or nurseries; and

(b) Notwithstanding Covid restrictions, to consider arranging for volunteers to return to the Children's Residential Home to work as before.

Recommendation 5

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43. The staff of the Society and in particular the Children's Residential Home are under tremendous stress, and require professional counselling and psychological debriefing. The Society should assess staff morale and address issues arising professionally.

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Table of Measures In Response to IRC Recommendations

Recommendation One: Total Replacement of Child Care Workers or Develop a Robust System of Monitoring and Supervision	
Implemented Measures	Planned Measures
1. Suspend or terminate the duties of all suspects	1. Complete change of all child care workers in children aged 2 to 3 ward and have a major re-engineering of staffing of the ward for children aged 18 to 24 months
2. Regular review of Children's Residential Home's selective cctv footage recording (weekly and monthly)	2. Increase frequency of regular review of Children's Residential Home's selective cctv footage recording to daily
3. Weekly additional body check of all children by nursing staff, to monitor completeness of children accident and injury reports, to identify suspected professional malpractice	3. On top of additional weekly body check, implement daily double check of children's Daily Care Record and implement 10% random check to ensure completeness of accident and injury report, to identify suspected professional malpractice.
4. Increase the manpower of child care centre supervisor to implement 6 centre checks a day, with on the spot supervision. If any professional malpractice is identified, appropriate disciplinary action would be taken.	4. On top of 6 centre checks a day, review the work scope, manpower and competence of Chief Child Care Workers and Assistant Superintendent, to enhance their effectiveness of supervision and leadership of child care staff team of the Home
Recommendation Two: Major Reform on Safeguarding and Child Protection Measures	
1) Existing safeguarding and Child Protection Measures - HKSPC has a Staff's Code of Conduct listing clear requirements on staff's commitment to agency mission, service unit objectives, work attitude, code of conduct. - In the section on "Respect and Protection of Service Users", it clearly require no physical punishment or aggressive acts be	1) Continue to implement existing measures with enhancement - Continue to enforce HKSPC's Staff's Code of Conduct and actively educate and promote staff to take action to stop and report other's physical punishment or aggressive acts toward children.

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inflicted to children and stated that the major duty of staff is protecting children and support their healthy development. If any staff has abusive acts towards any child, either verbally or physically, and has caused harm to a child physically or psychologically, would face summary dismissal. - The Code of Conduct also stated clearly if any staff see other person employing physical punishment to a child and takes no action to stop and report to his/her superior would receive disciplinary action.	
2) Have implemented enhancement on staff training for new and overall staff as below to prevent child abuse: - Require Chief Child Care Worker to provide regular supervision to new staff and support their adjustment to the new job actively - Have invited Family and Child Protection Services Unit of SWD and Division of Clinical Psychology of The Hong Kong Psychological Society to support planning and implementation of a series of staff training on child protection for new and existing child care workers and their supervisors. - Despite of the recent development of the pandemic, CRH has re-started Short Course on Prevention, Early Identification, Reporting and Handling of Suspected Child Abuse and Role of Carers in these issues.	2) New courses for continuous enhancement competence of new and existing staff to prevent child abuse: - Increase supervision of new staff to bi-weekly in first 2 months after they have reported duty to CRH - Provide 1 to 2 weeks systematic induction course for new staff - Add new courses on below: 1. How to provide appropriate care and development support to children with developmental delay or disabilities 2. Systematic training on supervision skills of Chief Child Care Workers 3. RE-vision brief course on child protection for all staff 4. Develop guidelines and professional practice indicators on effective handling of challenging and stubborn bahaviours and emotional and behavioural problems of children aged 18 months and above.

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- Have planned to start a short course to enhance competence of child care workers in handling age-appropriate challenging and stubborn behaviours of young children aged 18 months or above	5. Invite external professional help to plan and implement the above new courses.
Recommendation four: Enrich Learning and Development Resources for Children	
1) Liaise with SWD to arrange placement for children aged 3 and above to more appropriate care arrangement, as the Home is designed for younger children	1) Liaise with the responsible caseworker of children approaching 3 years old for possible arrangement for kindergarten education
2) The planned volunteer programme was put on hold with recent worsening of the pandemic	2) Depending on the development of the pandemic, restart volunteer programme as appropriate
Recommendation 5: Make arrangement for staff of the Home to receive professional counselling service	
1) Have started hotline service with telephone and face-to –face counselling support for needy staff, offered by the Hong Kong Christian Service	1) Continue the service with regular reviews
2) Have arranged 2-3 clinical psychologists of The Hong Kong Psychological Society to provide small group session to assist staff to handle their emotional disturbance this Thursday and Friday. Invitations have sent out to all staff.	2) Continue the support with regular review

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