

Going to the multidisciplinary case conference for child abuse: a review and guide to the medical practitioner

出席多專業虐兒個案會議：評論及給醫生的指引

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Multidisciplinary case conference is an important component in the management of suspected cases of child abuse and neglect in Hong Kong. The medical practitioner is one of the key professionals in the case conference to discuss the nature of the case, issues concerning child protection, and interventions to safeguard the child's subsequent welfare interests. Yet, specific guidance for the medical profession is lacking. In this article, the authors present an overview of the child protection case conference and practical suggestions for the medical practitioner when called to participate in the multidisciplinary case conference. (*Hong Kong j.emerg.med.* 2005;12:50-58)

在香港，「多專業模式」的個案會議是處理懷疑虐待兒童及疏忽照顧個案的一個重要組份。在個案會議中，醫生是關鍵專業人仕之一，會上討論個案的性質、保護兒童的議題，以及干預保障兒童日後的福利；然而，醫學專業上卻缺乏這方面特定的指引。本章作者描述保護兒童個案會議的概要，並給予被邀請參與多專業個案會議的醫生一些實用的建議。

Keywords: Case conference, case management, child abuse, child welfare, interdisciplinary communication

關鍵詞：個案會議、個案處理、虐待兒童、兒童福利、專業間的溝通

Introduction

Multidisciplinary case conference (MDCC) has long been regarded as one of the pivotal components in the management of suspected cases of child abuse and neglect in Hong Kong. Over 90% of the cases of suspected child abuse and neglect handled in public hospitals are followed by a MDCC.¹ In our institution, 756 (92%) out of the 826 cases seen from 1998 to June 2004 had a MDCC subsequent to the reporting.

The ad hoc meeting provides an arena where relevant professionals from the medical and mental health, nursing, social work, law enforcement, childcare agencies, and education who have active involvement with the child victim or the family concerned can share and exchange information and opinion, to determine the case nature and underlying problems, and to formulate a management plan for the protection and welfare of the child.

The modern management of child abuse and neglect stems from the breakthrough report of the "battered child syndrome" by a paediatrician called Henry Kempe in 1962,² and the current understanding on the issue has been enriched and broadened by ongoing medical researches. In corollary, the medical representative in the MDCC often plays an essential role in evaluating the child victim, explaining the

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injuries and damage, elaborating on the issues pertaining to child protection, and educating some of the less experienced participants. Because of the gravity of the decisions that are going to be made, participation in the MDCC should not be left to the inexperienced. With the knowledge and expertise in developmental and psychosocial needs, the paediatrician is often the most appropriate medical practitioner to sit in the conference. In our department, participation of junior members is strongly encouraged for training reasons. The importance of the simultaneous presence of a senior staff or the Medical Coordinator on Child Abuse cannot be overemphasised.

In this article, we shall first review the development of the MDCC and then make practical suggestions to the medical practitioner who has been invited to participate in the meeting. Most of the guidance on this topic have been written for social workers.^{3,4} Specific information for parents going to case conference is also available.⁴ However, articles tailored to the needs of the participating medical practitioner are lacking, or do not contain sufficient details for practical reference.⁵ The following discussions, based on a review of the literature and the authors' experiences, would be a useful reference to the medical profession.

The origin of MDCC

The modern management of child abuse and neglect in Hong Kong closely follows the British systems. The history of the child protection case conference has been recently reviewed.^{3,4,6} The original case conference was believed to have emerged during the 1940s as a team conference about child guidance where professionals – teachers, probation officers, social workers and medical staff – were invited for discussing a case before an audience interested in such work. A journal by the name of "Case Conference" appeared in the 1950s and later became the professional publication of the British Association of Social Workers. The majority of the subscribers were psychiatric social workers and childcare officers, suggesting that the use of case

conference prevailed in the psychiatric setting. Indeed, prior to 1950, the leading and determining role of the psychiatrist in the case conference was rarely challenged until the advent of children departments brought the conference into a new arena. Afterwards, the Ministries of Education and Health and the Home Office recommended the establishment of Coordinating Committees by local authorities to consider plans for families who neglected their children. Case conferences were officially recommended by government guidelines but doubts existed if these case conferences had been properly conducted. Death inquiries during the 1970s had noted the conspicuous absence of case conferences at key moments prior to the deaths of fatally abused children.

The wide acceptance of MDCC as an essential component of child abuse management started in 1975 after the Tunbridge Wells Study Group published the document on non-accidental injury in children.⁷ In an appendix on case conference, the Group advocated the MDCC as an arena for inter-professional collaboration, bringing together all who made decisions and all who provided information and services. It was stated that MDCC would help to develop mutual trust and increase the value of the contribution made to the family concerned.³ The shocking death of Maria Colwell in 1974 and the subsequent inquiry report was also catalytic in the development of multi-disciplinary collaboration.⁴ Area Review Committees (later renamed as Area Child Protection Committees) were set up to oversee local policies, to ensure that case conferences were held after every suspected case, and to set up central registries concerning children considered to be at risk of abuse.

During the next decade, the content and logistics of MDCC were continuously shaped by recommendations and guidelines developed by individual disciplines and by official reports. Inquiry reports on serious cases of child abuse specifically placed demands on the timeliness of MDCC, knowledge of the family, risk assessment, child protection registration, formulation of treatment plan,

parental participation and the assignment of a key-worker. The enactment of the "Children Act 1989" in the United Kingdom made the protection of the child a high priority when interventions of disadvantaged families were planned. Child protection became the main purpose of the case conference and its name was changed to child protection conference when the "Working Together under the Children Act 1989" was published.⁸

The initial Working Together document and its subsequent revised version⁹ specify two types of child protection conference: (i) the initial child protection conference, and (ii) the child protection review. There is also the pre-birth child protection conference when the risk to an unborn child raises sufficient concern to the child protection workers. Most of the discussions that follow refer to the "initial" child protection conference because the other two types of case conferences are rarely, if ever, carried out in Hong Kong, and the principles governing the operation of the other types of case conferences are similar.

Negative views on MDCC

Early observations suggested that at times professionals used case conferences to express their feelings of anger and distress about the case. At other times, differing views and the lack of trust among various professionals generated collusion or conflict. Thus, before the modern concepts and formats of MDCC were firmly established, resentment or confusions created during the course of the conferences might block understanding and effective interventions.³

A policy document written for the Society of Clinical Psychiatrists described MDCC as pernicious and immensely wasteful of professional time¹⁰ because: (1) case conferences were dangerously irresponsible as they had no continued existence and no one could be held personally accountable for their decisions; (2) case conferences entailed a gross breach of confidentiality; (3) case conferences were inherently ineffectual – the decision to judge the fitness of a parent to look after a child, the assessment of the parent's emotional

problems and response to intervention could not be a one-off decision and often called for the highest degree of professional competence rather than the result of a debate arising out of differences of opinion or emotional prejudices. These views, however, were not shared by others. Bentovim drew specific attention to the importance of inter-professional communication. Inquiry reports had mentioned that someone somewhere had the information that, if it had been shared, might have prevented fatal child abuses.¹¹ The latest report on Victoria Climbié revealed how a lack of coordination and communication among different disciplines gave rise to the demise of a young girl.¹² Keen believed that the ineffectiveness was not inherent in MDCC and suggested that it was related to the presence of irrelevant parties, absence of key persons like teachers or family doctors, poor quality of the information presented, unskilled chairmanship, and inexpertly written minutes,¹³ deficiencies that had also been pointed out in the literature review conducted by Hallet & Birchall,¹⁴ and the lecture by Davies during the Multi-disciplinary Conference on Child Abuse in Hong Kong.¹⁵

The cost of a MDCC is substantial, given the number of professionals involved and the time they spend on a meeting. Nevertheless, professionals who have participated in MDCC generally feel that the cost is justified when important issues concerning the welfare of the child and the family can be resolved.^{14,16}

The issue of family participation has also been controversial. Most professionals support the notion that effective intervention relies on the full involvement of the family and the child from the outset. However, there are worries that the presence of the alleged perpetrator in the MDCC may inhibit discussion and the child victim's interest may be overwhelmed by parental demands.¹⁷

Despite these criticisms, the MDCC has evolved into an important platform where professionals from various walks of life can contribute their expertise to understand the needs of maltreated children and to address the interventions necessary to safeguard their welfare.

MDCC in Hong Kong

In 1981, in response to a series of mismanaged cases, the Social Welfare Department (SWD) distributed procedures for handling child abuse to different government departments and non-government organisations concerned.¹⁸ As spelt out in the latest guidelines,¹⁹ MDCC has been charged with three main purposes: (1) to provide an arena where professionals from various disciplines can share and exchange information and knowledge about the circumstances of the suspected abuse; (2) to protect the safety and welfare of the child victim; and (3) to formulate necessary action plans according to the assessed risk. The main components of the MDCC and their inclusion in the successive guidelines during the past decade are listed in Table 1. Both the United Kingdom and Hong Kong procedural guidelines have indicated clearly that the MDCC is not a forum for a formal or legal decision that a person has abused a child, that being a matter for the court.^{8,9,19}

Reviewing the experience of child abuse management in the United Christian Hospital, Ip discussed about

the problems of MDCC.¹⁸ Guidelines prior to 2002 placed significant responsibilities on the chairman. Yet, their experience and training in terms of child protection were often limited. Discrepancy in the understanding of child abuse during the discussion of the case nature was common, given the lack of socially acceptable standard on the use of physical punishment in our society. In contrast to the British experience, there was a tendency for some child care workers to identify with the suspected abuser rather than the child victim. Excuses were made for the suspected perpetrator and emotive judgements were laid upon the child victim, making harmful acts forgivable and the recognition of child abuse elusive. Such excuses, as elaborated by Ma, included the apparent good intention of the alleged perpetrator or moralistic judgements on the child (justifying or rationalising the beating), and infrequent beating or relatively mild injuries (minimising the impact of the physical violence).²⁰ As Lui-Tsang has pointed out, the traditional belief of filial piety is deep-seated even among professionals, rendering objective assessment at times impossible.²¹ The other reason for the identification of the frontline workers with the parents

Table 1. Main components of the guidelines on MDCC in Hong Kong

Components	1993 ²⁵	1998 ²⁶	2002 ¹⁹
Objectives of the MDCC	✓	✓	✓
Responsibility to convene MDCC	Note 1	✓	✓
Need to hold MDCC within 10 days of referral	✓	✓	✓
Membership of the MDCC	✓	✓	✓
Chairmanship of the MDCC	✓	✓	✓ (Note 5)
Agenda of the MDCC	Note 2	✓	✓
Family/child participation	Note 3	✓	✓
Key-worker assignment	✓	✓	✓
Debriefing to parents/child after MDCC			✓
Need for review meeting			✓
Format of the minutes	✓	✓	✓
Attention to the Personal Data (Privacy) Ordinance	Note 4	✓	✓

Note 1: Not mentioned; included under the responsibility of the chairman.

Note 2: Included under the responsibility of the chairman.

Note 3: Briefly mentioned.

Note 4: Not applicable; confidentiality only assigned to the chairman.

Note 5: The chairman is required to have experience in family or childcare, and is experienced in child protection. This is not mentioned in the previous guidelines.

is the duration of exposure. Child protection workers who have been involved with a family for a prolonged period may have elevated their threshold of concern, making them less likely to respond to deterioration of the child's situation – a phenomenon that has been well described in the United Kingdom.²²

The outcomes of MDCC are apparently dependent on the experience of the participants. In a recent multi-hospital study, the probability of reaching an established case of child abuse is three times more likely in hospitals with a greater caseload.¹ The proportion of substantiated cases varied from 13% to 78% among the different public hospitals.²³ Age of the victim, type of suspected maltreatment, and prior registration with a childcare agency are also relevant factors, but the caseload of a particular hospital remains an independent predictive factor on the outcomes of MDCC when other factors are controlled.

Thus, the success of MDCC depends on the knowledge and experience of its participating members, and the way it is steered when complicated issues or discrepant views emerge. As mentioned in the historical review, the role and format of MDCC in the management process of child protection would continue to evolve according to changing societal and legal expectations. As one of the important participants, medical practitioners are also expected to contribute to this re-structuring process as needed from time to time.

The MDCC – brief outline¹⁹

With few exceptions, all cases of suspected child abuse will be referred to the Family and Child Protective Services Units under the SWD. A caseworker, either from the SWD or non-government organisations, will be assigned to carry out a detailed social enquiry. At the same time, the affected child will undergo medical and/or psychological evaluation as indicated. Under normal circumstances, a MDCC is called by the caseworker's supervising officer within 10 working days from the time of referral to the SWD. Professionals including doctors, social workers, the law enforcement, teachers and other childcare workers

from public, government or non-government organisations who have been closely working with the child or the family will be invited to participate. The invited professionals will receive a notice of the MDCC, addressing the participants' names, titles, and respective organisations, and an agenda of the meeting listing the order of reports to be made by the participants. Written documentations are expected from the key professionals for circulation at or prior to the MDCC.

At the start of the case conference, the chairperson will lead an introduction and address the purpose of the meeting. The participants will then address their reports according to the order of the agenda. At the end, the chairperson will lead the participants to draw a conclusion to the case nature and to formulate action plans for subsequent interventions and follow-up. The latter plans will include the needs of enrollment to the Child Protection Registry, application of statutory orders for child protection, and placement for substitute parental care. As mentioned previously, the findings and conclusions reached at the MDCC are solely made for child welfare purposes, and have no legal binding for criminal investigation carried out by the law enforcement.

The participating medical practitioner is expected to meet a panel of people coming from different disciplines with different levels of knowledge and experience in child protection. The following suggestions are listed to help the medical practitioner to fulfill his professional roles when sitting in the MDCC, as other participants often look to the doctor for professional opinion concerning developmental or long-term child health issues in relation to the well-endowed medical experience in child abuse and protection.

Practical suggestions to the medical practitioner

General preparations

1. Be familiar with the definition of child abuse – the 4 major forms of maltreatment (physical, psychological, sexual abuse and neglect), the major

categories of physical abuse (blunt force, sharp injury, thermal injury, chemical injury, suffocation and shaking/shearing forces), the 5 major categories of psychological abuse (spurning, corrupting, terrorising, isolating, and denial of emotional response), the 4 major categories of neglect (physical, emotional, medical, and educational neglect), and conditions involving falsification and fabrication (like Munchausen syndrome by proxy).

2. Be able to differentiate inflicted injuries from unintentional injuries – for physical signs of injury, and be able to differentiate non-patterned (inflicted or unintentional) from patterned bruises (often intentional).
3. Be convincing as an expert – for special patterns of injury or diagnosis such as shaken baby syndrome or gonorrhoea, and be ready to talk to a group of people with little medical training and knowledge to support your diagnosis. It is useful to speak to the key-workers early and individually before the MDCC, preach them the diagnosis and clear myths and mysteries. Eliminate the hurdles to establish the case prior to the MDCC is always a rewarding strategy.

Documentations before MDCC

1. Written documentation – Check that injuries are properly charted and measured. Comment on the injuries whether they are fresh or old. Correlate with the given account how each injury happened, whether it was inflicted or made unintentionally.
2. Photo-documentation – Check if clinical photos have been taken and make sure that the pictures will be ready on the date of the MDCC. Avoid Polaroid's. Camera with macro lens often produces the best pictures. A good clinical photo tells a story.
3. The medical report – Try to complete the medical report at least one day prior to the MDCC. Use the right and concise terms for layman – use "bleeding into the white of the eye" instead of "conjunctival haemorrhage"; "normal clotting screen" instead of listing the normal laboratory findings. Insert additional remarks that would help to explain the diagnosis – for instance, "metaphyseal fracture cannot be produced by falling or someone jumping onto the leg"; "normal genital finding does not exclude sexual abuse

because child sexual abuse is not commonly associated with positive clinical signs". It has been our practice to insert the following statement on top of the report: "This is a provisional report for reference in multi-disciplinary case conference for child abuse. The information should not be disclosed without the written permission of the Department of Paediatrics and Adolescent Medicine of Tuen Mun Hospital".

4. Diagram or drawing – Attach simple diagrams or drawings to help other people to understand the location, and thus the mechanism, of the injuries. For instance, a broken bone in the palm (metacarpal) marked on a drawing of hand bones would help to explain how the child was injured when he tried to defend himself from an attacking folding chair.

The agenda of the MDCC

1. Know the other participants – Be prepared to meet the other professionals who are coming for the MDCC. If there are too many people to speak, suggest to the chairperson at the beginning of the case conference how much time each person is allowed to address his/her report. It would be ideal if reports can be circulated prior to the meeting to save time in reading the reports in the MDCC.
2. Examine the sequence of the agenda – Do not always follow the sequence. It is often useful for the medical practitioner to speak first when the medical evidence is overwhelming. Try to include answers to those questions you know someone will raise.
3. Family participation – If family participation for the whole conference is contemplated, check with the caseworker how well the family has been prepared. Discuss with the caseworker about the case nature. If there is a discrepancy among the professionals towards the case nature, it is better to object to full-length participation. Remind everyone in the MDCC that family participation is not an arrangement to fill up incomplete investigation or to repeat the interrogative process.

Handling discussions in the MDCC

1. General attitude – Be professional, objective, resourceful and helpful to the other professionals.

Feel proud if you can help others to accomplish their job.

2. Examine what is spoken – Classify each important message into a *fact* (what actually happened), a *professional opinion* (based on a person's professional experience or training), a *feeling* (based on emotive reaction), or a *conjecture* (unfounded statement). For example, the family background and the physical signs are facts. That the injuries are compatible with beating with a rattan stick is a professional opinion. To say "the beating is not a big deal because my father did it to me when I was small" is a personal (or unprofessional) opinion. That the child is naughty is a feeling (unless the school or police record indicates otherwise). That the elder brother might have jumped on the baby (when no one actually saw it) is a conjecture. It is useful to apply this concept when summing up what a member has said and weigh it against your facts and professional opinion.
3. Special remarks about neglect and psychological abuse cases – It is often useful and convincing if the medical practitioner can summarise the facts from the social enquiry report and information gathered from other professionals and arrive at a diagnosis. Remember to thank them for their input or else you would not be able to arrive at the conclusion.

Deciding on the case nature

1. Lead the discussion – Try to speak first about the medical diagnosis and back it up with the facts and your opinion. Others who opine an alternative diagnosis will have a hard time to overcome your points of view.
2. The issue of certainty – The primary purpose of the MDCC is on child protection. It is not a substitute for trial or judgment of criminality. The discussion should be based on the balance of probabilities and not on "beyond reasonable doubts".
3. Ask for positive statements – When something has happened, there should be a positive opinion on the case nature. Do not allow anyone to get away with the statement "I do not think this amounts to child abuse". Ask them what they think has happened, or suggest to them if it is excessive corporal punishment. If they agree, ask them what prevents them from calling the injuries child abuse.
4. Mistaken arguments – That the abuser is poor, or has a good intention for the child in mind, that the beating is an isolated incident, or the child being closely attached to the abuser are not reasons to rule out physical abuse, although they are important factors to consider in the management plan. Point out that the remorse or cooperation of the parents after the incident has nothing to do with the case nature if someone tries to put this up to exclude physical abuse (see Table 2).

Table 2. Mistaken arguments against the diagnosis of child abuse

	Mistaken arguments	Why the arguments are fallacious
Intention/Motive	<ul style="list-style-type: none"> ▪ The alleged perpetrator did it (beat the child) for the child's own good. 	<ul style="list-style-type: none"> ▪ A good intention is not an excuse to inflict injury to someone else. ▪ A child does not need inflicted pain for growth and development.
"Accidental" injury	<ul style="list-style-type: none"> ▪ The alleged perpetrator did not mean to injure the child. ▪ The alleged perpetrator wanted to beat the child's arms, but the head was injured when the child tried to escape or defend. ▪ It was just an accident. 	<ul style="list-style-type: none"> ▪ Beating causes injury. ▪ It is natural for a victim to escape or defend; the one who beats is ultimately responsible for the injuries. ▪ Injury caused by beating is an expected or predictable outcome; it is not an "accident".
Frequency	<ul style="list-style-type: none"> ▪ This just happened once. 	<ul style="list-style-type: none"> ▪ Any significant injury inflicted once can be regarded as child abuse. ▪ Frequency of beating is generally used to rule in, but not to rule out, child abuse.
Perpetrator's reaction	<ul style="list-style-type: none"> ▪ The alleged perpetrator was remorseful and promised not to do it again. 	<ul style="list-style-type: none"> ▪ The diagnosis of child abuse refers to what has happened to the child.

5. Special cases – In case of shaken baby syndrome or gonorrhoea, the medical practitioner should guide the other members that it is a two-stage decision: (1) whether this is child abuse; (2) who the perpetrator is. Some people have difficulty to separate this logical sequence. They do not support a diagnosis of child abuse because they cannot figure out who the perpetrator is.
6. Indeterminate cases – There are instances in which the information surrounding the suspected incidence of abuse is incomplete, when the child victim is immature or unready to disclose, or when there are contradicting statements that are hard to prove or refute. Unless there are reasonable alternative diagnosis to account for the child's symptoms and signs, it would be more appropriate to conclude the case as indeterminate rather than exclusive of child abuse.

Follow-up, action plan and case review

1. Action plan with objective assessment – The follow-up plan should be laid down with objective criteria and behavioural indicators that signal positive changes, like willingness to improve parenting skills, active participation in psychiatric care, alcohol or substance abstinence, or resolution of conjugal conflicts. If medical follow-up is needed for the child, this should be clearly marked in the action plan.
2. Decide if it is necessary to review the case, say three months or six months later, especially if the follow-up plan could not be accomplished smoothly, or if the parents would change their minds easily. A case review is needed if there is any deviation from the action plan for follow-up.

The minutes of the MDCC

1. Always check if what you have said is correctly represented. Be obliged to amend and supplement those points if necessary.
2. Minutes are not verbatim. Points that you have raised during the meeting at different times should be summarised into the same section if they convey the same opinion. Irrelevant discussions should be deleted or remarked on appropriately.
3. Feel free to insert any reference or suggest an addendum if this additional information would

help the other participants to understand the salient issues.

Troubleshooting

If you have difficulty in following these rules immediately or thoroughly, don't panic. It takes the authors more than five years and sitting in a few hundred case conferences to lay them down. Consult a senior member of your department or the Medical Coordinator on Child Abuse in your institution. The people that you are working with are likely to be different, and additional or alternative strategies may be more applicable in your situation.

Summary

MDCC represents an important forum where professionals working and advocating for child health and welfare meet to share information and opinion on suspected cases of child abuse, determine the case nature and underlying problems, and formulate action plans to help the child victims to recover and rehabilitate from the maltreatment. The participating medical practitioner should be well equipped with knowledge and experience in child abuse, as well as the dynamics underlying inter-professional coordination. Although the emphasis of this article has been placed on the "case conference", the success of child protection management depends on the truthfulness of the "multi-disciplinary" collaboration.²⁴ The MDCC should not be regarded as the only means of inter-agency communication and decision-making. Indeed, communication between the medical practitioner and the caseworker before and after the MDCC can be equally, if not more, important as complex psychosocial issues do not dissolve right after the adjournment of the MDCC.

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