REPORT ON THE REVIEW PANEL'S FINDINGS AND RECOMMENDATIONS TO STRENGTHEN THE CHILD PROTECTION ECOSYSTEM

16 October 2025

TABLE OF CONTENTS

EXECUTIVE SUMMARY

I. In May 2025, following the sentencing of individuals involved in the murder of four-year old Megan Khung ("Megan"), the Ministry of Social and Family Development (MSF) set up a Panel to (i) review the actions of the relevant agencies involved in the case; (ii) review the enhanced protocols and processes that the agencies instituted after Jul 2020; and (iii) recommend if any further refinements are necessary, to enhance the safety of children while ensuring the practicality and sustainability of the measures for the agencies.

KEY EVENTS

II. In May 2017, Megan was enrolled in Playgroup at Healthy Start Child Development Centre (HSCDC). Megan progressed to Nursery 1 in 2018. Her attendance at preschool became irregular in early 2019, coinciding with her mother Mdm Foo Li Ping's ("Foo") move to a rented apartment with her boyfriend Mr Brian Wong ("Wong"). On 19 Mar 2019, Megan's teachers discovered bruises on her. This prompted intervention by HSCDC staff and community workers from Beyond Social Services (BSS), the community agency that operates HSCDC. The BSS community workers put in place a temporary care plan that required Megan to stay with her grandmother, to ensure her safety. BSS also submitted an incident report to the Early Childhood Development Agency (ECDA) on 5 Apr 2019. The incident report mentioned that HSCDC staff had "noted bruises on Megan's face, arms, thighs, feet and buttocks" on 19 Mar 2019, and stated that "Megan appears to be happy and had re-adjusted to the school schedule. No further injuries have been noted." ECDA acknowledged the report, and ECDA's correspondence with HSCDC ended after the principal confirmed that Megan was well and attending preschool regularly.

III. Megan last attended preschool on 5 Sep 2019. On 10 Sep 2019, Megan's grandmother informed BSS that Megan was staying with Foo. This was a breach of the temporary care plan. Foo became unresponsive to BSS community workers' attempts to engage her. On 17 Sep 2019, Foo emailed HSCDC to withdraw Megan from the preschool. During this period, Megan's grandmother was neither able to physically sight Megan, nor was she aware of Foo's place of residence. From end-Sep to Oct 2019, BSS community workers contacted various agencies – MSF Child Protective Service (CPS), ECDA, HEART@Fei Yue (HFY) Child Protection Specialist Centre (CPSC), and made informal checks with the Singapore Police Force (SPF). Despite advice to file a police report, Megan's grandmother hesitated, fearing that this would cause Foo to go further into hiding, and make it more difficult to contact her.

IV. On 17 Jan 2020, Megan's grandmother lodged a police report, accompanied by a BSS community worker. The case was initially assessed by SPF as low-risk, and the Investigation Officer (IO) assigned to the case attempted to locate Foo and Megan. The

IO was subsequently deployed for COVID-19 operations. On 20 Jul 2020, further police reports were filed by Megan's grandmother and Megan's father. SPF located Foo and Wong on 23 Jul 2020. They were arrested and charged for Megan's murder. Investigations revealed that Megan had been abused and died on 22 Feb 2020. A third individual, Ms Nouvelle Chua ("Chua"), was also arrested and charged for the concealment, desecration and disposal of Megan's body.

FINDINGS OF THE REVIEW PANEL

V. The Panel found that while there were appropriate actions taken by the agencies involved in some instances, there were also areas where agencies could have done better. The Panel also noted instances of a lack of clear understanding and communication among the agencies. Hence, this case held many lessons for each agency, on how they could have done more to protect Megan.

Finding #1: HSCDC teachers were prompt in reporting Megan's injuries. However, BSS's incident report to ECDA could have been more detailed in describing Megan's injuries, and timely.

VI. As the preschool principal was away on overseas leave, the incident report was sent to ECDA 17 days after the teachers first observed Megan's bruises. There could have been better internal coordination within BSS and HSCDC for the report to be sent by another staff on the preschool principal's behalf, given that it concerned a child presenting with multiple injuries.

VII. The incident report that was eventually sent to ECDA described Megan's injuries as "bruises on Megan's face, arms, thighs, feet, buttocks", and characterised the injuries as due to "physical punishment [that] was excessive". After examining the available information and BSS's representations, the Panel was of the view that the incident report to ECDA could have been more detailed in describing Megan's injuries. The incident report also did not mention Foo and Wong's possible drug use.

Finding #2: CPS could have been more sensitive to the information provided by BSS and could have probed further into the risk level of the case. Contrary to established processes, a record of BSS's call to CPS was neither created nor reviewed.

VIII. Between 20 and 25 Sep 2019, BSS made two calls to CPS. The recording of one of the calls was located. From the transcript of the call, the Panel was of the view that CPS could have gone beyond providing advice on the immediate steps BSS could take, to probe further to understand the risk-level of the case. In particular, although BSS provided limited information by summarising Megan's injuries sustained in Mar 2019 as "a lot of bruises", this past incident should have prompted CPS to ask questions to seek

greater detail on the extent of the bruises, to more accurately gauge the risk of Megan staying with her mother. CPS could have also been more sensitive to the information shared by BSS on Foo and Wong's involvement with drugs, and the concern expressed by BSS's community worker. The officer also did not register the call, contrary to established processes in CPS at that time. As a result, the call was not discussed further with the supervisor on duty, as was the standard treatment for all calls to CPS.

Finding #3: HFY tried to convene a meeting with Megan's family, but did not proceed further.

IX. On 25 Sep 2019, BSS called HFY and followed up with an email, stating that BSS "was looking for referral to triage". From the contents of the email, the Panel was of the view that while HFY tried to convene a meeting with the family, they should have treated BSS's call and follow-up email as a referral for HFY to take the case, rather than a referral for triage. This was in view of the following relevant information in BSS's email, namely that (i) Megan was unsighted, (ii) Megan had been exposed to excessive punishment in the past, (iii) a temporary care plan had not been complied with, and (iv) Foo was abusing drugs.

Finding #4: There was a prevalent impression that a police report about a missing child should be made by a family member.

X. BSS sought advice from CPS, HFY and ECDA in Sep and Oct 2019. Of the three agencies, CPS and ECDA advised that the grandmother should lodge a police report. One of the police officers whom BSS's community worker had informally checked with had also given general advice that a police report should be made. The BSS community worker attempted to convince Megan's grandmother to make a police report, but the grandmother was hesitant to do so as she did not want to be further estranged from Foo. The Panel noted that the law does not restrict who can make a police report. Anyone who has information about a crime or suspicious activity can report it to the police.

Finding #5: Individual SPF officers' failure to follow established processes prevented timely and appropriate action on the first report.

XI. On 17 Jan 2020 when the first police report was made, the Investigation Officer (IO) assessed the matter to be a case of child discipline with low safety concern. The IO had told the Officer-in-Charge (OC) of the duty team that she would follow up with contacting and tracing Foo. Hence, the OC did not raise this report for discussion in the regular case review sessions with supervisors the following day. The IO attempted unsuccessfully to locate Foo and Megan for about two weeks and was subsequently deployed for COVID-19-related duties. The IO and the OC's failure to follow established processes prevented timely and appropriate action on the first report.

RECOMMENDATIONS

XII. The Panel noted that Singapore's child protection ecosystem, which is premised on a whole-of-society approach, has evolved since 2020, with continuous efforts made to strengthen the ecosystem. The Panel made recommendations to further strengthen the child protection ecosystem.

XIII. **Recommendation #1: All cases of child abuse should primarily be handled by child protection case management agencies [1] and the agencies should be adequately resourced.** This means that all other parties should concentrate on detecting and reporting possible child abuse in a timely manner, for the case to be triaged and managed by child protection case management agencies. MSF should also ensure that these agencies are adequately resourced to be effective and able to carry out their roles in managing child protection cases.

XIV. **Recommendation #2: An appeals mechanism should be established to address cases where CPSC/Protective Service (PSV) have differing views from the reporting agency on risk levels and case management. This will ensure that all reports receive appropriate attention and improve consistency in triaging decisions.** Regardless of the parties involved, this mechanism should be able to take an objective stance on the appropriate triage decision.

XV. **Recommendation #3: MSF should review ECDA's role in triaging potential intra-familial child protection cases.** Although ECDA licensing officers are trained in the Child Abuse Reporting Guide (CARG), they are not trained child-protection specialists and may not have the expertise to guide preschools on how to manage the case in the interim.

XVI. **Recommendation #4: While MSF had formalised protocols for what agencies should do for a missing child, MSF should work with SPF to eliminate the wrong perception on the ground that only family members can make a police report of a missing child. A safe culture should be created, to encourage reporting, and social service professionals should be clear that they have a duty to report child abuse, even if only suspected, or missing children, to the authorities.** MSF should also work with SPF to take steps to raise awareness and correct the misconception that only family members can make a police report of a missing child. The Panel also suggested for MSF to look into creating a culture and environment where social service professionals feel

[1] For the purposes of this report, child protection case management agencies refer to Family Service Centres (FSCs), Child Protection Specialist Centres (CPSCs), Protection Specialist Centres (PSCs), as well as Child Protective Service (CPS), which are part of the national response to child abuse cases.

safe and supported in reporting potential child abuse cases, including lodging a police report.

XVII. **Recommendation #5: Lessons learnt from critical incidents should be routinely shared with community agencies to enhance practice.** MSF should provide a safe structure and space to promote learning amongst stakeholders in the ecosystem, to allow collective learning among stakeholders, and continuously improve on the standards and quality of practice. Relevant lessons should be incorporated in the training content for practitioners.

XVIII. **Recommendation #6: Professionals who work with children should be sensitised to issues pertaining to child safety.** The Panel believes it is important for all professionals who work with children to be familiar with the reporting and escalation system. The Panel notes that relevant training is available.

XIX. **Recommendation #7: A stronger culture of support should be promoted for practitioners involved in child protection work.** All levels of society should enhance the support given to practitioners engaged in child protection work. Employers (i.e. social service agencies and government agencies) should be encouraged to put in place structured support for practitioners involved in child protection cases so that practitioners working on these emotionally demanding cases have safe, conducive, and supportive work environments.

1. INTRODUCTION

1.1 In Feb 2020, a four-year old girl, Megan Khung ("Megan"), died from a punch to her stomach area, after being abused by Mr Brian Wong ("Wong") and Mdm Foo Li Ping ("Foo"). After Megan was withdrawn from the preschool on 17 Sep 2019 and taken to stay with Foo and Wong, the abuse escalated. In Jul 2020, Wong and Foo were charged for the murder of Megan. They, and a third individual, Ms Nouvelle Chua ("Chua"), were also charged with the concealment, desecration and disposal of Megan's body. Foo was Megan's mother, and Wong was Foo's boyfriend at the time Megan was killed. Chua was a friend of Foo and Wong.

1.2 In Apr 2025, Foo was sentenced to 19 years' jail for her role in Megan's death. Wong was sentenced to 30 years' jail and 17 strokes of the cane for his role in Megan's death and other drug crimes. At the time this report was prepared, sentencing proceedings for Chua were still pending.

1.3 On 8 Apr 2025, the Ministry of Social and Family Development (MSF) issued a press release on the lessons learnt from past child abuse cases over the decade. On 11 Apr 2025, MSF issued a second press release, stating that it would carry out a further review on Megan's case. The review would cover the responses of all agencies involved – from the preschool, social service agencies to the Early Childhood Development Agency (ECDA), Child Protective Service (CPS) and SPF. The review would also include additional information that Beyond Social Services (BSS), the community agency affiliated to the preschool attended by Megan, had obtained and shared with MSF, after the 8 Apr 2025 press release was issued.

A. Panel for the Review

1.4 In May 2025, the Minister for Social and Family Development, Mr Masagos Zulkifli, appointed a Review Panel to look into strengthening the child protection ecosystem, arising from the death of Megan. The Panel comprised:

- **Prof Kenneth Poon (Chairperson)**
  Singapore Representative
  ASEAN Commission on the Promotion and
  Protection of the Rights of Women and Children

- **Dr Corinne Ghoh**
  Associate Professor (Practice)
  Department of Social Work
  National University of Singapore

- **Dr Vincent Ng**
  Dean and Associate Professor (Practice)
  School of Social Work and Social Development
  Singapore University of Social Sciences

- **Mdm Zuraidah Abdullah**
  Chief Executive Officer
  Yayasan MENDAKI

1.5 The Panel's terms of reference were to:

- Review the actions of the relevant agencies involved prior to the discovery of Megan's death in Jul 2020;[2]
- Review the enhanced protocols and processes that the agencies instituted after Jul 2020; and
- Recommend if any further refinements are necessary, to enhance the safety of children while ensuring the practicality and sustainability of the measures for the agencies.

1.6 The Panel submitted its report to the Minister for Social and Family Development, Mr Masagos Zulkifli, and the Minister-in-charge of Social Services Integration, Mr Desmond Lee, on 16 Oct 2025.

B. Approach to the Review

1.7 The central purpose of undertaking a thorough review of the actions by the various individuals and agencies involved was to identify the gaps that exist in the ecosystem, so that the sector, in particular the agencies in the child protection ecosystem, can learn lessons from this case and improve, moving forward. During the course of the review, the Panel was guided by the following principles:

- The centrality of child safety, recognising it as the foremost consideration in child protection work;
- Families as the foundational unit of care for the child, which should be supported and empowered to fulfil this role effectively; and
- The need to take a whole-of-society and strengths-based approach to protect the child's safety and well-being.

1.8 The Panel met and interviewed all the relevant agencies involved from Jun to Aug 2025. Agencies were invited to share in detail their actions prior to the discovery of

[2] These were Healthy Start Child Development Centre (HSCDC), Beyond Social Services (BSS), Early Childhood Development Authority (ECDA), MSF Child Protective Service (CPS), HEART@Fei Yue (HFY) Child Protection Specialist Centre (CPSC), and the Singapore Police Force (SPF).

Megan's death in Jul 2020, whether the actions were in line with prevailing protocols and processes at the time, whether they had instituted enhanced protocols and processes after Jul 2020, and the impact of those enhanced protocols and processes. The Panel also sought written clarifications from agencies and reviewed relevant documents and statements to better understand the actions of the individuals directly involved in Megan's case and the context and considerations that informed them. In Aug and Sep 2025, the Panel also engaged key representatives from the child protection ecosystem on how the parties in the ecosystem worked together, and what areas could be improved to better enhance the safety of children.

1.9 The Panel carefully calibrated its approach with regard to divulging the names of the organisations and individuals involved, taking into consideration two objectives – first, providing sufficient details so that the lessons learnt are clear; and second, to maintain public trust by demonstrating transparency and accountability. Therefore, individuals have not been named in this report, and actions have been characterised as being undertaken by organisations and their representatives.

1.10 The Panel would like to acknowledge the support of the agencies by their forthcoming cooperation when information and clarifications were sought, as well as their openness in sharing their lessons learnt and improvements made. The Panel also thanks all agencies involved, as well as stakeholders who participated in the engagement session, for their inputs and feedback, as well as their commitment to work together to further improve the child protection ecosystem.

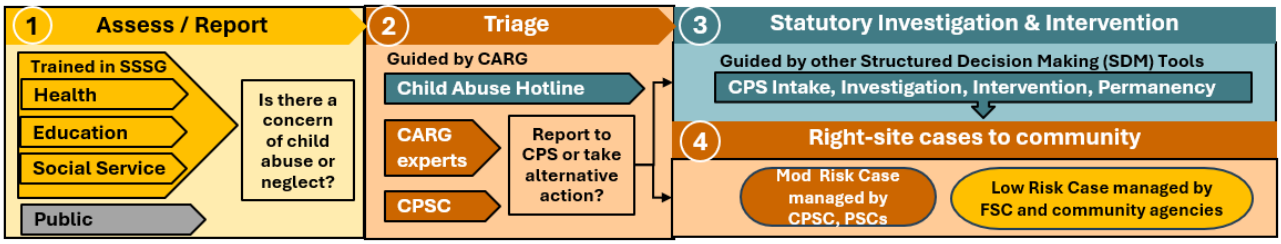
2. BACKGROUND

A. Overview of the Child Protection Ecosystem

2.1 The child protection ecosystem in 2019 was premised on a whole-of-society approach involving inter-agency collaboration. It was anchored by a Structured Reporting Framework across the various stakeholders and agencies involved (see Diagram 2.1).

2.2 The child protection ecosystem includes Family Service Centres (FSCs), Child Protection Specialist Centres (CPSCs), Protection Specialist Centres (PSCs), as well as CPS. These agencies are referred to as "child protection case management agencies" for the purposes of this report and are part of the national response to child abuse cases. CPS was a department under MSF which managed cases requiring statutory intervention, while FSCs, CPSCs and PSCs are funded by MSF to manage child abuse cases, depending on the assessed risks of the case.[3] Besides these agencies, there are other social agencies that operate in the community and may work with children, but do not have official case management responsibilities. These are referred to as "community agencies" for the purposes of this report (BSS is one such example).

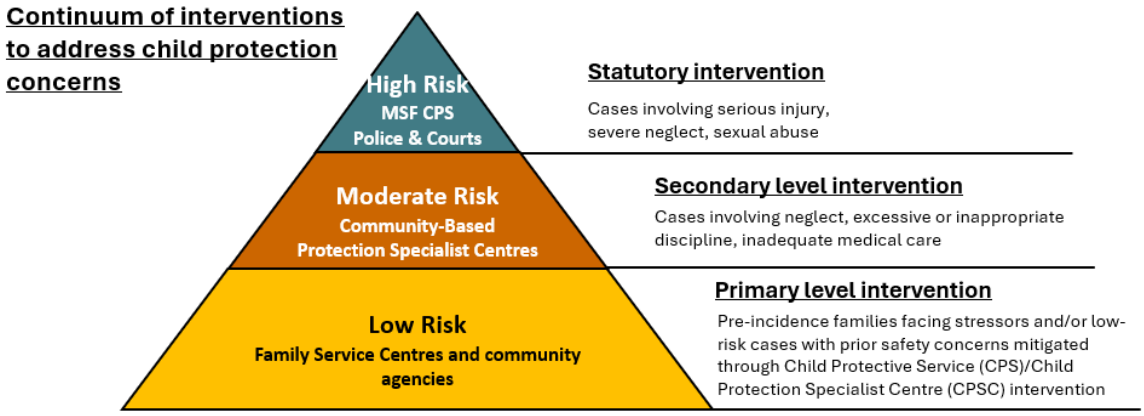
Diagram 2.1 Structured Reporting Framework



2.3 The Structured Reporting Framework was anchored in a continuum of interventions, such that management of cases with child protection concerns would be led by different child protection case management agencies, depending on the level of risk presented by the case (see Diagram 2.2). This was meant to minimise unnecessary state intrusion while ensuring timely detection, reporting, intervention and support for the full range of cases.

[3] FSCs, CPSCs, and PSCs are funded by MSF via funding agreements based on specified service models. CPS was a department under MSF. Since May 2025, CPS, Adult Protective Service (APS) and Children in Care (CIC) have been integrated to form Protective Service (PSV).

Diagram 2.2 Continuum of interventions



2.4 In 2019, based on the Structured Reporting Framework, persons were to report all suspected child abuse cases to CPS, or to ECDA for preschools. Professionals in the healthcare, education and social service sectors who interacted with children in the usual course of work were considered important stakeholders who could detect cases of child abuse. The Sector-Specific Screening Guide (SSSG)[4] was developed in 2015 and rolled out from 2016 to 2018 to support such professionals to identify any abuse concerns. In 2019, professionals were advised to use the SSSG, to assess if they should:

- Continue to monitor and observe for any change that would require a review of action to be taken;
- Consult an internal Child Abuse Reporting Guide (CARG)[5] expert (e.g. CPSCs, Lead School Counsellor, ECDA Licensing Officer); or
- Report to CPS.

2.5 While the SSSG did not touch on the lodging of a police report, the standard communication line in CPS's messaging to stakeholders and the public was "If there is imminent threat to life or safety, call the police at 999". In such situations, SPF would refer cases to CPS after addressing the imminent danger.

2.6 Similarly, CARG was developed in 2015 and rolled out from 2016 to 2018. CARG is used by professionals (e.g. CPSCs, Lead School Counsellor, ECDA Licensing Officer) to determine if the case should be:

- Reported to CPS (Diagram 2.1, Box 3); or

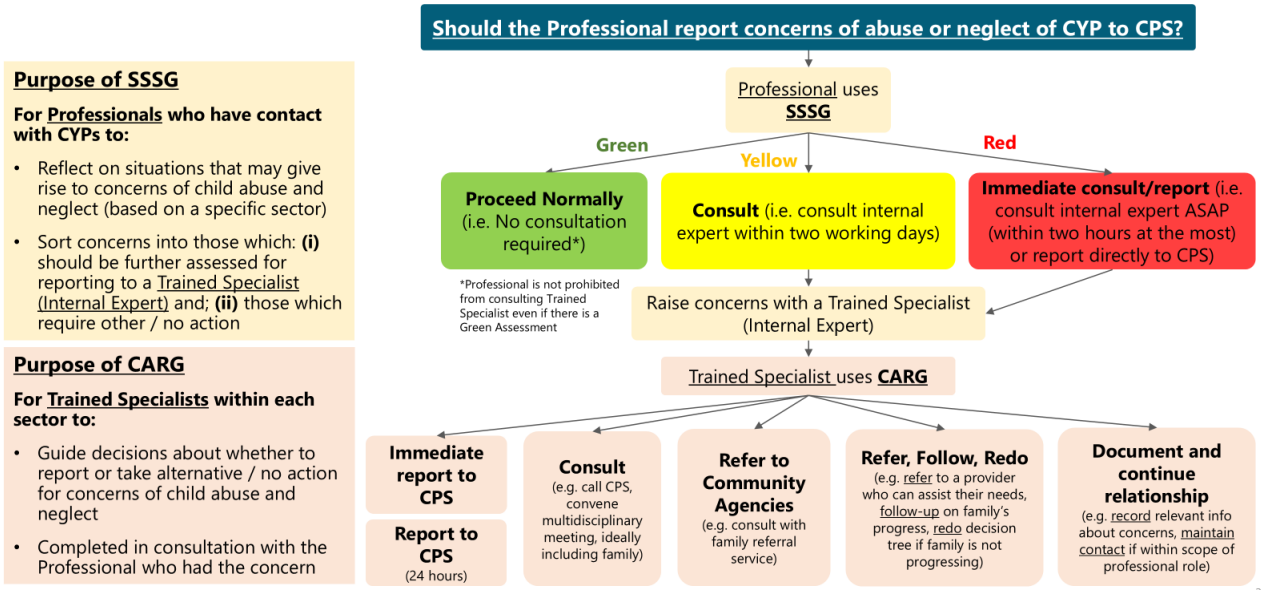
[4] The Sector-Specific Screening Guide (SSSG) is intended to be used by professionals who have contact with children/young persons (CYPs) to reflect on situations that may give rise to concerns of abuse and neglect, and to guide decisions on whether or not these concerns should be reported to an internal CARG expert or require alternative/no action for the concerns.

[5] The CARG is intended to be used by trained specialists, who are concerned about possible abuse or neglect of a CYP, to guide decisions on whether to report their concerns to MSF's CPS or take alternative/no action for the concerns.

- Referred to a CPSC or FSC (Diagram 2.1, Box 4).

2.7 Diagram 2.3 provides more details on the various outcomes following the use of SSSG and CARG.

Diagram 2.3 Overview of purpose of SSSG and CARG and possible outcomes of using SSSG and CARG



2.8 As cases of suspected child abuse require simultaneous police investigation and social interventions, SPF and CPS have developed joint protocols to coordinate actions. The protocols ensure that actions are consistent, regardless of whether a case is reported via the CPS Hotline or to the police.

B. Background of Healthy Start Child Development Centre (HSCDC) and Beyond Social Services (BSS)

2.9 BSS is a community agency that supports children and youth from less privileged backgrounds. It has a license to operate an Early Childhood Development Centre (ECDC), and the ECDC operates under the name of HSCDC. As the licensee, BSS is accountable to ECDA.

2.10 HSCDC is a preschool operated by BSS and their focus is on educating disadvantaged children whilst actively involving parents and/or caregivers. It aims to build up home-school partnerships and its preschool teachers work with BSS community workers who focus on strengthening partnerships between teachers and parents.

C. Chronology of Key Events

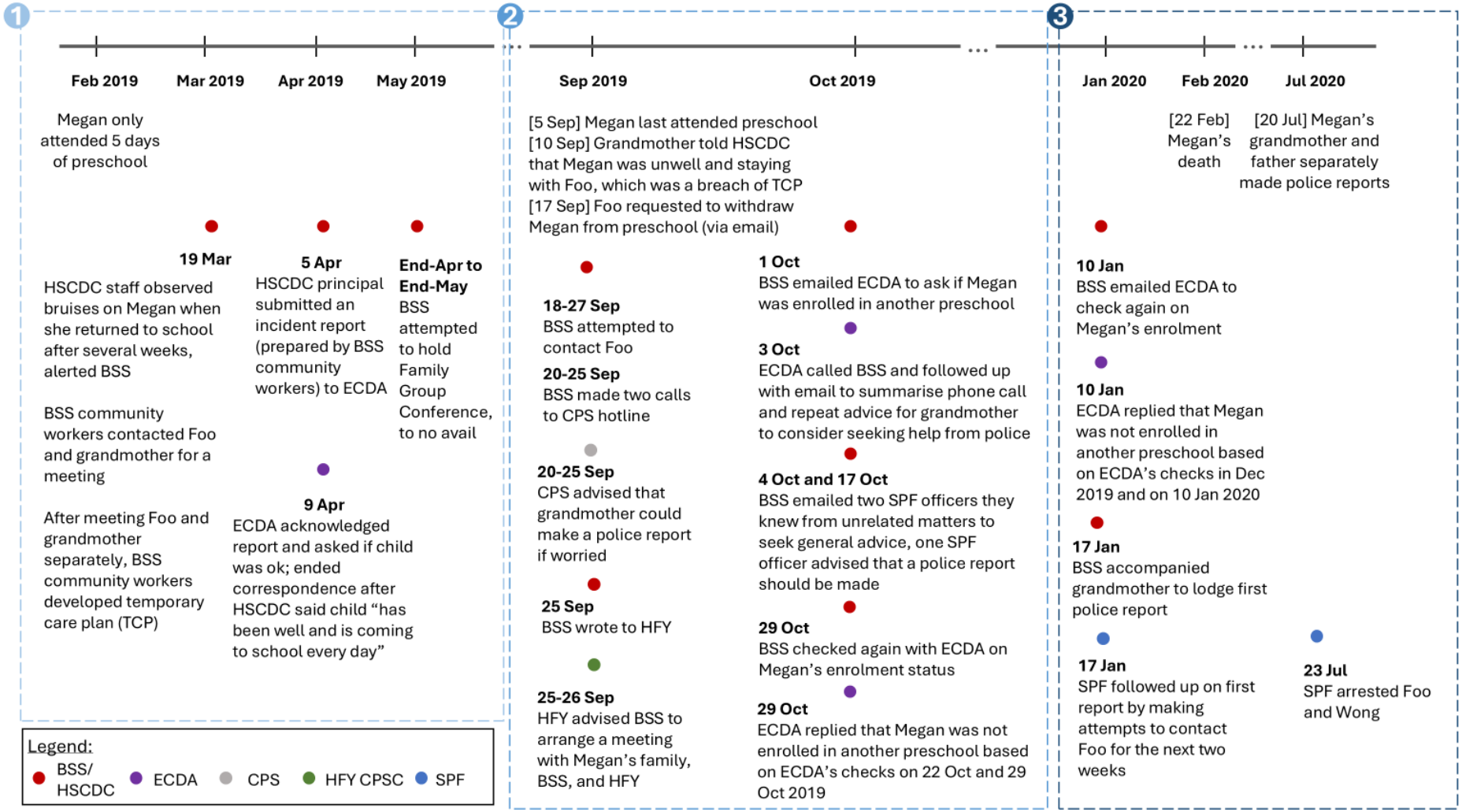
2.11 This section outlines the key events related to agencies' actions prior to the discovery of Megan's death across the following three time periods (as detailed in

sections below and summarised in Diagram 2.4):

- First Period (Mar to Aug 2019) – When Megan's injuries were first discovered at the preschool up to the point before Megan last attended preschool.
- Second Period (Sep to Dec 2019) – When Megan last attended preschool up to the point before the first police report was lodged.
- Third Period (Jan to Jul 2020) – When the first police report was lodged up to the point of discovery of Megan's death.

Subsequent sections of this report cover some of these events in greater detail, along with the Panel's findings.

Diagram 2.4 Chronology of key events across the three time periods



Events prior to Mar 2019

2.12 In Apr 2017, Megan and Foo moved to stay with Megan's maternal grandmother. In May 2017, Foo enrolled Megan in HSCDC's Playgroup. Megan progressed to Nursery 1 in 2018, and her attendance was regular until end-Jan 2019. BSS community workers worked with Foo through her participation in Home School Partnership efforts and programmes in 2017 and 2018. For example, Foo presented an appreciation speech at HSCDC graduation day in end 2017. They also corresponded with Foo to share parenting and discipline tips in Feb 2019, in response to Foo's query on when was the right age to be strict with a child.

2.13 In Jan 2019, Foo moved to a rented apartment in a condominium along Guillemard Road,[6] after entering into a relationship with Wong in Nov 2018. Megan continued to stay with her grandmother but would stay over at the rented apartment on some weekends.

2.14 Megan started to be absent from preschool more frequently from end-Jan to Mar 2019. She attended preschool for five days in Feb 2019 and was absent entirely from 18 Feb to 18 Mar 2019.

2.15 HSCDC staff and a BSS community worker communicated with Foo over WhatsApp regarding Megan's absence from preschool. On 9 Mar 2019, Foo told the community worker that Megan was not attending preschool as she had taken "disciplinary action" on Megan and "did not want the school to think that Megan had been abused". HSCDC staff and BSS community workers continued to engage Foo on when Megan would return to the preschool and the care arrangements for Megan.

First Period (Mar to Aug 2019)

When Megan's injuries were first discovered at the preschool up to just before Megan last attended preschool

2.16 On 19 Mar 2019, Megan returned to preschool. Her teachers observed that there were bruises on her body during their routine health and physical check, and alerted HSCDC staff and BSS community workers.

2.17 When questioned by HSCDC staff and BSS community workers, Foo said that some of the bruises were due to disciplinary action inflicted by her, while others were injuries sustained when Megan fell while cycling. BSS explained to the Panel that the community workers assessed that Foo was "open and honest about her methods of disciplining Megan" and "expressed willingness to collaborate with HSCDC staff in learning alternative ways of disciplining Megan". BSS had later in 2025 clarified to the Panel that the community workers also considered that there "were no [known] prior instances" of excessive discipline and "mother and child have shown to have a positive

[6] BSS and Megan's grandmother were not aware of the exact address of Wong's rented apartment.

relationship". The community workers assessed this to be a case of excessive discipline. In addition, as the grandmother was a safe adult who could be entrusted with Megan's care, the community workers then developed a temporary care plan to ensure the welfare of Megan. The terms of the temporary care plan included that (i) Megan would stay overnight only at grandmother's house until a long-term arrangement was fixed for Megan's care, and (ii) only grandmother would drop off and pick Megan up from the preschool. The temporary care plan was mutually agreed by Foo and Megan's grandmother and put it in place by the end of the day on 19 Mar 2019.

2.18 The temporary care plan was enhanced on 22 March 2019 after a quarrel involving Megan's grandmother, Foo, and Wong. Enhancements included returning Megan to the grandmother before 8pm if Foo took Megan out over the weekend. That same evening, the grandmother also expressed concerns about Foo and Wong's suspected drug-related activities to the community worker.

Submission of first incident report to ECDA

2.19 On 5 Apr 2019, HSCDC's principal[7] submitted an incident report[8] to ECDA. The report stated the following points:

- HSCDC staff "noted bruises on Megan's face, arms, thighs, feet and buttocks", on 19 Mar 2019, after one month's absence from school.
- Foo had admitted that some of the bruises were "inflicted by her" (to discipline Megan) and "others were a result of Megan falling down while cycling".
- BSS community workers told Foo that the physical punishment was "excessive and not acceptable as it affects the well-being of the child".
- The terms of the temporary care plan that the community workers had put in place on 19 Mar 2019 and enhanced on 22 Mar 2019.
- "Megan appears to be happy and had re-adjusted to the school schedule. No further injuries have been noted."

2.20 ECDA acknowledged the report, and ECDA's correspondence with HSCDC ended after the principal confirmed that Megan was well and attending preschool regularly.

2.21 Between Apr and Aug 2019, Megan attended preschool regularly and the teacher and community workers worked together to ensure that the temporary care plan was adhered to. The teachers monitored Megan's learning and well-being in the classroom

[7] HSCDC's principal was away on leave when Megan's bruises were discovered on 19 Mar 2019.

[8] At that time, Regulation 39 of the Early Childhood Development Centres (ECDC) Regulations 2018 required a licensee, a member of a licensee's staff, or an education service provider engaged by a licensee, to report to the Chief Licensing Officer in ECDA, when they have reasonable cause to suspect that a child enrolled in the licensee's centre had been subjected to physical or sexual abuse. Wilfully or unreasonably failing to do so is an offence.

while the community workers continued to engage Foo. The community workers attempted to hold a Family Group Conference involving Foo and Megan's other caregivers to establish a longer-term care plan for Megan. The Family Group Conference aimed to address concerns such as alternative care arrangements in the event Megan were to fall ill while her grandmother was at work, and to arrange a home visit to Wong's place of residence. Foo had initially agreed to the proposed Family Group Conference. However, it did not take place, despite the community workers' multiple attempts to set up a meeting, as Foo gave excuses to put off the meeting.

Second Period (Sep to Dec 2019)

When Megan last attended preschool up to the point before the first police report was lodged

2.22 Megan last attended preschool on 5 Sep 2019.[9] On 10 Sep 2019, Megan's grandmother informed HSCDC that Megan was unwell and was being cared for by and staying with Foo. This was a breach of the temporary care plan. Megan's grandmother subsequently updated Megan's teacher that Foo would bring Megan back to preschool on 17 Sep 2019. However, this did not happen. The community workers were also unsuccessful in their attempts to contact Foo.

2.23 On 17 Sep 2019, Foo emailed HSCDC to withdraw Megan from the preschool. The reason Foo gave was the preschool's lack of Chinese Language lessons. Megan's grandmother said she had video calls with Megan around 10 to 20 Sep 2019, and that Megan appeared to be fine.

BSS's communications with other agencies

2.24 Concerned for Megan's safety and unable to ascertain Megan's whereabouts since Foo had become unresponsive, the BSS community worker contacted various agencies, and relayed information about Megan's case to them. The key interactions that took place between 20 Sep and 17 Oct 2019 were as follows:

- Two calls to CPS between 20 and 25 Sep 2019;
- Calls and emails to HEART@Fei Yue (HFY) CPSC between 25 and 27 Sep 2019;
- Call and emails to ECDA in Oct 2019; and
- Emails to two different SPF officers on 4 and 17 Oct 2019.

Details of these key interactions are covered in Section 3.

2.25 Between Oct 2019 and Jan 2020, BSS remained in contact with Megan's grandmother to advise her to make a police report. Megan's grandmother was initially still

[9] HSCDC was closed from 6-9 Sep 2019 (Friday-Monday).

in contact with Foo. However, by Nov 2019, Foo had blocked calls from Megan's grandmother. Megan's grandmother was reportedly able to get her son (i.e. Foo's brother) to contact Foo sometime in Nov to Dec 2019. Foo's brother was told by Foo not to interfere with her affairs. Notwithstanding the community worker's advice to file a police report, the grandmother was unwilling to do so, as she was worried that this would cause Foo to go further into hiding and make it more difficult to contact her. BSS's community worker visited Wong's last known residence and checked with neighbours to gather any information about Foo and Megan's whereabouts, but to no avail.

2.26 BSS also checked with ECDA from Oct 2019 to Jan 2020 to find out whether Megan was enrolled in other preschools. ECDA checked and advised BSS in Oct 2019 that the grandmother could consider seeking help from the police if she had concerns about the whereabouts of the child. ECDA had, in total, checked their preschool system on five occasions from Oct 2019 to Jan 2020 and did not find records of Megan's enrolment in any other preschool.

Third Period (Jan to Jul 2020)

When the first police report was lodged up to the point of discovery of Megan's death

2.27 On 17 Jan 2020 (more than four months since Megan was last seen at the preschool), the community worker accompanied Megan's grandmother to lodge a police report. Based on the facts of the case, the Investigation Officer (IO) assigned to the case assessed the matter to be a case of child discipline with low safety concern, and told her Officer-in-Charge (OC) that she would attempt to contact and trace Foo. The IO attempted to locate Foo and Megan for about two weeks and was subsequently deployed for COVID-19-related duties. She did not follow up on the case thereafter.

Lodging of second and third police reports

2.28 On 20 Jul 2020, Megan's grandmother lodged a second police report. On the same day, Megan's biological father also made a police report. The case was classified as a missing persons case.

2.29 On 23 Jul 2020, SPF's follow-up investigations found Foo and Wong in their rented apartment. Foo and Wong were arrested for murder with common intention on the same day. Investigations into Foo, Wong, and Chua revealed that Megan had been abused at the rented apartment and died on 22 Feb 2020. On 24 Jul 2020, Chua was arrested for child abuse and consumption of controlled drugs.

3. FINDINGS OF THE REVIEW PANEL

3.1 This section details the Panel's assessment of the actions of the relevant agencies prior to the discovery of Megan's death.

A. First Period (Mar to Aug 2019)

When Megan's injuries were first discovered at the preschool up to just before Megan last attended preschool

Finding #1: HSCDC teachers were prompt in reporting Megan's injuries. However, BSS's incident report to ECDA could have been more detailed in describing Megan's injuries, and timely.

3.2 HSCDC teachers were vigilant in discovering Megan's bruises on 19 Mar 2019 and reported this internally to the BSS community workers within the day. The community workers then checked with Foo and Megan's grandmother and put in place the temporary care plan on the same day (see para 2.17). The teachers and community workers implemented and monitored the temporary care plan, and no further injuries were observed on Megan for the period the temporary care plan was in effect.

3.3 As the preschool principal was away on overseas leave on 19 Mar 2019, the incident report was sent to ECDA via email on 5 Apr 2019, 17 days after the teachers first observed Megan's bruises.

3.4 The Panel noted that at the relevant time, the ECDC Regulations 2018 and Code of Practice did not specify a timeframe for suspected child abuse reports to be made. That said, the Regulations did not specify that only the principal could report an incident to ECDA. There could have been better internal coordination within BSS and HSCDC for the incident report to be treated with greater urgency, given that it concerned a child presenting with multiple injuries, and for the report to be sent by another staff on the preschool principal's behalf.

3.5 The incident report that was eventually sent by the preschool principal to ECDA was prepared by the community workers based on what they discovered that day. In the covering email to ECDA, the preschool principal indicated that she was writing to inform ECDA of an "incident relating to disciplining methods by a mother towards her child at home". In the incident report attached to the email, the injuries were described as "bruises on Megan's face, arms, thighs, feet, buttocks", and characterised as being due to "physical punishment [that] was excessive". The incident report stated that Foo had "admitted that some bruises were inflicted by her and others were the result of Megan falling down while cycling".

3.6 The Panel noted that the description of Megan's injuries in the incident report differed from how Megan's teacher subsequently described them after Megan's death was discovered, with the benefit of hindsight (see Extract 3.1).[10] In particular, the incident report to ECDA did not record that injuries were sustained on the torso area (i.e. chest and back), which included a possible burn mark or wound of some kind and the extent of the other injuries.

Extract 3.1 List of Megan's injuries on 19 Mar 2019, as described by Megan's teacher in Aug 2020

a. Bruising on the forehead (across almost her whole forehead) and left cheek
b. A burn mark or wound of some kind on her right chest (about 1cm)
c. Scratches/bruising along the right chin line
d. Bruising and horizontal scratch marks under her left ear
e. Wounded lips
f. A big bruise on her left leg, spanning from the back of her knee up till about half her thigh
g. 2-3 horizontal marks on her left thigh
h. A horizontal scratch on her right leg, a few cm above the knee
i. Bruising on the right leg above the knee (two marks joined together about the knee, one mark higher up, all about 4-5cm long)
j. 2 bruises on the sole of her left foot that span across the foot
k. A circular bruise on the sole of her right foot
l. Two horizontal lines on her right foot
m. Bruises on her lower back (from her spine up to the sides of her body, on both sides)
n. Multiple bruises on her buttocks (both cheeks)
o. Red mark on her third finger of her right hand, at the knuckle
p. Vertical scratch mark on her left hand (from wrist downward, about 2cm)

3.7 The Panel understood that Megan's teacher recalled that on the day of discovering Megan's bruises, she had taken photographs of Megan's injuries and shared these with the community workers and the principal over the course of the day. While at the relevant time, the ECDC Regulations 2018 did not specify how injuries should be described in incident reports, the Panel noted that the photographs provided a clear picture of the extent of Megan's injuries and, if submitted with the incident report, would have made it plainly evident to ECDA that this was a case of child abuse.

3.8 The Panel acknowledged that from a professional practice perspective,

[10] Megan's teacher had detailed the list in Aug 2020 after Megan's death was discovered, following a discussion that BSS management had with current and former staff. The teacher detailed this list while referring to photographs she took of Megan in Mar 2019.

unnecessary photo taking is discouraged to avoid inflicting further trauma on the victim. The Panel also understood that the teacher and community workers were told to delete the photographs as they were taken without parent's consent, but the teacher did not delete the photographs as she felt it was important to have them as a record of the serious nature of the injuries on Megan. As a result, the photographs were available as part of the evidence collected during SPF's investigations into Foo, Wong, and Chua's alleged criminal actions.

3.9 On 22 Mar 2019, Megan's grandmother had mentioned in passing, in the presence of one of the community workers, that Foo could have been using drugs and Wong was a drug dealer. BSS explained to the Panel that this information was not included in the incident report submitted to ECDA on 5 Apr 2019 as it could not be verified.

3.10 The Panel believes these additional details on the full extent of the injuries and suspected drug use (even if said drug use was not verified) would likely have raised the level of suspicion and could have prompted ECDA to refer the case to CPS.

3.11 The Panel was of the view that the timely detection of child abuse depends on the quality of the information provided to the authorities (e.g. ECDA or CPS) by preschools, schools, healthcare and social services (i.e. agencies in Box 1 of Diagram 2.1). Incident reporting concerning a child's welfare should be structured and substantive with descriptions on the extent of injuries sustained, account of what happened, the level of risk assessment, and any immediate actions taken by the reporting party. In addition, if a child presents with injuries, medical attention and treatment should be provided, and the injuries should be documented by a qualified medical professional. This is important so that child protection case management agencies that receive such reports are able to make a proper assessment on the level of risk of harm to the child. In 2019, while there was a system in place for preschools to report suspected abuse, there was no guidance on how specific the description of injuries needed to be.[11] This lack of specificity would have meant that assessment by ECDA was shaped in part by what the preschool thought was relevant to include.

3.12 The Panel further noted that under the Structured Reporting Framework, health, education and social service professionals were meant to be trained in SSSG. However, in 2019, the SSSG was just introduced to the sector and had not yet been made mandatory. BSS community workers (in their capacity as social service professionals) and HSCDC staff (in their capacity as educators) had not been trained to use and, in this case, did not use the SSSG to determine whether to report the case to CPS.

3.13 Similarly, CARG was available in 2019 to assist parties notified of suspected child abuse to guide their decision on whether to report a case to CPS. However, CARG was

[11] While the ECDC Code of Practice for preschools in 2019 provided guidelines on what should be included in each incident report that preschools submit to ECDA, there was no specific guideline on how injuries should be described, other than to report on the "number and extent of injuries".

also not mandatory in 2019. ECDA licensing officers were given verbal instructions to use CARG for suspected child abuse reports, but officers would still make their own judgement whether to use CARG since there were no specific guidelines on circumstances in which to use CARG. In this case, the ECDA licensing officer did not use CARG upon receipt of BSS's incident report, as the report and reassurance from the principal did not raise suspicion of child abuse.

B. Second Period (Sep to Dec 2019)

When Megan last attended preschool up to the point before the first police report was lodged

Finding #2: CPS could have been more sensitive to the information provided by BSS and could have probed further into the risk level of the case. Contrary to established processes, a record of BSS's call to CPS was neither created nor reviewed.

3.14 The Panel was informed that shortly after Megan's death was discovered in 2020, BSS had shared with MSF that it made two calls to CPS sometime between 20 and 25 Sep 2019. At that time, MSF could not find the two calls in its case management system. Subsequently, BSS informed MSF that they had made a further effort to verify their statement and managed to locate, on 9 Apr 2025, the date and time of one of the calls. This was the additional information referred to in MSF's media release of 11 Apr 2025. With the date and time of call, MSF made a further search and managed to locate the audio recording of one of the calls.

3.15 The Panel reviewed the transcript of the call, and is of the view that BSS's communication of the situation to CPS could have been clearer. In particular, the community worker could have provided the following information to CPS in her call:

- A fuller description of the injuries (e.g. minimally, at the level of detail in the incident report submitted to ECDA, instead of "a lot of bruises")
- That a "temporary care plan" had been established on 19 Mar 2019, and that this had been breached when the grandmother left Megan with the mother on 10 Sep 2019.

3.16 The community worker summarised her concerns, mentioning Megan's bruises in late March, suspected drug use by her mother and mother's boyfriend, the fact that Megan had not been seen by her grandmother since 10 Sep 2019 and that she was with her mother with whom she was not supposed to be staying, at an unknown location. However, this was diluted when the community worker said that the grandmother "feels the child is fine [as of the moment]".

3.17 At the same time, the Panel noted that CPS did not pick up on the discrepancy

between what ought to be BSS's professional assessment of whether the child was safe vis-à-vis the grandmother's opinion. Instead, CPS seemed to also have accepted the grandmother's assessment of the risk and stated that it would be difficult to act if the child was not located. The call ended with CPS advising that "if grandma is worried, she can also make a police report where the child in this case is missing and she has concerns over child's safety".

3.18 The Panel was of the view that CPS could have gone beyond providing advice on the immediate steps BSS could take, to probe further to understand the risk-level of the case. In particular, although BSS provided limited information by summarising Megan's injuries sustained in Mar 2019 as "a lot of bruises", this past incident should have prompted CPS to ask questions to seek greater detail on the extent of the bruises to more accurately gauge the risk of Megan staying with her mother. CPS could have also been more sensitive to the information shared by BSS on Foo and Wong's involvement with drugs, and the concern expressed by BSS's community worker that "we do not have sight of the child, we do not know where the mom's address is, there's possible risky behaviours by the parent and we worry that there shouldn't be a repeat of what happened in March again", to probe further. Doing so could have been more likely to uncover information that would have prompted CPS to follow-up on the basis that Megan might be at risk of harm.

3.19 The Panel also noted that the officer did not register the call, contrary to the established processes in CPS at that time. As a result, the call was not discussed further with the supervisor on duty, as was the standard treatment for all calls to CPS. Had the call been discussed with the supervisor, the supervisor might have requested a call-back and suggested further probing into the case. The Panel noted the non-registration of the call also resulted in difficulties in locating the call record until Apr 2025, when BSS furnished the exact date and time of one of the calls.[12] The Panel was informed that MSF has commenced a disciplinary investigation into the actions of the CPS officer.

Finding #3: HFY tried to convene a meeting with Megan's family, but did not proceed further.

3.20 On 25 Sep 2019, BSS called HFY (a CPSC) and followed up with an email, stating that BSS "was looking for referral to triage".

3.21 On 26 Sep 2019, HFY proposed to BSS to "contact all the relevant parties to set up [a] meeting". In response, BSS explained that if the grandmother "informs Foo or her

[12] As at date of print, CPS is unable to locate the other call. There are no records in CPS's case management system of this call. BSS is also unable to provide the date and time of this missing call, unlike with the call that MSF eventually located. The Panel understands from BSS that during this missing call, CPS had asked BSS to contact CPSC, which BSS did, on 25 Sep 2019.

boyfriend about a meeting with HFY, there is a risk that they will stop all contact with her, and it will become even more difficult to locate Megan", and asked if the meeting could go ahead with the grandmother only.

3.22 On 27 Sep 2019, HFY sent an email to BSS agreeing that Megan's whereabouts and her welfare was "a pressing concern" and said HFY "would not be able to make any headway, for any concrete risk assessment or intervention plan if [they] could not locate the child, Megan, and her parent". HFY had also suggested "to continue to encourage [grandmother] to find ways to have physical contact with Megan, to check in on her well-being", and that HFY "could only take in this case if we have the address of the natural mum, to locate Megan". HFY had also told BSS if they had new information about the case, to "please feel free to call [HFY's] triage team for a consultation".

3.23 Even though the community worker had used "no sight of the child" in the email, HFY explained to the Panel that while there were concerns on the case, based on the discussion between the agencies, there was no evidence at that point to suggest that Megan was in imminent danger that required immediate intervention to ensure safety. Hence, their advice was to locate the child and parent, and for more information to be gathered for further assessment.

3.24 The Panel was of the view that HFY should have treated BSS's call and follow-up email as a referral for HFY to take the case, rather than a referral for triage. This was in view of the following relevant information in BSS's email, namely that (i) Megan was unsighted, (ii) Megan had been exposed to excessive punishment in the past, (iii) a temporary care plan had not been complied with, and (iv) Foo was abusing drugs.

Finding #4: There was a prevalent impression that a police report about a missing child should be made by a family member.

3.25 BSS sought advice from CPS, HFY and ECDA in Sep and Oct 2019. Of the three agencies, CPS and ECDA advised that the grandmother should lodge a police report. One of the police officers whom BSS's community worker had informally checked with had also given general advice that a police report should be made.

3.26 The community worker attempted to convince Megan's grandmother to make a police report, but the grandmother was hesitant to do so as she did not want to be further estranged from Foo. The Panel noted that family members commonly face such a dilemma. However, the Panel was of the view that by early Oct 2019, it should have been clear to BSS that they could have gone ahead to lodge a police report themselves. By then, Foo had ceased contact with the community workers and had been uncontactable for some time. It should have been clear to BSS that the wishes of the grandmother not to damage her relationship with Foo should no longer take priority over Megan's safety. Notwithstanding that the specific advice was for the grandmother to make the police

report, multiple parties had also conveyed the need for a police report to be made.

3.27 The Panel further noted that the law does not restrict who can make a police report. Anyone who has information about a crime or suspicious activity can report it to the police. A case of a missing child should have been sufficient cause for concern for anyone with knowledge of it to make a police report.

C. Third Period (Jan to Jul 2020)

When the first police report was lodged up to the point of discovery of Megan's death

Finding #5: Individual SPF officers' failure to follow established processes prevented timely and appropriate action on the first report.

3.28 On 17 Jan 2020 when the first police report was made, the IO assessed the matter to be a case of child discipline with low safety concern. SPF explained to the Panel that the IO had made the assessment based on how (i) HSCDC and BSS had assessed the case as one of "excessive discipline" after discovery of the bruises on Megan on 19 Mar 2019, with a safety plan in place, (ii) there were no other reports of suspected abuse between 19 Mar 2019 and 17 Jan 2020 (day of the police report), and (iii) Megan was with her biological mother. The OC of the duty team had checked all the reports lodged during the shift and noticed this case with element of child discipline tagged under the IO. The OC intended to raise this report for discussion in the regular case review sessions by supervisors the following day. However, after speaking to the IO, who said she would follow up with contacting and tracing Foo, he decided not to do so. The IO attempted unsuccessfully to locate Foo and Megan for about two weeks and was subsequently deployed for COVID-19-related duties.

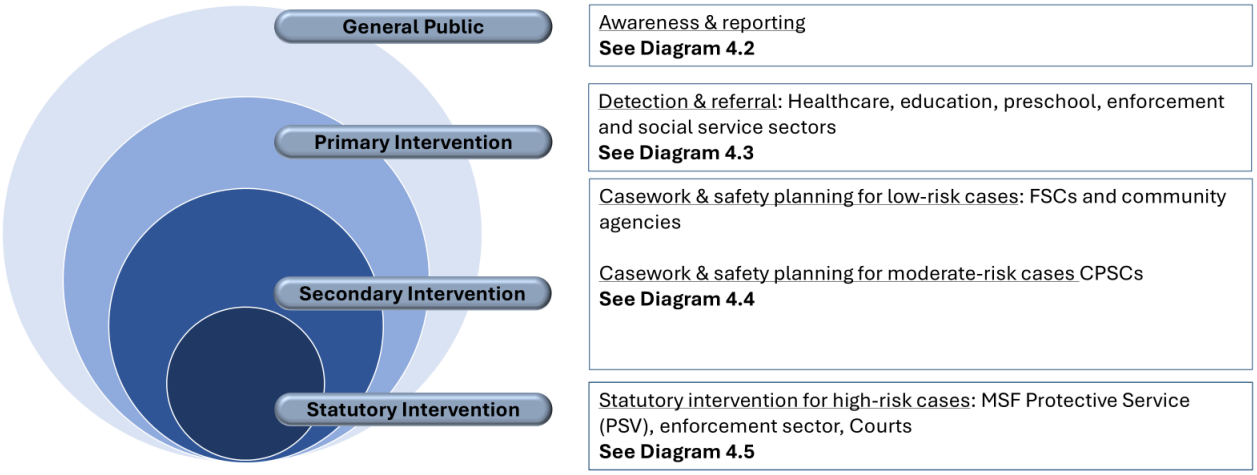
3.29 SPF reviewed the actions undertaken by the IO and OC when the first police report was lodged. SPF found that the IO should have surfaced the case to her supervisor when she was unable to contact Foo, thereby allowing the OC to provide guidance to the IO on the investigation approach for such cases to ensure the case was followed up appropriately. Had Megan's case been followed up on appropriately in Jan 2020, the likelihood of Megan being located earlier would have been higher.

3.30 The Panel noted SPF's explanation that internal controls were in place in 2020 to ensure that cases of missing children were followed up on. These included multiple levels of supervision and checks, with guidance by senior supervisors. The Panel was hence of the view that in this case, the IO and the OC's failure to follow established processes prevented timely and appropriate action on the first report. This matter has been formally addressed with both officers disciplined for not following procedures.

4. IMPROVEMENTS MADE TO THE ECOSYSTEM SINCE 2020

4.1 The Panel noted that Singapore's child protection ecosystem, which is premised on a whole-of-society approach, has evolved over the years, with continuous efforts made to strengthen the ecosystem. During the review, the Panel invited agencies to share the improvements they had made to protocols and processes since the discovery of Megan's death in 2020, to prevent such a tragedy from occurring again. Diagram 4.1 provides an overview of relevant improvements made as a whole to the ecosystem, which are elaborated on in this section. Improvements made by agencies are also included in this section.

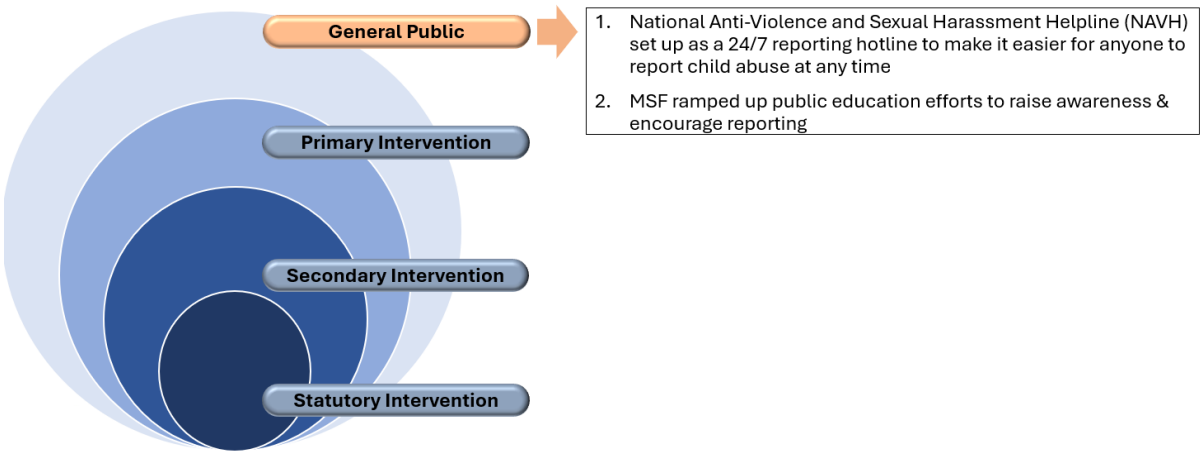
Diagram 4.1 Overview of improvements made since 2020



Improvement #1: MSF ramped up public education efforts on detection of abuse and made it easier for anyone to report abuse.

4.2 The establishment of the National Anti-Violence and Sexual Harassment Helpline (NAVH) in 2021 provided a 24/7 hotline for anyone to report domestic violence (including child abuse) concerns, an enhancement from the Child Protection Hotline that was only available during office hours. Additional avenues to report suspected child abuse were also launched – an online NAVH reporting form in 2022 and a feature on LifeSG in 2024. These enhancements were accompanied by public education efforts to raise awareness on abuse through the refreshed "Break the Silence" campaign.

Diagram 4.2 Improvements to support general detection and reporting of abuse



Improvement #2: ECDA established clear SOPs and format for preschools' reporting of child abuse cases.

4.3 In 2021, ECDA, in consultation with PSV, updated its ECDC Code of Practice to include clear guidelines and workflows on types of suspected abuse that preschools should report and the expected reporting timelines. In particular, preschools must report:

- Suspected/actual child abuse (by anyone on a child enrolled in a preschool, regardless of whether the abuse occurred within the preschool) to ECDA within 24 hours; and
- Serious cases of suspected/actual child abuse (e.g. sexual abuse, noticeable injuries, signs of immediate threat to child's safety) to NAVH within two hours and inform ECDA about the report.

4.4 In 2021, preschools were required to use SSSG to assess all cases of suspected child abuse that had taken place outside the preschool.[13] "Red" cases with noticeable injuries and signs of immediate threat to child's safety were to be reported to NAVH within two hours. Other types of "Red" cases and "Yellow" cases were to be reported to ECDA for consult within two and 24 hours respectively. When reporting cases to ECDA, preschools were required to submit an assessment based on SSSG,[14] with a body diagram (if applicable), along with their incident report.

4.5 When ECDA receives a report on suspected child abuse from a preschool, it is now mandatory for the ECDA licensing officer receiving the report to use CARG to determine the follow-up.

[13] If the concern was suspected sexual abuse, preschools are to skip SSSG assessment and directly report to NAVH within two hours of observing signs of the abuse.
[14] If SSSG assessment has not been done, the ECDA officer will guide the preschool through the SSSG assessment and administer the CARG with the preschool.

4.6 In line with these ECDA enhancements, BSS has put in place mandatory training for all HSCDC teachers in SSSG and CARG to equip staff to identify and escalate concerns. Additionally, escalation assessment in BSS is no longer handled solely by community workers. Any suspected case of abuse is also assessed by a team, which includes a CARG specialist, so that decision-making is more consistent, with reduced reliance on individual judgment in critical situations.

Improvement #3: BSS put in place enhancements to better detect and manage suspected child abuse.

4.7 BSS has also reviewed its internal processes, and has put in place the following key enhancements since 2020:

- Aligned BSS's SOPs with ECDA's ECDC Code of Practice on reporting of child abuse cases and strengthened working relationship with child protection case management agencies (e.g. real-time alerts to CPS and relevant authorities when contact is lost, formalising handover and communication protocols with other agencies).
- Introduced best practices in management of suspected child abuse, such as a two-day absentee rule which requires verified sighting of child and immediate escalation if concerns persist, and escalation assessment to be assessed by a team (including a CARG specialist).
- Enhanced capability building of teachers and community workers, by making it mandatory for them to be trained in SSSG.

Improvement #4: MSF and ECDA established protocols to ensure prompt reporting of missing children to the police.

4.8 In 2021, MSF and ECDA also established new protocols for preschools to alert ECDA or PSV[15] for follow-up when a child with protection concerns is absent without valid reason or withdrawn from preschool (whether or not there was a valid reason).[16] In such cases, PSV will undertake an onsite visit to ascertain the child's safety and well-being.

4.9 MSF implemented workflows for PSV to work with FSCs and SPF to find and assess unsighted children with protection concerns:

[15] As stated in Footnote 3, since May 2025, CPS, APS, and CIC have been integrated to form PSV.

[16] Valid reasons may include absences (e.g. due to illness, family went overseas). If preschools are unsure about the validity of the reasons given by parents in such cases, or have suspicions about the child's absence, they can still inform their Licensing Officer about the situation. The Licensing Officer will make a referral to PSV if it is not clear that the child is safe.

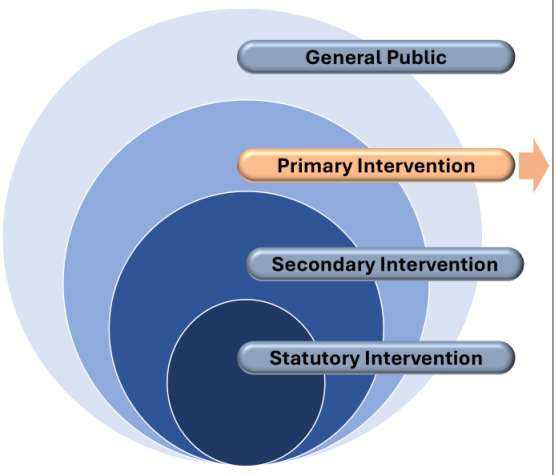
- FSCs will minimally make three attempts within five working days to sight the child. If the child cannot be sighted, FSCs will lodge a police report and report to PSV via NAVH.
- If the child is absent from preschool for a week and not physically sighted by PSV or a professional (e.g. FSC, other community agencies, student care), PSV will lodge a police report.

4.10 In event of a missing child, agencies will follow these enhanced formal protocols:

- For reports to PSV: PSV to lodge a police report within 24 hours.
- For reports to CPSCs or FSCs: CPSCs and FSCs to lodge a police report within 24 hours and concurrently alert PSV.

4.11 While the new protocols err on the side of multiple parties alerting SPF in the case of a missing child, this was a conscious decision, in order not to have a single point of failure to report.

Diagram 4.3 Improvements to strengthen the primary intervention role



Preschools

1. Clear guidelines and workflows on types of suspected abuses to report and reporting timelines introduced in 2021
2. Use of Sector Specific Screening Guide (SSSG) made mandatory for preschools since 2021
3. Protocols established for preschools to alert ECDA / PSV for follow-up when a child with protection concerns is absent or withdrawn from preschool without valid reason
4. Pre-service training content enhanced to include specific skills and knowledge to ensure child safety
5. All ECDA licensing officers are trained in Child Abuse Reporting Guide (CARG) and on managing reports of suspected child abuse

BSS

1. Aligned BSS's SOPs with ECDA's ECDC Code of Practice on reporting of child abuse cases and strengthened working relationship with child protection case management agencies (e.g. real-time alerts to CPS and relevant authorities when contact is lost, formalising handover and communication protocols with other agencies).
2. Introduced best practices in management of suspected child abuse, such as a two-day absentee rule which requires verified sighting of child and immediate escalation if concerns persist, and escalation assessment to be assessed by a team (including a CARG specialist).
3. Looked into the capability building of the teachers, by making it mandatory for all teachers to be trained in SSSG

Improvement #5: MSF and ECDA expanded competency building efforts in the sector to better detect abuse, manage disclosures, and ensure safe practice.

4.12 MSF and ECDA expanded training to better equip professionals with relevant skills to detect and respond to child abuse:

- In 2020, a comprehensive training roadmap was introduced to systematically and progressively deepen CPSC caseworkers' competencies in child protection.[17]
- In 2020, the FSC training roadmap was expanded to deepen FSC social workers' skills in safety assessment and intervention of child abuse cases.[18]
- In 2021, ECDA enhanced the pre-service training content for preschool educators to include specific skills and knowledge to ensure child safety.[19] In-service training was also expanded to include courses such as teaching children body safety skills and supporting children in emotional distress.
- Since 2021, all ECDA licensing officers are trained in CARG and the SOPs for managing reports of suspected child abuse.

4.13 Regular practice audits were introduced in FSCs and CPSCs to ensure safe practice:

- In 2022, practice audits were introduced to FSCs. The audits include review and evaluation of FSCs' casework practice and supervision structures to ensure safe practice.
- In 2024, practice audits for CPSCs were enhanced to include supplementary checks, on top of the practice audits conducted every three years. The practice audits and supplementary checks now cover areas such as adequacy of training and supervision for CPSC staff, and CPSC's utilisation of relevant assessment tools.
- In 2025, these audits were further expanded to cover how community enquiries and consults are triaged.

[17] The training roadmap for CPSC caseworkers includes training on protective behaviours, managing child sexual abuse cases, supporting clients in trauma recovery, crisis intervention, and supervisory practice.
[18] The expanded training roadmap for FSC social workers includes training on managing abuse-related disclosures, safety planning and monitoring.
[19] These include training preschool educators in identifying signs and symptoms of child abuse, responding appropriately to the indicators of child abuse, mandatory line of reporting for suspected child abuse, and on the use of SSSG.

Improvement #6: MSF enhanced screening capabilities to facilitate better assessment and sense-making by case workers.

4.14 Since Oct 2019, PSV's screening framework has been progressively expanded to allow MSF to ascertain if a child of concern is known to other key systems of support. Examples of other key systems of support are FSC (via the Social Service Net or SSNet system), enrolment in preschool/school (from ECDA/MOE), and the Immigration & Checkpoints Authority's entry/exit records.[20] With more sources of information, PSV can triangulate information more quickly, identify 'red flags' of concern (e.g. known to social services, no exit record but parent claims child has gone overseas), and touch base with protective networks (e.g. community agencies or informal networks such as relatives or neighbours) to support the child and the family.

4.15 With the launch of One Client View (OneCV)[21] in Feb 2021, FSCs, CPSCs and NAVH can now also screen for basic information (e.g. family's financial assistance history, whether the family is known to social services, period of PSV's involvement, if any). With stronger data and system links, these community partners have more information to supplement their own observations and judgment to assess the child protection concerns. Social service agencies which do not have access to OneCV can also call NAVH if they have concerns on child safety.

Improvement #7: MSF amended the Children and Young Persons Act (CYPA)[22] to make clearer when information sharing on a child is allowed, and extended legal powers to CPSCs, FSCs, and NAVH.

4.16 The amendments to the CYPA in 2019 made clearer that MSF is allowed to share information obtained in relation to a child with CPSCs, FSCs, and NAVH to enable them to intervene quickly to protect vulnerable children.[23]

4.17 CPSCs, FSCs and NAVH were also granted powers under CYPA to strengthen information gathering and assessment. These included powers to obtain and communicate information and produce a child for assessment or treatment. The powers were granted to CPSCs since 2020, NAVH since 2023, and FSCs since 2024.

4.18 The role of a "Volunteer Welfare Officer" was also introduced in CYPA in 2019,

[20] Prior to Oct 2019, then-CPS's protocol was to screen all children and parent/carers' past records with MSF and Prisons' internal records. Then-CPS would also approach agencies (e.g. CPSCs, FSCs) to check on any involvement with regard to the child of concern.

[21] OneCV allows frontline officers to obtain a comprehensive view of clients' circumstances and assistance received.

[22] Amended in 2019 but operationalised on 1 Jul 2020.

[23] The Act and Regulations set out the prescribed persons to whom the Director-General of Social Welfare (DGSW) or protector may communicate any information about a child, and the matters for which information sharing is allowed.

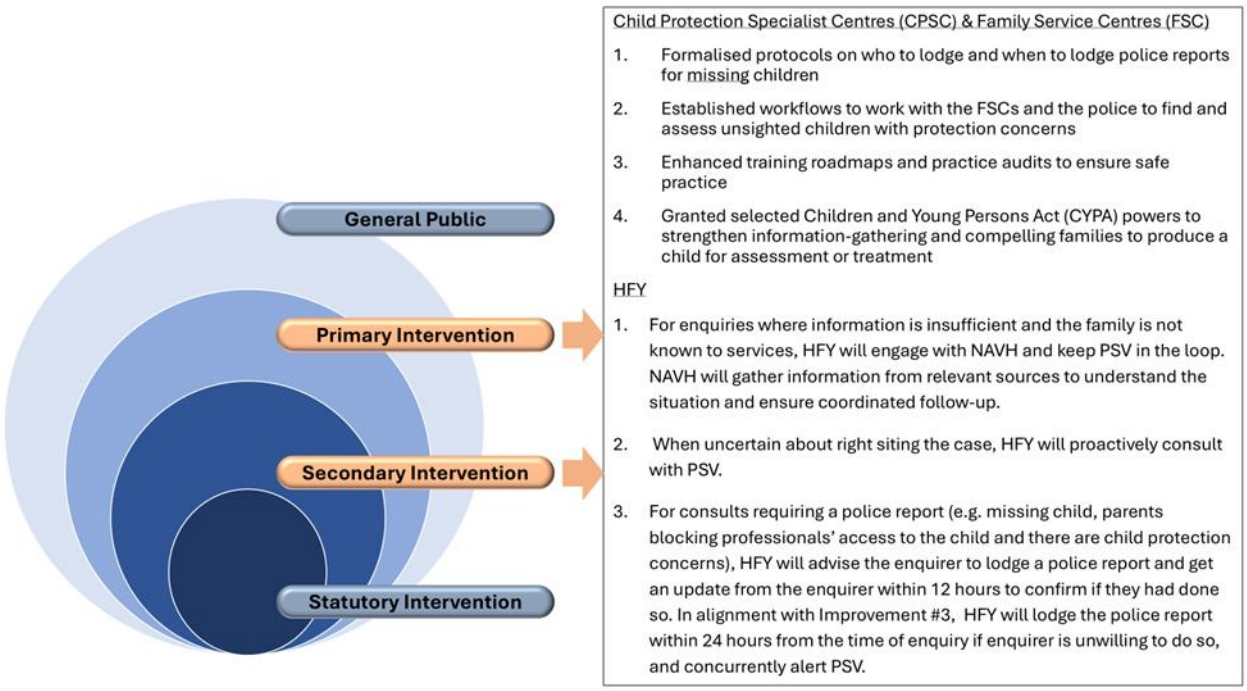
allowing MSF to appoint non-public officers (e.g. as Safety Check Officers) to conduct visits to a child's home to monitor the child's well-being and safety.

Improvement #8: HFY enhanced its protocols and processes to strengthen its work in the child protection ecosystem.

4.19 HFY enhanced its protocols and processes:

- For enquiries where information is insufficient and the family is not known to services, HFY will engage NAVH and keep PSV in the loop. NAVH will gather information from relevant sources to understand the situation and ensure coordinated follow-up.
- When uncertain about right-siting the case, HFY will proactively consult with PSV.
- For consults requiring a police report (e.g. missing child, parents blocking professionals' access to the child and there are child protection concerns), HFY will advise the enquirer to lodge a police report and get an update from the enquirer within 12 hours to confirm if they have done so. In alignment with Improvement #4, HFY will lodge the police report within 24 hours from the time of enquiry if enquirer is unwilling to do so, and concurrently alert PSV.

Diagram 4.4 Improvements to strengthen the primary intervention and secondary intervention role



Improvement #9: MSF tightened protocols for assessing children in-person and through video calls.

4.20 As mentioned in Improvement #4, MSF has formalised protocols for what agencies should do for a missing child**.** MSF also enhanced existing guidelines to provide clearer guidance to PSV officers and social service agencies on situations that warrant in-person visits or assessments. When case officers receive an inquiry, they gather information from the child, family, and other relevant persons to determine whether immediate intervention is required. The initial contact may be conducted via phone or video calls, but any indication of possible abuse will trigger further in-person assessments.

4.21 Guidelines are now also clearer on what PSV officers should look out for during assessments. This includes making observations of the living environment and conducting visual scans of the child's observable body parts for any signs of injury (e.g. asking the child to roll up his/her sleeves). Additionally, officers now conduct individual interviews with children, parents, and safe adults separately to ensure a more thorough assessment.

Improvement #10: SPF makes continuous efforts to enhance oversight of cases reported, including family violence.

4.22 SPF has an established supervisory and intervention framework to deal with police reports similar to the report lodged by Megan's grandmother, and regularly reviews it to ensure relevancy. To this end, since 2022, selected SPF officers from the Community Policing Units are ring-fenced to specialise in handling family violence cases. Training is provided to enable them to adopt a sensitive approach to such cases and to escalate potential high-risk cases for social intervention.[24]

4.23 In Apr 2023, SPF set up the Sexual Crime and Family Violence Command (SFC) to raise the standards of investigations and provide better oversight of the management of sexual crime and family violence cases, including child abuse cases. Officers in the SFC are equipped with specialised skillsets to better handle family violence cases, engage victims of abuse during investigation, and work closely with key stakeholders (e.g. MSF, MOE, social service agencies) to manage cases. SPF also formed Family Violence Teams at the seven police Land Divisions, comprising IOs and supervisors specially trained to handle family violence cases.

[24] Officers are trained to recognise signs and symptoms of family violence, as well as to engage and respond to persons involved in family violence based on the Safety-Emotion-Information (SEI) model. The SEI model is a framework that officers use to support victims. The model emphasises prioritising the victim's need to feel safe, need to express emotions and the need to know.

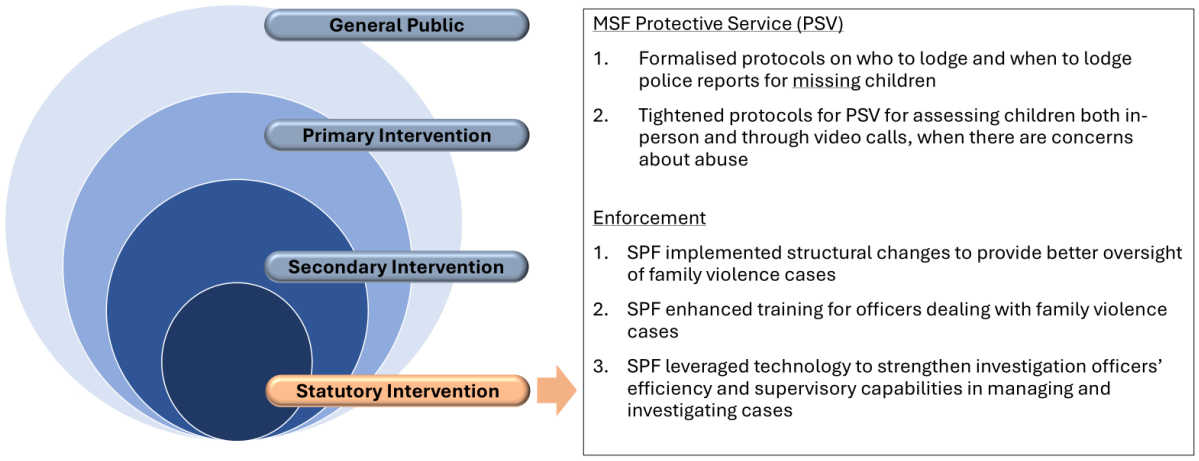
Improvement #11: SPF has been enhancing training for officers dealing with family violence cases

4.24 SPF has continuously enhanced its training for officers dealing with family violence cases. This includes providing all frontline officers and IOs with sensitivity training for family violence, and specialised courses for officers who deal with family violence cases. For example, in 2022, it introduced the Family Violence Training Package to enable SPF officers to adopt a sensitive approach to family violence cases. The initiative arose from a review of the family violence landscape following a spike in cases during the COVID-19 pandemic. SPF also works with key stakeholders such as MSF to conduct training for its officers.

Improvement #12: SPF continuously leverages technology to strengthen Investigation Officers' efficiency and supervisory capabilities.

4.25 Over the years, SPF has enhanced its case management systems, allowing SPF officers to better review, track and monitor cases.[25] In addition, SPF constantly updates its sense-making capabilities to strengthen SPF officers' ability to investigate cases, through enhancements to its screening systems. Such enhancements assist the officers and their supervisors in monitoring and investigating cases, to ensure that prompt, adequate and appropriate actions are taken to follow up on cases, particularly for sensitive cases, such as family violence cases.

Diagram 4.5 Improvements to strengthen the statutory intervention role

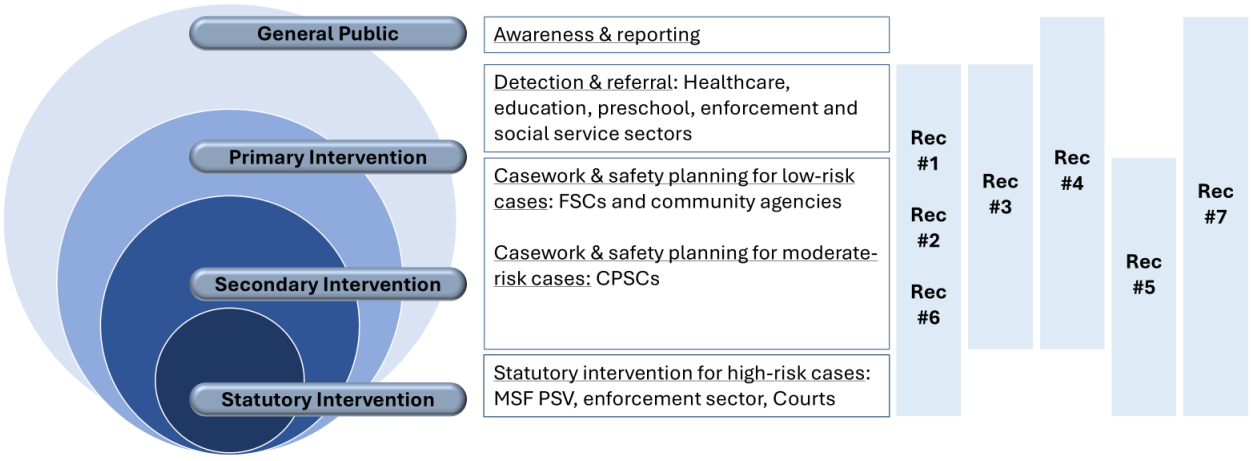


[25] The enhancements include automatic notifications to remind investigation officers and supervisors on tasks and timelines, and mandatory fields to guide the collection of crucial information, etc.

5. RECOMMENDATIONS

5.1 The improvements made to the ecosystem since 2020 have addressed many of the gaps identified in Section 3. The Panel was of the view that the changes have already helped to further strengthen the child protection ecosystem. Representatives from the ecosystem were also consulted in a sector engagement session conducted on 28 Aug 2025. With these in mind, the Panel makes the following recommendations to build on what has already been done, as summarised in Diagram 5.1.

Diagram 5.1 Overview of recommendations in relation to child protection ecosystem



Recommendation #1: All cases of child abuse should primarily be handled by child protection case management agencies, and the agencies should be adequately resourced.

5.2 Megan's case underscored the complexity of child abuse cases and the dynamic situation faced by agencies in handling such cases, such as the complexity of human relationships within the family system and its interaction with the child protection ecosystem. This requires professionals with the right competencies and experience, who are sited in agencies equipped with the systems and processes, to manage such cases.

5.3 The Panel also noted that the management of child abuse has grown in sophistication and complexity. For example, under the CYPA, child protection case management agencies are now empowered by the Director-General of Social Welfare with certain powers. Professionals from CPSCs may develop Voluntary Care Agreements (VCAs), provided for under the CYPA.[26] As part of the improvements made, child protection case management agencies are also granted powers to require parents to

[26] VCA under the CYPA, as introduced in the CYPA in 2011, are entered between the DGSW and parents/guardians of a child. VCAs represent an attempt to formalise and encapsulate the joint efforts of parents and PSV officers to work collaboratively on a voluntary basis and help parents to better understand and implement the steps needed to address the needs of their child. CPSCs were delegated the authority to sign VCAs on DGSW's behalf since 1 Jul 2020.

produce the child to be sighted. In addition to legal powers, child protection case management agencies are also equipped with data systems to support professionals to better assess and manage cases.

5.4 It is thus challenging for community agencies – that is, social agencies that operate in the community and may work with children, but do not have official case management responsibilities – to adequately manage cases with child protection concerns and the risk of harm.

5.5 The Panel therefore recommends that all cases of child abuse are to be managed primarily by the child protection case management agencies. This means that all other parties should concentrate on detecting and reporting possible child abuse in a timely manner, for the case to be triaged and managed by child protection case management agencies. All other parties should also collaborate with child protection case management agencies to support the welfare of the children and their families. For existing cases under agencies that are not child protection case management agencies, these agencies should hand over the cases to the appropriate child protection case management agency in a timely manner. Boards of these community agencies should be briefed on this recommendation so they can provide the proper governance and support to their management.

5.6 The Panel noted that the existing child protection case management agencies are not resourced to take on this responsibility fully, and the change may lead to a step-increase in the volume of cases that are surfaced to the child protection case management agencies. However, the Panel was of the view that it would make for a more reliable and robust system, for suspected cases to be surfaced early, and reported to child protection case management agencies as early as possible. The Panel also recommends that MSF ensure that these agencies are adequately resourced to be effective and able to carry out their roles in managing child protection cases.

Recommendation #2: An appeals mechanism should be established to address cases where CPSC/PSV have differing views from the reporting agency on risk levels and case management. This will ensure that all reports receive appropriate attention and improve consistency in triaging decisions.

5.7 The Panel noted the efforts made to ensure greater consistency in triaging, through structured tools like SSSG and CARG. While it would be impossible to completely eradicate variations in assessment through such instruments due to differences in human judgement, the Panel assessed that there was scope to improve the consistency of the triaging of cases.

5.8 First, the triaging agency must assess the information it receives with a critical eye. It needs to apply its professional judgement to be alert to the possibility that the way the

facts are presented can inadvertently affect the assessment of a case. Structured tools can reduce, but cannot entirely eliminate this risk. Attention should also be paid to the experience level, as well as the training and professional development needs of those engaged in frontline triage work. In addition, factors such as drug use, which should raise the risk level of a case, should be taken into account even where such information is not confirmed.

5.9 Second, triage decisions should be recorded, reviewed and audited to ensure consistency in practice. Feedback from referring parties/agencies and triage agencies should be gathered, with regular engagements between agencies and the data collected used to continuously fine-tune and improve the referral and triaging system. Operationally, risk levels fluctuate and changes in the circumstances of cases can change the risk status. As such, the system must be flexible to accommodate the dynamic changes in risk status of cases.

5.10 Third, even as structured assessment tools are used to guide the referral and triaging process, there can be differing judgments over whether cases meet referral and escalation thresholds. This is not a bad thing, as it avoids blind spots and the pitfalls of triage-by-rote. However, there should be a way for these differences to be resolved expediently and conclusively, so that all cases receive appropriate attention due to them. In situations where there are differing views on the risk levels and management of cases with the reporting agencies, there should be a mechanism to review the decisions. This mechanism should be able to take an objective stance on the appropriate triage decision, regardless of the parties involved. In addition, where the reporting agency continues to manage the case, they should receive adequate support and advice in doing so.

Recommendation #3: MSF should review ECDA's role in triaging potential intra-familial child protection cases.

5.11 Currently, ECDA's ECDC Code of Practice,[27] which derives powers from the ECDC Act and Regulations, requires preschools to report critical and urgent incidents, very serious incidents, and serious incidents to the ECDA Chief Licensing Officer (CLO). Drawing from the requirement stated in Regulation 39 of the ECDC Regulations, the Code of Practice specifies that preschools, as licensees, "must report the following incidences of suspected or actual abuse of any child (by any staff or persons, including intra-familial) to the CLO within 24 hours:

- Suspected physical or sexual abuse of any child who is enrolled in the licensee's Centre, whether or not such abuse occurred during the Centre's operating hours, or within the Centre; or

[27] Fourth edition, published Feb 2025.

- Suspected physical or sexual abuse of any child that occurred within the Centre, regardless of whether or not the child is enrolled in the licensee's Centre."

5.12 The Code of Practice also states that when there is a case of suspected child abuse that happened outside the preschool, preschools must refer to the SSSG and "conduct an assessment using the SSSG" (unless the concern was sexual abuse, for which the preschools should make a direct report to NAVH within two hours). The current workflow for preschools' referrals of such child abuse cases specifies that when the SSSG outcome is "Red", and there are noticeable injury or signs of immediate threat to the child's safety, preschools are to call NAVH within two hours. For other cases when the SSSG outcome is "Red", preschools are to consult their ECDA licensing officer within two hours. When the SSSG outcome is "Yellow" (broadly speaking, moderate-risk cases), preschools are to consult their ECDA licensing officer within 24 hours. The ECDA licensing officer will then go through SSSG and CARG with the Centre and follow up based on the CARG outcome.

5.13 Although ECDA licensing officers are trained in CARG, they are not trained child-protection specialists and may not have the expertise to guide preschools on how to manage the case in the interim. Having ECDA be the middleman for moderate-risk "Yellow cases" and "Red cases" with no noticeable injury or signs of immediate threat to the child's safety, where the injury reported may not have been sustained in a preschool in the first place, could lead to delays in right-siting cases that require urgent intervention in the family setting. The Panel therefore recommends that MSF review how the moderate-risk "Yellow cases" and "Red cases" with no noticeable injury or signs of immediate threat to the child's safety should best be managed to safeguard the welfare of the children, as management of these cases also entails providing advice and guidance to preschools on managing the child's welfare concerns. This arrangement can be reviewed alongside the wider review of the reporting, triage and escalation system.

Recommendation #4: While MSF had formalised protocols for what agencies should do for a missing child, MSF should work with SPF to eliminate the wrong perception on the ground that only family members can make a police report of a missing child. A safe culture should be created, to encourage reporting, and social service professionals should be clear that they have a duty to report child abuse, even if only suspected, or missing children, to the authorities.

5.14 Given that social service professionals work closely with families and children, they are well-placed to identify or be first informed of potential abuse. They should hence be clear of their duty to report to the authorities suspected cases of abuse or missing children that they encounter over the course of their work. The Panel noted that there seemed to be a misperception among professionals in the social and education sector,

that only family members could make a police report of a missing child. There also appeared to be some fear of reporting to the authorities, as it could affect the rapport between professionals and the clients or affect the reputation of the reporting agency, especially if suspicions of child abuse turned out to be inaccurate.

5.15 Further, as stated in para 3.27, the law does not restrict who can make a police report. Anyone who has information about a crime or a suspicious activity can do so. Examples of such offences include hurt or sexual offences against vulnerable persons, or a missing child. SPF takes a serious view of reports of missing children and will give priority to locating them. Practitioners who are concerned about missing children, where family members are unable or unwilling to make a report, should directly lodge a police report. A child or vulnerable person's risk of harm should override any concern social service professionals may have about preserving rapport or relationship with a possible abuser.

5.16 The Panel recommends that MSF work with SPF to take steps to raise awareness and correct this misconception. The Panel also suggests for MSF to look into how to create a culture and environment where social service professionals feel safe and supported in reporting potential child abuse cases, including lodging a police report.

Recommendation #5: Lessons learnt from critical incidents should be routinely shared with community agencies to enhance practice.

5.17 Thus far, where there has been a death of a child known to social services, MSF would engage the parties concerned, including community agencies, to review the handling and identify areas of improvement. This has largely been a bilateral process between MSF and the agency involved, and the review findings are not typically shared with the wider sector and ecosystem. The rationale could be to avoid pointing fingers publicly and exacerbating the pressures the social service professionals would already be facing in a time of tragedy. However, the Panel was of the view that the valuable lessons learnt from critical incidents should be shared so that the child protection ecosystem will continue to grow and thrive professionally.

5.18 The Panel therefore recommends that MSF provide a safe structure and space to promote learning amongst stakeholders in the ecosystem and sector, to allow collective learning among stakeholders, and continuously improve on the standards and quality of practice. Relevant lessons should be incorporated in the training content for practitioners. This will help cultivate a child-first culture where professionals' priority is the safety of the child.

Recommendation #6: Professionals who work with children should be sensitised to issues pertaining to child safety.

5.19 All professionals working with children – including community agencies and preschools that are not child protection case management agencies – should be sensitised to and understand issues pertaining to child safety. Given their nature of work, they should be familiar with the reporting and escalation system. The Social Service Institute's training on the use of SSSG and CARG has been available and free for all since 2019. MSF has also been extending its Domestic Violence Awareness Training to equip people across the people, public, and private sectors to spot and report signs of domestic violence and abuse. The Panel noted that Singapore's 6th periodic report to the United Nations Convention on the Rights of the Child in 2024 affirmed the importance of such training and strongly encourages professionals working with children to attend such training.

Recommendation #7: A stronger culture of support should be promoted for practitioners involved in child protection work.

5.20 The abuse and death of Megan provoked concern from Singaporeans, who asked if the child protection ecosystem did enough for this child. The practitioners involved in the case were negatively impacted as well, as they too questioned if they had done enough for Megan.

5.21 Child protection is a difficult area of work and practitioners are often under immense pressure when managing complex cases. The Panel notes that there are available resources to promote practitioners' well-being and recent efforts to celebrate the important but challenging work that practitioners in Singapore do. The Panel believes there is room to grow this and all levels of society should enhance the support given to practitioners engaged in child protection work. Employers (i.e. social service agencies and government agencies) should be encouraged to put in place structured support for practitioners involved in child protection cases so that practitioners working on these emotionally demanding cases have safe, conducive, and supportive work environments.

5.22 Whereas cases that fall short are often discussed in hindsight in the public sphere, there are many cases where the children's welfare is safeguarded and abuse nipped in the bud. The Panel recognises that few of the success cases are recognised publicly. The spirit of striving to do better for children and having a supportive environment for practitioners to work well are important ingredients for a robust child protection ecosystem in Singapore.

6. CONCLUSION

6.1 Child protection is a difficult and dynamic area of work as human relationships and behaviours are complex. Certain circumstances may also prevent cases from being detected and reported, or hinder efforts by the most well-intentioned and well-skilled professionals, especially when there is active concealment by close family members. The tragic case of Megan has provoked sober self-reflection within the child protection ecosystem, especially amongst agencies that worked with her or handled her case.

6.2 The Panel found that while there were appropriate actions taken by the agencies involved in some instances, there were also areas where agencies could have done better. The Panel also noted instances of a lack of clear understanding and communication among the agencies. The Panel also believes that its recommendations (Section 5), if accepted and implemented, will further strengthen the child protection ecosystem and the collective work of child protection case management agencies and community agencies.

6.3 The Panel would like to express its thanks to BSS, ECDA, HFY, PSV, and SPF for providing their account of events and for furnishing clarifications and additional information to support the review process. The Panel also appreciates the social sector professionals who provided suggestions for how to improve the child protection ecosystem.

6.4 Finally, the Panel hopes that lessons learnt from this case will serve to further strengthen the whole child protection ecosystem to keep every child safe, with families as the primary unit of care for the child.