Howth Road Mixed National School

Child Protection Policy

Ratified by Board of Management on _____

Signed _____
Chairperson, Board of Management. **Updated Nov. 2011**

Ethos and Rationale

The school aims to provide its pupils with the highest standards of care and protection, in order to promote each child's well being and safeguard him/her from harm while in the school. The Board of Management of Howth Road Mixed National School has adopted the "Children First" Guidelines of the Department of Children and Youth Affairs 2011 and the "Child Protection" Procedures of the Department of Education and Science 2001.

This policy is drawn up in accordance with the requirements of the Childcare Act 1991.

Designated Liaison Person (DLP)

The Principal, Martha Woolmington, will act as DLP. Should circumstances warrant it, the Deputy Principal, Elma Jackson, shall act as Deputy DLP.

The DLP has specific responsibility for child protection and will represent the school in all dealings with the HSE, An Garda Siochána and other parties in connection with allegations of abuse. All matters pertaining to the processing or investigating of child abuse should be processed through the DLP

The names of the DLP and the DDLP will be clearly displayed on the parent's notice board in the hall, near the main entrance and also on the staff room noticeboard. (Appendix 2)

"The Protections for Persons Reporting Child Abuse Act" 1998, makes provisions for the protection from civil liberty of persons who have communicated child abuse "reasonably and in good faith" to the HSE or other relevant statutory bodies.

Definition and Recognition of Child Abuse.

Abuse, can be defined in the "Children First" Guidelines in four main categories: neglect, emotional, physical and sexual.
The signs and symptoms of abuse are clearly listed and defined in Appendix 1.

All signs and symptoms must be examined in the total context of the child's situation and family circumstances. There are commonly three stages in the identification of child abuse.

- Considering the possibility
- Looking out for signs of abuse
- Recording of information

Garda Vetting

From 2011 forward the Garda vetting of all persons with unsupervised access to children in schools is a legal requirement. The vetting of teachers qualified prior to 2003 are to be vetted through the Teaching Council over the coming months however HRNS is seeking the Garda clearance of all staff through it's patron body, the Presbyterian Church in Ireland in the interim.
All new staff must be vetted prior to employment, including substitute staff.

The Principal is responsible for overseeing the administration of all Garda Vetting forms and procedures.

Education

The Board recognises that much Child Protection can be offered to its children through informing and educating them in this regard. In line with the "Children First" Guidelines it is now mandatory that the STAY SAFE Programme is taught by all teachers at a mainstream level annually.

All staff are aware of this requirement and are requested annually to sign an agreement to do so. (see Appendix 7)

The Principal can also ensure that this content is taught by way of the Cúntas Míosúil reports.

Handling Disclosures from Children

When information is offered in confidence the member of staff will need to act with sensitivity in responding to the disclosure. The member of staff will need to reassure the child, and retain his/her trust, while explaining the need to action and the possible consequences, which will necessarily involve other adults being informed. It is important to tell the child that everything possible will be done to protect and support him/her but not to make promises that cannot be kept e.g. promising not to tell anyone else. The welfare of the child is regarded as the first and paramount consideration. In so far as is practicable, due consideration will be given, having regard to age and understanding, the wishes of the child.

The following advice is offered to school personnel to whom a child makes a disclosure of abuse:-

- Remain calm.
- Listen to the child with sensitivity and openness.
- Take all disclosures seriously
- Do not ask leading questions or make suggestions to the child
- Offer reassurance but do not make promises
- Do not stop a child recalling significant events
- Do not over react
- Explain that further help may have to be sought from the DLP.
- **Record the discussion accurately and retain the record of dates, times, names, locations, context and factual details of conversation.**
- This information should then be passed onto the DLP and a record will be retained in the school for 21 years (see record keeping)
- If the DLP is satisfied that there are reasonable grounds for the suspicion/allegation, the procedures for reporting as laid out in 'Children First' - section 3 pages 13-17 will be adhered to.

Reporting-Designated Liaison Person (only)

If the DLP deems the nature of an allegation to merit reporting to the HSE and or An Garda Síochána, the procedure outlined in Appendix 4 must be followed.
This procedure includes documenting and reporting the incident and keeping clear records, along with notifying parents of the allegation where deemed appropriate. (see Appendix 4)

Allegations Against a School Employee

The most important consideration for the Chairperson, Board of Management or the DLP is the safety and protection of the child.

However, employees also have a right to protect ion against claims which are false or malicious.
As employers, the Board of Management should always seek legal advice as the circumstances can vary from one case to another.
There are two procedures to be followed:

- The reporting Procedure.
- The Procedure for dealing with the Employee.

In general, the procedures for reporting allegations are exactly as with any other person with the Board of Management taking a more active approach as employers in the situation.

The DLP has responsibility for reporting the matter to the HSE where the incident merits reporting.
The Chairperson, Board of Management has responsibility, acting in consultation with his/her Board, for addressing the employment issues.
If the allegation is against the DLP, the Chairperson of the Board of Management will assume the responsibility for reporting the matter to the HSE.

The DLP should immediately act in accordance with the procedures outlined in 'Child Protection'.

The DLP should always inform the Chairperson of the Board of Management.

School employees, other than the DLP who receive allegations against another school employee, should immediately report the matter to the DLP.
School employees who form suspicions regarding conduct of another school employee should consult with the DLP.

The Chairperson of the Board and DLP should make the employee aware privately

- that an allegation has been made against him/her.
- the nature of the allegation
- whether or not the HSE or Gardai has been /will be / must be / should be informed.

The employee should be given a copy of the written allegation and any other relevant documentation. The employee should be requested to respond to the allegation in writing to the Board of management within a specified period and told that this may be passed to the Gardai, HSE, and legal advisers.

The priority is all cases is that no child be exposed to unnecessary risk. Therefore, as a matter of urgency, the Chairperson should take any necessary protective measures. These measures should be proportionate to the level of risk and should not unreasonably penalise the employee in any way unless to protect the child.

If the nature of the allegations warrants immediate action in the Chairperson's opinion, the Board of Management should be convened to consider the matter. The Board will consider feedback if any has been received for the HSE, Gardaí or relevant source. This may result in the Board of Management directing that the employee absent him/ herself from the school forthwith while the matter is being investigated (Administrative leave of absence with pay and not suspension and would not imply any degree of guilt.)The DES should be immediately informed.

Record Keeping

- Children must be referred to in all documentation by their official roll number and not by name.
- Where incidents are reported to the HSE a note, dating the report, will be placed on the pupil's individual file by the DLP.
- The detailed copy of the report will be kept in a separate CHILD PROTECTION file, accessed solely by the DLP. Reports are filed chronologically.
- All records do not belong to individuals, but remain the property of the school at all times. Under the Freedom of Information Act (1997, 2003). Individuals are entitled to access the information about themselves, to seek amendments where it is deemed incorrect, incomplete or misleading. They also have the right to be given reasons for decisions made concerning themselves.
- All records will be marked from the outset with a disposal date pre-dated by 21 years. (Data Protection Act 1998,2003)

Board of Management

The Chairperson should inform the Board of Management of all the details and remind the members of their serious responsibility to maintain strict confidentiality on all matters relating to the issue and the principles of due process and national justice.

APPENDICES

1. Signs and Symptoms of Child Abuse
2. Sign notifying names of DLP and DDLP
3. Checklist for School Employees on Child Protection Guidelines
4. Reporting Procedures checklist for DLP
5. Standard Reporting Form to Statutory Body (DLP use)
6. Relevant Legislation
7. Signed agreement of staff Child Protection Policy requirements awareness.

Appendix 1: Signs and symptoms of child abuse

1. Signs and symptoms of neglect

Child neglect is the most common category of abuse. A distinction can be made between 'wilful' neglect and 'circumstantial' neglect. 'Wilful' neglect would generally incorporate a direct and deliberate deprivation by a parent/carer of a child's most basic needs, e.g. withdrawal of food, shelter, warmth, clothing, contact with others. 'Circumstantial' neglect more often may be due to stress/inability to cope by parents or carers.

Neglect is closely correlated with low socio-economic factors and corresponding physical deprivations. It is also related to parental incapacity due to learning disability, addictions or psychological disturbance.

The neglect of children is 'usually a passive form of abuse involving omission rather than acts of commission' (Skuse and Bentovim,1994). It comprises 'both a lack of physical caretaking and supervision and a failure to fulfil the developmental needs of the child in terms of cognitive stimulation'.

Child neglect should be suspected in cases of:
• abandonment or desertion;
• children persistently being left alone without adequate care and supervision;
• malnourishment, lacking food, inappropriate food or erratic feeding;
• lack of warmth;
• lack of adequate clothing;
• inattention to basic hygiene;
• lack of protection and exposure to danger, including moral danger or lack of supervision appropriate to the child's age;
• persistent failure to attend school;
• non-organic failure to thrive, i.e. child not gaining weight due not only to malnutrition but also to emotional deprivation;
• failure to provide adequate care for the child's medical and developmental problems;
• exploited, overworked.

2. Characteristics of neglect

Child neglect is the most frequent category of abuse, both in Ireland and internationally. In addition to being the most frequently reported type of abuse; neglect is also recognised as being the most harmful. Not only does neglect generally last throughout a childhood, it also has long-term consequences into adult life. Children are more likely to die from chronic neglect than from one instance of physical abuse. It is well established that severe neglect in infancy has a serious negative impact on brain development.

Neglect is associated with, but not necessarily caused by, poverty. It is strongly correlated with parental substance misuse, domestic violence and parental mental illness and disability.

Neglect may be categorised into different types (adapted from Dubowitz, 1999):

- **Disorganised**/chaotic neglect: This is typically where parenting is inconsistent and is often found in disorganised and crises-prone families. The quality of parenting is inconsistent, with a lack of certainty and routine, often resulting in emergencies regarding accommodation, finances and food. This type of neglect results in attachment disorders, promotes anxiety in children and leads to disruptive and attention-seeking behaviour, with older children proving more difficult to control and discipline. The home may be unsafe from accidental harm, with a high incident of accidents occurring.
- **Depressed or passive neglect**: This type of neglect fits the common stereotype and is often characterised by bleak and bare accommodation, without material comfort, and with poor hygiene and little if any social and psychological stimulation. The household will have few toys and those that are there may be broken, dirty or inappropriate for age. Young children will spend long periods in cots, playpens or pushchairs. There is often a lack of food, inadequate bedding and no clean clothes. There can be a sense of hopelessness, coupled with ambivalence about improving the household situation. In such environments, children frequently are absent from school and have poor homework routines. Children subject to these circumstances are at risk of major developmental delay.
- **Chronic deprivation**: This is most likely to occur where there is the absence of a key attachment figure. It is most often found in large institutions where infants and children may be physically well cared for, but where there is no opportunity to form an attachment with an individual carer. In these situations, children are dealt with by a range of adults and their needs are seen as part of the demands of a group of children. This form of deprivation will also be associated with poor stimulation and can result in serious developmental delays.

The following points illustrate the consequences of different types of neglect for children:

- inadequate food – failure to develop;
- household hazards – accidents;
- lack of hygiene – health and social problems;
- lack of attention to health – disease;
- inadequate mental health care – suicide or delinquency;
- inadequate emotional care – behaviour and educational;
- inadequate supervision – risk-taking behaviour;
- unstable relationship – attachment problems;
- unstable living conditions – behaviour and anxiety, risk of accidents;
- exposure to domestic violence – behaviour, physical and mental health;
- community violence – anti social behaviour.

3. Signs and symptoms of emotional neglect and abuse

Emotional neglect and abuse is found typically in a home lacking in emotional warmth. It is not necessarily associated with physical deprivation. The emotional needs of the children are not met; the parent's relationship to the child may be without empathy and devoid of emotional responsiveness.

Emotional neglect and abuse occurs when adults responsible for taking care of children are unaware of and unable (for a range of reasons) to meet their children's emotional and developmental needs. Emotional neglect and abuse is not easy to recognise because the effects are not easily observable. Skuse (1989) states that 'emotional abuse refers to the habitual verbal harassment of a child by disparagement, criticism, threat and ridicule, and the inversion of love, whereby verbal and non-verbal means of rejection and withdrawal are substituted'.

Emotional neglect and abuse can be identified with reference to the indices listed below. However, it should be noted that no one indicator is conclusive of emotional abuse. In the case of emotional abuse and neglect, it is more likely to impact negatively on a child where there is a cluster of indices, where these are persistent over time and where there is a lack of other protective factors.

- rejection;
- lack of comfort and love;
- lack of attachment;
- lack of proper stimulation (e.g. fun and play);
- lack of continuity of care (e.g. frequent moves, particularly unplanned);
- continuous lack of praise and encouragement;
- serious over-protectiveness;
- inappropriate non-physical punishment (e.g. locking in bedrooms);
- family conflicts and/or violence;
- every child who is abused sexually, physically or neglected is also emotionally abused;
- inappropriate expectations of a child relative to his/her age and stage of development.

Children who are physically and sexually abused and neglected also suffer from emotional abuse.

4. Signs and symptoms of physical abuse

Unsatisfactory explanations, varying explanations, frequency and clustering for the following events are high indices for concern regarding physical abuse:

- bruises (*see below for more detail*);
- fractures;
- swollen joints;
- burns/scalds (*see below for more detail*);
- abrasions/lacerations;
- haemorrhages (retinal, subdural);
- damage to body organs;
- poisonings – repeated (prescribed drugs, alcohol);
- failure to thrive;
- coma/unconsciousness;
- death.

There are many different forms of physical abuse, but skin, mouth and bone injuries are the most common.

Bruises
Accidental l bruises are common at places on the body where bone is fairly close to the skin. Bruises can also be found towards the front of the body, as the child usually will fall forwards.

Accidental bruises are common on the chin, nose, forehead, elbow, knees and shins. An accident-prone child can have frequent bruises in these areas. Such bruises will be diffuse, with no definite edges. Any bruising on a child before the age of mobility must be treated with concern.

Non-accidental
Bruises caused by physical abuse are more likely to occur on soft tissues, e.g. cheek, buttocks, lower back, back, thighs, calves, neck, genitalia and mouth.

Marks from slapping or grabbing may form a distinctive pattern. Slap marks might occur on buttocks/cheeks and the outlining of fingers may be seen on any part of the body. Bruises caused by direct blows with a fist have no definite pattern, but may occur in parts of the body that do not usually receive injuries by accident. A punch over the eye (black eye syndrome) or ear would be of concern. Black eyes cannot be caused by a fall on to a flat surface. Two black eyes require two injuries and must always be suspect. Other distinctive patterns of bruising may be left by the use of straps, belts, sticks and feet. The outline of the object may be left on the child in a bruise on areas such as the back or thighs (areas covered by clothing).

Bruises may be associated with shaking, which can cause serious hidden bleeding and bruising inside the skull. Any bruising around the neck is suspicious since it is very unlikely to be accidentally acquired.. Other injuries may feature – ruptured eardrum/fractured skull. Mouth injury may be a cause of concern, e.g. torn mouth (frenulum) from forced bottle-feeding.

Bone injuries
Children regularly have accidents that result in fractures. However, children's bones are more flexible than those of adults and the children themselves are lighter, so a fracture, particularly of the skull, usually signifies that considerable force has been applied.

Non-accidental
A fracture of any sort should be regarded as suspicious in a child under 8 months of age. A fracture of the skull must be regarded as particularly suspicious in a child under 3 years. Either case requires careful investigation as to the circumstances in which the fracture occurred. Swelling in the head or drowsiness may also indicate injury.

Burns
Children who have accidental burns usually have a hot liquid splashed on them by spilling or have come into contact with a hot object. The history that parents give is usually in keeping with the pattern of injury observed. However, repeated episodes may suggest inadequate care and attention to safety within the house.

Non-accidental
Children who have received non-accidental burns may exhibit a pattern that is not adequately explained by parents. The child may have been immersed in a hot liquid. The burn may show a definite line, unlike the type seen in accidental splashing. The child may also have been held against a hot object, like a radiator or a ring of a cooker, leaving distinctive marks. Cigarette burns may result in multiple small lesions in places on the skin that would not generally be exposed to danger. There may be other skin conditions that can cause similar patterns and expert paediatric advice should be sought.

Bites
Children can get bitten either by animals or humans. Animal bites (e.g. dogs) commonly puncture and tear the skin, and usually the history is definite. Small children can also bite other children.

Non-accidental
It is sometimes hard to differentiate between the bites of adults and children since measurements can be inaccurate. Any suspected adult bite mark must be taken very seriously. Consultant paediatricians may liaise with dental colleagues in order to identify marks correctly.

Poisoning
Children may commonly take medicines or chemicals that are dangerous and potentially life-threatening. Aspects of care and safety within the home need to be considered with each event.

Non-accidental

Non-accidental poisoning can occur and may be difficult to identify, but should be suspected in bizarre or recurrent episodes and when more than one child is involved. Drowsiness or hyperventilation may be a symptom.

Shaking violently

Shaking is a frequent cause of brain damage in very young children.

Fabricated/induced illness

This occurs where parents, usually the mother (according to current research and case experience), fabricate stories of illness about their child or cause physical signs of illness. This can occur where the parent secretly administers dangerous drugs or other poisonous substances to the child or by smothering. The symptoms that alert to the possibility of fabricated/induced illness include:

(i) symptoms that cannot be explained by any medical tests; symptoms never observed by anyone other than the parent/carer; symptoms reported to occur only at home or when a parent/carer visits a child in hospital;
(ii) high level of demand for investigation of symptoms without any documented physical signs;
(iii) unexplained problems with medical treatment, such as drips coming out or lines being interfered with; presence of unprescribed medication or poisons in the blood or urine.

5. Signs and symptoms of sexual abuse

Child sexual abuse often covers a wide spectrum of abusive activities. It rarely involves just a single incident and usually occurs over a number of years. Child sexual abuse most commonly happens within the family.

Cases of sexual abuse principally come to light through:

(a) disclosure by the child or his or her siblings/friends;
(b) the suspicions of an adult;
(c) physical symptoms.

Colburn Faller (1989) provides a description of the wide spectrum of activities by adults which can constitute child sexual abuse. These include:

Non-contact sexual abuse

- 'Offensive sexual remarks', including statements the offender makes to the child regarding the child's sexual attributes, what he or she would like to do to the child and other sexual comments.
- Obscene phone calls.
- Independent 'exposure' involving the offender showing the victim his/her private parts and/or masturbating in front of the victim.
- 'Voyeurism' involving instances when the offender observes the victim in a state of undress or in activities that provide the offender with sexual gratification. These may include activities that others do not regard as even remotely sexually stimulating.

Sexual contact

- Involving any touching of the intimate body parts. The offender may fondle or masturbate the victim, and/or get the victim to fondle and/or masturbate them. Fondling can be either outside or inside clothes. Also includes 'frottage', i.e. where offender gains sexual gratification from rubbing his/her genitals against the victim's body or clothing.

Oral-genital sexual abuse

- Involving the offender licking, kissing, sucking or biting the child's genitals or inducing the child to do the same to them.

Interfemoral sexual abuse

- Sometimes referred to as 'dry sex' or 'vulvar intercourse', involving the offender placing his penis between the child's thighs.

Penetrative sexual abuse, of which there are four types:

- 'Digital penetration', involving putting fingers in the vagina or anus, or both. Usually the victim is penetrated by the offender, but sometimes the offender gets the child to penetrate them.
- 'Penetration with objects', involving penetration of the vagina, anus or occasionally mouth with an object.
- 'Genital penetration', involving the penis entering the vagina, sometimes partially.
- 'Anal penetration' involving the penis penetrating the anus.

Sexual exploitation

- Involves situations of sexual victimisation where the person who is responsible for the exploitation may not have direct sexual contact with the child. Two types of this abuse are child pornography and child prostitution.
- 'Child pornography' includes still photography, videos and movies, and, more recently, computer-generated pornography.
- 'Child prostitution' for the most part involves children of latency age or in adolescence. However, children as young as 4 and 5 are known to be abused in this way.

The sexual abuses described above may be found in combination with other abuses, such as physical abuse and urination and defecation on the victim. In some cases, physical abuse is an integral part of the sexual abuse; in others, drugs and alcohol may be given to the victim.

It is important to note that physical signs may not be evident in cases of sexual abuse due to the nature of the abuse and/or the fact that the disclosure was made some time after the abuse took place.

Carers and professionals should be alert to the following physical and behavioural signs:

- bleeding from the vagina/anus;
- difficulty/pain in passing urine/faeces;
- an infection may occur secondary to sexual abuse, which may or may not be a definitive sexually transmitted disease. Professionals should be informed if a child has a persistent vaginal discharge or has warts/rash in genital area;
- noticeable and uncharacteristic change of behaviour;
- hints about sexual activity;
- age-inappropriate understanding of sexual behaviour;
- inappropriate seductive behaviour;
- sexually aggressive behaviour with others;
- uncharacteristic sexual play with peers/toys;
- unusual reluctance to join in normal activities that involve undressing, e.g. games/swimming.

Particular behavioural signs and emotional problems suggestive of child abuse in **young children (aged 0-10 years**) include:

- mood change where the child becomes withdrawn, fearful, acting out;
- lack of concentration, especially in an educational setting;
- bed wetting, soiling;
- pains, tummy aches, headaches with no evident physical cause;
- skin disorders;
- reluctance to go to bed, nightmares, changes in sleep patterns;
- school refusal;
- separation anxiety;
- loss of appetite, overeating, hiding food.

Particular behavioural signs and emotional problems suggestive of child abuse in **older children (aged 10+ years)** include:

- depression, isolation, anger;
- running away;
- drug, alcohol, solvent abuse;
- self-harm;
- suicide attempts;
- missing school or early school leaving;
- eating disorders.

All signs/indicators need careful assessment relative to the child's circumstance

Appendix 2

HOWTH ROAD MIXED NATIONAL SCHOOL

CHILD PROTECTION

Designated Liaison Person
Principal- Ms Martha Woolmington

Deputy Designated Liaison Person
Ms Elma Jackson

The above named person should be contacted in the event of a disclosure of child abuse. Disclosures must not be discussed with additional parties.

Appendix 3
Child Protection Guidelines Checklist for School Employees

Designated Liaison Person: __*Martha Woolmington (Principal)* _____

Deputy Designated Liaison Person: _*Elma Jackson (Deputy Principal)* ___

If a child discloses information to you:-

- Listen
- Do not ask leading questions
- Offer reassurance but do not promise not to tell
- Explain that other adults may need to be told - DLP
- Do not stop the child speaking
- Do not over react or comment
- Inform DLP - If you have a reasonable suspicion or reasonable grounds for concern that a child is at risk or has suffered abuse, the DLP should contact the Health Board for advice
- At the earliest opportunity, record accurately what the child has said – Using the child's own words. Record date/time and context of the disclosure. Use child's registration number – Not child's name
- Facts only
- Sketch signs of physical injury if appropriate
- Retain records for a period of 21 years in keeping with the school's Record Keeping Policy

The following should also be reported to the DLP:

- An account from a person who saw a child being abused
- Injury consistent with abuse
- Dysfunctional behaviour
- Implausible explanations for injury or behaviour
- Consistent evidence over a period of time that a child is being emotionally or physically neglected

Health Board Response:

- School is asked to monitor the situation
- Formal report is requested , sent by DLP and on receipt case is allocated to Social Worker
- Preliminary enquiry – Screening process
- Initial assessment

Possible outcomes:

- Case closed
- Family support
- Child Protection Plan (usually following a case conference)

Appendix 4
Reporting Procedures for DLP (Normally the Principal)

- DLP receives report of child protection concern
- DLP records the report – date/time/context. Child's registration number is used for recording purposes
- DLP makes decision on how to proceed based on information received
- DLP informs Chairperson of Board of Management that initial contact is being made with Health Board
- DLP makes contact with Health Board seeking advice (Do not give name of child at this point. Be very clear that you are seeking advice). Take the name of the person you spoke to and record conversation
- Duty Social Worker makes recommendation. This may involve school continuing to monitor the situation. Record this decision and send written record of this decision to Health Board. Alternatively a formal referral made on standard reporting form may be recommended by Social Worker (Keep a copy on file in a secure place)
- If Health Board not available and case warrants immediate response – Gardaí are informed
- Decision made on informing/not informing parents - taking safety of the child into consideration as number one priority. A decision NOT to inform parent/s should only be made where there is a genuine concern for the safety of the child. Be transparent with parent/s and ensure that they are aware that you have a non-negotiable responsibility as DLP to act in the best interests of the child (Refer to Children First)
- If DLP decides not to contact Health Board in relation to the case – person who made original report must be informed in writing
- Continued monitoring of child should be recommended
- Child Protection concerns that have been reported to the Health Board should be included in the Principal's Report to Board of Management Meeting - Child's name is not used

IMPORTANT TELEPHONE NUMBERS:

- **Chairperson BOM: _____*Rev L Kennedy Ritchie* 01 8332588____**
- **Health Board: _____*Dublin North City (Coolock)* 01 8164 200___**
- **Gardaí : _____*Clontarf Station* 01 666 4800_____**
- **Local Hospital: _____*Temple St* 01 878 4274_____**
- **School Nurse: ___*Marino Health Centre* 01 8333 421/8534 631____**
- **CAPP (Stay Safe Programme): _____01 6206346_____**
- **J.L.O: _____**

Appendix 5:

STANDARD REPORT FORM

for reporting child protection and/or welfare concerns to the HSE

See overleaf.....

FORM NUMBER: CC01:01:00

STANDARD REPORT FORM

(For reporting CP&W Concerns to HSE)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

A. To Principal Social Worker/Designate: _____

1. Date of Report

2. Details of Child

Name:		Male ☐		Female ☐	
Address:		DOB		Age	
		School			
Alias		Correspondence address (if different)			

3. Details of Persons Reporting Concern(s)

Name:		Telephone No.	
Address:		Occupation:	
		Relationship to client:	
Reporter wishes to remain anonymous ☐		Reporter discussed with parents/guardians ☐	

4. Parents Aware of Report

	Yes	No
Are the child's parents/carers aware that this concern is being reported to the HSE?	☐	☐

5. Details of Report

(Details of concern(s), allegation(s) or incident(s) dates, times, who was present, description of any observed injuries, parent's view(s), child's view(s) if known.)

FORM NUMBER: CC01:01:00

STANDARD REPORT FORM

(For reporting CP&W Concerns to HSE)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

6. Relationships

Details of Mother		**Details of Father**	
Name:		Name:	
Address: (if different to child)		Address: (if different to child)	
Telephone Nos.		Telephone Nos.	

7. Household composition

Name	**Relationship**	**DOB**	**Additional information, e.g. school/occupation/other**

8. Name and Address of other personnel or agencies involved with this child:

	Name	**Address**
Social Worker		
PHN		
GP		
Hospital		
School		
Gardaí		
Pre-School/Crèche/YG		
Other (*specify*):		

9. Details of person(s) allegedly causing concern in relation to the child

Relationship to child:		Age		Male	☐	Female	☐
Name:		Occupation:					
Address:							

10. Details of person completing form

Name:		Occupation:	
Signed		Date:	

Appendix 6:
Relevant Legislation

Children Act 2001
The Children Act 2001 replaced provisions of the Children Act 1908 and associated legislation with a modern comprehensive statute. The 2001 Act covers three main areas of the law. Firstly, and predominantly, it provides a framework for the development of the juvenile justice system. Secondly, it re-enacts and updates provisions in the 1908 Act protecting children against persons who have the custody, charge or care of them. Thirdly, it provides for family welfare conferences and other new provisions for dealing with children where there is a real and substantial risk to their life, health, safety, welfare and development.

Child Care Act 1991

The purpose of the Child Care Act 1991 is to 'update the law in relation to the care of children who have been assaulted, ill-treated, neglected or sexually abused, or who are at risk'. The main provisions of the Act are:

(i) the placing of a statutory duty on the HSE to promote the welfare of children who are not receiving adequate care and protection up to the age of 18;
(ii) the strengthening of the powers of the HSE to provide child care and family support services;
(iii) the improvement of the procedures to facilitate immediate intervention by the HSE and An Garda Síochána where children are in danger;
(iv) the revision of provisions to enable the Courts to place children who have been assaulted, ill-treated, neglected or
sexually abused, or who are at risk, in the care of or under the supervision of the HSE;
(v) the introduction of arrangements for the supervision and inspection of pre-school services;
(vi) the revision of provisions in relation to the registration and inspection of residential centres for children.

Criminal Justice Act 2006

Section 176 of the Criminal Justice Act 2006 introduced the criminal charge of 'reckless endangerment of children'. It states: 'A person, having authority or control over a child or abuser, who intentionally or recklessly endangers a child by –

(a) causing or permitting any child to be placed or left in a situation which creates a substantial risk to the child of being a victim of serious harm or sexual abuse, or
(b) failing to take reasonable steps to protect a child from such a risk while knowing that the child is in such a situation, is guilty of an offence.'

The penalty for a person found guilty of this offence is a fine (no upper limit) and/or imprisonment for a term not exceeding 10 years.

Domestic Violence Act 1996
The Domestic Violence Act 1996 introduced major changes in the legal remedies for domestic violence. There are two main types of remedies available:

(i) **Safety Order**: This Order prohibits a person from further violence or threats of violence. It does not oblige that person to leave the family home. If the parties live apart, the Order prohibits the violent person from watching or being in the vicinity of the home.
(ii) **Barring Order**: This Order requires the violent person to leave the family home.

The legislation gives the HSE the power to intervene to protect individuals and their children from violence. Section 6 of the Act empowers the HSE to apply for Orders for which a person could apply on his or her own behalf but is deterred from doing so through fear or trauma. The consent of the victim is not a prerequisite for such an application, although he or she must be consulted. Under Section 7 of the Act, the Court may, where it considers it appropriate, adjourn proceedings and direct the HSE to undertake an investigation of the dependent person's circumstances with a view to:

(i) applying for a Care Order or a Supervision Order under the Child Care Act 1991;
(ii) providing services or assistance for the dependent person's family; or
(iii) taking any other action in respect of the dependent person.

Protections for Persons Reporting Child Abuse Act 1998

This Act came into operation on 23 January 1999. The main provisions of the Act are:

(i) the provision of immunity from civil liability to any person who reports child abuse 'reasonably and in good faith' to designated officers of the HSE or to any member of An Garda Síochána;
(ii) the provision of significant protections for employees who report child abuse. These protections cover all employees and all forms of discrimination up to, and including, dismissal;
(iii) the creation of a new offence of false reporting of child abuse, where a person makes a report of child abuse to the appropriate authorities 'knowing that statement to be false'. This is a new criminal offence, designed to protect innocent persons from malicious reports.

A wide range of nursing, medical, paramedical and other staff has been appointed as designated officers for the purposes of this Act (*see Appendix 10 of the Children First: National Guidance*). Section 6 of the Act is a saving provision, which specifies that the statutory immunity provided under the Act for persons reporting child abuse is additional to any defences already available under any other enactment or rule of law in force immediately before the passing of the Act.

Data Protection Acts 1988 and 2003

The Data Protection Act 1988 applies to the processing of personal data. It gives a right to every individual, irrespective of nationality or residence, to establish the existence of personal data, to have access to any such data relating to him or her, and to have inaccurate data rectified or erased. It requires data controllers to make sure that the data they keep are collected fairly, are accurate and up-to-date, are kept for lawful purposes and are not used or disclosed in any manner incompatible with those purposes. It also requires both data controllers and data processors to protect the data they keep, and imposes on them a special duty of care in relation to the individuals about whom they keep such data.

Education Act 1998

The Education Act 1998 places an obligation on those concerned with its implementation to give practical effect to the constitutional rights of children as they relate to education and, as far as practicable and having regard to the resources available, to make available to pupils a level and quality of education appropriate to meeting their individual needs and abilities.

Education (Welfare) Act 2000

The Education (Welfare) Act 2000, which was fully commenced in July 2002, replaced previous school attendance legislation and provided for the creation of a single national agency, the National Educational Welfare Board (NEWB), which has statutory responsibility to ensure that every child either attends school or otherwise receives an education or participates in training. The NEWB also assists in the formulation and implementation of Government education policy.

Non-Fatal Offences against the Person Act 1997

The two relevant provisions of this Act are:

(i) it abolishes the rule of law under which teachers were immune from criminal liability in respect of physical chastisement of pupils;
(ii) it describes circumstances in which the use of reasonable force may be justifiable.

Freedom of Information Acts 1997 and 2003

The Freedom of Information Acts 1997 and 2003 enable members of the public to obtain access, to the greatest extent possible consistent with the public interest and the right to privacy, to information in the possession of public bodies. The specific provisions of the Acts include:

(i) to provide for a right of access to records held by such public bodies, for necessary exceptions to that right and for assistance to persons to enable them to exercise it;
(ii) to enable persons to have corrected any personal information relating to them in the possession of such bodies;
(iii) to provide for independent review by an Information Commissioner both of decisions of such bodies relating to that right and of the operation of the Acts generally;
(iv) to provide for the publication by public bodies of guides to their functions and national guidelines, such as these, for the public.

Under the Acts, a person about whom a public body holds personal information has:

(i) right of access to this information, subject to certain conditions;
(ii) the right to correct this information if it is inaccurate.

Where a public body makes a decision that affects an individual, that individual has a right to relevant reasons and findings on the part of the body reaching that decision.

The Acts are also designed to protect the privacy of individuals and, in general, requires the prior consent of an individual before releasing personal information about them. Where the release of social work or medical records contains information that would be harmful to a person's well-being, the release may be made to a health professional who acts on the person's behalf. Under the Acts, there are regulations and guidelines relating to access by parents to their children's records; these emphasize that the overriding concern is the best interests of the child.

The exemptions and exclusions that are relevant to child protection include the following:
(i) protecting records covered by legal professional privilege;
(ii) protecting records that would facilitate the commission of a crime;
(iii) protecting records that would reveal a confidential source of information.

Appendix 7

STAFF AGREEMENT

The below named staff agree that they are fully aware and familiar with the requirements both local and mandatory upon them with regard to child protection issues, in accordance with this policy.

Staff Member	Class/ Role	Date
_____	_____	_____
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_____	_____	_____
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