Inner City Helping Homeless

Child Protection/Safeguarding Policy

July 2018

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1.Introduction

1.1 Statement of Policy

Inner City Helping Homeless (ICHH) provides resources and provisions to the homeless in the Dublin area. The ICHH outreach volunteers are on the streets of Dublin city and surrounding areas 7 nights a week offering provisions to those sleeping rough. ICHH offer a 7-day advocacy service assisting homeless individuals and families and educating them on how to navigate through homelessness.

The aim and purpose of this Policy is to safeguard children, young people, families and volunteers. The ICHH Child Safeguarding Policy is a guidance document for ICHH volunteers in identifying and responding to allegations and suspicions of child abuse or neglect. The document is based on and adheres to the Department of Children and Youth Affairs *Children First: National Guidance for the Protection and Welfare of Children*, (henceforth the *National Guidance*) published in 2011 and the *Children First Act* (2015)

This Safeguarding Policy is displayed prominently on the ICHH website and in the ICHH office.

1.2 Scope of Policy

As per the Children First Act 2015, ICHH defines a child as a person under the age of 18 years, excluding a person who is or has been married.

The Safeguarding Statement applies to;

- all staff of ICHH
- volunteers
- board members

The Child Safe Guarding Statement applies when working in the ICHH office, on Outreach and while representing ICHH at other venues.

1.3 Key Principles of the Safeguarding Statement

The following principles underpin the Child Safeguarding Policy:

- The welfare and best interests of children are of paramount importance. ICHH is committed to respecting the right to dignity and bodily integrity of every child and to protecting those rights.
- All ICHH volunteers have a responsibility to protect children and therefore have a duty to report abuse as set out in the Children First Act 2015 and Children *First: National Guidance for the Protection and Welfare of Children (2011)*.
- ICHH fully accepts and endorses the Children First Act, *Children First Guidance* and the *Safeguarding Vulnerable Persons at Risk of Abuse: national policy and Procedures* (2014).
- ICHH will not knowingly engage with any person, organisation or fund any project that poses a risk to children or that does not meet the child protection and safeguards outlined in the Children First Act and the *Children First: National Guidance for the Protection and Welfare of Children (2011*).

- ICHH ensures that volunteers receive the appropriate training in child persons protection and welfare.

- ICHH recruitment policy adheres to best practice and ICHH ensures that all volunteers are vetted by the Garda Central Vetting Unit (GCVU).

1.4 Statement of Risk

ICHH has carried out an assessment of any potential for harm to a child while availing of our services.

The Child Safeguarding Statement identifies procedures to follow to mitigate risks that may present in the following identified scenarios:

- **Where children are working in the ICHH office (as volunteers) or children present in the offices for other reasons (such as attending a meeting with a parent/guardian);**

- **Where children are at events in which ICHH volunteers (for the purpose of the Safeguarding Policy to include volunteers and Board members) participate; and**

- **Where allegations/suspicions of abuse are made to ICHH staff by telephone, email, and letter or in person.**

2. Definitions of Child Abuse

The ICHH Safeguarding Policy is informed by the *Children First: National Guidance for the Protection and Welfare of Children* (henceforth the *National Guidance)* document.

ICHH recognises that child abuse falls into four main categories as identified in the *National Guidance.* These are neglect, emotional abuse, physical abuse and sexual abuse. For detailed definitions and examples of these types of abuse, please refer to *Appendix 1: Types of Child Abuse and Symptoms of Abuse*.

2.1 Neglect

Neglect can be defined in terms of an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care.

Harm can be defined as the ill-treatment or the impairment of the health or development of a child.

Whether it is significant is determined by the child's health and development as compared to that which could reasonably be expected of a child of similar age.

2.2 Emotional Abuse

Emotional abuse is normally to be found in the relationship between a parent/carer and a child rather than in a specific event or pattern of events. It occurs when a child's developmental needs for affection, approval, consistency and security are not met. Unless other forms of abuse are present, it is rarely manifested in terms of physical signs or symptoms.

2.3 Physical Abuse

Physical abuse of a child is that which results in actual or potential physical harm from an interaction, or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents.

2.4 Sexual abuse

Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others.

3. Recognising Child Abuse

3.1 Guidelines for Recognition

It can be difficult to recognise the signs and symptoms indicating that a child has suffered neglect or abuse.

Moreover in the case of neglect, a distinction can be made between 'wilful' and 'circumstantial' neglect.

For a detailed description of the signs, symptoms and characteristics of abuse please refer to *Appendix 1: Types of Child Abuse and Symptoms of Abuse*.

There are commonly three stages in the identification of child neglect or abuse. If an ICHH volunteer has identified the possibility that a child with whom they are in contact has suffered abuse (with or without disclosure by the child or a third party) then the following stages will normally occur.

1. considering the possibility;
2. looking out for signs of neglect or abuse; and
3. recording of information.

3.2 Reasonable Grounds for Concern

Where an ICHH volunteer has reasonable grounds for concern (see below) that a child may have been, is being, or is at risk of being abused or neglected, then the volunteer(s) with delegated responsibility (see 3.3 Designated Officer) must report their concerns to Tusla, the Child and Family Agency (see Appendix 2, *Child Protection Reporting Form*). Anyone who suspects child abuse or neglect should inform the parents/carers if a report is to be submitted to Tusla, the Child and Family Agency or to An Garda Síochána, unless doing so is likely to endanger the child. A suspicion that is not supported by any objective indication of abuse or neglect would not constitute a reasonable suspicion or reasonable grounds for concern.

Grounds for Concern include:

- **a specific indication from the child that he or she was abused;**
- **an account by a person who saw the child being abused;**
- **evidence, such as an injury or behaviour, that is consistent with abuse and unlikely to be caused in another way;**
- **an injury or behaviour that is consistent both with abuse and with an innocent explanation, but where there are corroborative indicators supporting the concern that it may be a case of abuse. An example of this would be a pattern of injuries, an implausible explanation, other indications of abuse and/or dysfunctional behaviour; and**
- **consistent indication, over a period, that a child is suffering from emotional or physical neglect.**

4. Safeguarding Children and Reporting

4.1 General Procedures for Safeguarding Children

It should be noted that ICHH does not usually work directly with children in its day-to-day activities but does engage with children on an occasional basis (for example as office-based volunteers) as well as liaise with organisations that work directly with children.

The following procedures are adhered to on occasions when ICHH volunteers engage with children at events or while working with or meeting with children in the ICHH offices.

ICHH endeavours to ensure that individual volunteers are not left alone with a child at an event or in the office. However, this may not always be feasible and ICHH ensures that, on all occasions, an appropriate balance is maintained between meeting the needs of the child, and the discharging of our professional responsibilities.

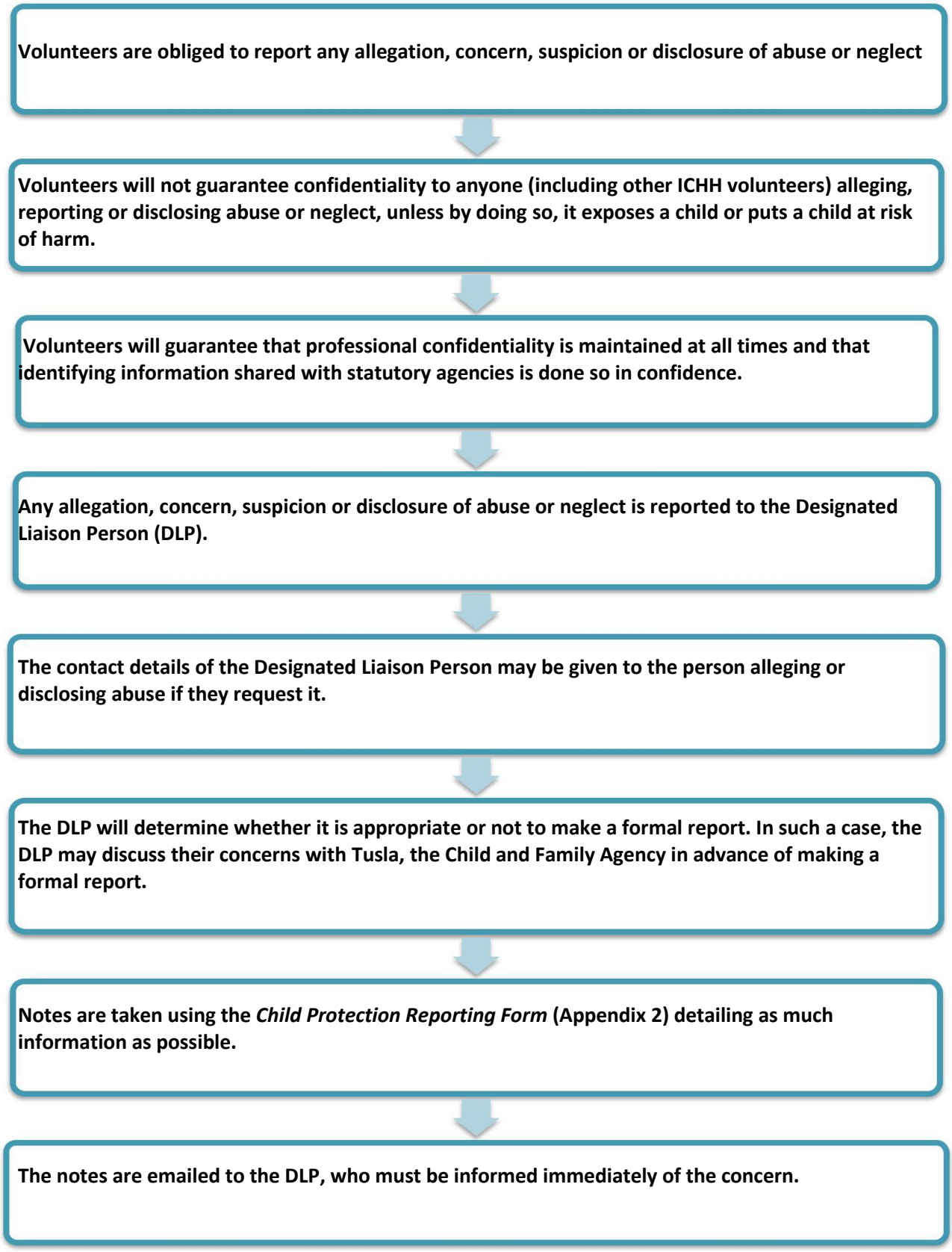
When children and young people are part of any project, service or work, volunteers will complete a written assessment of risk outlining measures to manage any identified risk in line with the Children First Act 2015. This will be done prior to engaging with children and young people (see Appendix 8).

4.2 Reporting Alleged/Suspected Abuse

The following procedures apply to all ICHH volunteers who engage in work involving contact with children or to whom allegations or suspicions of child abuse are made. These procedures are also appropriate in the case of anonymous reports, or reports from adults who experienced childhood abuse. The same procedures also apply in relation to reporting allegations of abuse made against an ICHH volunteer (see Section 5, *Reporting Alleged/Suspected Abuse by An Employee/Volunteer/Intern*) volunteer or intern. For additional information and guidance, see Appendix 5, *Guidelines for Responding to Disclosures*

The following steps must be adhered to by the ICHH staff member reporting an allegation or disclosure of abuse. These steps apply to a disclosure made in person, in writing (post or email) or by telephone.

Steps for Reporting an Allegation or Disclosure of Abuse



The DLP reports to the appropriate Tusla Child and Family Agency Office by telephone and by email.

A request is made of the appropriate Tusla contact to send an email to the DLP acknowledging receipt of the report.

The DLP will identify if any follow-up reporting is necessary.

Steps for Reporting an Allegation or Disclosure of Abuse Outside of Office Hours

If an allegation or disclosure is made to an ICHH staff member outside of normal office hours, or outside of the ICHH offices, then it is the responsibility of the individual to contact the DLP immediately.

If a report is made outside of office hours, and Tusla Children and Family Services cannot be contacted, the DLP member will contact An Garda Siochána.

If the DLP cannot be contacted, then that individual must assess the risk (for example, if it seems that a child is facing an immediate risk) and make an immediate referral to Tusla, Children and Family Services or (if a report is made outside of office hours) to An Garda Siochána.

Follow-up contact with Tusla Children and Family Services the next morning (or Monday morning if it happens on Friday evening).

4.3 Guiding Principles

If an ICHH member of staff has identified the need to contact Tusla, the Child and Family Agency or An Garda Siochána, then it is important to obtain and record as much information as possible (see Appendix 2) and then forward this information to the DLP. Observations should be accurately recorded, including the following, where applicable:

- dates;
- times;
- names,
- location;
- contact details; and
- context.

The guiding principles in regard to reporting child abuse or neglect may be summarised as follows:

1. The safety and well-being of the child must take priority.
2. All ICHH staff members have a responsibility to ensure that all allegations and suspicions of child abuse are treated seriously and with the utmost professional integrity, and must therefore be familiar with and adhere to the Child Safeguarding Policy.

Reports should be made without delay to Tusla, the Child and Family Agency.

4.4 Confidentiality

All volunteers are obliged to report any allegation, concern, suspicion or disclosure of abuse or neglect.

Volunteers will not guarantee confidentiality to anyone (including other ICHH volunteers) alleging, reporting or disclosing abuse or neglect, unless by doing so, exposes a child or puts a child at risk of harm. However, ICHH volunteers will guarantee that professional confidentiality is maintained at all times and that identifying information shared with statutory agencies is done so in confidence.

It is essential that all information regarding concern or assessment of child abuse should be shared only on "a need to know basis" in the interests of the safety and welfare of the child. The number of people who are informed of the allegation/disclosure must be kept to a minimum.

All notes and email correspondence relating to child protection concern and reports are kept in electronic form by the Designated Liaison Person. No other persons and staff members are permitted to access this information).

ICHH retains personal information relating to allegations/suspicions of abuse made to ICHH volunteers by telephone, email, letter or in person in order to be able to report such information to the appropriate authorities as specified in *Children First: National Guidance for the Protection and Welfare of Children (2011)*.

4.5 Designated Officer

Claire Sayers acts as the Designated Liaison Person as directed by the Chief Executive Officer, Anthony Flynn. The function of the Designated Liaison Person is as follows:

- Ensure that the ICHH Child Safeguarding Policy is followed.

- The Designated Liaison Person can delegate responsibility to the appropriate member(s) of staff.

- The Designated Liaison Person remains responsible for all cases of abuse or neglect reported to ICHH ensuring that details of all such cases are reported (using the *Child Protection Reporting Form*, Appendix 2) to Tusla, the Child and Family Agency or An Garda Siochána.

- The Designated Liaison Person will ensure that the ICHH Child Safeguarding Policy and documents implement the principles and procedures of the *National Guidance* and Children First legislation.

- The Designated Liaison Person is responsible for reviewing and updating the ICHH Child Safeguarding Policy and procedures.

- The Designated Liaison Person acts as a resource person to the volunteers of ICHH, providing support and guidance in matters relating to child safeguarding.

- The Designated Liaison Person is responsible for ensuring that a detailed record of all persons working on behalf of the Alliance who have access to children is kept by the organisation. This must include the following: full contact name and address, description of their role, confirmation that they have been vetted, and any other relevant information, such as training or qualifications.

- The Designated Liaison Person ensures that all staff members who have access to children have received sufficient training in accordance with guidance and standards set down by Tusla, the Child and Family Agency under the *Safeguarding Guidance for Organisations.*

- Where an allegation or concern is not reported to Tusla, a Designated Liaison Person's records should clearly indicate the basis of his/her decision not to report and any actions taken by him/her.

- All notes and email correspondence relating to the report are kept in electronic form by the Designated Liaison Person. No other persons and staff members are permitted to access this information.

5. Procedure for Allegations against Volunteers

5.1 Reporting Alleged/Suspected Abuse by a Volunteer

In the case of an allegation of abuse by a volunteer, the Designated Liaison Person (on receiving the complaint) will immediately ensure that no child is or continues to be exposed to unnecessary risk. The Designated Liaison Person will then seek legal advice and will liaise with the Chief Executive Officer who, acting on behalf of the volunteer will:

- inform the individual that an allegation has been made against them;
- explain to the volunteer the details of the allegation;
- tell the volunteer whether or not a report has been made to Tusla, the Child and Family Agency;
- perform a risk assessment (see Appendix 4, *Risk Assessment Form*) to identify whether or not suspension of the individual is appropriate;
- give the volunteer copies of any written records relating to the allegation;
- offer the volunteer an opportunity to respond to the allegation within a specific time frame; and
- forward the volunteer's response to Tusla, the Child and Family Agency (if appropriate).

If an allegation is made against the Designated Liaison Person, then the Chief Executive Officer or a person that he or she nominates, will carry out the above steps.

6. Safe Recruitment and Training

6.1 Safe Recruitment

It should be noted that ICHH does not usually work directly with children in its day-to-day activities but does engage with children on an occasional basis (for example as office-based volunteers) as well as liaise with organisations that work directly with children. The following procedures are observed by ICHH when engaging long-term volunteers:

- Prospective positions within ICHH are advertised widely.
- Advertised positions include a job/role description and person specification, detailing attributes identified as being associated with the position.
- Ideally, interviews are undertaken by at least two representatives of the organisation who are suitably qualified and/or have proven experience to undertake such interviews.
- At least two verbally confirmed references are required.
- Successful applicants are required to consent to undergo Garda vetting on commencing work.
- New volunteers are required to agree to all codes and policies, as outlined at Volunteer Induction.

6.2 Training and Supports

The Designated Liaison Person (see 4.5 Designated Liaison Person) is responsible for ensuring that all ICHH volunteers and Board members receive induction training in the child protection policy and procedures.

ICHH is responsible for ensuring that the ongoing training needs of volunteers and Board members in the area of child protection and welfare are fully addressed.

All training and guideline documents will be regularly reviewed and updated as appropriate and all volunteers will be informed of these updates.

ICHH recruitment policy adheres to best practice and ICHH ensures that all staff are vetted by the Garda Central Vetting Unit (GCVU).

When children and young people are part of any project, service or work, volunteers will complete a written assessment of risk outlining measures to manage any identified risk in line with the Children First Act 2015. This will be done prior to engaging with children and young people (see Appendix 8).

When ICHH is involved in organising or attending events involving the participation of children, the Designated Liaison Person will ensure that all volunteers and Board members follow the procedures outlined in the Alliance Code of Behaviour (see Appendix 9 Code of Behaviour).

Appendices

7.1 Appendix 1: Types of Child Abuse and Symptoms of Abuse

The following information has been reproduced from *Children First: National Guidance for the Protection and Welfare of Children* (2011).

Types of child abuse

This chapter outlines the principal types of child abuse and offers guidance on how to recognise such abuse. Child abuse can be categorised into four different types: neglect, emotional abuse, physical abuse and sexual abuse. A child may be subjected to one or more forms of abuse at any given time.

In the Children First: National Guidance, 'a child' means a person under the age of 18 years, excluding a person who is or has been married.

Definition of 'neglect'

Neglect can be defined in terms of an omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, and/or medical care.

Harm can be defined as the ill-treatment or the impairment of the health or development of a child.

Whether it is significant is determined by the child's health and development as compared to that which could reasonably be expected of a child of similar age.

Neglect generally becomes apparent in different ways over a period of time rather than at one specific point. For example, a child who suffers a series of minor injuries may not be having his or her needs met in terms of necessary supervision and safety. A child whose height or weight is significantly below average may be being deprived of adequate nutrition. A child who consistently misses school may be being deprived of intellectual stimulation.

The threshold of significant harm is reached when the child's needs are neglected to the extent that his or her well-being and/or development are severely affected.

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, and 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

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.

Definition of 'emotional abuse'

Emotional abuse is normally to be found in the relationship between a parent/carer and a child rather than in a specific event or pattern of events. It occurs when a child's developmental need for affection, approval, consistency and security are not met. Unless other forms of abuse are present, it is rarely manifested in terms of physical signs or symptoms. Examples may include:

- the imposition of negative attributes on a child, expressed by persistent criticism, sarcasm, hostility or blaming;
- conditional parenting in which the level of care shown to a child is made contingent on his or her behaviours or actions;
- emotional unavailability of the child's parent/carer;
- unresponsiveness of the parent/carer and/or inconsistent or inappropriate expectations of the child;
- premature imposition of responsibility on the child;
- unrealistic or inappropriate expectations of the child's capacity to understand something or to
- behave and control himself or herself in a certain way;
- under- or over-protection of the child;

- failure to show interest in, or provide age-appropriate opportunities for, the child's cognitive and
- emotional development;
- use of unreasonable or over-harsh disciplinary measures;
- exposure to domestic violence;
- exposure to inappropriate or abusive material through new technology.

Emotional abuse can be manifested in terms of the child's behavioural, cognitive, affective or physical functioning. Examples of these include insecure attachment, unhappiness, low self-esteem, educational and developmental underachievement, and oppositional behaviour. The threshold of significant harm is reached when abusive interactions dominate and become typical of the relationship between the child and the parent/carer.

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 occur 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.

Definition of 'physical abuse'

Physical abuse of a child is that which results in actual or potential physical harm from an interaction, or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust. There may be single or repeated incidents. Physical abuse can involve:

- severe physical punishment;

- beating, slapping, hitting or kicking;

- pushing, shaking or throwing;

- pinching, biting, choking or hair-pulling;

- terrorising with threats;

- observing violence;

- use of excessive force in handling;

- deliberate poisoning;

- suffocation;

- fabricated/induced illness (see Appendix 1 for details); allowing or creating a substantial risk of significant harm to a child.

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

Accidental 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 from 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:

- 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;

- high level of demand for investigation of symptoms without any documented physical signs;

- 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.

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:

- disclosure by the child or his or her siblings/friends;
- the suspicions of an adult;
- 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 circumstances.

Definition of 'sexual abuse'

Sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others. Examples of child sexual abuse include:

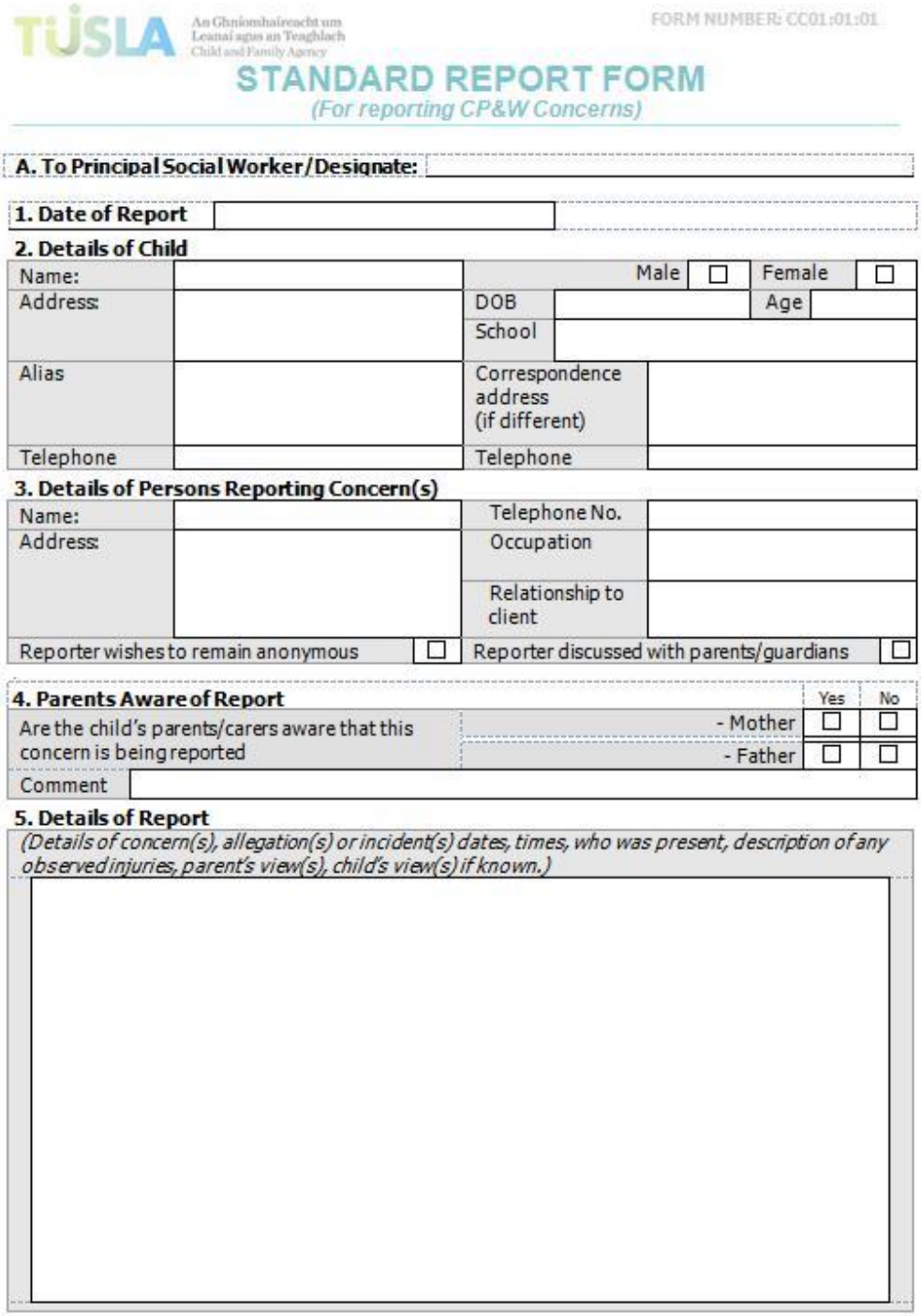
- exposure of the sexual organs or any sexual act intentionally performed in the presence of the child;
- intentional touching or molesting of the body of a child whether by a person or object for the purpose of sexual arousal or gratification;
- masturbation in the presence of the child or the involvement of the child in an act of masturbation;
- sexual intercourse with the child, whether oral, vaginal or anal;
- sexual exploitation of a child, which includes inciting, encouraging, propositioning, requiring or permitting a child to solicit for, or to engage in, prostitution or other sexual acts. Sexual exploitation also occurs when a child is involved in the exhibition, modelling or posing for the purpose of sexual arousal, gratification or sexual act, including its recording (on film, video tape or other media) or the manipulation, for those purposes, of the image by computer or other

means. It may also include showing sexually explicit material to children, which is often a feature of the 'grooming' process by perpetrators of abuse;

- consensual sexual activity involving an adult and an underage person. In relation to child sexual abuse, it should be noted that, for the purposes of the criminal law, the age of consent to sexual intercourse is 17 years for both boys and girls. An Garda Síochána will deal with the criminal aspects of the case under the relevant legislation.

It should be noted that the definition of child sexual abuse presented in this section is not a legal definition and is not intended to be a description of the criminal offence of sexual assault.

7.2 Appendix 2: Child Protection Reporting Form



TUSLA An Ghníomhaireacht um Leanaí agus an Teaghlach Child and Family Agency

FORM NUMBER: CC01:01:01

STANDARD REPORT FORM

(For reporting CP&W Concerns)

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)	
Telephone		Telephone	

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	- Mother	☐	☐
	- Father	☐	☐
Comment			

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.)

STANDARD REPORT FORM

(For reporting CP&W Concerns)

6. Relationships

Details of Mother		**Details of Father**	
Name:		Name:	
Address: (if different to child)		Address: (if different to child)	
Telephone No's:		Telephone No's:	

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:	
Address:		Telephone No's:	
Signed		Date:	

7.3 Appendix 3: Guidelines for Responding to Disclosures

This information is adapted from The *Southern Health Service Executive – Child Protection Policy 1996* and gives advice to staff on what to do if a child discloses that they are being abused, ill-treated or neglected. It should be noted that this is general advice and is no substitute for proper training in dealing with child abuse. It outlines for staff members the initial steps staff must take in such a situation. It must not be seen as constituting a comprehensive assessment or investigative interview, as these are the responsibility of specialist staff in the Health Service Executive and/or Gardaí.

Receive: It is essential that staff listen to what the child is saying, without communicating shock or disbelief (verbally or non-verbally). The child needs to see that the staff member accepts what they are saying, and that it is being taken seriously.

Reassure: Children who disclose abuse need to be reassured by the adult they are talking to, but it is essential that you reassure only as far as it is reliable to do so. This means that staff should not make promises, no matter how well intentioned, that they cannot reasonably keep. Telling a child that "everything will be alright" might seem like an appropriate response to a child in distress, but if you cannot be certain that this is the outcome from the disclosure, it is better not to say it at all. Equally important is not to make promises about confidentiality. Remember that child abuse survives in a climate of secrecy, so it is important not to collude with the child's sense of having secrets, by promising that you won't tell anyone – this is a promise staff cannot keep, as these procedures require staff to follow a pathway of referral after a disclosure. Lastly, it is appropriate to reassure the child that the alleged abuse or neglect is not their fault. No child is responsible for the abusive actions of adults.

React: Staff should react to the child only as far as is necessary for them to establish whether there are grounds for reasonably believing that the child is being ill-treated, abused or neglected. This means that staff need to probe the child in a non-intrusive or investigative way to ascertain exactly what it is the child wishes to say, and thereafter whether there are grounds for referring the matter further. Such questioning of the child should not constitute an interrogation of the child and should be conducted using "open questions" that facilitate the child to say what they need to say without having words put in their mouth by the adult. It is important that staff do not criticise the alleged perpetrator, and that they explain what they need to do next and who you have to tell about this information.

Record: An essential part of the disclosure process is to ensure that staff take contemporaneous notes of what the child says, **in the child's own words**, and that such records are dated and signed by the staff member. Where staff members record an opinion in respect of the disclosure, they are required to identify it as such. Staff should also be aware of the information required in the Standard Reporting Form, so as to try to ascertain as much of the needed information as possible. Lastly, in complying with this procedure, staff members that record a disclosure should record that they passed the information on to the Designated Officer.

Remember: In order to ensure that the child protection processes of the Children's Rights Alliance contribute to the promotion of children's welfare, it is necessary to follow these guidelines in conjunction with those contained in Department of Children and Youth Affairs *Children First: National Guidance for the Protection and Welfare of Children* (2011).

Relax: It is important to remember that dealing with child disclosures of neglect and abuse is stressful and can have an impact on one's emotional well-being. Therefore, staff should actively seek out support from peers and line management. The Alliance is committed to making available such support systems as required in these situations.

7.4 Appendix 4: Contact Details for Tusla, the Child and Family Agency

Head Office

Child and Family Agency,
Block D, Park Gate Business Centre,
Parkgate Street,
Dublin 8.
Ph: **01 6352854**
E-mail: info@tusla.ie

Regional Offices

DUBLIN (NORTH)
Swords Duty Social Work Department, 180-189 Lakeshore Drive, Airside Business Park, Swords, Co. Dublin 01 8708000
Blanchardstown Duty Social Work Department, Roselawn Health Centre, Roselawn Rd, Blanchardstown, Dublin 15 01 6464518
Coolock Duty Social Work Department, Health Centre, Cromcastle Rd, Coolock, Dublin 5 01 8164200 / 01 8160314
Finglas Duty Social Work Department, Health Centre, Wellmount Park, Finglas, Dublin 11 01 8567704
North Inner City Duty Social Work Department, 492 North Circular Rd, Parkview, Dublin 1 34 01 8566856
DUBLIN (SOUTH)
Tallaght Duty Social Work Department, Chamber House, Chamber Square, Tallaght, Dublin 24 01 4686289
Lord Edward Street Duty Social Work Department, Carnegie Centre, 21-25 Lord Edward Street, Dublin 2 01 6486500
Ballyfermot Duty Social Work Department, Bridge House, Cherry Orchard Hospital, Ballyfermot, Dublin 10 01 6206387
Dun Laoghaire Duty Social Work Department, Our Ladys Clinic, Patrick Street, Dun Laoghaire, Co. Dublin 01 6637300

7.5 Appendix 5: ICHH Child and Vulnerable Person Safeguarding Response Plan

Contacts

Role	Name	Email	Phone
Designated Liaison Person (DLP)	Claire Sayers	safeguarding@ichh.ie	086 185 3776
Deputy DLP	Catie McCarthy		087 121 0243
Deputy DLP	Karen Noonan		086 892 8818

Definitions

Child: a person under the age of 18 years, who is not or has not been married.

Vulnerable Person: an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation.

Mandated Persons

Mandated persons are people who have contact with children and/or families and who, because of their qualifications, training and/or employment role, are in a key position to help protect children from harm (Children First, 2017). The Children First Act 2015 places a legal obligation on mandated persons to report child protection concerns to Tusla – Child and Family Agency.

**ICHH Mandated Persons include all managers as per Children First, Appendix 2, 15 (b).

Acronyms

CYP = Child/Young Person

VP = Vulnerable Person

Response Pathways

Red Response	Amber Response	Green Response
What? - You recognise that a CYP/VP is at immediate risk of harm	**What**? - You have reasonable grounds for concern that a CYP/VP may have been, is being, or is at risk of being abused or neglected	**What**? - You observe / hear / suspect a CYP/VP may be in a vulnerable position or may be at risk
Who? - Contact Tusla Duty Social Worker (CYP only) Mon – Fri 9am – 5pm 01 856 6856 OR - If Tusla DSW cannot be reached, or in the case of a VP, call An Garda Síochána	**Who**? - Contact DLP - If DLP cannot be reached, contact a Deputy DLP	**Who**? - Contact DLP or Deputy DLP
When? - Immediately	**When**? - Immediately	**When**? - Immediately
How? - Phone call OR - In person	**How**? - Phone call OR - In person OR - Email	**How**? - Fill out Safeguarding Concern form and/or email DSP/Deputy DSPs (drop location for forms TBC) OR - Call DSL/ Deputy DSL
Follow up: - Inform DLP asap - Reporter and DLP will follow up together	**Follow up:** - For a CYP concern, DLP will report to Tusla for investigation - For a VP concern, DLP will report to relevant statutory authority	**Follow up:** - DLP/Deputy DLP may need further information from reporter - DLP/Deputy DLP will assess the situation and decide on appropriate response