POLICY*

Title:	*Child Protection (Ireland)*		
Applies Jurisdiction:	☐ ALL ☐ England	☐ Scotland ☒ Ireland	☐ Poland ☐ Netherlands ☐ Wales
Effective from:	January 2013	Division:	☒ ALL

Policy Statement

The Rehab Group is committed to actively safeguarding the welfare and protection of children who have contact with the organisation and the staff that provides our services.

The Rehab Group promotes the welfare of all children who access its services by means of education, staff training and the implementation of a process for staff to act on any concerns they may have for a child's welfare in a timely manner.

The Rehab Group considers it the duty of all those employed or involved with the organisation to take all reasonable measures to prevent or reduce the risk of abuse of all individuals with whom they come into contact. We acknowledge our responsibility to ensure that all legislation and statutory guidance concerning protection, including Children First National Guidance, is adopted, including reporting any protection issues alleged, suspected or disclosed. Rehab group will seek to establish reasonable grounds for onward reporting but does not carry out investigations into alleged, suspected or disclosed child protection issues. Rehab Group will only proceed to investigate an alleged, suspected or disclosed child protection issue when it has been reported to the relevant statutory body and the relevant statutory body has requested we do so.

In adapting the above good practice procedures the Rehab Group hope to minimize the possibility of false allegations against service users and or staff and volunteers
All Rehab Group Divisions will have the following in place:

- A recruitment process in line with the Rehab Group recruitment and selection process that ensures that all reasonable steps are taken to actively safeguard the welfare and protection of children who have contact with the organisation
- A staff induction process to ensure that newly recruited staff members read

* Rehab Group may amend, replace or withdraw this policy, and/or any related procedures or guidelines, from time to time at its absolute discretion

understand and accept the child protection policy & procedure

- Abuse and neglect awareness training and on going education for all staff in the dynamics of abusive and neglectful behaviour towards children and in the operation of the child protection policy & procedure, as relevant to their role and based on a training needs analysis

- A code of practice that outlines acceptable and unacceptable practice for Rehab Group staff in respect to their interactions with children (Child Protection (Ireland) Procedure Appendix 6 - *Rehab Group Standards of Best Practice in Protection.*)

- A system to raise awareness of child protection welfare issues in an accessible manner through supervision, support, training, assistance and advice

- A Designated Liaison Officer and structure of Designated Liaison Persons.
  - A structure, led by the Designated Liaison Officer to ensure any child protection concerns, allegations, disclosures will be raised by any member of staff and managed appropriately and in compliance with legislation. Please see Appendix 1 for Divisional Designated Liaison Officers and Persons

- A system to centrally log any child protection issues and to confidentially and appropriately manage and collate them

- A system to periodically review child protection issues in order to identify additional training needs

- A system whereby Rehab Group's child protection policies and procedures are readily available in an accessible format to children and young people accessing our services and their parents

- A system whereby senior management teams continuously monitor and decide on their divisions' protection training needs with reference to:
  - Risk factors relating to the nature of the activity they carry out
  - Regulatory & Funder requirements.

Rationale for Policy

The Rehab Group endeavours to safeguard the welfare and protection of all children who access Rehab services by endeavouring to protect them from all forms of abuse and neglect and endeavours to protect staff from false allegations of inappropriate behaviour.

Rehab Group POLICY

Scope

All Rehab Group Staff Members including applicable contractors as it applies to service provision, consultants, students on placement, agency staff and those acting in a voluntary capacity.

Definitions

Child	A child means a person under the age of 18 years, excluding a person who is or has been married

Related Policies

Adult Service User Protection
Behaviours That Challenge
Missing Service User
Personal Care
Back Ground Checks
Whistle Blowing
Risk Management
Positive Risk
Data Protection
Complaints
Restrictive Practices
Administration of Medication

Related Procedures and Guidelines

Divisional Child Protection Procedures and Guidelines

Reference Documents

- Child Care (Amdt) Act 2007 (Ireland)
- Child Care Act, 1991 (Ireland)
- Children First – National Guidelines for the Protection and Welfare of Children (Ireland)
- Trust in Care – HSE (Ireland)
- Our Duty to Care : the principles of good practice for the protection of children and young people – DOH 2002
  - Child Protection and Welfare Practice Handbook – HSE 2012
- Criminal Justice (Witholding of Information on Offences against Children and Vulnerable Persons) Act 2012
- Offences Against the State (Amendment) Act 1998
- Children Act, 2001

Rehab Group POLICY

National Policy and Procedure for the Protection and Welfare of Children, Young People and vulnerable Adults, October 2010

Non-Fatal Offences Against the Person Act, 1997

Protections For Persons Reporting Child Abuse Act, 1998.

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If you have any queries related to this policy, please email the Lead Executive COR-OPS-005@rehab.ie .

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PROCEDURE*

Title:	*Child Protection (Ireland)*		
Applies Jurisdiction:	☐ ALL ☐ England	☐ Scotland ☒ Ireland	☐ Poland ☐ Netherlands ☐ Wales
Effective from:	January 2013	Division:	☒ ALL

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1 - Definition and Recognition of Child Abuse – Children First 2011

Section 1 "*Definition and Recognition of Child Abuse – Children First 2011"* page 3-20 has been taken from Children First: National Guidance 2011. The sections part 2 section 2 and appendix 1 have been used in their entirety. In addition, further guidance can be found in "Our Duty to Care: the principles of good practice for the protection of children and young people" DOH 2002.

1.1 Types of child abuse - *Children First 2011- PG 8.*

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.

1.2 Neglect

1.2.1 Definition of 'neglect' - *Children First 2011- PG 8.*

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.

1.2.2 Signs and symptoms of neglect- *Children First 2011- PG 70.*

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.

1.2.3 Characteristics of neglect - *Children First 2011- PG 70.*

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.

1.3 Emotional Abuse

1.3.1 Definition of 'emotional abuse' - *Children First 2011- PG 8.*

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.

1.3.2 Signs and symptoms of emotional neglect and abuse- *Children First 2011- PG 71.*

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.

1.4 - Physical Abuse

1.4.1 Definition of 'physical abuse'- *Children First 2011- PG 9.*

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;
- Allowing or creating a substantial risk of significant harm to a child.

1.4.2 Signs and symptoms of physical abuse- *Children First 2011- PG 71.*

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 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:

- 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.

1.5 Sexual Abuse

1.5.1 Definition of 'sexual abuse' - *Children First 2011- PG 9.*

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.

1.5.2 Signs and symptoms of sexual abuse - *Children First 2011- PG 73.*

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.

Physical signs of Sexual Abuse

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.

1.6 Recognising child neglect or abuse - *Children First 2011- PG 10.*

Child neglect or abuse can often be difficult to identify and may present in many forms. A list of indicators of child abuse is contained below. No one indicator should be seen as conclusive in itself of abuse. It may indicate conditions other than child abuse. All signs and symptoms must be examined in the context of the child's situation and family circumstances.

1.6.1 Guidelines for recognition- *Children First 2011- PG 10.*

The ability to recognise child abuse can depend as much on a person's willingness to accept the possibility of its existence as it does on their knowledge and information. There are commonly three stages in the identification of child neglect or abuse:

- Considering the possibility;
- Looking out for signs of neglect or abuse;
- Recording of information.

1.6.2 Stage 1: Considering the possibility - *Children First 2011- PG 10.*

The possibility of child abuse should be considered if a child appears to have suffered a suspicious injury for which no reasonable explanation can be offered. It should also be considered if the child seems distressed without obvious reason or displays persistent or new behavioural problems. The possibility of child abuse should also be considered if the child displays unusual or fearful responses to parents/carers or older children. A pattern of ongoing neglect should also be considered even when there are short periods of improvement.

1.6.3 Stage 2: Looking out for signs of neglect or abuse- *Children First 2011- PG 10.*

Signs of neglect or abuse can be physical, behavioural or developmental. They can exist in the relationships between children and parents/carers or between children and other family members/other persons. A cluster or pattern of signs is more likely to be indicative of neglect or abuse. Children who are being abused may hint that they are being harmed and sometimes make direct disclosures. Disclosures should always be taken very seriously and should be acted upon, for example, by informing the HSE Children and Family Services. The child should not be interviewed in detail about the alleged abuse without first consulting with the HSE Children and Family Services. This may be more appropriately carried out by a social worker or An Garda Síochána. Less obvious signs could be gently explored with the child, *without direct questioning*. Play situations, such as drawing or story-telling, may reveal information.
Some signs are more indicative of abuse than others. These include:

- Disclosure of abuse by a child or young person;
- Age-inappropriate or abnormal sexual play or knowledge;
- Specific injuries or patterns of injuries;
- Absconding from home or a care situation;

- Attempted suicide;
- Underage pregnancy or sexually transmitted disease;
- Signs in one or more categories at the same time. For example, signs of developmental delay, physical injury and behavioural signs may together indicate a pattern of abuse.

Many signs of abuse are non-specific and must be considered in the child's social and family context.
It is important to be open to alternative explanations for physical or behavioural signs of abuse.

1.6.4 Stage 3: Recording of information- *Children First 2011- PG 10.*

If neglect or abuse is suspected and acted upon, for example, by informing the HSE Children and Family Services, it is important to establish the grounds for concern by obtaining as much information as possible. Observations should be accurately recorded and should include dates, times, names, locations, context and any other information that may be relevant. Care should be taken as to how such information is stored and to whom it is made available.

1.7 Children with additional vulnerabilities- *Children First 2011- PG 11.*

Certain children are more vulnerable to abuse than others. Such children include those children who are homeless and those who, for one reason or another, are separated from their parents or other family members and who depend on others for their care and protection. Children with disabilities may also be particularly at risk as the nature of their disability may make communication with others difficult and they may be more reliant on adults than other children.

The same categories of abuse – neglect, emotional abuse, physical abuse and sexual abuse – are applicable, but may take a slightly different form. For example, abuse may take the form of deprivation of basic rights, harsh disciplinary regimes or the inappropriate use of medications or physical restraints.

1.8 Fatal child abuse- *Children First 2011- PG 11.*

In the tragic circumstances where a child dies as a result of abuse or neglect, there are four important aspects to be considered: criminal, child protection, bereavement and notification.

Criminal aspects: This is the responsibility of An Garda Síochána and they must be notified immediately.
The Coroner must also be notified and his or her instructions complied with in relation to post-mortems and other relevant matters.

Child protection aspects: These will be particularly relevant if there are other children in the family/ in the same situation, and will therefore require immediate intervention by the HSE Children and Family Services to assess risk.

Bereavement aspects: The bereavement needs of the family must be respected and provided for and all family members should be given an opportunity to grieve and say goodbye to the deceased child.

Notification aspects: The HSE should notify the death of a child to the National Review Panel and to the Health Information and Quality Authority in accordance with the HIQA's Guidance for the Health Service Executive for the Review of Serious Incidents, including deaths of children in care (HIQA, 2010):

- All deaths of children in care, including natural causes;
- All deaths of children known to the child protection system;
- Serious incidents involving a child in care or known to the child protection services.

Managers and staff should cooperate fully with any review undertaken to establish the facts of the case and any actions that should be taken, to identify learning that will improve services in the future and to provide assurance to the public.

1.9 Points to remember- *Children First 2011- PG 12.*

- The severity of a sign does not necessarily equate with the severity of the abuse. Severe and potentially fatal injuries are not always visible. Neglect and emotional and/or psychological abuse tend to be cumulative and effects may only be observable in the longer term. Explanations that are inconsistent with the signs should constitute a cause for concern.

- Neglect is as potentially fatal as physical abuse. It can cause delayed physical, psychological and emotional development, chronic ill-health and significant long-term damage. It may place children at serious risk of harm. It may also precede, or co-exist with, other forms of abuse and must be acted upon.

- Experiencing recurring low-level abuse may cause serious and long-term harm. Cumulative harm refers to the effects of multiple adverse circumstances and events in a child's life. The unremitting daily impact of these circumstances on the child can be profound and exponential, and diminish a child's sense of safety and well-

being.

- Child abuse is not restricted to any socio-economic group, gender or culture. All signs must be considered in the wider social and family context. Serious deficits in child safety and welfare transcend cultural, social and ethnic norms, and must elicit a response.
- Challenging behaviour by a child or young person should not render them liable to abuse.
- Children in certain circumstances may present management problems. This should not leave them vulnerable to harsh disciplinary measures or neglect of care.
- Exposure to domestic violence is detrimental to children's physical, emotional and psychological well-being. The adverse effects of domestic violence have been well established.
- While the impact of neglect is most profound on young children, it also adversely affects adolescents. Neglect renders young people liable to risk-taking behaviours, such as running away, early school leaving, anti-social behaviour, mental health and addiction problems, including the risk of suicide.
- It is sometimes difficult to distinguish between indicators of child abuse and other adversities suffered by children and families. Deprivation, stress, addiction or mental health problems should not be used as a justification for omissions of care or commissions of harm by parents/carers. The child's welfare must be the primary consideration.
- Neglectful families may be difficult to engage. Research shows that families may be reluctant to seek help in response to experiencing the factors associated with neglect.
- Families where neglect and abuse are prevalent may go to considerable lengths to deceive professionals. It is important for professionals to approach cases with a wary trustfulness, seek evidence to substantiate claims of improvement and speak with the children concerned individually.

1.10 Peer Abuse

In some cases of child abuse, the alleged perpetrator will be another child. In a situation where child abuse is alleged to have been carried out by another child, the child protection procedures should be adhered to for both the victim and the alleged

abuser – i.e. it should be considered a child care and protection issue for both children.
Abusive behaviour that is perpetrated by children must be acted upon. If there is any conflict of interest between the welfare of the alleged abuser and the victim, the victim's welfare is of paramount importance.

1.11 Sexual abuse by Peers - *Children First 2011-Part 4, Section 9.*

Peers may also sexually abuse each other. In accordance with Children First: National Guidelines, such cases should be referred to the HSE through the same procedure. It is important that the different types of behaviour are clearly identified and that no young person is wrongly labelled 'a child abuser' without a clear analysis of the particular behaviour.

Four categories of behaviour warrant attention: normal sexual exploration; abuse reactive behaviour; sexually obsessive behaviour; and abusive behaviour by adolescents and young people.

- **Normal sexual exploration**: This could consist of naive play between two children that involves the exploration of their sexuality. This type of behaviour may be prompted by exchanges between children, such as 'You show me yours and I'll show you mine'. One of the key aspects of this behaviour is its tone: there should not be any coercive or dominating aspects to this behaviour. Usually, there is no need for child protection intervention of any kind in this type of situation.

- **Abuse reactive behaviour**: In this situation, one child who has been abused already acts out the same behaviour on another child. This is serious behaviour and needs to be treated as such. In addition to responding to the needs of the abused child, the needs of the child perpetrator in this situation must also be addressed.

- **Sexually obsessive behaviour**: In this type of situation, the children may engage in sexually compulsive behaviour. An example of this would be excessive masturbation, which may well be meeting some other emotional need. Most children masturbate at some point in their lives. However, in families where care and attention is missing, they may have extreme comfort needs that are not being met and may move from masturbation to excessive interest or curiosity in sex, which takes on excessive or compulsive aspects. These children may not have been sexually abused, but they may be extremely needy and may require very specific help in addressing those needs.

- **Abusive behaviour by adolescents and young people**: Behaviour that is abusive will have elements of domination, coercion or bribery, and certainly secrecy. The fact that the behaviour is carried out by an adolescent, for example, does not, in

itself, make it ‘experimentation’. However, if there is no age difference between the two children or no difference in status, power or intellect, then this indeed may be experimentation.

1.12 Bullying

Bullying can be defined as repeated aggression – whether it be verbal, psychological or physical – that is conducted by an individual or group against others. It is behaviour that is intentionally aggravating and intimidating, and occurs mainly among children in social environments such as schools. It includes behaviours such as teasing, taunting, threatening, hitting or extortion by one or more persons against a victim. Bullying can also take the form of racial abuse. With developments in modern technology, children can also be the victims of non-contact bullying, via mobile phones, the Internet and other personal devices.

Bullying of children can also be perpetrated by adults, including adults who are not related to the child. Bullying behaviour when perpetrated by adults, rather than children, could be regarded as physical or emotional abuse. However, other major forms of child abuse, such as neglect and sexual abuse, are not normally comprehended by the term ‘bullying’.

It is imperative that management have a policy in place to deal with bullying and that staff are aware of this policy and of procedural guidelines to deal with it.

2 – Procedures

2.1 Procedure - Receiving an Allegation, Disclosure or Concern of Child Abuse

Abuse may become apparent in a number of different ways. Below are outlined the three most common – Disclosure, allegation or a raised concern or suspicion. The principles and procedures for dealing with all three are the same. Once a disclosure, allegation or a raised concern is brought to the attention of a Rehab Group staff member it should be **submitted to the designated liaison person immediately and absolutely within a maximum of 24 hours**. No time limit is placed on reporting allegations, concerns or disclosures of abuse. In circumstances where a disclosure or allegation of abuse is received by any member of staff, where the victim is either at no further risk, or is now an adult, it is essential to still consider whether there may be risks to any child who could be in contact with the alleged abuser.

2.1.1 - Allegation of abuse

An allegation of abuse can present in a number of different ways

An allegation can be made by :	An allegation can be made against:
A Service User subject to the abuse A Staff member witness to the abuse A Service User witness to the abuse A member of the Public witness to the abuse. A family member/Carer/Next of Kin	A Service user of Rehab Group Services A Rehab Group Staff member A Third Party Contractor A member of the Public An external organisation A family member /Carer

These are not exhaustive lists

2.1.2 – Concern of Abuse

There may be instances when no specific allegation or disclosure of abuse arise. However you may have concerns that some form of abuse may be occurring as a result of observed indicators.
Concern of abuse may also result from an unexpected withdrawal of a child from a service or a child moving area or service provider unexpectedly. In such cases, the possibility of the parent/guardian of the child taking steps to prevent detection should be considered.

A concern is clearly different from an allegation and in each situation it is important to define which category the relevant incident falls into. However given the potential vulnerability of the Rehab Groups service users it is important to ensure that all staff address any concerns and act on them appropriately and fairly in relation to all parties involved. Children First: National Guidance specifies at 3.2.3 that "*child protection concerns should be supported by evidence that indicates the possibility of abuse or neglect.*" At 3.2.4 *it specifies that "a concern about a potential risk to children posed by a specific person, even if the children are unidentifiable, should also be communicated to the HSE Children and Family Services."*

The principles and procedures for dealing with raised concerns of abuse are the same as those applicable to abuse which is alleged or disclosed.

2.1.3 - Disclosure of Abuse

The following steps should be followed if a child discloses abuse:

Receive

- Listen to what is being said, without displaying shock or disbelief. Give the child time to say what he or she wants.
- Remain calm.
- Take all disclosures seriously.
- Try and ensure that the child is allowed to speak about the disclosure in an environment that respects the confidentiality of the matter and all individuals involved

in the matter.
- Ensure that the different communication, language or literacy needs of the individual child are catered for.
- Ensure that the language and wording used in conducting the interview are understood by and accessible to the individual child.
- Ensure that any particular communications assistance required by the child is made available for the interview.
- Take notes on the details of the disclosure as they are presented without expressing any opinion on these facts.

Reassure

- Reassure the child but do not make promises you may not be able to keep like, "I'll stay with you," or "Everything will be all right now".
- Do not promise confidentiality: you have a duty to refer. Explain to the child that you will need some help to deal with what he/she has told you.
- Do reassure and attempt to alleviate guilt, if the child refers to it.

React

- React to the child only as far as is necessary for you to establish whether or not you need to refer this matter.
- Do not 'interrogate' for full details.
- Do not stop the child recalling significant events, but don't make him or her repeat the story unnecessarily.
- Do not ask 'leading' questions such as "Did s/he touch your private parts?" Such questions may undermine the quality of the evidence obtained by you for the purposes of any subsequent prosecution.
- Do ask open questions i.e. questions that encourage the child to volunteer information rather than to answer "yes" or "no"
- Do not criticise the alleged perpetrator.
- Do explain what you have to do next and to whom you have to talk.

Record

- Make notes at the time and write them up as soon as possible. Where notes are written up some time after the disclosure of abuse/interview with the service user, the date and time of making the note should also be recorded. The note should be marked "retrospective note".
- Do not destroy these original notes.
- Record the date, time, place, any noticeable non-verbal behaviour and the words used by the child. If the child uses sexual 'pet' words, record the actual words used, rather than translating them into 'proper' words.
- Any injuries or bruises noticed should be recorded on the enclosed body map

(appendix 4), showing their position and extent.
- Record statements and observable things, rather than your interpretations or assumptions.
- Complete the internal reporting document in conjunction with your line manager (appendix 1) and **submit to the designated liaison person immediately and absolutely within a maximum of 24 hours.** Ensure to submit all supporting documentation with this report.

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 procedure and the possible consequence, 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, to the wishes of the child.

2.2 - Procedure - Reporting an Allegation, Disclosure or Concern of Child Abuse

2.2.1	If a staff member has a concern or has received a disclosure or allegation that a child has or is being abused, he/she should, in conjunction with his/her line manager or in the absence of the line manager a designee, report the matter to the DLP. In addition to reporting verbally, appendix 1 needs to be completed. This needs to be completed immediately and **absolutely within a maximum of 24 hours**. The individual staff member should follow the line management structure in the event that his/her manager is not available or is the subject of the allegation/disclosure/concern.	All Staff
2.2.2	If a staff member has a concern of abuse involving another staff member. The concerned staff member should raise it immediately with their own line manager or in the absence of the line manager a designee. Rehab seeks to reassure staff that an allegation made or concern reported in good faith, which turns out to be unfounded, will not have adverse repercussions for them. Confidentiality will be a primary consideration.	All Staff
2.2.3	After the initial report has been made to the DLP, the Manager should then gather all relevant reports and supporting documentation, as requested by the DLP and forward them to the Designated Liaison Person within an agreed timeframe using the internal reporting form – Appendix 1 A contemporaneous record of	Line Manager

	any verbal exchange should sent as part of the supporting documentation.	
2.2.4	In cases where the concern /disclosure /allegation involves more than one division the Designated Liaison Person of each division will agree their roles in coordinating a joint response and remain in constant communication on the issue until it has been resolved. In cases where a concern / disclosure / allegation is received by a staff member about a staff member from an other division, the Designated Liaison Officer will make contact with the Director / Designate of the employing division and agree an appropriate management response.	Designated Liaison Persons /Officer
2.2.5	On receipt of details of the allegation/disclosure or suspected child protection issue the Designated Liaison Person should consider all relevant documentation/information in order to establish whether there are "reasonable grounds for concern that a child may have been, is being or is at risk of being abused or neglected". In attempting to establish whether there are reasonable grounds for a concern that a child may have been, is being or is at risk of being abused or neglected, it may be necessary to consult expert persons to advise on how best to proceed e.g. the HSE Duty Social Worker The following are examples which would constitute reasonable grounds for concern: • An injury or behaviour that is consistent both with abuse and an innocent explanation, but where there are corroborative indicators supporting the concern that it may be a case of abuse. • Consistent indication over a period of time that a child is suffering from emotional or physical neglect. • Admission or indication by someone of an alleged abuse. • A specific indication from a child that he or she was abused. • An account from a person who saw the child being abused. • Evidence (e.g. injury or behaviour) that is consistent with abuse and unlikely to have been caused in any other way. *Ref – Child Protection & Welfare Practice Handbook – Page 30* *Please note: a concern which is not supported by any objective indication of abuse or neglect would not constitute a reasonable concern or reasonable grounds for concern*	Designated Liaison Person

2.2.6	The Designated Liaison Person will establish if there are 'reasonable grounds for concern' that a child may have been, is being or is at risk of being abused or neglected, and if so will communicate this to the HSE. Under the Department of Health's National Guidance for the Protection and Welfare of Children, any concerns/allegations or disclosures of protection concerns regarding children must be reported to the relevant personnel within the Health Service Executive (HSE) for investigation. In such cases a report will be made to the Principal Social Worker /Social Worker on Duty/ Designated Officer of the local health offices (or as appropriate), appendix 7 using the HSE Standard Reporting Form, appendix 2.	Designated Liaison Person
2.2.7	If an appropriate member of the HSE isn't available to receive a report and it is believed that a child is potentially in imminent danger of abuse the Gardai should be contacted. Under no circumstance should a child be left in a situation that exposes him or her to harm or to risk of harm pending HSE intervention.	Designated Liaison Person
2.2.8	There is a need to maintain **confidentiality** in dealing with any suspected protection issue both internally within Rehab Group and when communicating with external agencies. Appendix 9 details Rehab Group's communication strategy with external agencies.	All
2.2.9	The parent or guardians of the child should be informed of any reports made, as long as it is believed that informing them doesn't put a child in any danger. An appropriate communication strategy and timeframes will be agreed by the Designated Liaison Person and the service manager.	Designated Liaison Person / Service Manager
2.2.10	In cases where reasonable grounds for onward reporting has not been established, the source (staff member, service user or member of the public) who raised the concern (allegation, disclosure or concern) will be given a clear written statement of the reasons why Rehab Group is not taking such action. Service user's rights to adequate data protection will be considered throughout.	All
2.2.11	The source (staff member, service user or member of the public) who raised the concern (allegation, disclosure or concern) will be advised that if they remain concerned about the situation, they are free as individuals to consult with, or report to, the HSE or An Garda Síochána. The Protections for Persons Reporting Child Abuse Act, 1998 makes provision for the protection from civil liability of persons who have communicated child abuse 'reasonably and in good faith' to designated officers of the HSE or to any member of An Garda Siochana. This protection applies to	All

	organisations as well as to individuals. Therefore, even if a communicated suspicion of child abuse proves unfounded, a plaintiff who took an action would have to prove that the person who communicated the concern had not acted reasonably and in good faith. A person who makes a report in good faith and in a child's best interest may also be protected under common law by the defence of qualified privilege.	

3 - Suspected abuse by a Staff Member

Where an allegation or concern of abuse concerns a member of staff of Rehab Group, the most important consideration to be taken into account is the protection of children, and their safety and well-being. However, because of the involvement of staff members, Rehab Group has duties in respect of them as well. The Rehab Group in its continued commitment to its staff and service users aims to discharge its dual responsibilities in a supportive manner. These procedures, the applicable employment contract and the rules of natural justice and fairness should be followed. At all stages, it should be remembered that the first priority should be to ensure that no child is exposed to unnecessary risk. The Senior Manager/Director should, as a matter of urgency, take any necessary protective measures. These measures should be proportionate to the level of risk and should not unreasonably penalise the employee, financially or otherwise, unless necessary to protect children. The Child Protection Policy & Procedure is offered to assist management in having due regard to the rights and interests of the children under their care and those of the staff member against whom the allegation is made.

If a staff member has a concern of abuse against another staff member it should be raised immediately with the concerned party's line manager. The child must not be left at risk under any circumstances. Rehab seeks to reassure staff that an allegation made or concern reported in good faith, which turns out to be unfounded, will not have adverse repercussions for them. The good name of the person against whom the allegation is made will also be protected as appropriate. Confidentiality will be a primary consideration.

As with all suspected child protection issues and in line with the reporting procedure detailed in section 2, the Designated Liaison Person will consider whether the issue raised has reasonable grounds to proceed to be reported to the HSE as described in the reporting section of this document and in line with National Children First Guidance.

When a Senior Manager becomes aware of an allegation of abuse against a staff member, the Senior Manager in consultation with HR and the Designated Liaison Person should privately inform the staff member of the following:

- The fact that an allegation has been made against him/her and by whom.
- The nature of the allegation & the process that is going to be followed.
- Whether or not the matter has been reported to the HSE by Rehab Group.

While a HSE investigation is ongoing, the following steps may be taken in order to facilitate the smooth running and continuation of the service.

The member of staff may be:

- Moved to another area of work
- Placed under closer supervision
- Suspended from duty with full pay. Where the member of staff works fluctuating hours, pay will be based on the average weekly hours worked by the staff member in the 12-week period preceding the suspension.

The views of the staff member should be taken into consideration when determining the appropriate protective measures to take in the circumstances but the final decision rests with management. The taking of any such measures does not imply any degree of guilt on the part of the staff member and will be accompanied by swift investigation. It should be explained to the staff member concerned that the decision to re-locate/ put under closer supervision/ suspension is a precautionary measure and not a disciplinary sanction.

Where the Senior Manager/Director is unsure as to whether the nature of the allegations warrants the absence of the staff member from their place of employment while the matter is being investigated, s/he should consult with the Child Care Manager of the local HSE and/or An Garda Siochana for advice as to the action that those authorities would consider necessary. Following those consultations, the Senior Manager/Director should have due regard for the advice offered.

The decision to proceed with a disciplinary process against a staff member may be taken before, during or after a HSE guided investigation. This process should never however impede a HSE/Garda investigation.

4 - Outcome

The HSE will lead any investigation into suspected protection issues. Rehab Group will facilitate the HSE in this process as directed by the HSE. The Designated Liaison Officer will be the primary liaison with the HSE during their investigation and subsequent communication. The Rehab Group will consider any recommendations provided by the HSE as a result of an investigation.

If a HSE lead investigation finds that an alleged suspected or disclosed child abuse is unsubstantiated the following will be considered if the allegation was made against a Rehab Group staff member:

- If the person against whom the allegation is made, was transferred to another work location or suspended from duty, they will be returned to work and provided with relevant support. Management should ensure that the reputation and career prospects of the staff member concerned are not adversely affected by reason of the complaint having been brought against him/her.

  If appropriate, the staff member who made the complaint should be reassured that management appreciates that the complaint was made in good faith.

- If no evidence of abuse is found, but the finding is one of poor practice, then the person against whom the allegation has been made should receive immediate training followed by a period of closely supervised work assessment. 'Closely supervised' does not mean any form of intense supervision that can be interpreted as oppressive but will mean an increase in supervision with a view to improving performance in accordance with best practice. This may take place in the same or a different location to be determined by a senior manager in conjunction with the individual and a recommendation from the investigation team.

- If it is established that the allegation was malicious, disciplinary action in accordance with the Rehab Group's disciplinary procedure may be taken against the person or persons making it, depending upon the circumstances.

- Counselling or other support services as deemed appropriate will be offered to any victim of a malicious or unsubstantiated allegation. This will be organized by the Human Resources Department. Rehab Group has an Employee Assistance Programme that offers information, support and assistance 24 hours a day, 7 days per week. Free counselling is also available on this programme. The free phone help line number is 1800 201 346.

- The Designated Liaison Officer will make a decision regarding the ongoing retention of any documentation relating to the establishment of reasonable grounds where no grounds for further action have been established. As a general rule all records of unsubstantiated and unproved allegations against a staff member should be kept on a file separate from the employee's personnel file. The person against whom the unsubstantiated allegation was made should be informed of the fact that the details are being maintained on this separate file in an appropriately secure place.

- The person against whom the allegation was made will be informed of any decision to retain documentation and the reason for so doing. The Data Protection Acts 1988 and 2003 apply to individuals' personal data.

5 – Confidentiality

The effective protection of children and vulnerable adults often depends on the willingness of those involved with children and vulnerable adults to share and exchange relevant information. It is therefore critical that there is a clear understanding of professional and legal responsibilities with regard to confidentiality and the exchange of information.

No absolute undertakings regarding confidentiality can be given. Witnesses or others providing information cannot be guaranteed confidentiality, although they must be assured that all information received will be treated in an appropriate and respectful manner.

Ethical and statutory codes legislation concerned with confidentiality and data protection provide general guidance. However, they are not intended to limit or prevent the exchange of information between different professional staff with a responsibility for ensuring the protection and welfare of children.

The provision of information to the statutory agencies for the protection of a child is not a breach of confidentiality or data protection. However, all information regarding concern or assessment of child abuse or neglect should be shared on 'a need to know' basis in the interests of the child with the relevant statutory authorities.

Scope

All Rehab Group Staff Members including applicable contractors as it applies to service provision, consultants, students on placement, agency staff and those acting in a voluntary capacity.

Definitions

Child — A child means a person under the age of 18 years, excluding a person who is or has been married

Related Policies

Adult Service User Protection
Behaviours That Challenge
Missing Service User
Personal Care

Back Ground Checks
Whistle Blowing
Risk Management
Positive Risk
Data Protection
Complaints
Restrictive Practices
Administration of Medication

Related Procedures and Guidelines

Definitions of and recognising signs of
child abuse and the context it may occur
Children First National Guidance 2011
Procedures on Protected Disclosures of Information in the Workplace – (HSE)

Reference Documents

See the list(s) of reference documents in the related policies listed above

Lead Director:	Laura Keane	Contact (tel & email):	00353-1-2057393 laura.keane@rehab.ie
Business Area:	Corporate Affairs		
Version Number:	1.00		
Reference Number:	COR-OPS-005	Subject/Activity:	Operations

If you have any queries related to this policy, please email the Lead Executive COR-OPS-005@rehab.ie .

Appendix 1 - Internal Reporting Form
Note: To assist with a speedy reporting process this form can be emailed. However prior to doing so every care should be taken to ensure it is sent only to required addresses. In addition, it must be password protected with the password to open the document sent by text to the relevant person.

To: The Designated Liaison Person ……………………………...

This form should be completed to record a report of any form of alleged disclosed or suspected abuse. It should be completed by the person:

(a) Who observes the incident(s)
(b) To whom the allegation or concern of abuse is initially reported or identified by

Where there is more than one service user involved a separate form should be completed in respect of each individual.

On completion, the form should be forwarded to the Designated Liaison Person

Details of Person Making this Report:

Name:……………………………………….

Title:………………………………………..

Location:…………………………………… Date:……………….

Time:……………………………………….

Alleged Victim Details
Name:…………………………………...

Date of Birth:……………………………

Home Address: Service Address (if appropriate)
………………………………………

………………..……………………….

Contact Phone Number: ……………………

Alleged Perpetrator Details

Name:………………………………………

Date of Birth/Age:………………………….

Address:……………………………………

……………………………………….….

Relationship to Alleged Victim:……………………………………………….

Contact Phone Number: ……………………………………………….

Disclosure Details:

In the event of a disclosure being made complete the following Disclosure Details

Disclosed to:………………………………………………..

Date of Disclosure:………………………………………….

Time of Disclosure:………………………………………….

Location of Disclosure:………………………………………

Details of Alleged Incident(s):

Location:……………………………………………………………………………

Date:……………………………… Time:……………………………….

Description of Alleged Incident/ Situation:

Please give a **factual** account of what was either observed by you or reported to you.

………………………………………………………………………………………..

………………………………………………………………………………………..

………………………………………………………………………………………..

Signed:………………………………………….. Date:……………..

To be completed by the Line Manager on receiving the completed form

Name:………………………………………..

Position:………………………………………

Time and Date Received ……………………………………………………………..

Designated Liaison Person informed: Yes ☐

Time informed ……………………

Description of any safety precautions put in place

..……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

Signed:…………………………………………

Date:…………………………….

To be completed by the Designated Liaison Person on receiving completed Form

Name:……………………………………….

Position:……………………………………….

Signed:……………………………………… Date:………………

Appendix 2 -Notification of Suspected Abuse to Health Service

FORM NUMBER: CC01:01:00

STANDARD REPORT FORM

(For reporting CP&W Concerns to the HSE

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 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.)

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:	
Signed		Date:	

Appendix 2 -Notification of Suspected Abuse to Health Service Executive –Guidance Notes

The HSE has a statutory responsibility under the Child Care Act 1991 to promote the protection and welfare of children. The HSE therefore has an obligation to receive information about any child who is not receiving adequate care and/or protection.

This Report Form is for use by:
• Any professional, individual or group involved in services to children, including HSE personnel, who becomes aware of a child protection or welfare concern, or to whom a child protection or child welfare concern is reported.
• Professionals and individuals in the provision of child care services in the community who have service contracts with the HSE.
• Designated persons in a voluntary or community agency.

Please fill in as much information and detail as is known to you. This will assist the Social Work Department in assessing the level of risk to the child or the support services required. If the information requested is not known to you, please indicate this by putting a line through the question. It is likely that a social worker will contact you to discuss your report.

The HSE aims to work in partnership with parents. If you are making this report in confidence, you should note that the HSE cannot guarantee absolute confidentiality for the following reasons:
• A Court could order that information be disclosed.
• Under the Freedom of Information Act 1997, the Freedom of Information Commissioner may order that information be disclosed.

You should also note that in making a 'bona fide report', you are protected under the Protections for Persons Reporting Child Abuse Act 1998.

Appendix 3 -Notification of Suspected Abuse to Gardaí

Private and Confidential

To: Superintendent,
An Garda Síochána,

(This form should be accompanied by a report with the relevant information pertaining to the alleged victim, the details of the alleged abuse and the reasons for referring to the Gardaí)

Name of alleged victim …………………………... D.O.B.: ……………….

Service Details ..………………………………

…………………………………

…………………………………

Home Address ……………………………………….

…………………………………

…………………………………

Parent/carer: …………………………………

Address: …………………………………

…………………………………

…………………………………

Phone number: …………………………………

Relationship to alleged victim: ……………………………………………

Type of alleged abuse: ……………………………………………………………..

Location of alleged abuse: ……………………………………………………

Identity of alleged abuser: …………………………………………………………….

Relationship to alleged victim: ………………………………………………

When did the alleged abuse take place: ……………………………………………

Identity of informant: …..…………………………………………………

Appointed Person in ……………..….Services for dealing with this allegation is

……....…………………………………

Signed by: ________________________________
Designated Liaison Person

Date: ________________________________

Appendix 4 - Body Map

Name of Individual : ________________________________

H&S Incident Form No.: ________________________________

Name of Staff Member 1: ______________________ ____
Job Title of Staff Member 1: ____________________ ____

Name of Staff Member 2: ______________________ ____
Job Title of Staff Member 2: ____________________ ____

Service Details, address & telephone no. ________________________________

____

____

Date marks observed/Body map completed: __/__/__ *(date, month & year)*

Signature of Manager: ______________________ Date: __/__/__ *(date, month & year)*

Instructions for completing the body map:
Please only use this body map if you have been trained to do so and in a manner that maintains the dignity of the Service User.

When you notice an injury on a service user/staff member record as accurately as possible the following information for each injury by drawing on the body map in black ink:

1. Indicate the exact site of the injury (using arrows if necessary)

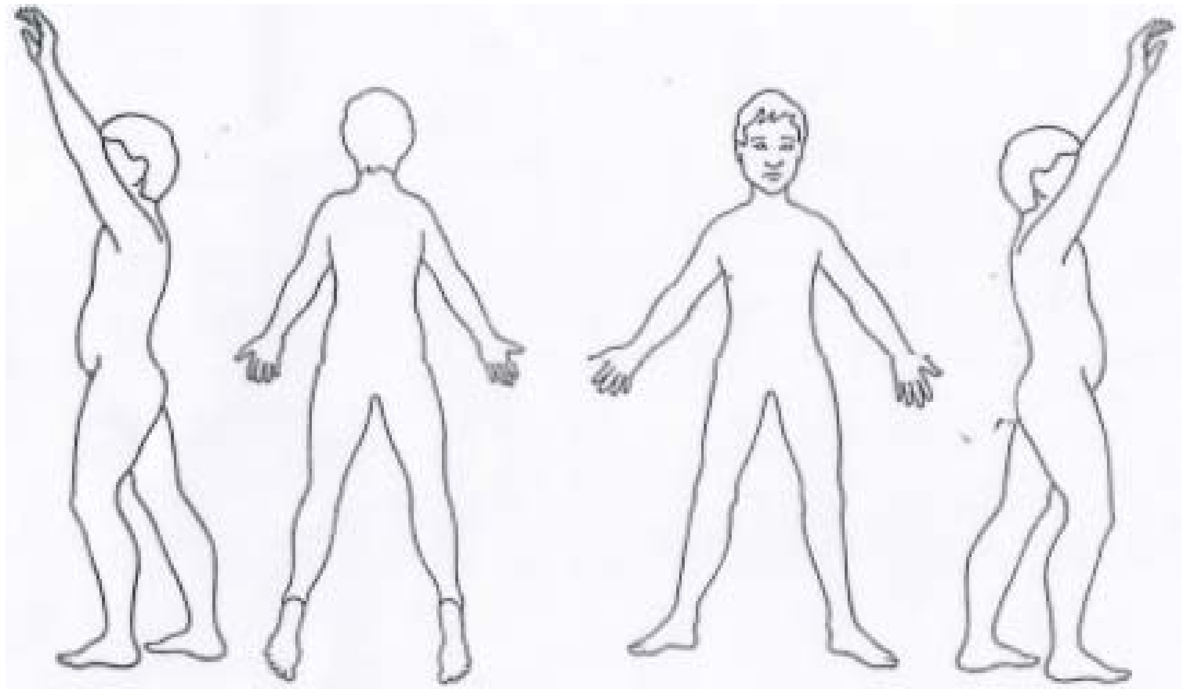
2. Use the following key to indicate the different types of injury i.e. (A) bruising (B) etc.

3. Use the space provided to make a 'close-up' drawing(s) of body parts/injuries highlighting and indicate where they appear on the body map.

4. Provide brief details for each injury e.g.
   (a) measurements of the injury (a ruler is provided to assist with measurement),
   (b) approximate shape of the injury e.g. round, square, straight line

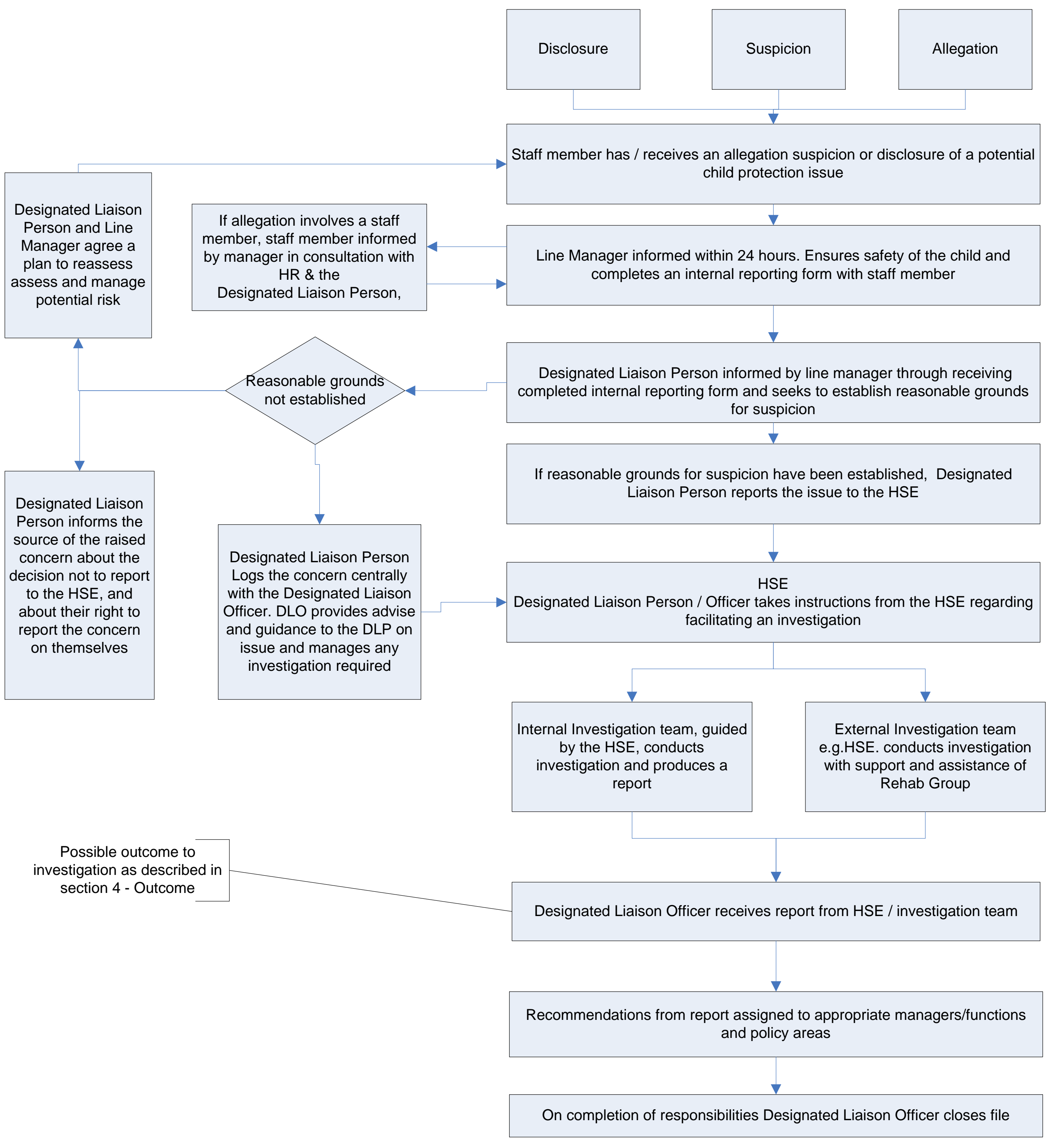
(c) colour of the injury - if more than one colour say so
(d) is the skin broken?
(e) is there any swelling at the site of the injury or elsewhere?
(f) is there a scab? / any blistering? / any bleeding?
(g) is the injury clean? or is there grit / fluff etc?
(h) does the site of the injury feel hot?

▨	A - pressure ulcers	▒	D - scratches, red areas (not broken down)
■	B - bruising	▦	E - scalds, burns
▤	C - cuts, wounds	□	F - other (specify e.g. bites/scratches)



Please use the space below to make “close up” drawing(s) of each injury.
Please indicate where each injury is located on the body and provide brief details of each injury.

Appendix 5 - Reporting Process Flow Diagram



Appendix 6 –Rehab Group Standards of Best Practice in Protection.

Overview
This Code of Practice is designed to set acceptable and unacceptable practice for Rehab Group staff in respect to their interaction with children who have contact with Rehab Services. Its aims to put in place a system of best practice in this regard and to protect staff members and service users from unfounded allegations.

If you find during the course of your work difficulty adhering to this code please raise these issues with your line manager.

The goal of this code is to:
- Promote the welfare of children who have contact with Rehab's Services.
- Safeguard the children who have contact with Rehab's Services at all times.
- Ensure the protection of staff from false allegations.
- Encourage and develop best practice among staff at all levels of the organisation.

Rehab Group expects that all of our staff will approach their work, perform their duties and conduct themselves in a professional and ethical manner at all times. As a general rule staff should treat service users with the same degree of courtesy and respect with which they themselves would wish to be treated.

Guiding Principles in Child Protection and Welfare

- The welfare of children is of paramount importance.
- A proper balance must be struck between protecting children and respecting the rights and needs of parents / carers and families; but where there is conflict, the child's welfare must come first.
- Children have a right to be heard, listened to and to be taken seriously. Taking account of their age and understanding, they should be consulted and involved in all matters and decisions which may affect their lives.
- Early intervention and support should be available to promote the welfare of children and families, particularly where they are vulnerable or at risk of not receiving adequate care or protection.
- Parents / carers have a right to respect and should be consulted and involved in matters which concern their family.
- Actions taken to protect a child, including assessment, should not in themselves be abusive or cause the child unnecessary distress. Every action and procedure should consider the overall needs of the child.
- Intervention should not deal with the child in isolation; the child must be seen in a family setting.

- The criminal dimension of any action cannot be ignored.
- Children should only be separated from parents / carers when all alternative means of protecting them have been exhausted. Re-union should always be considered.
- Agencies or individuals taking protective action should consider factors such as the child's gender, age, stage of development, religion, culture or race.
- Effective prevention, detection and treatment of child abuse or neglect requires a co-ordinated multi-disciplinary approach to child care work and effective inter-agency management of individual cases. All agencies and disciplines concerned with the protection and welfare of children must work co-operatively in the best interests of children and their families.
- In practice, effective child protection requires compulsory training and clarity of responsibility for personnel involved in organisations working with children.

Service Users Must Be:

- Recognised as individuals, addressed by their own names, encouraged to do things for themselves and be given an opportunity to understand and be understood.
- Treated with respect, addressed with respect, included in conversation, and involved in making decisions about themselves.
- Offered choices, listened to and ensured access to communication equipment, if required.
- Provided with a safe environment.
- Assured confidentiality except where there is a risk to themselves or others or concern that a child is at risk. In this instance confidentiality cannot be guaranteed and issues arising should be reported to the local manager in the first instance.

Staff Must:

- Ensure that relations with children who have contact with Rehab's Services should be on a professional basis at all times and within the requirements of the job. While the development of friendly, trusting relationships is important, professional boundaries must be maintained at all times.
- Always refer to service users by name (and never by disability).
- Treat all information confidentially, except for those who have a need to know.
- Respect the wishes and choices of children who have contact with Rehab Services and their families. Seek advice from your manager if you need it.
- Intervene as and where appropriate if they witness any abusive behaviour.
- Always seek advice from supervisors or another appropriate manager if they are unsure or have any concerns about appropriate behaviour to children who have contact with Rehab Services.

Staff Must Not:

1. Do things for service users, which they can safely do and wish to do for themselves.
2. Take service users to their, or another staff member's home.

3. Engage in rough, physical or sexually provocative games, including horseplay.
4. Engage in inappropriate touching of any kind.
5. Use inappropriate language.
6. Make sexually suggestive comments about or to a person, even in jest.
7. Develop personal relationships with an individual service user outside the professional boundary of their role.
8. Involve themselves in ambiguous situations where the service user is uncertain of his/her role.
9. Favour one service user over another.
10. Engage in sexual or suggestive conversations/activities.
11. Divulge your personal opinion about other service users or staff members.
12. Discuss service users in front of other service users.
13. Give detailed personal information (e.g. address, phone numbers, social website presence) about yourself or other staff members.
14. Offer accommodation to service users in a crisis.
15. Ask service users to undertake jobs for them outside of work (for example, babysitting).
16. Borrow money or accept hospitality outside the remit of agreed service provision from a service user.
17. Loan money or property to service users.
18. Indulge in dangerous behaviour leading to injury or risk of injury to a service user.
19. Use any restrictive practice with a service user without applying the restrictive practices policies and procedures.
20. Give service users lifts in your own private car, except in absolute emergencies or unless it is part of a programme and with the knowledge of the manager of the service.
21. Allow unnecessary situations to arise whereby you may be alone in the company of a service user for reasons not related to the provision of services.
22. Staff must not arrange or participate in personal or social activities with service users outside the professional remit of their role.

This list is not exhaustive and you should seek guidance from your manager if you wish to discuss any specific situations further. We would actively encourage all Rehab Group staff to be alert in helping to identify and prevent situations which may cause or lead to problems for either colleague our service users.

Staff Supports

Where serious emotional or personal difficulties arise with service users, staff should avoid becoming personally over-involved. Staff should access Rehab Group clinical supports such as Regional Psychologists and Rehabilitation Officers (NLN) and Behavioural Therapists and Clinical Psychologists (Rehab Care) in line with divisional practices. In such cases these supports will provide support for both staff and service users. Further staff support is available through the Employee Assistance Programme (EAP).

Best Practice

- If you become the recipient of inappropriate advances from a child who has contact with Rehab Services you should inform your manager immediately.
- In the main, a service user's wish for privacy must be respected except where, notwithstanding a service user's wish for privacy, it may be unsafe or even dangerous to leave him/her alone, unattended or unaccompanied.
- Where a number of service users are being driven in a Rehab Group vehicle, or contracted vehicle, (i.e. van/minibus) it is recommended that the last service user remaining in the vehicle be of the same sex as the driver, even if this means a longer journey.
- In a learning environment, where it is necessary to deal with a service user in a on a one-to-one basis during the course of your work, the meeting should be conducted in a quiet but observable area. Where this is not possible one or a combination of the following safeguards are advised:
    - Use an office or room with inside and outside windows.
    - Blinds or curtains should be open and the room well lit. If possible the door should be left open.
    - Inform a colleague that the meeting is taking place, its location and likely duration.
    - The meeting should not be any longer than is necessary.

Risk features to which staff are required to have consideration for.

There are a number of risk features pertaining to service users, of which staff members need to be aware. These include:

- Limited life experience and social contact means that some service users may not have had the chance to acquire the 'streetwise' behaviour and judgement of their non-disabled peers.
- Because of their dependency, some service users may be particularly at risk in understanding inappropriate behaviour.
- A person with an intellectual disability and/or poor communication skills may appear to be a 'safe victim', because he/she is less likely to complain or disclose.
- Because they are more likely to have a number of service providers, service users may be exposed to greater risk.
- Since it may be necessary to provide services of a personal nature, there are additional occasions where abuse may occur.
- Issues of power/powerlessness are particularly pertinent as many service users depend on our staff.
- Service users may demonstrate inappropriate behaviour towards other service users and the above principles apply in such cases, as one service user may be in a position to lead or coerce another service user.

Appendix 7 –National Contacts for HSE Children & Family Services.

Please note that the below information is also listed on HSE website: www.hse.ie/go/socialworkers

These contact numbers may be updated from time to time. Please check HSE website for latest information.

Please consider that there may be more than one HSE area associated to your service or the child that you have concern for. Relevant numbers should be available in all Rehab services

HSE Area	Address	Telephone No.
DUBLIN NORTH	Health Centre, Cromcastle, Coolock, Dublin 5 Social Work Department, 180-189 Lake Shore Drive, Airside Business Park, Swords, Co. Dublin	(01) 816 4200 (01) 816 4244 (01) 870 8000
DUBLIN NORTH CENTRAL	Social Work Office, 22 Mountjoy Square, Dublin 1 Ballymun Health Care Facility, Ballymun Civic Centre, Ballymun, Dublin 9	(01) 877 2300 (01) 846 7236
DUBLIN NORTH WEST	Health Centre, Wellmount Park, Finglas, Dublin 11 Social Work Department, Rathdown Road, Dublin 7	(01) 856 7704 (01) 882 5000
DUBLIN SOUTH EAST	Social Work Department, Vergemount Hall, Clonskeagh, Dublin 6	(01) 268 0320 (01) 2680333
DUBLIN SOUTH CITY	Duty Social Work Carnegie Centre, 21-25 Lord Edward Street, Dublin 2 Public Health Nursing, 21-25 Lord Edward Street, Dublin 2 Family Support Service, 78B Church House, Donore Avenue, Dublin 8	(01) 648 6555 (01) 648 6730 (01) 416 4441
DUBLIN SOUTH WEST	Milbrook Lawns, Tallaght, Dublin 24 Social Work Department, Old County Road, Crumlin, Dublin 12	(01) 452 0666 (01) 427 5000 (01) 415 4700
DUBLIN WEST	Social Work Department, Bridge House, Cherry Orchard Hospital, Ballyfermot, Dublin 10	(01) 620 6387
DUBLIN SOUTH	Social Work Department, Our Lady's Clinic, Patrick Street, Dun Laoghaire, Co. Dublin	(01) 663 7300
CARLOW	Carlow Social Work Office, Ground Floor, St. Dympna's Hospital, Athy Road, Co. Carlow	(059) 913 6587
CAVAN	HSE Community Child and Family Services, Drumalee Cross, Co. Cavan	(049) 437 7305 (049) 437 7306
CLARE	Clare Duty Social Worker, River House, Gort Road, Ennis, Co. Clare Social Work Department, Shannon Health Centre, Shannon, Co. Clare Social Work Department, Kilrush Health Centre, Kilrush, Co. Clare	(065) 686 3935 (Monday – Friday, 2-5pm) (061) 718 400 (065) 905 4200

CORK	North Cork Social Work Department, 134 Bank Place, Mallow, Co. Cork North Lee Child Lee Social Work Department, (adjacent to Shopping Centre), Blackpool, Co. Cork South Lee Social Work Department, St. Finbarr's Hospital, Douglas Road, Cork West Cork Social Work Department, Coolnagarrane, Skibbereen, Co. Cork	(022) 54100 (021) 492 7000 (021) 492 3001 (028) 40447
DONEGAL	Links Business Centre, Lisfannon, Buncrana, Co. Donegal (East Team) Euro House, Killybegs Road, Donegal, Co. Donegal (West Team) Social Work Department, Millennium Court, Pearse Road, Letterkenny, Co. Donegal East Central Team and West Central Team)	(074) 932 0420 (074) 972 3540 (074) 912 3672 (074) 912 3770
GALWAY	Galway City, Social Work Department, Local Health Office, 25 Newcastle Road, Galway, Co. GalwayGalway County, Tuam Social Work Department, Health Centre, Vicar Street, Tuam, Co. Galway Loughrea Social Work Department, Health Centre, Loughrea, Co. Galway Ballinasloe Social Work Department, Health Centre, Brackernagh, Ballinasloe, Co. Galway Oughterard Social Work Department, Health Centre, Oughterard, Co. Galway	(091) 546366 (093) 37200 (091) 847820 (090) 964 6200(091) 552200
KERRY	Social Work Department, HSE Community Services, Rathass, Tralee, Co. Kerry Killarney Social Work Department, St. Margaret's Road, Killarney, Co. Kerry	(066) 712 1566 (064) 663 6030
KILDARE	Social Work Department, St. Mary's Craddockstown Road, Naas, Co. Kildare	(045) 873200 (045) 882 400
KILKENNY	Social Work – Child Care Department, Child ,Youth and Families Carlow/Kilkenny, HSE South, St. Canice's Hospital, Dublin Road, Kilkenny	(056) 778 4057 (056) 778 4532
LIMERICK	Social Work Department, Health Centre, Kileely Road, Ballynanty Beg, Limerick Social Work Department Roxtown Health Centre, Roxtown Terrace, Old Clare Street, Limerick (East Team), Co. Limerick Parkbeg Social Work Department, Parkbeg House, 2 Elm Drive, Caherdavin Lawns, Ennis Road, Limerick, Co. Limerick Social Work Department, Southill Health Centre, O'Malley Park, Southill, Limerick, Co. Limerick Newcastlewest Social Work Department, Newcastlewest Health Centre, Newcastle West, Co. Limerick.	(061) 457 100 (061) 417 622 (061) 483 091 (061) 206 820 (061) 209 985 (069) 62155
LAOIS	Social Work Department, Child and Family Centre, Dublin Road, Portlaoise, Co. Laois	(057) 869 2567 (057) 869 2568
LEITRIM	Social Work Department, Community Care Office, Leitrim Road, Carrick-on- Shannon, Co. Leitrim	(071) 965 0324

LONGFORD	Social Work Department, Tivoli House, Dublin Road, Co. Longford	(043) 335 0584
LOUTH	Social Work Department, Local Health Care Unit, Wilton House, Stapleton Place, Dundalk, Co. Louth Ballsgrove Health Centre, Ballsgrove, Drogheda, Co. Louth	(042) 939 2200 (041) 983 8574 (041) 983 3163
MAYO	Ballina Social Work Team, Ballina Health Centre, Mercy Road, Ballina, Co. Mayo Castlebar Social Work Team, St. Mary's Headquarters, Castlebar, Co. Mayo Swinford Social Work Team, Swinford Health Centre, Aras Attracta, Swinford, Co. Mayo	(096) 21511 (096) 248 41 (094) 904 2283/4 (094) 905 0133
MEATH	HSE Children's Services,Navan Enterprise Centre, Trim Road, Navan, Co. Meath Community Social Work Services, Duty Social Work Department,25 Brewshill, Navan, Co. Meath Community Social Work Services, Dunshaughlin Health Care Unit, Dunshaughlin, Co. Meath	(046) 909 7800 (046) 903 0616 (01) 802 4102
MONAGHAN	Social Work Department, Local Health Care Unit, Rooskey, Co. Monaghan	(047) 30426 (047) 30427
OFFALY	Social Work Department, Derry Suite, Castlebuildings, Tara Street, Tullamore, Co. Offaly	(057) 937 0700
ROSCOMMON	Social Work Team, Abbeytown House, Abbey Street, Roscommon, Co. Roscommon Social Work Team, Roscommon PCCC, Lanesboro' Road, Roscommon, Co. Roscommon (Roscommon Area) Social Work Team, Health Centre, Elphin Street, Boyle, Co. Roscommon (Boyle Area) Social Work Team, New HSE Offices, Knockroe, Castlerea, Co. Roscommon (Castlerea Area)	(090) 662 6732 (090) 663 7528 (090) 663 7529 (071) 966 2087 (090) 663 7851 (090) 663 7842
SLIGO	Sligo Town and surrounding areas: Markievicz House, Barrack Street, Sligo, Co. Sligo South County Sligo: One Stop Shop, Teach Laighne, Humbert Street, Tubercurry, Co. Sligo	(071) 915 5133 (071) 912 0062
NORTH TIPPERARY	North Tipperary Duty Social Work Team, Civic Offices, Limerick Road, Nenagh, Co. Tipperary North Tipperary Child Protection Services: Social Work Department, Annbrook, Nenagh, Co. Tipperary St. Mary's Health Centre, Parnell Street, Thurles, Co. Tipperary	(067) 46 636 (067) 41 934 (0504) 24 609
SOUTH TIPPERARY	South Tipperary Child Protection Services: Social Work Team, South Tipperary Community Care Services, Western Road, Clonmel, Co. Tipperary	(052) 617 7302 (052) 617 7303

WATERFORD	Waterford: Social Work Service, Waterford Community Services, Cork Road, Co. Waterford Dungarvan and surrounding areas: Social Work Department, Dungarvan Community Services, St. Joseph's Hospital, Dungarvan, Co. Waterford	(051) 842827 (058) 20906
WESTMEATH	Social Work Department, Athlone Health Centre, Coosan Road, Athlone, Co. Westmeath Social Work Department, Child and Family Centre, St. Loman's, Springfield, Mullingar, Co. Westmeath	(090) 648 3106 (044) 934 4877
WEXFORD	Gorey Health Centre, Hospital Grounds, Gorey, Co. Wexford Enniscorthy Health Centre, Millpark Road, Enniscorthy, Co. Wexford New Ross Health Centre, Hospital Grounds, New Ross, Co. Wexford Local Health Office, Social Work Department, Ely House, Ferrybank, Co. Wexford	(053) 943 0100 (053) 923 3465 Contact through Ely House below (053) 912 3522 Ext. 201
WICKLOW	Social Work Department, HSE Glenside Road, Wicklow Town, Co. Wicklow Bray: Social Work Department,The Civic Centre, Main Street, Bray, Co. Wicklow Delgany: Social Work Department, Delgany Health Centre, Delgany, Co. Wicklow	(0404) 60800 (01) 274 4180 (01) 274 4100 (01) 287 1482

Appendix 8 – Role of the Designated Liaison Person / Designated Liaison Officer

Designated Liaison Person

- Seek to ensure adherence to this policy and procedure
- Seek to ensure adherence to Children First National Guidelines 2011.
- Act as liaison with statutory services in matters relating to child protection
- Ensure that they are knowledgeable about child protection and undertake any training considered necessary to ensure that they are kept updated on new developments.
- Act as a resource person to the organisation providing support and guidance in matters relating to child protection;
- Take the lead role in the reporting of child protection referrals to the statutory services and ensure that the procedures are followed systematically and thoroughly

Designated Liaison Officer

- Take the lead role in the follow up of child protection referrals to the statutory services in Ireland and ensure that the procedures are followed systematically and thoroughly.
- Take a lead role in the monitoring, auditing and the assessing compliance with the child protection policy and Children First National Guidelines.
- Coordinates the activities of the Designated Liaison Person’s
- Maintains a log of all raised protection issues.
- Manage any investigations Rehab Group is required to carry out.
- Seek to ensure that any recommendations from investigations (internal &external) are acted on appropriately.

Appendix 9 – Communication Strategy with External Organisations.

There is a need to maintain confidentiality in dealing with any suspected protection issue. However, no undertaking of absolute confidentiality can be given. Rehab Group may need to inform the relevant authorities so that action may be taken to protect service users from harm. Providing information for the protection of service users in such circumstances may not be a breach of confidentiality provided it is justified in the circumstances. However, the circumstances in which service user confidentiality can be breached depends on the circumstances. Where doubt arises, seek advice in the first instance from a senior colleague and, if appropriate and required, seek appropriate legal advice.

Release of such information is strictly on a "need to know basis". The communication of information must be confined to those who have an obligation to receive it, and others should not be privy to an allegation/suspicion or disclosure unless it is necessary to involve them. The minimum information that is necessary in the circumstances should be disclosed. You must be careful to disclose the information to an appropriate person (or body) who understands that the information must be kept confidential and who will be able to act on the information appropriately and effectively. If practicable, and if it would achieve the same potential benefits, consideration should be given to anonymisation of the information (sharing it without revealing the service user's identity) whether anonymisation is appropriate will depend very much on the purpose of the notification and to whom the notification is made.