Child Protection Policy

WALK Child Protection Policy Statement

The policy of WALK is to promote the safety, protection and wellbeing of children, to ensure that they are treated with dignity and respect, are protected from any form of abuse or neglect and that their rights are safeguarded at all times.

A child is a person who is under 18 years of age unless married or has been married.

Aim of Policy

The aim of this Policy is to promote the welfare of children by having systems and procedures whereby children are protected from the experience of abuse and neglect and information concerning abuse or alleged abuse and neglect can be disclosed and reported by the child or third party and such reports or concerns are acted upon consistently and appropriately by the receiver.

1 Introduction

1.1 WALK provides services to adults with intellectual disability. The PEER programme may mean that WALK directly supports children with disabilities (16-18) and/or support young adults or teenagers with disabilities through peer supporters who may also be aged 16-18. Children may on occasions be present in WALK Day Services or in Residential Houses during official functions or as part of visiting arrangements. While on WALK premises or in the course of events which WALK are responsible for WALK take the following actions;

- Managers must ensure there is an adequate adult child ratio. This will depend on the nature of the activity and the individual needs of children.
- Children are supervised according to their needs. This may involve agreement with

parents/guardians on their role and responsibilities during the event/activity/visit.

- Adequate numbers of employees are available to supervise the activities and/or the role of parents / guardians
- The assigned responsible adults know at all times where children are and what they are doing
- Any activity using potentially dangerous equipment has constant adult supervision
- Appropriate levels of risk must be considered and activities should not be available that carry too much risk or that are considered inappropriate to the age and ability of the child.
- Adverse incidents which may occur are appropriately reported and recorded

1.2 The policy of WALK is to promote the safety, protection and wellbeing of children to ensure that they are treated with dignity and respect, are protected from any form of abuse and neglect and that their rights are safeguarded at all times. The welfare and safety of the child is of paramount importance.

1.3 Vision & Mission of WALK

WALK's vision is of an inclusive society where communities value and treat all people as equal citizens This definition includes all people, both adult and child.

The mission of WALK is to support our service users to lead self-determined lives within socially inclusive communities.

WALK strives to:

- Promote and protect the rights of children availing of our services in a manner that respects their dignity and has their views taken into consideration.
- Promote the culture of an organisation which strives to maximise each child's quality of life.
- Provide quality child-centred services in partnership with all stakeholders to verifiable standards of best practice.
- Develop each child's full potential and ensure his or her long-term wellbeing within a positive environment.
- Support families in their commitment to the child with an intellectual disability
- Lead and manage services through efficient, effective and accountable use of available resources.

2 Principles of Good Practice

2.1 WALK is committed to providing an environment where children are listened to, are treated with dignity and respect and kept safe, where parents are supported and consulted and where employees and volunteers are trained, supported and protected. WALK acknowledges the Children First Principles.

To this end WALK:

- Acknowledges the rights of children to be protected, treated with respect, listened to and have their own views taken into consideration;
- Recognises that the welfare of children must always come first, regardless of all other considerations;
- Adopts a Child Protection Policy which raises awareness about the possibility of child abuse occurring and outlines the steps to be taken if it is suspected;
- Adopts safe practices to minimise the possibility of harm or accidents happening to children and protect workers from the necessity to take risks and leave themselves open to accusations of abuse or neglect;
- Follows clearly defined methods of recruiting employees and volunteers;
- Implements clear procedures for responding to accidents and complaints;
- Believes that early intervention with children who are vulnerable or at risk may prevent serious harm from happening to them at a later stage;
- Believes that a child's age, gender and background affect the way they experience and understand what is happening to them;
- Provides child protection training for workers which clarifies the responsibility of WALK and individuals, and shows the procedures to be followed if child abuse is suspected. Training includes Prevention, detection and reporting of abuse, the nature of abuse in institutional settings, practices designed to protect and promote the welfare of children, understanding their particular vulnerability to abuse, in particular those with communication difficulties, Child Protection Policy of WALK, Safe care practices, Promoting a culture and ethos of rights, openness and accountability.
- Has a policy of openness with parents/guardians that involves consulting them about everything that concerns their children, and encouraging them to get involved with WALK wherever possible;
- Co-operates with any other child care and protection agencies and professionals by sharing information when necessary and working together towards the best possible outcome for the children concerned;

- Makes links with other relevant organisations to promote child protection and welfare policies and practices.
- Has a complaints procedure for which the scope for complaints from Service Users and Third Parties of WALK relates to any complaints that can be made under the Health Act 2004 and regulations made thereunder.
- Has a Code of Conduct which all employees and volunteers are expected to adhere to.
- Has procedures and protocols for the use of photography of children.

[Adapted from Our Duty to Care p.4 HSE 2002]

2.2 Mandated Persons

From 11th December 2017 certain people have legal responsibilities under Children First Act 2015. These people are known as 'Mandated People'. There is an extensive list of 'mandated persons' in Schedule 2 of the act. They include:

- Registered Nurses within the meaning of section 2(1) of the Nurses and Midwives Act 2011.
- Social Care Worker who practises as such and who is eligible for registration in accordance with part 4 of the Health and Social Care Professionals Act 2005 in the register of that profession.

Mandated persons have two main legal obligations under the Act:

- To report the harm of children above a defined threshold to Tusla.
- To assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.
-

3 Legal and Policy Framework

3.1 This Child Protection Policy has given due consideration to the following legislation:

- The Child Care Act 1991
- Children Act 2001
- Protection of Persons Reporting Child Abuse Act 1998
- Domestic Violence Acts 1996 and 2002
- Non-fatal Offences Against the Person Act 1997
- Education Act 1998
- Education (Welfare) Act 2000
- Education for Persons with Special Educational needs Act 2004
- The Data Protection Acts 1988 and 2003

- Freedom of Information Acts 1997 and 2003
- Health Acts 1947 to 2008
- Ombudsman for Children Act (2002)
- Criminal Justice Act 2006

This list is not exhaustive

3.2 This Child Protection Policy has been written with due consideration given to the following national policies:

- 'Children First: National Guidance for the Protection and Welfare of Children' 2011
- Child Protection and Welfare Practice Handbook, 2011, Health Service Executive
- 'Our Duty to Care' The Principles of good practice for the protection of children and young people – Department of Health and Children 2002
- Trust in Care – Policy for Health Service Employers on Upholding the Dignity and Welfare of Clients and the Procedure for Managing Allegations of Abuse against Staff Members (2005)
- Dignity at Work Policy for Health Services (Health Services National Partnership Forum 2004)
- National Standards for Children's Residential Centres - Department of Health & Children (2001)

This list is not exhaustive

3.3 This document has been written with due consideration given to the following United Nation Conventions

- U.N. Convention on the Rights of the Child 1992
- U.N. Convention on the Rights of People with Disabilities 2007

3.4 This Child Protection Policy does not stand alone from any other WALK policy or procedure except for when this policy is explicit in relation to children. This policy has been therefore been written with due consideration given to all WALK Policies, Procedures, Guidelines and Codes of Practice, and the following WALK guidelines, policies and procedures are most immediately pertinent to this policy:

- Complaints Procedures
- Intimate Care Procedures
- Risk Management Procedures

- Health & Safety Statement and procedures
- Recruitment Policy and Procedures
- The Charter of Rights
- Guidelines for the Management of Behaviour that Challenges
- Guidelines on Performance Management and Development System
- Transport

3.5 These policies and legislation are binding upon all employees, volunteers and students of WALK who have a duty to be familiar with and abide by them and any amendments thereto.

4 What is Child Abuse?

4.1 It is well recognised that it is very difficult to give a comprehensive formulation of what constitutes abuse. For the purpose of this Policy, abuse can be defined as harm or potential harm caused to a child by physical abuse, emotional abuse, sexual abuse or neglect.

4.2 The definition above and those elaborated below are not intended as all encompassing or comprehensive in nature. They are given as a guide only of the type of situations, and/or conduct which is to be covered by the procedures set out in this Policy.

4.3 Children can be abused in a number of ways. Children First has outlined four definitions of abuse. They are:

4.3.1 Physical abuse

4.3.2 Emotional abuse

4.3.3 Sexual abuse

4.3.4 Neglect

The definitions outlined below are not exhaustive.

4.3.1 **Physical abuse**

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

Physical abuse can involve:

(i) severe physical punishment;
(ii) beating, slapping, hitting or kicking;
(iii) pushing, shaking or throwing;
(iv) pinching, biting, choking or hair-pulling;
(v) terrorising with threats;
(vi) observing violence;
(vii) use of excessive force in handling;
(viii) deliberate poisoning;
(ix) suffocation;
(x) fabricated/induced illness*
allowing or creating a substantial risk of significant harm to a child.

(Children First, page 8, 2011)

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

- bruises (*More details available at the back of this document*);
- fractures;
- swollen joints;
- burns/scalds (*More details available at the back of this document*);
- 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.

(Taken from Appendix 1 of Children First, 71, 2011)

4.3.2 **Emotional abuse**

Emotional abuse is normally to be found in the *relationship* between a parent/carer and

a child rather than in a specific event or pattern of events. It occurs when a child's developmental 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:

(i) the imposition of negative attributes on a child, expressed by persistent criticism, sarcasm, hostility or blaming;
(ii) conditional parenting in which the level of care shown to a child is made contingent on his or her behaviours or actions;
(iii) emotional unavailability of the child's parent/carer;
(iv) unresponsiveness of the parent/carer and/or inconsistent or inappropriate expectations of the child;
(v) premature imposition of responsibility on the child;
(vi) unrealistic or inappropriate expectations of the child's capacity to understand something or to
(vii) behave and control himself or herself in a certain way;
(viii) under- or over-protection of the child;
(ix) failure to show interest in, or provide age-appropriate opportunities for, the child's cognitive and emotional development;
(x) use of unreasonable or over-harsh disciplinary measures;
(xi) exposure to domestic violence;
(xii) 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. (Children First, pg8, 2011)

4.3.3 **Sexual Abuse**

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

(i) exposure of the sexual organs or any sexual act intentionally performed in the presence of the child;
(ii) intentional touching or molesting of the body of a child whether by a person or

object for the purpose of sexual arousal or gratification;

(iii) masturbation in the presence of the child or the involvement of the child in an act of masturbation;

(iv) sexual intercourse with the child, whether oral, vaginal or anal;

(v) 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, modeling 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;

(vi) 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. (Children First, Page 9, 2011)

4.3.4 **Neglect**

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

Harm can be defined as the ill-treatment or the impairment of the health or development of a child. Whether it is *significant* is determined by the child's health and development as compared to that which could reasonably be expected of a child of similar age.

Neglect generally becomes apparent in different ways *over* a *period of time* rather than at one specific point. For example, a child who suffers a series of minor injuries may not be

having his or her needs met in terms of necessary supervision and safety. A child whose height or weight is significantly below average may be being deprived of adequate nutrition. A child who consistently misses school may be being deprived of intellectual stimulation.

The *threshold of significant harm* is reached when the child's needs are neglected to the extent that his or her well-being and/or development are severely affected.
(Children First, Page 8, 2011)

4.4 Certain children are more vulnerable to abuse than others. Such children include those with disabilities, 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. 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. (Children First, Page 11, 2011)

5 Confidentiality

5.1 Confidentiality is a very important aspect of WALK Services. Parents and service users trust that information concerning them is treated with respect and in a confidential manner.

5.2 All WALK employees/students/volunteers sign a Confidentiality Statement. Employees must not disclose or appropriate for their own use, or for the use of any third party, any sensitive or confidential information of WALK. The purpose of the policy is to ensure non-disclosure of sensitive information.

5.3 However, in a situation where abuse or neglect is suspected or alleged in relation to a child, WALK is obliged to inform the HSE and cooperate with an Garda Siochana and provide them with the relevant information, as per guidelines set out in this policy.

- The effective protection of a child often depends on the willingness of the staff in statutory and voluntary organisations involved with children 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.

- 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.
- No undertakings regarding secrecy can be given. Those working with a child and family should make this clear to all parties involved, although they can be assured that all information will be handled taking full account of legal requirements.
- Ethical and statutory codes concerned with confidentiality and data protection provide general guidance. 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.
- It must be clearly understood that information gathered for one purpose must not be used for another without consulting the person who provided that information.
- The issue of confidentiality should be part of the training necessary for staff who work in the area of child protection and welfare and the general training of staff in organisations that work with children. Each organisation should have a written policy in this regard.

(Children's First, page 17, 2011)

5.4 Failure to report

Failure to report suspicions could lead to endangerment of a child and therefore a person who fails to report suspicions may be considered to be complicit in abuse that may occur. This will be a legal matter and WALK will comply with any questioning of legal proceedings. Failure to report will be considered a serious disciplinary matter which may, depending on the facts of the case, lead to dismissal. Failure to report suspicions contradicts the value system and ethical conduct expected of staff/volunteers/students who work/volunteer in any WALK service.

Note: Any information provided to the HSE and An Garda Siochana will remain confidential. The official policy of the HSE is that those receiving such information will only disclose it where the welfare of the child requires it, and then only to those with a legitimate "need to know". (Our Duty to Care. P22)

6 Designated liaison person

6.1 WALK has nominated the Director of Services, the Director or Residential Services and the Day Service Manager to be the Designated Person for Adult protection concerns and Designated Liaison Person for Child Protection concerns. In addition to these persons, due to the nature of the supports provided through our Louth offices, WALK has nominated a specific individual there as a Designated Liaison Person.

Director of Residential Services	**Director of Services**
Eamonn Teague 1 Longmile Road Walkinstown Dublin12 (01) 4650388	Catherine Kelly 1 Longmile Road Walkinstown Dublin 12 (0 1) 4650388
Day Services Manager Michael Teehan 1 Longmile Road Walkinstown Dublin12 (01) 4650388	**PEER Project Administrator** Karen Harrison WALK Louth Unit 4 Ardee Business Park Louth (041) 686 5823

6.2 The role of the Designated Liaison Person in WALK is:

- To ensure all the procedures contained in this document are carried out.
- To receive reports of all allegations or suspicions of abuse or neglect.
- To organise that the factual basis of the allegation/suspicions/concerns is established.
- To organise the support of an internal team to establish a factual basis in situations where the presenting allegation/concern/suspicion requires clarification.
- To ensure proper reporting to the Chief Executive Officer and keeping relevant people informed within the organisation.
- To provide proper reporting to the relevant HSE Duty Social Worker; and HSE Children and Families Services, by ensuring appropriate information is available at the time of referral and that the referral is confirmed in writing in a confidential manner.
- To ensure that confidential individual case records are maintained of the decisions reached, interviews undertaken, any action taken by the organisation, liaison with

families in relation to the allegation /concern and informing them of the report to the HSE, the liaison with other agencies, and documenting the overall outcome as advised both verbally and in writing by the HSE child protection services.

- To play a central role within the organisation in advising on the training needs of employees/volunteers in the area of child protection, and child's protection procedures.
- To establish contact with the senior member of Community Services responsible for child protection in the child's catchment area i.e. Duty Social Worker and/or Duty Social Work Team Leader.
- To provide information and advice on child protection within the organization.
- To liaise with Community Services/An Garda Siochana and other agencies as appropriate.
- To conduct an annual audit of all concerns/allegations reported.

6.3 The Designated liaison person is responsible for:

- Being a source of advice on child protection matters
- Coordinating action within the organization, and liaising with Health Service Executive and other agencies about suspected or actual cases of child abuse.
- Liaising with an Garda Siochana in relation to an emergency out of hours referral to them and supporting any investigation they are conducting.

6.4 The Designated liaison person will ensure that he/she will remain up to date in matters relating to legislation, policies and good practice in the area of child protection. He/she must have a thorough knowledge of the issues around child abuse and neglect, and be supported by the agency in this regard.

6.5 A person(s) will be nominated to act as Deputy Designated liaison person when the Designated liaison person is on any type of leave covered by the policies of WALK, for example, sick leave, annual leave, carer's leave, maternity leave. The names of the Designated Liaison Person and or the Deputy Designated liaison person will be made known to all at induction.

6.6 The Designated liaison person may consult with the duty social worker in a confidential manner, as to the appropriateness of completing a "standard form for reporting child protection and/or welfare concerns".

6.7 The Designated liaison person will ensure that, in the event of finding an objective basis, or

reasonable grounds for concerns, that the HSE will be informed.

6.8 The Designated liaison person will be the person responsible for liaising with the parents of the child in relation to concerns related to child protection issues. The Designated liaison person is obliged to liaise with the parents if any report is being made to the HSE (unless to do so is likely to endanger the child).

7 Reasonable Grounds for Concern

7.1 The Child Protection and Welfare Practice Handbook (2011, p30) outlines "What constitutes reasonable grounds for a child protection or welfare concern?"

The handbook names the following:

- 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. (An example of this would be a pattern of injuries, an implausible explanation, other indicators of abuse, dysfunctional behaviour).
- 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.

Please note the above list is not exhaustive.

7.2 Where there are reasonable grounds for concern, there is an obligation to report. (Read the section 4 of this policy on 'What is Child Abuse?' and also read appendix 1 of this policy 'Signs and Symptoms of Abuse'). Employees should, without delay, talk to their manager or the Designated ~~Liaison~~ Person if they have concerns about a child's safety or welfare.

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

1. The safety and well being of the child or the young person must take priority.

2. Reports should be made without delay to the HSE

(Children First, page 14, 2011)

7.4 In some situations it can be difficult for an employee to know whether or not their suspicions about child abuse are real. There may be other explanations for what they observed. If there is any suspicion by a staff member, however unfounded it may appear, they should discuss this with a relevant line manager and/or the Designated liaison person.

7.5 Protection for Persons Reporting Child Abuse Act 1998

Under the law nobody will be penalised for making a report of child abuse which turns out to be mistaken, as long as the report is not malicious and was made in good faith.

The provisions of the Protections for Persons Reporting Child Abuse Act 1998 apply once they communicate 'reasonably and in good faith'

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

1. The provision of immunity from civil liability to any person who reports child abuse "reasonably and in good faith" to designated officers of the HSE or any member of an Garda Siochana.
2. The provisions of significant protections for employees who report child abuse. These protections cover all employees and all forms of discrimination up to and including dismissal.
3. The creation of a new offence of false reporting of child abuse where a person makes a report to the appropriate authorities "knowing the statement to be false". This is a new criminal offence designed to protect innocent persons from malicious reports.

(Children First 2011, Appendix 7)

8 Reporting Procedure

8.1 Reporting protocol

How to deal with Anonymous Complaints:

Where an employee/volunteer/student receives an anonymous telephone call or letter alleging abuse the employee should:

- Request the caller to identify himself/herself.

- As soon as possible submit an immediate verbal and written report to a relevant Line Manager (regardless of whether or not the caller identified himself/herself)
- As soon as possible forward any anonymous letter(s) complaining of abuse to a relevant Line Manager.
- Follow the advice of the relevant line manager or the Designated Liaison Person.
- The relevant line manager must ensure a WACP form; see appendix 3 is completed by the employee/volunteer/student and forwarded to the Designated Liaison Person and that the Designated Liaison Person is informed. In an urgent situation, the line manager may accept the verbal report and inform the Designated Liaison Person.

What to do if an Employee/volunteer/student is present and <u>Witnesses</u> Abuse

8.1.1 The employee/volunteer/student must immediately inform a relevant line manager who will then inform the Designated liaison person in WALK. Where a relevant line manager is not easily accessible the employee/volunteer/student may directly contact the Designated liaison person. Please note that where appropriate before discussion with a relevant line manager or the Designated Liaison Person, the employee/volunteer/student may need to STOP OR SEEK TO STOP THE BEHAVIOUR (where appropriate and will not pose further risk to the child or employee it may involve moving the child from the situation), apply first aid (if appropriate and only by certified persons), and contact the emergency services, if required.

8.1.2 The line manager to whom the concern/disclosure is made must report this to the Designated liaison person. This is regardless of whether they consider the matter to fall under any definition of abuse/'reasonable grounds for concern' as defined above.

8.1.3 The WACP form must be completed as soon as is practicable but in any case within a 12 hour period, signed by the employee and counter signed by a relevant line manager (or the designated contact person if there is no relevant line manager readily available). The line manager then forwards the form to the Designated liaison person without delay. In an emergency situation a verbal report will initially suffice.

8.1.4 Employees must note carefully what they have witnessed and when the incident occurred. Obvious Signs of injury must be described in detail; note, this does not entail examining the child. Any comments about how the injury occurred should be

recorded quoting words actually and exactly used. This must be completed at the earliest possible time but in any case within 12 hours. When speaking with the child/person with the concern, ascertain the basic facts, using open questions. Do not use closed questions. Do not question in depth, as this will be done through investigation.

8.1.5 The Designated liaison person will promptly verbally inform and forward a standard reporting form (see appendix X)to the HSE Duty Social Worker.

8.1.6 The Designated liaison person, or a person requested to do so by the Designated liaison person, will contact the parents to inform the parents that the matter will be, or has been, reported to the H.S.E (unless it is in the best interests of the child not to do so at that time).

8.1.7 If the Designated liaison person does not maintain that there are reasonable grounds for concern, he/she will decide if the matter needs to be discussed with parents. In any case the Designated liaison person will also ensure that the incident is recorded and appropriately filed.

8.1.8 The following table outlines the procedures to be followed if there is an immediate or serious risk to a child identified by the Designated liaison person or the person deputising in this role.

Days and Times	**Who will report**	**Who will report be made to:**
Monday – Friday 09:00am – 17:00pm	Designated liaison person or person deputising	HSE Duty Social Worker or Duty Team Leader in child's catchment area.
Monday – Friday 17:00pm – 09:00am following morning.	Designated liaison person or person deputising	An Garda Síochána in any Garda Station.
Friday from 17:00pm to Monday morning at	Designated liaison person or person deputising	An Garda Síochána in any Garda Station.
Bank holiday Mondays to 09:00 following	Designated Liaison Person or person deputising	An Garda Síochána in any Garda Station.

Under no circumstances should a child be left in a situation that exposes him or her to harm or to risk of harm pending HSE intervention. In the event of an emergency where

you think a child is in immediate danger and you cannot get in contact with the HSE, you should contact the Gardaí. This may be done through any Garda station.

8.1.9 The Designated liaison person will contact the Garda Siochana directly at any Garda station. Should there be an immediate danger to a child, employees are advised to contact the Gardaí directly if there is likely to be any delay in making contact with the Designated liaison person or the Deputy Designated liaison person.

8.1.10 Under no circumstances should a child be left in a dangerous situation pending a HSE investigation.

8.1.11 The HSE will be informed of the situation when their offices reopen by the Designated liaison person.

8.1.12 The child protection concern will be assessed by the Duty Social Worker appointed by the HSE Duty Social Work Team. When the allegation/concern has been fully investigated, the Designated liaison person will receive written communication on the status of the investigation by the HSE Child Protection Services, with parental consent.

8.1.13 Following a referral to the HSE Duty Social Work Team, WALK through the Designated liaison person will fully cooperate with and follow the directions of the HSE/Gardai assessment/investigation. The Designated liaison person will work in consultation with them to:

(i) Gather more information
(ii) Agree a support plan for the child,
(iii) Plan the review date,
(iv) Agree a support plan for the family,
(v) Agree a support plan for employees,
(vi) Identify any service resource needs, and address them immediately with WALK management and the HSE
(vii) Where recommended, to facilitate arrangements for medical or specialist examination of the child, with the consent of parents.
(viii) Agree an action plan in relation to an allegation against an employee.
(ix) The Human Resources Manager is responsible for this in relation to employees, volunteers, and students.

8.1.14 Child Protection meetings are managed by the HSE management and are requested by the HSE Social Work Department. WALK is committed to engaging in this process.

9 What to do if abuse or neglect is suspected

9.1 Steps 8.1.1 – 8.1.4 in the event of witnessed abuse apply also to suspected abuse. In the case of suspected abuse when the Designated liaison person receives the information he/she will not decide whether abuse or neglect has occurred but will ascertain if there is an objective indication or 'reasonable grounds for concern' that abuse or neglect may have occurred. If it is found that there is a basis for the concern in relation to a child, the Designated liaison person or person nominated by him /her will verbally inform and forward a HSE standard reporting form to the HSE Duty Social worker

At that point Steps 8.1.8 – 8.1.14 that apply to witnessed abuse also apply to suspected abuse.

10 What to do if the situation relates to a child/children against whom an allegation of abuse has been made & their families

10.1 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.
(Children First, Page 60, 2011)

10.2 If a complaint of sexual abuse and/or physical or emotional abuse is made concerning a child against another child, the child against whom the allegation is made, and their family, shall be informed that the Designated liaison person will refer the concern/allegation to the HSE, the nature of the complaint and of any evidence to support the said allegation. The same will apply to the families of the alleged victim.

The Designated liaison person shall attempt to ensure that the person/next of kin is given all necessary assistance during the course of the assessment.

The Designated liaison person will work in cooperation with the HSE in implementing

any areas of an action plan, relevant to WALK's role in providing care for both the child victim and the child abuser~~,~~ to support, assist and counsel the child and, if appropriate, their family.

10.3 Following the outcome of the HSE assessment and any recommendations therein, the Designated liaison person shall carry out appropriate recommendations as it considers advisable and with the cooperation and support of the HSE which could include relocation; increased supervision; sex education or counselling; treatment; increased staff management or observation; and medical treatment for specific problems. These recommendations will be discussed with the relevant parents.

11 Actions to be taken when an Allegation is made Against an Employee/Volunteer/Students

11.1 When an allegation of abuse is made against an employee or volunteer or student the following two procedures need to be followed:

1. The reporting procedure in respect of the child, as outlined above. The Designated liaison person is responsible for this.

2. The procedure for dealing with the employee/volunteer/student. The Human Resources Manager is responsible for this.

11.2 Where an allegation is made against an employee

11.2.1 Where the Designated liaison person has reasonable grounds for concerns about the alleged abuse then the Designated ~~Liaison~~ Person will make a report to the Duty Social Worker, H.S.E.

11.2.2 The Designated liaison person is responsible for advising the parents of the child, and also the child depending on the age and level of understanding of the child, of concerns related to any allegations of abuse and that the HSE have been informed.

11.2.3 The Human Resources Manager will arrange a meeting with the staff member/volunteer/student advising them of their right to representation prior to the meeting. This meeting is not an investigation.

11.2.4 The Human Resources Manager will inform the staff member/volunteer/student

that an allegation has been made against them, and the nature of that allegation. The employee/volunteer/student will be afforded an opportunity to respond and may chose to be accompanied by a colleague or the employee representative at that meeting. At this meeting, Employees/volunteers/students will be informed that the matter will be/has been referred to the HSE Child Protection Services and/or an Garda Siochana. The staff member will be informed that it is the role of the HSE to notify An Garda Siochana in cases where the Designated liaison person in WALK has not already done so. Employees will be informed that the matter will be assessed by the DSW, HSE Children and Family Services. WALK employees and volunteers and Students are expected to fully cooperate with the HSE investigation.

11.2.5 The organisation may put the following protective measures, that are proportionate to the level of risk, in place for dealing with an employee/volunteer/student to ensure that no child or employee is exposed to unacceptable risk:

These protective measures, which will be proportionate to the level of risk, are not disciplinary measures and may include:

1. Providing an appropriate level of supervision
2. Putting the employee off duty with pay pending the outcome of the investigation. In the case of volunteers/students to put them off service pending the outcome of the investigation.
3. Moving the employee to a different service location and/or to work with a different cohort of people.

The views of the employee will be taken into consideration when determining the appropriate protective measures but the final decision rests with Human Resources Manager.

Putting the employee off duty pending the outcome of an investigation will be reserved for only the most exceptional of circumstances. It will be explained to the employee concerned that the decision to put him/her off duty is a precautionary measure and not a disciplinary sanction.

11.2.6 The Chief Executive Officer should be informed of the allegation and the implementation of any protection measures immediately. He/She will then inform the Chairperson of the Board of the matter.

11.2.7 The HSE are responsible for how they conduct an assessment and/or investigation alongside an Garda Siochana. Close liaison will be maintained between WALK and the HSE/Gardaí to ensure actions taken by WALK do not undermine or frustrate any investigations.

11.2.8 A meeting will be arranged by the HSE Children and Family Services between the HSE, WALK and the Gardai following an allegation of abuse against an employee/volunteer/Student.

'The HSE Children and Family Services should provide feedback to the employer or person-in-charge on the progress of a child abuse assessment/investigation involving an employee. The HSE should seek to complete its assessment as quickly as possible, bearing in mind the serious implications for innocent employees. Employers or persons-in-charge should be notified of the outcome of the HSE assessment and/or the Garda investigation. This will assist them in reaching a decision about the action to be taken in the longer term concerning the employee.'
(Children First, page 43, 2011)

WALK will be notified of the outcome of an investigation. The HSE will pass on reports and records to the employer and the employee in question, where appropriate.

11.2.9 The reports and records of the HSE may assist WALK in reaching a decision as to action to be taken in the longer term concerning the employee.

11.2.10 The Human Resources Manager may organise an internal investigation, in addition to information provided to them from the HSE/an Garda Siochana. This internal enquiry, alongside reports and records submitted by the HSE/An Garda Siochana, will be presented to the Chief Executive Officer who shall take such action as he/she considers appropriate which may be to reinstate, discipline or dismiss the employee, volunteer or student. Any question of discipline or dismissal of an employee will be dealt with under the WALK Staff Disciplinary Procedures.

11.2.11 Any information that is pertinent to any An Garda Síochána investigation that is presented during a WALK internal investigation will be promptly passed on to An Garda Síochána by the Human Resources Manager or the Designated Liaison Person.

11.3 When abuse has not occurred:

11.3.1 When the allegation/concern is not upheld, the management will ensure to the greatest extent practicable that the reputation and career prospects of the employee/volunteer/student concerned are not adversely affected by reason of the complaint being brought against him/her. Employee/Volunteers/students will be informed of the outcome of the investigation. They will be provided with support and invited to act as a volunteer again or continue their student placement.

11.3.2 The employee/volunteer/student will be offered counselling and any other reasonable supports necessary to restore his/her confidence or morale by their manager and/or by the Human Resource Manager.

11.3.3 Where it is found that the allegation is bona fide and made in good faith the employee/student/volunteer who made the allegation/expressed the concern will be reassured by their manager that management appreciates that the allegation/expression of concern was made in good faith.

11.3.4 Where it is found that a report was made maliciously, the employee/volunteer/student who made the allegation will be dealt with under disciplinary procedures. They may be guilty of an offence of false reporting under the Protection of Persons Reporting Abuse Act 1998 and under Health Act 2004.

11.3.5 A review of systems will be carried out where deficiencies have been identified and corrective measures put in place at the earliest possible time.

APPENDIX 1
SIGNS AND SYMPTOMS OF ABUSE

There are many signs and symptoms, which can indicate that a child is being abused.

Children First (2011) Appendix 1 describes these in the following way:

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.

Characteristics of neglect

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

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

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

- **Disorganised/chaotic neglect**: This is typically where parenting is inconsistent and is often found in disorganised and crises-prone families. The quality of parenting is inconsistent, with a lack of certainty and routine, often resulting in emergencies regarding accommodation, finances and food. This type of neglect results in attachment disorders, promotes anxiety in children and leads to disruptive and attention-seeking behaviour, with older children proving more difficult to control and discipline. The home may be unsafe from accidental harm, with a high incident of accidents occurring.

- **Depressed or passive neglect**: This type of neglect fits the common stereotype and is often characterised by bleak and bare accommodation, without material comfort, and with poor hygiene and little if any social and psychological stimulation. The household will have few toys and those that are there may be broken, dirty or inappropriate for age. Young children will spend long periods in cots, playpens or pushchairs. There is often a lack of food, inadequate bedding and no clean clothes. There can be a sense of hopelessness, coupled with ambivalence about improving the household situation. In such environments, children frequently are absent from school and have poor homework routines. Children subject to these circumstances are at risk of major developmental delay.

- **Chronic deprivation**: This is most likely to occur where there is the absence of a key attachment figure. It is most often found in large institutions where infants and children may be physically well cared for, but where there is no opportunity to form an attachment with an individual carer. In these situations, children are dealt with by a range of adults and their needs are seen as part of the demands of a group of children. This form of deprivation will also be associated with poor stimulation and can result in serious developmental delays.

The following points illustrate the consequences of different types of neglect for children:
• inadequate food – failure to develop;
• household hazards – accidents;
• lack of hygiene – health and social problems;
• lack of attention to health – disease;
• inadequate mental health care – suicide or delinquency;
• inadequate emotional care – behaviour and educational;
• inadequate supervision – risk-taking behaviour;
• unstable relationship – attachment problems;
• unstable living conditions – behaviour and anxiety, risk of accidents;
• exposure to domestic violence – behaviour, physical and mental health;
• community violence – anti social behaviour.

Signs and symptoms of emotional neglect and abuse

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

Emotional neglect and abuse occurs when adults responsible for taking care of children are unaware of and unable (for a range of reasons) to meet their children's emotional and developmental needs. Emotional neglect and abuse is not easy to recognise because the effects are not easily observable. Skuse (1989) states that 'emotional abuse refers to the habitual verbal harassment of a child by disparagement, criticism, threat and ridicule, and the inversion of love, whereby verbal and non-verbal means of rejection and withdrawal are substituted'. Emotional neglect and abuse can be identified with reference to the indices listed below. However, it should be noted that no one indicator is conclusive of emotional abuse. In

the case of emotional abuse and neglect, it is more likely to impact negatively on a child where there is a cluster of indices, where these are persistent over time and where there is a lack of other protective factors:

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

Signs and symptoms of physical abuse

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

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

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

Appendix 1: Signs and symptoms of child abuse

Children First: National Guidance for the Protection and Welfare of Children

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 pediatricians may liaise with dental colleagues in order to identify marks correctly.

Poisoning

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

Non-accidental
Non-accidental poisoning can occur and may be difficult to identify, but should be suspected in bizarre or recurrent episodes and when more than one child is involved. Drowsiness or hyperventilation may be a symptom.
Shaking violently Shaking is a frequent cause of brain damage in very young children.

Fabricated/induced illness

This occurs where parents, usually the mother (according to current research and case

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

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

Signs and symptoms of sexual abuse

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

Cases of sexual abuse principally come to light through:

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

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

Non-contact sexual abuse

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

Sexual contact

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

Oral-genital sexual abuse

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

Interfemoral sexual abuse

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

Penetrative sexual abuse, of which there are four types:

- 'Digital penetration', involving putting fingers in the vagina or anus, or both. Usually the victim is penetrated by the offender, but sometimes the offender gets the child to penetrate them.

- 'Penetration with objects', involving penetration of the vagina, anus or occasionally mouth with an object.
- 'Genital penetration', involving the penis entering the vagina, sometimes partially.
- 'Anal penetration' involving the penis penetrating the anus.

Children First: National Guidance for the Protection and Welfare of Children

Sexual exploitation

- Involves situations of sexual victimisation where the person who is responsible for the exploitation may not have direct sexual contact with the child. Two types of this abuse are child pornography and child prostitution.
- 'Child pornography' includes still photography, videos and movies, and, more recently, computer-generated pornography.
- 'Child prostitution' for the most part involves children of latency age or in adolescence. However, children as young as 4 and 5 are known to be abused in this way.
- The sexual abuses described above may be found in combination with other abuses, such as physical abuse and urination and defecation on the victim. In some cases, physical abuse is an integral part of the sexual abuse; in others, drugs and alcohol may be given to the victim.
- It is important to note that physical signs may not be evident in cases of sexual abuse due to the nature of the abuse and/or the fact that the disclosure was made some time after the abuse took place.

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

• bleeding from the vagina/anus;
• difficulty/pain in passing urine/faeces;
• an infection may occur secondary to sexual abuse, which may or may not be a definitive sexually transmitted disease.

Professionals should be informed if a child has a persistent vaginal discharge or has warts/rash in genital area;

• noticeable and uncharacteristic change of behaviour;
• hints about sexual activity;
• age-inappropriate understanding of sexual behaviour;
• inappropriate seductive behaviour;
• sexually aggressive behaviour with others;
• uncharacteristic sexual play with peers/toys;
• unusual reluctance to join in normal activities that involve undressing, e.g. games/swimming.

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

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

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

• depression, isolation, anger;
• running away;
• drug, alcohol, solvent abuse;
• self-harm;
• suicide attempts;

• missing school or early school leaving;
• eating disorders.
All signs/indicators need careful assessment relative to the child's circumstances.

APPENDIX 2
HEALTH SERVICES EXECUTIVE (HSE) REPORTING FORM

file:///C:/Users/Gale/AppData/Local/Microsoft/Windows/INetCache/IE/QCY30GZH/children-first-standard-report-form.pdf

APPENDIX 3
WALK CHILD PROTECTION FORM

WACP REPORT FORM

1.	Child's Name:			
2.	Address:			
3.	Date of Birth:		Case Ref No:	
4.	Centre Attended/ and residence if applicable			
5.	Details of Reported Incident			
7.	Date of Incident:		Time of Incident:	
8.	Place of Incident:			
9.	Person Reporting Incident (name, designation, address [if known]:			

	Are parents aware of the concern		Yes No I do not know	
10	Method of Report (phone, letter,			
11	Person Noting Report:			
	Designation:			
	Date:		Time:	

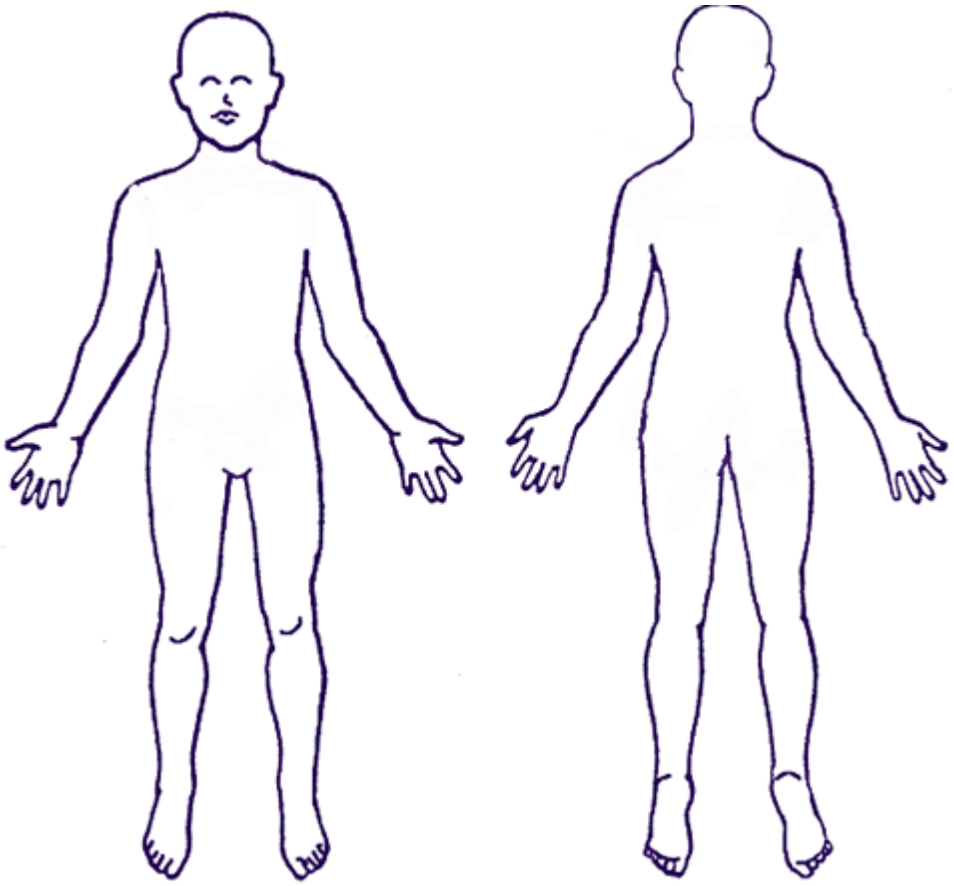
[ε] Any marking/injuries should also be noted on the Body Diagram overleaf

BODY DIAGRAM

NOTE: Medical examination should only be completed by a medical practitioner and with the full consent of the parents and child (depending on their age and understanding of such an examination)

Child's Name:			
Address:			
Date of Birth:		Case Ref No:	
Centre/Residence:			

Please complete this form only if there has been a physical injury.



Signature: _____

Date: _____

APPENDIX 4

PROCEDURES & PROTOCOLS REGARDING PHOTOGRAPHS AND OTHER IMAGERY IN RELATION TO CHILDREN

Definitions:

Child means any person under the age of 18 unless has been or is married.
Parent means parent or legal guardian of the child or person acting in *loco parentis*
Photographic imagery includes anything that can be produced using a camera, whether that be a filming camera or a still camera, including digital or otherwise.
Publicity materials include showing imagery on any WALK website, including social media websites, or in any WALK publications or in a public place.
Public place means areas where visitors to WALK have access.

Procedures for using or taking photographic imagery of children.

Photographs and other photographic/film imagery may only be taken of the child if there is express consent of the parent and child in the first instance. Even with a completed consent form by the parents/guardians, the procedures set out below must be followed by staff in relation to the taking, storage and use of photographic imagery.

Procedure:

Photographic imagery may only be used for publicity materials or in public places of WALK where it is agreed by both the parents and the child. Photographic imagery may be used otherwise only for home purposes for the child, that is, that photographs and other materials may be used by the child or the parents of the child. Photographs of the child are not to be kept by any staff member, either on WALK premises or off the premises. The Director of Services may, with consent of the parents, arrange for a suitable file to be set up with photographic imagery of the child by a designated member of staff. This file will be in a secure location(s) and may consist of both hard and soft copy.

Following permission by the parent and the child, photographic imagery may only be taken or used in places where there are more people present, ie a child must never be the subject of photography when only they and the staff member are present.

Photographic imagery may never be taken or used at any sporting event. Please note that schools and sporting clubs may have their own policies in place around the taking and recording of photographic imagery.

Photographic imagery may never be taken or used during any recreational activity where the child's clothing may appear more negligible than usual. For example, while at the beach or when the child's arms and legs are exposed.

In the event that photographic imagery is to be used for publicity information it is important that the child's name is not printed in the same publication, nor that other identifiers of the child are printed. In cases where there is promotional work being undertaken by WALK, the person producing the promotional material should aim to use other imagery, such as artwork belonging to the child as a means to represent the child.

Concerns:

If a staff member has concerns about the taking of photographic imagery or use of same by another member of staff they must immediately discuss their concerns with a line manager or the Designated Liaison Person as outlined in the Child Protection Policy.

Freedom of Information and Data Protection Acts:

Please note that WALK complies with Data Protection Acts, Freedom of Information Acts and regulations thereunder and as such recognise that any photographic imagery may be requested under these Acts.

Consent form for use of photographic imagery:

I agree to allow_____to be the subject of photographic imagery taken by staff of WALK in line with the procedures outlined in their 'Child Protection Policy'.

The procedures related to the taking and using of photographic imagery have been explained to me. In addition to these procedures I would like to outline the following further instruction if and when photographic imagery of the child may be taken or used:

_____

_____

_____

_____

_____

I understand that the proceedings may be photographed/videoed and used for promotional purposes with further consent by a parent/guardian of the child. I understand that photographic imagery will only be used for home purposes of the child.

I understand that I can at any stage revoke the consent provided in this form through submitting a written note to the Director of Services.

Signed (Guardian):	Guardian Name (block letters):	Date:
Signed (Child/Young Person):		Date:
Signed (Director of Services):		Date:

Relationship of Guardian to Child/Young Person:

_____

APPENDIX 6
USEFUL CONTACT DETAILS

Designated liaison persons	Eamonn Teague/Michael Teehan
Deputy Designated liaison person	Catherine Kelly
Complaints Officer	Gerard Mollaghan
HSE Social Work Duty Service Dublin South West	(01) 415 4700
HSE Social Work Duty Service Dublin South City	(01) 648 6555
Emergency Services	999/112
Crumlin Garda Station	Tel: +353 1 666 6200 Fax: +353 1 666 6240 (Public Office)
Tallaght Garda Station	
Clondalkin Garda Station	
Sundrive Garda Station	