Holy Trinity Preschool Safeguarding/Child Protection Policy.

Policy Approved by Management Committee.

Dated

Contents

General Principles

The general principles, which underpin our work, are those set out in the '**UN convention on the Rights of the Children'** are enshrined in the Children's (NI) Order 1995, the Department of Education (NI) guidance "Pastoral Care in Schools - Child Protection" (DENI Circular 99/10) and the Core Regional Child Protection Policy and Procedures (2017). The following principles form the basis of our Safeguarding Policy.

- It is the right of every child to always feel safe, to be heard, listened to, and taken seriously. We have a pastoral responsibility towards the children in our care and should take all reasonable steps to ensure their welfare is safeguarded and their safety is preserved.
- In any incident the child's welfare must be paramount, this overrides all other considerations.
- A proper balance must be struck between protecting children and respecting their rights and needs and families, but where there is conflict the child's interest must always come first.
- The holistic well-being and safety are regarded and monitored with the upmost importance.

We **in Holy Trinity Preschool centre** *have* a responsibility for the welfare and safety of the children in our care and we will carry out this duty by providing a caring, supportive, and safe environment, where each child is valued for their unique talents and abilities. We will ensure that all children can learn and develop to their full potential. Safeguarding also addresses the wider safety and protection needs of children, as well as addressing the issue of Child Protection in the context of abuse or maltreatment. All staff and volunteers have completed Child Protection/Safeguarding training which is updated every 3 years. They are aware of the signs of possible abuse and know the procedures to be followed. This policy sets out the guidance on the action, which is required where abuse/neglect of a child is suspected and outlines referrals within our preschool.

Holy Trinity Preschool centre has a commitment to the empowerment of all children to express and describe their feelings in an acceptable way. This will enable children to develop self-confidence and the skills and vocabulary to deal with inappropriate approaches.

Other Relevant Policies

Holy Trinity Preschool centre has a duty to ensure that safeguarding permeate all activities and functions. The Safeguarding Policy complements and supports a range of other preschool policies including:

- Promoting Positive Behaviour Policy
- Anti- bullying Policy
- Confidentially Policy
- Complaints Policy
- Social Networking Policy
- Staff development
- E-Safety/ICT Social Networking Policy
- Whistle blowing Policy.
- First Aid and the Administration of Medicines
- Health and Safety Policy
- Additional Needs Policy
- Intimate/Personal Care Policy
- Code of Conduct
- Data Protection Policy
- Security of the Setting Policy

These policies are available to parents/staff/and anyone wanting a copy should contact the leader.

Preschool Safeguarding Team

The following are the members of the Preschools safeguarding team.

- ❖ Representation on Management Committee – Mr John Reihill
- ❖ Designated Officer Preschool Leader - Lisa Keaveney
- ❖ Deputy Designated Officer – Maria Burns

Roles and Responsibilities

Chair of the Management Committee will

- Ensure that a safeguarding ethos is maintained with the preschool environment.
- Ensure that the preschool has a 'Safeguarding' Policy in place and that all staff and volunteers implement training.
- Ensure that the safeguarding team undertake appropriate safeguarding training.
- Ensure that a Designated Officer is always available.

- Assume lead responsibility for managing any complaints/allegations against the leader.

Designated Officer for Safeguarding – Lisa Keaveney will provide the safeguarding lead in order to advise the committee on:

- The role of the designated officers
- The content of safeguarding policies
- The content of a code of conduct for adults within the preschool
- The content of the full annual designated officers report
- Vetting of staff.

The Management Committee will:

- Ensure that there is a comprehensive 'Safeguarding' Policy in place and that staff implement it.
- Relevant Safeguarding training is kept up to date and a record kept of the same.
- Ensure that confidentiality is maintained, and such information will be passed on a need-to-know basis.

Leader – Lisa Keaveney will ensure:

- DENI 1999/10 guidelines are implemented within the setting.
- Act as a point of contact for staff and parents
- Designated officer and deputy are appointed.
- All staff receives Safeguarding training, so they are aware of duties, responsibilities, and role.
- All necessary referrals are taken forward in the appropriate manner.
- Chairperson of the management committee is kept informed.
- 'Safeguarding Policy' is reviewed annually, and all parents/carers receive a copy of the policy.
- Maintain records of safeguarding concerns
- Confidentiality is paramount - information passed on to management committee on a need to know.

Staff

- Refer concerns to the designated/deputy officer on 'Safeguarding' through **NOTE of CONCERN see Appendix1**
- Listen to what is being said, support the child and act promptly. Do not give child a guarantee of total confidentially regarding their disclosure. Do not investigate.
- Make a concise written record of a child's disclosure using actual words of the child.

- Keep Designated Officer informed through written "Record of Concern" or verbally regarding - poor attendance, punctuality, poor presentation, changed/unusual behaviour, deterioration in progress, discussions with parents.
- Avail of training related to the safeguarding of children.

Parents will play their part in Safeguarding by:

- Contacting the preschool on the morning of absence, so preschool is reassured as to the child's situation.
- Inform the preschool whenever anyone, other than themselves, intends to pick up the child.
- Inform the preschool in advance if their child is going home to an address other than their own home.
- Familiarise themselves with the preschool pastoral care, positive behaviour, and safeguarding policies.
- Raise concerns they have in relation to their/any child within the preschool.

Definition of Abuse

Child abuse occurs when a child/young person is neglected, harmed, or not provided with proper care. Children may be abused in many settings - in a family, in an institutional or community setting, by those known to them or more rarely by a stranger. There are different types of abuse, and a child may suffer more than one of them. There procedures outlined in this document are intended to protect children who are at risk, of shave suffered, significant harm because of abuse or neglect. (**Definitions of child abuse are taken from the Core Regional Child Protection Policy and Procedures.)**

Types of Abuse:

- **Neglect-** is the persistent failure to meet a child's physical, emotional and/or psychological needs, likely to result in significant harm. It may involve a parent/carer failing to provide adequate food, shelter, and clothing, failing to protect a child from physical harm or danger, failing to ensure access to appropriate medical care or treatment, lack of simulation or lack of supervision. It may also include nonorganic failure to thrive (faltering growth).
- **Physical Abuse** – is the deliberate physical injury/hurting to a child, or the wilful or neglectful failure to prevent physical injury or suffering. This may include hitting, biting, shaking, throwing, poisoning, burning/scalding, drowning, suffocating, confinement, or inappropriately giving drugs to control behaviour.
- **Emotional Abuse** - is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that he/she is worthless or unloved, inadequate, or valued

only in so far as they meet the needs of the other person. It may involve causing a child to frequently feel frightened or in danger, or the exploitation or corruption of a child. Some level of emotional abuse is involved in all types of ill treatment of a child, though it may occur alone. Domestic abuse, adult mental health problems and parental substance misuse may expose a child to emotional abuse. Emotional abuse may involve bullying through social networks, on-line games or mobile phones- by a child's peers.

- **Sexual Abuse –** involves forcing or enticing a child to take part in sexual activities for their own gratification or gain or the gratification of others. The activities may involve physical contact, including penetrative (rape, or oral sex) or non-penetrative acts such as kissing, rubbing, touching outside of clothing. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways. A child may suffer or be at risk of suffering from one or more types of abuse and abuse may take place on a single occasion or may repeatedly over time. Sexual abuse is not solely committed by adult males. Women can commit acts of sexual abuse, as can other children.
- **Exploitation –** is the intentional ill-treatment, manipulation or abuse of power control over a child or young person: to take selfish or unfair advantage of a child or young person or situation, for personal gain. It may manifest itself in many forms such as child labour, slavery, servitude, engagement in criminal activity, begging, benefit or other financial fraud or child trafficking. It extends to the recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation, Exploration can be sexual in nature.

Specific Types of abuse

In addition to the types of abuse described above there are also some specific types of abuse that we in Holy Trinity are aware of and have therefore included them in our policy. Please see **Appendix 2**

Children with Increased Vulnerabilities

Some children have increased risk of abuse due to specific vulnerabilities such as disability, lack of fluency in English. **See Appendix 3**

Responding to a Safeguarding and child Protection Concern

Safeguarding is more than child protection. Safeguarding begins with promotion and preventative activity which enables children and young people to grow up safely and securely in circumstances where their development and wellbeing is not adversely affected. It includes support to families and early intervention to meet the needs of children and continues through to child protection. Child protection refers specifically to the activity that is undertaken to

protect individual children or young people who are suffering or are likely to suffer significant harm[1].

If a parent has a potential child protection concern within the school

In Holy Trinity Preschool we aim to work closely with parents/guardians in supporting all aspects of their child's development and well-being. Any concerns a parent may have will be taken seriously and dealt with in a professional manner.

If a parent has a concern, they can talk to the Designated or Deputy Designated Leader for child protection or Safeguarding Manager for Preschool Mr J Reihill.

If they are still concerned, they may talk to the Manager of the Safeguarding team Mr J Reihill . At any time, a parent may talk to a social worker in the local Gateway team or. Details of who to contact are shown in the flowchart in **Appendix 5**

Where School Has Concerns or Has Been Given Information about Possible Abuse by Someone Other Than a Member of Staff

In if a child makes a disclosure to a Leader or other member of staff which gives rise to concerns about possible abuse, or if a member of staff has concerns about a child, the member of staff will complete a Note of Concern and act promptly. **They will not investigate** - this is a matter for Social Services - but will discuss these concerns with the Designated Leader or with the Deputy Designated Leader if he/she is not available.
The Designated Leader will consult with the Manager of the safeguarding team Mr J Reihill **always taking care to avoid due delay**. The Designated Leader may also seek clarification from the child or young person, their parent/carer.
If a child protection referral is not required the Preschool may consider other options including monitoring, signposting or referring to other support agencies e.g., Family Support Hub with parental consent and, where appropriate, with the child/young person's consent.

If a child protection referral is required, the Designated Leader will seek consent from the parent/carer and/or the child {if they are competent to give this} unless this would place the child at risk of significant harm.

The Designated Leader will phone the Gateway team and will submit a completed UNOCINI referral form.

Where appropriate the source of the concern will be informed of the action taken.

For further detail please see **Appendix 6**

Where a Complaint Has Been Made about Possible Abuse by a Member of the School's Staff or a Volunteer

When a complaint about possible child abuse is made against a member of staff the Management Committee (or the Designated Leader if the Management Committee is not available) must be informed immediately. If the complaint is against the Principal then the Designated Leader should be informed and he/she will inform the Chairperson of the Management committee who will consider what action is required in consultation with the employing authority. The procedure as outlined in **Appendix 7** will be followed.

Attendance at Child Protection Case Conferences and Core Group Meetings:

Designated Officer may be invited to attend an initial and review safeguarding case conference. A written report will be provided for these meetings. Feedback will be given to staff under the 'need to know principle' on a case-by-case basis. Children whose names are on the safeguarding register will be monitored in line with what has been agreed in each child's 'Safeguarding Plan'.

Confidentiality and Information Sharing:

In the interest of the child - information given to staff about possible child abuse cannot be held in confidence. Staff has a responsibility to share relevant information about the safeguarding of children with other professionals. Information can be passed on to Gateway without parental consent. We have a legal duty to report to any form of child abuse.

Record Keeping:

All 'Safeguarding' records, information and confidentiality notes are stored in a locked filing cabinet. Records are kept in an **'safeguarding book'** and are kept separate from any other information that is held on the child. Any records of concerns/possible child abuse – either referred to 'Gateway' or not, will be kept in preschool. If a child is placed on the Child Protection Register - a copy of such records is kept permanently in the preschool. A copy will also be sent to any other Education setting that the child will subsequently be transferred to.

Safe Recruitment Procedures:

Staff and volunteers who are appointed to positions in the preschool are vetted in accordance with VET1 Social Services procedures. Vetting letter of clearance will be received from Social Services before a new staff member commences employment. All applicants for employment will be interviewed before an appointment is made and two references are required. All such references will be followed up. In the case of an applicant with unexplained gaps in their employment history, or who have moved rapidly from one job to another, explanations will be sought. All applicants will be subject to a 3-month probationary period.

Parents who help out on an occasional basis do not require to be vetted – they will never be left alone and will not provide personal care to a child. Vetting will be required if a parent is more than 4 days in a 30-day period.

Code of Conduct for all Staff:

Staff will always be mindful that they hold a position of trust, and that their behaviour towards the children must be above reproach. The preschool has a code of conduct for staff which is to assist them in respect of the complex issue of child abuse, by drawing attention to the areas of risk from staff and by offering guidance on practical conduct. It is not intended to detract from the enriching experience children gain from positive interaction with staff within the education sector.

In order to achieve this 'Holy Trinity Preschool' will:

Ensure that all staff/volunteers will adhere to the following to guarantee child/adult protection:

- There will be at least two members of staff present at all times.
- The layout of the premises will permit constant supervision of all children/staff at all times.
- Staff will not do anything of a personal nature for a child that they can do for themselves.
- Children are encouraged to develop a sense of autonomy and independence through adult support, in making choices and in finding names for their own feelings and acceptable ways to express them. This will enable children to have self-confidence and the vocabulary to resist inappropriate approaches.
- Staff member will keep parent/carer informed if they have been or are regularly involved in the personal care of their child.
- Staff will always inform another member of staff where they are going with a child and length of time.
- While changing children - there will be no closed/locked doors to safeguard the staff and the children.
- Holy Trinity Preschool will inform Social Services of any changes made to the staff team.
-

Staff Training

'Holy Trinity Preschool' is committed to staff professional development. All staff receives training on policy and procedures with some members receiving more specialised training in line with their roles and responsibilities. All staff receives 'Safeguarding 'training and refresher training every 3 years. Designated officer, deputy and chairperson will also attend related safeguarding training courses. During induction a new member of staff will be briefed on the settings – Safeguarding Policy' and 'Code of Conduct'. They will also receive a copy of all policies within the setting.

The Preventative Curriculum

'Holy Trinity Preschool' introduces key elements of keeping children safe into our programme to support physical, mental, and emotional health and wellbeing of all children, so that they may grow to be strong, resilient, and listened to and that they may develop an understanding of why and how to keep safe.

Holy Trinity Preschool creates a culture of value and respect for every individual within the setting, having positive regard for children's heritage arising from their colour, ethnicity, languages spoken at home, cultural and social background.

We ensure that this is carried out in a way that is developmentally appropriate for all children.

The preschools regular circle time sessions are used as a means of encouraging children to raise social and emotional concerns in a safe environment and to build self-confidence, respect, and sensitivity among their classmates. Within the setting there is a 'feeling' area and children are encouraged to use it when needed.

We are also committed to empowering young children, through our curriculum, promoting their right to be strong, resilient, and listened to.

Internet Usage:

'Holy Trinity Preschool' have strict guidelines in place for the use of images and recordings from within the setting – Social networking Policy. No one other than a parent is to put any footage of a child on any internet website, e.g., Facebook/U tube/twitter. These guidelines apply to all staff/volunteers/ parents.

Collection of Children from Setting:

'Holy Trinity Preschool' has strict procedures in place for the collection of children from the setting (Child Collection Policy) If someone other than a parent/carer is collecting a child, the preschool must be informed prior to the collection and if staff is unsure then a phone call is made to the parent/carer. This ensures the safety of the child at all times. No one under the age of 18 is permitted to collect a child.

Parental Responsibilities:

Parents **must inform** the preschool if their child has any injuries which have happened outside the setting. Parents and staff are required to complete the '**Injuries on arrival'** detailing the type and cause of injury.

Monitoring and Evaluation

'Holy Trinity Preschool' will review and change the 'Safeguarding Policy' and procedures annually or when there is further guidance of change in legistration. The management committee will also monitor any 'Safeguarding' activity. They will support the implementation

of the policy on a regular basis through the provision of reports from the D O. On-going evaluation will ensure the effectiveness of the policy.

CCTV

'Holy Trinity Preschool' have CCTV in operation but only at that side of the mobile this is for monitoring the safety of the setting at night-time and during the holidays period. There is no direct view to record children.

Date: Jan 2024

Reviewed on:

Date: 11 January 2024 Signed: _____

Date: _____ Signed: _____

Appendix 1

CONFIDENTIAL

NOTE OF CONCERN

Child Protection Record - Reports to Designated Leader

Name of Pupil:
Year Group:
Date, Time of Incident/Disclosure:
Circumstances of Incident/Disclosure:
Nature And Description of Concern:
Parties involved, including any witnesses to an event and what was said or done and by whom:
Action Taken at The Time:

Details Of Any Advice Sought, From Whom and When:
Any Further Action Taken:

Written Report Passed to Designated Leader: Yes: No: If 'No' state reason:
Date And Time of Report to The Designated Leader:
Written Note from Staff Member Placed on Pupil's Child Protection File Yes No If 'No' state reason:

Name of Staff Member Making the Report: _____

Signature of Staff Member: _____ Date: _____

Signature of Designated Leader: _____ Date: _____

APPENDIX 2

Specific Types of Abuse

Grooming of a child or young person is always abusive and/or exploitative. It often involves perpetrator(s) gaining the trust of the child or young person or, in some cases, the trust of the family, friends or community, and/or making an emotional connection with the victim in order to facilitate abuse before the abuse begins. This may involve providing money, gifts, drugs and/or alcohol or more basic needs such as food, accommodation, or clothing to develop the child's/young person's loyalty to and dependence upon the person(s) doing the grooming. The person(s) carrying out the abuse may differ from those involved in grooming which led to it, although this is not always the case. Grooming is often associated with Child Sexual Exploitation (CSE) but can be a precursor to other forms of abuse. Grooming may occur face to face, online and/or through social media, the latter making it more difficult to detect and identify.

Adults may misuse online settings e.g., chat rooms, social and gaming environments, and other forms of digital communications, to try and establish contact with children and young people or to share information with other perpetrators, which creates a particular problem because this can occur in real time and there is no permanent record of the interaction or discussion held or information shared. Those working or volunteering with children or young people should be alert to signs that may indicate grooming and take early action in line with their child protection and safeguarding policies and procedures to enable preventative action to be taken, if possible, before harm occurs. Practitioners should be aware that those involved in grooming may themselves be children or young people and may be acting under the coercion or influence of adults. Such young people must be considered victims of those holding power over them. Careful consideration should always be given to any punitive approach or 'criminalising' young people who may, themselves, still be victims and/or acting under duress, control, threat, the fear of, or actual violence. In consultation with the PSNI and where necessary the PPS, HSC professionals must consider whether children used to groom others should be considered a child in need or requiring protection from significant harm.

If the staff in Holy Trinity Preschool become aware of signs that may indicate grooming, they will take early action and follow the school's child protection policies and procedures. The HSCT and PSNI should be involved as early as possible to ensure any evidence that may assist prosecution is not lost and to enable a disruption plan to reduce the victim's contact with the perpetrator(s) and reduce the perpetrator(s) control over the victim to be put in place without delay.

Child Sexual Exploitation (CSE) is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/ or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. (Co-operating to Safeguard Children and Young People in NI. DHSSPS version 2.0 2017).

Any child under the age of eighteen, male or female, can be a victim of CSE. Although younger children can experience CSE, the average age at which concerns are first identified is 12-15 years of age. Sixteen- and seventeen-year-olds, although legally able to consent to sexual activity can also be sexually exploited.

CSE can be perpetrated by adults or by young people's peers, on an individual or group basis, or a combination of both, and can be perpetrated by females as well as males. While children in care are known to experience disproportionate risk of CSE, **the majority of CSE victims are living at home**.

Statutory Responsibilities

CSE is a form of child abuse and, as such, any member of staff suspecting that CSE is occurring will follow the school's child protection policy and procedures, including reporting to the appropriate agencies.

Domestic and Sexual Violence and Abuse

The Stopping Domestic and Sexual Violence and Abuse in Northern Ireland: A Seven Year Strategy (2016) defines domestic and sexual violence and abuse as follows: -

Domestic Violence and Abuse:

'Threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member.'

Sexual Violence and Abuse

'Any behaviour (physical, psychological, verbal, virtual/online) perceived to be of a sexual nature which is controlling, coercive, exploitative, harmful, or unwanted that is inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability).' Please note that coercive, exploitative, and harmful behaviour includes taking advantage of an individual's incapacity to give informed consent.

If it comes to the attention of Preschool staff that Domestic Abuse, is or may be, affecting a child this will be passed on to the **Miss Lisa Keaveney/Mrs Maria Burns** who have an obligation to share the information with the Social Services Gateway Team.

Operation Encompass

We are an Operation Encompass school. Operation Encompass is an early intervention partnership between local Police and our school, aimed at supporting children who are victims of domestic violence and abuse. As a preschool, we recognize that children's exposure to domestic violence is a traumatic event for them.
Children experiencing domestic abuse are negatively impacted by this exposure. Domestic abuse has been identified as an Adverse Childhood Experience and can lead to emotional, physical and psychological harm. Operation Encompass aims to mitigate this harm by enabling the provision of immediate support. This rapid provision of support within the preschool environment means children are better safeguarded against the short, medium and long-term effects of domestic abuse.

As an Operation Encompass school, when the police have attended a domestic incident and one of our pupils is present, they will contact **the Mr. John Rehill** at the start of the next working day to share this information with a member of the Preschool safeguarding team. This will allow the Preschool safeguarding team to provide immediate emotional support to this child as well as giving the Designated Leadergreater insight into any wider safeguarding concerns.

This information will be treated in strict confidence, like any other category of child protection information. It will be processed as per DE Circular 2020/07 'Child Protection Record Keeping in Schools' and a note will be made in the child's child protection file. The information received on an Operation Encompass call from the Police will only be shared outside of the safeguarding team on a proportionate and need to know basis. All members of the safeguarding team will complete online Operation Encompass training, so they are able to take these calls. Any staff responsible for answering the phone at school will be made aware of Operation Encompass and the need to pass these calls on with urgency to a member of the Safeguarding team.

Female Genital Mutilation (FGM) is a form of child abuse and violence against women and girls. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The procedure is also referred to as 'cutting', 'female circumcision' and 'initiation'. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. FGM is a form of child abuse and, as such, teachers have a statutory duty to report cases, including suspicion, to the appropriate agencies, through agreed established procedures set out in our school policy. Where there is a concern that a child or young person may be at immediate risk of FGM this should be reported to the PSNI without delay. Contact can be made directly to the Sexual Referral Unit (based within the Public Protection Unit) at 028 9025 9299. Where there is a concern that a child or young person may be at risk of FGM, referral should be made to the relevant HSCT Gateway Team.

Forced Marriage is a marriage conducted without the valid consent of one or both parties and where duress is a factor. Duress can include physical, psychological, financial, sexual, and emotional pressure. Forced marriage is a criminal offence in Northern Ireland and if in Holy Trinity Preschool we have knowledge or suspicion of a forced marriage in relation to a child or young person we will contact the PSNI immediately.

Appendix 3

Children with Increased Vulnerabilities

- **Children With a Disability**

Children and young people with disabilities (i.e., any child or young person who has a physical, sensory, or learning impairment or a significant health condition) may be more vulnerable to abuse and those working with children with disabilities should be aware of any vulnerability factors associated with risk of harm, and any emerging child protection issues.

Staff at Holy Trinity Preschool must be aware that communication difficulties can be hidden or overlooked making disclosure particularly difficult. Staff and volunteers at Holy Trinity working with children with disabilities will receive training to enable them to identify and refer concerns early in order to allow preventative action to be taken.

- **Children With Limited Fluency in English**

Children whose first language is not English/Newcomer pupils should be given the opportunity to express themselves to a member of staff of Holy Trinity Preschool or other professional with appropriate language/communication skills, especially where there are concerns that abuse may have occurred. DTs and other relevant preschool staff should seek advice and support from the EA's Intercultural Education Service if necessary. All Preschool Staff should create an atmosphere in which pupils with special educational needs which involve communication difficulties, or pupils for whom English is not their first language, feel confident to discuss these issues or other matters that may be worrying them.

- **Pre-School Provision**

Many of the issues in the preceding paragraphs will be relevant to our young children who may have limited communication skills. In addition to the above, staff at holy trinity preschool will follow our Intimate Care policy and procedures in consultation with the child's parent[s]/carer[s]. Miss Keaveney and her staff of preschool will come into contact with children while helping them with toileting, washing and changing their clothing. Staff in Holy Trinity pre-school setting should consider whether the Code of Conduct meets the needs of their particular responsibilities and should make clear the boundaries of appropriate physical contact, and their Code to staff and parents.

- **Gender Identity Issues and Sexual Orientation**

The Preschool should strive to provide a happy environment where all young people feel safe and secure. All Children have the right to learn in a safe and secure environment, to be treated with respect and dignity, and not to be treated any less favourably due to their actual or perceived sexual orientation. DE requires all grant-aided preschools to develop their own policy on how they will address Relationships and Sexuality Education (RSE) within the curriculum. It is via this policy that schools are expected to cover issues relating to relationships and sexuality, (Age Appropriate) including those affecting LGB&T children and young people.

- **Work Experience, School Trips and Educational Visits**

Our duty to safeguard and promote the welfare of children and young people also includes periods when they are in our care outside of the preschool setting. We will follow Minimum standards / EA guidance on educational visits, school trips and work experience to ensure our current safeguarding policies are adhered to and that appropriate staffing levels are in place per our minimum standards ratio.

Appendix 4

Signs and Symptoms of Child Abuse

This section contains information for all preschool staff working with children and families and is not an exhaustive list. The following pages provide guidance only and should not be used as a checklist.

The first indication that a child is being abused may not necessarily be the presence of a severe injury. Concerns may become apparent in a number of ways e.g.

- by bruises or marks on a child's body
- by remarks made by a child, his parents, or friends.
- by overhearing conversation by the child, or his parents
- by observing that the child is either being made a scapegoat by or has a poor relationship/bond with his parents.
- by a child having sexual knowledge or exhibiting sexualised behaviour which is unusual given his age and/or level of understanding.
- by a child not thriving or developing at a rate which one would expect for his age and stage of development.
- by the observation of a child's behaviour and changes in his behaviour.
- by indications that the family is under stress and needs support in caring for their children.
- by repeat visits to a general practitioner or hospital.

There may be a series of events which in themselves do not necessarily cause concern but are significant, if viewed together. Initially the incident may not seem serious, but it should be remembered that prompt help to a family under stress may prevent minor abuse escalating into something more serious.

It is important to remember that abused children do not necessarily show fear or anxiety and may appear to have established a sound relationship with their abuser(s). Staff should familiarise themselves on 'attachment theory' and its implications for assessing the bond between parents and their children.

Suspicions should be raised by e.g.

- discrepancy between an injury and the explanation
- conflicting explanation, or no explanation, for an injury
- delay in seeking treatment for any health problem.
- injuries of different ages
- history of previous concerns or injuries
- faltering growth (failure to thrive)
- parents show little, or no, concern about the child's condition or show little warmth or empathy with the child.
- evidence of domestic violence

- parents with mental health difficulties, particularly of a psychotic nature
- evidence of parental substance abuse

Signs and symptoms are indicators and simply highlight the need for further investigation and assessment.

Parental Response to Allegations of Child Abuse Which Raise Concern

Parents' responses to allegations of abuse of their child are very varied. The following types of response are of concern:

- there may be an unequivocal denial of abuse and possible non-compliance with enquiries.
- parents may over-react, either aggressively or defensively, to a suggestion that they may be responsible for harm to their child.
- there may be reluctance to give information, or the explanation given may be incompatible with the harm caused to the child, or explanations may change over time.
- parents may display a lack of awareness that the child has suffered harm, or that their actions, or the actions of others, may have caused harm.
- parents may seek to minimise the severity of the abuse, or not accept that their actions constitute abuse.
- parents may fail to engage with professionals.
- blame or responsibility for the harm may be inappropriately placed on the child or an unnamed third party.
- parents may seek help on matters unrelated to the abuse or its causes (this may be to deflect attention away from the child and his injuries).
- the parents and/or child may go missing.

Physical Abuse

Children receive bumps and bruises as a result of the rough and tumble of normal play. Most children will have bruises or other injuries, therefore, from time to time. These will be accidental and can be easily explained.

It is not necessary to establish intent to cause harm to the child to conclude that the child has been subject to abuse. Physical abuse can occur through acts of both commission and/or omission.

Insignificant but repeated injuries, however minor, may be symptomatic of a family in crisis and, if no action is taken, the child may be further injured. All injuries should be noted and collated in the child's records and analysed to assess if the child requires to be safeguarded.

If on initial examination the injury is not felt to be compatible with the explanation given or suggest abuse it should be discussed with a senior paediatrician.

A small number of children suffer from rare conditions, e.g., haemophilia or brittle bone disease, which makes them susceptible to bruising and fractures. It is important to remain aware, however, that in such children some injuries may have a non-accidental cause. A "clotting screen" only excludes the common conditions which may cause spontaneous bleeding. If the history suggests a bleeding disorder, referral to a haematologist will be required.

Recognition of Physical Abuse

a) Bruises + Soft Tissue Injuries

Common sites for accidental bruising depend on the developmental stage of the child. They include:

- forehead
- crown of head
- bony spinal protuberances
- elbows and below
- hips
- hands
- shins

Less common sites for accidental bruising include:

- Eyes
- Ears
- Cheeks
- Mouth
- Neck
- Shoulders
- Chest
- Upper and Inner Arms
- Stomach
- Genitals
- Upper and Inner Thighs
- Lower Back and Buttocks
- Upper Lip and Frenulum
- Back of the Hands.

Non-accidental bruises may be:

- frequent
  patterned, e.g., finger and thumb mark.

in unusual positions, (note developmental level and activity of the child).

Research on aging of bruises (from photographs) has shown that it is impossible to accurately age bruises although it can be concluded that a bruise with a yellow colour is more than 18 hours old. Tender or swollen bruises are more likely to be fresh. It is not possible to conclude definitely that bruises of different colours were sustained at different times.

The following should give rise to concern e.g.

Bruising in a non-mobile child, in the absence of an adequate explanation,

bruising in a non-mobile child, in the absence of an adequate explanation,

bruises other than at the common sites of accidental injury for a child of that developmental stage,

facial bruising, particularly around the eyes, cheeks, mouth, or ears, especially in very young children.

soft tissue bruising, on e.g., cheeks, arms, and inner surface of thighs, with no adequate explanation.

a torn upper lip frenulum (skin which joins the lip and gum).

patterned bruising e.g., linear or outline bruising, hand marks (due to grab, slap or pinch may be petechial), strap marks particularly on the buttocks or back.

ligature marks caused by tying up or strangulation.

Most falls or accidents produce one bruise on a single surface, usually a bony protuberance. A child who falls downstairs would generally only have one or two bruises. Children usually fall forwards and therefore bruising is most usually found on the front of the body. In addition, there may be marks on their hands if they have tried to break their fall.

Bruising may be difficult to see on a dark-skinned child. Mongolian blue spots are natural pigmentation to the skin, which may be mistaken for bruising. These purplish-blue skin markings are most commonly found on the backs of children whose parents are darker skinned.

a) Eye Injuries

Injuries which should give cause for concern:

black eyes can occur from any direct injury, both accidental and non-accidental. Determining how the injury occurred is vital, therefore; bilateral "black eyes" can occur accidentally as a result of blood tracking from a very hard blow to the central forehead (Injury should be evident on mid-forehead, bridge of nose). It is rare for both eyes to be bruised separately, accidentally however and at the same time.

sub conjunctival haemorrhage.

retinal haemorrhage.

Burns and Scalds

Accidental scalds often:

1.are on the upper part of the body.
2.are on a convex (curved) surface.
3.are irregular.
4.are superficial.
5.leave a recognisable pattern.

c)

It **can be difficult to distinguish between accidental and non-accidental burns. Any burn or scald with a clear outline should be regarded with suspicion e.g.**

circular burns
linear burns
burns of uniform depth over a large area
friction burns.
scalds that have a line which could indicate immersion or poured liquid.
splash marks
old scars indicating previous burns or scalds.

When a child presents with a burn or scald it is important to remember:

a responsible adult checks the temperature of the bath before a child gets into it.

a child is unlikely to sit down voluntarily in too hot water and cannot accidentally scald his bottom without also scalding his feet.

"doughnut" shaped burns to the buttocks often indicate that a child has been held down in hot water, with the buttocks held against the water container e.g., bath, sink etc.

a child getting into too hot water of its own accord will struggle to get out and there are likely to be splash marks.

small round burns may be cigarette burns but can often be confused with skin conditions. Where there is doubt, a medical/dermatology opinion should be sought.

d) Fractures

The potential for a fracture should be considered if there is pain, swelling and discoloration over a bone or joint or a child is not using a limb, especially in younger children. The majority of fractures normally cause pain, and it is very difficult for a parent to be unaware that a child has been hurt. In infants, rib and metaphysical limb fractures may produce no detectable ongoing pain, however. is very rare for a child aged under one year to sustain a fracture accidentally, but there may be some underlying medical condition, e.g., brittle bone disease, which can cause fractures in babies.
The most common non-accidental fractures are to the long bones in the arms and legs and to the ribs.
The following should give cause for concern and further investigation may be necessary:

- any fracture in a child under one year of age
- any skull fracture in children under three years of age
- a history of previous skeletal injuries which may suggest abuse.
- skeletal injuries at different stages of healing
- evidence of previous fractures which were left untreated.

e) Scars

Children may have scars from previous injuries. Particular note should be taken if there is a large number of scars of different ages, or of unusual shapes or large scars from burns or lacerations that have not received medical treatment.

f) Bites

Bites are always non-accidental in origin; they can be caused by animals or human beings (adult/child); a dental surgeon with forensic experience may be needed to secure detailed evidence in such cases.

g) Other Types of Physical Injuries

- poisoning, either through acts of omission or commission
- ingestion of other damaging substances, e.g., bleach
- administration of drugs to children where they are not medically indicated or prescribed.
- female genital mutilation, which is an offence, regardless of cultural reasons.
- unexplained neurological signs and symptoms, e.g., subdural haematoma

h) Fabricated or Induced Illness

Fabricated or induced illness, previously known as Munchausen's Syndrome by Proxy, is a condition where a child suffers harm through the deliberate action of the main carer, in most cases the mother, but which is attributed to another medical cause.

It is important not to confuse this deliberate activity with the behaviour and actions of over-anxious parents who constantly seek advice from doctors, health visitors and other health professionals about their child's wellbeing.

There is a need to exercise caution about attributing a child's illness, in the absence of a medical diagnosis, to deliberate activity on the part of a parent or carer to a fabricated or induced illness, as stated in the Court of Appeal judgement in the case of Angela Cannings.
(R v Cannings (2004) EWCA Criminal (19 January 2004)).

The following behaviours exhibited by parents can be associated with fabricated or induced illness:

- deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation.
- interfering with treatments by over-dosing, not administering them or interfering with medical equipment such as infusion lines or not complying with professional advice, resulting in significant harm.
- claiming the child has symptoms which may be unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits.
- exaggerating symptoms, causing professionals to undertake investigations and treatments which may be invasive, unnecessary and, therefore, are harmful and possibly dangerous.
- obtaining specialist treatments or equipment for children who do not require them.

- alleging psychological illness in a child.

There are a number of presentations in which fabricated or induced illness may be a possibility. These are:

- failure to thrive/growth faltering (sometimes through deliberate withholding of food.)
- fabrication of medical symptoms especially where there is no independent witness.
- convulsions.
- pyrexia (high temperature).
- cyanotic episode (reported blue tinge to the skin due to lack of oxygen).
- apnoea (stops breathing).
- allergies
- asthmatic attacks
- unexplained bleeding (especially anal or genital or bleeding from the ears)
- frequent unsubstantiated allegations of sexual abuse, especially when accompanied by demands for medical examinations.
- frequent 'accidental' overdoses (especially in very young children).

Concerns may arise when:

- reported symptoms and signs found on examinations are not (3 explained by any medical condition from which the child may be suffering.
- physical examination and results of medical investigations do not explain reported symptoms and signs.
- there is an inexplicably poor response to prescribed medication and other treatment.
- new symptoms are reported on resolution of previous ones.
- reported symptoms and/or clinical signs do not occur when the carers are absent.
- over time the child is repeatedly presented to health professionals with a range of signs and symptoms.
- the child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder or disability from which the child is known to suffer.

It is important to note that the child may also have an illness that has been diagnosed and needs regular treatment. This may make the diagnosis of fabricated or induced illness difficult, as the presenting symptoms may be similar to those of the diagnosed illness.

Sexual Abuse

Most child victims are sexually abused by someone they know, either a family member or someone well known to them or their family. In recent years there has been an increasing recognition that both male and female children and older children are sexually abused to a greater extent than had previously been realised.

There are no 'typical' sexually abusing families. Children who have been sexually abused are likely to have been put under considerable pressure not to reveal what has been happening to them. Sexual abuse is damaging to children, both in the short and long term.

Both boys and girls of all ages are abused, and the abuse may continue for many years before it is disclosed. Abusers may be both male and female.

It is important to note that children and young people may also abuse other children sexually.

Children disclosing sexual abuse have the right to be listened to and to have their allegations taken seriously. Research shows it is rare for children to invent allegations of sexual abuse and that in fact they are more likely to claim they are not being abused when they are.

It is important that the indicators listed below are assessed in terms of significance and in the context of the child's life, before concluding that the child is, or has been, sexually abused.

Some indicators take on a greater, or lesser, importance depending upon the child's age.

Recognition of Sexual Abuse

Sexual abuse often presents in an obscure way. Whilst some child victims have obvious genital injuries, a sexually transmitted infection or are pregnant, relatively few children are so easily diagnosed. The majority of children subjected to sexual abuse, even when penetration has occurred, have on medical examination no evidence of the abuse having occurred.

The following indicators of sexual abuse may be observed in a child. There may be occasions when no symptoms are present, but it is still thought that a child may be, or has been, sexually abused. Suspicions increase where several features are present together.

The following list is not exhaustive and should not be used as a check list.

Pre-School Child (0-4years)

Possible physical indicators in the pre-school aged child include:

- bruises, scratches, bite marks or other injuries to buttocks, lower abdomen, or thighs
- itching, soreness, discharge, or unexplained bleeding
- physical damage to genital area or mouth
- signs of sexually transmitted infections
- pain on urination
- semen in vagina, anus, external genitalia
- difficulty in walking or sitting.
- torn, stained or bloody underclothes or evidence of clothing having been removed and replaced.
- psychosomatic symptoms such as recurrent abdominal pain or headache.

Possible behavioural indicators include:

- unusual behaviour associated with the changing of nappy/underwear, e.g., fear of being touched/hurt, holding legs rigid and stiff or verbalisation like "stop hurting me".

- heightened genital awareness - touching, looking, verbal references to genitals, interest in other children's or adults' genitals.

- using objects for masturbation - dolls, toys with phallic-like projections.

- rubbing genital area on an adult - wanting to smell genital area of an adult, asking adult to touch or smell their genitals.

- simulated sexual activity with another child e.g., replaying the sexually abusive event or wanting to touch other children etc.

- simulated sexual activity with dolls, cuddly toys.

- fear of being alone with adult persons of a specific sex, especially that of the suspected abuser.

- self-mutilation e.g., picking at sores, sticking sharp objects in the vagina, head banging etc.

- social isolation - the child plays alone and withdraws into a private world.

- inappropriate displays of affections between parent and child who behave more like lovers.

- fear of going to bed and/or overdressing for bed.

- child takes over 'the mothering role' in the family whether or not the mother is present.

Emotional Abuse

Emotional abuse is as damaging as other, visible, forms of abuse in terms of its impact on the child. There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to emotional abuse. Emotional abuse has an impact on a child's physical health, mental health, behaviour, and self-esteem. It can be particularly damaging for children aged 0 to 3 years.
Emotional abuse may take the form of under-protection, and/or over-protection, of the child, which has a significant negative impact on a child's development.

The parents' physical care of the child, and his environment, may appear to meet the child's needs, but it is important to remain aware of the interactions and relationship which occur between the child and his parents to determine if they are nurturing and appropriate.

An emotionally abused child may be subject to constant criticism and being made a scapegoat, the continuous withholding of approval and affection, severe discipline or a total lack of appropriate boundaries and control. A child may be used to fulfil a parent's emotional needs.

The potential of emotional abuse should always be considered in referrals where instances of domestic violence have been reported.

Recognition of Emotional Abuse

Whilst emotional abuse can occur in the absence of other types of abuse, it is important to recognise that it does often co-exist with them, to a greater or lesser extent.

Child Behaviours associated with Emotional Abuse

Some of the symptoms and signs seen in children who are emotionally abused are presented below. It is the degree and persistence of such symptoms that should result in the consideration of emotional abuse as a possibility. Importantly, it should be remembered that whilst these symptoms may suggest emotional abuse, they are not necessarily pathognomy of this since they often can be seen in other conditions.

Possible behaviours that may indicate emotional abuse include:

- serious emotional reactions, characterised by withdrawal, anxiety, social and home fears etc.
- marked behavioural and conduct difficulties, e.g., opposition and aggression, stealing, running away, promiscuity, lying.
- persistent relationship difficulties, e.g., extreme clinginess, intense separation reaction.
- physical problems such as repeated illnesses, severe eating problems, severe toileting problem.
- extremes of self-stimulatory behaviours, e.g., head banging, comfort seeking, masturbation etc.
- very low self-esteem, often unable to accept praise or to trust and lack of self-pride.
- lack of any sense of pleasure in achievement, over-serious or apathetic.
  over anxiety, e.g., constantly checking, or overanxious to please
- developmental delay in young children, and failure to reach potential in learning.

Parental Behaviour Associated with Emotional Abuse

Behaviour shown by parents which, if persistent, may indicate emotionally abusive behaviour includes:

- extreme emotions and behaviours towards their child including criticism, negativity, rejecting attitudes, hostility etc.
- fostering extreme dependency in the child
- harsh disciplining, inconsistent disciplining, and the use of emotional sanctions such as withdrawal of love
- expectations and demands which are not appropriate for the developmental stage of the child, e.g., too high, or too low.
- exposure of the child to family violence and abuse
- inconsistent and unpredictable responses to the child
- contradictory, confusing, or misleading messages in communicating with the child.
- serious physical or psychiatric illness of a parent where the emotional needs of the child are not capable of being considered and/or appropriately met.
- induction of the child into bizarre parental belief systems
- break-down in parental relationship with chronic, bitter conflict over contact or residence arrangements for the child

- major and repeated familial change, e.g., separations and reconstitution of families and/or changes of address.
- making a child a scapegoat within the family

Neglect

Neglect and failure to thrive/growth faltering for non-organic reasons requires medical diagnosis. Non-organic failure to thrive is where there is a poor growth for which no medical cause is found, especially when there is a dramatic improvement in growth on a nutritional diet away from the parent's care. Failure to thrive tends to be associated with young children but neglect can also cause difficulties for older children.

There is a tendency to associate neglect with poverty and social disadvantage. Persistent neglect over long periods of time is likely to have causes other than poverty, however. There has to be a distinction made between financial poverty and emotional poverty.

There are a number of types of neglect that can occur separately or together, for example:

- medical neglect
- educational neglect
- simulative neglect environmental neglect
- environmental neglect
- failure to provide adequate supervision and a safe environment.

Recognition of Neglect

Neglect is a chronic, persistent problem. The concerns about the parents not providing "good enough" care for their child will develop over time. It is the accumulation of such concerns which will trigger the need to invoke the Child Protection Process. In cases of neglect, it is important that details about the standard of care of the child are recorded and there is regular inter-agency sharing of this information.

It is important to remember that the degree of neglect can fluctuate, sometimes rapidly, therefore ongoing inter-agency assessment and monitoring is essential.

The assessment of neglect should take account of the child's age and stage of development, whether the neglect is severe in nature and whether it is resulting in, or likely to result in, significant impairment to the child's health and development.

The following areas should be considered when assessing whether the quality of care a child receives constitutes neglect.

Child

Health presentation indicators include:

- non-organic failure to thrive (growth faltering)
- poor weight gain (improvement when away from the care of the parents
- poor height gain
- unmet medical needs
- untreated head lice/other infestations
- frequent attendance at 'accident and emergency' and/or frequent hospital admissions
- tired or depressed child, including a child who is anaemic or has rickets.

- poor hygiene
- poor or inappropriate clothing for the time of year
- abnormal eating behaviour (bingeing or hoarding).

Emotional and behavioural development indicators include:

- developmental delay/special needs
- presents as being under-stimulated.
- abnormal reaction to separation/ or attachment, disorder
- over-active and/or aggressive
- soiling and/or wetting
- offending behaviour, including stealing food

Family and social relationship indicators include:

- high criticism/low warmth
- excluded by family.
- sibling violence
- isolated child
- attachment disorders and /or seeking comfort from strangers.
- left unattended/or to care for other children.
- left to wander alone day or night.
- constantly late to preschool/late being collected.
- not wanting to go home from school or refusing to go to school.
- poor attendance at preschool/nursery
- frequent name changes and/or change of address or parental figures within the home.
- management of a child with a disability who is not attaining the level of functioning which is commensurate with the disability.

Consideration should be given as to whether a child and adolescent mental health assessment is required. Have all children in the family been seen and their views explored and documented?

Parents

Lack of emotional warmth indicators include:

- unrealistic expectations of child
- inability to consider or put child's needs first.
- name calling/degrading remarks.
- lack of appropriate affection for the child
- violence within the home from which the child is not shielded.
- partner resenting non-biological child and hostile in attitude towards him.
- failure to provide basic care for the child.

Lack of stability indicators include:

- frequent changes of partners
- poor family support/inappropriate support
- lack of consistent relationships
- frequent moves of home
- enforced unemployment.
- drug, alcohol, or substance dependency
- financial pressures/debt
- absence of local support networks, neighbours etc.

Issues relating to providing guidance and setting boundaries indicators include:

- poor boundary setting
- inconsistent attitudes and reactions, especially to child's behaviour
- continuously failing appointments
- refusing offers of help and services.
- failure to seek or use advice and/or help offered appropriately.
- seeks to mislead professionals by providing inaccurate or confusing information.
- failure to provide safe environment.

Social Presentation

- aggressive/threatening behaviour towards professionals and volunteers
- disguised compliance
- IOW self-esteem
- lack of self-care.

Health

- mental ill health
- substance misuse
- learning difficulties
- (post-natal) depression
- history of parental child abuse or poor parenting
- physical health.

Home and Environmental Conditions

The following home and environmental conditions should be considered:

- poor housing conditions
- overcrowding
- lack of water, heating, sanitation
- no access to washing machine.
- piles of dirty washing
- little or no adequate clean bedding/furniture
- little or no food in cupboards
- human and/or animal excrement
- uncared for animals
- referrals to environmental health
- unsafe environment
- rural isolation.

Impediments to ongoing assessment and appropriate multidisciplinary support

- failure to see the child.
- no ease of access to whole house
- fear of violence and aggression
- failure to seek support and advice or consultation, as appropriate, from line manager.
- failure to record concern and initial impact.
- inability to retain objectivity.
- unwitting collusion with family
- failure to see beyond conditions in the home.

- child's view is lost.

- minimising concern
- poor networking amongst professionals
- inability to see what is/is not acceptable.
- familiarity breeding contempt; and
- failure to make connections with information available from other services.

(Hammersmith & Fulham Inter-Agency Procedures 2002) Safeguarding adults board.

When Preschool staff become aware of any of the above features, they should review the case with Designated Child protection officer Miss Keaveney or Mrs Burns.

Children with Disability

In recognising child abuse, all professionals should be aware that children with a disability can be particularly vulnerable to abuse. They may need a high degree of physical care; they may have less access to protection and there may be a reluctance on the part of professionals to consider the possibility of abuse.

Recognition of Abuse of Children with Disability

Recognition of abuse can be difficult in that:

- symptoms and signs may be confused.
- the child may not recognise the behaviour as abusive.
- the child may have communication difficulties and be unable to disclose abuse.
- there may be a dependency on several adults for intimate care.
- there is a reluctance to accept that children with disabilities may be abused.

Children with disability will usually display the same symptoms and signs of abuse as other children. These may be incorrectly attributed, however, to the child's disability.

Risk Factors Associated with Child Abuse

A number of factors may increase the likelihood of abuse to a child. The following list is not exhaustive and does not preclude the possibility of abuse in families where none of these factors are evident.

Child

- poor bonding due to neo-natal problems
- attachment interfered with by multiple caring arrangements.
- a 'difficult' child, a 'demanding' baby.
- a child under five years is considered to be most vulnerable.
- a child's name or sibling's names previously on the Child Protection Register
- a baby/child with feeding/sleeping difficulties.

- birth defects/chronic illness/developmental delay.

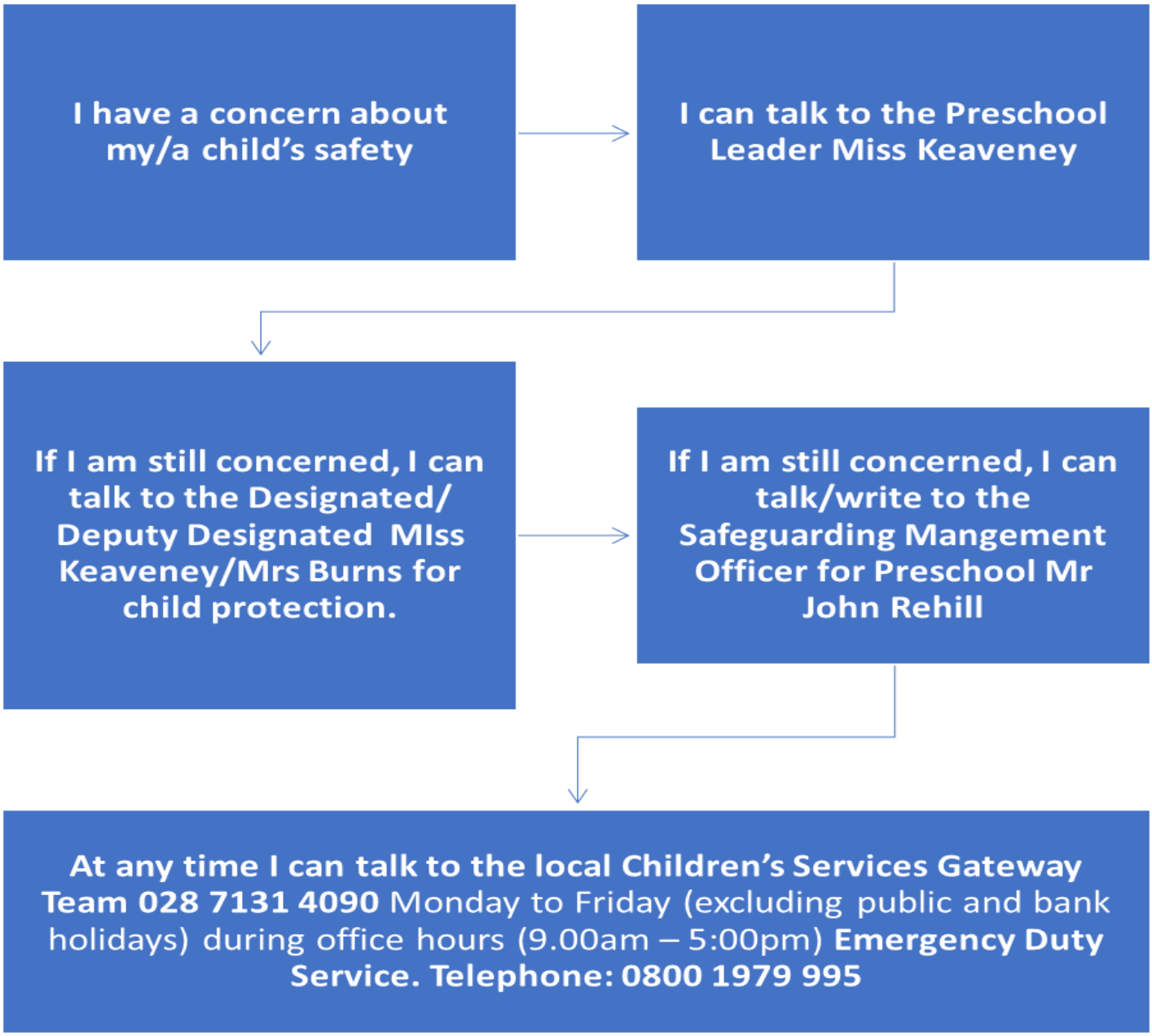
- both young and immature (i.e., aged 20 years and under) at birth of the child.
- parental history of deprivation and/or abuse
- slow jealousy and rivalry with the child
- expect the child to meet their needs.
- unrealistic expectations/rigid ideas about child development
- history of mental illness in one or both parents
- history of domestic violence
- drug and alcohol misuse in one or both parents of the child
- frequent changes of carers
- history of aggressive behaviour by either parent
- unrealistic expectations of themselves as parents.

Home and Environmental Conditions

- unemployment
- no income/poverty
- poor housing or overcrowded housing
- social isolation and no supportive family
- the family moves frequently.
- debt
- large family

APPENDIX 5

If a Parent Has a Potential Child Protection Concern Within the Preschool



If you have escalated your concern as set out in the above flowchart and are of the view that it has not been addressed satisfactorily, you may revert to the preschool's complaints policy. This policy should culminate in the option for you to contact the NI Public Services Ombudsman (NIPSO) who has the legislative power to investigate your complaint.

If a parent has a concern about a child's safety or suspect child abuse within the local community, it should be brought directly to the attention of the Children's Services Gateway Team. **028 7131 4090**

Emergency Duty Service. Telephone: 0800 1979 995

APPENDIX 6

Procedure Where the Preschool Has Concerns, or Has Been Given Information, about Possible Abuse by Someone Other Than a Member of Staff

Member of Preschool staff completes the Note of Concern on what has been observed or shared and must

ACT PROMPTLY.

Source of concern is notified that the preschool will follow up appropriately on the issues raised.

↓

Preschool Staff member discusses concerns with the Designated Leader Lisa Keaveney or Deputy Designated assistant Maria Burns in his/her absence and provides note of concern.

↓

Designated Leader Miss Keaveney should consult with the Safeguarding Management officer Mr John Rehill before deciding upon action to be taken, always taking care to avoid undue delay. If required advice may be sought from our Duty social worker.

↓

Designated LeaderMiss Keaveney Mrs Burns clarifies/discusses concern with child/ parent/carers and decides if a child protection referral is or is not required.

Child Protection Referral Is Required

Designated Leader Miss Keaveney seeks consent of the parent/carer and/or the child unless this would place the child at risk of significant harm then telephones the Children's Services Gateway Team and/or the PSNI if a child is at immediate risk. He/she submits a completed UNOCINI referral form within 24 hours.

Child Protection Referral Is Not Required

preschool may consider other options including monitoring the situation within an agreed timescale; signposting or referring the child/parent/carers to appropriate support services such as the Children's Services Gateway Team or local Family Support Hub with parental consent.

↓

Where appropriate the source of the concern will be informed as to the action taken. The Designated leader Miss Keaveney will maintain a written record of all decisions and actions taken and ensure that this record is appropriately and securely stored in the locked filling cabinet

APPENDIX 7

Dealing with Allegations of Abuse against a Member of Staff