Friends' School Lisburn Preparatory Department

Safeguarding Policy

1. ETHOS

The Friends' School Preparatory Department Child Safeguarding Policy is drawn up in the context of the ethos of the School and in line with our Mission Statement, which states that Friends' School seeks to provide an environment in which pupils, staff and parents are committed to the idea of excellence within a caring, supportive community.
We have a responsibility for the safeguarding and child protection of the children in our care. This policy sets out guidance on the action, which is required where abuse or harm to a child is suspected and outlines referral procedures within the Preparatory Department.

2. CONTEXT

This Policy is set within the context of:

- The United Nations Convention on the Rights of the Child 1991
- The Children (NI) Order 1995
- "Co-operating to Safeguard Children and Young People in Northern Ireland" (DHSSPSNI, 2017 and 2024)
- Department of Education (Northern Ireland) guidance "Safeguarding and Child Protection in Schools" Circular 2017/04 (and subsequent amendments)
- SBNI Core Child Protection Policy and Procedures (2017)

The child protection policy complements and supports a range of other Preparatory Department policies including:

- Positive Behaviour
- Pastoral Care
- Addressing Bullying
- Special Educational Needs
- First Aid and Administration of Medicines
- Intimate Care
- E-Safety
- Critical Incident

Copies of these policies are available to parents and can be obtained by contacting the School Office.

3. AIMS

Friends' School has a responsibility for the welfare and safety of all pupils and endeavours to maintain a strong pastoral ethos based on a commitment to care, open communication, relationships of trust, cooperation and good sense.

The aims of the Child Protection and Safeguarding Policy are:

- To provide a secure framework in relation to safeguarding/child protection
- To outline the signs and symptoms of possible child abuse
- To set down clear procedures to be followed when a disclosure or suspected child abuse incident occurs
- To define the roles and responsibilities of persons involved
- To provide a Code of Conduct for staff

The following principles form the basis of our Child Protection and Safeguarding Policy:

- The child or young person's welfare is paramount
- The voice of the child or young person should be heard
- Parents are supported to exercise parental responsibility and families helped stay together
- Partnership, Prevention and Protection
- Responses should be proportionate to the circumstances
- Evidence based and informed decision making

4. ROLES AND RESPONSIBILITIES

The following are members of the Department's Safeguarding Team:

- Chair of the Board of Governors **Andrew Greer**
- Designated Governor for Child Protection **Latifa McCullagh**
- Principal **Stephen Moore**
- Head of Preparatory Department and Designated Teacher **Ruth Watson**
- Deputy Designated Teacher(s) **Clare Monteith**

The team may co-opt other members as required to help address specific issues, for example the Learning Support Coordinator and ICT Coordinator, etc.

(a) Governors

The Board of Governors has a duty to safeguard and promote the welfare of all pupils at Friends' School and to ensure that an appropriate Safeguarding Policy and procedures are in place. Latifa McCullagh is the Governor with responsibility for Safeguarding. The Chair of the Board of Governors, Andrew Greer and Latifa McCullagh are members of Friends' School Safeguarding Team.

The Board of Governors has a duty to ensure that correct procedures are followed for recruitment and selection of staff and that all staff (paid and unpaid) are vetted in accordance with DE Circulars 2006/06, 2006/07, 2006/25 and 2008/03

(b) Principal

In the event of an allegation, suspicion or instance of Child Abuse, the **Principal** will:

- consider the report received from the Designated Teacher (or Deputy Designated Teacher)
- ensure that appropriate procedures are implemented, including the immediate safeguarding of a pupil considered at risk
- decide on the need for a referral, either informal or formal, to Social Services, to the Designated Officer of SEELB and to other agencies, as appropriate
- inform the Chair of the Board of Governors and the other members of the Safeguarding Team
- maintain records of disclosures of abuse, suspicions of abuse and complaints against staff
- inform parents, as and when appropriate
- initiate vetting procedures for all new staff and volunteers
- respond to concerns under the School's Complaints Procedure

(c) Designated Teacher/Deputy Designated Teacher

In Friends' School Preparatory Department, the Designated Teacher for Safeguarding is Ruth Watson Head of the Preparatory Department. The Deputy Designated Teacher is Clare Monteith, Pastoral Care Lead Teacher.

The **Designated Teacher** and **Deputy Designated Teachers** will:

- lead the planning, implementation and development of procedures for Safeguarding in Friends' School Preparatory Department
- train teaching and non-teaching staff and provide guidance in a Code of Conduct
- attend relevant training for DTs/DDTs in line with statutory requirements
- provide Child Protection and Safeguarding guidelines for temporary visitors to School, e.g., coaching staff and student teachers
- ensure that all pupils have been appropriately informed about the arrangements for Safeguarding in School
- receive concerns and reports from staff on all Child Protection matters
- collate details of such reports or concerns through Notes of Concern and the Child Protection List
- maintain child protection records in line with DE 2020/07
- keep the Principal informed of incidents and developments
- report incidents or suspicions of child abuse happening in or outside School to Social Services/SEELB Duty Officer on common format referral tool, the UNOCINI
- liaise with outside agencies
- liaise with parents concerned, as appropriate
- ensure that there is appropriate support available to children and young people on the Child Protection register, have disclosed abuse or are considered at particular risk
- communicate the Child Protection and Safeguarding Policy every two years with parents
- ensure that there is a timetabled annual review of the Child Protection and Safeguarding Policy

- report to Governors annually (It is best practice that they receive a termly report of child protection activities) This report should include details of the preventative curriculum and any initiatives or awareness raising undertaken within the school, including training for staff.
- plan opportunities within the PDMU curriculum to address issues with pupils

(d) Staff will**:**

- take steps to ensure that pupils in their care are protected from harm
- attend annual Safeguarding training
- be alert for signs and symptoms of possible Child Abuse
- know who the Designated Teacher and Deputy Designated Teachers are
- be familiar with the School's Safeguarding Policy
- be familiar with the School's Addressing Bullying Policy
- know and follow the child protection procedures
- know and follow guidance on talking with children in the event of a disclosure
- report disclosures or concerns of possible abuse to Designated Teacher or Deputy, via a Note of Concern
- Keep a brief written record of details
- ensure that their own professional conduct is prudent

(e) Parents

Friends' School Preparatory Department values and seeks to promote open communication and good relationships with parents, responding readily and consistently to any concerns raised. The primary responsibility for safeguarding and protection of children rests with parents, who should feel confident about raising any concerns they have in relation to their child.
Parents wishing to register concern about their child's welfare in School should take one of the following courses of action, depending on the nature of the concern:

- speak/write to a pupil's Class Teacher
- speak/write to Designated Teacher (Head of Department) or Deputy Designated Teacher (Pastoral Care Lead Teacher)
- speak/write to the Principal
- write to Chairman of Board of Governors

All concerns will be followed up as appropriate.

Parents can play their part in safeguarding by informing the school:

- If the child has a medical condition or educational need.
- If there are any Court Orders relating to the safety or wellbeing of a parent or child.
- If there is any change in a child's circumstances for example - change of address, change of contact details, change of name, change of parental responsibility.
- If there are any changes to arrangements about who brings their child to and from school.

- If their child is absent by telephone or email on each day of absence and should send in a note on the child's return to school. This assures the school that the parent/carer knows about the absence.

5. CHILD PROTECTION DEFINITIONS

Child Abuse occurs when a child is neglected, harmed or not provided with proper care. Staff in School are well placed to observe symptoms in pupils' appearance, behaviour, learning progress, attendance or language which may indicate incidents of actual or possible Child Abuse. ***ALL CONCERNS AND DISCLOSURES MUST BE REPORTED***

Appendix 1 contains details on the categories of Child Abuse.

6. RESPONDING TO SAFEGUARDING AND CHILD PROTECTION CONCERNS

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.

Appendix 2 contains details on signs and symptoms of abuse.

(a) Parental concerns

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 Class Teacher, the Head of Preparatory Department (Designated Teacher) or Deputy Designated Teacher for child protection or the Principal. If they are still concerned, they may talk to the Chair of the Board of Governors.
At any time, a parent may talk to a social worker in the local Gateway team or to the PSNI Central Referral Unit. Details of who to contact are shown in the flowchart in **Appendix 4**

(b) Pupil disclosure or staff concerns

In Friends' School Preparatory Department, if a child makes a disclosure to a teacher 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 school guidelines provide staff with a framework for action.

School recognizes that it takes courage and determination for a pupil to tell an adult that s/he is being abused and issues around disclosures are usually complex and very sensitive. Staff

can often feel vulnerable in this situation and the following points are designed to reassure staff and provide support for them in the situation.

Guidelines

- Ensure that the pupil is safe from risk
- React calmly without displaying shock or disbelief
- Reassure the pupil and tell him/her that s/he is not to blame
- Try to control feelings about the perpetrator
- Listen and accept what is said, without comment on what is disclosed
- **Do not investigate**, this is a matter for Social Services, ask questions for clarification only
- Do not promise confidentiality to pupil –only those persons who need to know will be told
- If possible complete a Note of Concern (see **Appendix 3**) Keep written notes of the incident including time/date/location/nonverbal behaviour/physical signs/to whom referral was made as close to incident occurring as possible
- Use the words the pupil uses
- **Act promptly**. Inform the Designated Teacher or the Deputy Designated Teacher if she is not available. Do not discuss with other colleagues.
- Be available to support pupil as appropriate after the disclosure

The Designated Teacher will consult with the Principal, **always taking care to avoid due delay.** If required, advice may be sought from the Education Authority Designated Officer for Child Protection. The Designated Teacher may also seek clarification from the child or young person, their parent/carer.

If a child protection referral is not required the school 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's consent.

If a child protection referral is required, the Designated Teacher 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.

In consultation with the Principal, the Designated Teacher will phone Social Services and/or the PSNI 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 5**

(c) 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 Principal (or the Designated Teacher, if the Principal is not available) must be informed immediately. If the complaint is against the Principal, then the Designated Teacher should be informed, and she will inform the Chairperson of the Board of Governors who will consider what action is required in consultation with the employing authority. The procedure as outlined in **Appendix 6** will be followed.

7. CONSENT

Prior to making a referral to Social Services the consent of the parent/carers and/or the young person (if they are competent to give this) will normally be sought. The exception to this is where to seek such consent would put that child or others at increased risk of significant harm or an adult at risk of serious harm, or it would undermine the prevention, detection or prosecution of a serious crime including where seeking consent might lead to interference with any potential investigation. Our primary consideration must be the safety and welfare of the child, and we will make a referral in cases where consent is withheld if we believe, based on the information available, that it is in the best interests of the child to do so.

8. CONFIDENTIALITY AND INFORMATION SHARING

Information given to members of staff about possible child abuse cannot be held "in confidence". In the interests of the child, staff have a responsibility to share relevant information about the protection of children with other professionals particularly the investigative agencies. In keeping with the principle of confidentiality, the sharing of information with school staff will be on a 'need to know' basis.

Where there have been, or are current, child protection concerns about a pupil who transfers to another school we will follow DE guidance in determining what information should be shared with the Designated Teacher in the receiving school.

Where it is necessary to safeguard children, information will be shared with other statutory agencies in accordance with the requirements of this policy, the school data protection policy and the General Data Protection Regulations (GDPR).

In accordance with DE guidance, we have clear guidelines for the recording, storage, retention and destruction of both manual and electronic records where they relate to child protection concerns.

To meet these requirements all child protection records, information and confidential notes concerning pupils in the Preparatory Department are stored securely and only the Designated Teacher/Deputy Designated Teachers and Principal have access to them. In accordance with DE guidance on the disposal of child protection records these records will be stored from child's date of birth plus 30 years.
If information is held electronically, it is stored in a Private Folder, encrypted and appropriately password protected.

These notes or records should be factual, objective and include what was seen, said, heard or reported. They should include details of the place and time and who was present and should be given to the Designated/Deputy Designated Teacher. The person who reports the incident must treat the matter in confidence.

If a pupil from our school attends an EOTAS provision, a member of the safeguarding team will share any child protection concerns they have with the DT in the centre. If child protection

concerns arise when the pupil is attending an EOTAS provision the designated teacher in EOTAS will follow child protection procedures and will advise a member of the school's safeguarding team of the concerns and any actions taken. It is the responsibility of EOTAS staff to maintain their records in accordance with DE Circular 2020/07 Child Protection: Record Keeping in Schools and any subsequent updates.

9. RECRUITING AND VETTING OF STAFF AND VOLUNTEERS

Vetting checks are a key preventative measure in preventing unsuitable individuals' access to children and vulnerable adults through the education system and schools must ensure that all persons on school property are vetted, inducted and supervised as appropriate if they are engaged in regulated activity. All staff paid or unpaid who are appointed to positions in Friends' School Preparatory Department are vetted/supervised in accordance with relevant legislation and Departmental guidance.

10. CODE OF CONDUCT FOR ALL STAFF

All actions concerning children and young people must uphold the best interests of the young person as a primary consideration. Staff must always be mindful of the fact that they hold a position of trust and that their behaviour towards the child and young people in their charge must be above reproach. All members of staff are expected to comply with the school's Code of Conduct for Employees and Volunteers which has been approved by the Board of Governors.

11. OPERATION ENCOMPASS

Friends' School Preparatory Department is 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 school, we recognise 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 school 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 school at the start of the next working day to share this information with a member of the school safeguarding team. This will allow the school safeguarding team to provide immediate emotional support to this child as well as giving the designated teacher greater 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.

For further information see The Domestic Abuse Information Sharing with Schools etc. Regulations (Northern Ireland) 2022.

12. RESIDENTIAL TRIPS

For trips in Categories 3, 4 and 5 (overnight stays), the Designated Teacher will brief the lead teacher on how to implement a Safety Plan in cases where a disclosure is made, or an incident takes place on the trip. Prior to departure, the Designated Teacher will also provide a safeguarding update for the lead teacher to include specific safeguarding needs. This will be done in liaison with the pupil and parent so that appropriate care can be implemented, and a specific Safety Plan will be provided where necessary. In cases where a decision is made that it is unsafe for a child to participate in a school trip, this will be done in consultation with the Principal, Head of Preparatory Department, lead teacher, pupil and parent.

13. THE PREVENTATIVE CURRICULUM

The statutory curriculum requires schools to give specific attention to pupils' emotional wellbeing, health and safety, relationships, and the development of a moral thinking and value system. The curriculum also offers a medium to explore sensitive issues with children and young people in an age-appropriate way which helps them to develop appropriate protective behaviours. (DE guidance "Safeguarding and Child Protection in Schools" Circular 2017/04 and subsequent amendments)

The Preparatory Department seeks to promote pupils' awareness and understanding of safeguarding issues, including those related to child protection, through its curriculum. The safeguarding of children is an important focus in the school's personal development programme and is also addressed where it arises within the context of subjects.

Through the preventative curriculum we aim to build the confidence, self-esteem and personal resiliencies of children so that they can develop coping strategies and can make more positive choices in a range of situations.

Throughout the school year, safeguarding and child protection issues are addressed through school assemblies and there is a permanent child protection display in the entrance area outside the school office. Relevant information is displayed around the school, in both the Prep 1-3 and Prep 4-7 areas, which provide advice and display child helpline numbers.

Other initiatives which address child protection and safety issues include an annual Wellbeing Week in October, Anti-Bullying Week in November and Internet Safety Day in February. Prep 7 take part in the Love for Life programme in term 3 and other visitors have included Made for More and paramedics, fire fighters and the PSNI.

Friends' School has a school nurse, Joan Newberry, who provides care for Preparatory Department pupils.

14. MONITORING AND EVALUATION

This policy will be reviewed and approved by the Board of Governors for dissemination to parents and staff. It will be implemented through the school's staff induction and training programme and as part of day-to-day practice. Compliance with the policy will be monitored on an on-going basis by the Designated Teacher for Child Protection The Board of Governors will also monitor child protection activity and the implementation of the Safeguarding and Child Protection policy on a regular basis through the provision of reports from the Designated Teacher.

Any member of staff who complies with School's procedures and guidance and who acts in good faith will receive the full support of the Board of Governors and will not be legally or financially liable.

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Next Review March 2028

Appendix 1

CATEGORIES OF CHILD ABUSE

Harm can be suffered by a child or young person by acts of abuse perpetrated upon them by others. Abuse can happen in any family, but children may be more at risk if their parents have problems with drugs, alcohol and mental health, or if they live in a home where domestic abuse happens. Abuse can also occur outside of the family environment. Evidence shows that babies and children with disabilities can be more vulnerable to suffering abuse.
Although the harm from the abuse might take a long time to be recognisable in the child or young person, professionals may be in a position to observe its indicators earlier, for example, in the way that a parent interacts with their child. Effective and ongoing information sharing is key between professionals.

Harm from abuse is not always straightforward to identify and a child or young person may experience more than one type of harm.

Harm can be caused by:

Sexual abuse
Emotional abuse
Physical abuse
Neglect
Exploitation

SEXUAL ABUSE occurs when others use and exploit children sexually for their own gratification or gain or the gratification of others. Sexual abuse may involve physical contact, including assault by penetration (for example, rape, or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside clothing. It may include non-contact activities, such as involving children in the production of sexual images, forcing children to look at sexual images or watch sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via e-technology). Sexual abuse is not solely perpetrated by adult males. Women can commit acts of sexual abuse, as can other children.

EMOTIONAL ABUSE is the persistent emotional maltreatment of a child. It is also sometimes called psychological abuse and it can have severe and persistent adverse effects on a child's emotional development.

Emotional abuse may involve deliberately telling a child that they are worthless, or unloved and inadequate. It may include not giving a child opportunities to express their views, deliberately silencing them, or 'making fun' of what they say or how they communicate. Emotional abuse may involve bullying – including online bullying through social networks, online games or mobile phones – by a child's peers.

PHYSICAL ABUSE is deliberately physically hurting a child. It might take a variety of different forms, including hitting, biting, pinching, shaking, throwing, poisoning, burning or scalding, drowning or suffocating a child.

NEGLECT is the failure to provide for a child's basic needs, whether it be adequate food, clothing, hygiene, supervision or shelter that is likely to result in the serious impairment of a child's health or development. Children who are neglected often also suffer from other types of abuse.

EXPLOITATION is the intentional ill-treatment, manipulation or abuse of power and 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, and 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. Exploitation can be sexual in nature.

Although 'exploitation' is not included in the categories of registration for the Child Protection Register, professionals should recognise that the abuse resulting from or caused by the exploitation of children and young people can be categorised within the existing CPR categories as children who have been exploited will have suffered from physical abuse, neglect, emotional abuse, sexual abuse or a combination of these forms of abuse.

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 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 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.

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. Any child under the age of eighteen, male or female, can be a victim of CSE. 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.

DOMESTIC AND SEXUAL ABUSE

The NI Domestic and Sexual Abuse strategy 2024 - 2031 defines domestic and sexual violence and abuse as follows:

Domestic Abuse is:

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 Abuse is:

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).

Further information about Domestic Abuse Information Sharing with Schools etc. Regulations (Northern Ireland) 2022 can be found by following the link to: https://www.legislation.gov.uk

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. 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.

CHILDREN WHO DISPLAY HARMFUL SEXUAL BEHAVIOUR

Sexually harmful behaviour is primarily a child protection concern. There may remain issues to be addressed through the school's positive behaviour policy, but it is important to always apply principles that remain child centred.

It is important to distinguish between different sexual behaviours - these can be defined as **normal, inappropriate, problematic, abusive or violent.**

Normal sexual behaviour will generally have no need for intervention; however, consideration may be required as to appropriateness within a school setting.

Inappropriate sexual behaviour requires some level of intervention, depending on the activity and level of concern. For example, a one-off incident may simply require liaising with parents on setting clear direction that the behaviour is unacceptable, explaining boundaries and providing information and education. However, if the behaviour is considered to be more serious, perhaps because there are a number of aspects of concern, advice from the EA Child Protection Support Service (CPSS) may be required. The CPSS will advise if contact with PSNI or Social Services is required.

Problematic, abusive and violent sexual behaviours are of significant concern and guidance on the management of the pupils within the school and referral to other agencies such as the PSNI or Social Services will be sought from CPSS.

DE Circular 2022/02 addresses concerns about harmful sexualised behaviour displayed by children and young people.

ONLINE SAFETY

Online safety means acting and staying safe when engaging in the online world. It is wider than simply internet technology and includes electronic communication via text messages, making comments on social media posts, social environments and apps, and using games consoles through any digital device. The overall strategic direction for child safety online is the **Keeping Children and Young People Safe: An Online Safety Strategy**, published in February 2021. It sets out the Northern Ireland Executive's ambition that all children and young people enjoy the educational, social and economic benefits of the online world, and that they are empowered to do this safely, knowledgably and without fear. The Strategy recognises that the ever-changing and fast-growing online environment presents both extensive educational benefits as well challenges in terms of keeping children and young people safe from the dangers of inappropriate communication and content.

Sharing nudes and semi-nudes is a term used to describe the sending or posting of

CHILDREN WITH INCREASED VULNERABILITIES

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) and children whose first language is not English may be more vulnerable to abuse. Communication difficulties make disclosure particularly difficult.

APPENDIX 2

Signs and Symptoms of Child Abuse

This section contains information for all professionals 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 and 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 marks
- 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,
- 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.

b) 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.

c) Burns and Scalds

Accidental scalds often:

- are on the upper part of the body
- are on a convex (curved) surface
- are irregular
- are superficial
- leave a recognisable pattern.

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. 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:

- 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 Criml (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 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 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 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 (3-4years)

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.

Primary School Age Children

In addition to the above there may be other behaviour especially noticeable in school:

- poor peer group relationships and inability to make friends.
- inability to concentrate, learning difficulties or a sudden drop in school performance.
- reluctance to participate in physical activity or to change clothes for physical education, games or swimming.
- unusual or bizarre sexual themes in child's art work or stories.
- frequent absences from school that are justified by one parent only, apparently without regard for its implications for the child's school performance.
- unusual reluctance or fear of going home after school.

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 pathognomic 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 over anxious 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 several 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
- repeated running away from home
- substance misuse
- 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 school/late being collected
- not wanting to go home from school or refusing to go to school
- poor attendance at school
- 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/her
- 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
- low 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
- 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
- geographical stereotyping
- 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)

When staff become aware of any of the above features they should review the case with their line manager.

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.**Parents**

- both young and immature (i.e. aged 20 years and under) at birth of the child
- parental history of deprivation and/or abuse
- show 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
- unplanned pregnancy
- 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 3

CONFIDENTIAL

Friends' School Lisburn
Preparatory Department

NOTE OF CONCERN

Child Protection Record - Reports to Designated Teacher

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 Teacher: Yes: No: If 'No' state reason:
Date And Time Of Report To The Designated Teacher:
Written Note From Staff Member Placed On Pupil's Child Protection File Yes No If 'No' state reason:

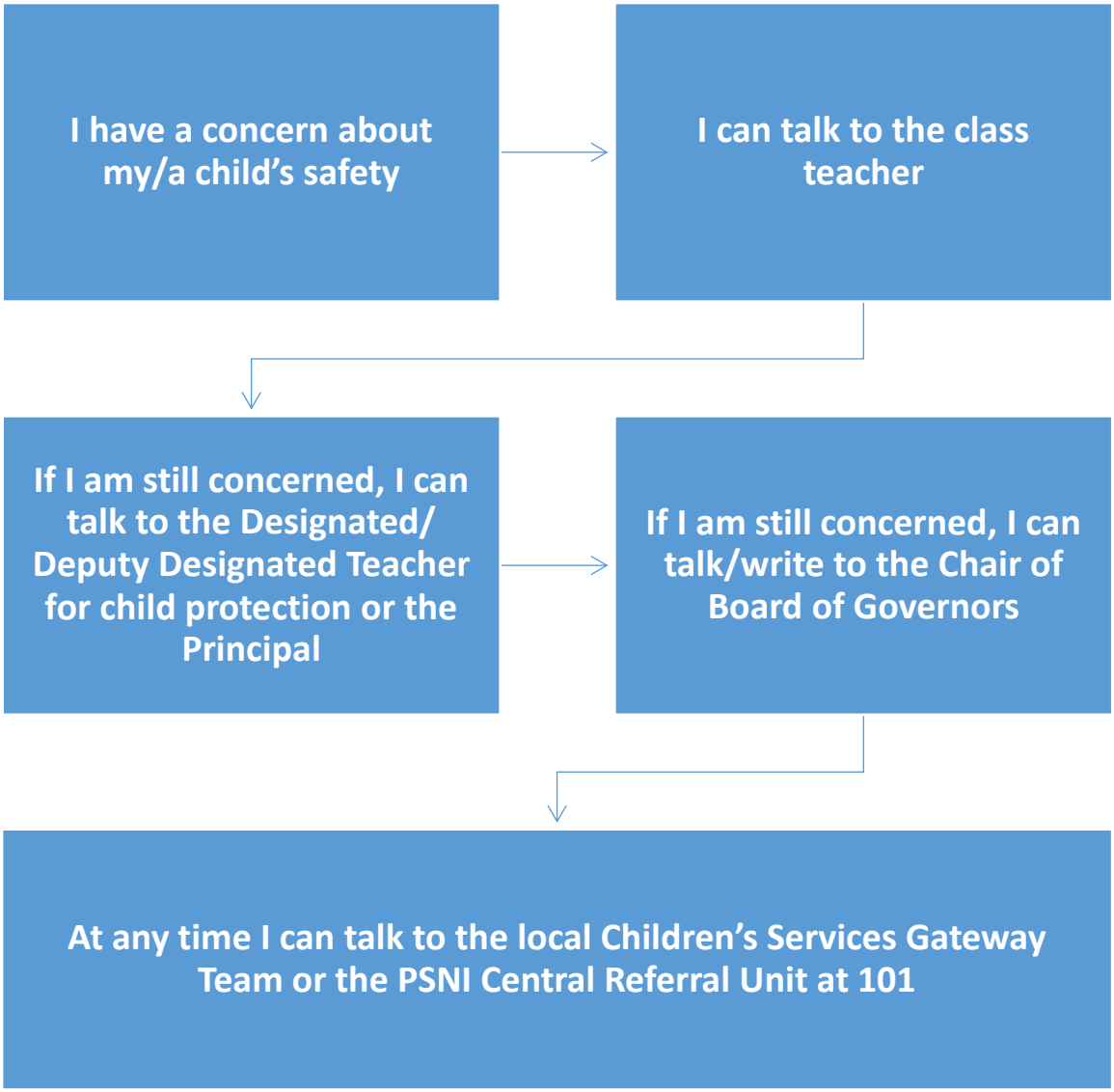
Name of Staff Member Making the Report: _____

Signature of Staff Member: _____ Date: _____

Signature of Designated Teacher: _____Date: _____

APPENDIX 4

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

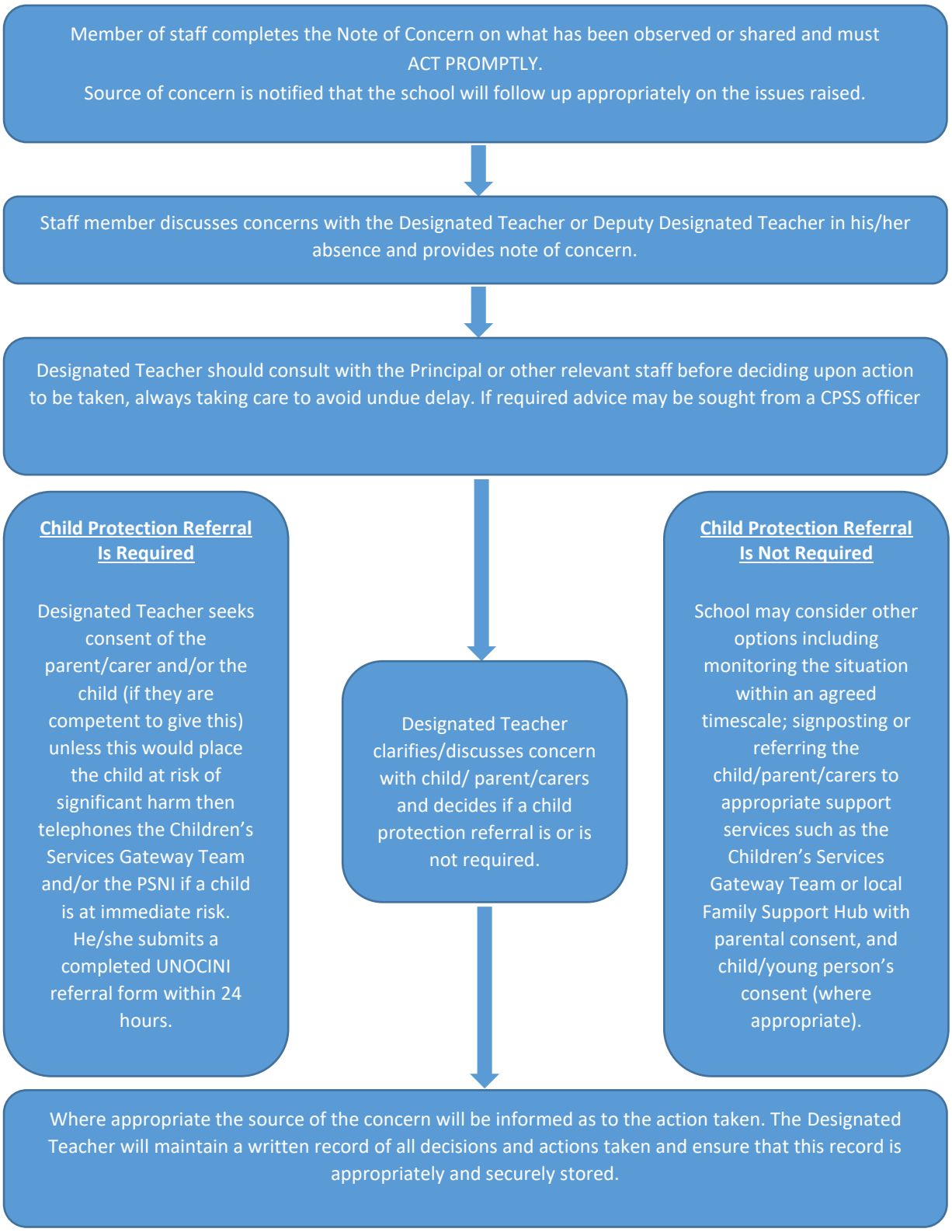


If you have escalated your concern as set out in the above flowchart and are of the view that it has not been addressed satisfactorily, you may revert to the school's complaints policy. This policy should culminate in the option for you to contact the NI Public Services Ombudsman (NIPSO) who has the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

APPENDIX 5

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



APPENDIX 6

Dealing with Allegations of Abuse against a Member of Staff