DOMINICAN COLLEGE MUCKROSS PARK

CHILD PROTECTION POLICY

(Revised policy adopted by the BOM 29th November 2016)

The Board of Management recognises that child protection and welfare considerations permeate all aspects of school life and must be reflected in all of the school's policies, practices and activities. Accordingly, in accordance with the requirements of the Department of Education and Skills' Child Protection Procedures for Primary and Post Primary Schools, the Board of Management of Muckross Park College has agreed the following child protection policy:

1. The Board of Management has adopted and will implement fully and without modification the Department's Child Protection Procedures for Primary and Post Primary Schools as part of this overall child protection policy.

2. The Designated Liaison Person (DLP) is Ms. Anne Marie Mee

3. The Deputy Designated Liaison Person (Deputy DLP) is Ms. Siobhán Kelly

4. In its policies, practices and activities, Muckross Park College will adhere to the following principles of best practice in child protection and welfare:
   The school will
   - recognise that the protection and welfare of children is of paramount importance, regardless of all other considerations;
   - fully co-operate with the relevant statutory authorities in relation to child protection and welfare matters
   - adopt safe practices to minimise the possibility of harm or accidents happening to children
   - protect workers from the necessity to take unnecessary risks that may leave themselves open to accusations of abuse or neglect;
   - develop a practice of openness with parents and encourage parental involvement in the education of their children; and
   - fully respect confidentiality requirements in dealing with child protection matters.

   The school will also adhere to the above principles in relation to any adult pupil with a special vulnerability.

5. This is a list of school policies, practices and activities that are particularly relevant to child protection:

POLICIES	**PRACTICES/ ACTIVITIES**	
Mission Statement	Supervision of Pupils	Sporting Activities
The Code of Behaviour	Laboratory Rules	School Outings/Trips
Anti-bullying Policy	SPHE/RSE	TY Work Experience

Day Trips Policy	Guidance Counsellor	CSPE
Overnight Trips Policy	Staff RecruitmentProcedures	Workshops
Code of Conduct for Sports Coaches	Changing for games, etc.	Retreats
Dignity Charter	Staff conduct	Music Events
Internet Use Policy	Recording of Accidents/Incidents	Debating
Pastoral Care Policy	Administering First Aid	Visiting students
Guidance Policy	One to One teaching/meeting	Home Economics
RE Policy	Visitors and Guest Speakers	Biology/Science/Chemistry/Physics labs
Special Needs Policy	P.E.	Parent Teacher Meetings
Substance Abuse Policy	Supervision & Substitution	After-School Study
Mobile Phone Policy	Student Attendance	Library
CCTV Policy	R.E.	Coaches
Health and Safety Policy	School Plant Maintenance staff School Security System	Curriculum content

The Board has ensured that the necessary policies, protocols or practices as appropriate are in place in respect of each of the above listed items.

6. This policy has been made available to school personnel and the Parents' Association and is readily accessible to parents on request. A copy of this policy will be made available to the Department and the patron if requested.

7. This policy will be reviewed by the Board of Management once in every school year.

This revised policy was adopted by the Board of Management on 29th November 2016

Signed: _____
Mary White
Chairperson of Board of Management

Date: 29th November 2016

Signed: _____
Anne Marie Mee
Principal

Date: 29th November 2016

Date of next review: ***November 2017***

Appendix 2: Checklist for Annual Review of the Child Protection Policy

The Board of Management must undertake an annual review of its child protection policy and the following checklist shall be used for this purpose.

The checklist is designed as an aid to conducting this review and is not intended as an exhaustive list.

Individual Boards of Management may wish to include other items in the checklist that are of particular relevance to the school in question.

	Yes/No
Has the Board formally adopted a child protection policy in accordance with the 'Child Protection Procedures for Primary and Post Primary Schools'?	Y
As part of the school's child protection policy, has the Board formally adopted, without modification, the 'Child Protection Procedures for Primary and Post Primary Schools'?	Y
Are there both a DLP and a Deputy DLP currently appointed?	Y
Are the relevant contact details (HSE and An Garda Síochána) to hand?	Y
Has the DLP attended available child protection training?	Y
Has the Deputy DLP attended available child protection training?	Y
Have any members of the Board attended child protection training?	Y
Has the school's child protection policy identified other school policies, practices and activities that are regarded as having particular child protection relevance?	Y
Has the Board ensured that the Department's "Child Protection Procedures for Primary and Post Primary Schools" are available to all school personnel?	Y
Has the Board arrangements in place to communicate the school's child protection policy to new school personnel?	Y
Is the Board satisfied that all school personnel have been made aware of their responsibilities under the 'Child Protection Procedures for Primary and Post Primary Schools'?	Y
Since the Board's last annual review, was the Board informed of any child protection reports made to the HSE/An Garda Síochána by the DLP?	N
Since the Board's last annual review, was the Board informed of any cases where the DLP sought advice from the HSE and as a result of this advice, no report to the HSE was made?	Y
Is the Board satisfied that the child protection procedures in relation to the making of reports to the HSE/ An Garda Síochána were appropriately followed?	N/A N/A
Were child protection matters reported to the Board appropriately recorded in the Board minutes?	Y
Is the Board satisfied that all records relating to child protection are appropriately filed and stored securely?	Y
Has the Board ensured that the Parents' Association (if any), has been provided with the school's child protection policy?	Y
Has the Board ensured that the school's child protection policy is available to parents on request?	N/A
Has the Board ensured that the Stay Safe programme is implemented in full in the school?	

(applies to primary schools)	
Has the Board ensured that the SPHE curriculum is implemented in full in the school?	Y
Is the Board satisfied that the Department's requirements for Garda Vetting have been met in respect of all school personnel (employees and volunteers)? *	Y
Is the Board satisfied that the Department's requirements in relation to the provision of a child protection related statutory declaration and associated form of undertaking have been met in respect of persons appointed to teaching and non-teaching positions?*	Y
Is the Board satisfied that, from a child protection perspective, thorough recruitment and selection procedures are applied by the school in relation to all school personnel (employees and volunteers)?*	Y
Is the Board satisfied that the 'Child Protection Procedures for Primary and Post Primary Schools' are being fully and adequately implemented by the school?	Y
Has the Board identified any aspects of the school's child protection policy and/or its implementation that require further improvement?	N
Has the Board put in place an action plan containing appropriate timelines to address those aspects of the school's child protection policy and/or its implementation that have been identified as requiring further improvement ?	N/A
Has the Board ensured that any areas for improvement that that were identified in any previous review of the school's child protection policy have been adequately addressed?	N/A

*In schools where the VEC is the employer the responsibility for meeting these requirements rests with the VEC concerned. In such cases, this question should be completed following consultation with the VEC.

Signed: *Mary White* Date: *29th November 2016*
Chairperson, Board of Management

Signed: *Anne Marie Mee* Date: *29th November 2016*
Principal

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Notification regarding the Board of Management's annual review of the child protection policy

To:_____

The Board of Management of Dominican College Muckross Park wishes to inform you that:

- The Board of Management's annual review of the school's child protection policy was completed at the Board meeting of *29th November 2016*.
- This review was conducted in accordance with the checklist set out in Appendix 2 of the Department's 'Child Protection Procedures for Primary and Post Primary Schools'

Signed: *Mary White* *Date: 29th November 2016*
Chairperson, Board of Management

Signed: *Anne Marie Mee* *Date: 29th November 2016*
Principal

Appendix 3: Signs and symptoms of child abuse

1. Signs and symptoms of neglect

Child neglect is the most common category of abuse. A distinction can be made between 'wilful' neglect and 'circumstantial' neglect. 'Wilful' neglect would generally incorporate a direct and deliberate deprivation by a parent/carer of a child's most basic needs, e.g. withdrawal of food, shelter, warmth, clothing, contact with others. 'Circumstantial' neglect more often may be due to stress/inability to cope by parents or carers.

Neglect is closely correlated with low socio-economic factors and corresponding physical deprivations. It is also related to parental incapacity due to learning disability or psychological disturbance.

The neglect of children is 'usually a passive form of abuse involving omission rather than acts of commission' (Skuse and Bentovim, 1994). It comprises 'both a lack of physical caretaking and supervision and a failure to fulfil the developmental needs of the child in terms of cognitive stimulation'.

Child neglect should be suspected in cases of:

- abandonment or desertion;
- children persistently being left alone without adequate care and supervision;
- malnourishment, lacking food, inappropriate food or erratic feeding;
- lack of warmth;
- lack of adequate clothing;
- inattention to basic hygiene;
- lack of protection and exposure to danger, including moral danger or lack of supervision appropriate to the child's age;
- persistent failure to attend school;
- non-organic failure to thrive, i.e. child not gaining weight due not only to malnutrition but also to emotional deprivation;
- failure to provide adequate care for the child's medical problems and developmental problems;
- exploited, overworked.

2. Characteristics of neglect

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

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

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

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

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

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

The following points illustrate the consequences of different types of neglect for children

- Inadequate food - failure to develop
- Household hazards – accidents
- Lack of hygiene – health and social problems
- Lack of attention to health – disease
- Inadequate mental health care – suicide or delinquency
- Inadequate emotional care – behaviour and educational
- Inadequate supervision – risk taking behaviour
- Unstable relationship – attachment problems
- Unstable living conditions – behaviour & anxiety, risk of accidents
- Exposure to domestic violence – behaviour, physical and mental health
- Community violence - anti social behaviour

3. Signs and symptoms of emotional abuse

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

Emotional neglect and abuse occurs when adults responsible for taking care of children are unaware of and unable (for a range of reasons) to meet their children's emotional and developmental needs. Emotional

neglect and abuse is not easy to recognise because the effects are not easily observable. Skuse (1989) states that 'emotional abuse refers to the habitual verbal harassment of a child by disparagement, criticism, threat and ridicule, and the inversion of love; whereby verbal and non-verbal means of rejection and withdrawal are substituted'.

Emotional neglect and abuse can be defined with reference to the indices listed below. However, it should be noted that no one indicator is conclusive of emotional abuse.
In the case of emotional abuse and neglect, it is more likely to impact negatively on a child where there is a cluster of indices, where these are persistent over time and where there is a lack of other protective factors

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

Children who are physically and sexually abused and neglected also suffer from emotional abuse.

4. Signs and symptoms of physical abuse

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

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

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

Bruises

Accidental

Accidental bruises are common at places on the body where bone is fairly close to the skin. Bruises can also be found towards the front of the body, as the child usually will fall forwards.

Accidental bruises are common on the chin, nose, forehead, elbow, knees and shins. An accident-prone child can have frequent bruises in these areas. Such bruises will be diffuse, with no definite edges. Any bruising on a child before the age of mobility must be treated with concern.

Non-accidental
Bruises caused by physical abuse are more likely to occur on soft tissues, e.g. cheek, buttocks, lower back, back, thighs, calves, neck, genitalia and mouth.

Marks from slapping or grabbing may form a distinctive pattern. Slap marks might occur on buttocks/cheeks and the outlining of fingers may be seen on any part of the body. Bruises caused by direct blows with a fist have no definite pattern, but may occur in parts of the body that do not usually receive injuries by accident. A punch over the eye (black eye syndrome) or ear would be of concern. Black eyes cannot be caused by a fall on to a flat surface. Two black eyes require two injuries and must always be suspect. Other distinctive patterns of bruising may be left by the use of straps, belts, sticks and feet. The outline of the object may be left on the child in a bruise on areas such as the back or thighs (areas covered by clothing).
Bruises may be associated with shaking, which can cause serious hidden bleeding and bruising inside the skull. Any bruising around the neck is suspicious since it is very unlikely to be accidentally acquired. Other injuries may feature – ruptured eardrum/fractured skull.
Mouth injury may be a cause of concern, e.g. torn mouth (frenulum) from forced bottle-feeding.

Bone injuries
Children regularly have accidents that result in fractures. However, children's bones are more flexible than those of adults and the children themselves are lighter, so a fracture, particularly of the skull, usually signifies that considerable force has been applied.

Non-accidental
A fracture of any sort should be regarded as suspicious in a child under 8 months of age. A fracture of the skull must be regarded as particularly suspicious in a child under 3 years.

Either case requires careful investigation as to the circumstances in which the fracture occurred. Swelling in the head or drowsiness may also indicate injury.

Burns
Children who have accidental burns usually have a hot liquid splashed on them by spilling or have come into contact with a hot object. The history that parents give is usually in keeping with the pattern of injury observed. However, repeated episodes may suggest inadequate care and attention to safety within the house.

Non-accidental
Children who have received non-accidental burns may exhibit a pattern that is not adequately explained by parents. The child may have been immersed in a hot liquid. The burn may show a definite line, unlike the type seen in accidental splashing. The child may also have been held against a hot object, like a radiator or a ring of a cooker, leaving distinctive marks. Cigarette burns may result in multiple small lesions in places on the skin that would not generally be exposed to danger. There may be other skin conditions that can cause similar patterns and expert paediatric advice should be sought.

Bites
Children can get bitten either by animals or humans. Animal bites, e.g. dogs, commonly puncture and tear the skin, and usually the history is definite. Small children can also bite other children.

Non-accidental
It is sometimes hard to differentiate between the bites of adults and children since measurements can be inaccurate. Any suspected adult bite mark must be taken very seriously. Consultant paediatricians may liaise with dental colleagues in order to identify marks correctly.

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

Non-accidental
Non-accidental poisoning can occur and may be difficult to identify, but should be suspected in bizarre or recurrent episodes and when more than one child is involved. Drowsiness or hyperventilation may be a symptom.

Shaking violently
Shaking is a frequent cause of brain damage in very young children.

Fabricated/induced illness
This occurs where parents, usually the mother (according to current research and case experience), fabricate stories of illness about their child or cause physical signs of illness. This can occur where the parent secretly administers dangerous drugs or other poisonous substances to the child or by smothering. The symptoms that alert to the possibility of fabricated/induced illness include:

(a) symptoms that cannot be explained by any medical tests; symptoms never observed by anyone other than the parent/carer; symptoms reported to occur only at home or when a parent/carer visits a child in hospital;

(b) high level of demand for investigation of symptoms without any documented physical signs;

(c) unexplained problems with medical treatment, such as drips coming out or lines being interfered with; presence of unprescribed medication or poisons in the blood or urine.

5. Signs and symptoms of sexual abuse

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

Cases of sexual abuse principally come to light through:

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

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

Non-contact sexual abuse

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

Sexual contact

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

Oral-genital sexual abuse

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

Interfemoral sexual abuse

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

Penetrative sexual abuse, of which there are four types:

- 'Digital penetration', involving putting fingers in the vagina or anus, or both. Usually the victim is penetrated by the offender, but sometimes the offender gets the child to penetrate them.
- 'Penetration with objects', involving penetration of the vagina, anus or occasionally mouth with an object.
- 'Genital penetration', involving the penis entering the vagina, sometimes partially.
- 'Anal penetration' involving the penis penetrating the anus.

Sexual exploitation

- Involves situations of sexual victimisation where the person who is responsible for the exploitation may not have direct sexual contact with the child. Two types of this abuse are child pornography and child prostitution.
- 'Child pornography' includes still photography, videos and movies, and, more recently, computer generated pornography.
- 'Child prostitution' for the most part involves children of latency age or in adolescence. However, children as young as 4 and 5 are known to be abused in this way.

The sexual abuses described above may be found in combination with other abuses, such as physical abuse and urination and defecation on the victim. In some cases, physical abuse is an integral part of the sexual abuse; in others, drugs and alcohol may be given to the victim.
It is important to note that physical signs may not be evident in cases of sexual abuse due to the nature of the abuse and/or the fact that the disclosure was made some time after the abuse took place.
Carers and professionals should be alert to the following physical and behavioural signs:

- bleeding from the vagina/anus;
- difficulty/pain in passing urine/faeces;
- an infection may occur secondary to sexual abuse, which may or may not be a definitive sexually transmitted disease. Professionals should be informed if a child has a persistent vaginal discharge or has warts/rash in genital area;
- noticeable and uncharacteristic change of behaviour;
- hints about sexual activity;
- age-inappropriate understanding of sexual behaviour;
- inappropriate seductive behaviour;
- sexually aggressive behaviour with others;
- uncharacteristic sexual play with peers/toys;
- unusual reluctance to join in normal activities that involve undressing, e.g. games/swimming.
-

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

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

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

- depression, isolation, anger;
- running away;

- drug, alcohol, solvent abuse;
- self-harm;
- suicide attempts;
- missing school or early school leaving;
- eating disorders;

All signs/indicators need careful assessment relative to the child's circumstances.

Appendix 4: Standard Report Form for reporting child protection and/or welfare concerns to the HSE

FORM NUMBER: CC01:01:00

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

STANDARD REPORT FORM

(For reporting CP&W Concerns to HSE)

A. To Principal Social Worker/Designate: _____

1. Date of Report

2. Details of Child

Name:		Male ☐		Female ☐	
Address:		DOB		Age	
		School			
Alias		Correspondence address (if different)			

3. Details of Persons Reporting Concern(s)

Name:		Telephone No.	
Address:		Occupation:	
		Relationship to client:	
Reporter wishes to remain anonymous ☐		Reporter discussed with parents/guardians ☐	

4. Parents Aware of Report

	Yes	No
Are the child's parents/carers aware that this concern is being reported to the HSE?	☐	☐

5. Details of Report

(Details of concern(s), allegation(s) or incident(s) dates, times, who was present, description of any observed injuries, parent's view(s), child's view(s) if known.)

National Child Care Information System Project – Phase 3

FORM NUMBER: CC01:01:00

STANDARD REPORT FORM

(For reporting CP&W Concerns to HSE)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

6. Relationships

Details of Mother		**Details of Father**	
Name:		Name:	
Address: (if different to child)		Address: (if different to child)	
Telephone Nos.		Telephone Nos.	

7. Household composition

Name	**Relationship**	**DOB**	**Additional information, e.g. school/occupation/other**

8. Name and Address of other personnel or agencies involved with this child:

	Name	**Address**
Social Worker		
PHN		
GP		
Hospital		
School		
Gardaí		
Pre-School/Crèche/YG		
Other (*specify*):		

9. Details of person(s) allegedly causing concern in relation to the child

Relationship to child:		Age		Male	☐	Female	☐
Name:		Occupation:					
Address:							

10. Details of person completing form

Name:		Occupation:	
Signed		Date:	

Guidance Notes

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

This Report Form is for use by:

- Any professional, individual or group involved in services to children, including HSE personnel, who becomes aware of a child protection or welfare concern, or to whom a child protection or child welfare concern is reported.

- Professionals and individuals in the provision of child care services in the community who have service contracts with the HSE.

- Designated persons in a voluntary or community agency.

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

The HSE aims to work in partnership with parents. If you are making this report in confidence, you should note that the HSE cannot guarantee absolute confidentiality for the following reasons:

- A Court could order that information be disclosed.

- Under the Freedom of Information Act, 1997, the Freedom of Information Commissioner may order that information be disclosed.

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

If you are unsure if you should report your concerns, please telephone the HSE duty social worker and discuss your concerns with them (*see **Appendix 5** of these procedures for a full list of HSE offices nationwide*).

Appendix 5: National contacts for the Children and Family Social Services of the HSE

Also listed on HSE website (www.hse.ie/go/socialworkers) and from HSE LoCall Tel. 1850 24 1850. These contact numbers may be updated from time to time. Please check HSE website for the latest information.

HSE area	Address	Telephone Number
DUBLIN NORTH	Health Centre, Cromcastle, Coolock, Dublin 5	(01) 816 4200 (01) 816 4244
DUBLIN NORTH CENTRAL	Social Work Office, 22 Mountjoy Square, Dublin 1 Social Work Office, Ballymun Health Centre, Dublin 11	(01) 877 2300 (01) 846 7236
DUBLIN NORTH WEST	Health Centre, Wellmount Park, Finglas, Dublin 11 Social Work Department, Rathdown Road, Dublin 7	(01) 856 7704 (01) 882 5000
DUBLIN SOUTH EAST	Social Work Department, Vergemount Hall, Clonskeagh, Dublin 6	(01) 268 0320 (01) 268 0333
DUBLIN SOUTH CITY	Duty Social Work Carnegie Centre, 21-25 Lord Edward Street, Dublin 2 Public Health Nursing, 21-25 Lord Edward Street, Dublin 2 Family Support Service, 78B Church House, Donore Avenue, Dublin 8	(01) 648 6555 (01) 648 6730 (01) 416 4441
DUBLIN SOUTH WEST	Milbrook Lawn,Tallaght, Dublin 24	(01) 452 0666 (01) 427 5000
DUBLIN WEST	Social Work Department, Bridge House, Cherry Orchard Hospital, Ballyfermot, Dublin 10	(01) 620 6387
DUBLIN SOUTH	Social Work Department, Our Lady's Clinic Patrick Street, Dun Laoghaire Co Dublin	(01) 663 7300

Appendix 6: Protocol authorising immediate action

The following protocol authorises immediate action under section 5.2 of the 'Child Protection Procedures for Primary and Post Primary Schools'.

Post-Primary

(A) In the context of these procedures, where circumstances warrant it, as a precautionary measure in order to protect the children in the school and in accordance with the principles of natural justice and the presumption of innocence, the school principal is authorised by the school management authority to direct an employee to immediately absent himself/herself from the school without loss of pay until the matter has been considered by the employer.

The employee will be invited to a meeting with the principal, the purpose of which is to inform the employee of the allegation and the action being taken. The employee may be accompanied by an appropriate person of his or her choice and will be so advised.

In any event, the employee will also be advised of the matter, in writing.

(B) In the case of a school or college under the aegis of a VEC, the decision to absent an employee in the circumstances outlined at (A) above will be taken by the CEO of the VEC or a person to whom this authority has been delegated.