Regional ACPC Policy and Procedures Amendment

Section One

UNOCINI

Where disciplines/other Agencies have access to UNOCINI (Understanding the Needs of Children in Northern Ireland) initial referral assessment forms these should be used to make referrals to the Gateway Teams.

The UNOCINI has been introduced in response to a number of key developments, recommendations from inspections and audits, developing best practice in response to these, lessons learned from local and regional Case Management Reviews. There is a need to have a common language and understanding about all aspects of assessing children's needs. There is also a need to develop a consistent method of gathering information, understanding and analysing the data and accessing the appropriate services to meet the child's needs.

UNOCINI provides an assessment and planning framework to assist professionals in identifying children and their family's needs. The framework offers a logical framework within which children and their family's circumstances can be considered, analysed and understood in order to develop robust plans that aim to improve outcomes for the child.

The UNOCINI framework can also be used to make referrals to Social Services and access children's services. Using UNOCINI will ensure that children being referred come with the wealth of information that has already been collected by professionals working with them. Each level of the UNOCINI assessment framework builds on the previous one, ensuring a continuity of assessment. This will mean that children and their families will not need to go through the same questions with new professionals that others have already asked.

It is hoped that the UNOCINI assessment framework will be used by all professionals working with children as a tool to help them identify the needs of children at an earlier stage so their needs do not unnecessarily escalate to a point where they subsequently require further intervention, including referral to statutory services.

Why Use UNOCINI?

When you have concerns about an unborn or new born baby, child, or young person, it's not always easy to know what to do. You may not be sure what the problem is. Even if you are reasonably sure of the problem, your service may not be able to help. You may not feel confident that you can get other services to help.

- UNOCINI can help you to identify the needs of the child.
- UNOCINI offers a structure for recording information that you collect in conversation with the child, young person or family.
- UNOCINI provides a logical framework to help you analyse your information and reach conclusions about the most appropriate response to the strength and needs you have identified with the child and family.
- UNOCINI can be used to communicate these needs clearly and concisely to professional colleagues, including those from outside your organisation.
- UNOCINI can assist in getting other services to help, because they will recognise that your concern is based on evidence.

Increasingly other services in your area will be using UNOCINI themselves and so will be familiar with the framework and language you are using to understand and express the needs of children.

Principles & Features

1. 'Assessment' is an activity undertaken with the child and their family.

2. Assessments are undertaken in partnership with the child and their family.
3. Assessments are balanced, incorporating all factors impacting upon the child and their family's lives.
    a. Build on the strengths of families to meet the needs of their children.
    b. Are child centred and rooted in child development.
    c. Are knowledge based and show the evidence, which underpins the assessment.
    d. Incorporate risk assessment within all assessments.
    e. Create a continuous process, not an assessment 'event'.
4. Utilise full inter-agency co-operation and involvement.
5. Are based on shared values.
6. Promote the UN Convention of the Rights of the Child.
7. Offer the potential for a universal set of documentation for all agencies in Northern Ireland working with children and families.
8. Improve information sharing by providing a shared format and language for understanding, and planning to meet, children's needs.
9. Balance data collection, analysis and conclusions.
10. Professionals working with children and their families need sufficient understanding of the needs of children through assessment to ensure that key decisions are safe. Professionals are then able to develop plans that improve outcomes for children.
11. Through earlier identification and better quality information about children and their family's needs UNOCINI will reduce unnecessary escalation of children's needs.
12. Assessment and decision making should always be quality assured by a designated manager.

The UNOCINI Guidance (www.dhsspsni.gov.uk/unocini_guidance.doc) refers to a number of standards for Children's/Social Services these standards are outlined within the UNOCINI Guidance document pages 103-105.

The UNOCINI Guidance standards which are of particular relevance to the Regional ACPC Policy and Procedures are as follows:

The corresponding paragraph from the Regional Policy and Procedures is noted in brackets.

Initial Assessment

(Standard 2)

> *"initial assessments should be completed within 10 days of receipt of initial referral – this includes quality assurance and sign off by the supervising manager" (Paragraph 5.35)*

(Standard 5)

> *"where a child protection concern is indicated then the ACPC Regional Policy and Procedures requirement must be adhered to whereby the child or young person must be seen within 24 hours of receipt of the referral " (Paragraph 5.28)*

(Standard 7)

> *"In instances where a child protection concern is indicated the social worker must establish what information is already known about the child and their family from other child welfare agencies before making contact with the family" (Paragraph 5.24)*

Child protection Pathway Standards

(Standard 1)

"UNOCINI Initial Child Protection Conference Reports are required to include holistic assessments of child or young person and their family's needs (i.e. all 12 domains must be considered)" (Paragraph 6.53)

(Standard 4)

"The UNOCINI Initial Child Protection Report will serve as the report to all Initial Case Conferences. The reports will include:

- *A recommendation regarding registration – (Paragraph 6.53)*
- *A recommendation regarding core group membership" – (Paragraph 6.85)*

(Standard 5)

"All Initial UNOCINI Child Protection Conference Reports will be quality assured and signed off by the supervising manager prior to sharing with the case conference chair and the child/family" – (Paragraph 5.36)

All other requirements within the existing Regional ACPCs' Policy and Procedures should be adhered to

Amendments

Section Two

Chapter 3

Board Designated Nurse for Child Protection and Trust Named Nurse for Child Protection

3.10 The Board should nominate a Designated Nurse for Child Protection and each HSC Trust, should appoint a Named Nurse for Child Protection.

The Named Nurse for Child Protection must have a high level of skill and expertise in children's health and development, child abuse and arrangements for the safeguarding of children. They will be able to give advice and guidance about child protection to all nurses in all settings in the Trust and identify uni-disciplinary and multi-disciplinary needs.

Social Workers in Family and Child Care Teams

3.11 The Child Protection work of Health and Social Care Trusts should be considered in the wider context of their work to assist families to care for their children and assist parents to fulfil their parental responsibilities through the provision of family support services. This provision can include advice, guidance and counselling, day-care facilities, residential accommodation and foster placements etc. Social Workers engaged in child protection work may also be involved in a wide range of other child care work. They are aware of the wider child care facilities provided by the HSC Trusts and other agencies and can draw on these in order to provide support and treatment services for children in need.

It is also anticipated that a Childcare/Mental Health Protocol will be in place within the Trust to address respective professional roles and facilitate positive communication where this interface exists.

Registration and Inspection Unit Inspectors

3.35 To be amended to Regulation and Quality Improvement Authority (RQIA) Inspectors

Learning Disability Nurses

3.51 Amendment to Learning Disability Nurses/Disability Services. Addition to existing paragraph.

Parents with a disability should have the same rights, responsibilities and opportunities to care for their children and some will require additional support in this role. However where a parent's disability impacts upon their capacity to safeguard a child, the Disability Service staff member must consider the risk to the child, bring the matter to the attention of their Manager and forward a referral to the Gateway Service. **This referral to be followed up in writing within 24 hours**.

Role of Hospital Social Worker 3.29 and implications for following paragraphs

3.29 When a Social Worker working in a Hospital setting has concerns or has been apprised of concerns by Nursing and or Medical Colleagues, these concerns should be discussed with their Line Manager. Nursing and Medical Colleagues should be consulted in respect of their involvement with the child and any observations which may assist in the assessment recorded. If there is clear evidence for concern an immediate referral should be made by the Hospital Social Worker to the relevant Family and Child Care Team/Gateway Team **and this should be followed up in writing within 24hours.**

Action to be taken by the Hospital Nurse in Cases of Suspected Physical, Sexual or Emotional Abuse and /or Neglect

3.64 3. Discuss concerns with his Manager, the Doctor responsible for the patients care and the Hospital Social Worker. It should be agreed who will forward the referral to the relevant Family and Child Care Team/Gateway Team. Normally this

should be the Hospital Social Worker but in the absence of a Hospital Social Worker, the Hospital Nurse/Doctor will ensure referrals are made to the Family and Child Care Team/Gateway Team. **This referral must be followed in writing within 24hours and a copy retained in the relevant records.** The Hospital Nurse will also inform the Named Nurse for child protection.

3.64 6. Make a verbal referral to the Hospital Social Work Manager. If no Social Work Department exists within that Hospital setting, a verbal referral must be made to the Social Work Manager/Family and Child Care Team/Gateway Team**. Verbal referrals must be followed up in writing within 24 hours.** Copies of referral forms must be forwarded to the relevant Social Work Departments, the Named Nurse for Child Protection, the Nursing Manager and a copy retained in the nursing records.

In the case of an urgent referral outside normal office hours a verbal referral must be made to the Out of Hours Social Work Service. **Written copies of this referral must be forwarded to the Hospital/Family and Childcare/Gateway Team/Social Work Manager/Nursing Manager and Named Nurse for Child Protection within 24 hours and a copy retained in nursing records.**

Professionals working in Mental Health settings

3.65 Children of parents who have a psychiatric condition may be considered as vulnerable and in need of additional support.

There may also be a link in some instances between parental psychiatric disorder and child abuse. This can result in varying degrees of abuse of children by a parent suffering from a psychiatric illness as well as the possible neglect and emotional deprivation of children whose parents suffer from chronic psychiatric conditions.

It is also anticipated that a Childcare/Mental Health Protocol will be in place within the Trust to address respective professional roles and facilitate positive communication where this interface exists and to ensure that the focus

remains upon the needs of the child/children in such circumstances.
Mental Health Service Personnel should follow the procedures set out below:

3.67 2. Where, after consultation, concerns remain, an immediate verbal referral should be made to the Social Work Manager in the Family and Child Care Team/Gateway Team during normal working hours. Parents should normally be informed that a referral is being made and the Hospital Social Work Team if applicable should be informed. It should be agreed who will make the referral to the relevant Family and Child Care Team/Gateway Team. Outside normal working hours, if the referral is urgent, a verbal referral must be made to the Out of Hours Social Work Service immediately. **Verbal referrals must be followed up in writing within 24 hours**

The Gateway /Family and Childcare Team will then undertake an assessment of the child's and family's needs in co-operation with mental health services, the patient and family

Allied Health Professional (AHP) Staff Working in Hospital and Community Settings

Addition to

3.69 4. In a Hospital setting, notify the Doctor responsible for the patient's care and the Hospital Social Worker and agree who will forward the referral to the relevant Family and Child Care Team/Gateway Team**. A verbal referral must be followed up in writing within 24hours.** In the case of there being no Hospital Social Work Department, or a concern arises in a community based AHP service, a referral must be made directly to the Gateway Team/Child and Family Care team .

Children presenting to Hospital Outpatient (including A&E Dept) or Inpatient Departments (including Family Planning Services).

3.85 When a case of child abuse is suspected or alleged in a Hospital setting, the Doctor should inform the Consultant responsible for the case or his Line Manager and consult the Hospital Social Worker. A Senior Paediatrician should immediately be consulted for advice, and agreement reached between the Hospital Social Worker as to who will forward the referral to the Social Work Manager in the relevant Gateway /Family and Childcare team. Where no hospital Social Worker is available it should be agreed who will forward the referral to the Gateway Team/ Family Childcare Team or Out of Hours Service and this should be recorded. This also applies to adolescents in the 14-17 year age group who may be admitted to adult wards**. Verbal referrals must be followed up in writing within 24hours.**

ADDITIONAL PARAGRAPH

Independent Counsellors/ Therapists

3 .135 Where independent counsellors/therapists are commissioned/ requested to provide a service, the referring agency (including statutory, voluntary or independent sectors) must ensure that the contract/service level agreement makes explicit the requirement that there is adherence to the Regional ACPC Policy and Procedures. It is expected that Independent Counsellors /Therapists will adhere to these Regional ACPC Policy and Procedures. Counsellors in all sectors should be aware that their responsibilities extend beyond their relationship with their client to include the welfare of children when their care is, or is likely to be compromised.

If during the course of their involvement with an individual or family group the Independent Counsellor/Therapist becomes aware that a child is or has suffered significant harm or is at risk of suffering significant harm a referral must be made to the

Gateway Team/Child and Family Care Team within the Trust.

Verbal referrals must be followed up in writing within 24 hours.

Section Three

Chapter 5

Anonymous Referrals

5.15 Anonymous referrals from members of the public are accepted and treated as any other referral on the basis of the information provided. It should be impressed upon the referrer that to intervene effectively maximum information is required, including details of other witnesses or means of verifying information. The referrer should be advised that in some circumstances the subsequent enquiries may lead the person suspected of abuse to deduce who the referrer might be. The referrer should also be advised to make contact if further concerns arise.

There may be exceptional circumstances, for example in acrimonious family/relationship disputes where allegations and counter allegations are being made, Social Services may require to disclose the identity of referrer in this eventuality. The referrer should be advised of this course of action.

Section Four

Chapter 6

Other Personnel who may be invited to an Initial Child Protection Case Conference 6.20

6.20 Other personnel may need to be invited as appropriate e.g. Representative of the NI Commissioner for Children and Young People.

(This will become the 15th bullet point)

Section Five

Chapter 8

MEDICAL ASSESSMENT OF ALLEGED OR SUSPECTED CHILD ABUSE

8.9 Medical practitioners who have examined a child for suspected abuse and disagree in their findings and /or conclusions should discuss their reports and resolve their differences where possible; in the absence of agreement they should identify the areas of dispute, recognising their purpose is to act in the best interests of the child.

In the event of failure to reach a resolution an opinion should be sought from the Designated Doctor/Senior Consultant Paediatrician for Child Protection. An accurate record should be made of any discussions which take place regarding these matters.

Section Six

Chapter 9

Child Protection in Specific circumstances

Amendments

Children Living Away from Home

9.5 Children living away from home includes those being cared for in residential settings e.g. schools, supported placements, holiday centres, health settings and youth justice etc and those in fostercare. This also includes children who are placed with host families by voluntary and charitable organisations. Such organisations should have a Child Protection Policy in place and have a designated senior person with responsibility for safeguarding and to ensure/monitor safeguarding arrangements for such placements. Placing organisations will also require to comply with current vetting requirements in respect of such placements. (Remaining bullet points in 9.5 apply)

Children who Sexually Abuse Others or Display Sexually Harmful Behaviour

The following amendments will replace the existing paragraphs 9.34 -9.46 (inclusive)

9.34 These procedures will be applied irrespective of who is the victim i.e. an adult or child, or the nature of the sexually harmful behaviour i.e. contact/non contact.

9.35 When abuse of a child is alleged to have been carried out by another child, a Child Protection Investigation should be carried out in respect of the alleged victim in accordance with Chapter 5 of these Procedures.

9.36 Following investigation into the allegations made by the victim where it indicates that the alleged sexually harmful

behaviour/s has taken place and it/they is/are believed to have been instigated by a child then the ensuing procedures with respect to sexually harmful behaviour must be followed.

9.37 Whether a child is responsible for sexually harmful behaviour, is a victim of sexual abuse, or both, it is important to apply principles that remain child centred. Sexually harmful behaviour by children must be recognised as harmful to both the victim and the child who abuses. A child who engages in sexually harmful behaviour may be suffering, or be at risk of, significant harm and may himself be in need of protection. A significant proportion of children who engage in sexually harmful behaviour may have been abused themselves. In such circumstances consideration must be given to convening a Child Protection Case Conference as detailed in 9.39. While the numbers who engage in this kind of sexually harmful behaviour are relatively small, particular concern remains about the reducing age of the children involved and the potential number and range of victims, which can include adults.

9.38 Sexually harmful behaviour, when identified in children, must be taken seriously by all agencies. It is important to distinguish between behaviours which are experimental in nature and those that are exploitative and harmful. In assessing such distinctions, it is necessary to consider issues of:

- consent (including age and level of understanding)
- equality
- authority and control
- co-operation
- compliance
- criminal offences

If there is any uncertainty as to whether the reported sexual behaviour is exploitative or harmful you must seek specialist advice.

Where it has been assessed that the behaviour indicates sexually harmful behaviour it is essential that staff/agencies

liaise with Social Services and PSNI to ensure that their investigative process is not impeded.

9.39 Where the child believed to have been involved in sexually harmful behaviour is deemed to be at risk of abuse and/or significant harm, Social Services will convene a Child Protection Case Conference in accordance with Chapter 5 of these procedures. The Child Protection Plan must specifically address how risk is to be assessed and managed.

9.40 The Child Protection Case Conference in addition should also address the following:

- the nature and extent of the sexually harmful behaviour (expert professional judgement may be required)
- the child's level of understanding and acceptance of the abuse
- the need to complete a risk analysis in relation to the child and his/her family
- the need to consider the broader risk in relation to public safety
- the parent's/carer's attitude and level of understanding in relation to the abuse and their capacity to protect against it
- The child's need for services and support to address his sexually harmful behaviour and who is best placed to provide these

9.41 Where the threshold for referring to Child Protection Case Conference is not met in respect of the child believed to have engaged in sexually harmful behaviour, then the Multi-Agency Case Planning process must be followed. A multi-agency plan must be developed which addresses both the risks and needs of the child. The same issues identified in 9.40 must be addressed.

9.42 Where the Child Protection Case Conference/Case Planning process has identified concerns regarding a child involved in sexually harmful behaviour a referral must be made to the appropriate specialist project.

The specialist projects have staff trained:

- to provide consultation and advice
- to assess risk
- to offer treatment programmes for children who are responsible for sexually harmful behaviour towards others

9.43 The specialist projects will screen all referrals and where appropriate undertake an assessment using the approved model, which addresses issues of risk, concerns, needs and strengths. They will make recommendations with regard to treatment, case management and case disposition.
It is important to recognise that the therapeutic needs of children who engage in sexually harmful behaviour are likely to be complex and require the active involvement of a range of agencies, not just the specialist projects.

9.44 **Treatment Programmes**
Treatment programmes should be tailored to meet the individual needs of each child. The purpose of treatment is to change those identified risk factors that are amenable to change. In order to achieve such an outcome, a multi-agency, multi-systemic approach should be actively considered and a structured programme offered. The components of treatment programmes should as a minimum include:

- An acceptance of responsibility
- Victim awareness and empathy
- Cognitive distortions
- Sexuality and relationships
- Communication, personal and social skills
- Assertiveness training
- Family dynamics
- Identification of risk factors

9.45 **Principles**

The following principles underpin effective child protection in respect of children who engage in sexually harmful behaviour:

- In any intervention, the welfare of the child/victim must always be paramount, and this overrides all other considerations.
- The needs of the children who engage in sexually harmful behaviour should be considered separately from the needs of their victims. Intervention and treatment should occur as soon as possible.
- The child involved in sexually harmful behaviour should be held accountable for their actions, with consideration given to their age, understanding and level of maturity. This may involve criminal prosecution.
- There should be a co-ordinated approach by childcare services and youth justice agencies. This should include appropriate communication between those professionals working with the victim and those working with the child who has acted in a sexually harmful manner and with their respective families.

9.46 **Refusal to Engage**

Where it is believed that a child has been involved in sexually harmful behaviour and the child/family are refusing to engage with services then the same processes as identified above must be followed. This should include a risk assessment based on available information. A risk management plan, reflective of the assessed risk, must be developed. Such a plan must be reviewed as appropriate through the Child Protection/Case Planning process. Regardless of the level of involvement of the child/family they will be kept informed of the plan made and attempts continue to be made to engage them.

9.47 **Interface with Public Protection Arrangements**

It is important that the transition phase where a young person who poses sexual risks moves into adulthood is

carefully managed. As a general rule children and young people (under 18 years) will remain subject to child protection or children in need procedural requirements. The Child Protection Conference or Case Planning Meeting should continue to take account of the assessed level of risk to determine whether, as part of this transition, there is a need to refer the case to the Public Protection Arrangements for Northern Ireland (PPANI) for assessment by the Local Area Public Protection Panel (LAPPP).

It is generally considered that this process will be activated as the young person approaches adulthood. It has however also been accepted that exceptionally, when a Health and Social Services Trust, PSNI, the Youth Justice Agency, the Northern Ireland Prison Service or the Probation Board for Northern Ireland consider that multi agency risk assessment and risk management is necessary in respect of a young person, who if he/she were an adult would meet the criteria of relevant offender they should refer the case to the PPANI for assessment by a LAPPP.

Section Seven

Appendices

Appendix 1

Relevant Publications & Bibliography

To be inserted

Circular HSS CC 3/96 (Revised)

SHARING TO SAFEGUARD
INFORMATION SHARING ABOUT INDIVIDUALS WHO MAY POSE A RISK TO CHILDREN
Department of Health Social Services and Public Safety
September 2008

SAFEGUARDING VULNERABLE GROUPS (NORTHERN IRELAND) ORDER 2007
Department of Health Social Services and Public Safety

Appendix 3

Contact Address-Telephone numbers

Addition to Contact Addresses

NI Commissioner for Children and Young People
NICCY
Millennium House
17-25 Great Victoria Street
Belfast
BT2 7BA
Tel: 028 9031 1616

The Regulation and Quality Improvement Authority
RQIA
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

All references to Registration and Inspection Units should now relate to RQIA.

Appendix 4

CHILD PROTECTION REGISTRATION APPEALS PROCESS

Following

4.11 insert addition to existing paragraph

> "In the event that the parent/child remains unhappy with the decision they are advised that they can make contact with the Trust Director of Children's Services who will decide if an Appeals Panel should be convened".

4.17 "Appeal Upheld
Amend bullet point 4

"The decision of the reconvened Case Conference will be final and should be confirmed in writing".

4.18 Appeal Not Upheld

- The decision of the Panel is final and will be confirmed in writing
- If the parent is still dissatisfied he should be advised of his right to contact the Ombudsman or the Commissioner for Children, or seek legal advice