Wigan Safeguarding Children Board

Safeguarding Children and Young People from Fabricated or Induced Illness Joint Working Protocol

1. INTRODUCTION

This Protocol has been developed by a multi agency Task and Finish Group under the oversight of Wigan Safeguarding Children Board. The following guidelines are intended to assist members of the workforce to respond appropriately and timely to a concern that a child's illness / symptoms / presentation may be fabricated or induced by their parent or carer.

These guidelines are to be followed by all agencies working within the Wigan Borough, in conjunction with the Wigan Child Protection Procedures, Ref, http://www.wiganlscb.com/childprotection.asp

All parents demonstrate a range of behaviour in response to their children's wellbeing or being perceived as ill. Some may become more stressed or anxious than others. Their response may in part be related to their perceptions of illness and to their expectation of the medical profession. Health professionals are taught to listen to the concerns of parents about their children's health and to act on these. Part of their role is not only to treat the sick child but also in collaboration with other professionals to assist parents to respond appropriately to the state of their children's health.

Some children may not be unwell but their parents need reassurance, where others may experience continuing difficulties in recognising that their child is healthy and exhibiting normal childhood behaviours.

Some parents can be helped to interpret and respond appropriately whilst others may continue to be anxious and/or to be unable to change their beliefs. In this group of parents who are more likely to present their children for medical examination although the children are healthy. These parents may have particular needs which result in them persistently presenting their children as ill and seeking investigation and medical treatment.

For a small number of children concerns will be raised when it is considered that the health or development of the child is likely to be significantly impaired or further impaired by action of the carer or carers having fabricated or induced illness. Where the impairment is such that there are concerns that the child is suffering or is likely to suffer significant harm at that stage these guidelines need to be followed.

Concern may arise about possible fabricated or induced illness when:

- Reported symptoms and signs on examination are not explained by a medical condition from which the child may be suffering.
- Physical results of medical examination do not explain the reported symptoms and signs.
- There is inexplicable poor response to prescribed medication and other treatment.
- New symptoms are reported on resolution of previous one.
- Reported symptoms and signs are not seen to begin in the absence of the carer.
- Over time the child is repeatedly presented with a range of signs or symptoms.
- The child's normal daily life activities are being curtailed, for example, school attendance beyond that which might be expected for any medical disorder from which the child is known to suffer.

2. DEFINITIONS

2.1 A condition whereby a child suffers harm through the deliberate action of her/his main carer and which is duplicitously attributed by the adult to another cause.

2.2 There are three main ways of the carer fabricating or inducing illness in a child:

- fabrication of signs and symptoms, including fabrication of past medical history;
- fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluids;
- induction of illness by a variety of means. This includes poisoning and the giving of inappropriate medication.

The above three methods are not mutually exclusive.

2.3 Harm to the child may be caused through unnecessary or invasive medical treatment, which may be harmful and possibly dangerous, based on symptoms that are falsely described or deliberately manufactured by the carer, and lack independent corroboration.

3 RECOGNITION & RESPONSE

Concerns may be raised by other professionals e.g. nurses, teachers or social workers who are working with the child and who may notice discrepancies between reported and observed medical conditions, such as the incidence of fits.

Professionals working with the child's parents may also note these concerns e.g. mental health professionals, may identify a child being drawn into the parents illness.

3.1 INDIVIDUAL AGENCY RESPONSES

3.1.2 Health Economy Agencies

Health professionals may be concerned at the possibility of a child suffering significant harm as a result of having illness fabricated or induced by her/his carer. These concerns may arise when:

1. reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering or,
2. physical examination and results of investigations do not explain reported symptoms and signs or,
3. there is an inexplicably poor response to prescribed medication and treatment or,
4. new symptoms are reported on resolution of previous ones or reported symptoms and found signs are not observed in the absence of the carer or,
5. the child's normal, daily life activities are being curtailed beyond that which might be expected from any known, medical disorder from which the child is known to suffer.
6. harm can be induced by a pregnant mother to her unborn child.

Concerns about a child's health should be discussed with the GP or Paediatrician responsible for the child's health.

If any professional considers their concerns are not taken seriously or responded to appropriately, these should be discussed with the Designated Doctor or Designated Nurse for Child Protection.

3.1.3 Bridgewater Community Healthcare NHS Trust Wigan Division

All health professionals working in Bridgewater Community Healthcare NHS Trust Wigan Division whether working with children or adults should be aware of the Bridgewater Community Healthcare NHS Trust Wigan Division Safeguarding Children Guidelines.

Health professionals who have suspicions about fabricated or induced illness must refer to the related guidelines and if needed seek advice from the Named Nurses for Safeguarding Children. Detailed documentation and a chronology of significant events should be available when seeking advice from the Named Nurses. All health professionals need to keep detailed notes of these discussions.

When health professionals are invited to contribute to either the initial assessment or Health professionals' meeting where there are concerns regarding signs and/or symptoms of Fabricated or Induced illness a family genogram and chronology should be made available to this and to any subsequent strategy meetings that the health professional attends thereafter. A high standard of record keeping to be maintained and the records kept in a secure place.

Health professionals should not discuss their concerns with the parents /carers at this time.

3.1.4 Primary Care Trust (PCT)

If a GP has concerns that may be related to a case of fabricated or induced illness, they should discuss their concerns with the Named Dr at the Acute Trust, if not available contact should be made with the Designated Doctor or Community Paediatrician. Allied Professionals should contact the Designated Nurse.

Where Primary Care Staff - GPs and Allied professionals - have concerns about possible FII they should ensure that the child is referred for a Paediatric Assessment. This referral should not delay usual safeguarding / child protection referrals processes to the Children's Social Care Duty Team. A detailed recording of the concern should be maintained on agency records. **Concerns should not be discussed with the parent(s)/carer(s) until Children's Social care advise to do so**.

3.1.5 5 Boroughs Partnership NHS Foundation Trust

All professionals working for 5 Boroughs Partnership NHS Foundation Trust should be aware of the 5 Boroughs Partnership NHS Foundation Trust Safeguarding Children Policy.

Any mental health professional who has suspicions of Fabricated or Induced Illness, as result of direct work with those adults who may be mentally ill, must complete the 5 Boroughs Partnership NHS Foundation Trust electronic Safeguarding Children Communication form and seek advice from the Named Doctor or Nurse for Safeguarding Children. **Concerns should not be discussed with the parents/carers until Children's Social Care advise to do so.**

If the mental health professional is invited to attend any strategy discussion or child protection conference, he/she will produce a report about their involvement with the adult who may be mentally ill.

In addition to the above all professional working at Child and Adolescent Mental Health Service [CAMHS] should be aware of the guidance outlined in The Working Together to Safeguard Children [2010] to ensure effective partnership working.

3.1.6 Peoples Directorate Adult Social Care

All social workers working in Wigan Council Adult Mental Health Teams and based within the 5 Boroughs partnership working with a child's parents who have suspicions about fabricated or induced illness must inform the service user's Clinician and/or Care Coordinator. Advice may be sought from the 5 Boroughs Partnership Named Nurse for Safeguarding Children. Detailed documentation and a chronology of significant events should be available when discussing the case with the Clinician and or Care Coordinator and when seeking advice from the named nurse. Social workers should keep detailed notes of these discussions.

When social workers are invited to contribute to the initial assessment where there are concerns regarding signs and/or symptoms of Fabricated or Induced illness detailed documentation and chronology should be made available to this and to any subsequent strategy meetings that the social worker attend thereafter. A high standard of record keeping is to be maintained and the records kept in a secure place.

Social workers should not discuss their concerns with the parents/carers at this time.

3.1.7 Education settings

3.1.7.1Schools and Early Years Settings

Schools and nurseries are best placed to detect fabricated or induced illness at an early stage. Education services have a statutory duty to report concerns where they suspect that a child may be at risk under Safeguarding Children in Education.

There are cases that are known to Educational Psychology which may cause safeguarding concerns in regard to FII. In these cases Educational Psychology will discuss these concerns with the Paediatric Department.

School attendance under 85% will automatically be referred to the Education Welfare Service. The Education Welfare Service will contact the child's GP in cases where medical reasons are given for frequent school absence.

If fabricated or induced illness by a carer is suspected, schools should consider first the possible reasons for the signs and symptoms. They should determine whether illness is being used, for example, to avoid certain lessons or being bullied. Whilst these have an impact on a pupil's behaviour and academic performance, these should be dealt with under existing guidance and do not fall within the scope of this policy.

Fabricated illness is often, but not always, associated with emotional abuse. Factors that may indicate risk of harm could include:

- Frequent and unexplained absences from school, particularly from PE lessons.
- Regular absences to keep doctor, optician, or hospital appointments.
- Repeated claims from carers that the child is frequently unwell and that he/she requires medical attention for symptoms that, when described, are vague in nature, difficult to diagnose and which teachers themselves have not noticed, e.g. headaches, stomach aches, seizures, dizzy spells, frequent contact with health professionals or referrals for second opinions.
- Over use / inappropriate use of drugs, including non-prescription drugs such as Calpol, laxatives etc.
- Refusal of permission for school medicals.

- Frequent illness, treatments or aliments not consistent, or considered to be excessive, in relation to a child's disability.

The child may disclose ill treatment to staff or complain about frequent doctor's visits. Carers, siblings and the child may present conflicting stories about illnesses and deaths. Where siblings are in the same school, concerns should be discussed with the relevant teachers.

Schools / nurseries must **not** make their own enquiries if they have reason to suspect possible or actual harm. School staff should discuss any child welfare concern with the designated teacher for child protection and school nurse. The designated teacher is then responsible for notifying Children's Social Care.

Wherever possible, schools should collate a record of absences and reasons given by the carer (if known), and record any discussions with the child, including quotes. The date, time, place and the names of any people present at the time should be recorded. This should be presented with the referral. A high standard of record keeping should be maintained and records should be kept in a secure and confidential place.

The referral should only be discussed with the carers /parents, and agreement sought, after the designated teacher agrees with Children's Social Care what the carers /parents will be told, by whom and when.

The designated teacher will be invited to attend any strategy discussions or child protection conferences. The designated teacher will be notified of the extent to which the carers have been notified of concerns and what information can be shared.

If, during an OFSTED inspection, inspectors become concerned that a child may be having illness induced or fabricated, then they should apply the OFSTED procedures.

3.7.1.2 Children Educated at Home

In all cases where a child is on roll at a school and is withdrawn to be home educated, the Local Authority will contact the school and ask for information on the child including if there are any concerns. The school cannot refuse to allow the child to be home educated but where there are concerns, they must report them to the designated child protection teacher and the Named nurse as described in paragraph re: Schools and Early Years settings.

In cases where children were not registered at a school and are home educated, or where suspicions or concerns arise through a monitoring visit to the child's home by the EHE officer, this must be reported to the Lead for Children Educated at Home, who in turn should discuss the concerns with Children's Social Care and the Designated / Named Nurses. The outcome may be to request that the GP makes a referral for a Paediatric Assessment.

There are also several cases where children that are home educated are not monitored by a visit and we must not assume that these children are at risk or suffering any harm. The only contact with these children may be through other services who would need to report their concerns through the agreed channels throughout this document.

3.1.8 CYPS Children with Complex Needs Team

All social workers within the Children with Complex Needs Team and those working with children with disabilities who have suspicions about fabricated illness must report their concerns to their manager.

It is important to remember that Children with complex needs and or disabilities are children first. All agencies should utilize the policies and procedures in line with the care and treatment of all children.

The range and combinations of disabilities experienced by children and young people and the resulting variations in behaviours, and symptoms impact on each person individually. This can make it difficult to determine whether parents are accurately and /or appropriately seeking advice and treatment for their child.

Parents can be naturally anxious about their children. Disabled children's care can include procedures outside that of ordinary parenting such as medications, moving and handling equipment and "nursing" tasks. Parental anxiety in regard to the disabled child's health can be compounded by the range of disabilities their child experiences and the reliance the parent to undertake what can be complex procedures. In contrast parents may feel they have to either highlight or minimize their children's needs to gain services or benefits. Determining when this is at a level of concern must involve a close working relationship with other agencies. Utilizing the expertise of health and education colleagues is essential.

Siblings must not be forgotten, their health and well being can be affected with /without fabricated illness being an element. Families with a disabled child have to juggle their time between their children's needs. Siblings can see illness as a way of gaining attention that they feel is missing in their lives. Parents may also keep siblings home from school to help at home. Diligent observations, accurate and regular recording and assessments, including a thorough chronology of events will enable early recognition of concerns. Combined with close and effective working relationships between agencies will help to identify issues within the whole family and safeguard children.

3.1.9 WWL Acute Trust

Any member of staff who suspects that a parent's presentation of a child's clinical problem is deliberately distorted should discuss their concerns with their line manager and the child's consultant.

The child's consultant should review the case in light of the concerns raised, ensuring that all the available clinical notes are reviewed - including information available on Electronic Patient Record.

The Consultant Paediatrician should ensure that the Named Doctor/Nurse for Child Protection for the Wrightington, Wigan and Leigh NHS Trust, as well as the Designated Doctor/Nurse for Wigan, is aware of the emerging concerns.

The Consultant Paediatrician should thereafter liaise with all the relevant professionals in order to ensure appropriate information is gathered regarding the index case and any siblings and parent/carer. Professionals contacted will include: - all relevant Consultants; General Practitioner; Health Visitor and/or School Nurse, Children's social care and Police

A Health Professionals' meeting should be organised and chaired by the Named/Designated Doctor to include representatives from all health disciplines / NHS Trusts across the Health Economy, (including those outside of the Wigan Borough) who are involved with the index child/family. (If some members are unable to attend their information and views must be clearly communicated by an appropriate representative agreed in advance with the Consultant Paediatrician.) Consultants (Acute or any other Consultants) who are crucial to the interpretation of the index child's clinical presentation and findings **must** be present. To ensure that all the relevant information is available to this meeting consideration should also be given

to any deceased siblings of the child or young person and the ante natal history of the child / young person and any deceased or live siblings.

NB If there are challenges to requests for information from out of Wigan Borough NHS Trusts this should be addressed by following the WSCB Escalation Policy ref: http://wiganlscb.com/downloads/WSCB%20Escalation%20Protocol.pdf. Discussions should take place between equivalent roles at each level of the escalation process between the Wigan NHS Trust and the other regional area NHS Trust.

The meeting must agree a plan of action including how to collate and review the health information and construct a health chronology highlighting:

- The number of presentations of the index case/siblings to health personnel.
- Complaints specified and in particular who was giving the history.
- Examination findings (both positive and negative).
- Obtain full account of child's activity of daily life both from home and school as well as school attendance.
- Investigations results recorded as normal or abnormal with abnormality specified.
- A family background history should be constructed highlighting any abnormal health problems in the parents or siblings.
- Any contradictions in the information gathered.
- Chronology should be prepared using an agreed format such as the template used in Serious Case Review. (Appendix 1)
- The child may need admission for further observation. This requires a pre admission MDT planning.
- It is important to have the child's view, by talking to the child and asking what he/she thinks and believes.

The preparation of the chronology is a complex and time consuming task comparable to a Serious Case Review. Adequate time and resources will need to be allocated. This should be done by the Named Consultant or Senior Nurse of the child.

A responsible Paediatric Consultant should take lead responsibility for all the decisions about the child's health care. Other Consultants should be made aware of any plans and if possible avoid altering the plan of care without first consulting the responsible Paediatric Consultant. Effective communication between colleagues is essential to ensure a good outcome for the child.

The Health Professionals meeting allows careful consideration of an individual case. These cases are often complex and difficult to give definitive judgements. Consideration should be given to the possible risk of harm to the child. Therefore the process should be overseen by a lead Consultant Paediatrician and completed in a timely fashion; the need to escalate and refer to Social Care will always be born in mind.

4. MEDICAL EVALUATION

4.1 Observation

When a child is in Hospital observation needs to be agreed as a part of care plan. Observation may be required to verify the reported history or there are concerns or if there are concerns of likelihood of harm, observation and supervision of the child may be discussed with other agencies such as Children's Social Care and the Police. If a child is not in hospital a planned admission may be undertaken in order to verify or clarify the reported symptom. During the

admission the child may need to be observed constantly and closely. If the carer refuses to admit the child and it is believed this may place the child at increased risk it may be appropriate to seek statutory involvement from Children's Social Care.

- The signs and symptoms require careful medical evaluation for a range of possible diagnoses.
- Where a reason cannot be found for the signs and symptoms, specialist advice and tests may be required.
- Normally, the doctor would tell the parent/s that s/he has not found the explanation satisfactory and record the parental response.
- Parents should be kept informed of further assessments /investigations / tests required and of the findings.
- **However, at no time should concerns about the reasons for the child's signs and symptoms be shared with parents if this information would jeopardise the child's safety.**

4.2 Use of Covert Video Surveillance

If covert video surveillance is considered necessary it must be managed and performed by the Police. The Chief Executive of the Trust must be informed of the use of covert video surveillance (CVS) and there should be close and detailed consultation with the staff caring for the child. All the times references must be made to Local Safeguard Board procedures developed jointly with the Police and Health professionals (see section 6 re: Police Investigation).

Supervision and support should be available to all health staff involved with covert video surveillance by the Named Health professionals within each health organisation and the and Designated Health professionals.

4.3 Recognition of Genuine Illness

If a genuine cause of the child's symptoms and signs is found and possibility of FFI is excluded, communicate this clearly and immediately to the clinical team including primary and secondary care and to the Children's Social Care. Always remember that genuine disease and FFI may co-exist. If the carers are already aware that FFI was being considered ensure that a full explanation is provided and an apology for any distress caused.

Ensuring medical examination takes into account what children are saying is always important. Every effort should be made to see a child without a parent being present. Some children may be competent to make their own decision on this matter.

There must be

- Clear agreement as to whether professionals' concerns are to be shared with the parent/carer and how this should be done. **No information should be shared if referral to Social Care is to be made.**
- Full documentation of what is to be said to parents.
- **All information needs to be kept in a confidential file kept at the back of the child's notes, separate from the main body of the record. This should be removed if parents wish to see the file.**

A conclusion of **no significant harm** may be reached if:

- The original concerns can be clearly explained by objective evidence that establishes the child / young person does have a disease process to account for his/her signs and symptoms.
- There are no concerns that the parent/carer's management of the condition is causing significantly harm to the child/young person.
- Social Services / Police / Education have no significant concerns regarding the index child or family.

The Health Professionals meeting should be minuted and the Consultant Paediatrician / Designated or Named Paediatrician should provide a report documenting the reasons for no further action. Copies of this report should be sent to the CYPS Children's Social Care and all relevant Health Professionals. Ongoing monitoring should be undertaken by the General Practitioner who often has access to more than one member of the family's appropriate person. Any person with further concerns can contact the Consultant Paediatrician.

If concerns remain that the parents' presentation of the child / young person's clinical symptoms or signs may be fabricated or induced the Consultant Paediatrician should liaise with a senior manager in Children's social care to request a multi agency strategy meeting at which a well constructed Health chronology highlighting relevant concerns should be presented.

5 INVOLVEMENT OF CHILDREN'S SOCIAL CARE

5.1 Referral to Children's Social Care

When a possible explanation for the signs and symptoms is that they may have been fabricated or induced by a carer and as a consequence the child's health or development is or is likely to be impaired a referral should be made to Children and Young Peoples Services *(Safeguarding Children in Whom Illness is Fabricated or Induced paragraph* 3.12*).*

The referral may follow a medical evaluation or be the result of concern by professionals or members of the public.

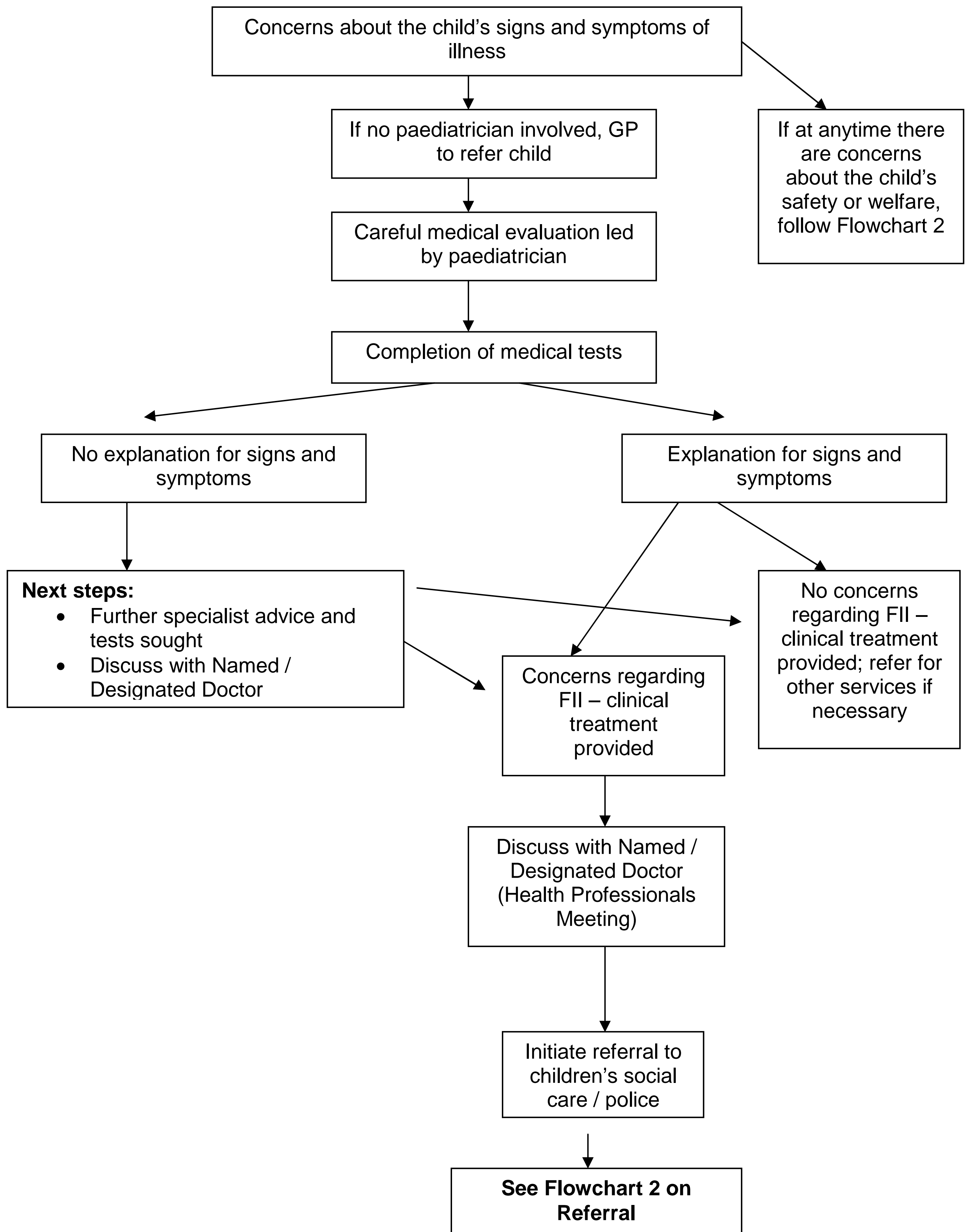
Whilst professionals should in general, discuss any concerns with the family and, where possible, seek agreement to making referrals to Children and Young Peoples Services, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm** *(Safeguarding Children in Whom Illness is Fabricated or Induced* paragraph 3.13 and *Working Together to Safeguard Children paragraph* 5.*6).*

See 5.2 which negates the need for the paragraph below

N.B. All this can be done and information shared without the parent's knowledge/consent.

*** See attached Flowchart 1 on next page.**

FLOWCHART 1 - MEDICAL EVALUATION WHERE THERE ARE CONCERNS REGARDING SIGNS AND SYMPTOMS OF ILLNESS



5.2 Initial Consideration Of Referral by Children's Social Care Duty Team

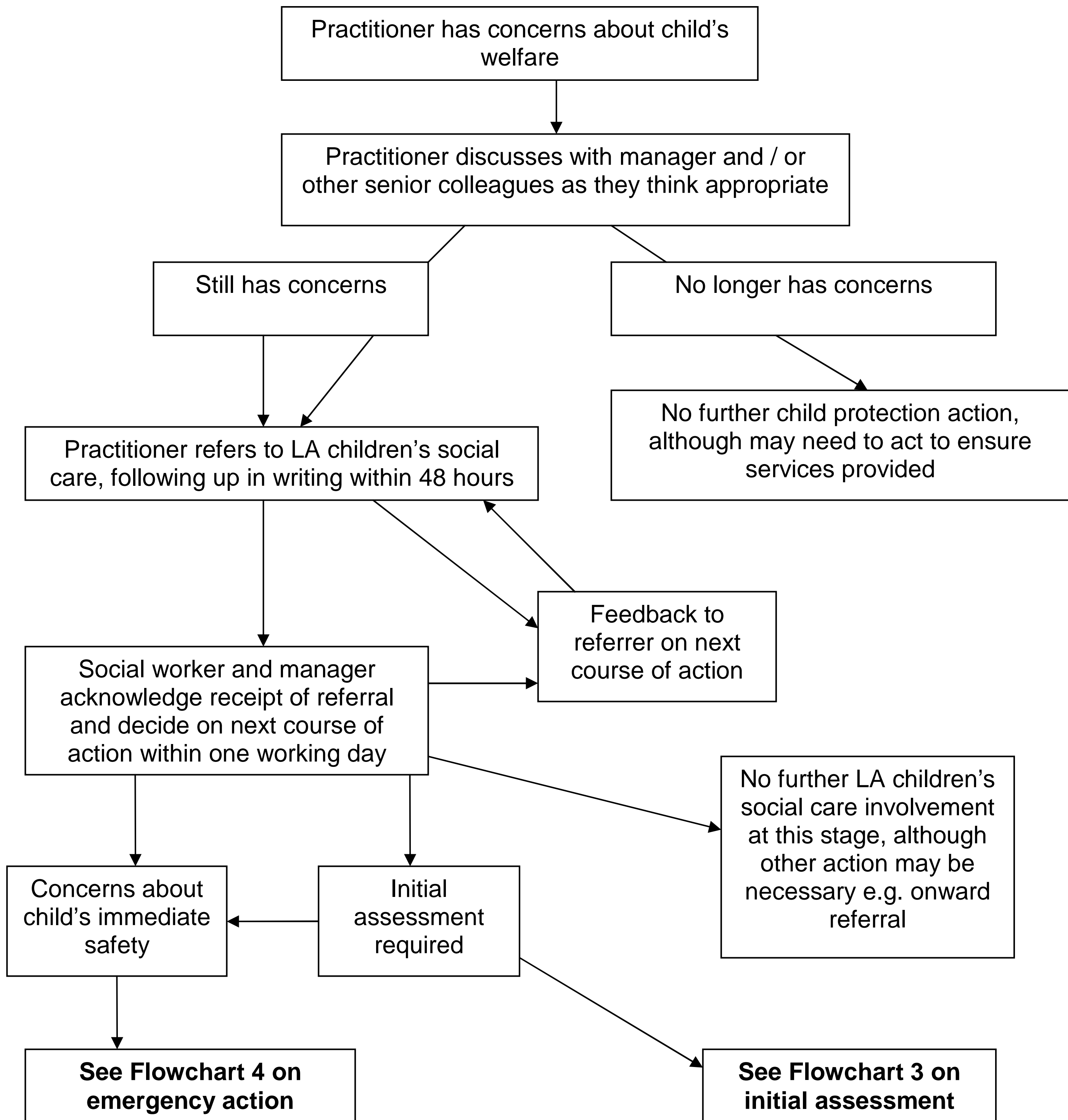
As with all other referrals, Peoples Services should decide, within 24 hours what initial response is necessary. In cases concerning FII this decision **must be taken** in consultation with the consultant paediatrician responsible for the child's health care and the Police PPIU (as any suspected case of fabricated or induced illness may also involve the commission of a crime).

This decision making process must agree what action needs to be taken by whom and within what time frame. All decisions about what information is shared with parents should be agreed between the Social Care Duty Team CYPS, and Consultant Paediatrician, bearing in mind the safety of the child and the conduct of any Police investigations. The possible outcome of referrals is the same as for any other referrals.

If emergency action is the required response e.g. if a child's life is in danger through poisoning or toxic substances being introduced into the child's blood stream, an immediate strategy discussion should take place, where possible, between CYPS (Social Care), PPIU, health and other agencies as appropriate.

See attached Flowchart 2 on next page.

FLOWCHART 2 – REFERRAL



5.3 Social Care Initial Assessment, Outcomes & Immediate Protection

An initial assessment should usually be undertaken under Section 17 of the Children Act 1989, as with all referrals following the guidance set out in the *Assessment Framework*. In cases of FII this must be undertaken in collaboration with the consultant paediatrician responsible for the child's health care.

The outcomes of the initial assessment are as described in Section 5 of Wigan's Child Protection Procedures. The decision should be made in consultation with the paediatric consultant and police, with agreement reached regarding what the parents should be told. 'Concerns should not be raised with a parent if it is judged that this action will jeopardise the child's safety.' *(Safeguarding Children in Whom Illness is Fabricated or Induced* paragraph 3.16)

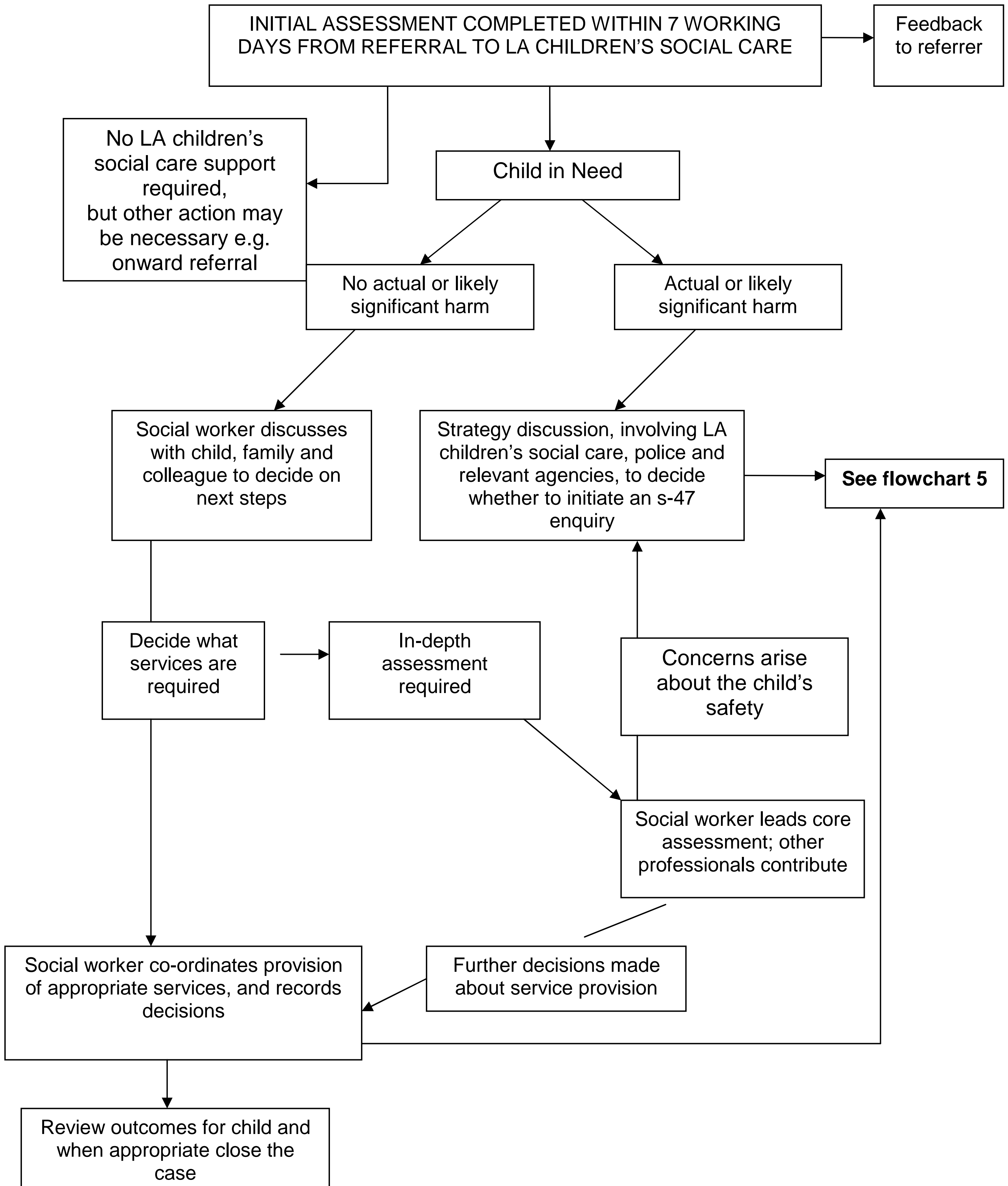
If at any point there is medical evidence to indicate that the child's life is at risk or there is a likelihood of serious immediate harm, an agency with statutory child protection powers (i.e. Social Care, Police) should act quickly to secure the immediate safety of the child.

5.4 In situations whereby the parent / carer is a member of staff from the children's workforce

If any concerns relate to a member of staff, at this stage these should be discussed with the relevant named or designated professional of that Agency before discussion with the Local Authority Designated Officer (LADO).
http://www.wiganlscb.com/Allegationsagainststaff.asp

See attached Flowchart 3 on next page.

FLOWCHART 3 - WHAT HAPPENS FOLLOWING INITIAL ASSESSMENT?



5.5 Strategy Meeting

If there is reasonable cause to suspect the child is suffering, or likely to suffer significant harm, Peoples Services, Social Care should convene and chair a strategy meeting involving all the key professionals. This meeting is strongly advised when considering this complex form of abuse.

This meeting requires the involvement of Social Care Service Managers (as listed on page 28) responsible for the child's welfare. At a minimum this must include Children's Social Care, police and the paediatric consultant responsible for the child's health. Additionally the following should be invited as appropriate:

- Named / Designated Doctor.
- GP.
- Health Visitor / School Nurse.
- Staff from education setting if appropriate age.
- Local authority's legal adviser.
- CAMHS / Adult Mental Health – (i) when they themselves identify / suspect FII concerns; (ii) in an advisory role to other professionals working with families re: interventions to parents / carers and; (iii) to offer Mental Health Assessment(s) and or specialist interventions to the parent(s) / carer(s).

If the agencies or professionals are not in agreement with the outcome a medical professional with expertise in FII needs to be consulted.

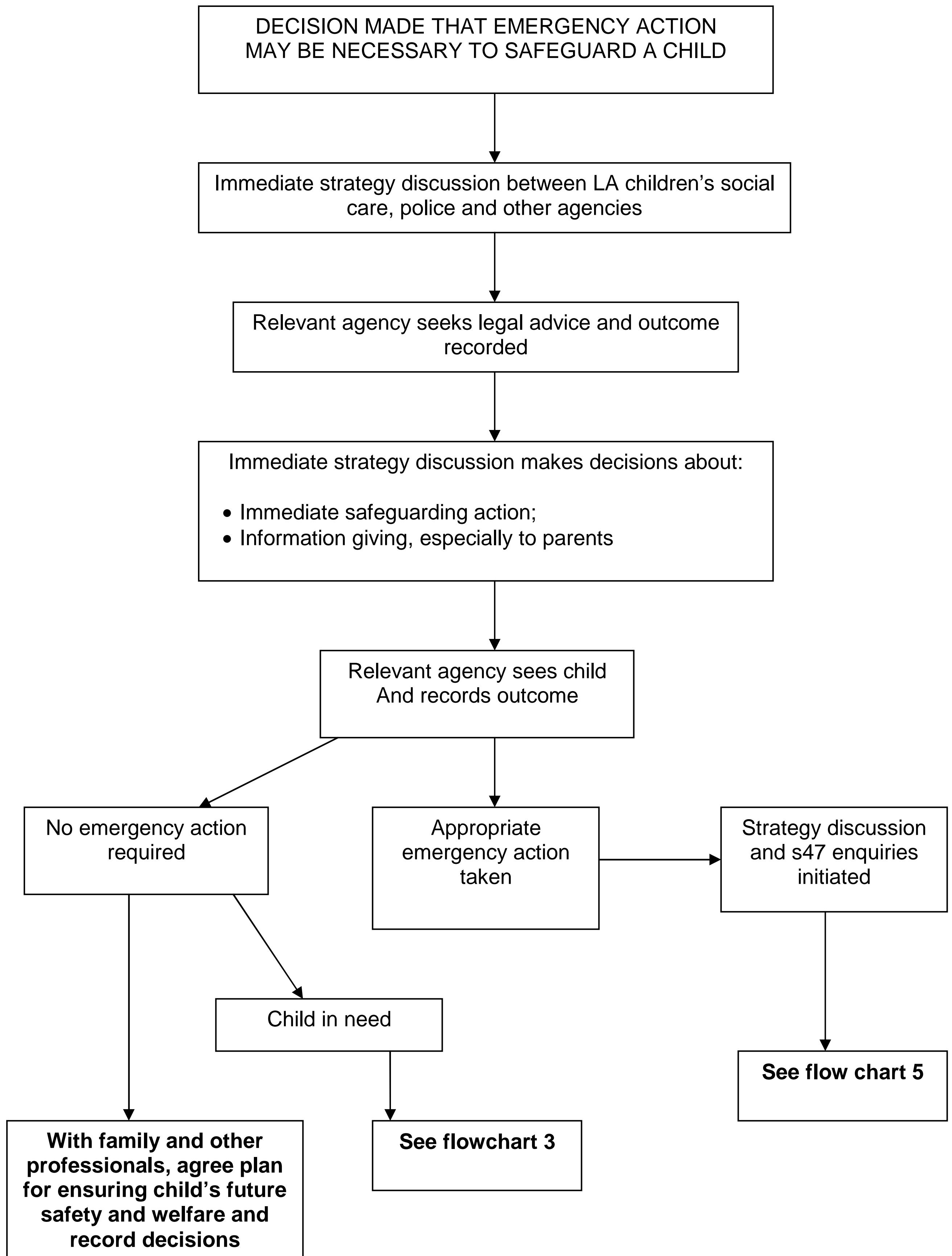
When it is decided that there are grounds to initiate a S.47 enquiry decisions should be made about how the S.47 enquiry as part of the core assessment will be carried out including:

- Whether the child requires constant professional observation, and if so, whether the carer should be present.
- The designation of a medical clinician to oversee and co-ordinate the medical treatment of the child to control the number of specialists and hospital staff the child may be seeing.
- Arrangements for the medical records of all family members, including children who may have died or no longer live with the family, to be collated by the consultant paediatrician or other suitable medical clinician.
- The nature and timing of any police investigations, including analysis of samples and covert surveillance (this will be police led and co-ordinated, with advice available from the National Crime Faculty).
- Covert Surveillance is led by the Police but needs to follow both Police and Health Guidance. Written permission for Covert Surveillance must be obtained from the Health Trust on whose premises the surveillance is taking place.
- The need for extreme care over confidentiality, including careful security regarding supplementary records.
- The need for expert consultation.
- Any particular factors, such as the child and family's race, ethnicity, language and special needs which should be taken into account.
- The needs of siblings and other children with whom the alleged abuser has contact.
- The needs of parents.
- Obtaining legal advice over evaluation of the available information (where legal adviser not present at meeting).

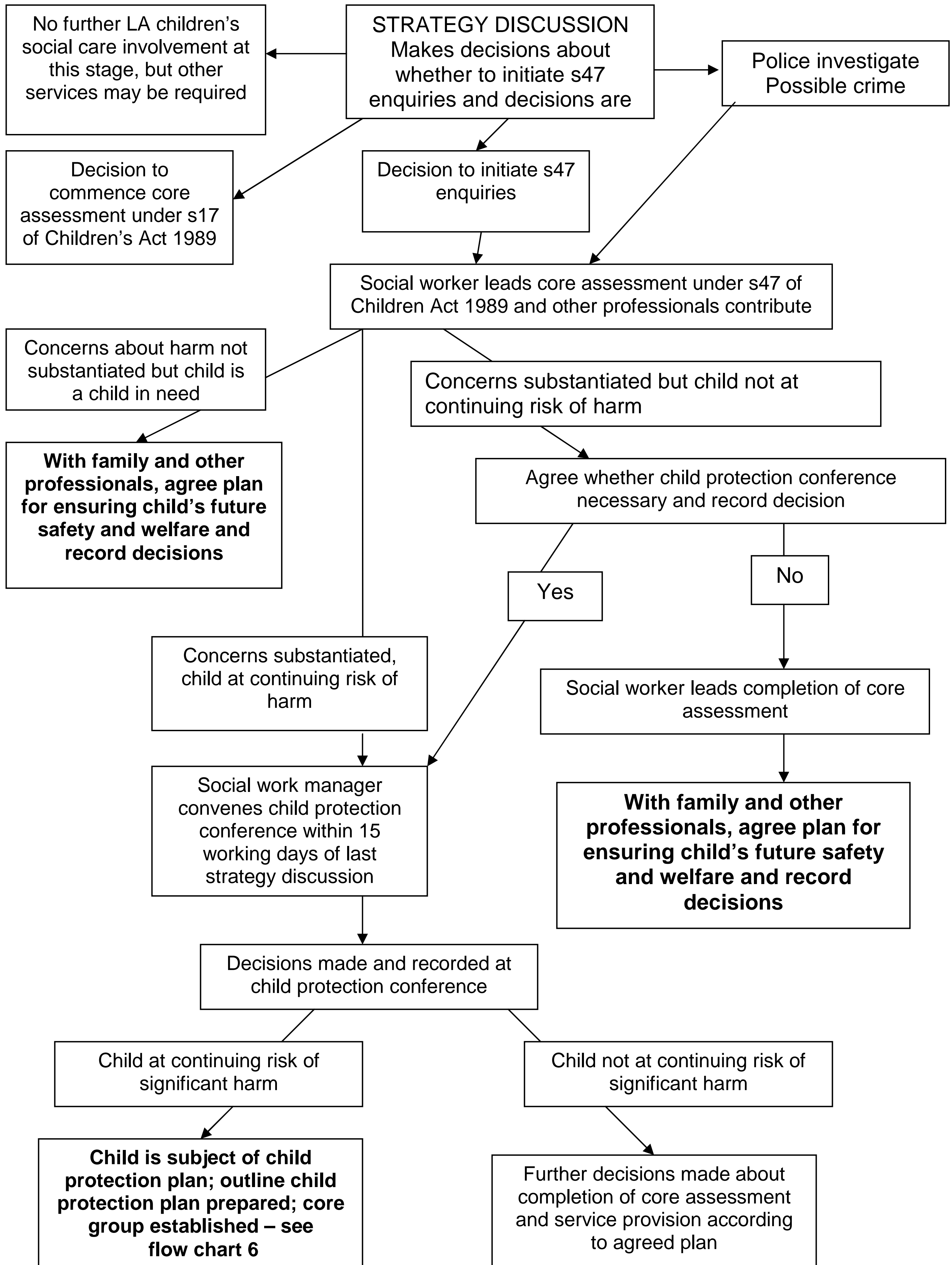
‘It may be necessary to have more than one strategy meeting. This is likely where the child’s circumstances are very complex and a number of discussions are required to consider whether and, if relevant, when to initiate s. 47 enquiries.’ *Safeguarding Children in Whom Illness is Fabricated or Induced (para* 4.32.)

See attached Flowcharts 4 and 5 on subsequent pages.

FLOW CHART 4 - URGENT ACTION TO SAFEGUARD CHILDREN



FLOW CHART 5 - WHAT HAPPENS AFTER THE STRATEGY DISCUSSION



6. Police Investigation

Any evidence gathered by police should be available to other relevant professionals, to inform discussions and decisions about the child's welfare and contribute to the S.47 enquiry and core assessment, unless this would be likely to prejudice criminal proceedings.

It is important that suspects' rights are protected by adherence to the Police and Criminal Evidence Act 1984, which would normally rule out any agency other than the police confronting any suspect persons.

6.1 Use of Covert Video Surveillance

The use of covert techniques for intelligence gathering is something the police may wish to consider. Such techniques are bound by the Regulation of Investigatory Powers Act 2000 and can only be used given the necessary levels of authority that the Act requires.

The police will need to consider the development of contingency plans (as part of their application) that manage the risk to children that may be revealed as victims of abuse as a result of such techniques being used.

See also paragraph 5.7 of *Fabricated or Induced Illness by Carers* (Royal College of Paediatrics and Child Health, 2002).

7 Outcome of Enquiries

As with all s.47 enquiries, the outcome may be that concerns are not substantiated – e.g. tests may identify a medical condition, which explains the signs and symptoms.

It may be that no protective action is required, but the family should be provided with the opportunity to discuss what further help it may require.

Concerns may be substantiated, but an assessment made that the child is not judged to be at continuing risk of harm. In this case, the decision not to proceed to a Child Protection Conference must be endorsed by a Service Manager in Children's social care

Where concerns are substantiated and the child judged to be suffering or at risk of suffering significant harm, a Child Protection Conference **must** be convened. All evidence should be thoroughly documented by this stage and the protection plan for the child already in place.

8 Initial Child Protection Conference

Ref: Chapter 5 of WSCB Child Protection Procedures
http://www.wiganlscb.com/childprotection.asp

The conference should be held within 15 working days from the **last** strategy meeting.

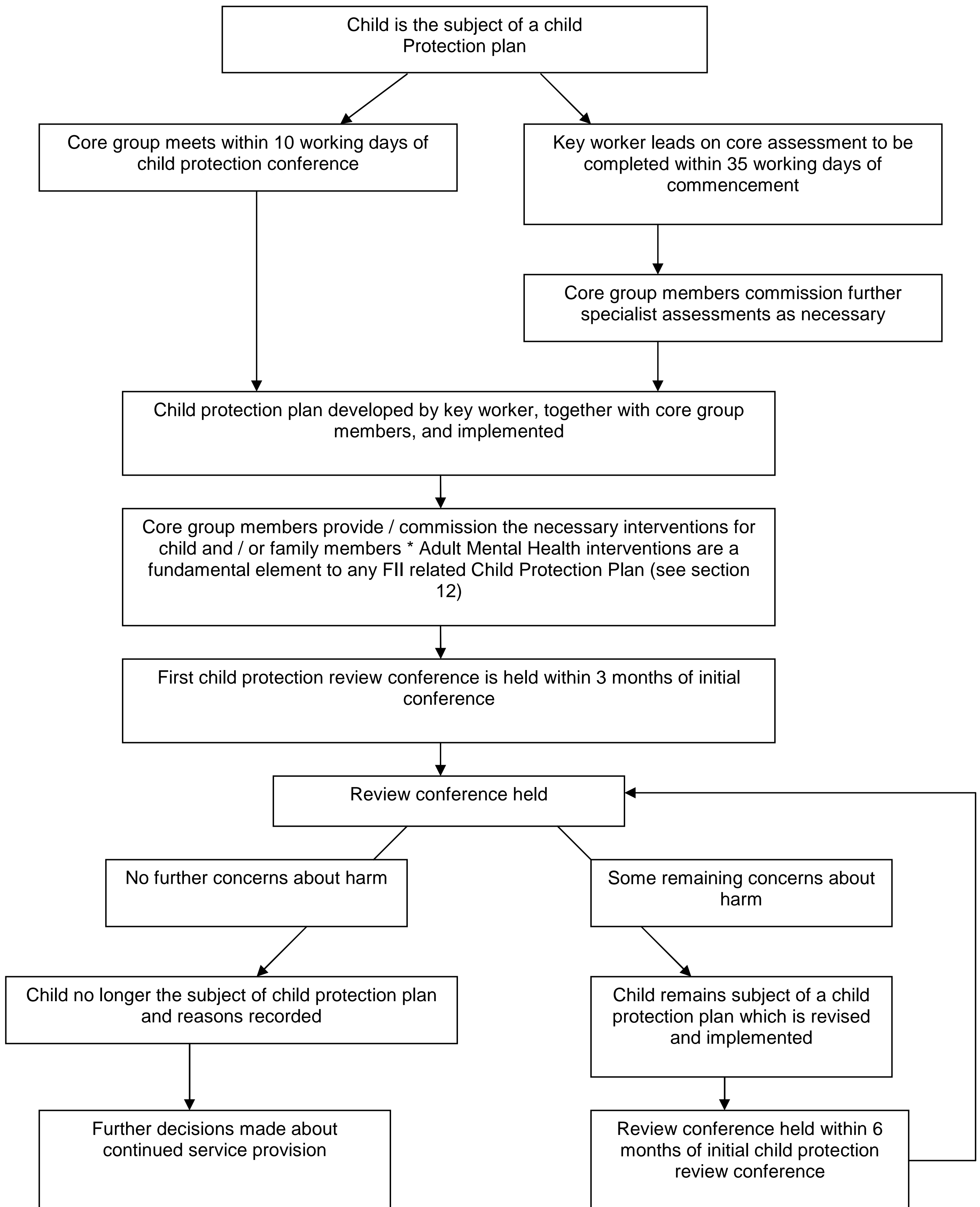
Attendance at this conference should be as for other initial conferences, with the additional experts invited as appropriate:

- Professional with expertise in working with children in whom illness is fabricated or induced and their families.
- Paediatrician with expertise in the branch of paediatric medicine, able to present the medical findings.

The decision as to whether a child / young person attend the Conference resides with the Independent Chair. Within this decision the welfare of the child / young person is paramount. During the Conference, consideration should always be given to any other siblings.

See attached Flowchart 6 on the next page.

FLOW CHART 6 - WHAT HAPPENS AFTER THE CHILD PROTECTION CONFERENCE, INCLUDING THE REVIEW PROCESS?



9 Pre-birth Conference

Evidence of illness having been fabricated or induced in an older siblings or another child abuse be carefully considered during the pregnancy of a woman who is known to have abused a child in this way. Some pregnant women may have a history of fabricating illness in themselves during previous pregnancies. This could include fabrication of medical problems whilst the baby is in the womb. Her behaviour may pose a risk to the unborn baby in the current pregnancy.

An assessment of the unborn baby should be undertaken and following S47 enquiries, a pre-birth conference should be convened if it is considered the unborn child's health to be at risk or the baby is likely to suffer significant harm following birth.

10 Allegations against Staff

Experience has shown that children can be subjected to abuse by those who work with them in any and all settings. Allegations may arise from a range of sources, including children themselves, parents, staff, foster carers or volunteers. Regardless of the source of the concern, allegations should be taken seriously and treated with accordance with WSCB Allegations against staff or volunteers LADO) Local Authority Designated Officer Protocol
http://www.wiganlscb.com/Allegationsagainststaff.asp

In this area of work, it is also the case that concerns may be expressed by parents/carers about one or more members of medical, nursing or other staff who are responsible for medical investigation, diagnosis or treatment of their child. Such concerns may or may not include elements of alleged abuse by the member of staff against the subject child. Similarly, such expressions of concerns may not relate to allegations of actual abusive behaviour by staff, but instead, in effect, be complaints which should be dealt with in accordance with the relevant agency's complaints handling process.

11 Information Sharing

Ref Chapter 3 of WSCB Child Protection Procedures
http://www.wiganlscb.com/childprotection.asp

12 Interventions with children, young people and family members / carers

Where a child has had illness fabricated or induced, the child protection plan should be carefully constructed on the basis of the findings of the assessment. Decisions about how to intervene, including what services to offer, should draw on evidence about what is likely to work best to bring about good outcomes for the child.
Interventions should specifically address:

- The developmental needs of the child.
- The child's understanding of what has happened to him or her.
- The abusing carer/child relationship and parental capacity to respond to the child's needs.
- The relationship between the adult carers both as adults and parents;
- family relationships; and
- The management of any presenting signs, illnesses or reports of symptoms.

Interventions should address the child's physical, social and emotional needs. If the child has been very ill as a result of their abuse, he or she may require a period of hospitalisation before

being well enough to be discharged. In parallel, work is likely to be necessary with family members in different groupings depending on the agreed plan; the relationship between the child and the carers responsible for the abuse; the parents' relationship with each other, with the abused child and with all their children; the family's relationships with health professionals; and individual work with the adult responsible for the abuse.

Parents with a psychiatric history may require immediate help if, for example they have a history of attempting suicide or self-harming. This intervention with the parent will be part of the overall programme of work which focuses on the child's welfare.

Information about past relationship difficulties and the nature and outcome of any previous therapeutic help should also inform decisions about how best to intervene in each family.

- **5 Boroughs**

CAMHS have a role in the provision of a range of psychiatric and psychological assessment and treatment services for children and families. Services that may be provided, in liaison with the Local Authority People's Directorate, Primary Care Trusts and other relevant agencies. Proactive partnership working arrangements are essential to protect and support children and young people.

- **Social Care - Children with complex needs / disabilities**

In line with Social Care, Children with Complex Needs team and those working with disabled children will continue to work closely and proactively with health, education colleagues and other relevant agencies. The team will utilize the knowledge of the child in a range of settings including their home. The social worker will be observant in regard to not only the disabled child but the other children in the household. Concerns will be reported to their line manager and safeguarding procedures initiated as appropriate.

13 Record keeping

Careful and detailed note taking by all staff, including health professionals, is fundamental to any police investigation or court action. All professionals must carry out meticulous, accurate contemporaneous recording of care. This must include who is carrying out care, visiting patterns of carers and others and interaction between child and carer. Document all discussions regarding a child, whether they are face to face or telephone. Any unusual events should be recorded and a distinction should be made between events reported by the carer and those actually witnessed by staff from the onset.

Notes should be timed, dated and legibly signed. Most importantly, notes should be kept in a secure place and clearly marked on whom can have access to them. All records should be kept securely to prevent unauthorised access and ensure they cannot be interfered with.

14 Training

The Designated Doctor, Designated and Named Nurses offer multi agency face to face training for relevant practitioners. In order to access this training, practitioners at Level C of the WSCB Training Strategy and Managers at Level D should complete the WSCB online Training Needs Analysis (TNA) and use their unique reference number to book on FII face to face ½ day training. This training will be overseen by the WSCB Training Pool and agency attendance will be monitored by the WSCB Training Strategy Delivery Group on behalf of WSCB.

It is imperative that relevant staff from within the Acute Trust (A&E staff, Midwives, Neo Natal and Paediatric staff), Adult and Children's Social Care (particularly Duty Team staff), GMP Police Public Protection Investigation Unit (PPIU) and Adult Mental Health / CAMHS Services staff attend this training, in order to ensure they can effectively identify, assess and respond to cases of FII and appropriately / timely safeguard children and young people.

15 Supervision and support for individual staff

The requirement to provide supervision and support to front line staff within child protection is well documented in statutory national guideline (Working Together to Safeguard Children, 2006 and 2010). This has also been identified in several local case reviews which have recently been published by the Wigan Safeguarding Children Board (2010). The National Service Framework for Children and Young People and Maternity Services - Standard 5 states that consistent high quality supervision is the cornerstone of effective safeguarding of children and young people. There is also a requirement for agencies to provide appropriate supervision to staff who work directly with children and young people and especially in relation to cases where there are concerns about harm, self-harm or neglect of a child or young person. Supervision and support can be sought from the named professionals or agency supervisors.

16 Responding to complaints

If a complaint is made by the parent / carers the individual agency complaints procedures should be followed.

17 References:

- Working Together To Safeguard Children; Department for Children & Schools and Families DCSF (2010)
- Supplementary Guide to Working Together to Safeguard Children: Safeguarding Children in Whom Illness is Fabricated or Induced, Department of Education & Schools and Families DCSF (2008)
- Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians, Royal College of Paediatrics and Child Health October (2009)

Appendices

Appendix 1 WSCB FII Chronology Template
Appendix 2 Contact list for relevant Health Professionals

This document was produced by the FII working group;
Chaired by Dr E Abbas, Consultant Community Paediatrician, Designated Dr for safeguarding children.

Members:
Kara Haskayne, Business Manager of Wigan Safeguarding Children Board
Tania Few, Named Nurse for Safeguarding 5 Boroughs Partnership
Jean Butcher, Named Nurse ALWCH NHS Trust
Sean Atkinson, Manager IRO Service, People Directorate
Angela Shortall, Social Care Team Manager, People Directorate
Cath Pealing, Principal Officer Pupil Inclusion, People Directorate

Appendix 1 **WSCB Fabricated / Induced Illness Chronology**

Childs Name:

Childs DOB:

Agency completing chronology:

Name and role of person completing chronology:

Date of completion:

Date	Time	Source of Information	Subject of recording	Event description, actions and outcomes	Expected Practice/Standards	Child Seen (y/n)
Enter the date dd/mm /yy ***ONLY***		*e.g. data systems, hard file, clinic interview, hospital admission.*	*e.g. Family member, using the provided code for name*	*Detail the event, any observations noted, reasons for decisions taken and action take/not taken with reasons*	*Refer to your own internal policies and standards and what was/was not met*	*Simply state* **Y** *or* **N**

Appendix 2

Contact list for relevant Health Professionals

Designated Nurse - NHS ALW	Joanne Hiley 01942 481159
Named Doctor - NHS ALW & ALWCH	Dr Justin Tankard 01942 481159
Named Nurses - ALW CH	Jean Butcher / Debbie Hammersley 01942 481161
Designated Doctor - WWL	Dr Elham Abbas Via Switchboard : 01942 244000 (Ext 2263)
Named Doctor – WWL	Dr Rob Downes Via Switchboard : 01942 244000 (Ext 2263)
Named Nurse – WWL	Debbie Spruce Via Switchboard : 01942 244000 (Ext 8782) Mobile: 07825 450276
Named Midwife – WWL	Caroline Ashton Via Switchboard : 01942 244000 (Ext 8630) Mobile: 07740 483282
Named Doctor – 5BP	Dr Nieves Mercadillo 01925 664121
Named Nurse – 5BP	Tania Few 01925 664121
Named Nurse – GMW	Carol Marsh 01942 487545

Police	Family Support Unit 0161 856 7954
NSPCC National Helpline	0808 800 5000
Social Care Service Managers	Lynn Fields (Locality 1) 01942 828468 Sharon Hawkins (Locality 2) 01942 776013 Diane Vincent (Locality 3) 01942 487200 Paul Connolly (Locality 4 and 5) 01942 404730
Children's Duty Team **Adults Duty Team** **Out of Hours**	8.45 am – 5 pm 01942 828300 5.00 - 8.00 pm 01942 828777 8.00 pm - 8.45 am 0161 834 2436