Avon and Somerset Joint Agency Protocol for the Management of Suspected Fabricated and Induced Illness in Children

May 2005

FOREWORD

There is unequivocal evidence that carers can and do cause harm to children through fabricated and induced illness. There are the intertwining problems of:

a) Fabrication or Illness Induction in Children by carers;

b) Whether the child has suffered significant harm or is likely to.

Professionals have difficulties because there are uncertainties about each of the threads in the double strands of harm and of mechanism of harm.

Uncertainty can be reduced through competent professional judgements, clear guidance, and maintaining the welfare of the child as a priority. Key to this is effective information sharing, collaboration, understanding joint decision-making, and trust between agencies.

These Joint Agency Guidelines for the Management of Suspected Fabricated and Induced Illness in Children have been drawn up locally by senior Officers and practitioners, across agencies. They build upon perceived good practice and are based on relevant research and guidelines. Their aim is to advance the essential processes of joint working and ensure clarity and consistency in the management of suspected fabricated and induced illness in children.

Wide consultation has taken place and representatives from the five local Area Child Protection Committees have contributed to their compilation. The guidelines have been endorsed by each of the Local Area Child Protection Committees (Bath and North East Somerset, Bristol, North Somerset, Somerset, South Gloucestershire) and will be incorporated into local Children in Need procedures.
The chairs of those Area Child Protection Committees have approved the implementation.

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Avon & Somerset Joint Agency Guidelines for the Management of Suspected Fabricated and Induced Illness in Children

These guidelines have been developed by a multi-agency working group across Avon and Somerset to ensure clarity and consistency in the management of suspected fabricated and induced illness in children. The guidelines apply to all children up to the age of 18. At the older end of the age range, consideration should be given to factors that would make the young person particularly vulnerable, and also to appropriate liaison with adult services.

The guidelines are intended to be used in conjunction with national guidance including Working Together to Safeguard Children; What to do if you are worried a child is being abused and Safeguarding children in whom illness is fabricated or induced, and with local Area Child Protection Committee (ACPC) Procedures. The guidelines are based on perceived good practice as outlined in the above documents and other relevant research and guidelines. Sources of further information are provided as an appendix.

Contents

Date for Review: January 2006

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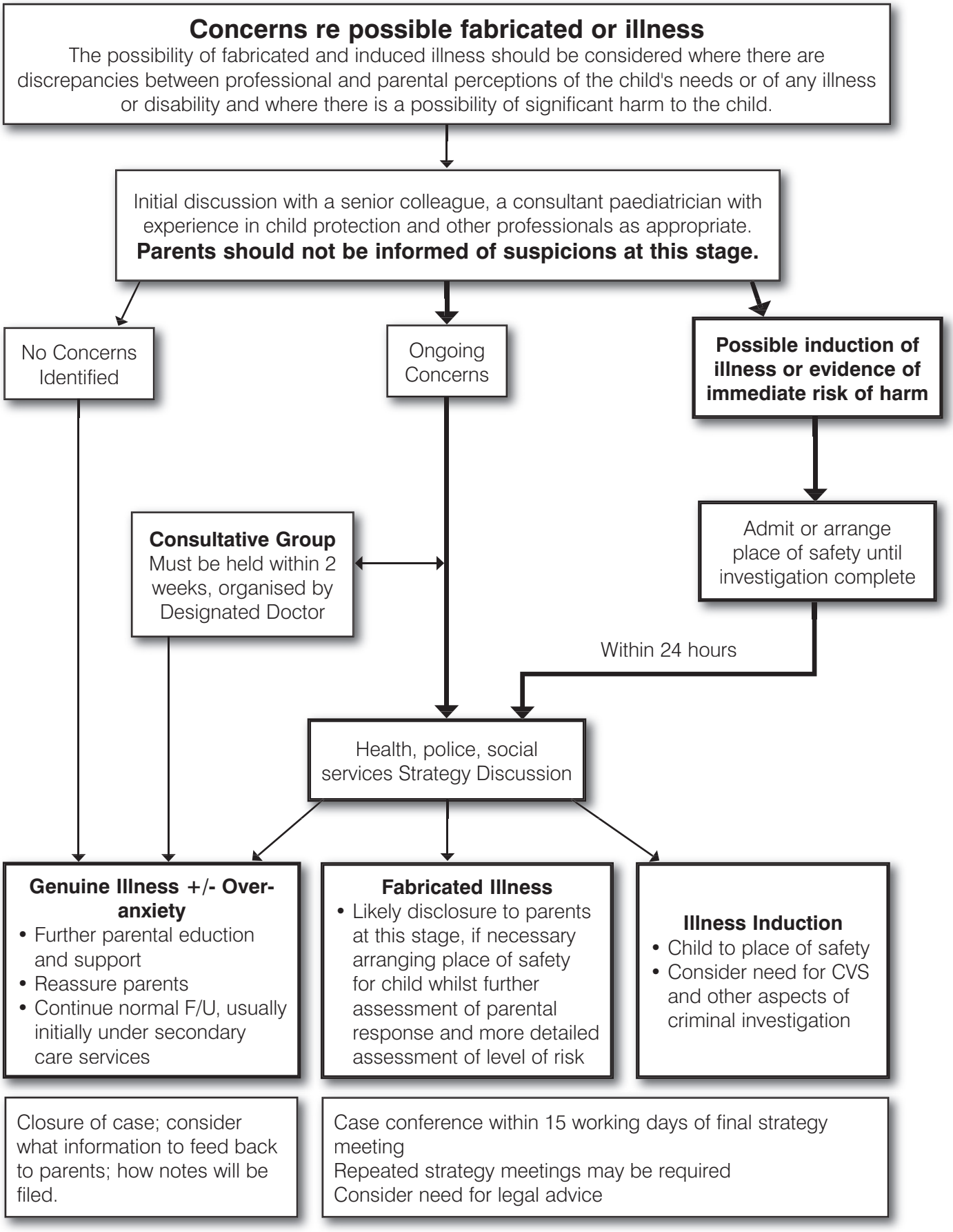
Flowchart


Concerns re possible fabricated or illness
The possibility of fabricated and induced illness should be considered where there are discrepancies between professional and parental perceptions of the child's needs or of any illness or disability and where there is a possibility of significant harm to the child.
Initial discussion with a senior colleague, a consultant paediatrician with experience in child protection and other professionals as appropriate.
Parents should not be informed of suspicions at this stage.
No Concerns Identified
Ongoing Concerns
Possible induction of illness or evidence of immediate risk of harm
Consultative Group
Must be held within 2 weeks, organised by Designated Doctor
Admit or arrange place of safety until investigation complete
Within 24 hours
Health, police, social services Strategy Discussion
Genuine Illness +/- Over-anxiety
• Further parental eduction and support
• Reassure parents
• Continue normal F/U, usually initially under secondary care services
Fabricated Illness
• Likely disclosure to parents at this stage, if necessary arranging place of safety for child whilst further assessment of parental response and more detailed assessment of level of risk
Illness Induction
• Child to place of safety
• Consider need for CVS and other aspects of criminal investigation
Closure of case; consider what information to feed back to parents; how notes will be filed.
Case conference within 15 working days of final strategy meeting
Repeated strategy meetings may be required
Consider need for legal advice

1 Child Welfare Concerns: Recognising And Responding To Possible FII

There are three main ways of a carer fabricating or inducing illness in a child. These are not mutually exclusive:

fabrication of signs and symptoms. This may include fabrication of past medical history;

fabrication of signs and symptoms and **falsification** of hospital charts and records, and specimens of bodily fluids. This may include also falsification of letters and documents;

induction of illness by a variety of means.

The possibility of fabricated or induced illness should be considered where there are discrepancies between professional and parental perceptions of the child's needs or of any illness or disability and where there is a possibility of significant harm to the child. Whilst differences of opinion do arise out of normal parental concerns and anxieties, professionals should be alert to the possibility that a small number of parents will either fabricate or induce illness in their child.

These cases will often be identified in a hospital setting, where a paediatrician is involved in the care of the child. They may however also arise in a variety of community settings including primary care, nurseries and education.

Any professional with concerns about possible fabricated or induced illness should consult at the earliest opportunity with a senior colleague and a consultant paediatrician with experience in child protection in order to decide on the appropriate course of action and likely level of risk.

Cases of suspected fabricated and induced illness will be investigated and managed by local teams through the normal child protection procedures as laid out by the relevant ACPC guidelines. However, these cases are often extremely complex and it is therefore important that professionals from all disciplines should have access to experienced colleagues with whom they can discuss concerns at an early stage. A consultative service is being established to facilitate such discussions in cases where there are diagnostic uncertainties or differences in professional opinion. This service does not take the place of a formal child protection assessment.

Any suspected case of fabricated or induced illness may also involve the commission of a crime and therefore the police should always be involved as early as possible in accordance with *Working Together.*

It is important to recognise that the child may have genuine medical needs either as a result of, or in conjunction with any fabricated illness. These medical needs must be responded to as a priority. Responding to the medical needs of the child should not be delayed or avoided because of any ongoing child protection investigation.

It is important to assess the child's understanding, if old enough, of their symptoms and the nature of their relationship with each significant family member (including all care-givers), each of the care-givers' relationships with the child, the parents' relationship with each other and the children in the family, as well as the family's position within their community.

If at any point there is medical evidence that the child's symptoms are being induced or the child is otherwise at risk of harm, immediate action may be required to ensure the child's life is not put at risk. Emergency action should normally be preceded by an immediate strategy discussion between the police, social services, health and other agencies as appropriate.

Consideration needs to be given to the long term needs of the child and family, including any mental health needs.

Care should always be taken over confidentiality in such cases. Sharing information with the family at an early stage may jeopardise any child protection investigation, and may put the child at further risk of harm. Sharing information with other professionals may influence the way they view or respond to the child and family.

Any notes or minutes made during the course of an FII investigation or discussion between agencies, may be required to be disclosed to the defence in any subsequent prosecution or inquest.

Where information is requested by the Data Protection Act under subject access, involved agencies should consult with each other prior to any decision being made on releasing the information.

2 Consultancy Service For FII

Role and Function of a consultancy service

Any professional who identifies concerns about the possibility of FII may benefit from talking their concerns through with experienced colleagues, preferably on a multi-agency basis. This would be before the case proceeded to a formal strategy and would not take the place of a formal multi-agency strategy meeting.

In order to facilitate this, a consultancy service is available to enable such discussions to take place at an early stage and in a confidential manner. This is an Avon and Somerset wide service drawing on a pool of professionals with appropriate expertise. The consultative group can be used at the earlier stages of concerns or if professionals feel unclear how to proceed. This would not take the place of formal referral for assessment or intervention by other agencies.

The role of this group is to advise and assist in decision making, and not to take over the clinical care of the child, nor to carry out a full child protection investigation.

If it was the lead professional's view (usually a Consultant Paediatrician) that the case was definitely FII, then proceeding to a multi-agency strategy must not be held up by talking to the consultative group.

Structure and Membership

The Consultancy Service consists of a group of core professionals who are able to be contacted and have time available to fulfil this role. They do not meet on a regular basis, but are convened according to need, often at short notice. There should be as little delay as possible in gathering the Consultancy Group together.

The Consultancy Service is made up of professionals experienced in child protection and when convened should include at least:

- The Designated Doctor for child protection for the area in which the child is resident (Chair)
- Designated Nurse – Child Protection
- Social Services Team Manager with appropriate experience
- Police representative from the Child Abuse Investigation Team. Normally this will be of DI level and should have appropriate experience in child protection.
- Where appropriate a specialist Consultant eg in epilepsy or SUDI, would be co-opted to the Consultancy Group if the clinical condition is complex.
- A representative from the Child and Adolescent Mental Health Service.

The referring professional will become a member of the Consultancy Group during the time relevant for their particular case.

Consideration should be given to inviting the GP, the health visitor or school nurse, and any other professionals with a close knowledge of the case including representatives from education.

Further advice could also be obtained from colleagues in adult mental health services as appropriate to the case.

Process of accessing consultation

The consultative service is a tertiary service for complex cases where diagnostic uncertainty remains after local case discussion.

Referrals to the service will normally be through the consultant in charge of the case. Other professionals, including GPs, head teachers, social services team managers or the police

Child Abuse Investigation Team can refer to the service, but all referrals should be made by a senior practitioner in the relevant agency. All referrals should be made through the Designated Doctor

All referrals should be backed up in writing by the referring professional with the following information:

- the presenting features of the case (including genogram)
- the main concerns of the professionals involved
- areas of possible professional and parental dispute
- a chronology of concerns and interventions.

The chair of Consultancy Group will confirm date, time and venue and distribute the relevant material to the group. The information provided should have been read by all members prior to the meeting. Each agency representative attending the meeting should prepare any relevant information to bring to the group.

Whilst professionals should seek in general to discuss any concerns with the family and, where possible, seek their agreement to cases being discussed and referred to social services, this should only be done when to do so will not place a child at risk of significant harm, as stated in Working Together. Because of the nature of Fabricated or Induced Illness it is likely that this criterion for not sharing concerns with the family is met and therefore discussion with the Consultation group without knowledge or agreement of parents is acceptable This decision and the reasons for not seeking consent should be clearly recorded.

It is important for referrers to the consultation group not to initiate too wide discussion amongst their colleagues at this point. This avoids the risk that parents/carers become aware of concerns before it is appropriate This could be either by being told by someone who does not share the concern or by being faced with altered reactions as others become suspicious that the parent/carer is making up symptoms.

Process of the consultation

The main topics to be covered at the meeting of the Consultation Service would be:

- To review the features of the case
- To identify any further information that may be required and how such information would be obtained, including consideration of how the child's own concerns and wishes can best be determined
- To identify any areas of concern, including identifying the needs of the child; assessing the parents'/carers' capacity to respond to those needs and to promote the child's health and development
- To make a decision on whether action is required to safeguard and promote the child's welfare. If the conclusion of the Consultation Service is that the child is at risk of significant harm and a child protection referral is necessary the most appropriate person to make the formal referral will be agreed. This would normally be the person making the initial referral to the group.
- To draw up a plan for the way forward with clear actions and persons responsible for each action
- To clarify what information will be shared with the parents and how this will be done

One of the group members will be identified to take documented minutes of the meeting including an identified action plan with individuals responsible for actions clearly stated (this should not be the chair or the referring professional). Anonymised minutes of the consultation will be sent to all those present.

The written minutes from the Consultation

Service should be kept securely to safeguard confidentiality. It may be necessary to keep these separately from the child's main health records during the early stages of the concerns being raised, if the notes are easily accessible to the parents or carers. However professionals must be aware that this documentation is available

The Consultant in charge would maintain responsibility for the care of the child throughout and management of the cases will not be taken over by the Consultation Group or the Named/Designated Doctor.

In cases where more than one consultant is involved, including cases referred from the region for a tertiary opinion, a lead clinician should be identified. This would normally be the child's local consultant in cases from the region. That consultant would be responsible for initiating any child protection procedures locally.

3 Referral and Investigation

If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, Social Services should convene and chair a strategy discussion which involves all the key professionals responsible for the child's welfare. It should, at a minimum, include the following:

- social services
- the police
- the medical consultant responsible for the child's health
- if the child is an in-patient, a senior ward nurse

It is also important to consider seeking advice from, or having present, a medical professional who has expertise in the branch of medicine, for example respiratory, gastroenterology, neurology or renal, which deals with the symptoms and illness processes caused by the suspected abuse. This would enable the medical information to be presented and evaluated from a sound evidence base.

Professionals involved with the child such as the GP, Health Visitor and staff from education settings should also be involved as appropriate.

It may also be appropriate to involve the local authority's solicitor at this meeting.

Staff should be sufficiently senior to be able to contribute to the discussion of often complex information, and to make decisions on behalf of their agencies.

Working Together does not require there to be a face to face meeting. In this complex type of abuse, however, a meeting **is likely to be** the most effective way of professionals discussing the child's welfare and planning future action.

The strategy discussion will be used to undertake the tasks set out in *Working Together*. It is vital that all available information is carefully presented and evaluated, and where possible, its accuracy having been verified at source. Where appropriate, legal advice should be sought when evaluating the available information. The following issues will need to be discussed:

- An outline of the concerns, the child's medical history and results of any investigations
- The child's current state of health and well being
- Any immediate risks to the child
- Relationships between the child and parents, along with other family dynamics
- The needs of siblings and other children with whom the alleged abuser has contact
- Any particular factors, such as the child and family's race, ethnicity and language which should be taken into account
- Whether the parents are aware of the concerns and what explanations they have given for the findings

An action plan will be drawn up at the strategy meeting indicating what action is to be taken, by whom and within what time scales. The action plan should address the following:

- What further information is required about the child and family and how it should be obtained and recorded
- Whether it is necessary for supplementary records to be kept in a secure place in order to safeguard the child and the manner in which they should be kept
- Whether the child requires constant professional observation and, if so, whether or when the carer(s) should be present
- Who will carry out what actions, by when and for what purpose, in particular the

planning of further paediatric assessment

The nature and timing of any police investigations, including the analysis of samples. This will be particularly pertinent if covert video surveillance is being considered, as this will be a task for which the police have responsibility (see section 5)

Legal advice should be sought, including whether an emergency protection order will be required

Ensuring the safety of any siblings

Who will undertake the section 47 core assessment and court reports

What information should be fed back to the parents/carers and to any professional staff; by whom and in what time scales (see 4.5)

Given the complexity of these cases, more than one strategy may be necessary. Dates and times of a review strategy should be arranged.

A copy of the strategy discussion should normally be kept in the child's medical notes. As the notes are openly accessible on the ward it may be appropriate for these decisions to be filed separately and confidentially until after any investigations are complete.

4 Criminal Investigations

Where it is decided that there are grounds to initiate a s.47 enquiry, decisions should be made about the nature and timing of any police investigations, including the analysis of samples. This will be particularly pertinent if covert video surveillance is being considered, as this will be a task for which the police should have responsibility.

Whenever the police are involved, the decision to inform the parents about any investigation will have a direct impact on the criminal investigation. The police must therefore always be involved in any discussions relating to what information is to be shared with parents, and when that information will be shared.

The police have a key role in assisting medical and social services staff to understand the reasons for the child's signs and symptoms. Whereas the police investigations may produce conclusive evidence of maltreatment, they may also confirm that the carer is not responsible for causing the child's condition.

The nature and timing of any criminal investigations will depend on the medical evidence. Whether or not police investigations reveal grounds for instigating criminal proceedings, any relevant evidence gathered by the police will be made available to other relevant professionals, to inform discussions about the child's welfare.

In cases where the police obtain evidence that a criminal offence has been committed by the parent or carer, and a prosecution is contemplated, it is important that the suspect's rights are protected by adherence to the Police and Criminal Evidence Act 1984. **This would normally rule out, for example, the suspect being confronted with the evidence by a paediatrician or any other personnel from the statutory agencies, except for the police, which is the lead investigative agency.**

Many of the children who have had illness fabricated or induced will be too young to be interviewed as part of any criminal investigation. If a decision is made to undertake an interview the guidance set out in *Achieving Best Evidence in Criminal Proceedings: Guidance for vulnerable or intimidated witnesses, including children* (Home Office et al, 2002) should be followed.

As well as planning the process of any investigation, the interagency team should, where possible, consider any strategy for arresting the parents or carers so that this can be achieved in an appropriate manner.

5. Covert Video Surveillance (CVS)

CVS is a legitimate investigative tool, but its use will only be considered when no other way of obtaining information that will explain the child's signs and symptoms is available, and a multi-agency strategy discussion has made a decision to use CVS.

Where CVS is likely to be considered the relevant Chief Executive of the Trust must always be consulted and the Chief Executive should be invited to attend the strategy meeting. The CVS operation can only be approved by the Chief Executive

CVS may also be considered in a community setting. The same principles will apply as to hospital settings and the procedures will be followed as governed by the Regulation of Investigatory Powers Act 2000.

The primary aim of CVS is to identify whether illness is being induced. Of secondary importance is the obtaining of criminal evidence.

Once this decision has been made, the police will be responsible for applying for the appropriate authority under the Regulation of Investigatory Powers Act 2000. If that authority is granted, the police will have sole responsibility for implementing and undertaking any such surveillance. Guidance on risk assessments in relation to CVS is available to the police within the NCOF/Centrex good practice document "Covert Video Surveillance in a Hospital Setting where Child Abuse is Suspected".

The safety and health of the child is the over-riding factor in the use of CVS, and the medical consultant responsible for the child's care should ensure that the necessary medical and nursing staff support the police operation.

All non-police staff involved will receive appropriate training from the police, and understand the need for strict secrecy during the operation.

Any CVS should be carried out locally. No hospital should be offering CVS as a regional or specialist service.

The decision to undertake CVS will be made at a multi-agency strategy meeting. The following professionals must be present:

- Senior officer from the police Child Abuse Investigation Team
- Social Services team manager
- Senior clinician – the consultant paediatrician responsible for the child's care
- Consultant paediatrician with child protection responsibility
- Trust Chief Executive or delegate
- Senior Nurse representative
- Child Protection Nurse Specialist/ Designated Nurse

The purpose of the strategy meeting will be to confirm the decision to undertake CVS; to clarify the aims of the surveillance; to develop an appropriate plan for undertaking the CVS. The following issues will need to be addressed:

- Where and when the surveillance will be carried out, including where the child and carer will be, and where the police team will be located
- If the child needs to be moved, e.g. from an open ward to a cubicle, how this will be managed
- How the equipment will be installed
- What the anticipated outcomes are; how these will be recognised by the police

team; what action may need to be taken and who will be responsible for taking it. If any medical intervention, e.g. resuscitation is required, how the nursing or medical staff will be notified; if police action, e.g. arresting a carer, is required, how this will be undertaken.

How long the surveillance will continue for and how and when the procedure will be reviewed.

Who will be notified that the surveillance is being carried out. As a minimum, this is likely to involve the consultant paediatrician on call, the senior ward nurse on each shift, and the clinical co-ordinator/nurse manager for each shift. The need for appropriate health personnel to be informed needs to be balanced against the needs for confidentiality, and to keep the operation covert. **It is important that only those staff who need to know are informed of the surveillance.**

The conduct of the surveillance will remain the responsibility of the police throughout. All videos will remain police property and are not available to the trust for any other purposes.

The use of CVS should be reviewed regularly through reconvened strategy discussions. Such discussions should be held at least every 48 hours whilst the surveillance is continuing, and more frequently if necessary. They should involve all those present in the initial discussion.

Following the termination of CVS, a further strategy discussion should be held to determine the ongoing management of the case.

At the point where CVS is stopped, appropriate feedback should be given to the family and to ward staff. The nature of this feedback will depend on the outcome, but will normally involve a full discussion of what has taken place, and should involve the senior police officer, senior clinician (consultant paediatrician) and senior ward nurse.

The police should arrange for the removal of any equipment as soon as possible in order to minimise any disruption to the ward.

Following any case involving CVS there should be a debriefing session for the ward staff involved. This should be attended by a senior manager, senior clinician and the child protection nurse specialist as well as representatives from social services and the police Child Abuse Investigation Team.

6. Concerns About Members Of Staff

Further guidance can be found in Working Together to Safeguard Children and Safeguarding Children in whom Illness is Fabricated or Induced. The basic principles described in these guidelines and local ACPC procedures for managing allegations against professionals should be applied.

Most cases of fabricated and induced illness involve parents or carers, however, experience shows that children can become victims of abuse by those who work with them in any setting. All allegations of abuse of children carried out by any professional staff member, foster carer, childminder or volunteer should therefore be taken seriously.

Allegations of abuse made against staff, whether historical or contemporary, should be referred to Social Services or the Police in the same way as any other concern about suspected abuse.

There are 3 separate aspects of the enquiries/ investigative process to consider:

- child protection enquiries
- a police investigation to determine whether a crime has been committed;
- single agency disciplinary procedures to determine whether there has been misconduct or gross misconduct on the part of the alleged abuser.

It is essential that the common facts of the alleged abuse are applied independently to each of these three strands of possible enquiry/ investigation. The fact that a prosecution is not possible does not mean that action in relation to safeguarding children, or employee discipline, is not necessary or feasible. It is important that each aspect is thoroughly assessed and a definite conclusion reached.

An initial strategy discussion should address all three aspects of the investigation. In addition to those normally present at a strategy meeting, there must be a senior management representative from the employing organisation present and consideration should be given to the involvement of human resources or legal representation. As well as considering risks to the child or children involved in the allegation, consideration should be given to other children in the individual's home, community or work life, and to the possibilities of more widespread or organised abuse.

Parents/main carers should be given information about the concerns and advised on the processes to be followed and the outcomes reached. However, the provision of information and advice must take place in a manner that does not impede the enquiry, disciplinary and investigative processes, and therefore it should be planned in discussion at the strategy meeting.

Staff members, foster carers and volunteers are owed a duty of care and should be treated fairly, honestly and without discrimination. They should be provided with support throughout the process; and should be helped to understand the concerns expressed and the processes being operated. They should be clearly informed about the outcome of any investigation and the implications for disciplinary or related processes. The investigation should be completed as quickly as possible, consistent with its effective conduct. The police and other relevant agencies should always agree jointly when to inform the suspect of allegations that are the subject of criminal proceedings.

Whenever an allegation or suspicion arises, managers and staff investigating allegations or complaints, under whatever procedure, must co-operate and communicate effectively in order to ensure the best outcomes for children. So

far as is possible, any evidence gathered by the local authority or the police in the course of the child protection enquiries, must be made available without delay to the staff responsible for disciplinary or complaint investigation. Investigations must be conducted in the strictest confidence so that information can be given freely and without fear of victimisation. Information about an allegation must be restricted to those who need to know in order to protect children; investigate the allegation; and manage disciplinary/ complaints aspects. Any breach of this may lead to disciplinary action.

Any staff member, who believes that allegations or suspicions have been reported to the line manager but are not being investigated properly, has a responsibility to report their concerns to a senior manager in their agency or a Designated professional. If there is reason to believe that this will hinder investigation, consideration should be given to reporting to an ACPC member from another agency.

It is possible that in cases where Fabricated or Induced Illness is suspected health professionals will become subject to malign allegation by a parent or carer who is the perpetrator. Where allegations are made as part of a complaint by a parent or carer this should not be dealt with under normal Trust complaints procedures without discussion with Designated child protection professionals (preferably from another Trust)

7. Concluding an Investigation

Outcome of Consultations, Strategy meetings or Section 47 Enquiries

Further guidance is provided in Safeguarding children in whom illness is fabricated or induced 3.38 – 3.63

Concerns not substantiated

It is possible that the outcome of the consultation or a single, or a series of, strategy meetings is that a clear and unequivocal reason is established for the child's signs and symptoms that does not indicate abuse or neglect and that the child is not at risk of significant harm and no further child protection action is necessary. This decision should be agreed at a strategy meeting.

In these cases it is important that there are clear decisions on ending the process, including:

- arrangements for monitoring the child's progress and responding to further concerns
- arrangements for reporting back to the person expressing the original concern if not part of the strategy discussions
- arrangements for sharing the concerns with the child's parents or carers and how much detail is shared about the discussions which have taken place between agencies

Careful planning will need to be undertaken as to how parents / carers are advised of the enquiries that have been made and the decisions reached. In cases where Fabricated or Induced Illness has been suspected informing parents / carers may lead them to be wary of future contact with health professionals even when their child may be genuinely unwell - resulting in possible harm to the child. Informing parents / carers where further monitoring is required or agencies feel there is insufficient evidence to formalise concerns at this time, could also lead to a child be placed at risk of harm if this exacerbates a situation where Fabricated or Induced Illness is present at a low or developing level. If it is decided not to inform the parents/carers about the investigations, which have taken place the reasons for this decision must be explicitly recorded.

Where discussions have been protracted a final meeting may need to be arranged to agree the decisions, or the chair of the strategy meeting should write to those involved confirming the outcome.

There may be circumstances where concerns have not been substantiated but doubts persist as to the reasons for a child's presentation and Fabricated or Induced Illness remains as a possibility. In these circumstances it may be appropriate for the strategy meeting to agree further assessment and monitoring as necessary to establish an adequate explanation. These may be of a single or multi agency nature and there must be a clear plan for reviewing the outcome of further assessments within an agreed timescale.

Concerns substantiated but the child not judged to be at continuing risk of significant harm

There may be circumstances where the concerns a child has suffered significant harm are substantiated but agencies agree, at a strategy meeting, that a plan to ensure the child's future safety and welfare can be developed without the need for a child protection conference and that family support can be provided within a Child in Need framework. This decision should be taken very carefully and endorsed by a senior manager from social services, the Designated Nurse, the Consultant with child protection responsibility and the Lead Consultant for the child. In these

circumstances the Strategy meeting should establish what action is necessary, and by whom, to complete a core assessment.

Concerns substantiated and the child judged to be at continuing risk of significant harm

An initial child protection conference would normally be convened within 15 working days of the decision to begin Section 47 enquiries. Because of the usual complexity of Fabricated or Induced Illness cases and the need to gather sometimes-extensive information, the planning and investigation of such cases may take longer than other child protection enquiries. Where a series of strategy meetings are required to plan the enquiries, the child protection conference must be held within 15 days of the final strategy meeting. The completion of the core assessment should be within 35 days of the final strategy meeting.

The Initial Child Protection Conference

In addition to the normal processes for convening child protection conferences outlined in ACPC guidance in cases of fabricated or induced illness particular consideration should be given to the following:

- Inviting a professional who has expertise in working with fabricated or induced illness cases
- Inviting a medical professional who has expertise in the branch of paediatric medicine that deals with the symptoms and illness processes caused by the suspected abuse. This will enable the medical information to be presented and evaluated from a sound evidence base;

Whether all or some parents/family members should be excluded from the conference

What information can be shared with family members. A senior manager from social services should endorse a decision that the initial child protection conference should go ahead without the knowledge of either parent. The decision and reasons for the decision must be recorded and signed by a senior manager.

If parents/carers have not been invited it is important to discuss whether they will be told the conference took place and if so by whom and when. The reasons for decisions made should be recorded.

The attendance of a legal advisor should be considered.

Each agency should ensure that a clear chronology of their agency's involvement is available to conference. For health this should be as comprehensive as possible and include the health history of any siblings not directly under consideration. Knowledge of the parents' medical and psychiatric histories should be considered, in particular the abusing parent's history

Particular attention should be paid if the child's life has been threatened by attempted smothering, poisoning or introducing noxious substances intravenously to ensure these actions cannot take place in future.

Where a decision is made to separate the child from the abusing parent contact must be managed so that it does not offer another opportunity to repeat the abuse. A professional with a level of knowledge to be alert to the precursors of further abusive behaviour should supervise contact.

Where a decision is made to institute legal proceedings it is important that a consultant with child protection responsibility agrees to support this action, since it is their medical evidence which will form a key part of the evidence presented to Court.

Action following a case conference

Following a case conference, any decision to hold core group meetings without inviting or

informing parents / carers should be endorsed (in writing) by a service manager within social services and the reasons recorded.

Review child protection conferences should be held as for any other situation. In these cases it is important that the fullest possible attendance is achieved across all involved agencies. Any decision to hold a review conference without informing parents must be agreed and recorded as above.

Pre Birth Conferences

The following should be considered as indicating an assessment is required surrounding an unborn child:

- Evidence of illness being fabricated or induced in another child
- History of the mother fabricating illness in herself during a previous pregnancy
- The mother behaving in ways that pose risks to the health of the unborn child in the current pregnancy and are seen in the context of fabricated or induced illness
- Other indicators of concern, e.g. previous alleged miscarriages/ bleeding in pregnancy in obstetric history, where there is an indication of fabrication.

All principles previously outlined in relation to the assessment and progression of these cases should be followed.

A pre birth conference should be convened if, following section 47 enquiries, the unborn child's health is considered to be at risk or the baby is likely to be at risk of significant harm following his or her birth.

8. Record Keeping

Further guidance is provided in *Safeguarding children in whom illness is fabricated or induced 6.35 – 6.45*

Careful, detailed and contemporaneous record keeping is essential in all cases of child abuse and especially where there are concerns about Fabricated or Induced Illness.

Although parents have a right on behalf of their child to have access to all records held, there are some restrictions that can be applied to this disclosure. Where there are parts of the record that it would not be in the best interest of the child to disclose and where third parties who have given information in confidence would be identified. It is vital that the lead consultant with child protection responsibility for the case is consulted before disclosure of records to parents is granted. Guidance may be sought first from the Trust legal advisors.

In order to limit the access to information about concerns, investigations or management of Fabricated or Induced Illness to those health professionals and others with a need to know it may be necessary to maintain a supplementary record to the main medical notes or child health record. If this to be the case the supplementary medical record should be held by the lead consultant with child protection responsibility for the case but a clear flag made in the main record about the existence, whereabouts and mechanism for access of this record.

At the conclusion of the investigation a decision must be made about where these records will be stored. At the stage where concerns have been fully addressed or substantiated, these notes should normally be incorporated in the child's main records. It may be necessary to annotate the notes to clarify the process and outcome of any investigation. Legal advice may be sought.

If concerns have not been fully substantiated, there is some ongoing concern, but a multi-agency decision has been made not to inform the parents of the concerns the record should be stored within the medical record in a sealed envelope with clear limitation and instruction about the appropriate process for professional access to it.

9. Contact Details

Local contact details to be customized for each ACPC

Avon & Somerset Police Public Protection Unit will hold responsibility for ensuring that the membership of the consultative group and contact details are kept up to date. Any changes should be notified to Ms Jane Hawker (jane.hawker@avonandsomerset.pnn.police.uk)

Name	Designation	Telephone
	Designated Doctor	
	Designated Nurse	
	Named Doctor	
	Named Nurse	
	Police Child Abuse Investigation Team	
	Social Services Duty Team	

MEMBERSHIP OF THE CONSULTATIVE GROUP

BANES

Social Services
Liz Price
Group Manager,
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Tel: 01225 477930
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Health
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Dr Rosemary Jones, Named Doctor Child Protection
Consultant Community Paediatrician,
BANES Primary Care Trust
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CAMHS
(Child and Adolescent Mental Health Service)
Karen Boucher, Consultant in Adolescent Psychiatry
Avon and Wiltshire Mental Health Partnership NHS Trust
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BRISTOL

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Health
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CMS Paediatrician, NBT
0117 959 5356

Juliet Norman
Designated Nurse
Bristol North PCT
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CAMHS
Madeline Durham
UBHT
0117 928 5414

SOMERSET

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East Somerset NHS Trust
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Taunton and Somerset NHS Trust, Musgrove Park
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Anne Allen
Consultant Nurse Safeguarding Children
Designated Nurse Child Protection and LAC – Somerset
Preston Road Clinic, Yeovil
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Dr Rob Clacey
Consultant Psychiatrist (Adult)
East Mendip Mental Health Team
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Dr Ann Wolton
Consultant Child and Adolescent Psychiatrist
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NORTH SOMERSET

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Children & Young People's Services
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David Gee
Team Manager
Children & Young People's Services
Weston Caseholding Team
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Town Hall
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Tel: 01275 888215

Health
Dr Deborah Barff
Consultant Community Paediatrician
Weston Area Health Trust
Drove House
Drove Road
Weston super Mare BS23 3NT
Tel: 01934 418804

Pat Richards
Designated and Named Nurse, Child Protection
North Somerset PCT and Weston Area Health Trust
Waverley House
Old Church Road
Clevedon
Tel: 01275 546770

CAMHS
Liv Kleve
Drove Road Children's Centre
Weston super Mare BS23 3NT
Tel: 01934 629660

Trisha Tallis
55 Highdale Avenue
Clevedon
BS21 7LT
Tel: 01275 543337

SOUTH GLOUCESTERSHIRE

Social Services
Verity Scott
Service Manager
Tel: 01454 865902
Email: verity.scott@southglos.gov.uk

Health
Cindy Chesterman
Senior Child Protection Nurse
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Email: cindy.chesterman@sglos-pct.nhs.uk

POLICE

DCI Stephen Foster
Child Abuse Investigation Team (CAIT)
Avon and Somerset Constabulary
Tel: 01275 816593
Email: stephen.foster@avonandsomerset.police.uk

DI Paul Aldus
Child Abuse Investigation Team (CAIT), South
Avon and Somerset Constabulary
Tel: 01934 638204
Email: paul.aldus@avonandsomerset.police.uk

DI Caroline Peters
Child Abuse Investigation Team (CAIT), North
Avon and Somerset Constabulary
Tel: 0117 945 4332
Email: caroline.peters@avonandsomerset.police.uk

10. Further Information/References

DoH, 2003 *What to do if you're worried a child is being abused*
www.dh.gov.uk/assetRoot/04/06/13/03/04061303.pdf

DoH, 1999 *Working together to safeguard children*
www.dh.gov.uk/assetRoot/04/07/58/24/04075824.pdf

DoH, 2002 *Safeguarding children in whom illness is fabricated or induced*
www.dfes.gov.uk/acpc/pdfs/safeguardingchildren2002.pdf

RCPCH, 2002 *Fabricated or Induced Illness by Carers*
www.rcpch.ac.uk/publications/recent_publications/FII.pdf

HMSO, 2000 *Regulation of Investigatory Powers Act*
www.hmso.gov.uk/acts/acts2000/20000023.htm

Home Office, 2002 *Achieving Best Evidence in Criminal Proceedings*
www.cps.gov.uk/publications/prosecution/bestevidencevol1.html

Freedom of Information Act, 2000
www.hmso.gov.uk/acts/acts2000/20000036.htm

Criminal Procedure and Investigation Act, 1996
www.hmso.gov.uk/acts/acts1996/1996025.htm

Concerns re Possible Fabricated or Induced Illness

The possibility of fabricated and induced illness should be considered where there are discrepancies between professional and parental perceptions of the child's needs or of any illness or disability and where there is a possibility of significant harm to the child.

Initial discussion with a senior colleague, a consultant paediatrician with experience in child protection and other professionals as appropriate.

Parents should not be informed of suspicions at this stage

Health, police, social services Strategy Discussion

Consultative Group

Must be held within 2 weeks, organised by Designated Doctor

No Concerns Identified

Case conference within 15 working days of final strategy meeting

Repeated strategy meetings may be required

Consider need for legal advice

Closure of case; consider what information to feed back to parents; how notes will be filed.

Illness Induction

Child to place of safety

Consider need for CVS and other aspects of criminal investigation

Genuine Illness +/- Over-anxiety

Further parental education and support

Reassure parents

Continue normal F/U, usually initially under secondary care services

Fabricated Illness

Likely disclosure to parents at this stage, if necessary arranging place of safety for child whilst further assessment of parental response and more detailed assessment of level of risk

Within 24 hours

Possible induction of illness or evidence of immediate risk of harm

Admit or arrange place of safety until investigation complete

Ongoing Concerns