**FII TOOLKIT**

The following appendices make up a toolkit for professionals which can be used by a single professional or a group of professionals. The order of the templates does not indicate the relative importance but is set out to assist the professional/s to manage their information in a way that assist them in dealing with suspected FII and gain a more holistic picture.

Appendix 1; Checklist for professionals worried that a child may be experiencing FII

Appendix 2; Chronology

Appendix 3;FII template

Appendix 4; FII spectrum table

Appendix 5; Analysis of risk and protective factors

Appendix 6; Voice of the child

Appendix 7; Management/Action plan

Appendix 1

**Checklist for Professionals worried that a Child may be Experiencing FII**

**Instructions for Completion of Checklist:**

1. The checklist should be completed in all cases in which a professional has concerns about the possibility of FII (it should be completed by the person raising concerns).
2. The child’s name, date of birth and NHS number should be recorded on every sheet of paper. The completed checklist must be filed in the child’s notes.
3. This checklist is to be used as an aide memoir to ensure that everything that needs to be done / considered is completed in a timely manner. The actual concerns / findings / notes about discussion taking place should be held in the child’s records.
4. The column headed “Action” should not be used to record information.
5. The column headed “Date Completed / Notes” **or** the column headed “Not applicable / not done (and reasons why)” for each line should be completed.
6. When completing the column headed “Date Completed / Notes” the date the action is completed should be recorded. This column can also be used to record who discussions took place with, who has been contacted, names of other identified children / vulnerable adults (or “none” if that is the case), what risk assessment has been done and the severity of risk identified. This column should not be used to record detailed information, for instance about the detail of discussions taking place. There is insufficient room to adequately record it within this table. It is important that this information is clearly recorded in the child’s notes, but not within this table.
7. The column headed “Not applicable / not done (and reasons why)” should not be used often. It should never be stated simply that an action has not been done without recording the reason.
8. It is important that the professional completing the template records their name, job title, contact details, the version of the chronology (this will change as it is added to) and the date this version is completed.

**Checklist for Professionals worried that a Child may be Experiencing FII**

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**Page 1**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Action** | **Date completed / Notes** | | **Not applicable / not done (and reason why)** |
| **Documentation of concerns and reasoning behind them (please state where concerns have been documented).** |  | |  |
| **Initial risk assessment** |  | |  |
| **Line manager informed (please state name of line manager)** |  | |  |
| **Discussion with named professional / duty social worker (please state name of person case discussed with)** |  | |  |
| **Checklist for Professionals worried that a Child may be Experiencing FII**  **CONFIDENTIAL: Not to be shared with family** unless **agreed at Multiagency Strategy Meeting**  **Page 2** | | | |
| **Action** | **Date completed / Notes** | **Not applicable / not done (and reason why)** | |
| **Consideration as to whether the risks are high and an immediate referral to social care and / or police is required (concerns about FII must be explicit)** |  |  | |
| **Have I considered and tried to contact others who may have helpful information / who need to know(if risks are considered high this should not delay referral to social care)** |  |  | |
| **Have I determined whether there are any other children or vulnerable adults in the family who might be at risk** |  |  | |

**Completed by:-**

Signature:

Name:

Job Title:

Date:

Appendix 2

**Chronology**

**Instructions for Completion of Chronology:**

1. All sheets of the chronology should have the child / young person’s name, date of birth and NHS Number / other local number that can be used to help identify him / her. The completed chronology must be filed in the child’s notes.
2. Date: Start from earliest event and progress to latest event.
3. Contact: This should include information about what the contacts were (phone call, face to face, letter, E-mail, and texts), where it took place (if face to face) and who the contact was between. It should be made clear if the child / young person was present and whether any of the information came from the child / young person.
4. Episode / event: This is a summary of what happened.
5. Comment: This is a column to record relevant comments. It should remain in even if not used.
6. Category: If any of the events correspond to one of the criteria in the FII template the number of the criteria should be written in here.
7. Significant life events include family deaths / births / new family members / separation / house moves / school moves.
8. Details of where the information has been obtained from need to be recorded (e.g. which notes / files have been accessed).
9. Further rows should be added to the columns as needed, for example the table on page 5 is usually going to require many more rows.
10. It is important that the professional completing the template records their name, job title, contact details, the version of the chronology (this will change as it is added to) and the date this version is completed.
11. Chronologies should always been done individually for each child as it is important to know what is going on for every individual. When looking at the chronologies of the family it may be decided that the chronologies should also be combined into a single family chronology. Another way of comparing what is going on at a particular time in the family is to lay all of the individual children’s chronologies side by side open at the same time period.

**Chronology**

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**Page 1 (All professionals)**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Age** | **Contact** | **Episode/Event** | **Comment** | **Category (from FII template)** | **Significant life event** |
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**Page 2 - Chronology** **(To be completed by Health Professional)**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Record of Medical Signs / Symptoms:

|  |  |  |
| --- | --- | --- |
| **Signs / symptoms** | **Reported by whom** | **Verified or witnessed by anyone else (if so state name and profession / relationship)** |
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**Page 3 - Chronology** **(To be completed by Health Professional)**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Record of Treatments (medication / operations / other):

|  |  |  |
| --- | --- | --- |
| **Investigations carried out** | **Indication for investigation** | **Result** |
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**Page 4 - Chronology** **(To be completed by Health Professional)**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Medical Teams Involved:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Team** | **Consultant child under care of** | **Where team is based** | **Indication for team’s involvement** | **Time period of involvement** |
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**Page 5 - Chronology** **(All Professionals)**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Chronology Completed using Information from the following Sources:

**Completed by:**

Signature:

Name:

Job Title:

Version of chronology:

Date of completion:

**FII Template**

Appendix 3

**Instructions for Completion of FII Template:**

1. All sheets of the FII template should have the child / young person’s name, date of birth and NHS Number / other local number that can be used to help identify him / her. The completed FII template must be filed in the child’s notes.
2. A FII template should be completed for each child individually and not used to record what is happening for the entire family. There are 2 sections of the template where family information should be recorded. The first is that for category 10 it is appropriate / a requirement to record information pertaining to other family members, as well as information pertaining to the child. The second section is category 8, which purely refers to information about other family members and not the child. The reason that each child being assessed for FII in the family needs a separate FII template completed is that not all children in a family experience the same abuse and not all are at risk to the same degree and it is important that this is recognised so that each child is dealt with as an individual within the context of their family background. Doing separate FII templates may also indicate that children are at particular risk
3. Every section must be completed. If information is not available this should be stated. For example if there is no information about what happens to a child’s symptoms when the parent is not present because this has not been tested / separation has not occurred then this must be stated. It is just as important to record events that do not support FII as it is to record events that do.
4. The “conclusion” column must be completed for every category. “Yes” should be used when it is considered that on the balance of probability the FII category is fulfilled and “no” used when it is considered that on the balance of probability the FII category is not fulfilled. “Possibly” would denote some concerns that the category is fulfilled but that it is not possible to be very confident. “Not known” could be used if information is missing. These are only examples of terms that can be used and there may be occasions when other words / phrases might be more appropriately used.
5. It is important that the professional completing the template records their name, job title, contact details, the version of the chronology (this will change as it is added to) and the date this version is completed.
6. The FII template might be used by a single professional trying to make sense of the information they have collected. It may also be used by a group of professionals within a Professional’s meetings or strategy meeting. This should be recorded so that it is clear whether this is the view of a single person / group of people.
7. Once the FII template has been completed it is important that the information is analysed and a conclusion is reached. This should be done by completing section 4.

**FII Template**

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**Page 1**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | **Warning Signs of Fabricated or Induced Illness** | **Examples seen in this child’s case / within this family**  **(If examples not seen within a category please write “none”.)** | **Examples of strengths / appropriate behaviour not supportive of category**  **(If examples not seen within a category please write “none”.)** | **Conclusion about whether criteria met – Yes / No / Possibly / Not known** |
| 1 | **Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.** |  |  |  |
| 2 | **Physical examination and results of medical investigations do not explain reported symptoms and signs.** |  |  |  |
| 3 | **There is an inexplicably poor response to prescribed medication and other treatment**. |  |  |  |
| 4 | **New symptoms are reported on resolution of previous ones**. |  |  |  |
| **Category** | **Warning Signs of Fabricated or Induced Illness** | **Examples seen in this child’s case / within this family**  **(If examples not seen within a category please write “none”.)** | **Examples of strengths / appropriate behaviour not supportive of category**  **(If examples not seen within a category please write “none”.)** | **Conclusion about whether criteria met – Yes / No / Possibly / Not known** |
| 5 | **Reported symptoms and found signs are not seen to begin in the absence of the carer.** |  |  |  |
| 6 | **The child’s normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.** |  |  |  |
| 7 | **Over time the child is repeatedly presented with a range of signs and symptoms.** |  |  |  |
| 8 | **History of unexplained illnesses or deaths or multiple surgeries in parents or siblings of the family**. |  |  |  |
| 9 | **Reported signs and symptoms fade or disappear once the perpetrator’s access to the child is restricted.** |  |  |  |
| **Category** | **Warning Signs of Fabricated or Induced Illness** | **Examples seen in this child’s case / within this family**  **(If examples not seen within a category please write “none”.)** | **Examples of strengths / appropriate behaviour not supportive of category**  **(If examples not seen within a category please write “none”.)** | **Conclusion about whether criteria met – Yes / No / Possibly / Not known** |
| 10 | **Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.** |  |  |  |
| 11 | **Incongruity between the seriousness of the story and the actions of the parents.** |  |  |  |
| 12 | **Erroneous or misleading information provided by parent**. |  |  |  |

**Completed By:**

Signature:

Name:

Job Title:

Date of Completion:

Completed individually / in a professional's meeting / in a strategy meeting:

**FII Spectrum Table**

Appendix 4

**Instructions for Completion of FII Spectrum Table:**

1. All sheets of the FII spectrum table should have the child / young person’s name, date of birth and NHS Number / other local number that can be used to help identify him / her. The completed spectrum table must be filed in the child’s notes.
2. The FII spectrum table should always be completed in conjunction with the FII template. The analysis should consider information from both section 3 and section 4.
3. Examples of presentation, underlying factors and carer’s insight should be written in the appropriate column. At least 1 column for these 3 rows should be completed, although there may be occasions where more than one column needs to be completed or different columns used pertaining to different carers. Information that goes against one of the 5 examples given may be helpful to record for example if the mother is known to have had a recent psychiatric assessment and no psychiatric diagnoses identified this should be recoded under example 4.
4. After completing the FII template and FII spectrum table an analysis of the information must be done and documented. The conclusion reached should state which part of the FII spectrum the child is thought to lie on and a brief summary of why that conclusion was reached. It is worthwhile also recording how definite people are about this conclusion and whether there are any differences of opinion amongst the professionals involved. It is also important to still keep an open mind and consider whether any other of the examples on the spectrum might also apply and what should be done to test this out.
5. It is important that the professional completing the FII spectrum table records their name, job title, contact details, the version of the chronology (this will change as it is added to) and the date this version is completed.
6. The FII spectrum table might be used by a single professional trying to make sense of the information they have collected. It may also be used by a group of professionals within a Professional’s meetings or strategy meeting. This should be recorded so that it is clear whether this is the view of a single person / group of people.

**Spectrum of Cases where FII concerns may arise**

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**Page 1**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Starting point: A child is presented for medical attention, possibly repeatedly, with symptoms or signs suggesting significant illness; an appropriate clinical assessment suggests that the child’s “illness” is not adequately explained by any disease. The examples below illustrate the range of possible considerations. Table can be used for individual children or for all children in the family. | | | | |
| ***Example 1*** | ***Example 2*** | ***Example 3*** | ***Example 4*** | ***Example 5*** |
| **Type of presentation** | | | | |
| Simple anxiety, lack of  knowledge about illness, over interpretation of normal or trivial features of childhood; may in some cases be associated with depressive illness in carer | Child’s symptoms are misperceived, perpetuated or  reinforced by the carer’s behaviour; carer may genuinely believe the child is  ill or may have fixed beliefs  about illness | Carer actively promotes sick  role by **exaggeration**,  **non-treatment** of real problems, **fabrication** (lying) or **falsification** of signs, and/or **induction** of illness (sometimes referred to as ‘true’ FII) | Carer suffers from psychiatric illness (e.g. delusional disorder) which leads them to believe child is ill | Unrecognised genuine  medical problem becomes  apparent after initial concern  about FII |
| Examples of presentation | | | | |
|  |  |  |  |  |
| **Spectrum of Cases where FII concerns may arise**  **CONFIDENTIAL: Not to be shared with family** unless **agreed at Multiagency Strategy Meeting**  **Page 2**  **Child’s Name:**  **Date of Birth:**  **NHS Number:**  **ICS/Pupil Number:** | | | | |
| ***Example 1*** | ***Example 2*** | ***Example 3*** | ***Example 4*** | ***Example 5*** |
| **Underlying factors** | | | | |
| Carer’s need to consult a  doctor may be affected by  inability to cope with other  personal or social stresses,  such as mental health issues | ‘Illness’ may be serving a  function for carer, and  subsequently for an older  child too (secondary gains) | There may be a history of  frequent use of, or dependence on, health services; carer may have personality disorder or the child’s ‘illness’ may be serving a purpose for the carer | Carer’s mental health problems |  |
| Information supporting evidence of underlying factors | | | | |
|  |  |  |  |  |
| **Spectrum of Cases where FII concerns may arise**  **CONFIDENTIAL: Not to be shared with family** unless **agreed at Multiagency Strategy Meeting**  **Page 3**  **Child’s Name:**  **Date of Birth:**  **NHS Number:**  **ICS/Pupil Number:** | | | | |
| **Carer’s insight** | | | | |
| It is usually possible to  reassure carer although they are likely to present again in  future | Difficult to reassure carer;  carer and professionals may not agree on the cause of  symptoms and/or the need to  consult or investigate further | It is not possible to reassure  carer; carer’s objectives are  diametrically opposed to those of professionals | Carer lacks insight into  their involvement in the  child’s supposed illness | Carer’s ‘illness behaviour’ will usually be appropriate for the signs displayed by child, although any child protection interventions may affect the carer’s behaviour |
| Information supporting evidence of carers insight | | | | |
|  |  |  |  |  |

**Spectrum of Cases where FII concerns may arise**

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**Page 4**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Analysis:

What is the conclusion of the discussion?

Is there anything else that might explain the picture seen that should be considered?

**Completed by:**

Signature:

Name:

Job Title:

Date of Completion:

Completed individually / in a professional’s meeting / in a strategy meeting:

**Analysis of risks and Protective Factors**

Appendix 5

**Instructions for Completion of Analysis of risks and Protective Factors:**

There are 4 parts to this analysis presented in 4 tables.

1. Table 1 looks at factors relating specifically to FII.

1. Table 2 looks at other forms of abuse and should be used to record any confirmed episodes, but also any episodes uncovered that could represent an abusive episode (e.g. bruising in a very young infant which was not properly investigated or where there was no evidence of abuse being a consideration). It is important when considering whether or not a child may be experiencing FII to also consider their exposure to other forms of abuse, which may or may not have been recognised previously.
2. Table 3 looks at the resilience – vulnerability matrix. It should be used to record a range of factors within the child, family and wider environment. Identified vulnerability factors should be weighed against identified resilience factors. It is important to consider how strong an influence these factors are, not just how many can be identified. From this it should be possible to work out whether the child is, on balance, predominantly resilient, or predominantly vulnerable. The same should be done to weigh up adversity and protective factors to conclude whether the child is, on balance, predominantly experiencing high adversity or living within a protective environment. The child at most risk is likely to fall within the vulnerable child experiencing high adversity with the resilient child living within a protective environment being least at risk. It is important to also try to identify and record the impact on the child and make it clear if this impact has been demonstrated or is presumed.
3. Table 4 is used to summarise the current situation looking at the past, present and also concerns / assumptions about the future.

**Analysis of risks and Protective Factors**

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**Page 1**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Table 1

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Example 1*** | ***Example 2*** | ***Example 3*** | ***Example 4*** | ***Example 5*** |
| **Type of presentation** | | | | |
| Simple anxiety, lack of  knowledge about illness, over interpretation of normal or trivial features of childhood; may in some cases be associated with depressive illness in carer | Child’s symptoms are misperceived, perpetuated or  reinforced by the carer’s behaviour; carer may genuinely believe the child is  ill or may have fixed beliefs  about illness | Carer actively promotes sick  role by **exaggeration**,  **non-treatment** of real problems, **fabrication** (lying) or **falsification** of signs, and/or **induction** of illness (sometimes referred to as ‘true’ FII) | Carer suffers from psychiatric illness (e.g. delusional disorder) which leads them to believe child is ill | Unrecognised genuine  medical problem becomes  apparent after initial concern  about FII |
| **Level of risk** | | | | |
| Seldom reaches the threshold of significant harm | May be disabling for the child; often some risk of significant harm, including emotional or educational harm, or social | High risk of harm; always some resultant harm, often severe | May be risk of harm | Risk of harm due to  inappropriate child protection  process and delay in correct  diagnosis |
| Evidence supporting level of risk (actual harm / concerns about probable harm) | | | | |
|  |  |  |  |  |
| **Analysis of risks and Protective Factors**  **CONFIDENTIAL: Not to be shared with family** unless **agreed at Multiagency Strategy Meeting**  **Page 2**  **Child’s Name:**  **Date of Birth:**  **NHS Number:**  **ICS/Pupil Number:** | | | | |
| **Iatrogenic harm** | | | | |
| Possible iatrogenic harm risk | Significant risk of iatrogenic harm | Very high risk of iatrogenic harm | Usually low risk of  iatrogenic harm | See page 1 |
| Examples of iatrogenic harm that has occurred | | | | |
|  |  |  |  |  |

**Analysis of risks and Protective Factors**

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**Page 3**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Table 2

|  |  |
| --- | --- |
| **Evidence of other types of abuse :-** | |
| Neglect |  |
| Physical abuse |  |
| Sexual abuse |  |
| Emotional abuse |  |

**Analysis of risks and Protective Factors**

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**Page 4**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Table 3

|  |  |
| --- | --- |
| **Analysis using Resilience – Vulnerability Matrix** | |
| **Vulnerabilities (within the child, family and wider community):** | |
| **Vulnerability Factor** | **Impact on Child** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Protective Factors (within the child, family and wider community):** | |
| **Protective Factor** | **Impact on Child (Has the protective factor reduced the risk?)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Resilience Factors (predominantly within the child):** | |
| **Resilience Factor** | **Impact on Child (Has the resilience factor reduced the risk?) / Vulnerable adult** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Where is Child on Resilience – Vulnerability Matrix (which situation)** |  |

**Analysis of risks and Protective Factors**

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**Page 5**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

**Resilience – Vulnerability Matrix (Daniel and Wassell 2002)**

Situation 2

Vulnerable Child

Protective Environment

Situation 4

Vulnerable Child

High Adversity

Situation 1

Resilient Child

Protective Environment

Situation 3

Resilient Child

High Adversity

Protective Environment

Adversity

Resilience

Vulnerability

**Analysis of risks and Protective Factors**

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**Page 6**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Examples of Resilience Factors

* Good attachment
* Good self-esteem
* Sociability
* High IQ (Intelligence Quotient)
* Flexible temperament
* Problem solving skills
* Positive parenting
* Attractive

Examples of a Protective Environment

* Good school experience
* One supportive adult
* Special help with behaviour problems
* Community networks
* Leisure activities
* Talents and interests

Examples of Adversity

* Life events / crises
* Serious illness
* Loss / bereavement
* Separation / family breakdown
* Domestic violence
* Asylum seeking status
* Serious parental difficulties e.g. drug / alcohol abuse or offending behaviour
* Parental mental illness

Examples of Vulnerability Factors

* Poor attachment
* Minority status
* Young age
* Disability
* History of abuse
* Innate characteristics in child or family which threaten and challenge development
* Social isolation / a loner
* Institutional care
* Early childhood trauma
* Communication difficulties / differences
* Inconsistent / neglectful care.

**Analysis of risks and Protective Factors**

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**Page 7**

**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

Table 4

|  |  |
| --- | --- |
| **Identify** |  |
| What has been happening? |  |
| What is happening now? |  |
| What might happen? |  |
| How likely is it? |  |
| How serious would it be? |  |
| Judgement of risk based on combination of likelihood and seriousness |  |

**Completed by:**

Signature:

Name:

Job Title:

Date of Completion:

Completed individually / in a professional’s meeting / in a strategy meeting:

**Voice of the Child**

Appendix 6

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**Child’s Name:**

**Date of Birth:**

**NHS Number:**

**ICS/Pupil Number:**

**It is essential that the child is listened to. In a pre-verbal child this may mean information needs to be gleaned from observation about their behaviour, perhaps in different environments.**

Has the child been given the opportunity to relate their story and views (when and by whom)?

Has the child been seen alone?

Have there been any observations about the child’s behaviour that indicate what he / she may be experiencing?

What has the voice of the child shown?

Is there anyone else who may have an idea of what the child may be experiencing?

**Direct quotes**

**Completed by:**

Signature: Job Title:

Name: Date:

Management / Action Plan

Appendix 7

CONFIDENTIAL: Not to be shared with family unless agreed at Multiagency Strategy Meeting

Child’s Name:

Date of Birth:

NHS Number:

ICS/Pupil Number:

Page 1 (action 1 – 4 must always be completed)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Need / risk identified** | **Action** | **Person Responsible** | **When action is to be completed** | **Outcome and date of completion** |
| 1) Responsible Consultant Paediatrician (RPC) to be identified for each child (may be the same or different professional) |  |  |  |  |
| 2) Referral to social care considered (essential if it is concluded that the child may be experiencing or be at risk of significant harm) / discussion with social care. |  |  |  |  |
| 3) If there are several children under different RPCs, who is going to co-ordinate a joined up health response? |  |  |  |  |
| 4) The needs of other children and vulnerable adults must be considered |  |  |  |  |
| Management / Action Plan  CONFIDENTIAL: Not to be shared with family unless agreed at Multiagency Strategy Meeting  Child’s Name:  Date of Birth:  NHS Number:  ICS/Pupil Number:  Page 2 | | | | |
| **Need / risk identified** | **Action** | **Person Responsible** | **When action is to be completed** | **Outcome and date of completion** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Completed by:**

Signature:

Name:

Job Title:

Date of Completion:

Completed individually / in a professio