**Decision making in FII strategy meeting**

The discussion should include consideration of:

**Assessment of risk and safety planning**

* Level of risk of harm to the child, that they may have already suffered;
* The risk of future harm and complicating factors;
* Current safety arrangements already in place;
* Any immediate steps necessary to reduce the risk of harm (for example cancelling unnecessary medical procedures or instituting closer observation of the child or whether the parent/carer should be allowed on the ward if the child is an inpatient, if this is deemed unsafe then consideration will need to be given to an Emergency order which may need to be instituted by either the police or the Local authority);
* Any potential implications for other patients or their carers who are on the ward at the time;
* Consideration of the child’s safety network and how it may be used to provide immediate safety;
* How the child can be given the opportunity to tell their story – this requires careful consideration and planning;
* Consideration of how all involved health professionals can work together to ensure a coordinated, informed response to any health problems;
* What is known about the parents/carers’ past behaviour, medical history, current health, aids and benefits being received either for themselves or the child;
* Consider risk to other siblings.

And should also include:

Joint decisions about what discussions are to take place with the parents/carers and by whom (must have medical input), must be made in the strategy meeting (and referrer should be advised).

**Information gathering**

* Any information investigations, further information gathering and any other opinions that would be helpful;
* The planning of further medical and nursing assessments
* The need for forensic sampling, direct observation or covert video surveillance:
* Development of Chronologies (if not already completed), agree who should do this.

Agencies should share information about their involvement with the family and any evidence to support the possibility of FII. This should include all chronologies completed at this point particularly any medical chronologies.

The meeting should look at the available the information, a useful method is to use the FII Template (**Appendix 3 – FII template**), to consider whether there is sufficient information to make a decision on Fabricated or Induced Illness at this stage, or what further information is required.

The meeting should also consider using the **Spectrum of cases where FII concerns arise – Appendix 4,** as having completed the FII template, this will enable a better analysis of the available information and the conclusion reached should state at which part of the spectrum the child is thought to lie. The group will then be able to give a brief summary of the conclusion and whether there is a difference of opinion from amongst the group and allow them to define this difference.

There may be insufficient information to make a firm diagnosis at this stage but it may be felt there are sufficient concerns to open a formal section 47 investigation.

**Analysis the information within the FII Strategy Meeting**

To ensure the meeting analyses the holistic view of the child and not just the concerns regarding FII. The meeting may find it useful to use the **Analysis of risk and Protective Factors tables – Appendix 5.**  This tool puts the factors relating to FII together and then looks at information and factors/confirmed episodes that could indicate other forms of abuse, then uses the resilience – vulnerability matrix and finally summarises the current situation by looking at the past, present and concerns/assumptions about the future.

**Action Planning**

* Plan for joint communication with carers including how, when and by whom (must involve health professional) they should be informed of any child protection concerns.

 The Action Plan needs to also cover the following areas:

* Responsibility for child and Family Assessment (care must be taken not to raise parents/carers anxiety by either not allowing them to know reason for assessment and disclosing FII before agreed disclosure process, the assessment should be holistic approach to concerns expressed about the development of the child);
* The security of the medical records;
* The level of professional observation required;
* Whether there should be use of covert video surveillance;
* Addressing the needs of the siblings and other children in the family;
* Addressing the needs of carers, particularly after disclosure of concern;
* Clarification of who will be Responsible Paediatric Consultant for the child (if not already explicit).

**Recording**

The meeting should be formally recorded as a strategy discussion by the chair using the electronic ICS Template for Strategy discussion.

The minutes of the meeting should follow guidance in Chapter 6 and include:

* Date, time and name of meeting;
* Name of child/family concerned;
* Attendance/apologies;
* Arrangements for child’s safety, including periods of contact with the alleged abuser;
* Main points regarding medical information;
* Whether diagnosis of Fabricated or Induced Illness made;
* Whether, and what, further information required;
* Conclusion and analysis of risk;
* Plan of action showing who is responsible for each task and timescales;

 **DISCLOSURE OF CONCERNS TO THE CHILD’S PARENTS/CARERS**

If the strategy meeting agrees that there are concerns about FII and that other agencies need to be involved, the possibility of FII will need to be discussed with the parents/carers. Professionals should be supported through the process of disclosure and the approach should be agreed in the strategy.

 The disclosure should be made in the presence of at least one other professional. In most cases the discussion will involve the Responsible Paediatric Consultant jointly with a social worker and/or the police. However, in cases where the police obtain evidence that a criminal offence has been committed, it is important that the paediatrician does not confront the parent/carers. This must be done by the police in order to ensure that the parent/carer’s rights are protected in accordance with the Police and Criminal Evidence Act 1984.

The carers should be invited to discuss the child’s progress in an appropriate place which provides privacy and confidentiality. If the child is an inpatient, the meeting should be away from the bedside. If possible, both parents/carers should be present at this meeting.

**FII is not confirmed**

In cases where the child’s perceived illness is not explained and FII is not confirmed. Again the strategy meeting should have planned for how the parents/carers will be informed of these concerns.

The discussion should be with more than one professional (in most cases the Responsible Paediatric consultant should be involved) and the discussion should be honest about reason for suspecting FII and give a plan for rehabilitation of the child back to normal functioning, including return to school, withdrawal of unnecessary equipment or aids and stopping unwarranted medication.

Consent should be sought from the carers for the child to be supported under section 17 of the Children Act 1989, and consideration of the child becoming involved with CAHMS as other areas of the child’s development may have been identified within the Strategy meeting as cause for concern. If the parents are unwilling to accept this approach there may be a need for further multi-agency discussion.

Case notes of the meeting should be clearly recorded and placed in the confidential part of the child’s records.