# Pan Merseyside Child Protection Advisors Group
# Guidelines for Health Professionals and Organisations
# Safeguarding Children in whom Illness is Fabricated or Induced

These guidelines should be read in conjunction with HM Government/DCSF "Safeguarding Children in whom Illness is Fabricated or Induced" (2008) and should form part of the LSCB Fabricated or Induced Illness multi agency procedures.

**NB : If at <u>any</u> stage in this process you have concerns about the immediate safety and/or welfare of a child / young person a referral to Children's Social Care must be made as per the usual LSCB procedure without delay.**

Introduction

There are three main ways in which a carer may fabricate or induce illness in a child. They are not mutually exclusive and include;

- 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 also include falsification of letters and documents
- Induction of illness by a variety of means

All health professionals should;

- be alert to potential indicators of illness being fabricated or induced in a child
- be alert to the risk of harm which individuals, or potential abusers may pose to children in whom illness is being fabricated or induced
- share, and help to analyse information so that an informed assessment can be made of the child's needs and circumstances
- contribute to whatever actions (including the cessation of unnecessary medical tests and treatments) and services are required to safeguard and promote the child's welfare and
    - regularly review the outcomes for the child against specific planned outcomes
    - work co-operatively with parents unless to do so would place the child at increased risk of harm
- Assist in providing relevant evidence in any criminal or civil proceedings, should this course of action be deemed necessary
- Such cases can pose conflicts of loyalty for health professionals for whom the child and the parents may also be patients. Such professionals have a duty to safeguard and promote the welfare of the child.

Health professionals are well placed to recognise the early signs and symptoms of fabricated or induced illness in a child through their monitoring of pregnancies and child health promotion. They may have unique knowledge of uncorroborated, odd or unusual presentations, which may present in acute, primary or secondary care.

Children who are having illness fabricated or induced may present with common problems, e.g. repeated nose bleeds, or un-witnessed seizure - like episodes, or

reports of claims which are unusual and not possible to test for, such as particular allergies.

**Stages of action (see flow chart for further details)**
**NB – cases will only progress to the next stage if clinically indicated.**

**Stage 1**

The Health Professional may observe unusual behaviour or unexplained incidents which may lead or give rise to a concern of a possible FII.

**In these circumstances any health professional with a concern should not share this information with the parents/carers as it may place the child at extreme risk.**

**You must inform and discuss the concern with the following professionals (as appropriate for the service/organisation) before taking any action;**

- Named Doctor/Nurse for Safeguarding Children and/or member of the Safeguarding Children Team
- Named midwife

The named professionals will review the information from the referrer. They will check that there has been challenge to the family where it has been safe to do so, and that this has been clearly documented. The named professional will then progress to Stage 2 if indicated.

**NB** The concerns may also originate from other professionals such as education staff who may be given information from a parent/carer which appears to be exaggerated in relation to the child's presentation in school. School staff may also be concerned about the excessive number of hospital / GP appointments a child is reported to require. School staff may share this information with the School Nurse who should then seek advice from the key health professionals noted above.

If concerns about possible FII are raised by any professional at a multi-agency meeting or during any assessment by Children's Social Care, the relevant health professional must be contacted and this process instigated without delay.

**Stage 2**

The health professional and the Named Doctor / Nurse (or member of the Safeguarding Children Team) must gather all the Trust's records (both paper and electronic) and meet to review the information. Liaison must take place between all health providers.

At this stage there needs to be a consideration as to whether F.I.I. concerns exist or whether, on review of the health information, these have been allayed. In the latter case, an action plan to manage the case should be prepared, led by the named professional from the organisation in which the concern was raised.
If at any stage of this process there is any difference of professional opinion the case must be escalated to the relevant Designated Doctor without delay.

## Stage 3

If there are ongoing concerns, these must be reported to the Designated Doctor who may allocate the case to a Consultant Community Paediatrician.

The Designated Doctor or the Consultant Community Paediatrician who has been allocated the case will co-ordinate and chair the Health Professional's FII meeting.

Prior to the meeting the Designated Doctor or the Consultant Community Paediatrician who has been allocated the case is responsible for seeking information from the Police, Social Care and Education to inform and assist the decision making.

The representative from each health organisation attending the meeting will be required to complete the health chronology template appended to this guidance document. The chronology will detail the involvement of all health professionals involved with the family from the organisation and a copy of this must be provided for the Chair of the meeting.

Key professionals who should attend the Health Professionals meeting are;

- Designated Doctor and/or Consultant Community Paediatrician
- Named Safeguarding Children professionals for Primary and Acute Trusts
- GP
- Attending Doctor / Nurse / Midwife
- Health Visitor or School Nurse

Other relevant professionals involved with the health care e.g.

- Dietician
- Therapist

This list is not exhaustive, relevant professionals should be identified by the review of the records in all Trusts.

At the end of the Health Professionals meeting a decision needs to be made as to whether there is;

- Likelihood of significant harm and meets threshold for referral to social care
- Concerns, but doesn't meet threshold for referral to social care
- No evidence of significant harm

## Stage 4

### a. Likelihood of significant harm and meets threshold for referral to social care

If there is evidence of, or risk of, significant harm, the Designated Doctor or the Consultant Community Paediatrician who has been allocated the case will;

- Liaise with the Local Authority Safeguarding Children Unit with notification that a referral for a possible case of FII is going to be made.
- Make a referral to the Local Authority Safeguarding Children Services in accordance with local procedures
- If there is a difference of opinion between agencies, the LSCB escalation procedure should be activated

From the point of referral, all professionals involved with the child should work together as follows:

- Lead responsibility for action to safeguard and promote the child's welfare lies with children's social care.
- Any suspected case of FII may involve the commission of a crime and therefore the police should always be involved
- The paediatric consultant is the lead health professional and therefore has lead responsibility for all decisions pertaining to the child's healthcare

**b. Concerns - but doesn't meet threshold for referral to social care**

An action plan will be put in place, which should include a containment strategy:

- A lead paediatrician to coordinate care and health information
- Primary care to ensure the child sees the same GP where possible who can liaise with the lead paediatrician if concerns arise
- Local AED department to be informed of containment strategy if indicated It might be helpful to:
- Challenge the carer if safe to do so
- Continue to observe child and family – are patterns emerging?
- Continue to keep detailed records being specific about the evidence base/source of information
- Continue to reassess the situation in the light of new information
- Arrange a date for a review meeting if appropriate

**c. No evidence of significant harm**

If there is no evidence of significant harm and sufficient objective evidence of organic disease to account for the presentation, the concerns and decisions should be documented and typed copies of the minutes sent to all members of the Health Professionals Group and contributing agencies. The family GP or identified Acute Trust health professional should take responsibility for the on-going monitoring of the case.

The outcome of stage 4 will be communicated by the chair to the designated nurse and to the designated doctor (if not the chair).

**Stage 5**

Children's social care is the lead agency following a referral. Local Authority Safeguarding Children Services will arrange and chair a multi agency strategy meeting. The designated doctor will inform the Local Authority of health professionals who should be invited.

**Record Keeping**

Good record keeping is an important part of the accountability of professionals to those who use their services. Records should use clear, straightforward language, should be concise, and should be accurate not only in fact, but also in differentiating

between opinion, judgements and hypotheses. It should be clearly documented which information has been obtained directly from carers.

Where it is considered that illness may be fabricated or induced, the records relating to the child's symptoms, illnesses, diagnosis and treatments should always include the name (and agency) of the person who gave or reported the information, and be dated ad signed legibly. All telephone conversations should be recorded fully.

The recording and retention of information, including information about covert video surveillance, should be made in accordance with the Data Protection Act 1998. All records should be kept securely to prevent unauthorised access and ensure they cannot be interfered with.

Requests for access to the child's records should be actioned in accordance with each agency's Access to Records policy and procedures. Where there is any doubt about the retention or disclosure of information, legal advice should be sought.

For further information see the HM Government/DCSF "Safeguarding Children in whom Illness is Fabricated or Induced" (2008)