



North Yorkshire and City of York Safeguarding Children Partnerships

# Fabricated and Induced Illness

Practice Guidance

# North Yorkshire and the City of York Safeguarding Children Partnerships

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# Fabricated and Induced Illness

## Practice Guidance

### Introduction

Fabricated or Induced Illness (FII) by parents or carers is child abuse and can cause significant harm to children.

FII involves a well-child being presented by a parent/carer as ill, or a disabled child being presented with more significant problems than he/she has in reality. This may result in extensive, unnecessary medical procedures and investigations being carried out in order to establish the underlying causes for the reported signs and symptoms. The child may also have treatments prescribed, investigations or operations which are unnecessary. These interventions can result in children spending long periods of time in hospital and some, by their nature, may also place the child at risk of suffering from harm (physical illness, disability or even death).

FII can also lead to emotional difficulties for the child and confusion over their own health status. Professionals need to focus on the impact of FII on the child's health and development – this is crucial to ensure an appropriate safeguarding response.

Other terms are sometimes used to describe FII, some of which are out of date or used predominantly in other countries (e.g. Munchausen's Syndrome by Proxy). For the purposes of this guidance, the accepted term 'Fabricated and Induced Illness' or 'FII' will be used.

### Aim of this Guidance

This guidance aims to support professionals from all agencies to recognise and respond to possible FII in order to effectively safeguard the child. It is necessarily detailed as it reflects the often highly complex nature of this form of abuse. It is also acknowledged that there are particular challenges for all professionals in terms of recognising and responding to possible FII. Ultimately the aim is to assess the impact of FII on the child's health and development, and to consider how to best safeguard the child's welfare. This requires a sound and clear multi-agency approach.

### Definition

FII is a spectrum of presentations rather than a single entity. At one end of the spectrum, less severe presentations may include a genuine belief that the child is ill or exaggeration by carers of the child's existing symptoms. At the other end of the spectrum, the behaviour of carers includes them deliberately inducing symptoms in the child.

For the purpose of this Practice Guidance, the presentations can be broadly divided into the following areas, whilst recognising that they are not mutually exclusive:

- Exaggeration of existing symptoms to an extent which leads to potential harm to the child, or significantly impacts on their day-to-day life;
- Fabrication of signs or symptoms;
- Falsification of hospital charts and records, and specimens of bodily fluids;
- Induction of illness by a variety of means.
- Consideration should also be given to FII presentations of the child with mental health symptoms in addition to presentations of physical symptoms.

According to statutory definitions of abuse and neglect (HM Govt, 2018) <sup>(1)</sup>, FII is referred to under the category of physical abuse. This is because FII often results in a physical impact to children. However, it should be recognised that some parental presentations can also be potentially regarded as neglectful in terms of the child's needs not being recognised or met, and the emotional impact of these presentations on children cannot be underestimated.

## Research Base

Published accounts show that virtually any medical condition can be fabricated and presented to professionals. Most of published literature has focussed on the complex and diverse presentations of the child with limited understanding of perpetrator. Once it was believed that FII was a relatively unusual presentation, but recent surveys have shown prevalence rates that range from 0.002% to 0.27%<sup>(2)</sup>.

A literature review in 2003 analysed 451 cases from 154 medical journals. Children averaged 21.8 months from onset of reported symptoms to diagnosis of FII, and mothers were perpetrators in 76.5% of cases <sup>(3)</sup>. The RCPCH guidance recognised the importance of early intervention in suspected cases. However the prognosis is dependent upon a number of factors <sup>(4)</sup>

- The length of time the abuse has been taking place.
- The degree of harm to the child.
- The degree of mental or emotional health difficulties in the perpetrator.
- The relationship between the child and the perpetrator
- The degree of long-term supervision by professionals.
- The social environment.

Obtaining information about outcomes is also difficult, as many children are 'lost to follow-up' once family supervision ceases. One study in Britain found that 8 out of 128 children (6%) died as a direct result of this form of abuse. A further 15 (12%) required intensive care and 45 (35%) suffered major physical illness <sup>(5)</sup>. The limited studies available suggest that children develop significant emotional problems in adulthood, including insecurity, avoidance of medical treatment, post-traumatic stress symptoms and inappropriate health seeking behaviours <sup>(6)</sup>

## Possible presentation of FII

Parents / Carers may exhibit a range of behaviours when they believe that their child is ill. A key task for professionals is to distinguish between the over anxious parent / carer and those who exhibit excessive health seeking behaviour.

In addition, recognising FII can be especially difficult because often the reported signs and symptoms cannot be confirmed as they may only be witnessed by the parent/carer (when they are being exaggerated or imagined) or they may be inconsistent (when they are induced or fabricated).

Table 1 identifies some of the 'warning signs' which should alert professionals to the possibility of FII. 'Symptoms' are subjective experiences reported by the parent / carer or the patient. 'Signs' are observable events reported by the carer or observed or elicited by professionals.

Professionals should keep in mind the limits of the table; it is intended to give an indication of whether fabricated or induced illness is a *possibility*.

Table 1 Extracted from the 'Michael' Serious Case Review, Cumbria Child Protection Committee (2004)<sup>(7)</sup> and Fabricated or Induced Illness by Carers, RCPH (2009)<sup>(4)</sup>

No	Possible warning signs
1.	<p><b>Reported signs and symptoms found on examination are not explained by any medical condition from which the child may be suffering:</b></p> <p>Here the health professional is attempting to put all the information together to make a diagnosis but the signs and symptoms do not correlate with any recognised disease or where there is a disease known to be present.</p>
2.	<p><b>Physical examination and results of medical investigations do not explain reported symptoms and signs:</b></p> <p>Physical examination and appropriate investigations do not confirm the reported clinical story e.g. <i>a child with frequent convulsions every day has no abnormalities on a 24-hour video-telemetry (continuous video and EEG recording) even during a so-called 'convulsion'.</i></p>
3.	<p><b>There is an inexplicably poor response to prescribed medication and other treatment:</b></p> <p>The practitioner should be alerted when treatment for the agreed condition does not produce the expected effect. This can result in escalating medications with no apparent response, using multiple medications to control a routine problem and</p>

	multiple changes in medication due to either poor response or frequent reports of side effects. Disguised compliance with medication regimes can occur with prescriptions not being requested /collected despite history to the contrary.
4.	<p><b>New symptoms are reported on resolution of previous ones:</b></p> <p>New symptoms often bear no likely relationship to the previous set of symptoms. <i>e.g., in a child where the focus has been on diarrhoea and vomiting, when appropriate assessments fail to confirm this, the story changes to one of convulsions.</i> Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.</p>
5.	<p><b>Reported symptoms and found signs are not seen to begin in the absence of the parent/carer, i.e. a parent/carer is the only witness of the signs and symptoms:</b></p> <p>For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly raise anxiety of FII where the severity and/or frequency of symptoms reported are such that the lack of independent observation is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. For example an education professional may describe an episode as ‘fits’ because they were told by the child’s parent/carer that was the appropriate description of the behaviour they were seeing.</p>
6.	<p><b>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:</b></p> <p>The parent/carer limits the child’s activities to an unreasonable degree and often without knowledge of health professionals or against their advice. <i>E.g. confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child’s school attendance.</i> In addition to the above there may be evidence of financial gain from the reported illness (e.g. receipt of benefits such as Disability Living Allowance). It is essential professionals remain focused on the impact in the child and respond accordingly.</p>
7.	<p><b>Over time the child is repeatedly presented to different health care settings with a range of signs and symptoms. At its most extreme this has been referred to as ‘doctor shopping’:</b></p> <p>The extent and extraordinary nature of the additional consultations is greater than what one would expect concerned parent would explore. Often consultations about the same or different problems are concealed in different health facilities. Thus the child might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different set of problems</p>

	(or even the same) without informing, or deliberately misleading these various health professionals about the other consultations.
8.	<p><b>History of unexplained illnesses or deaths or multiple surgeries in parent/carer or siblings of the family. The emphasis here is on the unexplained:</b></p> <p>Illness and deaths in parents or siblings can frequently be a clue to further investigations and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves which may include obstetric history, ranging from frequent consultations with the general practitioner through to the extreme of Somatising and Somatoform disorder (previously referred to as Munchausen’s Syndrome) where there are multiple presentations with fabricated or induced illness resulting in multiple unnecessary interventions.</p> <p>Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially might have been subject to FII abuse and their medical history should also be examined.</p>
9.	<p><b>Incongruity between the seriousness of the story and the actions of the parents:</b></p> <p>Given a concerning story, parents/carers by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is incongruity between their expressed concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend for crucial assessments (<i>e.g. somebody else’s birthday, thought the hospital was closed, went to outpatients on the wrong day etc.</i>). This has been described as the perpetrator ‘piloting care’.</p>
10.	<p><b>Behaviours of the parent/ carer who is the suspected as the perpetrator:</b></p> <p>Not as concerned about the child as medical personnel; Remaining with child on ward constantly. Investing significant emotional / intellectual effort in the illness; Having a history of conduct or eating disorders / contact with mental health agencies. Other carer uninvolved in child care. Reports of distant passive father.</p>



## Possible Barriers to Recognising FII

Number	Possible barriers to recognising FII
1.	<p><b>Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.</b></p> <p>This is an extension of category 8 in Table 1. On exploring reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They are largely or wholly fictitious and may be used to distract away from abusive behaviour.</p>
2.	<p><b>Erroneous or misleading information provided by parent.</b></p> <p>These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc.). An extreme example of this is that the parent may tell people that the child is going to die when in fact no one in the medical profession has ever suggested this.</p>
3.	<p><b>Perpetrators behaviour/manipulation of professionals.</b></p> <p>Perpetrators of FII will often try to develop over familiar relationships with professionals. However, when challenged they may threaten complaint or litigation. This can result in professionals' further pursuing investigations or treatment for the child. Professionals may be inhibited by the perceived threat and stall in their response to their suspicions.</p>

## Roles & responsibilities in recognising & responding to possible signs of FII

**Professionals not from a Health setting including Education/Early years/Early Help/Children's Social Care:** Professionals may have concerns because parents are describing a child's illness or health needs which are not witnessed by the professionals.

In such situations professionals should consider the other warning signs in Table 1. If they remain concerned or have heightened concerns they should discuss the child with the Safeguarding Lead within their organisation. If concerns remain, then the child should be discussed with relevant health professionals (e.g. GP, paediatrician, School Nurse). Consent from the parents to do this should be sought on the grounds that that this is usual practice where a child has an illness which is impacting on their health or development. At this stage

the concern about possible FII should not be disclosed to the parent/carer. If parents refuse consent for a discussion with health professionals then this should be discussed with the Safeguarding Lead to consider whether refusal increases the level of concern. When a parent/carer reports restrictions/limitations for normal school activities due to reported 'health' issues, it is important this is verified.

Professionals should keep careful and secure records of absences and reasons given by parents for absences so that these can be corroborated. The professionals should listen to the child and document what they are saying.

All discussions, including those with parents/carers, must be documented and kept in a secure record.

**0-19 Practitioners:** If practitioners have concerns that a parent / carer is impairing a child's health, development or functioning by fabricated or induced illness, they should meet with parents/carers or discuss the child's illness, parental concerns and ascertain which other health professionals are involved.

After discussion it may be that some parents may have misunderstood information, are anxious about their child or have concerns that their child's needs are not being met. This may lead to health-seeking behaviours or exaggeration of symptoms. The practitioner should seek parents/carers consent to discuss the child with those professionals involved including the consultant.

Where the practitioner has on-going concerns about FII and the child is already known to other health professionals, then information should be sought from those professionals regarding the medical illness/diagnosis, and advice or an appropriate care plan should be provided - at this point consent is not required. Concerns about possible FII must be shared with the other health professionals (including GPs).

**In all cases of suspected fabricated and induced illness advice and support should be sought from the Trust Safeguarding Children Team.**

**Midwives:** Midwives may be alerted to possible FII by mothers own health-seeking behaviour, history of unusual/unexplained illness, unusual complications of pregnancy, and unexplained deaths of previous children. If concerns are raised then previous pregnancy notes should be obtained and the Midwife must discuss concerns with the Trust Safeguarding Children Team.

**General Practitioners (GPs):** In cases of suspected FII, the GP is likely to have had a higher level of involvement and knowledge of the child and family than other health professionals. GPs involvement and contribution to the management of FII concerns is essential to ensure that all key information with regard to the child is shared. GPs will also be aware about parental health issues – including both physical and mental health – and these should be taken into consideration as part of any assessment and information sharing.

If there are concerns about the welfare of a child and FII is a consideration, the child's needs are paramount and **the GP has a duty to share any relevant and proportionate information that may impact on the welfare of a child**. This includes sharing relevant information about parents and carers as well as the child. GPs are well placed to recognise early symptoms and signs of FII in a child, and as the primary record keeper of all health records, can play a key role in recognising patterns of worrying behaviour from multiple presentations at different settings.

If there are concerns about FII and the child is not known to a Consultant they should be referred to a Paediatrician, Consultant Child Psychiatrist or Consultant Clinical Psychologist (dependent upon the presenting issues) with expertise in symptoms and signs that are being presented.

The GP should make it clear about their concerns re possible FII in the referral letter. This letter should **not** be copied to parent/carers. Timeliness of the referral will depend on presentation. For example if there are signs or symptoms of induced illness such as suffocation or poisoning then same day referral is needed with a concurrent urgent referral to Children's Social Care (CSC).

GPs should also discuss concerns with the Nurse Consultant for Safeguarding in Primary Care or Designated Health Professionals for Safeguarding Children. When recording concerns about FII, GP's should ensure that these concerns are recorded within the child's clinical record but that the entry is not visible on online access, as parental awareness of the concern may escalate the risk to the child.

**Child and Adolescent Mental Health Workers:** Staff within CAMHS may also be alerted to concerns about possible FII in the process of evaluating children for mental health and behavioural difficulties.

Repeated requests for a diagnosis of conditions such as Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD), especially when assessments have ruled out these conditions, should raise the index of suspicion for FII. However, it should be noted that it is not uncommon for parents to request second opinions, and consideration should be made to the fact that there are a number of children who do get a diagnosis of ADHD/ASD when reassessed. A repeat parental request for another medical/CAMHS opinion should not automatically trigger an investigation for FII, as this might be inappropriate.

In CAMHS cases of FII there have usually been very many requests for assessments for mental health diagnoses with repeated requests for second/third/fourth opinions.

Initial concerns about a child's presentation should be shared with the Paediatrician or GP that referred the patient and other relevant health professionals. If concerns continue then advice from the Trust Safeguarding Children Team should be sought.

**Adult Mental Health Services:** Adult mental health staff may become concerned about the welfare of a child in relation to possible FII. These concerns may be increased if a patient who is a parent is known to fabricate or induce illness in themselves, although this can exist within the parent's presentation and not the child's. If an adult mental health worker has any concerns of this nature about a child's welfare they should be discussed with the Trust Safeguarding Children Team. Confidentiality may need to be breached without consent in order to protect the child as there is a statutory obligation on all professionals to act in the best interests of children in order to safeguard children.

**Allied Health Professionals:** If staff have concerns about FII in children they are providing therapy and care for they should discuss with the Safeguarding Children Team within their Trust and GP or the practitioner who referred to their service. They should also discuss with their clinical manager.

**Consultant Paediatricians, Consultant Child Psychiatrist or Consultant Clinical Psychologist:** All cases of suspected FII should be led by a Consultant Paediatrician, Consultant Child Psychiatrist or Consultant Clinical Psychologist (dependent upon the concerns). This Consultant should take a lead role in this process.

During the thorough medical evaluation, the Lead Consultant should obtain information from the GP and other Consultants who have been involved in the child's care. This may include relevant information about the parent's health and the siblings.

Medical records of any siblings under 18 years of age should also be reviewed (see section on information sharing). The Consultant should discuss any cases with the Safeguarding Children Team and Named Doctor for Safeguarding/Child Protection.

In order to avoid unnecessary investigations and harm by further consultation, testing or treatment, a management plan for when the child presents to hospital or primary care should be decided in the early stages of the investigation. This should be clearly documented in the notes and shared with the GP and other relevant health professionals that notes can be appropriately flagged. It should not be shared with parents at this stage.

It is important that all discussions with parent / carers and other professionals are carefully recorded in the patient's notes, which should be kept securely.

**Other Consultant Specialists:** If another Consultant, other than a Paediatrician or CAMHS Consultant, has a concern about FII in a child in their care they should refer to a general or community Paediatrician (depending on local arrangements). The case should also be discussed with the Named Doctor for Safeguarding in the Trust and the Safeguarding Children Team. If there are immediate concerns for the child's safety an immediate referral should be made to Children's Social Care. If there are immediate concerns then it may be appropriate to ring 999.

The Lead Consultant (with guidance and assistance from the Named Doctor and Children's Safeguarding Team), should collate a chronology of the child's medical care on a standard chronology template. It is important that attendances at emergency departments in the local hospital trust and neighbouring trusts are included in the chronology where these are known.

A chronology is a complex and time consuming task and **adequate resources and time should be allocated**. The preparation of the chronology should not delay a referral to Children's Social Care (CSC) or any other interventions if this would put the child at risk of harm.

**Designated Professionals for Safeguarding Children:** Designated Professionals provide a valuable source of expert advice and support to health care professionals and colleagues from partner agencies. They can offer safeguarding supervision or facilitate professional discussions, particularly where the presenting issues are very complex. In cases where there is professional disagreement regarding the presenting concerns and/or the agreed management plan, the Designated Professionals Team should be consulted, in line with LSCB conflict resolution or challenge procedures.

**Health Professionals Meeting:** a health professionals meeting could be convened by the Lead Consultant in conjunction with the Trust(s) Safeguarding Children Team(s) when concerns are emerging but it is unclear whether a referral to CSC is indicated. Any health professional could request a meeting of this nature via the Safeguarding Children Team. Chronologies from each health professionals should be collated in preparation for this meeting using the standard template. The purpose of the meeting is to:

- Gather and share all relevant information (including previous investigations, results, current treatment, any known relevant information regarding parents/carers and siblings, etc.);
- Obtain clarity about the impact of presentations on the child's health, development and functioning (school, mobility, etc.);
- Distinguish between presentations which could be attributable to any pre-existing, confirmed medical conditions and those for which there is no confirmed diagnosis;
- Discuss the concerns;
- Consider other possible reasons for child and parents behaviour;
- Discuss the possibility of whether any early direct intervention, if any, should take place and what that should be;
- Reach a consensus regarding further actions and management;

If after the meeting or discussion concerns persist about FII then a referral to Children's Social Care should be made. Notes of meetings and discussions should be made and action plans should be documented. Follow up meetings should be arranged if FII is not thought to be an on-going concern at this time, but the child and their response to treatment should continue

to be closely monitored. If no concerns about the welfare of the child are present then feedback to parents regarding the plan for intervention should take place.

## Information Sharing, Consent and Confidentiality

The child's best interests must be the overriding consideration in making decisions about sharing information. In cases of suspected or confirmed FII, all decisions about what and when to tell parents and children should be taken by senior staff within the multi-agency team. While professionals should seek, in general, to discuss any concerns with the family and, where possible, seek their agreement to action, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm.** In all cases where the police are involved, the decision about when to inform the parents (about referrals from third parties) will have a bearing on the conduct of police investigation<sup>(6)</sup>.

It is important when obtaining and sharing information that consideration is given to what information is shared – this should be relevant and proportionate to the concern. For example only relevant health and social information about parents should be shared in order to protect the children. Further advice can be obtained from your organisations Safeguarding Lead and it may be necessary to consult with your organisations legal advisor.

Any decision on whether or not to share information must be clearly documented.

**Where there are sufficient concerns that a child may be suffering or is likely to suffer significant harm resulting from a parent or carer's persistent attempt to fabricate, induce or exaggerate an illness, a referral should be made to CSC as soon as possible in line with LSCB multi-agency procedures.**

When a referral to CSC is indicated in line with NYSCP and CYSCP procedures, discussions should take place between the referrer and CSC about what the parents or carers will be told, by whom and when, and details recorded on the child records.

## Record Keeping

Records should use clear and straightforward language, should be concise and accurate not only in fact, but in differentiating between opinion, judgements and hypotheses. It should be clearly recorded what is reported by the parents/carers and what has been directly observed by the practitioners. Where it is considered that illness may be fabricated or induced, the records relating to the child's symptoms, illness, diagnosis and treatments should always include the name (and agency) or the person who gave or reported the information. This should be dated and signed legibly.

## Chronologies

The purpose of a chronology is to help professionals get a clear picture of what is happening in a child's life and to help them form a judgement on the nature and level of risk to the child.

### Good chronologies:

- Are a summary of key information pertaining to the child – they should not just replicate the child's health record;
- Pay particular attention to the specific concerns that have been raised about the child;
- Clearly state what has been said, by whom and to whom;
- Record what has been reported or observed and whether this was observed by professionals;
- Record the source of information e.g. 'History taken from Mother';
- Are written in a way that can be understood by colleagues from other non-medical or professional backgrounds.
- Summarise large amounts of information where this appropriate. e.g. 'John was on the ward between 1 June and 4 June there are no recorded incidents of diarrhoea.'
- The comments section of the chronology can be used to highlight where there are particular 'warning signs' as identified in Table 1.

### Timescales

Chronologies should go back far enough to include relevant information. This will be a judgement to be made in each individual case. *Remember the purpose is to help make a judgement on risk to the child.*

In some instances a child may be said to have had a condition for many years. Whilst it may not be necessary to go back over all information from this period it is important where possible to confirm or refute specific information e.g. where a child is said to have been given a specific diagnosis evidence of that diagnosis should be sought, where evidence is not found the chronology should show that evidence has not been located.

### Appendix 1: FII Chronology Format

## Making a referral to Children's Social Care (CSC)

At the point of referral to CSC, advice should be sought from the organisational safeguarding lead regarding whether or not parents should be made aware of the referral, since doing so may increase the risk for the child/ren.

There will be situations where an urgent referral to CSC is required, for example induction of illness, poisoning or suffocation. If a Professional is concerned about the immediate safety of a child then an urgent referral must be made and consideration should be given to calling 999. The referrer should be clear regarding the significance and immediacy of the concerns.

All referrals to CSC must identify the exact nature of the concerns and explicitly state why FII is suspected.

## Response by Children's Social Care & Multi Agency Strategy Meeting

CSC will decide and record within 1 working day what action is required in response to the referral. Lead responsibility for action taken to safeguard and promote the children's welfare lies with CSC. The police must be involved throughout the safeguarding investigation.

In all cases where it is believed the information indicates suspected FII there should be an assessment undertaken which may result in a multi-agency strategy meeting which considers all children within the family.

The strategy must be a 'face to face' meeting and it is essential that the appropriate professionals attend. However, non-attendance of one or two key professionals should not delay the meeting if it is indicated the child may be at risk of significant harm. Any professionals who are unable to attend the meeting should send a brief summary of their involvement and whether they have any concerns re FII. Key professionals will include:

- Team manager or practice supervisor CSC
- Named/Designated Doctor
- Specialist/Named Nurse Safeguarding from relevant organisation
- Lead Paediatric Consultant/CAMHS Consultant (as applicable)
- Senior Police Officer from North Yorkshire Police
- The referrer
- Other allied health professionals involved in child's care
- Other Consultants involved in child's care.
- Adult Mental Health Consultant (if involved with a parent's care)
- General Practitioner
- School or early years setting representative
- Legal advisor to local authority

During the strategy meeting specific consideration must be given to what information is to be shared with the parents and when. In addition, decisions about involving the child in discussions must also take place and consideration must be given to any relevant therapeutic work.

The Paediatric Consultant or relevant senior clinician, for example CAMHS Consultant, is the lead health professional pertaining to the child's health care. It is critical that all agencies work together in making and taking forward decisions about the future action recognising individual roles.



## **Police response**

During the process of information sharing and assessment it may become apparent that there are indicators that a crime has been committed. This should be taken into due consideration during all stages of assessment and interventions and the police will provide direction regarding professional intervention in order to avoid disrupting any possible criminal investigation/process.

## **Emergency action**

Circumstances of the child can change at any point during the investigation, for example if parents or carers become aware of concerns they may escalate the abuse. Decisions about need for immediate action to safeguard the child/ren should be kept under constant review and appropriate legal advice sought where required

## References

- <sup>1</sup> Working Together to Safeguard Children – a guide to inter-agency working to safeguard and promote the welfare of children (2018)
- <sup>2</sup> Denny, S. J., Grant, C. C., & Pinnock, R. (2001). Epidemiology of Munchausen syndrome by proxy in New Zealand. *Journal of Paediatrics and Child Health*, 37(3), 240–243.
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- <sup>5</sup> McClure et al; Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. *Arch Dis Child*. 1996 Jul; 75(1):57-61.
- <sup>6</sup> Safeguarding Children in Whom illness is Fabricated or Induced – Department for Health (2008)
- <sup>7</sup> <http://www.cumbria.gov.uk/eLibrary/Content/Internet/327/3823713560.pdf>
- Multi-agency Child Protection Procedures:**
- North Yorkshire: <http://www.safeguardingchildren.co.uk/>
- City of York: <http://www.saferchildrenyork.org.uk/>

