

All Wales Child Protection Procedures

ALL WALES ACPC PROTOCOL

Safeguarding Children In Whom Illness is Fabricated or Induced 2004

(To be read in conjunction with DOH/WAG document: "Safeguarding Children in Whom Illness is Fabricated or Induced" and the "All Wales Child Protection Procedures 2002")

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1. INTRODUCTION

Fabricated/Induced Illness in children is recognised as being child abuse.

- 1.1 In 2002 the Department of Health, Home Office, Department of Education and Skills and the Welsh Assembly Government issued comprehensive guidance under statute, "***Safeguarding Children in Whom Illness is Fabricated or Induced***".
- 1.2 The guidance provides a national framework for all agencies and recommends that more specific and detailed guidance is available locally. In addition in 2001-2 The Royal College of Paediatrics and Child Health (RCPCH) produced their own working party report.
- 1.3 The guidance gives a comprehensive overview of Fabricated Illness, and in particular the complex issues of working with families.
- 1.4 The above national policy (Safeguarding Children in whom Illness is Fabricated/Induced) and this All Wales ACPC protocol should be viewed as addenda to the All Wales Child Protection Procedures and Working Together to Safeguard Children 2000
- 1.5 The above documents should be available to practitioners and must be read in conjunction with this protocol.
- 1.6 Referrals regarding fabricated/induced illness should be managed in accordance both with the All Wales Child Protection Procedures 2002, Part3 – Handling Individual Cases and with this protocol.

***Fabrication of symptoms and signs by a carer will result in harm to the child whether as a direct result of the carer's actions
OR
as a result of unnecessary medical investigation and treatment.***

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All professionals in all agencies should be alert to the possibility of Fabricated Illness.

1.7 The following may be present:

- Exaggerating real illness and symptoms
- Fabrication of symptoms e.g. sleep apnoea, seizures, asthma attacks and allergy etc
- Falsifying signs, tests and records, e.g. addition of blood or sugar to urine, false temperature records
- Inducing physical illness, e.g. poisoning, suffocation, starvation or inappropriate diet
- Sudden unexpected death of infant or child
- False allegations of abuse
- Encouraging or requiring the child to appear disabled, including learning disability and/or obtaining unnecessary specialist treatments or equipment for the child

2.0 Fabricated Illness may be unusual but should form part of a differential diagnosis/consideration for all professionals, especially Health, in working with/ treating children and young people.

2.1 In the case of suspected fabricated illness, a referral should be made to Social Services.

2.2 Where any such concerns arise:

- All professionals in all agencies need to be aware of the need to seek the advice of a senior key professional at an early stage (see list in Appendix D)
- Considerable care must be taken in deciding whether to share concerns with the family at this stage, and should only take place where it is clear that this will not further jeopardise the safety of the child. (This is highlighted as being different to the normal rule of partnership working with parents).

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- Action must be taken in a time frame which is not detrimental to the needs of the child
- All professionals **MUST** keep clear, accurate and contemporaneous records

2.3 An Initial Assessment will then be carried out by Social Services and a strategy meeting under child protection procedures will be held. The strategy meeting will include senior professionals from each relevant agency:-

- Senior Manager Social Services / Team Leader / Social Worker
- Named Doctor and Named Nurse or equivalent
- Senior Investigating Police Officer
- Local Authority Legal Adviser
- General Practitioner
- Other Health professionals as indicated (either involved with the family or an expert resource)
- Education and other agencies if indicated

2.4 Once it has been decided that a strategy meeting should be convened;

The Strategy meeting will:-

- Share information and plan to produce a detailed chronology of all of the issues, with clear recognition of confirmed signs and symptoms. (Health has a particular responsibility to explain the significance of the medical information). Decide whether S 47 enquiries should be initiated
- Confirm the key health professional and key professionals from the other agencies
- Clarify and possibly limit the number of health professionals seeing the child e.g. where possible ensure that the same GP responds to requests for consultation
- Consider the need to access the family's health records. This should be facilitated via the Named and/or Designated Doctor and Nurse

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- Make a decision on sharing or not sharing information with the family. (Fabricated Illness is an exception to “Partnership with Parents”.)
- Consider appropriate protection arrangements for the child
- Consider whether to consult a health professional who can give an expert opinion, and who is independent of the case
- Ensure that all agencies understand the need to work very closely together and to keep each other fully informed
- Only consider Covert Video Surveillance as a possible course of action following full discussion within a strategy meeting. It can only be initiated by the police according to their guidelines and must comply with the Regulation of Investigatory Powers Act 2000.
- Develop a clear action plan, although in many cases, especially if referral is at a very early stage, the next steps may be further collation of information
- Emphasise that each agency may need to take its own legal advice. In complex cases the legal advisers may also themselves need to meet with all of the relevant professionals
- Consider the need for further strategy meetings
- Be minuted, with strict control over the circulation of the minutes
- Consider the needs of, and provide support and supervision for all professionals involved with the family.

(There may be a series of strategy meetings under child protection procedures before a decision is made to proceed to a child protection conference.)

2.5 Specific action by the ACPC:

- Each ACPC needs to ensure that appropriate key professionals are nominated from each agency and to hold a list of these names (See Appendix E).
- Each ACPC, via Health, needs to ensure access to expert medical opinion.

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APPENDIX A

CONSIDERATIONS FOR HEALTH PROFESSIONALS

- 3.0** **Health** will often be the first agency to raise concerns. It is therefore important that Health has well-established links with Social/ Children's Services and the Family/Child Protection units of the Police, to enable early discussion of cases.

It is again imperative that within NHS settings and in particular where children and young people may be under the care of "non paediatric" specialists, health professionals are alert to the possibility of the diagnosis and aware of where to obtain advice. This will usually be from the Named Doctor and/ or Named Nurse Child Protection for the Trust.

It is imperative that Health Professionals are fully aware of the need to make an early decision on sharing information with the statutory agencies.

The Named Doctor/Named Nurse (or appropriate health professionals with expertise), should work with all involved health colleagues to draw together all available information and make an early decision on sharing information with Social Services.

3.1 Action for Health Professionals (if initial concerns raised by Health)

- 3.1.1** Medical and Nursing staff should record their concerns and seek further information regarding the family within their own department initially. (Health professionals should be aware of local protocols re the use of "supplementary type records". They **must** then communicate with other local health professionals, who may have had contact with the family, e.g. the General Practitioner, the Named and/or Designated Doctor and Nurse Child Protection and other agencies.

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- 3.1.2** Non- medical / non-nursing staff in Health should communicate with the appropriate Named and/or Lead Professional for Child Protection and document as advised.
- 3.1.3** A key health professional should be nominated to pull together **ALL** the health information across the acute units and the community. This should also include relevant family history available from the GP including relevant information regarding the child's carers
- 3.1.4** A health professionals' meeting may be convened at this stage including only relevant personnel, or an immediate contact made with social services. It is crucial that possible perpetrators are still not informed.
- 3.2 Additional Health Considerations:**
- 3.2.1** Ensure a "key" health professional is nominated, who will ensure agreement between primary and secondary services and also maintain communication with tertiary services
- 3.2.2** The key professional will need to monitor and liaise when advice is sought by the family from alternative or other specialist centres
- 3.2.3** Health will need to take steps to ensure that investigations/interventions are limited
- 3.2.4** If the GP is unable to attend strategy meetings the nominated health professional must ensure that all information is shared, but in such a way that the family are not alerted
- 3.2.5** Health professionals need to have a low threshold for sharing information with the statutory agencies
- 3.2.6** Health professionals should ensure that they refer to the national policy, "Safeguarding Children in Whom Illness is Fabricated/Induced" and the report of the Royal College of Paediatricians and Child Health (RCPCH), for further guidance and information.

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APPENDIX B

CONSIDERATIONS FOR SOCIAL SERVICES

Referrals to Social Services in relation to fabricated or induced illness should be managed in accordance with the *All Wales Child Protection Procedures (2002) (Part Three: Handling Individual Cases)*, and with the All Wales ACPC Protocol entitled *Safeguarding Children in Whom Illness is Fabricated or Induced*.

4.0 ACTION FOR SOCIAL SERVICES PROFESSIONALS

The role of Social Services is to undertake assessment and planning, to provide services and to review.

4.1 Key Considerations

4.1.1 Immediate Action

- If, at any stage, there is medical evidence to indicate that the child's life is at risk, immediate action should be taken by police and/or Social Services to secure the child's safety.
- The nature of the abuse will be the determining factor e.g. intentional suffocation or poisoning. Verbal fabrication only is unlikely to require such swift action.
- However, circumstances may change as the assessment progresses, especially if parents become aware that professionals are suspicious that symptoms are being fabricated. Decisions, therefore, about the need for immediate action should be kept under constant review.
- Social Services professionals should also consider whether any action is required to protect other children in the same household.

4.1.2 Information to Parents

- At each stage of the enquiries, from referral and case planning to intervention and review, careful consideration must be given to what information should be shared with parents, when and by whom, taking account of the child's welfare.

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- Decisions in respect of information- sharing with parents should be taken jointly by all the professionals involved, in line with the All Wales ACPC Procedures.
- Concerns should not be raised if it is judged that this action will jeopardise the child's safety.

4.2 Initial Assessment

- A chronology is an essential part of the initial assessment. The social worker should compile it from existing records and all available information in preparation for any inter-agency strategy or information-sharing meeting. The nominated key health professional responsible for collating all the health information in the child's case should also be preparing a health chronology.

4.3 Strategy Meeting (see also 2.4)

- There must always be a face-to-face strategy meeting rather than a telephone discussion.
- Police and Social Services should ensure the involvement of the child's medical consultant, the senior ward nurse (if the child is an in-patient) and other relevant professionals in their planning and decision-making, including decisions in respect of information-sharing with parents.
- More than one strategy meeting may be necessary in order to ensure that complex issues are discussed thoroughly before a decision is made to initiate S. 47 enquiries.

4.4 Initial Child Protection Conference

- The social worker should ensure that the initial child protection conference takes place within 15 working days of the strategy meeting. Given that there may be a number of strategy meetings, the conference should be held within 15 working days of the last one held.
- Consideration should be given by the social worker, in consultation with their line manager, to inviting a professional who has expertise in the field of fabricated or induced illness and also a medical professional such as a paediatrician with knowledge of the particular symptoms and illness processes caused by the suspected abuse e.g. gastroenterology, neurology, respiratory illness etc. These professionals can greatly assist the conference to make sense of all the information presented.

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- Children should be involved in the initial child protection conference in ways appropriate to their age and understanding. All are likely to have suffered emotional abuse and discussions should be carried out in a sensitive manner, with the child knowing they are safe. The child's safety should also be considered following the conference and how this should be conveyed to the child.
- Parents will normally be invited to the conference but it may not be possible for them all to attend at the same time. Preparation of family members should take place by the social worker prior to the conference, using her/his judgement from what she/he knows about each of them. The abusing carer may not wish to admit their behaviour in front of their partner and should not be put under pressure to talk about the abuse. These are matters to be dealt with outside the conference. Decisions on how the conference process is managed should be discussed with the conference chair.
- The social worker will contribute a report to the conference, along with other key professionals, setting out their involvement with the family. Factual accuracy is essential. A chronology, focusing particularly on the child's medical history, should be compiled in collaboration with the responsible Consultant Paediatrician involved and the health history of siblings should also be considered. Unusually, the social worker's report and the chronology will not necessarily be shared with parents prior to the conference. The social worker should discuss the timing of this with the conference chair. This applies to all professional reports.

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APPENDIX C

CONSIDERATIONS FOR THE POLICE

- 5.1.1** Any suspected case of fabricated or induced illness may also involve the commission of a crime and therefore the police should always be involved at an early stage in accordance with 'Working Together'.
- 5.1.2** Such complex cases must be led by an experienced Detective Supervisor who as part of the inter-agency management team should, if possible, consider an arrest strategy well in advance of it being carried out, in particular where such enquiries are conducted on hospital wards.
- 5.1.3** All investigative avenues must be considered, including the use of covert surveillance, ensuring that the very highest standards of professional integrity are maintained.
- 5.1.4** Covert Surveillance should only be used if there is no alternative way of explaining the child's signs and symptoms and if the multi-agency strategy meeting considers that its use is justified and proportional based on the medical information available.
- 5.1.5** Any application in relation to covert policing must comply with the Regulation of Investigatory Powers Act 2000 and, where necessary, Part 3 of the Police Act 1997.

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APPENDIX D

CONSIDERATIONS FOR EDUCATION SERVICES

6.0 THE ROLE OF EDUCATION

Schools have an important role to play in the identification and management of suspected cases of fabricated or induced illness. Through their day to day contact with children, teachers and other school staff are particularly well placed to notice outward signs of a child at risk of significant harm. Similarly, staff from LEA school support services, such as Education Welfare Officers, Education Social Workers and Educational Psychologists, are in a position to raise concerns.

6.1 Identifying Fabricated or Induced Illness

There are a number of factors that teachers and other school staff should be aware of that can indicate that a pupil may be the subject of fabricated or induced illness.

- Frequent and often unexplained absences from school.
- Regular absences to keep a hospital or doctor's appointment.
- Repeated claims by a parent/carer that a child is frequently unwell and that s/he requires medical attention for symptoms or illnesses that have not been observed by staff.
- Conflicting or patently untrue stories about illnesses, accidents or deaths in the family.

Schools should be aware of significant changes to a child's physical or emotional state, unexplained injuries, changes in behaviour and a failure to thrive.

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6.2 Action to be taken by School Staff

Where a teacher or other member of staff has cause to believe that a child is at risk from, or is the subject of, fabricated or induced illness, the teacher with designated responsibility for child protection should be immediately informed. As with all forms of suspected harm, the 'All Wales Child Protection Procedures' will apply and the designated teacher will take responsibility for making an appropriate referral to Social Services. All evidence relating to the concern should be kept safely as it may be needed to inform decision making or contribute to any consequent investigation.

Teachers and other school staff should not carry out their own investigations or discuss the matter with the child's parent/carer. With the safety of the child foremost in mind, the designated teacher will take advice as to whether the school should share its concerns with a child's parent/carer. After the designated teacher has referred a concern to Social Services, the lead agencies, including Education, will take the matter forward in line with local ACPC child protection arrangements.

6.3 Action to be taken by staff from LEA school support services

Staff from school support services should either refer their concerns to the designated teacher of the child's school or to the LEA senior officer with designated responsibility for child protection who will make the referral to Social Services.

6.4 Further advice

Further advice can be sought from the LEA senior officer with responsibility for co-ordinating action and policy on child protection.

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