NHS
Southend
Clinical Commissioning Group

# POLICY FOR THE MANAGEMENT OF CASES WHERE FABRICATED OR INDUCED ILLNESS IS A CONCERN

| | |
|---|---|
| **Policy Number:** | CP13 |
| **Version:** | 2.0 |
| **Ratified By:** | NHS Southend Clinical Commissioning Group Governing Body |
| **Date Ratified:** | November 2015 |
| **Name of Sponsor:** | Linda Dowse, Chief Nurse |
| **Name of Originator/Author:** | Designated Professionals and Named GP Safeguarding Children |
| **Date Issued:** | November 2015 |
| **Review Date:** | November 2018 |
| **Target Audience:** | All staff who work with children and their families<br>All line managers of staff who work with children and their families |

## CONTENTS


1.0 INTRODUCTION 3

2.0 PURPOSE 4

3.0 ROLES AND RESPONSIBILITIES 4

4.0 DEFINITIONS 5

5.0 POLICY PROCEDURAL REQUIREMENTS 6
- 5.1 Identification of FII
- 5.2 Management of FII
- 5.3 Considerations for Medical Evaluation
- 5.4 Record Keeping
- 5.5 Training, Supervision and Support
- 5.6 Covert Video Surveillance

6.0 MONITORING COMPLIANCE 13

7.0 ASSOCIATED DOCUMENTATION 13

8.0 REFERENCES 14

9.0 LIST OF STAKEHOLDERS CONSULTED 15

10.0 EQUALITY IMPACT ASSESSMENT 16

11.0 VERSION CONTROL 16

APPENDIX 1 – Spectrum of Cases Where FII Concerns May Arise 17

APPENDIX 2 – FII Flow Chart 18

APPENDIX 3 – Sample Chronology Template 19

## 1.0 INTRODUCTION

**1.1** All NHS services are required to fulfill their legal duty under section 11 of the Children Act 2004 and statutory responsibilities as set out in Working Together to Safeguard Children 2015.

***1.2*** This procedure is supplementary to national and local policy and should be followed in conjunction with *Safeguarding Children In Whom Illness Is Fabricated or Induced (HM Government 2008)* and *Southend Thurrock Essex (SET) Safeguarding and Child Protection Procedures 2015*

**1.3** This policy applies to all staff employed by NHS Southend Clinical Commissioning Group (CCG) which includes all staff and members and the above will be referred to as "all staff" in the policy.

**1.4** In this policy, the term 'children' will apply to all will apply to all children and young people who have not yet reached their 18th birthday as per the Children Act 1989. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital, in prison or in a young offender's institution, does not change his or her status or entitlement to services or protection under the Children Act 1989.

**1.5** Fabricated or induced illness (FII) is a form of abuse, not a medical condition. This was previously known as Munchausen Syndrome by Proxy but was changed as this label applied to the child not the perpetrator of the abuse.

**1.6** FII occurs when a caregiver (in 93% of cases, the mother [Schreier, 2004]) misrepresents the child as ill either by fabricating or producing symptoms and then presenting the child for medical care, disclaiming knowledge of the cause of the problem.

**1.7** FII is perpetrated by all social classes and is not associated with other types of family violence or crime. Although FII is uncommon it has a high morbidity and is often not recognised until the child has suffered a great deal, both physically and emotionally.

**1.8** Where concerns exist about possible FII, it requires professionals to work together, evaluating all the available evidence, in order to reach an understanding of the reasons for the child's signs and symptoms of the illness.

**1.9** The management of these cases requires a careful medical evaluation which considers a range of possible diagnoses. At all times professionals need to keep an open mind to ensure that they have not missed a vital piece of information. Following the identification of possible FII in a child being

perpetrated by a parent or carer, the way in in which the case is managed will have a major impact on the developmental outcomes for the child (HM Government, 2008).

## 2.0 PURPOSE

**2.1** To provide Southend CCG staff and members with information so that they may fulfill their statutory duties to safeguard and protect children and young people when there are concerns of possible FII.

**2.2** To provide a single consistent approach, across the local health economy, in the management of suspected FII that is consistent with national and local guidance. To clearly define roles and responsibilities so that the process is transparent and staff understand the complexities of the process and have realistic expectations about the timeframes within which the case can be managed.

## 3.0 ROLES AND RESPONSIBILITIES

**3.1** The **Chief Executive** of each organisation is responsible for ensuring compliance with this policy and procedures and for ensuring that the policy is effective.

**3.2** The **Chief Operating Officer** of each Clinical Commissioning Group (CCG) will be responsible for ensuring that the policy is implemented amongst all employed and hosted staff in the South Essex CCGs.

**3.3** **Designated and Named Safeguarding Children Professionals** are responsible for providing staff with advice and support when dealing with actual or suspected cases of FII and for promoting, influencing and developing training on this issue.

**3.4** **The responsible Paediatrician** is the Consultant responsible for the child's clinical care should take the lead responsibility to find out whether the child's illness and individual symptoms and signs have an unequivocal explanation as a natural illness. If this is not clear, the possibility of FII has to be considered as part of the differential diagnosis together with the effect on the child (Child Protection Companion, 2006). The responsible Paediatric Consultant should take lead responsibility for all decisions about the child's health care – these should not be delegated to a more junior member of staff although they may be involved in the process of assessment and subsequent management under the consultant's supervision.

**3.5** All **clinical staff** should**:**

- Be alert to potential indicators of FII;
- Be alert to the risk of harm which individual abusers, or potential abusers, may pose to children in whom illness is being fabricated or induced;
- be familiar with SET procedures and, in particular, know who to contact when they have child welfare concerns;
- Discuss all suspicions of FII with a named or designated safeguarding professional;
- 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;
- 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

## 4.0 DEFINITIONS

**4.1** **South Essex CCGs** are defined as Basildon & Brentwood; Castle Point & Rochford; Southend and Thurrock Clinical Commissioning Groups

**4.2** **Fabricated or Induced Illness (FII)** in a child is a condition whereby a child suffers harm through the deliberate action of her/his main carer and which is duplicitously attributed by the adult to another cause.

There are three main and not mutually exclusive ways of the carer fabricating or inducing illness in a child:

- Fabrication of signs and symptoms, including fabrication of past medical history
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters, documents and specimens of bodily fluids
- Induction of illness by a variety of means.

## 5.0 POLICY PROCEDURAL REQUIREMENTS

### 5.1 IDENTIFICATION OF FII

5.1.1 Identification of FII is not a swift or easy process; identifying the carer's patterns of behaviour will take a multi-agency approach, expertise and observation.

5.1.2 FII should be considered if a child's history, physical or psychological presentations or investigations lead to a discrepancy with a recognised clinical picture.

5.1.3 FII should be suspected if a child's history, physical or psychological presentations or investigations lead to a discrepancy with a recognised clinical picture and one or more of the following is present:

- Reported symptoms and signs only appear or reappear when the parent/carer is present;
- Reported symptoms are only observed by the parent/carer;
- An inexplicably poor response to prescribed medication or other treatment;
- The parent/carer appears to know a lot about the prescribed medicine and/or treatment;
- New symptoms are reported as soon as previous ones have resolved; There is a history of events that is biologically unlikely (e.g. infants with a history of very large blood losses who do not become unwell or anaemic);
- Although the parent/carer stays with the child all the time while he/she is in hospital and attends to him/her well, they do not appear as concerned about the child's wellbeing as the health care professionals who are providing treatment; in contrast they may appear overly concerned;
- Despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent/carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms;

- The child's normal daily activities (e.g. school attendance) are being compromised, or the child is using aids to daily living (e.g. wheelchairs) more than would be expected for any medical condition that the child has;

5.1.4 Diagnosis of FII can be especially difficult, because the reported signs and symptoms cannot be confirmed (when they are being exaggerated or imagined) or may be inconsistent (when they are induced or fabricated).

5.1.5 Features that may be associated with FII, but none of which are themselves indicative, are:

- Early commencement of the child's medical, especially hospital, treatment;
- The attendance at various hospitals, in different geographical areas;
- Development of feeding disorders, as a result of unpleasant feeding interactions;
- The child may develop abnormal attitudes to their own health;
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family;
- Past history in the carer of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault;
- Carers over involved in participating in medical tests, taking temperatures and measuring bodily fluids;
- Carers observed to be intensely involved with their children, never taking a much needed break nor allowing anyone else to undertake care for their child.

5.1.6 The Royal College of Paediatrics and Child Health (RCPCH) offer five examples across the spectrum of FII:

- Simple anxiety or over-interpretation of trivial symptoms;
- Child's symptoms are misperceived, perpetuated or reinforced:
- Carer actively promotes sick role by exaggeration, fabrication or falsification;
- Carer suffers from a psychiatric illness;
- Child has a genuine and unrecognized medical problem.

The spectrum is presented in further detail in Appendix 1.

## 5.2 **MANAGEMENT OF FII**

5.2.1 In some cases it will be Community Practitioners such as Health Visitors who begin to have an early awareness or sense that a parent/carer's behaviour (for example, over exaggeration of every ailment or constantly and repeatedly seeking advice) may be more than normal parental anxiety but the practitioner may have insufficient evidence to raise it as a fabricated/induced illness concern at that time. The Community Practitioner will share this information with the GP and/or Paediatrician so that it can inform the care and treatment of the child. This information will be shared in the knowledge that GP and/or Paediatrician will not pass these concerns onto the parent/carer.

5.2.2 A Practitioner concerned about a child's health should discuss this as early as possible with the child's GP and where relevant the child's Paediatrician. **Concerns regarding the possibility of FII must not be shared with parents/carers as this may increase the risk to the child.**

5.2.3 **If intervention is required immediately due to concern about immediate harm to the child e.g. observed that medication / feeds tampered with in hospital, medical staff should call the Police using the '999' service**

5.2.4 The Practitioner should inform their line manager and seek support and advice from their Safeguarding Children Team/Lead.

5.2.5 The Practitioner, with the support of the Safeguarding Professional, should start to prepare a chronology (appendix 3).

5.2.6 If at any time the Practitioner considers their concerns are not being taken seriously or responded to appropriately, s/he should discuss this with the Designated/Named Safeguarding Children professional. Concerns should be escalated in accordance with the SET Safeguarding and Child Protection Procedures (2015).

5.2.7 The Practitioner should record the concerns in the child's health record so that other clinicians will have access to the information. Parent/Carer's access to the record will need to be restricted.

5.2.8 With the support of their Safeguarding Lead, the Practitioner will arrange an initial Professionals Meeting to take place within 10 working days of initial identification of concerns. All health professionals involved in the child's care and the Designated Professionals for Safeguarding Children should be invited. All invitees **must** prioritise attendance at this meeting even if it means rescheduling other appointments. If attendance of a professional is still not possible then a fully briefed substitute may attend. The substitute must be able to make decisions on behalf of the professional. All professionals must attend the meeting fully prepared and able to discuss their concerns.

5.2.9 The responsible Consultant Paediatrician will lead the meeting. In cases where the child is not under care of a Paediatrician the Designated Doctor will lead the meeting.

5.2.10 Where the consultant has reasonable cause to suspect that a child is suffering or likely to suffer significant harm a referral should be made to children's social care. Discussions with a senior colleague in children's social care may also be helpful in deciding whether and when a referral should be made.

5.2.11 A chronology template will be sent by the commissioning safeguarding team to the practitioners to complete regarding their own involvement with child (appendix 3). This must be completed within 10 working days and returned to the commissioning safeguarding team administrator for collation. The composite chronology will be shared with the responsible Paediatrician, the Designated Doctor and any other relevant professional.

5.2.12 The responsible Paediatrician will arrange for a medical evaluation to take place.

5.2.13 If the child is not under the care of a paediatrician the GP will make a referral to an appropriate Consultant Paediatrician. This referral will be facilitated by Designated Doctor giving consideration to the need not to alert the parents/carer to the concern of the possibility of FII.

5.2.14 If a possible explanation for the signs and symptoms is that they may have been fabricated or induced by a parent/carer a referral should be made to Children's Social Care following consultation with the Designated Doctor. The Police Child Abuse Investigation

Team (CAIT) must be informed of any referral where FII is suspected as this may also involve the commission of a crime.

5.2.15 Whilst professionals should in general, discuss any concerns with the family and, where possible, seek agreement to making referrals to Children's Social Care, this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm.

5.2.16 A second Professionals Meeting with Designated Doctor and all other involved healthcare professionals will be arranged by the responsible paediatrician for feedback of the outcome and any further action required in line with SET Safeguarding and Child Protection Procedures (2015).

5.2.17 A flowchart of the procedure can be found in appendix 2

## 5.3 Considerations for Medical Evaluation

5.3.1 The signs and symptoms require careful medical evaluation for a range of possible diagnoses.

5.3.2 All tests and their results should be fully and accurately recorded, including those with a negative result. It is important that the child's records are not tampered with or test results altered in the child's notes.

5.3.3 If the child is not currently in hospital, consider whether a planned admission with careful observation would help to elucidate the clinical diagnosis.

5.3.4 Consider whether any immediate investigations or further opinions are likely to assist in the diagnosis.

5.3.5 Stop any harmful treatments or invasive procedures unless they are clearly indicated. It is unacceptable to cause a child further iatrogenic harm whilst the diagnosis of FII is being considered.

5.3.6 Do not wait to confirm the diagnosis before referring to children's social care as delay may be detrimental to the child. Referral is indicated if there is a risk of immediate harm to the child through illness induction, or harm through the carer's disagreement with the need for further observation or with paediatric consensus about the child's state of health.

5.3.7 A chronology of health involvement from all health agencies should be prepared so as to provide comprehensive information and an overall picture.

5.3.8 Concerns about the reasons for the child's signs and symptoms should not be shared with parents if this information is likely to jeopardise the child's safety.

## 5.4 RECORD KEEPING

5.4.1 Medical records should be kept in accordance with the Data protection Act 1998. Practitioners should follow the principles of record keeping set out in guidance documents supplied by their Professional bodies.

5.4.2 Detailed, accurate and informative medical records are pivotal to the management of a suspected FII case.

5.4.3 If a child moves between clinical teams or between organisations, it is best practice for the notes to follow the child. This may not always be possible and so a clinical summary must accompany the child.

5.4.4 It is essential that the records include a health chronology of the child's medical presentation, including aspects which may indicate FII. It is crucial to record the source of information, e.g. whether a symptom or sign was independently observed by staff or reported by a carer.

5.4.5 If FII is suspected, requests by a child's carer to access their records under the Data Protection Act 1998 may be refused either because:

- The disclosure would be likely to cause serious harm to the physical or mental health or condition of the child
- The child has provided the information in the expectation that it would not be disclosed to the carer;
- The data was obtained as a result of an examination or investigation to which the child consented in the expectation that the information would not be so disclosed;
- The child has expressly indicated that the information should not be so disclosed.

## 5.5 TRAINING, SUPERVISION AND SUPPORT

5.5.1 All staff who come into contact with children or their families should have a basic awareness of child protection principles, including a basic understanding of FII. Those specialising in the care of children or families need additional training to ensure a higher level of awareness and understanding of FII.

5.5.2 The goal of training should be to achieve better outcomes for children.
Professionals should be trained in order to achieve the greatest possible sensitivity and specificity in diagnosis; to gain a full understanding of the procedures to follow if there is a concern; and to understand how to contribute effectively to that process.

5.5.3 Staff will need support and supervision in dealing with cases of suspected FII. Staff support should be an integral part of a health professional's contract. It is important that line management and professional supervision and mentorship arrangements are explicit so that staff know how to access additional support when it is needed. The facilitation of debriefing sessions can be helpful in providing support for all members of the team.

## 5.6 COVERT VIDEO SURVEILLANCE

5.6.1 Covert video surveillance (CVS) is governed by the Regulation of Investigatory Powers Act (2000). After a decision has been made at a multi-agency strategy discussion to use CVS in a case of suspected FII, the surveillance should be undertaken by the police.

5.6.2 The CVS operation should be controlled by the police, who should supply and install any equipment and be responsible for the security of and archiving of the video tapes.

5.6.3 CVS should only be used if there is no alternative way of obtaining information which will explain the child's signs and symptoms, and the multi-agency strategy discussion meeting considers that its use is justified on the medical information available.

5.6.4 The safety and health of the child is the over-riding factor in the planning and carrying out of CVS and children's social care should have a contingency plan in place which can be implemented immediately if CVS provides evidence that the child is being harmed.

## 6.0 MONITORING COMPLIANCE

6.1 To ensure that safeguarding arrangements are satisfactorily monitored a review of the Section 11 audit should be undertaken annually.

6.2 An annual report on safeguarding children arrangements will be presented to the CCG Governing Body.

## 7.0 ASSOCIATED DOCUMENTATION

**7.1** This guidance is to be used in conjunction with:

- Working Together to Safeguard Children (2015) http://www.workingtogetheronline.co.uk/index.html
- Southend Thurrock Essex (SET) Safeguarding and Child Protection Procedures (2015)

  http://www.escb.co.uk/Home/tabid/430/ArticleID/497/ArtMID/1021/Default.asp
- NICE clinical guideline 89 When to suspect child maltreatment http://www.nice.org.uk/nicemedia/pdf/CG89NICEGuideline.pdf

- Royal College of General Practitioners http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx• HM Government 2008 Safeguarding Children In Whom Illness Is Fabricated or Induced https://www.education.gov.uk/publications/standard/publicationDetail/Page1/DC SF-00277-2008

- RCPCH Child Protection Reader, 2007 http://www.rcpch.ac.uk/child- health/standards-care/child-protection/publications/child-protection-publications

- RCPCH Child protection Companion, 2006 http://www.rcpch.ac.uk/child- health/standards-care/child-protection/publications/child-protection-publications

## 8.0 REFERENCES


***8.1*** Bools C N (1996) Factitious Illness by Proxy: Munchausen Syndrome by Proxy.
*British Journal of Psychiatry. 169: 268-275.*

***8.2*** Gray J and Bentovim A (1996) Illness Induction Syndrome: Paper I – A series of 41 Children from 37 Families Identified at The Great Ormond Street Hospital for Children NHS Trust. *Child Abuse and Neglect. 20 8: 655-673.*

***8.3*** Meadow R (1977) Munchausen syndrome by proxy. The hinterland of child abuse. *Lancet. 13: 2(8033):343-5.*

***8.4*** Schreier H (2004) Munchausen by proxy. *Current Problems in Pediatric and Adolescent Health Care*, 34(3): 126-143.

**8.5** Children Act 1989
http://www.legislation.gov.uk/ukpga/1989/41/contents

**8.6** Children Act 2004
http://www.legislation.gov.uk/ukpga/2004/31/contents

**8.7** Working Together to Safeguard Children 2015
http://www.workingtogetheronline.co.uk/index.html

## 9.0 LIST OF STAKEHOLDERS CONSULTED

| Name | Title | Comments received Y/N | Comments incorporated Y/N |
|---|---|---|---|
| Tricia D'Orsi, Linda Dowse, Lisa Allen and Jane Foster-Taylor | Chief/Executive Nurses for South Essex CCGs | No | N/A |
| Yvonne Anarfi, Sharon Connell, Dr Puvanendran and Dr Shrivastava | Designate Professionals Safeguarding Children | Yes | Yes |
| Dr Barusya | Named GP Safeguarding Children | Yes | Yes |
| Jane Herriott and Anita Erhabor | Associate Designate Nurse | No | N/A |
| Joy Edwards | Designate Nurse LAC | No | N/A |
| Dr Emcy | Named Doctor SUHFT | No | N/A |
| Gina Quantrill, Liz Glenister, Sue Kent | Named Nurse and Specialist Nurses Safeguarding Children SUHFT | Yes | Yes |
| Gill Parker, Yvonne Shaw and Marie Mitchell | Head Of Safeguarding Children and Named Nurses Safeguarding Children SEPT | Yes | |
| Ruth Baker | Group Manger Fieldwork, Southend Borough Council | Yes | |
| Mandy Nightingale | Service Manager, Assessment, Intervention and CWD, Essex County Council | No | |

**+**

## 10.0 EQUALITY IMPACT ASSESSMENT

NHS Southend CCG is committed to carrying out a systematic review of all its existing and proposed policies to determine whether there are any quality implications.

This policy has been assessed using the CCG's Equality Impact Assessment Framework which identified the following impacts upon equality and diversity issues:

| Age | Marital Status | Disability | Gender & Pregnancy | Race | Sexuality | Religion | Human Rights | Total Points | Impact |
|---|---|---|---|---|---|---|---|---|---|
| **2** | **0** | **2** | **1** | **2** | **1** | **2** | **1** | **11** | **medium** |

**Points**

| | |
|---|---|
| **3** | This area has a high relevance to equalities |
| **2** | This area has a medium relevance to equalities |
| **1** | This area has a low relevance to equalities |
| **0** | This area has no relevance to equalities |

**Scoring**

| | |
|---|---|
| **13 – 18 points** | High impact |
| **07 – 12 points** | Medium impact |
| **0 – 06 points** | Low or no impact |

The full EIA has been included in the NHS South Essex CCGs Safeguarding Children Policies and this should be referred to for further information.

## 11.0 VERSION CONTROL

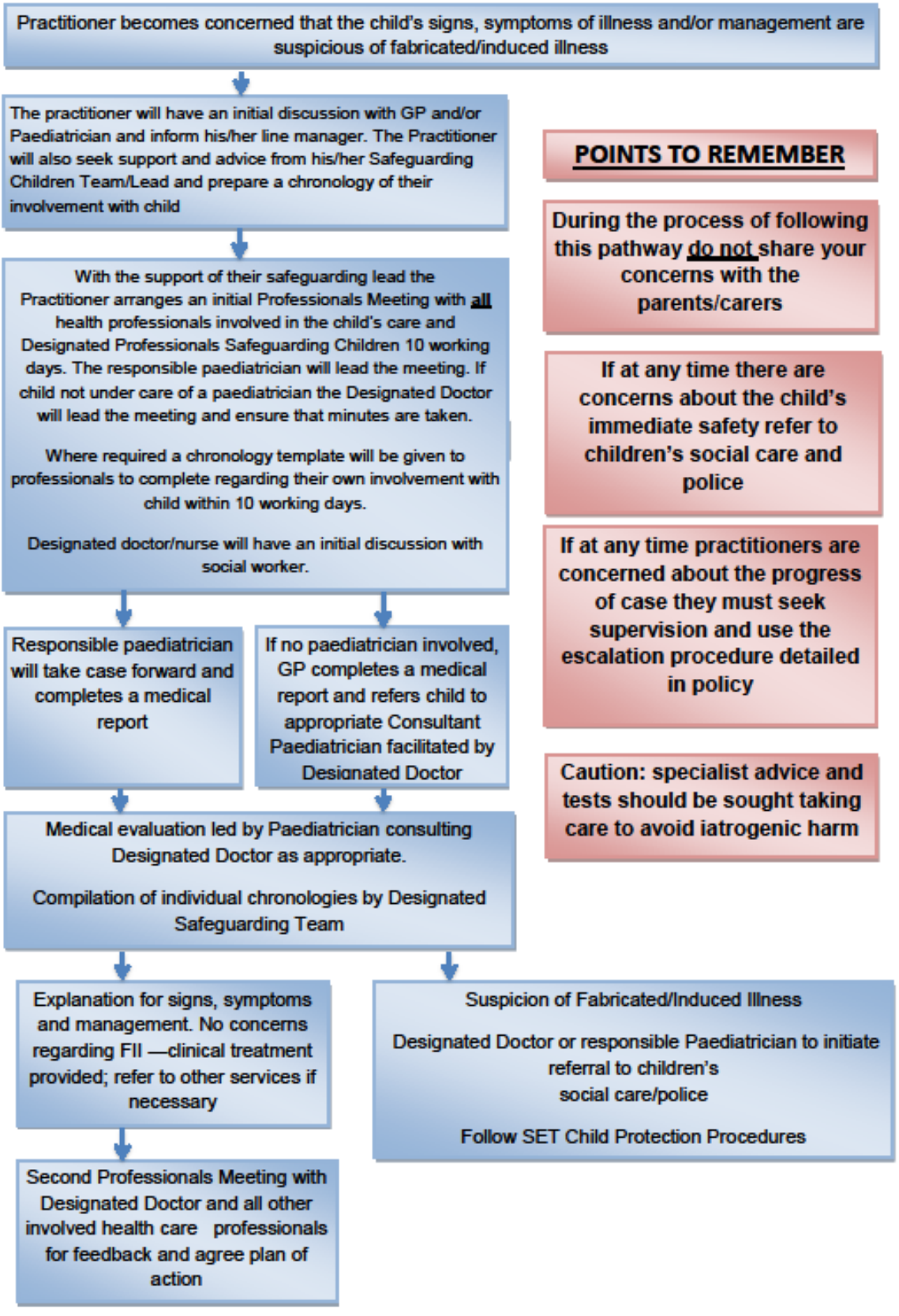
| Version | Date issued | Date of next review | Author Name & title | Comment |
|---|---|---|---|---|
| 001 | November 2013 | November 2015 | Designated Professionals Safeguarding Children | New policy |
| 002 | November 2015 | November 2018 | Designated Professionals Safeguarding Children | Updated references to national documents |

**APPENDIX 1 – Spectrum of cases where FII concerns may arise (RCPCH, 2006)**

| **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. | | | | |
|---|---|---|---|---|
| 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 carers 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 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 |
| 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 | Carers mental health problems | |
| Carer's insight | | | | |
| It is usually possible to reassure carer although they are likely to present again in the 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 inappropriate for the signs displayed by child, although any child protection interventions may affect carer's behaviour |

| Level of risk | | | | |
|---|---|---|---|---|
| Seldom reaches threshold of significant harm | May be disabling for the child; often some risk of significant harm, including emotional or educational harm, or social isolation | 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 |
| Iatrogenic harm | | | | |
| Possible iatrogenic harm | Significant risk of iatrogenic harm | Very high risk of iatrogenic harm | Usually low risk of iatrogenic harm | See above |
| Management | | | | |
| Discuss carer's concerns openly; manage case primarily by reassurance; try to address any wider needs of carer | Discussion with carer may need to be handled very sensitively; if in doubt discuss with appropriate colleague; firm reassurance will be needed; avoid iatrogenic harm by not conducting further unnecessary investigations and treatments; multiagency assessment may be needed to gain an understanding of what underpins carer's behaviour; child protection referral may be indicated | Local Safeguarding Children Board procedures apply; take immediate steps to reduce iatrogenic harm if possible; do not disclose concerns to carer(s) without first discussing the case with the safeguarding team | Discuss with carer whether they feel that they have any mental health needs and how these might be addressed; consider discussing with GP or other relevant professional 9bearing in mind the constraints of confidentiality); take steps to address carer's mental health needs; child may be a 'child in need' (Section 17, Children Act 1989) | Consult widely with colleagues if a 'false positive' child abuse diagnosis seems likely; if safeguarding procedures already activated, request immediate strategy discussion and discuss situation with carers without delay; the possibility of 'false positive' child abuse diagnosis must always be considered; the child's clinical progress should always be monitored in case genuine illness has been missed |

**APPENDIX 2 - FLOWCHART FOR HEALTH PROFESSIONALS WHERE FABRICATED/INDUCED ILLNESS IS SUSPECTED**



**APPENDIX 3 – Sample of Chronology Template**

| DATE | TIME | SOURCE OF INFORMATION | SIGNIFICANT EVENTS OR INCIDENTS (EG SEPARATIONS / MOVES/ CHANGES) | DEVELOPMENT INCLUDING ILLNESS / INJURIES | WAS THE CHILD SEEN, IF YES VIEWS OF THE CHILD | RESPONSE / ACTION INCL. REGISTER ENQUIRY | AUTHOR COMMENT |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |