Humber Teaching
NHS Foundation Trust

SAFEGUARDING CHILDREN FABRICATED OR INDUCED ILLNESS (FII) GUIDELINES

Supporting guidance

Document currently under review – please continue to use this version until it is replaced by the next approved version

Document Reference	G332
Version Number	7
Author/Lead **Job Title**	Kerry Boughen, Named Nurse Safeguarding Children Helen Young, Specialist Safeguarding Practitioner
Director's Name **Director's signature** **Date**	Hilary Gledhill
Date last reviewed, ratified and implemented (this version)	April 2021
Date of Next Review	April 2024
Consultation (Date and nature of contact)	Executive Director of Nursing, Allied Health and Social Care Professionals Designated Nurses Named Doctor Safeguarding Children Supervisors Division Groups Information Governance and legal team
Date Ratified **Name of Ratifying Committee**	14 April 2021 Quality and Patient Safety Group

VALIDITY – Guidance documents should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change Details
4.0	Stc10	ERYPCT Policy
5.0	Nov 2011	Reviewed no major changes, put into Trust Format
6.0	March 2018	Reviewed document, updated staff details to reflect multi-disciplinary employment within the Trust. Included Multi Agency working section. Removed 'A Broad View' section.
7.0	April 2021	Reviewed and amended to include the term perplexing presentation and reflect updated guidance, included new Trust Branding

Contents

1. FOREWORD/AGE RANGE/TERMINOLOGY 3
2. INTRODUCTION 3
3. DEFINITIONS 3
4. ROLES AND RESPONSIBILITIES OF PROFESSIONALS 5
5. ACTIONS FOR HEALTH STAFF TO FOLLOW IN CASES OF SUSPECTED FABRICATED OR INDUCED ILLNESS IN A CHILD 9
6. RESPONSES 9
7. HEALTH PROFESSIONAL LIAISON, CO-ORDINATION AND CONSULTATION 11
8. PREPARATION OF A CHRONOLOGY 12
9. ENGAGING THE PARENTS 13
10. CONCLUSION 13
11. IMPLEMENTATION AND DISSEMINATION 13
12. MONITORING AND REPORTING 13
13. EQUALITY AND DIVERSITY 13
13. BIBLIOGRAPHY AND REFERENCES 13
Appendix 1: The Legal Framework and Confidentiality, Human Rights and Data Protection 15
Appendix 2: Record Keeping 16
Appendix 3: Covert Video Surveillance 17
Appendix 4: Complaints 18
Appendix 5: Training and Development 19
Appendix 6: Equality Impact Assessment 20
Appendix 7: Document Control Sheet Template 22

1. FOREWORD/AGE RANGE/TERMINOLOGY

These guidelines have been developed for Humber Teaching NHS Foundation Trust staff to complement the Local Safeguarding Children Partnership procedures and guidance and are to be used in conjunction with the HM Government (2008) guidance Safeguarding Children in whom Illness is Fabricated or Induced.

The guidelines cover a wide-ranging spectrum from false-exaggerated histories through to abuse by poisoning, suffocation or sabotage of medical equipment.

Age Range
Children are defined as any person who has not yet reached their 18th birthday (Children Act 1989).

Terminology
The fabrication or inducement of illness in children by a carer has been referred to by a number of different terms, most commonly Munchausen Syndrome by Proxy (Meadow 1977). The use of terminology to describe the fabrication or inducement of illness in a child has been the subject of considerable debate between professionals. These differences of opinion may result in a loss of focus on the welfare of the child. This guidance refers to the fabrication or inducement of illness in a child.

The key issues are the impact of fabricated or induced illness on the child's health and development and consideration of how best to safeguard the child's welfare.

2. INTRODUCTION

Humber staff may see large numbers of children in the course of their everyday work. Most will have short term health needs and there will be no anxiety about the ability of their carers to meet their needs and safeguard their welfare. A minority will have symptoms or signs suggestive of Fabricated or Induced Illness; Therefore it is essential that staff should feel able to have confidential discussions with other agencies in order to collect information and build a more complete picture of the child and family.

3. DEFINITIONS

3.1 Perplexing Presentations (PP)
This term has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.

3.2 Medically Unexplained Symptoms (MUS)
This concerns situations where a child's symptoms, of which the child complains and which are presumed to be genuinely experienced, are not fully explained by any known pathology. The symptoms are likely based on underlying factors in the child (usually of a psychosocial nature) and this is acknowledged by both clinicians and parents. MUS can also be described as 'functional disorders' and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body. The health professionals and parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child or young person.

3.3 Fabricated or Induced Illness (FII)
Fabricated or Induced Illness (FII) is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident. It is important to distinguish the relationship between FII and physical abuse / non-accidental injury (NAI). In practice, illness induction is a form of physical abuse (and in Working Together to Safeguard Children (2018), fabrication of symptoms or deliberate induction of illness in a child is included under Physical Abuse). In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not there are recurrent presentations to health and other professionals. This particularly applies in cases of suffocation or poisoning.

Parental Behaviours
Carers exhibit a range of behaviours when they wish to convince others that their child is ill. A key professional task is to distinguish between the very anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour. Such abnormal behaviour can be present in one or both carers and often involves passive compliance of the child. The carer's behaviours may constitute ill treatment (section 31(9) of the Children Act 1989).
The following is a list of behaviours exhibited by carers that can be associated with fabricating or inducing illness in a child. This list is not exhaustive and should be interpreted with an awareness of cultural behaviours and practices which can be mistakenly construed as abnormal behaviours:

- deliberately inducing symptoms in children by administering medication or other substances, by means of intentional transient airways obstruction or by interfering with the child's body so as to cause physical signs;
- interfering with treatments by over dosing with medication, not administering them or interfering with medical equipment such as infusion lines;
- claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits. These claims result in unnecessary investigations and treatments which may cause secondary physical problems;
- exaggerating symptoms which are unverifiable unless observed directly, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous;
- obtaining specialist treatments or equipment for children who do not require them;
- alleging psychological illness in a child.

Whatever the motivations, actions and behaviours of the caregiver, the focus must remain on the child.

Multi-agency working
Investigation of FII and assessment of significant harm to a child falls under statutory framework provided by Working Together to Safeguard Children (2018) and Safeguarding Children in whom illness is fabricated or induced (HM Government 2008).

Promoting children's wellbeing and safeguarding them from significant harm, depends crucially upon effective information sharing, collaboration and understanding between agencies and professionals. These relationships may become strained where there are concerns that illness is being fabricated or induced in a child, there are differences in opinion about how best to safeguard the child's welfare or if the child is being abused. Constructive relationships between individual

workers should be supported by a strong lead from elected or appointed authority members, and the commitment of senior officers from each agency.

At strategic level, agencies and professionals should work in partnership with each other to plan comprehensive and co-ordinated children's services which have the capacity to respond to the identified needs of children.

Children who have had illness fabricated or induced will require co-ordinated help from a range of agencies such as health, education, social services and the voluntary sector over a sustained period of time. The nature of the input is likely to change as the child develops and his or her needs change; over time, therefore, the types of services required may differ considerably.

For those children who are suffering, or at risk of suffering significant harm, joint working is essential, to safeguard the child/ren and – where necessary – to take action, within the criminal justice system, regarding the perpetrators of crimes against children. In using this guidance all agencies and professionals should:

- be alert to potential indicators of illness being fabricated or induced in a child;
- be alert to the risks which individual abusers, 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 the child and promote his or her welfare; and regularly review the outcomes for the child against specific shared objectives.
- work co-operatively with parents unless this is inconsistent with ensuring the child's safety.
- assist in providing relevant evidence in any criminal or civil proceedings, should this course of action be deemed necessary.

4. ROLES AND RESPONSIBILITIES OF PROFESSIONALS

Humber Teaching NHS Foundation Trust holds responsibility for safeguarding children within their services. To achieve this, the Trust has an appointed Named Doctor (Consultant Community Paediatrician or a GP with paediatric expertise) and a Named Nurse for safeguarding children.

It is expected that all staff working with children should have knowledge of safeguarding children procedures. The average community service is likely to see one case per year of proven Fabricated Induced Illness (FII). However, there will be many occasions when FII may be considered as a possibility, without necessarily proceeding to the stage of requiring a strategy discussion. The Trust provides appropriate training on FII within the safeguarding children training programme, taking advice from the Designated Nurse/Doctor of Safeguarding Children. Supervision and support is available to staff.

There may be media interest in cases of FII. If any member of staff becomes aware that there may be media interest, then they should ensure that the Communications Manager and Service Manager are informed immediately. The Communications Manager will work together with any relevant partner organisations, which may include the police and Local Authority, to plan and agree the most appropriate handling of any such interest.

All staff

All Humber staff are provided with training to enable identification of uncorroborated, odd or unusual presentations. They will be aware of those children who are frequent attenders or where there may be discrepancies between the child's reported signs and symptoms and those observed. Although there may be conflicts of loyalty for staff, they should note that the child is a vulnerable

patient. Issues of confidentiality should be considered carefully, bearing in mind that the child's needs are paramount.

Practitioners should be familiar with the local safeguarding children guidelines. Advice on policy and procedures can be obtained from the Named Nurse or Named Doctor for Humber Teaching NHS Foundation Trust.

Humber staff are important members of multi-disciplinary teams and should contribute to the assessment of children at risk and to strategic discussion.

CAMHS professionals may receive requests for advice/consultation from other professionals where fabricated or induced illness is considered a possibility. This may be related to the assessment of the child, in particular the child's beliefs and possible anxieties about their state of health. Support from CAMHS may be considered for issues such as the relationships between family members or in circumstances where the child has experienced significant harm. Also individually led intervention as part of the child's overall plan may be required.

All staff should attend Child Protection Case Conferences when required.

They should keep accurate, contemporaneous and secure records of any actual or inferred physical or behavioural observations.

If samples have to be collected, e.g. urine or faeces, this should be done in such a way as to eliminate any possibility of interference. When contributing to the assessment, the following information should be carefully analysed:

- The contents of the GP's referral letter;
- Any history given by the parent/carer of strange illnesses, unusual complications of pregnancy, unexpected deaths in the family, family members with untreatable illnesses, children having complicated medical histories, histories of failure to thrive or non-accidental illnesses, and if signs and symptoms reported by the other are not observed by the clinician;
- Information available from previous case notes.

Named and Designated Health Professionals
The Named Doctor and Named Nurse in the Trust have central roles in individual cases as well as in organisation and collaboration. They have responsibilities for supervision, training, guidance and clinical governance. The named professionals liaise with lawyers, the courts, police and Children's Social Care. They should ensure that close links exist between acute, community and tertiary Paediatricians and with Child Psychiatrists and A&E Consultants.

The Named Professionals have regular contact with Designated Professionals who may be working across a number of trusts.

Paediatricians
Whenever concerns arise about FII, the Consultant responsible for the child's health care should take a lead role. There should be close liaison with the Named Doctor for safeguarding children. It is expected that there will be a high standard of record keeping.

The drawing up of a medical chronology should be a priority, if necessary using documents from primary care or from other health trusts. A colleague not involved with the care of the child may be invited to give a second opinion on the case history.

If it is identified that the child has suffered or is likely to suffer significant harm then a referral should be made to Children's Social Care. Paediatricians should be thoroughly familiar with the RCPCH (2002) publication "Fabricated or Induced Illness by Carers".

Adult Mental Health Services

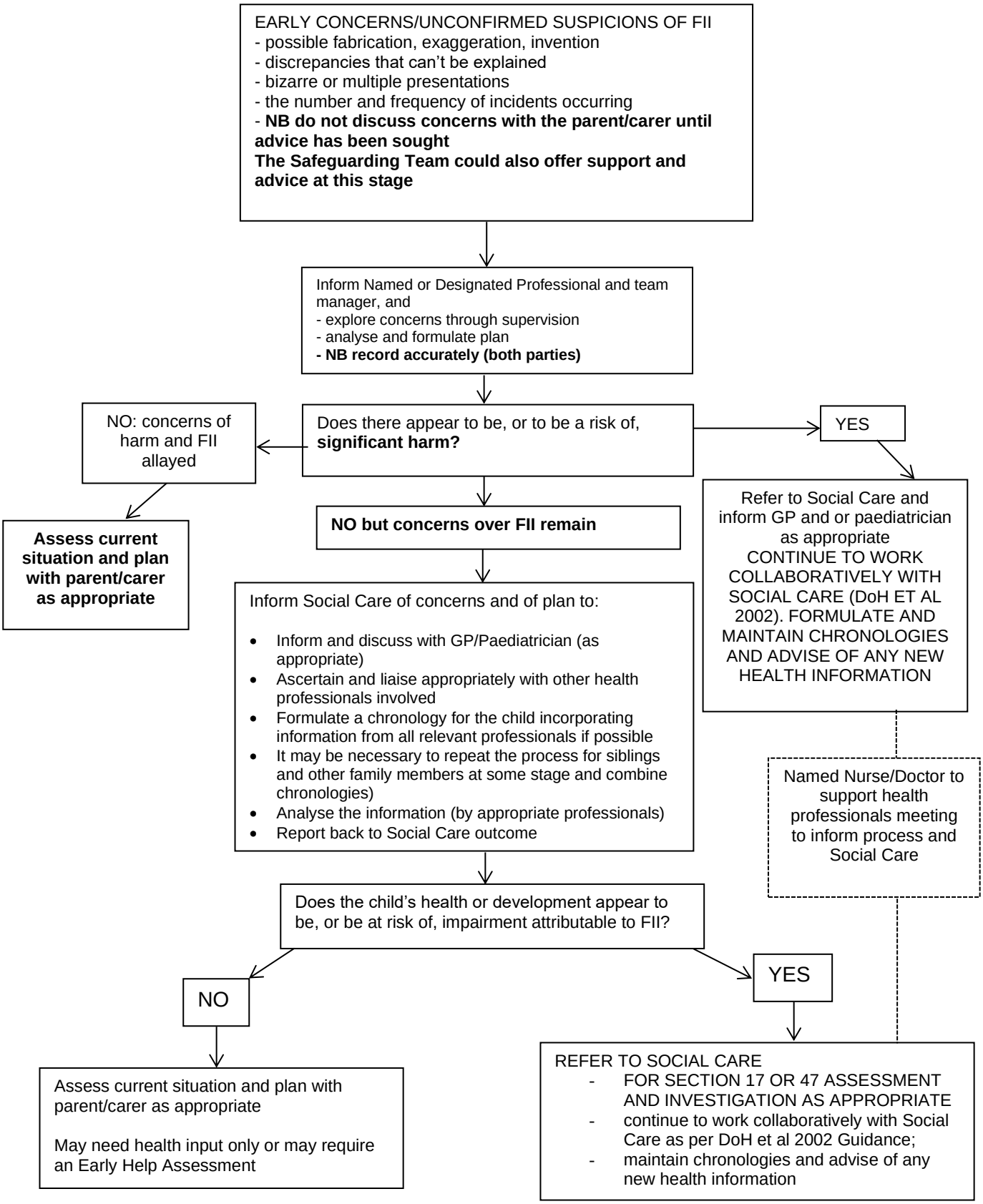
A number of adult mental health professionals, nurses, social workers, clinical psychologists and psychiatrists, may be involved in the assessment, planning and treatment of a carer. This may be before, during or after concerns are raised about FII. If through their involvement with a patient, adult mental health professionals become concerned for the welfare of a child they would be expected to contact the Named Nurse or Doctor for safeguarding children in the Trust or Children's Social Care. It is important that any concerns are not conveyed to the carers until further multi-disciplinary assessments are made. There should be close liaison with the named professionals for safeguarding children within the Trust.

Particular care should be taken in the case of individuals with multiple presenting symptoms, where no specific evidence of any underlying condition exists and in cases of Fabricated or Induced Illness in adults. It must be remembered that the needs of the child are paramount if the child is at risk of significant harm.

Following the verification of FII in a child or adult, Forensic Psychiatry have a role to play in assessing the presence, degree and severity of any mental illness or disorder the carer may have, including personality disorder. For details of the role of the adult/forensic psychiatrist please see paragraphs 4.39-4.52 of Safeguarding Children in Whom Illness is Fabricated or Induced (HM Government 2008)

5. ACTION FOR HEALTH STAFF TO FOLLOW IN CASES OF SUSPECTED FABRICATED OR INDUCED ILLNESS IN A CHILD

NB. It is noted that any concerns about a child's welfare would first be discussed with your safeguarding supervisor



6. RESPONSES

It must be acknowledged that parents may present to services with varying levels of anxiety and the initial actions for professionals may be in acknowledging and addressing these issues with the family without embarking on further invasive tests or investigations. Such early intervention may enable a clinician to identify causes of stress within a family unit which can then be signposted to appropriate early help services.

In the majority of cases of identifying FII, there will be uncertainty and insufficient evidence to confidently identify abuse, or the nature of the risk (if any) to the child may be unclear.

Concerns may slowly develop as discrepancies that cannot be explained or dispersed become more apparent.

There may be a sudden urgent need for social care referral, possibly because of an incident/episode that cannot be explained except by inducement, fabrication, exaggeration or invention. If clearly at risk of significant harm a referral must be made to Children's Social Care as per Trust Safeguarding Children policy

Sharing concerns
The dawning of concerns is a crucial time. This critical threshold is a matter of individual professional judgement but it is expected that a preliminary consultation with your safeguarding children supervisor in relation to your concerns will be undertaken. A safeguarding supervision session should take place and details recorded accordingly.

If concerns that FII is a possibility persist you should discuss your concerns with the Named Nurse, Doctor or Designated Nurse/Doctor and/or the Safeguarding Team, you should also make your manager aware.

6.1. Checking the history and gathering information

In conjunction with your Named Nurse or Named Doctor, check who is involved with the child/family. It is important that at this stage you look at the information you have, the health history of the child and other family members.

Complete a chronology of any Trust involvement, listing factual information from the Integrated Specialist Public Health Nursing Service, CAMHS and any A&E attendances and minor injury units available. This should be started before a referral to children's social care unless the concerns are urgent or there is already evidence of significant harm.

This information review could have three outcomes:

- **Concerns of FII or risk of harm may be allayed**. In this case record carefully information, decisions, and actions and continue with care. Consideration should be given at this point as to the appropriateness of following the Early Help process/further discussion through the supervision process.
- **Concerns about FII remain** but, with the information currently available, not to the threshold for a child protection referral. If this is the situation then Children's Social Care must be informed and further work undertaken to gather relevant information. Detailed health/medical involvement chronologies should be compiled for all relevant family members, the information analysed and the outcome reported back to Children's Social Care.
- **There appears to be a risk of significant harm to a child**. If this is the case, the child must be referred to Children's Social Care as per LSCB procedures.

If the findings are that the child's health or development appears to be, or be at risk of, impairment attributable to FII then a referral to Children's Social Care should be made and a health professionals meeting called.

6.2. Health professionals meeting

In conjunction with the referral process, an initial health professionals meeting must be called, supported by the Named Nurse/Named Doctor; this includes as a minimum the referrer, a Paediatrician, the child's GP, School Nurse/Health Visitors and a Named Doctor/Nurse and any other health professionals involved. The purpose of this meeting is to share information and work towards the completion of a chronology of health events and a consensus of opinion.

Following referral to Children's Social Care, the decision for assessment must be taken in consultation with the Consultant Paediatrician responsible for the child's health care, or the Designated Doctor for child protection in the Local Authority area, and the Police because any suspected case of fabricated or induced illness may also involve the commission of a crime.

All decisions about what information is shared with parents should be agreed between the Police, Local Authority Children's Social Care and consultant Paediatrician, bearing in mind the safety of the child and the conduct of the police investigations. The following processes will be led by either Children's Social Care, or the Police. The Health family are obliged to participate/collaborate throughout the process described below.

6.3. Initial Assessment under Section 17 of the Children Act 1989

Safeguarding children guidelines and procedures as set out by LSCPs provide an appropriate framework for enquiry. A section 17 assessment will determine and whether a more detailed assessment is required.

They allow for early inter-agency debate and consultation and are sufficiently flexible to accommodate a wide spectrum of harm including FII.

On completion of initial assessment, the Paediatrician and Children's Social Care should decide the following course of action.

6.4. Inter-agency strategy meetings

If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, children's social care should convene and chair a strategy discussion which involves all of the key professionals involved in the child's welfare including the Police.

If legal advice is required, the Chairperson should invite an appropriate legal advisor. In strategy meetings, as opposed to Child Protection Conferences, parents/carers do not attend. The main purpose is to share and evaluate information, to co-ordinate and pace the investigation, and allow pro-active planning. Where it is decided that there are grounds to initiate S47 enquiry, decisions should be made about:

- How the S47 enquiry as part of the Core assessment will be carried out – what further information is required about the child/family and how it should be obtained and recorded;
- Whether it is necessary for supplementary records to be kept in a secure place to safeguard the child and the manner in which they should be kept;
- Whether the child requires constant professional observation and, if so, whether or when the carer(s) should be present;
- Who will carry out what actions, by when and for what purpose, in particular the planning of further paediatric assessment;
- Any particular factors such as the child and family's race, ethnicity and language, which should be taken into account;
- The needs of siblings and other children with whom the alleged abuser has contact;

- The nature and timing of any Police investigations, including the analysis of samples. This will be particularly pertinent if covert video surveillance is being considered, as this is a task that the Police should have responsibility for.
- The needs of the parents or carers.

More than one strategy discussion may be necessary. This is likely where the child's circumstances are very complex.

7. HEALTH PROFESSIONAL LIAISON, CO-ORDINATION AND CONSULTATION

Cases of suspected FII are exceptionally complex and professionals should not work in isolation. A Consultant Paediatrician should be appointed to assess the case. Two key Consultant Paediatricians may need to share the management of the cases to provide mutual support and to cover absence.

Specialist Paediatric opinion and investigation (possibly involving a tertiary centre) may be required. It is essential that in the referral, the Paediatrician makes clear their concerns about possible FII in order to prevent unnecessary invasive investigation and to ensure that staff exercise appropriate vigilance. Referrals must be carried out on a controlled and planned basis. Pressure from parents for a change of Consultant should be resisted. At no time should the overall management of the case be allowed to drift from one Consultant to another, nor should decisions be left to junior medical staff.

The Named Nurses/Doctors for the Trust are integral to the co-ordination process. Guidance from a Consultant Child Psychiatrist may be sought at an early stage. Professionals may wish to seek legal advice from the Trust legal team before intervening in potentially very contentious cases in which threats of litigation are common.

8. PREPARATION OF A CHRONOLOGY

A very detailed chronology is likely to be required once concerns have been confirmed; this should include as a minimum, very detailed medical history (which has been validated against previous parental accounts and those of other witnesses) and must be taken for each and every illness event.

A crucial element is whether the illness always starts or occurs exclusively in the presence of one particular person. The hospital or community Consultant Paediatrician should also check all medical records of the child and siblings. These may involve several hospitals over a period of time. If there are gaps, or where information cannot be verified, this should still be included with a message stating so.

Information on the family /carers medical and psychiatric history that may have an impact on the child(ren)'s welfare will be needed from the General Practitioner. Records of previous infant deaths may be difficult to trace, and may require application to the coroner or information from the local pathology department.

A check for social work involvement can be carried out by Children's Social Care on the child and siblings. This will include the Children's Social Care client database, which indicates past or current Children's Social Care involvement with the family and can ascertain whether or not there is already a child protection plan in place for the child and any siblings.

The Protection of Vulnerable People Unit should be asked to look into whether parents or carers have a history of offences which may indicate that they pose a risk to children and identify any other significant information.

NHS Direct and the emergency services (Fire, Police and Ambulance) may be contacted, to ascertain their involvement, if any.

9. ENGAGING THE PARENTS

Professionals can experience intense emotional feelings towards such individuals, ranging from denial and disbelief to feelings of pity, anger and disgust. These strong feelings can threaten professional integrity and the following principles are important:

- Always keep the child in focus;
- Be polite, courteous and supportive but maintain clear professional boundaries;
- Listen carefully and actively to what the parent has to say but check veracity if possible;
- Try to engage with the non-suspected parent or carer if possible. A cautious enquiry may establish whether they have concerns about the nature of the child's illness;
- Be vigilant at all times. Make detailed observations and document carefully the parent-child interaction and the parent's care of the child and document carefully;
- All staff must be consistent in their approach to counter any divisiveness on the part of the alleged perpetrator;
- Maintain control. The carer may make certain demands e.g. for a quiet side ward (where observation would be difficult) or for more medical investigation etc. Staff may have to resist these in an assertive manner making it clear that these requests may not be appropriate at that time or not in the child's interest.

The most difficult dilemma for professionals is how and when to discuss concerns with parents.

In an appropriate situation, concerns may be broached at an early stage in a supportive manner leading to the provision of early help. Emphasis is placed on the interests of the child. It should be recognised that the parents themselves are in need of help. This is in keeping with conventional safeguarding children practice.

Whilst the abusing parent may not initially acknowledge the full extent of his/her activities, he/she may have sufficient insight to co-operate with an assessment and subsequent therapy, and this may be a good prognostic indicator.

The reality is usually far more complex and the usual response of the suspected perpetrator is that of denial. The presence of strong evidence where it can be substantiated, witnessed, or where forensic evidence is present will simplify the decision to challenge the parents. The sharing of concerns with parents must be planned with Children's Social Care and the Police within the context of strategy meetings.

Where there are strong suspicions but no conclusive evidence, the parents may still have to be challenged, with all the attendant dangers. This is clearly a situation which will require some risk analysis by the agencies. The situations which may dictate such a decision are:

- If an assessment by a child psychiatrist or child psychologist is necessary, the parents will require an explanation for this;
- If there is a clear need to separate the child from the suspected perpetrator for both evidential and child protection purposes;
- If professionals consider that they can proceed no further with their investigation without confronting the parents. Failure to do so would be to collude with the suspected perpetrator.

Staff support
Staff support is vital and is available from team managers, safeguarding supervisors and the Trust safeguarding team. This is available at a personal level (particularly for those working directly with the child and family) and at a team level. The latter should have access to expert legal, paediatric and relevant psychiatric advice.

It may also be helpful to have the informal but confidential advice and support of professionals who have already been involved in the management of such cases.

10. CONCLUSION

Awareness of FII should permeate safeguarding children practice and procedures. Trust staff may see large numbers of children in the course of their everyday work. Most will have short term health problems and there will be no anxiety about the ability of their carers to safeguard their welfare. A minority will have symptoms or signs suggestive of Fabricated/Induced Illness;

For the remainder it is essential that Trust staff should feel able to have confidential discussions with other agencies in order to collect information and build a more complete picture of the child and family. If there is concern about the risk of significant harm to a child, a referral should be made to Children's Social Care and Trust staff should construct a full chronology of events.

It is the expectation that all Trust staff will maintain accurate, contemporaneous records which will assist in the collaboration with other agencies if there is a need to safeguard a child's welfare.

11. IMPLEMENTATION AND DISSEMINATION

This guidance is discussed within the mandatory safeguarding children training programme, through briefings and updates to clinical teams and through supervision. It is available on the intranet and reflects the Local Safeguarding Children Partnership procedures and guidance.

12. MONITORING AND REPORTING

Use of this guidance is monitored by the Named and Designated Nurses for safeguarding children through their involvement within the process.

13. EQUALITY AND DIVERSITY

In developing this guidance, the Trusts screening tool was utilised to determine if a full impact assessment was required. The outcome was that an impact assessment was undertaken, and the results showed a positive impact for children as the guidance supports staff in protecting and promoting the welfare of all children. This guidance is regarded as being equitable to all and as a result of its implementation no individual will suffer from any form of discrimination, inequality, victimisation, harassment or bullying as a result of implementing this guidance.

14. BIBLIOGRAPHY AND REFERENCES

- Children Act 2004, London: HMSO
- Children Act 1989, London: HMSO
- Department of Health, Department for Education and Employment and the Home Office (2000) Framework for the Assessment of Children in Need and their Families, London: The Stationery Office
- HM Government (2008) Safeguarding Children in Whom Illness is Fabricated or Induced, London: DCSF (Department for Children, Schools and Families)
- East Riding Safeguarding Children Board Guidelines and Procedures (2007)
- HM Government (2018) Working Together to Safeguard Children, London: The Stationery Office
- HM Government (2004) Every Child Matters: Change for Children, DfES: available at www.everychildmatters.gov.uk/_files/F9E3F941DC8D4580539EE4C743E9371D.pdf
- HM Government (2016) Investigatory Powers Act. London. The Stationary Office

- Horwarth, J. and Lawson, B (Editors) (1995) – Trust Betrayed? Munchausen Syndrome by Proxy, Interagency Child Protection and partnership with Families, London: National Children's Bureau
- Hull Safeguarding Children Board Guidelines and Procedures (2006/2007)
- McClure, R.J., Davis, P.M., Meadow, S.R. and Silbert, J.R. (1996) Epidemiology of Munchausen Syndrome by Proxy, Non-accidental poisoning and non-accidental suffocation, Archives of Disease in Childhood, 75, pp 57-61
- Meadow, R. (1977) Munchausen Syndrome by Proxy: The hinterland of child abuse, The Lancet, August 13, 1977
- Royal College of Paediatrics and Child Health (2002) Fabricated or Induced Illness by Carers, London: Royal College of Paediatrics and Child Health
- Royal College of Paediatrics and Child Health (2021) Perplexing presentation (PP)/ Fabricated or Induced illness in Children RCPCH guidance.

Appendix 1: The Legal Framework and Confidentiality, Human Rights and Data Protection

The legal framework

Professionals can only work together to safeguard children if they can exchange relevant information. However, disclosure of personal information to others must have regard to both common and statute law. Care should be taken to work within information sharing protocols between the agencies and professionals involved, taking legal advice when necessary.

Confidentiality, Human Rights, Data Protection

Personal information about children and families held by professionals and agencies is subject to a legal duty of confidence and should not normally be disclosed without the consent of the subject. The law permits the disclosure of confidential information necessary to safeguard a child or children in the public interest.

This means that the public interest in safeguarding children may override the public interest in maintaining confidentiality. The European Convention on Human Rights states that Articles 2 and 3 (the child's right to life and the prohibition of torture and inhumane treatment) are **absolute.** The carer's right to privacy in Article 8 is **conditional.** The needs of the child must remain at the centre of the decision making and sometimes this will override the interests of the carers. Disclosure should be justifiable in each case, according to the particular facts of the case. The Data Protection Act 1998 allows for the disclosure of confidential information without the consent of the subject in certain conditions, including for the purposes of the prevention or detection of a crime, or for the apprehension or prosecution of offenders, and where failure to disclose would be likely to prejudice those objectives in a particular case. Legal advice should be sought in cases of doubt.

Appendix 2: Record Keeping

All records should use clear, straightforward language. They should be concise and accurate not only in fact but also in differentiating between opinion, judgements and hypothesis.

When considering the possibility of Fabricated or Induced Illness, the record of the child should always include the name and agency of the person who gave information. All telephone conversations should be recorded fully.

Records should be kept securely to prevent unauthorised access. If the child's safety is at risk it may be necessary to create a supplementary record, separate from the main record. Any supplementary notes should be kept in accordance with Data Protection principles, support can be accessed via the Trust Information Governance team.

Health records should record accurately all investigations, results, observations and consent to undertake examinations or treatment. They should be signed legibly and dated.

If there is a change of circumstances, for example a change of GP for a child where there are known safeguarding concerns the child's records should be updated promptly. If possible a telephone discussion followed by a written summary should be undertaken pending transfer of the records.

Appendix 3: Covert Video Surveillance

The use of covert video surveillance (CVS) is governed by the Regulation of Investigatory Powers Act 2016. If a decision is made at a multi-agency strategy discussion to use CVS the surveillance should be undertaken by the Police who will supply and install any equipment. CVS is likely to be used in a minority of cases when evidence cannot be gathered by other less intrusive means. Local Safeguarding Children Partnerships safeguarding children procedures should be followed. The safety of the child is of paramount concern. The Paediatric Consultant responsible for the child should ensure that the necessary nursing and medical staff are available to support the Police during this operation.

Appendix 4: Complaints

Complaints about practices within Humber Teaching NHS Foundation Trust should be responded to in accordance with the relevant complaints procedures. Where the complaint is about the functioning of a child protection conference or a decision about the child protection plan then Local Safeguarding Children Partnership's complaints procedures should be followed.

Appendix 5: Training and Development

Local Safeguarding Children Partnerships are responsible for the lead role in training relating to fabricated induced illness across partner agencies, Humber Teaching NHS Foundation Trust also ensure the provision of FII training within current safeguarding children training programmes.

There should be general awareness that FII is a form of child abuse and that practice and procedures form part of the overall guidance for safeguarding children.

All Trust staff working with children and families should have received FII training within their mandatory training requirements. Multi-agency training opportunities are accessible with the Local Safeguarding Children Partnerships. All staff are provided with appropriate training updates at intervals in accordance with Trust policies.

Appendix 6: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name:
2. EIA Reviewer (name, job title, base and contact details):
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?

Main Aims of the Document, Process or Service
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender Reassignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years		
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)		
Sex	Men/Male Women/Female		
Marriage/Civil Partnership			
Pregnancy/ Maternity			
Race	Colour Nationality Ethnic/national origins		
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief		
Sexual Orientation	Lesbian Gay men Bisexual		

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex		

Summary

Please describe the main points/actions arising from your assessment that supports your decision.	
EIA Reviewer: To be completed (April 2021)	
Date completed:	Signature:

Appendix 7: Document Control Sheet Template

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	GUIDANCE – SAFEGUARDING CHILDREN FABRICATED OR INDUCED ILLNESS (FII) GUIDELINES		
Document Purpose	To provide guidance to Trust staff relating to the identification, reporting and management of fabricated and induced illness.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	March 2021	Executive Director of Nursing, Allied Health and Social Care Professionals Designated Nurses Named Doctor Safeguarding Children Supervisors Division Groups Information Governance and legal team	
Approving Committee:	Quality and Patient Safety Group	Date of Approval:	3 October 2018
Ratified at:	N/A (director sign off)	Date of Ratification:	N/A
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*	Training in relation to Fabricated and induced illness provided within Trust safeguarding children training. No training required to implement this guidance.	Financial Resource Impact	Low
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	• Guidance to be discussed and acknowledged in safeguarding working lunches, MDT attendances and training • Email with reviewed guidance to be sent to all safeguarding supervisors • Notice to be placed in midday mail with directions to the guidance on the intranet • Guidance to be made available on the Trust intranet		
Monitoring and Compliance:	Compliance with guidance to be monitored by the safeguarding team.		

Document Change History:			
Version Number/Name of procedural document this supersedes	*Type of Change i.e. Review/Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
4.0	*Review*		*ERYPCT policy*
5.0	*Review*	*November 2011*	*No major changes*
6.0	*Review*	*March 2018*	*Reviewed document, updated staff details to reflect multi-disciplinary employment within the Trust.* *Included Multi Agency working section* *Removed 'A Broad View' section.*
7.0	*Review and update*	*March 2021*	*Reviewed and amended to include the term perplexing presentation and reflect updated guidance, included new Trust Branding*