



**Bedford Borough Safeguarding Children Board
& Central Bedfordshire Safeguarding Children
Board**

Working together to safeguard children



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Procedure & Guidance for dealing with

FABRICATED OR INDUCED ILLNESS/DISORDERS (FII/D) IN CHILDREN

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Glossary

FII	Fabricated or Induced Illness
FII/D	Fabricated or Induced Illness/Disorder
I.V lines	Intra-venous lines
IAT	Initial Assessment Team – Luton Children Social care
IAT	Intake & Assessment Teams – Bedford Borough & Central Bedfordshire Children Social care
EWOs	Education Welfare Officers – Bedford Borough & Luton Council
SAOs	School Attendance officers – Central Bedfordshire Council
CEO	Chief Executive Officer
NFA	No Further Action
S17	Children who are defined as being 'in need'.
S47	Child Protection Enquiries
CVS	Covert Video Surveillance
NSLEC	National Specialist Law Enforcement Centre
ACPO	Association of Chief Police Officers
DSCF	Department of Schools, Children & Families – disbanded in 2010 and replaced by the Department for Education DFE

This is a practice guidance based on local experience and national guidance: DSCF 2008 document 'Safeguarding Children in Whom Illness is Fabricated or Induced'.

The main changes as a result of the 2008 government guidance are:

- The emphasis on medical evaluation of the concerns
- The requirement to report any concerns to the child's GP who will refer the child to a paediatric consultant at an early stage
- The paediatric consultant is the lead health professional and therefore has lead responsibility for all decisions pertaining to the child's health care
- Any decision to use Covert Video Surveillance to be a multi agency decision at a Strategy Discussion/Meeting.

The Royal College of Paediatricians and Child Health's report '*Fabricated or Induced Illness by Carers*' (2002) can be found at the Royal College of Paediatrics and Child Health website provides more in-depth information for professionals, particularly those in health, describing the role of paediatricians and other healthcare professionals recommending how they should work with professionals from other agencies. The report is currently being updated to take account of Working Together 2010 and recent clinical developments.

1. Introduction

1.1 Fabricated or Induced Illness (FII) is a condition whereby a child suffers or is likely to suffer harm as a result of her/his main carer's behaviour or actions intended to either induce an illness or a disorder that does not exist or grossly exaggerate an existing illness or disorder.

1.2 This involves –

- Fabrication of signs or symptoms;
- Fabrication of signs and symptoms and falsification or distortion of documents and reports;
- Induction of illness or disorder by a variety of means, in some cases persistent reporting of symptoms of an illness or a disorder that can not be easily excluded by objective tests;

1.3 Carer's behaviour associated with FII/D –

- Deliberately inducing symptoms in children by administering harmful medication or substance, interfering with child's body to cause physical signs, intentionally causing suffocation;
- Interfering with the treatment;
- Claiming symptoms in child which is either not verifiable or does not match with observations by others e.g. nursing staff or school staff;
- Exaggerating symptoms which are not objectively verified leading to potentially harmful investigations, procedures (e.g. needing general anaesthetics), and treatment.
- Obtaining specialist treatments or equipments for children who do not require them;
- Alleging psychological or developmental disorders in a child.

It is a relatively rare but potentially fatal form of abuse.

1.4 Concerns will be raised for a small number of children when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by the actions of a carer or carers having fabricated or induced illness.

1.5 It is important that the focus is on the outcomes or impact on the child's health and development and not initially on attempts to diagnose the parent or carer.

1.6 The range of symptoms and body systems involved in the spectrum of fabricated or induced illness are extremely wide, as can be the medical services in which children present, spanning primary, secondary and tertiary care.

2. Impact on the child's health and development

2.1 Many of the children who do not die as a result of having illness fabricated or induced suffer significant long-term consequences. These may include long-term impairment of their physical, psychological and emotional development.

2.2 Fabrication of illness may not necessarily result in the child experiencing physical harm. Where children have not suffered physical harm, there may still be concern about them suffering emotional harm. Children may also suffer emotional harm as a result of an abnormal relationship with their mother (if she is responsible for the abuse) and their disturbed family relationships.

2.3 In their follow-up study of 54 children who were known to have had illness induced or fabricated, Bools et al (1993) found a range of emotional and behavioural disorders, and school related problems including difficulties in attention and concentration and non-attendance. These difficulties were present both in children who were living with their abusing parent and those who had been placed with alternative carers, suggesting the need for treatment regimes which specifically address the child's ongoing needs throughout childhood. McGuire and Feldman (1989) also reported a range of disorders in children known to have had illness fabricated or induced, depending on the age of the child; feeding disorders in infants, withdrawal and hyperactivity in pre-school children and direct fabrication or exaggeration of their own physical symptoms by older children and adolescents.

2.4 Whilst it is well documented that children who have been abused or neglected are likely to suffer impairment to their health and development, it cannot be assumed that all children suffering impairment have been abused. Where there are concerns about the reasons for a child's developmental delay, it is important to clarify the contributing factors and identify any underlying conditions. For some children the origins of their impairment or disability may be very complex with an underlying medical or developmental condition being further impaired by abuse or neglect. In these circumstances, detailed assessments are required to understand cause and effect (For further discussion, see Chapter 4: The Spectrum of Signs and Symptoms, Royal College of Child Health and Paediatrics, 2002).

3. PROCEDURE & PROTOCOL

Initial Considerations

3.1 This procedure needs to be followed in cases where there is concern that a child may be suffering or is likely to suffer significant harm resulting from a parent or carer's persistent attempt to fabricate, induce or exaggerate an illness, disorder (e.g. Autistic Spectrum Disorder) or disability (e.g. Learning Disability).

3.2 In these cases the onus should always be on what harm the child is suffering or is likely to suffer rather than the behaviour of the carer. The harm to the child needs to be categorised as physical, emotional, sexual abuse or neglect.

3.3 In considering harm or the likelihood of harm in the context of an illness, attention should focus on:

- The impact of invasive medical investigations, procedures or treatment on the health and well-being of the child;
- The impact of persistent absence from school/ other educational settings on the child's development and education;
- The harm from methods applied for induction or exaggeration of an illness e.g. suffocation, clandestine use of chemotherapeutic agents etc;
- Actual or potential harm from interference with treatment or falsification of medical records.

3.4 In the context of fabrication, inducement or exaggeration of a developmental disorder or disability, consideration should focus on:

- The impact on the child's health and development including emotional well-being.
- Restriction imposed on diet, activity or behaviour as a consequence.

3.5 On occasions, a parent/carer's behaviour may amount to criminal activity. For example:

- Falsification of records;
- Tampering with a treatment (sabotage of vital treatment procedures e.g. I.V lines, administering harmful drugs or substance by any route, substitution of medication, altering feeds (e.g. diluting it or adding salt to it etc.) ;
- Any action that poses imminent risk to life (e.g. suspected non-accidental suffocation);
- Tampering with biological samples for investigations;

3.6 Where a crime is suspected (as in 3.5 above) when a child is in the hospital (or any other setting) the Police must be consulted as soon as suspicion arises. Staff must not be tempted to gather more evidence to firm up their suspicions before contacting the police, as such evidence may not be admissible in court.

3.7 In a non-medical setting, (School or Nursery), harm may be caused through:

- Poor school attendance on the ground of fabricated illness;
- Withdrawal from school altogether by a carer on the ostensible ground that the child's special educational needs are not being met;
- Imposition of undue and severe restriction on the child's activities, behaviour or diet on contentious grounds including allergy, health or a disorder.

4. Pre-Referral Action (Action prior to referral to Social Care or Police)

All Agencies (Common Steps)

4.1 A range of professionals in different agencies who work with children may, in the course of their duties, become concerned about fabrication or exaggeration of an illness, disorder or disability. Professionals should follow this protocol interpreting it in their own professional context. However, professionals within health and education settings are more likely to be faced with incidents of FII/D. Therefore, there is particular mention of health and education action in successive paragraphs. The Children and Learning Dept (Social Care) and the police are also mentioned because of their statutory role in investigating the cases.

Recognition

4.2 Concerns arise when a professional observes:

- Significant discrepancies between signs, symptoms or difficulties the carer reported and what is actually observed by the professional;

- Reported signs, symptoms or difficulties in a child are not observed independently by any other agency;
- A given clinical picture is not explained sufficiently by the condition the child is alleged to be suffering from;
- Carer inhibits the child from speaking or is over suggestive to the child;
- Symptoms are not present when carer is not there;
- Carer often reports symptoms which can not be objectively verified or reliably excluded;
- Findings from medical examinations or investigations do not support the alleged condition;
- There is either no response to medication or any reported improvement is inexplicably short lived;
- Alleged illness or condition changes, defying normal expectation;
- A minor condition is hugely exaggerated (e.g. urine infection may be reported as kidney failure);
- A range of reported behavioural characteristics which point to a developmental disorder are not observed in other settings, e.g. school or clinic;
- Carer may deliberately give a distorted account of the condition and attribute this to a specialist or other professional's opinion.

Sharing of concerns with the carer and involving children

4.3 Research has shown that over 50% of children in whom illness is fabricated or induced are aged under 5 years and therefore they are unlikely to be directly involved in discussions about the nature of their abuse.

4.4 Professionals will need to determine how best to include children and young people in any decision making and planning processes. These decisions should be taken as part of the overall plan for therapeutic work with the family, factoring in the family relationships which have enabled the child to have been abused. Children and young people should be advised that ultimately, decisions will be made based on all available information contributed by themselves, professionals, their parents and other family members.

Information sharing

4.5 In deciding what information to share, professionals should consider their legal obligations, including whether they have a duty of confidentiality to the child. Where there is such a duty, the professional may lawfully share information if a competent child (or the parent of a child who lacks competence) consents or if there is a public interest of sufficient force. This must be judged by the professional on the facts of each case. Where there is a clear risk of significant harm to a child, or serious harm to adults, the public interest test will almost always be satisfied.

4.6 The child's best interests must be the overriding consideration in making decisions about sharing information. Please refer to the cross-Government practice guidance, Information Sharing: Practitioners' guide (HM Government 2006) for further information.

<https://www.education.gov.uk/publications/standard/publicationdetail/page1/D/CSF-00807-2008>.

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

4.7 However, cases of FII/D are quite challenging and pose unique difficulties.

4.8 It is important to note that where a parent/carer is being genuinely overanxious about their child's minor illness, health or development, the child's symptoms may

appear to be over amplified. In such cases all efforts should be made to reassure the parent/carer.

4.9 However, on occasions it may be an elaborate, calculated and persistent act or behaviour on the part of the parent/carer. In such cases, sharing FII/D concerns with the parent/carer at the outset may not be in the best interest of the child. By informing the parent/carer of the FII/D suspicion prematurely, harm may be perpetuated to the child as parents/carers may change doctors/ professionals or withdraw the child from school. At no time should a concern about FII/D be shared with the parent/carers, until there is sufficient evidence to enable decisive action ('Safeguarding Children in whom illness is fabricated or induced'; DCSF; 2008; para 3.13; 4.11). A Decision about when and how to share such concern with parent/carer should be planned at the strategy meeting.

4.10 However, if such a child has undergone any medical investigations, the professional must inform the parent/carer of the result of all tests, explaining the rationale for any medical intervention, while admitting that no satisfactory explanation has been found.

Recording

4.11 Professionals must keep an accurate record of contemporaneous notes including facts, opinion and reasons for not sharing their suspicion of FII/D. Professionals should retain all letters and correspondence.

Consultation within agency

4.12 Professionals identifying FII/D concerns should share their concerns with a senior colleague and/or a professional designated for safeguarding children within their organisation. After the consultation discussion, the suspicion may not be well founded or more information/observation may be required. In some cases, the discussion will result in a referral to the police or the children's social care.

Consultation with other agencies

4.13 If the situation warrants, consultation with professionals in another agency may be required to clarify FII/D concerns further. For example, a school may contact a GP or School Nurse to build a shared understanding of the concerns identified. It is essential that all professionals involved agree a coordinated approach, clearly identifying who is leading on the FII/D concerns.

4.14 If a paediatrician is not already involved, the child's GP should make a referral to a hospital paediatrician. Where the concerns relate to a developmental disorder or disability, the GP should refer to a community paediatrician.

N.B.A referral without proper deliberation may be detrimental, particularly if it falls short of the threshold for decisive action. The perpetrator may evade further suspicion by various means, but the harm to the child may continue.

Informal consultation with Children's Social Care (CSC) or Police

4.15 If in doubt about the level or nature of concern, an informal consultation with Children Social Care IAT (Initial/Intake Assessment Teams) or the Police could be helpful.

Referral Process

4.16 This is outlined in paragraph 5 below.

5. School / Nursery/ Other educational settings

5.1 Concerns may arise from frequent non-attendance at the school, nursery or setting on medical grounds but where a child looks well and healthy. The School/nursery/setting may be asked to restrict the child's diet, activities or participation on grounds of a medical condition. Symptoms maybe described, which are not observed at school e.g. child having several fits a day, but not a single one at school, or signs/ symptoms of a developmental disorder or disability which are not observed at school. In extreme cases a child may be withdrawn from the school.

5.2 In these situations, where a professional is concerned that a child is being harmed or likely to be harmed, the concern should be discussed with a senior member of staff or a staff with the designated role for safeguarding children.

5.3 The designated officer/senior member of staff should attempt to substantiate concerns by liaising with other agencies and professionals e.g. EWOs/SAOs (DCSF para 3.88 & 3.89). Contacting the GP may also help verify a concern about non school attendance because of a medical illness. If this is not possible then a referral to the Initial Assessment Team should be made.

5.4 In cases where there is lack of clarity and several professionals are involved, a Professionals' meeting should be called to clarify issues and coordinate action, making sure it is clearly documented who remains responsible for the case. The Children Social Care IAT may also participate in order to evaluate the evidence for themselves at first hand.

5.5 Monitoring: Ongoing monitoring by all professionals will be necessary in borderline cases or cases where the situation improves after supporting the carer or when an illness is being investigated by a Paediatrician and the case has not been referred to the Initial assessment Team. If at any time during monitoring; the concern remains or re-emerges, a referral must be made by the designated staff or staff who initiated the concern to the Initial Assessment Team.

5.6 Referral: If after initial discussion and information sharing, the concern remains or increases, a referral must be made as in paragraph 7.

6. Health

6.1 This is a generic protocol for all healthcare professionals. Individual healthcare professionals, particularly those in a hospital setting should also refer to the DCSF Guidance (ref 3) and RCPCH Guidance (ref 5) for details in specific circumstances.

- Suspicion about FII/D in relation to a child may arise within any healthcare setting. All steps described in 4.1 should be followed. Professionals dealing with adults should consider the implication of their patients' illness on any child in their care. This is particularly true where the adult presentation has an element of somatising, fabrication, exaggeration or mental health.
- The health professional who raised the initial suspicion should be responsible for following up the case unless **clearly** taken over by a Consultant Paediatrician.
- Where a concern arises in a primary healthcare setting, a referral should be made to a hospital paediatrician if a medical illness is involved or to a community paediatrician if a developmental disorder or disability is involved.

6.2 A healthcare professional who suspects FII/D should discuss their concerns with a senior colleague within the discipline or department to confirm if suspicion is objective.

6.3 If suspicion continues, the Named Doctor/Nurse/Professional for safeguarding children within the organisation should be consulted for advice, support and expertise. Health practitioners should not normally discuss their concerns with the parents/carers at this stage (ref 3: DCSF, para 3.13). Where appropriate, the Designated Doctor/Nurse can be consulted for further advice.

6.4 Health professional should consider gathering information from healthcare professionals in other settings involved with the case, to establish a shared understanding and a clearer picture.

6.5 The 'information gathering' may involve consulting with a nursery, school or other settings who may know the child.

6.6 Where a Paediatrician is not already involved, the Healthcare Professional (usually the GP) must make a referral to a Hospital Paediatrician for an alleged illness or to a Community Paediatrician for an alleged developmental disorder or neuro-disability. Normally, the outcome of a paediatric referral should be awaited, but where a healthcare professional remains sufficiently concerned, a referral to the Children Social Care IAT should be made

6.7 Where a number of professionals are involved and there remains a lack of clarity, a professionals' meeting may be called to consider all aspects of the case and to aid decision making regarding making a referral.

6.8 Where a FII/D concern has arisen while the child is in hospital, all records, investigations and treatment must be secured immediately and early consultation with the Police made. Where there is suspicion that a criminal act may have been committed or lack of clarity about the nature of the case, advice can be sought from Named or Designated Doctor/Nurse by the Consultant Paediatrician who is providing hospital care to the child. The Consultant Paediatrician should be responsible for the management of the case from FII/D point of view and it should not be delegated to a junior staff member. Where a Consultant from another department within the hospital has concerns, s/he should refer to a Consultant Paediatrician. Where insufficient explanation is found after reasonable medical investigations locally, referral to a tertiary specialist centre may be necessary to rule out any rare causes ensuring that there is direct and clear inter-professional communication (not relayed through the parent/carer).

6.9 In some cases gaining information from other health professionals or school may be necessary to build a clearer picture.

6.10 Professionals' meeting - see Para 5.4 above

7. Referral:

Immediate Protection:

7.1 If at any point there is medical evidence to indicate the child's life is at risk or there is a likelihood of serious immediate harm, an application for an Emergency Protection Order or Police Protection powers should be used to secure the immediate safety of the child.

7.2 Where necessary an informal discussion could take place either with the police or the children's social care and action taken accordingly. This can be done at the professional meeting stage by inviting them to attend.

7.3 Whilst the family's agreement, wherever possible, should be sought before making a referral to the IAT, this should only be done where such an agreement will not place a child at increased risk of Significant Harm.

7.4 To the IAT: Referral should be made at any of the stages above when there is sufficient concern and waiting any longer is judged to be more detrimental to the child. Referral will need to be made as child protection (s47) in writing ***stating that the suspicion is about fabricated or exaggerated illness or disorder as the case may be and indicating whether this concern has been shared with the carer.***

7.5 To the Police: When a crime is suspected or there is risk to life, a referral to Police must be made. When in doubt, it is important to discuss your concerns with the Police Child Abuse Investigation Unit as they may provide advice and expertise for evidence gathering. Do not be tempted to gather non-medical evidence with a view to make a stronger case, without first consulting with the police, as there are strict requirements about what evidence will be admissible in court, should it become necessary. Where decision is made to refer to the police it will be important to inform senior management in the referring organisation and notify the IAT too. The Police will decide what action to take. It may become entirely a Police criminal investigation in which case that will supersede this multi-agency protocol. In other cases, Police may work jointly with social care and others.

7.6 To the Police for urgent investigation (Covert or Overt Surveillance): In a hospital setting, where there is evidence of risk to the life of a child from a carer's behaviour or action, the Paediatrician involved should make an urgent referral to the Police. The Police may decide on a range of actions including; mounting a covert or overt surveillance to gather further evidence either way to resolve the issue (see Covert Video Surveillance). It would primarily be a police decision but in consultation with the IAT and the Paediatrician involved. The CEO of the hospital or a senior manager must be informed if such decisions are made. It would remain a police investigation in terms of resources, equipment and expertise.

8. Post-Referral Action by the Initial/Intake Assessment Teams (IAT)

8.1 Initial Response: Upon receipt of a referral, the IAT will make a decision within ***one working day*** and inform the referrer of their decision. It may either result in no further action with advice, an 'initial assessment' or an urgent 'strategy discussion'. At the end of it, where the concerns are unsubstantiated, the case may be concluded as 'No Further Action (NFA)' and the referrer informed. Where concerns remain either a Sec 17 or Sec 47 investigation may need to be undertaken.

9. Strategy Discussion / Meeting

9.1 If there is reasonable cause to suspect that the child is suffering, or likely to suffer significant harm, the IAT should convene a Strategy Discussion/Meeting involving all the key professionals.

9.2 Unless there is an emergency, this should be a Strategy Meeting, chaired by a manager from the IAT.

9.3 If emergency action is the required response, for example, if a child's life is in danger through poisoning or toxic substances being introduced into the child's blood stream, an immediate Strategy Discussion should take place.

9.4 The Strategy Discussion/Meeting requires the involvement of key senior professionals responsible for the child's welfare. At a minimum, this must include Children's Social Care Services, the Police and the Paediatric Consultant responsible for the child's health.

9.5 One of the considerations should be planning how much and when to share concerns with parents/carers.

9.6 Additionally the following should be invited to Strategy Meetings as appropriate:

- A senior ward nurse if the child is an in-patient,
- A medical professional with expertise in the relevant branch of medicine e.g. paediatric neurologist if epilepsy is involved
- GP, Health visitor and School Nurse
- Staff from education settings if appropriate
- Local authority's Legal adviser
- Designated Doctor
- Designated Nurse/Named Nurse

9.7 Where the Strategy Discussion/Meeting decides that a Section 47 Enquiry should be initiated, see, Section 47 Enquiry and Core Assessment.

9.8 Decisions about undertaking covert video surveillance and keeping records should be made at a Strategy Discussion/Meeting (see Section Covert Video Surveillance). Any such decision should be clearly recorded, with reasons given why it is necessary.

9.9 It may be necessary to have more than one Strategy Discussion/Meeting. This is likely where the child's circumstances are very complex and a number of discussions are required to consider whether and, if relevant, when to initiate a Section 47 Enquiry.

9.10 For some children it may be necessary to institute legal proceedings either immediately or soon after the Child Protection Conference has ended.

10. Section 47 Enquiry and Core Assessment

10.1 When it is decided that there are grounds to initiate a Section 47 Enquiry as part of a Core Assessment, decisions should be made at the Strategy Discussion about how the Section 47 enquiry will be carried out including:

- What further information is required about the child and family and how it should be obtained and recorded
- Whether it is necessary for records to be kept in a secure manner and how this will be ensured
- Whether the child requires constant professional observation and if so, whether or when carer(s) should be present
- Who will carry out what actions, by when and for what purpose, in particular planning further paediatric assessment(s)
- Any particular factors, such as the child and family's culture, religion, ethnicity and language which should be taken into account
- The needs of siblings and other children with whom the alleged abuser has contact
- The needs of parents or carers

- The nature and timing of any police investigations, including analysis of samples and covert video surveillance (see **Covert Video Surveillance**)
- How information will be shared with parents and at what stage
- Obtaining legal advice over evaluation of the available information (where a legal adviser is not present at meeting)

11. Covert Video Surveillance

11.1 The use of covert video surveillance (CVS) is governed by the Regulation of Investigatory Powers Act 2000.

11.2 After a decision has been made at a **Strategy Discussion** to use CVS in a case of suspected fabricated or induced illness, the surveillance should be undertaken by the Police. The operation should be controlled by the Police and accountability for it held by a Police manager. The Police should supply and install any equipment, and be responsible for the security of and archiving of video tapes.

11.3 The decision will only be made if there is no alternative way of obtaining information to explain the child's signs and symptoms and its use is justified on the medical information available.

11.4 The primary aim of the surveillance is to identify whether a child is having an illness induced; and the obtaining of criminal evidence is of secondary importance. The safety of the child is the overriding factor.

11.5 Any use of covert surveillance by the Police should be carried out in accordance with good practice advice available from the National Crime and Operation Faculty, the ACPO (2004) Manual of Surveillance Standards and the ACPO (2004) Policy for Covert Monitoring Posts, both of which are held by the National Specialist Law Enforcement Centre (NSLEC).

11.6 Officers planning surveillance in cases of suspected fabricated or induced illness should seek advice from the National Centre for Policing Excellence (NCPE) Operations Help desk and consult the confidential document, 'Suggested Good Practice for the use of covert surveillance equipment in a hospital', which can be obtained from the Help desk.

11.7 All personnel including nursing staff who will be involved in its use should have received specialist training.

11.8 The IAT should have a contingency plan in place, which can be implemented immediately if covert video surveillance provides evidence of the child suffering Significant Harm.

12. The Initial Child Protection Conference

12.1 There may be the need for more than one strategy discussion to arrive at a better decision. The initial child protection conference should be convened within 15 working days of the last strategy discussion.

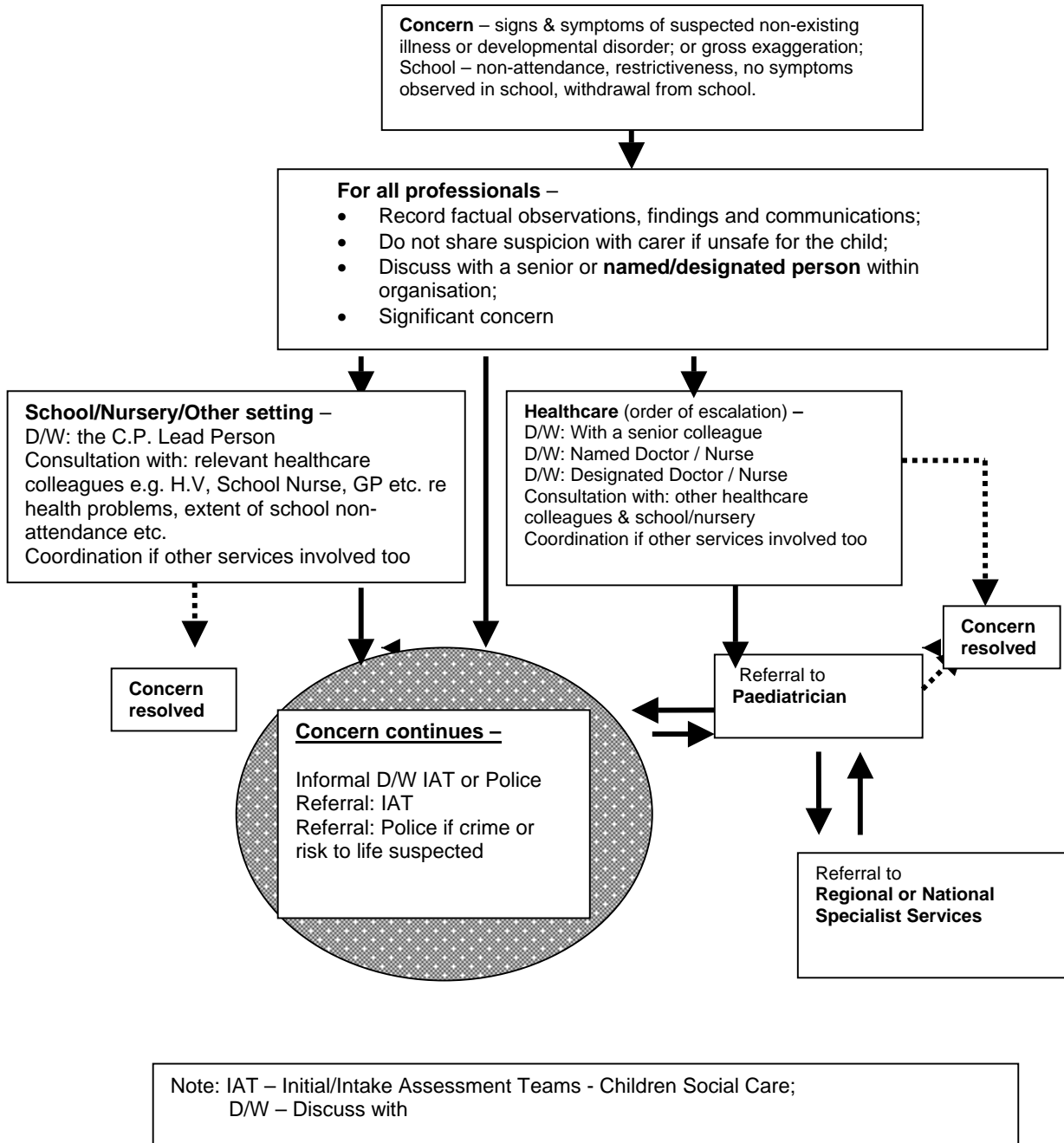
12.2 In addition to the relevant medical staff, social care, police and other staff involved with the case, the presence of a medical consultant with expertise in this field should be considered.

12.3 Children should be involved in ways appropriate to their age and understanding. This can be decided after discussing this with the child in a sensitive manner taking the nature of the case into account. Although parents /carers should normally be

invited to attend, exceptionally it may be necessary to exclude one or more family members from all or part of the conference. (Ref: Safeguarding children in whom illness is fabricated or induced; HM Government 2008; page 49; para 4.48).

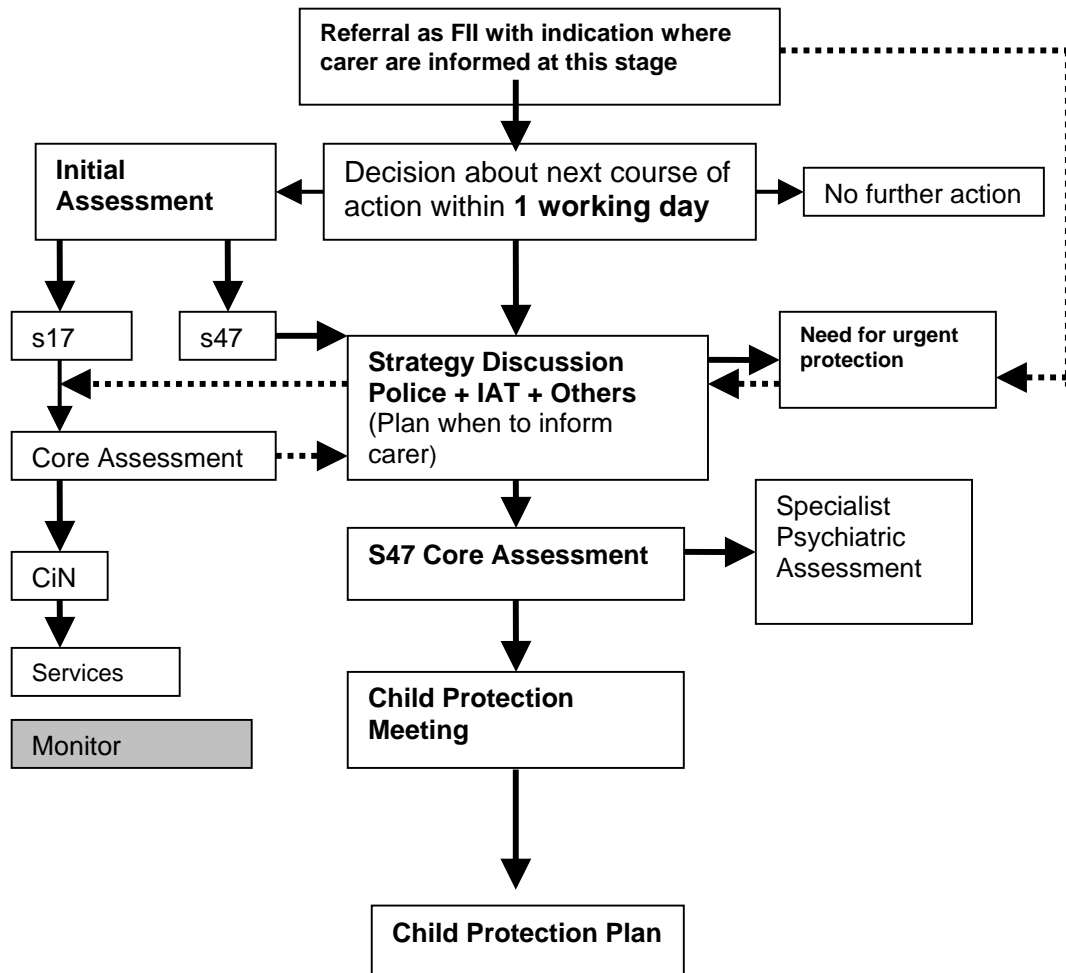
FLOW CHART 1 (Pre-Referral)

Please note that while it is important to refer to investigating agencies without delay, care should be taken to balance the risk of hasty referral on ill-founded suspicion and delayed referral.



FLOW CHART 2 (Post-Referral)

Based on generic procedure but incorporating main and specific elements of FII



Note: IAT – Initial/Intake Assessment Teams - Children Social Care;
 CIN – Child in Need
 S17 - Child in Need
 S47 – Child Protection Enquiries

References:

1. Audit of Munchhausen Syndrome by Proxy cases in Luton & Bedfordshire 1999 - 2004: Audit of all cases dealt within the protocol for MSBP (predates FII): 2004 (unpublished).
2. Safeguarding Children in Whom Illness is Fabricated or Induced: Department for Health: 2002.
3. Safeguarding Children in Whom Illness is Fabricated or Induced; Department for Children School & Families; 2008.
4. Fabricated or Induced Illness; Royal College of Paediatrics and Child Health; 2002.
5. Fabricated or Induced Illness by Carers: A Practice Guide for Paediatricians; Royal College of Paediatrics & Child Health; 2009.

This protocol was developed by a multi-agency task and finish group constituted under the Operational Sub-group of the LSCB.