

Serious Case Review

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LOCAL SAFEGUARDING CHILDREN BOARD

EXECUTIVE SUMMARY REPORT

SERIOUS CASE REVIEW

Children F, G and H

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1. Background to Serious Case Reviews

1.1. The Local Safeguarding Children Boards Regulations 2006 outline that LSCBs should undertake reviews in specified circumstances.

5 (1)(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

5 (2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.2. Given the timeframe for this Serious Case Review, it was commenced under the guidance contained in Working Together to Safeguard Children 2013, Chapter 4,¹ but completed with reference to the guidance in Working Together 2015.² This emphasises the importance of LSCBs developing a Learning and Improvement Framework and outlines that reviews should be completed in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- Is transparent about the way data is collected and analysed;
- Makes use of relevant research and case evidence to inform the findings.

1.3. Working Together 2015 encourages LSCBs to use a variety of models for undertaking SCRs, including the systems approach. The Significant Incident Learning Process (SILP) is one such model.

2. Introduction to the Significant Learning Incident Process (SILP)

2.1. The SILP methodology reflects on multi-agency work systemically. It engages frontline staff and their managers in the review, focussing on why those involved acted in a certain way at that time. Importantly it recognises good practice.

2.2. The SILP methodology adheres to the principles of;

- Proportionality
- Learning from good practice
- Active engagement with practitioners

¹ Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HMG, March 2013.

² Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Department for Children, HM Government 2015.

- Involvement of families

2.3. SILPs are characterised by practitioners, managers and Agency Report Authors coming together for a Learning Event. Agency Reports are shared in advance and the perspectives of all those involved are discussed and valued. The same group then comes together to consider the draft Overview Report at a Recall Event.

3. Process for this Serious Case Review:

3.1. In March 2014, the Chair of the Local Safeguarding Children Board made the decision to undertake a SCR in respect of the children. It was agreed that the criteria had been met under Paragraph 8.5., Working Together to Safeguard Children 2013.³ There was concern that the children in the family had been seriously harmed due to suspected fabricated and induced illness and there was cause for concern as to the way in which the Local Authority, Board partners and other relevant persons had worked together to safeguard the children.

3.2. Furthermore, a decision was taken that the SCR would be undertaken using the SILP methodology and a Scoping Meeting to discuss the Terms of Reference was held in July 2014.

3.3. The Lead Reviewer was Ms Ohdedar, and the Independent Report Author Ms Plunkett. Ms Ohdedar is a former Head of Law with a background in child and adult protection law and advocacy. She is involved in undertaking case reviews and training on the SILP methodology. Ms Plunkett is a qualified social worker, with a MA in Child Studies. She has substantial experience in Children's Social Care, including as a senior manager.

4. Introduction to the case under review:

4.1. This Serious Case Review relates to a large family where concerns about fabricated and induced illness came to the fore in 2013.

4.2. Several of the children in the family have extensive medical histories, including invasive surgical interventions. Their perceived medical needs impacted on their educational, social and emotional development. Over a significant period, a large number of hospitals and health practitioners were involved with the children; different hospitals treating different children and at times different hospitals treating the same child.

4.3. It is known that two of the children presented at Hospital 3 with 'high levels of symptoms' of asthma, and 'the level of treatments they received escalated and included 'beyond guidelines treatments to manage their conditions'. This was not unusual for a tertiary centre and although their treatments were extensive, they were not extraordinary and did not raise concern. Two of the children received treatment at five hospitals and were seen by more than 30 doctors. It appears that no one health practitioner had an overview of the children's medical treatment or co-ordinated this.

4.4. During the SILP Scoping Period Children's Social Care provided a service to the family as Children in Need and Direct Payments were funded. The Mother declined all other support services offered, e.g. social activities for the children,

³ HMG, March 2013.

respite care. It appears that practitioners, in health and education, had growing concerns about the possibility of fabricated and induced illness over some years.

5. Family Engagement:

5.1. Both parents were approached to participate in the Serious Case Review and both initially declined to do so. Mother subsequently agreed to meet with the LSCB Manager and Overview Report Author to hear about the outcome of the review. The children's Grandmother, Grandfather and Uncle met with the LSCB Manager and Overview Report Author.

5.2. The children were approached to ascertain if they wished to contribute to the SCR and meetings have been held with them. The purpose of this contact was to gain their views about the services offered to their family to ascertain if there were any lessons to prevent something similar happening to another child.

5.3. Overall, the children's view was that their Mother should not take the full responsibility for what happened to them and that the doctors should accept some responsibility, as they need to agree to any treatment a child receives. Doctors have many years of training, so why did they not suspect what was happening sooner?

5.4. All the children said they did not form a relationship with any of the doctors or nurses involved in their treatment. At appointments, it was generally their Mother talking and doctors seemed to be very reliant on what she was saying. Whilst doctors were talking to their Mother, the children would be playing or sitting on the bed. One child commented that they were not '*an important person in the conversation*'. All children believe that doctors should engage more directly with children and allow them to have more say in their treatment. One of the children did not understand why they were being tube fed, but this became a normal part of life, another knew they were having unnecessary treatment, but did not have the opportunity to tell anyone. One child spoke of not wanting the treatment and being scared, but thought it was okay because Mother was present.

5.5. The children had the following messages for practitioners:

- Involve the child more – talk to them on their own, get to know about their life and explain what is happening and why, so that they understand their treatment.
- Go with their 'gut feeling' – follow up on any suspicions. Don't do nothing.
- It is not enough to base a diagnosis and treatment solely on what a parent is saying – doctors need more evidence.

6. Scoping Period:

6.1. Child H attended two hospitals, the local district general hospital and Hospital 4, due to concerns about failure to thrive. Hospital 4 diagnosed coeliac disease and a gluten free diet was introduced, which led to Child H thriving and steadily gaining weight. However, Mother reported a very different picture of Child H's health to the two hospitals, with the district general hospital being presented with a child who had recurrent viral infections, which resulted in

missed schooling. Further tests were undertaken based on Mother's reported concerns, the results of which were normal. The Pharmacy Team identified ordering of high quantities of nutritional supplements, but were reassured by the GP and Dietician and the fact that the child's medical care was being managed by a tertiary centre.

6.2. Child G was seriously ill as a young child and tube feeding was introduced at the district general hospital. There was uncertainty about the exact nature of Child G's health difficulties, the GP identified Mother's extreme anxiety and CAMHS noted discrepancies between Mother's accounts and their observations. A referral was made to Hospital 4 and a gastrostomy was performed. Over a number of years, Mother failed to comply with the requirements of Child G's treatment; Mother did not engage in work with CAMHS and with the Feeding Clinic, which was aimed at reducing the dependency on tube feeding, and failed to change the feeds when required. Despite Child G presenting as well and gaining weight, continued health concerns were reported by Mother which led to a number of tests being undertaken, the results of which were normal. Child G had a gastrostomy in place for many years. Initially there were some medical indications for this, but these resolved and Mother consistently blocked attempts over several years to move away from tube feeding, which hence became normalised for Child G.

6.3. Child F has a complicated medical history. Child F was initially treated at Hospital 3 for asthma and Hospital 3 made a referral to Hospital 2 for treatment for gastro-oesophageal reflux. Mother was anxious for Child F to have a gastrostomy inserted and, despite some concern about the medical need for this, the procedure was undertaken. The plan was that oral feeding should still be encouraged, minimising the dependency on tube feeding. For the next two years Child F was seen routinely at the Outpatients Clinic, but Mother failed to engage with the Feeding Clinic and the Speech and Language Therapist, whose focus was on encouraging oral feeding. In order to gain a fuller picture of Child F's health needs, admission to hospital for observation was recommended twice, but Mother declined this.

6.4. Agencies Involvement:

6.4.1. During the Scoping Period for the SCR, a number of referrals were made by agencies to Children's Social Care (CSC). In 2003 a referral was made by the district general hospital due to Mother's extreme anxiety about Child G's health needs and concerns about the impact this was having on the family. In response CSC completed an Initial Assessment and Child in Need plans were put in place.

6.4.2. When Child G commenced at nursery, a multi-agency meeting was held to discuss medical provision and support. Mother refused to commit to the plan and withdrew the child from nursery.

6.4.3. The school made a referral in 2007 as Mother was having difficulty coping. The school requested an assessment of the underlying causes of the children's medical difficulties. Mother withdrew consent to the referral and, as no concerns were raised about the care of the children, no further action was taken.

6.4.4. During 2010 the concerns of the Consultant Paediatrician at the district general hospital increased. Letters were sent to Hospitals 2, 3 and 4 raising concerns about the children being over-investigated and over-treated due to the symptoms presented by their Mother. The Gastroenterologist at Hospital 4 suggested that Child G should be admitted to hospital locally to be weaned off the gastrostomy and planned to discuss with the Perplexing Presentation Multi-Disciplinary Team. The Consultant Paediatrician was to refer to Children's Social Care and the possibility of a Professionals' Meeting was to be considered. There is no evidence that these actions took place.

6.4.5. The Consultant Paediatrician also wrote to the GP outlining concerns about Mother's anxiety outweighing her ability to meet Child G's treatment needs, i.e. not supporting Child G to take food orally or to be admitted to hospital for observation. There is no evidence of follow up by the Paediatrician or the GP.

6.4.6. Later in the year the Consultant Paediatrician prepared a comprehensive written referral, raising clear concerns about fabricated and induced illness, for submission to CSC. However, this was not submitted as Child G was due to be admitted to Hospital 4 to be weaned from the gastrostomy, but this did not take place.

6.4.7. Agencies' concerns continued during 2011. The Consultant Paediatrician again wrote to the GP. There had been no success in arranging a multi-agency meeting and the plan was to refer the family to CSC, but there is no evidence this was progressed. The Consultant Clinical Psychologist, Hospital 3, wrote to the Consultant Paediatrician, copying in the GP, raising concerns about Mother's wellbeing and made a referral to CSC. Mother withdrew her consent to the referral and no further action was taken. Shortly afterwards the Consultant in Paediatric Respiratory Medicine, Hospital 3, made a referral to CSC for practical help, but again Mother withdrew her consent.

6.4.8. The Carers' Information Service (CIS) made a referral to the Children with Disabilities Team for support for the family. A Core Assessment was undertaken which noted that the house was very cluttered with crates of medicines, feeds, nappies and equipment. Mother presented as very anxious, stating that the children's father provided irregular support and should not be contacted. A network meeting was arranged involving the Respiratory Nurse, Hospital 3, CIS Manager, Social Worker and Mother. The focus of this was practical support needs and funding. The Children with Disabilities Panel agreed direct payments for household help. Mother declined any support services, e.g. befriending service, respite care. Following the assessment there were 6 monthly reviews of

the direct payments, but no active social work involvement and no direct contact with the children.

6.4.9. The School were increasingly concerned about their observations that the children were not displaying symptoms of their diagnosed health conditions and discussed this with the School Nurse. The children were seen eating normally in school. This led to the School Nurse and Children's Hospital at Home Team meeting with the Consultant Paediatrician, who agreed Mother was in a high state of anxiety, but did not consider there was sufficient evidence to make a referral to CSC in respect of fabricated and induced illness. The School Nurse went on to seek advice from the Named Nurse and raised concerns about the need for Child F to be tube fed with Hospital 2.

6.4.10. CSC undertook the review of the Child in Need plan in 2012. Mother declined additional support, i.e. short break activities. The children were not seen, nor was their father. The CWD Panel increased the direct payments. The Consultant Paediatrician wrote to the GP regarding the lack of support being offered to Mother. There is no evidence of any further action being taken.

6.4.11. In 2013 an assessment being undertaken by Hospital 3 identified a disparity between accounts given by Child F and Mother. The Specialist Paediatric Respiratory Nurse undertook a home visit and concerns identified were shared with the multi-agency team leading to a referral regarding FII by the Children's Hospital at Home Team to CSC's Children with Disabilities Team.

7. Emerging Themes:

7.1. Voices of the children:

7.1.1. All professionals work in partnership with parents and when making assessments of a child's health and development they are dependent on information provided by the parents. The picture gained from the discussions with the children during the SCR is of doctors predominantly talking to their Mother, whilst they played or sat on the bed. The children did not feel that they built up a relationship with any of the medical practitioners and the doctors agreed this had not been possible. Partly this was due to the spasmodic contact with the children, which would have made it difficult for the children to gain trust and confidence, but also Mother created barriers. The children recognise that their Mother would have made this difficult and would have tried to prevent Doctors talking to them directly. However, their firm view is that doctors need to try and find ways of talking to children directly and not base their diagnoses totally on what is reported by a parent.

7.1.2. From the Agency Reports, it is clear that Mother's voice very much dominated with practitioners and there was an almost total reliance on her accounts of the children's symptoms, leading to health professionals undertaking procedures which were not medically indicated. The children's views were not consistently sought and used to inform decision-making about treatment. Their voice was silent.

7.1.3. The risks to children from FII are not only physical, but also emotional and psychological. The extent of involvement in FII by children themselves varies on a continuum, from unawareness through passive acceptance to actual participation. The London Safeguarding Children Board Child Protection Procedures highlight that children living with FII can become confused about their state of health and many become preoccupied with anxieties about their health and survival.⁴ In this case Mother's extreme anxiety regarding the risks to the children was expressed in front of them; she repeatedly stated that they would become seriously ill or die if they did not receive certain treatments. This undoubtedly led to the children having a distorted view of their medical conditions and prognosis.

7.1.4. Overall, the Review has identified that there were limited efforts to communicate directly with the children and too great a dependence on Mother's reports by all practitioners. There needs to be a greater awareness of the importance of engaging directly with children and young people; intervention needs to be child centred. If a parent tries to block these attempts, then this should raise agencies' concern. This has been a strong message coming from the children, and practitioners at the Learning Event considered that the importance of remaining child-focused and listening to the child was one of the key learning points for them. This highlights that when there are concerns about FII, medical practitioners need to make additional efforts to speak to the child on their own, without the parent being present.

7.2. Policies and Procedures and knowledge regarding FII:

7.2.1. There is a need for all practitioners working with families, particularly those with children with complex health needs and/or disabilities, to have an understanding of the key elements of fabricated and induced illness (FII); how to recognise the warning signs and what action to take. This includes an awareness of the possibility of FII being a factor when children have genuine underlying medical problems. The NSPCC Research Briefing⁵ notes that although FII is relatively rare 'this should not undermine or minimise its serious nature or the need for practitioners to be able to identify when parents or carers are fabricating or inducing illness in children.'

7.2.2. Many of the agencies contributing to the SCR have identified that practitioners' level of knowledge and understanding of FII was extremely limited. There was no evidence that practitioners had accessed, consulted or implemented the multi-agency national guidance⁶. In addition, the guidance was not available on all the health trusts' intranets. This lack of awareness of the FII guidance is extremely concerning given that many of the practitioners were working with children with complex needs. It could be argued that if staff had had a working knowledge of the guidance they would have been more able to recognise the indicators of FII at an earlier stage and known, or sought advice about, what action to take.

⁴ LSCB London Child Protection Procedures, 2013.

⁵ Lazenbatt and Taylor, Fabricated or induced illness in children: a rare form of child abuse? NSPCC Research Briefing, July 2011.

⁶ Safeguarding children in whom illness is fabricated or induced: Supplementary guidance to Working Together to Safeguard Children, Department for Children, Schools and Families, 2008.

7.2.3. The DSCF Guidance provides practitioners with a helpful framework for managing these highly complex cases. Significantly, if the procedures for FII had been triggered, a multi-agency professionals' meeting would have been held and a Responsible Paediatric Consultant identified. The Royal College of Paediatrics and Child Health guidance⁷ highlights that the consultant responsible for the child's health is the clinical lead for the case and should take responsibility for all decisions about the child's healthcare, i.e. tests and treatment. This is a key step in dealing with cases of suspected FII, as there is then a clinician who can draw up a chronology and co-ordinate the involvement of health agencies and practitioners. This would have led to a joined-up approach and more robust consideration of whether further medical procedures were indicated for the children.

7.3. Early Recognition:

7.3.1. One of the key findings in the NSPCC Research Briefing is that 'Recognition of FII depends, in the first instance, on medical or paediatric clarification of the objective state of the child's health, followed by detailed and painstaking enquiry involving collection of information from many different sources and discussion with different agencies.'⁸ It is clear in this case that there was considerable information available, but it was not pulled together, or analysed, to provide an objective overview. As early as 2005 the GP was becoming concerned about the number of hospital attendances. There is evidence that Mother had a knowledge of medical procedures and was keen for the children to undergo tests and surgical procedures for which doctors did not see the need.

7.3.2. During the review, the factors below were identified which are likely to have contributed to why the early warning signs of FII were not identified and acted upon in a timely way.

- It is not unusual in cases of FII for the child to have a medical condition and this can present challenges for practitioners in assessing what are genuine symptoms and what are fabricated or induced. Concerns build up gradually and it can be a challenge for doctors to work out what is real and what is not real, and when concerns trigger the threshold for intervention.
- The large number of hospitals and doctors involved in the children's treatment mitigated against a comprehensive overview being gained of the children's medical conditions and treatment, and of Mother's presentation. No single health care provider had a full picture of the children's medical needs and treatment, or of the family functioning.
- The children were receiving tertiary care, i.e. highly specialised consultant care, in regional or national centres of excellence, which may have led to practitioners in community health and education relying on the

⁷ Fabricated or Induced Illness by Carers (FII) A Practical Guide for Paediatricians, Royal College of Paediatricians and Child health, 2009.

⁸ Lazenbatt and Taylor, NSPCC 2011.

professional expertise of these paediatric specialists in diagnosing, monitoring and managing the children's chronic conditions. Concern about FII was not raised by secondary or tertiary care specialists.

- The issue of hierarchy and power. The Consultant Paediatrician was reluctant to pursue a referral to CSC without the support of Hospitals 2 and 3. There was a perceived power differential between the district general hospital and the specialist centres. Similarly, the School felt that their concerns would carry less weight.
- Medical practitioners work in partnership with parents and their starting point is that parents know their children well and want the best for them. It is, therefore, a significant step to think that parents may have harmful intentions.
- Practitioners can have difficulty in re-evaluating their views about a family and can get stuck in a particular way of thinking. Supervision provides an opportunity for practitioners to review their understanding of situations. This is important as new information may become available which needs to be rigorously assessed, particularly if this appears to be at odds with the prevailing understanding of the case. In this case practitioners held the view that the family required support, as Mother was struggling to meet the demands of her children's complex medical needs. Practitioners were slow to reconsider this perception, despite the increasing body of evidence that there were inconsistencies in Mother's account of the children's medical conditions and a reluctance on her part to accept services which would help to normalise their lives.
- In view of the controversies relating to Doctors Meadows and Southall,⁹ Paediatricians appear to be cautious about raising, and recording, concerns about FII and of being publicly criticised if found to have made unsubstantiated child protection allegations. A survey by the Royal College of Paediatrics and Child Health (RCPCH) in 2003 found that paediatricians were reluctant to take on the role of Designated Doctor and that one in six had been the subject of a serious complaint. The President of the RCPCH noted that paediatricians were '*demoralised by the GMC case against Professor Meadow*' and there was '*a need to restore confidence in the profession*'.¹⁰
- Professionals need to feel very confident when referring a case of FII to Children's Social Care of meeting the threshold for intervention.
- Difficulty for a lone practitioner to raise the issue of FII, as this can lead to the worker becoming alienated from the team. The fear that the concern about FII is unfounded and the child may be seriously ill.

⁹ David Southall 'I will not apologise for what I did'. The Guardian, 5 May 2010.

¹⁰ Doctors reluctant to work on child protection committees, survey shows. British Medical Journal, 5 February 2004 (328).

- Iatrogenic harm, i.e. harm caused to the child by medical treatment. For medical practitioners, who had been treating a child over a considerable period of time, there will be emotional challenges in coming to terms with the fact that the illnesses could have been fabricated or induced and hence the medical interventions unnecessary.

7.3.3. The above is helpful in understanding why action was not taken much sooner in relation to concerns about FII. However, it is concerning that the practitioners did not access the support and advice that would have been available to them through Safeguarding Leads or consult the Guidance, which provides a helpful framework for managing cases when there are concerns about FII.

7.4. Communication between agencies:

7.4.1. There is considerable evidence that Consultants and Hospitals operated in silos, without considering the need to communicate with colleagues in the same hospital/other hospitals who were also treating children in the family. In addition, there was very limited direct communication between the hospitals and community health services, notably with the GP.

7.4.2. There were points when letters were sent evidencing serious safeguarding concerns which should have prompted an urgent response and an agreed plan of action. However, this did not happen. There was a pattern of letters to the GP being uploaded onto records, with little consideration of the contents.

7.4.3. There are examples of the School Nurse and the Children's Hospital at Home Team, despite having key roles with the family, not being included in communications and meetings. This meant that the views of the school were not promoted.

7.4.5. The GP Practice was well placed to gain an overview of the children's medical conditions and treatments. The Practice received letters from the routine clinic attendances, as well as the letters of concern from the Consultant Paediatrician. However, the GP did not take a central, co-ordinating role, maybe because this was a single-handed practice and given the number of hospitals and clinics involved it would have been a time-consuming task to do so. There was a tendency in the GP records for letters from hospitals to be logged onto the children's notes without any comments or actions documented. This meant that the GP failed to identify the pattern of concerns being raised.

7.4.6. The children's medical care was fragmented across primary, secondary, tertiary and specialist services with no one professional taking overall responsibility and, given the weaknesses in inter-agency communication, Mother was able to exploit the situation to fulfil her own needs.

7.5. Role of the parents:

7.5.1. Research indicates that in the majority of cases of FII the child's mother is responsible for the abuse. The behaviour of the mother is likely to be highly manipulative and controlling and will have a powerful impact on professionals, individually and collectively, i.e. on the effectiveness of multi-agency working.

Managing this behaviour, therefore, presents a real challenge to individual professionals, as well as to the functioning of the multi-agency network.

7.5.2. In this case Mother appears to have been extremely persuasive, with a good medical knowledge, enabling her to convince medical teams to undertake investigations/procedures for which there were not always medical indications, or to delay procedures which were believed to be in the children's best interest. Some of the invasive tests undertaken most parents would only agree to if they were convinced that they were necessary. Mother is described as being 'very believable' and what she reported over time became fact, without any evidence to support this. She is also described as being difficult to challenge, she tended to always have an answer to any queries raised and could become confrontational.

7.5.3. Mother had an ability to play professionals against each other, as was apparent between health and education, where Mother conveyed to health practitioners that the school was not making appropriate adjustments for the children's health difficulties. She blocked attempts to convene multi-agency meetings, telling school staff that it would be impossible for health staff to attend meetings.

7.5.4. Mother displayed disguised compliance. On the surface, she appeared to be co-operative, but actually she did not co-operate and was highly avoidant. There was a discernible pattern of her blocking offers of support services, particularly those that would enable practitioners to get close to the family and gain a fuller picture of the children's lived experiences. Mother co-operated selectively and on her own terms. There was a disconnect between Mother's presentation as being under considerable emotional and physical strain, but repeatedly not accepting services which would help to relieve some of the strain.

7.5.5. It is apparent that Mother's approach and behaviour had an emotional impact on practitioners. Presenting as the single parent of a number of children with complex health need, she could be very demanding emotionally. This may have affected practitioners' ability to maintain professional objectivity and to stand back and reflect. The longer the deception continued, the more Mother had to lose, including financially. Therefore, she had to work hard to maintain the picture that she had created, making her even more difficult for practitioners to challenge.

7.5.6. Dealing with the behaviour of parents is one of the real challenges in cases of FII and highlights the importance of practitioners seeking advice and consulting the national guidance at an early stage. This helps to minimise the sense of being overwhelmed and the risk of manipulation by parents.

7.6.6. Little information was available to the review in respect of the role of the children's father in the family. Mother portrayed him at different times to practitioners as being 'a friend and landlord', providing irregular support and being deceased. Mother minimised his role in the family and he was not engaged in the initial or core assessments undertaken by Children's Social Care.

8. Developments since Scoping Period:

- The outcome for the children has had an impact on all the health agencies involved in the SCR:
 - Health Service 1 holds monthly Clinical Governance Meetings, when specific cases are discussed.
 - Hospital 2 holds weekly multi-disciplinary meetings where complex families are discussed, and safeguarding issues addressed.
 - Hospital 3's safeguarding practice has developed, with increased engagement with safeguarding professionals and supervision.
 - Hospital 4 had reviewed all relevant cases and provided training in FII for Consultants.
 - A FII Aide Memoire and flow chart have been produced for GPs.
- Multi Agency Safeguarding Hub (MASH) established January 2014. Hub consists of staff from Children's Social Care, Police, Health, Education, Youth Offending Service, Early Intervention, Youth Service and Probation. It provides the capacity, skills and practical arrangements to collect analyse and securely store information held by all partners about children and families that is relevant to an assessment of safeguarding risk. A common set of risk indicators is used to ensure a consistent approach to identifying and categorising the level of risk.
- Greater scrutiny in respect of direct payments, with quarterly financial returns and six -monthly reviews.
- LSCB Fabricated and Induced Illness Training: Further Learning Events for dealing with cases of FII for key multiagency staff are planned.
- LSCB is developing training in working with challenging and uncooperative parents.
- LSCB Escalation Policy was developed and launched

9. Key Learning Points:

- GPs should take on a co-ordination role when a child is attending a variety of clinics/hospitals for treatment, review incoming communications thoroughly and respond to any concerns raised. GPs are well placed to identify patterns, e.g. appointments not attended/cancelled. Other agencies retain responsibility for communicating directly with the GP and highlighting any concerns.
- All practitioners should guard against relying solely on information provided by parents and ensure that the child's views are sought and listened to. If a parent is obstructive this should be highlighted as a cause of concern.

- Children should be fully engaged in their care and treatment and should be supported to gain an age appropriate understanding of the treatment they are receiving and the reasons why.
- Practitioners should be alert to signs of disguised compliance by parents and assess the impact of this on agencies' ability to safeguard and meet the needs of children and young people.
- Early concerns about Fabricated and Induced Illness should be recorded and discussed with Safeguarding Leads/Designated Doctors and Nurses. Government Guidance provides a sound framework to manage such concerns, including holding a Strategy Meeting where concerns can be shared, a multi-agency plan put in place and a Responsible Paediatric Consultant identified.
- The role of the Responsible Paediatric Consultant is crucial in pulling together a medical chronology, overseeing and co-ordinating children's treatment and preventing unnecessary medical interventions.
- Practitioners should not delay in making a referral to Children's Social Care on the basis that it will not be accepted. Better to make the referral and have the discussion, rather than not do so. Responsibility rests with the agency to submit a good quality referral, which provides sufficient information to evidence the concerns raised and assists CSC with decision-making.
- Practitioners need to be mindful of the impact on them of children being treated at a specialist unit or at a 'centre of excellence' and not allow this to prevent them raising valid concerns.
- Need for improved communication between Tertiary Hospitals and community health services, including District General Hospitals and GPs.
- Direct communication between professionals, e.g. telephone conversations, meetings, is the most effective way of sharing concerns and agreeing a way forward. Sending a letter raising a concern is not sufficient, this needs to be followed-up by direct communication in order to agree a way forward.
- The role of the School Nurse is important in providing a conduit between the school and health professionals.
- Reflective supervision and support is essential for practitioners working with families where there are concerns about FII, given the complexity and challenges of working with the parents.

- Practitioners need to maintain 'respectful uncertainty' and professional curiosity in cases where concerns emerge over a period of time.

10. Conclusion:

10.1. Cases of fabricated and induced illness are amongst the most complex, and professionally challenging, that practitioners working in child protection deal with. There can often be diverging views amongst medical practitioners and concerns, if proved wrong, about the consequences of not treating a seriously ill child. Parents are likely to be knowledgeable, plausible and difficult to challenge. Whilst such cases are not uncommon, practitioners are unlikely to have the opportunity to develop their skills and knowledge in this area. For these reasons knowledge of, and adherence to, the available guidance is essential to safeguard children and young people.

10.2. This Serious Case Review has identified the long standing physical and emotional abuse of the children due to Fabricated and Induced Illness. They received unnecessary and invasive medical procedures over a significant period of time, including after tests had shown that any medical symptoms had resolved. It is very clear that a number of practitioners had suspicions about fabricated and induced illness as early as 2005, but certainly by 2009. It is therefore of concern that it was not until some years later that multi-agency action was taken to safeguard the children. Until then child protection procedures had not been initiated, i.e. Strategy Meeting, Section 47 enquiries, Initial Child Protection Conference. The various guidance in respect of FII, both for health practitioners and for multi-agency working, had not been consulted.

10.3. Several factors have been identified which contributed to this delay; practitioners lack of knowledge of the FII guidance, lack of effective communication between health practitioners and with community services, Mother's disguised compliance and manipulative behaviour and practitioners' lack of engagement with the children, so that their voice was not heard.

10.4. The number of hospitals that the children attended made communication between medical practitioners more challenging, but also more essential. The GP should have assumed a co-ordination role but, as a single-handed Practice, did not do so. The fact that the children were receiving treatment from specialist clinics at 'centres of excellence' gave validation to their diagnosis and treatment, and led to other agencies, e.g. schools, feeling less able to challenge. There was a culture of letters between agencies and a pattern of these not being responded to, or followed up, even when they raised significant safeguarding concerns. Practitioners did not demonstrate professional curiosity. Mother could take advantage of this. There is particular learning here for hospital staff.

10.5. What has come through during the Serious Case Review from the medical practitioners is almost a fear of raising concerns about FII, due to worries about 'getting it wrong' when a child is seriously ill, but also about attracting unwanted criticism or media coverage for themselves and the hospital. A survey by the

Royal College of Paediatrics and Child Health ¹¹ indicates that this has been a national issue, which could be preventing doctors from taking safeguarding action and, if so, needs to be addressed.

10.6. It is important to listen to, and learn from, the children's views. Whilst it is recognised that Mother would have made it difficult, the children's firm view is that doctors should never rely solely on what a parent is telling them. Children need to be spoken to and helped to understand their medical condition and any proposed treatment. They should be given a voice. As one of the children has said, doctors should act on their '*gut feelings*', '*one child is too many*'. Practitioners should think the unthinkable.

10.7. This was a complex case for practitioners to deal with. Sadly, the lack of a robust, co-ordinated, response allowed the fabricated and induced illness to continue for many years. The longer it continued the more difficult it was to unpick what was fact and was not, and the greater Mother's commitment to maintaining the status quo.

10.8. There are many lessons for individual agencies and for multi-agency working from this Serious Case Review. These should be shared widely by the Local Safeguarding Children Board to reduce the likelihood of children experiencing similar abuse.

11. Recommendations for Local Safeguarding Children Board (Contained in Interim Report):

1. LSCB should promote the voice of the child and ensure that the importance of communicating with children and young people, including non-verbal communication, so that an understanding of their lived day to day experiences can be gained, is embedded in all procedures and training provided. This should be routinely audited through single and multi-agency case file audits.
2. Any practitioner who has concerns about possible fabricated and induced illness should, at an early stage, consult their Safeguarding Lead, e.g. Named GP, Named Doctors and Designated Professionals, and consider the need to initiate the FII Guidance, e.g. Strategy Meeting, Lead Professional.
3. LSCB should have a clear, accessible, escalation policy in place so that practitioners are informed about what action they should take if they have concerns about a child which they consider are not being responded to appropriately. Following an appropriate period there should be an audit of practitioners' knowledge and use of this policy.
4. LSCB should request a review of the national Child Protection Procedures in respect of dealing with cases of FII to ensure that learning from this SCR and NSPCC Research are reflected in the procedures. This should include:

¹¹ BMJ, February 2004.

- Highlighting the important role that can be played by GPs in identifying concerns about FII in a family.
 - Consideration of how to promote communication between tertiary, specialist and external agencies, including community and secondary health services, Children's Social Care and education.
 - The challenges for individual practitioners and the multi-agency network of working with parents in such cases, and the emotional impact this can have.
 - Single and multi-agency supervision training should highlight the key role of supervisors in providing reflection and challenge in potential cases of FII, which can present difficulties for practitioners in terms of dealing with parental behaviours and maintaining a focus on the needs of the child.
5. LSCB should share the learning from this SCR with NHS England, as there is significance nationally for tertiary hospitals, centres of excellence, District General Hospitals and community services in working effectively together to safeguard children and young people.
 6. LSCB's Independent Chair should write to the Department of Education to request that the supplementary guidance to Working Together, Safeguarding Children in whom illness is fabricated or induced, be updated to reflect the learning from this and other SCRs in relation to FII.
 7. LSCB's Independent Chair should alert the Association of Independent Chairs of LSCBs to the findings of the SCR and to the need for updated guidance.
 8. LSCB should request a report regarding the capacity of School Health/Nursing resources and the impact of this on services.