Good Practice Points for Health Visitors

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Excellence in Practice

Working with fabricated or induced illness (FII) by carers including perplexing presentations (PP):

Management of fabricated or induced illness in health visiting practice

This series of three Good Practice Points (GPPs) will help enhance health visitors' (HVs) understanding of Fabricated or Induced Illness (FII) and how it will impact their role and practice.

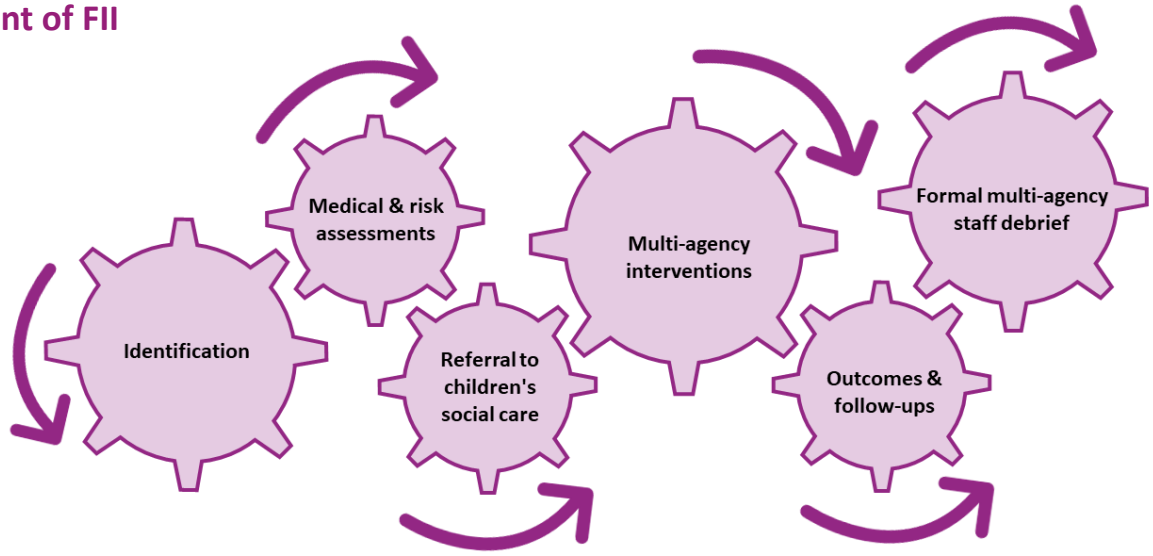
- GPP1: Recognising fabricated or induced illness (FII) in health visiting practice (FII GPP1)
- *GPP2: Management of FII in health visiting practice (FII GPP2)*
- GPP3: Impact of FII cases on professionals: Addressing potential dilemmas in health visiting practice (FII GPP3)

Introduction

This FII GPP2 provides an evidence summary to support HVs in their management of FII spectrum cases in frontline practice. This FII GPP2 should be read in conjunction with FII GPP1 and FII GPP3, as listed above.

1. FII is a form of child abuse, which involves a spectrum of behaviours and presentations, which may co-exist with other forms of child maltreatment and/or a genuine pathology[1-6].
2. Safeguarding and child protection are core activities of health visiting with HVs playing a key and unique role with families whilst keeping the child's safety and welfare as the primary focus of all of their professional activity at all times[3,5,7-8].
3. The key principle of management in FII cases is to avoid any ongoing harm to the child; therefore, it is essential that HVs/ other professionals keep an open mind to FII as part of the differential diagnosis, in each individual case, in the absence of all other explanations[1,3,5-6,8].
4. It is important that HVs recognise that FII, like any other form of child abuse, must be referred to Children's Social Care /M.A.S.H. as soon as actual or potential harm to the child is suspected by staff[3,5,8].
5. HVs have an extremely important role to play as part of the ongoing multi-agency team management of such cases until the child is fully protected[3,5-8].
6. FII may occur within the obstetric context affecting an unborn child, although such cases are very rare[1,3].
7. FII can occur in other settings, e.g. education, legal settings and psychological arena[1,3].

Management of FII



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HV role in identification, medical and risk assessments, referral to social care

- HVs must work within the national child protection/ safeguarding framework in an objective child-centred way, and should have a good working knowledge of the pertinent legislation, statutory guidance, national FII guidance and local Safeguarding Partnership protocols which inform that framework, to facilitate early identification and appropriate timely interventions in FII spectrum cases as and when they arise, in the best interests of the child victims[3,5,7-10].
- All HVs are required to have specific knowledge and skills leading to competencies in relation to identifying and managing child safeguarding including FII, as laid out in the Royal College of Nursing (RCN) and contributing organisation's Intercollegiate Document 2019. They should attend regular updates of FII training, preferably multi-agency training, which will further inform and enhance their role within that wider multi-agency child safeguarding team response[3-8,11-12].
- The child's safety is of paramount importance. Therefore, if the interests of the child conflict with parents/carers or others, it is the child's interests which take precedence. Immediately discuss with senior colleagues when concerns around actual or potential FII arise, e.g. manager, local Named or Designated Doctor or Nurse[5-6,8-9].
- See and talk to the child alone if age appropriate. However, it is important that HVs are alert to the fact that the child's health beliefs may have been influenced by the abusing carer, even to the extent that the child colludes with the carer[3,5,8,13-18].
- Follow national and local protocols and ensure that a timely referral to a consultant paediatrician is undertaken in the first instance. They will identify a lead paediatrician for the case who will be a consultant with expertise in the specialism most appropriate to the reported signs and symptoms[3-6].
- Following national and local protocols, ensure that a full assessment is undertaken by a consultant paediatrician as soon as possible, along with a risk of harm assessment. These may be undertaken at a hospital out-patient appointment or may require a planned admission to hospital[3-5,11,13-14,19]. Close professional liaison is essential to the best interests of the child but particularly at this stage between the health visiting team, GPs and paediatric team[3,5,6].
- HVs should always action their own concerns and refer to Children's Social Care/M.A.S.H. as soon as actual or potential FII harm is suspected. Do not wait for someone else to undertake the referral or for a diagnosis to be confirmed, as any delay could be detrimental to the safety and welfare of the child whilst a multi-agency team approach is key[3,5,8,11,20].
- Social Care decides what response is needed within one working day[5]. However, it is very important that HVs proactively pursue a response if they have not heard back within the agreed timeframe, in the best interests of the child's safety and welfare[5,8].
- In the context of thresholds, professionals including HVs must be aware that they may need to employ what Laming[14] described as 'respectful uncertainty' (p205) or/and 'healthy scepticism' (p205) to professionally challenge, or to activate the local Safeguarding Partnership professional escalation protocol in the best interests of the child, if they receive what they consider to be an inappropriate response to their concerns and referral from Children's Social Care. In FII spectrum cases, always work very closely with the Named and Designated professionals who will support HVs with this, including reframing and re-referring a case until the child is safeguarded[3,5-6,8,14-16,18].
- It is essential to objectively record everything fully and contemporaneously in the health visitor record, this includes all conversations, telephone calls, one-to-one and informal discussions/meetings which the health visitor has had, all investigations and results including any negative results, any accident and emergency department/other liaison reports, minutes etc. received, who has reported what to whom and when including any reactions of parents or child you note, all dated and timed very accurately[3,5,8,14-15,21-22].
- In the context of information governance and records management security, it is imperative to adhere to national and local guidance and keep all health visitor records in a secure place (electronic records and any paper records that may still exist), both to ensure that they are not tampered with and for the integrity of the chain of continuity of the records which may form part of a court bundle at a later date, or go forward to a complaint or to a Rapid Review/other Review, media quote etc[3,8,21-22].

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- Agree with the Named or Designated staff when to commence a detailed health visitor chronology on the child and family, preferably as soon as possible[3-4,8]. Best practice is to use the local Safeguarding Partnership/ L.S.C.B. template which will facilitate the integration of the HV chronology into the wider multi-agency chronology at a later date. The purpose of the chronology is to identify emerging themes, family patterns, possible intergenerational cycles, which will be key to confirming facts and reviewing the overall case and plays an important role in the multi-agency risk assessment. At a minimum, a chronology should include date, time and venue of contact, organisation, job title, source of information, history of event, description of presentation, what was reported and by whom, what the child said (if age appropriate) and what was observed (child-parent interactions, child-professional interactions and parent-professional interactions). Always specifically note what the child looked like including the child's eye contact, demeanor, clothing, condition of hair and any injuries along with the professional's comments on the contact including significance and actions taken.
- Keeping information on a need-to-know basis is always important. However, in FII spectrum cases in particular, information sharing is a dynamic, multifactorial process. Repeated reassessments and awareness of the whole child and family context within the framework of multi-professional, multi-agency team discussions and agreement are required, as well as highly coordinated actions, depending on where on the continuum a particular case is, e.g. perplexing presentations (PP) or more dramatic full-blown FII presentations. This applies both to what information is shared with professional colleagues (including those who are not involved in the case), as well as with the parent and child[21,23-24].

  At the PP end of the spectrum, once a health consensus led by the paediatrician has been reached, and provided any potential risks to the child are not increased, information will be discussed with the parents (and child if age appropriate) by the consultant paediatrician with another professional present, which may be the health visitor. The discussion will acknowledge the child's symptoms and the professional's concerns/issues and plan how best to work together to move forward in the child's best interests. Similarly, if or when a referral to Children's Social Care is necessary, the reasons for it will need to be discussed with the parents but only in cases where such discussion will not place the child at increased risk of significant harm[3,5-6,8,21].

  Because of the high risk for divisiveness between professionals in FII spectrum cases, it is imperative to maintain very strict professional boundaries with such parents at all times. HVs need to be very aware that the perpetrators of this form of abuse will work very hard at befriending professionals in order to potentially 'enmesh'[1] (p311) them and use them as their tool in the abusive cycle. They will also become hyper-critical of the health visitor/other professional as soon as the professional becomes suspicious and realises what is happening and at that point will frequently trigger the complaints system. Therefore, it is helpful for the health visitor or her/his Named Nurse or Named Doctor to alert the organisation's complaints department to such cases in advance (see FII GPP3)[1,3,6,23,25-26].
- HVs should proactively and regularly access high quality child safeguarding supervision from a manager, safeguarding lead, Named or Designated professionals during such cases. It should have a particular focus on the supportive and restorative functions of supervision where the professional may receive recognition and support of/for the emotional stress created by such child abuse cases[3,5-6,8,27-28].

HV role in multi-agency discussions and interventions

- In line with statutory guidance, a multi-agency meeting led by Children's Social Care and including as a minimum, health and police colleagues, must be convened to consider what next actions are needed which the health visitor should always attend as she/he will have vital contributions to make[3,5-6,8].
- The multi-agency meeting will decide on what interventions are required, by whom and in what timeframe. There are three possible pathways depending on the level of risk to the child and where on the FII continuum the individual case is. Remember to keep the focus on the harm suffered by the child from the impact of the carer's behaviour when assessing levels of risk. The three pathways are:
  i. Immediate emergency child protection action; **OR**
  ii. Formal child protection assessment by Children's Social Care; **OR**
  iii. Continued multi-agency monitoring at a child-in-need level, risk assessment and support plans, open access/admission to hospital, evaluation, and formal escalation plans. Continuity of care by lead paediatrician, health visitor and others. Planned provision to take emergency action and immediate protection should concerns by any professional re-emerge or increase.

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- Maintain a fully child-centered focus throughout with regular high quality multi-professional communication[3-6,8,13,29].
- Meaningful multi-agency team working is essential to the success of such cases and to optimising the outcomes for the child victims, with HVs playing a key role within the team. It is important to be alert to the fact that such parents/carers may travel long distances and cross multiple health and local authority catchment areas to get health assessments and treatments for the child. Therefore, excellent communication and high quality multi-professional team working across regions will be required. How the case is managed from the very beginning will impact the child's future health and wellbeing[3,5-6,8-10,29].
- A full history of the child and family should be taken by the appropriate lead professional from Children's Social Care and, in some cases, the police. Best practice for all professionals across health, social care, police, education and psychiatry is to question everything and to independently verify everything in such cases[1,3,6,16-17].
- Support should continue to be provided by the appropriate members of the multi-agency team for the parents/ carers, e.g. parent referrals to GP, adult psychiatry etc., however it is very important that HVs/ all involved professionals avoid being an advocate for or being used by the abusing carer to the detriment of the child victim (see FII GPP3)[1,3,5-6].
- Parents/Carers should be kept informed of findings from the multi-agency investigations. However, the child's best interests must be the overriding consideration in making decisions about what information to share with parents, when, how and by whom as this can potentially increase the risks to the child (see above). In FII cases within the multi-agency team, this task is usually undertaken by a senior social worker together with a consultant paediatrician or police colleague[3,5-6,8,21].
- The multi-agency team, led by the paediatrician from a health perspective, should reflect on whether any second opinions are needed in the best interests of the child, whilst being careful to avoid iatrogenic harm (see FII GPP3)[1,3-4,6,11].

Outcomes and follow-up for children and formal multi-agency debrief for HVs

- The child's outcomes may be divided into the more immediate child protection investigations outcome phase and the longer-term quality of life outcomes, including morbidity and mortality rates for the child victims of FII spectrum cases[3,5-6,30-32].

  There are three possible outcomes of the child protection investigations as follows:

  i. Concerns not substantiated, e.g. because a genuine medical reason was found which fully explained the child's presentation; **OR**
  ii. Concerns are substantiated however the child is not judged to be at continuing risk of harm, e.g. because the perpetrator has been removed or/and intense support is given to the family with a child-in-need plan implemented; **OR**
  iii. Concerns are substantiated with the child judged to be suffering or at risk of suffering significant harm. Full multi-agency child protection investigation with all actions immediately undertaken to protect the child and any siblings, including removing the child from the perpetrator if necessary.
- In the context of the long-term sequelae, little research has been undertaken. However, the available evidence to date, apart from the Black and Hollis study in 1996[33], suggests poor outcomes, particularly in relation to FII cases which involve deliberate physical abuse, fabrication or induction by the carer. These long-term sequelae affect the physical, psychological, emotional, educational and social aspects of the child victim's life. There are a multiplicity of reasons for this, not least because of the abusing carer's inability to acknowledge the abuse and to change their behaviour (See FII GPP3). Of note for HVs, the timing and quality of the professional interventions is very important, as is the context in which the work is undertaken - the key point being that a child protection framework is required to optimise the outcomes for the child[1-3,5,31,33-37]. In addition, it is important to note that there is no research-based evidence on outcomes in relation to early FII spectrum cases, e.g. MUS and PP, to date[6].
- In relation to outcomes for HVs/ other professionals involved in such cases, there is significant potential for professional dilemmas and conflict to arise, including divisiveness within and between teams. This is because carers who perpetrate this form of abuse are both very plausible and highly manipulative and may attempt to 'enmesh' professionals in the abusive cycle. Equally, such perpetrators may feel very comfortable using complaints systems, the media/social media, and threats of litigation against professionals both as a means of controlling the professionals they previously befriended and as part of their power game with them (see FII GPP3)[1,3,6,17].
- HVs/ other professionals may suffer crises of confidence in the aftermath of FII spectrum cases and should therefore have access to a highly skilled multi-agency group debrief. This should be undertaken by the Named or Designated professionals with all of the involved staff

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once the case has concluded and when it is legally appropriate to do so. Staff should also have continued access to empathetic supervision, occupational health and psychological follow-through care as required (see FII GPP3).

- It is important, therefore, that HVs are fully aware that FII spectrum cases should be managed within the statutory Child Safeguarding multi-agency framework in a pragmatically child-centric way, as well as of their own important role within that structure. It is equally important to acknowledge both the complexity of such cases along with the multiplicity of potential professional challenges that can and do arise whilst managing them on the frontline, which will be further explored in FII GPP3.

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