Learning and Improvement Framework

Report on Katie, a case of fabricated illness
Thurrock LSCB as part of its Learning & Improvement Framework to enable organisations to be clear about their responsibilities, to learn from experience and improve services, commissioned a light touch review in April 2013 of a case of fabricated illness. This review was undertaken using the principles established in Chapter 4 of Working Together 2013 in relation to the way in which reviews of cases should be conducted:

The case subject of this review was referred formally to the Thurrock Local Safeguarding Children Board (LSCB) September 2012. The Board’s Serious Case Review and Audit Panel met on 3rd October 2012 to consider the case for consideration of a serious case review under Regulation 5 of the Local Safeguarding Children Board Regulations 2006.

The Panel found that this Case did not meet the criteria for a Serious Case Review but felt that a review of the case would provide valuable lessons about working together and there was learning and better outcomes to be achieved from conducting a managed review.

Working Together 2013 allows LSCB’s to use any learning model consistent with the principles in the guidance, including systems based methodology.

With the opportunity to conduct a more systems approach to reviews the Board commissioned the NSPCC to conduct a light touch review looking at the subject area of Fabricated Illness that would enable structured reflection and raise questions about the way partner agencies worked together when dealing with these types of cases.

This light touch approach to reviews is new to both the Board and the NSPCC and an evaluation of the process will be undertaken to help inform local and national learning on the methodology for future managed reviews.

A learning event was held on 30th May 2013 attended by practitioners and their line managers involved in the specific case to help understand who did what and the reasons why; they also identified ways in which local practice should be improved.

The draft report was submitted to the Serious Case Review and Audit Panel for accuracy and content. Following some amendments the report was presented to the Board on 11th December 2013 who also made comment on proposed changes.

This final report provides findings that will enable agencies to reflect on current policy, process and working together practice. The review was not intended as a deep dive into the particular case and will have left some specific areas of the case
requiring further exploration and discussions between agencies. The Board publishes this document with those aspects acknowledged.

The Board are pleased to note that a number of issues arising during the review process were acted upon by individual agencies as the learning unfolded.

The findings of the review will be examined by the Board and an action plan implemented through the boards infrastructure and a stakeholder event with the original participants is planned. *(Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children -Working Together 2013 Paragraph 9)*

The resulting actions and learning from the review will be reported and published in an outcomes impact report by the board later in the year.

The Board are pleased that the review process has already stimulated encouraging feedback from senior management and safeguarding professionals involved in the review itself and during the compilation of the final report from across all the agencies involved in safeguarding children in Thurrock.

The Board would like to thank all those participants and advisers that supported the Board during the review process.

David Peplow
LSCB Independent Chair

Updated November 2014
Thurrock LSCB

Case review:
To establish how the multi-agency network in Thurrock responded to concerns about a child’s welfare where fabricated illness was identified & to learn lessons for future practice.

Multi-agency workshop: 30th May 2013
Report ratified by LSCB:

Report author: Kevin Ball, NSPCC Senior Consultant
Review team: Wendy Noctor & Fiona Becker, NSPCC Senior Consultants

This report was commissioned by Thurrock LSCB. Names have been anonymised in order to protect the identity of individuals.
1. About this review

1.1. Thurrock LSCB commissioned the NSPCC Consultancy Service to undertake this review with a view to being able to demonstrate structured reflection about the case and how it was managed, thereby allowing policy, procedure and practice to be strengthened should similar situations arise in the future.

1.2. Thurrock LSCB determined that this case did not meet the statutory criteria for undertaking a serious case review, but nonetheless it was agreed that there was learning to be pursued.

1.3. Working Together to Safeguard Children, 2013 \(^1\) states "...LSCBs should also conduct reviews of cases which do not meet the criteria for an SCR, but which can provide valuable lessons about how organisations are working together to safeguard and promote the welfare of children ...these reviews are important for highlighting good practice as well as identifying improvement which need to be made to local services ...".

1.4. The agreed aims for the review were to identify how the multi-agency network in Thurrock could respond most effectively to concerns about children’s welfare where fabricated illness is identified. Fabricated or induced illness is defined \(^2\) as occurring “...when a caregiver (93% of cases the mother) misrepresents the child as ill either by fabricating, or much more rarely, producing symptoms and then presenting the child for medical care, disclaiming knowledge of the cause of the problem. Usually this is with the purpose of obtaining an emotional or psychological benefit”. The review objectives were:

- To understand what happened and why in this case using a systems approach
- To identify the effective practice in this case
- To identify whether anything could have been done better in responding to the needs of the child and identify the reasons for it not happening at the time, and
- To capture learning, through discussion and recording, and then report.

2. Methodology

2.1. Our primary aim for this review was to provide the multi-agency network the opportunity to reflect, in a systematic and structured way, how the case in question was managed. This was achieved through a one day facilitated workshop.

2.2. A lighter touch approach was considered to be both appropriate and proportionate to the seriousness of the incident and complexity of the issues, but also the public interest in the outcome. Relevant agencies were asked to submit a time-line of their agency involvement which was subsequently collated into an overall time-line of multi-agency involvement.

2.3. The process was one of collaborative inquiry, creating an environment conducive to learning in the process of examining the detail of the case, while benefiting from local ownership of the findings and action planning. The review benefited from independent facilitation, thereby providing increased

\(^1\) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, HM Government, March 2013

challenge and scrutiny into the learning process. However, due to the lighter touch nature of this review process it has not been possible to triangulate single and multi-agency information, with the exception of the combined agency timeline. Inevitably, this limits the rigour of the review process, particularly when asking ‘why’ agencies acted as they did. That said, the incident and review process does provide a “window” on the system (Vincent 2004) – an opportunity to look back in order to look forward. The responsibility for following through any actions arising from this report rests with the LSCB.

3. Brief summary of the case leading to review

3.1. This case concerns one child, who at the time of writing this report, is aged four years. The child was born four weeks prematurely. The child’s mother, who is aged 29 years, presented the child to Accident & Emergency at four months old reporting seizures. Medication was prescribed at this point for epilepsy by the hospital. The mother presented the child at A&E on a number of subsequent occasions up until the child was approximately three years of age, stating further seizures, fitting and vomiting. Further medication was prescribed, often with increased dosage, however the mother reported that the seizures and vomiting continued despite the use of medication. The mother described a paternal family history of epilepsy, although the identity of the child’s father remains uncertain to this day. During this period, a wide range of agencies were involved with this child and mother including primary, secondary, and tertiary health services (e.g. GP’s, three community hospitals including A&E and health visiting services, plus Great Ormond Street hospital).

3.2. At 1 year 6 months the mother presented the child at A&E stating that the child had ingested a cube of cannabis. No evidence of the drug was found upon examination and the child was discharged the same evening. This incident prompted a child protection investigation resulting in the child becoming subject of a Child Protection Plan in December 2010 under the category of neglect. At a subsequent review this category was changed to emotional abuse.

3.3. At 3 years 3 months health professionals confirmed that the child did not have epilepsy and that the vacant type seizures were not epilepsy related. There were concerns about neglectful parenting and behavioural issues, as well as concerns expressed by the Designated Doctor about the medicines that had been prescribed, in particular the amounts and frequency via the GP surgery.

3.4. Further concerns in this case included:

- The mother’s refusal to engage with professionals or avoidance of appointments (e.g. between 2009 – 2012 36 health appointments were offered, with the mother attending only 6 and 3 were changed by the hospital);
- The mother’s own reported health problems;
- The mother’s personal experience of abuse and neglect as a child plus her experience of being in public care from 12 years of age;
- Reported incidents of domestic abuse by the child’s mother;
- The child alleging physical abuse at 3 years 1 month.

3.5. At 3 years 3 months the child was removed into local authority care on an Interim Care Order. At 3 years 8 months the Court made a Finding of Fact that the child does not have epilepsy and that

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the mother fabricated the child’s ill health but also fabricated her own health history. A Care Order was granted at 3 years 11 months with plans for the child to be adopted.

3.6. The child is currently placed in local authority care and thriving.

4. Agency involvement in this case

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<tr>
<th>Agency</th>
<th>Discipline</th>
<th>Time-line submitted</th>
<th>Present at learning event</th>
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<tbody>
<tr>
<td>On behalf of commissioning health services – for GPs</td>
<td>Designated Nurse Safeguarding Children</td>
<td>✓</td>
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<td>Local Authority - social care</td>
<td>Safeguarding Adults Team Children's Disability Team</td>
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<td>Basildon &amp; Thurrock University Hospitals (BTUH)</td>
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<td>North East London Foundation Trust (NELFT)</td>
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<td>Specialist Epilepsy Nurse</td>
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<td>Great Ormond Street Hospital (GOS)</td>
<td>Named Doctor Safeguarding Team &amp; Social Work Team Epilepsy Nurse</td>
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<td>Ambulance Service</td>
<td>Acute health care</td>
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The mother of the child was contacted in order to seek her views about agency involvement. These views are discussed in the analysis and commentary section.

The foster carer for the child was present at the learning event and was able to provide valuable information about the behaviour and progress of the child thus supporting a child focus.

5. Emerging issues from the multi-agency network

Through documentary review, but also relevant agencies sharing information about their involvement with the family, a number of threads began to emerge that highlighted where there might be a need to examine policy and practice in more detail.

5.1. Importantly, health professionals have to start from the premise that parents’ accounts of their concerns about their children are valid, true and reliable; in the majority of situations this is the case. Professionals do not routinely expect parents to be devious, deceitful or manipulative when
Reporting health problems about their children. The relationship between medical practitioner and patient is based on trust – therefore it is potentially shocking and disempowering, not only to individual practitioners but also the professional network, to discover that this has not been the case. Assuming a position of 'respectful uncertainty' in every professional interaction one has with someone has to be considered, and overreliance on parental reports without other witnesses or other supporting evidence avoided. On this occasion, once concerns were shared across agencies, professionals were able to adopt such a position.

5.2. There were unanswered questions around the early assessment, diagnosis and prescribing of medication. This included the following issues:

- Medication being prescribed by the hospital when the child was 4 months old having presented at A&E by the mother who was reporting seizures;
- Medical records stating that the child was a ‘known epileptic’ as early as the second presentation at hospital, aged 4 months 1 week, despite no formal assessment and diagnosis being given at this early age;
- What seems like an over-reliance by professionals on self-reporting by the mother of the child’s health problems, in the absence of medical evidence or observable concerns;
- No professional observation or witnessing of the ‘seizures’;
- Increases in medication at 4 months 3 weeks and 7 months 2 weeks having been seen by the paediatrician;
- The prescribing of repeat quantities of medication via the GP surgery over a 2½ year period, often it appears by administrative staff without the doctor seeing the child;
- The need for pharmacists to be more alert to repeat prescriptions and child protection issues (although this relies on the same pharmacy being used on a consistent basis, which is not known in this case).

It is unfortunate that there was no participation by any of the involved GPs at the learning event, so they were unable to provide an account of their role and what influenced their decisions. Future similar case review events need to secure the involvement of GPs.

5.3. Information was given by a number of health representatives about information sharing. There does appear to be a theme of inconsistency of practice, across health agencies, about the effectiveness of information sharing. Great Ormond Street Hospital first became involved when the child was 11 months old. The child became subject to a Child Protection Plan at 1 year 6 months old, however it appears that GOS did not know this until the child was 2 years 1 month of age. This is when a multi-disciplinary meeting took place involving GOS. Had GOS been aware of the child protection plan this would have triggered safeguarding processes when mother missed health appointments sooner than was the case. Similarly, the Speech & Language Service reported that ‘we wouldn’t have known about any concerns were it not for the multi-disciplinary meeting’. The first record of any doubts was when the child was 2 years 1 month “Mother reports events daily up to 2/3 times. Seizures not observed by health professionals. Doctors were not convinced that seizures were occurring”, but it appears it was another year until this was formally shared with agencies outside of health services. Once information was shared action quickly followed resulting in the child being removed from the mother’s care. From this point forward, there was a majority view that information sharing worked very well.

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4 The Victoria Climbié Inquiry Report, 2003, Lord Laming
5.4. A number of professionals highlighted some uncertainty about how best to approach case management, based on what they were seeing, hearing and experiencing. For example reports by the mother of the child vomiting and seizures, the pre-school nursery staff observing the child to be behaving inconsistently but also lethargic and uncoordinated, the child being hysterical following contact, the Physiotherapy Service reporting the child staring vacantly, variable balance problems with sudden behavioural changes. This raised doubts about whether professionals were dealing with inadequate parenting by the mother, neglectful parenting, parental learning difficulties, behavioural difficulties with the child, (as a result of either parenting, learning difficulty and developmental delay) or a medical condition.

5.5. The number of appointments missed or not attended was a recurrent theme in this case. As stated earlier, between 2009 and 2012, 36 health appointments were offered. Of these the mother attended only six, did not attend 27, with the hospital changing three appointments. This is significant. Appointments were cancelled or not attended with Occupational Therapists, Physiotherapists, Health Visitors and Portage Workers as well. The mother offered a range of plausible explanations at the time for these cancelled appointments, as opposed to just ‘not attending’. This may have been perceived by professionals as less significant at the time. This is valuable learning, as the impact on the child was negative. This level of non-engagement clearly raised questions about the affect this would have had on the assessment and diagnosis of either epilepsy, developmental delay, or other condition for the child, or fabricated & induced illness by the mother.

5.6. A question was raised about whether there should be further attempts by the Police to pursue a prosecution of the mother, under s. 23/24 of the Offences Against the Person Act 1861, regarding ‘maliciously administering poison …’. Pursuing a prosecution has been made difficult as the mother has stated that she only followed Doctor’s orders by prescribing medication, and that there is insufficient evidence from toxicology testing of administering an illegal drug or over-medicating the child. However, given the Finding of Fact made in the public law Care Proceedings, it was suggested that there may still be a case to consider through Criminal Proceedings and that further exploration of this may be beneficial.

5.7. The total number of different types of services involved with this case was 13 with 72 plus professionals having contact with mother and child. This is significant and questions were raised at the time by professionals involved about whether the professional system potentially over-loaded the mother with expectations, appointments and requests for information. While this may be relevant, it is also important to identify that the mother manipulated and provided misinformation to some professionals e.g. by using other appointments as an excuse to not attend an appointment with another professional when, in fact, neither was attended. This highlights the added complexity of multiple agencies and professionals being involved and the importance of ensuring that where any doubt exists that these are double checked.

5.8. As part of the process of hearing from each relevant agency at the facilitated workshop, other questions were raised:

- What was known about the child’s mother prior to the child being born, for example we are aware that the mother sought a termination at 10 weeks gestation?
- To what extent could any known risk factors e.g. the mother’s own care history, have indicated increased vulnerability and concern about her ability to provide safe and adequate parenting?
• How credible are the accounts about the reported incidents of domestic violence, particularly as reported incidents were not witnessed by others?
• In what circumstances is it considered appropriate to prescribe medication before assessment and monitoring has been undertaken by health professionals?
• How do we best understand and seek the voice of the child in such cases, especially when the child is so young? This is a reminder of the significance of adults needing to observe and interpret a child's presentation and behaviour.
• What is the most effective mechanism in maintaining an over-view of such cases, while remaining child focused? The consistency of the Core Group was noted to be a positive aspect; however it needed a second Health Visitor, with a fresh perspective, to become involved in this case in order for change to take place.
• There were a number of different Child Protection Conference Chairs involved in the case though and the extent to which this may have influenced the quality and effectiveness of case management was questioned?

6. What worked well in this case & why?

Many features of good practice were highlighted during the learning event. These included:

1. A second Health Visitor being appointed to the case, which brought a fresh perspective to the information and case records. The Health Visitor took the opportunity to go through the case notes and medical reports from other professionals and became concerned about conflicting information given by the mother to various professionals. This resulted in a chronology of events being produced and then being shared with other professionals at social services and hospitals. This proved to be the turning point in how this case was managed.

2. The creation of a multi-agency chronology of agency involvement in the case – resulting in the opportunity to take an over-view about the case and notice patterns of engagement by the mother with professionals such as social workers, occupational therapists, physiotherapists, health visitors and portage workers. This multi-agency chronology also revealed the high number of missed appointments.

3. A locally shared health record which allows health professionals to record case data on one single system. This enabled improved sharing of information (note: this was considered to be a factor that did work well however there are some contradictions and anomalies about this, as outlined in the previous section).

4. Professionals considered that perseverance and following 'niggling concerns' was a strong feature in this case and only by following these through did effective change occur to safeguard the child.

5. Once concerns had been identified and formally acknowledged through the child protection system, the strength, unity and continuity of the multi-agency core group enabled effective communication, information sharing and planning in order to safeguard the child.

6. The effective collaboration between hospital based professionals (both GOS and BTUH) and community based professionals (both health and social care), which resulted in the mother receiving a strong, consistent message about what was expected of her – once concerns had been identified. Plans to ensure formal assessment of the child were at this stage successful despite resistance from mother and resulted in sufficient evidence to remove the child from mothers care.
7. Again, once concerns had been formally identified and acknowledged there were no significant professional disagreements about how the case should be managed and how the child should be safeguarded. This allowed a switch to take place from being predominantly parent focused to child focused which was crucial in bringing about effective change and safeguarding the child.

8. The outcome of agency intervention resulted in the child being removed from the mother’s care; the child is now safe and thriving.

9. Many people participating in the learning event considered it to be positive that the multi-agency group had come together to share and learn about this particular case using the opportunity for structured reflection.

7. Analysis and commentary:

The details provided in individual agency time-lines and information from the facilitated workshop have highlighted a number of areas of practice where there may be scope to strengthen arrangements. These are now examined in further detail.

7.1. The recognition and management of a case by professionals where fabricated illness appears to be a feature: The Southend, Essex & Thurrock (SET) Child Protection Procedures (2011) provide guidance for practitioners on how to respond should concerns about fabricated or induced illness arise. This procedural guidance, which is essentially sound, does rely on the identification of fabricated or induced illness. In this case, it seems that procedurally, once concerns were identified the case was managed relatively smoothly, with the possible exception of some information sharing issues. It has been stated, as part of this review that health care professionals had to rely on the parent’s account of the child’s health before realising it to be a deceitful act. This is considered by Cumbria County Council in their Serious Case Review (2004) ⁵, “…that parents bring children who are sick and tell the truth about them and that doctors bring expertise and technology and act to do their best for children …”. If this status quo is violated it is important to recognise the emotional impact on professionals and ensure that appropriate support is available, through whatever mechanism, to ensure they are able to remain objective about the individual case and how potential risks to children are managed. Government guidance ⁶ highlights this “…following identification of fabricated or induced illness in a child by a carer, the way in which the case is managed will have a major impact on the developmental outcomes for the child. The extent to which the parents have acknowledged some responsibility for fabricating or inducing illness in their child will also affect these outcomes for the child”. The need to remain child focused, rather than maintaining the emphasis on the adult/parent account is vital.

Questions were also raised about the difficulty for practitioners knowing how best to manage the case e.g. whether the issues were about inadequate or neglectful parenting or a true medical/developmental condition. The NICE guidelines ⁷ do raise the question about the need to consider other explanations about indicators of fabricated or induced illness. Additionally, Horvath (2007) describes types of neglect, one being medical neglect. Both former and current Government

⁵ Public report to Cumbria child protection committee serious case review (conducted under the guidance of part 8 Working Together) of events leading to the death of Michael who was the victim of fabricated or induced illness (FII) (formerly known as Munchausen syndrome by proxy), March 2004
⁶ Safeguarding children in whom illness is fabricated or induced, 2008, HM Government
⁷ When to suspect child maltreatment, NICE Clinical Guideline, July 2009, Royal College of Obstetricians & Gynaecologists
guidance also provides for this type of neglect to be considered, and although primarily used for defining child protection planning, it may assist practitioners to fully explore concerns when considering case strategy and management.

In the light of the findings and learning from this review the LSCB may wish to consider reviewing the SET procedures to ensure that they adequately reflect how other cases of fabricated or induced illness might be managed, should they occur again. For example they might benefit from reflecting the notion that adults/parents may be deceitful in their accounts of their child's symptoms, and the need to consider the characteristics of neglect (through acts of commission or omission by the parent or carer) alongside the need to consider fabricated or induced illness.

Questions were raised by the review as detailed at 5.8; the LSCB may wish to consider how best to ensure the needs and views of the child, above the needs of the parent, are best secured, particularly where the child is young and their verbal abilities may be limited or impaired.

7.2. GP prescribing arrangements and pharmacy dispensation: A very strong emerging issue from this review is a concern about the practice of prescribing and issuing medication by GP's on the direction of the hospital. It has not been possible for us to undertake triangulation of the information, and GP’s were not able to give their account at the facilitated workshop. On the information gathered there are a number of questions which would benefit from further examination:

- On the basis of the findings from this case review, do local GP Practices need to provide the LSCB, but also the local health commissioning governance forums, reassurances that the procedure and mechanism for issuing repeat prescriptions for children is robust? If so, what is the best way of seeking this reassurance?

- In what situations would a GP reasonably share information with either a health colleague, or the local children’s services department, where there are concerns about a parent’s ability to adequately care for a child e.g. due to mental health problems, drug misuse or domestic violence?

- Given the vital role that they play, how can the LSCB effectively engage with GPs, but also pharmacists, to raise the profile of safeguarding and child protection?

- The above, should be considered alongside the Intercollegiate Document (2010) which provides a framework to ensure that ‘all health staff must have the competences to recognize child maltreatment and to take effective action as appropriate to their role. They must also clearly understand their responsibilities, and should be supported by their employing organization to fulfill their duties’; noting any changes to this framework following further review in 2013 in light of proposed structural changes across the NHS and other services in England.

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8 Working Together to safeguard Children, 2010 & 2013, HM Government
9 Safeguarding Child and Young People: Roles and competencies for healthcare staff, Inter-collegiate Document 2010, Royal College of Paediatrics and Child Health on behalf of contributing organisations
It is noted that in the serious case review in respect of Child S \(^{10}\), also concerning fabricated or induced illness, the prescribing of medication was an issue. A recommendation made referred to an alert system being used to identify over use of drugs. Thurrock LSCB may wish to seek further information about whether a similar system is in place locally, and if not, consider its merits and possible implementation.

There is a need to further examine the procedure and practice around prescribing and issuing of medication, particularly for children and learn whether this is a) systemic error that has allowed practice to evolve (either locally to a particular GP Surgery or more wide-spread), b) catalyst effect i.e. a build-up of events leading to concerning practice, or c) whether it is human error and attributable to individuals operating within the system.

Given the information presented and findings made the LSCB may consider setting up a time limited task group to further examine the outstanding questions posed in 7.2.

7.3. Consistency of Child Protection conference Chairs: Whilst it has been reported that changes in Child Protection Conference Chairs was not considered to have had an impact on this case, due to the consistency of the Core Group it will never be known what the impact would have been had there been consistency. It is apparent that once concerns had been identified, the case was managed well and ultimately, the child safeguarded. Nevertheless, it is important to acknowledge the value in consistency, particularly given the changes in organisational structures and working practices that take place across public services. That said, as is evidenced in this case there can also be benefits when a fresh pair of eyes joins a process.

In order to provide reassurance the LSCB may find it useful to undertake an audit, where children are subject to Child Protection Plans, to explore the frequency of Child Protection Conference Chairs being changed and whether this affects the overall scrutiny and decision making on cases.

7.4. Using single and multi-agency chronologies and historical information to inform case management and support effective recording: As described, the turning point in the management of this case appears to be the involvement of a new Health Visitor providing a fresh perspective, who looked at records to obtain an overview of the case, and in so doing identified a number of concerns and inconsistencies in information from the mother. This led to completion of a multi-agency chronology. The use of chronologies is well recognised as being a tool to identify patterns and risks as well as linking past behaviour and concerns with current issues. Often, these are created and maintained by a single agency, often as the lead agency when there are concerns about a child's welfare. Ofsted \(^{11}\) highlight the value of using all information available to inform assessment and intervention. The use of a multi-agency chronology is an important next step, especially where the case is complex, where there are a high number of agencies and professionals involved. There is considerable worth therefore in ensuring this good practice is not lost.

\(^{10}\) Executive summary of a serious case review in respect of Child S, South Tees LSCB, February 2008

\(^{11}\) Learning lessons from serious case reviews 2009–2010, Ofsted’s evaluation of serious case reviews from 1 April 2009 to 31 March 2010
When reviewing the SET procedures the LSCB may wish to consider in what circumstances and cases a multi-agency chronology might be useful as a tool for assisting professionals manage risks to children. For example when a high number of agencies are involved in a case or where the case is particularly complex.

7.5. The monitoring of missed appointments: By creating a multi-agency chronology, the monitoring of missed appointments was identified. This issue is a common theme in cases and one that is highlighted by Ofsted 12 (p.29), "...missed appointments were recorded, but no one collated the information or questioned its significance ...". It was also highlighted in the review that some areas of the health service were discharging patients due to non-attendance, based on the failure of the adult/parent not attending – this is not child focused and places children, with legitimate health issues at risk. The review was unable to gain comprehensive evidence about this issue but there may be benefit in exploring this further.

How can the LSCB best seek reassurance that:

1. Information from all agencies involved with a case, particularly where there are safeguarding concerns, is appropriately shared e.g. missed appointments to ensure that this information is included in decision making?

2. Health agencies discharge children at the appropriate time, rather than due to the possibility that their parents/carers failed to bring them to appointments?

The LSCB will also wish to seek reassurance that all agencies with safeguarding responsibilities have robust policies and procedures where appointments are not attended by service users.

7.6. The early diagnosis of epilepsy and the ability to challenge self-reporting: From documentary records it does appear that the child was labelled as being 'a known epileptic' despite their being no formal diagnosis. This was based on the mother’s self-reporting and resulted in medication being prescribed to the child from a very young age. This raised questions about the taking of a thorough history, clinical examination and observation and whether there is a need to refer children who are under two years to a tertiary health provision for assessment prior to commencing any medication. The need to consider fabricated or induced illness early on is an issue noted in a serious case review concerning child F 13.

However, it is also important to remain mindful that fabricated or induced illness is a process rather than a single event, as noted by Cumbria County Council 14, "Apart from severe induced illness, the illness picture develops insidiously in FII. It is often fragments of information that begin to suggest the possibility of abuse". It is only with the benefit of hindsight, in many of these instances, that one

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13 Serious Case Review Executive Summary Re: Child F, 2012, Cumbria Local Safeguarding Children Board
14 Public report to Cumbria child protection committee serious case review (conducted under the guidance of part 8 Working Together) of events leading to the death of Michael who was the victim of fabricated or induced illness (FII) (formerly known as Munchausen syndrome by proxy), March 2004
might have formed an earlier view and noted concerns. In the absence of an early definitive clinical diagnosis it is clear that maintaining, what Laming 15 described as ‘healthy scepticism’, would have been helpful. In future this will require a greater attention to recognising patterns, improvements in communication between acute clinicians and GPs and making clear records that highlight ‘only self-reported’ and/or if ‘not witnessed by professionals’. One might argue in this case that consideration regarding fabricated & induced illness could have taken place sooner in this case as there was no evidence at the time (over a period of nearly 3 years) of others/professionals witnessing seizures whatsoever and treatment was based only on mothers reports.

The LSCB may wish to consider how best to ensure all professionals, especially acute clinicians and GPs are aware of guidance and procedure (as amended) available to them in addressing the issue of fabricated and induced illness.

In addition to this, if and when reviewing the SET procedures, the LSCB may seek to review the referral documentation by health professionals for use between health disciplines to ensure that they include the factors listed in the NICE guidelines16 (p. 64) and the SET procedures17 (p. 202, 9.11.7).

7.7. Health information sharing: The use of the child protection core group once concerns had been identified is seen as a positive feature. The issue therefore seems to relate more to the period of time prior to recognition and identification of concerns about possible fabricated & induced illness. Notwithstanding the difficulties associated with agencies having different electronic databases and differing governance structures in the local health provision, there was a clear strength of feeling that improvements could be made in the way information is shared, particularly between the primary community health care providers – the GP and Health Visitor. Again, the local SET Child Protection procedures provide comprehensive guidance about information sharing and make reference to Government guidance on information sharing18. This guidance has been endorsed by a range of agencies including the GMC (General Medical Council) and the NMC (Nursing & Midwifery Council), both of whom regulate these professional groups. The issues highlighted in this review may therefore be more about professional culture and local practices e.g. local custom and practice that has developed within services. The parallel issue to consider when considering information sharing is confidentiality. The NICE guidelines (p.25) state “if healthcare professionals have concerns about sharing information with others, they should obtain advice from named or designated professionals for safeguarding children”. Suggestions offered during the learning event on how to improve practice included:

- Giving automatic consideration by GP’s to share records with Health Visitors (at present it is only the other way around);
- Having one single health record to include the GP information;,

15 The Victoria Climbié Inquiry Report, 2003, Lord Laming
16 When to suspect child maltreatment, NICE Clinical Guideline, July 2009, Royal College of Obstetricians & Gynaecologists
17 Southend, Essex & Thurrock Child Protection Procedures, 2011
18 Information Sharing: Guidance for practitioners and managers, HM Government 2008
• If the GP cannot attend the Child Protection Conference encourage them to share their information with the Health Visitor in order to represent their information;

• Health Visitors should be co-located with GP practices.

From an independent perspective, it is important not to allow the diverse interpretation of policy, procedure and protocol to prevent effective information sharing, thereby potentially adding to the risk of children being harmed.

*The LSCB will want to be reassured that cultural practices concerning the sharing of information about a child’s welfare, across the primary community based health providers, reflects guidance issued by NICE, HM Government and the GMC19, and does not place children at risk of harm.*

7.8. The mother’s perspective: The report author and one member of the review team met with the mother following the learning event. Seeking the mother’s views were an important part of this review, as it provided an opportunity to hear about agency intervention from a different perspective. Three key themes emerged from the meeting. Firstly, the mother discussed feeling sometimes overwhelmed by the number of meetings and appointments she had to attend or comply with. Secondly, she expressed some concern about whether one person knew what another was doing, as there often seemed to be so many people involved. She especially thought this was the case when it came to the number of different doctor’s she was seeing. Thirdly, the mother felt that there was no-one to support her. There were some contradictions to this final point, as she was able to describe one or two workers who were particularly supportive. She talked extensively about her learning difficulties, and a consistent issue behind these three themes, in her opinion, was the need for professionals to provide her with greater support to achieve the more basic practical tasks e.g. reading and understanding letters and reports, support her with parenting the child, and assisting her to navigate the various processes and systems so that she could take better care of the child and comply with requests. In this particular case, it has not been confirmed that the mother has learning difficulties, as she refused to be assessed during the Court proceedings.

Whilst it may be difficult to know how much weight to place on these views, as part of this review, it is not unreasonable to reflect on the levels of support all agencies might provide parents who have learning difficulties, particularly concerning some of the more basic tasks required, when they are embroiled in the formal child protection process. The LSCB may consider asking agencies to reflect on this.

8. Closing remarks

Our aim for this independent review was to identify how the multi-agency network in Thurrock can respond most effectively to concerns about children’s welfare where fabricated illness is identified.

The review has provided Thurrock LSCB with the opportunity to share and learn about many positive aspects of multi-agency practice. It has also provided them with the opportunity to learn valuable lessons, particularly about practice prior to the formal recognition and identification of fabricated or induced illness. Whilst the methodology does have limitations in respect to the rigour and depth of investigation the review has highlighted a number of areas where policy, procedure

19Protecting children and young people: The responsibilities of all doctors, General Medical Council, 2012
and practice can be strengthened. The review has offered a number of areas where it is believed that, if examined further, will assist and highlight areas for change and improvement. The responsibility for this rests with the LSCB as part of their statutory obligations for creating a local learning and improvement framework, as described in statutory guidance.²⁰

Appendix 1: Considerations & findings

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<tr>
<td>1</td>
<td>In the light of the findings and learning from this review the LSCB may wish to consider reviewing the SET procedures to ensure that they adequately reflect how other cases of fabricated or induced illness might be managed, should they occur again. For example they might benefit from reflecting the notion that adults/parents may be deceitful in their accounts of their child’s symptoms, and the need to consider the characteristics of neglect (through acts of commission or omission by the parent or carer) alongside the need to consider fabricated or induced illness (see pages 8/9). Questions were raised by the review as detailed at 5.8; the LSCB may wish to consider how best to ensure the needs and views of the child, above the needs of the parent, are best secured, particularly where the child is young and their verbal abilities may be limited or impaired.</td>
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<td>2</td>
<td>Given the information presented and findings made the LSCB may consider setting up a time limited task group to further examine the outstanding questions posed in 7.2 (see pages 9/10)</td>
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<td>3</td>
<td>In order to provide reassurance the LSCB may find it useful to undertake an audit, where children are subject to Child Protection Plans, to explore the frequency of Child Protection Conference Chairs being changed and whether this affects the overall scrutiny and decision making on cases. (see page 10).</td>
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<td>4</td>
<td>When reviewing the SET procedures the LSCB may wish to consider in what circumstances and cases a multi-agency chronology might be useful as a tool for assisting professionals manage risks to children. For example when a high number of agencies are involved in a case or where the case is particularly complex (see page 10).</td>
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<td>5</td>
<td>How can the LSCB best seek reassurance that:</td>
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<td></td>
<td>1. Information from all agencies involved with a case, particularly where there are safeguarding concerns, is appropriately shared e.g. missed appointments to ensure that this information is included in decision making?</td>
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<td>2. Health agencies discharge children at the appropriate time, rather than due to the possibility that their parents/carers failed to bring them to appointments? (See pages 10/11).</td>
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<td>The LSCB will also wish to seek reassurance that all agencies with safeguarding responsibilities have robust policies and procedures where appointments are not attended by service users.</td>
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<td>6</td>
<td>The LSCB may wish to consider how best to ensure all professionals, especially acute clinicians and GPs are aware of guidance and procedure (as amended) available to them in</td>
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²⁰ Working Together to safeguard Children, Chapter 4, 2013, HM Government
addressing the issue of fabricated and induced illness (see pages 11/12).

In addition to this, if and when reviewing the SET procedures, the LSCB may seek to review the referral documentation by health professionals for use between health disciplines to ensure that they include the factors listed in the NICE guidelines (p. 64) and the SET procedures (p. 202, 9.11.7) (see pages 11/12).

7 The LSCB will want to be reassured that cultural practices concerning the sharing of information about a child's welfare, across the primary community based health providers, reflects guidance issued by NICE, HM Government and the GMC, and does not place children at risk of harm (see page 12).