



DARLINGTON

Safeguarding Children Board

Fabricated and Induced Illness Practice Guidance



As agreed by LSCB:

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SAFEGUARDING CHILDREN IN WHOM THERE ARE CONCERNS THAT THE ILLNESS IS FABRICATED OR INDUCED

1. Introduction

- 1.2 The fabrication or induction of illness in children by a parent or carer has been referred to by a number of different terms, most commonly by Munchausen Syndrome by Proxy, Factitious Illness by Proxy or Illness Induction Syndrome. However, 'Fabrication or Induction of Illness' (FII) is the agreed term to be used locally. Fabricated or Induced Illness by parents or carers can cause significant harm to children. FII involves a well-child being presented by a parent or carer as ill or disabled, or an ill or disabled child being presented with a more significant problem than he or she has in reality, and is likely to be suffering harm as a consequence. There are particular challenges for professionals in terms of managing an FII case which are explored further in the document.
- 1.3 The key aim is to assess the impact of fabricated or induced illness on the child's health and development, and consideration of how to best safeguard the child's welfare within an agreed risk management framework such as the [multi-agency continuum of need](#) and the [multi-agency child protection procedures](#). This requires a sound and clear multi-agency approach with Children's Social Care as the lead agency and must ensure that all the appropriate health professionals, including Designated Paediatrician, to enable a thorough understanding of all aspects of the child's health and development.
- 1.4 Following identification of fabricated or induced illness in a child by a parent or 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 the outcomes for the child.
- 1.5 Any concerns about a member of staff instigating FII on children in their care should be dealt with immediately in line with the Darlington Safeguarding Children Board (DSCB) procedures for '[managing allegations and concerns against staff, carers or volunteers](#)' and to be discussed with the relevant Designated Officer.

2. Definition

- 2.1 The key issue is not what term to use to describe this abuse, but the impact of fabricated or induced illness on the child's health and development. If, as a result of a carer's behaviour, there is concern that the child is or is likely to suffer significant harm, this guidance should be followed (see also [DCSF, 2008](#)).

There are three main ways, not mutually exclusive, of a parent/carers fabricating or inducing illness in a child:

- Fabrication of signs and symptoms, for example, fabrication of past medical history.
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters, documents and specimens of bodily fluids.
- Induction of illness by a variety of means (for example deliberately inducing symptoms in a child by administering medication or other substances)

Please note FII takes a range of forms and can be difficult to recognise, but there are warning signs to look out for please see appendix one for more information.

2.2 FII is a condition whereby the child, usually under the age of five (although there is often considerable delay in the recognition of FII), suffers harm through the deliberate action of the main carer, in most cases the mother but not exclusively, but which is manipulated and attributed by the parent or carer, to another cause. For example, suffocation or deliberate poisoning of the child may be presented as cot death or an accidental overdose. Harm to a child may also be caused through unnecessary or invasive medical treatment based on symptoms that are falsely described or deliberately manufactured by the parent or carer, and lack of independent corroboration.

3. Recognition and Early Management

3.1 Indicators which should alert professionals to the possibility of FII are:

- A parent or carer reporting symptoms and observed signs that are not explained by any known medical condition.
- Physical examination and results of investigations that do not explain symptoms or signs reported by the parent or carer.
- The child having an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment.
- Acute symptoms that are exclusively reported by the parent or carer or observed in the presence of the parent or carer.
- On resolution of the child's presenting problems, the parent or carer reporting new symptoms or reporting symptoms in different children in sequence.
- The child's daily life and activities being limited beyond what is expected due to any disorder from which the child is known to suffer, for example, partial or no school attendance and the use of seemingly unnecessary special aids.
- Objective evidence of fabrication – for example, the history of events given by different observers appearing to be in conflict or being biologically implausible (such as small infants with a history of very large blood losses who do not become anaemic, or infants with large negative fluid balance who do not lose weight); test results such as toxicology studies or blood typing; evidence of fabrication or induction.
- The parent or carer expressing concern that they are under suspicion of FII, or relatives raising concerns about FII.
- The carer seeking multiple professional opinions inappropriately.

3.2 Concerns that a child may be suffering or is at risk of significant harm as a result of fabricated or induced illnesses, may be raised by a variety of professionals, family members (including a partner of the person possibly fabricating or inducing the illness) or members of the public.

4. Behaviours associated with fabricated/induced illness

4.1 Behaviours include parents or carers:

- Deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation.
- Interfering with treatments by overdosing, not administering them or interfering with medical equipment such as infusion lines.
- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting, or fits.
- Exaggerating symptoms, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous.
- Medicating for conditions such as constipation and epilepsy and/or obtaining specialist treatments or equipment for children who do not require them.
- Alleging psychological illness in a child. The majority of cases of fabricated or induced illness in children are confirmed in a hospital setting because either medical findings or their absence provide evidence of this type of abuse.
- Children displaying emotional and behavioural disorders as well as school related problems including difficulties in attention and concentration and/or non-attendance, feeding disorders in infants, withdrawal and hyperactivity in pre-school children.

4.2 The signs and symptoms presented in the child **require careful medical evaluation** for a range of possible diagnoses. Where no known reason can be found for the signs and symptoms presented in the child, specialist medical advice and tests may be required. It is imperative that all tests and their results should be fully and accurately recorded, and it is particularly important to ensure that these records are not tampered with or results altered in the child's notes.

It is very important that at all stages of investigation to differentiate between anxious or overprotective parents or carers, and those who might deliberately induce or fabricate illness in their child.

4.3 It is important to note that parents or carers who may fabricate or induce illness in a child, may continue to attend a number of hospitals in their pursuit for further investigation or treatment, including asking for second opinions. It is therefore important to ensure that as much medical information about the child and the histories of the child's presentation for treatment is fully examined and recorded.

5. What to do if you are concerned?

5.1 When a possible explanation for reported or actual signs and symptoms in a child is that they may have been fabricated or induced by a parent or carer and as a consequence the child's health or development is or is likely to be impaired the professional should discuss the case with their designated safeguarding lead and follow their own agency safeguarding procedures.

5.2 Consideration to a health professionals meeting should be given to assess the comprehensive reported health concerns and compile a health chronology, The health chronology should be as fully integrated as possible and should include; information from primary, secondary and tertiary care and from medical, nursing

and therapy professionals. The GP can play a key role in recognising patterns of worrying behaviour from multiple presentations at different settings and in making concerns known to the hospital team. It is therefore crucial to seek information from the primary care team and to liaise with the GP. It is also important to obtain information from day care or school about the child's state of health and functioning ([RCPCH 2012](#)).

- 5.3 Where there are sufficient concerns that a child may be suffering or is likely to suffer Significant Harm resulting from a parent or carer's persistent attempt to fabricate, induce or exaggerate an illness a formal referral should be made to children's services as soon as possible.

6. Making a referral

- 6.1 The most important principles in dealing with issues of suspected fabricated or induced illness in children are:

- (i) the necessity of multi-agency co-operation in information gathering and planning and
- (ii) the exclusion of the parent or carer from knowledge that this process is going on until the initial investigation stages are complete.

- 6.2 If you are concerned you must discuss with your manager or designated person responsible for child protection within your organisation. [Darlington Safeguarding Children Boards' multi-agency Child protection procedures](#) must be followed in cases of suspected fabricated or induced illness as soon as it is suspected.

- 6.3 If you believe the child may be at risk of significant harm or is Child in Need as defined by S17 of the Children Act 1989, you should contact the [Children's Access Point](#).

e-mail: childrensaccesspoint@darlington.gcsx.gov.uk

Telephone Number: 01325 406222

- 6.4 In situations of possible induced or fabricated illness **practitioners should not discuss their concerns with the parents/carers**. This is because such discussion may increase the risk of significant harm to the child. Decisions about what discussions are to take place with the parents or carers are to be made on a multi-agency basis, following the referral to Children's Social Care. In cases of suspected fabricated or induced illness, **the seeking of permission from parents or carers to the referral should only be done following discussion and agreement by all the agencies involved so that this will not place a child at increased risk of significant harm.** ([NSPCC definition](#) 'Disguised compliance' *'which involves a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention'*).

- 6.5 The child's best interests must be the overriding consideration in making decisions about sharing information. At no time should a concern be shared with the parent or carer until there is sufficient evidence to enable decisive action. Decisions should be agreed between the referrer and Children's Social Care (in line with Darlington's Child Protection procedures), about what the parents or carers will be told, by whom and when and details recorded on the child records.

- 6.6 Upon receipt of a contact Children's Services, the Children's Access Point has 24 hours in which to make a decision about any actions to be taken in respect of the child. When a decision is made that a contact should progress, it will be allocated to the relevant team and should be communicated to the original professional who made the initial contact. When safeguarding concerns are identified at the Single Assessment stage, a multi-agency strategy discussion should be held to determine if a Section 47 enquiry should be progressed. A series of strategy meetings may be required before a conclusion is reached on the need to start a Section 47 enquiry. It may be helpful for the first strategy meeting to scope the nature of the concerns, agree what further information is needed, how this will be gathered, and also whether immediate action is required. All agencies/professionals should produce a completed chronology for this and for subsequent strategy meetings.
- 6.7 Senior staff from each agency should attend the strategy meeting and should be sufficiently senior to be able to make decisions on behalf of their agencies.
- Children Services
 - Police
 - Education, nursery /school
 - Probation YOS, FIT
 - Health
- 6.8 The relevant health professionals will be invited to the Strategy Meeting:
- Medical Consultant responsible for the child's health care
 - Senior Ward Nurse (if the child is an in-patient)
 - GP
 - Health visitor/School Nurse
 - Named/Designated Dr
 - Named/Senior Safeguarding Children Nurse
 - Consideration may be given to inviting medical staff with expertise in the branch of medicine which deals with the presenting symptoms and illness
 - Tertiary centres involved and Senior Consultants as appropriate
- 6.9 Decisions about what discussions are to take place with the parents or carers, and by whom, are to be made at the strategy meeting (and the referrer should be advised).
Staff may be required to provide a chronology prior to the strategy meeting or this may be requested following the meeting.

Within this strategy discussion/meeting in cases where it is suspected that illness has been fabricated or induced, other issues for discussion should also include:

- Arrangements for the immediate protection and care of the child, including whether the child requires constant professional observation and if so, whether or when the parents or carers should be present.
- The nature and timing of any police investigations including the analysis of samples including use of police intelligence tools as appropriate.

Possible outcomes of the strategy meeting(s):

- No further action by Children's Care
- Provision of Services by one or more agencies
- Continued monitoring of specific concerns by identified professionals including responsible officer to lead on the monitoring activity
- Section 47 Investigation
- Immediate Legal Action to protect the child(ren)

- A further strategy meeting or series of meetings, and/or an Initial Child Protection Case Conference

7. Additional guidance

7.1 Professionals

Ensure that the people with the most relevant information attend initial Strategy Meetings. Once the level of risk becomes clearer it may be necessary to involve more senior professionals, with less direct knowledge of the situation, but who can authorise decisions such as emergency care proceedings or use of high level police intelligence tools.

Consider obtaining consultation from someone with experience and expertise in working with fabricated or induced illness.

Special attention should be paid to the medical records not just of the child in question but all the children in the family (including children, parents and carers who may have died or no longer live with the family and carers). This is because people who induce illness in children frequently fabricate illness themselves and may have injured other children in circumstances that were not questioned previously. It is the role of the Consultant Paediatrician to collate the relevant medical records.

Designate a medical practitioner to oversee and co-ordinate the medical treatment of the child to control the number of specialists and hospital staff the child may be seeing. This will usually be the Consultant Paediatrician.

Splits in the professional system often develop around those who support and those who suspect the mother. The mother, who may play one worker off against the other, sometimes deliberately engineers this splitting. Splitting can also be a result of anxiety often experienced within the professional system in the period when information is beginning to emerge but action is not yet taken.

Extreme care should be taken with confidentiality. This includes limiting attendance at Strategy discussions to people invited on a strict 'need to know' basis and careful management of the recording of information and decisions on case notes and medical records to avoid premature disclosure to the suspect.

Supervision arrangements may be particularly important when the child is in hospital and discharge planning is essential when a child is well enough to leave.

The decision to convene a Child Protection Conference should be informed by the need to have all the evidence thoroughly documented, and protection of the children already in place. It may necessitate conferences being called outside of recommended time scales.

Consideration should be given as to how the suspected parent or carer is challenged.

7.2 Parent or Carers presentations:

- Be prepared for the parent or carer to present as very plausible and well informed as to the nature of the child's medical problems.
- Information received directly from the family, especially the suspected abuser should be subject to independent verification to ensure its validity.
- Avoid confrontation with the suspected parent or carer until adequate evidence is obtained and a protection plan for the child is constructed.
- Keep focus on the impact of the parent or carer's behaviour on the child when assessing levels of risk. Many parents or carers who are suspected of Fabrication or Induction of Illness in children display differing behaviours themselves which might suggest mental health illness. It is important always to keep in mind the question of how her/his behaviour influences the safety and functioning of the child.
- Establishing more about the parent or carer of the children and not just the children themselves - Children under the age of five, especially preverbal children and children with an existing bona fide illness, disability and/or communication difficulties are at greatest risk because of their inherent vulnerability.
- Before placing children with other members of either extended family, be sure that thorough assessment of them has taken place. It is not uncommon for Fabricated or Induction of Illness to be a feature of the family behaviour in previous generations. Any alternative carer should demonstrate an ability to believe that the suspected abuser may have posed a risk to the child. This may be hard to ascertain if the alternative carer is a relative.
- Most importantly, whilst undertaking the assessment, ensure that **the child is spoken to and asked how they feel, how they think they became ill**; in some cases, it has been known that the child has known all along what the parent or carer has been doing, but has not been able to say. This has to be carefully undertaken as not to raise the suspicions of the suspected abuser.

8. Research, evidenced based practice and resources

[Working Together to Safeguard Children](#) – a guide to inter-agency working to safeguard and promote the welfare of children (2015)

[Multi-agency Child Protection Procedures](#) - Darlington Safeguarding Children Board

[Information Sharing Protocol](#) – Darlington Safeguarding children Board

[NSPCC Research Briefing](#) – FII in children a rare form of child; abuse (July 2011)

[The Royal College of Paediatrics and Child Health](#) (RCPCH) report – Fabricated or Induced Illness by Carers: A practical Guide for Paediatricians (2009)

[The National Institute for Health and Care Excellence](#) (NICE) guidance on when to suspect child maltreatment including fabricated or induced illness.

[Safeguarding Children in Whom illness is Fabricated or Induced](#) – Department for Health (2002)

[Safeguarding children in Whom illness is Fabricated or Induced](#) – Department for Children Schools and Families (2008)

Research

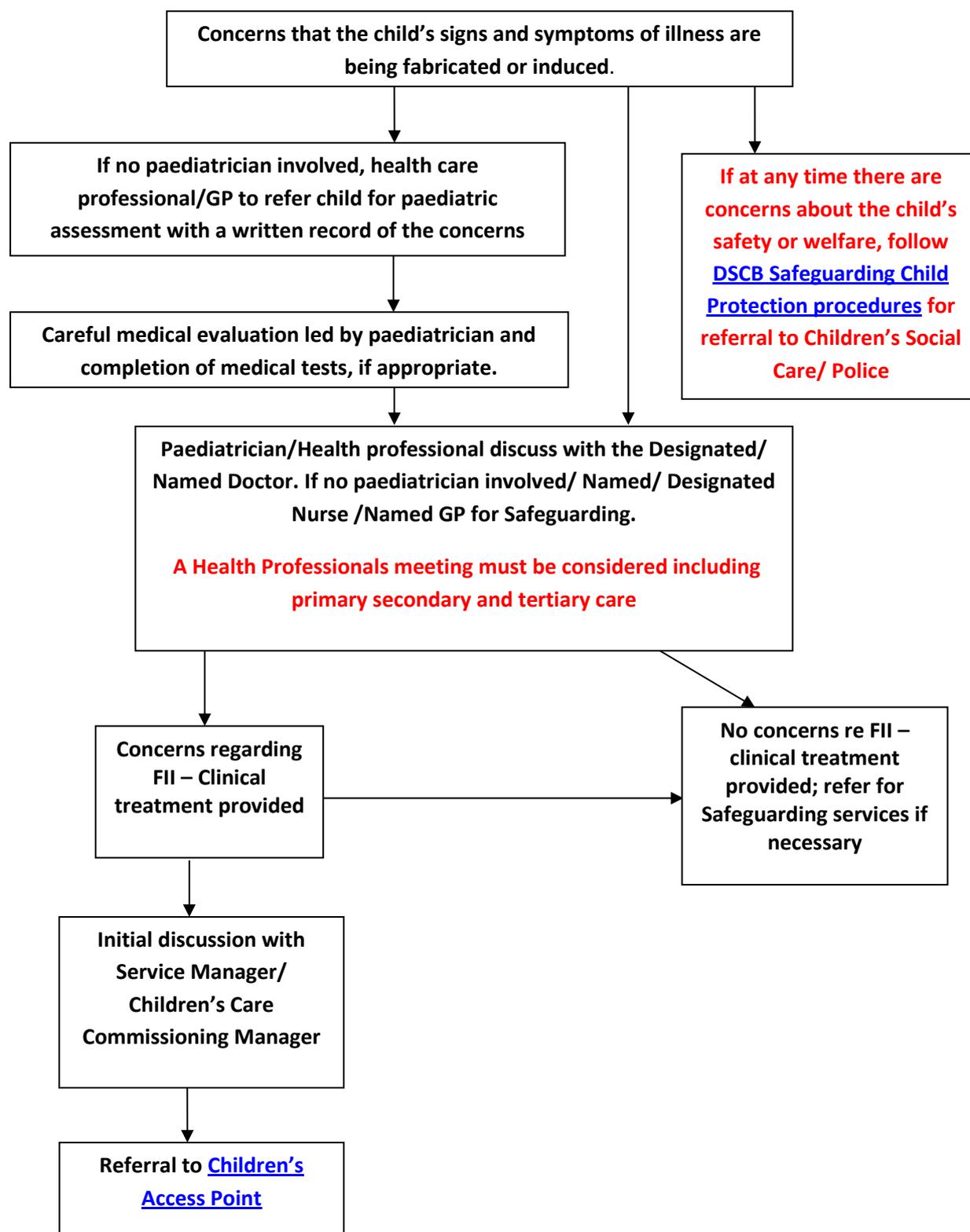
Central European Journal of Immunology - [Fabricated or induced illness in the oral cavity in children](#) – a systematic review and personal experience – Dorota Olczak-Kowalczyk, Beata Wolska-Kusnierz, Ewa Bernatowska (2015)

British Journal of Psychiatry (BJPSych) – the British Journal of Psychiatry – [Psychopathology of perpetrators of fabricated or induced illness in children](#): case series – Christopher Bass and David Jones (2011)

Pediatrics Official Journal of the American Academy of Pediatrics Case Report: [When an Induced Illness looks like a rare disease](#) – Ivana Rabbone, Alfonso Galderisis, Davide Tinti, Maria Giovanna Ignaccolo, Fabrizio Barbetti and Franco Cerutti (2015)

American Academy of Pediatrics – Caregiver – [Fabricated Illness in a child: A manifestation of child maltreatment](#) – Emalee G Flaherty, Harriett L MacMillan and Committee on Child abuse and Neglect (2013)

ADDITIONAL INFORMATION FABRICATED INDUCED ILLNESS FLOWCHART



Warning Signs of fabricated or induced illness

The abuse that occurs in fabricated or induced illness (FII) takes a range of forms and can be difficult to recognise, but there are warning signs to look out for.

[The National Institute for Health and Care Excellence](#) (NICE) guidance on when to suspect child maltreatment states that fabricated or induced illness may first be suspected if:

- physical or psychological examination and diagnostic tests do not explain the reported signs and symptoms

One or more of the following warning signs must also be present:

- symptoms only appear when the parent or carer is present
- the only person claiming to notice symptoms is the parent or carer
- the affected child has an inexplicably poor response to medication or other treatment
- if a particular health problem is resolved, the parent or carer suddenly begins reporting a new set of symptoms
- the child's history of symptoms does not result in expected medical outcomes – for example, a child who has supposedly lost a lot of blood but doesn't become unwell
- the parent or carer has a history of frequently changing GPs or visiting different hospitals for treatment, particularly if their views about the child's treatment are challenged by medical staff
- the child's daily activities are being limited far beyond what you would usually expect as a result of having a certain condition – for example, they never go to school or have to wear leg braces even though they can walk properly

Other identified warning signs include:

- the parent or carer having good medical knowledge or a medical background
- although the parent or carer is very attentive to the child and stays with them constantly in hospital, they do not seem too worried about the child's health – or overly worried in relation to the health professional in charge of their child's care
- the parent or carer trying to maintain a close and friendly relationship with medical staff, but quickly becoming abusive or argumentative if their own views on what is wrong with the child are challenged
- one parent (usually, but not always, the father) having little or no involvement in the care of the child
- the parent or carer encouraging medical staff to perform often painful tests and procedures on the child (tests that most parents would only agree to if they were persuaded that it was absolutely necessary)

Patterns and levels of abuse

The patterns of abuse found in cases of FII usually fall into one of six categories. These are ranked below, from least severe to most severe.

In the more severe cases of FII, the parent or carer may carry out behaviour from several or all categories.

The categories are:

1. exaggerating or fabricating symptoms and manipulating test results to suggest the presence of an illness
2. intentionally withholding nutrients from the child or interfering with nutritional intake
3. inducing symptoms by means other than poisoning or smothering – such as using chemicals to irritate their skin
4. poisoning the child with a poison of low toxicity – for example, using a laxative to induce diarrhoea
5. poisoning the child with a poison of high toxicity – for example, using insulin to lower a child's blood sugar level
6. deliberately smothering the child to induce unconsciousness

Previous case reports of FII have uncovered evidence of:

- parents or carers lying about their child's symptoms
- parents or carers deliberately contaminating or manipulating clinical tests to fake evidence of illness – for example, by adding blood or glucose to urine samples, placing their blood on the child's clothing to suggest unusual bleeding, or heating thermometers to suggest the presence of a fever
- poisoning their child with unsuitable and non-prescribed medicine
- infecting their child's wounds or injecting the child with dirt or faeces (stools)
- inducing unconsciousness by suffocating their child
- not treating or mistreating genuine conditions so they will get worse
- withholding food – which results in the child failing to develop physically and mentally at the expected rate

Assessment of risk and safety planning

- Level of risk of harm to the child, that they may have already suffered;
- The risk of future harm and complicating factors;
- Current safety arrangements already in place;
- Any immediate steps necessary to reduce the risk of harm (for example cancelling unnecessary medical procedures or instituting closer observation of the child or whether the parent/carer should be allowed on the ward if the child is an inpatient, if this is deemed unsafe then consideration will need to be given to an Emergency order which may need to be instituted by either the police or the Local authority);
- Any potential implications for other patients or their carers who are on the ward at the time;
- Consideration of the child's safety network and how it may be used to provide immediate safety;
- How the child can be given the opportunity to tell their story – this requires careful consideration and planning;
- Consideration of how all involved health professionals can work together to ensure a coordinated, informed response to any health problems;
- What is known about the parents/carers' past behaviour, medical history, current health, aids and benefits being received either for themselves or the child;
- Consider risk to other siblings.

And should also include:

Joint decisions about what discussions are to take place with the parents/carers and by whom (must have medical input), must be made in the strategy meeting (and referrer should be advised).

Information gathering

- Any information investigations, further information gathering and any other opinions that would be helpful;
- The planning of further medical and nursing assessments
- The need for forensic sampling, direct observation or covert video surveillance:
- Development of Chronologies (if not already completed), agree who should do this.

Agencies should share information about their involvement with the family and any evidence to support the possibility of FII. This should include all chronologies completed at this point particularly any medical chronologies.

The meeting should look at the available the information, to consider whether there is sufficient information to make a decision on Fabricated or Induced Illness at this stage, or what further information is required.

There may be insufficient information to make a firm diagnosis at this stage but it may be felt there are sufficient concerns to open a formal section 47 investigation.

Analysis of the information within the FII Strategy Meeting

To ensure the meeting analyses the holistic view of the child and not just the concerns regarding FII.

Action Planning

Plan for joint communication with carers including how, when and by whom (must involve health professional) they should be informed of any child protection concerns.

The Action Plan needs to also cover the following areas:

- Responsibility for child and Family Assessment (care must be taken not to raise parents/carers anxiety by either not allowing them to know reason for assessment and disclosing FII before agreed disclosure process, the assessment should be holistic approach to concerns expressed about the development of the child);
- The security of the medical records;
- The level of professional observation required;
- Whether there should be use of covert video surveillance;
- Addressing the needs of the siblings and other children in the family;
- Addressing the needs of carers, particularly after disclosure of concern;
- Clarification of who will be Responsible Paediatric Consultant for the child (if not already explicit).

Recording

The meeting should be formally recorded as a strategy discussion by the chair.

The minutes of the meeting should include:

- Date, time and name of meeting;
- Name of child/family concerned;
- Attendance/apologies;
- Arrangements for child's safety, including periods of contact with the alleged abuser;
- Main points regarding medical information;
- Whether diagnosis of Fabricated or Induced Illness made;
- Whether, and what, further information required;
- Conclusion and analysis of risk;
- Plan of action showing who is responsible for each task and timescales;

Disclosure of Concerns to the child's parents/carers

If the strategy meeting agrees that there are concerns about FII and that other agencies need to be involved, the possibility of FII will need to be discussed with the parents/carers. Professionals should be supported through the process of disclosure and the approach should be agreed in the strategy.

The disclosure should be made in the presence of at least one other professional. In most cases the discussion will involve the Responsible Paediatric Consultant jointly with a social worker and/or the police. However, in cases where the police obtain evidence that a criminal offence has been committed, it is important that the paediatrician does not confront the parent/carers. This must be done by the police in order to ensure that the parent/carer's rights are protected in accordance with the Police and Criminal Evidence Act 1984.

The carers should be invited to discuss the child's progress in an appropriate place which provides privacy and confidentiality. If the child is an inpatient, the meeting should be away from the bedside. If possible, both parents/carers should be present at this meeting.

FII is not confirmed

In cases where the child's perceived illness is not explained and FII is not confirmed. Again the strategy meeting should have planned for how the parents/carers will be informed of these concerns.

The discussion should be with more than one professional (in most cases the Responsible Paediatric consultant should be involved) and the discussion should be honest about reason for suspecting FII and give a plan for rehabilitation of the child back to normal functioning, including return to school, withdrawal of unnecessary equipment or aids and stopping unwarranted medication.

Consent should be sought from the carers for the child to be supported under section 17 of the Children Act 1989, and consideration of the child becoming involved with CAHMS as other areas of the child's development may have been identified within the Strategy meeting as cause for concern. If the parents are unwilling to accept this approach there may be a need for further multi-agency discussion.

Case notes of the meeting should be clearly recorded and placed in the confidential part of the child's records.