

Fabricated and Induced Illnesses and Supervision Orders Learning Event



**Suffolk
Safeguarding
Partnership**



**Norfolk Safeguarding
Children Partnership**

The background of the slide features three 3D humanoid figures standing on a dark, reflective surface. From left to right, the figures are grey, orange, and white. They are all facing forward with their arms slightly outstretched. The orange figure is in the center, the grey figure is to its left, and the white figure is to its right. The figures have a simple, rounded design with no facial features. The white figure's right arm is extended towards the orange figure. The orange figure's right arm is also extended towards the white figure. The grey figure's right arm is extended towards the orange figure. The figures are standing on a dark, reflective surface that shows their reflections. In the top left corner, there is a small blue rectangle. The text "Welcome and Introductions" is written in white, bold, sans-serif font on the left side of the slide, with a horizontal white line underneath it.

Welcome and Introductions

Agenda

- Welcome and Introduction – Bridget Griffin
- Introduction to Fabricated and Induced Illness – Jo Stroud
- Consultation on new FII Guidance – with tabletop discussion – Richard Allen
- Coffee Break
- Supervision Orders – with tabletop discussion - Carmen Hawkes, Sarah Whitworth, Polly Mann and Kate Lonergan
- Plenary – Abigail McGarry

Fabricated or Induced Illness

JO STROUD- PROFESSIONAL ADVISOR
SUFFOLK SAFEGUARDING PARTNERSHIP



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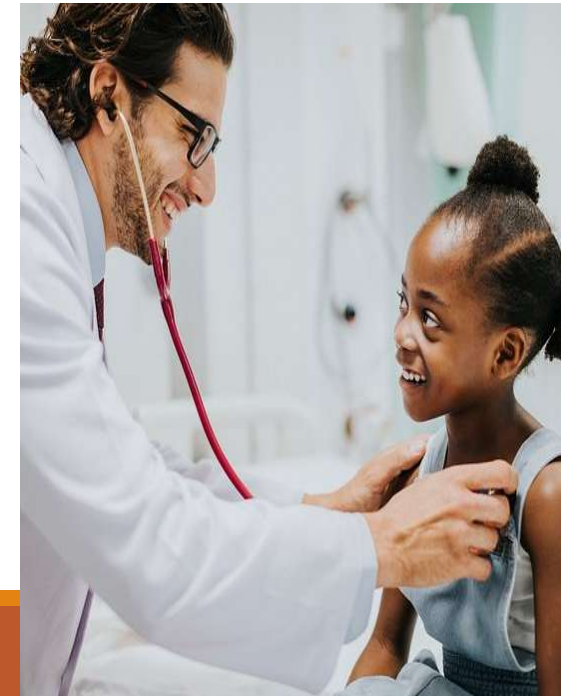
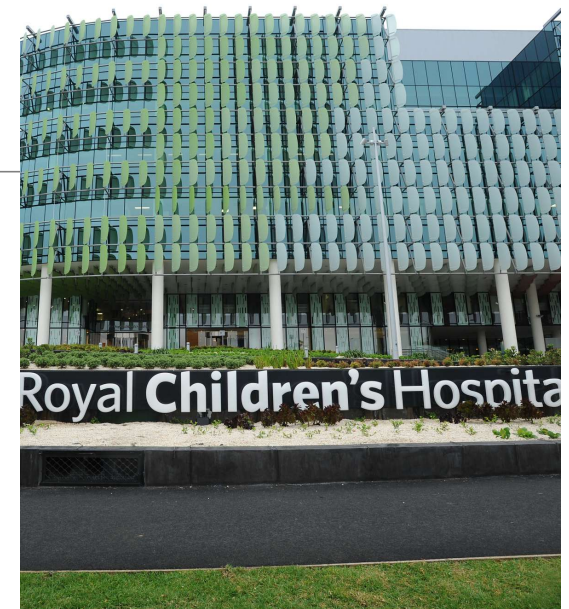
Today's morning Session

Introduction to FII- it's history, what it is and what it isn't

What do we know about FII? What does the research tell us?

The emotional landscape for professionals and families when there are FII concerns

What makes FII cases so challenging?



Setting the Scene



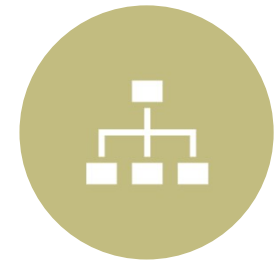
**SUGGESTED
INCREASE IN
PROFESSIONAL
CONCERN
RELATING TO FII**



**NATIONAL
REPORTS OF
INCREASE IN
REFERRALS TO
CYPS UNDER THE
UMBRELLA OF FII**



**RCPCH GUIDANCE
(2021) AND
INTRODUCTION
OF THE IDEA OF
PERPLEXING
PRESENTATION**



**REVOLVING DOOR
OF
NOMENCLATURE**

Language & Definitions

Medically Unexplained Symptoms (MUS)

- Child's symptoms, which are presumed to be genuinely experienced, are not fully explained by any known pathology.
- Symptoms are likely based on underlying factors in the child (usually of a psychosocial nature) and this is acknowledged by both clinicians and parents.
- The health professionals and parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child or young person.



RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health

**Perplexing Presentations (PP) /
Fabricated or Induced Illness
(FII) by carers**

RCPCH guidance

Language & Definitions

Perplexing Presentations (PP)

- There are alerting signs of possible FII (not yet amounting to likely or actual significant harm)
- When the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life.
- *The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.*



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**Perplexing Presentations (PP) /
Fabricated or Induced Illness
(FII) by carers**

RCPCH guidance



What is FII?

Fabricated or Induced Illness

‘when a caregiver elicits health care on the child’s behalf in an unjustified way’ (Bass & Glaser, 2014, p.1412)

‘when a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child’s state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case (RCPCH), 2021, p.11).

A large, irregular orange brushstroke shape serves as a background for the text. A thin horizontal line is visible behind the top of the brushstroke.

**What does research
tell us about FII?**

The Emotional Landscape of FII cases



The experiential impact of these types of multi-agency interactions within FII casework was described by practitioners as “frustrating”, “tension-filled”, “a struggle”, “stressful” and “emotional”.

What makes FII case work so challenging?

MULTI-AGENCY WORKING:

“EVERYONE WANTS TO DO THEIR BEST FOR THE CHILD BUT THE WAY THAT IS ACHIEVED WE ARE OFTEN AT ODDS ABOUT”.

BASW/RCPCH guidance

Differing professional approaches to evidencing the threshold for identifying FII

A lack of clarity on roles and responsibilities

A lack of confidence in understanding and applying process

Complexity of health needs and specialist knowledge

Who has the authority/power to make decisions.

Lack of single point of contact can lead to poor information sharing/misunderstanding

FAMILIES:

“THE *DOCTOR-PARENT RELATIONSHIP CAN CONFLICT WITH THE DOCTOR-PATIENT (CHILD) RESPONSIBILITY” (WILSON, 2001, P. 296).

Emotive reality of building relationship vs respectful uncertainty

Concerns that existing processes are overly critical of children and parents with particular conditions including NDD

Balance of parental choice/the parent or child as the expert vs professional experts

Medically complex cases may not always have a clear diagnosis/ diagnostic route- Children often have an evidenced medical diagnosis. Possibility of Diagnostic Overshadowing.

Right to choose can isolate services- establish the need for cross-boundary working

Ascertaining the voice of the child for children who may be non-verbal/atypical ways to communicate

Summary

FII related case work is emotive, hard, protracted, complicated, time-consuming and often hallmarked by professional conflict

- Practitioners must hold the tension between inter-agency working and that of **the importance of hearing the voice of the child**.
- Practice frustrations arise from the lack of agreed definitions and poor perceived acuity of existing processes but professionals have a unified desire to secure better outcomes for children and their families.
- The resolution of professional conflict in FII and the improved management of FII cases lies with **the right person, in the right role at the right time**.
- If we are to work effectually in partnership, roles and responsibilities need to be agreed and clearly defined. This enables expertise to be optimised as well as utilised to strengthen collaborative decision making within the professional group.



Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children NSCP/SSCP guidance

DR RICHARD ALLEN AND DR RACHEL FURLEY

DESIGNATED DOCTORS FOR SAFEGUARDING CHILDREN

NORFOLK AND SUFFOLK ICB



Background

Previous RCPCH FII Guidance published 2013

Conceptual changes around this area over last 10-15 years

Previous guidance 'binary'

- Paediatricians were asked 'is it FII or not?'
- Arose from the most severe cases – eg children being poisoned by parent – and hence there was often secrecy around cases with families not being informed for fear of increasing the risk to the child
- Lack of a collaborative approach with families
- Potential difficulties caused between families and multiagency partners

Perplexing Presentations (PP) /

Fabricated or Induced Illness

(FII) by carers

RCPCH guidance

Revised RCPCH Guidance (2021)

HENCE NEW RCPCH GUIDANCE
PUBLISHED WITH AN AIM TO
PROTECT CHILDREN FROM HARM,
BUT ALSO:

- Wherever possible work sensitively and collaboratively with parents and families
- Explicit differentiation of FII from PP and recommends different strategies for managing both scenarios

NSCP/SSCP Policy



Recommendation from a recent Norfolk Safeguarding Practice Review was for the current FII Policy to be reviewed and for the adoption of the same policy across the Norfolk and Suffolk Partnerships

The RCPCH guidance has been adopted by nearly all local authority areas in the UK

Consultations have previously been held with colleagues in Health, Social Care, Police and Education in Norfolk

Discussions have taken place between Designated Team and Social Care leads in Norfolk and Suffolk to agree a policy that can be adopted in both localities

FII - Key Concepts

- FII is about harm – not just deception
- It is rare
- Poses potential immediate serious harm to child's health/life
- Intent may be absent or unclear
- Requires prompt safeguarding discussion, referral to CSC and assessment of impact on child, not motive
- Parents not routinely informed of referral



Impact on Child - Health

- REPEATED UNNECESSARY INVESTIGATIONS
- POTENTIAL FOR IATROGENIC HARM
- GENUINE ILLNESS MAY BE MISSED
- POSSIBLE INDUCED ILLNESS (OR DEATH)



Impact on Child – Development

- POOR SCHOOL ATTENDANCE
- RESTRICTED NORMAL ACTIVITIES
- SOCIAL ISOLATION
- REINFORCEMENT OF 'SICK ROLE'



Impact on Child – Psychological

- ANXIETY AND CONFUSION
- DISTORTED HEALTH BELIEFS
- DEPENDENCY ON CAREGIVER
- POSSIBLE COLLUSION IN FABRICATION



Mechanisms of FII

- Fabrication of symptoms/history
- Falsification of records/tests/specimens
- Induction of illness (poisoning, suffocation, withholding care)



FII – Alerting Signs - Child



- Symptoms not independently observed
- Implausible or physiologically impossible findings
- Inconsistent clinical picture
- Poor response to appropriate treatment
- Functional impairment without clear cause

FII – Alerting Signs - Parent



- Persistent demand for investigations
- Multiple providers/opinions
- Frequent new symptoms reported
- Resistance to professional communication - frequent complaints
- Speaking for child / limiting direct assessment
- Requests for extreme interventions

Role of Health

- Paediatrician leads clinical evaluation (if not already involved needs referral)
- Establish 'paediatrician of reference'
- Avoid duplicated/unnecessary investigations
- GP provides longitudinal context



FII – Risk Assessment

- Key question: *Is there immediate risk of significant harm?*
- Indicators:
 - Illness Induction eg poisoning, suffocation (physical abuse)
 - Active deception (eg tampering with medical treatments or investigations)
- If YES → urgent referral to Social Care/Police



Perplexing Presentations (PP)

Much more common than 'true' FII...

Alerting signs in themselves are ***not evidence*** of FII

A single alerting sign by itself is unlikely to be FII

They are indicators of ***possible FII*** which require further assessment, investigation and management

Complex, challenging, time-consuming...



Possible alerting signs identified by other professionals

Discuss with safeguarding leads in own organisation to agree next steps

A 'health view' will be needed - discuss with child's paediatrician (if involved) or GP

ICB Designated Team can provide advice/support

GP as record keeper will have access to most information about the child's health and may also be aware of parental health issues

Cases which remain of concern should be ***referred to a paediatrician for medical assessment***

Managing PP
(No Immediate
Risk)

Consultant-led (with support of Named
or Designated Doctor)

Gather full chronology

Verify diagnoses

Assess real-world functioning (school,
daily life)

Seek child's voice

Multiagency Working

Discussion with parents about the perplexing nature of their child's presentation at an early stage (where this is not felt to increase risk)

- Share information proportionately
- Safeguarding overrides consent where necessary
- Include GP, education, social care
- Use formal professionals meetings
- Develop Health and Education Rehabilitation Plan (HERP)

Health and Education Rehabilitation Plan (HERP) - Purpose

- Establish actual health baseline
- Restore normal functioning
- Reduce medicalisation
- Reintegrate education





HERP – Key Features

- CONSULTANT-LED PLAN
- EXPLICIT GOALS AND TIMELINES
- MULTIAGENCY INVOLVEMENT
- REGULAR REVIEW
- ACTIVE FAMILY ENGAGEMENT REQUIRED

HERP

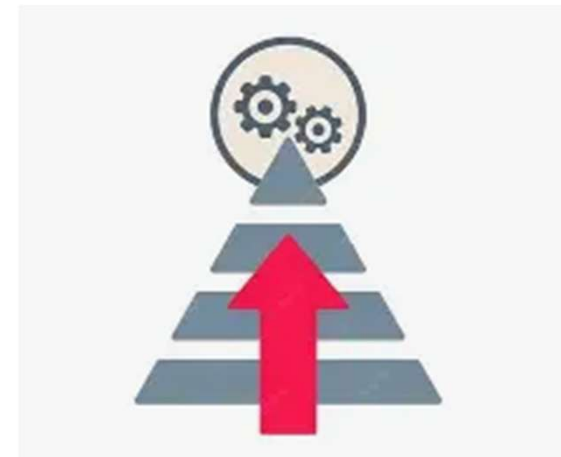
Health and Education Rehabilitation Plan Template

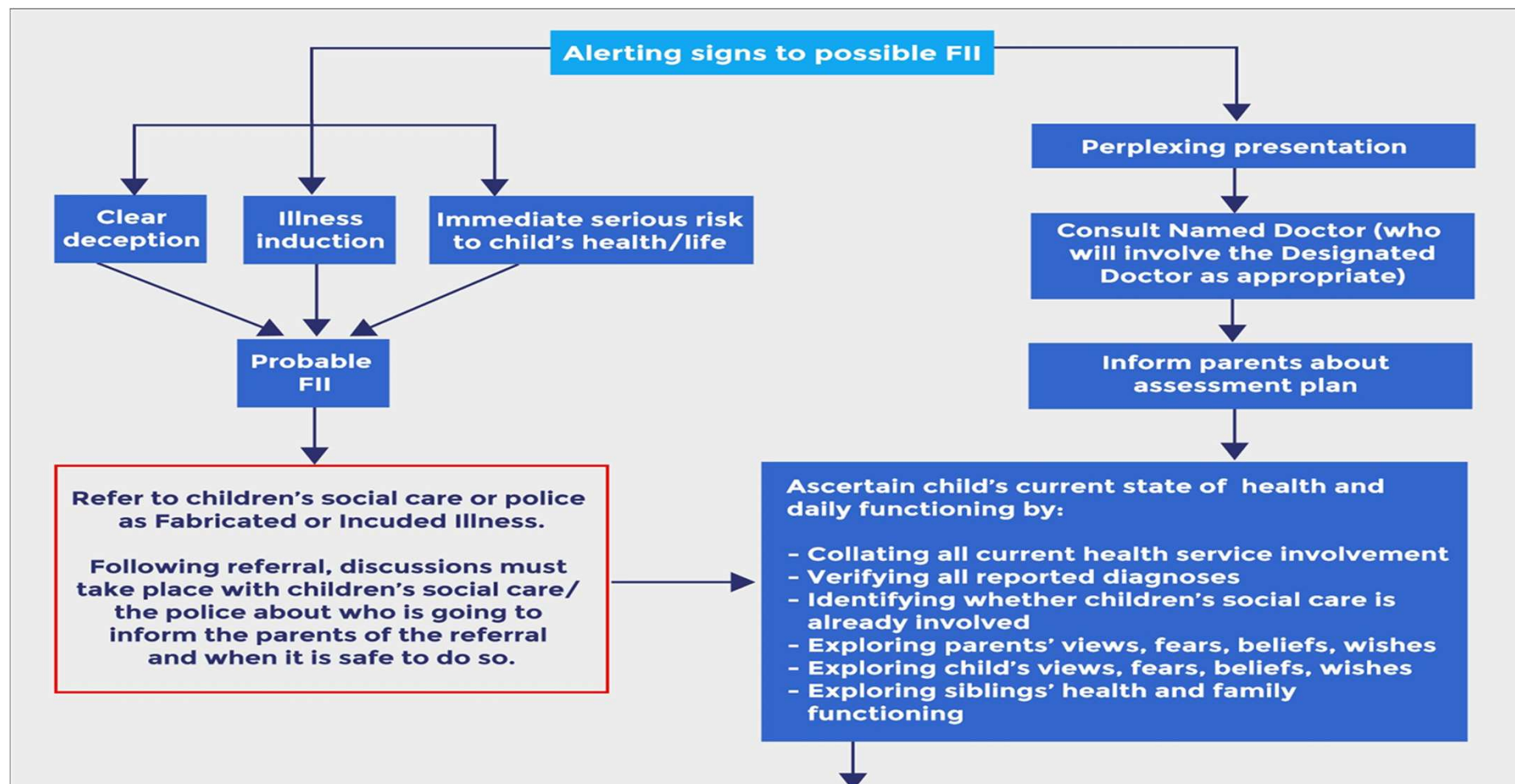
Child's name: _____ Name of responsible clinician: _____

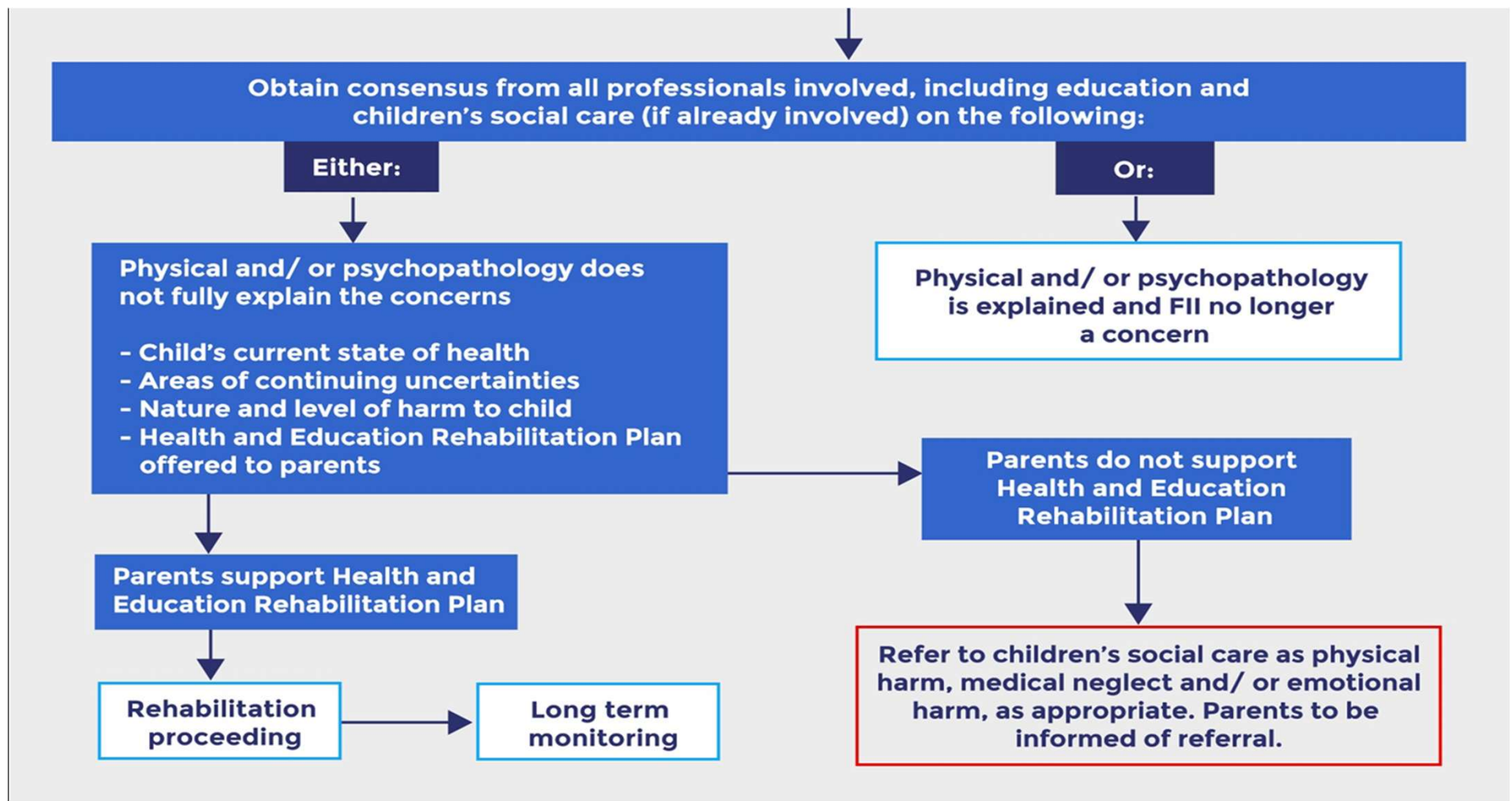
What does the child need?	Actions to achieving goal:	Who will ensure this happens?	When by?	Outcome for child:	Date for review:

Escalation?

- Non-engagement with HERP
- Ongoing uncertainty causing harm
- Increasing evidence of fabrication/induction
- → Refer to Children's Social Care







Strategy Discussion

- Multiagency decision-making forum
- Share all available intelligence
- Plan investigation and safeguarding
- Consider need for Section 47 enquiry

Section 47 Enquiry

- Triggered by suspicion of significant harm
- Defines investigation plan
- Includes medical, social and police input
- Considers siblings and wider risks

Possible Outcomes

- No substantiated concerns → support services
- Concerns but low risk → Child in Need plan
- Significant harm → Child Protection Conference

Key Safeguarding Messages

- Focus on lived experience of the child
- Harm can be immediate and severe or cumulative and subtle
- Professional over-investigation can contribute to harm
- Early coordinated and collaborative action is critical
- When a family moves, essential safeguarding knowledge can be lost
 - timely and effective sharing is paramount

Learning from Safeguarding Practice Review

- Child V - 2020



Child V – Family Context

Child V lived with both biological parents and siblings.

There had been prior Children's Social Care (CSC) involvement relating to supervision concerns.

The father had previous safeguarding history with another child.

Child V - Pregnancy and Birth

Mother presented late in pregnancy requesting termination, which was declined

Child V was born prematurely and required care on NICU

Due to prematurity, there was no antenatal multi-agency planning, and key assessments (e.g. Health Visitor antenatal visit) were missed

Child V – Early Clinical Presentation (Birth to 3 months)

On discharge, Child V was clinically stable (feeding and breathing normally)

Despite this, parents presented with concerns of:

- Apnoea episodes
- Feeding difficulties

Speech and Language Therapy confirmed normal sucking ability, recommending bottle feeding

Mother showed signs of reluctance to continue oral feeding

Child V – Hospital Presentations and Interventions

Respiratory Issues

At 3 months, Child V was referred to a tertiary centre due to parental concerns about breathing

Sleep studies showed some self-resolving apnoeas (prematurity-related)

Oxygen therapy was initiated as a short-term measure but continued (inappropriately) for nearly 2 years

Child V – Hospital Presentations and Interventions

Feeding Difficulties and Gastrostomy

Referral for feeding issues to another hospital led to misinterpretation of prior history (assumed abnormal swallow incorrectly)

No comprehensive swallow assessment completed

Mother forcefully advocated for surgical intervention, and a PEG (gastrostomy) was inserted at 7 months without full investigation

Child remained enterally fed until age 2, despite limited clinical justification

Child V – Recurrent Hospital Presentations

Multiple admissions to different hospitals including concerns about feeding and poor weight gain

Minimal parental visiting at times – different views about parents' care – some felt it was 'exemplary' while others had concerns

Father felt to 'take a back seat' when seen

Mother noted to have apparent high level of medical terminology/knowledge and questioned need for 'deep suctioning' and tracheostomy – neither clinically indicated

Multiple complaints against staff

Concerns were often attributed to family stressors, rather than safeguarding risk

Child V - Safeguarding Events – later infancy

Fractured Femur

Occurred while inpatient in sole care of mother

Initially not confirmed on X-ray (reducing concern) but later identified

Mother's explanation accepted - no safeguarding referral made.

Subdural Haematoma with Retinal Haemorrhages

Later, presented with suspected head injury (different hospital)

Strategy discussion held, but no Section 47 enquiry initiated – Section 17 (CWD)

Possible explanation given of rare life-limiting condition, though this was not confirmed. Later testing was negative, but this did not lead to a review of safeguarding concerns

Recommendation for “vigilance” was not widely shared across professionals.

Child V – Possible Salt Poisoning/Metabolic Crisis

Presentation with high sodium and glucose levels (life-threatening)

No medical cause identified

Team considered possible intentional administration (salt poisoning)

No referral to CSC/MASH

No discussion with known professionals (e.g. social worker)

Decision-making was based on lack of “certainty” rather than risk

Child V – ‘Epilepsy’

From 1-2 years mother reported “absences” (possible seizures) - not observed clinically or in other settings

Child commenced on epilepsy medication

At hospice mother brought preloaded syringes of rescue medication with 4× prescribed dose

Stated her willingness to administer excessive dosage

Child V – Escalation of Concerns

Clinicians increasingly described being “puzzled” by mismatch in symptoms
Concerns discussed in multidisciplinary settings and Hospital safeguarding meetings.

Continuing Care Nurses identified clear mismatch between diagnoses and presentation

Despite this: FII guidance not followed

No identified lead paediatrician

No CADS/MASH referral or strategy meeting triggered at various key points

Child V – Final Incident and Removal

Admission arranged for observation (mother initially resistant to this)

During admission, mother observed physically abusing Child V

Child was immediately safeguarded

After removal child rapidly improved:

- Feeding normally
- Walking
- No need for oxygen, medication, or suction
- No evidence of epilepsy

Child V – Group Discussion (10 mins)

What were the alerting signs of FII in this case?

At which stages could FII/PP guidance have been used?

How might following the guidance have helped in this case?

What were the possible barriers to progress?

Key events at which CSC referral should have been made?

How Use of FII/PP Guidance Could Have Helped

Early recognition of 'things not adding up' (PP)

Lead clinician identified to coordinate and avoid iatrogenic harm

Use of medical chronologies across hospitals/agencies

Use of Health and Education Rehabilitation Plan (HERP)?

Earlier referral would have prompted strategy discussion rather than multiple informal meetings

HYDRATION BREAK (AKA COFFEE)



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Norfolk Safeguarding
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SUPERVISION ORDERS





Introductions

- Carmen Hawkes Service Manager Court Work & Pre-proceedings Service Norfolk County Council
- Sarah Whitworth Senior Solicitor & People Team Manager Nplaw Norfolk County Council
- Polly Mann Legal Services Manager Suffolk County Council
- Kate Lonergan Senior Service Manager CAFCASS

Learning Outcomes

- Understand the legal framework and thresholds for a Supervision Order and how we can work in partnership to keep children safe
- Know what best practice for children and young people on Supervision Orders looks like.

QUIZ



Question 1

What is the primary purpose of a Supervision Order?

- **A)** To remove the child from their parents and place them into local authority care
- **B)** To give the local authority Parental Responsibility over the child
- **C)** To allow the local authority to advise, assist, and befriend the child without gaining Parental Responsibility
- **D)** To grant the local authority veto power over all medical decisions
- **E)** To ensure the local authority provides the child with resources and services

Answer: C To allow the local authority to advise, assist, and befriend the child without gaining Parental Responsibility





Question 2

Does a Supervision Order transfer Parental Responsibility (PR) from the parents to the local authority?

- **A)** Yes, fully
- **B)** No, the parents retain PR
- **C)** Yes, but only in emergency situations
- **D)** PR is shared equally between the parents, the court, and the local authority

Answer: B No, the parents retain PR

Question 3

For how long does a Supervision Order initially last in England and Wales?

- **A)** Until the Local Authority thinks it should end
- **B)** 3-12 months
- **C)** For the period specified by the Children's Guardian
- **D)** 3 years

Answer: B A child Supervision Order in the UK is typically granted for an initial period of **3 to 12 months**. The local authority can apply to the court to extend the order, but it can only run for a **maximum of 3 years** in total and automatically ends when the child turns 18.



Question 4

To justify making a Supervision Order, what legal threshold must be met?

- **A)** The local authority simply thinks it's a "good idea"
- **B)** The child's parents request state supervision
- **C)** There is evidence the child has suffered significant harm, or is at serious risk of it, or is beyond parental control
- **D)** The parents are going through a divorce

Answer: C There is evidence the child has suffered significant harm, or is at serious risk of it, or is beyond parental control





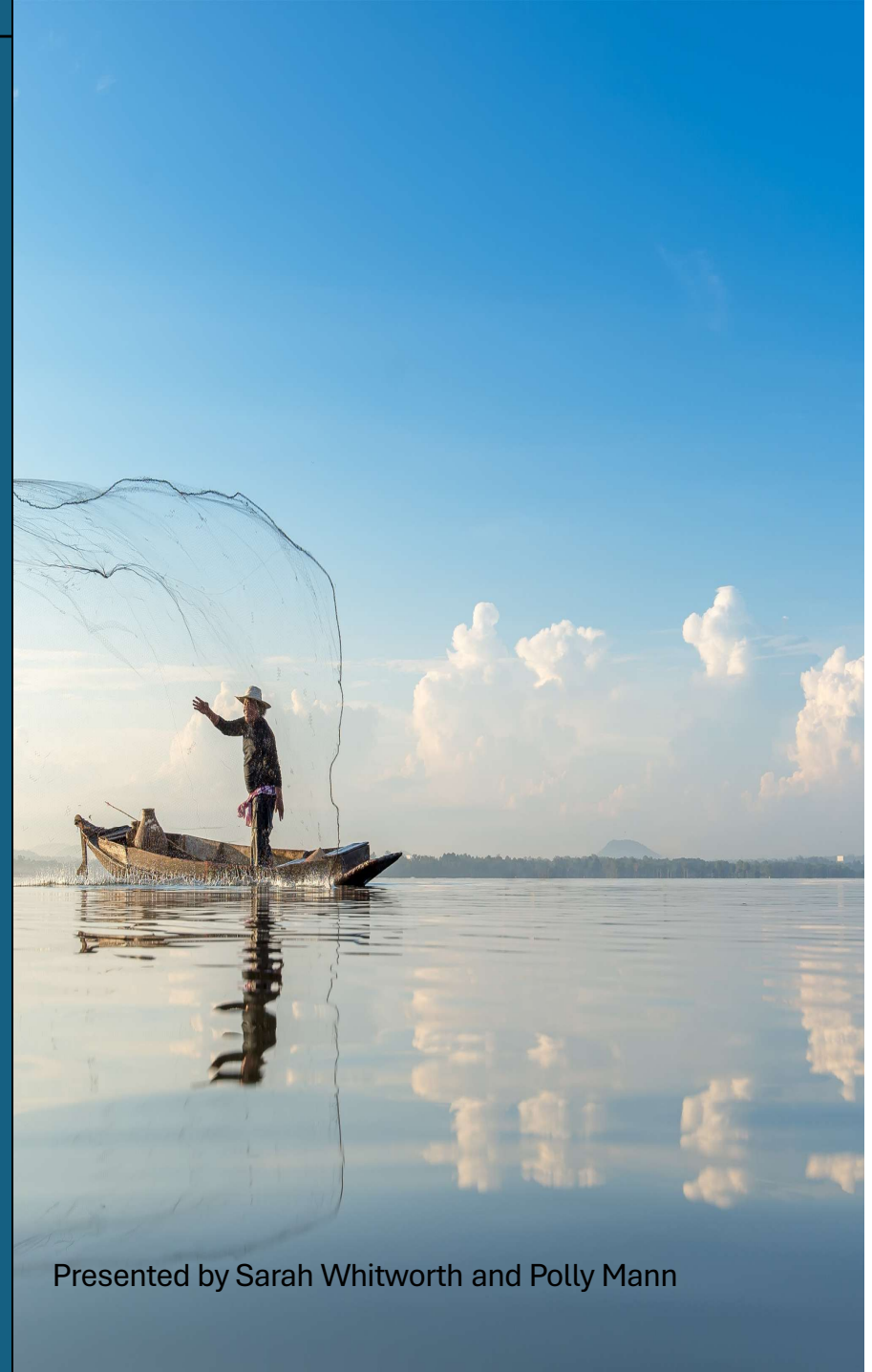
Question 5

What duties does a Supervision Order impose on the local authority?

- **A)** To take over the daily care, feeding, and schooling of the child
- **B)** To 'advise, assist and befriend' the child
- **C)** To pay a monthly allowance directly to the child
- **D)** To evict the parents from the home

Answer: B To 'advise, assist and befriend' the child

Challenges of the court process and the meaning of supervision orders



Presented by Sarah Whitworth and Polly Mann

OVERVIEW

SUPERVISION

- Supervision orders are s31 orders which is the highest threshold in the court alongside care orders
- What is the test for threshold under s31
- How do we then process/ manage an order for supervision in the Local Authority
- Impact upon thinking in a case

COURT WORK -PROVING AN INJURY

- When presented with threshold based upon an injury the court requires the LA to prove it
- Challenges to prove it
- What do we do when we don't

A court may only make a care order or supervision order if it is satisfied— .

(a)that the child concerned is suffering, or is likely to suffer, significant harm; and .

(b)that the harm, or likelihood of harm, is attributable to— .

(i)the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or .

(ii)the child's being beyond parental control.

TWO STAGE TEST

- LA to prove **Threshold**

- Court to consider **Welfare**

Threshold FOR S31
ca'89

Supervision orders

These are s31 orders – the same threshold as a care order – reached the same test

Most Local Authorities use the Child in Need process to manage supervision orders BUT they are different

- They are NOT reflecting a consensual relationship with parents seeking support as described under s17 of the Children act 1989
- They may be in circumstances where the court decide there is not enough **evidence** to remove from parent's care but they meet threshold for s31 AND we can work with the parents to keep them at home
- This is usually where the parents have made changes and engaged with services - is this disguised compliance ? Can they sustain change
- Supervision orders can be made up to 3 years although initially only 6-12 months and then extended up to 3 years
- Became commonly used by LAs and Cafcass to ensure service threshold were reached for other parties such as Special Guardians and confused professionals regarding purpose and level of monitoring

Supervision orders

Public Law Working Group led by Keehan J action on Supervision orders

Came out of 2022 research regarding use in cases of Special Guardianship orders

Professor Judith Harwin and Lily Golding for their 2022 research and report, **Supporting families after care proceedings: supervision orders and beyond: Parental perspectives on care proceedings, supervision orders and care orders at home**, which has proved a key foundation for this report.

[Supporting families after care proceedings: supervision orders and beyond](#)

Led to the recommendations for best practice for supervision orders April 2023

[April 2023 Report \(Supervision Orders\) – Final](#)

In particular Appendix C

Supervision orders

Based on findings following tracking 194 children from four local authorities in England during the course of the supervision order and for up to four years beyond (citation as per 2.1 above): A minority of the children (6%) had a permanent placement change or further section 31 proceedings. 24% experienced neglect or abuse. Neglect (18%) predominated and was most frequent amongst children aged one to four years. Case complexity was significantly associated with risk of abuse and neglect during the supervision order. Domestic violence, substance misuse, material difficulties and nonengagement with services were particularly likely to significantly increase risk.

- Children with emotional and behavioural difficulties (26%) or school attendance concerns (9%) were also at significantly increased risk of abuse or neglect during the supervision order.
- Of all the difficulties children experienced, housing and financial difficulties affected the greatest proportion over the four-year follow-up period. By the end of the follow-up period, 56% of the children had been exposed to parental housing difficulties and 49% to financial difficulties.

During the course of the supervision order and the follow-up period, the majority of children were dealt with as children in need cases, including in case in which abuse or neglect recurred.

Supervision orders

HOW do we avoid falling into the child in need plan s17 space.

Suffolk - new Model

Norfolk - Families first programme

Take aways - How do we recognise where your case comes from?? - A supervision order will have a specifically designed supervision plan which should be shared with professionals and reflected in the plan of work to be done and developed under multidisciplinary working so there is no doubt the background and findings of the court.

Court WORK and the Purpose of Proceedings

The Police – their role is to protect society and pursue individuals for committing a range of crimes - they usually do that by prosecuting individuals and the court and jury have to decide whether they are guilty

Children Services – Their role is to protect children and when the court is invoked by them the Court needs to decide what is safe for a child and their care plan for the long-term future. They do that by identifying who harmed a child and then using this to decide where it is safe for them to live and with whom

Criminal v Family court

There are a number of differences

Standard of proof -

For a crime this is beyond all reasonable doubt

In family – Balance of probabilities

WHY is NAI Threshold difficult

The burden of Proof falls on the Local Authority

They are highly evidential - no room for speculation and professional opinion. The court “make findings “ based on facts and they cannot do so if there are gaps in the evidence

It must exclude a medical cause - a condition, infection or disease

If it is an injury explores the mechanism of the injury

It considers whether accidental or deliberate cause – although either can lead to findings

Fact finding hearings

Driven by combination of medical evidence – may need several disciplines to report

It uses its investigative powers to determine what happened and then tries to identify the perpetrator – doesn’t always achieve this with some findings with perpetrator not identified or a pool of perpetrators identified

More complex – children surviving with structural brain issues where likelihood of spontaneous bleeds is not so easy to exclude

They cause delay/ higher costs waiting for a diminishing pool of experts willing to appear as professional witnesses

Vulnerable witnesses

Can lead to court exploring alternative routes / narrowing issues

CASE Law

G (A Child : scope of fact finding - only orders if they are necessary to achieve a just and proportionate welfare determination for the child

P and E (Care proceedings ; whether to Hold fact finding Hearing)

H and W (care proceedings; Further fact finding hearing) [2023]

K and G (Care proceedings: fact finding) 2025

A Local Authority v X and Y and others (No 2 fact finding) 2024

Not going through the cases but these are small example of a developing group of cases where challenges are identified

Vulnerable witnesses refusing to give evidence

Wider investigations perceived as too lengthy and expensive in proportion to the findings achievable

Medical evidence being more controversial

Impact upon professionals

Judgments can be critical if perceived to be brought by over bearing or bias Local Authority or they feel a professional witness is not even minded

Professionals often assume they are stuck with a judgment once made and are reluctant for a case to move on even if there is new evidence or a changing picture

Don't always get sufficient answer to adequately risk assess

Motivations and evidence allowed in court can be challenging in the digital age - volume, analysis and RiPA

Handing over to another LA, Hospital , Police may lead to reinvention or do over rather than a bigger picture



Fabricated Illness

AND finally

FII is a difficult landscape - combined with fact finds and the burden of truth combined with complex multi agency guidance it is preferred that cases are simply argued on the basis of s31 that a child is suffering or likely to suffer significant harm attributable to the care givers – the court does not need a specific psychological diagnosis of the parents and therefore don't be surprised that motivation is not an issue and most child protection lawyers will pursue a simple threshold of physical or psychological harm in a fact find . The issue of safety in parental care comes after this at the welfare stage and isn't always necessary if findings of harm are made

For lawyers pursuit of FII and guidance distracts professionals from the main issues at hand and can feed into distraction/ challenge from the parents in proceedings - so be transparent but think about whether it is covered by one of the 4 main child abuse descriptors

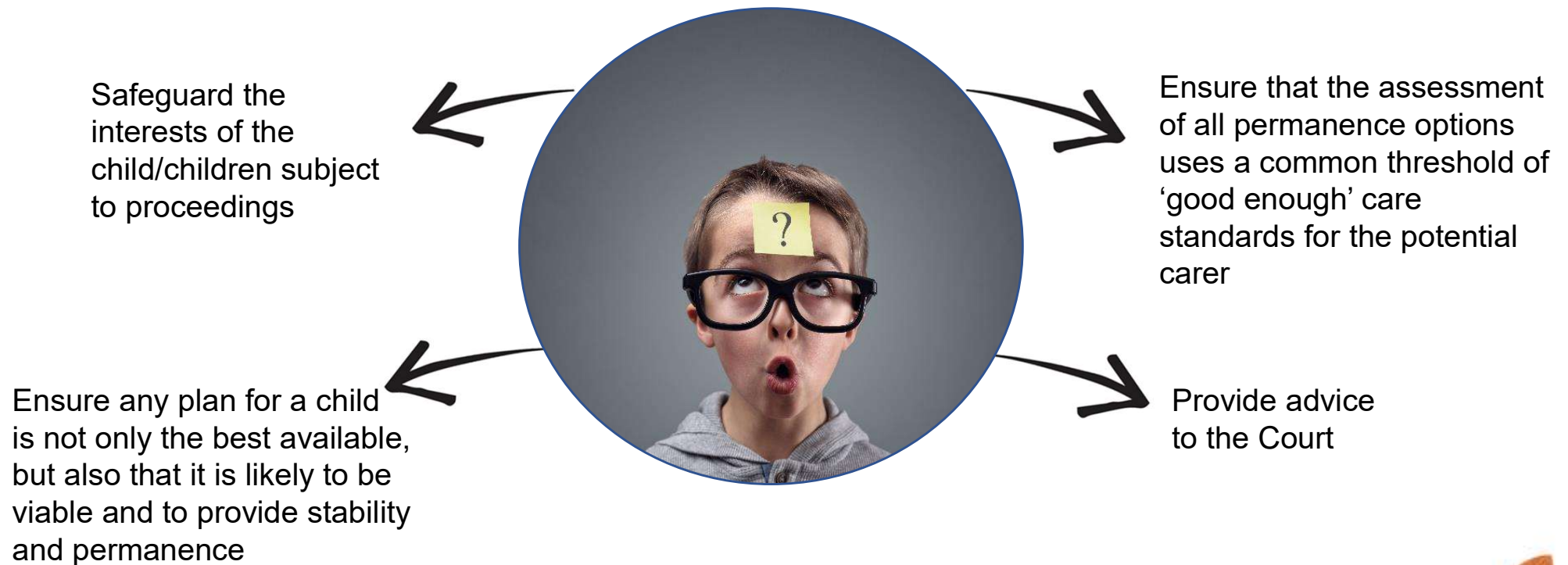


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Role of Cafcass



CAFCASS –Key tasks of the Children’s Guardian in Public Law



Cafcass Practice Changes Following Serious Case Reviews

Child Seeing
and
engaging
Policy

Monthly
Learning
from SIRs

Situational
Supervision
Triggers

Child Impact
and
Assessment
Framework

Practice
Quality
Standards in
Public and
Private Law



Supervision Orders and Reunification

1. Prior to unifying/reunifying children or if they remain with parents or family or friends in public law proceedings.
2. A case where it is proving difficult to decide what is in the best interests of the child including in the early stages of private law proceedings and depriving them of their liberty
3. Evidence of harm or risk of harm and a 16a risk assessment is required and/or referral to a local authority, and/or the police and /or a change of arrangements in public or private law may be appropriate
4. A decision not to see a child in person or in the agreed timescales set out in policy and the Child's Plan.
5. A case outcome in court that does not accept the FCA assessment of risk to the child and or may be considered unsafe for the child
6. significant shortfall identified initially in a QAI, significant incident notification or an associated case and/or learning review
7. Review of long running or delayed proceedings and the impact of this on the child following a review of the Child's Plan at 26 weeks



Supervision Orders and Reunification

Practice Quality Standards for public and private law are informed by serious case reviews, audits and learning

- Shift from compliance to reflective, analytical and supervised practice
- Stronger management oversight and defensible decision making

PQS9 Considering unification/re-unification

Situational supervision takes place prior to reunification and safety plans need to be visible on the child's file

Child Impact Assessment Framework also includes an aid for - A 12-step process for assessing the risk of re-abuse to a child, parenting capacity and prospects of safe and sustainable rehabilitation

Practice Quality Standard 11: Scrutinising a proposal for a Supervision Order (SO)

Emphasises the need for careful, critical scrutiny when considering a Supervision Order (SO), recognising the potential limitations and risks associated with its use in pressured children services. It highlights the importance of avoiding over-optimistic reliance on SOs in place of robust multi-agency child protection processes, while remaining alert to disguised compliance and ensuring parents are genuinely willing and able to engage.



Practice Challenges



Learning from Serious Case Reviews



Finley Boden

- Challenge of maintaining multi-agency planning and oversight during care proceedings – Court Work seen as a LA task only, no expectation from partners to be actively involved.
- Lack of multi-agency assessment and planning in relation to reunification to parents.

Sara Sharif

- Lack of multi-agency assessment and plan based on risks identified during proceedings
- No review of whether to extend
- *For Sara, the child in need plans developed alongside the supervision orders did not utilise the wealth of information gathered during the court hearings (Para 5.53)*

Victoria Martens

- At point of transfer [between LA's] of Sibling 1 there was no joint review of the care plan linked to the supervision order



Naming the Challenges

- Misunderstanding of Supervision Order Threshold compounded by SO's usually being managed by LA's in Child in Need pathways
- The wording of the legislation - that the order requires the LA to "advise, assist and befriend" does not always reflect the complexity of the child's situation including managing risk of harm.
- Culture of SO's being seen as a 'nothing order'
- Professional disagreement – whether a SO is necessary and/or over the length of SO required to address the risks.
- Evidence for Court vs professional instinct/judgement.
- Transfer of SO's between LA's – information sharing can be challenging in the context of lengthy care proceedings.
- Family members not understanding the purpose and threshold of a SO, compounded by all of the above.

Supervision Order Best Practice



Public Law Working Group (PLWG) 2023: 6 Best Practice Principles

Partnership and co-production with children and families

Trusting, supportive relationships between children, families and social workers are key.

Formal, robust review

The review process should be chaired by someone who is independent of the day-to-day conduct of the case or management oversight of it.

A clear, tailored plan

Addresses ongoing risks, and the findings and conclusions of the court in care proceedings.

Resource clarity

Resources and timescales are agreed prior to the conclusion of proceedings with the oversight of the Children's Guardian and Court.

Multi-agency, multi-disciplinary working

Children and families and the court should be clear how the plan will be delivered in a multi-agency context and how the family's plan have informed the multi-agency plan.

Accountability

Children and families are clear how the plan will be reviewed, how and with whom they can raise concerns about progress, the approach of Children's Services if they have concerns about progress.

Supervision Order Plan - PLWG

Supervision order plan – version

1) Who this plan is for and how long it will be in place: The child and family this plan aims to support are <u>insert names and dobs as appropriate</u>. The supervision order was made on <u>insert date</u> and it will last for <u>insert number of months and end on insert date</u>. A final review meeting will be held before the supervision order ends. It is agreed that review take place <u>insert month and year and confirm how many weeks or months before the end of the SO this will be</u>.	2) Keeping this plan up to date: This supervision order plan should be updated as things change and as progress is made. This is version <u>insert #</u> of the plan and it is dated <u>insert date</u>. It is agreed and signed by: Name, signature and date: _____ Name, signature and date: _____ Name, signature and date: _____
3) Reviewing progress To contain clear, precise information to satisfy best practice core principle 5 including the following Review meetings take place every <u>insert frequency</u>. Review meetings will be chaired by <u>insert role and name</u>. The first review of progress under this supervision order plan will take place on <u>insert date and time</u>. Before the review meeting, the family and others involved will receive: <u>insert the nature of the documents/information the family should be able to expect to receive e.g. agenda, updating report, list of attendees for next meeting and their role, whether in person or virtual</u>. After each review meeting <u>confirm what will be received, within what timescale and the process for raising queries etc</u> The people who will be invited to participate in the next review meeting will be: <u>insert list of core participants</u>.	4) Raising concerns or queries about the supervision support plan and progress <u>Insert statement about how raising of concerns or queries will be addressed having regard to best practice core principle 5. Information inserted should include the name and contact details of relevant people e.g. social worker, team manager, review chair etc.</u>

Key documents the family should have and may want to be able to refer to list to initial include key proceedings documents and to be updated over the life of the order:

- ☐ The final court order dated and judgment/Reasons dated []
- ☐ The findings including threshold criteria findings) dated []
- ☐ The supervision order plans dated [insert running versions.dates
- ☐ A copy of any assessments leading to the work provided for in this plan list briefly
- ☐ Reports produced during currency of the supervision order
- ☐ Notes of the review meetings of insert relevant dates as meeting come
- ☐ Version X of the supervision order plan dated

Supervision order plan – version

What are we worried about? <i>Should initially reflect the findings and conclusions of the court.</i>	What needs to happen to address this? <i>Specific actions are required. E.g. referrals that will be made; attendance at specific services or appointments, key conversations or meetings required, information to be shared, follow up support</i>	Who is going to do it? Who is going to provide help and support?	Date that these things will be done?	How will things be better? <i>This should focus on agreed, specific, manageable outcomes as well as any overarching outcome.</i>	How are things are going? What is the latest update? <i>Progress should be charted regularly and each version of the supervision order plan should contain the latest position. Any areas of disagreement should be captured here and the course of action taken to resolve them by the chair or others logged.</i>
1.					
2.					

Group Exercise



MAKING THE SUPERVISION ORDER WORK

Aim: Create a clear, child-focused multi-agency response to risks identified during a Supervision Order.

FICTIONAL SCENARIO: MIA AND HER FAMILY

Mia, 7, lives with her mother and younger brother under a 12-month Supervision Order. Court findings identified neglect linked to poor school attendance, missed health appointments, domestic abuse and parental alcohol use. Recently, Mia has been late and twice appeared tired and hungry; a planned health visit could not be completed; two social work appointments were cancelled; and the mother's former partner may be visiting. The plan currently says: "Professionals will monitor the children and support the family."

YOUR TASK

1 IDENTIFY

3 min

- What are the key risks?
- What does each agency know?
- What must be shared today?

2 STRENGTHEN

7 min

- Choose 3 principles below.
- Agree one action, owner and measure for each.
- Set a review point and contingency.

3 SHARE

5 min

- Highest-risk issue
- One multi-agency action
- What happens if risk increases?

SIX BEST-PRACTICE PRINCIPLES

☐ Partnership and co-production

☐ Multi-agency working

☐ Clear, tailored plan

☐ Resource clarity

☐ Formal, robust review

☐ Accountability

RECORD YOUR DECISIONS

Priority concern / outcome	Action and professional lead	How will we know?	Review / contingency

CLOSING TEST: Is it clear who will do what, how improvement will be measured, and what happens if concerns continue?

Resources

- [Recommendations to achieve best practice in the child protection and family justice systems: Supervision orders 2023](#)
- [Children and Families Moving Across Boundaries Policy | NSCP](#)
- [Moving Across Local Authority Boundaries — Suffolk Safeguarding Partnership](#)
- [NCC Supervision Order Practice Toolkit](#)
- [Care and Supervision Proceedings and the Public Law Outline](#) NCC Tri-X
- [Child Impact Assessment Framework \(CIAF\) | Cafcass](#)
- [Guidance for when Guardian and LA views fundamentally differ.pdf](#)
- [Child Safeguarding Practice Review Sara Sharif](#)
- [Protecting all vulnerable babies better: National review into the broader safeguarding issues raised by the death of baby Victoria Marten](#)
- [Local Safeguarding Practice Review Finley Boden](#)
- Relevant case law:
 - G (A Child : scope of fact finding - only orders if they are necessary to achieve a just and proportionate welfare determination for the child
 - P and E (Care proceedings ; whether to Hold fact finding Hearing)
 - H and W (care proceedings; Further fact finding hearing) [2023]
 - K and G (Care proceedings: fact finding) 2025
 - A Local Authority v X and Y and others (No 2 fact finding) 2024

Thank you



Plenary and Close



Suffolk
Safeguarding
Partnership



Norfolk Safeguarding
Children Partnership