

***SAFEGUARDING
CHILDREN IN WHOM
ILLNESS IS
FABRICATED OR
INDUCED***

**Safeguarding Children
North East England
Regional Inter-agency Procedures**

SAFEGUARDING CHILDREN IN WHOM ILLNESS IS FABRICATED OR INDUCED

1. Introduction

Professionals are expected to work in line with 'Safeguarding Children in Whom Illness is Fabricated or Induced' (DOH 2002), which includes:

- Extensive guidance for inter-agency practice in handling individual cases
- Expected roles and responsibilities for a wide range of professionals working within Health, Social Services, Police, Education etc.
- Key issues for working with families where fabricated or induced illness may be a feature.

2. Fabricated/Induced Illness

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

- Fabrication of signs and symptoms, for example, fabrication of past medical history
- Falsification of hospital charts, records, letters, documents and specimens of bodily fluids
- Induction of illness by a variety of means.

(Terms previously used have included Munchausen Syndrome by Proxy; Factitious Illness by Proxy; Illness Induction Syndrome and Paediatric Condition Falsification Factitious Disorder by Proxy)

3. Behaviours Associated with Fabricated/Induced Illness

Behaviours include:

- Deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation
- Interfering with treatments by over dosing, 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
- Obtaining specialist treatments or equipment for children who do not require them
- Allying psychological illness in a child.

4. Recognition

Where illness is being fabricated or induced, extensive, unnecessary medical investigations may be carried out in order to establish the underlying causes for the reported signs and symptoms. The child may also have treatments prescribed or operations which are unnecessary. These investigations can result in children spending long periods of time in hospital and some, by their nature, may also place the child at risk of suffering harm or even death.

Carers exhibit a range of behaviours when they believe that their child is ill. A key professional task is to distinguish between the over anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour. Such abnormal behaviour can be present in one or both parents/carers and often involves passive compliance of the child.

Many incidents of concern can be warning signs of fabricated or induced illness and practitioners should note the attached 'Possible Warning Signs of Fabricated or Induced Illness Template'.

5. Referral

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/carer, and as a consequence the child's health or development is or is likely to be impaired, a referral should be made to Social Services.

The referral may, for example, follow an evaluation of the child's signs and symptoms whilst an in-patient or be due to concerns held by professionals working with the child or concerns held by a member of the public who knows the child.

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/carers are to be made on an inter-agency basis, following referral to Social Services.

6. Response by Social Services and Strategy Meeting

Child protection procedures are to be applied to referrals about possible fabricated/induced illness and an inter-agency Strategy Meeting is to be held.

Staff attending the Strategy Meeting should be sufficiently senior to be able to contribute to the discussion of often complex information and to make decisions on behalf of their agencies.

At a minimum agency/professional representation at the Strategy Meeting should include:

- Social Services
- Child Protection Police
- Medical Consultant responsible for the child's health
- Senior Ward Nurse (if the child is an in-patient)
- GP
- Health Visitor
- Education staff as appropriate.

Consideration should be given to inviting:

- A medical professional who has expertise in the branch of medicine which deals with the symptoms and illness processes caused by the suspected abuse
- The Legal Advisor to the local authority

All agencies/professionals involved should be asked to furnish a completed chronology (see 10 below) for the Strategy Meeting.

Decisions about what discussions are to take place with the parents/carers, and by whom, are to be made at this Strategy Meeting (and the referrer should be advised).

Depending on the circumstances of the case, consideration should be given to the possibility of the use of Covert Video Surveillance (see 9 below).

7. Emergency Action

Sometimes it may be apparent at the point of referral to Social Services that emergency action is necessary, for example, when a child's life is in danger, possibly through poisoning or toxic substances being introduced into the child's blood stream. Emergency action should normally be preceded by an immediate Strategy Discussion between the Police, Social Services, Health and other agencies as appropriate.

8. Responsibilities

From the point of referral, Social Services, the responsible Paediatric Consultant and Child Protection Police are to work very closely together. Lead responsibilities are:

- Social Services for action to safeguard and promote the child's welfare.
- The Paediatric Consultant for the child's health care and decisions pertaining to it.
- The Police for investigating any crime which may have been committed and the management of how investigations are to be conducted.

9. Covert Video Surveillance

The DOH say that Covert Video Surveillance (CVS) should be used if:

- There is no alternative way of obtaining information which will explain the child's signs and symptoms.
- A multi-agency Strategy Meeting agreed that its use would be justified based on the medical information available.

In order to obtain authorisation, the Police have to demonstrate that CVS is necessary, in line with the Regulation of Investigatory Powers Act 2000. Where CVS is to be employed, the operation and management of this is to be controlled by the Police and accountability held by a Police Manager.

10. Chronologies and 'Possible Warning Signs of Fabricated or Induced Illness Template'

The use of chronologies and the attached 'Possible Warning Signs of Fabricated or Induced Illness Template' allows for systematic consideration of risk factors and risk assessment.

In compiling chronologies and using the attached template, the focus must be on:

Ensuring that all practitioners describe precisely what they have observed rather than using unfamiliar terminology

- Clarifying any concerns about medical information (treatments, expected findings, prognosis, etc) with an appropriate Doctor
- Focusing on the possible harm to the child, not the motivation of the parent/carer.

Professionals involved should formulate chronologies, as set out below, for discussion at the Strategy Meeting. Chronologies should not include every single contact, instead they should include any event that comes under any of the categories given in the attached 'Possible Warning Signs of Fabricated or Induced Illness Template'.

Social Services should then sort and merge the chronologies into one complete document, using this and the attached template to inform the risk assessment.

Any episode in which the parent/carer could be using the medical system to harm the child and all possible episodes of other forms of abuse must be included, including trivial injuries, which may be accidents or due to inflicted harm.

Chronology information should be set out on the following basis

Date	Name	Source	Episode/event	Category	Comment

Note: Date (self explanatory), Name is the individual involved in the episode, Source is the agency/practitioner Episode/event is a record from the story, Category is the category of warning sign as per the Template, Comment (self explanatory).

11. Risk from a Member of Staff

There may be times when a member of staff is responsible for the unexplained or inexplicable signs and symptoms in a child. This should be borne in mind when considering how to manage the child's care. Any such concerns about a member of staff should be discussed with the relevant Named Professional for Child Protection.

12. Further Information and Guidance about Fabricated or Induced Illness

For further information and guidance see:

'Safeguarding Children in Whom Illness is Fabricated or Induced' (DOH 2002)
www.dfes.gov.uk/acpc/pdfs/safeguardingchildren2002.pdf

Public Report: Serious Case Review 'Michael' (Cumbria Child Protection Committee 2004)

POSSIBLE WARNING SIGNS OF FABRICATED OR INDUCED ILLNESS TEMPLATE

The order of numbering in the template does not indicate the relative importance of each category.

‘Symptoms’ are subjective experiences reported by the carer or the patient. ‘Signs’ are observable events reported by the carer or observed or elicited by professionals. Set out below are some examples of behaviour to look out for.

Professionals should bear in mind the limits of the template, which is to give an indication of whether fabricated or induced illness is a possibility.

Category	Possible warning signs
1.	<p>Reported signs and symptoms found on examination are not explained by any medical condition from which the child may be suffering. Here the doctor is attempting to put all the information together to make a diagnosis but the signs and symptoms do not correlate with any recognised disease or where there is a disease known to be present. A very simple example would be a skin rash which did not correlate with any known skin disease. An experienced doctor must be on their guard if something described is outside their previous experience.</p>
2.	<p>Physical examination and results of medical investigations do not explain reported symptoms and signs. Physical examination and appropriate investigations do not confirm the reported clinical story. For example, it is reported a child turns yellow (has jaundice) but no jaundice is confirmed when the child is examined and a test for jaundice, if appropriate, is negative. A child with frequent convulsions every day has no abnormalities on a 24-hour video-telemetry (continuous video and EEG recording) even during a so-called ‘convulsion’.</p>
3.	<p>There is an inexplicably poor response to prescribed medication and other treatment. The practitioner should be alerted when treatment for the agreed condition does not produce the expected effect. This can result in escalating drugs with no apparent response, using multiple medications to control a routine problem and multiple changes in medication due to either poor response or frequent reports of side effects. On investigation, toxic drug levels commonly occur but may be interspersed with low drug levels suggesting extremely variable administration of medication fluctuating from over-medication to withdrawal of medication. Another feature may be the welcoming of intrusive investigations and treatments by the parent.</p>
4.	<p>New symptoms are reported on resolution of previous ones. New symptoms often bear no likely relationship to the previous set of symptoms. For example, in a child where the focus has been on diarrhoea and vomiting, when appropriate assessments fail to confirm this, the story changes to one of convulsions. Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.</p>

5.	<p>Reported symptoms and found signs are not seen to begin in the absence of the carer, i.e. the perpetrator is the only witness of the signs and symptoms. For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly raise anxiety of FII where the severity and/or frequency of symptoms reported are such that the lack of independent observation is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. In the case under review there was evidence that the school described episodes as ‘fits’ because they were told that was the appropriate description of the behaviour they were seeing.</p>
6.	<p>The child’s normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer. The carer limits the child’s activities to an unreasonable degree and often either without knowledge of medical professionals or against their advice. For example, confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child’s school attendance.</p>
7.	<p>Over time the child is repeatedly presented with a range of signs and symptoms. At its most extreme this has been referred to as ‘doctor shopping’. The extent and extraordinary nature of the additional consultations is orders of magnitude greater than any concerned parent would explore. Often consultations about the same or different problems are concealed in different medical facilities. Thus the patient might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different set of problems (or even the same) without informing these various medical professionals about the other consultations.</p>
8.	<p>History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family. The emphasis here is on the <u>unexplained</u>. Illness and deaths in parents or siblings can frequently be a clue to further investigation and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the general practitioner through to the extreme of Munchausen syndrome where there are multiple presentations with fabricated or induced illness resulting in multiple (unnecessary) operations. Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially might have been subject to FII abuse and their medical history should also be examined.</p>
9.	<p>Once the perpetrator’s access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above). This is a planned separation of perpetrator and child which it has been agreed will have a high likelihood of proving (or disproving) FII abuse. It can be difficult in practice, and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child’s bedside, is unusually close to the medical team and thrives in a hospital environment.</p>

10	<p>Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported. This is an extension of category 8. On exploring reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They were largely or wholly fictitious.</p>
11.	<p>Incongruity between the seriousness of the story and the actions of the parents. Given a concerning story, parents by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is incongruity between their expressed concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend for crucial assessments (somebody else's birthday, thought the hospital was closed, went to outpatients at one o'clock in the morning, etc). We have used a term, 'piloting care', for this behaviour.</p>
12.	<p>Erroneous or misleading information provided by parent. These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc). An extreme example of this is spreading the idea that the child is going to die when in fact no one in the medical profession has ever suggested this. Changing or inconsistent stories should be recognised and challenged.</p>