Fabricated or Induced Illness in Children

Multi- Agency
Practice Guidance

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1. Introduction

1.1 FII involves a child being presented with a more significant health problem than he/she has in reality and suffers harm as a result. This is a relatively rare form of child abuse (Lazenbatt & Taylor, 2011) but where there are concerns about FII, a multi-agency response is essential from an early stage to ensure that the child is appropriately protected. In the UK it is estimated that at least 0.5 per 100,000 children under 16 and at least 2.8 per 100,000 children under 1 are subject to FII (McClure et al, 1996).

1.2 For the purpose of this guidance, the term carers will be used to relate to birth parents and main carers alike.

1.3 This guidance should be read in conjunction with the National guidance for Child Protection in Scotland 2014 www.gov.scot/Publications/2014/05/3052 which details the role of all agencies in protecting children from harm and abuse. It also has some useful links. In addition further information is available from the National Institute for Health and Clinical Excellence http://www.nice.org.uk/guidance/cg89.

1.4 The Getting it Right for Every Child (GIRFEC) national approach requires practitioners across all services for children and adults to meet children's and young people's needs, working together where necessary to ensure they reach their full potential. www.scotland.gov.uk/Topics/People/Young-People/gettingitright

1.5. This guidance was developed by a Short Life Working Group (See membership at Appendix 7) and draws heavily on guidance from East Renfrewshire Child Protection Committee and Glasgow City Child Protection Committee.

2. Scope

2.1 This guidance is relevant for all staff working with children and young people across all services. It is also relevant for those working in adult services with parenting/caring responsibilities. It aims to provide guidance and advice for practitioners across all agencies on how to respond to concerns regarding FII.

3. Definition

3.1 FII used to be known as Munchausen's syndrome by proxy.

3.2 FII occurs when a carer misrepresents the child as ill either by fabricating, or much more rarely, producing symptoms and then presenting the child for medical care, disclaiming knowledge of the cause of the problem (Lazenbatt & Taylor, 2011).

3.3 It can involve reported concerns about both physical and mental health of the child, (McNicholas et al, 2000). (*See Appendix 1 – Key findings from research).*

4. Identifying Fabricated or Induced Illness

All parents exhibit a range of behaviours in response to their child being ill or perceived as ill. Professionals are required to distinguish between an anxious carer who may in fact be responding in a reasonable way to a sick child, and those who are exhibiting abnormal behaviours. Some carers may be more anxious than others, or have perceptions about illness and expectations of the medical profession which impact on how they cope with situations. Others may need reassurance that their child is indeed well. Some carers can be assisted to interpret and respond appropriately to their child's needs whilst others may not be able to alter their beliefs. **It is this group of carers who are most likely to present their child for medical examination even though they are healthy.**

4.1 Identifying FII is a complex process and identifying the carer's patterns of behaviour will require you to carefully record your concerns, and take action to involve other professionals and agencies. A concern about FII may be suspected more by those working in general practice, health visiting, NHS24 or paediatric services.

4.2 There are three main ways in which a parent/carer can fabricate or induce illness in a child (National Guidance for Child Protection in Scotland, 2014). These are not mutually exclusive and include:

- Fabrication of signs and symptoms, including fabricating the child's past medical history;
- Fabrication of signs and symptoms and falsification of hospital charts, records and specimens of bodily fluids. This may also include falsification of letters and documents; and
- Induction of illness by a variety of means.

(See Appendix 2– Indicators of harm and Appendix 3 - Characteristics /behaviours placing a child at risk).

5. Barriers to Identification of FII

The following factors may make it difficult to identify FII:

- Lack of awareness of the range of behaviours
- Concentration on "making a diagnosis" rather than appraising all presentations and the whole of the child's health in a broad and holistic fashion
- Tendency to consider this form of abuse as a "diagnosis of exclusion" or a last resort
- When children have naturally occurring illness it can make it more difficult to recognise FII
- Concern that there may be professional challenge if it is decided to stop investigations and or treatment
- Difficulty in recognising FII when there is a strong professional / parent relationship
- Reluctance of health practitioners to accept challenge or a different perspective from non health professionals

- Attempting to balance the messages from some research on the importance of listening to parents whilst maintaining appropriate professional curiosity to corroborate the information.

6. What to do, if FII is suspected

6.1 When a practitioner has a concern about possible FII, they should inform the Named Person for that child. There are a number of actions that can follow:

- Discuss with line manager or at supervision
- Make a referral to social work
- Agree who should contact the Child Protection Unit to commence early sharing and collation of information and seek advice. CPU maybe able to sign post staff to health professionals with relevant expertise
- Consider arranging a meeting of relevant professionals, possibly including CAMHS, Paediatrics and CPU to discuss the case.

National Child Protection Guidance 2014, advises that practitioners must work together, considering all the available evidence, in order to reach an understanding of the reasons for the child's signs and symptoms of illnesses", and "before a decision can be taken as to whether a child protection investigation is required, it is essential that **all relevant services** are engaged".

6.2 A child's multi agency chronology should be compiled to collate the available evidence. The chronology must clearly define the source and status of information. It is important to distinguish between signs and symptoms that have been reported by a carer and those that have been independently witnessed by a health professional or other person. All professionals involved in the child's care should contribute to a coherent chronology. It should also include any relevant information relating to the parents or siblings.

6.3 If the child is in hospital and there are concerns about possible significant harm as a consequence of FII, discharge should not take place until a multi-agency Child Protection Case Discussion is convened and the concerns are discussed. The Case Discussion is for professionals only and parents/carers are not involved or notified at this point. The safety of the child is paramount whilst FII is being considered.

6.4 The final diagnosis of FII should be made by a Consultant Paediatrician. Consultant paediatricians in charge should refer to *RCPCH (2013) Child Protection Companion (2nd Ed.)*

6.5 Practitioners should not discuss their concerns with carers at this stage.

6.6 Every practitioner should keep full and accurate records of their decision-making including the reasons why, contrary to general expectation, concerns about the child's welfare are not immediately shared with parent/carer.

6.7 If at any point there is evidence to indicate the child's life is at risk or there is likelihood of serious immediate harm, child protection procedures should be used to secure the immediate safety of the child.

7. Referral to Social Work

7.1 The referral should be made to the responsible Social Work Service in accordance with child protection procedures if FII is suspected. (There may have been a meeting between health professionals prior to referral to social work to discuss concerns). Referrals should not be delayed because the evidence available to the professional is not conclusive. The referrer should however be explicit about the concerns that FII may exist and they are referring the child in accordance with these procedures. Social Work will decide if reasonable concerns exist on the basis of information provided by the referrer and a child protection case discussion convened.

8. Professional Meeting

8.1 It may be necessary to convene a meeting for professionals to come together to discuss clarity of information and the impact on the child.
If the child is in hospital, any meetings should not be held on or near the ward where the child is.

8.2 When making practical arrangements for the meeting care should be taken to maintain confidentiality. The family name should be not used and the meeting should be booked under the name of the professional.

8.3 Attendance at Child Protection meetings is in line with current child protection policy and procedure however consideration should also be given to inviting the local authority legal services or children's reporter.

8.4 Attendance must be restricted to those who need to be aware of the concerns, in the best interests of the child. All participants need to be appraised of the utmost need for confidentiality. Parents/carers do not attend and are not notified.

8.5 Consideration should be given to inviting the Police.

8.6 The outcome of the meeting should be shared with key professionals e.g. GP's that have been unable to attend. *(See appendix 4).*

9. Further Child Protection Case Discussions

9.1 More than one case discussion may be required to consider the possible diagnosis of FII once the various enquiries are complete (including chronologies) to decide if concerns are substantiated and a child protection conference and/or other actions to safeguard the child are necessary.

10. Sharing concerns with the carer(s)

10.1 If FII is a real possibility, careful consideration will need to be given about if and when to share the concern with the parent. This should be addressed within the case discussion. This process requires

considerable skill and new consultants may require support. Support can be access from liaison CAMHS, Social Work and Clinical Psychology.

10.2 Considerations are:

a) The degree of certainty.
b) The balance between likely harm to the child from FII as opposed to the effects of any protective action.
c) The likely reaction of the parents.
d) Where a decision is taken to explain to a parent that it is thought they are perpetrating FII, the timing is crucial.
e) Whether the other parent or other relative should be present or told later of the suspicion of FII. The welfare of the child is paramount and will influence any decision regarding information sharing. Communication with the parent/carer should be on the basis of a clearly defined and agreed plan, developed in the professionals meeting.
f) The professionals meeting should decide who is best placed to share concerns with the carers. In most cases this is likely to be the consultant paediatrician. *(See Appendix 5).*

11. References & further reading

Bass, C & Glaser, D (2014) early recognition and management of fabricated or induced illness in children. *Lancet Vol.383* 1412 –1421

Buckingham Safeguarding Children Board (2013) Fabricated or Induced illness

East Renfrewshire Child Protection Committee, Multi – Agency Summary Guidance for Practitioners & Managers Fabricated or Induced Illness - Working Together to Keep Our Children Safe

HM Government (2008) Safeguarding Children in Whom Illness is Fabricated or Induced

Kingston LSCB (2011) Protocol for Fabricated or Induced Illness in a Child

Lazenbatt, A & Taylor, J (2011) Fabricated Induced Illness: a rare form of child abuse; Briefing paper NSPCC: London

McClure, RJ, Davis, PM, Meadow, R, Sibert, JR (1996) Epidemiology of Munchausen Syndrome by Proxy, non accidental poisoning and non accident suffocation. *Archives of Disease in Childhood*, 75:57-61

McNicholas F, Slonims, V, Cass H (2000) Exaggeration of symptoms or psychiatric Munchausen's syndrome by proxy? *Child Adolescent Mental Health*, 5 69-75

RCPCH (2009) Fabricated or Induced Illness by Carers (FII): A Practical Guide for paediatricians

RCPCH (2013) Child Protection Companion (2nd Ed.)

Scottish Government (2014) National Guidance for Child Protection in Scotland

APPENDIX 1: KEY FINDINGS FROM RESEARCH

- FII is a form of child abuse with boys and girls equally affected.
- It is perpetrated by those who have care of the child (usually the mother) and usually involves secondary medical services. It may be first manifested in primary care, consequently it may be detected first by GPs
- FII is seen in children of all ages. The reported severe or most dramatic events are usually seen in children under the age of 5 years – newborns in particular are most likely to be harmed. However, there is a spectrum of significant FII across age groups. The long term psychological effect on older children may result in them inadvertently colluding in the sick role with their carer.
- Although relatively rare, this should not undermine or minimise its serious nature or the need for practitioners to be able to identify when carers are fabricating or inducing illness in children.
- FII is a spectrum of disorders rather than a single entity. At one end less extreme behaviours include a genuine belief that the child is ill. At the other end the behaviour of carers includes them deliberately inducing symptoms by administering drugs, intentional suffocation, overdosing, tampering with medical equipment, and falsifying test results and observational charts.
- Recognition of FII depends, in the first instance, on medical or paediatric clarification of the objective state of the child's health. followed by detailed and painstaking enquiry involving the collection of information from many different sources and discussion with different agencies, e.g. social services, general practice, health visitors, schools, and when clearer indications of FII, the police.
- Affected children also live in a fabricated sick role and may eventually go on to somatise or simulate illness themselves and be diagnosed with hypochondria.
- Illness induction can cause death, disability and physicals illness. Both induction and fabrication can lead to emotional problems. There are significant risks of re-abuse. Following identification of FII in a child, the way in which the case is managed has a major impact on the developmental outcomes for the child. (Anne Lazenbatt and Julie Taylor, July 2011).
- Studies that bring together reported cases of FII suggest that the most common presentations are apnoea, diarrhoea and seizures. Males are no more likely than females to be subject to this type of maltreatment and the perpetrator is the mother in most cases. *When to Suspect Child Maltreatment, Clinical Guideline, July 2009 (revised update Dec 2009) (Page 63), NICE*

APPENDIX 2: INDICATORS OF HARM

The following is a list of indicators which may suggest concern regarding FII.

Over time the child is repeatedly presented with a range of signs and symptoms of various illnesses.

There tends to be no independent verification of reported symptoms.

Signs found on examination are not explained by any medical condition from which the child is known to be suffering.

Medical tests do not support any reported signs and symptoms.

Claiming symptoms which are unverifiable unless observed directly.

The response to prescribed medication and other treatment is inexplicably poor.

New symptoms are reported on resolution of previous ones.

Signs and symptoms do not begin in the absence of the carer.

The child's normal daily life becomes restricted in ways similar to those that might apply if they had a serious medical disorder from which they do not appear to suffer, or that is supported by medical evidence.

There is a mismatch of evidence from the presenting carer usually, but not always, the mother.

The reaction of the carer is disproportionate to the diagnosis or non diagnosis of the condition.

The characteristics of FII are that there is a lack of the usual corroboration of findings with signs and symptoms, or in circumstances of proven organic illness, lack of the usual response to proven effective treatments. It is this discrepancy that may alert the clinician to possible harm being suffered by the child.

Buckingham Safeguarding Children Board (2013)

APPENDIX 3: CHARACTERISTICS/BEHAVIOURS PLACING CHILD AT RISK

- Often has a current or previous psychiatric or psychological history e.g. anxiety, depression, past history of FII, previous self-harm, or history of eating disorders.
- Is more intelligent / dominant than partner.
- The partner is often detached from the family and has limited involvement with professionals.
- Behaviour is frequently compulsive and patterns of presentation are varied. A perpetrator may alternate between presenting her/himself as ill and the child/children as ill.
- The perpetrator may change the way they are maltreating the child.
- Perpetrators are likely to be seen as highly devoted to the child but paradoxically appear unconcerned about the child's illness.
- They appear disappointed at negative test findings.
- There may be extravagant claims made to a range of health professionals regarding the diagnosis and treatment of the child.
- The perpetrator is typically knowledgeable about the child's illness and treatment, is happy to be in hospital and forms close and often controlling relationships with the healthcare staff.
- Unannounced visits to the home have not been possible and GP/Health Visitor calls have always been pre-arranged.
- There has been persistent refusal of "in home" services, e.g. home care, home nursing, family support.
- Previous children may have been subjected to FII.
- There could be a history of unusual illness or unexplained death in previous children.
- There may be a background of seeking financial or other gains through illness behaviour.
- Often there is no previous child protection involvement.
- A resistance to accept hospitalisation.
- An avoidance of professionals who challenge/question – i.e. changing health professionals.

Some of the above may be present in entirely innocent situations. However, when FII is suspected, such features can contribute to:

- the diagnosis
- the understanding of the seriousness of the case
- understanding of the urgency of the need for intervention

Kingston LSCB (2011)

APPENDIX 4: Guidance for Chairs of Meetings

Professional invitations

The following professionals should be invited and should attend wherever possible

- Social Work Team Leader and allocated/assigned worker.
- Family Protection Unit (Police)
- Child Protection Team (where applicable) (SWS)
- Child Protection Unit (QEUH)
- Consultant Paediatrician(s) involved
- Named Doctor
- Named Nurse
- Adult Psychiatrist (where appropriate)
- Family GP
- Named Person
- Any other professional involved with the child in particular the health visitor, nursery nurse and school nurse/staff as appropriate.

Attendance must be restricted to those who need to be aware of the concerns, in the best interests of the child. All participants need to be appraised of the utmost need for confidentiality. Parents/carers do not attend and are not notified.

Agenda: Reason for Meeting:

The chair must ensure that participants are aware of the concerns and reason for the meeting

Information Sharing:

Relevant information from each agency about the child, siblings (even if adult or deceased), parent(s) and any other significant adults should be shared. 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 then consider the information against the FII Template in Appendix 6 to consider whether there is sufficient information to make a decision on FII 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 child protection investigation and to request all agencies to prepare detailed chronologies to inform the analysis of risk. Chronologies must contain the source of the information and whether it is fact or opinion.

Conclusions/Analysis of Risk:

The meeting must draw conclusions about the level of risk to the child and action to be taken on the basis of the information shared.

Planning:

The meeting must focus on the needs of the child and his/her safety. Legal advice should be sought to evaluate the information where required.

Decisions should be made about:

a) Whether further enquiries are necessary. If so, the meeting should plan how this will be carried out and the comprehensive assessment completed, what further information is required, how it will be obtained and recorded. Discuss the need for medical chronologies to be completed as part of a child protection investigation.

b) Whether the child requires constant professional observation, and if so, whether or when the carer(s) should be present.

c) Who will carry out what actions, by when and for what purpose, especially the planning of further paediatric assessment?

d) Any particular factors, e.g. child and family's race, ethnicity and language, which should be taken into account.

e) The needs of siblings and other children with whom the alleged perpetrator has contact.

f) The nature and timing of any police investigation, including the analysis of samples. This will be especially pertinent if covert video surveillance is being considered, as this will be a task for which the police will have responsibility.

g) The needs of parents/carers.

h) What is to be told to the parent/carers? (See Appendix 5)

i) How the child and any other children's safety is to be ensured, including immediate safety and safety during any contact with the suspected abuser. Other matters for discussion/decision might include:

j) If the child requires placement away from home, whether extended family or friends would be able to provide sufficient protection or whether foster care is more appropriate. (NB: Family and friends may be disbelieving that FII is a possibility).

k) Whether emergency legal intervention is necessary and, if so, arrangements for this.

l) Any further information required, how it is be obtained and when.

m) Whether there should be use of covert video surveillance.

n) Process for deciding on whether a child protection conference is necessary after completion of child protection investigation.

o) Agreement about who should receive minutes of the meeting.

p) Identification of a lead paediatrician to oversee and coordinate healthcare involvement

APPENDIX 5: Sharing concerns with the parent(s)

Considerations:

If FII is a real possibility, careful consideration will need to be given about if and when to share the concern with the parent. This should be addressed within the strategy discussion.

Considerations are:

- The degree of certainty.
- The balance between likely harm to the child from FII as opposed to the effects of any protective action.
- The likely reaction of the parents.
- Where a decision is taken to explain to a parent that it is thought they are perpetrating FII, the timing is crucial.
- Whether the other parent or other relative should be present or told later of the suspicion of FII. The welfare of the child is paramount and will influence any decision regarding information sharing. Communication with the parent/carer should be on the basis of a clearly defined and agreed plan, developed in the strategy meeting.

Who Should Address the Parent/Carer?
The following people will need to explain matters to the parent: -

- The doctor making the diagnosis, usually the Consultant Paediatrician should explain why the symptoms presented are believed to be FII.
- A Police Officer will have to arrest and question the parent if it is believed an offence has been committed.
- The Social Worker/Team Manager will need to inform the parent(s) of any steps being taken to protect the child/children. Not all these tasks need to be performed concurrently. If a criminal investigation is being pursued, a police officer and consultant should be the ones to confront the parent, followed by a social worker to explain actions taken to ensure the protection of the child/children. Where a criminal investigation is not being pursued, a doctor and social worker should jointly address the issues with the parent(s). Where the child is in hospital, venue is important and care should be taken not to share information in an environment which could disrupt a ward.

APPENDIX 6: FII Template

Category	Warning Signs of Fabricated or Induced Illness
1.	**Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.**
2.	**Physical examination and results of medical investigations do not explain reported symptoms and signs.**
3.	**There is an inexplicably poor response to prescribed medication and other treatment**.
4.	**New symptoms are reported on resolution of previous ones**.
5.	**Reported symptoms and found signs are not seen to begin in the absence of the carer**.
6.	**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.**
7.	**Over time the child is repeatedly presented with a range of signs and symptoms.**
8.	**History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family**.
9.	**Once perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above).**
10.	**Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.**
11.	**Incongruity between the seriousness of the story and the actions of the parents.**
12.	**Erroneous or misleading information provided by parent**.

APPENDIX 7

Membership of Short Life Working Group

Dr Kerry Milligan	GP Child Protection Unit/Homeless Families Healthcare Team/LAAC Health Team	NHSGGC
Karin O'Hagan	Team Leader	Glasgow North East
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