



## **LSCB Policy and Procedures**

### **Safeguarding Children and young people with suspected Fabricated or induced illness**

#### **Joint Working protocol**

<b>Date of next review</b>	May 2018
<b>Date of last review</b>	April 2017
<b>Date of approval</b>	April 2016

## **Introduction**

This guidance is not intended as a detailed practice guide. It does, however, set out clear expectations about the ways in which agencies should work together in the interest of children's safety and wellbeing.

This guidance is based upon, and should be read in conjunction with, Working Together to Safeguard Children, the supplementary guidance Safeguarding Children in Whom illness is fabricated or Induced (DCSF 2008) and North Lincolnshire LSCB policy and procedures.

Further guidance is available from the Royal College of Paediatricians and Child Health 2009.

## **Context**

Although child maltreatment due to abuse or neglect is pervasive within our society, less is known about Fabricated or Induced Illness (FII) which is considered to be a rare form of child abuse (Lazenbatt and Taylor 2011). Although relatively rare this should not undermine or minimise its serious nature or the need for practitioners to be able to identify when parents or carers are fabricating or inducing illness in children (Davis 2009)

FII is considered to be rare (McClure et al 1996) (Lazenbatt and Taylor 2011); however this varies in different health service regions and McClure suggests that FII is under reported nationally.

## **Definition**

Fabricated or Induced Illness (FII) is the systematic fabrication or induction of illness in a child. It is a condition whereby a child suffers harm through the deliberate action of his/her main carer., (Lazenbatt and Taylor 2011).

FII by carers can cause significant harm to children, it involves a well child being presented by a 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 suffering harm as a consequence (RCPCH 2009)

Fabricated or induced illness (FII) has had a number of names and a number of definitions. Münchausen syndrome by proxy (MSBP) and factitious disorder by proxy are also referred to in the literature under this subheading.

## **Identifying FII**

Identifying fabricated or induced illness is not a swift or easy process and identifying the carer's pattern of behaviour will require a multi-agency approach, experience and observation.

There are three main ways that a parent /carer or professional may fabricate or induce illness in a child, these are not mutually exclusive

1. **Fabrication** of signs and symptoms. this may also include fabrication of past medical history.
2. **Falsification** of hospital charts, letters, documents and records including falsification of specimens of bodily fluids.
3. **Induction** of illness by a variety of means, this includes poisoning and the giving of inappropriate medication.

## **Spectrum of “Harm”**

Some children may be presented for medical examination by their parent/carers when they are well. This can be due to overanxious parents/carers, or a lack of understanding. Support may be required in order that the parents/carers are able to interpret and respond appropriately to childhood illness.

A key professional task is to distinguish between the over anxious parent or carer who may be responding in an understandable way to a very sick child and those parent/carers who exhibit abnormal behaviour or have an unexpected response to a diagnosis.

For a small number of children, concerns will be raised when it is considered that the health or development of the child is likely to be significantly impaired or further impaired by action of the parents or carers having fabricated or induced illness.

## **Recognition of harm**

Harm to the child may be caused

- **directly** through physical harm or
- **indirectly** via unnecessary or invasive medical treatment which may be given in good faith based on symptoms that are falsely described or deliberately manufactured by carers.

There is a lack of the usual corroboration of findings with signs and symptoms or in circumstances of proven organic illness, a lack of usual response to proven effective treatments. It is this puzzling discrepancy that normally alerts the clinician to possible harm.

There may be a number of explanations for the circumstances that lead to Fabricated Induced Illness. Each requires careful consideration.

**Typical presentation may include the following, and should be considered on the spectrum :**

- 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 the 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 parent/carer
- The child’s daily life is 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/parent
- The reaction of the parent or carer is disproportionate to the diagnosis or non diagnosis of the condition.
- **Children with a known chronic illness may be more at risk of professionals not recognising where illness is fabricated, and professionals should not assume that all reported symptoms in such a child are due to the chronic illness, and may indicate harm.**

- **Children with a known disability may be more at risk of professionals not recognising where illness is fabricated, and professionals should not assume that all reported symptoms in such a child are due to the disability, and may indicate harm.**

### **NICE Clinical Guideline 89, 2009**

The National Institute for Health and Clinical Excellence identify that FII should be **CONSIDER**ed in all circumstances where a child's history, physical or psychological presentation or findings of assessments, examinations or investigations leads to a **discrepancy** with a recognised clinical picture. Fabricated or induced illness is a possible explanation even if the child has a past or concurrent physical or psychological condition.

The same guideline identifies that FII should be **SUSPECT**ed if a child's history, physical or psychological presentation or findings of assessments, examinations or investigations leads to a **discrepancy** with a recognised clinical picture and one or more of the following is present:

- Reported symptoms and signs only appear or reappear when the parent or carer is present.
- Reported symptoms are only observed by the parent or carer.
- An inexplicably poor response to prescribed medication or other treatment.
- New symptoms are reported as soon as previous ones have resolved.
- There is a history of events that is biologically unlikely (for example, infants with a history of very large blood losses who do not become unwell or anaemic).
- Despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms.
- The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for example, wheelchairs) more than would be expected for any medical condition that the child has.

Further information on Child's presentation in FII can be found at Appendix A.

Further information on Possible characteristics of parents/carer in FII can be found at Appendix B.

### **Managing Individual Cases**

#### **Where there are Emerging concerns**

Any professional who has concerns about a child's health should

- discuss these with the child's GP or, where involved, the consultant paediatrician responsible for the child's health care
- discuss the concerns regarding possible fabricated and/or induced illness with line manager and/or
  - within health services - Named Nurse or Named Doctor
  - within education services – identified child protection/safeguarding children leads
  - within children's social care – Team Manager.
- Arrange consultation or professionals meeting with agencies' involved. Consider inviting named/designated health professionals and key professionals from other agencies (e.g. education – school or EWO, other services involved with family)

- Gather information, using chronology template to inform next steps. (Guidance and template for chronology can be found at Appendix D.)

Other actions which should be considered include:

- Referral by the child's GP to a paediatric department if the child is not already under the care of a paediatrician.
- If child is not currently in hospital, consider whether a planned admission with careful observation would help to clarify the clinical diagnosis

### Consultation/Professional Meetings

The Aide Memoire as per Appendix C should be utilised to ensure consideration is given to information known by professionals involved.

A template for recording the meeting can be found at Appendix E.

**During professionals meeting, if immediate harm is deemed likely, formally refer family to Social Care urgently, request advice and/or strategy meeting.**

Legal advice may also be required.

While professionals should seek, in general, to discuss any concerns about a child's welfare with the family and, where possible, seek their agreement to sharing information or making referrals to other agencies, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of harm.**

If no immediate harm is thought likely, ensure services are offered and/or provided as appropriate.

### Involvement of family

In the case of FII, unless it is clear that the parent/carer is not involved in the fabrication, falsification or induction of illness, **parents or carer SHOULD NOT be informed of concerns or referral.**

### Maintaining records

- There is a need to ensure robust and holistic recording of concerns/carer behaviour/how carer behaviour may vary from expected behaviour.
- Records should use clear, straightforward language, should be concise and should be accurate not only in fact, but differentiating between opinion, judgement and hypothesis (DCSF 2008)
- Detailed accurate and informative medical records are pivotal to the management of all cases (RCPCH 2009)
- Where the possibility of FII is present, all records for the child should be kept in a more secure location than usual, for example, in a hospital setting, not on ward trolleys. (RCPCH 2009)
- A single health case record for medical and nursing staff will help to promote effective clinical communication. (RCPCH 2009)
- If a child moves between organisations, it is best practice for the notes to follow the child. This may not always be possible and so a clinical summary should follow the child (RCPCH 2009)
- It is essential that records include a health chronology of the child's medical presentation including any aspects which may indicate FII (RCPCH 2009)

- It is essential that clinicians concerns about FII are documented in the records; where there is uncertainty, this should be expressed as a differential diagnosis<sup>1</sup>. (RCPCH 2009)
- Record in the child or young person's record exactly what is observed and heard from whom and when.
- Record why this is of concern

### **Where FII is suspected**

Individual professionals, or following Professionals/consultation meeting, agencies should make a referral to Children's Social Care where FII is suspected.

The process for

- responding to Referrals
- determining next steps, and
- actions required to safeguard the child

should be followed as per LSCB procedures.

However, the following should be considered:

#### Involvement of family.

While professionals should seek, in general, to discuss any concerns about a child's welfare with the family and, where possible, seek their agreement to making a referral to children's social care, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm.**

In the case of FII, unless it is clear that the parent/carer is not involved in the fabrication, falsification or induction of illness, **parents or carer SHOULD NOT be informed of initial/emerging concerns or referral** to Children's Social Care.

Careful thought should be given to what parents/carers are told, when and by whom. Children's social care should involve the police, the child's paediatric consultant and GP, senior nursing staff (named nurse or senior ward) and other relevant professionals in making these decisions.

Legal advice may also be required.

#### Criminal Considerations

Consideration needs to be given to the potential consequences of the loss of evidence, including the obtaining of and preservation of evidence. Advice should always be sought from the police.

#### Preparation for Strategy Discussion/Meeting

In preparation for a strategy meeting the following steps should be taken.

ALL Practitioners should be advised that this is confidential and parents/carers are **not to be informed.**

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<sup>1</sup> Differential Diagnosis - the determination of which one of several diseases/circumstances may be producing the symptoms.

- All professionals attending the strategy meeting must provide a chronology of their involvement and frequency of contact with the child/parent. This includes Education/Health/Police/Social Care. (Guidance and template for chronology can be found at Appendix D.)
- Those professionals involved in the child's care should be identified as such to enable a coherent chronology.
- A chronology of health involvement with the child, including access to all health services should be prepared to provide comprehensive information. This includes information from A & E/GP/Hospital admissions/School Nurse/Health Visitor etc.
- Any relevant information relating to the parents or siblings.
- The medical/psychiatric history to be shared as appropriate and proportionate.
- **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 powers should be used to secure the immediate safety of the child.**

#### Attendees at Strategy Discussion/Meeting

The following professionals should be included in /invited to the Strategy Discussion/Meeting

- Social Worker
- Consultant Paediatrician
- Police
- GP of both child and parent/carer (if different)
- Health visitor/ school nurse
- Education Representative (if school aged child)
- All relevant professionals (especially for a child who has chronic medical condition, or disability).
- Named or Designated Nurse and/or Named or Designated Doctor

Consideration should also be given to including

- Adult mental health service representative
- Representative of LA legal service.
- Any other professionals.

#### Specific considerations within Strategy Discussion/Meeting

The LSCB Procedures should be followed in respect of conducting Strategy Discussion/Meeting, However, the following should be included:

- Clarification of the medical history, including details of any incidents that are reported to have occurred in the presence of people other than the suspected perpetrator.
- Verify the personal, family and social history. This includes the parent's Medical or Psychiatric history.
- Any other relevant agency/professional involvement
- Agree what, how and when parents/carers are informed of suspicions/ activity. Reference should be made to section above on Involvement of family.

The areas of focus for different professional as identified in the Appendix C should be included in the Strategy Discussion/Meeting discussions.

### Seeking and sharing information in respect to Parental health information where consent cannot be sought.

Parental health information can be shared with other professionals without the consent of the individual in circumstances where the benefits to a child or young person that will arise from sharing the information outweigh both the public and the individual's interest in keeping the information confidential. (GMC 2012, para 36)

Any decision to delay sharing information with an appropriate agency where a child or young person is at risk of, or is suffering, abuse or neglect must be taken cautiously and only in circumstances where the increased risk to the safety or welfare of the child or young person clearly outweighs the benefits of sharing information. (ibid para 39)

Whilst doctors, and other health professionals, need to justify, and record their reasons for sharing information without consent (ibid para 37-38), they equally are required to evidence why they delayed or declined to share information where a child or young person is at risk of, or is suffering abuse or neglect (ibid para 39)

### Effective support and supervision

Working with children and families where fabricated or induced illness is suspected or confirmed requires sound professional judgements to be made. This demanding work can be distressing and stressful and practitioners will need regular support and supervision to enable them to deal with the feelings, the suspicion or identification of this type of abuse, and to maintain focus especially when coming to terms with the fact that a child's illness has been caused by another person often the primary carer. Where a professional has come to know a family well and trusted them, e.g. where the child has a chronic medical problem or disability, this can be particularly challenging. Operational managers and/or supervisors should recognise the stress experienced by front-line staff who may have had a close professional relationship with a family.

Recognised emotional responses to fabricated or induced illness by **staff** involved include:

- Self-doubt
- Fear leading to inaction
- Loss of self-respect, self-esteem
- Failure / didn't recognise the signs / symptoms
- Feelings of failing the child
- Anger at colleagues who disbelieve / believe
- Loss of trust
- Anger at parents / how could they have used me?
- Feeling of being manipulated
- Feeling of being duped
- Fear of litigation / misdiagnosis
- Misdiagnosis
- Disbelief
- Denial
- Reluctance or unwillingness to pass on / share information
- Fear of being cruised
- Fear of challenging more senior colleagues / professionals and dealing with the power differential
- Helplessness

- Feeling unable to prepare a statement of evidence and/or giving evidence in court
- Fear of becoming frozen, unable to make decisions
- Becoming defensive
- Inability to treat the parents in a professional manner
- Knowing I was wrong / right

This is not an exhaustive list.

(from Incredibly Caring, DCSF 2008)

### **Allegations against staff or volunteers**

If the parents / carers are working with children in a professional capacity as either paid staff or volunteers, then appropriate action needs to be taken in respect of dealing with this situation. See North Lincolnshire Safeguarding Children Board policy for managing allegations against staff and volunteers working with children and young people.

## **Appendix A: Child presentation in fabricated/induced illness:**

**The following features can be associated with FII although none is indicative itself, and this is not an exhaustive list.**

- The child's medical (especially hospital) treatment begins at an early stage of their illnesses'
- Children often present with, or have a past history of both genuine and perceived feeding difficulties, faltering growth and reported allergies
- Non organic failure to thrive
- They may develop a feeding disorder as a result of unpleasant feeding interactions. This is not the same as an eating disorder which is associated with psychological factors for example anorexia nervosa or bulimia.
- This may also apply to toileting disorders.
- The child develops an abnormal attitude to his or her own health.
- Poor school attendance, including under achievement and deliberate underachievement by the child and there is a professional perception that the parent or carer is deliberately 'coaching the child to underachieve
- The child attends for treatment at various hospitals and other health care settings in different geographical areas. The child may also have been seen in centres for alternative medicine or by private practitioners.
- Incongruity between the seriousness of the story and the actions of the parents/carers
- The child may already have suffered other forms of abuse.
- History of unexplained death, illness multiple surgical episodes in parents and siblings.
- The parent or carer is observed to be intensely involved with the child for example not allowing anyone else to take over the child's care, medical tests, taking temperatures or measuring bodily fluids.
- The parent/carers may be unusually concerned about the results of investigations that may indicate physical illness in the child, although conversely they may appear not at all concerned.
- If age appropriate the child is perceived as not being allowed to speak for her/himself.

## **Appendix B: Possible characteristics of alleged abuser**

### **The following may be noticed or identified:**

- The child's parent or carer may have a history of childhood abuse. There may also be false or known allegations of physical or sexual abuse, self-harm and /or psychiatric disorder, especially personality disorder or psychotic illness (Eminson and Postlethwaite 1992) (Lazenbatt and Taylor 2011)
- Consideration must be given to the history and relevance of any previous mental ill health in the parent or carer.
- Parent or carer may have some medical knowledge and may try to intimidate health /educational professionals.
- Inaccurate or misleading information may be provided by the parent or carer.
- Parent or carer may refuse to allow professionals to share information regarding the child's presentation/illness
- Parent or carer may threaten law suits too readily
- Tends to be over friendly with health /educational professionals but may be abusive if practitioners do not comply with their wishes
- Often shows inappropriate behaviour, for example being over anxious or even less attentive than you would expect.
- May have mental health problems.
- Parent or carer is not always present when the victim has alleged or real symptoms or signs of illness, as presentation of symptoms may be deliberately delayed.
- Parent or care may be motivated by financial gain; this can be through receipt of benefits or compensation following an accident.

## **Appendix C: Aide Memoire for Professional/Consultation Meetings**

The purpose of any professional meeting is to gather and share information from a number of sources where there is concern for a child's welfare. When this level of concern regards the potential for Fabricated/Induced Illness consideration must be given that this may be the differential diagnosis<sup>2</sup>.

### **This meeting must be minuted and actions agreed.**

**This Aide Memoire is designed to help you: it is not exhaustive. Use and consider all aspects of this as necessary.**

This Aide Memoire should be used in conjunction with LSCB Procedures

### **Questions/considerations for all agencies**

- Which Agency arranged this meeting?
- Can the agencies identify any significant issues? What is the perceived gain for the carer?
- Are the correct agencies involved at this point?
- Who needs to be at this meeting? Consider Health/Police/Social Care/Education
- Have agencies worked together. If not what were the barriers?
- Are there any professional issues or misunderstanding preventing agencies from working effectively?

**NB. Not everyone will have experience of Fabricated or Induced Illness. Information should be shared respectfully. Be aware of fixed thinking!**

### **Considerations/ Questions for Specific Individual Professionals/ Agencies**

#### Health

- Is there clear evidence of diagnoses?
- Are appointments made and kept?
- Are parents/carers health shopping? That is taking their child to different doctors/clinics and seeking numerous medical opinions
- Has anyone other than the parent or carer witnessed the problems?
- Does the parent have an extensive history of involvement with any health services, including GP, medical/ surgical or mental health?

#### Police

- Is there evidence to suggest that a crime has been committed?
- Are parents/carers known' to the police? If so in what capacity, is it relevant.

#### Social Care

- Are the family known to social care?
- Are there any previous child protection concerns

#### Education

- What is the school attendance like?

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<sup>2</sup> Differential Diagnosis - the determination of which one of several diseases/ circumstances may be producing the symptoms.

- Has this deteriorated?
- Is there evidence of repeated patterns of non-attendance?
- What are the reasons for non-school attendance?
- Are absences always explained by parents, or have medical certificates, letters or reports been made available to school?
- How does the child present at school?
- Have parents/carers reported health problems/symptoms which are never apparent in school?

**What are the agencies expected to do now?**

- Is this child safe?
- Identify the lead professional for this case. It may not be the same person who called the meeting.
- Do you need to go away and gather more information?
- Does this need to be referred to Social Care/Police? (Strategy meeting)
- Has the threshold for significant harm been reached?

Be clear about who is going to do what. Timescales/next meeting

Chronology from each agency must be completed. This meeting must be minuted and actions agreed!

## **Appendix D: Chronology Guidance & Template**

### **Guidance**

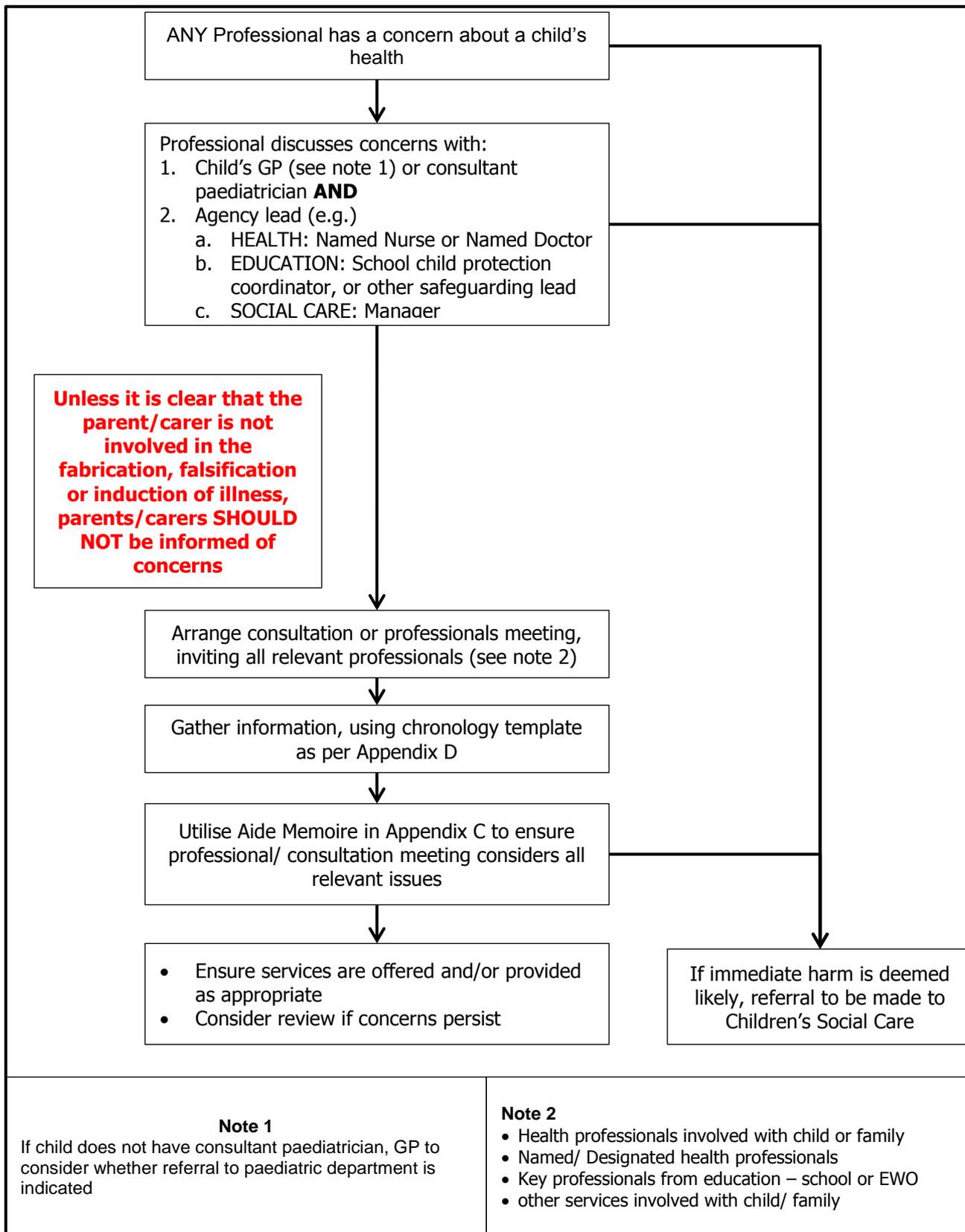
- A chronology should be a succinct summary and overview of the significant dates and events in a child's life. This may include events relating to significant others, where they have an impact on the child.
- Information included in a chronology should be relevant so as not to be lost in a mass of insignificant and irrelevant events.
- The key purpose of a chronology is to provide an early or clear indication of an emerging pattern of concern.
- A chronology, as the most robust mechanism of collating information, can reveal risks, concerns, themes and patterns, strengths and weaknesses within a family.
- However, chronologies should include, or be complemented by analysis of the available information.
- The analysis should outline the impact,
  - **actual** and **potential**, and
  - **immediate** and **cumulative**,of events and changes on the child's developmental progress.
- Professionals should draw on the expertise of professionals from other agencies when considering impact on child.
- It is essential that the analysis, facts, emerging themes and patterns drawn out from the chronology are agreed.



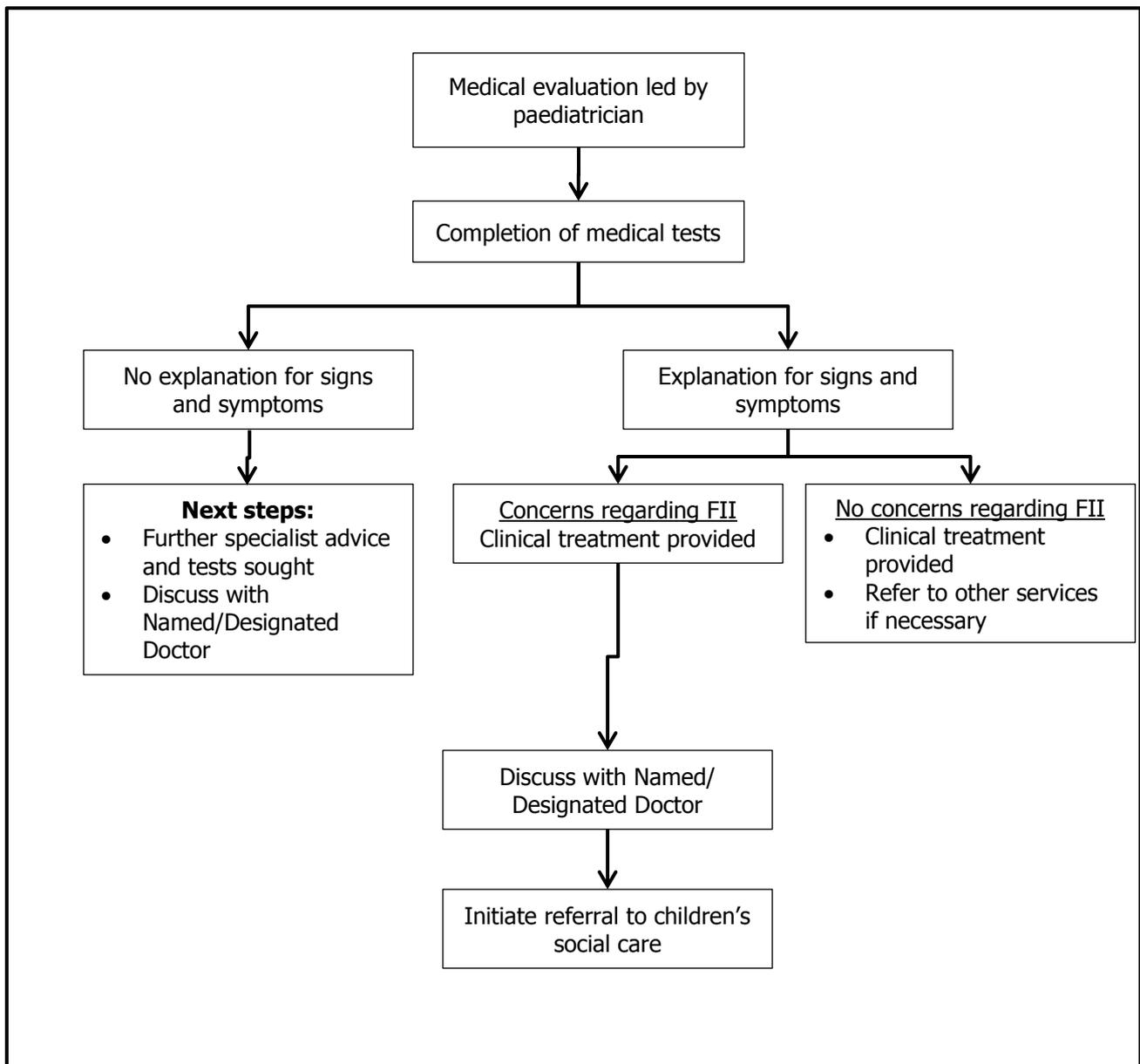


## Appendix E: Flow charts for process

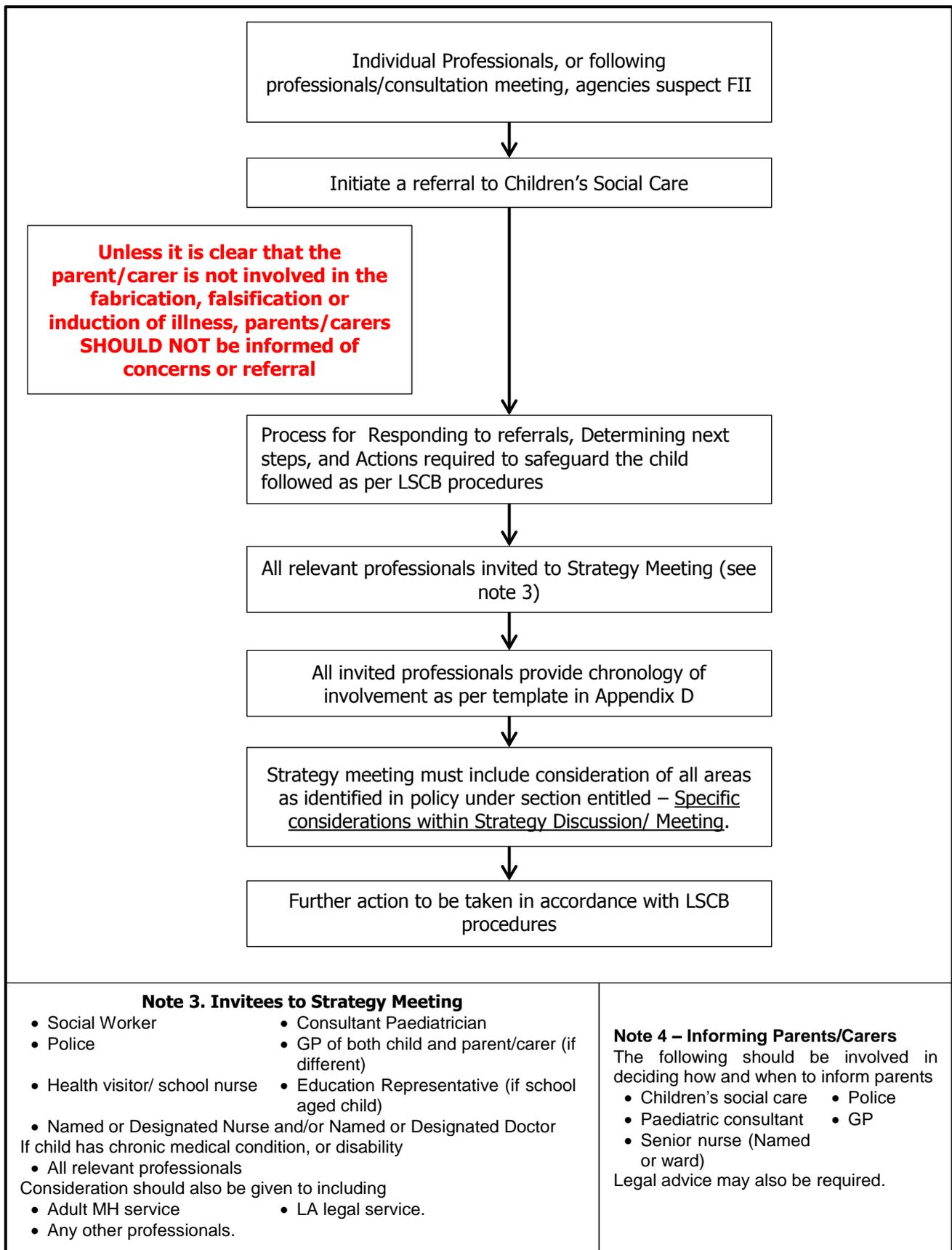
### Emerging concerns regarding FII



## Medical Evaluation by Paediatrician



## Where FII is suspected



## **Appendix F: Additional Reading and References**

Department of Children, Schools and Families (2008) *Incredibly Caring: A Training Resource for Professionals in Fabricated or Induced Illness (FII) in Children*, HM Government

Department of Children, Schools and Families (2008) *Safeguarding Children in Whom illness is fabricated or Induced*, HM Government

Eminson, M. D. and Postlethwaite, R. J. (1992) Factitious illness: recognition and management. *Archives of Disease in Childhood*. 67:1510-1516

Eminson, M. D. and Postlethwaite, R. J. (eds.) (2000) *Munchausen syndrome by proxy abuse: a practical approach*. Boston: Butterworth-Heinemann.

General Medical Council (2012) *Protecting children and young people: the responsibilities of all doctors*.

Lazenbatt A and Taylor J (2011) *Fabricated or induced illness in children: a rare form of child abuse?*, NSPCC Research Briefing

McClure, R. J., Davis, P. M., Meadow, S. R. and Sibert, J. R. (1996) Epidemiology of Munchausen syndrome by proxy: non-accidental poisoning and non-accidental suffocation. *Archives of Disease in Childhood*. 75(1): 57-61.

National Institute of Health and Care Excellence (NICE) (2009) CG89 *When to suspect child maltreatment* (last updated Jan 2014)

Royal College of Paediatrics and Child Health (2009) *Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians*, RCPCH