Safeguarding Children in Whom Illness is Fabricated or Induced

Guidance for Professionals

Policy Version History

Version	Date of Document	Date of Review	Document Author	Update
1	29/10/2015	October 2018	Dr Peter Powell	First Version
2		January 2023	Reviewed by Tracy Murphy, SSP	Document links and references to LSCB updated to SSP.

Contents

1.	Introduction	3
2.	Understanding Fabricated or Induced Illness (FII)	4
3.	Recognition of Emerging Concerns	6
4.	Characteristics of FII	6
5.	Multi-Agency Response Where FII Is Suspected	7
6.	Referral Process Where FII Is Suspected	10
7.	Conclusion and Summary	11

Appendices

Appendix 1: Warning Signs of Fabricated or Induced Illness

Appendix 2: Medical Evaluation Where There are Concerns Regarding Signs and Symptoms of Illness Flowchart

Appendix 3: FII Referral Flowchart

Appendix 4: Chronology Template

1. Introduction

1.1 Key Principles

All involved agencies need to be aware of the complex nature of these cases and the spectrum of behaviour involved. Promoting children's wellbeing and safeguarding them from harm depends crucially on effective information sharing, collaboration and understanding between agencies and professionals.

1.2 Scope of Policy

This policy is relevant to all staff working with children and young people.

This policy is derived from Safeguarding Children in Whom Illness is Fabricated or Induced, DCSF (2008), and Working Together to Safeguard Children (2018). It should be read in conjunction with Suffolk Safeguarding Partnership's procedures which provide further essential guidance.

The Royal College of Paediatricians and Child Health (2009) "Fabricated/Induced Illness by Carers" provides further guidance for Paediatricians.

The policy outlines the procedures to follow when professionals are concerned that the health or development of a child is likely to be significantly impaired by the actions of a carer(s) having Fabricated or Induced Illness.

1.3. Definition

Fabricated or Induced Illness is a condition whereby a child suffers harm through the actions of her/his main carer with the 'harm' often delivered by the way in which health professionals are drawn into investigating and then prescribing drugs or treatments for reported symptoms.

This rare and potentially dangerous form of abuse has also been known as:

- Munchausen's Syndrome by Proxy
- Fabricated Illness by Proxy
- Factitious Illness by Proxy
- Illness Induction Syndrome
- Maladaptive Caregiving Parenting Behaviour

But in order to keep the child's safety and welfare as the primary focus of all professional activity, this guidance refers to Fabricated or Induced Illness in a child (FII).

2. Understanding Fabricated or Induced Illness (FII)

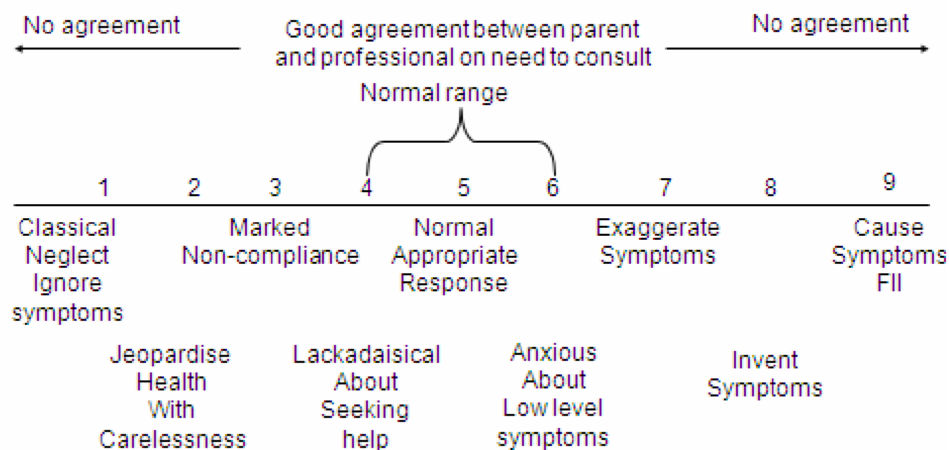
2.1 Identifying Fabricated and Induced Illness is not an easy or swift process. Identifying parental patterns of behaviour will take a multi-agency approach, using expertise and observation over time. A key part of the process being a careful drawing together of a Chronology of the case with detailed descriptions of who reported what to whom and what was independently observed or verified.

2.2 Clinical evidence indicates that Fabricated or Induced Illness is usually carried out by a female carer, usually the child's mother (Maker and Squier 1990).

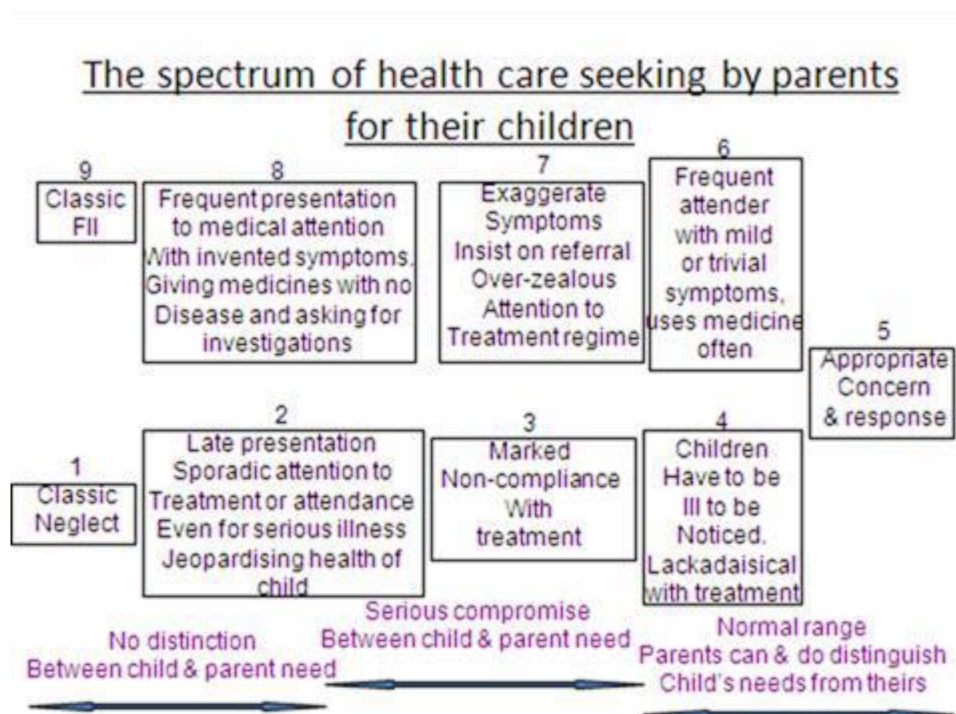
2.3 The FII Spectrum

The figure below describes how there is a natural variation in a Parent's desire to consult health professionals or others for their child's symptoms. It was published in 1992 by Dr Mary Eminson and Dr Bob Postlethwaite who have contributed to the national guidance in this area.

The key insight is that there is a spectrum of parenting behaviour and that FII just neglect is at one extreme of that spectrum, linked by the common theme of an inability to separate a parent's own needs from that of their child.



This is further illustrated by considering the differing levels of alignment of parental and children's individual needs.



2.4. The observed behaviours of parents or carers who do this are described in three ways; each increasingly dangerous to the child and each increasingly uncommon.

These are not mutually exclusive, but a particular behavioural pattern tends to remain in its original category; it just may take the investigating team some time before that category is accurately defined:

- **Fabrication** of signs and symptoms. This includes giving a false or grossly exaggerated past medical history.
- **Falsification** of test results and records. This includes altering charts and records and substituting specimens of body fluids.
- **Induction** of illness by a variety of means, administration of drugs, laxatives or even injection of toxic substances.

A child who suffers harm in this way is also likely to be severely restricted in the ways in which they are allowed to interact with the world, not being allowed to go to school, being taken to many contacts with health professionals or therapists and becoming socially isolated.

2.5. While these behaviours may seem inexplicable and extraordinary to professionals dealing with such cases it is important to realise that parents may genuinely believe that their child is ill and are trying to draw professionals' attention to that delusional belief. The parent may well have had an abusive or neglectful childhood themselves and they have commonly lost significant figures in their lives suddenly.

2.6. There is likely to be disordered attachment with the parent or carer struggling unsuccessfully to separate their own needs from the genuine needs of their child.

3. Recognition of Emerging Concerns

3.1. 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 (for more information on potential warning signs of FII, see Appendix 1).

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

3.3. Typical presentation may include the following:

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

4. Characteristics of FII

4.1. The following features can be associated with this form of abuse, though none is indicative in itself:

- The child’s medical, especially hospital treatment, begins at an early stage of their ‘illness’.
- They attend for treatment at various hospitals and other healthcare settings in different geographical areas.
- They may develop a feeding disorder as a result of unpleasant feeding interactions.
- A pattern of faltering growth.
- The child develops an abnormal attitude to his/her own health.
- Poor school attendance and under achievement.
- Incongruity between the seriousness of the story and the actions of the parents.

- The child may already have suffered other forms of abuse.
- Erroneous or misleading information provided by the carer.
- History of unexplained death, illness, or multiple operations in parents and/or siblings.
- Carer history of childhood abuse, (this may be genuine or complicated by additional false allegations of physical or sexual assault).
- Carer history of self-harm or psychiatric disorder (especially personality disorder with a history of neglect and poor parental attachment in the carer's own past).
- Carer over-involvement in medical tests, taking temperatures or measuring bodily fluids.
- Carers observed to be intensely involved with the child, e.g., not allowing anyone else to undertake their child's care.
- Carers may appear unusually concerned about the results of investigations that may indicate physical illness in the child, although conversely, they may not appear at all concerned.

5. Multi-Agency Response Where FII Is Suspected

5.1 Presentations in Education and Care settings

It is easy to get into a tangle with this sort of case and the tangles often arise because of incomplete or poor communication between professionals from different agencies and concerns about the degree of 'secrecy' with which to handle them.

This is further complicated by people not realising that there is a spectrum of behaviour so that we often cannot say at first encounter whether we are dealing with a case of exaggeration of symptoms by an anxious mother or if this is a more sinister and worrying case where physical acts of harm are taking place such as poisoning or starvation.

There is broadly a cut off between the most severe forms of FII where the parent(s) are using their hands rather than their tongues to deceive health professionals (Categories 8 and 9 on the Spectrum of FII) and the less severe categories where no physical action is being taken by the parent(s) but there
is exaggeration and confabulation of symptoms (Category 7 & sometimes 6).

In all cases where teachers or professionals in care settings become concerned about an apparent mismatch between what is being reported by parents about a child's state of health and what is evident from independent observation, they must seek to find out more about the situation and involved the relevant health professional in an attempt to demonstrate true curiosity about the health of the child.

This means liaison with Health Visitors, School nurses and GPs and with Paediatricians. Permission to find out more about the health status of the child should be obtained from the family but if it is denied then it is justified to share

concerns by contacting the relevant health professional even without parental permission under the overarching imperative of safeguarding the child, particularly if there appears to be significant impact on the child’s permitted functioning and participation in events at school or nursery.

5.2 Concerning situations in Educational settings

Children are presented at school or nursery with reports of illnesses that may be rare or ill-defined and the school is asked to restrict the child's activities in ways that seem excessive for their apparent problem.

The child might appear healthy and keen to participate in playing or running around but teachers have been told they cannot take part in PE or go on school trips or visits, or they are taking drugs or medications.

Walking, mobility aids, bandages, wheelchairs, helmets; anything that the parent insists must be worn or used at school but where the child seems to discard them or not truly need them particularly in the absence of the parent.
School being informed that the child needs to visit hospital frequently for investigations or treatments or they are reported to need a major operation with no apparent problem evident to staff observing the child independently.

The essential common theme is a discrepancy between what is reported by the parent and what is seen by others making independent observations of the child.

5.3 Actions to take:

- Be genuinely curious and ask to find out more about the medical problems.
- Always ask for written confirmation from the GP or Consultant Paediatrician or Physiotherapist about the need for any aids or restrictions on activities.
- Record the behaviour and activity of the child at school noting particularly if there are any functional deficits or in competencies.
- In more complex cases it may be important to gain written rather than verbal permission from the parent to obtain medical information about the child.
- Note as much information as possible about medical problems in other family members.
- Keep a careful chronology of any significant events including any pattern to absences and dates when the child is supposed to be attending hospital or therapist appointments.
- For cases where there is a serious concern that the child may be suffering significant harm make a Safeguarding referral to the MASH.
- In other cases, ask for input from the relevant Health professional - Health Visitor, School nursing service GP or Paediatrician.
- If you are still concerned and not satisfied that the Health Professional understands your concerns about possible FII then inform the Health

professional that you would like to make a referral to the MASH under the category of possible FII and you wish to involve either the named professional or the Designated professional.

5.4 **All health professionals** who have concerns or a suspicion that Fabricated or Induced Illness is being presented must consult with the child's Paediatrician if they already have one. The Paediatrician should discuss the case with their Named Doctor and/or Named Nurse for Safeguarding Children and have a **low threshold for consulting the Designated Health Professionals** too.

If no Paediatrician is involved with the child's care, consideration should be given to holding a Health Professionals Meeting with possible referral to a General Paediatrician describing the concerns about parental anxieties for the child.

All professionals are encouraged to compile a careful chronology of events including what was reported and what was observed independently using the designated format (see Appendix 4).

5.5 A careful medical evaluation will then be led by a Paediatrician (see Appendix 2). This will include a compilation of agency chronologies. The strategy meeting will determine who will collate the chronology for the agency.

5.6 **It is important to establish as clearly as possible at an early stage exactly what are or are not confirmed diagnoses in the child and with what degree of confidence such conditions are ascribed.**

5.7 Paediatricians, GPs and other health professionals should be strongly encouraged not to ascribe diagnoses where they are not corroborated by other evidence independently. There may well need to describe the child's reported symptoms as 'unexplained or of uncertain cause'.

5.8 Referral to a tertiary centre should only be considered after discussion with one of the Designated Doctors.

5.9 The child's records should be kept secure to prevent tampering and all entries legible, signed and dated. All records and referral letters should be completed and maintained in chronological order.

5.10 Professionals meetings or Strategy Meetings may be able to conclude that a case is in the less immediately worrying category of exaggeration rather than induction or inflicting illness in which case the response will be to organise a containment strategy built around establishing clearly what exactly is and is not wrong with the child and communicating this to all involved.

5.11 In the rarer groups of cases where there is a serious and immediate risk of harm then CYPS will act as the lead agency to protect the child and will involve the Police if necessary.

6 Referral Process Where FII Is Suspected

6.4 Following medical evaluation, consultation and review being undertaken with the Named or Designated Doctor for Safeguarding Children, if there is a possible explanation that the child's signs and symptoms may be FII, a referral should be made to the MASH (via Customer First on 0808 800 4005) (add link to new website) specifically stating that the concerns relate to FII and as such there should be a Strategy Meeting.

6.5 At this time the family must only be informed with agreement of the Designated Doctor. If no agreement to inform parents, this will be covered in the Strategy Meeting.

6.6 The Strategy Meeting should be chaired by a CYPS Safeguarding Manager with input from the Designated and/or Named Professionals and CYPS Legal.

6.7 Children & Young People's Services will have lead responsibility for actions to safeguard the child: the Paediatric Consultant will continue to hold the responsibility for the child's health and decisions pertaining to it.

6.8 The MASH will enable key agencies; Health, Police and Children's Services, to work together making joint decisions, especially about sharing information with the carers.

6.9 Carers, whilst being kept informed that in broad terms agencies are formulating plans to meet the child's putative needs, should at no time have the concerns about the reasons for the child's signs and symptoms shared with them, if to do so might jeopardise the child's safety.

6.10 If any professional considers that their concerns are not being responded to appropriately, the SSP Escalation Process (add link to new website) should be used, and support sought from a Named Professional for Safeguarding Children within their organisation.

6.11 If concerns relate to a member of staff, they must be discussed with a Local Authority Designated Officer (LADO). The LADO can be contacted via email on LADO@suffolk.gov.uk or the central telephone number 0300 123 2044.

The LADO guidance and referral form can be found at the following link on the Suffolk Safeguading Partnership website (add link to new website).

All forms and policies are available from the Suffolk Safeguarding Partneship website: www.suffolksp.org.uk

7 Conclusion and Summary

7.4 It is easy to make mistakes in this area of Safeguarding and difficult to get things right. It goes against the grain to shield such investigations from families but doing so may well be protective of the children involved until the plan for action is certain.

7.5 Professionals may well have become drawn into an unwitting collusive state with these families, and it therefore will often take a great deal of effort to sift through multi agency information to get to a consensus position on what is truly wrong with a child.

7.6 Acting too hastily when there is just an exaggeration of symptoms and no significant harm being done to a child will be catastrophic for all agencies relationships with families, but conversely, not thinking the unthinkable and missing cases of FII where children are suffering significant harm is just as catastrophic for the child.

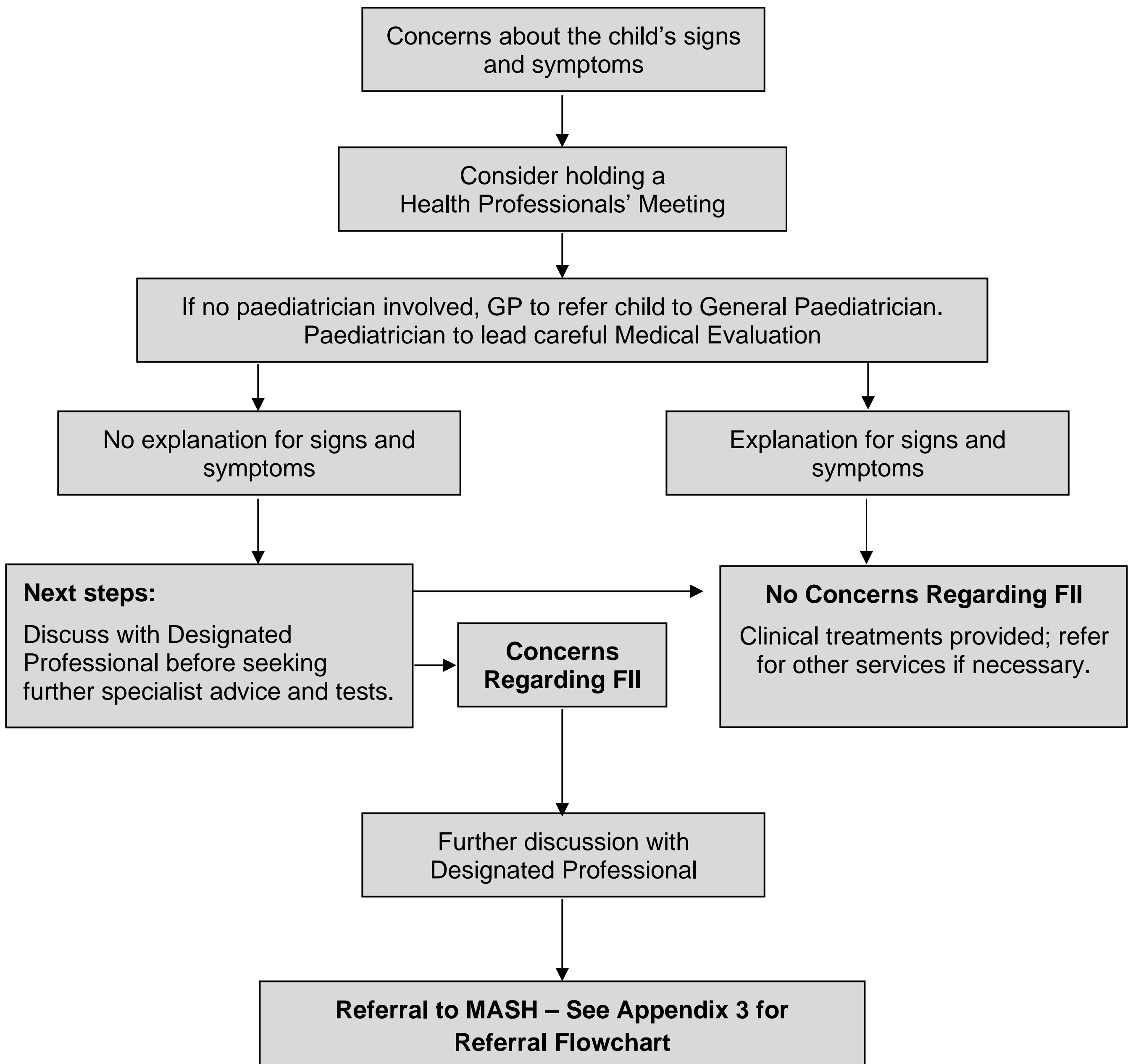
Appendix 1

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 surgeries in parents or siblings of the family.
9.	Once the 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 2

Medical Evaluation Where There are Concerns Regarding Signs and Symptoms of Illness

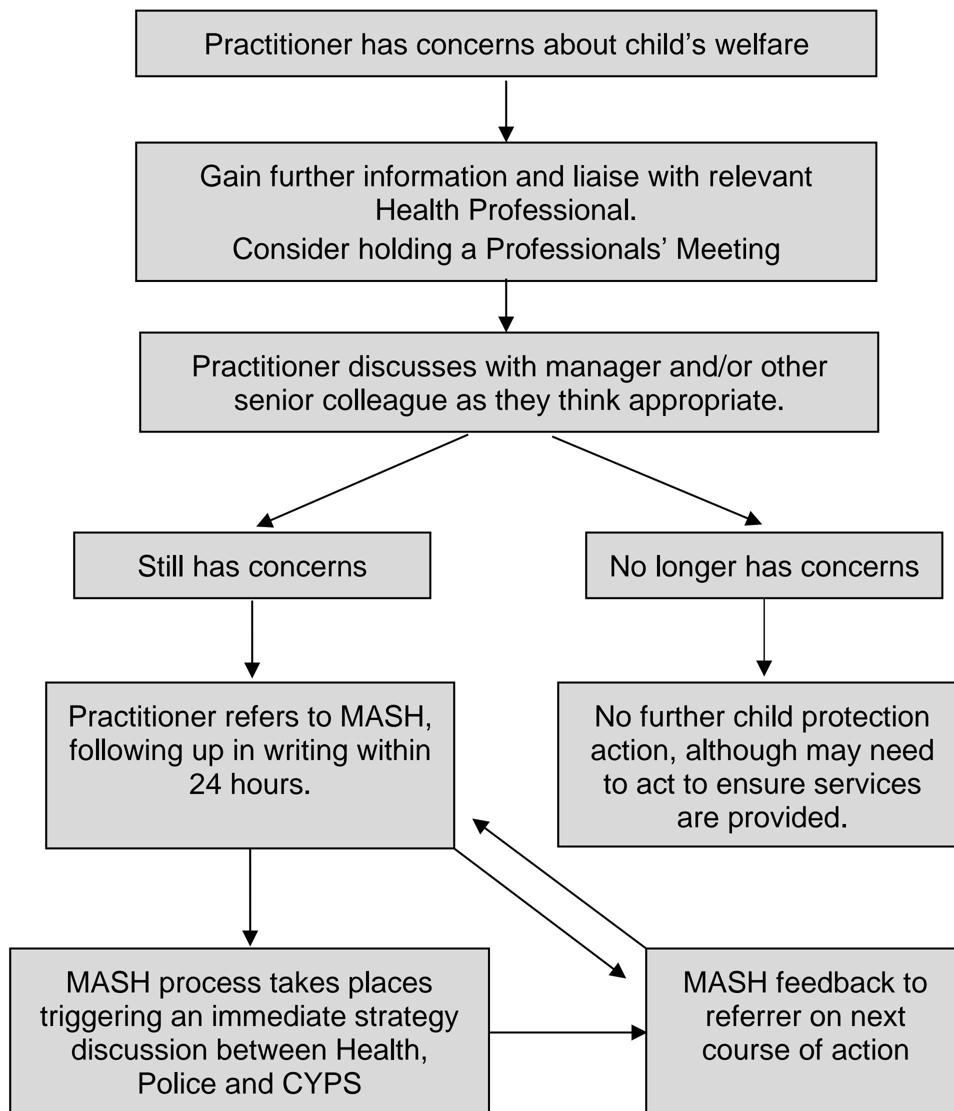
[based on DCSF Safeguarding Children in whom Illness is Fabricated or Induced]



Appendix 3

FII Referral Flowchart

[based on DCSF Safeguarding Children in whom Illness is Fabricated or Induced]



Appendix 4

Chronology Template

Date and Location	Symptoms and Events	Observed or Reported by Whom	Actions and Outcomes