

## Chapter Fourteen

### Fabricated or Induced Illness

#### Introduction

14.1 This chapter is written to provide local arrangements in accordance with the Department of Health Guidance '[Safeguarding Children in Whom Illness is Fabricated or Induced](#)', published in 2002. Unlike that guidance, the chapter does not provide a description of how to deal with a case from beginning to end, but identifies elements, which are different from standard cases. These include:

- recognition – the important role of Health – the need to re-evaluate previous diagnosis
- differences in how to deal with such cases, including time scales and parental involvement

#### Definition

14.2 Fabricated or induced illness (FII) is a form of physical abuse. Significant harm is caused to a child by the actions of a parent/carer who deliberately fabricates symptoms or induces medical symptoms in a child, which would not otherwise be present.

14.3 This can take the form of a range of behaviours by parents or carers, including:

- deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation
- intervening with treatments by over-dosing, not administering them or interfering with medical equipment such as infusion lines
- falsely claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, bleeding from orifices, vomiting or fits. These claims result in unnecessary investigations and treatments which may cause secondary physical problems
- falsifying medical charts and other documents
- exaggerating symptoms, causing professionals to undertake investigations and/or treatments which may be invasive, e.g. surgery or repeated X-rays, which are unnecessary and therefore are harmful and possibly dangerous
- interfering with specimens of bodily fluids by swapping samples or adding substances
- obtaining specialist treatments or equipment for children who do not require them
- unreasonably and persistently attributing psychiatric illness to a child

14.4 It is important to be clear that some parental behaviours connected with illness in children do not constitute FII. There is a wide spectrum of parental responses to children's illnesses. These include:

- over-anxious parents responding to a sick child
- dishonest presentation of physical injury as accidental to cover physical abuse
- rejecting or emotionally abusive behaviour towards an ill or disabled child
- neglect of treatment needed for an ill child
- mentally ill parents whose delusion includes that their child is ill

### **Recognition of Fabricated or Induced Illness**

14.5 The incidence of FII is considered to be rare – but probably under-reported.

14.6 FII is not easily identified. Identification will often start with puzzlement: the parent / carer's description may not fit either what is observed or the usual course of the reported illness; for example:

- reported symptoms and signs are not observed to commence, in the absence of the carer
- physical examination and results of medical investigations do not explain reported symptoms and signs
- there is an unexpectedly poor response to prescribed medication and other treatment
- new symptoms are reported on resolution of previous ones
- over time the child is repeatedly presented with a range of signs and symptoms
- 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

14.7 It should be noted that parents/carers may invent, fabricate or induce illness in a child who is genuinely ill or has disabilities. The genuine illness may have required extensive medical intervention. The process of recognition may require careful reassessment of previous diagnoses and treatment, some of which may, with hindsight, come to be seen as inappropriate and have inadvertently harmed the child.

14.8 In trying to make sense of any situation of possible FII, the focus should always be on the impact of what the parent/carer does on the child's health, development and safety.

### **Early Consultation and Medical Evaluation**

14.9 In most situations, it is important to take time to identify and clarify early suspicions with **care and without alerting the parent/carer to early suspicions**. It is also important to ensure that genuine illness continues to receive proper attention. For this reason, the procedures emphasise the need for a thorough consultation process.

14.10 **The clear exception is where a child is suspected of being at risk of immediate serious harm, such as through poisoning or suffocation. These cases should be referred immediately to children's social care or to the police.**

- 14.11 Where the concerns raised are not urgent but relate to puzzling presentations in the child or in the parent/carer's behaviour or concerns are not being responded to appropriately then these should be reported to either the designated doctor or designated nurse for child protection at Bridge Park Plaza for them to conduct a 'risk assessment'. The purpose of this consultation is to clarify the nature and degree of concern and to reach an early view on whether FII should be considered.
- 14.12 It is important not to initiate wide discussion amongst colleagues at this point. This avoids the risk that parents/carers become aware of concerns before it is appropriate. This could be either by being told by someone who does not share the concern or by being faced with altered reactions as others become suspicious that the parent/carer is making up symptoms.
- 14.13 The designated doctor or nurse will discuss the concerns with the referrer and will then decide if it is appropriate to start looking at the child's medical history and, where appropriate, the medical history of other family members, including any child deaths recorded within the family.
- 14.14 At this stage the designated doctor or nurse may decide to take specific steps such as discussing the case with the responsible medical practitioner to seek background information. It may also be appropriate for contact to be made at this stage with children's social care and the police child abuse investigation unit in order that their information systems can be checked as this could help inform the risk assessment.
- 14.15 If this action determines that FII is not, or is unlikely to be present, the designated doctor and the agency representative will agree any further action required. This may simply be a level of monitoring. If so, any such arrangements need to be explicit about how long this will continue and how progress of the child will be tracked. Alternatively, although FII is not seen as indicated, the discussions may have identified needs for support and/or other child protection concerns. These should then be addressed through normal channels.
- 14.16 The designated doctor or nurse will be responsible for maintaining a central record of all concerns notified to them. This record must include what decisions were made and actions taken.

### **Planning Section 47 Enquiries when Fabricated or Induced Illness is Suspected**

- 14.17 Once the designated doctor or nurse has examined a case then if they remain concerned that FII may be involved then a referral should be made to children's social care, stating clearly that there is suspicion of FII, and that this is supported by the designated doctor or nurse. Any suspected case of fabricated or induced illness may also involve the

commission of a crime and therefore the police should always be involved.

14.18 It remains essential that further information gathering and enquiries are carefully planned. This will invariably require a strategy meeting. It may be necessary to hold more than one strategy meeting if, for example, the case is complex and time is needed to gather the medical and social histories.

14.19 The strategy meeting will normally be chaired by a service manager from children's social care.

14.20 The strategy meeting will include:

- relevant doctors currently involved with the child/family.
- a senior ward nurse, if the child is an inpatient or regularly attends hospital
- the designated doctor or nurse who examined the case
- the named doctor or nurse (if directly involved)
- a senior police officer
- the child's social worker, or one who will carry out any enquiries
- a legal advisor

14.21 The meeting may also include:

- a specialist medical advisor, where relevant (the medical involvement should involve specialists who have substantial knowledge of the child, will be part of the investigation team, and will provide evidence in criminal or civil court proceedings)
- other agencies, only where necessary to plan enquiries

14.22 The GP will hold key information about the child and family's medical history, and it is vital to engage the GP in the process. Where the GP cannot attend the strategy meeting, the designated doctor for child protection will assist in ensuring that there is sufficient information available to the meeting and that a good level of communication is facilitated with the GP.

14.23 The purpose of the strategy meeting is:

- to collate medical knowledge about the child, the child's siblings and the parent/carers. This information should include children who no longer live with the family or who may have died
- to seek expert interpretation of these medical records
- to collate information about family structure and background information, including educational needs
- to identify and clarify information, which supports the view, that FII is a likely explanation for the child's presenting problems or supports the parents/carers' account of the child's illness
- to identify further information and evidence which needs to be gathered and collated, including the saving of forensic specimens for prosecution purposes and care proceedings

- to identify all relevant sources of information including all medical services which the parents may have approached (n.b. including NHS Direct)
- to identify how additional information is to be gathered and located, who is to be responsible for obtaining particular information, how it is to be recorded and stored and the time scales over which it is to be obtained. Key issues will include who has observed what symptoms in the child and in what context, and what verification is available. Clear recording systems need to be in place to ensure that future concerns are all captured and that it is clear from notes which symptoms have actually been observed by medical staff and which have been reported by carers but not witnessed
- to decide whether it is necessary for supplementary records to be kept in a secure place in order to safeguard the child
- identify a medical clinician to oversee and co-ordinate the medical treatment of the child to control the number of specialists and hospital staff that who see the child
- to decide whether the child requires constant professional observation, and if so, whether the carer should be present
- to decide immediate or contingency plans which might be necessary. This will include consideration of temporary surveillance measures which might be needed to alert medical and nursing staff where children with fabricated or induced illnesses may be presented at different hospitals or health centres
- to decide on the nature and timing of any police investigation including the analysis of samples and the use of covert surveillance
- to agree how to ensure maximum confidentiality, while enabling relevant staff to gather evidence, at the same time as protecting the child from harm
- to consider the degree of risk to siblings and what, if any, action should be taken to safeguard their welfare
- what, if anything, should be said to the parents/carers at this stage, and setting out arrangements for confidentiality. It may be useful to inform the parents that medical staff do not have an explanation for the signs and symptoms presented. The parents' response to any information given to them should be recorded

14.24 Surveillance may be considered in very restricted circumstances. The final decision rests with the police, operating under their own strict codes of practice. The chairperson for the meeting will be responsible for ensuring that, where this is raised as a possibility, the separate process for determining its usage is invoked.

14.25 Enquiries may be both more protracted and more involved than usual, and may require contingency arrangements about immediate action. It is important that the strategy meetings do not become substitute child protection conferences, in the absence of parents.

14.26 It must be kept in mind throughout the enquiries that the information gathered should focus on assessment of significant harm. What

matters ultimately is the impact of parental behaviour on the safety and welfare of the child, and not whether the parents' behaviour puts demands on others or creates anxiety.

### **Barriers to Assessment of FII, and in Particular, Assessment of the Medical History**

- 14.27 Perpetrators of FII are likely to be manipulative, divisive and/or deliberately deceptive. A feature of FII is thus that parents/carers may misrepresent what has been said by those professionally involved with their child to other professional staff. This may be either to support their own fabrications, or to foster division amongst those involved with them, which in turn prevents concerns being taken seriously.
- 14.28 Parents/carers may thus present very differently to different people and, in particular, may flatter and impress newly involved agencies/clinicians. They may also be both knowledgeable about the supposed illness and extremely persistent in their demands 'on behalf of' the child.
- 14.29 These presentations are likely to lead to conflicting opinions amongst professionals involved with a family.
- 14.30 FII concerns tend to emerge after significant medical input. Often a number of practitioners from different medical disciplines have acted, in good faith, on reported symptoms. When FII is then raised as a potential diagnosis, this will require review of previous diagnoses and interventions. Managing the review of medical intervention appropriately is vital in order to:
- avoid inappropriate criticism of previous intervention which may now appear to have been unnecessary
  - address conflicting medical opinion
  - disentangle actual illness from fabricated or exaggerated presentations
- 14.31 Agreed chronologies are particularly important in complex cases, or those which have involved expressions of concern over an extended period. Both medical and social chronologies are needed.
- 14.32 The designated doctor for child protection or a recognised medical expert in FII should review previous medical interventions and their outcome. Where doubt is raised about a previous diagnosis/intervention, applied by a different medical practitioner, it is vital that that person is invited to review their findings informed by the current concerns.
- 14.33 The process needed in individual cases should be detailed in the strategy meeting(s), and close liaison maintained between the designated doctor/other medical expert and the investigating social worker/police officer. This is, in particular, to identify and take account

of disagreements over medical diagnoses/interpretation of previous events.

14.34 The production of full medical chronologies for siblings is equally important.

### **Engagement with Parents**

14.35 No family member should be informed that a concern has been raised about possible FII abuse until this has been explicitly agreed by the police and children social care. This would not normally be prior to the first strategy meeting. The strategy meeting should reach an explicit decision about what and when to tell family members of the suspicions. Where it is agreed that initial enquiries will not be shared with family members, the subsequent strategy meetings must explicitly review this decision.

14.36 This reversal of the presumption of openness which underpins most work with parents/carers, reflects the physical risks to the child which are present in confirmed cases of FII. Confronting parents with the suspicion of FII in an unplanned way can increase the risk of direct harm to the child, particularly where the concern is that the parent/carer may have already directly harmed the child. Historically it has been noted that where a perpetrator is informed that professionals are doubting that their child is genuinely ill this can prompt an increase in their attempts to show that the child is, indeed, sick.

14.37 Where a criminal offence has, or may have been committed, it is important that any information to the parents does not interfere with the criminal investigation.

14.38 At the same time, it is important not to maintain secrecy any longer than necessary to safeguard the child, in order to:

- maximise the prospects of subsequent working relationships with the family
- be able to test out and gain a fuller view of suspicions
- capitalise on the strengths in the family as well as assessing the concerns

### **Outcome of the Section 47 Enquiry**

14.39 Because of the unusual complexity of FII cases and the need to gather sometimes-extensive information, the planning and investigation of such cases may take longer than other child protection enquiries. It is possible that the outcome of the single or a series of strategy meetings may be that the child is not at risk of significant harm. In these cases it is important that there are clear decisions on ending the process, including:

- arrangements for monitoring the child's progress and responding to further concerns
- arrangements for reporting back to the person expressing the original concern if not part of the strategy discussions

- arrangements for sharing the concerns with the child's parents or carers and how explicit this should be about the discussions which have taken place between agencies
- 14.40 Concerns may be substantiated but an assessment made that the child is not judged to be at continuing risk of harm. In such a case a decision not to proceed to a child protection conference may be agreed.
- 14.41 Where concerns are substantiated and the child judged to be suffering or at risk of suffering significant harm a child protection conference must be held within 15 working days from the last strategy meeting.
- 14.42 If it is decided not to inform the parents/carers about the investigations, which have taken place because this would jeopardise the safety of the child the reasons for this decision must be explicitly recorded.
- 14.43 Following identification of fabricated or induced illness in a child by a carer, the way in which the case is managed will have a major impact on the developmental outcomes for the child. Evidence suggests that outcomes have been poor for many children who have been the subjects of fabricated or induced illness, particularly where they have remained with the perpetrator of the abuse. Studies have found that where the child's safety had been addressed and long-term therapeutic work undertaken with the family then good outcomes were more likely. The extent to which the parents have acknowledged some responsibility for fabricating or inducing illness in their child will affect these outcomes for the child.
- 14.44 At the conclusion of the investigation the outcome should be agreed by the key senior professionals involved. This may require a further meeting to be convened.

#### **Assessment and Treatment of Carers**

- 14.45 Where the existence of FII is established, as well as ensuring the welfare of the child, attention should be given to ensuring that assessment and treatment of any illness is offered to the carer with this behaviour.
- 14.46 The named doctor for child protection at the Mental Health Trust should be contacted to nominate an appropriate colleague to carry out an assessment.
- 14.47 Adult psychiatrists are more likely to be involved at the point at which there is moderate to high degree of suspicion that a carer has been inducing symptoms, or a court has made a finding of fact that such behaviour has occurred. To inform core assessments, or a child protection conferences, it will be important to get an assessment from a psychiatrist who is familiar with both a) the relevant developmental and family psychiatric literature and b) risk and mental disorder literature,

especially in relation to personality disorder, since this is the diagnosis most often made in these situations.

14.48 The assessing adult psychiatrist cannot be involved until the medical process which has made a definition of offending behaviour by exclusion of any medical examination, has been completed. Assessing psychiatrists should be able to liaise with those assessing the child and those who have knowledge of the child's health. It will be helpful for the assessing psychiatrist to have access to the paediatric notes as well as the child's general practice notes.

14.49 If the assessing psychiatrist is being asked to comment about treatment, then this question should distinguish between treatment for the carer's psychological needs and the treatment for risk improvement. These aims are not necessarily the same. It should also be emphasised that currently the evidence base does not allow professionals to make clear statements about the risk assessment in the long term or even in the short term.

### **Concerns about Professionals**

**14.50** Most cases of FII involve parents/carers. The possibility that such behaviour could be found in professionals or volunteers acting in a caring capacity should be borne in mind. Such concerns should be raised discreetly and directly with the named doctor or nurse for child protection. It is vital that an individual does not discuss their concerns with other colleagues as this may inadvertently alert the perpetrator who could then take steps to cover up their actions or, worse still, escalate their behaviours. The process set out in this chapter must be followed, bearing in mind the additional factors set out in [Chapter 13: Allegations against a person who works with, or is in contact with, children in a work or care setting, including volunteers](#) of these procedures which set out arrangements for managing allegations of abuse made against professionals and volunteers.

### **Problem Resolution**

14.51 FII and its management raises considerable ethical dilemmas for practitioners and has high potential for conflict between agencies and practitioners. It is particularly important that these are aired between agencies openly, in order that the focus of concern remains the child. Please refer to the **Chapter 23: Resolving Professional Disagreements related to the safety of children.**

14.52 Where FII cases have raised particular concerns about the practice of individuals/agencies or the policies of agencies within this procedure, consideration should be given to debriefing meetings.