Guideline for Safeguarding Children in Whom Illness is Suspected to be Fabricated or Induced.

VERSION 2

Lead Person(s)	:	Safeguarding Children Team, SaTH
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For triennial review

Version	Implementation Date	History	Ratified By	Review Date
1	Dec 2008		Trust Safeguarding Group	2011
2	Dec 2018		Paediatric Governance	2022
3				
4				

1.0 Introduction

1.1 Following consultation, the Government issued the guidance: “Safeguarding Children in Whom Illness is Fabricated or Induced” in August 2002. The guidance relates to a national framework within which all agencies and professionals at a local level should develop their own policy for dealing with incidents where fabricated or induced illness is suspected.

1.2 RCPCH issued guidance in 2013 to the effect that nothing had changed since the original guidance in 2009 and that document still stood.

1.3 This guidance is to be read in conjunction with the RCPCH Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians 2009

2.0 Aim(s)

2.1 All staff working with children and families in the Shrewsbury & Telford NHS Trust should be aware of their child protection responsibilities in relation to fabricated or induced illness and this document will be relevant to members of staff who deal with children and families in clinics or on the wards.

3.0 Definitions

Fabricated or Induced Illness is a condition whereby the child suffers harm through the deliberate action of the main carer and which is attributed by the adult to another cause. Fabricated or Induced Illness is a form of child abuse and may exist with another type of abuse.

3.1 Presentation

There are many ways in which a child may present as having Fabricated or Induced Illness:

- Fabrication of signs and symptoms including past medical history and family history
- Falsification of medical or nursing records, including letters and documents
- Induction of an illness by a variety of means
- False specimens of bodily fluids

3.2 Risk factors

All professionals will need to be aware of some of the following risks within the child:

- The child may have been born prematurely
- May have suffered minor problems since birth
- Non-organic failure to thrive
- Alleged feeding problems
- Alleged allergies
- Other forms of abuse
- Various hospital or GP attendances, in different areas

- Referrals to tertiary centres
- Possible absences from school

Risks from the adult

- Usually the female carer
- Carer or parents previous medical history
- History of childhood abuse
- Psychiatric or Psychological histories
- Significant family bereavements in short time span
- Obstetric history may include miscarriages or stillbirths
- Relationship difficulties within the family.
- History of being in the medical profession or having medical knowledge.

A list of warning signs with further explanation is included in Appendices C and D.

3.3 Medically unexplained symptoms and 'perplexing presentations

Rather than 'true' FII where a carer presents false evidence of illness or induces illness, it is much more common to encounter a situation where a child presents with symptoms that cannot be explained by the medical team, who are confident that the symptoms do not represent a harmful underlying pathology. When the carer accepts this explanation, these are managed as medically unexplained symptoms. Reassurance and encouragement are often sufficient.

On occasion, the carer is resistant to this explanation and continues to insist on further investigations or onward referrals for specialist or second opinions and the symptoms subsequently amplify, driving further anxiety. Multiple specialities can become involved, complicating the diagnostic and management process and poor communication between different teams or between teams and the family can produce a complex situation that is difficult to resolve. There is not fabrication or induction of symptoms by the carer, but the carer's interpretation of the symptoms not only prevent optimal management but can lead to iatrogenic harm to the child. These can be termed 'perplexing presentations' (PP) and multiagency investigations are not the most appropriate initial approach to resolving them.

4. Approach to potential FII/PP

4.1 What is the first step if FII is suspected?

From the safeguarding point of view, once a possibility of FII is considered, the first logical step is identifying who will be the Responsible Paediatric Consultant (**RPC).** A Responsible Paediatric Consultant is needed for continuity of care, liaising with other professionals and controlling the case. Any request for changing the clinician or hospital should be resisted. This is also a useful approach where FII is not suspected, but many professionals are involved and the family are receiving lots of advice that is sometimes contradictory.

There should be clear documentation in the case notes of potential FII concerns so that all the relevant health professionals are aware of this possibility. A consideration

should be given to restrict carer's access to the hospital records. Also, consider a closer supervision of the child to ensure safety.

It is prudent to involve the Named Nurse and Doctor and other colleagues involved in the care of the child. An immediate risk assessment is needed. If there is an identified need for protection then the concern should be escalated straightaway.

Observation as an inpatient may be needed to confirm or refute the doubt, perform additional investigations and arranging appropriate referrals. Any invasive procedures or potentially harmful treatment should be instantly withheld unless absolutely necessary.

A clear plan of action should be made and communicated to the on-call colleagues for both FII and any organic illness.

If the following discussion with colleagues and Named Professionals, this is felt likely to represent PP, a different management approach is necessary.

4.2 Managing perplexing presentations (PP)

The key to deescalating PP is to reach concordance amongst the different health care professionals involved. The Responsible Paediatric Consultant firstly needs to review the child with a biopsychosocial approach in mind and appropriate time should be set aside for this consultation. The following information should be gathered from this consultation:

- Child's *current* state of health
    - Obtain history/observations from *all* carers
    - Collate all current medical/health involvement and treatment
- Document the child's current functioning (school, mobility, aids)
- Carers' views – explanations, fears, hopes for child's difficulties
- Child's views – illness beliefs, anxieties, mood
- Explore family functioning and effect on child's difficulties on
    - Siblings and their health
    - Family life and interactions

The Responsible Paediatric Consultant will need to liaise with **all** involved health care practitioners, including private practitioners and allied health professionals. Establishing the provenance of reported diagnoses is important, as is determining a list of *warranted* investigations required to *definitively* rule out sinister pathology. Like in FII, an elective admission to observe the nature of symptoms and the carers' response to them can be very useful, particularly if further investigations are felt to be needed.

Ideally, a professionals' meeting should be arranged, where a unanimous and concordant professional opinion can be reached, and a plan of management arranged.

Following this, the Responsible Paediatric Consultant and a senior nurse should meet with the family, explaining the professional opinion, presenting the biopsychosocial formulation and the resulting goal-based management plan. Should

the family accept this explanation and plan, the problem can be managed as a medically unexplained symptom(s).

However, should the family reject this explanation and plan, demonstrate poor concordance with management or attend their GP seeking new referrals or investigation for the symptoms, their lack of engagement with the management plan may be producing significant harm for the child and should meet the threshold necessary for a safeguarding referral.

Should the child present with altogether new symptoms that are unrelated to the previous presentation, these should be evaluated by the Responsible Paediatric Consultant and if a similar pattern arises, the question of whether this represents FII should once again be considered.

In either circumstance, the Responsible Paediatric Consultant should discuss the child again with the Named Doctor and Named Nurse and consider whether a safeguarding referral is appropriate.

4.3 Managing 'Did Not Attend' / 'Was Not Brought' appointments

When children are not brought to appointments, this should be managed as per Chapter 10 of the Safeguarding Children and Young People Policy and Procedure.

4.4 When should Social Care be informed?

Children's Social Care should be informed about the concerns as soon as the possibility of FII is considered. Waiting for a formal confirmation of the FII diagnosis is not necessary.

4.5 Is a Chronology useful?

Chronology is the key. It is a chronological summary of presentations/ events, which is helpful in establishing patterns of events. Where possible the chronology should be compiled using all medical/nursing notes to make it as complete as possible, including notes taken in the Emergency Department. In FII contradictions or fabrications may be become apparent, e.g. misreporting of information of medical professionals advice to other clinicians. This is very time-consuming and demanding work. It is therefore important to clarify the responsibilities and timescales. SaTH will be expected to support the clinician by providing appropriate time and resources to prepare the chronology. Chronology may be prepared in stages but a unified health chronology will be needed. A chronology template is included in Appendix B.

4.6 The Strategy Meeting

A strategy meeting will be needed for information sharing. From a health perspective, the Responsible / Lead Paediatric Consultant, Safeguarding Nurse (SaTH or Community) and the GP must attend the strategy discussion.

When considering if a condition is being fabricated or induced, the clinician must also consider the harm the child may be coming to. This may include undergoing unnecessary investigations, including endoscopies and even surgery. Consider the impact on the child's quality and normality of life. Consider if the child is missing school or is unable to take part in normal family and social life because of unnecessary or inappropriate restrictions. The child may also be given or use special aids or equipment such as a gastrostomy.

A clinical report including a clear problem list, action points and responsibilities should be prepared by the Responsible Paediatric Consultant. It is essential to maintain meticulous and contemporaneous records, as notes may well be needed in the court of law.

4.7 Covert Video Surveillance

If Covert Video Surveillance (CVS) is indicated, then this should be discussed and agreed upon in the strategy meeting, Police must be involved and the LSCB guidelines must be followed. The decision to go ahead with CVS must be discussed with the organisation's senior management and carefully documented in the notes. The need for CVS should be exceptional, and other options should be considered first. CVS is led by the Police

4.8 When to disclose to the family?

At the initial stage concerns about FII are not discussed with the family as this may put the child at risk of escalating parental behaviour. However, after the strategy discussion, a joint meeting with the carer should be organised involving lead consultant (RPC), senior nurse, Social worker and Police to disclose the possibility of FII. This could be a very difficult conversation and the multi-agency team should prepare in advance. The team should agree on what to be discussed and how the situation will be handled. It is usually helpful if the clinician sticks to the facts, explain the reasons behind consideration for FII, offer any other possible explanations, clarifies causes of symptoms/signs, elucidates the plan of management and prognosis of the child, offers support to the child/carer and ensures adequate follow up arrangements. Detailed and meticulous documentation is crucial to protect the professional and the child in any subsequent legal involvement.

4.9 What if it is not FII?

If a genuine cause for the child's difficulties is found at any time and the possibility of FII is excluded, this should be communicated and documented immediately with sensitivity to the parents and the multi-agency team. Full explanation and an apology should be given to the parents by the RPC.

The family may also require psychologist/psychiatric referral and support of other health care professionals.

4.10 Handling complaints or requests for a new Responsible Paediatric Consultant

It is important both during an investigation and after the investigation is complete for the Responsible Paediatric Consultant to remain the overall lead for the patient's care. Families may try to circumvent this by lodging formal complaints with the Trust or the General Medical Council, or liaising with the Patient Advice and Liaison Service (PALS) with the aim of being allocated a new consultant.

The standard Trust complaints procedure should be followed. The Medical Director should already be aware of the situation prior to any FII safeguarding referral being made and the support of the Named and Designated professionals may be required. Face-to-face meetings may be required with family. The goal is to restore a working relationship between the Responsible Paediatric Consultant and the family.

In exceptional circumstances, a new Responsible Paediatric Consultant may be the only viable solution. The choice of new Responsible Paediatric Consultant should be discussed with the Named Doctor and Paediatric Clinical Lead and appropriate time allocated for a detailed handover of all aspects of care, including any work undertaken towards building a chronology of the family's life.

5.0 Training

This policy will be discussed where appropriate at the monthly Child Protection Peer Review.

5.1 Audit criteria

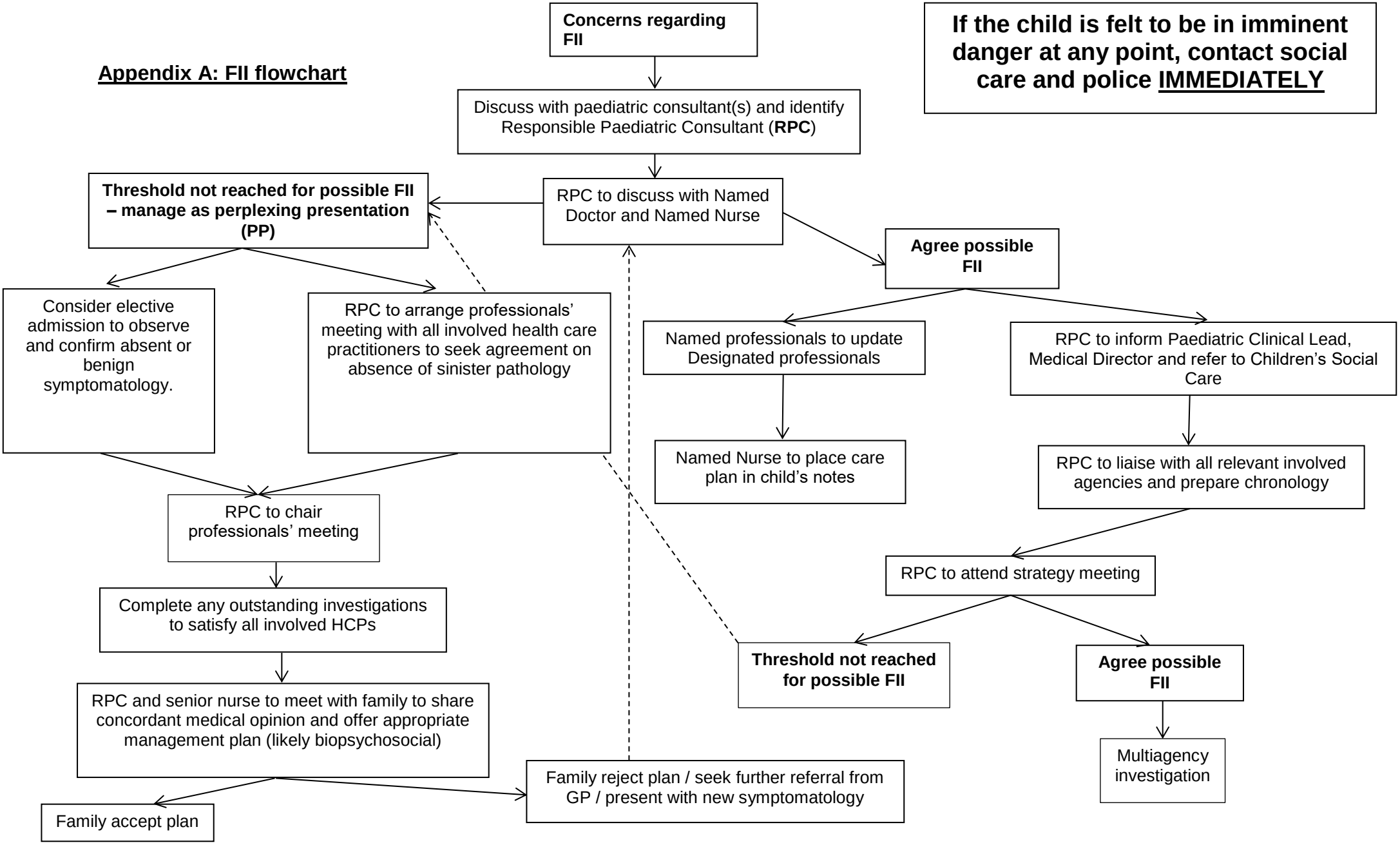
A literature review discovered no external auditable standards for fabricated or induced illness cases. However, serious case reviews into FII cases have suggested post facto audit of all cases to promote learning from experience.

The following local standards from this policy can be audited:

100% of Strategy Meetings should have the Responsible Paediatric Consultant, Safeguarding Nurse and GP in attendance.

100% of cases should be discussed at Child Protection Peer Review meetings within 3 months of the initial Strategy Meeting.

Appendix A: FII flowchart



Appendix B: Chronology template

CHRONOLOGY OF SIGNIFICANT EVENTS

Child(ren)s Name:		**DOB(s):**	
Significant Others:			

DATE	SIGNIFICANT EVENT	SOURCE	COMMENT

Appendix C: FII Warning Signs Template

Category	Warning signs of Fabricated or Induced Illness
1	Reported symptoms and signs are not explained by any medical condition from which the child may be suffering.
2	Physical examination and results of medical investigations do not support/ explain reported symptoms and signs.
3	There is an inexplicably poor response to prescribed medication and other treatment.
4	New symptoms are reported on the resolution of previous ones.
5	Reported symptoms and signs are not seen when the carer is not present.
6	Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear.
7	Repeated presentation to a variety of doctors with the same or different health problems.
8	History of unexplained illnesses or deaths or multiple surgeries in parents or siblings.
9	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.
10	The incongruity between the seriousness of story and action of parents.
11	Erroneous or misleading information provided by the parent.
12	Exaggerated catastrophes within other extended family members are reported.

Please Note: The categories within the template are not absolutes – there may be numerous possible explanations one of which is possible FII.

(with thanks to Dr Dhia Mahmood and Pan-Lancs Safeguarding Children Boards)

Appendix D: Warning Signs Template items explained

Category	Warning signs of Fabricated or Induced Illness
1	**Reported symptoms and signs are not explained by any medical condition from which the child may be suffering.** Information obtained through history and physical examination do not correlate with any recognised disease or where there is a disease known to be present. A very simple example would be a skin rash, which did not correlate with any known skin disease and had, in fact, been produced by the perpetrator. An experienced doctor should be on their guard if something described is outside their previous experience.
2	**Physical examination and results of medical investigations do not support/ explain reported symptoms and signs.** Physical examination and appropriate investigations do not confirm the reported clinical story. For example, it is reported a child turns yellow (has jaundice) but no jaundice is confirmed when the child is examined and a test for jaundice, if appropriate, is negative. A child with frequent convulsions every day has no abnormalities on a 24-hour video telemetry (continuous video and EEG recording) even during a so-called 'convulsion'.
3	**There is an inexplicably poor response to prescribed medication and other treatment.** The practitioner should be alerted when treatment for the agreed condition does not produce the expected effect, for example, asthma medications not making any difference to described wheezing and cough. This can result in escalating drugs with no apparent response, using multiple medications to control a routine problem and multiple changes in medication due to either poor response or frequent reports of side effects. On investigation, toxic drug levels commonly occur but may be interspersed with low drug levels suggesting extremely variable administration of medication fluctuating from over- medication to the withdrawal of medication. Another feature may be the welcoming of intrusive investigations and treatments by the parent.
4	**New symptoms are reported on the resolution of previous ones.** New symptoms often bear no likely relationship to the previous set of symptoms. For example, in a child where the focus has been on diarrhoea and vomiting when appropriate assessments fail to confirm this, the story changes to one of the convulsions. Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.
5	**Reported symptoms and signs are not seen when the carer is not present.** In this respect, the perpetrator is the only witness of the signs and symptoms. For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly raise the anxiety of FII where the severity and/or frequency of symptoms reported is such that the lack of independent observation is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. An example would be school describing episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.
6	**Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear.** This is a planned separation of perpetrator and child which it has been agreed will have a high likelihood of proving (or disproving) FII abuse. It can be difficult in practice and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child's bedside, is unusually close to the medical team and thrives in a hospital environment.

7	**Repeated presentation to a variety of doctors with the same or different health problems.** At its most extreme this has been referred to as 'doctor shopping'. The extent and extraordinary nature of the additional consultations are orders of magnitude greater than any concerned parent would explore. Often consultations about the same or different problems are concealed in different medical facilities. Thus the patient might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different set of problems (or even the same) without informing these various medical professionals about the other consultations.
8	**History of unexplained illnesses or deaths or multiple surgeries in parents or siblings.** The emphasis here is on the **unexplained**. Illness and deaths in parents or siblings can frequently be a clue to further investigation and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the general practitioner through to the extreme of Munchausen syndrome where there are multiple presentations with fabricated or induced illness resulting in multiple (unnecessary) operations. Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially might have been subject to FII abuse and their medical history should also be examined.
9	**The child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.** The carer limits the child's activities to an unreasonable degree and often either without knowledge of medical professionals or against their advice. For example, confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child's school attendance
10	**The incongruity between the seriousness of story and action of parents.** Given a concerning story, parents by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is an incongruity between their expressed concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend for crucial assessments (somebody else's birthday, thought the hospital was closed, went to outpatients at one o'clock in the morning).
11	**Erroneous or misleading information provided by the parent.** These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc.). An extreme example of this is spreading the idea that the child is going to die when in fact no-one in the medical profession has ever suggested this. Changing or inconsistent stories should be recognised and challenged. Accurate and detailed documentation is key here.
12	**Exaggerated catastrophes within other extended family members are reported.** This is an extension of category 8. On exploring reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They were largely or wholly fictitious.

(with thanks to Dr Dhia Mahmood and Pan-Lancs Safeguarding Children Boards)

References:

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