HALTON SAFEGUARDING CHILDREN BOARD

PRACTICE GUIDANCE 2: FABRICATED OR INDUCED ILLNESS

It is important to read this Guidance in conjunction with "Safeguarding Children in Whom Illness is Fabricated or Induced" (DCSF 2008)

The guidance is issued under Section 7 of the Local Authority Social Services Act 1970, which requires local authorities in their social services functions to act under the general guidance of the Secretary of State. It should be complied with by LAs carrying out their social services functions unless local circumstances indicate exceptional reasons that justify a variation. It is also issued under s16 of the Children Act 2004 which states that Children's Services Authorities and each of their Board partners, in exercising their functions in relation to LSCBs, must have regard to any guidance given to them by the Secretary of State for that purpose.

1. FABRICATED OR INDUCED ILLNESS

There are three main ways of the carer fabricating or inducing illness in a child.
These are not mutually exclusive:
A) **fabrication** of signs and symptoms. This may include fabrication of past medical history;
B) **fabrication** of signs and symptoms and **falsification** of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents;
C) **induction** of illness by a variety of means: e.g. administering medication or other substances, obstructing the child's airway, administering overdoses of bon-fide (i.e. prescribed or bought over the counter) medication or withholding it.
Many of the families in which a child has had illness fabricated or induced have experienced a number of stress factors in their lives. Providing services and support to these children and families may strengthen the capacity of parents to respond to the needs of these children before they reach the point where their reaction to their difficulties is to fabricate or induce illness in their child.

A significant number of children in whom illness is fabricated or induced will have been well known to health professionals from birth. Some also suffer from a verified acute or chronic medical condition. Some may previously have

been seriously ill, for example as a consequence of prematurity, while others may have had minor problems at birth or in their first few months of life. Consideration should be given to the possibility that the obstetric complications themselves may have been due to the mother interfering with her pregnancy to induce a premature birth (Jureidini, 1993). Children may have also experienced other forms of abuse, for example, physical abuse or neglect, prior to the identification of fabricated or induced illness (Bools et al, 1992).

Fabricated or induced illness is often, but not exclusively, associated with emotional abuse. There are a number of factors that teachers and other school staff should be aware of that can indicate that a pupil may be at risk of harm. Some of these factors can be:

• frequent and unexplained absences from school, particularly from PE lessons;
• regular absences to keep a doctor's or a hospital appointment; or
• repeated claims by parent(s) that a child is frequently unwell and that he/she requires medical attention for symptoms which, when described, are vague in nature, difficult to diagnose and which teachers/ early years staff have not themselves noticed e.g. headaches, tummy aches, dizzy spells. The child has frequent contact with opticians and/or dentists or referrals for second opinions.

The child may disclose some form of ill treatment to a member of staff or might complain about multiple visits to the doctor. Either the child or his or her parent(s) may relate conflicting or patently untrue stories about illnesses, accidents or deaths in the family. Where there is a sibling in the same institution, teachers/ early years staff should discuss their concerns with each other to see if children of different ages in the same family are presenting similar concerns. If they are, it is likely that more than one child in the family is affected. The school nurse may also be able to contribute to the initial evaluation of concerns.

Parent / Carer Behaviours

Carers exhibit a range of behaviours when they wish to convince others that their child is ill. A key professional task is to distinguish between the very anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour. All parents demonstrate a range of behaviours in response to their child being ill or perceived as ill. Some may become more stressed or anxious than others. Their responses may in part relate to their perceptions of illness and to their expectations of the medical profession. Some children may not be unwell but their parents need reassurance that they are indeed well, whilst others may experience continuing difficulty in recognising that their child is healthy and exhibiting normal childhood behaviours. Some parents can be helped to interpret and respond appropriately to their child's actions and behaviours, whilst others may continue to be anxious and / or unable to change their beliefs. **It is this later group of parents who are more likely to present their children for medical examination although the children are healthy.** Skilled

professional intervention is likely to enable most parents learn how to interpret their child's state of health and manage their own anxieties. There may be some parents for whom such early interventions are ineffective. These parents may have particular needs which result in them persistently presenting their child(ren) as ill and seeking investigations and medical treatment. For a small number of children, concerns will be raised when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by the actions of a carer or carers having fabricated or induced illness. Where the impairment is such that there are concerns the child is suffering or likely to suffer significant harm the guidance set out here must be followed.

The following list is of behaviours exhibited by carers which can be associated with fabricating or inducing illness in a child. This list is not exhaustive and should be interpreted with an awareness of cultural behaviours and practices that can be mistakenly construed as abnormal behaviours:
• deliberately inducing symptoms in children by administering medication or other substances, by means of intentional transient airways obstruction or by interfering with the child's body so as to cause physical signs.
• interfering with treatments by over dosing with medication, not administering them or interfering with medical equipment such as infusion lines;
• claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits. These claims result in unnecessary investigations and treatments which may cause secondary physical problems;
• exaggerating symptoms which are unverifiable unless observed directly, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous;
• obtaining specialist treatments or equipment for children who do not require them;
• alleging psychological illness in a child.

The majority of cases of fabricated or induced illness in children are confirmed in a hospital setting because either medical findings or their absence provide evidence of this type of abuse. If, as a result of a carer's behaviour, there is concern that the child is or is likely to suffer significant harm these Child Protection Guidelines / Procedures must be followed.

Concerns may arise about possible fabricated or induced illness when:
• reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
• physical examination and results of medical investigations do not explain reported symptoms and signs; or
• there is an inexplicably poor response to prescribed medication and other treatment; or
• new symptoms are reported on resolution of previous ones; or
• reported symptoms and found signs are not seen to begin in the absence of the carer; or
• over time the child is repeatedly presented with a range of signs and

symptoms; or
• the child's normal, daily life activities are being curtailed, for example school attendance, beyond that which might be expected for any medical disorder from which the child is known to suffer.

The characteristics of fabricated or induced illness are that there is a lack of the usual corroboration of findings with symptoms or signs, or, in circumstances of proven organic illness, lack of the usual response to proven effective treatments. It is this puzzling discrepancy which alerts in particular the medical clinician to possible harm being suffered by the child.

In addition, professionals working with the child's parents may be being given information by the parent about the child or observe the child directly and note discrepancies between what they are told about the child's health and development and what they see themselves.

Clinical evidence indicates that fabricated or induced illness is usually carried out by a female carer, usually the child's mother. Fathers and women other than the mothers have also be known to be responsible. It is common in these later cases for the adult to have undertaken significant responsibility for providing much of the child's daily care. Specific aspects of the carer's histories are likely to be troubled and they may also have considerable medical and physical histories. A significant number of parents are likely to report having experienced genuine medical problems. They may or may not have been substantiated by medical investigations. They may also have a history of inflicting deliberate self-harm. The mothers may have a complicated obstetric history. In addition – a significant number of parents wll have been assessed or treated for mental health problems. Following a formal psychiatric assessment, some may have been diagnosed with a personality disorder, but others may have no diagnosable psychiatric disorder. Parents also report having suffered a number of significant bereavements or losses in their lives with these having taken place within a relatively short span of time – the bereavements may be of significant adults in their lives, of offspring by miscarriage, stillbirth or child death and other losses through divorce or separation.

In the guidance the term 'carer' is used to mean 'parent or carer', i.e. any adult who is exercising parenting responsibilities for a child. Those with parenting responsibilities may include, for example, grandparents, foster carers, child minders, as well as those who have parental responsibility as defined in the Children Act 1989.

The child:

A significant number of children in whom illness is fabricated or induced will have been well known to health professionals from birth. Some also suffer from a verified acute or chronic medical condition. Some may previously have been seriously ill, for example as a consequence of Prematurirty, while others may have had minor problems at birth or in their first few years of life. As noted earlier, consideration should be given to the possibility that the

obstetric complications themselves may have been due to the mother interfering with her pregnancy to induce premature birth.

International research findings suggest that up to 10% of these children die and about 50% experience long-term consequent ill health. Many of the children who do not die as a result of having fabricated or induced illness suffer long-term consequences which may include impairment of their physical, psychological and emotional development. McClure (1996) found that 775 of children were under 5 years at the time of the identification of fabricated / induced illness with a median age of 20 months. The age of the child when fabrication or induction begins is usually much younger than when the abuse is identified because of the length of time it normally takes to identify this type of abuse.

Chronology / background;

Concerns about fabricated / induced illness are more likely to first come to the attention of health professionals. In any case of suspected fabricated or induced illness it is essential to carefully review the child's medical history – this should include reviewing all available medical notes and liaising with the child and family members' GP(s) and other relevant / involved health professionals including hospitals / Walk-in-Centres / A&E in the current area and previous areas if the child / family have recently moved. The drawing up of a detailed medical chronology is most important and will often confirm whether or not concerns of possible fabricated or induced illness require further evaluation and the urgency with which these should be undertaken. It can also help to identify undiagnosed medical conditions.

In drawing up a detailed chronology it is important to distinguish between signs and symptoms that have been reported by a carer and those which have been independently observed / witnessed by a health professional or other person. The chronology should also indicate the treatment and medication prescribed , if any, and the child's response to this and whether it was as should be expected for the presenting problem. Other non-health professionals should draw up a chronology of the child's involvement with their service e.g. school should indicate and analyse the child's attendance / absence patterns and the reason(s) for the latter and whether supported by a medical certificate etc.

Health staff that are concerned about the possibility of a child being affected by fabricated / induced illness should convene a Professionals Meeting and share and discuss / analyse the child's medical / social history and chronology. Having done so the meeting may conclude a number of things as follows;

- *that there is insufficient information / concerns to reach a decision about the cause of the child's reported problems (arrangements would then need to be made to further review the child) and a further meeting convened;*

- *that there was no basis for concerns relating to fabricated / induced illness;*

- *that there remains concern or concerns have escalated to suspicion that the child is being affected by fabricated / induced illness and a referral to CSC must take place on the basis that the child is suffering or likely to suffer significant harm.*

The Halton LSCB Multi-agency procedure for making a child protection referal to CSC would then be activated – the parent / carers of the child must not be informed at any stage that there are concerns / suspicions about fabrication / induction of illness in their child until the method of doing so and the timing has been discussed and agreed with Halton CSC via a Strategy Meeting convened following a child protection referal under the child protection procedures.

In situations where a staff member is suspected of causing harm to a child by inducing or fabricating illness, the procedures set out in paragraphs 6.6 – 6.9 in *Working Together* (2010) must be followed. This is in line with the Pan-Cheshire Multi-agency Safeguarding Procedures in respect of the LADO (Local Authority Designated Officer).

2. ACTION TO BE TAKEN IN RESPONSE TO A CONCERN THAT A CHILD IS OR IS LIKELY TO SUFFER SIGNIFICANT HARM DUE TO FABRICATED OR INDUCED ILLNESS.

When a possible explanation for the signs and symptoms is that they may have been fabricated or induced by a carer and as a consequence the child's health or development is or is likely to be impaired a referral must be made to Children's Social Care.

Parents should not initially be informed of a referral to Children's Social Care in these circumstances.

This referral may follow an evaluation of the child's signs and symptoms whilst an in-patient; it may be as a result of concerns held by professionals working with the child or it may be as a result of concerns held by a member of the public who knows the child.

3. ACTION TO BE TAKEN FOLLOWING A REFERRAL TO CHILDREN'S SOCIAL CARE

The response to a referral should be the same as for any other referral regarding the welfare of a child, outlined in Section 4 of these procedures. This action should be taken in conjunction with the following guidance and with that contained in 'Safeguarding Children in Whom Illness is Fabricated or Induced' (DOH, 2008).

Decisions about what the parents will be told, by whom and when must be made in agreement with the agencies involved and as part of any enquires

made regarding the child's welfare or Strategy Meeting held under these procedures.

The investigative team must ensure that all professionals involved are made aware of the importance of confidentiality in keeping the child safe. However, the investigative team must regularly review the decision not to inform the parent / carer to ensure that they are informed, when necessary, of the concerns relating to their child/ren. From the point of referral to Children's Social Care, the responsible consultant and Children's Social Care should work together although lead responsibility for action to safeguard and promote the child's welfare lies with Children's Social Care. Any suspected case of fabricated or induced illness may also involve the commission of a crime, and therefore the police should always be involved in accordance with Working Together 2010.

Where there are concerns about possible fabricated or induced illness the signs and symptoms require careful medical evaluation by a paediatrician(s). For children who are not already under the care of a paediatrician, the child's GP should make a referral to a paediatrician, preferably one with expertise in the specialism that seems most appropriate to the reported signs and symptoms.

The paediatric consultant has responsibility for the child's health care and decisions pertaining to it. In order to safeguard the child's welfare it is important that all three disciplines work closely together in making and taking forward decisions about future action, recognising each other's roles and responsibilities. If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm Children's Social Care should convene and chair a strategy discussion which involves all the key professionals responsible for the child's welfare. It should, at a minimum, include Children's Social Care, the police, the medical consultant responsible for the child's health and, if the child is an inpatient, a senior ward nurse.

It is also important to consider seeking advice from, or having present, a medical professional who has expertise in the branch of medicine, for example respiratory, gastroenterology, neurology or renal, which deals with the symptoms and illness processes caused by the suspected abuse. This would enable the medical information to be presented and evaluated from a sound evidence base.

Professionals involved with the child such as the GP, Health Visitor and staff from education settings should be involved also as appropriate. It may also be appropriate to involve the local authority's solicitor at this meeting. Staff should be sufficiently senior to be able to contribute to the discussion of often complex information, and to make decisions on behalf of their agencies. **Strategy discussions held under this procedure must be in the form a meeting, rather than telephone contact with individual agencies.**

The Chair of the Strategy Meeting should refer any decision not to inform the parent/carer to the Divisional Manager from Children's Social Care and the

Detective Inspector from the Police Public Protection Unit (Halton). Where there are suspicions of parents fabricating or inducing illness and the child is in hospital it is important to secure appropriately and to date relevant equipment e.g. syringes, feeding equipment and food/drink samples etc. for police investigation.

As noted earlier - In any case of suspected fabricated or induced illness it is essential to carefully review the child's medical history (see paragraph 6.21 on healthprofessionals sharing information with each other). This should include reviewing all available medical notes and liaising with the child and family members' GP(s) and health visitor(s) or school nurse.The drawing up of a detailed medical chronology is most important and will often confirm whether or not concerns of possible fabricated or induced illness require further evaluation and the urgency with which these should be undertaken. It can also help identify undiagnosed medical conditions.

Where primary care staff, including GPs, have concerns regarding possible FII they should ensure the child is referred to a paediatrician for a paediatric assessment. This should not delay referral to children's social care when appropriate.

All professionals and particularly health professioanls may find it useful to refer to the NICE Guidance 'When to suspect Child Maltreatment' (NICE 2009) which provides the following information about when to Consider or Suspect Fabricated or Induced Illness:

Consider:
The child's history, physical or psychological presentation, or findings of assessments, examinations or investigations, leads to a discrepancy with a recognised clinical picture, even if the child has a past or concurrent physical or psychological condition.

Suspect:
As above, plus one or more of the following:

- reported symptoms and signs are only observed by, or appear in the presence of, the parent or carer
- an inexplicably poor response to treatment
- new symptoms are reported as soon as previous symptoms stop
- biologically unlikely history of events
- despite a definitive clinical opinion being reached, multiple opinions are sought and disputed by the parent or carer and the child continues to be presented with a range of signs and symptoms
- child's normal daily activities are limited, or they are using aids to daily living more than expected

4. USE OF COVERT VIDEO SURVEILLANCE

The use of covert video surveillance is governed by the Regulation of Investigatory Powers Act 2000. The police will only be able to carry out covert

video surveillance if they obtain the necessary authorisation under this Act. Police should also be aware of the good practice advice for police officers which is available to them from the National Crime Faculty. Decisions about undertaking covert video surveillance should be made at a strategy discussion. Covert video surveillance should be used if there is no alternative way of obtaining information that will explain the child's signs and symptoms, and the multi-agency strategy discussion meeting considers that its use is justified based on the medical information available. The operation should be controlled by the police and accountability for it held by a police manager. The police should supply and install any equipment, and be responsible for the security of and archiving of the video tapes.

Doctors or other professionals should not independently carry out covert video surveillance. If the suspicion of child abuse is high enough to consider the use of such a technique, the threshold must have been passed to involve the police and children's social care services and a referral must be made.

The Chief Executive of NHS Acute Trust should be kept informed of any decisions to apply to use covert video surveillance in his/her Trust by the Police manager (see paragraphs 1.2 and 6.35 – 6.40 on covert video surveillance). Health staff should notify senior managers in the commissioning and provider arms of the health economy too.