West Dunbartonshire
Child Protection
Committee

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Fabricated or Induced Illness

Multi – Agency Summary Guidance for

Practitioners & Managers

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Protecting our people
COMMUNITY PLANNING
WEST DUNBARTONSHIRE

Public Protection
Chief Officers Group
WEST DUNBARTONSHIRE

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1. Introduction

1.1 Fabricated or induced illness (FII) involves a well child being presented with a more significant health problem than he/she has in reality and suffering harm as a result. This is a relatively rare form of child abuse[i] but where there are concerns about FII, a multi-agency response is essential from an early stage to ensure early sharing and collation of information to ensure that the child is appropriately protected.

1.2 This West Dunbartonshire Child Protection Committee guidance should be read in conjunction with the National Guidance for Child Protection in Scotland which details the role of all agencies in protecting children from harm and abuse.

www.scotland.gov.uk/Publications/2010/12/09134441/0

1.3 The Getting it Right for Every Child (GIRFEC) national approach requires practitioners across all services for children and adults to meet children's and young people's needs, working together where necessary to ensure they reach their full potential. The GIRFEC approach is incorporated into the working practices of all people working with children, young people and their families in Scotland.

www.scotland.gov.uk/Topics/People/Young-People/gettingitright

2. Scope

2.1 This guidance is relevant for all staff working with children and young people across all services including those working in adult services with individuals who may be a parent or carer. It aims to provide guidance and advice for practitioners across all agencies on how to respond to concerns regarding FII.

3. Definition

3.1 Fabricated or Induced illness (FII) in a child is a condition whereby a child suffers harm through the deliberate action of her/ his main carer and which is duplicitously to another cause[ii]. This rare and potentially dangerous form of abuse has previously been known as *"Munchausen Syndrome by Proxy/ Fabricated Illness by Proxy/ Factitious Illness by Proxy/ Illness Induction Syndrome".* This is known as Fabricated or Induced Illness.

3.2 Identifying Fabricated or Induced Illness

Identifying Fabricated or Induced Illness is a complex process and identifying the carer patterns of behaviours will require a multi-agency approach, expertise and close observation.

There are three main ways in which a parent/ carer may fabricate or induce illness in a child[iii]. These are not mutually exclusive and include:

- **Fabrication** of signs and symptoms – may include fabrication of past medical history.
- **Fabrication** of signs and symptoms and **falsification** of hospital charts and records, and specimens of bodily fluids – this may include falsification of letters and documents.
- **Induction** of illness by a variety of means.

Practitioners may find the following link useful:
http://www.nhs.uk/conditions/Fabricated-or-induced-illness/Pages/Introduction.aspx

4. Prevalence

The fabrication or induction of illness in a child by a carer has been considered to be rare. McClure at al (1996) carried out a two year study to determine the epidemiology of Munchausen Syndrome by Proxy, non-accidental poisoning and non-accidental suffocation in the UK and the Republic of Ireland. They analysed data from 128 confirmed cases notified to the British Paediatric Association Surveillance Unit during the period September 1992 to August 1994. Based on this data, the researchers estimated that the combined annual incidence in the British Isles of these forms of abuse in children under 16 years was at least 0.5 per 100,000 and for children under 1 years at least 2.8 per 100,000. The authors calculated that "in a hypothetical district of one million inhabitants therefore, the expected incidence would be approximately one child per year" (p.58).

This study showed that reported rates of fabrication or induced illness varied greatly between different health service regions and the researchers suggested it was under-reported nationally. At the time of their study their findings also suggested that paediatricians considered that the identification had to be virtually certain before a child protection conference is initiated. Thus a number of cases may be unrecorded because of the absence of irrefutable evidence in situations where the level of concern about harm to the child is extremely high. The cases may also present in ways which result in unnecessary medical interventions, for example, where symptoms are verbally reported to surgeons who then carry out operations without questioning the basis of this information. Consequently the estimate of one child per one million head of population is likely to be an under-estimate[iv] .

5. Indicators of Harm

All parents exhibit a range of behaviours in response to their child being ill or perceived as ill. Professionals are required to distinguish between an anxious parent/ carer who may in fact be responding in a reasonable way to a sick

child and those who are exhibiting abnormal behaviours. Some parents may be more anxious than others or have perceptions about illness and expectations of the medical profession which impact on how they cope with situations. Others may need reassurance that their child is indeed well. Some parents can be assisted to interpret and respond appropriately to their child's needs whilst others may not be able to alter their beliefs. **It is this group of parents who are most likely to present their child for medical examination even though they are healthy.**

A list of indicators which may suggest concern regarding FII [v]:

- Over time the child is repeatedly presented with a range of signs and symptoms of various illnesses.
- There tends to be no independent verification of reported symptoms.
- Signs found on examination are not explained by any medical condition from which the child is known to be suffering.
- Medical tests do not support and reported signs and symptoms.
- Claiming symptoms which are unverifiable unless observed directly.
- The response to prescribed medication and other treatment is inexplicably poor.
- New symptoms are reported on resolution of previous ones.
- Signs and symptoms do not begin in the absence of the 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, or that is supported by medical evidence.
- There is a mismatch of evidence from the presenting parent usually, but not always the mother.
- The reaction of the parent or carer is disproportionate to the diagnosis or non diagnosis of the condition.

5.1 The characteristics of fabricated or induced illness are that there is lack of the usual corroboration of finding with signs and symptoms, or in circumstances of proven organic illness, lack of the usual response to proven effective treatments. It is this discrepancy that may alert the clinician to possible harm being suffered by the child.

For characteristics of the child and the abuser in cases of fabricated/ induced illness please see Appendix 1 and 2.

Child Protection Procedures must always apply.

5.2 Clinical evidence indicates that fabricated or induced illness is usually carried out by a female carer, usually the child's mother. Fathers and woman other

than the mothers have also been known to be responsible[vi]. It is common in these latter cases for the adult to have undertaken significant responsibility for providing much of the child's daily care.

There is no evidence to support a unique profile of carers who fabricate or induce illness in their children. There is, however, evidence that as with many parents who abuse or neglect their children, specific aspects of their histories are likely to have been troubled. A careful assessment is required to understand the contribution which their past experiences have made to the child's illness fabrication or induction and the impact that past events may be having on their current ability to care for their child.

6. Action to be taken when fabricated or induced illness is suspected

6.1 A case of Fabricated or Induced Illness may involve the commission of a crime and the Police should be involved as early as possible to share information as appropriate and determine the next steps.

6.2 The response to a referral about FII should be the same as for any other referral regarding the welfare of a child and child protection procedures should be followed.

Decisions about what the parents are told, by whom and when must be made in agreement with all agencies involved and as part of any enquiries made regarding the child's welfare held under child protection procedures. All professionals must be aware of the importance of confidentiality in keeping the child safe. <u>However a decision not to inform the parents should be kept under review to ensure that they are informed when necessary of the concerns regarding their child.</u>

6.3 Chronology

Maintaining a detailed chronology in cases of suspected FII is most important and will often confirm whether or not concerns about possible FII require further evaluation and the urgency with which these should be undertaken. it can also help 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.

- Those professionals involved in the child's care should be identified as such to enable a coherent chronology. This includes Education/ Health/ Police/ Social Work.

- A chronology of health involvement with the child, including access to all health services should be prepared to provide comprehensive information. This includes information from A&E/ GP/ Hospital admissions/ School Nurse/ Health Visitor etc.

- Any relevant information relating to the parents or siblings.

- The medical/ psychiatric history to be shared as appropriate and proportionate.

- **If at any point there is evidence to indicate the child's life is at risk or there is likelihood of serious immediate harm, child protection procedures should be used to secure the immediate safety of the child.**

For further information please refer to SWIA - Improving Practice in Scotland, Practice Guide – Chronologies 2010
http://www.gov.scot/resource/doc/299703/0093436.pdf

Where there are concerns about possible fabricated or induced illness staff may need to seek medical advice about signs and symptoms. This may require evaluation by a paediatrician. For children who are not already under the care of a paediatrician the child's GP should be contacted to facilitate a referral. It may also be important to consider seeking advice from a medical professional with expertise in the particular area or medicine related to the child's symptoms.

Other professionals involved with the child such as Education, Health Visitor and GP should also be involved as appropriate.

7. Health Staff

7.1 All health professionals in the NHS or private sector may come across illness being fabricated or induced in a child. Personnel in these services are well-placed to note the number of presentations of a child, and the manner and circumstances in which these children present. It is essential that health professionals, whether working with children or adults, should familiarise themselves with the various presentations of this type of child abuse. Health professionals may also identify a carer who is fabricating or inducing illness in themselves. In these circumstances, they should consider whether any child(ren) of this adult is/ are having their health or development impaired.

All health personnel should be familiar with child protection procedures and, in particular, know who to contact when they have concerns. Close multi-

disciplinary and inter-agency working is essential in these cases.[vii]

7.2 Once a health practitioner has suspicions that fabricated or induced illness is being presented, he or she should consult the clinical manager (who has lead responsibility for contacting the social work department or the police) and / or the named or designated doctor or nurse for child protection. This will be clarified by the Child Protection Advisor Child Protection Unit, Yorkhill Hospital The named doctor or nurse should be contacted for support and advice. All health professionals should keep detailed notes of these discussions.

Health practitioners should not normally discuss their concerns with the parents/ carers at this stage.

Health staff must always refer to their own NHSGGC guidelines related to FII in the first instance.

7.3 West Dunbartonshire's HSCP Child Protection procedures should be followed. The social work department should be informed of these concerns at the earliest possible opportunity. Social Work has lead responsibility for undertaking an initial assessment and if appropriate and in conjunction with the police, a child protection investigation. This discussion will determine subsequent actions which should be strictly adhered to and regularly reviewed.

7.4 Where there are suspicions of parents fabricating or inducing illness and the child is in hospital it is important to secure appropriate and up to date relevant equipment e.g. syringes, feeding equipment and food/ drink samples etc for police investigation.

For all children, it is necessary that careful and complete notes are kept at every stage, together with the reasons why decisions are taken, for example, not to inform parents of concerns during particular periods in time in order to prevent the child suffering harm.

8. Effective Support and Supervision

Working with children and families where it is suspected or confirmed that illness is being fabricated or induced in a child requires sound professional judgements to be made. It is demanding work that can be distressing and stressful.

Practitioners are likely to need support to enable them to deal with the feelings, the suspicion or identification of this type of abuse. It can be very distressing to a professional person, who has come to know a family well and

trusted them, to have to deal with their feelings when they learn a child's illness has been caused by actions of the child's primary carer.

Possible known emotional responses to fabrication or induced illness by staff involved include:[viii]

- Self-doubt
- Fear leading to inaction
- Failure/ didn't recognise the signs/ symptoms
- Feelings of failing the child
- Feeling of being manipulated
- Fear of litigation/ misdiagnosis
- Misdiagnosis
- Disbelief
- Denial
- Reluctance or unwillingness to pass on/ share information
- Fear of being criticised
- Fear of challenging more senior colleagues/ professionals and dealing with the power differential
- Helplessness
- Feeling unable to prepare a statement of evidence and / or giving evidence in court
- Fear of becoming frozen, unable to make decisions
- Becoming defensive
- Inability to treat the parents in a professional manner
- Knowing I was wrong / right

This is not an exhaustive list.

Incredibly caring, Department of Children, Schools and Families 2008

Appendix 1

The Child:
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."

- Children in this group often present with, or have a past history of both genuine and perceived feeding difficulties, faltering growth and reported allergies.

- Non-organic failure to thrive (physical neglect)

- They may develop a feeding disorder as a result of unpleasant feeding interactions. This is different from an eating disorder which is abnormal feeding habits associated with psychological factors, including anorexia, bulimia nervosa, pica, and rumination disorder.

- This may also apply to toileting disorders.

- The child develops an abnormal attitude to his / her own health.

- Poor school attendance. Including both the under achievement and deliberate underachievement by the child.

- There is professional perception that the parent or carer is deliberately "coaching" the child to underachieve.

- The child attends for treatment at various hospitals and other healthcare settings in different geographical areas. They may also have been seen in centres for alternative medicine or by private practitioners.

- Incongruity between the seriousness of the story and the actions of the parents.

- The child may already have suffered other forms of abuse.

- History of unexplained death, illness or multiple surgeries in parents and / or siblings.

- The parent or carer is observed to be intensely involved with the child,

e.g. not allowing anyone else to undertake their child's care, medical tests, taking temperatures or measuring bodily fluids.

- The parent or carers may appear unusually concerned about the results of investigations that may indicate physical illness in the child, although conversely may not appear at all concerned.

- If age appropriate, the child is perceived as not being "allowed" to speak for him / herself.

Appendix 2

Characteristics of Alleged Abuser:
The following may also be noticed:

- The child's parent or carer may have a history of childhood abuse. There may also be false or known allegations of physical or sexual abuse, self harm and / or psychiatric disorder, especially personality disorder or psychotic illness. (Eminson & Postlewaite 1992) (Lazenbatt, 2013).

- Consideration must be given to the history and relevance of any previous mental ill health in the parent or carer.

- Parent or carer may have some medical knowledge and may try to imitate Health/ Educational professionals.
- Erroneous or misleading information provided by the parent or carer.

- Parent or carer refuses to allow professionals to "share" information regarding the child's presentation/ illness.

- Parent or carer may threaten law suits too readily.

- Tends to be over friendly with health/ educational staff but may be abusive if practitioners do not comply with their wishes.

- Often shows inappropriate behaviour, e.g. being over-anxious or even less attentive than you would expect.

- May have mental health problems.

- Parent or carer is not always present when the victim has alleged or real symptoms or sights of illness, as presentation of symptoms may be deliberately delayed.

- Parent or carer may be motivated by financial gain; this can be through the receipt of benefits or educational settings.

References:

[i] NSPCC Briefing - Fabricated or induced illness in children: a rare form of child abuse? Anne Lazenbatt and Julie Taylor July 2011

[ii] Royal College of Paediatrics and Child Health 2002:164

[iii] Safeguarding Children in Whom Illness is Fabricated or Induced (2008)

[iv] Safeguarding Children in Whom Illness is Fabricated or Induced (2008)

[v] Buckingham Safeguarding Children Board Fabricated or Induced Illness Guidance 2013

[vi] Makar and Squier, 1990; Samuels et al, 1992

[vii] Royal College of Paediatrics and Child Health, 2002

[viii] Buckingham Safeguarding Children Board Fabricated or Induced Illness Guidance 2013

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