PROTOCOL FOR FABRICATED OR INDUCED ILLNESS IN A CHILD

FII Version 2.0
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1. CHARACTERISTICS OF FABRICATED OR INDUCED ILLNESS:

1.1 Illness in a child which is fabricated or induced by a parent or someone who is in the position of a parent.

1.2 A child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.

1.3 The perpetrator often denies the explanation of the causes of the child’s illness.

1.4 Acute symptoms and signs cease when the child is separated from the perpetrator.

2. DEFINITION OF FABRICATED OR INDUCED ILLNESS:

2.1 In fabricated illness the perpetrator does not directly harm the child, but reports to doctors a clinical story which is eventually established to be fabricated.

2.2 In fabricated illness the clinical story may be “supported” by falsified specimens. These specimens have not been obtained by injuring the child. For example, mother’s menstrual blood may be added to the urine to simulate haematuria (blood in urine) or substances containing glucose added to the urine to simulate diabetes.

2.3 In induced illness, the perpetrator inflicts direct harm (hands on) to the child. This can range from trivial injuries, e.g. pricking the child to obtain blood to add to urine, through to suffocation.

2.4 The main methods of inducing illness are:

   a) Minor injury to the child to produce falsified specimens.
   b) Poisoning with a range of prescribed or non-prescribed substances. Included in this is excessive manipulation of prescribed drugs (both under and over administrations) such that harm to the child occurs.
   c) A direct injury to the child, including administration of substances through portals of entry to the body such as intravenous cannalae (drips).
   d) Suffocation.

2.5 Three factors are necessary for this form of abuse to occur:

   i. A dependent child is available to the carer and is under his/her control or influence.
   ii. A carer presents the child to the healthcare system with invented symptoms or fabricated signs.
   iii. A healthcare system exists in which healthcare personnel have almost unlimited capacity in terms of resources and technology to undertake investigations and interventions with children.

2.6 Fabricated or Induced Illness can take a number of forms and differing degrees of gravity. Professionals need to be mindful of a spectrum of concerns.
3. PRINCIPLES:

3.1 Focus should be on the harm to the child, not on understanding the characteristics or motivation of the perpetrator.

3.2 Keep an open mind.

3.3 Keep questioning your assumptions.

3.4 Be familiar with the range of behaviours that perpetrators of Fabricated or Induced Illness exhibit.

3.5 Communicate clearly.

3.6 Be familiar with barriers to identification of Fabricated or Induced Illness.

3.7 Be open to accept Fabricated or Induced Illness and objectively question information given by parents and to evidence it.

4. FEATURES OF FABRICATED OR INDUCED ILLNESS:

4.1 The Child

- A child is presented with a persistent or recurrent, unusual illness.
- Clinical findings do not fit the history and histories may not be consistent between absences over a period of time.
- Test results may be unusual and/or inconsistent with the description given of the illness.
- Symptoms trail off or fail to present when the child is under professional management and the carer is not present.
- Symptoms recur shortly after a well child has been discharged from hospital.
- Accounts of illness are not borne out by GP’s records.
- The child or other children in the family have been presented elsewhere with illness.
- Unusual illness or unexplained death in siblings.
- There may be previous history of abuse. Many victims of fabricated or induced illness may be too young to understand how the abuse is perpetrated and are unable to tell. Older children may collude with the fabrication because of fear of losing the parent if they do not play the sick role, or of benefits to them, e.g. time off school.

4.2 The Perpetrator

- Is often the child’s mother.
- Often has a current or previous psychiatric or psychological history eg anxiety, depression, past history of Fabricated or Induced Illness, previous self-harm, or history of eating disorders.
- Is more intelligent / dominant than partner.
- The partner is often detached from the family and has limited involvement with professionals.
- Behaviour is frequently compulsive and patterns of presentation are varied. A perpetrator may alternate between presenting her/himself as ill and the child/children as ill.
• The perpetrator may change the way they are maltreating the child.
• Perpetrators are likely to be seen as highly devoted to the child but paradoxically appear unconcerned about the child’s illness.
• They appear disappointed at negative test findings.
• There may be extravagant claims made to the GP, Health Visitor, School Nurse, School staff or Community Nursery Nurse regarding the diagnosis and treatment of the child or perpetrator.
• The perpetrator may have contacted self-help groups and organisations at a premature stage in the course of the “disease” and may have engaged with the media or sought status on other ways.
• The perpetrator is typically knowledgeable about the child’s illness and treatment, is happy to be in hospital and forms close, and often controlling, relationships with the healthcare staff.
• Ad hoc visits to the home have not been possible and GP/Health Visitor calls have always been pre-arranged.
• There has been persistent refusal of “in home” services, e.g. home care, home nursing, family support.
• Previous children may have been subjected to Fabricated or Induced Illness.
• There could be a history of unusual illness or unexplained death in previous children.
• There may be a background of seeking financial or other gains through illness behaviour.
• Often there is no previous child protection involvement.
• A resistance to accept hospitalisation.
• An avoidance of professionals who challenge/question – “shopping around”.

4.2.1 Some of the above may be present in entirely innocent situations. However, when Fabricated or Induced Illness is suspected, such features can contribute to:

- the diagnosis
- the understanding of the seriousness of the case
- an understanding of the urgency of the need for intervention.

4.3 Professional Entrapment in Fabricated or Induced Illness:

4.3.1 The raising of the possibility of fabricated illness may cause shock and anger amongst professionals and familiarity with the concept will be variable between individual professionals. A professional may be difficult to convince and may decide to act in a way she/he feels familiar and comfortable. Professionals may become polarised.

4.3.2 Hobbs et al 2000 summarised factors that may lead professionals to treat children at risk of Fabricated or Induced Illness as follows:

a) Skilful manipulation by the mother which creates an “irresolvable” problem.
b) Mother may have wide medical knowledge.
c) Mother may seem to be more like an appreciative colleague and an “ideal” mother.
d) These factors drive the doctors to consider more intrusive investigations, clearer tests and more abusive diagnoses.
e) All this goes along with mother’s criticism of other professionals. If professionals don’t examine this “criticism” they can possibly find themselves agreeing with the parent and in conflict with their colleagues.
f) If it was just the issue of the paediatrician’s complacency, knowledge and autonomous decision-making, things would be difficult enough, but add the issue of the doctor’s
“caring” and the bold, sometimes “adulatory support”, that these parents often express, and a situation is produced in which the question of caring is now tied in with his medical/clinical performance. Now, when things are not going well clinically, the doctor is left vulnerable to the self-accusation of not caring enough and feeling he needs to try harder. This step seals the “trap”.

4.4 Barriers to Identification of Fabricated or Induced Illness

- Lack of awareness of the range of behaviours.
- Concentration on “making a diagnosis” rather than appraising all presentations and the whole of the child’s health in a broad and holistic fashion.
- Minor abnormalities on investigation are unquestioningly accepted as “explaining” a substantial level of Fabricated or Induced Illness presentations.
- There is a tendency to consider this form of abuse as a “diagnosis of exclusion” or a last resort.
- Failure to take even the most rudimentary steps to corroborate the story given by the parents.
- Many of the children who suffer Fabricated or Induced Illness also have naturally occurring illness.
- There is a professional (and legal) risk in deciding to stop investigations.
- This form of abuse questions our beliefs about parenting and the doctor/patient relationship and is, therefore, emotionally challenging. It is only human to avoid thinking about such difficult ideas, especially with parents with whom one has already developed a trusting professional relationship.
- Failure of medical practitioners to accept questioning from non medical professionals.

5. HANDLING INDIVIDUAL CASES:

5.1 Wherever possible concerns exist of FII records should use clear straightforward language, should be concise, accurate not only in fact but also in differentiating between opinion, judgment and hypothesis. The records relating to the child’s symptoms, illnesses, diagnosis and treatment should always include the name and agency or the person who gave or reported the information. All telephone conversations should be recorded fully. Professionals who suspect FII may find it helpful to begin compiling a chronology at this stage to help collate the available evidence (see Appendix A)

5.2 Many incidents of concern may be warning signs of Fabricated or Induced Illness. One incident may fit more than one category. Equally, there may be other incidents of concern which do not fit any category, but could be indicative of Fabricated or Induced Illness.

5.3 The template enables analysis of clinical presentation. It can be used at regular intervals which means, that at the conclusion of each period, the information is not only analysed from that time period, but also accumulated information from earlier time frames.

5.4 The template enables professionals to organise information in a way which assists analysis and decision making. However, every warning sign has multiple possible explanations, only one of which is Fabricated or Induced Illness.

5.5 The warning signs should be considered as open questions, probing critical assessment of clinical presentations, rather than closed questions.
5.6 Fabricated or Induced Illness is only one form of child abuse and shares many common indicators with other forms of abuse. The history should, therefore, be examined for risk factors of other abuse.

5.7 The response to all child abuse is a multi-agency responsibility. A doctor has to decide whether the signs and symptoms described are a consequence of medical causes, but all agencies have a responsibility to contribute to the process of sharing information so that abuse can be identified. Background information about the family’s medical and social history is all necessary acting as pieces of a jigsaw which assist identification.

5.8 In all cases, the child/young person must be the primary focus and their views must be an essential part of any assessment.

5.9 The Template – a Summary

Note: the order of numbering does not indicate the relative importance of each category.

**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 surgery in parents or siblings of the family.
9. Once perpetrator’s access to 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 the parent.

**The Template – Explained**

Note: “Symptoms” are subjective experiences reported by the carer or patient. “Signs” are observable events reported by the carer or observed or elicited by professionals. Set out below some examples of behaviour to watch for.

**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. Here the doctor is attempting to put all of the information together to make a diagnosis but the symptoms and signs do not correlate with any recognised disease, or where there is 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, i.e. the symptoms and signs do not correlate with any recognisable disease or with a disease known to be present.
2. Physical examination and results of medical investigations do not 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 videotelemetry (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. 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 withdrawal of medication. Another feature may be the welcoming of intrusive investigations and treatments by the parent.

4. New symptoms are reported on 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 diarrhoea and vomiting, when appropriate assessments fail to confirm this, the story changes to one of convulsions. Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.

5. Reported symptoms and found signs are not seen to begin in the absence of the carer i.e. 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 anxiety of Fabricated or Induced Illness 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. Such people may use labels because they have been told that is the appropriate description of the behaviour they are seeing.

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. 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 and insisting on restrictions of physical activity when not necessary. Adherence to extremely strict diets when there is no medical reason for this and restricting the child’s school attendance.

7. Over time, the child is repeatedly presented with a range of signs and symptoms. At its most extreme this has been referred to as “doctor shopping”. The extent and extraordinary nature of the additional consultations is 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 surgical procedures in parents or siblings of the family. 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 Fabricated or Induced Illness abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the GP, 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 Fabricated or Induced Illness abuse and their medical history should also be examined.

9. Once 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) Fabricated or Induced Illness 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.

10. Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported. 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.

11. Incongruity between the seriousness of the story and the actions of the 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 Fabricated or Induced Illness abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is 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, etc.) The term, “piloting care” can be used to describe this behaviour.

12. Erroneous or misleading information provided by parent. These perpetrators are adept at spinning a web of misinformation which perpetrates 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.

6. PROCEDURE TO BE FOLLOWED IF FABRICATED OR INDUCED ILLNESS IS SUSPECTED BY ANY PROFESSIONAL:

As soon as a practitioner has a concern about possible Fabricated or Induced Illness, they should consult immediately with a “named person for child protection” within their own organisation to help decide whether to make a referral to children’s services in accordance with local policy. The agency “named person” may wish to consult with the ‘designated person’ for Child Protection prior to deciding on what action to take. (Specific issues for health professionals including the role of designated nurses and doctors are contained in APPENDIX C). Staff who are uncertain whether a referral should be made to children’s services can also use the facility for consultation.
The named or designated professional should decide whether to make an immediate referral to Safeguarding Services or, if they are uncertain, whether the concern is FII should convene a ‘Professionals Meeting’. Care should be taken to invite all staff, who have had a significant contact with the family and to ensure that all views can be expressed and shared. The meeting should be clearly minuted and the template used to assist decision-making. If the conclusion is that the child may be suffering significant harm as a consequence of FII a referral should be made to safeguarding services. If the meeting does not support a possible suspicion of FII at this stage the reasons must be clearly recorded and meeting should decide what further action by staff including monitoring and triggers for further action may be appropriate.

If an agency does not have a named person for child protection, consultation should take place with the relevant duty team within Children’s Safeguarding Services in accordance with local policy.

If the child is in hospital and there are concerns about possible significant harm as a consequence of FII, discharge should not take place until a multi-agency Child Protection Strategy Meeting has discussed the concerns. The Strategy Meeting is for professionals only and parents/carers are not involved or notified at this point. The safety of the child is paramount whilst Fabricated or Induced Illness is being considered. Additional guidance if Fabricated or Induced Illness is suspected should be sort from the Consultant Paediatrician/Psychologist.

Consider consulting with a Senior Paediatric Consultant from a tertiary centre who has expertise in Fabricated or Induced Illness.

Examination of the child must include a meticulous examination for petechiae, intra-oral or nasal trauma, poor growth and retinal haemorrhages.

History taking should be detailed, and where possible discussed with each parent separately for accuracy of detail and to avoid contaminated histories.

**Additional Guidelines for Junior Medical Staff**

Abnormal behaviour towards a child may present in a variety of ways. Most commonly, a child is presented repeatedly to hospital with a history of symptomatology which is incongruous with the clinical findings. There may be an escalating need for increasingly esoteric investigations. Standard monitoring or other processes go frequently wrong, e.g. intravenous needles need re-siting, tubes replaced, etc.

The presence of a known diagnosis should not prevent consideration of the possibility of FII.

You may be called to a child, who has been apnoeic or has had a seizure and find little wrong, or an abnormal parental affect, e.g. lack of anxiety, inappropriate cheerfulness. You may just feel confused and concerned that something does not feel right.

**What to do:**

a) Keep uppermost in your mind that the child’s safety is of paramount concern;
b) Do not inform the parents/family of your concerns.
c) Make an arrangement to speak to the Consultant concerned immediately. Take notes and x-rays with you.
d) You can assist any further investigations by telephoning the A & E units to ask for records of attendances.

FII Version 2.0
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e) If the child is of appropriate age to be moved out on to a ward for further investigation, this should be arranged as far as possible within the nature of the illness. If you can, within the extreme limits of reason, arrange for oxygen saturation and ECG monitoring, then request this. This may provide temporary reduction in risk.

f) Do not prevaricate on any suspicion of this type. If it arises in an outpatient setting it should be fully discussed with a Consultant immediately and further review transferred to consultant care.

**Not Informing Parent(s) of Concern and Informing Colleagues**

APPENDIX B gives further guidance on the issue of sharing information with parents. It is particularly dangerous for professionals to make their concerns explicit to the parents/family before they have sufficient evidence to ensure the adequate protection of the child. If the parent/family is informed of the suspicion of FII, the likely response will be anger and denial. If FII abuse is taking place, alerting parent/carer to suspicions is likely to make the abusing parent/carer more devious and manipulative and consequently FII abuse will be more difficult to identify and the danger to the child increased. Where a child is thought to be at risk of significant harm, Department of Health guidelines allow for professionals to share information and plan for an investigation without the parent being informed. Professionals must, however, record their reasons for not informing the parents.

Any practitioner is therefore advised not to discuss their suspicions with the parent/family until a strategy has been discussed and agreed with other agencies and the issue of what and how the parent/family should be told has been resolved.

In the meantime, given the intense loyalty which may be felt by other practitioners towards the family and the difficulties in establishing FII abuse, practitioners are advised not to discuss their suspicions widely.

Every practitioner should keep full and accurate records of their decision-making including the reasons why, contrary to general expectation, concerns about the child’s welfare are not immediately shared with parent/carer.

**7. INTER-AGENCIES WORKING IN FABRICATED OR INDUCED ILLNESS:**

**7.1 Referral**

The referral should be made to the responsible Safeguarding Service in accordance with local policy if there is reasonable cause to believe that a child may be suffering significant harm as a consequence of FII. Referrals should not be delayed because the evidence available to the professional is not conclusive. The referrer should however be explicit about the concerns that FII may exist and they are referring the child in accordance with these procedures. The Team Leader will decide if an initial assessment is required but if reasonable concerns exist this should be completed briefly without an initial visit to raise parental concerns on the basis of information provided by the referrer and other professionals and a strategy meeting convened chaired by the Team Leader of the Safeguarding Services Duty as a matter of urgency.
7.2 Strategy Meeting

7.2.1 Arrangements:

a) If there is an immediate risk to the child the LSCB Procedures for immediate protection apply and steps must be taken to secure the safety of the child if necessary before the strategy discussion.

b) The safeguarding Team Leader will liaise with the Safeguarding Service Manager who must convene a Strategy Meeting within 24 hours if there is an immediate risk to the child (72 hours in all other cases). The tasks of completing the strategy discussion will be assigned on the ICS system to the Safeguarding Chair. The Team Leader must ensure a full list of professional staff known to be involved with the family and supply details to the Safeguarding unit will be responsible for invitations and arrangements.

c) If possible, the meeting should be held on hospital premises to facilitate the attendance of health care professionals.

d) If the child is in hospital, the meeting should not be held on or near the ward where the child is.

e) The meeting should be booked in the name of one of the lead professionals, not the child or family – this should not be given.

f) Any discussions about the meeting and/or referral should be on a need to know basis.

g) The Team Leader should liaise with the Local Authority legal advisor if they may need to attend the strategy meeting.

7.2.2 Attendance

The following professionals should be invited and should attend wherever possible

- Team Leader Safeguarding Services and allocated/assigned worker.
- Detective Inspector or Detective Sergeant.
- Consultant Paediatrician(s) involved
- Named Doctor for Child Protection
- Named Nurse for Child Protection
- Adult Psychiatrist (where appropriate)
- Family GP
- Any other professional involved with the child in particular the health visitor, nursery nurse and school nurse/staff as appropriate. Attendance must be restricted to those who need to be aware of the concerns, in the best interests of the child. All participants need to be appraised of the utmost need for confidentiality. Parents/carers do not attend and are not notified.

7.2.3 Agenda: Reason for Meeting:

The chair must ensure that participants are aware of the concerns and reason for the meeting

Information Sharing:

Relevant information from each agency about the child, siblings (even if adult or deceased), parent(s) and any other significant adults should be shared. Agencies should share information about their involvement with the family and any evidence to support the possibility of FII. This should include all chronologies completed at this point particularly any medical chronologies. The meeting should then consider the information against the FII Template to consider whether there is sufficient information to make a decision on Fabricated or Induced Illness at this stage, or what further information is required. There may be insufficient information to make a firm diagnosis at this stage but it may be felt there
are sufficient concerns to open a formal section 47 investigation and to request all agencies to prepare detailed chronologies to inform the analysis of risk and the evidence to support a diagnosis of FII using the guidelines in APPENDIX A.

**Conclusions/Analysis of Risk:**

The meeting must draw conclusions about the level of risk to the child and action to be taken on the basis of the information shared.

**Planning:**

The meeting must focus on the needs of the child and his/her safety. Legal advice should be sought to evaluate the information where required.

**Decisions should be made about:**

a) Whether Section 47 enquiries are necessary. If so, the meeting should plan how this will be carried out and the core assessment completed, what further information is required, how it will be obtained and recorded. See Appendix A regarding the need for medical chronologies to be completed as part of a section 47 investigation.

b) Whether the child requires constant professional observation, and if so, whether or when the carer(s) should be present.

c) Who will carry out what actions, by when and for what purpose, especially the planning of further paediatric assessment?

d) Any particular factors, e.g. child and family’s race, ethnicity and language, which should be taken into account.

e) The needs of siblings and other children with whom the alleged perpetrator has contact.

f) The nature and timing of any police investigation, including the analysis of samples. This will be especially pertinent if covert video surveillance is being considered, as this will be a task for which the police will have responsibility.

g) The needs of parents/carers.

h) What is to be told to the parent/carers. (See APPENDIX B)

i) How the child and any other children’s safety is to be ensured, including immediate safety and safety during any contact with the suspected abuser. Other matters for discussion/decision might include:

j) If the child requires placement away from home, whether extended family or friends would be able to provide sufficient protection or whether foster care is more appropriate. (NB: Family and friends may be disbelieving that Fabricated or Induced Illness is a possibility).

k) Whether emergency legal intervention is necessary and, if so, arrangements for this.

l) Any further information required, how it is be obtained and when.

m) Whether there should be use of covert video surveillance.
n) Process for deciding on whether a child protection conference is necessary after completion of section 47 enquiries.

o) Agreement about who should receive minutes of the meeting.

p) Identification of a lead paediatrician to oversee and coordinate healthcare involvement

**Recording:**

The meeting should be formally recorded as a strategy discussion by the chair using the electronic ICS Template for Strategy discussion. The minutes of the meeting should include:

- Date, time and name of meeting
- Name of child/family concerned
- Attendance/apologies
- Arrangements for child’s safety, including periods of contact with the alleged abuser
- Main points regarding medical information
- Whether diagnosis of Fabricated or Induced Illness made
- Whether, and what, further information required
- Conclusion and analysis of risk
- Plan of action showing who is responsible for each task and timescales.

This will include:

- Arrangements for child’s safety (including contact)
- Arrangements for siblings/other children
- Arrangements for legal intervention if required
- Task in relation to seeking further information
- Whether joint Police/Children's Services investigation required
- If decision is made to use covert video surveillance, the name of the person responsible for making arrangements
- Arrangement for advising the parent of concerns where decision is taken to do this
- Arrangements for further inter agency meetings
- Identification of Lead Paediatrician
- Distribution of minutes.

7.2.4 Further Strategy Discussions

More than one strategy discussion will be required to consider the possible diagnosis of FII once the various enquiries are complete including chronologies to decide if concerns are substantiated and a child protection conference and/or other actions to safeguard the child are necessary.

7.3 Child Protection Conference Arrangements

7.3.1 Professionals attending the strategy discussion should wherever possible attend the child protection conference.

7.3.2 All available information should be given to the Chair prior to the conference, to enable adequate preparation time.

7.3.3 A written report must be provided, regardless of whether the representative is attending or not.
7.3.4 Child Protection Conferences will be held in accordance with local procedures.

8. HOME EDUCATION

In 2009 Graham Badman compiled a report to the Secretary of State on the Review of Elective Home Education. He had also been asked to include an investigation into suggestions that home education could be used as a ‘cover’ for child abuse. One of his recommendations was that those responsible for monitoring and supporting home education should be suitably qualified and experienced to discharge their duties and responsibilities as set out in the ‘Working Together to Safeguard Children’ document.

Most parents send their child to school, but they do have a right to educate their child at home.

The facts about home education are:

- the parent does not need to be a qualified teacher to educate your child at home
- the child is not obliged to follow the National Curriculum or take national tests, but a parent is required by law to ensure the child receives full-time education suitable to their age, ability and aptitude
- any special educational needs the child may have must be recognised
- no special permission from a school or local authority is required to educate a child at home, but if a child is being taken out of school notification to the school in writing is required
- the local authority needs to be notified if removing a child from a special school
- school hours do not need to observed, nor days or terms
- a fixed timetable, nor formal lessons are necessary
- there are no funds directly available from central government for parents who decide to educate their children at home
- some local authorities provide guidance for parents, including free National Curriculum materials

Local authorities can make informal enquiries of parents who are educating their children at home to establish that a suitable education is being provided. If the local authority makes an informal enquiry, evidence should be provided that the child is receiving an efficient and suitable education by:

- writing a report
- providing samples of the child's work
- inviting a local authority representative to the home, with or without the child being present
- meeting a local authority representative outside the home, with or without the child being present (representatives have no automatic right of access to the home)

If it appears to the local authority that a child is not receiving a suitable education, then it might serve a school attendance order. Although not legally required to inform the local authority when deciding to educate a child at home, it is helpful to do so. The only exception to this is where a child is attending a special school under arrangements made by the local authority. In this case additional permission is required from the authority before the child's name can be removed from the register.
Although the vast majority of families who educate their child at home do so with all the right intentions it is important for professionals to be aware that this could (in the minority) be used as a cover for child abuse and FII.
Linking Documents / References / Bibliography:

Cumbria LSCB: Serious Case Review / Chapter 8 Fabricated and Induced Illness 2008

Fabricated or induced Illness by Carers (FII): A Practical Guide for Paediatricians: RCPCH 2009


Safeguarding Children in Whom Illness is Fabricated or Induced by Carers: DOH 2002

Safeguarding Children in Whom Illness is Fabricated or Induced by Carers: Review: DOH 2008

What to do if you’re worried a child is being abused. DfES 2006

Working Together to Safeguard Children: DCSF 2010

A Training Resource for Professionals in FII in Children: DCSF 2009
APPENDIX A:

PREPARING A CHRONOLOGY

By the very nature of this form of abuse the information available to a meeting about a possible case of Fabricated or Induced Illness is enormous. This often overwhelms the meeting and furthermore, the collection of data often becomes obscured by pre-judgements about what is going on. Views are often polarised and this does not lead to a dispassionate consideration of the facts. The following describes one approach to constructing a chronology. As complete a picture of concerns and consultation behaviour in all the children and the perpetrator (usually the mother) as possible is essential. Almost invariably there is an enormous wealth of information which it is difficult to organise.

This information will need examining in different ways, for example, integrating all the reports, looking at an individual child, agency or institution. If freehand chronologies are provided by all the agencies and individual professionals concerned, this task becomes well nigh impossible.

Attached is a chronology template. The comment section allows for points to be noted, clarification to be sought and eventually an assessment of the significance of the event.

Date Name Source Episode/Event Category Comment
Figure: Format for chronology.
Notes: Date (self explanatory). Name: is the individual involved in the episode. Source: is the agency (Social Services etc.) or individual, it could invariably be either in the same chronology. Episode/event: is a record from the clinical story. Category: is the category of warning sign referred to in the template – see section 5 above. Comment: is self-explanatory.

The chronology is only one part of collecting information and will need supplementing by reports, which draw out messages from the chronology. Getting the facts agreed and seeing the overall pattern is crucial and often very revealing.

What to include in the chronology:
If every single contact with any professional is included, the chronology loses its value. On the other hand, any selection has the risk of excluding a vital detail.

The template described above should be used to organise the information. At this stage it is important to include any event that comes under any one of these categories of warning sign so that it can subsequently be discussed.

There is a basic implicit assumption in the way health resources are used that parents bring children who are sick and tell the truth about them and doctors bring expertise and technology to do their best for children. This has been referred to as the bargain in health care. In Fabricated or Induced Illness this bargain is infringed. The child is not sick, the perpetrator does not want them to get better and the actions (or stories) of the perpetrator lead the doctor to use their expertise and technology to harm the child. The warning signs are just the more common manifestations of the abuse of the bargain in health care. They should not be seen as being exclusive; any episode in which the perpetrator could be using the medical system to harm their child MUST be included on the chronology even if it does not fit nearly into any of the categories set out in the table. There is increasing recognition of the links between all other forms of abuse and Fabricated or Induced Illness; in general there is a major overlap in background factors, which result in all types of abuse.
The presence of other forms of abuse in families with Fabricated or Induced Illness:

a) Confirms the situation is abusive;
b) Increases the risk of severe Fabricated or Induced Illness. All possible episodes of other forms of abuse must be included on the chronology. It is advised at this stage to include relatively trivial injuries, which in fact may be accidents. In a number of cases of Fabricated or Induced Illness frequent accidents (falling off beds, cuts and bruises etc) have been dismissed and might have increased suspicions not only about Fabricated or Induced Illness but increased the risk of induced illness. Contact with medical facilities is also important but it is unhelpful to catalogue every single one. It is suggested that it is worth noting:

a) The number of signs or symptoms in the children. Initially there should be no judgement as to whether they are the result of real (intrinsic) illness or Fabricated or Induced Illness. The number of symptoms/signs reported in these children is frequently more than ten.
b) The number of medications and details. Reported side effects of medication are also important.
c) The number of invasive tests and/or operations should be included.
d) The number of different medical teams involved. Information tabulated in this way often reveals a startling picture.
APPENDIX B:

SHARING CONCERNS WITH THE PARENT(S)

Considerations:

If Fabricated or Induced Illness is a real possibility, careful consideration will need to be given about if and when to share the concern with the parent. This should be addressed within the strategy discussion.

Considerations are:

a) The degree of certainty.
b) The balance between likely harm to the child from Fabricated or Induced Illness as opposed to the effects of any protective action.
c) The likely reaction of the parents.
d) Where a decision is taken to explain to a parent that it is thought they are perpetrating Fabricated or Induced on their child, the timing is crucial.
e) Whether the other parent or other relative should be present or told later of the suspicion of Fabricated or Induced Illness. The welfare of the child is paramount and will influence any decision regarding information sharing. Communication with the parent/carer should be on the basis of a clearly defined and agreed plan, developed in the strategy meeting.

Who Should Address the Parent/Carer:

The following people will need to explain matters to the parent: -

a) The doctor making the diagnosis, usually the Consultant Paediatrician should explain why the symptoms presented are believed to be Fabricated or Induced Illness.
b) A Police Officer will have to arrest and question the parent if it is believed an offence has been committed.
c) The Social Worker/Team Manager will need to inform the parent(s) of any steps being taken to protect the child/children. Not all these tasks need to be performed concurrently. If a criminal investigation is being pursued, a police officer and consultant should be the ones to confront the parent, followed by a social worker to explain actions taken to ensure the protection of the child/children. Where a criminal investigation is not being pursued, a doctor and social worker should jointly address the issues with the parent(s). Where the child is in hospital, venue is important and care should be taken not to share information in an environment which could disrupt a ward.
APPENDIX C:

CONSIDERATIONS FOR HEALTH PROFESSIONALS

Behaviour of carers varies when they believe that their child is ill and a key professional task is to distinguish the overanxious carer that may be responding in an overanxious manner from those exhibiting abnormal behaviour. The first step to safeguarding the child is recognition of the potential harmful situation. Fabricated or induced illness could have a plethora of possible manifestations thereby presenting in various settings. Health will often be the first agency to raise concerns. It is therefore imperative that within NHS settings and in particular where children and young people may be under the care of ‘non-paediatric’ specialists, health professionals are alert to the possibility of the diagnosis and aware of where to obtain advice. This will usually be from the ‘named doctor’ and/or ‘named nurse’ for child protection for the trust (see below for information on named and designated doctors and nurses) The named doctor/named nurse should work with all involved health colleagues to draw together all available information and make an early decision on sharing information with Children’s services. These procedures allow the named doctor or nurse to convene a ‘professionals meeting’ if there is a need to share there information before a decision can be made on whether a formal referral needs to be made to children’s services. It is imperative that Health professionals are fully aware of the need to make an early decision on sharing information with statutory agencies.

Action for health professionals (if initial concerns raised by health):

Medical and nursing staff should record their concerns and seek further information regarding the family within their own department initially. They must then communicate with other local health professionals, who may have had contact with the family, e.g. the GP; the named doctor and named nurse child protection; and or other agencies. The named doctor and nurse have ‘a key role in promoting good professional practice within the Trust and provide advice and expertise for fellow professionals. They have specific expertise in children’s health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children. They support the trust in its clinical governance role by conducting audits and internal cases reviews.

All NHS organisations providing services for children should identify a named doctor and a named nurse/midwife for safeguarding at an operational level. The named professional offers advice on a day-to-day management of children and families where there are child protection concerns to all health specialities. Designated doctors and nurses take a strategic, professional lead on all aspects of the health service contribution to safeguarding children across the area they serve, and should cover all providers. The designated professional ensures that expert advice is available and will liaise with, advice and support the named professionals within the relevant trusts.
FLOW CHART
(‘What to do if you’re worried a child is being abused’ DfES 2006)

Concerns about suspected FII

Follow own agency’s child protection procedures and start to implement use of chronology

Referral

Has a medical evaluation already taken place?

no

Medical Evaluation

Assessment under s.17

Yes

No

Suspected Actual or Likely Significant Harm

Strategy Meeting

Concerns not substantiated

Concerns substantiated but child not at risk of significant harm

Child Protection Conference

Concerns substantiated and child at risk of significant harm

Does the child require immediate protection?

Suspected Actual or Likely Significant Harm

s. 47 Enquiries

Other needs identified/core assessment

Child in Need

NFA/Refer to other agency

Concerns substantiated and child at risk of significant harm

Concerns not substantiated

Follow own agency’s child protection procedures and start to implement use of chronology

Referral

Concerns about suspected FII
## CHRONOLOGY

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Source</th>
<th>Episode/Event</th>
<th>Category</th>
<th>Comment</th>
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### Warning Signs of Fabricated or Induced Illness

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.</td>
</tr>
<tr>
<td>2.</td>
<td>Physical examination and results of medical investigations do not explain reported symptoms and signs.</td>
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<td>3.</td>
<td>There is an inexplicably poor response to prescribed medication and other treatment.</td>
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<td>4.</td>
<td>New symptoms are reported on resolution of previous ones.</td>
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<tr>
<td>5.</td>
<td>Reported symptoms and found signs are not seen to begin in the absence of the carer.</td>
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<tr>
<td>6.</td>
<td>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.</td>
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<td>7.</td>
<td>Over time the child is repeatedly presented with a range of signs and symptoms.</td>
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<td>8.</td>
<td>History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.</td>
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<td>9.</td>
<td>Once perpetrator’s access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above).</td>
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<tr>
<td>10.</td>
<td>Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.</td>
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<tr>
<td>11.</td>
<td>Incongruity between the seriousness of the story and the actions of the parents.</td>
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<tr>
<td>12.</td>
<td>Erroneous or misleading information provided by parent.</td>
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