

# **Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians**

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## Foreword

Paediatricians are often faced with the clinical conundrum of ‘What is going on?’ When we think ‘This does not fit the usual pattern of organic illness’ we should reflect and consult. Sometimes we should suspect Fabricated or Induced Illness.

The 1<sup>st</sup> edition of *Fabricated or Induced Illness by Carers* was published in 2002. We have seen considerable changes and developments since then which affect the way we as paediatricians must act together with all the statutory and non-statutory agencies charged with protecting children. There have been the tragedies of Victoria Climbié and Baby Peter, resulting in the first and the second Laming reports, the revision of *Working Together* and the publication by the Department of Children, Schools and Families of *Safeguarding Children in Whom Illness is Fabricated or Induced*. We know that the 2002 document was useful and remains an important resource. This 2<sup>nd</sup> edition has been skilfully produced by Dr Paul Davis as chair of the working group, together with experienced colleagues from adult and child psychiatry, the Department of Health and lay representatives. It should be read in conjunction with the Government’s 2008 document *Safeguarding Children in Whom Illness is Fabricated or Induced: A review of the implementation of the 2002 guidance within the NHS*.

In the past 10 years we have learnt more about this complex condition, its multitude of presentations, and its potential for real and serious harm, including death. Through case studies we have learnt about the importance of early concern and identification and the critical importance of multi-agency working as laid out in *Working Together* (2006) and *Safeguarding Children in whom illness is Fabricated or Induced* (2008). Within this document the concept of the Fabricated or Induced Illness spectrum is presented – five examples are outlined, describing parents’ anxiety, misperceptions and abnormal beliefs, carers’ psychiatric illness, the unrecognised genuine medical problem and presentations where the carer has genuinely fabricated or induced illness in their child. I hope you find this approach helpful. We must prevent further harm occurring to the child, either through delay in identification or through well meaning investigations and procedures attempting to uncover an elusive explanation for the unknown illness.

This document is produced by the RCPCH for paediatricians. It has been written by a group of experienced colleagues and I am convinced it will be of use to health professionals from many backgrounds.

A handwritten signature in black ink, appearing to read 'Terence Stephenson', with a long horizontal flourish extending to the right.

Terence Stephenson  
President, Royal College of Paediatrics and Child Health



## 1. Introduction

- 1.1 Fabricated or Induced Illness by Carers (FII) can cause significant harm to children. FII involves a well child being presented by a carer as ill or disabled, or an ill or disabled child being presented with a more significant problem than he or she has in reality, and suffering harm as a consequence. There are particular challenges for paediatricians and other professionals in terms of managing an FII case.
- 1.2 In 2002, the RCPCH published *Fabricated or Induced Illness by Carers*<sup>1</sup> which aimed to assist paediatricians in the management of cases. Since 2002 the government in England and Wales has published safeguarding guidance<sup>2,3</sup> commonly referred to as *Working Together* and also more specific guidance relating to FII<sup>4,5</sup>. In the light of this guidance it was felt to be timely to review the 2002 document. Hence *Fabricated or Induced Illness by Carers: A Practical Guide for Paediatricians*, provides updated guidance and aims to encourage earlier recognition and an optimal response by improving the competence and confidence of paediatricians who encounter FII. Whilst this document was written for paediatricians, it is anticipated that it will be relevant to other health professionals in particular General Practitioners (GP's) and nurses. This document replaces the 2002 publication.
- 1.3 The document sets out the specific responsibilities of paediatricians working within the multi-agency framework as specified by Local Safeguarding Children Boards (LSCBs) in relation to children who may be subject to FII and who may be 'in need' under section 17 of the Children Act 1989<sup>6</sup>. This includes children who are suffering significant harm and those who are at risk of suffering significant harm. The document should be used in conjunction with LSCB procedures (formerly Area Child Protection Procedures) and the *Framework for the Assessment of Children in Need and their Families*<sup>7,8</sup>.
- 1.4 There is no specific government guidance on FII in Scotland and Northern Ireland and paediatricians have previously relied on local child protection guidance documents and on the previous RCPCH report<sup>1</sup>. Although safeguarding systems and structures may vary, the overall principles and guidance in this document are applicable to all four nations.
- 1.5 The document is based on the current literature and guidance on FII and related conditions. However, a new formal systematic review of the literature was not

conducted. The document starts by looking at the background and epidemiology of FII, and its effect on children. It then looks at how a paediatrician should recognise FII, manage a case before and after the strategy discussion, and when to refer to Children's Social Care. The document also looks at how to work with children and families, and finally deals with record keeping and training.

- 1.6 In line with *Safeguarding Children in Whom Illness is Fabricated or Induced*<sup>4,5</sup>, this document uses the term 'carer' to mean 'parent or carer' – in other words, any adult who is exercising parenting responsibilities for a child.

## 2. What is FII?

### The spectrum of cases

- 2.1 Fabricated and Induced Illness was first described as Munchausen Syndrome by Proxy (MSbP) in the Lancet in 1977<sup>9</sup>: *'Here are described parents who, by falsification, caused their children innumerable harmful hospital procedures – a sort of Munchausen syndrome by proxy'*. This and other early reports on Munchausen Syndrome by Proxy focused mainly on severe cases where the implication was that the carer was deliberately fabricating or inducing illness in the child. Such reports explicitly defined this as a form of child abuse<sup>10-28</sup>.
- 2.2 These early descriptions reflect those cases where a carer actively promotes the sick role by **exaggeration**, **non-treatment** of real problems, **fabrication** (lying) or falsification of signs, and/or **induction** of illness. See Table 1 for more detail. In severe cases, some of the behaviours by a carer that may result in harm include:
- Deliberately inducing symptoms by administering medication or other substances (this includes non-accidental poisoning), or by intentional suffocation<sup>29</sup>;
  - Interfering with treatments by over-dosing, not administering medication, or interfering with medical equipment such as infusion lines;
  - Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequent passing of urine, vomiting, or fits, resulting in unnecessary investigations and treatments;
  - Exaggerating symptoms, again resulting in unnecessary investigations and treatments;
  - Falsifying test results and observation charts;
  - Obtaining specialist treatments or equipment for children which are not required;
  - Alleging unfounded psychological illness in a child.
- 2.3 In addition to these severe cases, there are others where a child may present for medical attention with unusual or puzzling symptoms which are not attributable to any organic disease, and yet which do not involve deliberate fabrication or deception. Table 1 reflects the spectrum of cases; for example the child's carer may be over-anxious (Example 1), may genuinely believe that the child is ill due to misinformation (Example 2), or may have mental health problems (Example 4).

**Table 1: Spectrum of cases where FI concerns may arise**

Starting point: A child is presented for medical attention, possibly repeatedly, with symptoms or signs suggesting significant illness; an appropriate clinical assessment suggests that the child's 'illness' is not adequately explained by any disease. The examples below illustrate the range of possible considerations.

<i>Example 1</i>	<i>Example 2</i>	<i>Example 3</i>	<i>Example 4</i>	<i>Example 5</i>
<b>Type of presentation</b>				
Simple anxiety, lack of knowledge about illness, over interpretation of normal or trivial features of childhood; may in some cases be associated with depressive illness in carer	Child's symptoms are misperceived, perpetuated or reinforced by the carer's behaviour; carer may genuinely believe the child is ill or may have fixed beliefs about illness	Carer actively promotes sick role by <b>exaggeration</b> , <b>non-treatment</b> of real problems, <b>fabrication</b> (lying) or <b>falsification</b> of signs, and/or <b>induction</b> of illness (sometimes referred to as 'true' FI)	Carer suffers from psychiatric illness (e.g. delusional disorder) which leads them to believe child is ill	Unrecognised genuine medical problem becomes apparent after initial concern about FI
<b>Underlying factors</b>				
Carer's need to consult a doctor may be affected by inability to cope with other personal or social stresses, such as mental health issues	'Illness' may be serving a function for carer, and subsequently for an older child too (secondary gains)	There may be a history of frequent use of, or dependence on, health services; carer may have personality disorder or the child's 'illness' may be serving a purpose for the carer	Carer's mental health problems	
<b>Carer's insight</b>				
It is usually possible to reassure carer although they are likely to present again in future	Difficult to reassure carer; carer and professionals may not agree on the cause of symptoms and/or the need to consult or investigate further	It is not possible to reassure carer; carer's objectives are diametrically opposed to those of professionals	Carer lacks insight into their involvement in the child's supposed illness	Carer's 'illness behaviour' will usually be appropriate for the signs displayed by child, although any child protection interventions may affect the carer's behaviour

Level of risk				
Seldom reaches threshold of significant harm	May be disabling for the child; often some risk of significant harm, including emotional or educational harm, or social isolation	High risk of harm; always some resultant harm, often severe	May be risk of harm	Risk of harm due to inappropriate child protection process and delay in correct diagnosis
Iatrogenic harm				
Possible iatrogenic harm risk	Significant risk of iatrogenic harm	Very high risk of iatrogenic harm	Usually low risk of iatrogenic harm	See above
Management				
Discuss carer's concerns openly; manage case primarily by reassurance; try to address any wider needs of the carer	Discussion with carer may need to be handled very sensitively; if in doubt discuss with appropriate colleague; firm reassurance will be needed; avoid iatrogenic harm by not conducting further unnecessary investigations and treatments; multiagency assessment may be needed to gain an understanding of what underpins carer's behaviour (either 'Child in Need' (section 17, Children Act 1989) or child protection referral (section 47, Children Act 1989) referrals may be indicated)	LSCB procedures apply; take immediate steps to reduce iatrogenic harm if possible; do not disclose concerns to carer(s) without first discussing the case within the Safeguarding team.	Discuss with carer whether they feel that they have any mental health needs and how those might be addressed; consider discussing with GP or other relevant professional (bearing in mind the constraints of patient confidentiality); take steps to address carer's mental health needs; child may be 'Child in Need' (section 17, Children Act 1989)	Consult widely with colleagues if a 'false positive' child abuse diagnosis seems likely; if safeguarding procedures have already been activated, an immediate strategy discussion should be requested and the situation should be discussed with carers without delay; the possibility of 'false positive' child abuse diagnosis must always be considered; the child's clinical progress should always be monitored in case a genuine illness has been missed

- 2.4 The common feature linking these presentations is that the carer reports symptoms or signs, which initially suggests a significant disease, and yet appropriate clinical examination and investigation do not reveal any natural disease to adequately account for the child's illness.
- 2.5 Whether the carer is deliberately fabricating a child's illness, genuinely believes the child to be ill or is unduly anxious, the harm caused to the child can be significant and may include:
- Frequent and invasive medical investigations;
  - Unnecessary treatments;
  - Missed education and social isolation;
  - Limitation in daily life and the adoption of a sick role or lifestyle as a disabled person;
  - Characterisation as being disabled, through the receipt of disability benefits or special educational provision;
  - The child becoming anxious or confused about their state of health and abilities.
- 2.6 There will of course also be cases where an unrecognised genuine medical problem becomes apparent after initial concern about FII (see Table 1 example 5).
- 2.7 This document will primarily focus on the identification and management of the severe cases described above. However, the process of confirming this diagnosis will help to identify other types of cases in the spectrum.
- 2.8 It should be noted that the spectrum of cases described in Table 1 is not exhaustive and, for example, does not adequately describe those carers who exaggerate or falsify their child's illness to fraudulently obtain benefits such as Disabled Living Allowance (DLA) or other pecuniary advantage. These carers may not actively seek medical tests or treatment for the child and may actually avoid contact with medical services.
- 2.9 Older children may fabricate illness in themselves, or present with somatising disorders or medically unexplained symptoms, sometimes following an earlier case of FII. Although such children are likely to be 'in need' and may be 'at risk of harm', such cases are beyond the scope of this document.
- 2.10 Although the majority of reported cases involve a child's biological mother as the perpetrator of the harm<sup>30</sup> a significant number of examples have been described

where the father is the abuser. Occasionally two or more carers are involved jointly. Indeed, anyone in a caring role for a child can potentially perpetrate FII abuse.

- 2.11 Although unlikely, it is possible that a hospital staff member may abuse a child in hospital. However, this does not fall within the remit of this document.

## **Terminology**

- 2.12 There continues to be considerable debate about the nature and definition of FII in the media and amongst professionals. The term ‘Munchausen Syndrome by Proxy’ is now felt to be inappropriate as it can be taken to imply a psychiatric diagnosis, and removes the focus from the child. The original RCPCH report *Fabricated or Induced Illness by Carers*<sup>1</sup> replaced this terminology with the more descriptive term ‘FII’ and is used throughout this document. The term ‘FII spectrum’ may also help in differentiating between the different ways that a carer’s behaviour can harm their child.

- 2.13 The Government documents, *Safeguarding Children in whom illness is Fabricated or Induced*<sup>4,5</sup> refer to the ‘fabrication or induction of illness in a child’ rather than using any particular term. The documents describe fabrication of signs or symptoms, falsifications of charts or specimens, and induction of illness. The term ‘abnormal illness behaviour’ describes a range of abnormal social responses to illness and may be helpful in some suspected FII cases. However, it can be ambiguous and should be qualified with clarification about which type of case within the spectrum is being described. In the United States, the names, ‘factitious disorder by proxy’, or ‘pediatric condition falsification’, are often used for the same syndrome. New terminology is used in a recently published book from the US<sup>31</sup>. In the UK, the name ‘illness induction syndrome’ has also been used.

- 2.14 The important message from this discussion is that, in the absence of universal agreement on the definition of FII, when dealing with a case of possible FII, it is essential to describe as accurately as possible: any genuine illness, the child’s symptoms, what has happened to the child, and any harm that has or could have resulted. Detailed descriptions of the impact of the carer’s behaviour on the child are more useful than ‘pseudo-diagnostic’ labels which may distract from the central issue of harm to the child. The determination of what, if any, harm has been caused to the child is most important consideration. In addition, given the broad spectrum of cases, when dealing with a case of suspected FII, the starting position should always be that the cause of the child’s illness is unknown.

### **3. Epidemiology and research evidence**

- 3.1 Evidence for the existence of FII is one of the major challenges facing the paediatrician when explaining the case to carers and other professionals. A key paper is a literature review from 2003 which considers 451 cases from 154 journal articles<sup>30</sup>. *Munchausen Syndrome by Proxy Abuse: a Practical Approach (2000)* by Eminson and Postlethwaite<sup>32</sup> also provides useful references and information. FII is not confined to English speaking industrialised countries – Feldman and Brown<sup>33</sup> identified 59 articles from 24 countries describing at least 122 cases in 9 different languages.

#### **Incidence of FII**

- 3.2 While these case reports and case series provide an insight into the nature and severity of FII cases, they are not necessarily representative of the problem as it occurs in the population and tend to emphasise the more severe cases. There are considerable difficulties in undertaking population-based epidemiological studies in any form of child abuse, and this is particularly difficult in FII. Professionals should consider the limited number of epidemiological studies that have been published – McClure et al<sup>29</sup> (United Kingdom), Denny et al<sup>34</sup> (New Zealand), Ryan et al<sup>35</sup> (Australia) and Watson et al<sup>36</sup> (see Table 2).
- 3.3 Defining incidence rate depends upon the inclusion criteria adopted by a given study. McClure et al<sup>29</sup> was a national epidemiological survey, which collected data between 1992-94. The inclusion criteria were strict and only included those cases which had been discussed at a formal child protection case conference. This definition is equivalent to the first rank of diagnosis of abuse in the Cardiff Systematic Review<sup>37</sup>. The study identified 97 confirmed FII cases in the UK in the 2 year period, equating to a incidence of approximately 0.5 per 100,000. However this is likely to be a minimum figure given the relatively narrow inclusion criteria, and does not include the wider range of situations outlined in Table 1. Watson et al<sup>36</sup> used a broader inclusion criteria and estimated a significantly higher prevalence rate of 89 per 100,000 over a two year period. Thus, from the data available, most general paediatricians are likely to encounter very few confirmed cases involving deliberate and persistent deception or illness induction during their careers, but it is likely that there will be a larger number of children where the possibility of FII is raised.



**Table 2: Epidemiological studies of FII**

Publication	Study period	Population studied	Study inclusion criteria	Number of cases identified	Incidence rate	Mortality
McClure et al <sup>29</sup>	1992-4	UK. Munchausen Syndrome by Proxy (MSbP), Non-accidental Poisoning and Non-accidental Suffocation	Case Conference	128 total cases 97 of which were MSbP 55 MSbP alone. 42 more than one type of abuse.	The following is based upon total caseload of 128. 0.5/100,000 under 16 years, 1.2/100,000 under 5 years, 2.9/100,000 under 1 year.	From the total of 128 8 died either from poisoning or suffocation of which 1 was FII.
Denny et al <sup>34</sup>	1999	New Zealand	Paediatrician concern	18 cases (included 4 suffocation and 1 poisoning): 11 referred to Child Protection. 12 cases under 5 years	2.0/ 100,000 under 16 years, 1.2/ 100,000 under 16 years (if same criteria as McClure et al <sup>10</sup> )	No deaths
Watson et al <sup>36</sup>	1999 (2 years)	Health District in Manchester containing 65,000	Professional concern regarding abnormal illness behaviour	58 children in 42 families. 14 were on CPR usually for other reasons but factitious illness	89/100,000 over a 2 year period	No deaths
Ryan et al <sup>35</sup>	2000	Australia. Unclear if MSbP alone or included suffocation and poisoning	Paediatrician concern	11: 6 confirmed 8 cases under five	Not quoted in the 'Studies in Progress' report	No deaths

## **Age range of children**

- 3.4 The available research suggests that in many cases, FII has its onset in the early years of a child's life (Table 2). However, there is often a considerable delay in recognition, so the diagnosis may not be made until the child is much older. The mean age at diagnosis in Sheridan et al<sup>30</sup> was 21.8 months, and the median age at diagnosis in McClure et al<sup>29</sup> was 20 months.
- 3.5 Older children may also present with FII. They may have a disability or may be colluding with fabrication by a carer. They may also fabricate illness or disability in themselves or present with 'non-organic' symptoms. While this is not usually a child protection issue, there are occasions where the child may be at risk of harm, particularly if the parents are not supportive of attempts at rehabilitation and insist on more investigations. Such cases therefore come within the remit of LCSB procedures.

## **Common presenting features**

- 3.6 Conditions which are particularly vulnerable to fabrication are generally those where the diagnosis rests primarily on history and where abnormalities on physical examination or tests are episodic, with periods of normality in between, such as epilepsy. In other cases a carer may falsify objective features of illness, without directly harming the child. Examples include placing blood on the child's clothing or in their nappy, contaminating samples to mimic infection, and falsifying blood sugar records to suggest diabetes. Historically, falsification of fever took place using old mercury thermometers, but with the advent of electronic ear thermometers this is now less easy to fabricate. At the more damaging end of the spectrum, carers may induce illness in their child by smothering or poisoning, or by withholding food or essential medicines. All the deaths identified in McClure et al<sup>29</sup> were from either suffocation or poisoning. The most common presentations of children are summarised in Appendix 1.

## **4. Impact of fabricated or induced illness on the health and development of a child**

### **Child death and morbidity**

- 4.1 FII is associated with significant mortality, physical illness, and disability. Sheridan's literature review<sup>30</sup> considered 154 case reports and concluded that 6% of cases resulted in death and 7.3% of cases experienced long-term or permanent injury, although it should be noted that there is some bias in the review towards more severe cases involving illness induction.
- 4.2 McClure et al<sup>29</sup>, whose total sample size was 128, found that only one of the 97 children who were victims of FII died, but that four of 44 poisoning cases and four of 32 suffocation cases were fatal. A further 15 (12%) children required intensive care and an additional 45 (35%) suffered major physical illness as a result of the abuse.

### **Mortality and other outcomes for siblings**

- 4.3 In McClure et al<sup>29</sup>, 83 (65%) of the 128 index children had at least one sibling and of these, 15 had at least one sibling who had died previously (a total of 18 deaths, 10% of all siblings). Five of these deaths had been previously classified as Sudden Infant Deaths. The literature review by Sheridan<sup>30</sup> identified that 25% of known siblings of index children had died and 61.3% had illnesses similar to those of the victims.
- 4.4 Information about previous abuse or the death of siblings may only become known to professionals after a family history has been completed. At the time of death some cases may have been unexplained or thought to be natural causes, while others may have been known to be the result of abuse. It should be noted that previous physical abuse of siblings can be common in this group of children and that previous abuse may have included the fabrication or induction of illness.

### **Direct effects of FII**

- 4.5 Where illness is fabricated or induced, and often also when the carer misperceives or genuinely but mistakenly believes the child to be ill, (see Table 1) children may undergo extensive and often unpleasant investigations in order to establish the underlying causes for reported signs and symptoms. These investigations can

result in children spending long periods of time in hospital, as well as undergoing unnecessary treatments and operations. Daily life is also often affected; children may be given wheelchairs or special buggies, and limitations are often placed on their normal activities, especially school attendance and participation in sport and other activities. Children may be anxious or confused about their state of health and may believe themselves to be ill or disabled.

## **Involvement by the child**

- 4.6 The extent of involvement by children themselves varies on a continuum from unawareness, through to passive acceptance, actual participation, and active self-harm. Some children, particularly those who are older, may learn to collude with their carer in the management of a non-existent condition before eventually fabricating or inducing illness in themselves or developing a somatisation disorder.

## **The effects of FII on a child's development**

- 4.7 Although relatively few children exposed to FII will die, many will suffer significant long-term consequences. This includes long-term impairment of their psychological and emotional development, and emotional harm as a result of an abnormal relationship with the perpetrator(s). Few studies have sought the views of children. However, through their interviews with children, Neale et al<sup>38</sup> found that many had been unable to disclose the nature of their abuse. After disclosure of the abuse and placement with alternative carers, some children wanted continued contact with the perpetrator(s).
- 4.8 In their follow-up study of 54 children who were known to have had illness fabricated or induced, Bools et al<sup>39</sup> found a range of emotional and behavioural disorders and school-related problems. These difficulties were present both in children who were living with their abusing carer and those who had been placed with alternative carers.

## **Risks of further abuse**

- 4.9 There is evidence<sup>39,40</sup> that once FII is detected, there is a significant risk of further fabrication or other types of abuse. Among the 30 children in the Bools study<sup>39</sup> still living with the original abuser, 10 were the subjects of further illness fabrication, and there were other concerns about 8 children. In the study, the outcomes of children who had a period in foster-care following identification of the abuse were better than those who remained continuously with their carer.

- 4.10 Davis et al<sup>40</sup> followed up cases of children reported to have illness induced (median of 2 years), and concluded that none of their signs and symptoms were subsequently found to be due to intrinsic organic disease. In this study, 33% of the children remained on a child protection register and 24% continued to have signs and symptoms due to fabricated or induced illness. 17% of those who had not suffered direct physical harm had nevertheless subsequently suffered further abuse, such as neglect or physical abuse.
- 4.11 Berg and Jones<sup>41</sup> reported on the outcome of 13 children in a small study of 17 children consecutively admitted to an inpatient family unit after identification of ‘factitious illness by proxy’. These families were selected for therapeutic work on the basis of the likelihood of successful intervention. Of these, it was recommended that 10 children should be reunited with their biological parents and 3 should be placed in alternative care. At an average of 27 months after discharge from the unit, it was concluded that the children had done well overall in terms of their development, growth and adjustment. From this follow-up study it has been *‘cautiously concluded that family re-unification is reasonable to attempt for a selected subgroup of cases of factitious illness by proxy but, where this is attempted, long-term follow-up is necessary in order to assure that psychological maltreatment does not occur and that the parent's mental health is monitored.’*
- 4.12 A study by Gray and Bentovim<sup>42</sup> found evidence of good outcomes for children where the child's safety had been addressed and long-term therapeutic work had been undertaken with families. This work was based on the findings of an assessment, which identified the changes required in the family system. The study found that good outcomes occurred where:
- Cases were managed within a child protection framework;
  - Therapeutic interventions were focused on the protection of the child;
  - A thorough assessment was undertaken of the family's functioning and its ability to change and to protect the child, and;
  - Clear decisions were made about whether the child was able to live with both carers, a non-abusing carer, or should be placed in an alternative family context.

### **Summary**

FII can cause death, disability, physical illness, and emotional problems. There are significant risks of re-abuse. Following identification of FII in a child, the way in which the case is managed has a major impact on the developmental outcomes for the child.

## **5. Paediatric management of cases: recognition and early management**

### **Presenting features: towards earlier diagnosis**

- 5.1 Carers exhibit a range of behaviours when they believe their child is ill. The key task for the paediatrician is to distinguish between anxious carers whose children are genuinely sick and who are responding in a reasonable way, and the rare case of carers whose behaviour risks causing harm to the child by confusing and possibly fabricating the presentation.
- 5.2 Cases of FII may present in an acute situation in hospital or there may be a chronic evolution with frequent presentations of fabrications in a range of different settings. There may also be patterns of fabrication in a school setting without medical attention being sought. The key indicators which should alert doctors to the possibility of FII are shown in Table 3 below. Appendix 1 outlines the commonest presentations of children with FII in the McClure et al study<sup>29</sup>.
- 5.3 In addition to the indicators below, the child's school attendance may be poor and there may be evidence of financial gain resulting from their illness (e.g. DLA).

**Table 3: Indicators which should alert professionals to the possibility of FII**

<ul style="list-style-type: none"><li>• A carer reporting symptoms and observed signs that are not explained by any known medical condition.</li><li>• Physical examination and results of investigations that do not explain symptoms or signs reported by the carer.</li><li>• The child having an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment.</li><li>• Acute symptoms that are exclusively observed by/in the presence of the carer.</li><li>• On resolution of the child's presenting problems, the carer reporting new symptoms or reporting symptoms in different children in sequence.</li><li>• The child's daily life and activities being limited beyond what is expected due to any disorder from which the child is known to suffer, for example, partial or no school attendance and the use of seemingly unnecessary special aids.</li><li>• Objective evidence of fabrication – for example, the history of events given by different observers appearing to be in conflict or being biologically implausible (such as small infants with a history of very large blood losses who do not become anaemic, or infants with large negative fluid balance who do not lose weight); test results such as toxicology studies or blood typing; evidence of fabrication or induction from covert video surveillance (CVS).</li><li>• The carer expressing concern that they are under suspicion of FII, or relatives raising concerns about FII.</li><li>• The carer seeking multiple opinions inappropriately.</li></ul>
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## Practice Points

### Early recognition

- Suspect FII when the clinical features do not make sense (see Table 3).
- When FII is included in the differential diagnosis, put equal effort into confirming or excluding the diagnosis of FII and the exploration for genuine disease.
- FII is not a 'diagnosis of exclusion' and continued investigations for other less probable physical diagnoses may cause the child further harm.
- Proceed in a timely manner to the investigation which is most likely to confirm a diagnosis either of FII or an organic condition.
- Consider the differential diagnosis set out in Table 1 – is this child's 'illness' likely to fall into another category?

## What should the paediatrician do when FII is first suspected?

- 5.4 The consultant who is responsible for the child's health is the key clinical lead for the case and should take lead responsibility for all decisions about the child's healthcare. This role is known as the **responsible paediatric consultant**<sup>4</sup> and it is important that timely agreement is made of who takes on this responsibility.
- 5.5 This guidance should be read in conjunction with the government guidance<sup>4,5</sup> which includes flow charts outlining the processes, and also chapter five in *Working Together*<sup>2,3</sup>.
- 5.6 The paediatrician should begin by assessing the safety of the child, particularly in the case of suspected non-accidental poisoning and suffocation. Clear patterns of constant and careful observation of the child should be instituted. The essential questions for the paediatrician are:
- Does the child actually suffer from an illness?
  - If so, does the recognised illness explain all of the child's reported symptoms and observed signs and symptoms?
  - If not, what is the likely cause of the child's reported symptoms and observed signs?
  - Is the child suffering or at risk of harm?

- 5.7 FII is a clinical diagnosis, which must be based on a full consideration of the child's clinical features including past and present medical history, examination findings, and all available test results. As with most diagnoses of abuse, the diagnosis is not usually made on a single finding or a single event but often on a series of different events over a period of time.
- 5.8 A paediatrician who suspects FII should discuss the case at the earliest opportunity with a colleague who has expertise in child protection (this may be a Named or Designated Health Professional or a colleague with specific expertise) and with other relevant nursing and medical staff. If immediate protection is required, LSCB procedures should be followed.

### **Early history and concern about the child's health**

- 5.9 Many children in whom illness is fabricated or induced will have been well known to health professionals from birth. Some may previously have been seriously ill and some will have a significant genuine medical condition<sup>29</sup>. This may be directly related to the fabricated illness (for example, through non-treatment or exaggeration) or may be incidental. Prior to the identification of fabricated or induced illness a child may often have also experienced other forms of abuse, such as physical abuse or neglect<sup>29,43</sup>.
- 5.10 Consideration should be given to the possibility that obstetric complications affecting a child may have been due to a carer interfering with the pregnancy (for example, to induce a premature birth). Consideration should also be made of whether the past obstetric history given by the carer may itself be fabricated<sup>44</sup>.
- 5.11 The medical history of a child with suspected FII may be extensive. As stated above, the child may have been seen by a number of professionals in different geographical areas and different health settings (as can of course be found in cases of genuine illness).
- 5.12 For some carers, providing a clear and accurate history may be difficult. Paediatricians should be aware of these complexities and should have the relevant skills to deal with such situations.
- 5.13 Where appropriate, it is important to give the child with suspected FII, an opportunity to describe what has happened.



## **Practice Points**

### **Initial management**

- Agree who will assume role of ‘responsible paediatric consultant’.
- Use this guidance in conjunction with government publications<sup>2,3,4,5</sup>.
- Document early concerns in the child’s case notes so that other clinicians will have access to that information. Carers’ access to records may need to be restricted.
- Discuss concerns with Named and Designated Health Professionals and other relevant colleagues, including nursing staff involved with the child.
- Conduct and document an immediate assessment of the risk of harm based on available information: Is the child in need of immediate protection?
- If the child is not currently in hospital, consider whether a planned admission with careful observation would help to elucidate the clinical diagnosis.
- Consider whether any immediate investigations or further opinions are likely to assist in the diagnosis.
- Consider constant supervision of the child or other measures to reduce the risk of immediate harm.
- Stop any harmful treatments or invasive procedures unless they are clearly indicated. It is unacceptable to cause the child further iatrogenic harm whilst the diagnosis of FII is being considered.
- Consider whether there is concern that the child may be at risk of significant harm – if that concern cannot be resolved quickly and simply then a referral should be made.
- Do not wait to confirm the diagnosis before referring to children’s social care as delay may be detrimental to the child.
- Consider whether referral should be made to children’s social care. This is likely to be indicated if there is a risk of immediate harm to the child through illness induction, or harm through the carer’s disagreement with the need for further observation or with paediatric consensus about the child’s state of health.
- Prepare a chronology.

**At this stage concerns about FII can not be discussed with the family as the child may be put at risk.**

## **The chronology**

- 5.14 The key tool in diagnosis is the chronology. The preparation of a chronology is an essential part of confirming the abuse and plays an important role at a later stage in the multi-agency assessment. However, the preparation of the chronology should not delay intervention if this would put the child at increased risk of harm.
- 5.15 The process should start with a review of the records available to the responsible paediatric consultant and should be expanded to include all of the child's health records. The development of a chronology may be a staged process, with health professionals completing what can be done initially, then involving the local authority, and then moving to an enquiry under section 47 of the Children Act 1989<sup>45</sup>.
- 5.16 The health chronology should be as fully integrated as possible and should include information from primary, secondary and tertiary care and from medical, nursing and therapy professionals. The GP can play a key role in recognising patterns of worrying behaviour from multiple presentations at different settings and in making concerns known to the hospital team. It is therefore crucial to seek information from the primary care team and to liaise with the GP. It is also important to obtain information from day care or school about the child's state of health and functioning.
- 5.17 Some cases of severe FII involve fabrication in other aspects of life (such as in the media) and this information should be obtained if possible.
- 5.18 The consent of the competent child and young person should be obtained when sharing information. Where the child cannot make decisions for themselves those with parental responsibility have a legal right to make decisions on their behalf, unless doing so would place the child at risk of significant harm<sup>2,3</sup>.
- 5.19 Information on siblings, and the carers themselves, may also be of great value. Obtaining information about carers' own health will require their prior consent unless this can be justified under section 47 of the Children Act 1989<sup>45</sup> as prevention of significant harm or under a police investigation.
- 5.20 The chronology should be collated by experienced doctors or nurses – often these will be from the trust's child protection or management team.

- 5.21 The chronology should be prepared using an agreed format such as the template commonly used in serious case reviews (for example the ‘ChronoLator’)<sup>46</sup>.
- 5.22 The preparation of a chronology is a complex and time-consuming task – comparable to serious case reviews – and adequate time and resources will need to be allocated. This should be agreed with the Trust in general terms as soon as concerns about FII are raised and then again after a case is recognised.

## **Practice Points**

### **The chronology**

- Arrange for a chronology to be compiled in all cases of suspected FII.
- Decide who will do this and the timescales involved (this will depend on the immediacy of risk of harm to the child).
- Agree with Trust management for adequate time and resources to be allocated.
- Seek consent from the child’s carer(s) to access records from other centres, on the basis that you are trying to get to the root of the child’s problems and it would be helpful to draw together the entire medical history. At this stage it will not be appropriate to disclose to the carers that there are concerns about FII.
- The chronology will probably need to be done in stages as records from different services become available.
- Use a template for the chronology that is similar to that for serious case reviews.
- When available, review the chronology and consider diagnosis. Share with clinical colleagues and within a multiagency setting if appropriate.

## **Special tests and further investigations**

- 5.23 Consideration should be given to whether any specific tests might help the diagnosis. If these tests involve forensic work, such as DNA analysis of blood (for example, in urine or on clothing), they should be conducted after discussion with, and under the direction of, the police and forensic science service. This will therefore involve an early referral under the LSCB procedures to ensure any results obtained adhere to evidential rules.
- 5.24 The assessment of possible FII can be complex, as described in the review on salt poisoning by RCPCH<sup>47</sup>. It may be necessary to involve an appropriate tertiary specialist, such as a paediatric nephrologist in cases of possible salt poisoning, or

a paediatric neurologist in cases of possible factitious epilepsy. Tertiary specialists should be carefully briefed about the FII concerns, and the remit of their involvement should be clearly delineated – overall management of the case should remain with the responsible paediatric consultant.

## **The role of the responsible paediatric consultant**

- 5.25 As discussed above, the responsible paediatric consultant should take lead responsibility for all decisions about the child's healthcare<sup>4</sup>. It is essential that there is clarity about who is taking on this responsibility and that the role receives adequate support from colleagues and the Trust.
- 5.26 The responsible paediatric consultant should be closely involved with all clinical decisions and plans regarding the child. Other consultants (for example, those 'on service' or 'on call') should also be made aware of any plans and, if possible, should avoid altering the plan of care without first consulting the responsible paediatric consultant.
- 5.27 It had previously been thought that cases of FII should be managed by a doctor with specific expertise from outside the situation in which the identification was made. However, current best practice suggests this should only occur in exceptional cases and that there should be local expertise to manage most cases. This will help to ensure that the child and carer(s) do not seek multiple opinions resulting in further investigations and potential harm. Second opinions should usually only be requested on specific issues, with the approval of both the responsible paediatric consultant and the Named and Designed Health Professionals.
- 5.28 If at all possible, the case should continue to be managed by the same medical team in the same setting throughout its duration. A change of medical team at any stage can cause delays in the identification of FII thereby increasing the risk of further harm to the child. However, in cases where the child requires immediate tertiary care, a move cannot be avoided. Requests may be made by a carer for a change in consultant or a referral elsewhere due to 'loss of confidence' in the team – often when it is perceived that the clinical team are suspecting FII. At this point formal child protection procedures may need to be invoked.
- 5.29 If a referral is made to another Trust for clarification of a specific issue, responsibility for the case should still remain with the original responsible paediatric consultant.

- 5.30 The responsible paediatric consultant should not manage the case alone – the process of identification and management requires a team effort. Concerns should be discussed with a colleague with expertise in child protection (this may be a Named or Designated Health Professional or a colleague with specific expertise), and nursing staff.
- 5.31 Effective communication between colleagues is essential if to ensure a good outcome for the child is to be achieved. Concerns about FII should be mentioned in all communications about the case, and the responsible paediatric consultant should be the main conduit for communications.
- 5.32 The process of clinical decision-making for a case of suspected FII may be stressful, and disagreements about management and perceptions may arise. It is important that team members are fully informed, involved, and supported. Clinical decisions should be reached using sound professional judgements, based on careful collection and analysis of all available information. Local peer review mechanisms should be available to support this.
- 5.33 In cases where there have been duplicate presentations at multiple settings, and there are concerns about FII at more than one hospital or clinical setting, clinicians at each Trust and Named and Designated Health Professionals should together agree which Trust will take the lead role and who will be responsible paediatric consultant.
- 5.34 Surgeons should ensure that concerns about FII have been resolved and should seek agreement from the responsible paediatric consultant before proceeding with a surgical procedure on a child with previously suspected FII.
- 5.35 When a diagnosis of FII is confirmed, when a child's presentation involves a mental health disorder or if the child is displaying emotional or behavioural problem the local Child and Adolescent Mental Health Service (CAMHS) should be informed, and there should be processes in place to ensure timely communication between CAMHS and paediatric services.

## **Observation and supervision**

- 5.36 When a child is in hospital, the process of observation needs to be agreed as part of the care plan. This will have different purposes according to the case which in turn will influence the observation process. Observation may be required to verify

the reported history, or if there are concerns about the likelihood of possible harm, observation and supervision of the child may be discussed with other agencies such as children's social care.

- 5.37 If the child is not in hospital, a planned admission may be undertaken in order to verify or clarify the reported symptoms. During the admission the child will need to be observed constantly and closely.
- 5.38 If the carers refuse to admit the child, and this is believed to place the child at increased risk, it may be appropriate to seek statutory involvement from children's social care. Delay and prevarication should not be allowed if this places the child at risk of further harm.
- 5.39 There should be prior agreement between professionals about who is responsible for duties such as administering treatment, and collecting samples and observational recordings.
- 5.40 If Covert Video Surveillance (CVS) is considered necessary, this must be managed and performed by the police (see the following section on CVS and HM Government Guidance<sup>4,5</sup>).
- 5.41 The purpose of an admission should not be primarily to observe the carers but to find out what is wrong with the child. However, carers' involvement in the child's care should also be carefully observed. Abnormalities of carer-child interaction may include carers either being intensely involved with the child, or appearing strangely unconcerned. These observations, although helpful in obtaining a full picture of the child and family, are not diagnostic of FII by themselves.
- 5.42 The carers should be told explicitly that observation is necessary because of uncertainty among medical staff about the child's diagnosis.
- 5.43 At some stage in this assessment, the carers may begin to suspect that staff are concerned about the possibility of FII. If they voice these concerns, the responsible paediatric consultant should discuss the child's clinical features as openly and honestly as possible without, at this stage, disclosing the concern about FII. As discussed earlier, the carers may request a change of clinical team or hospital or may simply break contact with the medical team altogether.

## **Covert Video Surveillance (CVS)**

- 5.44 CVS is an option available to the child protection agencies when faced with concerns about child abuse which cannot be resolved in any other way<sup>48</sup>. There has been much debate about the use of CVS in health settings. In certain circumstances, CVS may be needed to confirm or refute child abuse and may therefore be life saving. However, the use of CVS should be carefully considered and public concerns regarding its use recognised. Appendix 2 may help to clarify whether CVS is likely to be helpful in a particular case. The guidance by HM Government<sup>4,5</sup> covers the subject in more detail.
- 5.45 The use of CVS should be agreed at the formal child protection multi-agency strategy discussion (see sub-section in chapter 6 on ‘The Strategy Discussion in FII Cases’). CVS can only be undertaken by the police, acting under the Regulation of Investigatory Powers Act 2000 (RIPA)<sup>49</sup> which includes a requirement for the police to obtain authorisation.
- 5.46 The Chief Executive of the Trust must be informed about the use of CVS, and there should be close and detailed consultation with the staff caring for the child. At all times, reference must be made to LSCB procedures, developed jointly with the police and health professionals – medical input to this process is crucial. If an LSCB policy is not in place, CVS should not be used.
- 5.47 It is important to ensure that the child is not exposed to unnecessary risk of harm in order to achieve a criminal standard of evidence. CVS is most unlikely to be justified if there is already cogent and compelling evidence of abuse to a civil standard of proof (on a balance of probabilities), enabling the child to be protected. However, if the child is likely to remain in the care of a suspected perpetrator because there is insufficient evidence to protect them, and is at a high risk of future harm, then the risks associated with CVS may be justified. Consideration must take place on a case by case basis.
- 5.48 Equal consideration should be given to the possibility that CVS may reveal signs of genuine illness, as well as the possibility that it may expose child abuse. **The starting position should be that the cause of the child’s illness is unknown.**
- 5.49 If CVS is used, there will need to be effective arrangements for immediately safeguarding the child’s welfare and ongoing medical monitoring, should an episode of witnessed abuse take place, including, for example, resuscitation arrangements.

- 5.50 The potential need for medical support for the carers should also be discussed, in the eventuality that abuse is discovered. Consideration should also be given to the need for staff support.

## **Practice Points**

### **Further medical management**

- Ensure that the responsible paediatric consultant maintains continuity and control of the case, irrespective of the involvement of other professionals.
- Resist requests for a change of clinical team or hospital as this may place the child at risk of harm.
- A clinical report should be prepared for the multi-agency strategy discussion outlining the medical concerns (see sub-section in chapter 6 on ‘The Strategy Discussion in FII Cases’).
- If the child is not at immediate risk of harm, consider whether further investigations or opinions are likely to assist. Are special forensic tests likely to help? If so, discuss these in the strategy discussion (see chapter 6).
- Keep detailed and meticulous medical and nursing records, recording all investigations, observations and consent (see chapter 9 for more detail on record management).
- Clinical and child protection plans must be shared with ‘on call’ staff in handover meetings.
- Consider whether the case may require the use of CVS (see Appendix 2). If so, discuss this in the Strategy Discussion.
- Ensure that any decisions to undertake CVS is recorded in the child’s record held by each agency involved in the decision, and that this is signed by a senior manager.

## **Recognition of genuine illness**

- 5.51 It is possible that in the course of further investigation and monitoring, additional information may emerge which indicates genuine illness in the child. The child may continue to have acute episodes of illness after the carers have been excluded from their care, or symptoms or signs may recur during constant observation.
- 5.52 It is not unusual for a child to have some genuine illness as well as elements of FII. If evidence of genuine illness is identified, the child’s whole medical history should therefore be reappraised and the diagnosis reconsidered to establish



whether this adequately accounts for all the child's reported symptoms and signs. It may be appropriate to seek further opinion or to carry out selected tests.

- 5.53 If the conclusion is that the child's reported symptoms and signs are adequately explained by the previously unrecognised genuine illness, then this should be communicated without delay to the carers, all those involved in the child's care, and the multi-disciplinary child protection team.
- 5.54 If the child's carers have been told about the diagnosis of FII or if this has been intimated, the responsible paediatric consultant should offer a full explanation of what has happened and why; an apology for any distress caused; and assurance that the child will not be subject to a child protection plan. If concerns regarding FII have extended to an enquiry under section 47 of the Children Act 1989<sup>45</sup>, involving children's social care, the explanation and apology for distress should be provided according to LSCB policies.

## **Practice Points**

### **Identification of genuine illness**

- If a genuine cause for the child's symptoms and signs is found and the possibility of FII is excluded, communicate this immediately and clearly to the clinical team, including primary and secondary care, and to children's social care.
- Always remember that genuine disease and FII may co-exist.
- If the carers were already aware that FII was being considered, ensure that a full explanation is provided, and an apology offered for any distress caused.

## **6. Paediatric management of cases: making a referral to children's social care**

- 6.1 As stated in chapter 5, there will be situations when an urgent referral to children's social care is required, following the LSCB procedures (or in Scotland, Interagency Child Protection Committee Procedures). If a paediatrician is concerned about the immediate safety of the child then a referral must be made, particularly in the case of suspected non-accidental poisoning and suffocation.
- 6.2 At any stage during the ongoing investigation, the responsible paediatric consultant may judge it appropriate to request an initial assessment by children's social care. In England and Wales this is defined by section 17 or section 47 of the Children Act 1989<sup>6,45</sup>, in Scotland by the Children (Scotland) Act 1995<sup>50</sup>, and in Northern Ireland by the Children (Northern Ireland) Order 1995<sup>51</sup>. The threshold for making a referral to children's social care should be concern that the child may be in need or that the child is suffering, or at risk of suffering, significant harm.
- 6.3 In Northern Ireland the term 'Child Protection Referral' is used to describe a notification to the police service from a Health and Social Services (HSS) Trust, or a notification from the police service to a HSS Trust, of an allegation or suspicion of child abuse. Such a referral will be made verbally in the first instance and will be followed up in writing on an approved form (Form PJI 1), according to the *Protocol for Joint Investigation by Social Workers and police officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland*<sup>52</sup>.
- 6.4 It is inappropriate to delay referral to children's social care pending confirmation of FII. The identification process can and will continue even after a referral is made and the additional information received in the course of the initial assessment may contribute significantly to the medical assessment.
- 6.5 At this stage, the carers should **not** be made aware of the concerns about FII or their consent sought for the referral, as this may put the child at additional risk of harm. Further management, including when to inform the parents of the concerns should be discussed at the multi-agency strategy discussion (discussed in more detail below).
- 6.6 The process arising from a referral of a child in need is explored in detail in *Working Together*<sup>2,3</sup> and should be referred to as required.

## The strategy discussion in FII cases

- 6.7 If the initial assessment suggests that there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm, children's social care should convene a multi-agency strategy discussion.
- 6.8 The conduct of strategy discussions is detailed in *Working Together*<sup>2,3</sup>. Where there is concern about FII, it is **essential that the responsible paediatric consultant is present**. The Health Visitor, School Nurse, and other health professionals should be present where relevant, and if the child is in hospital, senior nursing representatives should also attend. Legal advice is likely to be needed – this is usually provided by the local authority at strategy and legal meetings convened under *Working Together*, but there may also be a need for specific legal advice from a health perspective. Confidentiality at this stage is very important.
- 6.9 The strategy discussion should decide whether to initiate a formal enquiry under section 47 of the Children Act 1989<sup>45</sup>. For complex cases, more than one strategy discussion may be required. The discussion should include consideration of:
- The level of risk of harm to the child;
  - Any immediate steps necessary to reduce the risk of harm (for example, cancelling unnecessary medical procedures or instituting closer observation of the child);
  - Communication with carers and confidentiality (including how, when, and by whom they should be informed of any child protection concerns);
  - How the child can be given an opportunity to tell their story – this requires careful consideration and planning;
  - Any outstanding investigations, further information gathering, and opinions that would be helpful;
  - Responsibility for the Core Assessment;
  - The security of medical records (see chapter 9);
  - The level of professional observation required;
  - Whether the carers should be allowed on the ward if the child is an inpatient – if this is deemed to be unsafe then an emergency order may be required which will need to be instituted by either the police or the local authority;
  - Any potential implications for other patients or their carers who are on the ward at that time;
  - The planning of further medical and nursing assessment;
  - The need for forensic sampling, special observation or CVS (see chapter 5);
  - The needs of siblings and other children in the family;

- The needs of carers, particularly after disclosure of concerns;
- The development of an integrated health chronology (and agreement on who should do this);
- Clarification of who will be the responsible paediatric consultant for the child (if not already explicit);
- Any further opinions needed (including specialist child protection opinion or to address a specific clinical issue);
- What is known about the carers' past behaviour, medical history, current health state and any treatment, equipment, aids or benefits being received either for themselves or the child.

## **Practice Points**

### **The strategy discussion**

- Ensure key staff are present including the responsible paediatric consultant, senior nursing staff and the GP.
- Ensure a written report is available.
- Ensure a number of key issues are on the agenda and action points requiring input from health staff are documented and allocated (listed in section 6.9).

## **7. Paediatric management of cases: managing the case after the strategy discussion**

### **Disclosure of concerns to the child's carers**

- 7.1 A key task after the strategy discussion is to disclose the possibility of FII to the carers. Professionals should be supported through the process of disclosure and the approach should be agreed and discussed with the multi-agency child protection team and carefully planned beforehand. The disclosure should be made in the presence of at least one other member of the team. In most cases the discussion will involve the responsible paediatric consultant jointly with a social worker and/or the police. However, in cases where the police obtain evidence that a criminal offence has been committed, it is important that the paediatrician does not confront the carers – this must be left to the police in order to ensure that the carers' rights are protected in accordance with the Police and Criminal Evidence Act 1984<sup>53</sup>.
- 7.2 The carers should be invited to discuss the child's progress in an appropriate place which provides privacy and confidentiality. If the child is an inpatient, the meeting should be away from the bedside. If possible, both carers should be present at this meeting.
- 7.3 The discussion may include the following:
- The fact that FII is the most probable cause for the child's signs and symptoms;
  - The reasons why the identification of FII seems likely;
  - Any other possible causes for the child's signs and symptoms;
  - Any further investigations and their likely impact on the decision regarding FII;
  - The plan in terms of any ongoing management of the child's medical condition and monitoring arrangements, with likely timescales where possible;
  - The prognosis for the child;
  - Supportive services available for a carer who is suspected of abuse and for a non-abusing carer;
  - Follow-up arrangements, including a plan for further discussions (consistent with the multi-agency plan agreed at the strategy discussion).
- 7.4 Questions should be invited and answered as honestly and fully as possible. Any areas of uncertainty that are outside the paediatrician's expertise should be acknowledged.

- 7.5 This potentially difficult meeting must be handled sensitively and without causing unnecessary distress. The carers should have a full explanation of the evidence and what further action is needed. Support should be provided to the suspected perpetrator of the abuse after the meeting.
- 7.6 A detailed note of the discussion should be made in the child's case notes.
- 7.7 At this stage the child's carers may request a change of medical team. This should be considered by the child protection team, but, as discussed above, it will usually be unhelpful to have a change in medical personnel at this stage. As always, the overriding consideration should be the welfare of the child.

## **Practice Points**

### **Sharing concerns with the child's carers**

- Ensure this meeting is carefully planned by a multi-agency team (usually as part of the strategy discussion).
- Ensure that the medical diagnosis is explained in a non-judgemental, dispassionate, truthful and honest way, and without causing unnecessary distress.
- Follow the principles involved in the disclosure of any other serious medical diagnosis, bearing in mind that an abusive carer will presumably be well aware of the cause of the child's illness but other family members may be totally unaware.
- Consider how to support the perpetrator, family members, and staff after the disclosure meeting as this will be a very stressful event.
- Include the points outlined in section 7.3 in the agenda for the discussion.
- Keep detailed records of the meeting.

## **Complex cases where the child's perceived illness is not explained by any organic disease but FII is not confirmed**

- 7.8 It may be that the child's illness is not explained by any organic illness and that FII is also not confirmed, as the carer is not found to be actively exaggerating, fabricating or falsifying symptoms or inducing illness in the child. This should be decided following an assessment of the relative risks and benefits of further investigations. Investigation for reassurance purposes only, or to exclude highly

improbable conditions which would not explain the child's presentation, should be discouraged.

- 7.9 In such cases, the responsible paediatric consultant should inform the family that it has not been possible to give a physical diagnosis or to define the child's problem medically but that the symptoms are not life threatening or indicative of any severe underlying disease. The carers should be told that the child needs to be helped to function alongside his or her symptoms and will not come to harm as a result; they should be informed that further investigations are not needed and would be likely to cause harm. It is advisable that discussions with the carers are attended by the responsible paediatric consultant and at least one other member of the team. Detailed notes should be made at the time.
- 7.10 Consideration should be given to whether the child is fabricating their own illness, and what further action including a referral to CAMHS would be appropriate. It is preferable to avoid giving a name to disorders, such as 'chronic pain syndrome', as these may be understood by carers to indicate a genuine disorder.
- 7.11 A plan for rehabilitation of the child back to normal functioning, including a return to school, withdrawal of unnecessary medical equipment or aids, and stopping unwarranted medication should be outlined. If appropriate, consent should be sought from the carers for a referral to children's social care for additional support under section 17 of the Children Act, 1989<sup>6</sup>. The involvement of a child and adolescent psychiatrist or psychologist is likely to be helpful in implementing this plan.
- 7.12 If the carers are unwilling to accept this approach, and request more investigations or another opinion, concerns about perpetuating harm to the child may arise. Under these circumstances discussions with other members of the team and with children's social care are appropriate.

## **Practice Points**

### **Cases where neither organic disease nor FII is confirmed**

- These children come under the broad umbrella of ‘non-organic’ symptoms.
- Consider whether the child (if older) could be fabricating their own illness.
- Explain the differential diagnosis and likely diagnosis to the carers.
- Explain that medicine may not have the answer and some children have to ‘live with’ their symptoms.
- Avoid the use of unscientific terminology.
- Avoid further investigations to look for the highly improbable which might risk causing iatrogenic harm.
- Draw up a plan for rehabilitating the child.
- Consider making a CAMHS referral.
- If the carers request further investigations and there are concerns about the risk of significant harm, a referral should be made to children’s social care.

## **Ongoing paediatric monitoring**

- 7.13 Whether FII or another variant of abnormal illness behaviour is suspected, the child should continue to be reviewed for signs and symptoms of genuine disease, consequences of abuse, and emotional and behavioural outcomes.
- 7.14 If children’s social care remain involved, either under section 47 (Child Protection) or section 17 (Child in Need)<sup>4,5,6</sup> the responsible paediatric consultant should ensure regular communication, and should produce review reports when requested. Those responsible for follow-up need to be fully informed about the nature of the concerns which led to the section 47 enquiry.
- 7.15 As in the multi-agency strategy discussion, it is essential that there is senior medical input into section 47 child protection conferences<sup>4,5</sup> and all other ongoing discussions about the child. Paediatricians and health professionals are responsible for providing detailed report(s) for case conferences, and will also be responsible for a number of the actions identified.



## **Practice Points**

### **Ongoing paediatric monitoring**

- Monitor features of genuine disease, consequences of abuse or emotional and behavioural difficulties.
- Communicate with the child protection team, including children's social care, and other clinicians involved.
- Provide update reports, witness statements, and attend child protection conferences or court when appropriate.

## **Pre-birth child protection conferences in FII cases**

7.16 If another child in the family has been previously abused, it does not necessarily mean that subsequent children will be at risk of harm. Therapeutic work may have been successfully undertaken with the perpetrator(s) and family and other stressors may have been addressed. However, previous abuse of a child in the family does raise substantial concerns. An assessment of the needs of the unborn child should always be undertaken and a decision made about whether the unborn child is likely to be harmed in utero or following birth.

7.17 A pre-birth conference should be arranged if a previous child in the family has suffered FII abuse or if a pregnant woman has a history of fabricating illness in herself. The evidence relating to FII in the previous child will need to be reviewed and a report provided. Psychiatric assessment of the mother may also be indicated (see sub-section in chapter 8 'The role of the adult psychiatrist in assessing carers').

## **Practice Points**

### **Pre-birth protection conferences**

- If there has been previous paediatric involvement with the family, ensure a chronology is compiled and a paediatrician is involved in the multi-agency risk assessment process – if there is doubt about who should do this, the Named Doctor should be consulted.

## **8. Paediatric management of cases: following the initial child protection conference**

- 8.1 Following the initial child protection conference, it is important that the health management team, including the responsible paediatric consultant remain unchanged. The responsible paediatric consultant and the team will need to contribute to the child protection plan as agreed.
- 8.2 The health team should continue work on the chronology, linking in with the chronology prepared by children's social care. If protection through the courts is sought, the team will need to prepare individual reports and statements. This is a time consuming task and should be allocated appropriate resources by Trust management.
- 8.3 The multi-disciplinary team (including professionals from health and children's social care) should consider what ongoing work with the child and family is required after the initial child protection intervention. This will involve children's social care and possibly child and adolescent psychiatrists or psychologists, adult psychiatrists and paediatricians with a particular remit for child mental health.
- 8.4 The specific interventions which may be requested by the case conference or the courts should be based on evidence about what is likely to achieve the best outcomes for the child within an appropriate timescale. This may include an assessment of the child with a view to rehabilitation of the child with their carers or interventions with a more clinical remit, addressing perceived mental health needs of the child and the wider family.
- 8.5 Members of the multi-disciplinary team should try to reach a common understanding of the case, and at each stage in the process agree how the child and family will be involved in the child protection processes, and what information should be shared with them. From a health perspective, this work should be co-ordinated by the responsible paediatric consultant working with children's social care. In many cases the court will also be involved in these decisions.
- 8.6 Agencies and professionals should be honest and explicit with children and families about professional roles, responsibilities, powers and expectations, and about what is and is not negotiable. There should be a presumption of openness, joint decision-making, and a willingness to listen to families and capitalise on their strengths.

- 8.7 The guiding principle must always be what is in the best interests of the child and it is important to maintain a **clear focus on the child's safety**. It should be recognised that some children are vulnerable to manipulation by carers, and a minority of carers are actively dangerous to their children and to other family members or professionals. Some carers are unable to recognise or acknowledge the harm caused to the child and are unwilling and/or unable to change.
- 8.8 A key issue will be whether the child's needs can be met within the family context and within timescales that are appropriate for the child. These timescales may not be compatible with those of the carers who are in receipt of therapeutic help. This may mean that the child cannot be safely cared for by their current carers and will need to be moved to a family setting where they are not present. In the longer term it may be in the child's best interests to be placed in an alternative family context.
- 8.9 If the plan is to assess whether the child can be reunited with the carer who has been responsible for the abuse, very detailed work should be undertaken to assess the risk of harm and, if possible, to help the carer to develop the necessary parenting skills.
- 8.10 In addition to those adults who care for the child on a daily basis, views should be sought from non-custodial parents, grandparents, or other family members who play a significant part in the child's life. The child may also identify other adults who they see as important supportive influences in their lives and who they would like to be involved in decision-making. Some of these may have been excluded from contact with the child or may be unaware of the illness fabrication or induction.
- 8.11 It is equally important to identify any adult family members who may knowingly or unknowingly have supported the abusive carer in ways which enabled the abuse to continue. The nature of all family relationships should be taken into account in multi-agency deliberations when planning placements outside the birth family and contact between the child and the abusing carer.

### **Specific work with carers who have fabricated or induced illness**

- 8.12 Engagement with carers who have fabricated or induced illness is not necessarily a paediatric role, but may be a role for the wider child protection team or for a mental health professional at a later stage.

- 8.13 To gauge the prognosis for positive change in carers who have fabricated or induced illness it is essential to gain an understanding of:
- Their capacity to understand and acknowledge the harm which has been caused to the child;
  - The underlying motivations which led them to fabricate or induce illness;
  - The perpetuating factors which supported the continuation of the abuse and the extent to which these could be removed.
- 8.14 It is important to explore what life will be like now that the child has been found to be well or better than previously thought. Carers will require help with constructing an accurate narrative of the past which they can share with significant others in their life, including the family. They will require support in processing feelings of guilt and possibly also depression.
- 8.15 Thereafter, the carer who caused the abuse will require help in finding alternatives to those factors which previously motivated or supported the fabrication or induction of illness in the child, including, for example, employment and alternative sources of income to disability benefits.

## **Working with children**

- 8.16 Professionals will need to decide when and how to involve the child in the decision-making and planning processes. According to their age and understanding, children should be educated about how child protection processes work, how they can be involved, and how they can contribute to decisions about their future. Many children in whom illness is fabricated or induced are too young to be directly involved in discussions about the nature of the abuse. Children of sufficient age and understanding often have a clear perception of what needs to be done to ensure their safety and wellbeing. In cases involving older children it is important to ascertain the child's perceptions, beliefs, and feelings about their state of health, particularly their anxieties and beliefs about their future wellbeing. It is also important to elicit the child's view of their experiences of medical care.
- 8.17 Most children feel loyalty towards those who care for them, and have difficulty saying anything against them. Many do not wish to share feelings, or may not have the language or concepts to describe what has happened to them. Some may fear reprisals, or their removal from home and loss of siblings. Considerable secondary gains may have been involved for the child, such as the approval of the carer at times when the child was 'ill' or the receipt of attention and sympathy

through the adoption of the 'sick role'. The loss of this role may result in a loss of personal identity.

- 8.18 Whilst children may want the abusive behaviour to stop, some may knowingly choose to co-operate with the wishes of the abusing carer in order to maintain current family relationships, albeit recognising that they are well. Other children, as a result of being taught by an abusing carer to behave as if they are ill, may not be able to distinguish between reality and fabrication. These children may come to believe their symptoms are real and this false perception of illness will then be reinforced and rewarded by the abusing carer.
- 8.19 A child who has had illness fabricated or induced will need help in constructing a narrative about their previous state of ill health and about how they have come to recover and resume normal functioning. They will often require help in the process of rehabilitation into normal life, including returning to school. The process of adjustment and 'recovery' should include a review of the child's view of the carer who caused the abuse, which will be painful and will require the presence and support of another trusted primary carer.
- 8.20 The older child will also require continuing support and guidance in learning how to gauge their own physical symptoms and respond to them in an adaptive and safe way. This support should be sustained over a significant period of time to ensure that the child's long-term developmental needs are met.
- 8.21 A child who has had illness fabricated or induced may continue to experience the consequences of this abuse, particularly in terms of behavioural and emotional development<sup>39</sup>, irrespective of where they are placed permanently – whether reunited with their families or placed in a new family. Therapeutic work with the child should therefore continue, irrespective of where they are placed, to ensure their needs are responded to appropriately.

## **Working with the family**

- 8.22 Work with the family may be undertaken by social workers, child psychiatrists and psychologists, paediatricians with a special interest in child mental health and adult psychiatrists.
- 8.23 Work will need to be undertaken with the child and the abusing carer together. This will include: constructing an accurate account of what has happened; giving

the child an explanation of the carer's behaviour; allowing the child to express their feelings; and, when possible, allowing the carer to discuss their past abusive behaviours and to discuss how they might respond to and meet their child's needs. It is important to also work with the siblings of children who have been subject to illness fabrication or induction. These siblings may have felt excluded, and may have missed out on attention in favour of their seemingly sick sibling. There may well be a need for work with the carers and other significant adults within the family in reaching a new understanding of past events and in planning for the future. The whole family will require help in adjusting family life to the new circumstances of including a well child.

- 8.24 However sensitively enquiries are handled, many carers perceive professional involvement in their lives as painful and intrusive, particularly if they feel that their parenting is being called into question. This distress should always be acknowledged and should be minimised as far as possible. Families may be more accepting of professional involvement if it is clear that interventions in their lives, while firmly focused on the safety and welfare of the child, are also concerned with the wider needs of the family.
- 8.25 Children and families should always be informed of local and national advice and advocacy services which may support them through child protection processes.
- 8.26 Where children and families are involved as witnesses in criminal proceedings, the police, witness and other support services, such as Victim Support, can do a great deal to explain the process, make it feel less daunting, and ensure that children are prepared for and supported in the court process. Information about the Criminal Injuries Compensation Scheme should also be provided in relevant cases.

### **The role of the adult psychiatrist in assessing carers**

- 8.27 It is important that adult psychiatrists work closely with the health team to explore the family background and assess mental health needs.
- 8.28 The presence of a personality disorder in the child's carer is not necessarily an indicator of FII or any other form of child abuse. Most individuals with a personality disorder are not involved in child abuse, and many people found to be implicated in child abuse exhibit neither personality nor other formal psychiatric disorders. There is also little evidence that the presence or absence of personality disorder is a reliable indicator of prognosis in a child protection context.

- 8.29 However, it is important to understand the background of a carer who is thought to be implicated in FII – such as their intellectual capacity and their health beliefs – as this will help to evaluate their understanding of illness, including how they utilise medical services.
- 8.30 It should be recognised that it may be difficult for a psychiatrist who is treating the carers (and who may feel obliged to act as an advocate for them) to also undertake the role of an independent psychiatrist whose focus should be assessing the child protection context.

### **What should the adult psychiatrist do?**

- 8.31 The psychiatrist should undertake an evaluation of the carers including a full personal, family, medical, obstetric and psychiatric history. This should include gathering a history of the carers' relevant illness behaviour and their understanding of the meaning of symptoms. Some carers are uninformed or naïve about illness and the workings of the human body.
- 8.32 It is important to establish a common language between the carers, the family, and the health team, in order to ensure mutual understanding of the reporting of symptoms and signs.
- 8.33 Any obvious psychiatric disorder or illness should be excluded.
- 8.34 The adult psychiatrist should explore family relationships – for example, a mother who is suffering from domestic violence may be fabricating a child's illness in order to seek 'sanctuary' in hospital.
- 8.35 More severe degrees of personality disorder may be obvious from the history. However, it is important not to make assumptions – for example, suggesting that because the adult has a history of other anti-social behaviour they must be perpetrating FII. In addition to clinical assessment, formal personality testing may be useful.
- 8.36 There is increasing interest in conducting attachment assessments using standardised international instruments which explore the carer's attitudes to parenting and identify areas for possible intervention, such as 'unresolved bereavement'.

## **Recommendations for rehabilitation, reunification and treatment**

- 8.37 There is a distinction between (a) treatment for the needs of the carers only and (b) treatment that might promote the reunification of the family.
- 8.38 Any recommendations must be realistic, including being available and accessible within a timeframe that is reasonable for the child, with evidence of clinical effectiveness, and preferably with objective outcome goals.

### **Practice Points**

#### **Longer term involvement of the child health team**

- Ensure ongoing monitoring and review, whether or not the child remains within the family.
- Ensure the responsible paediatric consultant retains their role.
- Continue updating the chronology.
- Provide advice and reports in the child protection context.
- Facilitate contact with CAMHS or Adult Mental Health Services where appropriate – it will be important for mental health professionals to have a clear understanding of the paediatric issues.
- Continue to work in partnership with the carers and other agencies, with a clear focus on the welfare of the child.



## 9. Record keeping

- 9.1 Medical records should be kept in accordance with the Data Protection Act 1998 and its eight Data Protection Principles in *Records Management: NHS Code of Practice*<sup>54</sup> as well as the recommendations in the *Victoria Climbié Inquiry report*<sup>55</sup>. Doctors should follow the principles of record keeping set out in the *General Medical Council's Good Medical Practice*<sup>56</sup>. Nurses and midwives should follow the principles of good record keeping set out in the *Nursing and Midwifery Council's Advice on Record Keeping*<sup>57</sup>.
- 9.2 Detailed, accurate, and informative medical records are as pivotal to the management of a suspected FII case, as they are to the clinical management of all cases. Records may be disclosed in the context of legal proceedings, to help legal professionals to form a clear understanding of the events causing concern.
- 9.3 All records for the child (there may be more than one) should be kept in a more secure location than usual (for example, not in the ward notes trolley). The responsible paediatric consultant and Trust should be informed about where the notes are being stored, and should have access to this location.
- 9.4 Using a single case record for nursing and medical staff will help to promote effective clinical communication, as recommended in the *Victoria Climbié Inquiry report*<sup>55</sup>. In cases of FII, this approach is particularly to be commended as effective communication between nursing and medical staff is crucial.
- 9.5 If a child moves between clinical teams or between organisations, it is best practice for the notes to follow the child. This may not always be possible and so a clinical summary must accompany the child.
- 9.6 As stated in chapter 5 of this guidance, it is essential that the records include a health chronology of the child's medical presentation, including any aspects which may indicate fabricated or induced illness. It is crucial to record the source of information, for example, whether a symptom or sign was independently observed by staff or reported by a carer. Factual information provided by a carer should be corroborated where possible and the presence or absence of corroboration (or contradictory information) should be documented.
- 9.7 Where the veracity of information provided by a carer cannot be confirmed, opinions should be recorded in the notes to reflect this. It may be helpful for this

information to be recorded on a differential basis, for example, ‘if this aspect of the history is correct then it follows that... however if it is incorrect then the opinion would be different...’ It is essential that clinicians’ concerns about FII are documented in the records. Where there is uncertainty, this should be expressed as a differential diagnosis.

- 9.8 If FII is suspected, requests by a child’s carer to access their records under the Data Protection Act 1998<sup>58</sup> may be refused either because:
- The disclosure would be likely to cause serious harm to the physical or mental health or condition of the data subject – that is the child;
  - The child has provided the information in the expectation that it would not be disclosed to the carer;
  - The data was obtained as a result of an examination or investigation to which the child consented in the expectation that that the information would not be so disclosed;
  - The child has expressly indicated that the information should not be so disclosed.

## **Practice Points**

### **Record keeping**

- Ensure strict adherence to current best practice in record keeping (see references to documentation above).
- Always document concerns about possible FII – failure to do so will prevent important information from being shared, thereby increasing the risk of harm to the child.
- Carefully manage the carers access to medical records.
- Ensure the records clearly identify the responsible paediatric consultant.
- Keep multi-disciplinary case records.
- Provide an appropriate summary of the case if records do not follow the patient between Trusts or clinical teams.
- Document all decisions made and all information that influenced these.
- Record the source of all information and, if appropriate, document verbatim comments.
- Ensure records are stored securely and that the responsible consultant and Trust are informed of this location and have access to the records.

## **10. Training, supervision and support**

- 10.1 All staff who come into contact with children or their families should have a basic awareness of child protection principles, including a basic understanding of FII abuse, including the dynamics which may arise between carers and health professionals. Those specialising in the care of children or families need additional training to ensure a higher level of awareness and understanding of FII.
- 10.2 The goal of training should be to achieve better outcomes for children. Professionals should be trained in order to achieve the greatest possible sensitivity and specificity in diagnosis; to gain a full understanding of the procedures that follow if there is a concern; and to understand how to contribute effectively to that process.
- 10.3 Training in FII should be interagency – the *Incredibly Caring*<sup>59</sup> training materials have been developed for this purpose. Trusts should collaborate with the relevant LSCB(s) to develop a programme of training which addresses the development needs of all agencies. On a wider level, various organisations including RCPCH arrange relevant training events on a regular basis.
- 10.4 Staff will need support and supervision in dealing with cases of suspected FII. The realisation that they may have inadvertently caused harm to the child by conducting what become recognised as unnecessary investigations or unnecessary treatments may cause distress. The complexities of managing a child with suspected FII may require staff to be less open and honest than they would be normally, which may be challenging.
- 10.5 Staff support should be an integral part of a health professional's contract, and pastoral arrangements should be in place. It is important that line management, professional and educational supervision, and mentorship arrangements are explicit so that staff know how to access additional support when it is needed. The facilitation of debriefing sessions can be helpful in providing support for all members of the team.
- 10.6 Trusts should also be prepared for the impact of a case of suspected FII on the wider clinical team. There may be disagreements about the identification or management of FII, and these should be acknowledged and addressed by the clinical management team.

## **Practice Points**

### **Training, supervision and support**

- Ensure all staff involved in a case of suspected FII understand the epidemiology of FII and how it should be managed.
- Follow Trust guidance on where to turn for advice on child protection issues and FII in particular (this will usually be the Named or Designated Health Professional); if specific guidance on this is unavailable, ensure it is developed.
- Recognise how stressful cases of suspected FII can be for all concerned and ensure staff have access to the appropriate support services either from within the Trust or externally.
- Encourage the facilitation of debriefing sessions for staff involved after an FII case.
- Encourage external facilitation if an FII case has generated significant conflict within a clinical team.
- If the management of a case of suspected FII is in any way hindered by a lack of available resources, discuss this with Trust management.

## **Appendix 1: Table summarising key presentational features identified in the Cardiff Leeds Study<sup>60</sup>**

<b>Presenting feature</b>	<b>All cases</b>
Fits	24
Apparently life threatening events (ALTE)	22
Drowsy, coma	13
Blood loss in vomit or rectally	13
Failure to thrive, feeding difficulty	11
Bowel disturbance	9
Asthma	9
Vomiting, Gastro-Oesophageal Reflux	8
Blood loss, haemoptysis	5
Skin lesions	4
Fabricated disability	3
False allegations of abuse	3
Blood in urine	3
False disclosure of accidental overdose	3

## **Appendix 2: Covert Video Surveillance Checklist**

### **Covert Video Surveillance Checklist**

CVS may be helpful under the following circumstances:

- The cause of the child's illness is unexplained but FII abuse is suspected.
- The prevailing evidence for child abuse is not considered strong enough to allow effective protection of the child or other children.
- Other appropriate investigations have been undertaken and there is no realistic alternative investigation which may explain the child's illness.
- Overt surveillance has been considered and to be inappropriate.
- The child is having some type of 'episode' of illness with a reasonable frequency (i.e. sufficiently frequent that CVS is likely to capture an episode in a realistic timeframe).
- The 'episodes' occur in hospital if the child is not closely supervised.
- The location of the 'event' is predictable, i.e. the suspected abusive event is likely to be within the field of vision of CVS.
- The suspected act of abuse is likely to be recognisable on CVS.
- Appropriate resources and training can be made available to ensure that CVS can be undertaken efficiently and safely.

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