Cardiff and Vale of Glamorgan Local Safeguarding Children Board

Protocol For Fabricated or Induced Illness and Related Conditions

Contents

Appendices

1.0 Introduction and Aim

Fabricated or Induced Illness (FII) by carers 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. FII is a relatively rare form of child abuse, but where concerns about FII exist it requires professionals to work together at an early stage so that all information available can be evaluated and an understanding of the child's needs assessed. This Protocol has been developed as a localised agreement for practitioners within Cardiff and The Vale of Glamorgan Local Safeguarding Children Board areas to aid them in their practice when working together with such cases.

2.0 Definition

Fabricated or Induced Illness is a term used to describe when an infant, child or young person is presented for medical attention, usually repeatedly, with symptoms or signs of illness that have been fabricated or induced by their carer.

3.0 Terminology

There has been considerable debate about the terminology used to describe the Fabrication or Induction of Illness in a child. Safeguarding Children in Whom Illness is Fabricated or Induced (2008) describes the three main ways a carer may fabricate or induce illness in a child. These are not mutually exclusive and include:

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

4.0 Indicators

Examples of the types of abusive behaviours exhibited which might cause concerns about a child's welfare are described in the list of indicators below:

Indicators which should alert professionals to the possibility of FII:

- A carer reporting symptoms and observed signs that are not explained by any known medical condition.
- Physical examination and results of medical investigations that do not explain symptoms or signs reported by the carer.
- The child having an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment
- Acute symptoms that are exclusively observed by/in the presence of the carer.
- On resolution of the child's presenting problems, the carer reporting new symptoms or reporting symptoms in different children in sequence.
- 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.
- The carer seeking multiple opinions inappropriately.
- 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.
- The carer expressing concern that they are under suspicion of FII, or relatives raising concerns about FII.

5.0 Process

5.1 Handling Individual Cases

5.1.1 Whenever possible concerns exist of FII, records should use clear straightforward language, should be concise, accurate not only in fact but also differentiate between opinion, judgment and hypothesis. The records relating to the child's symptoms, illnesses, diagnosis and treatment should always include the name and agency or the person who gave or reported the information. All telephone conversations should be recorded fully. Professionals who suspect FII may find it helpful to begin compiling a chronology at this stage to help collate the available evidence. (See appendix 9 and 10).

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

5.1.3 As soon as a practitioner has a concern about possible Fabricated or Induced Illness, they should consult immediately with the "lead person for child protection" within their own organisation to help decide whether to make a referral to Children's Services in accordance with the All Wales Child Protection Procedures 2008.

5.1.4 When a decision is made to make a referral to Children Services consideration will be given to convening a strategy meeting.

5.1.5 If an agency does not have a lead person for child protection, consultation should take place with the relevant Assessment Team within Children's Services in accordance with the LSCB Procedures.

5.1.6 If the child is in hospital and there are concerns about possible significant harm as a consequence of FII, discharge should not take place until a multi-agency Child Protection Strategy Meeting has discussed the concerns. Where there is concern about FII, it is **essential that the responsible paediatric consultant is present**. The Strategy Meeting

is for professionals only and parents/carers are not involved or notified at this point. The safety of the child is paramount whilst Fabricated or Induced Illness is being considered.

5.2 The Use of a Chronology for all cases of suspected FII

By the very nature of this form of abuse the information available to a meeting about a possible case of Fabricated or Induced Illness is enormous. There can be a wealth of information which is difficult to organise. Appendix 9 is a word template for each agency chronology which can then be merged and sorted. Appendix 10 provides guidance on how to complete the chronology. The chronology will inform members of relevant information at a strategy meeting.

5.3.1 Flowcharts detailing what individual agencies should to do if FII is suspected in a case

The flow charts detailed in Appendices 1,2,3 and 4 have been devised for individual agency use. More in depth guidance can be found in Safeguarding Children in whom Illness is Fabricated or Induced (2008). These appendices detail the path to follow when FII is suspected in a case.

Appendix 1: Social Services Pathway
Appendix 2: Health Services Pathway
Appendix 3: Guidance for Police
Appendix 4: Guidance for School Service Staff

5.4 Disclosing FII Concerns to the Child's Carers

In the initial stages of an investigation it is important not to alert the family to the fact that FII is being considered. If they become aware of the concerns at this stage there are various risks:

- The perpetrator will want to evade detection and may break off all contact with the treating services. This may put the child at risk, the child may be deprived of necessary medical attention, or they may be presented to another unit where the FII concerns are not known.
- The perpetrator may (rarely) do something dramatic to try to 'prove' that the child is ill or to persuade medical services to 'take them seriously'. This may include severe abuse of the child such as smothering or poisoning.
- Non-abusing carers or other family members are likely to be angry and to support the abusing carer. They will often not find it easy to understand the concerns and often tend to be in denial about the abuse and the risks to the child.
- The abusing carer may report that the child is suddenly 'cured' and no longer needs medical attention. However the underlying problems with parenting (whatever they are) are likely to still be present.
- If the carers become aware of the concerns they are likely to destroy or conceal potential evidence of abuse, it becomes more difficult to elicit new evidence and it may prove more difficult to confirm a diagnosis one way or the other. The result is that the child is more likely to remain in the home without safeguards and may be exposed to further abuse.
- It may become more difficult to gather evidence for a criminal investigation.

When the decision is made, usually at a strategy meeting, that it is appropriate to share the FII concerns with the family the following principles should be followed.

5.5 Principles for planning the meeting with parents/carers

- Ensure this meeting is carefully planned by a multi-agency team of professionals (usually as part of the Strategy Meeting Discussion).
- These cases are difficult and must be discussed at a senior managerial level in all agencies.
- In most cases the discussion will involve the responsible paediatric consultant jointly with a social worker and/or the police. One or two other key people may need to be present but numbers should be carefully managed.
- If the police are initiating a criminal investigation this may determine how and when the child's carers are informed.
- Ensure an appropriate venue and that interruptions are kept to a minimum. For inpatients this will usually be at the hospital.
- Usually both parents/carers should be present. Consideration should be given to who else should be invited or if anyone should be excluded, consistent with the need to work in partnership with the parents, in the best interests of the child.
- Arrangements should be in place to ensure the child is safe during and after the disclosure.
- Consideration should be given to how to support the family during the meeting (the suspected abuser and non-abusing carers)
- The medical diagnosis should be explained in a, dispassionate, truthful and honest way, and without causing unnecessary distress.
- Medical staff should 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.
- Arrange to keep detailed records of the meeting.

5.5.1 The discussion may include the following:

- That FII is thought to be the most probable cause for the child's signs and symptoms.
- Any alternative explanations that are still being considered.
- The reasons why FII seems likely.
- The carers and other family members may need some information about FII and common misconceptions may need to be dispelled.
- Any further investigations and their likely impact on the decision regarding FII.
- The plan for ongoing management and monitoring of the child's medical condition, with likely timescales where possible.
- The prognosis for the child if known.
- Supportive services available for a carer who is suspected of abuse and for a non-abusing carer.
- The arrangements for ensuring that the child is safe whilst the investigation proceeds.
- Whether legal advice is being sought. It may be appropriate to advise the carers to seek their own legal advice.
- Follow-up arrangements and further contact with agencies, including a plan for further discussions (consistent with the multi-agency plan agreed at the strategy discussion).
- That the carers will not automatically be allowed to change the child's medical team or location of treatment simply because they do not accept the diagnosis. Decisions such as these should be made in a multiagency context in the best interests of the child.
- The carers should be offered the opportunity to ask questions and these should be answered honestly and as clearly as possible.

6.0 Other specific circumstances relating to FII

6.1 FII and Pregnancy

Two scenarios are sometimes encountered:

- A pregnant woman may cause concern by fabricating illness in herself, covered in section 6.2.-6.2.6
- A woman who has previously fabricated illness in a child (or whose partner has previously fabricated illness in a child) may become pregnant, covered in section 6.3- 6.3.6

6.2. Pregnant women who fabricate illness in themselves

6.2.1 A referral to Children's Services should be made if any professional suspects this to be the case. These cases may present to obstetric and gynaecological services, to general medical services (Primary Care, EU, acute medical or surgical intakes) or to a range of specialist services.

6.2.2 When concerns are raised it is important that medical information about the woman concerned is collated. The person responsible for this should be identified and agreed with the Specialist Nurse for Safeguarding Children for the unit concerned or with one of the Named Professionals. There may be multiple professionals involved and the opinions of the various clinicians may need to be explored with them individually if their views are not clear from the records.

6.2.3 It is not known how many women who fabricate illness in themselves will go on to fabricate illness in the child after birth, but it must be assumed that there is some risk and that safeguards will need to be in place to ensure the child is not harmed.

6.2.4 If the woman is actively harming the unborn baby and putting them at risk, e.g. injuring the abdomen or attempting to provoke early delivery, then immediate action is needed, and a referral should be made to Children's Services. In other cases there may be time to 'pause and plan'.

6.2.5 A Multi Agency Strategy meeting held under the All Wales Child Protection Procedures, 2008, should be convened to consider the level of perceived risk and to collate information available on the family. The mother's medical background will be important and the primary care team will have an important contribution to make. There will need to be consideration of how and when to disclose the concerns to the pregnant woman and her family. The outcome may be:

- No further action if the concerns are unsubstantiated.
- 'Watchful waiting' for low level concerns, in which case the mother's (and the baby's) medical carers will need to be aware of the concerns and monitor the situation carefully.
- Decision to undertake Section 47 enquiries / initial assessment.
- Disclosure of the concerns to the family and progression to a Child Protection Conference.
- Immediate concerns about the unborn baby or severe concern for the baby's safety immediately after birth, in which case legal advice will be sought.

6.2.6 If the mother will consent to a psychiatric assessment, this will need to be discussed urgently with the Adult Mental Health Service to try to arrange an urgent opinion. The psychiatrist will need to be provided with as much information as possible to have an understanding of the mother's behaviour and how it might put the infant at risk. The specific question that needs to be addressed by the mental health team (as well as their usual clinical role for the mother) is how the mother's behaviour and/or mental health problems is likely to impact upon their care of the child when born, and what risks are therefore implied for the child.

6.3 Pregnant women (or their partners) who have previously fabricated illness in a child

As soon as agencies become aware of the pregnancy a child protection referral should be made to Children's Services and a strategy discussion should follow.

6.3.1 Professionals attending the strategy meeting will need to bring information about the previous concerns. It is important not to rely on information provided by the family as family members may be in denial and may minimise the concerns or misrepresent information.

6.3.2 Previous child protection conference minutes and professional reports must be made available to the strategy meeting for review. If there were legal proceedings in relation to the previous child it will often be helpful to request access to the court judgment and expert reports, in order to understand the detail of the carer's behaviour in relation to the child concerned, and any psychiatric opinions expressed at the time. Sometimes a paediatric overview of the previous child's records may need to be carried out *de novo* and there should be discussions in a strategy meeting about who would do this.

6.3.3 If a psychiatrist was involved in assessing the carer in relation to the previous abuse, it might be helpful for the same person to be invited to join the discussions and/or express a view in relation to risk to the unborn child, or what safeguards may need to be in place.

6.3.4 The perceived risks should be discussed in a pre-birth child protection conference. Legal advice is essential. Factors that may affect the perceived risk to the new baby might include:

- The nature of the abuse to the previous child. Was there illness induction or just fabrication or exaggeration? How long did it go on? What was the impact on the child? What was the outcome, both for the child (medical, emotional, social, and educational) and of the previous child protection process.

- Has the carer acknowledged the concerns, did they show motivation to change, undergo therapy etc. It is important to determine the outcome of therapeutic interventions not just that they attended.
- Look at the carer's medical history, and that of any children under their care, for evidence of continued fabrication or exaggeration.
- Any previous psychiatric assessments of the carer.
- Are the carers of at least average ability and have they demonstrated adequate basic infant care skills?
- Does the non-abusing carer understand the nature of the past abuse and are they seen to be a useful protective influence within the family?

Remember that small babies are particularly vulnerable to FII abuse and that the postnatal period is a particularly difficult time for carers, when problems tend to be more pronounced.

6.3.5 If the infant remains in the home after birth, there will need to be careful monitoring. Any information provided about the infant's health would need to be objectively verified and communication between agencies would need to be prioritised.

6.3.6 As other forms of abuse often co-exist with FII, it is important not to be 'blinded' by the FII concerns and to consider all other possible risks.

6.4 The role of Mental Health Services in a suspected FII case

6.4.1 The diagnosis of FII is usually made by a paediatrician, but the management of the case after the initial confirmation of the cause of the child's illness should be expanded to include Mental Health Services if possible. The nature and extent of involvement will depend on local resources and the exact nature of the case.

6.4.2 Some perpetrators may already be known to Mental Health, in which case these services may be actively involved in managing the case from an early stage.

6.4.3 If the perpetrator or another family member has features of a mental health problem then they should be referred as usual by their GP.

6.4.4 Mental Health Services may be involved in supporting the perpetrator at the time of disclosure of diagnosis; this may form part of the advance planning for disclosure.

6.4.5 The perpetrator may be referred to Mental Health (with their consent) as a recommendation of the multiagency team involved within the Section 47 (child protection) assessment. This would need to be discussed with the Mental Health Service (usually with a consultant) to establish what their remit should be and how their assessment should be carried out. If the suspected perpetrator does not consent to a referral this should be documented.

6.4.6 A Court may direct that an independent expert or forensic assessment should be carried out. This would be in parallel with (not instead of) the involvement of clinical services.

6.4.7 Children who appear to have a mental health problem should be referred to CAMHS. The Child Psychiatrist will need to know what the concerns have been and the extent to which these have been agreed by a multiagency team or confirmed in a legal context.

6.4.8 CAMHS will often be able to assist in clarifying and understanding the parent-child interactions involved in the abuse. Their role should be discussed on a case by case basis and referral made as appropriate.

7.0 Review Meeting

As FII cases are challenging and can cause mixed emotions for those involved, practitioners should seek supervision and support. Following the conclusion of a case consideration should be given to hold a facilitated inter-agency de-brief/ reflective practice meeting for all staff involved with the case.

8.0 Training

Cardiff and the Vale of Glamorgan Local Safeguarding Children Boards will have in place a Joint Training package based on this Protocol.

9.0 Review

9.1 Cardiff and the Vale of Glamorgan Local Safeguarding Children Boards will review the progress of this Protocol after 12 months. The Boards will also consider the merit of any associated communication campaign for the community of Cardiff and the Vale of Glamorgan in relation to this Protocol.

9.2 The Local Safeguarding Children's Boards will also assess how data and performance information relating to this Protocol can be maintained by each agency and incorporated into the overall Safeguarding Children Board Performance Management Framework.

10.0 References

- All Wales Child Protection Procedures, 2008. http://www.awcpp.org.uk/9547.html?diablo.lang=eng
- Davis, P. (2009). Fabricated or induced illness in children: The paediatrician's role. Paediatrics and Child Health 19-11.
- Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians, Royal College of Paediatrics and Child Health (2009).
- Safeguarding Children in Whom Illness is Fabricated or Induced (2008). Supplementary guidance to Safeguarding Children: Working Together under the Children Act 2004, Welsh Government. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008714

Appendix 1 FII Social Services Pathway

Under the Children Act 1989, the Local Authority Children's Services have lead responsibility for the protection of children from harm. A key duty for the Local Authority is to both safeguard and promote the welfare of children. This duty has the 4 elements of protecting children from maltreatment; preventing the impairment of children's health or development; ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and enabling those children to have optimum life chances. In line with the *Assessment Framework* children's social care responsibilities fall into the four main areas of assessment, planning, provision of services and review.

When information is received, via multi agency referral form, regarding suspicion of FII either on an open case or a new referral:

1. Advice must be sought from a Children's Services Manager at an early stage.
2. Consideration must be given to the need for immediate protection of the child.
3. Consideration must be given to the needs of other children in the household and whether any action is required to protect them.
4. The family should not be contacted directly prior to Strategy meeting.
5. Initial Assessment to be undertaken and completion of the FII chronology template (see appendices 9 and 10). This must be compiled from existing records and all available information from other agencies in preparation for a child protection strategy meeting or other information sharing meeting. For further guidance see *Safeguarding Children in Whom Illness is Fabricated or Induced (2008) p.44.*
6. A strategy meeting under child protection procedures shall *always* be convened, for new referrals and open cases, following suspicions or allegations of fabricated or induced illness. A telephone strategy discussion is not adequate or appropriate.
7. More than one child protection strategy meeting might be necessary to ensure the issues are discussed thoroughly and all information shared before a decision is made to undertake child protection section 47 enquiries.

The strategy meeting will:

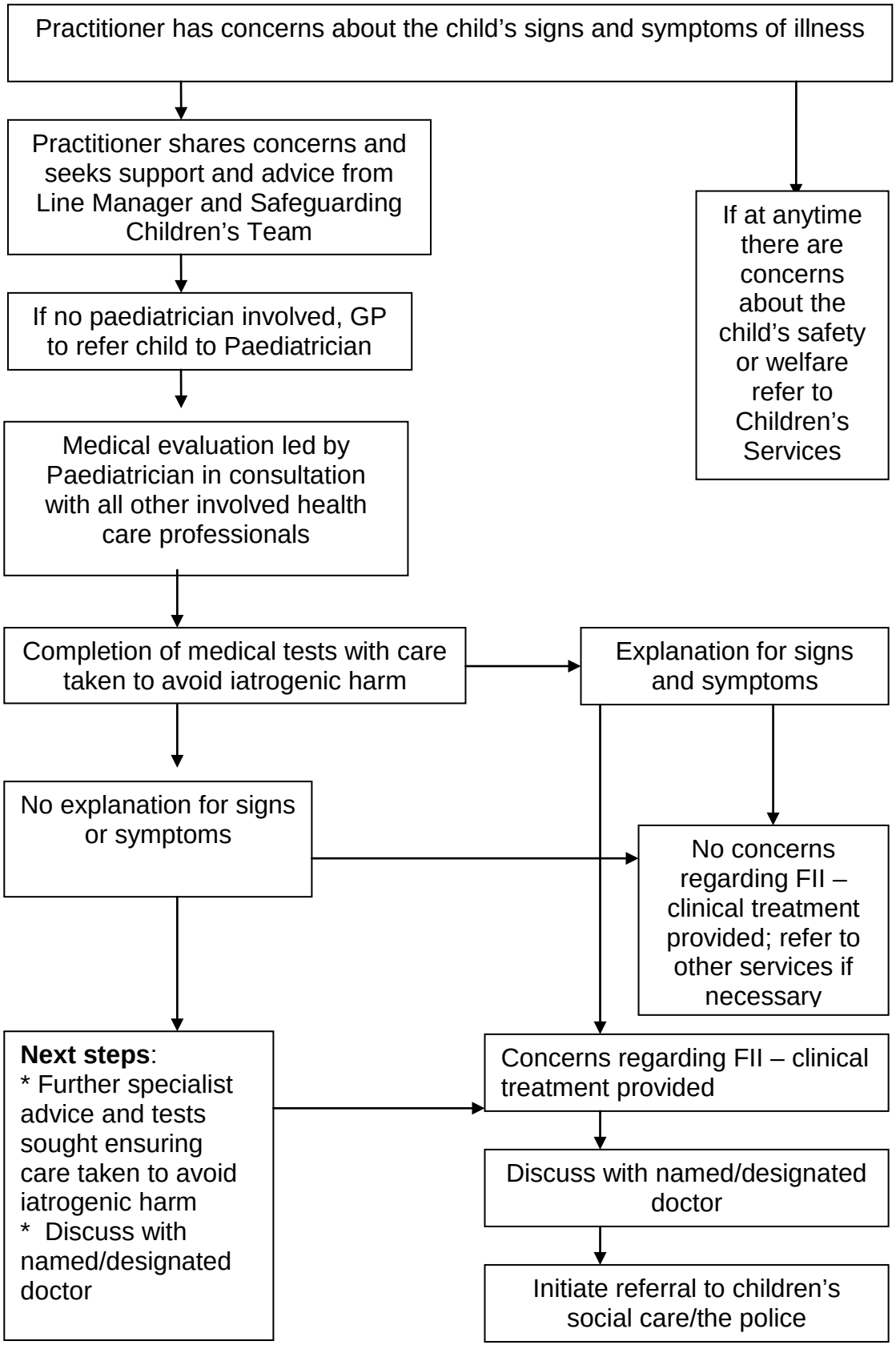
- Make decisions about sharing information with the family.
- Plan to produce a detailed chronology of all the issues; all relevant agencies will produce a chronology within an agreed timescale, using the chronology template. Agreement will be reached on which agency leads on compiling the merged chronology.
- Confirm the key professionals from other agencies.
- Consider the need for immediate protection
- Consider the need for Section 47 enquiries.
- Consider the need for individual agency legal advice.
- Agree a time-frame for further enquiries/investigation to be established.
- Consider the need for further strategy meetings.
- Consider the supervision and support needs of the Children Services staff involved with the case.

It is important to note that the professionals involved can only work together to safeguard children if there is an exchange of relevant information between them. For further guidance on information sharing refer to agency policy in addition to Chapter 14 Safeguarding Children: *Working Together Under the Children Act 2004.*

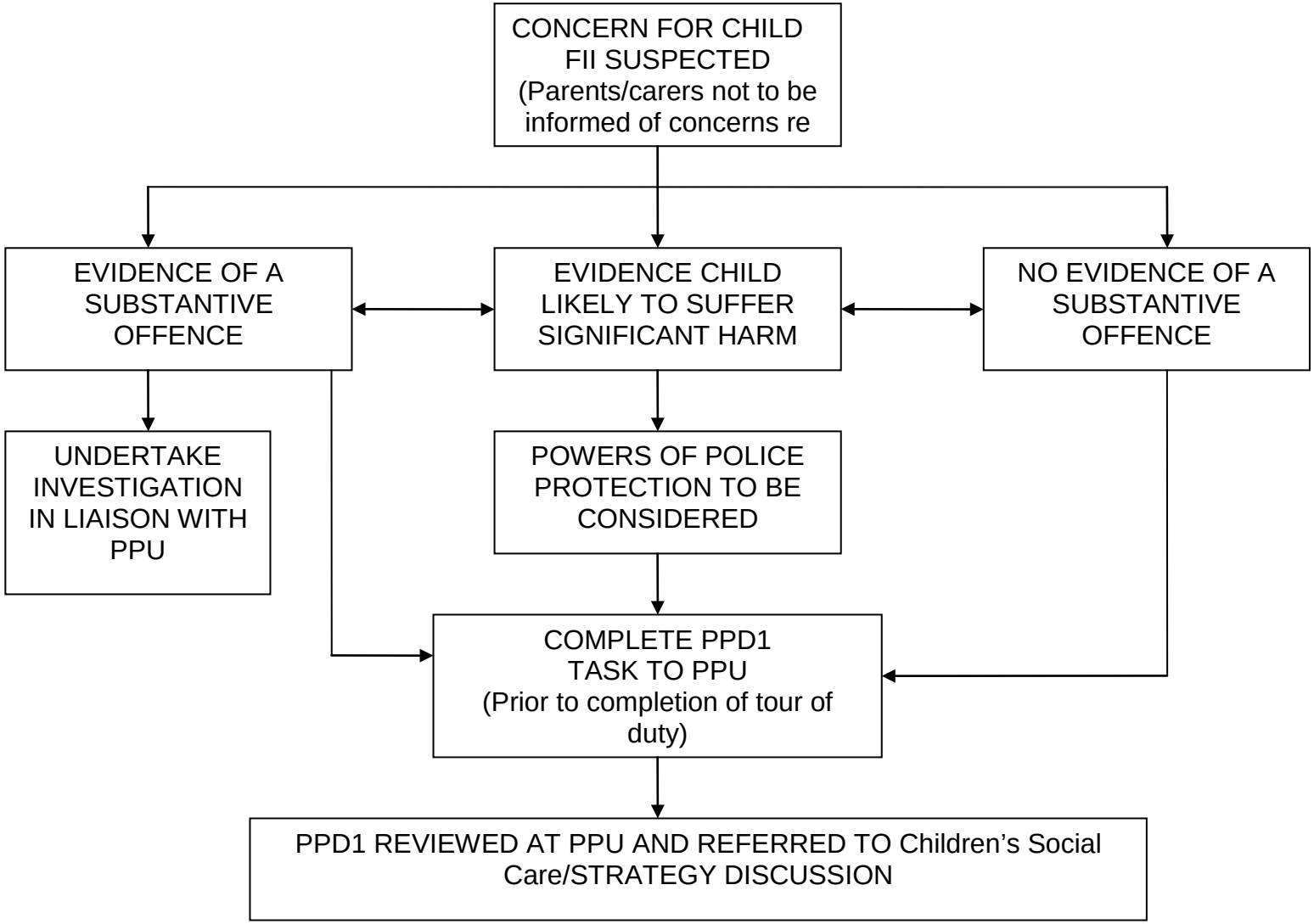
For further information on FII refer to guidance notes in *Safeguarding Children: Working Together Under the Children Act 2004 p.238; Safeguarding Children in Whom Illness is Fabricated or Induced (2008) p.12; All Wales Child Protection Procedures 2008 p. 399.* http://www.awcpp.org.uk/9547.html?diablo.lang=eng

See *Safeguarding Children in Whom Illness is Fabricated or Induced (2008) p.60-62,* flow charts 1-3.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008714

Appendix 2 Health Staff Flowchart for where FII is suspected



Appendix 3 FII Guidance for the Police



Appendix 4 FII Guidance for Schools Service Staff

Fabricated and induced illness can only be confirmed by a paediatrician.

However, there may be a number of identifying factors which could raise the concern of staff in schools and within the Schools Service as a whole:

- Frequent and often unexplained absences from school.
- Regular absences to keep a hospital or doctor's appointment.
- Repeated claims by a parent/carer that a child is frequently unwell and that they requires medical attention for symptoms or illnesses that have not been observed by staff.
- Conflicting or patently untrue stories about illnesses, accidents or deaths in the family. Including something said by the child that conflicts with the parents account.
- Parents seeking Special Educational Needs provision for children who do not appear to require it.

Schools should be aware of significant changes to a child's physical or emotional state, unexplained injuries, changes in behaviour and a failure to thrive.

Appendix 4a flowchart gives guidance on how to proceed when concerns arise.

Children's Services Contact Details

If at any time staff have immediate concerns for a child's safety and wellbeing a child protection referral should be made to Children's Services:

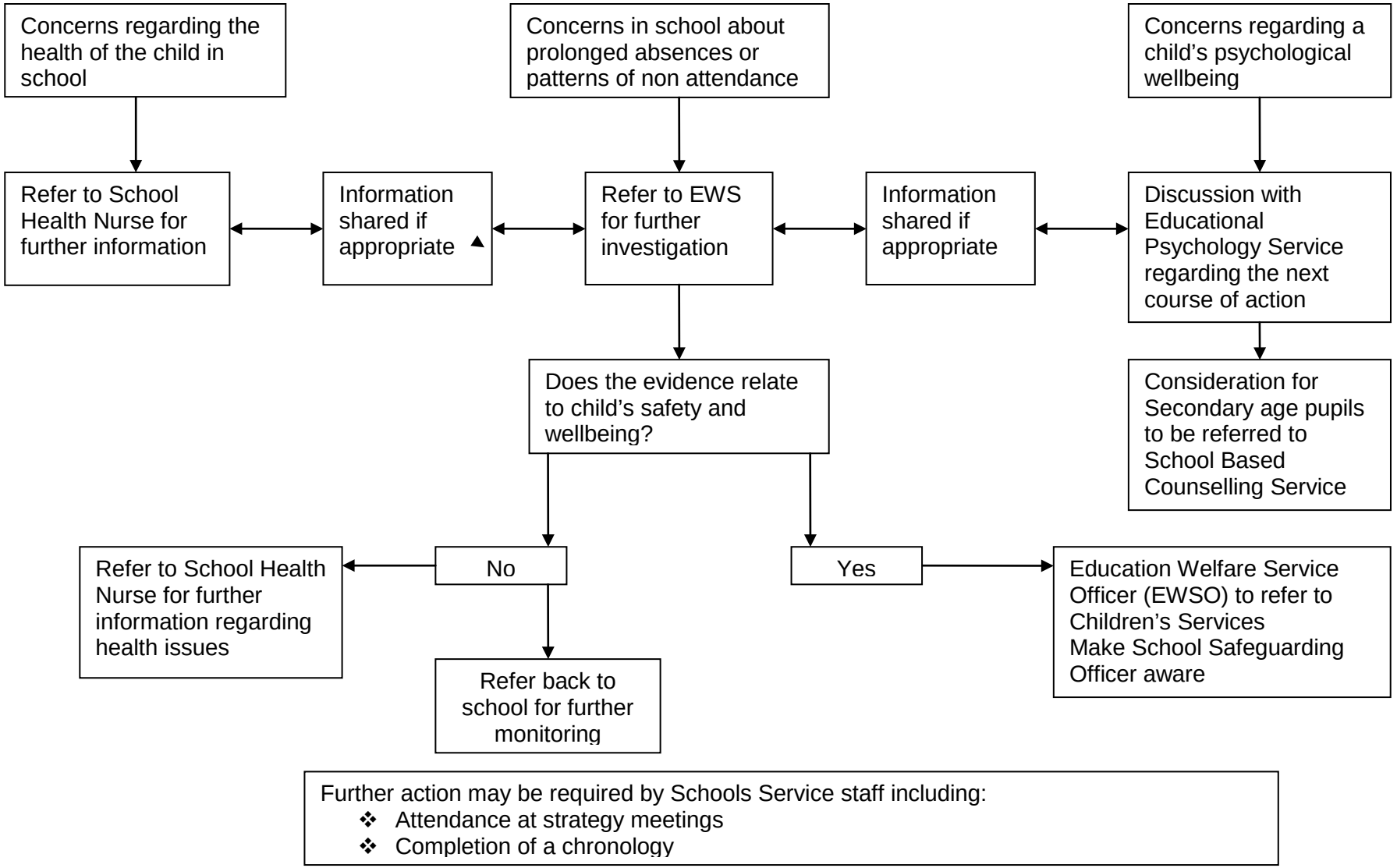
Cardiff Intake and Assessment Team - Tel. 02920 536400

Vale of Glamorgan Intake and Family Support - Tel. 01446 725202

For further information on FII refer to guidance notes in *Safeguarding Children: Working Together Under The Children Act 2004 p.238; Safeguarding Children in Whom Illness is Fabricated or Induced (2008) p.12; All Wales Child Protection Procedures 2008 p. 399.*
http://www.awcpp.org.uk/9547.html?diablo.lang=eng

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008714

Appendix 4a FII Guidance for School Service Staff



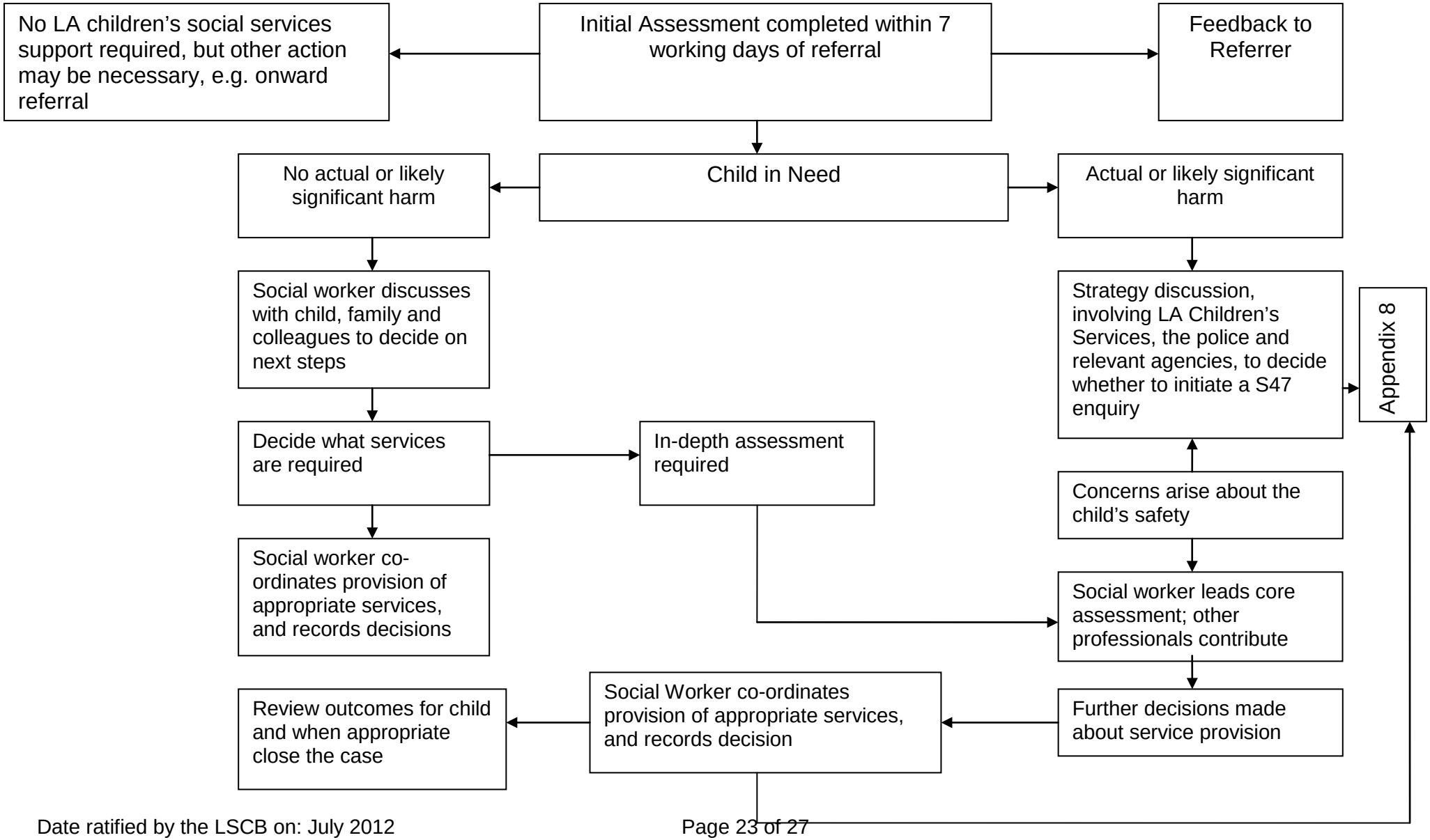
Appendix 5 Practice Points for Paediatricians

Initial management

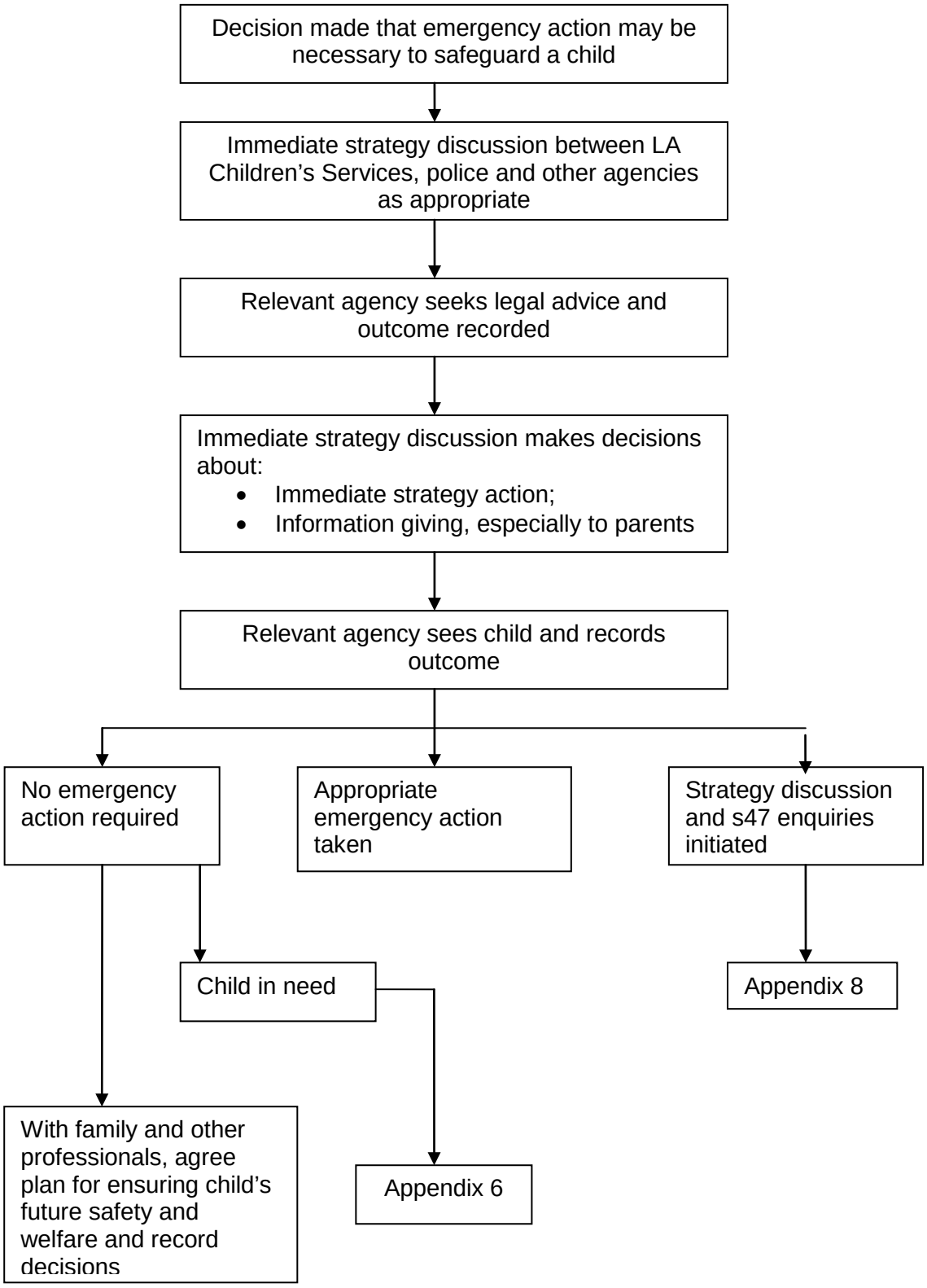
- Agree who will assume role of 'responsible paediatric consultant'.
- Document early concerns in the child's case notes so that other clinicians will have access to that information. Carers' access to records may need to be restricted.
- Discuss concerns with Named and Designated Health Professionals 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.

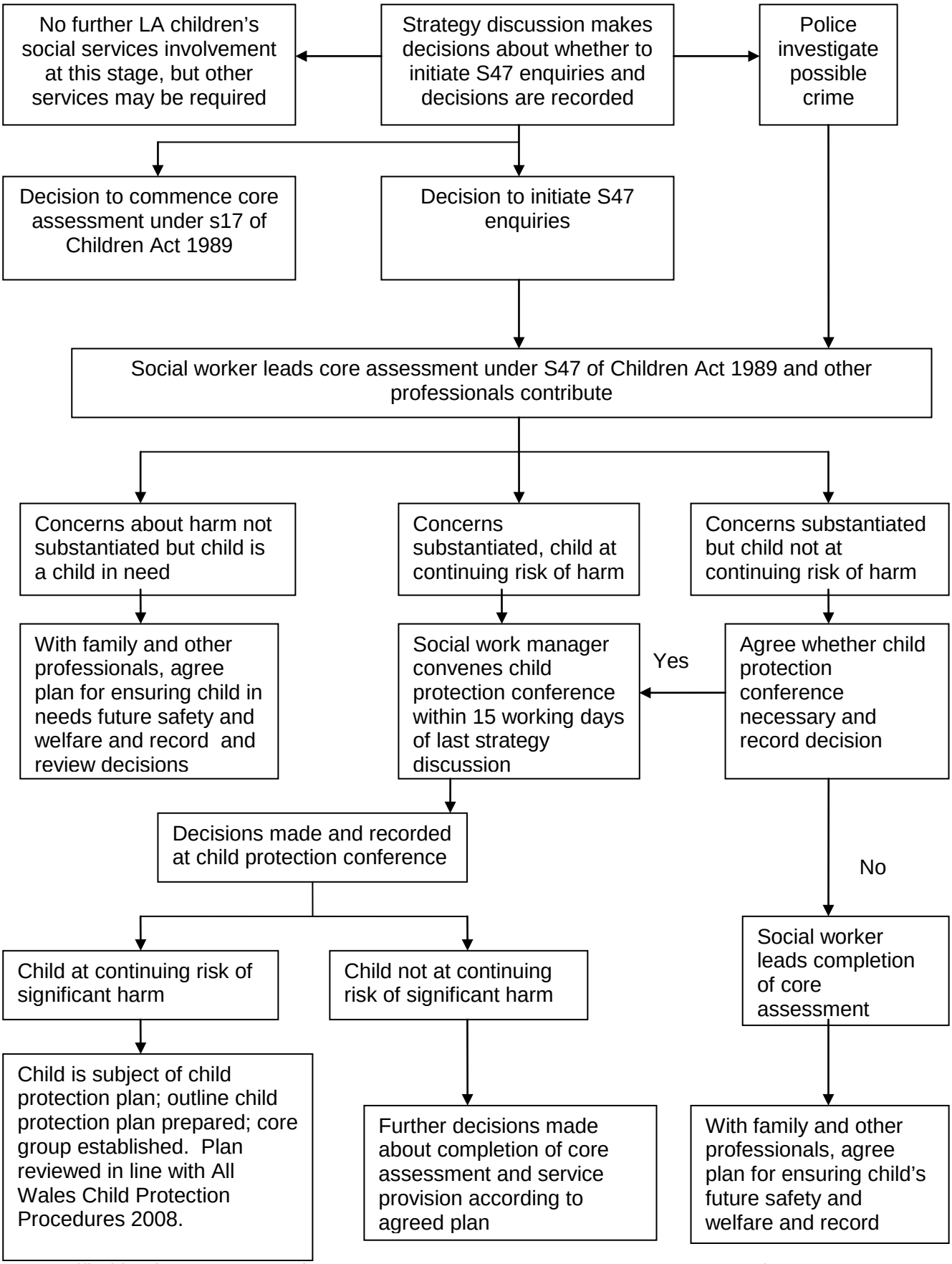
Appendix 6 Flow Chart 1. What Happens following Initial Assessment



Appendix 7 Flow Chart 2: Urgent Action to Safeguard Children.



Appendix 8 Flow chart 3: What Happens after the strategy Discussion?



Appendix 9 Joint LSCB Chronology Format for Cases of Suspected Fabricated or Induced Illness.

Name of person making entry	Date of event	Source of info/name	Event	Objective findings/comment	Action taken / by whom	Impact on child

Please enter date as e.g. 14.12.10

Appendix 10 Guidance for the Format of a Chronology to be Complied when Fabricated or Induced Illness is Suspected

Date – The date the event is said to have taken place (not the date of recording). The date format should be entered as e.g. 14.12.10.

Source of information – This is the origin of the information. This could be from agencies files or from individual sharing information, e.g. Children's Services electronic or paper files. For Police the occurrence number. Health, be specific whether acute records or Health Visitor records for example.

Event – This is a record from the clinical story. Any significant piece of information e.g. concern for a child, what was said and by whom and the professional's own observations.

Objective findings – Confirmed observed facts by a professional. Not reported descriptions from another party. E.g. Health professional may record child health low blood sugar. Children's Services may record at a visit the house was chaotic and untidy. Outline concerns about the history given. At the time, what was the professional opinion?

Action taken - This should inform the readers of any action taken in response to the event. Who is taking the action? Include discussions that have taken place between professionals. Attempts to gather more information e.g. convene a strategy meeting. Medical action, e.g. CT scan, surgery.

Impact on child – Actual / possible physical and emotional harm. Are child's activities being restricted? Effect on school attendance.