Part 33

SAFEGUARDING CHILDREN IN WHOM ILLNESS IS FABRICATED OR INDUCED

Introduction

1. This guidance is intended to provide a framework within which agencies and professionals should work together where illness may be being fabricated or induced in a child, by a carer who has parenting responsibilities for him or her.

2. It is addressed to all staff whose work brings them into contact with children and families. It is relevant to those working in the statutory, voluntary and independent sectors.

3. There are three main ways of the carer fabricating or inducing 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. Where there is any potential for the use of **covert video surveillance** the police should be informed and, within the multi-agency team, take the lead in co-ordinating such action.

5. All action should be undertaken in accordance with the SSCB safeguarding children procedures. Legal advice should be taken where there is any doubt about the use of covert video surveillance.

A Shared Responsibility

6. Joint working is essential and all agencies and professionals should:

   - be alert to potential indicators of illness being fabricated or induced in a child;
   - be alert to the risk of harm which individual abusers, or potential abusers, may pose to children in whom illness is being fabricated or induced;
   - inform social care/police about concerns;
   - share, and help to analyse information so that an informed assessment can be made of the child's needs and circumstances;
   - contribute to whatever actions (including the cessation of unnecessary medical tests and treatments) and services are required to safeguard and promote the child's welfare;
   - regularly review the outcomes for the child against specific planned outcomes;

- work co-operatively with parents unless to do so would place the child at increased risk of harm; and
- assist in providing relevant evidence in any criminal or civil proceedings, should this course of action be deemed necessary.

Incidence and Prevalence

7. In children between 1 - 16 years the prevalence is estimated as being at least 0.5 per 100,000, and for children under 1 years at least 2.8 per 100,000. In a district of one million inhabitants therefore, the expected incidence would be approximately one child per year".

Carers' behaviours associated with fabricated or induced illness

8. The following is a list of behaviours exhibited by carers, which can be associated with fabricating or inducing illness in a child. This list is not exhaustive and should be interpreted with an awareness of cultural behaviours and practices which can be mistakenly construed as abnormal behaviours:

- deliberately inducing symptoms in children by administering medication or other substances, by means of intentional transient airways obstruction or by interfering with the child's body so as to cause physical signs.
- interfering with treatments by over dosing with medication, not administering them or interfering with medical equipment such as infusion lines.
- claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous;
- obtaining specialist treatments or equipment for children who do not require them;
- alleging psychological illness in a child.

9. When a child is in hospital, carers (usually the child's parents) may be involved in the care of their child, including participating in medical tests, taking temperatures and measuring bodily outputs. Where illness is being fabricated or induced by a carer, these normal hospital practices afford the carer the opportunity to continue this behaviour. This may mean, for example, that treatments and tests may be interfered with and the reported signs and symptoms continue whilst the child is in hospital. Differences may be observed between the ways in which carers who fabricate or induce illness interact with their children compared with other carers.

10. Commonly, these carers are observed to be intensely involved with their children, never taking a much needed break nor allowing anyone else (either family members or professionals) to undertake any of their child's care. This behaviour may preclude adequate observation of the child. Some, however, spend little time interacting with their child. They may be very involved with other families on the ward and hospital staff rather than with their child. Another observed feature is that some carers appear unusually unconcerned about the results of investigations which may be indicative of a serious physical illness in the child.

11. The majority of cases of fabricated or induced illness (FII) in children are confirmed in a hospital setting because either medical findings or their absence provide evidence of this type of abuse.

Impact of fabricated or induced illness on the child

12. International research findings suggest that up to 10% of these children die and about 50% experience long-term consequent morbidity.

13. Many of the children who do not die as a result of having illness fabricated or induced suffer significant long-term consequences. Indeed in some cases, the child may not experience physical harm at all but may suffer emotional harm.

Age Range of Children

14. The age range of children in whom illness is fabricated or induced extends throughout childhood, although it is most commonly identified in younger children. In one study 77% of children were aged under 5 years at the time of identification with a median age of 20 months.

Gender of Carer Responsible for the Abuse

15. Clinical evidence indicates that FII is usually carried out by a female carer, usually the child's mother. However fathers and women other than mothers have also been known to be responsible.

Roles and Responsibilities

16. Children with suspected FII may present to the full range of medical specialists, although it is most likely to be a general paediatrician or paediatricians providing specialist care; but may also include general, orthopaedic and paediatric surgeons, surgical specialities particularly ENT, ophthalmology, orthopaedics, gynaecology and dermatology. Concerns may be raised by services to which the children present including pharmacists and allied health professionals.

17. In addition, carers of children may be in receipt of adult services, and the professionals involved in their care may have concerns about the welfare of these children. This could include professionals providing obstetric and gynaecological care to women, mental health services and the full range of medical and surgical specialities**.**

18. **It is important that any concerns about the children's welfare are not conveyed to the carers until further assessment and multidisciplinary decisions have been made about how and by whom these will be discussed with both the child's parents**.

19. In a very small number of cases, the use of covert video surveillance may be suggested. Decisions about its use should take place at a strategy discussion between relevant agencies and in particular, the police, children's social care, the consultant paediatrician responsible for the child's health care and the senior ward nurse. Senior officers of the relevant NHS Trusts should also be involved.

20. **The Chief Executive of NHS Trust should be kept informed of any decisions to apply to use covert video surveillance in his/her Trust.** Where it has been decided (at a strategy discussion) to carry out covert video surveillance because of the nature of concerns about how the child is suffering or likely to suffer significant harm, **the police should undertake this action.**

21. Whenever such concerns arise, the consultant responsible for the child's health care (i.e. the responsible paediatric consultant) should take lead responsibility for all decisions about the child's health care – these should not be delegated to a more junior member of staff although they may be involved in the process of assessment and subsequent management under the consultant's supervision. This lead responsibility should include getting information from any relevant GPs or consultants who have treated the child. It would be advisable to also inform or consult the Named or Designated Doctor at this point. Where there are concerns about a child's safety and welfare, discussion with children's social care can be on the basis of suspicion of significant harm – it does not have to be proved before contacting children's social care.

    For further details about individual professional or agency responsibilities please refer to:

    Safeguarding Children in whom illness is fabricated or induced. Supplementary guidance to Working Together to Safeguard Children HM Government, 2008

    Incredibly Caring. A Training Resource for Professionals in Fabricated or Induced Illness in Children (as a DVD). DCFS 2009

Paediatricians should also refer to:

Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians.
Royal College of Paediatrics and Child Health
October 2009.

Identification of FII

22. In educational and care settings staff should be alert to the possibility of FII when a child:

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

23. In health care settings concerns may arise about possible FII when:

- reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
- physical examination and results of medical investigations do not explain reported symptoms and signs; or
- there is an inexplicably poor response to prescribed medication and other treatment; or
- new symptoms are reported on resolution of previous ones; or
- reported symptoms and found signs are not seen to begin in the absence of the carer; or
- over time the child is repeatedly presented with a range of signs and symptoms; or
- the child's normal, daily life activities are being curtailed, for example school attendance, beyond that which might be expected for any medical disorder from which the child is known to suffer.

24. There may be a number of explanations for these circumstances and each requires careful consideration and review. A full developmental history and an appropriate developmental assessment should be carried out.

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

26. Professionals who have concerns about a child's health should discuss these with the child's GP or if the child is known to a hospital service, the consultant paediatrician responsible for the child's health care.

27. **Constructing a chronology of events and consultation with peers, named or designated professionals or colleagues in other agencies will be an important part of the process of making sense of the underlying reason for these signs and symptoms**.

28. **If any professional considers their concerns about fabricated or induced illness are not being taken seriously or responded to appropriately, they should discuss them with the named or designated doctor or nurse or follow part 34 of the SSCB Inter-agency Escalation Procedure. This procedure can be viewed by using the link below:**

    http://www.staffsscb.org.uk/Part34EscalationProcedure.pdf

Medical Evaluation

29. When signs and symptoms of illness present in a child are suggestive of FII professionals must remain open to all possible explanations.

30. Where there are concerns about possible FII, the signs and symptoms require careful medical evaluation by a paediatrician(s). For children who are not already under the care of a paediatrician, the child's GP should make a referral to a paediatrician, preferably one with expertise in the specialism which seems most appropriate to the reported signs and symptoms. Tests and their results should be fully and accurately recorded, including those with negative results. It is important to ensure these records are not tampered with or results altered in the child's notes: also, that the name of the person reporting any observations about the child is recorded clearly in the child's notes and dated.

31. Where, following a set of medical tests being completed, a reason cannot be found for the reported or observed signs and symptoms of illness, further specialist advice and tests may be required. Normally, the consultant responsible for the child's care will tell the parent(s) that they do not have an explanation for the signs and symptoms. The parental response to this information should be recorded**.** The consultant would then set out the next steps, including what further assessments/investigations/tests (perhaps in a more specialist setting) are required to tease out the possible explanations.

Parents should be kept informed of findings from these medical investigations but **at no time should concerns about reasons for child's signs and symptoms be shared with the parents if this information would jeopardise the child's safety.**

32. The child should continue to receive appropriate health care and support should continue to be provided to the child's carers by health professionals.

33. Ensuring a medical evaluation takes into account what children are saying is always important. In the case of suspected FII it is equally important, but can be complicated by some parents' reluctance to leave the child. This reluctance to allow their child to be talked to by a clinician has to be balanced against the need to see the child on their own in order to ensure the child's welfare. **Every effort should be made to see the child without the parent being present. Some children may be competent to make their own decisions on this matter.**

34. There may be times when a member of staff is responsible for the unexplained or inexplicable signs and symptoms in a child. This should be borne in mind when considering how to manage the child's care. Any such concerns about a member of staff should be discussed with the named or designated professional in accordance with the SSCB safeguarding children procedures.

35. While professionals should seek, in general, to discuss any concerns about a child's welfare with the family and, where possible, seek their agreement to making a referral to children's social care, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm**. Decisions should be agreed between the referrer and the recipient of the referral, in line with SSCB safeguarding children procedures, about what the parents will be told, by whom and when.

Strategy discussion

36. If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, children's social care will convene and chair a strategy discussion which involves all the key professionals responsible for the child's welfare. It should, at a minimum, include children's social care, the police, the paediatric consultant responsible for the child's health and, if the child is an in-patient, a senior ward nurse. It is also important to consider seeking advice from, or having present, a paediatrician who has expertise in the branch of medicine, for example respiratory, gastroenterology, neurology or renal which deals with the symptoms and illness processes caused by the suspected abuse. This would enable the medical information to be presented and evaluated from a sound evidence base.

37. **Decisions about undertaking covert video surveillance and keeping the records secure should be made at a strategy discussion**.

Assessment

38. Children's social care will take lead responsibility for undertaking the initial assessment in conjunction with the doctor who has lead responsibility for the child's healthcare (usually a consultant paediatrician) and other relevant agencies.

Police

39. Any suspected case of fabricated or induced illness may also involve the commission of a crime, and therefore the police should always be involved. Events such as intentional smothering or poisoning are clearly criminal assaults, but more subtle forms of child abuse, such as wilfully interfering with feeding lines or causing unnecessary medical intervention to be undertaken, may also be criminal acts.

40. The police use technical means to gather evidence in many types of criminal enquiry, and it may be appropriate to use such methods, for example covert video surveillance, in cases of suspected fabricated or induced illness.

41. **Doctors or other professionals should not independently carry out covert video surveillance**.

Use of Covert Video Surveillance

42. The use of covert video surveillance (CVS) is governed by the Regulation of Investigatory Powers Act 2000. After a decision has been made at a multi-agency strategy discussion to use CVS in a case of suspected fabricated or induced illness, **the authority to use CVS should be sought by the police**.

43. **CVS should only be used if there is no alternative way of obtaining information which will explain the child's signs and symptoms, and the multi-agency strategy discussion meeting considers that its use is justified based on the medical information available**.

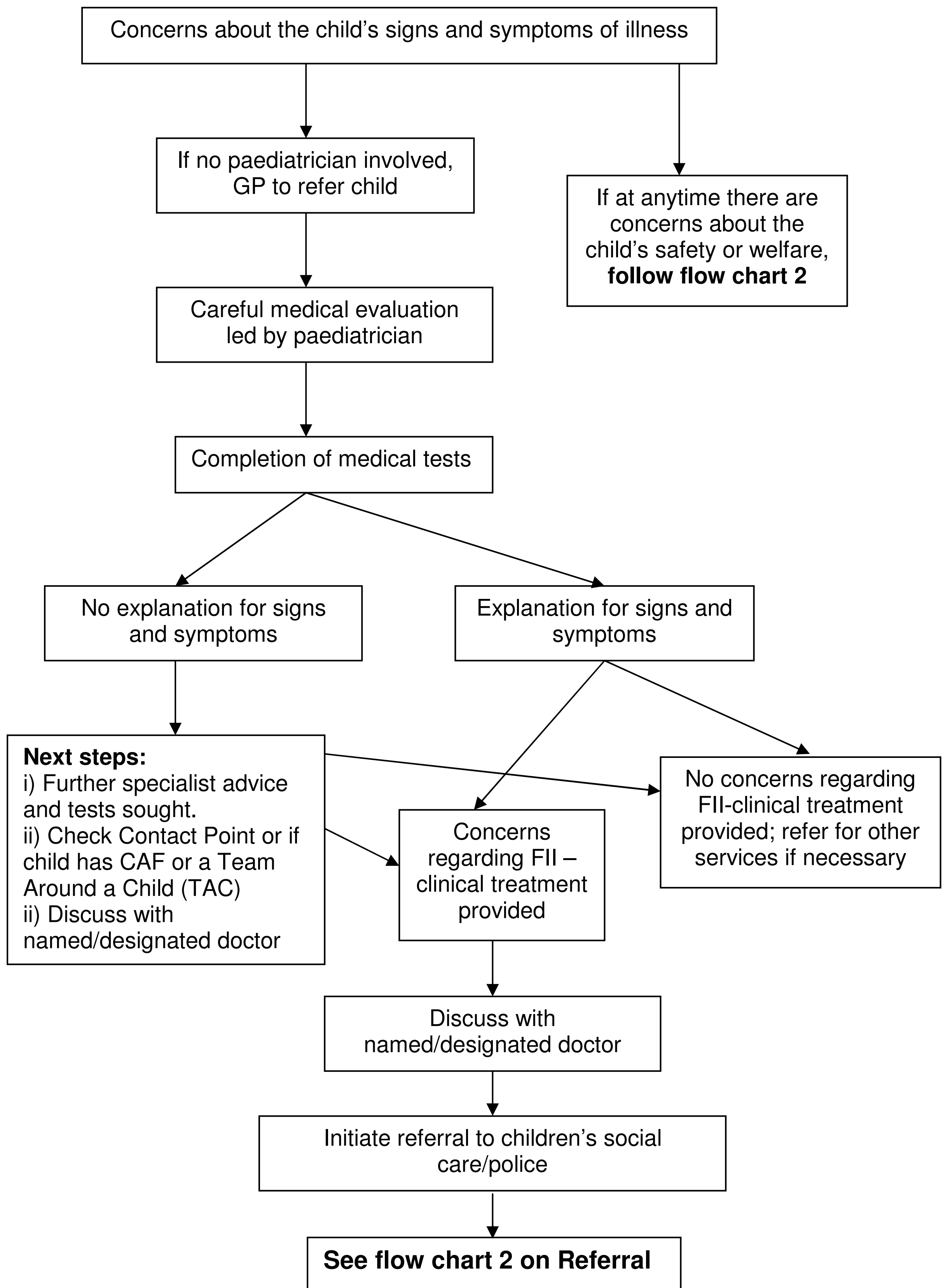
Criminal Investigation

44. In cases where the police obtain evidence that a criminal offence has been committed by the parent or carer, and a prosecution is contemplated, it is important that the suspect's rights are protected by adherence to the Police and Criminal Evidence Act 1984.

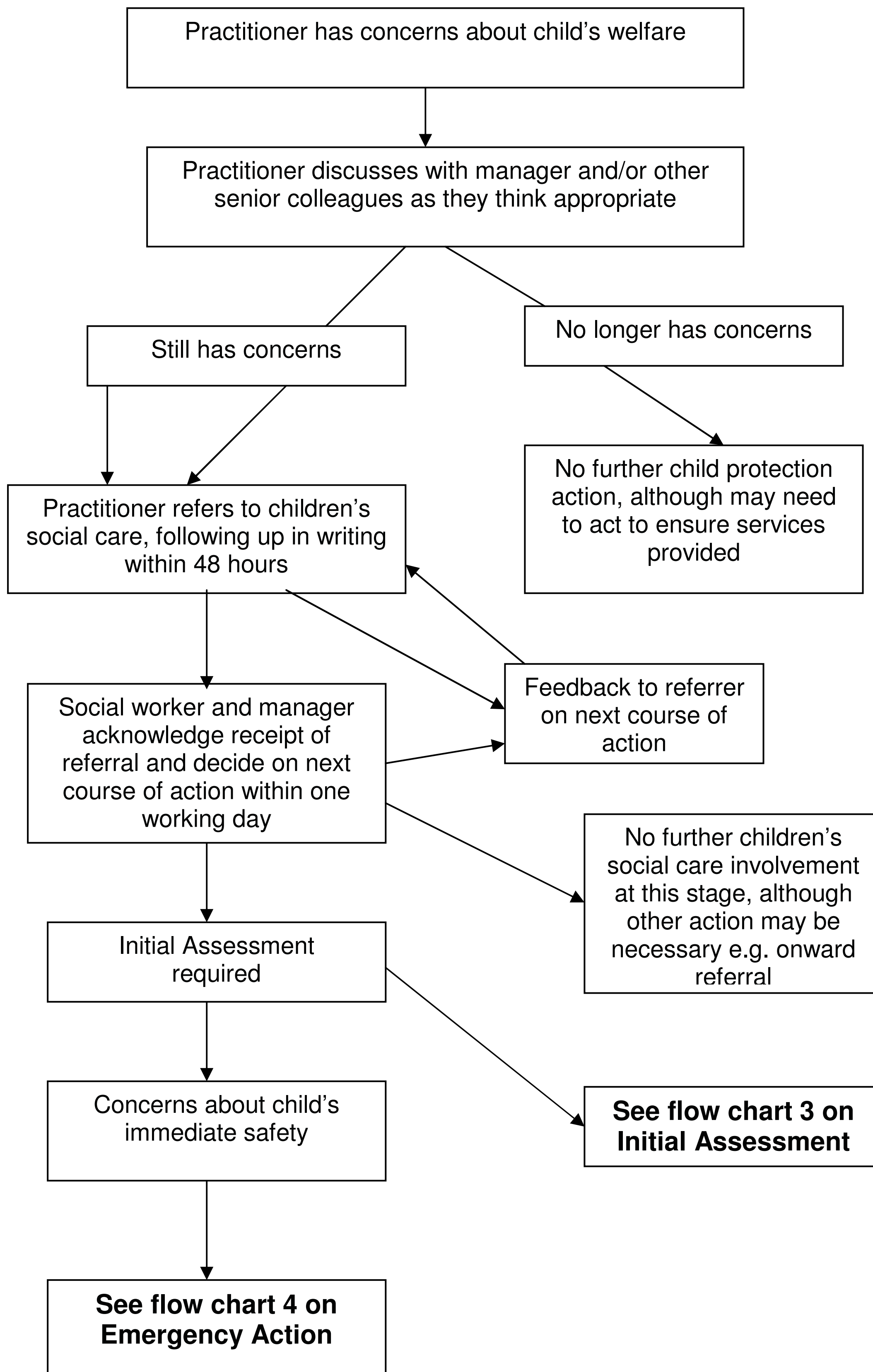
45. **This would normally rule out, for example, the suspect being confronted with the evidence by a paediatrician or any other personnel from the statutory agencies, except for the police, which is the lead investigative agency.**

Please refer to ‘Flow chart 1 below – *‘Medical evaluation where there are concerns regarding signs and symptoms of illness’.*

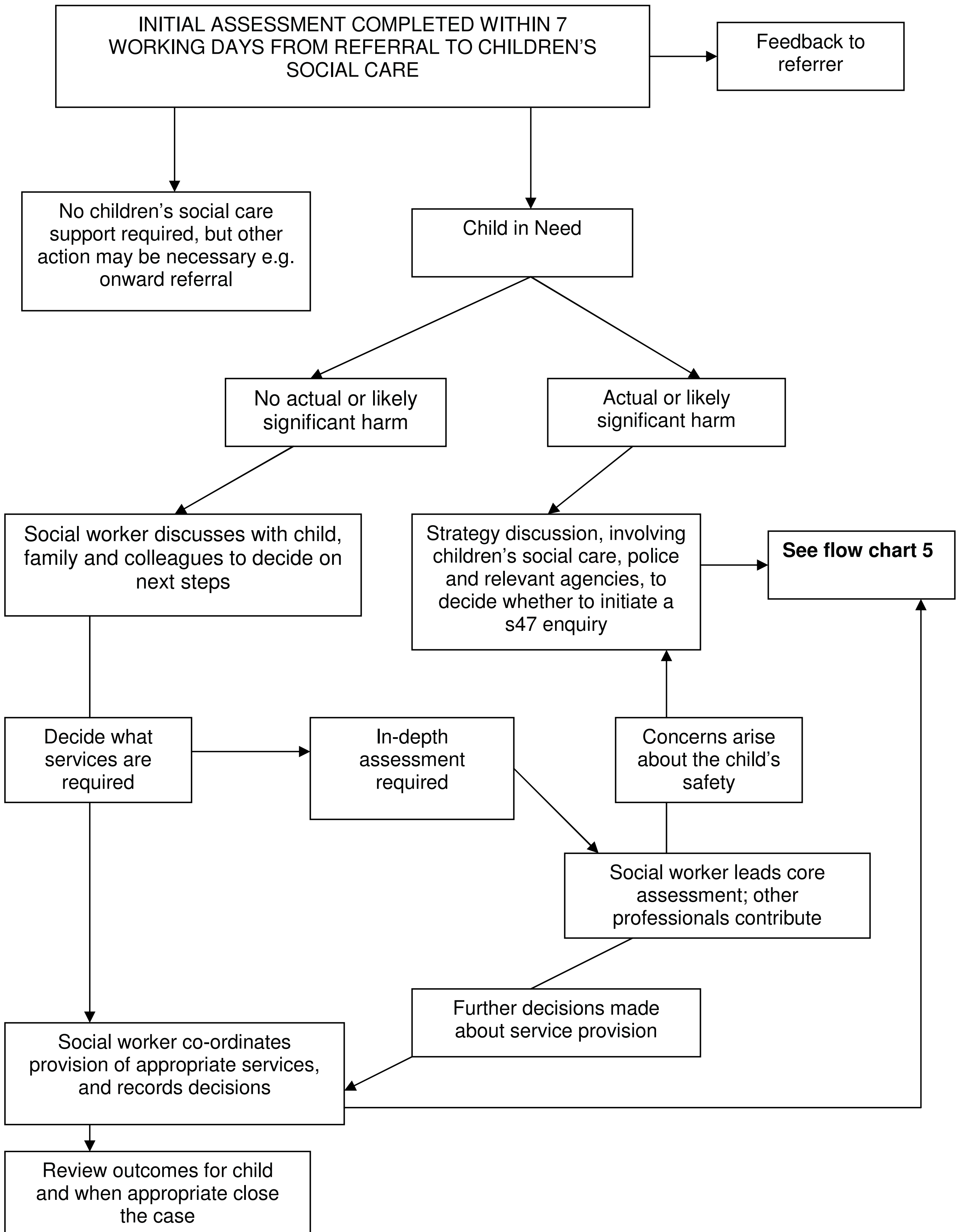
FLOW CHART 1 – MEDICAL EVALUATION WHERE THERE ARE CONCERNS REGARDING SIGNS AND SYMPTOMS OF ILLNESS



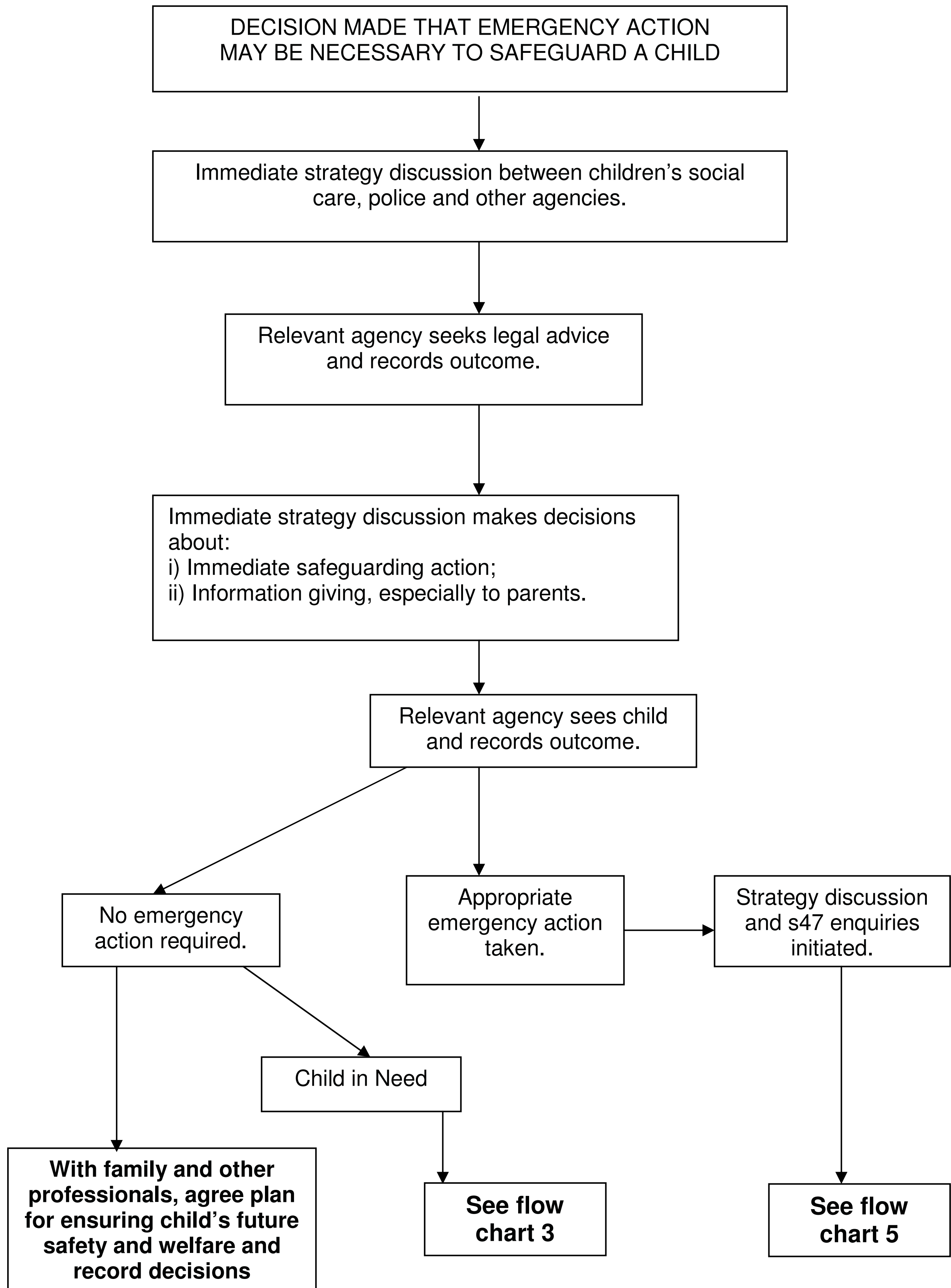
FLOW CHART 2 – REFERRAL



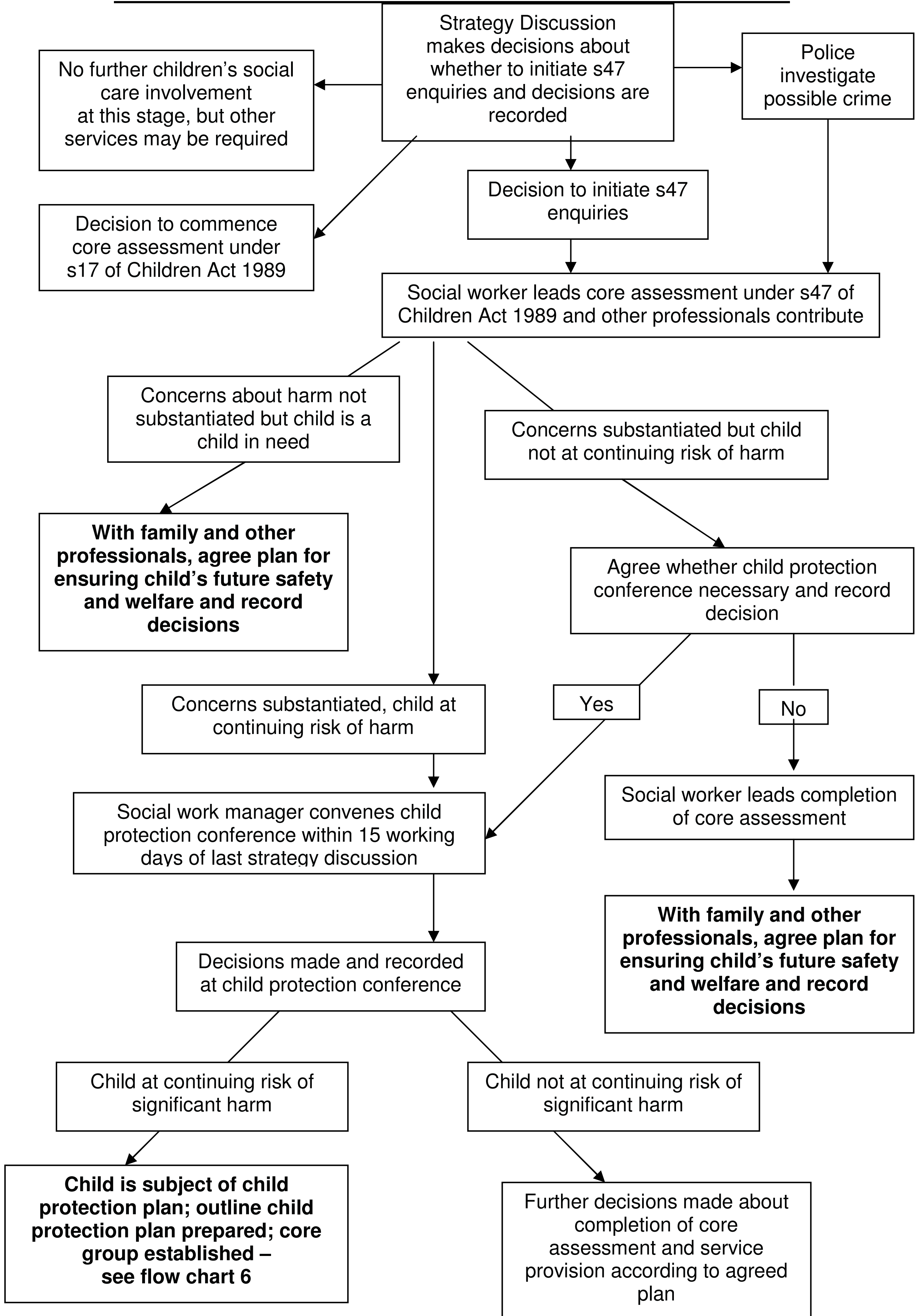
FLOW CHART 3 – WHAT HAPPENS FOLLOWING INITIAL ASSESSMENT?



FLOW CHART 4 – URGENT ACTION TO SAFEGUARD CHILDREN



FLOW CHART 5 – WHAT HAPPENS AFTER THE STRATEGY DISCUSSION?



FLOW CHART 6 – WHAT HAPPENS AFTER THE CHILD PROTECTION CONFERENCE, INCLUDING THE REVIEW PROCESS?