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Working together with Stoke-on-Trent Safeguarding Children Partnership

# **SAFEGUARDING CHILDREN IN WHOM ILLNESS IS FABRICATED OR INDUCED**

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## Introduction

Fabricated or Induced Illness (FII) is a potentially lethal form of abuse. It is probably generally under-recognised.

Children can have their health or development significantly impaired or can suffer emotional harm as a result of the actions of a parent or carer who either induces or fabricates illness or injury.

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.

## Features

Fabricated or Induced Illness is a condition whereby a child suffers harm through the deliberate action of their carer and which is attributed by the adult to another cause.

There are three main ways of the parent/carer fabricating or inducing illness in a child:

1. **Fabrication** of signs and symptoms, including fabrication of past medical history or mental health difficulties.
2. **Fabrication** of signs and symptoms and **falsification** of hospital charts, records, letters and documents and specimens of bodily fluids.
3. **Induction** of illness by a variety of means.

Harm to the child may be caused through unnecessary or invasive medical investigations and/or treatment, which may be harmful and possibly dangerous, based on symptoms that are falsely described or deliberately manufactured by the carer, and lack independent corroboration. The emotional impact of this on the child should always be considered.

There may be a number of explanations for these circumstances and each requires careful consideration and review.

Concerns about a child's health should be discussed with a health professional who is involved with the child.

If any health professional considers their concerns are not taken seriously or responded to appropriately, these should be discussed with the Named or Designated Doctor or Nurse for Safeguarding Children.

## **Carers' behaviours associated with fabricated or induced illness:**

The following is a list of some of the behaviours exhibited by carers, which can be associated with fabricating or inducing illness in a child:

- inducing symptoms in children by administering medication or other substances, or by intentional suffocation;
- interfering with treatments by overdosing with medication, not administering them or interfering with medical equipment such as infusion lines and feeding apparatus;
- 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;

- falsifying test results and observation charts;
- alleging unfounded psychological illness in a child;

Carers may be 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. Others may spend little time interacting with their child.

A key professional task is to distinguish between the very anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour.

## Identification of FII

### **Educational Care Settings Including Early Years:**

Staff should be alert to the possibility of FII when a child:

- has frequent and unexplained absences from school, particularly from PE lessons, or from early years settings;
- has regular absences to keep a doctor's or a hospital appointment;
- 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 e.g. headaches, tummy aches, dizzy spells, blank episodes, frequent contact with opticians and/or dentists or referrals for second opinions.

### **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;
- physical examination and results of medical investigations do not explain reported symptoms and signs;
- there is an inexplicably poor response to prescribed medication and other treatment;
- new symptoms are reported on resolution of previous ones;
- reported symptoms and found signs are not seen to begin in the absence of the carer;
- over time the child is repeatedly presented with a range of signs and symptoms and 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;
- the carer appears overly anxious for the situation or unconcerned in the face of apparently life threatening symptoms and signs;
- child may be presented at a number of different healthcare settings with diagnoses made on basis of parental reports

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.

## Making a referral

If a professional suspects that a child may be subject to FII, they discuss their concerns with a senior colleague or line manager and referred to children's social care. The child's carers should not be informed about this.

**If any professional considers their concerns about FII are not being taken seriously or responded to appropriately, they should discuss them with the named or designated doctor or nurse or follow the SCB Inter-agency Escalation Procedure. These procedures can be viewed on the SSCB website [www.staffsscb.org.uk](http://www.staffsscb.org.uk)**

## Medical Evaluation *(please also see flow chart 1)*

Consultation with peers or colleagues in other agencies is an important part of the process for identifying and interpreting the underlying reasons for these signs and symptoms. When signs and symptoms of illness present in a child are suggestive of FII professionals must remain open to all possible explanations.

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.

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 and compromise the child protection process and/or any future criminal investigation.

**Every effort should be made to see the child without the parent being present. Some children may be competent to be involved in the decision making process.**

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 SCB safeguarding children procedures. Where there are concerns that a member of staff may be responsible for unexplained or inexplicable signs and symptoms in a child then the local authority designated officer LADO should be contacted. The consultant paediatrician responsible for the child's health care and the police will also need to be informed and involved in the decision about any actions that may need to be taken.

## Strategy discussion

If there is reasonable cause to suspect that the child is suffering or likely to suffer significant harm, the children's social care should convene a strategy discussion involving all the key professionals.

The strategy discussion should take the form of a meeting, chaired by a principal manager from children's social care.

This meeting requires the involvement of key senior professionals responsible for the child's welfare. At a minimum, this must include children's social care, the police and the consultant paediatrician responsible for the child's health.

Additionally the following should also be invited:

- A senior ward nurse if the child is an in-patient
- A medical professional with expertise in the relevant branch of medicine
- GP
- Health visitor or school nurse as appropriate
- Staff from education settings if appropriate
- The local authority's legal adviser
- The named and/or designated professionals for safeguarding children

It may be necessary to have more than one strategy discussion/meeting. This is likely where the child's circumstances are very complex and a number of discussions are required to consider whether and, if relevant, when to initiate a section 47 enquiry.

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

Following the strategy discussion a decision to initiate a section 47 enquiry may be made.

Where there is risk to the life of a child or a likelihood of serious immediate harm, Childrens Social Care or the police should act quickly to secure the immediate safety of the child. Emergency action might be necessary as soon as a referral is received, or at any point in involvement with children and families.

## Section 47 Enquiry and Core Assessment

This will include:

- The need for extreme care over confidentiality, including careful security regarding supplementary records.
- The need for each agency to provide a written chronology of the contacts they have had with the child and family.
- The need for expert opinion.
- Whether the child requires constant professional observation, and if so, whether the carer should be present.
- Arrangements for the medical records of all family members, including children who may have died or no longer live with the family, to be collated by the consultant paediatrician or other suitable medical clinician.
- The designation of a medical clinician to oversee and co-ordinate the medical treatment of the child to control the number of specialists and hospital staff the child may be seeing.
- Any particular factors, such as the child and family's race, ethnicity, language and special needs which should be taken into account.
- The needs of siblings and other children with whom the alleged abuser has contact.
- The needs of parents.
- The nature and timing of any police investigations, including analysis of samples and covert video surveillance.
- Obtaining legal advice over evaluation of the available information (where a legal adviser is not present at meeting).
- Any evidence gathered by the police being made available to other relevant professionals, to inform discussions about the child's welfare and contribute to the section 47 enquiry and core assessment.

## Police

In cases where a criminal offence is suspected 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, which would normally rule out any agency other than the police confronting the suspect.

The police may 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.

## **Covert video surveillance**

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. This should be clearly recorded, with reasons given why it is necessary.

**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.**

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

Whilst the decision rests with the police, a children's social care senior manager must sign the record. The Chief Executive of the relevant NHS Trust should also be notified of any decision to apply to use covert video surveillance in their Trust.

The police should obtain the necessary authorisation. If that authority is granted, the police have sole responsibility for implementing and undertaking any such surveillance, including the supply and installation of any equipment and the security and archiving of the video records.

Any use of covert surveillance by the police should be carried out in accordance with good practice (see below).

Officers planning surveillance in cases of suspected fabricated or induced illness should have received specialist training and should seek advice from the National Centre for Policing Excellence (NCPE) Operations helpdesk.

The primary aim of the surveillance is to identify whether a child is having an illness induced; and the obtaining of criminal evidence is of secondary importance.

The safety of the child is the overriding factor. The level and nature of health involvement during the period of surveillance should be agreed at the strategy discussion. Children's social care should have a contingency plan in place, which can be implemented immediately if covert video surveillance provides evidence of the child suffering significant harm.

These procedures are based on:

## **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.

**Child Protection Companion ( 2<sup>nd</sup> Edition) 2013, Chapter 13, RCPCH**

Police should refer to:

**National Crime and Operation Faculty, the ACPO (2004) Manual of Surveillance Standards and the ACPO (2004) Policy for Covert Monitoring Posts, both of which are held by the National Specialist Law Enforcement Centre (NSLEC).**

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

