ERSCB
EAST RIDING SAFEGUARDING CHILDREN BOARD
Keeping children and young people safe

PROCEDURES AND GUIDANCE

Fabricated or Induced Illness

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FABRICATED OR INDUCED ILLNESS

1. Introduction

Fabricated or Induced Illness (FII) is a rare form of child abuse. It occurs when a parent or carer, usually the child's biological mother exaggerates or deliberately causes symptoms of illness in the child. The abuse that occurs in fabricated or induced illness takes a range of forms and can be difficult to recognise, but there are warning signs to look out for.

2. Warning signs

The National Institute for Health and Care Excellence (NICE) guidance 89 (2009) on when to suspect child maltreatment states that fabricated or induced illness may first be suspected if:

- Physical or psychological examination and diagnostic tests do not explain the reported signs and symptoms.

One or more of the following warning signs must also be present:

- Symptoms only appear when the parent or carer is present.
- The only person claiming to notice symptoms is the parent or carer.
- The affected child has an inexplicably poor response to medication or other treatment.
- If a particular health problem is resolved, the parent or carer suddenly begins reporting a new set of symptoms.
- The child's history of symptoms does not result in expected medical outcomes – for example, a child who has supposedly lost a lot of blood but doesn't become unwell.
- The parent or carer has a history of frequently changing GPs or visiting different hospitals for treatment, particularly if their views about the child's treatment are challenged by medical staff.
- The child's daily activities are being limited far beyond what you would usually expect as a result of having a certain condition – for example, they never go to school or have to wear leg braces even though they can walk properly.

<u>Other warning signs</u>

Other identified warning signs include:

- The parent or carer having good medical knowledge or a medical background.
- Although the parent or carer is very attentive to the child and stays with them constantly in hospital, they do not seem too worried about the child's health – or overly worried in relation to the health professional in charge of their child's care.
- The parent or careers trying to maintain a close and friendly relationship with medical staff, but quickly becoming abusive or argumentative if their own views on what is wrong with the child are challenged.
- One parent (usually, but not always, the father) having little or no involvement in the care of the child.
- The parent or carer encouraging medical staff to perform often painful tests and procedures on the child (tests that most parents would only agree to if they were persuaded that it was absolutely necessary).
- A tendency by carers to either organize their own referrals to a "Specialist" of their choice, or pressurize a member staff to refer.
- Irritation rather than relief, following normal results or reassurances.
- Pressure to request Disability Benefits, charitable grants, wheelchairs or other items that seem inappropriate.
- A tendency to groom a single, often well intentioned or less experienced individual member of staff to undertake requests on behalf of the carer.
- Avoidance of corroboration by those who would be in a good position to make a comment about a child's health or behaviour (e.g. Nursery or school staff).
- Medical records that seem excessive, given the apparent good health of the child.

3. Patterns and levels of abuse

The patterns of abuse found in cases of FII usually fall into one of six categories. These are ranked below, from least severe to most severe. In the more severe cases of FII, the parent or carer may carry out behaviour from several or all categories. The categories are:

- Exaggerating or fabricating symptoms and manipulating test results to suggest the presence of an illness.
- Intentionally withholding nutrients from the child or interfering with nutritional intake.
- Inducing symptoms by means other than poisoning or smothering – such as using chemicals to irritate their skin.
- Poisoning the child with a poison of low toxicity – for example, using a laxative to induce diarrhoea.
- Poisoning the child with a poison of high toxicity – for example, using insulin to lower a child's blood sugar level.
- Deliberately smothering the child to induce unconsciousness.

Previous case reports of FII have uncovered evidence of:

- Parents or carers lying about their child's symptoms.
- Parents or carers deliberately contaminating or manipulating clinical tests to fake evidence of illness – for example, by adding blood or glucose to urine samples, placing their blood on the child's clothing to suggest unusual bleeding, or heating thermometers to suggest the presence of a fever.
- Poisoning their child with unsuitable and non-prescribed medicine.
- Infecting their child's wounds or injecting the child with dirt or faeces (stools).
- Inducing unconsciousness by suffocating their child.
- Not treating or mistreating genuine conditions so they will get worse.
- Withholding food – which results in the child failing to develop physically and mentally at the expected rate.

4. How common is Fabricated or Induced Illness?

It is difficult to estimate how widespread FII is, because many cases may go unreported or undetected. In an average population of one million people, around one child per year would be affected. However, it's likely that this figure underestimates the true prevalence of FII.

FII can involve children of all ages, but the most severe cases usually involve children under five.

In over 90% of reported cases of FII, the child's mother is responsible for the abuse. However, cases have been reported in which the father, foster parent, grandparent, guardian, or a healthcare or childcare professional was responsible.

5. Motivation

It's not fully understood why FII occurs. In cases where the mother is responsible, it could be that the mother enjoys the attention of playing the role of a "caring mother". A large number of mothers involved in cases of FII had a previous history of unresolved psychological and behavioural problems, such as a history of self-harming, or drug or alcohol misuse, or have experienced the death of another child.

A high proportion of mothers involved in FII have been found to have so-called "somatoform disorders", where they experience multiple, recurrent physical symptoms. A proportion of these mothers also fabricate or induce their own illnesses.

A high proportion of mothers also have a type of mental health problem called borderline personality disorder, which is characterized by emotional instability, impulsiveness and disturbed thinking. There have been several reported cases where illness was fabricated or induced for financial reasons – for example, to claim disability benefits. The causes of fabricated or induced illness, however, previous traumatic experiences in the life of the parent or carer responsible seem to play an important role.

Recent studies have shown that mothers who carry out the abuse have abnormal "attachment" experiences with their own mothers, which may affect their parenting and ability to secure bonds with their children. An example of this is repeatedly seeing a doctor to satisfy an emotional need to get attention for the child.

Child abuse

One study found that almost half of mothers who were known to have fabricated or induced illness in their child were victims of physical and sexual abuse during their own childhood. However, it's worth noting that most people who were abused as children do not go on to abuse their own children.

Previous medical history

One or both parents may have a history of self-harm or drug or alcohol abuse. Some case studies also revealed that the mother may have experienced the death of another child, or a difficult pregnancy.

Personality disorder

A high proportion of mothers involved in FII have been found to have a personality disorder and, in particular, a borderline personality disorder.

Personality disorders are a type of mental health problem, where an individual has a distorted pattern of thoughts and beliefs about themselves and others. These distorted thoughts and beliefs may cause them to behave in ways that most people would regard as disturbed and abnormal.

A borderline personality disorder is characterized by emotional instability, disturbed thinking, impulsive behaviour, and intense but unstable relationships with others. However, it's important to note that not all mothers with borderline personality disorder go on to abuse their children.

Sometimes, people with personality disorders find reward in behaviour or situations that other people would find intensely distressing. It's thought that some mothers who carry out FII find the situation of their child being under medical care rewarding. Other mothers who have been involved in FII have reported feeling a sense of resentment towards their child because they have a happy childhood, unlike their own.

6. Initial Consideration of Referral

FII is a child protection issue and cannot be treated by the NHS alone. It cannot be emphasized strongly enough the importance of a multi-agency response to suspicions of FII where combined chronologies can provide a clearer picture of the situation.

Anyone who suspects FII is taking place must call the Early Help and Safeguarding Hub (EHaSH) on Tel. 01482 395500 (out of hours Tel. 01377 241273). If you suspect that someone you know may be fabricating or inducing illness in their child, it's not recommended that you confront them directly. A direct confrontation is unlikely to make a person admit to wrongdoing, and it may give them the opportunity to dispose of any evidence of abuse. It may also place the child at greater risk.

When considering FII it is important to review records and formulate a comprehensive chronology of both the child, siblings and parents/carers.

In cases involving administering unnecessary medicines or other substances, it's estimated that around 1 in 16 will die as a result of this abuse. A further 1 in 14 will experience long-term or permanent injury. In cases of FII, the first priority is to protect the child.

The decision must be taken in consultation with the consultant Paediatrician responsible for the child's health care, or the Designated Doctor for child protection in the Local Authority area, and the Police because any suspected case of fabricated or induced illness may also involve the commission of a crime.

All decisions about what information is shared with parents should be agreed between the Police, Local Authority Children's Social Care and consultant Paediatrician, bearing in mind the safety of the child and the conduct of the police investigations.

7. Initial Assessment, Outcomes and Immediate Protection

Local Authority Children's Social Care should usually undertake an initial assessment, as with all referrals, in collaboration with the Paediatrician responsible for the child's health care, as well as relevant other agencies (e.g. the child's school).

If there is reasonable cause to suspect the child is suffering, or likely to suffer, significant harm and immediate protection is required (e.g. if the child's life is in danger through poisoning or toxic substances being introduced into the child's bloodstream) an immediate strategy meeting/discussion should take place and legal advice must be sought. Concerns should not be raised with a parent if there is concern that this action will jeopardize the child's safety or where it may undermine a timely criminal investigation.

8. Strategy Meeting

If there is reasonable cause to suspect the child is suffering, or is likely to suffer harm, Local Authority Children's Social Care should convene and chair a strategy meeting involving all key professionals. A meeting, rather than telephone discussion, is strongly advised when considering this complex form of abuse.

The meeting should be chaired by the Local Authority Children's Social Care first line manager. Participants must include Local Authority Children's Social Care, Police and the Paediatrician responsible for the child's health, and as appropriate:

- 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;
- Staff from the educational setting;
- Local Authority legal adviser.

In cases of possible fabricated or induced illness, it may be necessary not to tell the parents about the meeting prior to it taking place in order to protect the child. When it is decided there are grounds to initiate a child protection investigation (Section 47, Children Act 1989), decisions should be made about how the investigation and assessment will be carried out, including:

- Whether the child requires constant professional observation and, if so, whether the carer should be present;
- 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;

- Arrangements for the medical records of all the 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 nature and timing of any Police investigations, including analysis of samples and covert surveillance (this will be Police led and coordinated, with advice available from the National Crime Faculty);
- The need for extreme care over confidentiality, including careful security regarding supplementary records;
- The need for expert consultation;
- Any particular factors, such as the child's and family's race, ethnicity, language and special needs, which should be taken into account;
- The needs of the siblings and other children with whom the alleged abuser has contact;
- The needs of the parents;
- Obtaining legal advice over evaluation of the available information (if a legal adviser is not present at the meeting).

It may be necessary to have more than one strategy meeting, as the child's circumstances are likely to be complex and a number of discussions may be required to consider whether and when to initiate a Section 47 enquiry.

9. Police Investigation

Evidence gathered by the Police should usually be available to other relevant professionals, to contribute to the Section 47 enquiry and single assessment. There will be occasions when the Police will not share information to protect a person's identity. However, if the need to protect the child is greater than the need to protect the source of the information, the necessary authority will be sought to share that information.

Suspects' rights are protected by adherence to the ***Police and Criminal Evidence Act 1984***, which would usually rule out any agency other than the Police confronting any suspect persons.

10. Outcome of Enquiries

As with all protection investigations, the outcome may be that concerns are not substantiated (e.g. tests may identify a medical condition that explains the signs and symptoms). It may be that no protective action is required, but the family should be provided with the opportunity to discuss whether they require support.

Where fabricated or induced illness is suspected, the child protection investigation may take more time than usual. However, whenever possible and consistent with the child's best interests, professionals should ensure any Child Protection Conference is held within 15 working days of the last strategy meeting/discussion and that regular meetings/discussions take place throughout the investigation.

Concerns may be substantiated, but an assessment may be formed that the child is not at continuing risk of harm. In this case, the decision not to proceed to a Child Protection Conference must be endorsed by the Local Authority Children's Social Care Manager.

Where concerns are substantiated and the child is judged to be suffering, or at risk of suffering, significant harm, a Child Protection Conference must be convened. All evidence should be thoroughly documented by this stage and the Protection Plan for the child already in place. Attendance at this conference should be as for other initial conferences with additional experts invited as appropriate:

- Professionals with expertise in working with children in whom illness is fabricated or induced and their families;
- Paediatrician with expertise in the branch of paediatric medicine able to present medical findings.

Local Authority Children's Social care should only convene an initial conference after reaching the point of discussing professional concerns openly with the parent/s, i.e. when it has been agreed that to do so will not place the child at increased risk of significant harm. This may be some time after the commencement of enquiries under Section 47 and a series of strategy discussions/meetings while the medical professionals undertake continuing evaluation and the Police progress a criminal investigation.

In some cases legal action may be necessary before this point is reached, in which case the appropriateness of holding an initial conference at this stage will need to be considered.