



## FABRICATED OR INDUCED ILLNESS Revised July 2011

### Assurance Statement

This policy aims to ensure that all agencies within Buckinghamshire working with Children and families know their responsibilities with regard to suspected or actual incidents of Fabricated/Induced Illness in a child, whether induced by a parent/carer/professional.

### 1. Introduction

1.1 This policy should be read in conjunction with Working Together (2010), DSCF 2008 document '**Safeguarding Children in Whom Illness is Fabricated or Induced**'. Further guidance is available from The Royal College of Paediatricians.

### 2. Definition:

2.1 The systematic fabrication or induction of illness in a child, causing that child to be seen as ill.

2.2 The following indicators are there to alert professionals to the presence of Fabricated or Induced Illness. In themselves there may be other explanations and therefore, they should be viewed in context.

2.3 Examples of presentation may include:-

- Pretending the 'victim' is ill or that they have been ill.
- Exaggerating real illness.
- Making the 'victim' ill, e.g. by poisoning.
- Making false allegations of abuse.
- Forcing the 'victim' to appear disabled (including learning disability)
- End result - disability or death.
- This rare and potentially dangerous form of abuse has also been known as: Munchausen' Syndrome by proxy
- Fabricated Illness by Proxy
- Factitious Illness by Proxy
- Illness Induction Syndrome.

2.4 There are three main ways of a carer/professional fabricating or inducing illness in a child. These are not mutually exclusive:

- **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 falsification of specimens of bodily fluids. This also may include falsification of letters and documents.
- **Induction** of illness by a variety of means.

### 3 Spectrum of Harm:

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

### 4 Recognition of Harm:

4.1 Harm to the child may be caused directly through physical harm or indirectly via unnecessary or invasive medical treatment, which may be given in good faith, based on symptoms that are falsely described or deliberately manufactured. (See appendix 1)

4.2 There may be a number of explanations for the circumstances that lead to Fabricated Induced Illness. Each requires careful consideration.

4.3 Typical presentation may include the following:

- Over time the child is repeatedly presented with a range of signs and symptoms.
- There tend to be no independent verification of reported symptoms.
- Signs found on examination are not explained by any medical condition from which the child is known to be suffering.
- Medical tests do not support the reported signs and symptoms.
- The response to prescribed medication and other treatment is inexplicably poor.
- New symptoms are reported on resolution of previous ones.
- Signs and symptoms do not begin in the absence of the carer.
- The child's normal daily life becomes restricted in ways similar to those that might apply if they had a serious medical disorder from which they do not appear to suffer.

## 5 The Child:

### 5.1 Characteristics of Fabricated/Induced Illness

The following features can be associated with this form of abuse, though none is indicative in itself:

- The child's medical, especially hospital treatment begins at an early stage of their 'illnesses'. (See appendix 2)
- They attend for treatment at various hospitals and other healthcare settings in different geographical areas.
- They may develop a feeding disorder as a result of unpleasant feeding interactions. **This is different from an eating disorder which is abnormal feeding habits associated with psychological factors, including** anorexia nervosa, bulimia nervosa, pica, **and** rumination disorder.
- Non-organic failure to thrive
- The child develops an abnormal attitude to his/her own health.
- Poor school attendance and under achievement.
- Incongruity between the seriousness of the story and the actions of the parents.
- The child may already have suffered other forms of abuse.

- History of unexplained death, illness or multiple surgery in parents and/or siblings.
- Carer over involvement in medical tests, taking temperatures or measuring bodily fluids.
- Carers observed to be intensely involved with the child, eg not allowing anyone else to undertake their child's care.
- Carers may appear unusually concerned about the results of investigations that may indicate physical illness in the child, although conversely they may not appear at all concerned.

## 6 The Abuser:

6.1 The clinical evidence indicates that, fabricated or induced illness is usually carried out by a female carer, usually the child's mother. (Wilson RG 2001)

6.2 The child's carer may have a history of childhood abuse, false allegations of physical or sexual abuse, self harm or psychiatric disorder (especially personality disorder or psychotic illness).

- May have some medical knowledge and may try to intimidate Health Professionals.
- Erroneous or misleading information provided by the carer.
- May threaten law suits too readily.
- Tends to be over friendly with health staff but may be abusive if staff do not comply with their wishes.
- Often shows inappropriate behavior, e.g. being over-anxious or even less attentive than you would expect.
- May have mental health problems.
- Is always present when the victim has alleged or real symptoms or signs of illness.

## 7 Action to be taken when fabricated or Induced Illness is suspected.

7.1 Initial concerns can come from any professional/lay person who has regular contact with the child. When a possible explanation for the signs and symptoms is that they may have been fabricated or induced by the carer and as a consequence the child's health and development is or is likely to be impaired, a **referral to should be made to Social Care or the police.**

7.2 Normally, a referral to Children's Social Care would be completed with the agreement of the child's carers however, particularly in the case of suspected fabricated/induced illness **this should only be done where discussions and agreement seeking will not place a child at increased risk of significant harm.**

(Appendix 3) (Safeguarding Children in Whom Illness is Fabricated/Induced, DCSF (2006), paragraph 3. 12/3. 13 and Working Together to Safeguard Children (2010) paragraph 5.18

(Appendix 4) Provides a flowchart summary of the initial management of Fabricated or Induced Illness in children, provided by Oxfordshire and Buckinghamshire Mental Health Trust (June 2011 – known as Oxford Health)

7.3 A case of Fabricated or Induced Illness may also involve the commission of a crime. The police Child Abuse Investigation Unit (CAIU) *should* always be involved as early as possible in accordance with Working Together to Safeguard Children (2010).

**Consideration needs to be given to the potential consequences of the loss of evidence, including the obtaining of and preservation of evidence. Advice should always be sought from the police.**

7.4 Children & Young People's Social Care services will have lead responsibility for actions to safeguard the child.

7.5 The Paediatric Consultant will continue to hold the responsibility for the child's health and decisions pertaining to it.

7.6 All professionals/volunteers who have concerns or a suspicion about Fabricated or Induced Illness must consult their Designated Lead for Child Protection for further advice.

## **8. In preparation for a strategy meeting the following Steps must be taken:**

- The social worker will collect initial detailed information from a variety of sources.
- A chronology of health involvement, including access to all health services should be prepared to provide comprehensive information.
- Any relevant information relating to the parents or siblings medical history to be shared as appropriate.
- **If at any point there is medical evidence to indicate the child's life is a risk or there is likelihood of serious immediate harm, child protection powers should be used to secure the immediate safety of the child.**

## **9. Strategy Discussions**

9.1 A strategy meeting must be held within one day of the decision that there is sufficient information to suspect Fabricated or Induced Illness. The following agencies should be invited to the meeting:-

- Social worker and team manager
- Thames Valley Police Child Abuse Investigation Unit
- Consultant Paediatrician
- General Practitioner
- Health Visitor/School Nurse
- Senior Nurse Child Protection
- Representative from Education.
- Representative of Childcare Legal Services
- Any other professionals as appropriate. E.g. Adult Psychiatrist

9.2 The purpose of the meeting is to plan any necessary child protection investigation and/or any criminal investigation needed to protect the child.

9.3 The task for the meeting is to consider the available information about the allegations and assess whether it is possible to substantiate the suspicion that the child's condition is being induced or fabricated by a parent or carer/professional.

## **10 The Process**

10.1 The strategy meeting must:

- Clarify the medical history, including details of any incidents that are reported to have occurred in the presence of people other than the suspected perpetrator.
- Verify the personal, family and social history. This includes the parent's medical/psychiatric history.
- Consider any previous social care involvement.

- Decide how any Section 47 (Children Act 1989) enquiry as part of the core assessment will be carried out. Consider what further information is required about the child and family and how this should be obtained and recorded. This includes any criminal investigation.
- Consider if immediate action is required to protect the child.
- Decide who will carry out what actions, by when and for what purpose, in particular the planning of further paediatric assessment.
- Consider the needs of siblings and other children with whom the alleged abuser has contact.
- The nature and timing of any police investigations, including evidence gathering techniques. (Safeguarding Children in Whom Illness is Fabricated/Induced, DCSF(2006),(paragraph 6.35 page 73)
- Discuss whether there is a need for a child protection Conference.
- Consider when and how parents/carers will be informed of suspicions.
- Set a date to reconvene and review the agreed action plan.

## **11 Outcomes from the strategy meeting:**

*e.g. No further action/Criminal Investigation/ Section 47 / Section 17 procedure initiated.*

### **11.1 Concern about Fabricated/ Induced Illness not substantiated:-**

11.1.1 If the meeting decides that the case does not appear to be one of Fabricated or Induced Illness, then consideration must be given as to what further help and support is needed from professionals. **There must be clear evidence explicitly outlining the decision making process not to hold an initial child protection conference/criminal proceedings.**

### **11.2 Concern about Fabricated Illness/ Induced Illness substantiated but the child is not judged to be at a continuing risk of significant harm:**

11.2.1 There may be substantiated concerns that the child has suffered significant harm, but it is agreed between the agencies involved with the child and the family that a Child In Need Plan is required to ensure the child's future safety and welfare can be implemented without the need for a Child Protection Plan.

**Any decision made, in these circumstances, must be agreed by all agencies present at the strategy meeting. Should professional disagreement remain unresolved, please see Buckinghamshire Safeguarding Board policy for Conflict Resolution.**

[www.bucks-lscb.org.uk/procedures](http://www.bucks-lscb.org.uk/procedures)

### **11.3 Concern about Fabricated Illness/Induced Illness substantiated:-**

11.3.1 If the meeting decides that there is sufficient information and that the child is being affected by Fabricated or Induced Illness, then clear recommendations must be made with timescales. Senior managers within all agencies must be informed of the recommendations. A child protection conference must be convened.

## **12. Concerns regarding Professionals/Volunteers working with Children and Families.**

### **12.1 Allegations against Professionals/Volunteers.**

**12.2** Experience has shown that children can be subjected to abuse by those who work with them in any and all kinds of settings.

**12.3** Employers should follow the guidance from the Working Together and the BSCB by reporting to the Local Authority Designated Officer (LADO) who will provide advice and support. See appendices 3 & 4

**Please see Buckinghamshire Safeguarding Board policy for managing allegations against staff and volunteers working with children and young people.**

[www.bucks-lscb.org.uk/procedures](http://www.bucks-lscb.org.uk/procedures)

## Appendix 1

System	Symptoms & Signs	Cause
Neurological	Seizures, collapse and loss of consciousness, ataxia, drowsiness; Development delay	Drugs, poison, suffocation or pressure on carotid sinus. Fabricated fits. Under stimulation, deprivation or sedation
Cardio respiratory	Disability	Enforces inappropriate use of wheelchair, crutches, braces, hearing/visual aids, nappies, etc.
	Apnoeic and cyanotic episodes, cardiac arrest, near-miss SIDS*	Suffocation with hands, cloth, plastic bag or film, insertion of fingers/objects down throat; On PICU – interfering with oxygen supply, ventilators, IV drugs/infusions
	Hypertension	Altering BP cuff size, instructions or chart
	Limb congestion	Ligature or digital compression at top of limb
	Cystic Fibrosis	Altering laboratory investigations, stealing sputum from other patients
	Asthma	Deliberate under/over treatment
	Cardiomyopathy	Ipecac poisoning

\* Frank bleeding from nose or mouth is suggestive of physical intervention and to be distinguished from blood tinged

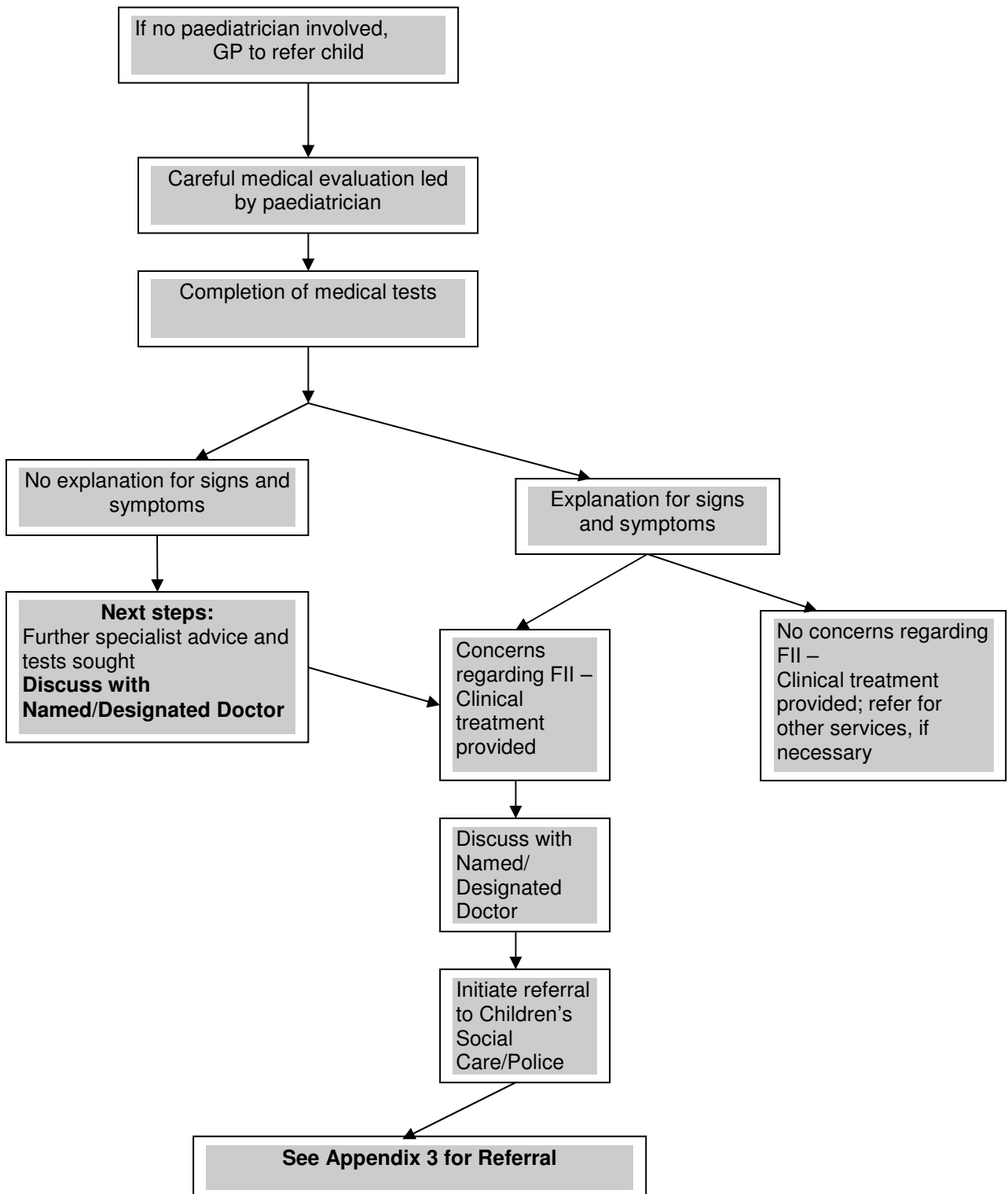
System	Symptoms & Signs	Cause
Gastro intestinal	Recurrent vomiting and/or diarrhoea	Drugs, e.g. laxatives, poisons or mechanically induced, fabricated vomiting
	Failure to Thrive  Feeding problems	Restricting intake, diluting feeds, altering intravenous infusion, aspirating or removing nasogastric tube, inappropriate dietary restrictions for allergy. Fabricating fluid/intake/output charts
Renal	Polyuria, polydypsia	Drugs, forcing excessive fluids, diluting feeds. Fabricated history
	Haematuria renal stones	Adding stone, parental or pet's blood and colouring substances to urine
	Bacteriuria	Swapping urine samples with parent or other patients
Haematological	Purpura	Injecting blood under the skin, rubbing skin
	Haematemesis, haemoptysis and rectal bleeding	Adding parental or pet's blood or colourings so specimens, clothing and nappies
Immunological	Recurrent fever, sepsis	Heating thermometer, injecting bacteriologically contaminated material, interfering with intravenous sites. Inappropriate use of rectal temperature measurements

	Allergy	Applying excessive environmental and dietary measures to avoid "allergen". Use of adrenaline for alleged anaphylaxis
Muco-cutaneous	Rashes	Applying irritants, scratching, friction, scalds, burns or injecting skin
	Conjunctivitis, stomatitis	Inserting caustic solutions in eyes and mouths
Orthopaedic	Fractures, osteomyelitis	Repeated assaults and dirtying wounds
ENT	Recurrent discharge, preterm labour	Inappropriate instrumentation/injury in orifices
Gynaecological problems in parent	Recurrent discharge, preterm labour	Inappropriate instrumentation/injury. False report of APH
	Premature rupture of membranes	Deliberate injury. Artefactual fluids in sanitary towels
Metabolic	Hypoglycaemia, glycosuria	Abuse of insulin, oral hypoglycaemic and sugar solutions
	Hypernatraemia	Adding salts to feeds

## Appendix 2

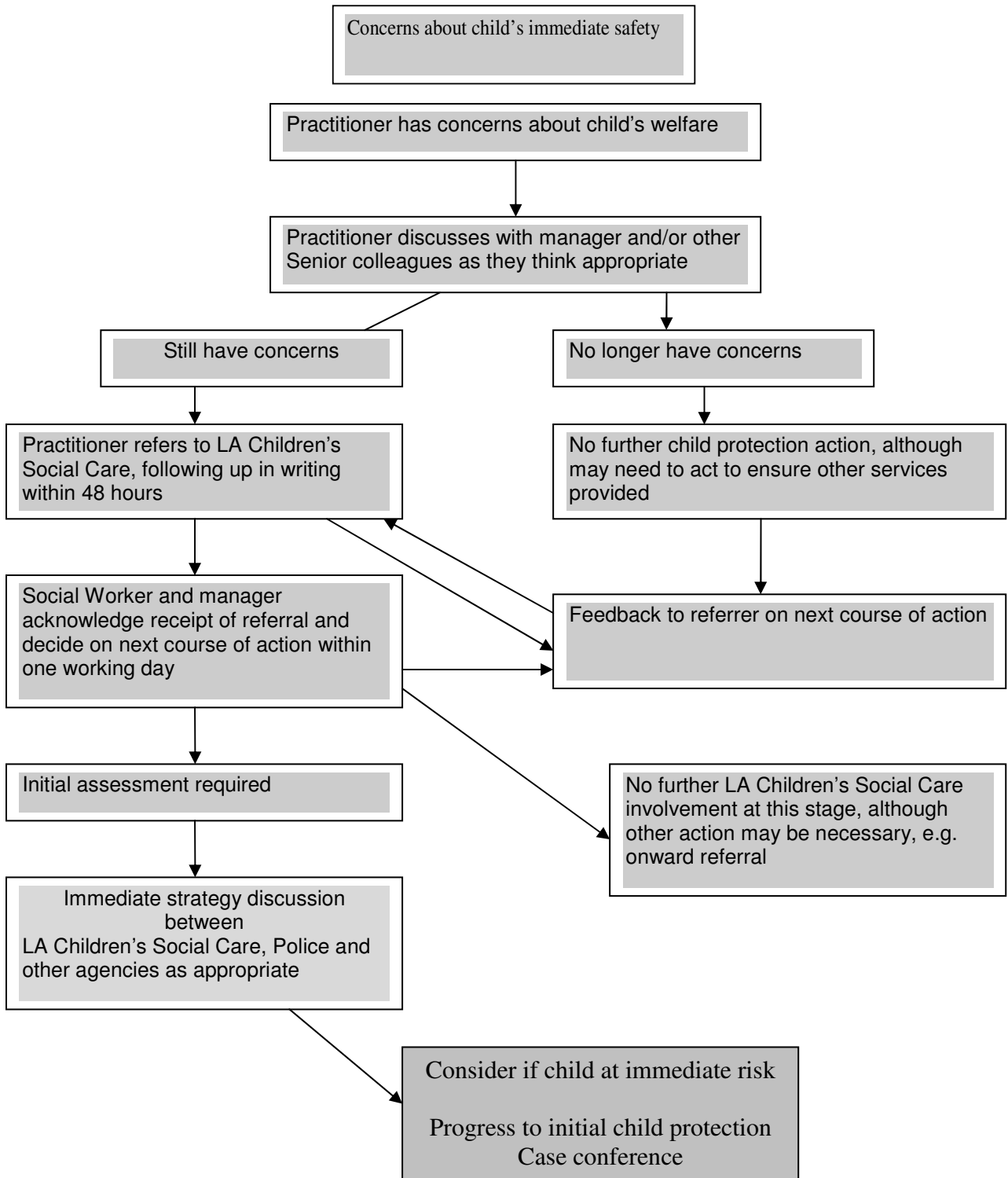
### Medical Evaluation where there are Concerns regarding Signs and Symptoms of Illness

[Reference: DCSF Safeguarding Children in whom Illness is Fabricated or Induced]



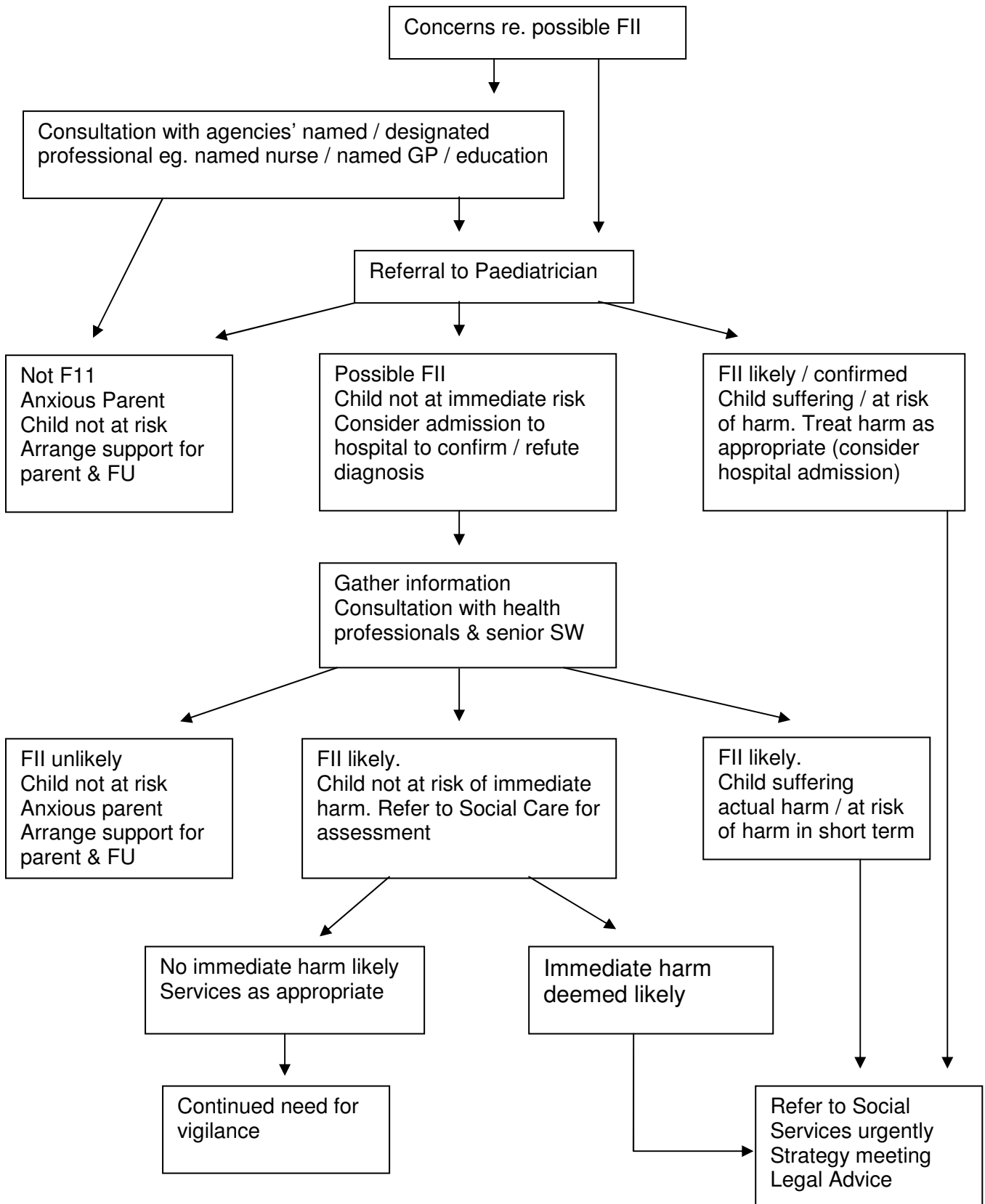
### Appendix 3 Referral

[Reference: DCSF Safeguarding Children in whom illness is Fabricated or Induced]

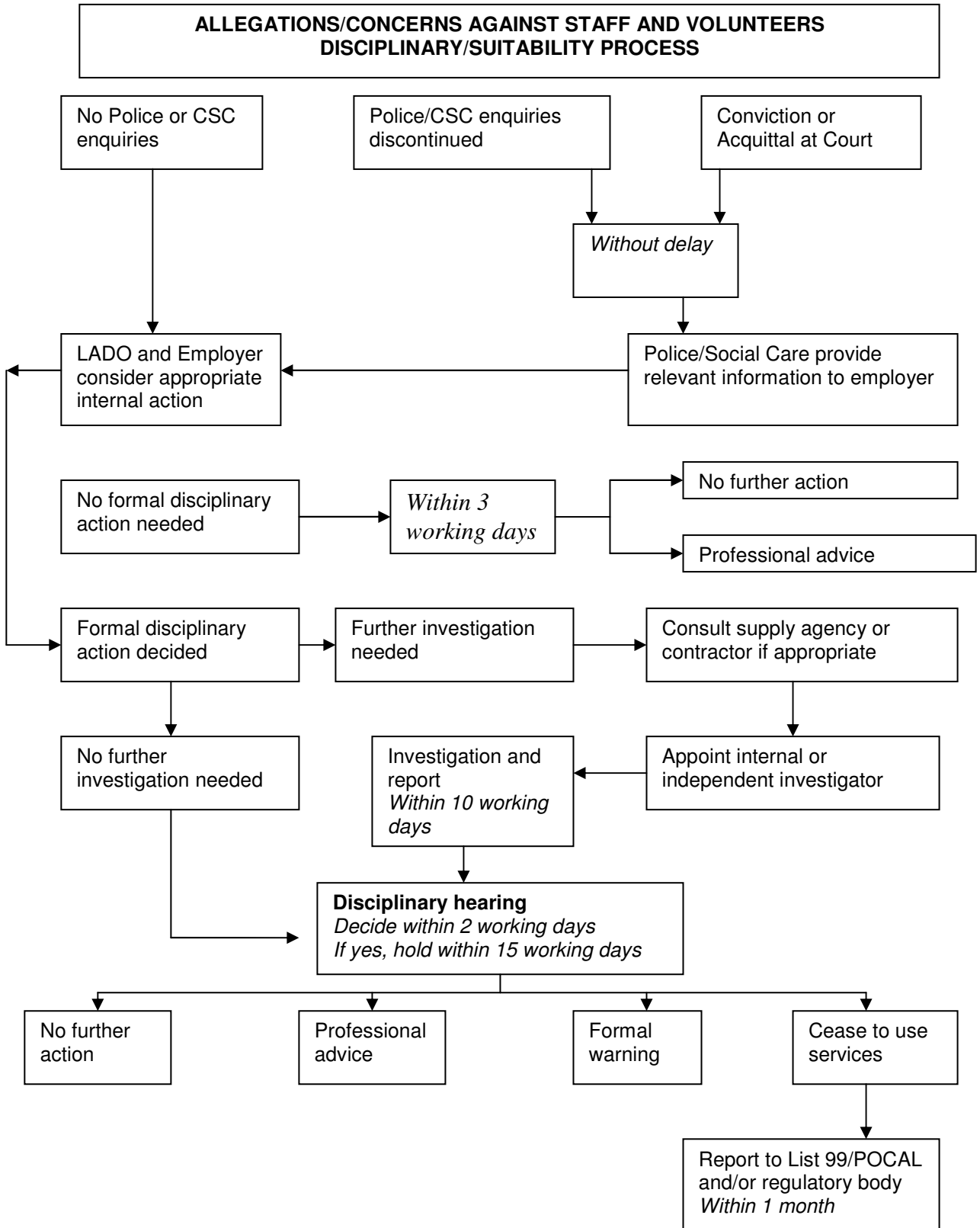


## Appendix 4

Initial Management of suspected FII (fabricated or induced illness in Children)



# Appendix 5



## **References**

DCSF Safeguarding Children in whom illness is Fabricated or Induced (2008)

Section 47 (Children Act 1989)

Working Together to Safeguard Children. (2010)

Ref. Wilson RG (2001) 'Fabricated or Induced Illness in Children, Munchausen by proxy comes of age. BMJ.

**BSCB Conflict Resolution:** ([www.bucks-lscb.org.uk/bscb\\_procedures1ver2.htm](http://www.bucks-lscb.org.uk/bscb_procedures1ver2.htm))

**Oxfordshire / Buckinghamshire safeguarding website:**

[http://portal.oxfordshire.gov.uk/content/publicnet/other\\_sites/oscb/manual/chapters/p\\_fabric\\_illness.html#mngt\\_sus\\_fii](http://portal.oxfordshire.gov.uk/content/publicnet/other_sites/oscb/manual/chapters/p_fabric_illness.html#mngt_sus_fii)