

SECTION 14

FABRICATED AND INDUCED ILLNESS

This section sets out –

- The definition of fabricated and induced illness;
- Events which may point to the possibility of fabricated or induced illness;
- The need for caution in interpreting this information;
- The need for a detailed chronology;
- Particular issues which must be addressed in the strategy discussion, the section 47 enquiries, the child protection conference, the core assessment and the child protection plan;
- When and how to consider carrying out covert video surveillance; and
- The need to ensure that records are kept securely.

Guidance

“Safeguarding Children in Whom Illness is Fabricated or Induced” [2008]
Published by the Department for Children, Schools and Families. This can be found on the Every Child Matters Website at www.everychildmatters.gov.uk/socialcare/safeguarding/

1. INTRODUCTION

- 1.1 The fabrication or induction of illness in children is a relatively unrecognised form of child abuse. It may be linked to the mental health of a parent/carer, but the behaviour may also be perpetrated for financial gain, the parent’s need for company, etc.
- 1.2 Where concerns exist about fabricated or induced illness, it requires professionals to work together, evaluating all the available evidence, in order to rule out a medical cause and reach an understanding of the reasons for the child’s signs and symptoms of illness. The management of these cases requires a careful medical evaluation which considers a range of possible diagnoses. At all times professionals need to keep an open mind to ensure that they have not missed a vital piece of information.
- 1.3 By their nature these types of cases require expert input from a range of disciplines, in particular paediatricians. It is therefore essential that all professionals who come into contact with children whose signs and symptoms may be being induced or fabricated are aware that this form of abuse exists. They should know what to do and who to consult within their own organisation or in the Police or the Children, Young People and Families Directorate.

Working Together

- 1.4 Professionals working across health, children's social care, education, schools, the Police and the independent sector should have an awareness of the possible ways in which illness can be induced or fabricated. Equally importantly, they should have an awareness of their respective roles and responsibilities and how they should work together from the point at which concerns are considered.

2. BEHAVIOURS

- 2.1 There are three main ways of 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 specimens of bodily fluids. This may include falsification of letters and documents;
- Induction of illness by a variety of means.

- 2.2 The following is a list of behaviours exhibited by carers which may be associated with fabricating or inducing illness in a child. The list is not exhaustive and should be interpreted in the context of the individual parents'/carers' cultural behaviours and practices, their understanding of, and attitude towards, the child's illness, their management of this and their views about the child's best interests:

- Deliberately inducing symptoms in a child by administering medication or other substances, by intentional suffocation, or by interfering with the child's body so as to cause physical signs;
- Interfering with treatments by overdosing, not administering them or interfering with medical equipment such as infusion lines;
- Claiming that the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits;
 These claims result in unnecessary investigations and treatments which may cause secondary physical problems.
- Exaggerating symptoms, causing professionals to undertake unnecessary investigations and treatments;
 These may be invasive, harmful and possibly dangerous.
- Repeated presentation to a variety of doctors in different settings;
- Obtaining specialist treatments or equipment for children who do not require them;

- Alleging psychological illness in a child;
- Reporting new symptoms on resolution of previous ones; and
- Curtailing the child's normal daily life activities beyond what might be expected for any medical disorder from which the child is known to suffer.

2.3 Many children who have illness induced or fabricated will suffer long term consequences. These may include impairment of their physical, psychological and emotional development.

3. CONCERNS FOR THE CHILD'S WELFARE

3.1 Child welfare concerns may arise when medical investigations into a child's illness conclude that:

- 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 found in the absence of the carer; or
- Over time the child is repeatedly presented with a range of symptoms and signs; or
- The child's normal daily life activities are curtailed beyond what might be expected for any medical disorder from which the child is known to suffer.

There may be a number of explanations for these circumstances, and a full developmental assessment should be carried out. Interagency consultation will be an important part of the process of making sense of the underlying reasons for the symptoms.

Working Together

- 3.2 Concerns may be raised by professionals other than medical clinicians who are working with the child, such as nurses, teachers, or social workers. For example -
- Professionals may note discrepancies between what the parent tells them about the child's health and development and what they see themselves. For example, in a school or nursery setting the staff may not observe any fits in a child who is described by a parent as having frequent fits during the day whilst in their care.
 - Mental health professionals may identify that a child is being drawn into the parent's illness when the parent describes signs and symptoms which replicate their own medical/psychiatric problems.
- 3.3 Any suspicions about possible fabricated or induced illness should be discussed with the designated or named health professional for child protection.

4. THE PARENT/CARER OF CONCERN

- 4.1 Fabricated or induced illness is most often carried out by the child's mother, but other persons, male and female, have been responsible in some cases, particularly when they have significant responsibility for the child's daily care. Carers exhibit a range of behaviours when they wish to convince others that their child is ill. It is important to distinguish between an anxious parent responding to a very sick child and those who exhibit abnormal behaviour.
- 4.2 When a child is in hospital, it is usual for the parents to be very involved in the child's care. Where illness is being fabricated or induced in the child, this gives the parent an opportunity to continue this behaviour. A number of patterns of behaviour have been observed –
- Commonly these carers are intensely involved with their children, never taking a break and not allowing anyone else – including family members – to undertake any of the child's care. This behaviour may preclude adequate observation of the child.
 - By contrast, some may spend little time interacting with their child, but may be very involved with other families on the ward, and with the hospital staff rather than with their own child.
 - Some carers appear unconcerned about the results of investigations which may be indicative of serious physical illness in the child.

5. THE NON-ABUSING PARENT

- 5.1 It is important to consider that the non abusing parent may have been innocently convinced by the other parent/carer that the child is seriously ill and therefore may be unwittingly involved in perpetuating the illness and in undertaking actions of concern, e.g. giving medication or supporting a limitation on the child's activity. It is therefore essential that any genuine concern held by this non abusing parent for the child's illness are acknowledged and addressed providing a history of evidence where possible.
- 5.2 Attention must also be paid to the possibility of active or passive collusion with the abuse by each parent: the assessment process must consider the role of each parent in the particular family system and ensure each parent has the opportunity to be seen alone.

**6. ABUSE BY PROFESSIONAL CARERS
(Persons in a position of trust)**

- 6.1 Children can be subjected to fabricated and induced illness in a variety of settings. Any concerns about the behaviour of professional staff must be taken seriously. These concerns may be raised by an unexpected pattern of incidents which seems to relate to patterns of caring and, when identified, should be discussed with the relevant named or designated professional for child protection, and dealt with as set out in Section 22 of these procedures [Concerns about Persons in a Position of Trust].

7. RESPONSE TO CONCERNS

- 7.1 Any concerns about possible fabricated or induced illness require careful medical evaluation by a paediatrician, preferably one with expertise in the specialism which seems most appropriate to the reported signs and symptoms, and by the named doctor for child protection. Discussions with a team manager in the Children, Young People and Families Directorate may also be helpful in deciding whether and when a referral should be made.
- 7.2 Professionals should be open to all possible explanations for the reported or observed symptoms.
- 7.3 Tests and their results should be fully and accurately recorded, including those with negative results. It is important to ensure that these records are not tampered with, and that the name of the person reporting any observations about the child is recorded clearly in the child's notes.

Working Together

- 7.4 Every effort should be made to see the child without the parent (or staff member of concern) being present, to give the child an opportunity to share their experiences and to provide an opportunity for independent observation of the child's illness or response to medication. However when fabricated or induced illness is suspected, this may be complicated by some parents' reluctance to leave the child, but it is an essential part of the investigation and therefore needs to be managed sensitively, particularly in the early stages when concerns are being identified.
- 7.5 When a possible explanation for the symptoms is that they may have been fabricated or induced by a carer, a referral should be made to children's social care.
- 7.6 It is important that professionals from health, children's social care and the Police work closely together in making and taking forward decisions, including decisions about what information should be shared with the parents, when and by whom. Parents should be kept informed of the findings of medical investigations, but at no time should concerns be shared with them if this would jeopardise the child's safety.

8. REFERRAL TO CHILDREN'S SOCIAL CARE

Strategy discussion

- 8.1 If there is reason to suspect fabricated or induced illness, it is vital that all available information is carefully evaluated and its accuracy verified where possible. Given the complexity of this type of abuse, it is likely that a face to face meeting will be the most effective way to carry out a strategy discussion.
- 8.2 Where emergency action is necessary to safeguard the child because it appears that a child's life is in danger, e.g. through poisoning or suffocation, the referrer must draw attention to this, and the social worker and Police will agree any necessary emergency action to safeguard the child before the strategy meeting is held.
- 8.3 It is important that professionals from health, children's social care and the Police work closely together in making and taking forward decisions, including decisions about what information should be shared with the parents, when and by whom. Parents should be kept informed of the findings of medical investigations, but at no time should concerns be shared with them if this would jeopardise the child's safety.
- 8.4 The strategy discussion should, as 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 may also be necessary to obtain the advice of a paediatrician who has expertise in the branch of medicine which deals with the particular symptoms and illness processes caused by the suspected abuse, and the named consultant paediatrician for child protection.

- 8.5 If there are grounds to carry out section 47 enquiries, the strategy discussion must in particular make decisions about:
- What further information about the child and family is required and how it should be obtained and recorded;
This may include the planning of further paediatric assessment.
 - Whether it is necessary to keep supplementary records in a secure place and the manner in which they should be kept (see Paragraph 13.1);
 - Whether the child needs constant professional observation and, if so, whether or when the carer(s) should be present;
 - Whether emergency action is necessary to safeguard the child
Such action may be necessary when it appears that a child's life is in danger, e.g. through poisoning or suffocation.
 - Any particular factors which may be impacting on the parents' attitude towards, and management of, the child's presenting illness such as the child and family's faith and culture;
 - Any particular factors, such as the child and family's race, ethnicity and language which should be taken into account;
 - The needs of siblings and other children with whom the suspected abuser has contact;
 - The nature and timing of any police investigations, including the analysis of samples.
This will be particularly pertinent if covert video surveillance (see Chapter 10 of this Section) is being considered, as this will be a task for which the Police will have responsibility.
 - What the parents should be told, when and by whom; and
 - The needs of the parents or carers.
- 8.6 More than one strategy discussion may be necessary where the child's circumstances are very complex.

Initial assessment

- 8.7 The strategy meeting may conclude that further tests and assessment are required to fully rule out a medical cause for the presenting illness, and/or that further information about the parents' understanding of the illness and management of it is needed before concluding that the illness is being fabricated. In this situation children's social care will complete an initial assessment in conjunction with the medical assessment and a date will be set for a review strategy meeting.

Working Together

- 8.8 When fabricated or induced illness by a carer is suspected, children's social care will conduct 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.
- 8.9 If, at the referral stage or at any time during the initial assessment, it is confirmed that the child is at risk of significant harm, then an assessment under section 47 of the Children Act 1989 must be initiated.

Section 47 enquiries

- 8.10 The nature of any further medical tests will depend on the evidence available about how the symptoms might be caused. A range of specialist assessments may be required, e.g. from physiotherapists, occupational therapists, speech therapists and child psychologists, from child and adolescent mental health professionals and from adult mental health and social care professionals.
- 8.11 The core assessment should include particular consideration of:
- The mental health history of the parent/carer;
 - The receipt of any state benefits and charitable donations relating to a disabled child; and
 - Any history of criminal involvement

That may provide insight into the actions of the parent.

- 8.12 If a psychiatric or psychological assessment of the child's carer is to be arranged, and the assessing psychiatrist/psychologist is to be asked to comment about current or proposed treatment, then this question should distinguish between treatment to meet the carer's needs and treatment to reduce risk to the child. These aims are not necessarily the same.
- 8.13 All staff must take careful and detailed notes, recording any unusual events and distinguishing between events recorded by the carer and those actually witnessed by staff from their onset. Notes should be timed, dated and signed legibly, and must be kept in a secure place so that they cannot be accessed by unauthorised persons.
- 8.14 If medical tests identify a medical condition which explains the child's symptoms, no further child protection action may be considered necessary. Where tests and assessments do not identify a clear explanation for the child's symptoms, or where there is no independent evidence of the existence of the symptoms when the child is constantly observed or is separated from the carer, a child protection conference should be arranged. This conference will make decisions regarding the threshold of significant harm and the need for a child protection plan.

9. CRIMINAL INVESTIGATION

- 9.1 The Police have a key role in helping health and children's social care staff understand the reasons for the parent/carer's behaviour and for identifying where criminal investigation is necessary and appropriate.
- 9.2 The nature and timing of any criminal investigations will depend on the medical evidence. Whether or not these investigations reveal grounds for instigating criminal proceedings, the Police should make the evidence they gather available to other professionals to inform discussions about the child's welfare and health needs.

10. COVERT VIDEO SURVEILLANCE

- 10.1 In cases in which fabricated or induced illness is suspected, the strategy discussion may conclude that it is appropriate to use covert video surveillance. This should only be considered if there is no other way of obtaining information which will explain the child's symptoms, and the multi-agency strategy discussion feels that its use is justified. The strategy discussion must involve the Police, children's social care, the consultant responsible for the child's health care and the senior ward nurse. It is important that only those who need to know that covert video surveillance is being used are involved in discussions and planning about its use.
- 10.2 If the strategy discussion decides to use covert video surveillance, the Police will undertake the surveillance. They will supply and install any equipment and will be responsible for the security and archiving of the videotapes, and a police manager will be accountable for the operation.
- 10.3 Before carrying out covert video surveillance the Police must obtain authorisation from an officer of the rank of Superintendent or above, which will only be granted if they can demonstrate that it is necessary to detect or prevent crime and that the evidence cannot be gathered by other less intrusive means.
- 10.4 The Chief Executive of an NHS Trust or Foundation Trust should be kept informed of any decision to apply for authorisation to use covert video surveillance in the Trust.
- 10.5 The safety (both long and short term) and health of the child is the overriding factor in the planning and carrying out of covert video surveillance. The primary aim is to identify whether the child is having illness induced. The obtaining of criminal evidence is of secondary importance.

Working Together

- 10.6 The Police should carry out any work within a hospital sensitively, keeping any disruption to normal ward life to a minimum. Any arrest or interview in a hospital setting should be carried out as sensitively as possible, ideally using plain clothes officers. The inter-agency management team should, if possible consider the arrest strategy well in advance of it being carried out.
- 10.7 The strategy meeting should establish a contingency plan which can be implemented immediately if the surveillance provides evidence that the child is being harmed.

11. CHILD PROTECTION CONFERENCES

- 11.1 When arranging a child protection conference, consideration should be given to inviting a professional who has expertise in working with fabricated or induced illness. It is also important to consider inviting, or seeking advice from, a medical professional who has expertise in the branch of paediatric medicine which deals with the symptoms and illness processes caused by the suspected abuse.
- 11.2 The extent and manner of involvement of family members in the conference should be carefully considered. An abusing carer may not feel able to acknowledge their behaviour to their partner or within the conference forum. A non-abusing carer may not wish to discuss the level of their awareness in front of the other parent. The conference chair must ensure that the conference provides both the abusing and non abusing parent with the best opportunity to present their views and wishes to the conference in order that the decision and any child protection planning is informed by this information.
- 11.4 If it is necessary to institute legal proceedings to protect the child, it is important that the doctors involved agree to support this action, as their medical evidence will be a key part of the case presented to the court.
- 11.5 In drawing up the outline child protection plan, particular attention should be given to the nature of contact between the child and the parents/carers to ensure it does not offer another opportunity to repeat the abuse. This may mean that contact has to be closely supervised –
- Where a family member is expected to provide this supervision it is vital that they are assessed as capable of undertaking this task and that they are continuously supported in this task with a 24 hour contact number for support and advice as required.
 - Where the risk of harm is assessed as high supervision will be best provided by a professional whose level of knowledge enables them to be alert to the precursors of further abusive behaviour.

- 11.6 The conference should consider the parents' medical and psychiatric histories. Services for the parents may be required immediately if, for example, there is a history of self-harming behaviour or a likelihood of a parent attempting suicide or developing other types of psychiatric symptoms.

12. THE CORE ASSESSMENT AND THE CHILD PROTECTION PLAN

- 12.1 In cases of fabricated or induced illness, the core assessment should particularly address:

- The need to clarify the cause of any presenting symptoms, illness or developmental delay, i.e. what may be organic in origin and what is likely to be related to abuse;
- The drivers for the actions of the abusing parent and where relevant their own mental health needs;
- The capacity of the abusing parent to recognise the damage they have done to their child's health and emotional welfare and their ability to change;
It may be helpful for an adult psychiatrist with expertise in this area to inform this part of the assessment.
- The capacity of each potential caregiver in the family to understand the abuse and their ability to believe that the child has been abused by another member of the family;
- The capacity of the non abusing parent to acknowledge the abusive actions and level of risk presented by the abusing parents and their ability to act to protect the child;
- The nature of the child's relationship with each family member and how he/she is perceived in the family and the local community;
- How the child's siblings perceive her/his health.

- 12.2 Children who have had illness fabricated or induced may continue to experience the consequences whether they are reunited with their families or placed in new families, particularly in relation to their behavioural and emotional development. Some children may be very aware of, for example, being given un-prescribed substances or being encouraged to feign illness. Some may choose to co-operate with the abuse in order to maintain current family relationships; others, as a result of the way that the parent has taught them to behave, may not be able to distinguish between reality and fabrication. These issues must be addressed in the overall plan for therapeutic work with the child and family.

13. RECORD KEEPING AND CHRONOLOGY

- 13.1 All records should be kept securely to prevent unauthorised access and ensure that they cannot be interfered with. In certain circumstances, where a child's safety is at risk, it may be necessary to create a supplementary record and hold it separately from the child's main records. This should not extend to keeping full duplicate records except in exceptional circumstances. A decision to keep supplementary records should be made at the strategy discussion.
- 13.2 Where it is considered that illness may be being fabricated or induced, the records relating to the child's symptoms, illnesses, diagnosis and treatments should always include the name (and agency) of the person who gave or reported the information, and should be dated and signed legibly.
- 13.3 When there are concerns about possible fabricated or induced illness, children's social care will collate the relevant information into a detailed chronology. This should include the medical, psychiatric and social histories of the child, parents, siblings and other significant family members. The chronology should allow a reader to track
- The relevant history of the child and family which led to any statutory intervention;
 - The nature of these interventions, including planned outcomes;
 - The means by which change is to be achieved; and
 - The progress which is being made in achieving these outcomes.
- 13.4 The chronology should enable patterns of presentation for medical treatment to be recognised not only for the child but also across generational boundaries. It will also inform decisions about how best to provide the services necessary to safeguard the child's welfare and achieve change in the family.