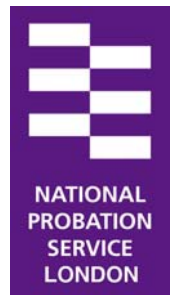




FABRICATED OR INDUCED ILLNESS IN A CHILD



a
KINGSTON
PROTOCOL



Working together for a safer London



DEFINITION

'Illness in a child which is fabricated or induced by a parent or someone who is in *loco parentis*' (Royal College of Paediatrics and Child Health)

A condition whereby a child suffers harm through the deliberate action of her/his main carer and which is duplicitously attribute by the adult to another cause.

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

- Fabrication of signs and symptoms, including fabrication of past medical history;
- Fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluid;
- Induction of illness by a variety of means.

The above three methods are not mutually exclusive.

Existing diagnosed illness in a child do not exclude the possibility of induced illnesses. The very presence of an illness can act as a stimulus to the abnormal behaviour and also provide the carer with opportunities for inducing symptoms.

IMPACT ON THE CHILD

The age of children in whom illness is fabricated or induced extends throughout childhood, although it is most commonly identified in younger children.

The adoption of the term Fabricated or Induced Illness (FII) symbolizes a wide spectrum of physical injury and psychological harm.

Many of the children that do not die as a result of having their illness fabricated or induced, suffer significant long term consequences.

Fabrication of illness may not necessarily result in a child experiencing physical harm, but there may be concerns about the child suffering emotional harm. They may suffer emotional harm as a result of an abnormal relationship with their mother and or disturbed family relationships. Depending on the age of the child, fabrication or induction of illness could result in feeding disorders in infants, withdrawal and hyperactivity in pre-school children and direct fabrication or exaggeration of physical symptoms by older children and adolescents

(*Safeguarding Children in whom illness is Fabricated or Induced* - DoH 2002)

In working with cases of suspected fabricated or induced illness, the focus has to be on child' physical and emotional health and welfare in the long term as well as immediately, and the likelihood of the child suffering significant harm

(*Fabricated or induced illness by Carers – Royal College of Paediatrics and Child Health*)

PERPETRATORS

There is no evidence to support a unique profile of carers who fabricate or induce illness in their children.

- Perpetrators are mothers in 85% to 89% of cases (*McClure 1996 and Royal College of Paediatrics and Child Health – 2002*)
- There is however, evidence that some of these parents have aspects of their histories which have been troubled:
 - Have history of physical or sexual abuse as child, been in local authority care or had childhood mental health issues
 - Have a history of unusual illness
 - Have Munchausen Syndrome or somatisation disorder
- Other aspects of their behaviour may include:
 - Not as concerned about child as medical personnel
 - Remain with child on ward constantly
 - Invest significant emotional/intellectual effort in the illness
 - Have a history of conduct or eating disorders/ contact with mental health agencies
 - Other carer uninvolved in child care
 - Reports of distant passive father ('*FII by Carers' Royal College of Paediatrics and Child Health – 2002*)

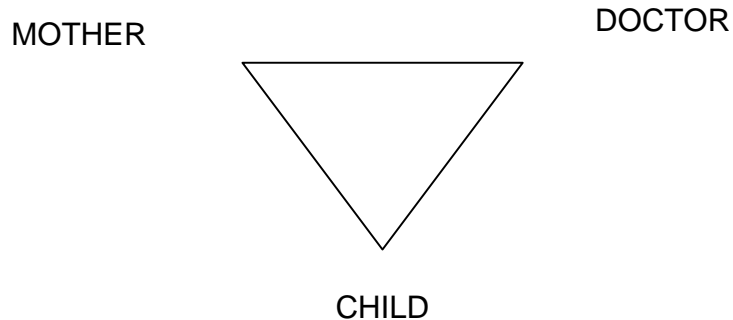
RECOGNITION / PRESENTATION

All practitioners who come into contact with children and their carers may come into contact with a child or carer where there are suspicions of FII.

These suspicions are likely to centre on discrepancies between what the carer says and what the practitioner observes.

In identifying and recognizing FII, professionals need to concentrate on the interaction of three variables:

1. the central one is the state of health of the child, which may vary from being entirely healthy to being sick;
2. the parental view which at one end is neglectful, and at the other end causes excessive intervention either directly or indirectly;
3. The doctors view which is equally on a spectrum from being dismissive at one end, to performing excessive intervention or treatment at the other



Concerns may arise 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 investigations do not explain reported symptoms and signs; or
- New symptoms are reported on resolution of previous ones; or
- Reported symptoms and found signs are not observed in the absence of the carer; or
- The child's normal daily life activities are being curtailed beyond that which may be expected from any known medical disorder from which the child is known to suffer
- Treatment for an agreed condition does not produce the expected effects; or
- Repeated presentations to a variety of doctors and with a variety of problems; or
- Specific problems, e.g. apnoea, fits, choking or collapse; or
- History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family
- A past history in the carer of child abuse, self harm or somatising or false allegations of physical or sexual assault.

ROLES AND RESPONSIBILITIES

(Please refer to 'Safeguarding Children in whom Illness is Fabricated or Induced'
HM Gov. 2002)

HANDLING INDIVIDUAL CASES

MEDICAL EVALUATION

The signs and symptoms require careful medical evaluation for a range of possible diagnoses. Where a reason cannot be found for the signs and symptoms, specialist advice and tests may be required. Normally, the doctor would tell the parent/s that s/he has not found the explanation and record the parental response.

Parents should be kept informed of further assessments / investigations / tests required and of the findings.

At no time should concerns about the reasons for the child's signs and symptoms be shared with parents if this information would jeopardise the child's safety.

If the child requires immediate protection, please refer to your local child protection procedures.

REFERRAL

1. When a possible explanation for the signs and symptoms is that they may have been fabricated or induced by a carer and as a consequence the child's health or development is or is likely to be impaired a referral should be made to Children Social Care Services Safeguarding Team, using the inter-agency referral form (Appendix 3).
2. At the point where a professional starts to suspect possible fabricated or induced illness in a child, he/ she should immediately **start to implement RBK Chronology** (Appendix 1)
3. While professionals should seek, in general to discuss any concerns with the family and where possible, seek their agreement to making referrals to Children Social Care Services, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk or significant harm.** The referrer, Children Social Care Services and CAIT (Child Abuse Investigation Team) should agree what the parents will be told, by whom and when.
4. The paediatric consultant has responsibility for the child's health care and decisions pertaining to it. In order to safeguard the child's welfare it is important that all three disciplines work closely together in making and

taking forward decisions about future action, recognising each other's roles and responsibilities.

5. Referrals may lead to no further action or to an initial assessment of the needs and circumstances of the child, and the provision of services or other help.
6. Sometimes it may be apparent at this stage that emergency action should be taken to safeguard a child. Emergency action should normally be preceded by an immediate strategy discussion between the police, Children Social Care Services, health and other agencies as appropriate.

INITIAL ASSESSMENT

An initial assessment under s.17 of the Children Act 1989, is undertaken to determine 'whether the child is in need, the nature of any services required, and whether a further more detailed core assessment should be undertaken' following the guidance set out in the *Assessment Framework*.

This should be carefully planned, with clarity about who is doing what, when and what information is to be shared with the parents.

On completion of the initial assessment, Children Social Care Services together with the medical consultant responsible for the child's health care should decide on the next course of action. Concerns should not be raised with the parent if it is judged that this action will jeopardize the child's safety.

NEXT STEPS

No Suspected Actual or Likely Significant Harm. The child may be in need and it may be appropriate to undertake a core assessment in order to determine what help may benefit the child and the family

Suspected Actual or Likely Significant Harm. Social Services to call a strategy meeting and to initiate enquiries under s.47

Careful thought should be given to what parents are told and by whom.

Children Social Care Services should involve Police and the child medical consultant in making these decisions.

IMMEDIATE PROTECTION

If at any point there is medical evidence to indicate that the child's life is at risk or there is likelihood of serious impairment of harm, an agency with statutory child protection powers should act quickly to secure the immediate safety of the

children considering whether emergency action is necessary, an agency should always consider whether action is also required to safeguard other children in the same household, the household of an alleged perpetrator, or elsewhere.

OUTCOME OF ENQUIRIES

Concerns not substantiated. Medical evaluations may reveal a medical condition which requires treatment and/or monitoring. Child and parents may still require support under s.17

Concerns substantiated but the child is not judged to be at risk of significant harm. In this case the decision not to proceed to a child protection conference should be endorsed by the Principal Manager

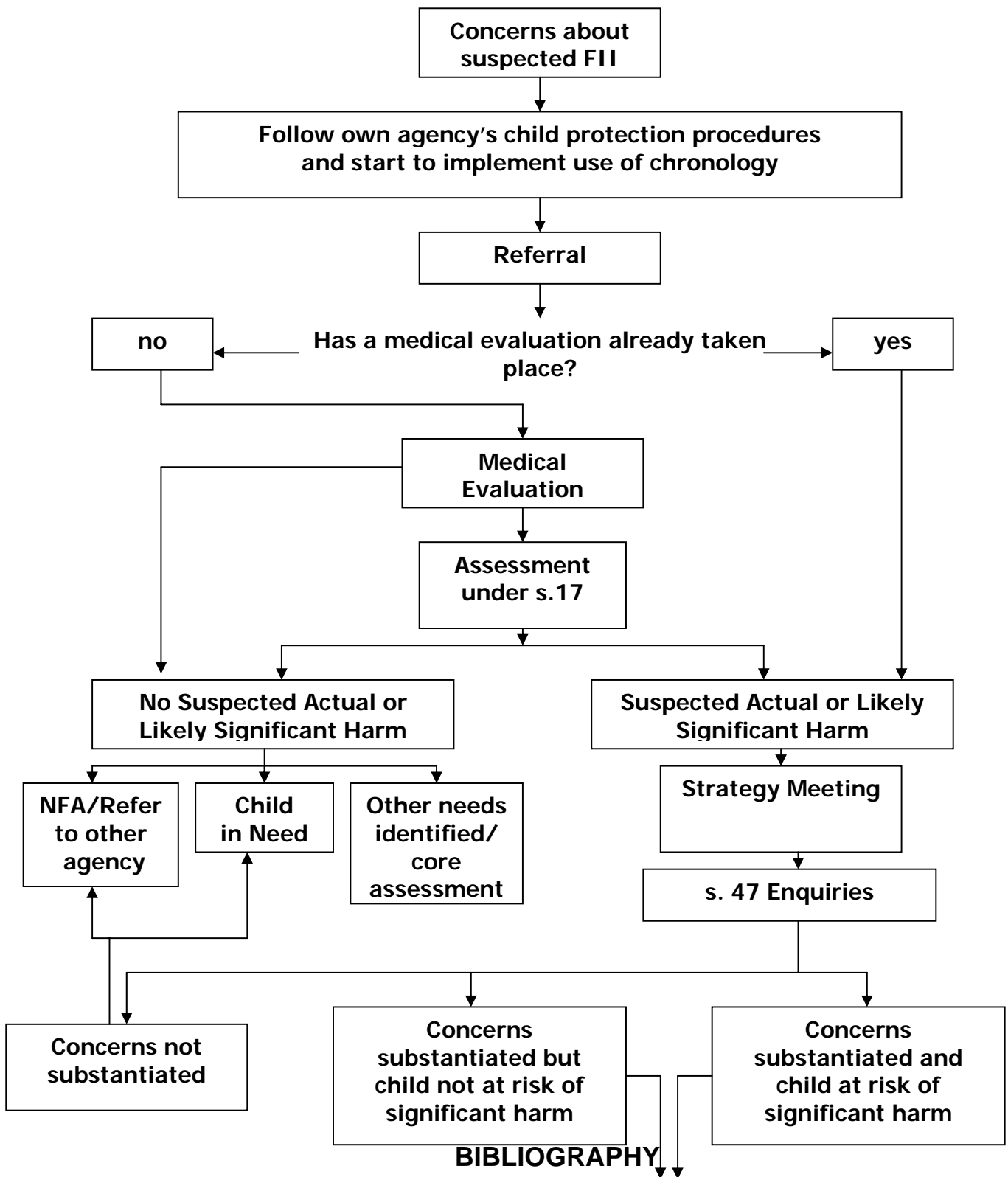
Concerns substantiated and the child is not judged to be at risk of significant harm. In this case, Children Social Care Services should convene a child protection conference to assess all relevant information, and plan how to safeguard the child and promote his/her welfare.

CONTACTS

AGENCY	DESIGNATED PROFESSIONAL		CONTACT NUMBER
	TITLE	NAME	
Kingston Hospital	Consultant Paediatrician	Dr Walid Anshasi	020 8934 3400
	Named Midwife	Sue Byford	020 8546 7711 x2741
	Named Nurse	Anne Boatman	020 8934 3401
KPCT	Designated Nurse	Rani Stewart	020 8546 1115 x318
	Named Nurse	Sara Patience	020 8546 1115 x307
	Named GP	Vacant	-
Police CAIT	DI	Pat Lewis	020 8247 7800
Children Social Care	Lead Strategic Manager, Children's Services & Safeguarding	Eoin Rush	020 8547 4725
ASKK	Service Manager	Claire Fry	020 8547 6505
Education	Principal EWO	Ming Zhang	020 8547 5243
CAMHS	Cons. Child Psychiatrist	Dr Diana Cassell	020 8296 1381
CAFCASS	Service Manager	David Stephens	020 8541 0233
Adult Mental Health Services	Named Nurse	Janette Brown	020 8682 6391

FLOW CHART

(Please also refer to 'What to do if you're worried a child is being abused' H M Gov. 2003)



Does the child require immediate protection?

This document is based on: Child Protection Conference

'Safeguarding Children in whom Illness is Fabricated or Induced' - DH, Home Office, DfES, Welsh Assembly Government 2002

'Working Together to Safeguard Children' DH 2006

'The Framework for the Assessment of Children in Need and their Families' DH 2000

'What to do if you're worried a child is being abused' 2003

'Children Act' 1989

'London Child Protection Procedures' second Edition 2003

'Fabricated or Induced Illness by Carers' Royal College of Paediatrics and Child Health 2002

APPENDIX 1

CHRONOLOGY

Purpose:

- Enables patterns of presentation for medical treatment to be recognised for child and across generational boundaries
- Informs decisions about services and change should include:
 - Medical, psychiatric and social histories of child, parents, siblings and significant others

Child's Name:

d.o.b.:

Address:

Family Composition:

Date	Location	Name of professional/s involved	Episode/ symptom/information	Source of information	Investigation	Treatment including duration of stay	Presumptive diagnosis	Discrepancies/ comments

APPENDIX 2

SCREENING OF A REFERRAL

New referrals and those on closed cases should be made to the duty officer of SSD. Referrals on open cases should be made to the allocated social worker (or in her/his absence the manager or a duty officer).

All referrals to SSD should initially be regarded as children in potential need, and the referral should be evaluated on the day of receipt (and no later than within 1 working day), and a decision made regarding the next course of action.

When taking a referral, staff must establish as much of the following information as possible:

- Full names, date of birth and gender of child/ren
- Family address and (where relevant) school / nursery attended
- Identity of those with parental responsibility
- Names and date of birth of all household members
- Ethnicity, first language and religion of children and parents/carers
- Any special needs of child/ren
- Any significant/important recent or historical events/incidents in child or family's life
- Cause for concern including details of any allegations, their sources, timing and location
- Child's current location and emotional and physical condition
- Whether the child needs immediate protection
- Details of alleged perpetrator, if relevant
- Referrer's relationship and knowledge of child and parents/carers
- Known involvement of other agencies/professionals e.g. GP
- Information regarding parental knowledge of, and agreement to, the referral

All professional referrals should be confirmed in writing, by the referrer, within 48 hours, using the RBK interagency referral form.