Summary guidance based on the Royal College Paediatrics Child Health (RCPCH) FII Practical Guide

For full guidance please refer to:
https://www.rcpch.ac.uk/sites/default/files/Fabricated_or_Induced_Illness_by_Carers_A_Practical_Guide_for_Paediatricians_2009.pdf

This guidance is aimed to provide clarity around the responsibility and accountability of professionals/ practitioners (both medical and non-medical) when concerns regarding potential FII are identified

Contents

1. INTRODUCTION

1.1 Fabricated or Induced Illness by Carers (FII) can cause significant harm to children. FII involves a well child being presented by a carer as ill or disabled, or an ill or disabled child being presented with a more significant problem than he or she has in reality, and suffering harm as a consequence.

1.2 Fabricated and Induced Illness was first described as Munchausen Syndrome by Proxy (MSbP) in the Lancet in 1977: *'Here are described parents who, by falsification, caused their children innumerable harmful hospital procedures – a sort of Munchausen syndrome by proxy'*. This and other early reports on Munchausen Syndrome by Proxy focused mainly on severe cases where the implication was that the carer was deliberately fabricating or inducing illness in the child.

1.3 These early descriptions reflect those cases where a carer actively promotes the sick role by **exaggeration**, **non-treatment** of real problems, **fabrication** (lying) or falsification of signs, and/or **induction** of illness.

In severe cases, some of the behaviours by a carer that may result in harm include:

- Deliberately inducing symptoms by administering medication or other substances (this includes non-accidental poisoning), or by intentional suffocation;
- Interfering with treatments by over-dosing, not administering medication, or interfering with medical equipment such as infusion lines;

- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequent passing of urine, vomiting, or fits, resulting in unnecessary investigations and treatments;
- Exaggerating symptoms, again resulting in unnecessary investigations and treatments;
- Falsifying test results and observation charts;
- Obtaining specialist treatments or equipment for children which are not required;
- Alleging unfounded psychological illness in a child.

1.4 In addition to these severe cases, there are others where a child may present for medical attention with unusual or puzzling symptoms which are not attributable to any organic disease, and yet which do not involve deliberate fabrication or deception. There may be a spectrum of cases; for example, the child's carer may be over-anxious, may genuinely believe that the child is ill due to misinformation, or may have mental health problems.

1.5 The common feature linking these presentations is that the carer reports symptoms or signs, which initially suggests a significant disease, and yet appropriate clinical examination and investigation do not reveal any natural disease to adequately account for the child's illness

1.6 Whether the carer is deliberately fabricating a child's illness, genuinely believes the child to be ill or is unduly anxious, the harm caused to the child can be significant and may include:

- Frequent and invasive medical investigations;
- Unnecessary treatments;
- Missed education and social isolation;
- Limitation in daily life and the adoption of a sick role or lifestyle as a disabled person;
- Characterisation as being disabled, through the receipt of disability benefits or special educational provision;
- The child becoming anxious or confused about their state of health and abilities.

1.7 There will of course also be cases where an unrecognised genuine medical problem becomes apparent after initial concern about FII.

1.8 In the absence of universal agreement on the definition of FII, when dealing with a case of possible FII, it is essential to describe as accurately as possible: any genuine illness, the child's symptoms, what has happened to the child, and any harm that has or could have resulted. Detailed descriptions of the impact of the carer's behaviour on the child are more useful than 'pseudo-diagnostic' labels which may distract from the central issue of harm to the child. The determination of what, if any, harm has been caused to the child is most important consideration. In addition, given the broad spectrum of cases, when dealing with a case of suspected FII, the starting position should always be that the cause of the child's illness is unknown.

2. IMPACT OF FII ON HEALTH AND DEVELOPMENT OF CHILD

2.1 FII can cause death, disability, physical illness, and emotional problems. There are significant risks of re-abuse. Following identification of FII in a child, the way in which the case is managed has a major impact on the developmental outcomes for the child.

3. PAEDIATRIC/MEDICAL PROFESSIONALS MANAGEMENT OF CASES

3.1 Indicators which should alert professionals to the possibility of FII

- A carer reporting symptoms and observed signs that are not explained by any known medical condition.
- Physical examination and results of investigations that do not explain symptoms or signs reported by the carer.
- The child having an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment.
- Acute symptoms that are exclusively observed by/in the presence of the carer.
- On resolution of the child's presenting problems, the carer reporting new symptoms or reporting symptoms in different children in sequence.
- The child's daily life and activities being limited beyond what is expected due to any disorder from which the child is known to suffer, for example, partial or no school attendance and the use of seemingly unnecessary special aids.
- Objective evidence of fabrication – for example, the history of events given by different observers appearing to be in conflict or being biologically implausible (such as small infants with a history of very large blood losses who do not become anaemic, or infants with large negative fluid balance who do not lose weight); test results such as toxicology studies or blood typing; evidence of fabrication or induction from covert video surveillance (CVS).
- The carer expressing concern that they are under suspicion of FII, or relatives raising concerns about FII.
- The carer seeking multiple opinions inappropriately.
- The carer falsifying clinic letters and or amending observation charts from health professionals.

3.2 Early recognition

- Suspect FII when the clinical features do not make sense (see Indicators for possible FII above).
- When FII is included in the differential diagnosis, put equal effort into confirming or excluding the diagnosis of FII and the exploration for genuine disease.
- **FII is not a 'diagnosis of exclusion' and continued investigations for other less probable physical diagnoses may cause the child further harm.**
- Proceed in a timely manner to the investigation which is most likely to confirm a diagnosis either of FII or an organic condition.
- Consider the differential diagnosis as below- is this child's 'illness' likely to fall into another category?

1) Simple anxiety, lack of knowledge about illness, over interpretation of normal or trivial features of childhood; may in some cases be associated with depressive illness in carer.
2) Child's symptoms are misperceived, perpetuated or reinforced by the carer's behaviour; carer may genuinely believe the child is ill or may have fixed beliefs about illness
3) Carer actively promotes sick role by **exaggeration**, **nontreatment** of real problems, **fabrication** (lying) or **falsification** of signs, and/or **induction** of illness (sometimes referred to as 'true' FII)
4) Carer suffers from psychiatric illness (e.g. delusional disorder) which leads them to believe child is ill
5) Unrecognised genuine medical problem becomes apparent after initial concern about FII

3.3 Initial management - non medical professionals/practitioners

For local pathway regarding FII concerns raised with non-medical professionals/practitioners please refer to flow chart 1 (below) in addition to this guidance. The Education Team should also refer to this.

3.4 Initial medical management

- Agree who will assume role of '**responsible paediatric consultant**" (RPC). If siblings are involved, consider lead consultant for each child.
- Use this guidance in conjunction with government publications (refer to RCPCH guidance references)
- Document early concerns in the child's case notes so that other clinicians will have access to that information. Carers' access to records may need to be restricted.
- Discuss concerns with Named and Designated Health Professionals and other relevant colleagues, including nursing staff involved with the child.
- Conduct and document an immediate assessment of the risk of harm based on available information: Is the child in need of immediate protection?
- If the child is not currently in hospital, consider whether a planned admission with careful observation would help to elucidate the clinical diagnosis.
- Consider whether any immediate investigations or further opinions are likely to assist in the diagnosis.
- Consider constant supervision of the child or other measures to reduce the risk of immediate harm.
- Stop any harmful treatments or invasive procedures unless they are clearly indicated. It is unacceptable to cause the child further iatrogenic harm whilst the diagnosis of FII is being considered.
- Consider whether there is concern that the child may be at risk of significant harm – if that concern cannot be resolved quickly and simply then a referral should be made.
- Do not wait to confirm the diagnosis before referring to Children's Social Care as delay may be detrimental to the child.
- If there is a risk of immediate harm to the child through illness induction, or harm through the carer's disagreement with the need for further observation or with

paediatric consensus about the child's state of health a referral to Children's Social Care must be made.
- Prepare a chronology.

At this stage concerns about FII cannot be discussed with the family as the child may be put at risk.

3.5 The initial and full medical chronology

- Arrange for a chronology to be compiled in all cases of suspected FII. If a referral is made, then the aim is to have the initial chronology completed within 28 days unless there is very serious risk of harm. It is the responsibility of the RPC to complete the chronology and if required, advice/guidance is available from the named doctors.
- If the timescales of 28 days are not achievable, the RPC should discuss the additional time needed for FII work with service leads and managers (i.e. their own safeguarding lead, Children's Social Care, Police etc.).
- Agree with Trust management for adequate time and resources to be allocated.
- Access records from other centres, on the basis that you are trying to get to the root of the child's problems, and it would be helpful to draw together the entire medical history. At this stage it will not be appropriate to disclose to the carers that there are concerns about FII.
- The chronology will probably need to be done in stages as records from different services become available.
- Use the standard template agreed.
- When available, review the chronology and consider diagnosis. Share with clinical colleagues and within a multiagency setting if appropriate.

3.6 Further medical management

- Ensure that the responsible paediatric consultant maintains continuity and control of the case, irrespective of the involvement of other professionals.
- Resist requests for a change of clinical team or hospital as this may place the child at risk of harm.
- A clinical report should be prepared for the multi-agency strategy discussion outlining the medical concerns (see sub-section in chapter 6 RCPCH guidance on 'The Strategy Discussion in FII Cases').
- If the child is not at immediate risk of harm, consider whether further investigations or opinions are likely to assist. Are special forensic tests likely to help? If so, discuss these in the strategy discussion (see chapter 6 RCPCH guidance).
- Keep detailed and meticulous medical and nursing records, recording all investigations, observations and consent (see chapter 9 RCPCH guidance for more detail on record management).
- Clinical and child protection plans must be shared with 'on call' staff in handover meetings and in Community setting with wider team involved in the child's care.
- Consider whether the case may require the use of CVS (see Appendix 2 RCPCH guidance). If so, discuss this in the Strategy Discussion.
- Ensure that any decisions to undertake CVS is recorded in the child's record held by each agency involved in the decision, and that this is signed by the Chief Executive where the CVS is to take place.

3.7 Identification of genuine illness

- If a genuine cause for the child's symptoms and signs is found and the possibility of FII is excluded, communicate this immediately and clearly to the clinical team, including primary and secondary care, and to Children's Social Care. Inform other agencies e.g. Education and Police who may have raised concerns initially.
- Always remember that genuine disease and FII may co-exist.
- If the carers were already aware that FII was being considered, ensure that a full explanation is provided, and an apology offered for any distress caused. Lead Consultant and lead social worker involved in case to jointly feedback to carers.

4 INITIAL CONSIDERATION OF REFERRAL TO CHILDREN'S SOCIAL CARE

As with all other referrals, LAs Children's Social Care should decide, within one working day, what response is necessary. Delay should be avoided by all agencies in all circumstances. (Threshold Document)

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, LA children's social care and consultant paediatrician, bearing in mind the safety of the child and the conduct of any police investigations.

The potential outcome of referrals is the same as for any other referral. See Referral and Assessment Procedures.

4.1 Assessments, Outcomes and Immediate Protection.

If the threshold for Section 17 assessment is met , the LA Children's Social Care should undertake an assessment, as with all referrals (see Referral and Assessment Procedures), in collaboration with the paediatrician responsible for the child's health care, as well as relevant other agencies (e.g. the child's school).

The potential outcomes of the assessment should be as described for other referrals in the Referral and Assessment Procedures. 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 a child's life is in danger through poisoning or toxic substances being introduced into the child's bloodstream) (see Child Protection Enquiries Procedure) an immediate strategy meeting/discussion should take place (see section below) and legal advice must be sought.

Concerns should not be raised with a parent if there is concern that this action will jeopardise the child's safety or where it may undermine a timely criminal investigation

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

The strategy meeting should be convened in line with Child Protection Enquiries Procedure. The meeting should be chaired by the LA Children's Social Care manager.

Participants must include LA 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 education settings;
- Local authority would consider if legal advice is required at the meeting.

In cases of possible FII, it may be necessary not to tell the parents about the meeting prior to it taking place in order to protect the child.

The LA to consider whether Legal advice is required. Confidentiality at this stage is very important.

5 STRATEGY DISCUSSIONS IN FII CASES

5.1 The strategy discussion should decide whether to initiate a formal enquiry under section 47 of the Children Act 1989. For complex cases, more than one strategy discussion and/or meeting may be required. The discussion should include consideration of:

- **The level of risk of harm to the child;**
- **Any immediate steps necessary to reduce the risk of harm (for example,**
- **cancelling unnecessary medical procedures or instituting closer observation of**
- **the child);**
- **Communication with carers and confidentiality (including how, when, and by**
- **whom they should be informed of any child protection concerns);**
- **How the child can be given an opportunity to tell their story – this requires**
- **careful consideration and planning;**
- **Any outstanding investigations, further information gathering, and opinions**
- **that would be helpful;**
- **the responsibility for the Social Care assessment lays with the LAs Social Care;**
- **The security of medical records**
- **The level of professional observation required**
- **Whether the carers should be allowed on the ward if the child is an inpatient**
  - **if this is deemed to be unsafe then an emergency order may be required**

- **which will need to be instituted by either the police or the local authority;**
- **Any potential implications for other patients or their carers who are on the**
- **ward at that time;**
- **The planning of further medical and nursing assessment;**
- **The need for forensic sampling, special observation or Convert Video Surveillance (CVS) (see chapter 5 RCPCH guidance);**
- **The needs of siblings and other children in the family;**
- **The needs of carers, particularly after disclosure of concerns;**
- **The development of an integrated health chronology (and agreement on who**
- **should do this);**
- **Confirmation of who will be the responsible paediatric consultant for the child;**
- **Any further opinions needed (including specialist child protection opinion or**
- **to address a specific clinical issue);**
- **What is known about the carers' past behaviour, medical history, current health**
- **state and any treatment, equipment, aids or benefits being received either for**
- **themselves or the child.**

5.2 The strategy discussion

- Ensure key staff are present including the responsible paediatric consultant,
- senior nursing staff and the GP most familiar with the child and family (if unclear to be decided with the practice manager).
- Ensure minutes and agreed multiagency actions from the social worker (Local Authority Children's Social Care) is available.
- Ensure a number of key issues are on the agenda and action points requiring
- input from health staff are documented and allocated.

5.3 Sharing concerns with the child's carers

- Ensure this meeting is carefully planned by a multi-agency team (usually as
- part of the strategy discussion).
- Ensure that the medical diagnosis is explained in a non-judgemental,
- dispassionate, truthful and honest way, and without causing unnecessary
- distress.
- Follow the principles involved in the disclosure of any other serious medical
- diagnosis, bearing in mind that an abusive carer will presumably be well aware
- of the cause of the child's illness but other family members may be totally unaware
- Consider how to support the perpetrator, family members, and staff after the
- disclosure meeting as this will be a very stressful event.
- Keep detailed records of the meeting.

5.4 Cases where neither organic disease nor FII is confirmed

- These children come under the broad umbrella of 'non-organic' symptoms.
- Consider whether the child (if older) could be fabricating their own illness.
- Explain the differential diagnosis and likely diagnosis to the carers.
- Explain that medicine may not have the answer and some children have to 'live with' their symptoms.
- Avoid the use of unscientific terminology.

- Avoid further investigations to look for the highly improbable which might risk causing further harm.
- Draw up a plan for rehabilitating the child if required.
- Consider making a CAMHS referral. For advice discuss with Named Doctor for Safeguarding CAMHS.
- If the carers request further investigations, then these should be considered with the RPC and where there are concerns that further investigation is not required then a referral should be made to Children's Social Care.

5.5 Longer term involvement of the child health team

- Ensure ongoing monitoring and review, whether or not the child remains within
- the family.
- Ensure the responsible paediatric consultant retains their role.
- Continue updating the chronology.
- Provide advice and reports in the child protection context.
- Facilitate contact with CAMHS or Adult Mental Health Services where
- appropriate – it will be important for mental health professionals to have a clear
- understanding of the paediatric issues.
- Continue to work in partnership with the carers and other agencies, with a clear
- focus on the welfare of the child.

Non-medical staff

Identification

All professionals who come into contact with children and their families, or adults who are parents, may come into contact with a child or parent where there are suspicions of fabricated or induced illness. These suspicions are likely to centre on discrepancies between what a parent says and what the professional observes.

In identifying and recognising fabricated or induced illness, professionals need to concentrate on the interaction of three variables:

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

Response

All professionals who have concerns about a child's health should discuss these with their line manager, their agency's designated safeguarding children adviser and the GP or paediatrician responsible for the child's health. If the child is receiving services from LA Children's Social Care, the concerns should also be discussed with them.

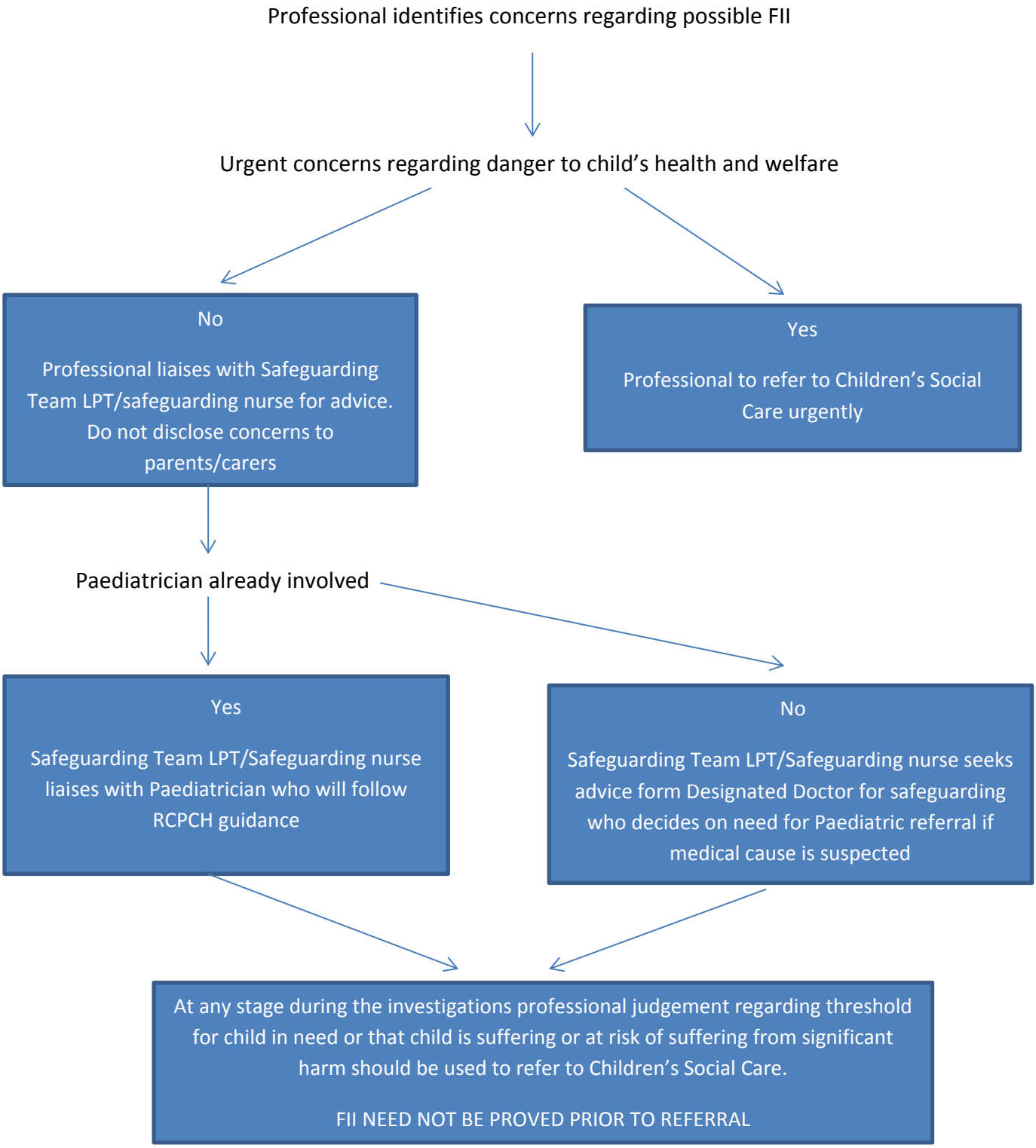
If any professional considers that their concerns are not taken seriously or responded to appropriately, they should discuss this as soon as possible with the designated doctor or nurse for child protection in their local authority area

If any concerns relate to a member of staff, professionals should discuss this with their line manager and their agency's designated safeguarding children adviser. See also Allegations Against Persons Who Work with Children procedure.

6 RECORD KEEPING

- Ensure strict adherence to current best practice in record keeping (see
- references to documentation above).
- Always document concerns about possible FII – failure to do so will prevent
- important information from being shared, thereby increasing the risk of harm
- to the child.
- **Carefully manage the carers access to medical records.**
- Ensure the records clearly identify the responsible paediatric consultant.
- Keep multi-disciplinary case records.
- Provide an appropriate summary of the case if records do not follow the patient
- between Trusts or clinical teams.
- Document all decisions made and all information that influenced these.
- Record the source of all information and, if appropriate, document verbatim
- comments.
- Ensure records are stored securely and that the responsible consultant and Trust
- are informed of this location and have access to the records.

FLOW CHART 1 FOR NON-MEDICAL PROFESSIONALS



FLOW CHART 2 FOR GPS

Concerns in primary care setting regarding possible FII

GP discusses case with their Named GP lead. Keep record of events.
Do not disclose concerns to parent/carer

Named GP lead may need to seek advice from Designated Doctor

Designated Doctor to consider need for referral to UHL/LPT if medical cause suspected

At any stage during the investigations, professional judgement regarding threshold for child in need or that the child is suffering or at risk of suffering from significant harm should be used to refer to Children's Social Care.

FII NEED NOT BE PROVED PRIOR TO REFERRAL