

# Safeguarding Children in whom there are Concerns that Illness is Fabricated or Induced Policy

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## 1 Introduction

- 1.1 Fabricated or Induced Illness by carers (FII) can cause significant harm to children. FII involves a well child 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. There are particular challenges for all professionals in terms of managing as FII case.
- 1.2 This policy should be followed if:
- There are concerns that illness may be fabricated or induced in a child.
  - There are concerns that the child's parent or carer may be fabricating or inducing illness in themselves and that this may cause harm to the child. Such concerns may also apply to unborn children.
  - An assessment of the *potential impact* of these risks upon the child should also be considered in the context of the age/vulnerability of the child concerned.
- 1.3 Professionals are expected to work in line with 'Safeguarding Children in Whom Illness is Fabricated or Induced' Safeguarding children in whom illness is fabricated or induced: The Department of Health – Pubs and stats: Publications (DoH 2008), which includes:
- Extensive guidance for inter-agency practice in handling individual cases.
  - Expected roles and responsibilities for a wide range of professionals working within Health, Children's Services, Police, Education etc.
  - Action to improve implementation of guidance for fabricated or induced illness.

This guidance is intended to provide a framework within which agencies and professionals at local level can work together when there are concerns that illness may be fabricated or induced in a child by a carer who has parenting responsibility. Health professionals should also refer to the guidance Fabricated or Induced illness by carers (FII): A Practical Guide for Paediatricians RCPCH (Oct 2009)<sup>1</sup>

## 2. Fabricated Illness

- 2.1 There are three main ways, not mutually exclusive, of a parent/carer fabricating or inducing illness in a child.
- Fabrication of signs and symptoms, for example, fabrication of past medical history.
  - Falsification of hospital charts, records, letters, documents and specimens of bodily fluids.
  - Induction of illness by a variety of means.

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<sup>1</sup> Fabricated or Induced illness by carers (FII): A Practical Guide for Paediatricians RCPCH (Oct 2009)

### **3. Behaviours Associated with Fabricated/Induced Illness**

Behaviours include:

- Deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation.
- Interfering with treatments by overdosing, not administering them or interfering with medical equipment such as infusion lines.
- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting, or fits.
- Exaggerating symptoms, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous.
- Obtaining specialist treatments or equipment for children who do not require them.
- Alleging psychological illness in a child.

### **4. Recognition**

- 4.1 Where illness is being fabricated or induced, extensive, unnecessary medical investigations may be carried out in order to establish the underlying causes for the reported signs and symptoms. The child may also have treatments prescribed or operations which are unnecessary. These investigations can result in children spending long periods of time in hospital and some, by their nature, may also place the child at risk of suffering from harm or even death.
- 4.2 Carers exhibit a range of behaviours when they believe that their child is ill. 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. Such abnormal behaviour can be present in one or both parents/carers and often involves passive compliance of the child. These behaviours by carers may constitute ill treatment (Section 31 (a) of the Children Act 1989).
- 4.3 Many incidents of concern can be warning signs of fabricated or induced illness and practitioners should note the attached 'Possible Warning Signs of Fabricated or Induced Illness Template.'

### **5 Sharing health Information when there are concerns regarding FII**

- 5.1 In all cases the overriding consideration in making decisions about information sharing must be the child's safety and wellbeing.
- 5.2 In situations of possible induced or fabricated illness practitioners should **not** discuss their concerns with the parents/carers. This is because such discussion may increase the risk of significant harm to the child. Decisions about what discussions are to take place with the

parents/carers are to be made on a multi-agency basis, following referral to Children's Services.

## **6. Discussion with Named or Designated Doctor for Child Protection**

In any case in which a paediatrician suspects FII they should discuss the case with the Named or Designated Doctor for Child Protection. In some cases it may be appropriate first to have a health professionals meeting to enable all health information about the child to be shared. At this meeting a decision should be made as to whether the child may be at risk of significant harm and if so a referral should be made to Children's Services.

- 6.1 In some cases the Designated Doctor for Child Protection, or the locality Safeguarding Children Team may choose to consult with the Safeguarding Service Manager, about the need for a referral to Children's Services.

## **7 Chronologies**

In all cases of suspected FII a chronology should be prepared. The preparation of the chronology should not delay intervention if this would put the child at increased risk of harm. It is the responsibility of the Responsible Paediatric Consultant to ensure that this chronology is completed. However it may be compiled by other health colleagues. Consideration should be given to contacting the Safeguarding Lead at NHS Direct to ascertain whether they have been contacted about the child.

## **8 Consent**

- 8.1 If you are suspicious a child may be suffering from FII then you should discuss the case further with a Consultant Paediatrician who, in turn should discuss this with the Designated Doctor for Child Protection.
- 8.2 Careful consideration should be given to consent issues. Consent should be sought for the sharing of such information unless doing so may:
- Lead to an unjustified delay in making enquiries about allegations of significant harm or
  - Put the child/ young person at increased risk of significant harm.
- Carers should be advised that this information is needed to help the doctor better understand the health concerns

## **9 Sharing health information without consent**

- 9.1 The key factors in deciding whether or not to share confidential information without consent are necessity and proportionality. i.e. whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing information overrides the interest in maintaining confidentiality. In making the decision the practitioner must weigh up what might happen if the information is shared against what might happen if it is not and make a decision based on professional judgement. The nature of the information to be shared is a factor in this decision making, particularly if it is sensitive information

where the implications of sharing may be especially significant for the individual or for their relationship with the practitioner and the service.

- 9.2 Where there is a clear risk of significant harm to a child the public interest test will almost certainly be satisfied. There will be some cases where the Practitioner will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action – the information shared should be necessary for the purpose and be proportionate. Information can be shared without consent if it can be justified under section 47 of the Children Act 1989 as prevention of significant harm or under a police investigation. The Children Act does not require information to be shared in breach of confidence but a practitioner should not refuse a request for information without considering the relative risks of sharing information, if necessary without consent, against the potential risk to the child if information is not shared.
- 9.3 If a decision is made to share confidential information without consent the Practitioner should explain to the carer that they intend to share the information and why, unless to do so may lead to an unjustified delay in making enquiries about allegations of significant harm or put the child/young person at increased risk of significant harm. It is important that any decisions made, are accurately documented and contemporaneous records are kept at all times.
- 9.4 In any case of doubt, advice should be sought from the Designated Doctor / Named Doctor / Named GP or the Safeguarding team/Designated Nurse.
- 9.5 For more on the legal background see Information Sharing: Further guidance on legal issues (2010)<sup>2</sup>

## **10 Referral to Children’s Services**

- 10.1 When a possible explanation for reported or actual signs and symptoms in a child is that they may have been fabricated or induced by a parent/carer and as a consequence the child’s health or development is being or is likely to be impaired, a referral should be made to Children’s Services. The referrer should make it clear in their referral that they are concerned about FII.
- 10.2 If the referrer is a health professional they should first discuss the case with child’s Paediatrician. If the child does not have a Paediatrician, the health professional should discuss the case with the Health Safeguarding Team or the on call Paediatrician who will advise on further management of the case. In all cases a Paediatrician should be identified who will act as the Responsible Paediatric Consultant and will take lead responsibility for all decisions about the child’s health care.
- 10.3 In all cases the Responsible Paediatric Consultant should discuss the case with the Designated or Named Doctor for Child Protection who will provide advice and support throughout the process.

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<sup>2</sup> Further guidance on legal issues://publications.education.gov.uk/eOrderingDownload/info-sharing\_legal-issues.pdf

- 10.4 At any stage the Responsible Paediatric Consultant may choose to consult with a team manager about the need for a referral to Children's Social Care and for a strategy meeting.
- 10.5 The referral may, for example, follow an evaluation of the child's signs and symptoms whilst an in-patient or be due to concerns held by professionals working with the child or concerns held by a member of the public who knows the child.

## **11. Response by Children's Services and Strategy meeting**

- 11.1 Upon receipt of a referral, Children's Services should undertake an Initial Assessment which must include a multi-agency strategy meeting. A series of strategy meetings may be required before a conclusion is reached on the need to start a Section 47 enquiry or core assessment. It may be helpful for the first strategy meeting to scope the nature of the concerns, agree what further information is needed, how this will be gathered, and also whether immediate action is required to safeguard the child. All agencies/professionals should produce a completed chronology in preparation for this or for a subsequent strategy meeting.(See section 26),
- 11.2 This meeting should be chaired by a Senior Team Manager with relevant experience in this area ( in some localities this may be the Independent Reviewing Officer).
- 11.3 In the vast majority of cases carers will not be aware that the strategy meeting is being held. In such cases professionals should not inform carers that the strategy meeting is occurring. Professionals should be aware that minutes from the Strategy Meeting may be shared with the family at a later date and if a case subsequently goes to Court will be made available for the Court Process.
- 11.4 Staff attending the Strategy meeting should be sufficiently senior to be able to make decisions on behalf of their agency.

## **12. Attendance at Strategy meetings**

- 12.1 The meeting should be organised to ensure that the following professionals can attend:
- Children's Services
  - Child Abuse Investigation Unit (police)
  - Designated Doctor/Responsible Paediatric Consultant
  - Relevant member of Safeguarding Children Team (PCT)
  - Named Nurse from the local acute NHS Foundation Trust
- 12.2 The following professionals may also be invited as necessary:
- Relevant Ward Nurse (if the child is an in-patient)
  - GP
  - Health Visitor



- Education staff as appropriate
- CAFCASS if involved
- The legal advisor to the Local Authority
- A medical professional who has expertise in the branch of medicine which deals with the symptoms and illness presenting

### **13. Decision making**

Decisions about what discussions are to take place with the parents/carers, and by whom, are to be made at the strategy meeting (and the referrer should be advised).

Support and supervision for staff completing reports for strategy meeting should be provided by their Child Protection Advisor or supervisor within their agency.

All agencies should provide chronologies for the strategy meetings.. These chronologies must be checked by the agency supervisor before submission to the meeting.

The strategy meeting should decide whether to initiate a formal enquiry under section 47 (CA 1989). For complex cases, more than one strategy discussion may be required.

The discussion should include:

### **14. Assessment of risk and safety planning**

1. The level of harm the child has already suffered;
2. The risk of future harm and any complicating factors;
3. Current safety arrangements already in place;
4. Whether an immediate safety plan is needed to reduce the risk of harm e.g.
  - cancelling unnecessary medical procedures
  - instituting closer observation of the child
  - 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;
5. Any potential implications for other patients or their carers who are on the ward at that time;
6. Consideration of the child's safety network and how it may be used to provide immediate safety
7. Consideration of how all involved health professionals can work together to ensure a coordinated, informed response to any health problems;

### **15. Information gathering**

1. Any outstanding investigations, further information gathering, and opinions that would be helpful;

2. The planning of further medical and nursing assessment;
3. The need for forensic sampling, special observation or Covert Video Surveillance (2009)<sup>3</sup>
4. The development of an integrated health chronology (and agreement on who should do this);
5. Any further opinions needed (including specialist child protection opinion or to address a specific clinical issue);
6. 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;
7. Strengths within the family.

## **16. Action Planning**

- 16.1 Plan for communication with carers including how, when, and by whom they should be informed of any child protection concerns. Action plans need to cover the following areas
1. How the child can be given an opportunity to tell their story
  2. Responsibility for the Core Assessment
  3. The security of medical records
  4. The level of professional observation required
  5. Addressing the needs of siblings and other children in the family
  6. Addressing the needs of carers, particularly after disclosure of concern
  7. Clarification of who will be the Responsible Paediatric Consultant for the child (if not already explicit);

## **17. Possible outcomes of the strategy meeting(s):**

- No further action by Children's Services following an Initial Assessment
- Provision of Services by one or more agencies
- Continued monitoring by identified professionals of specific concerns
- Core Assessment
- Section 47 Investigation
- Immediate Legal Action to protect the child(ren)
- A further strategy meeting or series of meetings, and/or an Initial Child Protection Case Conference
- Depending on the circumstances of the case, consideration may be given to the possibility of the use of Covert Video Surveillance (see section 25)

## **18. Disclosure of Concerns to the child's carers**

- 18.1 If the strategy meeting agrees that there are concerns about FII and that other agencies need to be involved, the possibility of FII will need to be discussed with the carers. Professionals should be supported through the

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<sup>3</sup> Fabricated or Induced illness by carers (F11): A practical guide for Paediatricians RCPCH ( Oct 2009 )

process of disclosure and the approach should be agreed and discussed with the multi-agency child protection team and carefully planned beforehand.

18.2 The disclosure should be made in the presence of at least one other member of the team. In most cases the discussion will involve the Responsible Paediatric Consultant jointly with a social worker and/or the police. However, in cases where the police obtain evidence that a criminal offence has been committed, it is important that the paediatrician does not confront the carers. This must be left to the police in order to ensure that the carers' rights are protected in accordance with the Police and Criminal Evidence Act 1984.

18.3 The carers should be invited to discuss the child's progress in an appropriate place which provides privacy and confidentiality. If the child is an inpatient, the meeting should be away from the bedside. If possible, both carers should be present at this meeting.

## **19 Discussion with carers**

19.1 The discussion may include the following:

- The fact that FII is the most probable cause for the child's signs and symptoms.
- The reasons why the identification of FII seems likely
- Any other possible cause for the child's sign and symptoms
- Any further investigations and their likely impact on the decision regarding FII
- The plan in terms of any ongoing management of the child's medical condition and monitoring arrangement, with likely timescales where possible
- The prognosis for the child
- Supportive services available for a carer who is suspected of abuse and for a non-abusing carer
- Follow-up arrangements, including a plan for further discussions (consistent with the multi-agency plan agreed at the strategy discussion).

19.2 Questions should be invited and answered as honestly and fully as possible. Any areas of uncertainty that are outside the paediatrician's expertise should be acknowledged. This potentially difficult meeting must be handled sensitively and without causing unnecessary distress. The carers should have a full explanation of the evidence and what further action is needed. Support should be provided to the suspected perpetrator of the abuse after the meeting.

19.3 A detailed note of the discussion should be made in the child's case notes.

19.4 At this stage the child's carers may request a change of medical team. This should be considered by the child protection team, but it will usually be unhelpful to have a change in medical personnel at this stage. As always the overriding consideration should be the welfare of the child.

## **20. Child Protection Conference**

- If the case proceeds to a child protection conference it is essential that the conference is organised so that key professionals including the Paediatrician can attend.
- Reports for conference must be checked by the agency supervisor before submission to the meeting and forwarded in advance of the meeting taking place to the Independent Reviewing Officer involved 24-48 hours before an Initial Child Protection Conference and in advance of a Review Child Protection conference ( see local guidance for timescales, this may vary across the localities). Consideration should be given as to how reports can be best shared with parents/carers prior to the conference.

## **21. Working with Carers who have fabricated or induced illness**

21.1 To gauge the prognosis for positive change in carers who have fabricated or induced illness it is essential to gain an understanding of:

- Their capacity to understand and acknowledge the harm which has been caused to the child;
- The underlying motivations which led them to fabricate or induce illness;
- The perpetuating factors which supported the continuation of the abuse and the extent to which these could be removed.

21.2 It is important to explore what life will be like now that the child has been found to be well or better than previously thought. Carers will require help with constructing an accurate narrative of the past which they can share with significant others in their life, including the family. They will require support in processing feelings of guilt and possibly also depression.

21.3 Thereafter, the carer who caused the abuse will require help in finding alternatives to those factors which previously motivated or supported the fabrication or induction of illness in the child, including, for example, employment and alternative sources of income to disability benefits.

## **22. Working with Children**

22.1 Professionals will need to decide when and how to involve the child in the decision-making and planning processes.

22.2 Children of sufficient age and understanding often have a clear perception of what needs to be done to ensure their safety and wellbeing.

22.3 In cases involving older children it is important to ascertain the child's perceptions, beliefs, and feelings about their state of health, particularly their anxieties and beliefs about their future wellbeing. It is also important to elicit the child's view of their experiences of medical care.

22.4 A child who has had illness fabricated or induced will need help in constructing a narrative about their previous state of ill health and about how they have come to recover and resume normal functioning. This

could be achieved by using therapeutic support. They will often require help in the process of rehabilitation into normal life, including returning to school.

- 22.5 The process of adjustment and 'recovery' should include a review of the child's view of the carer who caused the abuse, which will be painful and will require the presence and support of another trusted primary carer.
- 22.6 The older child will also require continuing support and guidance in learning how to gauge their own physical symptoms and respond to them in an adaptive and safe way. This support should be sustained over a significant period of time to ensure that the child's long-term developmental needs are met.

### **23. Emergency Action**

- 23.1 Sometimes it may be apparent at the point of referral to Children's Services that emergency action is necessary, for example, when a child's life is in danger, possibly through poisoning or toxic substances being introduced into the child's blood stream. Emergency action should normally be preceded by an immediate Strategy Discussion between the Police, Children's Services, Health and other agencies as appropriate.

### **24. Responsibilities**

- 24.1 From the point of referral Children's Services, the Responsible Paediatric Consultant and Police Child Protection Officers are to work very closely together. Lead responsibilities are:
  - 24.2 Children's Services - for action to safeguard and promote the child's welfare.
  - 24.3 The Responsible Paediatric Consultant - for the child's health care and decisions pertaining to it.
  - 24.4 The Police - for investigating any crime which may have been committed and the management of how investigations are to be conducted.

### **25 Covert Video Surveillance**

- 25.1 The use of covert video surveillance (CVS) is governed by the Regulation of Investigatory Powers Act 2000 (the 2000 Act)<sup>4</sup>. After a decision has been made at a multi-agency strategy discussion to use CVS in a case of suspected fabricated or induced illness, the surveillance should be undertaken by the police. The operation should be controlled by the police and accountability for it held by a police manager. The police should supply and install any equipment, and be responsible for the security of and archiving of the recorded images.
- 25.2 CVS should be used if there is no alternative way of obtaining information which will explain the child's signs and symptoms, and the multi-agency strategy discussion meeting considers that its use is justified based on the medical information.(DoH 2008)<sup>5</sup>

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<sup>4</sup> Regulation of Investigatory Powers Act 2000 ( Dec 2000 )

<sup>5</sup> Safeguarding children in whom illness is fabricated or induced: The Department of Health – Pubs and stats: Publications ( DoH 2008)

## 26 Chronologies

26.1 The use of chronologies and the attached 'Possible Warning Signs of Fabricated or Induced Illness Template' allows for systematic consideration of risk factors and risk assessment.

26.2 In compiling chronologies the focus must be on:

- Ensuring that all practitioners describe precisely what they have observed rather than using unfamiliar terminology. Fact and opinion should be clearly distinguished.
- Clarifying any concerns about medical information (treatments, expected findings, prognosis, etc) with an appropriate Doctor.
- Focusing on the possible harm to the child, not the motivation of the parent/carer.
- Any episode in which the parent/carer could be using the medical system to harm the child and all possible episodes of other forms of abuse must be included, including trivial injuries, which may be accidents or due to inflicted harm.

26.3 The chronology format will depend on the case. An example template is provided in Appendix 1  
Chronology information should be set out in the following template.

Date	Significant events / information about the child(ren)/family	Agency involvement/ action/Response	Child's views/direct observations of child	Other relevant information	Source of information

26.4 A decision should also be made by health professionals involved as to whether the chronology should be categorised using the template 'Possible Warning Signs of Fabricated or Induced Illness Template' in Appendix 2.

## 27 Risk from a member of staff

27.1 There may be times when a member of staff is responsible for the unexplained or inexplicable signs and symptoms in a child. This should be borne in mind when considering how to manage the child's care. Any such concerns about a member of staff should be discussed with the relevant Named Professional for Child Protection who will follow regional guidance.

## 28 Training supervision and support

28.1 All staff that come into contact with children or their families should have a basic awareness of child protection principles including a basic understanding of FII abuse, and the dynamics which may arise between carers and health professionals. Those specialising in the care of children or families need additional training to ensure a higher level of awareness and understanding of FII.

- 28.2 The aim of the training should be to achieve better outcomes for children. Professionals should be trained in order to achieve the greatest possible sensitivity and in diagnosis; to gain a full understanding of the procedures that follow if there is a concern; and to understand how to contribute effectively to that process. (2009)<sup>6</sup>
- 28.3 Staff will need support and supervision in dealing with cases of suspected FII. It is important that line management supervision arrangements are explicit so that staff know who and how to access additional support when it is needed. The facilitation of debriefing sessions can be helpful in providing support for all members of the team.

## 29 Further Information and Guidance

For further information and guidance see:

Safeguarding children in whom illness is fabricated or induced: The Department of Health – Pubs and stats: Publications (2008)

Public Report: Serious Case Review ‘Michael’ (Cumbria Child Protection Committee 2004)

Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians RCPCH (2009)

Information Sharing: Guidance for Practitioners and Managers HM Government March 2009

<http://publications.education.gov.uk/eOrderingDownload/00807-2008BKT-EN-March09.pdf>

Information Sharing: Further guidance on legal issues

[http://publications.education.gov.uk/eOrderingDownload/Info-Sharing\\_legal-issues.pdf](http://publications.education.gov.uk/eOrderingDownload/Info-Sharing_legal-issues.pdf)

Incredibly Caring (DVD) A training resource for professionals in Fabricated or Induced illness (FII) in children. Department for Children, Schools and Families.

Regulation of Investigatory Powers Act 2000 ( Nov 2000)

## 30. Possible warning signs of fabricated or induced illness template (regional guidance for fabricated illness 2005)

- 30.1 The order of numbering in the template does not indicate the relative importance of each category.
- 30.2 ‘Symptoms’ are subjective experiences reported by the carer or the patient. ‘Signs’ are observable events reported by the carer or observed or elicited by professionals. Set out below are some examples of behaviour to look out for.

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<sup>6</sup> Incredibly Caring (DVD). A training resource for professionals in Fabricated or Induced Illness ( FII) in children. Department of Schools and Families

- 30.3 Professionals should bear in mind the limits of the template, which is to give an indication of whether fabricated or induced illness is a possibility. (Please note this is not an exhaustive list).

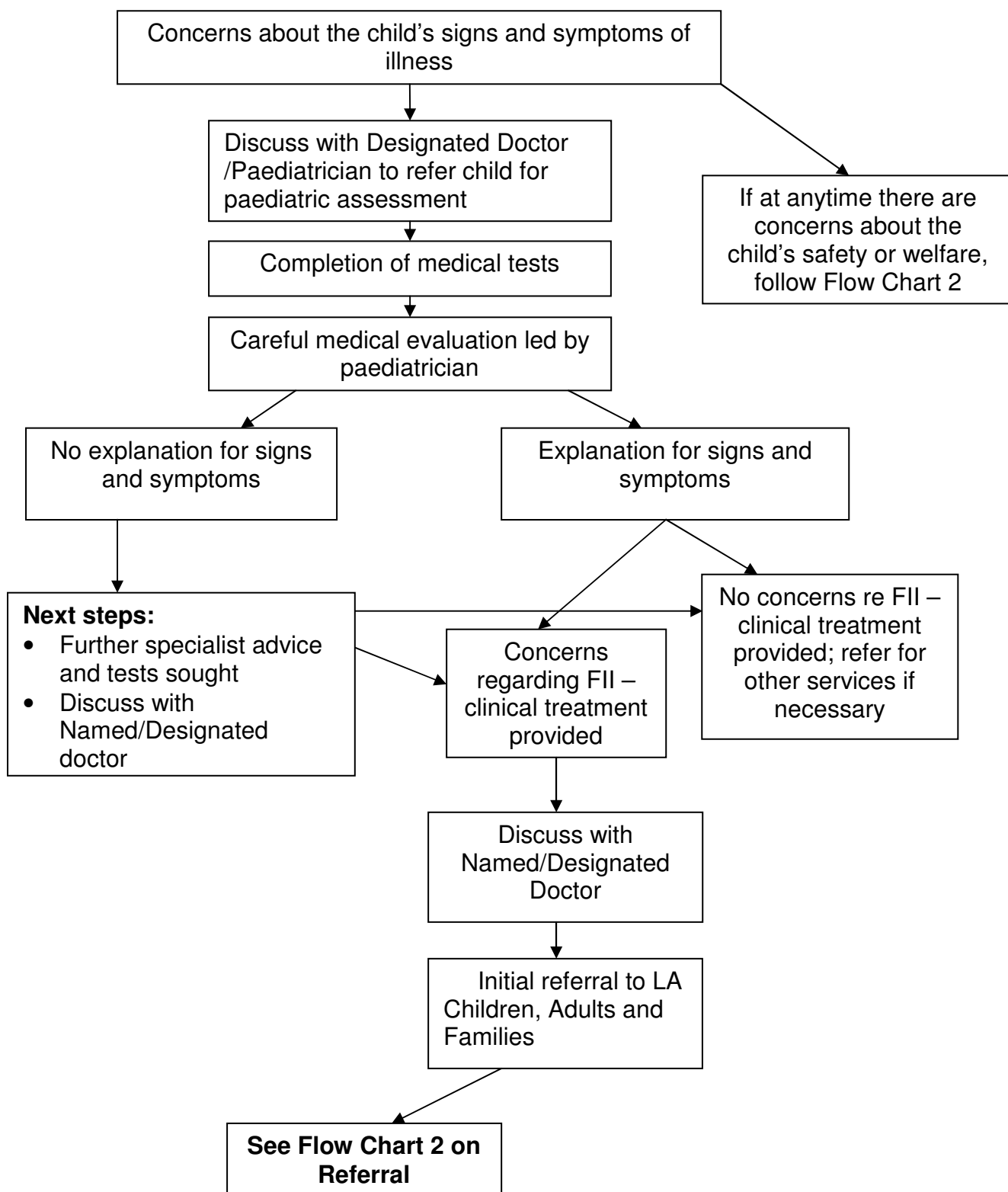
<b>Category</b>	<b>Possible warning signs</b> Please note categories 8 and 10 relate explicitly to parent/carer or siblings of the child concerned
1	<b>Reported signs and symptoms found on examination are not explained by any medical condition from which the child may be suffering.</b> Here the doctor is attempting to put all the information together to make a diagnosis but the signs and symptoms do not correlate with any recognised disease or where there is a disease known to be present. A very simple example would be a skin rash which did not correlate with any known skin disease. An experienced doctor must be on their guard if something described is outside their previous experience.
2	<b>Physical examination and results of medical investigations do not explain reported symptoms and signs.</b> Physical examination and appropriate investigations do not confirm the reported clinical story. For example, it is reported a child turns yellow (has jaundice) but no jaundice is confirmed when the child is examined and a test for jaundice, if appropriate, is negative. A child with frequent convulsions every day has no abnormalities on a 24-hour video-telemetry (continuous video and EEG recording) even during a so-called 'convulsion'.
3	<b>There is an inexplicably poor response to prescribed medication and other treatment.</b> The practitioner should be alerted when treatment for the agreed condition does not produce the expected effect. This can result in escalating drugs with no apparent response, using multiple medications to control a routine problem and multiple changes in medication due to either poor response or frequent reports of side effects. On investigation, toxic drug levels commonly occur but may be interspersed with low drug levels suggesting extremely variable administration of medication fluctuating from over-medication to withdrawal of medication. Another feature may be the welcoming of intrusive investigations and treatments by the parent.
4	<b>New symptoms are reported on resolution of previous ones.</b> New symptoms often bear no likely relationship to the previous set of symptoms. For example, in a child where the focus has been on diarrhoea and vomiting, when appropriate assessments fail to confirm this, the story changes to one of convulsions. Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.
5	<b>Reported symptoms and found signs are not seen to begin in the absence of the carer,</b> i.e. the perpetrator is the only witness of the signs and symptoms. For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly raise anxiety of FII where the severity and/or frequency of symptoms reported are such that the lack of independent observation



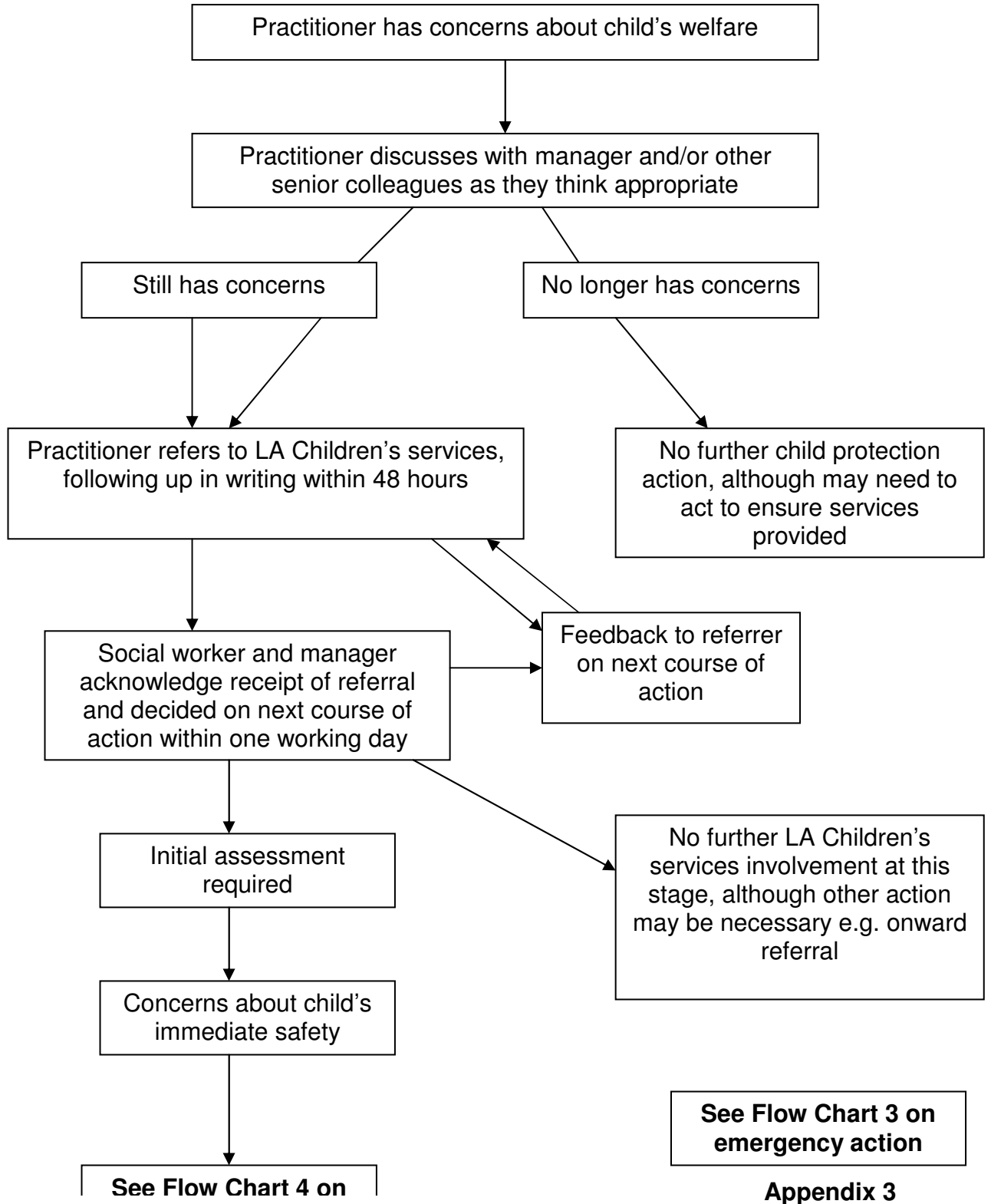
	is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. In the case under review there was evidence that the school described episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.
6	<b>The child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.</b> The carer limits the child's activities to an unreasonable degree and often without knowledge of medical professionals or against their advice. For example, confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child's school attendance.
7	<b>Over time the child is repeatedly presented with a range of signs and symptoms.</b> At its most extreme this has been referred to as 'doctor shopping'. The extent and extraordinary nature of the additional consultations is orders of magnitude greater than any concerned parent would explore. Often consultations about the same or different problems are concealed in different medical facilities. Thus the patient might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different set of problems (or even the same) without informing these various medical professionals about the other consultations.
8	<b>History of unexplained illnesses or deaths or multiple surgeries in parent/carer or siblings of the family.</b> The emphasis here is on the <u>unexplained</u> . Illness and deaths in parents or siblings can frequently be a clue to further investigations and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the general practitioner through to the extreme of Munchausen's syndrome where there are multiple presentations with fabricated or induced illness resulting in multiple (unnecessary) operations. Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially might have been subject to FII abuse and their medical history should also be examined.
9	<b>Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above).</b> This is a planned separation of perpetrator and child which it has been agreed will have a high likelihood of proving (or disproving) FII abuse. It can be difficult to practice, and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child's bedside, is unusually close to the medical team and thrives in a hospital environment.
10	<b>Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.</b> This is an extension of

	category 8. On exploring reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They were largely wholly fictitious.
11	<b>Incongruity between the seriousness of the story and the actions of the parents.</b> Given a concerning story, parents by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is incongruity between their expressed concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend for crucial assessments (somebody else's birthday, thought the hospital was closed, went to outpatients at one o'clock in the morning, etc). We have used a term, 'piloting care, for this behaviour.
12	<b>Erroneous or misleading information provided by parent.</b> These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc). An extreme example of this is spreading the idea that the child is going to die when in fact no one in the medical profession has ever suggested this. Changing or inconsistent stories should be recognised and challenged.

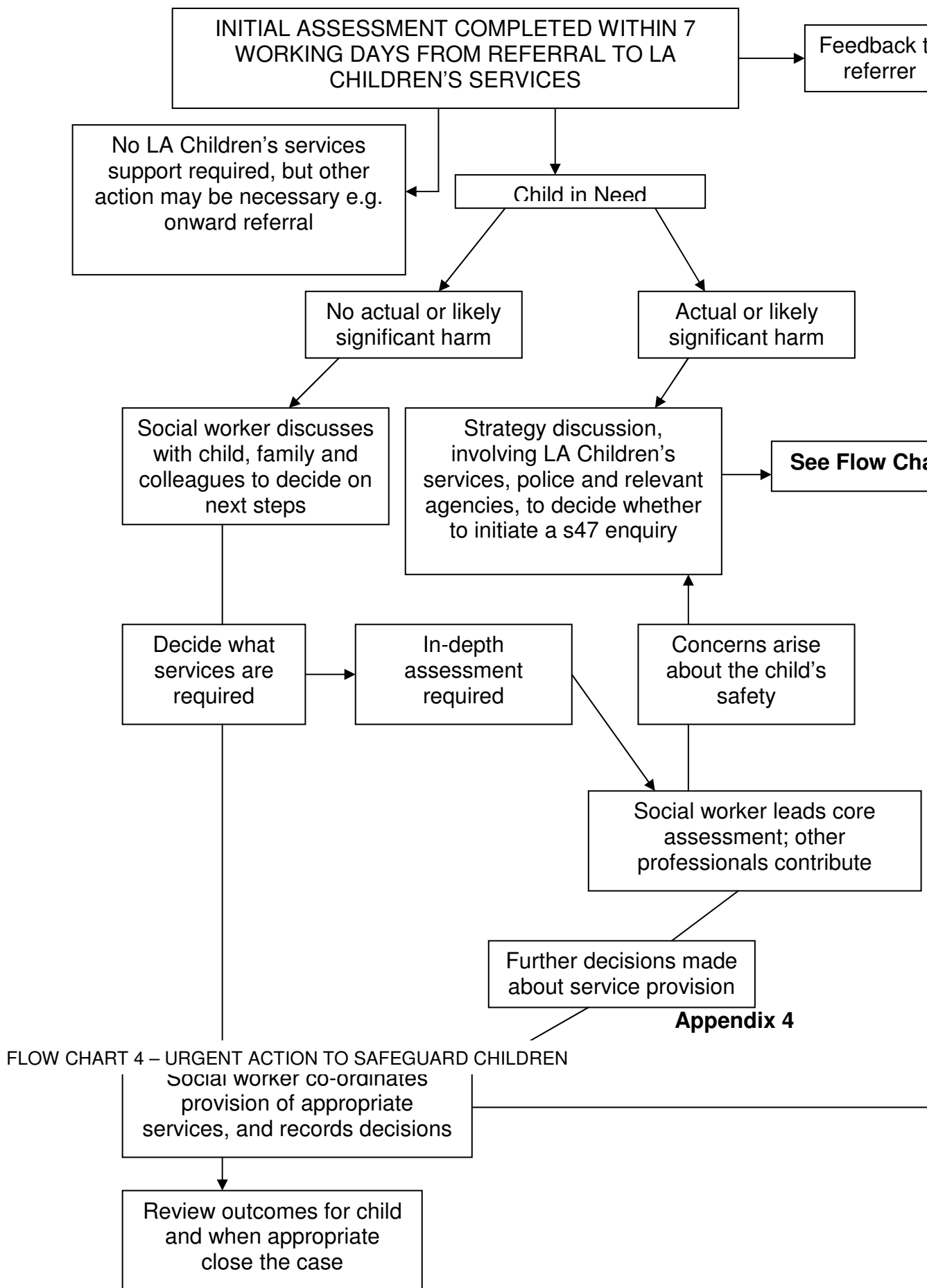
FLOW CHART 1 – MEDICAL EVALUATION WHERE THERE ARE CONCERNS REGARDING SIGNS AND SYMPTOMS OF ILLNESS

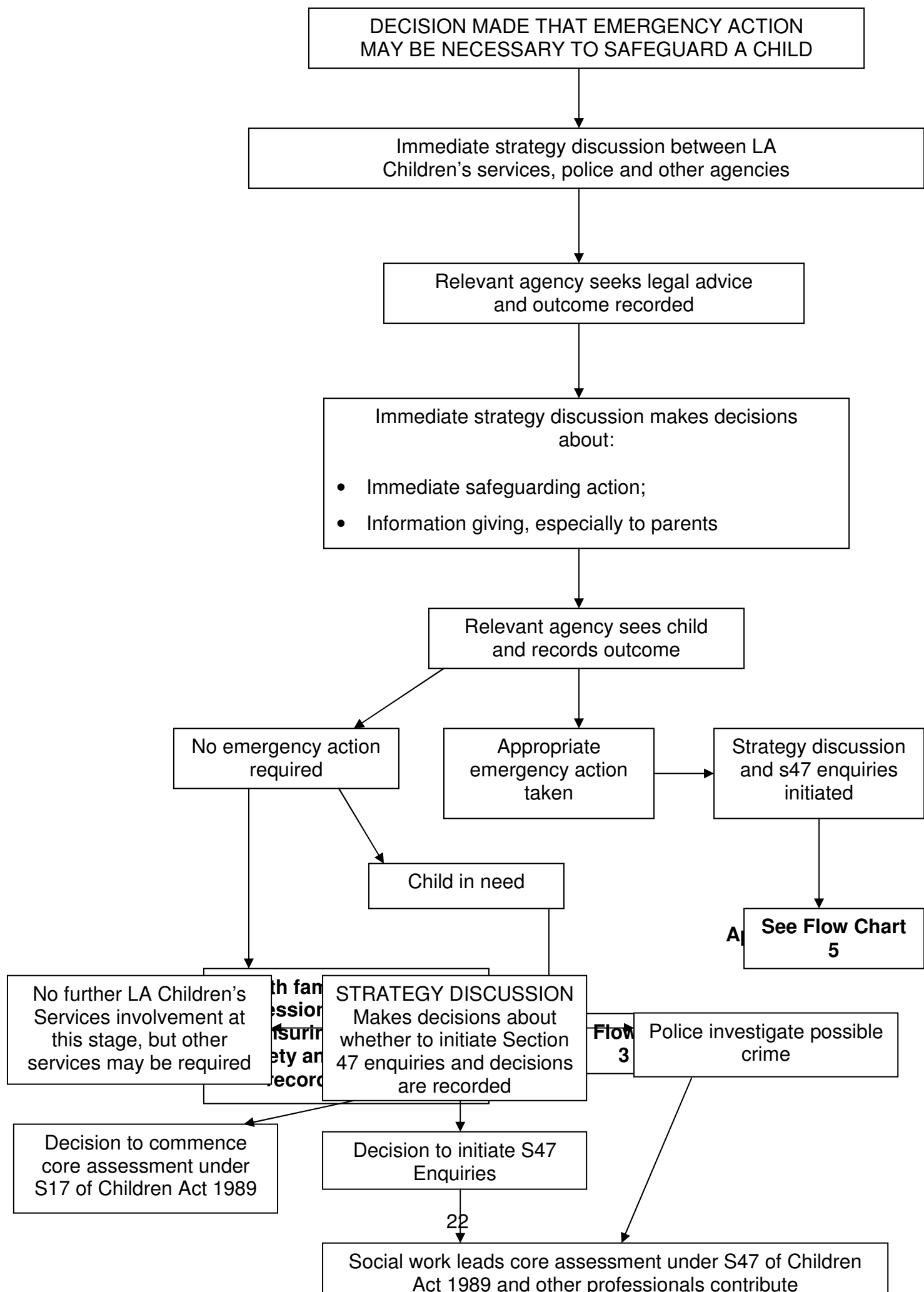


FLOW CHART 2 - REFERRAL



FLOW CHART 3 – WHAT HAPPENS FOLLOWING INITIAL ASSESSMENT?





FLOW CHART 6 – WHAT HAPPENS AFTER THE CHILD PROTECTION CONFERENCE, INCLUDING REVIEW PROCESS?

