



**PROTOCOL FOR SAFEGUARDING CHILDREN
IN WHOM
ILLNESS IS FABRICATED OR INDUCED**

Title of Policy	Safeguarding Children in whom Illness is Fabricated or Induced	
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Section		
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1.0 Purpose

1.1 All parents / carers demonstrate a range of behaviours in response to their children being ill or being perceived as ill. Some may become more stressed or anxious than others. However, there are some parents / carers, who for differing reasons may either induce or fabricate illness in their child. Such incidents are not commonplace. But they can significantly impact on the child's physical and emotional development.

1.2 The purpose of this protocol, therefore, has been developed to provide guidance to Barnsley Safeguarding Children Board (BSCB) partner agencies to safeguard and promote the welfare of children in whom there is a risk of harm or who are suffering actual harm as a result of fabricated or induced illness. It is a summary of national guidance published: [*Safeguarding Children in whom Illness is Fabricated or Induced*](#) (DCSF, HM Government 2008) and *Working Together to Safeguard Children* (HMSO, 2006). The guidance is issued under section 7 of the Local Authority Social Services Act, 1970, and section 16 of the Children Act, 2004.

2.0 Aim

2.1 The aim of this guidance is to support BSCB partner agency staff:

- to be aware of the signs and symptoms of fabricated or induced illness
- to be aware of how fabricating or inducing illness in children may impact on their physical or emotional development
- why parents / carers may take such action
- how to respond to any concerns they may have that a child is suffering from fabricated or induced illness
- what action may occur as a result of such a response.

3.0 Fabricated or Induced Illness (FII)

3.1 For a small number of children, concerns will be raised when it is considered that their health or development is likely to be significantly impaired, or further impaired, by the actions of a carer or carers having fabricated or induced illness, such that the child is suffering or is likely to suffer significant harm.

3.2 Health professionals are taught to listen to the concerns of parents about their children's health and to act on these. Part of their role is not only to treat the sick child but also, in collaboration with other professionals, to assist parents to respond appropriately to the state of their children's health. Some children may not be unwell but parents need reassurance that they are indeed well, whilst others may experience continuing difficulty in recognising that their child is healthy and exhibiting normal childhood behaviours. Some parents may be helped to interpret and respond appropriately to their child's actions and behaviours, whilst others may continue to be anxious and/or are unable to change their beliefs.

3.3 It is this latter group of parents who are more likely to present their children for medical examination although the children are healthy. Skilled professional intervention is likely to enable most parents to learn how to interpret their child's state of health and manage their own anxieties. There may be some parents for whom such early interventions are ineffective. These parents may have particular needs, which result in them persistently presenting their child(ren) as ill and seeking investigations and medical treatments.

Incidence and prevalence

3.4 The incidence rate of fabricated or induced illness is quite rare. McClure et al calculated that in a hypothetical district of one million inhabitants, the expected incident rate would be one child per year. In Barnsley, that would be approximately one case every four years. However, they also suggested that there was under-reporting in this area for a number of reasons:

- a) that paediatricians considered that the identification of FII had to be virtually certain before a child protection conference is initiated
- b) the absence of recorded cases because of the lack of irrefutable evidence even though the concern about the child is significant
- c) the cases may also present in ways which result in unnecessary medical interventions, for example, where symptoms are verbally reported to surgeons who then carry out operations without questioning the basis of this information.

3.5 Therefore the prevalence rate is likely to be more than the estimated incidence one case every four years in Barnsley.

Parent / carers' behaviours associated with fabricated or induced illness

3.6 Parents / carers may exhibit a range of behaviours when they wish to convince others that their child is ill. The professional involved has to assess whether they are overly anxious parents, or those who are exhibiting abnormal behaviour.

3.7 Such behaviour may involve both parents / carers, and passive compliance of the child (see s3.24). It may also constitute ill treatment (section 31(9) of the Children Act 1989).

3.8 The following is a list of behaviours that may be exhibited by parents / carers which can be associated with fabricating or inducing illness in a child. This list is not exhaustive. It should also be interpreted with an awareness of cultural behaviours and practices, which can be mistakenly construed as abnormal behaviours:

- deliberately inducing symptoms in children by administering medication or other substances, by means of intentional transient airways obstruction or by interfering with the child's body so as to cause physical signs
- interfering with treatments by over dosing with medication, 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. These

- exaggerating symptoms which are unverifiable unless observed directly, 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.

A Child in Hospital

3.9 When a child is in hospital, it is usual for parents / carers to be very involved in the care of their child, including participating in medical tests, taking temperatures and measuring bodily outputs. Where illness is being fabricated or induced these normal hospital practices provide the parent / carer with opportunities to continue this behaviour. This may mean, for example, that treatments and tests may be interfered with and the reported signs and symptoms continue whilst the child is in hospital. Differences may also be seen between the ways in which parents / carers who fabricate or induce illness interact with their children compared with other parents / carers.

3.10 Commonly, such parents / carers:

- are observed to be intensely involved with their children
- never take a much needed break
- never allow anyone else (either family members or professionals) to undertake any of their child's care.

3.11 This behaviour may preclude adequate observation of the child. However, others may

- spend little time interacting with their child
- may be very involved with other families on the ward and hospital staff rather than with their child.

3.12 They may also appear unusually unconcerned about the results of investigations which may be indicative of a serious physical illness in the child. The majority of cases of fabricated or induced illness in children are confirmed in a hospital setting because either medical findings or their absence provide evidence of this type of abuse.

Early history and concern about the child's health

3.13 A significant number of children in whom illness is fabricated or induced will have been well known to health professionals from birth. Some also suffer from a verified acute or chronic medical condition. Some may previously have been seriously ill, for example as a consequence of prematurity, while others may have had minor problems at birth or in their first few months of life.

3.14 Consideration should be given to the possibility that the obstetric complications themselves may have been due to the mother interfering with her

pregnancy to induce a premature birth. Children may have also experienced other forms of abuse, for example, physical abuse or neglect, prior to the identification of fabricated or induced illness. Children in this group often present with, or have a past history of both genuine and perceived feeding difficulties, faltering growth and reported allergies.

3.15 At the point that fabrication or induction of illness is confirmed the child may have organic problems which will require ongoing medical treatment. These may pre-date the abuse or be a consequence of it. It can be difficult to identify retrospectively the origins of a child's medical problems but, following identification of fabricated or induced illness, treatment for medical conditions should be undertaken as part of the child's overall plan.

3.16 The medical histories of this group of children are likely to have started early and in many instances will have become extensive by the time the suspected abuse is identified. Some children may have been referred to a tertiary paediatric centre because they were thought to have a serious or rare illness requiring expert diagnosis and treatment. They may have been seen at many hospitals in different geographical areas and by a number of professionals. They may also have been seen in centres for alternative medicine, or by private practitioners.

Child death and morbidity

3.17 International research findings suggest that up to 10% of these children die and about 50% experience long-term consequent morbidity. In the British study McClure et al (1996) found that 8 out of 128 (6%) children died as a direct result of abuse. A further 15 (12%) required intensive care and an additional 45 (35%) suffered major physical illness, again as a result of abuse. The way in which a child's circumstances are managed will impact on their outcomes but the lives of some who present at hospital in a life-threatening situation, for example having been poisoned, might not be able to be saved.

3.18 In the McClure et al (1996) study, 83 (65%) of the 128 index children had at least one sibling and of these, 15 (12%) had a sibling who died previously (a total of 18 deaths). Five (4%) of these deaths had been classified as Sudden Infant Deaths. Information about a death or previous abuse of siblings may become known to professionals only after a family history has been collated.

Impact on the child's health and development

3.19 Many of the children who do not die as a result of having illness fabricated or induced suffer significant long-term consequences. These may include long term impairment of their physical, psychological and emotional development (see paragraph 3.90 of *Assessing Children in Need: Practice Guidance* (Department of Health, 2000a)).

3.20 Fabrication of illness may not necessarily result in the child experiencing physical harm. However, where children have not suffered physical harm, there may still be concern about them suffering emotional harm, particularly if there are abnormal relationships with the parent / carer who is the alleged abuser, or other family relationship difficulties. Other manifestations of fabricated or induced illness may include a range of emotional and behavioural disorders, school related

problems including non-attendance and difficulties in concentration. Such issues may continue after the child is placed with non-abusing carers, which suggests that treatment and support needs to continue throughout childhood.

3.21 It should be noted though that whilst it is well documented that children who have been abused or neglected are likely to suffer impairment to their health and development, it cannot be assumed that all children suffering impairment have been abused. It is therefore important to clarify the contributing factors and identify any underlying conditions.

The experience of the abused child

3.22 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. Nearly all affected children undergo many unpleasant investigations and/or treatments but many children, especially young children, who have had illness fabricated or induced, may not be fully aware of the nature of their abuse.

3.23 Some children are confused about their state of health. Many are preoccupied with anxieties about their health and survival and may express suicidal thoughts as a result of their despair. Older children and adults who have been abused in this way may come to feel anger at their betrayal by their parent(s), and a lack of trust in those caring for them including medical professionals.

Involvement by the child

3.24 In children who have had illness fabricated or induced, there seems to be a continuum of involvement with their carer, which may range from naivety through to passive acceptance, actual participation and active self-harm. Some children, particularly those who are older, may learn to collude with their carer in the management of a non-existent condition before eventually fabricating or inducing illness in themselves or developing a somatisation disorder (mental factors e.g. stress causing physical disorders). Such children can continue to be dependent on their carer. As a consequence, some may lose the ability in childhood to identify true illness and become unable to act appropriately if they are ill. So, just as with other forms of child abuse, the effects of illness having been fabricated or induced may impact on a child for life.

Age range of children

3.25 The age range of children in whom illness is fabricated or induced extends throughout childhood, although it is most commonly identified in younger children. In the McClure et al (1996) study, 77% of children were aged under 5 years at the time of identification with a median age of 20 months.

Gender of parent / carer responsible for the abuse

3.26 Clinical evidence indicates that fabricated or induced illness is usually carried out by a female parent / carer, usually the child's mother, although fathers and other women have been known to be responsible. Whoever is the alleged abuser, it is likely that they have been undertaking the majority of the child's daily care. That does not necessarily mean that the other parent / carer were mere bystanders

in the process of illness induction. Each family should be assessed individually to understand the dynamics at play.

Parent / carers' previous histories

3.27 There is no evidence to support a unique profile of carers who fabricate or induce illness in their children. There is, however, evidence that as with many parents who abuse or neglect their children, specific aspects of their histories are likely to have been troubled. This requires careful assessment but may reveal:

3.28 **Physical health:** a significant number of parents are likely to report having experienced genuine medical problems, which may or may not have been substantiated by medical investigations. They may also have a history of inflicting deliberate self-harm. The mothers may have a complicated obstetric history. For some mothers, there may have been professional concern about them causing their own miscarriages.

3.29 **Psychiatric history:** a significant number of parents will have been assessed or treated for mental health problems. Following a formal psychiatric assessment, some may have been diagnosed with a personality disorder, but others may have no diagnosable psychiatric disorder.

3.30 Parents also report having suffered a number of significant bereavements or losses in their lives with these often having taken place within a relatively short time span. This may have included miscarriage, stillbirths, the death of parents or other supportive family member, or the loss of a partner through separation or divorce.

Other possible perpetrators

3.31 Although in the majority of such cases it is the mother who is the abuser, professionals should also be aware of the possibility of other perpetrators including siblings or other children, or professionals.

3.32 If a professional is concerned that a colleague or worker from another agency, including volunteers or foster carers, is fabricating or inducing illness in a child, they should immediately inform their line manager and the named professional for safeguarding within their agency. A referral should be made to the Local Authority Designated Officer, (01226) 772400.

3.33 Further information is available in Appendix 4 of the Barnsley Child Protection Procedures, 2007: [Allegations against Staff, Volunteers or Carers](#).

3.34 Advice can be obtained from Barnsley Safeguarding Children's Unit (01226) 772400.

Family relationships

3.35 Relationship problems between the child's parents are common, although they may not have been acknowledged prior to child welfare concerns being raised. Similarly, a number of parents may have experienced problems associated with taking on the role of parenthood. These may have been presented early on in their parenting careers.

Outcomes for children

3.36 There has been little research done on the longer-term outcomes for children in these circumstances, but the available evidence suggests that outcomes have been poor for many children who had illness fabricated or induced. Bools et al (1993) noted that nearly half of the children in their study were living with alternative carers but suffered ongoing psychological problems. Over half were still living with their mother (who was the abuser) and had either suffered further fabricated illness or other significant concerns. Nearly half of the 54 children in the study had unacceptable outcomes including conduct and emotional disorders, and difficulties at school including non-attendance, in addition to re-abuse.

3.37 In summary, following identification of fabricated or induced illness in a child by a carer, the way in which the case is managed will have a major impact on the developmental outcomes for the child. The extent to which the parents have acknowledged some responsibility for fabricating or inducing illness in their child will also affect these outcomes for the child.

4.0 Roles and Responsibilities

4.1 Any professional may come across a child who they suspect may have an illness that is fabricated or induced. They may suspect that an adult with whom they work is the perpetrator of such abuse, or that another child may be the abuser, or a professional. It is their responsibility to seek advice on their concerns if they are not sure what to do, and take action in consultation with their line manager and relevant others.

In the first instance advice and information can be obtained from Barnsley Safeguarding Children's Unit on (01226) 772400. Concerns about the child or the suspected abuser can be discussed with the Safeguarding Manager.

4.2 Once a referral has been made to Children's Social Care, it is the responsibility of the designated social worker to initiate investigations and coordinate the multi-agency response. S/he should liaise closely with the child's consultant paediatrician who should take responsibility for all decisions that relate to the child's health care, including the medical assessment and liaison with health colleagues. The Royal College of Paediatrics and Child Health Report on [*Fabricated or Induced Illness by Carers \(2002\)*](#) provides specific advice for paediatricians and other health professionals. In particular, Chapter 5, *Medical Evaluation: Procedures and Management* should be followed in conjunction with this guidance when there are concerns about fabricated or induced illness in a child.

4.3 Detailed guidance regarding roles and responsibilities for health organisations and health professionals, including specific disciplines, local authorities, Connexions, and children's centres, schools and further education establishments can be found on pages 16 – 27 in *Safeguarding Children in whom Illness is Fabricated or Induced* (DCSF, HM Government 2008).

4.4 Other professionals concerned about a child should also familiarise themselves with the information in section 3 of *Safeguarding Children in whom Illness is Fabricated or Induced* (DCSF, HM Government 2008). They should also consult [Barnsley Child Protection Procedures 2007](#), particularly Chapter 5, 6 and 7. These detail how to refer concerns about a child to Children's Social Care or the Police, subsequent actions they make take and the child protection conference system.

5.0 Managing Individual Cases

5.1 Concerns may arise about possible fabricated or induced illness for a number of reasons, including when:

- reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering
- physical examination and results of medical investigations do not explain reported symptoms and signs
- there is an inexplicably poor response to prescribed medication and other treatment
- new symptoms are reported on resolution of previous ones
- reported symptoms and found signs are not seen to begin in the absence of the carer
- over time the child is repeatedly presented with a range of signs and symptoms
- the child's normal, daily life activities are being curtailed, for example school attendance beyond that which might be expected for any medical disorder from which the child is known to suffer.

5.2 There may be other explanations, apart from fabricated or induced illness, for these circumstances. Therefore careful consideration and review is necessary and professionals should remain open to all possibilities at this stage. A full developmental history and an appropriate developmental assessment should be carried out. **Consultation with peers, named or designated professionals or the Barnsley Safeguarding Children's Unit will be an important part of the process of making sense of the underlying reason for these signs and symptoms.**

5.3 The characteristics of fabricated or induced illness are that there is a lack of the usual corroboration of findings with symptoms or signs, or, in circumstances of proven organic illness, lack of the usual response to proven effective treatments. It is this puzzling discrepancy which alerts in particular the medical clinician to possible harm being suffered by the child.

5.4 A thorough medical examination should be undertaken by a paediatrician. If the child is not already under such care, then the GP should make a referral. However, this may also be carried out as a result of initiating s47 enquiries. It would be most appropriate for the examination to be conducted by a paediatrician who has experience of fabricated or induced illness in children.

6.0 Referral to Children's Social Care

6.1 If it is decided that the child is at risk of, or likely to suffer significant harm as a result of suspected fabricated or induced illness, the professional should make a referral to the Duty Social Worker in the relevant Team (see Contacts p 20). Following receipt of such a referral health, police and Children's Social Care, and any other involved agencies should work together to safeguard and promote the welfare of the child. Children's Social Care should take the lead in co-ordinating the response. The police should be involved, as fabricating or inducing illness is a criminal offence and therefore a police investigation may follow.

6.2 Children's Social Care should decide, in consultation with the other agencies as to what, if any, further action is appropriate. If no further action is taken, feedback should be given to the referrer and any other agency involved. Alternatively, it may be decided that action is required. Therefore an initial assessment under s17 of the Children Act should be undertaken.

Initial assessment

6.3 This is to determine whether the child is in need or whether there are concerns about significant harm, the nature of any services required, and whether a further, more detailed core assessment should be undertaken. On completion of the initial assessment, careful consideration should be given by the social worker and the consultant paediatrician responsible for the child's health care, as to what the parents should be told, when and by whom, taking account of the child's welfare.

6.4 The time taken to complete the initial assessment may be very brief if it quickly becomes clear that there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm, in which case a strategy discussion should be held. If there is evidence to indicate the child's life is at risk or there is likelihood of serious, immediate harm, emergency legal action (e.g. Police Protection or Emergency Protection Order) may be required.

6.5 It is essential at this stage that the compilation of a medical chronology is commenced (see also section 6.15 Guidance for Gathering Information / Evidence and section 6.27 Information for Conference).

Strategy Discussion

6.6 If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, Children's Social Care should convene a strategy discussion, preferably a meeting. It should at a minimum, include Children's Social Care, Police, the paediatrician responsible for the child's health and, if the child is an in-patient, a senior nurse from the ward. It is also important to consider seeking advice from, or having present, a medical professional who has expertise in the branch of medicine, for example, respiratory, gastroenterology, neurology or renal, which deals with the symptoms and illness processes caused by the suspected abuse.

6.7 Professionals involved with the child such as the GP, health visitor, staff from education settings or other workers involved, should also be invited as appropriate. The Local Authority's solicitor may also be invited to attend this meeting. Staff

should be sufficiently senior to be able to contribute to the discussion of information, which is often complex, and to make decisions on behalf of their agencies. Decisions about undertaking covert visually recorded surveillance should be made at a strategy meeting.

Making Suspected Perpetrators Aware

6.8 If a parent/carer is the suspected perpetrator of the abuse, at the point it is decided to hold a strategy discussion careful thought should be given to what they are told, when and by whom. Children's Social Care should involve the Police, the child's consultant paediatrician, the Senior Ward Nurse (if the child is an in-patient) and other relevant professionals in making these decisions.

6.9 If it is believed that a criminal offence is being / has been committed and that a prosecution is a viable option, a police officer should caution the suspect. In such circumstances no one else should approach a parent about the concerns, without first discussing the possibility with the investigating police officers. An arrest may ultimately be necessary.

6.10 The consultant paediatrician should explain why the symptoms presented are believed to be due to fabricated or induced illness. A child protection social worker should inform the parents/carers of any steps being taken to ensure the safety of the child.

6.11 Not all these tasks will be performed at the same time. If a criminal investigation is being pursued then a police officer and doctor should be the ones to raise the issue with the parent (followed by a social worker explaining measures to protect the child). If not, then a doctor and a social worker should approach the parent together.

Section 47 Enquiries and Core Assessment

6.12 The nature of any further medical tests will depend on the evidence available about how the signs and symptoms are being caused. It is important to assess the child's understanding, as appropriate to their age, of their symptoms. The nature of their relationship with each significant family member (including all caregivers), each of the caregivers' relationships with the child, the parents' relationships with the child, the parents' relationship with each other and the children in the family, as well as the family's position within their community should also be taken into consideration.

6.13 The core assessment should also include the systematic gathering of information about the history of the child and each family member, building on that already gathered during the course of each agency's involvement with the child. Assessment of an unborn child should also be undertaken and a pre-birth conference held if there is considered to be risk.

6.14 Particular emphasis should be given to health (physical and mental), education and employment as well as receipt of state benefits relating to a disabled child, social and family functioning and any history of criminal involvement. A range of specialist assessments may be required. For example, physiotherapists, occupational therapists, speech therapists and child

psychologists may be involved in specific assessments relating to the child's developmental progress; child and adolescent mental health professionals and adult mental health professionals may be involved in assessments of individuals or families.

Guidance for Gathering Information / Evidence

6.15 From the time suspicions are first aroused, all specimens of urine, blood and any other required samples should be retained, securely stored, and a record made of who took each one and who subsequently handled them. This is to ensure continuity in any possible Court proceedings. If the use of Covert Visually Recorded Surveillance to gather evidence is discussed, guidance as detailed at section 6.35 should be followed.

6.16 As well as medical tests and investigations to find either a genuine cause for a child's symptoms or evidence of inducement of illness there is a need to establish if there are changes when controls are put in place. These could include restricting a child's intake of food and drink to only that provided by the hospital, ensuring medication is only administered by staff, or separation of parent and child.

6.17 Practitioners should not be 'influenced' by suspected perpetrators having a medical background; as they can use this to obtain misplaced confidence in their parenting and so cover abusive behaviour.

6.18 As far as possible, information given by the parent should be verified. A partner may be able to corroborate a parent / carer's account; the G.P. may provide information that substantiates reports of previous illness; and interviewing others who are said to have witnessed episodes of apnoea (stopping breathing) attacks or other symptoms could be informative.

6.19 Often there will be a need to painstakingly go through all medical notes to piece together the history of attention received by the child. A chronological record should then be produced with each entry giving:

- The date and place of each consultation and with whom
- What the symptoms were and, if possible to distinguish, whether they were seen by medical staff or just reported to them
- Any tests/investigations carried out and their results.

6.20 Comment can then be made on any discrepancy between the findings and the history given by the carer, or between that given by the carer and others, together with a view as to whether this is a result of fabrication or not. In addition, any disparity between the medical findings and known medical entities should be noted and a different diagnosis for the child's condition(s) given, in order of likelihood.

Recording Information

6.21 Careful and detailed note taking by all staff, including health professionals, is very important for any subsequent police investigation or court action. Any unusual events should be recorded and a distinction should be made between events reported by the parent / carer and those actually witnessed by staff. Notes should

be timed, dated and signed legibly. Most importantly, notes should be confidential and kept in a secure place so that unauthorised persons cannot access them. Storage of these records should be in accordance with agencies record policies.

Attendance at the Initial Child Protection Conference

6.22 All relevant professionals who have been involved in the child's life should attend the conference, as well as those who are likely to be involved in future work with the child and their family.

6.23 As well as the professionals detailed above, it is important to consider seeking advice from, or having present, a medical professional who has expertise in the branch of paediatric medicine, e.g. respiratory, gastroenterology, neurology or renal, which deals with the symptoms and illness processes caused by the suspected abuse. This would enable the medical information to be presented and evaluated from a sound evidence base.

6.24 The decision to include a child in a child protection conference should be based on their age and capacity to understand what will be discussed. Some children may not understand what has been happening to them and may, therefore, find it difficult to understand what professionals are discussing. Others may be very clear but may not have been able to talk to a trusted adult or may not have been listened to. In both situations it may be inappropriate to include the child. All children in whom illness has been fabricated or induced are likely to have suffered emotional abuse. If they do not attend the conference, consideration should be given as to who will tell them what was discussed. The safety of the child following the conference must also be carefully considered and an understanding of how it is to be ensured conveyed to the child.

6.25 Although exceptional to standard practice, in the case of a child in whom illness may have been fabricated or induced, it may be necessary to exclude one or more family members from all or part of the Conference. This decision should be based on considerations of ensuring the child's safety and be made by the Conference Chair on a case-by-case basis. Steps may also be required to protect professional staff from intimidation either in the Conference or after it.

6.26 The extent and manner of involvement of family members should be informed by what is known about them. The abusing carer may not be able to acknowledge their behaviour to their partner, the non-abusive parent may have had no knowledge of the abuse or they may have had some understanding, which now makes better sense to them. These are matters which should be addressed outside the conference in a sensitive manner.

Information for the Conference

6.27 Children's Social Care has responsibility for ensuring that, as far as is possible, a joint chronology has been drawn up from professionals who have seen the child over a period of time, with special emphasis on the child's medical history. The health history of siblings should also be considered, and action taken accordingly if there is any concern about their care. This includes risk of harm other than fabricated or induced illness. The Chair has responsibility for ensuring

that additional or contradictory information is presented, discussed and recorded in the Conference.

6.28 Careful consideration should be given to when agency reports will be shared with the child's parents. This decision will be made by the initial Child Protection Conference Chair, in consultation with the professional responsible for each report.

Action and Decisions for Conference

6.29 Particular attention should be given in the protection plan as to what steps will be necessary to safeguard the child. These will depend on the nature of the harm suffered by the child. If the child's life has been threatened by, e.g. attempted smothering, poisoning or introducing noxious substances intravenously; all necessary measures should be put in place to ensure that these actions cannot take place in the future. This may mean that the child has to be separated from the abusing parent, and if possible cared for solely by the other parent, or, if the abusing parent is unwilling to leave the house, placed in an alternative family context, or remain in hospital for further medical treatment before being well enough to be discharged. To avoid repeat abuse, contact may have to be closely supervised by a professional whose level of knowledge enables them to be alert to the precursors of further abuse.

6.30 Conference participants must be clear what actions will be taken to safeguard the child immediately after the Conference, as well as in the longer term. For some children it may be necessary to institute legal proceedings either immediately or soon after the Conference has ended. This decision should be taken by Children's Social Care in conjunction with its legal advisors. It is important that the doctors involved agree to support this action, since it is their medical evidence, which will form a key part of the evidence presented to a Court.

6.31 The Conference should also consider what action is required to protect siblings in the family. Abusive behaviour may transfer to another child in the family, once the identified child is placed in a safe environment.

6.32 Knowledge of the parents/ carers' medical and psychiatric histories, in particular the abuser/s, should be considered. Services for the parents / carers may be required immediately, e.g. if there is a history of self-harming behaviour or a likelihood they may attempt suicide or develop other types of psychiatric symptoms.

Adult Mental Health

6.33 Adult Mental Health Service guidance should be sought at the earliest opportunity for the adult carer, especially if there is a history of psychiatric illness and self-harming behaviour. A referral should be made, if appropriate, immediately.

Consultation

6.34 As fabricated or induced illness is a relatively rare phenomenon, it is unlikely that all members of the strategy meeting will have previous experience to work with the child and / or parent carer without expert support. Therefore consideration should be given to consultation with a professional who has recognised experience

in the field of fabricated or induced illness and is able to provide additional support to the meeting.

Covert Visually Recorded Surveillance (CVRS)

6.35 After serious consideration a decision may be made at the Multi-Agency Strategy discussion to use C.V.R.S. The surveillance **will be undertaken by the police**, the operation controlled and the accountability for it held by a Police Manager. **C.V.R.S. 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 Meeting considers that its use is justified based on the medical information available. All personnel including nursing staff, who will be involved in its use should have received specialist training in this area.**

6.36 The medical consultant responsible for the child's care should ensure that the necessary medical and nursing staff are available to provide the child with immediate and appropriate health care when necessary. The level and nature of health involvement during the period of covert surveillance should be agreed at the strategy discussion and all relevant staff briefed on the arrangements for the child's health care. All decisions to undertake covert visually recorded surveillance should be recorded in the child's records and signed by a Senior Manager.

6.37 The safety and health of the child is the overriding factor in the planning and carrying out of covert visually recorded surveillance. The primary aim of undertaking covert visually recorded surveillance is to identify whether the child is having illness induced, of secondary importance is the obtaining of criminal evidence. Legal advice should be sought where appropriate, or in cases of doubt.

6.38 The Social Services Directorate should have a contingency plan in place, which can be implemented immediately if C.V.R.S. provides evidence of child abuse. If there is no evidence of abuse the child may be a child in need.

Action in the Absence of a Diagnosis of Fabricated or Induced Illness

6.39 A diagnosis of fabricated or induced illness does not have to have been made in order to protect a child, even though it is suspected. Action can be taken where it can be established that significant harm has occurred, or is likely to occur, and that it can be attributed to a person with parental responsibility.

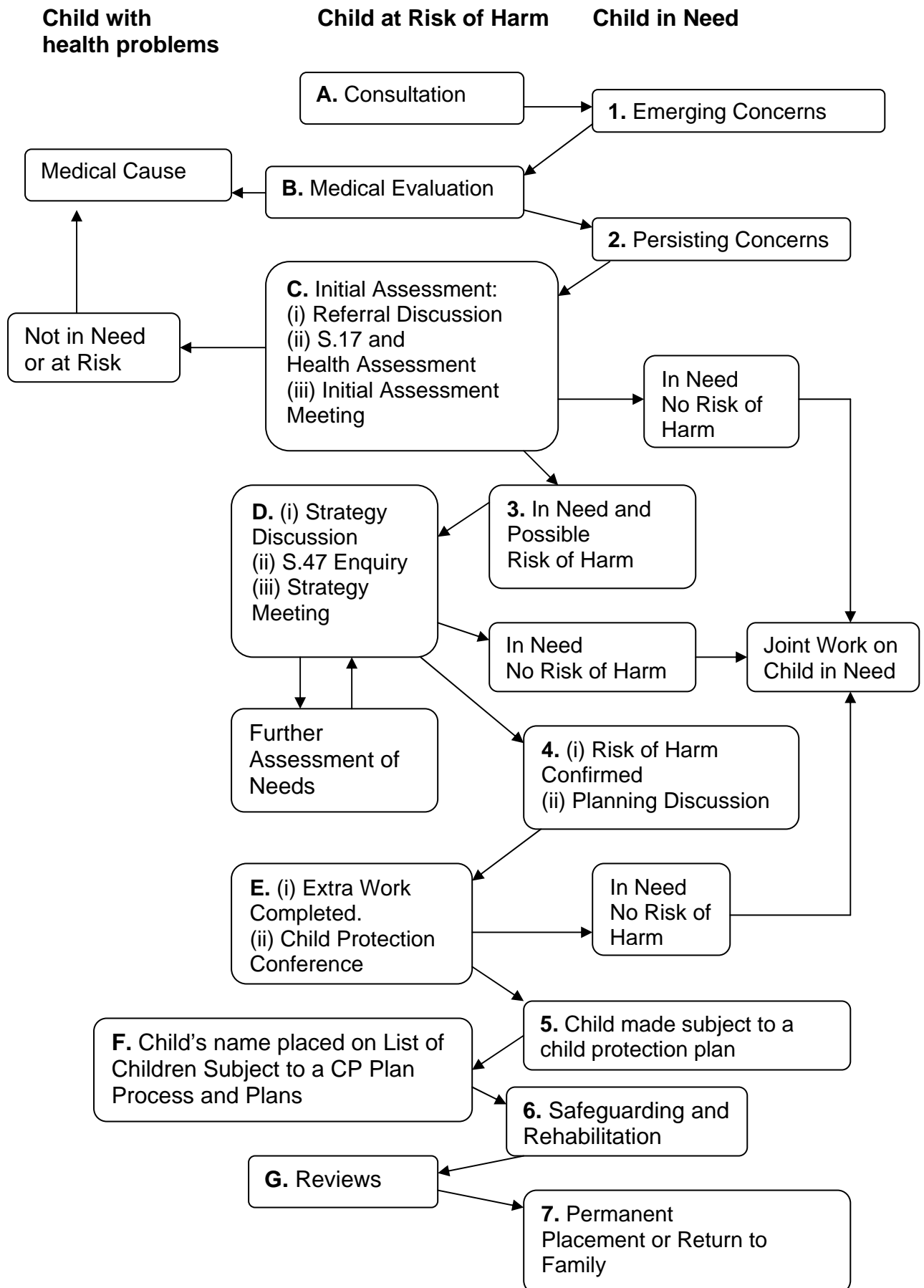
6.40 Once an assessment has been made the normal Child Protection Procedures should be followed and registration be considered under the categories of either Physical or Emotional Abuse. The range of legal powers available, to swiftly protect a child and prevent a parent from removing the child from hospital need to be considered, as in other child abuse cases. These include Police Protection, Emergency Protection Order and Child Assessment Orders. A Child Assessment Order allows for a child to be assessed in hospital, provided it is specifically requested. This would need to be stated in advance in the proposed plan in the application to the Court.

6.41 Careful consideration needs to be given to an alternative placement of a child away from the family home, with relatives or family friends. This is because people close to the parent / carer may find it difficult to accept the existence of fabricated

or induced illness as an explanation for the child's condition. This may make it easier for the parent / carer to obtain access to the child.

6.42 The response of the suspected parent / carer to these measures will set parameters for how much she or he can be worked with, both in terms of her/his own treatment and in ensuring the welfare of the child.

Flow chart



7.0 References

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8.0 Contacts

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