For non-Paediatricians: Flowchart 1. Fabricated or Induced Illness by Carers (FII) suspected by someone who is not a paediatrician

Fabricated or Induced Illness by Carers (FII): guidance for HIPS

Contents

1. National Guidance

Safeguarding children in whom illness is fabricated or induced (supplementary guidance to Working Together to safeguard Children) DCSF HM Government 2008. This is the main interagency guidance to be used in FII. References to this document are given in square brackets [ ].
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

Fabricated or induced illness by carers (FII): a practical guide for paediatricians, Royal College of Paediatrics and Child Health (RCPCH) Oct 2009. This document contains detail about the spectrum of clinical presentations, alerting features and potential outcomes of FII. It details the responsibilities of paediatricians and is an important resource for all health professionals. References to this document are given in curly brackets { }.
https://www.rcpch.ac.uk/system/files/protected/page/Fabricated%20or%20Induced%20Illness%20by%20Carers%20A%20Practical%20Guide%20for%20Paediatricians%202009.pdf

Perplexing presentations (including FII) chapter13 in Child Protection Companion. RCPCH 2nd Ed, 2013. This is the most up-to-date guidance from the RCPCH and it widens the guidance

around FII to include 'perplexing presentations'. References to this document are given in curved brackets (). http://pcouk.org/book.aspx?bookid=1674 (this webpage has limited access)

Child Maltreatment: when to suspect maltreatment in under 18s. NICE CG89 This guidance, updated in 2018, contains a short section on Fabricated or Induced Illness.
https://www.nice.org.uk/guidance/cg89

2. Why this guidance?

Once a professional considers or suspects that a child may be suffering harm due to possible fabricated or induced illness, national guidance is comprehensive in outlining the steps that should be taken and where responsibilities lie. The flowcharts at the end of this document are given as an interpretation of national guidance and steps that should be taken once FII is identified and a multiagency response is needed. The need for a detailed chronology is seen as paramount in FII (pg 113), and the flowcharts emphasise this.

Paediatricians frequently deal with anxious illness behaviour in carers where a child protection response may not be indicated if the child can be prevented from significant harm through containment and reassurance. Principles for managing perplexing presentations for paediatricians are given in the RCPCH Child Protection Companion, 2013 (13.4.8). There is a recognised need for more detailed guidance for paediatricians. Updated national guidance around perplexing conditions and FII from the Royal College of Paediatrics and Child Health (RCPCH) is awaited. Local guidance will then be developed from this as needed.

3. What is Fabricated or Induced Illness (FII)?

There is considerable debate about the nature and definition of FII and there are many different terms in use in the literature. It is likely that the terminology will change over time. FII is not a disease and the RCPCH emphasises that the terms 'fabricated illness' or 'Induced illness' should be used as a descriptions not as diagnoses [2.12].

FII might best be thought of as a child protection description. Therefore, FII might be said to be 'a condition whereby a child has suffered or is likely to suffer significant harm through the fabrication or induction of illness by a carer'.

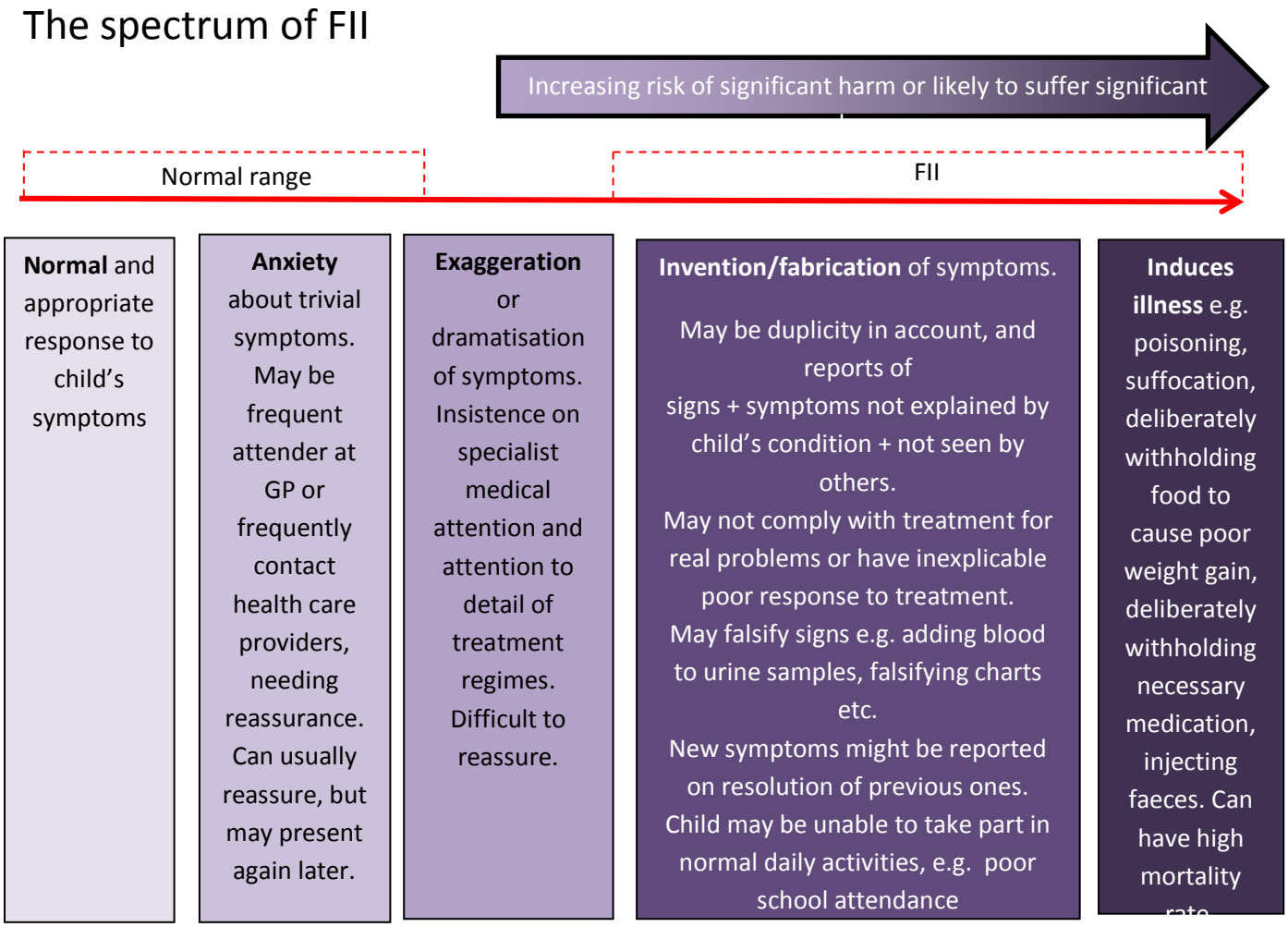
In making a referral, the harm should always be defined. It may include physical abuse, emotional abuse, neglect or impairment of health or development. The harm should not be described just as 'FII'.

Rarely, carers who have delusional disorders or other mental illness may present their children with bizarre or implausible histories of illness, but these are usually recognisable as the carer lacks insight, and the history does not sound plausible. These cases would not be described as FII, though a safeguarding approach is usually needed (13.1.17).

Allegations against staff are not included in this document. The DCSF guidance 2008 gives guidance about this in paragraphs 6.41-6.47

Flow Chart 1. - Fabricated or Induced Illness by Carers (FII) suspected by someone who is not a paediatrician

In practice, FII is often seen as occurring at one end of a spectrum of clinical presentations that are not adequately explained by any confirmed genuine illness. The diagram below demonstrates one way of considering this. The spectrum might best be thought of as showing the range of presentations that might be seen by professionals, rather than necessarily a pathway through which a child might progress.



4. Indicators/presenting features of FII

1. A carer reporting symptoms that are not explained by any known medical condition.
2. Physical examination and results of tests do not explain reported symptoms and signs.
3. The child has an inexplicably poor response to medication/treatment, or intolerance of treatment.
4. Symptoms are exclusively observed by/in the presence of one carer.
5. On resolution of the child's presenting problems, the carer reports new symptoms, in the child or in their other children.

6. The child's daily life and activities are limited beyond what is expected from any disorder the child is known to have. E.g. poor school attendance and use of specialist equipment.
7. The carer seeks multiple opinions inappropriately.
8. FII is associated with previous physical abuse or FII in siblings. A careful family history should be taken, including of any siblings who have died.

(13.1.2)

In some cases there is evidence of FII during pregnancy. When a pregnant woman fabricates illness in herself, this raises serious concerns about the welfare of the child after birth (including ongoing FII) and justifies a pre-birth strategy meeting and often a case conference (13.7.11-13).

There is no one psychological profile of carers. Most are mothers (96%[1]). Many (but not all) have mental health problems, including somatisation, anxiety, depression, history of self-harm, substance abuse, addictive behaviours or personality disorder (especially borderline personality disorder). The carer may themselves have a history of child abuse, including FII (13.8.2).

5. Consequences of FII

The harm done to a child might include physical abuse, emotional abuse and/or neglect, but often the main harm is in impairment of health or development. Children can undergo unnecessary extensive and unpleasant investigations, hospital admissions, treatments or operations. Limitations may be placed on daily life including participation in activities and school attendance.

Many children subject to FII can suffer significant long-term consequences, including long-term impairment of psychological and emotional development and emotional harm, including disordered illness behaviours.

At the extreme end of induced illness there is the risk of pain and distress of illness, a significant risk of death and a risk of under treatment for some conditions (13.3.2). There is evidence that once FII is detected, there is significant risk of further fabrication or other types of abuse.

Research shows that the way in which FII is managed has a major impact on the outcomes for the child. Outcomes are also affected by the extent to which the carers have acknowledged responsibility for FII [2.39]. Outcomes are known to be better where the work is carried out within a child protection framework [4.68]. In one study, the outcomes of children who were placed in foster care were better than those who remained continuously with the carer. Some good outcomes have been reported where there has been long-term therapeutic work with families.

6. Protection and action to be taken

When FII is suspected, it is important to recognise that continuing to carry out medical tests, procedures or treatments could cause the child harm. Medical investigations should take account of which is most likely to confirm either FII or a medical condition {5.3}. (13.4.8)

[1] Yates G., Bass C (2017). The perpetrators of medical child abuse (Munchausen Syndrome by Proxy) – A systematic review of 796 cases. *Child Abuse and neglect.* 72 (2017) 45-53

Flow Chart 1. - Fabricated or Induced Illness by Carers (FII) suspected by someone who is not a paediatrician

Where a child has suffered, or is likely to suffer, significant harm, it is essential to make a referral to children's social care/ MASH in accordance with the referrals procedure. Such referrals should be made in writing by the involved paediatrician to avoid misunderstandings and provide a clear audit trail, taking into account the following:

- Where there are concerns about possible fabricated or induced illness, the signs and symptoms require careful medical evaluation for a range of possible diagnoses by a consultant paediatrician (or their equivalent, e.g. specialty doctor working at consultant paediatrician level), who becomes the 'lead' or 'responsible' paediatrician.

- In a legal judgement, Judge Ryder cautioned that the term FII should be accompanied by a factual description of incidents and behaviours, and he emphasised that the label should not be used as a substitute for factual analysis and risk assessment[2]. It can be helpful to follow the 'three Ds' when considering whether FII presentations justify referral to the Multiagency Safeguarding Hub (MASH), and at all stages:

The three D's:

- **Describe the situation and its extent**
- **Define the harm done or the potential for harm**
- **Demonstrate uncontainability**

- Abusive carers can be manipulative and convincing. They may involve the media or make complaints, which can sometimes distract professionals from the safeguarding process. It is important that staff and senior managers in all agencies are aware of this possibility, and of the need to ensure that the welfare of the child is made paramount. Support for front-line staff should be provided at a senior level.

- When FII is being considered it should not be mentioned to carers if sharing this concern would jeopardise the child's safety or criminal proceedings. If a criminal investigation is needed it is important that a suspect's rights are protected by adherence to the Police and Criminal Evidence Act 1984. This would usually rule out, the suspect being confronted with the evidence by anyone other than the police [4.40]. Confronting carers with suspicions of FII can sometimes lead to them increasing the harmful behaviour in an attempt to be more convincing. There would also need to be caution if the suspected abuser has a history of self-harm or attempted suicide. In these instances a multiagency decision is usually needed about what parents should be told and by whom. Advice can also be sought from named and designated doctors at any point in the process.

- However, at stages earlier in the spectrum (when the child is not thought to be suffering, or likely to suffer significant harm), it is often appropriate for paediatrician to explain to the family that the child's symptoms are medically unexplained, with reassurance that the child would be expected to recover over time. The medical plan should include stopping any unnecessary investigations or treatment, rehabilitation to normal activities and ongoing

[2] A County Council, A mother, A father and XYZ [2005] EWHC 31 (Fam)

medical monitoring/referral to CAMHs as needed (13.1.4). If it is deemed appropriate to discharge a child from paediatric follow up, it is important that there is excellent communication with all professionals so that there is a robust plan for containment and details of how to refer the child back to a paediatrician if needed.

- The motivation of carers should not be the primary concern in initial stages when the priority is to identify whether or not the child is suffering significant harm, but it will become important later in the process when planning intervention and assessing future risk. Professionals who specialise in caring for children are often not equipped to diagnose psychiatric factors in a caregiver, and referral to appropriate adult psychiatric services may be needed[3].
- In complex cases, timescales for completion of any core assessments may need to be extended if specialist assessments can't be completed within the statutory time period [4.52]

7. Flowcharts 1-5:

For non- paediatricians:

1. Fabricated or Induced Illness by Carers (FII) suspected by someone who is not a paediatrician

For paediatricians:

2. Fabricated or Induced illness by Carers (FII) suspected by paediatrician
3. Fabricated or Induced illness by Carers (FII): initial assessment.
4. Fabricated or Induced illness by carers (FII): Section 47 enquiry
5. Fabricated or Induced illness by carers (FII): Child Protection Conference

8. Summary flowcharts 1 and 2

1. Summary flowchart from initial concern to Child Protection Conference
2. Fabricated or Induced illness by carers (FII): Summary of process for chronology

Abbreviations used in flow charts

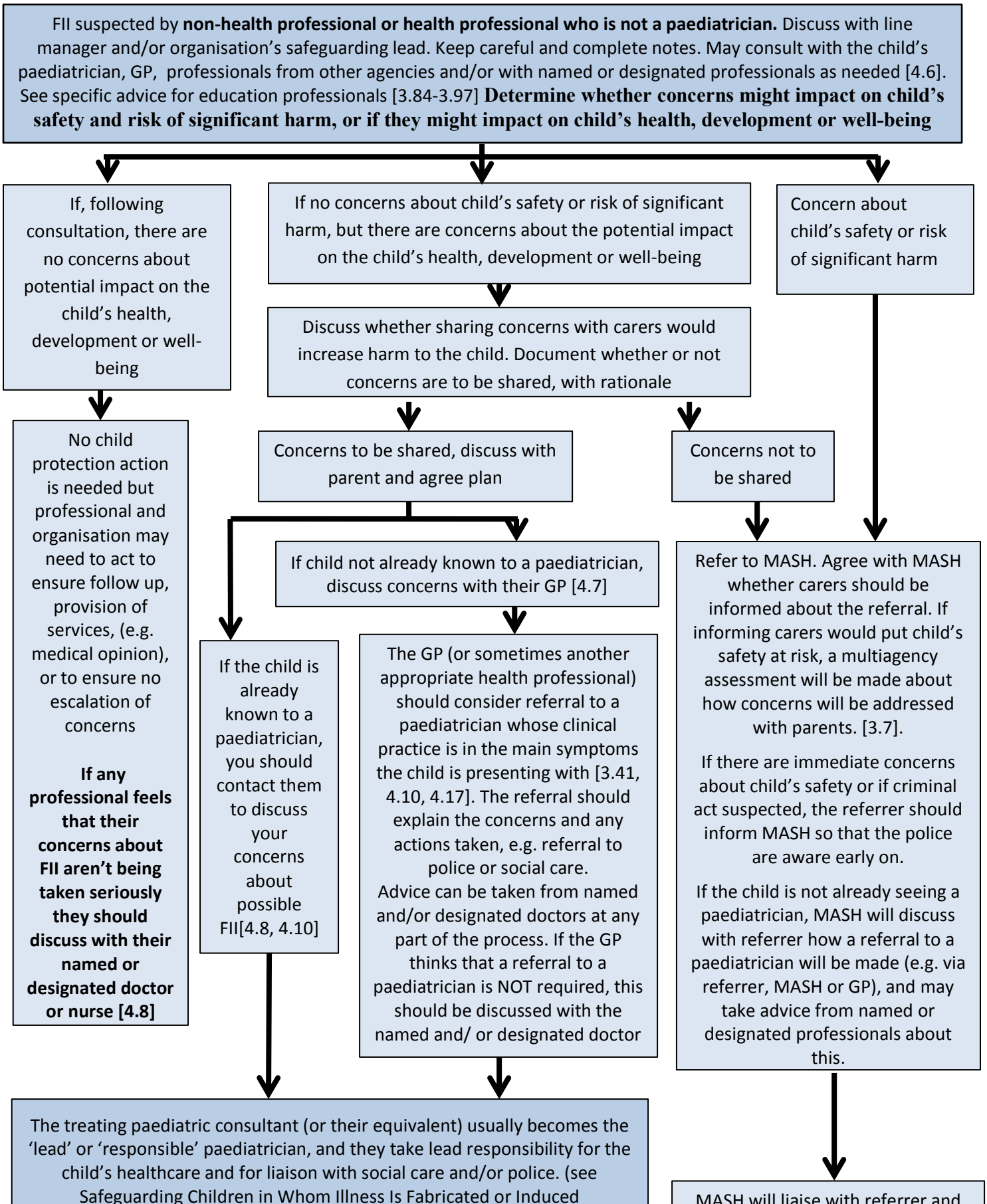
FII = Fabricated or induced illness by carers
LA = Local authority
MASH=Multiagency Safeguarding Hub
ICPC = Initial Child Protection Conference
CPC = Child Protection Conference
[n]= reference to paragraph number in Safeguarding children in whom illness is fabricated or induced (supplementary guidance to Working Together to safeguard Children) DCSF HM Government 2008.

[3] Lazenblatt A (2013). Fabricated or induced Illness in Children: A narrative review of the literature. *Child Care in Practice*. 19 (1):61-7

Flow Chart 1. - Fabricated or Induced Illness by Carers (FII) suspected by someone who is not a paediatrician

{n} = reference to paragraph number in Fabricated or induced illness by carers (FII): a practical guide for paediatricians RCPCH Oct 2009.

(n) = Perplexing presentations (including FII) chapter 13 in Child Protection Companion. Royal College of Paediatrics and Child Health 2nd Ed, 2013



For paediatricians: Flowchart 2. Fabricated or Induced illness by Carers (FII) suspected by paediatrician

The lead/responsible paediatrician suspects Fabricated or Induced Illness by carers (FII). They take lead responsibility for child's healthcare

- Immediate referral to MASH, in writing, from the paediatrician, if there is an acute event that could be due to physical abuse e.g. acute suffocation or poisoning. Secure any potential evidence. E.g. feeding bottles, giving sets, urine samples etc. Examine for NAI.
- Concerns about FII should not be discussed with parents. You can say you are very concerned about the child and need to observe them closely[4.11]
- In more chronic cases, consult with peers, seniors, colleagues and/or arrange a professionals meeting as needed [3.22]. The responsible paediatrician should also consult the named doctor about safeguarding concerns. If the responsible paediatrician is the named doctor, they should consult the designated doctor [3.21].
- Early concerns should be documented in the child's record in case the child is seen by clinicians who are not aware of the concerns. The carers access to the record may need to be restricted (13.4.9)
- Any specialists should be briefed about FII concerns and their remit should be clearly defined. The responsible paediatrician retains overall management of the case. Changes of clinical team should be resisted. Manage requests for second opinions carefully including with advice from named or designated doctors {5.25-5.35}.
- Discuss any forensic tests with the police, in conjunction with a referral to MASH, which should be made in writing by the paediatrician.
- Gather necessary information/health records from GPs, health visitors, ED, and other hospitals etc.[3.20, 3.24]. A health chronology should be developed. This may be done in stages. {5.14-5.22}. It is helpful if the agreed format is used from the outset (see end of this document). Seek consent to access records on basis that you are trying to get to the root of the child's problems. At this stage it is not appropriate to discuss FII with carers. The trust safeguarding team should be asked to assist with the chronology.
- If needed, arrange inpatient admission for observation of signs and symptoms. It is important to take into account what the child says. The paediatrician should make every effort to see the child without the parent present [4.12]

Discussions with a senior colleague in children's social care may be helpful in deciding whether and when a referral should be made. You can discuss with social care if there is suspicion of significant harm. FII does not have to be proved [3.20].

Use 3Ds- Describe situation, Define harm, Demonstrate uncontainability

If reasonable cause to suspect that a child is suffering or likely to suffer significant harm, refer to MASH [3.27] in writing. You should send a written clinical report, outlining the medical concerns.

At this stage you can explain to carers that symptoms are unexplained. Parents should be kept informed about results of medical tests. Multiagency assessment will be needed to decide who will discuss concerns about FII and the child's welfare with parents, and where and when this will be done. [3.7, 4.16].

If there are immediate concerns about a child's safety or if a criminal act is suspected, you should inform MASH. The police should always be involved in the MASH assessment [4.17]

Initial assessment required

See flowchart 3

If no further LA involvement at this stage, the referrer should be informed and any other actions agreed. The child should be monitored by health professionals. If further information leads professionals to believe the child may be at risk of significant harm, they should re-refer to MASH, as above

Flowchart 3. Fabricated or Induced illness by carers (FII): initial assessment.

Continued from flowchart 2

Initial assessment carried out by Children's Social Care (CSC). CSC takes lead responsibility for child's welfare and safeguarding [4.17] and conduct initial assessment in conjunction with the lead paediatrician. If a criminal act is suspected, the police take lead responsibility for investigation [3.99, 4.17]. The paediatrician takes lead responsibility for child's health care [4.17]. Immediate action may be required to ensure child's safety in which case an immediate strategy meeting is convened [4.21]

Concern substantiated but child not thought to be at risk of significant harm. +/- may initiate core assessment under section 17 of children act

A senior social worker should endorse any decision not to hold a CPC. [4.45]
Social worker discusses next steps with family and team decide what services are required, social worker co-ordinates provision of services and records decisions

Feedback to referrer [4.18]. Monitoring continues.

Concern is substantiated and child may be at risk of significant harm. CSC and paediatrician discuss next steps [4.22]

Strategy meeting.

To include a paediatrician with expertise in the symptoms the child is presenting with. Timing and location of the meeting will need to take account of the paediatrician's availability. [4.29, 4.32].

SHOULD AGREE WHAT PARENTS SHOULD BE TOLD AND BY WHOM.

Disclosure of concerns about FII should usually involve the paediatrician and social worker together, but if police investigation is planned, the police should do this. {See 7.1-7.7 of RCPCH guidance}

If concern substantiated and chronology needed:

The agencies should agree who will be responsible for gathering, coordinating and interpreting information /chronologies from different sources (and including siblings' chronologies if needed). For example: The responsible paediatrician (in conjunction with their Trust's safeguarding team) may be best placed to gather information from their own trust, other consultants and from hospitals, and they may be best placed to compile the complete health chronology. The MASH health representative may be best placed to request information from GPs and local health trusts (to be sent to the lead paediatrician). Social care and police may be best placed to gather information from their respective agencies, including information from other areas.

CSC should ensure that a comprehensive chronology of a child's history is compiled [3.69], and they would then have responsibility for combining chronologies from different agencies for discussion at a later strategy meeting or ICPC.

Chronologies should be gathered on a template, used across all agencies so that they can be easily combined and interpreted. The agreed template is at the end of this document.

FOLLOW NATIONAL GUIDANCE IF COVERT VIDEO SURVEILLANCE CONSIDERED [6.35-6.40]

Concerns not substantiated and child not thought to be at risk of significant harm. If no further CSC involvement at this stage, the referrer should be informed and any other actions agreed

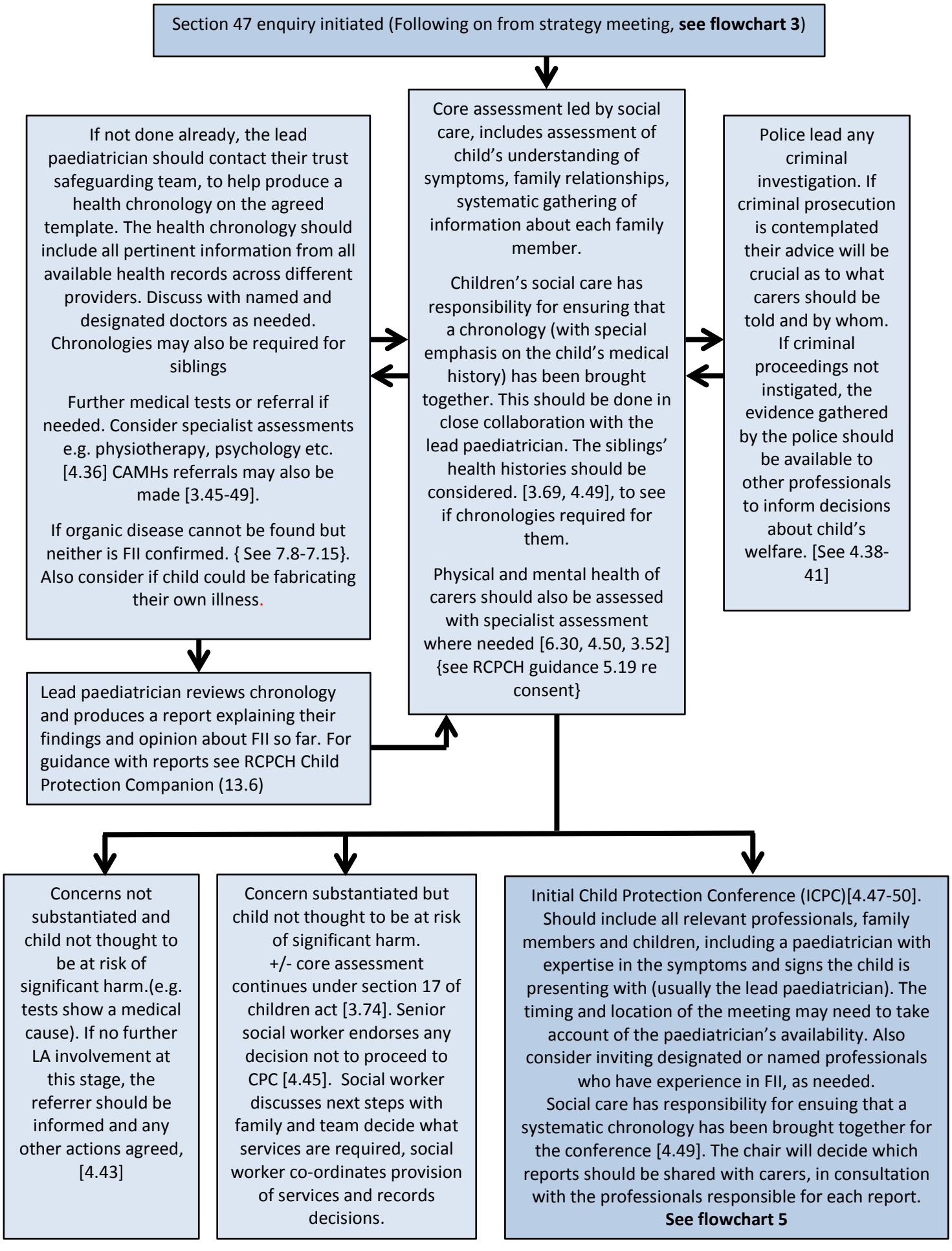
The child should be monitored by health professionals. If further information leads professional to believe the child may be at risk of significant harm, they should re-refer to MASH, as above

Concern substantiated and child thought to be at risk of significant harm. Section 47 enquiry initiated

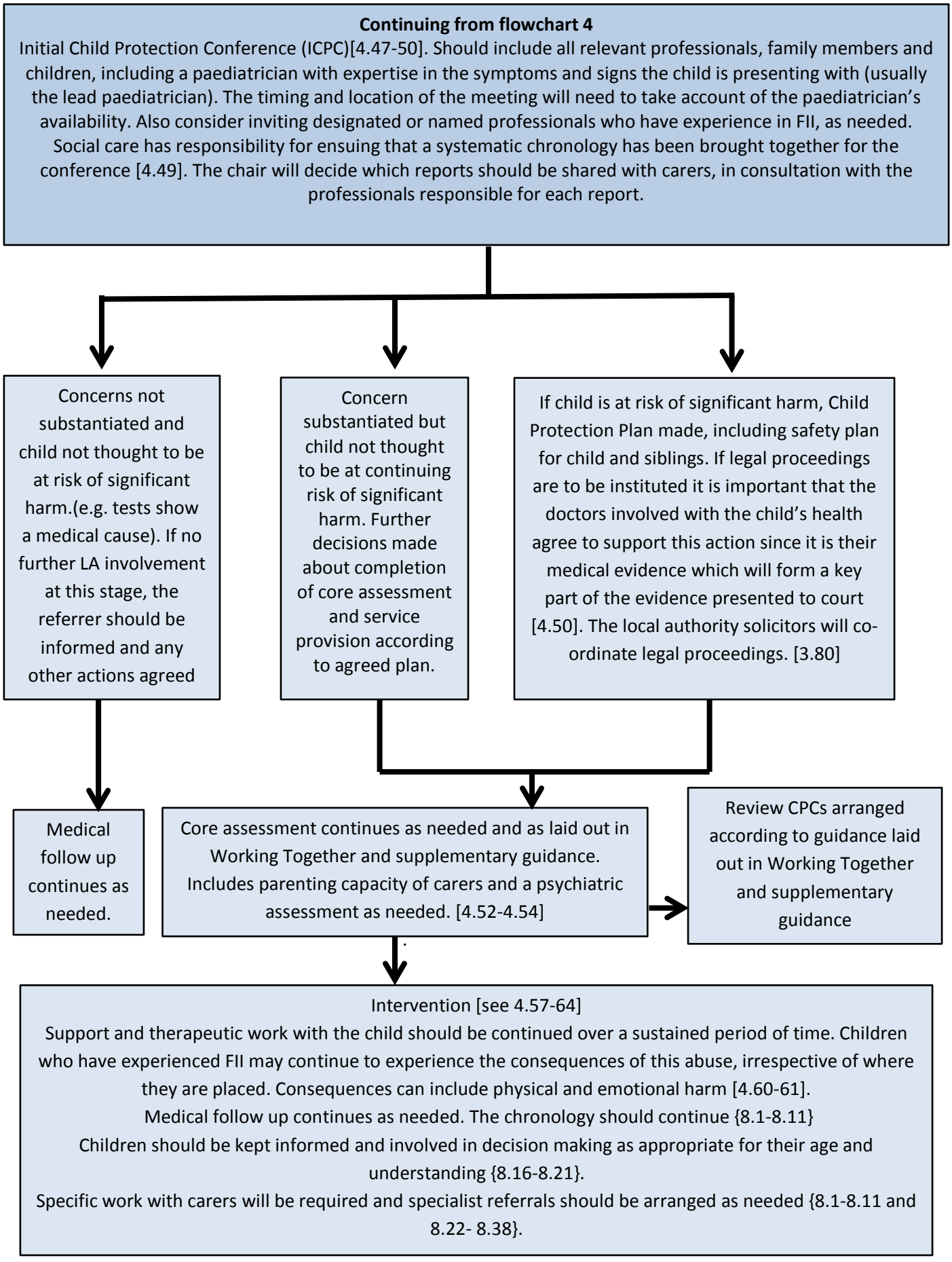
See flowchart 4

Police may investigate possible crime

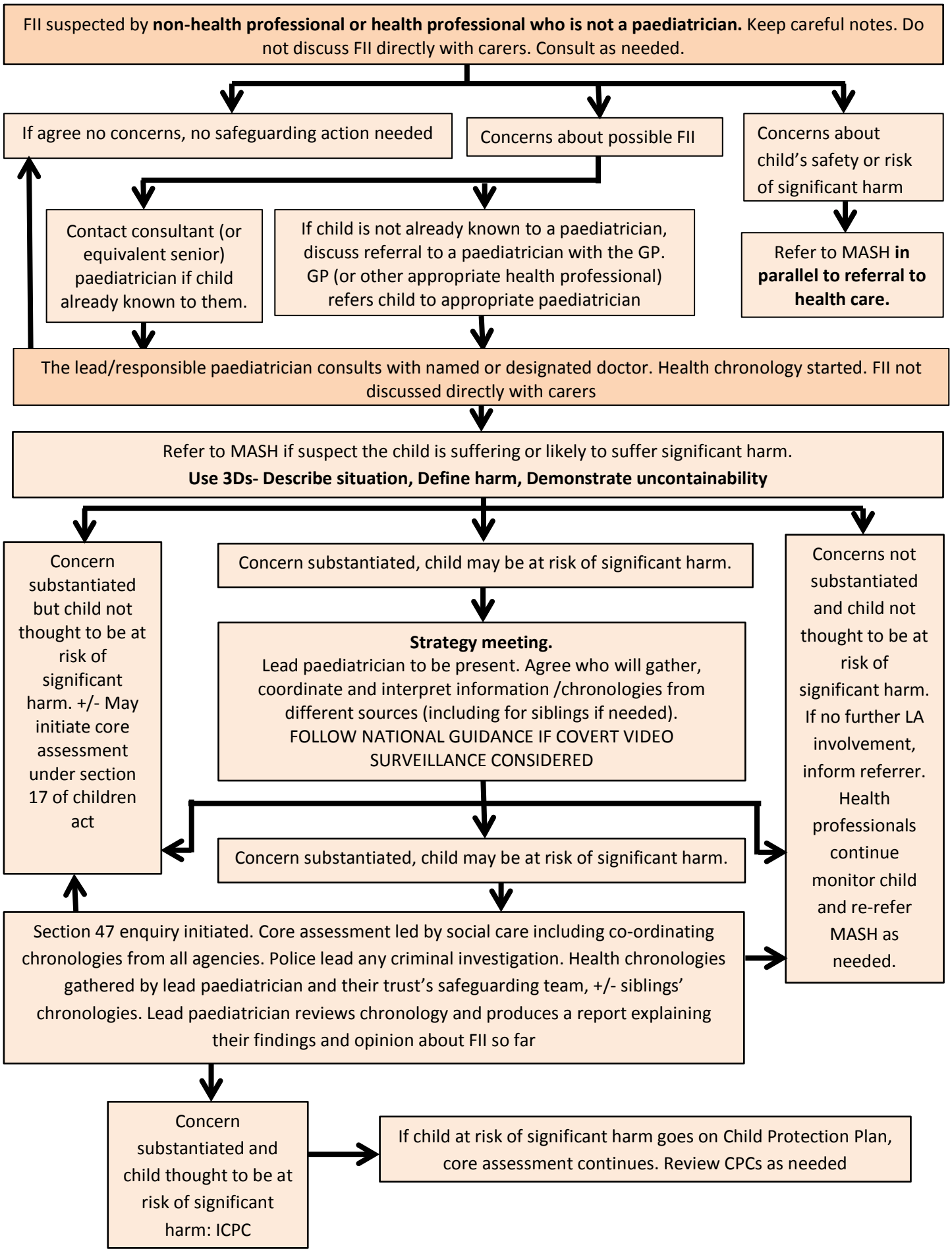
Flowchart 4. Fabricated or Induced illness by carers (FII) : Section 47 Enquiry



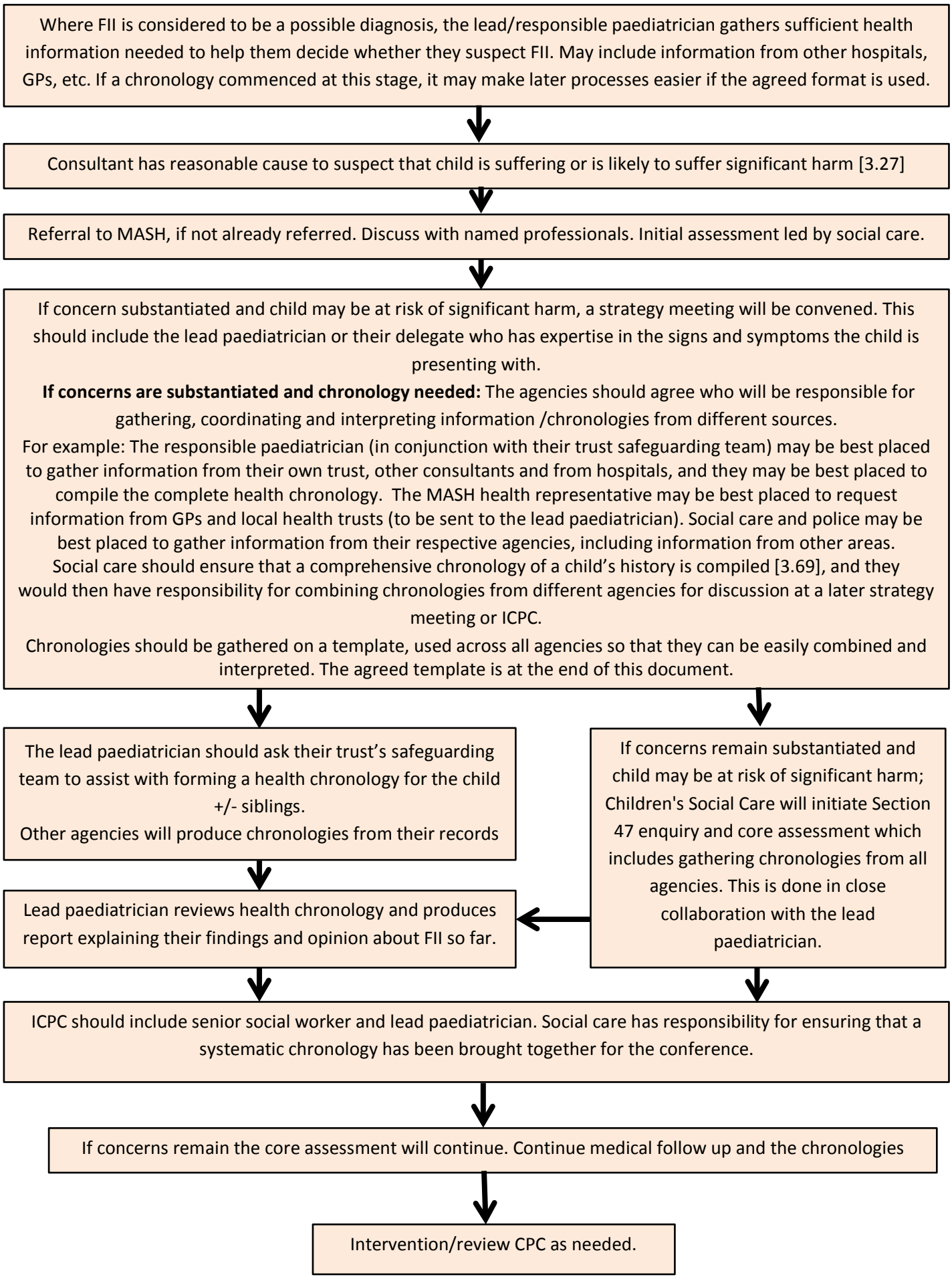
Flowchart 5: Fabricated or Induced illness by carers (FII): Child Protection Case Conference



Summary flowchart 1 Summary of process from initial concern to case conference.



Summary flowchart 2: Summary of process for chronology.



Chronology of events

Date chronology finalised

Name of child: ..... **Date of birth:** ..... **NHS number (if known):** .....

Produced by (name): ..... **Designation:** ..... **Organisation** .....

Date **PLEASE USE STANDARD FORMAT:** **Day/mth/yr:** **Eg 03/07/2018**	**Time of action**	**Organisation + job title of professional**	**Contact type** e.g. letter, phone, e-mail and **source of information, e.g. residential file, health visitor notes**	**Description.** This should be a **summary** of the record to include any actions taken, unless the words used are significant when the exact wording should be reproduced. Where relevant, include **WHO** reported the concerns, whether the reported signs and symptoms were **independently observed** and what the medical findings were. Also include any **effects** this had on the child, their siblings and their parents, e.g. on their health, school attendance, work and family and social life. Include the **parent's explanations** for the child's reported ill-health. Include any **changes of health care professional** and the reason for the change.	**Was child seen or spoken to? What was observed or communicated by the child?**	**Comments by author re significance**

N.B - I*t is vital that the chronology is completed to this format and that whenever abbreviations are used a glossary is provided*