

Safeguarding Children in Whom Illness is Fabricated or Induced

*A review of the implementation of the
2002 guidance within the NHS*

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Executive summary

This report reviews how the guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced*¹ is being implemented within NHS settings. The review followed a number of high profile serious case reviews highlighting system weaknesses in safeguarding children and young people. The review was established to consider how resilient the health system is in safeguarding children and young people being deliberately harmed by family and carers. The review was overseen by an Advisory Body of key stakeholders and individual experts.

The key findings of the review are drawn from a survey of NHS and social care staff attitudes on fabricated or induced illness, one-to-one interviews, focus groups and an analysis of serious case reviews in the public domain.

The survey provided evidence on staff attitudes to fabricated or induced illness and experience of managing cases in the context of organisational and multi-agency frameworks. 535 responses were received, which although self-selecting would allow some inferences about the views of staff working in the NHS to be drawn. Key findings highlight the following:

- Greater knowledge of the existence of the fabricated and induced guidance is needed amongst all NHS staff, (including paediatricians and generalists in a wide range of health services such as unscheduled care);
- More focused implementation of the guidance through better and shared multi-agency protocols and joint training;
- Better management of suspected cases, both clinically and in relation to co-ordination by local authority children's services; and
- Continuing personal anxiety amongst paediatricians about the implications of identifying fabricated or induced illness rightly or wrongly.

Summary of proposals

1. The Department for Children, Schools and Families and the Department of Health should agree ways to promote the revised guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced* (2008)³ so it is promoted extensively in the NHS and by the professional bodies.

- Ways should be found to bring it to the attention of private health providers of children's services, including providers of complementary therapies.
2. There needs to be wide-ranging readership of the guidance outside paediatric services. The Department for Children, Schools and Families and the Department of Health should consider an abridged or flowchart version for promotion in these various services on the basis of "what to do if fabricated or induced illness is suspected."
 3. When revising the report, *Fabricated or Induced Illness by Carers*, the Royal College of Paediatrics and Child Health should work collaboratively with the Academy of Medical Royal Colleges, the Nursing, Midwifery and other Royal Colleges, the Royal Pharmaceutical Society and other relevant professional bodies to make it a shared inter-collegiate document that is brought to the attention of a wide range of health care staff.
 4. Primary Care Trusts, NHS Trusts and Foundation Trusts' Boards should ensure that as part of working on effective arrangements within their Local Safeguarding Children Boards, they have robust arrangements in place for promoting the revised guidance, and for uptake of staff induction on safeguarding children and young people, which includes a focus on fabricated or induced illness and the role of named and designated professionals and how they can be contacted.
 5. As requested in 2006 by the Department of Health, the development of guidelines by the National Institute of Clinical Excellence on suspected child abuse should include identification of fabricated or induced illness.
 6. Clinical Medical Directors of paediatric services should ensure robust arrangements are in place in their NHS Trusts, Foundation Trusts or Primary Care Trusts to enable consultant paediatricians to have access to teams within their Trusts and across to other clinical networks outside their organisations, to discuss clinical concerns about identification, diagnosis and clinical management of fabricated or induced illness cases.
 7. As a general development to support more effective information on safeguarding children and young people, the development of the Care Services Improvement Partnership safeguarding children networks and website, and the plans to look at the feasibility of extending it to clinicians beyond designated and named doctors and nurses by providing a supra secure discussion forum for complex and forensic cases, is to be welcomed.
 8. The revision of the guidance (*Safeguarding Children in Whom Illness is Fabricated or Induced (2008)*)^{3]} to take account of changes to *Working*

Together to Safeguard Children is timely, and in the light of the findings of this Review welcome that the changes being made will:

- Emphasize the necessity for all staff to be aware of their Trusts' and Local Safeguarding Children Board's policies and practices;
 - Clarify the co-ordinating role of the lead paediatricians vis-a-vis the consultant in charge of the child's care if the consultant is not a paediatrician;
 - Include a pathways chart of responsibilities and actions to be taken which will cover what to do where fabrication is identified to be at the lower level or where the evidence of fabricated or induced illness is less certain;
 - Make more prominent in the pathways chart the need always to talk directly and involve the child or young person, where possible;
 - Affirm resolution protocols to be in place to support staff when professional conflict arises over identification, diagnostic and management decisions.
9. That the Healthcare Commission has regard for the content of this report in its assessment and inspection arrangements.
10. As part of promoting the revised guidance on fabricated or induced illness, the Department for Children, Schools and Families should:
- Remind Local Safeguarding Children Boards to incorporate the guidance into their local procedures and training, setting out in clear terms what is expected of adult mental health services, primary care and general practice and collaboration with the police and other agencies.
 - Ask Local Safeguarding Children Boards to ensure that their members, including Primary Care Trusts, NHS Trusts and Foundation Trusts, bring the guidance to the attention of all their staff, in accessible formats, promoting the pathways chart on fabricated or induced illness to clinicians and staff in all age specialties and services where children and young people are seen.
11. Widely promote the Department for Children, Schools and Families' forthcoming training resources on fabricated or induced illness, *Incredibly Caring DVD*, which is designed to assist with local implementation of the revised guidance *Safeguarding Children in Whom Illness is Fabricated or Induced (2008)*].

12. When the revised guidance is published, Local Safeguarding Children Boards should be asked to ensure that their multi-disciplinary and inter-agency safeguarding training programmes include fabricated or induced illness.

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CHAPTER 1

1.0 BACKGROUND

- 1.1. In 2004, Department of Health Ministers asked the Government's Chief Medical Officer, Sir Liam Donaldson, to review how the guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced*¹ was being implemented within the NHS. This is supplementary guidance to *Working Together to Safeguard Children*⁴. The review was to consider how resilient the health system is in safeguarding children being harmed deliberately or suspected of being harmed by their families or carers, including when a child is receiving care within an NHS setting.
- 1.2. This review follows a number of high profile serious case reviews highlighting system weaknesses in safeguarding children and young people and a report by the Royal College of Paediatrics and Child Health⁵. This highlighted how criticism of doctors in the media, high profile court cases and disciplinary action being taken by the General Medical Council, the medical regulatory body, was deterring some paediatricians from undertaking child protection work.
- 1.3. The statutory inquiry into the death of Victoria Climbié⁶, and the first joint Chief Inspector's Report on safeguarding children⁷, had identified the lack of priority status given to safeguarding matters within some NHS organisations and led to a range of developments across children's services under the *Every Child Matters*⁸ agenda and the provisions in the Children Act 2004⁹. This guidance and statutory provision placed a duty on all agencies to make arrangements to safeguard and promote the welfare of children, identifying the shared responsibility of safeguarding and the need for effective joint working between agencies and professionals who have different roles and expertise in promoting the welfare of children and protecting them from harm. Nationally, the responsibility for children's services and safeguarding them sits with the Department for Children, Schools and Families supported by other government departments including the Department of Health.

The review terms of reference

1.4 The purpose of the review was set out as follows:

- To review implementation of the guidance on *Safeguarding Children in Whom Illness is Induced or Fabricated*¹ in the NHS and assess if more effective implementation can be achieved by focusing on:
 - Clarity, accessibility and implementation of procedures in Primary Care Trusts, NHS and Foundation Trusts for safeguarding children, for identifying and managing child abuse and for reporting incidences. These should be integrated into each Trust's clinical governance arrangements;
 - Paediatricians' experience and views on responsibilities in handling individual cases especially in relation to child welfare concerns, identification of fabricated or induced illness in cases where there may be clear grounds to believe a child is suffering or is at risk of suffering significant harm, comprehensive medical evaluation, referral, contribution to assessments under the Children Act 1989¹⁰ and implementation of actions agreed;
 - On the matter of comprehensive medical evaluation, the review to take into account implementation of the relevant recommendations of Lord Laming's report⁶ as endorsed by the Government's response especially and including the need to take a history directly from the child even when the consent of the carer has not been obtained;
 - In terms of information collection, a review of how all the information available is collated, integrated together and systematically organised to ensure co-ordination of care with clear discussion to reconcile differences in medical opinion about diagnosis of deliberate harm and with a single consultant charged with the responsibility for the child protection aspects of the case and hospital discharge procedures. The review should reflect the report on clinical issues produced in February 2002 by the Royal College of Paediatrics and Child Health⁵, which advises on professionals suspending disbelief and putting the interests of the child foremost through application of competence and protocols;
 - The views and understanding of members of multi-disciplinary clinical teams, named and designated professionals in relation to the above points.

- To draw out lessons to be learnt from the review of cases about potential areas of vulnerability in the way current guidance on fabricated or induced illness is being implemented.
- 1.5 The review was supported by an Advisory Group, with representation from key stakeholder bodies (Annex A). The remit of the Advisory Group was:

“To improve NHS protection of children by advising the Department’s review of NHS implementation of guidance on fabricated or induced illness. In particular, to advise on the conduct of the review and to quality assure the findings as they emerge from the review”.

Gathering the information

- 1.6 The review drew on the following sources of research, information and opinions:
- An online anonymous staff attitude survey on the extent of the awareness of existing fabricated or induced illness guidance and how it is used;
 - An analysis of serious case reviews that were available in the public domain since the fabricated or induced illness guidance was published in 2002;
 - Semi-structured interviews with individuals involved in fabricated or induced illness work, with a particular focus on paediatricians; and
 - Focus groups to test the emerging themes from the staff attitude survey and follow-up telephone interviews undertaken, the serious case review analysis and the semi-structured interviews.
- 1.7 Originally, it had been planned the review would take a year to complete and report. However, the sensitive nature of the subject matter required careful development of the methodology to be used. The Advisory Group was consulted on the best way forward and used as a sounding board in the planning of the review processes, thus ensuring that once the review work commenced, it was able to move forward without hindrance.

The approach in this report

- 1.8 The four approaches set out above contributed to the overall findings of this report, which provides:

- A review of the evidence and relevant policy on fabricated or induced illness
 - Key findings from the information gathering
 - Issues and challenges in the system
 - Proposals for improving implementation of fabricated or induced illness guidance in the NHS.
- 1.9 Throughout this report when referring to the 2002 guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced*, the term “the guidance” is used.
- 1.10 Children’s services are used to describe local authority social services.

CHAPTER 2

2.0 FABRICATED OR INDUCED ILLNESS - EVIDENCE, POLICY CONTEXT AND PERFORMANCE ASSESSMENT

The evidence

- 2.1 Fabricated or induced illness - previously known as Munchausen syndrome by proxy (MSBP) - is a rare condition, in which a parent or carer fabricates or induces illness or injury in others, most usually a child, with no obvious motive or gain. A two-year study of the epidemiology of fabricated or induced illness published in 1996 suggested, “in a hypothetical district of one million inhabitants, the expected incidence would be approximately one child per year.”¹¹ A prevalence of 0.1 – 0.8 per 100,000 children under 16 years old was suggested in that study of child protection registrations but 2 per 100,000 was reported for the same age group in a later study in New Zealand, when awareness had improved¹². Half of those were associated with underlying chronic illness. Multiple symptoms featured in 72% of those cases.
- 2.2 In fabricated or induced illness, there may be a spectrum of behaviours of varying severity in impact on the child, ranging from fabricated illness where signs and symptoms are fabricated, to induced illness where there is direct interference and harm. Fabrication is present in most cases of induced illness. For both fabricated and induced illness, specimens may be falsified to support the story. An unpublished study, the Northern Borough Study (2) by Eminson, Watson and Coupe in 1999, identified 58 children from 42 families who had been subject to the behaviours, of whom six had suffered direct inductions. A literature review involving 566 papers with 677 index cases by Postlethwaite, Eminson and Vail, 2006, published in abstract only at present, found the following characteristics:
- The physical impact on children escalates according to whether it is verbal fabrications, withholding (nutrients or medicine) or inducing illness;
 - Death of the index case is highly associated with

inductions by toxicity; the relationship for siblings is less clear cut;

- Verbal fabrications may not progress over many years to induction attempts;
- Perpetrators are predominantly female;
- Some perpetrators had existing vulnerabilities such as childhood abuse or neglect; somatic focus on self; personality traits or disorders; relationship difficulties, a pre-existing mental illness or substance misuse problem;
- Other child abuse is commonly present; and
- Fabrication or induced illness can co-exist with an underlying medical condition in the child.

2.3 The literature available affirms that the medical system's 'investigation-orientated fascination with rare conditions,' inadvertently provides a readily available vehicle for enabling parents to perpetuate severely abusive behaviours on children through induced illness."¹³

2.4 The use of different terminology to describe fabricated or induced illness has been the subject of considerable debate between professionals. Terms used include Munchausen's Syndrome by Proxy¹⁴ or Factitious Illness by Proxy^{15,16} or Illness Induction syndrome¹⁷. Fabricated or induced illness rightly puts the focus on the child and the harm being suffered, rather than the perpetrator. The term Paediatric Condition Falsification is adopted by the American Professional Society on the Abuse of Children.

2.5 Fabricated or induced illness is a form of child abuse and may itself co-exist with other types of child abuse. The range of symptoms and body systems involved in the spectrum of fabricated or induced illness are extremely wide, as can be the medical services in which children present, spanning primary, secondary and tertiary care.

2.6 Despite the unequivocal evidence that carers can and do cause harm to children through fabricated or induced illness, recognising, identifying and accepting fabricated or induced illness is present is not easy and may require clinicians to suspend their disbelief, maintaining the welfare of the child as a priority. Amongst some clinicians, there is a reluctance to diagnose and be involved in child abuse cases¹⁸. A number of factors appear to contribute to this, amongst them fear of complaints whether locally or to the General Medical Council¹⁹, pressure from the media and parent groups representing those who believe their children have been

wrongly identified as a case of fabricated or induced illness, difficulties with multi-agency working and a strong sense of being isolated when involved in a contentious case of fabricated or induced illness.

- 2.7 A literature review of 'Munchausen Syndrome by Proxy' carried out in 2000²⁰ concluded that the professional community was now more aware of the situations and presentations of the condition and suggested further work is done to identify the many issues related to the epidemiology of fabricated or induced illness.
- 2.8 However, a search of a range of databases for literature and papers on fabricated or induced illness or however called, published since 2002, revealed a small number of relevant citations. The majority were reviews of previous literature, case reports, and discussions on ethical issues, journal letters or reports on court cases. There is a dearth of recent publications which review the epidemiology and next to nothing on the outcomes of interventions both in actual or suspected cases.

The policy context

- 2.9 Guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced*¹ provides a national framework within which agencies and professionals at local level – individually and jointly – should draw up and agree more detailed ways of working together where illness may be fabricated or induced in a child. To keep the child's safety and welfare as the primary focus of all professional activity and avoid difficulties with differences of opinion, the guidance refers to the "fabrication or induction of illness in a child". The guidance is intended to provide a process for professionals to follow if, as a result of a parent's or carer's behaviour or investigations, there is concern a child is suffering significant harm or is likely to do so. The key issue is the impact on the child's health and development and consideration of how best to safeguard and promote the child's welfare.
- 2.10 The guidance makes foremost the importance of working together across health, education services, social services, police, probation services and with others whose work brings them into contact with children and families, including people working in the voluntary and independent sectors. The guidance should be incorporated into local child protection procedures by Local Safeguarding Children Boards.
- 2.11 Earlier in the same year as the first edition of the guidance was issued, the Royal College of Paediatrics and Child Health published *Fabricated or Induced Illness by Carers*⁵ which deals with the clinical issues in more

detail. The College report provides practical advice for paediatricians on their role and how they can work with other agencies. It recognises the difficulties professionals may experience and the need to overcome incomprehension and disbelief when faced with the possibility of this form of child abuse. Both the guidance and the Royal College of Paediatrics and Child Health report also provide a brief overview of the literature and research.

- 2.12 Sir Ian Kennedy's 2001 report on children's heart services in Bristol ²¹, the First joint Chief Inspectors' Report on *Safeguarding Children* ⁷ in 2002, Lord Laming's report on the inquiry into the death of Victoria Climbié in 2003 ⁶ and Sir Michael Bichard's report into the child protection procedures in Humberside Police and Cambridgeshire Constabulary in 2004 following the murders of Jessica Chapman and Holly Wells ²², all highlighted a range of serious problems in the system in place to safeguard children. In the Government's systematic programme of work to improve outcomes for children, being safe and healthy are amongst five priorities that children and young people themselves identified ²³. The resulting vision and strategy puts children at the heart of public services and was set out in *Every Child Matters* ^{8,24}. The five key outcomes have a statutory underpinning in the Children Act 2004 ⁹. At the same time, the *National Service Framework for Children, Young People and Maternity Services*, to be implemented by 2014, set standards for health, education and social services which have safeguarding as a theme throughout, in addition to being a dedicated service standard ²⁵.
- 2.13 Following the enactment of the Children Act 2004, a series of statutory guidance ²⁶ was published to support local authorities and their partners, including Primary Care Trusts, NHS Trusts, Foundation Trusts and Strategic Health Authorities, to implement their new statutory duties, including the need to safeguard and promote the welfare of children and participate on Local Safeguarding Children Boards
- 2.14 An updated version of *Working Together to Safeguard Children* ⁴ was published in April 2006, following changes to safeguarding children processes arising from the 2004 Children Act ⁹. The guidance on fabricated or induced illness is currently being revised in the light of these developments and, when published, will be accompanied with support materials on training.

Performance assessment

- 2.15 The planning framework for health services from 2005/08, set out in *National Standards Local Action* published in July 2004, ²⁷ details core standards to be complied with now, and developmental standards to be

complied with over time. Child protection (C2 is a core standard to be complied with now. The National Service Framework for Children, Young People and Maternity Services, for implementation by 2014, has a dedicated safeguarding children standard and a recurrent safeguarding theme in the other ten standards.

- 2.16 In its function of encouraging improvement in the delivery of healthcare and public health in England, the Healthcare Commission has a duty to pay particular attention to the need to safeguard children and young people, promote the rights and welfare of children and promote the effectiveness of measures taken to do so. The Commission does so through a number of ways. Its annual health check of NHS performance covers safeguarding children by a self-assessment and declaratory process from NHS Boards against core standard C2 which states:

“Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.”²⁷

- 2.17 Self-declarations are checked against surveillance information and supplemented by comments from patient representatives and partners of the health bodies. 10% of health organisations are randomly selected for inspection of their declaration. For 2006/7, as part of the process of checking, the Commission invited Chairs of Local Safeguarding Children Boards to comment on the declarations from their Primary Care Trusts, NHS Trusts and Foundation Trusts and in particular, whether each Trust complies with national guidance in relation to cases of suspected fabricated or induced illness. The outcomes are set out in the annual health check published in 2007²⁸.

- 2.18 There is also a core standard C7 in the governance domain. This is framed to ensure healthcare organisations are providing the managerial and clinical leadership, accountability and culture necessary for continuous improvement, effective working systems and practices and patient safety. Core standard C7 states:

“Healthcare organisations: (a) apply the principles of sound clinical and corporate governance, ..., (c) undertake systematic risk assessment and risk management.”²⁷

- 2.19 The governance issues in safeguarding children and young people and safe systems of care are not specifically picked up in the assessment of this core standard C7 and, although the assessment of C2 includes such responsibilities as Trust Boards’ arrangements for safeguarding, it does not pick up the issues of risk management in systems to safeguard children and

young people who are in hospital care. A recommendation is therefore proposed in chapter 4 of this review report.

- 2.20 Working with Ofsted and the other national Inspectorates, joint area reviews are conducted every three years in every local authority that provides children's services, to look at the impact that local services and partnerships have on the outcomes experienced by children and families. The Inspectorates have recently changed the way in which joint area reviews are undertaken to focus more closely on the experiences of children who have the poorest outcomes, including those with disabilities and those looked after by local authorities. Safeguarding children remains a priority.
- 2.21 Improvement reviews are another type of independent assessment undertaken by the Commission to look at the quality of care provided by the health services, especially where there are substantial opportunities to help healthcare organisations to identify where and how they could improve or perform better. A review published this year on services for children in hospital reported serious concerns about quality and safety of care in a small number of trusts²⁹. Furthermore, child protection was identified as a major risk, with 58% of hospital services accessed by children and young people not meeting training standards in safeguarding. Improvement is being tracked through the annual Child Health Services Mapping project³⁰ and annual performance assessment of trusts.
- 2.22 Strategic Health Authorities set and manage the strategic direction of the NHS locally. They have a role both in ensuring local systems operate effectively and deliver improved health services, and that local services are of high quality and performing well. Strategic Health Authorities have a role in managing Trusts' performance against the core and developmental standards and Trusts' implementation of serious case review action plans. The duty in the Children Act 2004⁹ to co-operate with local authorities and their partners to make arrangements to safeguard and promote the welfare of children applies to Strategic Health Authorities, Primary Care Trusts, Foundation Trusts and NHS Trusts, as does membership of Local Safeguarding Children Boards. Strategic Health Authorities have been advised to consider how they effect this responsibility across the multiple local Safeguarding Children Boards authorities in their areas³¹.
- 2.23 The prominent safeguarding policy and performance framework described above needs to bite even more on addressing fabricated or induced illness in the health services. Chapter 3 reports the findings of the review and proposals for action are set out in Chapter 4.

Chapter 3

3.0 KEY FINDINGS AND CHALLENGES

- 3.1 The main findings of the Review are presented in this chapter. The methods used to gather the information are summarised at Annex B. Evidence was gathered from the four main sources below:
- An online and anonymous survey on staff attitudes with a telephone follow-up of 22 of the respondents;
 - Analysis of overview reports of four serious case reviews on fabricated or induced illness that have been published since the guidance ¹ was issued in 2002;
 - Individual semi-structured conversations with 21 professionals who had been involved in cases of fabricated or induced illness (of whom 10 were paediatricians) and
 - Seven focus groups to test the emerging findings with a wider range of staff (including GPs, education, police and health service managers).
- 3.2 The online survey targeted NHS staff and children's services staff who work with the health sector (Annex C). It provides evidence on staff attitudes to fabricated or induced illness and experience of managing cases in the context of organisational and multi-agency frameworks. 535 responses were received, which although self-selecting would allow some inferences about the views of staff working in the NHS to be drawn.
- 3.3 Consultant paediatricians and staff in a variety of "other roles" formed the majority of respondents -194 and 198 respectively (Annex D). "Other roles" comprised medical consultants other than paediatricians and included general practitioners, other doctors who were not consultant grade, nurses working in a variety of specialties, midwives, allied health professionals and social workers. The third largest group was specialist child protection staff i.e. health visitors, school nurses and nurse consultants in child protection or safeguarding roles (Table 1). Almost two thirds of all respondents (63%) could be described as having safeguarding children as an intrinsic part of their jobs i.e. consultant paediatricians and

specialist child protection staff. Where relevant, results were analysed further by designated/named professional roles ^a.

Knowledge, use and usefulness of guidance on fabricated or induced illness

Knowledge and use

3.4 73% of survey respondents knew about the guidance prior to taking part in the survey (Table 1). Expectedly, knowledge about the guidance was higher amongst consultant paediatricians and specialist child protection staff. Amongst staff in other roles, a lower proportion than could be expected knew of the guidance (55%). It is worrying that almost half of staff in “other roles” who see children in their work did not know about the guidance. Surprisingly, 15% of paediatricians and 16% of specialist child protection staff also did not know. The finding is consistent with the analysis of serious case reviews where a recurrent theme is professionals’ lack of knowledge of fabricated or induced illness. By contrast, almost all consultant paediatricians (91%) knew of the Working Party *Report on Fabricated or Induced Illness* ⁵ from the Royal College of Paediatrics and Child Health but less than half of specialist child protection staff knew about it.

Table 1: Numbers and proportions of respondents by knowledge of guidance and staff group (n=535)

Knowledge	Staff Group			Total Knowledge
	Consultant Paediatrician	Specialist Child Protection	Other Role	
NO	30 (15%)	23 (16%)	89 (45%)	142 (27%)
YES	164 (85%)	120 (84%)	109 (55%)	393 (73%)
Total Staff	194 (100%)	143 (100%)	198 (100%)	535 (100%)

3.5 The structured conversations and focus group discussions indicated that for many who do not work expressly in the area of safeguarding children, the guidance usually came to their attention once a case of fabricated or

^a Designated’ and ‘named professionals’ have specific roles and responsibilities for safeguarding children in Primary Care Trusts and provider trusts respectively. The designated doctor and nurse provide strategic safeguarding leadership in commissioning organisations and to named professionals. Named doctors and nurses promote good professional practice within trusts and advise staff on safeguarding issues within the organisations. If not already a board level director themselves, they should be accountable to such a director in their organisation who has executive responsibility for safeguarding children as part of their portfolio of responsibilities.

induced illness was suspected and identified. This was said to be unsatisfactory.

“Too often teams seem to learn on the case and this leads to clumsiness in dealing with the issues.”

- 3.6 There was insufficient evidence from the survey to suggest any association between knowledge of the guidance and type of NHS organisation. Nonetheless, it was thought by some that one of the reasons the guidance appeared to be overlooked in some care services -for example ambulance services, NHS Direct, unscheduled care, toxicology and pathology - might be because it did not fully encompass or recognise those functions and roles in identifying and managing cases of fabricated or induced illness. Others suggested that organisational changes in the NHS since 2002 may have hindered effective incorporation of the guidance into local procedures and training (training is discussed at paragraph 3.34 – 3.39 below). However, one respondent disclosed:

“I have recently taken up a new post in a new area, and now we have a case and I have been surprised at the lack of knowledge within all service areas. In my last area, we carried out a great deal of multi-agency training and ensured all were aware of the guidance. It appears nothing was done in my new area.”

.... another respondent said:

“Although there have been [national] guidelines I am not aware of any change in trust policy”

Usefulness of the guidance

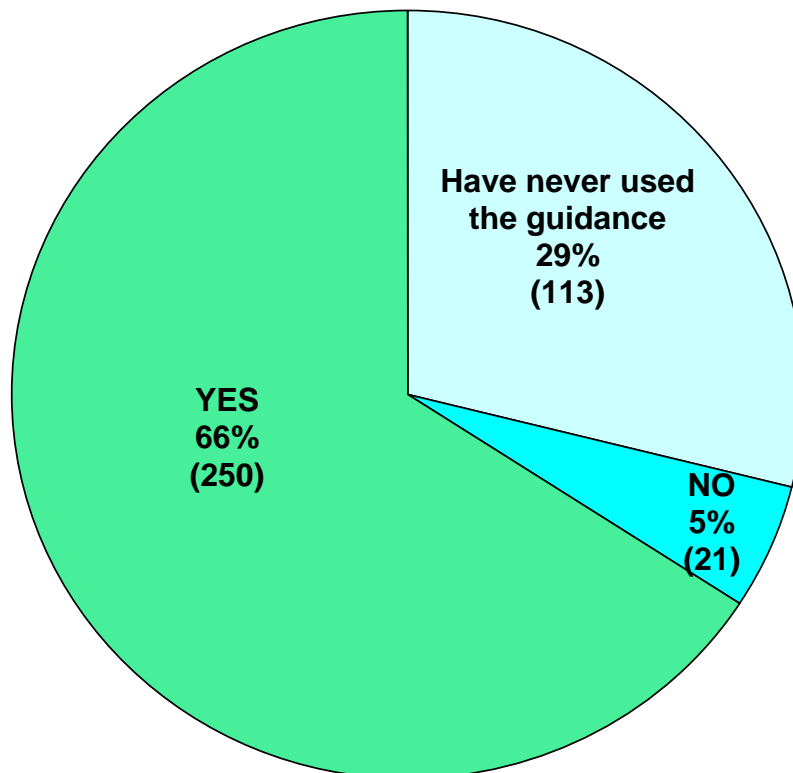
- 3.7 The numbers of consultant paediatricians who had dealt/not dealt with a case of fabricated or induced illness were almost split evenly (Table 2). Those who had dealt with a case were more likely to know about the guidance.

Table 2: Consultant paediatricians by knowledge of guidance and whether they have dealt with a case (n=193)

<i>Dealt with a Case</i>			
Knowledge	NO	YES	Total Knowledge
NO	21 (21%)	9 (10%)	30 (16%)
YES	78 (79%)	85 (90%)	163 (84%)
Total dealt with a case	99 (100%)	94 (100%)	193 (100%)

3.8 66% of survey respondents who knew about the guidance found it useful in their work whilst 29% had never used it (Figure 1). Excluding respondents who have never used the guidance, 93% of all respondents found the guidance useful.

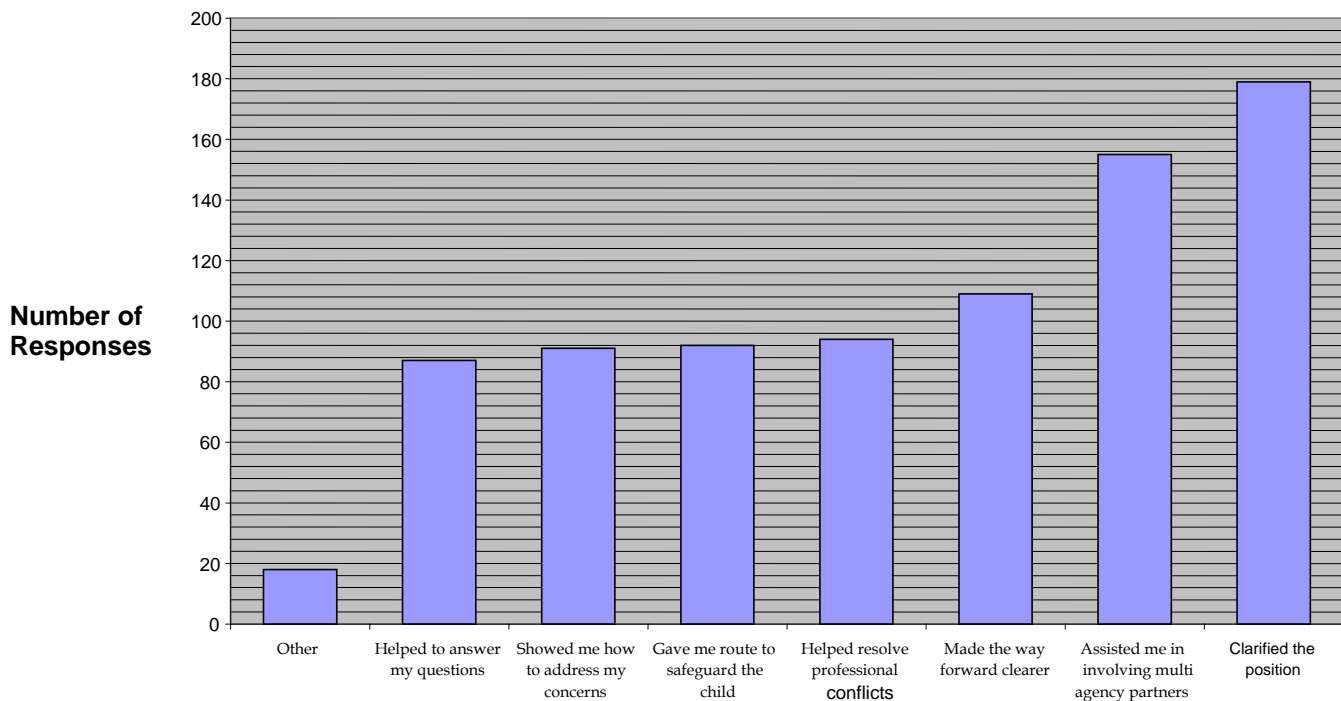
Figure 1: Proportion of respondents that find the guidance useful in their work (n=393)^b



^b Only the responses of those that confirmed they had prior knowledge of the guidance are included.

3.9 Overall, the majority of respondents who had knowledge of the guidance found it useful but there were notable differences such that consultant paediatricians (40%) and those in other roles (44%) found it less useful than staff in specialist child protections roles i.e. nurses (17%). The most common reasons for the guidance being useful was because it “clarified the position” (70%), followed by help “in involving multi-agency partners” (61%) – Figure 2.

Figure 2: Why the guidance is useful (n= 255)



3.10 Excluding those who had never used the guidance, 13% of consultant paediatricians, 8% of staff in other roles and 1% of specialist child protection staff did not find the guidance to be useful (main statistical report). The reason suggested in the interviews and focus groups was to do with cases where there was uncertainty about diagnosis and what should be done in those circumstances:

“The problem with the guidelines is that they are less good when dealing with the ambiguous situations”.

“Clearer guidance is needed to manage cases before a diagnosis has been made of FII an,d when there [is] a suspicion, how this can be managed”

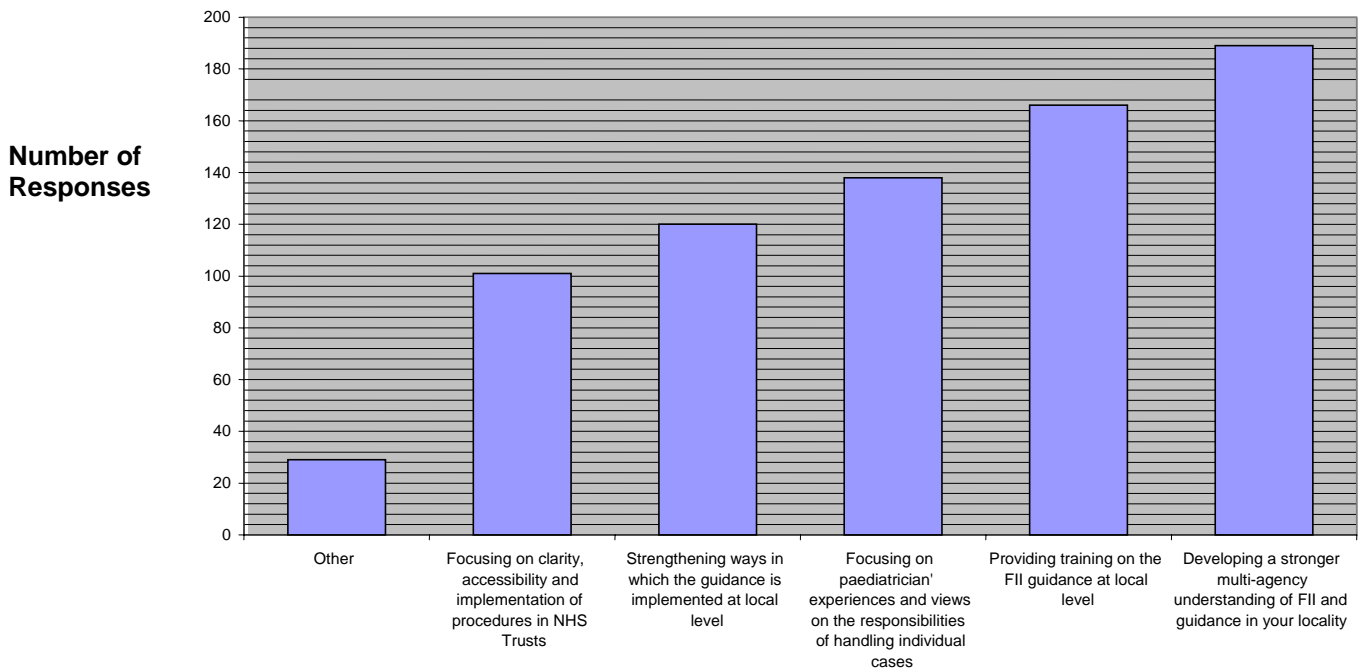
“I have recently undertaken an assessment/investigation and found there was a lack of text with regard to forming a risk assessment.”

3.11 From the discussions, other reasons given for the guidance not being useful included its length and unwieldiness and that it had been dated by successive organisational changes. Suggestions were made about strengthening the guidance in relation to diagnostic thresholds and what to do at varying levels. Tools to assist with identifying fabricated or induced illness would also be welcomed.

How implementation of the guidance could be improved

3.12 The three foremost answers to how implementation of the guidance could be improved (Figure 3), were: developing a stronger multi-agency understanding of fabricated or induced illness and guidance in the locality (69%); providing training on the fabricated or induced illness guidance at local level (61%) and focusing on paediatricians' experiences and views on the responsibilities of handling individual cases (51%).

Figure 3: Ways in which implementation of guidance could be improved (n= 273)



Staff attitudes to fabricated or induced illness

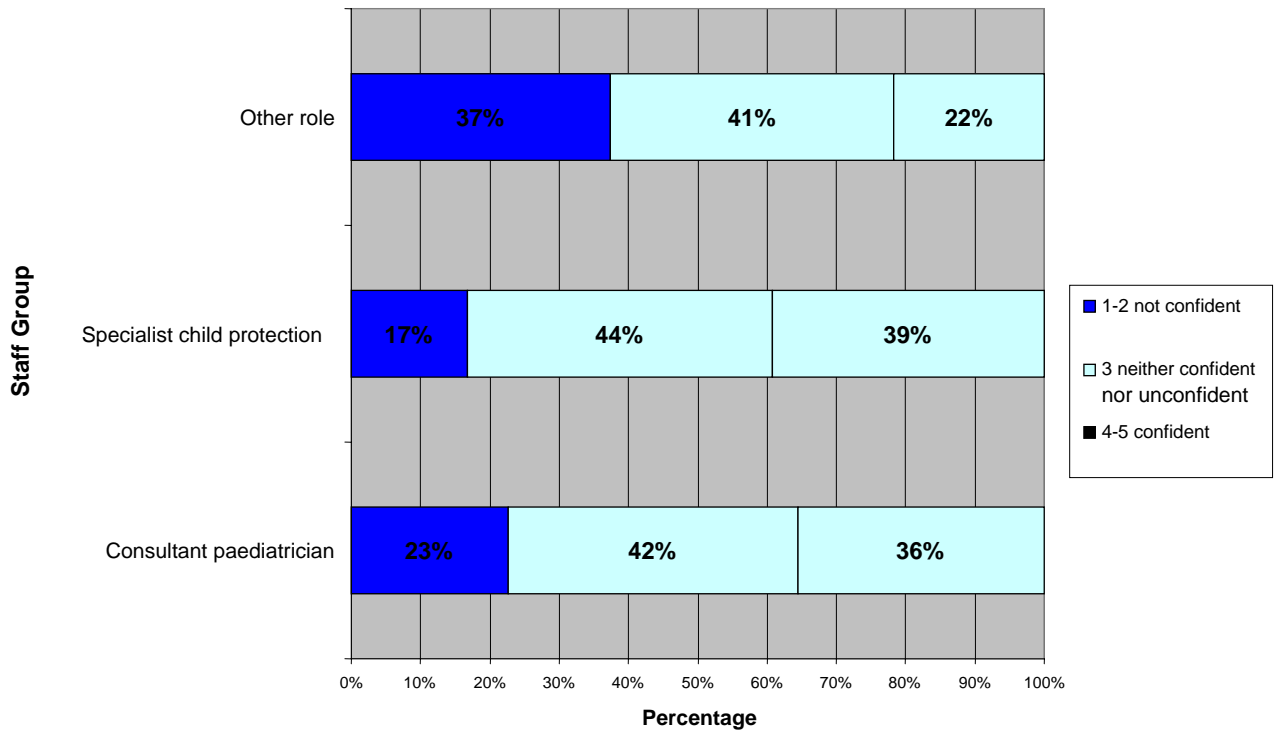
Terminology

- 3.13 Given the social disbelief about fabricated or induced illness and professional debate about prevalence (see chapter 2), the survey asked about use of terminology and confidence in dealing with suspected cases. Most respondents (88%), use the term 'fabricated or induced illness' but the majority of those who did not still used the term 'Munchausen's syndrome by proxy '(MSBP) or similar. Discussions suggested it was more likely that those who had a specific remit for safeguarding or working directly with children would use the term 'fabricated or induced illness' whereas for others who were not so closely connected with the issues, "Munchausen" or similar was still in common usage. Similar differences in the use of terms exist in the United States of America, where MSBP is largely used although the term "factitious disorder of childhood" is increasingly preferred.

Confidence in dealing with cases

- 3.14 It is startling that the majority (69%) of survey respondents rated themselves as neither confident nor unconfident (42%) in dealing with cases of fabricated or induced illness or lacking in confidence altogether (27%). Just under a third rated their confidence highly. Consultant paediatricians and specialist child protection staff were more confident in dealing with fabricated or induced illness than other professionals. However, only 36% and 39% of consultant paediatricians and child protection staff respectively rated their confidence highly, so in effect like staff in other roles, the majority of consultant paediatricians and staff in specialist safeguarding roles were neither confident nor unconfident in dealing with cases or lacked confidence altogether. Training did not appear to have a bearing on confidence and comments about current training suggest that it needs to be more effective.

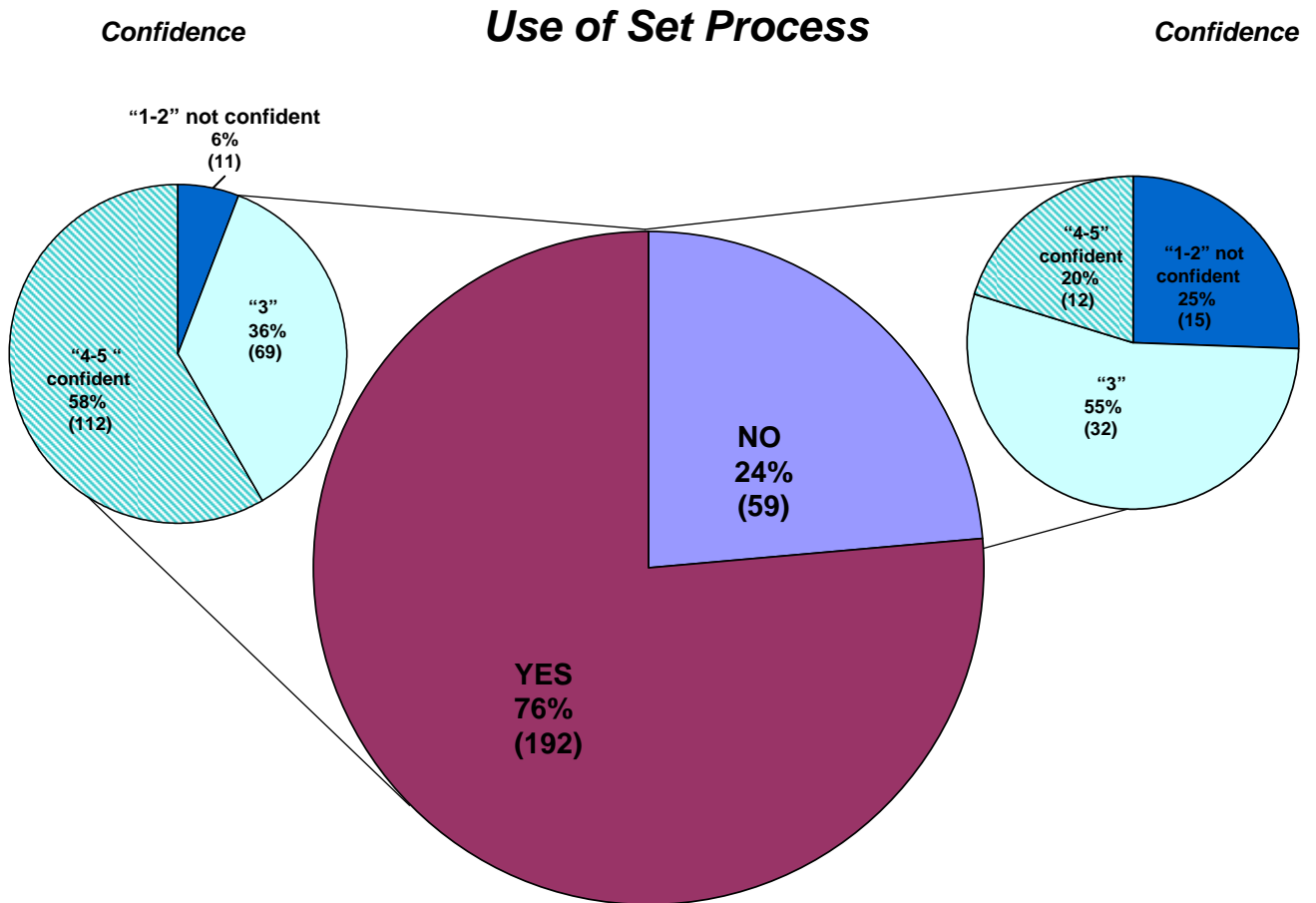
Figure 4: Confidence of each staff group (consultant paediatricians n= 194, specialist child protection n= 148, other role n= 193)



3.15 The survey returns imply that there may be a link between knowledge of the guidance and confidence in dealing with cases of fabricated or induced illness. 91% of those who rated their confidence highly had known about the guidance whereas 52% of those who rated their confidence as low did not know about it.

3.16 Experience of having dealt with a case seemed to be an important factor in raising confidence amongst individual respondents. 49% of all respondents had dealt with a case of fabricated or induced illness since the guidance was published in 2002. A higher proportion of designated/named doctors (61%) and designated/named nurses (79%) reported dealing with suspected cases. More than three-quarters of those who had dealt with a case had used the process set out in the guidance (Figure 5) and doing so was associated with greater confidence.

Figure 5: Use of the process set out in the guidance and confidence in dealing with a case (n=251)



- 3.17 Team factors were also at play in the link between confidence in dealing with a case of fabricated or induced illness and both team and individual awareness of potential indicators. The more confident respondents were in dealing with fabricated or induced illness cases, the more likely they were to give their team/individual awareness of potential indicators a high rating. However, 39% of those who said they were not confident rated their team awareness as good to excellent – this may be indicative of a range of experience in their teams.
- 3.18 Exploring people’s experiences in dealing with cases during the semi-structured interviews and focus groups exposed a difference of opinion about the incidence of fabricated and induced illness. There were those who thought fabricated or induced illness was rare:

"I am aware of the guidance and the issues. In the past five years I have not yet had a case where I have needed to use it."

"The incidence of FII is very small when compared to neglect. In twelve years of working in child protection I came across it only twice."

3.19 However, experienced doctors and nurses who had worked in child protection for some years believed it to be more common and had made clinical observations that supported their view that cases often fell in a continuum from mild to very severe (and rare) forms of abuse.

"FII is not a rare phenomenon in my experience, though the degree may be enormously variable."

"The majority of cases have some elements of FII about them, but there is usually an underlying disorder in the child which the carers are manipulating for their own ends."

"Roy Meadow's problems and his and David Southall's GMC appeals have left the view that there is little or no FII and that it is professionally dangerous to suggest that a child is the victim of such a case."

3.20 Experienced professionals took the view that the most useful threshold measure to apply in cases where they had lower level concerns was "impairment of the child's health and development" which is one of the key criteria for defining a child as being "in need" in the Children Act 1989¹⁰. Use of this measure enabled them and local authority children's services to assess the impact on the child of the parent/carer's behaviour and to work out interventions and packages of support.

The role of the consultant paediatrician

3.21 In recognition that most consultant paediatricians will see a child whom they suspect some or all of their presentation of illness is being fabricated or induced, the guidance set out specific advice on their roles and responsibilities. Survey respondents were asked to consider a set of statements about the role of the medical consultant taken from the

guidance and rate the likelihood of these practices occurring within their organisation.

3.22 In general, there was consensus on the likelihood of the recommended practices occurring in respondents' organisations. However, when replies of 'not likely', 'neither likely nor unlikely' and 'don't know' are taken together, they show a mixed picture where knowledge and practice needs to be improved in the following areas:

- The consultant paediatrician responsible for the child's healthcare taking the lead responsibility rather than delegating it;
- The responsible paediatrician consulting the named doctor/nurse and keeping them informed; and
- The role of adult and forensic psychiatry in assessing the presence of parental mental illness.

3.23 The structured conversations and focus group discussions revealed much richer and more frank information on some of these matters of practice:

- There was a measure of confusion and uncertainty about the workings of the role of the consultant in charge of the child's healthcare in taking the lead responsibility for clinical decisions in cases of suspected fabricated or induced illness because the clinical management of the case often became linked with the emerging child protection issues and role of social services;

"Practically, the difficulties in this area are in the management of cases after diagnosis, and this varies from case to case as the child protection plan is managed by social services."

"The DH should make it clear that suspecting fabricated or induced illness must come from health and not social workers who think they know all about it."

"Social services and police should take a more active role in confirming FII. Suspicions or opinions are not going to work as the doctor then stands very isolated and at risk of a complaint from the GMC."

- Professionals who had been involved in cases and worked with local authority children's services thought that doctors did not always

understand the nature of family support work. Examples were given that showed that in some cases clinicians were concerned that child protection procedures would be instigated if they spoke to children's services about possible cases, or that because diagnosis was less certain, children's services might do nothing. The serious case review of JOT/JAT Bracknell Forest (SCR 2005/6) recommended strongly that doctors need to develop a better understanding of how children's services work and to be clear about whether they are asking for support for a family (which can be provided under S17 of the Children Act 1989 ¹⁰) or for "immediate protection" as set out in the guidance;

- In spite of the level of confidence in dealing with cases of fabricated or induced illness reported in the survey, there was anxiety about the implications of diagnosing fabricated or induced illness and how this might impact on the individual doctor;

"It isn't a clinical issue any more, the media have taken over. If I had to do one I would be frightened and would do anything to avoid recrimination."

"I think the awareness of FII signs and symptoms is generally poor. This is compounded by fear, particularly amongst the medical profession, the consequences of diagnosis and the high media coverage recently given to such issues."

"There is a great deal of nervousness nationally within paediatrics, and this diagnosis is not made lightly – procedures do not protect clinicians or children if the legal systems are not sound."

"The fact that the GMC still pursues Prof Roy Meadows, despite the Court of Appeal finding him innocent, says it all. Surely no one is surprised that professionals now under-report cases, particularly of FII, and most juniors feel they will not cope with child protection issues when they become consultants."

- Nonetheless, others suggested ways in which the isolation of making a diagnosis could be mitigated, including more robust clinical supervision, consultant appraisals and in line with the current guidance, second opinions;

"I should think now that most clinicians would wish for further support and a second opinion from a colleague."

- Suggestions, including a template in the guidance to assist with charting accurate chronologies, were made about how the issue of threshold could be managed better;

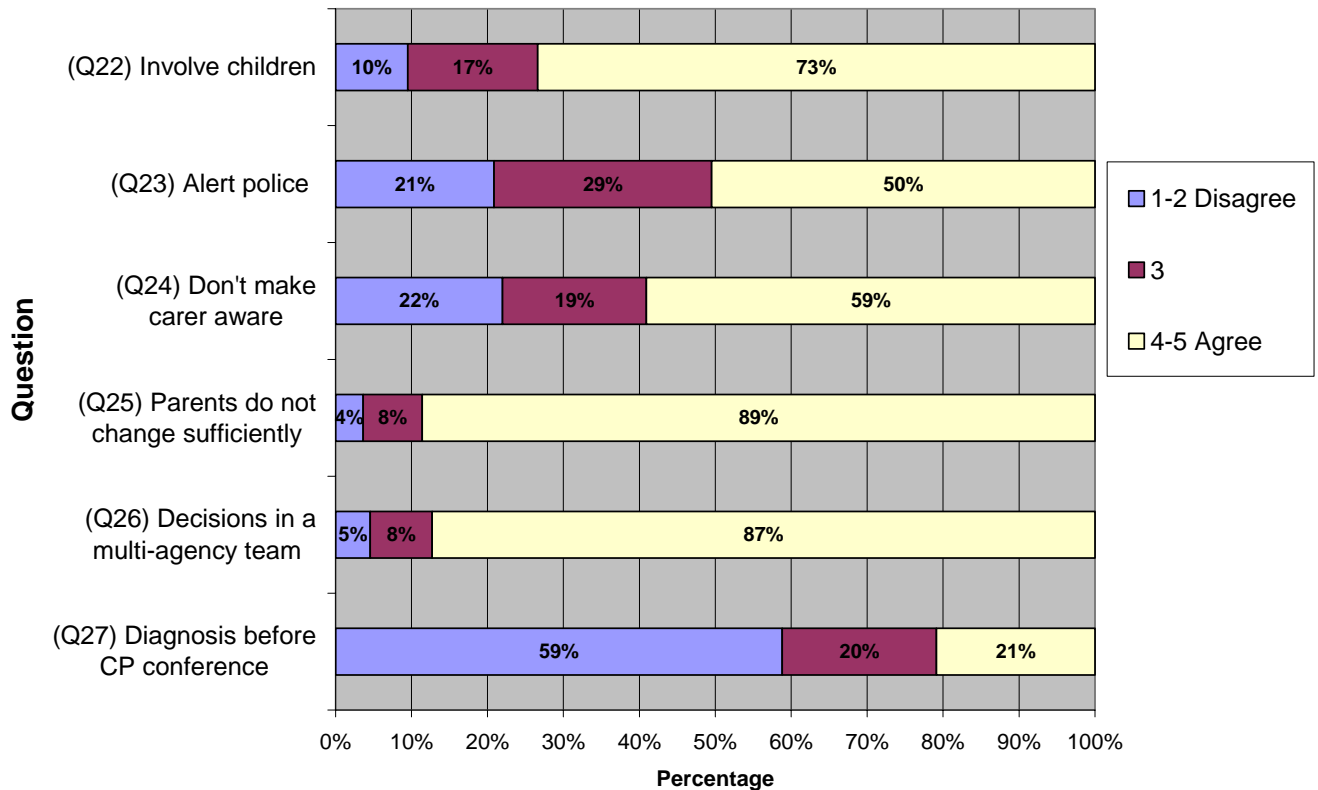
“So much depends on the threshold at which clinicians will consider FII and then aim to confirm or deal with it, either as a single professional or with other agencies. This depends on the severity and proof of the case - mild unprovable cases can be contained by the child’s paediatrician who maintains a regular follow up.”

“There are degrees of FII both in suspicion and in the likely danger to the child. Both have to cross certain thresholds before it is appropriate to activate the child protection process. This should be made clear in the guidance”.

Management of cases

3.24 Agreement or disagreement, mainly with statements from the guidance, was used to establish attitudes to managing suspected cases of fabricated or induced illness (Figure 6). There was a reasonable level of agreement on how cases should be managed in respect of responsibilities for telling parents and children and involving children in planning and decision-making. There was little sympathy for being “virtually certain” about identification of fabrication before initiating a child protection conference – a question brought into the survey to test attitudes about timing of referrals to social services. The response was slightly at odds with the disclosures on fear of reporting by doctors that came to light in the semi-structured interviews, suggesting a difference between what professionals disclosed in group discussions and what they did in their individual practices. Many professionals agreed that where a child is being maltreated, some parents might not change in time to prevent the child from continuing to suffer significant harm. Disagreement was highest about when a parent should be made aware of child protection concerns or when the police should be alerted.

Figure 6: Proportion of respondents that disagree/ agree with statements in questions 22 (n= 526), 23 (n= 527), 24 (n= 523), 25 (n= 527), 26 (n= 527), and 27 (n= 527)



3.25 The concord in the survey results on involving children was not borne out in the analysis of serious case reviews. By contrast, the theme emerging from serious cases is the lack of involvement of the children affected. This critical issue has recurred throughout most analyses of child deaths from different forms of abuse and not just fabricated or induced illness, most recently in the Victoria Climbié report⁴ and Westminster Child Abuse Case (09/02/2000). The semi-structured interviews and focus group discussions indicated an almost total acceptance of what the parent/carer was telling the medical team and the child's voice was not being heard. Co-morbidity was reported as a particularly difficult factor in making a differential diagnosis - in some cases, the child might also have a genuine diagnosable health problem, such as a physical or learning disability, Asperger's syndrome, autism, asthma, epilepsy or chronic fatigue syndrome.

3.26 This issue of why the child is not heard was examined cogently in the serious case review report into the death of MD, a 7 year old child³³. The

report described the notion of “the bargain of health care” as key to why cases of fabricated or induced illness were likely to be overlooked and the child’s need for protection was therefore not recognised. Professionals dealing with a sick child normally believe and trust the parent and mostly, it is the parent that tells the story about the child’s symptoms. There is an assumption made by doctors and health professionals that the parent brings the child to be made well. This unspoken “bargain” between the doctor and parent is challenged in fabricated or induced illness, where parents are out to lie, deceive or exaggerate, and thus asking the child may be essential to recognising the risk and doing something about it.

- 3.27 The majority of respondents disagreed with the statement that a diagnosis of fabricated or induced illness had to be certain before a child protection conference was initiated. However in the structured conversations and focus groups there was some evidence that medical teams were either unsure or reluctant to involve local authority children’s services in the early stages of a suspected case: clinicians spoke of being under pressure from colleagues and other agencies to make a firm diagnosis of fabricated or induced illness, particularly where safeguarding processes and court proceedings were involved. It was not always possible to be certain, and diagnosis might take a long time, for example if the child was referred for further tests or to a tertiary centre.

“We need guidance about when to refer to social services and how. There is always the danger we will be told we should have referred earlier. We need the back up of the guidance to protect us from complaints by parents.”

- 3.28 Several survey respondents, including paediatricians, agreed it was “likely or very likely” that once a health professional suspected fabricated or induced illness they would consult their clinical manager or designated / named doctor or nurse. From the structured interviews some respondents, (including the nurse groups), wanted systems in place to ensure that junior members of teams who had suspicions could speak up more clearly or were able to challenge the opinions of more senior team members. The serious case review analysis showed there had been cases where junior staff had felt suspicion or doubt about the behaviour of a parent towards a child and had felt unable to express this, had not been given the opportunity to do so or had expressed a view that was not taken on by the medical team.
- 3.29 There was less agreement about whether it was crucial for any criminal investigation that parents were not made aware about fabrication concerns

(59%) and about whether the police should be alerted to suspected cases as early as possible (50%). This is at odds with the process laid down in the guidance, but is representative of the material gathered in the structured conversations and focus groups, where several of those interviewed described situations where potential criminal proceedings had not commenced or been aborted because of disagreement with the police about how to handle the parents. Once the police were involved, there were examples of reluctance to engage with them about cases, for fear of complaints by parents. Some spoke of concerns that police might wish to use video surveillance techniques, which were viewed by some as intrusive and or “dangerous”. For example, video surveillance might be discovered by the parents and be destroyed or would be open to challenge and interpretation by the courts and was not always perceived as a process that would add value, or that parents may be “allowed” to harm the child in order to secure the video evidence, this in itself being dangerous to the child. In other cases, introduction of video surveillance by the police was described as unlikely to be acceptable to the employing organisations and therefore presented professionals involved in the child’s care with a conflict about how to proceed.

- 3.30 Most survey respondents rated themselves (90%) and their teams (80%) as being “open to all possible explanations” given the difficulty in identification of fabricated or induced illness. The analysis of serious case reviews did not support such a positive picture of openness. Typically, there were lengthy, complex arrangements made to try to establish the causes of illness in the children concerned. It was often not until a very late stage in the investigation and treatment of the child that fabricated or induced illness was considered. A number of cases described in the structured conversations also showed this pattern, with some professionals describing how they came to think of fabricated or induced illness as a potential explanation for the child’s illness almost by chance.
- 3.31 Management of suspected or cases of fabricated or induced illness is particularly challenging and difficult for teams who work with children.

“I was involved in a case ...resulted in a care order on a child , who is now adopted and the prosecution of the motherat the time it was a very stressful experience, splitting the unit nursing staff and causing a great deal of adverse publicity (which was never withdrawn when the court case backed my views).”

3.32 41% of survey respondents had been part of a team where there had been conflict and this figure rose to 49% and 63% for designated/named doctors and designated/named nurses respectively. The guidance was reported to have some use in clarifying processes and furthermore, many (91%) thought that, as set out in the guidance, there was likely or very likely to be an opportunity to seek a second opinion as the route to resolving local disagreements.

3.33 The conversations with professionals indicated a number of other concerns that they had:

- The capacity for parents to be knowledgeable about children's illness, and in cases of fabricated or induced illness to tell a more convincing story about the child, has been made easier by the availability of detailed medical and treatment information on the internet;
- Some professionals get caught up in focusing on issues around parental intent or motivation, rather than the impact on the child, where they think that parental mental illness or lack of parenting skills due to a learning disability or personality disorder is at play. In these circumstances, some expressed reluctance to use the child protection framework, because it was thought that the parent's intent was not malicious or deliberate;
- Difficulties in securing the co-operation of services, especially from adult mental health, were also reported;

"When involved in a case of FII we had a terrible problem trying to get a parent assessed for a psychiatric disorder which I am sure the mother had - we tried for more than a year..."

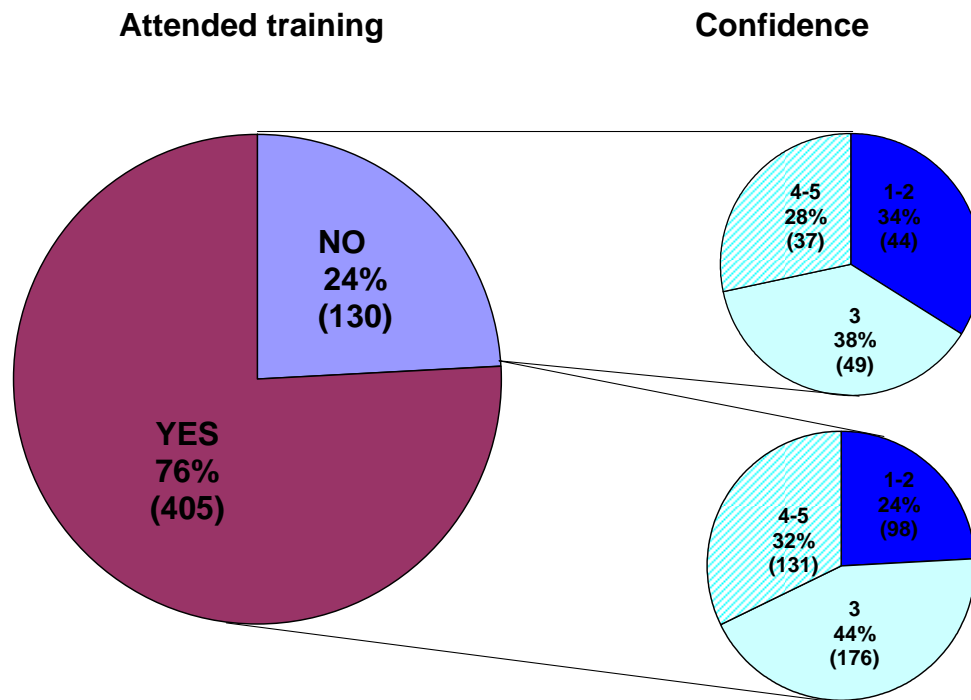
- A commonly expressed theme was the difficulty in engaging general practitioners on safeguarding children and this needed to be tackled for cases of suspected fabricated or induced illness to be identified at an early stage:

"...still very hard to engage with GPs and mental health workers in attending meetings as with anything to do with safeguarding children."

Training

3.34 Most respondents(76%) had received training on safeguarding children since the guidance was published in 2002. However, the lack of a link between attendance at training and confidence in dealing with a case suggests that fabricated or induced illness was either not covered in training or was not effectively delivered in training (Figure 8).

Figure 8: Proportion of respondents who had/had not attended child protection training since 2002 (when the guidance was published) and level of confidence in dealing with FII cases (n=535)



3.35 All respondents (535) were asked to comment on training needs ^c. The response is quite striking in embracing a full range of needs including training on the guidance as a whole and supporting the children and parents involved (Table 3). Training on the legal issues associated with fabricated or induced illness, assessment and diagnosis and local

^c Respondents could select more than one option.

procedures and protocols for dealing with fabricated or induced illness were topmost. More than half of all survey respondents wanted training in these specific areas and at least one third of consultant paediatricians felt they needed such training too.

- 3.36 Although all three staff groups had a similar pattern of training needs, a greater proportion of specialist child protection staff emphasised the need for training in the “legal issues”, “assessment/diagnosis of fabricated or induced illness”, “local procedures and protocols”, “supporting the children involved” and “supporting the parents/carers”, when compared to consultant paediatricians. Moreover, a greater proportion of those in the “other roles” group required training “on the guidance as a whole” in comparison to both consultant paediatricians and specialist child protection staff.

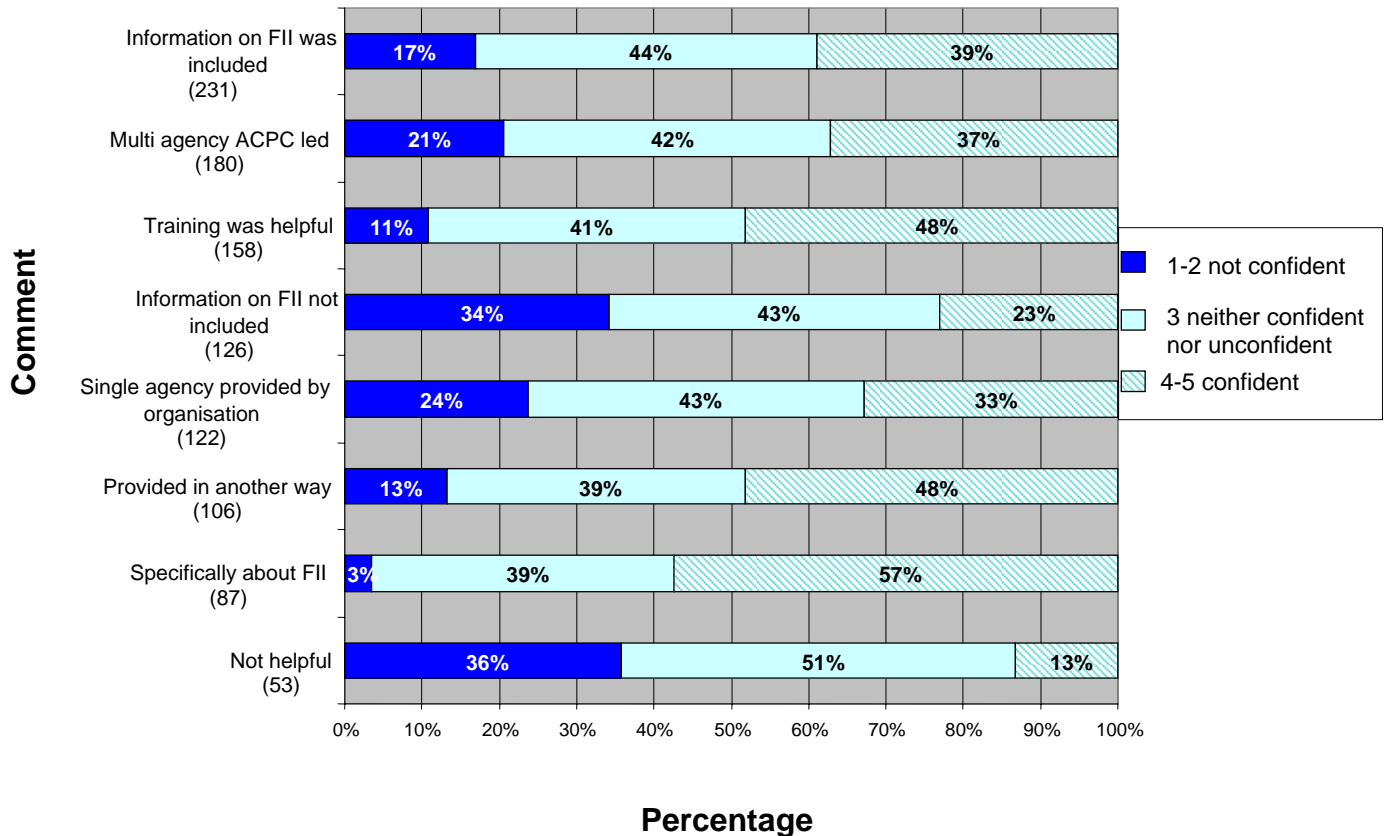
Table 3: Current training needs of all respondents (n=535)

Current Training Needs	Total Responses (n= 535)	Percentage of all Respondents (n=535)
Other	30	6%
No training need identified	43	8%
On supporting the parents/carers	228	43%
On the guidance as a whole	243	45%
On supporting the children involved	267	50%
Local procedures and protocols for dealing with FII	276	52%
On assessment/diagnosis of cases of FII	284	53%
Legal issues	355	66%

- 3.37 400 of all survey respondents commented further on their training, of which 58% said that information on fabricated or induced illness was included. Those who received training in which fabricated or induced illness was included and/or found the training helpful rated their confidence in dealing with such cases more highly than those who said fabricated or induced illness was not included in the training and/or had not found the training helpful. Evidence from the survey suggests that confidence in dealing with fabricated or induced illness may be improved

by improving safeguarding training to focus more on fabricated or induced illness.

Figure 9: Comments on training by confidence (n=400)



3.38 The structured conversations and focus groups delivered a strong message that training on fabricated or induced illness is needed urgently, and that to be most effective it should be done on a multi-agency basis.

“Needs multi-agency training so that each agency is clear about each other’s roles and responsibilities and holds each other to account. Single agency training does not address the issues effectively.”

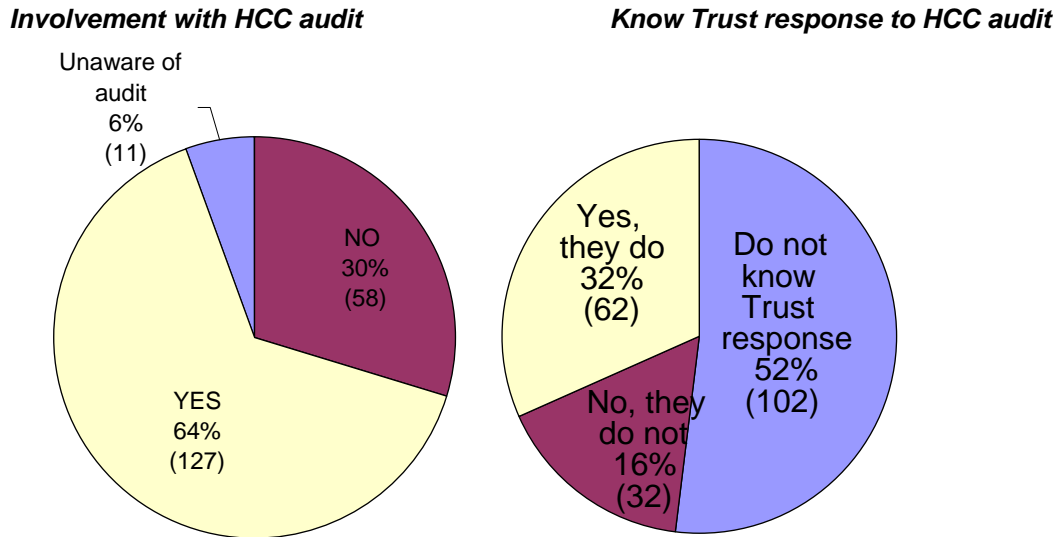
3.39 Others made a strong case for the subject of fabricated or induced illness to be included in all child protection training.

“It is much better, more realistic and better use of expensive resources to ensure that FII is included in all CP training and is not seen as something separate to physical abuse, emotional abuse, sexual abuse and neglect”.

Knowledge of governance arrangements and multi-agency working

- 3.40 The survey looked at awareness of organisational arrangements for monitoring and auditing compliance with the guidance on fabricated or induced illness. Responses suggest that most of the participating NHS Trusts, Primary Care Trusts or Foundation Trusts (83%) were said to have a Child protection/Safeguarding Committee.
- 3.41 Only 47% of all respondents thought that advice and support was readily available from designated and named doctors and nurses whereas 65% of these specialist safeguarding professionals had thought so.
- 3.42 There appeared to be a strong inconsistency between designated/named doctors' (79%) and designated/named nurses' (61%) understanding that their employing NHS organisations had local safeguarding procedures that included guidance on fabricated or induced illness. This may reflect poor or inaccurate knowledge in either group of doctors or nurses, possibly caused by poor access to routine information about local safeguarding policies and procedures. It also begs a question about access to quality local updates and training for this group of specialist safeguarding doctors and nurses.
- 3.43 A sizeable number of designated and named professionals (36%) were not involved in completing their Trusts' response to the Healthcare Commission's safeguarding annual performance assessment for 2004/5 (Figure 10). About half did not know their Trusts' response to the question on fabricated or induced illness in the Healthcare Commission's annual performance assessment but most of those that did agreed with it (not shown below).

Figure 10: Designated and named professionals responses to questions on involvement in HCC audit and their Trust's response (n= 196)

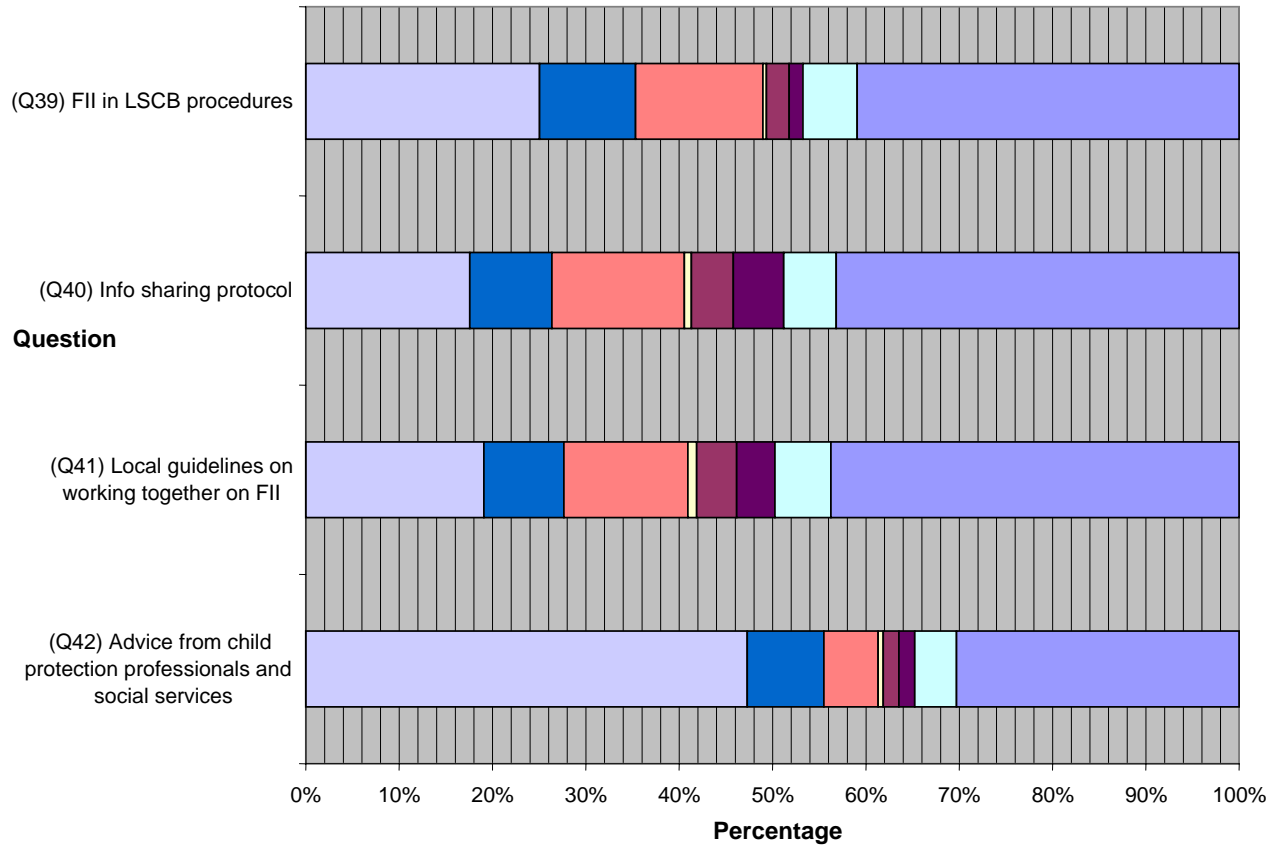


3.44 The survey looked at four aspects of multi-agency working. Respondents were asked to indicate the stage that their Local Safeguarding Children Boards (formerly Area Protection Committees) had reached with respect to recommendations in the guidance (Figure 12).

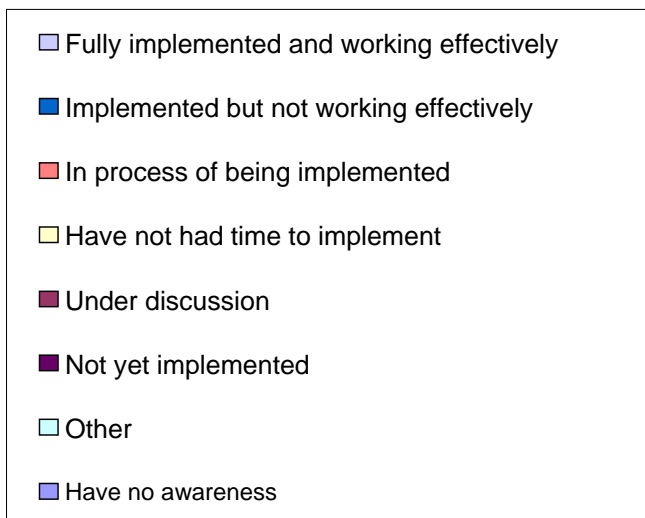
3.45 It would seem that the following multi-agency aspects of the guidance still needed to be implemented fully by Local Safeguarding Children Boards:

- Incorporation of the guidance on fabricated or induced illness into Local Safeguarding Children Boards' procedures. From the main statistical report (question 39) 25% of all respondents said their Local Safeguarding Children Board had fully implemented this recommendation and it was working effectively, but 41% had no awareness of this development;
- Information sharing protocols between agencies and professionals;
- Local agreements on detailed ways of working together on fabricated or induced illness.

Figure 11: Respondents' Local Safeguarding Children Boards' implementation on FII guidance on multi-agency working (n= 535 for questions 39 to 42)



Level of response



Chapter 4

4.0 ACTION TO IMPROVE IMPLEMENTATION OF GUIDANCE ON FABRICATED OR INDUCED ILLNESS

- 4.1 The terms of reference for this review required an assessment of how more effective implementation could be achieved. The response rate for the staff attitudes' survey is large enough to generalise the findings to the NHS workforce from which the sample was drawn. The structured conversations and focus groups provided rich material which either backed up the survey findings or elaborated on them. A number of recommendations are made in this report to improve the health services' response to suspected or proven fabricated or induced illness in children and young people.

Guidance in the NHS

- 4.2 During the course of the review, a further opportunity arose to update the guidance to bring it in line with the changes to safeguarding responsibilities and structures brought in by the Children Act 2004⁸ and the 2006 version of *Working Together to Safeguard Children*⁴. The Government is also taking forward the relevant findings of this review to improve clarity of roles and responsibilities of healthcare professionals in the forthcoming update of the guidance on fabricated or induced illness.

Knowledge, use and usefulness of guidance on fabricated or induced illness

1. The Department for Children, Schools and Families, and the Department of Health, should agree ways to promote the revised guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced* so it is promoted extensively in the NHS and by the professional bodies. Ways should be found to bring it to the attention of private health providers of children's services, including providers of complementary therapies.
2. There needs to be wide-ranging readership of the guidance outside paediatric services. The Department for Children, Schools and Families and the Department of Health should consider an abridged or flowchart version for promotion in these various services on the basis of "what to do if fabricated or induced illness is suspected."
3. When revising the report, *Fabricated or Induced Illness by Carers*, the Royal College of Paediatrics and Child Health should work collaboratively with the Academy of Medical Royal Colleges, the Nursing, Midwifery and other Royal Colleges, the Royal Pharmaceutical Society and other relevant professional bodies to make it a shared inter-collegiate document that is brought to the attention of a wide range of health care staff.
4. Primary Care Trusts, NHS Trusts and Foundation Trusts Boards should ensure that as part of working on effective arrangements within their Local Safeguarding Children Boards, they have robust arrangements in place for promoting the revised guidance, and for uptake of staff induction on safeguarding children and young people, which includes a focus on fabricated or induced illness and the role of named and designated professionals and how they can be contacted.

4.3 The nature of fabricated or induced illness is such that children can present anywhere in the healthcare system, not always within paediatric services. Application of the survey results to the relevant NHS workforce as a whole shows that only a small minority of NHS staff have knowledge of the guidance, most of whom are paediatricians or specialist child protection nurses, and largely where they have been involved in a case of fabricated or induced illness. There is an on-going need to ensure that

staff working with children or parents in services across the healthcare system, particularly within ambulatory services such as NHS Direct, unscheduled care, Ambulance Trusts or in important specialties such as pharmacy, toxicology and pathology or across private health organisations and providing services for children or those providing complementary therapies, have knowledge of the guidance.

- 4.4 The Royal College of Paediatrics and Child Health is planning to publish a revised edition of its report on fabricated or induced illness⁵ which clearly lays out the features of fabricated or induced illness and potential characteristics, signs and symptoms. The report is expected to link more coherently to the revised Government guidance and will clarify professional roles and clinical management of cases, highlighting the role of the lead paediatrician (the consultant with clinical management responsibility for the child where fabricated or induced illness is suspected) and updating on issues such as repeated medication. The revised report will supplement the College's recently published *Child Protection Companion*³³.

Identification and diagnosis of fabricated or induced illness

5. As requested in 2006 by the Department of Health, the development of guidelines by the National Institute of Clinical Excellence on suspected child abuse should include identification of fabricated or induced illness.
6. Clinical Medical Directors of paediatric services should ensure robust arrangements are in place in their NHS Trusts, Foundation Trusts or Primary Care Trusts to enable consultant paediatricians to have access to teams within their Trusts and across to other clinical networks outside their organisations, to discuss clinical concerns about identification, diagnosis and clinical management of fabricated or induced illness cases.
7. As a general development to support more effective information on safeguarding children and young people, the development of the Care Services Improvement Partnership safeguarding children networks and website, and the plans to look at the feasibility of extending that beyond designated and named doctors and nurses to include a supra secure discussion forum for complex and forensic cases, is to be welcomed.

- 4.5 Fabricated or induced illness is relatively rare and, whilst most likely to be seen in younger children, can also present in older children, often in association with underlying long term illness or disability. Clinicians who see children and not paediatric staff only therefore need to understand its presentation. The process of differential diagnosis is important in identifying fabricated or induced illness and the medical element of identification should not be left to chance or to when “things are not adding up”. The difficulty that doctors face in obtaining evidence that the signs and symptoms are being fabricated or induced cannot be underestimated. The triangulated relationship between doctor, child and parent is based on trust. Suspicion of the parent or carer requires the suspension of that trust. A clinician’s experience in dealing with a case of fabricated or induced illness appears to increase confidence, including identification.
- 4.6 Clinicians would benefit from sharing this expertise, in a context where suspected cases can be discussed and concerns raised early with peers and the multidisciplinary team, including local authority children’s services. A number of NHS Trusts have developed internal arrangements for such peer support on difficult aspects of child protection (Annex E). The formation of clinical networks^{34,35} across a number of NHS Trusts will be another way of expanding access to experienced peers and colleagues.
- 4.7 At regional level, the Care Services Improvement Partnership has funded the formation of safeguarding children networks, largely focusing on the needs of designated and named doctors and nurses in sharing information. The networks are supported by a website which includes a mediated password-protected discussion forum³⁶. A feasibility study is in progress to examine how these electronic facilities could be used for discussing anonymised clinical concerns about specific cases.
- 4.8 In 2006, the Department of Health invited the National Institute for Clinical Excellence: “To prepare a clinical guideline on the identification of children who have been subject to physical, sexual or emotional abuse or who have a fabricated or induced illness.” Clinicians have welcomed inclusion of fabricated or induced illness in the scope of the guidance which is expected in 2008 and will target professionals who see children but are not childcare experts³⁷.
- 4.9 It is unacceptable that some paediatricians do not feel able to act in the child’s interest where there is suspicion of fabricated or induced illness, fearing adverse publicity, litigation and complaints unless there is a “cast iron guarantee” of that illness being fabricated or induced. Increasingly, doctors are experiencing legal action because of decisions they have

taken to protect children from harm. There is a risk that this is acting as a deterrent to the profession as a whole when individuals are dealing with some cases of suspected child abuse. The UK courts have been quite clear in relation to the law of negligence that where professionals are undertaking child protection work, their first duty is to the children concerned. As far as the children's parents are concerned, professionals must simply act in good faith, exercising reasonable skill and care and in those circumstances, no duty of care is owed to the parent or carer of the child. In collaboration with the Royal College of Paediatrics and Child Health, the Department for Children, Schools and Families and the Department of Health have issued a joint statement on the duties of doctors and other health professionals in investigations of child abuse³⁸. The statement sets out the Government's understanding of the legal position and outlines professionals' duty of care and this is to be welcomed.

Management of suspected cases

8. The revision of the supplementary guidance, *Safeguarding Children in Whom Illness is Fabricated or Induced* to take account of changes to *Working Together to Safeguard Children* is timely and, in the light of the findings of this Review, it is welcomed that the changes being made will:
 - Emphasize the necessity for all staff to be aware of their Trusts' and Local Safeguarding Children policies and practices;
 - Clarify the co-ordinating role of the lead paediatricians vis-a-vis the consultant in charge of the child's care if the consultant is not a paediatrician;
 - Include a pathways chart of responsibilities and actions to be taken which will cover what to do where fabrication is identified to be at the lower level or where the evidence of fabricated or induced illness is less certain;
 - Make more prominent in the pathways chart the need to always talk directly and involve the child or young person, where possible;
 - Affirm resolution protocols to be in place to support staff when professional conflict arises over identification, diagnostic and management decisions.

- 4.10 In the process for identifying fabricated or induced illness, there is a need to improve the practical application of the roles of the medical consultant in charge of the child's healthcare, the responsible paediatric consultant (who may also be the consultant in charge of the child's care) and social services' responsibility for making decisions about safeguarding the child. The lead paediatrician co-ordinates all aspects of identification, clinical management of the suspected case, communication with the parents, named and designated safeguarding professionals and links with social services. Furthermore, consultant paediatricians wanted clearer guidance on what to do in cases where diagnosis and identification are less certain or are at the lower end of fabrication/harm, for example an over-anxious parent. The latter aspect touches on the issue of "threshold" at which to take safeguarding action. Threshold as perceived by paediatricians appears to have no consistent application between individual clinicians nor are the underlying concerns mutually understood by social services, who would emphasize that the need to safeguard a child and promote their welfare should not be lost through clinical uncertainty.
- 4.11 In the context where suspicion is not clearly proven and/or harm does not appear to be significant experienced, clinicians would refer the child for a "children in need" assessment under section 17 of the Children Act 1989 ¹⁰. The process set out in existing guidance needs to be highlighted and supported by a pathways chart in the revised version and made more prominent in the revision of the Royal College of Paediatrics and Child Health report ⁵.
- 4.12 Paediatricians and all health professionals should recognise and act on the need to talk to the child directly and involve them appropriately throughout. This is set out in the guidance but practice was wanting in the evidence from some of the serious case reviews.
- 4.13 The challenge of identifying and managing suspected cases can raise anxieties and conflict in the teams. Dissent about causation may lead to a loss of focus on the child with junior staff sometimes feeling intimidated and isolated; this maybe compounded by poor organisational awareness of safeguarding arrangements in the Trust. Staff need to know that they can go to the named professionals for safeguarding within their organisation for advice and support and, if necessary, to the designated safeguarding professionals. This is being made clearer in the revised guidance.

Organisational systems, governance and performance

9. That the Healthcare Commission has regard for the content of this report in its assessment and inspection arrangements.
10. As part of promoting the revised guidance on fabricated or induced illness, the Department for Children, Schools and Families should:
 - Remind Local Safeguarding Children Boards to incorporate the guidance into their local procedures and training, setting out in clear terms what is expected of adult mental health services, primary care and general practice and collaboration with the police and other agencies.
 - Ask Local Safeguarding Children Boards to ensure that their members, including Primary Care Trusts, NHS Trusts and Foundation Trusts, bring the guidance to the attention of all their staff, in accessible formats, promoting the pathways chart on fabricated or induced illness to clinicians and staff in all age specialties and services where children and young people are seen.

- 4.14 All health organisations, whether in the NHS or independent health care sector, are required to ensure safeguarding children is an integral part of their governance systems. It was not clear from this review whether such processes were in place within all organisations or who had responsibility for monitoring these processes, with many of those responding to the survey or interviewed, being unclear about or unaware of how these processes functioned within their organisation. Improving patient safety is a key concern of provider healthcare organisations, and the governance arrangements that Boards of healthcare organisations put into place for it should take account of safeguarding children more generally, and the particular systemic risks to fabrication or induction of illness in children and young people who are receiving hospital care (see paragraph 2.19).
- 4.15 Understanding fabricated or induced illness reaches beyond paediatricians and child health; because of the wide-ranging symptoms with which differing manifestations may present and the potential repetition of surgical and diagnostic interventions, professionals in other adult healthcare services where children or young people are seen need to know what to look out for and how to refer, where appropriate.
- 4.16 Where parental or a carer's mental illness might be an issue, the difficulty of engaging adult and forensic psychiatry in assessing for the presence of a mental illness or in recognising the need of the children involved is a recurrent theme of the serious case reviews analysed. This is a common concern in safeguarding children from all forms of abuse. Similar issues of

engagement with GPs were reported in the survey follow-up telephone conversations. There were too few GPs in the review to draw any inference but the insights they gave suggested that limited knowledge about local safeguarding arrangements and fabricated or induced illness sometimes act to dampen co-operation with other healthcare professionals and children's services. However, as part of the primary care team, health visitors and school nurses play a significant role in child protection and are able to support GPs and paediatricians in the process. As providers of a universal primary preventive service, health visiting teams see children in a family and social context. This gives them a key role in identifying possible cases of fabricated or induced illness at an early stage and providing some of the support that could prevent an escalation of the problem. Evidence from the Nurse Family Partnerships in the United States, which is being tested in 10 sites in England, was shown through three large-scale trials to reduce abuse and neglect in children ^{40,41}.

- 4.17 Inappropriate use of or frequent requests for medicines may be one of the manifestations of repeated use of health services for some fabricated or induced illness presentations. This may require action at several levels: where fabricated or induced illness is suspected, as a preventive measure, reviews of repeat prescribing for long-term conditions such as epilepsy or diabetes or accurate history-taking and accessing a range of notes held by prescribers, for example, in accident and emergency, walk-in centres, community.
- 4.18 The repeated use of health services, which may characterise some forms of fabrication, may be made easier with the multiplicity of ambulatory care options now available. The coming into being of the electronic national care record NHS Care Record Service and associated Secondary User Uses Service in conjunction with ContactPoint ⁴² (an information sharing index) should enable clinicians to examine the pattern of health services' use where there are concerns about fabrication or induction.
- 4.19 Patient safety systems play a key part in supporting care that saves lives and prevents harm to people receiving NHS care. Safeguarding children and young people in hospital care, in terms of reducing risks in systems of care, should be integral to promoting patient safety and reporting and learning from adverse events. The needs of children should be identified and addressed in taking forward the implementation of *Safety First: A report for patients, clinicians and healthcare managers* ³⁹.

Education and training

11. Widely promote the Department for Children, Schools and Families' forthcoming training resources on fabricated or induced illness, *Incredibly Caring DVD*, which is designed to assist with local implementation of the revised guidance on *Safeguarding Children in Whom Illness is Fabricated or Induced*.
12. When the revised guidance is published, Local Safeguarding Children Boards should be asked to ensure that their multi-disciplinary and inter-agency safeguarding training programmes include fabricated or induced illness.

- 4.20 *Working Together to Safeguard Children*⁴ provides guidance on training and development of staff in strategic and operational roles and on a single and multi-agency basis. Multi-agency approaches are required to promote a common and shared understanding of the roles, responsibilities and contributions of different organisations and professionals. Additional training is needed on the clinical aspects to meet the specialist needs of the different health disciplines. The review findings suggest that confidence in dealing with cases of fabricated or induced illness is improved by training, and particularly on a multi-agency basis. Furthermore, people thought fabricated or induced illness should be included in general training on safeguarding children.
- 4.21 A training package will be launched with the revised guidance on fabricated or induced illness to support its implementation.

The evidence base

- 4.22 "Diagnose and be damned, don't diagnose and be damned" is indicative of the dilemma that fabricated or induced illness can sometimes present to doctors. A lucid evidence base is critical for differential diagnosis of the clinical presentation, for example in cases of induced illness, between neglect and organic causes of failure to thrive or between induced illness and rare or unusual medical disorders neglect. Previously contentious conditions such as chronic fatigue syndrome have in the past benefited from delineation from fabricated or induced illness through improved guidelines on diagnosis and clinical management.

- 4.23 This report makes no new proposals because a number of initiatives are underway which would improve the evidence base for practitioners. The National Institute for Clinical Excellence guidelines on recognition of suspected child abuse is expected to be published in 2008. In addition, a jointly funded safeguarding research initiative will deliver a range of evidence-base guidelines to inform both clinical and interdisciplinary professional practice in the area of neglect, emotional abuse and the impact of interventions. Other important outputs from this initiative, which will address a range of concerns pertinent to fabricated or induced illness, include:
- Best practice on how GPs manage conflicts of interest between family work and acting in the best interests of a child at risk to significant harm;
 - Good practice on communication in the light of parents' experiences of being suspected of child abuse;
 - Tools for Local Safeguarding Children Boards to evaluate the effectiveness and impact of their training programmes.
- 4.24 Finally, proposals in *Bearing Good Witness*⁴³ for a national knowledge service to help improve the evidence base available to medical expert witnesses should, when established, assist in providing an up-to-date analysis of the facts in some of the difficult areas of clinical diagnosis and management.

Conclusion

- 4.25 Fabricated or induced illness is a form of child abuse occurring across a spectrum of presentations. A major problem and a common factor identified in public inquiries and serious case reviews of child abuse over the past three decades is that quite often, existing guidance and procedures have not been followed. The key issues these inquiries have raised include difficulties with multi-agency working and training, poor or non-existent area-wide safeguarding/child protection procedures, poor communication and poor clarity about responsibilities.
- 4.26 This review has highlighted similar findings and furthermore highlights the challenging and difficult nature that clinicians experience in identifying and managing cases. It is clear that some modification is needed to current guidance to clarify roles and responsibilities in clinical management in the healthcare sector and decisions about safeguarding. However, Primary Care Trusts, NHS Trusts and Foundation Trusts also need to play their

part in the work of Local Safeguarding Children Boards to ensure that the governance, procedural and training arrangements agreed for safeguarding children and young people from fabricated or induced illness are in place and working well. Local Safeguarding Children Boards are the cornerstone in co-ordinating the work of agencies and professionals in safeguarding children and young people and minimising risks to harm. Strategic Health Authorities, Primary Care Trusts, NHS Trusts and Foundation Trusts are statutory members of the Boards. The recommendations of the review report need to be reflected in the development of their work.

Annex A:

ADVISORY GROUP MEMBERSHIP

Anne Green	Consultant Biochemist, Director of Neonatal Screening and Inherited Metabolic Disorders Services, Birmingham Children's Hospital
Anne Orton	Ofsted
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Carole Mattock	South East Coast Strategic Health Authority Children's Lead
Christopher Verity	Neurologist, Cambridge
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Donna Kinnair	CPHVA/Amicus Union
Danya Glaser	Child and Adolescent Psychiatrist, Great Ormond Street Hospital
Jean Price	Community Paediatrician, Southampton Designated Doctor with experience of fabricated or induced illness
Dr. Rosalyn Proops	Named Doctor with experience of fabricated or induced illness
Fiona Smith	Royal College of Nursing
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Harvey Marcovitch	Paediatrician
Ian Wong	Director, Centre for Paediatric Pharmacy Research
Jan Horwath	Professor of Child welfare, Sheffield University
Jane Ratcliffe	Paediatric Intensive Care Society, and Alder Hey Children's Hospital
Karen Carruthers	Social Worker with experience of fabricated or induced illness
Kathy Dickinson	National Clinical Governance Support Team
Kathy James	National Association of Head Teachers
Lucy Thorpe	Policy Advisor, National Society for Protection of Cruelty to Children
Maddie Blackburn	Healthcare Commission
Mary Eminson	Child and Adolescent Psychiatrist
Neela Shabde	Named Doctor with experience of fabricated or induced illness
Pauline Lambert	Designated Nurse with experience of fabricated or induced illness
Peter Fleming	Paediatrician, Bristol
Adrian Newland	Royal College of Pathologists
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Sheila Adam	Director of Public Health, NE London SHA
Terence Stephenson	National Patient Safety Agency
Terry Grange	Association of Chief Police Officers, Chief Constable, Wales

Annex B:

Summary of methodology for gathering evidence

The review's methodology consisted of four components:

- A web-based anonymous staff attitude survey (and where the respondent agreed a follow-up telephone conversation);
- Structured conversations;
- Case analysis of serious case reviews; and
- A broad range of multi-professional focus groups.

The web based survey/follow-up conversations were conducted to establish the extent of the awareness of existing fabricated or induced illness guidance, how staff use the guidance, what helps and what more can be done to achieve effective implementation. A wide range of health and social care professionals (including managers) were targeted through internal and external bulletins, newsletters and through the Royal Colleges and professional bodies.

Of the 30 or so respondents to the survey who indicated a willingness to participate in a follow-up telephone interview 22 were interviewed by phone (the others being unavailable in the timescales) and included consultant paediatricians and psychiatrists, named and designated doctors and nurses, GPs, and social workers.

Structured conversations A further 21 semi-structured interviews or conversations were undertaken with staff from teams who have been involved in fabricated or induced illness work with a particular focus on paediatricians. Participants were identified through the Advisory Group members and other professional links.

An analysis of serious case reviews was planned to examine 10 serious case overview reports available in the public domain, since the guidance was published in 2002. Requests for assistance in identifying reviews were made to the Department for Education and Skills, Commission for Social Care Inspection, Advisory group members and a range of professional bodies. In the event, only four serious case reviews' overview reports were forthcoming.

Focus groups were used to test the emerging themes from the staff attitude survey and semi-structured interviews. Seven meetings were held with multi-agency professional groups in different areas of the country including GPs, accident and emergency consultants, education and children's social care professionals.

Annex C:

Online survey of staff attitudes - organisation type definition and number of respondents

Organisation type	Organisation respondents work for	Number of respondents
NHS Trusts	Acute NHS Trust	254
	Children's NHS Trust	19
	Foundation Trust	23
	Other NHS Trust	1
Acute Total		297
PCT	Health and Social Care Trust	5
	Multi-agency or Children's Trust arrangement	3
	Partnership arrangement	3
	Primary Care Trust	179
	Other PCT	3
PCT Total		193
Other	Combined Social Services/Education	4
	Education	4
	General Practice	4
	Independent sector	2
	Mental Health Trust	14
	Social Services	4
	Sure Start	1
	Voluntary organisation	1
	Other Organisation Type	11
Other Total		45
Total respondents		535

Annex D:

Online survey of staff attitudes - staff group definitions and number of respondents

Staff Group	Respondent's Job Title	Number of Respondents
Consultant paediatrician	Consultant paediatrician – community based	58
	Consultant paediatrician – hospital based	129
	Other consultant paediatric medical role	7
Consultant paediatrician Total		194
Specialist child protection	Child protection adviser/manager of a CP team	24
	Consultant – nurse	15
	Health visitor	48
	School nurse	13
	Other specialist child protection	43
Specialist child protection Total		143
Other role	Allied health professional	4
	Career grade paediatrician	15
	Consultant – CAHMS	2
	Consultant – forensic psychiatry	1
	Consultant – medical	1
	Consultant – nurse	4
	General practitioner	9
	Midwife	5
	Other non-consultant paediatric role	8
	Practice nurse	1
	Registered children's nurse	41
	Registered learning disabilities nurse	1
	Registered mental health nurse	3
	Registered nurse	13
	Senior House Officer - paediatrics	5
	Social services – other	5
	Social work team leader	2
	Social work team leader in community	2
	Social worker based in a hospital working with children	1
	Specialist registrar in paediatrics	41
Other role- not listed	34	
Other role total		198
Total respondents		535

Annex E:

Examples of Good Practice

1. Local Safeguarding Children Board, London Borough of Harrow

The London Borough of Harrow and relevant NHS Trusts have worked together to create a senior group of doctors, nurses and other relevant professionals to form a group that staff can use for consultation when NHS staff or other professionals have concerns that a case may be fabricated or induced illness. To support this work, they have developed a protocol which explains how professionals can access this group and what it can offer. The group also play a role in providing support for members of staff who are involved in cases of fabricated or induced illness which they do either directly or by ensuring that this is provided by an appropriate person.

In a similar way, Brighton and Hove Children and Young People's Trust are developing a reference group for discussing cases of fabricated or induced illness

2. Southampton Primary Care Trust and Southampton University Hospitals Trusts (SUHT)

These two organisations have developed local systems to ensure that there is multi-professional liaison between community paediatricians and community staff and their acute hospital trust colleagues. Agreement has been reached that where there are concerns about a child, the child will always be admitted to hospital under the same consultant paediatrician.

The Designated and Named professionals for child protection/safeguarding are involved from the earliest stage in all cases of actual or potential fabricated or induced illness and facilitate child protection strategy meetings, staff support and reflective practice groups. The fabricated or induced illness child protection strategy meetings are always chaired by a senior Social Worker and attended by a D.S. or above from the local police Child Abuse Investigation Unit along with the Designated and Named child protection professionals. Multi-agency, combined family chronologies are produced in all such cases. Awareness has been successfully raised amongst staff via training on the SUHT monthly child protection professional study days leading to earlier identification of such cases. Topic specific Fabricated or Induced Illness

half study days are planned for 2008 to further raise awareness amongst hospital staff.

3. Central Manchester and Manchester Children's University Hospitals NHS Trust

These two trusts have produced guidelines for the management of fabricated and induced illness which contain an audit tool with related standards for managing cases, a template for creating chronologies and specific guidance about the handling of individual cases. These have been distributed to Primary Care Trusts in the area.

4. Hertfordshire County Council and their local area child protection committee (now Local Safeguarding Children Board)

Working together, these organisations have worked with key professionals in their local area to raise awareness of fabricated or induced illness. They have encouraged the development of a best practice approach by wherever possible convening early multi-agency "professionals" meetings to consider cases where fabricated or induced illness may be a possibility. They have found it is essential that all key professionals, including the GP and any consultants who have worked with the child, attend this meeting and contribute to the creation of a chronology. The police are also invited to attend. The meeting is chaired by a senior officer with safeguarding knowledge and would not include parents but a key part of the meeting would be to agree what needs to be done about informing and involving them. These meetings are not easy to set up and administer but have been found to be invaluable in promoting a focus on the needs of the child and encouraging sharing between agencies about how to proceed.

5. Template for cases of fabricated or induced illness

The serious case review report to the Cumbria Child Protection committee (March 2004) contains a useful template "Warning signs of fabricated or induced illness". This was produced by the serious case review group who worked on the case of MD and is designed to "trigger" a professional into realising that things are not quite right and to give an indication as to whether fabricated or induced illness is a possibility.

www.cumbrialscb.com/pagesall.aspx?id=296

6. Policies for working with possible/actual cases of fabricated or induced illness when children are in hospital - Great Ormond Street

Great Ormond Street Hospital for Sick Children has developed a number of policies and procedures to support their staff in working with cases of or potential cases of fabricated or induced illness. These include a general policy on the management of fabricated or induced illness in the acute setting and a policy on observation and supervision of children.

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