ATT Safeguarding Briefing – Issue 5

## Fabricated or Induced Illness (FII)

Fabricated or induced illness (FII) is a rare form of child abuse. It occurs when a parent or carer, usually the child’s biological mother, exaggerated or deliberately causes symptoms of illness in the child. In fabricated or induced illness, the parent may present the child as ill when they are healthy, deliberately induce symptoms of illness, manipulate test results, or exaggerate or lie about symptoms.

FII is also known as "Munchausen's syndrome by proxy" (not to be confused with [Munchausen's syndrome](https://www.nhs.uk/conditions/munchausens-syndrome/), where a person pretends to be ill or causes illness or injury to themselves).

## How common is FII?

It's difficult to estimate how widespread FII is because many cases may go unreported or undetected, but it is thought to be very rare.

One study published in 2000 estimated 89 cases of FII in a population of 100,000 over a 2-year period. However, it's likely that this figure underestimates the actual number of cases of FII.

FII can involve children of all ages, but the most severe cases are usually associated with children under 5.

In around 85% of reported cases of FII, the child's mother is responsible for the abuse. However, there have been cases where the father, foster parent, grandparent, guardian, or a healthcare or childcare professional was responsible.

## Why does fabricated or induced illness happen?

The reasons why FII happens are not fully understood. In cases where the mother is responsible, it could be that she enjoys the attention of playing the role of a "caring mother".

A large number of mothers involved in FII have [borderline personality disorders](https://www.nhs.uk/conditions/borderline-personality-disorder/) characterised by emotional instability, impulsiveness and disturbed thinking.

Some mothers involved in FII have so-called "somatoform disorders", where they experience multiple, recurrent physical symptoms. A proportion of these mothers also have Munchausen's syndrome.

Some carers have unresolved psychological and behavioural problems, such as a history of [self-harming](https://www.nhs.uk/conditions/self-harm/), or drug or [alcohol misuse](https://www.nhs.uk/conditions/alcohol-misuse/). Some have experienced the death of another child.

There have also been several reported cases where illness was fabricated or induced for financial reasons. For example, to claim disability benefits.

## Indicators to look out for:

* symptoms only appear when the parent or carer is present
* the only person claiming to notice symptoms is the parent or carer
* the child doesn't respond well to medication or other treatment
* if one health problem is solved, the parent or carer may then begin reporting a new set of symptoms
* the child's symptoms don't seem plausible
* a history of changing GPs or visiting different hospitals for treatment
* limited activities as a result of having a condition – for example, missing a lot of school
* the parent or carer has a good medical knowledge or a medical background
* the parent or carer doesn't seem worried about the child's health, despite being very attentive
* the parent or carer develops close relationships with healthcare staff, but becomes argumentative if their views are challenged
* one parent - usually the father - has little or no involvement in the care of the child
* the parent or carer encourages professionals to perform painful tests and procedures on the child

## Patterns and levels of abuse:

The patterns of abuse usually fall into one of six categories.
These are ranked from least severe to most severe:

* exaggerating or making up symptoms and manipulating test results
* withholding nutrients from the child or interfering with nutritional intake
* inducing symptoms by means other than poisoning or smothering, such as using chemicals to irritate their skin
* poisoning the child with a substance of low toxicity, for example, laxatives
* poisoning the child with a poison of high toxicity, for example, insulin
* smothering the child to induce unconsciousness

## Previous cases have found evidence of:

* parents or carers lying about their child's symptoms
* parents or carers contaminating or manipulating clinical tests to fake evidence of illness
* poisoning their child with unsuitable and non-prescribed medicine
* infecting their child's wounds or injecting the child with dirt or poo
* inducing unconsciousness by suffocating their child
* not treating or mistreating genuine conditions so they get worse
* withholding food

## Here is an 8-minute clip that offers an overview of FII.

<https://www.safeguardinginschools.co.uk/fabricated-or-induced-illness/>

## Relevant News Article

<https://www.bbc.co.uk/news/uk-england-london-37048581>

## Related Case Study (Serious Case Review) – Baby H

Baby H was a 12-month-old baby girl who first came to the attention of paediatricians on 7 December 2012. Parents had called an ambulance at 02.25 that morning. Dad was with the baby when he heard her crying. He went to her at about 2 a.m. and noted she was making sounds as if her upper respiratory tract was blocked. He called the ambulance. A paramedic witnessed Baby H as vacant and not fully alert. In A&E, doctors felt that the ‘floppy episode’ was due to an upper respiratory tract infection with mucous blocking the upper airway. Baby H was admitted for observation and discharged later the same day.

On 25 January 2013 at 04.19 hours the hospital received a standby call for resuscitation. Baby H’s mother was woken up by Baby H crying. Mum found Baby H grunting, looking pale and breathing slowly. She called an ambulance. On examination at hospital, Baby’s oxygen levels were low and Baby H was upset. After oxygen was administered Baby recovered well. She was discharged on 27 January.

On 15 March 2013 the hospital received another standby call at 04.49 hours. Baby H had had chickenpox for several days. Mum got up to get a drink and found Baby to be gasping for breath. When the rapid response vehicle arrived Baby H was grey, unresponsive and making very little respiratory effort. She did not respond to oxygen therapy and was making a moaning cry on the way to hospital. On examination at hospital, doctors queried sepsis as the cause of her collapse. Baby was given antibiotics directly into her bone (interosseous). She was admitted to high-dependency unit (HDU) and was discharged on 19 March 2013.

On 3 April 2013 at 04.32 hours, the hospital received another standby call for resuscitation. Mum found Baby H gasping for breath. On examination in hospital Baby H appeared pale, floppy, vacant and gazing. After 20 minutes in resuscitation, Baby H was witnessed to have another episode where she became pale and unresponsive. Baby was admitted to the children’s unit.

Baby H was still in hospital on 12 April 2013. At 04.00 hours, Mum, who was resident, alerted staff to the fact that Baby H was struggling to breathe and was unresponsive. She was resuscitated, transferred to HDU and quickly recovered as before.

Paediatricians were starting to question what was happening at this point. They began to consider other differential diagnoses. FII was part of this consideration. The trust safeguarding team were contacted on 10 April 2013 by one of their most senior consultant paediatricians who was also designated doctor in one of the Clinical Commissioning Group areas within the trust footprint. He reported to the Head of Safeguarding that he was concerned and that, in the light of numerous normal tests, ‘we could really now be dealing with FII’. Further investigations were ordered and arrangements made for Baby H to be nursed in an open bay on the ward on her return from HDU rather than go back to the single room she had come from.

It was agreed that Baby H would not be discharged. The Head of Safeguarding recommended a professionals meeting to include CSC to ensure that everyone had the opportunity to discuss health and social issues with the family and assess the level of professional concern and necessity for action. Nursing staff were asked to pay particular attention to parent–child interaction on the ward.

## Investigations/observations

During her stay in hospital, Baby H had a battery of investigations including bloods, toxicology, computerised tomography (CT) scan, skeletal survey, ophthalmology, electroencephalogram (EEG) and magnetic resonance imaging (MRI) scan. All were normal.

Baby H’s parents were described as quite passive in nature and noted not to ask a lot of questions regarding their baby’s care. Mum sometimes seemed quite flat. She had told staff she had recently had the unpleasant task of agreeing to end active treatment for her brother who was on life support; this was on the same day that Baby H was first brought to hospital. It was noted that Mum was resident with Baby H and Dad and siblings visited appropriately.

## Liaison

The family included 10 children all living in the same house. No concerns existed with regard to the family from the point of view of the health visitor. No historical concerns were documented with child health. The family were not known to the named nurse for child protection in the community or to CSC. Checks were made with neighbouring hospitals and there were no concerns expressed from these quarters. The GP was contacted and expressed no concerns about the family.

In keeping with national and local guidance on FII, the safeguarding team agreed to liaise with a senior social worker and invite them to a professionals meeting to discuss the emerging issues from the case. The team manager for the local area office was contacted and this was put to her. She asked that a referral be made through the contact centre in the usual way. However, the safeguarding team felt that the threshold for a referral had not been met and wanted a conversation to gauge opinion before going straight to referral.

The Head of Safeguarding at CSC was contacted and she agreed initially that at this stage a formal referral was not necessary. The meeting invite, due for the 26 April, was again extended to the social work team manager. On the 25 April, an e-mail exchange took place between the Head of Safeguarding at PAHT and CSC.

**The Head of Safeguarding at CSC stated that:**

When we spoke a week ago you informed me that additional tests were to be done to rule out any other possibility for the baby’s difficulties . . . In holding the meeting arranged for tomorrow I presume these tests have now been done and have shown no organic cause for the six occasions on which she has had to be resuscitated? If that is the case then there are clearly significant concerns for her safety and protection and this is emphasised by the collapse she experienced whilst in hospital and led to her being moved from the privacy of a cubicle to a public ward. I understand that mother has been present throughout the child’s stay in hospital and was there at the time of her last collapse in the cubicle. I can see no other course of action that would not require the involvement of children’s social care at this stage and I presume you are of the same mind given your request for their attendance at tomorrow’s meeting . . . social work assessments are needed at the very least and action to safeguard the child cannot be ruled out. I must advise you to make a referral via the contact centre as a matter of urgency. It can be made clear that the child is currently safe . . . This will ensure that the referral is well managed and is not escalated unnecessarily.

The reply from the Head of Safeguarding at PAHT was intended to reassure CSC that, if it was felt the child was at risk or likely to be at risk of significant harm, then a referral would be forthcoming. However, she added:

. . . that is not where we are at the moment. Some tests remain outstanding and it is certainly not clear that the child’s condition is being induced. The point of the professionals meeting is to gather together our information with that of other professionals to help us identify the nature of the risk and what next steps should be to manage it. We have prepared a chronology which throws a slightly different light on things as there has been some professional witness to some of the incidents of collapse. We need to consider this in context of medical examination findings. It would be useful to have social work team manager with us during these deliberations . . . This is an extremely uncertain and delicate case which, if handled badly, could impact on the long term outcomes for the child. As soon as we have some consensus re: balance of probability then we will make a referral (or not).

A telephone discussion followed whereby it was pointed out that a referral was necessary to enter the case onto ‘the system’, thus explaining the activity of the social worker in attending the professionals meeting. The Head of Safeguarding at PAHT again resisted the request to make a referral because in doing so there would be a documented concern of significant harm which was not a true reflection of the professional opinion at the time. It was suggested that a referral be made just to get it on the system, but that health professionals could be assured nothing would be done until agreement was reached that this met the threshold for intervention. There was no agreement about this course of action.

Further conversations highlighted the concern in CSC that the hospital was allowing unsupervised contact between mother and baby and that presented a risk given the uncertain circumstances.

On 26 April, the professionals meeting took place and the social work team manager attended. Information was shared and a plan put in place that included:

* Health Vision will visit the property to ascertain sleeping arrangements
* doctor will complete outstanding tests such as MRI and sleep study
* Baby H to remain in hospital until tests completed and plan of action devised by professionals, nursed in an open bay
* to contact CSC and the police if mother tries to leave with Baby
* CSC to complete background checks on siblings and parents.

## Diagnosis

In early May, Baby H was transferred to a specialist hospital for sleep studies. On 15 May 2013, the consultant paediatrician at PAHT verbally confirmed with the Head of Safeguarding that the results from the extensive sleep studies, taken over 5 days, showed that Baby H was suffering from complex partial epilepsy. It was agreed that FII was no longer a feature of the case. The Head of Safeguarding at CSC was informed that no child protection referral would be forthcoming.

Baby H was transferred back to PAHT and work began with the parents to prepare Baby for discharge. Specialist training and equipment was to be ordered and in place prior to discharge. On 4 June 2013, Baby H experienced another episode from which she did not recover. Her heart stopped, she could not be resuscitated and she died. Concern about the cause of death and Baby H’s condition continued post mortem. However, a vast series of tests showed nothing to suggest that her death was as a result of FII.

## Systemic analysis

#### **Reporting culture: systems and technology**

Systems and technology influenced interagency discussion and co-operation. The opportunity to have a conversation with a social worker was governed by the need to enter the activity on ‘the system’, the initiation of which could only be achieved by a referral. This is despite the fact that the health professionals were not ready to make a referral. This was doubted by CSC who suggested we had reached that threshold and that was why we had moved baby and mother out of a single room into a four-cot bay. Reassurances were given by the Head of Safeguarding at CSC that if a referral was made and the system triggered, there would be no intervention and emphasised the point of the referral would be to open the gateway into the service. This was challenged by the hospital who felt that a referral under the Children Act 1989[19](https://www.ncbi.nlm.nih.gov/books/NBK274391/) would signal a level of concern, that the child was at risk of significant harm, that did not exist at that point, although it was constantly part of differential diagnosis considerations.

#### **Informed culture: dealing with uncertainty**

The Safeguarding Unit made reference to the fact that the hospital was leaving mother unsupervised with her baby and this concerned them. Significance was placed on moving mother and baby into a more open bay area. While it was acknowledged this was to facilitate observation, the hospital emphasised that it was not an indication that a decision had been reached about significant harm. This level of uncertainty proved very challenging to CSC who went on to indicate that the hospital should make a referral so that CSC could control the level of contact mother had with her baby. The risks that this posed in terms of identifying whether or not FFI was taking place was apparently not considered. The lack of evidence to support an application to court to secure the necessary authority to limit mother’s contact was also not considered. The need to apply a procedure as a means of securing a level of certainty and assurance that ‘something was being done’ seemed to override the facts of the case including the fact that the clinical staff would not support the recommended action.

The lack of diagnosis was less alarming to clinicians than to CSC who quickly assimilated that the cause was non-organic even though this had not been established or mentioned by medical staff. The need to ascribe the ‘non-organic’ status of the child’s condition was a key concern to CSC and the link between lack of diagnosis and concerns for safety and protection were automatically made with a level of certainty that was not apparent in the discourse of hospital staff who were more prepared to tolerate a level of uncertainty than CSC. This tolerance was probably underpinned by their constant and ongoing experience and interaction with the mother and her baby.

I presume these tests have now been done and have shown no organic cause for the six occasions on which she has had to be resuscitated? If that is the case then there are clearly significant concerns for her safety and protection and this is emphasised by the collapse she experienced whilst in hospital and led to her being moved from the privacy of a cubicle to a public ward.

The fear of consequences of not intervening and not applying procedures in this case seemed to be founded on a rapid hypothetico-deductive reasoning normally confined to the realms of case reductionism prominent in the field of medical science. The family were not known to CSC and no concerns had been expressed by any professionals in relation to the family. Indeed, contact with professionals was limited to essential contacts, probably due to the fact that there were nine other children in the household. The level of concern around significant harm from social care seemed to be based purely on the lack of diagnosis, observations about mother’s demeanour and the uncertainty of hospital staff and their decision to move mother and baby to a more visible area. Without any further information this lead to a false positive identification. When the certainty of a diagnosis was reached, all concerns disappeared.

## Conclusion

The need for a professional conversation with colleagues from other agencies is an essential feature of working together. The need to have ‘a case’ inputted onto ‘a system’ in order for that conversation to occur will hinder vital professional interaction and is highlighted by Munro. The practice of having ‘a discussion’ is included in *Working Together to Safeguard Children*:

All professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children’s social care.

p. 7 (*Working Together to Safeguard Children*, Crown Copyright 2013, licensed under the Open Government Licence v3.0)

The need to balance evidence as part of the process of balancing risk is also highlighted:

No system can fully eliminate risk. Understanding risk involves judgement and balance. To manage risks, social workers and other professionals should make decisions with the best interests of the child in mind, informed by the evidence available and underpinned by knowledge of child development.

p. 22 (*Working Together to Safeguard Children*, Crown Copyright 2013, licensed under the Open Government Licence v3.0)

The lack of tolerance of uncertainty coupled with the need to govern conversation through the presence and input on a system is prevalent in this case and could potentially have resulted in an inappropriate intervention removing a mother from her child prior to her death