



***Safeguarding Children in
Whom Illness is Fabricated
or Induced***

Department of Health
Home Office
Department for Education and Skills
Welsh Assembly Government



Supplementary guidance to
Working Together to Safeguard Children
which is available on the department's website at:
www.doh.gov.uk/qualityprotects

Contents

1	The Scope and Purpose of this Document	5
1.1	The Scope and Purpose of this Document	5
1.7	The Status of the Guidance	6
1.9	The Role of Guidance	6
1.11	The Policy Context	6
1.12	Legislative Framework	7
1.12	United Nations Conventions on the Rights of the Child	7
1.13	Children Act 1989	7
1.15	The Concept of Significant Harm	8
1.18	Human Rights Act 1998	9
1.21	Regulation of Investigatory Powers Act 2000	10
1.23	An Integrated Approach	10
1.25	A Shared Responsibility	11
2	Some Lessons from Research and Experience	12
2.1	Introduction	12
2.3	Incidence and Prevalence	12
2.5	Responding to reported signs and symptoms	13
2.9	Early history and concern about the child's health	13
2.14	Child death and morbidity	14
2.16	Impact of fabricated or induced illness on the health or development of a child	15
2.20	The experience of the abused child	15
2.22	Involvement by the Child	16
2.23	Age range of children	16
2.24	Age at onset of symptoms	16
2.25	Gender of carer responsible for the abuse	16
2.27	Carers' previous histories	16
2.32	Family Relationships	17
2.34	Long-term outcomes for carers who fabricate or induce illness	17
2.35	Outcomes for children	18
3	Handling individual Cases	20
3.1	Introduction	20
3.4	Child Welfare Concerns	20
3.8	Medical Evaluation	21
3.12	Referral	22
3.15	Initial Assessment under s17 of the Children Act 1989	22
3.19	Next Steps	24
3.24	Immediate Protection	24
3.25	Strategy Discussion	25
3.29	s47 Enquiries as part of a Core Assessment	26
3.34	Criminal Investigation	26
3.38	The Outcome of s47 Enquiries	27
3.40	Concerns substantiated, but child not judged to be at continuing risk of significant harm	27

3.41	Concerns substantiated and child judged to be at continuing risk of significant harm	28
3.42	The Initial Child Protection Conference	28
3.42	Timing	28
3.43	Attendance	28
3.44	Information for the conference	29
3.45	Action and Decisions for the Conference	29
3.46	Action following the placing of a child's name on the Child Protection Register	30
3.47	Core Assessment	31
3.50	Analysis of the child's circumstance and future planning	32
3.52	Intervention	32
3.60	Child Protection Review Conference	33
3.64	Pre-birth Child Protection Conference	34
4	Roles and Responsibilities	35
4.1	Introduction	35
4.2	Health	35
4.2.1	General	35
4.3	Primary Care Trusts in England	36
4.6	Local Health Boards in Wales	37
4.7	The General Practitioner and Primary Health Care Team	37
4.11	Roles and Responsibilities for Nurses, Midwives and Health Visitors	37
4.23	Acute and Mental Health NHS Trusts	39
4.24	The Paediatrician and the Trust	39
4.31	Professionals Allied to Medicine	40
4.33	Child and Adolescent Mental Health Services	40
4.39	Adult Mental Health Services	41
4.53	Local Authorities	43
4.56	Councils with Social Services Responsibilities	44
4.57	Assessment	44
4.63	Planning	45
4.67	Provision of Services	45
4.68	Reviewing	45
4.69	Local Authority Solicitors	45
4.70	Education including Early Years and Day Nurseries	46
4.75	Identification of fabricated or induced illness	46
4.78	Management of fabricated or induced illness	47
4.83	Police	48
4.90	Probation	49
4.92	Voluntary, Independent and Private Social Care Sectors	49
4.94	Children and Family Court Advisory and Support Services (CAFCASS)	49
4.98	Family Justice Courts	50
4.100	The Armed Services	50
4.102	Children of Foreign National Countries	50

5	Roles and Responsibilities of Area Child Protection Committee	51
5.6	Designated and Health Professionals	51
5.10	Specific Responsibilities of an ACPC	52
6	Working with Children and Families: Key Issues	53
6.3	What is meant by Working with Children and Families in Child Protection	53
6.6	Working with Children and Families	54
6.12	Involving Children	54
6.16	Support, Advice and Advocacy to Children and Families	55
6.18	The Legal Framework	56
6.22	The Common Law Duty of Confidence	56
6.24	The Data Protection Act	57
6.25	The European Convention on Human Rights	57
	Professional Guidance	57
6.27	Medical	57
6.32	Nursing	58
6.35	Record Keeping	58
6.46	Use of Covert Video Surveillance	60
6.52	Complaints Procedures	61
6.53	Allegations against staff	61
6.60	Supervision and Support	62
6.64	Inter-agency Training and Development	63
6.69	The purpose of Inter-agency Training	64
Appendix 1	Working Together to Safeguard Children – Individual Cases Flow Chart	65
References		66

1. The Scope and Purpose of this Document

- 1.1 This document is based on *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (Department of Health et al, 1999 and National Assembly for Wales, 2000) and the *Framework for the Assessment of Children in Need and their Families* (Department of Health, 2000 and National Assembly for Wales, 2001). *Working Together* sets out how all agencies and professionals should work together to safeguard and promote children's welfare and the Assessment Framework outlines a framework for use by all those who work with children and families determining whether a child is in need under the Children Act 1989 and deciding how best to provide help.
- 1.2 This supplementary Guidance *Safeguarding Children in whom Illness is Fabricated or Induced* is intended to provide a national framework within which agencies and professionals at local level – individually and jointly – draw up and agree upon their own more detailed ways of working together where illness may be being fabricated or induced in a child by a carer who has parenting responsibilities for him or her. It is addressed to those who work in the health and education services, the police, social services, the probation service, and others whose work brings them into contact with children and families. It is relevant to those working in the statutory, voluntary and independent sectors. **It is intended that Area Child Protection Committees' (ACPCs) local child protection procedures should incorporate this Guidance and its references to Covert Video Surveillance, rather than having separate Guidance on fabricated or induced illness in children. Within the local procedures, the section on the use of Covert Video Surveillance should make reference to the good practice advice for police officers which is available to them from the National Crime Faculty.**
- 1.3 The fabrication or induction of illness in children by a carer is referred to by a number of different terms, most commonly Munchausen Syndrome by Proxy (Meadow, 1977), Factitious Illness by Proxy (Bools, 1996; Jones and Bools, 1999) or Illness Induction syndrome (Gray et al, 1995). In the United States, the term Paediatric Condition Falsification is being adopted by the American Professional Society on the Abuse of Children (APSAC). This terminology is also used by some as if it were a psychiatric diagnosis. The American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM-IV) has proposed using the term factitious disorder by proxy for a psychiatric diagnosis applicable to the fabricator.
- 1.4 The use of terminology to describe the fabrication or induction of illness in a child has been the subject of considerable debate between professionals. These differences of opinion may result in a loss of focus on the welfare of the child. In order to keep the child's safety and welfare as the primary focus of all professional activity, this Guidance refers to the '**fabrication or induction of illness in a child**' rather than using a particular term. If, as a result of a carer's behaviour, there is concern that the child is or is likely to suffer significant harm, this Guidance should be followed. The key issue is not what term to use to describe this type of abuse, but the impact of fabricated or induced illness on the child's health and development, and consideration of how best to safeguard the child's welfare.
- 1.5 There are three main ways of the carer fabricating or inducing illness in a child. These are not mutually exclusive:
 - **fabrication** of signs and symptoms. This may include fabrication of past medical history;

- **fabrication** of signs and symptoms and **falsification** of hospital charts and records, and specimens of bodily fluids. This may include also falsification of letters and documents;
- **induction** of illness by a variety of means.

Examples of the types of abusive behaviours exhibited are further elaborated in paragraph 2.7, and paragraph 3.5 sets out the types of situations which may cause concern about a child's welfare.

- 1.6 In the Guidance the term 'carer' is used to mean 'parent or carer', i.e. any adult who is exercising parenting responsibilities for a child. Those with parenting responsibilities may include, for example, grandparents, foster-parents, child minders, as well as those who have parental responsibility as defined in the Children Act 1989.

The Status of This Guidance

- 1.7 This Guidance, prepared and issued jointly by the Department of Health, the Home Office, the Department for Education and Skills and the Welsh Assembly Government, is supplementary to *Working Together to Safeguard Children* and should be followed in conjunction with the main Guidance. All assessments should be undertaken in accordance with the *Framework for the Assessment of Children in Need and their Families*. Where appropriate, paragraphs are cross-referenced to *Working Together* and the *Assessment Framework*.
- 1.8 **It is issued under Section 7 of the Local Authority Social Services Act 1970, which requires local authorities in their social services functions to act under the general guidance of the Secretary of State. As such, this document does not have the full force of statute, but should be complied with unless local circumstances indicate exceptional reasons which justify a variation.**

The Role of Guidance

- 1.9 Processes and procedures are never ends in themselves, but should always be used as a means of bringing about better outcomes for children. No guidance can, or should attempt to, offer a detailed prescription for working with each child and family. Work with children and families where there are concerns about a child's welfare, is sensitive and difficult. Work in situations where illness has been fabricated or induced can be very stressful. Good practice calls for effective co-operation between different agencies and professionals; sensitive work with parents and carers in the best interests of the child; and the careful exercise of professional judgement, based on thorough assessment and critical analysis of the available information
- 1.10 The Royal College of Paediatrics and Child Health has issued a report on *Fabricated or Induced Illness by Carers* (2001). It describes the role of paediatricians and other child health service professionals and recommends how they should work with professionals from other agencies. The Royal College's report has informed the development of this Guidance and provides more in-depth information for professionals, particularly those in health.

The Policy Context

- 1.11 In 2000 the *Report of a review of the research framework in North Staffordshire Hospital NHS Trust* (Department of Health, 2000b) was published. It called for a wide range of measures to improve research governance across the NHS. In addition, it recommended the development of guidelines

to assist the identification of children who have had illnesses fabricated or induced by their carer. The Department of Health responded to this later recommendation with a commitment to produce “new guidelines for professional practice and inter-agency working in responding to concerns that a child may be having illness feigned or induced by a carer. These guidelines will be drawn up within the framework of *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children* (1999)”.

Legislative Framework

United Nations Convention on the Rights of the Child

1.12 This Guidance reflects the principles contained within the United Nations Convention on the Rights of the Child, ratified by the UK Government in 1991. Specifically:

- Article 3: the best interests of the child should be a primary consideration when action is taken concerning children;
- Article 9: children should not be separated from their parents unless such separation is necessary in the best interests of the child;
- Article 19: children should be protected from abuse or neglect;
- Article 37: no child should be subjected to torture or other cruel, inhumane or degrading treatment or punishment. No child shall be deprived of his or her liberty unlawfully or arbitrarily;
- Article 39: all appropriate measures should be taken to promote the physical and psychological recovery and social reintegration of a child victim of any form of neglect or abuse.

Children Act 1989

1.13 It is particularly informed by the requirements of the Children Act 1989, which provides a comprehensive framework for the care and protection of children.

1.14 The Children Act 1989 places two specific duties on agencies to co-operate in the interests of vulnerable children:

Section 27 provides that a local authority may request help from:

- any local authority;
- any local education authority;
- any local housing authority;
- any health authority, Local Health Board (in Wales), Special Health Authority, Primary Care Trust or National Health Service Trust; *and*
- any person authorised by the Secretary of State in England or the Welsh Assembly Government in Wales for the purposes of this section.

in exercising the local authority's functions under Part III of the Act. This part of the Act places a duty on local authorities to provide support and services for children in need, including children looked after by the local authority and those in secure accommodation. The authority whose help is requested in these circumstances has a duty to comply with the request, provided it is compatible with its other duties and functions and does not unduly prejudice the discharge of any of that authority's functions.

Section 47 places a duty on:

- any local authority;
- any local education authority;
- any housing authority;
- any health authority, Local Health Board (in Wales), Special Health Authority, Primary Care Trust or National Health Service Trust¹; *and*
- any person authorised by the Secretary of State in England or the Welsh Assembly Government in Wales

to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, unless doing so would be unreasonable in all the circumstances of the case.

The Concept of Significant Harm

1.15 The Children Act 1989 introduced the concept of significant harm as the threshold justifying compulsory intervention in family life in the best interests of the child. A court may only make a care order (committing the child to the care of the local authority) or supervision order (putting the child under the supervision of a social worker, or a probation officer) in respect of a child if it is satisfied that:

- the child is suffering, or is likely to suffer, significant harm; *and*
- that the harm or likelihood of harm is attributable to a lack of adequate parental care or control (s31).

Under s31(9) of the Children Act 1989:

'harm' means ill-treatment or the impairment of health or development;

'development' means physical, intellectual, emotional, social or behavioural development;

'health' means physical or mental health; and

'ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical.

Under s31(10) of the Act:

Where the question of whether harm suffered by a child is significant turns on the child's health and development, his health or development shall be compared with that which could reasonably be expected of a similar child.

¹ Including those NHS trusts and PCTs re-designated as Care Trusts under Section 45 of the Health and Social Care Act.

- 1.16 There are no absolute criteria on which to rely when judging what constitutes significant harm. Sometimes, a single traumatic event may constitute significant harm, for example a violent assault, intentional suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical, social and psychological development. Long-term physical or emotional abuse can cause impairment to such an extent that it constitutes significant harm. For each child, it is necessary to consider the harm they have suffered in the context of the family's strengths and supports.
- 1.17 In deciding whether a child has been or is likely to suffer significant harm, it is necessary to consider the information gathered during an assessment under each dimension heading in the Assessment Framework (Department of Health et al, 1999). This includes:
- the family context;
 - the child's development within the context of their family and wider social and cultural environment;
 - any special needs, such as a medical condition, communication difficulty or disability that may affect the child's development and care within the family;
 - the nature of harm, in terms of ill-treatment or failure to provide adequate care;
 - the impact on the child's health or development; *and*
 - the adequacy of parental care.

It is important always to take account of the child's reactions, and his or her perceptions, according to the child's age and understanding.

Human Rights Act 1998

- 1.18 The Human Rights Act 1998 is also fundamental to this Guidance. Section 6(1) places a duty on all public authorities to act in a way that is compatible with the rights and freedoms of the European Convention of Human Rights that have been incorporated by the 1998 Act. These convention rights include Article 3 – “no one shall be subjected to torture or to inhumane or degrading treatment or punishment” and Article 8 – “everyone has the right to respect for his private and family life, his home and his correspondence”.
- 1.19 The Human Rights Act places obligations on public authorities both to refrain from certain action and in some circumstances to take positive steps or measures to protect the Convention rights of individuals.
- 1.20 A public authority includes “any person certain of whose functions are functions of a public nature”. There will be some bodies, for example, local authorities which are clearly public authorities under the Act. However other bodies may exercise both public and private functions and where those functions are public they must be exercised compatibly with the convention rights incorporated by the Human Rights Act. Where there is any doubt, it is important that bodies seek their own legal advice.

Regulation of Investigatory Powers Act 2000

- 1.21 Of particular significance is the Regulation of Investigatory Powers Act 2000. The main purpose of this Act is to ensure that investigatory powers are used in accordance with human rights. These powers include the use of covert surveillance such as covert video surveillance, in the course of specific operations. Part II and Schedule 1 to the Act set out a system of authorisations for the use of surveillance.
- 1.22 **This guidance suggests that where there is any potential for the use of covert video surveillance the police should be informed and, within the multi-agency team, take the lead in co-ordinating such action** (see paragraphs 3.23, 4.86 and 6.46–6.51). All action should be undertaken in accordance with the local ACPC child protection procedures (see paragraph 1.2). Where there is any doubt about the use of covert video surveillance legal advice should be taken.

An Integrated Approach

- 1.23 Children have varying needs which change over time. Judgements on how best to intervene when there are concerns about harm to a child will often and unavoidably entail an element of risk – the two extremes being, leaving a child for too long in a dangerous situation and removing a child unnecessarily from their family. The way to proceed in the face of uncertainty is through competent professional judgements based on a sound assessment of the child's needs, the parents' capacity to respond to those needs – including their capacity to keep the child safe from significant harm – and the wider family circumstances (Department of Health et al, 2000).
- 1.24 Effective measures to safeguard children cannot be seen in isolation from the wider range of support and services available to meet the needs of children and families:
- many of the families in which a child has had illness fabricated or induced have experienced a number of stress factors in their lives. Providing services and support to these children and families may strengthen the capacity of parents to respond to the needs of these children before they reach the point where their reaction to their difficulties is to fabricate or induce illness in their child;
 - child protection enquiries may reveal significant unmet needs for support and services among children and families, particularly in relation to the needs of the parents and the way in which the family members relate to each other. These should always be explicitly addressed if the family member so wishes, even where concerns are not substantiated about significant harm to a child;
 - if child protection processes are to result in improved outcomes for children, then effective plans for safeguarding children and promoting their welfare should be based on a wide ranging assessment of the needs of the child and their family circumstances, taking account of past histories of all family members;
 - all work with children and families should retain a clear focus on the welfare of the child. Just as child protection processes should always consider the wider needs of the child and family, so broad-based family support services should always be alert to, and know how to respond quickly and decisively to potential indicators of illness being fabricated or induced in a child.

A Shared Responsibility

- 1.25 Promoting children's wellbeing and safeguarding them from significant harm, depends crucially upon effective information sharing, collaboration and understanding between agencies and professionals. These relationships may become strained where there are concerns that illness is being fabricated or induced in a child and there are differences in opinion about how best to safeguard the child's welfare or indeed if the child is being abused. Constructive relationships between individual workers should be supported by a strong lead from elected or appointed authority members, and the commitment of senior officers from each agency.
- 1.26 At the strategic level, agencies and professionals should work in partnership with each other and with service users, to plan comprehensive and co-ordinated children's services which have the capacity to respond to the identified needs of children. Children who have had illness fabricated or induced and their families will require specialised services, some of which may not be available locally and will have to be secured from either regional or national resources. One case can make considerable demands on an agency's available resources. On these rare occasions, senior managers should be involved in deciding how to allocate resources deemed necessary to bring about the best outcomes for the child.
- 1.27 Children who have had illness fabricated or induced will require co-ordinated help from a range of agencies such as health, education, social services and the voluntary sector over a sustained period of time. The nature of the input is likely to change as the child develops and his or her needs change; over time, therefore, the types of services required may differ considerably.
- 1.28 For those children who are suffering, or at risk of suffering significant harm, joint working is essential, to safeguard the child/ren and – where necessary – to take action, within the criminal justice system, regarding the perpetrators of crimes against children. In using this Guidance all agencies and professionals should:
- be alert to potential indicators of illness being fabricated or induced in a child;
 - be alert to the risks which individual abusers, or potential abusers, may pose to children in whom illness is being fabricated or induced;
 - share, and help to analyse information so that an informed assessment can be made of the child's needs and circumstances;
 - contribute to whatever actions (including the cessation of unnecessary medical tests and treatments) and services are required to safeguard the child and promote his or her welfare; *and*
 - regularly review the outcomes for the child against specific shared objectives.
 - work co-operatively with parents unless this is inconsistent with ensuring the child's safety.
 - assist in providing relevant evidence in any criminal or civil proceedings, should this course of action be deemed necessary.

2. Some Lessons From Research and Experience

Introduction

- 2.1 Our knowledge and understanding of children's welfare – and how to respond in the best interests of a child to concerns about abuse and neglect – develop over time, informed by research, experience, and the critical scrutiny of practice. Sound professional practice involves making judgements supported by evidence: evidence derived from research and experience about the nature and impact of abuse and neglect, and when and how to intervene to improve outcomes for children; and evidence derived from thorough assessment about a specific child's health, development and wellbeing, and his or her family circumstances.
- 2.2 This chapter begins by reporting research findings on the incidence and prevalence of illness being fabricated or induced in a child by a carer and describes some of the types of behaviours exhibited by carers which can be associated with illness fabrication or induction. It goes on to summarise available research findings and practice experience specific to this type of abuse, and concludes with what is known about how best to secure optimal outcomes for children in whom illness has been fabricated or induced.

Incidence and Prevalence

- 2.3 The fabrication or induction of illness in a child by a carer is considered to be rare. McClure et al (1996) carried out a two-year study to determine the epidemiology of Munchausen Syndrome by Proxy, non-accidental poisoning and non-accidental suffocation in the UK and the Republic of Ireland. They analysed data from 128 confirmed cases notified to the British Paediatric Association Surveillance Unit during the period September 1992 to August 1994. Based on this data, the researchers estimated that the combined annual incidence in the British Isles of these forms of abuse in children under 16 years was at least 0.5 per 100,000 and for children under 1 years at least 2.8 per 100,000. The authors calculated that "in a hypothetical district of one million inhabitants therefore, the expected incidence would be approximately one child per year" (p. 58).
- 2.4 This study showed that reported rates of fabricated or induced illness varied greatly between different health service regions and the researchers suggested it was under-reported nationally. Their findings also suggested that paediatricians considered that at the time of their study the identification had to be virtually certain before a child protection conference is initiated. Thus a number of cases may be unrecorded because of the absence of irrefutable evidence in situations where the level of concern about harm to the child is extremely high. The cases may also present in ways which result in unnecessary medical interventions, for example, where symptoms are verbally reported to surgeons who then carry out operations without questioning the basis of this information. Consequently the estimate of one child per one million head of population is likely to be an under-estimate.

Responding to reported signs and symptoms

- 2.5 Where illness is being fabricated or induced, extensive, unnecessary medical investigations may be carried out in order to establish the underlying causes for the reported signs and symptoms. The child may also have treatments prescribed or operations which are unnecessary. These investigations can result in children spending long periods of time in hospital and some, by their nature, may also place the child at risk of suffering harm or even death.
- 2.6 Carers exhibit a range of behaviours when they believe that their child is ill. A key professional task is to distinguish between the over anxious carer who may be responding in a reasonable way to a very sick child and those who exhibit abnormal behaviour (see paragraphs 3.1–3.3). Such abnormal behaviour in a carer can be present in one or both carers and often involves passive compliance of the child (see paragraph 2.20). These carer behaviours may constitute ill treatment (section 31(9) of the Children Act 1989).
- 2.7 The following list is of behaviours exhibited by carers which can be associated with fabricating or inducing illness in a child. This list is not exhaustive and should be interpreted with an awareness of cultural behaviours and practices which can be mistakenly construed as abnormal behaviours:
- deliberately inducing symptoms in children by administering medication or other substances, or by means of intentional suffocation;
 - interfering with treatments by over dosing, not administering them or interfering with medical equipment such as infusion lines;
 - claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting, or fits. These claims result in unnecessary investigations and treatments which may cause secondary physical problems;
 - exaggerating symptoms, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous;
 - obtaining specialist treatments or equipment for children who do not require them;
 - alleging psychological illness in a child.
- 2.8 The majority of cases of fabricated or induced illness in children are *confirmed* in a hospital setting because either medical findings or their absence provide evidence of this type of abuse.

Early history and concern about the child's health

- 2.9 A significant number of children in whom illness is fabricated or induced will have been well known to health professionals from birth. Some may previously have been seriously ill, for example as a consequence of prematurity, while others may have had minor problems at birth or in their first few months of life. Consideration should be given to the possibility that the obstetric complications themselves may have been due to the mother interfering with her pregnancy to induce a premature birth (Jureidini, 1993). Children may have also experienced other forms of abuse, for example, physical abuse or neglect, prior to the identification of fabricated or induced illness (Bools et al, 1992)

- 2.10 Non-organic failure to thrive is a common feature of this group of children who may have been presented to professionals or agencies earlier in their lives with failure to thrive, alleged allergies and/or feeding problems (Bools et al, 1992; Gray and Bentovim, 1996; Rosenberg, 1987).
- 2.11 At the point the fabrication or induction of illness is confirmed the child may have organic problems which will require ongoing medical treatment. These may pre-date the abuse or be a consequence of it. It can be difficult to identify retrospectively the origins of a child's medical problems but, following identification of fabricated or induced illness, treatment for medical conditions should be undertaken as part of the child's overall plan.
- 2.12 The medical histories of this group of children are likely to have started early and in many instances will have become extensive by the time the suspected abuse is identified. Some children may have been referred to a tertiary paediatric centre because they were thought to have a serious or rare illness requiring expert diagnosis and treatment. They may have been seen at many hospitals in different geographical areas and by a number of professionals. They may also have been seen in centres for alternative medicine or by private practitioners.
- 2.13 When a child is in hospital, it is usual for carers (usually the child's parents) to be very involved in the care of their child, including participating in medical tests, taking temperatures and measuring bodily outputs. Where illness is being fabricated or induced by a carer, these normal hospital practices afford the carer the opportunity to continue this behaviour. This may mean, for example, that treatments and tests may be interfered with and the reported signs and symptoms continue whilst the child is in hospital. Differences may be observed between the ways in which carers who fabricate or induce illness interact with their children compared with other carers. Commonly, these carers are observed to be intensely involved with their children, never taking a much needed break nor allowing anyone else (either family members or professionals) to undertake any of their child's care. This behaviour may preclude adequate observation of the child. Some, however, spend little time interacting with their child. They may be very involved with other families on the ward and hospital staff than their child. Another observed feature is that some carers appear unusually unconcerned about the results of investigations which may be indicative of a serious physical illness in the child.

Child death and morbidity

- 2.14 International research findings suggest that up to 10% of these children die and about 50% experience long-term morbidity. In the British Isles study referred to in paragraph 2.3, McClure et al (1996) found that 8 out of 128 (6%) children died as a direct result of abuse. A further 15 (12%) required intensive care and an additional 45 (35%) suffered major physical illness, again as a result of abuse. The way in which a child's circumstances are managed will impact on their outcomes but the lives of some who present at hospital in a life-threatening situation, for example having been poisoned, might not be able to be saved.
- 2.15 In the McClure et al (1996) study, 83 (65%) of the 128 index children had at least one sibling and of these, 15 (12%) had a sibling who died previously (a total of 18 deaths). Five (4%) of these deaths had been classified as Sudden Infant Deaths. Information about a death or previous abuse of siblings may become known to professionals only after a family history has been collated. At the time of death some may have been unexplained or ascribed to natural causes, while others may have been known to have occurred as a result of abuse. Previously reported physical abuse of siblings is common in this group of children and previous abuse may have included the fabrication or induction of illness. A child may be considered to be at risk of significant harm because of abuse inflicted on siblings, or the death of siblings due to abuse.

Impact of fabricated or induced illness on the health or development of a child

- 2.16 Many of the children who do not die as a result of having illness fabricated or induced suffer significant long-term consequences. These may include long-term impairment of their physical, psychological and emotional development (see paragraph 3.90 of *Assessing Children in Need: Practice Guidance* (Department of Health, 2000a)).
- 2.17 Whilst it is well documented that children who have been abused or neglected are likely to suffer impairment to their health and development, it cannot be assumed that all children suffering impairment have been abused. Where there are concerns about the reasons for a child's developmental delay, it is important to clarify the contributing factors and identify any underlying conditions. For some children the origins of their impairment or disability may be very complex with an underlying medical or developmental condition being further impaired by abuse or neglect. In these circumstances, detailed assessments are required to understand cause and effect (For further discussion, see Chapter 4: *The Spectrum of Signs and Symptoms*, Royal College of Child Health and Paediatrics, 2001).
- 2.18 Fabrication of illness may not necessarily result in the child experiencing physical harm. Where children have not suffered physical harm, there may still be concern about them suffering emotional harm. Concerns about children being brought up in a fabricated sick role are further discussed in paragraph 2.21. Children may also suffer emotional harm as a result of an abnormal relationship with their mother (if she is responsible for the abuse) and their disturbed family relationships (see paragraphs 2.30 and 2.31).
- 2.19 In their follow-up study of 54 children who were known to have had illness induced or fabricated or induced, Bools et al (1993) found a range of emotional and behavioural disorders, and school related problems including difficulties in attention and concentration and non-attendance. These difficulties were present both in children who were living with their abusing parent and those who had been placed with alternative carers, suggesting the need for treatment regimes which specifically address the child's ongoing needs throughout childhood. McGuire and Feldman (1989) also reported a range of disorders in children known to have had illness fabricated or induced, depending on the age of the child; feeding disorders in infants, withdrawal and hyperactivity in pre-school children and direct fabrication or exaggeration of physical symptoms by older children and adolescents.

The experience of the abused child

- 2.20 Nearly all affected children undergo many unpleasant investigations and/or treatments but many children, especially young children, who have had illness fabricated or induced may not be fully aware of the nature of their abuse. Few studies have sought children's views on this matter, but Neale et al (1991), through their interviews with children, found that many had not been able to disclose the nature of their abuse, in part because of the skill of their mothers (the perpetrators) in teaching the children to present a rosy picture to the external world whilst they were being subjected to extensive physical and emotional abuse at home. These children were attached to their mothers and even after disclosure of the abuse and placement with alternative carers, some still wanted continued contact with them.
- 2.21 Some children are confused about their state of health. Many are preoccupied with anxieties about their health and survival and may express suicidal thoughts as a result of their despair. Older children and adults who have been abused in this way may come to feel anger at their betrayal by their parent(s), and a lack of trust in those caring for them including medical professionals.

Involvement by the child

- 2.22 In children who have had illness fabricated or induced, there seems to be a continuum of involvement with their carer, from naivety through to passive acceptance, actual participation and active self-harm (Sanders, 1995). Some children, particularly those who are older, may learn to collude with their carer in the management of a non-existent condition before eventually fabricating or inducing illness in themselves or developing a somatisation disorder. Such children can continue to be dependent on their carer and use her/him as a reference point for their own state of health. As a consequence of this dependency, some may lose the ability in childhood to identify true illness and become unable to act appropriately if they are ill. Some older children and adults feel guilty for their perceived collusion. So, just as with other forms of child abuse, the effects of illness having been fabricated or induced may impact on a child for life.

Age range of children

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

Age at onset of symptoms

- 2.24 The age of the child when the symptoms begin is usually much younger than when the abuse is identified because of the length of time it normally takes to identify this type of abuse. Schreier and Libow (1993), in their survey of 362 cases, found that the average length of time to identification was greater than 6 months in a third of the cases and more than a year in a fifth of the cases.

Gender of carer responsible for the abuse

- 2.25 Clinical evidence indicates that fabricated or induced illness is usually carried out by a female carer, usually the child's mother. Fathers and women other than the mothers have also been known to be responsible (Makar and Squier, 1990; Samuels et al, 1992). It is common in these latter cases for the adult to have undertaken significant responsibility for providing much of the child's daily care.
- 2.26 Therapeutic work undertaken with families has revealed the extent to which both mothers and fathers were involved in perpetuating the belief that the child was seriously ill. It is not, therefore, appropriate to always consider the fathers to be mere bystanders in the process of illness induction: their role in each particular family system must be understood as part of the assessment process (Griffith, 1988; Manthei et al, 1988).

Carers' previous histories

- 2.27 There is no evidence to support a unique profile of carers who fabricate or induce illness in their children. This is, however, evidence that as with many parents who abuse or neglect their children, specific aspects of their histories are likely to have been troubled. A careful assessment is required to understand the impact that past events may be having on their current ability to care for their child.

- 2.28 The child's carers, who are usually their parents, may have histories of having experienced childhood abuse or privation. This can include all forms of abuse, including emotional (Bools et al, 1994; Samuels et al, 1992; Southall et al, 1997).
- 2.29 The parents may also have considerable medical and psychiatric histories which may or may not be able to be verified independently. The same may be so in relation to the obstetric history of the mother. This information may not be easily accessible and considerable effort may be required to gather it together into a detailed chronology.
- 2.30 Reported features of the parent's health histories include:
- **Physical Health.** A significant number of parents are likely to report having experienced genuine medical problems. They may or may not have been substantiated by medical investigations. They may also have a history of inflicting deliberate self-harm. The mothers may have a complicated obstetric history. For some mothers, there may have been professional concern about them causing their own miscarriages.
 - **Psychiatric history.** A significant number of parents will have been assessed or treated for mental health problems. Following a formal psychiatric assessment, some may have been diagnosed with a personality disorder, but others may have no diagnosable psychiatric disorder. **Paragraphs 4.39–4.52 on Adult Mental Health explore this area in more depth.**
- 2.31 Parents also report having suffered a number of significant bereavements or losses in their lives with these often having taken place within a relatively short time span (Gray and Bentovim, 1996). The bereavements may be of significant adults in their lives (a parent or other supportive family member), of children in the areas of conception, miscarriage, stillbirth or death and the losses of partners through divorce or separation.

Family relationships

- 2.32 Relationship problems between the child's parents are common, although they may not have been acknowledged prior to child protection concerns being raised. Similarly, a number of parents may have experienced problems associated with taking on the role of parenthood. These may have been presented early on in their parenting careers.
- 2.33 In families where it has been identified that a child's illness has been fabricated or induced, these past problems are often revealed in the course of an assessment or therapeutic work. This knowledge may, however, not have been held by those professionals who had responsibility for the child's health care.

Long-term outcome for carers who fabricate or induce illness

- 2.34 There is no systematic research information available on the long-term outcomes for those carers who have received therapeutic help following identification of them fabricating or inducing illness in children (Bluglass, 2001; Brooke and Adshead, 2001). Some information is available from individual case studies (Nicol and Eccles, 1985; Black and Hollis, 1996; Coombe, 1995) and indirectly from research on outcomes for children. This means that decisions about the child's safety have to be made on a case by case basis drawing on professionals' knowledge base about the abuse or neglect of children (see paragraphs 4.49–4.52).

Outcomes for children

- 2.35 There has been little research done on the longer-term outcomes for children in these circumstances, but the available evidence suggests that outcomes have been poor for many children who had illness fabricated or induced. In one such study, a cohort of 54 children who had experienced attempted suffocation, poisoning or having symptoms such as seizures fabricated was followed up on average 5.6 years after the abuse had been identified (Bools et al, 1993). Thirty of the children were living with their mother – the abuser – and 24 were in alternative care, either with family members or foster carers. Among the 30 children living with the original abuser, a third had had further illness fabricated and there were significant other types of concerns about another third. Many children placed in new families also suffered from psychological disorders, in many cases a continuation of an earlier disorder. The difficulties of 5 children where suffocation had been attempted were clearly related to their previous abusive experiences. Two children had died during the follow-up period and nearly half had unacceptable outcomes including conduct and emotional disorders, and difficulties at school including non-attendance, in addition to re-abuse. An analysis of the findings from this study indicated that where at follow-up the children were being cared for by their mothers (who had been responsible for the abuse), a greater proportion of those who had an acceptable outcome had experienced a period in foster-care following identification of the abuse, compared with those who remained continuously with their mother.
- 2.36 In Davis' follow up study (median of 2 years) of children reported to have had an illness induced, none of their signs and symptoms had been found subsequently to be due to intrinsic organic disease (Davis et al, 1998). At follow-up, forty percent of the children were living at home with the abusing parent, but only 24% of those where they had been poisoned and only 10% of those where suffocation had been intentionally attempted. Thirty-three percent of the children still had their names on the child protection register and 24% still had signs and symptoms due to fabricated or induced illness. 17% of those who had not suffered direct physical harm had nevertheless subsequently suffered further abuse.
- 2.37 The Park Hospital group (Berg and Jones, 1999) has reported the outcome of work with a consecutive series of 17 children and their families who were admitted to its inpatient family unit after the abuse had been identified. In 13 of the 17 cases selected on the basis of the likelihood of successful intervention, therapeutic work was undertaken to establish whether the child could be re-united with their family. Of these, it was recommended that 10 children should be reunited with their natural parents and 3 should be placed in alternative care as it was not considered sufficiently safe for them to return home. All these recommendations were followed and at an average of 27 months after discharge from the unit, the children had done well overall in terms of their development, growth and adjustment. One child, who had been re-abused by her mother, was subsequently being cared for solely by her father. From this follow-up study it has been "cautiously concluded that family re-unification is reasonable to attempt for a selected subgroup of cases of factitious illness by proxy but, where this is attempted, long-term follow-up is necessary in order to assure that psychological maltreatment does not occur and that the parent's mental health is monitored" (Berg and Jones, 1999).
- 2.38 Another study found that there was evidence of good outcomes for children where the child's safety had been addressed and long-term therapeutic work had been undertaken with families. This work was based on the findings of an assessment which identified the changes required in the family system for the child to be safe and achieve his or her optimal health and developmental milestones (Gray et al, 1995). These good outcomes occurred where cases were managed within a child protection framework, therapeutic interventions were focused on the protection of the child, a thorough assessment was undertaken of the family's functioning and its ability to change and protect the child, and clear decisions were made about whether the child was able to live with both parents, the non-abusing parent or should be placed in an alternative family context.

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

3. Handling Individual Cases

Introduction

- 3.1 All parents demonstrate a range of behaviours in response to their children being ill or being perceived as ill. Some may become more stressed or anxious than others. Their responses may in part relate to their perceptions of illness and to their expectations of the medical profession. Health professionals are taught to listen to the concerns of parents about their children's health and to act on these. Part of their role is not only to treat the sick child but also, in collaboration with other professionals, to assist parents to respond appropriately to the state of their children's health.
- 3.2 Some children may not be unwell but parents need reassurance that they are indeed well, whilst others may experience continuing difficulty in recognising that their child is healthy and exhibiting normal childhood behaviours (for further discussion see Eminson, 2000a and 2000b; Eminson and Postlethwaite, 1992). Some parents may be helped to interpret and respond appropriately to their child's actions and behaviours, whilst others may continue to be anxious and/or are unable to change their beliefs. It is this latter group of parents who are more likely to present their children for medical examination although the children are healthy. Skilled professional intervention is likely to enable most parents to learn how to interpret their child's state of health and manage their own anxieties. There may be some parents for whom such early interventions are ineffective. These parents may have particular needs which result in them persistently presenting their child(ren) as ill and seeking investigations and medical treatments.
- 3.3 For a small number of children, concerns will be raised when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by the actions of a carer or carers having fabricated or induced illness. Where the impairment is such that there are concerns the child is suffering or is likely to suffer significant harm this Guidance should be followed.

Child Welfare Concerns

- 3.4 This chapter should be read in conjunction with Chapter 5 in *Working Together*. It follows the processes set out in Appendix 1 which has been reproduced from *Working Together* (p.116). In this supplementary guidance, the focus is on specific issues which relate to situations where there are concerns that a child is suffering or likely to suffer significant harm as a result of having illness fabricated or induced by their carer. These concerns may be raised by a number of different types of professionals or, more rarely, by family members or members of the public.
- 3.5 Child welfare concerns may arise when:
 - reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
 - physical examination and results of medical investigations do not explain reported symptoms and signs; or
 - there is an inexplicably poor response to prescribed medication and other treatment; or

- new symptoms are reported on resolution of previous ones; or
- reported symptoms and found signs are not seen to begin in the absence of the carer;
- over time the child is repeatedly presented with a range of signs and symptoms; or
- the child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.

There may be a number of explanations for these circumstances and each requires careful consideration and review. A full developmental history and an appropriate developmental assessment should be carried out (see paragraph 2.17). **Consultation with peers or colleagues in other agencies may be an important part of the process of making sense of the underlying reason for these signs and symptoms.** The characteristics of fabricated or induced illness are that there is a lack of the usual corroboration of findings with symptoms or signs, or, in circumstances of proven organic illness, lack of the usual response to proven effective treatments. It is this puzzling discrepancy which alerts the medical clinician to possible harm being suffered by the child.

- 3.6 Concerns may be raised by professionals other than medical clinicians, such as nurses, teachers or social workers who are working with the child. For example, in a school or nursery setting the staff may not observe any fits in a child who is described by a parent to be having frequent fits during the day whilst in their care. In addition, professionals working with the child's parents may be being given information by the parent about the child or observe the child directly and note discrepancies between what they are told about the child's health and development and what they see themselves. For example, mental health professionals may identify a child being drawn into the parent's illness behaviour by having signs and symptoms described by the parent which replicate their own medical/psychiatric problems.
- 3.7 Concerns about a child's health should be discussed with the GP or paediatrician responsible for the child's health. If any professional considers their concerns are not being taken seriously or responded to appropriately, these should be discussed with the Designated Doctor or Nurse.

Medical evaluation

- 3.8 Signs and symptoms present in a child may be suggestive of fabricated or induced illness. The reasons for these may prove difficult to elucidate for a variety of reasons. Professionals should be open to all possible explanations.
- 3.9 The signs and symptoms require careful medical evaluation for a range of possible diagnoses. All tests and their results should be fully and accurately recorded including those with negative results. It is important to ensure these records are not tampered with or results altered in the child's notes: also, that the name of the person reporting any observations about the child is recorded legibly in the child's notes and dated.
- 3.10 Where a reason can not be found for the signs and symptoms, specialist advice and tests may be required. Normally, the medical doctor would tell the parent(s) that they do not have an explanation for the signs and symptoms. The parental response to this information should be recorded. The medical doctor would then set out the next steps, including what further assessments/investigations/tests (perhaps in a more specialist setting) are required to tease out the possible explanations. Parents should be kept informed of findings from these medical investigations but at no time should concerns about reasons for child's signs and symptoms be shared with the parents if this information would jeopardise the child's safety. The child should continue to receive appropriate health care and support should continue to be provided to the child's carers by health professionals.

- 3.11 There may be times when a member of staff is responsible for the unexplained or inexplicable signs and symptoms in a child. This should be borne in mind when considering how to manage the child's care (see paragraphs 6.53–6.59). Any such concerns about a member of staff should be discussed with the relevant named professional in accordance with the local ACPC child protection procedures.

Referral

- 3.12 **When a possible explanation for the signs and symptoms is that they may have been fabricated or induced by a carer and as a consequence the child's health or development is or is likely to be impaired a referral should be made to Social Services.** This referral may follow an evaluation of the child's signs and symptoms whilst an in-patient; it may be as a result of concerns held by professionals working with the child or it may be as a result of concerns held by a member of the public who knows the child. While professionals should seek, in general, to discuss any concerns with the family and, where possible, seek their agreement to making referrals to Social Services, **this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm** (from paragraph 5.6, *Working Together*). Decisions should be agreed between the referrer and the recipient of the referral, in line with local ACPC child protection procedures, about what the parents will be told, by whom and when.
- 3.13 Following referral, Social Services should decide, within one working day what response is necessary. From the point of referral to Social Services, the responsible consultant and Social Services should work together although lead responsibility for action to safeguard and promote the child's welfare lies with Social Services. Any suspected case of fabricated or induced illness may also involve the commission of a crime, and therefore the police should always be involved in accordance with *Working Together* (paragraph 5.8). The paediatric consultant has responsibility for the child's health care and decisions pertaining to it. In order to safeguard the child's welfare it is important that all three disciplines work closely together in making and taking forward decisions about future action, recognising each other's roles and responsibilities. All decisions about what information should be shared with the parents, when and by whom should be taken jointly in line with local ACPC Child Protection procedures. In all cases where the police are involved, the decision about when to inform the parents (about referrals from third parties) will have a bearing on the conduct of police investigations (see paragraph 5.11. *Working Together*).
- 3.14 Referrals may lead to no further action or to an initial assessment of the needs and circumstances of the child, and the provision of services or other help. Where Social Services decides to take no further action at this stage, feedback should be provided to the referrer. In the case of public referrals, this should be done in a manner consistent with respecting the confidentiality of the child. Sometimes it may be apparent at this stage that emergency action should be taken to safeguard a child (see paragraph 3.24). Such action may be necessary when a child's life is in danger, for example, through poisoning or toxic substances being introduced into the child's blood stream. Emergency action should normally be preceded by an immediate strategy discussion between the police, social services, health and other agencies as appropriate.

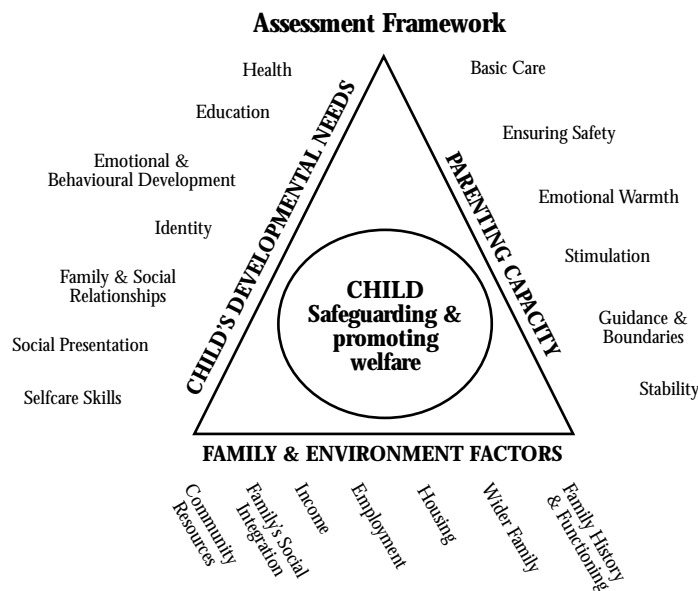
Initial Assessment under s17 of the Children Act 1989

- 3.15 An initial assessment under s17 of the Children Act 1989, is undertaken to determine "whether the child is in need, the nature of any services required, and whether a further, more detailed core assessment should be undertaken" (paragraph 3.9, *Assessment Framework*). The initial assessment should be carefully planned, with clarity about who is doing what, as well as when and what information is to be shared with the parents.

3.16 Social Services has lead responsibility for undertaking an initial assessment together with all other relevant agencies. The initial assessment should follow the Guidance set out in the *Assessment Framework* (paragraphs 3.9–3.10) and be concluded within a maximum of 7 working days (paragraph 3.9, *Assessment Framework*). Its timing and operation should be undertaken in collaboration with the medical consultant who is responsible for the child’s health care (or a consultant’s deputy nominated specifically for this case under consultant supervision). It should cover the dimensions with the three domains of the *Assessment Framework* (see Figure 1) and address the three questions set out in paragraph 5.13 of *Working Together*.

- “What are the needs of the child?
- Are the parents able to respond appropriately to the child’s needs? Is the child being adequately safeguarded from significant harm, and are the parents able to promote the child’s health and development?
- Is action required to safeguard and promote the child’s welfare?”

Figure 1: Assessment Framework



3.17 The time taken to complete the initial assessment may be very brief if it quickly becomes clear that there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm. This may occur, for example, when toxicology results indicate the presence of medication that had not been prescribed. In some instances, the child’s circumstances may require a more in-depth core assessment under s17 of the Children Act 1989 (paragraph 3.11, *Assessment Framework*) before any decision can be reached about whether the criteria are met for initiating a s47 enquiry. In addition, during the course of providing services to a child and family, concerns may be raised about the possibility of illness being fabricated or induced.

3.18 On completion of the initial assessment, Social Services together with the medical consultant responsible for the child’s health care (or nominee, see paragraph 3.14) should decide on the next course of action. At this stage careful consideration should be given to what the parents should be told, when and by whom, taking account of the child’s welfare (5.17, *Working Together*). Concerns should not be raised with a parent if it is judged that this action will jeopardise the child’s safety.

Next Steps

- 3.19 **No Suspected Actual or Likely Significant Harm.** The child may be a child in need and it may be appropriate to undertake a core assessment in order to determine what help may benefit the child and family. Alternatively, services may be offered based on the findings of the initial assessment. It may be helpful for relevant professionals to discuss the findings of the initial assessment to inform decisions about what types of services, including a more in-depth assessment, it would be appropriate to offer. Decisions about further action should be discussed with the parents in the light of the findings of the initial assessment and consideration of what would be most helpful to the child and family.
- 3.20 If at any point in the core assessment or later in the course of professional involvement with the child and family, there is reasonable cause to suspect a child is suffering or is likely to suffer significant harm, a strategy discussion should be initiated.
- 3.21 **Suspected Actual or Likely Significant Harm.** Where the initial assessment identifies that the child is suspected to be suffering, or is likely to suffer significant harm, Social Services is required by s47 of the Children Act 1989 to make enquiries, to enable the local authority to decide whether it should take any action to safeguard and promote the child's welfare. Where a criminal offence may have been committed against a child the police should be involved at the earliest opportunity. This will enable Social Services and the police to consider jointly how to proceed in the best interests of the child.
- 3.22 It is the responsibility of Social Services in the local authority area in which the child is currently residing to initiate a strategy discussion or to apply for an application (under section 44 of the Children Act 1989) unless appropriate alternative arrangements have been made with the responsible local. If the child is normally resident in another Local Authority, the one in which the child is residing should negotiate a transfer of statutory responsibility to the child's Local Authority of residence and agree how the child's case will be managed before relinquishing lead responsibility for the child's safety and welfare.
- 3.23 Careful thought should be given to what parents are told, when and by whom, at the point it is decided to hold a strategy discussion. Social Services should involve the police, the child's medical consultant, the senior ward nurse (if the child is an in-patient) and other relevant professionals in making these decisions.

Immediate Protection

- 3.24 If at any point there is medical evidence to indicate that the child's life is at risk or there is a likelihood of serious immediate harm, an agency with statutory child protection powers **should act quickly to secure the immediate safety of the child.** Emergency action might be necessary as soon as a referral is received, or at any point in involvement with the child and their family. Alternatively, the need for emergency action may become apparent only over time as more is learned about the circumstances of a child or children. When considering whether emergency action is necessary, an agency should always consider whether action is also required to safeguard other children in the same household (for example siblings), the household of an alleged perpetrator, or elsewhere. The nature of the abuse will be a key determining factor i.e. if it is known a child is being intentionally suffocated or poisoned then **immediate action ought to be taken.** If the child is subject to verbal fabrication only, and not the induction of physical signs, it is unlikely it will be necessary to act as quickly to secure the immediate safety of the child. The circumstances may change significantly if, however, the carers become aware that the professionals think the child's symptoms are being fabricated. Decisions, therefore, about possible immediate action to protect a child should be kept under constant review.

Strategy Discussion

- 3.25 If there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, Social Services should convene and chair a strategy discussion which involves all the key professionals responsible for the child's welfare. It should, at a minimum, include social services, the police, the medical consultant responsible for the child's health and, if the child is an in-patient, a senior ward nurse. It is also important to consider seeking advice from, or having present, a medical professional who has expertise in the branch of medicine, for example respiratory, gastroenterology, neurology or renal, which deals with the symptoms and illness processes caused by the suspected abuse. This would enable the medical information to be presented and evaluated from a sound evidence base. Professionals involved with the child such as the GP, Health Visitor and staff from education settings should be involved also as appropriate. It may also be appropriate to involve the local authority's solicitor at this meeting. Staff should be sufficiently senior to be able to contribute to the discussion of often complex information, and to make decisions on behalf of their agencies. **Decisions about undertaking covert video surveillance should be made at a strategy discussion** (see paragraphs 6.46–6.51 on Covert Video Surveillance).
- 3.26 *Working Together* does not require there to be a face to face meeting (paragraph 5.30). In this complex type of abuse, however, a meeting **is likely to be** the most effective way of professionals discussing the child's welfare and planning future action.
- 3.27 The strategy discussion will be used to undertake the tasks set out in 5.28 of *Working Together*. It is vital that all available information is carefully presented and evaluated, and where possible, its accuracy having been verified at source. Where appropriate, legal advice should be sought when evaluating the available information. Where it is decided that there are grounds to initiate a s47 enquiry decisions should be made about:
- how the s47 enquiry as part of the core assessment will be carried out – what further information is required about the child and family and how it should be obtained and recorded;
 - whether it is necessary for supplementary records to be kept in a secure place in order to safeguard the child and the manner in which they should be kept;
 - whether the child requires constant professional observation and, if so, whether or when the carer(s) should be present;
 - who will carry out what actions, by when and for what purpose, in particular the planning of further paediatric assessment;
 - any particular factors, such as the child and family's race, ethnicity and language which should be taken into account;
 - the needs of siblings and other children with whom the alleged abuser has contact;
 - the nature and timing of any police investigations, including the analysis of samples. This will be particularly pertinent if covert video surveillance is being considered, as this will be a task for which the police should have responsibility;
 - the needs of the parents or carers.

- 3.28 More than one strategy discussion may be necessary. This is likely where the child's circumstances are very complex and a number of discussions are required to consider whether and, if so, when to initiate s47 enquiries.

s47 Enquiries as part of a Core Assessment

- 3.29 The nature of any further medical tests will depend on the evidence available about how the signs and symptoms might be being caused (see the Royal College of Paediatrics and Child Health *Report on Fabricated or Induced Illness by Carers* (2001) for further consideration of possible medical tests).
- 3.30 It is important to assess the child's understanding, if old enough, of their symptoms and the nature of their relationship with each significant family member (including all caregivers), each of the caregivers' relationships with the child, the parents' relationship with each other and the children in the family, as well as the family's position within their community.
- 3.31 The core assessment should also include the systematic gathering of information about the history of the child and each family member, building on that already gathered during the course of each agency's involvement with the child. Particular emphasis should be given to health (physical and psychiatric), education and employment as well as receipt of state benefits and charitable donations relating to a disabled child, social and family functioning and any history of criminal involvement (see paragraphs 6.22–6.23 on the Common Law Duty of Confidence and paragraphs 6.27–6.34 for information on the disclosure of information by medical and nursing professionals).
- 3.32 A range of specialist assessments may be required. For example, physiotherapists, occupational therapists, speech therapists and child psychologists may be involved in specific assessments relating to the child's developmental progress; child and adolescent and adult mental health professionals may be involved in assessments of individuals or of families.
- 3.33 Careful and detailed note taking by all staff, including health professionals, is very important for any subsequent police investigation or court action. Any unusual events should be recorded and a distinction should be made between events reported by the carer and those actually witnessed by staff from their onset. Notes should be timed, dated and signed legibly. Most importantly, notes should be kept in a secure place so that they cannot be accessed by unauthorised persons.

Criminal Investigation

- 3.34 The police have a key role in assisting medical and social services staff understand the reasons for the child's signs and symptoms. Whereas the police investigations may produce conclusive evidence of maltreatment, they may also confirm that the carer is not responsible for causing the child's condition. In this later situation, the police may be involved in investigating who is responsible or, if there is not evidence of a crime being committed medical staff can continue looking for a medical problem which arises from intrinsic illness within the child rather than from externally induced or invented causes.
- 3.35 The nature and timing of any criminal investigations will depend on the medical evidence. Whether or not police investigations reveal grounds for instigating criminal proceedings, any evidence gathered by the police should be available to other relevant professionals, to inform discussions about the child's welfare.

- 3.36 In cases where the police obtain evidence that a criminal offence has been committed by the parent or carer, and a prosecution is contemplated, it is important that the suspect's rights are protected by adherence to the Police and Criminal Evidence Act 1984. **This would normally rule out, for example, the suspect being confronted with the evidence by a paediatrician or any other personnel from the statutory agencies, except for the police, which is the lead investigative agency.**
- 3.37 Many of the children who have had illness fabricated or induced will be too young to be interviewed as part of any criminal investigation. If a decision is made to undertake an interview the guidance set out in *Achieving Best Evidence in Criminal Proceedings: Guidance for vulnerable or intimidated witnesses, including children* (Home Office et al, 2002) should be followed.

The Outcome of s47 Enquiries

- 3.38 **Concerns not substantiated.** Medical tests may identify a medical condition which explains the child's signs and symptoms and, therefore, no further child protection action may be considered necessary. In this situation, it is important to discuss with the parents, drawing on knowledge of the implications of the medical condition for the child and family members' lives, what further help or support they may require. This may be related to the child's state of health or to more general matters.
- 3.39 There may be situations where concerns remain about significant harm and where no tests or assessments have identified a clear explanation for the child's signs and symptoms, or where there is a lack of independent evidence of their existence even when the child is constantly observed, or separated from the carer. This is more likely to be where parents report the child is having problems of a non-specific nature, such as aches and pains, or allege allergies to foods or to their environment. There could be many explanations for these symptoms, including that they are being fabricated. For these children, it is important to try to understand their origin and consider whether help is required. It may be that the child's health will require continued monitoring to see how it progresses. If problems have been recognised during the assessment process, the family may want to receive help, for example, with parenting difficulties or with improving the family's ways of relating to each other. In addressing wider family issues, it may be that the child's wellbeing improves.
- 3.40 **Concerns substantiated, but the child is not judged to be at continuing risk of significant harm**
- There may be substantiated concerns that a child has suffered significant harm, but it is agreed between the agencies involved with the child and family, that a plan for ensuring the child's future safety and welfare can be developed and implemented without the need for a child protection conference or a child protection plan (paragraph 5.48, *Working Together*). For example, the carer may have taken full responsibility for the harm they have caused the child or the family's circumstances may have changed. The development of the plan may, however, require the core assessment to be completed. In these circumstances, the child's health and development would require careful monitoring by a paediatrician or other health professional over time with milestones for progress clearly set out in the child in need plan. The nature and purpose of this monitoring by health and/or other agencies should be clearly explained to the child, as appropriate, and the parents.
 - **The social services department, in consultation with other agencies, should take carefully any decision not to proceed to a child protection conference where it is known that a child has suffered significant harm as a result of fabricated or induced illness.** "A suitably qualified and senior designated person within the social services department should endorse the decision. Those professionals and agencies who are most involved with the child and family, and those who have taken part in enquiries, have the right to request that social services convene a

child protection conference if they have serious concerns that a child may not otherwise be adequately safeguarded. Any such request which is supported by a senior manager, or a named or designated professional, should normally be agreed. Where there remain differences of view over the need for a conference in a specific case, every effort should be made to resolve them through discussion and explanation, but as a last resort ACPCs should have in place a quick and straightforward means of resolving differences of opinion” (paragraph 5.51, *Working Together*).

3.41 **Concerns substantiated and child judged to be at continuing risk of significant harm**

- Where the agencies most involved judge that a child may continue to suffer, or to be at risk of suffering significant harm, social services should convene a child protection conference. The aim of the conference is to enable those professionals most involved with the child and family, and the child and family themselves, to assess all relevant information, and plan how to safeguard the child and promote his or her welfare (paragraph 5.52, *Working Together*). This may include situations where the child’s life has not been placed in immediate danger, but continuation of the fabrication or induction of illness would have major consequences for the child’s long-term health or development (see paragraphs 2.16–2.19).

The Initial Child Protection Conference

3.42 **Timing**

Working Together states that an initial child protection conference should be held within 15 working days of the date of the strategy discussion. Paragraph 5.54 of *Working Together* states that there may need to be more than one strategy discussion in order to enable the best decisions to be taken about safeguarding the child’s welfare. If more than one strategy discussion is held as part of a series of discussions, the initial child protection conference should be held within 15 working days of the last strategy discussion.

3.43 **Attendance**

- **Professional staff.** All relevant professionals who have been involved in the child’s life should attend the conference, as well as those who are likely to be involved in future work with the child and family. Consideration should be given to inviting a professional who has expertise in working with children and families where a caregiver has fabricated or induced illness in a child. Their knowledge would be invaluable in helping conference members make sense of the information presented at the conference. It is also important to consider seeking advice from, or having present, a medical professional who has expertise in the branch of paediatric medicine, eg respiratory, gastroenterology, neurology or renal, which deals with the symptoms and illness processes caused by the suspected abuse. This would enable the medical information to be presented and evaluated from a sound evidence base.
- **Child.** Children should be involved in the initial child protection conference in ways appropriate to their age and understanding. This includes discussions with them about the purpose of the conference and the means by which they wish their views to be conveyed, as well as what they want said to whom. Some children may not understand what has been happening to them and may, therefore, find it difficult to understand what the professionals are telling them. Others may be very clear but may not have been able to talk to a trusted adult or may not have been listened to. All are likely to have suffered emotional abuse. This means that discussions should be carried out in a sensitive manner with the child knowing they are now safe. The safety of the child following the conference must also be carefully considered and an understanding of how it is to be ensured conveyed to the child.

- **Family Members.** Parents should normally be invited to child protection conferences and helped to participate. Exceptionally, it may be necessary to exclude one or more family members from all or part of the conference. This decision should be based on considerations of ensuring the child's safety and be made by the conference chair on a case by case basis. Steps may also be required to protect professional staff from intimidation either in the conference or after it.
- It may not be possible for all family members to be present at the same time. The extent and manner of involvement of family members should be informed by what is known about them. The abusing carer may not be able to acknowledge their behaviour to their partner for fear of what this knowledge would do to their relationship. They should not be put under pressure to talk about their part in the abuse within the conference. The non-abusive parent may have had no knowledge of the abuse or they may have had some understanding which now makes better sense to them but not wish to discuss it at a conference. Again their need to not discuss their knowledge in such a public setting should be respected. These are matters which should be addressed outside the conference in a sensitive manner.

3.44 Information for the conference

- Each agency should contribute a written report to the conference which sets out the nature of their involvement with the family. This information should be precise and, where possible, validated at its source. The child may have been seen by a number of professionals over a period of time: Social Services has responsibility for ensuring that, as far as is possible, this chronology (with special emphasis on the child's medical history) has been systematically brought together for the conference. Where the medical history is complex, this should be done in close collaboration with the medical consultant responsible for the child's health care. The health history of any siblings should also be considered. The chair has responsibility for ensuring that additional or contradictory information is presented, discussed and recorded in the conference.
- Careful consideration should be given to when agency reports will be shared with the child's parents. This decision will be made by the initial child protection conference chair, in consultation with the professional responsible for the each report.

3.45 Action and Decisions for the Conference

- The conference should decide whether the criterion set out in *Working Together*, namely that the child is at continuing risk of significant harm, and that the child is, therefore in need of a protection plan, is met for placing the child's name on the child protection register. It may be decided that the child's name will not be placed on the register. In this situation, consideration should be given to the child's needs and what future help would assist the parents in responding to them.
- If the child's name is placed on the register, an initial child protection plan should be developed following the guidance set out in paragraphs 5.68 and 5.69 of *Working Together*. Particular attention should be given to what steps will be necessary to safeguard the child. These will depend on the nature of the harm suffered by the child. If the child's life has been threatened by, for example, attempted smothering, poisoning or introducing noxious substances intravenously, all necessary measures should be put in place to ensure that these actions cannot take place in the future. This may mean that the child has to be separated from the abusing parent, and if possible cared for solely by the other parent, or, if the abusing parent is unwilling to leave the house, placed in an alternative family context, or remain in hospital for further medical treatment before being well enough to be discharged. The nature of contact must be carefully

thought through to ensure it does not offer another opportunity to repeat the abuse. This may mean contact has to be closely supervised by a professional whose level of knowledge enables them to be alert to the precursors of further abusive behaviour.

- Conference participants must be clear what actions will be taken to safeguard the child immediately after the conference, as well as in the longer term. For some children it may be necessary to institute legal proceedings either immediately or soon after the conference has ended. This decision should be taken by social services in conjunction with its legal advisers. It is important that the doctors involved agree to support this action, since it is their medical evidence which will form a key part of the evidence presented to a court.
- The conference should also consider what action is required to protect siblings in the family. It may be that the abusing parent transfers his or her abusive behaviour to another child in the family, once the identified child is placed in a safe environment.
- Knowledge of the parents' medical and psychiatric histories, in particular the abusing parent's, should be considered. Services for the parents maybe required immediately, if, for example, it is known that there is a history of self-harming behaviour or a likelihood of a parent attempting suicide or developing other types of psychiatric symptoms.

3.46 **Action following the placing of a child's name on the Child Protection Register**

- A key worker should be appointed from Social Services and membership of the core group decided as set out in *Working Together* (see paragraphs 5.75 – 5.80). The initial child protection plan will have identified the most appropriate setting in which the child should live following the conference, with whom and on what statutory basis. The plan should also have recommended the nature of contact between the child and the abusing parent, and between the child and other family members and whether it should be supervised by a professional person. These matters should be kept under constant review as the child's situation may change quickly. The conference should also agree a contingency plan which addresses the possibility that the plan agreed at the conference cannot be put into action, for example, if a court application is not successful or a parent removes the child from hospital.
- The child and family members should be provided with appropriate services whilst the core assessment is completed. The child may require further medical investigations to ascertain his or her current state of health as well as receive ongoing treatment. This could range from intensive involvement, if the child is seriously ill as a result of their abuse, to no treatment but careful monitoring if the child has been found to have no medical problems and is healthy now that the abuse has stopped.
- Parents with a psychiatric history may require immediate help if, for example, they have a history of attempting suicide or self-harming. This intervention will be part of the overall programme of work which focuses on the child's welfare.
- Information about past relationship difficulties and the nature and outcome of any previous therapeutic help should also inform decisions about how best to intervene in each family.

Core Assessment

- 3.47 The core assessment, which will have begun at the time the s47 enquiries commenced, should be completed within a maximum of 35 days as set out in the *Assessment Framework*, recognising that some specialist assessments may not be able to be completed within this period. Indeed, it may only become clear that certain types of assessments are required part way through or at the end of the core assessment. This is more likely to be so when the child's needs are very complex.
- 3.48 The assessment should follow the Guidance set out in the *Assessment Framework*. It should address:
- The child's current health status and his/her developmental progress, clarifying where possible the cause of any presenting symptoms, illness and/or developmental delay i.e. what may have been organic in origin and what is likely to have been related to abuse. It should also ascertain the child's educational, emotional and behavioural level of development as well as the nature of his or her relationship with each family member and how he or she is perceived within the family and their local community. A thorough understanding of the child's needs is necessary to inform decisions about how best to intervene.
 - The developmental needs of the child's siblings should also be assessed, using the Assessment Framework, as they may also be children in need. Siblings should be involved in future therapeutic work. It is important to understand how they perceive their brother or sister's health.
 - The capacity of both parents should be assessed as well as that of other caregivers or potential caregivers. The latter is particularly important if consideration is being given to other family members looking after the child. Their understanding of the abuse and ability to believe the child has been abused by another member of their family will inform decisions about where the child lives and contact arrangements with family members. Other members of the family may not be able to protect the child if they do not believe abuse has occurred or where they can not guarantee the child's safety from abuse whilst in their care.
 - The capacity of the abusing parent to recognise their child's needs is very important. They may not be able to recognise the damage they have done to their child's health. It is therefore often helpful for a psychiatrist with expertise in this area to meet with the parent(s).
 - The histories of both parents will provide valuable information about their needs both as adults and as parents. It is important to ascertain the quality of the parents' relationship, including in situations where they are not living together. This information will inform decisions about what future work will be required with each parent individually, as a couple, as parents and as a family. It will also determine which professionals should be involved at what stages during the therapeutic process.
 - An assessment of appropriate wider family members will provide information about the capacity of these adults to support the child and his/her parents. Many parents in these circumstances are isolated from their families or have kept them unaware of the difficulties they are experiencing in their parenting role. Family patterns around illness may also be identified, for example, histories of illnesses which have not been medically identified or of a somatising behaviour.
- 3.49 All other professionals should liaise closely with Social Services (the lead agency) in gathering relevant historical material and integrating this within an assessment of the child's developmental needs and the capacity of their parents to respond to these needs. This information, including the capacity for change, should be used to inform decisions about the child's safety and future work with the child and family.

Analysis of the child's circumstances and future planning

- 3.50 Chapter 4 in the *Assessment Framework* describes the processes by which information obtained during the assessment can be analysed, and professional judgement used to inform decisions about how best to intervene. Paragraph 4.1 states that the conclusion of the assessment should result in:
- an analysis of the needs of the child and parenting capacity to respond appropriately to those needs within their family context;
 - identification of whether and, if so, where interventions will be required to secure the wellbeing of the child or young person;
 - a realistic plan of action, a timetable and a process for review.
- 3.51 The *Assessment Framework* states that “in drawing up a plan of intervention, careful distinction should be made between **judgements** about the child's developmental needs and parenting capacity and **decisions** about how best to address these at different points in time” (paragraph 4.20). It then sets out a number of factors which should be taken account of when making decisions about how best to address the child's identified needs. This should include ensuring the child is not the subject of further unwarranted medical intervention.

Intervention

- 3.52 A programme of interventions, where a child has had illness fabricated or induced, should be carefully constructed on the basis of the findings of the assessment. Decisions about how to intervene, including what services to offer, should draw on evidence about what is likely to work best to bring about good outcomes for the child (paragraph 5.89, *Working Together*). The core group has responsibility for developing and implementing the child protection plan within the outline plan agreed at the initial child protection conference (paragraphs 5.77 and 5.80, *Working Together*).
- 3.53 Interventions should specifically address:
- the developmental needs of the child;
 - the child's understanding of what has happened to them;
 - the abusing carer/child relationship and parental capacity to respond to the child's needs;
 - the relationship between the adult carers both as adults and parents;
 - family relationships;
 - the management of any presenting signs, illnesses or reports of symptoms.
- 3.54 A key issue will be whether the child's needs can be responded to within his or her family context, and **within timescales that are appropriate for the child**. These timescales may not be compatible with those for the carer who is in receipt of therapeutic help. This may mean a child cannot be safely cared for by this carer and has, therefore, to be living in a family setting where the carer is not present. In the longer term it may mean it would be in the best interests of the child to be placed in an alternative family context.

- 3.55 There is likely to be intensive activity in the period immediately following the initial child protection conference. This activity should be sustained over a significant period of time to ensure that the child's long-term developmental needs are met. As a result of interventions either the required changes will take place within the family system enabling the child to be safe and healthy within their family, or an alternative family context will need to be identified which will be able to respond to the child's ongoing needs.
- 3.56 Children who have had illness fabricated or induced may continue to experience the consequences of this abuse irrespective of where they are placed permanently: whether reunited with their families or placed in new families. This is particularly so in relation to their behavioural and emotional development (Bools et al, 1993). These findings suggest that therapeutic work with the child should continue, irrespective of where the child is placed, in order to ensure the needs of the child are responded to appropriately.
- 3.57 Interventions should address the child's physical, social and emotional needs. If the child has been very ill as a result of their abuse, he or she may require a period of hospitalisation before being well enough to be discharged. In parallel, work is likely to be necessary with family members in different groupings depending on the agreed plan; the relationship between the child and the carers responsible for the abuse (usually the child's mother); the parents' relationship with each other, with the abused child and with all their children; the family's relationships with health professionals; and individual work with the adult responsible for the abuse.
- 3.58 If the plan is to assess whether the child can be reunited with a carer responsible for the abuse, very detailed work will be required to help this carer develop the necessary parenting skills. For younger children this may involve learning to feed the child in a pleasant manner, to play with the child and facilitate their developmental progress, and to respond to the child's needs in an age appropriate manner. For older children, this may involve learning to interact with them as a well and healthy child, ensuring they attend school and facilitating the development of normal sibling and peer relationships. For all children, this should include the appropriate accessing of health care by their carers.
- 3.59 "It is important that services are provided to give the family the best chance of achieving the required changes. It is equally important that in circumstances where the family situation is not improving or changing fast enough to respond to the child's needs, decisions are made about the long-term future of the child. Delay or drift can result in the child not receiving the help she or he requires and having their health or development impaired" (Paragraph 4.31, *Assessment Framework*).

Child Protection Review Conference

- 3.60 The child protection review conferencing and decision making processes should follow the guidance in *Working Together*. Decisions should be made on the basis of evidence of the child's developmental progress and meeting the targets set for improvement, as well as changes in the way in which the family functions. The child must be living within a safe family environment.
- 3.61 It has to be recognised that, in families where a child has been maltreated, there are some parents who will not be able to change sufficiently within the child's timescales in order to ensure the child does not continue to suffer significant harm (Jones (1998) in Department of Heath et al (2000), paragraph 4.25). The *Assessment Framework* states that "In these situations, decisions may need to be made to separate permanently the child and parent or parents. In these circumstances decisions about the nature and form of any contact will also need to be made, in the light of all that is known about the child and the family, and reviewed throughout childhood. Key to these considerations is what is in the child's best interests, informed by the child's views (Clever, 2000)" (paragraph 4.25).

- 3.62 The *Assessment Framework* sets out criteria which have been identified as suggesting a poor outcome for reuniting children who have been maltreated with their parents (paragraph 4.26), those features which suggest there are better prospects of achieving good outcomes for children (paragraph 4.28) and those where the findings from the core assessment may provide an uncertain picture of the family's capacity to change (paragraph 4.30). These criteria should be borne in mind when assessing a family and the impact of therapeutic help on the parents' capacity to respond appropriately to the child's needs.
- 3.63 Outcomes for children who have had illness fabricated or induced are known to be better where the work is carried out within a clear protective framework and a sustained therapeutic programme is undertaken on a multi-agency, multi-disciplinary basis focusing on safeguarding and promoting the child's welfare (see paragraphs 2.35–2.39).

Pre-Birth Child Protection Conference

- 3.64 Evidence of illness having been fabricated or induced in an older sibling or another child should be carefully considered during the pregnancy of a woman who is known to have abused a child in this way. Therapeutic work may have been successfully undertaken in relation to the abuse of a previous child, but an assessment of the unborn child should be undertaken. A pregnant woman may have a history of fabricating illness in herself during a previous pregnancy. This could include the fabrication of medical problems while the baby is in the womb. She may also be behaving in ways which pose risks to the health of the unborn child in the current pregnancy. A pre-birth child protection conference should be convened if, following s47 enquiries, either the unborn child's health is considered to be at risk or the baby is likely to be at risk of harm following his or her birth.

4. Roles And Responsibilities

Introduction

- 4.1 A clear understanding of the roles and responsibilities of others is essential for effective collaboration. This section outlines the main roles and responsibilities of statutory agencies, professionals, the voluntary sector, and the wider community in relation to circumstances where illness has been fabricated or induced in a child by a carer. Joint working should extend across the planning, management, provision and delivery of services. This chapter does not stand alone and, in particular, should be read in conjunction with Chapters 1 and 3 of this document.

Health

4.2 General

- 4.2.1 All health professionals in the NHS or private sector may come across illness being fabricated or induced in a child. Personnel in these services are well-placed to note the number of presentations of a child, and the manner and circumstances in which these children present. It is essential that health professionals whether working with children or adults should familiarise themselves with the various presentations of this type of child abuse. Health professionals may also identify a carer who is fabricating or inducing illness in themselves. In these circumstances, they should consider whether any child(ren) of this adult is/are having their health or development impaired.
- 4.2.2 Children who are having illness fabricated or induced may present to NHS Direct, a Walk in Centre, the primary health care team or to the community or hospital based paediatrician. Some may be presented with claims of unusual allergies or, for example, emitting smells which cannot be tested for. It is not unusual for the carers of this group of children to be either seeking repeated attention or avoiding contact with all statutory agencies. Carers may convince the child that he or she has an illness which results in them having little or no social and educational experiences. Although not life threatening, these situations can be some of the most debilitating for children's health and development.
- 4.2.3 All health personnel should be familiar with their local ACPC child protection procedures and in particular know who to contact when they have child welfare concerns.
- 4.2.4 Once a health practitioner has suspicions that fabricated or induced illness is being presented, he or she should consult the clinical manager (who has lead responsibility for contacting Social Services or the police) and/or the named or designated doctor or nurse for child protection. The named doctor or nurse should be contacted for support and advice, but if unavailable, the designated doctor/nurse should be contacted. All health professionals should keep detailed notes of these discussions.
- 4.2.5 Health practitioners should not normally discuss their concerns with the parents/carers at this stage (see paragraphs 6.27–6.34 on professional guidance).

- 4.2.6 Local ACPC child protection procedures should be followed. Social Services should be informed of these concerns at the earliest possible opportunity. It has lead responsibility for undertaking an initial assessment and, if appropriate, should convene a strategy discussion. This discussion will determine subsequent actions which should be strictly adhered to and regularly reviewed.
- 4.2.7 In a small number of cases, the use of covert video surveillance may be suggested. Discussions about its use should take place at the strategy discussion between relevant agencies and in particular, the police, Social Services, the consultant responsible for the child's health care and the senior ward nurse. Senior officers of the relevant NHS Trusts should also be involved. **The Chief Executive of NHS Trust should be kept informed of any decisions to apply to use covert video surveillance in his/her Trust (see paragraphs 1.21–1.22 and 6.46–6.51 on covert video surveillance).**
- 4.2.8 Where it has been decided (at a strategy discussion) to carry out covert video surveillance because of the nature of concerns about how the child is suffering or likely to suffer significant harm, the police should undertake this action (see paragraphs 6.46–6.51 on covert video surveillance).
- 4.2.9 For all children, it is essential that careful and complete notes are kept at every stage, together with the reasons why decisions are taken, for example, not to inform the parents of concerns during particular periods in time in order to prevent the child suffering harm (see 6.35–6.45 on record keeping).
- 4.2.10 If a child protection conference is convened all information should be pooled and discussed in order to inform decision making about how best to safeguard the child's welfare.
- 4.2.11 Close multidisciplinary and interagency working is essential in these cases (Royal College of Paediatrics and Child Health, 2001).

Primary Care Trusts in England

- 4.3 The named public health professional with responsibility for children in need and children protection within the PCT should be familiar with the modes of presentation of fabricated or induced illness in a child and the extreme difficulties such cases may present, together with the need for senior practitioner involvement. (Child Protection Responsibilities of Primary Care Trusts, letter from Jacqui Smith, 28 January 2002.)
- 4.4 Support should be made available:
- i. for advice via the designated doctors and nurses in managing such cases;
 - ii. for funding of additional support staff and venues (particularly if covert video surveillance is to be used);
 - iii. for the staff involved including ensuring their protection if necessary (the impact of identifying and working with such cases can be extremely stressful);
 - iv. in the preparation of any appropriate media handling strategy (which should be undertaken in conjunction with other agencies involved).
- 4.5 The PCT should ensure that appropriate training on fabricated or induced illness is made available to professional staff at all levels in all disciplines. The designated doctors and nurses should advise on the commissioning of this training, recognising that the average PCT is likely to see one case a year of fabricated or induced illness. Each PCT should ensure that agencies with whom they have commissioning arrangements provide training for their staff.

Local Health Boards in Wales

- 4.6 In Wales, Local Health Boards (LHBs) will replace Local Health Groups from 1 April 2003. The Welsh Assembly Government will be issuing Guidance in respect of the responsibilities of LHBs in the area of child protection.

The General Practitioner and Primary Health Care Team

- 4.7 The GP and all members of the Primary Health Care Team (PHCT), particularly midwives, health visitors and practice nurses, are all well placed to recognise the early signs and symptoms of fabricated or induced illness in a child, through their monitoring of pregnancies and child health promotion. Primary health care teams may include employed or attached psychologists or counsellors. Such professionals may infrequently be involved in consultations with patients that reveal the possibility of fabricated or induced illness by the individual who is being counselled or supported (see paragraphs 6.22–6.23 on the Common Law Duty of Confidence).
- 4.8 Professionals in PHCTs may have unique knowledge of uncorroborated, odd or unusual presentations. Also, of those children who frequently attend the clinic where there is a discrepancy between the child's reported signs and symptoms and those observed, and where there is a history of abnormal illness behaviours in the family.
- 4.9 Such cases can pose conflicts of loyalty for primary care staff. Such professionals have a responsibility to the carer as well as the child but should note the child is a vulnerable patient and they should seek to safeguard and promote the child's welfare.
- 4.10 GPs and PHCT members should consider issues of confidentiality carefully and in the context of the particular individual case with which they are dealing. They should be aware of the guidance issued by the General Medical Council (see paragraphs 6.27–6.31). Where they have concerns that an illness is being fabricated or induced in a child, they should follow the child protection processes as set out in Chapter 3 of this document.

Roles and Responsibilities for Nurses, Midwives and Health Visitors

- 4.11 Nurses, midwives and health visitors work with children and families in a range of roles and in a variety of environments. Some nurses and midwives may experience a conflict of loyalty where their primary client is not the child. In this situation it is their duty to seek to safeguard and promote the child's welfare.
- 4.12 A practising midwife is responsible for providing midwifery care to a mother and baby during the antenatal, intra-natal and postnatal periods (UKCC, 1998).
- 4.13 The primary focus of health visitors' work with families is health promotion. Like few other professional groups, health visitors provide a universal service which, coupled with their knowledge of children and families and their expertise in assessing and monitoring child health and development, means they have an important role to play in all stages of family support and child protection. Health visitors are often the starting point for all child protection referrals and their continuing work in supporting families places them in a unique position to continue to play an important part as enquiries progress.

- 4.14 School nurses have an important role to play in meeting the needs of school-aged children and young people. Their role includes identifying health related learning needs of children, adolescents and their families and stimulating awareness of this need at local and national level. They undertake health surveillance and provide therapeutic help to individual children and adolescents.
- 4.15 The identification and management of fabricated or induced illness involves many disciplines. Because of their close contact with children and families in community and hospital settings, nurses, midwives and health visitors are important members of the multi-disciplinary team and should contribute to assessment, planning and child protection conferences, as well as to the provision of services.
- 4.16 Fabricated or induced illness is an aspect of child protection of which all nurses, midwives and health visitors working in any setting should be aware. In the course of their work they may be in a position to recognise its signs and symptoms.
- 4.17 Where a nurse, midwife or health visitor has concerns that a carer is impairing a child's health and development by fabricating or inducing illness, the nurse, midwife or health visitor should explore the presenting information to see where it is on the continuum from parental concern, over-anxiety, through to suspected significant harm. In cases where fabricated or induced illness is suspected the child protection processes should be followed in accordance with Chapter 3 of this Guidance.
- 4.18 Advice and support is available from designated and named nurses for child protection and from social services. All referrals should be made in accordance with local ACPC child protection procedures.
- 4.19 The nurse, midwife or health visitor may observe unusual behaviour or unexplained incidents. An accurate, contemporaneous and secure record of actual or inferred physical or behavioural observations should be kept (see paragraphs 6.35–6.41 on record keeping).
- 4.20 During the course of a medical evaluation the nurse may be responsible for the collection of specimens such as urine or faeces. These should be collected and sent off for analysis in such a way that they cannot be interfered with (for further information see Section 5.3, Medical Evaluation of Symptoms and Signs in the Report of the Royal College of Paediatrics and Child Health, 2001).
- 4.21 Nursing, midwifery or health visiting assessments will contribute to the overall family assessment (paragraphs 5.24–5.25, *Assessment Framework*), by defining any known problems that the family is experiencing, and understanding how and if these problems have contributed to the maltreatment of the child.
- 4.22 When midwives are contributing to the assessment, information obtained at booking should be carefully analysed. This could include:
- The contents of the General Practitioners referral letter (where applicable);
 - Information given by the mother, particularly if the woman gives a history of strange illnesses; unusual complications of pregnancy, unexpected deaths in the family; family members with untreatable illnesses; or her children having complicated medical histories; histories of failure to thrive or non accidental injuries; and if signs and symptoms reported by the mother are not observed by the midwife;
 - Information available from previous midwifery case notes.

Acute and Mental Health NHS Trusts

4.23 Children with suspected fabricated or induced illness may present to the full range of specialists. In addition, their carers may be in receipt of adult services, and the professionals involved in their care may have concerns about the welfare of their children. This could include professionals providing obstetric care to a pregnant woman. It is important that any concerns are not conveyed to the carers until further assessment and multidisciplinary decisions have been made about how and by whom these will be discussed with the child's parents (see paragraphs 3.10, 3.15 and 3.20). Every Trust should have a named doctor and nurse with whom professional staff should liaise if they have concerns about a child's welfare.

The Paediatrician and the Trust

4.24 All consultant paediatricians are likely to be faced at some time with a child in whom they suspect some or all of their signs and symptoms of illness are being fabricated or induced by a carer. Whenever such concerns arise, the consultant responsible for the child's health care should take lead responsibility for decisions about the child's health care – these should **not** be delegated to a more junior member of staff although they may be involved in the process of assessment and subsequent management under the consultant's supervision.

4.25 The Royal College of Paediatrics and Child Health Report on *Fabricated or Induced Illness by Carers* (2001) provides specific advice for paediatricians. In particular, Chapter 5, Medical Evaluation: Procedures and Management should be followed in conjunction with this Guidance when there are concerns about fabricated or induced illness in a child.

4.26 The responsible consultant should consult the named doctor about child safety concerns and keep him or her informed in the process. If the consultant is themselves the named doctor, they may wish to consult with the designated doctor. Discussions with a senior colleague in Social Services may also be helpful in deciding whether and when a referral should be made.

4.27 The consultant should ensure a high standard of record keeping (paragraphs 6.34–6.35) and ensure the records are kept in a secure place (paragraph 6.36).

4.28 In any case of suspected fabricated or induced illness it is essential to carefully review the child's medical history (see paragraph 6.21 on health professionals sharing information with each other). This should include reviewing all available medical notes and liaising with the child and family members' GP(s) and health visitor(s). If there are separate child health records these should be accessed and consideration given to making enquiries of other local hospitals (it is not unknown, particularly in a metropolitan area, for a child to be being seen in more than one paediatric department at the same time). Likewise, if the family has recently moved, contact should be made with the paediatric services in the previous area. The named doctor for the Trust from which notes are being sought can often facilitate this process. The drawing up of a medical chronology will often confirm whether or not concerns of possible fabricated or induced illness require further evaluation and the urgency with which these should be undertaken. It can also help identify undiagnosed medical conditions.

4.29 It may be helpful to invite a colleague, not involved in the clinical care of the child, to review the notes or to give an opinion as to whether any organic condition may have been overlooked. Likewise a general or community paediatrician may wish to discuss the case with a tertiary paediatrician who has knowledge of rare disorders.

- 4.30 Where the consultant has reasonable cause to suspect that a child is suffering or likely to suffer significant harm a referral should be made to Social Services (see paragraph 3.12 of this Guidance). For referrals from a tertiary hospital this will be to Social Services local to the hospital (unless specific other local arrangements are in place between neighbouring social services departments). This may not be the same as Social Services for the area in which the child resides. If the child is an in-patient in a hospital outside their local area, Social Services local to the hospital has a responsibility to liaise with the appropriate one. A social services department may already be involved with the child as a 'child in need' or have had involvement in the past with either this child or their family and know the family well. Equally, there may have been no previous involvement.

Professionals Allied to Medicine

- 4.31 All health professionals whether working with children or adults who are parents should be aware of the local ACPC child protection procedures. A range of professionals working in health settings, for example pharmacists, physiotherapists, occupational therapists, speech therapists, nursery nurses and play specialists will have important roles to play in identifying and managing fabricated or induced illness in children. If, in the course of their work, professionals have concerns about illness being fabricated or induced by a carer, they should discuss these with their clinical manager or, if the child has been referred to them, with the referring medical doctor. All health professionals should have access to further advice from the Trust's named doctor or nurse.
- 4.32 Some health professionals may have been working already with a child when the concerns are raised and be a part of the initial assessment and decision making processes; some may become involved subsequently, often in a more in-depth assessment of the child's needs and the provision of services. Professionals such as physiotherapists, speech and occupational therapists, nursery nurses or play specialists are likely to be closely involved where a child's developmental progress has been impaired as a result of their illness fabrication or induction.

Child and Adolescent Mental Health Services

- 4.33 The roles of CAMHS professionals may include recognition of situations where emotional (psychological or psychiatric) and behavioural symptoms are being fabricated or induced. In the course of their work, professionals in Child and Adolescent Mental Health Services (CAMHS) may identify or come to suspect that fabricated or induced illnesses are being presented to them in the form of fabricated or induced emotional or behavioural symptoms. Fabricated or induced illness in mental health settings is particularly difficult to identify for a variety of reasons, not least because in some psychiatric conditions the symptoms which signify a mental health disorder in children (which is not fabricated or induced) are observed to vary in the degree to which they are present in different settings.
- 4.34 CAMHS professionals will also receive requests for advice from other professionals who are working with families where fabricated or induced illness is considered a possibility. This will usually be where fabricated illness or repeated presentation with different unexplained or unsubstantiated symptoms is thought to be taking place, or where the parent is seeking inappropriately invasive medical care for a proven physical illness, but may also be in the early stages of evaluating the possibility of more serious illness induction. The service will need to respond promptly in these circumstances. Help may be required to provide an opportunity for the other professionals to clarify their own thinking, and consider possible reasons for parental behaviours and anxieties, consider ways to explain and engage parents with professional concerns and provision of psychiatric expertise in considering the child's welfare and responses. CAMHS professionals may also help other professionals who are assisting parents with difficulties in the parenting roles or management of chronic illness, where these are a part of the

overall situation. There may be an opportunity for some families to receive direct interventions from the CAMHS service. Careful notes of these conversations and of the conclusions drawn must be kept, including key decisions such as to call a strategy meeting or initiate child protection procedures.

- 4.35 A third role for CAMHS professionals is in the course of assessment of families where fabricated or induced illness is an issue. The service will receive requests from various sources, during the course of an overall assessment. The service should contribute with other professionals to the provision of an assessment as laid out in the *Assessment Framework*. Paragraphs 2.1–2.25 of the *Assessment Framework* describe the particular areas to be addressed during an assessment. The most important areas will be in assessment of the child's psychological functioning, ways to support this family functioning, ways to improve this, and assessment of parenting capacity.
- 4.36 A contribution to an assessment of the mental health functioning of a parent may also be made by the CAMHS professionals whose training has included adult mental health. This may include, in addition to an assessment of family history, family functioning and parenting capacity, an assessment of the mental state a parent displays in the course of the assessment and the level of engagement he or she has achieved with the service. Here it will be important to liaise with colleagues in adult mental health services and where appropriate undertake a joint assessment (see Falkov et al, 1998 for further discussion on joint working between adult and child and family psychiatrists).
- 4.37 CAMHS will receive requests from various sources for treatment for families in which abuse of this kind is an issue or where a child is in need but concerns about significant harm have not been substantiated. CAMHS may need to offer assistance with parenting skills, work on relationships between family members. Individual work with children may also be appropriate and if appropriate, note healthcare seeking responses to stressful circumstances.
- 4.38 In circumstances where the child has suffered significant harm, CAMHS may need to offer a range of interventions and services as part of the child's overall plan. This may include intensive work on family relationships and attachments and individual work with both parents and children. There may be a need to call on specialist resources beyond the capacity of many districts. Wherever possible, CAMHS professionals should be able to use existing resources to initiate or continue treatment or children and families, in close liaison with other professionals and services.

Adult Mental Health Services

- 4.39 A range of adult mental health professionals – nurses, social workers, clinical psychologists and psychiatrists – may be involved in the assessment, planning and treatment of a carer. This may be before any child care concerns in relation to fabricated or induced illness in a child have been raised, during the course of child protection enquiries and subsequent actions or following the identification of the carer's involvement in abuse or likely abuse of a child.
- 4.40 Through their involvement with a patient, adult mental health professionals may become concerned about the welfare of a child. In particular, this may be if a carer has a somatising disorder or is known to fabricate or induce illness in themselves. If adult mental health professionals have concerns about a child they should discuss these concerns with a named or designated doctor in their NHS Trust or with their local Social Services.
- 4.41 Adult psychiatrists are more likely to be involved at the point at which there is a moderate to high suspicion that a carer has been inducing symptoms or a court has made a finding of fact that such behaviour has occurred. To inform core assessments, or child protection conferences, it will be important

to get an assessment from a psychiatrist who is familiar with both a) the relevant developmental and family psychiatric literature and b) the risk and mental disorder literature, especially in relation to personality disorder, since this is the diagnosis most often made in these situations.

- 4.42 Following the verification of illness being induced or fabricated in a child, adult and forensic psychiatry have a role to play in assessing the presence, degree and severity of any mental illness or disorder that the carer may have, including personality disorder. Psychiatrists should draw on the risk and mental disorder literature when asked to give an opinion about risk of significant harm to a child or children who have had illness fabricated or induced.
- 4.43 An adult psychiatrist can carry out a basic evaluation which will include a full family medical history, including a developmental history of the carer, and a full obstetric history (see paragraph 6.21 on health professionals sharing information with each other). Access to the GP notes and/or the obstetric notes will be helpful. General practice notes will give some indication about how parents have interacted with healthcare professionals prior to concerns being raised about their having fabricated or induced illness in their child.
- 4.44 An adult psychiatrist should, therefore, take a careful history of illness behaviour, particularly the history of somatisation. Manifestations of somatisation disorder may be more obvious from the general practice notes than they are from the psychiatry notes.
- 4.45 There are many aspects of the history which should be included in any assessment by an adult psychiatrist. Any psychiatric disorder (including personality disorder) should to be carefully described in terms of its presentation, severity and treatment. To be safe and of value in future decisions about the child's welfare, a report should attempt to set out not only the nature of any disorder but also suggestions as to how best the adult carer's mental health might be managed. The issue of treatability is but one consideration.
- 4.46 Consideration should be given to external stressors in the carer's life. Some of the child abuse literature suggests that abuse to a child may be triggered by some other external stressors, especially violence within the home. Assessment psychiatrists should ask routinely about domestic violence. A significant proportion of women have experienced victimisation as adults such as domestic violence or rape. It may also be important (particularly in the context of abnormal illness behaviour) to enquire about the health of family members and/or recent bereavements.
- 4.47 Clearly the psychiatrist should take a good history of rule breaking or criminal behaviour. It must be emphasised, however, that this will not necessarily be easy with an adult who already feels under suspicion, but has not been charged with any criminal offence. Parents who are being assessed in the context of child protection proceedings are likely to be defensive and hostile, and this should **not** prima facie be taken as an indication of a personality disorder or guilt.
- 4.48 It may be helpful to obtain formal personality assessments from a forensic psychiatric team.
- 4.49 An inpatient assessment may be appropriate where the carer has a mental disorder and/or is at risk of harming themselves or others. A voluntary admission to a psychiatric setting allows for repeated interviews and some gaining of the parent's trust which may reduce his or her defensiveness. Those working with offenders are familiar with the process by which people are often very defensive and in denial at the start of an investigation process, but over a period of time may be more able to acknowledge what they have done. Given that complete denial of any offending behaviour and a projection of responsibility on to others is a poor prognostic sign in terms of treatment, then it is very important to assess the issue of denial carefully and thoughtfully. Non-compliance with treatment may need to be a point of starting the intervention rather than a reason for abandoning it. Any psychiatrist

assessing an adult who is thought to have harmed a child in this way should consider this issue thoughtfully. There may be a conflict between the adult's timescales for change and the child's need for permanency. This may mean that decisions have to be made to place the child in an alternative family context before the adult's treatment has been successfully completed.

- 4.50 The assessing adult psychiatrist cannot be involved until the medical process which has made a definition of offending behaviour by exclusion of any medical examination has been completed. Assessing psychiatrists should be able to liaise with those assessing the child and those who have knowledge of the child's health. It will be helpful for the assessing psychiatrist to have access to the paediatric notes as well as the child's general practice notes.
- 4.51 As in all forensic cases it is helpful to separate out those clinicians who undertake assessments for either quasi legal or active legal proceedings, and those who offer treatment. It is helpful for an assessing psychiatrist to liaise with the treating psychiatrist during the process of completing an assessment.
- 4.52 If the assessing psychiatrist is being asked to comment about treatment, then this question should distinguish between treatment for the carer's psychological needs and treatment for risk improvement. These aims are not necessarily the same. It should also be emphasised that currently the evidence base does not allow professionals to make clear statements about risk assessment in the long term or even in the short term. Naturally, it is hoped that if a parent feels better in themselves they will "behave better", but at this time the forensic psychotherapy evaluation literature does not allow professionals to state that categorically. A focus of treatment which emphasises risk reduction would be consistent with other treatment innovations in forensic psychiatry and psychology, and has the advantage of transparency. However, the fact that a parent will not be reunited with their child(ren) should not be reason for not offering treatment for risk. This is particularly so if the mother is of child bearing age.

Local Authorities

- 4.53 The welfare of children is a corporate responsibility for the entire local authority, working in partnership with other public agencies, the voluntary sector, and service users and carers. It is recognised that Local Authority Departments such as Housing, Leisure and Environmental Health are less likely to be involved in using this Guidance. However, if they are involved with a child where it is suspected or known the illness is being fabricated or induced, they should follow the Guidance in *Working Together* which sets out their roles and responsibilities.
- 4.54 Local authorities have a duty to plan services for children in need, in consultation with a wide range of other agencies, and to publish the resulting children's services plans. The local authority should also take the lead responsibility for the establishment and effective functioning of Area Child Protection Committees (ACPCs) – the multi-agency forum which acts as a focal point for local co-operation to safeguard children (paragraph 3.2, *Working Together*).
- 4.55 Many authorities have put in place management structures which cut across traditional departmental and service boundaries and which bring together a range of children's services. Where this guidance refers to Social Services, this indicates that part of the local authority which carries out social services' functions.

Councils with Social Services Responsibilities

4.56 Under the Children Act 1989 Social Services have lead responsibility for the protection of children. A key duty for Social Services is to both safeguard and promote the welfare of children. Safeguarding has two elements: a duty to protect children from maltreatment and a duty to prevent impairment (paragraph 1.15, *Assessment Framework*). This section which sets out the roles and responsibilities of Social Services should be read in conjunction with paragraphs 3.4 to 3.9 of *Working Together* and paragraphs 5.9 to 5.15 of the *Assessment Framework*. The focus in this supplementary guidance is on the specific responsibilities of Social Services in the management of cases where children are suffering or likely to suffer significant harm as a result of illness which has been fabricated or induced by a carer. These responsibilities fall into four main areas: assessment including s47 enquiries, planning, provision of services and reviewing children's progress.

Assessment

- 4.57 Social Services has lead responsibility for undertaking an initial assessment of a child in need. This will include circumstances in which fabricated or induced illness by a carer is suspected, where Social Services will conduct the initial assessment in conjunction with the doctor who is medically responsible for the child's health and other relevant agencies.
- 4.58 Social Services is also responsible for any core assessment and will co-ordinate the process of systematic information gathering to build up a medical, psychiatric and social history and an understanding of the child's needs and the parents' capacities to ensure the child's health and developmental progress is optimal. Social Services should ensure that a full chronology of the child's history is compiled.
- 4.59 Social Services should work collaboratively with all other agencies currently involved with the child and family. In addition, it is likely to be necessary to contact agencies with past involvement in order to prepare a full history of the child's health and family situation.
- 4.60 There must be clarity about roles and responsibilities during the assessment process, and about what information can be shared with parents, including issues of timing, as well as between agencies.
- 4.61 Social Services also have a duty, under s47 of the Children Act 1989, to make enquiries if they have reasonable cause to suspect that a child in their area is suffering, or likely to suffer significant harm. This will include cases where the harm may be a result of fabricated or induced illness. These enquiries will enable them to decide whether they should take any action to safeguard and promote the child's welfare. A core assessment is commenced at the point at which section 47 enquiries are initiated at a strategy discussion. The Police will decide whether to instigate a criminal investigation having considered the views of other agencies (section 5.8, *Working Together*).
- 4.62 Social Services are responsible for convening strategy discussions, and, when appropriate, initial and review Child Protection Conferences, in order to review the child's situation and to decide and plan any further action which may be necessary. Any agency may request a strategy meeting or child protection conference, if it has concerns that a child may be suffering significant harm.

Planning

- 4.63 An outcome of s47 enquiries may be that the concerns are substantiated but the child is not judged to be at continuing risk of harm (see paragraph 3.40). A child in need plan may be developed at the conclusion of the core assessment, which will involve the child and family members as appropriate and the contributions of all agencies (paragraph 4.33, *Assessment Framework*). The plan will set out the services to be provided by which agency, the objectives to be met if the child is to achieve optimal developmental progress, and which agency has lead responsibility for reviewing the plan at regular intervals (Figure 7, *Assessment Framework*).
- 4.64 At child protection conferences, Social Services must ensure that their staff are sufficiently senior to be able to commit the department to following through on recommendations regarding action to be taken immediately after the conference. This is particularly relevant for recommendations regarding the seeking of emergency protection or interim care orders; where the child should live; and the nature and frequency of contact with parents or other carers.
- 4.65 Social Services is responsible for co-ordinating a multi-agency child protection plan to safeguard the child. It will also act as the principal point of contact for other agencies which may want to report new or further concerns about the child.
- 4.66 Where the child's welfare cannot be safeguarded if he or she remains at home, Social Services may apply to the courts for a Care Order, or if the child is in immediate danger, for an Emergency Protection Order. This should involve the local authority's solicitor who has responsibility for co-ordinating the legal proceedings. Social Services should co-ordinate further medical investigations, expert opinions, assessments and intervention, and arrange placements and contact between the child and parents. Where necessary, contact should be supervised.

Provision of Services

- 4.67 Social Services have a duty to safeguard and promote the welfare of children in need in their area, through the provision of services appropriate to the needs of such children and as far as is consistent with this, to promote, the upbringing of children within their families (s17 of the Children Act 1989). They should do this by working with parents and in a way which is sensitive to the child's race, religion, culture and language. Social Services are responsible for providing direct services as appropriate and co-ordinating all services, which are indicated by the assessment.

Reviewing

- 4.68 Social Services has lead responsibility for reviewing any child protection or care plan, and if agreed by the parties, a child in need plan (paragraphs 4.32–4.37, *Assessment Framework*).

Local Authority Solicitors

- 4.69 If legal action is planned, a local authority solicitor will co-ordinate these proceedings (see paragraph 3.54). They are also able to provide advice to local authority staff on legal matters relating to the child's welfare and the nature and quality of any evidence of the child suffering or being likely to suffer significant harm, as well as advice on matters such as consent, confidentiality and disclosure of information.

Education including Early Years and Day Nurseries

- 4.70 Paragraphs 3.10–3.15 of *Working Together* sets out the role of Education Services. Advice is also contained in the DfES Circular 10/95 and the Welsh Office Circular 52/95 *Protecting Children from Abuse: the Role of the Education Service*.
- 4.71 Existing guidance on child protection procedures provides advice to the education service on what they should do if they have reason to believe a pupil is being harmed or is at risk from harm. Through their day-to-day contact with children, teachers and other school staff are particularly well placed to notice outward signs of harm. These can take the form of physical injuries, changes in behaviour or a failure to achieve their optimal development. Although these signs can do no more than raise concerns about possible significant harm, they are signs that all teachers and other staff should be alert to. They should know how to seek further information and to whom they should address their child welfare concerns.
- 4.72 It is important that schools do not undertake their own enquiries if they have reason to suspect possible or actual harm. They should not take action beyond that which has been agreed in the child protection procedures set down by the local Area Child Protection Committee (ACPC). Enquiries into child care concerns are the responsibility of the appropriate local agencies such as Social Services or the police. They have the necessary professional expertise to take such enquiries forward.
- 4.73 Schools have an important role to play in the identification and management of suspected cases of fabricated or induced illnesses and further guidance is set out below. As with all other forms of suspected harm, school staff should refer any child welfare concerns they have to the teacher with designated responsibility for child protection. He or she should act as a source of expertise and advice, and is responsible for co-ordinating action within the institution and liaising with other agencies. The designated teacher can, in turn, seek advice from their LEA senior officer with responsibility for co-ordinating action and policy on child protection. This person is also usually Local Education Authority's representative on the ACPC.
- 4.74 Absences from school are common and occur for many reasons including legitimate medical and hospital appointments. If fabricated or induced illness by a carer is suspected, schools should consider first the possible reasons for the signs and symptoms. They should try to determine whether illness is being used, for example, to avoid unpopular lessons or being bullied. It is not within the scope of this document to offer guidance in these circumstances. Such concerns should not be dismissed. On the contrary, they are very real and have an impact on pupils' behaviour and academic performance. Schools should have their own procedures in place for dealing with such situations. (Guidance on these issues is available in the National Assembly for Wales Circular 3/99 and the DfEE Circular 10/99 *Social Inclusion: Pupil Support*). When an illness is genuine the schools' own sickness procedures will apply.

Identification of fabricated or induced illness

- 4.75 Fabricated or induced illness is often, but not exclusively, associated with emotional abuse. There are a number of factors that teachers and other school staff should be aware of that can indicate that a pupil may be at risk of harm. Some of these factors can be:
- Frequent and unexplained absences from school, particularly from PE lessons;
 - Regular absences to keep a doctor's or a hospital appointment;

- Repeated claims by parent(s) that a child is frequently unwell and that he/she requires medical attention for symptoms which, when described, are vague in nature, difficult to diagnose and which teachers have not themselves noticed eg headaches, tummy aches, dizzy spells, frequent contact with opticians and/or dentists or referrals for second opinions.

- 4.76 The child may disclose some form of ill-treatment to a member of staff or might complain about multiple visits to the doctor. Either the child or his or her parent(s) may relate conflicting or patently untrue stories about illnesses, accidents or deaths in the family. Where there is a sibling in the same school, teachers should discuss their concerns with each other to see if children of different ages in the same family are presenting similar symptoms. If they are, it is likely that more than one child in the family is affected.
- 4.77 There are also circumstances under which a child will demonstrate his or her anxiety or insecurity by presenting symptoms of an illness that will allow them to stay at home. This may occur as a response to family problems, for example, as a reaction to a parent is ill, who has been in hospital or, after a divorce or separation.

Management of fabricated or induced illness

- 4.78 Where a teacher or other member of staff has reasonable cause to believe a child is at risk from, or is the subject of, fabricated or induced illness, the school's child protection procedures apply. This will require the member of staff to refer his or her concerns to the designated teacher for child protection who is then responsible for making a referral to Social Services.
- 4.79 Schools should, in particular, be alert to any significant change in the child's physical or emotional state, in his or her behaviour or failure to develop and draw these to the attention of the designated teacher.
- 4.80 It is helpful if, prior to referral to the designated teacher, the member of staff concerned can present a diary of events, including a record of absences and the reasons for absence given by the parent (where known). He or she should also listen carefully to what the child relates and should record any discussions with the child, including quotes of what the child said. The time, date, place and names of any people who were also present at the time should also be recorded.
- 4.81 As stated above, neither schools nor members of staff should carry out their own enquiries. After the designated teacher has referred a concern, it is for those agencies with a professional interest, i.e. Social Services or the police to take matters forward in line with local ACPC child protection procedures. The designated teacher is normally invited to attend any strategy discussions or child protection conferences. The conference should notify the designated teacher of the extent to which the child's parents have been notified of the concern for the child and what information can be shared. All parties should follow the decisions made at the strategy discussions and conferences, in particular in relation to what information may be shared.
- 4.82 If, in the course of an OFSTED inspection, inspectors become concerned about the possibility that a child may be having illness fabricated or induced, they should follow the child protection procedures of OFSTED in England and ESTYN in Wales.

Police

- 4.83 This section should be read in conjunction with paragraphs 3.57 to 3.64 of *Working Together* which sets out the principles applying to the police role in child protection investigations.
- 4.84 Any suspected case of fabricated or induced illness may also involve the commission of a crime, and therefore the police should always have been involved in accordance with paragraph 5.8 of *Working Together*. Events such as intentional smothering or poisoning are clearly criminal assaults, but more subtle forms of child abuse, such as wilfully interfering with feeding lines or causing unnecessary medical intervention to be undertaken, may also be criminal acts.
- 4.85 The police should be alerted to suspected cases of fabricated or induced illness as early as possible, and it may be crucial for any ongoing criminal investigation that the carer is not made aware of the child protection concerns. There are many low key enquiries which can be made by the police before any proactive investigation is launched. At this stage, i.e. before suspicions are confirmed, the medical consultant with responsibility for the child's health should retain the lead role for the child's health, and the priority of police officers should be to assist the paediatrician in reaching an understanding of the child's health status. The balance may change when it becomes clear whether or that a crime appears to have been committed. In such circumstances, the police will need to ensure the rights of the suspect are upheld and that evidence is gathered in a fair and appropriate way.
- 4.86 The Police Service is the prime agency for gathering evidence in connection with criminal cases. There is sometimes a reluctance on the part of doctors to involve the police, but it must be remembered that all professionals should be working towards the same goal, i.e. securing the safety of the child. It may well be that enquiries made by the police assist in identifying that the underlying explanation for the child's symptoms is not related to harm caused by a carer. In any case, the police should work within the multi-agency framework, and all relevant information should be shared with those treating the child. Any evidence of child abuse gathered by the police will normally be available for use by the local authority in care proceedings.
- 4.87 The police use technical means to gather evidence in many types of criminal enquiry, and it may be appropriate to use such methods, for example covert video surveillance, in cases of suspected fabricated or induced illness. In a case, where this is indicated as appropriate by the multi-agency strategy discussion (see paragraph 3.25), the police will supply any equipment required and be responsible for monitoring and managing the process. The police, like other public authorities, are bound by the Human Rights Act 1998, and the Regulation of Investigatory Powers Act 2000. Any operations within this context therefore will be carefully controlled and police managers will be fully accountable. **Doctors or other professionals should not independently carry out covert video surveillance.** If the suspicion of child abuse is high enough to consider the use of such a technique, the threshold must have been passed to involve the police and Social Services. The National Crime Faculty provides confidential good practice advice for police officers.
- 4.88 The police should carry out any work within a hospital sensitively and delicately, with any disruption to normal ward life being kept to a minimum. Any arrest or interview in a hospital setting should be carried out as sensitively as possible, ideally using plain clothes officers, to avoid disruption to patients and staff. The inter-agency management team should, if possible, consider the arrest strategy well in advance of it being carried out.
- 4.89 Irrespective of what evidence is likely to be used in the Civil Court or the Criminal Court or both, it must be gathered to the highest standards. When the police are involved in a situation where induced or factitious illness is suspected, even greater care should be taken to ensure that the investigation is thorough and professional, and led by an experienced senior investigating officer.

Probation

- 4.90 The range and roles of responsibilities of the probation service in relation to safeguarding children is set out in paragraphs 3.65–3.67 of *Working Together*. Probation services have a statutory duty to supervise offenders effectively in order to reduce offending and protect the public. In the execution of that duty probation officers will be in contact with, or supervising, a number of men (and, to a far lesser extent, women) who have convictions for offences against children. A very small number may have been convicted for offences relating to the fabrication or induction of illness in a child. It is, however, more likely that probation officers may become aware of past events which cause them to suspect that the person they are supervising has been involved in the fabrication or induction of illness in a child. For example, they may become aware that a child died in suspicious circumstances and suspect the child had been intentionally smothered rather than dying from natural causes.
- 4.91 Where probation officers, in the normal course of their work in the community, become concerned about the safety of a child or children they should work closely with the police, social services and other relevant organisations to assess the risk of harm posed to children by known and suspected offenders.

Voluntary, Independent and Private Social Care Sectors

- 4.92 Voluntary organisations and independent and private sector providers play a significant role in the provision of services to children in need. They provide a wide range of supportive services and may be involved in providing services after fabricated or induced illness has been identified.
- 4.93 The range of roles fulfilled by these organisations means that they should have clear guidance and procedures in place to ensure that, when they are concerned a child may be suffering significant harm, appropriate referrals are made in accordance with local ACPC child protection procedures. Staff and volunteers should be trained so that they are aware of the indicators of possible harm in the children with whom they are working. This general responsibility also applies in instances where a concern arises that a child may be subject to maltreatment due to fabricated or induced illness.

Children and Family Court Advisory and Support Service (CAFCASS)

- 4.94 The role of the Guardian ad Litem and Reporting Officer (GALRO) service, set out in paragraphs 3.82–3.86 of *Working Together*, was subsumed into CAFCASS with effect from 1st April 2001, together with the work of Family Court Welfare function provided by the Probation Service and the Children's Branch of the Official Solicitor's Department. Within CAFCASS, officers of the service undertake a range of functions, including involvement in care and related proceedings under the Children Act 1989, and many proceedings under adoption legislation. Their duties are to safeguard and promote the interests of individual children who are the subject of proceedings by providing advice to the court as an independent professional, not as an officer of the court. In care-related applications where the child is a party to the proceedings, the officer appoints a solicitor to represent the child and is responsible for instructing the solicitor.
- 4.95 In care-related proceedings the officer of the service is referred to in court rules as the '*children's guardian*'. This role is limited to the duration of the court proceedings, including any appeal that might be lodged. In each case the *children's guardian* should exercise discretion over how best to undertake enquiries, assess information, consult a range of professionals and report to the court at interim hearings, directions appointments and at the final hearing.

- 4.96 Officers of the service have a statutory right of access to and to take copies of local authority records which relate to the child concerned and any application under the Children Act 1989. That power also extends to other records which relate to the child and the wider functions of the local authority or records held by an authorised person (i.e. the NSPCC) which relate to that child.
- 4.97 Officers of the service appointed by the court in the role of *children's guardian* should always be invited to formal planning meetings convened by the local authority in respect of the child. This includes statutory reviews of children who are accommodated or looked after and child protection conferences. The *children's guardian* may sometimes wish to attend such meetings to obtain information. The conference chair should ensure that all those attending such meetings, including in particular the child and any family members, understand that the presence of the *children's guardian* does not imply any responsibility for decisions reached at such meetings.

Family Justice Courts

- 4.98 In the event that proceedings are issued for a Care or Supervision Order under the Children Act 1989 (see paragraph 3.45), all professionals involved should adopt an inter-disciplinary approach to their work. An awareness of the tasks and responsibilities of other professionals increases the possibility of consensus on issues, if not on outcome. These considerations are of particular importance in those cases where difficult issues of fact or opinion have been referred to more than one forensic expert.
- 4.99 If good practice issues or difficulties seem to recur in any locality, they may be referred to the Designated Judge of the relevant Care Centre or to the Business Committee which the Judge chairs.

The Armed Services

- 4.100 In England and Wales, local authorities have the statutory responsibility for the protection of the children of service families living in their area.
- 4.101 When Service Families (or civilians working with the Armed Forces) are based overseas, the responsibility for the protection of their children is vested with the MoD. The military authorities work in conjunction with the specialist authorities, particularly SSAFA-FH, who provide a fully qualified Social Work and Community Health service in major overseas locations (for example, Germany and Cyprus). For further discussion on Service Families based overseas, see paragraphs 3.91–3.96, *Working Together*.

Children of Foreign Nationals

- 4.102 Where child protection concerns regarding fabricated or induced illness are raised in children who are foreign nationals, the same procedures apply.

5. Role and Responsibilities of the Area Child Protection Committee

- 5.1 The roles and responsibilities of Area Child Protection Committees are set out fully in Chapter 4 of *Working Together*.
- 5.2 The Area Child Protection Committee (ACPC) is a local multi-agency forum for agreeing how the different services and professional groups should co-operate to safeguard children in that area, and for making sure that arrangements work effectively to bring about good outcomes for children.
- 5.3 The ACPC should be chaired by somebody of sufficient standing and expertise to command the respect and support of member agencies, and who has a firm grasp of local operational issues.
- 5.4 ACPCs should have members from each of the main agencies responsible for working together to safeguard children, whose roles and seniority enable them to contribute to developing and maintaining strong and effective inter-agency child protection procedures and protocols, and ensuring that local child protection services are adequately resourced. The ACPC should make appropriate arrangements to involve others in its work with a relevant interest; this could include, for example, adult and child and adolescent mental health services.
- 5.5 The ACPCs will have in place local procedures about the conduct of s47 enquiries and associated police investigations; child protection conferences; registration; and handling complaints from families about matters relating to the functioning of child protection conferences. These will also apply to the management of cases involving fabricated or induced illness, but should be read in conjunction with this Guidance. It is not intended that ACPCs have separate guidance on fabricated or induced illness in children, but that local area child protection procedures should reflect this Guidance.

Designated and Named Health Professionals

- 5.6 In England, guidance in paragraph 3.23 of *Working Together* has been updated to take account of the changes brought about by *Shifting the Balance of Power within the NHS: Securing Delivery* (Department of Health, 2001). The Child Protection Responsibilities of PCTs, resulting from Health Authority responsibilities being devolved to PCTs are set out in a letter from Jacqui Smith to Chief Executives of PCTs and PCGs dated 24 January 2002.
- 5.7 Each PCT is responsible for ensuring it has a designated doctor and designated nurse to take the professional lead on all aspects of the health service contribution to safeguarding children. The designated professionals will normally be based in a Trust, but will have responsibilities across the PCT area including for all providers. The designated professional responsibility of a PCT may be shared with neighbouring PCTs where the size of the PCT area is such that it would be an inefficient use of resources to have a designated professional covering only that PCT area. These designated health professionals should comprise part of the local health service representation on the ACPC.

- 5.8 Each PCT, acute trust, and mental health trust is expected to have a named doctor and a named nurse for child protection. Each NHS Direct site and Walk in Centre should have a named professional for child protection. The named doctor and named nurse will take a professional lead on child protection matters within their Trust, NHS Direct site or Walk in Centre. The Designated Doctor or Nurse should establish regular contact with named professionals in all Trusts, NHS Direct sites and Walk in Centres (including PCTs).
- 5.9 For Wales, please refer to paragraph 4.6.

Specific Responsibilities of an ACPC

- 5.10 The specific responsibilities of an ACPC in relation to cases involving fabricated or induced illness are:
- to ensure that the ACPC child protection procedures reflect this Guidance;
 - to ensure that there is a level of agreement and understanding across agencies about operational definitions and thresholds for referral and intervention, and to communicate clearly to individual services and professional groups their shared responsibility for protecting children within the framework of this national Guidance;
 - to encourage and help develop effective working relationships between different services and professional groups, based on trust and mutual understanding;
 - to audit and evaluate how well local services work together to protect children, to improve joint working in the light of knowledge gained through national and local experience and research, and to make sure that any lessons learned are shared, understood, and acted upon;
 - to identify the number of children in need who are at risk of significant harm as a result of fabricated or induced illness, or who have suffered significant harm, and to identify resource gaps (in terms of funding and/or the contribution of different agencies);
 - to help improve the quality of child protection work and inter-agency working through specifying needs for inter-agency training and development about the management of cases involving fabricated and induced illness, and to ensure that training is delivered; *and*
 - to raise awareness within the wider community of the need to safeguard children who may be at risk of this type of abuse and promote their welfare and to explain how the wider community can contribute to these objectives.
- 5.11 Where the ACPC has a planned programme of work on fabricated or induced illness, this should be agreed and endorsed at a senior level within each of the main member agencies, within the framework of the children's services plan, and should be set out in an annual business plan. The ACPCs may find it useful to set up a working group or sub-group, on a short-term or a standing basis, to carry out specific tasks (for example maintaining and updating procedures and protocols; reviewing serious cases; identifying inter-agency training needs) and/or to provide specialist advice in relation to this Guidance.

6. Working with Children and Families: Key Issues

- 6.1 Common principles and ways of working which should underpin the practice of all agencies and professionals working to safeguard children and promote their welfare are set out in Chapter 7 of *Working Together*. This chapter describes how these might be used when working with families where illness is being fabricated or induced in a child.
- 6.2 Family members have a unique role and importance in the lives of children, and children attach great value to their family relationships. Family members know more about their family than any professional could possibly know, and well-founded decisions about a child should draw upon this knowledge and understanding. Family members should normally have the right to know what is being said about them, and to contribute to important decisions about their lives and those of their children. Research findings brought together in *Child Protection: Messages from Research* (Department of Health, 1995b) and the *Children Act Now: Messages from Research* (Department of Health, 2001) endorse the importance of good relationships between professionals and families in helping to bring about the best possible outcomes for children.

What is meant by Working with Children and Families in Child Protection?

- 6.3 Where there are concerns about significant harm to a child, Social Services have a statutory duty to make enquiries and if necessary, statutory powers to intervene to safeguard the child and promote his or her welfare. Where there is compulsory intervention in family life in this way, parents should still be helped and encouraged to play as large a part as possible in decisions about their child. Children of sufficient age and understanding should be kept fully informed of processes involving them, should be consulted sensitively, and decisions about their future should pay attention to their views.
- 6.4 *The Challenge of Partnership in Child Protection* (1995a) outlined 15 basic principles for working in partnership, which are reproduced in *Working Together* (p. 76).
- 6.5 Partnership does **not** mean always agreeing with parents or other adult family members, or always seeking a way forward which is acceptable to them. The aim of child protection processes is to **ensure the safety and welfare of the child, and the child's interests should always be paramount**. Not all parents may be able to safeguard their children, even with help and support. Some children may be vulnerable to manipulation by a perpetrator of abuse. A minority of parents are actively dangerous to their children, other family members, or professionals, and unwilling and/or unable to change. A clear focus on the child's safety and what is best for the child should always be maintained.

Working with Children and Families

- 6.6 Those working together to safeguard children should agree a common understanding in each case, and at each stage of work, of how children and families will be involved in child protection processes, and what information is shared with them. There should be a presumption of openness, joint decision making, and a willingness to listen to families and capitalise on their strengths, but the guiding principle should always be what is in the best interests of the child.
- 6.7 Where it is suspected or confirmed that illness has been fabricated or induced in a child, all decisions about what and when to tell parents and children should be taken by senior staff within the multi-agency team. While professionals should seek, in general, to discuss any concerns with the family and, where possible, seek their agreement to action, **this should only be done where such discussion and agreement-seeking will not place a child at risk of significant harm**. In all cases where the police are involved, the decision about when to inform the parents (about referrals from third parties) will have a bearing on the conduct of police investigation (see paragraph 5.11 of *Working Together*).
- 6.8 Some information known to professionals should be treated confidentially and should not be shared in front of some children or some adult family members. Such information might include personal health information about particular family members, unless consent has been given, or information which, if disclosed, could compromise criminal investigations or proceedings.
- 6.9 Agencies and professionals should be honest and explicit with children and families about professional roles, responsibilities, powers and expectations, and about what is and is not negotiable.
- 6.10 Working relationships with families should develop according to individual circumstances. From the outset, professionals should assess if, when and how the involvement of different family members – both children and adults – can contribute to safeguarding and promoting the welfare of a particular child or group of children. This assessment may change over time as more information becomes available or as families feel supported by professionals. Professional supervision and peer group discussions are important in helping to explore knowledge and perceptions of families' strengths and weaknesses and the safety and welfare of the child within the family, and how family members can play a role in the future safety of the child.
- 6.11 Family structures are increasingly complex. In addition to those adults who have daily care of a child, estranged parents (for example, birth fathers), grandparents or other family members may play a significant part in the child's life, and some may have parental responsibility even if they are not involved in day to day care. Some children may have been supported during family difficulties by adults from outside the family. Professionals should make sure that they pay attention to the views of all those who have something significant to contribute to decisions about the child's future. Children can provide valuable help in identifying adults they see as important supportive influences in their lives. It is equally important to identify any adult family members who may knowingly or unknowingly support the abusive parent in ways which mean the child is continuing to be abused. The nature of all family relationships should be taken account of when planning placements outside the birth family and contact between the child and the abusing parent.

Involving Children

- 6.12 Research has shown that over 50% of children in whom illness is fabricated or induced are aged under 5 years. This means that at least half of children about whom there are concerns are unlikely to be able to be directly involved in discussions about the nature of their abuse. For these children, it will be important to gain information by observing the child's interactions with family members, peers and

professional staff and noticing any differences between the child's interactions with different people, as well as listening carefully to the child. For children who use specific communication methods, it is important that they are enabled to communicate using their normal means of communication. This may require the involvement of a specialist with knowledge of their means of communication (see paragraphs 3.128–3.138 in the Assessment Framework Practice Guidance (Department of Health, 2000a).

- 6.13 Listening to children and hearing their messages requires training and special skills, including the ability to win their trust and promote a sense of safety. Most children feel loyalty towards those who care for them, and have difficulty saying anything against them. Many do not wish to share confidences, or may not have the language or concepts to describe what has happened to them. Some may fear reprisals, or their removal from home and loss of siblings.
- 6.14 Children of sufficient age and understanding often have a clear perception of what needs to be done to ensure their safety and wellbeing. Some older children may be very aware of, for example, being given unprescribed substances by a parent or being encouraged to feign different types of illness behaviour. Whilst all children will want this abusive behaviour to stop, some may knowingly choose to co-operate with their parents' wishes in order to maintain current family relationships but remain clear in their own minds that they are well. Other children, as a result of the way in which their parent has taught them to behave as if they are ill, may not be able to distinguish between reality and fabrication. These children seem to come to believe their symptoms are real and this false perception of being ill is reinforced and rewarded by their abusing parent.
- 6.15 If children have had illness fabricated or induced, professionals will need to decide when and how to involve them in the decision-making and planning processes. These decisions should be taken as part of the overall plan for therapeutic work with the family and take account of the fragile family relationships which have enabled the child to have been abused. According to their age and understanding, children should know how child protection processes work, how they can be involved, and that they can contribute to decisions about their future. However, they should understand that ultimately, decisions will be taken in the light of all the available information contributed by themselves, professionals, their parents and other family members, and other significant adults.

Support, Advice and Advocacy to Children and Families

- 6.16 However sensitively enquiries are handled, many families perceive as painful and intrusive professional involvement in their lives which they have not requested, particularly if they feel that their care of their children is being called into question. This should always be acknowledged. Agencies and professionals can do a considerable amount to make child protection processes less stressful for families by adopting the principles set out above. Families will also feel better supported if it is clear that interventions in their lives, while firmly focused on the safety and welfare of the child, are concerned also with the wider needs of the child and family.
- 6.17 Children and families may be supported through their involvement in child protection processes by advice and advocacy services, and they should always be informed of those services which exist locally and nationally. Where children and families are involved as witnesses in criminal proceedings, the police, witness support services and other services such as those provided by Victim Support, can do a great deal to explain the process, make it feel less daunting and ensure that children are prepared for and supported in the court process. Information about the Criminal Injuries Compensation Scheme should also be provided in relevant cases.

The Legal Framework

- 6.18 Professionals can only work together to safeguard children if there is an exchange of relevant information between them. This has been recognised in principle by the courts (see comments by Butler Sloss LJ in *Re G (a minor)* [1996] 2 All ER 65 at 68)². Any disclosure of personal information to others must always, however, have regard to both common and statute law.
- 6.19 Normally, personal information should only be disclosed to third parties (including other agencies) with the consent of the subject of that information. Wherever possible, consent should be obtained before sharing personal information with third parties. In some circumstances, consent may not be possible or desirable but the safety and welfare of a child dictates that the information should be shared.
- 6.20 The best way of ensuring that information sharing is properly handled is to work within carefully worked out information sharing protocols between the agencies and professionals involved, and taking legal advice in individual cases where necessary. The Information Commissioner has produced a checklist for setting up information sharing arrangements which is reproduced at Appendix 4 of *Working Together*, and issued more recently guidance on the Use and Disclosure of Health Data (Information Commissioner, 2002) <http://www.dataprotection.gov.uk/dpr/dpdoc.nsf>.
- 6.21 Health professionals may share information about a patient with another medical professional as part of providing care and treatment to that patient. This should be done in accordance with the common law duties of confidentiality, the Data Protection Act 1998 and the Human Rights Act 1998. Particular regard should be had to all the Data Protection Principles. Any disclosure should be considered on a case by case basis and limited to disclosing the information that it is necessary to disclose for the medical care and treatment of the child. As a matter of practice seeking the consent of the parent on behalf of the child (where the child is not Gillick competent), should always be considered although where the safety of the child may be threatened by the disclosure such consent may not always be necessary. Where there is any doubt legal advice about the particular circumstances should be sought.

The Common Law Duty of Confidence

- 6.22 **Personal information about children and families held by professionals and agencies is subject to a legal duty of confidence, and should not normally be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information necessary to safeguard a child or children in the public interest: that is, the public interest in child protection may override the public interest in maintaining confidentiality. Disclosure should be justifiable in each case, according to the particular facts of the case, and legal advice should be sought in cases of doubt.**
- 6.23 Children are entitled to the same duty of confidence as adults, provided that, in the case of those under 16, they have the ability to understand the choices and their consequences relating to any treatment. In exceptional circumstances, it may be believed that a child seeking advice, for example on sexual matters, is being exploited or abused. In such cases, confidentiality may be breached, following discussion with the child.

² “The *Working Together* booklet does not have any legal status, but with the lesson of *Cleveland CC v F* in mind, the emphasis upon co-operation, joint investigation and full consultation at all stages of any investigation are crucial to the success of the government guidelines. The consequence of inter-agency co-operation is that there has to be free exchange of information between social workers and police officers together engaged in an investigation. The information obtained by social workers in the course of their duties is however confidential and covered by the umbrella of public interest immunity. It can however be disclosed to fellow members of the child protection team engaged in the investigation of the possible abuse of the child concerned.”

The Data Protection Act

6.24 The Data Protection Act 1998 requires that personal information is obtained and processed fairly and lawfully; only disclosed in appropriate circumstances; is accurate, relevant and not held longer than necessary; and is kept securely. The Act allows for disclosure without the consent of the subject in certain conditions, including for the purposes of the prevention or detection of crime, or the apprehension or prosecution of offenders, and where failure to disclose would be likely to prejudice those objectives in a particular case (for further guidance see *Data Protection Act 1998: protection and use of patient information* (Department of Health, 1998). Legal advice should be sought where appropriate or in cases of doubt.

The European Convention on Human Rights

6.25 Article 8 of the European Convention on Human Rights states that:

- (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
- (2) There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

6.26 Disclosure of information without consent might give rise to an issue under Article 8. Disclosure of information to safeguard children will usually be for the protection of health or morals, for the protection of the rights and freedoms of others, and for the prevention of disorder or crime. Disclosure should be appropriate for the purpose and only to the extent necessary to achieve that purpose. Legal advice should be sought where appropriate, or in cases of doubt.

Professional Guidance

Medical

6.27 The General Medical Council (GMC) has produced guidance entitled *Confidentiality: Protecting and Providing Information* (2000). It emphasises the importance in most circumstances of obtaining a patient's consent to the disclosure of personal information, but makes clear that in their view information may be released to third parties – if necessary without consent – in certain circumstances. Those circumstances include the following³:

6.28 **Children and other patients who may lack competence to give consent.**

“Problems may arise if you consider that a patient is incapable of giving consent to treatment or disclosure because of immaturity, illness, or mental incapacity. If such patients ask you not to disclose information to a third party, you should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse and you are convinced that it is essential, in their interests, you may disclose relevant information to an appropriate person or authority. In such cases you must tell the patient before disclosing any information, and, where appropriate, seek and carefully consider the views of an advocate or carer. You should document in the patient's record the steps you have taken to obtain consent and the reasons for deciding to disclose information” (paragraph 38).

3 Relevant extracts which should be read in the context of the full document.

6.29 “If you believe a patient to be a victim of neglect or physical, or sexual or emotional abuse, and that the patient cannot give or withhold consent to disclosure, you should give information to an appropriate responsible person or statutory agency, where you believe disclosure is in the patient’s best interests. You should usually inform the patient that you intend to disclose the information before doing so. Such circumstances may arise in relation to children where concerns about possible abuse may need to be shared with other agencies such as social services. Where appropriate you should inform those with parental responsibility about the disclosure. If, for any reason, you believe that disclosure is not in the best interests of the abused or neglected patient, you must still be prepared to justify your decision” (paragraph 39).

6.30 **Disclosure to protect the patient or others**

“Disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm. Where third parties are exposed to a risk so serious that it outweighs the patient’s privacy interest, you should seek consent to disclose where practicable. If it is not practicable, you should disclose the information promptly to an appropriate person or authority. You should generally inform the patient before disclosing such information” (paragraph 36).

6.31 The General Medical Council has confirmed that its guidance on the disclosure of information which may assist in the prevention or detection of abuse, applies both to information about third parties (for example adults who may pose a risk of harm to a child), and about children who may be the subject of abuse.

Nursing

6.32 The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) has produced *Guidelines for professional practice* (1996), which contains the following advice on providing information⁴:

6.33 “Disclosure of information occurs:

- with the consent of the patient or client;
- without the consent of the patient or client when the disclosure is required by law or by order of a court; and
- without the consent of the patient or client when the disclosure is considered to be necessary in the public interest.

6.34 The public interest means the interests of an individual, or groups of individuals or of society as a whole and would, for example, cover matters such as serious crime, child abuse, drug trafficking or other activities which place others at serious risk (paragraphs 55–56).

Record Keeping

6.35 The recording and retention of information, including information about covert video surveillance, should be made in accordance with the Data Protection Act 1998. In particular bodies need to be mindful of the eight Data Protection Principles – for example the requirement that the information is adequate, relevant and not excessive in relation to the purpose or purposes for which it is held

4 Relevant extracts which should be read in the context of the full document.

(principle 3); it is accurate and up to date (principle 4); it is not kept for any longer than it is necessary to do so (principle 5) and appropriate technical and organisational measures are taken to guard against unlawful or unauthorised processing or accidental loss or destruction of or damage to the information (principle 7).

- 6.36 Good record keeping is an important part of the accountability of professionals to those who use their services. It helps to focus work, and is essential to effective working across agency and professional boundaries. Clear and accurate records ensure that there is a documented account of an agency, or professional's involvement with a child and/or family. They help with continuity when individual workers are unavailable, or change, and they provide an essential tool for managers to monitor work or for audit and peer review. Records are an essential source of evidence for s47 enquiries and investigations, and may also be required to be disclosed in court proceedings. Records relating to cases where enquiries do not result in the substantiation of referral concerns should be retained in accordance with individual agency record retention policies. These policies should ensure that records are stored securely and can be retrieved promptly and efficiently.
- 6.37 To serve these purposes, records should use clear, straightforward language, should be concise, and should be accurate not only in fact, but also in differentiating between opinion, judgements and hypothesis. Where it is considered that illness may be being fabricated or induced, the records relating to the child's symptoms, illnesses, diagnosis and treatments should always include the name (and agency) or the person who gave or reported the information. All telephone conversations should be recorded fully.
- 6.38 All records should be kept securely to prevent unauthorised access and ensure they cannot be interfered with. In certain circumstances, where the child's safety is at risk, it may be necessary for a supplementary record to be created and held separately from the main records. This should not extend to keeping full duplicate records except in the exceptional circumstances. Any supplementary notes should be kept in accordance with the Data Protection Principles (see paragraph 6.35). A decision to keep a supplementary record should be made at the strategy discussion (see paragraph 3.27).
- 6.39 Well kept records provide an essential underpinning to good child protection practice, and are particularly important in cases where it is suspected that illness is being fabricated or induced in a child. They are equally important when abuse is confirmed. Information should be brought together from a number of sources, and their veracity and accuracy checked before making careful professional judgements on the basis of this information. Records should be clear and comprehensive, and judgements made, and action and decisions taken should be carefully recorded. They should also be signed legibly and dated. Health records, in particular, should record accurately all investigations, results, observations and consent to undertake examinations or treatment. Nurses and midwives should follow the principles of good record keeping set out in the UKCCs *Guidelines for records and record keeping* (UKCC, 1998). Where decisions have been taken jointly across agencies, or endorsed by a manager, this should be clearly recorded. All decisions to undertake covert video surveillance should be recorded in the child's records held by each agency involved in the decision and signed by a senior manager.
- 6.40 Relevant information about a child who is the subject of concerns about fabricated or induced illness and the family will normally be collated in one place by social services. These records should provide a detailed chronology of the case. Specifically, the reader should be able to track:
- the relevant history of the child and family which led to any intervention;
 - the nature of interventions, including intended outcomes;
 - the means by which change is to be achieved; and
 - the progress which is being made.

- 6.41 The recording of a detailed chronology which includes the medical, psychiatric and social histories of the child, parents, siblings and other significant family members is particularly important when identifying fabricated or induced illness in a child. It enables patterns of presentation for medical treatment to be recognised not only for the child but also across generational boundaries. It will also inform decisions about how best to provide the services necessary to safeguard the child's welfare and achieve change in the family.
- 6.42 Careful consideration should be given as to which agencies and professionals need to be informed about relevant changes of circumstances, for example the change of GP of a child whose name is on the child protection register. Each agency should ensure that when a child moves from their area, the child's records are transferred promptly to the relevant agency within the new locality. A telephone discussion followed up by a written summary may be necessary pending transfer of the records to ensure continuity of safe care. Where children have had illness fabricated or induced, it is essential that the new professionals involved are fully aware of the child's history to enable them to continue to monitor appropriately the child's health and development.
- 6.43 Requests for access to the child's records should be actioned in accordance with each agency's Access to Records policy and procedures. Where a child is not Gillick competent and a parent seeks access to his medical notes, access to all or part of the notes can be denied where disclosing the information would, in the view of an appropriate health professional, be likely to cause serious harm to the physical or mental health or condition of the child or any other person (see the Data Protection (Subject Access Modification) (Health) Order 200 SI No 413).
- 6.44 A health professional is defined in section 69 of the 1998 Act and includes a registered medical practitioner, a registered nurse or midwife, a clinical psychologist, child psychotherapist or speech therapist. An appropriate health professional is broadly the health professional who has the most recent and relevant care of the child.
- 6.45 Where there is any doubt about the retention or disclosure of information, legal advice should be sought.

Use of Covert Video Surveillance

- 6.46 The use of covert video surveillance (CVS) is governed by the Regulation of Investigatory Powers Act 2000 (the 2000 Act). After a decision has been made at a multi-agency strategy discussion to use CVS in a case of suspected fabricated or induced illness, **the surveillance should be undertaken by the police**. The operation should be controlled by the police and accountability for it held by a police manager. The police should supply and install any equipment, and be responsible for the security of and archiving of the video tapes.
- 6.47 **CVS should be used if there is no alternative way of obtaining information which will explain the child's signs and symptoms, and the multi-agency strategy discussion meeting considers that its use is justified based on the medical information available** (see also paragraph 5.7 of *Fabricated or Induced Illness by Carers* (Royal College of Paediatrics and Child Health, 2001)). The police will only be able to carry out CVS if they obtain the necessary authorisation under the 2000 Act. In summary, this means that they will need to demonstrate that the use of CVS is necessary to detect or prevent crime or serious crime within the meaning of the 2000 Act, depending on the type of surveillance intended, and that the evidence cannot be gathered by other less intrusive means. It is, therefore, likely to be used in a minority of cases. It is important that only those who need to know CVS is being used are involved in discussions and planning about its use. When it has been decided to use CVS the local ACPC child protection procedures should be followed. Police officers should carry out any necessary monitoring, and all personnel, including nursing staff, who will be involved in its use should have received specialist training in this area.

- 6.48 The medical consultant responsible for the child's care should ensure that the necessary medical and nursing staff are available to support the police during this operation. Their role will be to provide the child with immediate and appropriate health care when necessary. The level and nature of health involvement during the period of covert video surveillance should be agreed at the strategy discussion and all relevant staff briefed on the arrangements for the child's health care.
- 6.49 The safety (both short and long-term) and health of the child is the over-riding factor in the planning and carrying out of covert video surveillance. The primary aim of undertaking covert video surveillance is to identify whether the child is having illness induced, in situations where a multi-agency decision has been taken, at a strategy discussion, that its use is justified (see paragraph 3.25). Of secondary importance is the obtaining of criminal evidence. In any event, the use of CVS must be proportionate to the aim to be achieved. Legal advice should be sought where appropriate, or in cases of doubt.
- 6.50 Social Services should have a contingency plan in place which can be implemented immediately if CVS provides evidence of child abuse.
- 6.51 Plans should also take account of the possibility that there may be no evidence of abuse, but the child may be a child in need.

Complaints Procedures

- 6.52 Complaints about individual agencies, their performance and provision (or non-provision) of services should be responded to in accordance with the relevant agency's complaints handling process. Complaints about matters relating to the functioning of child protection conferences, including those relating to the fact or category of child protection registration decisions, should be responded to in accordance with the arrangements established by the relevant Area Child protection Committee (ACPC). Where the complaint involves a health professional the involvement of the designated doctor or nurse will be helpful in planning how best to respond.

Allegations against Staff

- 6.53 Experience has shown that children can be subjected to abuse by those who work with them in any and all settings. Allegations may arise from a range of sources, including children themselves, parents, staff, foster carers or volunteers. Regardless of the source of the concern, allegations should be taken seriously and treated with accordance with local child protection procedures.
- 6.54 In this area of work, it is also the case that concerns may be expressed by parents/carers about one or more members of medical, nursing or other staff who are responsible for medical investigation, diagnosis or treatment of their child. Such concerns may or may not include elements of alleged abuse by the member of staff against the subject child. Similarly, such expressions of concerns may not relate to allegations of actual abusive behaviour by staff, but instead, in effect, be complaints which should be dealt with in accordance with the relevant agency's complaints handling process (see 6.48 above).
- 6.55 Where allegations or expressions of concern relate to matters of abuse, the issue should be referred to Social Services, in the same way as any other concern about possible abuse. Social Services should always discuss such cases with the police at the first opportunity if a criminal offence may have been committed against a child.

- 6.56 Any subsequent investigation may well have three related, but independent strands:
- Child protection enquiries, relating to the safety and welfare of any children who are or who may have been involved;
 - Police investigation into a possible offence;
 - Disciplinary procedures, where it appears that the allegations may amount to misconduct or gross misconduct on the part of staff.
- 6.57 It is essential that the common facts of the alleged abuse are applied independently to each of the three strands of possible enquiry/ investigation. The fact that prosecution is not possible does not mean that action in relation to safeguarding children, or employee discipline, is not necessary or feasible. The important thing is that each aspect is thoroughly assessed, and a definite conclusion reached.
- 6.58 In the event that such allegations are made, consideration will need to be given to whether it is appropriate for the staff member concerned to remain engaged in his or her normal range of duties. An employee should not be suspended simply because enquiries/investigations are being made in relation to him/her. The decision to suspend should be a separate matter. The question of whether an employee should be suspended is one of reasonableness (on the information available at the time) (see the judgement of the Court of Appeal in *Goyay v. Hertfordshire County Council, Times Law Reports, 3rd October 2000*). At the same time, it will also be important that children who have been in contact with the subject of the allegations continue to receive full and consistent care.
- 6.59 Further guidance on this issue may be found at paragraphs 6.13–6.22 of *Working Together*.

Supervision and Support

- 6.60 Working with children and families where it is suspected or confirmed that illness is being fabricated or induced in a child is demanding and can be very distressing and stressful. Practitioners are likely to need support to enable them to deal with the feelings the suspicion or identification of this type of abuse engenders, particularly if they have been very involved in the child's previous care and have formed close relationships with the family. It can be very distressing to a professional person, who has come to know a family well and trusted them, to have to deal with their feelings when they learn a child's illness has been caused by actions of that child's primary carer.
- 6.61 All of those involved in such work should have access to advice and support from peers, managers, named and designated professionals and external professionals with experience of fabricated or induced illness. For health professionals, the named doctor or nurse for child protection matters within the Trust will provide advice on how to manage these cases. If unavailable, or for those health professionals working independently, the designated doctor or nurse within the relevant PCT in England or Local Health Board in Wales will fulfil this role. Supervisors should be available to practitioners as an important source of advice and expertise, and may be required to endorse judgements at certain key points in child protection processes. Supervisors should also record key decisions within case records.
- 6.62 It is not uncommon for staff within a team to have different opinions on how to manage cases where illness is being fabricated or induced in a child. This phenomenon is more likely where some staff do not believe that illness is being fabricated or induced in the child despite the objective evidence. Where these situations arise senior staff should take responsibility for deciding how to manage this conflict. Open discussion of feelings and problems within the staff group can be very helpful. One option may be to use a professional from either within the team or who is well-known to the team, such as a child and family

psychiatrist, to assist them in managing this group process: another may be to engage the services of an independent person who has the appropriate skills. Irrespective of the method chosen, it is essential that staff are helped to understand what actions are necessary to safeguard the child and are clear that they should carry out their role according to the agreed multi-agency plan.

- 6.63 For all practitioners effective supervision will be important to ensure good standards of evidence based practice which are consistent with ACPC and organisational procedures. It should ensure that practitioners fully understand their roles, responsibilities, and the scope of their professional discretion and authority. It should also help identify the training and development needs of practitioners, so that each has the skills to provide an effective service.

Inter-agency training and development

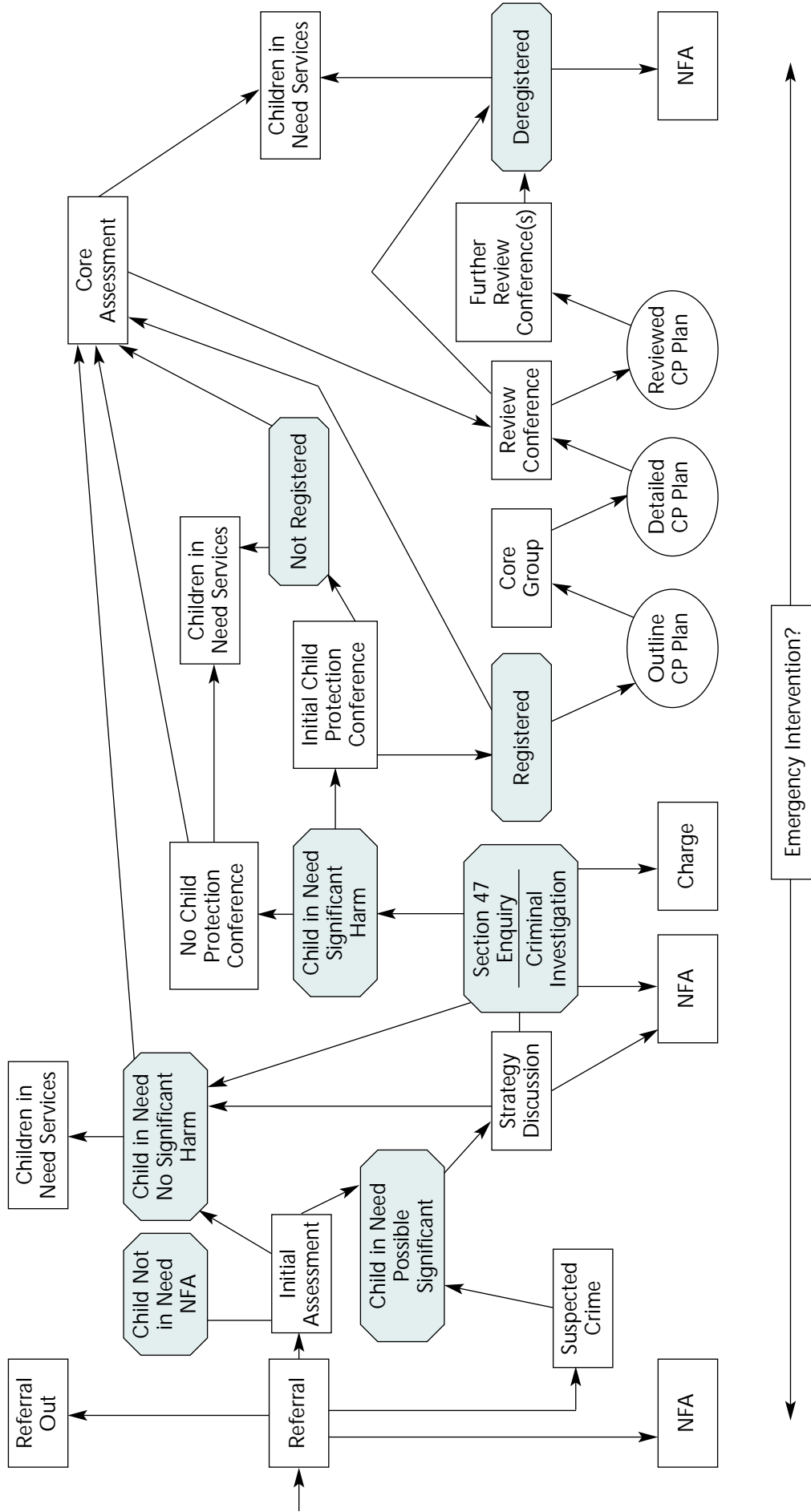
- 6.64 Chapter 9 in *Working Together* sets out in detail the importance of inter-agency training and development to support the use of the Guidance. This section does not repeat what is set out in *Working Together* but addresses the specific training implications of identifying and managing situations where it is suspected or known that illness is being fabricated or induced in a child by a carer. Training on fabricated or induced illness in children requires specialist knowledge and the training needs of one discipline may be quite different to those of another. This requirement should be built into programme planning and programmes tailored to address the range of professional roles and responsibilities set out earlier in Chapter 4.
- 6.65 Individual employers are responsible for ensuring that continuing professional development is provided to enable their employees to develop and maintain the necessary knowledge, values and skills to work together to safeguard children. Staff should be able to exercise professional skill in terms of effective information sharing where they have concerns about illness fabrication or induction. They should also be able to use their knowledge and skills in collaborating with other agencies and disciplines in this area of work. They need a sound understanding of the legislative framework within which they will be working, especially with regard to the use of covert video surveillance and information sharing.
- 6.66 The Workforce Development Confederations have a key role to play in the way in which staff are trained and as part of their responsibility towards the whole health care workforce. They hold the Multi-Professional Education and Training Budget for use in supporting health care staff's education and training (Department of Health, 2002)
- 6.67 All PCTs and NHS Trusts should ensure appropriate training is available to professional staff at all levels and in all disciplines including surgery. PCTs should also satisfy themselves in their roles as commissioners of services, that appropriate training is available to all those in organisations which have regular contact with children. Named doctors and nurses in conjunction with designated doctors and nurses are responsible for advising on such training. The Royal Colleges have a role in incorporating appropriate training in the recommended syllabuses of both post-graduate and continuing professional development programmes.
- 6.68 Employers should ensure that their staff are aware of indicators of abuse including the fabrication or induction of illness, and what constitutes safe practice within their work setting before attending inter-agency training.

The purpose of inter-agency training

- 6.69 Inter-agency training should complement the training available to staff in single agency or professional settings. It should be an effective way of promoting a common and shared understanding of the respective roles and responsibilities of different professionals set out in Chapter 4 and contribute to effective working relationships.
- 6.70 Training should be available at a number of levels to address the learning needs of different staff. The framework set out in *Working Together* (p. 100) outlines three stages of training, and matches them with target audiences who have different degrees of involvement or decision-making responsibility for children's welfare. Decisions should be made locally about how the stages are most appropriately delivered in respect of fabricated or induced illness in children and this should be part of the ACPC's training strategy.
- 6.71 The detailed content of training at each level of the framework shown should be specified locally. The content of training programmes should be regularly reviewed and updated in the light of research and practice experience.
- 6.72 There are significant numbers of people who are in contact with children away from their families. Their introductory training on safeguarding children should include being alert to children who are deemed to be ill by their parents but who do not exhibit the expected signs and symptoms of such an illness and knowing who to discuss any concerns with in accordance with the local ACPC procedures.

Appendix 1

Working Together to Safeguard Children – Individual Cases Flow Chart



Reproduced from Working Together to Safeguard Children (Department of Health et al, 1999, p116) The Stationery Office, London.

References

- Adshead G and Brooke D (2001) *Munchausen Syndrome By Proxy. Current Issues in Assessment, Treatment and Research*. Imperial College Press, London.
- Berg B and Jones D P H (1999) Outcome of psychiatric intervention in factitious illness by proxy (Munchausen syndrome by proxy). *Archives of Disease in Childhood*. **81**: 0-7.
- Black D and Hollis P (1996) Psychiatric treatment of factitious illness in an infant (Munchausen by Proxy Syndrome). *Clinical Child Psychology and Psychiatry*. **1**: 89-98.
- Bluglass K (2001) *Treatment of Perpetrators*. In Adshead G and Brooke D (eds) (2001) *Munchausen Syndrome By Proxy. Current Issues in Assessment, Treatment and Research*. Imperial College Press, London.
- Bools C N (1996) Factitious Illness by Proxy: Munchausen Syndrome by Proxy. *British Journal of Psychiatry*. **169**: 268-275
- Bools C N, Neale B A and Meadow S R (1992) Co-morbidity associated with fabricated illness (Munchausen Syndrome by Proxy). *Archives of Disease in Childhood*. **67**: 77-79.
- Bools C N, Neale B A and Meadow S R (1993) Follow up of victims of fabricated illness (Munchausen Syndrome by Proxy). *Archives of Disease in Childhood*. **69**: 625-630.
- Bools C N, Neale B A and Meadow S R (1994) Munchausen Syndrome by Proxy: A Study of Psychopathology. *Child Abuse and Neglect*. **18**: 773-788.
- Brooke D and Adshead (2001). *Current Challenges in the Management of Perpetrators*. In Adshead G and Brooke D (2001) *Munchausen Syndrome By Proxy. Current Issues in Assessment, Treatment and Research*. Imperial College Press, London
- Children Act 1989 (1989)*. HMSO, London.
- Cleaver H (2000) *Fostering Family Contact: a study of children, parents and foster carers*. The Stationery Office, London.
- Coombe P (1995) The in-patient psychotherapy of a mother and child at the Cassel Hospital: A case of Munchausen's Syndrome by Proxy. *British Journal of Psychotherapy*. **12**: 195-207.
- Data Protection Act 1998 (1998)*. HMSO, London.
- Davis P, McClure R J, Rolfe K, Chessman N, Pearson S, Sibert J R, Meadow R (1998) Procedures, placement, and risks of further abuse after Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. *Archives of Disease in Childhood*. **78(3)**: 217-221.
- Department for Education and Employment (1995) *Protecting Children from Abuse: the Role of the Education Services*. DfEE Circular 10/95.

- Department for Education and Employment (1999) *School Inclusion: Pupil Support. The Secretary of State's guidance on pupil attendance, behaviour, exclusion and re-integration. Circular No. 10/99.*
- Department of Health, Department for Education and Employment and the Home Office (2000) *Framework for the Assessment of Children in Need and their Families.* The Stationery Office, London.
- Department of Health, Home Office, Department for Education and Employment and the National Assembly for Wales (1999) *Working Together to Safeguard Children: A guide for inter-agency working to safeguard and promote the welfare of children.* The Stationery Office, London.
- Department of Health, Social Services Inspectorate (1995a) *The Challenge of Partnership in Child Protection: Practice Guide.* HMSO, London.
- Department of Health, (1995b) *Child Protection: Messages from Research.* HMSO, London.
- Department of Health (1998) *Data protection Act 1998: protection and use of patient information.* Department of Health, London.
- Department of Health (2000a) *Assessing Children in Need and their Families; Practice Guidance.* The Stationery Office, London.
- Department of Health (2000b) *Report of a review of the research framework in North Staffordshire Hospital NHS Trust.* Department of Health, London.
- Department of Health (2001) *Shifting the Balance of Power within the NHS: Securing Delivery.* Department of Health, London.
- Department of Health (2001) *Children Act Now: Messages from Research.* The Stationery Office, London.
- Department of Health (2002) Shifting the Balance of Power: The Next Steps.* Department of Health, London.
- Eminson M (2000a) *Munchausen Syndrome by Proxy Abuse: an introduction.* In Eminson M and Postlethwaite R (2000) *Munchausen Syndrome by Proxy Abuse: A Practice Approach.* Butterworth - Heinemann, Oxford.
- Eminson M (2000b) Background In Eminson M and Postlethwaite R (2000). *Munchausen Syndrome by Proxy Abuse: A practical approach.* Butterworth - Heinemann, Oxford.
- Eminson D M and Postlethwaite R J (1992) Factitious Illness: recognition and management. *Archives of Disease in Childhood.* **67**: 1510-1516.
- Eminson D M and Postlethwaite R J (2000) *Munchausen Syndrome by Proxy Abuse: A practical approach.* Arnold, London.
- Falkov A, Mayes K, Diggins M, Silverdale N, and Cox A, (1998) *Crossing Bridges – Training resources for working with mentally ill parents and their children.* Pavilion Publishing, Brighton.
- General Medical Council (2000) *Confidentiality: Protecting and Providing Information.* General Medical Council, London.

- Gray J and Bentovim A (1996) Illness Induction Syndrome: Paper I - A series of 41 Children from 37 Families Identified at The Great Ormond Street Hospital for Children NHS Trust. *Child Abuse and Neglect*. 20 **8**: 655-673.
- Gray J, Bentovim A and Milla P (1995) *The treatment of children and their families where induced illness has been identified*. In: Horwath J and Lawson B (eds) (1995) *Trust Betrayed? Munchausen Syndrome by Proxy - inter-agency child protection and partnership with families*. National Children's Bureau, London.
- Griffith J (1988) The Family Systems of Munchausen Syndrome by Proxy. *Family Process*. **27**: 423-437.
- Home Office, Lord Chancellor's Department, Crown Prosecution Service, Department of Health and National Assembly for Wales (2002) *Achieving Best Evidence in Criminal Proceedings; Guidance for vulnerable or intimidated witnesses, including children*. Home Office, London.
- Horwath J and Lawson B (eds) (1995) *Trust Betrayed? Munchausen Syndrome by Proxy: inter-agency child protection and partnership with families*. National Children's Bureau, London.
- Human Rights Act 1998* (1998) The Stationery Office, London.
- Information Commissioner (2002) *The Use and Disclosure of Health Data*.
- Jones D P H (1998) The effectiveness of intervention. In Adcock M and White R (eds) (1998) *Significant Harm: its Management and Outcome*. pp. 91-119. Significant Publications, Croydon.
- Jones D P H and Bools C N (1999) *Factitious illness by proxy*. In David T J (ed) *Recent Advances in Paediatrics*. 17 pp 57-71. Churchill Livingstone, London.
- Jones D P H, Byrne G and Newbold C (2002) In Eminson M and Postlethwaite R (2000) *Munchausen Syndrome by Proxy Abuse. A practical Approach*. Butterworth - Heinemann, Oxford.
- Jureidini J (1993) Obstetric Factitious Disorder and Munchausen Syndrome by Proxy. *The Journal of Nervous and Mental Disease*. **181** (2): 135-137.
- Makar A and Squier P (1990) Munchausen Syndrome by Proxy: father as a perpetrator. *American Journal of Paediatrics*. **85**: 370-373.
- Manthei D J, Pierce R L, Rothbaum R J, Manthei U and Keating J P (1988) Munchausen Syndrome by Proxy: Covert Child Abuse. *Journal of Family Violence*. 3 **2**:131-140.
- McClure R J, Davis P M, Meadow S R and Sibert J R (1996) Epidemiology of Munchausen syndrome by proxy: non-accidental poisoning and non-accidental suffocation. *Archives of Disease in Childhood*. **75**: 57-61.
- McGuire T L and Feldman K W (1998) Psychological morbidity of children subjected to Munchausen Syndrome by Proxy. *Paediatrics* **83**: 289-292.
- National Assembly for Wales (1999) *School Inclusion: Pupil Support. The Secretary of State's guidance on pupil attendance, behaviour, exclusion and re-integration*. Circular No. 3/99
- National Assembly for Wales (2000) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. The Stationery Office, London.

- National Assembly for Wales and Home Office (2001) *Framework for the Assessment of Children in Need and their Families*. The Stationery Office, London.
- Neale B, Bools C and Meadow R (1991) Problems in the assessment and management of Munchausen Syndrome by proxy abuse. *Children and Society*. 5 4: 324-333.
- Nicol A R and Eccles M (1985) Psychotherapy for Munchausen Syndrome by Proxy. *Archives of Diseases in Childhood*. 60: 344-348.
- Regulation of Investigatory Powers Act 2000* (2000) HMSO, London.
- Rogers D, Tripp J, Bentovim A, Robinson A, Berry D and Golding R (1976) Non-accidental poisoning: an extended syndrome of child abuse. *British Medical Journal*. 1: 793-796.
- Rosenberg D (1987) Web of Deceit: A literature review of Munchausen Syndrome by Proxy. *Child Abuse and Neglect*. 11:547-563.
- Royal College of Paediatrics and Child Health (2001) *Fabricated or Induced Illness by Carers*. RCPCH, London.
- Samuels M, McClaughlin W, Jacobson R, Poets C and Southall D (1992) Fourteen cases of imposed upper airway obstruction. *Archives of Disease in Childhood*. 67: 162-170.
- Sanders M J (1995) Symptom coaching: Factitious disorders by proxy with older children. Special Issue: The impact of the family on child adjustment and psychopathology. *Clinical Psychology Review*. 15: 423-442.
- Schreier H A and Libow J A (1993) *Hurting for Love: Munchausen by Proxy Syndrome*. The Guilford Press, New York.
- Southall S P, Plunkett M C B, Banks M W, Falkov A F and Samuels M P (1997) Covert Video Recordings of Life-threatening Child Abuse: Lessons for Child Protection. *Paediatrics*. 100 5:735-760
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1996) *Guidelines for professional practice*. UKCC, London.
- United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1998) *Guidelines for records and recording keeping*. UKCC, London.
- Welsh Office (1995) *Protecting Children from Abuse: The Role of the Education Service*. Welsh Office Circular 52/99.



© Crown Copyright
Produced by Department of Health
28835 1p 30k Aug 02 (ESP)
CHLORINE FREE PAPER

The text of this document may be reproduced without formal permission or charge for personal or in-house use.

First published: August 2002

If you require further copies of this publication quote 28835/*Safeguarding Children in Whom Illness is Fabricated or Induced* and contact:

Department of Health Publications
PO Box 777
London SE1 6XU
Tel: 08701 555 455
Fax: 01623 724 524

28835/*Safeguarding Children in Whom Illness is Fabricated or Induced* can also be made available on request in braille, on audio cassette tape, on disk, in large print, and in other languages on request.

28835/*Safeguarding Children in Whom Illness is Fabricated or Induced* is available on the department's website at:
www.doh.gov.uk/acpc
www.doh.gov.uk/qualityprotects