

The logo for Darlington Safeguarding Partnership features the text "Darlington Safeguarding Partnership" in a dark red serif font. Below this, the tagline "Protecting Children and Adults" is written in white on a dark blue rectangular background. The text is partially enclosed by a light blue circular graphic element on the right side.

**Darlington
Safeguarding
Partnership**

Protecting Children and Adults

Fabricated and Induced Illness Practice Guidance

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Fabricated and Induced Illness Practice Guidance

1. Introduction

This guidance should be used by practitioners where:

- there are concerns that illness may be being fabricated or induced in a child, or;
- There are concerns that the child's parent or carer may be fabricating or inducing illness in themselves and that this may cause harm to the child. Such concerns may also apply to unborn children

Any concerns about any member of staff instigating FII on children in their care¹ should be dealt with immediately in line with the Darlington Safeguarding Partnership procedure for '[managing allegations and concerns against staff, carers or volunteers working with children](#)' and should be discussed with the [Designated Officer](#) (formerly LADO) within the Local Authority. Agencies should make arrangements to ensure systems are secure in these instances.

This guidance is intended to support practitioners in recognising and responding to possible FII in order to effectively safeguard the child and to provide a framework to support agencies and practitioners at a local level when there are concerns that illness may be being fabricated or induced.

Additional National Guidance is also available in [Safeguarding Children with whom illness is fabricated or induced](#) (Department of Health 2008).

Partner agencies should also refer to any guidance published for their respective profession.

2. Definition of Fabricated or Induced Illness (FII) and Identifying Risks

Fabricated or Induced illness (FII) is the agreed term to be used locally. There is no nationally agreed definition of Fabricated or Induced Illness (FII) however guidance available describes FII as behaviours by a parent or carer that may result in harm to a child or young person which may include one or more of the following:

- Deliberately inducing symptoms or signs including past medical history;
- Interfering with treatments;
- Exaggerating or falsifying symptoms;
- Falsifying results of investigations, observations, medical letters and documents;
- Obtaining specialist treatment or equipment that are not required;
- Alleging unfounded psychological illness.

¹ Managing allegations procedures apply to: those in paid employment; those undertaking unpaid voluntary work; individuals contracted to work in the provision of services of children; foster carers and approved adopters; childminders

In addition to these cases there are others where a child may be presented for medical attention with unusual or perplexing symptoms which are not attributable to, or adequately explained by any confirmed genuine illness, and yet may not involve any deliberate fabrication or deception. These may be called 'perplexing presentations' or 'Medically Unexplained Symptoms'.

FII can occur when a child or young person also has a confirmed diagnosis of illness or disability and the two may coexist but the health seeking behaviour or presentation is outside that expected for the condition or disability.

The most important consideration is the impact on the child's health, wellbeing or development rather than the intent of the parent or care giver i.e. is the child suffering or at risk of suffering significant harm as a result of their parent or carer's behaviour.

The key aim is to assess the impact of FII on the child's health and development, and consideration of how to best safeguard the child's welfare within an agreed risk management framework in line with Darlington Safeguarding Partnership [Continuum of Need Indicators](#) and the Darlington Safeguarding Partnership [Multi-Agency Child Protection Procedures](#). This requires a sound and clear multi-agency approach with Children's Social Care being the lead agency and who must ensure that the Police and all the appropriate health professionals, including Designated Paediatrician, are involved to enable a thorough understanding of all aspects of the child's health status.

FII is a form of abuse associated with a range of poor outcomes for children and young people extending to the serious harm or even death of the child.

Harm to the child may be caused by them experiencing one or more of the following:

- a disordered perception of their own illness and health, leading to anxiety about their health and consequently them displaying abnormal illness behaviour
- inadvertent harm caused by health professionals (iatrogenic harm) including admission to hospital, exposure to hospital acquired infection, blood tests or X-rays. In extreme cases this may include surgical procedures, insertion of venous lines, artificial feeding, anaesthesia or prolonged hospital admissions
- a greater degree of medical attention than is truly justified. This may include specialist medical plans, equipment or attention in school that is unnecessary
- interference with normal life, including school attendance, social activities, relationships or educational achievement.

The risk of harm to the child may escalate at the point the parents/carers suspect or are made aware of the professional's concerns.

It is important that the focus is on the outcomes or impact on the child's health and development and not on attempts to 'diagnose' the parent or carer.

3. Behaviours Associated with Fabricated and Induced Illness

The following behaviours may be associated with FII:

- observations or experience of the child or young person in settings where the parent or carer are not present do not support the parent or carer's reports e.g. in school, nursery, respite care
- reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering

- a carer reporting symptoms and observed signs that are not explained by any known medical condition
- physical examination and results of investigations do not explain the symptoms or signs reported by the carer
- the child has an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment;
- acute symptoms and signs are exclusively observed by/in the presence of one carer
- on resolution of the child's presenting problems, the carer reports new symptoms or reports symptoms in different children in sequence
- the child's daily life and activities are limited beyond what is expected due to any disorder from which the child is known to suffer, for example partial or no school attendance and the use of seemingly unnecessary special aids
- older children may appear to support their parents/carers in their presentation, even to the point of being complicit with active deceit
- the parents/carers seeks multiple opinions inappropriately.

Concerns may be raised by anyone in contact with the child and/or parents/carers who may notice discrepancies between reported and observed medical conditions. Due to the complexity of these cases it can be extremely challenging for professionals to decide when a case has reached the threshold for a referral to be made. In some cases professionals are likely to develop concerns over a period of time as indicators of FII start to gradually emerge. Parents who harm their children this way may appear to be plausible, convincing and have developed a friendly relationship with practitioners before suspicions arise. They may also demonstrate a seemingly advanced and sophisticated medical knowledge which can make them difficult to challenge.

The national supplementary guidance on Fabricated and Induced Illness provides detailed guidance on this and states:

'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.'

It is important for professionals to establish with the parent/carers what their concerns are and if possible support them to interpret and respond more appropriately to their child's state of health which may involve management of their own anxieties. It is also important to hear the voice of the child or young person. This may be difficult in

settings where the child is always in the presence of their parent/carer but easier in settings away from their parent e.g. at school.

There are some parents for whom careful efforts to reassure may be ineffective. In these instances, there are a number of options available and professionals may choose one or more depending on the situation. The family could benefit from a multi-agency approach and could be supported via a CAF to help understand the situation from the perspectives of the child, family and other agencies involved. This may help to resolve or clarify concerns and address the needs of the child and family appropriately. If the family are unable or unwilling to engage with the CAF process then this may support a referral to social care.

Professionals should discuss the situation with colleagues, or team, and consider the information they have, what the concerns are and why. It is often helpful at this stage to compile and analyse a chronology of involvement of the service or agency in the child or young person's care. **See Appendix 3 for a chronology template.**

At this stage there should usually be discussion with the child's GP with referral to a Paediatrician if one is not already involved. This allows a detailed review of the child and of the parental concerns about the child's health. It is an opportunity to carefully consider if further tests or investigations are warranted to tease out possible explanations for the signs and symptoms. A period of overt, close or constant observation of the child may be indicated as an inpatient and any agreed definitive, warranted investigations should take place to clarify diagnosis. Police Officers planning surveillance in cases of suspected fabricated or induced illness may seek advice from the National Crime Agency, Telephone: 0370 496 7622 (communication@nca.x.gov.uk).

Normally the doctor would tell the parent/s that s/he has not found the explanation for the signs and symptoms and record the parental response. Many parents or carers of children or young people with perplexing or medically unexplained symptoms will accept that whilst the signs and symptoms remain unexplained, they will be reassured that they are not life threatening, that further investigations are not warranted and are more harmful than not doing any more, that the child needs to function alongside symptoms and that the child will not come to harm as a result. They will accept a management plan which supports rehabilitation and coping with symptoms programme with the aim of resolving the situation for the child / young person and allowing them to return back to a more normal lifestyle.

In other circumstances the family are unable to accept this narrative and decline the plan, request further investigations or seek further opinion when more than one has already been provided and professionals consider on balance that further investigations, assessment and referral would have an adverse impact on the child's well-being (through unnecessary tests or by re-enforcing an illness role for the child or young person) and may impede the process of rehabilitation, symptom control and/or programme of return to education and social activities invasive given professionals.

In this instance if there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, children's social care should convene and chair a strategy discussion which involves all the key professionals responsible for the child's welfare, such discussions should consider all aspects of the child's welfare and not solely concentrate on whether there is suspected FII or not.

Parents should be kept informed of further medical assessments/ investigations/tests required and of the findings but at no time should concerns about the reasons for the child's signs and symptoms be shared with parents if this information would jeopardise the child's safety and compromise the child protection process and/or any criminal investigation. If the signs and symptoms remain unexplainable this should be explained to the parents.

At any time, professionals could also discuss the case at supervision, or with the named or designated person responsible for safeguarding within their agency. Other sources of advice if further support is needed are named or designated doctors, or a senior colleague in children's social care.

4. What to do if you have concerns regarding Fabricated and Induced Illness and require a multi-agency safeguarding response

If you are concerned that a child or young person is at risk of or may be suffering significant harm as a result of the parent/carer fabricating or inducing illness, then you should make a referral to children's social care in the usual way [insert hyperlink].

Whilst the guidance is the same for any referral there are some considerations that are especially important when making a referral for FII [this can include forgoing the need to notify the parents/carers of the referral as further explained below].

From the point of the referral, all professionals involved with the child should work together as follows:

- lead responsibility for action to safeguard and promote the child's welfare lies with Children's Social Care
- any suspected case of FII may involve the commission of a crime and therefore the police should always be involved
- the paediatric consultant is the lead health professional and therefore has lead responsibility for all decisions pertaining to the child's health care.

There should be a strategy discussion between social care, the police and health before any decision is made to inform the parents / carers of concerns. It may be necessary to seek legal advice regarding this issue. The referrer should be clear about the reason for the referral and their concerns and the potential impact on the child.

The potential complexity of the case may require special consideration about the timing of the strategy meeting. These strategy meetings will normally be chaired by a Children's Social Care Service Manager, but consideration should be given to whether there are any suitably experienced officers of an appropriate grade who would be best placed to chair this meeting. A representative of legal services should also be present wherever possible. Health input at the appropriate level, i.e. from someone with the

necessary expertise to give an informed assessment, will be essential to the efficacy of the meeting. The chair should consider what information is known and which agencies or services still need to be contacted, including relevant health services, in order to ensure that a detailed chronology can be compiled as this is likely to be of significant benefit in progressing the assessment.

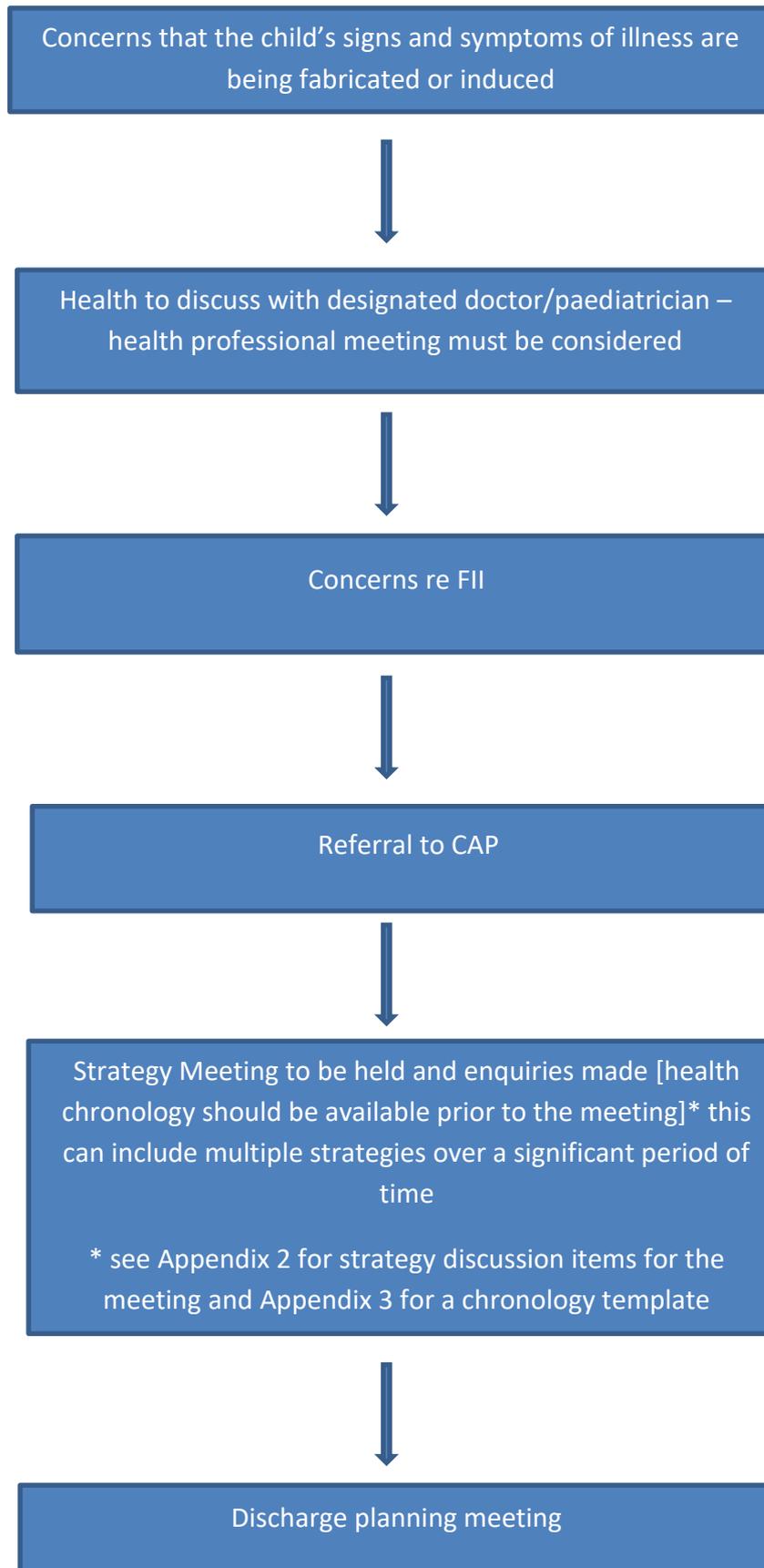
As in any safeguarding work professionals involved should remember joint working is essential and all agencies and professionals should:

- be alert to potential indicators of illness being fabricated or induced in a child
- share and help to analyse information so that an informed assessment can be made of children's needs and circumstances
- contribute to whatever actions and services are required to safeguard and promote the child's welfare
- assist in providing relevant evidence in any criminal or civil proceedings
- it is important that there is a discussion and decision about when the concerns will be raised with parents/carers. There may be a need for multiple strategy meetings in order to determine the concerns and the evidential basis for those concerns. There should be a clear communication plan regarding how information will be shared, how and by whom
- only once a strategy discussion decides that the case does not meet the threshold for section 47 enquiries the parents/carers should be informed that professionals have had the discussion about why the child's signs and symptoms remain unexplained including consideration of whether the parental /carer response to the child's illness may be impacting on the lack of progress or deterioration for the child. There should be a clear plan as to who is best placed to have these conversations in a supportive way which will maximise the ability of the parents/carers to continue to engage with involved professionals.

Any suspected case of Fabricated or Induced Illness may involve the commission of a crime and therefore the police should always be involved.

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.

FABRICATED INDUCED ILLNESS FLOWCHART



APPENDIX 2

ADDITIONAL AGENDA ITEMS FOR STRATEGY MEETING

- Chronology from health [suitably analysed together with a view from the lead designated health professional regarding the confirmation of FII]
- Chronology from education
- Chronology from social care
- Chronology from other relevant agencies involved with the family/child(ren)
- Police information
- When does CSC become visible to the family [if not actively involved with the family/child(ren)]
- What information is shared with the parents/carers, how and when is this to be done and by whom [this is not the sole responsibility for CSC in all cases]
- Timescales for agreed actions [is this to be police lead as a result of a crime being established and committed]
- Has a crime been committed and is there an immediate safeguarding response required



FII Chronology Template

Name of child:	DOB (dd/mm/yy):
Compiled by:	Agency:

DATE	TIME	NAME	SOURCE	EPISODE/EVENT	COMMENT / DISCREPENCY
dd/mm/yy	24 Hr Clock e.g. 14.35	Name of child (there may be more than one child affected)	Agency and source within that agency	Describe the event/episode	With particular reference to any warning signs

DATE	TIME	NAME	SOURCE	EPISODE/EVENT	COMMENT / DISCREPENCY