

# Fabricated or Induced Illness by Carers

February 2002

Royal College of Paediatrics  
and Child Health



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# **FABRICATED OR INDUCED ILLNESS BY CARERS**

Report of the Working Party  
of the Royal College of Paediatrics and Child Health  
February 2002

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## FOREWORD

Health professionals who work with children learn right at the start of their training about the vital importance of listening to parents and working with them in partnership for the good of the child. Because of that mindset, most clinicians perceive child protection as a difficult and often distressing issue. There is one group of children whose parents maltreat them in strange and complex ways, by creating, mimicking or attributing to them the features of physical or, less often, psychological illnesses. When first recognised, this phenomenon was named “Munchausen syndrome by proxy” or MSbP for short. Children who are the subjects of “MSbP” are at serious risk of suffering harm and present major challenges to health professionals, who sometimes find that they themselves have unwittingly been the instruments of harm to these children.

My predecessor, the late Professor David Baum, proposed shortly before his untimely death in September 1999 that our College should review the literature and the clinical experience on the subject. In January 2000 we invited Dr Richard Wilson, consultant paediatrician at Kingston Hospital, to lead a small working group and prepare a report. The choice of a generalist as chairperson, rather than a specialist in child protection, was deliberate, since the aim was to produce guidance that would be relevant to all paediatricians.

Dr Wilson brought to this task a wealth of experience in paediatrics and a long-standing interest in working with parents and the voluntary sector in the area of bereavement. He has drawn on the expertise of our Child Protection Committee, and of colleagues in community paediatrics and many other disciplines. A number of parents have shared their experiences and their views with the working group. On behalf of the College, I thank them all. Mrs Edwina Currie, Lord Justice Matthew Thorpe, and Mr David Derbyshire were invited to be lay members of the group, to monitor the gathering and analysis of evidence and to ensure fairness and objectivity. Their help has been invaluable.

This report and its companion entitled *Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities*, soon to be published by the Department of Health, will be essential reading for all paediatricians and other members of the multi-disciplinary team in the field of child protection. The Department of Health document sets out policy and guidelines for all professionals, whereas the College document discusses clinical issues in more detail and provides practical advice for paediatricians. Dr Wilson and his colleagues propose that the term MSbP be replaced by “Fabricated and Induced Illness” (FII) and stress the very wide spectrum of problems that are subsumed under this heading. They emphasise that the first duty of the clinician is to the child and describe how paediatricians should proceed when they suspect that a child may have FII, in line with the Department of Health guidance in “Working Together”.

In recent years, a number of doctors have been the subject of complaints with regard to their work in child protection. This report stresses the importance of following the agreed procedures as set out in “Working Together”. It argues for a departure from current practice - when complaints arise in spite of correct practice, the response to the complainant, and the subsequent investigation if one is indicated, should be the joint responsibility of the statutory agencies rather than that of the NHS on its own.

Dr Wilson and his colleagues make some important observations on how little we know about prevention, early detection, management and the long term impact of these experiences. We hope that this report will stimulate more research on all aspects of child abuse and neglect and that the volume and quality of new evidence and data will soon demand a second edition.

David Hall, President RCPCH

21.02.2002.

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‘ In essence, we wish to increase understanding of the way in which the health care system may be used to harm children, rather than benefit them, and the way in which health workers may become the unwitting instruments of this harm. We believe that an understanding of parents and of consultations, combined with good basic skills in history taking and observation, are the keys to the early recognition of these situations, to ensuring that children receive appropriate health care, to the prevention of further harm, to the protection of children from abuse, and to the design of training for health workers which creates thoughtful, skilful and non judgmental professionals. Understanding the range and nature of parents behaviour is also key to the development of child protection systems. These should integrate the skills of all children’s professionals to support families, to prevent abuse by the health care system and to foster children’s development in the best way possible.’

- Eminson and Postlethwaite, *Munchausen Syndrome by proxy abuse: a practical approach* (2000)

*The vignettes in this report are fictional but illustrate types of situations which Paediatricians have reported. They are not all completed stories because we are often faced with uncertainty and there are no standard answers. Sometimes our initial views change, sometimes a clear resolution is possible, sometimes carers are able to accept help, often there are children who are at risk of harm for whom it is difficult to be sure of the best way to provide help and protection.*

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## 1. AN OVERVIEW

### 1.1. *Introduction*

Protecting children from harm is a priority for Paediatricians. Knowledge of the complexities of fabrication and induction of illness has steadily accumulated but has been accompanied by many difficulties.

Terms have been used inconsistently, there is anxiety about how to proceed when suspicions are first aroused, there have been disputes over covert video surveillance, parents felt they were being “accused” by paediatricians while we have been trying to help families sooner and there has been huge diversity of opinions among professionals.

It seemed time to review the responsibilities and problems of paediatricians in the face of so much uncertainty. We consulted widely. We are part of a multidisciplinary system and welcome the new DoH guidance. We have looked at the role of doctors in identifying and preventing harm, and how they are sometimes used to deliver harm. We recognise the huge spectrum of this behaviour and that we do know little of long term effects. We have aimed to review and clarify the current situation so that we can stimulate future discussion and believe there should be another review in 2 or 3 years. We want to give practical guidance to paediatricians now. We wish to move some of the focus from the carers, and make the welfare of the child the absolute priority.

### 1.2. *Scope and Purpose*

There is unequivocal evidence that carers can and do cause harm to children through fabricated and induced illness. There are the intertwining problems of:

- a) Fabrication or Illness Induction in Children by Carers;
- b) Whether the child has suffered significant harm or is likely to.

The key issue for this report is the role of the Paediatrician and the Child Health Services and how they work with other agencies. Professionals have difficulties because there are uncertainties about each of the threads in the double strands of harm and of mechanism of harm. **Uncertainty can be reduced through competent professional judgements, clear protocols, and maintaining the welfare of the child as a priority.** Protocols are the skeleton for action but this depends on effective information sharing and allocation of adequate resources and on collaboration, understanding joint decision making, and trust between agencies. Even then uncertainty may remain and the courts have to examine all the issues to ensure that the welfare of the child takes priority over all other issues.

The initial role for the Paediatrician is to find out whether a child's illness and individual symptoms and signs have an unequivocal explanation as a natural illness. If this is not clear the possibility of fabrication or illness induction and the effect of this on the child has to be considered as part of the range of possibilities. Psychiatrists and psychologists may be needed to look at the effects on the child, and establish whether there are underlying disorders in the carer. Police must investigate a possible crime. Social workers make an assessment of our concerns about the child's welfare or the risk of harm and provide support to parents during the assessment.

Work is needed to clarify how to improve the essential processes of joint working. The RCPCH Working Party was set up to look into problems and ways forward for Paediatricians to play a full and effective role in this incompletely understood area of children's welfare.

### **1.3 Remit**

The remit of the Working Party as set down by the College was to:

- a) commission a literature search.
- b) examine the evidence base around Fabricated Illness
- c) investigate and document ways of managing the condition.
- d) establish the particular roles of paediatricians in relation to other professionals, including the judiciary, Social Services, and Police Child Protection Teams.
- e) receive views of parents on the management of this condition.
- f) issue a report and guidance.

### **1.4. Existing Guidance**

Current guidance is based on existing documents:

- Child Protection: Medical Responsibilities, Dept of Health, 1989
- Children Act: 1989
- Evaluation of suspected imposed upper airway obstruction, BPA 1994
- Human Rights 1998
- Working Together to Safeguard Children: Dept of Health *et al* 1999
- The Framework for the Assessment of Children in Need and their Families: Dept of Health *et al* 2000
- Regulation of Investigatory Powers Act 2000
- Safeguarding Child in whom Illness is Induced or Fabricated by Carers with Parenting Responsibilities, Consultation Document, DOH July 2001.

We have found great help in two publications:

- *Significant Harm, its management and outcome*, Adcock and White, Second edition 1998 (Significant Publications).
- *Munchausen Syndrome by Proxy Abuse*, Eminson and Postlethwaite, 2000 (Arnold).

## 1.5. Evidence Gathering

Evidence was gathered from:

1. Individual contributions on particular topics.
2. An analysis of the literature, Postlethwaite R. 2001 (in press)
3. Results of a questionnaire to Paediatricians, Child Psychiatrists, GPs, and Paediatric Surgeons.
4. Views of parents were sought directly through those who contacted the RCPCH with complaints or queries, through professionals who were in contact with parents who had been through rehabilitation, and via voluntary organisations.
5. Consultation with representatives of The Royal College of General Practitioners, The Royal College of Nursing, The Association of Chief Police Officers, The Foundation for the Study of Infant Death, The Royal College of Psychiatrists, The National Society for the Prevention of Cruelty to Children, Action for Sick Children, The National Children's Bureau, Partnership with Parents, and the Family Rights Group.
6. Readers were appointed by the Royal College of Paediatrics and Child Health and The Royal College of Psychiatrists.

The work was collated and scrutinised and analysed by the Working Party. The Steering Group met to discuss and criticise the work as it progressed and made many constructive suggestions and perceptive comments. The draft report went to the Executive Committee and Council for approval.

*Case Example 1: A baby had several episodes of vomiting, but despite admission no cause was found. He then presented with fevers and on the second admission his mother fabricated the fever by warming the thermometer. This led to angry scenes and self-discharge. The baby thrived but the underlying issues were not recognised until the mother attempted suicide.*

*Case Example 2: A child presented with a story of fever and the GP found blood in the urine but no other abnormality. A second reported febrile illness showed proteinuria and she was referred for investigation. Discrepant results led to identification of egg albumin in the urine. An undisclosed history emerged that there had been a previous child who died from renal agenesis. Discussion and support from the Paediatrician, Social Worker, Health Visitor and Nursery helped the mother to lose her preoccupation with the dead child. This child then remained well.*

## **2. HISTORY AND DEFINITION**

The paper by Asher in 1951 describing persistent presentation to health services with factitious somatic complaints used the title Munchausen Syndrome. This gave it prominence but was rapidly taken up since it allowed non-psychiatric professionals to “cope” by using humour. Patients who had a very severe mental disorder came to doctors specialising in physical disease. They persisted, they fooled us, they used up scarce resources, and doctors had few skills to help them.

At the same time out of the mass of physical disorders the problem of child abuse was emerging. Kempe had to use emotive terms such as “baby battering” to arouse interest. Cases of repeated poisoning by carers were published in the 1960s and 1970s, and in 1977 Meadow and separately Burman and Stevens published papers on child abuse which included fabrication. This triad of the “duped doctor”, “harmed child” and “fabricating parent” was named “Munchausen by Proxy Syndrome” by Roy Meadow.

The controversy over definition has not been resolved. An important series of papers was published together as a ‘Controversy’ (*Archives of Disease in Childhood*, 1995: volume 72 pp 528-538) which should be read in full. However we would agree with the proposal of Fisher and Mitchell *et al*, in that:

***‘The condition known as Munchausen Syndrome by Proxy or other variations does not satisfy criteria for acceptance as a discrete medical syndrome because of the wide variation.’***

Discussion points raised in the ‘Controversy’ include:

- Some pointers which should raise suspicion of the problem have been elevated to the status of being diagnostic
- Whether motivations should be part of identification or not.
- The difficult borderline between fabrication and exaggeration.

We accept the four points proposed by Meadow *et al*, but we note that the last two criteria cover many child abuse situations:

1. Illness in a child which is fabricated or induced by a parent or someone who is in *loco parentis*.
2. A child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
3. The perpetrator denies the aetiology of the child’s illness.
4. Acute symptoms and signs cease when the child is separated from the perpetrator.

Semantically the term Munchausen Syndrome by Proxy is only valid when a person who has Mun-

chausen Syndrome themselves uses others, particularly children, to manifest their disorder. We should note that even when one parent has Munchausen Syndrome it may be the other parent who is harming the child. We must not be diverted by arguments over semantics. Fabrication or illness induction includes all forms of such activity and do not inevitably clarify the motivation of the carer, which may be difficult to ascertain. It can include the old terms MSbP or MbPS whether applied to carer, child or scenario, and includes delusion, excessive anxiety, masquerade, hysteria, doctor shopping, doctor addicts, mothering to death, seekers of personal help or attention or financial gain, and those who fail to give needed treatment as well as those who treat unnecessarily.

Adoption of the term FII symbolises awareness of the wide spectrum of physical injury and psychological harm. We are also aiming to recognise warning signs and provide help earlier than in the past. One can argue that FII always brings harm, but earlier identification will make assessment of the child's needs or risks a very individual process. The essential focus is on the child's physical and emotional health and welfare in the long term as well as immediately, and the likelihood of the child suffering harm. The Working Group accept that the term "Munchausen by Proxy" is no longer appropriate or helpful and should be abandoned.

***We therefore recommend that Paediatricians should talk about Fabricated or Induced Illness.***

*Case Example 3: Three children from one family presented with various fabricated illnesses. They were judged not to be at high risk and were seen regularly by one consultant. The oldest child when a teenager was taken to the Accident and Emergency Department with a sports injury, and asked to see the Consultant Paediatrician. He said "I thought I ought to let you know that our mum made all those stories up, but don't tell her I said so will you".*

*Case Example 4: A foster mother took a 6 year old child in her care to her GP with a history of tonic clonic convulsions. Referral to a Paediatrician led to finding slow wave dysrhythmias on EEG. Treatment with Tegretol seemed ineffective and she was brought to hospital in a post-ictal drowsy state several times. Tegretol levels were high. During hospital admission treatment was withdrawn and no fits occurred, except that one day the mother alleged the child had had a fit and fabricated incontinence of urine. The child was also emotionally very blunted. Investigations showed the foster mother had lied about herself. She became very threatening but then left the country.*

### **3. IDENTIFICATION, ASCERTAINMENT AND EPIDEMIOLOGY**

#### **3.1. Introduction**

We favour the use of the term “Identification” since it is a behaviour and its consequences that is being identified and not a medical condition which is being diagnosed. A number of markers have been used in the literature to ascertain cases and derive statistics:

1. Unexpected deaths reported to the coroner.
2. Repeated deaths.
3. Rulings of the Criminal Courts.
4. Rulings of the Family Courts.
5. Child Protection conferences which have substantiated fabricated or induced illness.
6. Judgements by individual Paediatricians or Child Psychiatrists.
7. Evidence of harm caused by unnecessary investigations, medical treatment or surgery.
8. The experience of doctors and nurses in primary care.

#### **3.2 Unexpected Deaths**

Unexpected deaths may be due to illness induced by a parent, although deaths are rare in the context of FII. Unexpected deaths are referred to the coroner who has to decide whether a death is due to natural causes. There are major problems about accurate analysis by coroners of factors leading to death in infancy. There is often a lack of paediatric medical input and a lack of the sort of assessment which takes place when there are concerns about possible abuse of a live child. There is also a reliance on pathology opinions which do not always have the backing of sufficient expertise or resources in paediatric pathology, or of background information, to be satisfactorily reliable. Even forensic pathologists do not routinely employ radiological or toxicological investigations. This has therefore led to the unprovable suspicion that in the past children who were considered to have died from natural causes were killed and the parent is the inevitable suspect. The suggestion is that they may have poisoned or smothered the child and that homicide was either deliberate (murder) or accidental (manslaughter). It also makes it possible for homicide or accidents to remain unidentified. The knowledge that they have been responsible for such a mistake in the past has led some forensic pathologists to advise that one should begin with the assumption that every unexpected infant death is due to homicide, and at best to use the term “unascertained”.

Since 1971 the ONS has identified the unexpected deaths of infants due to natural but unascertained cause. The term used after ascertainable causes have been excluded by autopsy is Sudden Infant Death Syndrome. The existence of such a Syndrome is supported by repeatable characteristics and by the effect of the Reduce the Risk Campaign in this country which reduced such deaths from around

2000 per year to a current estimate of 333 deaths in England and Wales. The inconsistent use of “unascertained” makes recent numbers less reliable, and this figure includes 90 “unascertained” deaths.

Information currently available does not permit confident conclusions about the interrelationship of homicide, manslaughter, accidents, rare medical disorders, acute illness, sudden infant death syndrome and care by parents or professionals. Registered causes of death normally include the illness and its aetiology whether congenital or acquired. A child’s death also depends on the vulnerability of the child, and the care given. While these are factors in every death, they are only looked into when the “registrable” cause is unclear.

The figures for “homicide” (including infanticide) are ascribed to the year of registration and not the year of death. The numbers of cases in infants (under 1 year) registered in 1996, 1997 and 1998 were 27, 33 and 37. Over 60% of infant homicides are due to skull fracture or intracranial haemorrhage, which would be identified by a competent post mortem.

The Confidential Enquiry into Sudden Deaths in Infancy (CESDI) survey of infant deaths only looked at cases where the police had not considered there were obvious or suspicious features of homicide. In CESDI cases after extensive enquiries there were 6% where it was thought that maltreatment (including neglect as well as deliberate harm) accounted for the death. In a further 8% of deaths there was thought to be inappropriate care. We do not know what this might be when deaths are due to identified natural causes.

There is widespread agreement that the present system of investigation is unsatisfactory. The Home Office is engaged in a review of the coroners system. The Foundation for the Study of Infant Deaths (SIDs) has suggested that a medical assessment and information gathering should inform a full investigation by a paediatric pathologist and lead to a case review by all professionals involved. The American Academy of Paediatrics has just issued a policy statement on “Distinguishing sudden infant death syndrome from child abuse fatalities” which contains similar principles. This would lead to more dependable conclusions, as well as providing help for the bereaved.

### **3.3 Recurrent Deaths**

Cases of repeated deaths and child abuse by parents in individual families have been known to occur for many years.

Second deaths in families who have had a cot death can undoubtedly be due to natural causes, although these include both identified and unidentifiable causes.

Some clinical categories of FII cases are associated with an increase in child deaths of siblings in the past. Some of these were ascribed to SIDS. The level of investigation in the previous siblings was not always good enough to give a conclusive diagnosis.

There is no way of reliably estimating the possibility that an individual second death is due to natural or other causes using statistics or family characteristics. Statistics are only valid for populations not for individuals. Parental smoking, poverty and high parity in a young mother are major risk factors for sudden unexplained infant death, with an incidence of 1 in 214 live births. The risk in the rest of the population is 1:8543, but there is no evidence that this is a homogeneous group, and some families in that group will have a much higher risk due to unidentified factors. If the factor was thought to be genetic the family would be given an empirical recurrence rate of 1:100. The same socio-economic disadvantages lead to congenital abnormality, infection, accidents and SIDS, as well as child abuse. This does not mean that one manifestation is the cause of another.

Serial killings by professional carers are also well recognised and are also a form of FII. H R Oswald recalled in his memoirs that a baby died in a Blackheath Infant Welfare Centre while his mother was working. There was a mark on the forehead, said to be caused by having fallen against a corner of the cot. In the preceding 2 months 6 babies had been similarly injured and 3 of them had died. They had all been in the care of nurse Grace Thompson when they had “fallen against their cot”. Unsteadiness thought to be due to rickets was common. However the nurse was a confirmed drug taker, had a violent temper, and had been responsible for 3 earlier murders. She was found guilty but insane and sent to Broadmoor in 1918. (H R Oswald, *Memoirs of a London county Coroner*).

### **3.4 The Criminal Courts**

Relatively few prosecutions are made, particularly when the suspect is a parent. This process may be the one which when there is a conviction provides the most certain “proof” of induced illness/death. However the adversarial system is not always the best way to establish the truth and certainly there will be carers who are either not brought to trial or are acquitted who did cause harm and death. One may also assume that on rare occasions convictions may be unsafe, but when criminal prosecutions are made the evidence is usually compelling. The requirement that the case be proved beyond all reasonable doubt to the satisfaction of the jury means not only that many people are acquitted, it can also lead cases to be presented in a fashion alien to the ethics of evidence based medicine. There are concerns in the medical profession about the weight attached to medical opinion in criminal trials involving Fabricated or Induced Illness by a carer. The opinion is often delivered with great authority and courts and juries are dependent upon it when reaching their conclusions. In alleged smothering cases there is often no motive, no weapon, no injury, and no pathological finding. The Courts have a difficult task in these circumstances where the possibility of a murder conviction may rest on collateral information and medical opinion rather than on material evidence. Our profession needs to be very

sure indeed that medical opinion is soundly based on good scientific research verified by others. There are major problems for the Courts when doctors cannot agree. It might be preferable if the adversarial process were preceded by an independent review of the medical evidence for the court from a panel of experienced doctors. This would not only come to conclusions, but would make it clear what the strength of evidence was for each conclusion. This might better inform the Court, who would not be totally dependent on adversarial opinions.

### **3.5 The Family Courts**

The standard of proof required in family courts is different from that in criminal proceedings. The House of Lords approved the following principle: ‘The standard of proof is the balance of probabilities. The more serious the allegation, the more convincing the evidence needed to tip the balance in respect of it.’ The main point is that in the Family Court the focus is on the child and their welfare and not on the parent. However the parents do feel that they have been found guilty and punished when a child is made the subject of a Care Order. This is particularly so if they have been already acquitted in a criminal court, or where criminal charges were not pursued. However the fact that the evidence necessary to prove guilt and send a carer to jail is not available, is not a reason for society to fail to protect a child where it seems necessary on the balance of probabilities.

### **3.6 Paediatricians and Other Professionals in Specialist Services**

Health professionals are not uncommonly faced with parents who show a range of abnormal behaviour in seeking health care for their child. There are many causes for this and most can be solved in initial consultations, often with the support of other health professionals, such as the Health Visitor. At the extreme end of this spectrum there is deliberate deception and physical and emotional harm to the child. In comparison with other forms of child abuse, Fabricated or Induced Illness is unique in that health professionals have key involvement from the early stages of emerging concerns through to the completion of enquiries and investigations. This is a difficult and stressful process.

Harm may be recognised by a variety of health professionals:

- There is a small but well substantiated experience that harm can be induced by a pregnant mother to the unborn child. While this may be principally the province of Obstetricians, it is an area that Neonatologists need to be reminded does exist. Adult Psychiatrists caring for women who are mothers or mothers to be also need to be well informed on these issues.
- Child Psychiatrists may also encounter fabrication of emotional or behavioural symptoms.
- Surgeons dealing with children are certainly involved and need to be aware of FII. They are more likely to be misled if they are not working closely with paediatric colleagues. The insertion of

central lines and of operations such as gastrostomy and Nissen fundoplication seem particularly common in cases of FII. Fabrication in ENT clinics has also been recorded. Although surgeons are not usually the first to query the possibility of FII, they are certainly beginning to do so and to ask for the views of paediatric colleagues. All children admitted to hospital should be under the care of a named paediatrician as well as a surgeon.

- Paediatric pathologists in all disciplines can be very important allies in medical and forensic investigation. They are becoming aware that equivocal or inexplicable results may raise the possibility of FII.
- Paediatricians are commonly the group who are first approached for help, but may be misled, and the duped doctor is an intrinsic part of the process. We are looking therefore not only at the action of carers towards children, but the carers interaction with professionals, particularly Paediatricians. Paediatricians are concerned about the concept of a threshold for referral to Social Service Department. Some social workers and police believe that Paediatricians will not make a referral until they are virtually certain that there is fabrication or illness induction. This means that children are being harmed by extensive unnecessary medical investigations and a prolonged stay in hospital, as well as a prolonged risk of illness induction directly by carers. There are also assumptions by other professionals that Paediatricians should have no difficulty in distinguishing between the over-anxious carer of a sick child, and parents who exhibit abnormal illness behaviour and may be causing harm. This can be a difficult and slow process. An assessment can now be done via the 'Framework for the Assessment of Children in Need and their Families.' (DoH et al 2000) This is best achieved by the psycho-social professionals in the paediatric team who can introduce the Social Service Department procedures.
- There is also a hidden group of children from more affluent backgrounds whose problems are camouflaged by private education and private doctors or "alternative" practitioners . There may not be the necessary exchange of information between professionals in these circumstances, so that the whole picture will not be available to anybody. Furthermore some of the doctors consulted may have practised in sub-specialties of adult medicine or in adult surgery without having any paediatric training and may be unaware that they are obliged to follow procedures in "Working Together". Some patients in this group make little or no use of their NHS general practitioner, and there may be no focal point to which all information can be directed. The Community Paediatrician may become aware of some issues around these children, but has no power to obtain information to evaluate the need for intervention.

### **3.7 Doctors and Nurses in Primary Care**

General practitioners and Health Visitors may be the first people to be aware of abnormal illness behaviour by a parent or carers especially because of multiple complaints or numerous consultations. However some parents involve large numbers of different doctors through different A&E and Paediatric Departments, and a variety of GPs by staying with grandparents or consulting when on holidays, etc. Health Visitors will similarly see many anxious parents and may use their “cause for concern” mechanism to seek support from the named or designated nurse for child protection. Both GP and health visitor may be holding very important information. They may also be at risk of being persuaded by the harming carer into discarding suspicions. Primary care professionals may occasionally be contacted by a worried friend or relative. Sensitive and aware staff in primary care may be able to prevent escalation by early identification and referral to a consultant paediatrician with a request for a definitive opinion on the child’s health.

The acute risk of death from induced illness is rare for Paediatricians and even rarer for General Practitioners to experience. However the long-term effects of chronic fabrication can cause very significant harm, and general practitioners will have much experience of trying to sift cases of excessive parental anxiety from fabrication. This area is one in which Paediatricians and family doctors can jointly develop skills in diagnosis and identification, management and collaboration. Many children with behaviour problems and somatising syndromes are initially referred to Paediatricians. Closer working across the primary care and specialist paediatric interface is appropriate in the changing Health Service, would improve the care of children, and could be an important field for joint training. This might also avoid children being referred unnecessarily to highly specialised Paediatric units, where unnecessary investigations are more invasive, extensive and harmful.

### **3.8 Epidemiology**

Epidemiology is difficult because there has been no agreed definition, because criteria for inclusion and methods of ascertainment vary, and because early series were inevitably personal and perhaps non-representative. Cases can vary in the nature of their presentation, in the urgency of the need to prevent physical harm and death, and in the severity of the harm to the child which can be of a chronic disabling nature as severe as an acute life threatening one. Harm to the child is an important feature, but one has to act also on the basis of risk of harm. We do not currently know what the risk of escalation of harm is; this is different from continuation of the same level of risk, although both have major effects on the child.

The most authoritative UK epidemiological study to date is one carried out between 1992 and 1994 by McClure *et al.* Ascertainment utilised the BPSU (British Paediatric Surveillance Unit) reporting

system, and the entry criterion was a child protection conference which concluded that a child was suffering or was likely to suffer significant harm due to fabrication or illness induction. The incidence of newly diagnosed cases was 0.4 per 100,000 children under 16 years old per year, and 2.8 per 100,000 in children in the first year of life.

Watson Eminson and Coupe studied one health district with 65000 children under 16 years over a 2 year period. Cases were nominated where excessive seeking of healthcare or abnormal illness behaviour by the parent caused consideration of whether significant harm was occurring to the child. This revealed 58 children in 42 families, i.e. 45 per 100,000 per year.

In the BPSU study there was a wide variation between different regions from 0.1 to 0.8 per 100,000 per year which has not been explained. This may be because of different reporting rates or different procedures, but may just reflect the variation found by a cross sectional study.

*Case Example 5: A child with mild asthma caused concern because he had multiple visits to the A&E Department and was receiving increasing doses of steroids. His mother was very anxious about allergies but refused advice from a Paediatric Allergist. A private allergist sees him for opinion and treatment, but writes no letters except to ask the GP to prescribe syringes and needles. There are a number of concerns for the community paediatricians about his school attendance, and his mother's claim that he now has ME. Despite this he is making good physical and academic progress.*

*Case Example 6: On moving to a new area two junior school children presented to Education with reports from a private psychologist which said they had learning disability and communication disorders. At the parents' request they attended a special school, but the staff felt they were inappropriately placed. The parents refused medical investigation and educational assessment. However after careful collaboration and planning this was carried out under an "Assessment Order". Careful documentation was ensured. Eventually the children were taken into care.*

*Case Example 7: A mother with a history of dependence on sleeping tablets presented her 9 year old child with mild asthma and many allergies. The child was on a strange diet and not attending school. After a great deal of work mother was able to acknowledge some of her behaviour. She relocated to be nearer her parents and the symptoms reduced and school attendance increased. The child was later alleged to have specific learning difficulties, but this was understood and the family were helped with this. Multidisciplinary effort and good family support over several years produced clear benefits.*

## **4. THE SPECTRUM OF SIGNS AND SYMPTOMS**

### **4.1. The Range**

The range varies in the nature of the presenting symptoms, the severity of the initial illness, the age at which harm starts, the length of time before any action (as distinct from identification) takes place, whether the fabrication escalates, and whether the child is drawn into collusion and self-perpetuating illness.

The hospital paediatrician sees cases of fabricated or induced illness including acutely ill children who may indeed have their lives saved by prompt recognition and resuscitation. In the out-patient clinic one meets less life-threatening cases but they may still have severe long-term effects. The community paediatrician oversees a number of arenas in which children play out their lives – nurseries, schools, at home, visiting the A&E department etc. He or she will often be more aware of children from deprived backgrounds or siblings of children who previously have had problems.

Verbal fabrications are much commoner than induced illness. The quality of our skills in consultation determines whether we identify the disparity between what we are told and what exists and whether we can help or make it worse. The fabrication may be thought to be mild when the child is not thought to be at risk of death or unnecessary surgery.

We do not know what is mild or severe in long-term effects on children of distorting their perception of themselves and health and illness. Instincts are probably right in believing that the effects on the child of exaggerating symptoms, of obsessional protection from infections and allergies, of excessive medication, etc., are not necessarily severe in a child who is emotionally robust. A variety of professionals try to steer these children through childhood supporting their parents, minimising any interference, reinforcing the child's view of himself as competent, until they reach a more independent period of their lives. We can make the situation worse by endorsing the view that the child is "sick", and through excessive medical investigation or treatment. But we do not really know the effects of this "mild" fabrication in the longer term and in particular how it will affect their skills as parents. We know it is frequent and said to occur in 5% of children attending allergy clinics, (Warner 1984) 1% of children attending asthma clinics, (Godding 1991).

A psychological perspective of normal and abnormal human development is as important to the practice of Paediatrics as keeping up to date with the modern advances in genetics and immunology. Fabricated or induced illness lies at the severe end of the spectrum of human behaviour that may seem incomprehensible and unbelievable. It presents a challenge to know when to intervene for children in order that the child's needs can come first.

Existing diagnosed chronic illness in a child does not exclude the possibility of induced illness. The very presence of an existing illness can act as a stimulus to the abnormal behaviour and also provide the carer with opportunities for inducing symptoms. Furthermore, the close relationship with health professionals may both fulfil the needs of the parent and reduce suspicion in the professionals.

Eminson and Postlethwaite suggested there is a spectrum of parental attitude which may be concordant or discordant with the doctor's objective view of the child. When the parental view is that the child needs less intervention, this may be so extreme as to constitute neglect. If the parents extreme concern for more intervention is the problem, then it leads to fabrication. Fabrication of a state of health which is better or worse than we believe is the truth, can occur at either extreme of this spectrum. Illness induction occurs at the excessive intervention end. This ability to achieve concordance of views between carer and doctor is fundamental to an agreement to proceed with medical investigations, treatment, etc.

Eminson *et al* focused on one side of the continuum, i.e. the parental view. The assumption was that the doctor had an objective reasoned proportionate appraisal. This is not always so. Both doctors and parents can be off the mark. So we are looking at the interaction of three variables. The central one is the state of health of the child, which may vary from being entirely healthy to being sick. There is the parental view which at one end is neglectful, and at the other end causes excessive intervention either directly or indirectly. The doctors view is equally on a spectrum from being dismissive at one end, to performing excessive intervention and treatment at the other. In the majority of cases doctors and parents are agreed and are right about the reality of the child's condition. This however is not always so.

Uncertainty of the origins of a child's symptoms is not rare. One review showed that 9% of inpatients and 24% of outpatients were discharged without a confirmed abnormality. Some genuine disorders whether physical or psychological have no objective physical signs, no definitive investigations and are often multifactorial. Paediatricians often work with the uncertainty of whether physical symptoms have an important psychological component, and training in this area is essential. However, in good faith, parents or professionals may seek refuge from uncertainty in a more definite opinion. Some disorders are exceedingly rare but to pursue every physical cause without looking at more likely factors will lead to both physical and psychological harm to the child.

In complex disorders like Chronic Fatigue Syndrome there is a risk that differences of opinion can lead to the suspicion of FII. An erroneous diagnosis of FII can have tragic consequences for the family and child. However more often a combination of parents, paediatricians, psychiatrists and physiotherapists agree to work together accepting the uncertainty. In this way much can be achieved, and despite uncertainty help for the child need not be delayed.

Paediatric consultations are different as normally we not only have a doctor-patient relationship, but every patient is accompanied by an advocate. The advocate – usually the parent – is the carer who has responsibilities for the child and who we assume is trustworthy. However carers, like doctors, also have personal experiences, lives and views and are not always objective. If the carer and the doctor agree on the significance of symptoms and the severity of the situation they are probably right. But concordance does not always prove correct. If both say the child is well and he is sick – is this an honest error or neglect, or negligent, or incompetence or what? If they both say he is sick and he is well is it just a mistake or collusion or is one duping the other? If they conflict in their views it is even more complex.

All this overlooks the child who may indeed have views which differ from both the other parties in what he or she thinks is important. The child may also have views on what he perceives as harmful. The child may not accept that the venepuncture needed to diagnose hypothyroidism is anything other than a harmful experience, and he will be right from a short-term perspective. It does harm even though the intention is for his benefit. However harm caused for the benefit or gratification of somebody else whether carer or doctor is child abuse. We know that the rule of “primum non nocere” requires that we limit the harm we do, but still believe we are doing it for the child’s good. It is said that Donald Winnacott left paediatrics for child psychiatry because “he did not want to harm any more children”. Parents too may believe that they are acting in their child’s best interest when they are nevertheless harming them, or they may cause harm because they subordinate the child to their own needs. While we view the anxious parent quite differently from the carer who harms the child and deceives us it is still the harm to the child that is important. In these situations we must try to allow the child to communicate what they know and feel and want. The only way to achieve that is to practice it as a routine in every consultation. There is however no easy way out because children may be misled or simply wrong too. Ultimately we may need to ensure the child’s welfare and protection including the use of the Family Justice System.

***However, we must first be sure that we have honed our skills  
in consultation.***

Carers Ability to distinguish child's need from their own	The Spectrum of Care Seeking Behaviour	Agreement with doctor on need to consult
NONE at times	Classical Neglect Ignoring symptoms	0
Seriously compromised	Late seeking help Does not get/give treatment Fails to attend	
Can be helped	Marked non-compliance with treatment Erratic care in many ways Children have to be quite ill to be noticed	?
NORMAL Can and do	Appropriate recognition of sickness Concern, action and thoughtful care	+
Can be helped	Exaggerates symptoms Seeks multiple opinions Gives over zealous medication	?
Seriously compromised	Very frequent consultations with demands for tests and more specialist opinions Giving medication for minimal disease and inventing some symptoms	
NONE At times	Fabrication Induction of Illness	0

## **4.2 Symptomatology and Mechanisms**

Fabrication or illness induction can simulate almost any disorder. Although we have included this Table there are several major caveats in focusing on medical presentations. Identification of fabrication has to take place before such a list has any value. It may then help to identify how abuse was caused. It does not help in identifying fabrication since focussing on "typical scenarios" can miss cases of FII, or fail to identify genuine disorders. Resourceful parents can use any medical presentation. Lists contain the most florid examples but the majority of cases may hide under less dramatic disguises.

4.2.1 **Symptomatology**

<b>System</b>	<b>Symptoms</b>	<b>Cause</b>
<b>Neurological</b>	Seizures, collapse and loss of consciousness, ataxia, drowsiness: Developmental delay	Drugs, poisons, suffocation or pressure on carotid sinus. Fabricated fits. Fabrication of abilities, under stimulation, deprivation or sedation.
	Disability	Enforced/inappropriate use of wheelchair, crutches, braces, hearing/visual aids, nappies, etc.
<b>Cardiorespiratory</b>	Apnoeic and cyanotic episodes, cardiac arrest, near-miss SIDS *	Suffocation with hands, cloth, plastic bag or film. Insertion of fingers or objects down throat. On PICU, interfering with oxygen supply, ventilators, IV drugs/infusions
	Hypertension	Altering BP cuff size, instructions or chart.
	Limb congestion	Ligature or digital compression at top of limb
	Cystic fibrosis	Altering laboratory investigations and stealing sputum from other patients
	Asthma	Deliberate under/over treatment
	Cardiomyopathy	Ipecac poisoning
<b>Gastrointestinal</b>	Recurrent vomiting and diarrhoea	Drugs (eg laxatives), poisons or mechanically induced. Fabricated vomiting
	Failure to thrive Feeding problems	Restricting intake, diluting feeds, altering intravenous infusion, aspirating or removing nasogastric tube, inappropriate dietary restrictions for allergy. Fabricating fluid/intake/output charts
<b>Renal</b>	Polyuria, polydipsia	Drugs, forcing excessive fluids, diluting feeds. Fabricated history
	Haematuria, renal stones	Adding stone, parental or pet's blood and colouring substances to urine
	Bacteriuria	Swapping urine specimens with parent or other patients

<b>System</b>	<b>Symptoms</b>	<b>Cause</b>
<b>Haematological</b>	Purpura	Injecting blood under skin, rubbing skin
	Haematemesis, haemoptysis and rectal bleeding	Adding parental or pet's blood, or colourings to specimens, clothing and nappies
<b>Immunological</b>	Recurrent fever, sepsis	Heating thermometer, injecting bacteriologically contaminated material, interfering with intravenous sites
	Allergy	Applying excessive environmental and dietary measures to avoid "allergen". Use of adrenaline for alleged anaphylaxis. Inappropriate use of rectal temperature measurements
<b>Muco-cutaneous</b>	Rashes	Applying irritants, scratching, friction, scalds, burns or injecting skin
	Conjunctivitis, stomatitis	Inserting caustic solution in eyes and mouth
<b>Orthopaedic</b>	Fractures, osteomyelitis	Repeated assaults and dirtying wounds
<b>ENT</b>	Recurrent aural/nasal bleeding or discharge	Inappropriate instrumentation/injury in orifices
<b>Gynaecological problems in parent</b>	Recurrent discharge, preterm labour	Inappropriate instrumentation/injury. False reports of APH
	Premature rupture of membranes	Deliberate injury. Artefactual fluids in sanitary towel
<b>Metabolic</b>	Hypoglycaemia, glycosuria	Abuse of insulin, oral hypoglycaemics and sugar solutions
	Hypernatraemia	Adding salt to feeds

\* Frank bleeding from nose or mouth is significant of physical intervention, and to be distinguished from blood tinged secretions.

### **4.3. Clinical Clusters in Fabricated or Induced Illness Abuse**

(These are categories of physical intrusiveness)

A literature review (RJ Postlethwaite and DM Eminson: in press) identified 605 cases of FII. This consisted of 313 cases in single case reports and small case series and 292 in more extended case series (Meadow, Southall, McClure, Feldman and Light). The literature review collates the information from the 313 cases and compares it with the more extended published case series. The present summary highlights some of the details from the review of the 313 cases.

The analysis of these 313 cases is mostly concerned with physical harm and death. It does not attempt to look at the long-term effects of less acute abuse which could nevertheless be very severe. Paediatricians and family doctors are aware of this issue but the necessary long-term studies are lacking. Another important unanswered question is whether there may be escalation of abuse. It is important to bear in mind that the cases are subject to biases in identification, in reporting and in categorisation into clinical groupings. Additionally much of the information from all the reports is incomplete.

The analysis grouped cases into 'clinical categories' according to the physical intrusiveness of the most severe FII abuse suffered by the index case. The clinical categories were:

1. Verbal fabrications including fabrication of records or tests but no direct illness induction. The symptoms reported commonly included bleeding, apnoea, seizures, diabetes, recurrent infections etc.

2. Withholding nutrients.

3. Production of signs and symptoms other than by poisoning or smothering (other inductions). These were children with fevers, rashes, bleeding, renal stones etc.

4. Poisoning of low toxicity. Children presented with diarrhoea, vomiting, dehydration and failure to thrive which was due to administration of emetics, laxatives and diuretics.

5. Poisoning of high toxicity:

i) Agents which caused hypoglycaemia such as Insulin

ii) Salt poisoning

iii) Many other agents producing signs such as coma, seizures, breathing difficulties, ataxia, bleeding. There were a very wide number of agents administered including pepper, barbiturates, antidepressants, anticoagulants, phenothiazines, chloral, bleach, arsenic, diazepam etc.

6. Apparent Life Threatening Events (ALTE) which includes smothering to produce signs. Some of the findings from the literature review are presented in Table 1. Much information about the psychopathology of the perpetrators, pregnancy and perinatal problems and the profession of perpetrators was incomplete.

## CLINICAL CATEGORIES OF PHYSICAL INTRUSIVENESS

Physical Intrusiveness Index case	1	2	3	4	5	6	Total
Number	67 (21%)	14 (4%)	62 (20%)	41 (13%)	90 (29%)	39 (12%)	313 (100%)
Age of first Presentation*	1.25 (0.25-3.38)	-	0.66 (0.091-2.96)	0.375 (0.1-2.1)	2.5 (1.259-5.5)	0.123 (0.019-0.25)	
Age at Identification*	5.5 (2.0-9.0)	1.33 (1.091-1.85)	3 (1.16-7)	1 1.75 (1 (0.83-4)	2..5 (1.159-5.5.)	0.4 (0.019-0.25)	
Death index case	0	0	3 (5%)	5 (12%)	22 (24%)	7 (18%)	37 (12%)
Death index case or sib or ALTE sib	3 (4.5%)	2 (14%)	7 (11%)	6 (15%)	44 (49%)	23 (59%)	94 (30%)
Perpetrator female	64 (95.5%)	10 (71%)	60 (97%)	41 (100%)	79 (88%)	32 (82%)	286 (91%)
Perpetrator Male	1 (1.5%)	0	2 (3%)	0	9 (10%)	6 (15%)	18 (6%)
Perpetrator both	2 (3.0%)	4 (28%)	0	0	2 (2%)	1 (3%)	9 (3%)
Falsified charts or specimens	24 (35%)	0	3 (5%)	0	3 (5%)	1 (3%)	31 (10%)
Physical/sex abuse index or sib	2 (3%)	3 (21%)	10 (16%)	0	19 (21%)	3 (7%)	37 (12%)
Intrinsic illness	6 (9%)	0	6 (15%)	2 (5%)	0	1 (3%)	15
Any surgery Index case	18 (27%)	-	37 (60%)	26 (63%)	12 (13%)	7 (18%)	100**

Table 1 – Summary of key features from 313 cases  
For key to vertical columns see text

\* Age in years (median and upper and lower quartiles)

\*\* Only 299 cases at risk (information not available in PII 2)

This information requires further analysis to explore the relationships between the various factors.

Some preliminary comments are:

1. The deaths of both index and siblings cases increase with increasing intrusiveness of the index abuse.

The surprising exception to this is the unexpectedly small number of deaths in category 6.

2. The age of identification of verbal fabrications is significantly older than other more intrusive forms of FII abuse. If, however, the age of the first presentation is established Verbal Fabrication starts in early childhood with an age of onset no different from the other clinical categories.

a) If FII abuse is a manifestation of parenting problems this would be expected. Demands on parents are greatest and the child is most vulnerable in infancy. It would be predicted, therefore, that all forms of fabricated or induced illness would start in early childhood.

b) This information emphasises the many years of abuse with multiple admissions, investigations, and procedures that 'mild' cases of FII abuse have been subjected to. The long term implications for the psychological wellbeing of these children and their ability to form relationships in adult life and develop good parenting skills is enormous.

c) For this subset of verbal fabrications the abuse does not appear to have progressed to more physically acute abuse even over many years. This does not preclude the possibility that in other cases there has been progression from mild (verbal fabrication) to more severe illness (illness induction) but does suggest that some perpetrators probably never cross the threshold to illness induction. The factors that prevent this progression are worthy of study.

3. There are few male perpetrators but they tend to perpetrate the more severe forms of abuse.

4. Falsified specimens and/or charts are reported largely in association with verbal fabrications.

5. Additional reported physical and/or sexual abuse showed an increase with increasing physical intrusiveness of FII abuse. This suggests that direct induction of illness and physical/sexual abuse is linked in families.

6. Induced illness and 'intrinsic illness' are not exclusive categories. Overall 5% of cases of illness induction occurred in the context of an 'intrinsic illness'.

7. The literature underlines the consequences when these fabrications are believed by doctors. In the different clinical categories the rates of surgery ranged from 13% to 63%. This surgery was usually multiple and often preceded by massive medical investigation. Not only is the surgery traumatic and risky in itself but it provides other routes for the perpetrator to utilise. In 29 (48%) of the 62 cases of 'Production of signs by other means' the route for illness induction was an iatrogenically produced portal of entry to the body and in the majority this was the only method of illness induction used by the perpetrator. Thus doctors are not innocent bystanders in this complex form of abuse

#### **4.4. False allegations of sexual abuse**

Some children are repeatedly presented with complaints of painful micturition and vaginal irritation following an alleged sexual offence. These children often undergo numerous genital examinations, some under anaesthesia. False allegations may encompass intentional fabrication for revenge against the accused, or the false belief that the child has been abused, or an unintentional misinterpretation or distortion of symptoms. Parents may induce physical signs of sexual trauma to support their sexual abuse allegation. It must be acknowledged however, that if a child continues to have contact with a suspected perpetrator it would be understandable for the caring parent to become extremely anxious about possible trauma and abuse and would therefore urgently need to seek the truth and protect the child. Such parents may present as over anxious and possibly hypervigilant. Such people however would usually be relieved by negative findings, would maintain contact with health professionals if requested and follow advice offered. These latter two points do not necessarily occur in those families where induced illness or fabrication are occurring.

The conclusions that abuse has or has not taken place need to be definitive to prevent repeated questioning, audiotaping, videotaping child's play or statements and repeated presentation for medical and/or psychological evaluation.

#### **4.5. Psychiatric Presentations and Psychological Harm**

In the book *Munchausen Syndrome by Proxy Abuse*, Green describes a small number of cases presenting with neuropsychiatric syndromes. These are uncommon and not likely to present solely to paediatricians.

In some circumstances it may be difficult to establish the extent to which symptoms such as fatigue and unexplained physical symptoms are due to psychological symptoms or disorders, such as depression or somatising disorders, or where they have a physical cause. This may be because there is a lack of definitive physical investigations, because a rare physical disorder has not been easily identified, or because the two are co-existing. Without exemplary liaison between paediatricians and mental health specialists, there is a risk that such disorders might occasionally be erroneously thought to be FII – or the reverse.

Emotional symptoms can be exaggerated or fabricated in a child, but the child may also suffer psychological harm from abuse which presents as a physical disorder and from the ensuing medical investigations. The long term psychological consequences of prolonged abnormal illness behaviour and illness induction need to be researched further. Undoubtedly there will be children who do not have the emotional resilience to escape unscathed from what may appear to be “Mild” abuse.

#### **4.6. Collusion**

It is recognised that children may adopt their parents' perception of illness and comply with bogus symptoms. Children believe what they are told by adults and they copy adults behaviour and learn from their interaction with parents. Some children will be aware of what their parents are doing, for example placing blood in the child's urine, but they never volunteer this information. It may become important that they are asked what might be happening. Child victims may participate in the fabrication of symptoms for fear of abandonment by their mother if they stop being sick. These children become extremely dependent on their mother who moulds them into becoming an invalid.

Older child victims may become compliant as a consequence of frequent school absences which result in impoverished peer relationships and therefore they do not enjoy school. Sanders (1995) describes 4 levels of collusion:

- Naïvety: probably accounts for most cases
- Passive acceptance:
- Active participation, without appreciating the serious consequences
- Active harm when children engage in self-harm, possibly to maintain the relationship with their mother.

These complex interactions can only be unravelled by a full child and family assessment.

#### **4.7. Descriptions of Perpetrators**

Case reports and series have included descriptions of many characteristics of those who have carried out fabrication or induction. They have been accumulated from many situations and types of fabrication and these overall percentages can not be used as definitive evidence in an individual case. Fabricated or induced illness arises when a mixture of factors coincides: factors in the child, the fabricator, the family, social circumstances and the health care arena. We do not yet understand the way in which these risk factors may interact with other characteristics of the child, carer or the health care system to produce a risk of fabrication or illness induction. Skilled and experienced assessments of the carer are an important part of the whole process, but there is no psychiatric condition which inevitably leads to child abuse. Psychiatric opinions cannot replace the foundation of the identification of fabricated or induced illness, which is the paediatric evaluation of the child and the causes of the child's symptoms and signs.

However, these descriptions of predisposing characteristics are important for three reasons. First, they constitute a set of potential risk factors for a range of difficulties which carers have and which may affect the care of children. We should be alert because they may well indicate that the child is "in need". Second, study of the interaction of these factors, with others, may help in our understanding of the origins of these behaviours. Third, they serve as a reminder that in any individual clinical case,

factors which are identified in the parents will need careful assessment (by an appropriate person) in terms of the nature and severity of the risk they pose and the way this will be managed in both short and long term. The variety of dynamics and family constellations observed is a warning against adopting typologies prematurely. Such characteristics should be assessed in the context of other risk factors for child and family. [See P280, Figure 13.2, “MSBP Abuse: a practical approach” Jones, Byrne and Newbould, 2000. Eds. Eminson and Postlethwaite].

Characteristics of fabricators or illness inducers in the 313 cases include:

1. The perpetrator is the child's mother in 89%, a mother substitute in 3%, a male in 5%.
2. Previous paramedical training is only present in less than 20% of cases where occupation was ascertainable and in 7% overall
3. Existing mental health difficulties have been reported. These include Somatising and Somatoform Disorder (formerly Munchausen Syndrome), Personality Disorders, Eating Disorders, self-harm, alcohol and drug abuse.
4. Previous contact with mental health agencies is reported in 30%. This needs to be compared with controls for parents attending general outpatients which are almost as high. Fabricators often have a history of somatisation disorder or other episodes of fabrication.
5. Personal histories of fabricators also include reports of physical or sexual abuse as a child (25%), being in local authority care during childhood (children's homes or foster care), and childhood mental health difficulties history of many kinds often associated with concurrent abuse.
6. Various patterns of family relationships have included reports of a distant, passive or absent father.

NB: Perpetrators may be skilled in concealing their activities and in misleading professionals. They appear on occasion to be strongly motivated to continue or even escalate the abuse. Many deny their activities when challenged, may be very guarded and defensive and may seek alternative healthcare or move to another area, with continuing risk of harm to the child.

#### **4.8. Outcomes**

Estimates of death rates in index cases from the literature are around 10 to 12%. The risk of death should be zero in cases identified by a child protection conference, and in those index children identified by intensive surveillance for ALTE to be suffering from recurrent imposed apnoea. Death in siblings has been used to assess risks on the assumption that death in a sibling of an abused child was also due to abuse. There is no doubt that repeat deaths occur in families due to abuse, especially in cases of poisoning and suffocation. Sibling death rates vary from 5 to 55%. Death of a child from abuse may not be recognised at the time because of current defects in the system of investigating deaths referred to the coroner. Not all deaths from poisoning and suffocation are due to illness induction by a carer.

In the BPSU report there was follow-up with a median of 2 years. This had some important findings:

- a) None of the cases identified had been found subsequently to be due to intrinsic organic disease.
- b) 40% were living at home with the perpetrator, but only 25% of those where there had been poisoning and only 10% of those where there had been suffocation. 33% were still on child protection registers, 25% still had symptoms or signs. 17% of those who had not suffered direct physical harm had nevertheless subsequently suffered further abuse.

The chances of successful rehabilitation are extremely difficult to assess, but current views have been summarised after Jones et al who considered prognosis in relation to different domains of influence upon child outcome.

There has been no systematic audit of all children entering the process of enquiry, protection and rehabilitation with their own family or re-establishment in a new family so we do not know outcomes at each stage, except for some valuable but limited selected accounts. It is probably reasonable to assess the potential for family re-unification in selected cases, who have at least some better prognostic factors, while simultaneously being alert to the possibility of enduring and severe personality disorders to be present in some parents.

*Case Example 8: A baby was admitted with unexplained apnoeic attacks. On the ward round the baby's nurse reported the baby had had another apnoeic attack, apparently when the SHO had been present. The SHO said he had not been there. Further medical investigation identified no medical cause for the alleged symptoms. With full involvement of Social Services and the Police it was agreed that covert video surveillance was appropriate and this was done at the local hospital. It was in fact a male adult who was inducing apnoeic attacks and he ended up in a secure prison. The child remained with his mother and has done well.*

*Case Example 9: A 4 month old baby was admitted with intractable conjunctivitis since a few weeks' old. Biopsies in several hospital had not clarified the diagnosis. The child then started having cyanotic episodes. Clinical examination and X-ray revealed healing rib fractures. It was thought that the cyanotic episodes had been induced. Father who was an alcoholic later admitted to putting bleach in the child's eyes; the child is now blind.*

TABLE (from Jones *et al*)

Domain	Poor prognosis	Better prognosis
Abuse	Induced harm Sadistic element Accompanying child sexual abuse or physical abuse Deaths of earlier children Harm to animals	Fabrication Shorter duration of MSBP abuse
Child	Development delay Physical sequelae of MSBP abuse Development of somatizing behaviour	Absence of delay or sequelae of abuse
Parent	Personality disorder Denial Lack of compliance Alcohol/substance abuse Abuse in childhood – unresolved.	Personality strengths Acknowledgement of abuse Compliance Treatment-responsive mental illness Adapted to childhood abuse
Parenting and parent-child interaction	Disordered attachment Lack of empathy for child Own needs before child	Normal attachment Empathy for child
Family	Domestic violence Multi- generational abuse	Non-abusive partner Supportive extended family
Professional	Lack of informed resources	Partnership with parents Long-term psychological treatment and social casework
Social setting	Violent, unsupportive neighbourhood Isolation	Local child support facilities Social support.

*Case Example 10: A 9 year old boy was referred with a history of bizarre dreams and hallucinations, fever and headaches. No organic cause was found for these. A few months later his mother requested special foods on prescription because she said his symptoms were due to sugar intolerance according to a medically qualified relative of hers. Investigation for sugar intolerance was refused and she went for private consultations. She then said the diagnosis was confirmed but when it was found that this was untrue she threatened to complain and take legal action.*

*Case Example 11: An 8 year old girl was kept off school for about a week each month. Mother said that she was having very painful periods. School doctor found she was a completely normal 8 year old with no evidence of puberty and investigation also confirmed that she was prepubertal. During child protection investigations the general practitioner informed the meeting that the child's mother had had a hysterectomy shortly before the child began to be kept off school. The hysterectomy had been for medical reasons, mother was very reluctant to agree to it. Counselling was arranged for the mother and the child began to attend school regularly.*

## **5. MEDICAL EVALUATION: PROCEDURES AND MANAGEMENT**

### **5.1. Introduction**

Guidance on child protection procedures is laid down in *Working Together to Safeguard Children* (Department of Health *et al* 1999), and it is incorporated into local child protection protocols. In the past the identification of the possibility of non-accidental injury and of harm to children, often lay initially with medical and nursing teams. When they were fairly clear in their views the child was referred to Child Protection Agencies who then took over. Now there is a new focus on children in need, and on making assessments and taking decisions jointly between health, social services and when appropriate education, and the police. This may make it possible for collaborative work to take place sooner, and improve care for the child in a preventive way. Certainly we should be able to move from the concept of a single threshold for referral to social services departments or police. This will require major changes in attitudes and actions by staff in health, social services and police.

The NHS Trust Named Paediatrician for child protection, working with the Named Nurse for child protection, has a central role in individual cases as well as for organisation and collaboration. The detailed job descriptions of named doctors may change, but they have responsibilities for supervision, training, guidance, clinical governance and liaison with the lawyers, police and social services which will continue. It is equally important that they foster close collaboration between the various sections of the Health Service, so that acute general paediatricians, community and tertiary paediatricians, child psychiatrists and A&E consultants all work effectively and harmoniously to prevent or identify the risk of harm to children.

All paediatricians should have the knowledge, skills and training to contribute to the care of such children, but the named paediatrician has the responsibility for leading this work.

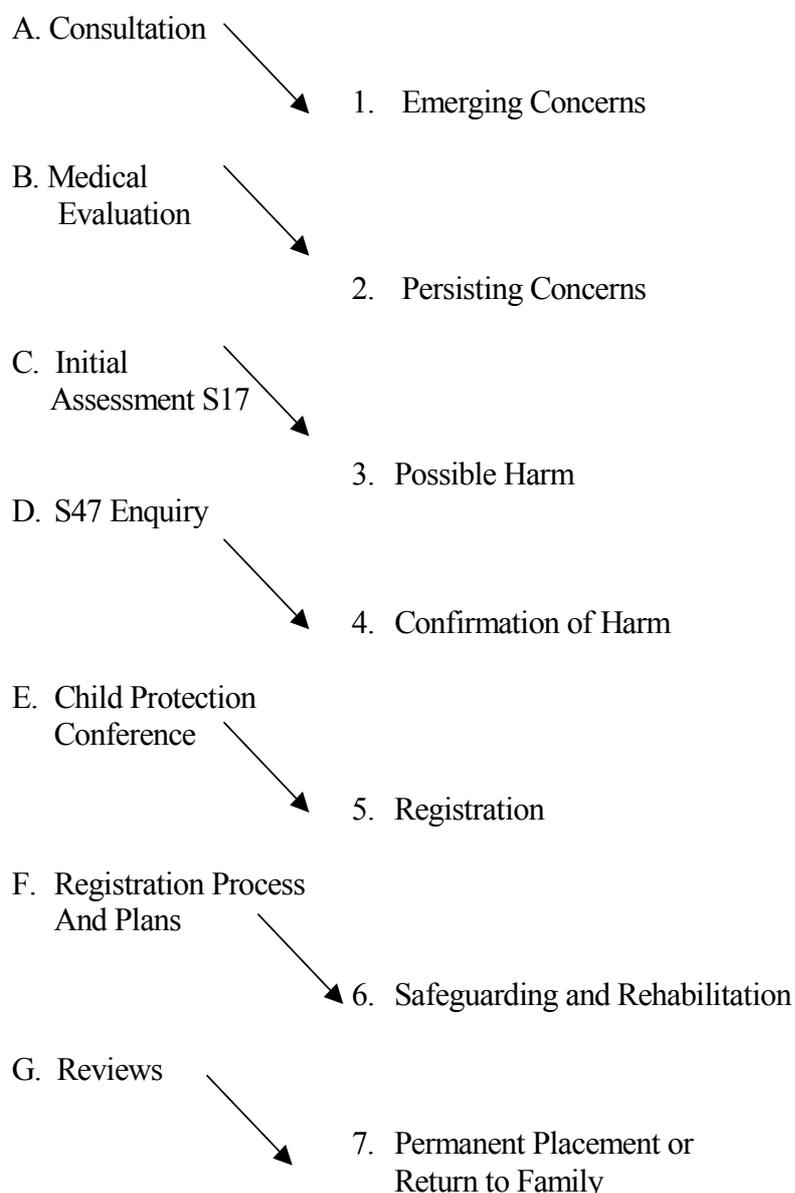
At any stage in this scheme there may be:

- a) A need to safeguard the child urgently when one may move immediately to protection, and quickly to a child protection conference (Section 47 Children Act).
- b) A need to safeguard the child which is not so urgent or immediate.
- c) An explanation of the symptoms which shows they were not fabricated or induced. It is inevitable that some children will be rightly investigated over concerns about FII who are found to have organic disease. We need to explore ways of minimising the stress for the child, the carers and the professionals in this situation. The child will need appropriate treatment with support to the family

and continuing medical review. The family may still have needs which must be assessed and services provided even though the concern about significant harm has resolved.

When the process of evaluation or assessment of a child for the possibility of significant harm comes to an end, that closure needs to be managed well. The current Guidance (Working Together to Safeguard Child) does not cover this in great detail. We need work on how the agencies engage with child and family and collaborate to clarify what has happened and why, to justify conclusions, to discuss queries, to look to the future, and hopefully resolve anger and anxieties. This will include working with families to ensure that their family, friends and neighbours and all professionals understand the explanation of the symptoms.

## 5.2. Procedures and Progressive Assessment



Although the first phases A and B are led by health professionals it is just as important for social workers and police to support individual health professionals in these early stages, as it is for health professionals to be closely involved with the care of children throughout the whole process.

At any stage prior to child protection registration it may be decided the reasons for the child's signs and symptoms are not related to abuse by a carer. The child and family however may require continued provision of service from health and other agencies such as the social services department or specialist education.

## **A. CONSULTATION**

The foundation of all clinical work, not only in FII, is the consultation. The child is presented by a carer to a health worker for consideration of the child's health need. The organisation of health services gives the responsibility for evaluating patients ultimately to a consultant or trained family practitioner. The initial presentation may be to other staff or to trainees. The responsibility for medical diagnosis still ultimately rests with an individual medical practitioner.

Children should be asked about their symptoms and signs as in routine practice. As with possible sexual abuse there should be no direct questioning about the possibility of illness induction at this stage.

Children's consent is needed for investigations if they can understand their purpose. They need information in order to understand them. Failing this parents need information and to give consent.

The skill of consulting work determines the appropriateness of what follows; the possibility of fabrication or illness induction should never be ruled out at the beginning.

### **1. EMERGING CONCERNS**

The first threshold to be crossed is in the mind of the Paediatrician. The concerns may be raised by non-specific feelings that the account does not feel right, or from the attitudes, behaviour and responses of the carer. These are inevitably going to resonate with one's own past experience and raise issues in one's mind about the child's welfare. Some of these triggers are:

- Reported symptoms which do not correlate with any recognisable disease (or with a disease known to be present).
- Signs which do not correlate with any disease.
- Signs which do not correlate with reported symptoms.
- Investigations which do not correlate with signs.
- Treatment for an agreed condition which does not produce the expected effect.
- Repeated presentations, particularly to a variety of doctors and with a variety of problems.

- Specific problems, e.g. apnoea or loss of consciousness, fits, choking or collapse
- History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.
- A past history in the carer of child abuse, self harm or somatising disorder or false allegations of physical or sexual assault.

## **B. MEDICAL EVALUATION OF SIGNS AND SYMPTOMS**

This evaluation is to consider whether there are child welfare concerns which might explain discrepancies in the child's symptoms or response to treatment.

The evaluation should bear in mind the three questions set out in para 5.13 of Working Together which cover the three domains of the Assessment Framework, and which a S17 assessment will consider. If there is actual evidence that symptoms are being fabricated or induced child protection agencies should be informed immediately. More often medical evaluation takes time before it is clear that there are factors operating other than natural disorders. Details are set out in the next section.

## **2. PERSISTING CONCERNS**

At some point in this process it will be clear to the paediatrician that the concerns are not being allayed. When there are PERSISTING CONCERNS there should be a wider assessment by the social services department. The criterion for referral is that the paediatrician has continuing concerns about the child's welfare and not that fabrication or illness induction or harm has been proved.

## **C. INITIAL ASSESSMENT**

The consultant should first have A REFERRAL DISCUSSION with the social services department. This may be in a meeting or in some other way but the record of the discussion should form part of the separate file on the child. Social Services INITIAL ASSESSMENT OF THE CHILD IN NEED (S17) will take place in collaboration with the Consultant paediatrician. It is very important that the initial discussion and assessment plans are formulated at the highest level because continuity is crucial. If a second medical opinion has not been obtained it should be done now. If there is an urgent problem it should be fast-tracked. The Section 17 assessment and any further medical work should be completed within seven days, and there will then be a need for AN INITIAL ASSESSMENT MEETING to reach conclusions. The meeting may conclude that there is no evidence that the child is in need or at risk of harm and the health services will continue to manage the family. If it is established that the child is a child in need, then joint work will continue and it may be appropriate to carry out a core assessment

## **3. POSSIBLE HARM**

The conclusion that the child is at risk of Possible Harm or has suffered harm, and that this is a result of fabrication or illness induction will lead to a STRATEGIC DISCUSSION to decide whether the

criteria are met for initiating a SECTION 47 ENQUIRY.

#### **D. SECTION 47 ENQUIRY**

A Strategy Discussion is required to plan a Section 47 Enquiry. A STRATEGIC MEETING may be the best way to undertake a STRATEGIC DISCUSSION. There may be a need for a series of STRATEGIC DISCUSSIONS before this phase is complete. It is important that a definitive medical opinion is reached during the SECTION 47 ENQUIRY to avoid understandable confusion for statutory child protection staff and controversy later in the courts. It may be preferable to ask for the views of a medical panel which would include a general paediatrician, either a named child protection consultant or a forensic paediatrician, and a paediatrician from a relevant subspecialty. This is preferable to social workers asking for an “expert witness” in fabricated or induced illness.

#### **4. CONFIRMATION OF HARM**

If the risk of harm is confirmed during the SECTION 47 ENQUIRY A CHILD PROTECTION CONFERENCE will be convened. This should take place within fifteen working days of the last STRATEGIC DISCUSSION.

#### **E. CHILD PROTECTION CONFERENCE**

The Child Protection Conference has specific purposes laid down in Working Together to Safeguard Children). Its purpose is:

- To bring together and analyse in an interagency setting the information which has been obtained about the child’s health, development and functioning, and the parents or carers capacity to ensure the child’s safety, and promote the child’s health and development;
- To make judgement about the likelihood of a child suffering significant harm in the future;
- To decide what future action is needed to safeguard the child and promote his or her welfare, how that action will be taken forward, and with what intended outcome

It is absolutely essential that the Consultant paediatrician and GP attend this conference and provide a chronology and a full report. The conference may conclude that there are innocent explanations for the child’s symptoms and no fabrication or induction of illness. Nevertheless it is likely at this stage that concerns about the child and the family and their needs will persist. These must be addressed and the Social Service Department remains involved as well as medical and other agencies. If the conference decided that the child is at continued risk of suffering harm, the child’s name will be placed in the Child Protection Register and there will be a child protection plan which will be reviewed at specified intervals.

If there is found to be significant harm or a risk of significant harm due to fabrication or illness induction the child may need safeguarding via the Family Courts. The decision to initiate action in the

Family Justice system will be taken by the social services department

If the carers actions are considered criminal the police, and then the Criminal Prosecution Service, may seek to take action through the criminal courts as well. It is important to note that if police contemplate a prosecution the suspects rights must be protected under the Police and Criminal Evidence Act 1984. This rules out the Paediatrician confronting the carer with the accusation (unless this is the plan agreed by the police and other members of the child protection conference).

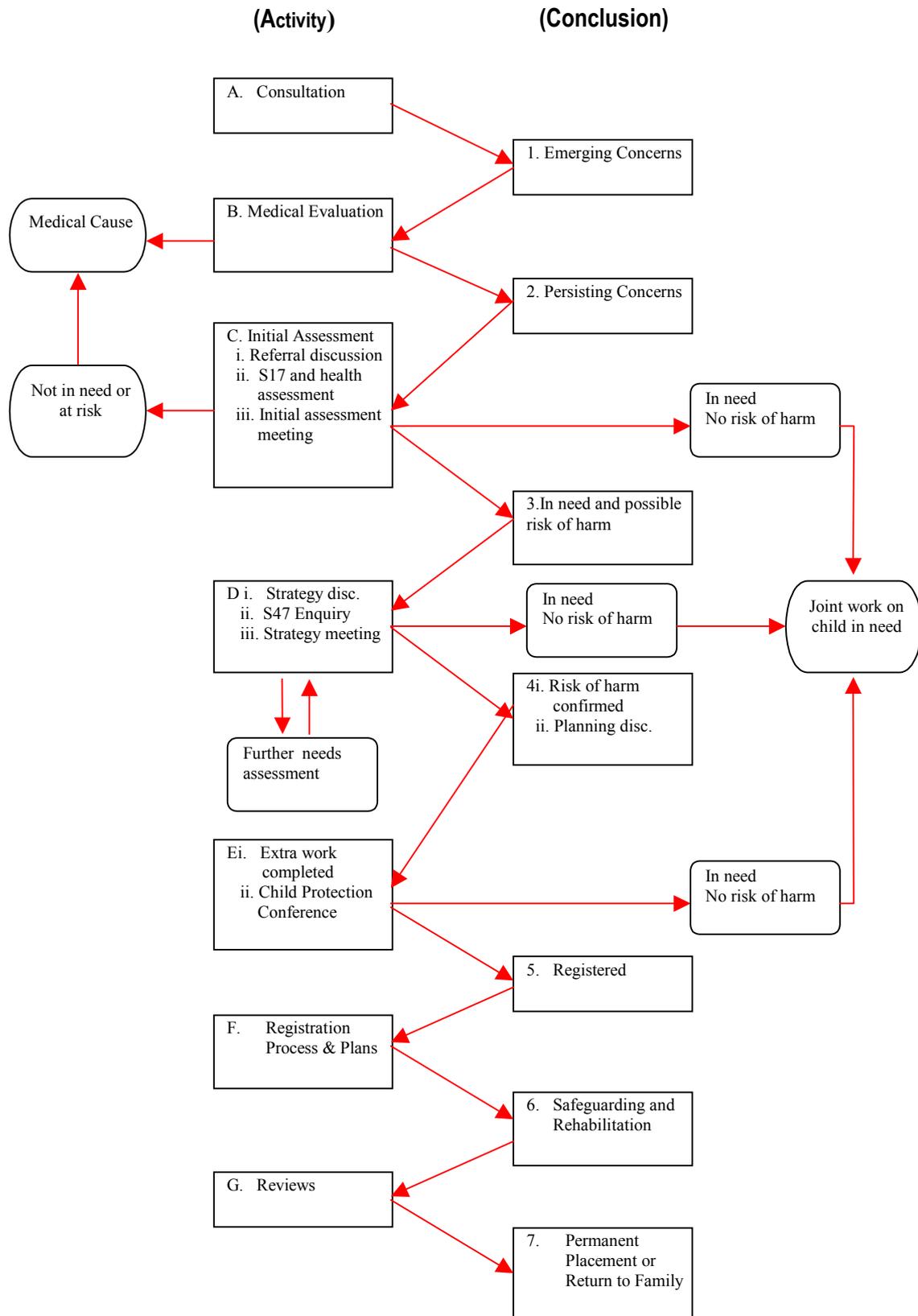
## **5. REGISTRATION**

If the child's name goes onto the Child Protection Register the continuing process is set out in detail in Working Together to Safeguard Children and need not be repeated here except in outline (see F, 6, G, 7). The same Consultant paediatrician should remain involved throughout the whole time. It is unlikely that anybody except the Paediatrician and the GP will maintain a professional medical relationship with the family until the child enters adulthood. Paediatricians must recognise that the police have a central role in child abuse and they have the responsibility to investigate possible criminal actions. The aims of safeguarding or rehabilitating children are not incompatible. However children should not be left "looked after" on a prolonged "temporary" basis. They should be able to look forward to a settled future with or without their biological family.

**Child with Health Problems**

**Child at Risk of Harm**

**Child In Need**



### **5.3 Medical Evaluation of Symptoms and Signs**

#### 1. General Principles

- (i) A careful complete history and clinical examination with a review of all other documentation is essential. The history of particular events must include the pre-event situation, and a description of the onset of the event, and not just the consequences. The notes must detail who gave the history, who took the history, who was present, and the date and time, on every occasion.
- (ii) When the child is acutely ill and harm is therefore clear, and there is a strong suspicion or proof of FII the need for action is obvious.

If there are concerns that the child is at risk of such harm and the child's safety is an issue, the child should be admitted for close observation until the medical evaluation is complete.

- (iii) When the child's health and safety are more secure, the priority is to obtain as much information about the child and family as possible. The history should be taken separately from each family member, carer or other witness to obtain corroboration. This will include staff in hospital, particularly in the A&E Department, and in primary care which the Liaison Health Visitor may be well placed to co-ordinate. Sensitively made enquires from nurseries and schools may also be helpful.
- (iv) The inappropriate use of medications prescribed for the child or even for other members of the family or friends is common in illness induction. Details of any prescribed drugs should be obtained from the GP as well as the carers. Health professionals may have access to these substances. Carers should be questioned about what "over the counter" (OTC) medications they have, and illegal substances must not be forgotten. Any information about available drugs or drugs which might lead to the particular clinical presentation will help with toxicology investigation.
- (v) ALTE. When an episode of an apparent life threatening event is reported, the main difficulty is to obtain a corroborated history in detail of the precise evolution of the event from the time at which the child was last well. If the child has as usual fully recovered the main reason for admission is to observe such an event. One's concern is raised if the episode leads to bleeding from the nose and/or mouth, and if there are petechial haemorrhages around the neck or on the face. It would be unusual if such episodes began after the baby was 6 months old. It is always helpful if at least some of the events have occurred from the initiation in the presence of a reliable independent observer. Not all

episodes will be induced, some will be fabricated, and when these episodes only occur during daytime hours and the child has never been seen by anybody to be unwell following this, ones concerns are obviously raised.

- (vi) It is essential that everything that happens to a child during an inpatient stay is recorded in minute detail. This includes prior stipulation of who is to record routine observations and obtain samples. It is of crucial importance to record whether episodes happen to the child only when the carer is present, or at times too when they are absent. The observation of the mother and other carers with the child while preparing feeds or feeding, bathing, changing, playing or having tests will give an understanding of the relationship between the child and the carer. However this must all be meticulously recorded with times and clear signatures. The “Newcastle” flow charts of events are very useful to document the whole chronology of symptoms and who was present.
- (vii) It may be wise to space the evaluation over several days to allow time for the necessary consultations and review of results. If suspicion of induced illness becomes stronger as a result of observation or further adverse events, immediate consultation with a named paediatrician for child protection is required with urgent referral to Social Services.

## 2. Tests in specific circumstances:

### 2.1. Coma, drowsiness and seizures:

If a BM glucose estimation stick suggests hypoglycaemia, take a true blood sugar (fluoride oxalate) and 2ml of blood (in lithium heparin or serum) for C peptide and insulin. If insulin is present/high and levels of C peptide low, the implication is that exogenous insulin has been given. It is important to separate these samples as soon as possible. Look also for evidence of oral hypoglycaemics. Hyperglycaemia may be due to “stress” or rebound after hypoglycaemia.

#### Drugs/hormones

It is unhelpful to collect samples and send off for “toxicology screen”. Untargeted analysis for unknown administered compounds is not possible – the chemistry is too diverse even within one class, e.g. drugs and the methodologies very different. The preferred sample will vary, e.g. whole blood (EDTA) for some heavy metals, urine for drugs of abuse, serum for hormones and common medications. Sample volume is likely to dictate extent of investigations so get as much as possible.

Collect urine specimens in the 6 hours after a “collapse” or suspected poisoning in a plain bottle and freeze them until they can be analysed. Ensure that the child’s name,

and date and time of collection is clearly documented. Ensure that the time and amount of any medication the child has been given by nursing staff is clearly documented.

In suspected poisoning collect specimens of vomit, stool, serum as well as urine – all clearly labelled. Discuss the case with the clinical biochemist or toxicologist and ensure they are taken to the lab where they are appropriately stored initially and then analysed. Make sure that relevant samples are able to be stored securely in the lab freezer. Wrongly labelled or lost samples may crucially delay an investigation.

Consider administration of prescribed or OTC medication or available compounds (e.g. health care worker) and depending on presentation: Collect serum (preferred) or plasma (Li Hep anticoagulant) and a random urine ensuring timing of samples is noted on the request form and sample container. Further urines may be recommended.

Drugs – Most labs measure classes of drugs of abuse by immunoassay so it is important that both clinicians and biochemist know what has been looked for or reliably excluded. Thin layer chromatography screening may identify a range of compounds but again it is necessary to know the limitations of what can and can not be detected.

#### Other substances

E.g. Lead, mercury and some other heavy metals – whole blood is required (EDTA/Li Hep) although urine may also be useful. A difficulty arises where administered compounds occur naturally (e.g. catecholamines, steroids). It may be appropriate to look at metabolite profiles in urine by GC/mass spectrometry.

#### Salt administration

Biochemical estimations should be made at least of sodium and chloride, potassium creatinine and acid base balance on blood and urine. Check urine osmolality. Fluid balance details including weight must be accurately measured and recorded. A raised serum sodium may be the alerting factor as this result is soon available. Sodium output in a timed urine sample is the gold standard. The sodium/creatinine ratio in urine should be measured: a ratio over 100 indicates salt poisoning. The fractional sodium excretion may also help.

Gastric aspirate may be difficult to analyse locally for sodium as the extreme pH can interfere with the electrodes, but any relevant material including feeds should

be collected and stored appropriately.

#### Seizures

Prolactin rises immediately after a tonic clonic seizure, and if blood is taken in the first hour, this may help distinguish between pseudo and true seizures – however this is usually not possible as often the presentation is a history of seizures and so repeated EEGs and prolonged EEGs with video monitoring may be required.

#### 2.2. Apparent bleeding disorders

Full blood count and coagulation studies. Evidence of trauma. If blood is present in samples, e.g. urine, ask haematology if they can group the blood in the specimen and compare it to the child's blood group and if the same group, check the DNA profile. (A forensic laboratory may be necessary).

#### 2.3 Legal implications

Chain of custody packs for sample collection are available to purchase. The less legal alternative is to ensure traceability of the sample from collection to production of a result of storage of the samples by informing the laboratory what is happening or delivering samples by hand so that further handling can be accurately documented.

### **5.4. *The Paediatrician and Colleagues in the Child Health Team***

Nursing and other members of the Child Health Team have their own professional organisations, and we do not presume to make statements on their behalf. However we work so closely together that Paediatricians need to be aware of issues which affect our colleagues. We have therefore included views particularly from nursing colleagues on the paediatrician's role.

It is important in FII as in all child protection matters that we recognise our inter-dependence, and our need to work as a team with other professionals. Indeed to see independence as isolation rather than the basis for inter-dependence introduces extra hazards for children and for ourselves. We all need interagency training, clear procedural plans, and understanding of who to turn to. We may all feel shocked, guilty and angry at the possibility of having been duped, such that at times we cannot believe parents' behaviour and our lack of awareness. We all have difficulty in facing angry parents and need training to do this as well as support at the time.

Although the doctor feels duped by the parent, she/he has some control over the situation. The doctor may rightly have to conceal concern from nurses and others, who then feel doubly deceived. Some

staff, like health visitors, may feel anxiety that they are carrying the responsibility for the child's safety, while they are also professionally isolated. Everybody should know who they should turn to for support. Paediatricians must be approachable and available.

The strain this imposes on trust between individuals can be reduced by open discussion within closed meetings. If doctors, nurses, therapists, mental health professionals, social workers, all meet on a regular basis to discuss individual children and their own feelings, trust will have been strengthened by experience. The protocols will have been honed by joint decisions, the arrangements about keeping records and confidentiality will be in place and easily accessible. The named doctor and the named nurse will be known and can provide guidance and support. This will reduce the chance of individuals being isolated and vulnerable to collusion or threats from aggressive parents and their supporters. The weekly psychosocial ward meetings which take place in many units and include colleagues from child psychology or psychiatry are one example of the opportunity to discuss difficult issues confidentially.

The close relationship between some carers, e.g. parents and nursing staff, may obscure the fact that the professionals' main relationship is with the patient. The patient is the child not the parents. Remembering this may help staff when it is necessary in the interests of the child to refrain from sharing concerns with parents at that point.

Professionals working in a non-paediatric setting have the same needs but can have particular problems if they suspect something odd in a child who may be under a surgeon, or in the Accident and Emergency Department. The Consultant paediatricians should have clear written authority from the Trust for shared consultant care of every child under any NHS consultant, and should make themselves known to the staff in those departments.

## **5.5 Records**

Careful record keeping has been emphasised. However there remain some unclear areas. It is lawful to keep some confidential notes separate from the main records so that they are not freely available. Staff must know that these exist and must have been carefully briefed and feel part of the care plan.

Parents have the right on behalf of their child to apply to see all the notes. However there are reasons to enable disclosure to be restricted. One is when parts of the notes contain entries which it would not be in the interests of the child to disclose. Another is when they contain information which will reveal the identity of third parties who have imparted information in confidence. It is particularly important in possible cases of FII to make quite sure that disclosure of the notes will not be granted by the Medical Records Department without reference to the Consultant Paediatrician responsible for the case.

A separate issue is accessibility of confidential records to other staff. It is acknowledged that to keep such information in the medical file allows access to more people than necessary. However to keep all such records separately involves a risk to the child. They could be admitted acutely unwell and nobody would be aware of the important background issues or the involvement of other agencies. A system may be needed which alerts staff to the fact that other information is available elsewhere on proper request.

Finally in cases of acute induced illness it is important that no system enables carers to know that their activities are under observation. Some authorities have formulated their own plans for these problems (e.g. Newcastle, North Staffordshire and Hampshire) but there is no generally agreed procedure.

## **5.6 Overt Surveillance, Overt Video Monitoring and Physiological Monitoring**

### a) Overt Surveillance

Surveillance has the purpose of confirming that reported episodes have occurred spontaneously, and this can be very helpful in confirming that parents' reports are not fabricated. This may need to be done in an inpatient setting if the presentation is with an event that could be life threatening.

The first kind of surveillance is that of carefully observed and recorded observations of the child while in hospital. It is absolutely crucial that staff understand the importance of recording events clearly, accurately and in detail to distinguish between what was reported, what was seen, what time things happened, what times drugs were administered, who actually gave them, who actually collected specimens, who handled them, etc.

It is equally important that the records of community child health contacts and assessments are obtained and carefully documented. All events from primary care, community and both DGH and tertiary hospital records, should be collated for all members of the family and close contacts. They should be charted in parallel according to date in every case where it is possible that a child may be at risk of harm. The clarity of thought will improve decision making and assist court actions.

### b) Overt Video Monitoring

There is increasing use of video surveillance for security in hospitals to try to prevent theft (including theft of infants) or vandalism. Videos may also be used to provide nursing surveil-

lance of children or babies who may not otherwise be easily observable. Accidental recording of events involving babies and children should be sought on these routine recordings.

In addition parents who report symptoms of uncertain nature, e.g. possible convulsions, can be asked to use their own or a loaned video camera to record the events at home. Subsequently ambulatory EEG/video monitoring may be appropriate.

c) Physiological Monitoring

There is a second situation in which there is a need for more detailed investigation of infants and children suffering from recurrent, apparent life-threatening events or other unexplained episodes. Physiological monitoring over a prolonged period can sometimes be a great help in understanding the mechanism. Infra-red video recording can be particularly helpful, specifically where episodes of abnormal breathing pattern, abnormal movement, oxygen, saturations, bradycardia or other identified physiological disturbance occur. They may by chance record such episodes in the absence of any physical contact from parent or carer. This can take place under medical supervision in the hospital and the home. Although the video recording may not elucidate the nature or cause of the episodes, it does make clear that they are not occurring as a result of parental intervention. The role of physiological investigations is to identify or exclude serious natural disturbances of physiology as a cause for apparent life threatening events. This means that covert video surveillance should not be carried out in this setting.

## **5.7 Covert Video Surveillance**

Deliberate video surveillance of children with unexplained symptoms may be part of the search for physical explanations. However it has shown other scenarios particularly with reported episodes of apnoea, choking or convulsions. Records showing superimposed airway obstruction have been of basic importance in understanding mechanisms which can lead to a child having recurrent, apparently life threatening events. An assault on a child may not be by the person who was thought to be responsible, or there may be other explanations. However there is now established that proof that smothering does occur. The College has already produced guidelines.

Surveillance of the child also involves surveillance of the carers and their rights must be protected. This therefore becomes the responsibility of the police who can be authorised to undertake surveillance of possible criminal activities. In future they will undertake any covert video surveillance after consultation. This would usually take place in the District General Hospital and requires the consent of the Chief Executive. There are now fewer cases where this is needed.

## **5.8. Separation from the Carer**

The debate continues over whether separation is justifiable as a diagnostic means to determine whether symptoms are related to fabrication or induction by a carer. It may sometimes be essential. Of course one does not wish to separate children from parents without good cause, and one must be able to provide as good a caring, and consistent and loving environment as is possible. Intensive supervision of parents may be extremely difficult on the modern day children's ward because of the rapid daily turnover of patients, doctors and nurses, and determined parents can repeatedly outwit the staff. It is also difficult to provide good surrogate care. It is nowadays less likely that one would be able to arrange total exclusion of parents on a voluntary basis. This should not prevent us from asking the parents if they would agree to this if they understand how useful this would be to establish a diagnosis and indeed free them from suspicion. Separation has been of enormous use in the past in establishing that emotional deprivation is the cause of growth failure. However growth in length and weight is easily measured and one needs clear parameters and criteria for measuring changes which occur in the home environment compared with the "protected" situation. The periodicity of the illness has to be taken into account, and if the episodes reported are very frequent, then the time of separation can therefore be relatively short. Quite often exclusion is needed for a period of two weeks or more. During this time one has to be sure that parents cannot have any indirect effect on the child, either by the use of other people, or any other mechanism e.g. by things which have been left behind.

Although this is potentially an extraordinarily useful mechanism for establishing both innocence and implication in causation, it should be done after initial procedures have been carefully evaluated, and when a good environment can be provided. It may prevent iatrogenic harm to the child from unnecessary and invasive investigation. It is important to help both social services and the courts and the parents understand that doing this is not a judgement, but it is being done as a diagnostic manoeuvre and may well show that the problem persists in the absence of the parents. The family courts will need clear evidence for the need to make an order for no contact, and any application would be made by the local authority. The parameters to be recorded, the length of separation and the significance of findings must be agreed before the separation.

## **5.9 Medical Review**

It may be helpful to invite a consultant colleague, not involved in the clinical care of the patient, to review the notes to give an opinion as to whether any organic condition may have been overlooked. In the face of possible fabricated or induced illness, paediatricians need to consider carefully the need for extensive medical investigation to exclude all possible organic illness. The improbability of an obscure diagnosis needs to be balanced against the probability of harm from unnecessary investigation or treatment. This harm includes the effect of continued investigation on parents who are anxious, and who conclude that the doctors believe there must be some undiscovered cause or they

would not do these tests.

When there are recurring or chronic symptoms which may be partly or totally fabricated, but there is no suspicion of induced illness, the risk of harm to the child may be uncertain. It is important to remember that the assessment of potential harm does not depend on having excluded every rare condition and must not be ignored or delayed until “medical” tests are finished. An active liaison child psychiatrist or the inclusion of a child psychologist in the team is invaluable. If we are to improve our care of children we need to be able to involve colleagues in social services and the police before our concerns are confirmed, and therefore before an actual referral has been made. The presence in the paediatric team of a social worker with expertise in work with children and families is essential. A skilled and active paediatric social worker will have already created a greater awareness of the social and emotional issues for families, and medical and nursing teams will therefore be more effective.

The way consultants review difficult cases will vary. Some will work alone, others through ward rounds, and some have regular or *ad hoc* multidisciplinary meetings. They will need to obtain information and opinions and consider:

- a) What is the cause of the child’s symptoms or signs. This will include gathering together all available information on the medical and social background of the child and family, and the observations of staff in hospital and outside.
- b) What further, if anything should be done to exclude any likely organic diagnosis.
- c) What information should be given to the family and child about the symptoms? It is important that concern about FII not be voiced before consultation with Social Services. The continuing dialogue with parents should be maintained by the consultant paediatrician who should explain (and record) the continuing paediatric uncertainty about the child’s state of health and what is causing the problem.

The Paediatrician and health colleagues have to make their medical evaluation of the cause of the illness, and the signs and symptoms. The possibility of fabricated or induced illness should be considered, as should the possibility that the child’s health or development is being, or is likely to be impaired. These are difficult questions, and the advice of the Named Doctor and personal discussion with a senior member of the Social Service Child Protection Team can clarify many individual situations. We should not wait until harm or fabrication or illness induction have been confirmed. If we have no adequate medical explanation and we have concerns about the child’s welfare or the possibility of harm, we should proceed to the next stage of assessment of the child’s needs.

**FLOW CHART OF EVENTS**

Date	Site	Witness	Type of Episode Symptoms	Examination Finding (A)	Investigations	Treatment (B)	Duration of stay (C)	Presumptive Diagnosis	Discrepancies

## **6. COLLABORATION WITH THE STATUTORY SERVICES**

### **6.1 Statutory Guidance**

Essential guidance is contained in the following documents which must be consulted.

- Working Together to Safeguard Children, Department of Health 1999
- Assessing Children In Need and Their Families, Department of Health 2000
- Safeguarding Children in whom Illness is Induced or Fabricated by Carers with Parenting Responsibilities, Consultation Document, Department of Health 2001.

### **6.2 Working With the Police**

This should be read in conjunction with paragraphs 3.57 to 3.64 of *Working Together to Safeguard Children* (WT), which sets out several principles applying to the police role in child protection investigations.

The local relationship between the senior police officers working in the child protection arena and their counterparts in Paediatrics, should be fostered so that a feeling of trust and understanding emerges. Depending on the structure of the area's police force, senior detectives either from child protection units, divisional police stations, or serious crime teams may be designated to manage criminal investigations where fabricated or induced illness is identified. They need to understand the difficulties faced by doctors when they are treating children with undiagnosed symptoms. Ideally, they should get to know each other through ACPC meetings or liaison events, so that when an incident occurs there is already a degree of rapport to build upon.

The police have a role in assisting paediatricians in their work by gathering information. There are many low key enquiries which can be made by the Police before any investigation is launched. Paediatricians need to be reassured that simple background checks, or asking Police to review the family history with the doctor can be very helpful in building up an accurate picture.

#### **Area Child Protection Committee**

It is accepted that Fabricated or Induced Illness takes many forms, and at the lower end of the continuum, e.g. over anxious parenting, there is likely to be no need for police involvement. The

Police have a statutory role in multi-disciplinary child protection procedures, and it is important that once the child is identified as suffering, or likely to suffer harm, a referral is made. A difficult area is that of medical tests. If, for example, a child unnecessarily has a blood sample taken, or is given a barium meal and x-rayed, because of a deceitful carer, it could be argued that a criminal assault (by the carer) has occurred, but many doctors would not see these procedures as causing harm to the child. There is no definitive answer to the question of the threshold, but the Police would like Paediatricians to “ask the difficult question” earlier, and if they suspect a child is being abused refer it promptly, rather than when they are sure. Failure to alert the Police or Social Services early enough is likely, in proven cases, to lead to greater suffering by the child and hamper the chances of successfully concluding the enquiry.

It is also crucial for any ongoing enquiry, that the carer is not made aware at this stage of child welfare concerns. This is a difficult issue, which goes against the culture of openness within the Health Service. If word leaks out that doctors suspect the carer, the likely consequence is that the carer will change tactics to a more subtle form of abuse, or else remove the child to a different medical location and start again. In order to ensure the child’s safety, the Consultant paediatrician may need to restrict his or her suspicions to as small a group of people as possible.

Perpetrators of FII will rarely admit any wrongdoing without firm evidence, and even then confessions are often minimised to what can be proved. One can actually place the child in more danger therefore, by carrying out a less than thorough enquiry, because it is unlikely that a perpetrator will stop the abuse altogether. Police are encouraged to appoint a senior detective to work on these cases, and to gather the evidence in a professional and careful way. To protect the child in the long term, a substantial level of evidence is required.

Any Police investigation would be greatly helped if the Consultant paediatrician ensured a regime of detailed note taking by all staff. Notes should be timed, dated and signed legibly, and most importantly should be kept discreetly, separate from any notes to which the carer has access. Any statement needed for evidence in court proceedings can simply be based around the notes made at the time.

**It is essential that the consultant paediatrician attends, and takes a key role in any multi-agency strategy discussion held in accordance with *Working Together to Safeguard Children*. If they are able to prepare a full summary of the medical history’s of the child, his/her siblings and the carer, it would be extremely valuable in planning an approach to the child’s welfare.**

Paediatricians have a right to expect the police to carry out any work within a hospital sensitively and delicately. If the police are involved in taking action within the hospital, there must be a great

deal of understanding about the considerations of staff and patients, with any disruption to normal ward life being kept to a minimum. This may apply particularly if an arrest needs to be made in a hospital, and the multi-agency management team should consider the arrest strategy well beforehand.

While the child's signs and symptoms are being evaluated and before concerns are confirmed, the consultant paediatrician should retain the lead role, and the priority of police officers should be to assist the paediatrician with identification of the reason for the child's symptoms. The balance will change when it becomes clear that a crime appears to have been committed, and the Police will need to ensure the rights of the suspect are upheld and that evidence is gathered in a fair and appropriate way.

It is the role of the Police to investigate cases of possible criminal action and they are the prime agency responsible for gathering evidence in connection with criminal cases. There is often 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 and wellbeing of the child. It may well be that enquires made by the police could show there was definitely an organic cause for the child's symptoms, rather than any abuse by the carer, thereby allowing medical staff to concentrate solely on looking for a genuine condition. In any case, the police will work within the full multi-agency framework, and all relevant information will be shared with those treating the child. Any evidence gathering by the police will be shared with the Consultant paediatrician, and will normally be available for use by the Local Authority in care proceedings

Any suspected case of Fabricated or Induced Illness may also have involved the commission of a crime, and if so the police should always have been involved in accordance with *Working Together to Safeguard Children* paragraph 5.8. Events such as smothering or poisoning are clearly criminal assaults, but more subtle forms of abuse such as wilfully interfering with feeding lines, or causing unnecessary medical intervention to be undertaken, may also be criminal acts.

The police use technical means to gather evidence in many types of criminal enquiry, and it may be appropriate to use covert video surveillance in dangerous cases of fabricated or induced illness. In any case where this is indicated to be appropriate either by the multi-agency strategy discussion, or initiated by the police themselves, they will supply any equipment required and be responsible for monitoring and managing the process. The Police are bound by the Human Rights Act 1998, and the Regulation of Investigatory Powers Act 2000, and therefore any operations within this context will be carefully controlled and Police managers will be fully accountable. On no account should doctors or other professionals independently carry out covert video surveillance, given that if concern about child abuse is high enough to consider such a technique, the threshold must have been passed whereby the

Police and Social Services should have been involved.

Police officers may not have a full understanding of the distinctions between different disciplines within the medical profession, e.g. the differences between surgeons and physician, neurologist or gastroenterologist. A classic example is for the Police to ask for children's x-rays to be reported on by a Radiologist, not realising that a Paediatric Radiologist would give a better interpretation.

It is important that the lead consultant paediatrician assists them in understanding the expertise of the various disciplines.

If an investigation does show that a carer is deliberately abusing the child to a criminal degree, it is not appropriate for a paediatrician to "confront" the perpetrator, or to try and get them to admit what they have been doing.

If the carer now becomes a suspect, their rights under the Police and Criminal Evidence Act 1984 (e.g. being cautioned, having access to a solicitor and the interview being tape-recorded) must be upheld. This is a source of possible tension which requires careful management.

*Case Example 12: A baby had persistent diarrhoea due to allergic colitis. This required special nasogastric feeds for some months which were then discontinued. At the age of 7 he was referred for surgery for a hernia and his mother asked if he could also have a gastrostomy tube. This was organised without referral to the original centre. It transpired that the parents had divorced, mother had a new partner who suggested they could raise some money for a trip to Disneyland. The step-father was found to have several convictions for fraud. The child was weaned off gastrostomy feeds onto normal feeds.*

*Case Example 13: A young single, unsupported mother with mild learning difficulties had told Social Services that she was not coping but no help had been provided. The baby was admitted at 18 months as mother reported repeated vomiting and diarrhoea and the baby did lose significant amounts of weight. In hospital a nurse observed mother putting her fingers down the baby's throat and the baby vomited. Mother said she was clearing vomit from the baby's throat. After confrontation the vomiting stopped and the child regained all the lost weight. Social Services declined to hold a Child Protection Conference.*

## **7. TRAINING FOR PAEDIATRICIANS**

Paediatricians need training so that they can recognise and manage situations when they think that children are being used for parents' needs.

This may require in some cases a shift in emphasis so that the child truly becomes the primary client. Parents need to be listened to but not always agreed with. The needs of the children must be held as paramount. Understanding the dynamics in consultation is essential for success in all clinical situations. The issues in fabricated illness are a model which could be used for training in consultation skills. Experience and training in Fabricated or Induced Illness should be a compulsory part of the training programme for paediatricians at SHO and SpR level, in addition to training in the psychological components in physical disorders.

If the Paediatrician does not take responsibility for recognising and dealing with fabricated or induced illness, then the multiagency approach is unlikely to be able to safeguard the child. The Paediatrician who denies this form of abuse or who meets his or her own needs through meeting parents needs will unwittingly contribute to the harm that the child suffers.

Effective multi-agency working together requires trust and an understanding of each other's roles. It also requires an understanding of the limits of the resources available to other agencies to protect children.

What training must address is a change in attitude amongst some doctors and hospital staff so that it becomes possible not only to recognise abuse, but also to report it and ensure the child's welfare is safeguarded and promoted. This can lead to conflict in the doctor-parent relationship that can be threatening for staff and parents and which poses considerable challenges.

In addition there should be a training for all Paediatricians in recognition and the initial management of FII. There is a need for forensic paediatric expertise in particular areas such as child sexual abuse. However we do not want a situation in which there are paediatricians who only see child abuse cases without continuing work with general paediatric problems. Nor should other consultants become de-skilled by passing all such work onto a Designated or Named consultant at an early stage.

The current training in paediatrics emphasises medical disease models rather than the childcare perspective of children's problems. For example everyone knows the laboratory tests that can be done in failure to thrive but fewer are competent at extracting a detailed dietary or feeding history or in defining the emotional components of this problem. It is not surprising that the behavioural and interactional clues in the recognition of abuse are not always appreciated. A shift towards a more behavioural science approach in medical training generally would assist doctors in recognising abuse.

Training also needs to include the obstacles which stand in the way of paediatricians recognising the condition and not continuing to investigate. They include the following:

- Discomfort with not believing a parent, on whose history paediatricians rely;
- Discomfort with not understanding the child's presentation;
- Concern about missing a treatable condition;
- Rising to the challenge of making a diagnosis of an obscure condition, especially if reportedly 'missed' by another doctor;
- Concern about litigation, complaints to Trust or the GMC.

Training should cover:

1. Clinical skills in consultations.
2. Physical and emotional presentations, including a development and behavioural perspective.
3. Epidemiology, current research and outcomes
4. Understanding the "Framework for assessment of the child and family in need". This includes making enquiries where there are concerns about a child's welfare.
5. Court skills training
6. Understanding the respective role of the social worker, police and other professionals, and how to work together effectively to ensure the child's welfare is safeguarded and promoted.
7. Role of the mental health team for child and carers.

Training may be offered at 3 levels:

**Level 1:**

- *Training in recognition of fabrication or induced illness and of significant harm to children*
- *Different presentations*
- *Evaluation of emerging concerns in acute and chronic situations*
- *Referral pathways to more specialist services*
- *Statutory assessments*

**Level 2:**

Is for those involved in child protection and in addition to Level 1 training this should cover:

- *A strong multi agency element*

- *Knowledge of psychiatric and psychological issues*
- *Risk assessment*
- *Court skills training*
- *Report and statement writing*
- *Recognition of the consequences of the effect of criminal investigation and statutory action*
- *Role of forensic paediatricians, psychiatrists and psychologists*

**Level 3:** for tertiary specialists in child protection:

The role of the “expert witness” and sufficient training to be a credible expert.

*Case Example 14: A mother moved into the area having had three previous children who died in infancy as cot deaths. Previous Social Services and Paediatricians said she should not care for the new baby. On looking more carefully she had one child alive and well by her first partner, and then three deaths by her second partner and she was now in her fifth pregnancy with a third partner. Of the three babies who died, one had had a fundoplication for reflux, and one had a fatty liver at post mortem. The investigations had not excluded a recessive disorder. This was a new partner and social circumstances had completely changed. A Paediatrician and a GP supported close supervision of the new baby who thrived, as has a subsequent child by the new partner and the original child has been returned to their care.*

*Case Example 15: A 10 year old girl presented with recurrent hip and groin pain and had been seen by numerous consultants in medicine, surgery, gynaecology, orthopaedics, A&E, etc. Her father was on disability benefit. Her brother was on home education with a diagnosis of ADHD but seemed to behave normally when he visited his sister on the ward. With the help of physiotherapy the girl was rehabilitated and the family returned frequently to A&E and outpatients. Although they prefer to see junior staff the rule has been made that one particular consultant sees the child on every hospital contact and this has reduced the attendance rate.*

*Case Example 16: A 4 year old child who had been seen by every other consultant in the Department was brought in a pushchair, her mother saying she cried constantly with pain. The child played happily during the consultation and no significant abnormalities were found. The mother is disabled by a chronic neurological disorder and father has given up work to be her carer. Mother's father is in prison for sexually abusing the family, and there is a great deal of family conflict. It became clear that her mother was very scared of her daughter being separated from her, and was therefore labelling her daughter as ill and disabled.*

## **8. COMPLAINTS PROCEDURES**

Complaints against members of the Child Health Team which are related to their work in child abuse cases need careful investigation. One may uncover serious errors of omission or commission, or deliberate malign allegations by abusing parents and their supporters. The procedures must be able to ensure public confidence that errors will be identified, however, we must not allow child protection work to be inhibited by fear. We suggest that Royal Colleges and the Department of Health should consider whether changes should be made to avoid the deficiencies arising from current guidance that each organisation should make its own enquiries. We believe that these are not adequate to deal with the complexities in complaints which may involve child protection and multi-disciplinary work. We suggest:

1. Any complaint from the family should be first investigated as a complaint against the employing health or social service departments. **The health trust or social service department should not be empowered to conduct this investigation, without involving the other body who carries joint responsibility for child protection.** It should be confirmed that individuals have followed the local policies and procedures, and the management plan agreed jointly for an individual child.
2. If in the course of the investigation an individual is found to have failed to follow joint policies and decisions, then they should be investigated as an individual. The responsible employing authorities, i.e. social services and health, should work in collaboration and with legal advice. The members of the investigating group should have appropriate experience and qualifications, and come from outside the district.
3. When a complaint is made against a paediatrician the trust must ascertain whether this is being made to block consideration of fabrication or other forms of child abuse. Access to notes should not be granted automatically in any case unless it is clear that this is in the best interest of the patient (i.e. the child) and that there is no infringement of the rights of third parties quoted in the records.
4. In complaints about child abuse cases there should be a comprehensive investigation which includes an attempt to understand the motivation and circumstances of the family.
5. A Designated Paediatrician for child protection should always be part of investigation at any level.
6. Complaints about quite different issues may originate in dissatisfaction with the professional over the part they may have previously played in child abuse proceedings.

## **9. RECOMMENDATIONS**

(These are not in order of priority)

1. Paediatricians need to recognise that fabrication of symptoms or signs, and sometimes the induction of illness, by carers may be the explanation for a child's illness.
2. Fabrication or induced illness by a carer is the preferred terminology for this form of behaviour which is likely to cause significant harm to a child.
3. Paediatricians need to be aware of the very wide range of illness and symptomatology which may result from fabrication or illness induction by a carer.
4. Paediatricians need to be aware of the very wide range and severity of harm that may result, ranging from the induction of acute life-threatening illness to the less well researched harm from verbal fabrication of symptoms which overlaps with excessive anxiety and misunderstanding by the carer.
5. Paediatricians need to recognise that fabrication of symptoms or signs without actual physical injury by the carer does result in harm to the child from unnecessary investigation and treatment.
6. Paediatricians need to be aware of the potential for long term harm as a result of fabrication or illness induction.
7. When suspicion of fabricated or induced illness first arises, the paediatrician has a duty to consult widely in an attempt to confirm or refute the suspicions.
8. A review of all available health records for the child with careful documentation of all events and the parties involved can be very helpful in establishing whether fabrication or illness induction has taken place.
9. When concerns of fabrication or induced illness persist after consultation and review, the risk of significant harm becomes a priority and requires assessment within the framework of child protection.
10. Covert video surveillance is required when life threatening induced illness is sus-

pected and satisfactory evidence cannot be obtained in any other way. It should only be considered by a child protection strategy meeting and can only be instituted by the police authority according to their guidelines.

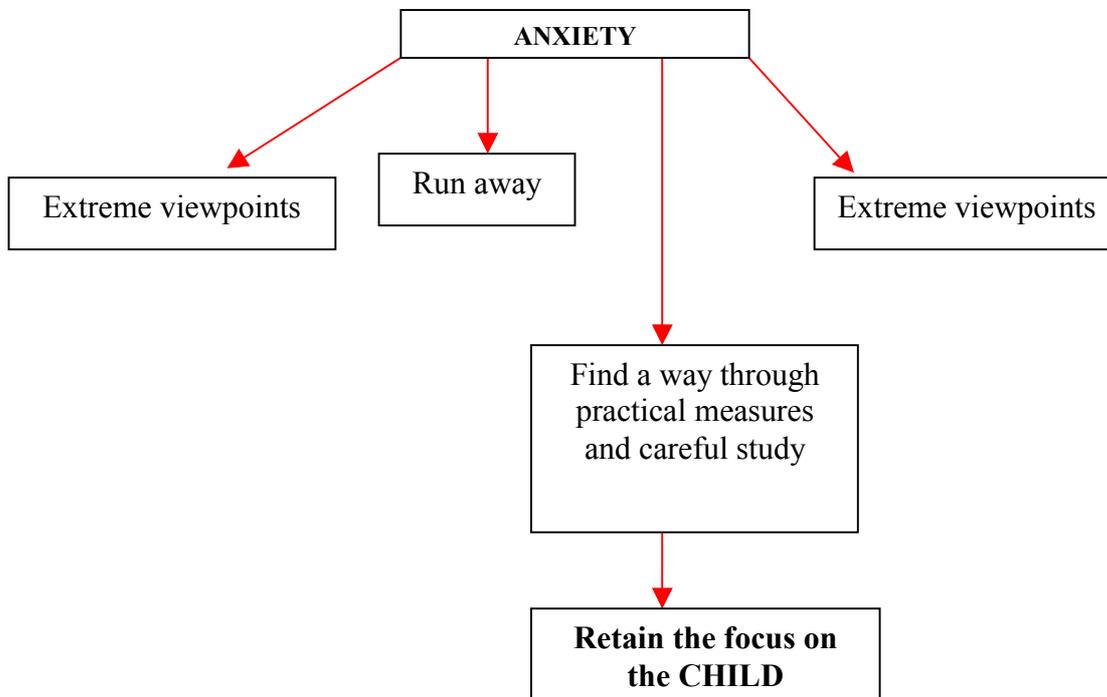
11. Paediatricians who suspect fabrication or induced illness need to retain a central role throughout the continuing assessment and enquire whether the child is reunited to his/her parents or not.
12. Fabrication or induced illness, and the carer behaviour giving rise to it, need to form a specific part of the core curriculum for training all paediatricians.
13. Failure to scrutinise the records of all members of the family, including siblings, can lead to a lack of awareness of very significant histories.
14. All children admitted to hospital under a surgeon should also be under the care of a Paediatrician. This is in line with the guidance that Paediatricians should have overall care of children's wards and that no child should be admitted to an adult ward.
15. There should be social work support based in every Paediatric Unit and Child Health Department. Paediatricians and General Practitioners should always attend Child Protection Conferences and time must be made available for this to happen.
16. Paediatricians must recognise the potential for causing severe distress to some families, particularly when the suspicion of FII turns out to be incorrect. Better use of the guidelines should give families the knowledge that they have been evaluated fully, fairly and appropriately.
17. There should be regular liaison meetings in every borough between Police, Social Services and medical and nursing health staff from primary care and from specialist services.
18. A review of the operation of complaints procedures when there are issues which may relate to child protection should be undertaken urgently

## APPENDIX I - VIEWS OF PROFESSIONALS

A questionnaire was sent to all members of RCPCH, and to examiners for the Diploma in Child Health so as to include a number of surgeons, family doctors and child psychiatrists. The objective was to identify key issues for a wide range of experience, views and problems. We recognised that responses would come from those with specific motivations or experiences, as well as those with a sense of corporate responsibility, so that one could not analyse these in a quantitative way. The questionnaires were scrutinised by members of the Working Party who extracted key points. The scrutiners did not know the type of practice of the respondent, or their identity. The responses came from:

- Family Practitioners
- Community Paediatricians
- Child Psychiatrists
- General Paediatricians
- Paediatric Surgeons
- Specialist Paediatricians

The Professional's Response to an Emotive Emerging Ill-Defined Entity with much Inconsistency and Disagreement



The replies fell into four groups:

1. The main body of replies were thoughtful, practical, aware of the difficulties, and looking for progress and guidance from the College. These views have been incorporated into the main report.
2. In addition there was a small group who honestly and openly wished to have nothing to do with the problem.
- 3/4. There were also views from two extremes which clearly derive from personal experience, and helpfully demonstrated the major problems which paediatricians have had to contend with:
  1. The majority group of views were characterised by:
    - a clear recognition that fabrication or illness induction exist and cause harm to children
    - a recognition of a spectrum of behaviour which can result in significant harm
    - an uncertainty about when, in some individual cases, to refer to child protection agencies
    - an understanding of the outcomes which include psychological and personality difficulties for the child, as well as physical trauma
    - the difficulties of the assessment of the risk of harm and intervention if the harm is not immediately life threatening
    - the fact that features such as parental history and personality do not conclusively identify that abuse is occurring, but are important alerting indicators to the possibility
    - the need for any case to be managed personally by a consultant
    - the uncertainty about the risk of escalation of harm
    - the need to reinforce the basic principles of good history taking, and clinical examination before investigation, as well as the need to gather all possible information and keep meticulous records
    - the understanding that abnormal illness behaviour is itself a sickness in an adult which needs help
    - an awareness that paediatricians are gullible and can be easily misled, while the child is being harmed
    - a call for CAMHS resources to be strengthened so that they can work alongside paediatricians not separately, and can identify ways of helping families who refuse help

- the importance of corroboration so that one thinks twice before treating conditions like epilepsy or asthma
- the need to retain general and wise paediatricians in teaching hospitals, since immersion in a tertiary speciality and poor communication are putting children at risk of harm which may be delivered by doctors although caused by carers.
- the focus on the child and possible harm rather than motivation of the carer
- concern about the impact of human rights legislation
- the benefits of multi-disciplinary training to increase the trust of paediatricians in child protection staff and the understanding of those staff of the difficulties which paediatricians face in identifying children who are being harmed
- the advice that one should never work alone and the need for clear paths to obtain support
- the perplexity of how to obtain the views of the child
- the uncertainty of what constitutes significant harm (e.g. does continued exposure of an allergic child to a known allergen constitute harm, or does the continued administration of inappropriate, ineffective but non-toxic medication cause harm)
- the hope of finding ways of picking up cases sooner, possibly by monitoring of all consultations and attendances
- the fact that special needs children are also vulnerable
- the importance of correcting public misconceptions
- the tip that “the bit that does not fit” contains the clue to the truth
- the particular medical responsibility to prevent harm from unnecessary investigations, medications and operations.

2. Those who wished to run away. This was a very small but outspoken group whose views varied:

a) Those who gave thanks that they had not had to deal with it and prayed that they never would.

b) Those who wished to avoid the issue because they were afraid of litigation and cited others who now refused to do child protection work.

c) Those who did not wish to answer questions because we were consulting non-medical people.

d) Those who said that this was no part of a paediatrician's work. A doctor in A&E would stitch up an adult who had been assaulted and call the police; we should hand over all assessment investigation of possible harm immediately to statutory child protection services.

3. Many who work in child protection have had personally traumatic experiences of verbal or other

attacks. This is a serious problem. There is a strong and understandable sense of being isolated, unsupported and unprotected. The College and colleagues are criticised, “many paediatricians are in denial”, and some are seen to be “colluding with abusing parents” if they advise or support accused parents. “There is a network of paediatricians who wish to abolish the concept and defend parents”.

These views of colleagues are accompanied by views on parents such as “a refusal to accept reassurance is MSbP”, on the subject such as “a significant proportion of cot deaths are murder cases”, and on social workers “who have difficulty in grasping the problem at times”. Politicians are said to put their head in the sand, “and vilify the messenger”. It is very important that we understand how and why paediatricians have developed these views.

4. Others see a situation where “the subject is dominated by a small number of sincere and accomplished professionals”. It is recognised that encountering child abuse of a kind which is almost unbelievable will engender a zeal to protect children. However it is then suggested that “medical opinions secure convictions, which are then cited as proof in scientific papers to secure further convictions”. The scientific basis is seen as anecdotal and uncontrolled. “I just feel that MSbP is a bandwagon at the moment”. “The credibility of the profession is brought into disrepute by doctors who over-diagnose the condition”. It is perceived that the experts only appear for the prosecution, so that innocent parents cannot obtain medical support or defence. There is also a concern about the actions of social workers after referral, “who then wade in with all guns blazing”.

## **COMMENT**

All of these attitudes are recognisable and understandable. Disagreements are not quoted to engender conflict but we need to take all these viewpoints seriously and recognise that in the bits that do not fit we may find the key to further progress in better care for children.

*Case Example 17: A child who seemed to be growing slowly was found to have hypothyroidism and established on treatment. Later blood tests started to show low levels of T4 and dosage was increased several times. Parents affirmed that they were giving the prescribed treatment but it subsequently emerged that they had been giving homeopathic Thyroxine. Supervised treatment of normal doses of Thyroxine BNF produced normal blood tests and compliance improved. The motivation remains unclear.*

## APPENDIX II - VIEWS OF PARENTS

*The views of parents are important, but there are difficulties in obtaining them and therefore interpreting them.*

- We wrote to parents and others who on their behalf had made complaints about the present process to the Royal College.
- We obtained views of parents who had been “rehabilitated” and reunified with their children.
- We tried to obtain views from a wider group of parents including those who had no involvement. This has proved virtually impossible without setting up a special project.
- We made enquiries through voluntary organisations who gave us useful insights, most of whom fall within useful insights into the problems of parents who were having difficulties with the system and may in some ways have overlapped with the first group.

Parents were sent the questionnaire which had been sent to professionals, their views were also obtained from letters and free text. We were able to extract a series of points which we felt were valid and required further discussion. We found a series of questions which we felt we should try to answer. There were many other points which related to individual cases which we could not address but found illuminating to read. We did not use this enquiry to enter into the acrimonious debate which has been taking place on the internet. We believed that we should concentrate on children’s health and welfare, and that we might be adversely influenced by what could be seen as intemperate accusations. We have however addressed some of these issues when looking at complaints.

- a) Points from parental returns on which we might be able to find agreement:
- Parents who have had one child die will be more anxious with subsequent children.
  - Paediatricians do not cope well when a parent disagrees.
  - Parents today are more likely to question diagnoses because they have more information.
  - It is difficult to decide who is telling the truth about a child’s illness.
  - Paediatricians should use second opinions more often.
  - Professionals should work with families to rectify problems rather than separate them.
  - Professionals do not always recognise the warning signs which might prevent child abuse
  - Children taken into care may still receive less than optimal care.
  - Infanticide is not usually due to attention seeking behaviour.
  - The variation in opinions and interpretations by pathologists suggests that this is an area which

needs urgent review, (although this is not the direct responsibility of the College of Paediatrics).

- The term “fabrication” could be applied to professionals who exaggerate or slant their reports in our adversarial system. Paediatricians need to look at the impact of the “think dirty” movement on the reputation of the medical profession.
- Statistics do not provide proof.
- Psychiatric diagnoses should not be used as proof, and “profiling” a parent can lead to false accusations or false reassurance.

b) Questions which parents felt needed discussion:

- Why is there a wide regional variation in frequency?
- Are the epidemiological papers sound?
- Has retrospective review found hidden diagnoses, missed because of lack of adequate investigation?
- Why is smothering, poisoning, shaken baby syndrome included in Munchausen by Proxy Syndrome?
- What investigation has been made on the effects of the diagnosis of Munchausen by Proxy Syndrome on the child and the parents? Have the original cases been reviewed?
- What does the College view as the qualification for a Paediatrician to be described as an expert witness, and how does the College monitor the quality of evidence given?
- Should proof of abuse depend on scientific forensic techniques?

#### THEMES FROM VIEWS OF REUNIFIED PARENTS

Parents have particularly appreciated those paediatricians who have been non-accusatory and non-judgemental in their approach to them, and by corollary found it exceptionally hard when subjected to the paediatrician’s anger.

Quite a number of parents describe feeling considerable relief when the paediatrician revealed they had unravelled the fabrication.

For many parents though, their initial response was indignant denial, anger, or even apparent incredulity, yet they had been able to appreciate the paediatrician’s concern later, once they had been in some form of therapeutic work, or where they had had time to reflect further.

Many parents would have liked an opportunity, after they had come to terms with what had occurred, to go back to the original paediatrician and talk with him/her but this never seemed possible.

For many parents the problems really hit home once they had received help and were rehabilitated with their children and then there were difficulties obtaining paediatric help, developmental surveillance, etc., in the months and years which followed. They then felt always tarred with the brush of Munchausen

Syndrome by Proxy and for many this converted into consultation behaviour which bordered on neglectful, because they feared that every presentation would be perceived as further evidence of a factitious disorder.

Some raised the possibility that it would be better to change paediatricians from the one, or the team, who were involved in the diagnosis or identification phase, if they were successfully rehabilitated.

Many said in one way or another that they did appreciate the times when the focus was on the child's needs, rather than on the parental action.

Many appreciated honest feedback from the paediatricians after fabrication had been unravelled but few really obtained this because they felt that paediatricians found this especially hard to convey.

For quite a few parents there had been a combination of genuine illness in their child, combined with fabrication. Then, parents were especially indignant when all the problems that their child faced were assumed to be fabrications or inductions.

For several parents the role of family lawyers had been especially helpful in coming to terms with what the paediatrician fed back to them. Similarly, for certain parents the role of well meaning, but nonetheless misguided, defence expert witnesses had proved especially unhelpful because of the degree to which this delayed their process of help seeking and coming to terms with the fabrication.

Some parents persisted with a chilling disregard and lack of appreciation of the devastating effect that fabrication and induction had on the morale of the paediatric team who had identified their problems, and who of course would have been used to trusting parents. For these parents, despite making progress in many respects to their children, they had been unable to appreciate the impact on the paediatric team in the past (to a large extent this might be a reflection on their disturbed personality and lack of capacity for empathy).

For many parents their views about paediatricians and paediatric teams evolved and changed as their understanding about themselves and their relationships with their children improved through treatment work. They would often change from initial hostility to a greater appreciation of the role and purpose of the paediatric team at the time of identification. Even in these cases, however, they found it extremely hard to come to terms with the hostility they recalled receiving from doctors and nurses at the time of identification and immediately following it.

## **VOLUNTARY ORGANISATIONS**

Some voluntary organisations explained that parents believe that undue weight is placed by social workers, police and the courts on the opinion of a single paediatrician. They believe that it is difficult to obtain a second opinion, and that requests for this are cited as examples of failure to cooperate. They confirm that outcome for children and their families are immeasurably improved when the 15

principles of Working Together in Partnership are applied. These are to be found in Working Together to Safeguard Children 7.5.

- Treat all family members as you would wish to be treated, with dignity and respect.
- Ensure that family members know that the child's safety and welfare must be given first priority, but that each of them has a right to a courteous, caring and professionally competent service.
- Take care not to infringe privacy any more than is necessary to safeguard the welfare of the child.
- Be clear with yourself and with family members about your power to intervene, and the purpose of your professional involvement at each stage.
- Be aware of the effects on family members of the power you have as a professional, and the impact and implications of what you say and do.
- Respect the confidentiality of family members and your observations about them, unless they give permission for information to be passed to others or it is essential to do so to protect the child.
- Listen to the concerns of children and their families, and take care to learn about their understanding, fears and wishes before arriving at your own explanations and plans.
- Learn about and consider children with their family relationships and communities, including their cultural and religious contexts, and their place within their own families.
- Consider the strengths and potential of family members, as well as their weaknesses, problems and limitations.
- Ensure children, families and other carers know their responsibilities and rights, including any right to services, and their right to refuse services, and any consequences of doing so.
- Use plain, jargon-free language appropriate to the age and culture of each person. Explain unavoidable technical and professional terms.
- Be open and honest about your concerns and responsibilities, plans and limitations without being defensive.
- Allow children and families time to take in and understand concerns and processes. A balance needs to be found between appropriate speed and the needs of people who may need extra time in which to communicate.
- Take care to distinguish between personal feelings, values, prejudices and beliefs, and professional roles and responsibilities, and ensure that you have good supervision to check that you are doing so.
- If a mistake or misinterpretation has been made, or you are unable to keep to an agreement, provide an explanation. Always acknowledge any distress experienced by adults and children and do all you can to keep it to a minimum.

## APPENDIX III - THE APPROACH TO COURT CASES CONSIDERING FABRICATED OR INDUCED ILLNESS

### General

- The paediatrician must approach the case in concert with other professionals and not in isolation.
- The first step in medico-legal work is to assemble a chronology.
- In order to do this in a case of fabrication or illness induction, the lead paediatrician will have to obtain the following documents:
  - 1) the child's general practitioner and health visitor records and/or community child health records
  - 2) the child's records from any hospital the child has attended
  - 3) the minutes of all Social Services meetings and child protection conferences
  - 4) the medical and social records of parents and siblings and other carers with consent or by Court Order
- Using these documents, and from the paediatrician's own experience of the case, a written report should be prepared. The following format should be adopted.

*(The pages should be numbered)*

The date of the report

Name of child and date of birth

Your full name

Position

Qualifications

Experience

*Requested by .....*

Based on

- personal experience
- documents
- other sources
- Consent

*Detailed account of the child's medical problems*

Chronology

History ("what you are told") including therapy/interventions

*Examination ("what you find")*

- be graphic
- include photos/charts

- the date of the examination

*Opinion*

***Has Fabricated or Induced Illness occurred?***

Mechanisms

The future likelihood of suffering significant harm, and the prognosis

*Conclusions*

Signed, dated

- It is important that although the clinician has to rely on other people's documents, they should not rely on another professional's chronology. Chronologies prepared by Social Services or lawyers often omit important medical facts and only a paediatrician may have the insight to realise the significance of these. Wherever possible, the paediatrician should indicate what aspects of the history were told to that paediatrician personally, and what parts of the history were copied from previous medical notes. Similarly, the paediatrician should make clear what aspects of the examination of the child were undertaken by the author and to what extent the paediatrician is actually recording the examination findings of others.

## **THE BURDEN OF PROOF**

### Family Cases

Children Act 1989 proceedings divide into public law (where the local authority seek to terminate or share parental responsibility) and private law (where the dispute is internal between family members). In all family proceedings the burden of proof used throughout the case is "balance of probability". This means "it is more likely than not that fabrication or illness induction occurred" and this is a more helpful statement for the court than "consistent with fabrication or illness induction". However this is a flexible standard and the more serious the allegation, the more convincing the evidence needed to tip the balance in respect of it.

### **Criminal Cases**

Criminal proceedings are usually brought by the Crown Prosecution Service and only occur in a small fraction of child abuse cases. They are heard in front of a jury and the burden of proof required to reach a verdict of guilty is "beyond all reasonable doubt". Therefore, it may be true that it is more likely than not that a child was abused by a parent but it may not be possible to prove this beyond all reasonable doubt.

## JUDGE OR JURY

In a family case, which is usually heard by an experienced high court or circuit judge in complex child protection matters such as alleged fabrication or illness induction, a medical witness is truly independent. This means the paediatrician is there to assist the court by helping the judge to interpret the terminology and applied science which underlies clinical medicine. Irrespective of whether the paediatrician is called or instructed by one side or the other, the role of the paediatrician is not to be an advocate for that side but to independently advise the court to the best of his or her ability. Latterly, there has been an increasing trend for joint instruction by all the parties or for the paediatrician to be instructed by the guardian *ad litem* acting for the children. In a family case, therefore, the paediatrician has a fairly free rein over the matters they can discuss and can draw the judge's attention to, even if these are not raised by the barristers or solicitors in evidence in chief or cross examination. Furthermore, the paediatrician can have quite technical discussions of aspects of fabricated or induced illness since the judge and lawyers involved in the case often have very considerable experience of this very small and specialist field of paediatrics.

In contrast, in a criminal case, the paediatrician will have been instructed by one side or the other. Whilst the paediatrician must still be independent and impartial in the advice he or she gives, they are likely to be led to a much greater extent through their evidence in chief and there is much less opportunity for them to raise matters which they may perceive as important but to which neither prosecution nor defence draw attention. Of greater significance, the judge is there to see that the trial is fair but is not the judge who reaches a verdict. The advocates are at pains to influence the 12 members of the jury not the judge, and the jury is largely made up of lay people. It is highly unlikely that they will ever have had previous experience of a case of child protection, let alone the much rarer aspects of fabrication or illness induction. The whole concept of a mother deliberately harming her child may be difficult for a jury of lay people to accept even with something relatively straightforward such as shaken baby syndrome. In the much more complex area of fabrication or illness induction, a jury of lay people may struggle with the concept that a parent might deliberately harm his or her child, not in anger, but with the goal of gaining hospital admission and gaining attention for themselves. Similarly, preplanned deliberate and conscious partial suffocation is likely to be much more difficult for a jury to understand than a parent who reacts violently on the spur of the moment to a fractious young child.

For these reasons, in a criminal trial, the prosecution may elect not to try to convince the jury that the harm done to the child was part of a series of events which clinicians would perceive as coming under the category of fabrication or illness induction. The prosecution may take the view that it would be much easier to convince the jury that the accused had harmed the child on one or more occasions, than it would be to convince the jury that this was all part of an elaborate illness involving both fabrication and induction of symptoms.

## **THE ROLE OF THE EXPERT WITNESS**

*In addition to the documents listed above, the expert witness also ought to see the following documents:*

1. The child's general practitioner notes
2. The child's community child health records (Health Visitor, School Nurse and medical)
3. The child's hospital(s) records (including nursing and physiotherapy records)
4. The siblings' general practitioner notes
5. The siblings' health visitor records
6. The siblings' hospital(s) records (including nursing and physiotherapy records)
7. The mother's general practitioner records (assuming she is the suspected perpetrator)
8. The mother's hospital(s) records (including obstetric and psychiatric records)
9. All social services records, child protection conference minutes, police interview transcripts and so on
10. Any previous expert reports
11. Any other relevant "shopping" (see text)

In theory, the child's own paediatrician could request access to these documents but if permission were not given the paediatrician would have no power to insist on this. In contrast, the expert witness can request these documents from the court and the court does have the power to obtain these.

There can be some blurring of the margins between a witness to fact and an expert witness. A witness to fact needs to concern him or herself only with what they themselves have been told, what they have observed personally and the results of any medical tests of which they have knowledge. However, medical practitioners will almost invariably be asked for their interpretation of those facts. The paediatrician who is not claiming to have particular expertise in the rare field of fabrication or illness induction would still be expected to form opinions commensurate with their specialist training and experience. A junior trainee should be allowed to confine themselves to factual matters when giving oral evidence.

In contrast, expert witnesses in cases of alleged fabrication or illness induction have no first hand knowledge of the facts and must derive all their information from the written records and, if necessary, from interviews with the alleged perpetrator, the child and other professionals involved. Expert witnesses must draw attention to alternative explanations to what appear superficially to be suspicious events. Every childhood illness that cannot be explained or diagnosed is not necessarily fabricated or induced. More general points about the role of the expert witness in medico-legal cases have been given by others.

### **Giving oral evidence**

Irrespective of whether the paediatrician is a witness to fact or an expert witness, and irrespective of whether it is a family case or a criminal case, in as complex an area as fabrication or illness induction, it is very likely that the paediatrician will be called to give oral evidence rather than just relying on a submitted statement or affidavit. The key elements of preparation are as follows:

- Meticulous preparation beforehand
- familiarity with all the papers
- an independent and professional approach, not appearing as an advocate for either side
- clinicians should keep uppermost in their mind that the welfare of the child is paramount under The Children Act 1989
- the paediatrician is most use to the court if he or she speaks, clearly and uses plain language avoiding technical terms. The witness should be aware of whether it is the judge or the jury or the jury who they are addressing
- the witness should be prepared to say “I don’t know”, or “I know where I can find that out”, or “I need more time to consider or read this” rather than to be hurried into an opinion which they regret
- the witness should confine themselves to their area of expertise

### **Fatal cases of fabrication or illness induction**

Some of these cases will have been referred to a coroner’s court at the time of death and long before fabrication or illness induction is suspected, and long before there is any civil or criminal court case. A coroner’s court is an inquisitorial court and the paediatrician, who has been involved with the child before or around the time of death, is likely to be there largely as a witness to fact.

In some families, fabrication or illness induction is suspected first because there are two or more deaths in the family. Obviously, the fact that there are two deaths within a family does not immediately imply that one or both the deaths were unnatural. The Care of the Next Infant (CONI) study suggests that of 5,000 families enrolled because at least one previous child had died in the family, there were a further 44 deaths over 10 years. This suggests therefore that there are five families each year in the UK who have had a child die of SIDS and in which there is at least a second death. In addition, there will be other families in which there will be two deaths where the reasons are known, such as congenital anomalies such as heart disease which can recur in families or familial inherited metabolic diseases. These are unlikely to give concerns about fabrication or illness induction since the cause of death will be clear either in life or at post mortem. The question of fabrication or illness induction is much more likely to be raised when there appear to have been two or more cases of sudden infant death syndrome within one family. In the CONI series of 44 cases, only 8 of those were unequivocally thought to be unexplained deaths. This would suggest, from the CONI data, perhaps one family a year in the UK where there are unequivocally thought to be two unexplained deaths.

Another reason that fabrication or illness induction may be suspected in fatal cases is because there have been previous episodes of acute life threatening events or apnoeic episodes prior to death. Epidemiological data suggests that in only a minimum of SIDS cases has there been a previous life threatening event. Other factors which may point to suspicious circumstances, but which do not unequivocally prove that the death was unnatural, are deaths which occur outside the usual peak age range for SIDS, deaths occurring in the mother's presence in the daytime. However the difficulties of a medical witness trying to combine these factors into some crude statistical assessment of likelihood (in order to address the balance of probability argument – see above) is extremely difficult.

Clearly, from any of the above figures, the chances of having two deaths in a family are much less likely than having two live children. However, that is not the test of balance of probability. The test of balance of probability is whether it is more likely, or less likely, that in a particular family both deaths were natural deaths or one or both deaths were unnatural. In making judgements along these lines, it is necessary to have a comprehensive post mortem investigation to exclude as many natural causes as possible. The investigations recommended in the West Midlands have been published. Unfortunately the majority of coroners investigations are not of the minimum standard required.

### **Other Factors Influencing the Paediatrician's Approach to Cases Involving Fabrication or illness induction**

The "Working Together" guidance published in 1999 gives advice on the conduct of a Chapter 8 Review (commonly known as a Part 8 Review). This is undertaken where death or untoward event occurs and it is felt that this was avoidable or that lessons can be learnt in the case. Chapter 8 reviews may include fatal or non-fatal cases of fabrication or illness induction, particularly where there has been extensive Social Services and health involvement with other children before the fatal case, and paediatricians who participate in Chapter 8 reviews, either as members of staff who were involved in the case, or outside experts, need to be familiar with this document.

### **Professional Independence**

It is crucial that any expert asked to give an opinion on a case of potential fabrication or illness induction, whether at the early stage of a strategy review meeting before the parents have been informed and before any court cases are underway or much later as an expert witness, should be a clinician from outside the region where the case occurred. The reasons for this are twofold. Firstly, in arriving at a diagnosis of fabrication or illness induction, there is often implicit criticism of the clinicians previously involved since it may be the expert's view that previous investigations, treatment or surgery were inappropriate and it may be difficult to state this if the expert works day

in, day out with the clinicians involved. On the other hand, if the local clinicians feel that the diagnosis is one of fabrication or illness induction and the expert disagrees, the implication is that the clinician caring for the child has missed some rare diagnosis which could explain all the previous unexplained symptoms. Secondly, the parents are invariably extremely angry when it is suggested that one or other of them is deliberately making their child ill. If the expert paediatrician is from outside the region, then it is harder for that anger to be brought to bear against the paediatrician or his or her family.

*Case Example 18: A single deprived mother who needed a great deal of support complained that her infant was always falling asleep. Toxicology was negative. Paediatricians considered looking for a pineal tumour. However in voluntary foster care the symptoms ceased abruptly. On returning to her mother the child again became withdrawn. A Care Order was obtained and adoption is being considered.*

*Case Example 19: A child of 2 years old was failing to thrive but was not fully assessed. 10 years later the child was attending a special school, in a wheelchair, very overweight, and receiving attendance allowance. A Paediatric Registrar collated all the concerns over the years from multiple sources, and it now appears likely that there has been fabrication. It seems that there was serial acceptance by doctors of what other doctors were said to have said.*

*Case Example 20: Over 50 years ago a young single girl had moved from her village to a large town in early pregnancy, found a job and rented a room. The pregnancy was concealed from the landlady. The baby was hidden but was brought to hospital after midnight several times with trivial complaints. She was not seen for several weeks, and then mother came with the baby very early in the morning. She had been afraid that the baby's crying would be heard by the landlady and she would be thrown out of the house. The mother had learnt to quieten the baby with a pillow but on the last occasion the baby died.*

## **APPENDIX IV - PARENT PROTEST**

It has been distressing to discover the nature and extent of criticism and actual harassment reported by Paediatricians and nurses involved in child protection cases. These professionals had specifically been involved in investigation of suspected cases of what was known as Munchausen by Proxy Syndrome.

Attacks against doctors who work in child protection may also be mounted against them by complaints arising in other areas of their work. There may be evidence of collusion by complainants in organising these attacks.

The accusations include statements that doctors have wilfully prevented the course of justice by hiding or destroying evidence. Attacks also include letters to the College and the media, and particularly on the Internet where some of the more intemperate claims have been made. We are aware of paediatricians who have been reported to the General Medical Council and nurses who have been reported to the UKCC but not of any outcomes. Professionals have also received direct personal attacks and threats. It would appear that there is no adequate protection against such actions by parents or complainants.

We have included this issue as a separate appendix because it is NOT the focus of our working party, but cannot be ignored. Our focus is on prevention of harm to children and how we can increase our skills and abilities and help families who have difficulties. However we strongly suggest that there is a need for discussion between the Department of Health, the College and the Police, in addition to our suggestions about the complaints procedures.

## **APPENDIX V - NAMED AND DESIGNATED DOCTORS AND NURSES**

The importance of Named and Designated Doctors and Nurses cannot be overemphasised. They have statutory responsibilities, the RCPCH has laid out model job descriptions for doctors. The organisation of the health service alters with political directives and their position in the structure may change. Strategic Health Authorities will continue to need advice and monitoring of child protection services and training. The Designated Staff may not be able to sit on all ACPC's. Equally the named professionals for each PCT, hospital and community trust may need to be rationalised to have responsibility for all the children under any Trust, in particular district, possibly a local authority. Excellent networks of such staff with particular responsibilities exists in some parts of the country for joint working, audit, training and cross cover. The work of ensuring that health services for child protection are effective will be assisted by such networks.

### **THE ROLE OF THE NAMED PAEDIATRICIAN**

1. Day to day clinical supervision of Child Protection within the Trust
2. To advise on all Child Protection matters within the Trust
3. To provide appropriate Child Protection training within the Trust
4. To ensure there is a quality service within the Trust
5. To monitor Child Protection services within the Trust
6. To carry out internal management reviews, following a serious incident or a child death.

### **THE ROLE OF THE DESIGNATED PAEDIATRICIAN**

1. To co-ordinate all aspects of Child Protection work (currently working for the Health Authority).
2. To provide advice and support to all professionals (multi-disciplinary) on Child Protection matters.
  1. To act as the Health Authority Representatives on ACPC's
  2. To ensure there is appropriate and equitable training across the area.
  3. To ensure that there are appropriate and equitable health services across the area.
  4. To set standards in Child Protection work.
  5. To audit, monitor and research Child Protection issues.
  6. To carry out needs assessments where needed.
  7. To be the Health Authority's representative on Chapter 8 Reviews (following the death of a child)

## References

- Asher R. (1951) "Munchausen syndrome" *Lancet* 1951; 81: 1140-2.
- Blix S, Brack G (1998) "The effects of a suspected case of Munchausen's syndrome by proxy on a pediatric nursing staff" *Gen Hosp Psychiatry* 10: 402-9.
- Bluglass K (1993) "'Factitious' illness or 'Munchausen by proxy'" *Current Paediatrics* 1993; 3: 81-85.
- Bools CN, Neale BA, Meadows SR (1992) "Co-morbidity associated with fabricated illness (Munchausen syndrome by proxy)" *Arch Dis Child* 67: 77-9.
- Davis PM, McClure RJ, Rolfe K, Chessman N, Pearson S, Sibert JR, 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* 1998; 78: 217-221.
- 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 Skills (2001). *Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities*. London: DoH.
- Fisher GC, Mitchell I (1995) "Is Munchausen syndrome by proxy really a syndrome?" *Arch Dis Child* 1995; 72: 534-8.
- Fleming PJ, Bacon CJ, Blair PS, Berry PJ eds. (2000) *Sudden unexpected deaths in infancy; the CESDI SUDI studies 1993 to 1996*. London: Stationery Office.
- Garralda ME, Bailey D (1990) "Paediatric identification to psychological factors associated with general paediatric consultations" *J Psychom Res* 1990; 34: 303-12.
- Godding V, Kruth M (1991) "Compliance with treatment in asthma and Munchausen syndrome by proxy" *Archives of Disease in Childhood* 1991; 66: 956-960.
- Goss PW, McDougall PN (1992) "Munchausen syndrome by proxy – a cause of pre-term delivery" *The Medical Journal of Australia* 1992; 157: 814-817.
- Gray J, 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: 655-673.
- Green MA (1999) "Time to put 'cot death' to bed?" *Brit Med Journal* 1999; 319: 697-8.
- Hey E, Chalmers I (2001) "Open letter to the chief medical officer. Learning from Bristol: the need for a lead from the chief medical officer" *Brit Med Journal* 2001; 323: 280-281.
- Horwath J, Lawson B (eds) (1995) *Trust Betrayed? Munchausen Syndrome by Proxy: inter-agency child protection and partnership with families* National Children's Bureau, London.
- Jureidini J (1993) "Obstetric Factitious Disorder and Munchausen Syndrome by Proxy" *The Journal of Nervous and Mental Disease* 181 (2): 135-137.
- Kelly C, Loader P (1997) "Factitious disorder by proxy: The role of child mental health professionals" *Child Psychology and Psychiatry Review*, 2, 116-124.
- Kempe RS, Kepme CH (1978) "The untreatable family" In: Kempe RS, Kempe CH, eds. *Child Abuse*, pp128-131. London: Open Books.
- Krener P, Adelman R (1998) "Parent salvage and parent sabotage in the care of chronically ill children" *American Journal of Diseases of Childhood*, 142, 945-951.
- Krous HF (1996) "International standardised autopsy protocol for sudden unexpected infant death." Fitzgerald, K. "SIDS global strategy task force." June 27-28 1996, 15-39. 1996. Washington DC. Third SIDS global strategy meeting. (Generic)
- Limerick S (1999) "Not time to put cot death to bed" *Brit Med Journal* 1999; 319: 698-700.

- Loader P, Kelly C (1996) "Munchausen Syndrome by Proxy: A Narrative Approach to Explanation" *Clinical Child Psychology and Psychiatry*, 1(3): 353-363.
- McClure RJ, Davis PM, Meadow SR, Sibert JR. "Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation." *Arch. Dis. Child* 1996; 75: 57-61
- Meadow R (1977) "Munchausen syndrome by proxy. The hinterland of child abuse." *Lancet* ii: 343-5.
- Meadow R (1984) "Management of Munchausen syndrome by proxy" *Arch Dis Child* 1984; 60: 385-93
- Meadow R (1995) "What is, and what is not, 'Munchausen syndrome by Proxy?'" *Arch Dis Child* 1995; 72: 534-8.
- NHS Executive West Midlands Regional Office (2000) "Report of a review of the research framework in North Staffordshire Hospital NHS Trust" In: Leeds: NHS Executive (Griffiths report).
- Pickering D (1964) "Salicylate poisoning: the diagnosis when its possibility is denied by the parents" *Acta Paediatrica Scand* 1964; 53: 501-4
- Pinching AJ (2000) "Chronic Fatigue Syndrome" *Prescribers Journal* 2000, Vol 40: No. 2.
- "Psychiatric Munchausen Syndrome by Proxy" *Child Psychology and Psychiatry Review*, Vol 5, No 2, 2000.
- Office for National Statistics (1999) "Recent trends in deaths from homicide in England and Wales" *Health Statistics Quarterly* 03, Autumn 1999.
- Rogers D, Tripp J, Bentovim A, Robinson A, Berry D, Golding R (1976). "Non-accidental poisoning: an extended syndrome of child abuse" *British Medical Journal* 1: 793-796.
- Rosenberg DA (1987) "Web of deceit: a literature review of Munchausen syndrome by proxy" *Child Abuse and Neglect* 1987; 11: 547-563 (Medline).
- Sanders MJ (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 HA, Libow JA, eds. (1993) *Hurting for love – Munchausen by proxy syndrome*. New York: Guilford Press.
- Schreier HA (1997) "Factitious presentation of psychiatric disorder: When is it Munchausen's syndrome by proxy?" *Child Psychology and Psychiatry Review*, 2, 108-115.
- Shabde N. (1998) "Covert video surveillance is acceptable – but only with a vigorous protocol" *British Medical Journal* 1998; 316: 1603-05
- Southall DP, Plunkett MC, Banks MW, Falkov AF, Samuels MP (1997) "Covert video recordings of life-threatening child abuse. Lessons for child protection" *Pediatrics* 1997; 100: 735-760
- Southall DP, Stebbens VA, Rees SV, Lang MH, Warner JO, Shinebourne EA (1987) "Apnoeic episodes induced by smothering: two cases identified by covert video surveillance" *BMJ* 1987; 294: 1637-41
- Stephenson TJ (1996) "Munchausen syndrome by proxy – presenting evidence in court" In *Trust Betrayed* Eds Horwath J, Lowson B. National Children's Bureau Publications, February 1996.
- Stewart M *Medical Journal* 1991 (84:1)
- Taylor DC (1991) "Outlandish factitious illness" In David T, ed. *Recent advances in paediatrics, Vol 10*, pp 63-76. London: Churchill Livingstone.
- Warner JO, Hathaway MJ (1984) "Allergic form of Meadow's syndrome (Munchausen by proxy)" *Archives of Disease in Childhood* 59: 151-156
- Wilson RG (2001) "Fabricated or induced illness in children, Munchausen by proxy comes of age" *BMJ* 2001; 323: 296-297 (11 August).
- Wolkind S, Taylor EM, Waite AJ, Dalton M, Emery JL (1993) "Recurrence of unexpected infant death" *Act Paed* 82: 873-6.
- Working Party of the British Paediatric Association (1994) *Evaluation of suspected imposed upper airway obstruction*. London: British Paediatric Association.

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## Summary of Cases of Fabricated or Induced Illness by Physical Intrusiveness Category

The table provides details of 313 cases classified into Physical Intrusiveness categories. Additionally the presenting symptoms and/or signs are summarised. The first five references identify major series up to the date of preparation of this review, which are not included in the table. The cases in these references should be seen as complementing the details presented in the table. References 6 to 162 are the sources from which the details of the 313 cases in the table were extracted.

PIC	Number of index cases	Details of index fabrication
1	44(14%)	abdominal pain <sup>6,7</sup> , apnoea <sup>6, 8,9</sup> , asthma <sup>10-12</sup> , ataxia <sup>6</sup> , chest pain <sup>13</sup> , choking <sup>14</sup> , conduct disorder <sup>10</sup> , deafness <sup>15</sup> , falling <sup>16</sup> , feeding difficulty <sup>17</sup> , food intolerance <sup>6, 18, 19</sup> , headaches <sup>10,20</sup> , joint pains <sup>10</sup> , lethargy <sup>21</sup> , multiple sclerosis <sup>20</sup> , multiple <sup>22</sup> , polyuria/polydipsia <sup>14</sup> , pyrexia <sup>20</sup> , recurrent infections <sup>23</sup> , respiratory problems <sup>6</sup> , seizures <sup>6, 23-27</sup> , swallowed coins <sup>28</sup> , sweating <sup>6</sup> , thyroid disease <sup>20</sup> , vomiting and/or diarrhoea <sup>6, 29</sup> .
1	23(7%)*	bleeding diathesis <sup>30</sup> , bleeding from mouth and/or ears <sup>31-33</sup> , CSF otorrhoea <sup>34</sup> , cystic fibrosis <sup>35</sup> , diabetes insipidus <sup>6</sup> , fever <sup>6</sup> , glycosuria <sup>32, 34-38</sup> , haematemesis and/or melaena <sup>39-41</sup> , haematuria <sup>6, 42-46</sup> , hyperkalaemia <sup>47</sup> , jaundice <sup>16</sup> .
2	14 (4.5%)	behaviour problems <sup>6</sup> , failure to thrive <sup>6, 48</sup> , feeding problems <sup>6</sup> , generalised oedema <sup>48</sup> , rickets <sup>48</sup> .
3	62 (20%)	central line complications other than infection <sup>6, 49,50</sup> , central lines recurrent sepsis due to interference with <sup>6,24, 51-62</sup> , dermatitis artefacta <sup>25,12, 63-66</sup> , gastrointestinal pseudobstruction <sup>67-69</sup> , injury to mouth and/or ears <sup>24, 70-76</sup> , other <sup>6, 16, 39, 49, 70, 77-81</sup> , recurrent infections <sup>6, 54, 56, 82-85</sup> , renal stones <sup>86-88</sup> .
4	41 (13%)	diuretics <sup>89,90</sup> , emetics/laxatives <sup>6,9, 16, 91-107</sup> , fruit juice <sup>9, 104</sup>
5	90 (29%)	anticoagulants <sup>108-111</sup> , antidepressants <sup>112-114</sup> , arsenic <sup>17, 115</sup> , barbiturates <sup>70, 90,112, 116-118</sup> , bleach <sup>119, 120</sup> , chloral <sup>26,121,122</sup> , diazepam <sup>119</sup> , hypernatraemia <sup>6, 43, 90,123-127</sup> , hyponatraemia <sup>128, 129</sup> , insulin alone <sup>130-135</sup> , insulin plus another drug <sup>136,137</sup> , miscellaneous <sup>6, 9, 12, 16, 90, 116, 120, 138-144</sup> , multiple <sup>23, 70, 108, 116, 138</sup> , oral hypoglycaemic <sup>90</sup> , pepper <sup>119, 145,146</sup> , phenothiazines <sup>32, 147-149</sup> .
6	39 (12.5%)	Apnoea/seizures/near miss cot death/cardiac arrest <sup>9, 17, 29, 72, 98, 103, 112, 120, 138, 150-162</sup> .
<b>Total</b>	<b>313</b>	
<b>Table - Overview of cases</b>		
* Fabrication plus the falsification of specimens or charts		

### References

- Bools CN, Neale BA, Meadow SR. Co-morbidity associated with fabricated illness (Munchausen syndrome by proxy). Arch Dis Child. 1992;67:77-79.

2. McClure RJ, Davis PM, Meadow SR, Sibert JR. Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. *Arch Dis Child*. 1996;75:57-61.
3. Southall DP, Plunkett MCB, Banks MW et al. Covert video recordings of life-threatening child abuse: lessons for child protection. *Pediatrics*, 1997, **100**, 735-760,
4. Light MJ, Sheridan MS. Munchausen syndrome by proxy and Apnea. A survey of Apnea programs. *Clinical Paediatrics* 1990; **29**, 162-8.
5. Feldman KW, Hickman RO. The central venous catheter as a source of medical chaos in Munchausen syndrome by proxy. *J Pediatr Surg*. 1998;33:623-7.
6. Gray J, Bentovim A. 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 Negl*. 1996;20:655-73.
7. Main DJ, Douglas JE, Tamanika HM. Munchausen's syndrome by proxy. *Med J Aust*. 1986; 145: 300-301.
8. Klebes C, Fay S. Munchausen syndrome by proxy: a review, case study, and nursing implications. *J Pediatr Nurs*. 1995;10:93-8.
9. Lacey SR, Cooper C, Runyan DK, Azizkhan RG. Munchausen syndrome by proxy: patterns of presentation to pediatric surgeons. *J Pediatr Surg*. 1993; 28:827-32.
10. Roth D. How "mild" is mild Munchausen syndrome by proxy? *Isr J Psychiatry Relat Sci*. 1990;27:160-7.
11. Masterson J, Dunworth R, Williams N. Extreme illness exaggeration in pediatric patients: a variant of Munchausen's by Proxy? *Amer J Orthopsychiatr*. 1988; 58: 188-195.
12. Black D. The extended Munchausen Syndrome: a family case. *Brit J Psychiat*. 1981; 138: 466-469.
13. Kahan BB, Yorker BC. Munchausen syndrome by proxy. *J of School Health*. 1990; 60: 108-110
14. Ifere OA, Yakubu AM, Aikhionbare HA, Quaitey GE, Taqi AM. Munchausen syndrome by proxy: an experience from Nigeria. *Ann Trop Paediatr*. 1993;13:281-4.

15. Kahn G, Goldman E. Munchausen syndrome by proxy: mother fabricates infant's hearing impairment. *J Speech Hear Res.* 1991 ;34:957-9.
16. McGuire TL, Feldman KW. Psychologic morbidity of children subjected to Munchausen syndrome by proxy. *Pediatrics.* 1989 ;83:289-92.
17. Alexander R, Smith W, Stevenson R. Serial Munchausen syndrome by proxy. *Pediatrics.* 1990;86:581-5.
18. Kahan B, Yorker BC. Munchausen Syndrome by Proxy: clinical review and legal issues. *Behavioural Sciences and the Law.* 1991; 9: 73-83.
19. Masterson J, Wilson J. Factitious illness in children: the Social Worker's role in identification and management. *Social Work in Health Care.* 1987; 12: 21-30.
20. Woollcott P, Aceto T, Rutt C et al. Doctor shopping with the child as proxy patient: a variant of child abuse. *J Pediatr.* 1982; 101: 297-301.
21. MacDonald TM. Myalgic encephalomyelitis by proxy. *Brit Med J.* 1989; 299:1030.
22. Fialkov M. Peregrination in the problem pediatric patient: the paediatric Munchausen syndrome? *Clin Pediatr.* (1984);23: 571-575.
23. Woody RC, Jones JG. Neurologic Munchausen-by-Proxy Syndrome. *Southern Med J.* 1987; 80: 247-248.
24. Goldfarb J, Lawry KW, Steffen R, Sabella C. Infectious diseases presentations of Munchausen syndrome by proxy: case report and review of the literature. *Clin Pediatr (Phila).* 1998;37:179-85.
25. Atoynatan TH, O'Reilly E, Loin L. Munchausen syndrome by proxy. *Child Psychiatry Hum Dev.* 1988;19:3-13.
26. Croft RD, Jervis M. Muchausen's syndrome in a 4 year old. *Arch Dis Child.* 1989; 63: 740-741.
27. Guandolo VL. Munchausen syndrome by proxy: an outpatient challenge. *Pediatrics.* 1985 ;75:526-30.
28. Lim LC, Yap HK, Lim JW. Munchausen syndrome by proxy. *J Singapore Paediatr Soc.* 1991;33 :59-62.
29. Mitchell I, Brummitt J, DeForest J, Fisher G. Apnea and factitious illness (Munchausen syndrome) by proxy. *Pediatrics.* 1993;92:810-4.
30. Oyelami OA, Alhaj AM, Airede IK. Munchausen syndrome by proxy--a case report and review of literature. *Cent Afr J Med.* 1994;40:222-6.
31. Amegavie L, Marzouk O, Mullen J, et al. Munchausen's syndrome by proxy: a warning for health professionals. *BMJ.* 1986; 293: 855-856.

32. Verity CM, Winckworth C, Burman D et al. Polle syndrome: children of Munchausen. *BMJ*. 1979; 2: 422-423.
33. Bouchier D. Bleeding ears: case report of Munchausen syndrome by proxy. *Aust Paediatr J*. 1983;19:256-7.
34. Gilbert RW, Pierse PM, Mitchell DP. Cryptic otalgia. *J Otolaryngology*. 1987; 16, 231-233.
35. Orenstein DM, Wasserman AL. Munchausen syndrome by proxy simulating cystic fibrosis. *Pediatrics*. 1986;78:621-4.
36. Nading JH, Duval-Arnould. Factitious diabetes mellitus confirmed by ascorbic acid. *Arch Dis Child*. 1984; 59: 166-167.
37. McSweeney JJ, Hoffman RP. Munchausen's syndrome by proxy mistaken for IDDM. *Diabetes Care*. 1991;14:928-9.
38. Wigg S, Wright E, Breach P, Wilson JD. Is it diabetes mellitus or Munchausen's syndrome? *Aust N Z J Med*. 1996;26:841.
39. Griffith JL. The family systems of Munchausen syndrome by proxy. *Fam Process*. 1988;27:423-37.
40. Mills RW, Burke S. Gastrointestinal bleeding in a 15 month old male: a presentation of Munchausen's syndrome by proxy. *Clin Pediat*. 1990; 29: 474-477.
41. Stevenson RD, Alexander R. Munchausen syndrome by proxy presenting as a developmental disability. *J Dev Behav Pediatr*. 1990;11:262-4.
42. Clayton PT, Counahan R, Chantler C. Munchausen syndrome by proxy. *Lancet*. 1978; i: 102-103
43. Meadow R. Munchausen syndrome by proxy: the hinterland of child abuse. *Lancet*. 1977; ii: 343-345.
44. Outwater KM, Lipnick RN, Luban NL et al. Factitious haematuria: Diagnosis by minor blood group typing. *J Pediatr*. 1981; 98: 95-97.
45. Salmon RF, Arant BS, Baum MG, Hogg RJ. Factitious haematuria with underlying renal abnormalities. *Pediatrics*. 1988; 82: 377-379.
46. Waller DA. Obstacles to the treatment of Munchausen by proxy syndrome. *J Amer Acad Child Psych*. 1983; 22: 80-85.
47. Magen D, Skorecki K. Extreme hyperkalaemia in Munchausen-by-Proxy Syndrome. *New J Med*. 1999; 340:1293-1294.
48. Roberts IF, West RJ, Ogilvie D, Dillon MJ. Malnutrition in infants receiving cult diets: a form of child abuse. *BMJ*. 1979; 1: 296-298.

49. Saulsbury FT, Chobanian MC, Wilson WG. Child abuse: parenteral hydrocarbon administration. *Pediatr*. 1984; 73, 719-722.
50. Malatack JJ, Wiener ES, Gartner JC, et al. Munchausen syndrome by proxy: a new complication of central venous catheterization. *Pediatrics*. 1985; 75: 523-525.
51. Bryk M, Siegel PT. My mother caused my illness: the story of a survivor of Munchausen by proxy syndrome. *Pediatrics*. 1997;100:1-7.
52. DiBiase P, Timmis H, Bonilla JA, Szeremeta W, Post JC. Munchausen syndrome by proxy complicating ear surgery. *Arch Otolaryngol Head Neck Surg*. 1996;122:1377-80.
53. Frederick V, Luedtke GS, Barrett MD, et al. Munchausen syndrome by proxy: recurrent central catheter sepsis. *Pediatr Infect Dis J*. 1990, 9, 440-442.
54. Halsey NA, Frenz JM, Tucker TW, Sproles T, Redding J, Daum RS. Recurrent nosocomial polymicrobial sepsis secondary to child abuse. *Lancet*. 1983;2:558-60.
55. Hodge D, Schwartz, Sargent J. et al. The bacteriologically battered baby: another case of Munchausen by proxy. *Annals of Emergency Medicine*. 1982; 11: 205-207.
56. Kohl S, Pickering LK, Dupree E. Child abuse presenting as immunodeficiency disease. *J Pediatr*. 1978; 93: 466-468.
57. Liston TE, Levine PL, Anderson C. Polymicrobial bacteremia due to Polle syndrome: the child abuse variant of Munchausen by Proxy. *Pediatr*. 1983, 72, 211-213.
58. Palmer AJ, Yoshimura GJ. Munchausen syndrome by proxy. *J Am Acad Child Psychiatry*. 1984;23:503-8.
59. Rubin LG, Angelides A, Davidson M, Lanzkowsky. Recurrent sepsis and gastrointestinal ulceration due to child abuse. *Arch Dis Child*. 1986; 61: 903-905.
60. Rosenberg DA. Web of deceit: a literature review of Munchausen syndrome by proxy. *Child Abuse Negl*. 1987;11:547-63.
61. Schade DS, Drumm DE, Eaton RP, Sterling WA. Factitious brittle diabetes mellitus. *Amer J Med*. 1985, 78, 777-783.
62. Seferian EG. Polymicrobial bacteremia: a presentation of Munchausen syndrome by proxy. *Clin Pediatr (Phila)*. 1997;36:419-22.
63. Clark GD, Key JD, Rutherford P, Bithoney WG. Munchausen's syndrome by proxy (child abuse) presenting as apparent autoerythrocyte sensitization syndrome: an unusual presentation of Polle syndrome. *Pediatrics*. 1984; 74: 1100-1102.

64. Jones DPH. Dermatitis artefacta in mother and baby as child abuse. *Brit J Psychiat.* 1983;143:199-200.
65. Stankler L. Factitious skin lesions in a mother and two sons. *Brit J of Dermatology.* 1977; 97: 217-219
66. Weston WL, Morelli JG. "Painful and disabling granuloma annulare": a case of Munchausen by proxy. *Pediatr Dermatol.* 1997;14:363-4.
67. Baron HI, Beck DC, Vargas JH, Ament ME. Overinterpretation of gastroduodenal motility studies: two cases involving Munchausen syndrome by proxy. *J Pediatr.* 1995;126:397-400.
68. Kosmach B, Tarbell S, Reyes J, Todo S. "Munchausen by proxy" syndrome in a small bowel transplant recipient. *Transplant Proc.* 1996;28:2790-1.
69. Sugar JA, Belfer M, Israel E, Herzog DB. A 3-year-old boy's chronic diarrhea and unexplained death. *J Am Acad Child Adolesc Psychiatry.* 1991;30:1015-21.
70. Livingston R. Maternal somatization disorder and Munchausen syndrome by proxy. *Psychosomatics.* 1987;28:213-4, 217.
71. Lee DA. Munchausen syndrome by proxy in twins. *Arch Dis Child.* 1979; 54: 646-647.
72. Manning SC, Casselbrant M, Lammers D. Otolaryngologic manifestations of child abuse. *Int J Pediatric Otolaryngology.* 1990; 20: 7-16.
73. Mra Z, MacCormick JA, Poje CP. Persistent cerebrospinal fluid otorrhea: a case of Munchausen's syndrome by proxy. *Int J Pediatr Otorhinolaryngol.* 1997;41:59-63.
74. Grace A, Kalinkiewicz M, Drake-Lee AB. Covert manifestations of child abuse. *BMJ.* 1984; 289: 1041-1042.
75. Zohar Y, Avidan G, Shvili Y, Laurian N. Otolaryngologic cases of Munchausen's syndrome. *Laryngoscope.* 1987; 97: 201-203.
76. Magnay AR, Debelle G, Proops DW, Booth IW. Munchausen syndrome by proxy unmasked by nasal signs. *J Laryngol Otol.* 1994;108:336-8.
77. Taylor D, Bentovim A. Recurrent nonaccidentally inflicted chemical eye injuries in siblings. *J of Pediatric Ophthalmology.* 1976; 13, 238-242.
78. Proesmans W, Sina JKA, Debucquoy P, et al. Recurrent acute renal failure due to nonaccidental poisoning with glafenin in a child. *Clin Nephrol.* 1981; 16, 207-210.
79. Porter GE, Heistch GM, Miller MD. Munchausen syndrome by proxy: unusual manifestations and disturbing sequelae. *Child Abuse and Neglect.* 1994; 18: 789-794.

80. Turk LJ, Hanrahan KM, Weber ER. Munchausen Syndrome by Proxy: a nursing overview. *Issues Compr Pediatr Nurs.* 1990;13:279-88.
81. Yomtovian R, Swanger R. Munchausen syndrome by proxy documented by discrepant blood typing. *Am J Clin Pathol.* 1991;95:232-3.
82. Koch C, Hoiby N. Severe child abuse presenting as polymicrobial bacteremia. *Acta Pediatr Scand.* 1988; 77: 940-943.
83. Pickering LK, Kohl S. Munchausen syndrome by proxy. *Am J Dis Child.* 1981; 135:288-289
84. Rumans LW, Vosti KL. Factitious and fraudulent fever. *Amer J Med.* 1978; 65: 745-755
85. Wood PR, Fowlkes J, Holden P, Casto D. Fever of unknown origin for six years: Munchausen syndrome by proxy. *J Fam Pract.* 1989;28:391-5.
86. Douchian F. Lithiase urinaire 'factice': syndrome de Munchausen par procuration? *La Presse Medicale.* 1987; 16, 179.
87. Sneed RC, Bell RF. The Dauphin of Munchausen: factitious passage of renal stones in a child. *Pediatrics.* 1976; 58, 127-130.
88. Senocak ME, Turken A, Buyukpamukcu N. Urinary obstruction cause by factitious urethral stones: an amazing manifestation of Munchausen syndrome by proxy. *J Pediatr Surg.* 1995; 30: 1732-1734.
89. Chan DA, Salcedo JR, Atkins DM, Ruley EJ. Munchausen syndrome by proxy: a review and case study. *J Pediatr Psychol.* 1986 ;11:71-80.
90. Rogers D, Tripp J, Bentovim A, et al. Non-accidental poisoning: an extended syndrome of child abuse. *BMJ.* 1976; 1: 793-796.
91. Berkner P, Kastner T, Skolnick L. Chronic Ipecac poisoning in infancy: a case report. *Pediatrics.* 1988; 82: 384-386.
92. Ackerman NB, Strobel CT. Polle syndrome: chronic diarrhea in Munchausen's child. *Gastroenterology.* 1981; 81: 1140-1142.
93. Epstein MA, Markowitz RL, Gallo DM, Holmes JW, Gryboski JD. Munchausen syndrome by proxy: considerations in diagnosis and confirmation by video surveillance. *Pediatrics.* 1987;80:220-4.
94. Goebel J, Gremse DA, Artman M. Cardiomyopathy from ipecac administration in Munchausen syndrome by proxy. *Pediatrics.* 1993;92:601-3.
95. Sutphen JL, Saulsbury FT. Intentional ipecac poisoning: Munchausen syndrome by proxy. *Pediatrics.* 1988;82:453-6.
96. Colletti RB, Wasserman RC. Recurrent infantile vomiting due to intentional ipecac poisoning. *J Pediatr Gastroenterol Nutr.* 1989;8:394-6.

97. Johnson JE, Carpenter BLM, Benton J, et al. Hemorrhagic colitis and pseudomelanosis coli in Ipecac ingestion by proxy. *J Pediatr Gastroenterology and Nutrition*. 1991; 12: 501-506.
98. Jureidini J. Obstetric factitious disorder and Munchausen syndrome by proxy. *J of Nervous and Mental Disease*. 1993; 181: 135-137.
99. Carlson J, Fernlund P, Ivarsson SA, Jakobsson I, Neiderud J, Nilsson KO, Svensson M, Swanstein U. Munchausen syndrome by proxy: an unexpected cause of severe chronic diarrhoea in a child. *Acta Paediatr*. 1994 ;83:119-21.
100. Santangelo WC, Richey JE, Rivera L, Fordtran JS. Surreptitious Ipecac administration simulating intestinal pseudo-obstruction. *Ann Int Med*. 1989; 110: 1031-1032.
101. Schneider DJ, Perez A, Knilamus TE, Daniels SR, Bove KE, Bonnell H. Clinical and pathologic aspects of cardiomyopathy from ipecac administration in Munchausen's syndrome by proxy. *Pediatrics*. 1996 ;97:902-6.
102. McClung HJ, Murray R, Braden NJ, et al. Intentional Ipecac poisoning in children. *Amer J Dis Child*. 1988; 142: 637-639.
103. Manthei DJ, Pierce RL, Rothbaum RJ, et al. Munchausen syndrome by proxy: covert child abuse. *J of Family Violence*. 1988; 3: 131-140.
104. Volk D. Factitious diarrhea in two children. *Amer J Dis Child*. 1982; 136: 1027.
105. Cooper CP, Kamath KR. A toddler with persistent vomiting and diarrhoea. *Eur J Pediatr*. 1998 ;157:775-6.
106. Fleisher D, Ament Me. Diarrhea, red diapers, and child abuse. *Clin Pediat*. 1977; 17, 820-824.
107. Feldman KW, Christopher DM, Opheim KB. Munchausen syndrome by proxy/bulimia by proxy: Ipecac as a toxin in child abuse. *Child Abuse and Neglect*. 1989; 13: 257-261,
108. Ayass M, Bussing R, Mehta P. Munchausen syndrome presenting as hemophilia: a convenient and economical "steal" of disease and treatment. *Pediatr Hematol Oncol*. 1993;10:241-4.
109. Babcock J, Hartman K, Pedersen A, Murphy M, Alving B. Rodenticide-induced coagulopathy in a young child. A case of Munchausen syndrome by proxy. *Am J Pediatr Hematol Oncol*. 1993 ;15:126-30.
110. Souid AK, Korins K, Keith D, Dubansky S, Sadowitz PD. Unexplained menorrhagia and hematuria: a case report of Munchausen's syndrome by proxy. *Pediatr Hematol Oncol*. 1993;10:245-8.
111. White ST, Voter K, Perry J. Surreptitious Warfarin ingestion. *Child Abuse and Neglect*. 1985; 9: 349-352.

112. Zitelli BJ, Seltman MF, Shannon RM. Munchausen's syndrome by proxy and its professional participants. *Amer J Dis Child.* 1987; 141: 1099-1102.
113. Watson JBG, Davies JM, Hunter JLP. Nonaccidental poisoning in childhood. *Arch Dis Child.* 1979; 54: 143-144.
114. Manikoth P, Subramanyan R, Menon S, Al Khusaiby SM. A child with cardiac arrhythmia and convulsions. *Lancet.* 1999;354:2046.
115. Embry CK. Toxic cyclic vomiting in an 11-year-old girl. *J Amer Acad Child Adol Psychiat.* 1987; 26: 447-448.
116. Lorber J, Reckless JPD, Watson JBG. Nonaccidental poisoning: the elusive diagnosis. *Arch Dis Child.* 1980; 55:643-647.
117. Rendle-Short J. Non-accidental barbiturate poisoning of children. *Lancet.* 1978; 2: 1212.
118. Osbourne JP. Non-accidental poisoning and child abuse. *BMJ.* 1976; 1: 1211.
119. Dine MS, McGovern ME. Intentional poisoning of children – an overlooked category of child abuse: report of seven cases and review of the literature. *Pediatrics.* 1982; 70: 32-35.
120. Emery JL. Families in which two or more cot deaths have occurred. *Lancet.* 1986; i: 313-315
121. Lansky SB, Erickson HM. Prevention of child murder: a case report. *J Am Acad Child Psychiatry.* 1974; 127, 275-276.
122. Lansky LL. An unusual case of childhood chloral hydrate poisoning. *Am J Dis Child.* 1974; 127: 275-276.
123. Baugh JR, Krug EF, Weir MR. Punishment by salt poisoning. *South Med J.* 1983; 76: 540-541.
124. Feldman K, Robertson WO. Salt poisoning: presenting symptom of child abuse. *Veterinary and Human Toxicology.* 1979; 21: 341-343.
125. Pickel S, Anderson C, Holliday MA. Thirsting and hypernatremic dehydration – a form of child abuse. *Pediatrics.* 1970; 45: 54-59.
126. Yorker BC, Kahan BB. Munchausen's syndrome by proxy as a form of child abuse. *Arch Psychiatric Nursing.* 1990; IV: 313-318.
127. Nicol AR, Eccles M. Psychotherapy for Munchausen syndrome by proxy. *Arch Dis Child.* 1985; 60: 344-348.
128. Mortimer JG. Acute water intoxication as another unusual manifestation of child abuse. *Arch Dis Child.* 1980; 55: 401-403.

129. Partridge JC, Payne ML, Leisgang JJ, et al. Water intoxication secondary to feeding mismanagement: a preventable form of familial seizure disorder in infants. *Am J Dis Child*. 1981; 135: 38-41.
130. Marks V. Hypoglycaemia--real and unreal, lawful and unlawful: the 1994 Banting Lecture. *Diabet Med*. 1995 ;12:850-64.
131. Scarlett JA, Mako ME, Rubenstein AH, et al. Factitious hypoglycemia: diagnosis by measurement of serum c-peptide and insulin-binding antibodies. *New Eng J Med*. 1977; 297: 1029-1032.
132. Dershewitz R, Vestal V, Maclaren NK, Cornblath M. Transient hepatomegaly and hypoglycemia: a consequence of malicious insulin administration. *Am J Dis Child*. 1976; 130: 998-999.
133. Edidin DV, Farrell EE, Gould VE. Factitious hyperinsulinemic hypoglycemia in infancy: diagnostic pitfalls. *Clin Pediatr (Phila)*. 2000;39:117-9.
134. Mayefsky JH, Sarnaik AP, Postellon DC. Factitious hypoglycemia. *Pediatrics*. 1982; 69: 804-805.
135. Kovacs CS, Toth EL. Factitious diabetes mellitus and spontaneous hypoglycemia: consequences of unrecognised Munchausen syndrome by proxy. *Diabetes Care*. 1993; 16: 1294-1295.
136. Bauman WA, Yalow RS. Child abuse: parenteral insulin administration. *J Pediatr*. 1981; 99: 588-591.
137. Mehl AL, Coble L, Johnson S. Munchausen syndrome by proxy: a family affair. *Child Abuse and Neglect*. 1990; 14: 577-583.
138. Jones JG, Butler HL, Hamilton B, et al. Munchausen syndrome by proxy. *Child Abuse and Neglect*. 1986; 10: 33-40.
139. Arnold SM, Arnholz D, Garyfallou GT, Heard K. Two siblings poisoned with diphenhydramine: a case of factitious disorder by proxy. *Ann Emerg Med*. 1998;32:256-9.
140. Lyall EG, Stirling HF, Crofton PM, Kelnar CJ. Albuminuric growth failure. A case of Munchausen syndrome by proxy. *Acta Paediatr*. 1992;81:373-6.
141. Hill RM, Barer J, Hill L, et al. An investigation of recurrent pine oil poisoning in an infant by the use of gas chromatographic-mass spectrometric methods. *J Pediatr*. 1975; 87: 115-118.
142. Marcus A, Ammermann C, Bahro M, Schmidt MH. Benzodiazepine administration induces exogenic psychosis: a case of child abuse. *Child Abuse Negl*. 1995;19:833-6.

143. Mahesh VK, Stern HP, Kearns GL, Stroh SE. Application of pharmacokinetics in the diagnosis of chemical abuse in Munchausen syndrome by proxy. *Clin Pediatr*. 1988;27:243-6.
144. Valentine JL, Schexnayder S, Jones JG, Sturner WQ. Clinical and toxicological findings in two young siblings and autopsy findings in one sibling with multiple hospital admissions resulting in death. Evidence suggesting Munchausen syndrome by proxy. *Am J Forensic Med Pathol*. 1997;18:276-81.
145. Adelson L. Homicide by pepper. *J Forensic Sciences*. 1964; 9: 391-395.
146. Cohle SD, Trestrail JD, Graham MA, et al. Fatal pepper aspiration. *Am J Dis Child*. 1988; 142: 633-636.
147. Dine MS. Tranquilizer poisoning: an example of child abuse. *Pediatr*. 1965; 36: 782-785.
148. Hvizdala EV, Gellady AM. Intentional poisoning of two siblings by prescription drugs: an unusual form of child abuse. *Clin Pediatr*. 1978; 17: 480-482.
149. Shnaps Y, Frand M, Rotem Y, Tirosh M. The chemically abused child. *Pediatr*. 1981; 68: 119-121.
150. Byard RW, Burnell RH. Covert video surveillance in Munchausen syndrome by proxy: ethical compromise or essential technique? *Med J Aust*. 1994; 160: 352-356.
151. Bath AP, Murty GE, Gibbin KP. Munchausen syndrome by proxy: otolaryngologists beware! *J Laryngol Otol*. 1993;107:151-2.
152. Goss PW, McDougall PN. Munchausen syndrome by proxy--a cause of preterm delivery. *Med J Aust*. 1992;157:814-7.
153. Geelhoed GC, Pemberton PJ. SIDS, seizures or 'sophageal reflux? Another manifestation of Munchausen syndrome by proxy. *Med J Aust*. 1985;143:357-8.
154. Hoorntje TM, Langerak W, Sreeram N. Munchausen's syndrome by proxy identified with an implantable electrocardiographic recorder. *N Engl J Med*. 1999;341:1478-9.
155. Jones VF, Badgett JT, Minella JL, Schuschke LA. The role of the male caretaker in Munchausen syndrome by proxy. *Clin Pediatr (Phila)*. 1993 ;32:245-7.
156. Kurlandsky L, Lukoff JY, Zinkham WH, et al. Munchausen syndrome by proxy: definition of factitious bleeding in an infant by <sup>51</sup>Cr labelling of erythrocytes. *Pediatrics*. 1979; 63: 228-231.

157. Lyons-Ruth K, Kaufman M, Masters N, Wu J. Issues in the identification and long-term management of Munchausen by proxy syndrome within a clinical infant service. *Infant Mental Health J.* 1991; 12: 309-319.
158. Makar AF, Squier PJ. Munchausen syndrome by proxy: father as a perpetrator. *Pediatrics.* 1990;85:370-3.
159. Pickford E, Buchanan N, McLaughlan S. Munchausen syndrome by proxy: a family anthology. *Med J Aust.* 1988; 148: 646-650.
160. Richardson GF. Munchausen syndrome by proxy. *Am Fam Physician.* 1987;36:119-23.
161. Boros SJ, Brubaker LC. Munchausen syndrome by proxy: case accounts. *FBI Law Enforcement Bulletin.* 1992; 61:16-20.
162. Rosen CL, Frost JD, Bricker T et al. Two siblings with recurrent cardiorespiratory arrest: Munchausen syndrome by proxy or child abuse? *Pediatrics.* 1983, 71, 715-720.

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