

Pan-Lancs Safeguarding Children Boards

FABRICATED OR INDUCED ILLNESS

FII

April 2016

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Fabricated or Induced Illness (FII)

1. Definition

Fabricated or Induced Illness (FII) (Known previously as Munchhausen Syndrome by Proxy; other synonyms: Factitious disorder imposed on another) is a spectrum of conditions where a child experiences or likely to experience significant harm and impairment due to the health care seeking behaviour and actions of the caregiver(s), usually the mother. Such behaviour and actions may take one or more of the following forms:

- A. Erroneous (incorrect or misleading) reporting of medical history, symptoms or signs, **with or without an intention to deceive** which may include

False reporting of non-existing symptoms and signs,

Exaggeration of existing symptoms and signs,

Misinterpretation of real events on the basis of mistaken belief about their meaning.

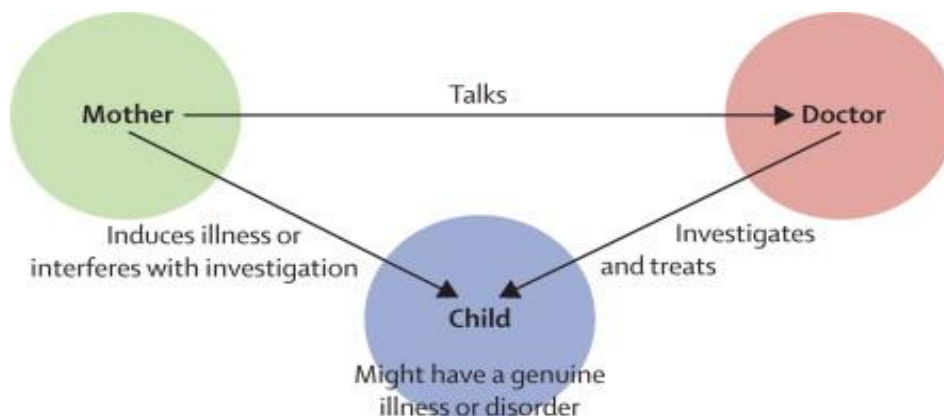
- B. Deception by use of hand including:

Falsification of medical records

Interference with investigations, specimens, intravenous lines,etc

Inducing illness in the child by overdosing, poisoning (e.g. Adding salt to baby's feed), suffocation, none administration of medications (e.g. inhalers for asthma, medication for epilepsy, thyroxin for under active thyroid gland), Etc.

For the abuse in FII to occur, there needs to be a three way interaction between the caregiver (usually the mother), the child, and health professionals as illustrated below.



2. The FII Spectrum

The FII spectrum includes cases with varying degree of severity. The emphasis when investigating such cases should be on the impact of parents' health care seeking behaviour on the child. Cases therefore may be classified as high risk (to the child), and lower risk, cases.

- A. High risk Cases are those where there is suspicion of induction and/ or fabrication /exaggeration (as described earlier) of symptoms and signs, with the intention to deceive. It is very likely that children are at significant risk of harm as a result of parents' actions.

- B. Lower risk cases are those in which parent(s) exaggerate/ misinterpret symptoms and signs due to their strong, but false, belief that the child is ill/ more ill; or when parents suffer from a psychiatric illness (e.g. delusional disorder) which leads them to believe that the child is genuinely ill. In these cases, although the carer may genuinely believe that the child is ill/ more ill, there may be harm and impairment to the child in terms of frequent, invasive and unnecessary medical investigations or treatment, limitation in daily activities and missed educational opportunities.

- C. There is a category of cases where carers exaggerate or falsify their child's illness to fraudulently obtain benefits. These carers may not actively seek medical tests or treatment for the child and may actually avoid contact with medical services. The degree of impact on the child in these cases may vary. In a proportion of these cases harm or potential harm to the child in terms assuming the sick role, loss of education, and possible investigations, may be significant, and FII therefore, should be considered.

It must be made clear from the outset that the way in which various cases within the spectrum are dealt with may vary significantly: In "high risk" cases when there is suspicion of induction or deception by carer(s) with significant risk of harm to the child as a result, an immediate referral to social services is indicated.

Lower risk "of harm" cases listed above are usually dealt with by health care professionals to change carer's perception of their children's health issues. In these cases referral to social services would be considered when such attempts by health care professionals fail, and the child continued to be at risk of harm from parents' actions.

The guidelines will in the main be dealing with the "higher risk" aspect of the spectrum of cases. In situations when we will be dealing with other low risk cases, these will be specifically mentioned as such.

3. Impact of FII on child

The impact of FII on the child can be significant. Research suggests that FII can result in death (6%), requirement for intensive care treatment (12%), and significant emotional problems in the child. There are also significant risks of re-abuse. Following identification of FII in a child, the way in which the case is managed has a major impact on the developmental outcomes and morbidity for the child.

The harm to the child can be grouped within three domains:

A. Physical health

- a. The child has repeated procedures, investigations and treatment that are unnecessary.
- b. Illness induction usually associated with serious harm/ death.

B. Daily life and functioning

- c. Low or interrupted school attendance and education.
- d. Few normal activities such as sport.
- e. Assuming of a 'sick role'
- f. Social isolation.

C. Psychological health

- g. Develop a distorted view of health
- h. Develop anxiety
- i. Develop fabricated or somatoform (characterised by symptoms suggesting a physical disorder but for which there is no known organic cause or physical findings) disorders in the future
- j. Collude with illness presentation

4. When to suspect FII

The following are indicators that should alert professionals that a child is likely to be suffering harm as a result of FII. These indicators form the basis for the template used to assist in the diagnosis FII (appendix 1 &2):

- A. Reported symptoms and signs are not explained by any 'known' medical condition;
- B. Physical examination and results of investigations do not explain reported symptoms and signs;
- C. New symptoms are reported on resolution of previous ones;
- D. Reported symptoms and identified signs are not observed in the absence of parent(s);
- E. Treatment for an agreed condition does not produce the expected effects;
- F. Repeated presentations to a variety of health care professionals and with a variety of problems;
- G. The child denies parental reports of symptoms.
- H. The child's normal daily life activities are being curtailed beyond that which may be expected from any known medical disorder from which the child is known to suffer;
- I. Child usually presents with specific unexplained episodic problems such as apnoea, fits, choking or collapse.
- J. History of unexplained illnesses or deaths or multiple surgery in parents or siblings.
- K. Past history in the parent of child abuse, self-harm, somatisation, or false allegations of physical or sexual assault
- L. Objective evidence of fabrication or induction. Examples include biologically implausible events, test results such as toxicology studies or blood typing; and direct evidence of fabrication or induction.

5. Characteristics of the perpetrator of FI

- A. FI is not a recognised psychiatric condition.
- B. Studies vary in describing the characteristics of perpetrators depending on population and case definition. However, in many studies, perpetrators of FI tend to share a number of characteristics.
- C. Perpetrators of FI are usually mothers (over 70%), and are also mostly females (93%). Remember however that fathers and other carers (e.g. grandparents) may be implicated.
- D. A number of studies have shown that many perpetrators have a somatoform (physical presentation without any organic cause that can be identified) or factitious disorder(s).
- E. Other studies have identified personality disorders in high percentage of parents.
- F. In general, the non-perpetrating fathers tend to be distant, uninvolved, and emotionally and physically detached from the family system. Some fathers are truly unaware, some might believe the mother's contentions, and some might be suspicious and attempt to challenge the mother unsuccessfully.
- G. Alleged perpetrators are likely to be seen as highly devoted to the child but paradoxically appear unconcerned about the child's illness (particularly if the illness is genuine).
- H. They appear disappointed at negative test findings.
- I. The alleged perpetrator is typically knowledgeable about the child's illness and treatment, is happy to be in hospital and forms close, and often controlling, relationships with the healthcare staff.
- J. There may be a background of seeking financial or other gains through illness behaviour.
- K. An avoidance of professionals who challenge or question (i.e. shopping around).

6. What to do when you suspect FII: All Professionals (Flow chart appendix 2)

- A. Concerns regarding FII may be raised by professionals from a number of agencies, including health, education, children's social care, voluntary sector, and possibly police. The majority of concerns however, arise within health.
- B. The emphasis of these concerns should be on the impact that any suspected fabrication and/or induction of illness has on the child and the possible risk of harm; especially where there is suspicion of induction of illness (or risk of immediate harm) **In such cases immediate referral to Child Social Care (CSC) is indicated.**
- C. Any Professional who has concerns that a parent or carer may be fabricating or inducing illness in a child must discuss their concerns with their line manager and their agency's nominated safeguarding children adviser / lead. It is vital that other professionals are aware of the concerns. Information sharing (without parental consent) is encouraged at an early stage in the best interests of the child, both within the agency (e.g. with other members of a GP practice) and within the wider team (eg the health visitor/school nurse).
- D. If it is deemed that such concerns have substance they should be discussed with the child's lead health professional who would then follow their internal safeguarding processes. The child's GP and Paediatrician (if the child is under the care of a Paediatrician), must also be consulted. N.B **Parents must not be informed of FII suspicion at this stage.**
- E. All health care staff in primary, secondary or tertiary care settings such as Paediatrics, CAMHS, Learning Disability, Physiotherapy, Universal services etc. should consult with their safeguarding leads or other experienced colleagues within their own organisation.
- F. The Paediatrician looking after the child will assume the role of the "responsible Paediatrician". If a number of Paediatricians are involved in the care of the child, they must collaborate and nominate a lead paediatrician who will be the "responsible Paediatrician" for the coordination of health care across all providers.
- G. There may be occasions where concerns arise regarding FII when children are under the care of consultants who are not paediatricians, or not under the care of any consultant. In cases where there are physical symptoms and signs, a referral to a paediatrician should be made. Such referral would preferably be made to a senior consultant or a consultant with a subspecialty and expertise in the signs and symptoms the child is presenting with.
- H. In cases where a referral to a Paediatrician is not deemed necessary, the case should be discussed with the designated or named doctor for safeguarding who will assume the role of the "responsible Paediatrician".

- I. Medical / health practitioners are ideally placed to recognise anxiety related, misconstrued, and exaggerated illness, within the context of any perplexing or medically unexplained conditions.
- J. Where safe to do so, and in the absence of evidence of significant harm or suspicions of deception or induction, formulating a supportive safe plan aimed at containing the escalation of health seeking behaviours may suffice (seek the advice and support of agency nominated safeguarding leads). Early intervention in such low risk cases may negate the need for a referral to Children Social Care.
- K. If there is full agreement that such course of action should be followed, then the lead paediatrician and relevant colleagues can meet with the parents and explain that they are unable to give a diagnosis or an explanation because they
 - a. 'do not know'
 - b. There is no explanation for reported signs and symptoms
 - c. Reported symptoms are not 'life threatening'
 - d. There is no medical treatment
 - e. Further investigations and repeat presentations to medics are more harmful than doing nothing
 - f. The child and the family need to be helped to function alongside the symptoms
 - g. The child will not come to any harm as a result of no further action
- L. The doctor can then initiate a rehabilitation programme and work towards full return to normal function / better state of health.
- M. If following containment and an attempt at 'rehabilitation' parents are still exhibiting 'exaggeration' of health care seeking behaviours, a period of hospital observation and only if necessary, any possible further investigations, may be considered.
- N. However in this milder end of the FII spectrum, if Parents / carers:
 - i. disagree with or dispute independent / clinical observations and / or request more investigations
 - ii. seek more medical opinions when more than one already obtained
 - iii. decline rehabilitation plan & child's functioning is being impaired

Then a referral to CSC should be considered in conjunction with the named/ designated safeguarding individual. The referrer should make it clear that s/he is making the referral under FII procedures.

- O. In the high risk severe end of spectrum where:
 - a. Deception by carer is strongly suspected in child's presentations,
 - Or
 - b. Suspicion of induction arise at any time,

Then a referral to Children Social services should be made. Parents in these categories should not be informed of FII suspicions at this stage.

- P. Parents should not be informed of the referral at this stage. Under no circumstances should the parent/carer be challenged or confronted by anyone outside a multi-agency planned approach

- Q. Once a referral is received Children's Social Care should decide, and record within one working day, what response is necessary.

- R. The majority of the children where the risk to the child is more serious will be dealt with through investigations by the Police and Children's Social Care under Section 44 of the Children Act 1989. However for those children to whom the risk is very great they may be in need of immediate protection. Children subject to such immediate risk can be removed from parents care via the Police through a Police Protection Order or through an application by the Local Authority for an Emergency Protection Order. Such significantly interventionist action however requires clear medical evidence of the child being at imminent risk of significant harm through action attributable to their parents/carers.

- S. It is expected that the paediatric consultant responsible for the child's healthcare is the lead health professional and therefore has lead responsibility for all decisions appertaining to the child's healthcare. All previous records, plus out of area, should be scrutinised by the consultant paediatrician

- T. Any suspected case of fabricated or induced illness may involve the commission of a crime and therefore the police should always be involved during the investigation stage.

- U. **All professionals involved with suspected FII cases must ensure that their record keeping is detailed and accurate including clear documentation of all decision making. It is particularly important to document who attends with the child and who reports which symptoms. Any examination should be thoroughly described including negative findings. Professionals should also clearly document what they have recommended. This will clarify any misinformation that may arise from parents reporting different versions to different professionals.**

- V. Any involved professional can request that a strategy meeting be held although this is usually the role of social care.
- W. The strategy meeting will be chaired by an experienced Independent Reviewing Officer (IRO), or other personnel as per local guidance of each LSCB, who have sufficient understanding of managing the complexities involved in possible FII
- X. It is strongly advisable that early on in the process when suspicions arise, a chronology of child's health history should be compiled to focus attention and aid in the identification of possible FII. Chronologies will be discussed further later on in the guidelines..

7. **The Strategy Meeting:**

- A. If there is a reasonable cause to suspect that the child is suffering, or likely to suffer, significant harm, or that parent(s) actions have significant negative impact on the child, children's social care (CSC) should convene and chair a strategy meeting, in line with section 47 child protection enquiries, involving all the key professionals.

Participants must include as a minimum:

- Chaired by IRO (or an alternative chair as per each specific LSCB guidelines)
- Children social care.
- Police
- The "responsible Paediatrician".
- GP or their report.
- School/ nursery if applicable

As medical information are crucial in these meetings, it is extremely important that as much as possible, the date, time and place of the meeting should be suitable for the GP and Paediatrician to attend.

Other professionals are invited as appropriate and may include:

- A senior ward nurse if the child is an in-patient;
- A medical professional with expertise in the relevant branch of medicine;
- Allied health professionals
- Health visitor or school nurse;
- CAMHS services
- Named/ designated safeguarding professionals.
- Local authority Legal Advisor (In some LSCBs this is a must attend)

- B. The participants in the strategy meeting would examine evidence of FII and explore the impact of carer's actions on the child and other children in the family.

- C. Such evidence is usually presented in the form of chronologies of significant events prepared by different agencies with opportunity to debate and challenge provided. If chronologies are not available for the first strategy meeting, they should be available for a subsequent strategy meeting to have an informed discussion.
- D. As the child's circumstances are likely to be complex, it may be necessary to have more than one strategy meeting.
- E. Chronologies from different agencies should eventually be merged together into a multiagency chronology. This is usually done by the Children Social Care.
- F. Staff attending should be sufficiently senior to be able to contribute to the discussions of very complex information, and to be able to make decisions on behalf of their agency
- G. If the outcome of the strategy meeting(s) is that section 47 enquiry is needed, the following issues should be determined:
 - a. The level of risk of harm to child and siblings, and any immediate steps necessary to reduce such risks
 - b. Communication with carers and confidentiality (including how, when, and by whom they should be informed of any child protection concerns). It is advisable that informing parents should be done jointly by CSC and health, with police involved if criminal aspect is suspected.
 - c. The planning of further medical and nursing assessment, including any outstanding investigations. This may include cancelling unnecessary medical procedures or instituting closer observation of the child.
 - d. The development of an integrated health (and other) chronology (and agreement on who should do this)
 - e. Whether the carers should be allowed on the ward if the child is an inpatient
 - f. The level of professional observation required
 - g. The need for forensic sampling, special observation or Covert Video surveillance (CVS)
 - h. The needs of carers, particularly after disclosure of concerns
 - i. Clarification of who will be the responsible paediatric consultant for the child (if not already explicit)
 - j. In many cases of suspected FII, information about siblings and carers, including their past medical history, current health and any treatment, equipment, and benefit they receive, are very relevant to the case discussed. Such information are very likely to aid in the diagnosis of FII and need to be shared.

8. Information sharing and consent

- A. Information sharing (2015), states that, where possible, information are shared with consent. However, the guidelines also states that “if it is unsafe or inappropriate to do so, i.e. where there are concerns that a child is suffering, or is likely to suffer significant harm” , one “would not need to seek consent”. So sharing information without consent should be done when it is judged that seeking consent would places the child at risk.
- B.** In the majority of cases of suspected FII, consent to obtain information regarding siblings and parents is not possible as parents are usually not informed of suspicions in this early stage of investigation. Seeking consent is likely to jeopardise the investigation and very likely to put the child at risk of harm. ***Consent to obtain information in most FII cases is, therefore, unnecessary, and is not required.***
- C. It is important that any information shared should be necessary (for the purpose for which it is shared for), proportionate, relevant, adequate, accurate (up to date, and based on facts not opinion), timely and shared securely.

9. Chronology (Pro forma Appendix 3)

- A. A child’s chronology forms an important tool in the identification and management of cases of FII and therefore should be compiled in **all cases** of suspected FII.
- B. An experienced person from each agency should compile the chronology for that agency and should be given adequate time and resources to do so.
- C. Chronologies should then be merged in a “multi-agency” Chronology. This is usually done by children’s social care.
- D. The chronology should points to the actual or potential harm to the child caused by various events in terms of unnecessary investigations and treatment, loss of education, and curtailment of activities, possible psychological effects.... etc..
- E. It is very useful that each chronology would attempt to reference some significant events in child’s life to different FII warning signs if applicable.
- F. Each chronology should have a summary of events and their impact on the child.
- G. A chronology regarding siblings and possibly carers may be required to have a full picture of the extent of the problem, and would likely to aid in diagnosis. As discussed earlier, consent is not required in obtaining such information in most cases.
- H. Once available, the chronology should be shared with clinical colleagues and within the multiagency setting of the strategy meeting and case conference, if applicable.

10. Outcome of section 47 investigation

- A.** Investigation may show that concerns are not substantiated (e.g. tests may identify a medical condition that explains the signs and symptoms).
- B.** It may be that no protective action is required, but the family should be provided with the opportunity to discuss whether they require support.
- C.** As in all areas of child protection certainty is not required but evidence – written, verbal and observed, should be considered and professional judgement on the likelihood of risk of actual harm should be made on the balance of probability. To protect children we must concentrate on assessing harm to the child.
- D.** Concerns may be substantiated, but an assessment may be formed that the child is not at continuing risk of harm. In this case, the decision not to proceed to a child protection conference must be endorsed by the LA children's social care manager or child protection advisor
- E.** Where concerns are substantiated and the child is judged to be suffering, or at risk of suffering, significant harm, a child protection conference must be convened. All evidence should be thoroughly documented by this stage and the protection plan for the child already in place.
- F.** Child protection investigations in FII may take more time than usual. However, professionals should ensure that any child protection conference is held within 15 working days of the last strategy meeting, and that regular strategy discussions take place throughout the investigation.
- G.** The maximum timeframe for the assessment to conclude, such that it is possible to reach a decision on next steps, should be no longer than 45 working days from the point of referral.
- H.** If, in discussion with family and other professionals, an assessment exceeds 45 working days the social worker should record the reasons for exceeding the time limit. Whatever the timescale for assessment, where particular needs are identified at any stage of the assessment, social workers should not wait until the assessment reaches a conclusion before commissioning services to support the child and their family. In some cases the needs of the child will mean that a quick assessment will be required.

11. **Covert Video Surveillance (CVS)**

- A. The use of covert video surveillance should be the last resort in FII investigation. It may be considered when there is no alternative way of obtaining information to explain child's signs and symptoms.
- B. The decision to use CVS may be made only by the multiagency strategy discussions to investigate suspected FII.
- C. The use of CVS is governed by the Regulation of Investigatory Power Act (the 2000 Act). The operation is controlled by the police and accountability for it is held by police manager. They will need to demonstrate that the use of CVS may lead to detection or prevention of crime.
- D. Police officers should carry out any necessary monitoring. All personnel, including nursing staff, who will be involved in its use, should have received specialist training in this area.

Appendix 1**FII Warning Signs Template *(WST)**

Category	Warning signs of Fabricated or Induced Illness
1.	Reported symptoms and signs are not explained by any medical condition from which the child may be suffering.
2.	Physical examination and results of medical investigations do not support/ explain reported symptoms and signs.
3.	There is an inexplicably poor response to prescribed medication and other treatment.
4.	New symptoms are reported on resolution of previous ones.
5.	Reported symptoms and signs are not seen when the carer is not present.
6.	Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear.
7.	Repeated presentation to a variety of doctors with the same or different health problems.
8.	History of unexplained illnesses or deaths or multiple surgery in parents or siblings.
9.	The child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.
10.	Incongruity between seriousness of story and action of parents
11.	Erroneous or misleading information provided by the parent.
12.	Exaggerated catastrophes within other extended family members are reported.

***Please Note: The categories within the template are not absolutes – there may be numerous possible explanations one of which is possible FII.**

Appendix 2:

Warning Signs Template items explained

1.	<p>Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.</p> <p>Information obtained through history and physical examination do not correlate with any recognised disease or where there is a disease known to be present. A very simple example would be a skin rash, which did not correlate with any known skin disease and had, in fact, been produced by the perpetrator. An experienced doctor should be on their guard if something described is outside their previous experience.</p>
2.	<p>Physical examination and results of medical investigations do not explain reported symptoms and signs. Physical examination and appropriate investigations do not confirm the reported clinical story. For example, it is reported a child turns yellow (has jaundice) but no jaundice is confirmed when the child is examined and a test for jaundice, if appropriate, is negative. A child with frequent convulsions every day, has no abnormalities on a 24-hour video telemetry (continuous video and EEG recording) even during a so-called 'convulsion'.</p>
3.	<p>There is an inexplicably poor response to prescribed medication and other treatment.</p> <p>The practitioner should be alerted when treatment for the agreed condition does not produce the expected effect, for example asthma medications not making any difference to described wheezing and cough. This can result in escalating drugs with no apparent response, using multiple medications to control a routine problem and multiple changes in medication due to either poor response or frequent reports of side effects. On investigation, toxic drug levels commonly occur but may be interspersed with low drug levels suggesting extremely variable administration of medication fluctuating from over- medication to withdrawal of medication. Another feature may be the welcoming of intrusive investigations and treatments by the parent.</p>
4.	<p>New symptoms are reported on resolution of previous ones.</p> <p>New symptoms often bear no likely relationship to the previous set of symptoms. For example, in a child where the focus has been on diarrhoea and vomiting, when appropriate assessments fail to confirm this, the story changes to one of convulsions. Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.</p>
5.	<p>Reported symptoms and found signs are not seen to begin in the absence of the carer,</p> <p>In this respect, the perpetrator is the only witness of the signs and symptoms. For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly raise anxiety of FII where the severity and/or frequency of symptoms reported is such that the lack of independent observation is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. Example would be school describing episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.</p>

6.	<p>Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above).</p> <p>This is a planned separation of perpetrator and child which it has been agreed will have a high likelihood of proving (or disproving) FII abuse. It can be difficult in practice, and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child's bedside, is unusually close to the medical team and thrives in a hospital environment.</p>
7.	<p>Repeated presentation to a variety of doctors with a same or different health problems.</p> <p>At its most extreme this has been referred to as 'doctor shopping'. The extent and extraordinary nature of the additional consultations is orders of magnitude greater than any concerned parent would explore. Often consultations about the same or different problems are concealed in different medical facilities. Thus the patient might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different set of problems (or even the same) without informing these various medical professionals about the other consultations.</p>
8.	<p>History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.</p> <p>The emphasis here is on the unexplained. Illness and deaths in parents or siblings can frequently be a clue to further investigation and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the general practitioner through to the extreme of Munchausen syndrome where there are multiple presentations with fabricated or induced illness resulting in multiple (unnecessary) operations. Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially might have been subject to FII abuse and their medical history should also be examined.</p>
9.	<p>The child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.</p> <p>The carer limits the child's activities to an unreasonable degree and often either without knowledge of medical professionals or against their advice. For example, confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child's school attendance</p>
10.	<p>Incongruity between the seriousness of the story and the actions of the parents.</p> <p>Given a concerning story, parents by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is incongruity between their expressed concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend for crucial assessments (somebody else's birthday, thought the hospital was closed, went to outpatients at one o'clock in the morning).</p>
11.	<p>Erroneous or misleading information provided by parent.</p> <p>These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc.). An extreme example of this is spreading the idea that the child is going to die when in fact no-one in the medical profession has ever</p>

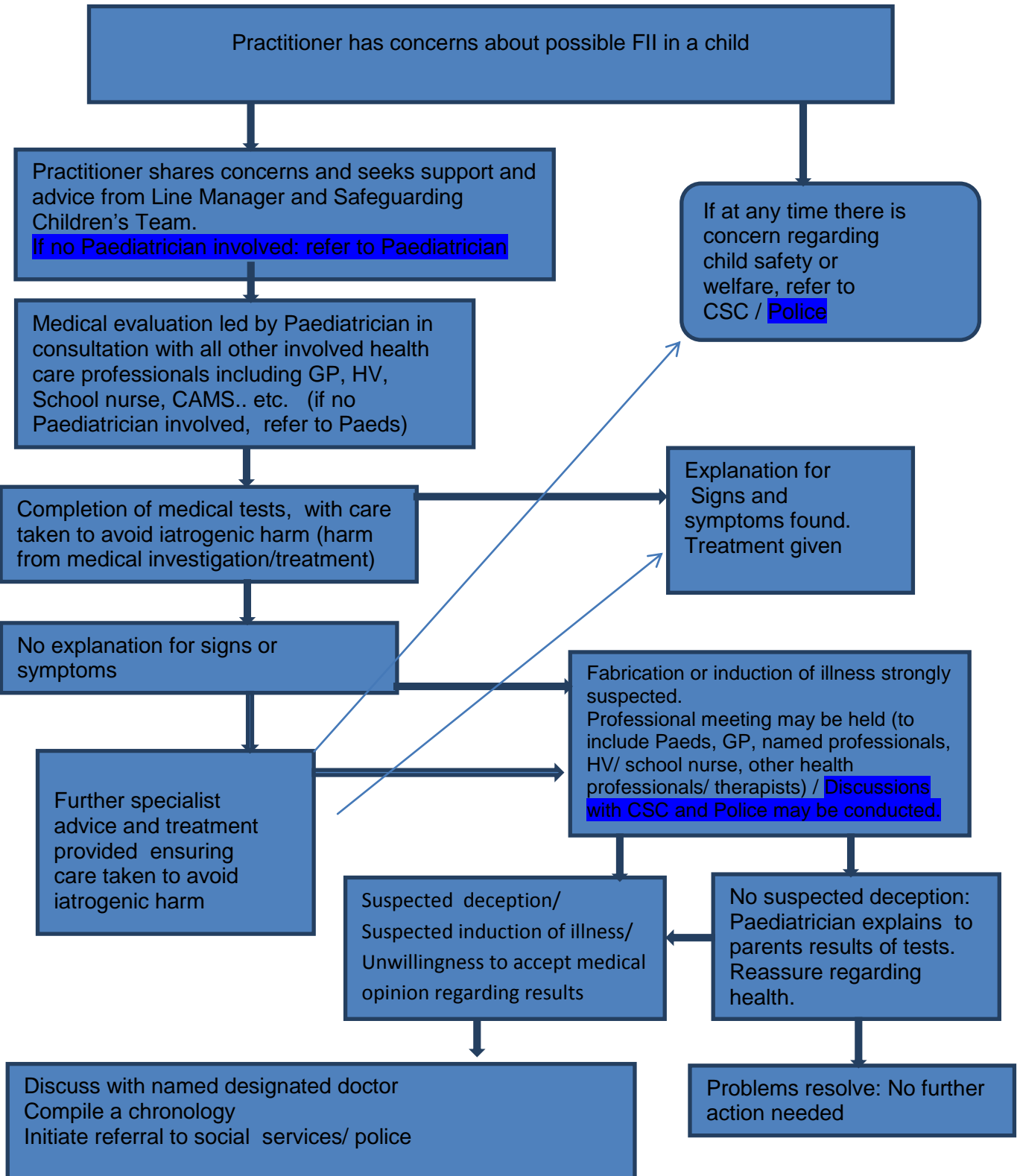
	suggested this. Changing or inconsistent stories should be recognised and challenged. Accurate and detailed documentation is key here.
12.	Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported. This is an extension of category 8. On exploring reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They were largely or wholly fictitious.

Appendix 3

The Chronology

Date	Source	Event	Action taken	Actual/ potential impact/harm on child	Template category corresponding to FII warning signs.

Appendix 4: Flowchart when FII is suspected



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