PUBLIC REPORT

REPORT TO
CUMBRIA CHILD PROTECTION COMMITTEE

SERIOUS CASE REVIEW

(CONDUCTED UNDER THE GUIDANCE OF PART 8 *WORKING TOGETHER*)

of events leading to the death of Michael

who was the victim of fabricated or induced illness (FII)

(formerly known as Munchausen syndrome by proxy)

MARCH 2004

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1. INTRODUCTION

1.1 This Serious Case Review examines inter-agency working following the death of Michael. Michael was a victim of fabricated or induced illness (FII). This form of abuse presents great challenges to intra-profession, inter-profession and inter-agency working.

1.2 Fabricated or induced illness is a form of child abuse. It is the intention of the Review Group that professionals reading this report will increase their understanding of this type of abuse.

1.3 As this Serious Case Review was being completed the report of the inquiry by Lord Laming into the death of Victoria Climbié was published.[1] Lord Laming identified shortcomings in the system which had also been found by this Review Group and anticipated a number of our recommendations.

2. THE CHILD'S STORY

2.1 Michael died on 14 October 2000. He was only seven years old. His short life had been full of difficulties, particularly in the latter years. He died in hospital in Leicester, after several months on a life support system, because of the effects and complications caused by pneumonia. He had been treated for epilepsy for several years, and had been admitted to hospital a number of times for investigations and treatment, and had been found on more than one occasion to have toxic levels of prescribed medication in his blood.

2.2 Criminal proceedings against the mother resulted in her conviction on 22 July 2002 of the attempted murder of Michael and four cruelty charges against Michael.

2.3 Mother was sentenced on 13 January 2003; on the attempted murder of Michael, to life imprisonment. She was also sentenced to a further period of imprisonment on each of the cruelty charges against Michael.

2.4 On 8 June 2004 mother was successful in appealing the conviction of attempted murder. The Court of Appeal dismissed arguments that the sentence in respect of cruelty charges should be reduced, saying it was amongst the most serious child cruelty cases and the sentence had been justified.

2.5 In passing sentence on 13 January 2003 the Judge made a number of comments on mother's conduct which apply as much to the cruelty convictions as to the attempted murder conviction which has now been set aside. The judge accepted the conclusion of Dr Holloway, Consultant Forensic Psychiatrist, 'I would have grave concerns about the safety of any child in her care for the foreseeable future'. Whilst accepting that Michael may have had mild symptoms of epilepsy at the beginning, the judge continued 'thereafter you deliberately lied to your general practitioners so as to obtain prescriptions of drugs that Michael did not need in ever increasing amounts. You reinforced those lies with further exaggeration and lies to other health professionals, school staff, friends and family. You also used dishonesty and subterfuge to obtain large extra quantities of these drugs with which you overdosed him further. The tragic consequence of all this was that he was caused years of misery and he was reduced from a normal little boy with some

easily manageable health problems to the pitiful state in which he was before his final admission to hospital'.

2.6 Michael was born prematurely by caesarean section in February 1993. After delivery he needed special care in an incubator and for a short time was on a ventilator. Initially he developed normally, but was treated for asthma as a baby almost exclusively on the basis of his mother's report. When he was three and a half years old his mother described 'absences' to the family doctor and he was treated for epilepsy. There was never any conclusive proof of this epilepsy in spite of repeated consultations and investigations. Michael's mother obtained quantities of the prescribed medication which were far in excess of his requirements. The prescribed medication was primarily administered by his mother or under her control and direction, and over a long period of time many drugs were tried but his 'fits' allegedly got worse. The toxic effects of the drugs caused chronic ill health for Michael. He was eventually unable even to attend school and had been fitted with a naso-gastric tube to administer food and drugs.

2.7 In April or May 1999 the mother told a teacher that Michael had Lennox Gastaut Syndrome and that it was a terminal illness. At around the same time she told a relative that she had been told by the GP that 'they could do no more for Michael'. Suggestions that Michael was going to die continued to appear, generated by the mother. In June 2000 the family doctor arranged for Michael to be admitted to West Cumberland Hospital, but on the morning of 26 June which was the day that he was due to be admitted, there was an urgent call to the family doctor because Michael was having difficulty in breathing. The family doctor arranged an ambulance before visiting Michael, and after having examined him, instructed his mother not to give him any further medication before he was admitted. In spite of this advice, a further dose of medicine was given to Michael by his mother through the naso-gastric tube when he was in the ambulance. At the hospital, it was found that the tube was not in the correct place, but had doubled back on itself so that any medicines or food injected through it could pass into the windpipe and lungs rather than the stomach.

2.8 Michael was transferred to Newcastle and then to Leicester for special treatment of the pneumonia caused by this lung damage. Sadly the treatment was not effective and Michael died on 14 October 2000.

3. UNDERSTANDING FABRICATED OR INDUCED ILLNESS

3.1 The defining characteristics of fabricated or induced illness are:[2]

i. Illness in a child which is fabricated or induced by a parent or someone who is in the position of a parent.
ii. A child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
iii. The perpetrator often denies the aetiology (explanation of the causes) of the child's illness.
iv. Acute symptoms and signs cease when the child is separated from the perpetrator.

3.2 The identification of previously unrecognised forms of child abuse has followed a characteristic pattern, first seen in the 1950s with physical abuse and subsequently in the identification of sexual abuse. Slow gathering of acknowledgement by clinicians was

accompanied in the literature by case reports from strongly polarised views. Then, as widening awareness of the form of abuse occurred, over-identification became a problem with clinicians uncertain about the boundaries of pathological signs and distinction from 'normal' signs. Attempts followed to develop 'litmus tests' for the condition to simplify what was required to identify it. There is often argument about the terms and categories used during the course of this. This, in turn, is followed by cynicism about the existence of the form of abuse. Finally, refinement of clinical markers, better research and a better academic base are established.

3.3 In 1951 the term 'Munchausen syndrome' was used by Asher[3] to describe a persistent pattern seen in adults, of presentation to health services with factitious somatic complaints. The patients in this original paperwork were extremely persistent in their demands, often persuasive and readily exploited the goodwill of nurses and doctors. By using the eponymous title, Asher brought such patients to a new prominence, although by using a jokey title for the 'syndrome' – the name of a hazy, foreign, fantastic tale-telling character, drawn to deceit – Asher obscured the 'dreadful import of the situation'.[4] The risks the patients took with themselves and the flagrant abuse of trust and the resources of the Health Service are somewhat glossed over.

3.4 Early papers on factitious presentations of children to doctors begin in the 1960s with literature on non-accidental poisoning. In the 1970s a wider recognition of the different forms of paediatric presentations began. It was described in 1977 as a form of child abuse in which parents 'by falsification caused their children innumerable harm for hospital procedures – a sort of Munchausen syndrome by proxy'.[5] Thus, by 1977 the term 'Munchausen syndrome by proxy' (MSBP) was introduced into the clinical vernacular.[6] Understanding of this type of abuse has developed rapidly since then.

3.5 It is important to be aware that FII is only one manifestation on the spectrum of child abuse. Risk factors which are now acknowledged as common in cases of abuse may be indicators of FII as much as any other form of abuse.[7,8] These other risk factors include:

- The parents' own childhood being characterised by abuse and neglect with a failure to receive compensatory positive experiences.
- Characteristics in the parents such as low intellectual ability, personality disorders, longstanding drug and alcohol dependency.
- The parents' failure to develop parenting skills which may be influenced by depression or other psychiatric problems, youth or immaturity.
- The physical environment including poor housing, debt, a neighbourhood culture of violence and fear.
- Domestic violence.
- Lack of social support either in the form of a partner who is absent or unhelpful, lack of support of friends and neighbours etc.
- Immediate triggers such as substance abuse, tiredness.
- Characteristics of the relationship with the child such as problems developing a normal attachment, an unwanted pregnancy, early separation.

- Characteristics in the child which can increase the likelihood of the child becoming a victim of abuse, e.g. having special needs, chronic illness or 'difficult' temperament.

3.6 It is important to stress that these risk factors do not automatically create an abusive parent. Many parents with these disadvantages still provide good nurturing safe care to children. However, where abuse occurs a number of these risk factors are often present.

3.7 The most recent guidance produced by the Department of Health[9] advised that the use of the term Munchausen syndrome by proxy should be abandoned and recommended use of the term fabricated or induced illness (FII). This definition focuses on the harm to the child. It does not consider perpetrator characteristics or motivation.

3.8 In **fabricated illness** the perpetrator does not directly harm the child but reports to doctors a clinical story which is eventually established to be fabricated.

3.9 In fabricated illness the clinical story may be 'supported' by **falsified specimens.** These specimens have not been obtained by injuring the child. For example, mother's menstrual blood may be added to the urine to simulate haematuria (blood in the urine) or substances containing glucose added to the urine to simulate diabetes.

3.10 In **induced illness** the perpetrator inflicts direct (hands-on) harm on the child. This can range from trivial injuries, such as pricking the child to obtain blood to add to the urine, through to suffocation.

3.11 The main methods of inducing illness are:

i. Minor injury to the child to produce falsified specimens.
ii. Poisoning with a range of prescribed or non-prescribed substances. Included in this is excessive manipulation of prescribed drugs (both under- and over-administrations) such that harm to the child occurs.
iii. A direct injury to the child, including administration of substances through portals of entry to the body such as intravenous cannulae (drips).
iv. Suffocation.

3.12 Three ingredients are required for this form of abuse to occur:[6]

i. A dependent child is available to the carer and is under her or his control, influence or behest.

ii. A carer presents the child to the health care system with invented symptoms or fabricated signs.

iii. A health care system exists in which doctors, nurses and other health care personnel have almost unlimited capacity in terms of resources and technology to undertake investigations and interventions with children.

This triad – doctor, carer and child – provides the boundary within which FII abuse takes place. The doctor stands for the resources of the health system, the parent/carer presents the child and the dependent child 'carries the illness'.[7]

3.13 **The 'bargain' of health care.**

'Most of those who work in Western medical systems, especially those who work with children, do so within a belief system that assumes health care happens when parents bring children to medical settings because the parent notices that something is wrong with the child's health, and that the parent gives a faithful account, as far as they are able, of what symptoms the child has experienced. The health care worker, in accordance with their belief about their own role, sees him or herself as entering a contract to bring to a situation both their own knowledge and skill about the range of diseases which might explain this set of symptoms, and also the technological might of medical science in carrying out investigations and bringing forward treatments. Invasive investigations are justified in the search for disease; a physical cause for a symptom or a rare illness must not be missed. There is an implicit bargain here: **that parents bring children who are sick and tell the truth about them and that doctors bring expertise and technology and act to do their best for children.**'[7] 'We may teach, and I believe should teach, that mothers are always right; but at the same time we must recognise that when mothers are wrong they can be terribly wrong'.[5] Many changes in medicine and in the relationship between health professionals and parents since 1977 have made it even more difficult for professionals to consider the possibility that the basic bargain of health care has been infringed and that things are going terribly wrong.[7] This difficulty for professionals must not be underestimated.

3.14 **How common is FII? Importance for all practitioners.**

The most widely quoted figure for the incidence of fabricated or induced illness is that reported by McClure.[10] The figures for different regions of the UK and Republic of Ireland varied from 0.1 to 0.8 per 100,000 children under sixteen years of age. On average this equates to approximately one occurrence per health district per annum in the United Kingdom. This survey used tightly defined criteria (disability or illness fabricated by an adult in a child, non-accidental poisoning and deliberate suffocation of children). Even with this tight definition it is noteworthy that there was an eight-fold variation in the reported incidence. The authors attributed this variation, at least partly, to under-reporting.

3.15 Clinical experience suggests fabrication is far more common and this is supported by a survey performed by Watson *et al*.[11] Professionals in a single health district comprising 65,000 children and adolescents under 16 years of age were asked to identify where 'concern that excessive seeking of health care (excessive and unnecessary consultations, imaginary or exaggerated illnesses) or abnormal illness behaviour (unnecessary use of medication or hospital appointments) by the parent on behalf of a dependent child' caused the professional to consider whether significant harm was occurring to that child. 58 children were identified from 42 families in a two-year period. This is equivalent to 89 per 100,000 children who are reported to have experienced parental abnormal illness behaviour over a two-year period. This study further reinforces the dimensional view of factitious illness by proxy, with a large unseen 'iceberg' of parental excessive or discrepant health care seeking in relation to children, surmounted by a 'tip' of clearly more severe factitious illness.[7] Thus all doctors who manage children, particularly general practitioners, will be familiar with this type of behaviour and recognise the potential for abuse.

3.16 **What should happen if FII is suspected?**

The Department of Health guidance[9] states 'if there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, Social Services should convene a strategy discussion'. The Group is concerned that this sets too high a threshold for a strategy discussion to be convened. Further guidance is required and should be addressed in the amendment of the current child protection procedures.

3.17 A further problem arises when doctors have a suspicion of FII but limited evidence of harm. How far can they consult anonymously to help clarify their concerns? Use of the 'child in need' (section 17 Children Act 1989) model can encourage planning meetings to discuss the appropriate level of family support, the roles and responsibilities of each agency and the next steps if the plan is not working. Information is shared with the focus on supporting the child and family, not on deciding whether or not the child is being abused.

3.18 This approach can also be helpful in involving parents. Involving parents in section 17 planning meetings can be extremely constructive.

3.19 If FII is recognised as a possibility then a strategy can be devised for its management. Professionals will be alert to the need to verify histories given by the parent/carer and the medics can contain the consultation behaviour ensuring that no direct harm is done to the child.

3.20 Additional guidance is required about the steps to be taken either to confirm or to rule out the suspicion of FII and in managing uncertainty. Persistent parents[12] (frequent attenders) need a strategy for support and engagement with medical services. They need consistency and continuity. The 'worrying' parent will be supported and reassured. The 'harming' parent will break out of any containment strategy.

3.21 The identification of FII will not always result in the removal of a child. Where the abuse is at the 'fabricated' end of the spectrum (excessive and unnecessary consultations, imaginary or exaggerated illnesses) containment strategies within the community may be indicated. Many 'mild' cases of fabrication are contained by sensible, primary care; indeed this is one of the strengths of the health care system in the United Kingdom.

3.22 **Holding meetings without parents**

It is rarely likely to be helpful to include a parent in a meeting which has been convened to consider the possibility of FII. Instead of allowing the professionals space and time to compare chronologies against the indicators of FII, the carer is likely to be plausible in explaining away concerns, covering up inconsistencies and obtaining the sympathy of the professionals present. It is very uncomfortable for any professional to be voicing the possibility that an apparently nurturing carer of a poorly child might be deliberately harming that child. There can be no doubt that the carer's presence would inhibit free and frank exchange of information which is essential to the identification of FII and the protection of the child.

3.23 **Motivation of the perpetrator**

Does understanding the perpetrator help in identifying the abuse? The emphasis in this question is on 'help in identifying the abuse'. Motivation of the perpetrator is of great

interest in terms of outcomes, response of perpetrators to therapy and culpability but attempts to understand motivation can be a barrier to identification of abuse. Professionals sometimes deny the possibility of FII because they cannot understand why or how it has been perpetrated. Furthermore, some perpetrators are adept at presenting themselves as nurturing, concerned parents and one stereotype is of the extremely devoted parent who is overly involved with health professionals.[13] It is even more difficult to consider that such an apparently exemplary parent could be abusing their child. **To protect children we must concentrate on assessing harm to the child rather than trying to understand something which is not rational.**

3.24 **Is it a mental illness?**

The reasons for FII not being a mental illness from which the perpetrators suffer are best summarised by Fisher and Mitchell. 'If it is a situation or parental behaviour (a fabrication) that has come to be known as Munchausen syndrome by proxy or factitious illness by proxy then logically there cannot be a disease or illness entity, or a condition, or even a syndrome called Munchausen syndrome by proxy or factitious illness by proxy that perpetrators have. Instead perpetrators have various psychological, psychiatric and environmental "pathways" leading to a behaviour of fabricating illness in a child'.[14]

3.25 This might be easier to understand if we draw an analogy with non-accidental injury. Again there are numerous pathways by which non-accidental injury arises. Some abusing parents will have a psychiatric illness such as depression or schizophrenia. Nobody, however, would consider it sensible to say that perpetrators of non-accidental injuries (NAI) suffered from a mental illness called non-accidental injury. It is the child who suffers a non-accidental injury; the parents perpetrate NAI for many different reasons.

3.26 Perhaps the new terminology will be helpful. Whereas it is perhaps understandable that people had the misunderstanding that perpetrators suffered from an illness 'Munchausen syndrome by proxy', it is difficult to see how the same mistake can be made with the term 'fabricated or induced illness'. This is clearly an abuse suffered by the child and it is obviously absurd to suggest that 'fabricated or induced illness' is a mental disease in the perpetrator.

3.27 **Describe what is seen**

Michael's mother persuaded numerous professionals that Michael was suffering from epileptic fits. School records suggested a number of absences were possibly observed but very few, if any, tonic/clonic seizures. It is important that the recording of an episode is described factually by reference to what is seen rather than by a technical term which someone else advises should be applied. In this case the word 'absence' or 'fit' came to be used to describe a number of different phenomena. There were a few occasions in this case where the mother described something as a fit which clearly was not one.

3.28 **The task of the Review Group**

This review is not about apportioning blame but about learning for the future. Michael and his family were in contact with people who were striving to provide care of a very high quality. The response of agencies has demonstrated a willingness to learn lessons and improve practice.

3.29 The Review Group has the benefit of the 'retrospectoscope' in reviewing events. There are at least two elements of this in the context of FII. First, over the period that this case was evolving there have been major advances in understanding and managing FII. Secondly, there is the problem of 'hindsight bias'.[15,16] Once a positive indicator of FII is identified, for example, reported illnesses in a child resolve completely when the child is removed from the perpetrator, then the myriad of ambiguous messages that professionals have been struggling with fall into a glaringly obvious and sinister pattern. This awful denouement probably impacts most on the very professionals who have been struggling with the problem. Not surprisingly the usual responses of these individuals are shock, disbelief and anger. There is evidence that such feelings can seriously interfere with even senior professionals' ability to deal with abuse cases in the future.[17] There is no doubt that such an awful outcome can also affect team working and inter-agency working.[17,18,19,20] Thus whilst we must be extremely rigorous in our review to try to establish what went wrong, failure to recognise and address the very serious impact on individuals and systems of both the recognition that abuse had occurred and of this review might negate the value of any recommendations that are made. Picking up the pieces is an essential responsibility in any child abuse case and particularly so in FII. A review that further shattered the pieces so that they could not be put back together would have incalculable consequences for all subsequent cases of child abuse in Cumbria.

3.30 **Root cause analysis**

'When things go wrong … the response has often been an attempt to identify an individual or individuals who must carry the blame'.[21] However, '**incompetent people are, at most, 1% of the problem. The other 99% are good people trying to do a good job who make very simple mistakes and it is the processes that set them up to make these mistakes'.**[22] 'Human error may sometimes be the factor that immediately precipitates a serious failure, but there are usually deeper, systemic factors at work which if addressed would have prevented the error or acted as a safety net to mitigate the consequences'.[21] Root cause analysis is a technique for analysing incidents. This has been defined as 'a process for identifying the most basic or causal factor or factors that underlie variation in performance, including the occurrence of an adverse sentinel event'.[16]

3.31 A harmful episode can be the result of an unsafe situation caused by the unfortunate coincidence of a number of factors. These factors can be broken down as follows:

- **System error:** this is an organisational error that allows unsafe situations to arise.

- **Catalyst effects:** events outside the control of the system which when combined with another error can create an adverse event. An example of a system error and a catalyst effect working together might be the case where two patients with the same name are on the ward at the same time. The system error would be an inadequate labelling of records but this would only lead to an unsafe situation where the catalyst effect arises, i.e. two patients with the same name are admitted to the same ward.

- **Human errors:** errors committed by those individuals working 'in the field'.

3.32 Human beings are not automatons and the world would be a poorer place if they were. Our humanity enriches the lives of those with whom we come into contact, particularly those who choose to enter the caring professions in education, medicine or social work. They bring highly prized personal qualities to the work that they do. That is the strength of any humane system. On the other side of the coin is the issue of human fallibility. Our humanity is usually a strength but can also be a weakness. Human errors will always occur. Thus the objective of this review is to highlight system errors which can be addressed so as to minimise the impact of future catalyst effects and human errors.

3.33 A continuing theme throughout this case was the lack of understanding of and training with regard to FII. The Review Group has identified this as **system error 1** and has made four recommendations. Neither the child protection procedures in place at the time of the events considered by the Review Group nor the current child protection procedures adequately address the multi-agency approach required in relation to fabricated or induced illness. Additionally, training has not kept pace. The Review Group intends that in future adequately trained staff in all professions will have an increased awareness of the features of FII, the ability to identify its features and the confidence in their own knowledge to contribute to the convening of, and analysis at, a multi-agency meeting.

3.34 The Review Group's recommendations are:

Recommendation 1 **To the ACPC:** Cumbria Child Protection Procedures should be amended. The guidance in the Department of Health (DOH) document 'Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities'[9] should be included in Cumbria Child Protection Procedures. (Issues which need to be addressed are set out in appendix 6.)

Recommendation 2 **To the ACPC:** The term 'fabricated or induced illness' should be adopted in accordance with the DOH guidance.

Recommendation 3 **To the ACPC:** The ACPC should produce a training programme to familiarise all relevant staff with the identification of FII. (Issues to be included in the training programme are identified in more detail in appendix 6.)

3.35 Many incidents of concern can be warning signs of FII. The Review Group has developed a template which it intends shall be used in future and which, subject to the appropriate training, would assist in the identification of FII in a future case.

3.36 The benefit of the template is that it analyses the clinical presentations. Preparing the information in the form of this template should prompt a review of other information which might be relevant to FII in particular or abuse in general.

Recommendation 4 **To the ACPC:** The ACPC should promote the adoption and use of the template as an aid to the identification of FII.

3.36 The Review Group received a large volume of information and is indebted to internal agencies for the information they provided. It would have been very difficult to have analysed that information without the help of the template. The Review Group was

disappointed at the response of the Tertiary Centres to the Serious Case Review process and has made a fifth recommendation to the Department of Health accordingly.

Recommendation 5 **To the Department of Health:** The Department of Health explores ways in which serious case enquiries can be coordinated across a number of health trusts to clarify lines of accountability and to make the Chief Executive of each Strategic Health Authority responsible for initiating enquiries in such cases.

3.38 Sadly the voice of the child is noticeably absent from this story. Agencies must hear what children say and when that contradicts or conflicts with what the parent is saying there is a clear 'duty of care' to make a vigorous, robust and thorough investigation. The Review Group has made a sixth recommendation.

Recommendation 6 **To all Agencies:** All staff must be reminded through the normal programmes of in-house and multi-agency child protection training, and individually in writing, of the importance of actively seeking the views of children, listening to them and involving them in decisions about their health, education and welfare.

3.39 The response to child abuse, including this particular form, is a multi-agency responsibility. A doctor has to decide whether signs and symptoms described can be a consequence of medical causes. However, most individuals, regardless of medical qualification, can identify whether or not a child is suffering harm. All agencies have a responsibility to contribute to the process of sharing information so that the abuse can be identified. The background information about the family's functioning and social history are all necessary pieces of the jigsaw which assist that identification.

3.40 The 2001 Cumbria Child Protection Procedures[23] provide for strategy discussions to take place. Family members do not take part in strategy discussions and the purpose of the discussion includes to:

- Decide what action is needed immediately to safeguard the child and any other child and/or provide interim services and support;

- Determine what information about the strategy discussion will be shared with the family unless such information sharing may place a child at risk of significant harm or jeopardise police investigations into alleged offence.

3.41 We recognised earlier (para 3.22 above) that it is rarely likely to be helpful to include a parent in a meeting which has been convened to consider the possibility of FII. There can be no doubt that the carer's presence would inhibit free and frank exchange of information which is essential to the identification of FII and the protection of the child.

3.42 While it is only right that parents and carers should play an active part in the overwhelming majority of child protection and child-in-need assessments and investigations, existing child protection procedures do allow for strategy meetings to take place without parents or carers being present, but clearer guidance is needed where there are suspicions of FII. The Review Group has made a seventh recommendation.

Recommendation 7 **To Department of Health:** The guidance on the circumstances under which meetings may be called without the involvement of parents and carers should be revised. Where FII is suspected the focus should be on the potential level of harm to the child, rather than the needs or rights of the parents and carers. Clearer guidance is required on the level of parental involvement in a range of meetings.

3.43 **The 'seniority gradient'**

'In many adverse incidents a junior team member was aware of a serious threat to patient safety, but was unable to effectively communicate this in such a way as to convince a senior team member to take appropriate action. This becomes particularly likely when teams experience a steep seniority gradient between very junior and very senior individuals'.[24] These power gradients become steeper when non-doctors are involved whether professional or lay.

3.44 A recurring problem in disasters, industrial and medical areas is that of the seniority gradient. The Review Group has identified this as **system error 2**. Professionals must be taught self-awareness so that power or seniority gradients do not prevent communication. The Review Group makes recommendations 8 and 9.

Recommendation 8 **To ACPC:** Training must equip all individual members of staff with the confidence to question the opinion of professionals in all agencies, including doctors, no matter how eminent those professionals appear to be.

Recommendation 9 **To ACPC:** Training must ensure all staff are aware of the concept of 'seniority gradient'. Professionals with more 'authority' must be taught self-awareness so that power gradients do not prevent communication. The more senior the professional, the greater the responsibility both to talk to people so that they can understand and to be able to listen.

3.45 **System error 3** is the absence of a lead doctor. The key medical professional with responsibility for Michael's care was his GP. The GP sought the advice of consultants but remained Michael's primary doctor. The possibility of FII was first raised by a medical professional, the consultant paediatric neurologist at Newcastle in July 1999. He should have taken the lead in investigating further the possibility of this form of child abuse. During Michael's admission to the Newcastle Hospital from West Cumberland Hospital between 5 and 12 January 2000, Michael was admitted under the care of the consultant paediatric neurologist but there appears to have been a lack of coordinated care between him, the paediatrician and the dietician with the outcome that Michael was discharged with a naso-gastric tube fitted but no clear management plan in place. The Review Group makes recommendations 10 and 11.

Recommendation 10 **To Department of Health:** A system is devised for identifying the lead doctor with overall responsibility for a child (in addition to the GP) in all cases, especially those which are complex and in particular where the possibility of FII is present.

Recommendation 11 To Health Services: Where multiple specialists are involved in tertiary facilities there should be a lead specialist who takes responsibility for the welfare of the child whilst in that tertiary facility. This includes identification of irregularities in medicine management which could indicate FII. This lead specialist remains lead specialist throughout the tertiary referral even if the child is transferred to another hospital unless the transfer of responsibility is agreed between consultants and recorded in writing.

3.46 Communication (or the lack of it), the failure to identify information as of sufficient importance and the failure to share information is a continuing theme in cases of child abuse. Any individual who has information that suggests something about the situation of the child is 'not right' must be empowered to make their voice heard.

3.47 In this case Michael's paternal grandmother deserves special mention. She felt there was something 'not right' about Michael's situation and tried to draw this to the attention of various agencies. Unfortunately, on her first contact, the significance of her information was not recognised. She made further representations after Michael was admitted to hospital for the last time. Although those representations did not save Michael's life they were important in contributing to knowledge and understanding of this family.

4. WARNING SIGNS OF FABRICATED OR INDUCED ILLNESS

4.1 **Introduction**

Throughout the course of this report the Review Group has endeavoured to ensure that practical solutions to the complex issues of identifying FII are explored and utilised. With this in mind the Group highly recommends the use of the template the Group has developed (see 3.35 above) to practitioners who suspect that FII is being perpetrated. In fact the 'triggering' of a professional to consider the use of the template is the first step in realising that things are not quite right and probably the biggest hurdle to overcome in terms of addressing the potential occurrence of FII.

4.2 Utilising the template will enable professionals to analyse any suspicions by categorising events and other available facts. In this respect the template should be complemented by the preparation of a chronology which is also an invaluable tool in assisting the identification of FII or any suspected case of child abuse. Events need to be drawn together from all the available information known to a professional or agencies and will result in a process leading to a result which may be:

- Concerns ruled out.
- Concerns not substantiated.
- Continuing uncertainty. Concerns remain about significant harm. There could be many explanations for the child's symptoms including that they are being fabricated. It may be that the child's health will require continued monitoring to see how it progresses.[9(3.39), 25]
- Concerns substantiated, but the child is not judged to be at continuing risk of significant harm.
- Concerns substantiated and child judged to be at continuing risk of significant harm.

4.3 Also, a word of warning: just because a suspected case of FII encompasses all the categories in the template does not necessarily mean that the child is being abused. The categories are indicators and there may be justifiable reasons for an event occurring which can be categorised within the template.

4.4 It is useful to consider the following points when utilising the template or preparing a chronology:

- Ensure that people describe precisely what they have observed rather than using unfamiliar terminology.
- Clarify any concerns about medical information (treatments, expected findings, prognosis, etc) with an appropriate doctor.
- Do not try to understand the motivation of the carer; concentrate and focus on the possible harm to the child.

4.5 The template will not provide solutions to any identification or planned process of dealing with FII; that is down to the professionals involved in the care of the child, but it gives an indication of whether FII is a possibility.

THE TEMPLATE – A SUMMARY

Note: the order of numbering does not indicate the relative importance of each category.

Category	Warning signs of Fabricated or Induced Illness
1.	Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.
2.	Physical examination and results of medical investigations do not 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 found signs are not seen to begin in the absence of the carer.
6	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.
7.	Over time the child is repeatedly presented with a range of signs and symptoms.
8.	History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.
9.	Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5, above).
10.	Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.
11.	Incongruity between the seriousness of the story and the actions of the parents.
12.	Erroneous or misleading information provided by parent.

THE TEMPLATE – EXPLAINED

Note: 'Symptoms' are subjective experiences reported by the carer or the patient. 'Signs' are observable events reported by the carer or observed or elicited by professionals. We set out below some examples of behaviour to look out for.

Category	Warning signs of Fabricated or Induced Illness
1.	**Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.** Here the doctor is attempting to put all of the information together to make a diagnosis but the symptoms and signs 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, i.e. the symptoms and signs do not correlate with any recognisable disease or with a disease known to be present.
2.	**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 videotelemetry (continuous video and EEG recording) even during a so-called 'convulsion'.
3.	**There is an inexplicably poor response to prescribed medication and other treatment**. The practitioner should be alerted when treatment for the agreed condition does not produce the expected effect. 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.
4.	**New symptoms are reported on resolution of previous ones**. 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.
5.	**Reported symptoms and found signs are not seen to begin in the absence of the carer,** i.e. 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. In the case under review there was evidence that the school described episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.
6.	**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**. 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.
7.	**Over time the child is repeatedly presented with a range of signs and symptoms**. At its most extreme this has been referred to as 'doctor shopping'.[26] 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.
8.	**History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.** The emphasis here is on the <u>unexplained.</u> 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.
9.	**Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above)**. 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.
10.	**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.
11.	**Incongruity between the seriousness of the story and the actions of the parents.** 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, etc). We have used a term, 'piloting care', for this behaviour.
12.	**Erroneous or misleading information provided by parent.** 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 suggested this. Changing or inconsistent stories should be recognised and challenged.

5. SUMMARY AND ANALYSIS OF AGENCY INVOLVEMENT

The Review Group has considered the length of Michael's life broken down into 12 time periods.

5.1 Period 1: Up to 31 August 1994

5.1.1 During this period there were multiple presentations to the Primary Care Team, some referrals to Social Services and depression in the mother was a continuing problem. Michael was premature and required ventilation and tube feeding and was treated in Newcastle Hospital, some distance from the family home. Pregnancy and neonatal problems are extremely common antecedents of severe FII.

5.1.2 When he was less than 18 months old Michael's mother reported Michael to have 'asthma attacks daily, lips go blue, falls over, tight wheeze, fights for breath'. The consultant paediatrician who received this description found it 'slightly alarming as not her experience of young child'. When he was admitted to hospital, all tests were normal but Michael was still on multiple asthma medication.

5.1.3 The Review Group does not say that by this stage in 1994 professionals should have recognised FII in this case. It does say that, had all available bits of information been put together and had 2004 standards of knowledge been applied, then FII could have been suspected and professionals thereafter could have recognised FII as a possibility and this would have affected their interaction with the family.

5.1.4 The Review Group has identified the lack of a system for identifying and reviewing the reasons for frequent attendance in primary care as **system error 4.**

A special analysis of the frequency with which children contact the Primary Care Team was carried out for us by the Royal College of General Practitioners. This shows that 95% of one-year-olds make fourteen or fewer contacts with the practice each year, and 99% fewer than twenty contacts each year. Frequency of contact reduces as children grow up and in five to fifteen-year-olds the frequency of consultation is about one half the rate of one-year-olds. We therefore suggest frequent contact should be defined as:

14 contacts a year or more in children under 1 year of age.
12 contacts a year or more in children aged 1–2.
9 contacts a year or more in children 3–4.
7 contacts a year in children over 5.

5.1.5 The Review Group has made a recommendation to Primary Care Trusts to address this (recommendation 12).

Recommendation 12 **To Primary Care Trusts:** Systems should be developed by which Primary Care Teams can identify and review frequent attenders. This should include all members of the Primary Care Team, and in particular health visitors who have a crucial role in any meetings and should always be included. Frequent attenders should be looked at in the light of the template for identifying FII.

5.2 Period 2: 01.09.94 – 09.12.97

5.2.1 The first story of Michael's epilepsy appeared December 1996/January 1997 and by the end of 1997 he was on multiple medications for asthma and epilepsy. He was referred to a paediatric neurologist in Newcastle in December 1997 because his 'fits' were regarded as drug resistant.

5.2.2 Continuing incidents and accidents raise concern about physical abuse and neglect. There were five accidents sustained within the family and, in addition, on two occasions Michael ingested excessive drugs but there were only two referrals to Social Services in this period.

5.2.3 Information about domestic violence was given to the child psychiatrist on 20 November 1997 and this was another indicator that parental history should be explored. Not all parents who suffer domestic violence abuse their children but domestic violence is a frequent common denominator in cases where children are abused and can amount to abuse in itself.[27]

5.2.4 A new feature during this period is the emergence of a pattern in mother's engagement with medical care, manipulating those with whom she had contact. For example, to support her reports of Michael's epilepsy she claimed that Michael's absence had been seen by an Educational Psychologist. We refer to this element of mother's behaviour as 'piloting care'. This could be defined as a pattern of engagement with the medical system which is manipulated to avoid the illness story being confronted and allows the situation/illness to continue and possibly escalate. 'When a halt is called … and the

doctor does have the courage to confront the issue (and courage it does take) then the mother will leave and assign that doctor to the worthless, criticised "bunch of useless professionals" and move to someone else who will, with her, repeat the cycle'.[28]

5.2.5 The referral to a paediatric neurologist in December 1997 provided the opportunity for a review of Michael's condition which could have led to recognition of FII.

5.3 Period 3: 10.12.97 – 05.07.99

5.3.1 This period begins with Michael's referral to the paediatric neurologist in Newcastle. An EEG was conducted on 24 February 1998 in Newcastle. On 10 March 1998 a prolonged EEG with MRI was proposed. On 1 May 1998 an MRI scan was unsuccessful as Michael was awake. Eventually, almost 12 months later, on 4 January 1999 Michael was subject to MRI under general anaesthetic at Newcastle and the results were normal. A later recommendation was that Michael should be the subject of videotelemetry. This was eventually conducted when Michael was in hospital on 7 January 2000 – see period 6.

5.3.2 Michael's deterioration at school seems to have been dramatic during this period. In April 1998 when Michael would have been 5 years old a specialist teacher recorded that since her involvement in November 1997 she had witnessed a progressively severe deterioration of Michael's physical condition. Michael changed from a child who was fully mobile and conversant to a boy who could not walk or talk.

5.3.3 By March/April 1999 repeat prescriptions of one particular anti-epileptic drug were being obtained more frequently than the prescription indicated. This was identified by the Group as another system error (**system error 5**). The Group is advised that this has already been addressed within the internal agency. Accordingly the Review Group adopts the recommendation of the internal agency report as recommendation 13 and makes an additional recommendation about the role of community pharmacists (recommendation 14).

Recommendation 13 **To all Primary Care Trusts**: Repeat prescriptions should always be monitored with alert systems in place to block overuse and abuse.

Recommendation 14 **To Health Services**: The role of community pharmacists should be developed to include assistance in medicine management in primary care.

5.3.4 After 12 months of assessment, during which time no tests had given any independent confirmation that Michael was suffering epilepsy, no diagnosis had been made and he had still been on ever-increasing amounts of medication, he was referred to a leading medical practitioner. However, there appears to have been no urgency attached to the management of his case. The Review Group has identified the lack of appropriate timescales in completing the investigations as **system error 6** and has made a further recommendation (recommendation 15).

Recommendation 15 **To the Secondary and Tertiary Health Services:** Following a referral from a GP or another consultant a timescale within which investigations should be completed must be agreed at the first appointment with the consultant. If those investigations are not

completed within the set timescale it is the responsibility of the consultant to find out why and to consider FII as a possibility by applying the template. If there is a possibility of FII, agreement of appropriate timescales for investigations becomes crucial.

5.3.5 During this period the administration of drugs to Michael at school first by his mother and subsequently by teaching staff commences and becomes frequent. An attempt was made to regularise the arrangements for treating Michael in school in May 1999 by the use of the form of guidelines for the administration of rectal diazepam at school.

5.3.6 The Review Group commends school staff who assist in enabling children who are otherwise disabled to lead as normal a life as possible by being prepared to administer medication. Over-rigid guidelines could be detrimental to the well-being of children. Nonetheless it is essential that the administration of medication in school is in accordance with guidelines and properly managed. The management of the drug administration at the school allowed the mother to manipulate practice. The Review Group has identified this as **system error 7** and recommended accordingly (recommendation 16).

Recommendation 16 To the Education Department: Guidelines over administration of drugs in school must be revised to include the details identified in appendix 6.

5.3.7 In October 1998 the health visitor made a referral to Social Services for support which was dealt with by the social worker for children with disabilities. The social worker arranged from November 1998 for Key Care to provide help in the home. Key Care is an independent home care provider offering practical support to families and children in their own homes.

5.3.8 In April/May 1999 the first record appears of mother telling the school that Michael was suffering from Lennox Gastaut Syndrome and that it was a terminal illness. As far as can be ascertained, no doctor had suggested this possible diagnosis, and certainly this diagnosis had not been made. Additionally, this syndrome is not terminal.

5.3.9 There is very little information to suggest that Michael was actually seen by the GP between the end of 1997 and July 1999. The possibility of Michael talking to people about his situation was minimal from July 1998 when he was described as a boy who could not walk or talk.

5.3.10 Although the referral to the Social Services social worker for children with disabilities did not take place until October 1998 Michael was already a seriously 'disabled' boy by the end of July 1998. Procedures for the protection of children apply equally to disabled children as they do to children who are not disabled. However, the labelling of a child as 'disabled' can result in resources being channelled in such a way that it is more difficult to recognise a disabled child as a child in need of protection. The Social Services internal agency report has recommended an amendment to section 12.3.4 in the Child Protection Handbook to address the circumstances of a disabled child.

5.3.11 The Review Group has been unable to establish exactly when Michael was seen by the paediatric neurologist and it is clear that on some occasions Michael was seen by a junior doctor (**system error 8**). The Review Group endorses the appropriate use of junior

doctors as long as it is subject to proper review and supervision and has made a recommendation (recommendation 17).

Recommendation 17 To Tertiary Centres: They should ensure that there are guidelines in each clinic with regard to the appropriateness of review by junior doctors and supervision of such consultations. Records should indicate who saw the child in clinic and the details of supervision.

5.4 Period 4: 06.07.99 – 06.08.99

5.4.1 It is clear that the paediatric neurologist in Newcastle to whom Michael had been referred was at this stage including FII in the possible explanations for Michael's presentations. In his EEG request form he specifically mentioned '? Non-epileptic attacks? Factitious seizures/? Meadows synd'. In his letter to the GP he stated 'I would suggest having an open mind as to the diagnosis of epilepsy in this lad', commented on the lack of an independent witness to the mother's report and asked the GP to keep the letter confidential. During the same month the paternal grandmother raised concerns with Social Services. These concerns were multiple and included reference to 'Munchausen'. As these were child protection concerns the investigation was appropriately transferred from the social worker for children with disabilities to a social worker in the Children and Families Intake Team. The information provided by the paternal grandmother would fit a number of indicators of FII within the template but no similar 'tool' was available at the time.

5.4.2 The social worker should have conducted checks of other agencies (known locally as the CACL checks) including contacting the GP. It is difficult and unhelpful to speculate on what those checks might have produced where, as in this case, the lead doctor (i.e. the GP) was enmeshed with the family. The contact by the social worker with him was unlikely to have resulted in action to protect the child. The routine (CACL) checks do not include contacting any consultant or the designated doctor and the Review Group believes this should take place in a case of FII and has accordingly made recommendation 18.

Recommendation 18 To Social Services, Secondary and Tertiary Health Centres and Designated Doctor: Where FII is raised as a possibility the social worker conducting checks of the other agencies must consider additional checks. The view of the designated doctor (child protection) should be sought. The GP should identify whether a referral has been made to a secondary or tertiary centre and, if so, the name of the consultant with lead responsibility for the child. The designated doctor should take responsibility for raising the possibility of FII with medical colleagues and assist in gathering notes and compiling a chronology. The social worker must ensure that the additional check is made, either by themselves or via the designated doctor, to the consultant with lead responsibility for the child.

5.4.3 Other features during this time were the continuing avoidance by the mother of admission of Michael to hospital. The reasons given were inconsistent with reasons given later on. The Review Group sees this as further evidence of the mother piloting care. The consequences of piloting care include continuing medical attention (outpatient

and inpatient), multiple investigations, escalating treatments, and, for some perpetrators, opportunities to induce illness.

5.4.4 There was an opportunity for a multi-agency strategy meeting. The difficulty is in recognising when such a confidential meeting needs to take place. Recognition of FII as a possibility can only occur once all agencies have pulled together the information available to them and analysed that information. Existing guidance needs to be strengthened.

5.4.5 The paediatric neurologist should have made a check of the child protection register and made contact with Social Services as he probably would have done in any other case where child abuse was considered a possibility. Had a multi-agency strategy discussion occurred at this stage, the paediatric neurologist should have attended and undertaken a role as lead professional. The meeting could have accessed his suspicions and combined them with the information from the grandmother. It could have reviewed incidents since Michael's birth against the indicators of FII identified in research now reduced to the template. The administration of medicine within the school environment could have been reviewed and tighter controls effected.

5.4.6 The terminology used by the paediatric neurologist was ambiguous. 'Medically unexplained symptoms' or 'parental persistence'[12] are both accepted medical terms which include possibilities ranging from unidentified pathology through to FII. Medical and lay professionals need to develop an improved understanding of the language used in this difficult area, which should be addressed in training. The use of ambiguous language has been identified as **system error 9** and is addressed by the Review Group's recommendation 19.

Recommendation 19 To All Agencies: When a possible explanation for symptoms and signs is that they may have been fabricated or induced by a carer this must be explicitly indicated in any communication and ambiguous circumlocutions must be avoided. The concerns should only be disclosed to the carers after discussion with Social Services if it is decided that sharing information will not place the child at increased risk of harm. If in a case there are unexplained symptoms or signs but application of the template suggests the possibility of FII is low, the use of the terms 'parental persistence' and/or 'medically unexplained symptoms/signs' is advocated. In such cases the possibility of FII should be regularly revisited until the symptoms/signs have been explained.

5.4.7 The Review Group has identified as **system error 10** the problem of dealing with the identification of FII as a medical assessment rather than regarding it in the wider context and identifying it as child abuse. Improvements in child protection procedures, training in the understanding of FII and in the use of the template should ensure an appropriate response in the future (recommendations 1, 3 and 4 above).

5.4.8 The Review Group has identified as **system error 11** the response by the Social Services Department to the contact by the grandmother. The Social Services Department did not have a 'tool' available to them against which to check the possibility of FII. The recommendations made addressing child protection procedures, training programme and using the template should secure a better response to such cases in the future. (Recommendation 1, 3 and 4 above.) The Review Group also recommends:

Recommendation 20 To all Agencies: Any time FII is mentioned to any agency the template should be applied, the possibility of child abuse should be considered and enquiries should be made.

5.5 Period 5: 07.08.99 – 04.01.00

5.5.1 During this period mother avoided Michael's admission for observation tests and treatment until he was admitted to hospital as an emergency on 04.01.00.

5.5.2 The school recorded mother administering rectal diazepam on two occasions when he was not fitting and on one occasion when he was coming out of a fit rather than when he was having one. This was contrary to the guidance which said Michael should receive the drug whilst he was having a fit. At the time the school did not appear to recognise the significance of this. The mother was reporting almost constant seizures in Michael. In school, however, observations of confirmed tonic/clonic fits were limited. The Review Group has identified the escalation of administration of medication in school by an intrusive route as **system error 12**. The failure to recognise and record in order to challenge the discrepancy between observations of convulsions and mother's reports is identified as **system error 13**. These system errors are addressed by recommendations 3, 4 and 16 (training, using the template and revising the guidelines over the administration of drugs in school).

5.5.3 On 24.11.99 the child psychiatrist wrote to the GP describing his own observation of Michael in school on 30.09.99 which was consistent with a child having fits. This letter was copied to the consultant paediatrician, the paediatric neurologist and Michael's mother. The observation of the child psychiatrist in a single visit to the school was given greater weight than the absence of confirmed observations of fitting at other times during the school day.

5.5.4 Michael's admission to hospital as an emergency at the beginning of January 2000 was a further opportunity for the professionals involved in his care to consider his history and to reach a diagnosis of FII.

5.5.5 During a visit by the social worker, mother claimed GP had warned her little more could be done for Michael and spoke about the possibility of him dying during one of his seizures. She requested counselling for all the family. This created further confusion about the status of Michael's illness. It provided more opportunities for mother to predict Michael's death and culminated in the involvement in period 7 of the Children's Community Nursing Team (Diana Nurses) who care for terminally ill children and the Rainbow Trust who provide respite for the carers and siblings of children who are terminally ill. There was no evidence that Michael's illness was terminal, which is normally understood to mean that the inevitable consequence of an illness is death. There is little evidence that Michael's illness was life threatening except in so far as an extreme attack of epilepsy, like an extreme attack of asthma, could occasionally put a patient's life in danger.

5.5.6 A suggestion that a child is going to die is of such importance that it requires a proper response. Once it is known that the illness is terminal, all support systems need to work together for the benefit of the child and the family in the last stages of the child's illness. It frequently occurs in cases of FII that false information is given predicting a child's death. Wherever there is a suggestion a child is going to die it is essential that agencies

working for the benefit of the child and family check the details with the medics. The Review Group has identified as **system error 14** the fact that the mother's claim that her child was dying was accepted without question. Recommendation 21 is the consequence.

Recommendation 21 To All Agencies: Where information is given by a carer that a child is dying, confirmation should be sought from medical personnel able to make this prognosis. This is with a view to offering multi-agency support to provide optimum care and support for the child and family. If medical personnel fail to confirm a child is dying when that information is given by a carer then FII should be considered.

5.5.7 The Review Group has identified as **system error 15** the failure to explore and/or investigate the reasons for mother's avoidance of definitive investigations. Inconsistencies and incongruities in the story were not recognised. Application of the template should have eliminated this system error and is addressed by recommendation 4.

5.6 Period 6: 04.01.00 – 14.01.00

5.6.1 Michael was admitted to hospital as an emergency on 4 January 2000. The need for assessment in a controlled hospital environment had been established in July 1999, but it was some six months later before Michael was admitted and only then because of an emergency admission. Multiple tests were carried out, none of which supported the mother's claims about Michael's severe epilepsy. In particular, the videotelemetry showed no simultaneous changes on EEG to coincide with jerking, etc, i.e. the test was negative even though mother reported signs during the test. No attention seems to have been paid in the Newcastle Hospital during this time to the possibility of identifying FII or securing a strategy for Michael's safety. The Review Group has identified as **system error 16** the failure to analyse information (which could now be compared against the template) which led to the lack of recognition of FII despite the fact that the evidence was now very strong even without the detail of the previous history. The negative outcome of the videotelemetry should have led to action to protect the child. This system error is addressed by recommendations 3 (training) and 4 (use of template).

5.6.2 Blood samples were taken to ascertain drug levels. Levels of two of these drugs were in the toxic range.

5.6.3 When Michael was eventually discharged he was more vulnerable than ever. A decision had been made for a naso-gastric (NG) tube to be inserted to be used during the night to feed him. Despite the need for nutritional support, discharge of him to the care of his mother with this tube in place maximised her opportunities to poison him. The Review Group has identified as **system error 17** the fact that the naso-gastric tube feeding seems to have been instituted without a clear management plan and within the narrow focus of the patient's nutritional needs. Recommendation 22 addresses this.

Recommendation 22 To Health Services: Before any physically intrusive device or treatment is introduced which is planned to continue at home, the possibility of FII should be considered by reviewing the information available in the case against the template. If it is decided to proceed, then a clear management plan must be in place

to include the reasons for the treatment, a consideration of advantages and disadvantages, the planned duration of the use of the device, the responsibility for review of its use and possible complications in the use.

5.6.4 If at any stage before this admission a multi-agency meeting had occurred, the most important issue would have been how to prove that the multiple warning signs did indeed indicate FII. Admission to hospital with videotelemetry would have been the sensible way forward and this was eventually achieved but no analysis seems to have been conducted of the outcome, which could not have been more clear-cut. The Review Group has formed the view that the treatment of Michael appears to have been compartmentalised with no overall review of the problem. The Group has identified this as **system error 18**. The recommendations about the identity of a lead consultant (recommendations 10 and 11) would address this system error.

5.6.5 Following Michael's discharge home the mother complained to her GP about the paediatric neurologist, and the GP agreed to refer her for a second opinion to another paediatric neurologist at Alder Hey. The Review Group has identified this referral for a second opinion as **system error 19** and makes recommendation 23.

Recommendation 23 To Health Services: Any tertiary specialist asked for a second opinion should contact the original specialist to ascertain the background to the case. If the reason for the referral for a second opinion is that a parent is claiming they have been blamed for causing the illness:

i) the possibility of FII should be considered
ii) the parent's claim should be clarified with the original doctor
iii) the parent's claim should be included in the referral letter
iv) the person receiving the request for a second opinion should clarify the reasons for it.

5.7 <u>Period 7: 14.01.00 – 15.03.00</u>

5.7.1 During this period the children's Community Nursing Team (Diana Nurses) became involved on the basis that Michael's condition was chronic and potentially life threatening even though there had been no such diagnosis. They in turn involved the Rainbow Trust. The Review Group has identified as **system error 20** the continuing uncertainty about the likely outlook for the child, i.e. whether his illness was life threatening/terminal and has addressed this by recommendation 21.

5.7.2 The children's community nurse recorded the possibility of investigating the use of midazolam as rectal diazepam was reported to be losing its effectiveness. Midazolam is a drug to be applied buccally, i.e. into the gum/cheek area. A protocol about the administration of midazolam was drawn up by the children's community nurse. Midazolam was not to be administered at the same time as rectal diazepam.

5.7.3 Mother disengaged Michael's care from Newcastle and he was seen by another paediatric neurologist at Alder Hey Hospital on 8 March. The new paediatric neurologist wished to admit Michael as an inpatient to conduct further tests but was surprised at

mother's reluctance. The Review Group has identified as **system error 21** the lack of clarity about the roles of the different consultants which has been addressed by recommendations 10 and 11.

5.7.4 The paediatric neurologist at Newcastle is to be commended for the letter he sent to the paediatric neurologist at Alder Hey on 29 February providing a very full account of his involvement with Michael. However, he failed to communicate expressly the continuing possibility of FII which he had raised in July 1999. He stated only that he 'had entertained the possibility of non-epileptic seizures' until he received the report that the child psychiatrist had observed fits in school. The Review Group has identified this as **system error 22** and makes recommendation 24 accordingly.

Recommendation 24 To All Agencies: At any stage where any individual considers FII is a possibility, this possibility needs to be communicated to medical and other professionals who need to be aware of the possibility in order to safeguard the welfare of the child. If concerns about FII are not subsequently pursued then the reasons for not doing so should be identified and recorded.

5.7.5 Despite the absence of specific reference to FII the paediatric neurologist at Alder Hey had sufficient information from which he should have included FII in the range of possibilities. Instead he chose to repeat investigations which the Review Group has identified as **system error 23**. This is expensive and exposes the child to unnecessary investigations. The medical system becomes actively involved in contributing to FII. The Review Group makes recommendation 25.

Recommendation 25 To Health Services: Tests and investigations should not be repeated unless there is reasonable doubt about the accuracy of previous investigations or new features of the illness have appeared which could justify further investigation.

5.7.6 Repeat prescriptions had since April 1999 allowed mother to obtain medication more frequently than the prescription indicated. This allowed dual administration of rectal diazepam and buccal midazolam. The Review Group has identified this as **system error 24** and in addition to recommendations 13 and 14 (monitoring repeat prescriptions and the development of the role of the community pharmacist) makes recommendation 26.

Recommendation 26 To Health Services: The system should clearly identify any changed medication, new medication and discontinued medication, and should ensure systems so that everyone charged with administration of medication is clear what medication is currently prescribed.

5.8 <u>Period 8: 16.03.00 – 27.05.00</u>

5.8.1 More medical professionals were accepting the idea that Michael's illness was terminal. Although the paediatric neurologist at Alder Hey stated Lennox Gastaut Syndrome was not particularly life-threatening the GP said that it was. The paediatric neurologist at Newcastle stated he believed Michael's condition to be life-threatening. The family was given access to an increasing number of agencies which would have been appropriate if in fact Michael had been terminally ill. The Review Group has identified as **system error 25** the inaccurate description by doctors that the child was suffering from a life-

threatening illness. It is essential that doctors provide factually accurate reports when seeking to increase support for a family. Failure to do so can result, at the very least, in an inappropriate distribution of finite resources. At worst it is dangerous and in FII cases creates confusion which abusive carers can exploit. Recommendation 27 addresses this issue.

Recommendation 27 To Health Services: Guidance must be provided to all medical personnel highlighting the dangers of overstating the facts of a case, even though the actions are taken with the child's best interests at heart, with a view to obtaining support additional to that which would otherwise be available.

5.8.2 Mother was increasingly taking control of Michael's health care, e.g. through the fitting of the naso-gastric tube, introducing the idea of drug therapy 'zonisamide' which was not then licensed in this country (and which was not prescribed) and negotiating to agree her terms over Michael's admission to Alder Hey. At the end of the period there was a sequence of phone calls between mother and the community nurse which is quite baffling. Despite Michael being poorly, mother was resistant to contacting the GP and West Cumberland Hospital.

5.8.3 Michael was admitted to hospital twice in this period. The first admission was at midnight on 20 April and he was discharged the following day. The second admission was on 24 May. Once again Michael's admissions to hospital, when they happened, were in emergency situations to the local hospital and not planned admissions addressing his wider needs.

5.8.4 A full review of all the information available at this stage could still have led to the identification of FII and steps for Michael's protection.

5.9 <u>Period 9: 28.05.00 – 25.06.00</u>

5.9.1 During this period mother continued to avoid Michael's admission to Alder Hey hospital. The dual usage of midazolam and rectal diazepam continued to take place. Michael attended school for only two days and part of a third between 14 and 19 June.

5.9.2 The Review Group has identified three system errors during this period. **System error 26** is that the child's perspective on the family situation never appears to have been sought. The need to listen to children has been reinforced by recommendation 6.

5.9.3 **System error 27** is the continuing irregularities in the administration of medication and in the care of gastrostomy (naso-gastric tube). The recommendation about the need for a clear management plan has been addressed in recommendation 22.

5.9.4 **System error 28** is the lack of appropriate timescales in completing the investigation suggested by the paediatric neurologist at Alder Hey. The health of the child must always be paramount and if parents obstruct appropriate investigations, no matter what the reason, the doctor must ensure investigations take place within an appropriate timescale. This has been addressed by recommendations 15 (timescales) and 25 (avoid unnecessary repeat tests).

5.10 Period 10: 26.06.00 – 04.07.00

5.10.1 On 26 June Michael was admitted as an emergency to West Cumberland Hospital. Whilst in the ambulance mother administered medication to Michael via the naso-gastric tube despite the GP having expressly told her not to. The tube was incorrectly positioned. On Michael's admission to West Cumberland Hospital, fluid was in his lungs which ultimately caused his death by the complications brought on by pneumonia. Blood samples indicated prescribed drug levels in the toxic range. It was recorded that he was bleeding from a perforated ear drum and there was a two to three week history of purulent left ear discharge. On 27 June Michael was transferred to hospital at Newcastle upon Tyne.

5.10.2 On 30 June paternal grandmother contacted the NSPCC anonymously and informed them of her concern that mother could be harming Michael. She was encouraged to raise her fears with the medical staff in Newcastle and did so, confirming her fears in writing. The Review Group commends the work of the NSPCC in the way it engaged with the grandmother, taking her concerns seriously and empowering her to raise her concerns with the medical profession at Newcastle. The NSPCC wrote to Newcastle Hospital Social Services but should also have made a referral to Cumbria Social Services in accordance with procedures.

5.10.3 On 3 July 2000 a meeting was held at the practice surgery in west Cumbria. The Social Services Department were invited but the significance of the meeting was not made clear. They did not attend and were not sent minutes of this meeting. From the minutes it was reported that another paediatric neurologist at Newcastle accepted FII was a possibility and the GP feared that if this was the case the rest of the family may be at risk in the future and that there was obvious immediate concern. The recommendation of this meeting was that a child should not be left in mother's care. This was not communicated by the surgery to Social Services.

5.10.4 The Review Group has identified as **system error 29** the fact that those who attended the meeting at the surgery did not follow child protection procedures afterwards by contacting Social Services. The child protection procedures current at the time required 'all cases of suspected child abuse must be reported to the local Social Services office'.[29]

5.10.5 On 4 July a senior member of Social Services was contacted by a consultant paediatrician at Newcastle expressing concerns about Michael and was asked to convene a management meeting to discuss the situation. This was arranged for 11 July.

5.11 Period 11: 05.07.00 – 10.07.00

5.11.1 Michael was transferred to Leicester on 5 July 2000. At this time there were increasing concerns about the possibility of FII. Paternal grandmother had made great efforts to ensure that her concerns were communicated to any hospital to which Michael was transferred and this was reiterated in a letter from the NSPCC social worker to the Newcastle Hospital Social Services Department and supplemented by further contact on 5 July. There is no information to suggest that the Newcastle Hospital Social Services Department took action on this information.

5.11.2 The letter sent by the junior doctor (Intensive Care) on Michael's transfer to Leicester on 5 July 2000, although some five pages in length, raised the possibility of FII only

fleetingly. The impression given by this letter is in marked contrast to the need perceived by the consultant paediatrician at Newcastle for a high level multi-agency meeting. The fact that the consultant paediatrician in Newcastle had arranged for this meeting to be convened was not mentioned in the letter. The lack of clear consistent communication has been identified by the Group as **system error 30**. As a consequence it appears that no risk assessment was conducted. The Review Group has accordingly made recommendation 28.

Recommendation 28 To Health Services and Social Services: When concerns about the deliberate harm of a child have been raised, particularly in cases of FII, an immediate risk assessment must be undertaken and concerns clearly communicated to those with responsibility for the care and protection of the child. This is particularly important where there is high risk of induced illness. The risk assessment is not only in relation to the child presented, and their protection whilst in the hospital, but also for other children outside the hospital environment who may nonetheless be at risk.

5.11.3 The lack of communication between professionals on Michael's transfer which resulted in the receiving hospital not being alerted to the possibility of child abuse has led to recommendation 29.

Recommendation 29 To Health Services: Hospital Trust Chief Executives must introduce systems to ensure that no child about whom there are child protection concerns is transferred to another hospital without communicating these concerns and agreeing an action plan. (Laming recommendation 71, modified).

5.11.4 On 8 July there was an incident where Michael's feeding pump malfunctioned and he received more feed that he should. It is probable that this malfunction was caused by Michael's mother. The Review Group has identified as **system error 31** the absence of sufficient surveillance even though two-to-one nursing was standard for the treatment Michael was receiving. One-to-one nursing, either formally established or assumed because a child is in intensive care, does not protect from illness induction and even two-to-one nursing will not protect a child unless there is an awareness of concerns of FII. The Review Group makes recommendation 30.

Recommendation 30 To Health Services: Where a child is admitted to hospital and FII is suspected:

- Strict two-to-one nursing and/or covert surveillance to assist the gathering of information is essential if there is significant risk of illness induction.

- Those responsible for the child's day to day care, particularly the nurses, must be aware of the concerns of FII.

5.11.5 The consultant paediatrician in Leicester was suspicious that Michael had been deliberately overdosed with carbamazepine on Michael's arrival at Leicester on 5 July 2000. He was sufficiently concerned about the cocktail of drugs, presumably prescribed

for epilepsy that he amended the treatment regime, and his discussion with the Clinical Lead and Service Manager who involved the Glenfield Hospital Lead Nurse for Child Protection initiated contact to the Newcastle General Hospital on 6 July 2000 to voice concerns. It was during this telephone conversation that Leicester Hospital was informed that there was a meeting planned for the following week without the family's knowledge. No referral was made to the local Social Services Department and no action of a child protection nature appears to have been taken by staff at Leicester Hospital between 6 July (when Newcastle was contacted) and 12 July (when the consultant paediatrician from Newcastle advised that a strategy meeting had been held). During this period Michael's feeding pump malfunctioned, probably caused by Michael's mother. The Review Group has identified this as **system error 32** and makes recommendation 31.

Recommendation 31 To Health Services: When a child is admitted or transferred to a hospital and deliberate harm is suspected, the doctor or nurse admitting the child must enquire and obtain information about any previous hospital admissions. The consultant in charge of the case must review this information when making decisions about the child's future care and management. Hospital Chief Executives must introduce systems to ensure compliance with this recommendation. (Laming recommendation 73, modified)

5.12 Period 12: 11.07.00 – 13.07.00

5.12.1 On 11 July 2000 a multi-agency briefing meeting was held. This had been set up as a consequence of the consultant paediatrician's contact with Social Services in Cumbria. The written information available to that meeting came from the Social Services Department and there was a short 'health visitor and school nurse reporting form'.

5.12.2 No written reports were brought by anyone from the medical profession (apart from health visitor/school nurse) or the school. The absence of written reports can only have hampered the discussions at the meeting of 11 July. When they were made available, the police action, jointly with Social Services, was launched.

5.12.3 The Social Services Department is commended for its very thorough report of the contact between the Social Services Department and the family, presented to the meeting on 11 July.

5.12.4 The Review Group highly commends the actions of the police. Within two days of becoming involved they had recognised that this was an extremely serious case of FII. The police and Social Services, working together, then took swift action for the protection of Michael.

5.12.5 The Review Group has identified the lack of written medical reports as **system error 33**. It has made a recommendation (recommendation 32). Additionally a chronology of each agency involvement would have been critical in evaluating the available information and a further recommendation is made (recommendation 33).

Recommendation 32 To Health Services: A detailed review of medical information is critical to identifying this form of abuse, and must be undertaken where it is suspected and put in writing.

Recommendation 33 To all Agencies: When FII is suspected, a written chronology of each agency involvement must be compiled and shared with other agencies and the information gathered should be compared against the template.

5.12.6 By the time of the meeting on 11 July it is likely that the majority of those present would have been aware of the suspicion that this was a case of fabricated or induced illness. Curiously, professionals seemed to be reluctant to name this as a possibility. A reluctance to name FII as a possibility will result in cases of FII not being recognised and more children suffering harm. The Review Group has identified the reluctance to name the possibility of FII as **system error 34**. The earlier recommendations about the use of language (recommendation 19) and use of the term FII (recommendation 2) will address this.

5.12.7 From the meeting on 3 July it might have been thought that the GP recognised FII was a possibility. By contrast, at the meeting on 11 July he was the strongest advocate for the mother saying that she 'is very impressionable and has misjudged the situation but there is no evidence of deliberate poisoning'. There is no mention anywhere in the minutes of the meeting on 11 July that a meeting took place on 3 July. The failure of the meeting of 11 July to reach a consensus that FII was indeed evident in this case delayed the police investigation and action to protect the child. The Review Group has formed the view that subjective judgement of, and empathy with, the mother affected contributions to the information provided at the meeting on 11 July and to the discussion that followed and has identified this as **system error 35**. The Group has made recommendation 34 about the need to avoid becoming enmeshed.

Recommendation 34 To all Agencies: All professionals need to concentrate on dispassionately reporting the facts rather than trying to understand the parent's motivation in cases of FII. The critical task is to assess the likely risk of harm to the child. Personal judgements of the parents are highly likely to severely interfere with that process. Chronologies, use of the template and a systematic consideration of risk factors for abuse should be the focus of professionals' reports.

6. BARRIERS TO IDENTIFICATION

6.1 **Could abuse have been recognised earlier?**

Given the numerous warning signs of FII in this family and the multiple risk factors for FII one may question why abuse was not identified sooner. Some of the reasons for this have been touched on in our description of the development of the concept of fabricated or induced illness (see 3.2) and the 'hindsight' bias (3.29).

There are three further issues with regard to identification of FII:

- FII is very complex.
- Apart from severe induced illness it is a process rather than an event.
- Professional entrapment.

6.2 **The complexity of FII**

It is a commonplace now to refer to the 'jigsaw of child abuse'.[30] If we develop this analogy we could think of physical abuse as a simple linear jigsaw. Sexual abuse presents far more problems and might be portrayed as a quadrangular puzzle without a picture to help in the solution. Fabricated or induced illness is orders of magnitude more complex. It might be thought of as a 3-dimensional polygonal puzzle in which the clues to the solution of any one side are scattered around other sides. Furthermore, if any one side is solved, the picture is one of those optical illusions which looks quite different to different individuals. Another analogy might be a Rubik's cube. Here if you 'solve' one side, you discover to your dismay that the other five sides still do not make sense and you are even more dismayed when your attempts to 'solve' other sides actually destroy the careful picture you have assembled on one side. Even this is not sufficiently complex to illustrate the difficulties in struggling to identify FII. You do generally look at the other sides of a Rubik's cube; all too often this does not happen in FII. Furthermore, in some mysterious way, on the Rubik's cube every unit is linked to every other unit so that movement of one inevitably influences the others. Inter-agency working is the analogy in FII and all too often this mechanism does not operate. To make things even more difficult in FII, there are often far more than 16 squares on each side and rarely as few as six sides to reconcile.

6.3 **FII is a process not an event**

In most cases of physical abuse the child presents with a clear-cut incident, for example, a fractured arm or bruises. These are easily identifiable events which require an explanation. Apart from severe induced illness, the illness picture develops insidiously in FII. It is often fragments of information that begin to suggest the possibility of abuse. This has been noted before: 'We were struck throughout our enquiry by the way in which fragments of medical evidence, which, if assembled, would have pointed to Allitt as the malevolent cause of the unexpected collapses of children, lay neglected or were missed altogether. Taken in isolation, these fragments of medical evidence were not all very significant nor was failure to recognise them very culpable. But collectively they would have amounted to an unmistakable portrait of malevolence. The principal failure of those concerned was in not collecting those pieces of evidence.'[31] We echo these comments and emphasise that these fragments have to be collected from many different

sources and will be balanced by professionals who support the mother and provide much apparently compelling evidence that this is a very noble mother struggling with a major burden.

6.4 Professional entrapment in FII

We have already touched on this above (system error 35). Schreier and Libow[32] provide a detailed explanation as to how intelligent, concerned professionals have been persuaded to investigate and treat these children, and this has usefully been summarised by Hobbs *et al*.[28] Factors involved include:

- Skilful manipulation by the mother which creates an 'unsolvable' problem.
- Mother may have wide medical knowledge.
- Mother may seem to be more like an appreciative colleague and an 'ideal' mother.
- These factors drive the doctors to consider more intensive investigations, cleverer tests and more obscure diagnoses.
- All of this goes along with mother's criticism of other professionals – setting them off against each other. If professionals don't examine this 'criticism' they can quickly find themselves agreeing with the parent and in conflict with their colleagues.
- 'If it were just the issue of the paediatrician's competency, knowledge, and autonomous decision making, things would be difficult enough. But add the issue of the doctor's "caring" and the bold and sometimes "adulatory support" that these parents often express, and a situation is produced in which the question of his *caring* is now tied in with his medical/clinical *performance*. Now, when things are not going well clinically, the doctor is left vulnerable to the *self*-accusation of not caring enough and feeling he needs to try harder. And this step seals the "trap".'[32]

6.5 We have already called attention to the courage needed to confront this situation (5.2.4 above). A further challenge to this courage is the almost inevitable fact that, in the present climate in the NHS, the doctor will be complained against. Not only is this a further barrier to considering FII, it is time consuming and feeds into the questioning of his caring and performance that is probably already concerning the doctor. This is a very major and urgent problem. The Department of Health guidance briefly discusses this issue.[9] A much more detailed review of the problems and possible solutions has recently appeared.[33]

6.6 Developing a clinical method that increases the likelihood of identifying FII

In the process of analysis of this case we have made numerous specific recommendations which we hope will make it easier to identify FII. However, there are five crucial over-arching messages:

- ***Keep an open mind.***
- ***Keep questioning your assumptions.***
- ***Be familiar with the range of behaviours that perpetrators of FII exhibit.***
- ***Communicate, clearly.***
- ***Be familiar with barriers to identification of FII.***

Keep an open mind.

'Until about 30 years ago scientists mostly believed that their task was to find as many examples as they could to confirm their theories. Now they realise that they have to look for examples that are apparently inconsistent with their theories. Karl Popper is to blame, and particularly his slogan **"No number of sightings of white swans can prove that all swans are white. The sighting of just one black swan may disprove it"**'.[34] In the field of FII the 'fragments of information'[31] which are inconsistent with the view that the parent is honouring the 'bargain in health care'[7] are the black swans: the triggers to reconsider the **whole** situation even when there are many white swans around. The logic is utterly simple: if there is a **single** black swan it **cannot be** the case that all swans are white.

What can happen when somebody reports having seen a black swan:

It will be decided that:

- There has been some error in the reported observation OR
- The bird was not really a swan, it should be called something else.

These reactions typify the frequent response to information that challenges our view of a parent and the situation is very much more complex than the categorisation of swans as either black or white.

(i) The existence of FII questions our basic beliefs about the parents and parent–professional relationships.

(ii) The warning signs and risk factors for FII all have alternative explanations. They are probably sensitive but not specific indicators of FII. The majority of cases with these warning signs and risk factors **will <u>not</u> be cases of FII.**

(iii) Many of the risk factors will be very common in socially and/or economically deprived families, and such families are known to make increased demands on health services and have increased admissions to hospital.

(iv) Many families with a child with a severe chronic illness (particularly when there are limited social or economic resources) will place very heavy demands on professionals. Many devoted professionals have enormous empathy with these families and do everything they can to mitigate the burden for these families. In many respects the professionals with the most empathy are the ones most vulnerable to being enmeshed in FII (see appendix 5).

(v) Lack of clarity of medical opinions.

(vi) Imbalance in power between:

Tertiary hospitals and district hospitals
District hospitals and primary care
Doctors and other professionals
Other professionals and health professionals
Junior and senior professionals

Non-professionals and professionals

(vii) Piloting of care by the perpetrator guides people to see what she sees: that all swans are white. **The message is very clear, no matter what the evidence to the contrary (no matter how many white swans) a single well documented event that suggests the bargain in health care has been broken needs to be fully evaluated. Individuals who have relatively little power in the systems must be empowered to express their concerns and they must be taken seriously.**

Keep questioning your assumptions – make sure you are on the right motorway and going in the right direction.

- Use the template of warning signs
- Set up and test hypotheses

(i) The consequence of failing to keep an open mind is that you never question if your assumptions are correct. You end up hurtling down the wrong motorway in the wrong direction.

(ii) Each of the critical events in the chronology was a point at which assumptions should have been critically reviewed.

(iii) In any unresolved clinical problem it is routine to review the story for clues to so far undiagnosed naturally occurring illness. It is essential that such reviews include the consideration of a wider variety of hypotheses including the possibility that there may have been distortion in the account the professional has been given.

(iv) Failure to take even the most rudimentary steps to corroborate the story given by the parents is the commonest reason that FII is not identified.

(v) It is clear that the obstacles to looking for black swans are so great that reliance cannot be put on professionals automatically including consideration of FII in their hypotheses to examine unresolved clinical problems. It should become a formal requirement for professionals to do this. This requires as a minimum:

- A full history of the child, siblings and parents, including health facilities they have used.
- Seeking corroboration of the reported symptoms from the other sources (the child, the family, the school, the GP, other professionals etc.).
- Corroborating information about the child's previous illness.
- Review of this information to see if there are any warning signs of FII.

This could be seen as analogous to the skeletal survey in physical abuse. It will be frequently negative but this is the cost of identifying FII.

(vi) It is critical **<u>before</u> the introduction of invasive treatments, particularly via portals of entry to the body, to question assumptions about the child being treated. 50% of reported cases of illness induction use routes which have been produced by doctors.** With the explosion in gastrostomies, home

antibiotic treatment, bladder catheterisation, etc. inevitably some parents will use these routes to abuse their children. **The checklist for FII we have suggested above should be applied in these cases, <u>even if there seems to be a bona fide naturally occurring illness,</u> before the treatment is commenced.** The introduction of the use of rectal diazepam and naso-gastric tube feeding in this child were two of the most critical events.

Be familiar with the range of behaviours that perpetrators of FII exhibit – know how to map read.

(i) The concept of MSBP abuse (now FII) and systems to detect this form of abuse have developed rapidly during the period of the case under review (see section 3.2 above).

Application of current understanding to analyse this case should maximise the lessons that can be learnt for the future. When considering the management of the case, however, the knowledge available to professionals at the time needs to be taken into account.

(ii) Probably before 1994 in this case, the abuse consisted only of fabrication which led to over-prescription of medication. It is only recently that this form of FII has received sufficient attention most clearly in the new term to describe this abuse, i.e. fabricated and induced illness.

(iii) Awareness of the links between all other forms of abuse and FII.

(iv) All children suffer naturally occurring illnesses. Additionally, induced illness results in real illness in the child. Thus, independent observations of definite clinical signs does not exclude FII. For example, if occasional tonic/clonic convulsions were observed this would still be at variance with a parental report that many such convulsions were occurring every day.

(v) The interaction between the perpetrator and professionals including enmeshment and entrapment.

(vi) Piloting of care by the mother.

Communicate, clearly.

(i) Hobbs *et al* conclude their diagram illustrating professional entrapment with the question: Do the various doctors talk to each other?[28]

(ii) Sometimes the problem is one of vocabulary. There is no accepted vocabulary for describing and communicating concerns when the concerns are only beginning to arise in the professional's analysis of a case (dawning of private concerns). 'Excessive consultation behaviour' or 'parental persistence' as suggested by Waring are possibly useful terms.[12] The latter has a slightly pejorative tone to it but Waring makes it clear that there are a range of reasons for parental persistence, most of which are benign. See analysis of period 4 and recommendation 19 'use of language'.

(iii) The recommendation that all correspondence about a child should be copied to the parents (Kennedy Report)[35] may cause problems in communication in the early stages of concern about FII.

(iv) It is essential that communication is factually correct.

(v) It is usual for perpetrators to seek further opinions, particularly if any doctor confronts the issue directly or indirectly. Too often the medical 'facts' of the case are communicated but not the concerns about their aetiology and rarely are the latter set out as clearly. There are a number of instances of this in this case particularly the referral to Alder Hey and the transfer to Leicester. This allows (and allowed) the cycle of abuse to be repeated.

(vi) Communication within agencies or institutions is also essential. Other specialists involved must be fully appraised of the concerns as this might have significant implications for their decisions (particularly the placement of the naso-gastric tube).

(vii) Delays in review of patients or in organising investigations can cause major problems in communication.

(viii) Communication is much more effective if pathways agreed in child protection procedures are followed.

(ix) Organising the information can be a major problem. A standard format is helpful (see appendix 4).

(x) Observations and actions of senior medical professionals led to insufficient consideration being given to the concerns of less qualified staff.

(xi) The time taken for outpatient appointments to occur can impede communication.

(xii) Recruitment of more and more agencies in different areas can cause confusion.

(xiii) Transfer of patient to another consultant can lead to lack of clarity about the lead consultant.

Be familiar with barriers to identification of FII.

Finally there are well described barriers to the identification of FII. These are set out in the table.

Barriers to the identification of FII[36]

- Lack of awareness of the range of behaviours.
- Concentration on 'making a diagnosis' rather than appraising all presentations and the whole of the child's health in a broad and holistic fashion.
- Minor abnormalities on investigation are unquestioningly accepted as explaining a substantial level of FII presentations.
- There is a tendency to consider this form of abuse as a 'diagnosis' of exclusion or last resort.
- Failure to take even the most rudimentary steps to corroborate the story given by the parents.
- Many of the children who suffer FII also have naturally occurring illnesses.
- There is a professional (and legal) risk in deciding to stop investigations.
- This form of abuse questions our beliefs about parenting and the doctor–patient relationship and is, therefore, emotionally challenging. It is only human to try to avoid thinking about such difficult ideas, especially with parents with whom one has already apparently developed a trusting professional relationship.

7. CONCLUSION

Of all forms of recognised child abuse, fabricated or induced illness presents most challenges to all professionals. We hope the complexity of FII has been demonstrated in this report.

We hope this report will assist practitioners to recognise in future when FII should be considered as a possibility in the management of the care of a child. In analysing the range of parental behaviour the focus must always be on the evidence of harm to the child. Ultimately the child's welfare is the paramount consideration.

8. RECOMMENDATIONS

Page No	Rec No	To	Recommendation	System Error	System Error No	Related Laming Recommendation
13	1	ACPC	**Amend Child Protection Procedures** Cumbria Child Protection Procedures should be amended. The guidance in the Department of Health (DOH) document 'Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities' should be included in Cumbria Child Protection Procedures. Issues which need to be addressed are set out in appendix 6.	The lack of understanding of and training with regard to FII.	1	None identified.
13	2	ACPC	**Use the term 'FII'** The term 'fabricated or induced illness' should be adopted in accordance with the DOH guidance.	The lack of understanding of and training with regard to FII.	1	None identified.
13	3	ACPC	**Training** The ACPC should produce a training programme to familiarise all relevant staff with the identification of FII. Issues to be included in the training programme are identified in more detail in appendix 6.	The lack of understanding of and training with regard to FII.	1	None identified.
13	4	ACPC	**Using the template** The ACPC should promote the adoption and use of the template as an aid to the identification of FII.	The lack of understanding of and training with regard to FII.	1	None identified.
14	5	DOH	**Involvement of Tertiary Centres in Serious Case Reviews** The Department of Health explores ways in which serious case enquiries can be coordinated across a number of health trusts to clarify lines of accountability and	None identified.		Recommendation 5: The National Agency for Children and Families should, at their discretion, conduct serious case reviews (Part 8 reviews) or oversee the process if they decide to delegate this task to other agencies following the death or serious

			to make the Chief Executive of each Strategic Health Authority responsible for initiating enquiries in such cases.			deliberate injury to a child known to the services. This task will be undertaken through the regional offices of the Agency with the authority vested in the National Agency for Children and Families to secure, scrutinise and analyse documents and to interview witnesses. I consider it advisable that these case reviews are published, and that additionally, on an annual basis, a report is produced collating the Part 8 review findings for that year.
14	6	All Agencies	**Speak and listen to children** All staff must be reminded through the normal programmes of in-house and multi-agency child protection training, and individually in writing, of the importance of actively seeking the views of children, listening to them and involving them in decisions about their health, education and welfare.	None identified.		Recommendation 13: The Department of Health should amalgamate the current *Working Together* and the National Assessment Framework documents into one simplified document. The document … must make clear in cases that fall short of an immediately identifiable section 47 label, that the seeking or refusal of parental permission must not restrict the initial information gathering and sharing. **This should, if necessary, include talking to the child.** Recommendation 26: Directors of Social Services must ensure that no case involving a vulnerable child is closed until the child and the child's carer have been **seen and spoken to**, and a plan for the ongoing promotion and safeguarding of the child's welfare has been agreed. Recommendation 35: Directors of Social Services must ensure that children who are the subject of allegations of deliberate

						harm are seen and spoken to within 24 hours of the allegation being communicated to Social Services. If this timescale is not met, the reason for the failure must be recorded on the case file. Recommendation 40: Directors of Social Services must ensure that no case that has been opened in response to allegations of deliberate harm to a child is closed until the following step has been taken: • The child has been spoken to alone.
15	7	DOH	**Holding meetings without parents** The guidance on the circumstances under which meetings may be called without the involvement of parents and carers should be revised. Where FII is suspected the focus should be on the potential level of harm to the child, rather than the needs or rights of the parents and carers. Clearer guidance is required on the level of parental involvement in a range of meetings.	None identified.		
15	8	ACPC	**Training about the seniority gradient** Training must equip all individual members of staff with the confidence to question the opinion of professionals in all agencies, including doctors, no matter how eminent those professionals appear to be.	The existence of the 'seniority gradient'.	2	Recommendation 37: The training of social workers must equip them with the confidence to question the opinion of professionals in other agencies when conducting their own assessment of the needs of the child. Recommendation 100: Training for Child Protection Officers (Police) must equip them with the confidence to question the views of professionals in other agencies, including doctors, no matter how eminent

						those professionals appear to be.
15	9	ACPC	**Training about the seniority gradient** Training must ensure all staff are aware of the concept of 'seniority gradient'. Professionals with more 'authority' must be taught self-awareness so that power gradients do not prevent communication. The more senior the professional, the greater his responsibility to talk to people so that they can understand and to be able to listen.	The existence of the 'seniority gradient'.	2	None identified.
15	10	DOH	**Need to identify lead doctor** A system is devised for identifying the lead doctor with overall responsibility for a child (in addition to the GP) in all cases, especially those which are complex and in particular where the possibility of FII is present.	Absence of a lead doctor.	3	Recommendation 76: When a child is admitted to hospital with concerns about deliberate harm, a clear decision must be taken as to which consultant is to be responsible for the child protection aspects of the child's care. The identity of that consultant must be clearly marked in the child's notes so that all those involved in the child's care are left in no doubt as to who is responsible for the case.
16	11	Health Services	**Need to identify lead doctor** Where multiple specialists are involved in tertiary facilities there should be a lead specialist who takes responsibility for the welfare of the child whilst in that tertiary facility. This includes identification of irregularities in medicine management which could indicate FII. This lead specialist remains lead specialist throughout the tertiary referral even if the child is transferred to another hospital unless the transfer of responsibility is agreed between consultants and recorded in writing.	Absence of a lead doctor.	3	Recommendation 76: When a child is admitted to hospital with concerns about deliberate harm, a clear decision must be taken as to which consultant is to be responsible for the child protection aspects of the child's care. The identity of that consultant must be clearly marked in the child's notes so that all those involved in the child's care are left in no doubt as to who is responsible for the case.
22	12	PCTs	**System to review frequent attenders**	No system to identify and	4	None identified.

			Systems should be developed by which Primary Care Teams can identify and review frequent attenders. This should include all members of the Primary Care Team and in particular health visitors who have a crucial role in any meetings and should always be included. Frequent attenders should be looked at in the light of the template for identifying FII.	review frequent attenders.		
23	13	PCTs	**System to monitor repeat prescriptions** Repeat prescriptions should always be monitored with alert systems in place to block overuse and abuse.	No system to monitor repeat prescriptions.	5	None identified.
23	14	Health Services	**Improve medicine management** The role of community pharmacists should be developed to include assistance in medicine management in primary care.	No system to monitor repeat prescriptions.	5	None identified.
23	15	Secondary and Tertiary Health Services	**Set agreed time scales** Following a referral from a GP or another consultant a timescale within which investigations should be completed must be agreed at the first appointment with the consultant. If those investigations are not completed within the set timescale it is the responsibility of the consultant to find out why and to consider FII as a possibility by applying the template. If there is a possibility of FII, agreement of appropriate timescales for investigation becomes crucial.	Lack of appropriate timescales in completing investigations.	6	None identified.
24	16	Education	**Revise Guidelines** Guidelines over administration of drugs in school must be revised to include the details identified in appendix 6.	Management of drug administration in school allowed mother to manipulate practice.	7	None identified.
25	17	Tertiary	**Oversight of junior doctors**	Use of junior doctors.	8	

		Centres	They should ensure that there are guidelines in each clinic with regard to the appropriateness of review by junior doctors and supervision of such consultations. Records should indicate who saw the child in clinic and the details of supervision.			
25	18	Social Services, Secondary and Tertiary Health Centres and designated doctor	**Additional checks to make in cases of suspected FII** Where FII is raised as a possibility the social worker conducting checks of the other agencies must consider additional checks. The view of the designated doctor (child protection) should be sought. The GP should identify whether a referral has been made to a secondary or tertiary centre and, if so, the name of the consultant with lead responsibility for the child. The designated doctor should take responsibility for raising the possibility of FII with medical colleagues and assist in gathering notes and compiling a chronology. The social worker must ensure that the additional check is made, either by themselves or via the designated doctor, to the consultant with lead responsibility for the child.	None identified.		
26	19	All Agencies	**Use of language** When a possible explanation for symptoms and signs is that they may have been fabricated or induced by a carer this must be explicitly indicated in any communication and ambiguous circumlocutions must be avoided. The concerns should only be disclosed to the carers after discussion with Social Services if it is decided that sharing information will	Use of ambiguous language to signal concern.	9	Recommendation 13: The Department of Health should amalgamate the current *Working Together* and the National Assessment Framework documents into one simplified document. The document … must establish a 'common language' for use across all agencies to help those agencies to identify who they are concerned about, why they are concerned, who is best placed to respond to those

			not place the child at increased risk of harm. If in a case there are unexplained symptoms or signs but application of the template suggests the possibility of FII is low, the use of the terms 'parental persistence' and/or 'medically unexplained symptoms/signs' is advocated. In such cases the possibility of FII should be regularly revisited until the symptoms/signs have been explained.			concerns, and what outcome is being sought from any planned response.
26	1, 3 and 4		**Amend Child Protection Procedures, training, using the template**	Dealing with the identification of FII as a medical assessment rather than regarding it in the wider context and identifying it as child abuse.	10	Recommendation 77: All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide Social Services with a written statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood. Recommendation 83: The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease.
26	1, 3 and 4		**Amend Child Protection Procedures, training, using the template**	The Social Services Department did not have a 'tool' available to them against which to check the possibility of FII.	11	None identified.
27	20	All Agencies	**Using the template** Any time FII is mentioned to any agency the template should be applied, the	The lack of understanding of or training with regard to FII. Dealing with the	1, 10 and 11	None identified.

			possibility of child abuse should be considered and enquiries should be made.	identification of FII as a medical assessment rather than regarding it in the wider context and identifying it as child abuse. The Social Services Department did not have a 'tool' available to them against which to check the possibility of FII.		
27	3, 16		**Training, Education Guidelines**	Escalation of administration of medication in school by an intrusive route.	12	None identified.
27	3		**Training**	Failure to recognise and record in order to challenge the discrepancy between observations of convulsions and mother's reports.	13	None identified.
28	21	All Agencies	**Report of dying child** Where information is given by a carer that a child is dying, confirmation should be sought from medical personnel able to make this prognosis. This is with a view to offering multi-agency support to provide optimum care and support for the child and family. If medical personnel fail to confirm a child is dying when that information is given by a carer then FII should be considered.	Mother's claim that her child was dying was accepted without question.	14	None identified.
28	4		**Using the template**	Failure to explore and/or investigate the reasons for mother's avoidance of definitive investigations. Inconsistencies and incongruities in the story were not recognised.	15	None identified.
28	3, 4		**Training, using the template**	The failure to analyse	16	None identified.

				information which could now be compared against the template led to the lack of recognition of FII despite the fact that the evidence was now very strong even without the detail of the previous history. The negative outcome of the videotelemetry should have led to action to protect the child.		
28	22	Health Services	**Naso-gastric tube** Before any physically intrusive device or treatment is introduced which is planned to continue at home, the possibility of FII should be considered by reviewing the information available in the case against the template. If it is decided to proceed, then a clear management plan must be in place to include the reasons for the treatment, a consideration of advantages and disadvantages, the planned duration of the use of the device, the responsibility for review of its use and possible complications in the use.	Naso-gastric tube feeding seems to have been instituted without a clear management plan and within the narrow focus of the patient's nutritional needs.	17	None identified.
29	10, 11		**Need to identify lead doctor**	Treatment of Michael appears to have been compartmentalised with no overall review of the problem. The dietician who discussed the introduction of the NG tube does not seem to have been working as part of a team with the paediatric neurologist who had already	18	Recommendation 76 which is reproduced above.

				considered the possibility of FII.		
29	23	Health Services	**Use of second opinions** Any tertiary specialist asked for a second opinion should contact the original specialist to ascertain the background to the case. If the reason for the referral for a second opinion is that a parent is claiming they have been blamed for causing the illness: i) the possibility of FII should be considered ii) the parent's claim should be clarified with the original doctor iii) the parent's claim should be included in the referral letter iv) the person receiving the request for a second opinion should clarify the reasons for it	A second opinion seems to have been arranged on the basis of mother's reports about what the paediatric neurologist had said.	19	None identified.
29	21		**Report of dying child**	Continuing uncertainty about the likely outlook for the child, i.e. whether his illness was life threatening/ terminal.	20 (see also 14)	None identified.
30	10, 11		**Need to identify lead doctor**	Lack of clarity about the roles of the different consultants.	21 (see also 3 and 18)	Recommendation 76 has already been reproduced above.
30	24	All Agencies	**Communicate concerns about FII** At any stage where any individual considers FII is a possibility, this possibility needs to be communicated to medical and other professionals who need to be aware of the possibility in order to safeguard the welfare of the child. If concerns about FII are not subsequently pursued then the reasons for not doing so	Failure to communicate concerns about FII.	22	Recommendation 67: When differences of medical opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one the diagnosis of deliberate harm must

			should be identified and recorded.			not be rejected without full discussion and if necessary obtaining a further opinion.
30	25	Health Services	**Avoid repeat investigations** Tests and investigations should not be repeated unless there is reasonable doubt about the accuracy of previous investigations or new features of the illness have appeared which could justify further investigation.	Unnecessary repeat investigations harm the child.	23	None identified.
30	26 (see also 13 and 14)	Health Services	**Avoid repeat prescriptions, improve medicine management, monitor changes in medication** The system should clearly identify any changed medication, new medication and discontinued medication, and should ensure systems so that everyone charged with administration of medication is clear what medication is currently prescribed.	Failure to monitor repeat prescriptions allowed dual administration of drugs that should not have been mixed.	24 (see also 5)	None identified.
30/31	27	Health Services	**Report of dying child, do not overstate the case** Guidance must be provided to all medical personnel highlighting the dangers of overstating the facts of a case, even though the actions are taken with the child's best interests at heart, with a view to obtaining support additional to that which would otherwise be available.	Inaccurate description by doctors that child was suffering from a life-threatening illness.	25 (see also 14)	None identified.
31	6		**Speak and listen to children**	The child's perspective on the family situation never appears to have been sought. When information was volunteered contradicting the mother's account this was not acted on.	26	The relevant parts of recommendation 13 and recommendations 26, 35 and 40 are reproduced above.
31	22		**Naso-gastric tube**	Continuing irregularities in	27 (see	None identified.

				the administration of medication and in the care of gastrostomy.	also 17)	
31	15, 25		**Set agreed timescales**	Lack of appropriate timescales in completing investigations suggested by the paediatric neurologist. The health of the child must always be paramount and if parents obstruct appropriate investigations, no matter what the reason, the doctor must ensure investigations take place within an appropriate timescale.	28 (see also 6)	None identified.
32	3		**Training**	Those who attended the meeting at the surgery did not follow child protection procedures afterwards by contacting Social Services. The child protection procedures current at the time required 'all cases of suspected child abuse must be reported to the local Social Services office' (section C1.2).	29	None identified.
33	28	Health Services and Social Services	**Conduct a risk assessment** When concerns about the deliberate harm of a child have been raised, particularly in cases of FII, an immediate risk assessment must be undertaken and concerns clearly communicated to those with responsibility for the care and protection of the child. This is particularly important where there is high risk of induced illness. The risk	Lack of clear consistent communication between professionals.	30	Recommendation 63: 'Hospital social workers must always respond promptly to any referral of suspected deliberate harm to a child. They must see and talk to the child, to the child's carer and to those responsible for the care of the child in hospital while avoiding the risk of appearing to coach the child'.

			assessment is not only in relation to the child presented, and their protection whilst in the hospital, but also for other children outside the hospital environment who may nonetheless be at risk.			
33	29	Health Services	**Communication on transfer between hospitals** Hospital Trust Chief Executives must introduce systems to ensure that no child about whom there are child protection concerns is transferred to another hospital without communicating these concerns and agreeing an action plan.	Lack of communication between professionals.	30	Recommendation 76: 'When a child is admitted to hospital with concerns of deliberate harm a clear decision must be taken as to which consultant is to be responsible for the child protection aspects of the child's care'.
33	30	Health Services	**Action in case of FII** Where a child is admitted to hospital and FII is suspected: • strict two-to-one nursing, and/or covert surveillance to assist the gathering of information is essential if there is significant risk of illness induction. • those responsible for the child's day to day care, particularly the nurses, must be aware of the concerns of FII.	One-to-one nursing, either formally established or assumed because a child is in intensive care, does not protect from illness induction and even two-to-one nursing will not protect the child unless there is an awareness of concerns of FII.	31	None identified.
34	31	Health Services	**Responsibility of receiving hospital** When a child is admitted or transferred to a hospital and deliberate harm is suspected, the doctor or nurse admitting the child must enquire and obtain information about any previous hospital admissions. The consultant in charge of the case must review this information when making decisions about the child's future care and management. Hospital Chief Executives must introduce systems to ensure compliance with this recommendation.	Although the consultant paediatrician was suspicious that Michael had been deliberately overdosed, insufficient steps were taken for Michael's protection which may have allowed his mother to interfere with his feeding pump.	32	(73)
34	32	Health	**Detailed review of information**	Lack of written medical	33	Recommendation 77: 'All doctors

		Services	A detailed review of medical information is critical to identifying this form of abuse, and must be undertaken where it is suspected and put in writing.	reports for the meeting on 11 July. Lack of clarity of medical information and differences of opinion between doctors creates major problems. Summarising the views is essential.		involved in the care of a child about whom there are concerns about possible deliberate harm must provide Social Services with a written statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood'.
35	33	All Agencies	**Prepare a chronology** When FII is suspected, a written chronology of each agency involvement must be compiled and shared with other agencies and the information gathered should be compared against the template.	Lack of written medical reports for the meeting on 11 July. Lack of clarity of medical information and differences of opinion between doctors creates major problems. Summarising the views is essential.	33	
35	19, 2		**Use of language, use the term FII**	There is no record of the use of the term Munchausen syndrome by proxy (now FII) by any medical personnel during the meeting on 11 July 2000 until the discussion about the way ahead. It is essential that doctors are explicit where they are concerned that FII might be occurring.	34 (see also 9)	Recommendation 13
35	34	All agencies	**Avoid becoming enmeshed** All professionals need to concentrate on dispassionately reporting the facts rather	Subjective judgement of, and empathy with, the mother affected contributions to the	35	

			than trying to understand the parent's motivation in cases of FII. The critical task is to assess the likely risk of harm to the child. Personal judgements of the parents are highly likely to severely interfere with that process. Chronologies, use of the template and a systematic consideration of risk factors for abuse should be the focus of professionals' reports.	information provided and the discussion that followed.		

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APPENDIX 1

MEMBERSHIP AND REMIT OF THE REVIEW GROUP

This Review Group was set up by Cumbria Child Protection Committee following the death of Michael. The timing of such Review Groups is always a sensitive issue. Michael died on 14 October 2000 and his death was reported to the Cumbria Child Protection Committee on 24 January 2001 when it was agreed that a Serious Case Review in accordance with the guidance of *Working Together*[1] should be instigated. In July 2000 a massive police investigation commenced leading to the eventual conviction on 22 July 2002 of Michael's mother of attempted murder and other charges of child cruelty. She was sentenced on 13 January 2003 to a lengthy term of imprisonment. It was a concern to the Child Protection Committee that the setting up of a Review Group should not impede the police investigations or the subsequent trial.

The Child Protection Committee experienced some difficulty in identifying a suitable independent Chair. Eventually the services of Dr R J Postlethwaite, Consultant Paediatric Nephrologist of Manchester Children's Hospital NHS Trust, were secured. Dr Postlethwaite has contributed to and co-edited the book *Munchausen Syndrome by Proxy Abuse: a Practical Approach*.[2]

Other Group members were:

Barry Archibald, Attendance and Exclusion Manager, Education Welfare Service, Cumbria County Council (CCC)
Elizabeth Benson, Children's Services Manager, NSPCC
Kevin Quinn, Acting Service Manager, Assessment & Care Management, Social Services, CCC
Detective Superintendent Jon Rush, Cumbria Constabulary
David Siddall, Acting Head of Children's Services, Social Services, CCC
Alison Smith, Assistant Head of Legal Services (Child Care), CCC
Dr Peter Tiplady, Consultant in Public Health, Cumbria and Lancashire Health Authority (formerly Director of Public Health, North Cumbria Health Authority)

The Review Group met on twenty occasions between October 2001 and 29 June 2003 and the substantive report was presented to the Area Child Protection Committee on 24 July 2003. The final report was presented to the Area Child Protection Committee on 12 May 2004.

In the absence of any defined terms of reference being provided by the Area Child Protection Committee the Review Group took its terms of reference from the 1999 Department of Health Publication *Working Together*.[1] These are to:

- establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children

- identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and, as a consequence,

- improve inter-agency working and better safeguard children.

The Group defined the period under review as commencing with the birth of the child and ending with the date on which protective action was taken.

The Review Group endorses the guidance given in *Working Together*[1] when it states that case reviews are not enquiries into how a child has died or who is culpable.

Three of the Review Group members were involved in the later stages of the period covered by this review. In order to protect the integrity of the Group these members were excluded from discussion of the period in which they were operationally involved.

The amount of information with which the Review Group had to deal was immense. Reports were received from:

- NSPCC
- Education
- North Cumbria Mental Health and Learning Disabilities
- Social Services
- Police
- Newcastle and North Tyneside Health Authority

From North Cumbria Health Authority the Review Group received the Health Services Management Review prepared by the designated Doctor in Child Protection.

Additional background papers were seen by the Review Group and medical notes were made available to the Group's Chair.

The Review Group expresses its thanks to all the authors of the internal agency review reports for the painstaking effort required in the production of their report. In some cases the agency report author has been requested to undertake further enquiries and the Review Group is indebted to them.

The Review Group was disappointed by the response of Tertiary Centres outside Cumbria.

The Review Group has recognised the difficulty of coordinating serious case reviews across a number of health trusts and has made an appropriate recommendation (recommendation 5).

It is noted in the Review Group's report that medical professionals have a key role in the identification of fabricated or induced illness. They have to decide whether signs or symptoms described can be a consequence of medical causes. The purpose of this Serious Case Review is to learn lessons to prevent children like Michael from dying. It is hoped that improved communication across a number of health trusts will ensure that the lessons to be learned are addressed both within and outside Cumbria.

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APPENDIX 2

DEVELOPING THE TEMPLATE

Over the years a list of associated features of FII has emerged. There has been much debate about their status and usefulness.[1,2,3] They have been variously described as warning signs and guidelines to diagnosis. There have been two major concerns about these warning signs:[1,2]

1. Though undoubtedly they should raise the possibility of FII, some of them are so commonplace, particularly in a socially deprived population, they are very non-specific.
2. There has been a concern that some of these pointers have been elevated to the status of being diagnostic.

The fullest list of features is provided by Parnell who refers to them as 'guidelines'.[4] She lists 18 features under 3 headings (see Figure 1).

Child-victim features
1. Persistent or recurrent illness that cannot readily be explained by the consulting physician despite thorough medical workup
2. A 'diagnosis' that is merely description of the symptoms, or diagnosis of an extremely rare disorder
3. Symptoms that do not respond to the usual treatment regime
4. Physical or laboratory findings that are not consistent with the reported history
5. Physical findings and reported symptoms that are at odds with the child's generally healthy appearance
6. A temporal relationship between the child's symptoms and the mother's presence
7. Pertinent medical history that cannot be substantiated
8. Presenting complaints that include bleeding, seizures, unconsciousness, apnea, diarrhoea, vomiting, fever and lethargy
Mother-perpetrator features
9. Reluctance to leave the child while the child is in the hospital
10. Development of close personal relationships with hospital staff
11. Educational or employment background in the medical field or the desire to be employed within the medical field
12. Unusual calm in the face of problems with the child's care
13. Medical problems similar to those of the child or other unusual symptoms
14. Fabrication of information about many aspects of her life
Family features
15. Unexplained illness or death in a sibling of the victim or in another child in the mother's care.
16. A marital relationship that is emotionally distant
17. Perpetrator's family of origin marked by emotional, physical or sexual abuse
18. Perpetrator's family of origin exhibits a pattern of illness behaviour
Figure 1: Guidelines for identifying cases of FII[4]

A number of these guidelines are generic to child abuse and non-specific for FII.

Most of the six 'guidelines' listed under mother-perpetrator features are post hoc assessments; they make sense when FII has been identified but are almost useless and probably misleading in identifying abuse. They include a number of features (reluctance to leave the child when the child is in the hospital, development of close personal relationships with hospital staff, unusual calm in the face of problems with the child's care) which are not only ambiguous but very subjective and reflective of a particular stereotype of perpetrator. Indeed there is a grave danger that the use of these 'features' has the risk of FII being presumed to be present because of certain judgements about the mother.

There do seem, however, to be two useful strands to these lists of features and guidelines:

1. Features which highlight unusual aspects in the illness in the child and other family members.
2. General risk factors for abuse.

The usefulness of this approach was dramatically emphasised by the police assessment of this case. Their use of a list of warning signs was critical in crystallising concerns about FII. It seemed worthwhile, therefore, to develop the template of warning signs both to analyse this particular case and hopefully for use in other cases.

In developing the template of warning signs, three sources were used:

1. The seven 'child welfare concerns' included in the Department of Health advice about fabricated or induced illness.[5]
2. The 'emerging concerns' included in the RCPCH report *Fabricated or Induced Illness by Carers*.[6]
3. The list used in this case by the police.

There is much overlap in the terminology of these different sources and this is illustrated in Figure 2, which aligns the differing terminology. The warning signs which were adopted for our template are highlighted in bold.

In producing the template from these sources:

1. The Department of Health warning signs were given precedence.[5]
2. To these were added additional categories included in the RCPCH guidance.[6]
3. Categories unique to the police listing were included.
4. From previous experience two further categories were added:

    i. Incongruity between the seriousness of the story and the action of the parents.
    ii. Erroneous or misleading information provided by parent.

Thus the 12 categories of warning signs used in our template were identified.

The terminology is not always easy to understand and so the template is set out again in Figure 3 where we also provide some examples of how we interpreted these categories.

Category	DOH – Child Welfare Concerns[5]	RCPCH – Emerging Concerns[6]	Police – Warning Signs
1.	**Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.**	Reported symptoms which do not correlate with any recognisable disease (or with a disease known to be present).	Symptoms and pattern of illness are acute, unusual, puzzling, or inexplicable physiologically.
		Signs which do not correlate with any disease.	
2.	**Physical examination and results of medical investigations do not explain reported symptoms and signs.**	Investigations which do not correlate with signs.	Repeated hospitalisations, tests by medical disciplines fail to reveal conclusive diagnosis.
		Physiological findings consistent with induced illness.	Physiological findings consistent with induced illness.
			Results of medical observations inconsistent with perpetrator's given history.
			Medical concerns at inability to identify cause, not matched by perpetrator.
3.	**There is an inexplicably poor response to prescribed medication and other treatment.**	Treatment for an agreed condition which does not produce the expected effect.	
4.	**New symptoms are reported on resolution of previous ones.**		
5.	**Reported symptoms and found signs are not seen to begin in the absence of the carer.**		Perpetrator is only witness of symptoms.
6.	**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.**		
7.	**Over time the child is repeatedly presented with**	Repeated presentations, particularly to	

	a range of signs and symptoms.	a variety of doctors and with a variety of problems.	
		Specific problems, e.g. apnoea or loss of consciousness, fits, choking or collapse.	
8.		**History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.**	Other siblings have had unexplained illnesses.
		A past history in the carer of child abuse, self harm or somatising disorder or false allegations of physical or sexual assault.	
9.			**Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear.**
			Perpetrator unusually close to medical team, thrives on hospital environment.
			Perpetrator insists on remaining at the child's bedside.
			Perpetrator may have medical or nursing education.
10.			**Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.**
			Perpetrator welcomes painful tests to child.

Figure 2: Warning signs from DOH Guidance, RCPCH Document and Police Checklist.
Entries in bold are the categories we adopted for the template.

Category	Warning signs of possible Fabricated or Induced Illness	Examples of patterns to look for
1.	**Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.**	• Symptoms and pattern of illness are acute, unusual, puzzling, or inexplicable physiologically • Never seen anything like it before • Symptoms reported not confirmed by professional assessment
2.	**Physical examination and results of medical investigations do not explain reported symptoms and signs.**	• Signs reported not confirmed by professional assessment • Signs do not correlate with any disease • Investigations do not correlate with signs • Repeated hospitalisations, tests by medical disciplines fail to reveal conclusive diagnosis • Physiological findings consistent with induced illness
3.	**There is an inexplicably poor response to prescribed medication and other treatment.**	• Escalating drug doses with no apparent response • Requirement for multiple medications to control a routine problem • Multiple changes in prescribed medication often because of reported side effects • Includes over use and under use of prescribed medication
4.	**New symptoms are reported on resolution of previous ones.**	• New symptoms as old ones resolve • Consultation behaviour transfers to another child
5.	**Reported symptoms and found signs are not seen to begin in the absence of the carer.**	• Severity and/or frequency of symptoms reported is such that the lack of independent observation is remarkable • Perpetrator is only witness of symptoms • Results of medical observations inconsistent with perpetrator's given history • Once perpetrator's access to child is restricted, signs and symptoms fade and eventually disappear.

6.	**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.**	• Exclusion from PE • Exclusion from school • Unwarranted and often extreme dietary restrictions • Wearing dark glasses • Confined to a wheelchair • Limiting social contacts
7.	**Over time the child is repeatedly presented with a range of signs and symptoms.**	• Multiple symptoms • Multiple doctors
8.	**History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.**	• Complex medical history in perpetrator • Psychiatric problems in perpetrator • Multiple illness in siblings
9.	**Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear.**	• Dramatic recoveries in hospital
10.	**Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.**	• Claiming child has terminal illness when this is not the case
11.	**Incongruity between the seriousness of the story and the actions of the parents.**	• Failure to attend for outpatients, investigation or admission inconsistent with serious parental concern • Medical concerns at inability to identify cause, not matched by perpetrator
12.	**Erroneous or misleading information provided by parent.**	• Claims a diagnosis has been made but subsequent communication shows it has not • Claims advice has been offered when it has not • Changing or inconsistent stories

Figure 3: The 12 categories of warning signs with some examples

The template proved invaluable in organising the information and the analysis of this case and we hope it is found useful in other cases. There are a number of other important points to make:

1. Every warning sign has multiple possible explanations, only one of which is fabricated or induced illness.
2. The warning signs should be considered as open questions, probing critical assessment of clinical presentations rather than closed questions.
3. The template needs further analysis particularly in different contexts (most appropriate to a medical context at the present time), making the questions helpful for other professionals for one of the tasks of further training.
4. Fabricated or induced illness is only one form of child abuse and shares many common antecedents with other forms of abuse. Thus, in addition to warning signs of fabricated or induced illness, the history should be examined for risk factors of abuse. These are summarised in Figure 4.

Risk factors for abuse[2, 7]
Characteristics of the parent's own childhood
Parents' enduring characteristics
Factors which affect the skills a parent develops
The physical environment
The parent's social supports
Immediate or proximal triggers in the family situation
Characteristics of relationships with the child
Characteristics which increase the likelihood of this child becoming a victim of abuse

Figure 4: Risk factors for abuse

1. Fisher, G.C. and Mitchell, I. (1995) Is Munchausen syndrome by proxy really a syndrome? *Archives of Disease in Childhood*: **72**: 530–534.
2. Eminson, M. Background. In Eminson, M. and Postlethwaite R.J. (eds). (2000) *Munchausen syndrome by proxy abuse: a practical approach*. Oxford: Butterworth-Heinmann: 17–70.
3. Meadow, R. (1985) Management of Munchausen syndrome by proxy. *Archives of Disease in Childhood*: **60**: 385–393.
4. Parnell, T.F. Guidelines for identifying cases. In Day, D.O. and Parnell, T.F. (eds). (1998) *Munchausen by Proxy Syndrome: Misunderstood Child Abuse*. Thousand Oaks: Sage Publications: 47–67.
5. Department of Health. (2002) *Safeguarding children in whom illness is induced or fabricated by carers with parenting responsibilities*.
6. Royal College of Paediatrics and Child Health. (2002) *Fabricated or Induced Illness by Carers. Report of the Working Group.*
7. Jones, D.P.H., Byrne, G. and Newbould, C. Management, treatment and outcomes. In Eminson, M. and Postlethwaite, R.J. (eds). (2000) *Munchausen syndrome by proxy abuse: a practical approach*. Oxford: Butterworth-Heinmann: 276–294.

APPENDIX 3

ROOT CAUSE ANALYSIS

Root cause analysis[1] has been widely advocated both in the UK[2] and USA.[1,3,4] It is beyond the scope of this appendix to describe this technique in detail, but in brief outline the steps in root cause analysis are:

1. Gather the facts
2. Choose the team
3. Determine the sequence of events
4. Select root causes
5. Develop corrective actions and follow-up plan.

Steps 1 and 2 largely pre-date the establishment of the Review Group and the follow-up plan is the responsibility of the ACPC and the agencies. The Review Group was mainly concerned with steps 3 to 5.

Determining the sequence of events

The sequence of events was determined by the Review Group from the internal agency reports and is set out in section 5 of the report.

Selecting root causes

Fundamental to root cause analysis are **error chains**. These are illustrated in Figure 1.

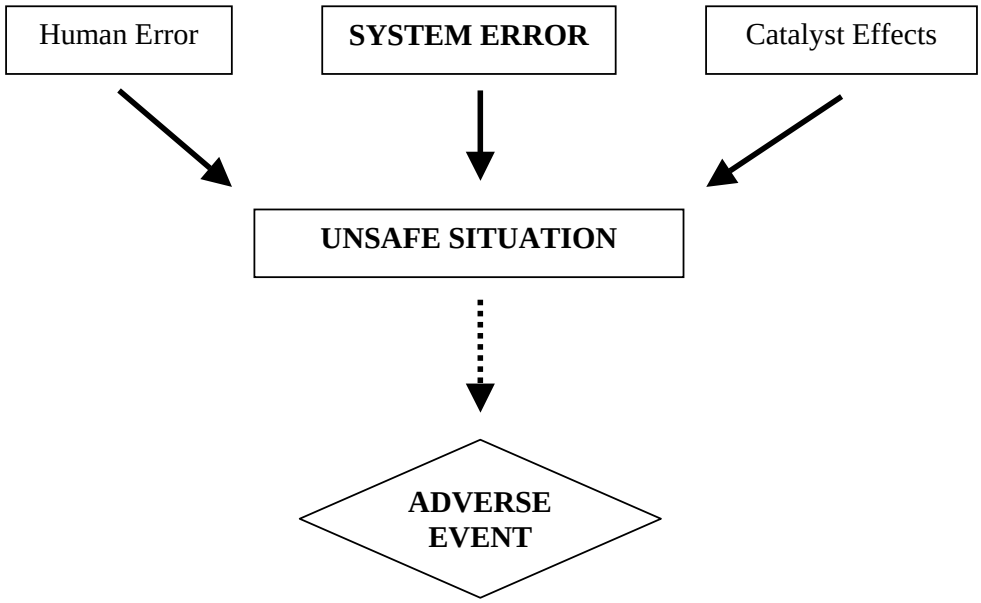

Figure 1: Error chain

As indicated in Figure 1 by the dotted line, unsafe situations arising from errors of all types do not necessarily result in adverse events.

In many clinical situations it is when error chains build into error trees that unsafe situations develop into adverse events. This is illustrated in Figure 2. Even this example is very simple with just five unsafe situations. Again, as illustrated by the broken line, a single adverse event rarely results in a final, irretrievable error. Thus it is important to concentrate on all the preceding error chains and their causes rather than focusing on the final error.

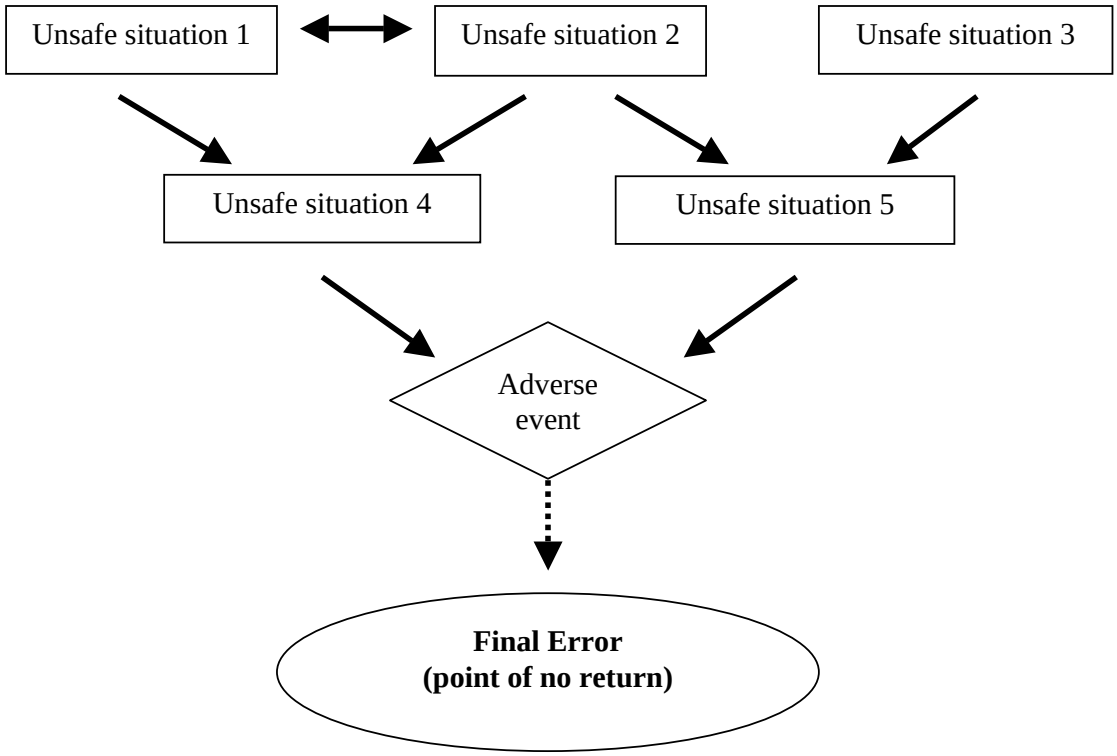

Figure 2: An error tree: Interaction between a number of error chains resulting in an adverse event

For the purpose of this analysis three types of errors were distinguished:

System errors are organisational errors, which allow unsafe situations to arise. A serious case review is tasked with examining inter-agency working. Failures in this area are clearly systems failures and properly the concern of the review.

Catalyst effects are events outside the control of the system which can, however, energise an error chain or tree. A simple example would be two patients with the same name on the ward at the same time. This might expose a systems error which otherwise might not lead to an adverse event, for example incomplete labelling of laboratory specimens.

Human errors are errors by those 'on the shop floor'. These are not the concern of a serious case review.

But we would want to emphasise:

- Human error is inevitable and the need is to build systems which protect against catastrophic consequences from a simple human error. This is particularly the case in child protection.

- Given the many system errors and catalyst events in this case, it would be grossly unfair to concentrate on the failure of an individual or an individual agency.

Thus root cause analysis is concerned with identifying the system errors which have given rise to the adverse outcome. The lessons learned should allow for better systems to be developed and part of this improvement is to reduce the risk from human errors and catalyst events.

1. Joint Commission on Accreditation of Healthcare Organizations. (1996) *Conducting Root Cause Analysis in response to a sentinel event.* Oakbook Terrace, III: Joint Commission on Accreditation of Health Care Organizations.
2. Department of Health. (2000) *An organisation with a memory*. Report of expert group on learning from adverse effects in NHS.
3. Millenson, M.L. The patient's view of medical errors. In Rosenthal, M.M. and Sutcliffe, K.M. (eds). (2002) *Medical error: What do we know? What do we do?* San Francisco. Jossey-Bass: 101–113.
4. Dawson, M.C., Munro, A.P. and Appleby, K.J. *et al*. Risk management and medical errors. In Rosenthal, M.M. and Sutcliffe, K.M. (eds). (2002) *Medical error: What do we know? What do we do?* San Francisco. Jossey-Bass: 137–156.

APPENDIX 4

CONSTRUCTING A CHRONOLOGY IN CASES OF SUSPECTED FABRICATED OR INDUCED ILLNESS

By the very nature of this form of abuse, the information available to a meeting about a possible case of FII is enormous. This often overwhelms the meeting and, furthermore, the collection of data often becomes obscured by pre-judgements about what is going on. Views are often polarised and this does not lead to a dispassionate consideration of the facts. **It is essential that each agency/professional produces a chronology before any such meeting.** This appendix describes one approach to constructing a chronology.

1. As complete a picture of concerns and consultation behaviour in all the children and the perpetrator (usually the mother) is essential.

2. Almost invariably there is an enormous wealth of information which is difficult to organise.

3. This information will need examining in different ways; for example, integrating all the reports, looking at an individual child, agency or institution. If freehand chronologies are provided by all the agencies and individual professionals concerned, this task becomes well nigh impossible.

4. The use of a standard simple format for each chronology, which can be merged and sorted, is tremendously efficient and helpful. We have found the format below to be helpful. It could be constructed as a table, spreadsheet or database. All these will allow for merging and sorting. The comment section allows for points to be noted, clarification to be sought and eventually an assessment of the significance of the event to be made. At a simple level, presenting the table in landscape rather than portrait format increases the space for narrative in episodes and comments columns.

Date	Name	Source	Episode/event	Category	Comment

Figure 1: Format for chronology

Notes: *Date* (self explanatory). *Name* is of the individual involved in the episode. *Source* is the agency (social services etc.) or individual (it could variably be either in the same chronology). *Episode/event* is a record from the clinical story. *Category* is the category of warning sign. *Comment* is self explanatory.

5. Page 48 of the RCPCH report[1] includes another suggested format to record events. We have found that less easy to use than the format we have developed in this report.

6. The chronology is only one part of collecting information and will need supplementing by reports, which draw out messages from the chronology. Getting the facts agreed and seeing the overall pattern is crucial and often very revealing.

What to include in the chronology?

If every single contact with any professional is included, the chronology loses its value. On the other hand, any selection has the risk of excluding a vital detail. Some guidance is necessary as to what should be included.

1. The template we have described should be used to organise the information. **At this stage it is important to include any event that comes under any one of these categories of warning signs so that it can subsequently be discussed.**

2. There is a basic implicit assumption in the way health resources are used: '**that parents bring children who are sick and tell the truth about them and that doctors bring expertise and technology and act to do their best for children'**. This has been referred to as the bargain in health care.[2] In fabricated or induced illness this bargain is infringed. The child is not sick, the perpetrator does not want them to get better and the actions (or stories) of the perpetrator lead the doctor to use their expertise and technology to harm the child. The warning signs are just the more common manifestations of the abuse of the bargain in health care. They should not be seen as being exclusive; **any episode in which the perpetrator <u>could</u> be using the medical system to harm their child MUST be included on the chronology even if it does not fit neatly into any of the categories set out in the table.**

3. There is increasing recognition of the links between all other forms of abuse and FII; in general there is major overlap in the background factors, which result in all types of abuse. The presence of other forms of abuse in families with FII:

   (a) Confirms the situation is abusive.
   (b) Increases the risk of severe FII.

   All possible episodes of other forms of abuse must be included on the chronology. We would advise at this stage including relatively trivial injuries, which in fact may be accidents. In a number of cases of FII, frequent accidents (falling off beds, cuts and bruises etc) have been dismissed, which might have increased suspicions not only about FII but increased the risk of induced illness.

4. Contact with medical facilities is also important but it is unhelpful to catalogue every single one. We would suggest it is worth noting:

   (a) The number of signs or symptoms in the children. Initially there should be no judgement as to whether they are the result of real (intrinsic) illness or FII. The number of symptoms/signs reported in these children is frequently more than 10.
   (b) The number of medications and details. Reported side effects of medication are also important.
   (c) The number of invasive tests and/or operations should also be included.
   (d) The number of different medical teams involved.

Information tabulated in this way often reveals a startling picture.

1. Royal College of Paediatrics and Child Health. (2002) *Fabricated or Induced Illness by Carers. Report of the Working Group.*
2. Eminson, M. Background. In Eminson, M. and Postlethwaite R.J. (eds). (2000) *Munchausen syndrome by proxy abuse: a practical approach*. Oxford: Butterworth-Heinmann: 17–70.

APPENDIX 5

EFFECTS OF FABRICATED OR INDUCED ILLNESS ON PROFESSIONALS

Fabricated or induced illness has a profound effect on the professionals who have been involved in the case. 'Perhaps what is most obviously vulnerable to breakage in cases of MSBP abuse is trust. Three main areas are seen to be at risk: the paediatric healthcare professional's trust in the parent (or other perpetrator), trust in the judgement and support of others in the clinical team (in one's own discipline or another) and trust in one's own judgement and ability to spot deception'.[1] Here we are most concerned with the second two aspects of broken trust. Breaking trust can also be viewed against betrayal of the usual bargain of health care.

This breakage in trust has been most written about with regard to doctors. The parents 'create a veritable minefield for a physician faced with the skilful manipulations of the MSBP mother when she creates an "unsolvable" clinical problem. The far reaching knowledge of matters medical exhibited by these mothers and the support they express for the work of the doctor ("Doctor I know you are doing your best, stay with it, let's work together. We'll support you.") combine to encourage the paediatrician's empathic identification with the mother. She begins to look like an appreciative colleague *and* like an ideal mother ... If it were just the issue of the paediatrician's competency, knowledge, and autonomous decision making, things would be difficult enough. But add the issue of the doctors "caring" and the bold and sometimes even bald manipulation of "adulatory support" that these parents often express, and a situation is produced in which the question of his caring is now tied to his medical/clinical *performance*. Now, when things are not going well clinically, the doctor is left vulnerable to this self accusation of not caring enough and feeling that he needs to try harder. And this step seals "the trap". It is this intense inward focus by the physician, the self blame for whatever is going wrong clinically in the case (the kind of doubt that doctors and clinicians too frequently do not share with their colleagues) that is transformed into self-doubt. These self-doubts in turn cause otherwise competent doctors to miss or misinterpret obvious clues concerning MSBP behaviour. Moreover there may well be an element of truth to the self-blame and self-doubt if the physician finds himself/herself fleeing from the demands and needs of an engulfing MSBP mother to actual avoidance of the desire to get rid of the problem'.[2]

Hobbs *et al* commented on this and underlined the courage needed to confront the issue:[3] 'However, when a halt is called to this and the doctor does have the courage to confront the issue (and courage it does take) then the mother will leave and assign that doctor to the worthless, criticised "bunch of useless professionals" and move to someone else who will, with her, repeat the cycle. The parents will consolidate their beliefs and positions and the child is usually subjected to "further illness creating situations" to challenge the next doctor to even more efforts'. His paper is also referred to in the body of this review report in the analysis of Period 2, paragraph 5.2.5.

While all these comments refer to doctors, there is no doubt nurses experience similar reactions to fabricated or induced illness. This is summarised in Lloyd and MacDonald.[4] Some themes are shock, disbelief and anger. The anger was identified as being towards the parent (usually), themselves (for having been deceived) and the doctors. This anger towards doctors was for having given less support than the nurses felt they should, for having left the nurses at the sharp end, and for sometimes having been slow in taking the nurses' concerns seriously.

There is little published work about other professionals but here is little doubt, therefore, that the reactions described in detail for doctors and nurses are shared by other professionals involved in such cases. Probably the more empathic and close the professional is to the family, the more likely they are to be seriously affected by identification of fabricated and induced illness.

No doubt the Serious Case Review process creates further problems for all these professionals. It is essential that the individuals concerned have appropriate support and that the additional burden of the Serious Case Review process for these individuals needs to be considered. Lloyd and MacDonald provide suggestions as to how staff can be supported (Figures 1 and 2). These are specifically framed for nurses but can be adapted for other staff.[4]

Figure 1: Proactive measures to assist staff with the emotional burden of involvement in cases of MSBP abuse.

Training

- MSBP abuse should be covered in nurse and medical training.
- Such training should cover common effects on staff (so that reactions can be expected, understood and recognized in self and others), and advice given about methods of dealing with such issues.
- Continuing education/continuing professional development for children's health care personnel should cover MSBP abuse.

Up to date information on MSBP abuse

- Should be to hand on wards, and included in child protection policies and procedures.
- Should be included in formal orientation and induction programmes.

Communication

- Psychosocial or other ward meetings to act as a regular multi-disciplinary forum in which issues can be raised and discussed at an early stage, and a culture developed which encourages staff to reflect on the emotional demands of cases and promotes the recognition and labelling of the emotions evoked.
- Careful liaison between departments, between hospital and community teams, and between agencies.

Paired working

- In complex cases and where index of suspicion is high, to provide opportunity for 'checking out' experiences and impressions.

Clinical supervision systems

- To enable nurses and other staff to voice suspicions in a safe environment and examine evidence at an early stage.
- Adequate resourcing of such systems is essential.

Audit

- All the above should be effected in individual case review format and in the context of wider audit.

All the above measures aim to increase awareness, encourage questioning and reflection and reduce isolation.

Figure 2: Reactive measures to assist staff with the emotional burden of involvement in cases of MSBP abuse.

Communication

- May be enhanced by involvement of fewer, rather than more staff.
- Once suspicions are voiced, multi-disciplinary (MD) meetings of involved staff to discuss formulation and management plans, to afford the opportunity to question and to acknowledge some of the conflicts and anxieties experienced by the staff.
- After events, meetings for the staff to continue and tie up relevant issues. If MD meetings did not occur whilst the case was 'active', then a meeting or series of meetings may still be useful at this stage.

Clarity

- Of management plan, including how to deal with parents while suspicions remain covert.
- Of lines of responsibility.

Paired working

- To reduce isolation of staff and to afford opportunities for 'checking out' impressions and experiences.

Clinical supervision systems

- When effective, can provide added support and containment to staff.
- Supervisors should monitor the reactions of their supervisees.

External support

- After particularly traumatic cases, the opportunity to speak to someone outside the clinical team may be valuable, either individually or as a group.

Audit

- Post facto audit of all cases of MSBP abuse to promote 'learning from experience'.

1. Eminson, M. Background. In Eminson, M. and Postlethwaite R.J. (eds). (2000) *Munchausen syndrome by proxy abuse: a practical approach*. Oxford: Butterworth-Heinmann: 17–70.
2. Schreier, H.A. and Libow, J.A. (1993) *Hurting for love: Munchausen by Proxy Syndrome*. Guildford Press.
3. Hobbs, C.J., Hanks, H.G.I. and Wynne, J.M. (2000) Poisoning, suffocation and factitious illness. In *Child Abuse and Neglect: a clinician's handbook*. Churchill-Livingstone, London, 2nd ed: 299–316.
4. Lloyd, H. and MacDonald, A. Picking up the pieces. In Eminson, M. and Postlethwaite, R.J. (eds). (2000) *Munchausen syndrome by proxy abuse: a practical approach*. Oxford: Butterworth-Heinmann: 295–314.

APPENDIX 6

Recommendation 1: Issues to be addressed in the Child Protection Procedures

- Fabricated or induced illness (FII) should be the term used to replace ‘induced illness’, ‘factitious illness’ and ‘Munchausen syndrome by proxy’.

- The risk of harm to the child from ‘fabricated’ as well as ‘induced’ illness must be acknowledged.

- FII should be dealt with in a separate appendix to the Child Protection Procedures not, as currently, linked to failure to thrive.

- Procedures should stress the role of each agency, and each individual within each agency, in the identification of FII.

- Procedures should be clear about the steps to be taken when FII is a suspicion. Professionals may be concerned about the possibility of FII but of the view that there is insufficient evidence for a firm identification. At this stage the child is at risk of significant harm without directed inter-agency consultation. Issues to address include:

    - Review of risk factors for abuse from all inter-agency information including Social Services, A and E attendances and GP records.

    - Mechanism to share and exchange information without the knowledge of the parent or carer (a meeting is often the best forum).

    - System of peer support by a colleague with experience of FII.

    - Use of explicit language by medical personnel with lay professionals where terms such as ‘parental persistence’, ‘medically unexplained symptoms’ and ‘unusual consultation behaviour’ may have little meaning.

- Procedures should be clear about the use of a template to identify incidents of concern which could be indicative of FII.

- Procedures must be clear about the plan and the timescale for an assessment process when FII is raised as a concern.

Recommendation 3: Identified needs to be included in training programme

Objective:

At the conclusion of the training, participants will be familiar with the warning signs of FII at a level appropriate to their professional position.

Participants will be aware:

- Of the barriers to identification of FII.
- Of the importance of keeping an open mind.
- Of the range of behaviours that can be presented by a perpetrator.
- Of the effect of the perpetrator's action on the ability of health professionals to provide the best care for the child.
- Of the futility of trying to understand the perpetrator.
- Of the importance of speaking to the child and finding out how things appear to them.

Participants will:

- Learn that FII is another form of child abuse and has many common characteristics.
- Learn that the key to the identification of FII is the identification that the child is suffering significant harm.
- Be clear about their own role and the role of other individuals and agencies in the identification of FII. Participants, medic or non-medic, will be confident about the template and how to apply it in a given situation.
- Be equipped with the confidence to question the views of professionals in other agencies, including doctors, no matter how eminent those professionals appear to be.
- Be aware of the concept of 'seniority gradient': professionals with more 'authority' must be taught self awareness so that power gradients do not prevent communication. The more senior the professional, the greater his responsibility to talk to people so that they can understand and to be able to listen.
- Learn the importance of describing what they see, not what someone else tells them they have seen.
- Be confident about using their common sense. If something is 'not right', participants will understand the individual obligation to pursue the matter further.

At the conclusion of the course, participants will be clear how FII fits into Child Protection Procedures and will be in a position to identify further training needs which may be required.

Recommendation 16: Elements to be included in the procedure for the administration of drugs in school must include:

- Health care plans must be signed by suitably qualified medical personnel.
- Administration of drugs must be in accordance with the prescription.
- Any variation in prescriptions must be confirmed with medical personnel and not implemented solely on parental advice.
- Any concerns about drug administration should be communicated directly to medical personnel, not via the parent.
- All administration of medication should be recorded.
- Where pupils have a statement of special educational needs, the administration of medication should be reviewed at least annually.
- Where pupils have a statement of special educational needs, there should be a protocol for the respective roles of teachers and non-teaching assistants, LEA staff and outside agencies.
- Health personnel must demonstrate invasive means of drug administration.
- Guidelines must be especially rigorously applied where the drug is uncommon, may carry side effects, where the application of the drug is invasive or intrusive, or where withholding the treatment could result in serious illness or death.

APPENDIX 7

GLOSSARY OF ABBREVIATIONS, MEDICAL TERMS AND DRUGS/SIDE EFFECTS

Glossary of Abbreviations

DOH	Department of Health
EEG	Electroencephalogram
FII	Fabricated or induced illness; the preferred term for the form of child abuse formerly known as Munchausen syndrome by proxy
LEA	Local Education Authority, Cumbria County Council
MMR	Measles/Mumps/Rubella vaccination
MRI	Magnetic-resonance imaging
MSBP	Munchausen syndrome by proxy: first identified publicly by Dr Meadow The term 'fabricated or induced illness' (FII) is now preferred
NG	Naso-gastric
RCPCH	Royal College of Paediatrics and Child Health

Glossary of medical terms

ABSENCE:	Epileptic absence, petit mal, attacks of brief clouding of consciousness which usually may be brought on by hyperventilation. The absences may be unaccompanied (simple) or accompanied (complex) by other abnormalities.
AETIOLOGY:	Explanation of the causes.
ATAXIA:	Shaky movements and unsteady gait.
BUCCAL:	Relating to the mouth, the hollow part of the cheek.
CONVULSION:	A term which closely corresponds with generalised tonic/clonic seizure.
EEG:	The technique for recording the electrical activity from different parts of the brain and converting it into a tracing called an electroencephalogram.
ENCEPHALOPATHY:	Any disease of the brain.
EPILEPSY:	Any of a group of disorders of brain function characterised by recurrent attacks that have a sudden onset.
GASTROSTOMY:	The making of an opening to introduce food into the stomach.
GRAND MAL:	Major epilepsy. Sometimes called tonic/clonic fit. The tonic phase begins when the patient falls to the ground unconscious with his muscles in a state of spasm. This is replaced by the convulsive movements of the clonic phase, when the tongue may be bitten and urinary incontinence may occur.
LENNOX GASTAUT SYNDROME:	LGS is one of the more severe and difficult to control forms of epilepsy. It usually develops between one and eight years of age and is characterised by several seizure types in addition to development delay.
MRI:	Magnetic Resonance Imaging (imaging of soft tissues of the body).
PETIT MAL:	A form of idiopathic epilepsy in which there are brief spells of unconsciousness, lasting for a few seconds, during which posture and balance are maintained and the eyes stare blankly. Petit mal seldom appears before the age of three or after adolescence. It may be accompanied or followed by a grand mal.
SEIZURE:	An attack, the sudden onset of a disease or of certain symptoms such as convulsions.

Glossary of drugs/side effects

All explanations have been obtained from the ABPI Compendium of Data Sheets and Summaries of Product Characteristics 1999–2000 (with the Code of Practice for the Pharmaceutical Industry) published by Datapharm Publications Ltd., 12 Whitehall, London SW1A 2DY.

ANTI-EPILEPTIC DRUGS (ANTI-CONVULSANTS)

CARBAMAZEPINE: Brand name **Tegretol.** Prescribed in tablet or chewable tablet form and in a liquid form. A high dose of Tegretol can cause the following side effects: dizziness, headache, ataxia, drowsiness, fatigue, diplopia, nausea or vomiting.

In relation to the central nervous system (neurologically) it would cause a number of side effects including, frequently, dizziness, ataxia, drowsiness, fatigue and occasionally headache, diplopia and blurred vision. On rare occasions it can cause oculomotor disturbances (movements of the eye), speech disorders, abnormal involuntary movements (tremor, asterixis, orofacial and dyskinsia [involuntary movements of limbs and mouth]).

DIAZEPAM: Prescribed in rectal tubes also called **rectal Valium**. The lowest dose that can control the symptoms should be used. Doses should only be repeated on medical advice. The following side effects can be caused by diazepam: drowsiness, sedation, blurring of vision, unsteadiness and ataxia. Overdose of diazepam can show the following symptoms: drowsiness, ataxia, and dysarthia with coma or cardio-respiratory depression in very severe cases.

MIDAZOLAM: Prescribed as **Hypnoval** in 10mg/2ml ampoules. This is used as an intravenous sedative before and during minor surgery. It has only recently been used in the treatment of epilepsy. When used in the treatment of epilepsy it is to be given buccally. That is the ampoule to be drawn up in a syringe, the needle discarded, and the contents of the syringe squirted into the area between the teeth and gums. It has not been evaluated for use as an intravenous sedative in children. Indeed, following intravenous application of midazolam, respiratory depression and respiratory arrest have occurred. The symptoms of overdose are mainly an intensification of the therapeutic effects, namely sedation, muscle weakness, profound sleep or paradoxical excitation.

APPENDIX 8

SUMMARY OF CASES OF FABRICATED OR INDUCED ILLNESS REPORTED IN THE LITERATURE UP TO 2000

The table which follows provides details of 313 cases of FII reported in the literature up to 2000. These are classified using the descriptive categories proposed by Bools.[1] Postlethwaite *et al*[2] have developed an alternative categorisation. Additionally the presenting symptoms and/or signs are summarised.

The first five references in the table 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.

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Variety of FII[ref]	Number of index cases	Details of index fabrication
Fabricated Illness		
Verbal fabrications	44 (14%)	abdominal pain,[6, 7] apnoea,[6, 8, 9] asthma,[10–12] ataxia,[6] chest pain,[13] choking,[14] conduct disorder,[10] deafness,[15] falling,[16] feeding difficulty,[17] food intolerance,[6, 18, 19] headaches,[10, 20] joint pains,[10] lethargy,[21] multiple sclerosis,[20] multiple,[22] polyuria/polydipsia,[14] pyrexia,[20] recurrent infections,[23] respiratory problems,[6] seizures,[6, 23–27] swallowed coins,[28] sweating,[6] thyroid disease,[20] vomiting and/or diarrhoea.[6, 29]
Verbal fabrications plus the falsification of specimens or charts	23 (7%)	bleeding diathisis,[30] bleeding from mouth and/or ears,[31–33] CSF ottorhoea,[34] cystic fibrosis,[35] diabetes insipidus,[6] fever,[6] glycosuria,[32, 34–38] haematemesis and/or malaena,[39–41] haematuria,[6, 42–46] hyperkalaemia,[47] jaundice.[16]
Induced Illness		
Withholding nutrients or medicines to produce signs	14 (4.5%)	behaviour problems,[6] failure to thrive,[6, 48] feeding problems,[6] generalised oedema,[48] rickets.[48]
Production of signs by other means	62 (20%)	central line complications other than infection,[6, 49, 50] central lines recurrent sepsis due to interference with,[6, 24, 51–62] dermatitis artefacta,[25, 12, 63–66] gastrointestinal pseudobstruction,[67–69] injury to mouth and/or ears,[24, 70–76] other,[6, 16, 39, 49, 70, 77–81] recurrent infections,[6, 54, 56, 82–85] renal stones.[86–88]
Fabrication associated with poisoning to produce signs	131 (42%)	diuretics,[89, 90] emetics/laxatives,[6, 9, 16, 91–107] fruit juice,[9, 104] anticoagulants,[108–111] antidepressants,[112–114] arsenic,[17, 115] barbiturates,[70, 90, 112, 116–118] bleach,[119, 120] chloral,[26, 121, 122] diazepam,[119] hypernatraemia,[6, 43, 90, 123–127] hyponatraemia,[128, 129] insulin alone,[130–135] insulin plus another drug,[136, 137] miscellaneous,[6, 9, 12, 16, 90, 116, 120, 138–144] multiple,[23, 70, 108, 116, 138] oral hypoglycaemic,[90] pepper,[119, 145, 146] phenothiazines.[32, 147–149]
Fabrication associated with smothering	39 (12.5%)	apnoea/seizures/near miss cot death/cardiac arrest.[9, 17, 29, 72, 98, 103, 112, 120, 138, 150–162]
Total	313	
Summary of cases in literature up to 2000.		

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