

Serious Case Review

No: 2017/C6969

Published by the NSPCC

On behalf of an unnamed local safeguarding
children board

This report was written by an independent author and is owned by the
commissioning LSCB.

This report is published by the NSPCC with the agreement of the National
Panel of Independent Experts.

Publication of this report by the NSPCC does not constitute endorsement of
the contents.

Copyright of this report remains with the commissioning LSCB.

Serious Case Review Overview Report

Services provided in a complex case of Fabricated or Induced Illness

Serious Case Review Chair

Consultant in Public Health

Independent Lead Reviewer

Keith Ibbetson

Services provided in a complex case of Fabricated or Induced Illness

1	Reasons for conducting the Serious Case Review, focus of the review and agencies involved	2
2	Key events	7
3	Serious Case Review Findings	17
3.1	How was the child harmed and what was the evidence of Fabricated or Induced Illness (FII)?	17
3.2	Challenges faced by professionals in the health service	20
3.3	Social care management and the coordination of a multi-agency response	32
3.4	Research, professional understanding of Fabricated or Induced Illness (FII) and the limitations of existing guidance and research	37
4	Recommendations	47
	Appendices	52
I	Principles from statutory guidance informing the Serious Case Review method	53
II	How the review was undertaken	55
III	SCR panel	56
IV	Roles of staff interviewed or in attendance at group sessions	57
V	References	58
VI	Views of family members	59
VII	Flowchart proposed by Bass and Glaser for the medical management of unexplained presentations and FII	60
VIII	Medication known to have been prescribed to Child Y	61

1. INTRODUCTION

- 1.1. Between November 2015 and March 2017, the Local Safeguarding Children Board (the LSCB) conducted a Serious Case Review (SCR) in relation to the services provided for a teenage boy, referred to in this report as Child Y. Child Y's circumstances are believed to be an example of fabricated or induced illness (FII) which has severely impaired his health and development.¹ Details of his contact with health professionals and the impact of the treatments that he has received are set out in section 2 of this report. Child Y has a younger teenage sister and her contact with services is also considered, but in less detail.
- 1.2. The SCR was carried out under the guidance *Working Together to Safeguard Children 2015*. Its purpose is to undertake a '*rigorous, objective analysis...in order to improve services and reduce the risk of future harm to children*'. The LSCB is required to '*translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children*'.²
- 1.3. The LSCB has removed identifying features of the health trusts and local authorities that worked with the family from this published SCR report. This is because the specific circumstances make the individuals concerned readily identifiable to many people. Publishing the full report could jeopardise the right of the children to a private and family life and risk causing further harm. Publishing this version of the report will also prevent the published case details being linked with the family court proceedings, in line with the request of the judge who heard the case.
- 1.4. The full report has been presented to the LSCB and to all participating agencies and it will be used as the basis for briefing and training locally. It has also been shared with central government bodies in the normal way.

¹ Section 3.4 of the report discusses the problems associated with defining and understanding FII as well as some limitations of current knowledge. The term FII is used throughout this report because it has been the term used in almost all in UK discussions since 2002. Other terms such as Munchausen Syndrome by Proxy (MSbP) are used internationally and are used in this report when distinguishing the two is required in order to understand a research document or a professional view.

² *Working Together to Safeguard Children* (2013), 4.1 and 4.6

Reasons for conducting the Serious Case Review

- 1.5. In July 2015 the local authority brought the case of Child Y and his sister to the attention of the LSCB because of concerns about how the risk to Child Y had been assessed and managed and how agencies had worked together to safeguard him. At that point the local authority was preparing an application in the family court to seek a finding that the children had suffered significant harm.
- 1.6. The case was formally considered by the LSCB Serious Case Review Group in November 2015, after a period during which agencies compiled case histories. The delay in gathering detailed information was due to the complexity of the children's circumstances, which will be apparent from the rest of this report.
- 1.7. At that point the LSCB was informed that:
 - in four years the children had presented over 250 times at hospital emergency departments, with no medical causes found for many of that symptoms repeatedly described
 - there had been a substantial number of medical interventions, including numerous medications, intrusive investigations and surgery
 - the children's school attendance had been extremely poor for several years with a consequent negative impact on their education
 - the children had moved to Local Authority 1 in 2012 from another area where they had been the subject of a child protection plan
 - in Local Authority 1 they had been the subject of child protection plans from July 2014
 - during 2015 Child Y had had a potentially life threatening fall from a high building, which was believed to have been accidental; fuller details of this incident had been hard to obtain but the circumstances were potentially very concerning and this had triggered the decision of the local authority to seek legal measures to protect the children

The scrutiny of records had only extended to local agencies known to have been involved. Subsequent review found that two other hospital trusts had played a significant role in the case history. It also became clear that the high level of contact between the children and hospital emergency departments went back many years and that the children had lived at addresses or received services in neighbouring local authorities.

- 1.8. The case review sub-group of the LSCB recommended that the children's circumstances met the criteria for a SCR on the grounds that they had suffered serious harm and there was cause for concern about the way in which agencies had worked together to safeguard them. It was apparent that there had been a substantial delay in acting on

concerns that Child Y was being affected by FII. The independent chair of the LSCB, confirmed the decision to hold a SCR in December 2015.

The focus and scope of the Serious Case Review

- 1.9. Child Y and his sister received a very high level of input from health trusts for over a decade. It was clear that without a disproportionate use of resources it would be impossible to map these contacts comprehensively and to reconcile all of the gaps and discrepancies in records that inevitably arise in such a case. However it was agreed that this would not prevent useful lessons from being learnt. At the outset it was clear that this was not a case in which specific individual errors or shortcomings had been decisive in determining the outcome: rather there were patterns of family and professional behaviour that had been repeated many times, featuring an evolving group of health, school and social care professionals.
- 1.10. In its initial discussions the case review group agreed to limit the scope of the review to the period between June 2012 (when the family moved to Local Authority 1) and October 2015 (when the local authority made an application in the family court). It also agreed that on the basis of a broadly accurate but not necessarily comprehensive understanding of the case history the review would seek to identify 1) the factors that had shaped professional behaviour towards the family and 2) why it was that professionals had recognised the children's difficulties but been unable to resolve them. It was also clear that the SCR should seek to understand the value of current local and professional guidance on FII. These topics are the focus of Section 3 of this report.
- 1.11. The report contains references to the contact of agencies with Child Y's sister. It is apparent from the records that in many respects Child Y's sister had begun to present similar concerns to her brother, taking account of the difference in age. Agencies were struggling to respond effectively, even though they were aware and concerned that her behaviour appeared to be following a similar pattern. Although at points it contains references to Child Y's sister the review does not comment in detail about the provision made for her since all of the relevant learning can be identified in relation to Child Y without the additional but unnecessary disclosure of sensitive information about his sister.³

³ The focus of the review is on services provided. The review found no significant difference attributable to gender between the response of services to the two children, hence the focus on one child to simplify the presentation.

Agencies involved

1.12. The SCR considered the work of the following agencies and contracted professionals:

- Local Authority 1 (children's social care)
- Hospital Trust 1 (Emergency Department and Department of Paediatrics and other specialists at two district general hospital sites)
- Hospital Trust 2 (Emergency Department, paediatrics and a number of specialist outpatient and inpatient services at the hospital)
- Hospital Trust 3 (children's cardiology, pain management clinic, endocrinology and neurology)
- Community Health Trust (school nurse and CAMHS services)
- Ambulance Service
- GP and primary care services in Local Authority 1
- Two academy schools
- Police Service

The review also received background information and copies of documents from Local Authority 2, a neighbouring borough where the family lived prior to 2012. The review was also informed by documents which were part of the Local Authority 1 social care record but originally written by staff working in Local Authority 3, where the family lived in a refuge before moving to Local Authority 1.

How the review was undertaken

1.13. Details of the principles underlying the approach to review and the steps taken to carry it out are set out in Appendices 2 and 3.

1.14. The review has involved extensive discussion with staff who worked with the family and staff in specialist safeguarding roles in the organisations concerned. In order to be able to understand this case in the context of wider practice over cases of suspected FII the review has also summarised the findings of a number of other Serious Case Reviews, sought data from the NHS on serious incident (SI) reports and from Cafcass on other FII cases in the family courts.⁴ The author also presented the findings (anonymously) at a conference of designated and named health professionals and to groups of local GPs as part of their annual training programme and has taken account of the views expressed in those forums about the management of FII.

⁴ Children and Family Court Advisory and Support Service, <https://www.cafcass.gov.uk/> Cafcass involvement with the children began only after the end of the period which has been reviewed.

- 1.15. Child Y's mother was informed about the SCR in May 2016 in anticipation that she would be involved in the review and also help the independent reviewer to understand how best to involve Child Y and his sister. Her views of the services provided are summarised in Appendix 6.

Parallel investigations and proceedings

- 1.16. A local authority application in the family court ran concurrently with the SCR. The LSCB made the judge who was responsible for the conduct of the proceedings in the family court aware of the SCR and the court gave agreement for expert assessments prepared for the family court to be disclosed to the SCR lead reviewer. Their findings assisted the work of the SCR, though this report has not relied on or quoted them.
- 1.17. There has been no criminal investigation.

2. BACKGROUND AND KEY EVENTS

- 2.1. This section summarises important contacts with Child Y's family and agencies with safeguarding responsibilities. It lists the main health problems presented by Child Y and the responses of health professionals. It concludes with information available in early 2017 about the extent of actual health problems faced by Child Y during this period.
- 2.2. Limited detail is provided in some areas in order to protect the privacy of family members. Some events are described further in Section 3 of the document when this assists in the evaluation of services.

Family background and relationships

- 2.3. Child Y was aged 12 when he moved to Local Authority 1 in 2012. His sister was 10. The children have a half-sister who was an adult by this time.
- 2.4. Between 2002 and 2011 the children lived with their mother in Local Authority 2. During this time the mother made 14 reports of domestic abuse by her ex-partner (the children's father) to the police. 12 of these incidents were reports of threats and breaches of injunctions and other court orders, usually by contacting the mother or visiting the family home.
- 2.5. On two occasions assaults were alleged. The mother told the SCR that she suffered a broken finger and an injured shoulder. There is no record of evidence to corroborate the allegations of physical violence (for example reports to other agencies, accounts of witnesses, visits to the GP, or visits to hospital emergency department with injuries). Statements made to the police were withdrawn and no charges resulted. However a MARAC meeting in 2011 categorised the risk to the mother as 'high'. Experienced social workers working with the children's father during 2015-16 told the SCR that he could be abusive and threatening, particularly when he appeared to be drunk.
- 2.6. In late 2011 the family were rehoused to a domestic violence refuge in Local Authority 3 where they lived for a few months. Records do not show why the mother and her children were admitted to the refuge at that point and there were no new, serious reported incidents. The mother told the SCR that moving and concealing her address was the only way she could ensure that the children's father did not continue to harass her.
- 2.7. The records (from the period prior to 2012) also show one allegation against the mother of harassment (of a head teacher).
- 2.8. During the brief time when the family were living in the refuge referrals were made to the local authority because Child Y was being taken to

large numbers of medical appointments. He was reported to have taken other children's blood pressure with a monitor purchased by his mother and had been observed bullying other children. In March 2012 (in Local Authority 3) the children were made the subject of a child protection plan under the category of emotional abuse. In her records and reports the health visitor who regularly visited the refuge had identified this as a possible case of FII.

Transfer to Local Authority 1

2.9. In June 2012 the children were discussed at an initial (transfer) child protection conference in Local Authority 1. This had access to records of events in the refuge and assessment reports from the Local Authority 3 social worker. The conference took the unanimous view that the children should be treated as children in need who would be offered services. The case was seen as one of a family fleeing domestic violence where the mother and children needed support. The decision making and interventions planned at child protection conferences in Local Authority 1 are considered in detail in Section 3.3.

2.10. By this time Child Y had had medical assessments and treatments in relation to the following:

- Chest pains and breathing difficulties
- Bowel problems
- Endoscopy and colonoscopy, appendectomy and tonsillectomy

His sister was reported to have been a regular attender at an emergency department since being very small. She had repeated reported stomach pains and urinary infections, though subsequent review of all test results shows that no infection was ever confirmed.

2.11. Two hospitals were involved with the children during this period. Hospital Trust 1 was the local district general hospital and had an emergency department; Hospital Trust 2 was located about 15 miles from the family home and provided a range of services (including both emergency medical services, other local services and some specialist services). According to the records reviewed there was no communication between the hospitals over the children at this stage, though both communicated in the usual way with the family GP. The role of the hospitals and GPs is explored in detail in Section 3.2.

Provision for Child Y and his siblings as children in need June 2012 – July 2014

2.12. Between June 2012 and July 2014 there were serious concerns over the children's school attendance (which averaged at between 40 - 60%) and its negative impact on their ability to learn and mix with other children. Efforts to improve attendance were hampered by the fact that absences due to illness and hospital appointments were

authorised by GP letters.⁵ On a number of occasions Child Y complained of severe chest pains during the school day and was taken to hospital by ambulance as school staff, understandably and quite correctly, felt that he had to be medically assessed. School staff attended child in need meetings but despite the fact that health concerns had a direct impact on both children's education, they had no means of making direct contact with the hospital professionals who at that time were expressing serious reservations about the veracity of the children's presentations. Section 3.3 considers the early identification of possible cases of FII.

- 2.13. There were several changes of social worker. In August 2012 the local authority provided a Section 37 report which concluded that the parents were no longer together and that the children were having no contact with their father.⁶
- 2.14. After the court hearing the social care team wanted to cease contact with the family, but this did not happen because of the children's poor school attendance. Health agencies also pressed the local authority to remain involved.
- 2.15. During this period the children attended hospital very frequently both at ED, sometimes leading to admission, and outpatient appointments. Presentations included reported chest pain, abdominal pain and allergies, urinary tract infections. Child Y underwent exploratory operations over reported testicular pain as well as an urgent transoesophageal echogram (an intrusive ultrasound of the chest in which a sensor is passed into the oesophagus).
- 2.16. By September 2012 there is evidence that the two hospitals were more aware and concerned about one another's involvement as a result of which the named doctor with responsibility for safeguarding in the local hospital drafted reports covering discharge and diagnosis which were copied to the other consultants involved as well as the family GP.
- 2.17. Throughout this period the attitude of social care was that the family should be seen as one that was overcoming the impact of domestic abuse and where the mother was becoming better at meeting the health needs of her children (which were accepted as being 'complex'). Many health professionals dealing with the family did not know about the reported domestic abuse. Others knew but did not believe that it should be the main focus of concern.

⁵ Serious concerns about attendance remained until 2015 though later some figures show higher rates of attendance because the children attended projects off the school site that provide education, including at one point when both the children (only one of whom was an inpatient) attended the education unit in a hospital.

⁶ A Section 37 report may be requested by the court in private family law proceedings (such as a divorce) when the local authority is working with the family.

2.18. From early in 2014 staff at the district general hospital regularly discussed the family at psychosocial meetings because of the large number of attendances, appointments and investigations that had not confirmed the existence of any significant medical condition. The meeting in April 2014 suggested that there were grounds for a child protection conference.

July 2014 - children made the subject of child protection plan

2.19. In July 2014 both children were made the subject of child protection plans. The child protection conference was convened because of the continuing high level of hospital attendance of both children, persistent very poor school attendance and growing concerns about Child Y's obesity. The conference was well attended, though Hospital Trust 2 was not invited. It was comprehensively documented, with 94 pages of reports, minutes and plans. Concerns were noted about the apparent lack of coordination and prescription between hospitals and GPs and it was recognised that the child in need plan had not affected any real change.

2.20. The mother had a detailed discussion with the conference chair after the meeting. She explained that she did not mind the children being the subject of a child protection plan but did not like or accept 'how she was being portrayed' and refused to accept that the professional concerns were legitimate. This conversation was reflected in the conference record.

2.21. The detailed protection plan ran to four pages and sought to address the problems of Child Y's obesity and both children's poor school attendance. It aspired to achieve a coordinated response to medical presentations between GPs and hospitals. The conference reports and minutes do not identify this as being a suspected or confirmed case of FII. The category of registration was emotional abuse.

2.22. The consultant paediatrician from Hospital Trust 1 (who had previously tried to improve the coordination of the health provision) attended the initial conference and offered to convene a meeting of all health professions and trusts at the GP surgery to ensure that health interventions were coordinated. It was decided that this would happen after the current set of investigations of a possible kidney complaint had been completed. It was suggested that Child Y could be dealt with by one GP and one acute trust.

2.23. Shortly after the conference Child Y underwent a cardiac angiogram at Hospital Trust 3, administered as a day patient under full anaesthetic.⁷ The findings were normal. The hospital also reviewed all of the

⁷ https://www.medicinenet.com/coronary_angiogram/article.htm

previous cardiac tests where reports could be provided and confirmed that Child Y had no underlying heart condition. This exhausted the cardiac investigations that could be undertaken (other than repeating previous tests, which later happened).

July 2014 – January 2015: parallel but separate coordination of services through the health service and the child protection plan

- 2.24. Over the following 12 months, review conferences took place more frequently than was required by guidance and there were regular core group meetings. These were largely attended by the local authority, the children's schools, the school nurse and sometimes CAMHS, but not the acute trusts, tertiary hospitals or GPs. The conference chair and professionals who attended were concerned that there was no proper overview of the different types of medication being prescribed for Child Y which could be having a detrimental impact on his health.
- 2.25. The children's mother contributed to conferences and expressed her concern that 'she had been made to feel unable to meet the children's needs' but that she 'now feels confident' about this. She promised to cooperate with plans made by professionals but there is no evidence that over the next nine months any improvement in the concerns originally identified occurred.
- 2.26. After the initial child protection conference the sole health attendee at child protection review meetings was the school nurse who was asked to coordinate information and interventions from the health sector. The consultant paediatrician from Hospital Trust 1 (referred to above) was not invited to conferences and says he was not aware of the tasks allocated to him in the protection plans. Tertiary hospitals (Hospital Trusts 2 and 3) were also not invited. Section 3.3 considers the role and effectiveness of child protection planning arrangements.
- 2.27. During this period Child Y was the subject of a parallel series of multi-disciplinary meetings convened by the main health trusts involved, some internal and others involving other health trusts and social care.
- 2.28. In October 2014 the Hospital Trust 1 convened a large and lengthy multi-disciplinary meeting. At that point Child Y was an inpatient at Hospital Trust 2 because of reported neurological problems (reported back pain, tingling in his toes and fingers and other possible neurological symptoms).
- 2.29. The following professionals attended:
 - Paediatric Department (Hospital Trust 1)
 - Consultant Paediatricians (4)
 - Speciality Doctor in Paediatrics (1)
 - Hospital Trust 1 Emergency Department
 - Paediatric Lead Nurse

- Safeguarding Paediatric Liaison Nurse
- CAMHS
 - Child and Family Psychotherapist
- Ambulance Service (2 representatives)
- Schools and education representatives (2)
- School Nurse
- General Practitioner
- Local Authority 1 social care
 - Social worker
 - Consultant Practitioner
- Hospital Trust 3 (by teleconference)
 - Paediatric Cardiologist
 - Paediatric Pain Nurse Specialist
- Hospital Trust 2
 - Consultant Paediatric Gastroenterologist

2.30. The attendance shows both the range of services involved and the scale of the task of coordination. The meeting focused again on the negative social and health impact on the children of repeated hospital attendances and admissions. Child Y was described as 'fabricating textbook symptoms' in his presentations. It noted that whilst it had been established that Child Y was not suffering a heart condition the results of gastroenterology and neurology tests were awaited.

2.31. The meeting reached a series of further decisions about management of the case. Plans were proposed as to how Child Y would be treated in future by the ambulance service and in emergency departments. These were to be shared with Child Y's mother at a meeting with the Consultant Paediatrician from Hospital Trust 1 who knew Child Y best and the family GP. They would then be circulated to the ambulance service and the allocated social worker

2.32. The meeting also made an appeal to social services to stay involved with Child Y because he was having a very abnormal life, missing out on education and normal social interaction. Social services was asked to provide a clear plan for Child Y. Plans continued to be reviewed and updated at the child protection conferences.

2.33. Section 3.2 considers the work of the ambulance service and GPs in detail as part of a wider discussion about the attempts to coordinate provision to the family. Section 3.3 deals with the role of social care.

2.34. During this period Child Y was referred to a number of pain management services. By now he was reporting chest pain, back pain, tingling and general pain in moving and walking due to his weight. The

place of services for 'pain management' is considered in Section 3.2 alongside that of child and adolescent mental health services.

- 2.35. The investigation of neurological symptoms showed a degeneration in the spinal cord believed to be linked to Vitamin B12 deficiency. This is a known but rare side effect of the long term use of Nitrous Oxide (gas and air) which had been administered to Child Y by the ambulance service, though there may have been other contributory factors.
- 2.36. In January 2015 at the end of the admission there was a further discharge planning meeting. The majority of attendees at this meeting were from the Hospital Trust 2 where Child Y was now being treated. They included four members of the Hospital Trust 2 neurology team; a member of the paediatric liaison team; Consultant Psychiatrist; hospital school representative; Safeguarding Advisor and Paediatric Ward Sister. External attendees were the Consultant Paediatrician from Hospital Trust 1 (the same member of staff who had agreed to take a lead in working with the GP and family) and the allocated local authority social worker.
- 2.37. It was noted that the condition had been treated successfully but that Child Y continued to report pain in his back. Scans showed that neither the location of the pain nor its episodic nature were consistent with the medical understanding of the degeneration in the spine (which had now been treated). Child Y and his mother attended part of this meeting where the proposed care plan was explained to them. Child Y responded by seeking separate meetings with members of the multi-disciplinary team. That evening he walked out of the hospital saying he did not feel safe there, though it was never clear what this meant. He was later returned by ambulance.
- 2.38. Hospital Trust 2 wrote to everyone involved shortly after the meeting setting out proposed approaches to managing pain that should be adopted by Child Y, the family and the hospital emergency departments. This focused on the use of distraction (e.g. going for a walk), simple pain relief such as paracetamol and the avoidance of Entonox and morphine-based pain relief. On this occasion no specific proposed protocol was agreed for the ambulance service (which had not been invited to the meeting). Again it was noted that the Paediatric Consultant and the GP would meet with the family to assist in implementing the plan.

Serious accident

- 2.39. Efforts to implement this new, more detailed plan were thwarted by events. Two weeks after the meeting Child Y was discharged from Hospital Trust 2. Two days later (31 January 2015) he had an unexplained, accidental fall from the second floor of a high building, fracturing his pelvis. CCTV footage showed that nobody else was

present. Child Y denied remembering any details of the event, the circumstances or his motives. The psychiatrist who interviewed him found no evidence of suicidal intention or psychiatric disorder. She was from Hospital Trust 2 and knew both Child Y and his family.

- 2.40. After a delay of some days in which Child Y's injuries were assessed and treated, the local authority held a strategy meeting and allocated a new social worker to the case. From this point the social workers and managers involved viewed Child Y as being at considerable potential risk and saw the case as being one of possible FII. As a result they made concerted efforts to gain an overview of the reported health problems and to coordinate services. After a further hospital admission lasting nearly six weeks a further lengthy discharge planning meeting was held.

Decision to initiate care proceedings

- 2.41. A legal planning meeting was held in March 2015 to determine whether the threshold to initiate care proceedings would be met. Legal advice was that it was. The first step was a letter setting out the local authority concerns and formal meetings with the children's mother. A report was to be commissioned from an independent expert on FII.
- 2.42. In May 2015 a second planning meeting agreed to discontinue this course of action. Instead of the proposed specialist assessment, the Designated Doctor for Safeguarding for the local area (who had not previously been involved and had only a limited understanding of the case) prepared a report which set out five areas in which progress was needed and confirmed his belief the family was making, or had promised to try to make, progress in each of them. A different local authority manager took the view that this was evidence that the family was cooperating with the child protection plan and the measures proposed to safeguard the children.
- 2.43. Any such progress was not sustained and it was noted that the mother was no longer cooperating with the proposed plans. At this point an application for a Supervision Order was agreed. There were disagreements between staff and managers in the local authority as to how to proceed, with a series of different middle managers taking different views.
- 2.44. Care proceedings were initiated in October 2015. Prior to this Child Y was noted to be under investigation for possible kidney problems (which his mother said ran in the family). By now there were concerns that Child Y's obesity had created a real cardiac risk because of raised cholesterol levels, for which he was prescribed statins.
- 2.45. Subsequently it has been recognised that Child Y shows symptoms of having become addicted to prescribed pain relief, though suspicions about this were voiced by the local authority earlier. Between March

and October 2015 the local authority sought a comprehensive chronology of health service contacts with the family but this could not be provided.

An overview of Child Y’s contact with health services

2.46. Child Y’s contacts with the hospitals involved are summarised in Table 1 below. The figures are based on reports by independent experts who have reviewed the medical records. It is very likely that not all records from all trusts have been accessed so this may be an underestimate.

Table 1 list of Emergency Department attendances and admissions to Hospital Trusts 1,2 and 3 documented in a report prepared for the family court ⁸

Year	ED attendances (Hospitals 1 and 2)	Hospital admissions (three hospitals)
2010	14	6
2011 *	4	2
2012 *	16	7
2013	28	7
2014	88	11
TOTAL	150	33

2.47. At a number of points attempts were made within the child protection planning and the care proceedings to draw together a full chronology and health contact and a list of the medications being taken by the children. This was never achieved during the period under review. Section 3.2 addresses the question of prescribing and control of medication and the role of acute health trusts and GPs in this.

The actual conditions from which Child Y suffered

2.48. A paediatric review of Child Y’s health records prepared in early 2016 has found that he has suffered from the following conditions:

- atopy (allergic reaction in the skin to a variety of substances)
- bowel disturbance and constipation
- obesity
- degenerative disorder in the spine

⁸ For part of the year the family lived out of these hospital catchment areas. Real totals may be higher as 1) these figures may not include all attendances as some original records may not have been scrutinised and 2) they only include the trusts listed above. Hospital Trust 3 has no Emergency Department

- 2.49. There is no evidence of an endocrinal or other medical cause for his obesity. Both this and the bowel disturbance (which largely presented prior to 2011) are likely to be caused or worsened by poor diet and lack of exercise.
- 2.50. The degenerative disorder was believed to have been due to a Vitamin B12 deficiency which is a recognised though unusual side effect of the repeated use of Nitrous Oxide (gas and air) which was given to Child Y for reported chest pains.
- 2.51. Child Y had some allergies but many children and their families manage the sort of allergic reactions described without any significant impairment of functioning.
- 2.52. It was repeatedly confirmed that Child Y had no heart condition or other cause for his chest pain. His sister has no serious medical condition. Her most common presentation was for possible urinary tract infections, but when systematically reviewed none of the investigations for this condition proved positive.

3. SERIOUS CASE REVIEW FINDINGS

3.1. How was the child harmed and what was the evidence of Fabricated or Induced Illness (FII)?

Introduction

- 3.1.1. The treatment of Child Y by his mother is considered to be FII as it is defined within current child protection procedures. The evidence for this is set out in paragraphs 3.1.6 –3.1.17, along with evidence of the harm caused.
- 3.1.2. The case history raises wider questions about the understanding of FII, research into its prevalence and characteristics and the value of current guidance and procedures. Although health professionals currently working in the NHS told the SCR that this case was ‘very typical’, its history varies in important respects from the profile of FII cases described in the literature and envisaged in guidance. This highlights the lack of recent population-based research on FII and inconsistencies in medical and safeguarding guidance. These issues are addressed in Section 3.4.
- 3.1.3. Review of this case in the context of wider writing about FII and discussions with the practitioners who were involved leaves no doubt that FII is a safeguarding concern that can cause children serious harm. Many of the difficulties arise from the fact that rather than being a disease with a cause and established treatments, FII is a feature of the interactions between health professionals and parents. In cases that involve older children the child can become an active participant as well.⁹
- 3.1.4. Parents in such cases often have complex psychological histories.¹⁰ The actions and decisions of health professionals are shaped by a range of organisational and cultural factors, as well as their own knowledge of FII. The meaning of health and ill-health are not static and are in many senses socially constructed. This may influence the behaviour of children who present symptoms of illness. With the advent of the internet knowledge about the symptoms of illnesses (even rare illnesses and syndromes) and their treatment is no longer the preserve of health professionals.

⁹ Bass and Glaser argue that FII depends on the behaviour and interaction of three parties - parent, child and health professionals. Christopher Bass, Danya Glaser (2014) ‘Early recognition and management of fabricated or induced illness in children’, www.thelancet.com Vol 383 April 19, 2014.

¹⁰ Christopher Bass and David Jones (2011) ‘Psychopathology of perpetrators of fabricated or induced illness in children: case series’, *The British Journal of Psychiatry* 199, 113–118

3.1.5. Section 3.4 of the report considers this further in the light of other case reports suggesting that (what is referred to as) FII may increasingly be a presentation of older children. Whether this then ceases to be FII, or is best described as a more complex form of the condition, is a matter for debate.

Evidence of Fabricated or Induced Illness (FII) identified by the SCR

3.1.6. FII is defined in the London Child Protection Procedures 5th edition as follows:¹¹

2.1.1	Fabricated or induced illness is a condition whereby a child has suffered, or is likely to suffer, significant harm through the deliberate action of their parent and which is attributed by the parent to another cause.
2.1.2	<p>There are three main ways of the parent fabricating (making up or lying about) or inducing illness in a child:</p> <ul style="list-style-type: none"> • Fabrication of signs and symptoms, including fabrication of past medical history; • Fabrication of signs and symptoms and falsification of hospital charts, records, letters and documents and specimens of bodily fluid; • Induction of illness by a variety of means.
2.1.3	The above three methods are not mutually exclusive. Existing diagnosed illness in a child does not exclude the possibility of induced illnesses. The very presence of an illness can act as a stimulus to the abnormal behaviour and also provide the parent with opportunities for inducing symptoms.

3.1.7. Child Y reported 'pain' in his chest, arm, stomach, back and testes, as well as allergic reactions, and was presented on numerous occasions for medical assessment and treatment. Despite frequent reassurance that (for example) he did not have a heart condition, Child Y's mother repeatedly presented him at hospital. Problems were sometimes reported to different hospitals in parallel.

3.1.8. When clinicians tried to set limits to the repetition of investigations and treatments, Child Y and his mother are reported to have complained, sometimes behaved aggressively and then sought treatment elsewhere.

¹¹ http://www.londoncp.co.uk/chapters/fab_ind_ill.html

- 3.1.9. Child Y's mother misrepresented the outcomes of tests and investigations. For example by misleading doctors that she understood that tests undertaken had revealed '*a problem with the left side of his heart*' when it had been made absolutely plain that this was not the case. She told the case review that he had had abnormal ECG tests, though the records show no evidence to support this. Any minor ambiguity or uncertainty in what health professionals said was transformed by the family into a belief that Child Y had a serious condition. Presentations were often made to appear more complex or grave by reporting a family history of the condition.
- 3.1.10. There is no evidence that Child Y's mother made efforts to address the children's anxieties about their health. She and her children became increasingly preoccupied with symptoms of illness and disease at the expense of their ordinary social and emotional development.
- 3.1.11. The review has found no evidence that Child Y's mother induced illness in the children by poisoning them, mis-administering medication or altering records. However the repeated presentation of children in different settings has contributed to a situation in which doctors have prescribed a very large number of medications with a diminished ability to monitor their interaction or overall impact. This has left family members as the only people with oversight of the very significant number of medications prescribed, though not necessarily of their impact or potentially harmful interactions between them.
- 3.1.12. At times there has been suspicion that family members have obtained medication that doctors would not prescribe or additional supplies of prescribed medication from the internet. This is speculation based on accounts of the medication that family members have said that they have had at home, but it was never investigated.
- 3.1.13. Appendix 8 sets out a list of medications prescribed at different points to Child Y. This is drawn from the chronologies submitted to the SCR and is unlikely to be comprehensive. The role of GPs in seeking to maintain oversight of prescribed medication is addressed in Section 3.2.
- 3.1.14. Health professionals told the SCR that they had been amazed by the knowledge that family members had about drugs, investigations and treatments. As the children grew older they became active participants in the fabrication of illness. They appear to have believed that they were ill and were genuinely experiencing the symptoms they describe.
- 3.1.15. The recent assessment that Child Y has been addicted to prescribed pain killers for a number of years suggests an additional layer of complexity. This physical addiction may have driven Child Y's desire for medical attention in addition to and independently of his mother's

belief that he was ill. For example there is evidence in GP records of the 15 year old Child Y insisting that his mother attend the GP seeking stronger painkillers for him.

- 3.1.16. At times health professionals tried hard not to collude in the provision of unnecessary healthcare but they were defeated by the family and by the complexities of the systems in which they work. This is examined further in Section 3.2.
- 3.1.17. Regardless of the cause or the role of different parties there is no doubt as to the extent of the harm that Child Y has suffered. This has included: significant loss of school attendance and associated delay in educational and social development; unnecessary medical intervention including intrusive investigation; unnecessary surgery and medication that served no purpose and may have had harmful side-effects. The worst known of these has been a degenerative spinal condition and the development of an addiction to opiates administered by health professionals.

3.2. Challenges faced by professionals in the health service

Introduction

3.2.1. This section of the report identifies the specific difficulties faced by health professionals. Section 3.3 focuses on the role of the local authority and the overall management and coordination of safeguarding concerns. This addresses the early identification of what are termed 'perplexing presentations' and FII which also centrally involves health professionals.

3.2.2. The health sector in this case consisted of:

- i. Hospital Trust 1 where the children frequently attended ED, paediatric outpatients and other specialists; this could be thought of as the family's local hospital, though there is now no such thing as a hospital catchment area
- ii. Hospital Trust 2 which provides both local acute services (including an ED) and specialist tertiary services; Child Y had two lengthy inpatient stays in this hospital during 2014 – 15

All of the ED attendances cited in Table 1 (page 15) were at these hospitals. Before 2012 the family used both hospitals in parallel. Both separately reported on interventions to the family GP. From 2012 the hospitals became aware of one another's involvement and began to copy letters and discharge summaries to consultants in the other hospital.

From 2014 the family became increasingly hostile to staff at the local hospital and insisted wherever possible on attending the second hospital. This made it more difficult to ensure correct

attendance at safeguarding meetings including child protection conferences.

- iii. Hospital Trust 3 which is a specialist children's hospital.
Both of the 'local' hospitals were aware of the involvement of the specialist children's hospital (Hospital Trust 3) and at points there was discussion about which specialist should see the family
- iv. GP practices (a more detailed description is provided below)
- v. Child and Adolescent Mental Health Services (more detailed description is provided below)
- vi. The Ambulance Service – which attended numerous calls to the family's home addresses.

Efforts by the hospital trusts to avoid duplication of care and unnecessary tests and treatments

- 3.2.3. During 2013 paediatricians and staff in the ED at Hospital Trust 1 became increasingly concerned about the presentation of the family at their hospital, triggering several discussions at the hospital's psycho-social meetings. Both general hospitals became increasingly aware of the extent to which Child Y was being presented or taken to different hospitals and made efforts to discourage this.
- 3.2.4. In 2014 and 2015 large meetings of involved clinicians were convened at the hospitals, leading to two attempts to prepare plans to coordinate the medical care being provided. Neither was implemented because on both occasions they were superseded by events and overwhelmed by the complexity of working with the family.
- 3.2.5. Hospital Trust 2 held two substantial discharge meetings following lengthy paediatric ward admissions (late 2014 and early 2015). Both meetings prepared detailed discharge plans setting out roles and responsibilities. After the first meeting Child Y fell off a high building, making the plans redundant because of physical injuries. His further admission (to Hospital Trust 2) following that and the sharing of information at the discharge meeting triggered the action of the local authority in initiating legal proceedings.
- 3.2.6. Sometimes the complexity of the health system enabled the family to thwart the attempts of health professionals to place limits on the number of investigations and treatments. The example of Child Y's obesity illustrates this. Throughout the period under review Child Y became increasingly obese, to the point where it became a significant health concern. A paediatrician at Hospital Trust 1 undertook basic tests in order to establish whether a hormonal problem was a factor in this. Knowing the family extremely well he took a conscious decision not to refer Child Y to an endocrinologist, fearing that this might trigger a series of further unnecessary investigations and trials of

treatments. He was certain that the family was not following advice about diet and that Child Y was very inactive. He strongly encouraged them to attend to these issues and arranged for further advice about diet.

- 3.2.7. Some months later Child Y was seen in the cardiology department of another hospital. Having established that there were no underlying heart problem the doctors were naturally concerned over Child Y's weight. Having been told that he had tried to lose weight without success, the discharge letter to the family GP included the suggestion that Child Y should be referred locally to an endocrinologist with an interest in obesity, effectively but unintentionally undermining the first paediatrician's attempts to avoid further specialist referrals.

Efforts to implement medical guidance on FII

- 3.2.8. The guidance prepared by the Royal College of Paediatrics and Child Health and HM Government both envisage the paediatrician responsible for the child's care acting as the 'responsible paediatric consultant'.¹² This person's role includes preparing a comprehensive chronology to be prepared and for action to ensure that treating clinicians are in regular contact with one another.
- 3.2.9. The Royal College of Paediatrics and Child Health (RCPCH) guidance suggests that the chronology should include information from GPs and schools.¹³ Bass and Glaser suggest a specific range of tasks that the paediatrician should undertake, reproduced as Appendix 7 of this report.¹⁴ Guidance on FII is discussed in more detail in Section 3.4.
- 3.2.10. On several occasions senior paediatric consultants in the local hospital or members of the hospital safeguarding team tried to adopt the envisaged coordinating role, but the complexity of the case defied management along these lines. Each time efforts failed so that several months later further meetings were held to renew attempts at coordination. Factors that explain this include:
- the attempted coordination was happening at a relatively late point in the case history by which time there had been a high level of contact by many doctors for several years¹⁵
 - during the period under review there was never a point when there was only one consultant paediatrician involved; there was always

¹² DCSF (2008) pages 19 – 20; RCPCH (2009) page 19; Glaser

¹³ RCPCH (2009) Section 5.16

¹⁴ Bass and Glaser (op cit) Appendix to the *Lancet* article

¹⁵ In contrast paediatricians told the SCR that they think this approach is effective when dealing with perplexing presentations or possible FII at the early stages, often with very young children and this may account for the small numbers of such cases that now cause very serious concerns.

more than one hospital trust involved with Child Y and more than one consultant in each

- patient record systems were too fragmented to allow this to happen; even in one acute health trust, the use of different record keeping systems made it difficult to keep track of all contacts.
- the amount of time, effort and administrative support that would have been required to do this was not available and that this was not a task which staff with other significant responsibilities could accomplish
- when meetings were held different professionals were in attendance because between the meetings the family had presented a different range of symptoms and engaged new clinicians, who were not all aware of previous problems and decisions.

3.2.11. This suggests that unless specific systems are set up and resourced within the local health network it will be extremely difficult for any individual clinician to hold an overview of the interventions and investigations in a suspected FII case, once it has progressed beyond its early phase, especially when as in this case where there are numerous trusts and individual providers, sometimes accessed by the family without reference to one another.

3.2.12. During the care proceedings the local authority found it very difficult to obtain a comprehensive overview of health provision and medication. Even during the period when the SCR was taking place (i.e. long after all agencies were fully aware of the complexity and risk associated with the case, several months after the care proceedings had been initiated granting parental responsibility to the local authority, and after Child Y had spent some time in an inpatient mental health unit) it remained a matter of great concern to the LSCB that the health sector was still struggling to achieve the kind of coordination necessary. It required the intervention of the LSCB chair and very senior managers in several agencies to ensure that meaningful steps were taken towards the creation of such a plan.

The role of general practitioners in the oversight and coordination of health care

3.2.13. Government and RCPCH guidance envisage an important role for the GP in identifying possible cases of FII and collaborating with paediatricians to provide information for the comprehensive chronology of events. This case history demonstrates that in a complex or developing case of suspected FII it is likely to be extremely difficult for GPs to have oversight of the care being provided.

3.2.14. Oversight of prescribed medication is dealt with separately below.

- 3.2.15. In the two year period from September 2013 the GP chronology for Child Y contains 102 entries for GP surgery consultations, correspondence and phone communication with specialists and contacts for repeat prescriptions. This includes several periods when he was an inpatient and so would not have attended the surgery.
- 3.2.16. There is also evidence of a small number of unsuccessful attempts by GPs to exercise a degree of control over treatment of the children because some of the GPs involved had an awareness that the family was dictating the terms of their contact and that this was not helping the children.
- 3.2.17. It is very likely that the SCR has not been able to access all the relevant GP notes. Child Y and his sister were registered briefly with a GP in Local Authority 3 when they lived in the refuge. There are no significant entries and no reference to safeguarding concerns although the children were briefly subject to a child protection plan during this time. Records from this surgery end in June 2012.
- 3.2.18. Child Y and his sister were both registered with a local GP late in mid 2013, a year after moving to Local Authority 1. It is not clear whether they had had no GP involvement in the previous 12 months or whether there are other notes that have never been connected to the current GP record. This seems to be the more likely explanation as during this period Child Y had a very large number of ED and outpatient appointments.
- 3.2.19. If it is difficult to reconstruct the records of such a family for a SCR, where there is a need and the means are available, it will be extremely unlikely that practitioners will do so in the course of their ordinary work with a family, when there may not appear to be any need and there is no additional time to carry out the work.
- 3.2.20. There was a further change in GP in mid-2015, because the family moved home. It is only in the final GP practice, during a period when the local authority had initiated care proceedings and with the direct support of the Clinical Commissioning Group Designated Nurse for Safeguarding, that the GP practice was able to play a proactive role in efforts to coordinate work with the children.
- 3.2.21. The difficulty of accessing a comprehensive set of records will have been made worse by the fact that GPs now work very largely from the summary pages of the electronic records. These usually contain a brief synopsis of problems and contacts. They reflect third party contacts, which are particularly significant in a case of possible FII, much less well.
- 3.2.22. The lack of access to comprehensive GP records made it more difficult for the GP to work with an assist other professionals as this entry from November 2014 reveals:

'Also discussed ongoing chest pains. Awaiting MRI, under the care of Hospital Trust 2 and Hospital Trust 3 and frequently ends up at Hospital Trust 1 when the chest pains come on at school. (every 2 days). Need to chase his old notes, before any letter can be done for school.'

- 3.2.23. Even if all of the notes had been available to the GP, they would not have been in a format that would have aided understanding significantly. This would have required the creation of a chronology similar to (and probably as part of) the exercise required of the responsible paediatrician (see 3.2.8 above).
- 3.2.24. Effective oversight of care is made more difficult by the large number of GPs seen within individual practices. At one practice during 2013-15 Child Y's sister saw at least seven GPs. Child Y saw a similar number. The notes suggest that very often problems were presented to the GP receptionist or practice manager as an emergency requiring an urgent appointment. This led to appointments being offered at the end of surgery and / or by locum doctors. In fact the presentations were part of a persistent pattern which would have been better dealt with after a reasonable delay by an identified GP. This would also have allowed the GP concerned to review notes and correspondence and also to try to contact other professionals involved. GPs realised this and achieved it on a small number of occasions.
- 3.2.25. The children were subject to child protection plans in 2012 (briefly) and from 2014 – 2015. The GP records contain occasional reference to the receipt of minutes but no saved requests for reports or completed reports for child protection conferences. The local authority child protection conference records show GP attendance at one meeting, the initial conference in June 2014. At this meeting it was suggested that as part of the protection plan the family should be dealt with by one GP and one acute trust but there is no reference to this plan in subsequent minutes.
- 3.2.26. Later records show decisions that a consultant paediatrician twice planned to meet with the GP and the family but this did not happen. Engagement of GPs in multi-agency working was minimal until the local authority initiated care proceedings, by which time the family had moved and registered with a different GP practice.

Control and oversight of medication

- 3.2.27. Appendix 8 is a list of the medications that were evident on a very brief review of his GP chronology during 2013-15. It contains 12 medications for pain relief; several antibiotics; several allergy treatments and vitamin supplements; one medication for the relief of ulcers and one for the reduction of cholesterol.

- 3.2.28. This is likely to be a partial picture as there are certainly other medications prescribed during outpatient appointments and hospital inpatient stays which do not feature in the GP record. Health professionals suspect that the family obtained medication from other sources and Child Y is noted to have been in possession of an Epipen (adrenalin for the urgent treatment of allergic reactions) and a GTN spray (for pain relief) that no one has a record of giving him.
- 3.2.29. The normal arrangement for hospital prescribing is that the clinician will initiate the medication and the hospital will provide an initial supply. For a period medications may be prescribed without full reference to medication already being taken, however the prescribing clinician will be mindful of the potential conflicts or contra-indications. Discharge or review letters containing details of the medication are then sent to the GP who should have oversight of all the medication being prescribed for a patient. The GP will normally then assume responsibility to prescribe the medication, except for those medicines that guidance determines can only be prescribed by a specialist.
- 3.2.30. Repeat prescriptions are monitored by the GP practice, but if medication is prescribed from different sources, there may be a delay in the GP knowing about all medications being prescribed. Depending on the circumstances repeat prescriptions will be issued either at a GP consultation or administratively. When multiple medications are prescribed from different sources there is always a risk of error or difficulties in the interaction of medications.
- 3.2.31. In this case only the family (or perhaps in the end Child Y himself) appears to have had oversight of the medications being taken. Family members appear to have taken medication according to their own view about its value and impact, rather than following advice given. Clinicians relied on the family to say what was being taken and what was working and the family may not have always been honest.
- 3.2.32. GPs had only a limited oversight of medication, though there were a number of points when the GPs expressed disquiet about the prescribing of some medications, either in principle or in particular combinations. The notes describe consultations that were described as '*difficult*' when GPs would only give sufficient medication to take the patient through to the next scheduled appointment or a planned review. One more than one occasion GPs recognised the need to review what was happening, but never accomplished this as the situation kept changing, making it difficult to discern a specific intervention to review. In parallel specialists were trying to undertake separate reviews of specific presentations.

Tertiary hospitals and specialists

3.2.33. Two tertiary centres treated Child Y. One had a dual role as it also served as a local hospital with an Emergency Department. The role of tertiary centres adds an additional complication to the management and coordination of cases of FII. The following were involved:

Hospital	Date	Department and function
Hospital Trust 2	2010	Paediatric gastroenterology and surgery
	2013	Paediatric urology
	2013	Dental
	2013	Referred to Dietetics but refused as out of borough so not eligible
	2013	Cardiology
	2013	Allergy
	2014	Neurology
	2014	Anaesthetics and paediatric pain management
	2015	Orthopaedics
	2015	Physiotherapy
Hospital Trust 3	2014	Cardiology
	2014	Endocrinology
	2015	Neurology rapid assessment unit

Once again it is impossible to be certain that there were no other interventions or even different hospitals involved.

3.2.34. Rather than examine each of these contacts, the review has highlighted themes and questions that are relevant to a number of interventions, bearing in mind that health professionals were often perplexed or suspicious about the validity of presentations:

- Letters referring Child Y to tertiary services were not always explicit about previous investigations, the existence of numerous perplexing presentations and the fact that the children were subject to child protection plans
- Neither tertiary centre made comprehensive checks with colleagues before initiating investigations, though they did consistently tell the family GP surgery what action they were taking

- Internal referrals between specialist teams in tertiary centres are often made; this can speed up delivery of services and make a high level of expertise available, but it can reduce oversight by GPs and others who know the child and might lead to unnecessary investigations

3.2.35. There is always a risk that clinicians in tertiary centres will seek the explanation for a child's presentation in interesting but rare syndromes (of which a growing number exist in every field of medicine) and not recognise the likelihood (statistically much greater) that there are significant social or emotional problems in the family. The literature notes that the labelling of a collection of symptoms and converting them into a disorder such as 'chronic pain syndrome' is particularly unhelpful in cases of possible FII, as it creates the impression that a child has a specific disease when in fact the term is merely a shorthand for a combination of unexplained and possibly non-existent symptoms.¹⁶

3.2.36. There was great variation in the extent to which clinicians in tertiary centres were engaged in multi-agency discussions. One tertiary centre arranged very useful discharge planning meetings, involving some of the relevant agencies. At other times records indicate that staff in tertiary centres were not aware that children were subject to child protection plans and were not invited to conferences. In one instance clinicians became aware of this through attending a multi-agency meeting, but then did not record this or share the information with colleagues in their hospital.

3.2.37. In discussions with the author a GP expressed concern that some of the discharge letters written about the family by specialists were insufficiently definitive about their findings, leaving the family room to seek further investigations and treatments.

The role of the ambulance service

3.2.38. At the peak of its involvement during 2013-14 the ambulance service attended two or three calls per week to the family home. The most frequent condition reported was that Child Y had severe pain starting in his chest and radiating to other parts of the body. As with many of the descriptions of symptoms, there was open suspicion that they followed 'textbook' (i.e. internet) accounts.

3.2.39. The service responded to each incident on its merits and gave routine treatments in line with protocols that are set out for particular presentations. Staff dealing with callouts do not have the capacity to

¹⁶ Royal College of Paediatrics and Child Health (2009) *Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians* (Section 7.10)

review the history of previous contacts at an address or with an individual.

- 3.2.40. Commonly Child Y was conveyed to the local hospital ED. The ambulance service threshold for taking an apparently sick child to hospital is a low one. A standard part of the treatment for reported chest pain is Nitrous Oxide and Oxygen (gas and air). A possible side effect of the regular and repeated use of this is Vitamin B12 deficiency, which is in turn implicated in the neurological symptoms that Child Y suffered from late 2014.
- 3.2.41. The ambulance service is able to adopt a tailored approach (known as a patient specific protocol) to patients who present frequently and where standard responses are not perceived as being helpful. More than once multi-disciplinary meetings discussed the potentially harmful effects of treatment with anything more than minor painkillers and the fact that it was unnecessary. Minutes of a meeting held in later 2014 note that clinicians including paramedics should only administer paracetamol or similar medications and avoid the use of Entonox, GTN spray and opiates.
- 3.2.42. This did not happen because the ambulance service will only introduce an individual patient protocol on the written recommendation of the trust that is responsible for the care of the child and with the agreement of the Medical Director. Although agreed in principle this was not provided because there was a breakdown in communication about the fact that it needed to happen.
- 3.2.43. On another occasion Hospital Trust 2 issued a letter with very specific advice about the approach to be adopted to pain relief, but did not consider the role of the ambulance service in that communication.

The role of CAMHS and services offering psychological therapies

- 3.2.44. Between 2011 and March 2015 Child and Adolescent Mental Health Service (CAMHS) professionals made six attempts to offer a service to Child Y, the mother or to the family as a whole. These included offers of outpatient appointments at the local hospital and appointments at the local CAMHS service. Both were offered following discussion with paediatricians and staff in the ED. Neither proved successful because the family missed appointments or would attend once and then fail to keep follow up appointments. Child Y's mother told the SCR that CAMHS had failed to provide counselling services that were included in agreed plans but no evidence could be found to support this in the records.
- 3.2.45. The lack of engagement is not surprising since the premise of the CAMHS professionals was that Child Y and his family needed to understand that he had no serious illness, and that other factors such as anxiety might be behind his behaviour, while the family was

convinced that he had illnesses that health professionals were failing to identify and treat. This gave no scope for any mutual agenda for work. Interventions aimed at changing the family's fundamental thinking and behaviour about seeking unnecessary health care only gained traction when it was agreed as part of a formal plan made in the care proceedings.

- 3.2.46. The focus of interventions changed to a degree from 2014 when a number of clinicians referred the family to 'pain management services'. These will offer advice to patients where there appears to be a psychological basis to reported pain or the reported pain appears to be disproportionate to an underlying condition. There was limited engagement of the family. By this time this is likely to have been explained by the fact that Child Y was most concerned to obtain pain relief medication, rather than find alternative ways of managing pain.

Additional cultural factors that made it harder for health professionals to avoid unnecessary investigations and interventions

- 3.2.47. Discussions with health professional highlighted a further range of cultural and organisational factors that made it more difficult to limit unnecessary interventions and to reach a diagnosis of FII.
- 3.2.48. Health service reforms made over the last 15 years enable patients to exercise far greater freedom to decide who they have as their GP and where they are referred for treatment. During the same period the health economy has changed substantially, abolishing in effect the established and relatively straightforward relationship between a GP, a district general hospital and tertiary specialists who would tend to receive referrals from a defined area. A wide variety of trusts now offer similar, competing services making it more difficult to limit the number of organisations and services that are involved with a patient and. These factors in combination make it much more difficult for any one clinician to anticipate which services might be involved and to have oversight of the investigations and treatments being undertaken.
- 3.2.49. Recent decades have seen a diminution in the authority of health professionals. Very experienced and able clinicians told the case review that they find it increasingly difficult to refuse to undertake investigations and treatments. Patients increasingly believe that their role is to act as 'empowered consumers' whose right it is to challenge the decision making and advice of health professionals, if necessary using the complaints procedures.
- 3.2.50. One of the paediatricians who saw Child Y told the review that it is not at all unusual for a patient to present a child at the clinic already having used the internet to research their symptoms and armed with knowledge of the first set of tests that might be required, and

sometimes the next set of tests to investigate rarer explanations and syndromes.

- 3.2.51. Staff in the local hospital ED say that when challenged or refused treatment Child Y and his family became hostile and frequently threatened to complain. When such strategies were unsuccessful they tried to bypass the local hospital. Staff also believe that they became adept at manipulating hospital systems, knowing which clinicians (often the less experienced) would find it harder to resist requests for treatment.
- 3.2.52. Health professionals believe that their work has become increasingly specialist. As the number of syndromes from which patients may suffer increases it becomes more difficult not to refer a patient on to someone who appears to have more specialist knowledge.
- 3.2.53. In combination these factors make the recognition of FFI more difficult since it relies on the ability to spot the parent who is manipulating the health system demanding further tests and treatments for their child. In relation to FFI this is seen as an indicator of risk. However within the wider culture it has come to be viewed as socially acceptable, necessary and positive in order to overcome the indifference or intransigence of health professionals who are presented as denying parents the diagnosis they think fits their child's problem, the medication they believe the child needs or the access to resources that a diagnosis can provide. Parents who battle the system to achieve the diagnosis they believe their child merits and the services that may follow from that diagnosis are often held in high regard.
- 3.2.54. Taken together these factors have made health professionals much more risk averse and in particular more wary about not undertaking or commissioning a further examination or investigation. This will very often seem like the low risk, 'what harm can it do?' option. Clinicians are also likely to be less willing to openly challenge parents if they are suspicious about presentations and symptoms.
- 3.2.55. Given this context senior managers in the health service have an important role to play in supporting staff who want to refuse investigations and treatments that they believe are not clinically justified or to put explore a possible diagnosis of FII. They however face the same pressure and fear of complaints.
- 3.2.56. Section 3.4 considers how far current professional guidance assists health professionals in addressing these challenges.

3.3. Social care management and the coordination of a multi-agency response

Evidence identified by the SCR

- 3.3.1. In June 2012 Local Authority 1 convened an initial (transfer in) child protection conference about Child Y and his sister, which decided not to make the children the subject of a child protection plan. Social work intervention during the following months focused on the children's poor school attendance and the preparation of a court report dealing with the parents' separation and possible contact arrangements. After the court report was completed the local authority sought to close the case but was persuaded that the problem of poor school attendance required continuing involvement.
- 3.3.2. Health professionals raised concerns on several occasions about the large number of hospital attendances but the view of the local authority was that this was '*not a case of FII*'. In July 2014 the children were made subject to a child protection plan because it was evident that there had been no improvement in the problems caused by repeated medical appointments for which no medical cause could be found and the very poor school attendance of both children.
- 3.3.3. In March 2015 Child Y seriously injured himself in a fall from a high building. A new social worker and team manager became responsible for the case and immediately viewed this a case of possible FII. Strategy discussions and legal planning meetings began in April 2015, though it was not until November 2015 that a court application was made.

The difficulty in considering this as a possible case of FII

- 3.3.4. It is difficult to understand why the initial child protection conference in June 2012 did not recognise this as being a case of possible FII, particularly as it had been identified as such by professionals in the previous authority and in reports which appear to have been available to the conference. It is possible that these papers were not read by some or all of the participants. There was no paediatrician at the conference, despite the referred problems focusing on the large number of medical appointments.
- 3.3.5. Close review of the conference minutes suggests that professionals believed that the mother had been a victim of domestic violence whose experience made her vulnerable and lacking in confidence. The children's behaviour (school refusal and anxiety about their health) could be explained by the exposure to domestic violence. Professionals present appear to have perceived the case history as being one that fitted easily into this common 'narrative' that they would have felt comfortable with. As a result the professionals (such

as social workers) who were not dealing directly with the family's unnecessary day to day demands for health care were very sympathetic to the mother and focused on her need for help in *'meeting the children's health needs'*. It is a concern that it took two years for the accumulating evidence from health professionals to influence the thinking of the local authority.

- 3.3.6. The provision made for Child Y and his sister during these two years illustrates the difficulties in arriving at a shared understanding that this was a case of FII, despite the fact that a number of the health professionals involved believed that the children were being presented for medical treatments without good cause and on numerous occasions. It may be significant that during this period there were changes of social worker responsible for children, diminishing any overview of the history and the extent of the difficulties. Categorised as children in need the case is unlikely to have been a priority for reflection and discussion in supervision.
- 3.3.7. The lead professional for the children was the allocated social worker. Health professionals told the review that the social workers did not feel that they were qualified to understand or to take a lead in addressing issues about the children's health and the family's relationship with the health service. The large number of health problems and services left health professionals unable to arrive at a clear process for eliminating conflicts and uncertainties over diagnosis so that firmly established safeguarding concerns could be presented to the local authority.
- 3.3.8. In hindsight health professionals realised that they had organised and attended a significant number of multi-disciplinary and multi-agency meetings about the family but that there had been insufficient clarity about the purpose of the meetings and who should attend them, rendering them all much less useful. It remained unclear who had the responsibility for arriving at the decision that this was a case of FII. Did this sit with the health professionals as a diagnostic one? Or should it be considered as a safeguarding issue from the point at which suspicions were first aroused and thus be a matter for multi-agency decision making?
- 3.3.9. Resolution of this is fundamental to securing more effective early identification of FII. Recent health sector guidance strongly suggests that health professionals need to identify cases with medically unexplained symptoms (sometimes referred to as perplexing presentations) at an early point and to act collaboratively to coordinate information, confirm or eliminate possible diagnoses. They should then address the lack of a medical explanation or the inconsistency between presentations and medical findings with the

parents.¹⁷ If the parents cannot accept at this point that their behaviour needs to change the matter should be considered as a potential safeguarding concern. Local arrangements need to ensure that the local authority can feel confident that medical issues have been explored fully.

Period of management under a child protection plan

- 3.3.10. The growing number of hospital attendances and further deteriorating school attendance prompted the local authority to convene a child protection conference in June 2014. By this point Child Y had attended Emergency Departments on more than 100 occasions and been admitted to hospital more than 20 times. Despite the well documented concerns of health professionals highlighting the unnecessary nature of these attendances, the conference focused its discussion largely on areas where professionals felt more comfortable in intervening in family life: the children's poor school attendance and its negative impact on their academic attainment and social development; Child Y's obesity and its possible long-term impact on his health. His numerous A&E attendances were noted but described in a way that avoided suggesting that Child Y was being harmed by this. The conference noted concerns about his *'perception of his health and the impact on his self-esteem'*; his mother's *'insight into the situation and whether she can deal with the issues and appropriately parent the children'*. As he was sometimes aggressive the meeting also wondered whether Child Y was *'repeating the past pattern of the domestic violence between his parents in his relationship with his mother'*.
- 3.3.11. The children were made subject to a child protection plan but little tangible progress was made until March 2015 when Child Y was seriously injured in a fall. At this time the local authority view changed in part because it was recognised that he could easily have killed himself, but also because this was the first time that staff in the local authority had accepted in full that the children were not ill, with the exception of some difficulties that would have been considered minor in most families and other conditions brought on by health professionals' interventions.
- 3.3.12. A service manager who had attended this meeting also noted for the first time that the family had benefited from a housing transfer and disability benefits that might not in hindsight be justified. This was one of the first formal meetings that social care had attended at which Child Y's mother was not present. There was also a new social worker and manager, who were open to the possibility that this may be a

¹⁷ Royal College of Paediatrics and Child Health (2013) *Child Protection Companion*, Section 13

case of FII, became involved. They were able to move away from the existing stereotypical assumptions about what was causing the family's problems.

Conduct of child protection conferences

- 3.3.13. The child protection conferences that took place between mid 2014 and 2015 had rightly identified the need to bring together a fuller and more coherent account of the family's contact with health agencies. This was not achieved so that at the beginning of the care proceedings (April 2015) social care had to ask again for a chronology of health contacts, even though there had been several discussions during the preceding 12 months about the need to compile this information. The social worker was also unable to obtain a list of the medications prescribed for Child Y.
- 3.3.14. These efforts failed in part because of the complexity of the case but also because of very limited health professional representation at child protection conferences. There had been no health attendance at the initial conference in 2012. The GP and consultant paediatrician attended the initial conference in June 2014. From that point, despite the growing concerns about unnecessary hospital attendance, the only health professional attending or providing reports to conferences was the school nurse (and on one occasion a therapist). The records suggest that representation from the local hospital fell away as the family increasingly bi-passed it and went to other trusts, while at the same time health professionals who were becoming more involved with the family were not added to the list of invitees.
- 3.3.15. With the exception of the initial conference in June 2014 the same person chaired all of the conferences held in 2014 and 2015. She was aware of this difficulty, but found it hard to find a route to engage more senior managers in the health sector about the need for a more coordinated approach. This role was eventually taken on by the Designated Nurse for Safeguarding.
- 3.3.16. In the meanwhile the child protection plans relied on the School Nurse to compile information from the health sector and ensure a coordinated approach from health professionals. In a case with numerous health trusts and medical specialisms involved reliance should never have been placed on the school nurse, but the approach was not challenged in the meetings or in supervision in any of the agencies.
- 3.3.17. Discussions in the child protection conferences followed a format which the local authority says has been adopted from the 'Signs of Safety' model of safeguarding risk assessment; identifying factors pointing to potential harm, complicating factors, strengths and areas of safety. Participants guided by the conference chair then draw

together statements of risk and safety as well as expressing their perception of the level of risk in numerical terms.¹⁸ Under each heading material is set out as a series of bullet points, which staff comment on. Similar material appears under several headings and the distinctions between categories are not clear from the written documents. The documentation captures no overall evaluation of risk. It is the responsibility of the core group to develop a detailed plan for the day to day protection of the children.

- 3.3.18. It is also significant that none of the conference minutes refer explicitly to concerns or suspicions of FII and the conference chair confirmed that she could not recall the term being used in any of the conferences. It is correct that the task of the conference is to identify risks and strengths; however in this case progress was only made when professionals were able to name FII as the possible cause of the problems. The conference chair told the review that the approach used for conferences can be very good, but also very challenging because it is sometimes difficult for professionals to be open and frank about their views. Overall it appears that this model for the conduct of child protection conferences was not well suited to the circumstances of a case of FII. The review has been told that from January 2017 the local authority has introduced a revised template for recording conferences and it may be useful for the authority to see if this case offers further learning.

Limitations in the role that could be played by schools

- 3.3.19. Between June 2012 (when Child Y was 12 and his sister 10) and July 2014 there were serious concerns over the children's school attendance (which averaged at between 40 - 60%) and its negative impact on their ability to learn and socialise with other children. Efforts to improve it were hampered by the fact that absences invariably related to illness and hospital appointments and were authorised by GP letters. On a number of occasions when Child Y's school encouraged him to attend, he complained of chest pains during the school day and was taken to hospital by ambulance as school staff, understandably and quite correctly, felt that he had to be medically assessed. School staff attended child in need meetings but despite the fact that health concerns had a direct impact on both children's education, they had no means of making direct contact with the hospital professionals who at that time were expressing serious reservations about the veracity of the children's presentations.

¹⁸ <http://www.signsofsafety.net/signs-of-safety-2/> The SCR recognises that this commentary should not necessarily be treated as criticism of the Signs of Safety approach itself, since it is not in a position to determine whether the approach taken to these conferences is consistent with the model. The local authority is not part of the formal Signs of Safety network.

3.3.20. Experience in other cases suggests that poor school attendance due to medical difficulties may be an indication of possible concerns, which should be investigated. However it will be difficult for school staff to do this if they have no direct contact with health professionals, or those health professionals are themselves unsure as to the significance of the child's presentation. Child Y's mother told the review that offers of counselling and additional educational support were agreed as part of child in need and child protection plans (particularly for Child Y's sister) but were not delivered. The most likely explanation for this was that the implementation of plans was disrupted by the large amount of school that the children missed.

3.4. Research, professional understanding of Fabricated or Induced Illness (FII) and the limitations of existing guidance and research

Overview

- 3.4.1. This section of the report places the learning from this case in a wider context by referring to relevant research, learning from other case reviews, NHS Serious Incident (SI) reports, cases of suspected FII in family law proceedings and the published UK medical and multi-disciplinary guidance on FII.
- 3.4.2. This report uses the term FII, which has been favoured in the UK since 2002, though one of the difficulties with the wider literature is that different terms are used, both historically and internationally.¹⁹ Sometimes the same term has inconsistent definitions. The most recent UK medical guidance urges clinicians to treat FII as part of a wider concern about 'perplexing presentations'.²⁰ Sometimes during the investigation of possible FII clinicians refer to 'medically unexplained symptoms'.
- 3.4.3. Descriptions in the literature of what the condition includes vary. For example, some definitions refer to the motivation of the perpetrator and in particular whether there are financial, material or secondary benefits from the behaviour. A recent UK article suggests that the impact on the child should be treated as the critical issue rather than the motivation of the alleged perpetrator, but there is no consensus

¹⁹ The main terms used are FII; Munchausen syndrome by proxy (1977) which was abandoned in the UK in 2002 but remains popular in Europe and the USA; Factitious Disorder by Proxy or 'imposed on another' (older American terms); Paediatric condition falsification (widely used in the USA, along with other terms); medical child abuse (in the USA); Factitious disorder imposed on another (American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th edn. Washington, DC: American Psychiatric Association, 2013.); Induced or Fictitious Illness Spectrum (2009 UK)

²⁰ Royal College of Paediatrics and Child Health (2013), *Child Protection Companion*, Chapter 13

on this. UK medical guidance warns against 'pseudo-diagnostic' labels.²¹

Research

- 3.4.4. Early research on what was then referred to as Munchausen Syndrome by Proxy (MSbP) took the form of case histories, beginning with papers describing individual and small clusters of cases, some larger series and then studies based on clinic populations (such as children attending asthma clinics and paediatric inpatient clinics in specialist centres). The first frequently quoted population-based study was undertaken in 1996, relying on UK national data from 1992-94.²² This estimated an annual incidence of 0.5 cases per 100 000 children and 2.8 per 100 000 children under the age of 12 months. This was believed to equate to one case presenting per year in a UK health district with a population of a million. A study using similar criteria estimated a rate of 2 per 100 000 children, but no deaths.²³ A study with wider criteria for inclusion suggested an incidence of 89 children and adolescents 100 000 children per year (again with no deaths).²⁴
- 3.4.5. These case examples and population studies led the literature to describe an archetypal FII case characterised by the overstatement of symptoms or falsification of medical data by the parent of a pre-school age child. Allowing for delays in detection of several months or even years, the typical victim was very young. Some studies showed that the adult responsible was more likely to be female (unlike most other forms of physical abuse) and included a disproportionate number of health professionals.²⁵
- 3.4.6. Given that many clinicians with an interest in safeguarding told the review that they view fabricated illness as a current and serious

²¹ Royal College of Paediatrics and Child Health (2009)

²² McClure et al, McClure RJ, Davis PM, Meadow SR, Sibert JR. 'Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation'. *Archives of Diseases in Childhood*, 1996; 75: 57–61.

²³ Denny SJ, Grant CC, Pinnock R. Epidemiology of Munchausen syndrome by proxy in New Zealand. *J Paediatric Child Health* 2001; 37: 240–43.

²⁴ Watson S, Eminson DM, Coupe W. Personal communication. In: Eminson M, Postlethwaite RJ, eds. *Munchausen syndrome by proxy abuse: a practical approach*. 2000: Oxford, Butterworth Heinemann: 17–70.

²⁵ For example: 'typical victims may be either males or females, usually 4 years of age or under. Victims averaged 21.8 months from onset of symptoms to diagnosis. Six percent of victims were dead, and 7.3% were judged to have suffered long-term or permanent injury. Twenty-five percent of victims' known siblings are dead, and 61.3% of siblings had illnesses similar to those of the victim or which raised suspicions of Munchausen by proxy'. Mothers were perpetrators in 76.5% of cases...'. Mary Sheridan (2003) 'The deceit continues: An updated literature review of Munchausen Syndrome by Proxy', *Child Abuse and Neglect*, 27, 431-51. The author recognises that accounts of published cases do not form a random sample.

concern it is significant that there is so little recent research. There has been no UK population based study for more than 15 years. The literature review cited above dates from 2003.²⁶ There are accounts of the psychological make up of alleged perpetrators. The most recent is based on a series of 28 cases referred for psychiatric assessment by the family courts and social care and assessed by the same clinicians spanning the period 1996 – 2009.²⁷

- 3.4.7. The most recently cited research is a prospective study of children referred for inpatient care in a specialist Italian paediatric unit.²⁸ This identified 14 of 751 (2%) of children referred to the unit as suffering from 'factitious disorder' and four children (a prevalence of 0.53%) meeting more stringent criteria for an induced illness (which the study refers to as MSbP). The authors of this study ascribe the higher prevalence to the high level of awareness in the multi-agency team which was trained to look for MSbP in cases being treated by the team, whereas previous studies had been carried out through retrospective review of case records.
- 3.4.8. The difference in methodology, patient group and cultural context make it impossible to be certain from a single article whether there has been an increase in the incidence of FII. The most striking difference between the Italian and previous studies is the age of the children and the accounts of their behaviour. The mean age in the 'factitious disorder' group is 8.4 years and the much smaller (MSbP) group 10.5 years. The detailed case examples of 'factitious disorder' described as 'characteristic' all feature children aged 11-16. Their histories included false presentations of fever, abdominal pain, lower back pain and dizziness. In all cases the patients admitted the falsification when confronted. There is no suggestion that health professionals are disproportionately represented as carers, though the alleged perpetrators in the very small number of MSbP cases are all women (three mothers and a grandmother).²⁹

²⁶ Mary Sheridan, (2003) op cit

²⁷ Christopher Bass and David Jones (2011) 'Psychopathology of perpetrators of fabricated or induced illness in children: case series', *The British Journal of Psychiatry* 199, 113–118

²⁸ Ferrara P, Vitelli O, Bottaro G, et al. Factitious disorders and Munchausen syndrome: the tip of the iceberg. *J Child Health Care* 2013; 17: 366–74.

²⁹ It is also important to recognise in making comparisons that there is a gap of almost twenty years between the studies, which take place within an entirely different health economy and an entirely different cultural context.

Learning from case reviews, serious incidents and case examples

- 3.4.9. A search of the national repository of SCRs identified 11 published SCRs that refer to FII.³⁰ A brief summary of the content is set out in Table 2 below. Of the 11 reports, three (spread over a 10 year period) appear to be confirmed FII cases with comprehensive analysis and recommendations for local services (Cases 1, 9, 11).³¹
- 3.4.10. The largest group consist of four cases (Cases 2, 3, 8, 10) in which abuse and illness coexisted in the child and in hindsight the SCR questions whether they might have been cases of FII that were not recognised or assessed. It is this which has led to the inclusion of the case in the keyword search, rather than specific findings about FII. Case 6 sits somewhere between these clusters and it is impossible to place it more reliably on the basis of the summary.
- 3.4.11. There are three cases in which children were poisoned with illicitly obtained drugs or medication prescribed for the adult (Cases 4, 5, 7) but on the information publicly available it is not clear that these cases would have met the criteria for FII.

Table 2 Summary of findings from SCRs mentioning FII

Case 1 – describes a severe FII case in detail and identifies both good practice and shortcomings. The difficulties faced by health professionals in obtaining an overview of the case and coordinating their interventions echo those in the current SCR
Case 2 – describes a case in which there is both complex illness and abuse – which it is suggested would not meet the definition of FII
Case 3 - the death of an adolescent by hanging. It refers to a ‘failure to consider FII as a contributing factor to Child F’s difficulties’
Case 4 – a 9 month old infant poisoned with adult medication; there had been a lot of medical assessments but it is not clear from the summary if this is a case of FII
Case 5 – a child age two years suffering from opiate poisoning – previous children removed, mother ‘diagnosed with MSbP’ (though this is not a psychiatric diagnosis)
Case 6 a child diagnosed with a rare skin condition aged 4 months but also had other

³⁰ <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/> The search was carried out in August 2016 using the NSPCC search tool for the terms FII and commonly used alternatives. As the term FII is used consistently in the UK searching for the term FII revealed all of the cases. Reports that were published in full were read but some predate the requirement for full SCR publication so only executive summaries could be obtained.

³¹ Case 1 = Thurrock LSCB (2014); Case 9 = South Tees LSCB (2008), Case 11 = Cumbria Child Protection Committee (2004). Case 1 was a learning review, rather than a SCR, but it is the practice of the board concerned to publish all of its reviews.

injuries which were eventually attributed to her mother. The child also underwent invasive tests and treatments over several years. The diagnosis of a very rare condition allowed mother to become the 'expert' and manipulate health professionals. It is not clear from the summary whether the diagnosis was correct or induced, or whether this remains unclear.

Case 7 – a child age 20 months who was poisoned with prescribed medication. The review states that the assessment should have included consideration of FII but it is not clear that this case would have fitted the definition

Case 8 – a foster carer /private foster carer who abused a large number of children in her care. As the children had had numerous medical appointments it is hypothesised that this may have been an unrecognised case of FII

Case 9 - a 10 year old boy who suffered non-accidental amitriptyline poisoning and underwent unnecessary medical interventions. The child lived with his mother and had many health problems from an early age and multiple GP and hospital attendances, including admissions, contact with psychological services and a paediatrician. He was subject to surgical interventions, and concerns were raised in relation to FII, but they were not assessed.

Case 10 – a 9 year old boy who died as a result of salt poisoning. The review suggests that professionals were insufficiently aware of the possibility of FII and did not assess this.

Case 11 – A 7 year old who died as a result of FII. The child probably had mild epilepsy (though this diagnosis remains in doubt) and was admitted to hospital a number of times for investigation and treatment. Toxic levels of medication were found in his body on more than one occasion. His mother lied to GPs about his condition to obtain increasing amounts of prescription medication which was then used to overdose him. Mother misled professionals and relatives that the child had a terminal illness. FII caused chronic ill health, withdrawal from school and unnecessary invasive treatment which eventually contributed to his death. The review contains detailed information and recommendations on dealing with suspected FII, including warning signs and barriers to identification.

3.4.12. There is little other recent published critical evaluation of practice.

3.4.13. Statistics provided on Child Death Reviews ³² in England and Wales identify cases in which death has been caused by deliberately inflicted injury, abuse or neglect but do not further distinguish the type of abuse. Any case judged to have been the result of FII should have been the subject of a SCR and a summary of its findings would have been included in the national SCR repository once published.

³² Arrangements are set out in *Working Together to Safeguard Children* (2013) Chapter 5.

- 3.4.14. The patient safety team at NHS Improvement conducted a search of its Strategic Executive Information System (StEIS) database of reported serious incidents using search terms designed to identify cases of FII and provided the SCR with a summary of cases that had been identified by health trusts under the NHS serious incident procedures since 2005.³³ This identified approximately one reported case per year. This should not be treated as an indication of the incidence of FII cases known to the NHS because the main purpose of the reporting system is to identify and learn from cases in which there has been an error or omission on the part of healthcare staff, so not all cases of FII would be reported.
- 3.4.15. The sample included specific concerns related to FII, such as cases where *'further illness was induced by a parent whilst the child was an inpatient, or by breaches of confidentiality related to FII, or concern that there were lapses in the healthcare response to suspicions of FII, and in some cases by concern that a parent might also pose a risk to patients other than their child/children through healthcare employment'*. Some were reported without further details and may have been suspected or confirmed cases of FII where there were no specific practice concerns. There was insufficient information to comment on the age or any other characteristic of the children involved. The majority of reports indicated that a specialist tertiary centre (including the regional children's specialist hospitals) had been involved. Although this sample included only a small number of cases, further dialogue with these institutions or more detailed scrutiny of case records were identified as potential avenues of research.
- 3.4.16. The SCR sought information from Cafcass about its understanding of cases involving FII that were the subject of applications by local authorities in the family courts.³⁴ Cafcass does not collect data that would allow cases of FII to be identified. Soundings among experienced Cafcass practitioners and managers indicate that it is very rare for FII to form the principal grounds for the significant harm threshold to be met and that local authorities more commonly rely on other issues, such as neglect, to prove cases. FII may be an unproven background concern in more cases, though that cannot be quantified.

Guidance and procedures

- 3.4.17. The definition of physical abuse in the UK has historically included poisoning, though not all cases of poisoning will constitute FII and not all cases of FII involve the administration of drugs or poisons. The

³³ Communication from NHS Improvement to the Local Safeguarding Children Board (January 2017).

³⁴ Communication from Cafcass (Children and Family Court Advisory and Support Service) to the Local Safeguarding Children Board (January 2017).

1999 edition of *Working Together to Safeguard Children* explicitly referred to factitious illness and MSbP as part of this definition.³⁵

- 3.4.18. The Royal College of Paediatrics and Child Health (RCPCH) produced the first comprehensive guidance on FII in 2002.³⁶ This drew on the research described above but was also intended to address serious contemporary concerns about the unregulated use of covert video surveillance of families (CVS). These focused on the rights of patients and parents and confusion between activity being carried out for research, clinical management of cases and safeguarding of children.³⁷
- 3.4.19. In 2008 the government produced multi professional guidance on FII.³⁸ This document can be found on the internet. It is outdated in that it takes no account of changes in practice, research or other guidance since its publication and refers to a number of organisations and arrangements that no longer exist. It is not clear if the intention of government is to update this guidance as current government policy is not to provide detailed practice guidance.
- 3.4.20. The RCPCH guidance was revised in 2009 to take account of the changes in clinical practice but also as part of a wider exercise to underline the responsibilities of health trusts and professionals in the light of the findings of the enquiries into the deaths of Victoria Climbié and Peter Connolly.³⁹ It seeks to distinguish FII from apparently similar presentations which have different causes. Part of this classification is set out in Table 3. This very helpful differential approach has not so far been reflected in other local or national statutory safeguarding guidance. The guidance does not seek to explain the phenomenon (described in detail by clinicians who contributed to the review and suggested by the most recent research cited above) of an increasing number of older children who present and elaborate false symptoms.

³⁵ *Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as factitious illness by proxy or Munchausen syndrome by proxy.* Department of Health, Home Office, Department for Education and Employment, (1999) *Working Together to Safeguard Children* (p5)

³⁶ Royal College of Paediatrics and Child Health (2002) *Fabricated or Induced Illness by Carers*

³⁷ At the time the professional standing of a number of the paediatricians most closely associated with developing and promoting practice in relation to MSbP and cot death during the 1980s and 1990s had been strongly challenged in a series of legal cases.

³⁸ Department for Children, Schools and Families (2008) *Safeguarding Children in whom Illness is fabricated or induced – supplementary guidance to Working Together to Safeguard Children*

³⁹ Royal College of Paediatrics and Child Health (2013),

Table 3 Spectrum of cases where FII concerns may arise ⁴⁰

Starting point: A child is presented for medical attention, possibly repeatedly, with symptoms or signs suggesting significant illness; an appropriate clinical assessment suggests that the child's 'illness' is not adequately explained by any disease. The examples below illustrate the range of possible considerations.	
Example 1	Simple anxiety, lack of knowledge about illness, over interpretation of normal or trivial features of childhood; may in some cases be associated with depressive illness in carer
Example 2	Child's symptoms are misperceived, perpetuated or reinforced by the carer's behaviour; carer may genuinely believe the child is ill or may have fixed beliefs about illness
Example 3	Carer actively promotes sick role by exaggeration, nontreatment of real problems, fabrication (lying) or falsification of signs, and/or induction of illness (sometimes referred to as 'true' FII)
Example 4	Carer suffers from psychiatric illness (e.g. delusional disorder) which leads them to believe child is ill
Example 5	Unrecognised genuine medical problem becomes apparent after initial concern about FII

As with the spectrum of presentations referred to above in medical guidance the concept of 'perplexing presentations' is not currently reflected in local or national multi-agency safeguarding procedures.

3.4.21. The RCPCH has also published overall guidance for members on safeguarding.⁴¹ The section of this document dealing with FII urges paediatricians to consider FII as part of a wider spectrum of 'perplexing presentations' in the hope that 'early recognition by paediatricians of perplexing presentations with alerting signs, followed by direct observation of the child, might obviate the full development of fabricated or induced illness'.⁴² This guidance proposes that paediatricians undertake a considerable amount of preliminary diagnostic work, including for example gathering information from schools before considering referral to the local authority. Only clearly diagnosed cases (where all alternative medical explanations have been eliminated) or those where there is believed to be an evidenced threat of suffocation or poisoning or physical harm should be referred to the local authority, the latter early on.

3.4.22. This approach rightly locates the responsibility for resolving health issues with clinicians. It may also reflect some hesitancy on the part

⁴⁰ RCPCH (2009) page 8

⁴¹ Royal College of Paediatrics and Child Health (2013) *Child Protection Companion*, Section 13

⁴² Bass and Glaser (op cit)

of health professionals to share information and join multi-agency discussions about children without telling parents, until they have eliminated possible alternative causes. It should not do so as all health professionals work within guidance that enables them to share information, including with colleagues in other agencies if they believe that there are safeguarding concerns.⁴³

- 3.4.23. This case review has demonstrated (3.2.1 – 12) that it is unrealistic to expect paediatricians with full clinical responsibilities to have enough time to coordinate work on a complex FII case.
- 3.4.24. In contrast, the 2008 central government guidance and local multi-agency procedures tend to advocate early consultation with the local authority and urgent action, because they are based on the notion that a typical case involves potentially severe harm to a very small child, rather than a complex set of interactions between many health professionals and an older child.
- 3.4.25. It was the intention of the 2008 government guidance that procedures dealing with FII should be integrated into local child protection procedures and this appears to have happened. However there are now considerable differences between local procedures. The London Child Protection Procedures (which should have assisted staff in this case) acknowledge the complexity of FII but then offer few concessions to its specific features, for example indicating that normal timescales for the completion of strategy meetings and child protection conferences should be adhered to. In reality the nature of such meetings in a case of suspected FII are likely to be very different, requiring longer to plan and convene. Research would seem to suggest that genuinely life-threatening cases of FII that need to be dealt with as an emergency are very rare. Other safeguarding procedures do evidence an attempt to respond to the more specific nature of FII.⁴⁴

Summary

- 3.4.26. Despite the apparently considerable literature and guidance, there is little research carried out over the last decade on which safeguarding professionals can base their interventions. The lack of a recent population study makes it impossible for professionals to feel confident about the prevalence or incidence of FII, particularly as

⁴³ See for example the *General Medical Council Protecting Children and Young people the Responsibilities of Doctors* http://www.gmc-uk.org/guidance/ethical_guidance/13260.asp

⁴⁴ For example the Greater Manchester Safeguarding Partnership guidance offers more detailed and practical support for professionals including for example a template for the coordinating clinicians chronology. http://greatermanchesterscb.proceduresonline.com/chapters/p_fab_ind_illness.html?zoom_highlight=FII#med_evaluation

there is so much dispute about definition and criteria for the inclusion of cases.

- 3.4.27. This is of particular concern if, as the report has argued in Section 3.1, FII is a safeguarding concern that is constructed in the interaction between parent, health professional and child. This would suggest that it has no simple cause and that it might be manifest in different ways at different points in time and in different cultural contexts.
- 3.4.28. Based on the evidence of the health professionals in this case, in addition to the recognised individual mental health problems that affect parents in FII cases, parents, children and health professionals are all subject to wider societal pressures and influences. However there is little other than anecdotal knowledge about the way in which the wider social factors set out in Section 3.2 impact on FII and the responses of health professionals and others.
- 3.4.29. Research does not address the extent to which the earlier reported age distribution of FII remains valid or whether it has now become a phenomenon that involves older children and young adolescents who actively participate in the presentation of falsified symptoms.
- 3.4.30. If growing numbers of older children and adolescents are fabricating their own symptoms it is important to try to understand why. Are they, for example, children who in early childhood experienced the classically described form of FII who are now fabricating illnesses of their own, assisted by the detailed accounts of symptoms and tests readily available on the internet? Or is this a different phenomenon in which society is offering older children and adolescents incentives to adopt a sick role and the information with which to act it out?
- 3.4.31. Despite its potentially grave consequences we do not know how far FII remains a seriously concerning risk to infants and small children in the way that was initially described in the 1970s – 1990s. There are many unanswered questions. Has the harm subsided because health professionals are now alert to the risks and spotting such cases early? Or are there still severe cases that are not being reported because reporting criteria are not designed to capture all cases or because in cases of FII a large number of health trusts may have been involved but no single trust will view it as a serious case? Or are trusts under-reporting cases where they have contributed to iatrogenic illness? Older studies found that health professionals were over-represented among perpetrators, but has this become less relevant as information about the signs and symptoms of complex and rare diseases are now readily widely accessible?
- 3.4.32. The review of published guidance has identified a divergence between the professional guidance given to paediatricians and local safeguarding procedures. This may lead different professional groups

to approach cases in different ways, in particular over whether in its early stages FII is a medical condition that needs to be diagnosed by doctors or a child protection concern that requires multi-agency management. It may be that it is only through practice experience that trust between professionals will develop. However given the low incidence of FII and the rapid turnover of social care managers in many authorities, it is likely that opportunities for joint working on more than a single case will be rare.

4. Summary of findings and recommendations

Introduction

- 4.1.1. The SCR has highlighted the difficulties faced by professionals in working with a family in which FII was suspected. These proved difficult to overcome despite the fact that a significant number of the professionals involved were concerned that this might be a case of FII and were actively seeking the best ways of protecting the children. Considerable effort went into coordinating work.
- 4.1.2. These efforts were unsuccessful for more than three years as a result of the difficulty of responding to an unusual and entrenched presentation within complex health and local safeguarding arrangements. Challenging the family and coordinating the kind of response that was required were not supported either by the prevailing organisational arrangements and culture within which health care was provided, or by the way in which agencies with safeguarding responsibilities worked together. The main difficulties in the case did not arise as a result of individual errors.
- 4.1.3. The SCR proposes that action is needed in five areas. It will be for the LSCB and other agencies to consider these further and determine how to take them forward, by the agencies involved in the case, across London and in some instances nationally. If it is agreed that action can be taken quickly across London there may be less need for specific action in Local Authority 1. If not, local action should be taken.

Recommendation 1

- 4.1.4. **The LSCB should develop and implement a pathway for the early identification and management of perplexing presentations, including cases where there are suspicions about FII.**

Examples of such pathways exist in the research literature (see for example Section 3.4). Given the existence of pan-London child protection arrangements and the likelihood that and suspected FII case will involve health providers in different localities, these should

also be developed across London. In Local Authority 1 this could form part of local guidance on the management of complex cases and should certainly take emerging work on that issue into account.

Drafting of a pathway for early identification should take account of the following specific learning from this review

A pathway for the early identification and management of perplexing presentations should enable health professionals to explore the causes of medical symptoms, gathering information about the child and family from a variety of sources while at the same time maintaining an open mind about possible safeguarding concerns.

The pathway should consider mechanisms for complex cases where a multi-agency group can consider a case and own the diagnosis of FII, rather than it be solely the responsibility of one clinician

Such cases rarely involve only one health trust or provider working with the family. The pathway needs to take account of the roles and responsibilities of all of the agencies who might be involved and identify resources accordingly.

Any health clinician who is asked to act in a coordinating and lead professional role needs the time, resources and knowledge to carry the task out.

Summaries of research and existing health guidance suggests the appointment of lead professional at an early point who is confident in dealing with health concerns, knowledgeable about the range of health providers likely to be involved and has sufficient time to draw together information about the case.

The roles of designated and named professionals in relation to 'perplexing presentations' and FII should be defined in local procedures

Clinicians who are seeking to clarify concerns about 'perplexing presentations' and FII at an early point need to be able to draw on supervision and peer discussion

Schools need to be engaged in earlier discussion of health concerns in possible FII cases

There should be a facility to provide health chronologies at key meetings and to maintain them subsequently.

Existing guidance allowing the sharing of information between professionals where there are safeguarding concerns needs to be reinforced.

The pathway should recognise the key role of senior managers in

protecting staff who are working on such cases and making difficult professional judgements about whether investigations and treatments are necessary. Senior managers need to be briefed about contentious cases, not in a defensive way but in order to be able to support clinical staff who are exploring different explanations including FII or who face complaints when they refuse to be drawn into conducting further tests and surgery.

Greater awareness of signs and symptoms of FII is needed in social care. Social care professionals need to be able to consider alternative accounts and explanations of behaviour and not stick rigidly to an established 'narrative' in the presence of mounting conflicting evidence

The ambulance service needs to increase staff awareness of FII as a possible factor with children who are 'frequent fliers' and be able to test whether the circumstances match common patterns of symptoms in FII. Greater awareness is needed of the arrangements for implementing an individual patient protocol in children's cases

Tertiary health providers should be more aware of risks of FII and seek more detailed background information about previous tests and investigations.

Recommendation 2

- 4.1.5. **The LSCB should develop a pathway for the management of identified cases of FII (or cases where there is a strong and well-founded suspicion) including those children who are subject to child protection plans.** This should apply both in the area where this case occurred and across London

Drafting of a pathway for the management of identified cases of FII should take account of the following specific learning from this review

Information sharing arrangements (whether they be part of day to day working or part of a child protection plan) need to encompass the whole health economy i.e. including GPs and primary care, community health services, acute sector and tertiary and other specialists.

Given the complex nature of FII cases and the large number of professionals who are involved, it is not uncommon for key people to miss some meetings on cases. Information sharing arrangements need to take this into account and ensure that information is shared with all professionals involved including those unable to attend a meeting.

When a Child Protection Conference is being held on a case of

suspected or identified FII, invitations should be sent to all involved health trusts and to named health professionals staff in the trust.

Timescales for calling initial conferences should take account of the need to obtain comprehensive information and good health service attendance

Procedures should consider the effectiveness of child protection conferences and core groups and whether there is scope for professional meetings that do not involve parents

Chairs and administrators need to be better educated about roles of different health professionals, for example which health professionals could successfully take on a coordinating role in a case of suspected FII.

Conferences need to strive to achieve a consistent membership and attendance in complex cases. This can be facilitated by informing the named professionals from the trust about the conference

Conference administrators should consult the child's GP to provide details of all health professionals who need to be invited, including those working with the parents if that will be beneficial

The model of child protection conference discussion should match the needs of the case and the specific risks to the child in cases of FII. In such cases 'engaging' with services may not be a positive marker for progress or a strength.

Recommendation 3

4.1.6. **The LSCB should ensure that its training and procedures address particular difficulties that emerged in this case, including:**

- Local procedures to clarify the nature and status of different meetings in complex cases, including cases of FII. This should address the question of who should attend them and when meetings will be held without informing parents
- Local procedures to agree how parental health records can be obtained when it will assist in the diagnosis of a child's health condition
- Specific training and awareness raising for GPs about FII and the difficulties that such cases can pose for general practice and primary care
- Specific training on the new pathways proposed in recommendations 1 and 2

Recommendation 4

- 4.1.7. **The LSCB should ask the Department of Health and the Department for Education to commission national research to establish the current prevalence, incidence and case characteristics and outcomes for children who have either perplexing presentations or FII.**

This research should draw on current experience of paediatricians and other front line staff so as to have a contemporary rather than a focus on the most serious cases or a historical focus.

Recommendation 5

- 4.1.8. **The London Safeguarding Board should update the current practice guidance on FII to take account of more recent guidance from the Royal College of Paediatrics and Child Health and other relevant developments in research and clinical experience. Child protection processes (such as the timing of meetings) should take account of the specific nature of FII.**

The LSCB and the London Safeguarding Board should invite HM Government to consider issuing updated guidance on perplexing presentations and FII.

Appendices

Appendix 1	Principles from statutory guidance informing the Serious Case Review method, Terms of Reference and lines of enquiry
Appendix 2	How the review was undertaken
Appendix 3	SCR panel members
Appendix 4	Roles of staff interviewed or in attendance at group sessions
Appendix 5	References
Appendix 6	Views of family members
Appendix 7	Proposed flowchart for the medical management of unexplained presentations and FII
Appendix 8	Medication known to have been prescribed to Child Y

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

- Recognise the complex circumstances in which professionals work together to safeguard children.
- Seek to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Be transparent about the way data is collected and analysed.
- Make use of relevant research and case evidence to inform the findings.

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

Terms of Reference and details of areas to be considered by the review

1 Overall purpose and terms of reference

The purpose of the review is to undertake a '*rigorous, objective analysis...in order to improve services and reduce the risk of future harm to children*'. The LSCB is required to '*translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children*'.⁴⁵

The specific objectives of the review are

1. To establish what happened
2. To establish why professionals acted as they did
3. To identify and understand the significance of a range of contributory factors that shaped the practice of professionals, including wider organisational factors.

⁴⁵ HM Government (2015) *Working Together to Safeguard Children*

4. To identify any episodes and background factors that may have a direct bearing on the harm caused to the children and therefore may be relevant to a consideration of whether or not the injuries could have been prevented.
5. In addition the review will seek to understand what the case history tells us about the strengths and weaknesses of local safeguarding arrangements (sometimes referred to as using the individual case as a 'window on the system').⁴⁶
6. The review will explore aspects of the assessment of vulnerability, need and risk that it determines are relevant, whether any potential indicators of abuse and neglect were recognised and the provision that was made for the children and other family members.
7. The review will seek to establish whether the multi-agency working met the expectations of the LSCB for a case such as this. In particular did it enable a good overall assessment; coordinated support; identification of discrepancies in information given by the parents; provision of services to meet needs?

⁴⁶ Charles Vincent (2010) Patient Safety second edition

How the review was undertaken

1. The LSCB asked member agencies to compile a chronology of key events based on the written and electronic agency records. Agencies also compiled brief initial reviews of the possible learning for their own agency
2. The LSCB established a review panel to oversee the conduct of the review consisting of the independent lead reviewer and senior staff from participating agencies and commissioners who had not been involved in the work with the family. The review panel was chaired by the Consultant in Public Health for the local authority area
3. The lead reviewer met with the authors of the chronologies to discuss key events and possible learning in more detail
4. The lead reviewer met with a group of managers in the local authority to discuss the case
5. The lead reviewer and the consultant in public health met health staff who had been involved in working directly with the family to discuss their experience and possible learning
6. The review team held individual interviews with members of staff and managers, supported by review of records where this assisted
7. The lead reviewer drafted findings which were discussed with the review team
8. The findings and possible learning were discussed with staff and other representatives from agencies who had worked with the family
9. The reviewer sought wider views on the case by making an anonymous presentation at a number of training events for health professionals, including local GPs
10. Views of Cafcass and NHS England were sought about the wider incidence of reported cases of FII
11. The lead reviewer interviewed the children's mother to obtain her views about the services provided
12. Further drafts of the report were prepared and circulated to panel members
13. The LSCB Executive group discussed and agreed drafts of the report and recommendations

SCR REVIEW TEAM MEMBERSHIP

Independent and LSCB representatives	
Local Authority	Consultant in Public Health (Panel Chair)
Keith Ibbetson	Independent Lead Reviewer
Business Manager	Safeguarding Children Board
Administrator	Safeguarding Children Board
Review Team Representatives	
Agency	Designation
Police Service	Serious Crime Review Group Reviewing Officers
Local Authority 1	Principal Social Worker
	Director Children Services
	Assistant Director Learning & Achievement
	Legal Services
Hospital Trust 1	Named Nurse
	Deputy chief nurse
Hospital Trust 2	Named Nurse
Hospital Trust 3	Head of Safeguarding and Named Nurse
Clinical Commissioning Group	Designated Nurse for Safeguarding Children
	Named GP
Community Health Trust	Assistant Director Children Services
	Named nurse safeguarding children
Ambulance Service	Safeguarding Lead
Academy Schools	Head / Deputy Head

Roles of staff and managers involved in discussions over the findings of the SCR

Local Authority 1

Principal Social Worker
Service Manager (Children in Need)
Independent Reviewing Officer
Manager of IROs and Child Protection Conference Chairs

Hospital Trust 1

ED Paediatric Nurses, Staff Nurses and Sister
Consultant Paediatricians
Named Nurse

Hospital Trust 2

Named Nurse
Named Doctor

Hospital Trust 3

Named Nurse
Named Doctor

Clinical Commissioning Group and Primary Care

Designated Nurse
Named GP
Local GPs (through a presentation and discussion at local training events)
Family GP

Community Health Trust

Named Nurse
CAMHS psychotherapist
School Nurse

Ambulance Service

Safeguarding lead

Academy Schools

Head / Deputy Head

Police Service

Child Abuse Referrals desk Detective Sargeant

References

- Christopher Bass and David Jones (2011) 'Psychopathology of perpetrators of fabricated or induced illness in children: case series', *The British Journal of Psychiatry* 199, 113–118
- Christopher Bass, Danya Glaser (2014) 'Early recognition and management of fabricated or induced illness in children', www.thelancet.com Vol 383 April 19, 2014.
- Children and Family Court Advisory and Support Service, <https://www.cafcass.gov.uk/>
- Denny SJ, Grant CC, Pinnock R. Epidemiology of Munchausen syndrome by proxy in *New Zealand. J Paediatric Child Health* 2001; 37: 240–43.
- Department for Children, Schools and Families (2008) *Safeguarding Children in whom Illness is fabricated or induced – supplementary guidance to Working Together to Safeguard Children*
- Ferrara P, Vitelli O, Bottaro G, et al. Factitious disorders and Munchausen syndrome: the tip of the iceberg. *J Child Health Care* 2013; 17: 366–74.
- General Medical Council Protecting Children and Young people the Responsibilities of Doctors http://www.gmc-uk.org/guidance/ethical_guidance/13260.asp
- HM Government (2015) *Working Together to Safeguard Children*
- McClure et al, McClure RJ, Davis PM, Meadow SR, Sibert JR. 'Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation'. *Archives of Diseases in Childhood*, 1996; 75: 57–61.
- National Repository of Serious Case Reviews <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/>
- Royal College of Paediatrics and Child Health (2002) *Fabricated or Induced Illness by Carers*
- Royal College of Paediatrics and Child Health (2009) *Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians*
- Royal College of Paediatrics and Child Health (2013) *Child Protection Companion*, Section 13 <http://www.signsofsafety.net/signs-of-safety-2/>
- Mary Sheridan (2003) 'The deceit continues: An updated literature review of Munchausen Syndrome by Proxy', *Child Abuse and Neglect*, 27, 431-51
- Charles Vincent (2010) *Patient Safety* second edition
- Watson S, Eminson DM, Coupe W. Personal communication. In: Eminson M, Postlethwaite RJ, eds. *Munchausen syndrome by proxy abuse: a practical approach*. 2000: Oxford, Butterworth Heinemann: 17–70.

VIEWS OF CHILD Y's MOTHER ABOUT THE SERVICES PROVIDED

1. Child Y's mother said that the reason the family visited so many hospitals was that the family was always moving around so much.
2. Each hospital had different views on how to treat her son or what medication to give.
3. Staff within and in different hospitals were contradicting each other, so she did not know what to believe and what to do.
4. She had suffered domestic abuse from the children's father (including a broken finger and an injured shoulder) and harassment at court and at her flat
5. Plans that were agreed and written down were not implemented for example her son saw a therapist and should have also seen a physiotherapist, but nothing materialised.
6. Her daughter had issues at school but did not like to admit that she had trouble with learning. Her troubles affected the whole family

Excerpt from, 'Proposed flowchart for the medical management of unexplained presentations and FII'

Christopher Bass, Danya Glaser (2014) 'Early recognition and management of fabricated or induced illness in children', www.thelancet.com Vol 383 April 19, 2014 Supplementary Appendix

Lancet 2014; published online March 6. [http://dx.doi.org/10.1016/S0140-6736\(13\)62183-2](http://dx.doi.org/10.1016/S0140-6736(13)62183-2)

<p>Nominate a lead paediatrician (if child under more than one specialty)</p> <p>Discuss discrepancies with other medical services including GP</p> <ul style="list-style-type: none">• If parents reluctant for this, explore reasons <p>Compile chronology of involvement with all health services and any social care contacts, noting:</p> <ul style="list-style-type: none">• Who reported concerns<ul style="list-style-type: none">○ Whether the reported symptoms and signs were independently observed○ What were the medical findings○ Whether they explained the reported concerns○ Whether they warranted the functional impairment of the child• What 3 the outcome was<ul style="list-style-type: none">○ Whether there has been frequent change of doctors, including due to geographical moves <p>Obtain information about health of siblings</p> <p>Obtain full account 3 or other aids</p> <ul style="list-style-type: none">• How the child's reported ill health is affecting family life, including siblings and the parents' work <p>Elicit the parents' explanations for the child's reported ill-health</p> <p>Carry out definitive, warranted investigations to clarify diagnosis. This may include admission to observe child constantly & requires a multidisciplinary internal planning meeting</p> <ul style="list-style-type: none">• If parents refuse admission, support for this will be required from children's social care <p>Talk with child on her/his own to ascertain her/his view, experiences and possible anxieties about their health</p>

Medication known to have been prescribed to Child Y

Child Y was not taking all of this medication simultaneously, though it is impossible to track from the medical records exactly when each medication was prescribed, when he took it and how much of any medication he took.

Medical or proprietary name	Description
Amlodipine	Used to treat chest pain and other conditions caused by heart disease
Augmentin	Antibiotic containing penicillin and other antibiotic
B12 injections	Counteracts reduction in B12 caused by Entonox
Cephalexin	Antibiotic
Chlorpheniramine	Antihistamine – reduction of allergic symptoms
Co-codamol	Paracetamol based pain relief
Codeine	Morphine based pain relief
Co-dydramol	Combination pain relief
Diazepam	Muscle relaxant – anxiety relief
Di-hydro codeine	Opiate based pain relief
Entonox	Nitrous oxide
Folic Acid	Vitamin B9
Gabapentin	Anti-epileptic, treatment for nerve pain
Oramorph	Oral morphine pain relief
Paracetamol /	Pain relief
Promethazine	Treatment of allergies
Ranitidine	Stomach ulcers
Simvastatin	Statin to reduce cholesterol level
Tramadol	Opiate based pain relief

On one occasion a review at Hospital Trust 2 showed him to be taking the following, not listed above

- Omeprazole – reduces stomach acidity
- Protonic - similar
- Loratidine – for the treatment of rhinitis and allergies

At a number of points Child Y was noted to be using a GTN spray (for pain relief). He told ED staff that he had been given it by the ambulance service, but this seems unlikely as the ambulance service will only use this spray for adults, so it may have been obtained elsewhere.

He also possessed an EpiPen (one off injection of adrenalin to counter allergic reactions) though it is not clear who issued this. The local hospital does not prescribe this as a ‘take home medication’ and it would normally be prescribed by an allergy specialist. However the GP records contain no evidence of this. EpiPens may be purchased on line.