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Full Title

**Safeguarding Children when Fabricated or Induced illness (FII)
is suspected or proven: Reviewing the experiences of Local
Safeguarding Children Boards (LSCB) in England**

Running headline

**Fabricated or Induced illness and Local Safeguarding Children
Boards**

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Abstract

The fabrication or induction of illness (FII) is a relatively rare situation which can lead to serious physical and/or emotional harm to a child. FII is often difficult for professionals to identify and manage. In this study the views of representatives from the 147 Local Safeguarding Children Boards in England were sought on the challenges to safeguarding children from FII, and how these might be overcome. Despite a low response rate of only eighteen from the 147 LSCBs, seventeen challenges were identified. The most reported were inadequate training and resources, poor multi-agency collaboration, uncertainties and anxiety among professionals tasked with identifying FII, issues inherent in the relative rarity of FII and the variety of ways in which it can present. To overcome these challenges, LSCB respondents suggested that more training, specific to particular professions and using video case studies where possible, should be conducted on a wider scale, and consideration should be given to ensuring that professionals are familiar with relevant guidance.

KEY PRACTITIONER MESSAGES:

- Professional uncertainty and anxiety are key challenges to safeguarding children from FII.
- More training would help overcome professionals' uncertainty and anxiety.
- Finding ways to ensure that existing guidance is read, understood, and

applied, across all relevant professions would support the development of greater knowledge about how best to respond to FII cases.

- The inclusion of FII within broader safeguarding training, using video case studies, and conducting profession-specific training, may constitute ways to improve training and promote knowledge of the guidance.

KEYWORDS: fabricated; induced; FII; Munchausen; training

Introduction

The nature of fabricated or induced illness

The fabrication or induction of illness in a child by their carer (abbreviated to FII) is a relatively rare form of child abuse. It involves a parent, or other carer, verbally fabricating symptoms, significantly exaggerating them, or inducing physical signs of illness in a child (and in the latter process directly physically harming the child). It is a scenario in which the usual elements of honesty and openness in the professional - service-user relationship are seriously challenged by deliberate deceit by the adult who is primarily responsible for the welfare of the child. Not surprisingly, FII is usually 'difficult to detect' (Rees *et al.*, 2017, p.2). There has been controversy and debate about the nature of FII, the terminology used to describe the scenario, and even whether it exists (Kaplan, 2008). In the UK, there was concern that this controversy could contribute to 'a loss of focus on the welfare of the child' (HM Government, 2008, p.2).

Government guidance and Local Safeguarding Children Boards

To assist in the management of suspected FII, statutory guidance *Safeguarding Children in Whom Illness is Fabricated or Induced* (HM Government, 2008) was published. It was accompanied by training materials, *Incredibly Caring*, that included a reader and DVD (Bools, 2009; Department for Children, Schools and Families, 2009). These materials were commissioned by the government to assist in implementing the guidance. These were distributed to the chairs of the Local Safeguarding Children Boards (LSCB) in 2009. In England, the Children Act 2004 required each local authority to establish a Local Safeguarding Children Board for their area with specified representatives, for example from social care, the health service and the police. Broadly, the role of the LSCB through their chairs was to develop local safeguarding policy and procedures and scrutinise local arrangements, i.e. to evaluate, and improve procedures in situations where children are at risk of, or suffering from, harm (HM Government, 2015).

This study aimed to utilise the unique perspectives of LSCBs to:

1. Identify the ongoing challenges to safeguarding children from FII
2. Establish how extensive and useful current training is (with a focus on *Incredibly Caring*); and
3. Understand where and how policy and practice might be improved.

Additionally, although the LSCBs have now been abolished and replaced by

new local safeguarding arrangements (HM Government, 2018, pp.72-73), the focus of this research is on safeguarding children from FII, not the potential effects of this change.

Background

Challenges for professionals identified in the literature

As this paper is concerned with professionals' experiences of FII, and potential ways to improve policy, guidance, and training, previously identified challenges in these areas are the focus of this review.

A range of challenges to safeguarding children from FII have been identified by various authors. Working in the USA, Squires and Squires (2010) identified six challenges: (1) electronic medical records are often vast, cluttered, and highly summarised, making inconsistencies difficult to identify; (2) acquiring medical records can be difficult, and may require parental consent; (3) diagnostic tests may be harmful to the child, and rarely provide incontrovertible evidence, thus may only compound the abuse; (4) what they term the 'drive for patient satisfaction' means 'the "grade" given by a consumer often serves as a substituted standard for quality measurement' (p.251), therefore potential abusers are not adequately investigated; (5) the 'impact of the internet' enables abusers to access medical information that can be used to mislead professionals, and to use social media as a platform to publicly voice complaints against medical professionals; and (6) 'fractured care' in health services means

'no one member of the treatment team may be in the position to question the need or appropriateness for planned tests or procedures' (pp.70-71).

Some authors have reported additional issues related to these challenges. Kozłowska (2014), a paediatrician working in Australia, found that limited access to medical records from other countries can hinder effective investigation when suspected abusers are no longer in their country of birth. Brown *et al.* (2014) found that online groups and social media can play a part in fulfilling the motives of an abuser, as well as being a platform from which to voice complaints. Several authors have also noted that reluctance to investigate FII may be a significant issue regardless of the 'drive for patient satisfaction'. Kozłowska (2014, p.383), for example, suggests that some professionals 'will take the stance of least resistance, which is to do nothing'. Walk and Davies (2010, p.22) proposed that doctors could feel passively implicated in the abuse, and therefore 'may find it difficult to step forward'. By contrast, in a study highlighted by the UK media (Wheeler, 2015), Colby (2014) reports that, between 1991 and 2014, the Tymes Trust had advised on 121 cases where parents of Myalgic Encephalomyelitis sufferers were involved in investigations regarding child abuse or neglect, or had had their child forcibly confined to a psychiatric unit when there was no evidence of maltreatment. She states that these suspicions led to 'bullying and state oppression' (2014, p.2).

In addition to the issues highlighted by Squires and Squires, it has been noted

that FII consists of an extremely broad range of potential symptoms (Bass and Halligan, 2014), and that a 'single and specific causal explanation...for a set of presenting symptoms' is unlikely to present itself (Eminson and Jureidini, 2003, p.414). Indeed, a professional may also feel significant uncertainty as to whether a presented condition is FII at all, or a condition they cannot identify (Yates and Bass, 2017). Furthermore, though historical discussion on FII has focused on fabricators who seek the 'sick role by proxy' (Bury and Monaghan, 2013), Chafetz and Dufrene (2014, p.1756) note that there are also reported presentations that involve 'the intentional production or exaggeration of symptoms for obtaining compensation or avoidance of duty/punishment', something they term 'malingering by proxy' (MBP). As the personality, characteristics, and specific actions of perpetrators are key elements in raising suspicion of possible FII (Day *et al.*, 2017; Yates and Bass, 2017), and these are likely to be different in MBP abusers (Chafetz and Dufrene, 2014), indicators of abuse may be more varied and difficult to identify. Another difficulty, highlighted by Zeitlin (2016) is that misrepresenting symptoms is more common than physically inducing illness, yet much of the published material on FII involves illness induction with direct physical harm to the child (Davis, 2009). Professionals, therefore, may be less uncertain of what action to take if they suspect fabricated or exaggerated illness, without the added and more immediate danger of illness induction. Taking into consideration the above issues and the number of areas of uncertainty it is perhaps understandable that the decision to initiate a section 47 enquiry into possible FII may provoke significant anxiety in the professional.

Finally, it must be acknowledged that all methods of investigating FII have been criticised. Many medical diagnostic tests, as Squires and Squires (2013) noted, are invasive, often inconclusive, and potentially harmful. Separating a child from the suspected abuser/s, a common strategy for investigating FII (Yates and Bass, 2017), has been criticised from two perspectives: it may be ineffective if the child has also developed a somatoform disorder (Foto Özdemir *et al.*, 2013); and, it may create a 'self-fulfilling prophecy' that results in inaccurate perceptions of improvement in the child (Pankratz, 2010). Similarly, collating medical records to identify inconsistencies can result in investigators 'searching for the slightest discrepancies that can be interpreted as deception' (Pankratz, 2010, p.308). Lastly, the use of covert surveillance has been criticised for being an invasion of privacy (Vaught, 2004), and for allowing abuse to be observed rather than prevented (Flannery, 1998). These criticisms further highlight that investigating possible FII is usually a complex task requiring careful consideration, and discussion between professionals to agree on a clear plan of action. Current policy and government guidance are intended to assist professionals when they are undertaking this complex task.

The role of Guidance and Training Materials

The Government's 2008 statutory guidance describes appropriate procedures for responding to concerns about FII, which should be followed within the framework of the current *Working together to safeguard children* guidance (2018). 'Working Together' requires local agencies to ensure support and

supervision for front-line health and child protection professionals, which may assist in overcoming some of their anxieties (Zeitlin, 2016). In addition, the *Incredibly Caring* training materials that accompany the 2008 guidance include exercises designed to support professionals in a variety of different situations, including how to act if one suspects different types of FII; when and how to use covert video surveillance; dealing with professional disagreements and communication difficulties; managing complaints; supervising and supporting staff involved with the enquiries; ensuring a child focused assessment; and, overcoming the many factors that can distort an objective assessment (Department for Children, Schools and Families, 2009).

Purpose of the current study

In respect of a continuing need for professionals to develop the knowledge and skills required to safeguard children from FII, this study investigated three main questions:

1. What are the challenges to effective identification, assessment, and intervention in FII?
2. What is the frequency and usefulness of training on FII, particularly of *Incredibly Caring*?
3. Where and how can identification, assessment, and intervention in FII be improved?

Methods

Review of literature

Firstly, to identify reported challenges for professionals, reviewed in the background section above, the literature was searched using the terms FII, Munchausen syndrome by proxy, medical care abuse, and factitious illness. This took into account the lack of consensus about terminology.

Sample

All 147 Local Safeguarding Children Boards in England were invited to participate in the study. Of these, eighteen took part: 15 by the completing the survey; one by taking part in an interview, and three by both completing the survey and taking part in an interview. Of the 18 completing the survey, responses from 14 LSCBs indicated that 12 were from the south of England and two from north of the Humber. The respondents' backgrounds were social work (n=7), the police (n=7) and nursing (n=3).

Procedure

Data were gathered using a combination of an electronic survey and telephone interview. The survey was conducted between February and June 2017, and interviews were conducted between July and November 2017. A survey was created in Google Forms and sent, through the Association of Independent LSCB Chairs who held a list of names of Chairs of LSCBs and their email addresses, to all 147 LSCB chairs in England. Individuals who chair multiple boards were asked to complete a separate survey for each board they

represent. The survey covered four areas: the frequency of FII and different incidences related to it; the frequency and efficacy of training practices; a review of different agencies efficacy in FII cases; and questions about the challenges to safeguarding children from FII. A combination of closed and open questions was used: the closed questions either employed a 5-point Likert scale where 0 = low/poor and 4 = high/good, or requested a simple frequency; and the open questions aimed to allow the chairs to frame concerns and recommendations in the manner they deemed appropriate (Bryman, 2016). Strict anonymity was afforded to all participants.

Interviews by telephone

After receiving the survey results, and recognising the low response rate, four telephone interviews were conducted. This was a selected sample based on the researcher's knowledge of the interviewee and their Local Safeguarding Children Board. The goal of these was to further investigate the survey results by gathering a detailed understanding of the everyday challenges in safeguarding children from FII, as well as policy suggestions (Cresswell and Plano Clark, 2011). To do this, semi-structured interviews, individually tailored to each interviewee and their LSCB, were conducted to gather more detailed information about each interviewee's experiences of FII within the LSCB; including identifying, investigating and intervening, with a focus on challenges and suggestions. The interviewees consisted of one chair who had responded to the survey, two who had not, and a representative of an LSCB that had responded to the survey, but was not the chair (hereafter, interviewees/survey

respondents are referred to as 'LSCB representatives').

Qualitative Data Analysis

A thematic analysis, in NVivo, was employed to analyse the qualitative data emerging from both the open-ended survey questions and the interviews. The responses from the open survey were initially transcribed in 17 separate NVivo 'internals'. The data was very 'thin' so that coding was a direct and simple process. Coding consisted of two nodes: 'challenges'; and 'suggestions for improvement'. The initial coding was constructed by JR and then reviewed and revised by other listed authors who had access to the survey responses. A 'selective coding' approach was taken (Braun and Clarke, 2013), which focused on what was directly stated by LSCB representatives, allowing the creation of a list of specific 'challenges' and 'suggestions for improvement'. Furthermore, to suggest how salient each challenge is, the 'challenges' were quantified. The 'suggestions', however, involved specific ideas, of varying detail, which were inappropriate for quantification.

Data from the four interviews

The additional data from the four interviews was amalgamated into the survey data (n=18) (noting three overlapped)). Coding was completed for challenges as for the survey data. The suggestions for improvement were not coded but are reported descriptively.

Impact of low response rate on findings and data analysis

As the survey response rate was low (n=18/147, 12%), statistical data has only been used to add context to the thematic data. Similarly, the focus on policy and practice, and relatively few interviews, means the richer narratives usually associated with qualitative research (Mason, 2002) were minimal. For this reason, quotes are only used to add additional context.

Ethical issues

Approval was obtained from the Department of Sociological Studies ethics committee, at the University of Sheffield. All participants were guaranteed anonymity and no individual data about fabricators or victims of FII was collected. In addition, the Association of Independent LSCB Chairs agreed to contact the LSCB Chairs to invite them to participate in the study.

Findings

LSCB experience of FII cases and related training

Nine of the 19 responders indicated that in the last five years their board had discussed a case of FII, two had had a case in the local authority that had not been discussed by the board and three had had no experience of FII. Of the four interviewees, two had a lot of experience of FII and two had some experience of fabrication (one of these of fabricated accusations of abuse rather than of illness).

LSCBs experiences of FII training

Only nine of the valid survey responses indicated their LSCB had held *any* training on FII in the last five years, and only ten out of 17 were aware of the training package *Incredibly Caring*. Furthermore, when survey respondents were asked how well they believed different agencies collaborate in FII cases, a fairly low mean score of 1.77/4 (n=13) was given. These issues, when seen in combination, suggest improvements in training and collaboration are required.

Challenges identified by respondents

The main (twelve) overarching challenges expressed by the LSCB representatives, and the frequency of each, are listed in Figure 1. Those challenges (five) expressed only once or twice are not in the figure and are listed here; lack of independent oversight (2), controversy in the methods used to investigate FII (2), inappropriate electronic medical record systems (1), focus on cases involving serious physical harm (1), and child believes they were/are ill (1).

< FIGURE 1 here >

Seventeen challenges were recorded: the most frequently mentioned fall into four broad domains; training, issues for social care professionals, issues within medical systems and its interface with social care systems, and intrinsic difficulties in the nature of FII. Neither the challenges nor the domains are

mutually exclusive.

When survey respondents were asked how well FII is being identified within their local authority area, they gave a marginally positive mean score of 2.2/4 (n=14), implying current practice is acceptable, albeit with room for improvement. This raises the possibility that the high frequency of challenges may be partly a result of the methodology, which has highlighted concerns rather than offered an overall picture of how effectively children are being safeguarded from FII. This may be particularly pertinent to the number of times 'a lack of training' and 'inadequate inter-agency collaboration' were identified as challenges. At the time of this study, two of the key responsibilities of LSCBs were to facilitate and improve training and collaboration, therefore they were particularly likely to identify deficits in these areas.

Suggestions for improvement

The suggestions made by the respondents can be considered to fall into four broad domains. These are training, multi-agency collaboration/working, medical, and knowledge. There is overlap, for example, the suggestion about medical records falls within a medical domain as well as multi-agency collaboration, and knowledge of FII definitions and variations fits into the training domain as well as the knowledge domain.

Training

Given the challenges reported it is unsurprising that many of the LSCB representatives believed more training would improve practice. Specific recommendations on how this could be actioned were made: one LSCB representative (who was aware of the training resource *Incredibly Caring*) requested an updated training package; two suggested smaller 'bitesize' training packages would be useful for raising awareness; two noted that video case studies, of different forms of FII, with different outcomes, were a particularly effective form of training; and three suggested that 'bespoke' training for different professions would be beneficial, particularly for medical, education/school, social work, early help, and mental health staff.

Multi-agency collaboration

Another responsibility of the LSCBs was to facilitate multi-agency collaboration, and the LSCB representatives made numerous suggestions. Several of these were very large in their scope. For instance, three LSCB representatives suggested that a medical records system capable of alerting staff when a child has been brought to multiple hospitals would help identify potential FII sooner. Indeed, one relayed that their local authority is in the process of setting up a system capable of doing this.

Another suggestion was to create what one LSCB respondent called an 'identifiable national forum' of individuals who specialise in FII, which could facilitate 'multi-agency discussion' and 'provide support'. Given how frequently

'uncertainty' and 'anxiety' were considered a challenge, this could provide an additional focal point for guidance and support.

Several LSCB representatives stated that professionals working in education/schools are well-placed to observe and describe a child's actual physical condition, however, they are under-utilised during investigations. With this in mind, a way to 'triangulate' information was recommended: specifically, it was suggested medical and education/school staff exchange reports as part of a medical investigation into FII.

Medical

One suggestion in the medical domain explicitly recommended an adaptation to existing guidance – that when medical professionals can share information should be 'clarified'. Notably, though, the General Medical Council's (2018a) guidelines entitled 'Protecting children and young people' involves an entire section on when to share information against a caregiver's wishes, and states that 'If a child or young person is at risk of, or is suffering, abuse or neglect, it will usually be in their best interests to share information with the appropriate agency' (General Medical Council 2018a, section 37). As a different LSCB representative stated, then, it may be reasonable to conclude guidelines *are* adequate, it is only that 'knowledge of them is not'.

Two other suggestions concerned possible changes to practice in medical institutions, and again these would require action on a large scale. The first of

these was that medical records should customarily state what the caregiver reported, and the medical professional's analysis of this information, regardless of whether FII is suspected – the LSCB representative who stated this considered that currently too many records only state what action the medical professional has taken, and therefore do not show when a caregiver's reports do not correlate with medical analysis. The other suggestion was that recipients of complaints against medical professionals should not immediately apologise, as they felt currently tends to happen, but neither confirm nor deny any wrongdoing, and promise to investigate, thereby protecting staff who have legitimate concerns of abuse and have acted accordingly.

Lastly, it was noted by one LSCB representative that there is no 'Read Code' (an NHS medical terminology database) for FII. However, from 2018 to 2020 Read Codes are set to be replaced by 'SNOMED CT', an international database of a similar nature. This system includes 'Munchausen Syndrome by Proxy' (MSBP), a phrase also commonly used to denote FII, but which was described by one LSCB representative as an 'inappropriate' term. As such, this study suggests that 'FII' should replace 'Munchausen Syndrome by Proxy' on 'SNOMED CT'.

Knowledge of FII

Another two recommendations were focused on knowledge of FII. One of these was simple in principle – collating the nationwide number of section 47 enquiries where FII was considered and confirmed may assist in describing its epidemiology. The second was that a better understanding of FII, particularly regarding its definition and variations, would be useful for identifying and assessing it more effectively. As the LSCBs who identified this noted, though, this could risk distracting attention away from the key focus of any FII case – the needs of the abused child. Nevertheless, examples where parents had fabricated illness to excuse their child from school or were ‘overly-anxious’ about their child’s health, which were unduly escalated as FII, were relayed. Critically, though, the 2008 guidance (HM Government, 2008, p 32) explicitly states that fabricating illness solely to excuse a child from school is not FII (although it may denote another serious issue), and that an element of medical care for children is helping parents to manage their anxieties about their child.

Discussion

Challenges

The challenges identified by the responding chairs of the LSCBs suggest that safeguarding children from FII remains a difficult task for professionals.

It is important to note that three of the listed 17 challenges are effectively broader versions of issues identified in the existing literature. The first of these is “the variety of forms of, and motives for, FII”, which denotes the challenges arising from FII’s broad potential symptomology and the variation in motives

(specifically, the 'sick role by proxy', and 'Malingering By Proxy', and additionally a notion of 'over-anxious caregiving' arose in this study). Similarly, the 'drive for patient satisfaction' was incorporated into 'anxiety at the repercussions of reporting FII' as it is not a separate challenge, but a direction in health care considered likely to increase anxiety among professionals. Lastly, it was posited by an LSCB representative that a child may reasonably believe they are/were ill, therefore the 'child believes they are/were ill' is defined here as a challenge rather than a definition that explicitly refers to a diagnosis of a somatoform disorder presenting in a child.

The following seven challenges, however, were not recognised in the literature review: a 'lack of training' for professionals; 'inadequate time and resources' to properly investigate FII; 'inadequate inter-agency collaboration'; the 'rarity of FII', which, according to LSCB respondents for this study meant it is unlikely to be at the forefront of a professional's mind, and tended to be a low priority for local authorities; 'professionals not questioning presentations' often because, as one LSCB representative phrased it, they have been 'groomed' to support the abuser; 'too much evidence needed to take the case forward'; and a 'lack of independent oversight', specifically that, according to one LSCB respondent, was a problem due to the relative independence and isolation of 'early help' teams, and according to another, was a potential issue once LSCBs are abolished.

Insufficient training and poor inter-agency collaboration are logistical

challenges, inherently associated with policy, resources, and organisation, as indeed is 'inadequate time and resources'. The joint second most widely identified issues, however, 'anxiety at the repercussions of reporting FII' and 'uncertainty of the diagnosis', represent difficulties for the individual professionals who suspect FII. These two types of challenge may be intrinsically linked – as one LSCB representative stated, "It's not a matter of reluctance [to report FII], it is a matter of staff training, knowledge, skills and confidence". In other words, the best way to overcome uncertainty and anxiety may be through effective training and collaboration.

Suggestions for Improvements

Training

It is notable that just over 40% of respondents were not aware of *Incredibly Caring*. Only one of the 60% who was aware requested an updated training package. Two LSCB representatives praised video case studies. Considering that *Incredibly Caring* includes several video case-studies, an updated training package may not be necessary. However, 'bitesize' training opportunities may offer a way of training staff when time and resources are limited. This could be achieved by providers of broader training on safeguarding children including a section on FII, either by utilising appropriate sections of the *Incredibly Caring* materials or, if possible, by disseminating 'bitesize' materials derived from *Incredibly Caring* to training providers. This approach would not replace the need for more thorough training about FII for core professionals – rather, the

suggestion is that this method of training could spread awareness of FII on a wider scale and be tailored to different professions with greater ease.

Priority given to providing training about FII is likely to be determined by demand (and perceived need), in the context of other demands and the allocation of limited training resources. Given that FII is relatively uncommon, the demand for training may not be a high priority. However, across agencies it is worth considering that lack of training may result in less cases of FII being correctly identified and this may have an effect on the demand which may be less than is objectively warranted.

Multi-agency collaboration

With regard to the suggestion to exchange reports and consult with education/school staff, this would be undertaken in accordance with government guidance, and the professional's own guidance on consent and confidentiality, and their roles and responsibilities (HM Government, 2008, 2018). It is notable that if/when an assessment/section 47 enquiry has been initiated by local authority children's social care, both health and education/school staff should be involved. This study's findings draw attention to the benefit to the assessment process of triangulating the relevant knowledge and expertise of all professionals involved in a FII case, to provide a more complete assessment: As the *Working Together to Safeguard Children* statutory guidance states, "no single practitioner can have a full picture of a child's needs and circumstances ..." (HM Government, 2018, paragraph 16).

Further exploration of the suggestion to introduce a medical records system capable of alerting staff when a child has been presented to multiple hospitals is beyond the scope for this study. Nevertheless, it is worth noting that such a system could assist with overcoming the identified challenges of 'fractured care' and potentially with 'uncertainty of the diagnosis'.

The suggestion to create an 'identifiable national forum' of individuals who specialise in FII is laudable but would be a considerable undertaking. Issues such as the membership, how confidentiality would be maintained, and how it would be funded, remain challenges for the future.

Medical

The importance of clarifying when information may be shared by medical/health professionals, which is critical to multi-agency collaboration, was accompanied by an appreciation that it is already addressed in GMC guidance, raising the question of knowledge of the GMC guidance (General Medical Council, 2018a; 2018b). However, resolving professionals' anxieties about information sharing is likely to be more complicated than gaining knowledge alone, as illustrated by the issues discussed in the papers reviewed above. A key challenge is uncertainty about the diagnosis (perhaps more so in the absence of illness induction) with related concerns about the level of evidence and threshold for sharing, and the fractured nature of medical care and records. Some of these practice dilemmas are covered by the government guidance on FII. Medical

professionals were not the respondents for this study and further consideration would be beyond the scope of this study.

Respondents considered that medical records should contain details of caregiver reports (more) precisely as well as the medical staff's professional opinion. The GMC's advice to doctors is that medical records require 'relevant clinical findings' and 'the information given to patients' be recorded (General Medical Council, 2018b, section 21). Therefore, when reviewing the medical notes they should usually provide the required information about the presented condition of a child and the parallel clinical findings that may be critical to identifying FII. The identified problem of lack of or missing information seems to be one of detail and therefore length of records. The suggestion regarding handling of complaints (presumably in situations where there is at least some suspicion of fabrication) may be one for local procedures. Some local procedures may already require complaints to be handled in the suggested manner, with the initial neutral response likely to be helpful in an FII context. It is unclear whether these suggestions are measurable and to what extent they are already practiced, however, they serve to highlight two relevant issues.

Knowledge

The two suggestions about improving knowledge are very different. To collate information from section 47 enquiries nationally would require dedicated personnel and funding, although the findings could be extremely valuable. The second to improve understanding of FII, particularly regarding its definition and

variations, is a matter of education/training. As raised by one respondent the specific focus on FII should not distract from the needs of the child. With this in mind it is worth noting here that the concept of “significant harm” to the child (HM Government, 2008, p.38) is important in thinking about the threshold for FII involving fabrications/exaggerations without direct physical harm.

Strengths and Limitations

The invitation to chairs of the LSCBs to contribute to this study allowed those working in a key role with local authorities to respond with their experiences of the challenges of dealing with cases of FII across England. Their perspectives are valuable as they are unique and overarching, concerning both practice and training. Despite the low response-rate many of the challenges identified fitted with those identified in the literature, although some were worded differently, as well as adding others not previously reported. The low response rate means that it is difficult to state to what extent these findings are representative of a national view of the LSCBs’ perspectives, or the extent and efficacy of training. A useful number of suggestions for improvement were made by respondents; some concerned how training could best be delivered, while others were of such a large scale that they would require major national initiatives to implement.

Conclusion

This study considers a range of challenges to identifying, assessing, and intervening in FII as reported by survey respondents from LSCBs. The response rate from invited LSCBs was disappointing. Some reported challenges were the same as those identified in earlier literature and some were new. Particular areas highlighted include lack of training, issues for individual professionals, the role of medical systems especially regarding inter-agency collaboration, and the nature of FII (variety and rarity). Suggestions made by respondents addressed these areas, especially for more training in various forms. There were also suggestions for medical professionals who were not represented in the respondents. The importance of familiarity with existing government guidance on FII, and also specifically for doctors the guidance on confidentiality and child safeguarding were highlighted. The infrequent provision of local training and lack of knowledge of the Government commissioned training materials, 'Incredibly Caring' issued in 2008, was perhaps surprising given the reported challenge of lack of training and suggestions for more training about FII. This seems to invite the strengthening of efforts in training as one way to safeguard children from the physical and psychological impacts of having illness fabricated or induced.

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Challenges reported by LSCBs (number of times reported)	Suggestions made by LSCBs
Training (11) Lack of training	Training Updated training package Bitesize training Include video case studies Bespoke training for different professionals
Issues for professionals (10) Anxiety at repercussions of reporting (3) Too much evidence required to take forward (4) Professionals not questioning presentations (8) Inadequate time and resources	See training
Medical & multi-agency interface (10) Uncertainty of diagnosis (7) Inadequate inter-agency collaboration (4) Limited access to complete records (4) Fractured care	Medical Record caregiver report more clearly in medical records as well as medical analysis and opinion. Medical records system able to alert staff Consider Read / SNOWMED code of FII
	Multi-agency interface Clarify when medics can share information Identifiable national forum More use of school to triangulate information
Knowledge (9) Variety & forms of FII (5) Rarity of FII (4) Impact of the internet	Knowledge Update epidemiology with section 47 collation Definitions and variations to be clarified

Figure 1. Challenges and suggestions made by LSCBs