Fabricated induced illness – an epidemic of unfounded allegations?

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Family Law

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Within the last 18 months, I have seen an escalation in families becoming subject to child safeguarding proceedings; the largest accusation by far being 'Fabricating or Inducing Illness', now known as 'FII', formerly Munchausen's and Munchausen's by proxy.

Early references and descriptions of FII reflected an active promotion of a 'sick role' by exaggeration, failing to obtain treatment for real problems, fabricating or falsifying signs, and/or the induction of illness. Beverley Allitt, a nurse who was convicted of murder in 1991, is frequently cited as an example of this type of child abuse and crime.

In reality, the incidence and prevalence of FII has been considered to be rare and studies carried out in 1996 and 2000 sought to determine the epidemiology of FII within the UK and Republic of Ireland. The 1996 study estimated the combined incidence in children under 16 years, was 0.5 per 100,000 and, for children under 1 year, at least 2.8 per 100,000. The authors calculated that in a hypothetical district of one million inhabitants, 'The expected incidence would be approximately one child per year'. The later study, in 2000, estimated a rise in number of 89 confirmed cases of FII, per 100,000, over a two year period. In conclusion, it was agreed that health and social care practitioners are likely to encounter very few confirmed cases during their careers, although they would raise concerns about many cases which would ultimately be disproven or be found inconclusive.

As a former detective, working in a safeguarding team, I investigated and provided evidence resulting in the conviction of only 2 individuals of Munchausen's by proxy, in my entire 20 years. The current impact of escalating numbers of referrals to the courts and families and the child/ren who become enmeshed within the process, is therefore a matter of great concern.

Casework

In the last 2 years, I have received in excess of twenty calls from families who, having called upon the statutory bodies for help, have been accused of FII, overtly or covertly and in 98% of the cases, the children are independently diagnosed with Autistic spectrum conditions and associated disorders. It may be that lack of social care funding is fuelling an epidemic of safeguarding allegations. FII is so broad and unspecific that cases frequently drag on for years, leaving families stigmatised, isolated and without support.

Commonly, the FII cases reported to me display five consistent factors:

1. Parents are inexperienced/divorced/separated/single.

2. Parent/s are educationally intelligent and/or professionals.

3. A worker who is unqualified to do so, presents a diagnosis of mental illness or disorder in the mother.

4. The parent (frequently mother) has alleged perplexing presentations, disturbing or challenging behaviour in their child/ren which is disputed by professionals who see the child/ren frequently ie school or social care and/or health.

5. Parent (frequently mother) dares to challenge or make complaints regarding the professionals involved with assessments or treatment of the child/ren.

Families often come to me as a last resort, when they have exhausted all lines of enquiry and have been unable to find an expert who is not only willing, but competent, to challenge the might of the safeguarding process and, if necessary, call into question the ensuing family court proceedings.

The role of local authorities

The interim report of the Public Law working group (2019) (www.judiciary.uk/related-offices-and-bodies), highlighted the steep rise in the issue of public law proceedings. One explanation referred to the apparent development of the local authority's 'risk-aversive' culture, resulting in cases, previously dealt with by local authorities outside of court, now being brought before the court.

It is no secret that local authorities are struggling economically. They are dramatically cutting budgets and mandatory training is being rolled out in the least expensive way, often e-learning or using in-house trainers who have no or very little direct experience of conducting investigations. The absence of independent scrutiny and sometimes haphazard supervision has, in some places, encouraged the growth of poor practice which can risk being less about family needs and more about safeguarding the practitioner or the authority's purse. The 'working group' highlighted this particular aspect,

> '. . . the balance of inexperienced social worker and managers with well-established and authoritative legal advisors has created a position where there has been a tilt away from positive strengths-based practice and move towards a rigid interpretation of threshold and an assumption that if threshold is met the most draconian action is required, even before all support has been adequately explored . . . '

Sir James Munby has, throughout his career, spoken out about the draconian and abusive nature of removing children from their parents unless there is risk of imminent and immediate danger. My experience of FII allegations and court proceedings has led me to suspect cash-strapped local authorities are seeking to avoid incurring the costs of providing adequate and/or appropriate care and support plans for children and young adults in need. (Once the allegation is made, the better-funded fostering and adoption options come into play and the local authority is able to avoid accepting responsibility for the child/ren and/or fulfilling their duty to meet those needs).

So how can families challenge the might of a local authority when they sincerely believe this applies to them? The families I have encountered have, without exception, reported how their 'challenge' of decisions has resulted in the safeguarding process being triggered, FII being cited as the rationale behind 'concerns'. Another key issue appears to be a wide variance in an acceptance of experts in the process and this has left families feeling helpless and hopeless.

Out of the numerous families with whom I have worked, I have selected two anonymised examples which are fairly typical.

1. Family A

Parents intelligent/professionals, contacted health and social care asking for help and support, regarding their daughter from age 5 years (albeit they had concerns from age 9 months). Their daughter displayed self-harming and aggressive behaviours towards self, family and friends, poor hand eye co-ordination, delayed speech, violent

outbursts, incontinence, inappropriate sexualised behaviour, high intellectual functioning and poor social skills. The family suspected she had an Autistic condition.

They were told the concerns were unobserved and fabricated. They asked for a second opinion and complained that the paediatrician was rude and dismissive, arguing he had spent too little time assessing their daughter and failed to accurately record her behaviour during the appointment. The hospital reported suspected FII to the local authority children's services. The family endured in excess of 6 years of social care interventions with 'threats' to remove their child, although this never actually occurred. The parents' marriage failed with the stress. The mother has a history of childhood abuse and was assessed as having mental health issues, by a newly-qualified, children and families' social worker.

After the family instructed me as an independent safeguarding expert, I provided evidence to demonstrate there were insufficient grounds to substantiate any form of abuse by the parents and questioned the behaviour of the professionals, which in my opinion was abusive and sincerely wrong. Eventually, after a protracted battle, a judge accepted that the evidence of experts should be allowed and directed the local authority to close the safeguarding investigation. The family, however, have never been officially exonerated by the local authority and because they live in fear of it happening again are now seeking Judicial Review. The child has been formally diagnosed as having Asperger's Syndrome.

2. Family B

Young newly married couple, both parents educated professionals. They had a baby, 8 weeks premature, and due to him failing to gain weight as quickly as expected, he was readmitted to hospital for observation. During the readmission, a serious medical error occurred which would have led to the death of the baby had the nurses not intervened. Parents made a complaint. Within days of the incident, staff began to covertly report concerns of FII. A senior paediatrician raised the alarm 1 month later when she alleged she had collated evidence which proved the parents were fabricating and reporting 'unexplained medical symptoms' and a nurse alleged that mother had tampered with the baby's feeding device, on three occasions within a 24 hour period.

A s 47, Children Act 1989, child safeguarding enquiry began. The local authority and hospital trust took the case to family court and a care order was granted. Seven months later, an independent medical expert was instructed by the court who concluded the non-existence of FII.

After a subject access request, the family discovered that there was no factual evidence to support any of the allegations presented to the court and there was a failure to adhere to a disclosure order issued by the court. They requested an independent enquiry and the local authority agreed on the proviso they used a company of their choosing (the company later turned out to be linked to the council via their adoption and fostering team and were, in fact, responsible for writing the council's FII guidance). As a result, the family argued a conflict of interest and at that point, I was instructed. Although I was able to outline and identify flaws in the evidence used to substantiate the FII allegation and breaches by the trust and local authority to follow due process, the family were never officially exonerated by the local authority and they live in fear of it starting all over again.

Outcomes

My assessments have led me to identify emerging patterns and I would suggest some local authorities are not equipping practitioners to fully understand the needs of families or signposting them to other appropriate pathways and services. It usually takes interventions such as mine for the local authority to redefine its cause for concern from significant harm to a 'child in need', at which point they seek to provide the services which were initially requested by the parent/s.

Conclusion

The Royal College of Paediatrics and Child Health guidance (www.rcpch.ac.uk) and government guidance, *Safeguarding children in whom illness is fabricated or induced* (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf) both agree that the existing guidance regarding FII is overdue for review, particularly as the listed indicators do not support expert opinion regarding perplexing presentations in children with Autism spectrum conditions and/or other associated conditions. Nor does it take into account a large number of parents, never formally diagnosed with disorders themselves, who may have increased anxiety when they observe unusual behaviours in their child/ren. In these circumstances, what they in fact require is objective and sympathetic support from professionals, who are trained and experienced in this field, not condemnation and unfounded judgement.

After all, families depend upon education, health and social care to attend to their cries for help, in a positive and constructive way. Many get this right but many, perhaps due to funding pressure, do not.

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