

A new name for Munchausen Syndrome by Proxy: Defining Fabricated or Induced Illness by Carers

Ellen Fish, Leah Bromfield and Daryl Higgins

The deliberate production or fabrication of physical or psychological symptoms in a child by a parent or carer is defined as "Fabricated or Induced Illness by Carers" (FIIC). Professionals typically begin to suspect that a carer has fabricated or induced an illness in their child when children are repeatedly presented to medical practitioners or hospitals with difficult to explain illness symptoms. The authors describe this somewhat controversial phenomenon and explore some implications of FIIC for practitioners working to protect children from harm.

Background to the paper

Since mid-2004 the National Child Protection Clearinghouse has had several queries in relation to Munchausen Syndrome by Proxy (MSbP). Issues associated with MSbP were also popular among discussants on the Clearinghouse's "childprotect" email discussion group. Issues raised included: whether MSbP was the most accurate terminology to describe cases in which parents were alleged to have fabricated or induced illness in their child; the association between MSbP and multiple unexplained deaths, in particular in relation to Meadow's Law; and the implications for MSbP of Roy Meadow being struck off the General Medical Register. In addition, several court cases were raised as having implications for bringing MSbP cases before the court with a particular focus on the evidence of expert witnesses. There appeared to be much confusion among practitioners about how recent events would impact upon their ability to intervene in cases in which a parent or caregiver had allegedly fabricated or induced an illness for a child.

The aim of this paper is to provide an update on Fabricated or Induced Illness by Carers (formerly MSbP), with a focus on definitional issues of relevance to child protection practitioners. Specifically, this paper will describe: what Fabricated or Induced Illness by Carers (FIIC) is and the history of the phenomenon, including an update Roy Meadow and the current preferred terminology. Given the controversy surrounding the phenomenon, a discussion is presented on whether FIIC exists and its prevalence. The perspectives of the different disciplines involved in FIIC cases are described along with some indicators of how FIIC might present and the characteristics of caregivers who have been found to have fabricated or induced illness in their children. A brief discussion presented on the relationship between FIIC and multiple unexplained deaths and some pertinent legal issues associated with finding that a caregiver has fabricated or induced an illness are discussed. Finally, the paper is closed with a summary discussion on the usefulness of the label FIIC for protecting children from harm in the context of statutory child protection services.

Join the National Child Protection Clearinghouse mailing list

To join the National Child Protection Clearinghouse mailing list please go to the following website and fill out the online form:

www.aifs.gov.au/nch/nchmailform.html



Australian Government

Australian Institute of Family Studies
National Child Protection Clearinghouse

The National Child Protection Clearinghouse has operated from the Australian Institute of Family Studies since 1995. The Clearinghouse is funded by the Australian Government Department of Family and Community Services as part of its response to child abuse and neglect. The Clearinghouse collects, produces and distributes information and resources, conducts research, and offers specialist advice on the latest developments in child abuse prevention, child protection, and associated family violence.

Contents

What is Fabricated or Induced Illness by Carers?	2
The history of Munchausen Syndrome by Proxy	2
Update on “MSbP” and Roy Meadow	2
Does FIIC exist?	3
A new name for MSbP	4
What is the focus of the different disciplines?	4
How does FIIC present?	5
What are the characteristics of parents who fabricate or induce illness in their children?	5
Is FIIC related to multiple unexplained, unnatural deaths?	6
What are the legal issues?	6
How useful is the FIIC label for protecting children from harm?	10
References	11

The authors

Ellen Fish is a Writer/Editor for the National Child Protection Clearinghouse and Editor with the Publishing Unit at the Australian Institute of Family Studies.

Leah Bromfield is a Research Fellow and Assistant Manager of the National Child Protection Clearinghouse at the Australian Institute of Family Studies.

Daryl Higgins is a Senior Research Fellow and General Manager of Research at the Australian Institute of Family Studies.

Acknowledgements

The authors would like to thank the following people for their valuable suggestions and contributions to this article:

Judge Jennifer Coate, President, Children’s Court of Victoria.

Dr Anne Smith, Paediatrician, The Gatehouse, Royal Children’s Hospital, Melbourne.

Dr Lynda Campbell, Coordinator, Bachelor of Social Work Program and Convenor, Children, Young People and Families Research Unit, School of Social Work, University of Melbourne.

Professor Dorothy Scott, Director of the Australian Centre for Child Protection, University of South Australia.

Associate Professor Judy Cashmore, Honorary Research Associate, SPRC, University of New South Wales.

Dr Arnold Smith, Gastroenterologist, Royal Children’s Hospital, Melbourne.

Child Abuse Prevention Issues series

Child Abuse Prevention Issues are refereed papers.

Editor of the *Child Abuse Prevention Issues* series is Dr Daryl Higgins, Manager, National Child Protection Clearinghouse.

They are edited by Ellen Fish, Writer/Editor, National Child Protection Clearinghouse.

For a complete list and the full text of the papers in the *Child Abuse Prevention Issues* series, visit the NCPC website at www.aifs.gov.au

© Australian Institute of Family Studies – Commonwealth of Australia 2005.

Views expressed in Clearinghouse publications are those of individual authors and may not necessarily reflect Government, Institute or Clearinghouse policy.

Australian Institute of Family Studies
300 Queen Street, Melbourne 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839
Email: ncpc@aifs.gov.au Internet: www.aifs.gov.au

Designed by Double Jay Graphic Design, Printed by Almar Press

ISBN 0 642 395 322
ISSN 1446-9995 (Print) ISSN 1447-0004 (Online)
Print Post Approved PP349181/00604



What is Fabricated or Induced Illness by Carers?

The deliberate production or fabrication of physical or psychological symptoms in a child by a parent or carer is defined as “Fabricated or Induced Illness by Carers” (FIIC). This phenomenon was previously known as “Munchausen Syndrome by Proxy” (MSbP) (Pritchard 2004; Royal College of Paediatrics and Child Health 2002; Wilson 2001). Fabricated or Induced Illness by Carers has also been referred to as Munchausen by Proxy; Munchausen by Proxy Syndrome; Meadow’s Syndrome; Factitious Disorder by Proxy; and Fictitious Disorder by Proxy.

The history of Munchausen Syndrome by Proxy

Munchausen Syndrome was named after a German cavalry officer Baron von Munchausen (1720-1797), a man who travelled widely and was known for his dramatic but untruthful stories. In 1951 Richard Asher described a pattern of self-abuse, where individuals fabricated histories of illness. These fabrications most often led to complex medical investigations, hospitalisations, and needless surgery. Remembering Baron von Munchausen and his mythical tales, Asher named this condition Munchausen Syndrome.

Munchausen Syndrome by Proxy, often referred to as MSbP, is a term coined by paediatrician Professor Roy Meadow in 1977. The term refers to the circumstance where the child is the subject of the fabrication of an illness by the parent. It was thought that the parent “with MSbP” was motivated by trying to gain attention from medical professionals by inducing or fabricating the sickness in their child. In Meadow’s first article, he explored two case studies of children admitted to hospital with illnesses thought to be fabricated or induced by their carers: “These two [parents] flourished there [in the hospital] as if they belonged, and thrived on the attention that staff gave to them ... In these cases, it was as if the parents were using the children to get themselves into the sheltered environment of a children’s ward surrounded by friendly staff” (Meadow 1977: 344-345). The emphasis on the motivation of the parent or carer was tied to the classic definition of Munchausen Syndrome by Proxy. Most of the literature until recently has focused on the medical diagnosis of the *syndrome* MSbP (Meadow 1982, 1984, 1985; Rosenberg 1987).

Update on “MSbP” and Roy Meadow

The older “Munchausen Syndrome by Proxy” label is now undergoing intense scrutiny worldwide. MSbP as a

syndrome diagnosis and “Meadow’s Law” have been called into question in recent criminal court cases. This scrutiny began in the United Kingdom.

Meadow gave evidence in three high-profile child murder trials. His “expert testimony” in these trials meant that some mothers were convicted and children removed from their families and taken into out-of-home care because they were seen as “at risk” (Hayward-Brown 2004: 33).

On 21 June 2005, Professor Roy Meadow appeared before the Fitness to Practise Panel with a charge of “Alleged Serious Professional Misconduct”. The Panel inquired into the allegation about Roy Meadow’s engagement as an expert by the Cheshire Police, where he assisted them in their investigation into the deaths of two children. On 15 July 2005, Roy Meadow was struck off the General Medical Register as a result of the evidence he gave during the Sally Clark child murders trial. Notably, in the case of *R v Sally Clark*, Meadow testified that the chance of two children dying of sudden infant death in an affluent family is 73 million to one (BBC MMV 2005). The Register panel found him guilty of “serious professional misconduct” and concluded that he had “abused his position as a doctor” by giving evidence which was misleading (General Medical Council, 2005)

The overturning of the conviction of Sally Clark on appeal, and other high-profile acquittals have created doubt about Meadow’s evidence regarding MSbP as a diagnosis and the use of Meadow’s Law in evidence regarding unexplained multiple child deaths in a family.

Does FIIC exist?

There are significant differences of opinion on whether Munchausen Syndrome by Proxy exists, however there is evidence that the pattern of behaviours described by the label “Fabricated or Induced Illness by Carers” does exist. There is video surveillance that has demonstrated that there are some parents who harm their children and then present the child as having an unexplained medical condition and who consent to, and indeed pursue, unneeded medical procedures (Southall, Plunkett, Banks, Falkov and Samuels 1997). Paediatric research has also demonstrated that there are some children admitted to hospital paediatric and emergency wards apparently suffering from an unexplained illness that is subsequently found to have been caused by the child’s parent or caregiver (Meadow 1977).

Fabricated or Induced Illness by Carers does exist, that is, some carers do fabricate or induce illness in children. The central definitional issue is whether or not carers who fabricate or induce illness in children have the personality profile “MSbP” (Lasher and Sheridan 2004; Hayward-Brown 2004), and whether assigning a carer a syndrome label such as FIIC or MSbP is sufficient to demonstrate protective concerns about the child.

Munchausen Syndrome by Proxy has never been listed in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association as a clinically diagnosable personality or psychiatric disorder. “Factitious Disorder by Proxy” is listed in the DSM-IV (the fourth edition of the manual, which is the current edition) in the appendix as a topic or classification for further study, but it is not yet recognised as a clinical condition (American Psychiatric Association 2004).

Thus, in cases in which a carer is found to have fabricated or induced illness in a child it is not accurate to say that the carer had a personality disorder or mental illness called “MSbP”, because as yet, it has not been recognised as part of DSM-IV, the most widely recognised classification system of mental disorders.

Rate of Fabricated or Induced Illness by Carers. The following statistics are a snapshot of the rate of Fabricated or Induced Illness by Carers both internationally and in Australia in recent years:

- An estimated six hundred cases of two forms of MSbP (suffocation and non accidental poisoning) were estimated to occur in the United States in 1996 (Ayoub et al. 2002);
- Eighteen reported cases per annum were reported in New Zealand (Denny et al. 2001 cited in Pritchard 2004);
- About fifty cases a year were reported in the UK (Meadow 1994 cited in Pritchard 2004);

- What has been known as MSbP has been reported as occurring in 24 different countries (Feldman and Brown 2002, cited in Pritchard 2004).
- An estimate from one Australian study was an annual rate of between 15.2 and 24.5 cases (Tait, Donal, Moran, Jureidini and Schreier 2004).

The small numbers reported in available statistics internationally and nationally appear to point to the rarity of Fabricated or Induced Illness by Carers when compared with other child maltreatment sub-types.

Key message:

In brief, Fabricated or Induced Illness by Carers *does* exist. However, the personality disorder MSbP does *not* currently exist as a formally recognised mental disorder for the purposes of clinical diagnosis.

Fabricated or Induced Illness by Carers is relatively rare but this should not undermine or minimise its serious nature or the need for practitioners to be able to identify when parents or carers are fabricating or inducing illness in children.

A new name for MSbP

The term *Fabricated or Induced Illness by Carers* is gaining popular use: it was coined in the United Kingdom when the Royal College of Paediatricians and Child Health recommended that the syndrome be re-categorised as *Fabricated or Induced Illness by Carers* (FIIC) (Royal College of Paediatrics and Child Health 2002). This label – preferred by the National Child Protection Clearinghouse – is seen as being more accurate than Munchausen Syndrome by Proxy as it describes a *pattern of behaviour* rather than an underlying *psychiatric syndrome* (Pritchard 2004; Royal College of Paediatrics and Child Health 2002; Craft and Hall 2004).

What is the focus of the different disciplines?

The issue of Fabricated or Induced Illness by Carers has been addressed differently within different fields:

Paediatrics is concerned with children's wellbeing, focusing on why some children present with unexplained injuries, and inconsistent symptoms. Paediatricians seek to explain why these children keep coming to their attention with illnesses and injuries (see Meadows, 1977).

Psychiatry (and to some extent psychology) is concerned with diagnosing and treating mental illness. Psychiatry is trying to explain why some parents intentionally fabricate illnesses in their children, or harm them in order to mimic symptoms of recognised illnesses so that appropriate treatment may be given the parent to reduce this behaviour.

The *judiciary* is concerned: (a) in criminal cases where a carer has been charged with a criminal offence(s), evidence of the acts which constitute the offence(s) and the intention of the accused who is alleged to have perpetrated those acts; or (b) in child protection cases with evidence as to whether a child has been harmed or is at risk of harm and is in need of protection as a consequence of a caregiver's actions.

The role of *social work* is to provide individuals and families in need with social services to prevent or ameliorate difficulties that might occur or have occurred because a parent has fabricated or induced illness in a child.

Child protection combines a legal and social work perspective – that is, child protection workers operate within a legislative framework and may use the court to ensure the safety of a child who has experienced, or is at risk of a caregiver fabricating or inducing an illness in that child. However, child protection workers also draw on the principles of social work to focus on the needs of families.

Key message:

Practitioners need to be aware of different perspectives when making decisions and dealing with professionals from different disciplines who may be involved in a case. The various perspectives may each make a contribution to the wellbeing of the child and the parent.

How does FIIC present?

Children who *are* subjected to Fabricated or Induced Illness by Carers may be taken to hospital or a medical practitioner and present with symptoms that are induced (for example breathlessness or choking caused by suffocation) or fabricated (for example, fictitious seizures).

The outcomes for children are on a spectrum of mild to severe harm and in extreme cases FIIC may result in child death. The different behaviours of the carer could be categorised according to the traditional maltreatment sub-types - physical abuse, emotional abuse and neglect. However, there are characteristics of Fabricated or Induced Illness by Carers not shared by other maltreatment sub-types. For this reason, some authors argue that FIIC should be considered as a separate maltreatment sub-type (Lasher and Sheridan 2004).

Carers who fabricate or induce illness in children may cause or place children at risk of: (1) physical or psychological harm as a consequence of the carer's behaviour (for example, poisoning), and failure to provide a nurturing environment to meet the child's emotional and developmental needs; or (2) physical or psychological harm as a consequence of unnecessary medical intervention (for example, unnecessary surgery, psychological assessment, medication or hospitalisation).

What are the characteristics of parents who fabricate or induce illness in their children?

Research has shown that Fabricated or Induced Illness by Carers is typically carried out by women, specifically mothers (95 per cent) (Pritchard 2004; 63), although there have been cases where fathers, foster or adoptive parents, or other carers have been involved (Sanders and Bursch 2002). This may be more a reflection of the disproportionate number of women relative to men who are the primary carer for a child, than a true gender difference in these types of behaviours directed towards children (Pritchard 2004).

Common characteristics of parents or carers who fabricate or induce illness in children have been identified. Caution should be applied in using these characteristics as many of the characteristics are also true of many parents (for example, they are usually the child's primary caregiver, often present initially as "good" carers, may appear to be overanxious, overprotective, mistaken or deluded). These characteristics should not be used to confirm or deny the existence of FIIC. The identification of characteristics consistent with parents or carers fabricating or inducing illness in children may add to suspicions during the investigation process, but do not constitute a profile (Lasher and Sheridan 2004). Furthermore a profile cannot be used as evidence in court cases.

With these limitations in mind, the following characteristics may be present (in some combination) in those carers who fabricate or induce illness in children:

- they are usually the child's primary caregiver;
- they often present initially as "good" carers;
- they are usually accomplished liars and manipulators;
- they are usually the only ones consistently present or associated with the onset of the child's symptoms (when the carers are absent, symptoms or illnesses are not reported or may begin to improve);
- they may have a history of self-induced symptom/illness exaggeration, falsification or induction;
- they may have mental health evaluations indicating they are "normal";
- they may have no prior involvement with child protection services:

- they may appear to be overanxious, overprotective, mistaken or deluded;
- they may have a background in the health profession or an unusual degree of knowledge about health; and
- they may seek publicity or attention from a variety of people.

These parents or carers do not necessarily stop their behaviour towards the child when under suspicion or caught, but may change tactics by:

- changing health professionals;
- denying all or part of what they have done, even when there is overwhelming evidence; and
- accusing their accusers, and shifting blame onto those who are aware of their behaviour (Lasher and Sheridan 2004; Dr Arnold Smith, personal communication, 24 May 2005).

Is FIIC related to multiple unexplained, unnatural deaths?

Fabricated or induced illness by carers has been linked to unexplained, unnatural deaths, and in particular to multiple, unnatural deaths in a family, primarily through Roy Meadow who, in addition to his contribution to the field in the area of MSbP, also coined what became known as “Meadow’s Law”. Ongoing research into mothers who have killed their children, shows that apart from the women who had some psychotic breakdown at the time of serious injury or killing of their child, a significant number of women demonstrated a pattern of behaviours consistent with the definition of FIIC (Stroud 2003, cited in Pritchard 2004). Meadows has acted as an expert witness in criminal cases where mothers have been accused of infanticide, using his much quoted (and since disputed) “Meadow’s Law” – “one cot death is a tragedy, two is suspicious, and three is murder” (Meadow 1997). The inference underlying “Meadow’s Law” is that a parent in families in which there are multiple unexplained deaths, fabricated or induced an illness in their child and this resulted in their child’s death. Carpenter and colleagues (2005) conducted the largest follow-up study of families who had a sudden unexpected and unexplained infant death (for example, SIDS). The authors of this study reported that “the occurrence of a second or third sudden unexpected death in infancy within a family, although relatively rare, [was] in most cases from natural causes” (p. 34).

On the basis of research available it would appear that there are many potential causes of multiple child deaths in a family and it may not be possible to discover the truth in every case:

- some children may die as a consequence of an unidentified genetic disorder, illness or disease;
- some children may die as a consequence of maltreatment other than Fabricated or Induced Illness by Carers (for example, a parent smothering an infant and claiming that the child died while sleeping); and
- some children die as a consequence of the carer inducing or fabricating an illness.

Caution should be taken in applying dogmatic rules such as Meadow’s Law. Medical science is constantly progressing and subsequent research may enable the identification of conditions that are currently unexplained (Priddis 2004).

What are the legal issues?

Prior to discussing the specific legal issues for FIIC that have arisen as a result of recent court cases, there is some legal background knowledge that child protection practitioners should be aware of before taking cases involving Fabricated or Induced Illness by Carers to court.

It is important to distinguish between criminal trials and child protection hearings. The focus of a criminal trial is the hearing of criminal charge or charges against a person who is alleged to have committed a crime or crimes. In such a trial, the onus is on the prosecution to prove that the accused person committed certain acts, and committed those acts with criminal intent. The proving of criminal intent is essential to the criminal trial. In child protection hearings, the focus of the hearing is whether or not a child is in need of protection. In such a hearing, the onus is on the child

protection authority to prove that a parent or carer has done or failed to do certain acts and as a consequence, a child has suffered or is likely to suffer some form of harm. Unlike the focus on intention in the criminal trial, the intention of the carer or parent is often not particularly relevant.

Standards of proof

Different legal proceedings, not only have different aims but different rules of evidence, and different standards of proof. The rules of evidence in criminal trials are far stricter than those applied in child protection hearings.

To prove a criminal case, the prosecution must produce evidence that establishes the guilt of the accused on the standard of proof known as “beyond reasonable doubt”. In *child protection cases*, the standard of proof applied to the evidence is the lesser standard, that is “on the balance of probabilities”. Thus, evidence about Fabricated or Induced Illness by Carers is likely to be treated vastly differently in the two types of courts because of their differing aims and standards of proof.

Australian Children’s Courts applying the lower standard of proof in care and protection proceedings may take into account relevant findings from previous criminal proceedings if presented to them in the court hearing. Statements on the law however, made in the course of a criminal trial where MSbP (or FIIC) was raised as an issue, may not be relevant in the very different arena of child protection proceedings.

Evidence

Evidence usually fall into three broad categories: (1) *direct evidence*, that is, what has been seen or heard or acquired or experienced through the senses by the witness; (2) *real or physical evidence*, which may constitute objects such as documents, photographs, videos, diaries, reports, or x rays; and (3) *opinion evidence*, that is evidence which contains the opinion of the witness in circumstances where it is established that there is a recognised body of relevant learning, outside the experience of ordinary men and women in which the proposed witness holds relevant qualifications.

Grounds for intervention

In each Australian state or territory legislation outlines the grounds on which care and protection proceedings are usually brought before the court. Although the legislation differs slightly between jurisdictions, there are broad similarities. The statutory child protection authorities are mandated to respond where a carer’s act of omission or commission has caused the child to be harmed: physically, emotionally, or psychologically. This includes acts of physical abuse, sexual abuse, psychological abuse, and neglect (Bromfield and Higgins 2005).

Cases in which it is alleged that a carer has put a child at risk by fabricating or inducing an illness in their child may be brought before the court supported by direct evidence of acts which back up such assertions. It would usually be essential that such cases would be supported by the opinion of a suitably qualified expert both as to the interpretation of the asserted acts and the consequent risk or risks to the child.

Key message:

Care and protection proceedings in which it is alleged a child is at risk of harm because a carer has fabricated or induced an illness in their child may be brought before the court using the grounds for intervention set out in each state or territory’s legislation. The actual grounds used must relate to the individual facts in the case and the risks those facts pose for the child who is the subject of the application.

Recent cases associated with Meadow’s Law or FIIC/MSbP

There are a small number of recent criminal cases that have led people to question the likelihood that any courts will hear cases in which it is alleged that a parent has fabricated or induced an illness in their child, in particular where this case is made on the basis of expert testimony rather than direct evidence. Cases heard in the UK Criminal Appeals Court in relation to testimony by Roy

Meadow on the basis of “Meadow’s Law” also appear to have contributed towards confusion over the use of expert witnesses. Three recent cases that have been associated with MSbP or Meadow’s Law are highlighted in Box 1 and the pertinent findings described. Of note, *some* courts are now taking a more cautious approach to expert testimony in criminal cases where FIIC is the issue and in some criminal appeals cases (particularly those in the UK concerning Meadow’s Law) courts have criticised experts who have given dogmatic evidence.

Box 1. Recent cases associated with FIIC or Meadow’s Law

In the *United Kingdom*, Criminal Appeal Courts:

R v Sally Clark [2003] EWCA Crim 1020, 11 April

- In the case of R v Sally Clark, Meadow testified that the chance of two children dying of sudden infant death in an affluent family is 73 million to one (BBC MMV 2005). It was found that Meadows’ description of the research oversimplified the findings of a key report (see paragraphs 94-103, especially 101-103).
- This case resulted in Meadow being called before the General Medical Council and he was subsequently struck off (General Medical Council, 2005).

R v Angela Cannings [2004] EWCA Crim 1, 19 January

- The presumption that multiple deaths in the same family indicates the cause was not natural (“Meadow’s law”) is too dogmatic, particularly when the aetiology of SIDS is still not fully understood (see paragraph 20)
- The inference that if the child was apparently healthy (when seen) a very short time before the death, then the death was not due to natural causes, is also inappropriate (see paragraphs 150-152)
- The inference that a history of apparent life threatening events (ALTEs) without demonstrable medical cause means a subsequent unexplained death is not natural is also inappropriate (see paragraphs 153-6)
- If such events only occurred when the person is alone with their children, that may lend some weight to the suggestion that there was foul play, but this weight is not overwhelming (see paragraph 157)
- Future research may change the understanding of these deaths. The position of the court is that findings from research are not set in stone, that SIDS is imperfectly understood, and that keeping tabs on future research is needed. In other words, the courts hope that genetic causes may become clearer. (see paragraph 22)

In *Australia*, the Supreme Court of Queensland, Court of Criminal Appeal:

R v LM [2004] QCA 192

- In R v LM [2004] the court held that there is no distinguishing feature for Munchausen Syndrome by Proxy, and that it is “not a diagnosis of a recognised medical condition, disorder or syndrome” but rather a pattern of behaviour to which a label had been given. Thus, there was no value in presenting an expert witness to the court simply to give evidence on what MSbP was, or an opinion that a person suffered from it. (See paragraphs 67-68, 71 and 97).
- The appeal judges noted that at the initial trial, the accuracy of what was depicted in the tapes was not in dispute. (see paragraph 87)

Key message:

In Australia, the Supreme Court of Queensland, Court of Criminal Appeal found that Munchausen Syndrome by Proxy was not a diagnosis of a recognised medical condition, disorder or syndrome, and therefore there was no value in presenting an expert witness in a criminal trial simply to give evidence on what MSbP is, or an opinion that a person suffers from it. It should be noted that this decision may have limited application to child protection matters.

A Children's Court Perspective on MSbP and FIIC

In an interview with the National Child Protection Clearinghouse Judge Jennifer Coate, President of the Children's Court of Victoria responded to some questions about Munchausen Syndrome By Proxy and Fabricated or Induced Illness by Carers. An edited excerpt from this interview is presented in Box 2.

Box 2. Interview with Judge Coate: A children's court perspective

What does the Children's Court consider as evidence in cases involving FIIC?

Judge Coate: What evidence is before the Court is a matter for each of the parties to the hearing. In an adversarial system like ours, the court does not make decisions about what evidence is to be produced. The Court's role is to make decisions about whether or not the party bearing the onus of proof has proved its case on the evidence, and if so, what order should then be made. In child protection cases, the person or party bringing the application must provide evidence to support their claim. Evidence coming before a children's court, like any other court, can be in the form of *direct evidence*, *real or physical evidence* or *expert evidence*.

The most common kind of evidence is *direct evidence*. So in a Munchausen's case, the sort of direct evidence one would anticipate may be produced, may be things such as nurses' observations, doctors' observations, maybe an eye witness account of a carer doing or saying something it is alleged supports ... the case being put to the court. If physical evidence such as a video which contains relevant footage for example of the interaction between the child and carer were available one would expect that to be produced into evidence.

One would also expect that expert evidence would be produced in such a case.

Expert witnesses have to fit some criteria first before they are able to do what no other witness is able to do – that is to give an opinion that falls into the category of opinion evidence. The use of an expert, or expert evidence has conditions attached. First the party seeking to call the expert witness must establish that the witness is going to give an opinion based on a recognised body of learning outside the ordinary experience of people. Next, it must be established that this particular witness holds appropriate qualifications in the recognised field.

What are the best grounds for making a child protection application involving FIIC?

Judge Coate: What the "best grounds" are will be a matter for legal advice after an assessment of what the facts are in the case and how the facts fit the law. There is no simple formula. It needs to be brought on the basis of the relevant grounds for intervention listed in that jurisdiction's child protection legislation (in Victoria, the grounds for intervention are defined in Section 63 of the Children and Young Persons Act 1989). In cases such as these one would expect that the application would usually be based on one or more of the following grounds: physical, emotional or psychological abuse.

What is the view of the Children's Court on Munchausen Syndrome by Proxy and Fabricated or Induced Illness by Carers?

Judge Coate: As a judicial decision making body, the child protection arm of a children's court does not commence its judicial decision making task with any view as to the existence of a condition such as FIIC. The court must bring an impartial mind to its role. It is up to the party bringing the application to provide the relevant direct and/or expert testimony to show actual or likely harm to the child, and to relate this directly to the grounds for child protection intervention in that state or territory. How that is done, as I said, is a matter for the party bringing the action.

I venture that it would be impossible to prove to a court that a child was in need of protection from a parent on the basis that the parent suffered from FIIC without producing the evidence of an expert to that effect. The expert would have to establish that there is a recognised body of learning in this area, which has been accepted authoritatively (for example by some College or Institute or group of recognised experts). One would anticipate that the expert would be cross examined as to the different views held inside this recognised body of learning.

The standard of proof and the onus of proof in these cases and the rules of expert evidence are the same in these cases as they are in other cases.

What is the primary thing child protection practitioners should know when taking a case involving FIIC to court?

Judge Coate: They need to understand that this is a complex area in which many experts have differing views. Indeed, the very question of relevant expertise is a vexed question in this area. So, the first question that they should ask themselves is, "Is this a useful way to conduct the application or may there be another way to approach it consistent with the capacity of the applicable child protection law to provide grounds for such an application?" If you are concerned that you don't have the expert opinion of sufficient weight to support such a "diagnosis", consider bringing your application on other grounds such as those relating to physical or psychological maltreatment. This may well be done perfectly successfully without having to go down the path of producing an expert witness.

Note: The National Child Protection Clearinghouse is not qualified to provide legal advice. The information provided by Judge Coate relates to general principles of law. Caution should be taken in applying these principles in different jurisdictions without first confirming their accuracy with an appropriate legal advisor.

Courts will always approach a new case based upon the facts presented for that case, but general principles for good practice in bringing cases of alleged Fabricated or Induced Illness by Carers to courts may be drawn from the findings for recent court cases and the general principles for bringing care and protection proceedings before the court presented. Priddis (2004) proposed the following as principles for good practice when presenting a fabricated or induced illness or unexplained death case before the court on the basis of expert testimony:

- the cause of an injury or an episode that cannot be explained remains ambiguous
- recurrence is not in itself proof of FIIC;
- particular caution is necessary in any case where the medical experts disagree and one of the experts is refusing to exclude a natural cause;
- caution is necessary in cases where experts provide dogmatic evidence or where their professional reputation is invested in a particular theory;
- opinions on human behaviour should be avoided unless they are firmly founded on accepted scientific research; and
- medical knowledge is constantly developing. New medical knowledge may explain medical conditions for which there is currently no known cause (rather than attributing these unexplained medical conditions to FIIC).

How useful is the FIIC label for protecting children from harm?

Fabricated or Induced Illness by Carers previously known as Munchausen Syndrome by Proxy is not a condition, psychiatric disorder or diagnosis that a parent or carer *has*. Fabricated or Induced Illness by Carers is what a parent or carer *does* to a child. It is important that child protection practitioners, doctors and other professionals who work with children are made aware that there are instances where parents intentionally deceive health practitioners about their children's symptoms so that children are subjected to unnecessary and often painful medical procedures.

Parents who fabricate or induce symptoms of illness in their children may cause their child to experience physical pain/injury or psychological distress. Child protection workers do not need to make claims about the mental capacity or intention of the parents in order to demonstrate negative child outcomes. This raises the question: is the label useful for child practitioners seeking to intervene in order to make children safe?

Practitioner knowledge of Fabricated or Induced Illness by Carers is important in identification, as unless the possibility of FIIC is considered, the cause of a child's symptoms in such cases may not be discovered and the child may continue to be harmed (Lasher and Sheridan 2004).

When applying for a court order, it is better to talk about the parental behaviour (that is, poisoning) and the risk of harm to the child (that is, physical harm and potentially death) as a consequence of that behaviour (Priddis 2004).

Following substantiation of maltreatment within the child protection system, knowledge of FIIC may be useful to guide therapeutic intervention for parents and the strategies put in place to prevent further harm to the child (Pritchard 2004).

Key message:

It is not necessary to use the label Fabricated or Induced Illness by Carers to bring care and protection proceedings before the court. However, the label may be useful in assisting workers to identify the phenomenon and for guiding therapeutic interventions with parents who carry out these behaviours.

References

- American Psychiatric Association (1994), *Diagnostic and statistical manual of mental disorders*, fourth edition, American Psychiatric Association, Washington, DC.
- Asher R. (1951), "Munchausen syndrome", *Lancet*, vol. 1, pp. 339-341.
- Ayoub, C., Alexander, R., Beck, D., Bursch, B., Feldman, K., Libow, J., Sanders, M., Schreier, H. & Yorker, B. (2002), "Position paper: Definitional issues in Munchausen by Proxy", *Child Maltreatment*, vol. 7 no. 2, pp. 105-111.
- BBC MMV (2005), "Profile: Sir Roy Meadow", BBC News UK edition, 10 December 2003, BBC MMV, London, <http://news.bbc.co.uk/1/hi/health/3307427.stm>, accessed 22 November 2005.
- Bromfield, L. & Higgins, D. (2005), "National comparison of child protection systems", *Child Abuse Prevention Issues*, no. 22, Autumn, Australian Institute of Family Studies, Melbourne. Available at: <http://www.aifs.gov.au/nch/issues/issues22.html>
- Carpenter, R.G., Waite, A., Coombs, R.C., Daman-Willems, C., McKenzie, A., Huber, J. & Emery, J.L. (2005), "Repeat sudden unexpected and unexplained infant deaths: natural or unnatural", *Lancet*, vol. 365, January.
- Craft, A.W. & Hall, D.M.B. (2004), "Munchausen syndrome by proxy and sudden infant death", *British Medical Journal*, vol. 328, 29 May.
- General Medical Council (2005), Fitness to Practise Panel Hearing: 21 June – 15 July 2005, http://www.gmc-uk.org/concerns/decisions/search_database/ftp_panel_meadow_20050715.asp, accessed 22 November 2005.
- Hayward-Brown, H. (2004), "Munchausen syndrome by proxy (MSBP): Some medico-legal issues", *Judicial Officers' Bulletin*, vol. 16, no. 5, June.
- Lasher, L. & Sheridan, M. (2004), *Munchausen by Proxy: Identification, intervention and case management*, The Haworth Maltreatment and Trauma Press, New York.
- Meadow, R. (1977), "Munchausen syndrome by proxy: The hinterland of child abuse", *Lancet*, vol. 2, pp. 343-345.
- Meadow, R. (1982), "Munchausen syndrome by proxy", *Archives of Disease in Childhood*, vol. 57, pp. 92-98.
- Meadow, R. (1984), "Fictitious epilepsy", *Lancet*, vol. 2, pp. 2-28.
- Meadow, R. (1985), "Management of Munchausen Syndrome by Proxy", *Archives of Disease in Childhood*, vol. 60, pp. 385-393.
- Meadow, R. (1997), "Fatal abuse and smothering" in R. Meadow (ed.) *ABC of Child Abuse*, 3rd edition, BMJ Publishing Group, London, pp. 27-29.
- Pritchard, C. (2004), *The child abusers: Research and controversy*, Open University Press, Maidenhead, United Kingdom.
- Priddis, V. (2004), "Expert evidence: Munchausen Syndrome by Proxy", *ChildRight*, December, pp. 19-20.
- Royal College of Paediatrics and Child Health (2002), *Fabricated or Induced Illness by Carers*, Royal College of Paediatrics and Child Health, London.
- Rosenberg, D. (1987), "Web of deceit: A literature review of Munchausen Syndrome by Proxy", *Child Abuse and Neglect*, vol. 11, pp. 547-563.
- Sanders, M. & Bursch, B. (2002), "Forensic assessment of illness falsification, Munchausen by Proxy, and Factitious Disorder, NOS", *Child Maltreatment*, vol. 7, no. 2, pp. 112-124.
- Southall, D.P., Plunkett, M.C., Banks M,W., Falkov, A.F. & Samuels, M.P. (1997), "Covert video recordings of life-threatening child abuse: Lessons for child protection", *Paediatrics*, vol. 100, pp. 735-760.
- Tait, P., Donal, T., Moran, K., Jureidini, J. & Schreier, H. (2004), *Munchausen by Proxy Syndrome in Australia*, Paper presented at the IPSCAN conference, 19-22 September, 2004, Brisbane.
- Wilson, R.G. (2001), "Fabricated or induced illness in children", *British Medical Journal*, vol. 323, pp. 296-297.
- Yeo, S.S. (1996), "Munchausen Syndrome by Proxy: Another form of child abuse", *Child Abuse Review*, vol. 5, pp. 170-180.



Australian Government

Australian Institute of Family Studies
National Child Protection Clearinghouse