Training Requirements for Police in Responding to and Investigating Fabricated and / or Induced Illness in Children

A thesis submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy (Applied Criminology)

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September 2009
Candidate’s Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any other university or institution. To the best of the candidate’s knowledge the thesis contains no material previously published or written by another person, except where due reference has been made in the text of this thesis.

No other person’s work has been used without due acknowledgement in the main text of the dissertation. The researcher’s Aunt and Uncle, Judy and Peter Hunter, read drafts of the thesis (see acknowledgements).

The dissertation has not been submitted for the award of any other degree or diploma in any other University either in Australia or in any other country.

The content of this thesis is the result of work which has been carried out since the official commencement of the approved research program.

Signed

Catherine Wilkins (nee Swaine)

Dated: 25/08/2009
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# Abbreviations

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<tr>
<td>CIU</td>
<td>Criminal Investigation Unit</td>
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<td>CPU</td>
<td>Child Protection Unit</td>
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<td>CSV</td>
<td>Community Services Victoria</td>
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<td>CVS</td>
<td>Covert Video Surveillance</td>
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<td>CYFA</td>
<td>Children, Youth and Families Act</td>
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<tr>
<td>CYPA</td>
<td>Children and Young Persons Act</td>
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<tr>
<td>DHS</td>
<td>Department of Human Services</td>
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<tr>
<td>FDP</td>
<td>Factitious Disorder by Proxy</td>
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<td>FII</td>
<td>Fabricated and/or Induced Illness</td>
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<td>FIIC</td>
<td>Fabricated and Induced Illness by Carers</td>
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<tr>
<td>FMO</td>
<td>Forensic Medical Officer</td>
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<td>MBP</td>
<td>Munchausen by Proxy</td>
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<tr>
<td>MSBP</td>
<td>Munchausen Syndrome By Proxy</td>
</tr>
<tr>
<td>PA</td>
<td>Protection Application</td>
</tr>
<tr>
<td>PCF</td>
<td>Paediatric Condition Falsification</td>
</tr>
<tr>
<td>RCP</td>
<td>Royal College of Pathologists</td>
</tr>
<tr>
<td>RCPCH</td>
<td>Royal College of Paediatrics and Child Health</td>
</tr>
<tr>
<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
</tr>
<tr>
<td>SOCA Course</td>
<td>Sexual Offences and Child Abuse Course</td>
</tr>
<tr>
<td>SOCAU</td>
<td>Sex Offences and Child Abuse Unit</td>
</tr>
<tr>
<td>SUDI</td>
<td>Sudden Unexpected Death of Infants</td>
</tr>
<tr>
<td>VCDRC</td>
<td>Victorian Child Death Review Committee</td>
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Abstract

This thesis explores the training requirements for Victoria Police members in responding to and investigating fabricated and/or induced illness in children (FII), also known as Munchausen by proxy (MBP). It particularly aims to understand the police role with FII/MBP cases, the level of police awareness and knowledge of FII/MBP within Victoria and the knowledge and skills required by Victoria Police members to respond to and investigate FII/MBP cases from a police and multidisciplinary perspective.

The research recognises the importance of a multidisciplinary approach in FII/MBP cases and of the need for police to have an understanding of other agencies’ roles and of the issues overlapping medical, child protection and policing boundaries. In this light, this research has adopted a strong multidisciplinary focus to the research.

FII/MBP is a serious form of child abuse generally committed by mothers. It includes the verbal fabrication of illness symptoms, planting evidence to give the appearance of an illness and direct assaults on a child to induce sickness. Such abuse can cause lifelong psychological scars, permanent physical damage, life-threatening injuries and/or death. It is therefore vital that police likely to be responsible for such investigations are aware of its existence and possess the knowledge and skills to investigate allegations of such abuse.
This thesis utilises a mixed method research design incorporating quantitative and qualitative research methodologies. It is guided by an interpretative framework, and draws upon the general child abuse literature, literature specific to FII/MBP and existing FII/MBP training programs. Additionally, selected theoretical perspectives associated with language, gender, power and crime are examined to assist in understanding this abuse and professionals' response towards it.

The literature review undertaken in this study revealed minimal Australian research on FII/MBP from a criminal justice perspective. Further, limited international research was found which specifically focused on police knowledge of FII/MBP investigations and police training requirements for dealing with such abuse. As such, the value of this research is significant.

The quantitative component of this research consisted of a forty-five item questionnaire conducted with 1,238 Victoria Police members. The members were from uniform stations, Criminal Investigation Units (CIU), Sexual Offences and Child Abuse Units (SOCAU) and the Victoria Police Academy. The qualitative component comprised twenty in-depth interviews with Victorian professionals who had dealt with a FII/MBP case, including police, child protection workers, doctors, psychologists, a psychiatrist, and a retired school principal.

The findings highlight the challenging, complex and multidisciplinary nature of FII/MBP investigations and show that, whilst Victorian police are generally aware of the existence of FII/MBP, they lack a true understanding of it,
although SOCAU members were significantly more informed than detectives, uniform members and recruits. The media, in particular television and newspapers, was shown to have a significant impact in raising police awareness of FII/MBP, whilst training and/or SOCAU experience appeared to be the two key influences responsible for increasing members’ understanding of this abuse.

Four key training modules emerged from this study as being important for police required to respond to and investigate FII/MBP cases. These modules were ‘Identifying and understanding FII/MBP cases’, ‘The police role in FII/MBP cases’, ‘The multidisciplinary response’ and ‘The Investigation of FII/MBP cases’. Finally, the research demonstrates a need generally for clarity, guidance and structure to be provided for Victorian professionals required to manage FII/MBP cases.
Chapter 1

The Focus of the Research

Highly professional, well trained, and suitably experienced staff and sufficient government resources are essential to ensure early identification of abuse by deceptive parents and to provide adequate protection for children.

Southall et al. 1997: 753

1.1 Introduction

Fabricated and/or induced illness (FII) in children (also known as Munchausen by proxy [MBP]) has traditionally been viewed as a medical problem rather than a form of criminal behaviour (Boris et al. 1995). However, more recently, it has been recognised as a form of child abuse requiring medical, child protection and police attention (Fox, 1995; Department of Health, 2001; Royal College of Paediatrics and Child Health [RCPCH], 2002). FII/MBP may consist of verbal illness fabrications, planting evidence to support verbal fabrications, and/or direct offending against a child to produce illness symptoms (Sheridan, 2003).

This form of abuse requires trained and experienced professionals to be assigned to such cases (Southall et al. 1997; Artingstall, 1999; Lasher and Sheridan, 2004). However, the literature also suggests professionals lack
knowledge of this offending (Kaufman et al. 1989; Hochhauser and Richardson, 1994; Lasher and Sheridan, 2004) and feel ill-prepared to manage such abuse (Blix and Brack, 1988; Bufton, 1996). This thesis seeks to understand the police position and determine training needed by police to effectively respond to and investigate FII/MBP cases, both from a police and multidisciplinary perspective.

This chapter details the background to this study. It outlines the rationale for this research, the scope of the research problem, the research aims and questions, and the contribution this thesis will make to knowledge in this field. Finally, it sets out the structure of this thesis and the chapters it contains.

1.2 Background

Reports of parents presenting their children to doctors with factitious symptoms or illnesses began appearing in the medical literature in the early 1960s and 1970s (Pickering, 1964; Dine, 1976; Rogers et al. 1976). However, it was not until Meadow (1977) introduced the term, ‘Munchausen syndrome by proxy’ (MSBP) to describe this type of behaviour that such abuse started to become known (Wilson, 2001). The term MSBP also caused much confusion and controversy for professionals (Fox, 1995;

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1 Meadow (1977) adopted the term ‘Munchausen’ from Asher (1951) who had previously applied the name ‘Munchausen Syndrome’ to describe adults who presented themselves to doctors with false illness allegations. Asher (1951) in turn adopted the name ‘Munchausen’ from the 18th century storyteller Baron von Munchausen who was well known for making up stories.
Horwath and Lawson, 1995; RCPCH, 2002) and, over time, a range of other terms emerged within the literature\(^2\).

As terminology associated with MBP was unclear at the time of critiquing the literature for this research, a mixture of terms were utilised in this thesis including: fabricated and/or induced illness in children (FII), fabricated and/or induced illness/injury in children, Munchausen syndrome by proxy (MSBP), Munchausen by proxy (MBP) and factitious disorder by proxy (FDP). Preference is given to the term ‘FII’ over ‘MBP’, however, due to much of the literature utilising MSBP or MBP terminology the researcher chose to adopt the term FII/MBP to reflect this position. To avoid confusion, the term FII/MBP has been used consistently throughout this thesis, except in direct quotations.

FII/MBP is generally committed by the biological mother of the child (Rosenberg, 1987; Sheridan, 2003). Fathers, carers, aunts, nurses and grandmothers have also been reported as committing this abuse, although to a much lesser degree (Schreier & Libow, 1993; Artingstall, 1999). Historically, society has held mothers ‘above suspicion’ (Artingstall, 1999: 7). In fact, the mother-infant relationship has been portrayed as universally sacred (Schreier and Libow, 1993). Some professionals still appear to have difficulty accepting that a mother could harm her young child (see Schreier and Libow, 1993; Horwath and Lawson, 1995; Artingstall, 1999) and, despite overwhelming evidence\(^3\), some question the reality of FII/MBP altogether.

\(^2\) Refer to Chapter Two (2.2) for an insight into the issues surrounding MBP terminology and to Appendix 1 for an overview of terms used in association with this abuse.

\(^3\) FII/MBP cases have been reported in over twenty countries around the world (Brown and Feldman, 2001). Numerous cases have been through the court system resulting in a
FII/MBP victims are generally babies or young children (Meadow, 1982, 1994; Rosenberg, 1987, 1997; Sheridan, 2003). However, older children (Bryk and Siegel, 1997; Gregory, 2003) and adults (Meadow, 1984; Ben-Chetrit and Melmed, 1998) have also suffered this abuse. Jureidini (1993) also reported this abuse occurring with babies whilst still in their mother’s womb. FII/MBP can have mild to serious ramifications for children, even death (Rosen et al. 1983; Bools et al. 1992, 1993; Southall et al. 1997). However, in some families, the mother’s behaviour has been successfully managed (see Gray et al. 1995; Berg and Jones, 1999).

1.3 The rationale for this research

Initially, the concept for this research arose through the researcher’s involvement, as a police instructor, with the Victoria Police Sexual Offences and Child Abuse (SOCA) Course. It became apparent to the researcher that police members working in the child abuse field had little knowledge about FII/MBP and would benefit from training in this field. A decision was made to include a session about FII/MBP into the SOCA course. Concurrently, the

conviction of the mother; see Chadwick, 1994; Stanioch, 1994; Fox, 1995; Shepherd, 1995; Boros and Brubaker, 1995; Birge, 1996.

4 The researcher spent five years delivering training to police responsible for responding to and investigating child abuse in Victoria. In addition, the researcher worked closely with the Department of Human Services (DHS) Child Protection as a joint Police and DHS trainer.
researcher was offered a university scholarship to complete a Masters Degree\(^5\). As minimal literature was located from a criminal justice perspective on FII/MBP within Australia, the researcher accepted the university offer and chose the topic of police training and FII/MBP; with the aim of improving police knowledge and skills for dealing with FII/MBP cases.

As an operational police member working in the area of child abuse and as a police trainer working jointly with the Department of Human Services, Child Protection, the researcher was also very aware of the importance of the multidisciplinary aspect to child abuse investigations and for police to understand other agencies’ roles and how to work effectively with other agencies. The researcher chose to reflect the multidisciplinary nature of child abuse investigations within her research. The literature on FII/MBP also reflects a strong multidisciplinary requirement with FII/MBP cases and of the need for police, medical professionals and child protection workers to work collaboratively in the investigation and management of such cases, supporting the researcher’s chosen position (see Horwath and Lawson, 1995; Artingstall, 1999; Lasher and Sheridan, 2004).

The researcher was awarded, the ‘Tynan and Eyre’ Police Scholarship\(^6\) to travel overseas to gain a basic understanding of FII/MBP. The scholarship enabled the researcher to travel to America, Canada, and England for nine weeks conducting interviews with many professionals (doctors, police, child

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\(^5\) The researcher previously completed a Bachelor of Arts in Criminal Justice Administration and holds a Diploma of Education.

\(^6\) The Tynan and Eyre police scholarship was set up in remembrance of two police officers killed on duty. The Scholarship provides funding to police members to conduct studies on areas of relevance to policing.
protection, legal professionals) experienced in dealing with FII/MBP cases. This opportunity provided the researcher with the knowledge to consolidate the framework for her Masters degree and assisted with designing the research instruments utilised in the research. The degree was later upgraded to a PhD owing to the magnitude and significance of the research.

In her role as a police trainer, and separate to this research, the researcher developed a basic introductory FII/MBP training session for the SOCA course. This session was not formally recognized in any way and was delivered by the researcher throughout 2000-2003 to approximately 140 police members attending the SOCA course\(^7\). Additionally, in 2004, the researcher delivered this training to three detective classes, presenting to approximately 90 new detectives\(^8\). It is hoped this research will provide the background material and evidence needed to more formally assess the training requirements for police within Victoria in relation to FII/MBP cases and to further develop and build upon the introductory package.

Finally, in undertaking this research, the researcher was mindful of the high level of confusion and uncertainty which FII/MBP has caused for professionals around the world, the limited literature concerning the police role with FII/MBP cases, perceived limited police knowledge of this abuse, and limited police FII/MBP training. Further, limited information exists in

\(^7\) Due to a restructure of the SOCA Course in 2004, the FII/MBP session was moved to SOCAU professional development days.

\(^8\) Whilst this session was well received by the detectives, work and study commitments led the researcher to postpone the training.
Australia surrounding the police interface with other professionals in the investigation and management of FII/MBP cases.

With the above in mind, the researcher considered it necessary to firstly gain an understanding of the broader picture of FII/MBP within Victoria in order to understand the background knowledge requirements of police in dealing with FII/MBP cases. This included an understanding of language used in association with this abuse and professionals’ interpretations and perceptions of FII/MBP; the types of FII/MBP cases occurring within Victoria and professionals’ dealings with FII/MBP perpetrators, spouses and victims. Secondly, the researcher needed to establish what the police role was with FII/MBP cases in Victoria to assist in understanding the depth and extent of training required by police and to ensure such training met the needs of the role. Thirdly, a baseline understanding of police FII/MBP knowledge needed to be established to allow for the identification of strengths and knowledge gaps and the capacity to tailor training accordingly and measure future improvements. Finally, the researcher needed to understand the investigative and multidisciplinary needs of FII/MBP cases and associated police knowledge and skill requirements.

1.4 Scope of the Problem

The literature strongly supports the need for trained and experienced professionals to manage FII/MBP cases and of the need for police, child protection and medical professionals to work together in dealing with this
abuse (Horwath and Lawson, 1995; Artingstall, 1999; RCPCH, 2002; Lasher and Sheridan, 2004). Various researchers suggest a lack of knowledge about this abuse and a lack of coordination between agencies can potentially place a child’s life at risk (Artingstall, 1999; Lasher and Sheridan, 2004) and/or result in delays in the police investigation and damage to the criminal case (Fox, 1995; Shepherd, 1995; Wilkinson and Parnell, 1998).

Due to the complexity of FII/MBP cases, Artingstall (1999: 193) suggests there is inadequate time, during the course of such investigations, to understand this abuse. She suggests professionals involved with such cases need to be knowledgeable about the fundamentals of FII/MBP methodology and of the different job related requirements connected with such cases. Lasher and Sheridan (2004: 79) note that ‘discussion, strategizing and decision making are counterproductive if key players do not have a solid and correct MBP information base’. Further, the Department of Health (2000) suggest professionals involved in multidisciplinary investigations require additional knowledge and skills than those dealing with single agency issues and stress that an understanding of the perspectives, language and culture of other professionals can assist in communication and preventing misunderstanding.

Whilst the literature is quite clear about the need to have experienced and knowledgeable professionals, including police, assigned to FII/MBP cases, little research has been undertaken within Australia to establish what professionals know and need to know about this abuse in order to respond to and investigate it effectively. Internationally, there has been some work in
this area\textsuperscript{9}, although minimal from a police perspective, with the exception of Artingstall (1999) who provides much practical advice for police. Researchers in the UK (Fox, 1995; Bufton, 1997) and US (Artingstall, 1999; Chiczewski and Kelly, 2003) generally believe though, that police are unprepared and ill equipped to deal with FII/MBP cases, including those cases involving infant deaths.

1.5 The research aims and research questions

This research is exploratory in nature. It is guided by an interpretative framework and utilises a mixed method research design. Additionally, it draws upon the literature in this field and a number of selected theoretical perspectives associated with gender, language, power and crime. Ultimately this study aims to:

Identify the training requirements for Victoria Police in responding to and investigating FII/MBP, from both a police and multidisciplinary perspective.

In order to provide a broad and rich examination of the topic this objective is supported by five research questions:

- What is the police role in FII/MBP cases?

\textsuperscript{9} See surveys by researchers such as Blix and Brack, 1988; Kaufman et al. 1989; Hochhauser and Richardson, 1994 and Ostfeld and Feldman, 1996. Further, researchers such as Horwath and Lawson (1995) and Lasher and Sheridan (2004) address a range of training issues for professionals in relation to FII/MBP cases, with a child protection focus.
- What knowledge do Victoria Police members have about FII/MBP and the investigation and management of FII/MBP cases and what gaps exist in members’ knowledge?

- Do Victoria Police members require training in relation to FII/MBP?

- If so, what knowledge and skills do Victoria Police members require to respond to and investigate FII/MBP cases from a police and multidisciplinary perspective?

- What members would require training?

1.6 Contribution to knowledge

The original aim of this research was to make a contribution to the understanding of police training requirements with FII/MBP cases in Victoria; in particular, to establish a baseline understanding of what police know of this abuse, to define the police role with FII/MBP cases and to identify the knowledge and skills required by police to effectively respond to and investigate this abuse, both from a police and multidisciplinary perspective. Because of the multidisciplinary component of this research, it became apparent that this study had wider applicability than just police, and could assist to improve the Victorian multidisciplinary response to FII/MBP cases as a whole. Finally, through its exploratory nature, the research generates debate and issues for further research.
1.7 Structure of the thesis

Chapter 2 reviews the literature associated with FII/MBP, examines a number of theoretical perspectives associated with gender, language, power and crime thought to be relevant to this research and presents an overview of FII/MBP training material.

Chapter 3 explains the research structure, including the theoretical framework and theoretical perspectives incorporated into this study, the research aims and questions, methodology and methods, and ethical considerations.

Chapter 4 presents qualitative findings and draws on the experiences of professionals who have had direct dealings with FII/MBP cases in Victoria. It aims to gain a contextual and background insight into FII/MBP cases from a Victorian perspective and to begin to understand potential background knowledge requirements of police who may be potentially assigned to FII/MBP cases.

Chapter 5 is divided into two parts. The first part presents primarily qualitative findings and presents data on the police role with FII/MBP cases and cases involving the sudden unexpected death of an infant. Additionally, the section examines the need for suitably qualified personnel to be assigned to FII/MBP cases. Part two presents predominantly quantitative data and explores the findings relating to the level of awareness by police in Victoria
about FII/MBP, how police learn of FII/MBP, and actual levels of understanding by police of this offending.

Chapter 6 presents predominantly qualitative findings and concentrates on the multidisciplinary aspect of FII/MBP cases and police requirements in this area. It identifies the importance of a coordinated multidisciplinary approach with FII/MBP cases and of a need for police to have an understanding of other agencies' roles and perspectives.

Chapter 7 presents the qualitative findings relating to investigative techniques applicable to FII/MBP cases and the strengths and limitations of such techniques. It suggests a need for police to be educated about FII/MBP investigations and potential investigative techniques that may be applicable to FII/MBP cases.

Chapter 8 analyses the quantitative and qualitative research findings from this study. It draws upon the theoretical concepts contained within this research and the cited literature and training FII/MBP programs. It begins to draw conclusions regarding the training requirements for police in responding to and investigating FII/MBP cases.

Finally, Chapter 9 addresses the primary research objective and questions formulated for this thesis. In doing so, it summarises the key findings from this research and identifies the key training requirements for police in dealing with FII/MBP cases. Additionally, it outlines the strengths and limitations of this research and identifies areas for future study.
Chapter 2

An Investigator’s Almanac

Unravelling the complexities of FII/MBP

The complex myriad of factors that produce MBP presents the ultimate challenge to any profession it touches. This is no less true for law enforcement than it is for health care.

Shepherd, 1995: 325

2.1 Introduction

This chapter reviews the research relating to the investigation of fabricated and/or induced illness in children (FII) or Munchausen by proxy (MBP) and police training requirements with this abuse. A number of theoretical perspectives thought pertinent to this study are also included. The review is written primarily from a criminal justice perspective, but also draws upon medical, child protection, and mental health research. The literature is predominantly from the United Kingdom, United States of America, and Australia.

This chapter is divided into six themes with various sub-themes. Theme one focuses on background material associated with FII/MBP cases and contains the following sub-themes: an overview of child abuse; terminology and the reality of FII/MBP; the spectrum of FII/MBP, and FII/MBP perpetrators’,
spouses and victims. Finally it examines the personal impact of FII/MBP cases on professionals.

Theme two focuses on the police role with FII/MBP and cases of sudden unexpected deaths of infants. It explores the timing of police involvement, issues facing police in their dealings with such cases and what guidance exists for police in the management of FII/MBP cases.

Theme three focuses on the multidisciplinary aspect of FII/MBP investigations. It highlights the importance of a coordinated approach by agencies in managing FII/MBP cases and examines the role and challenges facing different professionals in dealing with this abuse.

Theme four examines potential avenues of investigation associated with FII/MBP cases and evidence standards required in criminal matters.

Theme five examines a number of theoretical perspectives associated with language, power, gender and crime and their potential link to FII/MBP cases.

Finally, Theme six examines the need for police to receive training about FII/MBP, including those cases involving sudden and unexpected deaths of infants or children. It presents published and unpublished training literature associated with FII/MBP and identifies the key themes emerging from this literature.
2.2 Background topics

This theme explores a number of topics relevant to the background of FII/MBP investigations. Firstly, it presents a general overview of child abuse and provides definitions of physical abuse, sexual abuse, emotional abuse and neglect. It highlights that problems associated with definition, identification and intervention are not unique to FII/MBP and to current times. Secondly, it explores terminology and the reality of FII/MBP; the spectrum of FII/MBP; a synopsis of the research about FII/MBP perpetrators, their spouses and their victims, and the personal impact of FII/MBP on professionals.

2.2.1 An overview of child abuse

Child abuse has existed throughout the ages (Lynch, 1985). However, it was not until 1962 that it really gained public attention, with Kempe et al. (1962) generally being attributed as the catalyst for this recognition (Goddard, 1996; Hobbs, Hanks and Wynne, 1999). Kempe et al. (1962) coined the term ‘battered child syndrome’ to describe physical injuries inflicted on children and raised much awareness about physical abuse and the importance of the professionals’ role in protection. By the late 1960’s child abuse was reported in Australian medical journals (Birrell and Birrell, 1966, 1968) and in 1981, Australia became a signatory to the United Nations Declaration of the Rights of the Child recognising that children are individuals with distinctive rights (James, 2000a). In 2006-07, there were 309, 517 notifications (reports) to Australian statutory child protection services and 58, 563 verified cases of
abuse or neglect, with Aboriginal and Torres Strait Islander children over-represented in these statistics (Bromfield and Holzer, 2008). Richardson (2004) defines child abuse as:

An act by parents, caregivers, other adults or older adolescents that endangers a child or young person’s physical or emotional health or development. Child abuse can be a single incident but usually takes place over time.

Richardson (2004: 1)

However, Richardson (2004: 1) also notes that in practice defining child abuse tends to be ‘a process of judgment and ultimately rests on value decisions’. Goddard (1996: 33) contends that different professions may define child abuse differently based on their role and the timing of their intervention. He highlights Charlesworth et al.’s (1990) position that police may focus their attention on whether a case exists that will meet the criteria required to prove criminal activity in court whereas a social worker may be concerned with immediate protection and not assigning guilt. Finally, James (2000a) suggests the parameters of how we define child abuse are constantly changing and will continue to be problematic, particularly when attempting to construct universal definitions.

In Australia, each State/Territory has its own legislation and definitions of what constitutes child abuse. Whilst it is generally recognised that it is no longer appropriate to view individual forms of abuse in isolation (Tomison, 1997; James, 2000a), child abuse tends to be categorised into one of four areas (Richardson, 2004). These areas are: physical abuse, sexual abuse, psychological and emotional abuse, and neglect.
Physical abuse is generally defined as ‘non-accidental physical injury inflicted upon a child’ (Tomison, 2001). Richardson (2004: 2) describes physical abuse as ‘physical injury’ caused by ‘punching, hitting, kicking, beating, biting, burning, shaking or otherwise harming a child’. Sexual abuse is defined as ‘the use of a child (female and male) for sexual gratification by an adult or by a significantly older child or adolescent’ (Tomison, 2001: 48). Sexual abuse did not cause widespread public concern until the 1970’s (Tomison, 2001:48), with Goddard and Carew (1993) suggesting the myths surrounding child sexual abuse still continue to hamper our response to this abuse.

Perhaps the most concealed and underestimated form of child abuse is emotional abuse or ‘psychological maltreatment’ of children (Tomison and Tucci, 1997). Defined as ‘a sustained pattern of verbal abuse and harassment by an adult with the aim of damaging a child’s self esteem or social competence’ (Tomison, 2001: 48), it is considered more difficult to detect due to a lack of physical injuries (Tomison and Tucci, 1997) and more difficult to prove within the courts (Goddard, 1996: 91). However, Bromfield and Holzer (2008) note the scope of what constitutes child protection has recently been broadened within Australia to include emotional abuse and neglect and the witnessing of domestic violence. They note that in 2006-2007 emotional abuse and neglect were the most commonly substantiated maltreatment types within Australia. It is also of note that significant changes have been implemented within Victoria in relation to the reporting and management of domestic violence which have also strengthened the
protection of children and families, including the introduction of *Family Violence Protection Act, 2008* (Department of Justice, 2008).

Neglect is defined as ‘a consistent pattern of behaviours that involve failure to provide for a child’s basic needs’ and is often referred to as ‘acts of omission’ (Richardson, 2004: 4). It includes ‘physical neglect (such as the failure to provide adequate nutrition, clothing, accommodation, and supervision),’ ‘abandonment,’ ‘medical neglect,’ ‘emotional neglect,’ and ‘educational neglect’ (Richardson, 2004: 4). Neglect also includes fatalities arising through neglect of a child by a caregiver (Lawrence and Irvine, 2004). The identification of child neglect in connection with the industrial revolution led to the first formation of child protection societies and legislation designed to protect children (Lynch, 1985, Tomison, 2001). Solomon (1973: 776) suggests neglect is potentially more dangerous than other forms of abuse as the damage may be more difficult to reverse.

Fabricated and induced illness (FII) or Munchausen by proxy (MBP) contains elements of physical abuse, emotional abuse and neglect. Cases of fabricated sexual abuse where the primary reason for the fabrication appears to be linked to attention have also been recognised as similar to FII/MBP cases (Meadow, 1993; Schreier, 1996; Postelthwaite, Samuels and Baildam, 2000) FII/MBP began to emerge within the literature during the 1960’s and 70’s (Pickering, 1964; Dine, 1976; Rogers et al1976). However it wasn’t until 1977 when Meadow coined the term Munchausen by proxy (MBP), for journalistic purposes, to describe this abuse that it started to become known (Wilson, 2001). Meadow (1977) used the term MBP to describe the
behaviour of two mothers factitiously creating illnesses in their children. He adopted the term ‘Munchausen’ from Asher (1951), who utilized the term ‘Munchausen syndrome’ to describe adults who fabricated illnesses within themselves.

Throughout the 1990’s, other forms of child abuse also gained public attention such as ‘systems abuse’, paedophilia, sexual abuse of children by persons in positions of trust (such as the clergy), and ritual or satanic abuse (James, 2000a). The term child abuse was also expanded to encompass child pornography, the abuse of children in sex tourism and the use of children in child prostitution (Grant et al. 1999). More recently issues of child sexual abuse over the internet have also emerged (Stanley, 2001) Bromfield and Holzer (2008: 2) note families coming to the attention of Australian child protection agencies ‘may experience multiple complex problems including alcohol and drug abuse, family violence, mental illness, parents with past experiences of maltreatment, social isolation and parental physical and intellectual disability’. They note that shifting community values and an increased awareness of child abuse has contributed to recent changes within Australia to the scope of child protection services and the response provided to victims of child abuse. This is discussed further in section 2.4.5.3.

Advances in research continue to increase our understanding of child abuse and of the interactive links between identification, intervention and prevention (Tomison, 1997; James, 2000a). However, much work is still needed to

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10 See Appendix 1 for some of the different interpretations and definitions of FII/MBP which appear in the literature.
improve the capacity of professionals and systems to detect, investigate and manage child abuse (Tomison, 1995; Tomison and Tucci, 1997; RCPCH, 2002) and to implement and evaluate prevention initiatives (James, 2000b). Lasher and Sheridan (2004: 71) suggest ‘the situation with MBP is similar to the situation with child maltreatment several decades ago and with sexual abuse more recently’ in that there are still professionals who question its reality and a general community who lack awareness of such abuse, including ‘many health care, legal system, child protection’, and ‘educational’ professionals (Lasher and Sheridan, 2004: 69).

2.2.2 Terminology and the reality of FII/MBP

Whilst the term MBP has assisted in raising public awareness about fabricated and induced illness in children, it has also caused considerable confusion and controversy for professionals (Meadow, 1995; 2002a; Fisher and Mitchell, 1995; Jones, 1996) and ‘for partially deflecting professionals’ understanding away from the reality’ of its existence (Fox, 1994: 25). Further, researchers such as the Department of Health (2001), Ayoub and Alexander (1998) and Lasher and Sheridan (2004) suggest that language controversy surrounding FII/MBP may lead to a loss of focus by professionals on the welfare of the child (Department of Health, 2001) and to misunderstandings in managing such cases (Ayoub and Alexander, 1998; Lasher and Sheridan, 2004).

One primary area of confusion with MSBP relates to its interpretation as both a category of child abuse and as a mental health condition suffered by the
mother (Meadow, 1995; 2002a; Lawson and Horwath, 1995; Bools, 2001). Meadow (2002a) intended the former. Lasher and Sheridan, (2004: 18-23) suggest that much confusion surrounding MSBP arose due to its inclusion (under the term Factitious Disorder by Proxy [FDP]) in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994). MSBP was added to this manual for further research purposes. However, many professionals misinterpreted its inclusion to mean that MSBP was now a recognized mental disorder, which is not the case (Lasher and Sheridan, 2004; see also Feldman, 2004a; Fish et al. 2005). Use of the term ‘MSBP’ in Australia varies ‘from a pediatric to a psychiatric application’ (Hayward-Brown, 1999: 44). As awareness of MSBP grew, some professionals omitted the term ‘syndrome’. They considered it gave the appearance of an illness (Feldman, 2004a) and inferred a lack of accountability by the offender for his/her actions (Artingstall, 1999; Lasher and Sheridan, 2004).

Over time, the term MBP has involved ongoing controversy (Earl Howe in Lords Hansard, 2001; Tzioumi, 2004). Hayward Brown (1999: 39) contends such a label excludes consideration by professionals of other factors that may be causing the child’s illness, casts doubt on the mother’s credibility and contributes to a ‘snowball effect’ with doctors who quickly inform others of

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11 Examples, such as the Beverly Allit case, where a nurse was portrayed by the media as suffering from MBP (Meadow, 1995: 535), and of a description provided by Fox (1995: 74) of a social worker recording that a child had Munchausen’s disease as if it were a physical condition like measles, demonstrate the confusion that MBP created for professionals.

12 The fact that Munchausen Syndrome (which is a psychiatric disorder, American Psychiatric Association, 2000) and MBP share the same name compounded this issue (Ayoub, Alexander, Beck, Bursch, Feldman, Libow, Sanders, Schreier and Yorker, 2002).
their suspicions. She further suggests the MBP label isolates families from treatment and support.

Several professionals, including Hayward-Brown (1999), question the reality of FII/MBP altogether (Pragnell, 2002b, 2004; Lord Clement-Jones in Lords Hansard, 2004). Seibel and Parnell (1998: 74) claim that a FII/MBP diagnosis may be linked to carelessness by medical professionals, indicating doctors may fail to obtain and review all available information about the child, although they also thought that FII/MBP was more likely to be overlooked or ignored than diagnosed carelessly. However, Hayward-Brown (1999: 48-51) contends that medical data surrounding MBP cases is usually ‘unreliable and unacceptable’ and that ‘every attempt should be made by professionals to protect parents from such allegations’. Further, the media has played a significant role in creating much uncertainty around FII/MBP and contributing to professionals’ reluctance to become involved in this abuse. In the UK in 1999, a highly publicised trial involving Sally Clark and the deaths of her two sons created media headlines (Dyer, 2005). During this trial, Dr Roy Meadow gave statistical evidence in relation to the chances of Sudden Infant Death Syndrome (SIDS) occurring twice within the one family. Despite the fact that SIDS had ‘not seriously been considered’ as a cause of death in these cases and the defence had never objected to the admissibility of Meadow’s statistical evidence or challenged it during cross examination (Horton, 2005), Dr Roy Meadow was deemed by the General Medical Council, as a result of a complaint by the defendant’s

13 See also Morley (1995) and Stephenson (1995).
father, to have given inappropriate statistics outside his area of expertise (Dyer, 2005). This resulted in the conviction of the mother being overturned, various other cases being acquitted and a review of all Meadow’s cases (Meadow, 2002b). Meadow was further found guilty of serious professional misconduct by the General Medical Council and was struck off the medical register (General Medical Council, 2005). However, an appeal to the High Court overturned this ruling (Rozenberg, 2006).

Horton (2005) notes that whilst Meadow’s statistical evidence in relation to SIDS was clearly inappropriate in the matter of Clark, the first appeal court examining Clark’s case unanimously concluded there was overwhelming evidence of the guilt of the appellant. Horton (2005) indicates there was evidence of bruising, soft tissue injuries, bleeding and inflammation in the lungs, haemorrhages in the eyes and spinal cord, brain tears and rib injuries, among other lesions. The first appeal court contended that had there been no error in relation to statistics at the trial, the jury would have convicted on each count (Horton, 2005: 3). In the second appeal concerning Clark new evidence was introduced suggesting that infection with *Staphylococcus aureus*, at multiple sites, could have accounted for one of the boy’s deaths and Clark’s conviction was subsequently quashed. The second appeal did not relate at all to Meadow’s evidence.

Unfortunately, there has been much negative and inaccurate publicity surrounding Meadow and the UK court cases (see Kaplan, 2008 and reply by Jureidini and Donald, 2008). Craft (cited in Munby, 2004: 30) notes many UK paediatricians, primarily as a result of what happened to Meadow, are
reluctant to become involved in child protection cases and to give expert
evidence within the courts. Craft and Hall (2004:1) suggest ‘media vilification’
of paediatricians has threatened the systems designed to protect vulnerable
children. Goddard and Saunders (2001: 28) suggest the media, at times,
may have a greater influence on policy and practice than professionals
working in the field and note the importance of informed media coverage to
ensure the needs of the child are kept in the political agenda and
professionals remain accountable.

Whilst there has been uncertainty and extreme criticism surrounding FII/MBP,
the harsh reality remains that some parents do fabricate and/or induce illness
in their children\textsuperscript{14}. Kennedy (cited in RCP and RCPCH, 2004) states that:

\begin{quote}
Despite our unwillingness to accept the possibility, we have learned
conclusively in the last 30 years that some mothers, fathers and other
carers do induce illnesses in their children and sometimes fatally harm
them.

\textit{Kennedy, cited in RCP and RCPCH, 2004: 15}
\end{quote}

Various researchers note the dangers for children when professionals fail to
accept the reality of this abuse (Southall et al. 1997; Feldman, 2004a).
Lasher (2003: 409) stresses if ‘victims are to be identified and protected’
there must be ‘general public and professional awareness’ that this abuse
exists.

\textsuperscript{14} Cases of FII/MBP have been reported in more than twenty countries worldwide (Brown and Feldman, 2001). See also Gray and Bentovim, 1996; McClure et al. 1996; Brown and Feldman, 2001.
The term ‘fabricated and induced illness’ (FII) has since replaced MBP terminology within the UK (Department of Health, 2001; RCPCH, 2002)\(^{15}\). Craft and Hall (2004:3) note the term FII ‘keeps the focus on the presenting features of the child [needing protection], rather than on the supposed psychopathology of the parent’. Meadow (1995) emphasized:

> Whatever term is used and in whatever way, does not alter the fact for an individual child who has been abused the most important thing is for the assessors to define accurately what has happened.

Meadow, 1995: 538

Not all professionals have embraced the change to FII terminology; Pragnell (2004) contends that FII is merely a variant of MBP and not based on any scientific research.

In Australia, MBP or MSBP still appear to be commonly used terms (Freeland and Foley, 1992; Donald and Jureidini, 1996; Yeo, 1996). However, there have been some moves to abandon this terminology (Fish et al. 2005). The terms FII (Annual Report Deaths of Children and Young People Queensland, 2004-05: 115) and ‘fabricated and induced illness by carers’ (FIIC)\(^{16}\) (Fish et al. 2005) have more recently appeared within the Australian literature. In the US, professionals have moved to replace MBP with the terms ‘Paediatric Condition Falsification’ (PCF) and ‘Factitious Disorder by Proxy’ (FDP)

\(^{15}\) See also Warner in Lords Hansard, 2004; Merton Area Child Protection Committee, 2004; Blackburn with Darwen Borough Council, 2004; Sussex Police (undated); North East Regional Inter-Agency Procedures Project, 2005.

\(^{16}\) Fish et al. (2005: 4) recommended use of the term ‘fabricated or induced illness by carers’ (FIIC) citing the RCPCH (2002) as their point of reference. Whilst the RCPCH (2002) use the term FIIC as the title of their publication the term FII is recommended within the publication itself.
(Ayoub and Alexander, 1998; Ayoub, Alexander, Beck, Bursch, Feldman, Libow, Sanders, Schreier and Yorker, 2002). Such terms have appeared in some articles (Hyman et al. 2002; Schreier, 2002), although MBP and MSBP also still commonly appear in US literature (Lasher and Sheridan, 2004; Feldman, 2004a). Whilst the UK and US have adopted different terminology, Bools (2001) suggests their intentions are similar; to differentiate what happens to the child from a psychiatric diagnosis of the perpetrator.

2.2.3 The spectrum of FII/MBP

In child abuse cases, FII/MBP is considered to be relatively uncommon (Lawson and Horwath, 1995), although possibly ‘underidentified because of a lack of professional expertise and public awareness’ (Craft and Hall, 2004:2). The following paragraphs provide some insight into the spectrum of this behaviour.

Fabricated illness includes: (a) the exaggeration of a genuine illness (Eminson and Postelthwaite, 1992; Department of Health, 2001); (b) the verbal fabrication of illness symptoms (Meadow, 1989; Department of Health, 2001); and (c) the deliberate adding, tampering and altering of medical records and specimens to portray the existence of an illness (Meadow, 1989, 1994; Department of Health, 2001). Examples of fabrication include: the

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17 The American Professional Society on the Abuse of Children adopted the terms ‘Pediatric Condition Falsification’ to describe fabricated or induced illness as a form of child abuse, and ‘Factitious Disorder by Proxy’ to describe a psychiatric diagnosis applicable to a person who falsifies signs or symptoms in a victim (not always a child) to meet their own self serving psychological needs’ (Ayoub and Alexander, 1998: 7-9).

18 See Appendix 2 for an overview of symptoms, signs and diseases that have been reported in FII/MBP cases and their causes, as detailed by Plunkett and Southall cited in Adshead and Brooke 2001: 80-81.
reporting of non-existent seizures to doctors (Meadow, 1982a; 1984; Guandolo, 1985\textsuperscript{19}), interference with temperature readings to simulate fevers (Feldman and Ford, 1994; Mian and Huyer, 1995), and the adding of blood to a child’s nappy to give the appearance of illness symptoms (Meadow, 1982b; Boros et al. 1995). Cases of fabricated sexual assault, where the primary reason for the fabrication appears to be attention seeking have also been recognised as similar to FII/MBP cases (Meadow, 1993; Schreier, 1996; Postelthwaite, Samuels and Baildam, 2000). In some instances fabricated sexual abuse and fabricated illnesses may co-exist (Meadow, 1993; Schreier, 1996; Artingstall, 1999). Finally, researchers have recognised that medical treatments by doctors, as a result of verbal fabrications by parents, may have just as serious consequences for children as the more direct forms of this abuse (Fox, 1995; Rosenberg, 1997).

Induced illness involves both verbal fabrications and direct actions to induce sickness or give the appearance of illness symptoms (Meadow, 1994; Rosenberg, 1997). Cases of induced illness include: the deliberate contamination of a child’s skin or wounds (Johnston, 1995; Bryk and Siegel, 1997); the administration of medications, poisons or inappropriate substances (Meadow, 1977; Henretig, 1995\textsuperscript{20}); smothering (Southall et al.\textsuperscript{30}).

\textsuperscript{19} See also Bannon and Carter, 2001; Barber and Davis, 2002.
\textsuperscript{20} See also: Schreier and Libow, 1993; Stanioch, 1994; Birge, 1996; Loader and Kelly, 1996; Feldman and Hickman, 1998; Goldfarb et al. 1998; Schreier, 2002; Dyer, 2004; BBC News, 2005.
1997; Stanton and Simpson, 2001\(^{21}\)); and withholding a child’s food supply resulting in a failure to thrive (Fox, 1995; Gray and Bentovim, 1996\(^{22}\)).

The most common illness symptoms fabricated or induced in children are seizures, fevers, diarrhoea, and apnoea (Rosenberg, 1987; Sheridan, 2003). However, Rosenberg (1987: 558) suggests methods of simulating or producing illnesses in children are ‘virtually limitless’ and that ‘almost nothing is ridiculous or far fetched’. Child victims of FII/MBP may also be subjected to other forms of child abuse (Bools et al. 1992; Southall et al. 1997) or may suffer from a genuine illness (Schreier and Libow, 1993; Hall et al. 2000).

2.2.4 FII/MBP perpetrators, spouses and victims

An overview of the literature associated with perpetrators who fabricate and/or induce illness in their children, their spouses and their victims is presented.

2.2.4.1 Offenders

The biological mother is consistently reported as the dominant perpetrator in FII/MBP cases (Rosenberg, 1987; Sheridan, 2003). Fathers, carers, grandparents, aunts and nurses have also been reported as perpetrators, although to a much lesser degree (Rosenberg, 1987; Sheridan, 2003). Feldman (2004: 124) suggests there are many theories about the dominance

\(^{21}\) See also Rosen et al. 1983, 1986; Epstein, Markowitz and Gallo et al. 1987; Williams, and Bevan, 1988; Boros and Brubaker, 1992; Samuels, MacClaughlin and Jacobson, 1992; Emery,1993; Byard and Burnell, 1994, Shepherd, 1995; Adshead, Brooke, Samuels, Jenner and Southall, 2000; and Chiczewski and Kelly, 2003.

\(^{22}\) See also Bahen et al. 1988; Roesler et al. 1994; and Alexander and Frasier, 1995.
of female offending, but the main reason may be ‘the greater time spent by women in caretaking roles and the correspondingly greater unsupervised and unwitnessed access to children’. However, Meadow (1998) suggests the caretaker explanation does not account for the fact that physical abuse is equally committed by mothers and fathers, despite mothers generally being the primary carer. Meadow (1998) suggests the overrepresentation of female FII/MBP perpetrators may be linked to the emphasis in published reports on the perpetrator being the child’s mother, therefore, discouraging some professionals from identifying male perpetrators.

Lasher and Sheridan (2004: 25) highlight that some researchers, such as Guerisik (1997), suggest women are ‘disproportionately’ accused of FII/MBP because of their ‘marginalized and discounted status in society’. Further, Robins and Sesan (1991: 287) suggest the typical family unit may mean women are more vulnerable than men and use their children to meet their own needs.

To educate others, many researchers have documented indicators, characteristics, or behaviours associated with FII/MBP perpetrators or their offending that may prompt professionals to consider this abuse (Meadow, 1982, 1994; Rosenberg, 1987; Samuels and Southall, 1992). The benefit of

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23 Researchers use different terminology in relation to women who fabricate and/or induce illness in their children. Some will refer to them as ‘mothers’, ‘parents’ or ‘carers’ (Schreier and Libow, 1993; Department of Health, 2001, RCPCH, 2002), others may use words such as ‘perpetrators’ (Artingstall, 1999; RCPCH, 2002; Lasher and Sheridan, 2004; Feldman, 2004a) or ‘offenders’ (Artingstall, 1999). The researcher has sought where possible to utilise the terminology employed by the individual researchers, although, at times, this proved difficult when utilising multiple references.

24 Refer Appendix 3 for an overview of warning signs that might alert a clinician to the presence of factitious illness (Plunkett and Southall, cited in Adshead and Brooke, 2001: 79).
these descriptions is controversial (Morley, 1995; Hayward-Brown, 2004; Sanders and Bursch, 2002). Meadow (1994: 125) suggests whilst ‘warning signals may be helpful they are by no means a universal characteristic of every perpetrator’. He cautions against professionals viewing such perpetrators as a ‘homogenous group,’ due to the ‘different personalities and types of perpetrators’. Morely (1995: 50) and Hayward-Brown (1999: 45) argue behavioural profiles associated with FII/MBP may lead medical practitioners to wrongly interpret behaviour and to hastily accuse women of harming their child. Further, Sanders and Bursch (2002: 117) note that behaviours associated with FII/MBP perpetrators can also be commonly seen in mothers who are ‘strong advocates for their genuinely ill children’ and that some FII/MBP perpetrators will not fit the traditional MBP profile. Makar and Squier (1990: 372) also suggest that fathers perpetrating this abuse may be even more difficult to detect if they do not fit previously described personalities and traits associated with mothers.

By contrast, authors such as Artingstall (1999), Samuels (2001), Plunkett and Southall (2001) and Lasher and Sheridan (2004) emphasise that behavioural information relating to FII/MBP perpetrators is invaluable in prompting professionals to consider the possibility of abuse. Researchers such as Fox (1995) and Lasher and Sheridan (2004) believe that FII/MBP cases are often missed because professionals lack knowledge of such abuse and fail to recognise its patterns. Sheridan (2003) concluded that:
The most important decision is whether a child is being maltreated and whether knowledge about MBP may help professionals deal with the maltreatment.

Sheridan, 2003: 444

Mothers who fabricate and/or induce illness in their children may range from very bright (Rosenberg, 1987; Schreier and Libow, 1993), to low level functioning (Schreier and Libow, 1993; Rosenberg, 1997), and/or belong to a range of social classes (Rosenberg, 1987; Gray and Bentovim, 1996). Some may possess medical training or a good knowledge of medical procedures (Rosenberg, 1987; Sheridan, 2003). However, Morley (1995) and Hayward-Brown (2004) note that parents of genuinely sick children may also be well informed about their child’s illness and consequent medical procedures.

Additional information on the background behavioural and personal characteristics of offenders who fabricate and/or induce illness in their children follows.

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25 The very nature of MBP abuse, such as the undetected interference with catheters and feeding tubes over lengthy periods, was seen in itself to require a certain level of knowledge and intelligence (Artingstall, 1999).

26 Schreier and Libow (1993: 17) observed that these women whilst seemingly ‘intellectually sophisticated and generally well educated’, may also ‘appear shallow’ in their ‘other interactions’, ‘have limited interpersonal skills outside of medical issues’, and ‘exhibit poor judgment’. Schreier and Libow (1993: 17) gave the example of one offending mother who knew the name of several types of human blood vessels, but did not know the number of weeks in a year.

27 Rosenberg (1987) found 27% of offenders to have had nursing training or experience and an additional 3% to have had medical office experience. Of the 451 MBP cases Sheridan (2003) examined in her literature review, she found 64 (14.16%) of the offenders had employment or training in a health related profession, with nurse (n=28) being the most common occupation followed by nursing assistant (n=13).

28 These characteristics are not intended to portray a profile of these perpetrators, but rather
a. Deception

Mothers who fabricate and/or induce illness in their children are often described as seemingly loving, caring and doting mothers (Meadow, 1982b; Rosenberg, 1987, 1997; Bryk and Siegel, 1997; Stanton and Simpson). However, covert video hospital surveillance has shown that within seconds of being alone with their child, FII/MBP perpetrators can become cruel and sadistic (Southall et al. 1997; Hall et al. 2000). Wilkinson and Parnell (1998: 233) stress that police need to be ‘aware’ that MBP perpetrators can be some of the ‘smoothest liars’ they will ‘ever encounter’. Some perpetrators will even obtain financial benefits for their child as a result of their deception (Pickford et al. 1988; Freeland and Foley, 1992; Fox, 1995). Eminson (2000: 65) believes the more intellectually able the parents, the more capable they will be at carrying out and concealing their abuse.

Schreier and Libow (1993: 58-59) suggest ‘social distortions cause us to idealize motherhood; to take the appearance of ‘good motherhood’ for its reality and therefore often ignore evidence that points to the mother as the

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29 Rosenberg (1997: 417) suggests that FII/MBP perpetrators are highly effective in playing the role of a mother with a sick child and can perceive what the doctors expect right ‘down to the subtlest nuance’.

30 A victim of induced illness, as documented by Bryk and Siegel (1997: 5) describes her mother: ‘My mother is an incredible liar and a powerfully deceptive actress. To date unexpectedly she denies ever abusing me, my brother or herself. Also may family members, friends and neighbours continue to view her as the model mother’. By six years of age, this victim had lost three quarters of her skin on one arm due to third degree burns inflicted by her mother. The burns were mistakenly diagnosed by medical personnel for severe skin infections. There is no indication of criminal charges being pursued in this case.

31 The ability of such women to deceive and ‘engage the trust and compassion’ of others is verified by Stanton and Simpson (2001: 458) who reported a case of a mother who murdered two of her own children and then proceeded to murder a neighbour’s child whom she had persuaded the parents to baby-sit.

32 See also Fox, 1995; Shepherd, 1995; Artingstall and Brubaker, 1995; Stanton and Simpson, 2001.

33 Freeland and Foley (1992:144) describe one mother who successfully applied for public housing to accommodate a non-existent child who was allegedly confined to a wheelchair.
cause of harm to her child’. Horwath and Lawson (1995a: 191) suggest professionals need to be mindful that their perceptions may become distorted by their image of motherhood, particularly when conducting risk assessments.

b. **Power and control**

Child victims of FII/MBP are frequently described as ‘tools’ or ‘objects’ in the hands of their mothers (Sigal et al. 1989; Schreier and Libow, 1993; Shepherd, 1995)\(^{34}\). A victim of FII/MBP, as reported by Bryk and Siegel (1997: 5), indicated her mother would try and keep her ‘dependent’, ‘demean her’, and ‘destroy her self esteem’\(^{35}\).

The literature frequently reports such women dominate their spouses (Bryk and Siegel, 1997; Gregory, 2003; Benns, 2003) often described as controlling and manipulative (Donald and Jureidini, 1996; Schreier, 2002). Researchers note such women may demand multiple and unnecessary invasive medical procedures be performed on their child (Guandolo, 1985; Bryk and Siegel, 1997). However, Sanders and Bursch (2002: 117) also stress that concerned parents with a genuinely ill child may well ‘advocate’ for medical tests and allow doctors to perform whatever tests deemed necessary. Additionally, Eminson (2000b: 39) believes medical professionals now feel ‘a greater

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\(^{34}\) Mothers may dominate their children’s actions and/or conversations (Guandolo, 1985; Bryk and Siegel, 1997; Gregory, 2003). Older children may be isolated from other children through restricted schooling and living activities (Woollcott et al. 1982; Meadow, 1984; Guandolo, 1985; Feldman, 2004a).

\(^{35}\) The victim further stated: ‘I became truly terrified of her and understood the extent of her power over me. Her love was connected to hurting me and keeping me sick. She threatened that if I told the truth no one would believe me. I would be taken away from the family forever. It was enough of a threat to keep me silent for 30 years’ (cited in Bryk and Siegel, 1997: 3).
compulsion to comply with parents' medical requests due to fear of litigation and suggests this has altered the traditional power relationship between parents and doctors. She states ‘for parents who have perhaps been relatively powerless’ in their lives this would be ‘a novel and exciting position’ (Eminson, 2000b: 41). Ayoub et al. (2000: 219) describe FII/MBP perpetrators taking ‘pride in their deception’ and feeling ‘exhilarated’ by fooling ‘important and influential people’.

Doctor shopping is also commonly reported in association with FII/MBP (Libow and Schreier, 1986; Rosenberg, 1987). However, Lasher and Sheridan (2004) note doctor shopping may not always be present if current professionals meet the needs of such women. Hayward-Brown (2004) notes that doctor shopping is perfectly normal for genuinely concerned parents wishing to obtain additional medical opinions.

c. Loneliness and a lack of self worth

These mothers have also been described as possessing underlying qualities of loneliness, abandonment, lack of self worth, neglect and/or isolation (Schreier and Libow, 1993; Fisher, 1995a). Guandolo (1985) and Eminson (2000b) believe the medical system provides a means for these women to feel important and to address inadequacy and self worth feelings. Finally, Schreier and Libow (1993) and Artingstall (1999) suggest such women may be oppressed through their role of caregiver and use their child to gain power and control. Schreier and Libow (1993: 105, 113) note that whilst motherhood provides its rewards ‘it does little to address many women’s
continuing needs for a sense of self esteem and a sense of recognition and power as an autonomous person’ and suggest it is not surprising that some of these mothers find hospital life attractive and want to remain in this exciting and nurturing environment.

d. **Attention seeking**

These mothers are frequently reported displaying attention seeking behaviour (Meadow, 1982, 1995; Birge, 1995; Schreier and Libow, 1993) and to thrive in the hospital environment (Hall et al. 2000; Gregory, 2003). However, Morely (1995: 49) also notes that it is not unusual for parents of genuinely sick children to be ‘pleased with the attention from staff’.

Additional environments where these women seek attention include schools (Palladino, 1998; Feldman, 2004a), churches (Feldman, 2004a), the community (Freeland and Foley, 1992; Feldman, 2004a); the media (Schreier, 2002); police and the fire-brigade (Artingstall, 1999). Rosenberg (1997: 416) suggests such women’s attention seeking behaviour may ‘extend to many realms and consume much of their time’. The perpetrator’s spouse

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36 Birge (1995) described one mother who continually sought attention throughout her life. This included the production of weapons whilst at secondary school, the lighting of fires, reporting false pregnancies and rapes, using false details, and inducing illness/injury in her children, in two cases fatally.

37 See also Birge, 1995; Fox, 1995; Shepherd, 1995; Southall et al. 1997; Goldfarb, 1998; Artingstall, 1999; Hall et al. 2000; Sanders and Bursch, 2002; Schreier, 2002; Ayoub, Schreier and Keller, 2002; Lasher and Sheridan, 2004.

38 Such families have been reported to thrive on fundraising and charity events (Feldman, 2004a).

39 Attention seeking behaviours may include: false reports of burglaries or sexual assault to the police (Rosenberg, 1987; Birge, 1995; Artingstall, 1999); false reports of fires to the fire-brigade (Artingstall, 1999); cruelty to pets (Southall et al. 1997; Brown, 2003) and false employment backgrounds (Guandolo, 1985; Feldman, 2004a).
may also form a key reason for the behaviour of these women (Alexander, 1995; Hall et al. 2000; Coren, 2005).

e. Dysfunctional histories

Rosenberg (1987), Southall et al. (1997) and Sheridan (2003) found mothers who deliberately induce illness symptoms in their child have often lived dysfunctional lives. They describe behaviours such as self harm, eating disorders, overdoses, domestic violence, attention seeking, and abnormal illness behaviour. Further, such women may have experienced sexual, physical and/or emotional abuse (Black, 1981; Rosenberg, 1987; Fisher, 1995; Sheridan, 2003). Sheridan (2003) identified 21.7% (98) of offenders in her research with a personal history of abuse, either in childhood or in a partner relationship. Fisher (1995: 47) reported all of the women he had treated had experienced some form of emotional, physical or sexual abuse. Further, numerous researchers reported these women lacked attachment with either one or both of their parents (Nicol and Eccles, 1985; Schreier and Libow, 1993). By contrast, Samuels and Southall (1992) found sexual and physical abuse was infrequently associated with such women and Rosenberg (1987) reported physical and emotional abuse as

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40 Hall et al. (2000) raised the possibility that the mother is rewarded when the child is ill as the father, who generally works long hours, spends more time with the family.
41 Fisher (1995: 47) reported all of the women he had treated had experienced some form of emotional, physical or sexual abuse.
42 Sheridan (2003) identified 21.7% (98) of offenders in her research with a personal history of abuse, either in childhood or in a partner relationship.
uncommon. Finally, Schreier and Libow (1993: 20) suggested that some of these mothers will possess a normal family background.

f. The issue of intent

Researchers, such as Boros et al. (1995), Southall et al. (1997) and Stanton and Simpson (2001) suggest mothers who fabricate and/or induce illness symptoms in their children generally comprehend their actions and are fully aware of the consequences for their child. Boros et al. (1995: 772) indicate FII/MBP is ‘cold’, ‘premeditated’, and often requires ‘meticulous preparations’. Further, Southall et al. (1997: 753) suggest covert video surveillance has proven the deliberate and calculated nature of this abuse. By contrast, Bluglass (2001: 177-178) suggests the intent of these perpetrators is diverse and that ‘the severity of the intent can not always be directly inferred from the behaviour’.

The issue of intent is relevant to police investigation\(^{45}\). Ultimately it influences what charges are laid, possible arguments raised during trial, and the offender’s final sentence (Ayoub, Deutsch and Kinscherff, 2000). Kinscherff and Ayoub (2000: 252) suggest ‘from a legal perspective people are ordinarily expected to be responsible for the reasonably predictable consequences of their action’. They suggest that in assessing criminality the courts examine such factors as ‘evidence of planning, efforts to hide actions or destroy evidence of actions, and the degree of predictability between the

\(^{45}\) The mother’s intent is also relevant to child protection proceedings as it may influence access decisions relating to the mother with her child (Rosenberg 1995) and treatment options for the mother (Meadow, 1985; Rosenberg, 1995).
defendant’s behaviour and its outcome upon the victim’ (Kinscherff and Ayoub, 2000: 253). Interestingly, male perpetrators of FII/MBP are more likely to incur criminal prosecution than female perpetrators and to receive harsher penalties (Meadow, 1999; Artingstall, 1999). Artingstall (1999) suggests courts may have difficulty seeing these women as perpetrators of crime.

Perpetrators’ legal sanity may be raised within the courts (Ayoub et al. 2000). It is generally agreed they do not suffer a mental illness (Rosenberg, 1987; Southall et al. 1997⁴⁶), although Wilkinson (Wilkinson and Parnell, 1998: 244) believes some of these mothers will be mentally ill, but not to the level of an insanity case. However, many researchers identify personality disorders in these mothers (Bools et al. 1994; Fisher, 1995; Southall et al. 1997).

The question of whether these mothers actually intend to kill their children is contentious (Sigal et al. 1989; Rosenberg, 1995; Chadwick, 1996). Artingstall (1999: 273) suggests ‘homicidal intent’ must be ‘individually’ evaluated with each case and that there may be a ‘fine line between intentional and accidental homicide’ (Artingstall, 1999: 252). She highlights an offender may shift to killing her child due to issues of ‘detection’, ‘medical complication(s)’, ‘convenience’, or ‘dissatisfaction’ with the abuse as a means of ‘power and control over interpersonal familial relationships’ (Artingstall, 1999: 274)⁴⁷. Further, Artingstall (1999: 273-274) claims these offenders

⁴⁶ See also Meadow, 1985; 1994; Leeder, 1990; Samuels and Southall, 1992; Feldman, 2004a.
⁴⁷ Brown (2003) in an article in the Herald Sun (Knowles, May 22, 2003: 5) described her sister, Kathleen Folbigg, as killing her four children because they were simply in the way of
may only ever intend to make their child sick, but may misjudge the effects of their actions, or the child’s body may not cope with the subsequent medical treatment, resulting in death.

Finally, the issue of what motivates these women is considered to be complex (Meadow, 1995; Shepherd, 1995; Artingstall, 1999). Varied motivational theories associated with FII/MBP exist within the research. Fisher (1995a: 46) believes there is generally a ‘mixture of variables’ or a ‘set of risk factors’ present and when exposed to certain situations these compound to trigger such abuse (Fisher, 1995a: 45; see also Eminson, 2000b: 32). However, researchers also argue that not enough is yet known about the ‘pathways’ and ‘motivations’ that may lead mothers to fabricate and/or induce illness in their children (Eminson, 2000b: 30; see also Samuels et al. 1992; Fisher, 1995a).

2.2.4.2 The spouses

Mothers who fabricate and/or induce illness in their children are generally married (Alexander et al. 1990; Southall et al. 1997), although some may be single parents (Lasher and Sheridan, 2004). Much research suggests that spouses of perpetrators are often emotionally or physically distant within the
family and tend to play a passive role in their child’s care (see Meadow, 1982; Schreier and Libow, 1993; Loader and Kelly, 199650). However, researchers, Schreier and Libow (1993); Sanders and Bursch (2002) and Lasher and Sheridan (2004), note it is not unusual within our culture for fathers of sick children to be less involved in their care than the mother. Finally, researchers such as Artingstall (1999) and Parnell (1998a) believe there is ‘often severe and long standing, but well hidden marital discord in these families’ (Parnell (1998a: 59)51.

Typically, spouses in FII/MBP cases genuinely believe in their child’s illness and are oblivious to their wife’s offending (Meadow, 1982; Schreier and Libow, 1993), although, whilst considered rare, some spouses may assist in the abuse (Meadow, 1994). Artingstall and Brubaker (1995: 82) contended the spouse was generally the ‘most entrenched’ person in their wife’s lies and ‘twists of reality’52.

When confronted by the truth such spouses will often initially be in shock and then vehemently defend their wife (Bryk and Siegel, 1997; Schreier and Libow, 199353). However, some spouses will protect their child (Schreier and

50 Loader and Kelly (1996: 538) describe one father as being a ‘shadowy member of the family’ who was ‘unsupportive’ of ‘his wife’ and ‘uninvolved’ with his ‘children’. They indicated that he was ‘unaware of his wife’s mounting desperation and of the danger to his child’ (Loader and Kelly, 1996: 361).
52 Benns (2003: 145) described the husband of Kathleen Folbigg as besotted with his wife even after four of his children had died in somewhat unexplained circumstances; he had found his wife with another man; and he had located his wife’s diary containing incriminating comments suggesting she murdered their four children.
53 See also Zitelli et al. 1987; Freeland and Foley, 1992; Artingstall and Brubaker, 1995; Loader and Kelly, 1996; Bryk and Siegel, 1997; Parnell, 1998b, Ayoub et al. 2000; Schreier, 2002; Benns, 2003; Gregory, 2003.
Libow, 1993) and others have been described as displaying a sense of passivity towards the situation (Guandolo, 1985\textsuperscript{54}; Orenstein and Wasserman, 1986). Lasher and Sheridan (2004) emphasise the spouse must acknowledge his wife’s offending if he is to protect his child. Finally, Schreier and Libow (1993) and Alexander (1995) suggest the spouse plays a complex role in the existence of such abuse and in these family dynamics and that further research is required in order to understand the spouse’s position.

2.2.4.3 \textit{The victims}

Victims of FII/MBP abuse are generally young babies to children up to about five to six years of age (Meadow, 1982b, 1994; Rosenberg, 1987, 1997; Sheridan, 2003)\textsuperscript{55}. However, such abuse has also been reported with babies in the womb (Jureidini, 1993), older children (Guandolo, 1985; Sanders, 1995), adolescents (Bryk and Siegel, 1997; Gregory, 2003), and adults (Smith and Arden 1989; Sigal and Altmark, 1995; Ben-Chetrit and Melmed, 1998\textsuperscript{56}). Gender is not considered a factor in becoming a victim (Rosenberg, 1987; Sheridan, 2003)\textsuperscript{57}.

\textsuperscript{54} The father described in Guandolo (1985: 529), whilst cooperative with professionals, was also described as being ‘indifferent and aloof’ to the situation.

\textsuperscript{55} Summit (1990) highlights that children are the perfect victims, noting they are entirely dependent and innocent, and seek the attention, approval and affection of adults.

\textsuperscript{56} Ben-Chetrit and Melmed (1998) reported a case of a 73 year old woman, whose daughter (a nurse) was suspected of injecting her with insulin.

\textsuperscript{57} Of the 117 cases Rosenberg (1987) studied, 46% were male victims, 45% females and 9% were unidentified. The results suggest that mothers that commit this form of abuse (which is the majority of offenders) are not gender specific with their victims. Sheridan found of 415 children examined, 52% were male victims and 48% were females. Sheridan’s research (2003: 436), however, also identified that with the few fathers who committed this form of abuse, the sons tended to be abused more than the daughters (twenty-one males to seven females).
Perpetrators generally offend against one child in the family at a time, with the abuse shifting to a younger sibling as the initial child grows older (Alexander et al. 1990). However, cases of abuse occurring simultaneously with multiple siblings (Lasher and Sheridan, 2004) or with only one child (Hall et al. 2000) have also been reported. Perpetrators have also been noted to escalate or de-escalate their behaviour (Schreier and Libow, 1993; Southall et al. 1997; Seibel and Parnell, 1998), stop their abuse for a period and recommence at a later date (Gregory, 2003), alter their method of offending (Lasher and Sheridan, 2004) or begin offending on themselves (Bryk and Siegel, 1997). In some cases, with professional intervention, the abuse may subside (Nicol and Eccles, 1985\(^58\); Gray et al. 1995).

FII/MBP can have mild to serious ramifications for children, including life threatening injuries or death (Bools et al. 1992, 1993; Southall et al. 1997\(^59\)). Libow (1995) reported victims may experience emotional stress, serious depression, insecurity, low self esteem and problems with school. Moran (2001:3) suggests this type of behaviour may lead to a child ‘developing a learned pattern of illness behaviour that becomes entrenched and influences how he or she manages a variety of situations in adulthood’. Further, researchers such as Fox (1995) and Bryk and Siegel (1997) report permanent physical scarring with some victims and irreparable damage.

\(^58\) See also Eminson and Postelthwaite, 1992; Sanders, 1996; Parnell and Day, 1998; Berg and Jones, 1999.

Artingstall (1999: 112-113) suggests whether these children understand their mother’s abuse will depend on their ‘physical age’ and ‘covert skill’ of the mother. Schreier and Libow (1993: 26) report many cases where toddlers have been aware of their mother’s actions, with researchers such as Porter, Heitsch and Miller (1994); Day and Ojeda-Castro (1998) and Awadallah et al. (2005) noting children may demonstrate evidence of abuse through their behaviour and/or play. However, Howes (1995) and Feldman (2004) also emphasize that young children may be unable to differentiate reality from their mother’s lies.

The literature reports that some mothers may coach their child into being sick (Sanders, 1995; Hall et al. 2000). Further, a form of collusion may arise between older children and their offending mother (Waller, 1983; Meadow, 1985). Artingstall (1999: 54) reports the child may view their illness as connected to their mother’s love and therefore will help to maintain the deception rather than risk parental abandonment. Goddard (1988, cited in Stanley and Goddard, 2002:154) used the term ‘hostage theory’ to describe this type of collusive relationship and noted that a similar process can occur between child protection workers and parents (Stanley and Goddard, 2002).

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60 Hall et al. (2000: 1311 found through covert video surveillance (CVS) with audio facilities, mothers coaching their children to have illness symptoms.
62 The use of the word, ‘collusion’ to describe this situation is controversial. Some argue that as the child may not have the skills or emotional maturity to do anything but support the mother, the word collusion is not appropriate (Rosenberg, 1995; Parnell, 1998; Lasher and Sheridan, 2004).
63 Stanley and Goddard (2002: 154) indicate that ‘some children who have been maltreated respond with helplessness and use defence mechanisms, such as denial, disassociation and identification with the aggressor’.
There is limited, but growing research (Libow, 1995; Bryk and Siegel, 1997; Gregory, 2003; Feldman, 2004a) indicating the victims’ perspectives in relation to FII/MBP. One victim comments:

Each time I review my medical records, I go through a period of mourning for a childhood lost. In the name of sickness…I am disfigured with permanent physical scars. Because of distorted motherly love, I continue to battle deep emotional wounds.

Cited in Bryk and Siegel, 1997: 4

By contrast, Hayward-Brown (1999: 38) contends mothers in FII/MBP cases are the victims. She suggests mothers are being wrongly suspected of this abuse and made to feel isolated and guilty for something they have not done (Hayward-Brown, 1999: 4). Hayward-Brown (1999) recorded the words of one mother:

I feel that I have been emotionally raped and my trust in people that I don't know very well is practically nonexistent.

Hayward-Brown, 1999: 43

However, Fox (1995: 108) maintains where the focus is on protecting children there will ‘inevitably be cases where innocent people are caught up in the assessment process, as happens in all aspects of child protection work and indeed investigation into all types of crime’. Further, Feldman (2004a: 123) warns whilst some mothers will be wrongly accused there are some, guilty of

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64 Mitchell, (2001) thought this was possibly due to difficulties in confirming this abuse and a lack of follow up with the children involved.
such abuse, who will align themselves with people and groups that promote their perceived innocence and conceal their crimes.\textsuperscript{65}

\subsection*{2.2.5 The personal impact of FII/MBP cases on professionals}

In responding to and investigating FII/MBP cases, the literature typically reports such cases as being complex, time-consuming and taxing on professionals’ time, energy and emotions (Meadow 1985; Freeland and Foley, 1992).\textsuperscript{66} Freeland and Foley (1992: 141-142) state ‘the stress, emotional turmoil and energy’ required with FII/MBP cases ‘can exceed that required in almost any other kind of casework activity’ and that ‘even the most experienced practitioner is likely to be tested by serious Munchausen by Proxy cases’. Lawson and Horwath (1995: 2) suggested any professional involved with a FII/MBP case would be ‘unlikely to forget the experience’. Doctors (Australian Paediatric Surveillance Unit, 2000:2), child protection workers (RCPCH, 2002) and police (Artingstall, 1999) are challenged by FII/MBP cases. The Australian Paediatric Surveillance Unit (2000:2) found that doctors, particularly those working in rural regions lacking the support of a multi-disciplinary child protection team, find FII/MBP cases stressful. The RCPCH (2002: 61-62) describe child protection workers as feeling ‘isolated, unsupported and unprotected’ in dealing with these cases. Artingstall (1999: 38) reports such cases can create ‘havoc’ within police agencies, challenge the ability of detectives, and confront police officers’ emotions. She further

\textsuperscript{65} Feldman (2004a: 123) reports ‘an entire industry’ of psychologists, attorneys and people lacking clinical experience has arisen in support of such women and suggests these professionals fail to see the potential danger for the child.

\textsuperscript{66} See also Goldfarb, 1998; Whelan-Williams and Baker, 1998; Eminson and Jureidini, 2003; Feldman, 2004a. Refer Appendix 4 for an overview of common issues experienced by professionals involved with FII/MBP cases.
suggests the emergence of FII/MBP cases in the criminal justice system has been met by a ‘flurry of confusion and disbelief’.

2.3 The police role with FII/MBP cases and cases of sudden unexpected deaths of infants.

This section examines the police role with FII/MBP cases and cases of sudden unexpected deaths of infants (SUDI). Additionally, it examines documentation that guides the police response to child abuse cases in Victoria.

2.3.1 The police role with FII/MBP cases

Police involvement in FII/MBP cases is a relatively new development. This form of abuse has traditionally been viewed as a medical problem, rather than a type of criminal behaviour (Fox, 1995; Boris et al. 1995; Shepherd, 1995). The RCPCH (2002) describe the police role with FII/MBP cases to investigate cases of possible criminal action and gather evidence in connection with such behaviour. The Department of Health (2001) indicate that:

Any suspected case of fabricated or induced illness may also involve the commission of a crime therefore the police should always be involved.

Department of Health, 2001: 45

Shepherd (1995: 325), a US police officer, defined the police role as conducting:
A systematic inquiry to either prove or disprove an allegation, complaint, or incident report of a criminal nature.

Shepherd, 1995: 325

Police also have a role to play in ensuring the child’s safety (Shepherd, 1995; DHS and Victoria Police, 1998; Artingstall, 1999). Fox (1995: 108) concluded police must ‘aim to prevent further unnecessary harm to the child, preserve evidence, and ensure that the perpetrator does not become aware of an impending investigation, thereby covering their tracks and perhaps continuing the abuse in some more subtle, less detectable form’. Southall et al. (2003: 1) further suggest if criminal abuse is likely ‘police must lead and be responsible for the child protection process’. They considered police officers were less easily intimidated than social workers and trained in the forensic aspects of gathering evidence necessary to ensure a rigorous investigation.

In Victoria, FII/MBP cases are generally handled jointly by a member from a Sexual Offences and Child Abuse Unit (SOCAU) and a detective from a Criminal Investigation Unit (CIU). If a death is involved the Homicide Squad are consulted and may become involved if there are suspicious circumstances. The UK Department of Health (1999: 24) stress safeguarding children is not solely the role of CPU (Child Protection Unit) officers, but a fundamental part of all police officers’ duties. The DHS/Victoria Police (1998:4) protocol also supports this position.

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67 See Appendix 5 for an overview of these policing areas. On 1 July 2006 the Major Crime Desk and Crime Theme Desks were introduced into Victoria to assist in the management of major crime investigations.
2.3.2 The involvement of police in practice

Researchers, Horwath and Kessel (1995) and Bentovim (2001) considered whether professionals involved police partly depended upon how they viewed these offenders and their offending. Bentovim (2001: 5) suggested there is a ‘division’ in the ‘child abuse field’, between those who feel such parents should be punished for their actions and those who feel they need ‘treatment and understanding’. Horwath and Kessel (1995: 79) suggest professionals can hold preconceived ideas of how other agencies operate resulting in reluctance to involve such agencies. They note a common reluctance by medical personnel to involve the police until all other alternatives have been considered. Goddard (1996: 145) suggests whilst it is generally accepted that child abuse can involve criminal behaviour, there is much uncertainty about the use of the criminal law in response to child abuse. He also suggests there is general concern about police involvement and the possibility of the parents being criminally charged which may contribute to a reluctance to report. Meadow (1985: 390) thought police would be unlikely to devote a great deal of time or energy to FII/MBP cases unless they believed a criminal prosecution might result.

Limited Australian research exists that examines the police role with FII/MBP cases. However, a number of Australian articles highlight the need for professionals, including police, to work cooperatively if these cases are to be successfully managed (Batten, 1987; Roberts and Carmichael, 1999; Fish et al. 2005).
2.3.3 Issues facing police in dealing with FII/MBP cases

The literature reports a range of issues associated with police and FII/MBP investigations. These issues can be divided into three main areas; those that relate to the police officers themselves, those associated with other agencies and those linked to the very nature of FII/MBP cases.\(^{68}\)

2.3.3.1 Issues relating to police

The literature discusses a range of issues associated with the police officers themselves which impact on the police response to FII/MBP cases. Such issues include a lack of knowledge by police about FII/MBP investigations (Fox, 1995; Birge, 1996; Artingstall, 1999); an inability by police to see patterns of victimization due to ingrained investigative techniques (Artingstall, 1999) and a fear of failure or embarrassment of losing a case in court and therefore not wanting to commit police resources to a case (Artingstall, 1999). Artingstall (1999) also suggests liability concerns may influence the police investigation and lead to decisions not to pursue a particular avenue of investigation such as the use of covert video surveillance. Finally, Artingstall (1999: 203) suggests victims may be devalued by police: - ‘it’s just a child; if he dies then we will just work a homicide case’ - and individual members punished for getting involved with such a case: - ‘We think that you are misguided and need a break so we’re transferring you (to a remote post). Of course, all your records will be shredded in accordance with policy’.

\(^{68}\) See also Appendix 6 which presents a précis of points covered in section 2.3.3 and Appendix 4 which addresses common issues facing professionals involved with FII/MBP cases.
2.3.3.2 Other agencies’ perspectives

Issues that impact on the police response to FII/MBP cases may also be linked to other agencies. Such issues include a lack of trust of police (Horwath and Lawson, 1995; Fox, 1995), a reluctance to involve police until all other alternatives have been considered (Horwath and Kessel, 1995; Fox, 1995) and a stereotypical image of police resulting in fear that police will be insensitive and upset the family and hospital ward life (Horwath and Kessel, 1995). Reynolds (personal communication, 2005) also described the potential for information sharing to be impeded by privacy legislation and/or a doctors’ fear of civil litigation.

2.3.3.3 The nature of FII/MBP cases

Finally, the very nature of FII/MBP cases was found to create difficulties for the police investigation (Artingstall, 1999; Department of Health, 2001). This included a lack of concrete evidence in FII/MBP cases (Batten, 1988; Yeo, 1996); the young age of the victims, and the manipulative and deceptive nature of FII/MBP perpetrators, with this offending typically committed in the privacy of the home (Artingstall, 1999).

2.3.4 Guidance for police dealing with FII/MBP cases in Victoria

There are no specific documents that provide guidance for police in dealing with FII/MBP cases. However, various police framework documents and/or statements exist relevant to FII/MBP cases (Victoria Police Mission statement; Department of Human Services (DHS) and Victoria Police, 1998;
The Victoria Police mission statement is ‘to provide a safe, secure and orderly society by serving the community and the law’ (The Victoria Police Manual, 2003). The DHS and Victoria Police (1998) protocols provide the cooperative framework necessary ‘to ensure that an effective response to child abuse is provided during protective and criminal investigations’ (DHS and Victoria Police, 1998:1) and outline the key responsibilities of Victoria Police in relation to child abuse:

- Ensure all police accept and carry out their responsibilities under the CYPA

- Conduct all investigations on the basis that the safety and welfare of the child are paramount

- Plan investigations in collaboration with other relevant agencies

- Work with other agencies in line with agreed work practices

- Provide information to other relevant agencies

- Provide training for staff, and jointly, with relevant agencies.

DHS and Victoria Police, 1998: 4

Whilst FII/MBP is not defined in the protocol it has features of physical abuse, as well as neglect and emotional abuse which are described within the
protocol. It may also fall within the realms of sexual abuse (see section 2.2.3). The protocols depict that police must report to Child Protection all allegations and situations of physical abuse, sexual abuse, emotional abuse and neglect, where protective issues are likely to be involved. Child Protection must report to Police all allegations and situations of sexual abuse, physical abuse and serious neglect to a child or young person.

In reference to investigating crime, the Victoria Police Manual (2003) states that Victoria Police members have a responsibility to:

- Determine if a crime has been committed
- Determine the facts of the offence
- Obtain all evidence and
- Bring the person/s committing the crime before a court.


Additionally, police must comply with legislation such as the Children Youth and Families Act, 2005, the Crimes Act, 1958 and the Human Rights Charter.69

69 The Human Rights Charter is a law that places legal responsibilities on public sector employees to protect the human rights of all people in Victoria (Department of Justice, 2007).
2.3.5 Police and SUDI cases

Some FII/MBP cases may involve the sudden and unexpected death of an infant (SUDI\textsuperscript{70}) or child (Meadow, 1990; 1999; Craft and Hall, 2004) or multiple infant/child deaths (Southall et al. 1997; RCP and RCPCH, 2004). A multidisciplinary approach to SUDI case management is generally supported (RCP and RCPCH, 2004; Fleming et al. 2004; NSW Child Death Review Team, 2005). Police play a key role in this approach (RCP and RCPCH, 2004; NSW Child Death Review Team, 2005). However, tension exists between police and medical personnel regarding the police role (see RCP and RCPCH, 2004: 13). For example, the RCP and RCPCH (2004: 13) report suggests police need to understand that the majority of SUDI cases will be genuine SIDS deaths and that only a few SUDI cases should give cause for police suspicion. However, the police component of this report emphasises the need for police to investigate SUDI cases on behalf of the deceased child and any future siblings, and suggests that as the percentage of SIDS cases decreases through education the proportion of homicide cases will increase (RCP and RCPCH, 2004: 66). The NSW Child Death Review Team (2005: 33) supports a balance between providing care for the family and conducting an investigation on behalf of the deceased infant.

The Foundation for the Study of Infant Deaths found that parents of a child who has died suddenly and unexpectedly will accept the need for a police

\textsuperscript{70} The literature reflects that the term SUDI is starting to be used as an umbrella categorisation of deaths of children under one year of age in which no cause of death is immediately obvious. This categorisation also includes sudden infant death syndrome (Krous et al. 2004; The Commission for Children and Young People and Child Guardian, 2004-2005: 131; The NSW Child Death Review Team, 2005).
investigation, providing it is managed sensitively and ensures a proper balance between medical and forensic elements’ (cited in RCP and RCPCH, 2004: 55). The RCP and RCPCH, (2004: 67) recommend a detective of at least Inspector rank attend the death scene and take charge of such investigations. Additionally, a child protection background is considered important (RCP and RCPCH, 2004; NSW Child Death Review Team, 2005). In contrast, Scurlock, Jennings, Nolte and Freemantle (2006) suggest police attendance may further traumatize these families. Finally, it is generally recognised that further work is needed by agencies, including police, to improve the investigation and management of SUDI cases (Fleming et al. 2000; Levene and Bacon, 2004).  

2.4 A Multidisciplinary Approach to FII/MBP investigations

This section examines the multidisciplinary aspect to FII/MBP investigations and the importance of shared understanding between agencies and agreed multidisciplinary management practices in dealing with FII/MBP.

2.4.1 Why the need for a multidisciplinary approach?

Due to the overlapping medical, protective and policing issues that inevitably arise with FII/MBP cases, a multidisciplinary approach is generally considered to be the best strategy for handling such cases (Department of Health, 2001; RCPCH, 2002; The RCP and the RCPCH, 2004). Lasher

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71 See also RCP and RCPCH, 2004; NSW Child Death Review Team, 2005; American Academy of Pediatrics, 2006.
72 See also Batten, 1987; Horwath and Lawson, 1995; Mian, 1995; Southall et al. 1997;
and Sheridan (2004: 66) suggest agency differences can strengthen such investigations, enhance professionals’ understanding of the situation and allow better management plans to be formulated. Horwath and Lawson (1995: 190) identify ‘working with other professionals’ as a key training area for professionals, including police, involved in FII/MBP cases and suggest such training can improve the quality of investigations, including an increased knowledge of investigation and assessment techniques, and allow for the identification of practice issues and strategies for improvement (Horwath and Lawson, 1995: 208).

Many researchers note individual agencies often hold relevant pieces of information that, only when combined, detail the full picture of the child’s situation (Freeland and Foley, 1992; Yeo, 1996; Samuels, 2001). Wilkinson and Parnell (1998: 222) suggest ‘only through a detailed, coordinated effort that involves a high level of communication among disciplines are the dual goals of child protection and perpetrator accountability likely to be achieved’. Goddard (1996: 115) agrees that interagency work is ‘problematic in the extreme’, however, contends it is ‘unavoidable and ultimately the abused child’s protection depends upon it’. However, James (2000a:4) contends in practice multidisciplinary investigations are extremely difficult to implement.

2.4.2 Individual and Interagency Stress and Conflict

Conflict between agencies handling FII/MBP investigations is also well documented (Fox, 1995; Whelan-Williams and Baker, 1998). The Department of Health (2001: 10) indicate relationships can ‘become strained where there are concerns that illness is being fabricated or induced... and there are differences about how best to safeguard the child’s welfare or indeed whether the child is being abused’. The existence of ‘interagency conflicts’ and ‘a lack of synchronization of services’ have been identified as potentially placing a child’s life at risk and creating rifts between agencies (Dale and Davies, 1985: 451 cited in Bahen et al. 1988: 57).

Internal agency conflict has also been reported. Various researchers note professionals dealing with FII/MBP cases may encounter resistance from colleagues and be the subjected to verbal abuse (Seibel and Parnell, 1998; Parnell, 1998a; Feldman, 2004a). Goddard (1996: 118) describes internal conflict between the Victorian Community Policing Squad and Criminal Investigation Branch in dealing with child abuse and notes the ‘assumptions that regard police as a complete and separate entity are misguided’.

\[73\] See also Neale et al. 1991; Feldman and Hickman, 1998; Lloyd and MacDonald, 2000.

\[74\] See also Freeland and Foley, 1992 and Artingstall, 1999.

\[75\] Parnell (1998a: 66) suggests personal attacks on professionals handling FII/MBP cases can deflect their attention away from the investigation and drain their energy, resulting in professionals’ reluctance to be involved.

\[76\] Now called Sexual Offences and Child Abuse Units (SOCAU).
2.4.3 A failure to share information

Professionals may fail to work together and share information in FII/MBP cases (Fox, 1995; Yeo, 1996; Dyer, 2004). Southall et al. (1997: 233) noted in most families they had dealt with, substantial concerns existed (based on ‘family and social histories’), yet this information was ‘often only known by particular professionals’. The literature suggests communication between agencies is an ongoing issue (Batten et al. 1987; VCDRC, 2006) and is often reported in association with child deaths (Goddard, 1996).

Privacy legislation and/or medical professionals’ fear of civil litigation (Reynolds, personal communication, 2005) have also impeded information sharing in Victoria with police. However, Clark (2005, pers comms) considered a lack of training and an understanding of the Act, rather than the legislation per se as more responsible for issues surrounding information sharing.

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77 In the late 1980’s, Batten (1987: 13), highlighted a lack of integration and communication in Victoria by medical, child protection and police professionals regarding the management of FII/MBP cases. Some twenty-five years later, communication between agencies still remains an issue. The VCDRC (2006: xii) identified ‘problematic communication and collaboration between Child Protection, hospital services and community based health services’ as a cause for concern in relation to infant deaths in families with DHS involvement.

78 Other factors reported in association with child deaths include: ‘staff shortages’; ‘poor management’; ‘the failure to follow procedures’; ‘inadequate recording’ and ‘confusion over roles’ (Goddard, 1996: 179).

79 The Victorian Government, DHS, Child Protection Outcomes Project recommended a review be conducted within Victoria in relation to the flow of information in the child protection system and confidentiality and privacy issues (The Allen Consulting Group, 2004: 34).
2.4.4 Promoting interagency understanding and cooperation

The RCPCH (2002: 5) identify ‘uncertainty’ as one of the main issues facing professionals in their handling of FII/MBP cases. They suggest this uncertainty can be reduced through having ‘competent’ professionals, ‘clear protocols, and maintaining the welfare of the child as a priority’. Further, ‘effective information sharing’, ‘allocation of adequate resources’, collaboration’, ‘understanding’, ‘joint decision making’ and ‘trust between agencies’ were seen as essential for managing this abuse (RCPCH, 2002, also supported by: Fox, 1995; Artingstall, 1999; Department of Health, 1999).

The use of multidisciplinary guidelines to provide clarity for professionals and to minimise the potential for interagency conflict were also considered important for addressing FII/MBP cases (Southall et al. 1993; Whelan-Williams and Baker, 1998). Jones and Pickett (cited in Maher, 1988: 143) note that interagency work generally is ‘a highly challenging and sometimes disturbing experience, especially for those who have no prior experience of such matters’. They suggest that ‘there is real danger that the interests of the child will suffer in absence of effective policies and systems to guide and regulate such interprofessional contact’. Finally, the DHS and Victoria Police (1998: 1) protocols warn that whilst protocols can ‘aid effective communication’, they do ‘not replace the requirements for open and collaborative relationships between police members and protective workers at the operational level’.
2.4.5 The Role of Professionals

This section examines the role of doctors, nurses, child protection workers, mental health practitioners and schools in dealing with FII/MBP cases. The Department of Health (2000: 63) recognises that professionals working with other agencies require an additional set of knowledge and skills than those working in a single agency and stress that an understanding of the perspectives, language and culture of other professionals can assist in communication and preventing misunderstanding. Blyth and Milner (1990) suggest professionals need to clearly understand their own roles and those of other agencies and that having a full understanding of what actions need to be taken allows the worker to play a more effective role and to assist others if required.

2.4.5.1 The medical role

The detection of FII/MBP is ‘neither straightforward nor reached quickly’ (Samuels, 2001: 89). Donald and Jureidini (2001) claim parents who fabricate and/or induce illness in their children can produce symptoms/signs which are indistinguishable from those occurring with a genuine illness. Whilst most literature suggests doctors will only diagnose FII/MBP after much careful consideration and often as a last resort (Stephenson, 1995;81, 2001). See also Rosenberg, 1987; Meadow et al. 1996; Seibel and Parnell, 1998; Eminson, 2000a; Moran, 2001. Refer to Appendix 7 for an overview of issues facing medical professionals with FII/MBP cases.

80 See also Rosenberg, 1987; Meadow et al. 1996; Seibel and Parnell, 1998; Eminson, 2000a; Moran, 2001. Refer to Appendix 7 for an overview of issues facing medical professionals with FII/MBP cases.

81 Stephenson (1995: 19) pointed out that doctors spend most of their time trying to help children and parents by diagnosing and treating illness. He considered that the possibility that ‘a prolonged and difficult illness in a child may have been fabricated or induced by a parent is only accepted reluctantly’ and that doctors may still fear they have missed an extremely rare diagnosis. He further highlighted that medical personnel are also partly admitting fault, due to the unnecessary examinations and treatments they may have conducted on the child.
Postelthwaite, Samuels and Eminson, 2000) others such as Morley (1995: 50, 54), Hayward-Brown (1999) and Pragnell (2004) believe doctors are too hasty to diagnose this abuse based on relatively little evidence.

The research suggests the biggest obstacle to detecting FII/MBP is doctors’ failure to consider it (Rosenberg, 1995; RCPCH, 2002). Various researchers indicate the doctors’ role is traditionally one of trust (Fox, 1995; Wearne, 2000; Postelthwaite, Samuels and Eminson, 2000) and that doctors will generally accept what parents of allegedly sick children tell them (Donald and Jureidini, 1996; Samuels, 2001). Kahan and Yorker (1991: 78) emphasise the ability of doctors ‘to function as health care providers would otherwise be compromised if doctors continually doubted the truthfulness of parental reports’. In contrast, Seibel and Parnell (1998: 69) believe doctors working with children are increasingly aware of the need to consider ‘the veracity of information given to them by their patients’ parents’. Zitelli et al. (1987: 1101) warn that professionals, including ‘physicians, social workers and legal professionals’, may become ‘unwitting participants’ in FII/MBP, if they fail to recognize this abuse and allow unnecessary diagnostic tests to be performed on the child.

Besides failing to consider the possibility of FII/MBP, the literature highlights many reasons why doctors may not detect this abuse. These include a lack

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82 The literature also highlights that this is also not unique to FII/MBP cases. The findings from the death of two year old Daniel Valerio in Victoria in 1990 found that ‘for child abuse to be believed by some of the doctors, other medically more palatable but far less frequent diagnoses had to be discarded, like leukaemia and haemophilia’ (see Goddard, 1996: 180).


84 See Appendix 7 for an overview of issues facing medical professionals with FII/MBP and/or
of knowledge (Donald and Jureidini, 1996; Abdulhamid and Siegel, 2006), a fear of being wrong (Kinscherff and Ayoub, 2000), the young age of the child (Artingstall, 1999), no obvious physical injury (Samuels, 2001), the involvement of multiple specialists (Donald and Jureidini, 1996) and medicolegal and societal pressures (Moran, 2003). Craft (cited in Munby, 2004) and Horton (2005) also suggest that doctors are reluctant to become involved with FII/MBP cases and to give expert evidence within the courts. Interestingly, Kempe et al. 1962, some forty-seven years ago, reported a general emotional unwillingness by physicians to accept a diagnosis of child abuse as the cause of a child’s problems and reluctance to refer matters on to the appropriate authorities. This issue still appears to exist today.

In contrast, Pragnell (2004) suggests doctors may deliberately and inappropriately diagnose FII/MBP in order to taint the mother’s credibility, making it difficult for her to lay a complaint or take legal action against them. Finally, Schreier and Libow (1993: 58) suggest television has distorted people’s views of doctors by idealising doctors as heroic figures incapable of any wrongdoing. They suggest this image has added to the difficulty of detecting FII/MBP cases, as people are reluctant to challenge doctors’ opinions.

issues associated with the medical role.

Further, Hall (2003) suggests some doctors will deliberately ignore the possibility of such abuse to avoid involvement in a child abuse matter.
i) Reporting suspected FII/MBP abuse

Medical personnel are often reluctant to report their suspicions of suspected FII/MBP to child protection and/or the police (RCPCH, 2002). Shepherd (1995: 326) suggests medical professionals are more likely to view victims of FII/MBP 'from a patient perspective rather than a criminal justice perspective. The child is seen as sick or injured rather than a victim of a criminal act…' (see also Taylor, 2000). Yeo (1996) and Fox (1995)86 claim that, even when information clearly indicates a crime has been committed some doctors fail to pass information on to relevant authorities87.

Conte (1988, cited in Goddard, 1996) suggests the failure of professionals to report child abuse, even when mandatory reporting applies, has been a long term problem as professionals become concerned about the involvement of other professionals and what reporting will mean for the child’s future care. Conte (1988 in Goddard, 1996) notes many professionals often do not want police involvement and do not see the problem of child abuse as a matter for the criminal justice system. Other researchers, such as O'Toole, Turbett and Nalepka (1983) and Katz et al. (1986), report that class, race and ethnicity can bias physicians defining and reporting child abuse. Katz and colleagues

86 Fox (1995) highlights an example of where a doctor failed to see the importance of police involvement. The child in this case ingested rat poison that had been mixed in with his milk powder. An investigation was subsequently launched by police into contamination of the milk powder by the factory, with all milk powder tins ordered to be removed from chemist shelves. Several days later the same child was poisoned with potassium chloride, a potentially fatal drug. His mother was found by nursing staff to be in possession of a stolen box of potassium chloride. Police were not notified about the potassium chloride and the mother possessing same, until several days later and continued to investigate the factory for contamination of the milk powder. Fox (1995) noted that such a delay in notifying the police potentially endangered the child’s life and ruined any collection of evidence.

87 Freeland and Foley (1992: 148) suggest problems arise when hospitals are 'content to be places of health and healing' and not instigators of protective action.
(1986) found that injuries to children in poorer families might more frequently be diagnosed as ‘abuse’ compared to ‘accidents’ in more affluent families\(^{88}\).

In Victoria, mandatory reporting of child abuse to DHS exists for doctors, nurses, teachers, principals and police in relation to physical and sexual abuse where the parents have not protected or are unlikely to protect a child from harm of that type (Sections 182 (1) a-e, 184 and 162 c-d of the *Children, Youth and Families Act, 2005*)\(^{89}\).

There is no legal requirement by doctors or child protection workers in Victoria to notify the police. However, the DHS and Victoria Police (1998) protocols require DHS to notify police of all allegations of sexual and physical abuse and serious neglect of a child or young person (DHS and Victoria Police, 1998: 5)\(^{90}\).

The RCPCH (2002: 50) suggest the threshold for police referral may be difficult with some FII/MBP cases. They emphasize ‘a failure to alert Police or Social Services early is likely, in proven matters, to lead to greater suffering by the child and hamper the chances of successfully concluding the enquiry’. Fox (1995: 107, 114) emphasizes agencies must ‘share their concerns of suspected abuse as soon as they have them and not when they

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\(^{88}\) Whether an injury is determined to be accidental or abuse seems to be associated with the degree of social distance between the physician and the parents.

\(^{89}\) Refer Appendix 8 for legislation relating to mandatory reporting.

\(^{90}\) The protocol stipulates that this notification must be ‘prior to Child Protection visiting any parties or commencing their investigation’ (Human Services and Victoria Police, 1998: 27).
are 90 per cent sure that abuse is taking place. The Department of Health (1999: 24) guidelines state that police notification does not necessarily mean a criminal investigation will occur or that there will be any further police involvement, but that police should retain the opportunity to be informed and consulted before making a final decision regarding their role in these matters. The DHS and Victoria Police (1998: 9) protocols state, ‘It is crucial that police are involved at the earliest stage of notification of sexual abuse, physical abuse and serious neglect’. Seibel and Parnell (1998: 72) believe early police involvement in FII/MBP cases is vital, but suggest that it is also rare (see also Fox, 1995; Artingstall, 1999). Finally, Fox (1995: 109) stresses medical personnel need to be reassured that referring a suspicion to police will not result in unleashing ‘an uncontrollable monster’ and that police will be sensitive to the needs of medical personnel and of the hospital environment.

ii) The boundary between medical and policing roles

The boundary between a doctor’s role and the police role is somewhat blurred with FII/MBP cases (Meadow, 1985; Adshead, 2001).

Some researchers (Meadow, 1985, and Smith (in Bahen, Blake and Smith, 1988) regard medical personnel as better placed than child protection workers or police to conduct investigative tasks associated with FII/MBP cases. Smith (in Bahen et al. 1988) indicates that:

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91 Fox (1995: 107-108) gave an analogy of a thief stealing morphine from a hospital cabinet or money from a patient’s room and indicated that medical personnel would have no hesitation in calling police to investigate these matters and trust the officers to carry out their role.
…although we [doctors] are poorly trained as criminal investigators and have no legal authority to assume the role we are the only investigators who have a background which will allow us to differentiate real from imposed unreal illness.

Smith in Bahen et al. 1988: 46

There is a perceived need by doctors to possess concrete evidence of FII/MBP before reporting their suspicions to child protection or the police (Wilkinson and Parnell, 1998; Artingstall, 1999: RCPCH, 2002). However, researchers such as Shepherd (1995), and Samuels and Postelthwaite (2000) suggest it would be unnatural for medical personnel to assist in gathering evidence against the child’s mother for a criminal matter. Bahen (in Bahen et al. 1988: 49) stresses ‘the hospital’s role in child abuse is the identification and treatment of children and families, and not investigation’.

Further, Adshead (2001) states:

It is the police who investigate the suspected crime of child abuse and not the doctors who have no public mandate to do so or the requisite training. …Confirming the occurrence of a crime is not the same as diagnosis; not least because it has implications for the suspect’s place in society which are quite different to those which follow a diagnosis of an illness.

Adshead, 2001: 205

Wilkinson and Parnell (1998: 224) note doctors may ‘not feel confident enough in their suspicions to consider them anything beyond speculation’ and may therefore wish to confirm their suspicions.
The RCPCH (2002) provide some clarity on the medical and police roles with FII/MBP cases:

While the child’s signs and symptoms are being evaluated and before concerns are confirmed, the consultant paediatrician should retain the lead role, and the priority of police officers should be to assist the paediatrician with identification of the reason for the child’s symptoms. The balance will change when…a crime appears to have been committed, and the police will need to ensure the rights of the suspect are upheld and that evidence is gathered in a fair and appropriate way.

RCPCH, 2002: 51

The RCPCH (2002: 51) notes where abuse is suspected but unsubstantiated, police can make many tactful inquiries to assist paediatricians in ruling out possible abuse, thereby allowing medical staff to concentrate on identifying a potential medical cause.

2.4.5.2 The role of nurses

Where a child is hospitalized, nurses can play a valuable part in FII/MBP investigations as they are in a unique position to observe the child’s day.\(^93\)

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\(^93\) Stanioch (1994) provided a case example where a nurse was able to provide corroborative information to the police that assisted in the police investigation. The nurse informed police that the mother was always in possession of a pink toilet bag and recalled how the mother had taken her child who had two I/V poles attached to her, to a toilet at the other end of the ward squeezing the child and the child’s two I/V poles into the small toilet cubicle and closing the door, which was not normal practice given the location of the toilet and young age of the patients. The mother then called out to the nurse that she had forgotten her toilet bag, which the nurse subsequently got and gave to the mother. The nurse revealed that this mother spent all day and night with her child, sleeping in a lounge chair next to the child’s cot and was often alone with the child particularly at night. The mother’s pink toilet bag was later found to contain syringes and bodily fluids used by the mother to create infections in her child.
This includes: interactions with family and staff; the child’s meal times; administration of medications; the collection of specimens\(^94\); the handling of medical equipment; the changing of nappies, and in their general medical treatment (Schreier and Libow, 1993; Stading and Boros, 1995; Seibel and Parnell, 1998). However, it is also noted that nurses may harm these cases if they fail to accept that the mother may be potentially harming her child (Blix and Brack, 1988\(^95\); Seibel and Parnell, 1998; Stading and Boros, 1995)\(^96\).

2.4.5.3   The role of child protection

The child protection role with FII/MBP cases is identified by Fish et al. (2005) as combining a legal and social work perspective to ensure the safety of the child and to address the needs of families. In Australia, there are eight child protection systems. Each has their own procedures and legislation which assists to govern professionals’ response to child abuse (Bromfield and Holzer, 2008). In Victoria, the statutory role of Child Protection is pursuant to the legal framework set out in the *Children, Youth and Families Act, 2005* (CYFA, 2005) which provides for the protection of children and young people who have suffered, or who are likely to suffer, significant harm within the

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A further example of a nurse’s observations proved invaluable is provided by Boros and Brubaker (1992) who described a case of a 10 month old child who was admitted to hospital with life threatening apnea who became hysterical if anyone touched her face. This observation was enough to raise suspicions and the father was later caught on video attempting to smother his child.\(^94\) Christian (1995: 136) provided an example of bleeding only occurring in the mother’s presence or abnormal specimens may only appear when the parent is involved with some aspect of the collection.\(^95\) A 1988 survey by Blix and Brack indicated that only 10% of the nurses surveyed had knowledge of or experience with MBP, with most indicating they were professionally and personally unprepared for such problems.\(^96\) Stading and Boros (1995: 295) suggested a lack of awareness by nurses could lead to a ‘delayed identification, continued abuse and in the extreme murder’. Artingstall (1999) also noted nurses may also inadvertently be teaching the mother technical expertise to enable her to offend. See also hospitalization in section 2.5.3.1
family unit from: abandonment, physical abuse, sexual abuse, emotional
abuse or neglect (see Appendix 8). This legislation, which replaced the
Children and Young Persons Act, 1989 in 2007, revolves around the 'Best
Interests Principle' which states that 'in determining a child’s best interests,
the need to protect a child from harm, protect his or her rights and promote
his or her development must always be considered' (State Government
Victoria, 2006: 2).

The focus on the child’s development is new and
represents a stronger recognition ‘of the longer term and wider ranging
impacts of harm on a child’ (State Government Victoria, 2006: 2).

In Victoria, DHS and Victoria Police SOCAU members work jointly in
responding to child abuse. Police focus on criminal aspects and DHS on the
protection and safety of the child (DHS and Victoria Police, 1998). However,
police also have statutory responsibilities pursuant to the CYFA, 2005, in
relation to the protection of children. This power is primarily for emergency
purposes to remove a child from immediate harm (DHS and Victoria Police,
1998: 5).

i) Critical decisions for child protection workers

Critical decisions for child protection workers with FII/MBP cases include the
assessment of risks facing children (Department of Health, 1999), the timing
of parental involvement (Gray, 2001), and judging the threshold at which
active intervention should occur (Horwath and Lawson, 1995a; Baildam and

97 The ‘Best Interests Principle’ also covers a wide range of other factors for professionals to
consider in their response.
Eminson, 2000). Such decisions are regarded by many as requiring multidisciplinary input (Batten, 1987; Department of Health, 1999; Lasher and Sheridan, 2004).

ii) Parental collaboration and a discussion on rights

A primary aspect of child protection work is working with families to strengthen their ability to deal with their problems (Health and Community Services, 1994; Department of Health, 1995; 1999; Samuels and Postelthwaite, 2000). Many researchers stress parental collaboration may be inappropriate in FII/MBP cases as it may endanger the child (Southall et al. 1997; Pearce and Bools, 2000; Gray, 2001). Sheehan (2000) suggests the Children and Young Persons Act 1989, which focuses on the best interests of the child, fails to clearly acknowledge when a child’s best interests may not lie with the family (see also Fogarty, 1993; Auditor General’s Report, 1996). Implications of the new legislation may not be known for some time.

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98 Refer Appendix 9 for further issues facing child protection personnel in dealing with FII/MBP cases.
99 The death inquiry literature (Fogarty, 1993; Community Services Victoria, 1991) also reflects this position. Fogarty (1993) notes that child protection workers can focus too much on the rights of the parent to the detriment of the rights of the child providing the parent with ample opportunities to improve their care of their child and mistakenly believing that supervision provided by child protection and other services would enable the child to survive. Fogarty (1993) suggests professionals can underestimate the seriousness of neglect and the risks posed to children in this situation but in the same breath acknowledges the difficult role that child protection must play in deciding whether to remove a child from the family.
100 The Auditor General’s report (1996: 240) suggests in some cases the focus of the family unit and parents’ ownership of children, seems to prevail over the rights of the child to a safe and nurturing environment.
iii) The timing of intervention

Child protection intervention requires judgments on how best to intervene. In the extreme, there are risks associated with leaving a child for too long in a dangerous situation and in removing a child unnecessarily from their family (Department of Health, 2001: 9). Baildam and Eminson (2000: 203) suggest:

It may be necessary to act when one is sure that harm has occurred or is likely to occur in order to protect the child, even if this early intervention jeopardized the collection of evidence for a water tight medico-legal case.

Baildam and Eminson, 2000: 202-203

In contrast, others (Southall et al. 1997; Artingstall, 1999) believe it may be better to take some evaluated risks to collect evidence that would ensure the long term safety of the child and meet the standard of evidence required by the courts (Artingstall, 1999; Taylor and Nicholls, 2001). Artingstall (1999) states:

If the child is prematurely removed from the custody of the suspected offender, then the long term result will arguably be case dismissal.

Artingstall, 1999: 212

2.4.5.4 The role of mental health practitioners

The mental health practitioner’s role is generally described as ensuring the child, offending parent and family receive appropriate medical and psychological care (Waller, 1983; Kelly and Loader, 1997). Additionally,
mental health practitioners can provide support and opinions to medical and child protection personnel about the mental state of the mother, child and family members (Jones and Newbold, 2001) and assist in the planning of the child’s future care and safety (Loader and Kelly, 1997; Jones and Newbold, 2001).

A dilemma for mental health practitioners appears to be in balancing the rights of the parent against those of the child (Schreier and Libow, 1993; Parnell, 1998b). Fisher (1995b: 391-392) indicates the psychiatrist finds himself ‘conflicted between confidentiality and duty’. He states ‘this is particularly so when rapport has been well established with an alleged perpetrator and much highly personal information has been entrusted to the psychiatrist’. Fisher (1995b: 392) acknowledges the need at times for mental health practitioners to disclose information to other professionals to ensure the safety of the child, but also believes that mothers who fabricate illnesses in their children most likely will have been ‘emotionally betrayed many times throughout their lives’ and will see the practitioner’s disclosure as ‘another form of betrayal’.

2.4.5.5  The role of schools

The research in relation to FII/MBP cases in schools is limited but growing (Palladino, 1998; Ayoub, Schreier and Keller, 2002; Feldman, 2004a). The Department of Health (2001: 43) note that teachers ‘through their day to day contact with children are particularly well placed to notice outward signs of harm’. However, it is important for schools not to undertake their own
enquiries if they suspect child abuse, but to report such matters to social services or the police, who have the appropriate expertise to manage such cases. Palladino (1998: 273) maintains that often FII/MBP cases are not reported by education personnel because they are ‘just too hard’. Feldman (2004a) details one teacher’s encounter with this abuse where the mother made false allegations to the principal, who automatically believed the mother without consulting the teacher (Feldman 2004a: 143-144). Ayoub, Schreier and Keller (2002) suggest ‘the emotional cost to staff and the effect on limited school resources in these situations can be enormous’.

2.5 The Investigation of FII/MBP

This section examines the standard of evidence required in criminal investigations and explores potential avenues of investigation with FII/MBP cases\(^{101}\) to confirm or disprove the existence of such abuse.

2.5.1 The standard of evidence

Obtaining the best possible evidence in FII/MBP cases is vital for child victims and innocent parents (Byard and Burnell, 1994; Samuels, 2001). Rogers (1998: 46) concluded ‘it is important for professionals to obtain as much collateral information as possible, from as many sources as possible, in order that a correct diagnosis can be made’. Kinscherff and Ayoub (2000) and Samuels and Postelthwaite (2000) regard physical or direct evidence as the best means for proving FII/MBP cases. However, evidence in FII/MBP

\(^{101}\) Refer also Appendix 10 for an overview by Samuels (2001: 93) of methods for confirming FII/MBP.
cases tends to be largely circumstantial (Plum, 1995: 348; Wilkinson and Parnell, 1998), although Kinscherff and Ayoub (2000: 247-248) note that such evidence can still be very strong if supported by multiple evidentiary aspects.

Artingstall (1999: 153) suggests professionals may not recognise or may misinterpret available evidence in FII/MBP cases. She further suggests there is sometimes ‘an unwillingness’ by professionals ‘to expand investigations to the sophisticated degree required in MBP case analysis either due to monetary constraints or disbelief that MBP is tangible’ (Artingstall, 1999: 83). Lasher and Sheridan (2004: 81) suggest ‘professionals who are not trained investigators with considerable MBP knowledge and experience may inadvertently compromise victim safety or the investigation’. Birge (1995) emphasises the need for ‘sensitivity, good judgment and good investigative skills for police officers to determine if a suspected offender is just an overly concerned non-abusive parent or the cause of their child’s illness’.

Kinscherff and Ayoub (2000: 248) outline in order to prosecute under criminal law two factors need to be established beyond reasonable doubt: ‘Actus Reus – that the person was engaged in the alleged act’ and ‘Mens Reus – that the person had the prerequisite mental state and intent to harm the child’. The Department of Health (1999: 24) maintain the decision to initiate criminal proceedings in FII/MBP cases should be based on three key factors: ‘whether or not there is sufficient evidence to prosecute; whether it is in the public interest that proceedings should be instigated against a particular offender, and whether or not a criminal prosecution is in the best interests of
the child'. The Department of Health (1999: 24) states that sometimes criminal proceedings will not be instigated in these matters due to the higher standard of proof, ‘beyond reasonable doubt’, required by the criminal courts\textsuperscript{102}. However, child protection proceedings are generally heard as the standard of proof is based on the ‘balance of probability’ (Department of Health, 1999: 24).

### 2.5.2 Case conferences

Case conferences were considered a valued mechanism for professionals to address suspected FII/MBP cases, by sharing concerns, exchanging information, and devising an agreed course of action. Professionals attending case conferences were generally thought to require knowledge of FII/MBP (Fox, 1995) and to occupy senior positions within their respective organisations (Department of Health, 2001) in order to make management decisions.

Some controversy exists within the literature over who should be invited to attend case conferences and/or informed of the suspected abuse. Meadow (1985) and Fox (1995) contend professionals who are unable to accept the possibility of FII/MBP should not be involved as they may prematurely release information to the parent and endanger the child. In contrast, Chan et al. (1986) argue all medical personnel involved should be alerted to the

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\textsuperscript{102} Wilkinson and Parnell (1998) and Kinscherff and Ayoub (2000: 247) suggest that there is a lack of literature relating to the criminal prosecution of MBP cases. The researcher observed that the literature in this area is growing, but may not necessarily refer specifically to MBP (Yorker and Kahan, 1991; Stanioch, 1994; Fox, 1995; Shepherd, 1995; Birge, 1996; Chadwick, 1996; Yeo, 1996; Southall et al. 1997; Artingstall, 1999; Kinscherff and Ayoub, 2000: 248).
mother’s behaviour, due to the serious nature of this abuse. The involvement of an independent specialist with knowledge of FII/MBP was considered valuable in FII/MBP case conferences (Schreier and Libow, 1993; Lasher and Sheridan, 2004). Finally, parental involvement in such meetings was generally considered, initially, to be unsafe for the child (Pearce and Bools, 2000; Dyer 2004: 2\textsuperscript{103}).

2.5.3 The collection and gathering of evidence

A synopsis of potential avenues for collecting and gathering information and evidence in relation to FII/MBP cases is outlined in this section.

2.5.3.1 Surveillance

i) Hospitalization

Hospitalization allows medical personnel to observe and monitor the child, and the alleged illness, over a period of time (Schreier and Libow, 1993; Samuels, 2001). Nurses may observe inconsistencies and unusual behaviour (Pickford et al. 1988\textsuperscript{104}); direct abuse (Griffiths, 1988\textsuperscript{105}); unusual

\textsuperscript{103}The Michael Dickinson findings (cited in Dyer, 2004: 2) show that greater ‘guidance’ is needed ‘for professionals on when child protection meetings may be held in the absence of parents’ and suggest greater emphasis needs to be placed on the child’s rights. See also Bahen et al. 1988; Bulton, 1997; Gray, 2001; Lasher and Sheridan, 2004; London Child Protection Procedures (undated); and Sussex Police (undated).

\textsuperscript{104} Pickford et al. (1988: 647) described how nurses observed fresh blood in a child’s ear within 15 minutes of the child being in the mother’s presence. Up to that point only old blood had been found in the child’s ear.

\textsuperscript{105} Griffiths (1988: 424) described a nurse covertly watching a mother ‘place a syringe in the child’s rectum and administer a water enema, withdraw the stool and water, then feed the fluid to the baby in an apparent effort to create the appearance of diarrhea and vomiting’.
telephone calls (Baildam and Eminson, 2000); and unusual problems with medical equipment (Liston et al. 1983).

The relaxing and tightening of supervision levels and the use of two hospital charts was seen to be of some benefit in FII/MBP investigations in identifying inconsistencies and recording important observations. One on one nursing was also considered to be a potential option, although Yorker and Kahan (1990: 317) suggested if designed to produce evidence or prevent further abuse that this would place heavy responsibilities on the nurses involved with the child, indicating it was a difficult position to both ‘protect a child’ from suspected abuse and obtain ‘reliable evidence of criminal behaviour’. Samuels and Postlethwaite (2000: 116) indicated if close nursing supervision was to be adopted nurses needed to be ‘involved in the decision and be willing to accept the responsibility’. Finally, Alexander (2000: 237) suggests the advantages and disadvantages of putting a child in hospital need to be carefully considered before implementing such a process.

Liston et al. (1983) described a case of a mother who admitted injecting contaminated water into the child’s intravenous tubing. The nurses recalled seeing spraying leaks from the intravenous tubing that were temporally related to episodes of illness.

A comparison of specimens taken during different periods of supervision may reveal remarkably different findings (Samuels and Postlethwaite, 2000; Seibel and Parnell, 1998). Boros and Stading (1995) also indicated that the use of two patient charts; one that is accessible to the parent and one that isn’t; with the second chart recording personal interactions, conversations, potential inconsistencies and staff meeting impressions, could quickly identify issues of concern.

Samuels and Postlethwaite (2000: 116) indicated a plan needed to be developed with the nursing staff, in conjunction with child protection involvement, around what to tell the parents, what to do if abuse was observed and what actions to take if the mother disagreed or became suspicious. Due to the stress placed on staff and the difficulty in monitoring the child fulltime one to one nursing was not considered to be the best option with FII/MBP cases.
ii) Separation of mother and child

Separation of a suspected offending parent from their hospitalized child is considered by many to be a valuable mechanism for confirming or disproving FII/MBP (RCPCH, 2002: 46). In a literature review of 451 FII/MBP cases, Sheridan (2003: 439) found separation data was the most common verification of the existence of fabricated and/or induced illness in a child (54 cases). However, Morley (1995) contends a child’s recovery could also be attributed to other causes, including natural recovery. Finally, Samuels and Postelthwaite (2000: 117) say that any evidence obtained through separation will be ‘challenged by experts’ in the courts and contend that separation has been superseded by covert video surveillance.

iii) Overt and covert video surveillance

Overt video recordings can be valuable for ‘observing events or behaviours that health professionals would not usually see but which may help in the management of a reported clinical problem’ (Samuels and Postelthwaite, 2000: 118). However, in cases of fabricated incidents ‘events may not be recorded for a variety of reasons (eg interference or breakdown of equipment), or fabricated events may be observed on tape’ (Samuels and Postlethwaite, 2000: 118). In the case of potentially life threatening events, covert video surveillance (CVS) may therefore need to be considered (Samuels and Postelthwaite, 2000: 119).

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110 See also Plum, 1995; Artingstall, 1999; Mitchell, 2001; Lasher and Sheridan, 2004.
Covert video surveillance has been used in hospitals, predominantly in the UK and US since the early 1980’s, to aid in the detection of child abuse; in particular with smothering and poisoning cases (Rosen at al. 1983; Southall et al. 1997; Hall et al. 2000)\(^{111}\). There is limited Australian research concerning CVS in hospitals\(^{112}\).

Whilst CVS has been found to be morally, ethically (Shinebourne, 1996; Shabde and Craft, 1998) and legally acceptable (Williams and Bevan, 1988) in detecting serious forms of child abuse, it is also regarded unfavourably by some researchers (Foreman and Farsides, 1993; Morley, 1995; Pragnell, 2004). The decision to use CVS is generally considered to require multi-agency input (Southall and Samuels, 1996; Shabde and Craft, 1998) and to require a high level of authority from the courts (Fox, 1995). Fox (1995) indicates UK cases requiring CVS are judged on a case by case basis using rigorous multi-agency protocols\(^{113}\). He states CVS is used only after it can be ‘demonstrated that other more conventional methods of investigation have failed or are not practical because of the circumstances’ (Fox 1995: 110).

No multidisciplinary guidelines associated with CVS usage were located within Victoria.

\(^{111}\) Further studies that have utilized covert video surveillance to detect suffocation include: Rosen et al. 1986; Epstein at al. 1987; Williams and Bevan, 1988; Samuels et al. 1992b; Boros and Brubaker, 1992; Samuels, MacClaughlin and Jacobson, 1992; Byard and Burnell, 1994; Chadwick, 1996, and Chiczewski and Kelly, 2003.

\(^{112}\) CVS has been utilized in Australian hospitals in South Australia (Byard and Burnell, 1994; Chadwick, 1996) and Queensland (Herald Sun, 2004). However, no Victorian cases were located.

\(^{113}\) Numerous researchers support the use of protocols in relation to the use of CVS (Mercer and Perdue, 1993; Brahams, 1993; Shaw, 1995; Ostfeld, 1995; Southall and Samuels, 1996; Shabde and Craft, 1998; Seibel and Parnell, 1998; Whelan-Willimas and Baker, 1998; Samuels and Postelthwaite, 2000).
Many researchers suggest without CVS much of this abuse would go undetected or at the very least delay that detection, potentially endangering the child’s health (Pickford et al. 1988; Byard and Burnell, 1994; Hall et al. 2000). Undetected harm, either at home or the hospital, is suggested to be far more dangerous than the risks posed to a child under observation within a hospital (Samuels, 2001). The installation and management of CVS within a hospital is generally regarded as a police responsibility (Department of Health, 2001; RCPCH, 2002), although, in the past, it was primarily regarded as a medical role (Southall and Samuels, 1993). The Department of Health (2001: 57) emphasise that medical and nursing staff should support police during the CVS process and that all personnel involved ‘should receive specialist training’.

Arguments raised against CVS include an invasion of parental rights (Foreman and Farsides, 1993; Morley, 1995)\textsuperscript{114}, subjection of the child to further risk (Ostfeld, 1995; Morley 1998) and the entrapment of the parents (Morley, 1998). The opposing argument states CVS is not a form of entrapment as the offender is not encouraged to commit a crime (Fox, 1995), nor does the presence of video equipment mean a crime will be committed (Shepherd, 1995). Further, researchers such Kahan and Yorker (1991) and Byard and Burnell (1994) contend the child’s needs far outweigh the privacy interests of the parents.

\textsuperscript{114} Yeo (1996) noted the NSW court in Australia had rejected the use of CVS considering it to be a violation of the mother’s rights, despite professionals having concerns for the child and believing the hospital was the best place to monitor the mother’s behaviour.
2.5.3.2  The collection of physical evidence

i)  Crime scene investigation

Artingstall (1999: 154) suggests the definition of a crime scene with FII/MBP cases may be ‘vast’ and may ‘incorporate ordinary items which normally would be overlooked due to acceptable presence’. Artingstall (1999: 3) indicates the ‘crime scene will talk to the detective if the detective knows how to listen’. Examples of physical evidence found in FII/MBP cases include: implements used by the offender to commit their crime (syringes, poisons, cellophane, plastic wrap, blanket, pillow, medications); drug packaging, prescriptions and store receipts; medical and documented records; lab specimens, and toxicology reports (see Wilkinson and Parnell, 1998 and Artingstall, 1999). Further, apnea monitors (Shepherd, 1995\textsuperscript{115}), emergency telephone calls, photos of the child, and CVS (Artingstall (1999) may be potential sources of physical evidence.

The collection of evidence at sudden and unexpected infant/child deaths is controversial (RCP and RCPCH, 2004: 37). Tension exists between police ‘wanting to secure the evidence quickly’, and the need for ‘parents not to be placed under unnecessary suspicion’ (RCP and RCPCH, 2004: 13). Controversy also exists over the seizure of items such as the child’s bedding (Artingstall, 1999; RCP and RCPCH, 2004).

\textsuperscript{115} Shepherd (1995) highlighted a case of suffocation in which it was able to be proven that the child’s apnea monitor had been tampered with by the mother.
ii) **Medical files and other records**

Due to the nature of FII/MBP, the family’s medical files are vital for investigators (Meadow, 1985; Seibel and Parnell, 1998). The RCPCH (2002: 58) indicate that a failure by professionals ‘to scrutinize’ medical records can ‘lead to a lack of awareness of very significant histories’.

Typically, much of the medical history associated with FII/MBP perpetrators and their children is false and lacks corroboration (Meadow, 1982; Goldfarb, 1998; Schreier, 2002)\(^{116}\). Most researchers attribute this to the mother’s fabrications. However, Hayward-Brown (1999: 38) contends that medical professionals may have tampered with the family’s medical files or fabricated evidence to convince others of their beliefs.

In addition to medical files, a range of other records such as child protection, police, ambulance, and autopsy reports, are considered valuable in investigating suspected FII/MBP and obtaining an overall picture of the mother’s behaviour (Artingstall, 1999; Lasher and Sheridan, 2004)\(^ {117}\).

iii) **Toxicology tests**

Toxicology analysis can assist professionals in detecting whether a child has been administered an inappropriate substance. However, Samuels and Postelthwaite (2000: 117) also identify that a negative screen does not

\(^{116}\) As previously highlighted, a state that has been attributed to both the fabrications of the mother and/or a failure by medical professionals to check and substantiate information supplied to them (Donald and Jureidini, 1996; Wearne, 2000).

\(^{117}\) Refer to Artingstall (1999) and Lasher and Sheridan (2004) for a more detailed insight into record inquiries.
necessarily mean that a child has not been poisoned. They explain the drug may have been excreted rapidly, the wrong specimen may have been obtained (blood as opposed to urine), the timing of the specimen collection may have been wrong, or the specific test used may have been unable to detect the toxin. Additionally, it was noted that accidental ingestion may also account for the detection of an offending substance (Samuels and Postelthwaite, 2000: 118). Finally, chain of evidence procedures\footnote{Processes that ensure that the specimen can be reliably traced back to the patient. This was seen to consist of carefully witnessed steps that are documented with signatures.} (Artingstall, 1999; Samuels and Postelthwaite, 2000) was identified as important for criminal proceedings.

2.5.3.3. Interviews and information sharing

Interviews make up ‘a large proportion’ of an ‘investigation portfolio’ in FII/MBP cases (Artingstall, 1999: 177)\footnote{See Appendix 11 for a list of potential interviewees.}. Lasher and Sheridan (2004: 128) suggest such interviews have ‘two major purposes’; firstly, to provide ‘new information’, and secondly, to ‘clarify, augment, corroborate, or identify discrepancies in information already obtained’\footnote{Refer to Artingstall, 1999 and Lasher and Sheridan, 2004 for a list of questions and considerations in conducting interviews dealing with FII/MBP cases.}. Artingstall (1999) and Lasher and Sheridan (2004) suggest interviews in FII/MBP cases need to be conducted separately with each person to allow for data comparisons and for any inconsistencies to emerge. However, Morley (1995: 48-49) contends inconsistent information may well depend on how the information is obtained and ‘whether the same questions are asked’ of different people ‘in the same way’. Finally, from a police perspective, Artingstall (1999: 177) notes that
people’s testimonies need to be ‘locked into an official sworn statement format’.

In obtaining information from the parents, numerous researchers stress the importance of not forewarning them that they are under suspicion as such notification may endanger the child and/or limit the collection of further information (Byard and Burnell, 1994; Rosenberg, 1997). The importance of cross referencing and verifying the mother’s information is also well reported (Mian, 1995; Samuels, 2001; Lasher and Sheridan, 2004).

Victims of FII/MBP may also provide valuable information to professionals and should be consulted separately from their parents (Artingstall, 1999; Lasher and Sheridan, 2004). The research suggests, however, that child victims may be overlooked or disbelieved by professionals (Bryk and Siegel, 1997; Gregory, 2003; Goddard, 1996121). Finally, it is suggested that the majority of FII/MBP victims will be ‘too young to be interviewed as part of a criminal investigation’ (Department of Health, (2001: 25) and police may not be adequately trained to conduct such interviews (Artingstall, 1999; Lasher, 2003)122.

121 The case of Daniel Valereo in Victoria in 1990 highlights the importance of listening to child witnesses and not focusing on the voices of adults (see Goddard, 1996). Goddard (1996) states that children are often not the major focus of professionals’ work with families as it is easier to talk with adults and to concentrate on the parents’ needs rather than dealing with the abused child.

122 See also Gray, 2001. There is no research within Victoria to say whether interview training provided to police members is adequate for interviewing children subjected to fabricated and/or induced illness.
2.5.4 Confrontation of the suspect

Confronting a parent who is suspected of fabricating and/or inducing illness in his or her child is a ‘source of possible tension’ for professionals and requires ‘careful management’ (RCPCH, 2002: 52). In particular, controversy exists about who should conduct this interview (RCPCH, 2002), which professionals should be present (Mian, 1995; Wilkinson and Parnell, 1998), and whether parents should be interviewed together or separately (Meadow, 1985; Mian, 1995). Further, professionals may hold different perceptions regarding the purpose of such an interview. In general, medical personnel viewed this interview as a forum for informing the parents of the medical facts (Meadow, 1985; Mian, 1995; Sanders, 1999), child protection saw it as a means for discussing the allegations and assessing the child’s safety (Pearce and Bools, 2000; Lasher and Sheridan, 2004) and police regarded it as a means of confirming whether a crime had been committed and/or formally putting the allegations to the offender (Fox, 1995; Shepherd, 1995; Artingstall, 1999).

Artingstall (1999: 140, 154) contends the greatest evidence in FII/MBP cases may ‘often remain locked within the offender’, requiring professionals with excellent interviewing skills and knowledge of such abuse. Some suggest a doctor is best placed to conduct this interview (Meadow, 1985; Samuels

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124 Meadow (1985: 391) suggests that a medical professional needs to explain to the mother: ‘the way in which her actions are harming her child and the dangers these have for the child’s future;’ what actions have been ‘taken for the care of her child and help for her and the family’; and what information will be shared with the father. See also Schreier and Libow, 1993, and Pearce and Bools, 2000.
and Southall, 1992). Others see this as a police role (Fox, 1995; RCPCH, 2002) or that of a multidisciplinary team (Stading and Boros, 1995; Whelan-Williams and Baker, 1998)\(^{125}\).

In considering confrontation, the RCPCH (2002) emphasize that the suspect’s legal rights must be adhered to. They state that:

> If an investigation does show that a carer is deliberately abusing the child to a criminal degree, it is not appropriate for a pediatrician to “confront” the perpetrator, or to try and get them to admit what they have been doing.

RCPCH, 2002: 52

In Victoria, offenders are entitled to a caution and rights where there is a reasonable suspicion they may have committed a crime (Crimes Act, 1958).

In interviewing offenders, Artingstall and Brubaker (1995: 82) and Meadow (1985)\(^{126}\) recommend professionals adopt a ‘non-judgmental and empathetic approach’. Mothers accused of FII/MBP may react in numerous ways, including extreme emotion (Artingstall, 1999)\(^{127}\), anger (Waller 1983: Schreier and Libow, 1993), disbelief (Meadow, 1985; Artingstall, 1999) and/or a

\(^{125}\) Stading and Boros (1995: 304) indicated that their confrontation team consisted of physician, nurse specialist, a social worker or child protection worker and a police officer. Whelan-Williams and Baker (1998) indicated a doctor, police officer, child protection and mental health practitioner would be involved.

\(^{126}\) Meadow (1985: 391) suggests professionals need to explain to the mother that they know what she is doing, understand, and wish to try to help her and her child.

\(^{127}\) Artingstall (1999: 134) indicated that MBP perpetrators may fabricate intense emotions such as crying or anger in order to avoid or divert the reality of the situation. Artingstall (1999: 134) stated that this ‘evasive technique has been observed to be flowing as if regulated by a faucet switch which is turned off as quickly as it is turned on’. 

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peculiar sense of calm (Schreier and Libow, 1993). Others note such women may escalate their offending (Mitchell et al. 1993; Seibel and Parnell, 1998), alter their methods of offending (RCPCH, 2002); change medical practitioners (RCPCH, 2002) and/or relocate address (Artingstall, 1999). Both Rosenberg (1997) and Lasher and Sheridan (2004) stress that confrontation does not guarantee the mother’s abuse will cease. Finally, FII/MBP perpetrators may recruit powerful allies (Feldman, 2004a; Lasher and Sheridan, 2004), lay complaints or bring about litigation charges (Rosenberg, 1997; Eminson, 2000b) and/or contact the media (Lasher and Sheridan, 2004).

The ability of FII/MBP perpetrators to deny, minimize, justify and offer plausible explanations for their behaviour is well documented within the research (Palmer and Yoshimura, 1984; Nicol and Eccles, 1985)\(^{128}\). Morely (1995), however, emphasizes that this would also be perfectly normal for mothers wrongly accused.

Finally, some FII/MBP perpetrators do admit to their offending or part thereof (Freeland and Foley, 1992; Whelan-Williams and Baker, 1998\(^{129}\)). However, the research also shows that perpetrators are likely to minimize the seriousness of their actions (Loader and Kelly, 1996; Chadwick, 1996)\(^{130}\).

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\(^{128}\) Artingstall (1999: 136) claims lying is ‘a way of life’ for these offenders and even when faced with strong evidence, ‘reality may not be enough to persuade [them] to tell the truth’. See also Sigal et al. 1989; Samuels and Southall, 1992; Meadow, 1982, 1995; Schreier and Libow, 1993; Loader and Kelly, 1996; Southall et al. 1997; Parnell, 1998; Gregory, 2003; Feldman, 2004a.

\(^{129}\) Whelan-Williams and Baker (1998) noted that eight of the nine women they interviewed admitted to their actions and attribute this to the existence of multidisciplinary protocols.

\(^{130}\) For example, Chadwick (1996: 31) described a mother who had murdered two of her children and was caught on video surveillance attempting to suffocate her third. When told of
deny any allegations of intent to harm their child (Kinscherff and Ayoub, 2000) or withdraw their admissions once the crisis confrontation period is over (Freeland and Foley, 1992; Ayoub et al. 2000). However, Fox (1995) and Feldman (2004a) also suggest some FII/MBP perpetrators will just be relieved that they have been caught.

2.6 Linking theory to FII/MBP cases

It is outside the scope of this research to present all of the theoretical literature that may be relevant to this study. However, a number of theoretical perspectives associated with issues such as language, gender, power and crime have been selected for review. This section provides an overview of such theories. As there is no existing application of such theories to FII/MBP cases, the section identifies potential links to the existing FII/MBP literature. In doing so, it provides a basis for how such theories will be applied in this research, which is addressed in Chapter 3.

2.6.1 The significance of language and meaning in understanding crime

White and Haines (2005: 19) state that how we view and define what is harmful can ‘have major ramifications for how we propose to deal with crime at the level of policy, institution and strategy’. Language connected with FII/MBP and the interpretation and application of this label is a point of the surveillance she commented that ‘this was the first time she had ever done such a thing’. In another case, Loader and Kelly (1996: 354) described a woman who stated she had overmedicated her child because he was an embarrassment in front of the other mothers.
contention within the literature (see section 2.2.1). Three theoretical perspectives (symbolic interactionism, labelling and post-modernism) associated with language are examined and potential links to FII/MBP cases.

2.6.1.1  **Symbolic interactionism**

Symbolic interactionism, as outlined by Patton (2002), is a social-psychosocial theory most closely related with the work of George Herbert Mead (1934) and Herbert Blumer (1969). Blumer (1969, cited in Patton, 2002) bases symbolic interactionism on three fundamental premises:

1. Human beings act toward things on the basis of the meaning that the things have for them
2. The meaning of things arises out of the social interaction one has with one’s fellows
3. The meanings of things are handled in and modified through an interpretative process used by the person in dealing with the things he or she encounters.


Blumer (1969: 5, cited in Schwandt, 1994: 124) considered that through communication ‘significant symbols are created and produced’ and through an interpretive process ‘meanings are established and modified’. Blumer also suggests ‘the actor selects, checks, suspends, regroups, and transforms meanings in light of the situation in which he is placed and the direction of his action’. ‘Meanings are used and revised’ and act as ‘instruments for the

White and Haines (2005: 83, 85) state ‘the symbolic nature of human behaviour means that the first stage of any interaction is one of definition’ and that ‘when people share the same definitions, communication is likely to be straightforward and clear’. White and Haines (2005: 84) emphasise the actual situation is insignificant compared to how it is defined. Winfree and Abadinksy, (1996: 256) suggest that ‘social interpretation is subjective’, and that what is ‘believed to be true is indeed so if persons organise their responses or behaviour according to that interpretation’. Downes and Rock (1986: 146) state ‘language is the common meaning which integrates public activity’. They note that interpretation is predominantly linguistically orientated, but can also include ‘gestures, expression, clothing and context to convey meaning’. The literature reflects that FII/MBP cases have produced a range of reactions from professionals and that there is a considerable degree of confusion about how it is defined and understood (see section 2.2.2). There is also limited understanding about how police acquire meaning of FII/MBP and what influences and shapes police response to such abuse (see section 2.7.2). The principles of symbolic interactionism may be important in understanding these issues.

Labelling theory is closely associated with symbolic interactionism (Berger and Luckman, 1971; Chan, 1997). Williams (2004: 371) reports ‘labelling theory centres its study on how symbols, namely labelling someone, can be used, or can be seen, to influence someone’s action’. It examines society’s
reaction to those labelled as deviant and the effects this labelling may have on the individual (Williams, 2004: 371). Labelling theory raises some important issues about how best to manage criminal behaviour.

Police are thought to play a key role, particularly in the preliminary stages, in determining behaviour as criminal. Research identifies a range of factors which may influence police in this role such as a person’s attitude and appearance (Williams, 2004), the media (Williams, 2004), expectations about appropriate gender role behaviour (Domfield and Kruttschnitt, 1992: 401) and race and social class (Paternoster and Iovanni, 1989, as cited in Winfree and Abadinsky, 1996: 264).

White and Haines (2005: 78) note that power relationships can play a significant role in determining what (or who) is deemed to be deviant or an offender. In FII/MBP cases doctors play a powerful role in detecting and managing such cases. Schreier and Libow (1993) also suggest that FII/MBP cases may go undetected because professionals are reluctant to challenge doctors’ opinions131. In contrast, Pragnell (2004) suggests doctors are inappropriately diagnosing FII/MBP to avoid complaints by carers who may be unhappy with the treatment provided to their child. Pragnell (2004) suggests, through such a label, the carer is portrayed as a liar and thus less likely to be taken seriously by hospital personnel.

131 Jones and Pickett (1988) suggest a doctor’s opinion can carry more weight than a social worker’s, even when the doctor has no direct experience of the issue in hand.
Williams (2004: 377) suggests the act of being labelled is often insufficient to affect an individual and that for any stigmatisation to occur people, significant to the person concerned, must know about the label. White and Haines (2005) claim people will respond differently to labels and that whilst one individual may become entrenched in the label, another may cease offending because of the stigma of being caught. Williams (2004: 382) also suggests the effects of labelling are not easily predicted and that the benefits for the law abiding community in preventing further violations of the law may potentially outweigh the negative effects of labelling on the offender. Williams (2004: 382) further stresses that labelling theory can place too great an emphasis on the offender’s needs and ignore the real victims. As there has been considerable angst for professionals and the community alike, about FII/MBP and ‘MBP’ terminology (see 2.2.2), the use and impact of labels would appear relevant to this study.

2.6.1.3 Postmodernism

Postmodernism is linked to language and power. Postmodernism theorists investigate the way language constructs social relationships to the advantage of some and disadvantage of others (Vold et al. 2002; White and Haines, 2005). White and Haines (2005: 206) suggest ‘crime is defined in terms of linguistic production and relationships of power that shape the nature of this production’. Those controlling the means of expression may control and exercise power over others. Postmodernism investigates how particular voices within the criminal justice system may be overlooked and seeks to
expose the different ways in which language interests are valued and devalued.

Vold et al. (2002: 265) suggest postmodernists aim to expose how language creates dominant relationships. Consideration is given to ‘how language is embedded in [...] roles and [...] shapes and forms the way people in these roles think and speak’ (Vold et al. 2002: 261). The social position of the person who is speaking or writing is considered in order to understand the meaning of what is said or written (Vold et al. 2002). For example, White and Haines (2005) suggest police may not entirely control their own thoughts, but rather be influenced by language and culture embodied in the role of being a police officer. Foster (2003: 196) also reminds us that the police force is not ‘homogenous and one dimensional’ but made up of many subcultures, including ‘street cops and management cops, detectives and uniform members and response and community police officers’. She suggests there are many ‘nuances and differences within and between different elements of the police organisation and the people who work in it’. Due to the multidisciplinary aspect of FII/MBP cases and need for agencies to work collaboratively (see section 2.4) an examination of language and professionals’ perceptions associated with FII/MBP cases may be useful in understanding the multidisciplinary response to this abuse and police training issues.
2.6.2 The influence of power and gender

A number of theories highlight power as a central factor in how crime is determined and perceived by society. Power is essentially linked to gender, class, ethnicity, language and employment. As FII/MBP is predominantly committed by women, this section focuses on gender and feminist theories. Whilst the literature has traditionally ignored the study of women and crime, gender is now seen as a significant issue (Heidensohn and Silvestri, 1996). The concept of critical criminology is also explored briefly and how this may relate to FII/MBP investigations.

2.6.2.1 Patriarchal theories

Feminists argue women who do not occupy appropriate gender roles may be viewed by the courts as ‘doubly deviant’ and thus subjected to harsher penalties for relatively less serious crimes (Carlen, 1983; Kennedy, 1992 cited in Williams, 2004: 456). White and Habibis (2005: 217) suggest ‘dominant discourses about masculinity construct men as naturally aggressive and sexually promiscuous, while those about femininity construct notions of the good women as passive, gentle and faithful’.

White and Haines (2005) propose that behaviour, marital status and the appearance of women are constantly linked to particular ideas of femininity. They suggest ‘what is labelled as criminal or an act of victimisation depends to a large extent upon the perceived sexual behaviour and social status of the woman in question’ (White and Haines, 1995: 123). The literature associated with FII/MBP reflects that FII/MBP perpetrators are often not viewed as
deviant (see section 2.2.4.1 (i)) and that the deceptive ability of such women and/or inability by society to accept that a mother would offend on her own child plays a part in allowing such perpetrators to continue to offend (see 2.2.4.1 (a)). An awareness of the influence FII/MBP perpetrators may hold would appear to be significant for all professionals involved in FII/MBP investigations.

2.6.2.2 Female oppression

There is general agreement within feminist literature that women are oppressed. However, varying perspectives exist about the causes of such oppression (Dominelli and McLeod, 1989; Humm, 1992; Dominelli, 2002). Liberal feminists believe women are oppressed through lacking the same opportunities as men and fight for women to have equal employment, equal educational opportunities and the right to equal shares of resources (Fulop and Linstead, 1999). Radical feminists believe women are dominated by a male society (Humm, 1989) and viewed as an inferior class (Humm, 1989). They focus on the patriarchal elements within society and the suppression of women by men (Humm, 1989; Dominelli, 2002). Marxist feminism suggests the oppression of women is linked to capitalism and patriarchy (Hartman, 1979 in Curthoys, 1988). The structure of society itself is seen as a ‘major source of inequality and differential treatment’ (White and Haines, 2005: 96). It is suggested that in order to understand crime, it is necessary to examine the roles of both the powerful and less powerful in shaping a particular kind of social order (White and Haines, 2005: 100). The powerful are believed to design the laws in their own collective interest and to have greater capacity to
defend themselves if they break the law. The less powerful are thought to become the main focus of law enforcement and to commit crime out of economic need and social alienation (White and Haines, 2005). Theories linked with gender and power may be important in endeavouring to understand FII/MBP cases as this abuse is typically committed by females and diagnosed by doctors.

2.6.2.3 Critical criminology

Critical criminologists investigate power that is ingrained in social structures and how this power can oppress specific categories of people, such as the ‘working class, women, ethnic minority groups and indigenous people’ (White and Haines, 2005: 202). The primary task of critical criminologists is ‘to expose the nature of the underlying power relations that shape how different groups are treated in and by the criminal justice system’ (White and Haines, 2005: 202). Institutions such as education, family, work and the legal system are considered important structures in the development of social responses to crime and deviant behaviour (White and Haines, 2005: 13). The literature on FII/MBP captures the power that professionals hold in detecting, reporting and investigating FII/MBP cases (see section 2.4). An understanding of the power relationships that may exist in FII/MBP cases may be valuable for police in their approach to FII/MBP cases.
2.6.3 Psychological and sociological theories and criminal behaviour

Psychological theories focus on mental processes to explain criminal behaviour. Behaviour is thought to be determined or shaped by biological, psychological or social factors outside the immediate control of the individual (White and Haines, 2005: 41-46). Addressing crime is about identifying reasons that firstly caused the offending behaviour and then developing measures or treatment to address such causal factors. Sociological explanations of crime focus on structural factors within society. In analysing child abuse, Belsky (1987) cites the following social factors as contributing to such abuse: unemployment, social isolation, powerlessness, marital stress, violence and inadequate parenting and coping skills.

A child’s early years are considered important in shaping personality and behaviour in later life. Siegel (2002) suggests abuse in early years can provide a foundation for the development of violent and anti-social behaviour. Perry (2002: 95) suggests if the child suffers attachment problems with their parents and does not develop attachment with significant others, the child is likely to possess very poor or even pathological social-emotional functioning. Finally, Alder (1997) suggests women may be characterised as offenders, when their behaviour may be predominantly linked to coping strategies and/or a way of seeking independence and control in their lives. Some FII/MBP perpetrators have been described as possessing dysfunctional backgrounds and/or lack attachment with one or both parents (see section
2.2.3). An understanding about FII/MBP perpetrators may assist police in their investigations and dealings with such offenders.

Finally, the study of cultural criminology or the emotions of crime may be relevant to FII/MBP cases. The focus is about emotions that correlate with criminal behaviour, such as ‘humiliation, arrogance, ridicule, pleasure and excitement’. Artingstall (1999: 85) suggests FII/MBP perpetrators may perceive life’s mundane activity as a form of ‘neglect producing a sense of inner worthlessness’. She suggests ‘significant events producing emotional benefits of contentment, usefulness and distinction appear to provide ideological guidelines or pathways towards contentment’ for these offenders.

2.7 A Need for Training and Organisational Supports

2.7.1 The importance of education and support and suitable personnel

The identification, investigation and management of FII/MBP cases require experienced and trained professionals\(^\text{132}\) (Zitelli et al. 1987; Artingstall, 1999; Lasher and Sheridan, 2004\(^\text{133}\)). Artingstall (1999) states that:

\(^{132}\) Refer Appendix 12 for an overview of some of the professionals with training needs in relation to FII/MBP, as identified by Horwath and Lawson (1995a: 184).

The more investigators know about Munchausen syndrome by proxy the better able they will be to identify perpetrators, clear innocent suspects and most importantly protect children.

Artingstall, 1995: 5

Education is considered essential for enhancing professionals’ decision making in these investigations and minimizing the risks of misjudgement (Department of Health, 2001; RCPCH, 2002; Lasher and Sheridan, 2004). Wilkinson and Parnell (1998), Fox (1995) and Shepherd (1995) stress that a lack of police knowledge about FII/MBP may result in delays in the investigation and potentially damage the criminal case. Lasher and Sheridan (2004) state:

Staff who do not understand MBP basics are likely to dismiss reports, fail to assign them proper priority, make inappropriate decisions, or even fail to identify the described suspicious behaviour as possible MBP.

Lasher and Sheridan, 2004: 118

Various researchers stress the need for any myths surrounding FII/MBP to be dismissed (Horwath and Lawson, 1995a; Artingstall, 1999). Yorker and Kahan (1991: 56-57) stress ‘just as the signs and symptoms of sexual abuse have become widely understood by professionals who work with children, the signs and symptoms of MBP must also become familiar…’. Birge (1995: 9) emphasises ‘early recognition may prevent children from enduring lifelong memories of atrocities inflicted on their fragile bodies and psyches’.
Finally, Artingstall (1999: 83) and Sheridan (cited in Feldman, 2004a: 146) suggest knowledge regarding FII/MBP investigations is typically considered irrelevant by professionals until they personally become involved with a case. Artingstall (1999: 193) suggests this is inadequate as there is insufficient time during the course of a FII/MBP investigation to obtain a fundamental understanding of this abuse due to ‘victim safety’ and ‘flight risk’.

Also relevant is a reported lack of knowledge and expertise in relation to the handling of SUDI cases (Bufton, 1996; RCP and RCPCH, 2004; The NSW Child Death Review, 2005) and of a need for professionals involved with SUDI cases to be educated about their roles (RCP and RCPCH, 2004; NSW Child Death Review, 2005). Currently in Victoria limited training and information is specifically provided to police recruits, and uniform members in this area (pers comms Victoria Police Academy, recruit training, March 2005). SOCAU members receive a basic session\textsuperscript{134}.

Whilst regarded as critical, education alone is considered insufficient to address FII/MBP cases (Horwath and Lawson, 1995a; Lasher and Sheridan, 2004). Various researchers emphasise the need for improvements in systems responsible for dealing with child abuse, FII/MBP cases and infant deaths (Hall, 2003; Craft and Hall, 2004). Horwath and Lawson (1995a: 182) suggest FII/MBP training needs to be delivered within ‘a context of clear guidelines and procedures’, supported by adequate resources and supervision (Freeland and Foley, 1992\textsuperscript{135}, Yeo, 1996\textsuperscript{136}). The use of

\textsuperscript{134} Introduced by the researcher in June 2006.
\textsuperscript{135} Freeland and Foley (1992: 151) stress there must ‘be no lone ranger workers’ dealing with
multidisciplinary protocols or guidelines to provide clarity and guidance for professionals involved with FII/MBP cases is strongly supported by research (Whelan–Williams and Baker, 1998; Department of Health 2001; RCPCH, 2002). Artingstall (1999:3) states there is ‘no other type of investigation that requires an understanding and protocol between agencies to the degree required in MBP investigations’. The researcher observed multidisciplinary protocols specific to FII/MBP investigations did not appear to exist within Victoria or Australia.

Finally, people possessing the right attitude and expertise were considered critical with FII/MBP investigations (Horwath and Lawson, 1995a; Fox, 1995; Lasher and Sheridan, 2004), SUDI cases (The RCP and The RCPCH, 2004; NSW Child Death Review Team, 2005) and suspicious deaths in general (Shipman Inquiry, 2001, Second Report, 2003).

2.7.2 Police knowledge of FII/MBP

Limited research exists which explores police knowledge of FII/MBP and none exists in Australia. However, in the UK and US police are typically

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FII/MBP cases and that ‘workers on the ground must be strongly linked to, and supported by, line management’.


137 Within the UK the Department of Health, Home Office, Department for Education and Skills and the Welsh Assembly have published guidelines titled ‘Safeguarding Children in whom Illness is Fabricated or Induced’ (2001). These guidelines, in addition to the government’s child protection guidance ‘Working Together to Safeguard Children’ (1999), provide a national framework within which agencies and professionals at a local level can individually and jointly use to develop their own ways of working together (Eagle cited in House of Commons Hansard, 2006).

138 See also Merton Area Child Protection Committee, 2004; Blackburn with Darwen Borough Council, 2004; Sussex Police (n/d), and North East Regional Inter-Agency Procedures Project, 2005.

139 Fox (1995: 98) noted with one MBP case the ‘classic signs of MBP were either not seen or were ignored by medical staff, social workers and police officers and professionals failed to work together in protecting the children involved’.
described as being unfamiliar and inexperienced to deal with this offending (Fox, 1995; Bufton, 1996; Artingstall, 1999 Chiczewski and Kelly, 2003\textsuperscript{140}). Artingstall (1999: 83) considered FII/MBP cases may go undetected by professionals due to ignorance; tunnel vision; a lack of knowledge; a misunderstanding regarding MBP; and/or societal group labelling which promotes mothers as infallible. Lasher (2003: 409-410) suggests many highly regarded professionals ‘know little about MBP, have misconceptions about it and lack the knowledge and experience to undertake case involvement’. Finally, some professionals believe there has ‘developed some kind of no-go area around MBP – a dirty word which experienced professionals will not contemplate in spite of the obviousness of it all to an outsider’ (Horwath and Lawson, 1995b: 218, see also Fox, 1995).

Two small scale US and UK studies provide some insight into police knowledge of FII/MBP (Kaufman et al. 1989; Bufton, 1997). Kaufman et al. (1989) in a US survey, of 86 professionals, including six police officers, found that knowledge of MBP was ‘differentially related to the professional’s work setting’\textsuperscript{141}.

In an unpublished UK study, Bufton (1996) conducted a questionnaire with 37 police officers\textsuperscript{142} and 11 child protection workers in the Staffordshire region, attempting to identify their involvement in FII/MBP cases and the level of

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\textsuperscript{140} Chiczewski is a sergeant with the Chicago Children’s Advocacy Centre at the Chicago Illinois Police Department. Kelly is the Deputy Chief of the Hinsdale Illinois Fire Department.\textsuperscript{141} Similarly, Ostfeld and Feldman (1996) in their US study found that 89% of child psychiatrists surveyed had heard of MBP, but that only 42% of social workers had heard of this behaviour. Refer Appendix 13 for an overview of a number of surveys connected with FII/MBP located within the literature.\textsuperscript{142} The police officers consisted of uniformed police constables, detective inspectors, child protection constables, and child protection sergeants.
\end{flushright}
training they had received in relation to FII/MBP. Bufton (1996: 5, 69) found that of thirteen child protection police surveyed, ten had attended a FII/MBP case. Overall, the survey findings showed that the members were ‘unprepared’, ‘untrained’ and ‘inadequately supported’ in relation to their handling of FII/MBP cases and infant deaths (Bufton, 1996: 64, 69). Bufton (1996: 69) considered these elements had consequences for both the children and the professionals involved. Bufton (1996) commented:

To provide effective protection for children, organizations have a duty to ensure that investigations into child protection matters are conducted efficiently and effectively. That in itself means that adequate training and support should be provided for professionals who are expected to deal with this.

Bufton, 1996:2

Awareness of FII/MBP has been found to vary significantly amongst medical (Blix and Brack, 1988143), child protection (Freeland and Foley, 1992) and mental health professionals (Ostfeld and Feldman, 1996). However, physicians (Kaufman et al. 1989; Ostfeld and Feldman, 1996) and psychiatrists (Ostfeld and Feldman, 1996) were generally more informed of this abuse than social workers (Kaufman et al. 1989; Ostfeld and Feldman, 1996).

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Additionally, Kaufman et al. (1989); Hochhauser and Richardson (1994), and Ostfeld and Feldman (1996) cite journal articles and colleagues as important sources of professional education. Sheridan (2003) notes, however, that most articles tend to be published in medical journals, with only a few appearing in social science, police or other journals.

Finally the media has been reported as having little impact on professionals’ awareness of FII/MBP (Kaufman et al. 1989; Ostfeld and Feldman,1996) although Ostfeld and Feldman (1996) note media coverage concerning FII/MBP cases has heightened since conducting their survey. Ostfeld and Feldman (1996: 115) believe ‘enhancements in training and greater dissemination of professional articles’ will contribute to a more timely diagnosis of FII/MBP cases.

2.7.3 Existing training

2.7.3.1 Published training

The implementation of FII/MBP training for professionals is well supported within the research (Horwath and Kessel, 1995: Artingstall, 1999; Lasher and Sheridan, 2004). However, despite much FII/MBP literature, limited published training programs exist for professionals dealing with this abuse. Horwath and Lawson (1995a) have undertaken some work in this area, with

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144 Research conducted by these researchers relates primarily to professionals from a medical or mental health background.
145 See also Hochhauser and Richardson, 1994.
146 The UK have recently compiled a book produced by the Department of Child (2008) titled ‘Incredibly Caring: A training resource for professionals in fabricated or induced illness (FII) in children’ but it is currently unavailable.
an emphasis on child protection personnel. They support single, multidisciplinary (interdepartmental), and interagency training to improve professionals’ awareness and knowledge about FII/MBP and to develop agreed management strategies. Further, they recognise a need for managers and supervisors to be informed about this abuse. Due to limited published training programs on FII/MBP and, therefore, the significance of Horwath and Lawson’s work, an overview of the training is presented below.\footnote{Full details are provided in Appendix 14.}

Horwath and Lawson’s (1995) single agency training aims to promote a basic awareness among a particular practitioner group about MBP, how a case might unfold and how MBP issues might affect that particular group. Further, the training aims to instil an understanding about their role and responsibilities in relation to managing allegations of MBP, ensuring protection for the child and how to deal with the difficult and complex dynamics that will have to be addressed with such cases. A particular reference is made to police and of their need to know how to investigate allegations of MBP appropriately, including the use of CVS.

Multidisciplinary training within a single agency focuses on developing a common understanding of, and a coordinated response to, suspicions of MBP abuse by different departments or units within a single agency. It aims for units to agree to a system for managing the difficult and complex interpersonal dynamics likely to arise with such cases and to discuss and
agree on to how best to carry out assessments and investigation work in relation to MBP abuse.

Interagency training aims to improve the quality of investigations into MBP, by allowing the opportunity for agencies to familiarise themselves with existing protocols, operationalise those protocols through the use of a case study, educate professionals about what investigative and assessment techniques to use and when, and equip professionals with the skills to implement CVS. Further it aims to promote the identification of practice issues and development and implementation of strategies to address such issues.

Finally, multi-agency training aims to bring professionals together to focus on how cases are processed through the child protection and related legal systems, to address some of the potential hurdles they may encounter, and to ensure agencies are clear about how they can work together effectively to maximise the protection of children while having due regard for the rights and sensitivities of parents.

2.7.3.2 *Unpublished training material*

The researcher collected some unpublished FII/MBP training material\(^{148}\). An overview and comparison of this material is presented in Appendix 15.

\(^{148}\) This material was given to the researcher by other police colleagues. Other than Artingstall (2000) the researcher did not meet with the trainers. Additionally, the researcher attended a training workshop about FII/MBP presented by Lasher (2001). This workshop was primarily geared towards the child protection response but also covered issues of relevance for police and all professionals involved in FII/MBP cases.
Subjects that were covered in two or more of the presentations are listed below:

- Definitions of factitious disorders, MBP and Munchausen syndrome
- MBP maltreatment basics
- Common MBP suspicion indicators/ behavioural clues
- Differences between MBP and other kinds of abuse
- MBP symptoms (fabricated and induced)
- MBP behavioural typology
- MBP case study
- Profile of offender
- Offender motivational factors
- Father’s role in MBP cases / non-offending parent
- Victim profile and affects on victims
- Case management – multidisciplinary team
- Confronting the offender
- Victim safety planning
- Previously ruled SIDS or homicide
- MBP investigative checklist
- Legal issues.

The unpublished training programs are considered in the final analysis in Chapter 8.
2.8 Conclusion

Like other forms of child abuse, FII/MBP has met resistance (Pragnell, 2002b, 2004) and encountered problems with acceptance, definition and intervention (Lasher and Sheridan, 2004). However, the evidence overwhelmingly shows there are individuals, primarily women, who fabricate and/or induce illness in their children and sometimes fatally harm them (Kennedy, cited in RCP and RCPCH, 2004: 15) and that agencies need to ensure their staff are appropriately educated and equipped to deal with this abuse.

Whilst there has been considerable literature written about FII/MBP, there is limited research from a policing perspective, particularly within Australia. A US police officer Artingstall (1999) has published the most detailed material to date. However, a lack of information exists surrounding the police role with FII/MBP cases and there is a general belief that police knowledge about FII/MBP is poor (Fox, 1995; Bufton, 1996; Chiczewski and Kelly, 2003). However, the literature also reflects, that any suspected FII/MBP case may involve the commission of a crime and that police, therefore, need education about this abuse (Fox, 1995; Artingstall, 1999).

This chapter and associated appendices also demonstrate the multidisciplinary nature of FII/MBP cases and of the need for a coordinated approach by agencies in handling such matters. It suggests professionals involved with such cases, require additional knowledge and skill sets than those working in a single agency including education about the role and
responsibilities of other agencies and how to work effectively with diverging interests. The use of multidisciplinary protocols are considered critical for regulating and guiding professionals' involvement with this abuse and agencies' interaction and management of such cases (Horwath and Lawson, 1995a; RCPCH, 2002; Lasher and Sheridan, 2004).

Finally, this chapter reveals limited research which examines police FII/MBP knowledge and police FII/MBP training requirements. Further, no multidisciplinary guidelines specific to FII/MBP cases were found to exist within Victoria. This chapter, therefore, provides a strong rationale for this study. Additionally, through its depth and breadth, it provides a valuable foundation for the analysis of the research findings. The following chapter provides the methodology framework for this research.
Chapter 3

A Mixed Method Study

How we do something in research depends on what we are trying to find out.

Punch, 1998: 5

3.1 Introduction

This chapter builds on information presented in Chapters 1 and 2. It presents the research aims and questions; the theoretical orientations; the research design; the research methods and methodology including the research instruments, participant selection process, the conducting of the research and methods of analysis, and finally, ethical considerations in relation to the research.

3.2 The research aims and questions

This study aims:

To identity the training requirements for Victoria Police in responding to and investigating FII/MBP, from both a police and multidisciplinary perspective.

In order to provide a broad and rich examination of the topic this study is supported by five additional research questions:
• What is the police role in FII/MBP cases?
• What knowledge do Victoria Police members have about FII/MBP and the investigation and management of FII/MBP cases and what gaps exist in members’ knowledge?
• Do Victoria Police members require training in relation to FII/MBP?
• If so, what knowledge and skills do Victoria Police members require to respond to and investigate FII/MBP cases from a police and multidisciplinary perspective? and
• What members would require FII/MBP training?

3.3 Theoretical Orientations

This section presents the theoretical framework which underpins this research and theoretical theories selected to assist in gaining a broader understanding of the issues raised in this research. Leask (2007:6) contends theories provide different lenses for researchers to ‘look at problems’, to ‘focus their attention’ and to provide a ‘framework for analysis’. They provide a conceptual understanding of things that cannot be pinned down: how societies work, how organisations operate and why people interact in certain ways. Howe (1987, cited in Fernandez, 1996:49) suggests all practice is theoretically linked and that different theories lead to different interpretations about the nature of individuals and the nature of society.
3.3.1 An interpretivist approach

An interpretivist framework has been adopted for this research. Interpretivists aim ‘to understand the world of lived experience from the point of view of those who live in it’ (Schwandt, 1994: 118; see also Denzin, 2001). The task is to understand how people in a social setting make meaning of and construct the world around them (Glesne and Peshkin, 1992; Williamson, Burstein and McKemmish, 2000).

Interpretivists aim to understand a particular context. They view knowledge as understanding rather than the ability to control. The purpose is to offer a perspective that helps the reader understand a particular phenomenon studied. Understanding is not a singular but a multiple understanding of a particular situation (McQueen, 2002 in Willis, 2007: 194). The purpose of seeking multiple perspectives on the same situation or context is not to determine which one is the right perspective. Instead, interpretivist social science is much more inclusive than extreme positivism. From the positivist viewpoint there is only one correct answer; in contrast the interpretive paradigm allows multiple positions to be taken into account when attempting to analyze a situation (McQueen, 2002 in Willis, 2007: 194).

Interpretivists do not object to traditional postpositivist research, however, this is viewed as simply one of many sources of knowledge and it does not hold a privileged position over other ways of understanding. Interpretivists are not searching for an objective external answer to their questions because they view the world through a series of individual’s eyes. People have their own
interpretations of reality and interpretivists choose methods that encompass this worldview (McQueen, 2002 cited in Willis, 2007: 194). Iran-Nejad (1990 in Willis, 2007) states:

The more meaningful, the more deeply or elaboratively processed, the more situated in context and the more rooted in cultural, background, metacognitive and personal knowledge an event the more readily it is understood, learned and remembered.

Iran-Nejad (1990:511 in Willis, 2007:132)

Schwandt (1994: 118) states interpretivists interpret how ‘particular actors, in particular places, at particular times, fashion meaning out of events and phenomena through prolonged, complex processes of social interaction involving history, language and action’. Williamson et al. (2000: 31) state the interpretivists’ ‘concern is with the beliefs, feelings and interpretations of participants’. They indicate that:

The central tenet of Interpretivism is that people are constantly involved in interpreting their ever-changing world. They develop meanings for their activities together, that is they socially construct reality. [...] They also make sense of their world on an individual basis, that is, they develop their own meanings, which often differ from one person to another. In other words they personally construct reality.

Williamson et al. 2000: 30

Endeavouring to capture peoples’ perspectives and meanings of the social world can present difficulties for researchers as researchers also bring their own beliefs and experiences to the research process (Williamson et al. 2000;
Denzin, 2001; Patton, 2002). Patton (2002: 41) indicates the ‘focus becomes a balance in understanding and depicting the world authentically in all its complexity while being self analytical, politically aware, and reflexive in consciousness’. Holstein and Gubrium (1994: 266) consider knowledge is not built upon a clean slate but rather influenced by an awareness of ‘recognizable categories, familiar vocabularies, organisational missions, professional orientations, group cultures and other existing frameworks for assigning meaning to matters under consideration’.

Williams (2003: 55-56) refers to Weber’s (1978) notion that moving from *atuelles Verstehen* (descriptive understanding, where one understands what is happening, that is, someone is digging with a shovel) to *erklärendes Verstehen* (explanatory understanding, where one comes to know why, that is, to plant potatoes) depends crucially on the existence of shared cultural resources. The researcher suggests she brings to this research a certain level of shared cultural understanding with the interview participants having worked on the frontline in dealing with child abuse and having gained an understanding of FII/MBP cases through overseas research and the literature review. It is believed this common ground will assist the researcher in conducting this research and interpreting the research findings.

Finally, an interpretivist approach was selected for this research because it supports the use of multiple perspectives in understanding the topic at hand and the involvement of people who have personal knowledge of the subject area and/or are most likely to be affected by the topic. Additionally, interpretivism recognises the importance of peoples’ experiences and
interactions in understanding present circumstances and in progressing into the future. The researcher considered such philosophy important due to the relatively unchartered nature of the subject area studied and complexity and multidisciplinary nature of FII/MBP cases. The researcher wanted an approach that supported a broad, yet, in-depth and practical understanding of police FII/MBP training requirements within a Victorian context.

### 3.3.2 Theoretical concepts linked to language, gender, power and crime

A number of theoretical perspectives associated with language, gender, power and crime are included in this research for consideration in the analysis and final conclusions in understanding FII/MBP investigations and police FII/MBP training requirements. The key concepts have already been described in Chapter 2. Their application to this research is now presented.

#### 3.3.2.1 The significance of language

Due to the evolving nature of FII/MBP terminology, diverging interpretations of FII/MBP and potential impact which language may have for professionals involved with FII/MBP cases and for those accused of such abuse. Symbolic interactionism, labelling and postmodernism are associated with language. Such theories are incorporated in this study
Symbolic interactionism

Closely linked to interpretivism is symbolic interactionism. Interpretivism is considered to be a broader term than symbolic interactionism, with most research in the symbolic interactionism tradition falling within the realms of interpretive research (Willis, 2007: 179).

Symbolic interactionism asserts that individuals structure their worlds through meanings gained from interaction with others. The central theme is about how individuals come to share meanings. Patton (2002: 132) states that symbolic interactionism focuses on the common set of symbols and understandings that are used to give meaning to people’s interactions. He suggests:

[…] the study of the original meaning and influence of symbols and shared meanings can shed light on what is most important to people, what will be most resistant to change, and what will be most necessary to change if the program or organisation is to move in new directions.

Patton (2002: 113)

Symbolic interactionism is relevant to this study as the researcher is interested in understanding how police learn about FII/MBP and potential influences which may shape and influence police perceptions and knowledge. Additionally, this thesis recognises the inconsistency in terminology surrounding FII/MBP. It seeks to consider the principles of symbolic interactionism in understanding the Victorian perspective of FII/MBP cases, what language professionals use to describe this abuse and how
professionals perceive and understand the term FII/MBP and what implications this may have for police training.

i) Labelling

White and Haines (1995: 86) see the crucial issue with labelling as understanding who gets labelled by whom and the consequences of the labelling. The query in this research concerns the use of terminology and the potential effects that language may have for women suspected of committing this abuse and the relevance of this for police training.

ii) Postmodernism

Postmodernists, in part, investigate how language is embedded in people’s roles and shapes and forms the way people think and speak. They examine the way language constructs social relationships to the advantage of some and disadvantage of others (Vold et al. 2002; White and Haines, 2005: 206). This study will examine how different professionals, including police, perceive and interpret FII/MBP and what impact this may have for professionals’ response and behaviour.

3.3.2.2 The influence of gender and power:

As FII/MBP is typically committed by females, gender is an important area of study. This study draws upon feminist and patriarchal theories.
i) Feminist perspectives

Feminists explore who holds and wields power in society and how this impacts on women. Women are thought to be structurally disadvantaged and oppressed in the present patriarchal, male dominated society. Fundamental inequalities are argued to exist between males and females. Further, the ways in which women are processed by the criminal justice system as victims and offenders is thought to be influenced by gender (White and Haines, 2005).

ii) Patriarchal theories

Patriarchal theorists suggest that women are disadvantaged by the criminal justice system as double standards are imposed upon them. White and Haines (2005: 123) suggest ‘what is labelled criminal depends to a large extent upon the perceived sexual behaviour and social status of the woman in question’. This research explores, in part, whether FII/MBP perpetrators are advantaged or disadvantaged by being female and whether issues linked to gender and FII/MBP need to be included in FII/MBP police training.

3.3.2.3 Power and social structures

i) Critical criminology

The structuralist approach to critical criminology sees power as ‘ingrained in social structures’. Power is reflected through ‘institutions and the activities of sectional interest groups’ (White and Haines, 2005: 202). Critical criminologists see the criminal justice system as ‘unfair, biased and
operat[ing] in ways that advantage certain groups or classes above others’ (White and Haines, 2005: 202). This research examines the underlying power relations that may exist in FII/MBP cases and aspects relevant to police FII/MBP training.

3.3.2.4 **Psychological and social explanations for crime**

Psychological theories focus on processes of the mind to explain criminal behaviour. A child’s early years are considered influential in shaping personality and behaviour later in life. Social theories, however, focus on structural factors within society that may contribute to criminal behaviour, such as unemployment, marital stress and social isolation. Whilst this research does not deal directly with FII/MBP perpetrators, it does provide insights into professionals’ experiences in dealing with such women. As such psychological and social factors may emerge that may be of relevance to understanding this offending and why women perpetrate this abuse on their children.

3.4 **The research design – a mixed method study**

A mixed method research design incorporating qualitative and quantitative methodologies was selected for this study (Bird, 1992; Querishi, 1992; Byman, 1992). Denzin and Lincoln (1994: 2) suggest the use of multiple methods reflects the attempt to secure an in-depth understanding of the phenomena in question. Further, Creswell et al. (2004) indicate:
The underlying logic of mixing is that neither quantitative nor qualitative methods are sufficient in themselves to capture the trends and details of the situation. When used in combination, both quantitative and qualitative data yield a more complete analysis, and they compliment each other.

Creswell et al. 2004: 2

Onwuegbuzie and Leech (2004: 770-771) suggest the mixed method design enables ‘researchers to be more flexible and holistic in their investigative techniques as they endeavour to address a range of complex research questions…’. Further, it enables researchers ‘the opportunity to combine macro and micro levels of study’ (Onwuegbuzie and Leech, 2004: 771). Finally, Tashakkori and Teddlie (2003a) suggest mixed method research is now regarded as a methodological entity in its own right and has become increasingly popular in addressing practical research problems (see also Roberts, 2002; Fontana and Frey, 2003; Onwuegbuzie and Leech, 2004).

However, some philosophers scorn mixed method research. Within the social sciences and educational literature a long standing debate exists around quantitative and qualitative methodologies and which is the superior method for studying and understanding our world (Lincoln and Guba, 1985; Tashakkori and Teddlie, 1998; Silvermann, 2005). This debate has naturally flowed to question whether such methodologies can be combined. Silvermann (2005: 122) believes there are problems in developing a philosophical model that will ‘suit both constructs of social reality’ that lie behind the qualitative and quantitative paradigms, and indicates a preference for researchers to adopt one or the other. Others, however, claim that both
methodologies typically have elements of the other within their designs (Bullock et al. 1992; Hammersley, 1992; Patton, 2002) and that the key differences are what make each powerful in its own right. A mixture of the two methodologies has the potential to strengthen the research design (Tashakkori and Teddlie, 2003b; Creswell, 2005). Bullock et al. (1992: 88) suggest that many social researchers ‘allow their work to be dominated by one stance without fully understanding or harnessing the benefits of the other’. Many researchers support that the choice of method should not be dominated by a preference for a particular theoretical viewpoint, but rather geared towards what one is trying to establish and the problems sought to be answered (Hammersley, 1992; Punch, 1998; Oakley, 2000). Bullock et al. (1992: 86, 89) considered that mixed approaches only fell short when selected for ‘convenience rather than relevance’

Traditionally, the interpretive paradigm has been linked to qualitative research (Denzin, 1989; Hopf, 2004). However, the benefits of using both qualitative and quantitative methodologies within an interpretative framework, has also been acknowledged (Weber, 1975; Guba and Lincoln, 1994; Williams, 2003). Williamson et al. (2000: 37) suggest that ‘interpretivists need to make compromises for practical reasons’ and indicate that where the research questions support a combined approach this should be a viable option. Hammersley (1992) believes what we are trying to achieve should not depend upon ideological commitments to one methodological paradigm or another, but on what we are trying to find out. It is questionable whether an interpretive approach relying only on qualitative data could obtain the
macro and micro perspectives sought by this research. Finally, it was observed that the use of questionnaires and interviews are often combined to achieve research aims (Kellehear, 1993: Patton, 2002).

The quantitative and qualitative components of this research are given equal importance and take on the principles of expansion\(^{149}\) (Greene et al. 1989); data triangulation\(^{150}\) (Denzin, 1978); complementarity\(^{151}\) (Brannen, 1992); and parallel mixed analysis\(^{152}\) (Onwuegbuzie and Leech, 2004). Essentially, the quantitative and qualitative methodologies operate independently of the other; that is they explore two different aspects of the research problem, produce two different types of data (Brannen, 1992) and involve separate data analyses (Onwuegbuzie and Leech 2004: 779)\(^{153}\). The quantitative and qualitative analyses are then brought together (Creswell et al. 2004) and a final interpretation of the data is made (Garman, 1996)\(^{154}\).

\(^{149}\) Expansion is where combined methodology seeks to expand the breadth and scope of inquiry by using different methods for different aspects of the research problem (Greene et al. 1989).

\(^{150}\) Data triangulation asserts that different data may be obtained through applying different methods or through the use of the same method at different times or with different sources. Data may be collected at different points in time and in a variety of contexts, situations and settings. Data may relate to ‘different levels of social analysis: the individual level, the interactive or the collective level’ (Brannen, 1992: 12).

\(^{151}\) Brannen (1992: 12) indicated that where ‘each approach is used in relation to a different research problem or different aspect of a research problem’ that this has been described ‘in terms of the complementarity of the two approaches’.

\(^{152}\) Onwuegbuzie and Leech (2004: 779) refer to ‘parallel mixed analysis’ as opposed to ‘concurrent’ or ‘sequential analysis’. They indicate that parallel analysis involves the least amount of mixing of qualitative and quantitative methods because the data is not mixed or integrated until the interpretation stage of the research process. Kelle and Erzberger (2004) and Creswell et al. (2004) considered this type of study was more common than an integrated approach.

\(^{153}\) Due to the differing needs of the research inquiries in this study the researcher concluded that the quantitative and qualitative components could operate primarily independently of the other. Practical aspects such as time and resources also played a role in shaping a separate research design rather than an integrated approach. The questionnaire does, however, assist in the identification of potential interview candidates and some research questions are explored in both inquiries.

\(^{154}\) Due to word restrictions the interview analysis also brings in the quantitative analysis and
This research is considered to be exploratory. No research exists in Victoria which focuses on the training requirements for police with FII/MBP cases. Further, there is limited research worldwide specifically orientated to police training requirements for dealing with this abuse (refer Chapter 1.4). This thesis aims to provide a solid foundation to begin to understand the needs of police with FII/MBP cases in Victoria and to act as a catalyst for further research in this field.

As explained within Chapter 1.3, a multidisciplinary focus has been adopted in this research. In summary, this approach has been chosen due to the multidisciplinary nature of FII/MBP cases and support within the literature for a coordinated multidisciplinary approach to this abuse. Further, the researcher's own awareness, through her role as a police trainer and operational police member working in the child abuse field, contributed to a practical understanding of the importance of police possessing multidisciplinary knowledge and skills in dealing with child abuse investigations.

3.5 The quantitative research

3.5.1 Choosing the research method and methodology

In selecting a research method to identify the level of knowledge held by Victoria Police members about FII/MBP, including gaps that exist in findings to produce an overall analysis of the data. The final chapter then provides a final interpretation of this analysis.
members’ knowledge, the researcher arrived at the conclusion that the method needed to meet the following requirements:

- Target police throughout Victoria from Sexual Offences and Child Abuse Units (SOCAU’s) and Criminal Investigation Units (CIU’s). These areas were selected due to the potential for such members to be assigned to FII/MBP investigations. Additionally, recruits and uniform members were surveyed to gain an indication of FII/MBP police knowledge levels prior to commencing operational commencing (recruits) and prior to entering specialist areas (uniform). This knowledge would assist to gauge FII/MBP training needs of members encountering FII/MBP for the first time

- Target police from the following ranks: recruit, constable, senior constable, sergeant, senior sergeant

- Collect data in a relatively timely manner

- Produce data that was compact, easily comparable, and able to be generalised

- Provide the macro picture of the police position in relation to awareness and knowledge of FII/MBP, including a snapshot of strengths and weaknesses
- Cover sufficient content related to FII/MBP investigations, in order to gain a broad perspective of members' knowledge in this area.

A mailed written questionnaire was considered the most appropriate method of inquiry for meeting these requirements. Questionnaires are particularly suited to obtaining a structured data set (De Vaus, 2001), gaining a broad perspective of the issues (Bullock et al. 1992) and describing a population too large to be directly observed (Babbie, 2001). They are a common research instrument in the social sciences (Burns, 2000; Hoyle et al. 2002). Written questionnaires are considered to be more practical, reliable, cost effective, and consistent in the delivery of information provided to participants (Babbie, 2001). Given the geographical distances involved in this study (227,600 square kilometres), the number of operational police to be surveyed (1,238) and the desire to obtain compact and standardised data, other research methods such as face to face interviews, telephone surveys or online surveys\(^{155}\) were not considered feasible options for this part of the research. Additionally, privacy and confidentiality requirements and time and resources were influential in the choice of research methods.

Questionnaires fall under the umbrella of quantitative methodology. Quantitative research has its roots in the scientific philosophy of the social world and relies on statistical and mathematical techniques (Patton, 1994). It is seen as scientific and objective and concentrates on areas that can be

\(^{155}\) An online survey was not considered to be appropriate due to a desire to maintain participants' anonymity and instil confidence in the members that this would occur. Due to the sensitive nature of the topic, a mailed survey was thought to provide a better means of ensuring privacy and confidentiality and to enable members to choose where they completed the questionnaire.
counted (Bullock et al. 1992; Williams, 2003). Its focus is generally on the macro perspective (Bullock et al. 1992; Punch, 1998; Williams, 2003). The standardized structure of questionnaires enables the data to be produced in the same format (Burns, 2000) and for the same set of variables to be measured with a large population (Babbie, 2001). Patton (1990) states:

The advantage of a quantitative approach is that it’s possible to measure the reactions of a great many people to a limited set of questions, thus facilitating comparison and statistical aggregation of data.

Patton, 1990: 14

Finally, quantitative research consists of research processes that can be checked and replicated (Gomm, 2004) and provide results that can be generalised about the sample population.

The disadvantage of questionnaires was also considered. Questionnaires do not allow for a detailed exploration of people’s experiences, thoughts and opinions. Nor do they allow for the inclusion and exploration of new ideas or for the clarification of participants’ questions (Hoyle et al. 2002). Finally, Hoyle et al. (2002) note there is no control over how participants may respond to the questionnaire, including who they may consult, the order in which they complete it, and whether they, in fact, return the document at all. The disadvantages were partly addressed through the inclusion of five opinion questions within the questionnaire, the capacity for questionnaire participants to speak with the researcher and the opportunity to volunteer to take part in the interview component of the research if they have had experience in dealing with this abuse. Additionally, the voluntary nature of
the questionnaire, the assurance of anonymity and capacity to complete the questionnaire during work time may have contributed to the completion and return rate of the questionnaires. Further, a reminder notice may also have assisted to trigger members’ participation.

On this occasion, the advantages of questionnaires were considered to outweigh the disadvantages, and more suited to achieving the research goals.

3.5.2 Designing the questionnaire

No questionnaires were available from the literature that fulfilled this study’s requirements. Therefore, the questionnaire utilised in this research was designed by the researcher. Prior to compiling the questionnaire, the researcher spent time in America, Canada and England with professionals who had expertise with FII/MBP cases and conducted an extensive literature review.

The final questionnaire (see Appendix 16) comprised two self assessment ratings, eight background information questions and forty-five structured statements. A self assessment rating was included at the commencement and conclusion of the questionnaire. These ratings provided a means for establishing how members perceived their knowledge prior to completing the questionnaire and whether their views altered upon completion. Further, they enabled comparisons to be made between perceptions and actual performance and provided an additional means for enhancing the validity and
reliability of the questionnaire. However, it is also acknowledged that participants, for whatever reason, may not truthfully record their perceptions (Babbie, 2001).

Eight background questions were included at the start of the questionnaire to enable statistical comparisons between the data. These questions collected information about the participant and their place of work and sought to identify whether members had heard of Munchausen syndrome by proxy, how they had heard about it, and finally, whether they had received any police training on the topic.

The body of the questionnaire was comprised of forty factual statements and five opinion questions. The statements are well supported by the literature and cover a diverse range of topics. The questionnaire utilises a Likert scale (see Neuman, 1997: 159); that is, participants were asked to indicate their level of agreement or disagreement with each statement, where 1 was strongly disagree, 2 disagree, 3 unsure, 4 agree, and 5 strongly agree. Babbie (2001: 240, 248) asserts the Likert scale uses space efficiently, is faster for participants to complete, and enables comparability, by participants and the researcher, of responses to different questions.

Due to the controversial nature of FII/MBP investigations and the relatively recent emergence of such cases into the criminal justice arena (Artingstall, 1999), the researcher considered it important to explore members’ opinions on a number of issues, including the involvement of police with cases of
induced illness, the monitoring of covert video surveillance in hospitals, and confrontation of FII/MBP perpetrators.

The researcher was sensitive to the wording, format, and layout of the questionnaire, and to the need to have clear instructions for its completion (Burns, 2000). Burns (2000) stated:

A well planned and carefully constructed questionnaire will increase the response rate and will greatly facilitate the summarisation and analysis of the collected data.

Burns, 2000: 332

At the time of developing the questionnaire (2000) terminology associated with FII/MBP was inconsistent, posing some difficulty for the researcher. After some consideration, the following terms were selected for use within the questionnaire: ‘Munchausen syndrome by proxy’, ‘Factitious disorder by proxy’, and ‘fabricated and/or induced illness/injury in children’.

3.5.3 Reliability and validity

Various measures were taken to enhance the reliability and validity of the questionnaire including an extensive literature review to provide content validity to the questionnaire content and answers, consultation with overseas professionals with expertise in the subject area and pilot testing. A pilot

\footnote{Refer to Chapters 1.2 and 2.2.2.}
\footnote{This included Professor David Southall (England), Detective Sergeant Kathy Artingstall (USA), Detective Inspector John Fox (England), and Detective Sergeant David Rodgers (England).}
questionnaire and one on one interviews were undertaken with fourteen police members. The purpose of the pilot was to identify statements that had the potential to cause problems or misinterpretation for professionals and make any necessary amendments (Babbie, 2001). De Vaus (1991) defined reliability and validity in this way:

A reliable measure is one where we obtain the same result on repeated occasions. If people answer a question the same way on repeated occasions then it is reliable.  

De Vaus, 1991: 54

Further,

A valid measure is one which measures what it is intended to measure. In fact it is not the measure that is valid or invalid but the use to which the measure is put.

The validity of a measure then depends on how we have defined the concept it is designed to measure.

De Vaus, 1991: 55

As a result of feedback received, the researcher was able to identify any questionnaire statements with potential to cause problems or be misinterpreted and make any necessary changes (Babbie, 2001).

The diversity of the questionnaire statements is further thought to contribute to the content validity of the questionnaire design as a diverse measuring device allows for a broader coverage of the subject (De Vaus, 2001: 30). However, it is also acknowledged, that attempting to measure knowledge, in
any subject area, is a difficult task as knowledge is such a broad and somewhat undefined and changing concept. Answers to the questionnaire statements were based on what was generally accepted to be true or correct at the time of conducting this research.

To add to the reliability and validity of the questionnaire, confidentiality and anonymity were guaranteed for the questionnaire participants (Babbie, 2001). This measure was considered to encourage honest answers, thereby enhancing the ability of the questionnaire to measure what it was designed to measure and to do so on repeated occasions.

### 3.5.4 Selection of questionnaire participants

A stratified random sampling method was utilised to select the questionnaire participants. The stratified aspect of the sampling involved selecting members from three different policing areas: Uniform; SOCAU; and CIU’s. Each group was treated separately with the following ranks included in each pool: constable, senior constable, sergeant and senior sergeant. Potential members from each group were then scrambled and the first, third and fifth members were selected. This process was undertaken with the assistance of the Victoria Police Research Department who subsequently supplied the researcher with a mailing list of the generated members.

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158 Refer to Appendix 5 for further information regarding these policing areas. These areas, by their policing nature were deemed more likely to become involved or exposed to a case of FII/MBP, compared to other areas within Victoria Police.
The sample sizes required for each policing area (excluding recruits), to represent the respective populations with a 95% confidence level and 5% confidence interval, were calculated with the assistance of the Victoria Police research department\textsuperscript{159}. In finalising the number of surveys to be sent, the issue of non-response based upon a 60% return rate for Uniform and CIU members and a 70% return rate for SOCAU members, was also taken into account. In total 1,238 questionnaires were posted to operational members (Uniform, SOCAU and CIU). Of this number, 655 questionnaires were received for analysis, including 310 from uniform members, 113 from SOCAU, and 232 from CIU’s.

The perspective of recruits prior to commencing operational duties was also considered valuable. At the time of conducting the survey, there were 375 recruits at the Victoria Police Academy. Three squads consisting of a total of 105 members were forwarded the questionnaire. All 105 questionnaires were completed and returned, giving a grand total of 760 questionnaires for analysis.

3.5.5 Conducting the questionnaire

The questionnaires were primarily distributed through the internal Victoria Police mailing system, with the exception of recruit questionnaires which were hand delivered to the Police Academy for personal distribution. All questionnaire participants were supplied with a copy of the plain language statement (or information letter) outlining the research, a questionnaire and a

\textsuperscript{159} The police population samples were based on July 2001 figures.
self addressed return envelope (refer Appendix 16). Members had permission to complete the questionnaire during work time at their place of employment. It was estimated that the questionnaire would take approximately 10-15 minutes to complete. An email was sent to all stations alerting managers of the forthcoming questionnaire and permission for members to complete the questionnaire on duty. The recruit questionnaires were distributed and returned in July 2001. The SOCAU, Uniform and CIU questionnaires were distributed in September and October 2001 and returned throughout September – December, 2001. A reminder notice was sent to all SOCAU, Uniform and CIU members two weeks after the questionnaires were forwarded.

3.5.6 Analysis of the questionnaires

The questionnaires were analysed using SPSS.10, a computer software program. Questions written in the negative were reverse scored and the five point Likert scale was condensed to a three point one: ‘agree, unsure, disagree’ to make the analysis process easier. Based on what was generally accepted to be true at the time of conducting this research, according to the literature and consultation with specialists in the field, members’ answers were marked as either ‘correct’ or ‘incorrect’. Statements marked as ‘unsure’ were left as is; that is they were marked neither ‘correct’ nor ‘incorrect’. Due to the evolving literature in this field and changes to terminology and policy and practices associated with FII/MBP cases, some of the statements, at the time of analysis, were deemed no longer suitable or thought to require further research. Such statements were not incorporated into the final analysis.
Finally, whilst a range of analyses were possible with this study, three key areas were selected for this purpose, namely: police department; rank; and FII/MBP training. The questionnaire also contained five opinion questions, these questions were analysed separately, focusing on members' views rather than the assessment of knowledge.

Due to the volume of data and word limitations of this study a decision was made to present the quantitative findings and bulk of the analysis of such findings in Chapter 5 and to draw on this data in the final analysis in Chapter 8. Finally, the questionnaire provided a means of identifying potential interview candidates for the qualitative component of this research.  

3.6 The qualitative research

3.6.1 Choosing the research method and methodology

In contemplating a research method for understanding the police role with FII/MBP cases and for supplementing the quantitative data in understanding police knowledge and skill requirements with FII/MBP from both a police and multidisciplinary perspective, the researcher concluded the method needed to:

- Target police who have had involvement with a FII/MBP case

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160 The information letter that was forwarded with the questionnaire invited members with experience with FII/MBP cases to volunteer to participate in the interview component of the research.
• Target child protection workers, doctors, and psychologists who have dealt with a FII/MBP case\textsuperscript{161}

• Possess the capability to provide rich descriptive data to provide insight into professionals’ personal experiences in dealing with FII/MBP

• Allow the participants, with minimal prompting, to do most of the talking to gain their perspectives

• Allow the opportunity and flexibility to clarify ideas, raise questions, and build upon existing and emerging data.

Interviews were considered the best medium for addressing these goals. Unlike the quantitative research which sought to obtain the macro perspective, this inquiry sought to gain a deeper understanding of the issues at hand and to have the flexibility to explore issues as they arise. Fontana and Frey (1994: 361) state interviews are ‘one of the most common and most powerful ways to try and understand our fellow human beings’.

Interviews fall within the qualitative paradigm. Qualitative research associated with the study of human life originated in the 1920’s and 1930’s with the Chicago School and has its roots in the humanities (Denzin and Lincoln, 1994). Its recognised strengths are in providing data that has ‘a

\textsuperscript{161} During the course of the research a school principal and a psychiatrist were also interviewed. Refer also to section 3.7.2.
concrete, vivid, meaningful flavour’ (Miles and Huberman, 1994: 1) and in its flexibility to explore new ideas as they emerge from within the data (Patton, 2002). Patton (1990) states:

Qualitative methods are the best way...of getting the insider’s perspective, the actor’s definition of the situation, the meanings people attach to things and events. Qualitative data has a holism and richness.

Patton, 1990: 243

Qualitative research does, however, have its critics. Such research is considered to be unscientific and biased, due to its heavy reliance on the researcher to conduct and interpret the research (noted by researchers such as Finch, 1986; Denzin and Lincoln, 2003; Creswell, 2005). However, it is also argued that quantitative data too is subjective as it relies on a human being to compile its testing instruments (Patton, 1987, 2002; Bullock et al. 1992). Patton (2002: 51) contends that subjectivity versus objectivity is a futile debate and recommends that researchers aim towards ‘honest, meaningful, credible and empirically supported findings’. This study recognises the strengths of both quantitative and qualitative research methodologies and that different research inquiries may be more suited to a particular research method. A quantitative approach alone would not have achieved the aims of this research.
3.6.2 The interview design

An open and semi-structured interview design was chosen for this inquiry. Minchiello et al. (1995: 65) suggest in this approach the ‘topic area guides the questions asked, but the mode of asking follows an unstructured process’. Fontana and Frey (1994: 365) suggest this style has the capacity to foster rapport and obtain a breadth of information. Williams (2003) considered the establishment of rapport essential when dealing with sensitive issues, which FII/MBP cases are. In comparison, Bryman (1992: 72) suggests structured closed questions are considered to lack rapport building opportunities and to encourage short replies.

An aide memoire was utilized with all interviews during this inquiry (see Appendix 17). An aide memoire is described as a memory guide that aids the researcher in ensuring that key aspects have been covered during the interview. The guide is revised and added to throughout the interview process as participants provide new information (Burgess, 1982, cited in Minchiello et al. 1995: 82). Initially, the researcher placed themes on the aide memoire which she considered relevant, based on the literature review, her overseas research and work conducted on the quantitative inquiry associated with this research (Bulmer, 1979; Ryan and Bernard, 2003). The aide memoire was then utilised as a working document to shape and develop the research themes as they emerged from the interviews and to generate future interview questions.
3.6.3 Selection of interview participants

Interviews were conducted with four doctors, six police officers, five child protection workers\(^{162}\), three psychologists, a retired principal, and a psychiatrist. All professionals had some involvement with a FII/MBP case and were current practitioners in their field (except the retired principal). The professionals all worked within Victoria and came from a range of different departments within their respective organisations\(^{163}\). The police officers interviewed were either detectives or SOCAU members. It must be stated that the views of individuals quoted in this research are personal and not necessarily representative of their organisations.

The school principal was not initially included within the original research and ethics proposal for this study; however, an opportunity arose to conduct this interview. The school principal provided an additional and valuable perspective highlighting some of the issues facing educationalists in dealing with FII/MBP cases and the interagency problems that can arise for schools in managing this abuse. Ethical clearance was obtained for this interview to be included within the research.

The identification of, and access to, professionals with expertise in relation to FII/MBP investigations were important considerations for the researcher in developing the qualitative component of this research. Through her police training background, the researcher was fortunate to draw upon established

\(^{162}\) One interview was not utilised in the final analysis due to a faulty tape recording.

\(^{163}\) Whilst not asked directly, the researcher perceived that all participants interviewed would have had at least ten-fifteen years experience in their field based on their work positions and through the information revealed (i.e. 5 cases in 15 years).
links with medical, child protection and mental health personnel to gain the support required for this research. Managers from the respective disciplines provided excellent assistance in identifying potential interview candidates and introducing the researcher to them. In addition, the professionals themselves provided the researcher with further referrals. The acquisition of medical, child protection, and mental health practitioners for this study was thus based on purposive and snowball sampling (Neuman, 1997).

The identification of potential police interviewees occurred through the questionnaire, email, and word of mouth. A list of twenty police members was compiled by the researcher and eventually two detectives and two SOCAU members were selected for interview. The selection process with the police participants was based on theoretical (Strauss and Corbin, 1990) and purposive sampling (Neuman, 1997). That is, the selection process was based upon the relevance of the members’ cases to emerging themes and of the need to ensure a cross section of policing areas to allow for the emergence of new themes. During the course of the research, two further detectives were interviewed due to their involvement in a case containing themes relevant to this study. This interview was conducted jointly with the detectives.

It is acknowledged that other professionals such as nurses, teachers, prosecutors and magistrates would also be of relevance to this research, however, due to the already extensive nature of the research a decision was made to focus on the nominated professions. Some of the issues associated
with the professional groups have however, been captured in the literature review and will be drawn upon in the analysis.

### 3.6.4 Conducting the interviews

The interview participants were initially contacted by the researcher by telephone in order to obtain their verbal consent to participate. They were then forwarded the relevant written documentation, including:

1. A plain language statement outlining the research project and expectations of the research participants. Doctors, psychologists and the psychiatrist were also supplied with a hospital information sheet.

2. A university consent form requesting participant’s permission in writing to participate in the interview. Doctors, psychologists and the psychiatrist were also required to sign their own hospital consent form.

3. A copy of the Victoria Police approval letter to conduct the research.

4. A copy of the participant’s organisation approval to conduct the research.

This process enabled participants to know the research was being conducted in a professional and ethical manner under university guidelines.

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164 This statement is a university requirement. Refer Appendix 17.
165 This was a requirement of the hospital ethics’ process.
166 Refer Appendix 17 for consent forms
167 Refer Appendix 18 for research approval documentation
The researcher conducted all interviews. This provided consistency to the research and enabled issues to be readily progressed as they emerged from within the data. Further, the researcher’s sound background in the child abuse field, experience in utilising open questioning interview techniques and knowledge of FII/MBP investigations enabled rich and in-depth data to be collected. Miles and Huberman (1994: 38) suggest in conducting interview research, the issues of ‘instrument validity and reliability ride largely on the skills of the researcher’.

One interview was conducted with each professional and varied between 1-2 hours in length. The interviews were conducted between July 2001 and January 2005, with the majority of interviews conducted in 2001-2002. Two joint interviews were undertaken due to professionals having involvement with the same case: Police 5 and Police 6, and Police 3 and the school principal. All interviews, bar one, were conducted at the participant’s place of employment. The joint police/principal interview was conducted at the principal’s home residence. The interview participants were not interviewed in any specific order, but rather in line with emerging themes, the availability of professionals, and the researcher’s work commitments.

The interviews were taped ensuring the information provided was documented accurately and able to be rechecked later, thereby enhancing the validity and reliability of the research process. The interviews began with

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168 The researcher spent five years working as a Victoria Police trainer in the area of child abuse and sexual assault. Part of this time was spent teaching members how to conduct interviews with abused children. Such interviews very much rely on police having excellent skills in utilising open ended questions; an inability to do so resulting in cases being lost at court and children potentially being returned to abusive homes.
an exploration of terminology and participants’ understanding of FII/MBP, followed by an opportunity for professionals to describe their own experiences in managing this abuse. Finally, any issues raised by the participants during the interviews were clarified and the key themes in the aide memoire were explored. Participants were informed they would be sent a summary of the research findings. Due to timeframes transcripts were not forwarded to the participants for review, however, if requested transcripts would have been made available.

3.6.5 Analysis of the interviews

In analysing the interviews, the researcher drew on a number of sources including thematic analysis (Patton, 1990; Kellehear, 1993); bracketing, construction and contextualisation (Denzin, 1989); and open, axial, and selective coding (Straus, 1987) (see Figure 3.1). Thematic analysis begins from the first interview and is concerned with identifying themes and re-occurring themes and patterns. It then seeks to obtain further data which may support those themes and gradually, inferences are made about the data through the links that are formed (Patton, 1990).

In undertaking such research, the researcher generally begins with a blank slate and the issues are allowed to emerge from within the data, rather than commencing with a theory and then trying to prove it (Strauss and Corbin, 1990: 23). Whilst this approach was essentially adopted, it must also be acknowledged that having designed the quantitative component of this study and conducted research overseas, the researcher already possessed
significant knowledge about the research topic prior to commencing the
interviews and as such did not begin with a blank slate. Many, however,
support this position as prior knowledge fosters a deeper understanding of
the situation being studied (Weber, 1978; Holstein and Gubrium, 1994;
Williams, 2003). The researcher was careful not to allow her knowledge to
inhibit or impede the participants’ views (Strauss and Corbin, 1990).

On completion of each interview, consistent with thematic analysis
(Kellehear, 1993), open coding (Strauss, 1987) and bracketing (Denzin,
2001), the researcher listened to the interview (tape) and made notes of the
key themes. These were then added to the aide memoire. Kellehear (1993:
39) suggests the task is ‘to break the whole into parts; sections which have
smaller bits of meaning in themselves’. Denzin (2001: 75) describes
bracketing as taking the phenomenon ‘out of the world where it belongs’ and
‘uncovering, defining and analysing its elements and essential structures’.

A second stage of analysis termed axial coding (Neuman, 1997) or
construction (Denzin, 2001) then took place. This stage involved organising
and categorizing the data and looking for linkages between concepts or
themes. The ‘researcher asks about causes and consequences, conditions
and interactions, strategies and processes, and looks for categories or
indicates that ‘if bracketing is taking something apart, constructing is putting it
back together’. Again, the aide memoire was utilised to assist with this
process, with the data being reorganized and reshaped according to the
convergence of themes and emergence of new ideas. The data was then
considered in line with the research aims, questions, and theoretical framework (Patton, 2002: 503) and questions were generated for exploration with future interviews.

Upon completion of all interviews, the researcher revisited the interview transcripts searching for major issues, themes and sub-themes. Patton (2002) indicated that:

…the qualitative inquirer consciously works back and forth between parts and wholes, separate variables, and complex, interwoven constellations of variables in a sorting-out then putting-back together process.

Patton, 2002: 67

The final stage of analyzing the data is described as selective coding or contextualization. This involves the researcher revisiting the data to collect examples that contextualise or enrich the identified themes. Contextualization, consistent with interpretivism, presents the phenomenon in professionals’ own ‘terms’, ‘language’ and ‘emotions’ (Denzin, 2001: 79). The data was then condensed, consolidated and interpreted. Patton (2002) states:

Interpretation means attaching significance to what was found, making sense of findings, offering explanations, drawing conclusions, extrapolating lessons, making inferences, considering meanings, and otherwise imposing order on an unruly but surely patterned world.

Patton, 2002: 480
As a qualified teacher and experienced police officer who has worked and taught in the area of child abuse, the researcher is well placed to identify, analyse and assess areas of significance to police training.

Finally, agonizing decisions were made about what data would not be included within this thesis. Loftland (1971, cited in Patton, 2002) states:

…one can hopefully bring himself to accept the fact that he cannot write about everything that he has seen (or analysed) and still write something with overall coherence or structure.


The interview analysis is presented in Chapter 8. Chapter 8 also brings together the qualitative and quantitative findings and presents a detailed overall analysis of this study’s findings. It draws upon the literature review, existing FII/MBP training and theoretical concepts selected for consideration within this research. Finally, Chapter 9 provides a final interpretation of this study’s findings and addresses the research questions and overall research objective.

3.7 Ethical considerations

3.7.1 Research approval

Approval was obtained from all organizations involved with this research, including authorization from the necessary ethics committees (a Metropolitan Hospital, Victoria Police and RMIT University). See Appendix 18 for relevant
ethics approvals. The police ethics process was dependent upon the acceptance of a number of conditions (Refer Appendix 18). The Department of Human Services (DHS) did not require this research to pass through a full ethics committee as the researcher was not accessing client details and had confidentiality procedures in place for its participants. Approval was provided in writing by DHS for its workers to be involved (see Appendix 18).

The original ethics proposal included two hospitals. Due to the cumbersome process in obtaining ethics approvals and/or clearances from multiple organisations, and the already extensive nature of this research, a decision was made to utilise just one hospital.

3.7.2 Privacy, confidentiality, and informed consent

FII/MBP is a sensitive and controversial topic. This research, therefore, needed to be conducted in a non-threatening and confidential manner so that professionals would feel comfortable in disclosing and expressing honest opinions. The researcher was committed to conducting honest, rigorous and logical research producing useful, meaningful, valid, reliable, enriching, and ethical findings (Garman, 1996: 18-19).

Due to the uniqueness of FII/MBP cases, the researcher took steps to protect the privacy of research participants, victims and their families. Victoria Police, The DHS (Child Protection), and the medical institution involved with this research all require stringent standards of confidentiality within their respective organisations. The hospital involved in this study was prepared to
be identified; however, during the course of the research, the researcher formed the belief that, due to the nature of the cases studied, it was not in the interest of the victims, families or professionals spoken of in this research to identify the hospital concerned. All information identifying the hospital has therefore been removed. Original documentation is kept in a secure location at RMIT University.

Further, to assist in maintaining ethical standards, the researcher has not identified professionals specific work locations. Professionals are referred to by profession and differentiated from each other by number; for example Doctor 1, Doctor 2, Police 1, Police 2. Any identifying information that potentially might reveal a professional, victim or family’s identity has been removed. No victims’ details were accessed.

All professionals participated in this study voluntarily. Professionals participating in the interview component of this study signed an informed consent form giving their permission to be interviewed and for their interviews to be tape recorded. The interview tapes were identified by number and profession, with no reference made to the person interviewed or place of employment. Confidentiality was guaranteed. The interviews were transcribed by persons known to the researcher. No professionals’ details were released to the transcribers and confidentiality agreements were signed. Cases still under investigation were transcribed by the researcher. Funding assistance was provided by RMIT University for interview transcription.
Questionnaire participants were informed in writing of the research and guaranteed complete anonymity. Returned questionnaires were unable to be traced back to the participants. To assist with the qualitative component of this research, questionnaire participants were asked to volunteer their details if they had been involved with a FII/MBP case. Such information was kept confidential by the researcher.

3.8 Conclusion

In conclusion, this research has been driven by the research aims and questions underpinning this study. It utilises an interpretive framework, a mixed method research design and encompasses a number of theoretical perspectives associated with language, gender, power and crime. This approach meets the primary objectives of this thesis in understanding the police role with FII/MBP cases, existing police knowledge levels, and the knowledge and skill requirements of police in responding to and investigating FII/MBP cases from both a police and multidisciplinary perspective. The multiple sources and types of data collected in this research provide a powerful means for addressing this study’s goals and for contributing to knowledge in this field.
Chapter 4

An Insight into Victorian Professionals’ Experiences in Dealing with FII/MBP

The home was spotlessly clean, with toys everywhere. This woman was intelligent, articulate and deceptive. The mother presented as loving and caring, as though butter wouldn’t melt in her mouth. She took the stance that there was obviously something wrong with her child and that it was ridiculous for professionals to think otherwise.

Police 1

4.1 Introduction

This chapter presents qualitative findings. It seeks to understand FII/MBP from a Victorian perspective and to gain contextual and background information that may be relevant for police who have no prior knowledge about FII/MBP. It examines terminology used in Victoria in association with FII/MBP and professionals’ application of such language; the types of FII/MBP cases handled by professionals interviewed in this study and professionals’ recollections of their dealings with FII/MBP perpetrators, spouses and victims (see Police 1 above). Finally, it presents professionals’ feelings and emotions in dealing with FII/MBP cases and illustrates the personal impact such cases can have on professionals.
The qualitative data collected from professionals in this study was collected from a police training frame of reference. Professionals interviewed clearly understood from the outset that the purpose of the interview was to identify police training requirements with FII/MBP cases and to progress police understanding of FII/MBP. Professionals primarily achieved this objective by speaking about their own experiences in dealing with FII/MBP cases and then offering advice based on those experiences. This chapter presents professionals’ direct descriptions and accounts of their dealings with FII/MBP cases. Explicit links to police training are made during the analysis in Chapter 8. The researcher considered this approach maintained the richness of the interview data and provided transparency to the research.

This chapter begins by presenting an outline of the professionals interviewed in this thesis.

### 4.2 The professionals interviewed

Throughout 2001-2005 the researcher interviewed twenty Victorian professionals who had dealt with a case involving fabricated and/or induced illness in a child (see Table 4.1)\(^{169}\). The professionals were from the following backgrounds: medical, child protection, police, mental health and education. Further, they came from a range of different departments within their respective organisations, were experienced in their fields\(^{170}\) and, with

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\(^{169}\) One interview was not used in the final analysis due to a faulty tape recording.

\(^{170}\) Whilst the professionals were not specifically asked how long they had been working in their respective professions, from the information supplied and positions held, the researcher concluded that the professionals interviewed possessed at least ten years’ experience in their fields.
the exception of the school principal, were current practitioners. The professionals came from country and metropolitan locations. Due to privacy and confidentiality requirements (see Chapter 3.7) only a basic overview can be provided of these professionals (see Table 4.1).

Table: 4.1: Overview of interview participants and thesis coding

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number of professionals interviewed</th>
<th>Description</th>
<th>Thesis coding (Referred to as)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>6</td>
<td>2 x Detectives (CIU) (1 country, 1 city)</td>
<td>Police 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 x Homicide members (detectives) (city)</td>
<td>Police 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 x Sexual Offences and Child Abuse Unit (SOCAU) members (country)</td>
<td>Police 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Police 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Police 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Police 4</td>
</tr>
<tr>
<td>Department of Human Services (DHS), Child Protection</td>
<td>5 171</td>
<td>Team managers or trainers (city)</td>
<td>Child Protection 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Child Protection 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Child Protection 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Child Protection 4</td>
</tr>
<tr>
<td>Doctor</td>
<td>4</td>
<td>Attached to a city hospital (various departments)</td>
<td>Doctor 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Doctor 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Doctor 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Doctor 4</td>
</tr>
<tr>
<td>Psychologist</td>
<td>3</td>
<td>Attached to a city hospital</td>
<td>Psychologist 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychologist 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychologist 3</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>1</td>
<td>Attached to a city hospital</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>School Principal</td>
<td>1</td>
<td>Retired (country)</td>
<td>Principal</td>
</tr>
</tbody>
</table>

171 One child protection interview was not used in the final analysis owing to a faulty tape recording.
4.3 Terminology and Understanding of FII/MBP

4.3.1 Terminology

Professionals were informed that varied terminology existed about FII/MBP and were then asked what terminology they used, or were familiar with, to describe this type of child abuse. Professionals utilised a variety of terms, including ‘Munchausen syndrome by proxy’, ‘Munchausen by proxy syndrome’, ‘Munchausen by proxy’, ‘Munchausens’, ‘fabricated illness by proxy’, ‘Paediatric factitious disorder by proxy’, factitious disorder by proxy’, ‘fabricated illness by proxy’, and ‘fabricated illness’. The two most frequent terms were ‘Munchausen by proxy’ (MBP) and ‘Munchausen syndrome by proxy’ (MSBP). The police participants utilised the terms ‘MSBP’, ‘MBP’, ‘fabricated illness’ and ‘fabricated illness by proxy’.

Police 6 and Doctor 1 suggested ‘colourful’ and ‘catchy’ terms such as ‘Munchausen syndrome by proxy’ or ‘Munchausen by proxy’ ‘can often stick’ and believed they were most widely used for this type of child abuse (Doctor 1). Doctor 3 suggested some people were unhappy with the term MBP. He thought ultimately language was not that important, but also indicated that ‘some uniformity in terms’ helps ‘to minimise confusion’. Child Protection 2 considered that “Munchausen” as a diagnostic label served only to summarize a set of conditions, a set of factors, or a set of variables’. She suggested that, although enormous debate exists about ‘MBP’, it is generally agreed certain things happen in such families to place the child at risk.
Police 5 indicated that initially he had used the term ‘MBP’, but now adopted the terms ‘fabricated illness’ and ‘fabricated illness by proxy’, which he considered to be in line with recent literature. Police 6 observed that older DHS workers tended to use the term ‘MBP’, whereas younger ones were starting to use the term ‘fabricated illness’. Child Protection 2 and Doctor 2 both considered that for court purposes professionals, including police, should not use ‘Munchausen’ terminology. They highlighted such language only creates confusion and can result in professionals becoming involved in a ‘Munchausen debate’, rather than focusing on the actual abuse suffered by the child (see below).

**Child Protection 2:** Never argue a case in the Children’s Court based on Munchausen Syndrome by Proxy, but rather, focus on the abuse suffered by the child. […] if you run your cases around Munchausens, I think you get distracted in to ‘is it or isn't it?’ and my experience is that the medical profession is always incredibly divided on whether it is or whether it isn’t.

The Psychiatrist and Psychologist 3 believed the term ‘MBP’ was being too ‘liberally used’ at the ‘softer end’ of these cases and ‘without firm evidence’ (Psychiatrist). However, Doctor 4, Child Protection 3 and Child Protection 4 felt there was reluctance by professionals to use or apply MBP terminology.

**Doctor 4:** It is not a label you particularly want to put on people and people are very hesitant to use it, very conservative.

**Child Protection 3:** No one was prepared to quote it on record. All professionals were scared of using a MBP diagnosis.
The Psychiatrist and Psychologist 3 saw the labelling of MBP as ‘quite confounding if not used at the right time and in appropriate circumstances’ (Psychologist 3). They considered such terminology had the potential to alienate people from treatment and support and that police needed to be mindful of this aspect.

### 4.3.2 Understanding of FII/MBP

In addition to terminology, professionals were asked how they defined or understood the term FII/MBP. The majority understood ‘MBP’ as a form of child abuse where the mother fabricates or induces illness in her child to gain attention from professionals.

**Police 5:** Fabricated illness – what it says where people fabricate their own illness for attention or appears to be for attention which you get in both children and adolescents and the by proxy part is where it’s other people fabricating the illness in a third person or a victim as such to get attention for themselves basically. Basically, a parent who will inflict some sort of harm to their child in order to gain attention for themselves.

However, one police officer (Police 2) and a doctor (described by Child Protection 1) described the perpetrators of such abuse as ‘diagnosed with’ or ‘suffering from’ MBP. Child Protection 1 indicated the doctor had said and recorded in his medical notes that, ‘This woman has MBP’. Two child protection workers used the term ‘MBP’ to describe both a type of child abuse and a health condition suffered by the mother (Child Protection 1, Child Protection 2).
Protection 3). Two police officers (Police 2, Police 4), the psychologists and the Psychiatrist included fabricated sexual assault in their interpretations of MBP, where the focus of the mother was to gain attention from professionals through her allegedly abused child.

Police 2: My understanding of it is very limited, what little understanding I have of it I probably gained from being at the Rape Squad. ...I suppose my involvement came a bit more heightened when I actually investigated a job, where ...well I’ll call her a victim, was suffering from MSBP. I recall reading a handout on it.

Police 3 indicated that none of the professionals involved with her case had any idea of what they were dealing with because ‘Munchausen’ hadn’t been heard of, they just knew that the child shouldn’t be in her mother’s care.

Three doctors, Child Protection 2, the Psychiatrist and Psychologist 1 described MBP as lying on a continuum with the fabrication of symptoms (and/or the exaggeration of existing symptoms) at one end and the induction of symptoms at the other. Doctor 1 and Psychologist 3 confined the criteria for MBP to situations involving direct physical action by a parent to make his/her child sick. They did not see verbal fabrications on their own as fitting under the MBP umbrella. Doctor 2 suggested there was not ‘a universally recognized set of criteria or an adequate gold standard’ for professionals to use to define MBP. She outlined some general principles which she applies to this abuse:
Doctor 2: I look at it as having four criteria:

- the first being that the person presented as the patient has either fictitious or induced harm
- there’s a person who gains from this and has some input into either causing the harm or creating the fictitious symptoms or signs
- the dynamics are that person one is dependent in some degree on person two, that there’s a power differential and
- that person two has the potential to harm person one. That there’s an element of harm in all of this.

Child Protection 2 thought that child protection workers would probably see many low level Munchausen cases. She stressed that MBP ‘should not be seen as something all by itself and different’ but rather viewed ‘on a spectrum of a range of child abuse’. Finally, three doctors (Doctor 1, Doctor 2, Doctor 3), the Psychiatrist and Child Protection 3 pointed out that doctors may contribute to this abuse by failing, despite existing warning signs being present, to consider it as a possibility. The Psychiatrist indicated that ‘sometimes the drive for ongoing medical investigations in FII/MBP cases comes from the medical side’ and is not ‘purely driven by the parents’.
4.4 Methods of Offending

This section examines the type of FII/MBP cases handled by Victorian professionals interviewed in this study\textsuperscript{172}. All cases described occurred in Victoria, Australia, over a twenty year period (1985-2005). In order of frequency, the type of abuse reported included: the giving of substances to a child to make him or her sick ($n=10$), fabricated sexual abuse ($n=7$), smothering ($n=4$), fabricated illnesses ($n=4$), and the withholding of food ($n=1$). The majority of professionals expressed a need for police to know about FII/MBP and how this abuse may be perpetrated.

4.4.1 The administration of inappropriate substances

The diagnosis of induced illness, or suspected induced illness, through poisoning was generally based on an accumulation of observations by professionals, information supplied by others, and occasionally an admission by the perpetrator. Often, it was unknown what the mother was giving to her child or how she was administering the offending substance. However, there would generally be sufficient circumstantial evidence to conclude that the mother was poisoning her child or that this position was highly probable. Child Protection 2 indicated that in the two year period in which she supervised a family, whilst it was never conclusively confirmed how and what the mother was doing to her children, the mother made statements to her that

\textsuperscript{172} The researcher could not be certain, owing to victims’ details being confidential, as to whether there had been any repetition of cases reported in this study. From the information supplied the researcher suggests that repetition was minimal, although thought that the Psychiatrist and Doctor 2 may have dealt with the same Leukaemia case. The joint interviews conducted with the Principal & Police 3 and Police 5 & Police 6 were taken into consideration. Appendix 22 provides a more detailed overview of the cases described within this study. Some professionals had involvement with multiple cases.
clearly indicated that she was responsible for making her children sick. Child Protection 2 outlined that two of the three children in this family had extensive medical histories and had undergone many invasive surgical procedures that had left permanent physical scarring on them. Doctor 4 described a case in which a child’s drip continually kept falling out and needed to be replaced every three to four hours, as opposed to the standard three to four days. He strongly suspected that the mother was removing her child’s feeding drip and was the cause of her child’s illness.

In two further cases, Doctor 3 and Child Protection 3 described children who were alleged to suffer from chronic gastrointestinal or bowel disorders who were being subjected to unnecessary medical examinations and/or surgery. The case described by Doctor 3 is covered in some detail in section 4.7. The case described by Child Protection 3 involved four children in the one family being subjected to medical testing in approximately eight different hospitals, with the eldest, a six year old boy, enduring fifteen operations. The worker outlined the latest position with this case was that the mother was insisting that the older boy needed a bowel operation and was searching for a doctor to perform the surgery. Child Protection 3 and the doctors believed the mother was administering substances to her children to induce their gastrointestinal and bowel problems. However, there was insufficient proof to substantiate such beliefs. Finally, in two cases in this study, reported by Doctor 3, positive findings were reported of offending substances; in one case, poison, and in a second, laxatives and salt.
4.4.2 Fabricated sexual abuse

Fabricated sexual assault, consistent with behavioural indicators of FII/MBP, was the second most common form of offending reported in this study. It was stressed that such cases could consume a considerable amount of professionals’ time and resources, involve multiple agencies, see a child subjected to multiple genital examinations\(^{173}\), and in some cases involve fabricated illness\(^{174}\). In the case described by Police 4 the mother fabricated false reports of sexual abuse with her two children over a three year period. These children were subjected to numerous medical examinations, two police video interviews, child protection interviews, and counselling sessions. Police 4 believed over the years the children slowly took on their mother’s skewed sense of reality. He was uncertain about the children’s awareness of the situation, but noted the older child actively supported his mother’s allegations. Police 4 described the mother as thriving on the attention which she received from police and other professionals (see section 4.5.2). Police 2 and Psychologist 1 also described cases of fabricated sexual abuse in which the mothers seemed to thrive on police involvement. The mother described by Police 2 went to extensive lengths to fabricate a rape on herself, an attempted burglary and abduction of her child. It was also alleged that the baby in this case had been ill as a result of immunization. However, Police 2 did not make the link to the possibility that the illness may have been

\(^{173}\) Doctor 2 highlighted a child who was subjected to fourteen genital examinations by fourteen different doctors.

\(^{174}\) Psychologist 2 described a case where the mother was fabricating a range of illnesses in addition to sexual assault. Police 2 described a case involving a mother who falsely reported an attempted abduction of a child and a rape on herself. The child also had allegedly been sick.
fabricated. The mother in this case was charged with false report to police in relation to the rape and attempted abduction\textsuperscript{175}.

4.4.3 Smothering

Four cases of smothering (or attempted smothering) were described within this study (Doctor 1, Doctor 2 x 2, Police 1). Police 1 detailed a case involving a mother who regularly took her child to the doctors (20-30 times a month) with breathing problems. Ambulance workers were frequently called to this family’s house to revive the child. The child had two older siblings who had a similar history of breathing problems, one of whom died allegedly from SIDS, and the other whose problems ceased with age. Professionals held a range of opinions as to the genuineness of these children’s breathing problems. Police 1 highly suspected the mother was abusing her children, but was unable to prove his suspicions.

Doctor 2 described one case in which a child, on two to three occasions, was admitted to the hospital emergency department with life threatening breathing difficulties that required resuscitation. On the last occasion, the treating doctor confronted the mother with the possibility that she was deliberately inducing breathing problems in her child. The mother strongly denied the allegation and the child was sent home with an apnoea mattress. The child later died whilst off the mattress\textsuperscript{176}. Doctors strongly suspected the mother was responsible for the child’s death. Doctor 2 also described another child

\textsuperscript{175} Due to timeline requirements having not been met with the brief of evidence, the matter did not proceed to court.

\textsuperscript{176} See Chapter 7.4.2 for further details surrounding this case.
who was subjected to ongoing life threatening smothering incidents. In this case, the mother admitted to the hospital registrar that she had been placing her hand over her child’s mouth and nose to stop her child’s breathing. No permanent harm came to this child\textsuperscript{177}. Finally, Doctor 1 described a case in which a child received acute brain injury as a result of deliberate asphyxiation by the mother.

4.4.4 Fabricated illness / withholding of food

A number of cases involving fabricated illness were reported in this study (Police 3/Principal, Doctor 2, Doctor 4, Psychiatrist, Child Protection 4, Psychologist 2, Psychologist 3). Police 3 and the Principal, in particular, vividly recalled a case involving a mother who feigned multiple illnesses in her ten year old daughter\textsuperscript{178}. The two older siblings also endured similar treatment (see section 4.7). In another case, Doctor 4 described blood appearing occasionally in an eight year old girl’s urine, with the mother reporting a range of unexplained illnesses. Whilst it was suspected that the mother may have been fabricating her child’s symptoms, this was never conclusively confirmed.

Two professionals (Doctor 2, Psychiatrist) reported cases of fabricated Leukaemia\textsuperscript{179}. Doctor 2 indicated the case came to the hospital’s attention

\textsuperscript{177} See Chapter 7.4.3 for further details.

\textsuperscript{178} The illness fabrications included asthma, ear infections, mental retardation, speech problems, kidney problems, heart problems, ulcers, vision problems, bone problems, depression, gland problems, a collapsed lung, and curvature of the spine.

\textsuperscript{179} The researcher suggests that the Psychiatrist and Doctor 2 may have dealt with the same case, but as the victim’s details were not released to the researcher, the researcher had no way of verifying this belief.
when a school principal phoned making inquiries about symptoms of Leukaemia. The Principal stated there were two children at the school who suffered from Leukaemia, but were presenting and behaving completely differently from each other. It was subsequently discovered that the hospital had never heard of one of the boys and an investigation was launched by the hospital and DHS. The mother on becoming aware that she was under suspicion began using hair removing tonic on her child to give the appearance of chemotherapy and made a sore on her child’s back to resemble a lumbar puncture, also going to the extent of using the same hospital smiley bandaids. The mother in this case eventually admitted to medical personnel that she had fabricated the Leukaemia. The Psychiatrist described a similar case (See Appendix 22). This mother also admitted fabricating her son’s illness. The Psychiatrist indicated that the husband had informed him that his wife had previously made up stories about her own life in order to gain attention for herself.

Finally, the Psychiatrist reported several cases involving children who were being starved of appropriate nutrition due to alleged food allergies. The Psychiatrist suggested these children may well have suffered from genuine allergies, but that the parents’ response was not in proportion to their child’s situation and was impacting on their child’s health.

### 4.5 The perpetrators

The child’s mother was the perpetrator in all FII/MBP cases described by professionals in this study (see Appendix 22). These mothers were
described as coming from varied backgrounds with diverse levels of intelligence, communication skills and financial status.

Professionals generally felt police responding to and investigating these cases required an awareness of how such women may present and behave, and of their capacity to deceive those around them. A number of themes emerged from professionals’ descriptions of these women. These included: deception, attention seeking, power and control, the presence of prior medical history and dysfunctional pasts (see below). Four professionals (Police 5, Doctor 2, Principal, Child Protection 2), however, also emphasized the need for professionals not to ‘pigeon hole’ the behaviour of these mothers based on existing descriptions provided within the literature, as there may be a perfectly rational explanation for the mother’s behaviour (Police 5). Police 5 further highlighted that this offending may also be overlooked if professionals adhered to particular descriptions and stressed the importance for police to be open minded if FII/MBP was suspected. Child Protection 2 indicated that ‘warning signs of Munchausen’s can also be warning signs for a heap of other things’ and thus professionals need to think very broadly when confronted with the possibility of such abuse. Finally, eight professionals interviewed, indicated that an awareness of characteristics and behaviour associated with FII/MBP had assisted them in identifying and managing this abuse.
4.5.1 Deception

Child Protection 2 indicated that ‘fundamental to understanding MBP is understanding the mother’s deception’. Professionals described some of these women as capable of practising extreme forms of deception. Elements linked to this deception, although not always apparent, included the mother’s appearance and behaviour, a reasonable level of intelligence, good verbal communication skills, medical knowledge, and a consistent ability to deny their offending. The following provides a snapshot of professionals’ recollections of these offenders (see also the quote by Police 1 at the start of this chapter).

**Police 4:** When you meet this mother, she’s quite an attractive woman, she’s really well dressed, she’s very well spoken and quite likeable. She’s a very dependant individual, but if you met her down the street you would think that she’s really intelligent and appears fairly confident.

**Police 3:** Mum was just a bundle of raw nerves – which you wondered if they were raw nerves or that was what she was putting out to get your sympathy. You know… like it’s all too much. She came running out of the house wearing a dressing gown and nightie. She seemed flustered and distressed. She took us into the house, hastily explaining that she had a very sick child to care for, hence the untidy house and her state of dress.

**Police 5:** She’s confident, she’s well spoken, educated, she’s actually a nurse. Yeah, comes across very confident.
Doctor 1: They vary in presentation. Certainly the most recent one involved a pretty working class lady, not all that bright a lady either. But I have had others certainly where they are very middle class, very controlled. A nurse, for instance, who was given access to her child, she came from a very eastern suburbs middle class family. Although when we dug into the family history there were things going on there, but certainly her presentation was very middle class. She was quite an intelligent woman. She had a nursing degree and was apparently very well thought of at the place that she worked. She was working part time, was a very pleasant woman, very engaging woman. All the nursing staff found it very hard to imagine that this was happening.

Child Protection 4: Mum was keeping proximity with her child. She would be sitting next to the bed. She didn’t like leaving the room. She would be monitoring whatever was happening with her child. She was the best mother in the world. […] In another case, the mother came from a low income disadvantaged background. This mother’s reasoning and behaviour was not as sophisticated as that of the first mother.

The majority of professionals described the women in their cases as possessing a reasonable knowledge of medical terms and procedures associated with their child’s illness (see below). A number were noted to have received medical training (Doctor 1 (2 cases), Psychiatrist (2 cases), Psychologist 1, Police 5)\textsuperscript{180}.

\textsuperscript{180} The mother’s employment was not specifically explored with professionals in this study. This information was volunteered by the interview participants.
Child Protection 4: She was very calm and empowered in terms of knowledge and was very focused. [...] She was really well kitted up with what had been happening for her child. Initially, I thought she must have been a nurse because of her medical terminology. She talked at length about her concerns and what she thought should be happening to her child. She was articulate; the terminology stuff was mind blowing.

Child Protection 1: Oh yeh. We got bamboozled that was part of the problem. She was using lots of terminology stuff that we didn’t understand and she was actually explaining to us the different procedures that the child had been through. She was sort of disputing the facts that we had, the things that we said to her about our understanding of what had happened. She would talk about all these different procedures and we’d get lost in that. She knew a hell of a lot more about it than we did.

Principal: She always talked to us as though she was very knowledgeable in medical matters, and that we really were, although she respected us, amateurs in the field, which we were.

4.5.2 Attention seeking

‘Attention seeking’ behaviour was commonly reported in association with the FII/MBP perpetrators described in this study. Professionals interviewed claimed these women appeared to flourish on the responses received from professionals through having a sick or an abused child. Approximately half of
the professionals described the attention seeking behaviour of the mother as extending to other realms other than the medical arena\textsuperscript{181}.

**Police 4:** Each step was important for the mother; she thrived on having new people come on board. I remember driving the mother and child to the city for a medical appointment one day, the mother was on an absolute high.

**Doctor 2:** The mother had a skewed way of looking at the world; very egocentric and viewing the world very much by ‘how it relates to me’ sort of an approach.

**Doctor 3:** Sometimes these mothers so desperately need the attention of care that hopefully a system will provide a parent with a sick child, that they’re prepared to sacrifice other important things in life to achieve it. […] in some cases I virtually ignored the patient and the symptoms and became interested in the mother and how her life was working out and that seemed to lead to the mother being less interested in offering symptoms and disease as a mechanism of getting attention.

**Doctor 4:** It’s not the action of doing it that they’re after, but the response. There is some sort of gratification or it’s fulfilling a need for them to see the response of the medical and nursing people once they’ve done something.

\textsuperscript{181} Professionals described these perpetrators as seeking attention from police, child protection workers, psychologists, the community, charity organisations, schools, the media and government personnel.
Child Protection 4: She was really enmeshed with her child. She appeared to be identifying herself through her child’s illness, and the illness was clearly made up, according to the doctors.

Principal: The focus was the mother. She would constantly be saying: ‘I was up all night; I was this, I was that; I had to take her to the doctors; I had to change her; I had to do this; I had to do that’. She was sort of the focus as she saw it. The child could have been a dog that she had with her. That was the impression I got over a period of time. She hardly ever referred to her child by name.

Psychologist 3: I imagine its stuff that they didn’t get as a child that they’re now trying to get as an adult, but in a very extreme way and even when they do get the attention, it doesn’t seem to be enough.

The persistent nature of these offenders was frequently highlighted within this study.

Police 5: One child had 180 odd medical visits in three years and one had close to 400 in four years and even the child that died at eleven months had had three hospital admissions and probably forty other medical attendances.

Police 4: There was almost two and a half years of basically constant police, medical, and DHS involvement. [...] This woman would come into the police station wanting us to investigate and we’d say, ‘No, we’ve already investigated. We’re not going to look at it any further’. We kept getting calls from the mother wanting us to come around, wanting us to
get involved. This was a constant thing. She’d say we need to get her assessed, we need her to have a medical. What if there have been problems? We need to get the information on video. All those sort of approaches. She’d try to come at us from every angle she could. When she didn’t get anywhere with us, she then would go to DHS and do the same thing. She periodically in between would go to a doctor a couple of times.

**Doctor 1:** The child was about 3 years of age and had been coming to the hospital for two years at least with a story of recurring diarrhoea and a failure to thrive and grow.

Child Protection 2, who monitored a family for approximately two years under a court order, said the mother on one occasion had been bitten by a dog. She indicated that the mother never fully recovered from the dog bite and pondered whether the mother had reverted to offending against herself to gain attention, instead of her children. Doctor 2 described one mother who spent many hours at Melbourne University law library researching her arguments for a High Court appeal.

Bizarre forms of behaviour by these perpetrators were described by some professionals (Police 2, Police 4, Psychiatrist, Doctor 4, Child Protection 1). For instance, Police 2 indicated the mother had reported theft of a maternity bra from her clothesline, gym flyers being placed under her door (which she found unusual), and receiving bizarre stalking letters. Doctor 4 described a

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182 The stalking letters outlined to the mother that she should not dress her baby in a certain hat and clothes because it made him look like a sissy.
mother who was collecting urine samples from her child at home and bringing them into the hospital. Doctor 3 reported one mother requesting to use the hospital computer to research MBP and the Psychiatrist described a mother who claimed to have had a stillbirth and to have buried the baby under the verandah. Finally, Police 4 reported one mother who claimed she knew her child had been sexually abused during the night because petrol was missing from her car.

In several instances, professionals described mothers obtaining financial and community benefits in association with their child’s illness (Doctor 1, Doctor 2, Doctor 4, Principal, Psychiatrist). The Principal described one mother who received an intellectual disability allowance for her child, despite the school never having been consulted or informed of this disability. Doctor 4 outlined a FII/MBP case where the primary focus of the investigation shifted from investigating the possibility of the child’s illness symptoms being fabricated to investigating financial embezzlement by the mother. Doctor 4 suggested it was easier for the police to prove embezzlement than the illness fabrications. The Psychiatrist believed that the obtaining of financial benefits in FII/MBP cases is primarily driven by the caring response received by the mother from those around her, rather than the money itself. Doctor 2 captured the type of response these families may receive:

**Doctor 2:** School staff then did their usual very helpful thing and organised all sorts of extra support and people took casseroles and took the child on outings. He met footballers and he had flights in helicopters
and had a wonderful time all organised by local support people and school staff.

Four professionals provided explanations for why mothers may have commenced this type of offending. These explanations appear to be linked to a need for attention and/or an inability to cope with parenting and/or life’s pressures.

**Police 4:** This probably did start with Mum wanting to get back at the ex-boyfriend, but because it went over such a long period of time those feelings of hatred for that ex-de facto diminished and this MBP thing just took over, and she just enjoyed the attention she got from everyone involved.

**Doctor 4:** The kid had a genuine skin condition. I think that’s where things started off. But all these other things came on top of it and it was obvious that whenever the skin condition was getting better, mum would get a little bit anxious because the child would get discharged, so she would escalate the problem. Then they would go home for some weeks, and nobody would see them for a while. Then they would appear back again.

**Child Protection 2:** In simple terms, it seemed to me that the family dynamics were beginning to form when the older child was born, but hadn’t reached a full blown ‘Munchausen’s’ status until the third child was born. So maybe the dynamics were forming with the first child and she was a victim of dynamics. Then with the birth of the second child, the
mother’s capacity diminished because there were two children and so the
processes that contributed to ‘Munchausens’ became more pronounced.
Then by the time the third child was born, she was the most severely
damaged by medical procedures, you had a full blown, if you like
‘Munchausens’. [...] look I suppose I was always struck by the magistrate
who determined the matter. He was full of compassion and said that it is
clear that the basic problem here is the mother cannot cope.

Child Protection 4: As we got talking to her we realised that we
recognised this woman. [...] it was clear to us after a period of time that
she was so stressed and needy that she would call us out as after hours
workers to talk to us about her child with all these made up symptoms.
Her needs far outweighed the child’s.

Finally, Police 6 described his view on FII/MBP cases involving child deaths.
He stated these deaths were a ‘little bit left of field’ compared to other child
deaths he had investigated. He indicated this offending was ‘a different
style’, had ‘a different motive behind it’ and involved a completely ‘different
set of circumstances’. Police 6 explained that in the majority of child deaths
he had dealt with (approx. 20 cases) the offender was male and was usually
the de facto of the natural mother, or the de facto in conjunction with the
mother. He indicated the reason for the deaths was generally due to the
behaviour of the child, a lack of tolerance for the child, or a transference of
abuse suffered by the offender from his own childhood. However, in FII/MBP
cases, he noted the offender was generally the child’s mother and that there
appeared to be a need for attention intertwined in the mother’s offending.
4.5.3 Power and control

The majority of professionals interviewed described controlling behaviour in association with the mothers they had dealt with who were fabricating and/or inducing illness in their child. Such behaviour included dominance, deceit, denial, persistence, evasiveness, anger and/or escalation of the offending.

Psychologist 3 and Child Protection 4 stated the mothers in their cases used their children like pawns to glean attention from professionals. The children were described as objects through which their mothers met their own needs. The Principal described one mother as prepping her child by telling her what the symptoms were of her illness. He stated ‘some of the things [X] seemed to know were way beyond her capacity to in any way comprehend what was happening’. The Principal and Police 4 both described the mothers as dominating their child’s conversation. The Principal also indicated the mother forbade her child to participate in sporting activities and only permitted her to play with certain kids in certain areas of the playground.

The mothers were also reported to dominate their spouses (see section 4.6) and manipulate professionals (Police 1, Police 3, Police 4, Doctor 2, Doctor 3, Psychiatrist, Psychologist 3, Child Protection 1, Child Protection 2, Child Protection 3, Child Protection 4). Police 3 stated the mother was ‘adept at manipulating the system to her advantage and had out manoeuvred most people who attempted to help her and her children’. The Principal, who dealt with this same case, indicated the mother would actively seek out medical practitioners who agreed with her diagnosis, and had manipulated one doctor
into signing medical certificates without sighting the child. Doctor shopping
was evident in several of the cases described within this study (Child
Protection 2, Child Protection 3, Child Protection 4, Doctor 1, Doctor 2,
Doctor 3, Psychologist 2, Police 5).

Doctor 3 suggested that ‘the parent gets some enjoyment out of misleading
and fooling people and showing that they are cleverer than the people they
are seeking assistance from’. Doctor 3 and Child Protection 1 described
cases where child protection staff had been manipulated by these women.
Doctor 3 indicated that with two cases in which he had involvement, the
mothers manipulated the return of their children from child protection, despite
magistrates ruling differently. In one of the cases, at the mothers’ request,
DHS excluded the original treating doctors from seeing the children (see
Chapter 6.4 for an overview of one of the cases). Finally, Child Protection 1
vividly described how she was manipulated and deceived by a mother into
believing that she genuinely had a very sick child (see Chapter 7.4.3). She
suggested that child protection professionals may find these women more
challenging than other offenders, as they may be bright, intelligent, middle
class people able to argue effectively and convince others of their cause.

Some of the professionals described the mothers in their cases as
sometimes displaying evasive behaviour (Principal, Police 2, Police 3, Child
Protection 1, Child Protection 3, Child Protection 4, Doctor 1, Doctor, 2,
Psychiatrist, Psychologist 1, Psychologist 2). Such behaviour ranged from
the changing of doctors and welfare groups, to attempts to change the child’s
school, to an abrupt disappearance of the family from court proceedings.
Child Protection 4, the Principal, Psychologist 1, and Psychologist 2 also described the mothers as reluctant to become involved in conversations about their own personal history or marital relationships, and really only happy to talk about their child and their child’s illness.

**Child Protection 4:** She was really difficult to engage about other things except her child’s illness. She was really really guarded about any of her historical stuff and her marital relationship.

**Psychologist 2:** She was pretty guarded and she didn’t always tell me the truth. At one stage we built up a relationship but she was the sort of person who would withdraw again. I still didn’t feel that she was very open with me, but she started to share some concerns and thoughts and that was good, but it was very hard work.

**Psychologist 1:** Often her conversation would...go round and round and you would try and get detail and you wouldn’t get it. The only thing you could get detail about was specific incidents of sexual abuse. She had that absolutely word perfect almost. [...] She was very evasive. We tried to get specific developmental history about the kids from the parents and the family history and broader issues. We had a great deal of difficulty getting that. In fact we hardly got anything at all. She would go off on all sorts of things that were more important to her than what we were trying to achieve with our assessment.

Several professionals (Doctor 1, Doctor 2, Doctor 3, Police 5) stated these families may frequently move address to avoid detection. Police 5 noted the
family had lived in nine different police CIU jurisdictions. Doctor 1 highlighted one case where a child was reporting to him on a regular basis for medical check ups, as pursuant to a court order, when the father ‘piteously got a new job interstate, resulting in the child’s non-attendance at the clinic’. Child protection staff took the matter back to court, but the court failed to take any action and the family was simply lost. Finally, Doctor 3 noted one case where a mother had fled through three different countries to avoid investigation\textsuperscript{183}.

4.5.4 Medical histories and dysfunctional pasts

Professionals interviewed in this study overwhelmingly reported significant medical histories, dysfunctional pasts, or issues with siblings or parents in association with the mothers whom they had dealt with, who had fabricated or induced illness in their children or were highly suspected of committing such abuse\textsuperscript{184}.

\textbf{Police 3:} Referring to a psychiatrist’s notes, the mother had a seven year history of attendances as an outpatient, in which for months at a time she had daily contact with the centre by phone. Her diagnosis was neurotic depression and she was described as having a highly dependant personality. The mother took frequent small overdoses.

\textsuperscript{183} Refer also to Chapter 7.4 ‘Confrontation of the FII/MBP perpetrator’.
\textsuperscript{184} Participants described significant medical histories (9); separation from a husband/partner (9); the use of drugs (5); personality and emotional problems (4); isolation and loneliness (3); eating problems (3); reoccurring unexplained illnesses in childhood or adolescents (3); domestic violence (2); depression (2); multiple losses of loved ones (2); problems with alcohol (2); disruptions in attachment with parents or adopted parents (2); estrangement from the grandparents (2); Munchausen Syndrome (2); a sibling death in the family growing up (1); sexual abuse (1); self injury (1); and physical abuse (1).
Police 2: The stepfather indicated that her own father has nothing to do with her. [...] She’s got three sisters all of whom are professional people, dentist, physio, midwife. The stepfather mentioned he felt she believed she was a lesser person because all of her siblings were professional people, quite well off, married, happy relationships, etc.

Police 5: Coincidently, the mother also had the same medical problems herself as a child, and had some frequent hospital attendances for apnea from when she was about 15-16 years of age.

Doctor 1: The mother herself had had an illness in adolescence that was never satisfactorily explained. I gained access to files 15-20 years old and there was never any explanation for her reoccurring illness. She was away from school for about 2 years in her adolescence. Her mother had said that the daughter had always been a sickly and very lonely child and very different compared with her other children.

Doctor 2: Single mum, very precarious social situation, very little in the way of support, domestic violence, alcoholism, a real risky situation to start with.

Doctor 3: The mother had a history of self injury. Some of it was not recognised and none of it was revealed to us. In obtaining the mother’s medical history we realised that in retrospect there were many unexplained events linked to the mother’s medical history that were clearly self-induced illness, which weren’t recognised by people looking after her at the time. Things like wounds being very slow to heal and so on.
**Psychiatrist:** She had significant trauma as a young child herself. There had been major disruptions in her attachments as an infant and young child, she had been adopted and there had been problems – her adoptive father died, she had multiple losses. A possible hypothesis was that illnesses of the children were a way that she had of trying to repair the disruption in attachment which she’d had with her carers as a child. The medical system was a psychological substitute for the parents she’d lost.

**Child Protection 1:** She talked about her own medical history, about being in and out of hospital for bizarre medical problems, as well, as a child.

**Child Protection 2:** She had a prescribed medication addiction; question mark - illicit substances abuse problem and a very, very complex history of her own illness. Ultimately, I think the mother became a ‘Munchausen Syndrome’ rather than ‘by proxy’.

**Child Protection 4:** They weren’t short of money. They weren’t struggling. They weren’t disadvantaged. It was obvious that the relationship between mum and dad was strained. She was isolated from her family. She operated very much in a solo capacity and was really enmeshed with her child.

In a second case, Child Protection 4 described the mother as in her late thirties and as having ‘an incredibly significant history with DHS around sexual abuse and family violence’. She indicated she was ‘constantly
transient, had half a dozen kids to different fathers, and had a really disadvantaged history’. The mother was described as being ‘isolated, in poverty, and with no networks’. Child Protection 4 contrasted this with the first woman’s situation who was middle class, articulate, and certainly not poor in any way’. However, Child Protection 4 noted that both women ‘didn’t necessarily have any networks’.

4.5.5 An awareness of their actions and a question of intent

The issue of how aware these offenders are of their actions and their level of intent was not fully explored in this study. However, several participants shared their views of such issues\textsuperscript{185}. Three professionals considered such perpetrators to be aware of their actions.

\textbf{Child Protection 2:} Yes, I believe she knew what she was doing. First of all, I discussed it many times with the mother and she would overtly say, ‘I didn’t know what I did or what I was doing’, but there’d be other times when, in a different context, she’d make statements that clearly indicated that she did know. In the cases I’ve been involved with, there is cessation of the abuse at the point of confrontation. So, if they didn’t know what they were doing, why would it stop because somebody finds out?

\textbf{Doctor 2:} I know some people think there’s this transient psychosis, but most MBP is long term, carefully planned, considering all the options sort of an approach and I do think they know what they’re doing.

\textsuperscript{185} This issue was not explored with Doctor 1, the Psychiatrist, Psychologist 1 and Psychologist 2.
**Doctor 3:** They know what they are doing, and what they’re doing is bad and dangerous.

In contrast, Child Protection 1, Child Protection 3, Doctor 4 and Psychologist 3 felt these women may not be fully conscious of the reality of their offending and believed that they did not deliberately intend to harm their children.

**Child Protection 1:** The mother didn’t believe there were any concerns. I don’t believe she knew she was lying.

**Psychologist 3:** I don’t think it is simple. I think they know what they are doing, as in know yes I am injecting something into my child, but I imagine in their heads there’s such strong convictions about what they’re doing. I think they have a whole lot of unmet needs, emotional needs, and I don’t think it’s a conscious thing. Like I think they’re doing these things, but they’re so… they’re not very aware people.

**Doctor 4:** I’m not convinced that these women are doing it with any particular criminal intent or whatever. I do I think they know what they are doing, that’s why they’re doing it. They know the response of what will happen when they do it. They’re not so much looking for, it’s not the action of doing it that they’re after, they’re after the response, they enjoy the response.

Doctor 4 and Police 4 both thought that killing the child would be counterproductive to the mother’s cause. Doctor 4 suggested that MBP was
'a symbiotic relationship' and that the mother needed ‘the child alive to get the attention’. He indicated that,

Doctor 4: [...] otherwise you get a funeral and you don't get anything after that. No doctor is going to be interested in you after the funeral and similarly making a child really sick and ending up in intensive care is probably not what they want to do either; they want to tread a middle course.

Two police officers indicated that whilst they believed the mothers were fully aware of what they were doing, they had encountered controversy from the medical profession around this issue. In one case a doctor considered the mother to be delusional and in the second case there were conflicting medical opinions on this issue. The police officers indicated that due to the doctor’s opinions no charges were laid against the mothers.

The majority of professionals interviewed considered these women to be sane and not to be suffering from any mental disorders, although a number suggested they may have significant issues in their lives and/or suffer from a personality disorder (see section 4.5.4). In contrast, Psychologist 3 believed these women did suffer from a mental illness, but thought that it was not easily treatable. Doctor 4 was uncertain about the mental state of these women, but thought it likely that there would be ‘a variety of conditions’ present that would lead someone to abuse their child in this manner.
4.6 The offender’s spouse

The majority of mothers described within this research were married (15\textsuperscript{186}), followed by separated (9), not known (4) and de facto (1). Whilst professionals were unable to recall a large amount of detail about the spouses/husbands, some general descriptions were provided. Firstly, many described the spouse as appearing to be the less dominant partner in the marriage or relationship (Police 2, Police 3, Police 4, Police 5, Psychiatrist, Child Protection 1, Child Protection 2, Doctor 2, Doctor 3). Police 5 suggested that in his case such dominance may be due merely to a language barrier and that dad may be more dominant when mixing with people of his own cultural background.

Secondly, a number of professionals commented that the spouse\textsuperscript{187} appeared to be distant and to have little to do with the parenting of his child (Child Protection 2, Child Protection 3, Child Protection 4, Police 2, Police 3, Police 4, Psychiatrist, Psychologist 3, Doctor 1). Finally, the majority of professionals described the spouse as oblivious to his wife’s offending, bewildered by the news of his wife causing harm to their child and as having difficulty in accepting and comprehending this information. Doctor 3 believed that the spouse whilst able to possibly accept intellectually that his wife is harming their child, would have difficulty emotionally accepting this concept.

\textsuperscript{186} One of the mothers separated from her husband years later. Another mother separated from her first husband and remarried.

\textsuperscript{187} In most cases this was also the father of the child.
Police 3: What I remember about Dad is that he just sat quietly in his vegie garden poking; he was just like a phantom. I remember feeling really sorry for him because he had this haunted look in his eyes, like ‘I don’t know what I’ve got myself into here’.

Doctor 2: Dad was a fairly emotionally estranged sort of chap, who just appeared bewildered and lost and, according to him, ‘he had not at any stage twigged that it wasn’t real’. Doctor 2 stated dad gave the impression that ‘he was really in the dark.’

Child Protection 1: I’ll always remember dad. Dad was just again the classic stuff that you read about with MBP, just so completely oblivious to what was going on, so supportive of mum. Really lovely guy. ‘Really, I don’t understand why all this is happening. My daughter’s been really sick and my wife’s been doing everything she possibly can’. He just couldn’t understand what was going on.

Four professionals interviewed in this study portrayed the spouse as being supportive and defensive of their wife, yet, also passive towards professionals (Child Protection 1, Child Protection 3, Police 3, Police 4). Two professionals described the spouse as being strongly defensive of their wife (Police 6, Doctor 3). Child Protection 2 considered that generally non-offending parents in FII/MBP cases are defensive and supportive of their wife, but noted one father who was neither angry nor supportive. Owing to the vivid description provided by Child Protection 2 and limited research on spouses within the literature, Child Protection 2’s recollection is presented in some detail.
**Child Protection 2:** I found dad a great source of concern, in his weakness, in his lack of perception of the depth of anguish that was confronting his wife and a lack of perception of the seriousness of the risk to which his daughters were confronted. He cooperated in that he was always available for visits, but mind you I tended to make my visits at times that would suit him. I suppose the best way to explain it is that he was sort of an absent father and wasn’t a particularly supportive fellow. He couldn’t understand his wife’s need for a high level of support. […] He insisted that he had a very busy and demanding job. My view was that it was more busy and more demanding than it actually needed to be. It was no flash job or anything, but you know he was a little man and his job was a way of making himself appear important. I think he struggled enormously with his role as family provider because she’d never worked and it was quite a traditional household. I think he struggled to realize that when you have a wife and family you put certain constraints on what you can do and so one of his big frustrations was that he could only play basketball once a week instead of four times a week. That kind of thing. I think he managed to somehow just deflect just how serious everything was. He was a very pleasant, happy go lucky sort of a guy who never really took any responsibility for having a role in the abuse. And, I suppose, when I thought about it, and really looked at the evidence that was presented to me, I’d have expected a reasonable person to have known something was wrong, well in advance of it coming to light. There was enough worrying indicators there to make you question, ‘Well, is this all it’s meant to be?’ And he certainly never asked those questions. He was not a particularly reflective sort of man and I suppose I was always struck by his lack of anger towards his wife. The other non-offending parents that I’ve worked with in these sorts of cases tend to become
extraordinarily supportive and defensive of the perpetrator. This guy was interesting; he was neither angry nor supportive.

The Psychiatrist described the fathers with whom he had dealt in FII/MBP cases as ranging from ‘strongly supportive of their wife, to being fairly passive about it all, to being angrily condemning of her’. He felt the majority of these men fitted into the last two categories. The Psychiatrist described a husband whose wife had fabricated Leukaemia in their son. He indicated that one might think that the father might be furious and sever the relationship with his wife, but instead, the father’s initial response was, ‘Why did you do it?’ and ‘Oh, well, let’s get on with things’ in a ‘sort of passively forgiving manner’. Child Protection 3 stated the father in her case thought the mother was ‘just jinxed’ and that it was ‘just hard luck, really’. The father in the case of Police 5 was described as deeply religious with an attitude ‘that it was the will of God that all his children had died’.

Two doctors felt the fathers may have their suspicions about their wives, but believed that they would rarely voice such beliefs (Doctor 1, Doctor 3).

Doctor 1: Many of these men do have at the back of their mind a suspicion that something is going on. Obviously they find that so appalling that they just push that thought further back.

Doctor 3: …he (Dad) looked at me straight in the eye and said, ‘You know it’s strange, Doc, it’s only ever happened when my wife’s with the baby, never ever happened any other time’. I think he was implying, although he never said it in words, and never has said it in words, that he
had his suspicions. If it’s difficult for a professional to accept somebody might be so harmful of their own children, it’s almost unacceptable for a close family member to accept that.

Child Protection 1 and Child Protection 2 thought the fathers in their cases would struggle to adequately protect their child because of an inability to accept the possibility of their wife harming their child.

4.7 The child victims

The majority of victims described within this study were either babies or young children up to about ten years of age\textsuperscript{188}. Some children were reported to have been abused for several years (Police 1, Police 3, Police 4, Police 5, Child Protection 2, Child Protection 3, Doctor 1, Doctor 3, Doctor 4, Psychiatrist, Psychologist 2). A number of professionals believed the child will have some consciousness of what their mother has been doing (Child Protection 2, Police 3, Psychiatrist, Police 4, Psychologist 1). The Psychiatrist indicated that ‘often children will become aware at some point of their mother’s behaviour, but because of the emotionally and physically dependent relationship with their mother will go against it’. Police 3 suggested the child in her case had some awareness that her mother was not always right regarding her illness but was not able to fully grasp this position as her world revolved around being sick. In contrast, other professionals suggested child victims of FII/MBP are generally too young to

\textsuperscript{188} Twelve of the victims were under two years, ten were aged between three and six years, and five were aged between seven and ten years of age. Eleven children’s ages were not provided; however, they were described as being young children.
be aware of their mother’s behaviour (Police 1, Police 4, Child Protection 1,
Child Protection 2, Child Protection 3, Child Protection 4, Psychiatrist, Doctor
1, Doctor 2, Doctor 3, Doctor 4, Psychologist 2, Psychologist 3).

Approximately half of the child victims described in this study also had
siblings suspected of being abused\textsuperscript{189}. However, some professionals could
not recall whether the siblings had been harmed (Psychiatrist, Doctor 2,
Doctor 3), or in fact, whether there were any siblings (Doctor 1, Doctor 2,
Psychiatrist, Doctor 4). Others noted the siblings appeared to be perfectly
healthy (Child Protection 1, Doctor 1, Doctor 2, Doctor 3). Where siblings
were suspected of having been abused, the offending occurred either serially
from one child to the next (Police 1, Police 3, Police 5, Child Protection 2,
Doctor 1, Doctor 3, Doctor 4) or simultaneously on all children within the
family (Police 4, Child Protection 3, Psychiatrist x 2, Psychologist 1, Doctor
3). In some cases the victim was an only child (Psychiatrist, Psychologist 2 x
2, Child Protection 1, Child Protection 4, Doctor 1, Doctor 2 x 3, Doctor 4).

There was limited detailed information surrounding professionals’ interactions
with victims of this abuse\textsuperscript{190}. However, three professionals (Principal, Police
3, Doctor 3) provided significant information in relation to two children\textsuperscript{191}. The
Principal and Police 3 recalled their dealings with a child victim of extensive
fabricated illnesses by her mother. The Principal described this child as
having been ‘mentally raped’. He indicated that the child was ‘mentally

\textsuperscript{189} Refer to Appendix 19.
\textsuperscript{190} This appeared to be due to the young age of the victims and in other cases professionals
having no direct interaction with the child in relation to his or her mother’s suspected abuse.
\textsuperscript{191} The Principal and Police 3 dealt with the same case.
numbed and retarded in personal growth by a sick mother who insisted on her child being in a constant state of illness and crisis’. The Principal described the mother as constantly telling the child about what illnesses she did and did not have. He indicated that the child was ‘never allowed to be herself’ and was always ‘somebody else’s plaything’.

**Principal:** You could hardly ever get a conversation with [child]. She was almost infantile in her behaviour, as soon as you saw her you saw her as somebody who was alone in her mind. In other words, she was not spontaneous and would not initiate a conversation. She was almost like a rabbit if you caught a rabbit in a spotlight. Not so startled, but almost fixed in her patterns of movements. Physically she was almost limp; if you picked up her arm, it would almost flop back down again. Sounds awful, but that’s the way she was. She looked a little bit malnourished and she would sleep readily. We talked to the mother about that. She would say that because she was so ill all the time, with all these mystery diseases, she was up all night and didn’t get much sleep.

The above child was eventually removed from her parents and placed into foster care. Police 3 followed up with the foster mother.

**Police 3:** We spoke to the foster care mother one day and she said, ‘It’s amazing [the child] will scratch her finger and race inside and say, “Quick! Emergency! I must be rushed to Melbourne, I’ve got blood poisoning and this and that and the other is going to happen to me”, and I would get out a bandaid and kiss it better and she would run out and happily play’. The foster care mother was just amazed at the number of times [the
child] rushed to her in a state of agitation. If she sneezed she was going to get pneumonia and the foster care mother had better put her on all this medication and take her to x, y and z specialists. Over time the foster care mother said [the child] was no longer rushing to her and was gradually settling down into a normal childhood behaviour pattern.

In another case, Doctor 3 described meeting an adult whom he had treated as a child years earlier for ‘apparent chronic gastro-intestinal disorders which had led to extensive investigations, long periods of intravenous feeding, some reversible surgery and some pretty dangerous complications of treatment’. Doctor 3 indicated that he had taken the matter to court where a magistrate had made a finding to remove the child from his parents’ care. However, within a very short period child protection personnel had returned him to his parents. Doctor 3 indicated that now, as an adult, this man was retracing his medical records and querying why no one had protected him as a child. The man has permanent physical scars from the many unnecessary medical procedures conducted on him and experienced ‘a very troubled teenage period with disruptive family issues and some problems with drug taking’. The man believed his mother had ‘surreptitiously administered stuff to him well into his late teens’ and indicated that even today he would still not eat his mother’s cooking. He indicated his parents had since separated and that he had confronted his father who eventually agreed that the abuse had in fact happened. Doctor 3 noted this man appeared to be slowly recovering from his mother’s years of abuse and was endeavouring to get on with his life.
Apart from the two cases described, Psychologist 3, Police 4 and the Psychiatrist also made the following comments in relation to victims of fabricated and/or induced illness and the effects of this abuse on children.

**Police 4:** The big fear I have with this case is that this kid now clearly believes that she has been abused, because mum’s educated her so much. In the first interview the child didn’t disclose anything, but then after two years, she came back and the disclosures were horrific and I believe in that time the mother’s actually educated the child. I remember walking away at the end, feeling good about the younger child, because she was just too young to be really affected by it all, whereas the older child will carry it for the rest of her life.

**Psychologist 3:** You see these children come through who are quite well adjusted early on and then you see them a few years later and they’ve taken on the kind of influence of their mother and they’re developing the same kind of characteristics. They’ve sort of become part of her reality, they can’t separate it out. I mean, if you’re just living with one person whose reality is skewed all the time, then you’re going to end up like that yourself, because you haven’t got any other perspective.

The Psychiatrist described a case involving two children with major gastrointestinal symptoms who failed to thrive. These children had prolonged periods in hospital and underwent numerous operations. One child had a tube placed into one of the big veins near the heart which the Psychiatrist stated was ‘quite invasive and potentially dangerous’.
**Psychiatrist:** The younger of the two, who would have been about 4-5 years of age, was referred to our department because she seemed psychotic, which was very unusual at that age. She had very bizarre ideas and behaviour and talk. In the end it was because she knew what the mother was doing, but she felt she couldn’t do anything about it. She was trapped. The mother had been giving the children medication to induce severe diarrhoea.

### 4.8 Professionals’ feelings and emotions

The majority of professionals found FII/MBP cases to be complex and physically and emotionally draining. They described feelings of anger, distress, loneliness and frustration. However, some also found these cases to be fascinating and professionally challenging. Whilst professionals did not necessarily suggest police needed to be educated about the personal impact of FII/MBP, the researcher considered due to the experiences described by professionals interviewed, that this was an important subject area for analysis and for consideration of inclusion in police FII/MBP training. Some of the professionals’ descriptions are presented below.

**Police 4:** I was angry and annoyed that the mother just kept continually at us and just used her child as a means to get to us.

**Police 5:** Frustration with the bureaucracy, but not frustration with the people you deal with. Unfortunately the ants on the ground that are doing all the work all have the same bureaucracy at various levels. [...] the current case is obviously draining. [...] these cases don’t unfold as easily
as the run of the mill homicide because there are no overt confessions in relation to ‘I beat a child to death of one year of age’. You’ve got to use a lot of other resources, a lot of other techniques to get the evidence that you require and so they are very frustrating.

**Doctor 1**: They take an enormous amount of time and emotional effort. By the end you’re pretty wrung out. […] Most doctors don’t like to be deceived and most doctors get very angry with MBP.

**Doctor 3**: I think most of my colleagues who are now reasonably aware of this abuse tend to shy away from it. They don’t want to get involved and don’t want to investigate. It really is a horrendous position to be in. I shudder when I come across it. I can’t ignore it and I can’t pass it on to somebody else and I know what a hassle it’s going to involve and how much personal distress is going to go on. […] It’s always there too, the present risk that you are going to be pilloried in the media.

**Psychologist 3**: People get very angry at being deceived. You spend so much time treating people and fixing up kids who have really serious medical conditions, that when you come across a situation where it’s been inflicted deliberately or intentionally, you get very angry and sometimes its very difficult to respond in a I guess a more objective way. […] There’s also a certain amount of fascination with these cases.

**Child Protection 1**: The Director of Medicine was explaining what the issues were and was talking about the medical history and I remember feeling quite overwhelmed in terms of trying to understand the
complexities. All the experts in the hospital were involved and there were lots and lots of tests discussed. They're incredibly complicated cases.

**Child Protection 2:** I find them particularly fascinating, particularly stimulating, but I suppose I don’t see enough of them to get as comfortable as I might with other forms of abuse. […] Because it was such new ground I've never forgotten it, but would say the learning out of that case has really influenced all the others that I’ve handled. I think what its done for me as a practitioner is made me very wary when any problem is medicalised, so I would take it on board and think about it and have a look; well, what is going on here? Is this legitimately a sick child or is there something else operating? […] They’re fairly lonely cases. It’s very, very difficult to predict what the risks are going to be in the future and it takes a lot longer than usual to get an understanding of the triggers and parental functioning and all of those sorts of things. […] That’s my first case and I never wish to repeat it.

**Child Protection 3:** You often end up handling these cases quite in isolation.

**Child Protection 4:** I think they’re incredibly fascinating cases and I know for me my ears would prick up if a case had any hint that it was Munchausens, because it might be more interesting, more challenging and take in a new dimension, like ‘What makes a mother do this sort of stuff? I think that workers, competent enough intellectually to be able to consider it, would really enjoy taking their investigation process to the next level.
4.9 Conclusion

This chapter presents a rich and powerful insight into Victorian professionals’ experiences in dealing with FII/MBP cases and provides a wealth of information for examining the background knowledge requirements for police in dealing with FII/MBP cases. It captures four key sub-themes for analysis in Chapter 8, namely: terminology and definitions; methods of offending; perpetrators, spouses and victims and the personal impact of FII/MBP cases on professionals.

The next chapter explores the police role with FII/MBP cases, the need for suitably qualified police to be assigned to FII/MBP matters and the level of awareness and knowledge police have about FII/MBP.
Chapter 5

The Police Role and Police Knowledge of FII/MBP

‘69% of 760 Victoria Police officers surveyed had heard of MBP’

Questionnaire findings

5.1 Introduction

Chapter 5 is divided into two parts. The first part presents qualitative findings pertaining to the police role in FII/MBP cases and cases involving the sudden unexpected death of an infant. Additionally, it examines the laying of police charges and the need for suitably qualified personnel to be assigned to FI/MBP cases. Some links are made to the quantitative findings, with the primary analysis presented in Chapter 8.

The second part presents primarily quantitative findings and focuses on the level of police awareness of FII/MBP and police knowledge of this abuse. An analysis of the findings is presented within this section and is further drawn upon in Chapter 8.

In order to develop police FII/MBP training one must first understand the role police play in FII/MBP cases, what knowledge police currently possess about FII/MBP and the investigation and management of FII/MBP cases and what gaps exist in members’ knowledge.
PART 1: THE POLICE ROLE in FII/MBP CASES

5.2 The police role in FII/MBP cases

5.2.1 The police perspective

Police members interviewed unanimously agreed that police have a role to play in FII/MBP cases. However, they disagreed on the timing of that involvement and whether police should play a preventative role. Members interviewed generally considered the police role in FII/MBP cases to be to establish whether a crime had been committed and to collect the evidence needed to take the matter before the courts.

Three of the four detectives interviewed (Police 2, Police 5, Police 6) thought that police should only become involved in FII/MBP cases upon the establishment of a crime, or once there was some clear evidence to suggest criminal activity, although they were happy for SOCAU members to be notified simultaneously with DHS. However, Police 5 and Police 6 also suggested the police role in FII/MBP cases was to determine whether or not a crime had been committed but considered police involvement was very much dependent upon the medical findings. Police 5 and Police 6 felt that realistically police did not have the time or resources to investigate cases where there was no evidence of a crime and that police involvement in such cases may cause unnecessary stress to the parents.

**Police 5:** From a parent’s point of view, I would be horrified if I was genuinely taking my child to a doctor for illnesses to find that because
medical staff somewhere had a concern about this, that police had become involved. I mean it would be bad enough if DHS became involved, but as a parent I could kind of understand that more, than suddenly being a subject of a police investigation.

In contrast to Police 5 and Police 6, the two SOCAU members (Police 3, Police 4) interviewed believed police should be notified early about the possibility of FII/MBP once a doctor had formed a reasonable belief that such abuse existed. They considered police should be notified regardless of whether doctors had concrete proof to support their suspicions and that police should work proactively with medical professionals and child protection workers to determine whether abuse had been committed. Police 1 thought police should play a proactive role, but suggested most police would be reluctant to get involved in these cases unless there was concrete evidence to support the presence of abuse.

**Police 1:** These cases are very frustrating as it is difficult to be certain that the mother is offending on her child even though you are fairly sure that this is what is occurring. Police may not want to get involved with these cases if there is no clear cut evidence of an offence and you may get a lot of disagreement by professionals as to whether such abuse exists. These cases are very difficult for police.

The SOCAU members (Police 3, Police 4) also identified that whilst their job was partly to establish whether a crime had been committed, it predominantly became a preventative role. The SOCAU members found themselves working closely with DHS to stop the mother from offending on her child and
from using professionals to meet her own needs. The two homicide detectives, on the other hand, emphasised that the preventative role was not an investigator’s responsibility.

Police 5: The preventative role is not really our role, certainly not as investigators. I mean, I’m very concerned about the living child and that’s why I notified DHS, but that was all I was prepared to do. I’m not prepared to go out with the workload that I’ve got here and do a protection application for the child, which is effectively the investigation I would have been doing. That’s not my role. I just don’t have the time to do that. I would have to ignore five other bodies and the relatives associated with those victims.

Police 1 considered that police could play a preventative role in FII/MBP cases, but thought that police were ‘not adequately trained in this field’\(^{192}\).

Finally, the police members interviewed generally regarded non-fatal FII/MBP cases to be the responsibility of a SOCAU in consultation with the relevant CIU, and for fatal cases to be investigated by either a CIU or the Homicide Squad. An examination of police involvement in this research revealed that where police were involved, they were attached to the following areas: SOCAU\(^{193}\), CIU, the Coroner’s Office, or the Homicide Squad. The police members interviewed identified a range of notification sources concerning

\(^{192}\) The issue was not explored with Police 2.

\(^{193}\) This unit also used to be referred to as the Community Policing Squad. The name changed to better reflect the duties of the squad (See Appendix 5 for more information about this squad).
FII/MBP cases. These included an ambulance officer, a school principal, a psychologist, the coroner’s office and a victim.

The quantitative findings from this research showed that 65% of members surveyed agreed that police should become involved with cases of induced illness, with 27% of these members strongly supporting this position. However, perhaps of some concern, was the fact that 23% of police were uncertain about police involvement and 12% thought that police should not become involved with such cases. Viewing this question by police work area, 69% of recruits, 59% of uniform members, 64% of detectives and 77% of SOCAU members believed that police should become involved with cases of induced illness in children. It seems probable that SOCAU members, most likely because of their role with child abuse and training in this field, possess a higher appreciation of FII/MBP as a potential form of criminal behaviour than recruits, uniform members and detectives.

5.2.2 Other professionals’ perspectives on the police role

The majority of professionals interviewed in this research, other than police, supported police involvement in FII/MBP cases, although Psychologist 1 and Psychologist 2 feared police may hamper the therapy process with the mother and subpoena their files for court purposes. Psychologist 2, Doctor 2, and the Psychiatrist felt it would be useful to talk to police in relation to evidentiary issues without fearing a full scale formal police investigation. The Psychiatrist suggested this also applied to DHS.
The professionals generally viewed the police role in FII/MBP cases as to identify whether a crime had occurred and to investigate the criminal aspects. It was also suggested police needed to work closely with other agencies to prevent and stop this offending, to provide evidentiary advice and where warranted, to take the matter before the courts. Over half of the professionals interviewed indicated they had minimal or no police involvement in their case.

Child Protection 1, Child Protection 3 and Child Protection 4 emphasized a need for early police involvement in managing FII/MBP cases. Child Protection 1 considered that FII/MBP cases required a shift in thinking by police and other professionals. She highlighted that evidence of a crime may not always be apparent with FII/MBP cases, but that child victims of this abuse depended on professionals to take active steps to investigate the possibility when suspicions of abuse were raised. Child Protection 2 and Child Protection 3 suggested police needed to be more proactive in working with other agencies.

**Child Protection 1:** I’d like to think police are involved from the beginning. I know that’s difficult, but I would like to think when you have the initial case conference, where you are all talking about it, where decisions are being made, the police are involved at that stage. I think it would make it easier to identify the offence stuff and what needs to happen in terms of the legal stuff, at the same time as us being able to identify the protective stuff and then jointly coming up with a plan to address it. There are 50 million things that happen. To make it more
expedient it would be better to have the police there from the word go, so you've got the information and they're clear about the process from the beginning about what's happening.

Three Child Protection workers (Child Protection 1, Child Protection 2, Child Protection 3), the three psychologists, and one doctor (Doctor 1) found their experience in dealing with police in FII/MBP cases was that police did not want to become involved in the case until there was some clear evidence of a crime or an offence that could be pinpointed (see below). This was consistent to the experience described by the detectives.

**Child Protection 1**: [...] the police weren’t involved because they couldn’t pinpoint an offence or they couldn’t pinpoint her actually doing something. So, it was sort of like, ‘Yeh, it’s serious, it’s really concerning, but it’s a nightmare in terms of us being able to pinpoint an offence’. So we just kept the police up to date in terms of what we did and our involvement. But they didn’t do anything with it. It would have been good to have had a little more involvement by the police.

**Child Protection 2**: [...] it was referred to police and my recall is that they basically threw their hands up in horror and said, ‘It’s too hard, we really wouldn’t know’. They had never heard of these cases before. By the stage it was detected and referred to the police, both the younger children had had multiple surgery. They’re really quite severely scarred with all sorts of abdominal surgery. The police were saying, ‘Well who knows whether it was the doctor or the parent? And tracing it back would be too difficult because of mum’s medication or substance problems’. I
suggest police need to have a little more knowledge of this abuse and work with other agencies in its management.

**Doctor 1:** [...] the police say, ‘Look, there’s nothing we can really do until you can give us a pretty definite diagnosis’ and DHS say precisely the same thing. I think that’s reasonable and I think in many cases where you’re trying to prove the diagnosis you’re not really going to succeed if police come knocking at the door saying, ‘We’d like to have a talk with you’, or if the DHS do this. ‘Cos whatever the mother is doing to the child, it almost certainly is going to stop at that point, and will only occur again when the pressure goes off. They are probably not going to continue to do it in which case, you’re going to have trouble trying to prove the diagnosis.

Additionally, the four doctors interviewed were reluctant to fully involve the police or DHS in FII/MBP cases until they had some concrete evidence to support the presence of abuse.

**Doctor 3:** We don’t have skills in investigation, nor do we have the legal right to investigate. On the other hand, because a child is so dependent on the parent, we are very reluctant to appear to be accusing the parent of any wrong doing and as soon as we involve the police we do that. There is no other way that involvement of police or indeed the CSV [DHS] can be seen by the parent. So we have this problem that we need to get to the stage that we’re reasonably convinced and we have evidence that we can use to convince the CSV officers or the police that an investigation needs to be undertaken.
However, the doctors were generally happy for police to be notified in the initial stages of FII/MBP investigations, but for police not to take an active role. Doctor 1, however, also indicated that it depended on what was happening to the child.

**Doctor 1**: I think police need to be involved when the diagnosis has been thought of and steps are being taken to try and prove or disprove it. That process will often involve police investigation. I think, in any case, police need to be informed of the possibility of MSBP even at that initial stage, although no particular action is required by them. The proof of it is largely a medical one, but it depends really on what it is thought is being done to the child. [...] There are some mechanisms of MSBP where there really isn’t going to be anything that can be medically detected – smothering is an obvious example. If the child’s being smothered then there are no tests that you can do on the child that will prove or disprove that. The only way to really diagnose that of any certainty is for either the mother to acknowledge it or for someone to see her doing it; in those cases, surveillance, and that includes police surveillance, may well be necessary.

Two doctors (Doctor 2, Doctor 3) interviewed indicated a preference to notify police directly, rather than transferring information via DHS (see below). Police 1 also indicated a preference to be notified directly by medical personnel.

194 As discussed in Chapter Two, mandatory reporting provisions in Victoria require doctors to notify Child Protection of physical and sexual abuse. There is no legal requirement for doctors to notify the police. Protocols between Human Services and Victoria Police (1998: 5) require
Doctor 2: The legislation means that we notify DHS. Personally, I think it’s always a good thing to have direct communication with police. Otherwise it’s that Chinese Whispers thing. Yes, DHS need to be at all points, [...]. Only that there are some issues that I think are better understood directly between medical staff and police and sometimes vital information can be watered down or lost if it goes through too many people.

5.2.3 The police role with Sudden Unexpected Deaths in Infants (SUDI)

Towards the completion of this research, it became apparent that the attendance and role of police at Sudden Unexpected Deaths of Infants (SUDI) (includes SIDS) was a topic worthy of investigation. Whilst this topic was only explored with three of the police interviewees (Police 1, Police 5, Police 6), the researcher considered the findings to be important for police practice and training.

The three detectives interviewed unanimously agreed police should attend all SUDI cases, including SIDS.

Police 5: The problem with SIDS is that it’s a definition of exclusion. It’s not a cause. So you’ve still got an unanswered question, even where the pathologist is quite happy to say that it’s a SIDS matter. [...] I believe police need to attend SIDS cases to have an initial look at things. It’s no good three weeks later, or even after a post mortem three days later,

that Child Protection must report to police 'all allegations and situations of sexual abuse, physical abuse and serious neglect to a child or young person', although these protocols are not legally binding.
finding out that: ‘Gee! We’ve got some questions here that we can’t answer about this kid’ and police then getting notified. Your crime scene is gone and everything else is gone. There wouldn’t be any harm in police at least making some observations in the room where the child was found and taking a couple of quick photographs.

Police 5 and Police 6 believed that the majority of SUDI cases would be due to SIDS, but also recognised the possibility of a crime having been committed and the need for a balanced investigation. These members were very conscious of the effect that police attendance could have on parents in these cases.

**Police 6:** [...] the majority of SUDI cases involve people who are non-culpable, innocent, a victim of circumstances. There must be a balance in how you go about investigating when there are no overt signs of criminality involved and the parents have probably had the worst thing that could ever happen to them in their lives; that their child has inexplicably died.

The three detectives saw the police response to SUDI cases as a tiered approach, with uniform members attending first, followed by a CIU or SOCAU member, and then, if required, a detective from the Homicide Squad. Police 6 had some concerns with a CIU member attending these cases. He suggested that through television there was now a certain stigma attached to the detective role, that ‘detectives investigate crime’, and that given that the majority of people involved in unexplained child deaths were not culpable they would find it quite traumatic to have police attend their house. He
highlighted the need for police not to place the parents under any unnecessary suspicion. Police 6 supported the handling of these cases by a SOCAU member indicating that such members will have had more experience than detectives in dealing with families and children, and in examining scenes involving child abuse. In contrast, Police 5 suggested from an evidentiary perspective it was important that a detective attend SUDI cases to make some observations of the child, family, and place of death and secure any potential evidence of a crime. Police 1 supported either a detective or a SOCAU member to handle these cases.

In relation to handling multiple unexplained child deaths, Police 5 considered police resources in Victoria were not ideal to effectively investigate such cases. He claimed that in order to manage such a large investigation, ‘police members needed to be in an environment where they could focus on the task and not be called out to other jobs’. Police 6 stated there were difficulties with taking members ‘off call’ due to limited resources and that assessments had to be made regarding ‘the number of members involved in lengthy committals and trials, other competing jobs on the go, and new […] jobs coming in’. Police 5 and Police 6 thought a multidisciplinary unit or task force would be ideal for SUDI cases and those involving multiple child deaths. Police 6 highlighted there was a big push within Victoria Police towards ‘task force policing’ ‘where police put a large contingent of resources into the bigger jobs to try and wind them up quicker’.

195 ‘Off call’ means that police are not called out to respond to a new incident and can focus on the current jobs they have on file.
196 Police 5 likened such a unit to the Major Collision Squad that deals with fatal motor vehicle collisions, in that such a unit contains a wealth of expertise that is not just made up of all police members.
5.2.4 Police charges

The qualitative findings revealed that whilst police and some of the professionals interviewed were supportive of criminal charges in FII/MBP cases, the majority of professionals interviewed displayed uncertainty as to whether women who induce illness in their children should be charged for their actions\textsuperscript{197}.

The police interviewees, Child Protection 2 and Doctor 3 believed that women who induced illness in their child should be charged.

**Police 1**: If it can be established beyond reasonable doubt that the mother, due to her deliberate actions, is placing the child’s life in danger or her actions have caused the death of the child, then she must be charged with the appropriate offences and placed before the court.

**Police 5**: I have a strong view that they should be charged. Clearly they have committed a criminal offence upon a helpless individual. This does not mean that they should not get some form of psychiatric help as well, but sometimes the charging and medical intervention can go hand in hand. The other thing is that it is hard enough to get people to believe that mothers do this to their children and if we do nothing about it from the criminal angle, then it is a tantamount to accepting it and hiding such things from the general community.

\textsuperscript{197} The issue was not explored with Doctor 1 or Child Protection 4.
**Police 6:** There is no other option in my mind than to charge them and have the full weight of the law come down upon them.

Police 1 considered ‘specific legislation was needed to deal with Munchausen cases’ and that the ‘only way for this to occur’ was ‘to place these cases before the courts so that the public could become aware of the problem’. Police 1, Police 5, and Doctor 3 felt there was a need for a public statement in relation to this offending in order to diminish the prospect of denial and of the same behaviour subsequently being perpetrated without people knowing the mother's previous history. Doctor 3 felt public trial offered some opportunity for making the recognition permanent. He was very clear in his beliefs that women who induce illness in their children have committed a crime and should therefore be dealt with by the law.

**Doctor 3:** I have a great deal of sympathy for a mother who is so disturbed that she can do such a thing to her own child, but on the other hand I don’t think that we should allow that sympathy to sway us in how we approach the problems in the criminal justice system.

Child Protection 2 suggested that the mother should be charged, but believed that careful consideration needed to be given to sentencing options.

**Child Protection 2:** I suppose I would wonder what on earth we would achieve by charging and potentially incarcerating such a parent. On the other hand, I am well aware of the level of fatalities and it is certainly a crime like every other crime. It’s a very serious invasion and assault of children, so they should be charged. I suppose, maybe the bigger issue
is what kind of sentencing options are available? I think it would have been a tragedy for this mother, and the others that I’ve known, to end up incarcerated. I think on the balance, yeah they should be charged, but somehow, somehow the criminal court outcomes have to be linked to the welfare of the children.

In two police cases (Police 1, Police 4) medical opinions ultimately impacted on the laying of charges against the mother. In one case induced illness via suspected smothering occurred (Police 1) and in the other, fabricated sexual assault (Police 4). In both cases, the police members believed criminal action should have been initiated against the mother. However, because doctors suggested in both cases that the mothers were delusional and considered the issue more of a health problem rather than a criminal one, criminal charges were not pursued. In the case of Police 1 there were also conflicting medical opinions about whether the child had died of SIDS or was smothered (Police 1).

In relation to fabricated illness, the police members interviewed considered this behaviour to be not as straightforward as induced illness in terms of police being able to prove that an assault has taken place. Police 3 and Police 4 suggested that emotional and psychological abuse associated with fabricated illness would be more difficult to prove in the courts than direct abuse associated with induced illness. Police 5 and Police 6 considered cases involving fabricated illness may not warrant police involvement and may be resolved by medical and child protection personnel.
Doctor 2 felt the laying of criminal charges could not be generalised but doubted whether these women had any criminal intent. Doctor 2 suggested for some of these mothers criminal charges were appropriate as they were committing life threatening assaults on their babies, but for others, criminal prosecution may have a detrimental effect in trying to assist the mother to take responsibility for her actions and adopt more appropriate parenting practices. Child Protection 1 and Child Protection 3 felt the mothers, in their cases, had not intentionally caused their child harm and thus were uncertain as to whether criminal charges should be laid. Child Protection 3 considered that it also depended on the significance of the offence. She thought the community needed to take some sort of action with these cases, but felt charging was punitive and would not work with FII/MBP cases.

Finally, the quantitative aspect of this research explored the views of police about whether mothers who induce illness in their children should be charged for their actions and prosecuted in court. The majority of police surveyed (72%) considered that such women should be charged, with 20% being ‘unsure’ and 7% disagreeing. When viewing this question by ‘police work area’ a higher percentage of SOCAU members (84%) compared to detectives (73%), recruits (72%) and uniform members (66%) felt that mothers who induced illness in their children should be charged for their actions. One might suggest the higher level of support for criminal charges by SOCAU members is not surprising given that a large percentage of their work is with child abuse victims.
5.3 A need for suitably qualified personnel

All six police members, three of the four child protection workers and the school principal indicated that at the time of becoming involved with a FII/MBP case, they had received no training in relation to this abuse and had minimal or no knowledge of this offending. The police officers did not feel properly equipped to deal with this abuse. The police participants learnt of FII/MBP through journal articles (4), television (2), other colleagues (2), medical personnel in Victoria (1), and police and medical professionals overseas (1). Child Protection participants learnt of MBP through an overseas medical specialist (1), Victorian medical personnel (1), child protection training (1) and colleagues (1). Medical professionals acquired their understanding of this offending predominantly through their involvement with numerous cases, other colleagues and medical journals.

Doctor 3, Child Protection 2 and the Psychiatrist emphasized that FII/MBP can be difficult for people to accept and understand.

Child Protection 2: We may be able to understand a mother who gets fed up with her baby and pitches him across the room or thumps him or whatever, everybody can relate to stressful situations where a mum may just lose the plot, but as an ordinary person how do you understand a mother who didn’t do that but very secretively and deceitfully went about perpetrating extraordinary harms on her child, and in a sense seduces

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198 One police participant indicated that she only discovered years later from a television documentary that this was what she had dealt with many years earlier.
somebody else into harming her child as well. It’s a very difficult dynamic
to get your head around.

**Doctor 3:** I think the social worker found it extremely stressful. I don’t think he could believe that a parent could do such a thing and he couldn’t cope emotionally with the concept. [...] there are a number of professionals within the community, including doctors, child protection workers, police, psychologists and magistrates, who hold firm and unalterable convictions that MBP does not exist.

Doctor 3 further commented:

**Doctor 3:** The first piece of advice that I give, is that we should not involve members of any profession, in the investigation of these cases, who cannot emotionally accept that a parent can deliberately kill or maim their child.

Doctor 3 suggested if the wrong people became involved with FII/MBP cases they could completely ‘destroy an investigation and outcome and leave a child unprotected’. He indicated that it is ‘necessary to have people who can assess the evidence in a fair and objective way in order to determine whether the accusations are true or not’. Many professionals reiterated the importance of having the right professionals, with the right attitude and expertise, assigned to FII/MBP investigations (Police 4, Police 5, Child Protection 3, Child Protection 2, Child Protection 4, Doctor 1, Doctor 2, Doctor 3, Psychiatrist, Principal). All professionals interviewed considered it was important for police and other professionals, who through their positions
may encounter FII/MBP, to be aware that this type of abuse exists and to receive some training with respect to its management. Professionals generally agreed that junior personnel should not be assigned to these cases.

**Police 1:** You need professionals investigating these cases who are on the same wave length, who have the same background knowledge and understanding of these cases.

**Police 2:** My understanding of it is very limited, but I suppose my knowledge became a bit more heightened when I actually investigated a job. I suggest that detectives need some awareness of this disorder and how to investigate it.

**Police 4:** As crime investigators they need to possess a good knowledge of this, a good knowledge that it exists and to be able to identify it if they come across it. Look how long it took us to get there. Some training would have been good.

**Police 5:** You need to have a good understanding that this abuse actually exists. I think that’s the first thing. There’s certainly no training. I knew a very small amount about it anyway just from my own reading of stuff over the years, but I guarantee 80% of the police force wouldn’t have a clue what it is. They’ve probably heard the term MBP and if you asked them what it was I’d be surprised if many of them knew. So, maybe there needs to be a little bit done in terms of training, just to let police know that it’s a possibility.
Doctor 1: They are normally invariably extraordinarily complex, difficult cases that take an enormous amount of professionals’ time. They are not cases that junior doctors or junior police or junior DHS people should be involved in. They take a lot of skill and knowledge. These cases should involve senior police, senior DHS and senior doctors from within the hospital; in particular, involving those doctors and professionals who have skills and experience in dealing with child abuse and an appreciation of other agencies’ roles.

Doctor 3: I have no doubt that the average Constable at the local police station or average detective would be totally unsuitable. First of all, they have no experience, they have no expertise and also I don’t think this is a concept for them to get their minds around the first time they come across it. Police also need the skills to work with other agencies in investigating these cases.

Child Protection 2: I think that what’s vital is that only experienced protective workers are assigned to these cases.

Child Protection 3: Police, protective workers, doctors and magistrates need training with these cases as they are all susceptible to the mother’s deception. These cases need people who have a knowledge base about FII/MBP and know what the issues are. They have an insight into these matters and other agencies’ roles and are able to pull everything together.
Child Protection 4: We need to do some development with professionals, as well as kitting ourselves from ground level up as to what we should be looking for and how best to deal with it.

Principal: [...] it seems to me that if we had had some training, some knowledge and skills that allowed us to identify the condition or the symptoms, then that would have assisted us a lot earlier in coming to some conclusions.

Finally, two police officers (Police 1, Police 4), four child protection workers and one psychologist highlighted a need for supervisors to also possess some knowledge of this offending in order to be able to provide support and guidance for their staff.

PART 2: POLICE KNOWLEDGE OF FII/MBP

5.4 Profile and response rate for the questionnaire

During 2001-2002, the researcher distributed 1,238 questionnaires to Victoria Police members working in general duties at police stations (uniform), Criminal Investigation Units (CIU) and Sexual Offences and Child Abuse Units (SOCAU). An additional 105 questionnaires were distributed to recruits at the Academy (refer to Table 5.1 for an overview of the sampling plan and return rates). The purpose for the questionnaire was to gain an indication of the level of familiarity and knowledge held by police about FII/MBP to assist with understanding the training needs of police in relation to this abuse. It
was not designed to measure attitudes, but rather knowledge held by police at a particular point in time to assist with analysing police training needs.

Of the 1,238 questionnaires distributed to uniform, CIU and SOCAU areas, 20% were returned due to errors in work address. This situation most likely arose due to computer records of members’ work locations being out of date. Owing to time and resource restraints these questionnaires were not redistributed. Of the questionnaires remaining (986), 66% (n=655) were completed and returned. Additionally, 105 recruits completed the questionnaire, giving a grand total of 760 completed questionnaires for analysis. The final sample consisted of: recruits (n=105), uniform members (n=310), detectives from CIU’s (n=232) and SOCAU members (n=113). The participants were from the following ranks: recruits (n=105), constable (n=50), senior constable (n=457), sergeant (n=119), senior sergeant (n=26). Police experience ranged from recruit to 37 years, with a mean level of experience of 12.32 years (SD=8.67567). Members were from both country (n=225) and city locations (n=426). They were aged between 19 and 57 years of age, with a mean age range of 35.34 years (SD=7.68). Gender of the members surveyed was not explored. Twelve per cent of the members surveyed, (n=88) had received some police training about this abuse. This figure consisted of 64 SOCAU members (73%), 11 detectives (12.5%), 11 uniform members (12.5%) and 2 recruits (2%).

Retracing the members’ whereabouts would have been a very time consuming exercise. Two people did not respond to this question. The 105 recruits were classified as neither country nor city. Four people did not respond to this question.
The questionnaire utilised in the quantitative research employed a range of different terminology (see Chapters 1.2; 2.2.2; 3.5.1.2; Appendix 18). For consistency purposes with the rest of this thesis, the term FII/MBP is utilised in this chapter.

Table 5.1: Sampling Plan for Questionnaire Research

<table>
<thead>
<tr>
<th>Policing Area</th>
<th>Population Sample (July 2001)</th>
<th>95% Confidence level</th>
<th>Actual number sent</th>
<th>Returned due to incorrect address ²⁰²</th>
<th>Total Number received</th>
<th>Return response rate (*based on these figures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniform</td>
<td>5,010</td>
<td>357</td>
<td>600</td>
<td>137 (leaving 463*)</td>
<td>310</td>
<td>67%</td>
</tr>
<tr>
<td>SOCAU</td>
<td>242</td>
<td>148</td>
<td>212</td>
<td>54 (leaving 158*)</td>
<td>113</td>
<td>71%</td>
</tr>
<tr>
<td>CIU</td>
<td>768</td>
<td>256</td>
<td>426</td>
<td>61 (leaving 365*)</td>
<td>232</td>
<td>64%</td>
</tr>
<tr>
<td>Totals</td>
<td>6,150</td>
<td>761</td>
<td>1238</td>
<td>252 (leaving 986)</td>
<td>655</td>
<td>66%</td>
</tr>
</tbody>
</table>

5.5 Police familiarity with the term FII/MBP

Overall, the quantitative findings showed 521 (68.6%) of the 760 police officers surveyed had heard of FII/MBP. An analysis of the data by police work area, found 99% of SOCAU members (n=112), 48% of recruits, (n=50), 59% of uniform members, (n=184) and 75% of detectives (n=175) had heard

²⁰² It would appear computer records were not always up to date with members’ movements or had the wrong work station listed.
of FII/MBP (see Figure 5.1). An analysis of the data by rank found 48% of recruits \((n=50)\), 44% of constables \((n=22)\), 74% of senior constables \((n=339)\), 74% of sergeants \((n=88)\) and 81% of senior sergeants \((n=21)\) had heard of FII/MBP (see Figure 5.2). It was concluded more SOCAU members and detectives had heard of FII/MBP than uniform members and recruits, and more members higher in rank had heard of this abuse than the lower ranks. Metropolitan members had a slightly higher percentage (75%, \(n=318\)) of members who had heard of FII/MBP compared with their country counterparts (67%, \(n=151\)). The qualitative findings revealed police, in describing this abuse, utilised the terms: ‘MSBP’; ‘MBP’; ‘fabricated illness’, and ‘fabricated illness by proxy’.

In analysing police familiarity with FII/MBP, the researcher suggests the question relating to this inquiry also needs to be considered. The question asks members whether they have heard of the condition Munchausen Syndrome by Proxy (also known as Factitious disorder by proxy). In hindsight, the researcher would not have used the word ‘condition’ as it may suggest a health issue rather than a form of child abuse. However, at the time of compiling the questionnaire, terminology associated with FII/MBP was varied and inconsistent, which has naturally impacted somewhat on this research. The researcher suggests, though, the use of more concrete terminology throughout the questionnaire balances this position. Further, the qualitative component of this research and literature review, provide additional means for exploring and analysing police knowledge of FII/MBP.
Figure 5.1: Percentage of Victoria Police members who have heard of FII/MBP, by police work area.

Figure 5.2: Percentage of Victoria Police members who have heard of FII/MBP, by rank
5.6 How did police hear of FII/MBP?

An analysis was conducted to establish how Victoria Police members heard of FII/MBP. A total of 1,109 responses were received for this question, with the majority of members supplying more than one response\textsuperscript{203}. The most common means of hearing of this abuse was through television ($n=393$). Other sources, listed in order of frequency, included: newspapers ($n=191$), ‘on the job’ ($n=166$), magazines ($n=151$), police training ($n=88$), family and friends ($n=82$), other means ($n=16$) (such as conferences, the radio, movies, medical personnel), other reading ($n=14$), and school ($n=8$). Figure 5.3 presents these results in percentage terms. Unfortunately the study did not extend to investigating the type of television shows, newspaper articles and magazines through which members heard about FII/MBP. However, it could be surmised that these sources, as well as other sources such as family and friends, are potentially unreliable. Therefore, 73% of the sources of learning about FII/MBP listed in this study are potentially unreliable.

\textsuperscript{203} The questionnaire provided the facility for members to tick more than one response. Refer to Appendix 18 for a copy of the questionnaire.
Figure 5.3: How Victoria Police Members Heard of FII/MBP (in percentage terms)

It was also of interest to examine whether sources of information about FII/MBP varied as a function of police work area. As shown in Table 5.2 members working at SOCAU units heard of FII/MBP predominantly through work, television and police training. Both detectives (CIU) and uniform members reported hearing of FII/MBP predominantly through television, newspapers and magazines. A sizeable proportion of detectives also reported hearing of FII/MBP through their work. In contrast, most recruits reported hearing of FII/MBP through television, and to a lesser extent through newspapers and family/friends.
Table 5.2: How Victoria Police members heard of FII/MBP

<table>
<thead>
<tr>
<th></th>
<th>Recruits</th>
<th>Uniform</th>
<th>Detectives</th>
<th>SOCAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television</td>
<td>54%</td>
<td>40%</td>
<td>36%</td>
<td>25%</td>
</tr>
<tr>
<td>Work</td>
<td>2%</td>
<td>7%</td>
<td>15%</td>
<td>28%</td>
</tr>
<tr>
<td>Police training</td>
<td>2%</td>
<td>3%</td>
<td>3%</td>
<td>22%</td>
</tr>
<tr>
<td>Newspaper</td>
<td>13%</td>
<td>21%</td>
<td>20%</td>
<td>11%</td>
</tr>
<tr>
<td>Magazine</td>
<td>7%</td>
<td>16%</td>
<td>17%</td>
<td>8%</td>
</tr>
<tr>
<td>Family/friends</td>
<td>11%</td>
<td>9%</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>Other means</td>
<td>1%</td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

5.7 Police members’ own ratings of their knowledge

At the commencement and completion of the questionnaire (see Appendix 18), participants were asked to rate how well informed they considered themselves to be about FII/MBP. The findings from this self assessment showed that recruits, uniform members and detectives generally considered themselves poorly to very poorly informed and SOCAU members to be medium to poorly informed. These ratings remained fairly consistent after the completion of the questionnaire (refer Figure 5.5). As a whole, the self assessment ratings were also consistent with actual performance levels; that is how members viewed their knowledge was mirrored by their results (see Figures 5.4 & 5.5). Such findings add credibility and validity to the questionnaire design.
Figure 5.4: Self assessment rating of knowledge of FII/MBP (Commencement of questionnaire)

Figure 5.5: Self assessment rating of knowledge of FII/MBP (completion of questionnaire)
5.8  Overall police knowledge of FII/MBP

Overall, Victoria Police members performed poorly on the questionnaire and displayed a high level of uncertainty about FII/MBP. Indeed, as seen in Figure 5.6, respondents were ‘uncertain’ with almost half (49%) of the questionnaire items, recording a mean overall score of 34% of ‘correct’ answers and 12% of ‘incorrect’ responses.

Figure 5.6: Overall mean percentage questionnaire results

5.8.1  By police work area

Examination of members’ knowledge about FII/MBP by police work area revealed substantial differences in overall mean knowledge levels. The mean number of correct, incorrect, and uncertain responses on the questionnaire (expressed as a percentage) by recruits, uniform members,
CIU detectives, and SOCAU members are presented in Table A5.3. A multivariate analysis of variance of these data showed a significant multivariate (Wilks’ lambda) effect, $F(15, 2076.34) = 8.07$, $p<.000$, and significant univariate effects for each dependent variable: number 'correct', $F(3, 756)=30.73$, $p<.000$; number 'incorrect', $F(3, 756)= 7.65$, $p<.000$; number 'unsure', $F(3, 756)=20.50$, $p<.000$. In terms of the number 'correct', follow up Bonferroni comparisons showed that although all groups (recruits, uniform, detectives and SOCAU) scored relatively poorly, SOCAU members, on average, scored five questions higher than members in all other groups. Thus, SOCAU members scored a mean percentage of 50% of answers correct ($SD=16.32$) compared to recruits ($M=31$, $SD=18.80$, $CI=11.94; 26.40$), uniform members ($M= 30$, $SD= 20.65$, $CI=15.13; 26.91$) and detectives ($M= 33$, $SD=20.23$, $CI=11.50; 23.75$).

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204 Located in Appendix 21.
205 Multivariate analysis is the analysis of the simultaneous relationships among several variables (Babbie, 2005: 485). Univariate analyses is the analysis of a single variable, for purposes of description. Frequency distributions, averages and measures of dispersion would be examples of univariate analysis, as distinguished from bivariate and multivariate analysis (Babbie, 2005: 490). Wilk’s Lambda is one of a number of possible statistics available to determine whether the overall or multivariate effect is significant.
206 'The Bonferroni correction is ‘a procedure for guarding against an increase in the probability of a type I error when performing multiple significance tests’ (Everitt, 2002: 50).
207 ‘An average computed by summing the values of several observations and dividing by the number of observations’ (Babbie, 2005: 485).
208 SD stands for Standard Deviation and is ‘a measure of dispersion around the mean, calculated so that approximately 68 per cent of the cases will lie within plus or minus one standard deviation from the mean, 95 per cent will lie within plus or minus two standard deviations, and 99.9 percent will lie within three standard deviations. The smaller the deviation, the more tightly the values are clustered around the mean; if the standard deviation is high, the values are widely spread out (Babbie, 2005: 489).
209 CI stands for Confidence Interval. Confidence intervals allow us to tell whether the differences between groups are significant. ‘A 95% confidence interval tells us the values of the differences between groups between which 95% of samples will fall. […] If the confidence interval does not cross zero (i.e. both values are positive or negative then we can be confident that we would find a difference between the groups in 95% of samples taken from the same population, […]and] confident that genuine group differences exist (Field, 2004: 411).
In addition, SOCAU members marked significantly fewer answers as being ‘unsure’ ($M=33.24$, $SD=18.14$, $CI=8.53$; $26.44$) compared with recruits ($M=50.71$, $SD=23.83$), detectives ($M=51.10$, $SD=25.10$, $CI=10.56$; $25.75$) and uniform members ($M=53.83$, $SD=25.87$, $CI=13.97$; $28.50$). However, SOCAU members did not differ significantly from recruits, detectives and uniform members in their number of ‘incorrect’ answers. This finding may reflect a greater confidence by SOCAU members in their beliefs regardless of whether their beliefs are right or wrong.

5.8.2 By rank

When viewing knowledge levels by rank (recruit, constable, senior constable, sergeant, senior sergeant) there were no significant differences between the mean percentage of ‘correct’ and ‘unsure’ responses (see Table A5.3). Sergeants scored the highest with a mean percentage of 36% of answers ‘correct’, followed by senior constables (35%), recruits and senior sergeants (31%), and constables (30%). Multivariate tests (Wilks’ lambda) by rank revealed a significant overall effect within subjects, $F(12, 1,987.251)=3.324$, $p>.000$. Univariate analysis found that there were no significant differences by rank in terms of either the mean number of ‘correct’, $F(4, 753)=1.164$, $p<.05$ or ‘uncertain’ responses, $F(4, 753)=.55$, $p>.05$, but that there was a significant difference between ranks in the mean number of ‘incorrect’ responses, $F(4, 753)=4.20$, $p<.002$; that is some ranks got more answers
wrong than others. Post Hoc testing\textsuperscript{210}, however, revealed that this statistically significant difference in ‘incorrect’ responses was the result of recruits on average, scoring an extra one item wrong compared to the other ranks.

5.8.3 By police training

Lastly, comparisons were made between members who had received police training on FII/MBP (n=88) and members who had received no training in this subject area (n=672). The mean number of correct, incorrect, and uncertain responses on the questionnaire (expressed as a percentage) of trained and untrained members were subjected to multivariate analysis. This analysis revealed a significant overall effect, $F(3, 756)=28.426$. Subsequent univariate analyses showed that members who had received training has significantly higher mean levels of 'correct' responses, $F(1, 758)=81.22$, $p<.000$, ($M=52.10$, $SD=15.31$, $CI=16.43$; 25.50), and lower mean levels of 'unsure' responses, $F(1, 758)=57.97$, $p<.000$, $M=31.04$, $SD=16.24$, $CI=16.19$; 27.31) than members who had received no training ($M=31.98$, $SD=20.31$). There was no difference in the level of 'incorrect' responses for members with training ($M=13.35$, $SD=5.78$) and those without training ($M=11.46$, $SD=7.99$), $F(1, 758)=5.194$, $p<.023$. It is also notable that the majority of members who had received training on FII/MBP worked in SOCAU units (n=64, 73%).

\textsuperscript{210} Post-hoc analysis or comparisons are ‘analyses not explicitly planned at the start of a study but suggested by an examination of the data’ (Everitt, 2002: 294).
5.9 The five knowledge domains of the questionnaire

The bulk of the questionnaire was structured around five knowledge domains, or themes, associated with FII/MBP in order to gain a broad perspective of members’ knowledge in the subject area. The five knowledge domains and applicable questions are presented below in Table 5.4. Additionally five opinion questions were included in the questionnaire (see section 5.10). Finally, as alerted to in Chapter 3.5.1.6 a number of questionnaire statements were removed from the final analysis. Whilst this naturally will have some bearing on the results, it would appear, owing to the strength and consistency of the research findings, that any impact has been minimal.

Examining knowledge levels on any topic is a difficult task, made more difficult when the subject area is controversial and still relatively new and evolving. Answers to the questionnaire items were based on what was generally accepted to be true at the time of conducting this research (see Chapter 3.5.1.3). It is acknowledged that some of the answers viewed as correct will no doubt change with the course of time. The researcher concluded that whilst the questionnaire will provide a valuable aid for Victoria Police trainers to gain an indication of police training needs in relation to FII/MBP investigations, the findings must also be viewed in the context of the time in which the research was conducted and in light of any new research in the field.
Table 5.4: The five knowledge domains of the questionnaire

<table>
<thead>
<tr>
<th>Knowledge Domains</th>
<th>Questionnaire Item Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of offenders</td>
<td>1, 2, 8, 10, 14, 16, 23</td>
</tr>
<tr>
<td>Knowledge of spouses</td>
<td>15, 39</td>
</tr>
<tr>
<td>Knowledge of victims:</td>
<td>24, 22</td>
</tr>
<tr>
<td>Knowledge of offending:</td>
<td>5, 6, 7, 12, 13, 29, 30, 32, 36, 43</td>
</tr>
<tr>
<td>Knowledge of investigation/management:</td>
<td>9, 19, 20, 21, 25, 26, 34, 38, 40, 41, 44</td>
</tr>
</tbody>
</table>

5.9.1 Exploring the five knowledge domains

The analysis of the five knowledge domains identified whether participants performed better in certain areas than in others, and whether police work area, rank, and training influenced how participants performed in each of the five knowledge domains. Table A5.5 presents the mean percentage results recorded in each of these areas.

Overall police were found to possess limited knowledge of FII/MBP in all five of the knowledge domains, scoring less than 52% of ‘correct’ responses in all five areas. The highest mean percentage of ‘correct’ response was recorded in relation to knowledge of spouses (51%), followed by knowledge of offenders (42%), offending (32%), investigation and management (31%), and knowledge of victims (18%) (see Figure 5.7).

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211 Refer Appendix 20.
5.9.1.1    *By police work area*

When examining results by police work area, the findings showed SOCAU members scored higher mean levels of knowledge in four of the five knowledge domains (offenders, spouses, offending and investigation and management) compared to recruits, uniform, and CIU members. SOCAU members scored only slightly higher in their knowledge of victims. Figure 5.8 presents the mean percentage results according to work area.
When examining the five knowledge domains and the mean percentage of correct responses by rank, the findings revealed relatively similar results across all ranks (recruit to senior sergeant) (see Figure 5.9 below and Table A5.5).
Finally, comparing members who had received training about FII/MBP with those who had received no training revealed members with training scored higher mean percentages in all five of the knowledge domains, although in two areas the mean results were under 50% (Refer Table A5.5).

5.9.1.3 **Knowledge of offenders**

Seven questions focused on members' knowledge of offenders who fabricate and/or induce illness in their children (see Table 5.4). The questions focused on gender, behaviour, background and the offenders’ awareness of the effects of their actions on their victims. The findings showed that the majority of police were uncertain about these offenders. The following overall mean
percentage results were recorded: ‘correct’ (41%, $SD=30.91$), ‘uncertain’ (54%, $SD=32.50$) and ‘incorrect’ (4%, $SD=8.76$) (see Table A5.5).

Viewing the data by police work area, the findings showed SOCAU members were moderately well informed about these offenders, recording a mean percentage of 65.36, ($SD=24.73$) of ‘correct’ answers, compared with recruits ($M=38$, $SD=28.24$), uniform members ($M=35$, $SD=29.94$) and detectives ($M=38$, $SD=30.53$) (see Table A5.5).

The findings from Question One are significant. Question One explored members’ knowledge of gender associated with offenders who fabricate and/or induce illness in their children. The research demonstrates that females (generally the biological mother) significantly offend more than males (Rosenberg, 1987; Sheridan, 2003). The researcher suggests that persons who have any knowledge of FII/MBP would be aware of the female dominance with this form of offending. The questionnaire findings revealed that 83% of SOCAU members were aware of this dominance, compared to 54% of detectives, 45% of uniform members and 44% of recruits.

An analysis by rank of the mean levels of knowledge held by police about FII/MBP offenders revealed relatively similar results: recruits ($M=37.55$, $SD=28.24$), constables ($M=36.86$, $SD=30.96$), senior constables ($M=42.11$, $SD=31.51$), sergeants ($M=40.94$, $SD=31.12$), senior sergeants ($M=35.16$, $SD=29.48$). In contrast, when examining the impact of training on members’ results in this section, the findings revealed considerable differences. Members who had received training on FII/MBP scored a mean percentage
of 66.55 ($SD=23.22$) of ‘correct’ answers in this section compared with a mean percentage score of 37.37 ($SD=30.20$) recorded by members who had received no training.

5.9.1.4 **Knowledge of spouses**

The second knowledge domain focused on members’ knowledge of spouses of FII/MBP offenders. At the time of compiling the questionnaire there was limited research in this area. However, the researcher considered two recurring concepts within the literature to be relevant to police. These concepts relate to knowledge by the spouse of their partner’s offending, and the reaction of the spouse upon being informed of the abuse.

Overall, participants scored poorly in this section. Members recorded a mean percentage of 51% ($SD=41.42$) of ‘correct’ responses, 39% ($SD=42.33$) of ‘unsure’ responses and 9% ($SD=16.63$) of ‘incorrect’ answers. When viewing the data by police work area SOCAU members scored substantially better results, recording a mean percentage of 70%, compared with recruits 46%, uniform members 46% and detectives 50% (refer Table A5.5). Also, members who had received training scored higher in this section, recording a mean percentage of 67% compared with those who had received no training (37%).

The first question in this section examined the spouse’s awareness of their wife or partner’s offending. Whilst some researchers suggest that collusion may be present between parents with this type of offending (Freeland and
Foley, 1992; Schreier and Libow, 1993; Berkowitz, 2001), most commentators argue that spouses of FII/MBP offenders will generally have no knowledge of their partners’ abusive behaviour (Meadow, 1982; Schreier and Libow, 1993; Artingstall, 1999). The questionnaire findings revealed 45% of police surveyed believed the spouse would usually be unaware of their partner’s offending, with 38% being ‘unsure’ of this position (see also qualitative findings, Chapter 4.6. Further analysis of this question is conducted in Chapter 8).

The second question in this section examined members’ knowledge of the defensive response typically adopted by FII/MBP spouses towards their wife or partner on being informed about their offending. The literature indicates spouses of these offenders will initially be in shock and then usually defend their partner (Freeland and Foley, 1992; Schreier and Libow, 1993; Artingstall and Brubaker, 1995). The spouse’s defensive stance was described as occurring even when children were severely injured (Zitelli et al. 1987; Benns, 2003) or their children reported the abuse to them (Bryk and Siegel, 1997; Gregory 2003). A passive type of response by spouses also appears within the literature, although not as common (Guandolo, 1985; Orenstein and Wasserman, 1986). Orenstein and Wasserman (1986) describe a sense of passivity in spouses who appeared to know or should have known of their wife’s abuse. Guandolo, (1985: 529) describes one spouse as being helpful to professionals, but also ‘indifferent and aloof’.

Fifty-six percent of police thought that, on being informed of their partner’s offending the spouse would outwardly defend his wife. Thirty-nine percent of
police were ‘unsure’ of the spouse’s reaction. In light of the qualitative findings of this study which adds more weight to a defensive but also passive type response by spouses (refer Chapter 4.6 and 8.2.3.2) the researcher suggests this question needs to be viewed cautiously and the wording of the questionnaire statement amended with any future studies. This topic is discussed further in Chapter 8.

5.9.1.5 Knowledge of victims

Two questions explored participants’ understanding of child victims of FII/MBP. The overall findings for this section showed police participants displayed a high level of uncertainty in this area, recording a mean percentage of 67%, \((SD= 36.24)\) of ‘unsure’ responses. SOCAU members, however, scored slightly better than other policing areas, although still performed poorly in this section (see Table A5.5).

Question 24 explored members’ understanding of the gender of victims. The research on FII/MBP shows the level of offending by female perpetrators against girls and boys is relatively the same (Rosenberg, 1987; Sheridan, 2003)\(^{212}\). Sheridan (2003), however, found that with the small percentage of men committing this abuse they offended against boys slightly more than girls. The quantitative findings revealed 77% of police were unsure as to whether gender correlated with victimisation. This finding of uncertainty was

\(^{212}\) Sheridan (2003: 433) and Rosenberg (1987) conducted extensive literature reviews on MBP cases. Sheridan found of the 415 children examined, 52% were male victims and 48% were females. Out of 117 cases Rosenberg (1987) studied, 46% were male victims, 45% females and 9% were unidentified. Results suggest mothers that commit this form of abuse (which is the majority of offenders) are not gender specific with their victims.
consistent across all work areas: 71% recruits, 78% uniform, 77% detectives, and 76% of SOCAU members.

Question 22 explored members’ knowledge of the potential for collusion to form between the victim and offender in FII/MBP cases. The research indicates that some FII/MBP victims may collude with their perpetrator (Meadow, 1982; Waller, 1983; Schreier and Libow, 1993; Rosenberg, 1993). The quantitative findings found 58% of police were unsure of the potential for collusion between victim and offender in FII/MBP cases. In viewing the findings by work department, all areas revealed a high level of uncertainty on this issue. The following results marked as ‘unsure’ were recorded: recruits, 69%; uniform, 61%; detectives, 54%; and SOCAU members, 47%. SOCAU members recorded the greatest awareness of this issue. Thirty percent of SOCAU members correctly identified that FII/MBP victims may collude with their offender. The topic of collusion is explored further in Chapter 8.

5.9.1.6 Knowledge of offending

The fourth section explored members’ knowledge of the methods employed by women to fabricate and/or induce illness in their children. The results showed that overall police had very little knowledge in this area. Members recorded a mean percentage of 32% ($SD= 24.85$) of correct answers for this section; the second lowest result of the five knowledge domains$^{213}$. Viewing results by police work area, SOCAU members scored substantially better ($M=49\%, SD 21.96$) than recruits ($M= 31\%, SD= 22.36$), uniform members

$^{213}$ The field pertaining to knowledge of victims scored the lowest.
(M= 28%, SD= 24.92) and detectives (M= 30%, SD= 23.92), although still scored less than 50% on seven of the nine questions in this section (Questions: 5, 7, 12, 29, 32, 36, 43). Rank was found to have no direct bearing on knowledge held in this area with the following mean percentage results recorded: recruit, (31%), constable, (30%), senior constable, (33%), sergeant, (32%), and senior sergeant, (28%). Members with training scored higher in this section than those without training. Members with training recorded a mean percentage of 51%, (SD= 20.61) compared to a mean percentage of 30%, (SD= 24.31) recorded by those with no training.

The findings from Questions 5, 7, 12 and 29 demonstrate a clear deficit in knowledge by police in relation to medical aspects of FII/MBP.

- Question 5 found that 80% (n= 607) of police lacked knowledge about whether seizures and fevers were common forms of fabricated illness symptoms in children. Rosenberg (1987) and Sheridan (2003) both confirm these symptoms as being common with FII/MBP.

- Question 7 revealed 82% (n= 623) of police surveyed were ‘unsure’ if adding large amounts of salt to a child's diet would induce illness in that child. The research presents numerous cases where salt has been used by a mother to induce illness in her child, sometimes fatally (Meadow, 1977; Dine and McGovern, 1982; Braugh et al. 1983; Meadow, 1993; Fox, 1995; Kinscherff and Ayoub, 2000).
• Question 12 showed 61% (n=467) of police surveyed were ‘unsure’ if epilepsy was easy to fabricate. Only 10% (n=73) answered this question ‘correctly’, with 27% (n=208) answering ‘incorrectly’. Epilepsy is considered easy to fabricate as doctors rely heavily on what they are told by their patients or parents of patients (Meadow, 1984; Guandolo, 1985; Barber and Davis, 2002).

• Question 29 found 61% (n=467) of members were ‘unsure’ if false medical history was associated with FII/MBP. SOCAU members were more informed of this connection, scoring a mean percentage of 61% of ‘correct’ responses, compared to detectives (31%), uniform members (29%) and recruits (39%). The research shows that false medical history is often associated with FII/MBP (Meadow, 1984; Rosenberg, 1997; Sanders and Bursch, 2002).

When analysing Questions 5, 7 and 12 by police work area, it was found that SOCAU, CIU, uniform members and recruits all recorded a high level of uncertainty in relation to these issues.

Finally, the researcher considered the findings from Question 13 as important. Question 13 explored members’ understanding of whether a mother inducing illness in her child may continue to offend against her child within the hospital environment. Fifty-five per cent of police answered this question ‘correctly’, 38% were ‘unsure’ and 5% answered ‘incorrectly’\textsuperscript{214}. Viewing the results by work area, 80% of SOCAU members answered

\textsuperscript{214} 2% was recorded as missing data
‘correctly’, compared to 52% of detectives, 49% of uniform members and 50% of recruits. The literature associated with FII/MBP contains numerous accounts of mothers offending on their child within the hospital environment (Rosenberg, 1987; Boris and Brubaker, 1992; Stanioch, 1994; Southall et al. 1997). The researcher considered that such knowledge could be pertinent to saving a child’s life and therefore relevant to police and other professionals working on FII/MBP cases.

5.9.1.7 Knowledge of investigation and management

The final knowledge domain explored police members’ knowledge of investigation and management aspects associated with FII/MBP investigations. It included topics of mandatory reporting; the investigation of suffocation in young children; obtaining evidence through toxicology testing; obtaining admissions from offenders; the multidisciplinary response to FII/MBP investigations; and the detection of FII/MBP offenders from parents of genuinely ill children.

Overall, participants scored poorly in this section. They recorded the following overall mean percentage results: ‘correct’ responses, 31%, (SD= 19.27), responses marked as ‘unsure’, 45%, (SD= 26.50) and ‘incorrect’ responses, 22%, (SD= 15.21). Whilst all police areas performed poorly, SOCAU members performed substantially better than detectives, uniform members and recruits. SOCAU members recorded a mean percentage of 44%, (SD= 19.15), compared to detectives (31%, SD= 18.47), uniform members (27%, SD= 18.56), and recruits (27%, SD= 16.98). Detectives,
uniform members and recruits scored less than 50% with eight of the eleven statements (Questions 9, 19, 21, 25, 26, 38, 40, 44), whilst SOCAU members recorded results of less than 50% with five of these questions (Questions 9, 19, 21, 25, 40).\(^{215}\)

Whilst performing poorly, members who had received training on FII/MBP performed better in this section scoring a mean percentage of 46\%, \((SD=18.23)\) compared to those without such training - 29\%, \((SD=18.51)\).

The five questions in which members performed very poorly are examined below (Questions 9, 19, 21, 25, 40).

- Question 9 explored police members’ understanding of the availability of evidence in cases of induced illness through toxicology testing. The research in this area highlights evidence is not readily available through toxicology testing and that toxicologists generally require some input as to what substances to test for (Rosenberg, 1987; Henretig, 1995; Samuels and Postelthwaite, 2000). The majority of police, 63\%, indicated that they were ‘unsure’ about whether evidence was readily available through toxicology reports with cases of induced illness. Twenty-two percent believed evidence would be readily available. Viewing the results by police work area, all areas indicated a high level of uncertainty about this question: recruits (66\%), uniform

\(^{215}\) The results highlight a clear deficit in knowledge in the following areas: mandatory reporting of child abuse, the investigation of suffocation in young children; and the obtaining of evidence through toxicology testing.
(64%), detectives (63%), and SOCAU (58%). SOCAU members were marginally more informed (22%), compared to recruits (4%), detectives (16%) and uniform members (12%). Members higher in rank, whilst still relatively poorly informed of this issue, were more knowledgeable than lower ranks: senior sergeants (35%), sergeants (16%), senior constables (15%), constables (6%) and recruits (4%).

- Questions 19 and 21 explored members’ understanding of mandatory reporting requirements by professionals in Victoria with regard to child abuse. In Victoria, doctors, nurses, teachers, principals and police are mandated to report physical and sexual abuse to DHS (Child Protection), where the child’s parents have not protected or are unlikely to protect the child from harm of that type (Children, Youth and Families Act, 2005 s. 184). There is no legal requirement in Victoria for doctors or child protection workers to report child abuse matters to the police. However, protocols operating between DHS and Victoria Police, promote reporting of physical and sexual abuse by child protection workers to the police (DHS and Victoria Police, 1998).

The findings from Questions 19 and 21 revealed that a notable percentage of police members believe that doctors (62%) and DHS, Child Protection workers (50%) are legally mandated to report cases involving induced illness/injury in children to the police. Viewing the data by police work area, 82% of SOCAU members, 62% of detectives, 56% of uniform and 57% of

216 See Appendix 8.
recruits considered that doctors were legally mandated to report cases involving induced illness in children to the police. Further, 66% of SOCAU members, 50% of detectives, 44% of uniform and 49% of recruits considered child protection workers were mandated to report such cases to the police, with 5% of SOCAU members, 43% of detectives, 49% of uniform and 47% of recruits being uncertain of child protection reporting requirements. The researcher suggests these findings are important for police trainers working in the field of child abuse.

- Question 25 explored members’ understanding of the detection of suffocation in a child at autopsy. The literature reflects that suffocation of a child or young infant will not always be detected at autopsy, with some cases being wrongly diagnosed as SIDS (Boris & Brubaker, 1995; Southall et al. 1997; Benns, 2003). Almost half of the police sampled (46%) thought that suffocation of a child would be detected at autopsy, with 38% being ‘unsure’, and 15% ‘correctly’ identifying that suffocation is not always detected. The researcher is aware that whilst there have been advances in medical research in this area, cases involving suffocation of children still continue to go undetected at autopsy (refer Chadwick, 1996; Southall et al. 1997; Benns, 2003).

- Question 40 explored police members’ knowledge of the link between induced illness and Sudden Infant Death Syndrome (SIDS). The research in this area clearly reflects there is a link between the two, with a small percentage of induced illness via suffocation or poisoning
being incorrectly diagnosed as SIDS (Southall et al. 1997; Meadow, 1999; Truman and Ayoub, 2002). The majority of police, (72%) indicated they were unsure of this link, with only 9% of members ‘correctly’ answering this question. The literature emphasizes that members attending sudden unexpected infant deaths (SUDI), which also includes SIDS, require appropriate training and expertise to handle these cases (RCP and RCPCH, 2004; NSW Child Death Review Team, 2005). The findings in relation to both Questions 25 and 40 suggest that further training is required by members in this area.

Questions 26, 38 and 44 were also poorly answered by the majority of members. These questions relate to the likelihood of admissions from FII/MBP offenders, the potential for conflict to arise between professionals dealing with this abuse, and the difficulty in distinguishing FII/MBP offenders from parents of genuinely ill children.

5.10 Exploring police members’ opinions

The questionnaire contained five opinion questions. The findings from each of these questions are presented below.

- Question 3 explored police members’ views on whether police should become involved in cases of induced illness in children. The majority of police (65%) agreed that police should become involved with 27% of these members strongly supporting this position. However, twenty-
three percent of police were uncertain about police involvement and 12% thought that police should not become involved with such cases. Viewing this question by police work area, 69% of recruits, 59% of uniform members, 64% of detectives and 77% of SOCAU members believed that police should become involved with cases of induced illness in children. It is likely that SOCAU members, through their work and training, possess a higher appreciation of FII/MBP as a potential form of criminal behaviour than recruits, uniform members and detectives.

- Question 27 explored police members’ opinions about whether a doctor should confront these offenders. The questionnaire findings found the majority of police either disagreed (47%) that a doctor should confront such offenders or were unsure of this issue (39%). An analysis by police work area produced a similar result: disagreed: recruits (43%), uniform (40%), detectives (54%), SOCAU (51%); uncertain: recruits (36%), uniform (40%), detectives (38%), SOCAU (41%). The literature highlights there is tension between medical, police and child protection professionals surrounding this issue. The presence of such controversy was also reflected in the qualitative findings of this study (see Chapter 7.4). Such controversy suggests problems will arise between medical and police personnel in Victoria when faced with this situation.
Question 28 explored members’ opinions about whether covert video surveillance (CVS) in a hospital should be monitored only by the medical profession. The majority of police surveyed (71%) considered that this should not be the case. This view was held by: 77% of SOCAU members, 78% of detectives, 66% of uniform members and 63% of recruits. Unfortunately, this question did not extend any further to identify members’ views about whether police should play a role in the monitoring of CVS. However, the qualitative findings briefly touch on this area (refer Chapter 7.3.1.2).

The issue of whether a multidisciplinary team consisting of doctors, child protection workers and police should be assigned to FII/MBP cases was explored in both the quantitative and qualitative aspects of this research. The questionnaire findings showed 77% of police members surveyed agreed with a multidisciplinary approach. When looking at this issue by ‘police work area’ and ‘rank’ the findings reflected a relatively high response in favour of a multidisciplinary investigative team to manage these cases: by police work area: SOCAU (91%), detectives (76%), uniform (74%), recruits (72%); by rank: recruit (72%), constable (66%), senior constable (79%), sergeant (79%) and senior sergeant (69%). Professionals interviewed in the qualitative component of this research, also generally supported a multidisciplinary response (see Chapter 6.2).
The last question in this section, Question 45, explored police members’ views about whether mothers who induce illness in their children should be charged for their actions and prosecuted in court. The majority of police surveyed (72%) considered that such women should be charged, with 20% being ‘unsure’ and 7% disagreeing. When viewing this question by ‘police work area’ a higher percentage of SOCAU members (84%) compared to detectives (73%), recruits (72%) and uniform members (66%) felt that mothers who induced illness in their children should be charged for their actions. One might suggest the higher level of support for criminal charges by SOCAU members is not surprising given that a large percentage of their work is with child abuse victims. For alternate views posed by other professionals such as doctors and child protection workers refer to qualitative findings section 5.2.4.

5.11 Discussion

This chapter has shown that whilst the qualitative findings support police having a role in FII/MBP cases, there is much uncertainty surrounding the police role and, as revealed by the quantitative findings, a lack of knowledge by police about FII/MBP investigations.

Whilst still relatively ill informed, SOCAU members were shown to be far more knowledgeable about FII/MBP than recruits, uniform members, and CIU detectives. Interestingly, the questionnaire findings reflected that recruits, uniform members and detectives possessed similar levels of knowledge.
about FII/MBP, suggesting police experience has little influence on actual understanding of this offending, although members higher in rank were more likely to be aware of its existence than lower ranks.

The quantitative findings suggest training and/or SOCAU experience are the two key factors differentiating SOCAU members from detectives, uniform members and recruits and thus most likely responsible, at least in part, for SOCAU members’ increased knowledge about FII/MBP. Fifty-seven percent of SOCAU members surveyed indicated they had received training about FII/MBP, compared to 5% of detectives, 5% of uniform members and 2% of recruits. Interestingly, television was also revealed as a significant influence for all members in making them aware of FII/MBP, but for SOCAU members television influence was potentially balanced by their exposure to FII/MBP training and/or SOCAU experience.

Whilst training appears to have benefited SOCAU members’ knowledge of FII/MBP, it is also clear that such training is deficient in some areas and needs to be reviewed. In particular, SOCAU members were found to lack knowledge about victims of fabricated and/or induced illness; the nature and methods of offending, and the investigation and management of FII/MBP cases. Further, the low numbers of detectives and uniform members who have received training on FII/MBP compared to SOCAU members suggests FII/MBP training may not be as readily available to these members. The researcher concluded from the questionnaire findings that the initial introductory training on FII/MBP provided predominantly to SOCAU members now needs to be expanded to include additional subject areas and made
more accessible, in particular to detectives who may be assigned to such cases.

In considering the quantitative findings from this study, one must reflect on the questionnaire utilised to collect the data. In designing the questionnaire, the researcher took considerable steps to address reliability and validity issues including conducting an extensive literature review, pilot testing, obtaining feedback from professionals who possessed knowledge in the field and the inclusion of self assessment ratings. Whilst the topic of FII/MBP, and the management of such cases, has evolved since the time of undertaking this research, police training in relation to FII/MBP within Victoria has remained static and thus it is likely members' knowledge about FII/MBP has not improved.

The issue of sample representativeness and the confidence with which conclusions can be generalised about the target populations must also be examined. In order to maximise the generalization of findings, this study utilized a stratified random sampling approach with members working in uniform, CIU and SOCAU areas (see Chapter 3.5.1.4). Whilst the figures needed to generalise such findings about the target populations with a 95% confidence level and 5% confidence interval were not fully reached (see Table 5.1), the relatively high return rate, 66%, for an unsolicited questionnaire is significant and adds weight and confidence to the conclusions that can be drawn from this study, at least within a Victorian context. Further, it is suggested that members who chose not to participate in the questionnaire would most likely be less interested and perhaps less
knowledgeable on the topic of FII/MBP compared to those who responded. Findings from the questionnaire are therefore likely to be an overestimation, rather than an underestimation of knowledge levels held by police members on FII/MBP. In relation to rank and recruits, it was never the intention of the researcher to generalise such findings back to the broader populations. The aim here was simply to provide an insight into these areas at the particular point in time in which this study was conducted for consideration of police trainers.

The overall findings from this thesis are consistent with UK research conducted by Bufton (1996) (see Chapter 2.7.2). Bufton (1996) found police in the Staffordshire region were ‘unprepared’, and ‘untrained’ to deal with FII/MBP cases and those of sudden infant death. Other international police researchers, such as Fox (1995); Birge (1996) and Artingstall (1999) also suggest that knowledge held by police about FII/MBP is generally poor. While there is no reason to assume that the findings in other Australian states would be any different from those in this study, further research using national samples would be required before drawing any definitive conclusions.

Finally, the questionnaire utilised for this research is specific to FII/MBP investigations and does not attempt to explore police members’ general investigative knowledge and skills. As a police officer, the researcher suggests the nature of police work is extremely varied and requires a natural degree of inquisitiveness and investigative ability to seek knowledge where information is unknown. The qualitative findings of this study confirm this
position\textsuperscript{217}. However, it is also clear from the literature (Horwath and Lawson, 1995; Artingstall, 1999; Lasher and Sheridan, 2004), that knowledge about FII/MBP enhances professionals’ ability to recognise this abuse, make informed decisions regarding its management and to deal with the complexities that inevitably arise with these investigations. Poor knowledge, on the other hand, is thought to hinder professionals’ ability to deal with such cases and may have implications for the child victims, FII/MBP perpetrators, the multidisciplinary investigation and the professionals themselves (Artingstall, 1999; Lasher and Sheridan, 2004).

5.12 Conclusion

The findings in this chapter support the need for clarity surrounding the police role in FII/MBP cases in Victoria and for greater knowledge by police about the investigation and management of FII/MBP matters. The researcher concluded that a lack of clarity surrounding the police role, the poor level of knowledge held by police in Victoria about FII/MBP and the high level of media influence on police awareness of this abuse, may potentially lead to FII/MBP cases remaining undetected, police forming misconceptions about FII/MBP, and FII/MBP cases not being investigated and properly managed. A broader analysis of this study’s findings, incorporating some of the issues raised in this chapter, appears in Chapter 8.

\textsuperscript{217} See Chapter 4.3.2 which highlights that Police 2 and Police 3 had very limited or no knowledge about FII/MBP, yet as revealed in Chapter 5, 6 and 7 both police officers were aware that there was something wrong and pursued thorough investigations.
The following chapter presents the findings pertaining to the multidisciplinary aspect of FII/MBP cases. It examines the role of different professionals, the management of case conferences, interagency relationships and dynamics, and the need for multidisciplinary protocols to regulate and guide professionals' response to FII/MBP cases.
Chapter 6

The Multidisciplinary Response to FII/MBP Cases

There’s got to be more thought into how 'Munchausen’s is managed within police, DHS and the hospitals.

Doctor 1

6.1 Introduction

This chapter focuses on the multidisciplinary nature of FII/MBP cases, which is considered by many to be a significant part of FII/MBP investigations (Horwath and Lawson, 1995; Whelan-Williams and Baker, 1998; RCPCH, 2002; Lasher and Sheridan, 2004).

Professionals interviewed in this study identified a need for police, who may become involved with FII/MBP cases, to be educated about the multidisciplinary nature of such cases. This included an understanding of the need for a collaborative approach by agencies in handling FII/MBP investigations; an understanding of other agencies’ roles and the issues overlapping agency boundaries; and an appreciation of the difficulties facing agencies in their dealings with FII/MBP cases. The value of case conferences and multidisciplinary protocols in FII/MBP investigations was also highlighted. Finally, professionals described tension and conflict between agencies, which the researcher considered relevant for police
training. This chapter seeks to provide an insight into these topics in order to
gain an understanding of the knowledge and skills required by police in
working with other agencies.

Every effort has been made to give weight to the police findings. However,
other professionals interviewed in this research had far greater experience in
dealing with FII/MBP compared to the police members interviewed and hence
provided richer and more in-depth material. The researcher considered,
given the infancy of police FII/MBP training, the relatively recent exposure of
FII/MBP in the criminal justice arena and the multidisciplinary nature of
FII/MBP investigations, that the direct experiences of professionals, other
than police, with FII/MBP cases were extremely valuable to this research.
The researcher considered such interviews provided the breadth needed to
understand the multidisciplinary nature of FII/MBP investigations within a
Victorian context and the police training requirements for working with other
agencies. The findings in this chapter are presented predominantly from the
perspective of professionals’ direct experiences (refer Chapter 4.1), with
Chapter 8 analysing the findings from a police training perspective.

6.2 Working together

As indicated above, the majority of professionals interviewed within this study
recognized a need for a coordinated multidisciplinary approach to FII/MBP
cases and a need for police to be aware of this position.
**Police 1:** The perfect way to conduct investigations into Munchausens in my opinion is to have the medical profession, DHS and police work together as a team; with all three professions feeding off each other’s expertise.

**Child Protection 1:** It might be part of the process or strategy that you set up for these sorts of cases; that all key professionals need to be notified when the notification is made. This allows for everyone to be clear about the facts, to get the chronology, to be clear about what the next step is going to be and to keep everybody on track and make sure people aren’t getting sucked into particular dynamics that may be operating.

However, the involvement and timing of professionals in this approach varied and seemed partly dependent upon the nature of the case and the role, or perceived role, of different professionals (see Chapters 5.2; 6.3; 6.4; 7.4).

The issue of whether a multidisciplinary team (consisting of doctors, child protection workers and police) should be assigned to FII/MBP cases was also explored with police in the quantitative research. The questionnaire findings showed 77% of police members surveyed agreed with a multidisciplinary approach. When looking at this issue by ‘police work area’ and ‘rank’ the findings reflected a relatively high response in favour of a multidisciplinary investigative team to manage these cases: by police work area: SOCAU (91%), detectives (76%), uniform (74%), recruits (72%); by rank: recruit (72%), constable (66%), senior constable (79%), sergeant (79%) and senior sergeant (69%).
6.3 Understanding agency roles

Professionals identified a need for police to understand various professional roles in dealing with FII/MBP cases and the issues facing different professions. This section provides an insight into the role of medical professionals, psychologists, psychiatrists, child protection workers, and education personnel in the management of FII/MBP cases.

6.3.1 The medical role

The doctors, Psychologist 3, and the Principal interviewed in this study thought it was difficult for medical professionals to detect FII/MBP. Many professionals claimed it often took months, or sometimes years, before FII/MBP was even considered (Police 1, Police 4, Psychologist 1, Psychologist 2, Psychologist 3, Principal, Doctor 1, Doctor 2, Doctor 3, Doctor 4, Child Protection 2, Child Protection 3). The doctors, as highlighted by Doctor 4’s comments below, stressed a need for police to have an appreciation of the doctor’s position in relation to FII/MBP cases.

**Doctor 4:** I think there’s a whole lot of background stuff the police need to understand why it’s so difficult for doctors to put a diagnosis on this. Here’s a young copper who is talking to a doctor who thinks the doctor should be able to diagnose everything. ‘You know you can diagnose measles, why can’t you diagnose this?’ So there needs to be a lot of understanding of the difficulties of diagnosis. […] We do see a group of children who genuinely need to come back for lots of medical attention and testing with serious illness and recurring illness. Then there are just
a couple of cases a year that we’re involved in that might be MBP, but unfortunately they’re stuck in the middle of the 60,000 children we see. So, how do you pick them out? […] The sort of text book things that people look for, I’ve found are often unhelpful, particularly as it looks all too easy when you look at a text book and you say, ‘This is how you make your diagnosis of MBP’. In practice, things are a lot more subtle than what it suggests. I don’t think we’ve got particularly good ways of picking them out, it just takes somebody who’s sort of tuned in to the possibility.

The doctors stressed that their profession revolved around trust as opposed to the ‘suspicious’ nature of police work.

Doctor 3: The whole ethos of medicine requires that we believe what the patients tell us and that they believe that we are working in their best interests. The medical profession has a low level of suspicion. That’s a good thing, but it’s also a bad thing with these types of cases.

Doctor 4: Basically, as medical people we’re trusting people; we trust what the parents are telling us out there on the floor every day. We see lots and lots of kids and we believe what the parents are saying to us. We are not inherently cynical or disbelievers or anything like that. […] Certainly, in my experience it is not until parents have presented on many, many occasions that somebody sort of thinks, ‘Something is not quite hanging together’.
Psychologist 1 and Psychologist 3 felt police were uniquely placed compared to mental health, medical and, to a certain extent, child protection personnel to be able to approach suspected FII/MBP cases with suspicion. Psychologist 3 considered that ‘if medical personnel and psychologists worked with the suspicion that parents were making their child’s symptoms up, it would be very difficult for such professionals to do the rest of their work’.

In general, the doctors described medical professionals as reluctant to consider the possibility of FII/MBP, to diagnose this abuse and/or to become involved with such cases.

**Doctor 3:** I think that most of my colleagues are now reasonably aware of the existence of MBP. Often they tend to shy away from it. They don’t want to get involved and don’t want to investigate.

Two doctors (Doctor 1, Doctor 2) emphasized a need for medical professionals to consider FII/MBP early in their diagnosis alongside other possible causes, rather than waiting to rule out the possibility of a rare disease.

**Doctor 1:** [...] It’s not really a diagnosis of exclusion, you don’t have to do tests to try and find a disease that is so rare that there are only about seven cases that have been described in the entire world before you are willing to actually turn your mind to MBP. It needs to be in the list of possible causes and be thought of and investigated to see whether, in fact, it is so.
**Doctor 2:** [...] there’s this element of doubt that could it be some organic process. [...] Let’s make people recognise Munchausen Syndrome by Proxy relatively early and it then becomes an evidence gathering exercise, rather than ruling out the rare ‘hens’ teeth’ type medical conditions.

Child Protection 3 believed doctors occasionally needed to be ‘put under the grillar’ in relation to their handling of FII/MBP cases. She indicated that by failing to recognize or consider this abuse doctors became part of the problem and contributed to the child’s harm (this was also recognized by Child Protection 1, Psychiatrist, Doctor 1, Doctor 2, Doctor 3).

The doctors generally regarded the child’s health as paramount and saw the police role as secondary to the medical investigation.

**Doctor 4:** [...] I think police do need to be involved. I think they need to be involved early on, but in maybe a minor role at the start. The primary problems are with making a diagnosis and the well being of the child. That has to be paramount.

The researcher formed an opinion that the medical personnel interviewed in this study were caught between wanting to help and protect the family from a medical perspective whilst acknowledging that a crime may have been committed requiring the involvement of the law.

**Doctor 3:** I believe that in retrospect these cases should not have gone through the Community Services [DHS] system, but that they really
should have been reported directly to the police. After all, if we had somebody poisoning their grandmother and with the potential of killing them, we wouldn’t hesitate to work through the criminal system; we would see that as being a criminal occurrence that needed the full investigation that the police can mount and which should result in the protection of potential victims through the criminal system. So, I think we erred on trying to see the behaviour of the mother as being pathological and trying to protect the mother and protect the family. What we should have been doing was more actively protecting the child.

Two police officers (Police 5, Police 6) and two child protection workers (Child Protection 1, Child Protection 3) considered medical professionals needed a better system to detect and report FII/MBP cases. Police 5 believed medical professionals were often reluctant to report child abuse matters because of privacy issues. He further suggested that medical professionals’ ‘concerns lay primarily in getting the child well’ and that as long as this occurred ‘some considered their job complete and did not take the matter any further’.

**Police 5**: Somehow it should have been picked up that these children were having an incredible number of hospital attendances and it wasn’t. That’s the first deficiency in the system. […] The fact, also, that MBP was mentioned in the medical notes two years earlier, should have seen this case being detected a lot earlier. Multiple children died in this case.

The Psychiatrist suggested that whilst some of the older paediatricians were ‘very confident and competent’ in handling FII/MBP cases, some of the
‘younger paediatricians’ would find these cases ‘very daunting and difficult, and may mix their roles trying to be the police officer, rather than the paediatrician’. The researcher observed that in some cases, it was clear that abuse had or was likely to have occurred, yet police were not notified or had not become actively involved in the investigation (Child Protection 1, Child Protection 2, Psychologist 1, Psychologist 2, Doctor 1, Doctor 2, Doctor 3, Doctor 4).

6.3.2. The role of psychologists and psychiatrists

The psychologists and the psychiatrist generally described their role with FII/MBP cases as working in a therapeutic capacity with the mother, the children and the non-offending father. They explained that they often experienced difficulties, even with a court order, in carrying out this role as the mother would not generally commit to long term therapy and was not interested in receiving treatment. The psychiatrist indicated that part of his role may involve attending case conferences to provide an opinion about whether a case might involve FII/MBP.

The main concerns for the psychologists in working with other agencies, and in particular the police, on FII/MBP cases were fear of having their files subpoenaed at court and the potential to breach confidentiality and ethics agreements with their clients. Confidentiality of patient information was considered important in building a trusting relationship with the mother. The psychologists indicated that they would require consent from the mother before becoming involved in any multidisciplinary type discussions in relation
to a case. Psychologist 2 compared the psychologist’s role with that of a
priest, yet highlighted the same privileges of protection were not extended to
psychologists. She stated psychologists’ files were often used
inappropriately in the court environment to the detriment of the
mother/psychologist relationship. She suggested that such files should be
made available to the judge, but not to everybody else involved with the case.

6.3.3. The child protection role

The child protection workers in this study became involved with a FII/MBP
case either through a notification by medical personnel or existing DHS
involvement with the family. The child protection workers stated DHS
involvement with FII/MBP cases was generally dependant upon a medical
diagnosis and the support of medical personnel at court. The critical issues
for DHS with FII/MBP cases were to establish the risks for the child, working
out how to ensure the safety of the child, and identifying when to return a
child to his or her parents. Risk assessment was seen as being particularly
difficult due to the lack of evidence typically associated with these cases, the
deceptive and relatively intelligent nature of some of these offenders (see
Chapter 4.5.1), and the passive and defensive stance often adopted by the
spouse and extended family towards the perpetrator (see Chapter 4.6 and
below). Risk assessment with siblings was thought to be even more
difficult. Child protection workers considered it important that police were aware of the difficulties in conducting risk assessments with FII/MBP cases.

**Child Protection 2**: The difficulties in implementing the orders were endless. One of the real tensions for Child Protection then, as now, is that we in fact lack evidence as to what the risks are. [...] There was a lack of understanding of what was going on for the mother who was the perpetrator. There was an absence of acknowledgement of responsibility by the father for his role. The grandparents basically couldn’t accept that the children were at risk. [...] The critical issue I suppose, was working out when the younger children could go back to parental care and how we’d define safety. [...] It is very, very difficult to predict what the risks are going to be in the future and it takes a lot longer than usual to get an understanding of triggers and parental functioning.

Child Protection 2 stated DHS’s role was governed by the *Children and Young Persons Act, 1989* (CYPA), with section 63 the critical section for grounds to initiate a protection application. She indicated DHS’s involvement would depend on how the mother presents, what the actual concerns are, whether there is evidence of abuse and where the child is placed. Child Protection 2 claimed it was not DHS’s role to actually investigate and establish the evidence first hand, but rather to coordinate and collate the evidence and focus on managing and reducing the frequency of medical

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218 Assessing and proving risks facing siblings in FII/MBP cases was described as being particularly difficult for DHS because generally, at the time of assessment, there would be no evidence of abuse with these children (Child Protection 1, Child Protection 2). Child Protection 2 indicated that child protection workers must make some likelihood arguments regarding the potential for siblings to be harmed. She considered that this was not done particularly well by child protection staff and not particularly well accepted by the courts, although also indicated that evidence with siblings may be 'far too nebulous and abstract' to meet the requirements of the courts.
intervention. Child Protection 3 believed DHS lacked the resources to fully carry out an investigative role, but also considered that DHS were too reactive in their current approach with FII/MBP cases and needed to adopt a more proactive approach in ensuring the protection of the child. She also considered that the CYP A legislation, with its focus on working in partnership with families and the reunification of children, failed to take into account the seriousness of FII/MBP cases and the likelihood of significant harm for child victims. Finally, Police 5 believed DHS needed to ‘strengthen their investigative styles and probably be a little bit more regimented and less social worked in order to be able to prevent this abuse from happening’.

FII/MBP cases that contained little or no evidence were considered ‘trickier to manage’ for DHS. Child Protection 4 suggested such cases would be managed along similar lines as those involving sexual abuse, with DHS attempting to link these families to monitoring agencies. Child Protection 4 indicated that DHS would then rely on the ‘staying power’ of these agencies and on their ‘commitment to re-notify’ if suspicions of abuse arose. Child Protection 4 suggested this was not a ‘sure fire way’ of managing these cases, but indicated it was ‘difficult to do much else where there was no evidence to substantiate suspicions’. Child Protection 1 and Child Protection 4 both highlighted the existence of high risk infant (HRI) workers for cases of child abuse involving children under the age of three years.
Monitoring of families

Several professionals identified a problem in suspected FII/MBP cases with the protective system’s ability to monitor such families over a lengthy period of time. Child Protection 3 cited deficiencies in the CYPA 1989 (see below). Others (Police 5, Doctor 1, Doctor 2, Doctor 3) identified a tendency for some of these families to move address, making monitoring difficult.

**Child Protection 3**: We can’t check up on kids in a year’s time. Once a case is closed it is not reopened unless someone in the community makes another notification. […] The law doesn’t realistically allow us to work with these cases; we are in and then we are out. There’s no monitoring body, and the mother will continue to shop around. The likelihood of picking it up is difficult.

In contrast, Child Protection 2 outlined a historical FII/MBP case in which a court order enabled her to monitor a family over a two year period. Child Protection 2 indicated that having a DHS worker turn up once a week ‘come rain, hail or shine’ was what ‘protected the children’, highlighting there was always ‘somebody watching, monitoring and questioning’. She stated:

**Child Protection 2**: My sense was that the real safety was nothing I did or didn’t do, but my presence and the fact that it was out in the open and there was a network that had some understanding of what the risks actually were.
Child Protection 2, however, also suggested the world was different in the 1980’s and thought that it would be more difficult to instigate such monitoring nowadays. She also considered that the level of litigation was nowhere near as significant in the 1980’s as now, and that parents were much more likely to be cooperative and consent to protective orders.

Finally, Doctor 2 and Child Protection 4 highlighted issues with monitoring and supervising a suspected child victim of FII/MBP within the hospital environment. Doctor 2 indicated that hospital personnel generally considered it was not their role to supervise a child within the hospital in order to prevent offences and suggested this role fell to DHS. Child Protection 4, on the other hand, explained that from a DHS perspective, the hospital was a relatively safe environment where supervision could be provided and that the hospital had a duty of care towards the child. However, she also acknowledged that as these mothers generally stayed overnight within the hospital it would be ‘pretty heavy work’ for the hospital to effectively supervise them. She stated if the child’s physical safety was threatened, or a mother attempted to remove the child from the hospital, that DHS would then intervene.

6.3.4 The role of the school

The Principal stated that whilst a school’s role was to teach, there was little point in teaching children who had been abused the night before. The Principal highlighted a case involving a mother who fabricated an extensive range of illnesses in her ten year old child, as well as alleging that she suffered from an intellectual impairment for which the mother claimed an
allowance. The child missed many days of school, was restricted in her schooling activities, and frequently attended school appearing drained and fatigued from allegedly having been up all night sick.

The Principal highlighted that, at the time of this case, education professionals were discouraged from interfering with families and felt very uncomfortable in dealing with child abuse matters\(^{219}\). He suggested the school had placed this family into the ‘too hard basket’. He indicated that the child had two older siblings who had endured similar problems prior to his arrival at the school. The Principal identified one of the main issues facing the school was in collecting sufficient information to enable a notification to police and child protection personnel. He indicated the school possessed only one small part of the case and ‘did not have the authority, the power, the ability or the skill to track the mother down’. He stated initially he had received little support from outside agencies and basically had to rely on his own intuition and investigative inquiries to get results.

Principal: We didn’t have the kind of guidance in the system at the time to give us some framework with which to make considered decisions. So, we found ourselves making considered decisions based almost on intuition. [...] I was told by other people I was mad taking someone fronting up to court. But, anyway, we weren’t mad.

At the time of this case, the idea of pursuing criminal charges with FII/MBP cases was not common practice. The main focus by police with this case

\(^{219}\) This case occurred more than twenty years ago.
was therefore in working with DHS and the school to ensure the safety and well being of the child. The Principal and Police 3 considered that the school and police had a fairly good working relationship when it came to dealing with child abuse matters (Principal, Police 3)\textsuperscript{220}. In addition, a home school liaison officer played a significant role, within the school, in the management of child abuse\textsuperscript{221}. The principal considered it was important that police had an understanding of the difficulties for schools in reporting suspected abuse with little evidence to support such suspicions and that it was important for police and child protection to work with schools.

6.4 Case Conferences – Coordinating the investigation and management of FII/MBP cases.

Case conferences were generally seen as essential for professionals to share information and plan a suitable response. Professionals generally identified a need for police to be involved in case conferences and for police to have an understanding of how case conferences work and of police requirements. A number of professionals further identified areas where case conferences might be improved. This is of relevance to all professionals involved with FII/MBP cases, including police.

**Police 1:** You need to bring professionals together from different professions to help coordinate the management of these cases. Each

\textsuperscript{220} Police 3 highlighted that the school was very knowledgeable with regards to police requirements and knew not to question the child or to interfere with potential evidence. In turn, police had respect for the school environment and were discreet in their dealings with pupils.

\textsuperscript{221} The Principal indicated that the home school liaison officer (HSLO) would assist children whom the school suspected were having difficulties other than with their schooling. The Principal indicated that this system had worked extremely well with child abuse cases; with the HSLO assisting children through relevant court proceedings.
profession has their own agenda that can impact on another agency’s role. Police need to know about case conferences and their requirements with such conferences.

**Doctor 3:** I think that it is essential to have case conferences. You can’t conceivably manage such a case without involving many other professionals both within the hospital organization, within the community and within the protective forces, both police and Department of Human Services.

Child Protection 2: I think prior to the mother being confronted my preference would be that there is a case conference to discuss, pool and share information. I see no reason why police shouldn’t be part of that.

The psychologists, however, whilst acknowledging the importance of professionals working together in addressing FII/MBP cases, had some concerns about direct involvement in this process, due to ethical and confidentiality obligations to the mother.

**Psychologist 2:** How do we know it’s MBP? It’s almost like a circular thing, you’ve got to get everybody together to get all the info together and know it’s MBP, yet by doing that you’re already breaking confidentiality. So, it’s tricky.

All professionals, except for two police officers (Police 2, Police 5), had attended a multidisciplinary case conference relating to FII/MBP. Doctor 1, whilst acknowledging the importance of case conferences, found them to be
relatively unproductive as the police officers generally wanted a fairly firm diagnosis and clear evidence of abuse and the DHS workers were typically junior and inexperienced.

The actual organization of FII/MBP case conferences, which may include up to 20-25 professionals, was noted to be a logistical nightmare (Psychologist 2, Psychologist 3, Child Protection 1, Psychiatrist). It was highlighted that careful consideration needed to be given as to who was invited to attend such meetings (Doctor 1, Doctor 2, Doctor 3, Child Protection 1, Child Protection 4, Psychiatrist).

Doctor 3: It's very much a matter of making sure it's people who need to know are informed, you have a conflict; you need to protect the child whilst you're investigating the situation to try and prevent any further episodes. But, on the other hand, the more people who are informed the higher the risk is that confidentiality will be lost [...]. And of course, the more people you involve the more likely you'll come across somebody who does not believe the diagnosis and will side with the parent and tell them everything they know.

Doctor 2, Doctor 3 and Doctor 4, the Psychiatrist and Child Protection 1 noted that some of these mothers formed close relationships with medical personnel and vice versa, resulting in information potentially being prematurely leaked and the child's safety placed at risk. Further, some professionals were described as unable to accept that mothers could harm
their children in this manner. The inclusion of such staff in FII/MBP case conferences was thought to be counter-productive.

The timing of police involvement in FII/MBP cases, as highlighted in Chapter 5.2, is somewhat controversial. However, many regarded early police involvement as essential due to the complexity and seriousness of this offending. Psychologist 2 described one case conference which police attended. She noted that the police attendance had made a ‘big difference’ as they helped to ‘shed a lot of light on things and to get things to move’. She considered that ‘sometimes DHS feel powerless to act’.

Parental notification and/or the involvement of parents in case conferences was also a contentious topic, although the majority considered it inappropriate to involve or inform such parents of professionals’ suspicions until there was sufficient evidence to support such beliefs (Police 1, Police 3, Police 4, Psychiatrist, Child Protection 1, Child Protection 4, Principal, Psychologist 3, Doctor 1, Doctor 3).

**Police 4:** I would have preferred not to invite the mother as I knew she would just thrive on all the attention, which is exactly what she did.

**Psychiatrist:** It isn’t very helpful to forewarn the family if you’re considering the diagnosis of MBP, until you’ve got all your evidence and all the stories from all the people collected. [...] It becomes defensive, it gets the lawyer in and it makes it very difficult to collect the data that you need.
By contrast, Psychologist 2 felt parents should be notified early of professionals’ suspicions and, where possible, included in FII/MBP case conferences. Police 4 and the Psychiatrist interviewed in this study, also indicated that they had had involvement with child protection workers who held this view.

Five professionals (Child Protection 1, Child Protection 4, Doctor 1, Doctor 3, Psychiatrist) stressed that professionals needed to plan a coordinated approach for dealing with the parents. The Psychiatrist described a case conference in which he was asked for his opinion about the possibility of FII/MBP. He stated he had spoken freely about the case and had indicated that ‘from what he understood it seemed quite possible and consistent with that sort of picture’. The child protection worker subsequently included his comments into the case conference minutes and circulated these to the family. This placed the Psychiatrist in an awkward position, ‘as the mother now saw him as part of the persecutory system’ which made any future therapy work difficult with the family. The Psychiatrist felt DHS should not have released such information and at the very least should have consulted with him prior to doing so.

Several professionals cautioned that parents may indirectly become aware of doctors’ suspicions of maltreatment through accessing their child’s medical files (Psychiatrist, Doctor 1, Doctor 2, Doctor 3, Psychologist 3). Professionals warned that such action could endanger the child and jeopardise the investigation. Doctor 3 suggested doctors were ‘not very good at hiding what they were doing, because this was not what they were in the
business of doing most of the time’. He also indicated that ‘hospitals by their very nature were very open places with very poor security of information’.

The Psychiatrist further commented:

**Psychiatrist:** [...] you have to assume that the parents are going to be able to read what’s written in the hospital record either with or without permission. If the child’s in hospital for a week, it’s not uncommon for a parent to flick through their file late at night when there is no-one around or quite legally get access to it through Freedom of Information. That’s happened on a few occasions.

Finally, the Psychiatrist and Doctor 1 identified that case conferences need to be chaired by an experienced professional with knowledge of FII/MBP and of the likely multidisciplinary issues to emerge. They indicated they had been involved with meetings led by too junior and inexperienced DHS staff who had encountered difficulty in managing the varied and complex issues that arose during the meeting. In contrast, Child Protection 1 and Child Protection 2 identified problems with medical professionals and their use of medical jargon and described feeling slightly intimidated by all the medical specialists. They emphasized the need for medical terminology to be clarified for non-medical personnel. Finally, Child Protection 1, Doctor 2, and the Psychiatrist highlighted problems with case conference attendees speaking on behalf of others or failing to remain for the entire conference making it difficult to clarify issues.
6.5 Interagency relationships and dynamics

Overall, professionals in this study described effective and ineffective working relationships between agencies. The researcher observed at times there appeared to be a lack of trust, understanding, respect and team work between professionals in managing this abuse. In most cases some form of conflict arose between the responding professionals. This conflict appeared to be the result of differing perspectives and organisational practices, the blurring of role boundaries, and a lack of similar expertise. Further, the lack of concrete evidence typically associated with such cases, privacy legislation and bureaucratic hurdles in obtaining and sharing of information contributed to such conflict. Finally, some professionals were thought to have a poor attitude towards child abuse cases and a reluctance to become involved in such matters. The examples below highlight the different dynamics operating between agencies in this study.

**Police 3:** Whilst one doctor was really great, you had some medicos who didn’t know or didn’t care or both and that compounded problems.

[...] We had to go through this DHS forum process which was in my opinion fairly farcical. It took a long time before cases could be brought before this committee and that meant the kid was at risk in the meantime.

[...] we did have the advantage of a very good network of welfare workers in those days. We were able to get reports from the schools, the high school where the older girls had been or were still at, and from the psych services with mum’s history, and the history of one of the older
There was a fairly blanket decision made amongst all the different people that dealt with kids that if it benefited the child in the long run you did it. No one even considered getting permission in those days. I suppose we all trusted and knew each other.

**Police 5:** It’s not that staff don’t want to work with us. I mean some of the stuff that goes under the table between DHS and the police to get the job done. It is wrong that you have to do that. That’s the problem there’s too many stumbling blocks.

**Police 4:** So DHS rang the SOCA unit and said, ‘Look we have no ability to respond to this, can you go in our place?’ We attended and worked closely with DHS. [...] The doctor drove all the way from Melbourne to [country location] to be involved in the case conference. [...] DHS wanted to invite the mother to the case conference. I didn’t support this position as the mother would just thrive on being the centre of attention, which is exactly what occurred.

**Principal:** [...] and that was when I really became constructively aggressive that we had to do something. I made contact with police, and I rang the doctor and spoke to him. [...] He was a really lovely man, but his first reaction was, ‘Look I don’t really want to get involved’.

[...] there was a forum held with police, medical, court, lawyers, social workers. It was a DHS thing, a pilot project. When I came out of that meeting I felt really satisfied that there had been a good understanding of what our concerns were within our knowledge.
Child Protection 1: […] at that stage we went out and consulted with the mental health service. We’d actually spoken to them before we went to the house and had asked if they would come with us, they weren’t able to. […] So we got on the phone at the house and we said to the psychiatrist we’re a little bit worried about this woman and about the situation; can you give us some advice. […] I don’t think he had much experience, he was saying to us, ‘Oh may be you shouldn’t be removing the child, may be that’s the worst thing you can do’. […] he was really minimising I suppose what was going on. […] and we got really confused by that […], so we thought, ‘Okay you’re telling us that may be we are doing the wrong thing’. So it was just really lots of conflict.

Child Protection 2: […] the family refused to continue working with the hospital that had originally diagnosed the disorder and changed hospitals and the two consulting psychiatrists, both of whom were very well respected practitioners, had differing views on how to manage the case. […] Although the Department [DHS] and the hospital didn’t always agree on directions, I think there was a terrific team working with that family.

Psychiatrist: The surgeon was quite convinced that there was no possibility that the mother had fabricated or induced the hematuria whereas others involved felt it was quite possible.

Doctor 3: We spent a lot of time and effort persuading the Human Services Victoria that this was really what was happening. […] The social worker and non-governmental agency unilaterally decided that she did not believe the diagnosis and that the whole process, including the Magistrate’s decisions, was incorrect. She then, I believe colluded with
the mother to progressively exclude from on-going involvement anybody who had contact prior to the case going to court. […] We as an institution and I as an individual argued strongly against that and wrote many letters to the Community Services Victoria.

Internal conflict was also present within single agencies (Doctor 1, Doctor 2, Doctor 3, Doctor 4, Psychiatrist, Child Protection 2, Child Protection 3, Police 1). Examples include differences in opinion about whether a case involved FII/MBP (Child Protection 3, Police 1); differences in how cases should be managed (Police 1, Police 3, Police 4, Child Protection 1 Child Protection 2, Child Protection 3, Child Protection 4, Doctor 1, Doctor 2, Doctor 3, Doctor 4, Psychiatrist, Psychologist 2; Principal); disagreement between police bosses as to whether a matter warranted police investigation (Police 1, see below); and disagreement between child protection staff as to whether a child should be removed from the mother’s care and/or the timing of his or her return (Child Protection 1, Child Protection 2).

**Police 1**: Some bosses said it was a load of rubbish and others said to go ahead with it. It was a very difficult situation and very frustrating. I knew something was wrong but others just couldn’t see it. They either didn’t want to touch it, were not interested or thought it was over the top.

Differences in opinion, particularly with nursing staff, at times created a division between staff members (Psychiatrist, Doctor 2, Doctor 4). Two child protection workers and one police officer highlighted differences in medical opinion could impact on their protective and criminal roles respectively. Child
Protection 1 identified that because medical professionals were in disagreement about the child’s position this naturally created doubt for her and made her role in dealing with the mother more difficult.

Child Protection 3 stated she was unable to initiate protective proceedings because medical professionals disagreed about whether the mother was causing her child’s illness. Similarly, Police 1 indicated that a difference in medical opinion, surrounding whether a child had died of abuse or SIDS, had impacted on the police investigation and chances of a full coronial inquiry.

Doctor 1 emphasized that it was ‘an absolute disaster to have ongoing conflict between professionals’ with FII/MBP cases. Several professionals stressed a need for professionals to be open about their differences in order to arrive at an agreed course of action (Child Protection 1, Child Protection 2, Doctor 1, Doctor 2, Doctor 3, Psychiatrist).

**Police 1:** Internal politics need to be cast aside as the lives of innocent, helpless children are at risk.

**Child Protection 2** [...] it’s probably really necessary that you’ve got a good profession support network where you can really bounce ideas off each other, and that the professionals who are working with such a family need to be very supportive of each other and very, very open about their differences. Certainly professional disagreements can blow a case apart when it’s Munchausens.
Finally, a number of professionals identified a lack of follow up with child victims of fabricated and/or induced illness and a lack of feedback to professionals about the eventual outcome with these families.

6.6 Multidisciplinary protocols

Many of the professionals interviewed considered that Victorian professionals would benefit from the development of multidisciplinary protocols to assist in the management of FII/MBP cases (Police 1, Police 3, Police 4, Child Protection 1, Child Protection 3, Child Protection 4, Principal, Doctor 1, Doctor 3, Psychiatrist).

Police 4: I think these cases are very messy and complex. Anything that can assist professionals in their response would be beneficial. I know I would certainly have benefited from some guidelines or protocols.

Child Protection 1: The hospital needs to have a system for managing these cases. Once they get to a point where they are dealing with something concerning, there needs to be a way of everybody else being able to manage them as well. [...] some sort of protocol or plan of action or management plan to deal with these sorts of cases, which really should involve the Police, DHS, everybody that needs to be a part of these cases. [...] If you want to make it easier for people to deal with complexity then you have to have some clear structure stuff that people need to do or need to follow. Otherwise, people just get seduced into whatever mum or dad’s issues are.
**Doctor 1:** MSBP cases are not well managed in Victoria. It is basically left to the Paediatric doctor to make the diagnosis and he of course may have very little experience, because it is not a common condition. The Department [DHS] finds it a very difficult subject also and usually wants absolutely conclusive proof before they will do anything. The police also find it fairly difficult to deal with. […] There is no protocol, or guidelines as to how it is dealt with. Each case is basically dealt with as it arises. Some cases are dealt with well and some aren’t. There’s got to be more thought how MSBP is managed within police, DHS and the hospitals. […] If some agreed protocol could be thrashed out, it would mean that these very difficult cases could be managed better.

### 6.7 Conclusion

Professionals interviewed in this research generally considered it important that police understand the role of other agencies in dealing with FII/MBP cases, the challenges facing such agencies in their dealings with this abuse, and the importance of case conferences and a coordinated approach to managing FII/MBP cases. Further, the chapter has captured the potential for tension and conflict to arise between professionals involved in FII/MBP cases and suggests the need for multidisciplinary FII/MBP guidelines to be introduced in Victoria to provide clarity for professionals involved. An analysis of these findings from a police training perspective is presented in Chapter 8.
The next chapter examines the investigative techniques applicable to FII/MBP investigations and provides an insight into the issues associated with such techniques.
Chapter 7

Investigative Techniques applicable to FII/MBP

The mother will argue black and blue that it’s not happening and you've got a father too saying that it is ridiculous and absurd. How do you prove it? You can’t just get up in court and say it's your gut feeling.

Psychologist 3

7.1 Introduction

This chapter focuses on potential avenues of investigation of FII/MBP cases and contains a number of sub-themes. The material presented in this chapter is predominantly qualitative with some reference to the quantitative research. Professionals interviewed generally identified a need for police, who may encounter FII/MBP through their role, to be trained in FII/MBP investigations and to possess knowledge of potential investigative techniques applicable to such cases and the strengths and weaknesses associated with such techniques. As such, this chapter presents the investigative methods described within this research and explores issues associated with such techniques. The analysis undertaken in Chapter 8 examines these findings further and draws upon the FII/MBP training literature to draw conclusions about the police FII/MBP investigative training requirements.

As with Chapter 6, many of the findings in this chapter are presented from the perspective of professionals other than police, due to their greater
involvement and experience in dealing with FII/MBP cases. However, the researcher suggests such findings are invaluable for police training given the multidisciplinary nature of FII/MBP investigations and limited research in this field within Australia.

7.2 Suspecting FII/MBP

The interviews reflected that the detection of FII/MBP generally occurs over a period of time through an accumulation of information and an ability of professionals to consider the possibility of such abuse (see below). Five professionals believed FII/MBP cases were often placed into the ‘too hard basket’ and not acted upon appropriately (Police 4, Principal, Child Protection 1, Child Protection 2, Doctor 3). Professionals in this study described a range of observations of the child and/or his or her family (presented in Appendix 21) that raised their level of suspicion of FII/MBP and suggested police needed to be aware of factors that may trigger concern.

Doctor 1: In my mind it is a penny drop diagnosis. What happens is the doctor is puzzled because the child doesn’t improve with the normal treatment that is given. The disease doesn’t fit any known described disease and the doctor is puzzled as to why the child is not improving. It’s often a colleague who might mention casually, ‘Have you considered that perhaps the parent might be doing something to the child?’ I’ve seen that happen once, and the sort of sudden stunned look that came across the face of the doctor involved. He sat down and didn’t say anything for about 10 seconds and then politely said, ‘Oh my God’. So it is that penny
drop diagnosis. You don’t think about it, and as soon as you do, the little bits start to fall into place.

Doctor 4: Certainly in my experience, it is not until parents have presented on many, many occasions that somebody sort of thinks something is not hanging together. [...] It’s my experience it’s not something somebody comes out with one day: ‘You know I think it’s this’. People maybe get a feeling in the back of their mind, ‘Gee, that’s a little bit odd’, but you accept that people behave oddly sometimes. Then one staff member will mention it to another staff member that it as a bit odd and then finally something drops at the end of the day.

Child Protection 2: It was only over time when you looked at the indicators that you started to question what was really going on.

Psychologist 3: Getting to the point where everyone is really sure of what’s going on takes so much time and the problem is that before this point there is often many years of multiple, multiple agencies and of professional involvement with the family.

Principal: As you can see it was a mystery bag we just didn’t know. Everybody knew [...] things weren’t as they should have been. It had been clearly identified that this poor girl had been an issue in this school for some time. People had placed this case into the too hard basket. They weren’t prepared to go that next step.
7.3 Collecting and gathering the evidence

7.3.1 Surveillance of the child and family

In endeavouring to confirm or disprove the existence of FII/MBP, two formalised surveillance methods were described by professionals interviewed in this study; separation of the mother and child, and covert video surveillance. A need was identified for police to be familiar with such methods and the strengths and weaknesses associated with such techniques. A brief overview of these surveillance options is, consequently, presented below.

7.3.1.1 Separation of the mother and child

Two of the doctors (Doctor 2, Doctor 3) raised separation of the mother and child, as a potential method for collecting information with FII/MBP cases, although Doctor 2 also stated that medical personnel would require a court order by DHS to initiate such a process as medical personnel had ‘no right to prohibit a mother from seeing her child’ and the process was ‘too risky to implement on a voluntary basis’. Doctor 3 highlighted that medical professionals would generally already possess a substantial amount of evidence regarding the possibility of FII/MBP before considering separation as a means to support that belief. He pointed out that separation evidence was only one small part of an overall investigation, but could help to ‘consolidate a case’. He further indicated that police, and other professionals, also needed to be mindful that it ‘may be only a coincidence that a child recovers in his or her mother’s absence and gets sick again on
the mother’s return’ as ‘some naturally occurring diseases could fluctuate in their presentations’. Finally, he emphasized a need for any professionals, considering the use of separation, to ensure that the mother does not attempt to access her child through indirect means.

**Doctor 3:** The effect of the separation is the back-up evidence and you’ve got to not only exclude the parent, but everybody else who might act as a vector between the mother and the child. We’ve had circumstances where the mother gave the grandmother something [...] to bring in and feed the baby or spoke to the lady in the kitchen saying, ‘My child’s a patient in the ward. Would you mind just making sure that he gets it?’ Of course, the lady in the kitchen is not privy to the diagnosis and the investigation and she’s just being nice and helpful and being kind in a way that we’d expect people to be kind to mothers of sick children.

Doctor 3 and Child Protection 1 both described cases in this study where separation of the mother and child happened by default and the child’s health improved remarkably in the mother’s absence\(^{222}\) strengthening professionals’ beliefs that they were dealing with a FII/MBP case.

### 7.3.1.2 Covert video surveillance

The topic of covert video surveillance (CVS) in hospitals to detect induced illness was explored with four of the six police officers and the four doctors\(^{223}\). All professionals interviewed on this topic, except one doctor (Doctor 2),

\(^{222}\) In the case of Doctor 3 the mother was hospitalized and in the case of Child Protection 1 the mother became involved with other family matters and was unable to attend the hospital for several days.

\(^{223}\) The issue was not explored with Police 2 and Police 3.
considered that covert video surveillance should be a viable option for professionals in cases of suspected induced illness in children. Two contrasting doctors’ comments in relation to the use of CVS follow:

**Doctor 2:** I have some difficulty in just ethically dealing with a concept that says you allow a child to have further harm done to them in order to gain evidence. You wouldn’t send kids home to get two more fractures before you went, ‘Right, we’ve got enough evidence now to go to court’. We’d jump in there and try to prevent the harm at all costs. In covert video surveillance, we are putting these, usually infants, in a very dangerous situation, a risky situation where we honestly believe there’s such sufficient risk of harm that we want to catch it on video and we’re not prepared to sit here for three weeks to do it. I wonder whether we’ve already got enough evidence to go at least to the Children’s Court and say, ‘This is the evidence on which we’re concerned, now you assess whether there’s enough there to act’. Most of the time there is. I think we’re probably too hesitant to say, ‘We’ve got enough evidence’. Covert video surveillance is great for the criminal prosecution, but the question is, ‘Is criminal prosecution the best management for these cases?’ And I don’t know.

**Doctor 3:** I think that covert video surveillance is justifiable. I think it has to be regulated very carefully and it has to be only undertaken where there is a reasonable level of suspicion. I think it should be the responsibility of the police force to actually do the surveillance, but I think the hospital authorities and DHS need to be involved in the decision of each individual case at the highest level. I think it is justifiable, the same
as if there was a person out there who was going to shoot somebody, it would be justifiable to undertake covert surveillance in order to obtain the evidence to protect the person who was going to be shot.

Doctor 1 highlighted that CVS was considered for use with one of his cases, however, did not proceed due to numerous issues arising, including: who would watch the surveillance, the criteria for intervention, where and how the equipment should be set up, the costs of such surveillance and medical legal staff wanting to notify the mother of the surveillance prior to implementation.

Both Doctor 1 and Doctor 2 believed there were still many issues to be resolved surrounding the use of CVS in Victoria and recommended a working committee, of which police needed to be included, be established to undertake this task. Doctor 1 stated

**Doctor 1:** It doesn’t mean that we should necessarily use it, but at least the topic should be given a thorough discussion and, if it were introduced, the issues around how we should do it would be sorted out. At present people are very confused. Perhaps they have vaguely heard about video surveillance, but haven’t really gone through all the issues about how it would be established if, in fact, that could be done. If we could actually set out how it could be established, then I think people could argue for and against it from a position of greater knowledge. It may well be that people still feel it shouldn’t be done. My personal opinion is that it should.

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224 Doctor 2 indicated that CVS was a complex issue and although not supportive of the process, suggested if it were to be implemented it would be ideal to have a group of experts to work out under what criteria it would be reasonable to use, how it should be implemented, who should fund it, and who should be monitoring it.
Police 1 stressed that CVS exists in service stations, nightclubs and in our city streets to prevent and capture criminal activity and is regularly used by police to investigate crime. He emphasized that ‘you can’t leave a mother to play Russian roulette with her child’s life’ and that if ‘CVS could assist in preventing a child from being potentially murdered then it should be an option’. Police 6 considered that, although the technique was extremely resource intensive, it was justified where the circumstances of the case warranted such action, such as the child’s life being at risk and/or previous child deaths. Police 4, whilst supportive of CVS, also considered it to be a legal nightmare and thought the admissibility of CVS within the courts would be dubious. Police 6 indicated that in order to implement CVS in Victoria, police would require, under the Surveillance Devices Act, the permission of the occupier, which in FII/MBP cases would generally be the hospital, and authorization by the Supreme Court for a surveillance warrant. Police 6 suggested police may experience difficulties in securing sufficient evidence to be able to apply for such a warrant, indicating that some judges would deny such action based on the grounds that police were just ‘fishing for information’. Both Police 5 and Police 6 considered that where police have requested the use of CVS then they should be responsible for its implementation and monitoring. Police 1, 4, 5 and 6, despite the issues raised with CVS, believed police should be educated about CVS and its advantages and disadvantages and skilled in its usage.

Finally, the quantitative research explored members’ opinions about whether covert video surveillance (CVS) in a hospital should be monitored only by the
medical profession. The majority of police surveyed (71%) considered that this should not be the case. This view was held by: 77% of SOCAU members, 78% of detectives, 66% of uniform members and 63% of recruits. Unfortunately, this question did not explore whether police should play a role in the monitoring of CVS.

7.3.2 The collection of physical evidence

Most professionals interviewed in this study described a lack of concrete evidence associated with FII/MBP cases. Further, three police officers believed that it may be difficult to reach the standard of evidence, ‘beyond reasonable doubt’ required by the criminal courts (Police 1, Police 5, Police 6). Police 5 believed court cases were very much reliant upon medical findings.

Three avenues of investigation to collect physical evidence in connection with FII/MBP cases are presented below: specimen analysis, medical files, and crime scene investigation\(^\text{225}\). Professionals spoken to about such topics generally felt police should be made aware of the issues raised.

7.3.2.1 Specimen analysis

The topic of specimen analysis was discussed with three of the four doctors (Doctor 1, Doctor 2, Doctor 3). A number of issues were raised. Firstly, the doctors stressed that police needed to be aware that routine toxicology screens do not necessarily detect all foreign substances and that

\(^{225}\) Covert video surveillance is also of relevance to this section (see section 7.3.1.2).
toxicologists require input from professionals about what substances to test for and how an offending substance might come to be present in the child’s system. Secondly, the importance of methodical procedures surrounding the collection and handling of specimens was emphasized, particularly for the purposes of court proceedings (Doctor 1, Doctor 3). Thirdly, Doctor 1 and Doctor 3 suggested police needed to be aware that these mothers may raise all sorts of accusations in relation to the collection and testing of specimens; may directly attempt to interfere with the analysis process; and/or lay blame on everyone but themselves for a positive finding.

**Doctor 1:** The specimen was divided into three parts and was analysed in three laboratories. The mother never acknowledged that she had been giving laxatives to the child. She said that the test was wrong and she wanted the test repeated. She wanted to talk to the laboratory staff who’d done the tests, as perhaps they had put something in the specimen. She blamed nursing staff for muddling up the specimens or for taking it from someone else. At one stage she blamed the nursing staff for secretively putting laxatives in the child’s stool. Her accusations became increasingly bizarre and fanciful, but at no stage did she acknowledge that she had done it herself.

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226 Child Protection 2 detailed a case where every time the kids got sick the mother, allegedly at the doctor’s request, would scrape vomit samples off the floor and take it to the doctor for analysis. However, the doctor would invariably send the results back saying, ‘Well, it doesn’t test for anything because we’ve got to know what to test for before we can validate it’. Child Protection 2 indicated that it was really quite a game for the mother. In another case, Psychologist 3 described doctors as at a loss as to why the child had bacteria in her system that was consistent with pond water. It wasn’t until the mother was found by nursing staff injecting her child with water from a flower vase located next to her child’s bedside that the findings made sense.
Finally, Doctor 3 suggested police also needed to be mindful that some professionals may be reluctant to stand by their findings because they do not wish to become involved in child abuse matters. Doctor 3 described one case where something was found in a baby’s stool that was incompatible with normal infant stools. However, this finding was later withdrawn. Doctor 3 suspected the withdrawal of such findings had occurred not because the finding was not true, but because people did not want to become involved. Doctor 3 believed the mother had endeavoured to mislead him by exchanging the baby’s stool for an older child’s.

7.3.2.2  The family’s medical files

Most professionals interviewed identified that police needed to be aware that the family’s medical files are an essential source of inquiry with suspected FII/MBP cases and that child victims of FII/MBP will frequently have volumes of medical files (Police 1, Police 3, Police 5, Doctor 1, Doctor 3, Doctor 4, Child Protection 2, Child Protection 3, Psychiatrist). Professionals highlighted that police needed to be mindful of the potential for false and uncorroborated medical history in FII/MBP cases (Child Protection 2, Child Protection 3, Doctor 1, Doctor 2, Psychiatrist).

Police 5: The collation and obtaining of the medical records and/or grouping the hospital records is important but a humungous task. However, from an investigative point of view I need to read all of those records before I speak to the doctors, its pointless talking to the parents until I’ve got an appreciation of the situation.
**Doctor 1:** A lot of medical involvement in these cases does involve going back over old files, talking to other doctors and institutions that have been involved with this child or sometimes other children in that family, to try and build up a picture of what’s happening […], you have to go back through all the notes and check them, ‘cos most doctors unlike lawyers and unlike police, basically accept at face value what they are told by the parents. […] In these cases, of course, you accept that nothing is true unless you can prove it. Check all the history, all the statements that have been made by mum and see whether there are any inconsistencies or any untruths.

Tracking the child’s medical files was described as a tedious and time-consuming exercise due to the involvement of numerous hospitals and private and public doctors (Police 5, Doctor 1, Doctor 2, Doctor 3, Doctor 4, Psychiatrist). Doctor 1 highlighted that there were no formal links between hospitals in Victoria, so a mother could go to one hospital in the morning and another in the afternoon and no one would know. Doctor 3 also explained that if a child attended the same hospital but a different hospital department, the original treating doctor would not know of the child’s attendance unless he had a subsequent appointment to see that child.

Medical personnel generally considered police and DHS staff to be better placed than doctors to track down the medical files of these families. Police 5 suggested that generally DHS would obtain the child’s medical files a lot quicker than police, which he thought was quite reasonable as DHS had to meet tight timelines around protective court proceedings. Police 5 indicated
that with the case he was working on, police and DHS personnel had worked cooperatively in locating and obtaining the family’s medical files.

Police 5 and Police 6 noted the importance for police to be educated about how to obtain medical information and of the issues police may encounter during this process. Police 5 reported that police can access a family’s medical files through the parents’ consent, a warrant, or a coroner’s authority. The parents’ consent was generally considered to be the best option (Police 5, Police 6)\textsuperscript{227} with issues identified for police with the warrant and coroner’s authority process.

**Police 5**: It’s fine for mum to sign a medical release and we’re fortunate that she did in this case to allow us access to the records, but if she hadn’t then how do we get them, we can’t get a search warrant, because to get a search warrant we’ve got to show that some type of crime has been committed and we’re not in that position at this stage. Even if we’re fortunate enough to find a magistrate that grants us a search warrant and a doctor gives us the records I still need to decipher them. If he tells me, ‘Well I’m not talking to you ‘cos I might get sued by mum’. What do we do?’

**Doctor 3**: Often the parents will give their consent if they don’t realize, if you’re not suspicious of them. What they’re interested in is building a case for illness and so they will often allow you to obtain evidence from

\textsuperscript{227} Several professionals indicated that they had been given consent by these parents to access the family’s medical files (Police 5, Child Protection 3, Child Protection 4, Doctor 1, Doctor 3).
elsewhere in the belief that that builds their case, without them realising it builds yours.

Police 6 described the dangers for police in getting a coroner’s authority to access the child’s medical files:

**Police 6:** It is important that police be educated about how to obtain medical information. […] You can get a coroner’s authority, but the problem with the coroner’s authority is that you can’t use the material obtained in criminal proceedings. It’s a minefield as far as using an authority and the same issues arise as if you had consent, as far as talking to the doctors.

A discussion was held with some of the professionals about whose role it should be to review the medical files associated with FII/MBP cases. All recognised a need for a person with medical expertise to be involved in this process.

**Doctor 1:** The doctor is the only person who can find his way round thick medical history, knows all the terms that are used, understands the disease patterns, and can start to see things that don’t seem to be quite as they should be through a medical history.

Police 6 indicated that police would generally utilise a Forensic Medical Officer (FMO) for this task as he or she is able to ‘see the perspective of a case from the coroner, the pathologist and as an FMO’. A number of police and child protection workers also revealed a need to review the medical files
of these children for their own job-related purposes (Police 1, Police 5, Police 6, Child Protection 1, Child Protection 2, Child Protection 3, Child Protection 4).228

Finally, at the time of conducting the interviews for this study, the Privacy Act, 2001 was being introduced into Victoria. A number of professionals highlighted issues with this legislation or identified issues perceived to arise in the future (Police 5, Police 6, Doctor 3, Doctor 4).229 Police 5 and Police 6, in particular, described the privacy legislation as stifling police investigations by either restricting access to certain information or slowing down police inquiries. Police 5 believed the issue of privacy in Victoria had just ‘gone berserk’ (see also section 7.3.3) and noted that, even with the simplest of requests, police had to follow a protocol or obtain a warrant or coroner’s authority before agencies would release information. Police 5 was also of the belief that the ‘problem lay with the system and not the people’ and indicated that ‘sometimes policies were just overlooked in order to get the job done’. The issue of privacy was considered an important police training and policy/practice issue.

7.3.2.3 Crime scene investigation

The majority of professionals interviewed in this study appeared to lack a sound knowledge of crime scene investigation as it relates to FII/MBP cases. In most cases where offending was suspected and police were not involved,

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228 Police 2, Police 3, and Police 4 did not require access to medical files, either due to the nature of the case (Police 2, Police 4) or to beliefs at the time that the matter was more a welfare issue than a criminal one (Police 3).

229 Several of the police officers did not experience issues with privacy legislation. These cases did not involve other agencies (Police 2), were historical in nature (Police 1 and Police 3) or primarily involved DHS rather than medical personnel (Police 4).
no action appeared to be taken from a criminal perspective; - the focus was on getting the child well and on protecting the child (Doctor 1, Doctor 2, Doctor 3, Doctor 4, Child Protection 1, Child Protection 2, Child Protection 3, Psychologist 2, Psychiatrist). There was limited evidence of medical and police professionals working together to collect evidence of this abuse (Doctor 1, Doctor2, Doctor3, Doctor 4, Police 1, Police 5, Child Protection 1, Child Protection 2, Child Protection 3). The researcher formed the belief that professionals, including police, generally did not regard the hospital environment as a potential crime scene.

Police 2, who responded to a fabricated rape and attempted abduction of a child, believed police required investigative abilities to recognize fabricated evidence and to identify inconsistencies between what they are told and what is presented at the scene. Police 2 outlined numerous findings which were inconsistent with the mother’s account of events. These included a fly screen cut from the inside to appear like a forced entry; undisturbed dust on the window sill where the alleged offender entered the house; and cuts on the woman’s nightie and bra that were alleged to have occurred as a result of an attempted rape, yet there were no marks on the woman’s body. Police 2 stressed the need for police to be educated to carefully consider the scene and what it may be telling them.

The initial police investigation of SUDI (includes SIDS cases) was explored with three of the police officers (Police 1, Police 5, Police 6). Police 5 pointed out that there was no specific approach for police within Victoria in relation to these cases. He suggested police needed to be taught to make some
observations of the child, family, and place of death and identify whether there was any potential evidence of a crime. He suggested police would also look at: ‘the bed, bedding materials, the ventilation and temperature of the room, other signs in the house, whether the parents were smokers or whatever else, and whether there was something else in the house that might explain the death or respiratory problems of the child’. Police 6 stated Homicide would generally only become involved in SUDI cases when there were ‘substantial indicators to suggest a child had been deliberately harmed’, such as unexplained injuries reported by medical personnel or the Coroner’s Office. Police 5 indicated that when ‘Homicide’ was involved, photographs would be taken and, where necessary, items such as cots, bedding, and mattresses seized. Police 6 described Homicide’s role:

**Police 6:** [...] we’d just do things as we do them in a normal crime scene. We’d view the scene. We’d view the deceased. We’d speak to witnesses. We’d speak to doctors. We’d get history, including the antecedent of the parents involved, the antecedent of the child, and the history of the child, and then consider our verdict.

Finally, Child Protection 2 suggested in investigating suspected FII/MBP cases professionals need to ‘tip everything upside down in order to make sense of it all’ and suggested that ‘all the normal things in crime scenes tended to be missing’ with FII/MBP cases. She suggested police need to be taught to keep an open mind and to actively investigate the situation to support or disprove the possibility of abuse, as evidence may lay hidden in these cases.
7.3.3 Interviews and information sharing

The majority of professionals interviewed regarded medical personnel as an important source of inquiry for professionals investigating suspected FII/MBP cases. Police 5 suggested police needed to speak with every doctor who has had involvement with the family. Three professionals (Doctor 1, Doctor 3, Psychologist 3) considered police needed to be mindful of how doctors may be feeling in relation to the alleged abuse, as he or she may be angry at having been deceived by the mother or having indirectly contributed to the harm suffered by the child.

While privacy legislation has restricted information sharing between agencies in Victoria (Police 5, Police 6, Doctor 3, Doctor 4), both Doctor 3 and Doctor 4 indicated that if information was required to protect a child they would release it. Doctor 4 noted, however, if there was other information relevant to the case that was not strictly linked to ensuring the child’s safety and security he would require either permission from the parent or a court order to divulge such information and that police needed to be aware of this aspect. Police 5 suggested police and doctors were being placed in difficult positions regarding information sharing and believed that there were presently ‘too many stumbling blocks’. Police 5 considered that one’s day worth of inquiries by each agency may potentially save the other three months in investigation time and suggested police needed to be made aware of the difficulties associated with obtaining information from doctors and be working towards improving current practice.
Police 5: We have this ludicrous system, now, where we wind up doing these section 56A’s in the Magistrate courts to get doctors to give evidence because they can’t legally make a statement to us. We can, however, only use this process in situations where we’ve already charged someone. If I have a job, for instance, where I have a doctor that’s treated a suspect that’s made an admission to a murder and we don’t have any other evidence at that stage to charge the suspect, I run the risk that the doctor will turn around to me and say, ‘This is what this bloke said to me, but I’m not giving you a statement’. I have no way of getting that statement at the moment. If the suspect’s not charged, I can’t get the statement and if a doctor makes a statement to me he runs the risk of being sued by the suspect for having breached the legislation. It’s bloody crazy. […] Police investigators need to be made aware of the issues in obtaining information from doctors.

Police 6 described problems with police providing information to medical personnel. He indicated that if he had information about a woman, under investigation for the murder of her children, who was applying for a position at a kindergarten or a hospital, he would be unable to alert such organizations of the current homicide inquiry, although could pass this information on to DHS. Police 6 believed police needed to be educated about what information they could and could not share with other agencies. Problems with information sharing between police and DHS were also described by some of the other professionals interviewed (Police 4, Police 5, Police 6, Child Protection 1, Child Protection 3). In contrast, Police 3 who was involved in a FII/MBP case in rural Victoria described information as being readily shared
between professionals, if thought to be in the best interests of the child, although he also noted that times had changed.

Parents were also considered to be a key avenue of inquiry for professionals investigating the possibility of FII/MBP. However, some professionals were wary of alerting parents to professionals’ suspicions of FII/MBP for fear of endangering the child and/or limiting the provision of future information from the family (Police 3, Police 4, Child Protection 2, Child Protection 4, Doctor 1, Doctor 3, Psychiatrist, Principal) (see also Chapter 6.4). Doctor 1 indicated that he’d ‘learned over the years that these women can be extremely difficult and dangerous to deal with’ and emphasized that police, and other professionals, needed to be ‘very careful in how they deal with them’. Several professionals highlighted the potential for information supplied by the mother to be false and stressed the need for it to be checked (Child Protection 2, Child Protection 3, Doctor 1, Doctor 3, Psychiatrist).

In collecting information from the mother, a number of professionals described themselves as feeling quite deceptive (Principal, Police 4, Doctor 1, Child Protection 1). The Principal and Police 4 described themselves as almost having to feed on the mother’s vanity in order to obtain the information they needed for their investigation.

**Principal:** We just had to be damn right sneaky, in that we had to enter into just a tiny bit of Mum’s world to get her confidence to get the information we needed. It’s almost deception in a way. However, if you believe in your heart that something’s wrong then you’ve got to lead a
little bit in order to illicit the information and confirm whether your doubts and concerns are valid or not. You’re not going to get that kind of discussion going if you’re treating them like dirt, so you positively feed on their vanity almost.

The Principal explained that the school was eventually able to gain the mother’s confidence enough to cross reference the information she gave them and prove that what the mother described as major life threatening, close to death experiences suffered by the child were in fact nothing.

Professionals interviewed considered that the fathers were generally supportive and defensive of their wives and that police needed to be mindful of this aspect in their investigations (see Chapter 4.6). However, Doctor 3, Police 4 and Child Protection 3 also indicated the fathers had supplied important information that had assisted them in their investigation and confirmed their suspicions. Doctor 3 indicated the father had disclosed that his wife had admitted she was deliberately making their children sick. This information was enough to consolidate the doctor’s already existing suspicions and to take active steps towards protecting the children. Child Protection 3 explained that in her case there were two fathers. She indicated that both had innocently provided valuable information, such as the mother utilising numerous doctors and hospitals, reports of the child vomiting faeces, and that the mother herself had suffered from strange illnesses. Police 4 indicated that the father had innocently provided information that he had walked in on the mother showing her child a pornographic video. This
information helped to explain the child’s detailed explanations in relation to allegations of sexual abuse.

Child Protection 3 considered it was important for professionals to speak to the father first before approaching the mother. In contrast, Doctor 3 considered this would be counter-productive as the spouse would not keep the information confidential and would inform his wife. He suggested the father should not be spoken to until professionals are ready to confront the mother. Child Protection 2 believed that DHS needed to do more to involve the non-offending parent to gain their support. She suggested that child protection workers can alienate the father who will then support the mother.

Finally, Police 6 stated the father must not be discounted as a potential offender and that police should be taught to consider all possibilities.

In addition to the father, Doctor 1 suggested police needed to be aware that inquiries with the mother’s local GP, her parents, her brothers and sisters, and her grandparents, could form a valuable part of FII/MBP cases, particularly in establishing a picture of the mother’s early life and perhaps gaining an understanding of why she may be behaving in this way. Further, a number of professionals interviewed were involved in dialogue with the child victims and felt police should be made aware of the potential for victims, if of ‘verbal age’, to supply valuable information to the investigation (Police 3, Police 4, Child Protection 2, Psychologist 1, Psychologist 2, Psychologist 3, Psychiatrist, Doctor 2).
Police 3 interviewed a ten year old child who was a victim of extensive fabricated illnesses by her mother. Police 3 stated that in planning this interview police were very aware of the mother’s dominance over her child and that their first priority was to separate the mother and child. This interview is presented in Appendix 22. The interview enabled police to gain an insight into the child’s perspective. This child possessed some awareness that her mother was not always right regarding her illnesses, but was unable to fully grasp this concept. The importance for police to speak to child victims away from the alleged suspect was emphasized by Police 3, the Principal and the Psychiatrist.

Police 4 interviewed a six year old who was a victim of fabricated sexual abuse. He described the boy’s disclosures as being ‘very elaborate and clear with no ambiguity’ and indicated that the abuse appeared to be ‘completely staged by both the mother and child’. Police 4 was unsure about the child’s level of awareness of the situation and wondered whether the child thinks, ‘I’m getting away with it, these people are believing me?’ Or, whether he thinks, ‘Oh, this must be all true’? Police 4 suggested, however, that it was not the police role to interrogate the child about whether what he had said was what his mother had told him to say or what had actually happened to

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230 They did this by stressing to the mother that they did not want to further traumatize the child any further by talking in front of her as she had enough on her plate. The mum latched onto this concept and gladly went with one member to make a statement, leaving the other member to talk to the child. Police 3 noted that the child was thrilled to have an adult talk to her without her mother being present. When the mother returned, the child immediately became quiet.

231 Permission has been provided from Victoria Police to include this interview which is now over 20 years old. Any identifying features have been removed. Whilst the interview is dated, the researcher suggests it provides a valuable insight into how FII/MBP victims may respond. Further, the researcher was unaware of any other police interviews with child victims within the literature.
him. Police 4 felt the more professionals spoke to this boy the more they cemented the idea that he had been abused. Police 4 indicated that over time the boy presented with conflicting stories and it became quite clear to professionals that the mother was using her son as a means to gain attention for herself. Finally, Police 4 considered police were not adequately trained to interview child victims of FII/MBP. The Psychiatrist, however, thought police could conduct factual type interviews with these children.

7.4 Confrontation of the FII/MBP perpetrator

Significant controversy arose within this study about whether medical, child protection or police should be responsible for confronting a mother suspected of fabricating and/or inducing an illness in her child and the purpose of this interview. As a result, this section is presented in some detail and presents information about who should confront the mother, the timing of the confrontation interview, and how the confrontation interview should be conducted.

7.4.1 Who should confront the mother?

7.4.1.1 The police perspective

The police officers interviewed suggested the police role in confronting a mother suspected of fabricating and/or inducing an illness in her child very much depended on the existing evidence, the type of case and medical

\[232\] The words 'confronting', 'confrontation', and 'confrontational' have been used in this thesis to differentiate this type of interview from an information gathering type interview where no allegations of abuse are raised.
opinions. In cases where there was clear evidence of an assault, the police members highlighted the need for such an interview to be conducted from a criminal perspective. They stressed that any allegations needed to be formally put by police to the mother with adherence to her legal rights. Involving medical and child protection professionals in this interview was recognized as a consideration for police. However, Police 5 and Police 6 thought such involvement would be difficult to implement in a practical and legal sense. Police 1 considered that if a multidisciplinary task force has managed the FII/MBP investigation, then that team should follow through in conducting the interview with the mother.

Where the evidence was unclear, the police members saw the confrontational interview as an opportunity to try and identify the mother’s position (Police 1) and stop her behaviour (Police 3, Police 4). It was suggested in some cases there may be no need for police involvement (Police 5, Police 6). Police 5 thought that medical and DHS interviews may in fact be advantageous to the police investigation as medical and DHS professionals are ‘not investigating officials under section 464 of the Crimes Act and therefore not required to caution the parent’, yet the information can still be utilised by police. Where a doctor held a reasonable suspicion that abuse was occurring, the police members believed that police should at least be consulted prior to the perpetrator being confronted.

The quantitative research explored police members’ opinions about whether a doctor should confront these offenders (Question 27). The questionnaire findings found the majority of police either disagreed (47%) that a doctor
should confront such offenders or were unsure of this issue (39%). An analysis by police work area produced a similar result: disagreed: recruits (43%), uniform (40%), detectives (54%), SOCAU (51%); uncertain: recruits (36%), uniform (40%), detectives (38%), SOCAU (41%). The literature highlights there is tension between medical, police and child protection professionals surrounding the confrontation interview (RCPCH, 2002). Such controversy suggests problems will arise between medical and police personnel in Victoria when faced with this situation.

7.4.1.2 The medical perspective

The medical professionals interviewed considered that confrontation of a mother suspected of fabricating and/or inducing an illness in her child should be primarily driven by medical personnel. They generally regarded this interview to be part of the medical diagnosis; that is a means for medically determining what is happening to the child, in order to provide the best medical care for that child. Doctor 2 suggested the doctor would have built up a certain level of trust with the parent and that it would ‘be easier for him or her compared with DHS, to walk the mother along the path of how this behaviour may have come about’. The Psychiatrist, Child Protection 1, Child Protection 2 and Child Protection 4 pointed out that a doctor would be able to rebut any questions on the technical side of the child’s symptoms and treatment. Child Protection 1 indicated that if the hospital did not say anything to the mother then she would constantly come back with, ‘Well, the hospital hasn’t said anything. They don’t think there is a problem. My doctor
thinks that everything is fine. So, why have you guys got a problem?’ Further comments included:

**Doctor 4**: It should be the doctor. I believe it’s a medical diagnosis. The doctor has to maintain a treating relationship primarily with the child and secondary with the mum. I think if you get to a stage when the medical people say, ‘Well, somebody else should talk to them’. It’s a cop out. I’m not saying that other people shouldn’t be there at the time. The same issue arises here, when we get kids brought in with accidental and non-accidental injuries. Who should talk to the parents about the possibility that an injury is non-accidental? Should it be the doctor, the police, the social worker? I think it’s totally unfair for it to be anybody else except the doctor.

The doctors differed in their opinions about whether a DHS worker and/or a police officer should be involved in interviewing the mother. **Doctor 2** suggested most doctors would be unwilling to notify DHS behind the parents’ backs and would generally want to speak with the parents first before involving DHS. However, Doctor 2 also acknowledged that in some cases it may be necessary to involve DHS, and/or the police, to plan what approach to take with the mother and develop contingency plans for ensuring the child’s safety. **Doctor 1** also acknowledged the importance of pre-planning between agencies to ensure the protection of the child. He indicated that in some cases DHS may need to get a court order to prevent the mother from removing her child from the hospital. **Doctor 3**, Child Protection 1 and the
Psychiatrist felt DHS and police needed to be involved directly with medical personnel in the confrontation interview with the mother.

**Doctor 3:** I've been involved in the confrontation on each occasion. I've tried where possible to involve other people at the same time, because I think it has to be witnessed and preferably by other disciplines and by people from other organizations. If I had the opportunity, I would involve police and DHS in that confrontation. That’s ideal.

Doctor 3 explained that in the past he had arranged for DHS to be involved in such an interview but the workers did not attend. He believed this reflected the ‘natural human disinclination to be involved in such extremely uncomfortable circumstances’. Child Protection 1 and the Psychiatrist suggested the doctor should begin the interview with the mother and then hand the interview over to DHS and the police. Finally, a number of professionals felt the confrontation process may be overwhelming and intimidating for the mother if too many professionals become involved in this meeting (Child Protection 4, Psychologist, Psychiatrist). In contrast, Police 4 indicated that the mother in his case had simply thrived on the attention afforded to her from the multidisciplinary environment.

7.4.1.3 *The child protection perspective*

Child protection professionals generally regarded the confrontational interview as a forum for establishing any risks to the child, assessing the mother’s capacity to parent her child, and highlighting to the mother any inconsistencies in her information. In this light, they saw a key role for
medical personnel and DHS, although Child Protection 4 (and Doctor 2) believed child protection workers were generally not equipped to confront such mothers and saw this as a role primarily for medical personnel.

**Child Protection 4:** She was talking double Dutch to me […]. I’m not sure if protective workers are equipped to deal with the sophistication of their explanations. That’s why I think you need a medical team to conduct this interview. They would be able to completely pull down her stories and point out the inconsistencies.

**Doctor 2:** I’m all for general discussions first, plan the approach. However, I think it’s an almost impossible role for DHS to interview the mother convincingly. You’ve got enormous potential for them to either not be effective in convincing the parents that there’s sufficient evidence to really consider Munchausens as a diagnosis, or, get sucked on side and it then puts parents and DHS against these wicked doctors who are thinking the worst things about this really nice mum. It’s just fraught with difficulties.

All four child protection workers also recognized the potential for criminal issues to be associated with FII/MBP cases and that police may need to become involved in the planning of this interview with DHS and medical personnel.

**Child Protection 2:** Sixty-four dollar question, isn’t it? I think it has to be a key medical practitioner, because they’ve actually got the facts, if you like. But I also believe it needs to involve child protection because we
have statutory authority and statutory responsibilities and I think we've got to own that process. I actually think we can get valuable information at that point that will help case management. Now the dilemma around confrontation is also where that may fit in with a criminal investigation, and so it’s a matter of at what stage are we going to go to the police, and what the police response is, etc. Whether that’s something that we stay well out of and leave to the police in line with other forensic investigations, I don't know. I see no reason that the police can’t be involved in a case conference with child protection and the medical practitioner around the confrontation process. Certainly the police response can help shape who will do the confrontation. But my sense is that child protection and a medical practitioner definitely need to be involved in the interview with the mother.

7.4.2 The timing of the confrontation interview

The majority of professionals stressed that actually arriving at the point of confronting a mother suspected of fabricating and/or inducing illness with her child may take months to sometimes years, because of the difficulties in identifying and confirming the presence of such abuse. However, the importance of planning in relation to the timing of such an interview was considered important (Doctor 1, Doctor 2, Doctor 3, Psychiatrist, Child Protection 1, Child Protection 4). Two child protection workers (Child Protection 1, Child Protection 4) and a doctor (Doctor 2) quoted cases in which a child’s life was either put at risk or extinguished because professionals confronted the mother too early with minimal planning. Child Protection 1 indicated that the doctors, without notifying DHS or police, had
suggested to the mother that she was causing her child’s illness. This resulted in the mother removing her child from the hospital and taking her child home with a drip still attached. Doctor 2 described a case where a child died not long after medical personnel suggested to the mother that she was harming her child.

Doctor 2: One case I was involved with where it was handled badly, the child had been admitted two or three times following life-threatening events. A little baby, single mum, very precarious social situation, very little in the way of support, domestic violence, alcoholism, a really risky situation to start with. The mum presented on several occasions with the baby in the emergency department having been resuscitated by her at home, when she was alone with the baby. The baby had pink, frothy mucus coming from its nose, really looking mottled and really required a lot of resuscitation in the emergency department. On the third trip in, the baby was sent off to [X] for monitoring and had cardiac monitoring and breathing studies and EEGs and all sorts of things, rather than being in here. Then the mother was told that ‘Look, we haven’t found a sensible medical cause for this. Maybe you’re doing something?’ to which she then became very defensive and said, ‘Just because you can’t find a reason, doesn’t mean that I’m doing anything. You’re all nuts’. That didn’t work well. Following that episode, the child went home with an apnoea mattress, because I don’t think the doctors were really that convinced that it was Munchausens. They had an element of doubt about it, maybe reinforced by the mother’s approach that ‘You’re missing something, you’re missing something’. The baby died at a time when he was off the
Apnea mattress, and the mother’s response was ‘See, I told you he was going to’.

Doctor 1, Doctor 3, the Psychiatrist and Child Protection 4 emphasized that professionals increased the risk to the child if they interviewed the mother without having solid evidence. By contrast, Child Protection 2 suggested whilst professionals needed to have more than ‘a flight of fancy’, they also needed to act when there was a ‘reasonable belief that abuse was occurring’, suggesting if professionals ‘awaited solid evidence they may be waiting too long’.

Most professionals interviewed in this study identified a need for professionals to be well prepared both personally and professionally before confronting a mother suspected of fabricating and/or inducing illness in her child. The importance for interviewers to be well briefed in relation to the medical circumstances and history of the child was evident within this study (Police 1, Police 3, Child Protection 1, Child Protection 3, Child Protection 4, Doctor 1, Doctor 2, Doctor 3, Doctor 4, Psychiatrist). Doctor 1 also stressed the importance for doctors to put aside any anger they may be experiencing towards the mother and think through very carefully what should be said to the parents and how the interview should be managed. Many of the professionals interviewed considered that planning and communication between agencies were an important part of these interviews (Police 1, Police 3, Police 4, Child Protection 1, Child Protection 3, Child Protection 4, Doctor 1, Doctor 2, Doctor 3, Psychiatrist, Principal).
**Police 4:** We went to the DHS case office with our managers and discussed the case. We all agreed that the issues had been previously investigated and were identical and that we needed to confront the mother about the allegations. We agreed to do this jointly. I think it is important that DHS and Police work together in addressing these types of issues.

**Child Protection 4:** I would perhaps recommend that more investigative procedures occur prior to interviewing the mother. So, to some degree you've built up your knowledge to test your assumption. Again, I'd be saying that needs to be done by a multi-disciplinary approach. You know, with medicos, police, everyone there and within that context putting everyone's heads together. I think this is most beneficial as it gets people to look at a case in a variety of ways. You need to do your homework before you go in there to interview her.

**Doctor 4:** I think you need to know as much as you can about the circumstances before you do anything. There's nothing better than to really try and acquaint yourself with everything that's really been going on with the child. And if you can get it straight to the mother that you've got a good background knowledge of what's been happening to them, it prevents them going off on tangents and telling you the intricacies of the child's medical condition which is not what you want to do at all.

Finally, three professionals noted that these mothers may not cease offending on their child just because they have been confronted with such an allegation and/or admitted to such abuse (Doctor 1, Doctor 3, Psychiatrist).
7.4.3 How the confrontation interview should be conducted

Professionals in this study generally described or recommended a direct and/or an empathic approach to confronting a mother suspected of fabricating or inducing illness in her child.

Doctor 2 highlighted a direct approach that was utilised with a mother who was fabricating Leukemia in her child.

**Doctor 2**: ‘It appears that on the one hand people have been led to believe that your son has Leukemia, but on the other hand, there’s this whole lot of evidence that seems to suggest that’s not the truth and we need to sort out exactly what’s going on, because some how things aren’t matching, somehow things aren’t right and we wouldn’t want the child to come to any harm’. We used the example of, ‘What if he got hit by a car and people thought that he had terminal Leukemia. If he was to be given a blood transfusion, he might be given too many platelets, and that would make his blood sludgy and harm could be done to him by people thinking he had Leukemia when really he didn’t.’

The mother in this case eventually admitted that she had fabricated her son’s Leukemia. She was described as being ‘embarrassed’, ‘defensive’, ‘angry’, and ‘annoyed that she had been caught out’. She also held the belief that she had a ‘right to do what she did as she was getting things for her child that he would not otherwise have got’ (Doctor 2). Doctor 2 also described a direct approach that was not successful (see section 7.4.2).
Doctor 4 also described a direct approach.

**Doctor 4**: [...] don’t forget this is a mother, if you’re the treating doctor, that you’ve had a lot of contact with over months if not years. So, it’s not somebody out of the blue that has just walked in and sat down. I think you need to do it in a context of summarizing what the medical issues are and then at some stage putting it to the mum that things don’t add up medically and that there’s something else going on. You need to explain that it is in the child’s best interests that you find out what it is that’s going on and the possibility is that the mother’s got something to do with it. You can couch it in fairly general terms to start with, but at the end of it you have to end up being fairly blunt.

Police 2 and Police 4 adopted a direct approach, but were not successful in obtaining any admissions of guilt. Police 2, who was involved in investigating a false report of rape and an attempted abduction of a child\(^{233}\), formally interviewed the mother in this case. The mother neither admitted nor denied the allegations, despite fairly strong forensic evidence that she had fabricated the alleged crimes.

**Police 2**: She pretty well adopted the attitude of ‘Well, okay, if you don’t believe me then okay I made it all up then’. This is obviously not what we were really looking for ‘cos we really wanted to just put our concerns to her and have her answer them. In my mind she took the easy way out by saying, ‘Well look, just forget it then if you don’t believe me. I give up, it’s all too hard’.

\(^{233}\) The child was also believed to have suffered from an illness as a result of vaccination. However, this was not investigated as part of the police inquiry.
Police 4 outlined a case involving a mother who, over a two year period, fabricated stories of her two children being sexually abused. The mother in this case was confronted by police and DHS, in a case conference type environment, utilising a direct approach234.

**Police 4:** It was an arranged intervention. It wasn’t something that was sprung on her. She knew there was an appointment and she attended of her own free will. I think it was totally appropriate to confront her with it then and there. We were just straight down the line with her. This is what we are going to do, even to the point where we clearly told her we didn’t believe her.

Police 4 highlighted that instead of admitting to what she had done, the mother escalated the situation to ensure the investigation continued.

**Police 4:** [...] this is what really peeved me off big time because this had been going on for so long. It was clear that what we were saying to the mother was that her behaviour was not going to go on any further. When we did this she realized that she had been backed into a corner. She then fabricates this story that she has seen the offender. So what do we do? We’re left in a real bind, because we now have an adult witness who is saying that she has seen a child being penetrated by an adult. She’s never ever said this to us ever before... She’s never witnessed anything. So what does this do? This keeps the investigation going, with us starting all over again. That really threw me. I didn’t believe anyone could go to that extreme.

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234 These allegations were not put to the mother in a criminal sense, but rather in a protective capacity in an effort to try and obtain an admission from her.
Doctor 1 emphasised that the confrontational interview should not be seen as a type of confrontation which ‘conjures up feelings of anger’, but rather as a meeting designed to ‘share professionals’ concerns with the parent and to hopefully obtain information as to what he or she has been doing to the child. A number of professionals (Doctor 1, Doctor 2, the Psychiatrist, Psychologist 3, Child Protection 1) described an empathic approach, to confronting such mothers.

**Doctor 2**: I think it depends on how it’s handled. I think if someone’s confronted with, ‘You’ve done a bad thing,’ the immediate response is, ‘No, I haven’t. You’ve got it wrong. Everybody’s against me’. It’s that defensive posturing. But I think if it can be handled in a way that is sharing a really sad situation, ‘that life must be really terrible for you, that you’ve felt so desperate that this has happened’, then that might reduce that defensiveness. So I think approach is critical.

Doctor 2 provided the following example:

**Doctor 2**: [...] one of the registrars who admitted the baby at the hospital went through the story with the mother, and took a very, very gentle approach with her. The registrar indicated that, ‘Occasionally babies that we see in here are because someone’s put something over the baby’s mouth and nose, or stopped their breathing for a little while, and then resuscitated them. It’s very sad when that happens, but we really understand that people are under a lot of stress if this sort of situation arises’. The mother said, yes that’s what she’d done. So that really caring ‘Let’s see if we can really understand what’s happening here. Let’s do
what we can for your baby. Let’s give your family the help it needs. Let’s give you the help you need. That really caring, nurturing approach to the mum worked'. Of course it can also backfire. But it can work well.

Psychologist 3 suggested ‘it’s all about acknowledging how difficult life is for these people’. The Psychiatrist indicated in the ‘absence of a watertight case he would not challenge the mother’, but rather ‘focus on the child, the child’s experience and his or her needs’. The Psychiatrist outlined he would generally ‘present the facts as he knows them and would then try and be supportive of the parent and engage the parent co-operatively’. He indicated he would try to ‘explain to the mother why she may have done what she did’ and provide support to her, even though there would be ‘inevitable consequences for her actions’. Child Protection 3 considered professionals needed to confront these mothers just enough to address the issues, but not too much to alienate them and/or destroy the ability of professionals to work with the family. Three professionals (Doctor 1, Doctor 2, Psychiatrist) highlighted an empathic type of approach with FII/MBP cases may result in an admission from the mother. In contrast, Child Protection 1 described problems with the empathic interview style.

**Child Protection 1:** So we turned up at the house and what I remember about this case, was just how seductive she was in terms of the way that she communicated with us and the way that she really turned us around to seeing her side of the story - that she basically just had a very very sick child and that the doctors just didn't understand and the medical system was hopeless. [...] She was really, um, seductive is probably the
best description. We were there from probably 3-4 in the afternoon until 10 o’clock at night and we hadn’t issued the protection application. We were caught up in talking with her. We had gone off and consulted with our management who were saying, ‘Go back in there and hand the papers’. And we were saying, ‘No, we can’t. It’s not the right thing to do. It’s a sick child’. We were saying ‘She’s still not well, there’s still issues here, there must be a better way round it. Just removing this child from her care is that the best thing to do?’ Now we had specifically sat down and read the guidelines before we left and had talked about the fact that escalation was a real possibility and how it could lead to the child’s death. We’d actually rated her as being very high on that scale given that she had now been effectively told that she had MBP or everybody thought she had MBP and that she was fabricating illness in her child. But we still really got caught up in dynamic with her to the point where we were almost arguing over the phone with our senior management. Then it just got too tiring and we just both said, ‘Okay, we’ll do it’ and we just went back in and executed the PA [protection application]. […] We just got caught up in it really badly. It was kind of weird afterwards. When you look back on it you think, ‘God, that was pathetic. I got dragged into that. I got seduced into that’! But at the time it was terrible.

Child Protection 1 stated in hindsight she would have used a more direct approach. She stated, ‘professionals need to be very clear about what they have to do and to go in and just do it’. In her case, she attributed the eventual removal of the child to a very clear, firm and independent supervisor who directed that such action be taken. Due to a number of learning outcomes arising from Child Protection 1’s experience, an excerpt from her
The importance of good supervision was emphasized by all of the child protection workers interviewed in this study and Police 1. Further Child Protection 1 stressed the importance of taking breaks away from the mother in order to reframe and remain objective to the task at hand.

7.5 Conclusion

This chapter has presented potential avenues of investigation of suspected FII/MBP cases. The findings reflect that much work is needed within Victoria to resolve many of the issues raised within this chapter. However, the issues generated are pertinent to police training and the investigation of FII/MBP cases. The findings provide a valuable insight into applicable investigative techniques with FII/MBP cases and the advantages and disadvantages of such techniques. Further, the findings highlight the need for police to be educated about the collaborative nature of FII/MBP investigations and how to work effectively with other agencies to confirm or disprove the existence of FII/MBP.

The following chapter provides an analysis of the research findings from a police training perspective. In particular, it brings together the qualitative and quantitative findings from this study and examines such findings in light of the existing FII/MBP training material, the general FII/MBP literature and the theoretical framework and theoretical perspectives employed within this research.
Chapter 8

Merging the Evidence and Analysing Police Training Needs

We cannot find out everything we might want to know using only one approach and we can often increase the scope, depth and power of research by combining the two approaches.

Punch, 1998: 243

8.1 Introduction

This chapter consolidates and analyses in detail the qualitative and quantitative data presented in Chapters 4 to 7. The chapter contains five key themes. Each theme contains a number of sub-themes. The chapter draws upon the general, FII/MBP and training literature and theoretical concepts incorporated in this research. At the end of each sub-theme, conclusions are drawn about FII/MBP police training requirements. The following paragraphs present the key themes explored within this chapter.

Theme one analyses the background knowledge required by police about FII/MBP. It includes the following sub-themes: terminology, definitions and implications of labels; methods of offending; perpetrators, spouses and victims; factors that shape and influence professionals' perceptions and response to FII/MBP cases, and finally, the personal impact of FII/MBP on professionals.
Theme two analyses the police role with FII/MBP including police attendance at such cases and the laying of criminal charges. Additionally, it examines the police role at sudden unexpected deaths of infants (SUDI) and which police should be responsible for such investigations.

Theme three explores police familiarity and knowledge about FII/MBP and establishes a baseline understanding of police strengths and weaknesses in this area with which to begin to gauge police FII/MBP training needs.

Theme four analyses the multidisciplinary aspect of FII/MBP investigations and police knowledge and skill requirements for working with other agencies in investigating and managing FII/MBP cases. It includes the following sub-themes: the importance of a multidisciplinary approach; the role of other agencies; key issues facing police and Victorian professionals, and the interrelationships, power and dynamics that exist between agencies.

The final theme explores potential methods of investigation applicable to FII/MBP cases, the advantages and disadvantages of such methods and police training requirements.
8.2 Background knowledge of FII/MBP

8.2.1 Terminology, definitions and implications of labels

One key theme which emerged during the interviews was the varied and inconsistent use of terminology and interpretations of FII/MBP by Victorian professionals (see Chapter 4.3)\(^\text{235}\). A number of professionals also noted the potential impact which ‘MBP’ terminology can have for women wrongly accused of such behaviour and the importance for police to be aware of this impact.

8.2.1.1 Terminology and definitions

Professionals viewed FII/MBP as either a form of child abuse or a health condition suffered by the mother. Some professionals used the term interchangeably to describe both abuse and a health issue. Further, consistent with symbolic interactionism principles, some professionals were observed to modify their language according to circumstances (for example, giving evidence in court) and/or according to what they perceived to be correct at the time. Whilst the interview sample was relatively small, the level of variance and seniority of professionals interviewed strengthens this study’s findings and is likely to be indicative of the broader Victorian position.

\(^{235}\) Professionals utilised a range of terms including MSBP, MBP, Munchausens, factitious disorder by proxy, Paediatric factitious disorder by proxy, fabricated illness by proxy and fabricated illness. The two most frequent terms were ‘Munchausen by proxy’ (MBP) and ‘Munchausen syndrome by proxy’ (MSBP). The police participants utilised the terms ‘MSBP’, ‘MBP’, ‘fabricated illness’ and ‘fabricated illness by proxy’.
The quantitative research, whilst exploring police awareness of FII/MBP, regrettably did not extend to police officers’ direct understanding of this term nor the use of alternate language. In hindsight, this would have been valuable to the research. However, the interview findings alone, sufficiently demonstrate a need for clarity surrounding FII/MBP terminology within Victoria. International literature also reflects that the use and application of FII/MBP terminology is inconsistent (Fox, 1994; Meadow, 2002a; Lasher and Sheridan, 2004).

Researchers contend language controversy surrounding FII/MBP may potentially lead to a loss of focus on the welfare of the child (Department of Health, 2001) and to misunderstandings in managing such cases (Ayoub and Alexander, 1998; Lasher and Sheridan, 2004). In the UK, ‘MBP’ terminology has since been replaced with the term ‘FII’ which has become standard in this country (RCPCH, 2002). Australian literature reflects moves to follow a similar path (Commission for Children and Young People and Child Guardian, 2004-2005; Fish et al. 2005). However, such a shift is still in its infancy.

In the light of the principles of symbolic interactionism, the term ‘FII’ may be more favourably understood than ‘MBP’ and enhance communication between professionals. However, more concrete terminology may also be required to fully clarify what is happening to the child. Meadow (1995) stresses whatever term is used professionals must define accurately what has happened.
Finally, whilst professionals interviewed held varying views about FII/MBP language and its application, not one questioned its reality, although some suggested there were professionals who doubted its existence. Doctor 3, in particular, emphasized such professionals could completely ‘destroy an investigation and leave a child unprotected’. Historically, issues with recognition, acceptance and definition are common with child abuse, with individual values and judgments typically influencing people’s perspectives (See Chapter 2.2.1). Lasher (2003: 409) stresses if FII/MBP ‘victims are to be identified and protected’ there must be ‘general public and professional awareness’ that FII/MBP exists.

8.2.1.2 Implications of language, labels and perceptions

Some professionals interviewed suggested ‘MBP’ terminology may disadvantage women accused of such abuse (see Chapter 4.3.1). Four professionals considered such terminology may lead professionals to categorise women, who display characteristics consistent with such a diagnosis, when a perfectly rational explanation for their behaviour may exist. Two professionals considered the MBP label isolates families from treatment and support (Psychologist 3, Psychiatrist), although it was also noted that even with a court order these women typically do not attend therapy and treatment sessions. Finally, although two professionals thought the FII/MBP’ label was too liberally applied in less severe cases, most professionals thought doctors were reluctant to diagnose or were too hesitant to apply the ‘MBP’ label, (see Chapter 4.3).
There is limited research on the impact of MBP terminology. However, Hayward-Brown (1999) suggests it can destroy a mother’s credibility and contribute to her having difficulties in trusting people. Others infer that women, who genuinely fabricate and induce illness in their children, seem to enjoy the attention and power afforded to them through their behaviour and not to internalise such a diagnosis (Bryk and Siegel, 1997; Gregory, 2003). White and Haines (2005) stress people will respond differently to labels and whilst one individual may become entrenched in the label, another may cease offending because of the stigma of being caught. Further, Williams (2004) stresses in examining the effects of labels one must not lose sight of the real victims.

The researcher suggests, regardless of what language is used to describe FII/MBP, there will always be negative connotations for women accused of such abuse as such behaviour is generally not tolerated by society. However, it is acknowledged that ‘MBP’ terminology has attracted a certain stigma and that alternate language may be less damaging for such women. It is also recognised that language associated with FII/MBP must allow for a common understanding of professionals’ concerns about this abuse and that this is more important than trying to protect parents.

8.2.1.3  Police training considerations

The training literature examined in this thesis utilises the term ‘MBP’ rather than ‘FII’. The researcher suggests the content still remains relevant but needs to adopt a FII focus. Horwath and Lawson (1995: 204, 206) identify
that professionals need ‘to know what MSBP is [...]’ and to develop ‘a common understanding of MSBP [...]’. Further, unpublished training material features definitions of MBP and an understanding of MBP basics. Artingstall (2000) also includes the history of MBP in such training.

The findings from this study show that police must firstly be able to accept that FII/MBP exists and any myths police may have about FII/MBP dispelled. Secondly, police must understand what FII/MBP is, methods of offending and how perpetrators carry out this abuse. Lastly, the researcher concurs with Artingstall (2000) that ‘MBP’ history is important for police training. The researcher considered such background may assist police to understand and deal with the controversy, apprehension and inappropriate attitudes that exist towards this abuse.

The researcher concluded that police in Victoria, particularly due to the multidisciplinary nature of FII/MBP investigations, need to be educated about the varied use and application of FII/MBP terminology and made aware that, despite overwhelming evidence to the contrary, some professionals may not accept the existence of FII/MBP. The importance of clarifying exactly what is happening to the child also needs to be emphasised.

More broadly, and in light of the principles of symbolic interactionsim, the findings and analysis from this study support the need for standard terminology in Victoria in relation to FII/MBP and a common platform of shared language and understanding by professionals about this abuse. The findings and literature (see 2.2.2) support a move by Victorian professionals
to follow the UK’s lead in abandoning ‘MBP’ terminology and adopting the term ‘FII’.

Finally, whilst there is no reference in the unpublished or published training literature, cited in this study, to the topic of ‘labelling’, the researcher suggests due to the potential impact FII/MBP terminology may have for individuals and the recent introduction of the Human Rights Charter within Victoria, that the topic of labelling should be considered for inclusion within police FII/MBP training236.

8.2.2 Methods of offending

Professionals interviewed described many ways in which FII/MBP perpetrators may offend on their child237. The literature also describes similar examples and suggests this offending is virtually limitless (Rosenberg, 1997) and only restricted by the offender’s imagination. Further, the findings and literature (see Chapters 4.4; 2.2.1; 2.2.3; 2.2.4.3) show that FII/MBP has features of physical abuse, neglect, and emotional and psychological abuse. Cases of fabricated sexual abuse which possess similar characteristics as FII/MBP offending have also been reported and/or noted to coexist with fabricated or induced illness238. The link between FII/MBP and SUDI deaths is also evident both within this research and in the literature (Southall et al.

236 See also section 8.2.3 regarding the application of FII/MBP behavioural characteristics.
237 Professionals described FII/MBP cases involving smothering, the administration of inappropriate substances, the withholding of food, and fabricated illnesses. Additionally, seven professionals spoke
238 See section 4.4.2 which contains cases of fabricated sexual abuse in which there were similar behavioural indicators present as that of FII/MBP. Further, the psychologist described the coexistence of fabricated sexual abuse with fabricated illness. Police 2 also described a case where the mother fabricated sexual assault on herself and there was the potential that she may have fabricated illness with her child (see also Appendix 19).
Finally, the questionnaire findings found police lack knowledge of FII/MBP offending, particularly in relation to medical aspects of this abuse (see Chapter 5.9.1.6).

8.2.2.1 Police training considerations

From a training perspective, the majority of professionals interviewed considered police needed to be educated about potential methods used to fabricate and/or induce illness in children (see Chapter 4.4; 4.5). Training material, cited in this research supports this position (see Appendix 15). Yorker and Kahan (1991: 56-57 stress that ‘just as the signs and symptoms of sexual abuse have become widely understood by professionals who work with children, the signs and symptoms of MBP must also become familiar.’

The researcher concluded that police needed to be educated about how perpetrators may fabricate and induce illness in children, the links from FII/MBP to child abuse more generally, and the seriousness and potential fatal nature of FII/MBP offending. Additionally, the researcher considered police needed to understand how FII/MBP cases may unfold and provided with case studies.

8.2.3 The perpetrators, spouses and victims

The professionals interviewed described their recollections of dealing with FII/MBP perpetrators, the spouses and to a lesser extent, the child victims. The researcher considered such information was invaluable for police training
as it provides an insight to this offending and how perpetrators, spouses and victims may behave. Police training is further discussed in section 8.2.3.4.

8.2.3.1 Perpetrators

A number of observations and analyses need to be made about the perpetrators described within this study. Such findings add to the literature in this field and are important for police training.

All of the perpetrators described within this research were female and the mother of their child victim(s). The literature reflects that whilst men and other female carers commit this abuse it is often committed by women and the mother of the child (Rosenberg, 1997; Sheridan, 2003).

A high percentage of the mothers described within this research possessed dysfunctional pasts, had seemingly significant medical histories and/or issues with their parents or family members (see Chapter 4.5.4). Southall et al. (1997) and Sheridan (2003) also report dysfunctional pasts in association with FII/MBP perpetrators. Rosenberg (1987) and Sheridan (2003) found a proportion of these women had their own significant medical histories, much of which was falsified. Finally, a number of researchers reported a lack of attachment by these women with either one or both of their parents (Schreier and Libow, 1993; Meadow, 1994; Howes, 1995). Psychological and social theories claim early childhood experiences can impact on behaviour later in life (Bowlby, 1973, Fisher, 1995; Perry, 2002). Alder (1997) and Dominelli (2002) suggest the criminal justice system needs to take into account the
complexity and diversity of women’s lives in order to understand their offending. Consistent with feminist theories, women who fabricate and/or induce illness in their children are possibly oppressed and disadvantaged by their environment and past (see also section 8.2.4).

Professionals interviewed described these women as typically very deceptive (see Chapter 4.5.1). Such women were often well dressed, articulate, intelligent, seemingly loving towards their child, very adamant of their innocence, and well supported by their spouse. However, some mothers were described as dishevelled in appearance, from low income backgrounds, and less sophisticated in their thinking (see Chapter 4.5.1; 4.5.4). The literature also reflects the diversity of FII/MBP perpetrators (Artingstall, 1999) and their remarkable ability to deceive and manipulate those around them, including police and other professionals (Fox, 1995; Stanton and Simpson, 2001; Abdulhamid and Siegel, 2006).

Professionals interviewed also typically described attention seeking behaviour in these mothers (see Chapter 4.5.2). The mothers appeared self-centred and egocentric, their lives revolving around their own needs rather than their child’s. The literature also strongly links attention seeking with FII/MBP perpetrators (Meadow, 1982; Southall et al. 1997; Feldman, 2004), although Morley (1995) suggests it would be perfectly normal for parents of genuinely sick children to embrace attention from hospital staff. Obtaining financial benefits in association with FII/MBP was also described by five professionals interviewed (see Chapter 4.5.2). The Psychiatrist believed such behaviour was linked to attention received through deception, rather
than money. Financial deception associated with FII/MBP cases is also evident within the literature (Pickford et al. 1988; Freeland and Foley, 1992; Ayoub et al. 2000). However motivation with FII/MBP is generally portrayed as complex (Meadow, 1995; Eminson, 2000b), varied (Loader and Kelly, 1996), and relatively unexplained (Fisher, 1995a; Loader and Kelly, 1996).

Mothers described in this study often displayed manipulative or controlling behaviour with their child, spouse and professionals (see Chapter 4.5.3; 4.7). Psychologist 3 and Child Protection 4 described mothers using their children like pawns to achieve their own needs. Some perpetrators pushed for further ongoing investigations and treatment for their child (Child Protection 3, Child Protection 4, Police 3, Police 4). Child victims of FII/MBP are often described in the literature as ‘tools’ or ‘objects’ in their mother’s hands (Sigal et al. 1989; Schreier and Libow, 1993; Shepherd, 1995). Further, researchers frequently report these perpetrators’ ability to manipulate their spouse and professionals (Guandolo, 1985; Bryk and Siegel, 1997; Schreier, 2002). However, Sanders and Bursch (2002: 117) also note that a concerned parent of a genuinely ill child may ‘advocate’ for medical tests and allow doctors to perform procedures considered necessary.

Eleven professionals interviewed described evasive behaviour in these mothers, such as changing medical practitioners, shifting home address, and evasiveness in describing their own personal backgrounds (see Chapter 4.5.3). Doctor shopping (Meadow, 1994; Rosenberg, 1987) and shifting home address (Artingstall, 1999) are evident within the literature, although Lasher and Sheridan (2004) suggest if current doctors are meeting the
perpetrator’s needs doctor shopping may not be present. Hayward-Brown (2004) also argues that doctor shopping is not uncommon for parents of genuinely ill children, wishing to seek additional medical opinions. Finally, Artingstall (1999: 134) notes FII/MBP perpetrators may display evasive behaviour when interviewed by professionals, by fabricating intense emotions, such as crying or anger, to evade, or divert, the reality of their situation.

Mothers in this study were often reported to possess knowledge of medical terms and procedures associated with their child’s illness (see Chapter 4.5.1). Six women possessed medical training. Four professionals (Principal, Child Protection 1, Child Protection 4, Police 3) described these women as possessing a sense of superiority over non-medical professionals and found the mother’s language confounding and challenging as they lacked the same degree of knowledge. Child Protection 1 stressed police and other professionals must be well briefed about these families’ medical history otherwise the mother will outsmart and bamboozle them. The literature demonstrates mothers who fabricate and/or induce illness in their children will often be knowledgeable about medical terminology and procedures (Meadow, 1982, 1984; Guandolo, 1985; Bryk and Siegel, 1997). Further, Rosenberg (1987) and Sheridan (2003) found a percentage of such women had received medical training. However, Morley (1995: 49) suggests it would be normal for parents of genuinely ill children to be well informed about their child’s illness and associated medical needs.
Four professionals interviewed provided opinions about why the mothers in their cases may have commenced fabricating and/or inducing illness in their child (see Chapter 4.5.2). The opinions included abuse originating from a genuine medical problem suffered by the child, as a means of retaliation on an ex-boyfriend, and due to family dynamics and/or the mother’s inability to cope with parenting or life’s pressures. Three of the mothers were described as needy or dependent on others. There is general agreement within the literature that not enough is known about the pathways leading mothers to fabricate and/or induce illness in their child (Eminson, 2000b: 30; Loader and Kelly, 1996). However, Donald and Jureidini (1996) and Rosenberg (1997) suggest that in some cases the child may have been genuinely ill and the attention received triggered the onset of the mother’s abuse. Further, Fisher (1995a) and Eminson (2000b) suggest these women may have a ‘mixture’ of ‘variables’ or ‘risk factors’ present that compound when exposed to certain situations and trigger the mother’s behaviour (Fisher, 1995a:45). Such explanations can be linked to psychological and social theories of crime (see Chapter 2.6.3).

8.2.3.2 Spouses

A number of observations were made about the spouses described within this research which the researcher considered relevant to police FII/MBP training.

The majority of offenders in this study were married. However, some were separated or in de facto relationships. In some cases marital status was
unknown (see Chapter 4.6). The research generally suggests women who fabricate and/or induce illness in their child are married, but, also notes cases involving single parents (Lasher and Sheridan, 2004).

The spouse was generally described as distant and the less dominant partner in the marriage, although Police 5 considered in his case that the mother’s apparent dominance may be due to a language barrier and the father may be the more dominant partner in his own cultural environment. The spouse’s role in FII/MBP cases is still relatively under-researched (Schreier and Libow, 1993; Schreier, 2002). However, like this study’s findings, the literature also portrays such spouses as distant and the less dominant partner (Meadow, 1982; Schreier and Libow, 1993; Howes, 1995). This would appear to contrast with patriarchal perspectives which suggest female inferiority. However, the fact that these spouses are often absent from their family raises questions about the potential dynamics that exist in such relationships (see also Chapter 4.5.2; 4.6).

The qualitative findings (see Chapter 4.6), consistent with the literature (see Meadow, 1982; Schreier and Libow, 1993; Goldfarb, 1998), suggest spouses in FII/MBP cases are generally unaware of their partner’s offending and will disbelieve any allegations against their partner. However, two doctors in this study also indicated that, sometimes, such spouses were aware of their partners’ abuse, but unable to voice their beliefs. Further, one child protection worker suggested, from the evidence available, the spouse should have known something was wrong (see Chapter 4.6). Artingstall and Brubaker (1995:82) contend the spouse is generally the ‘most entrenched’
person in their wife’s lies and ‘twists of reality’. The quantitative component of this research found police were either aware or uncertain as to whether the spouse would have knowledge of their wife’s offending.

The spouse’s reaction to his wife’s abuse was explored in both the qualitative and quantitative aspects of this study, with conflicting positions. The quantitative study, based on existing literature, sought to explore police members’ awareness of the usual outwardly defensive position adopted by the spouse. The findings revealed that 56% of police thought the spouse would outwardly defend his wife, with 39% being unsure about the spouse’s response. The qualitative findings, however, revealed that such spouses, whilst defensive of their wife, may not be ‘outwardly’ defensive and in some cases may adopt a passive response. For example, spouses described their wife as just ‘jinxed’ and their situation as ‘just hard luck’ (Child Protection 3) or that it was ‘the will of God’ that their children had died (Police 5). The Psychiatrist described one father as passively forgiving his wife, asking why she had done it and then adopting the approach of ‘oh well, let’s get on with things’. In light of the qualitative findings from this research, which add to the existing literature in this field, the researcher suggests the quantitative findings now need to be viewed cautiously and the wording of the questionnaire statement revised with any future research.

Child Protection 1 and Child Protection 2 noted concerns about spouses in FII/MBP cases regarding their ability to actively protect their children due to their disbelief of their wife’s abuse (see Chapter 4.6). Lasher and Sheridan (2004) also note similar concerns, suggesting the non-offending parent must
be able to acknowledge their partner’s offending if they are to protect their child. Finally, the researcher considered ‘hostage theory’ (Goddard, 1988 as cited in Stanley and Goodard, 2002: 109) may be relevant in understanding the relationship that exists between FII/MBP perpetrators and their spouse.

8.2.3.3 **Victims**

The police members surveyed displayed poor knowledge about victims of FII/MBP (see Chapter 5.9.1.5). In examining and analysing the qualitative findings a number of themes emerged (see Chapter 4.7) which were considered important for police training.

Victims of FII/MBP reported in this study were babies, young children and adolescents (see Chapter 4.7 and Appendix 19). The literature generally describes FII/MBP victims as primarily young pre-school children (Meadow, 1994; Sheridan, 2003). However, growing research shows that older children (Gregory, 2003; Awadallah et al. 2005) and adults (Meadow, 1984; Ben-Chetrit and Melmed, 1998) are also subjected to this abuse. In contrast, Hayward-Brown (1999) portrays the mothers in FII/MBP cases as the victims (see Chapter 2.2.4.3).

Professionals interviewed described FII/MBP as occurring singularly with one child in the family239, progressively from an older child to a younger child, or simultaneously with multiple children within the same family (see Chapter 4.7

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239 Includes families with only one child and families with multiple children where only one child is being offended against.
and Appendix 19). In some cases this information was not supplied. Such presentations also appear within the literature (see Rosenberg, 1987; Southall et al. 1997; Hall et al. 2000). The questionnaire findings show police are generally uncertain about the different forms this abuse may take, but that SOCAU members are more aware than detectives, recruits and uniform members.

Doctor 2 in her interpretation of FII/MBP highlights the vulnerability of victims in FII/MBP cases citing the power differential between victim and offender, the degree of dependency by the victim on the offender and the potential for the offender to harm the victim. The literature also notes the vulnerability of FII/MBP victims (Blix and Brack, 1988; Southall et al. 1997; Gregory, 2003), particularly, when the mother is also a nurse in charge of her child’s hospital care (Blix and Brack, 1988).

The interview findings revealed FII/MBP can have significant physiological and/or psychological effects on children, including death (see Chapter 4.4, 4.7). This is consistent with the literature (Rosenberg, 1987; Sheridan, 2003). However, there is also evidence, both within this study and the literature, which suggests, if given appropriate supports, child victims of FII/MBP can have good outcomes (see Nicol and Eccles, 1985; Gray et al. 1995).

The interview findings suggest children may display through their behaviour evidence of abuse and/or knowledge of their mother’s offending (see Chapter
4.7)\(^{240}\). This is also evident within the literature (see Awadallah et al. 2005). Artingstall (1999) notes the importance for professionals to be aware of this (see also Porter and Heitsch, 1993; Day and Ojeda-Castro, 1998).

Three professionals interviewed stated child victims of FII/MBP may genuinely believe they are ill or have been abused (Psychiatrist, Police 3, Police 4)\(^{241}\). The literature demonstrates young children may be unable to differentiate reality from untruths (Meadow, 1984; 1985; Howes, 1995). Links can also be made to symbolic interactionism and how people behave and modify their behaviour. Police 3 described a child victim of fabricated illness who, when placed in foster care, still ran to the foster parents complaining of illnesses and telling them to take her to x, y and z specialists. However, over time, she adapted and settled into a normal childhood (See Chapter 4.7).

The topic of collusion between victim and offender in FII/MBP cases was explored in the quantitative findings of this study, with the majority of police unsure about the potential for this to occur (see Chapter 5.9.1.5)\(^{242}\). Whilst not specifically raised with the interview participants, Police 4 described a

\(^{240}\) The Psychiatrist described one child as having ‘very bizarre ideas, behaviour and talk’. He indicated the child’s behaviour seemed psychotic which he noted was very unusual for a four to five year old. It was later discovered that this child knew that her mother was giving her medication to make her sick, but was unable to do anything about it. Similarly, Awadallah et al. (2005: 935) describe a fourteen year old boy who displayed outbursts, for which he received psychiatric treatment, because he was sick of being sick.

\(^{241}\) Police 3 suggested the child in her case had some awareness that her mother was not always right regarding her illness but was not able to fully grasp this position as her world revolved around being sick (see Chapter 4.7 and Appendix 22).

\(^{242}\) The researcher notes that some researchers disagree with use of the term ‘collusion’ to describe the symbiotic relationship between mother and child in FII/MBP cases, as the child is generally young, dependent and naturally loyal to his parents and the mother is skilled at manipulation (Rosenberg, 1995; Parnell, 1998; Lasher and Sheridan, 2004). In hindsight, the researcher may have chosen another word. However, the term ‘collusion’ is commonly used within the literature, in association with this abuse (Waller, 1983; Meadow, 1985; Schreier and Libow, 1993; Sanders, 1995; Artingstall, 1999).
form of collusion between the child and mother, although Police 4 was uncertain whether the child was consciously making up the abuse to support her mother or whether she in fact believed the abuse had occurred (see Chapter 7.3.3). The literature indicates some children will be aware of their mother’s abuse and actively collude with her to protect her secret (Waller, 1983; Meadow, 1985; Sanders, 1995). Stanley and Goddard (1995: 27) note that some children may display hostage-like behaviour and establish ‘a pathological attachment’ to the abuser.

Finally, of some concern in the interview findings was two police members’ failure to acknowledge that fabricated illness may have just as serious consequences for children as induced illness (see Chapter 5.2.4). Researchers such as Fox (1995) and Rosenberg (1997) stress fabricated illness can cause just as much damage to children through unnecessary medical testing and procedures as direct abuse associated with induced illness. Further, Artingstall (1999) suggested police may devalue victims and place a greater emphasis on court outcomes and how this will impact on police rather than victims’ needs (see section 2.3.3.1).

8.2.3.4 Police training considerations

Unpublished training material contained within this thesis (Walsh, 1997; Artingstall, 2000; Lasher, 2001) supports police awareness about FII/MBP perpetrators, spouses and victims.
Walsh (1997), Michlelman (1999); Artingstall (2000) and Lasher (2001) incorporate in their training agendas common suspicion indicators, or behavioural clues, to aid in the detection of FII/MBP (see Appendix 15). Additionally, Artingstall (2000) covers types of offenders (help seekers, doctor addicts and active inducers); family background and histories; and how FII/MBP perpetrators may differ from other offenders. Further, both Artingstall (2000) and Walsh (1997) cover offender motivational factors.

As evident in this research and the literature (Meadow, 1994; Artingstall, 1999; Samuels, 2001) the use of perpetrator behavioural indicators to consider the possibility of FII/MBP is controversial. Four professionals interviewed noted that such information may result in women being pigeon-holed as FII/MBP perpetrators when there may be a perfectly rational explanation for their behaviour. Police 5 further highlighted that such offenders may be overlooked if professionals adhered to particular descriptions. However, eight professionals noted the value of behavioural indicators in the identification and management of this offending. Artingstall (1999) and Sheridan (2003), suggest behavioural indicators can prove valuable in alerting professionals to consider the possibility of FII/MBP. However, Morely (1995) and Hayward-Brown (1999) contend behavioural profiles may lead medical practitioners to wrongly interpret this behaviour and to hastily accuse women of harming their child. Sheridan (2003: 444) suggests ‘the most important decision is whether a child is being maltreated and whether knowledge about MBP may help professionals deal with the maltreatment’.
The researcher concluded that an understanding of how FII/MBP perpetrators may behave may be valuable for police in identifying and investigating FII/MBP. However, such information must be considered cautiously and alongside other information. Police must also understand a mother with a genuinely sick child may display the same behavioural characteristics as a FII/MBP perpetrator and that misinterpreted behaviour can have detrimental consequences for such families.

Further, the findings from this research support the need for police to be educated to look at FII/MBP cases holistically. This includes the parents’ backgrounds; the role of the spouse and nature of the marital relationship; evidence of attention seeking behaviour and/or prior offending; evidence that may suggest parent(s) may not be coping with family pressures; the capacity of individuals to offend on the child, such as medical knowledge and access to the child, and the parents’ interaction with the medical system and other professionals. The findings also reflect the need for police to be made aware of the importance of planning in FII/MBP investigations and of the need for independent supports to assist in police remaining objective and dealing with the deception and manipulation often present in FII/MBP cases.

In addition to knowledge of perpetrators, knowledge of the spouse’s role and potential spousal behaviour was also considered important for police FII/MBP training (see Chapter 4.6 and unpublished training material by Michleelman, 1999; Artingstall, 2000 and Lasher 2001). The findings show limited existing knowledge by police in this area and suggest improved knowledge may assist police in their planning and approach to FII/MBP investigations and
perhaps in understanding potential motive for this offending. Artingstall (2000) also includes the father as the perpetrator. The researcher considered this topic, whilst not evident in this study’s findings, was also relevant to police FII/MBP training.

Finally, this study’s findings and unpublished training material (Walsh, 1997; Artingstall, 2000; Lasher, 2001) support police education about potential FII/MBP victims. The research findings, in particular, reflect a need for police to be educated about the vulnerability of victims; the physical, psychological and emotional effects of this abuse on children; potential behaviour that may be displayed by victims and the potential for collusion to occur between victim and abuser (see Chapter 4.7). Additionally, the literature suggests an emphasis needs to be placed on the rights of the child victim and ensuring police provide the same level of attention to child abuse investigations as they would for investigations involving adults (Chapter 2.3.3.1). Artingstall (2000) also includes information on secondary victims, elderly victims, and victims’ siblings, which the researcher considered relevant to FII/MBP police training.

8.2.4 The FII/MBP perpetrator and notions of power

In analysing this research, the concept of power emerged frequently in association with FII/MBP perpetrators and thus has been allocated a separate section.
The researcher considered whether women who perpetrate FII/MBP occupy positions of power or alternatively, are disadvantaged and oppressed. Further, why are more women reported perpetrating this abuse than men? The exploration of such issues may assist police to better understand this offending and perhaps potential associated motivation factors.

Whilst such a topic is too complex to fully dissect within this research, a number of findings are relevant. Firstly, women accused of FII/MBP were often reported as the more dominant and controlling partner in their marriage. Secondly, such women came from a range of socio-economic backgrounds. Thirdly, they were often described as confident, attractive and intelligent women. Fourthly, they generally displayed a sense of superiority over professionals involved with their child and were skilled in deception. Finally, such women appeared to take advantage of the medical system and its open and trusting philosophy. These findings are also evident within the literature (see Rosenberg, 1987, 1997; Schreier and Libow 1993; Feldman, 2004).

Based on such descriptions, it appears that female FII/MBP perpetrators occupy positions of advantage and have considerable power and control, rather than being marginalized or inferior. However, this study’s findings also offer an alternative view as the majority of women described within this research possessed dysfunctional histories and craved attention and recognition. Further, a number had poor marital relationships (see Chapter 4.5.2; 4.6).
Consistent with feminist theories, it may be argued that women who fabricate and/or induce illness in their children are oppressed and disadvantaged and are exerting, through the abuse of their child, one of the few options open to them to assert power. The literature also suggests this perspective (Schreier and Libow, 1993; Artingstall, 1999). However, the cruel and calculated nature of FII/MBP offenders is also emphasised (Rosenberg, 1997; Southall et al. 1997; Artingstall, 1999).

The relationship between mother and doctor and the medical environment itself is also important in analysing concepts of power and the FII/MBP diagnosis. Whilst it may be contended that FII/MBP perpetrators, due to their knowledge of why their child is ill, occupy a position of power in the doctor/patient relationship, others suggest it is the doctors who hold the power in these cases due to their position.

Professionals interviewed also described a range of factors linked to the medical and/or the multidisciplinary response system that possibly advantaged these women in their offending. Such factors include open hospital environments that encourage parental involvement in child care, non-connecting hospital databases that allow perpetrators to attend multiple hospitals on the same day unnoticed, the introduction of privacy legislation restricting information sharing between agencies, and finally a reluctance by doctors to become involved in FII/MBP cases. The literature also describes aspects of the medical system that may favour these women, such as the trusting nature of the doctor’s role (Wearne, 2000), a drive by the medical profession to find a medical cause (Donald and Jureidini, 1996), added
medicolegal and societal pressures on doctors (Moran, 2003) and a reluctance by doctors to become involved in a child abuse matter (Hall, 2003). Further, Schreier and Libow (1993) suggest the heroic image portrayed of doctors contributes to an unwillingness to challenge medical opinions.

In contrast, consistent with critical criminology, some researchers such as Morely (1995) and Hayward-Brown (1999) maintain power structures like the medical profession ultimately hold the upper hand in FII/MBP cases and that women accused of this abuse are oppressed by the power that doctors hold. Hayward-Brown (1999: 4) argues doctors are wrongly diagnosing FII/MBP and make women feel isolated and guilty when they are innocent. Finally, Feldman (2004) suggests women may be disproportionately accused of FII/MBP because women are more likely than men to be responsible for the care of children. Robins and Seal (1991) suggest the typical family unit may contribute to women’s vulnerability.

This study gives support to the idea that the caregiver role may contribute to this abuse. All of the perpetrators described within this study were mothers and appeared to be the primary carer. Additionally, there was some evidence that spouses in FII/MBP cases may provide little support to their partner in their parenting role (see Chapter 4.6). However, Meadow (1999) suggests the caretaker explanation does not account for the fact that physical abuse is equally committed by mothers and fathers, despite mothers being the primary carer. Meadow (1999) contends the overrepresentation of
female FII/MBP perpetrators may be simply linked to the way these cases have been reported and portrayed within the literature.

8.2.4.1 Police training considerations

Whilst the concept of power and FII/MBP perpetrators is not specifically mentioned within any of the existing training agendas, the subject area would appear relevant to police training. The researcher considered knowledge of the potential power dynamics operating in FII/MBP cases may assist police to better prepare for dealing with FII/MBP cases and to prompt police to consider and explore potential motives linked to issues of power and control.

8.2.5 Factors impacting on professionals’ perceptions and response to FII/MBP cases

During the interview analysis, a range of factors were identified which impacted on professionals’ perceptions and response to FII/MBP cases. The researcher considered an awareness of such factors may assist police to deal with FII/MBP cases and the external influences and pressures typically existing with such matters. Key factors are discussed briefly below with links made to police training.

8.2.5.1 Professional discipline

The qualitative findings from this research, consistent with postmodernist perspectives, illustrate that peoples’ professional backgrounds influence how they perceive their world, the language they use and the actions they take. In this thesis, police officers were more inclined to perceive women who
fabricate and/or induce illness in their children as offenders in comparison to medical and child protection professionals who, whilst acknowledging the potential for such women to have committed a crime, tended to perceive such women as needing help and support, although this was not always the case (see Chapter 5.2.4). The offender versus victim perspective is also described within the literature (Shepherd, 1995; Bentovim, 2001). Shepherd (1995) also suggests it extends to the child, where some professionals perceive the child as sick while others perceive him or her as a victim of crime.

This study's findings revealed police and to a lesser extent child protection workers, were able to approach FII/MBP cases from a more suspicious and investigative stance than medical and mental health practitioners whose roles pivoted primarily around trust (see Chapter 6.3.1). It was suggested police, who have no long term requirement to establish trusting relationships with these families, are better placed than medical and child protection personnel to approach these families with suspicion (see Chapter 6.3.1).

The findings also revealed police from different areas can perceive the management of FII/MBP cases very differently and that this has the potential to cause conflict, delays and poor outcomes for the child. Goddard (1996: 33) indicates that different professions may define child abuse differently based on their role and the stage at which they intervene. The potential for conflict in FII/MBP cases was common (Fox, 1995; Whelan-Williams and Baker, 1998).
The researcher concluded police needed to be educated about the potential influence a person’s professional background may have on their perceptions of FII/MBP and its management and that diverging perspectives, if not properly managed, may result in conflict and issues for the child's safety. Horwath and Lawson (1995) claim professionals need to have agreed practices for investigating FII/MBP allegations and managing inter-agency conflict. Unpublished training literature supports the inclusion of multidisciplinary case management within FII/MBP training (Walsh, 1997; Michlelman, 1999; Artingstall, 2000; Lasher, 2001).

8.2.5.2 Experience

In dealing with FII/MBP, the qualitative findings suggest professionals both socially and personally construct meanings of this abuse. Through interacting with others, professionals acquire knowledge and meaning which they then adapt to their own experiences and/or modify their response. For example, Doctor 3 changed from viewing female FII/MBP perpetrators as needing help and protection to focusing on the needs and protection of the child through the active involvement of the law (see Chapter 6.3.1). Child Protection 2 believed, as a result of her extensive involvement with a FII/MBP case, she was more wary when problems were ‘medicalised’ and would take longer to assess whether a child was legitimately sick or whether something more sinister was happening (see Chapter 4.8). Child Protection 1 indicated from her experience she would adopt a more direct rather than empathic management style with future cases (see Chapter 7.4.3).
The qualitative findings also suggest where police have limited knowledge of FII/MBP cases they will naturally use their police experience and training to deal with this abuse, although all six police officers interviewed recognised greater FII/MBP knowledge would have assisted them in their investigations. The quantitative findings revealed police may form strong beliefs about particular issues (see Chapter 5.9.1.7), although such beliefs may not always necessarily be correct. The researcher concluded that whilst personal experience was invaluable in FII/MBP cases, so too was training and the need for professionals to gain accurate information.

8.2.5.3 Training

The qualitative findings revealed all professionals interviewed supported FII/MBP training for police and other professionals who, through their position, may potentially encounter FII/MBP cases. The quantitative findings revealed existing police FII/MBP training has had a positive impact on police, in particular SOCAU members, but has not gone far enough in educating members about this abuse. The findings are consistent with what FII/MBP police training has been provided to date in that it has been primarily awareness based and targeted at SOCAU members.

The researcher concluded existing police FII/MBP training now needs to be expanded to address police FII/MBP knowledge gaps; additional subject areas, and members not yet exposed to FII/MBP training who require it, such as the CIU. The literature affirms education is essential for enhancing professionals’ ability to detect FII/MBP cases, making decisions regarding its
management and for minimising the risks of misjudgment (Department of Health, 2001; RCPCH, 2002; Lasher and Sheridan, 2004).

8.2.5.4 The level of evidence

Professionals interviewed typically described a lack of concrete evidence surrounding FII/MBP cases (see Chapters 4.4; 7.3.2). Often this led to conflict and apprehension about how cases should be managed, including the need for police involvement, the timing of parental involvement and the timing of protective intervention (see Chapters 5.2.2; 6.3.3; 6.4). Due to a lack of evidence, amongst other factors, professionals were often reluctant to become involved in FII/MBP cases and/or did not regard it as their role to collect the evidence needed to confirm or disprove the presence of such abuse. Child Protection 1 stressed often the evidence is hidden in FII/MBP cases and child victims depend on professionals to proactively investigate. The RCPCH (2002: 5) suggest ‘uncertainty’ is one of the main issues facing professionals in FII/MBP cases, which can be reduced by having ‘competent’ professionals, ‘clear protocols, and maintaining the welfare of the child as a priority’.

The researcher concluded that police need to be educated about the potential lack of concrete evidence in FII/MBP cases and subsequent uncertainty this may cause for professionals regarding case management. Police need encouragement to work proactively with other agencies in planning a coordinated response to suspected FII/MBP cases.
8.2.5.5  *Perpetrators, gender and motherhood*

Most professionals interviewed described FII/MBP perpetrators as deceptive and manipulative of those around them (see Chapters 4.5.1; 4.5.3; 7.4.3 and section 8.2.3.1). Child Protection 1 clearly demonstrates the influence the image of a mother with a sick child can play in this deception and that even the most experienced and ‘FII/MBP’ educated professionals can be deceived (see Appendix 23). Overall, however, experience appeared to enhance professionals’ detection and handling of FII/MBP cases (see Chapter 7). Police also appeared aided by the suspicious nature of the police officer role (see 7.3.2.3).

The literature affirms that women who fabricate and/or induce illness in their children will be some of the ‘smoothest liars’ police will ‘ever encounter’ (Wilkinson and Parnell (1998: 233) and that the mother-child image can create difficulty for professionals, including police, in contemplating the mother as a potential abuser (Horwath and Lawson, 1995; Artingstall, 1999; see also Chapter 4.5.1 and Appendix 23). Goddard (1980: 5) describes the potential for child protection workers to form an alliance with the abuser, similarly seen with hostages, or to develop ‘unfounded optimism’ for parents, resulting in a loss of focus on their protective role (Goddard, 1988 cited in Stanley and Goddard, 2002). Patriarchal perspectives suggest the appearance and behaviour of women is linked to how we perceive and respond to them. It is, therefore, understandable that professionals will have difficulty in viewing a mother with a small child as a potential offender when mothers are historically portrayed as nurturing and caring figures in society.
Doctor 3, however, emphasises that professionals involved with FII/MBP cases must be able to accept that women do harm and maim their children.

The researcher pondered whether a father with a perceived sick child would have the same influence as the mother. However, as this study involved only mothers the researcher was unable to compare gender influences. Interestingly, Meadow (1999) points out male FII/MBP perpetrators are more likely to incur criminal prosecution than female perpetrators and to receive harsher penalties within the courts. Whilst this research did not extend to the court environment, Doctor 3 and Child Protection 3 maintained magistrates were also susceptible to the deception employed by female FII/MBP perpetrators. Artingstall (1999) also held this belief. This would appear to be in contrast with feminist perspectives which suggest female offenders, who do not occupy appropriate gender roles, may be viewed as doubly deviant and disadvantaged by the criminal justice system (see Chapter 2.6.2.1). However, FII/MBP perpetrators may also not be perceived as deviant but as women struggling to carry out their appropriate gender role (see also section 8.3.1.5).

From a training perspective, the researcher concluded that police needed to be educated about the deceptive and manipulative capability of FII/MBP perpetrators and difficulty which police may experience in viewing a mother as a potential offender. This is supported by Horwath and Lawson (1995) who identify the potential impact of the mother-infant relationship on
professionals as a significant training issue\textsuperscript{243}. Goddard’s ‘hostage theory’ (Goddard, 1988 cited in Stanley and Goddard, 2002) would also appear relevant for police training. Finally, given the deceptive and manipulative nature of FII/MBP perpetrators, the literature encourages the use of additional supports by professionals involved in FII/MBP cases, such as FII/MBP specialists and a multidisciplinary approach to the management of FII/MBP cases (see Chapter 2.4.1; 2.5.2). This thesis also highlights a need for supervisors to be educated about FII/MBP to support and guide their staff (Chapter 6.5; Appendix 23).

8.2.5.6 \textit{The media}

The quantitative findings from this study show that the media, in particular television, has had a significant impact on police awareness of FII/MBP\textsuperscript{244} (see Chapter 5.5; 5.6). The researcher considered such influence was potentially concerning without other input, as information from the media may be inaccurate and may contribute to police misconceptions about this abuse (see Chapter 5.6; 5.12). The qualitative findings revealed apprehension by professionals about potential media involvement and concerns about how the media may portray a case.

Interestingly, unlike the findings from this study, FII/MBP surveys contained within the literature reflect a low level of influence by the media on

\textsuperscript{243} Unpublished training programs also include information on FII/MBP perpetrators (see Appendix 15 and section 8.2.3).

\textsuperscript{244} Television has not, however, impacted on members' actual understanding of this offending.
professionals’ awareness of FII/MBP. However, Ostfeld and Feldman (1996) suggest they would expect to see greater media influence in later research; which is certainly evident in the case of Meadow (Craft cited in Munby, 2004; Craft and Hall; 2004). Coverage on Meadow, whilst having a detrimental effect on professionals’ willingness to become involved in FII/MBP cases, played a significant role in triggering change within the UK with regards to the management of FII/MBP cases (Department of Health, 2001; RCPCH, 2002). Goddard and Saunders (2001: 28) suggest the media, at times, can have more influence on policy and practice than professionals working in the field.

Published and unpublished training agendas cited in this study (see Appendix 15) do not include the topic of ‘the media’ within their training agendas. However, the findings from this research clearly demonstrate the topic of ‘the media’ is highly relevant to FII/MBP cases and should be included within police training.

8.2.5.7  Fear of being sued

There was some indication within this research that a fear of litigation may influence professionals’ response to FII/MBP cases. Police 5 described reluctance by doctors to share information with police for fear of being sued by the mother. Child Protection 2 also thought that litigation had impacted on parents’ voluntary cooperation with protective orders. The literature suggests civil litigation has influenced the traditional power dynamics between

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245 Refer surveys conducted by Kaufman et al. 1989; Hocchausen and Richardson, 1994; Ostfeld and Feldman, 1996.
agencies and their clients and that doctors tend to be reluctant to deny parents’ requests for treatment of their child (Eminson, 2000b). The researcher concluded that police needed to be made aware of the influence which civil litigation may have on the police role and other professionals’ involvement in FII/MBP cases.

8.2.5.8 Legislation

The CYPA and privacy legislation both impact on Victorian professionals’ response to FII/MBP cases (see Chapters 6.3.3; 7.3.2.2; 7.3.3). Child Protection 3 suggests the CYPA focuses on the reunification of families and fails to cater for the seriousness of FII/MBP cases and long term monitoring of this abuse. Two of the police officers interviewed suggested privacy legislation had significantly impacted on police investigations; particularly with accessing and obtaining information from the medical profession.

Whilst it is not within the scope of this research to fully explore these issues there is some literature which supports the concerns raised246 and it would appear there is a need for police to be made aware of such legislative influences. Finally, it is noted the Children, Youth and Families Act, 2005 has since replaced the CYPA and that issues raised would need to be examined within the new framework, although the impact of such legislation may not be known for some time.

246 The Auditor General’s report (1996) and Sheehan (2000) both suggest the CYPA may not adequately cater for child abuse cases where the child’s best interests may lie outside the family. Reynolds (2005) and Clark (2005) confirm that privacy legislation has caused problems for Victorian professionals involved in child abuse cases.
8.2.5.9 Police training considerations

In conclusion, this study’s findings and analysis demonstrate that there are a range of factors operating in FII/MBP cases which have the potential to impact on police perceptions and response to such matters. The researcher concluded that knowledge of such factors may assist police to be better prepared and equipped for dealing with FII/MBP investigations and the underlying issues and dynamics associated with such cases.

8.2.6 The personal impact of FII/MBP on professionals

Professionals interviewed described a range of feelings and emotions in dealing with FII/MBP cases and the impact which FII/MBP can have on professionals. The police members interviewed described feelings of frustration and anger. These feelings arose because of bureaucratic interference in obtaining information, conflicting medical opinions, slow decision making processes that appeared to leave the child unprotected, the persistent nature of this abuse, and the inability, despite clear evidence of fabrication, to obtain an admission from the offender (see Chapter 4.8).

The doctors interviewed described FII/MBP matters as complex and stressful cases. Doctor 3 stated, ‘I think most of my colleagues who are now reasonably aware of this abuse tend to shy away from it. They don’t want to get involved and don’t want to investigate. It really is a horrendous position to be in’. Child protection workers interviewed also found them stressful, as well as describing such cases as isolating, frustrating, and overwhelming. However, two child protection workers found FII/MBP cases fascinating and
personally challenging. Four professionals interviewed revealed professionals handling FII/MBP cases may incur verbal abuse from the mother, other professionals, other parents and/or community members (Psychiatrist, Principal, Child Protection 1, Doctor 3).

Many professionals identified a need for persons with the right attitude to be assigned to FII/MBP cases. Doctor 3 reiterated the dangers of having the wrong people involved, suggesting it could completely ‘destroy an investigation and leave a child unprotected’. He indicated that professionals who are unable to accept that a mother could harm her child should not be assigned to FII/MBP cases. It was generally recognised that junior personnel were not appropriate for FII/MBP cases.

The literature affirms FII/MBP investigations are complex and taxing on professionals’ time, energy and emotions (Meadow 1985; Eminson and Jureidini, 2003; Feldman, 2004) and that, similar to this study’s findings, professionals involved with such cases may experience hostility from both internal and external sources, including supervisors (Freeland and Foley, 1992; Artingstall, 1999; RCPCH, 2002; Craft and Hall, 2004). The literature espouses the need for trained and experienced professionals to be assigned to FII/MBP cases supported by adequate organisational supports, appropriate resources and informed supervisors (Horwath and Lawson, 1995; Southall et al. 1997; Artingstall, 1999; Lasher and Sheridan, 2004).
8.2.6.1 **Police training considerations**

Unpublished and published training material cited within this research does not appear to address the potential impact of FII/MBP cases on professionals. However, the researcher concluded this topic was essential for police FII/MBP training and preparing police, both personally and professionally, for dealing with FII/MBP cases. This conclusion was derived from the demonstrated stress which FII/MBP cases can cause professionals, the serious nature of FII/MBP cases and potential for poor case management if members are not adequately supported. Finally, the researcher concluded that police assigned to FII/MBP investigations should be ideally experienced in dealing with child abuse matters, mentally and physically equipped to manage such cases and adequately supported by informed supervisors and appropriate organisational guidelines and protocols.

8.3 **The Police Role and Police Knowledge of FII/MBP**

8.3.1 **The police role in FII/MBP cases**

8.3.1.1 *Do police have a role in FII/MBP cases?*

The police role with FII/MBP cases was primarily examined through the qualitative research. However, the quantitative study through the inclusion of five opinion questions, provided glimpses about how police perceive the police role with FII/MBP cases.

Professionals interviewed in this study generally agreed police had a role to play in FII/MBP cases due to the potential of a crime having been committed.
However, the nature and timing of the police role was controversial and unclear, even amongst the police officers themselves. Additionally, the findings highlighted that whilst the police response to FII/MBP cases can be looked at holistically, it must also be examined from the perspective of individual police departmental roles, including the role of SOCAU, detectives and homicide members. Foster (2003: 196) reminds us that the police force is not ‘homogenous and one dimensional’ but made up of many subcultures (see section 8.3.1.2).

The police members interviewed generally regarded SOCAU members, in conjunction with a CIU member, as responsible for handling FII/MBP cases. (Police attendance at SUDI cases is discussed separately below). No specific research was located in this area, although it was generally inferred such police needed to be at detective level (Shepherd, 1995; Artingstall, 1999).

The quantitative findings showed that 65% of police surveyed agreed that police should become involved with cases of induced illness in children, with SOCAU members more strongly supporting police involvement (77%) compared to uniform members (59%). Twenty three per cent of members surveyed were unsure as to whether police should become involved with cases of induced illness in children and 12% thought police should not become involved with such cases. The researcher considered the stronger SOCAU position was most likely due to a greater understanding by SOCAU members about FII/MBP and a higher appreciation of FII/MBP as a potential form of criminal behaviour.
The literature supports that police have a role in FII/MBP cases (Fox, 1995; Artingstall, 1999). The Department of Health (2001) stipulates that any suspected FII/MBP case may involve the commission of a crime and, therefore, police need to be involved. However, the literature also reflects that police involvement in FII/MBP cases is relatively new, with FII/MBP traditionally considered a medical problem (Fox, 1995; Boros et al. 1995, Shepherd, 1995).

The researcher concluded, due to SOCAU members’ skills in dealing with child abuse and external agencies associated with child abuse investigations, that the SOCAU role should focus on the initial investigation with FII/MBP cases, including working with other agencies to establish whether a crime has been committed and assisting with preventative intervention. The CIU should work closely with the SOCAU member, provide investigative advice, investigate evidence of criminal activity and, where applicable, take the matter before the courts. A preventative role should also be undertaken if circumstances require it. Police training considerations for the ‘police role in FII/MBP cases’ are addressed in section 8.3.3.

8.3.1.2 What is the police role in FII/MBP cases?

The police members, and other professionals, interviewed in this study generally described the police role with FII/MBP cases as establishing whether a crime has been committed, to conduct an investigation into that crime and, where applicable, take the matter before the courts (see Chapter 5.2). Controversy existed, both amongst police and the doctors interviewed,
about whether police should become involved in FII/MBP cases upon the establishment of evidence to suggest criminal activity or whether police should form part of the evidence gathering process to determine criminal involvement (see Chapter 5.2.1).

In cases of fabricated abuse the police members considered this behaviour to be not as straightforward as induced illness in terms of police being able to prove that an assault has taken place and extremely difficult to prove in the courts. Two detectives considered cases involving fabricated illness may not warrant police involvement and may be resolved by medical and child protection personnel. The police officers interviewed in this study differed in their opinions about whether police should play a preventative role in FII/MBP cases or focus purely on the investigation (see Chapter 5.2.1).

Whilst the topic of emotional abuse and the police response to this abuse was not specifically explored within this research, comments provided by the detectives in relation to the police response to fabricated illness, suggest a potential lack of understanding of the association between FII/MBP cases and emotional abuse and of the potential impact emotional abuse can have for children. The findings in relation to SOCAU members (see Chapter 5.2.1; section 8.3.1.3) suggest these members may be more likely to become involved with Child Protection in investigating cases of emotional abuse where there are risks of harm for the child.

Finally, there were many aspects associated with the police role described in this study that required further analysis and research than this study could
afford. These included the police role in interviewing child victims, confrontation of FII/MBP perpetrators, the implementation of covert video surveillance, and the tracking and deciphering of medical files. Issues with privacy legislation and the sharing of information between agencies also required further exploration. The UK, primarily due to the situation of Meadow, has explored some of these issues (RCPCH, 2002; RCP and RCPCH, 2004).

No detailed Australian literature was located about the police role in FII/MBP cases. International literature was also limited in this area. The RCPCH (2002) describe the police role as to investigate cases of possible criminal action and gather evidence in connection with such behaviour. Fox (1995:108) notes police must ‘aim to prevent further unnecessary harm to the child, preserve evidence, and ensure that the perpetrator does not become aware of an impending investigation, thereby covering their tracks and perhaps continuing the abuse in some more subtle, less detectable form’.

The literature generally supports police having a preventative role in FII/MBP cases (Fox, 1995; Artingstall, 1999) and suggests the protection of children is not solely the role of police working in the child abuse field but that of all police members (DHS and Victoria Police, 1998; Department of Health, 2001). The introduction of the Children, Youth and Families Act, 2005 and change in scope to include emotional abuse, neglect and the witnessing of domestic violence, reflects efforts to improve the protection of children in Victoria in relation to the effects of cumulative harm; with an increase in substantiated emotional abuse and neglect cases recently reported
(Broomfield and Holzer, 2008). The *Family Violence Protection Act, 2008* also strengthens professionals’ response to protecting children and families.

In reference to investigating crime, the *Victoria Police Manual* (2003, crime scenes:1) states that Victoria Police members have a responsibility ‘to determine if a crime has been committed, to determine the facts of the offence, to obtain all evidence and to bring the person/s committing the crime before the courts’. The DHS and Victoria Police (1998:4) protocols also identify a need for police to ‘plan investigations in collaboration with other relevant agencies’ and provide training for staff both internally and jointly. Such comments support a need for a collaborative approach by police and other agencies towards FII/MBP investigations.

8.3.1.3 *When should police become involved in FII/MBP cases?*

The police SOCAU members supported early police involvement with FII/MBP cases (see Chapter 5.2.1). They suggested police needed to be involved once a doctor formed a reasonable belief that such abuse existed, regardless of whether concrete proof existed or not, and should work with other agencies in determining whether abuse had been committed. However, the detectives generally thought police should only become involved in FII/MBP cases once there was some clear evidence to suggest criminal activity (see Chapter 5.2.1), although were happy for SOCAU members to be notified simultaneously with DHS and recognised that SOCAU members possess additional skills in working with families and children. The two detectives felt detectives did not have the time or
resources to investigate cases in which there was no evidence of a crime and that police involvement in such cases may cause unnecessary stress for the parents. It was also thought that police involvement in FII/MBP cases was very much dependent upon the medical findings (see Chapter 5.2.1).

Seven professionals interviewed (3 child protection workers, 3 psychologists and 1 doctor) described their dealings with police in FII/MBP cases as being consistent to the perspective of the detectives (see Chapter 5.2.2). Doctor 1 noted that police, and DHS, typically want ‘a pretty definite diagnosis’ before they become involved in FII/MBP cases. Child Protection 1 emphasised that evidence of a crime may not always be apparent with FII/MBP cases but that child victims depended on professionals to investigate the possibility when suspicions of abuse were raised. Child protection workers generally supported early police involvement in FII/MBP cases and considered police needed to work proactively with other agencies in confirming or disproving the possibility of such abuse (see Chapter 5.2.2).

Medical professionals thought police should be notified early in FII/MBP cases, but initially not to assume an active role (see Chapters 5.2.2; 7.4.1.2). Doctor 1 noted an investigation is not going to succeed if police come knocking at the door saying, ‘we’d like to have a talk to you’, because whatever the mother is doing will almost certainly stop and only occur again once the pressure is off, making it difficult to prove the diagnosis (see Chapter 5.2.2). Doctor 4 stressed the primary issue must be with making a diagnosis and the well being of the child. However, Police 5 also believed
that sometimes medical professionals considered their job complete once the child was well and did not take the matter any further (see Chapter 6.3.1).

The findings also suggest a general reluctance by doctors to report suspected FII/MBP cases and that doctors generally feel a need to acquire sufficient evidence before reporting their suspicions (see Chapter 6.3.1). This was also evident in the literature (Kempe et al. 1962; Fox, 1995; Yeo, 1996; Craft cited in Munby, 2004; Horton, 2005). Goddard (1996: 145) suggests there is much uncertainty about the use of the criminal law in response to child abuse and general concern about police involvement and the possibility of the parents being criminally charged which can contribute to a reluctance to report. This would appear consistent with this study’s findings.

The literature also suggests police may be reluctant to become involved in child abuse cases where there is insufficient evidence to prove criminal activity in the courts (Charlesworth et al. (1990, cited in Goddard, 1996; Artingstall, 1999). This study lends some support to this position (see 5.2.1; 5.2.2), although other factors, such as a lack of knowledge about FII/MBP, as evident by this research, would need to be considered.

The FII/MBP literature generally supports early police involvement in FII/MBP cases (Fox, 1995, RCHCH, 2002). The RCPCH (2002: 50) emphasize ‘a failure to alert Police or Social Services early is likely, in proven matters, to

247 The school principal interviewed in this research also suggested education personnel tend to want to secure sufficient evidence of abuse before reporting their suspicions to authorities (see Chapter 6.3.5).
lead to greater suffering by the child and hamper the chances of successfully concluding the enquiry’. Finally, the literature recognises the overlapping boundary in FII/MBP cases between medical and policing roles with regards to evidence collection (see section 2.4.5.1 (ii) and supports a collaborative approach by doctors and police in this area. The researcher suggests the RCPCH (2002) provide the much needed clarity on this topic which is needed in Victoria (see Chapter 2.4.5.1, ii).

8.3.1.4 The police role in sudden unexpected deaths of infants (SUDI)

The role of police with SUDI matters is relevant to FII/MBP cases, as some FII/MBP cases will involve the death of an infant or child (RCP and RCPCH, 2004). The questionnaire findings from this study found police lack knowledge about SUDI investigations. This is consistent with a general belief in the literature that police (Bufton, 1996) and other professionals lack knowledge in this area (RCP and RCPCH, 2004: 12; Craft and Hall, 2004).

The interview findings, similar to the literature (RCP and RCPCH, 2004), show tension exists with the police role in SUDI cases (see Chapter 5.2.3). Police 5 for instance thought it necessary to secure the evidence quickly at the scene, whereas Police 6 did not want to place the parents under unnecessary suspicion. The RCP and RCPCH (2004: 13) protocol also reflects tension surrounding whether police should approach SUDI cases from the perspective that the majority will be genuine SIDS deaths or from the perspective that every deceased child deserves an investigation into his or her death.
Police members interviewed in this study were also concerned about the effect that police attendance may have on parents who have genuinely lost a child to SIDS, but at the same time, recognised a need for police to conduct an investigation on behalf of the child. The literature reveals disagreement surrounding the effects of police attendance on parents in these cases (see RCP and RCPCH, 2004; Scurlock et al. 2006).

The police officers interviewed considered police attendance at SUDI cases should follow a hierarchical pattern, consisting firstly of the uniform response, secondly, the attendance of a SOCAU or CIU member, and finally the involvement of homicide, if substantial indicators suggested a child had been deliberately harmed. There was some disagreement between police about whether a CIU or a SOCAU member should attend the death scene (See Chapter 5.2.5). The literature suggests police attending SUDI cases should ideally have a child protection background (NSW Child Death Review Team, 2005; RCP and RCPCH, 2004), with the RCP and RCPCH (2004: 67) recommending a detective of at least inspector rank attend the initial scene to take charge of such investigations.

Finally, as a result of the findings from this research, combined with the researcher’s involvement in a multiple child death investigation, the researcher has implemented significant changes in Victoria regarding police policy, practice and training in relation to the investigation and management of sudden unexpected deaths of infants. Such changes include:
• the implementation of police policy clearly detailing which police members must attend SUDI incidents

• the development and implementation of a detailed SUDI checklist, in conjunction with experts around Australia with specialised knowledge of SUDI matters, for completion by police attending the scene of such deaths. The checklist is designed to collect information at the scene to assist the coroner in determining a cause of death and in assisting to distinguish between unknown causes, accidental death and homicide

• the development of comprehensive guidelines to assist police members attending SUDI incidents

• the development and implementation of training for police in relation to responding to and investigating SUDI incidents, including the involvement of relevant agencies

• a shift in culture from a welfare response to a balanced investigative/welfare response

• the formation of a working group to continue to drive improvements in this field.

In addition, such change has had a flow on effect with other agencies contributing to changes in their practices and/or training. Such agencies include the Victorian Institute of Forensic Medicine, the Coroners Court of
Victoria, SIDSandKIDS Victoria, the Metropolitan Fire Brigade, Metropolitan Ambulance Service and Victorian hospitals. Finally, police changes implemented in Victoria with regards to SUDI investigations have attracted the interest of other Australian police services (in particular Northern Territory (Darwin and Alice Springs, New South Wales and Queensland) with a view to adopting similar measures. It can, therefore, be seen that this research has already significantly contributed to making a practical difference and will continue to do so.

8.3.1.5 The laying of criminal charges

The interview findings from this study found the majority of professionals interviewed were generally uncertain about whether criminal charges should be laid against women who fabricated and/or induced illness in their children. Some professionals felt such women had no criminal intent to harm their child (Child Protection 1, Child Protection 3, Doctor 4) and that a punitive approach was inappropriate in these cases (Child Protection 3, Doctor 2). Further Doctor 2 thought criminal prosecution may be detrimental in assisting the mother to take responsibility for her actions and adopt more appropriate parenting practices.

In contrast, all police members interviewed and Doctor 3 and Child Protection 2 felt charges should be laid as women who induce illness in their children commit a criminal offence upon a helpless individual. Further, Police 5 suggested charges helped to make a public statement and might assist to diminish the prospect of denial and the mother subsequently offending.
without people knowing the previous history. He highlighted criminal charges did not mean these women would not receive any medical help and indicated sometimes criminal charges and medical intervention went hand in hand. Child Protection 2 supported criminal charges, but suggested sentencing options needed to be considered as jail was not the answer for these women. Doctor 4 suggested the decision to prosecute these women needed to be made on a case by case basis.

Interestingly, Doctor 3 described how his views changed over time, from seeing women who induce illness in their child as people he should try and help, to perpetrators of crime from whom their children needed protection through the active involvement of the law. Such modification is consistent with interpretivism that reflects people are constantly involved in interpreting their ever-changing world through their personal experiences and interaction with others (Williamson et al. 2000:30).

Finally, there were two police cases in this study where police felt charges should have been laid against the mother, but ultimately, due to medical opinions, or conflicting medical opinions, such action was not taken. This highlights the dependency of the police role in FII/MBP cases on medical professionals. The literature reflects the issue of criminal charges against FII/MBP perpetrators is a complex and controversial issue (Department of Health, 1999; Artingstall, 1999; Craft and Hall, 2004).
8.3.2 Police awareness of FII/MBP and gaps in knowledge

The questionnaire findings demonstrate that whilst the majority of police in Victoria have heard of FII/MBP, much uncertainty and lack of understanding surrounds this abuse, although SOCAU members were more informed than detectives, uniform members and recruits. The interview findings found police lack awareness and understanding of FII/MBP prior to becoming involved with a case.

The quantitative findings revealed of the 760 police officers who returned their surveys, 69% had heard of FII/MBP, with 99% of SOCAU members having heard of this abuse compared to 48% of recruits, 59% of uniform members and 75% of detectives.

In analysing police FII/MBP knowledge levels, the questionnaire findings from this study showed that recruits, uniform, CIU and SOCAU members possessed relatively low levels of knowledge about FII/MBP and its investigation and management. Although SOCAU members, whilst still poor in their knowledge, were shown to have significantly greater knowledge than recruits ($CI=11.94; \ 26.40$), uniform members ($CI=15.13; \ 26.91$) and detectives ($CI=11.50; \ 23.75$). SOCAU members scored a mean percentage of 50% of answers correct ($SD=16.32$) compared to recruits ($M=31, SD=18.80$), uniform members ($M= 30, SD= 20.65$) and detectives ($M= 33, SD=20.23$).
In analysing the research content and strengths and gaps in members’ knowledge, the questionnaire findings revealed overall police had a greater understanding about offenders and spouses associated with FII/MBP than about victims, methods of offending and investigation and management practices. Police scored less than 52% of ‘correct’ responses in all five knowledge areas contained within the questionnaire. The highest mean percentage of ‘correct’ response was recorded in relation to knowledge of spouses (51%), followed by knowledge of offenders (42%), offending (32%), investigation and management (31%) and knowledge of victims (18%). As there has been limited police training in this area, since the time of conducting this research, the researcher does not expect the findings from this study to have changed significantly.

The quantitative findings showed television to be the main source of learning for police about FII/MBP. Only SOCAU members identified police training as a key factor in their learning, with a sizeable proportion of detectives and SOCAU members also identifying work as having some input. The qualitative findings revealed none of the six police members interviewed had received training about FII/MBP at the time of becoming involved with a case.

There has been little research undertaken on a large scale, and certainly none in Australia, that examines police knowledge of FII/MBP and the investigation and management of FII/MBP cases. However, researchers generally believe police lack knowledge about this abuse (Bufton, 1996; Artingstall, 1999) and that this has the potential for cases to be missed (Fox 1995), delays in the investigation (Shepherd, 1995), damage to the criminal
case (Wilkinson and Parnell, 1998) and poor outcomes for the child (Fox, 1995; Artingstall, 1999; Lasher and Sheridan, 2004). Lasher and Sheridan (2004: 81) suggest ‘professionals who are not trained investigators with considerable MBP knowledge and experience may inadvertently compromise victim safety or the investigation’.

8.3.3 Police training considerations

Police and other professionals interviewed considered police required an understanding of the police role in relation to FII/MBP. However, it was also clear that clarification is required in Victoria surrounding the police role with this abuse. Further, as captured by the police members’ findings, the role of police in FII/MBP cases is not homogenous and needs to be considered both holistically and from the perspective of individual police departments, in particular SOCAU, CIU and Homicide. The researcher considered police FII/MBP training also needed to be viewed in this light.

Horwath and Lawson (1995: 203) state professionals must ‘know what their role and their responsibilities are in relation to managing allegations of MSBP abuse’ and ‘what their responsibilities are in relation to the protection of the child and in dealing sensitively with children’. Unpublished training literature by Walsh (1997), Michlelman (1999), Artingstall (2000), Lasher (2001), whilst not specifically citing the police role within their training agendas, include the multidisciplinary team management of FII/MBP cases which may cover the
police role. In relation to SUDI cases, the literature reflects it is important for police to be trained about their role in such investigations (Bufton, 1996; Walsh, 1997; RCP and RCPCH, 2004; NSW Child Death Review Team, 2005). Finally, the findings suggest police need to be educated about the preventative role which police may be required to play in FII/MBP cases and made aware of the importance of considering emotional abuse in their decision to become actively involved in investigating FII/MBP allegations.

The researcher concluded that low levels of knowledge by police in Victoria about FII/MBP and the investigation and management of such cases was concerning, particularly given police in Victoria are becoming involved with such cases (see Chapter 4) and that all FII/MBP cases may potentially involve a crime (Department of Health, 2000). Bufton (1996) and Artingstall (1999) stress that organisations have a duty of care to ensure staff are provided with the necessary training and supports to deal with FII/MBP cases, including those involving infant deaths (see also RCP and RCPCH, 2004). Further, Artingstall (1999: 5) states that the more investigators know about FII/MBP ‘the better able they will be to identify perpetrators, clear innocent suspects and most importantly protect children’. The researcher concluded that police assigned to FII/MBP cases, require training to undertake this role and that, where possible, training should be tailored to meet different police departments’ needs and knowledge gaps.

248 The researcher was only privileged to powerpoint notes.
8.4 The Multidisciplinary Response

8.4.1 The importance of a multidisciplinary approach

The professionals interviewed in this study, whilst not always in agreement regarding agency roles and the timing of agency involvement, generally recognised a need for a multidisciplinary approach with FII/MBP cases due to the overlapping medical, protective and criminal issues potentially associated with such matters (see Chapter 6.2). The psychologists, however, had some difficulty being involved in this process without the mother’s consent, although acknowledged the importance of professionals working together (see Chapter 6.3.2; Fisher, 1995).

Similarly, the literature recognises the importance for agencies to come together in FII/MBP cases to plan a coordinated response (Zitelli et al. 1987; RCPCH, 2002; Fleming et al. 2004) and notes the difficulty for mental health practitioners to be involved in this process (Fisher, 1995). Published (Horwath and Lawson, 1995) and unpublished training material (Walsh, 1997; Michleman, 1999; Artingstall, 2000; Lasher, 2001) recognise the importance of multidisciplinary case management within FII/MBP training, with Horwath and Lawson (1995) placing a heavy emphasis on this area. The researcher concluded a multidisciplinary component should form a part of police FII/MBP training, including an understanding of the importance of a multidisciplinary approach with FII/MBP cases.
8.4.2 The role of other agencies in FII/MBP cases

One of the key sub-themes that emerged from the qualitative findings was the need for police to have an understanding of the different agencies involved in FII/MBP cases, what roles such agencies play and the difficulties facing agencies in dealing with FII/MBP cases. The findings reflected that police need to understand the different perspectives other agencies come from and how they differ from the police role. This included the trusting nature of the doctor’s position and low level of suspicion which doctors have about their clients (see Chapter 6.3.1); the therapeutic position of mental health practitioners and difficulties which such professionals have in sharing information with other agencies (see Chapter 6.3.2); the protective role of child protection professionals and difficulties in conducting risk assessments (see Chapter 6.3.3); and the difficult role of schools in reporting suspicions without concrete evidence to support their allegations (Chapter 6.3.4). During the course of this research it was also clear that other professionals, apart from the ones interviewed in this research, were important in FII/MBP cases and that police should have an understanding of their roles. These included, but were not limited to, nurses, paramedics and magistrates.

Finally, the quantitative findings revealed a lack of knowledge by police of other agency role requirements and difficulties such agencies may face in handling FII/MBP cases. In particular, police were relatively ignorant of the difficulties facing medical professionals in distinguishing FII/MBP offenders from parents of genuinely ill children, although SOCAU members were more informed than uniform members, recruits and detectives (see Chapter
5.9.1.7). Members also lacked knowledge of mandatory reporting as it relates to child abuse (see Chapter 5.9.1.7).

The literature affirms the importance for professionals dealing with FII/MBP cases to understand other agencies’ perspectives and roles (Department of Health, 2000; RCPCH, 2002; Fish et al. 2005). The Department of Health (2000) highlight that an understanding of the perspectives, language and culture of other professionals can aid communication and reduce the potential for misunderstanding. Blyth and Miller (1990) contend that professionals who have an understanding of their role and those of other agencies are able to play a more effective role in cases and are better placed to assist others if required. Artingstall (1999: 3) stresses that there is ‘no other type of investigation that requires an understanding […] between agencies to the degree required in MBP investigations’.

8.4.3 Key issues facing police and Victorian professionals

The interview findings captured the complexity of FII/MBP cases and difficulties Victorian professionals face in handling such matters. An analysis of the findings, revealed fifteen key issues facing police and Victorian professionals in the investigation and management of FII/MBP cases. These issues are presented below249. They are relevant not only for police FII/MBP training but for Victorian professionals as a whole in improving the Victorian response to FII/MBP cases.

249 These issues are not listed in order of any importance.
1. The terminology and confusion surrounding FII/MBP
2. The deceptive and manipulative capabilities of FII/MBP perpetrators contributing to difficulties in the detection and management of such cases
3. The lack of evidence generally associated with FII/MBP cases, contributing to some professionals’ reluctance to become involved with such cases, conflict between agencies and apprehension regarding how suspicions of this abuse should be managed
4. The young age of the victims
5. The serious and potentially fatal nature of FII/MBP cases
6. The potential for serial offending
7. The potential for collusion, or a hostage-type relationship, to occur between the child and mother, husband and wife, and mother and professionals
8. The safety of the child and siblings
9. A lack of knowledge by professionals about FII/MBP and SUDI cases
10. A lack of clarity, understanding and guidance surrounding the multidisciplinary investigation and management of FII/MBP cases, including roles and role boundaries, the difficulties facing other agencies, agency referrals, information sharing and the management of case conferences
11. A lack of clarity and understanding surrounding investigation methods connected with FII/MBP cases, including tracking and reviewing of medical files, separation of mother and child, the use of CVS in Victorian hospitals and confrontation of the suspect
12. A lack of clarity in relation to SUDI investigations, including which police should attend such deaths, the approach to be taken by police and what evidence should be collected at the scene.

13. A lack of clarity regarding protective intervention, including the timing of child protection involvement, the timing of parental involvement, the involvement of the non-offending spouse and the monitoring of child victims.

14. The stressful nature of FII/MBP investigations and the impact of such cases on professionals.

15. Conflicting views about women FII/MBP perpetrators and what should happen to such women. Some professionals perceived these women as persons in need of help and support and others viewed them as perpetrators who should be held accountable in law.

The mixed methodology utilised in this research provided an ideal model for gaining an insight into the issues facing police and Victorian professionals in relation to FII/MBP cases. In hindsight, further correlation between the two methodologies, at the research stage, may have provided further value. However, time and resource constraints and the perceived needs of the research, at the time of compilation, kept the two methodologies relatively separate. Nevertheless, the parallel nature of the quantitative and qualitative studies and final analysis of this data provide a valuable understanding of the police and multidisciplinary response to FII/MBP cases in Victoria and of police training requirements and practice issues.
Symbolic interactionism principles (see Chapters 2.6.1.1; 3.2.2.1(i)) may assist in understanding the haphazard type response to FII/MBP cases in Victoria. Currently, as this research illustrates, there is minimal multidisciplinary guidance available for police and Victorian professionals involved in FII/MBP cases and a lack of consistency regarding language associated with this abuse and professionals’ understanding of it. An inconsistent and muddled type response to these cases is therefore understandable.

In the UK, constructive steps have been taken to improve professionals’ understanding of FII/MBP and to provide clarity and direction in relation to the management of such cases. Such steps include the introduction of multidisciplinary guidelines, the enhancement of training for medical personnel and the implementation of multi-agency protocols (surrounding issues such as SUDI investigations, and covert video surveillance in hospitals) (Department of Health, 2001; RCPCH, 2002; RCP and RCPCH, 2004). The researcher considered such measures and the introduction of standard terminology around FII/MBP would greatly assist to improve the identification, investigation and management of FII/MBP cases within Victoria and ultimately compliment and improve police FII/MBP training and the police response to this abuse. Finally, Horwath and Lawson (1995) identify a need for professionals to have a shared understanding of the issues associated with FII/MBP cases and to work together to improve multidisciplinary practice.
8.4.4 The interrelationships, power and dynamics that exist between agencies

The interview findings reflected that FII/MBP cases are multidisciplinary cases in which agency roles intertwine and impact on each other. Police and child protection professionals interviewed generally indicated that they depended on medical findings to support their roles and that conflicting medical opinions could make their roles more difficult (see Chapter 5.2.1; 5.2.4; 6.5). Doctors were generally portrayed as holding a certain degree of power and influence in these cases. This was particularly evident in relation to detecting and reporting this abuse and giving expert evidence of its existence within the courts (see Chapter 5.2.2; 6.3.1). Further, two police officers and three child protection workers described reluctance by police and child protection workers to question or challenge medical professionals (see Chapters 5.2.4; 6.3.1). Two child protection workers also identified issues with medical jargon at case conferences and feeling slightly intimidated by medical specialists.

Child protection and police were also shown to exert considerable power in FII/MBP cases. In two cases described by Doctor 3, Child Protection were shown to override other agencies’ (doctors and magistrates) decisions surrounding the removal of a child from his or her family, with the original treating doctor excluded from further involvement with the family (see Chapters 6.5). Police were thought to have more power than other agencies to legally investigate FII/MBP cases and lay charges where appropriate,
although in some cases described within this study police chose not to become involved or were not consulted.

The literature also reflects the different degrees of power professionals hold in FII/MBP cases (Freeland and Foley, 1992; Horwath and Kessel, 1995) and demonstrates that agencies can negatively impact on each other’s roles with potential implications for the investigation and protection of the child (Dale and Davies, 1985: 451 cited in Bahen et al. 1988: 57; Freeland and Foley, 1992; Artingstall, 1999). Postmodernist and critical theories reflect that power is embedded in language and social structures respectively and suggest a need for an awareness of how power can disadvantage others involved. Further, the FII/MBP literature (Artingstall, 1999; RCPCH, 2002; Lasher and Sheridan, 2004) supports a need for agencies to use their expertise and skills in a collaborative way to achieve the best outcome for the child.

Whilst this study revealed effective working relationships between agencies involved in FII/MBP cases, instances of tension, apprehension, and conflict were also apparent. The interview findings, for example, revealed conflicting views about the use of covert video surveillance, the timing of child protection and police referral, the timing of parental notification and agency responsibility in confronting the offending parent. Further, professionals proffered numerous recommendations regarding each other’s roles, such as a better system by medical professionals for detecting this abuse (see Chapter 6.3.1), a stronger and more investigative approach by child protection workers (see Chapter 6.3.3) and a more proactive stance by police
in working with other agencies (see Chapter 5.2.2). Finally, the questionnaire findings revealed police were generally unaware of the likelihood of conflict to occur in FII/MBP cases. This may result in police being unprepared to manage such differences when they arise and not fully understanding the reasons underpinning the conflict.

The presence of conflict in the management of FII/MBP cases is prevalent in the literature (Whelan-Williams and Baker, 1998; Lloyd and MacDonald, 2000; Feldman and Hickman, 1998). Many researchers emphasise the dangers of such conflict for the investigation and child (Freeland and Foley, 1992; Artingstall, 1999) and stress the need for good interagency relationships and agreed management strategies for dealing with FII/MBP cases and the complex interpersonal dynamics likely to arise with such matters (Horwath and Lawson, 1995; Artingstall, 1999; Lasher and Sheridan, 2004). The RCPCH (2002) further identify trust, effective information sharing, and team work as important and suggest knowledge of FII/MBP, clarity regarding professionals’ roles, and the use of multidisciplinary guidelines can assist professionals’ managing FII/MBP cases. Such factors were often absent with Victorian cases (see Chapters 5.8; 6.5; 6.6; 7.3.1.2). This was considered relevant to police training and to improve police knowledge, skills and attitude for dealing with FII/MBP cases.

Finally, theories pertaining to symbolic interactionism, postmodernism, labelling, feminism and critical criminology have assisted this research in understanding some of the issues that exist with FII/MBP cases and why tension often exists between professionals involved in these matters.
However, other theories, whilst not within the scope of this thesis to examine, may also be relevant, including family theory and theories pertaining to conflict and group dynamics.

8.4.5 Police training considerations

The researcher concluded police needed to be educated about the different professionals who may potentially become involved in FII/MBP cases; the different roles, positions and perspectives which professionals may bring to these cases, and how best to work with multidisciplinary professionals and diverging interests (see Chapter 6 and 7). Further, police need to possess good interpersonal and communication skills and an awareness of the potential issues likely to arise between agencies in FII/MBP cases. The value of multidisciplinary knowledge and training in FII/MBP cases is well supported by the literature (Artingstall, 1999; RCPCH, 2002; Lasher and Sheridan, 2004).

Finally, this study's findings, and the literature, support the need for a collaborative approach to the investigation and management of FII/MBP cases, including a shared understanding by police and other Victorian professionals about FII/MBP and agreed management and conflict resolution strategies for dealing with this abuse. Interdepartmental and interagency training and the use of multidisciplinary guidelines were considered vital for professionals involved in FII/MBP cases (Horwath and Lawson, 1995; RCPCH, 2002) and should be considered for implementation within Victoria.
8.5 The Investigation of FII/MBP

8.5.1 Avenues of inquiry and methods of investigation

This section examines the key investigative techniques associated with FII/MBP cases described within this research and police training requirements necessary with such techniques. Horwath and Lawson (1995) cite the need for professionals to know what investigative and assessment techniques are available in FII/MBP cases and to know what techniques to use and when, including the use of covert video surveillance. Byard and Burnell (1994) and Samuels (2001) maintain professionals must be adequately trained to investigate FII/MBP cases and to obtain the best available evidence to confirm or disprove its existence. The quantitative findings reflect poor knowledge by police about FII/MBP investigations (see Chapter 5.9.1.7).

Three police officers interviewed (Police 1, Police 5, Police 6) suggested it may be difficult with FII/MBP investigations, particularly those lacking medical support, to reach the necessary standard of proof, ‘beyond reasonable doubt’, required by criminal courts. The Department of Health (1999: 24) also held this view. However, much literature substantiates that FII/MBP perpetrators are convicted within the criminal courts (Stanioch, 1994; Yorker, 1995; Yeo, 1996; Kinscherff and Ayoub, 2000).
8.5.1.1 Observations of the child and family

The majority of professionals interviewed identified observations of the child and/or family as valuable in triggering an investigation (see Appendix 21). For instance, professionals described observations of the child’s physical appearance and behaviour as inconsistent with his/her alleged illness. One boy, for example, was alleged to be suffering from severe Leukemia yet appeared healthy and robust. Another child who was believed to have lost his hair through chemotherapy had patchy tuffs of hair on his head which were inconsistent with such treatment. Other observations included the child’s medical equipment being unusually faulty, the child’s siblings suffering similar problems, previous deaths of siblings, and the child and mother possessing significant medical histories. Professionals also observed inconsistencies in the mother’s behaviour with the alleged seriousness of her child’s situation such as reporting her child abused yet not taking her to the doctor. Attention seeking behaviour by the mother, and the presence of dysfunctional histories were also present with many of these women (see Appendix 21; Chapter 4.5.1; 4.5.4). Such findings are consistent within the literature in this field (see Pickford et al. 1989; Meadow, 1990; Stading and Boris, 1995; Southall et al. 1997).

The researcher concluded it was important for police to be aware of potential observations and inconsistencies that may present with FII/MBP cases and of the need for such findings to be followed up with relevant professionals. The training literature supports the need for professionals to be aware of warning
signs and potential behavioural clues which may suggest the presence of FII/MBP (See Appendix 15).

8.5.1.2  *The crime scene*

Apart from Police 2, crime scenes associated with FII/MBP investigations were not raised by professionals interviewed in this study\(^{250}\). Police 2 who was involved with offences more traditionally linked with crime scene investigation (an attempted rape and abduction of a child) stressed it was important for police to be able to identify inconsistencies between what they have been told and information presented at the scene\(^{251}\). In a number of cases, despite the potential for abuse occurring to a child within the hospital (Child Protection 1, Child Protection 2, Doctor 4), the hospital was not considered a potential crime scene. The quantitative findings revealed that a relatively high percentage of police (38%) were unaware that FII/MBP perpetrators may continue to offend within the hospital (refer Chapter 5.9.1.6). Further, consistent with the findings from this research, crime scene investigation appears to be rarely considered within the literature. The exception is Artingstall (1999) and, to a lesser extent, Wilkinson and Parnell (1998) and Lasher and Sheridan (2004).

Crime scene management of SUDI cases was explored with three of the police officers interviewed in this study (see Chapter 7.3.2.3). All three supported police attendance at such deaths, although tension existed

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\(^{250}\) Crime scenes associated with SUDI cases is explored separately in the next paragraph.

\(^{251}\) Police 2 identified dust being present on a window sill where the offender was alleged to have entered, a fly screen that had been cut from the inside to make it look like a forced entry, and cuts on the woman’s nightie and bra that were alleged to have occurred during the attempted rape, yet there were no marks on the woman’s body.
surrounding the management of such scenes (see also section 8.3.1.4). The literature also reveals tension in this area (Artingstall, 1999; RCP and RCPCH, 2004). Finally, the researcher observed that existing police guidelines for attending SIDS deaths in Victoria were not nearly as comprehensive and forensically balanced as the SUDI guidelines and research compiled by the RCP and RCPCH (2004) and the NSW Child Death Review Team (2005).

The researcher concluded police needed to be educated about potential crime scenes with FII/MBP cases, including consideration of the hospital environment. Existing training programs cited in this research, apart from Walsh (1997), do not appear to address crime scenes as a separate training topic. Finally, the researcher suggests existing SIDS guidelines in relation to the police role at SIDS incidents requires updating to reflect the broader ‘SUDI’ terminology and the balanced investigative and welfare role police play at these cases (see also section 8.3.1.4).

8.5.1.3 *Separation of the mother and child*

Separating mother and child has been acknowledged, both within this research and the literature, as a valuable step in determining whether FII/MBP may be present (Meadow, 1985; Schreier and Libow, 1993; Rosenberg, 1995). However, the RCPCH (2002) also stress that it should only be undertaken after careful evaluation and only once a safe environment can be provided for the child. In using separation, Doctor 3, concurs with researchers (Morley, 1995; Samuels and Postelthwaite, 2000), that
professionals must be wary that it may be only coincidence that a child recovers in the mother’s absence and gets sick again on her return, indicating that some naturally occurring diseases could fluctuate in their presentations. Finally, Samuels and Postelthwaite (2000: 117) stress any evidence obtained through separation will be heavily ‘challenged by experts’ in the courts and suggest, whilst valuable, this option has been ‘superseded’ by covert video surveillance.

The researcher concluded that police needed to be aware of separation as a potential tool to collect evidence of FII/MBP, the pitfalls of using this technique and the fact that better evidence may be gained through the use of CVS. ‘Separation’ as an investigative tool was not specifically cited within training material cited in this research.

8.5.1.4  **Covert video surveillance (CVS)**

During the course of this research, the topic of CVS emerged as an area of interest. The topic was pursued with five of the six police officers and the four doctors. Eight of these professionals regarded CVS as a valuable tool for detecting induced illness in children (see Chapter 7.3.2.1). Doctor 3 emphasised that CVS could assist in detecting life-threatening abuse and in protecting vulnerable children. Further, Police 1 noted CVS was regularly used by police to investigate crime and was carried out in service stations, nightclubs, and in city streets. In contrast, Doctor 2 considered CVS placed a child, already deemed at risk, at further risk and the amount of evidence required for the courts to approve such surveillance would be sufficient in its
own right, to initiate protective proceedings. Police 4, whilst acknowledging
the value of CVS, also suggested it was a legal nightmare and the
admissibility of CVS within the courts would be a difficult process. Two
doctors suggested the topic of CVS in hospitals needed clarification within
Victoria.

The literature shows CVS has been used in hospitals since the early 1980’s,
predominantly in the UK and US, to aid in detecting child abuse, particularly
with smothering and poisoning cases (Southall et al. 1997; Hall et al. 2000).
There is some evidence of such surveillance being used in Australia (Byard
and Burnell, 1994; Chadwick, 1996), but not within Victoria. The research
shows the use of CVS is controversial (Foreman and Farsides, 1993; Morley,
1995), but is generally accepted as a potential investigative tool with some
FII/MBP cases (Department of Health, 2001; RCPCH, 2002). Overt video
surveillance is also seen as valuable but thought to be problematic in
FII/MBP cases (Samuels and Postelthwaite, 2000).

The quantitative component of this study found the majority of police
considered the monitoring of CVS not solely the responsibility of the medical
profession (see Chapter 4.3.6). Regrettably the questionnaire did not explore
this issue any further. However, two police officers interviewed felt where
police had requested such surveillance they should then be responsible for
monitoring that surveillance (see Chapter 7.3.2). In the UK, the Department
of Health (2001) and RCPCH (2002: 51) nominate police as the prime
agency responsible for the installation, monitoring and management of CVS.
The Department of Health (2001: 57) also suggest medical and nursing staff
should be available to support police during this process and that ‘all personnel involved should receive specialist training’. The researcher noted there were no multidisciplinary protocols to guide medical, police and child protection professionals in the use of CVS within Victorian hospitals and certainly no multidisciplinary training.

The researcher concluded the use of CVS in hospitals should be an option with serious FII/MBP cases. The decision to use CVS should be made by a multidisciplinary forum utilising specific multidisciplinary guidelines developed for this purpose. The researcher considered that all alternate investigative methods must be considered prior to implementing CVS, including the use of overt video surveillance. The researcher concluded that police should assume ultimate responsibility for the implementation and management of CVS in hospitals (Department of Health, 2001; RCPCH, 2002) and should be trained in relation to its usage, approval, implementation and management processes. Horwath and Lawson (1995), Artingstall (2000) and the Department of Health (2001) support police being trained in the use of CVS.

8.5.1.5 *Medical files*

The family’s medical files were identified, both within this research and the literature, as an important source of inquiry in FII/MBP cases for medical, mental health, child protection and police professionals (refer Chapter 7.3.2.2). Professionals interviewed stressed these files needed to be checked for any inconsistencies or untruths to investigate what might be happening to the child (refer Chapter 7.3.2.2). The questionnaire findings,
However, revealed police generally were relatively unaware of the potential for such files to contain untruths or false data, although SOCAU members were quite aware of this (refer Chapter 5.9.1.6).

This study’s findings highlight a number of issues associated with accessing, collecting, reviewing and deciphering the family’s medical files, including issues with privacy legislation in sharing information (see Chapter 7.3.2.2). Further, it was noted that FII/MBP perpetrators may try and access their child’s medical files, potentially endangering the child and progress of the investigation (refer Chapter 6.4). The literature also explores these issues (Rosenberg, 1993; Department of Health, 2001; Stading and Boros, 1995; Siegel and Parnell, 1998). The researcher concluded police needed to understand the importance of medical files in FII/MBP cases and the difficulties surrounding accessing and reviewing such files. Michlelman (1999) and Artingstall (2000) cover records to examine and the importance of the medical files in their training programs.

8.5.1.6 Specimen analysis

Two doctors (Doctor 1, Doctor 3) interviewed in this study identified toxicology screens as important in suspected FII/MBP cases. However, the limitations of such testing were also noted and the potential for the mother to interfere with the testing or lay blame on others for a positive finding. Additionally, the importance of meticulous collection procedures surrounding the handling of specimens was emphasised, particularly for court proceedings. The questionnaire findings revealed police were generally
uncertain, in cases of induced illness, about the availability of evidence through toxicology testing. Samuels and Postelthwaite (2000: 124) suggest forensic analysis of specimens and covert video surveillance provide the best forms of evidence in FII/MBP cases. However, they also note that toxicology testing has its limitations\(^{252}\) and that the detection of an inappropriate substance may not necessarily mean a child has been abused, as accidental ingestion may have occurred (Samuels and Postelthwaite, 2000: 118).

The researcher concluded police needed to understand the benefits and limitations of toxicology testing, the importance of documented procedures associated with specimen collection and the fact that perpetrators may attempt to interfere with testing processes. Such a topic is not specifically addressed within the FII/MBP training literature.

### 8.5.1.7 Interviews

Professionals interviewed in this study generally identified the mother, father, child and medical professionals as key sources of inquiry for investigators in FII/MBP cases. Lasher and Sheridan (2004) also identify a range of other professionals as relevant in these cases, including doctors, nurses, pharmacists, mental health practitioners, emergency responders, welfare agencies and teachers (see also Appendix 11).

\(^{252}\) Samuels and Postelthwaite (2000: 117) point out that a negative screen can not completely rule out the possibility of poisoning as the drug may have been excreted rapidly, the wrong specimen may have been obtained, the timing of the specimen collection may have been wrong, or the specific test used may have been unable to detect the toxin.
Some of the key points which emerged from the research included the potential danger of forewarning parents of professionals’ suspicions of FII/MBP without a concrete basis to support such beliefs; the likelihood of false information supplied by the mother and the importance of considering the spouse in FII/MBP investigations. Child victims were also recognised as a key source of inquiry in FII/MBP cases, although there was disagreement surrounding whether police should interview FII/MBP child victims. Finally, the issue of privacy legislation in gaining information from other agencies was raised as an important police training issue (Doctor 3, Doctor 4, Police 5, Police 6).

The literature also notes the dangers of pre-warning parents (Artingstall, 1999; Samuels, 2001), the likelihood of false information from the mother (Meadow, 1982; Schreier, 2002) and the importance of timing and planning when speaking to the parents (Rosenberg, 1997; Lasher and Sheridan, 2004). The Department of Health (2001: 25) also thought that many FII/MBP victims would be ‘too young to be interviewed as part of a criminal investigation’. Artingstall (1999) considered, similar to Police 4, that interviews with child FII/MBP victims should be left to professionals with specialized expertise. Finally, the literature recognised the importance of information sharing between agencies and that privacy legislation may hamper child abuse investigations (Allen Consulting Group, 2004; Reynolds, personal communication, 2005).

From a training perspective, Artingstall (2000) covers in her training program interviewing the non-offending parent, interviewing family members and
neighbours (including babysitters) and interviewing the perpetrator. Walsh (1997) focuses on investigating fatal child abuse cases and covers witness interviews and interviewing the perpetrator. Lasher and Sheridan (2004: 128) contend that a 'skilled investigative interviewer who has a solid understanding of MBP maltreatment and MBP perpetrator characteristics' should undertake all interviews and associated inquiries in FII/MBP cases.

The researcher concluded police needed to be skilled in conducting FII/MBP interviews and to possess an awareness of the dangers of forewarning parents of professionals’ suspicions of FII/MBP without concrete evidence to support such allegations. Further, police needed to be informed about potential interviewees, the importance of interview planning and of potential issues that may arise, due to privacy legislation, in collecting information from other professionals. Finally, police need to be made aware of the potential for false information to be supplied by FII/MBP perpetrators and of the need for their information to be corroborated.

8.5.1.8  Confronting the perpetrator

The findings from this study reveal there is significant controversy surrounding the confrontation interview. This included who should be responsible for confronting the mother, the purpose for such an interview, the timing of such an interview and how it should be undertaken (see Chapter 7.4). Medical personnel generally viewed the confrontation process as part of the medical diagnosis in determining the cause of the child’s condition. Child protection workers saw it as a means for determining any risks facing
the child and identifying the parenting capacity of the mother, whilst police regarded this interview as a means for formally putting the abuse allegation to the parent and adhering to any legal requirements. Diverging opinions in this area also exist within the literature (Meadow, 1985; Samuels et al. 1992; RCPCH, 2002).

The RCPCH (2002: 52) contend where criminal behaviour is suspected it is not appropriate for a paediatrician to confront the mother, nor to try and obtain an admission from her. Further, Fox (1995: 7, 109) emphasize the dangers of failing to consult police as this may ‘result in a ‘loss of evidence’ necessary to protect the child and ‘jeopardize any future police interview’ (also supported by Artingstall, 1999).

The timing of the confrontation interview was considered crucial and raised mixed opinions (Doctor 1, Doctor 2, Doctor 3, Psychiatrist, Child Protection 1, Child Protection 4). Four professionals thought it was better to wait until there was some concrete evidence to support the existence of abuse before interviewing the mother (Doctor 1, Doctor 3, Psychiatrist, Child Protection 4). However, Child Protection 2 suggested where a ‘reasonable belief existed that abuse was occurring’ that professionals should act as the child may be endangered if professionals awaited solid evidence. The literature also reveals differing opinions on this issue, with researchers recognising the chances of a mishap occurring to the child if the situation was left too long (Rosenberg, 1994) and/or the long term safety of the child jeopardised if professionals acted too early (Southall et al. 1997; Artingstall, 1999).
Professionals interviewed in this study recommended utilising a direct and/or an empathic approach when confronting parent(s) suspected of fabricating and/or inducing illness in their child (see Chapter 7.4.3)\textsuperscript{253}. Professionals generally agreed that an accusatory type approach to confronting such women should be avoided as this would most likely result in denial (refer Chapter 7.4.3). The research in relation to interviewing perpetrators of suspected FII/MBP is still relatively new (Artingstall and Brubaker, 1995; Siegel and Parnell, 1998; Artingstall, 1999). However, there is some evidence to support the use of a non-judgmental and empathic approach with such interviews (see Meadow, 1985; Artingstall and Brubaker, 1995; Moran, 2001).

Professionals interviewed emphasized the importance for the police interviewer to be personally and professionally prepared for dealing with such cases and to be well briefed in relation to the medical circumstances and history of the child. Two child protection workers and a doctor highlighted cases in which children’s lives were either put at risk or extinguished due to professionals’ confronting parents too early with minimal planning (see Chapter 7.4.2). The literature also emphasises the need for professionals to be well prepared for such interviews (Artingstall, 1999; Samuels, 2001). Samuels (2001: 101) claims confrontation of a parent suspected of fabricating or inducing illness in his or her child without sufficient evidence

\textsuperscript{253} For example, Child Protection 1 who was tasked with attending a house to remove a child victim of induced illness described how she was seduced by the mother into believing that the doctors had got it all wrong and the child was genuinely sick. She suggested in hindsight she had been too empathic towards the mother and recommended that professionals adopt a more direct approach when dealing with such women. However, in another case, Doctor 2 described a registrar who obtained an admission from the mother by using a gentle nurturing approach.
and planning can lead to denial, and the child being discharged and later returned deceased or with serious injuries (also supported by Waller, 1983 and Meadow, 1990). Existing FII/MBP training programs by Walsh (1997), Micheleman (1999), Artingstall (2000) and Lasher (2001) all cover the topic of ‘confronting the perpetrator’ in their training agendas.

The researcher concluded police needed to be informed about the importance of multidisciplinary planning with confrontation interviews and of the dangers in carrying out such an interview without consulting other agencies. Police also need to be made aware that conflict may exist between police, child protection and medical professionals surrounding who should confront the perpetrator and of the need for this issue to be raised and clarified early in case conferences. Finally, police must be well briefed and prepared for confronting FII/MBP perpetrators and experienced with the different interview styles that have proved successful in these cases.

8.5.2 Police training considerations

This section has analysed a range of investigative options for confirming or disproving the existence of FII/MBP and identified issues of relevance to police FII/MBP training. Horwath and Lawson (1995) suggest professionals, including police, involved in FII/MBP cases require a shared understanding of potential avenues of investigation and must work together to investigate FII/MBP allegations. The quantitative findings from this research found police in Victoria lack knowledge about the investigation and management of
FII/MBP cases (see Chapter 5.9.1.7) and require further knowledge in this area.

The researcher concluded that police, who may potentially become involved in FII/MBP cases, must be educated about the potential investigative options applicable to such investigations and appropriately skilled to work closely with other agencies in carrying out their investigations. The researcher also considered that in addition to the subjects analysed within this research, other training topics, such as ‘victim safety’ (Artingstall, 2000; Lasher, 2001); ‘legal issues’ (Michielemman, 1999); ‘the long term management of FII/MBP cases’ (Artingstall, 2000; Lasher, 2001) and topics associated with child death investigations, as covered by Walsh (1997), should be considered for inclusion within police training. Additionally, the researcher considered brief and court preparation as important254.

8.6 Conclusion

This chapter explores and analyses the findings from this research and examines police FII/MBP training requirements from five points of reference, namely: police background FII/MBP knowledge requirements; the police role with FII/MBP and implications for training; existing police FII/MBP knowledge levels and gaps in knowledge; the multidisciplinary aspect of FII/MBP cases and what this means for training, and the investigation of FII/MBP and key knowledge and skill requirements.

254 This was not covered within this research as the primary focus of this study was on the initial response and investigation of FII/MBP cases.
The chapter makes links to existing published and unpublished FII/MBP training material and begins to draw conclusions about the requirements of police with FII/MBP investigations and FII/MBP police training content. Finally, it demonstrates a broader need within Victoria for improved policies and systems to guide and regulate Victorian professionals’ management of FII/MBP cases. The final chapter returns to the primary research objective and questions for this research and presents the final conclusions and recommendations from this study.
Chapter 9

Final Conclusions and the Way Forward

There’s got to be more thought into how MBP cases are managed, including police, medical and child protection professionals.

Doctor 1

9.1. Introduction

This chapter revisits the primary research objective and research questions. It examines how they were addressed and answered and considers the findings in light of the theoretical framework and theoretical perspectives explored within this study. Finally, the strengths and limitations of the data are presented as well as ideas for future considerations and recommendations for future research in this field.

The interpretative framework, mixed method research design and theoretical perspectives utilized in this study enabled a broad insight into the training requirements for police in responding to and investigating FII/MBP, from both a police and multidisciplinary perspective. It is hoped the findings from this research assist to improve not only police FII/MBP training but the greater multidisciplinary response to FII/MBP cases in Victoria.
9.2 Addressing the objective and research questions

The objective of this research was to identify the training requirements for Victoria Police in responding to and investigating FII/MBP, from both a police and multidisciplinary perspective. In order to gain a broad and in-depth understanding of the topic, this research was supported by five research questions:

- What is the police role in FII/MBP cases?
- What knowledge do Victoria Police members have about FII/MBP and the investigation and management of FII/MBP cases and what gaps exist in members’ knowledge?
- Do Victoria Police members require training in relation to FII/MBP?
- If so, what knowledge and skills do Victoria Police members require to respond to and investigate FII/MBP cases from both a police and multidisciplinary perspective? and
- What members would require FII/MBP training?

This chapter draws upon the analysis undertaken in Chapter 8 to provide a final interpretation of the research findings. It addresses the research questions individually and then returns to the primary research objective.
9.2.1 What is the police role with FII/MBP cases?

This question was primarily addressed by the qualitative component of this research. However, the quantitative component provided some input through the opinion questions.

The qualitative research, through the involvement of multidisciplinary professionals and inclusion of different policing departments, enabled insights into the police role in FII/MBP cases from multiple perspectives. The findings and analysis found that whilst police and other professionals generally agreed police had a role to play in FII/MBP cases, there was a high level of uncertainty and controversy surrounding the nature and timing of that role. Further, the police findings highlighted that police are not a homogenous body and that different police departments may perform different roles in dealing with this abuse. The quantitative findings revealed police uncertainty about their role in FII/MBP cases and a lack of understanding about FII/MBP (see 5.10; 8.3.1.1).

The researcher concluded the police role in FII/MBP cases in Victoria was unclear and that this position had the potential to cause confusion and conflict both internally and between agencies and to lead to inconsistency in the police response and quality of police investigations. The literature supports the need for clarity surrounding professional roles and role boundaries in FII/MBP cases (Artingstall, 1999; RCPCH, 2002). Existing FII/MBP training literature recognises the importance of professionals, including police, to be educated about their role and responsibilities in
relation to FII/MBP cases (Horwath and Lawson, 1995). This is also supported by the general literature in this field (Blyth and Milner, 1990; Fox, 1995; Bufton, 1996; Artingstall, 1999; Lasher and Sheridan, 2004).

- Based on the findings and analysis undertaken in Chapters 5 and 8 a number of conclusions were drawn about the police role in FII/MBP and SUDI cases, all of which are relevant for police FII/MBP training.

- The police role in FII/MBP cases is to establish whether a crime has been committed, to conduct an investigation into that crime and to, where applicable, take the matter before the courts.

- The SOCAU member should conduct the initial investigation, including working with other agencies to confirm or disprove the existence of FII/MBP, establishing whether a crime has been committed and assisting with preventative intervention.

- The CIU member should work closely with the SOCAU member and provide investigative advice, investigate evidence of criminal activity and, where applicable, take the matter before the courts. In SUDI matters, the Homicide Squad should be consulted and become involved if indicators suggest suspicious circumstances.

- Uniform members in their role as first responders may also become involved in FII/MBP and/or SUDI cases, with the case then being referred to a SOCAU or CIU member.
• In cases involving infant death police act on behalf of the coroner to collect information at the scene that may assist in determining how the child died and in distinguishing between unknown causes, accidental deaths and murder. Police need to ensure balance is provided between conducting an investigation on behalf of the deceased child and any future siblings and providing care for the parents.

• The laying of criminal charges in FII/MBP cases needs to be judged on a case by case basis. The researcher concurs with the Department of Health’s (1999: 24)255 recommendations regarding criminal proceedings in FII/MBP cases (refer Chapter 2.6.1) and suggests police need to be made aware of key considerations in deciding whether to lay criminal charges.

• All police have a responsibility to ensure the protection of the child and prevent further abuse.

• Police must be notified early in suspected FII/MBP cases due to the potential of a crime having been committed, the complexity and seriousness of such cases and multidisciplinary nature of FII/MBP investigations.

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255 The Department of Health (1999:24) recommended that the decision to initiate criminal proceedings should be based on three key factors: 'whether or not there is sufficient evidence to prosecute; whether it is in the public interest that proceedings should be instigated against a particular offender, and whether or not a criminal prosecution is in the best interests of the child'.
• Police need to be made aware of the difficulty of FII/MBP cases and uncertainty which often surrounds this abuse and its management. Police need to be taught how to conduct a balanced investigation which is sensitive to the needs of the child, parents and other agencies.

• The police role is partly dependent upon the medical findings, although in some cases, such as suspected smothering, there may be limited medical evidence and other forms of evidence gained through the police investigation may take precedence.

• Police, supported by medical personnel, are responsible for the implementation and monitoring of the use of CVS in hospitals.

• FII/MBP training should be focused at SOCAU, CIU and Homicide members, with training made accessible to uniform members only if they require it.

• Police (uniform, SOCAU, CIU and homicide members) need to be educated about their role in FII/MBP and SUDI cases and made aware of the different police departments’ roles in responding to and investigating such matters.

• Police training needs to reflect the multidisciplinary nature of FII/MBP investigations. Police need an understanding of other agencies’ roles, potential interagency issues that may arise and how best to work
effectively as a team to achieve the best outcome for the child. Police need to be taught how to work proactively with other agencies.

- Police training and internal police guidelines are needed to provide clarity about the police role.

Finally, as captured in Chapter 8 many aspects associated with the police role were found to require further exploration and/or clarification than what this study could afford (see Chapter 8.3.1.2). It is hoped this research will act as a catalyst for further research in these areas.

9.2.2 What knowledge do Victoria Police members have about FII/MBP and the investigation and management of FII/MBP cases and what gaps exist in members’ knowledge?

This question was primarily addressed through the quantitative research, although, the qualitative data lent some support to the quantitative findings. Adopting interpretive principles, the researcher sought to identify FII/MBP knowledge levels of police most likely to be assigned to FII/MBP investigations (SOCAU and CIU). Additionally, recruits and uniform members were surveyed to gain an understanding of members’ FII/MBP knowledge levels, in the case of recruits, prior to commencing operational duties and in the case of uniform members, prior to entering specialist areas. This would provide an indication of potential FII/MBP training requirements of newly appointed SOCAU and CIU members.
The analysis of the quantitative findings undertaken in Chapters 5 and 8 clearly show that whilst police in Victoria are generally familiar with FII/MBP they lack detailed knowledge about this abuse and the investigation and management of such cases, although SOCAU members, whilst still poor in their knowledge, were shown to be significantly more informed than recruits, uniform members and detectives (see Chapter 5.8.1). The qualitative findings revealed police were relatively ignorant of FII/MBP until involved with a case. Poor knowledge by police about FII/MBP was also thought to be the case within the UK (Bufton, 1996) and US (Artingstall, 1999).

Members surveyed in this research were found to have poor levels of knowledge about FII/MBP in all five knowledge domains (offenders, spouses, victims, offending, and investigation and management) contained within the questionnaire, scoring less than 52% of correct responses in all five areas. Overall, police were shown to have a greater understanding about offenders and spouses associated with this offending than about victims, methods of offending and investigation and management practices. SOCAU members were shown to have significant gaps in their knowledge about the nature and methods of offending, the investigation and management of FII/MBP cases and information pertaining to victims. Detectives had significant knowledge gaps in all five knowledge domains and were shown to require more extensive training, as opposed to SOCAU members, if expected to investigate and manage such cases.

Whilst it may be argued that measuring knowledge is a subjective and difficult task as the classification of what knowledge is to be measured is ultimately
reliant upon a human being, the researcher suggests the benefits of approaching such a task are also clear, and indeed, essential for advancement. In conducting the quantitative component of this research a number of steps were taken to enhance the validity and reliability of the research findings. This included an extensive literature review, international research, the implementation of a pilot survey, and consultation with experts in the field. Further, the diverse content base of the questionnaire; size of the research (1,238 questionnaires); 66% response rate, and distribution of the questionnaire to police officers throughout Victoria, allowed for a broad overview of the different aspects of FII/MBP cases to be measured and for a consistent picture to emerge of the different policing departments’ knowledge of FII/MBP. Finally, members’ own self assessment ratings, the qualitative data, and international literature in this field corroborated the overall quantitative findings.

However, this study also found, through the merging of the quantitative and qualitative findings, that what constitutes knowledge is not always clear and that knowledge may change with the course of time (see Chapters 5 and 8). The findings from this research must therefore, as with any study, be considered in light of the time in which the research was conducted and in relation to any new research in the field. As such, this research provides a foundation to begin to understand the training requirements of police with FII/MBP cases and as a base for further progression.

The researcher concluded that the low levels of knowledge held by police in Victoria about FII/MBP was concerning, particularly in relation to SOCAU
members and detectives who would most likely be assigned these cases. Low levels of knowledge have the potential to place SOCAU and CIU members at risk of stress, the investigations at risk of not being properly conducted and the child, and or siblings, at risk of inadequate protection. Researchers (Fox, 1995; Artingstall, 1999; Lasher and Sheridan, 2004) suggest poor knowledge of FII/MBP by police can be detrimental for both the child and the investigation. The researcher concluded due to the seriousness and complexity of FII/MBP cases that the risks associated with poor FII/MBP police knowledge could not be justified and that members potentially dealing with FII/MBP cases needed to be appropriately trained.

9.2.3 Do Victoria Police members require training in relation to FII/MBP?

This question was addressed through both the quantitative and qualitative components of this research. The quantitative research identified how police learn about FII/MBP, existing police FII/MBP knowledge levels and gaps in that knowledge. The qualitative component examined the need for police to receive training, the nature of FII/MBP cases and the police role in such matters. Together the quantitative and qualitative findings and analysis provide a strong argument for police, in particular SOCAU, CIU and Homicide Squad members, to be trained in FII/MBP investigations. A number of points emerged from this study, which support this position:
• All suspected FII/MBP cases may also involve the commission of a crime, therefore, police should always be involved (Department of Health, 2001:45).

• Victoria Police members are becoming involved in FII/MBP cases and have an important role to play in these investigations.

• Police in Victoria, whilst generally aware of FII/MBP, possess a poor understanding about this abuse and the investigation and management of such cases.

• Poor knowledge levels by members assigned to FII/MBP investigations have the potential to negatively impact on the criminal investigation and protection of the child, as well as creating stress for the investigators themselves.

• Professionals, including police, assigned to FII/MBP investigations should be experienced and senior professionals in their field and be educated about FII/MBP and the investigation and management of such cases.

• 73% of the sources through which police currently acquire knowledge about FII/MBP are potentially unreliable. Television was the main source of learning for police about FII/MBP, with some SOCAU members having exposure to an introductory FII/MBP training package.
• Existing FII/MBP training is primarily awareness based, as opposed to covering investigative aspects, and has predominantly only been delivered to SOCAU members.

• A range of factors and dynamics operate in FII/MBP cases that have the potential to negatively influence and shape police perceptions and response to such matters.

• FII/MBP cases may involve serious physical, emotional and psychological abuse of infants or young children. Such abuse also has the potential to be fatal and serial.

• FII/MBP cases can be stressful, time-consuming and emotionally and physically draining on professionals. Additionally, such cases may have a high media interest.

• FII/MBP perpetrators are skilful, deceptive and very good at manipulating the system and those around them, including police.

• Concrete evidence is often initially not available in FII/MBP cases. Such cases, therefore, require skilled and knowledgeable professionals to investigate and confirm or disprove the possibility of FII/MBP.
• FII/MBP cases are complex and multidisciplinary cases that require police to have input into multidisciplinary discussions and the planning of a coordinated response.

• FII/MBP cases may require complex decisions regarding case management and investigative approaches. Police may be required to provide advice regarding the use of CVS and or to implement and monitor such surveillance.

• Diverging perspectives typically exist in FII/MBP cases, which, if not properly managed, may cause conflict between professionals and result in delays in the investigation and safety issues for the child.

The literature clearly portrays a need for police and other professionals working in areas where child abuse potentially exists to be educated about FII/MBP (Horwath and Lawson, 1995; Fox, 1995; Artingstall, 1999; Department of Health, 2001; Lasher and Sheridan, 2004). Knowledge of this abuse can improve the identification, investigation and management of such cases (Artingstall, 1999; Lasher and Sheridan, 2004), assist to enhance professionals’ decision making and minimise the risks of misjudgement (Department of Health, 2001; RCPCH, 2002). Lasher and Sheridan (2004) stress that professionals ‘who do not understand MBP basics are likely to dismiss reports, fail to assign them proper priority, make inappropriate decisions and even fail to identify the described suspicious behaviour as possible MBP’.
The researcher concluded SOCAU, CIU and Homicide members required FII/MBP training. Such training will provide police with an understanding of their role and the knowledge and skills to respond to and investigate FII/MBP cases, including the ability to recognise potential FII/MBP abuse; deal with suspected FII/MBP perpetrators, their spouses and victims; identify and collect sources of evidence; manage potential conflict and inter agency issues, and work proactively with other agencies in investigating and managing FII/MBP cases and in protecting the child. Such training will also assist to prepare police for dealing with the taxing and stressful nature of FII/MBP investigations and internal and external pressures which exist.

Drawing on theoretical principles associated with symbolic interactionism, which asserts that human beings act toward things on the basis of the meaning that the things have for them and that meaning of things arises out of social interaction with one’s fellows, it makes sense that training will provide police with a greater knowledge base with which to investigate FII/MBP cases. Such knowledge naturally being further shaped as police deal directly with FII/MBP cases and interact with others.

Symbolic interactionists also assert that when people share the same definitions and meanings, communication and understanding is improved. In this light, consideration needs to be given to involving a mix of different police departments within police FII/MBP training and to implementing interagency training. The end result will be a shared understanding by professionals about FII/MBP cases, reduced tension between internal police departments and between agencies, and improved multidisciplinary practices and
relationships in managing FII/MBP cases, ultimately leading to better quality investigations and better outcomes for child victims.

Finally, it was recognised both within this study and in the literature that police FII/MBP training needs to be supported by other factors. Such factors include internal and multidisciplinary guidelines; agreed management and conflict resolution strategies between agencies, and the right people assigned to FII/MBP cases who possess the right attitude towards child abuse and good communication and interpersonal skills to be able to work collaboratively with other agencies. Further, educated supervisors were considered essential for providing support and guidance to staff.

9.2.4 What knowledge and skills would be required of police to respond to and investigate FII/MBP cases from a police and multidisciplinary perspective?

The interpretive paradigm underpinning this research promotes the use of multiple perspectives and the involvement of individuals most associated with the topic to help understand the particular phenomenon being studied. It suggests there is no one correct way of viewing the world but rather that multiple perspectives help us to gain a better understanding of the situation. This thesis utilised both quantitative and qualitative research methodologies to understand police FII/MBP training requirements from both the police perspective and that of multidisciplinary professionals experienced in dealing with FII/MBP cases. Such a framework enabled a valuable and in-depth insight into FII/MBP cases and revealed a broad level of education needed
for police assigned to such matters. Additionally, the theoretical perspectives incorporated in this research, promoted a deeper analysis and consideration of training issues from the perspective of the victim, offender and other professionals.

Based on the research findings, the literature and analysis, the researcher concluded police responding to and investigating FII/MBP cases required specific knowledge and skills. Such knowledge and skills are captured by four training modules which are examined below:

1. Identifying and understanding FII/MBP cases
2. The police role in FII/MBP cases
3. The multidisciplinary response
4. The investigation of FII/MBP cases

A further module relating to brief preparation the presentation of FII/MBP cases before the courts was also considered relevant, but, due to the already complex nature of this research was not covered within this study. Additionally, it is recognised that police involved in FII/MBP investigations will need to draw on a wide range of other policing skills and investigative knowledge. This includes, but is not limited to, evidence handling; statement taking; interviewing of victims, witnesses and perpetrators; family violence processes and powers; search and arrest powers; documenting, recording and reporting processes, and legislative and force requirements.
9.2.4.1 Identifying and understanding FII/MBP cases

The literature, research findings and analysis clearly depict a need for police, particularly those who may encounter FII/MBP, to identify and understand this abuse. Yorker and Kahan (1991: 56-57) stress that ‘just as the signs and symptoms of sexual abuse have become widely understood by professionals who work with children, the signs and symptoms of MBP must also become familiar.’ The analysis in Chapter 8 identifies nine key topics important for police to acquire a background understanding of FII/MBP cases and prepare them for dealing with such matters. The nine topics are:

- The use of language associated with FII/MBP and potential implications of language and labels;
- The history of FII/MBP;
- Methods of offending;
- FII/MBP and SUDI;
- The nature of FII/MBP and how a case may unfold;
- Factors which may shape professionals’ perceptions, knowledge and response to FII/MBP cases;
- Perpetrators, spouses and victims;
- Potential power dynamics operating in FII/MBP cases, and
- The impact of FII/MBP on professionals.

The researcher concluded a contextual and background understanding of FII/MBP cases would enhance police ability to recognise FII/MBP; work with FII/MBP perpetrators, spouses and victims; plan their investigations, and
work collaboratively with other agencies. Further, such knowledge would assist police to build resilience to cope with the inevitable dynamics, conflict and influences that arise in FII/MBP cases. Artingstall (1999: 5) states that the more investigators know about FII/MBP ‘the better able they will be to identify perpetrators, clear innocent suspects and most importantly protect children’.

9.2.4.2  **The police role in FII/MBP cases**

The findings and analysis from this study found police need to be educated about their role in FII/MBP and SUDI cases and equipped with the knowledge and skills to carry out that role. Blyth and Miller (1990) contend professionals need to clearly understand their own roles and those of other agencies and that having a full understanding of what actions need to be taken allows the worker to play a more effective role and to assist others if required. Further, Lasher and Sheridan (2004: 18) suggest ‘professionals who are not trained investigators with considerable MBP knowledge and experience may inadvertently compromise victim safety or the investigation’.

Holistically, police need to be taught to conduct a sensitive and balanced investigation in conjunction with other agencies; to identify and collect potential sources of evidence; to establish whether a crime has been committed and to lay applicable charges where deemed appropriate. Further, police need to be educated about their responsibility in working with other agencies to protect the child and prevent further abuse. This study’s findings and analysis also suggest SOCAU, CIU and Homicide members play
different roles in FII/MBP investigations and that training where possible, should be tailored to address different departments’ needs.

The researcher concluded a clearer understanding by police about their role in FII/MBP cases will assist to minimise the tension between police departments and improve the police response to FII/MBP matters both internally and with other agencies. Further, it will contribute to a more proactive, investigative and preventative approach by police in managing and investigating FII/MBP cases which will ultimately benefit the child victims.

9.2.4.3 *The multidisciplinary response*

The literature, findings and analysis clearly demonstrate, due to the overlapping medical, protective and criminal issues existing in FII/MBP cases (Artingstall, 1999; RCPCH, 2002), a need to include a multidisciplinary component within police FII/MBP training (Horwath and Lawson, 1995; Walsh, 1997; Michlelman, 1999; Artingstall, 2000; Lasher, 2001). Police need to be educated about other agencies’ roles and role boundaries, potential issues arising between agencies involved and the importance of a coordinated proactive approach to managing FII/MBP cases (see Chapter 8.4; Department of Health, 2000; RCPCH, 2002). Further, police need to possess the knowledge and skills to work effectively as part of a multidisciplinary team, including effective interpersonal and communication skills; conflict resolution skills; case conference skills; and legislative knowledge about privacy, as well as mandatory reporting of child abuse. Wilkinson and Parnell (1998: 222) suggest ‘only through a detailed,
coordinated effort that involves a high level of communication among disciplines are the dual goals of child protection and perpetrator accountability likely to be achieved’. Finally, to effectively participate in complex multidisciplinary discussions and decisions regarding suspected FII/MBP cases, police require a solid understanding of FII/MBP investigations and a thorough knowledge of the police officer’s role and limitations of that role.

Multidisciplinary training will equip police with the necessary knowledge and skills to work with other agencies in the investigation and management of FII/MBP cases and to represent the police perspective in light of other agencies’ requirements. Ultimately, improved police knowledge of the multidisciplinary aspect of FII/MBP cases will contribute to better relationships between agencies and to more coordinated and timely FII/MBP investigations. Horwath and Lawson (1995: 190) identify ‘working with other professionals’ as a key training area for professionals involved in FII/MBP cases, including police.

**9.2.4.4 The investigation of FII/MBP cases**

The findings and analysis from this research found police in Victoria lack knowledge about FII/MBP investigations and that there is little guidance for police, and other Victorian professionals, about investigative techniques associated with FII/MBP cases (see Chapter 8.2.6; 6.2.6.1; 8.5.1.4). The literature suggests a lack of FII/MBP knowledge as the potential to contribute to FII/MBP cases being missed (Fox 1995), delays in the investigation
(Shepherd, 1995), damage to the criminal case (Wilkinson and Parnell, 1998) and poor outcomes for the child (Fox, 1995; Artingstall, 1999; Lasher and Sheridan, 2004).

The analysis in Chapter 8 demonstrates police need to be educated about potential investigative techniques associated with FII/MBP cases, how and when to use them and the advantages and disadvantages of such techniques. Further, the findings and analysis reflect multidisciplinary clarity is needed for professionals in Victoria, including police, surrounding investigative techniques associated with FII/MBP cases. This includes the use of CVS, separation of the suspected perpetrator and child to gain evidence, the collection and reviewing of medical files, and confrontation of FII/MBP perpetrators (see Chapter 8.5). The analysis also suggests clarity is needed between medical and policing professions in relation to the timing of police involvement in FII/MBP cases and evidence collection associated with such matters (see Chapter 8.3.1.3).

The researcher concluded police who are equipped with the knowledge and skills to consider, discuss and implement investigative techniques applicable to FII/MBP cases will be a valuable asset to FII/MBP investigations and be better placed to identify perpetrators and clear innocent suspects.
9.2.4.5  **Overview of FII/MBP training modules**

This section presents a final overview of the four FII/MBP police training modules considered important for police responding to and investigating FII/MBP cases.

i)  **Identifying and understanding FII/MBP cases**

*Background*

- History of MBP (including an understanding of why confusion and controversy surrounding MBP exists)

- Terminology and definitions (emphasis placed on MBP as a form of child abuse and the adoption of FII terminology).

- Effects of labels (Advise that FII/MBP terminology can negatively impact on women accused of this abuse)

- Methods of offending, common presentations of this abuse, case studies, links to physical, psychological and emotional abuse, neglect and sexual abuse

- Knowledge of the link between SUDI and FII/MBP

- Seriousness of FII/MBP cases and potential for such abuse to be fatal and serial
• Knowledge of how suspected FII/MBP cases may progress

• Awareness that FII/MBP cases may lack concrete evidence and the importance of looking beyond presenting factors

• Awareness of the potential factors that may shape and influence professionals’ perceptions of FII/MBP and the perpetrators who commit this abuse (including gender and the image of motherhood, the impact of the media, and a person’s professional background)

• Awareness that some professionals may be reluctant to become involved in FII/MBP cases and/or lack the knowledge and skills to investigate and manage such cases

• The potential impact of the media

• The power dynamics that may operate in FII/MBP cases.

Detecting FII/MBP

• Warning signs/indicators that may raise the suspicion of FII/MBP (to be used as a guide only)

The mother as offender

• Characteristics and behaviours commonly associated with FII/MBP perpetrators, including deception, power and control, attention
seeking, a lack of self worth, dysfunctional pasts, significant medical histories, doctor shopping, financial deceptions and the potential to move address. Members also cautioned to keep an open mind and to be aware that just because such indicators may be present this does not correlate to the mother abusing her child. Indicators are there to prompt members into considering FII/MBP and investigating the matter further.

- How professionals may be influenced by perceptions of a mother with a sick child
- Potential for women perpetrators to be oppressed in their lives
- Awareness that offenders may relocate address to avoid detection or investigation
- Potential for the mother’s fabrications and/or attention seeking behaviour to extend into other realms of her life
- An awareness that FII/MBP perpetrators may lay complaints and/or recruit powerful allies
- Awareness that FII/MBP perpetrators may continue to offend within the hospital.
The non-offending parent

- Characteristics and behaviours that have been associated with the non-offending parent include a potential lack of knowledge of their partner’s abuse and a high probability that they will defend their partner, suggesting they may be incapable of protecting their child.

Victims of FII/MBP

- Characteristics associated with FII/MBP victims include the young age of the victims (though not always), no preference regarding gender, the issue of collusion between mother and child, and the dominance of the mother over her child

- Effects of this abuse on child victims

- Potential for older children to collude with the mother

- Understanding of the risks posed to victims, including the potential for life-threatening and/or fatal abuse and serial offending

- Difficulties for victims in disclosing abuse

- Child victims may display evidence of abuse through their behaviour.

- Police members’ wellbeing and organisational considerations
• An awareness of the potential impact of FII/MBP cases on professionals

• Importance of self care, supervision and support when managing FII/MBP cases

• Implications of FII/MBP cases for resources, policy, procedure and practice.

ii) **The police role in FII/MBP cases**

• The police role in FII/MBP and SUDI cases

• The timing of police involvement

• Internal reporting requirements, - notification to a SOCAU and CIU, and/or Homicide Squad in cases involving infant/child deaths

• Responsibilities relating to the protection of children / mandatory reporting.

iii) **The multidisciplinary nature of FII/MBP cases**

• Importance of investigating these cases collaboratively and holistically

• Agency roles and role boundaries
- Difficulties and limitations facing professionals

- Differing perspectives which professionals may bring to these cases due to their professional backgrounds

- Dynamics that may exist between agencies

- Likely issues to arise between agencies

- Dealing with difficult and complex dynamics that may arise in suspected FII/MBP cases and working with conflicting agency views

- Information sharing between agencies

- Privacy legislation

- Reporting processes / mandatory reporting

- Multidisciplinary case conferences.

iv) **Safety and protection of the child**

- Child’s health and safety must take priority

- Referral processes / mandatory reporting requirements
• Role of professionals in ensuring the safety and wellbeing of the child, obligations under the Children, Youth and Families Act, 2005

• Understanding how cases are processed through the protective court system

• Understanding the issues surrounding the timing of parental involvement

• Balancing the rights of the child with those of the parents

• Monitoring of suspected FII/MBP child victims within hospital and ensuring their safety

• Awareness of the Human Services and Victoria Police (1998), Protecting Children protocols.

v) The investigation of FII/MBP cases

• Observations of the mother and child

• Tracking, collecting and reviewing of medical files

• Awareness that parents may access and/or alter their child’s medical files

• Interviewing professionals
• Interviewing family, relatives, friends and/or other witnesses

• Awareness of the potential dangers of alerting perpetrators that they are under suspicion before concrete evidence is secured of their offending

• Interviewing and dealing with the non-offending parent

• Interviewing the child

• Toxicology testing

• Hospitalization of the child and the collection of information/evidence from within the hospital

• Collection of physical evidence

• Crime scenes

• Warrants, the coroner’s authority, and the parents’ consent

• Potential records for checking

• Separation of mother and child

• Covert video surveillance
• Confrontation of the perpetrator.

It is acknowledged that police FII/MBP training must compete with other police training needs and that police members’ time is a valuable commodity. Whilst this research did not extend to the implementation of FII/MBP training, it is suggested trainers, in this technological age, may need to be innovative in delivering such training and in how they make such information accessible to members. FII/MBP training may compromise of information sheets, a workbook, face to face training, case studies and interagency discussions and scenarios.

9.2.5 What members would require FII/MBP training?

This question was addressed through both the quantitative and qualitative components to this research. The quantitative study focused on existing FII/MBP knowledge and knowledge gaps and the qualitative research examined the police role with FII/MBP cases and which police would be assigned to such matters.

Based on the quantitative and qualitative findings and analysis undertaken in Chapter 8, the researcher concluded SOCAU, CIU and Homicide Squad members would require FII/MBP training and should ideally complete all four training modules, with consideration given to the different unit roles and existing FII/MBP knowledge levels. For example, SOCAU members were shown to play a greater initial investigation role and to have a greater FII/MBP knowledge base than other members surveyed, thus FII/MBP
training for SOCAU members\textsuperscript{256} may be more geared towards the second, third and fourth training modules than the first module which covers FII/MBP basics. Detectives, who may play more of an investigative role than SOCAU members yet have limited FII/MBP knowledge, may require more extensive training and a greater emphasis on the investigative component, particularly in relation to the use of CVS. Homicide members who are responsible for the investigation of suspicious deaths will require greater training in infant death investigations.

Whilst it was recognised that uniform members may play a role as first responders in FII/MBP and SUDI cases, the researcher considered due to the greater roles played by SOCAU, CIU and/or Homicide, that FII/MBP training should be focused towards these members and made available to uniform members only if required.

Finally, the analysis from this study suggests, due to the tension and contrasting perspectives which exist between police departments regarding the police role and management of FII/MBP cases, there is a need for police interdepartmental FII/MBP training and for the development of internal FII/MBP police guidelines to provide clarity and consistency to the police response to FII/MBP cases. Further, multidisciplinary training and guidelines were also considered essential for developing a shared understanding by Victorian professionals about their roles in FII/MBP cases, building healthy interagency relationships and ensuring a collaborative approach to the management of FII/MBP cases.

\textsuperscript{256} Who have previously received initial FII/MBP training.
9.2.6 Final comments: achieving the research objective

This research achieved the primary research objective and questions in a number of ways and contributed significantly and originally to the literature in this field. Firstly, the multidisciplinary framework for this research, which is unique to this area, enabled the researcher to gain a powerful insight into the Victorian context of FII/MBP cases and to identify police training requirements for recognising this abuse and responding to and investigating such cases from both a police and multidisciplinary perspective. Secondly, again unique to this field\(^\text{257}\), a questionnaire was implemented involving 1,238 police members with a 66% response rate\(^\text{258}\). The questionnaire enabled the identification of the level of awareness by police of FII/MBP, how police acquire FII/MBP knowledge, gaps in members’ knowledge of FII/MBP and police training requirements in the subject area. In addition, the questionnaire enabled the identification of different police departmental training needs.

From an interpretive perspective ‘the more meaningful, the more deeply elaboratively processed, the more situated in context and the more rooted in cultural, background, metacognitive and personal knowledge an event the more readily it is understood, learned and remembered’ (Iran-Nejad, 1990: 511 in Willis, 2007: 132). The researcher suggests this study has provided

\(^{257}\) Kaufman et al. 1989 surveyed 6 police officers to identify whether they had heard of MSBP. Bufton (1997) surveyed 37 police officers to establish whether they had heard of FII/MBP, their involvement with FII/MBP cases and whether they had received training on the topic (refer Appendix 6). Neither study researched the level of knowledge police have about FII/MBP.

\(^{258}\) 1,238 surveys were distributed with 20% returned due to errors in work address. Of the questionnaires remaining (986), 66% \(n=655\) were completed and returned.
the opportunity for significant and meaningful learning from multiple sources within a Victorian context and presents a solid basis of knowledge to understand the training requirements of police in Victoria with FII/MBP cases.

This research concluded police, in particular SOCAU, CIU and Homicide Squad members, need to receive FII/MBP training (see section 9.2.5) and that such training should consist of the completion of four key FII/MBP police training modules, with consideration given to existing police knowledge and different departmental roles (see section 9.2.4). The benefits of police training in the investigation and management of FII/MBP cases are numerous. These include better recognition and understanding of FII/MBP; a clearer understanding of the police role, and an improved police capacity to investigate suspected FII/MBP cases and work proactively with other agencies (see section 9.2.4).

However, this research also recognises that police FII/MBP training must be supported by other factors including internal police FII/MBP guidelines; multidisciplinary FII/MBP guidelines; interdepartmental and interagency FII/MBP training and adequate time and resources for police to conduct such investigations. Finally, police assigned to FII/MBP cases must be adequately supported by supervisors who have knowledge of FII/MBP; an awareness of the challenging nature of FII/MBP cases and an understanding of the personal impact which such matters can have on professionals, including police (Horwath and Lawson, 1995; Lasher and Sheridan, 2004).
In conclusion, this research provides a valuable foundation for understanding the training requirements for police in dealing with FII/MBP cases. Additionally, it identifies broader issues and where improvements might be made to the multidisciplinary management of FII/MBP cases in Victoria and potential areas for future research. However, as with any study, this research has its strengths and limitations which are presented in the next section.

9.3. Strengths and limitations of the research

9.3.1 Strengths

This research has a number of strengths.

1. There is limited research within Australia on FII/MBP, particularly from a criminal justice perspective and no research conducted that examines the training requirements for Victoria Police in responding to and investigating FII/MBP. Further, there is limited research worldwide that examines police knowledge of FII/MBP, how police learn about this abuse and their training requirements. This research will therefore significantly contribute to knowledge in this area.

2. This research involved a mixed method research design. It incorporated 760 questionnaires, 19 in-depth interviews and an extensive literature review. Such a design provided richness, depth and breadth to the research.
3. The extensive nature of the quantitative research undertaken in this study (760 members) strengthens the quantitative findings. International surveys previously conducted with police in this subject area use only small samples. For example, the survey conducted by Kaufman et al. (1989) involved only six police members and that by Bufton (1996) involved thirty-seven.

4. In some cases the interview findings shed new and conflicting light on the questionnaire data. Whilst some may regard this negatively, the researcher suggests it is one of the strengths of mixed method research as it ultimately allows knowledge to grow. The researcher suggests the quantitative component of a mixed method research design must make some allowances for diverging findings in associated qualitative studies and harness such findings in future research.

5. The inclusion of police from different policing departments, both in the quantitative and qualitative components of this research, has allowed an insight into what members from different areas know about FII/MBP and how they perceive its management. The findings clearly highlight the presence of internal tension and thus the need for cross departmental training and internal organisational structures to provide guidance for members in their response to FII/MBP cases.

6. The involvement of multidisciplinary professionals experienced in dealing with FII/MBP cases enhanced the scope of this research and
enabled the consideration of police FII/MBP training requirements from a broader perspective.

7. The theoretical perspectives incorporated in this research contributed to a deeper level of analysis and to consideration of FII/MBP from the perspective of the victim, offender and the multidisciplinary investigation.

8. Due to the multidisciplinary nature of this research, this study has uncovered a multitude of issues facing not only police, but the broader multidisciplinary system as well. It will thus contribute significantly to improving the overall response to FII/MBP cases in Victoria.

9. The identification in this research of a lack of knowledge by police about SUDI incidents, combined with the researcher’s involvement in a multiple child death investigation, has led the researcher, in conjunction with relevant agencies, to instigate significant changes and reform within Victoria in relation to police policy, practice and training relating to the response and investigation of SUDI matters (see Chapter 8.5.1.2). This has also led to improvements by other agencies in their handling of SUDI matters and to changes in their practice and/or training. Such agencies include the Victorian Institute of Forensic Medicine, The Coroner’s Court of Victoria; the Metropolitan Ambulance Service, the Metropolitan Firebrigade Service, SIDSandKIDs Victoria, and Victorian hospitals. Interstate
police (Northern Territory [Alice Springs and Darwin], Queensland and New South Wales) are also now considering implementing similar changes.

9.3.2 Limitations

This research also has a number of limitations.

1. It is acknowledged that other professionals, such as magistrates, police prosecutors, psychiatric nurses, general nurses and family doctors would also have contributed to providing valuable information of relevance to police FII/MBP training. However, as with any research, decisions have to be made about the research scope and in this case, due to the already extensive nature of the research, a decision was made not to include these professionals.

2. Due to the magnitude of the research and controversy surrounding FII/MBP investigations, it was difficult to fully explore many of the issues that emerged within this thesis. Many of the topics, such as the use of CVS, interviewing child victims and the effects of privacy legislation on FII/MBP investigations, are essentially a thesis in their own right and require further exploration. The researcher concluded this research will act as a foundation for the development of police training and a catalyst for further studies.
3. Whilst undertaking this research, knowledge surrounding FII/MBP cases evolved. Therefore, the findings in this study must be viewed in light of the time in which the research was conducted, and any new research in the field.

4. This research would have benefited from additional police interviews. However, a multidisciplinary focus was selected for this study, rather than concentrating purely on the police response. The researcher suggests the benefits of a multidisciplinary focus have been clearly demonstrated throughout this research. However, with time and more police having greater dealings with FII/MBP cases, this will benefit police FII/MBP training.

5. The perpetrators described in this research were all females. This limited the capacity to make any comparisons between the two genders and professionals’ response to female and male perpetrators.

6. Finally, the figures needed to generalise the questionnaire findings back to each of the target populations, with a 95% confidence level and 5% confidence interval, were not fully reached with some of the samples in this study. However, the relatively high return rates received in this research are significant and add weight and confidence to the conclusions that can be drawn from the quantitative data, at least within a Victorian context.
9.4 Future considerations

This research has identified a number of subject areas that have been addressed, or are currently being addressed, internationally, but not within Victoria. These include the abandonment of MBP terminology and the adoption of the term ‘FII’, the development of multidisciplinary guidelines for the handling of FII/MBP cases, the development of covert video surveillance protocols and the implementation of SUDI guidelines and certified training for professionals involved with SUDI matters. The researcher suggests it is now time for Victorian professionals to progress these issues.

Finally, a number of topics were identified in this research to require further follow up work and analysis. Such topics include the impact of privacy legislation on the accessing and sharing of information, the tracking, obtaining and reviewing of medical files, and the implementation of case conferences. Finally, the question of whether police are suitable to interview child victims of FII/MBP was raised in this research and requires further exploration.

9.5 Recommendations for future research

As limited research has been conducted within Australia on police training and FII/MBP cases the scope for future research is vast. The following presents a précis of some topics that could be pursued in this area:
1. The diversity of FII/MBP offending has enormous research potential. It is suggested that multidisciplinary research in this area will continue to improve the identification and response towards FII/MBP cases.

2. Limited research has been undertaken with FII/MBP offenders (including male perpetrators), their spouses, and victims of this abuse. It is suggested that research in this area will greatly assist to improve professionals’ understanding of this offending and management and investigative practices associated with it. The findings from this research show dysfunctional backgrounds of many of these women. This lends support for further research in this field and consideration of psychological and sociological theories pertaining to their behaviour.

3. This research and the literature (RCPCH, 2002) highlight the need for further research surrounding the multidisciplinary response to FII/MBP cases and how agencies can better work together.

4. Some cases of FII/MBP involve the deaths of multiple children (Southall et al. 1997; Artingstall, 1999). The literature reflects the need for further research in this area to assist professionals in differentiating between those deaths that are genuine and those that have had been deliberately caused (Craft and Hall, 2004; Rafferty in Munby 2004). The researcher concurs with this position.
5. Whilst growing, there is still relatively limited information on FII/MBP cases appearing before the courts, particularly in Australia. It is suggested that more research in this area would be advantageous for police investigators.

6. The topic of emotional abuse and FII/MBP cases could be explored further and professionals’ response to such cases.

7. Finally, the theories explored within this research, primarily linked to language, power and gender, could be pursued further, in more depth or from different perspectives. Potentially, other theories could be explored, such as hostage theory, family theory, cultural criminology, and theories pertaining to group dynamics.

9.6 Conclusion

This research provides a practical and theoretical contribution to identifying the training requirements for police in responding to and investigating FII/MBP cases, from both a police and multidisciplinary perspective. In seeking to understand the research topic, this study supports the use of mixed method research, multiple perspectives and theories and the involvement of police and other professionals most closely associated with the subject area. The findings demonstrate a strong need for FII/MBP police training, with key training requirements classified into four modules. Finally, this research emphasises a need for a balanced, proactive and collaborative approach by police to FII/MBP investigations and suggests a greater understanding by police about their role and investigative and
multidisciplinary requirements with FII/MBP cases will ultimately result in better quality FII/MBP investigations, better internal and interagency relationships and better outcomes for child victims.

The researcher hopes this research will be valuable not only to police, but to all professionals involved in the education of this challenging form of child abuse.
References


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Appendices
Appendix 1

Defining FII/MBP
Some interpretations from the literature
Defining FII/MBP: some interpretations from the literature


Criteria for Munchausen syndrome by proxy

1. Illness fabricated (faked or induced) by the parent or someone in loco parentis.

2. The child is presented to doctors, usually persistently; the perpetrator (initially) denies causing the child’s illness.

3. The illness goes when the child is separated from the perpetrator.

4. The perpetrator is considered to be acting our of a need to assume the sick role by proxy or as another form of attention seeking behaviour.

Meadow, 2002a: 506

Stages of falsification

1. False illness story alone. Even though the mother is not directly harming the child, the child may suffer considerably as a result of the mother’s persistent stories of illness. The child incurs many investigations, therapies and restriction of activities and education.

2. A false illness story with falsification of signs and/or samples. The mother seems to feel that she has to convince the doctors that the child is ill by tampering with samples and charts.
3. Induced illness. The mother not only invents a false story, but injures the child by poisoning, smothering, scarification of the skin or other physical injury to mimic genuine illness.

Meadow, 1994: 122


MBP appears in the DSM-IV in Appendix B (725-727) under the term Factitious Disorder by Proxy (FDP). FDP was included in the DSM-IV purely for further study. The term has not officially been recognised as a clinical condition (see Lasher and Sheridan, 2004: 16-23).

The suggested research criteria for FDP are:

- Intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual’s care.
- The motivation for the perpetrator’s behaviour is to assume the sick role by proxy.
- External incentives for the behaviour (such as economic gain) are absent.
- The behaviour is not better accounted for by another mental disorder.
3. Artingstall (1999: 5-6)

Munchausen by proxy (MBP) defined

Whenever a person, regardless of whether afflicted with Munchausen Syndrome or not, utilizes another person in a replacement capacity for his/herself for the purposes of assuming the sick role, the offensive action becomes Munchausen by Proxy (MBP). Determination of the presence or absence of MBP is predicated upon the examination of behaviour. Offenders do not suffer from MBP — they inflict the behaviour of MBP onto their victim.

MBP is defined as the DSM-IV as Factitious Disorder Not Otherwise Specified and is sometimes called Factitious Disorder by Proxy. MBP is described as the intentional production or feigning of physical or psychological signs or symptoms in another person who is under the individual’s care for the purposes of indirectly assuming the sick role.’ Research criteria for MBP (Factitious Disorder by Proxy) is listed within the DSM-IV as the exact diagnostic criteria for Factitious Disorder (Munchausen Syndrome) with additional elements which include recognition the MBP behaviour usually occurs to a person who is under the care of another and the behaviour is not better accounted for by another mental disorder. […] The description of MBP in the DSM-IV does not render MBP as a mental illness and does not set the premise that all MBP offenders are mentally ill. There is a common misconception that a person who exhibits the behaviour of Munchausen by Proxy is considered mentally ill which often proves to be problematic in the overall criminal justice process of convicting responsible MBP offenders. It is
a myth that all or even most MBP offenders possess mental illness which relieves them of responsibility for their actions.


MSBP encompasses many different situations in which children are presented as sick. They have in common the fact that a child's illness is not due to a disease or an openly acknowledged external cause such as an accident. Instead, the child's illness has arisen as a result of the parent’s actions in producing a factitious illness: by making the child ill by suffocating, poisoning or physically harming the child to produce sickness (induced illness), or by the adult telling a story of symptoms which lead health professionals to believe the child has an illness. The professional then investigates and treats the child's supposed condition (invented illness. In the second case, the professional harms the child on the parent’s behalf. Both of these scenarios may constitute MSBP abuse, as both result in unnecessary and preventable harm to children enacted through the health care system.

The ingredients of MSBP abuse

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

2. A dependent child is available for a parent (or person in loco parentis) and is under her or his control, influence or behest.
3. A parent, or person in loco parentis, presents the child to the health care system with invented symptoms or fabricated signs.

5. **Bentovim (2001: 3)**

It is currently recognised that Munchausen by Proxy has been used as a term to encompass the attribution of an illness state to the child (through description of physical symptoms, or falsification of specimens, temperature, charts, etc.), the induction of an illness state (through the actual administration of noxious substances) and the maintenance of an illness state (by direct interference with wounds or fractures).


The fabrication or induction of illness in children by a carer is referred to by a number of different terms, most commonly Munchausen syndrome by proxy, Factitious illness by proxy or Illness Induction syndrome. In the United States the term Paediatric Condition Falsification is being adopted by the American Professional Society on the Abuse of Children (APSAC). This terminology is also used by some as if it were a psychiatric diagnosis. The American Psychiatric Association’s Diagnostic and Statistical Manual (DSM-IV) has proposed using the term factitious disorder by proxy for a psychiatric diagnosis applicable to the perpetrator.

The use of terminology to describe the fabrication or induction of an illness in a child has been the subject of considerable debate between professionals.
This Guidance refers to the ‘fabrication and induction of an illness in a child by a carer’ rather than using a particular term. There are three main ways of the carer fabricating or inducing illness in a child:

- Fabrication of signs and symptoms. This may include fabrication of past medical history;
- Fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may include also falsification of letters and documents;
- Induction of illness by a variety of means.


The controversy over definition has not been resolved. An important series of papers was published together as a ‘Controversy’ (*Archives of Disease in Childhood*, 1995: volume 72 pp 528-538) which should be read if full. However, we would agree with the proposal of Fisher and Mitchell et al. in that, ‘The condition known as Munchausen Syndrome by Proxy or other variations does not satisfy for acceptance as a discrete medical syndrome because of the wide variation. Discussion points raised in the ‘Controversy’ include:

- Some pointers which should raise suspicion of the problem have been elevated to the status of being diagnostic;
- Whether motivations should be part of identification or not;
- The difficult borderline between fabrication and exaggeration.
We accept the four points proposed by Meadow et al. but we note that the last two criteria cover many child abuse situations:

1. Illness in a child which is fabricated or induced by a parent or someone who is in loco parentis;
2. A child is presented for medical assessment and care, usually persistently, often resulting in multiple procedures;
3. The perpetrator denies the aetiology of the child’s illness;
4. Acute symptoms and signs cease when the child is separated from the perpetrator.

Semantically, the term Munchausen Syndrome by Proxy is only valid when a person who has Munchausen Syndrome themselves uses others, particularly children, to manifest their disorder. We should note that, even when one parent has Munchausen Syndrome, it may be the other parent who is harming the child. We must not be diverted by arguments over semantics. Fabrication or illness induction includes all forms of such activity and do not inevitably clarify the motivation of the carer, which may be difficult to ascertain. It can include the old terms MSbP or MbPS whether applied to carer, child or scenario, and includes delusion, excessive anxiety, masquerade, hysteria, doctor shopping, doctor addicts, mothering to death, seekers of personal help or attention or financial gain, and those who fail to give needed treatment, as well as those who treat unnecessarily.

Adoption of the term fabricated or induced illness symbolises awareness of the wide spectrum of physical injury and psychological harm. […] The
working group accept that the term Munchausen by proxy is no longer appropriate of helpful and should be abandoned. We therefore recommend that Paediatricians should talk about fabricated or induced illness.

8. Rosenberg (2003: 426)

Defined MSBP as ‘the persistent fabrication of illness in one person by another’. Rosenberg (2003) developed medical diagnostic criteria for different degrees of MSBP diagnostic conviction, including: definitive, possible and inconclusive.

9. Jureidini, Shafer and Donald (2003:1)

The label, ‘Munchausen by proxy syndrome’ is best applied to cases of child abuse in which a caregiver, usually the child’s mother, fabricates symptoms or induces illness in a dependent child, and the doctor mistakenly believes that a naturally occurring illness is present. Thus an active interaction between the caregiver- perpetrator and medical professional is required for the syndrome to occur.

10. Lasher and Sheridan (2004: 3)

Munchausen by proxy (MBP) is a dangerous kind of maltreatment (abuse and/or neglect) in which caretakers, usually parents, deliberately and repeatedly exaggerate, fabricate, and/or induce a problem or problems in someone who is under their care.
11. Fish et al. (2005: 1)

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.
Appendix 2

Presentations (symptoms, signs and diseases) that have been reported in Munchausen Syndrome by Proxy
### Presentations (symptoms, signs and diseases) that have been reported in Munchausen Syndrome by Proxy, and their causes (where positively identified) (Plunkett and Southall\(^{259}\), cited in Adshead and Brooke, 2001: 80-81)

<table>
<thead>
<tr>
<th>System</th>
<th>Symptom/Sign/Disease</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cystic fibrosis</td>
<td>Altering laboratory investigations and stealing sputum from other patients (Orenstein et al. 1986)</td>
</tr>
<tr>
<td></td>
<td>Asthma</td>
<td>Deliberate under/over treatment (Godding and Kruth, 1991 and Masterson et al. 1988)</td>
</tr>
<tr>
<td>Renal</td>
<td>Polyuria, polydipsia</td>
<td>Drugs (Verity et al. 1979)</td>
</tr>
<tr>
<td></td>
<td>Haematuria, renal stone</td>
<td>Adding stone, parental blood and colouring substances to urine (Meadow, 1977)</td>
</tr>
<tr>
<td></td>
<td>Bacteruria</td>
<td>Swapping urine specimens with parent or other patients (Meadow, 1977)</td>
</tr>
</tbody>
</table>

\(^{259}\) Plunkett and Southall (2001: 78) stress that this list is not conclusive but provides a description of the type of reported symptoms and positively identified causes.
<table>
<thead>
<tr>
<th>System</th>
<th>Symptom/Sign/Disease</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haematological</td>
<td>Purpura</td>
<td>Injecting blood under skin, rubbing skin (Meadow, 1982)</td>
</tr>
<tr>
<td></td>
<td>Haematemesis, haemoptysis and rectal bleeding</td>
<td>Adding parental blood to specimens, clothing and nappies (McGuire and Feldman, 1989; Alexander et al. 1990; Meadow, 1998 and Berger, 1979)</td>
</tr>
<tr>
<td>Immunological</td>
<td>Recurrent fever, sepsis</td>
<td>Heating thermometer (Meadow, 1982), injecting bacteriologically contaminated material, interfering with intravenous sites (Boros et al. 1995 and Kohl et al. 1978)</td>
</tr>
<tr>
<td>Allergy</td>
<td></td>
<td>Applying excessive environmental and dietary measures to avoid &quot;allergen&quot; (Warner and Hathaway, 1984 and Roesler et al. 1994)</td>
</tr>
<tr>
<td>Dermatological</td>
<td>Rashes</td>
<td>Applying irritants, scratching or injecting the skin (Southall et al. 1997; Meadow, 1982 and Magnay et al. 1994)</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Hypoglycaemia, glycosuria</td>
<td>Abuse of insulin and sugar solutions (Verity et al. 1979 and McGuire and Feldman, 1989), drugs (Rogers et al. 1976)</td>
</tr>
<tr>
<td></td>
<td>Hypernatraemia</td>
<td>Adding salt to feeds (Southall et al. 1997; Meadow, 1977; Meadow, 1993b and Rogers et al. 1976)</td>
</tr>
</tbody>
</table>
Appendix 3

Warning signals that might alert a clinician to the presence of a factitious illness
Warning signals that might alert a clinician to the presence of a factitious illness. (‘These signals may be viewed as clinical alerts rather than a profile of the abuser’). Plunkett and Southall, cited in Adshead and Brooke, 2001: 79)

<table>
<thead>
<tr>
<th>In the child</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Illness (or signs and reported symptoms) that defy explanation leading experienced clinicians to remark that they have not seen the like of it before.</td>
</tr>
<tr>
<td>• Symptoms and signs that start only when a particular carer (usually the mother) is present.</td>
</tr>
<tr>
<td>• Symptoms and signs that resolve spontaneously (or do not recur) when the child is separated from a particular carer.</td>
</tr>
<tr>
<td>• Multiple physician involvement in child's management.</td>
</tr>
<tr>
<td>• Treatments that are unexpectedly ineffective or poorly tolerated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the child's history</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reported symptoms which may be unverifiable.</td>
</tr>
<tr>
<td>• Multiple hospitalisations experienced by child.</td>
</tr>
<tr>
<td>• Alleged allergies to a great variety of foods and drugs.</td>
</tr>
<tr>
<td>• Serious illnesses claimed to have been identified at other hospitals.</td>
</tr>
<tr>
<td>• Complex pattern of previous medical care hidden by carer from the paediatrician.</td>
</tr>
<tr>
<td>• Inconsistencies between carer's historical accounts and clinical/laboratory findings of recognisable diseases.</td>
</tr>
<tr>
<td>• Apparent life-threatening events associated with bleeding from the nose or mouth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the family history</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Families in which unexplained infant deaths have occurred.</td>
</tr>
<tr>
<td>• Families in which many members are alleged to have different serious medical disorders.</td>
</tr>
<tr>
<td>• Families with a history of unexplained infant death or unexplained apparent life-threatening events associated with bleeding from the nose or mouth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In the carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Other carer typically uninvolved in the care of the child.</td>
</tr>
<tr>
<td>• Carers; who have (or falsely claim to have) medical (or nursing/paramedical) knowledge or training. Carers who are not as concerned by the child's illness as the medical and nursing staff, who remain with the child constantly or who are happily at ease on the children's ward, forming unusually close relationships with the staff.</td>
</tr>
<tr>
<td>• Carers who have invested significant emotional/intellectual effort in the illness. This may be exhibited in their involvement in self-help and activist groups and subsequent courting of press publicity, where the illness becomes part of their identity. Carers; who have a history of conduct or eating disorders.</td>
</tr>
<tr>
<td>• Carers who have a history of unusual illness (which may be unverifiable) or themselves have suffered or give a history of physical, emotional or sexual abuse in childhood.</td>
</tr>
<tr>
<td>• Carers who have Munchausen Syndrome or somatisation disorder.</td>
</tr>
</tbody>
</table>
Appendix 4

Common issues facing professionals
Common issues facing professionals

- Lack of knowledge and understanding of this abuse (Kaufman et al., 1989; Feldman and Ford, 1994; Horwath and Lawson, 1995; Horwath and Kessel 1995; Donald and Jureidini, 1996; Postlethwaite, Samuels and Eminson, 2000; Abdulhamid and Siegel, 2006)
- Difficulties in accepting the existence of this offending (Guandolo, 1985; Pape, 1995; Horwath & Kessel, 1995; Feldman and Hickman 1998; Fox, 1995; Southall et al. 1997)
- Workers own values, attitudes and previous experiences, as well as a perception of the norms and standards of society impact on worker’s views (Horwath and Kessel, 1995)
- Tendency of some professionals to deny the possibility of life threatening abuse (Southall et al. 1997)
- A lack of knowledge by professionals of SUDI cases (RCP and RCPCH, 2004; NSW Child Death Review Team, 2005)
- FII/MBP cases are emotionally challenging (Ostfeld and Feldman, 1996; Postlethwaite, Samuels and Eminson, 2000)
- Professionals can become immobilized by the implications of the MBP label and avoid making decisions (Horwath and Kessel, 1995)
- Confusion with MBP label (Horwath and Kessel, 1995)
- A failure to acknowledge the seriousness of this offending (Meadow, 1990; Southall et al. 1997)
- The potentially fatal nature of FII/MBP (Freeland and Foley, 1992; Alexander et al. 1990)
• A failure to see the seriousness of abuse (Roberts and Carmichael, 1999; Artingstall, 1999)

• Potential to be manipulated and deceived (Meadow, 1982b; Waller, 1983; Zitelli et al. 1987; Neale, Bools and Meadow, 1991; Pape, 1995; Rosenberg, 1987; 1997 Chadwick, 1996; Southall et al. 1997; Artingstall, 1999; Chiczewski and Kelly, 2003)

• Parents may provide elaborate and plausible explanations to behaviour (Southall et al. 1997; Artingstall, 1999)

• The startling tie that appears to exist between the mother and the child (Waller, 1983; Pickford et al., 1988; Meadow, 1985)

• Worker may collude with the mother (Horwath and Kessel, 1995)

• Professionals can become over-involved with mothers (Horwath and Kessel, 1995)

• Professional objective judgments can become clouded (Fox, 1995; Banks, 1995)

• Worker may wrongly rationalize the mother’s behaviour (Horwath and Kessel, 1995)

• The mother may evoke sympathy and a caring response (Freeland and Foley, 1992)

• The image of motherhood (Schreier and Libow, 1993)

• The importance of being open minded (Yeo, 1996)

• Mother’s medical knowledge may make it easier for them to present false information credibly (Freeland and Foley, 1992)

• Insufficient evidence (Yeo, 1996)

• Evidence is often circumstantial (Batten, 1987)
• The mother's denial (Artingstall, 1999; Fox, 1995)
• The young age of the child (Shepherd, 1995; Artingstall, 1999)
• Time consuming investigations (Meadow, 1985; Freeland and Foley, 1992; Whelan-Williams and Baker, 1998)
• Issue of uncertainty with FII/MBP cases (RCPCH, 2002)
• The need for a good understanding and working knowledge of indicators and dynamics of this abuse (Roberts and Carmichael, 1999)
• Workers may struggle to maintain professional distance (Freeland and Foley, 1992)
• Professionals may experience self doubt in shifting through the facts (Freeland and Foley, 1992)
• Concerns over confidentiality (Yeo, 1996)
• The importance of collecting accurate data (Southall et al. 1997)
• The effect of these cases on workers' emotions (Freeland and Foley, 1992; Artingstall, 1999)
• Monitoring of children in hospital (Bahen et al. 1988; Rosenberg, 1993; Samuels and Postelthwaite, 2000)
• Conflicting medical opinions (Yeo, 1996)
• Conflicting opinions between professionals (Freeland and Foley, 1992; Department of Health, 2001)
• The importance of working with other agencies (Southall et al. 1997; Lasher and Sheridan, 2004)
• A need for understanding and respect amongst team members (Artingstall, 1999)
• The importance of trust between agencies (Freeland and Foley, 1992; Artingstall, 1999)

• The need for shared understanding of dynamics within the multidisciplinary team and between the team and other systems (Freeland and Foley, 1992)

• Focus needs to be on protecting the child (Freeland and Foley, 1992; Lasher and Sheridan, 2004)

• The importance of accurate, open and frequent information sharing (Freeland and Foley, 1992; Fox, 1995; Yeo, 1996; Southall et al. 1997; Lasher and Sheridan, 2004)

• Value of seeking advice and consultation from all available sources (Freeland and Foley, 1992; Lasher and Sheridan, 2004)

• Isolated incidents have no significance until viewed in totality (Yeo, 1996)

• In an attempt to avoid being faced with acknowledging that a mother may be fabricating or inducing illness, professionals may subconsciously ignore or fail to report certain pieces of information (Horwath and Kessel, 1995)

• Degree of coordination between agencies required in FII/MBP cases is more complex and demanding than other cases, lying outside the experience of a number of professionals and extending beyond the limits of some service functions (Freeland and Foley, 1992)

• Needs to be a consensus about diagnosis or workers will unconsciously sabotage plans for integrated intervention (Batten, 1987)
• Ability of team to relate laterally and not necessarily through a hierarchical, bureaucratic or professionals structure or a leader (Freeland and Foley, 1992)

• Acknowledge some tasks overlap professional boundaries and can be done cooperatively (Freeland and Foley, 1992)

• The importance of inter-agency protocols for improved communications, coordination and role definition (Yeo, 1996; Artingstall, 1999)

• Recognise unique skills of each discipline (Freeland and Foley, 1992)

• Focus of team needs to be on getting the job done rather than reinforcing professional territory (Freeland and Foley, 1992)

• Conflict with other agencies (Artingstall, 1999)

• Other agencies overstepping their roles (Artingstall, 1999)

• Confusion over roles (Horwath and Kessel, 1995)

• Splits in the team over perceptions about the extent of the abuse and its entrenched nature (Freeland and Foley, 1992; Fox, 1995; Department of Health, 2001)

• The importance of support for workers from management to direct case, ensure appropriate resources and supervisory care and support (Freeland and Foley, 1992; Roberts and Carmichael, 1999)

• Threats towards team members (Freeland and Foley, 1992)

• Professionals views become polarized, with different agencies feeling a need to demonstrate that their professional perspective is appropriate (Horwath and Kessel, 1995)
• Preconceived views of professionals can result in a reluctance to involve agencies (Horwath and Kessel, 1995)

• Tension between professionals regarding whose role it should be to confront the offender (Fox, 1995; RCPCH, 2002)

• A failure of professionals to work together (Fox, 1995)

• Gathering and interpreting medical histories is painstaking and time consuming due to the involvement of many hospitals and doctors (Freeland and Foley, 1992; Artingstall, 1999)

• Family may have moved numerous times making information gathering difficult (Roberts and Carmichael, 1999)

• If litigation is involved, parents may be less willing to provide information (Freeland and Foley, 1992)

• Child needs to be protected before parents are confronted (Roberts and Carmichael, 1999)

• Large multidisciplinary case conferences (Freeland and Foley, 1992)

• The use of CVS – ethical and legal issues (Yeo, 1996)

• Stress of court proceedings (Batten, 1987)

• Backlash of groups of parents who allege they have been falsely accused of FII/MBP (Wearne, 2000).
Appendix 5

Victoria Police overview
Victoria Police Overview

Victoria Police provides a 24 hour police service to the community of Victoria, which has a population of over five million people. The stated mission of Victoria Police is to “provide a safe, secure and orderly society by serving the community and the law.” The organisation has a total workforce of approximately 13,600 (Full Time Equivalent). Approximately 11,300 (FTE) are sworn members (police officers) and about 2,300 (FTE) are unsworn members (Victoria Police People Information and Analysis, Human Resource Department, Victoria Police Website, December 2006). The unsworn members include public servants, forensic officers and other specialists.

The following provides a brief description of the policing areas involved in this thesis.

Victoria Police Recruits

Victoria Police recruits are selected for training at the Victoria Police Academy after passing a written exam, a physical test, a panel interview and a medical examination. Many recruits live at the Academy during the Probationary Constables’ Course. At the time of implementing the survey (2001) there were 375 recruits participating in the Probationary Constables’ Course.
**Uniform Members**

Uniform members, or general duties members as they are also called, perform the ‘coal face’ police work; responding to the community’s needs as they arise. At the time of conducting the questionnaire for this research there were 5,010 uniform members (constable to senior sergeant) at stations throughout Victoria.

**Sexual Offences & Child Abuse Unit (SOCAU) Members**

The role of the Sexual Offences and Child Abuse Units is to provide a specialist response to victims of sexual assault and physical assault on children. SOCA Unit police have chosen to work with children who have been sexually or physically abused and, adults who have been sexually abused. SOCA Unit members are generally Senior Constables when first appointed to a SOCA Unit, but in a few instances Constables have been appointed. SOCA Unit members have received three weeks specialised training to perform their role. This role is generally victim related and involves tasks such as interviewing victims and witnesses, taking statements, arranging medical examinations, working with statutory bodies such as Child Protection and facilitating links with support agencies. SOCA Unit members may also investigate and follow a case right through, including interviewing and charging suspects, however this is more often in relation to less serious assaults.
There are 29 SOCA Units throughout Victoria. 10 of these Units are in metropolitan Melbourne. At the time of conducting the questionnaire there were 242 SOCAU members, including male and female members (approximately 40% : 60%). The number of members at each location varies, with the larger metropolitan Units having around 18 staff and the country Units generally having 1 to 4 staff.

**Criminal Investigations - Detectives**

Police who are appointed to a specialist role investigating crime are required to hold an Advanced Diploma in Public Safety (Police Investigations) or its previous equivalent. (Prior to the formal accreditation of the current training, police qualified as Detectives at a twelve week internal course). Police members who are specialist investigators have the designation of ‘Detective’ included prior to the rank, for example: Detective Senior Constable.

Detectives are based at Criminal Investigation Units throughout Victoria, or at specialised Crime Squads and taskforces. They are primarily responsible for collecting evidence and interviewing and charging offenders, particularly in relation to more serious assaults and injuries.

There are 93 Criminal Investigation Units (CIU’s) in Victoria. At the time of implementing the questionnaire there were 768 (senior constable to senior serjeant) detectives. Detectives working at a CIU are responsible for the investigation of crime within their designated area (generally corresponding to
Local Government Area boundaries), in accordance with an assessment process.

The Crime Department is a centralized pool of specialist investigators and support areas. Serious crimes are categorized according to a model (known as the Accountability and Resource Model) and a decision is then made as to who will take the lead role in the investigation. Depending on the individual circumstances, a major crime may be investigated with the Crime Department having prime responsibility for the investigation and the local CIU (and other police) providing support in accordance with guidelines. Alternatively the matter may be allocated to the local CIU, with the Crime Department providing support in accordance with the relevant guidelines. For example, in the case of a murder where the offender had not been identified, it is likely that the investigation would be allocated to the Homicide Squad. Where a child had an injury inflicted by a known person, it is likely that the matter would be investigated by the CIU that covers the area where the incident occurred.
## Rank Structure of Victoria Police – Sworn Employees

<table>
<thead>
<tr>
<th>Rank</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit</td>
<td>Must successfully complete a twenty week Probationary Constables’ Course – full time at the Victoria Police Academy. Appointed as a Constable on graduation. (The number of recruits at any given time varies greatly).</td>
</tr>
<tr>
<td>Constable</td>
<td>On probation for the first two years after appointment. Perform general policing duties and continuing on-the-job training during this time. Required to complete the Diploma of Public Safety (Policing) prior to confirmation.</td>
</tr>
<tr>
<td>Senior Constable</td>
<td>Constables are eligible for promotion to Senior Constable four years after appointment. Leading Senior Constables have additional responsibilities to assist and develop junior members.</td>
</tr>
<tr>
<td>Sergeant</td>
<td>Front line supervisors – often with around 15 years policing experience on promotion to this level, but this timeframe varies significantly.</td>
</tr>
<tr>
<td>Senior Sergeant</td>
<td>Mid level management – the rank usually held by those in charge of a police station, or unit. Usually in excess of 20 years policing experience on promotion to this level.</td>
</tr>
<tr>
<td>Officers: Inspector, Chief Inspector, Superintendent, Chief Superintendent, Commander, Assistant Commissioner, Deputy Commissioner</td>
<td>Senior management roles. (The ranks of Chief Inspector and Chief Superintendent are currently being phased out)</td>
</tr>
<tr>
<td>Chief Commissioner</td>
<td>Head of the organization</td>
</tr>
</tbody>
</table>

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Appendix 6

Some of the issues facing Police with FII/MBP cases
Some of the Issues facing Police with FII/MBP cases

- A reluctance by medical personnel to involve the police until all other alternatives have been considered (Horwath and Kessel, 1995)
- Late notifications or a reluctance to involve the police (Fox, 1995; Horwath and Lawson, 1995; Artingstall, 1999)
- Police not being informed of relevant issues (Fox, 1995)
- A stereotypical image of police resulting in fear that police will be insensitive, upset the family and disrupt the ward (Horwath and Kessel, 1995)
- A lack of trust of police (Horwath and Lawson, 1995; Fox, 1995)
- Controversy surrounding the timing of when to involve the police (RCPCH, 2002)
- A perceived need by doctors to possess concrete evidence before reporting their suspicions (McClure et al. 1996; Wilkinson and Parnell, 1998; RCPCH, 2002; Lasher and Sheridan, 2004)
- A lack of perceived knowledge by police about FII/MBP investigations (Fox, 1995; Birge, 1996; Artingstall, 1999; Lasher and Sheridan, 2004)
- Tension surrounding the role of police at SUDI cases (RCP and RCPCH, 2004)
- A lack of evidence in FII/MBP cases creating difficulties for the police investigation (Artingstall, 1999; Department of Health, 2001)
- Potential loss of evidence due to a lack of communication or a lack of knowledge by police (Fox, 1995)
• Professionals underestimating the offender’s capabilities (Shepherd, 1995; Artingstall, 1999)
• A failure by professionals and police to understand the complexity or sophistication of FII/MBP (Artingstall, 1999)
• Some police have the wrong attitude towards FII/MBP cases (Meadow, 1985; Artingstall, 1999)
• Inability of police management to ‘by into’ the reality of MBP victimization: ‘We don’t believe that MBP is real, you must be kidding’. (Artingstall, 1999: 203)
• Inability by police to see patterns of victimization due to ingrained standardized investigative techniques (Artingstall, 1999)
• Unwillingness by police to expand investigations to the sophisticated degree required in FII/MBP cases due to monetary constraints or disbelief FII/MBP is tangible (Artingstall, 1999: 83)
• Issues surrounding the use of covert video surveillance (Artingstall, 1999; Southall, et al., 1997, Shepherd, 1995; Chadwick, 1996)
• Liability concerns by professionals may influence investigation: ‘We don’t want to institute video surveillance because then we would be acknowledging the suspicion that abuse is occurring’ (Artingstall, 1999: 203)
• Blurring of role boundaries between police and medical personnel (Meadow, 1985; Bahen et al. 1988; Siebel and Parnell, 1998; Adshead, 2001; RCPCH, 2002)
• Police reliance on medical professionals for court purposes (Artingstall, 1999)
• FII/MBP cases challenge the ability of detectives (Artingstall, 1999)
• FII/MBP cases confront detective’s emotions (Artingstall, 1999)
• Privacy legislation can impede police inquiries (Reynolds, personal communication, 2005)
• Police inquiries can be impeded through doctors’ fear of civil litigation (Reynolds, personal communication, 1995)
• Victim devaluation by police: ‘It’s just a child; if he dies then we will just work a homicide case’. (Artingstall, 1999: 203)
• Fear of failure or embarrassment: ‘We just went through a case like this and lost in court. We are not going to commit the resources to a case that seems unwinnable’. (Artingstall, 1999: 203)
• Money: ‘You can work the case, but you can’t have any overtime’. (Artingstall, 1999: 203)
• Employees in over their heads: ‘Here is an unusual abuse case, see what you can do with it. Good luck’ (Artingstall, 1999: 203)
• Passing the buck: ‘Let’s refer this family to another larger hospital for future treatment, so that another jurisdiction can deal with the problem’ (Artingstall, 1999: 203)
• Quick fix: ‘We’ll just have social services remove the child from the family and our problem will be solved. It doesn’t matter that the case is weak’ (Artingstall, 1999: 203)
• Misinformed management resolution: ‘We think that you are misguided and need a break so we’re transferring you (to a remote post). Of course, all your records will be shredded in accordance with policy’ (Artingstall, 1999: 203).
Appendix 7

Issues facing or associated with Doctors and FII/MBP
Issues facing or associated with Doctors and FII/MBP

- FII/MBP behaviour can produce symptoms/signs indistinguishable from those resulting from a natural disease (Jureidini and Donald, 2001)
- The mother’s medical knowledge may contribute to difficulties in detection (Guandolo, 1985; Fox, 1995)
- A failure by doctors to consider FII/MBP (Rosenberg, 1995; Postelthwaite, Samuels and Eminson, 2000; RCPCH, 2002)
- The trusting nature of doctors with their clients (Fox, 1995; Wearne, 2000; Samuels, 2001)
- Too accepting of reported histories (Donald and Jureidini, 1996; Wearne, 2000; Samuels, 2001)
- A failure to check and corroborate the parent’s information (Postelthwaite et al. 2000)
- Doctors become part of the problem by failing to recognize such abuse and allowing unnecessary tests to be performed on the child (Zitelli et al. 1987)
- Doctors work on the assumption that the parent/patient tells the truth because they wish to optimize the chance of their child’s recovery. In FII/MBP cases this minimizes the chances of the abuse being detected and drives a doctor to investigate further (Jureidini and Donald, 2001)
- Self doubt about their suspicions (Waller, 1983; Seibel and Parnell, 1998)
- Fear of being wrong (Kinscherff and Ayoub, 2000)
• Fear of legal ramifications if they stop their investigations (Postlethwaite et al. 2000; Shepherd, 1995)
• Doctors may avoid disclosing they don’t know for fear of revealing their ignorance (Jureidini et al. 2003)
• Doctors may be unable to accept their limitations in dealing with an undiagnosable illness or abusive mother-child relationships (Jureidini et al. 2003)
• Doctors may investigate further than is logically warranted for fear that other colleagues may diagnose an illness (Jureidini et al. 2003)
• A focus on making a diagnosis, especially a rare one (Postlethwaite et al. 2000; Donald and Jureidini, 1996; Ostfeld and Feldman, 1996)
• Doctors may associate more personal status with finding a diagnosis than with clarifying that a problem has multiple ill-defined causes (Jureidini et al. 2003)
• Increased emphasis on risk management leading to a desire to ensure all possible medical explanations are considered and more extensive investigations (Jureidini et al. 2003)
• Doctors are more accountable these days to parents to provide answers (Jureidini and Donald, 2001)
• The co-existence of factitious illness with a genuine illness (Meadow, 1993; Schreier, 1996; Artingstall, 1999; Postlethwaite et al. 2000)
• Absence of physical injury in the child (Samuels, 2001)
• Open and relaxed hospital environments (Kaufman et al. 1989)
• The involvement of parents in the care of their child within the hospital (Hall et al. 2000)
• The ease with which parents can swap physicians (Hall et al. 2000)
• The distortion by television shows that doctors can do no wrong – resulting in a reluctance by people to challenge doctors’ opinions (Schreier and Libow, 1993)
• A failure to consult the child if of older years (Bryk and Siegel, 1997; Gregory, 2003)
• Guilt felt by having indirectly contributed to the abuse (Seibel and Parnell 1998; Ostfeld and Feldman, 1996)
• The involvement of multiple specialists and increased medical subspecialisation leading to less collaboration between doctors (Donald and Jureidini, 1996; 2001; Jureidini et al. 2003)
• Information may not be cross-referenced i.e., numerous hospitals involved (Horwath and Kessel, 1995)
• Close relationships formed between staff and the mother (Feldman and Hickman, 1998; Fox, 1995, Postlethwaite et al. 2000; Abdulhamid and Siegel, 2006)
• Doctors can lose clarity between professional assessment of the carer and their personal feelings towards them as individuals (Horwath and Kessel, 1995)
• Doctors may have difficulty in acknowledging their role in causing harm (Freeland and Foley, 1992)
• Doctors may be unable to see the deception they have been subjected to (Freeland and Foley, 1992)
• Doctor may find it difficult to shift their stance from that of a treating physician to protector of the child (Freeland and Foley, 1992)
The focus on child protection can become lost to medical intervention (Horwath and Kessel, 1995)

Some doctors can be intimidated by the mother (Fox, 1995)

Increased consumer consultation- may result in ongoing consultations with parents rather than with colleagues providing an opportunity for parents to push for additional investigations and/or treatments (Jureidini et al. 2003)

The makeup of some doctors may make them more vulnerable to manipulation (Jureidini and Donald, 2001)

Poor history taking contributes to existence of FII/MBP (Donald and Jureidini, 1996)

Doctors may rationalise their lack of action by stating it is not part of their role (Horwath and Kessel, 1995)

Doctors must exercise great care when describing the acts and consequences of abuse. A careless choice of words can have significant legal consequences and grave implications for children (Boros et al. 1995)

Some doctors may ignore the abuse to avoid becoming involved in a child abuse matter (Hall, 2003)

Some doctors may diagnose FII/MBP to avoid a complaint or legal action by a carer who may be unhappy with the treatment they have provided (Pragnell, 1994).
Appendix 8

Issues facing Child Protection Workers
with FII/MBP cases
Issues Facing Child Protection Workers with FII/MBP Cases

- Medical professionals may fail to consider FII/MBP and therefore may not involve child protection until many tests have been performed on the child (Horwath and Kessel, 1995)
- Doctors may be sceptical and hostile towards child protection personnel who may pursue a FII/MBP hypothesis (Freeland and Foley, 1992)
- Primary physicians may be reluctant to take protective action (Freeland and Foley, 1992)
- A reluctance by agencies to invest time and energy to investigate and obtain evidence required by child protection to intervene (Freeland and Foley, 1992)
- Parental collaboration may endanger the child (Southall et al. 1997; Pearce and Bools, 2000; Baildam and Eminson, 2000; Freeland and Foley, 1992; Rosenberg, 1997; Department of Health, 2001)
- Difficulties in moving away from the traditional child protection role of working closely in partnership with parents (Department of Health, Social Services Inspectorate, 1995; Southall et al., 1997; Jones and Lynch, 1998)
- A need to look at new approaches to identify abuse in situations in which it is not possible to trust or work in partnership with parents (Southall et al. 1997)
• The legislative focus is on the reunification of families – this may present problems in FII/MBP cases (Department of Health, Social Services Inspectorate, 1995)

• Timing of parental involvement (Byard and Burnell, 1994; Department of Health, 2001; Gray, 2001)

• Important for family to be unaware of social services involvement in the early stages of investigation therefore social worker is unable to work in an open and up front way with the family (Roberts and Carmichael, 1999)

• Differences about whether the child is being abused and/or how to best safeguard the child’s welfare (Department of Health, 2001)

• Arriving at a collective viewpoint regarding case management can be difficult (Freeland and Foley, 1992)

• Difficulty in judging the threshold at which active intervention should occur (Horwath and Lawson, 1995; Baildam and Eminson, 2000; Department of Health, 2001)

• Difficulties in assessing risks facing children and siblings (Department of Health, 1999)

• Difficulties in determining significant harm (Adcock and White, 1991; Department of Human Services, 2002)

• Inappropriate risk assessment tools (Lasher and Sheridan, 2004)

• The image of motherhood and the impact on risk assessment (Horwath and Kessel, 1995; Horwath and Lawson, 1995)

• A failure to identify and quantify risks (Banks, 1995)
• A lack of awareness or ability to secure protection for siblings (Davis et al. 1998)
• Issues with protecting future children (Rosenberg, 1993)
• An inappropriate level of trust with extended family members (Artingstall, 1999)
• Difficulties in providing an investigative approach, which is most likely required with FII/MBP cases (Southall et al. 1997)
• Difficult for workers to accept that in some serious FII/MBP cases no treatment options will work (Freeland and Foley, 1992)
• Workers can be in conflict with their personal and professional principles in relation to assisting the parents to solve their problems which led to the abuse of their child (Freeland and Foley, 1992)
• Timing of when to send a child home (Rosenberg, 1993)
• Polarization regarding case management options between those who argue to remove the child from parental care and those who support protection of the child within the family (Freeland and Foley, 1992)
• Such abuse presents challenges to the way in which social workers and social policy view the balance of children’s rights and those of parents (Banks, 1995; Horwath and Kessel, 1995)
• Concerns may shift to how the parent is feeling rather than focusing on the child’s needs (Horwath and Kessel, 1995)
• Attractive personality of the mother versus the effects of the abuse on the child – workers can be divided in their views (Freeland and Foley, 1992)
• Always think the best of parents; - over-optimism by workers (Horwath and Kessel, 1995; Southall et al. 1997)

• Care needs to be taken with placement of the child as the level of support for the family from extended family is generally high (Roberts and Carmichael, 1999)

• Refusal to consider case as a child protection referral (Horwath and Kessel, 1995)

• Father unable to accept criticism of his wife due to disbelief of situation (Freeland and Foley, 1992)

• Different responses towards the father ranging from sympathy to anger (Freeland and Foley, 1992)

• Father unable to protect child due to disbelief (Freeland and Foley, 1992; Lasher and Sheridan, 2004)

• Long term monitoring of families (Bahen et al. 1988)

• Problems for staff in monitoring families if they move (Neale et al. 1991)

• Debriefing of workers (Freeland and Foley, 1992)

• The importance of relief strategies (Freeland and Foley, 1992)

• Worker assigned are generally young and inexperienced (Meadow, 1985)

• Workers feel too intimidated by other professionals to state that they do not understand what FII/MBP is describing and try and guess at its meaning (Horwath and Kessel, 1995)

• Certain professionals may be perceived as powerful and workers may feel intimidated to challenge their opinions (Horwath and Kessel, 1995)
• Acceptance by supervisors of information from known workers without thoroughly reviewing information (Horwath and Kessel, 1995)

• Dismissal by supervisor’s of worker’s opinions (Horwath and Kessel, 1995)

• The stress, emotional turmoil and energy of FII/MBP cases can exceed that required in almost any other kind of casework activity (Freeland and Foley, 1992)

• Child protection workers can feel isolated, unsupported and unprotected (RCPCH, 2002).
Appendix 9

Children, Youth and Families Act, 2005

‘Mandatory reporting’ & ‘When is a child in need of protection’
Children, Youth and Families Act 2005

Mandatory Reporting (section 184)

1) A mandatory reporter who, in the course of practising his or her profession or carrying out the duties of his or her office, position or employment as set out in section 182, forms the belief on reasonable grounds that a child is in need of protection on a ground referred to in section 162(c) or 162(d) must report to the Secretary that belief and the reasonable grounds for it as soon as practicable-

(a) after forming the belief; and

(b) after each occasion on which he or she becomes aware of any further reasonable grounds for the belief.

Penalty: 10 penalty units.

(2) It is a defence to a charge under subsection (1) for the person charged to prove that he or she honestly and reasonably believed that all of the reasonable grounds for his or her belief had been the subject of a report to the Secretary made by another person.

(3) The requirement imposed by subsection (1)(b) applies to a mandatory reporter referred to in paragraph (f) to (l) of section 182(1) even if his or her belief was first formed before the relevant date under section 182(1) for that paragraph.

(4) For the purposes of this section, a belief is a belief on reasonable grounds if a reasonable person practising the profession or carrying out the duties of the office, position or employment, as the case requires, would have formed the belief on those grounds.
Children, Youth and Families Act 2005 – Sect. 162

When is a child in need of protection?

162. When is a child in need of protection?

(1) For the purposes of this Act a child is in need of protection if any of the following grounds exist-

(a) the child has been abandoned by his or her parents and after reasonable inquiries-

(i) the parents cannot be found; and
(ii) no other suitable person can be found who is willing and able to care for the child;

(b) the child’s parents are dead or incapacitated and there is no other suitable person willing and able to care for the child;

(c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child’s parents have not protected, or are unlikely to protect, the child from harm of that type;

(d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child’s parents have not protected, or are unlikely to protect, the child from harm of that type;

(e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child’s emotional or intellectual development is, or is likely to be, significantly damaged and the child’s parents have not protected, or are unlikely to protect, the child from harm of that type;

(f) the child’s physical development or health has been, or is likely to be, significantly harmed and the child’s parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

(2) For the purposes of subsections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.
Appendix 10

Methods for confirming MSBP

(Samuels, cited in Adshead and Brooks, 2001: 93)
### Methods for confirming MSBP


| **History** | — obtain reports from independent witnesses for symptoms/signs of illness  
|            | — verify details of reported personal, social and family history  
|            | — check illness history of siblings and parents with GP/other hospitals  
|            | — consider motivation/gain obtained by illness behaviour  |
| **Examination** | — complete and forensic in approach (consider signs of other abuse)  |
| **Observations** | — for in-patients: nurse (not parent) records all observed (versus reported) symptoms/signs  
|            | — one-to-one nursing observation  
|            | — record all parent visits and activities with child for temporal associations  |
| **Investigations** | — forensic process for collection of specimens  
|            | — analysis of source and identity (patient, mother, other) of specimen  
|            | — toxicology screening (consider use of police forensic laboratory)  
|            | — obtain video records of symptoms and signs  
|            | — physiological (event) recordings (cardiomemo, multi-channel respiratory or neurophysiological recordings)  
|            | — covert video surveillance  |
| **Management** | — provide parents with letter for open access to admission unit to confirm reported symptoms  
|            | — stop medications/observe/document baseline investigations  
|            | — food or substance challenges (double blind)  
|            | — one-to-one nursing  
|            | — exclusion of parents (voluntarily or by statutory intervention)  
|            | — professionals strategy meeting (chaired by social services)  
|            | — child protection investigation  
|            | — confrontation (beware in illness induction)  |
Appendix 11

Who should be interviewed

(Lasher and Sheridan, 2004: 131)
Who Should Be Interviewed

(Lasher and Sheridan, 2004: 131)

Anyone with potential information about the nuclear or extended family should be interviewed. This often includes the following:

1. Suspected/confirmed perpetrator(s), but only after victim safety is assured.
2. Suspected/confirmed victim(s), if old enough, but only after their safety has been assured. Some victims have said later that they had information to give but were never asked.
3. Suspected perpetrator's spouse/significant other(s), past and present, including child's father.
4. Day care or school staff.
5. Other individuals presently or formerly living or working in the home.
6. Present or former relatives, friends, neighbours.
7. Professionals or other staff mentioned in records or involved in producing records. (Such individuals often have much more information than they documented.)
8. Professionals or other staff not mentioned in records, but known to have had contact with the family.
9. Individuals who supposedly witnessed the alleged symptoms/illness/behaviour or relevant events.
Appendix 12

Some of the professionals with training needs in relation to FII/MBP

(Horwath and Lawson, 1995)
Some of the professionals with training needs in relation to MSBP abuse

(Horwath and Lawson, 1995: 184, Figure 6)
Appendix 13

FII/MBP Surveys
Blix and Brack (1988) conducted a large pediatric hospital on the campus of a large midwestern medical school. They surveyed 20 pediatric nurses that had direct dealings with a MSBP case.

- Only 10% of staff had previous experience with such a case.
- 55% had not heard of the diagnosis.
- More than 70% of the staff felt they were professionally and personally unprepared for the case. Their initial reaction to the suspected diagnosis ranged from shock and disbelief to nausea and anger.
- The majority had perceived the parent as supportive, loving and concerned.
- Many did not know how to define their role in such a situation (how to document the parent's behaviour, how to interact with the parents etc).
- Although every nurse eventually accepted the diagnosis they felt their relationships with parents in general had changed. At first, the majority of nurses reported they were less trusting and more observant with the parents. Further, 40% felt they would continue to be more vigilant and perhaps less trusting.
- Many highlighted the need for staff support and staff discussion of negative feelings was important.
- More than a quarter of staff mentioned the need for
obtaining more information about the case. Many felt the need for appropriate information was important in dealing with the professional and personal effects of such a case.

- The importance of communication between nursing staff and physicians was emphasized in assisting nurses to prevent being manipulated by these women.

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Professionals Represented</th>
<th>Findings</th>
</tr>
</thead>
</table>
| Kaufman et al. (1989)        | US, survey conducted at a two day regional child abuse conference held annually and sponsored by Columbus Children’s Hospital in conjunction with Ohio State University. | 86 professionals representing hospital or other medical settings (43%), community social services (18%), state children’s service services (22%), law enforcement agencies (7%) and other (10%). | • 50% of professionals had heard of MSBP  
• 86% of professionals working in the medical setting had heard of MSBP  
• 24% employed in community service agencies had heard of MSBP  
• Respondents who routinely worked with physicians were significantly more likely to be aware of MSBP than their counterparts  
• Journal articles and colleagues were the primary sources of participants’ knowledge of MSBP  
• A total of 77 possible cases of MSBP were reported by participants. |
| Hochhauser and Richardson (1994) | US, Midwest children’s hospital. | 320 registered nurses. | • 47% indicated they had not heard of MSBP  
• Of the respondents who had heard of MSBP (149)  
  65.8% (98) had not been involved in a case, and  
  34.2% (51) indicated that they had been involved in |
<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Sample Size</th>
<th>Main Findings</th>
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<tbody>
<tr>
<td>a case</td>
<td>87.9% indicated that they were not the first to suspect MSBP</td>
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<tr>
<td>12.1% indicated that they were the first to suspect MSBP</td>
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<td>On the whole the paediatric nurses exhibited a moderate level of awareness of MSBP</td>
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<tr>
<td>35.6 % of nurses who had heard of MSBP through other nurses, 12.8% at nursing school, 17.5% through physicians, 14.1% through journals, 6.7% through newspapers, 2.7% through a professionals conference, 2% at a staff conference, 1.3% through a social worker and 4.8% through other sources.</td>
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<tr>
<td>Ostfeld and Feldman (1996)</td>
<td>US, Jefferson and Mobile counties in Alabama.</td>
<td>687 primary care physicians and mental health practitioners.</td>
<td>Psychiatrists (89%) and psychologists (69%) were more aware of the disorder that were social workers (42%)</td>
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<tr>
<td>Years in practice were not associated with awareness of Factitious disorder by proxy</td>
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<tr>
<td>Psychiatrists were more likely than psychologists or social workers to have had exposure through an actual case or through their professional journals</td>
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<tr>
<td>Since social workers and psychologists often have earlier and more broader opportunities than psychiatrists in working with families, enhancements in training and the professional literature in these disciplines are needed if FDP is to be considered and identified</td>
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<tr>
<td>Psychiatrists (65%) most frequently cited their</td>
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</table>
training as an information source with FDP
- Journals were cited more often by psychiatrists (52%) and psychologists (44%) than by social workers (9%)
- There were no differences among the groups in knowledge of FDP through conferences or the mass media; fewer than 23% of respondents referred to these categories
- Social workers most often cited their colleagues (57%) as their primary information source.

| Bufton (1997) (Masters/unpublished) | Staffordshire, UK | 37 police (11 child protection constables, 14 uniformed police, 10 detective inspectors and 2 child protection sergeants) and 11 child protection personnel. | 9 of the 11 child protection constables had been involved in an investigation into MSBP
  - 8 had been involved in 2 or more cases of MSBP
  - All 11 of the child protection constables had received no training in relation to MSBP
  - 9 of the 11 child protection constables had been involved in the investigation of an infant death
  - 11 had received no specific training in relation to the investigation of child deaths
  - 6 of the 8 uniformed police constables had heard of Munchausen syndrome
  - 5 of the 9 uniformed constables had heard of MSBP
  - 1 of the 2 child protection sergeants had been involved in an investigation into MSBP. Neither had received training on this topic
  - 1 of the 2 child protection sergeants had been involved in the investigation of an infant death. |
<table>
<thead>
<tr>
<th>Australian Paediatric Surveillance Unit (APSU) (2000)</th>
<th>Australia</th>
<th>Medical practitioners (study still in progress- 11 confirmed or suspected MBP cases reported in 2000). (Study dependent on practitioners notifying APSU).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neither had received training in respect of investigating child deaths.</strong></td>
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<tr>
<td>• Six notifications received from Victoria, four from New South Wales and one from Queensland.</td>
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<td>• In all cases the mother was thought to be the perpetrator</td>
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<td>• Three of the six mothers were listed as being a nurse, a nurse's aid and a nurse in training. The occupation was not stated for the other three.</td>
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<tr>
<td>• Outlines situations leading to the suspicions of MSBP and features that helped to confirm the diagnosis</td>
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<tr>
<td>• The total number of doctors involved in the care of confirmed MSBP cases ranged from one to twelve</td>
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<td>• The number of hospital admissions per child attributed to MSBP ranged from none to six, whilst days in hospital ranged from none to 24 days</td>
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<tr>
<td>• Types of presentations included symptoms that were not confirmed during hospital admission, active interference with monitoring equipment, non-compliance with treatment and negative allergy testing in a child with allergic symptoms</td>
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<tr>
<td>• The reaction of doctors involved in the diagnosis was one of stress. This was a particular problem for doctors who worked in rural regions who lacked the support of a multi disciplinary child protection team.</td>
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</tbody>
</table>
| Bannon and Carter (1998 cited in Bannon and Carter, 2001:68) | UK | Postal questionnaire survey amongst a random 10% sample of GP’s in England. | Main training themes identified were:  
- Detection of the abuse – a perceived need to develop improved standards in the prompt identification of all types of child abuse and neglect  
- Legal aspects – improved understanding of legislation and an appreciation of the medico-legal implications for doctors of their involvement in the child protection process  
- Intervention Procedures – when abuse suspected/identified, including an appreciation of when the threshold for intervention had been exceeded as well as local referral processes  
- Interagency Liaison: - an appreciation of the roles of other agencies as well as a means of communicating with them  
- Child protection case conferences: - a greater understanding of the wider implications for them when they attended conferences, guidance with preparation and presentation of reports for conferences, how to deal with the parents presence at case conferences  
- Support for families – an understanding of available sources and mechanisms of support for families after the intervention/investigation process had been completed  
- Emotional reaction: training required by doctors to cope with their own feelings when they encounter child abuse or neglect |
<table>
<thead>
<tr>
<th>The Royal College of Paediatrics and Child Health (2002)</th>
<th>UK</th>
<th>Family practitioners, community paediatricians, child psychiatrist, general paediatricians, paediatric surgeons, specialist paediatricians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>- The majority of replies were 'thoughtful, practical, aware of the difficulties and looking for progress and guidance from the college'. A small percentage 'honestly and openly wished to have nothing to do with the problem'. Finally, there emerged 'views from two extremes which clearly derive[d] from personal experience'. Refer to RCPCH (2002: 59-62) for further findings.</td>
</tr>
</tbody>
</table>
Appendix 14

Single and multi-agency training

(Horwath and Lawson, 1995)
Single discipline training within a single agency  
(Horwath and Lawson, 1995: 204-205)

<table>
<thead>
<tr>
<th>Definition and target group:</th>
<th>Training delivered to one discipline only e.g. police officers, social workers, health visitors, paediatricians, probation officers, paediatric nurses, guardians ad litem, psychiatrists.</th>
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</thead>
<tbody>
<tr>
<td>Maximum number:</td>
<td>24</td>
</tr>
<tr>
<td>Length of course:</td>
<td>1 or 2 days</td>
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</tbody>
</table>
| Aims and objectives:       | 1. To promote a basic awareness among a particular practitioner group of MSBP abuse. (This basic awareness would be the same for different disciplines.)  
2. To promote a particular understanding of how MSBP abuse issues would affect that particular group of practitioners.  
3. To provide the practitioner group with an experience of how a case might unfold and how other people might react. (Material from the case study, see Exercise 4 in this chapter, might be used here, adapted for local needs.)  
4. For participants to understand their responsibility in relation to MSBP abuse and how to discharge that responsibility appropriately in seeking to ensure the protection of the child. |
| Style of delivery:         | Formal inputs, handouts, small group exercises and discussions, case study, skill rehearsal. |
| Trainers required:         | Preferably two trainers who are used to working together and are familiar with the material. |
| Learning objectives:       | 1. Know what MSBP is and how it should be responded to;  
2. Know what their role and their responsibilities are in relation to managing allegations of MSBP abuse;  
3. Be aware of how cases of suspected MSBP are likely to progress;  
4. Know how to deal with the difficult and complex dynamics that will have to be addressed;  
5. Know what their responsibilities are in relation to the protection of the child and in dealing sensitivity with children. |
Particular practitioners could also pursue specific issues. For example:

<table>
<thead>
<tr>
<th>For paediatricians:</th>
<th>How to deal with the interpersonal dynamics of working with a parent suspected of MSBP.</th>
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</thead>
<tbody>
<tr>
<td>For probation officers:</td>
<td>How to prepare a pre-sentence report and supervise a convicted perpetrator.</td>
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<tr>
<td>For police officers:</td>
<td>How to investigate allegations of MSBP appropriately, including the use of CVS.</td>
</tr>
<tr>
<td>For paediatric nursing staff:</td>
<td>How to maintain principles of family-centred care while working with a suspected case of MSBP.</td>
</tr>
<tr>
<td>For social workers:</td>
<td>How to undertake investigative and assessment work. How to involve family members appropriately.</td>
</tr>
</tbody>
</table>

**Multidisciplinary Training within a Single Agency**
*(Horwath and Lawson, 1995: 206-207)*

**Definition and possible target groups:**
This is training which is delivered to a number of different disciplines working within the same agency. Ideally these courses should follow single discipline awareness training. Three main worksites would seem likely to have multidisciplinary training needs around MSBP abuse: primary health care, children's hospital wards and court settings.

**Maximum number:**
Dependent on worksite and staff release issues.

**Length of course:**
Could be done on a half-day or full-day basis with further sessions if necessary.

**General aims and objectives:**
1. To develop a common understanding of and a coordinated response to suspicions of MSBP abuse.
2. To agree a system for managing the difficult and complex interpersonal dynamics likely to arise out of dealing with a suspected case of MSBP abuse.
3. To discuss and agree how best to carry out assessment and investigation work in relation to MSBP.

**Style of delivery:**
Team building focusing on group process, case studies, skill rehearsal and development.

**Trainers required:**
Trainer with experience in team building, experience of work setting and who is familiar with both group process issues and MSBP.

**Learning objectives:**
1. Have a common understanding of MSBP and the issues involved for the particular worksite; 2. Have agreed a coherent and consistent multidisciplinary approach to dealing with suspicions of MSBP abuse; 3. Have agreed a system for managing the conflicts and disagreements that are likely to arise;
4. Have agreed how to carry out investigation and assessment in relation to suspicions/allegations of MSBP.

<table>
<thead>
<tr>
<th>Suggested content and emphasis for each worksite:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary health care teams should receive training in recognition, referral and management. Here it will be the relationship between GP and health visitor that will be crucial. However, the importance of checking concerns and getting information from other members of the team should be emphasised. Hospital ward staff face similar but much more intense issues, as the family may be on the wards regularly and for long periods. Such training should involve paediatric doctors, nurses and ancillary staff, including receptionists and other administrative workers involved in contact with families. The courts have to make judgements with regard both to the care of children and the guilt or innocence of alleged perpetrators in relation to the criminal aspects of MSBP. Both civil and criminal courts need to be aware of relevant case law and the appropriate use of expert witnesses. This can probably be best achieved through joint training for clerks, magistrates and judges.</td>
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</tbody>
</table>

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**Inter-agency training**  
(Horwath and Lawson, 1995: 208)

### Definition:
Inter-agency training usually takes place between two agencies, either working on the same site or sharing a similar responsibility. The most common form of inter-agency training is joint investigation training between the police and social services. Such training should ideally be provided following basic awareness training.

### Target Group:
Joint training between hospital social workers, police officers and paediatricians in any combination. They may share either a worksite or a common investigative purpose. The group may cross more than one ACPC area, as police forces and hospitals often work with more than one ACPC area.

### Number:
Variable depending on area.

### Aims and objectives:
For participants to:
1. Improve the quality of investigations into MSBP;
2. Familiarise themselves with any agreed protocol on investigations in relation to MSBP, including the use of CVS;
3. Have an opportunity to operationalise the protocol through the use of a case study;
4. Discuss, agree and implement any practice recommendations arising from the training.
Style of delivery: Formal input, case study, small group discussion, skill rehearsal and development.

Trainers required: Senior member of ACPC to explain protocol. Two trainers experienced in MSBP and in the use of CVS. Could be run on a regional or consortia basis.

Learning outcomes: At the end of the course participants should:
1. Know how to improve investigations into MSBP;
2. Know what investigative and assessment techniques to use and when;
3. Know when it is appropriate to use CVS;
4. Have the necessary skills to implement such a surveillance;
5. Identify areas for improving practice and act on them.

Multi-Agency training
(Horwath and Lawson, 1995: 209)

Definition: Training delivered to staff from a number of different agencies and disciplines based at different worksites. Training can be at the same level in organizations (for example, practitioners, supervisors, policy makers) or across levels. Such training would ideally be delivered following awareness, multidisciplinary and inter-agency training.

Target Group: Any combination of groups already mentioned where a need has been identified in bringing those particular groups together.

Maximum number: 24.

Aims and objectives: To bring participants together to focus on how to work with MSBP abuse effectively through the following processes:
referral
investigation
conference
assessment
core group
court processes

Style of delivery: Case studies, small group exercises and discussions, action planning, handouts.

Trainers required: Two, who are familiar with both MSBP and multi-agency working

Learning outcomes: By the end of the course participants should:
1. Be familiar with how cases of MSBP are processed through the child protection and related legal
systems;
2. Be familiar with some of the pitfalls along the way and how some of these can be addressed;
3. Be clear about how they can work together effectively to maximize the protection of children while having due regard for the rights and sensitivities of parents.
Appendix 15

FII/MBP related Training (unpublished)
# FII/MBP training programs

## A comparison of unpublished training content

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<tr>
<th></th>
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<tbody>
<tr>
<td>Overview of child abuse and unexpected deaths</td>
<td>Y</td>
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<tr>
<td>Overview of fatal abuse</td>
<td>Y</td>
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<tr>
<td>Definition of factitious disorders, MBP and Munchausen syndrome</td>
<td>MBP defined</td>
<td>MBP defined</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>MBP maltreatment basics</td>
<td>Overview of offending</td>
<td>Common presentations of MBP and the usual methods of deception</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>Common MBP suspicion indicators / behavioural clues</td>
<td>Patterns of behaviour, recognition and warning signs</td>
<td>Guidelines for suspecting and identifying MBP</td>
<td>Y</td>
<td></td>
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<tr>
<td>History of MBP</td>
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<td>Y</td>
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<tr>
<td>Differences between MBP and other kinds of maltreatment</td>
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<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>Mental illness or criminal act?</td>
<td>Y</td>
<td></td>
<td></td>
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<tr>
<td>MBP symptoms (fabricated and induced)</td>
<td>Common disorders / symptoms</td>
<td>Y</td>
<td></td>
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<tr>
<td>MBP behavioural typology</td>
<td>Patterns of behaviour</td>
<td>Y</td>
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<tr>
<td>Limitations of MBP</td>
<td></td>
<td>Y</td>
<td></td>
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<tr>
<td>MBP Case study</td>
<td>Y</td>
<td>Presents findings from a survey with paediatric neurologists and gastroenterologists</td>
<td>Y</td>
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<tr>
<td>Redflag stories from caretakers</td>
<td>Y</td>
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<tr>
<td>Survey of pediatric neurologists and gastroenterologists regarding FII/MBP case involvement</td>
<td></td>
<td>Y</td>
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<tr>
<td>Profile of offender</td>
<td>Y</td>
<td>Y</td>
<td>Description of mother</td>
<td>MBP perpetrator characteristics</td>
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<tr>
<td>Types of offenders: help seekers, doctor addicts, active inducers</td>
<td></td>
<td>Y</td>
<td></td>
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<tr>
<td>Background of offenders/family histories</td>
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<tr>
<td>Father’s role in MBP cases / non-offending parent</td>
<td>Y</td>
<td>Description of father</td>
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<tr>
<td>Interviewing the non-offending parent</td>
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<tr>
<td>Father as the offender</td>
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<tr>
<td>Offender motivational factors</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Victim profile and affects on victims</td>
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<tr>
<td>Cases involving the elderly</td>
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<td>Topic</td>
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<td>Y2</td>
<td>Y3</td>
<td>Y4</td>
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<td>Secondary victims</td>
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<td>Information on siblings</td>
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<tr>
<td>MBP confirmation – disconfirmation process (basics)</td>
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<tr>
<td>Investigation steps</td>
<td>Y1</td>
<td>Y2</td>
<td>Y3</td>
<td>Y4</td>
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<td>Case management – multidisciplinary team</td>
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<td>Y2</td>
<td>Y3</td>
<td>Y4</td>
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<tr>
<td>Role of mental health professionals</td>
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<td>Paramedics</td>
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<td>Steps in organising and planning initial meetings</td>
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<td>Y1</td>
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<tr>
<td>Case planning</td>
<td>Y1</td>
<td>Y2</td>
<td>Y3</td>
<td>Y4</td>
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<tr>
<td>Records to examine</td>
<td>Y1</td>
<td>Y2</td>
<td>Y3</td>
<td>Y4</td>
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<tr>
<td>Crime scene issues</td>
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<tr>
<td>Covert video surveillance</td>
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<tr>
<td>Confronting the offender</td>
<td>Y1</td>
<td>Y2</td>
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<tr>
<td>Offenders response to allegations</td>
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<tr>
<td>Victim safety planning</td>
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<tr>
<td>Topic</td>
<td>Y</td>
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<td>Case resolution factors</td>
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<td>Guidelines for Case management</td>
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<td>Activities and decision making regarding victim out of home placement</td>
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<td>Investigating fatal child abuse</td>
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<td>Previously ruled SIDS: MBP or homicide?</td>
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<td>Sudden infant death syndrome, theories on causes of SIDS</td>
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<td>Fatal child abuse vs homicide (differences)</td>
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<tr>
<td>Impulse or anger homicides</td>
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<tr>
<td>Head injuries, fatal falls, chest injuries, internal injuries,</td>
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<td>abdominal injuries, fractures</td>
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<td>Shaken baby syndrome</td>
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<td>Neglect, negligent supervision</td>
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<td>Manners of death</td>
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<tr>
<td>Infanticide, Neonatacide, abuse related deaths</td>
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<td>Battered child syndrome</td>
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<tr>
<td>Children's anatomy</td>
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<tr>
<td>Investigation checklist</td>
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<td>Guidelines for verifying MBP</td>
<td>Y</td>
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<tr>
<td>Legal issues</td>
<td>Y</td>
<td>Common MBP maltreatment defence strategies to anticipate and overcome</td>
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<tr>
<td>Tragic costs of MBP</td>
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<tr>
<td>Court preparation and presentation (child Protection focused)</td>
<td></td>
<td>Y</td>
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</tbody>
</table>
Appendix 16

Questionnaire Documentation
September/October 2001

Dear member,

My name is Cath Swaine, I am a Senior Constable of Police based at the Sexual Offences and Child Abuse Co-ordination Office located at the Victoria Police Centre in Melbourne. My role at this office is in training, policy and research within the areas of child abuse and sexual assault.

I am currently undertaking a Master of Arts Degree by Research with the Department of Justice and Youth Studies at RMIT University, Bundoora Campus. My thesis topic is: “Training Requirements for Victoria Police in Investigating the ‘Fabrication and Induction of Illness/Injury’ in Children (Munchausen Syndrome By Proxy)”.

Approval has been granted by the Victoria Police, The Royal Children’s Hospital and the Department of Human Services to conduct this research.

The investigation of cases involving the ‘fabrication and induction of illness/injury’ in children is a relatively new field of police work. The level and accuracy of information police have about this topic is not known and police training in this subject area is in the beginning stages of being developed.

Request to complete survey

Part of the research involves conducting a survey with 1300 police officers. You have been randomly selected to complete this survey. The survey is designed to gauge the level of knowledge individual members have about ‘fabricated and induced illness/injury in children’ (Munchausen syndrome by proxy). The survey should take approximately 10-15 minutes to complete. Members have permission to complete the survey during work time.

It must be acknowledged that ‘fabricated and induced illness/injury’ in children is a sensitive topic area. Should you become distressed during the completion of the survey, please stop and consult your supervisor or myself.
Members are assured of anonymity during the research process and in the published findings. Participation in the survey is completely voluntary.

Please send completed surveys to:
S/C Cath Swaine

(Address withheld)

Findings from study

The findings from the study will be used to develop police training in relation to the investigation of ‘fabricated and induced illness/injury in children’. The findings may also be utilised to assist with the development of multidisciplinary protocols between police, hospitals and child protection, to co-ordinate the multidisciplinary response and investigative processes towards these cases.

Interviews

I am also keen to interview members who have been directly involved with cases of ‘fabricated and induced illness/injury’ in children. I am requesting interested members to supply their details below.

| Name: ___________________ | Contact Phone Number: ___________________ |

If you have any questions please contact me directly on: (Detail withheld)

Yours sincerely

Cath Swaine
S/C 29494

Supervisors & police consultants for degree

- Marg Liddell (Senior supervisor) - Bundoora RMIT Dept. of Justice & Youth Studies
- Dr David Smith (Second supervisor) – Bundoora RMIT, Dept. of Justice & Youth Studies
- Act/Sgt Sandy James (Sexual Offences and Child Abuse Co-ordination Office)
- Det. S/Sgt David Wilkins (Ethical Standards Division)
Background Information  (Please answer all questions)

1. **Work Location**: Recruit  □  Uniform  □  Criminal Investigation Unit  □  Sexual Offences & Child Abuse Unit  □
   Suburb/town (if unsure) ________

2. **Work Area**: Country □  City □  Suburb/town (if unsure) ________

3. **Age**: ________ yrs

4. **Rank**: Recruit □  Constable □  Senior Constable □  Sergeant □  Senior Sergeant □  Inspector □

5. **Years as a police officer**: ________ yrs

6. **Have you ever worked at a Sexual Offences & Child Abuse Unit?**
   Yes □  No □  (Time worked ______ )

7. **Have you heard of the condition Munchausen syndrome by proxy (also known as Factitious disorder by proxy)?**
   Yes □  No □

8. **If yes, where have you heard about Munchausen syndrome by proxy?** Tick as many as applicable
   - On the job at work □
   - Police training □
   - Television □
   - Magazines □
   - Newspaper □
   - Family/friends □
   - Other _____________

Survey

On the following scale, please rate how well informed you consider yourself to be on the topic of: Munchausen syndrome by proxy  also known as Factitious disorder by proxy  (‘Fabricated and/or induced illness/injury’ in children)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Very poorly informed</td>
<td></td>
<td></td>
<td></td>
<td>Very well informed</td>
</tr>
</tbody>
</table>
Listed below are a series of statements about Munchausen syndrome by proxy. Please circle the response that best indicates the extent to which you agree or disagree with each of these statements, using the following scale: **One** equals “strongly disagree” and **five** equals “strongly agree”.

Please answer all questions.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Induced illness in children is normally committed by males.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>2. Offenders who induce illness in their children normally present as very loving and caring individuals.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>3. Mothers who induce illness in their children should not be dealt with by the police.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>4. The motivation for offenders who fabricate or induce illness/injury in children seems to lie in the offender’s need for attention.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>5. Some of the most common forms of fabricated illness symptoms in children are seizures and fevers.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>6. Fabrication of illness in a child may include the exaggeration of a real illness.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>7. Inducing illness in a child may be caused by adding large amounts of salt to a child’s diet.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>8. Munchausen syndrome by proxy offenders often have a teaching background.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>9. With induced illness in children, evidence is usually readily available through toxicology reports.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>10. Offenders of fabricated and induced illness in children are generally of low intelligence.</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Unsure</td>
<td>Agree</td>
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<tr>
<td>11. Offenders who fabricate or induce illness in their child usually start offending against their child, when their child is around 3 years of age</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>12. Epilepsy is easy to fabricate.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>13. A mother who is inducing illness in her child, won't offend against the child if the child is in hospital.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>14. Munchausen syndrome by proxy offenders generally come from a lower economic background.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>15. The spouse of an offender who is ‘fabricating or inducing an illness’ in their child is usually aware of what is occurring.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. The majority of offenders who ‘induce illness in children’ know what effects their actions will have upon the health of their victim.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td>17. Offenders who fabricate and/or induce illness in their children primarily to receive financial benefits.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>18. Parents who drug their children to keep them quiet, fit the criteria for Munchausen syndrome by proxy.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>19. Doctors are legally mandated to report to police cases involving induced illness/injury in children.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>20. Child protection measures need to be implemented prior to police confronting offenders of ‘fabricated and/or induced illness’in children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>21. Department of Human Services (Child Protection) are legally mandated to notify police of cases involving induced illness in children.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Unsure</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<tr>
<td>22. Victims of fabricated and/or induced illness/injury may collude with the offender.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>23. Munchausen syndrome by proxy offenders make up stories about their own lives.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>24. Girls are generally more likely to be victims of ‘fabricated and induced illness’ than boys.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>25. Suffocation of a child by smothering is usually detected at autopsy.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>26. Munchausen syndrome by proxy offenders will normally freely admit guilt when interviewed by police.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>27. Confrontation of an offender who is fabricating and/or inducing illness in their child should be done by the doctor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. If covert video surveillance is required in a hospital to assist in detecting abuse against a child, this video should be monitored only by the medical profession.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>29. False medical history is common with Munchausen syndrome by proxy.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>30. Munchausen syndrome by proxy offenders may stop their offending for a period and restart at a later time.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>31. A mother who continually makes false allegations that her daughter has been sexually abused in order for the mother to gain attention for herself, is likely to be a Munchausen syndrome by proxy offender.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>32. Munchausen syndrome by proxy offenders usually will offend against all children in the family simultaneously, not just one child at a time.</td>
<td>1</td>
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<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Unsure</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<tr>
<td>33.</td>
<td>A single blood test will show what is being given to a child to make the child sick.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>Speaking with all family members is a vital part of investigating induced illness/injury in children.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>35.</td>
<td>Professionals working with a child victim of induced illness are often deceived by the offending mother, due to her apparent medical background.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>36.</td>
<td>Generally Munchausen syndrome by proxy offenders try to avoid getting too close to the professionals who are treating or questioning their victim for fear of being discovered.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>37.</td>
<td>The behaviour of parents who push their children to train exhaustively in sport in order that the child achieves excellence in sport, should be considered a form of Munchausen syndrome by proxy abuse.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>38.</td>
<td>Munchausen syndrome by proxy cases often create conflict between professionals who are involved with the case.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
</tr>
<tr>
<td>39.</td>
<td>The spouse of a Munchausen syndrome by proxy offender will often outwardly defend his/her partner, when initially informed that the partner is causing their child to be sick.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>40.</td>
<td>There is no link between induced illness and Sudden Infant Death Syndrome.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>41.</td>
<td>Munchausen syndrome by proxy cases need to be investigated by a multidisciplinary team including doctors, child protection workers and police.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>42.</td>
<td>Parents who suffocate their child to get them to stop crying do not fit the criteria for Munchausen syndrome by proxy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>43.</td>
<td>Munchausen syndrome by proxy offenders tend to actively encourage doctors to perform tests on their child, even if this may cause distress to the child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
44. Munchausen syndrome by proxy offenders are difficult to distinguish from parents of genuinely ill children.

45. Mothers who induce illness in their children should be charged and prosecuted in court.

Please rate again on the following scale, how well informed you consider yourself to be on the topic of: Munchausen syndrome by proxy.

Very poorly informed

Very well informed

Thankyou for your time

Cath Swaine

S/C 29494
Appendix 17

Interview Documentation
Ref: Master’s Research Project
Date:

Dear ____________________

My name is Cath Swaine, I am a Senior Constable based at the Sexual Offences and Child Abuse Co-ordination Office located at the Victoria Police Centre in Melbourne. My role at this office is in training, research and policy within the areas of child abuse and sexual assault.

I am currently undertaking a Master of Arts Degree by research with the Department of Justice and Youth Studies at RMIT University, Bundoora Campus. I have two Bundoora RMIT supervisors for this degree: Dr. Margaret Liddell from the Department of Justice and Youth Studies (Senior Supervisor) and Dr David Smith from the Psychology Department (Second Supervisor), and two police consultants: Acting Senior Sergeant Sandy James and Detective Senior Sergeant David Wilkins.

My research topic is:

Training Requirements for Victoria Police in Investigating the 'Fabrication and Induction of Illness/Injury in Children.'

The investigation of cases involving the 'fabrication and induction of illness/injury' in children is a relatively new field of police work. The level and accuracy of information police have about this topic is not known and police training in this subject area is in the beginning stages of being developed.
My research, which is designed in two parts, is intended to:

- ascertain the current knowledge level held by police on the subject of 'fabricated and induced illness/injury' in children and
- to identify multidisciplinary training issues arising with these investigations.

One part of the study involves a random stratified survey of a large cross section of police to ascertain their knowledge level of the subject area. The other half of the study, involves conducting interviews with key professionals who have had experience with these type of investigations.

Data collected through the surveys and interviews, in conjunction with an extensive literature review, will be used to identify training requirements for Victoria Police in responding to and investigating 'fabricated and induced illness/injury' in children. Findings will be passed on to the Sexual Offences and Child Abuse Co-ordination Office to assist in the development of police training in this area. The findings may also be utilised to assist with the development of multidisciplinary protocols between police, hospitals and child protection.

This letter is to invite you to participate in the interview component of the research. The following professionals will be asked to participate in the study: child protection workers, doctors, police and psychologists. Approval has been granted by Victoria Police, The Department of Human Services, and a Victorian hospital to carry out this research.

'Fabricated and induced illness/injury' in children is a sensitive topic area. Participation in the interview is completely voluntary and you have the right to withdraw from the study at any time. Should you become distressed (for any reason) during the interview, please inform the researcher and the interview will be suspended or discontinued.

The researcher is well aware of confidentiality issues regarding the identity of victims and offenders and at no point in the research will participants be asked to disclose this information. The research is purely aimed at identifying training issues, in order that the police and multidisciplinary response and investigation towards these cases can be improved.

Professionals agreeing to participate in the interview will be requested to sign a letter of consent. This letter of consent is a university requirement whereby participants give their permission to be interviewed for the purposes of this research.

Interview participants should be aware that if having participated in the research, they decide at a later stage, that they don't wish their data to be included or they decide they don't wish to be involved in a second interview, their decision will be respected.

The interview will take approximately 60 minutes to complete. Unless otherwise requested, all interviews will be tape recorded. Tape recording ensures the information is recorded accurately and also enables the researcher to review and collate the material at a later date. Tapes will be numbered and will not contain the participant's details. All tapes will be kept in locked filing cabinets at the Victoria Police Centre and at the researcher's
home address. The principal researcher will be the only person with key access to these tapes. Should there be a need to discuss the research data, the two police consultants may have access to the tapes and participants’ details. University supervisors and people involved in the tape transcription will only have access to the processed data and will not have access to the participant's details and organisations with which they are affiliated.

Interviews can be carried out at your work place or at the Victoria Police Centre, in Melbourne. The researcher will be in touch to organize an agreed time, place and venue.

Participants are assured of anonymity during the research process and in the published findings.

Participants are welcome to a copy of a summary of the results.

Should there be any questions regarding the interview process please don't hesitate to call me on: (Phone numbers withheld).

Yours sincerely,

Cath Swaine
Sgt 29494

Any queries or complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. Phone: (03) 9925 1745.
PARTICIPANT INFORMATION STATEMENT

Project No

Title of Project

Training Requirements for Victoria Police in Investigating the ‘Fabrication and Induction of Illness/Injury’ in children.

Thank you for taking the time to read this Information Statement. This information statement is 4 pages long. Please make sure you have all the pages.

You are invited to participate in a Research Project that is explained below.

What is the Research Project about?

This research project is part of a Masters Degree, which is being completed through Bundoora RMIT. The project is designed to identify:

- The current knowledge level of Victoria Police members in relation to ‘fabricated and induced illness/injury’ in children (survey of relevant Victoria Police departments)
- What skills and knowledge Victoria Police need to respond to and investigate cases of ‘fabricated and induced illness/injury’ in children, from a police and multidisciplinary perspective (extensive literature review & interviews with key professionals who have been involved with these cases: doctors, police, psychologists, child protection workers)
- What content should go into a Victoria Police training package on the subject of ‘fabricated and induced illness/injury’ in children (findings from: literature review, survey & interviews)

Information collected from this research will be used to develop and improve police training in how to respond to and investigate cases of ‘fabricated and induced illness/injury’ in children. It is also envisaged that this research will assist in the future development of shared protocols between Victoria Police, (the Hospital involved) and The Department of Human Services to improve the multidisciplinary response towards these investigations.

Who are the Researchers?

Principal Researcher

There is only one researcher primarily involved with this research project, - Senior Constable Cath Swaine. S/C Cath Swaine has initiated this research project due to identifying a perceived lack of police knowledge and training in the subject area. S/C Cath Swaine will be responsible for conducting the research, analyzing the research and writing up the research findings.

S/C Cath Swaine has ten years policing experience and is currently working at the Sexual Offences and Child Abuse Co-ordination Office at the Victoria Police Centre in Melbourne and is involved in police training, policy and research within the areas of child abuse and sexual assault.

(Organization details withheld)
RESEARCH PROJECT INVOLVING HUMAN SUBJECTS

Please note: This is a prescribed form. It is a requirement of the RMIT Human Research Ethics Committee.

DEPARTMENT OF: Justice & Youth Studies

FACULTY OF EDUCATION, LANGUAGE AND COMMUNITY SERVICES

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Name of participant: ____________________________________________

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Training requirements for Victoria Police in Investigating the 'Fabrication and Induction of Illness/Injury' in Children</th>
</tr>
</thead>
</table>

Name of investigator(s): Senior Constable Cath Swaine

Telephone numbers withheld

Please see attached for details of researcher’s supervisors and police consultants.

1. I consent to participate in the above project, the particulars of which - including details of the interview - has been explained to me and are appended hereto.

2. I authorise the investigator or his or her assistant to interview me.

3. I acknowledge that:

   (a) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied;
   (b) The project is for the purpose of research and/or teaching and not for treatment.
   (c) I have read and retained a copy of the Plain Language Statement, and agree to the general purpose, methods and demands of the study.
   (d) The project may not be of direct benefit to me.

2.
STANDARD INFORMED CONSENT FOR PARTICIPANT TO PARTICIPATE IN A RESEARCH PROJECT

Title of Project
Training Requirements for Victoria Police in Investigating the ‘Fabrication and Induction of Illness/Injury’ in Children.

Principal Investigator(s) Senior Constable Cath Swaine (Will be conducting all interviews)
Police Consultants: Act/S/Sgt Sandy James, Det S/Sgt David Wilkins
Associate Investigator (Details withheld)
University Supervisors: Marg Liddell (Justice & Youth Studies Dept.) & Dr. David Smith (Psychology Dept.) (Bundoora RMIT)
(Bundoora RMIT)

Brief outline of research project including benefits, possible risks, inconveniences and discomforts (12 lines maximum)
This research project seeks to identify the current knowledge level of Victoria Police members in relation to ‘fabricated and induced illness/injury’ in children; what skills and knowledge Victoria Police need to respond to and investigate these cases, from a police and multidisciplinary perspective; and what content should go into a Victoria Police training package on the subject of ‘fabricated and induced illness/injury’ in children.

Information collected from this research will be used to develop and improve police training in how to respond to and investigate cases of ‘fabricated and induced illness/injury’ in children. It is also envisaged that this research will assist in the future development of shared protocols between Victoria Police, (the Hospital concerned, details withheld), and The Department of Human Services to improve the multidisciplinary response towards these investigations.

S/C Cath Swaine is a police officer with 10 years policing experience and is an experienced police researcher and forensic interviewer of children. S/C Cath Swaine is aware of the sensitive nature of the topic and the difficulties faced by those professionals encountering this type of abuse, and in recalling such incidents. All interviews will be conducted by S/C Cath Swaine in an informal relaxed manner, at the convenience of the participant.

I, (Name withheld)
voluntarily consent to taking part in this research project, which has been explained to me by

I understand that I will receive a copy of this consent form.
SIGNATURE (Signature withheld)
Date 6/8/02

I have explained the study to the participant who has signed above, and believe that they understand the purpose, extent and possible effects of their involvement in this study.
RESEARCHER'S SIGNATURE Date 6/15/02
Interview Aide Memoir (Example)

Terminology

With regards to fabricated and/or induced illness in children or MBP there are various names for this. What terminology do you tend to use or are familiar with?

Defining

The literature uses various criteria and boundaries to define MBP. What is your understanding of MBP?

Experience

Have you hand any involvement with FII/MBP cases? Tell me about your experiences

Recognising FII/MBP

How did you come to realise that someone was causing the child’s illness or fabricating illness symptoms? Difficulties? Can you give any advice to professionals to be able to recognise this behaviour or offending sooner?

Case conference

Was a case conference held? Tell me about your experience
Who attended? Who should attend? How did you find the case conference? Useful? Problems? What information should be supplied to case conference attendees? Verbal/written?

Offender

Tell me about the offending mother
Do you know if the mother had a history of fabricating her own illnesses? What advice can you give to police in dealing with such women? How did you find the mother to deal with? Is there anything you can tell me about your dealings with such women that might be useful from a police training perspective?

Spouse

Tell me about the spouse
Whose role should it be to approach the spouse? Were there any supports in place for the father?
Victim

Tell me about the victim (remind not to disclose personal details)
Age?
Did you speak with the victim? Comments
Type of abuse

Response/Investigation

Tell me about your experience in responding to and investigating a FII/MBP case
Difficulties encountered?
Were you able to prove what was occurring?
Where do you see that improvements could be made?

Multidisciplinary response

Tell me about your experience in working with other professionals
What professionals were involved?
How was the case handled? Who played what roles?
How did different professionals work together?
Were there differing viewpoints?
Is there any system in place to respond to these cases?
What steps were taken in relation to identifying what was happening?
Were there any support networks in place for professionals working with the case?
Were there any supports in place for dad? Non-offending parent?
Whose role is it to go through the medical reports? Collate?
Whose role is it to confront offender? At what stage should this be done? How?
If mother is at home with child – who to confront? How undertaken?
Did you confront the mother? How undertaken? When? Reaction of mother? Who present?
Was child interviewed? Views here.

Did you feel equipped to answer mum’s questions? If no, how can we improve? If yes, why?
How are cases documented?
If conflict arises between professionals – steps taken
Are there protocols or documented procedures you must follow when responding to these cases?
Are you aware of any cases that have gone to court?
How can we improve the multidisciplinary response?
Do you think these cases should be handled at a regional level or by a statewide team of experts?

Child Protection

Was child protection involved?
Tell me about your experience with child protection?
At what stage should DHS become involved?
What is the likelihood of a sibling being PA’d if no proven abuse specifically relating to them?
How best do we protect the child in these cases?
Can you keep child in hospital separated from mother? Need court order?
How long did DHS stay involved? Monitoring processes?
Police

Police involved? Which police?
Should police become involve? At what stage became involved?
Police role?
Tell me about your experience with police
Thoughts on their involvement? At what stage do you think police should become involved?
What evidence do you think would be important in these cases – if the matter went to court?
What offences considered?
Collecting / searching for evidence?
What do you think police need to know about these cases? Knowledge? Skills?
If police suspect this abuse is occurring what steps would you recommend?
What issues do you consider relevant for police training?

Doctor

Number of doctors involved?
Type of doctors involved?
Who took key responsibility?
How defining subject?
Tell me about your experience with medical professionals
Are systems interlinked throughout hospital? Would emergency department be aware child being seen within hospital for other matters? Other departments?
If a FII/MBP case is suspected but no firm evidence – what steps would be looked at?
If the media become involved – how would hospital address?
What is the best way for police to obtain medical files?
If you notified DHS, would you be happy to sign a release for mother to know you were the notifier?
Communication between doctors? Hospitals?
How long were doctors involved prior to identification? After identification?
How long are medical notes kept for?

Court

Did case go to court?
Experience?
Were professionals happy to give evidence?

Covert video surveillance

Thoughts? Agree/disagree on usage?
Who should conduct? How run?
Are there any guidelines?

What should happen to the offender?

What do you believe should happen with these cases? Mother? Should the mother be charged for her actions?
Debriefing for staff

Was this done?
Formally/informally
Comments

Training

Have you ever received any training? How did you learn about FII/MBP?

Anything further to add?

Questions
Appendix 18

Ethics and/or Organisational Approvals
28 December, 2000

S/Constable C SWAINE

(Details withheld)

S/Constable SWAINE,

Responding to and Investigating Munchausen by Proxy
(RCC#2000-094)

The Research Coordinating Committee (RCC) has approved your application to conduct the above study involving Victoria Police.

An Access Agreement is enclosed which you should initial or sign and date, and return at your earliest convenience. The agreement can be returned to the Secretary RCC, at the Research Unit, Policy and Research Division, DX210065.

Please contact me (6732) if you have any issues concerning the arrangements for your study. In the mean time, good luck with your research!

Laurie Atkins

Secretary, Victoria Police Research Coordinating Committee

Our reference: 019701/00
VICTORIA POLICE
Research Coordinating Committee

CONDITIONS OF ACCESS TO POLICE RESOURCES
TO CONDUCT RESEARCH

Approval for the researcher to conduct research using Victoria Police resources is dependent on the acceptance of the conditions, where applicable, set out below. Research Coordinating Committee (RCC) reserves the right to withdrawn support for a project at any time during its life due to non-compliance with this agreement, lack of acceptable progress, and inappropriate conduct of the researchers.

______________________________          ________________________________
(Full Name)                                      (Residential Address)

HEREBY AGREE AND ACKNOWLEDGE THAT:

Information to which the applicant gains access

1. Only information relevant to the research project will be gathered.

2. Any information gathered will not be used for any purpose, other than for that in the agreed project plan.

3. Any changes required to implement the project after the initial approval must have prior written approval of the RCC.

4. Any information relating directly or indirectly to the internal operations, practices or affairs of the Victoria Police to which I may have access as a consequence of this approval, will not be disclosed, divulged or released in any form to any other person, firm, corporation or government authority or department.

Access to police members

5. The involvement of members of Victoria Police Force in the research project will be voluntary.

6. The approval of their supervisor/s to involve these members will be obtained by the RCC.

7. The research proposal must be fully explained to all participants, whose consent will be sought prior to their involvement.
Management of data collected or obtained

8. It is the researcher's responsibility to ensure security procedures are maintained that will ensure the confidentiality of data collected. This could include secure storage, removing identifying information from records, and computer holdings held under password protection.

9. Research data resulting from the project must be held for a period of five years unless otherwise specified or agreed by the RCC.

10. All copies of confidential material (including data in a machine-readable form) will be returned to the Victoria Police Force upon completion of the relevant stage of the project.

Progress reporting

11. The researcher/s will provide the RCC with progress reports at stages of the project deemed appropriate by the RCC.

Reporting the results of research

12. Where the views of individual members of Victoria Police (whether sworn or unsworn members) are quoted in the final research report, unless such members have been authorised to comment on behalf of Victoria Police, it must be stated that these views are personal and are not necessarily representative of Victoria Police in general.

13. Where, in the opinion of the Research Coordinating Committee confidential material can be provided to the researcher/s, such material identifying, either directly or indirectly, any section or person involved in the said material will be removed prior to publication.

14. A final draft copy of the research report, or comprehensive extracts of any passages referring either directly or indirectly to the Force, including any findings and or recommendations, must be submitted to the RCC prior to publication. Sufficient time must be given to the Committee to assess the material and provide comment.

15. The RCC reserves the right to have an accurate reflection of its views incorporated into the final report where it is considered that misuse of information, misrepresentation or inaccuracies have occurred. The RCC also reserves the right to provide comment upon any aspect of the project.

16. A complete copy of the final report, must be provided to the Force for circulation within the Force and possible lodgement in the Victoria Police Central Library.

17. Victoria Police has the right to utilise the findings of research projects, but no unpublished information will be released without the permission of the author.

Additional conditions

18. Final reporting of case studies or police reports must not identify the subjects involved.

Reporting schedule

19. Progress reports requested at: close of survey returns; then three-monthly thereafter.
Endorsement of Researcher and Research Coordinating Committee

\[\text{Signature}\]

SIGNED ........................................................................
Secretary, Victoria Police Research Coordination Committee

DATE ..................................................
Dear Cath,

I am writing in response to your letter to Peter Leslie from the Child Protection Training and Development Unit dated 22 September 2000, requesting permission to interview child protection workers regarding their experiences with investigations involving “Munchausen syndrome by proxy”. I apologise for the delay in replying to your query.

Although you have specifically requested approval from the DHS Ethics Committee, you do not need this level of approval as long as your interviews do not contain any identifying client information.

Your request has been discussed within the Quality, Monitoring and Improvement Unit and it has been decided that it is appropriate to progress your research by undertaking these interviews.

I am aware that you have had a recent discussion with Julie English from the QMI Unit and that she has agreed to contact the participants of the meeting held on 15 March 2000, once you send her the names. Julie will give them a brief outline of your proposal and also make it clear that participation continues to be voluntary, and that in no circumstances must they reveal any identifying client details, or provide any information which might lead to the identification of a client.

Good luck with your research.
ETHICS IN HUMAN RESEARCH
COMMITTEE APPROVAL

<table>
<thead>
<tr>
<th>REF. No:</th>
<th>(Reference number withheld)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROJECT TITLE:</td>
<td>Training requirements for Victoria Police in Investigating the 'Fabrication and Induction of Illness/Injury' in Children</td>
</tr>
<tr>
<td>Documents approved:</td>
<td>Illness/Injury' in Children</td>
</tr>
<tr>
<td>Approved Protocol:</td>
<td>Detail of Organizational Representative withheld</td>
</tr>
<tr>
<td>INVESTIGATOR(S):</td>
<td>C Wilkins, S James, D Wilkins</td>
</tr>
<tr>
<td>DATE OF RENEWAL APPROVAL:</td>
<td>3 October 2003</td>
</tr>
<tr>
<td>DURATION:</td>
<td>24 months</td>
</tr>
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<td>COMMITTEE REPRESENTATIVE</td>
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</table>

APPROVED SUBJECT TO THE FOLLOWING CONDITIONS:

ALL PROJECTS
1. Any proposed change in protocol or any other approved document and the reasons for that change, together with an indication of ethical implications (if any), must be submitted to the Ethics in Human Research Committee for approval.
2. The Principal Investigator must notify the Secretary of the Ethics in Human Research Committee of:
   - Actual starting date of project.
   - Any adverse effects of the study on participants and steps taken to deal with them.
   - Any unforeseen events.
   - Investigators withdrawing from or joining the project.
3. A progress report must be submitted annually and at the conclusion of the project, with special emphasis on ethical matters. Please note that it is the Investigator's responsibility to ensure that the approval remains current for the entire duration of the project.

DRUG TRIALS
4. The investigators must maintain all records relating to the study for a period of 23 years.
5. The investigator(s) must report to the Sponsor and the Ethics in Human Research Committee within 24 hours of becoming aware of any serious adverse event experienced by any subject during the trial.
6. The investigators must ensure that all externally sponsored Clinical Drug Studies have insurance coverage that is current for the entirety of the study.
ETHICS IN HUMAN RESEARCH COMMITTEE

CHAIRMAN'S APPROVAL

April 6, 2001

(Detail withheld) (Reference number withheld)

PROJECT TITLE: Training requirements for Victoria Police in Investigating the Fabrication and Induction of Illness/Injury in Children

INVESTIGATORS: C. Swain, S. James, D. Wilkins, (Name withheld)

Status Of Application: New

Duration: 24 months

Technical Panel Chairman: (Name withheld)

Reviewer:
Name: (Name withheld)
Appointment: (Department Name withheld)
Department:

External Reviewer: (None) (Name withheld)

Chairman's comment: .................................................................
.................................................................
.................................................................
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.................................................................

(Signature, Name and Organization Name withheld) 6/4/61

Date
## ETHICS IN HUMAN RESEARCH COMMITTEE

### APPROVAL

<table>
<thead>
<tr>
<th>PROJECT TITLE:</th>
<th>Training requirements for Victoria Police in Investigating the 'Fabrication and Induction of Illness/Injury' in Children</th>
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<tr>
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<table>
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<tr>
<td>DURATION:</td>
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<tbody>
<tr>
<td></td>
<td>COMMITTEE REPRESENTATIVE 6/4/01 DATE</td>
</tr>
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</table>

### CONDITIONS

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   - Actual starting date of project.
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Appendix 19

Summary of FII/MBP Cases
# Summary of FII/MBP Cases

<table>
<thead>
<tr>
<th>Participants</th>
<th>Case Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Protection 1</strong></td>
<td><strong>Gastro</strong></td>
</tr>
<tr>
<td>• DHS notified by hospital</td>
<td>18 month old child – gastro problems. Older child 6-7 years – no health issues</td>
</tr>
<tr>
<td>• Family = middle class. Parents married. Mother articulate, intelligent and well versed in medical terminology. Dad supportive of mum, oblivious to what was happening</td>
<td></td>
</tr>
<tr>
<td>• Mother had own bizarre medical problems as a child</td>
<td></td>
</tr>
<tr>
<td>• Two hospitals involved</td>
<td></td>
</tr>
<tr>
<td>• Conflict between medical personnel as to whether mum was harming her child</td>
<td></td>
</tr>
<tr>
<td>• Head doctor confirms – MBP</td>
<td></td>
</tr>
<tr>
<td>• Mother believed to be fiddling with feeding tube and giving child something – unconfirmed exactly what mother was giving to her child</td>
<td></td>
</tr>
<tr>
<td>• Mother and child separated for a time due to another family matter – child’s health recovers. When the mother returned the child’s health deteriorated</td>
<td></td>
</tr>
<tr>
<td>• Mother alluded to the fact that MBP had been diagnosed</td>
<td></td>
</tr>
<tr>
<td>• Mother removes child from the hospital and takes the child home</td>
<td></td>
</tr>
<tr>
<td>• Mother claims child has some bizarre disorder that she had found on the internet</td>
<td></td>
</tr>
<tr>
<td>• Case conference at hospital: DHS and medical personnel</td>
<td></td>
</tr>
<tr>
<td>• Police notified but do not become involved with case</td>
<td></td>
</tr>
<tr>
<td>• Protection Application (PA) taken out by DHS</td>
<td></td>
</tr>
<tr>
<td>• DHS workers executing PA struggle to remove child – mother convinces workers child is genuinely sick and doctors have got it wrong</td>
<td></td>
</tr>
<tr>
<td>• DHS supervisor directs child protection workers to remove child from parents’ care. Child removed</td>
<td></td>
</tr>
<tr>
<td>• At court the child is returned to the parents and a supervision order is granted</td>
<td></td>
</tr>
<tr>
<td>• A PA was also taken out for the older child. The PA for this child was thrown out at court as it was too difficult to substantiate risks.</td>
<td></td>
</tr>
<tr>
<td><strong>Child Protection 2</strong></td>
<td><strong>Gastro - intestinal</strong></td>
</tr>
<tr>
<td>• The DHS worker in this case became involved with the family at the time of court and carried out a supervision order on the mother for three years. The order required the DHS worker to attend the family’s house once a week</td>
<td></td>
</tr>
<tr>
<td>• Three children (8 yrs, 3yrs, 2 yrs)</td>
<td></td>
</tr>
<tr>
<td>• Older child – issues related to family dynamics at the time rather than a victim of FII/MBP</td>
<td></td>
</tr>
<tr>
<td>• Younger children – life time history of illness. Both</td>
<td></td>
</tr>
</tbody>
</table>
suffered very invasive multiple procedures in relation to gastrointestinal problems. Children quite scarred from all sorts of abdominal surgery

- Confirmed MBP diagnosis
- Never confirmed though exactly what mother was doing to her children
- Mother made partial admissions to the child protection worker of offending on her children
- Parents married
- Mother had a prescribed medication addiction / illicit substances abuse problem and a very complex history of her own illness
- After the abuse was detected, the worker believed the mother began offending on herself rather than her children
- Dad was an absent father and was not particularly supportive of his wife. He couldn’t understand his wife’s need for a high level of support. Lacked the perception of the seriousness of the situation
- Younger two children removed from parent’s care by the court and placed in foster care. Older child remained in mother’s care
- Decision was appealed and the two children were returned to the parents – 3 year supervision order put in place, carried out by DHS
- Paternal grandparents disbelieved that children were at risk
- Extensive professional involvement with family, in addition to DHS
- Police notified of case but had no involvement.

<table>
<thead>
<tr>
<th>Child Protection 3</th>
<th>Gastro/bowel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital reported parenting concerns to DHS</td>
<td></td>
</tr>
<tr>
<td>MBP not raised in initial stages</td>
<td></td>
</tr>
<tr>
<td>Four children – all with histories of gastro or gastro&amp; bowel problems</td>
<td></td>
</tr>
<tr>
<td>Two fathers (separated / married)</td>
<td></td>
</tr>
<tr>
<td>6-8 hospitals involved. Numerous general practitioners</td>
<td></td>
</tr>
<tr>
<td>Focus was on older child – 6 yrs – History of going in and out of hospital. Underwent approx. 15 bowel operations</td>
<td></td>
</tr>
<tr>
<td>Mother insisting child needed another bowel operation</td>
<td></td>
</tr>
<tr>
<td>MBP raised by DHS but not confirmed. Disagreement existed within DHS regarding MBP and the management of the case</td>
<td></td>
</tr>
<tr>
<td>Various professionals suspected MBP but did not want to commit to such a diagnosis</td>
<td></td>
</tr>
<tr>
<td>Fathers provided significant information about the mother. One father reported that the mother had told him that the older child had vomited faeces</td>
<td></td>
</tr>
<tr>
<td>Husband reported mother had strange illnesses herself</td>
<td></td>
</tr>
</tbody>
</table>
| **Child Protection 4** | before having children  
• Family estranged from grandparents  
• One of the husbands thought the mother was just jinxed  
• Insufficient evidence for protection application  
• Undertaking signed by father that the children were not to be left unsupervised with the mother. Agreement to have DHS involved with the family. Insufficient evidence to take matter further  
• No police involvement. |
| **Gastro** | Hospital notified DHS ‘After Hours’  
• DHS notified police  
• Joint police/DHS visit to hospital  
• One year old child (no siblings) – gastro problems – child in and out of hospital. Medical personnel suspect mum is giving something to the child  
• Doctors described MBP, but didn’t use this terminology  
• Child admitted to hospital  
• DHS speak to mother – nothing of value obtained  
• Mother was isolated from her family and operated very much in a solo capacity  
• Mother was really enmeshed with her child  
• Mother was articulate and very well versed in medical terminology  
• Poor marital relationship / Father not actively involved in the parenting  
• After hours DHS recommend – multidisciplinary team meeting by region (business hours)  
• Not known DHS outcome  
• Police outcome not known  
• Mother moves child to another hospital. |
| **Doctor 1** | Involved with around 6-7 cases  

**Smothering**

**Case 1**

• Infant was transferred to a Victorian hospital from an interstate hospital, with parent saying child had stopped breathing and was fitting  
• The infant was extensively investigated elsewhere. No cause for the child’s alleged fits and cessation of breathing were found  
• Baby suffered acute brain injury related to the asphyxia  
• Doctor goes back over old files  
• MBP diagnosed  
• No conclusive evidence that the mother had been recurrently smothering the child  
• However, interstate magistrate is sufficiently impressed by medical evidence and removes child from parents  
• Mother had her own reoccurring unexplained illnesses as
an adolescent and was described by her mother as a sickly and very lonely child. Mother had begun nursing training and had applied to become a nurse

- Parents married. Father was distant from his wife. Doctor believed father had his suspicions, but supported his wife
- Mother was a fairly working class lady, not all that bright.
- No Victorian police involvement. Not known re interstate.

**Case 2**

- Child = 3 yrs of age (second child in family). First child perfectly healthy
- Doctor treating child suspects foul play and calls in specialist doctor (child abuse)
- Child had been coming to hospital for about 2 years with a story of reoccurring diarrhea, failure to thrive, failure to grow
- Mother = nurse. Middle class, intelligent, well thought of at her work place, pleasant, engaging woman
- Husband – fairly distant, seemed rather passive about everything.
- Extensive series of investigations conducted on child
- Specimen of child’s stools collected – laxatives found in stools
- MBP diagnosed
- Mother accuses staff of muddling up the laxative test results. Blames nursing staff for adding laxatives
- Case conference called at hospital
- Police involved – no grounds to conduct a search of mother or her belongings
- DHS involved – supervision order granted by court / child remained in parent’s care
- Part of court order stipulates that child must see a particular doctor
- Father allegedly gets job interstate and family move interstate
- Court does not take any action
- Contact and monitoring of family lost.

**Doctor 2**

**Leukemia**

**Case 1**

- School contacts doctor
- 6 yr old child presented at school as having leukemia

Involved with around 10-12 cases
<table>
<thead>
<tr>
<th>Suspected Suffocation</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>School rang mother re late fees and mother gave story of leukemia</td>
<td>Baby admitted to hospital 2-3 times following life threatening events</td>
</tr>
<tr>
<td>School organized assistance for mother, outings for the child</td>
<td>Single mum, very little in the way of support</td>
</tr>
<tr>
<td>Principal became concerned because there were two children at the school with leukemia and this child did not appear sick like the other child</td>
<td>Very precarious social situation, domestic violence, alcoholism, a really risky situation to start with</td>
</tr>
<tr>
<td>Principal rang hospital seeking information on leukemia. Hospital had never heard of child</td>
<td>Mum presented in emergency department on several occasions stating baby was resuscitated by her at home when she was alone with the baby</td>
</tr>
<tr>
<td>Mother alleged child had just had a bone marrow transplant / was absent from school 2 days a week – apparently to attend blood tests and lumbar punctures</td>
<td>Stated baby had pink frothy mucus coming from nose</td>
</tr>
<tr>
<td>Mother put hair remover on child’s hair in an effort to portray chemotherapy</td>
<td>Required resuscitation in the emergency department</td>
</tr>
<tr>
<td>Mother used same band-aids as hospital to portray a lumbar puncture on the child’s back</td>
<td>Third trip in – baby was sent to another hospital for monitoring and breathing studies. No explanation found</td>
</tr>
<tr>
<td>Parents married</td>
<td>Mother was confronted with possible allegation that she was doing something to the child, mother became</td>
</tr>
<tr>
<td>Father had not twigged illness wasn’t real. Father appeared bewildered and lost</td>
<td></td>
</tr>
</tbody>
</table>
### Case 3

- Mother presented at hospital with a baby who had repeated episodes of life threatening events that required resuscitation at home
- Baby was in mother’s care and nobody else was ever around when child suffered problems
- Registrar at hospital took a gentle approach with the mother
- Mother admitted to registrar that she had put her hand over her child’s mouth and nose and stopped child’s breathing
- Baby did not suffer any permanent injury
- MBP diagnosed
- DHS involved. Case conference held
- No police involvement

### Case 4

- 3 yr old child. Mother was alleging sexual abuse of her daughter by ex husband. Child had been taken to hospitals in four states of Australia
- 12-14 doctors had conducted genital examinations
- MBP diagnosed (but with less certainty than case 1)
- Family Law Court became involved
- Mother took flight and went interstate / mother eventually apprehended
- Father gained custody of children with supervised access by the mother
- Mother intended to appeal decision through the High court.

### Case 1

- Two small children with apparent chronic gastro-intestinal disorders
- Extensive investigations

<table>
<thead>
<tr>
<th>Doctor 3</th>
<th>Gastro-intestinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smothering</td>
<td>defensive</td>
</tr>
<tr>
<td>• Child went home with apnea mattress</td>
<td></td>
</tr>
<tr>
<td>• Doctors not really convinced MBP, element of doubt, possibly reinforced by her comments “You’re missing something”</td>
<td></td>
</tr>
<tr>
<td>• Baby died at home at a time when s/he was off the apnea mattress</td>
<td></td>
</tr>
<tr>
<td>• Mother’s response - “I told you s/he was going to”</td>
<td></td>
</tr>
<tr>
<td>• Case conference was called</td>
<td></td>
</tr>
<tr>
<td>• DHS were involved</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t recall any police involvement.</td>
<td></td>
</tr>
</tbody>
</table>

| Sexual abuse | |
| Case 3 | |

| Case 4 | |

| Doctor 3 | |

| Gastro-intestinal | |

| Case 1 | |

Failure to thrive

- Long periods of intravenous feeding
- Some irreversible surgery & some pretty dangerous complications of treatment
- Over a period of a couple of years MBP diagnosis was reached
- No conclusive evidence
- Mother revealed behaviour to father who then relayed information to doctors
- Father then denied giving this information
- Mother was hospitalized, had a problem with valium related drugs, persuaded to get treatment
- All treatment with children was withdrawn and both children became well
- Doctors had difficulty convincing DHS that mother was harming children. DHS eventually became involved
- Matter went to court
- Children taken into care
- A non-government agency was delegated the care of the family
- The social worker and non-government agency decided that the MBP diagnosis and court decision were incorrect and colluded with the mother
- Everyone that had been involved prior to the court case was now excluded from the case
- Hospital was progressively frozen out, and denied information and involvement with the children
- One of the children returns to the hospital as an adult seeking to understand why he wasn’t protected from his mother and to review his medical records. Man confronts father who confirms the mother’s abuse
- Parents were married at the time but later separated
- Man describes a troubled teenage period, including some drug taking – but states he is now coping
- Believes mum administered stuff to him well into his teens. States today he will not eat his mother’s cooking
- No police involvement.

Case 2

- Child was hospitalized for long periods
- Child endured extensive medical tests and intravenous feeding
- Doctors prove child had been administered laxatives and salt
- DHS involved
- Matter went to court
- Child removed from care
- Senior DHS worker within 24 hours decides child should
| Poisoning | go back into the care of the mother and that the court was wrong  
| Child returned to mother  
| No police involvement. |
| Case 3 |  
| International case  
| Mother had 4 previous children born overseas, two of whom had died  
| Court case found mother had poisoned children  
| Two remaining children put into care  
| Mother challenged decision and recruited powerful allies, including prominent psychologists who defended her  
| Mother leaves one country and travels to another and has a fifth child to another partner  
| Authorities become aware of her history and attempt to gain supervisory orders  
| Mother recruits media to produce documentary – she accuses people of tormenting and persecuting her  
| Mother comes to Australia  
| Mother has another baby in Australia  
| Mother presents child to hospital with gastrointestinal symptoms  
| Mother reveals to a nurse on nightshift that she had been suspected of MBP. Mother requests access to the hospital computers for information about this disorder  
| Doctor confronts mother, DHS involved, as well as hospital administration and social workers  
| Doctor suspects the mother swapped the baby’s stool for that of the older child in order to mislead him  
| Initial investigation reveals something in the stool to suggest it was not the stool of a baby. This information was later changed. The doctor believes the change in findings was not because it wasn’t true but because staff did not want to become involved  
| Mother leaves Australia  
| Mother & father accuse doctor of not doing enough for their child  
| Mother recruits powerful allies and writes letters of complaint to hospital and medical board about doctor  
| Husband supports wife  
| No police involvement in Victoria  
| Case ongoing |
| Doctor 4 |  
| Gastro/bowel |  
| Case 1 |  
| Child seen multiple times from when he was about 6 months old |
| **Blood in urine** | • Last contact the doctor had with the child, the child was 2 ½ years  
• Child had genuine skin problem, but then started getting other strange problems such as fevers, vomiting, dehydration, and bowel obstructions  
• Child had multiple x-rays and hospital visits  
• Child required a drip very frequently  
• Drip would often stop working. ‘Normally if you put an IV line in someone, in most kids you can get that to last for 3-4 days before it stops working whereas his would always stop working in a number of hours’  
• Child would spike fevers which doctors could never find a cause for  
• Older child had similar problems when she was younger. Her medical problems miraculously got better when the younger child was born  
• Possibility of MBP was raised by medical staff  
• Mum had her own illnesses as well as some long standing neurological eating problems  
• Mother in a de-facto relationship  
• Case created an enormous amount of discussion and tension between staff as to whether the abuse was legitimate or not  
• Child slowly got better over the years  
• A lot of professional attention was given to the mother  
• DHS & Police involved. DHS took out a protection order  
• Mother also embezzled money from a fund that was set up to help her child. Police were more involved with this than the possibility of induced illness  
• Mother was charged with fraud. |
| **Case 2** | • Child 8-9 years at the time  
• Unexplained problems, blood in the urine… ‘some times it was there, sometimes it wasn’t’  
• Multiple medical investigations. Nothing found  
• Medical investigations quite uncomfortable for child. Some involved passing cathedras into the bladder  
• Nursing staff noticed strange behaviour of the mother who went home collecting urine samples  
• Mother and father separated at time  
• Unsure whether police/ DHS involvement  
• MBP considered but not confirmed. |
| **Police 1 Suspected** | • Child = toddler - 12-18 months old  
• Mother always going to doctor - 20-30 times a month.  
• Child = Short of breath |
| Suffocation                                      | 5-6 times ambulance had to go to house to revive child |
|                                                | Ambulance notified police                              |
|                                                | Parents had a previous child die off SIDS              |
|                                                | Both SIDS child and an older child had a medical      |
|                                                | history. The older child’s problems ceased with age    |
|                                                | CIU detective believes mother was causing her child’s  |
|                                                | breathing problems                                    |
|                                                | Doctors divided in their opinions                      |
|                                                | One doctor who reviewed case believed the matter was a |
|                                                | medical issue and not a criminal one, stating the     |
|                                                | mother was delusional                                  |
|                                                | Mother presented as loving & concerned                 |
|                                                | Mother very articulate and presented as very loving    |
|                                                | and caring.                                           |
|                                                | Marital status not known                               |
|                                                | Police unable to take matter anywhere, due to         |
|                                                | conflicting medical opinions and no support from      |
|                                                | officer’s immediate bosses                             |
|                                                | Homicide wanted no involvement owing to lack of       |
|                                                | evidence                                              |
|                                                | CIU detective quit in disgust                          |
|                                                | DHS remained involved with family.                     |

| Police 2                                      | Adult female alleges male person broke into her house, |
| Sexual abuse                                  | raped her and tried to abduct her baby                  |
|                                                | Police attend scene and investigate                    |
|                                                | Sufficient evidence is collected to show mother made up |
|                                                | everything                                              |
|                                                | In the past baby had some sort of illness allegedly    |
|                                                | due to immunization.                                   |
|                                                | No link was made by police to the possibility the      |
|                                                | illness may have been fabricated or induced            |
|                                                | DHS not involved                                       |
|                                                | Mother charged with false report to police.           |
|                                                | Mother neither denies nor admits to false report.      |

| Police 3 / Principal (Joint Interview)        | School notifies DHS about a ten year old child whom    |
| Fabricated illnesses                          | they believed the mother was fabricating illnesses    |
|                                                | Over two year period mother alleged child had: asthma, |
|                                                | ear infections, mental retardation, speech problems,  |
|                                                | kidney problems, heart problems, ulcers, vision       |
|                                                | problems, bone problems, depression, gland problems,   |
|                                                | collapsed lung, curvature of the spine etc etc        |
|                                                | Two older siblings – also with a history of illness   |
|                                                | Police are notified by the school and become actively |
|                                                | involved in the investigation                         |
|                                                | Nil charges                                           |
|                                                | Multidisciplinary case conference held                |
|                                                | Police assist child protection with protection        |
|                                                | application                                           |
|                                                | Magistrate removes child – child placed in foster     |
- Child continually goes to the foster mother with claims that she needs medical attention
- Child's health and well being improves in foster care
- MBP was not considered in this case as professionals had not heard of it
- Years later professionals see a television documentary on MBP and connect it to this case.

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<th>Police 4</th>
<th>Sexual abuse</th>
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| - Police notified by a psychologist  
- Mother alleged her two children had been severely sexually abused by their father: children 5 and 2 years  
- Joint visit by police and DHS was conducted  
- Video interview was conducted by police with older child  
- Police form the impression the child had been ‘worded up’ by the mother  
- Mother quite intelligent  
- Mother believed to have some history of chronic depression  
- Mother well versed in police and medical processes  
- Mother contacts principal stating she was moving her daughter to foster care to break the cycle of sexual abuse  
- Principal notifies DHS  
- DHS notify police. DHS unable to respond due to short staff  
- Police attend school and speak with child. Impression gained that mother is trying to get at the father and is making child say things, as well as physically hurting the child  
- Police officer believes mother initially hated child’s father and wanted to get back at him, but eventually this hatred diminished and the attention seeking just took over  
- Mother changed all the locks in the house  
- Mother convinced child getting out at night, by crawling under beam and opening locks  
- Child disclosed sexual assault very clearly  
- Case conference held – police, DHS, medical  
- Child's stories start to conflict re how she got bruises  
- Mother constantly contacts police & DHS wanting for them to investigate something  
- Mother alleges child has been taken out of house during the night sexually abused and then returned in the morning. Mother states she knows this because petrol is missing from her car, mother later changed story  
- Mother thriving on attention  
- Child's father questioned – quite innocently stated that he had walked in on the mother one day and she was showing the child a porno. Police suggest this would
explain how the child might make a disclosure
- Ongoing involvement by DHS and police over a number of years
- Mother kept a log book of involvement
- Police recommend that they have no further involvement with children. This was supported by the doctor. Police case closed.
- Doctor states mother is delusional and suggests charges not appropriate
- Police member believes mother knew what she was doing and that charges should have been seriously considered.
- The older child is convinced that she had been sexually abused.
- Police were involved with case for 4 years

| Police 5 and 6 (Joint Interview) Still under investigation | Multiple deaths of children (under 5 years of age) in the one family. This matter is still under investigation. Details of case withheld. |
|==========================================================|===================================================================|
| Psychologist 1 Sexual abuse                               | - Allegations of quite extensive sexual abuse by family members  |
|                                                          | - Two children: 6 yr old & 9 year old                            |
|                                                          | - Mother frequently rang anonymously the on call hospital service prior to becoming involved directly with the hospital |
|                                                          | - DHS involved                                                  |
|                                                          | - At the hospital - three psychologists became involved (one for each child and one for the mother) |
|                                                          | - Children received approximately six counselling sessions      |
|                                                          | - MBP considered – not diagnosed                                |
|                                                          | - Mother presented detailed document which outlined sexual abuse history of children |
|                                                          | - Mother had some training in pharmacology and was well versed in medical terminology |
|                                                          | - Difficult to say whether any of allegations were true – everything was blurred |
|                                                          | - Police became involved                                      |
|                                                          | - The mother latched onto police and stopped attending counselling sessions |
|                                                          | - Mother had complex history of her own illnesses              |
|                                                          | - Father supported mother                                      |
|                                                          | - Outcome not known                                            |
| Psychologist 2 Sexual abuse                               | Case 1                                                         |
|                                                          | - One year old child                                           |
|                                                          | - Mother took child to numerous organisations saying she
### Sexual abuse

- had been sexually abused by the father
  - Mother also took child to numerous hospital departments
  - Mother alleges child has a urinary tract infection and ear, nose and throat problems
  - Child was three years when psychologist became involved
  - Saw child, mother and father for about three years
  - Doctor (from child abuse section) wrote a letter when child was 12 months stating child was not to continue to be examined as doing more harm than good
  - Continued court cases relating to custody of child, father wanted custody
  - Child exhibits sexualised behaviours
  - Mother kept reporting allegations of abuse, but did not follow through with taking the child immediately to the doctors
  - No confirmed MBP diagnosis, but suspected
  - No police involvement.
  - Final outcome unknown

### Case 2

- Mother presents child as sick and as having been sexually abused
  - Mother and father separated
  - Low functioning family
  - Mother quite obese, personality and emotional problems of her own / mother has eating problems
  - Relationship between mother and father was physically abusive
  - Problems with boundaries between mother and child - child would masturbate herself against mother’s leg
  - Mother didn’t always tell the truth to psychologist and was pretty guarded with her personal history
  - Two Family Court cases – psychologist cross examined. Notes subpoenaed
  - Legal processes destroyed potential for therapeutic relationship
  - Child remained with mother, with supervised access
  - Mother withdrew from counselling and abruptly went away. Nine months later reappeared
  - DHS involved
  - Police were not involved

### Psychologist 3

- This worker discusses the issues in a more general fashion and doesn’t concentrate on a specific case

### Psychiatrist

**Case 1**
| **Gastro bowel** | • Number of children in family presented with different symptoms  
  • Youngest was two years – chronic constipation, unexplained systemic collapse, sick, lethargic  
  • Child endured fairly intrusive gastric washouts of the bowel  
  • Blood was found in child’s urine. Several doctors believed mother was fabricating child’s illnesses. Surgeon was not convinced.  
  • Mother = nurse  
  • Mother and father separated  
  • Paediatrician – attends home address to provide treatment  
  • Mother accuses paediatrician of having a relationship with her and of breaching boundaries of patient care  
  • Paediatrician states mother fabricating stories of his intervention and of child’s symptoms  
  • Lots of conflict between staff  
  • Mother had major disruptions in her attachments as an infant ie. adopted, father died, multiple losses  
  • Possible hypothesis was that illnesses in the children were a way of trying to repair the disruption in attachment which she’d had with her caregivers as a child. The medical system was a psychological substitute for the parents she’d lost.  
  • Quite bright  
  • Case was messy, unclear, no firm resolution  
  • Major case conference, led by DHS  
  • MBP considered  
  • Staff divided over MBP diagnosis  
  • Child’s symptoms subsided  
  • Case ongoing  
  • Mother angry and in denial  
  • No police involvement |
| **Leukemia** | **Case 2**  
  • Eight year old child  
  • Mother convinced everyone her child had leukemia  
  • Mother used hair removing tonic on his hair  
  • Convinced school and husband child was sick  
  • School became aware illness was false  
  • DHS involved / child temporarily removed from mother’s care  
  • Mother had quite a few losses as a child. Mother had also fabricated remarkable stories with her husband – which were found to be untrue  
  • Mother eventually disclosed what she was doing. |
### Gastro/intestinal Failure to thrive

- Appeared quite relieved she was sprung, had got herself too far into it and couldn’t get herself out.
- Father claimed he believed his child to be sick
- Father passively forgiving
- Unsure of end result
- Unaware of police involvement

### Case 3
- Mother = nurse
- Dependent on minor tranquillizers and alcohol
- Major disruptions in attachments and her relationships when she was a child
- Parents married.
- Three children, younger two had major gastro-intestinal symptoms and failure to thrive, thought to have unusual malabsorption syndrome
- Endured prolonged periods of parental nutrition feeding with a tube into one of the big veins near the heart
- Numerous operations
- Older child (4-5 years) was referred to a psychiatrist. She seemed quite psychotic, with bizarre ideas and behaviour. In the end it turned out she knew what her mum was doing but was unable to tell anyone
- Mother had been giving medication to induce severe diarrhea
- DHS and police involved. Children were removed from mother’s care, although it was thought she still had some access.
- Police were involved. Possible criminal prosecution.

### Allergy / failure to thrive

### Case 4
- Three-four children from different families were presented with multiple allergies
- Psychiatrist indicated they probably did have an underlying allergy problem but the parents’ response was way over the top
- Parents were starving children and restricting their lifestyle
- Parents confronted – angry denial
- Parents joined together and laid complaints
- Parents informed their member of parliament
- Unsure of DHS involvement
- No police involvement.

### Sexual abuse

### Case 5
- Two children
• Mother alleged child (4 yrs) had been sexually abused by her father
• Mother reported alleged abuse to a number of Sexual Offences & Child Abuse units
• Child had been taken to numerous doctors and hospitals
• Mother manic depressive = psychiatric treatment
• Family Court involved. Children placed with father as mother’s psychiatric treatment had lapsed and she was in breach of an order.
• Not classic MBP, but the mother had a fixed delusional belief that her husband had sexually abused her children. Psychiatrist indicated it was quite conceivable that he may have.
Appendix 20

Mean Percentage Questionnaire Results

Tables 5.3 & 5.5
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Appendix 21

Professionals’ observations of

the child and family
### Professionals’ observations of the child and family

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<th>Observation</th>
<th>Source(s)</th>
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<td>Unusual behaviour inconsistent with normal medical treatment, such as intravenous lines frequently falling out of the child</td>
<td>Doctor 4, Child Protection 1, Child Protection 2, Child Protection 4</td>
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<td>The inconsistent appearance of the child with the alleged illness or treatments for that illness, such as patchy hair allegedly due to chemotherapy treatment for leukaemia that was inconsistent with this process</td>
<td>Doctor 2, a sore on the child’s back covered with Betadine and a hospital bandaid that was intended to represent a lumbar puncture</td>
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<tr>
<td>The child’s illness did not follow a normal pattern</td>
<td>Doctor 1, Doctor 2, Doctor 3, Doctor 4</td>
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<tr>
<td>The child had an extensive medical history</td>
<td>Child Protection 1, Child Protection 2, Child Protection 3, Police 1, Police 3, Police 4, Police 5, Doctor 1, Doctor 2, Doctor 3, Doctor 4, Psychiatrist, Psychologist 1, Psychologist 2</td>
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<tr>
<td>False medical history was identified in association with the child</td>
<td>Doctor 1, Doctor 2, Doctor 3, Doctor 4</td>
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<tr>
<td>The child only appears to become sick in the mother’s presence</td>
<td>Doctor 1, Doctor 2, Doctor 3, Child Protection 1</td>
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<tr>
<td>The child’s knowledge of illnesses or sexual abuse is inconsistent with his/her age</td>
<td>Police 4, Psychologist 1, Principal</td>
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<tr>
<td>Observations that, when the child’s genuine illness gets better, the</td>
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</table>

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260 Some professionals described more than one case. Information pertaining to a particular case has not been differentiated in this table.
<table>
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<th>fabricated problems escalate (Doctor 4)</th>
</tr>
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<tr>
<td>The mother’s behaviour not being appropriate in the circumstances, such as the mother reporting serious abuse, but not following through with immediate medical action (Psychologist 2, Police 4)</td>
</tr>
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| The mother appears to be thriving on the attention provided by professionals (Child Protection 1, Child Protection 2, Child Protection 3, Child Protection 4, Police 1, Police 2, Police 3, Police 4, Police 5, Psychologist 2, Psychologist 3, Doctor 1, Doctor 2, Doctor 3, Doctor 4, Psychiatrist, Principal) |

| Bizarre behaviour and stories such as: the mother collecting urine samples at home (Doctor 4); alluding to the fact that she had been diagnosed with MBP and then asking to use the hospital computer to research MBP (Doctor 3); stating that she had buried a baby in the front garden (Psychiatrist); explaining that she knows the child had been taken away and abused during the night because the petrol was lower in her car (Police 4); claiming her child has a bizarre disorder which she found on the internet (Child Protection 1); or alleging theft of a maternity bra, unusual telephone calls, and stalking letters (Police 2). |

| The mother has her own extensive medical history (Police 1, Police 3, Police 4, Police 5, Child Protection 1, Child Protection 2, Child Protection 3, Psychiatrist, Doctor 1, Doctor 2, Doctor 3, Doctor 4, Psychologist 1, Psychologist 3) |

| The planting of fabricated evidence ie. the mother cut the wire on the window to give the appearance of a break in, rape and attempted abduction of her child (Police 2) |

<p>| Complaints made by the mother against staff (Child Protection 1, Doctor 2, Doctor 3, Doctor 4, Psychiatrist, Principal) |</p>
<table>
<thead>
<tr>
<th>The mother has a reasonable knowledge of medical terms and procedures or has medical training (Child Protection 1, Child Protection 2, Child Protection 3, Child Protection 4, Police 2, Police 3, Police 5, Psychiatrist, Doctor 1, Doctor 2, Doctor 3, Psychologist 1)</th>
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<tr>
<td>Escalation of abuse after the mother had been confronted by allegations (Doctor 2, Police 4)</td>
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<tr>
<td>Hoax phone calls made by the mother (Psychologist 1)</td>
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<td>The obtainment of financial benefits by the mother (Principal, Doctor 2, Doctor 4, Psychiatrist)</td>
</tr>
<tr>
<td>A previous child that had died in the family in relatively unexplained circumstances (Doctor 1, Doctor 3, Police 1, Police 5)</td>
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<td>The child's older siblings have their own extensive medical history (Police 1, Police 3, Police 4, Police 5, Child Protection 2, Child Protection 3, Psychiatrist, Doctor 3, Doctor 4, Psychologist 1)</td>
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<td>The family moves around frequently (Doctor 1, Doctor 2, Doctor 3, Police 5)</td>
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<td>Federal law court order in existence (Psychiatrist)</td>
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<td>Poor spousal relationship (9 cases)</td>
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Appendix 22

Police interview with a

child victim of fabricated illness
Reference RCC: 094

20 May 2005

Ms Cath Wilkins

(Address withheld)

Training requirement for police in responding to and investigating fabricated and/or induced illness in children.

Dear Ms Wilkins

I have the pleasure to advise you that the Victoria Police Research Coordinating Committee has approved your request to include the specified police interview (conducted with a ten year old child in 1980) into your thesis. It is clear from your presented information, that the interviewer and the interviewee will remain unidentifiable within the publication of your thesis.

Please do not hesitate to contact me by phone (9247 6728) or facsimile (9247 6712) if you have any questions you wish to raise.

All the best,
A police interview with a ten year old child victim of fabricated illness

Police 3:

She appeared quite pleased at having a visitor and settled down immediately to an animated conversation, during which time I had trouble getting a word in. She was lying on the couch from memory, rugged up watching tellie or something and seemed thrilled to death to have somebody, an adult she didn’t know, all to herself, without having her mother present. She just bubbled to me and what she bubbled about was her illnesses. I said ‘I here you’re not too well?’ ‘No I’m not’. She was just so enthusiastic rattling off the names of the illnesses, rattling off the names of the specialists, and giving me their qualifications. These were real people in Melbourne that she had been taken to with various symptoms and illnesses. After a while I asked her a question along the lines of, ‘How did she know she was actually sick? and ‘What told him/her that she had each illness?’ She sat very quietly, and she suddenly became very, not withdrawn, but very quiet and she said that mum told her and that she only knew because mum would tell her, ‘Did you know during the night that you got this that or other illness’ and would talk to the child about what the illnesses were, which was just coaching her. Then we just talked about her [pets] which was her only hobby and I think after that we just chatted about cabbage patch dolls and things like that because the [other police officer] was still going with mum and mum was just giving an amazing amount of information which was captured in the statement about the traumas that she had had with these children. I agree with what the Principle said about [the child] being very quiet and like a rabbit in the spotlight, but that was when mum came back into the room. When the kid was just with
me, she was, just as I said, thrilled to death to have an adult to talk to without mum being present. That’s the way I saw it at the time.

Some of the conversation with the child as recorded by Police 3

Police: How often do you get sick?
Child: Ten times a month.
Police: Do you feel sick when you wake up or later in the day?
Child: When I wake up.
Police: When you wake up, do you feel sick yourself or does mum tell you you’re sick?
Child: I am sick.
Police: Who tells you that you’re sick?
Child: Mum does.
Police: How does she know you’re sick?
Child: She sees a blob of white stuff on my pillow and it might come from my ear and it might be glandular fever.
Police: Do you feel sick right now?
Child: (She hesitated, then said very quietly) ‘No’
Police: Do you think mum might have made a mistake about you being sick?
Child: (Again she hesitated and said) ‘Yes’
Police: Has mum been mixed up any other times and thought you were sick when you really weren’t?
Child: Sometimes.

Police 3:

During this part of the conversation the child had become quite subdued and seemed confused. The rest of the time she bubbled over with information about her many illnesses she had suffered from over the years. She seemed
particularly keen on contracting the measles as s/he assured me she hadn’t had the needle or the virus. Her knowledge of the names of doctors, specialists and diseases was unusual in a child so young. She referred constantly to things getting sick and dying. For instance, she said she had been greatly upset by the recent fowl plague and she talked about her [pet] dying. Otherwise, she was bright and happy. She enjoyed showing me her toys. She was a forward [child] who accepted me as an old friend.
Appendix 23

Child Protection 1:
Reflections on executing a protection application on a mother believed to be inducing illness in her child
Child Protection 1: Reflections on executing a protection application on a mother believed to be inducing illness in her child

So, the first time we went out to see the family after the case conference the police didn’t go with us it was kinda odd, we in terms of actually going out to see this family. […]

I remember before we left the office we’d been briefed by some of the senior management in the office saying, ‘Right. This is extremely serious; she has been diagnosed with MBP’.

You know, before we went there, we had been told by our senior management that really the only option for us was to issue the protection application, that having the diagnosis from this doctor, having an ill child that really couldn’t speak for him/herself that still had the gastro tube in him/her, who mum was still claiming had some very bizarre disorder that mum had found on the internet. You know it was all like that; that really we had no other option.

So we turned up at the house. And what I remember about this case was just how seductive she was in terms of the way that she communicated with us and the way that she really turned us around to seeing her side of the story that she basically just had a very, very sick child and that the doctors just didn’t understand and the medical system’s hopeless.
She was really, um, seductive’s the best thing, we were there from probably 3 to 4 in the afternoon and we were still there at 10 o’clock at night and we hadn’t issued protection application stuff. We were caught up in talking with her. We had gone off and consulted with our management who were saying go back in there and hand the papers and we were saying, ‘No, we can’t. It’s not the right thing to do. It’s a sick child.’ We weren’t that caught into it; we were saying she’s still not well. There’s still issues here, but there must be a better way round it. Just removing this child from her care… Is that the best thing to do?

It was interesting too. She talked about her own medical history, about being in and out of hospital for bizarre medical problems, as well, as a child. So we were thinking, ‘Well, this is interesting. Maybe there was something that happened in her childhood.’ The things that she was saying just didn’t ring true, was almost like this happened to me and I was treated really badly through the medical system and I’m sure it’s just happening to my child again.

Oh yeh, we got bamboozled. That was part of the problem. She was using lots of terminology stuff that we didn’t understand and she was actually explaining to us the different procedures that the child had been through and that’s how she was sort of disputing the facts that we had, the things that we said to her about our understanding of what had happened and that’s where she would dispute and she would talk about all these different procedures and we’d get lost in that. She new a hell of a lot more than we did.
At the time we were saying, ‘Look, we are going to have to issue a protection application. This is what it will involve, etc.’ She got really upset and started frothing at her mouth. Like, she was frothing! And I’ve never seen anyone froth at their mouth, and I remember thinking at the time, ‘This is extreme, this is bizarre behaviour.’ And, having done lots of protection applications, by that stage we were thinking, ‘No. Never seen this before. This is really quite bizarre.’ And we went out and consulted with the mental health service, ‘cos we’d actually spoken to them prior to even going out on the visit. We’d been talking to them about the fact that we would be going out to see this family. ‘Could they come with us?’ was one thing we asked. They weren’t able to do that, so we said, ‘We will need to be in contact with you over the phone because we’re not experts in the psychiatric area and there might be some assistance you can offer us’.

So we got on the phone after we’d seen her frothing at the mouth and we said to the psychiatrist, ‘We’re a little bit worried about this woman and we’re a little bit worried about the situation, but can you give us some advice? Is this sort of normal stuff, or what are we dealing with here?’ Not knowing a lot about MBP, neither of us had been involved with a MBP case, but we’re getting some advice from him. He was like… and this was part of the problem, I don’t think he had that much experience. He was saying to us, ‘Oh, maybe you shouldn’t be removing the child. Maybe that’s the worst thing that you can do. I think what you should do is just work with her and over a lengthy period of time we’ll get her to come and see us or see a psychiatrist, or whatever, and set up an appointment.’ He was really minimizing, I suppose, what was going on, but we were going, ‘Hang on a
minute! This woman is frothing at the mouth. That’s not normal, is it?’ We got really confused by that, ‘cos again we were talking to a psychiatrist who was actually quite well respected in the region. So we thought, “Okay, so you’re telling us that may be we are doing the wrong thing’, so it was just really, …lots of conflict.

Now we specifically sat down and read the guidelines before we left and we talked about lots of things. And in the guidelines it talked about the fact in MBP the escalation of acts and how it can lead to death, so very, very serious escalating stuff and we’d actually rated her as being very high on that scale given that she had now been effectively told that she had MBP or everybody thought she had MBP and that she had was fabricating illness in her child. But we still really got caught up in dynamic with her to the point where we were almost arguing over the phone with our senior management. And then we just got… it got that tiring, we just both said, ‘Okay, we’ll do it. We’ll just…’ We went back in and we did it and we executed the PA.

Afterwards, I just said to the other worker… We were just like, ‘Thank God we had that structure of consulting and thank God that our senior management stayed really clear and hardline in terms of, ‘No, this is the action that needs to be taken. There’s basically no other option’. I often think now, we should have gone in there and quickly done it. We shouldn’t have mucked around. We should have just interviewed her and interviewed the little girl. We had to wait for dad to come home so it sort of delayed things a bit. But we should have just gone ahead and done what we needed to do, ‘cos we just got caught up in it really badly. It was kinda weird, ‘cos
afterwards, when you look back on it, you think, ‘God, that was pathetic! I got dragged into that. I got seduced into that. But at the time, … terrible’.