

### **Mismanagement: Social and Family Policy**

**Mr Bruce Clark, DfES: 2000-2005**

## **MISDIRECTION of SOCIAL POLICY**

**Assessing Ordinary Parents as Abusers  
Assessing Ordinary Children as Victims**

Re: Munchausen Syndrome by Proxy; fabricated or induced illness; shaken babies; medical evidence;  
taking into care; adoptions; re-classification of sick children as abused children;  
the misdirection of Social Work, Child Protection and of the Family Courts

# INTRODUCTION

The Consensus Report is a 105-page document, written in the formal language of Whitehall, telling the full story of how the notorious official guidelines on MSBP came to be introduced.

Several years after the successful Clark and Cannings appeals, it turns out that social workers are still being deliberately trained nationwide to make the same mistakes.

The Consensus Report explains how this happened.

The Report considers a dozen typical MSBP cases at pages 69-79. But the Report is not primarily concerned with individual injustices. It concentrates instead on the defects in the official MSBP guidelines.

The Report shows how the obvious flaws in the Guidelines, which still set the national standard, were bound to create miscarriages of justice on a wide scale.

The Report argues that the misconceived MSBP guidelines are an engine of systemic injustice.

The primary focus of the Report, which is anonymous, provides a troubling insight into the inner workings of Government. It explains how self-evidently foolish guidelines can be pushed through without scrutiny - almost irrespective of their contents - by a determined and unaccountable inner clique. It is an Inside Whitehall Story: of shamateurism, sleight-of-hand, zealotry, and a grotesque abuse-of-process.

It seems that Ministers had very little knowledge of what their civil servants were up to on MSBP. This Report depicts an irrational world stood on its head. In these pages, Ministers may *propose*. But civil servants *dispose*. Ministers have minor walk-on/walk-off parts. Ministers are told whatever their civil servants want them to believe. This is a tale told from the inside, largely through a sobering compilation of impeccable official sources, in their own words: Hansard, Government reports, departmental circulars, local authority policy documents and the like.

There is a suggestion, at page 3 and the early footnotes, that the same process of intellectual dishonesty, embodied in the MSBP guidelines, may have contaminated other areas of family law. Given the Whitehall culture of 'no-blame', it is possible that other equally inept misadventures are already in the making within officialdom.

The Consensus Report, released (or perhaps leaked) in September 2005, brings the covert process of Whitehall's mismanagement of social policy into the open. The report is causing increasing embarrassment at senior levels. To find out why, read on...

## **NOTE ON THE CONSENSUS PROCESS**

### **Documentation:**

This document is the third part of a three-piece suite of papers lodged by Consensus with the Permanent Secretary (DfES), five Ministers (DfES and DCA) and the relevant line managers cataloguing the mismanagement of family policy in two sectors:

- private law Family Law cases
- public law Family Law cases

In both sectors, the mismanagement shows common features; - in particular, of internal departmental processes contrived by Government officials (or a Government official) in such a manner that policy-as-envisioned by Ministers was replaced by wholly different policies; with one policy substituted for another whilst it was officially maintained that the original policy continued under development.

Documentation lodged to date consists of:

1. 26 April 2005 – the originating document summarising the case in both the private and public sectors:
  - (i) Private Law: Section 8 contact disputes / Early Interventions / Child Contact and Adoption Bill
  - (ii) Public Law: MSbP / Shaken Babies / Social Service interventions / Child Protection / adoptions
2. 20 May 2005 – lodgement of full particulars re the Private Law mismanagement of EI and Section 8
3. 19 July 2005 – lodgement of full particulars re the Public Law mismanagement of MSbP etc (herewith)

### **Procedure**

On 28 April 2005 the DfES Permanent Secretary Sir David Normington responded on behalf of the initial recipients (see Paragraph One above) with the undertaking of a full departmental investigation. A prerequisite, agreed thereafter by Consensus in correspondence with Sir David Normington was the submission by Consensus of full particulars in relation to (i) Private Law (ii) Public Law. Item (i) was lodged on 20 May 2005; Item (ii), on 19 July 2005.

As of 19 July 2005, the DfES was in a position to commence its investigations.

The covering letter from Consensus to Sir David, which accompanied the 19 July 2005 papers, noted that the objective of Consensus was structural change. A timetable of two months from receipt of the MSbP papers was suggested by Consensus as an appropriate span for the Department to respond with the indications of good faith sought by Consensus.

A copy of this letter from Consensus, if not appended to this document, may be available on application from the Permanent Secretary.

### **Private Law: Confirmation of Mismanagement by Mr Bruce Clark**

On 17 May 2005 the DfES, in response to various requests, furnished Consensus with the Minutes of the first DfES Design Team meeting (of 17 March 2004) on the Private Law Section 8 EI reform project. These Minutes confirm, on the Department's own records, the charge against Mr Clark:

- by the time the Design Team first met, the approved EI project had been buried and was lost without trace

During the period October '03-March '04, when the EI project underwent its unauthorised disposal, the EI project was under Mr Clark's control. The Private Law issue is concluded in the Appendices at Endnote ix.

**HOW A FLAWED SET OF GUIDELINES  
DISTORTED  
SOCIAL and FAMILY POLICY in BRITAIN  
2000-2005**

**A set of flawed Guidelines, which initiated an alert for a hypothetical medical condition known as MSbP, was introduced nationwide as a result of mismanagement by government officials. <sup>1</sup>**

**These Guidelines, issued in 2002, are indefensible - for medical, legal, social and intellectual failings.**

**The flawed Guidelines were disseminated through many sectors and many layers of institutional thinking. They have distorted institutional practice.**

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<sup>1</sup> If MSbP exists, which is less than certain, it remains (in the stated view of its supporters) a rare condition. It has no particular significance and no significant application.

# SUMMARY

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# 1. MSbP Guidelines: The Root of a Social Disaster

1. Para 3.12 of Britain's official Guidelines on "MSbP"<sup>2</sup> provides that:

“ When a *possible* explanation for signs and symptoms is that they *may* be fabricated or induced by a carer, and as a consequence the child's health or development is or is *likely* to be impaired, *a referral should be made to Social Services.*”

*Safeguarding Children in whom Illness is Induced or Fabricated*  
Department of Health Guidelines, July 2002, para 3.12

2. These MSbP Guidelines initiated a national alert for families:

- who '*might*' display any one of scores of innocent characteristics
- which '*might*' - *perhaps* - account for a child's medical symptoms

3. Parents falling under this suspicion are, by the thousand, treated as abusive.

4. Parents seeking medical help for their children are common targets.

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<sup>2</sup> MSbP stands for "Munchausen Syndrome by Proxy": a condition where a carer is said to fabricate or induce an illness in a child. It is an extremely loose term, the 'symptoms' of which are mimicked by dozens of *bonafide* neuro-developmental disorders.

For practical purposes, a reasonable working definition of an MSBP child is "a child with a disorder which cannot always be immediately be diagnosed". These cases have been classified not as medical cases but as the victims of child abuse.

It is accepted as a truth by Consensus that some parents (and some carers) do take actions - whether deliberately or negligently - which harm their children. Nothing in this document, here or elsewhere, should be taken for a suggestion that this does not happen. It does. In all probability, this unfortunate trait forms an innate part of the human condition; it has in all probability been with us from time immemorial; it has long been acknowledged as a proper basis for Child Protection.

For the purposes of this paper, the proper issues are whether there is a 'syndrome' to this effect; and whether this syndrome is accurately defined and accurately diagnosed; and whether this syndrome forms a helpful prism through which to view (and discern fault in) the ordinary traits and ordinary behaviours of humankind.

## 2(i): How the Guidelines work in Practice

### A. THE REFERRAL

**The effect of the MSbP Guidelines is that parents can be referred to Social Services for MSbP - at any time, for any reason, by any person:**

1. The Guidelines provide lists of ‘non-exhaustive’ factors (under scores of broad categories) which *may* indicate that parents *may* be guilty of harming their children.
2. Any of these factors (commonly present in normal parents and non-abused children) is regarded as sufficient to indicate that a child’s symptoms *may* be *likely* to have been fabricated or induced by a carer<sup>3</sup>.
3. There is no need for an actual diagnosis.
4. If *anyone*<sup>4</sup> thinks that the criteria *may* be satisfied, the Guidelines stipulate that a referral to Social Services should be made under Para 3.12:
 

*“ When a possible explanation for the signs and symptoms is that they may be fabricated or induced by a carer, and as a consequence the child’s health or development is or is likely to be impaired, a referral should be made to Social Services.”*
5. Thereafter, Social Services are enjoined to treat the parents as though a real risk is present; and as though the parents are suspects against whom a case has already been made.

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<sup>3</sup> The signs and symptoms listed in the Guidelines include - for instance – children whose parents “may” interact differently “compared with other parents”.

Secondary Local Authority publications, built on the back of these Whitehall guidelines, list conditions such as “allergies”, “asthmatic attacks”, “non-attendance at school ( even when medical explanations are provided)” and “applications for financial help, e.g. Disability Living Allowance” as potential telltales of abuse sufficient to trigger a referral.

<sup>4</sup> The Guidelines confer *locus standi* on the entirety of the nation’s agencies and individuals who have a link with the child in question.

Despite RCPCH guidelines, the originating suspicion, sufficient to trigger a referral, need not emanate from a person with a medical qualification. An information lodged by a neighbour, or a nursery nurse, or an unqualified school assistant will suffice.

## 2 (ii): How the Guidelines work in Practice

### B. AFTER THE REFERRAL

**Once a referral to Social Services has been made, the parents are trapped - whether they deny the accusations or admit them.**

1. Once a referral is made under Para 3.12, there is no real provision for this referral to be revisited.<sup>5</sup>
2. As an almost invariable rule, after the referral, there will be no further professional evaluation of the child for an alternative diagnosis to MSbP; there will merely have been an original referral - on the basis of 'concerns' about 'possibilities'. This triggers an investigation into the parents.
3. Subsequent Child Protection proceedings, which are innately damaging, are skewed by an extreme imbalance of power. Everyone knows it is within the power of Social Services to proceed at will to a removal of the child<sup>6</sup>.
4. By virtue of the referral, Social Services proceed on the premise that an illness has been fabricated: medical issues are to the background; psycho-analytic issues, in particular "denial", are to the fore. An objective is to shift the parent's "belief" that the child is ill. Parents find they have two options:
  - (i) to deny the accusations and insist the child has genuine medical problems
    - *this is interpreted by the Child Protection Committee as presenting a high-risk to the child*<sup>7</sup>
    - *such parents are 'entrenched' in wrong thinking and cannot 'change' their 'perceptions'*
    - *proceedings may be initiated for removal (irrespective of medical reports to the contrary)*
  - (ii) to 'work with' the Social Services and 'admit' the child is well
    - *parents are coerced, under the threat of removal, into viewing their child 'more positively'*
    - *re-evaluations are limited to evaluating the change in the parent's "perceptions"*
    - *the child's actual medical and educational needs are less likely to be met or considered*
5. A consequence of 'multi-disciplinary working' is that no one person has authority to remove the allegation of MSbP; it will stay on all records.

<sup>5</sup> Any subsequent review can only be according to the same lax criteria as the original referral.

<sup>6</sup> The charge of MSbP, or its cousins, can be successfully maintained under the Guidelines on almost any pretext.

<sup>7</sup> The Guidelines, para 3.61: " *There are some parents who will not be able to change sufficiently within the child's timescales in order to ensure the child does not continue to suffer significant harm...In these situations, decisions may need to be made to separate permanently the child and parent or parents.*"

### 3. How and Why Things Went Wrong

#### A. TAKING THE WRONG TURNING

1. The Guidelines launched the mistake they were intended to prevent.
2. Things were set on the wrong path by a simple and well-documented sleight of hand in the year 2000:
  - (i) **The misadventure began** with a commendable professional attempt - the “Griffiths Report” - to head this disaster off
  - (ii) The commendable impulse behind the Griffiths report was twisted
  - (iii) **The misadventure ended** by misuse of the Griffiths Report as a springboard to construct:
    - (a) misguided ‘parent-blame’ theories based on MSbP
    - (b) misguided social machinery to apply the misguided theories
3. These misguided theories, and their attendant social machinery, were promulgated nationwide in 2002 by the DoH Guidelines ‘*Safeguarding Children in whom illness is induced or fabricated by carers*’

#### B. PARENT-BLAME THEORIES

1. These official Guidelines furnished a green light for converting surmise and basic misapprehensions - about children with minor ailments or neuro-developmental disorders - into serious accusations against parents.
2. The requisite safeguards, the creation of which was envisaged by the Griffiths Report, were replaced by a gung-ho opposite and applied across the nation.
3. The Griffiths Report was expressly cited by the Guidelines as the originating justification for this inversion of process.

## 4. A Bleak Harvest?

Adverse consequences of the MSbP misadventure seem to include, each year:

- multiple thousands of needless and damaging investigations<sup>8</sup>
- widespread and wrongful removal of children from their parents<sup>9</sup>
- the potential for (or actuality of) wrongful criminal convictions
- extreme familial disruption and needless personal ruination
- a misallocation of resources deflected from children in real need

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<sup>8</sup> See page 49.

<sup>9</sup> Figures put forward in the media (e.g. “An estimated 30,000 children have been taken away from their parents after a diagnosis of Meadow’s pet condition”, *Sunday Times*, 25 June 2005) may be inflated.

## 5. Outline Chronology of a Disaster

### **PHASE ONE: PROFESSIONAL CONCERNS** **1990s-2000**

1990s - professional concerns arose about Dr Southall and the evidence for MSbP etc  
 2000 - The Griffiths Report commended development of proper MSbP diagnostic criteria  
 2001 - The Clark Working Party was set up in response to the Griffiths Report

### **PHASE TWO: DISTORTION - The Working Party on MSbP** **2001**

The Working Party, consisting of eight members led by Mr Bruce Clark in the DoH, was defective in its composition and in its approach. The Working Party made no attempt at a balanced inquiry; instead, it was turned as a device to promote what it was intended to stop.

The Working Party focussed on the construction of national screening for MSbP - on the unexamined assumption that Dr Southall's intuitions and the MSbP / FII hypotheses were correct.

### **PHASE THREE: THE WORKING PARTY'S GUIDELINES** **2001/2**

The flawed Working Party issued misconceived draft guidelines based on the premise that:

- (i) there were no professional concerns over MSbP etc
- (ii) MSbP etc was a real and present threat of a widespread nature
- (iii) MSbP etc could be inferred from a broad range of nebulous trivia
- (iv) social machinery should be set up to take extreme action on these inferences

Mr Clark's draft Guidelines provided no bar against wholesale misdiagnosis by an extensive range of professionals, including ancillaries and those with no medical qualifications. After a period of supposed consultation, the flawed Guidelines were released with no significant changes.

### **PHASE FOUR: THE AFTERMATH – Dissemination** **2001-2005**

In the course of being issued nationwide, the flawed Guidelines underwent further degradation. The unsurprising end-results included an extensive catalogue of miscarriages of justice; wrongful takings into care, wrongful adoptions and fosterings; a plague of unwarranted investigations; and the mis-direction of Social Services and Child Protection.

### **PHASE FIVE: DAMAGE-LIMITATION** **2004-5**

In the wake of Cannings, Mr Clark issued a DfES circular which had the effect of ensuring that the anticipated review into the consequences of Professor Meadow's flawed thinking (and of Mr Clark's flawed Guidelines) did not take place.

*Each of these five aspects is considered separately – see Contents at page 12*

## A Note on ‘Parent-Blame’ Theories

1. MSbP, itself an extremely loose term, is generally used throughout this document to designate MSbP and its various cousins and aliases, including:
  - *fabricated or induced illness* (‘FII’)
  - *factitious illness*
  - *parent-blame theories generally*
  - *non-medical ascriptions such as ‘attachment disorders’ or ‘attention-seeking’*<sup>10</sup>
2. The ‘FII’ designation used in the Guidelines was adopted as a name-change in the course of preparing the Guidelines. It came to be realised that the concept of MSbP might be medically untenable. The two ascriptions - MSbP and FII - cover exactly the same range of conditions. The change is without significance.
3. The diagnostic criteria in the Guidelines for MSbP are capable of embracing almost anyone. Hence the common pattern - of reckless interventions by Social Services justified on the basis that the Guidelines were not breached.

The ‘shaken baby syndrome’ is an offshoot of MSbP towards the harder end of the spectrum.

The ‘shaken baby’ notion derives from the MSbP concept of parent-blame. Parents are supposed to shake their babies with a view to inducing symptoms which entail hospitalisation and medical investigations.

If the child lives, this is a standard form of MSbP; if the child dies, the ‘shaken baby’ enterprise is regarded as MSbP gone-wrong. This sort of result is supposed to be a validation of the dangerousness of MSbP; it ‘justifies’ the draconian and widespread interventions encouraged by the MSbP guidelines. Variants of the Shaken Baby Syndrome include inferred suffocation and inferred poisoning (frequently with salt).

In fact, the supposed Shaken Baby diagnostic telltale of retinal haemorrhaging can actually arise in many other possible ways, many of them innocent - to the extent that this ‘syndrome’ should be discarded.

Pages 35-37 of this document deals with issue of differential diagnosis.

In essence, not only do the Guidelines omit the concept of diagnosis (i.e. how to tell when the supposed MSbP-type condition is there) - they also omit the concept of ‘differential diagnosis’ (i.e. how to tell when the supposed condition is not there - but something else is).

The scientific and medical evidence for all or most of the MSbP cases is accordingly of a negligible order. Deficiencies in the medical evidence tend to be supplemented by the auxiliary of the equally-deficient MSbP-type “profiling”.

<sup>10</sup> In its ultimate form the MSbP diagnosis is diluted into mere (but equally deadly) stock turns of phrase, such as parents who *‘use the child to satisfy their own ends’*.

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A general summary of the five phases is set out at page 10, 'Key Events: An Outline

## PHASE ONE: Professional Concerns

1990ish-2000

### Summary

*1990s - professional concerns arose about the medical evidence for MSbP*

*2000 - The Griffiths Report commended development of serious diagnostic criteria for MSbP*

*2000 - The Clark Working Party was set up in response to the Griffiths Report*

### The Initial Period

In 1977, Dr Roy Meadow published a report of a new form of child abuse called 'Munchausen syndrome by proxy' ('The Hinterland of Child Abuse', *Lancet* 1977 Aug 13). Dr Meadow described two patients.

In the early 1990s, Dr David Southall supervised paediatric research studies at North Staffordshire Hospital.

Both Dr Meadow and Dr Southall initially regarded MSbP as a rare complaint requiring sophisticated diagnostic skills. In theory at least, a properly-conducted case involved careful evaluation by two types of specialist: a paediatrician to arrive at a settled view that the child's symptoms did not add up, and an adult psychiatrist to confirm the carer was actually suffering from MSbP.

#### MISDIRECTION (1)

Here, in a nutshell, is everything that has gone wrong. The limited, original concept has - via the Guidelines - undergone almost infinite expansion and 'dumbing down'.

A very rare condition, subject to numerous professional caveats and careful diagnosis, was re-branded as a universal label applicable to all-and-sundry with no diagnostic criteria.

In this process, the medicals who initiated the theories became a victim of their own dubious success. The originating allegation need no longer emanate from a doctor. Doctors are brought in, if at all, long after the Social Services' "investigative" process has acquired momentum - by which time, a medical opinion is redundant.

Five years down the line, the terms MSbP, and FII, and the companion notion that 'the parents are making it up', are distributed like confetti - on evidence of autism, asthma, allergies, Aspergers or pleas for help.

In 2000 an independent report, known as the Griffiths Report<sup>11</sup>, gave formal tongue to various doubts which had accumulated around Dr Southall's research and methods. These

<sup>11</sup> Report of a Review of the Research framework in North Staffordshire Hospital NHS Trust (DoH 2000) 222

concerns included the controversial and unprecedented frequency with which Dr Southall arrived at a diagnosis of 'MSbP'.

The thrust of the Griffiths Report, adopted by the Government as a programme for action, was a challenge to Dr Southall and his methodology.

### **The Problems with MSbP**

By the time of the Griffiths Report, the basis of MSbP had long been under fire. The actual focus of legitimate debate was on whether it existed at all<sup>12</sup>.

The problems with MSbP were threefold - and all problems grew from the same root: the signs and symptoms of MSbP are diffuse and all-prevailing.

So, first, the condition was hard to diagnose accurately; and second, it was easy to diagnose inaccurately. And third, by the same tokens, MSbP was a natural candidate for widespread misdiagnosis.

Concerns about MSbP soon made their appearance in the professional press (see Endnote <sup>i</sup>, Appendices). It was clear that the nature of MSbP included an obvious capacity to mutate from a rare and uncertain condition, via unfounded suspicions and allegations, into its wrongful misapplication as a common and certain condition.

It was this mutation that the Griffiths Report and the Government intended to check; and it was this intention that was subverted.

### **The Griffiths Report**

Para 12.4 of the Griffiths report, published on 8 May 2000, made the suggestion that:

*“In order to assist in the **correct identification** of children who have either had illnesses induced or fabricated by their carer, the Review recommends that the DoH should convene an Expert and multidisciplinary panel which **reviews methods of identification**”*

Bold Added

On 10th October 2000 the status of the Griffiths Report was clarified in the House of Lords:

“Lord Walton of Detchant asked Her Majesty's Government:

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<sup>12</sup> To answer this question in the affirmative does not move matters forwards. If the condition does exist, it is (on its supporters own figures) rare to the extent that it poses no particular threat.

*‘Whether they support the findings and conclusions of the Griffiths report of 8th May reviewing the research framework in the North Staffordshire National Health Service Trust in the light of the criticisms set out in the paper by Sir Iain Chalmers and Dr Edmund Hey, published in the British Medical Journal on 22nd September.’*

The Parliamentary Under-Secretary of State, Department of Health (Lord Hunt) replied:

*‘My Lords, the Government accepted all the recommendations made in the Griffiths report, which mainly concern improving research governance and guidance.’*

Hansard

Chairmanship of the Expert and multidisciplinary panel envisaged by Professor Griffiths fell to Mr Bruce Clark.<sup>13</sup>

### **MISDIRECTION (2)**

The actual incidence of serious child abuse leading to child deaths has not changed over the last 15 years.

Meanwhile, the focus of Social Work has drifted from its real purpose to secondary digressions – which, as it happens, provide a journey through relatively agreeable terrain:

- the actual job of Social Services is to deal with dangerous and unpleasant people
- it is understandable to prefer dealing with those who are pleasant but who are not dangerous

This inversion of priorities, in part accomplished through the MSbP debacle, creates more convivial working conditions for Social Service staff. It does not meet the Service’s remit.

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<sup>13</sup> The reader is referred to the Consensus papers on EI for the ‘similar evidence’ on the fashion in which Mr Clark put an end to the envisaged and approved reforms to the Private Law system.

As to Mr Clark’s conduct of Public Law, the Department will not be assisted by basing a response on the footing that the Griffiths report somehow did not say what it said; or that Mr Clark’s remit was not as set out in the Griffiths report. Such an impulse (even if successful) goes only to mitigation on the limited aspect of intent. The remainder of the charge, including negligence and recklessness, stands; in that is apparent on first principles that the MSbP Guidelines produced by the Working Party are flawed, untenable and dangerous; and that they must (irrespective of the Griffiths Report) undergo review.

## PHASE TWO: DISTORTION - The Working Party on MSbP 2001

### Summary

*The Clark Working Party, which consisted of eight members led by Bruce Clark, was defective as to its composition and approach.*

*No attempt was made at a balanced inquiry into MSbP – for which its members lacked the relevant expertise. The intended issue of “correct identification” was not considered; the “methods of identification” for MSbP were not reviewed. These primary considerations were bypassed.*

*Instead, the Working Party became a device to promote what it was intended to stop. The Working Party validated, built on and rolled-out Dr Southall’s theories without any or any proper inquiry into the medical or scientific basis of these theories.*

*The Working Party proceeded straight to the construction of national screening for MSbP on the assumption that Dr Southall’s intuitions and the MSbP / FII hypotheses were correct. Notwithstanding, the Working Party was passed off as a direct linear continuation of the Griffiths Report - which it had buried.*

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The preparation of the Guidelines on MSbP etc was flawed from the first by two fundamental errors:

1. Adopting the Wrong Remit for the Working Party
2. Setting up a Working Party with Little or No Relevant Knowledge of the Issues

These two sources of error are considered below.

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### SECTION 1: Adopting the Wrong Remit for the Working Party

The establishment and control of the Working Party appears to have passed to Bruce Clark, who is believed to have been seconded to the Department of Health in 1999 after a career in the NSPCC. Mr Clark does not appear to have a medical training or a legal training.

Mr Clark seems to have been responsible for selecting the members of the Working Party and running the team as an in-house project of which he had effective control <sup>14</sup>:

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<sup>14</sup> There is a parallel here with the hi-jacking of the EI project (see Consensus, Mismanagement, 26 April 2005; Consensus, Supplementary Evidential Papers, 20 May 2005).

The EI project was developed by professionals working out-house; on receipt of the project for implementation, Mr Clark similarly elected not to open a dialogue with the project originators. Instead, the project was run in-house as a ‘closed’ entity via controllers, administrators and designers who had no knowledge of the project under supposed development. The original EI project was entirely abandoned or destroyed before work on it started

A similar tendency is discernible here.

### **Intended and Acknowledged Reason for the Working Party:**

- an inquiry into the correct diagnosis of MSbP (Griffiths Report, Para 12.4 – see p14)
- a challenge to Dr Southall’s questionable MSbP approach

### **Purpose for which the Working Party was Actually Used:**

- to promote Dr Southall’s questionable MSbP approach
- to roll-out apparatus to apply the questionable approach nationwide

## **PUTTING THE CART BEFORE THE HORSE**

The Working Party omitted to undertake the essential preliminary of diagnostic groundwork.

The key issues - ‘*When is MSbP present? How can you tell? Are there reliable indicators? What are the other possible explanations? How can you tell which is which? Does MSbP exist with any frequency? Does it exist at all?*’ - were not broached by the Working Party.

Instead, the Clark Working Party proceeded straight to the construction of nationwide machinery based on the premises, which they had not investigated, that:

- MSbP could be reliably identified by ephemeral and ambiguous tell-tales
- MSbP was a real and prevalent condition
- MSbP posed a real and widespread threat to the nation’s children

In this vein, the second paragraph (1.2) of the Clark Guidelines affirm:

“ This supplementary Guidance... is intended to provide a **national framework**... It is addressed to those who work in the **health** and **education** services, the **police, social services** departments, the **probation service**, and **others** whose work brings them into contact with children and families. It is relevant to those working in the **statutory, voluntary** and **independent** sectors.” Bold Added

### **A False Prospectus?**

Notwithstanding, the Clark Guidelines were presented as the direct linear descendant of their opposite, the Griffiths Report, which they eschewed. In fact, the Working Party set off in the reverse direction from the original Griffiths remit, which was:

*“ to assist in **the correct identification** of children who have either had illnesses induced or fabricated by their carer, the Review recommends that the DoH should convene **an Expert and multidisciplinary panel which reviews methods of identification** ”*

Bold Added

No notice was drawn to the extreme dissonance between the objective claimed for the Clark Guidelines and the objective actually pursued by the Clark guidelines.

Instead, the one was presented as the seamless continuance of the other<sup>15</sup>.

Social policy was, at and from this point, misdirected.

### **Chalk and Cheese?**

The disjunct between Griffiths and Clark is clearly apparent at Paragraph 1.11 of the Clark Working Party Report. The top paragraph is original Griffiths Agenda; and the lower, the interpolated Clark Agenda.

The two agendas, which in the original text of the Guidelines are presented as a single unbroken paragraph, are separated by an unbridgeable intellectual gulf. Quoting from the Clark Guidelines at para 1.11:

#### **“THE POLICY CONTEXT**

*1.11 In 2000 the Report of a review of the research framework in North Staffordshire Hospital NHS Trust (Department of Health, 2000b) was published. It (**the Griffiths Report**) called for a wide range of measures to improve research governance across the NHS. In addition, it recommended the development of guidelines to correctly identify children who have had illnesses fabricated or induced by their carer.*

**= The Griffiths Agenda**

*= the prudent development of new and proper diagnostic criteria*

*The Department of Health responded to this later recommendation with a commitment to produce new guidelines for professional practice and interagency working in responding to concerns that a child may be having illness feigned or induced by a carer. These guidelines will be drawn up within the framework of Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (1999)”.*

**= The Clark Agenda**

*= the imprudent construction of a national framework to apply non-existent diagnostic criteria - irrespective of whether these non-existent diagnostic criteria were improper)*

When taken in conjunction with Paragraph 1.2 of the Clark Guidelines, which specify that the Clark Guidelines are indeed intended as a ‘national framework’, the scale of the disjunct becomes apparent.

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<sup>15</sup> There is a further parallel here with the hijacking of the EI project (see the Consensus Early Interventions submissions of 26 April and 20 May 2005). The intended Section 8 project (EI) was swapped for a different project (Family Resolutions). The two projects were opposites. Mr Clark has tried to pass them off as the same.

The cart was put before the horse.

By the end of Para 1.11 of the Guidelines (on the second page of text) national policy has been firmly pointed down the wrong track.

The intended agenda – of competent professional reflection on how to act for the best – had been replaced by action in the absence of prior reflection

### **Corroboration: An Elementary Gaffe**

Confirmation of this defective approach can be found in the Guidelines as early as Para 1.4, i.e., on the first page of text. This paragraph acknowledges that is ‘considerable debate’ amongst professionals about MSbP.

This fundamental stumbling block is, in the same sentence, relegated to a mere matter of ‘terminology’ - and hence, as a thing of no moment.

A clear and basic misrepresentation was involved in putting forward this interpretation:

- (i) the “considerable debate” – the existence of which was acknowledged – was *not* about what “MSbP” should be called.
- (ii) the debate was about when and whether the condition (*irrespective of what it was called*) existed.

It was disingenuous of the Working Group to conflate these issues.

Questions may arise as to how an error of such an elementary nature could have arisen in the absence of intent. In any event, the consideration central to the Guidelines (*‘does the condition exist, and if so, how can you tell?’*) does not feature again in the ensuing 67 pages of the Guidelines.

Instead, the Clark Guidelines openly affirm it is not their purpose to consider whether the condition which is ascribed to the child and parent is actually present, or whether the condition actually exists; or whether it is likely to exist.

The express point is - apparently - for multiple thousands of professionals and ancillaries, lacking the relevant qualifications, to act on ‘concerns’ irrespective of whether these concerns are substantive, and irrespective of whether there are any grounds for these concerns, and irrespective of whether there is evidence that the condition is present or could be present<sup>16</sup>:

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<sup>16</sup> The July 2005 issue of *Paediatrics* raises a similar concern in a different context. In America, the equivalent threshold is “reasonable suspicion”; whereas here – see above – the Guidelines admit the concept of *un*reasonable suspicion. The study in *Paediatrics* considered whether the American

**“The use of terminology to describe the fabrication or induction of illness in a child has been the subject of considerable debate between professionals. These differences of opinion may result in a loss of focus on the welfare of the child. In order to keep the child’s safety and welfare as the primary focus of all professional activity, this Guidance refers to the ‘fabrication or induction of illness in a child by a carer’ rather than using a particular term. If, as a result of a carer’s behaviour, there is concern that the child is or is likely to suffer significant harm, this Guidance should be followed.”**

Bold Added

The express priority revealed by this enjoiner is not whether there were grounds for concerns; the priority is to act on concerns - irrespective of whether are were groundless or likely to be groundless.

In this process, Social Services and the like were encouraged to be suspicious; and to be suspicious for ambivalent and trivial cause; and to use those suspicions as a platform to initiate drastic pre-emptive interventions liable to involve the child and the child’s family in damage.

If this be doubted as an extreme interpretation, the rebuttal lies in the MSbP Guidelines themselves, not just as to their generality, but as to their specific exhortation on this particular point:

- 3.12. When a **possible** explanation for the signs and symptoms is that they **may** be fabricated or induced by a carer, and as a consequence the child’s health or development is or is **likely** to be impaired, **a referral should be made to Social Services.**

Bold Added

In this process, the welfare of children was forfeit on a broad scale.

### **The Buried Contradiction**

Between the two stools of the Griffiths Report and the MSbP Guidelines, a whole tier of essential intellectual activity has vanished. In the vernacular, the appropriate words to designate this omission in the MSbP Guidelines would be:

*“We decided not to do that. Instead, we decided to do the opposite.”*

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requirement for “reasonable suspicion” as applied created an adequate and consistent test. It did not. The situation in Britain, where the starting point is not of reasonable suspicion but of surmise and contingent speculation, may be imagined. See the Appendices (Reasonable Suspicion? – *Paediatrics* July 2005) for an abstract of this study, which reads in part:

*“Both practically and conceptually, significant problems arise from this lack of direction: inconsistent reporting of (possible) abuse, unequal protection of children, inequitable treatment of parents, inefficient use of child protection service resources, and substantial ambiguity about the nature and meaning of the threshold in judging whether to report.”*

It is a question of who was made aware of this shift in policy; and, in particular, whether the change was drawn to the attention of:

- (a) Ministers
- (b) Members of Mr Clark's Working Party <sup>17</sup>

## **SECTION 2: Setting up an Inadequate / Inappropriate Working Party**

### **COMPOSITION OF MR CLARK'S WORKING PARTY**

The Working Party was:

- (i) unfit to carry forward the remit of the Griffiths Report<sup>18</sup>
- (ii) perhaps unfit to carry forward any serious work in this important area

The composition of the Working Party, as relayed to the House of Lords and listed below <sup>19</sup>, has important characteristics considered below under four heads:

#### **DEFECT 1: The Working Party - Medical Qualifications?**

Irrespective of whether the Working Party was following the Griffiths remit or the Clark remit, the Working Party should have focused on when and where there might be legitimate "concerns" that a child may have been subjected to MSbP.

This was and is a medical issue.

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<sup>17</sup> There is another parallel here with the hijacking of the EI project.

By the time that Mr Clark's EI "Design Team" first met, Mr Clark had eradicated the EI project. His Design Team members were not made aware of the fact that there had been a fully-designed EI project ready for implementation. They started anew, from a blank sheet of paper, working up a different project, with eight years of development work discarded.

<sup>18</sup> re is a parallel here on both counts with the hijacking of the Early Interventions project.

The Design Team selected for the EI project was likewise unsuited to progressing the EI Section 8 project (only one of its nine members had bare familiarity with the outline of EI). But, in addition, the Design Team was unsuited to construct *any* Section 8 project. The possibility is that, of its nine members, only 2 had been inside a family court to follow a Section 8 case; and one of those represented an organisation widely and correctly regarded as the root-cause of the problem.

<sup>19</sup> Dr G Adshead, Royal College of Psychiatry; Ms I Charles-Edwards, English National Board of Nursing, Midwifery and Health Visiting; Mr J Fox, Association of Chief Police Officers; Ms S Hensman, Royal College of Nursing; Ms D Kinnair, Community Practitioner and Health Visitors Association; Ms S Smallman, United Kingdom Central Council for Nursing, Midwifery and Health Visiting; Dr D Sowden, Royal College of General Practitioners ; Mr A Webb, Association of Directors of Social Services

An appropriate body would, at its heart, have included a number of professionals drawn from a minimum of two key sectors:

- specialised paediatricians (to comment on the child-related aspects)
- adult psychiatrists (to comment on the adults' involvement)

Other candidates would include psychologists and specialists in the relevant areas of differential diagnosis.

There would be no difficulties in assembling a balanced group of this type. Instead, a nine-person team (including Mr Clark) was assembled of which only two members were medically qualified:

Dr G Adshead - Royal College of Psychiatry  
Dr D Sowden - Royal College of General Practitioners

Dr Adshead, who is a named co-worker on published research by Dr Southall, was the only relevant specialist on the Working Party.

Leaving the issue of objectivity to one side, it is not cynical to observe that the possibilities for debate between one individual are limited.

### **DEFECT 2: Working Party - Bias (Exclusions)**

The Working Party:

- excluded all medical authorities who had criticised Dr Southall and his methodologies
- excluded all professionals who had criticised Dr Southall and his methodologies

### **DEFECT 3: Composition: Bias (Inclusions)**

The Working Party:

- included known adherents of Dr Southall and the MSbP hypothesis

e.g. Dr G Adshead; Detective J Fox; and, presumably, the Chair Bruce Clark

Detective Fox also appears to have a background as a committed and active supporter of the MSbP hypothesis.

Detective Fox's presence on the Committee raises a further question. The true and stated remit of the committee was to devise a method for the 'correct identification' of cases – which is, as stated, a medical issue.

Once an appropriate method of differential diagnosis had been devised, the appropriate working sequence would be to relay these medical criteria to the investigative branch, i.e. the police. In fact, the process was inverted, with the police involved in construction of the medical criteria.

Detective Fox's presence on the Working Party is a puzzle.

#### **DEFECT 4: Composition: Eminence / relevant knowledge (?)**

Two of the institutions represented on the Clark Working Party no longer exist (the English National Board of Nursing, Midwifery and Health Visiting; the United Kingdom Central Council for Nursing, Midwifery and Health Visiting).

Doubtless Ms Charles-Edwards and Ms Smallman, who represented these organisations on Mr Clark's Working Party, are of outstanding professional stature; but it is scarcely invidious to observe they are not household names. Nor are the names of Ms S Hensman or Ms D Kinnair, also selected for the Working Party, widely known for their publications or work in this field.

The names of all four seem to be unfamiliar to specialists in this field.

It is easy to see how the Working Party could have become a passive conduit either for the promulgation of untutored MSbP theories, or for the personal views of the Chair Mr Clark; in both cases uninformed by relevant corrective input.

#### **DEFECT 5: A Distorted Reading List ?**

The Reading List appended to the Draft Guidelines reveals a further flaw.

The reading list consists of an assiduous trawl of pro-MSbP literature; from which the counterbalance of anti-MSbP literature is notable by its absence.

The draft Guidelines issued by Mr Clark (which went on to traverse the Consultation Process with no significant alterations) listed some 40 source documents:

- three of the first four are co-authored by Professor Meadow
- a further 12 are authored or co-authored by professionals regarded as extreme supporters of MSbP and / or Dr Southall.

Excluding official publications (e.g. the Children Act, the Data Protection Act etc) only a total of 24 works are cited. No work is cited which is critical of the MSbP hypothesis.

## DEFECTS IN THE WORKING GROUP: IMPLICATIONS

There was no-one on the Working Party:

- minded to examine the MSbP hypothesis *and/or*
- qualified to examine the MSbP hypothesis

It may also be – it is, indeed, a likelihood – that no-one on the Working Party was made aware that their remit was to examine the MSbP hypothesis<sup>20</sup>.

By way of summarising the Working Party's general tenor, a quotation is appended hereunder from the Social Care Consultant Charles Pragnell, who submitted evidence to the Working Group:

*“The review as envisaged by Griffiths and concerned professionals was not carried out.*

*It might have been reasonably expected that a Review of such an important matter as the lives and welfare of children, would have commenced with the commissioning of independent research into FII/MSBP, an invitation for submissions and an oral discussion with the persons who made submissions to clarify and extend their evidence, and thereafter a consultative document circulated of the preliminary findings and inviting further comment. After careful consideration of all of this evidence, it would then have been possible to produce a reasoned and evidence-based document for professionals engaged in child protective work.*

*However, no statistics have ever been collected on the number of cases of FII/MSBP and there is therefore no data or information concerning its usage or the numbers of false negatives. Such information could have been obtained from local authorities over a given period of time and would have been a vital ingredient of any impartial and objective investigation. This process was not undertaken by Mr Bruce Clark and his Working Group.*

*There was no independent research carried out, no discussion of submissions, and no attempt was made to obtain statistical data. All that was done by the Working Group was a literature trawl of books and articles which supported this unscientific theory, mainly the works of Sir Roy Meadow and Professor David Southall (the major proponents of FII/MSBP).*

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<sup>20</sup> It may be proposed that Mr Clark received clear instructions from his Ministers to omit the essential preliminary stage of considering what the problem was before proceeding to the construction of machinery to deal with the supposed or imagined problem; it may be argued that he was instructed from on high to proceed as he did, and ‘fast-forward’ to the construction of machinery on the basis that a serious problem did exist.

In these circumstances, as the servant of his Ministers, Mr Clark would of course have been obliged (even if under protest) to undertake the biased promulgation of the MSbP hypothesis under the screen of a neutral Working Party. If so, presumably evidence to this effect can be produced.

*I submitted a Paper to the Working Group expressing my concerns regarding FII/MSBP but received no acknowledgement. I was aware that other professionals had also submitted papers expressing their concerns. There was an immense amount of controversy and dispute – which also went unacknowledged - among professionals surrounding the validity and utility of FII/MSBP in the U.K. and in many other countries.”*

It is an inevitability that a defective Working Party, working to the wrong brief, would produce the wrong guidelines; as indeed happened. This aspect - the consequential deficiencies in the Guidelines - is considered in the next Section, Phase Three.

## PHASE THREE: THE WORKING PARTY'S GUIDELINES 2001/2

### Summary

*In July 2001, Mr Clark's defective Working Party issued a set of misconceived draft guidelines based on the premise that:*

- (i) there were no professional concerns over MSbP etc*
- (ii) MSbP etc was a real and present threat of a widespread nature*
- (iii) MSbP etc could be inferred from a broad range of nebulous trivia*
- (iv) social machinery should be set up to take drastic action on these inferences*

*Mr Clark's draft Guidelines provided no bar against wholesale misdiagnosis by an extensive range of professionals, including ancillaries and those with no medical qualifications. All were encouraged to participate in a nationwide screening of the general population. Parents seeking help were treated as suspects.*

*The Guidelines promoted ambivalent trivia as a sufficient indication on which to initiate the process of taking away.*

*After a period of supposed consultation, these 68-page draft Clark guidelines were released with no significant changes.*

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### OVERVIEW: Re-classifying Sick Children as Abused Children

The Guidelines allowed the MSbP diagnosis (or related 'parent-blame' theories) to be applied against parents who had children with a wide range of organic medical disorders.

It is not necessary for the parents to have done anything.

The main effect of the Guidelines, deliberate or otherwise, has been to re-classify large numbers of children (with conditions requiring special educational and / or health provision):

- as children who do not require these expensive resources
- as children whose problems have occurred as a result of abuse

The Guidelines furnish Local Education Authorities with a reliable means of reducing their expenditure on special educational needs.

This 'workload' has, in essence, been redefined as Child Protection, with the expense transferred that budget. Set against the increase in Child Protection's expenses are two further effects - which may perhaps be regarded as benign<sup>21</sup> by Child Protection advocates:

- an increase in the (apparent) rate of child abuse
- an (apparently) infallible means of detecting abusers

The net result of this administrative change is misery and ruin for thousands of families.

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<sup>21</sup> It is an oddity that – presumably – Child Protection is a 'business' which operates on the same footing as any other. It seeks to expand. Hence the discovery of new tools which promise to unearth a (rich) new seam of (supposed) child abuse may be seized upon with more relish than reason.

## **The Core Problem with the Diagnostic Indicators**

The central problem is that the MSbP Guidelines are, in diagnostic terms, all but incapable of breach. The diagnostic net is of the finest mesh. It is composed of a mish-mash of diffuse and all-encompassing indicators cast widely over the general population.

It is an express proviso to the Guidelines that these telltales do not actually have to be there.

The nebulous symptoms sought by the Guidelines may, or may not, be present.

Either will do.

The primary focus of the Guidelines is not on how to decide if MSbP is present, but on the procedure to be followed when there is a suspicion that MSbP might be suspected. The Guidelines make it plain that this suspicion can legitimately arise on very slender grounds.

The actual issue (are there reasonable grounds for the suspicion?) is not addressed <sup>22</sup>.

## **Illusory Safeguards: An Hermetic System**

A key point is that the Guidelines provide an hermetic system from which it is very hard to escape. It is very easy to 'get in'; and very hard to 'get out' (See Endnote <sup>ii</sup>, A Note on Post-Referral Procedure).

In this vein, Para 1.28 of the Clark Guidelines enjoins "all agencies and professionals" to be alert to:

- "potential" indicators of MSbP
- "potential" MSbP abusers

It is hard to get much more all-encompassing than this. A 'potential' abuser, who displays a nebulous 'potential' indicator, would and should be caught by the Guidelines - as long as that potential indicator is deemed to have the 'potential' for significant harm (as defined) if taken into consideration together with other attributes which did not themselves have the potential for significant harm.

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<sup>22</sup> Under the Guidelines, any subsequent re-evaluations should of course be undertaken on the same flawed basis which the Guidelines stipulate were sufficient to prompt the original concerns.

In practice, the professionals involved in MSbP-cases commonly take the view that their predecessors have already carried out the evaluation which they themselves do not carry out. In fact, evaluations are – under the Guidelines – not required, since they specify that a mere suspicion of a possibility is sufficient grounds for referral. In addition, and as noted elsewhere, it is a tenet of the MSbP belief-system that medical investigations (i.e. second opinions) are themselves a further form of abuse.

Thus a doctor with a patient s/he cannot diagnose may make a relatively-casual MSbP referral - on the assumption that the local authority will carry out a proper evaluation; and the local authority will take the referral on the basis that a proper evaluation already has been carried out by the doctor. And so on.

The single word encapsulating this process is ‘caprice’.

### **The Clark Guidelines: Diagnostic Criteria**

The following diagnostic features of the Guidelines are noteworthy:

- (i) the lack of a real requirement for ‘significant harm’
- (ii) the broad and conditional nature of the Guidelines
  - *the presence of MSbP can be indicated by nondescript features...*
    - ... *which may be present*
    - ... *which may not be present*
    - ... *which are indeterminate*
    - ... *which are commonplace*
    - ... *which are neutral*
    - ... *which derive from subjective inferences or attributions*
    - ... *which indicate other conditions*
- (iii) the range of professionals encouraged to apply the Guidelines is very broad
  - *the list extends beyond doctors to those with no medical knowledge*
- (iv) the lack of regard paid by the Guidelines to alternative and more likely explanations
  - *alternative explanations are all but unmentioned*
  - *the concept of ‘differential diagnosis’ is unremarked*

These four strands of the Guidelines are considered subsequently, as is the puzzling question of how the guidelines were authored.

These aspects cover a deeper mystery.

### **A Non-Existent or Marginal Problem?**

On the Guidelines’ own say-so, the evidence is that there is no particular MSbP problem.

Incidence of MSbP is put forward by the Guidelines as statistically negligible (*see post*).

In cases where it matters, MSbP is a form of physical abuse. Carers harm their children. This has always been a proper priority for Child Protection. There is no new risk, or no new significant risk.

Quite apart from the issue of the nature of the ‘national framework’ created in the Guidelines, there is a question about whether there is a need for a national framework at all.

## DEMERIT ONE: ELIMINATING the ‘SIGNIFICANT HARM’ TEST?

*The MSbP guidelines advocate a substantial erosion of the ‘significant harm’ test which a case must surmount if state intervention is to be warranted.*

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### Lowering the Threshold of the Significant Harm Test

The Guidelines suggest that the ‘significant harm’ test can be met by a wide array of ordinary circumstance. Para 1.16 takes as a starting point:

*“There are no absolute criteria on which to rely when judging what constitutes significant harm.”*

A couple of dozen variable, interdependent and discretionary criteria are then put forward.

Each of these considerations can be taken into account with another; and these considerations raise other considerations; and all the considerations are subjective. A family’s ‘context’, the ‘cultural’ environment, ‘communication’ difficulties and the child’s ‘reactions’ and ‘perceptions’ are merely part of an initial list to be factored into a general grab-all formula.

The Guidelines make plain that significant harm may reside in a wide array of dispersed features, including future events which, by their nature, have not happened. The Guidelines also embrace the concept of ‘emotional’ harm, which thus extends to a *potential* for future ‘emotional’ harm - as well as future ‘events’ of a type which it is thought may ‘change’ a child’s ‘social and psychological development’; and to ‘circumstances’ where a child’s development may be ‘neglected’.

In addition:

- events which of themselves do not constitute significant harm may cause significant harm as part of ‘a compilation’ of significant events
- there is no requirement for significant harm to be present
- the ‘likelihood’ of significant harm (as defined above) will suffice

Para 1.23 concludes, “The way to proceed in the face of uncertainty is through competent professional judgements”. A list of further open-ended subjective attributes is appended by way of example. They too are open to interpretation at will:

*‘a sound assessment of the child’s needs, the parents’ capacity to respond to those needs – including their capacity to keep the child safe from significant harm – and the wider family circumstances’*

As a result, there is nothing to stop any set of circumstances being construed as meeting the ‘significant harm test’ under the MSbP guidelines.

For instance, MSbP is *pre-defined* as carrying a risk of emotional harm; and Social Services are required to act as though MSbP is present if they have concerns that MSbP may be present. Hence the mere intuition of MSbP will, by definition, meet the significant harm test.

### **‘Significant Harm’: an Accidental Inversion**

Obviously it is important, when considering the question of ‘significant harm’ to consider a wide spread of components. The MSbP guidelines reverse this process.

The Guidelines consider the wide spread of components - without considering the issue of significant harm. In this process, a ‘happorth of tar’, derived from an imputation, is promoted as sufficient cause to lose a ship.

The potential for actual harm as a result of applying the Clark test can be considered under two heads:

#### **(i) the initiation and pursuit of a wrongful investigation**

Whether or not a wrongful investigation ends in the greater wrong of an improper taking away, the process of a wrongful investigation is of itself a malign and damaging event, often of a serious nature with long-term consequences.

#### **(ii) wrongful takings-away**

The final safeguard against a wrongful taking away, which is the natural end of an improper investigation, should be provided by the Courts.

The High Court judiciary are rightly respected for their robust approach to reckless applications originating from a Local Authority. There are about a dozen High Court family judges.

Whether the lower judiciary at County Court level (whose numbers run into many hundreds) can be relied upon to take a comparably robust stand is a matter of question.

Rights of appeal are constrained.

### **DEMERIT TWO: The Broad and Conditional Nature of the Guidelines**

*The Guidelines on the indicators for MSbP are scattered over many paragraphs. Scores of possible indicators are listed - maybe in excess of hundred. The majority (or perhaps all) of them may or may not be present; and the majority (or all) of them are widespread, subjective and non-determinate.*

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### **THE SUPPOSED ATTRIBUTES of MSbP**

The diagnostic indicators are many, varied, uncertain and contradictory.

To substantiate a suspicion of MSbP, it will be sufficient to have concerns about either a child or a parent. The Guidelines set out when such concerns are merited according to lists of various tell-tales. They are capable of covering everyone.

### **The Indicators of an MSbP Child (One Hat fits All)**

Any of the following will suffice to initiate a process leading to removal of a child:

- the MSbP child ‘may’ have had ‘unnecessary’ medical investigations Para 2.5
- the child ‘may’ have had ‘unnecessary’ treatments 2.5
- the child ‘may’ evince ‘passive compliance’ with the unnecessary treatment 2.6
- a ‘significant number’ will be ‘well known to health professionals from birth’ 2.9
- ‘some’ of the children ‘may have been seriously ill’ 2.9
- ‘non-organic failure to thrive’ is a ‘common feature’ 2.10
- the child ‘may’ have ‘organic problems’ 2.11
- the child ‘may’ have ‘alleged allergies and/or feeding problems’ 2.10
- the child’s medical history is ‘likely to have started early’ 2.12
- ‘some’ children may have been thought to have ‘a serious or rare illness’ 2.12
- ‘many’ children may not be ‘fully’ aware of ‘the nature of their abuse’ 2.20
- many children ‘have not been able’ to ‘disclose’ the nature of their abuse 2.20
- some children ‘may’ present ‘a rosy picture to the external world’ 2.20
- some children remain ‘attached to their mothers even after disclosure of the abuse’ 2.20
- ‘some’ children are ‘confused about their state of health’ 2.21
- ‘some’ children can ‘continue to be dependent on their carer’ 2.22
- a child may suffer ‘emotional’ harm from an ‘abnormal’ relationship with the mother’ 2.18
- there may be unexplained absences from school, particularly from PE lessons 4.75
- there may be absences from school to keep a doctor’s appointment 4.75

In addition:

*“The age range of children in whom illness is fabricated or induced extends throughout childhood’ (2.23)*

The list of potential MSbP victims includes children who have not been born:

*“Evidence of illness having been fabricated or induced in an older sibling or another child should be carefully considered during the pregnancy of a woman who is known to have abused a child in this way.”*

In these circumstances, children who are unborn should be ‘assessed’ and, if necessary, be removed from their parents at the time of birth<sup>23</sup>:

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<sup>23</sup> Removal at birth happens with significant and increasing frequency since introduction of the Guidelines.

*“Therapeutic work may have been successfully undertaken in relation to the abuse of a previous child, but an assessment of the unborn child should be undertaken. A pregnant woman may have a history of fabricating illness in herself during a previous pregnancy. This could include the fabrication of medical problems while the baby is in the womb.”*

Para 3.64

Para 2.18 specifies that ‘harm’ may reside in a future prospect of diffuse emotional upset:

*“ Fabrication of illness may not necessarily result in the child experiencing physical harm.*

*Where children have not suffered physical harm, there may still be a concern about them suffering emotional harm with their mother (if she is responsible for the abuse) and their disturbed family relationships”*

And so on; the above is a sample only.

### **Indicators of an MSbP Parent: One Hat fits All**

With parents, any of the following will also suffice to initiate the removal of a child<sup>24</sup>:

- the MSbP carer ‘may’ respond to the child’s sickness with ‘abnormal’ behaviour 2.6

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<sup>24</sup> This is not fanciful. It is a standard mindset. A current case going to Appeal involves a social worker who turned up on a Sunday to ‘supervise’ the mother, who had a roast chicken on the table for Sunday lunch. In the report the caseworker said the mother had been trying to ‘feed the child a whole chicken’.

This type of distortion is endemic to Social Service reporting.

The evidential platform for the cases, and the evidence and reports put to the Child Protection Committees, is contaminated at the moment of inception.

The standard pattern is of a caseworker observing an innocent household activity (the input) and producing a report (the output) where the same innocent activity is misdescribed (by minor pieces of slant, or adjustments to phraseology or perceptions, or a quasi-invisible rewriting of domestic interchanges, or selectivity, or misremembering) as a noxious activity. Innocent input is thereby translated into a noxious output. The transmutation takes place in the minutiae of the report-writing process. Thereafter, the investigative process is irredeemably flawed.

The Child Protection Committee believes it is acting on the evidence - based on the facts - as set out in the reports. In actuality, the Committee is equally likely to be acting not on the facts, and not on the evidence, but on the *interpretation* of those facts (as set out in the reports). These two aspects – the facts and the interpretation put upon them under the guise of presenting the facts – may be unrelated.

The only incident known to Consensus of a Social Worker who was covertly tape-recorded (while interviewing a subject preparatory to writing a report) shows the Case Worker making things up. The finished report was a fantasy, loosely based on actual events, with the facts misrepresented and/or entirely inverted by the process of interpretation. Since a case will almost certainly come to the first Child Protection Committee meeting with reports already written (behind the parents’ back and without the parents’ input, or comment) the whole process will be skewed. A Committee will traditionally be interested not in the *how* of how the Social Workers reached their conclusions but in the *what* of what conclusions they reached; which are arrived at by viewing the facts through the distorted prism imparted by the Guidelines.

- the carer ‘may’ induce symptoms by giving children medicines or other ‘substances’ 2.7
- the carer ‘may’ induce symptoms by ‘not administering’ medicines 2.7
- the carer ‘may’ exaggerate the child’s symptoms 2.7
- the carer ‘may’ claim the ‘symptoms’ (eg pain) are unverifiable unless observed ‘directly’ 2.7
- the carer ‘may’ allege the child suffers from a ‘psychological illness’ 2.7
- some mothers may induce ‘obstetric complications’ to achieve a ‘premature birth’ 2.9
- a parent ‘may’ interact differently ‘compared with other parents’ 2.13
- some MSbP carers are commonly ‘intensely involved with the care of their child’ 2.13
- some carers appear ‘unusually *un*concerned about the results of investigations 2.13
- other MSbP carers ‘are more likely’ to engage with ‘other families’ than their child 2.13
- some parents ‘may’ have histories of childhood abuse or privation 2.28
- this abuse can include ‘all forms of abuse including emotional’ 2.28
- the parents ‘may’ have considerable medical and psychiatric histories 2.29
- the psychiatric histories ‘may or may not’ be able to be verified independently. 2.29
- ‘significant’ numbers are likely to report having ‘genuine medical problems’ 2.30
- these problems ‘may or may not’ be substantiated by medical investigations 2.30
- some MSbP carers may have been diagnosed as having ‘a personality disorder’ 2.30
- others carers may have ‘no diagnosable psychiatric disorder’ 2.30
- some parents may report having suffered ‘a number of significant bereavements’ 2.31
- these bereavements ‘may’ have taken place within a ‘relatively short time span’ 2.31
- many MSbP families have experienced ‘a number of stress factors’ in their lives 1.24
- ‘relationship problems’ between the child’s parents are ‘common’ 2.32
- the carer at fault is ‘usually’ the mother 2.25
- it ‘is not always appropriate’ to consider fathers to be ‘mere bystanders’ 2.26

And so on. Clause 2.7 points out that lists of this type, which are ‘not exhaustive’, serve only to indicate the type of suspect ‘behaviours’ which may (or may not) be present.

## **GENERAL THRUST OF THE INDICATORS**

MSbP and / or its various ‘parent-blame’ cousins can be successfully invoked against ordinary parents and ordinary children in a wide or all-embracing range of circumstances. The typical targets are:

### **The Type of Parents Commonly Regarded as Potential Abusers**

(i) parents who take a child to the doctor with a condition the doctor does not diagnose

*- MSbP referrals are actively sought through the medical profession in the event of diagnostic uncertainty*

(ii) parents who seek help from Social Services

- Social Services are trained in the MSbP Guidelines as front-line troops

### **The Type of Children Commonly Regarded as Abused**

- (i) normal children with moderate behavioural anomalies
- (ii) children with behavioural anomalies whose symptoms arise from the illnesses associated with neuro-developmental conditions

## **DEMERIT THREE: Professionals Sectors applying the Guidelines**

The MSbP Guidelines, and the indicators listed above, are to be vigilantly applied by:

- Doctors
- Nurses
- Health Visitors
- Those who work in the health services
- Teachers
- Those who work in the education services
- The Police
- Probation Officers
- Area Protection Committees
- Those whose work brings them into contact with children and families
- The voluntary sector
- The statutory sector
- The independent sector

The 'reach' of these guidelines within these (massive) sectors is total. For instance, in the health sector, the Guidelines are not merely to be applied by doctors:

4.31 **All health professionals** whether working with children or adults who are parents should be aware of the local ACPC child protection procedures. A range of professionals working in health settings, **for example pharmacists, physiotherapists, occupational therapists, speech therapists, nursery nurses and play specialists** will have important roles to play in identifying and managing fabricated or induced illness in children. If, in the course of their work, professionals have concerns about illness being fabricated or induced by a carer, they should discuss these with their clinical manager or, if the child has been referred to them, with the referring medical doctor. All health professionals should have access to further advice from the Trust's named doctor or nurse.

Bold Added

And so on, sector by sector.

It is unlikely that less than 100,000 professionals have been co-opted into an unstinting hunt for a statistically negligible condition.

What started as the exclusive preserve of a careful dual-tier diagnosis by a consultant paediatrician working in concert with a psychiatrist, applicable in a small number of rare cases, ended as universal sticky label - offered as a diagnostic panacea to dentists, vets, psychotherapists, physiotherapists, nurses, relief nurses, nursery school teachers, day-course participants and charity workers.

## **DEMERIT 4: the lack of regard paid to alternative explanations**

### **The Omission of Caveats**

The notion that a child or parent evincing an MSbP indicator may not be an MSbP-case receives scarce mention in the Clark Guidelines.

The possibility is hardly addressed.

The overriding criterion is whether there may be concern based on the universal criteria listed above.

There are no pronounced gateway caveats.

### **Differential Diagnosis: Occasional Snippets**

The concept of possible explanations other than MSbP does occasionally makes a guest-appearance in the detail of the text. But the notion of alternatives and contra-indications is (at best) swamped in a sea of indications<sup>25</sup>.

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<sup>25</sup> The following extracts may (or may not) amount to the totality of caveats and qualifications in the Guidelines (71pp):

- 2.6 *A key professional task is to distinguish between the over anxious carer who may be responding in a reasonable way to a very sick child from those who exhibit abnormal behaviour...*
- 2.17 *Whilst it is well documented that children who have been abused or neglected are likely to suffer impairment to the health or development, it cannot be assumed that all children suffering impairment have been abused...*
- 3.1 *All parents demonstrate a range of behaviours in response to their children being ill or being perceived as ill...*
- 3.3 *For a small number of children, concerns will be raised when it is considered that the health or development of a child is likely to be significantly impaired or further impaired by the action of a carer or carers having fabricated or induced illness. When the impairment is such that there are concerns that the child is suffering or is likely to suffer significant harm, this Guidance should be followed.*
- 3.39 *Signs and symptoms require careful evaluation for a range of possible diagnoses... There could be many explanations for these symptoms, including that they are being fabricated*

A closer look at the way the qualification in e.g. Para 3.3 (see Footnote 25) actually works confirms how ineffective these contraindications are (see Footnote 26 below). In any event, there are serious conceptual problems with ‘differentiating’ other conditions from a profile which does not, in fact, exist<sup>26</sup>

In fact, the Guidelines make clear that a proper notion of safeguards should be rejected:

3.12. When a **possible** explanation for the signs and symptoms is that they **may** be fabricated or induced by a carer, and as a consequence the child’s health or **development** is or **is likely** to be **impaired**, a **referral should be made to Social Services**.

In the Guidelines themselves, the whole of this text is picked out in bold<sup>27</sup>.

### The Exclusion of Caveats

Paras 2.10 and 4.2 expressly exclude a common range of alternative explanations from being regarded as alternative explanations.

Instead, the Guidelines provide that the presence of alternative explanations, contra-indicating MSbP, is to be treated as an indicator of MSbP:

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(i) The central proviso at e.g. 3.3 is at odds with itself:

Although MSbP is said to be limited to a ‘small’ number of children, the Guidelines encourage the users of the Guidelines to identify the condition in a large number of children.

(ii) No indication is provided on what ‘small’ means.

The term bears interpretation of an almost infinitely elastic nature.

(iii) Erosion of the ‘significant harm test’

The 3.3.stipulation (that action should only be taken where there is a prospect that the child’s development is likely to be ‘further’ impaired) is a green light to intervene with no significant pretext.

The prospect does not have to be of significant future harm; it is of ‘further’ future harm.

The subsequent caveat that this ‘further’ harm is subject to the significant harm test is negated by the fact that the Guidelines have eroded or negated the test for significant harm.

27 The footing of this complaint is that, rather than the Griffiths remit of developing proper criteria, the Guidelines took the route of urging the rank-and-file of the professions to take drastic steps - on the surmise of a possibility - of a future impact - of a diffuse nature. And that is the proposition the Guidelines endorse and highlight at Para 3.12.

The use of bold text is unusual in the Clark Guidelines. Section 3.12 above appears on page 24; by this stage in the document, the technique of highlighting-in-bold has been used on six or seven occasions.

2.10 *Non-organic failure to thrive is a common feature of this group of children who may have been presented to professionals or agencies earlier in their lives with failure to thrive, alleged allergies and/or feeding problems (Bools et al, 1992; Gray and Bentovim, 1996; Rosenberg, 1987).*

4.2.2 *Children who are having illness fabricated or induced may present to NHS Direct, a Walk in Centre, the primary health care team or to the community or acute paediatrician. Some may be presented with claims of unusual allergies or, for example, smells which cannot be tested for.*

### **The Considerations Omitted (medical)**

The following is a brief and incomplete listing of conditions precipitative of symptoms which might fall within the diffuse spectrum of MSbP / FII symptomatology.

None are mentioned in the Clark Guidelines (save for allergies, which are dismissed):

apnea, reflux, GORD, iatrogenic damage, pre-existing auto-immune disorders, congenital disorders, allergies, Asperger's Syndrome, autism, ADHD, hyperactivity disorders, ME, CSS, cerebral palsy, dyslexia, neurological problems, post-vaccine adverse reactions, i.e. DPT vaccine including thimerosal; Propulsid (Cisapride)<sup>28</sup>; vitamin depletion, rickets-type fractures, liver damage, haemorrhages, conditions causing the symptoms of bruising and / or the symptoms of fractures; low levels of certain types of enzymes; congenital disorders, birth injuries; chronic fatigue syndrome

And so on.

### **An OVERRIDING ENIGMA: MSbP as a negligible or non-existent problem?**

The Guidelines concede that MSbP and its various cousins appear, on the best available figures, to be a negligible problem.

Para 2.3 of the Guidelines asserts:

**2.3 The fabrication or induction of illness in a child by a carer is considered to be rare.** McClure et al (1996) carried out a two-year study to determine the epidemiology of Munchausen Syndrome by Proxy, non-accidental poisoning and non-accidental suffocation in the UK and the Republic of Ireland. They analysed data from 128 cases notified to the British Paediatric Association Surveillance Unit during the period September 1992 to August 1994. **Based on this data, the researchers estimated that the combined annual**

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<sup>28</sup> This drug has now been withdrawn; it is known to cause serious side-effects including death. Some parents of the children to whom this drug have been administered have been convicted of causing the iatrogenic reactions.

**incidence in the British Isles of these forms of abuse in children under 16 years was at least 0.5 per 100,000 and for children under 1 years at least 2.8 per 100,000.**

**The authors calculated that “in a hypothetical district of one million inhabitants therefore, the expected incidence would be approximately one child per year”.**

Bold Added

On this basis, the Clark Guidelines, and the substantial re-gearing of Social Services, would have been set in train to filter out 50 cases a year, the great majority non-life-threatening and, very probably, evident through existing procedures. It is a possibility that multiple thousands, or multiple tens of thousands, have been wrongfully caught the net.

Although para 2.4 of the Guidelines goes on to suggest that the figure of one-in-a-million may be *underreporting*<sup>29</sup>, an equal, and perhaps stronger, likelihood is that the one in a million figure is *over-reporting*:

- The 128 cases cited to support the one-in-a-million figure were not cases established as MSbP cases, but cases ‘notified’ as possible MSbP cases, i.e. referrals
- These referrals would include cases where there were nebulous ‘concerns’

Similarly, the suggestion in the first sentence of the Guidelines’ Para 2.4 (see Footnote 29) is open to a contrary assertion. The large ‘regional variations’ referred to may indicate merely that in the ‘high’ regions an individual practitioner – say, Dr Southall or one of his supporters - skewed the figures by making a high number of MSbP misdiagnoses (see *post*, page 54, *Suggestive Official Figures*).

## **THE GUIDELINES: Composition and Provenance?**

As detailed above, the Guidelines suffer from elementary flaws of the first magnitude; it is manifest that their adoption reliably furnishes an engine of social harm.

In this context the manner of their composition is a question.

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<sup>29</sup> 2.4 This study showed that reported rates of fabricated or induced illness varied greatly between different health service regions and the researchers suggested that it was under-reported nationally. Their findings also suggested that paediatricians consider the identification has to be virtually certain before a child protection conference is initiated. Thus a number of cases may be unrecorded because of the absence of irrefutable evidence in situations where the level of concern about harm to the child is extremely high.

The cases may also present in ways which result in unnecessary medical interventions, for example, where symptoms are verbally reported to surgeons who then carry out operations without questioning the basis of this information. Consequently the estimate of one child per one million head of population is likely to be an under-estimate.

It cannot be beyond possibility that the Guidelines were produced by a number of individuals on a Working Party, working in concert, each ‘chipping in’ various bits. But any such collaborative process can only have taken place in the absence of editorial control or other form of intellectual grip.

For this reason, it is difficult to envisage the Guidelines either as the work of a single mind; or as a project overseen by a single mind.

An alternative explanation may be that the Clark Guidelines were not ‘written’ in the customary sense.

Perhaps the Guidelines were ‘cut-and-pasted’ from some other source – which, again, may have derived from elsewhere, and so on. This process of unconsidered copying could perhaps extend back over time, to some original impulse - which has now escaped review up to and beyond its incorporation into official ‘guidelines’ issued by Britain’s Department of Health.

## **PHASE FOUR: The Aftermath Consultation, Dissemination and Degradation 2001-2005**

### **Summary**

*The defective draft Guidelines underwent a supposed Consultation Process; after which, in despite of numerous powerful objections, the Guidelines were issued in their original defective form.*

*In the course of their nationwide dissemination, the defective Guidelines underwent further degradation.*

*The unsurprising results include an extensive catalogue of miscarriages of justice; wrongful takings into care, wrongful adoptions and fosterings; children wrongfully placed on the At Risk Register; and a huge number (possibly extending into hundreds of thousands) of damaging and wrongful investigations.*

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The considerations listed above are dealt with in three Sections:

**Section 1:** The Supposed Consultation Process

**Section 2:** Dissemination and Degradation

**Section 3:** A Statistical Overview

A bleak possibility is considered at Section 3 under the heading, 'A Dark Secret'.

A selection of case studies can be found in the Appendices.

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### **SECTION 1: The Supposed Consultation Process**

The Clark Guidelines issued in July 2001 were a consultation document.

After the consultation process, the original draft guidelines were reissued with no significant changes in July 2002.

The Consultation Process demonstrated a number of features:

- (i) The lack of changes to the draft Guidelines originally proposed**
- (ii) Misdirection of the Consultation Process itself**
- (iii) Disregarding the Responses to the Consultation**
- (iv) Undertakings that the Disregarded Responses would be Taken into Account**

At the conclusion of this process, the Guidelines – with their capacity for harm undiluted – went into distribution and implementation on a national basis. The anticipated consequences flowed.

The four itemised points above are considered separately below.

### **CONUNDRUM 1: Lack of Changes to the Draft Guidelines**

The MSbP draft guidelines emerged intact, warts and all, at the end of the Consultation.

There were no significant alterations.

The central misapprehensions remained in place:

- referrals should be made on any concerns of the possibility of MSbP / FII
- an extensive list of features (see pp 31-33) should trigger these concerns

Alterations to the original Guidelines were of a very minor order. The vast majority of the original document, and the whole of its presumptive framework, survived verbatim. All of the sourced quotations used so far in this document first appeared in the original 2001 Consultation Paper; and survived intact into the 2002 final official version.

Changes were minimal; and of no import; and are properly relegated to a footnote <sup>30</sup>

### **CONUNDRUM 2: Misdirecting the Consultation Process**

The process of consultation misdirected potential respondents.

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<sup>30</sup> For instance, para 2.6 was amended to read: *A key professional task is to distinguish between the over anxious carer who may be responding in a reasonable way..*” The first four words, in the Draft, originally read: *‘Professionals should be able’* to distinguish between...

A few of the more outlandish indicators were dropped – but the retention of so many other outlandish indicators (coupled with the negation of the original remit for the ‘correct identification’ of MSbP) voided the step of significance.

Items dropped (from the original Section 2.16) cited ‘attachment disorders’, ‘low self-esteem’ and ‘under-achievement at school’ as indicators of MSbP; and went on to yoke together cause and effect together in a surprising way:

“Specific problems may occur as a result of the nature of the abuse (Jones and Bools, 1999). For example:

- delay in speech and language or motor development **as a result of** distress
- development of feeding disorders **as a result of** unpleasant feeding interactions
- dislike of close physical contact and cuddling **because** it recalls episodes of smothering

The official questions raised with potential respondents for the purposes of the Consultation did not raise the key issue.

**The Actual Issue:**

*Are the guidelines for the correct identification of MSbP more-or-less right?*

Instead, the specific issues put to respondents related to secondary matters of procedure:

**The Issue Substituted for the Actual Issue:**

*Are the procedures for processing cases, after they have been identified - no matter how – about right?*

This change of tack is of-a-piece with the original by-passing of the Griffiths Report. It is again an oddity that, in the approach to potential Respondents, the Department continued to cite the jettisoned Griffiths Report as the basis of the approach. The standard DfES letter to potential respondents to the Consultation on the Draft Guidelines is set out at Endnote <sup>iii</sup> in the Appendices. The following features are noteworthy:

- (i) express reliance on the original Griffiths remit
- (ii) clear departure from the Griffiths remit
- (iii) misdirecting the Respondents' attention to the substitute agenda

These three distinct components were mis-presented as a seamless whole

**CONUNDRAS 3 and 4: Disregarding Responses to the Consultation  
Undertakings that these Responses would be Taken into Account**

The extent to which objections and evidential submissions sent to the DfES were disregarded cannot be known without opening the DfES files. In this respect, the objections made in the course of the Consultation to the DfES were and are 'private'.

Pages 43 and 44 of the original 26 April 2005 Consensus FLR submission, reprinted at the footnote below<sup>31</sup>, may provide an indication of how the 'private' element of the

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<sup>31</sup> "In the run up to the Lords debate there was a flurry of activity. Earl Howe met Lord Hunt of Kings Heath of the Department of Health who would reply to the debate for the Government. Lord Hunt was flanked by key civil servants. Earl Howe presented Lord Hunt with a compelling dossier of case histories and other information questioning or disproving the hypotheses of Meadow and Southall and suggesting that the proposed guidelines on FII were entirely inappropriate.

He came away with the impression that this was the first time that key civil servants had heard anything contrary to the Meadow/Southall view. Earlier in that same summer I had written to Beverley Hughes and to Harriet Harman requesting a meeting to discuss MSBP. I had known and worked with Harriet on the issue of after school and holiday provision. My letter was ignored until after Earl Howe's meeting with Lord Hunt. *cont.*

Consultation was handled (as does the quotation from the Social Work Consultant Charles Pragnell cited at page 24 hereof).

However, the full text of the 17 October 2001 House of Lords debate on the Clark Guidelines is on the public record. The gist of the House of Lords debate is readily summarised:

- authority after authority raising grave concerns about the MSbP guidelines
- Government undertakings to pay regard to these concerns

Thereafter:

- the reservations expressed in the House of Lord were overlooked
- the draft Guidelines went ahead with their substance unaltered
- the usual claims were made of an ‘extensive consultation’

The full text of the House of Lords Debate runs to many pages and is excerpted in the Appendices as an Endnote<sup>iv</sup>. The nature of the reservations expressed by their Lordships will already be familiar to readers of these pages. They consist of the obvious comments arising from the Guidelines’ obvious flaws.

The opening and closing speeches in the Lords capture the flavour of the proceedings (**Bold Added**):

#### **LORD HOWE: OPENING**

Alongside the worrying numbers of genuine child abuse cases there is a parallel cause for worry, which is that **many innocent people are being wrongly accused of child abuse and whose lives in consequence are being turned upside down without due justification.**

I should like to talk today about two of the triggers for false accusations....

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Suddenly I was summoned to the Department of Health. I took Lisa Blakemore Brown and my husband with me. We met with two of the same civil servants who had flanked Lord Hunt at his meeting with Earl Howe. They were fascinated by what we were saying and cancelled their next meeting to spend longer with us. I concentrated on the role of voluntary organisations whose propaganda leaflets were causing much confusion by citing as symptoms of supposed Child Abuse many things which could equally be symptoms of Autism, Asperger’s Syndrome, ADD/ ADHD, Dyslexia, Dyspraxia, CFS/ME and a whole host of other childhood illnesses or disabilities. The civil servants were effusive in their thanks and pressed us to contribute written comments on the FII guidelines. We submitted a thick lever arch file of compelling evidence from parents and professionals, together with conference speeches, academic theses etc. Other key professionals including Dr Paul Shattock OBE of Sunderland submitted their separate evidence.”

**I come now to the second major trigger for false accusations that particularly concerns me, and that is the condition known as Munchausen Syndrome by Proxy or MSBP.**

MSBP is one of a number of terms used to describe the fabrication or deliberate creation of illness in a child by a parent or carer. The existence of such a syndrome was first put forward in the 1970s and received a good deal of publicity a few years ago during the trial of Beverley Allitt, a nurse who was subsequently convicted of murdering several children in her care. In the past 10 years or so the MSBP theory has been widely promoted in this country and is a firm feature of social work training.

**The danger of such a broad spectrum of behaviour being packaged into a single portmanteau term, MSBP, is that in the hands of those who are not sufficiently trained or experienced to know better, it is a label that is all too easily applied without due care.**

**This is all the more true when one considers the so-called profile of characteristics that are said to mark out a person suffering from MSBP. These characteristics include such things as privation during childhood, repeated bereavement, miscarriage, divorce and past health problems. An over-intense relationship with the child and a desire to be the perfect parent are other supposed markers.**

**Regardless of the fact that there are very many perfectly innocent, sane people around who might have such characteristics, the very idea of a tell-tale profile of this kind is an open invitation to apply the MSBP label without properly looking at what may or may not be happening to the child. Put at its simplest, there is all the difference in the world between a Beverley Allitt, whose severe personality disorder led her to murder young children, and a mother who invents reasons why she and her child should visit the doctor. Yet under the all-embracing banner of MSBP, and in the hands of the untrained, the two are treated as being practically indistinguishable. It does not matter whether one calls the condition "MSBP" or "factitious illness by proxy", or by any other name. The point remains the same.**

**LORD HUNT OF KINGS HEATH: CLOSING**

The Parliamentary Under-Secretary of State, Department of Health

**I listened with great interest to the noble Earl, Lord Howe, and the noble Lord, Lord Astor. I shall be happy to discuss with the noble Lord, Lord Astor, the specific issue of autism, which he has again raised in your Lordships' House. I am sure that all parents would be concerned if children were being taken away from their families on the basis of false accusations, founded on misguided and scientifically unproved theories.**

With regard to Munchausen's syndrome by proxy, I understand that it was first described by Professor Roy Meadow in 1977. **I also understand that there is a**

**widespread dispute about whether the syndrome exists.**<sup>32</sup> I know that cases have been identified involving suffocation, poisoning, often with prescribed drugs, active interference with medical treatment, fabrication of illness, and active withholding of food. **It is very difficult for us to enter into the whys and wherefores of Munchausen's syndrome by proxy. It has been a long-running and at times very technical debate.**

We are concerned to protect children from harm. That is why we have issued for consultation guidance on children in whom illness is induced or fabricated by carers with parenting responsibilities. **I listened with great interest to the comments made about that consultation and I can assure noble Lords that they will be fed into the consultation process.**

Our effort must be to obtain a child protection service where the procedures are operated with fairness, rigour and, above all, the interests of children at heart. **I have no doubt that our determination to do that will be informed by the debate tonight.**

## **SECTION 2: Dissemination and Further Degradation**

The Consultation closed on 31 October 2001. In line with normal time-spans, the final version of the guidelines (identical in every material respect to the draft guidelines) was released on 25 July 2002.

On 8 August 2002, a DfES circular (averring that the draft guidelines had been ‘subject to an extensive consultation exercise’) called for the across-the-board implementation of the guidelines by 31 July 2003 by a substantial raft of professionals and agencies:

- Child Protection Committees
- Directors of Social Services
- Directors of Local Education Authorities
- Chief Executives, Primary Care Trusts
- Chief Executives, NHS trusts.
- Royal Colleges
- Chief Officers of Police
- CAFCASS
- Royal Courts of Justice
- Voluntary Children’s Organisations

Some of these organisations ‘adopted’ the Guidelines wholesale by importing the whole of the Clark Guidelines; others (who nonetheless adopted the recommendations wholesale and set up the relevant procedures) in addition set about producing their own versions of the

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<sup>32</sup> This statement establishes beyond doubt that the Under-Secretary was aware of the actual nature of (i) the core objection to the MSbP Guidelines (ii) the core problem with the MSbP diagnosis. This analysis corresponds to the premise animating the Consensus documentation *ab initio*: of Ministers moving in one direction and Whitehall (the Ministers’ servants) moving in another. See page 19.

Clark Guidelines. Devon, for instance, produced a digest, as did East Sussex (7 pages); and so on.

In the process of dissemination, the next level of foreseeable mutation occurred.

### **FUTHER DEGRADATION**

On release, the concept of MSbP underwent an additional series of marked deteriorations:

#### **Downward Impulse 1: False prominence**

Distribution of the Clark Guidelines promoted MSbP etc from its actual status as a rare and interesting anomaly to new and unmerited pre-eminence: as a primary and commonplace source of physical (and emotional) abuse.

#### **Downward Impulse 2: Further Dilution / ‘dumbing down’**

The concept of MSbP (which had already undergone near-infinite degradation inside the cloisters of the DoH) underwent an additional process of intellectual dissipation during its release to multiple thousands of professionals and their ancillaries.

The net effect was to remove MSbP-type disorders from any serious link with medical disciplines. In the place of pathology, a new and indeterminate concept was imported via the language of therapy and feelings.

Extreme local interpretations were applied to the centrally-originated Guidelines - which were themselves already extreme. In the course of this ‘double-whammy’, the notion of diagnosis evaporated almost entirely. In its place a new Social Services orthodoxy was encouraged amongst caseworkers:

- ‘see’ a sick child
- ‘think’ an abused child

#### **Downward Impulse 3: Further Extension**

The untoward process of degradation was compounded by a final aggravating feature.

The MSbP-type conditions had started life as a rare curiosity in the hands of Doctors Meadow and Southall as a medical phenomenon: disturbed parents damaged their children. This was a matter for the Department of Health.

But, as time elapsed, so these same children grew up - and went to school to acquire an education. So the educational problems created by the real disorders of these children spread to another department: the Department for Education and Skills - which, by its

nature, was further removed from the source of the problem (health) and closer to its physical location (education, i.e. schools).

The result was a massive and unproductive expansion in terms of Guideline-based training and responsibilities in a context all but voided of significant health-based components.

Parents seeking special educational support for their children, or residential schools, or the Disability Living Allowance, were more likely to find themselves under investigation for abuse

Taking these elements in turn:

## 1. DEGRADATION BY FALSE PROMINENCE

Many of the various agencies under a duty to adopt the Clark Guidelines added their own 'topspin'. By way of example - and the wording below is absolutely standard - the London Borough of Hillingdon issued a guide for parents on its website ([www.hillingdon.gov.uk/care/childsafety/protectionenqs.php](http://www.hillingdon.gov.uk/care/childsafety/protectionenqs.php)):

### **“Who is this guide for?”**

You are probably reading this guide because someone has told Social Services that you may be having problems caring for your child. You might not be having problems, but a professional is concerned that something is wrong. Either way, you may be feeling scared, angry, upset or all three! We hope this guide will help you do something positive with these feelings.

The document then asks, “*What sort of ‘significant harm’ are professionals worried about?*” The answer is: “*There are four ways in which adults can put children and young people in danger of abuse and major harm.*” Each of these four ways is described. One is ‘physical abuse’. Under this heading, the London Borough of Hillingdon’s Guide reads:

### **Physical abuse:**

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, harm, or otherwise causing physical harm to a child.

**Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child they are looking after. This situation is commonly described using terms such as fabricated or induced illness.**

Bold Added

At a stroke, the extreme rarity of MSbP attained equal-top-billing as the pre-eminent cause of physical abuse, subject to the proviso (already detailed in the Guidelines themselves) that its presence could be inferred on the basis of normality. Similar documentation was rolled-out to hundred(s) of thousands of professionals across Britain.

## 2. DEGRADATION BY FURTHER DILUTION

### A: In the World of Officialdom

The concept of MSbP, disseminated to hundred(s) of thousands of practitioners as a major cause of child abuse, now underwent a further downward lurch.

Below are verbatim extracts from a five-page document entitled “*Kent Child Protection Committee - Safeguarding children in Whom illness is Fabricated or induced*” (approved by KCPC on 26 January 2004). The document may be viewed at [www.kcpc.org.uk/sup\\_procedure](http://www.kcpc.org.uk/sup_procedure). It specifically cites various ordinary childhood ailments which are said to be possible indicators of child abuse.

Para 2.1 specifies that investigations must be carried out without the parents’ knowledge; and hence, without an opportunity to comment on the allegations, defend themselves or explain things (Bold Added) <sup>33</sup>.

#### **2. Procedures**

***2.1 The most important principle in dealing with issues of suspected induced or factitious illness in children is the necessity of multi-agency co-operation in information gathering and planning, and the exclusion of the parent from the knowledge that this process is going on until the initial investigation stages are complete.***

*Although this exclusion of the parent is contrary to the spirit of working in partnership with parents that is enshrined in the Children Act 1989 it is recognised by the Department of Health in their supplementary guidance contained in “Safeguarding children in whom illness is fabricated or induced” .*

***2.2 If fabricated or induced illness is suspected, a referral must be made to Social Services.***

Caseworkers are enjoined not to believe the parents:

#### **3. Practice guidelines**

*Be prepared for the carer to present as very plausible and well informed as to the nature of the child’s medical problem.*

Finally, caseworkers are specifically enjoined to consider MSbP as a real possibility for a spread of normal and innocent occurrences, including:

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<sup>33</sup>The net result is that the parents are admitted to the first Child Protection Conference to find that reports on them (prepared without reference to them) are already complete and that they face a *fait accompli* enshrined in official reports. See Footnote 24.

- running a temperature
- asthma
- allergies
- applications for the Disability Living Allowance

Quoting verbatim from the Kent Guidelines:

**“5. Presentations in which induced/fabricated illness may be a possibility**

- *Failure to thrive (sometimes through deliberate withholding of food).*
- *Fabrication of medical symptoms, especially where there is no independent witness:-*
- *Convulsions*
- *Pyrexia (high temperature)*
- *Cyanotic episode (reported blue tinge to the skin due to lack of oxygen)*
- *Apnoea (stops breathing)*
- *Allergies*
- *Asthmatic attacks*
- *Unexplained bleeding (especially anal or genital or bleeding from the ears)*
- *Frequent unsubstantiated allegations of sexual abuse, especially when accompanied by demands for medical examinations*
- *Frequent accidental overdoses (especially in very young children)*
- *Failure of a child to respond to treatment which should assist their recovery (carer may be obstructing drips or tampering with medication)*
- *Non-attendance at school, even when medical explanations for absence are provided*
- *Applications for financial help, e.g. Disability Living Allowance or other services e.g. residential special school that depend on proof of severity of child’s medical condition”*

**B: Supplementary Degradation by non-official Auxiliaries**

Various out-house agencies and individuals soon established themselves as Course Providers, trainers, and authorities on MSbP. Their remit was to train Social Service staff.<sup>34</sup>

To take one example from many, a Caroline Archer (who appears to have no professional qualifications other than being ‘a member of Adoption UK’) runs courses and seminars on the problems commonly experienced within the world of adoption and fostering.

The possibility is (see *post*) that these sectors are in part driven by the inflow of MSbP-children removed from their parents on the basis that their real conditions are imaginary.

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<sup>34</sup> The Guidelines specifically provide that staff should be ‘trained’ in the Guidelines: 6.69 “Inter-agency training should complement the training available to staff in single agency or professional settings. It should be an effective way of promoting a common and shared understanding of the respective roles and responsibilities of different professionals set out in Chapter 4 and contribute to effective working relationships. 6.70 Training should be available at a number of levels to address the learning needs of different staff...Decisions should be made locally about how the stages are most appropriately delivered in respect of fabricated or induced illness in children and this should be part of the ACPC’s training strategy.”

Caroline Archer's publication, *'Making Sense of Attachment in Adoptive and Foster Families'*, is widely used in the training of social workers and child protection teams. Her title, *'Next Steps in Parenting the Child who Hurts'* ISBN 13: 978 1 85302 802 1 was first published in 1999. It is now in its sixth impression.

The common theme of these works is that perhaps the entirety of children's medical symptoms are non-medical in origin and may be ascribed to 'attachment disorders' and the like, including trauma inflicted by the parents.

Page 52 of *Next Steps* dismisses the whole run of MSbP-type medical disorders, and the whole subject of differential diagnosis, in a single sentence:

*"Please try to bear in mind that the common link between every one of these diagnoses may be the effects of repeated early childhood trauma on attachment and development"*

The 'these diagnoses' which are dismissed in favour of an emotion-based template includes a score of conditions, such as:

*"Developmental disorders, attention deficit disorder, post-traumatic stress disorder, obsessive compulsive disorder, conduct disorders, emotional and behavioural difficulties, borderline personality disorder, anti-social personality disorder, anorexia, bulimia, major depressive disorder, mild depression"*

This approach typifies a general approach now promulgated beyond Social Services into the multi-disciplinary world of Child Protection Committees and thence into their various auxiliaries. Misconceived theory consigns ailing children to a false model of 'disrupted early attachments' rather than the correct diagnosis of medico-developmental disorders.

The underlying idea (commonly contradicted by actual case outcomes) is that the children should get better on principle when removed from their parents. This is how the Social Services workforce is now trained.

### **SECTION THREE: A STATISTICAL OVERVIEW**

Figures are not kept for the number of MSbP-type allegations; the nature of the published figures is less than comprehensive.

The best that can be done is to sketch out the major areas of disquiet<sup>35</sup>.

#### **1. The total number of referrals of children for all reasons**

In 2003 there were a total 570,220 referrals to Social Services.

Each of these referrals would tend to involve two parents, giving a round figure in excess of 1,000,000 parents per annum undergoing investigation by Social Services.

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<sup>35</sup> Figures for this section are taken from the DoH website, *Children looked after in England*, [www.dh.gov.uk/publicationsAndStatistics](http://www.dh.gov.uk/publicationsAndStatistics)

It would seem that (see below) some 95% of these cases do not result in a child being placed on the 'At Risk' register. Where MSbP and its cousins are involved, each referral is an innately damaging and terrifying process from the outset. For the parents, the essence of the Child Protection dialogue is:

**either** to satisfy Social Services that a child who they know to be ill *is* in fact ill, by justifying every trip to the doctor and by providing evidence on every upset; no matter how minor; and to do so in the context where (i) this route risks removal of their child (ii) the mindset of the Social Services is not to believe the parents

**or** to retrench, 'admit' that they are wrong, and stage a show of more 'positive' attitudes in proof of their 'altered thinking'; and co-operate by attending Parent Education Classes and/or submit to whatever other regime the Social Services impose.

This latter is very likely to include a stop on taking the child to the doctor and/or hospital (with the standard *sequellae* if in fact the child is not well).

## **2. Initial Assessments**

In 2003, some 264,000 of these 570,22 referrals progressed to the stage of an "Initial Assessment".

It is at the stage of Initial Assessments that the marked stress to which parents are subjected undergoes exponential increase. Common and foreseeable results (termed the 'continuum of damage') include: inability to work, financial problems, housing problems, emotional problems, marital problems, development of illnesses and suicide.

Initial Assessments should, in consequence, only be undertaken for good cause.

Initial Assessments are implements of familial destruction.

Under the MSbP Guidelines, the Social Services are encouraged to undertake Initial Assessments on caprice. Ninety per cent of these Initial Assessments do not lead to a child being placed on the At Risk register<sup>36</sup>.

## **3. The total number of Core Assessments**

In 2003, there were 55,700 core assessments.

By this stage, a decision has been taken not to take any further action on 90% of the referrals, which have been dismissed at a high social and personal cost.

## **4. The number of children on the At Risk register**

Following a core assessment, 26,600 children were put on the At Risk register in 2003, with a significant chance of being taken into care.

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<sup>36</sup> Placement on the At Risk register is, under the MSbP Guidelines, not an indication that the child is at actual risk. The Guidelines enable and encourage this penultimate sanction in the absence of anything untoward.

This figure represents 24 per 10,000 children under 18 on the At Risk register for all forms of abuse.

The Department's figures<sup>37</sup> of 1-in-a-million incidence (per head of population) for MSbP suggest that the total number on the At Risk register nationwide for MSbP-type conditions should be around 50 children.

The total number put on the At Risk register each year (for all sources of suspected abuse) is 500 times higher. The total number of referrals (for all sources of suspected abuse) is 10,000 times higher.

Key issues include the total figure on the At Risk register for MSbP-type disorders.

The Department does not have a breakdown of these figures.

It is only possible to proceed by the broadest of indicators.

### **5. The Proportion of Children who may have been treated as MSbP-type cases**

Typically around 38% of the children who have been taken into care can probably be excluded from MSbP-type disorders. Official figures categorise these cases as falling within the proper areas of Social Service intervention, such "Families in Acute Distress", "Parents' illness or disability" or "Absent Parents".

The rump, or 62%, fall under the generalised heading of 'Abuse and Neglect' capable of containing the MSbP contingent.

Thus in 2004, 62% of the 61,000 children who were then in care had been classified as the victims of 'Abuse and Neglect' - making for some 38,200 children who could, or could not, have been placed in care for MSbP-type disorders.

In a broadly similar pattern, 24,600 children were taken into care for the year 2004. Of these, some 11,800 children (or 47%) again fell under the general category of 'Abuse and Neglect' capable of containing the MSbP caseload.

### **6. The Core Statistical Questions**

The questions are, for the 'Abuse and Neglect' children, either in care or 'At Risk':

- how many of the 38,000 children in care are there for MSbP-type conditions?
- how many of the 11, 800 put on the At Risk register p.a. are for MSbP-type conditions?

Questions for the antecedent figures are:

- how many of the 570,000 referrals p.a. are for MSbP-type conditions?
- how many of the 264,000 Initial Assessments are for MSbP-type conditions?

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<sup>37</sup> See page 38.

- how many of the 55,500 Core Assessments are for MSbP-type conditions?

The legitimate MSbP-component within these figures would, on the Department's figures, appear to be in range of 50 cases per annum – maybe more, maybe less – or, say, somewhere between one-thousandth and one ten-thousandth of the overall throughput.

## 7. Broad Indicators

The indicators for the actual number of cases treated as dangerous MSbP-type cases can be considered under three headings:

- Guesstimates
- Official Pronouncements
- Suggestive Official Figures

Each is considered in turn.

### Indicator 1: Guesstimates

Qualified practitioners working in this area who are conversant with the deficit in the MSbP-type profile use terms in the spectrum of 'significant', 'substantial' and 'commonplace' to convey their feeling of the size of the MSbP-type intake. In the broadest of terms, this might embrace overall percentages in the region of, say, 10%-50%.<sup>38</sup>

### Indicator 2: Official Pronouncements

Official thinking would seem to run on the unexceptional line that multiple thousands of cases could be involved. In the wake of the 19 January 2004 Cannings Appeal, pronouncements to this effect were made by the Minister.

At that time, it seemed as though the whole of the MSbP-area would be opened up for review.

A particular problem for the family justice system was that Professor Meadow, as he now was, had been involved in a sequence of three major cases (Clark, Patel, Cannings) in each of which his evidence was found wanting; in that it consisted not of realistic medical assessment but of unscientific dogma.

There was a concern both about the limited number of cases in which Professor Meadow had been involved personally, and the much higher number of cases in which Professor Meadow's thinking had been involved.

This latter embraced the MSbP / FII doctrine, with which Professor Meadow had always been credited and which had in any event (as previously documented) been under suspicion

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<sup>38</sup> If these guesstimates are correct, the MSbP-type intake could exceed its actual MSbP component by factors involving more than one zero.

long before the dramatic sequence of high-profile cases brought his reputation into question. There was, too, an additional element speedily recognised by the media.

In criminal cases, it might be that the effect of misleading evidence emanating from Professor Meadow and his thinking would be minimised by the high burden of proof ('beyond reasonable doubt'). In civil cases brought under the Children Act and heard in the Family Division, no such safeguard applied: 'the balance of probabilities' sufficed. In criminal cases, defective evidence might be weeded out; in civil cases, the chance of correction was much lower, with an attendant risk of a high proportion of miscarriages of justice for a far-higher numerical caseload.

Quoting from the 19 January 2004 Judgement in the Cannings case:

"The flawed evidence [Professor Meadow] gave at Sally Clark's trial serves to undermine his high reputation and authority as a witness in the forensic process. It also, and not unimportantly for present purposes, demonstrates not only that in this particular field which we summarise as "cot deaths", even the most distinguished expert can be wrong, but also provides a salutary warning against the possible dangers of an over-dogmatic expert approach."

This 'salutary warning' about the 'flawed evidence' of Professor Meadow led to media calls for reviews into possible miscarriages of justice. In criminal cases, the Attorney General announced a review of 278 cases on the day of the Cannings judgement.

In the far more numerous civil cases, where the lower burden of proof made for a greater chance of error, the Minister – as reported in Hansard – was soon talking in terms of multiple 'thousands' of cases which might have to re-opened (See Endnote<sup>v</sup>).

The notion of the possibility of many 'thousands' of misdecided cases, held out by the Minister, tallies with:

- the guesstimates from qualified sources on the likely scale of the misadventure
- intrinsic likelihoods arising from the flawed Guidelines and their wide dissemination

### **Indicator 3: Suggestive Official Figures**

Official figures disclose high regional variations for the incidence of child abuse.

The figures are tantamount to a suggestion, which is hard to credit, that people in some counties are dozen(s) of times more likely (and maybe much more than that) to be child abusers than in others.

A more probable explanation might be that, in certain areas of Britain, the MSbP hypothesis is disregarded – whereas in others, it is taken as gospel and applied with zeal. Since the MSbP theories are capable of yielding an inexhaustible harvest of supposed child abuse, the results of these divergent approaches would produce widely divergent figures.

This is the actual pattern.

Here are some 2003 figures for the number of Initial Assessments undertaken by region:

Bucks:	540
East Sussex:	1,835
West Sussex:	5,295
Kent:	12,510

The variation by region, adjusted for the size of the population base<sup>39</sup>, is by a factor of 10.

Pages 48-49 are worth re-visiting with regard to the figures from Kent.

Similar fluctuations are observable at every stage of the process. Thus the rate at which 'referrals' are pursued also varies by at least a factor of ten. Similar variations are discernible for the number of Section 47 assessments undertaken (where there is significant harm or the 'likelihood' of significant harm)<sup>40</sup>:

Regional variations – say, of the order of 10 or more – might be repeated at every stage of the chain – with say, one region receiving a lower numbers of referrals; and each referral leading to a lower likelihood of an Initial Assessment; and each Initial Assessment leading to a lower likelihood of a Core Assessment; and so on. Thus the tenfold variation apparent on the face of the figures could conceal differences greater by several orders of magnitude, perhaps attributable to the rigour with which the defective Guidelines are pursued.<sup>41</sup>

These figures also provide an accurate indication of the amount of needless familial distress inflicted, region by region, by the Child Protection sector.

The figures for the total number of children in care has risen year on year – from 49,500 in 1994 to 61,100 in 2004. This may, or may not, be what one would expect from a society of steadily-increasing prosperity and education; it may, or may not, be precipitated by a progressive redefinition of normality as a criterion of child abuse.

<sup>39</sup> For the mathematically inclined, the 2003 populations are: Kent: 1,599,000; West Sussex, 755,000; East Sussex, 744,000; Bucks, 688,000

<sup>40</sup> DoH figures, Para 3.6. *Nationally, 46 % of referrals lead to an initial assessment. At a local council level however, reported figures show considerable variation including two councils below 10 % which suggests that the vast majority of referrals did not lead to assessments) to five councils with 100% (which suggests that every referral to an initial assessment).*

DoH figures, Para 4.11. *Individual local authority figures show great variation [for the number of Section 47 assessments undertaken], from 11 per 10,000 for one council to over 200 per 10,000 for 4 councils. Such extreme variation may be the result of difference in collection methods or interpretation of guidance...*

<sup>41</sup> Thus Kent receives (2003) 12,510 referrals; of which all 12,510 proceed to initial assessments; whereas Buckinghamshire receives 2665 referrals, of which 540 proceed to an assessment; and West Sussex receives 10,945 referrals, and undertakes 5295 assessments.

A sample of specimen case studies, showing how the MSbP guidelines work in practice, is included in the Appendices.

### **A DARK SECRET?**

It is the persistence of ‘intransigent’ parents (who refuse to back down and ‘admit’ that their child is well) which is liable to trigger a Protection Committee’s concerns that may end in removal of a child. Hence:

- removals can happen to children who have a *bonafide* illness<sup>42</sup>
- once such children are taken into care (on the basis that their symptoms are imaginary) the symptoms arising from real disorders will persist<sup>43</sup>

The question of what happens to these children, when in care, acquires compelling interest when considered in conjunction with the sub-set of these children who are subsequently put out to adoption.

### **Full Disclosure**

Each year, some 6% of those taken into care are put out to adoption (the figure for 2004 is 3,700 children).

When these children are advertised for adoption, it is a convention that full disclosure is made of any relevant medical conditions and behavioural disorders. To do otherwise could invite litigation.

Hence a possible pattern for children taken into care, who progress to adoption, would be:

- children taken from their parents on the (mistaken) grounds that the child is well
- these same children advertised for subsequent adoption by Social Services as:
  - (i) suffering from the condition the Social Services said they did *not* have
  - (ii) suffering from the *same* condition which, when claimed by their child’s parents to be real, warranted the child’s removal on the grounds that it was false

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<sup>42</sup> The scale of the problem is presumably of not less than hundreds of wrongful removals p.a.

<sup>43</sup> A potential for official duplicity may hang on this point.

A key component of a successful application to take a child into permanent care is likely to be the proposition that, once the child was removed from the (supposedly) abusive parents, the child recovered. This is a solidly-stated criterion for MSbP in the RCPCH guidelines. Hence averrals to this effect form a regular part both of the court case itself and of the preceding operations of the Child Protection Committee.

The adoption advertisements discussed later in the Section suggest that, in fact, children who are subject to such ‘clean bill of health’ statements from officialdom may in fact have had continuing problems of which officialdom was aware.

## The Adoption Advertisements: A Possibility of Wrongful Removals?

The specialist magazines which advertise children for adoption suggest that this unhappy lapse may occur.

The two lead magazines in this field are *'Be My Parent'* and *'Children Who Wait'*, both published monthly, both restricted circulation. A number of children have been advertised for adoption with indications in the text:

- (i) that they suffer from the type of disorders which the MSbP Guidelines regard as imaginary / symptomatic of abuse / a reason for removal
- (ii) that the children really do suffer from those same conditions
- (iii) that the children *still* suffer from those conditions notwithstanding the removal

Several such suspect advertisements sometimes appear on the same page of these magazines<sup>44</sup>. There are typically half-a-dozen advertisements per page with say, 100 words of text and a photograph of the child.

This section of this document considers a few examples from these magazines of particular children advertised for adoption, starting with an advertisement in *Be My Parent* in April 2004, for a girl, born in January 1998. The advertisement says:

*"Following early experiences, B finds it difficult to form trusting attachments"*

In addition, the advertisement notes:

*"Her new family would need to be understanding and patient and able to accept ongoing support. Although she does flit from one activity to another, B's concentration is improving"*

In other words, here is a child believed to suffer from an 'attachment disorder' – which is, as previously described, an unrecognised non-medical attribution of the type caseworkers are urged to 'diagnose' when confronted by a child displaying the symptoms of, say, Attention Deficit Disorder.

Thus parental protestations that the child actually suffered from ADD might have led to removal of the child – who, as the Advertisement now concedes, the authorities now seem to accept, suffers from... ADD.

The same page of the same edition of *Be My Parent* features another child, born in 1999 and apparently removed from the parents in similar circumstances:

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<sup>44</sup> It is possible that some of the children may have been given up voluntarily for adoption rather than being forcibly taken away. The official figures are that some 10% of children are voluntarily surrendered into care. This figure may perhaps be on the high side by virtue of *force majeure*, with some 'voluntary' adoptions achieved on the basis that the parents have to volunteer or face the consequences.

*“Following early experiences, she finds it difficult to form trusting attachments with adults.”*

However, it again seems that, despite being removed from her parents, the child’s difficulties and/or organic problems have persisted. She is now aged six:

*“Her new family would need to be understanding and patient and able to accept ongoing support... She is developing interactive play with help from adults. Her concentration is also improving.”*

So, again, there is still something not right with the child – even though the child is beyond the reach of any harm thought to emanate from her parents. The child’s difficulties, which are now admitted, could have been (this is no more than a possibility) the cause of removing the child from the blood-parents - on the supposed grounds that the child did not in fact have these genuine difficulties.

The same page of the same magazine features another child. This time, the element of the *faux* ‘attachment disorder’ is absent. All that is apparent from the advertisement is that the child has learning difficulties - of a type which, again, may or may not have warranted removal under the MSbP guidelines:

*“He is bright and alert, with a lively imagination and a good memory, but receives extra help at mainstream school to help him concentrate.”*

The discredited phenomenon of Shaken Babies is no stranger to these adoption magazines. Here is a boy, advertised in June 2005 (dob May 2004):

*“X sustained an injury with shaken baby syndrome at one month old. He has cerebral palsy and global developmental delay”*

This particular child is under an Interim Care Order, suggesting that Social Services may not as yet have full legal rights over a child who they have advertised for adoption.

In the same edition is another boy, born June 2002, with another confident attribution of the dubious Shaken Baby syndrome. Apparently, the child was:

*“shaken as a baby, which has resulted in some brain damage. He has been diagnosed with cerebral palsy and has some developmental delay.”*

The cerebral palsy will be real. The symptoms misattributed to the Shaken Baby syndrome can arise in any one of a number ways excluding parental culpability and including e.g. adverse reaction to medication or vaccination<sup>45</sup>.

The same edition also advertises a child, born in March 2003 who ‘has some mild features of Autism’. Autism is, again, the type of disorder which can lead to removal under the MSbP Guidelines on the grounds that its symptoms result from abuse and / or are imaginary.

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<sup>45</sup> VAERS Data Sheets to this effect are available.

An advertisement from the February 2005 edition features a girl born in April 2003. She too - despite being offered for adoption - is under no more than an Interim Care Order. She suffers from symptoms readily classifiable as the ‘failure to thrive’ frowned upon in the MSbP guidelines. She was *‘born prematurely and experiences some difficulties with feeding and subsequent weight gain’*. It will be borne in mind that premature birth can fall within the cited indicators of MSbP, as are difficulties with feeding and / or weight-loss.

Removal of the child from her parents has not, apparently, brought about the anticipated reversal of the child’s difficulties<sup>46</sup>.

The March 2004 edition of *Be My Parent* advertises two sisters, born December 2002 and December 2000. The eldest was taken into care *‘after experiencing accidental and non-accidental injuries in her birth family’*. These injuries might, or might not, have fallen into the category of innocent medical symptoms misinterpreted as manifestations of abuse by Social Services, perhaps acting on principles adumbrated in the Guidelines.

In the circumstances where one child is taken, it would be customary for Social Services to consider taking into care any siblings to prevent their also falling victim to abuse (whether real or imaginary) from the same source. In this case, the younger sibling is said to demonstrate *“projectile vomiting after feeding”*. This symptom can be caused by any one of a number of medical conditions, including reflux (GORD); it is also one of the supposed MSbP indicators. In addition, the child *“has some developmental delay”* - commonly and wrongfully ascribed to parents by virtue of MSbP-type conditions. Again, these conditions have persisted after the child’s removal from the parents.

On the opposite page, in the same edition of *Be My Parent*, is a child born in April 1999 who is described as *“diagnosed as having autistic spectrum disorder”*. This, again, is the type of disorder liable to lead to improper removal under the Guidelines on the basis that in actuality the child is well<sup>47</sup>.

This same page advertises another child, born in January 1998, with *“cerebral palsy and developmental delay.”* Undiagnosed symptoms of cerebral palsy (and it is not easy for Social Workers with no medical training to make accurate medical diagnoses) could trigger wrongful removal under the MSbP guidelines.

The October 2003 edition of *Be My Parent* advertises twin brothers, taken into care *“following early lack of care and boundaries”* in 2001. Despite being taken into care and

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<sup>46</sup> The intellectual refuge of Social Services in this extremity is commonly to take the line that persistence of the problem indicates the ‘long-lasting’ effects of abuse.

This position - which may perhaps appear opportunistic to more cynical readers - will be the reverse of the footing on which the original application was mounted, namely, that removal from the parents *would* make the child well. Hence, to argue this counter-point at the original application might end the prospects of the application’s success.

<sup>47</sup> There is no particular reason for children to be adopted merely because they are autistic. Given a chance, parents can and do care for such children at home.

removed from their parents (which should, under the Guidelines, have led to the children's recovery by elimination of the causative abuse by the parents) the children still have "a current need for attention". Interestingly, both been "prescribed medicine for ADHD" – being a condition which could have precipitated their removal on the basis that the ADHD symptoms actually arose from abuse and/or neglect.

This same edition of *Be My Parents* also advertises a girl, born in May 1998, who suffers from 'developmental delay, particularly in social and communication skills... her developmental difficulties probably result from a mixture of her past experiences and her intrinsic communication difficulties.' An alternative explanation might be that her 'communication difficulties', now admitted as intrinsic at least in part, were formerly dismissed as extrinsic; and that the child was wrongfully removed on these grounds.

The September 2003 edition of *Be My Parent* advertises a child (dob January 1996) who "watches other children rather than interacts". Apparently "he has autistic tendencies and associated developmental delay". This child, put up for adoption, is also under no more than an Interim Care Order.

A refusal by the authorities to concede the child was autistic could (or could not) have led to the child's original removal from his parents. The April 2004 edition of *Be My Parent* advertises another boy, born in 1994, who is again the subject of no more than an Interim Care Order. The child "can appear introverted, but his communication skills are improving". He needs "additional support for his special educational needs... His asthma is well controlled." The reader is referred to page 48 hereof for the Kent Child Protection guidelines and their stricture on *asthma* as a telltale of abuse.

The advertisements singled out above are representative of a general trend.

### **An Acid Test**

All of these removals may of course have been perfectly proper.

It is no more than a possibility that some of these children may have been wrongfully removed from their parents on the grounds that their disorders were fabricated or induced.

It is not open to Consensus to test this hypothesis. But it is open to the DfES to test it.

The advertisements for adoption are anonymised. Consensus is not in a position to identify the parents of these children in order to establish the circumstances of their children's removal. The DfES is under no such constraints. A sample, say, of 100 children can be taken; and from these, those who appear to suffer from bona-fide disorders can be separated out; and, for these cases, Social Service records can be accessed to see if the children's removal was accomplished on the twin grounds:

- that Social Services said the child was well
- that the parents said the child was ill - with the condition which is now admitted

**PHASE FIVE: DAMAGE-LIMITATION?****2004-5**

*The Cannings judgement of 19 January 2004 (following as it did on the Clark appeal and the Patel acquittal) led to calls for a review of cases in which Professor Meadow had been involved.*

*The concerns were not confined to the relatively low number of cases in which Professor Meadow had been personally involved; they properly extended to a re-examination of cases which might have miscarried through the influence of Professor Meadow's thinking (of which MSbP and FII were an acknowledged part)*

*The terms of the review into criminal cases were set by the Attorney General. Two hundred and seventy eight suspect criminal cases were identified.*

*The terms of the review of the **non**-criminal cases (where Professor Meadow's influence had been numerically far more important) were set by the DfES, where Mr Bruce Clark now worked.*

*On 24 February 2004 Mr Clark issued a departmental circular which had the effect of limiting the review process of the non-criminal cases to figures which may be at or around zero. Accordingly there has been no review either of Professor Meadow's influence on civil cases or of the resultant miscarriages of justice.*

*A consequence is that, if there is systemic error arising from the Clark MSbP Guidelines, this error continues in operation; with new miscarriages of justice created on an unabated scale.*

**Context**

The Cannings judgement of 19 January 2004 contained references to the evidence of Professor Meadow. Comments from the bench were, to a large degree, carefully-guarded<sup>48</sup> and confined to broadly delineated observations about the limitations of expert knowledge, the dangers of an over-dogmatic approach, and the need to examine cases from an appropriate starting point.

Particular care was taken to highlight the dangerous nature of starting from the wrong assumption in an area where there was conflicting medical opinion and limited knowledge.

Given the highly-publicised background (where a sequence of three cases had, in the course of one year, showed that that the evidence of Professor Meadow was suspect) there was a high public expectation of a review process.

In criminal cases these expectations were, to a degree, met. In civil cases – including the MSbP / FII cases – they were not.

<sup>48</sup> This is an appropriate constitutional approach.

## The Cannings Judgement: Options

The nature of the Cannings judgement conferred unlimited discretion upon the DfES as to the nature of any review it might, or might not, undertake<sup>49</sup>. The judgement imposed no duty to undertake a review. Hence the terms of any review of civil cases can be regarded as within the DfES's 'gift'.

Broadly speaking, if there was to be a review of civil cases, it could take one of three lines:

- (i) a review into cases where Professor Meadow's flawed thinking was involved
  - = (i) *re-opening a high number of cases*
  - (ii) *a review of FII / MSbP*
  
- (ii) a more limited review of cases e.g. where either Professor Meadow, and /or his disciples, had given flawed evidence
  - = (i) *re-opening a lower number of cases*
  - (ii) *a review of FII / MSbP*
  
- (iii) a nominal review
  - = (i) *no cases reopened*
  - (ii) *no review of FII /MSbP*

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<sup>49</sup> From the Judgement , para 178:

*The trial, and this appeal, have proceeded in a most unusual context. Experts in many fields will acknowledge the possibility that later research may undermine the accepted wisdom of today. "Never say never" is a phrase which we have heard in many different contexts from expert witnesses. That does not normally provide a basis for rejecting the expert evidence, or indeed for conjuring up fanciful doubts about the possible impact of later research. With unexplained infant deaths, however, as this judgment has demonstrated, in many important respects we are still at the frontiers of knowledge. Necessarily, further research is needed, and fortunately, thanks to the dedication of the medical profession, it is continuing. **All this suggests that, for the time being, where a full investigation into two or more sudden unexplained infant deaths in the same family is followed by a serious disagreement between reputable experts about the cause of death, and a body of such expert opinion concludes that natural causes, whether explained or unexplained, cannot be excluded as a reasonable (and not a fanciful) possibility, the prosecution of a parent or parents for murder should not be started, or continued, unless there is additional cogent evidence, extraneous to the expert evidence, (such as we have exemplified in paragraph 10) which tends to support the conclusion that the infant, or where there is more than one death, one of the infants, was deliberately harmed. In cases like the present, if the outcome of the trial depends exclusively or almost exclusively on a serious disagreement between distinguished and reputable experts, it will often be unwise, and therefore unsafe, to proceed.***

The strictures in this paragraph of the judgment apply with equal force to MSbP / FII. The judgment could, in other words, have been used to launch a review into MSbP; or (as actually occurred) to preclude a review of MSbP.

At the time of the Cannings judgement, it seems that both the public and the Ministers felt that the first option - a full and proper review - was unavoidable (see Endnote v).

### **The Cannings Judgement: Outcome**

On 24 February 2004, Mr Clark (who was, as recited, responsible for the defective MSbP Guidelines) issued a circular which had the effect of shielding the MSbP Guidelines from review.

The Clark circular stated that the actual review would be confined to cases where there was a conflict of evidence between two expert witnesses (see Endnote <sup>vi</sup> for the full text). The relevant passage of the circular directed Local Authorities to “identify all cases where a final care order was made”...

*“In cases where final care orders are in place and the finding of significant harm turned on disputed medical evidence*

*This category encompasses cases where care orders have been made, and are still in place, where the finding by the court of significant harm depended exclusively, or almost exclusively, on a serious disagreement between medical experts about the cause of harm”.*

In these limited and specific circumstances, Local Authorities were directed to “consider, in the light of the judgment, whether there are now doubts about the reliability of the expert evidence.”

### **The Nature of the Review**

On the bare wording of the DfES circular, it might appear as though a review should have taken place into every case in which the MSbP / FII guidelines were involved.

Readers of these pages will be aware that the existence and prevalence of these syndromes, and of their numerous cousins, had been a matter of ‘disputed medical evidence’ since and before the FII / MSbP Guidelines were prepared. The wording of the Clark Circular might seem to be a mandate to go back to the Griffiths Report and undertake the original task from the year 2000 of ensuring that these cases were ‘correctly identified’.

In fact, no such course was contemplated; or understood; or undertaken. Instead, the review was restricted to those cases which turned on disputed medical evidence - in the sense of those cases where two medical experts had argued the case out within the legal process.

If the Circular was worded to create the impression that there would be a review of the MSbP area, this fine-wording ensured that they would not.

### **The Interpretation of the Review Guidelines**

It is unusual for there to be two expert witnesses in civil cases.

The exact proportion of such cases is not known. However, a published letter of 24 June 2004 to the BMJ ‘Rapid Responses’ column suggests that expert evidence may only be the determining factor in 7.5% of the relevant caseload (i.e., 385 out of 5175 cases):

*"Mrs Hodge last week announced the results of the first stage of the care cases review, covering children who have been the subject of care proceedings since 23 February this year. Of 5175 cases involving 9195 children, in only 385 cases did the finding of significant harm depend on expert evidence."*

Having one expert making a material contribution to a case seemed to be rare enough. The requirement for *two* conflicting expert reports, or a dispute over medical evidence, reduced the number of cases for review towards zero or near zero.<sup>50</sup>

Hence:

- there was, at the time of the Cannings judgement, an opportunity to review the deleterious effect of Professor Meadow’s thinking in respect of MSbP-type conditions
- Mr Bruce Clark was responsible for disseminating Professor Meadow’s flawed thinking via a flawed set of Guidelines
- Mr Bruce Clark was responsible for issuing the departmental circular which enabled the anticipated review to be avoided

There are parallels here with the mis-processing of the Griffiths report. In both cases, in the year 2000 and the year 2004, initiatives which would have resulted in the rational evaluation of the “MSbP / FII / Professor Meadow / Professor Southall” hypothesis were deflected; on one occasion, triggering the damage; and on the other, paving over the damage which had been triggered.

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<sup>50</sup> The traditional pattern is that the original referral into the MSbP system, which triggers the Child Protection process, is commonly and mistakenly regarded as an expert opinion of itself for the purposes of justifying the Child Protection intervention. It is no such thing.

Thereafter, an actual expert opinion is not really considered necessary; or, if it is, it will be sought from those who do not consider the possibilities of alternative explanations, i.e. ,hard-line proponents of MSbP.

A common practice is of reports prepared by the Social Services themselves and their ancillaries, with paediatric input a seeming rarity. Frequently, medical input will take the form of a retrospective ‘I agree’ by a medic co-opted to a Child Protection Committee – by which time the misconceived process is out of his/her hands.

Medical reports, when they are provided, may be provided by non-independent medicals salaried by the Local Authority. The pressure to conform (in the emergency deemed to face the child) is of an order that the single doctor on the case may be swayed even in the circumstances where he/she had previously made a contrary diagnosis - for instance, the pathologist Dr Williams in the Clark case. A common mechanism to explain away this contradiction appears to be via an admission that the doctor was ‘duped’ or ‘beguiled’, i.e., deceived by the parents. This formula has the twin advantages of absolving the doctor of blame for the error; while, at the same time, bolstering the diagnosis of MSbP. See also Endnote ii .

The consequences are that old injustices have not been reviewed; and that errors and misjudgements precipitated by the MSbP / FII guidelines continue into the present as a source of new injustices.

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*This concludes the current analysis of Mr Bruce Clark's  
influence on public law Family Law cases.*

*The reader is referred to the companion Consensus documentation for an analysis of Mr  
Clark's influence on private law Family Law cases.*



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## CASE STUDIES

*The following pages set out 14 case studies, some relatively detailed, others in abbreviated format. These case studies are contributed from her own knowledge by Lisa Blakemore-Brown, BSc., MSc., CPsychol., AFBPsS.*

*Lisa Blakemore-Brown is familiar with scores of similar cases - as are other practitioners in this well-documented area.*

*Stories of the type set out here are representative of a broad stream of similar cases. Misadventures of this kind are, in addition, familiar across the country to GPs and MPs – who are as impotent as the general public in their dealings with, and misgivings about, Social Services interventions based around MSbP. The standard Social Service response, when challenged, is less than helpful: it consists of the assertion that the Guidelines (which are not capable of diagnostic breach) have been followed.*

*Many of the affected families belong to a support network. Hence each of these families will tend to be aware of scores of similar cases; and each of the cases known to them will similarly tend to be aware of scores of others. A subclass of disenfranchised and persecuted families, spread across the nation, can be accessed by the interested inquirer.*

*Useful organisational contacts include:*

*AIMS (Association for Improvement in the Maternity Services)  
Autism Research Unit, Sunderland University  
PACE  
PPCUK (Parents, Professionals & Politicians Protecting Children with Illness and Disabilities)  
The National Autistic Society  
The Tymes Trust (and other ME/CFS groups)*

*Individuals with longstanding professional concerns, who may point the inquirer towards similar cases and who have consented to be named in this connection, include: Dr Helen Hayward-Brown, Social Anthropologist, Australia; Luke Beardon, Lecturer, UK; Dr Michael Innis, Haematologist Australia; Charles Pragnell, Social Work Consultant UK and Australia; Jean Robinson, Honorary Research Officer AIMS UK ; Paul Shattock, Pharmacist UK; and Dr Mark Struthers GP.*

*There are also numerous Court Experts of a similar persuasion in every field of working practice, including lawyers.*

## CASE NOTES: ONE

### *Family Background*

Reverend and Mrs A lived together in -shire. Mrs A suffered from epilepsy and a blood condition requiring Heparin which she took during her pregnancies. The couple had five children when Mrs T was falsely accused by Social Services some 8 years ago.

### *Background to Referral*

The family's youngest children, boy and girl twins (A and B) were born prematurely with mild Cerebral Palsy. The little girl (B) required splints on both legs. Both children had early neuro-developmental problems. Given their motor problems, they needed to be 'transported' in their twin buggy for longer than other children. The little boy (A) had speech and language problems, obsessional behaviour and extreme emotional reactions.

A local Educational Psychologist, acting in concert with social workers, embarked upon an extended process of claims that the children did not have the problems which Mrs A reported. The pattern of intimidation and questioning echoed the interrogative methods directed against terrorists. As in other MSBP cases, the innocent mother (struggling to care for 5 children including twins with neuro-developmental disorders) was treated as a liar who was abusing her children. In the view of officials, she had to be broken to 'confess'. Proven health and educational difficulties were waved away by Social Workers. Medical notes were ignored or misinterpreted. The team of accusers were supplemented by a local paediatrician.

The family were forced to remove the splints from the legs of B; and forced to stop using the twin buggy.

The support the children required was stopped. The family lived in fear. As the proceedings moved toward taking the children into care, the parents considered suicide. False allegations, personal insults and threats were routine. The children were terrorised by Social Workers into thinking that they might be taken from their parents.

The family still live with that fear - even though the proceedings ended four years ago. Some four years of harassment preceded the eventual court hearing. The denigration of the family continued in Court – by which time the boy A had been diagnosed with Asperger Syndrome.

At the hearing, the Social Services' barristers asserted that the mother did not have the illnesses with which she had been diagnosed. For instance, they denied that Mrs A had a tumour which was evident on the X-Rays

and described in the doctor's notes. The Judge, who had mastered the file, threw out the case, telling the mother that she could leave the Court 'without a blemish on her character'. As will be seen, this was not the end of the story.

At the end of the hearing, the judge ordered an Inquiry. It was carried out internally. If any fault was laid at anyone's door, the family have never been told. They have never had an apology. A gagging order was placed on the family. This strong and loving family, which was ruined by false MSBP allegations, will not recover from the ordeal.

### *Effects on the Family*

The damage did not stop after the falsity of the allegations was exposed in Court<sup>51</sup>. The ongoing use of the 'Read Code', and possibly of other secret codes permanently attached to their files, means that the authorities can doggedly continue to believe that they were right – and behave as though they right. In the view of Social Services, the Judge was duped and the accused 'let off' on a technicality'.<sup>52 53 54</sup> This 'MSBP family' have continued to suffer serious medical problems with no help. Their child A had to struggle and suffer (as have the schools and his family by his behaviour) with the Asperger Syndrome. The system continues to deny the existence of his and his mother's medical conditions, and provides no support. The family are too frightened to fight for their own rights or the rights of their children.

Three years after the Social Service process ended, the parents' eldest daughter died on Good Friday 2004 aged 19 years. She was in the Army and in Army barracks. She had developed headaches two weeks before. She was too afraid to go to the GP for fear of

<sup>51</sup> As a general rule, the exculpation of parents in court simply shifts the (mis)conduct of Social Services from overt to covert.

<sup>52</sup> Professor David Southall never admits he may have been wrong. When challenged by Genevieve Westcott, TV3 New Zealand 1997, who referred to a woman who had her children returned after the Appeal Court through out his allegations, he described this as a 'technicality'. ('Lies, Lies and Diagnoses 20/20 TV3 March 1997)

<sup>53</sup> Professor David Southall was taken to the General Medical Council for claiming, after watching a TV documentary, that Steven Clark, Sally Clark's husband, had murdered their two baby sons. Despite being disciplined for his zealotry and told he cannot be involved in child abuse work for 3 years, he would not apologise and clearly does not consider he was wrong.

<sup>54</sup> Professor Roy Meadow is currently facing the General Medical Council for using a false statistic in the Criminal Court in the Sally Clark case. He continues to infer that he was right and that the babies died of unnatural causes.

re-awakening the spectre of MSbP. She reasoned that the doctors would not listen to her, as per her mother's experience. She collapsed, was taken to intensive care, and died of a brain aneurysm the next day. Her premature death cannot be separated out from the MSbP allegations and the effect of those false allegations.

As part of the MSbP process, Mrs A had been forced to remove G's splints by social workers who had no medical knowledge.

In 2005, the twin B was at last seen by a specialist for her longstanding and officially-denied mild CP. Mrs A was now blamed again – this time for the opposite reason. She was criticised by the specialist not for *taking* B to the doctor – but for *not taking* B to the doctor with the bona-fide problem before (B's feet were turning in).

Unsurprisingly, Mrs A had lived in fear that if she went to the doctors again about twin's problems, the allegations would recommence. When she had plucked up the courage for a previous attempt to mention the problem to a medic who she felt she could trust, she found his letter of referral was headed MUNCHAUSEN BY PROXY in capital letters. Obviously this label would preclude access to proper diagnosis and proper treatment both for her children and for herself – as has happened. The fact that the Court case exonerated her was in small lettering at the bottom.<sup>55</sup>

Mrs A's health has now deteriorated badly. She is confined to a wheelchair with chronic health problems after the neglect of her own health needs over many years. Despite the gross errors and the Judge's demand for an Inquiry, she has still not secured the requisite treatment for herself. What with her MSbP records, she has been left for years with obvious and serious health needs. Last time she came out of intensive care (in 2004) she was told her survival could not be guaranteed next time.

On a rational basis, one might consider that this means the medical team now understand the blood and inner organ condition which runs in her family - which was diagnosed before social workers became involved. In theory, everyone concerned should be aware of the seriousness of her condition. In practice, nothing has been done - despite the mother being told that one kidney was no longer functioning and the other very

swollen. This, notwithstanding the involvement of the MP and the GP.

Attempting to hold the officials accountable has proved impossible.

## CASE NOTES: TWO

*Family Background:* Mother and Father living together in Kent; Mother suffered from depression and had seen a psychiatrist regularly for that depression. She also was on Heparin<sup>56</sup> for a blood condition and took this through both of her pregnancies. Her two children are both girls, currently aged 6 and 3.

The children were placed on the At Risk Register from which they were recently removed after months of despair and fear. The punitive and patronising treatment of the family continues.

The family were able to access various records using the Data Protection Act. These have unravelled a history of official deceit.

### *Background to the initial referrals.*

The eldest child (C) experienced reactions to vaccines. These were well-documented in the medical notes and baby book. C was a clear case of delayed and disordered development. At age 6, C is still doubly-incontinent with recently diagnosed ASD. The paediatrician had also diagnosed her as ASD earlier in her life but did not inform the parents. This was written onto his referral for a Fragile X test.

The family had difficulties obtaining a school placement at their preferred school for C and in getting C a statement of special educational needs. C was eventually given 25hrs 1:1 LSA support because of her double incontinence, speech and language disorder, absences and behaviour problems. The parents' preferred mainstream school was obliged to receive C after a Special Unit placement was turned down by the parents who felt at the time mainstream inclusion would be best.

<sup>56</sup> In both Case One and Case Two, the mothers took Heparin. In Case One, the mother also needed anti-convulsant medication. Both medications (as Professor Meadow himself has reported (*Anti-Convulsants in Pregnancy Archives of Disease in Childhood*, Meadow R 1991; 66; 62-65) have side-effects. These side-effects are capable of being misconstrued as falling within the "MSbP spectrum". It is only necessary to omit the fact of the medication-intake from the file for the case to be misdiagnosed – as happened in both cases.

<sup>55</sup> This minor incident provides an illustration on what happens once innocence is proven. Social Services decline to accept the acquittal. The paperwork is distorted.

Omissions and side-effects of this type (which are not limited to the two drugs involved in these two cases) may account for a common stream of miscarriages of justice - the 'iatrogenic' cases.

After several weeks at the school, where many of C's problems were noted in her school contact book, her class teacher changed and support was gradually withdrawn. The family disputed this withdrawal and eventually started SENDIST Tribunal proceedings against the school to secure the help M needed. Within days of receiving notification of the tribunal - and this is probably the trigger of everything which subsequently occurred - the headmaster Mr G had a meeting with C's Speech and Language therapist and the school SENCO.

The school's position at this stage was that it was applying for more money for C from the LEA. A probability is that this request was denied and that, at some stage and some level, an indication was given that a referral to Social Services might be more welcome. Within two days it was a done deal.

The background to these events was the introduction of the relevant sections of The Children Act 2002 which switched responsibility for the health needs of 'vulnerable children' from the Department of Health to the Department for Education and Skills.

The referral was duly made to Social Services on the grounds that C did not show the symptoms described by her mother.

In fact, the evidence is that all the problems *had* been seen. They were noted in C's contact book. The Headteacher had attempted to gain funding for the requisite support; and the Speech and Language Therapist had recommended a scarce-to-get place within a language unit<sup>57</sup>.

Several secret meetings of the CP 'assemblage' took place. The record shows that lies were told, and that fantasies or suppositions were concocted. Mr G's initial inference of MSbP was reinforced and never challenged. There was never a critical analysis of the facts.

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<sup>57</sup> Here is a potent example of the way the Guidelines unravel normal thought-processes and good practice. These same professionals had (before donning the 'magic spectacles' of MSbP) already arrived at a reverse conclusion - which MSbP promptly erased as though it had never existed.

The official tendency in these cases is either to remove contradictory evidence of this type, or, if this is not practicable, to reason it away on the grounds that the officials were 'duped'. This stance *begins* by *assuming* the *conclusion* which it should *end* by *proving*. It is, accordingly, self-fulfilling; and capable of overturning any evidence to the contrary. It forms an innate part of the cognitive distortions engendered by MSbP.

There are Social Worker notes of five supposed visits to A&E in one week - but no evidence to back this statement. In fact, they did not happen. Actual medical operations on C were deemed to have been imagined by Mrs C because they had been carried out in the private sector; or, in the alternative, these operations were dismissed on the grounds that the surgeons were 'duped'. No attempt was made to contact the surgeons involved. The family are now in possession of letters from both the surgeons involved saying they were never contacted by Social Services and that, in their opinions, the operations were necessary.

Mrs C had approached Social Services herself some months before the initial referral, asking Social Services for help during school holidays. This was an error; it delivered her family in to the hands of Social Services. She heard nothing until a Social Worker made an appointment to see her and the family some two months later. The Social Worker had by then been briefed about the Child Protection proceedings and the supposed reasons for it. It may be that the Social Worker did not attend to offer help for the family but in order to help build a case against them. Mr and Mrs C complained about the tenor of this Social Worker's report when it was presented to them. They could not understand many of the comments; they had had no idea that proceedings were under way against them.

Meanwhile, Mr G had asked for Mr C to be named in the proceedings.

Social Services did not contact or involve the family GP of 15 yrs. They did not seek the opinion of Mrs C's psychiatrist of 12 yrs - except when carrying out a risk assessment a few days before the Initial Child Protection Conference. Both these medical professionals have stood by the family. They have never had any worries about the children's welfare or Mrs C's capacity as a mother.

The letter informing the family that a Child Protection Conference had been called was hand-delivered only five working days before the Conference was due. The letter was misdated to a week before, creating the impression that the family had adequate time to prepare themselves and that the timetabling set out in the Guidelines had been followed. The letter, of which the family had no advance notice, was delivered a time when Social Services knew that Mr and Mrs C were out (Mr C was at work and Mrs C at a school function). Social Services were already aware that Mrs C suffered from clinical depression. They knew she would be alone when she opened the letter.

In the family's Social Work files it is clear that there was reluctance from any of the professionals involved to visit the family to deliver the invitation to the CP Conference or to explain the reasons for it. Dr S, the

Community Health Consultant who had formerly diagnosed autism, now pressed for the Police to be brought into the case.

The family was not given the opportunity to present their evidence either at the CP conference or thereafter. The medical chronology presented at the Conference was inaccurate. It cherry-picked comments from reports to show the family in a poor light and to reinforce the MSbP thesis. The report gave the wrong date of birth for C and shows her sister as having treatment from the GP before she was born.

#### *Catalogue of Shoddy Practice*<sup>58</sup>

1. Timescales laid down in *Safeguarding Children in whom Illness is Fabricated or Induced* have not been adhered to.
2. The Chairman of the Conference has changed twice.
3. A failure to supply documents upon request (one of which was requested by the family and their solicitor seven times).
4. Ignored requests for attendances at meetings by third parties.
5. Failure to respond to written responses to Minutes of the conferences.
6. Vital medical records missing / appear to have been lost.
7. School / LEA reports have not been read.
8. Many promised calls not returned.
9. Professionals late for meetings by half an hour
10. A Core Group Meeting time changed without the family being notified
11. Missing records and other relevant documents supplied by the family ignored.
12. Reports by the same professionals contradict themselves, saying at one time that C has problems and then at a later date saying she has none of the problems.

Social Services have always maintained (in the face of medical evidence to the contrary) that there is nothing wrong with C. The Consultant Community Paediatrician Dr S stated at a later Core Group Meeting that he was foolish to have written a letter asking for C to be issued a Blue Badge; whereas, at the first Core Group he said that C showed many autistic traits. In the Social Service notes, Dr S states that Mrs C shows no signs of 'remorse' and that the Police should be asked to visit her.

<sup>58</sup> These traits are observable as standard in many cases. The underlying pattern is of (i) omitting evidence (and indeed professionals) which/who should be included (ii) distorting the evidence which is included (iii) proceeding by terror (suicides are not uncommon; indeed, it is said to be a sign confirming MSbP).

The family have written evidence that before the proceedings Dr S diagnosed C with Autism. With the passage of time the goal posts changed. The professionals became aware that there really were problems with C. So the problems identified in the Core Assessment changed.

Professionals were deliberately obtuse in their reporting of progress. For example, the school reported that C was now dry – as an indicator of supposed progress. Only after many weeks of argument did the family discover that the so-called significant 'discrepancy' related simply to C going to (i.e. physically walking to) the toilet when asked in school, but not doing so when asked at home. There was no change: C was still soiling at school.

C's grandmother asked Social Services if she could commission a full assessment of C. This was agreed. When the results were presented - showing that C was on the Autistic Spectrum - a further secret meeting was held. It was decided that the school should withdraw permission for the psychologist to observe C in school. Social Services attempted to explain this away on the immaterial grounds they had not realised that it was be a 'full' assessment. They still refuse to accept the professional diagnosis of Autism.

#### *Outcomes*

The children were recently removed from the At Risk Register. Typically, this has brought no remission in Social Service activity.

Social Services continue to be afflicted by an ongoing denial of ASD. But in a school assembly recently attended by mother and grandmother, C sat oblivious of the proceedings (in the characteristic manner of ASD children). She was the only child out of 30 who was not able to participate in individual shows of poem-telling etc.

Behind the backs of the parents and of the incontinence nurse, the school has embarked on its own efforts to prove the Local Authority case. It has become clear that C is being taken out of her 'pull up' nappy at school during the day, and being dressed in normal underwear – perhaps purchased by the school.

The idea is presumably to show that the Social Services and the school were right - by treating this un-normal child as though she were normal. In order to keep up this pretence, the soiled and wet clothing is being washed each day. At the end of the day, and to prevent the parents from finding out what is happening, C is put back in her pull-up on return from school. This creates an opportunity to tell the parents that, since the fresh pull-up has not had time to be soiled, the child is fine in school. This specious assertion can be used to

'confirm' the MSbP diagnosis. It may also explain why the psychologist was not allowed to have access to the school.

C has become more agitated during this time. Her toileting habits are now worse at home. The family are incensed that this pattern of interference has been going on despite their daughter being off the At Risk Register. When the incontinence nurse was asked to find out what was happening, at first she denied any knowledge of the toileting regime; she later confirmed what they suspected. A call between Mr C and the Headteacher fully confirmed it.

In the second meeting attended by the psychologist, the Headteacher made clear reference to the need to take advice from Social Services before making any decisions, including whether the psychologist could go into school to observe M<sup>59</sup>. The Headteacher apologised to the CP Chair for not seeking permission before giving the initial agreement to the psychologist's visit.

Following social work intervention, D (the youngest child) has had her Epipen taken away. She had been given one following an anaphylactic shock when stung by a wasp. It is to be hoped that D does not get stung again.<sup>60</sup>

The extended family, their neighbours and their friends are devastated by these proceedings. No credit is extended to the Social Service's version of events. Many of the family's friends and professional and medical colleagues offered written character references. The family have lived through nine months expecting Social Services to remove the children - without notice and without any method of appeal. The children realised there was something amiss. They became fretful and clingy. Mrs C's mental and physical health deteriorated. Mrs C's mother and father's health have also suffered. Feelings of impotence were increased by Social Services saying that they were not interested in the wider family - only in the children. No end to this story is yet in sight.

### CASE NOTES: THREE

Parents living together in Essex. Eldest child (E) of 3 developed reflux (GORD) and associated autistic traits. He needed to be fed through a feeding-tube.

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<sup>60</sup> Social Workers are now deciding the medical needs and educational needs of these young children. The headmaster is at the Social Service's beck-and-call. Education and Health workers are told what to do by Social Workers. Independents are not allowed to make routine observations.

The local Social Services decided this was MSbP. The family were forced to become in-patients in an Oxfordshire Hospital. CCTV was in operation. The children were told daily that they might not see their parents again.

The mother was pregnant with another child. She was told she would have to have it aborted. E was awaiting an operation for GORD. The operation was denied to him. His autism was denied. Social Services insisted E did not need his feeding tube.

By extreme and concerted exertions from a variety of professionals, the proposed abortion was stopped. Two separate diagnostic teams independently diagnosed Asperger Syndrome. The family was allowed home. E was admitted to another hospital for the fundoplication. A gastro-specialist working for the NHS established that the delays in undertaking the explorations and the operation had caused significant damage to the child's diaphragm.

### CASE NOTES: FOUR

Mother separated from her husband. London.

The child, a boy (F), developed severe autism and a bowel disorder after vaccine. He was under the care of the Royal Free. His mother had a history of psychiatric difficulties but these were held at bay. She worked hard on ABA programmes and a gluten- and casein-free diet with her son. Her ex-husband was a known drug addict; the mother claimed he had beaten her up.

When her own mother died, the mother was overwhelmed by her continuing struggle to cope with a constantly-soiling and autistic son. One day she called the police for help. She asked if her son could be taken into care temporarily as she needed some respite.

The police kept her out of her home and were in her flat for two hours taking photographs. Subsequently she was taken to Court and her son was removed.

The framework of the allegations was MSbP. F's bowel-problems were linked to the mother's supposed inability to know how to feed her son. Ignorance on the part of Social Workers extended to their being unable to understand the culture of serving a roast dinner from the table at Sunday lunch. The observing social worker claimed that the mother was 'trying to feed F a whole chicken'. This was used as evidence of the mother's inability to understand what her son needed to eat.

The psychologist - who challenged the allegations, pleading for more home support - was vilified in turn. Her report was dismissed. The child was removed from the mother and custody given to the father. He has since been charged with GBH toward his current

partner. He is known to still be using drugs. As far as is known, he is not receiving help from Social Services either. The mother has recently lost an Appeal in the Family Court.

### CASE NOTES: FIVE

Single mother, south London and South Coast. Adopted two pre-school children (G and H) with known disabilities. After the adoption, the mother began to realise that she was being suspected of causing the problems from which the children had suffered before she met them.

The pre-adoption notes on these problems - including hearing problems, developmental delays etc - were omitted from the Social Services files. The local medics treating the children were not invited to give a view. Their reports were ignored. When an audiologist read that the Social Workers' documentation alleged that the mother had 'said' child G was deaf and that she had obtained Hearing Aids 'for attention', he was enraged. In a letter, he referred to the 'bright spark' with no medical knowledge who questioned his competence. He had been the one to *diagnose* a hearing problem and *prescribe* hearing aids.

Child H had mild cerebral palsy, recognized pre-adoption. His mother took him to Disability Swimming. He underwent a series of thorough assessments by various sports examiners as a prelude to assigning him to the appropriate category for disability sports.

This was seen as attention-seeking and child abuse (i.e., making the child think he was disabled when - according to Social Services - he was not). H excelled at swimming and won numerous medals and cups. However, H now feels the awards were worthless, and himself too, given the Social Service's position that he had no disability.

Both children have clear autistic traits, H being Asperger. They are now off the At Risk register but there is ongoing denial of the children's educational and health needs.

### CASE NOTES: SIX

Parents living together in Liverpool. Eldest daughter (J) reacted to vaccine with very high fever and a comatose state for many hours. When she emerged from this state she reacted to egg in her custard by violently spitting it out. A date-encoded videotape shows the marked change in J's behaviour pre- and post-vaccine. J developed diarrhea, a dribble, allergies and autistic traits.

The dribble has continued into her teenage years. She also suffered from ongoing bowel problems.

As the mother fought for educational provision for her child, she became aware that she was being treated as MSbP. At every turn she was thwarted from accessing appropriate education for her daughter, whose problems were regarded as 'behavioural'. Autistic traits were vehemently denied. The child herself was also blamed: J was told she had to take responsibility for her actions - but she could not, of course, control her reactions. The Local Authority entirely sidelined her neuro-developmental problems and replaced the description (and explanation) with 'behavioural problems'.

The mother repeatedly lost at Tribunals. Instead, she was encouraged by one Tribunal Chair to lodge a complaint about the psychologist who had by then assessed J. This particular Tribunal Chair had refused to accept the psychologist's report (on the grounds that it was late evidence) suggesting that the child would be prejudiced.

The mother was suspicious of the Chair's motives. She set about finding out who he was. It transpired that he was a solicitor who worked in Leeds, and was linked to St James Hospital via a legal Consultancy group, and had accepted experts from there for decades. This was where Professor Meadow worked and would undoubtedly have known this Chair.<sup>61</sup>

### CASE NOTES: SEVEN

Single mother living on the Isle of Wight; her son (K) had developed reactions to vaccine. As time passed, the mother sought support to help him. When the educational authorities went against her, she made a case to the Tribunal.

At this point Social Services became involved and she was 'encouraged' to drop her Tribunal case. The clear implication was that if she did not, they would become involved. She feared the loss of her child. She dropped her case.

### CASE NOTES: EIGHT

Mother and step-father of child with Asperger Syndrome (L) living on the Isle of Wight.

L developed neuro-developmental problems as a very young child. His mother and step-father have had many years of struggle and near-bankruptcy to find the correct education to support L.

<sup>61</sup> Other cases suggest that independent Tribunal panels are increasingly using the MSbP thinking.

Documents now reveal that there are MSbP-type allegations against the mother despite a very clear autism in the child, diagnosed by a leading academic authority.

This false assertion led to years upon years of no help; and years upon year of struggle to help L and enormous struggles for L himself. He is now beyond school age.

### **CASE NOTES: NINE**

Single Mother of an autistic son (M) in Berkshire. The mother has a history of mild psychiatric problems (anxiety attacks etc). She has suffered enormously from behind-the-scenes criticism. She had to fight cases with social workers and psychotherapists. She lost her home and her daughter N – who suddenly 'disappeared'. She has not seen N for many years. She is racked by grief for the loss of this child. She needs to know what has happened to her daughter. This would entail openness from the system in examining what went wrong. In addition, help for her phobic Asperger son would not come amiss.

Through the Data Protection Act, the mother has now discovered that her son and daughter's health and developmental problems were being dismissed. Instead, they were seen as part of "mother's own needs". The agenda was MSbP.

It seems likely that her daughter was encouraged by Social Services to leave home for her own safety and to never contact her mother again.

The mother and grandmother still wait for the daughter to come back home. They fear that N has been so brain-washed this will never happen. Meanwhile M is not having his educational needs met and is increasingly phobic. This, in turn, is further blamed on his mother.

### **CASE NOTES: TEN**

Single mother in Hampshire. Her son P reacted to vaccines. The nature of her son's problems were queried when she tried to get educational support. P was taken to a hospital and, unknown to her, CCTV was used. Nothing was found, and the child's reflux, bowel impairment and feeding problems were no different when he came out. But the hospital claimed they had 'changed his diet' implying that the mother had been at fault for not feeding him properly.

This case, which is still current, has only just started down the Social Services route. A possible prospect is of years of error, mismanagement and persecution.

### **CASE NOTES: ELEVEN**

Parents living together in Essex, Mr and Mrs S; two teenage sons with Asperger Syndrome. The family fought for educational provision for the boys and won an Educational Tribunal in 1997. The family were praised for their case-statement and the Local Authority was severely criticised. From that point on, the family was refused the support to which they were entitled by law. Over the years, the pressure of having to support the boys without the requisite provision became insupportable.

Mrs S had during that time been diagnosed as mild-Asperger herself by a leading academic authority. She identified a local company which claimed to be able to support AS children. Through her MP she was able to force the LEA to employ this service in order to help her children.

The company used 'neuro-linguistic programming' and, when this failed to help the children, they shifted to a position of making judgments about the parents. In a confidential report prepared for Essex Social services, an unqualified company director concluded that 'Mr and Mrs were consciously or unconsciously using their children own needs'. Subsequent to this report the family were invited to attend a CP Conference, where they discovered that other CP meetings had already taken place without their knowledge. The children were placed on the At Risk register. The day after this happened the mother succumbed to vomiting. She did not inform anyone, regarding this as a consequence of Social Service allegations.

A psychologist became involved, and attended the next conference, as did a MENCAP representative and a solicitor. The usual efforts were made to intimidate the non-MSbP believers; the medical aspects of the case were dismissed without examination; the Local Authority psychologist, when conjoined to the case, saw his role as confined to taking notes.

For the next few months a gradual easing of the family's intimidation occurred as an increasing number of AS experts became involved in the case. The media also became involved. At the end of the year the children were removed from the At Risk register.

However, the children were still not provided with the appropriate support which had been stated seven years previously. The mother had, in this process, lost four stones in weight. She was in considerable pain. In fact, she had cancer. She did eventually go to her GP, but, in the general plethora of misery and anguish, an organic cause of her pain was not suspected. Mrs S was, after all, an MSbP suspect – trying to dupe the doctor into carrying out unnecessary tests.

When a blood test eventually was taken, and the results seen to be clearly indicative of a serious problem, this too was ignored. The GP, who now recognized the seriousness of the condition, was unable to persuade the hospital (still on the MSbP tramlines) to undertake further investigations. Another hospital, attended by Mrs S because she thought she had a back problem, similarly dismissed her symptoms as arising from her own 'perception of pain'. This hospital too would have seen Mrs S's records and her MSbP-provenance.

Mrs S died of her cancer four months after the children were taken off the At Risk register.

### **CASE NOTES: TWELVE**

A single mother living in Hampshire. She had twins, very premature. Typical neuro-developmental problems were dismissed. The children were described by one of the original medical exponents of MSbP as perfectly normal.

The mother was accused of MSbP and all five children were removed by the Family Courts. Social Services pursued the mother to the far side of the globe to prevent her raising children. She has been hounded almost to death.

### **CASE NOTES: THIRTEEN**

Parents living together in Hampshire. The father had two older children from a previous marriage, and the mother one older son from a previous marriage. The baby born to this couple was very small and reacted after the DPT: very high temperature, being sick, going off her food, and ill enough to require hospitalisation. She was sent home a few days later, still without having regained the lost weight, and still very difficult to feed. It is a possibility that the hospital suspected that the child would shortly die.

A day or so later, the father was trying to feed the baby when she became highly distraught and went into a state of collapse. She was rushed to hospital and died there. This happened within 10 days of the DPT vaccine. According to the VAERS Data Sheet, this happens.

Both parents were arrested and had to stay overnight in the police station. After intensive questioning, the mother was released. The father was charged with shaking his baby to death.

Years passed before the case came to trial. Meanwhile the Clark and Cannings cases came and went. Instead of withdrawing the proceedings, Social Services progressed the case. Meanwhile the father was sent to prison on remand: he broke his bail by going to see his new baby (born during these protracted proceedings).

Such was the conflict between experts that, after many weeks, the Judge was obliged to instruct the Jury to acquit. However, once the criminal trial was over, another one began - in the Family Court where Social Services could proceed under the 'balance of probabilities' rather than the higher threshold of 'beyond reasonable doubt'.

The upshot, brought about by Social Services, shows the strong-arming typical of this sort of case. The standard negotiating position of Social Services is that the couple must separate. The "non-abusing" parent is told that, unless s/he concedes that the "abusing" parent presents a risk, s/he will be unable to protect the child; in which case, the couple is seen as 'colluding'.

The clear threat is that a refusal to co-operate will result in taking the child into care. On this scenario, numerous families have been destroyed and homes broken up. This standard pattern was followed in this case. The father has been ousted from his home; the marriage has been destroyed; and the father can only secure intermittent access to the baby born during the proceedings (under Social Service or other agreed supervision) for two hours at a time.

It is manifest that the child's death was of natural or vaccine-induced causes.

### **CASE NOTES: FOURTEEN**

Parents living together in London (Mr and Mrs B). Their son (Q) is an 11-year-old with autism, inflammatory bowel disease and epilepsy (which began after vaccine). Mrs B worked in the local Social Services.

For years the family coped with the child's problems, meticulously working out what Q needed to keep him from pain and what he could eat. They attended the Royal Free.

With the implementation of the Children Act (2002) in the autumn of 2004, the family's lives took a turn for the worse<sup>62</sup>. It became clear that they were being scrutinised about their son's longstanding problems. With new powers under the Act, the Headteacher at Q's school made a child protection referral on grounds of 'the parents use of anal suppositories'.

These had been prescribed by Q's paediatric gastroenterology consultant and GP. On 14 October 2004 the Head stated in a professional meeting with

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<sup>62</sup> The effect of the Act (in the wake of *Climbie*) was to confer additional powers on Social Services, acting in conjunction with educationalists, with regard to health matters.

the parents that his school was no longer appropriate for Q.

To go ahead, in March 2005 the Headteacher would go to a Strategy Meeting to deliver a report on Q's medical condition that made no mention of (i) medical information contained in numerous letters on Q's school file (ii) various telephone calls from medics and parents about Q's condition (iii) an hour-long meeting with Q's consultant paediatric gastroenterologist (iv) several meetings with a paediatric dietician.

*Catalogue of errors and poor practice:*

1. On 19 October 2004 Mrs B went to work at her job in Social Services. One hour later she noticed her son's name on the duty white board in full view of her colleagues. The Director of Social Services later apologised to Mrs B via their MP for the failure to follow procedures for referrals involving staff.

2. The contact sheet on the file says Q's school had made a child protection referral on 4 October 2004. It transpired that, between 4 and 19 October 2004, the Head and Deputy:

- twice raised CP concerns
- twice requested a social worker to attend a meeting of professionals at school
- declined to specify their concerns on five occasions when asked by social workers
- contrary to the protocol on the referral form, did not inform parents
- allowed unspecified CP allegations to hang in the air for 16 days

On 19 October, the day Mrs B saw her son's name on duty board, the Head finally retracted his concerns about the suppositories prescribed by Q's doctors.

3. Despite the record of the contact sheets, which clearly show the Head had made a CP referral on 4 October 2004, and repeated it on 13 October, senior social workers and LEA officers met on 19 October and claimed that the Head had *not* made a referral. Rather, the head had "requested a social worker to attend a professionals' meeting" with parents at school on 14 October.

4. Recommendation 21 of the Climbie Inquiry states: "When a professional makes a referral to social services concerning the well-being of a child, the fact of that referral must be confirmed in writing by the referrer within 48 hours."

5. Mr B complained to their MP about the Head's inappropriate referral. The MP wrote to Directors of

Social Services and the LEA; and, with Mr B, met two senior officers from the two departments on 3 March. The officers agreed to interview the Head and report back to the MP.

5. Following the interview with the officers, the Head was invited to submit a detailed report on the supposed abuse at a Strategy Meeting to be held on 17 March 2005<sup>63</sup>. This was attended by 12 officers of the LEA and officials from the Legal Department, Primary Care Trust and Police.

6. Strategy Meetings are only to be held if there are "suspicions or allegations about child maltreatment and concern that the child may or is likely to suffer significant harm" (DoH/DfES (2000) *Framework for the Assessment of Children in Need and their Families*).

7. Notwithstanding the fact that he had already withdrawn his substantive allegation, the Head was allowed to speak to his report, which produced 21 bullet-points on his issues with Q's medication and suppositories. These issues included the assertion that the mother's feeling that her child's autism might be caused by MMR was suspicious and a justification for the referral (or non-referral).

8. Medical letters and minutes of school meetings were not produced at this first Strategy Meeting. This allowed unfounded suspicions to survive throughout a sequence of the meetings and into the core assessment.

9. The minutes of the first strategy meeting (where no doctor was present) questioned:

- administration of 'unnecessary high level' of prescribed medication, especially anal suppositories
- paediatric gastroenterologist's advice on when to recognise pain and administer suppositories
- Q's medically-approved diet

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<sup>63</sup> In other words, the case gathered momentum rather than losing momentum. It may be - and this is a matter of common report - that the parents' attempt to involve an outsider fuelled the zeal of Social Services and triggered a 'retaliatory' Strategy Meeting.

Complaining of mistreatment is regarded as an aggravating feature indicative of parents who are reluctant to toe the line. Schools seem to be resorting to child protection procedures to discipline children labelled as 'challenging' and parents labelled 'unco-operative'. In this vein, a report in this case stated by way of generalisation "These parents (*words added: i.e. parents like this*) often have problems working with professionals who do not support their views."

- parents for being ‘unco-operative’ with professionals

10. A further Strategy Meeting at the GP’s surgery on 22 March was abandoned after 10 minutes because the GP had not been told of the meeting.

11. Another Strategy Meeting took place on 29 March which was attended by the GP. He rang the Bs that evening to tell them of the outcome. They were to be given an ultimatum: *either* consent to a Core Assessment *or* Social Services would apply to the court for an assessment and consider undertaking a child protection investigation.

12. In the event, and after intensive efforts, the Senior Team Leader Children’s Services wrote to Mr B on 22 April 2005 in a less stark form, saying “The meetings decided that, based on the information given, Q was not a child in need of protection and no further investigation was required.” However the caseworkers continued the case, arranging another Strategy Meeting and conducting further interviews.

13. A particular focus of these inquiries was their worry that the mother felt that the MMR vaccine may have caused her child’s problems. This was seen as a child-abuse issue.

## CONCERNS

1. The 17 March minutes contain 46 inaccuracies, 41 gaps and several personal judgments on the Bs’ character.
2. The Social Services chair allowed unqualified professionals to question medical information throughout the Strategy Meetings.
3. Social Services used the MP’s privileged communication to the Directors of Social Services and Education, where she was representing Mr B’s concerns, as the basis for holding three Strategy Meetings to discuss suspicions that Q was at risk of significant harm – concerns that had been previously retracted in October. See Footnote 63
4. The Head, who had retracted his CP concerns, was invited to submit a report on his retracted CP concerns and address the Strategy Meeting on this basis.
5. Almost all of these concerns could have been settled if the relevant medical information and records had not been omitted.
6. The Bs were not invited to the Strategy Meetings and did not know about the meetings on 17 and 29

March. They were denied an opportunity to set the record straight.

7. It transpired that there had been a Child-in-Need meeting on 26 Nov 2004. This had minuted that the Bs’ involvement in the core assessment would be voluntary and that the Bs could consider whether they would participate.

However, Social services continued to ‘build their case’ thereafter with the Headteacher – which, in reality produced little or nothing which could not be explained by the child’s medical records, had they not been omitted from consideration<sup>64</sup>.

Notwithstanding, there were no new grounds for introducing compulsion to enforce participation, nor grounds to claim the Bs had withdrawn their consent.

8. The Bs are concerned at possible consequences of questioning of prescribed medication for Q’s medical condition. Medical letters warn that the consequences of not treating Q are, among other things, megacolon and epileptic fits.

**Effect on parents:** Mrs B’s high blood pressure is of medical concern; Mr and Mrs B were distracted from helping their elderly parents during several hospital stays and from the admission of Mr B’s parents to a nursing home (which requiring close attention to financial and legal issues). The parents were deeply distressed by what they see as unnecessary questioning of parental responsibility initiated by inappropriate referral.

Social Services have now ‘backed off’.

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<sup>64</sup> The frequency with which this unusual approach is adopted, when considering medical issues, suggests that there may be a standing instruction that medical views are to be ignored.

## ENDNOTES

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### ENDNOTE <sup>i</sup> : Early Professional Misgivings about MSbP

On 1 January 1995, *Archives of Disease in Childhood* published an article by Dr C Morley of The University of Cambridge School of Clinical Medicine (Department of Paediatrics, Addenbrookes. Entitled “Practical concerns about the diagnosis of Munchausen syndrome by proxy”, the article stated:

*“The purpose of this paper is to share concerns about the difficulties and pitfalls with the diagnosis of Munchausen syndrome by proxy in general and in particular with regard to suffocation.*

#### **Concern about the Use of the label Munchausen Syndrome by Proxy**

*Following the suggestion that Beverley Allitt had Munchausen syndrome by proxy this diagnosis has become charged with emotion and those who are now accused are tarnished with her reputation. The diagnosis of Munchausen syndrome by proxy gives no indication about what happened to the child. As a substitute it is suggested that the exact nature of the problem should be stated: suffocation, poisoning, putting blood in the urine, falsely reporting fits, or whatever is the problem.*

#### **Concern about the Criteria for diagnosing Munchausen Syndrome by Proxy**

*It has been suggested that the term can be used if the following criteria are fulfilled. However, they are very non-specific and can be misinterpreted.”*

Dr Morley’s article went on to list obvious problems with the supposed diagnostic criteria then in circulation. To take the first three headings only of Dr Morley’s observations:

***THE ILLNESS IS FABRICATED BY THE PARENT OR CARER:*** *A mother may superficially appear to the doctors to fabricate her child's symptoms when in reality they have not listened carefully to her story. Many mothers are just over-anxious and trying to get the doctor to listen, or exaggeration may be part of her normal language.*

***THE CHILD IS PRESENTED TO DOCTORS, USUALLY PERSISTENTLY:*** *The frequency of mothers presenting their children for medical care is not known and therefore we do not know what is normal or abnormal. Some mothers maintain their children are never ill and anxious mothers request advice almost weekly. Children who are seen frequently may genuinely be ill.*

#### ***THE PERPETRATOR (INITIALLY) DENIES CAUSING THE CHILD'S ILLNESS:***

*The 'perpetrator' may genuinely be innocent and that is why she persistently and vehemently denies harming her child. I am concerned that in some cases the mothers are told they have to confess to harming their child before they can have treatment and if they do not confess they are unlikely to have their children back. This is blackmail and may result in a false confession from a mother desperate to get her child back. Surely help, counselling, and treatment can be started and continue without a 'confession'.*

(72: 528-530)

The article continues at some length in the same vein.

An early expression of concern in the psychological as opposed to medical literature is in *The Psychologist* September 1997 p393 Blakemore-Brown LC *Munchausen Syndrome by Proxy*; with a back-up article in *The Therapist* Vol 5 No 2 Spring 1998 *False Illness in Children - or simply false accusations?* (‘Once the albatross of MSBP has been placed on a woman’s shoulders, it cannot be removed’).

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### ENDNOTE <sup>ii</sup> : A Note on Post-Referral Procedure

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Once an initial wrongful referral has been made on the grounds of a baseless suspicion, there is no real provision to have things put right. There will be no further post-referral diagnosis; just as, almost certainly, there will have been no pre-referral diagnosis to trigger the original referral (for which a ‘concern’ that something ‘might’ be happening will suffice).

Post-referral re-evaluations consist in monitoring the change in the parents’ perceptions as the parents ‘work with’ Social Services to relinquish their ‘belief’ that the child has a medical problem.

Under paragraph 3.2 of the Guidelines, the initial Child Protection assessment triggered by the referral will lead to one of two outcomes – immediate dismissal of the allegation or its further processing by a Section 17 “Core Assessment” (there is a third option – the immediate provision of Services which is a shorthand for immediate acceptance of the need to intervene upon the basis of the allegation).

### **Core Assessments**

The nature of MSbP (when compounded by the guidelines) means it is hard for Social Services to dismiss the allegations out of hand. Hence the only viable recourse tends to be an Assessment for MSbP - which must, by definition, be undertaken on the basis put forward by the Guidelines, whereby (a) the presence of the ordinary appurtenances of normality may indicate guilt (b) the question of differential diagnosis and alternative explanations is not considered to any material degree.

Every aspect of the case, and every iota of the parents’ behaviours (stretching back over years) must be and is viewed through the lens that the parents are either in denial or are motivated by a need to conceal the truth.

Things are misinterpreted as a matter of principle arising from the original referral; see Footnote 24. The Protection Committee proceeds on the assumption that reports from the caseworkers describe events that have actually happened (i.e. that they contain ‘evidence’); when, in reality, the reports often suffer from systemic vitiation through the interposition of the report-writer’s perceptions. The reports are not evidence-based; they are interpretation based. A common flaw is highly-selective reporting, with events mis-presented in the fine text (by misconstruing innocent occurrences, or by minute reconstruction of domestic trivia or re-sequencing events) as indications of guilt. All previous evidence – and the whole previous case-history – is routinely discarded on the basis that it has no significance; all prior information (e.g. the views, diagnoses and assessments of the medical establishment) can be discounted on the pretext that the previous doctor will have derived information about the child from a duplicitous parent.

This allows all antecedent medical procedures to be labelled as child abuse, with the Social Services taking the role of ‘enlightening’ the doctor into the unfortunate and abusive role he/she unwittingly played. It is part and parcel of the general Child Protection approach that independent medical assessments are contra-indicated. There are two reasons for this.

First, Social Services take the view that the original referral (for whatever reason the suspicion arose) constitutes a sufficient diagnosis of itself. Second, the MSbP doctrine holds that it is in medical investigations that the process of abuse lies. Considerable or extreme pressure may be used to prevent parents seeking second opinions.

The Guidelines:

- impose a need for speed and urgent action which encourage cavalier and off-the-cuff medical referrals
- offer doctors an opportunity to achieve a diagnosis in cases which they feel they cannot otherwise readily diagnose - by voicing a suspicion that there is a possibility that MSbP might be involved
- replace consideration with speculation
- erode the difference between diagnosis and referrals, which come to be regarded as synonymous

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- invoke a sense of panic, and an absolute need for radical precautions, and a feeling that the end justifies the means; which, in turn, undercut the possibility for reflection and a sensible outcome
  - provide a set of Guidelines as an operating manual or Bible (divorced from science, logic, reality, customary restraints / checks-and-balances) imbued with misconceived rectitude

Anecdotal evidence is that it is unusual for paediatricians to attend Child Protection conferences. Many of those present at the Conference will not have met the child, or the parents; their acquaintance (if any) with the child is likely to be fleeting.

The Chairman, whose decision is final, will not have met the child, will not have visited the child's home, and will not have met the parents (or have heard what they have to say) before the Child Protection Conference.

The information before the Committee will consist of pre-written reports prepared without the parents knowledge and hence, without the parents' having an opportunity to comment on the allegations or, indeed, explain things. By the time the first Conference begins, it is taken as read that FII or MSbP is involved, enabling evidence of innocence to be interpreted as evidence of guilt via 'concealment theories'.

The Conferences are run as an extremely tight-ship, at bewildering speed, with little or no opportunity for the parents to contribute put their case; and the parents are commonly in shock. A typical Child Protection team at the Conference would number some ten or 12 professionals; an instance of 27 professionals has been reported. Many of these people, who will have discussed the parents before they are admitted to the meeting, will be unknown to the parents. The outcome of the Conference will be decided by the reports prepared behind the parents' backs.

In the event of inconvenient opinion, the Guidelines seem to suggest that the dissenters should be taken aside to have their thinking adjusted. Quoting from the Guidelines, the first paragraph below makes the unambiguous error of assuming what should be proved by starting from the premise that the case actually does involve MSbP. This entails an inversion. The MSbP is regarded as a fact; the idea that MSbP may not be present is described as a mere 'belief':

*6.62 It is not uncommon for staff within a team to have different opinions on how to manage cases where illness is being fabricated or induced in a child. This phenomenon is more likely where some staff do not believe that illness is being fabricated or induced in the child despite the objective evidence.*

*Where these situations arise senior staff should take responsibility for deciding how to manage this conflict. Open discussion of feelings and problems within the staff group can be very helpful. One option may be to use a professional from either within the team or who is well-known to the team, such as a child and family psychiatrist, to assist them in managing this group process: another may be to engage the services of an independent person who has the appropriate skills. Irrespective of the method chosen, it is essential that staff are helped to understand what actions are necessary to safeguard the child and are clear that they should carry out their role according to the agreed multi-agency plan*

Bold Added

Professionals enlisted by Social Services to provide this service are liable to be 'believers' in MSbP.

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### **ENDNOTE <sup>iii</sup> : DFES Circular to Potential Respondents' on the Draft Guidelines (July 2001)**

The official text is reprinted below. Editorial interpolations from Consensus are highlighted in italics.

Dear Colleague,

**Safeguarding Children in Whom Illness is Fabricated or Induced by Carers with Parenting Responsibilities**

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*Step One: Express Reliance on the original Griffiths remit*

In 2000, the Report of a review of the research framework in North Staffordshire Hospital NHS Trust (Department of Health, 2000b) was published. It called for a wide range of measures to improve research governance across the NHS. In addition, it recommended the development of guidelines to correctly identify children who have had illnesses fabricated or induced by their carer. The Department of Health responded to this later recommendation with a commitment to produce "new guidelines for professional practice and interagency working in responding to concerns that a child may be having illness feigned or induced by a carer." These guidelines will be drawn up within the framework of *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (1999)* ". An Inter-Departmental group has now produced new supplementary guidance to *Working Together, Safeguarding Children in Whom Illness is Fabricated or Induced by Carers with Parenting Responsibilities*.

*Step Two: Departure from the Griffiths remit*

A copy of the new guidance is attached. It highlights the shared responsibility of services, professionals and the wider community for safeguarding children in whom illness is fabricated or induced by carers with parenting responsibilities and promoting their welfare. It emphasises the need for all services to focus on securing the best possible outcomes for such children. It takes account of lessons from research and experience, and of developments in policy and practice. Publication of this new guidance is an important component of a wide-ranging programme of Government activity to strengthen protection for children and to improve the support provided to vulnerable children and families.

The guidance is being issued in draft form to give you an opportunity to give us your views before final publication in the Spring of next year. A number of specific questions are attached to this letter. Please let me have your comments, at the address overleaf, **BY 31 OCTOBER 2001 AT THE LATEST**. If you wish your views to be kept confidential, please indicate this in your response.

Department of Health, Fabrication and Induced Illness Consultation  
Room 113, Wellington House, 133-155 Waterloo Road, London SE1 8UG

*Step Three: Misdirecting Respondents' attention to the substitute agenda*

**Q1:** Are there changes to the guidance which would further strengthen the way in which it promotes effective inter-agency practice which keeps a clear focus on securing good outcomes for children in whom illness have been fabricated or induced?

**Q2:** Are the roles and responsibilities set out clearly and correctly?

**Q3:** Are there any elements of the guidance where greater clarity, or more detail, is needed?

**Q4:** Has there anything important been left out which should be included?

**Q5:** The guidance includes material from **Working Together to Safeguard Children** and **The Framework for the Assessment of Children in Need and their Families**. Do you consider there is too much, too little or the correct amount of cross-reference to these publications in the document?

**Q6:** What needs to be done, and by whom, to implement the new guidance? How might Government most helpfully support implementation?

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**ENDNOTE <sup>iv</sup> : 17 October 2001 House of Lords debate on the Clark Guidelines**

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The following are extracts taken from Hansard:

**Earl Howe:**

Alongside the worrying numbers of genuine child abuse cases there is a parallel cause for worry, which is that many innocent people are being wrongly accused of child abuse and whose lives in consequence are being turned upside down without due justification.

I should like to talk today about two of the triggers for false accusations. I come now to the second major trigger for false accusations that particularly concerns me, and that is the condition known as Munchausen Syndrome by Proxy or MSBP. MSBP is one of a number of terms used to describe the fabrication or deliberate creation of illness in a child by a parent or carer. The existence of such a syndrome was first put forward in the 1970s and received a good deal of publicity a few years ago during the trial of Beverley Allitt, a nurse who was subsequently convicted of murdering several children in her care. In the past 10 years or so the MSBP theory has been widely promoted in this country and is a firm feature of social work training.

The danger of such a broad spectrum of behaviour being packaged into a single portmanteau term, MSBP, is that in the hands of those who are not sufficiently trained or experienced to know better, it is a label that is all too easily applied without due care. This is all the more true when one considers the so-called profile of characteristics that are said to mark out a person suffering from MSBP. These characteristics include such things as privation during childhood, repeated bereavement, miscarriage, divorce and past health problems. An over-intense relationship with the child and a desire to be the perfect parent are other supposed markers.

Regardless of the fact that there are very many perfectly innocent, sane people around who might have such characteristics, the very idea of a tell-tale profile of this kind is an open invitation to apply the MSBP label without properly looking at what may or may not be happening to the child. Put at its simplest, there is all the difference in the world between a Beverley Allitt, whose severe personality disorder led her to murder young children, and a mother who invents reasons why she and her child should visit the doctor. Yet under the all-embracing banner of MSBP, and in the hands of the untrained, the two are treated as being practically indistinguishable. It does not matter whether one calls the condition "MSBP" or "factitious illness by proxy", or by any other name. The point remains the same.

In quite a number of the cases I have encountered, when an allegation of MSBP has been made, the mother, in protesting her innocence, has pointed to unexplained symptoms or behaviour in her child. She may have raised her concerns about these with the doctor on more than one occasion. Unfortunately, the act of denial is itself seen as a marker of MSBP--a "Catch 22" if ever there was one. But the danger of having, as it were, an identikit profile of an adult considered likely to be an abuser or potential abuser is that judgments can be made too much by reference to perceptions of the parent and not enough--sometimes not at all--from a proper and thorough examination of the child. I have been made aware of cases where MSBP has been alleged without any outward sign whatever of harm to the child, beyond some odd or atypical behaviour.

Often, the allegations have been pursued doggedly by social workers over a long period, and it is only after months of anguish, when children have been placed on the "at risk" register and proceedings have been brought in the family courts, that the parents have been completely exonerated--exonerated, that is, if they are lucky; but exoneration, when it comes, is frequently by way of a specialist diagnosis of an unobvious clinical condition in the child: a congenital disorder, a birth injury, an allergy, autism, Asperger's syndrome, an adverse reaction to a vaccine, attention deficit and hyperactivity disorder, chronic fatigue syndrome, I suggest that it takes a lot more than a recently acquired social work diploma to be able to diagnose a condition such as MSBP and to attribute symptoms in a child to the wilful actions of a parent. Dare I say also that there are some paediatricians who are not qualified to do this? If MSBP is a valid term at all, it identifies what amounts to a serious psychiatric disorder. That kind of diagnosis should be left to those who are properly trained to make it; namely, qualified psychiatrists.

We should remember that all the indications from research are that MSBP is very rare. But it is worth noting that the scientific basis for MSBP as a recognised condition is, at best, thin. As a theory it rests on a small number of anecdotal cases. It has never been tested under clinical conditions and none of the evidence has ever been approved by a national medical or scientific body.

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Where real physical harm is inflicted secretly on a child there is no difference between this type of violence and any other sort.

There is a considerable weight of published research on these matters. It is this that gives me good grounds for believing that we are dealing with a substantive problem. In that context, the Government's recent consultation document on safeguarding children in whom illness is induced or fabricated, despite some laudable features, is deeply flawed--principally because it fails almost wholly to acknowledge that the topic is highly controversial and that erroneous diagnosis is a real risk.

I hope that the Government will take these issues in hand and examine them seriously. It is a subject which a Select Committee, either in this House or in another place, could examine to advantage. Having made a personal study of these matters, I believe them to be of deep significance for the well-being of countless children and families up and down the country. My Lords, I beg to move for Papers.

**The Countess of Mar:**

A terrible injustice is done to the families involved. Virtually without warning, the parent or parents find that they have been unjustly and unnecessarily investigated under the child protection proceedings of Section 47 of the Children Act 1989. Somehow, the Act has been so misconstrued as to enable some social services departments, paediatricians and organisations such as the NSPCC to abuse their powers, through misplaced zeal and ideology or through sheer incompetence, to create tremendous distress and psychological damage to parents, children and the wider family, sometimes destroying the family structure. There is no measuring the levels of anxiety or the harm done to children and their carers while the whole weight of the law is brought to bear on them.

**Lord Lucas:**

My Lords, I do not share the impression that I gained from the speech of the right reverend Prelate that, because of the horrendousness of the effects of child abuse, we should pay any less attention to the horrendousness of the effects of false accusations of child abuse. Nor do I share--I am sorry that the noble Lord is not in his place--the impression given by the noble Lord, Lord Carlile, that the problem lies in cases that reach the courts. It appears to me that the problems lie in cases that do not reach the courts and in what happens in the months and years before that stage is reached.

With regard to the question raised so aptly by my noble friend, my feeling is that things do not feel right. There is too much pain, and too many of the expressions of pain feel real and justified. The outlying situation is one in which we could reasonably expect there to be a witch hunt.

I am particularly disappointed that the Department of Health should have published its consultation document as it has. The department has made great strides under this Government in evidence-based medicine. I applaud it for NICE, and I applaud it for doing the things that have needed doing for a long time. But here is an example of the Department of Health publishing a document which simply is not based on research or proper consideration. I hope that the department will recover its balance in this matter.

**Baroness Fookes:**

I have tried to think what it might be like for a loving and innocent parent suddenly to find himself or herself in a welter of accusations. That must be a complete nightmare and something about which one could not think with any degree of belief. We owe it to such people to do the best we can when investigations are being carried out.

It also seems to be a prudent and sensible suggestion to have an inquiry by a Select Committee. That could be by this House, which I believe would be admirably suited to do that; by the other place, or by a Joint Committee, if that were considered a good idea. I do not think that we can leave things as they are.

Lord Northbourne: The criterion for decision, I believe, should be: is more damage likely to be caused to the child by pursuing the case or by not pursuing the case? Before deciding to pursue the case it would be logical to ensure that there is corroborative evidence, that the accuser does not have a private agenda: for example, revenge or financial gain.

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There will be a need to change government guidelines and possibly the law. It has been suggested that false accusations of sexual abuse should become a criminal offence.

**Lord Astor of Hever:**

My Lords, I want to raise the concerns of some parents of children with autism and attention deficit hyperactivity disorder. I declare an interest. My wife and I have one daughter with autism and another with ADHD. My wife is patron of the ADHD charity, ADDIS.

One child in every 100 in the United Kingdom is autistic. The National Autistic Society is extremely concerned about false accusations of child abuse. They are directly and personally involved with families affected by it. ADDIS is also concerned about these false accusations. Because of the unwillingness of some social workers to accept ADHD as a recognised condition they sometimes wrongly assume that the symptoms of ADHD are symptoms of abuse.

However, I am concerned that a small minority of social workers are misusing their enormous powers. Families have powerful evidence of cases where child protection procedures are not being implemented in an impartial, objective and even-handed manner. The evidence to prove their innocence when charged with child abuse is not being admitted to child protection conferences. I agree with my noble friends Lord Howe and Lord Lucas that the rights of parents should be strengthened in that regard.

The NAS is particularly concerned about the draft guidance on identifying MSBP. Worryingly, all the symptoms described are also applicable to autism. But the guidance is likely actively to encourage people to focus attention on MSBP--as my noble friend Lord Howe said, a very rare condition--before discounting other possibilities such as autism.

Can the Minister tell the House why, given the far higher prevalence of autism, it is so neglected in terms of adequate guidance? Also, does the Minister agree that autism and ADHD awareness training is needed for social workers, area child protection committees and the police?

**Lord Clement-Jones:**

The line of cases through Rochdale, Cleveland and the Orkneys must surely convince us all of the dangers. Use by a powerful group of individuals--paediatricians, social workers and the police--of some dubious diagnostic technique or social work theory, whether it is recovered memory, belief in satanic ritual abuse or anal dilatation, can lead to massive injustice and family break-up without any objective justification at all.

I confess that I am disquieted about the use of the diagnosis of MSBP, the way in which allegations of abuse are made and the draconian way in which they are sometimes acted upon. I am doubtful about the level of understanding by doctors and social workers of the condition. Indeed, I am doubtful as to whether it really is a scientifically or medically established condition. I share that view with the noble Earl, Lord Howe. Where is the scientific scrutiny of the condition?

I am doubtful too about what the diagnosis consists of and who should make it. After all, what are the clear and unambiguous symptoms? Is it for a paediatrician to make or a psychiatrist? How qualified are paediatricians to make what often appears to be not a physical diagnosis about a child but a psychiatric diagnosis about a parent? I am doubtful about whether the paediatricians involved have become too hooked on the diagnosis and have, in many cases, acted as judge and jury. The discoverer of the condition, Professor Roy Meadow, admitted that,

"there is a real danger of the term being overused".

As a result, I doubt whether child protection agencies have in all cases established whether a child has a real disorder before making an MSBP diagnosis. Above all, I am worried that MSBP by its very nature can be a self-fulfilling prophesy. Attention-seeking behaviour confirms the diagnosis; so does denial. Much can be made to fit into an MSBP profile. As a result, parents can, as the noble Earl, Lord Howe, said, find themselves in the classic catch-22 situation.

I therefore welcome the fact that, following the North Staffordshire inquiry, a new draft guidance has been produced by the Department of Health on induced or fabricated illness. However, I am disappointed that the

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review of MSBP as a condition, due from the Royal College of Paediatricians, has not yet emerged. The question is whether the guidance will perform the dual task of protecting children and preventing injustice and false allegations. However, we surely should not finalise the guidance until the college's review is available.

It must be made clear by the guidance that, where no criminal offence is alleged, a parent would have an adequate opportunity to contest the evidence put forward at case conferences. There must be a proper opportunity for parents to participate in the discussion. Equally importantly, the child in question, if of sufficient age, must have his or her views heard and considered. There should be a right to independent advocacy. I am disappointed that the only body that I believe had a role in that respect was disbanded as a result of lack of government funding.

**The Parliamentary Under-Secretary of State, Department of Health (Lord Hunt of Kings Heath):**

I listened with great interest to the noble Earl, Lord Howe, and the noble Lord, Lord Astor. I shall be happy to discuss with the noble Lord, Lord Astor, the specific issue of autism, which he has again raised in your Lordships' House. I am sure that all parents would be concerned if children were being taken away from their families on the basis of false accusations, founded on misguided and scientifically unproved theories.

With regard to Munchausen's syndrome by proxy, I understand that it was first described by Professor Roy Meadow in 1977. I also understand that there is a widespread dispute about whether the syndrome exists. I know that cases have been identified involving suffocation, poisoning, often with prescribed drugs, active interference with medical treatment, fabrication of illness, and active withholding of food. It is very difficult for us to enter into the whys and wherefores of Munchausen's syndrome by proxy. It has been a long-running and at times very technical debate.

We are concerned to protect children from harm. That is why we have issued for consultation guidance on children in whom illness is induced or fabricated by carers with parenting responsibilities. I listened with great interest to the comments made about that consultation and I can assure noble Lords that they will be fed into the consultation process.

Our effort must be to obtain a child protection service where the procedures are operated with fairness, rigour and, above all, the interests of children at heart. I have no doubt that our determination to do that will be informed by the debate tonight.

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**ENDNOTE <sup>v</sup> : The Post-Cannings Review of MSbP Cases**

**Extracts from Hansard: Mr. George Osborne (Tatton) (Con): 24 February 2004**

I welcome this timely opportunity—in fact, more timely than I thought when I applied for the debate—to discuss issues that the Minister raised in her statement to the House yesterday...

The Government and the medical and legal establishment are now falling over themselves to unravel what may be the greatest miscarriage of justice in this country in living memory—mothers wrongfully imprisoned after already suffering the agony of losing a child, families torn apart by evidence that, in some cases, they never even saw and could not challenge, lives destroyed by spurious medical theories, and a world of social services departments and family courts that were convinced by them... ..

When I applied for the debate two weeks ago, before I went off on my half-term holiday with my children, I feared that the Government were not doing all they could to right the wrongs of what had happened or to address all the implications of the Angela Cannings judgment.

On the day of that judgment a month ago, the Attorney-General announced an immediate review of 258 criminal convictions for the murder, manslaughter and infanticide of a child under two where there may have been similar miscarriages of justice.

From the response of the Solicitor-General to an urgent question asked in the House the next day by my hon. Friend the Member for Beaconsfield (Mr. Grieve), it was clear that the work of identifying those 258 cases had begun the moment that Angela Cannings was released and before the Court of Appeal had published its full judgment...

As I said, the Attorney-General announced last month that there would be a review of the 258 criminal convictions.

It was also clear from the question that I asked the Solicitor-General on the same day that no similar review was under way for family court cases. Instead, she told me:

"The process of how to go about a review in family cases is now being considered."—[Official Report, 20 January 2004; Vol. 416, c. 1221.]

It was not clear at the time, and it is still not clear, why the Government had not done the same preparatory work on a review of family court cases as they appeared to have done for a review of criminal cases while awaiting the full judgment of the Court of Appeal. Instead—I warn the right hon. Lady that this is the only criticism that I intend to make, but I will get it out of the way—the Minister gave an ill-advised interview to The Sunday Telegraph the day before the judgment on 18 January, which she may concede was a mistake.

Certainly, the headline, "'We can't reunite thousands of mothers with children wrongfully taken from them'—Minister admits", caused many families unnecessary distress. The Minister went on to say that the number of family cases could run into "thousands or even tens of thousands", that the Government could not "turn back the clock", and that she "hoped families understand that these are really, really difficult decisions we have to take."

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## **ENDNOTE <sup>vi</sup>: Mr Clark's Circular on the Review of Cases with Suspect Evidence**

As set out below:

25/02/2004	<b>Published date:</b>
Professionals	<b>Primary audience:</b>
2004	<b>Gateway reference:</b>
LAC (2004)5	<b>Series number:</b>
A4	<b>Document size:</b>
6p	<b>Pages:</b>
No	<b>Electronic only:</b>
Crown	<b>Copyright holder:</b>

This guidance is issued to councils with social services responsibilities under section 7 of the Local Authority Social Services Act 1970, which requires councils to act under the guidance of the Secretary of State. It contains guidance to councils about the actions needed in the light of the judgment of the Court of Appeal in the criminal case of R v Angela Cannings ("the judgment"). The Attorney General has announced his intention to consider 258 past convictions for the murder, manslaughter or infanticide of children under 2 by their parents, in order to ascertain whether the court decision may have been unsafe. The intention is that such cases might then be looked at further by the Criminal Cases Review Commission or be the subject of an appeal. Local authorities

are asked, through this Circular, to take action in relation to the following cases: those which are covered by the Attorney General's review; those where care proceedings have been commenced and the court has not yet made a final care order; those where final care orders are in place and the finding of significant harm turned on disputed medical evidence; those where the council has decided that adoption is in the best interests of a child in respect of whom a care order was made that falls within the scope of this review.

Although many of the Department of Health's Children and Families functions have transferred to the Department for Education and Skills (DfES), these circulars will continue to be issued in the Local Authority Circular (LAC) series for the foreseeable future.

[Download LAC \(2004\)5 Review of children's cases \(PDF, 19K\)](#)

### **Enquiries**

Enquiries about this Circular should be made in the first instance to:

	Contact
Department for Education and Skills	Name
Bruce Clark	

The LAC (2004)5 Circular, referred to above, is set out below.

The 'active' element of the Review is picked out in talics:

{PRIVATE }

### **LOCAL AUTHORITY CIRCULAR LAC(2004)5**

To: The Chief Executive County Councils  
 Metropolitan District Councils  
 England Shire Unitary Councils  
 London Borough Councils  
 Common Council of the City of London  
 Council of the Isles of Scilly  
 The Director of Social Services

25 February 2004

### **REVIEW OF CHILDREN'S CASES: SUMMARY**

1. This guidance is issued to councils with social services responsibilities under section 7 of the Local Authority Social Services Act 1970, which requires councils to act under the guidance of the Secretary of State. It contains guidance to councils about the actions needed in the light of the judgment of the Court of Appeal in the criminal case of R v Angela Cannings ("the judgment").
2. The judgment made clear that, in relation to sudden unexplained infant deaths, where "the outcome of the trial depends exclusively, or almost exclusively, on a serious disagreement between distinguished and reputable experts, it will often be unwise, and therefore unsafe, to proceed".
3. You will probably be aware that, as a result, the Attorney General has announced his intention to consider 258 past convictions for the murder, manslaughter or infanticide of children under 2 by their parents, in order to ascertain whether the court decision may have been unsafe. The intention is that such cases might then be looked at further by the Criminal Cases Review Commission or be the subject of an appeal. Local authorities are asked, through this Circular, to take action in relation to the following cases:
  - \_ those which are covered by the Attorney General's review
  - \_ those where care proceedings have been commenced and the court has not yet made a final care order

- 
- \_ those where final care orders are in place and the finding of significant harm turned on disputed medical evidence
  - \_ those where the council has decided that adoption is in the best interests of a child in respect of whom a care order was made that falls within the scope of this review

## **ACTION**

Local authorities are asked to take the following action:

### **In cases covered by the Attorney General's review**

- \_ Stand ready to take action in relation to cases reviewed by the Attorney General, but only after appropriate action has been determined by him.

### **In cases where care proceedings have been commenced and a final care order has not yet been made**

- \_ Within 4 weeks of the date of this circular, identify current cases where care proceedings have been commenced and where a final care order has not yet been made by the court.
- \_ In these cases, a review of the child's case should take place, in accordance with the Review of Children's Cases Regulations 1991.

As part of this process, the council should review, together with their lawyers, the evidence in the care proceedings in the light of the judgment. This should be considered alongside an assessment of the child's current needs, his/her parents' capacity and wider environmental factors. In the light of this, the council will then decide whether or not the child's care plan remains appropriate, and whether or not to continue with the current care proceedings.

### ***In cases where final care orders are in place and the finding of significant harm turned on disputed medical evidence***

*This category encompasses cases where care orders have been made, and are still in place, where the finding by the court of significant harm depended exclusively, or almost exclusively, on a serious disagreement between medical experts about the cause of harm.*

- \_ *Within 12 weeks of the date of this circular, in conjunction with their legal advisers, identify all cases where a final care order was made in the circumstances described above and consider, in the light of the judgment, whether there are now doubts about the reliability of the expert evidence.*

*In these cases, a review should take place as soon as practicable, in accordance with the Review of Children's Cases Regulations 1991.*

*The council should consider the child's current needs, his/her parents' capacity and wider environmental factors. In the light of this, the council will then decide whether or not the child's care plan remains appropriate. If it is decided, as part of this review process, that the care plan should be changed, the council should then specify the steps required to implement the revised plan. If the aim of the new care plan is for the reunification of the child with the birth parents, the appropriateness of the use of the Placement with Parents Regulations 1991, with a shorter or longer term plan to apply for discharge of the care order, should be considered.*

### **In cases where the council has decided that adoption is in the best interests of a child in respect of who a care order was made which falls within the scope of this review**

Where an application for an adoption order has been made in respect of a child placed for adoption, but that application has not yet been determined by the court, the council should, in conjunction with their lawyers, consider the implications of the judgment for that case. The council should draw their conclusions to the attention of the court, if appropriate.

Where a child has been placed for adoption (whether or not a freeing order is in place), the Review of Children's Cases Regulations 1991 do not apply. Nevertheless, where the placement is on the basis of a care order which falls within the scope of the review, the case should be included in the review of care order cases, as set out in this Circular. Similarly, where the placement is on the basis of a freeing order made following a care order that would otherwise have fallen within the scope of the review, the case should also be included in the review. The council will need to consider carefully the implications of the

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judgment for these cases. The reviews should be completed within the same timescales as for all other care order cases.

Where a freeing order has been obtained but a child has not yet been placed, the Review of Children's Cases Regulations 1991 will apply.

Where the freeing order was made following a care order that would otherwise have fallen within the scope of the review of care order cases set out in this Circular, the council should include such cases within the scope of their review. The council will need to consider carefully the implications of the judgment for these cases, and should not proceed with a placement for adoption until the review has been completed and any concerns arising from the review have been addressed.

#### **In all other cases where a care order has been made**

Cases which do not fall within the categories above will be reviewed as normal within the time scales set out in the Review of Children's Cases Regulations 1991.

#### **In cases where an adoption order has been made**

Councils should ensure that their adoption support services adviser is aware of the judgment and of the content of this Circular and stands ready to provide advice and support as appropriate to adopted children and adoptive parents. Councils should also ensure that if birth parents contact them they are directed to appropriate sources of advice and support.

#### **CANCELLATION OF CIRCULARS**

This Circular should be cancelled on 31st August 2004.

#### **ENQUIRIES**

Enquiries about this Circular should be made in the first instance to:

Bruce Clark Vulnerable Children Division, Department for Education and Skills, Caxton House, 6-12 Tothill Street, London SW1H 9NA Tel 020 7273 1288

E-mail: [bruce.clark@dfes.gsi.gov.uk](mailto:bruce.clark@dfes.gsi.gov.uk)

From: Vulnerable Children Division, Department for Education and Skills, Caxton House, 6-12 Tothill Street, London SW1H 9NA.

Current circulars are now listed on the Department of Health web site on the Internet at: <http://www.dh.gov.uk/letters>

Full text of recent circulars is also accessible at this site.

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For the sake of completeness, the ADSS circular of 21 January 2004 is reprinted below:

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## **ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES**

### **The Cannings Judgement**

**DATE: January 21 2004  
FOR IMMEDIATE RELEASE  
PRESS RELEASE**

ADSS President Andrew Cozens has stressed the importance of the Cannings judgment, and the association's sympathy to all those caught in this complicated predicament.

He said: "It is important that nobody over-reacts concerning the implications of the judgment. Our views and actions need to be balanced in a way which do not distract us from concentrating on the over-riding interests of children's welfare and wellbeing. Many cases in the past years have been

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processed in the family and criminal courts based on individual confessions and credible medical evidence.

"No child will have been adopted or taken into care solely on the basis of expert witnesses. Decisions to recommend their adoption and being received into care will have been made by courts who will have ascertained that the cases pass all the other welfare tests contained within children's legislation.

"Councils must continue to do whatever is in the best interests of children, and promote the welfare needs and interests they have now. Action needs to be prompt and thorough – but commensurate with the needs and interests of the children involved.

"We anticipate that councils will need to take legal advice on those cases which they feel warrant further investigation, and which can be identified via the normal review processes. Meanwhile local authorities and directors of social services are anticipating further guidance from the Department for Education and Skills."

ENDS

For further information, please contact:

Andrew Cozens, ADSS President, 01162 528310  
Drew Clode, ADSS Policy/Press Adviser, 020 8348 5023/07976 837755

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## **ENDNOTE vii : Reasonable Suspicion ? – Paediatrics July 2005**

**PEDIATRICS Vol. 116 No. 1 July 2005, pp. e5-e12**

### ***Reasonable Suspicion: A Study of Pennsylvania Pediatricians Regarding Child Abuse***

*Objective.* It has long been assumed that mandated reporting statutes regarding child abuse are self-explanatory and that broad consensus exists as to the meaning and proper application of reasonable suspicion. However, no systematic investigation has examined how mandated reporters interpret and apply the concept of reasonable suspicion. The purpose of this study was to identify Pennsylvania pediatricians' understanding and interpretation of reasonable suspicion in the context of mandated reporting of suspected child abuse.

*Methodology.* An anonymous survey was sent (Spring 2004) to all members of the Pennsylvania chapter of the American Academy of Pediatrics ( $n = 2051$ ). Participants were given several operational frameworks to elicit their understanding of the concept of reasonable suspicion, 2 of which are reported here. Respondents were asked to imagine that they had examined a child for an injury that may have been caused by abuse and that they had gathered as much information as they felt was possible. They then were asked to quantify (in 2 different ways) the degree of likelihood needed for suspicion of child abuse to rise to the level of reasonable suspicion.

The physicians were asked to identify (using a differential-diagnosis framework) how high on a rank-order list "abuse" would have to be for it to rise to the level of reasonable suspicion (ie, first on the list, second, third, and so on, down to tenth). The second framework, estimated probability, used a visual analog scale of 0% to 100% to determine how likely suspected abuse would have to be for physicians for them to feel that they had reasonable suspicion. That is, would they need to feel that there was a 99% likelihood that abuse occurred before they felt that they had reasonable suspicion, a 1% likelihood, or something in between?

In addition to standard demographic features, respondents were queried regarding their education on child abuse, education on reasonable suspicion, frequency of reporting child abuse, and (self-reported) expertise regarding child abuse. The main outcome measures were physician responses on the 2 scales for interpreting reasonable suspicion.

*Results.* Pediatricians ( $n = 1249$ ) completed the survey (61% response rate). Their mean age was 43 years; 55% were female; and 78% were white. Seventy-six percent were board certified, and 65% reported being in primary care. There were no remarkable differences in responses based on age, gender, expertise with child abuse, frequency of reporting child abuse, or practice type. The responses of pediatric residents were indistinguishable from experienced physicians, and the responses of primary care pediatricians were no different from pediatric subspecialists.

Wide variation was found in the thresholds that pediatricians set for what constituted reasonable suspicion. On the differential-diagnosis scale (DDS), 12% of pediatricians responded that abuse would have to rank first or second on the DDS before the possibility rose to the level of reasonable suspicion, 41% indicated a rank of third or fourth, and 47% reported that a rank anywhere from fifth to as low as tenth still qualified as reasonable suspicion.

On the estimated-probability scale (EPS), 35% of pediatricians responded that for reasonable suspicion to exist, the probability of abuse needed to be 10% to 35%. By contrast, 25% of respondents identified a 40% to 50% probability, 25% stipulated a 60% to 70% probability, and 15% required a probability of  $\geq 75\%$ .

In comparing individual responses for the 2 scales (ie, paired comparisons between each pediatrician's DDS ranking and the estimated probability he or she identified), 85% were found to be internally inconsistent. To be logically consistent, any score  $\geq 50\%$  on the EPS would need to correspond to a DDS ranking of 1; an EPS score of  $\geq 34\%$  would need to correspond with a DDS ranking no lower than 2; an EPS score of  $\geq 25\%$  no lower than a DDS ranking of 3; and so on. What we found, however, was that pediatricians commonly indicated that reasonable suspicion required a 50% to 60% probability that abuse occurred, but at the same time, they responded that child abuse could rank as low as fourth or fifth on the DDS and still qualify as reasonable suspicion.

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**Benjamin H. Levi, MD, PhD\*** and **Georgia Brown, RN, BSN<sup>†</sup>**

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**Key Words:** child abuse • mandated reporting • pediatricians • suspicion

**Abbreviations:** DDS, differential-diagnosis scale • EPS, estimated-probability scale

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accepted Jan 14, 2005.

*Conclusions.* The majority of states use the term "suspicion" in their mandated reporting statutes, and according to legal experts, "reasonable suspicion" represents an accurate generalization of most mandated reporting thresholds. Our data show significant variability in how pediatricians interpret reasonable suspicion, with a range of responses so broad as to question the assumption that the threshold for mandated reporting is understood, interpreted, or applied in a coherent and consistent manner. If the variability described here proves generalizable, it will require rethinking what society can expect from mandated reporters and what sort of training will be necessary to warrant those expectations.

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**Key Words:** child abuse • mandated reporting • pediatricians • suspicion

**Abbreviations:** DDS, differential-diagnosis scale • EPS, estimated-probability scale

At least 1 million cases of child abuse occur each year in the United States,<sup>1</sup> and it is estimated that child abuse is present in >50% of families in which domestic violence occurs.<sup>2-4</sup> Mandated reporting of suspected child abuse has existed now for >30 years, requiring individuals who interact with children in a professional capacity to contact child protection services whenever they have reasonable suspicion that a child has been abused. Despite wide variation in the actual statutory language, the majority of state laws use the term "suspicion,"<sup>5</sup> and several major textbooks identify "reasonable suspicion" as the general, standard threshold for mandated reporting.<sup>6,7</sup> An enormous literature exists to help identify conditions, injuries, and even behavior that warrant concern regarding possible child abuse. However, there is no substantive guidance for defining what reasonable

suspicion and its related terms actually mean and, as such, little direction for mandated reporters as to what level of concern must be reported.<sup>8</sup>

Both practically and conceptually, significant problems arise from this lack of direction: inconsistent reporting of (possible) abuse, unequal protection of children, inequitable treatment of parents, inefficient use of child protection service resources,<sup>9-13</sup> and substantial ambiguity about the nature and meaning of the threshold in judging whether to report.<sup>14,15</sup> These difficulties, in turn, are compounded by (1) the multitude of individuals who qualify as mandated reporters, (2) lack of education regarding what circumstances warrant reporting,<sup>11,16,17</sup> (3) absence of meaningful oversight concerning actual reporting practices,<sup>18-20</sup> and (4) reporters' immunity from civil or criminal liability.<sup>8,21-24</sup>

Of course, multiple factors give rise to the variability in how mandated reporters understand, interpret, and apply their responsibility to report suspected child abuse, including the circumstances of individual cases, perceived efficacy of child protection services, perceptions of blame, and personal experience with abuse.<sup>9,10,17,20,25-28</sup> However, despite considerable investigation examining such causes of inconsistency, little research has examined possible confusion over what "suspicion" and "reasonable suspicion" mean. These concepts are fundamentally important, because they define the threshold for determining whether a report is warranted and hence form the basis for reporting practices. Various state supreme courts have affirmed mandated reporting statutes on the assumption that reasonable suspicion is readily understood and consistently applied by ordinary persons. However, there is reason to doubt this assumption.<sup>8,15</sup>

If reporting practices are to be consistent, just, and effective in protecting children, a broad consensus must exist regarding the meaning and proper application of reasonable suspicion vis-a-vis child abuse. Moreover, the validity of current thresholds for mandated reporting depends on the existence of such a consensus. The present study investigates the extent to which a standard interpretation exists among Pennsylvania pediatricians for reasonable suspicion.

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### **ENDNOTE viii: Current Medical Thinking on Social Services, Misdiagnosis and MSbP**

The following five pages, reproduced from the June 2005 edition of the *Journal of the Royal Society of Medicine*, exemplify the current disquiet in medical and paediatric communities. The article, which takes a different starting point and a different angle - medical as opposed to administrative - arrives at substantially the conclusions. Just as MSbP and its cousins are administratively flawed, so are they medically flawed.

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## **Wrongful diagnosis of child abuse—a master theory**

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*'Please, if there is any way you could help with our situation, by yourself or anyone you know, could you please get in touch. We can honestly say, hand on heart, we haven't done anything to hurt our baby. We are now been [sic] assessed and we got told [sic] that when we go to the finding of facts hearing and we still insist we haven't done anything, our twins will go up for adoption.'*—Letter from parent

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*'For me, the unusual feature is death so soon after being seen well, the fact that there have been previous deaths in the family and the fact that he had had an episode of some sort only nine days before he died that caused him to be assessed in hospital, because those features are ones that are found really quite commonly in children who have been smothered by their mothers. So the diagnosis for me, the clinical diagnosis, would be this was characteristic of smothering.'*—Testimony of Professor Sir Roy Meadow, R v Cannings, March 2002

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The authority of medicine derives from its science base, so it would be reasonable to assume that doctors when called on to give their expert opinion in court would have a thorough balanced grasp of the relevant scientific evidence. The successful appeals of Sally Clark and Angela Cannings against their convictions for child murder would suggest otherwise, as does the recent ruling of the Attorney General that a further twenty-eight cases of parents convicted of smothering or shaking their children are 'potentially unsafe'.<sup>1</sup>

Nor can that be all, for the Attorney General's review was restricted to the Criminal Courts and thus does not take into account the several hundred cases a year heard in the Family Courts whose less stringent standards of proof ('balance of probability' rather than 'beyond reasonable doubt') would further increase the risk of unsafe convictions. Thus the medical advocacy of contentious theories of the mechanisms of child abuse is likely to have been responsible for a systematic miscarriage of justice on a scale without precedent in British legal history—with devastating consequences for the parents wrongly convicted.

Here I offer a 'master theory' to explain how this extraordinary situation has come about.

## **THE HIDDEN EPIDEMIC OF CHILD ABUSE**

Since Kempe's description of the 'battered-child syndrome' in 1962, paediatricians have become only too familiar with the burns, bruises, fractures and neglect of the child victim of abusive physical assault.<sup>2</sup> The current concerns about the wrongful diagnosis of child abuse, however, centre on a trio of very different clinical situations whose defining characteristic might be described rather as one of uncertainty or ambiguity.

Sudden infant death syndrome—SIDS remains much the commonest cause of unexpected death in childhood, whose primary aetiology, despite much research, has proved elusive

Childhood injuries—children are by nature accident-prone but sometimes the severity of their injuries might seem disproportionate to the explanation provided.

Medically unexplained symptoms—all doctors have patients whose signs and symptoms are difficult to explain. Doctors are no different from anyone else in being reluctant to admit they 'do not know'. Why, for example, might SIDS affect two or more children in the same family, or how might a seemingly trivial accident cause an acute intracranial injury?

Some might thus be unduly susceptible to the notion that the uncertainties arise not from their lack of knowledge or clinical skills but from parental concealment—that each of these ambiguous clinical situations is potentially a form of hidden or covert abuse inflicted by parents in such a way as to hide their intentions from external scrutiny. Further, these clinically ambiguous situations are not uncommon, which would suggest that child abuse is both more prevalent than is widely appreciated and perpetrated by even the most apparently respectable of parents. Paediatricians clearly have a major responsibility in identifying these concealed forms of abuse if they are to protect children from further injury or death.

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## THE EVIDENCE FOR A HIDDEN EPIDEMIC OF CHILD ABUSE

The proposition that there might be a hidden epidemic of abusive injury of children emerged in the 1980s with the description by British paediatricians of two covert forms of child abuse—factitious illness and smothering. Roy Meadow, in his pioneering paper on Munchausen’s syndrome by proxy,<sup>3</sup> described two cases illustrating a phenomenon, familiar now but puzzling at the time, where mothers sought the sympathy of doctors and nursing staff by fabricating the symptoms of a perplexing illness in their child that warranted repeated hospital admissions and investigative procedures.

In the first case the mother contaminated her six-year-old daughter’s urine specimens to simulate recurrent urinary tract infections, while in the second the mother fed her six-week-old son high doses of salt, causing him to be admitted to hospital several times with ‘unexplained’ hypernatraemia. Four years later Meadow reported a further series of nineteen cases in which ‘fraudulent clinical histories and fabricated signs’ encompassed the entire spectrum of paediatric illness— bleeding from every orifice, neurological symptoms of drowsiness, seizures and unsteadiness, rashes, glycosuria, fevers and ‘biochemical chaos’.<sup>4</sup>

The implications of Munchausen’s syndrome by proxy were twofold: it alerted doctors to the possibility of fabricated illness as a potential differential diagnosis in children with unexplained symptoms. But it also demonstrated how the seemingly most devoted of parents might, in reality, be potential child abusers. Meadow himself, commenting on the mothers in the cases he described, observed how they were ‘very pleasant to deal with, cooperative and appreciative of good medical care.’

David Southall’s innovative technique of covert video surveillance for investigating apnoeic episodes in children vividly confirmed the sinister reality of hidden abuse.<sup>5,6</sup> Now paediatricians attending meetings and conferences could see for themselves the blurry black and white images of mothers caught in the act of smothering or choking their babies. Southall’s study widened the spectrum of child abuse in two significant directions.

It offered, in smothering, a plausible explanation for why a child might experience recurrent acute life-threatening events necessitating urgent admission to hospital. And it emphasized, once again, the possibility that some at least of those children whose deaths were labelled as SIDS might have been the victims of smothering. Southall in a further report of thirty children undergoing covert video surveillance identified twelve siblings who had died unexpectedly, eight of whom the parents subsequently confessed to having smothered. Thus parental smothering must be a clear possibility in any child with recurrent acute life-threatening events where there has been more than one unexplained childhood death in the family.<sup>7</sup>

## THE HIDDEN EPIDEMIC REVEALED

There could be no doubt following Meadow and Southall’s findings that paediatricians must have been missing a substantial number of cases of child abuse and would in future need to be much more alert to the possibility of parental harm where the diagnosis was not clear.<sup>8</sup> Frequently, however, such suspicions could not be confirmed with the sort of direct evidence provided by techniques such as covert videosurveillance. So how could doctors be confident that covert abuse was the cause—and convince others to take the necessary steps to protect the child from further danger?

Significantly there were certain similarities in the signs and symptoms of children with these clinically ambiguous situations and those recorded in well authenticated forms of abuse such as smothering, poisoning and abusive head injury. Thus it seemed reasonable to infer, by extrapolation,

that these presentations were ‘characteristic’ of covert forms of abuse which could then be confidently diagnosed—even in the absence of any other circumstantial evidence such as bruises, signs of neglect or parental history of violence.

During the 1980s the trio of clinically ambiguous situations would become redesignated as ‘child abuse syndromes’. A key influence was ‘Meadow’s rule’ regarding SIDS. While the absence of reliable pathological findings made it difficult to distinguish SIDS from smothering, Meadow argued that two or more childhood deaths in the same family, along with a recognizable ‘pattern’ of events (such as previous acute life-threatening episodes) was strongly suggestive of infanticide: ‘two is suspicious and three murder unless proved otherwise . . .’.<sup>9–11</sup>

Another was the proposal that two specific presentations of childhood injury were ‘characteristic’ of abusive assault. Caffey’s original description of shaken baby syndrome suggested that the whiplash effect of vigorous shaking offered a ‘reasonable explanation’ for the presence of subdural and retinal haemorrhages in severely abused children.<sup>12</sup> The imagery of how the violent to-and-fro movement of the baby’s head could cause bleeding of the vessels of the eye and brain proved very persuasive and it seemed logical to infer that any child presenting with retinal and subdural haemorrhages must have been shaken—despite the absence of other circumstantial evidence of abuse.<sup>13–15</sup>

Similarly, Caffey attributed a radiological ‘bucket handle’ appearance of the metaphyses of the long bones in severely abused children as being due to a ‘twisting and wrenching’ of the child’s limbs by the parents.<sup>16</sup> Subsequently, it was suggested that those children in whom abuse was suspected should have a skeletal survey for similar ‘suspicious’ metaphyseal lesions that were interpreted as being characteristic of abusive assault—again, despite the absence of clinical signs of fracture or subsequent radiological evidence of healing.<sup>17,18</sup>

A third was a widened case definition for Munchausen’s syndrome by proxy. Meadow, in his initial series, had confirmed the diagnosis either by covert surveillance or by confronting the perpetrator and obtaining a confession. In a widened definition the presence of ‘diagnostic pointers’ was proposed for use in children with medically unexplained symptoms. They included:

- . Parents unusually calm for the severity of illness
- . Parents unusually knowledgeable about the illness
- . Parents fitting in contentedly with ward life and attention from staff
- . Symptoms and signs inconsistent with known pathophysiology
- . Treatments ineffective or poorly tolerated.<sup>19,20</sup>

## **THE HIDDEN EPIDEMIC CONFIRMED**

These novel child abuse syndromes, taken together, represented a major conceptual breakthrough in paediatrics. The uncertainty of clinically ambiguous situations had given place to the certainty of the single unifying and plausible diagnosis of covert abuse. The scale of the hidden epidemic then turned out to be substantially greater than had been expected, with a fourfold increase in the number of child abuse cases in the ten years from 1978 to 1988. This was reflected regionally in an increase from 40 to over 200 cases a year in the City of Leeds while, by the end of the decade, an extra 7500 children every year were being placed on the child protection register on the grounds of physical abuse.<sup>21–23</sup>

Nonetheless, the facility with which the syndromes could bring to light covert abuse concealed from view their poor evidential basis. The causal link between the putative mechanism of assault and subsequent injury could be neither independently confirmed nor experimentally investigated. It might seem reasonable to extrapolate from the presence of retinal and subdural haemorrhages in the battered child that these features had the same significance in a child with no other circumstantial

evidence of injury. Certainly the powerful imagery of violent shearing forces disrupting the blood vessels was persuasive, but shaking has never been directly observed or proven to cause such injuries; the supposition that they do is based on (contested) theories of biomechanics.<sup>24</sup> Rather, the legitimacy of the syndromes was predicted on two related and highly improbable assumptions, scientific and legal.

The scientific assumption was that there could be no other explanation, either known or that might be discovered at some time in the future, that might explain these ‘characteristic’ presentations. Meadow’s ‘rule’, for example, precluded the possibility that there might be some unknown genetic explanation for multiple unexpected childhood deaths in the same family, while the ‘characteristic’ pattern of shaken baby syndrome precluded the possibility of some alternative explanation for the retinal and subdural haemorrhages—such as an acute increase in retinal venous pressure from intracranial bleeding caused by accidental head injury.<sup>25</sup> The legal assumption presupposed that these presentations were so specific for abuse that they were by themselves sufficient to secure a conviction—even in the absence of the sort of circumstantial evidence of violence or neglect that would normally be required to return a guilty verdict in a court of law.

Put another way, the ‘characteristic’ presentations of the syndromes could not sustain the interpretation placed upon them: they might be ‘consistent with’ but could not, by themselves, be ‘diagnostic of’ child abuse. Thus some at least of the parents contributing to the statistics of the fourfold rise in child abuse were likely to be innocent.

Three additional factors, in particular, bolstered the credibility of the syndromes in the Family and Criminal Courts.

### **The authority of the child abuse expert**

By the close of the 1980s, the leading experts in child abuse had acquired an international reputation and were thus called on to instruct and educate not just their fellow paediatricians but also the police, lawyers, social workers and judges in the child abuse syndromes. Their persuasive expert opinion, when expressed in court, was guaranteed a sympathetic hearing, while their confidence in the syndromes they had discovered was virtually unchallengeable.

Further, they could scarcely accept the force of contrary evidence since to do so would require them to concede that their expert testimonies might, in similar cases, have resulted in wrongful conviction. Meanwhile the costs of the process of investigating allegations arising out of the child abuse syndromes rose to an estimated £1 billion per year, with the more prominent experts receiving fees for the preparation of their reports and appearances in court in excess of £100 000 a year.<sup>26</sup>

### **The circular argument of successful convictions**

The validity of the child abuse syndromes would appear to be confirmed by the high proportion of successful convictions that followed the courts’ careful scrutiny of the allegations against parents. These convictions, however, came to rely increasingly on a circular argument—whereby the main evidence for the child abuse syndrome of which the parents were accused was that parents had been convicted of it in the past. Thus parents whose child presents with subdural and retinal haemorrhages are accused of inflicting shaken baby syndrome because, in the vast majority of cases, parents of children with subdural and retinal haemorrhages are convicted of causing shaken baby syndrome.<sup>27</sup>

Similarly, Meadow argued that ‘the likelihood that the court verdicts about parental responsibility for [causing their children’s death] were correct was very high indeed’, without making clear that it

was his expert testimony that repetitive SIDS was ‘murder unless proved otherwise’ that had been a major factor in securing those convictions.<sup>10</sup> There is a further element of circularity in the presumed pathogenesis of the syndrome of which the parents are accused. The theory of shaken baby syndrome presupposes that violent, abusive force (comparable, it is claimed, to that sustained in a high-speed road traffic accident or a fall from a second storey window) is necessary to cause retinal and subdural haemorrhages. The parents are then caught in the catch-22 of either confessing to the alleged assault (for which they might be offered the inducement ‘if you say you did it we will let you have your child back’) or denying it, in which case their denial is evidence they must be lying about the events surrounding their child’s injury, which is then further evidence of their guilt.<sup>28</sup>

### **The silencing of parents**

The forces of expertise ranged against the parents were formidable enough, but it is apparent too from their personal accounts that they were subjected to a series of intimidatory tactics to silence their protestations of innocence and deny the validity of their testimony as the only witnesses of the circumstances surrounding their child’s injury or death.<sup>29,30</sup> Thus parents describe how, when summoned to see the consultant to learn (they presume) about their child’s progress, they were ‘ambushed’ with the diagnosis of, for example, shaken baby syndrome, presented to them as irrefutable fact (‘your son must have been violently shaken for several minutes to cause these injuries’) without any suggestion that there could be some alternative explanation. The prompt involvement of the police and social workers would lead to further accusatory interrogations that begin from the principle that the parents must be guilty—as the doctors would not have made such serious accusations if they were not convinced they were true.

The transcript of these interrogations would subsequently be turned against them in court so that any inconsistencies in their explanations of how their child’s injuries might have occurred were then presented as evidence of their efforts to conceal their guilt.<sup>31</sup> Parents describe the same pattern of events where they would only be informed late on a Friday evening that a preliminary court hearing had been arranged for the following Monday morning—thus leaving them the weekend to find a lawyer (who was unlikely to have any expertise in this field) to contest their child being taken into foster care.<sup>32</sup> These psychological tactics were a prelude to the yet more powerful intimidatory weapon of technical obscurantism—the description of their child’s injuries and couching of the charges against them in a language in which the professionals were fluent but the bewildered parents were not. How could they hope to dispute the allegations when they did not know what was being talked about?

Parents are of course entitled to seek their own expert opinion, but soon discovered that the overwhelming consensus about the validity of the child abuse syndromes meant it was very difficult to find anyone to argue in their defence; or worse, the expert reports they requested were actively detrimental to their case.<sup>33</sup> This silencing of parents was made more effective still by the rules of confidentiality that wrap the proceedings of the Family Courts in a cocoon of secrecy, making parents liable to a charge of contempt of court if they sought advice or support from anyone not directly involved in their case. This secrecy in turn protected the proceedings of the court, and in particular the testimony of expert witnesses, from external scrutiny while concealing from public view the spectacle of so many apparently respectable parents being convicted of inflicting these terrible injuries on their children—without any circumstantial evidence that they had done so.

### **THE UNMASKING OF CHILD ABUSE SYNDROMES: THE CRISIS FOR PAEDIATRICS**

For parents there was no escaping their fate. From the moment of the initial allegation against them, the alliance of medical experts, police, social workers and an unsympathetic judiciary—well organized, experienced and well financed—meant that their eventual conviction was almost

a foregone conclusion. Nonetheless, the two assumptions, scientific and legal, of the specificity of the syndromes as being diagnostic of abuse remained as insecure as ever, with the courts' willingness to convict parents in the absence of circumstantial evidence of abuse resting almost entirely on their faith in the reliability and trust worthiness of medical expert opinion. The first sign that such faith might be misplaced came in 2003 during Sally Clark's successful appeal, with the revelation of 'fundamental errors' in the testimony of Meadow and other prominent experts that had resulted in her original conviction.<sup>34–36</sup>

Their credibility was further undermined by Justice Judge's Appeal Court ruling exonerating Angela Cannings of murdering her two children.<sup>37</sup> Justice Judge dismissed the central plank of the prosecution case, Meadow's claim that there had been a 'pattern of events' leading up to the deaths of children that was 'characteristic' of smothering: 'We doubt the aptness of the description "pattern" . . . the history of each child was different from every other child.' Further research would refute Meadow's claim (as reflected in his 'rule') that recurrent SIDS in the same family was 'extremely rare'—in other words, that in such cases the cause was likely to be unnatural.

On the contrary, a follow-up study of SIDS families found two or more deaths in the same family to be 'not uncommon' with the overwhelming majority (80–90%) due to natural causes.<sup>38</sup> There are, it has subsequently emerged, several genetic mechanisms that could account for recurrent SIDS including congenital visceromotor dysfunction and cardiac dysrhythmias.<sup>39,40</sup> Similarly, further research has undermined the validity of retinal and subdural haemorrhages as being characteristic of shaken baby syndrome, with an evidence-based review finding 'serious data gaps, flaws of logic and inconsistency of case definition' in the relevant scientific work.<sup>41</sup>

Shaken baby syndrome was not, as its name implied, a 'syndrome' but rather encompassed several different forms of brain injury, with different clinical history and neuropathology, involving some mechanism other than shaking to account for the presence of retinal haemorrhages.<sup>42,43</sup> Thus a series of independently witnessed accidents confirmed that, as parents had maintained, minor falls could cause an acute subdural bleed with the retinal haemorrhages being due to a sudden rise in retinal venous pressure.<sup>44</sup> Further, parental histories of a preceding episode of respiratory collapse were compatible with the very different pathological findings of anoxic brain damage, with disturbance of the microcirculation causing thin subdural and retinal haemorrhages.<sup>45,46</sup>

Meanwhile, the widened definition of Munchausen's syndrome by proxy based on 'diagnostic pointers' has also resulted in wrongful convictions, with the child's unexplained symptoms proving to be due to some rare or unusual medical condition with which the doctor was not familiar.<sup>47</sup> Subsequently the syndrome would be renamed 'factitious illness' in recognition of the fact that, while some parents may fabricate the symptoms of their child's illness, the combination of unexplained symptoms and the mother's personality profile did not constitute a syndrome of abuse.<sup>48,49</sup>

Finally, radiologists' misinterpretation of normal variants of ossification in the first year of life as being metaphyseal fractures accounts for the obvious discrepancy between the findings of multiple fractures on skeletal survey and the absence of any clinical signs of abusive injury.<sup>50</sup> This serial collapse of the improbable scientific assumption that there could be no explanation other than abuse for the characteristic presentation of these syndromes has exposed in turn the equally improbable legal assumption that, contrary to sound judicial practice, it is possible to convict parents without there being additional circumstantial evidence or reasonable motive for their abusive intentions.

Thus Justice Judge would, in his exoneration of Angela Cannings, draw attention to 'the absence of the slightest evidence of physical interference which might support the allegation she had deliberately harmed them'. And, again, he emphasized how 'the absence of any indication of ill temper or ill treatment of any child at any time' and 'the evidence of both her family and outsiders

about the love and care she bestowed on her children' made it extraordinarily unlikely that she might have smothered them.

## CONCLUSION

Justice Judge's exoneration of Angela Cannings' character as a loving mother focuses attention on the moral and judgmental dimension of the child abuse syndromes arising from extrapolation from Meadow's original description of Munchausen syndrome by proxy that all parents are potential child abusers. Is this extrapolation plausible? The psychological profile of those who unambiguously have harmed their children reveals, as would be expected, them to be psychopaths, criminals, opioid abusers, alcoholics and so on.<sup>51,52</sup> So when parents such as Angela Cannings, with no blemish on their character, appear as loving, concerned parents, the likelihood must be that it is because they are loving concerned parents—and very powerful evidence is required to argue otherwise.

Meadow and the proponents of the child abuse syndromes necessarily take the contrary view, and in so doing are required to portray parents' protestations of innocence as deceitful. That moral judgment, together with the failure to recognize that medical knowledge may be incomplete, meant that Angela Cannings' wrongful conviction for infanticide was almost inevitable.<sup>53</sup> The question remains how many other parents have similarly been wrongly convicted of the terrible crime of injuring their children, and been robbed of their families, livelihoods and good name.

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## **ENDNOTE ix: Private Law Cases and the Disposal of the Early Interventions project**

*As set out at page 2 hereof, this document (which concerns Public Law) is part of a three-document package recording the mismanagement of family policy. Parallel documentation was lodged with the DfES Permanent Secretary on 20 May 2005 in respect of the mismanagement of Private Law.*

*Since that date, the concerns of Consensus in relation to Private Law have been verified by departmental records. For convenience, this matter is dealt with here.*

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The full particulars prepared by Consensus in relation to the destruction of the Early Interventions project stated, at page 5:

### ***Investigation: An Acid Test***

*Probably the simplest approach is to secure the Minutes of the 17 March 2004 first Design Team meeting. Unless these have been doctored (and, if they have, there will be gross discrepancies with the surrounding documentation) they will show the EI project was never discussed by the Design Team as a completed project ready for implementation.*

*Instead, the Minutes will show that if EI was mentioned, it was merely as a name to be changed before embarking on the design of a different project (Mr Clark’s Family Resolutions project).*

*From this it would follow that EI was dead before the first Design Team meeting.*

*That is, during the period when the EI project was in Mr Clark’s sole care, it disappeared; to the extent that when the time came to implement it, no-one on Mr Clark’s committee knew that they were meant to be implementing EI. In this context, responsibility for the substitution is easy to localise.*

On 17 May 2005, the DfES furnished Consensus with the Minutes of the 17 March 2004 meeting.

These Minutes confirm the position predicted by Consensus.

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### **The Allegation Confirmed**

The EI reform project had indeed disappeared without trace by the time of the first DfES Design Team meeting. That is, it had disappeared while in the care of Mr Clark.

The 17 March 2004 Minutes:

- do not mention ‘the NATC Early Interventions project’
- do not mention ‘the NATC’
- do not mention ‘the Early Interventions project’
- do not mention either of the EI project originators
- do not mention the principles on which the NATC EI project was based
- do not mention that the NATC EI project is and was:
  - (i) already fully-specified
  - (ii) already fully-designed
  - (iii) awaiting implementation

It is, further, a fact that the EI project papers were not present at the Design Team meeting (or any other Design Team meeting). The papers were mislaid. The Design Team proceeded unaware that the work on which they proposed to embark had already been completed (after eight years in professional development).

Under the heading, ‘Background’, paragraph 2 of the DfES Minutes makes a passing reference to ‘an intervention’ scheme, which – in so far as it was the NATC EI scheme – is misdescribed or described by its inessentials.

There is no awareness in the Minutes that the NATC EI project exists as a finished entity; or that the NATC EI project had secured a quite unprecedented degree of professional support; or that the High Court judiciary had declared that it was this project they wished to see implemented.

Instead, the Design Team Minutes embark on the contrary voyage. The DfES Design Team misdirects itself into a dream remit of devising its own project specification without reference to the agreed, approved and completed design.

### **The Upshot**

The consequences are well-known. The bulk of the Design Team (including Mr Clark) had little or no knowledge of the relevant aspects of private law contact litigation, in particular of its presumptive framework. In consequence, the DfES produced a misconstructured scheme (Family Resolutions) based around inoperable thinking, which committed the Government to four principles, all of them contradictory and all of them either imaginary or mistaken. The official Government stance is now:

- (i) that the Fam Res scheme is not based on the presumption of contact
  - *this is an impossibility; the Children Act as applied is based on the presumption of contact*
- (ii) that the Government supports the principle and presumption of meaningful contact

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- *this contradicts (i) above; the presumption of meaningful contact apparently endorsed by the Government is higher by many orders of magnitude than the presumption of contact - rejected by the Government*

(iii) that the presumption of meaningful contact is embodied in case law

- *this is untrue; and is, by virtue of the point below, an impossibility*

(iv) that 'every case is different'

- *this proposition is at odds with the stated policies at (ii) and (iii) above; and is, in addition, untrue or non-viable in the absence of careful and indispensable qualification.*

A failure to show an interest in the rudiments of the area - in which it was felt the finished Family Law reform project would operate - has ended in a nothing.

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Interventions, Social Policy EXAMPLES OF SOCIAL POLICY INTERVENTIONS [1] EVALUATION OF THE EFFECTS OF SOCIAL POLICY INTERVENTIONS [2] BIBLIOGRAPHY [3] Social policy interventions include policies affecting the social conditions under which people live. Social policy interventions include policies affecting the social conditions under which people live. Social policy aims to improve human welfare and to meet human needs. Many policies that are ostensibly economic, such as cash assistance to the poor, fall under the rubric of social policy interventions because they have a direct impact on the social conditions under which people live and are aimed at improving human welfare and meeting human needs. The Department of Social Policy & Social Work was established in 1965 and has an international reputation for its work. The City of York itself was the site of one of the world's first scientific studies of poverty – Seebohm Rowntree's *Poverty: A Study of Town Life* (published in 1901). Degree programmes. Our courses reflect the latest thinking in the field of social policy. They draw on ideas from across the social sciences and adopt a critical perspective that looks to both understand what welfare states seek to achieve but to critique them when they fail to deliver. Some programmes offer