

Health Staff Professional Guidance on the Management of Perplexing Presentations (including Fabricated or Induced Illness)

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Guidance for Health Staff

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Summary

The purpose of this guidance is to clarify the process, roles, responsibilities and working arrangements for health professionals within Bedfordshire and Luton, who work with children who present with perplexing presentations (PP) and Fabricated or Induced Illness (FII) is suspected. It should be read in conjunction with the national guidance Working Together to Safeguard Children (2018), Safeguarding Children in whom illness is fabricated or induced (HM government 2008), [Perplexing Presentations \(PP\)/Fabricated or Induced Illness \(FII\) in Children RCPCH guidance Updated Feb 2021](#)

Introduction;

The revised Royal College of Paediatrics and Child Health guidance on Perplexing Presentations/ Fabricated or Induced Illness in Children sets out the following;

“There is often uncertainty about the criteria for suspecting or confirming PP/FII and the threshold at which safeguarding procedures should be invoked. In the UK, there has been a shift towards earlier recognition of possible FII (which may not amount to likely or actual significant harm) and intervention without the need for proof of deliberate deception. While earlier presentations and those involving erroneous reporting form the majority of cases seen by paediatricians, most cases in literature report deliberate physical abuse by the carer. Children and young people with perplexing presentations often have a degree of underlying illness, and exaggeration of symptoms is difficult to prove and even harder for health professionals to manage and treat appropriately.

This guidance supports that in the absence of clear evidence about risk of immediate serious harm to the child’s health, an early recognition of possible FFI (not amounting to likely or actual significant harm) is better determined Perplexing Presentation, requiring an active approach by paediatricians and an early collaborative approach with children & their families. It is important to recognise any illness that may be present, whilst not subjecting the child to unnecessary investigations or medical interventions, always bearing in mind the fact that verified illness & fabrication may both be present.

FII can cause death, disability, physical illness, and emotional problems. There are significant risks of re-abuse. Following identification of FII in a child, the way in which the case is managed has a major impact on the developmental outcomes for the child, professionals involved and parents. Support should be given early and as appropriate.”

(RCPCH 2019 Fabricated & Induced Illness by Carers (FII) A Practical Guide for Paediatricians)

Definitions:

Medically Unexplained Symptoms (MUS)

A child’s symptoms, of which the child complains and which are presumed to be genuinely experienced, are not fully explained by any known pathology. The symptoms are likely based on underlying factors in the child (usually of a psychosocial nature) and is acknowledged by clinicians and parents. MUS can also be described as a ‘functional disorders’ and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body. The health professionals and parents work collaboratively to achieve evidence-based therapeutic work in the best interest of the child or young person.

Perplexing Presentations (PP)

The term Perplexing Presentations (PP) has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual harm), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. The essence of alerting signs is the presences of discrepancies between reports, presentations of the child an independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.

Fabricated or Induced Illness (FII)

FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired that is actually the case). FII results in physical and emotional abuse and neglect, as a result of the parent's actions, behaviours or beliefs and from the doctors' response to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident.

It is important to distinguish the relationship between FII & physical abuse/non-accidental injury (NAI). In practice, illness induction is a form of physical abuse (in Working Together to Safeguard Children, fabrication of symptoms or deliberate induction of illness in a child is included under Physical Abuse). In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not here are recurrent presentations to health and other professionals. This applies in cases of suffocation or poisoning.

Professional Responsibility

Doctors may feel under pressure to investigate and treat the child, without a clear understanding of the condition the child is suffering from. This may result from the clinical information 'not adding up'. ***It is very important at an early stage in the process to avoid iatrogenic harm (harm as a result of unnecessary medical intervention) and only to undertake tests or introduce treatments that are clearly indicated. Treatment may be initiated on a trial basis but if it is not seen to work, it should be withdrawn.***

At the earliest identification of concern professionals should seek advice and support with seniors & peers known to be involved with the individual child.

Immediate serious risk to child's health/life

The most important question to be considered is whether the child may be at immediate risk of serious harm, particularly by illness induction. This is most likely to occur when there is evidence of frank deception, interfering with specimens, unexplained results of investigations suggesting contamination or poisoning or actual illness induction, or concerns that an open discussion with the parent might lead them to harm the child.

- An urgent referral must be made to the police and children's social care as a case of likely significant harm due to suspected or actual FII, and this should lead to a

strategy discussion that includes health representatives as per the latest interagency guidance. The safety of siblings also needs to be considered.

- Securing any potential evidence (eg feed bottles or giving sets, nappies, blood/urine/vomit samples, clothing or bedding if they have suspicious material on them). Documenting concerns in the child's health records (eg 'this unusual constellation of symptoms, reported but not independently observed, is worrying to the extent that, in my opinion, there is potential for serious harm to the child'). This is important in case the child is seen by other clinicians who are not aware of the concerns.
- Considering whether the child is in need of immediate protection and measures taken to reduce immediate risk.
- In very rare cases, covert video surveillance may be used as part of multi-agency decision-making and is led by the police.

All practitioners should be mindful of situations where to inform the parents of the referral would place a child at increased risk of harm. In this situation, carers should not be informed of the referral before a multiagency discussion has taken place. This would usually be in the form of a formal strategy discussion.

Where FII is suspected, the child protection investigation may take more time than usual. However, whenever possible and consistent with the child's best interests, professionals should ensure any child protection conference is held within 15 working days of the strategy meeting / discussion, where the decision was made to initiate s47 enquiries. Further regular strategy meetings / discussions should take place throughout the period of the investigation.

Response to Perplexing Presentations (PP)

This is a complex and time-consuming process, led by the Responsible Paediatric or CAMH Consultant with advice from the Named Doctor and the health safeguarding team (who do not have clinical responsibility for the child). All should be supported and have protected time to provide the necessary focus. Responding to PP requires a multidisciplinary approach, although it is imperative that the responsible consultant continues to have overall clinical responsibility for the child and that the background safeguarding processes are supported by the Named Doctor and the health safeguarding team.

If the Responsible Paediatric or CAMH Consultant (who may change during the process) is also the Named Doctor, then another paediatrician in the Trust will need to undertake this consultative role, possibly the Designated Doctor. This means that safeguarding decisions can be made objectively, free from duress, threats and complaints and the responsible paediatric consultant has appropriate support in these challenging cases.

The essence of management is establishing, as quickly as possible, the child's actual current state of physical and psychological health and functioning, and the family context. The responsible paediatric consultant will need to explain to the parents and the child (if old enough) the current uncertainty regarding the child's state of health, the proposed assessment process and the fact that it will include obtaining information about the child from other caregivers, health providers, education and social care if already involved with the family, as well as likely professionals meetings. Wherever possible this should

be done collaboratively with the parents. If they do not give agree for this to happen, the parents' concerns about this process should be explored and can often be dispelled. However, under the NHS' interpretation of General Data Protection Regulations (GDPR), information sharing can take place without consent if:

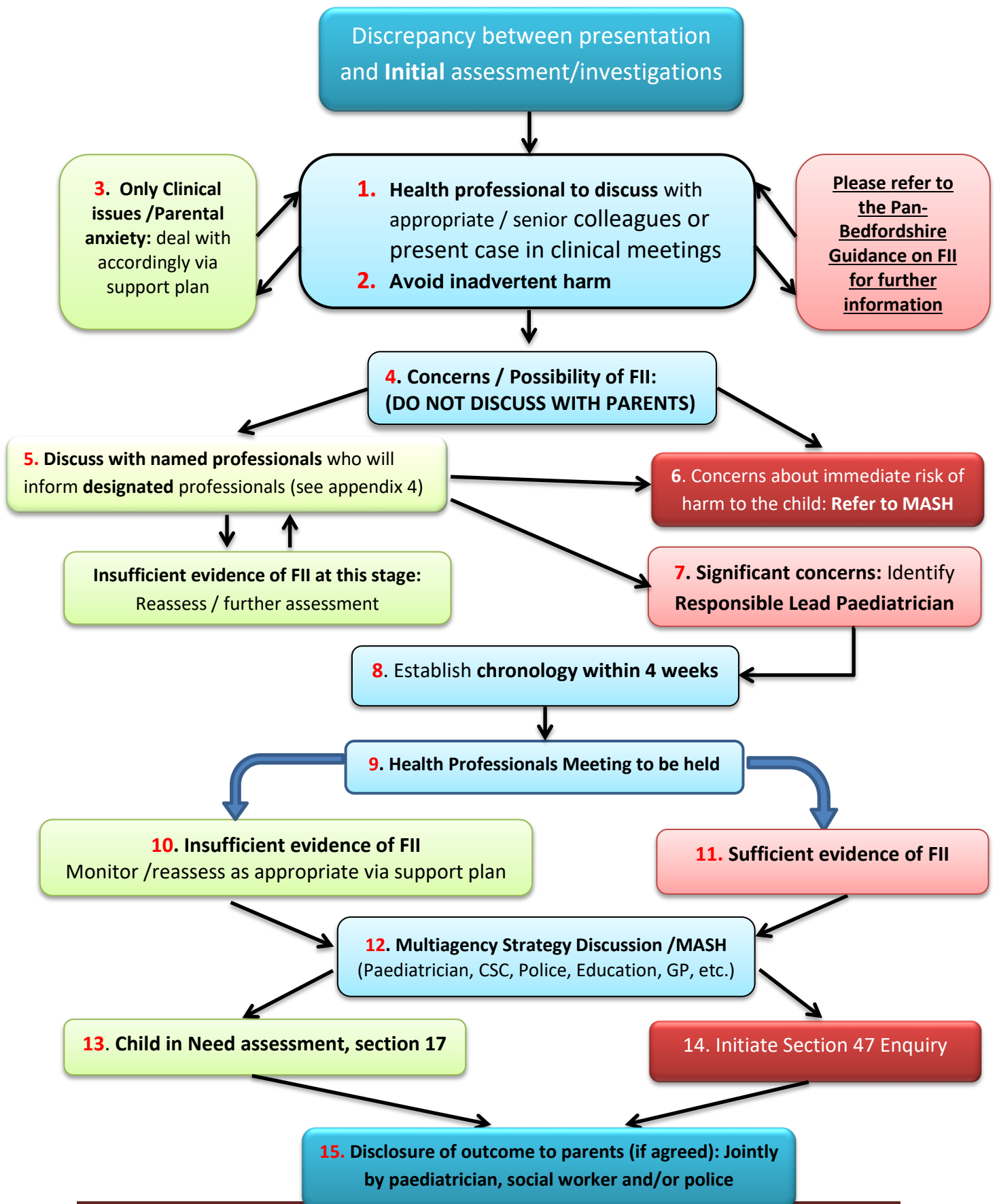
- there are safeguarding concerns,
- it is in the best interests of the child,
- is necessary and proportionate and is done in a manner according to the regulations.

Strong parental objections could indicate a referral to children's social care on the grounds of medical neglect - that the doctors are unable to establish the state of health and medical needs of the child.

When paediatricians become concerned about a perplexing presentation, an opinion from an experienced colleague needs to be obtained and a tertiary specialist may be necessary. Parents themselves may request another opinion and it is their right to do. However, this opinion giver should be supplied with all the background information to help in informing the opinion and to avoid the repetition of investigations unnecessarily. The seeking of multiple alternative opinions, particularly when there has already been a reasonable diagnostic formulation, is almost always harmful to the child and may well increase concern about FII.

There may need to be one or more professionals' meetings to gather information, and these can be virtual meetings. Where possible, families should be informed about these meetings and the outcome of discussions as long as doing so would not place the child at additional risk. Care should be given to ensure that notes from meetings are factual and agreed by all parties present. Notes from meetings may be made available to parents, on a case by case basis and are likely to be released to them anyway should there be a Subject Access Request for the health records.

Pan Beds Perplexing presentation and FII Pathway



Pan Beds Perplexing presentation and FII Pathway guidance

1. Discrepancy between presentation and Initial assessment/investigation

When a health professional identifies a discrepancy between presentation and **Initial** assessment/investigation he/she should discuss with appropriate colleagues at routine clinical meetings as part of Peer Review processes or Multi-Disciplinary Team meetings. For example ward round/discussion, GP Lead, Direct Line Manager, Peer Supervision, Team Around the Child Meeting (TAC) etc.

2. Avoid Inadvertent Harm

Avoid inadvertent harm and stop any procedures, tests or treatments that are not clearly indicated. ***It is unacceptable to cause further iatrogenic harm for a child with a perplexing presentation, where the presence of an organic illness has not been confirmed or whilst a true case of FII is being confirmed.***

3. Outcomes of Health Professionals discussions; Clinical issues/carer anxiety.

A probable explanation for the discrepancy between presentation and assessment is that, there may be a medical investigation that could confirm or negate the presence of an organic disease. This should be undertaken promptly, but the temptation to keep investigating without clear indications must be resisted. It is vital to explain to carers the rationale for certain investigations and the reason why no further investigations will be done. Further unwarranted investigation at this time is likely to cause harm and distress to the child and is not in the child's best interest.

A probable explanation for the discrepancy between presentation and assessment is;

- carer/parental anxiety
- misunderstanding or unusual beliefs about illness
- child adopting a sick role due to unusual parent-child dynamics
- the carer/parent suffering from a mental health difficulty which may not have been diagnosed

To assist the clinical management and onward referral for early help/safeguarding procedures, the MDT members should identify an appropriate Responsible Paediatrician. The Responsible Paediatrician would normally be a consultant paediatrician. Other health colleagues are required to support the development and implementation of the support plan. In the case of possible FII, the Responsible Paediatrician as defined in RCPCH guidance, will be identified and other health colleagues will be responsible to assist him/her.

Support Plan

If the conclusion is that this is a 'perplexing presentation' but not a 'true' FII, then a conservative support plan will be appropriate. The support plan will give due consideration to the following;

- A period of close or constant observation of the child may be indicated.

- Ensure that while decisions are being made, the child's daily functioning are normalised as best possible.
- This support plan must be shared with parents/carers and all professionals involved in supporting the child/young person. For example education professionals, early years and/or statutory education or Children's Social professionals involved as part of early help or Children with Disabilities Team. This assists in ensuring a consistent approach to the case, with support and monitoring. This may include support of the parent/carers by other professionals.
- When parents/carers request a second medical opinion or change of specialist clinician, the GP or specialist clinician should seek to understand the rationale behind this request. Onward referral should only be actioned if, the clinician feels that there would be a real benefit to the child. This referral should include the fact that there has already been clinical input from other clinicians and the conclusions of those clinicians.
- The professional **must always maintain sight of the impact on the child**, and invoke local safeguarding procedures when alerted to indicators of neglect and abuse. If there are concerns of immediate safety for the child at any point, a referral to Children's Social Care via the Multi-Agency Safeguarding Hub (MASH) or out of hours to the Emergency Duty Team (EDT) must be made. Routine local safeguarding children protocols **must be followed**.

4. **Likelihood of 'true' Fabricated or Induced Illness**

A probable explanation of discrepancy between presentation and assessment maybe that there is true' FII. This involves the deliberate deception of medical services by the carer; and may include actions to falsify specimens or investigations, or the induction of actual illness in the child.

5. **Discussion with Named Professional for Safeguarding Children**

At this stage it would be appropriate for the Responsible Paediatrician to consult with the Named Professional for Safeguarding Children, for advice and support. The Named Professionals for Safeguarding Children will inform the CCG Designated Professional for Safeguarding Children, if necessary. The role of the Designated Professional would be to support the Responsible Paediatrician to escalate where drift or difference of professional opinion are unresolved.

6. **Immediate risk of serious harm**

Where there are concerns that the child is at immediate risk of serious harm, routine local safeguarding procedure must be followed. A referral must be made to the Multi-Agency Safeguarding Hub (MASH) or out of hours to the Emergency Duty Team (ETD)

If intervention is required immediately due to concern about immediate serious harm to the child e.g. observed that medication / feeds tampered with in hospital, medical staff should call the Police using the '999' service.

Concerns regarding the possibility of FII must not be shared with parents/carers as this may increase the risk to the child.

7. Identification of Responsible Paediatrician

A Responsible Paediatrician, as defined in RCPCH guidance, will be identified and other health colleagues will be responsible to assist. The Responsible Paediatrician will consult with the Named Safeguarding Professional who will inform the Designated Doctor for the local Clinical Commissioning Group (CCG), if necessary.

8. Establish Chronology within 4 weeks

The Responsible Paediatrician will establish a comprehensive health chronology within four weeks of the concern being raised. To enable this they will request comprehensive chronologies from other appropriate health professionals. The formatted letter and chronology template as appendix 2 & 3 will assist. Other professionals have a responsibility to provide the requested information in the identified format within two weeks of receipt of this request. The Responsible Paediatrician will take the responsibility to collate returned chronologies into a combined health chronology.

9. Health Professionals Meeting

By week five a health professional meeting must be held and chaired by the Responsible Paediatrician, on the day as stipulated in the letter. The combined health chronology will be circulated by the Responsible Paediatrician prior to the scheduled meeting. Each professional will have a responsibility to analyse the chronology in advance of the scheduled meeting. This preparation will inform decision making at the health professional meeting.

Outcome is either;

10. Insufficient evidence of FII at this time

This may be due to clinical issues or parental issues. The process will revert to a co-ordinated Support Plan, including continuing monitoring and review of the child's situation. This may require consideration of referral appropriate to the child and carers needs. This will include consideration for referral to early help or Children Social Care section 17 Child In Need of assessment. The evidence should be reassessed specially in subsequent presentations and a referral to Multiagency Safeguarding Hub (MASH) should be initiated as appropriate

11 Evidence of FII:

This will require that the Responsible Paediatrician **must** make an immediate referral to Children's Social Care (MASH). Referral should include the comprehensive chronology and professional analysis to support the FII concern. The referral should request a Strategy Meeting to include all appropriate health professionals and other professionals who have contact with the child; this will ensure co-ordinated and measured health, social care and police response. The outcome of the meeting could be either to proceed to section 47 enquiries or section 17 child in need assessment

13. Disclosure of outcome to parents /carers

Disclosure of outcome to parents should be made only in agreement with the paediatrician, social work manager and police and, should be made jointly if appropriate

Professional Documentation

At all times health professionals are required to maintain detailed contemporaneous records. Where there are concerns about perplexing presentation professionals must keep detailed notes and clearly state what was observed by the professional and who reported what. When information/explanation is provided to the carer/parent the professional must record detailed accounts of what and how information/explanation was provided, stating who, what and how the information was provided and received. Chronologies must be commenced at the earliest opportunity supported by regular summaries in the records.

The use of covert video recording is not permitted without full agreement and direction from the police.

References

Child Protection Companion 2013 2nd Edition

Safeguarding Children In Whom Illness Is Fabricated or Induced (HM Government 2008)

RCPCH 2021 Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children
RCPCH guidance

Pan-Bedfordshire Safeguarding Working Group

Date 01/7/2021

Table 1: Spectrum of cases where FII concerns may arise

Starting point: A child is presented for medical attention, possibly repeatedly, with symptoms or signs suggesting significant illness; an appropriate clinical assessment suggests that the child's 'illness' is not adequately explained by any disease. The examples below illustrate the range of possible considerations.				
<i>Example 1</i>	<i>Example 2</i>	<i>Example 3</i>	<i>Example 4</i>	<i>Example 5</i>
Type of presentation				
Simple anxiety, lack of knowledge about illness, over interpretation of normal or trivial features of childhood; may in some cases be associated with depressive illness in carer	Child's symptoms are misperceived, perpetuated or reinforced by the carer's behaviour; carer may genuinely believe the child is ill or may have fixed beliefs about illness	Carer actively promotes sick role by exaggeration, non-treatment of real problems, fabrication (lying) or falsification of signs, and/or induction of illness (sometimes referred to as 'true' FII)	Carer suffers from psychiatric illness (e.g. delusional disorder) which leads them to believe child is ill	Unrecognised genuine medical problem becomes apparent after initial concern about FII
Underlying factors				
Carer's need to consult a doctor may be affected by inability to cope with other personal or social stresses, such as mental health issues	'Illness' may be serving a function for carer, and subsequently for an older child too (secondary gains)	There may be a history of frequent use of, or dependence on, health services; carer may have personality disorder or the child's 'illness' may be serving a purpose for the carer	Carer's mental health problems	
Carer's insight				
It is usually possible to reassure carer although they are likely to present again in future	Difficult to reassure carer; carer and professionals may not agree on the cause of symptoms and/or the need to consult or investigate further	It is not possible to reassure carer; carer's objectives are diametrically opposed to those of professionals	Carer lacks insight into their involvement in the child's supposed illness	Carer's 'illness behaviour' will usually be appropriate for the signs displayed by child, although any child protection interventions may affect the carer's behaviour

Level of risk				
Seldom reaches threshold of significant harm	May be disabling for the child; often some risk of significant harm, including emotional or educational harm, or social isolation	High risk of harm; always some resultant harm, often severe	May be risk of harm	Risk of harm due to inappropriate child protection process and delay in correct diagnosis
Iatrogenic harm				
Possible iatrogenic harm risk	Significant risk of iatrogenic harm	Very high risk of iatrogenic harm	Usually low risk of iatrogenic harm	See above
Management				
Discuss carer's concerns openly; manage case primarily by reassurance; try to address any wider needs of the carer	Discussion with carer may need to be handled very sensitively; if in doubt discuss with appropriate colleague; firm reassurance will be needed; avoid iatrogenic harm by not conducting further unnecessary investigations and treatments; multiagency assessment may be needed to gain an understanding of what underpins carer's behaviour (either 'Child in Need' (section 17, Children Act 1989) or child protection referral (section 47, Children Act 1989) referrals may be indicated)	LSCB procedures apply; take immediate steps to reduce iatrogenic harm if possible; do not disclose concerns to carer(s) without first discussing the case within the Safeguarding team.	Discuss with carer whether they feel that they have any mental health needs and how those might be addressed; consider discussing with GP or other relevant professional (bearing in mind the constraints of patient confidentiality); take steps to address carer's mental health needs; child may be 'Child in Need' (section 17, Children Act 1989)	Consult widely with colleagues if a 'false positive' child abuse diagnosis seems likely; if safeguarding procedures have already been activated, an immediate strategy discussion should be requested and the situation should be discussed with carers without delay; the possibility of 'false positive' child abuse diagnosis must always be considered; the child's clinical progress should always be monitored in case a genuine illness has been missed

Perplexing Presentation with safeguarding concern – CASE REVIEW CHRONOLOGY FORM

NHS No: if known

Child's Full Name:

Parents/ Carers Full Names

Date chronology completed:

Agency:

Date of Incident/contact	Reason for contact Please state scheduled or unscheduled contact.	Child's views & presentation.	Impact on child's welfare & development	Action taken	Source (where, whom and how information obtained, date recorded)

For Health Professionals Only

Once this document is saved please add an entry 'Potential Safeguarding Concern– Case Review Chronology Form completed' in the Safeguarding Child Information section of your records.

Private & Confidential: Safeguarding Concern

Not for sharing or requiring parental consent to share information

Name:
 Designation:
 Organisation:
 Base Address:
 Telephone:
 FAX:

Insert professional title:
 Address:
 Telephone:
 Fax:

Date:

Dear

Re: Childs details / Address / D.O.B. / NHS number

There are concerns that the health or development of this child is potentially being impaired by a parent or care giver who has fabricated or induced illness, in the child.

As the Responsible Paediatrician (as per RCPCH guidance 2008), I am responsible for collating information from involved health professionals to support discussion at a health professionals meeting.

You are required to provide relevant background information from your records, for this child, by completing the attached chronology template. This will support a full assessment of needs.

Please can this information be provided to me by *insert date 2/52 timeframe....* to allow information to be collated for the professionals meeting

It is important that information is not shared with the parents or carers. You should be aware that doing so could significantly increase risk to the child.

You are requested to attend the professionals meeting arranged for.....*Insert date time & venue.....*

Please confirm your attendance as soon as possible.

Yours sincerely

Named Safeguarding Professionals

Bedfordshire & Luton CCG / Bedfordshire & Luton CCS / ELFT / Bedford Hospital / Luton & Dunstable Hospital

Name	Designation	Contact Number	E-mail address
BEDFORDSHIRE CCG			
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