



South East London
Clinical Commissioning Group

NHS South East London Clinical Commissioning Group

**GUIDANCE FOR THE MANAGEMENT OF CASES OF
PERPLEXING PRESENTATIONS, OR, SUSPECTED
FABRICATED OR INDUCED ILLNESS**

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1. Introduction

This guidance is written to support multi-agency frontline practitioners to make appropriate decisions on how to safeguard children who present with perplexing presentations (PP) and Fabricated Induced Illness (FII), and advise practitioners on how to recognise these issues, how to assess risk and how to manage these types of presentations in order to obtain better outcomes for children.

This guidance is based on the Royal College of Paediatrics and Child Health (RCPCH) 2021 guidance as well as learning from Serious Case Reviews, and aims to put the RCPCH 2021 guidance in context for South East London Integrated Care Partnership based practitioners (SELICB).

Whilst mainly applicable to health practitioners, this multiagency guidance is applicable to all frontline staff working with children, young people, and their families.

The term 'children' or 'child' applies to all children and young people who have not yet reached their 18th birthday as per the Children Act 1989. The fact that a child has reached 16 years of age; is living independently or is in further education; is a member of the armed forces; is in hospital; in prison or in a young offender's institution, does not change his or her status or entitlement to services or protection under the Children Act 1989.

2. Purpose

The purpose of this policy is to:

- Provide the integrated care partnership with a single consistent approach in the management of PP, or suspected FII.
- To advise safeguarding partnerships of a single consistent approach across local providers and staff in the management of PP, or suspected FII.
- Provide staff with the information and guidance they need to fulfill their statutory duties to safeguard and protect children and young people when there is suspected PP or FII.
- To clearly define roles and responsibilities so that the process is transparent, and staff understand the complexities involved and have realistic expectations about the timeframes within which any given case can be managed.

3. Descriptions

Medically Unexplained Symptoms (MUS)

The symptoms which the child complains, and which are presumed to be genuinely experienced are not fully explained by any known pathology. These are usually psychosocial and may be part of PP or FII.

Perplexing presentations (PP)

Alerting signs only; There may be discrepancies between reports, presentations and observations, or implausible descriptions, findings, or parental behaviours, (not yet amounting to likely or actual significant harm). Needs a specified paediatric /CAMHS lead to collate and assess all information, supported by Named Doctor to assess risk, and a multi-professional and holistic medical and psychosocial consensus approach to agree when to gain views and involve parents and child in the discussions. Any second opinion must

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include all background information and must be reasonable. Lack of engagement or concerns may lead to referral to Children's social care.

Fabricated and Induced Illness (FII)

Clear deception/ illness induction or immediate, serious risk to life

4. Considerations if there are Alerting signs

- Illness may not be independently verified, there may be unusual results, unexpectedly poor treatment response, impaired daily living more than expected. These signs may be in context of known illness.
- Parents may want more investigations, multiple opinions or present with new symptoms. Despite this, the child may not be taken to appointments, and may not be able to be seen alone. Parents may object to communication between professionals and may make frequent complaints about professionals.
- The paramount consideration for health professionals is the impact of the situation on the child's health and wellbeing.
- These signs may not amount to probable FII or PP but should also be considered along with general safeguarding concerns as to whether there is harm to the child.

5. Imminent risk to life/health

1. When there is evidence of deception, interfering with specimens, unexplained results of investigation suggesting contamination or poisoning or actual induction of illness or concerns that open discussion with parent might lead them to harm about a child's health this should be discussed urgently with the child's GP, the practitioners safeguarding lead, and with the child's Paediatrician if known to their service.
2. Concerns regarding the possibility of FII **must not** be shared with parents/carers as this may increase the risk to the child and this should be reiterated as part of the discussion. Decision should be made as to the urgency of any further meeting or referral to children's social care
3. If intervention is required immediately due to concern about immediate harm to the child e.g., observed that medication / feeds tampered with in hospital, medical staff (supported by the clinical and safeguarding lead) should call the Police using the '999' service, otherwise a referral should be made to the Police and MASH with a request for an urgent strategy discussion.
4. The practitioner should inform their line manager and safeguarding lead and seek support and advice from their Safeguarding Children Team/Lead.
5. Referral should be made to Children's Social Care and the Police, and an urgent strategy meeting should be requested with key professionals as to immediate next steps.

6. The formal strategy meeting should take place as soon as possible involving as a minimum the lead clinicians and safeguarding lead, and Designated Professionals from the relevant borough base of SEL ICB for Safeguarding Children should be invited. Involved clinicians should all be invited, including the GP. All invitees must prioritise attendance at this meeting even if it means rescheduling other appointments. If attendance of a professional is still not possible then a fully briefed substitute must attend. It is important that the substitute be able to make decisions on behalf of the professional. All professionals are expected to attend the meeting fully prepared and able to discuss their concerns and understand that concerns should not be shared with the parents at this stage.
7. If at any time the practitioner considers their concerns are not being taken seriously or responded to appropriately; s/he should discuss this with Named safeguarding professional, or the Designated Safeguarding Children professionals within the CCG. Concerns should be escalated in accordance with this policy.
8. Agreement is needed about the safeguarding response, and when and who should inform the parents.
9. The practitioner, with the support of the Safeguarding Professional, should prepare a chronology (see appendix 2)
10. The practitioner should continue to record their concerns and observations accurately and objectively in the child's health record so that other clinicians have access to the information. In such cases parent/carers access to the record will need to be restricted, with a clear note to reflect this, if there would be risk to the child.
11. A follow up Professionals' Meeting with the Designated Doctor and all other involved healthcare professionals will be arranged by the Responsible Paediatrician for feedback of the outcome and any further action required. If the child had been referred to CSC, then this should be prior to discharge from CSC oversight and otherwise within six weeks to allow time to gather any further information if needed. See Flow charts in Appendices

6. Management of probable FII

1. There may be clear deception, or illness induction, or serious immediate risk to life/health and it will be essential to act directly as for probable FII (section 5 above). Where the risk is not immediate and the consultant has reasonable cause to suspect that a child is suffering or likely to suffer significant harm (*from probable FII or other reason*), a referral should be made to the police and local authority's Children's MASH Services for an urgent strategy discussion with professionals involved with the child.
2. If the child is not under the care of a consultant, the GP will need to make a referral to an appropriate Consultant Paediatrician. This referral will be facilitated by the Named/SEL ICB (Borough based) Designated Doctor and should reiterate the need not to alert the parents/carer to the possibility of FII at this stage. The Responsible Paediatrician/CAMHS doctor will arrange for a medical evaluation to take place as appropriate.

3. Identification of probable FII can be a difficult and protracted task and may require a multi-agency approach and expertise and relatively long periods of observation.
4. **Information gathering is usually needed to understand if this is Probable FII, or PP, or MUS** as the management is very different. (also see considerations for medical evaluation).
5. If concerns persist about probable FII, and it is still unclear whether this meets the threshold for referral to children's social care (i.e., as for 'probable FII' above, then, with the support of their Safeguarding Lead, the lead clinical practitioner will arrange an initial professional's Meeting to take place within 10 working days, or earlier if required. All health professionals involved in the child's care should be invited. All invitees must prioritise attendance at this meeting even if it means rescheduling other appointments. If attendance of a professional is still not possible then a fully briefed substitute must attend. It is important that the substitute be able to make decisions on behalf of the professional. All professionals are expected to attend the meeting fully prepared and able to discuss their concerns and) understand that concerns should not be shared with the parents at this stage. Children's social care, the school and the child's GP should be invited to this meeting.
6. The meeting should explore and find agreement about any deception, or illness induction, and if there is potential serious or immediate risk to the child's life as well as any other safeguarding risk.
7. The decision from this meeting should consider: -
 - a. If this is 'Probable FII' with immediate serious risk to the child's health or life (see flowchart below), or if this is not
 - b. It should be managed as a perplexing presentation
 - c. If there are any other safeguarding risks including for other children.
 - d. If a detailed chronology will be helpful, it should be completed by all involved practitioners regarding their own involvement with the child (see appendix 2) within 10 working days (or sooner if necessary) and returned to the Responsible Consultant for the case for collation within health in conjunction with the Named Doctor. The composite chronology will be shared with the Named Doctor if not already involved, the Designated Doctor.
8. The 'Responsible Paediatrician'/ 'Responsible CAMHS doctor' will chair the meeting. Clear terms of reference and records of the meeting must be made available at the time, the arrangement of these made by the chair. In cases where the child is not under care of any tertiary doctor, the SEL ICB (Borough Based) Designated Doctor will chair the meeting.
9. Whilst professionals should in general, discuss any concerns with the family and, where possible, seek agreement to making referrals to Children's Social Care, this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm, and for probable FII should only be shared after agreement at the multiagency strategy discussion.
10. At this stage any referral to social care and police as appropriate should lead to a strategy discussion with key professionals involved with the child.

11. If there is no obvious deception, illness induction and no serious immediate risk, in which case the clinical management should be managed as for PP as below.

5. Perplexing Presentations and Management

1. Alerting signs are present e.g., illness not independently verified, or results are not as expected, or the child has impaired daily life more than expected and the parents may want more investigations or opinions, and may be reluctant to allow professionals to communicate, or allow discussion with the child on their own.
2. The Responsible Paediatrician/CAMHS doctor will arrange for a medical evaluation to take place as appropriate. If the child is not under the care of a paediatrician, the GP will need to make a referral to an appropriate Consultant Paediatrician. This referral will be facilitated by the Named/ SEL ICB (Borough based) Designated Doctor and should reiterate the need *not* to alert the parents/carer to the possibility of FII at this stage (see 6.2.2).
3. ***If it assessed that there is NO clear deception, no illness induction, and no immediate serious risk to life or health, then these are treated as PP.***
4. There must be a lead/responsible clinician who should discuss with their clinical supervisor, who should discuss with the Named Doctor of the trust (the Designated doctor if the responsible clinician is the Named Doctor). If the concern arises in General Practice, then the Named GP should be consulted.
5. Third sector volunteers and staff should discuss with their safeguarding supervisor, who will need to discuss with the Named Doctor in the trust. There needs to be a carefully planned approach.
6. The responsible clinician should obtain a history and observations from caregivers, explore parental views, family functioning and support and any need for/previous early help or social care involvement. (A chronology may be helpful, see chronology template in appendix 3)
7. The child's view should be explored alone, to find out their view and beliefs as well as worries, mood and wishes. The Three Houses tool is useful to explore their views, or RCPCH tools referenced in the 2021 guidance.
8. There may be safeguarding, or welfare needs that are unmet, and these must be considered separately to the clinical picture; these may need action independent of any consideration of immediate risk relating to the clinical picture.
9. **There needs to be an assessment of risk, and a consensus reached between all health professionals known to the child.** Then, if there is no immediate risk, then the supervising doctor along with a colleague will involve parents in the assessment plan
10. If the referral is from school, then the school must tell the parents that they need information from health to understand e.g., poor attendance. If the parents do not agree with this health referral, then the school should follow safeguarding guidance as to whether to escalate to children's social care. **Do NOT use the terminology Fabricated and Induced Illness.**

11. With PP, the responsible clinician (paediatrician or CAMHS) needs to maintain a clinical oversight and continue to see the child even after usual discharge from care.
12. The Named doctor will take the *safeguarding* decisions to maintain clinical continuity of care. The child's consultant should collate all information including diagnoses, investigations, and referrals, as well as information from school and other professionals. Notes from meetings may be given to parents. Any second opinion should be reasonable. **Safeguarding and clinical care are kept separate by two different clinicians.**
13. It is **essential** to try to reach a consensus in a health professionals meeting with information from all involved health professionals, as to whether perplexing presentation is explained, and resolved, or concerns remain; this should be chaired by the Named Doctor and the parent informed of this.

The outcome of this meeting needs to be a consensus about the following.

 - i. Medically explained/unexplained symptoms,
 - ii. Actual or likely harm/not
 - iii. Further investigations?
 - iv. Support needs of family
 - v. Health of siblings
 - vi. Consider Local service consultant if only tertiary care
 - vii. What to do if parents disengage
 - viii. Plans for meeting with parents (and which two professionals will attend)
14. NB If there is no consensus, then this may need the Designated Doctor to chair a health professionals meeting
15. The Responsible Consultant should meet with the parents to share the consensus and plan which can be negotiated with the young person if possible
16. A co-constructed plan should be made with Education to get a child back to school and be carefully monitored by health and education. This should be led by the Lead professional who should call a Team around the Child (TAC) meeting (this plan may be called a Health and Education Rehabilitation plan). IF the child has already been referred to CSC and escalated then this would be included in the CIN or CP plan.
17. Referral to children's social care may be needed, and the reasons shared with the family, for example if the parents do not support a Health and Education Rehabilitation plan.
18. The child's GP should always be informed and be able to give a view as to the plan and may need to support the parent/carer with any known mental health difficulties e.g., anxiety.
19. Parents and young people should be informed of the outcomes of professional meetings if it is safe to do so.

6. Considerations for Medical Evaluation

1. All signs and symptoms must be subject to careful medical evaluation for a range of possible diagnoses.
2. All tests and their results should be fully and accurately recorded, including those with a negative result. It is important that the child's records are not tampered with, or test results altered in the child's notes.
3. If the child is not currently in hospital, consider whether a planned admission with careful observation would help to elucidate the clinical diagnosis.
4. Carefully consider whether any immediate investigations or further opinions are likely to assist in the diagnosis.
5. Stop any harmful treatments or invasive procedures unless they are clearly indicated. It is unacceptable to cause a child further harm from medical actions, whilst the diagnosis of FII is being considered.
6. Do not wait to confirm the diagnosis before referring to children's social care as a delay may be detrimental to the child. Referral is indicated if there is a risk of immediate harm to the child through illness induction, or harm through the carers disagreement with the need for further observation or with paediatric consensus about the child's state of health.
7. A chronology of health involvement from all health agencies should be prepared to provide comprehensive information, an overall picture and evidence.
8. Concerns about the reasons for the child's signs and symptoms should not be shared with parents if this information is likely to jeopardise the child's safety.

7. Considerations for MASH on receipt of referral

1. Imminent or probable risk to child's health/ life from FII or another cause should involve an urgent strategy discussion involving as a minimum the lead clinicians and safeguarding lead, and Designated Professionals from SEL ICB (Borough based) for Safeguarding Children should be invited. Involved clinicians should all be invited, including the GP. No information should be shared with the parents (sections 5 and 6 above)
2. If referral received and uncertain if FII, will always need consideration of any harm to the child and needs discussion with the clinical lead consultant for the child / Named Doctor (or the Designated Doctor if there is no allocated consultant yet and the referral is for example from Education). Parents must not be informed of the progress at this stage, but the case may be managed as for perplexing presentations in the first instance (section 7).
3. Failure to progress in management of perplexing presentations will need a professional's meeting with an agreed plan. This would need to be referred to child and family assessment.

4. At any stage in the process referral may be made because of likely /experienced harm and will need to be managed as usual through the MASH process.

8. Record Keeping

1. Medical records should be kept in accordance with the Data Protection Act 1998. Practitioners should also follow the principles of record keeping set out in guidance documents supplied by their Professional bodies.
2. Detailed, accurate and informative medical records are pivotal to the management of a suspected FII case. If a child moves between clinical teams or between organisations, it is best practice for the notes to follow the child. This may not always be possible and so a clinical summary must accompany the child.
3. It is essential that the records include a health chronology of the child's medical presentation, including aspects which may indicate FII. It is crucial to record the source of information, e.g., whether a symptom or sign was independently observed by staff or reported by a parent / carer.
4. If FII is suspected, requests by a child's parent / carer to access their records under the Data Protection Act 1998 may be refused if:
 - The disclosure would be likely to cause serious harm to the physical or mental health or condition of the child
 - The child has provided the information in the expectation that it would not be disclosed to the parent / carer
 - The data was obtained because of an examination or investigation to which the child consented in the expectation that the information would not be so disclosed
 - The child has expressly indicated that the information should not be so disclosed.

9. Training and Supervision Requirements

1. All staff who come into contact with children or their families should have appropriate safeguarding training and an understanding of PP and FII. Those specialising in the care of children or families need additional training to ensure a higher level of awareness and understanding of PP and FII.
2. Staff will need support and supervision in dealing with cases of PP or suspected FII. Staff support should be an integral part of a health professional's contract. It is important that line management and professional supervision and mentorship arrangements are explicit so that staff know how to access additional support when it is needed. The facilitation of debriefing sessions can be helpful in providing support for all members of the team.

10. Monitoring

This guidance and application will be reviewed annually at the Safeguarding Named and Designated Professionals Meeting.

11. Equality and diversity statement

NHS Southeast London CCG is committed to equality of opportunity for its employees and members and does not unlawfully discriminate based on their “protected characteristics” as defined in the Equality Act 2010 - age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. An Equality Impact Assessment has been completed for this policy.

If members or employees have any concerns or issues with the contents of this policy or have difficulty understanding how this policy relates their role, they are advised to contact the Chief Operating Officer.

13. Links to other Policies/Documents and Guidance

This guidance is to be used in conjunction with:

- RCPCH (2021) PP or Fabricated Induced Illness in Children guidance
- Working Together to Safeguard Children 2018

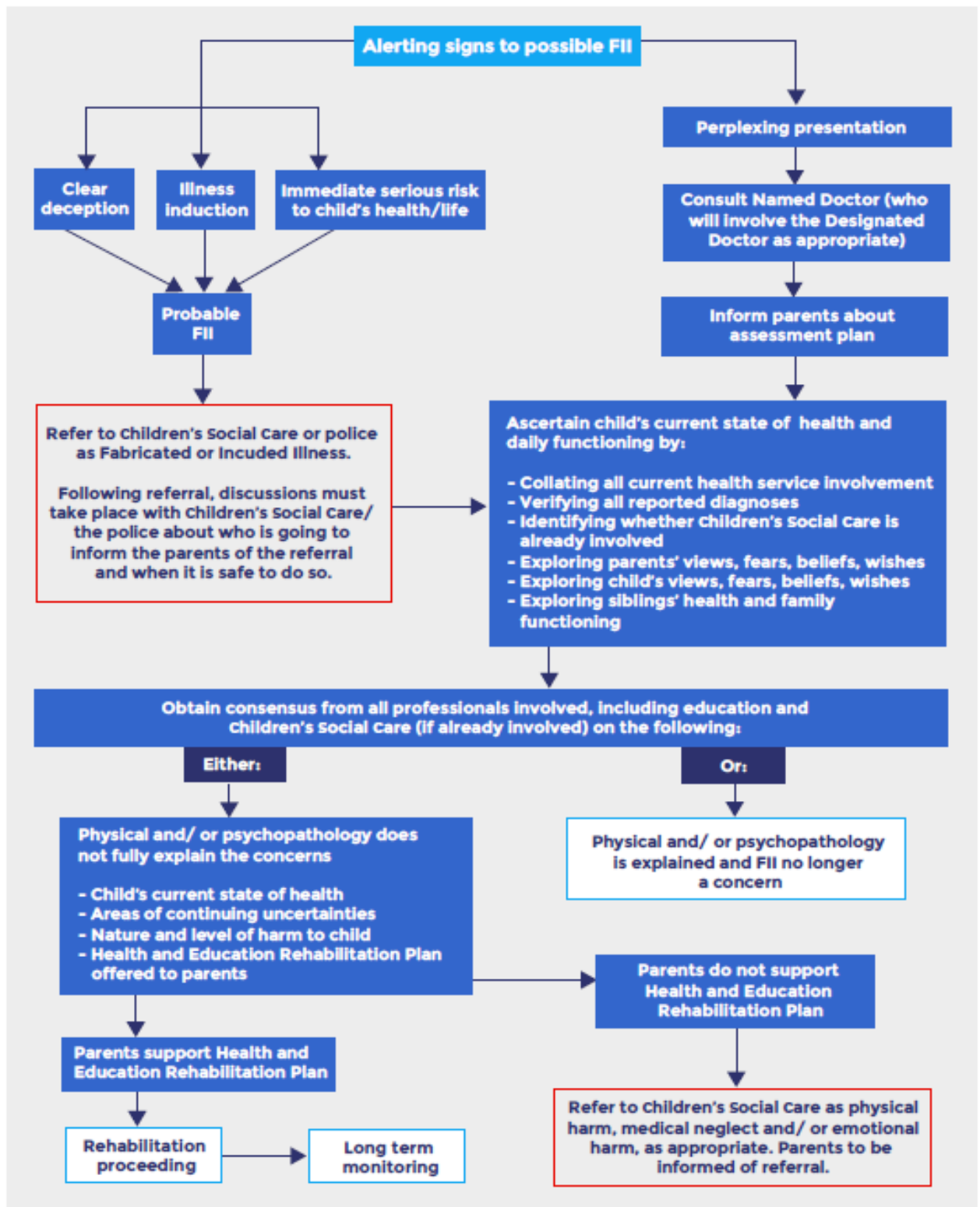
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8. Sheridan (2003) The deceit continues: an updated literature review of Munchausen Syndrome by Proxy. Child Abuse and Neglect 431-451 <https://pubmed.ncbi.nlm.nih.gov/12686328/>
7. RCPCH (2021) PP or Fabricated Induced Illness in Children guidance <https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/>

(BHC)

Appendix 1: Generic flow chart when there are alerting signs

This diagram outlines the pathway approach to be followed after identification of alerting signs.



Appendix 2: Spectrum of cases where FII concerns may arise (RCPCH, 2013)

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.				
Example 1	Example 2	Example 3	Example 4	Example 5
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 carers 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, 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	Unrecognized 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 the 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 inappropriate for the signs displayed by child, although any child protection interventions may affect 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	Significant risk of iatrogenic harm	Very high risk of iatrogenic harm Usually low risk of	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 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; child protection referral may be indicated	Local Safeguarding Children Board procedures apply; take immediate steps to reduce iatrogenic harm if possible; do not disclose concerns to carer(s) without first discussing the case with the safeguarding team	Discuss with carer whether they feel that they have any mental health needs and how these might be addressed; consider discussing with GP or other relevant professional (bearing in mind the constraints of confidentiality); take steps to address carer's mental health needs; child may be a 'child in need' (Section 17, Children Act 1989)	Consult widely with colleagues if a 'false positive' child abuse diagnosis seems likely; if safeguarding procedures already activated, request immediate strategy discussion, and discuss situation 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 genuine illness has been missed

Appendix 3: Sample of Chronology Template

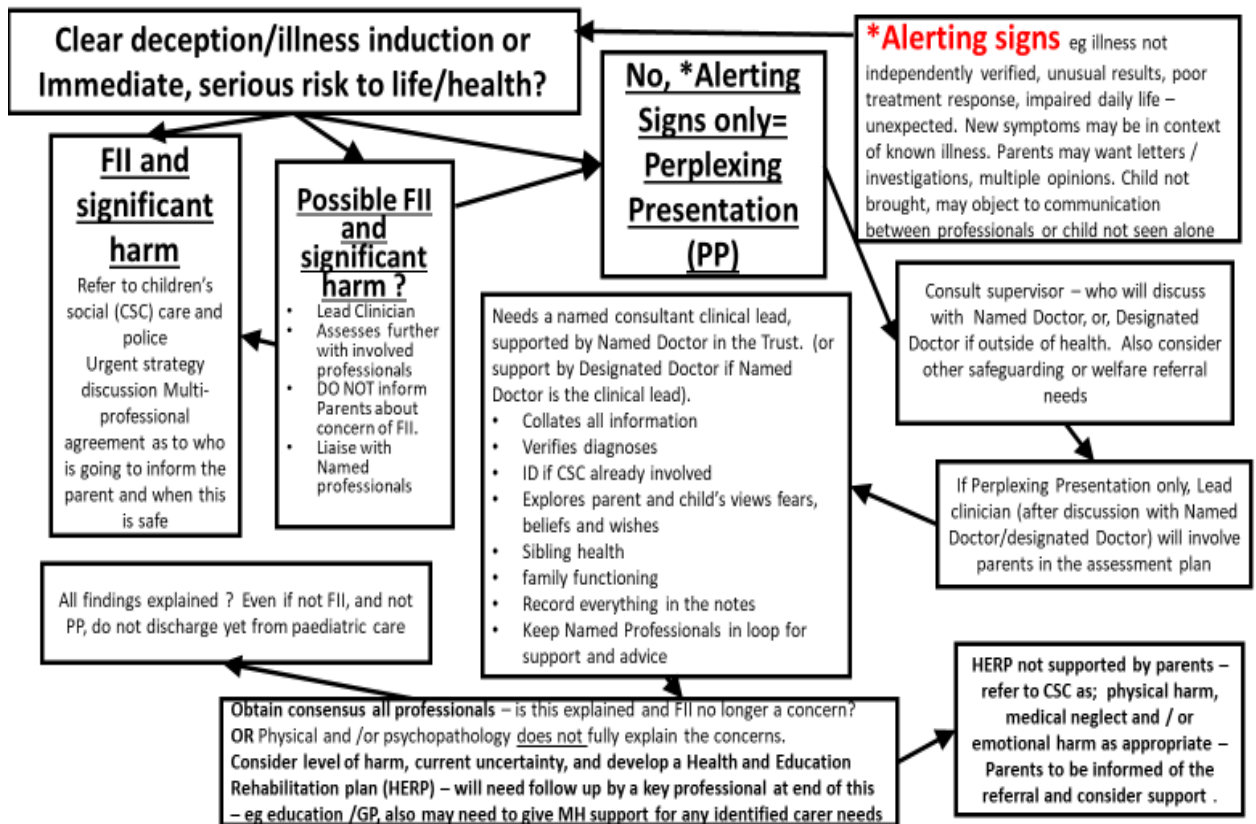
DATE / TIME and AGENCY	WHAT WAS REPORTED	SOURCE OF INFORMATI ON	WHAT WAS OBSERVED BY WHOM	WHAT ACTION WAS TAKEN AND ON WHAT BASIS	OUTCOME OF ACTION	ANALYSIS	COMMENT

Date approved:

Review date:

Appendix 4: Over View Chart

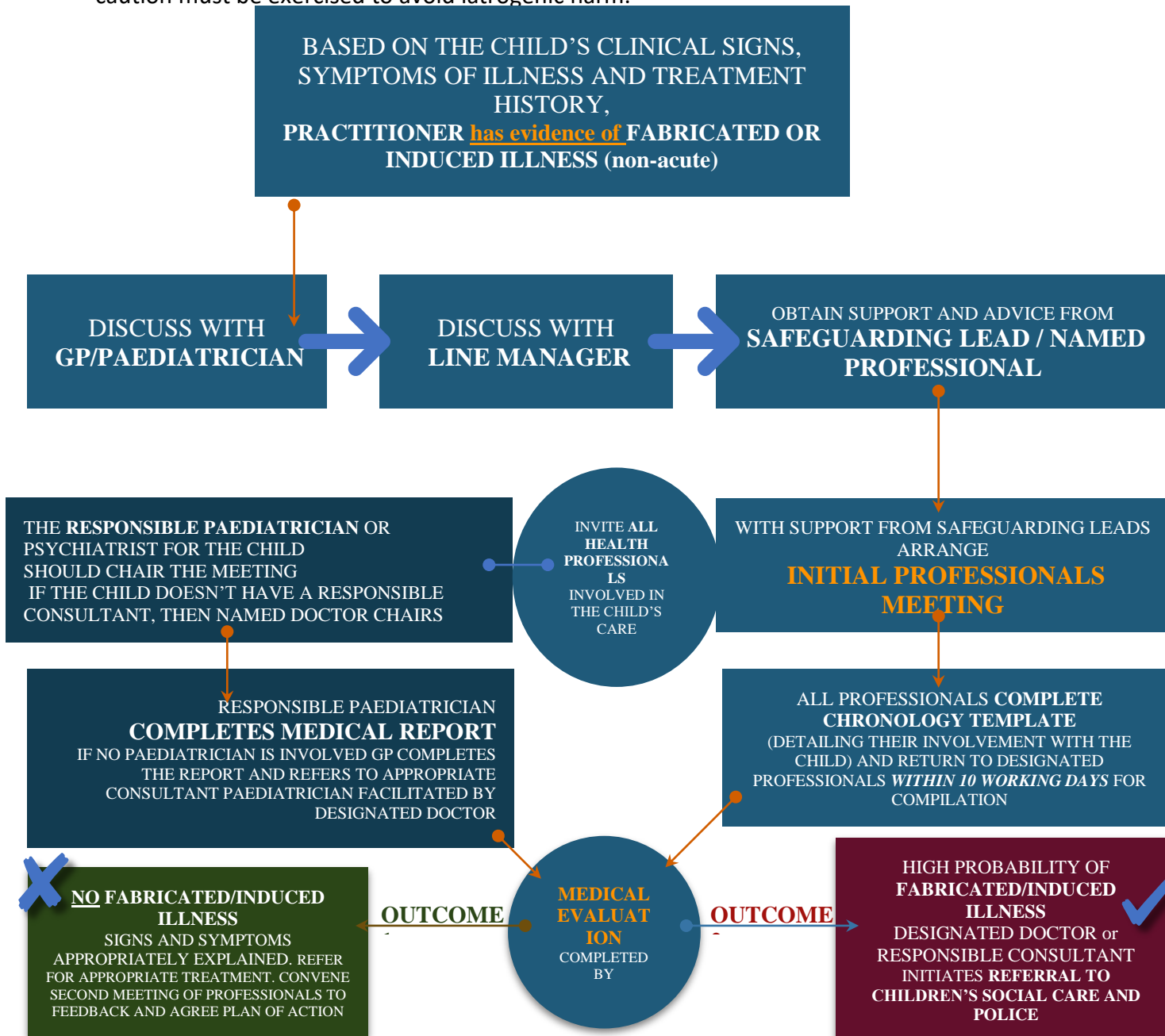
Summary diagram of actions if there are alerting signs



Appendix 5: Flowchart for Health Professionals where there is Probable FII and there is no immediate risk to life of the child

Throughout the process outlined below the following overarching principles must be followed at all times:

1. Do **NOT** share your concerns with parents or carers
2. If there is risk of significant harm or there are emergent concerns about the child's immediate safety refer immediately to Children's Social Care and the Police -*do not hesitate*
3. If the progression through the pathway stalls or sufficient progress isn't being made, practitioners **MUST** seek supervision and escalate the case using the procedure set out in this policy
4. Specialist advice and appropriate medical tests are not altogether contraindicated; however, caution must be exercised to avoid iatrogenic harm.



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