Acacium Group

Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children Policy

Policy Reference | CLIN 66

Version | 1.0

Policy Name	Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children Policy
Purpose of Document	To set out the Acacium Group Approach to how PP and FI are managed in line with Safeguarding Children Policy
Target Audience	All Acacium Group Employees
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Author	Charlotte Reeves
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Risk and Resource Implications	Risk – Children at risk are not identified or managed appropriately Resource - Training
Associated Strategies and SOPs	CLIN 08 Safeguarding and Protecting Children (England, Wales and Northern Ireland) CLIN 09 Safeguarding Vulnerable Adults at Risk
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
V0.1	Dec 2023	DRAFT	Charlotte Reeves
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1. Introduction

1.1 Behaviours in FII can include a parent or carer who persuades healthcare professionals that their child is ill when they're healthy. They can exaggerate or lie about their child's symptoms and manipulate test results to suggest the child is ill, for example, by putting glucose in urine samples to suggest the child has diabetes.

1.2 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.

1.3 This policy will reflect the supplementary guidance to Working Together to Safeguard Children in whom illness is fabricated or induced (**H.M. Government 2008**) and Perplexing Presentations (PP)/Fabricated or Induced Illness in Children Guidance (**RCPCH 2021**).

1.4 Since the publication of the Royal College of Paediatrics and Child Health (RCPCH) guidance on Fabricated or Induced Illness by Carers (FII) in 2009, there have been significant developments in the field. The RCPCH Child Protection Companion 2013 extended the definition of FII by introducing the term Perplexing Presentations with new suggestions for management.

1.5 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 (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 many cases seen by paediatricians, most cases in the literature report deliberate physical abuse by the carer.

2. Purpose and Policy Statement

2.1 Safeguarding Children in Whom Illness is Fabricated or Induced (supplementary guidance to Working Together to Safeguard Children, HM Government 2008) recognises that the use of terminology to describe the fabrication or induction of illness in a child has been the subject of considerable debate between professionals. That guidance states that there are three main ways of fabricating or inducing illness in a child. These are not mutually exclusive and include:

a) Fabrication of signs and symptoms. This may include fabrication of past medical history
b) Fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents
c) Induction of illness by a variety of means.

3. Scope of Policy

3.1 Royal College of Paediatrics and Child Health guidance **Perplexing Presentations (PP)/Fabricated or Induced Illness in Children (2021)** uses the following definitions.

3.2 **Medically Unexplained Symptoms**

3.2.1 Medically unexplained physical symptoms (MUPS) are when someone suffers from physical symptoms for which no underlying physical cause can be found. The child complains of symptoms which are genuinely experienced but not fully explained medically. Physical illness or injury may be a factor at the beginning, but when no obvious physical explanation can be found, emotional or psychological problems need to be considered. This is acknowledged by

both clinicians and those with parental responsibility who work collaboratively to achieve therapeutic work in the best interests of the child.

3.3 **Perplexing Presentations (PP)**

3.3.1 The presence of alerting signs of possible Fabricated or Induced Illness but when the actual state of the child's physical/mental health is not yet clear and there is no perceived risk of immediate serious harm to the child's physical health or life. The actual state of the health of the child will need to be established.

3.3.2 The essence of alerting signs is the presence of discrepancies between reports, presentation of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.

3.4 **Fabricated or Induced Illness (FII)**

3.4.1 A clinical situation in which a child is, or is very likely to be, harmed due to parental/carer behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired or more impaired than is actually the case. FII can result in emotional and physical abuse and neglect as a result of parental/carer actions, behaviours or beliefs and from doctors' responses to these. This can include inadvertent harm caused by medical professionals such as unnecessary invasive investigations/procedures. The parent/carer does not necessarily intend to deceive, and their motivations may not be initially evident. Previously known as Munchausen Syndrome by Proxy.

4. Definitions

Definition	Explanation
Perplexing Presentations (PP)	Presence of alerting signs when the actual state of the child's physical/mental health is not yet clear but there is no perceived risk of immediate serious harm to the child's physical health or life.
Fabricated or Induced Illness (FII)	FII is a clinical situation in which a child is, or is very likely to be, harmed due to parental behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect.
Medically Unexplained Symptoms (MUS)	The child's symptoms, of which the child complains, and which are genuinely experienced, are not fully explained by any known pathology but with likely underlying factors in the child (usually of a psychosocial nature), and the parents acknowledge this to be the case. The health professionals and parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child or young person. MUS can also be described as 'functional disorders' and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body.

5. Roles & Responsibilities

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision.
Paediatric Consultant or Psychiatrist	Determine whether presentation of child by parents is indicative of FII or Perplexing Presentation but requires all professionals involved with child to respond to any emerging concerns by seeking further information from other professionals involved with child and family.
Professionals from a non-health setting	Report concerns and work closely with team to safeguard the child and all involved
Professionals from Health Setting	Where practitioners have concerns that a parent/carer is impairing a child's health, development, or functioning, they should meet with parents/carers to discuss the child's illness, parental concerns and ascertain which other health professionals are involved.
Named Doctor/Named Nurse for Safeguarding Children	The Named Doctor/named nurse is there to provide advice and support to the lead consultant; they will be expected to chair health professionals' meetings. If the named doctor is also the lead paediatrician, then the designated doctor will provide advice and support.
Health Care Practitioners including other Consultant Specialists	If a Health Care Practitioner including Consultant, other than a Paediatric or CAMHS Consultant, has a concern about PP/FII in a child in their care they should refer to a Consultant Paediatrician or discus with Safeguarding Children Team.
Designated Professionals for Safeguarding Children	Designated professionals can offer safeguarding supervision or facilitate professional discussions, particularly where the presenting issues are very complex. If named doctor is also child's paediatrician, then designated doctor will provide advice and support and chair professional meetings.
Clinical Advisory Group (CAG)	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

6. Alerting Signs of Possible Fabricated or Induced Illness

6.1 The following are indicators that should alert any professional to concerns that a child is suffering, or at risk of suffering Significant Harm as a result of having Illness Fabricated or Induced (FII) by their healthcare worker/family member:

a) Reporting symptoms and observed signs that are not explained by any known medical condition.
b) Reporting to professionals that a diagnosis has been made by another professional when this is not true and giving conflicting information to different professionals.
c) Missed appointments especially if the appointments are not leading in the desired direction for the healthcare worker of family member.
d) Physical examination and results of investigations that do not explain symptoms or signs reported by the healthcare worker/family member
e) The child having an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment.

f) Acute symptoms that are exclusively observed by/in the presence of the healthcare worker/family member.
g) On resolution of the child's presenting problems, the healthcare worker/family member reporting new symptoms or reporting symptoms in different children in sequence.
h) The child's daily life and activities being limited beyond what is expected due to any disorder from which the child is known to suffer, for example, partial or no school attendance and the use of seemingly unnecessary special aids.
i) Objective evidence of fabrication - for example, the history of events given by different observers appearing to be in conflict or being biologically implausible (such as small infants with a history of very large blood losses who do not become anaemic, or infants with large negative fluid balance who do not lose weight); test results such as toxicology studies or blood typing; evidence of fabrication or induction from covert video surveillance (CVS);
j) The healthcare worker/family member expressing concern that they are under suspicion of FII, or relatives raising concerns about FII;
k) The healthcare worker/family member seeking multiple opinions inappropriately. There may be a number of explanations for these circumstances, and each requires thorough and thoughtful review.

6.2 A characteristic of FII in the child is a discrepancy between the findings of the professional and signs and symptoms reported and/or observed. In diagnosed organic illness the professional may observe a lack of usual response to proven effective treatment (i.e. a child who suffers from asthma). It is this puzzling disparity that alerts the professional to the potential for harm to the child particularly where over time the child is repeatedly presented with a range of signs and symptoms or reported symptoms and found signs are not seen to begin in the absence of the healthcare worker:

6.3 FII may be manifest in a child in a number of ways. Fabrication of signs of illness may include false reporting of current symptoms or a fabrication of previous medical history. In addition to false reporting; falsification of letters, documentation and hospital charts and physical interference with specimens such as urine or stool samples may also be seen. Induction of illness can be achieved by a variety of means including, but not limited to, administration of household substances to induce vomiting, salt poisoning, withholding or over administration of medications, withholding of nutrition or intentional suffocation.

6.4 FII is relatively common in children who have an existing medical diagnosis including children with disabilities and developmental difficulties. This may be in the form of exaggeration of symptoms or unexpected responses to medications or treatment. Statistics show that disabled children are at increased risk of abuse ***(Jones et al, 2012).** FII can easily remain unappreciated and undetected in children who already have existing health care needs.

6.5 The needs of the child and the potential for significant harm must always be the first priority; however, it is important to consider what secondary benefit the parent/healthcare worker may receive by presenting their child to services in this way. This can take many forms. It is important to note that the exaggeration or falsification of conditions, existing or otherwise, may be perpetrated in an attempt to retain or qualify for financial aid in the form of disability living allowance.

6.6 The presenting signs and symptoms need careful evaluation for a range of possible causes. Professionals must remain open minded to all possible explanations. When dealing with their concerns for a child, a child may present for medical/health attention with unusual and puzzling symptoms that are not attributable to any organic disease and yet which do not involve deliberate fabrication or deception.

6.7 Concerns that a child's illness may be fabricated or induced are most likely to come from health professionals. However, any agency in contact with a child may become concerned, for example

educating staff where a child is frequently absent from school on questionable health grounds or nursery staff may not observe fits in a child who is described by a parent to be having frequent fits etc. It is essential that a paediatrician is involved in the assessment of FII. However the paediatrician will almost always need the help of social care and other agencies in gathering information needed to confirm or refute the diagnosis. The paediatrician will play a key role in the collation and interpretation of health information / evidence for non- health professionals.

***Jones, L. et al (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. Lancet 380(9845): 899-907.**

7. Harm to the Child

7.1 Harm to the child takes several forms. Some of these are caused directly by those with parental responsibility , intentionally or unintentionally, but may be supported by the doctor; others are brought about by the doctor's actions, the harm being caused inadvertently. The following three aspects need to be considered when assessing potential harm to the child. As FII is not a category of maltreatment in itself, these forms of harm may be expressed as emotional abuse, medical or other neglect, or physical abuse. There is also often a confirmed co-existing physical or mental health condition.

8. Child's health and experience of healthcare

8.1 The child undergoes repeated (unnecessary) medical appointments, examinations, investigations, procedures & treatments, which are often experienced by the child as physically and psychologically uncomfortable or distressing:

a) Genuine illness may be overlooked by doctors due to repeated presentations.
b) Illness may be induced by the parent (e.g. poisoning, suffocation, withholding food or medication) potentially or actually threatening the child's health or life.
c) Effects on child's development and daily life
d) The child has limited / interrupted school attendance and education.
e) The child's normal daily life activities are limited.
f) The child assumes a sick role (e.g. with the use of unnecessary aids, such as wheelchairs);
g) The child is socially isolated.
h) Child's psychological and health-related wellbeing
i) The child may be confused or very anxious about their state of health;
j) The child may develop a false self-view of being sick and vulnerable and adolescents may actively embrace this view and then may become the main driver of erroneous beliefs about their own sickness. Increasingly young people caught up in sickness roles are themselves obtaining information from social media and from their own peer group which encourage each other to remain 'ill';
k) There may be active collusion with the parent's illness deception;
l) The child may be silently trapped in falsification of illness;
m) The child may later develop one of a number of psychiatric disorders and psychosocial difficulties.

9. Emerging Concerns; Managing Uncertainty

9.1 It must be acknowledged that parents may present to services with varying levels of anxiety and the initial actions for professionals may be in acknowledging and addressing these issues with the family without embarking on further invasive tests or investigations. Such early intervention may enable a

clinician to identify causes of stress within a family unit which can then be signposted to appropriate services

9.2 In the majority of cases of identifying FII, there will be uncertainty and insufficient evidence to confidently identify abuse or the nature of the risk (if any) to the child may be unclear.

9.3 N.B. Uncertainty can be reduced by establishing facts.

9.4 The following checklist can be used by any professional dealing with a possible case of FII:

- Focusing on safeguarding and promoting the welfare of the child at all times and follow local safeguarding guidelines.
- Complete a chronology, listing what is evidence-based. This should be started before a referral to children's social care unless the concerns are urgent or there is already evidence of significant harm (see exemplar Chronology Template below);
- There is a need to cross reference the chronologies for different children in the family as illness behaviour can switch between different children in the family;
- Listing inconsistencies and gathering more information from family members and other professionals to clarify inconsistencies.
- Continuing to observe child and family - are patterns emerging?
- Keeping detailed records: being specific about the evidence base/source of information - for example, observation, informed opinion, hearsay, etc; report on Datix as per policy
- Testing alternative explanations; review with a senior colleague or expert; complete medical tests and social work assessment; Paediatricians should discuss these cases with their named or designated doctor;
- Continuing to re-assess the situation in light of new information, bearing in mind that it is important not to miss any signs symptoms that could be genuine so that treatment can be initiated.
- It is usually not appropriate to share concerns about FII with parents at this stage, but plans need to be agreed between the lead paediatrician and the social worker manager regarding the appropriate response to managing concerns in order to protect the child. Also what it is or is not appropriate to discuss with the parents depending on circumstances but trying to be as open and transparent as possible needs to be agreed and documented between the different agencies /professionals involved;
- Accessing information on the legal issues and national and local guidance.

***Incredibly Caring. Department for Children, Schools and Families. 2008.**

10. Response

10.1 All professionals who have concerns about a child's health should discuss these with their line manager or their agency's nominated safeguarding lead and the GP or clinician responsible for the child's health.

10.2 If the child is receiving services from Children's Social Care, the concerns should be discussed with them immediately.

10.3 If the child is within a hospital setting you must follow the trust escalation process

10.4 If the health professional has concerns about the mental health of the healthcare worker/parent/carer they should consider if a referral to the mental health access team would be appropriate. This assessment would then be available to inform the overall assessment. This referral would have to be made with the consent of the adult, if they refuse this should be documented.

10.5 Joint working is essential, and all professionals should:

- Be alert to potential indicators of illness being fabricated or induced in a child;
- Be alert to the risk of harm which individual abusers may pose to children in whom illness is being fabricated or induced.
- Share and help to analyse information so that an informed assessment can be made of children's needs and circumstances.
- Contribute to whatever actions and services are required to safeguard and promote the child's welfare.
- Assist in providing relevant evidence in any criminal or civil proceedings.
- It is an expectation that a senior health professional leads for health and the same should apply for all other agencies as these cases are complex and difficult

10.6 A Health Professionals meeting should be arranged by the lead Paediatric Consultant for who the Acacium Group division is providing a service for. All professionals involved with the child and family who have produced chronologies will be invited to review and discuss the case and contribute to the decision-making process around future management.

10.7 If any professional considers that their concerns are not taken seriously or responded to appropriately, they should discuss this as soon as possible with the designated doctor or designated nurse for child protection/safeguarding.

10.8 If any concerns relate to a member of staff, professionals should discuss this with their line manager and the nominated safeguarding children lead.

10.9 All concerns and discussions must be recorded contemporaneously in their agency records for the child, dated and signed.

11. Chronology and Strategy Meetings

11.1 Information gathered from the child's records and tabulated in the form of a chronology is key to confirming whether the situation is abusive. The documentation of facts and evidence in this format often reveals a startling picture. Getting the facts agreed and seeing the overall pattern is crucial and often very revealing. Please seek specific advice and support to collate chronological reports.

12. Referral

12.1 Where there are suspicions of FII in a child, a referral must be made to Children's Social Care in accordance with the Making Referrals to Children's Social Care Procedure.

12.2 From the point of the referral, all professionals involved with the child should work together as follows:

- Lead responsibility for action to safeguard and promote the child's welfare lies with Children's Social Care;
- Any suspected case of FII may involve the commission of a crime and therefore the police should always be involved;
- The paediatric consultant is the lead health professional and therefore has lead responsibility for all decisions pertaining to the child's health care.

12.3 At all stages it is important to discuss what information will be shared with parents and by whom. Clear decisions need to be made about who will monitor the child’s health and development.

13. Effective Support and Supervision

13.1 Working with children and families where it suspected or confirmed that illness is being fabricated or induced in a child requires sound professional judgments to be made. It is demanding work that can be distressing and stressful. Practitioners are likely to need support to enable them to deal with the feelings the suspicion or identification of this type of abuse engenders. It can be very distressing to a professional person, who has come to know a family well and trusted them, to have to deal with their feelings when they learn a child's illness has been caused by actions of that child's primary healthcare worker/parent/carer.

14. Allegations Against Staff

14.1 In this area of work, it is a possibility that complaints may be expressed by parents/healthcare workers about one or more members of staff and their handling of the case. During assessment parents may formally complain about any member of staff which will be managed through the Acacium Group Complaints and Incidents Policies

15. Associated Policies / SOPs

Policies
CLIN 08 Safeguarding and Protecting Children (England, Wales and Northern Ireland)
CLIN 09 Safeguarding Vulnerable Adults at Risk

16. References

- Royal College of Paediatrics and Child Health (2021) Perplexing Presentations (PP)/Fabricated or Induced Illness by Carers (FII) in Children. RCPCH, London.
- Department for children, schools and families (2008) Incredibly Caring. Radcliffe Medical Press. Abingdon.
- Safeguarding children in whom illness is fabricated or induced (HM Government 2009).
- Jones, L. et al (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. Lancet 380(9845): 899-907.
- DOH Safeguarding Children in whom illness is fabricated or induced https://www.celcis.org/application/files/4316/2185/5361/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf
- Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance (March 2021) This guidance, published in March 2021, provides best practice advice for paediatricians in the medical management of PP and FII cases to obtain better outcomes for children.

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla Part of Acacium Group	Ellea Nursing Part of Acacium Group	CHS Healthcare Part of Acacium Group
DUNN REGULATORY ASSOCIATES Part of Acacium Group		

Appendix B: Legislation

1. This Policy is supported by legislation and national guidance as set out in the table below.

   National policies, guidance, and legislation, supporting reporting and managing incidents.

Act, policy, guidance	Explanation
Health & Safety at Work Act 1974	The Health & Safety at Work Act 1974 requires that all organisations with more than three staff have in place processes to promote the health and safety of their staff.
Control of Substances Hazardous to Health (COSHH) Regulations 2002	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's Control of Substances Hazardous to Health (COSHH) Regulations 2002. Under the regulations, organisations have a duty to assess the risk, eliminate, substitute, and limit and control exposure to latex, unless there is a need to use it.
RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995	There is a requirement to report diagnosed cases of Occupational dermatitis (schedule 3) to RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995.

2. **Equality and diversity**

   Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.