# Perplexing Presentations and Fabricated or Induced Illness

## Related guidance

RCPCH, Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children Guidance

## 1. Introduction

Although child maltreatment due to abuse or neglect is pervasive within our society, less is known about fabricated or induced illness which is considered to be a less common type of child abuse. Although relatively rare this should not undermine or minimise its serious nature. Fabricated or Induced Illness has the potential to cause significant health and development consequences for children and ultimately can result in fatality. It is therefore imperative that practitioners are able to identify when parents or carers are fabricating or inducing illness in children.

This guidance is based upon, and should be read in conjunction with, Working Together to Safeguard Children 2018, the supplementary guidance Safeguarding Children in Whom Illness is Fabricated or Induced (DCSF 2008) and NEL Safeguarding Children Partnership policies and procedures. Further guidance is available from the Royal College of Paediatricians and Child Health (RCPCH 2021).

## 2. Definition

### Medically Unexplained Symptoms

In 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. They are likely underlying factors in the child (usually of a psychosocial nature), and the parents and clinicians acknowledge this to be the case.

### Perplexing Presentations (PP)

The term Perplexing Presentations (PP) has been introduced to describe the commonly encountered situation when there are alerting signs of possible fabricated or Induced Illness (not yet amounting to likely or actual significant 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 presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.

**Fabricated or Induced Illness**

Fabricated or induced illness 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 than is actually the case). Fabricated or Induced Illness results in physical and emotional abuse and neglect, as a result of parental actions behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident.

## 3. Identifying Fabricated or Induced Illness

Identifying fabricated or Induced Illness is not an easy or quick process due to the complex nature of its presentation. Identifying the carer's pattern of behaviour requires a multi-agency approach, experience and observation.

There are three main ways that a parent /carer or professional may fabricate or induce illness in a child, these are not mutually exclusive:

1. Fabrication of signs and symptoms. This may also include fabrication of past medical history;
2. Falsification of hospital charts, letters, documents and records including falsification of specimens of bodily fluids;
3. Induction of illness by a variety of means, this includes poisoning and the giving of inappropriate medication.

Often symptom occurrence is linked to one setting only (child symptoms are seen within the home, whilst not observed within educational or clinical settings). Often cases will present on parental/carer verbal accounts although may include photographic evidence that cannot be confirmed as the child in question. There is a lack of the usual corroboration of findings with signs and symptoms or in circumstances of proven organic illness, a lack of usual response to proven effective treatments. It is this puzzling discrepancy that normally alerts the clinician to possible harm.

There may be a number of explanations for the circumstances that lead to fabricated or induced illness. Each requires careful consideration.

The National Institute for Health and Clinical Excellence (NICE) identify that fabricated or Induced Illness should be considered in all circumstances where a child's history, physical or psychological presentation or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture. Fabricated or induced illness is a possible explanation even if the child has a past or concurrent physical or psychological condition - NICE NG 89 (2009).

The same guideline identifies that fabricated or induced illness should be suspected if a child's history, physical or psychological presentation or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture and one or more of the following is present:

- Reported symptoms and signs only appear or reappear when the parent or carer is present;

- Reported symptoms are only observed by the parent or carer;
- An inexplicably poor response to prescribed medication or other treatment;
- New symptoms are reported as soon as previous ones have resolved;
- There is a history of events that are biologically unlikely (for example, infants with a repeated history of very large blood losses who do not become unwell or anaemic);
- Despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms;
- The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for example, wheelchairs) more than would be expected for any medical condition that the child has.

### 3.1 Child presentation in fabricated or induced illness

The following features can be associated with fabricated or induced illness though none is indicative itself, and this is not an exhaustive list.

- The child's medical (especially hospital) treatment begins at an early stage of their illnesses;
- Children often present with, or have a past history of both genuine and perceived feeding difficulties, faltering growth and reported allergies;
- Non-organic failure to thrive;
- They may develop a feeding disorder as a result of unpleasant feeding interactions. This is not the same as an eating disorder which is associated with psychological factors for example anorexia nervosa or bulimia;
- This may also apply to toileting disorders;
- The child develops an abnormal attitude to his or her own health;
- Poor school attendance, including under achievement and deliberate underachievement by the child and there is a professional perception that the parent or carer is deliberately 'coaching the child to underachieve;
- The child attends for treatment at various hospitals and other health care settings in different geographical areas. The child may also have been seen in centres for alternative medicine or by private practitioners;
- Incongruity between the seriousness of the story and the actions of the parents/carers;
- The child may already have suffered other forms of abuse;
- History of unexplained death, illness multiple surgical episodes in parents and siblings;
- The parent or carer is observed to be intensely involved with the child for example not allowing anyone else to take over the child's care, medical tests, taking temperatures or measuring bodily fluids;
- The parent/carer may be unusually concerned about the results of investigations that may indicate physical illness in the child, although conversely, they may appear not at all concerned;
- If age appropriate the child is perceived as not being allowed to speak for themselves.

### 3.2 Possible characteristics of parents/carers

The essence of fabricated or induced illness is the parents focus on engaging and convincing health professionals about their erroneous (mistaken) view of the child's state of health, parental behaviour may or may not include deception, it may be motivated by anxiety, attention seeking and/or by gain for the parents (RCPCH 2021).

The following characteristics/behaviours may be noticed or identified:

- The child's parent or carer may have a history of childhood abuse. There may also be false or known allegations of physical or sexual abuse, self-harm and /or psychiatric disorder, especially personality disorder or psychotic illness;
- Consideration must be given to the history and relevance of any previous mental ill health in the parent or carer;
- Parent or carer may have some medical knowledge and may try to intimidate health /educational professionals;
- Inaccurate or misleading information may be provided by the parent or carer;
- Parent or carer may refuse to allow professionals to share information regarding the child's presentation/illness;
- Parent or carer may threaten lawsuits too readily;
- Tends to be over friendly with health /educational professionals but may be abusive if practitioners do not comply with their wishes;
- Often shows inappropriate behaviour, for example being over-anxious or even less attentive than you would expect;
- May have mental health problems;
- Parent or carer is not always present when the victim has alleged or real symptoms or signs of illness, as presentation of symptoms may be deliberately delayed;
- Parents or carers may be motivated by material/financial gain; this can be through receipt of benefits or compensation following an accident.

## 4. Harm and Impact on the Child

Harm to the child takes several forms. The following three aspects need to be considered when assessing potential harm to the child. As fabricated or induced illness 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.

1. Child's health and experience of healthcare (direct impact)
    - The child undergoes repeated (unnecessary) medical appointments, examinations, investigations, procedures and treatments, which are often experienced by the child as physically and psychologically uncomfortable or distressing;
    - Genuine illness may be overlooked by doctors due to repeated presentations;
    - 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.

2. Effects on child's development and daily life (indirect impact)
    - The child has limited/interrupted school attendance and education;
    - The child's normal daily life activities are limited;

- The child assumes a sick role (e.g., with the use of unnecessary aids, such as wheelchairs);
- The child is socially isolated.

3. Child's psychological and health related wellbeing (emotional harm)

- The child may be confused or very anxious about their state of health;
- 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';
- There may be active collusion with the parent's illness deception;
- The child may be silently trapped in falsification of illness;
- The child may later develop one of a number of psychiatric disorders and psychosocial difficulties.

## 5. Managing Concerns and Actions to be Taken

### 5.1 Emerging concerns

In situations where there are perplexing presentations of a child, often this may occur within education settings/community settings, early help processes should be initiated by the agency raising the concern. It is imperative that a health professional is included in the early help plan.

Where concerns are identified within the community, frontline/universal health professionals (may include health visitor/school nurse or GP) should take the lead role in liaising with wider health agencies, this may include tertiary care centres and targeted services, for example, Children and Young People's Mental Health Services (CYPMHS). The identified health professional should ensure arrangements are in place for Consultant Paediatric oversight where appropriate.

Where concerns are identified by professionals within the acute provider, they should take the lead role of liaising with wider health agencies, this may include tertiary care centres and targeted services.

Full medical evaluation by Paediatrician will be required to include the completion of medical investigations. This may involve admission to the ward for a period of observation and/or referral to a specialist Tertiary Centre if clinically appropriate.

If there is no agreed medical explanation from admission or investigations (medically unexplained symptoms) The paediatrician to meet with parents to discuss, reassure and arrange Health and Education Rehabilitation Plan. For no further investigations and reduction of interventions.

Throughout the process, they should also discuss and liaise/seek supervision with the Named Doctor and Northern Lincolnshire and Goole NHS Trust (NLaG) Safeguarding Children Team.

Supervision must be sought from safeguarding leads within the professional's own organisation and advice, guidance and supervision can be sought from the safeguarding team in NEL ICB.

Children's social care consultation line can be used to gain support and advice around referrals to Children's services.

### 5.2 Health and Education Rehabilitation Plans

Consensus about the child's state of health needs to be reached between all health professionals involved with the child and family, including GPs, Consultants, private doctors and other significant professionals who have observations about the child, including education and children's social care if they have already been involved. A multi-professional meeting is required in order to reach consensus. This professionals meeting should be chaired by a clinician experienced in safeguarding with no direct patient involvement to ensure a degree of objectivity and to preserve the direct doctor-family relationship with the responsible clinician. Parents should be informed about the meeting and receive the consensus conclusions with an opportunity to discuss them and contribute to the proposed future plans. A Health and Education Rehabilitation Plan agreed by professionals and families is an essential feature of management in all cases of MUS/PP/fabricated or Induced Illness, whether or not children's social care are involved. Development of the Health and Education Rehabilitation Plan requires a coordinated multidisciplinary approach and negotiation with parents and children and usually will involve their attendance as appropriate at the relevant meetings. The Plan is led by one agency (usually health) but will also involve education and possibly children's social care. It should also be shared with an identified GP. The Plan must specify timescales and intended outcomes.

### 5.3 Where Fabricated or Induced Illness is suspected

Where concerns are such that professionals feel that fabricated or Induced Illness is suspected, if the child or young person is not currently under the care of a Paediatric Consultant, a referral should be made by the child/young person's GP. If the child or young person is already under the care of Paediatrics, the named Paediatrician and NLAG Safeguarding Children Team should be made aware of the presenting concerns.

Parents should be kept informed of further medical assessments/investigations/tests required and of the findings but **at no time should concerns about the reasons for the child's signs and symptoms be shared with parents if this information would jeopardise the child's safety and compromise the child protection process and/or any criminal investigation**.

Where immediate harm is thought likely, such as evidence of inducing illness, urgent action should be taken by the identifying agency an urgent referral must be made to the police and/or children's social care, in line with the Report a concern about a child process as a case of likely significant harm due to suspected or actual fabricated or induced illness, 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.

### 5.4 Maintaining records

- There is a need to ensure robust and holistic recording of concerns/carer behaviour/how carer behaviour may vary from expected behaviour;
- Records should use clear, straightforward language, should be concise and should be accurate not only in fact, but differentiating between opinion, judgement and hypothesis (DCSF 2008);
- Detailed accurate and informative medical records are pivotal to the management of all cases (RCPCH 2021);
- Where the possibility of fabricated or Induced Illness is present, all records for the child should be kept in a more secure location than usual, for example, in a hospital setting, not on ward trolleys. (RCPCH 2021);
- A single health case record for medical and nursing staff will help to promote effective clinical communication (RCPCH 2021).

Records should be kept in line with each organisational record-keeping policy (including electronic record keeping) which should be mindful of sensitive safeguarding information, including how and where to record this and patient access to records:

- If a child moves between organisations, it is best practice for the notes to follow the child. This may not always be possible and so a clinical summary should follow the child (RCPCH 2021);
- It is essential that records include a health chronology of the child's medical presentation including any aspects which may indicate fabricated or induced illness (RCPCH 2021);
- It is essential that clinicians concern about fabricated or induced illnesses are documented in the records; where there is uncertainty, this should be expressed as a differential diagnosis. (RCPCH 2021);
- Record in the child or young person's record exactly what is observed and heard from whom and when;
- Record why this is of concern.

### 5.5 Further considerations/actions

Where concerns in respect of perplexing presentations, or possible fabricated or induced illnesses are identified, there is a responsibility on the professional/ service who identifies the concerns to be clear about the nature, rationale and evidence (including lack of evidence of carer reported signs or symptoms) for the concerns. Any referral to Children's Services, where fabricated or Induced Illness is believed to be evidenced, must be confirmed in writing which clearly outlines the rationale for the professional opinion that fabricated or Induced Illness is present, or a significant risk.

As in other forms of harm, where there are professional concerns in respect of perplexing presentations or fabricated or induced illness, referral to another service or agency does not reduce the responsibility of the referrer to actively participate in activity to understand and reduce the risk posed to the child. Where concerns are identified within tertiary care settings, tertiary care safeguarding teams should take the lead role in liaising with wider health agencies, this may include targeted services, for example, CYPMHS.

If significant harm has occurred or is likely occur the lead responsibility for the coordination of action to safeguard lies with Children's Social Care. Any suspected case of fabricated or induced illness may involve the commission of a crime and therefore the Police should always be involved. The Consultant Paediatrician is the lead health professional and therefore, has lead responsibility for all decisions pertaining to the child's health care.

In cases where the police obtain evidence that a criminal offence has been committed by the parent or carer, and a prosecution is contemplated, it is important that the suspect's rights are protected by adherence to the Police and Criminal Evidence Act 1984.

Seeking supervision in these complex cases is imperative and organisations should have a safeguarding supervision policy in place that provides robust support and guidance to practitioners.

## 6. Further Information

Fabricated or Induced Illness

Safeguarding Children in Whom Illness is Fabricated or Induced (supplementary guidance to Working Together to Safeguard Children), HM Government 2008

Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in Children Guidance, Royal College of Paediatricians and Child Health 2021