Management of Perplexing Presentations and Fabricated or Induced Illness in Children Policy

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## Introduction

There is often uncertainty about the criteria for suspecting or confirming Perplexing Presentations/Fabricated or Induced Illness and the threshold at which safeguarding procedures should be invoked. In the UK, there has been a shift towards earlier recognition of possible Fabricated or Induced Illness (which may not amount to likely or actual significant harm), and intervention without the need for proof of deliberate deception.

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.

In the absence of clear evidence about risk of immediate serious harm to the child’s health or life, the early recognition of possible Fabricated or Induced Illness (not amounting to likely or actual significant harm) is better termed Perplexing Presentations, requiring an active approach by paediatricians and an early collaborative approach with children and their parents/carers.

Whilst recognising that an underlying medical condition may be present children should not be subject to unnecessary investigations or medical interventions. Consideration should be given that verified illness and fabrication may both be present.

Children have a right to the best possible health, privacy and for their views to be sought. They are also entitled to protection from all forms of abuse and to rehabilitation when they have been maltreated. These principles are enshrined in Articles 12, 13, 16, 19, 24 and 39 of the UN Convention on the Rights of the Child (UNCRC).

In this policy, the term ‘children’ will apply 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.

Both clinical experience and research indicate that the mother is nearly always involved or is the instigator of FII. The caregiver may be a single parent, or may be acting alone, unbeknown to the father. The involvement of fathers is variable. The father may be unaware, be suspicious but side-lined or may be actively involved. Rarely, fathers are solely involved. The parent may be actively supported by grandparents and there may be an intergenerational pattern. Rarely, foster carers have been known to be involved in FII. There is currently no data on same sex parental couples.

## Purpose

To provide all staff in MSE ICB with information so that they may fulfil their statutory duties to safeguard and protect children and young people when there are concerns of Perplexing Presentations and Fabricated or Induced Illness.

To provide a single consistent approach, across the local health economy, in the management of Perplexing Presentations or suspected Fabricated or Induced Illness that is consistent with national and local guidance. To clearly define roles and responsibilities so that the process is transparent, and staff understand the complexities of the process and have realistic expectations about the timeframes within which the case can be managed.

This policy is applicable to the Board, every member of staff within the MSE ICS Board and those who work on behalf of the MSE ICS Board irrespective of age, disability, sex, gender reassignment, pregnancy, maternity, race (which includes colour, nationality, and ethnic or national origins), sexual orientation, religion or belief, marriage or civil partnership.

## Scope

This policy applies to all Mid and South Essex (MSE) Integrated Care Board (ICB) members and staff (including temporary/bank/agency/work experience staff, students and volunteers).

## Definitions

### Royal College of Paediatrics and Child Health guidance definition

* + 1. These definitions are taken from Royal College of Paediatrics and Child Health guidance issued in March 2021

[*Perplexing Presentations/Fabricated or Induced Illness in children*](https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/)

### Medically Unexplained Symptoms (MUS)

* + 1. 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. The symptoms are likely based on underlying factors in the child (usually of a psychosocial nature) and this is acknowledged by both clinicians and parents. 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.

### Perplexing Presentations (PP)

* + 1. Perplexing Presentations (PP) is the term used to describe the commonly encountered situation when there are alerting signs of possible FII (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 (FII)

* + 1. 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 than is actually the case). FII 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

## Roles and Responsibilities

### ICB Board

* + 1. The ICB Board is accountable and responsible for ensuring that the ICB has effective processes to ensure compliance. The Board is assured through the work of the Quality Committee.

### Quality Committee

* + 1. This committee is responsible for the detailed oversight and scrutiny of the ICB’s processes for ensuring compliance with the safeguarding guidance.

### Chief Executive

* + 1. The Chief Executive has responsibility for ensuring the provision of high quality, safe and effective services within MSE NHS Body. The Chief Executive has overall responsibility and is accountable for ensuring a safe and effective response to people experiencing and exposed to abuse and neglect in line with statutory duties. This role is supported by the Chief Nurse, who in turn is supported by the Designated Nurses for expert advice.

### Chief Nurse

* + 1. The Chief Nurse is the overall executive lead for safeguarding and:
* Is responsible for the execution of all safeguarding responsibilities on behalf of the Chief Executive and the Board members.
* Promotes the safeguarding of children and adults within commissioning arrangements to meet identified quality standards through quality scrutiny processes.

### Executive and Non-Executive Board Members

* + 1. All Board members must:
    - Maintain a continued awareness of current safeguarding issues and the Body’s responsibilities/accountability.
    - Maintain a knowledge base through reports, newsletters and training/development sessions regarding the above.
    - Attend safeguarding training and/or a development event on an annual basis.
    - Promote the welfare of children and adults in both personal and professional activity and comply with all organisational, safeguarding board/partnerships’ multi-agency policies and procedures relating to safeguarding.
    - Consider the requirement of safeguarding in all activities both professionally and personally, in particular through contracting and performance monitoring.

### Designated Professionals (Safeguarding & LAC)

* + 1. Designated Professionals take a strategic, professional and advisory lead on all aspects of the health service contribution to safeguarding across the MSE NHS Body area, which includes all providers.

### All Staff

* + 1. All staff must:
    - Comply with all policies procedures and guidance in relation to safeguarding.
    - Attend safeguarding training at the appropriate level to their role and maintain a level of knowledge and skills appropriate to their role as per the intercollegiate documents.
    - Protect vulnerable children and adults at risk by recognising and responding to abuse and neglect, know what action to take to make appropriate referrals, and where appropriate contribute to multi-agency activity as per safeguarding policy and procedures.
    - Access safeguarding advice and supervision at the appropriate level for their role.
    - Take part in audits and evaluations regarding safeguarding as appropriate.
    - Take immediate and appropriate action regarding allegations against people who work with children or adults at risk as outlined in the Whistleblowing Policy and the Managing Allegations Policy.

## Policy Detail

### Parent/caregiver motivation and behaviour

* + 1. FII is based on the parent’s underlying need for their child to be recognised and treated as ill or more unwell/more disabled than the child actually is (when the child has a verified disorder, as many of the children do). FII may involve physical, and/or psychological health, neurodevelopmental disorders and cognitive disabilities. There are two possible, and very different, motivations underpinning the parent’s need: the parent experiencing a gain and the parent’s erroneous beliefs.
    2. In the first, the parent experiences a gain (not necessarily material) from the recognition and treatment of their child as unwell. The parent is thus using the child to fulfil their needs, disregarding the effects on the child. There are a number of different gains - some psychosocial and some material.
    3. The second motivation is based on the parent’s erroneous beliefs, extreme concern and anxiety about their child’s health (e.g. nutrition, allergies, treatments). This can include a mistaken belief that their child needs additional support at school and an Education Health and Care Plan (EHCP). In pursuit of an explanation, and increasingly aided by the internet, the parent develops a belief about what is wrong with their child. The parent exhibiting such behaviour cannot be reassured by health professionals or negative investigations. The parent’s need here is to have their beliefs confirmed and acted upon, but to the detriment of the child.
    4. In FII, parents’ needs are primarily fulfilled by the involvement of doctors and other health professionals. The parent’s actions and behaviours are intended to convince health professionals, particularly paediatricians, about the child’s state of health.
    5. Parents engage health professionals, in the following ways:
* The most common form is by presenting and erroneously reporting the child’s symptoms, history, results of investigations, medical opinions, interventions and diagnoses. There may be exaggeration, distortion, misconstruing of innocent phenomena in the child, or invention and deception. In their reports, the parents may not be actually intending to deceive, such as when they hold incorrect beliefs and are over-anxious, to the child’s detriment.
* A less common way of engaging health professionals is by the parent’s physical actions. These actions nearly always include an element of deception. They range from falsifying documents, through interfering with investigations and specimens such as putting sugar or blood in the child’s urine specimen, interfering with lines and drainage bags, withholding food or medication from the child and, at the extreme end, illness induction in the child.

### Doctor’s involvement

* + 1. Doctor’s involvement consists of:
* Taking a history.
* Examining the child.
* Ordering investigations to ascertain the correct diagnosis/es.
* Supporting and/or not disputing the need for limited school attendance, use of aids e.g. wheelchairs, financial and other support for care of the sick child.
* Accepting the parent as the conduit of information between professionals.
* Initiating or agreeing to further referrals, medications and other treatments.
  + 1. However, in children with unrecognised FII, some of these actions may contribute to iatrogenic harm. In addition, the practice of repeating previous, no longer relevant, or not independently substantiated problems/diagnoses in medical correspondence and documents, perpetuates an erroneous view of the child’s state of health.

### Harm to the child

* + 1. Harm to the child takes several forms. Some of these are caused directly by the parent, 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.
    2. Child’s health and experience of healthcare
* 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.
* Genuine illness may be overlooked by doctors due to repeated presentation.
* 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.
* Effects on child’s development and daily life.
* 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.
  + 1. Child’s psychological and health-related wellbeing
* 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.
  + 1. Severity of FII can be considered in two ways:
    2. Severity of the parent’s actions - This can be placed on a continuum of increasing severity which ranges from anxiety and belief-related erroneous reports, to deception by fabricating false reports, to interfering with samples through to illness induction. However, there is no evidence about the likelihood or factors associated with a parent moving from one point on this continuum to another.
    3. Severity of harm to the child - The different aspects of harm to the child may coexist. Severity of the harm to the child needs to be assessed according to both the intensity of each aspect of the harm, and by the cumulative effect of all the aspects.

### Alerting signs to possible FII

* + 1. In the child
* Reported physical, psychological or behavioural symptoms and signs not observed independently in their reported context.
* Unusual results of investigations (e.g. biochemical findings, unusual infective organisms).
* Inexplicably poor response to prescribed treatment.
* Some characteristics of the child’s illness may be physiologically impossible e.g. persistent negative fluid balance, large blood loss without drop in haemoglobin.
* Unexplained impairment of child’s daily life, including school attendance, aids, social isolation.
  + 1. Parent behaviour
* Parents’ insistence on continued investigations instead of focusing on symptom alleviation when reported symptoms and signs not explained by any known medical condition in the child.
* Parents’ insistence on continued investigations instead of focusing on symptom alleviation when results of examination and investigations have already not explained the reported symptoms or signs.
* Repeated reporting of new symptoms.
* Repeated presentations to and attendance at medical settings including Emergency Departments.
* Inappropriately seeking multiple medical opinions.
* Providing reports by doctors from abroad which are in conflict with UK medical practice.
* Child repeatedly not brought to some appointments, often due to cancellations.
* Not able to accept reassurance or recommended management, and insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments (sometimes based on internet searches).
* Objection to communication between professionals.
* Frequent vexatious complaints about professionals.
* Not letting the child be seen on their own.
* Talking for the child / child repeatedly referring or deferring to the parent.
* Repeated or unexplained changes of school (including to home schooling), of GP or of paediatrician / health team.
* Factual discrepancies in statements that the parent makes to professionals or others about their child’s illness.
* Parents pressing for irreversible or drastic treatment options where the clinical need for this is in doubt or based solely on parental reporting.

### Response to alerting signs

* + 1. If one alerting sign is present, it is essential to look for others. Alerting signs should be discussed with the MSE ICB safeguarding team. Alerting signs by themselves do not amount to fabrication but mandate further investigation to ascertain whether the child has an underlying illness.
    2. At the point of alerting signs being identified, consideration of possible mental ill-health in the parent is not immediately relevant. While it may transpire later that the alerting signs were not indicative of FII, it is imperative that their presence is acted upon.
    3. If alerting signs are found in primary care or by education or allied health professionals in the community, it is appropriate that a paediatrician/CAMHs professional becomes involved as the resolution lies in ascertaining the actual state of the child’s health. One of two courses of action need to be followed depending on whether there is or is not an immediate serious risk to the child’s health/life.

### Immediate serious risk to child’s health/life

* + 1. The most important question to be considered is whether the child may be at immediate risk of serious harm, particularly by illness induction.
* 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 (e.g. 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 (e.g. ‘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.
  + 1. 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 would 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.

### Alerting signs with no immediate serious risk to the child’s health / life – Perplexing Presentations (PP)

* + 1. Perplexing Presentations nevertheless indicate possible harm to the child which can only be resolved by establishing the actual state of health of the child. They therefore call for a carefully planned response. This will be led by the responsible clinician with advice from the Named Doctor, usually in the secondary, and occasionally tertiary centre, in which paediatricians or CAMHS clinicians are employed. The essence of the response is to establish the current state of health and functioning of the child and resolve the unexplained and potentially harmful situation for the child.
    2. If the initial concerns arise directly from school as opposed to health, it is recommended that school explain to the parents that information is required from health to understand the concerns e.g. poor school attendance. It is then appropriate for either the parents or education to contact health (either GP, consultant paediatrician or child psychiatrist) with their query about the actual health of the child.
    3. At this stage, professionals should refrain from using FII terminology, as the state of the child’s health has not yet been assessed. If primary healthcare is the only contact for the child, then they may wish to refer to a paediatrician for further assessment of the child’s health. If concerns arise within General Practice, there should be consultation with the Named GP for Safeguarding Children in the first instance.
    4. At any stage during this process, should new information come to light to suggest that the child is currently suffering from significant harm, referral to children’s social care and/or the police must be made, alongside the process outlined in this guidance. The urgency with which this is done and whether or not parents are informed about the referral before a professional multiagency discussion will vary according to the circumstances of each case.

### Response to Perplexing Presentations (PP)

* + 1. 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).
    2. 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.
    3. 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.
    4. 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.
    5. 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.
    6. **Child’s health and wellbeing**
    7. The responsible paediatric consultant should:
* Collate all current medical/health involvement in the child’s investigations and treatment, including from GPs, other Consultants, and private doctors, with a request for clarification of what has been reported and what observed.
* Consider inpatient admission for direct observations of the child, including where relevant the child’s input and output (fluids, urine, stool, stoma fluid as applicable), observation chart recordings, feeding, administration of medication, mobility, pain level, sleep.
* Consider whether further definitive investigations or referrals for specialist opinions are warranted or required.
* Obtain information about the child’s current functioning, including: school attendance, attainments, emotional and behavioural state, peer relationships, mobility, and any use of aids.
  + 1. **Parents’ views**
    2. The responsible paediatric consultant should:
* Obtain history and observations from all caregivers, including mothers and fathers; and others if acting as significant caregivers.
* Explore the parents’ views, including their explanations, fears and hopes for their child’s health difficulties.
* Explore family functioning including effects of the child’s difficulties on the family (e.g. difficulties in parents continuing in paid employment).
* Explore sources of support which the parent is receiving and using, including social media and support groups.
  + 1. **Child’s view**
    2. The responsible paediatric consultant should:
* Explore the child’s views with the child alone (if of an appropriate developmental level and age) to ascertain the child’s own view of their symptoms; the child’s beliefs about the nature of their illness; -worries and anxieties; mood; wishes.
* Observe any contrasts in verbal and non-verbal communication from the child during individual consultations with the child and during consultations when the parent is present.
  + 1. See Appendix B for the pathway to be followed after identification of alerting signs.

### Reaching a consensus formulation about the child’s current health, needs, and potential or actual harm to the child

* + 1. 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.
    2. A multi-professional meeting is required in order to reach consensus. This professionals meeting should be chaired by the Named Doctor (or 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.
    3. A decision needs to be made about whether the perplexing presentation is explained and resolved by a verified medical condition in the child, or whether concerns remain. In order to resolve this, a consensus needs to be reached in a meeting between all professionals about the following issues that either:
* All the alerting signs and problems are explained by verified physical and/or psychiatric pathology or neurodevelopmental disorders in the child and there is no FII (false positives).
* Medically Unexplained Symptoms from the child free from parental suggestion.
* That there are perplexing elements, but the child will not come to harm as a result.

Or

* That any verified diagnoses do not explain all the alerting signs.
* The actual or likely harm to the child and or siblings.

And agree all of the following

* Whether further investigations and seeking of further medical opinions is warranted in the child’s interests.
* How the child and the family need to be supported to function better alongside any remaining symptoms, using a Health and Education Rehabilitation Plan (see below for details).
* If the child does not have a secondary care paediatric Consultant involved in their care, consideration needs to be given to involving local services.
* The health needs of siblings.
* Next steps in the eventuality that parents disengage or request a change of paediatrician in response to the communication meeting with the responsible paediatric consultant about the consensus reached and the proposed Health and Education Rehabilitation Plan.
  + 1. Significant disagreements between health professionals about any important aspects of the diagnosis and medical management of the child, will need to be resolved. In such cases, the Named or Designated Doctor for Safeguarding Children should convene and chair a Health Professionals Meeting to agree on the medical issues.
    2. The Designated Doctor can only perform this role if they have never been clinically involved with the case - another Designated Doctor from a neighbouring area should chair such a meeting in the eventuality that this is required.
    3. Escalation to the Medical Director is required where there are significant concerns about how a case is being managed.

### Communication to parents and child

* + 1. Once health consensus has been achieved, a meeting should be held with the parents, the responsible paediatric consultant and a colleague (never a single professional). The meeting will explain to the parents that a diagnosis may or may not have implications for the child’s functioning, and that genuine symptoms may have no diagnosis. It is preferable to acknowledge the child’s symptoms rather than use descriptive ‘diagnoses’.
    2. The current, as of now, consensus opinion is offered to the parents with the acknowledgment that this may well differ or depart from what they have previously been told and may diverge from their views and beliefs. A plan is then made with the parents about what to explain to the child and what rehabilitation is to be offered and how this will be delivered.
    3. This plan should be negotiated with the parents and child if of sufficient maturity, as engagement in such a plan is necessary for it to work. The plan should be explained to younger children even if they are not sufficiently mature to be involved in the plan’s construction.
    4. It is premature, and important not to discharge the child from paediatric care even if there is no current verified illness to explain all the alerting signs, until it is clear that rehabilitation is proceeding.

### Whether to refer to children’s social

* + 1. If there is actual or likely harm to the child or siblings, the implication is that the child has been subject to FII. The question of future harm to the child hinges on whether the parents recognise the harm and are able to change their beliefs and actions in such a way as to reduce or remove the harm to the child.
    2. In order for this to be tested the consensus medical view about the child’s actual state of health and the consequences needs to be discussed with the parents and the child in terms of likely reduced medical intervention, the child’s improved daily functioning and a revised view of the child’s state of health. This requires the co-construction of a Health, Education and Rehabilitation Plan with the parents and child and implementation of this plan (see details below). However, the question arises as to whether in addition to this, there needs to be a referral to children’s social care at this point.
    3. In some situations, the severity of the harm to the child therefore mandates immediate referral to children’s social care due to the level of harm that has been, or is likely to be, caused to the child. However, outside the court arena, there is no absolute clarity about when harm reaches the threshold of significance. Arguably, in some cases, if parents and child (if of an appropriate developmental level) are able to understand the need for and are able to agree a Health and Education Rehabilitation Plan, immediate referral to children’s social care may not be necessary as long as the plan is being monitored carefully, proceeding satisfactorily and agreed goals are being reached.
    4. The decision whether to refer to children’s social care at this point in the process lies ultimately with local health professionals working within their multi-agency procedures. However, if a referral is made, the reasons for this referral will need to be discussed with the family beforehand and, from a health point of view, the Health and Education Rehabilitation Plan will need to continue wherever possible regardless of referral.
    5. Professionals in health should be aware that they do not always have all the pieces of the safeguarding jigsaw puzzle. When a decision is being made about whether to refer children to children’s social care, professionals should consider whether they have all the information from other agencies which is required to inform their risk assessment about levels of harm. If there is concern that they do not have this information particularly when parents decline to give consent for information sharing, a referral to children’s social care may be necessary because of professional inability to assess the level of harm without the intervention of children’s social care.

### Liaising with General Practitioners (GPs)

* + 1. GPs may have extensive knowledge and relationships with multiple generations of families. It is essential that GPs are kept fully informed and involved in the management of children with perplexing presentations or where there are concerns about FII so they can support children and their families as appropriate as well as work in partnership with other professionals involved to ensure the best outcomes for children.

### Health and Education Rehabilitation Plan

* + 1. This plan should be developed and implemented, whatever the status of children’s social care involvement is. 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.
    2. There may well be a number of acceptable approaches and in most cases engagement and agreement by the child and family is pivotal to the success of the Plan. 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.
    3. The Plan must specify timescales and intended outcomes. There needs to be agreement about who in the professional network will hold responsibility for coordinating and monitoring the Plan, and who will be the responsible paediatric consultant (most likely to be a secondary care paediatrician).
    4. Consideration needs to be given to what support the family require to help them to work alongside professionals to implement the Plan. This may include psychological support and/or referral to children’s social care for additional support.
    5. The Plan requires health to rationalise and coordinate further medical care and may include:
* Reducing/stopping unnecessary medication (e.g. analgesics, continuous antibiotics).
* Resuming oral feeding.
* Offering graded physical mobilisation.
  + 1. There should be a discussion with the patient’s registered GP regarding what role they may be able to take in supporting the management and care of the patient.
    2. **Regular review of Plan**
    3. The Health and Education Rehabilitation Plan needs to be reviewed regularly with the family according to the timescales for achieving the specified outcomes, especially regarding the child’s daily functioning. This should continue until the aims have been fulfilled and the child has been restored to optimal health and functioning and the previous alerting signs are no longer of concern.
    4. Agreement needs to be reached by the professionals involved and the family about who will review the plan and when. It is essential to identify a lead professional to coordinate care and organise regular review of the plan. This may be the previous responsible consultant paediatrician or another more appropriate health professional as decided by the multi-disciplinary team.
    5. If the child has either a Child in Need or a Child Protection Plan it may be appropriate for a social worker to take the lead in coordination in conjunction with health and education teams, as the aims of the Health and Education Rehabilitation Plan would form part of that plan.
    6. It is important to guard against what might be seen as disguised compliance by the parents. An important aspect of the fulfilment of the Health and Education Rehabilitation Plan is the parent’s ability to now hold a realistic view of the child’s health and health-related needs and to be seen to have to communicated this to the child.
    7. **Long term follow-up**
    8. All children who have required a Health and Education Rehabilitation Plan, unless there is a permanent positive change in primary caregivers, will require long term follow up by a professional at the closure of the plan. Depending on individual circumstances it is advisable to continue to be alert to possible recurrence of concerns either in the child(ren) or their siblings. Education and primary health are the appropriate professionals to monitor the children’s progress and to identify re-emerging or new concerns.

### When the Health and Education Rehabilitation Plan is not working – necessary referral to children’s social care

* + 1. If the parents disagree with the consensus feedback and an effective Health and Education Rehabilitation Plan cannot be negotiated, or it becomes apparent that there is lack of engagement with the Plan which had been agreed with them, then it is necessary to refer the child to children’s social care. This is on the basis that the child’s functioning and/or development is being avoidably impaired by the parents’ behaviour and any harm caused has now become significant.
    2. The referral to children’s social care should be discussed with parents and the reasons for professional concern explained. The emphasis should be on the nature of the harm to the child including physical harm, emotional harm, medical or other neglect and avoidable impairment of the child’s health or development. In order to help to ensure that the referral is acted upon appropriately it should describe the concerns, define the harm and provide evidence of inability of the health professionals to manage the situation on a voluntary basis.
    3. The reason for referring the child to social care is the need to reduce the harm to the child. Children's social care in turn undertake an assessment to determine whether the significant harm threshold has been reached, what the child’s needs are and to intervene to reduce or prevent harm.
    4. If the referral is declined as not reaching the threshold for children’s social care assessment and support, or the response does not appear to be appropriate, then every effort should be made for health and children’s social care to understand each other’s professional opinions and the escalation process followed in accordance with SET Procedures.

### Record-keeping

* + 1. All health records must be kept in accordance with the Data Protection Act 2018 and the General Data Protection Regulations (GDPR). Practitioners should follow the principles of record keeping set out in the guidance documents supplied by their professional bodies.
    2. All notes about a child’s condition should clearly state who reported the concerns, what was observed, and by whom. Records of key discussions and safeguarding supervision notes about the child’s care should be kept within every organisation’s main health record pertaining to the child to ensure that the child does not come to further harm (as per recommendations from the Victoria Climbié Inquiry).
    3. A formal agreed consensus document or minutes of professionals’ meetings shared across all participant organisations will avoid discrepancies in individual’s recollection/recording across the multi-professional group, and is preferable to individual entries in notes.
    4. These records should be factual and agreed by all parties present. Records must provide a clear statement of what has and has not been discussed with parents. Despite the difficulties of this approach, legal advice and GMC rulings suggest that individual doctors and health teams could be potentially criticised in any subsequent legal proceedings for not keeping a single record accessible to the whole health team, and potentially their evidence could be undermined in court if this is not done. Any emails between clinicians about a child, between parents and clinicians, and between children and clinicians, form part of the health record.
    5. Chronologies of significant health events are useful in understanding recurring patterns of behaviour and concerns in PP and FII. In cases involving PP, the initial assessment should focus on understanding the child’s current functioning and any discrepancies between what is reported and what the child is observed or considered to be able to achieve, given objective medical information about proven pathology (physical and psychiatric). Chronologies are particularly valuable when there is uncertainty about the extent or pattern of past reported illnesses/significant events and/or there is a requirement to make a case for a significant harm threshold for child protection or court proceedings.
    6. Although very useful, chronologies are usually time consuming to compile and are not always necessary. Assessment of current functioning and a management plan should not await the production of chronologies as appropriate action for the child should not be delayed.
    7. Health chronologies should be compiled by multi-professional health teams and must include an experienced and senior health professional that fully understands the presenting health issues so as to interpret significant events through this lens (usually a consultant paediatrician or a Child and Adolescent Psychiatrist).
    8. Chronologies should aim to be objective in determining which significant events are included. They must contain balanced information, including significant positive information about family functioning or test/observation results not necessarily in keeping with the overall concerns. Recording of facts in chronologies should be kept separate from opinion and analysis, but it is important that this is included in order for non-health professionals to easily make sense of the information presented.
    9. Although chronologies are often requested as standalone documents, they can be misleading without a summary and overall analysis. This analysis should include proven diagnoses, important comments by both parents and child, information about parent/child perception of illness, important discrepancies in reporting and observed health information and recurring patterns of behaviour/presentation. This analysis could include commentary on whether the overall situation is likely to meet the significant harm threshold.
    10. See Appendix 10 for chronology template.

### Transitions

* + 1. Once children are 16 years old, they are presumed in law to be competent to make decisions about their health. Young people aged 16 and 17 years old require particular support as many start their journey towards independence at this time. For those with health conditions, there can be many challenges as they start the transition from children’s health services to adult health services. Great care needs to be taken that young people in this age group who have medically unexplained, functional disorders and perplexing presentations, or where there are concerns about FII, don’t fall off a ‘cliff edge’ between child and adult services. Timely and robust information sharing between child and adult services as well as with the young person’s GP is essential to ensure the young person continues to be supported and their needs met. Coordinated care, ideally through meetings with the key professionals and/or young person and their family will ensure safe and efficient information sharing and planning for their future care.

## Monitoring Compliance

To ensure that the safeguarding arrangements are satisfactory, a safeguarding audit should be undertaken by the Safeguarding Team as part of the annual safeguarding audit programme. The results of the audit will be submitted to the Patient Safety and Quality Committee.

Further audits may be undertaken in relation to specific circumstances to ensure compliance with, for example: statutory review recommendations, Children Act/Care Act statutory requirements.

## Staff Training and supervision

All staff are required to have the necessary knowledge and skills in relation to perplexing presentations and fabricated or induced illness as set out in the intercollegiate document [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff](https://www.rcn.org.uk/professional-development/publications/pub-007366)

Safeguarding supervision is an essential means of providing professional support and guidance for safeguarding practitioners and is fundamental to good safeguarding practice for those working with children and adults. “Effective professional supervision can play a crucial role in ensuring a clear focus on a child’s welfare. Supervision should support professional to reflect critically on the impact of their decisions on the child and their family”.

## Arrangements for Review

This policy will be reviewed no less frequently than every two years. An earlier review will be carried out in the event of any relevant changes in legislation, national or local policy/guidance, organisational change or other circumstances which mean the policy needs to be reviewed.

If only minor changes are required, the sponsoring Committee has authority to make these changes without referral to the Integrated Care Board. If more significant or substantial changes are required, the policy will need to be ratified by the relevant committee before final approval by the Integrated Care Board.

## Equality Impact Assessment

This document has been assessed for equality impact on the protected groups as set out in the Equality Act 2010 and has identified no equality issues with this policy.

The EIA has been included as Appendix A.

## Appendix A - Equality Impact Assessment

**INITIAL INFORMATION**

|  |  |
| --- | --- |
| **Name of policy:** Mental Capacity Act 2005 and Deprivation of Liberty Policy    **Version number (if relevant): 1.0** | **Directorate/Service**: Quality |
| **Assessor’s Name and Job Title:**  Safeguarding Clinical Network Business Manager | **Date:**  May 2022 |

|  |
| --- |
| **OUTCOMES** |
| *Briefly describe the aim of the policy and state the intended outcomes for staff* |
| To provide all staff in MSE ICB with information so that they may fulfil their statutory duties to safeguard and protect children and young people when there are concerns of Perplexing Presentations and Fabricated or Induced Illness. |
| **EVIDENCE** |
| *What data / information have you used to assess how this policy might impact on protected groups?* |
| N/A |
| *Who have you consulted with to assess possible impact on protected groups? If you have not consulted other people, please explain why?* |
| N/A |

**ANALYSIS OF IMPACT ON EQUALITY**

The Public Sector Equality Duty requires us to **eliminate** discrimination, **advance** equality of opportunity and **foster** good relations with protected groups. Consider how this policy / service will achieve these aims.

N.B. In some cases it is legal to treat people differently (objective justification).

* ***Positive outcome*** *– the policy/service eliminates discrimination, advances equality of opportunity and fosters good relations with protected groups*
* ***Negative outcome*** *–**protected group(s) could be disadvantaged or discriminated against*
* ***Neutral outcome***  *–**there is no effect currently on protected groups*

Please tick to show if outcome is likely to be positive, negative or neutral. Consider direct and indirect discrimination, harassment and victimisation.

| Protected  Group | Positive  outcome | Negative  outcome | Neutral  outcome | Reason(s) for outcome |
| --- | --- | --- | --- | --- |
| Age |  |  | X | No impact identified |
| Disability  (Physical and Mental/Learning) |  |  | X | No impact identified |
| Religion or belief |  |  | X | No impact identified |
| Sex (Gender) |  |  | X | No impact identified |
| Sexual  Orientation |  |  | X | No impact identified |
| Transgender/Gender Reassignment |  |  | X | No impact identified |
| Race and ethnicity |  |  | X | No impact identified |
| Pregnancy and maternity (including breastfeeding mothers) |  |  | X | No impact identified |
| Marriage or Civil Partnership |  |  | X | No impact identified |

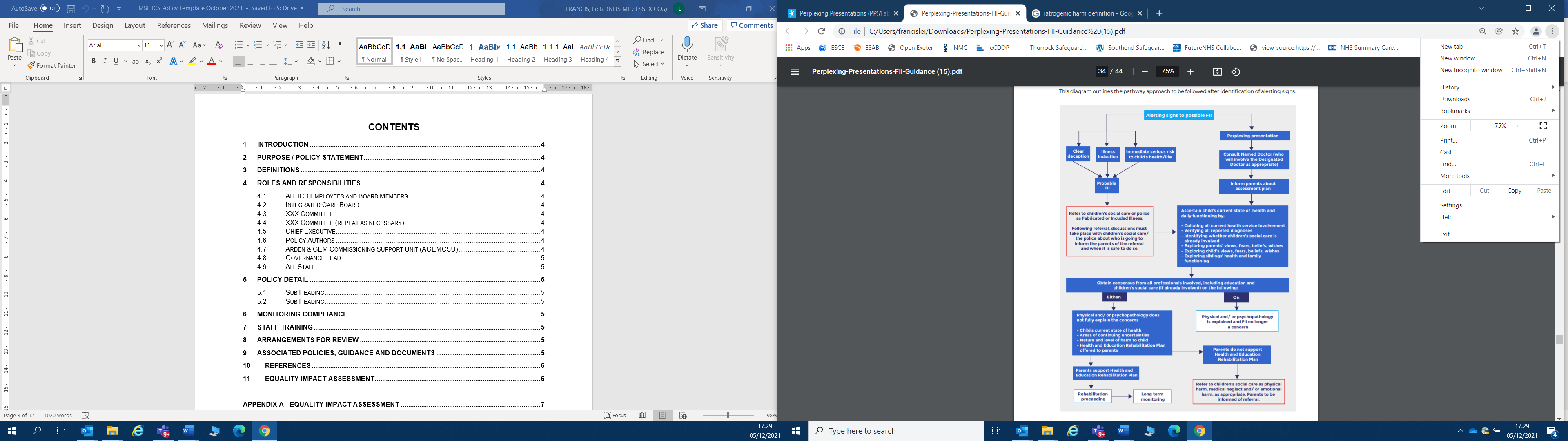
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| **MONITORING OUTCOMES** |
| Monitoring is an ongoing process to check outcomes. It is different from a formal review which takes place at pre-agreed intervals. |
| *What methods will you use to monitor outcomes on protected groups?* |
| Analysis of complaints, claims, incidents and any other relevant data. |

|  |
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| **REVIEW** |
| *How often will you review this policy / service?* |
| Every 2 years as a minimum and earlier if there are any significant changes in legislation, policy or good practice. |
| *If a review process is not in place, what plans do you have to establish one?* |
| N/A |

## Appendix B – Pathway to be followed after identification of alerting signs

Pathway from RCPCH March 2021

[*Perplexing Presentations/Fabricated or Induced Illness in children*](https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/)



## 

## Appendix C – Chronology Template

| **Date** | **Time** | **Source of information** | **Significant events or incidents** | **Development including illness & injuries** | **Was the child seen, if yes views of the child** | **Response/action taken** | **Author comment** |
| --- | --- | --- | --- | --- | --- | --- | --- |
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