



**Guidance for health professionals and the multi-agency team on perplexing presentations and fabricated or induced illness.**

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**Distribution:**

- GPs & GP sub group
- All acute paediatric and community paediatric staff
- Child Protection Advisors (Health & Education)
- Integrated Family Teams, Highland Council
- Associate Lead Nurse for Child Protection
- CAMHS
- Child health manager for Children and Families, Argyll and Bute
- Strategic Lead - Early intervention and Protection, Health & Social Care Highland Council
- Lead for Allied Health Professionals, Highland Council
- Highland Child Protection Committee
- Health Visitors
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## 1. Introduction

This document provides local guidance to multi-agency staff on the recommended process for managing concerns when a child presents with medically unexplained symptoms or there is an unusual pattern to the presentation that is concerning to professionals working with the family. This is termed a 'perplexing presentation' and can include fabricated or induced illness.

Fabricated or induced illness falls under the wider umbrella term of emotional abuse, also called harmful parent-child interactions. Training on forms of emotional abuse is available through the Highland Child Protection Committee website: [www.hcpc.scot](http://www.hcpc.scot)

## 2. Background

This guideline had been produced in consultation with staff and is based on:

- Child Protection Companion, RCPCH 2013
- National Guidance for Child Protection in Scotland 2021 – updated 2023
- Perplexing Presentations (PP) /Fabricated or Induced Illness (FII) in Children RCPCH guidance (2021)
- Child protection training seminar with Dr Danya Glaser (2018)
- United Nations Convention on the Rights of the Child: UNCRC (Incorporation) (Scotland) Act 2024

*'Paediatricians should not underestimate indicators of family dysfunction and what is already known about the child and family by the wider professional network when assessing the needs of children. The challenge is to correctly identify any illness present whilst at the same time not performing unwarranted investigations or interventions driven by exaggerated reporting of symptoms.'* (RCPCH guidance, 2021)

## 3. Presenting Features of Perplexing Presentations

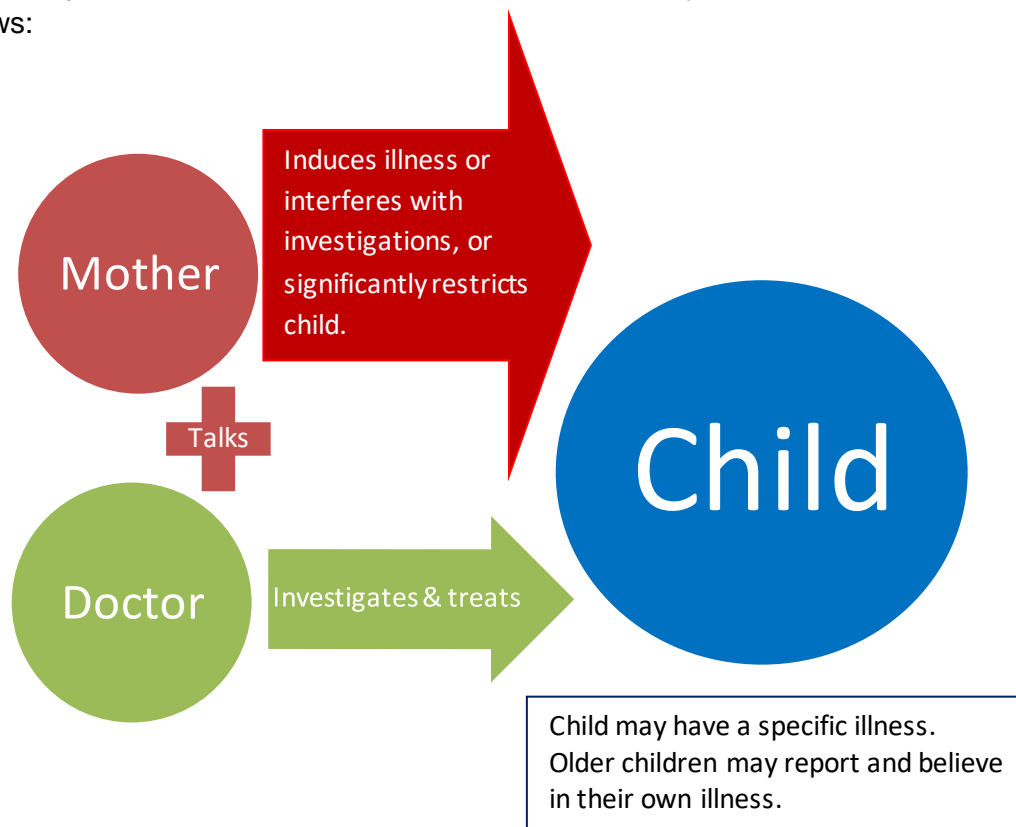
These include:

- Reported symptoms not present & signs not observed by others, or independently of the child's main carer (usually their mother).
- Reported symptoms & signs not explained by child's medical condition, if they have one.
- Parents may move from one issue to another, many of these are often vague and unclear.
- Physical examination & results of investigations do not explain reported symptoms or signs
- Inexplicably poor response to medication, treatment or procedures.
- Repeated presentation to different doctors due to parents failing to be reassured by negative test results.
- Professionals feel a parent is more animated or gets enjoyment derived from the telling of the child's health story.
- Parent(s) request more investigations, assessment, and continuation of (unwarranted) treatment or new treatment.
- Impairment of child's daily life beyond any known disorder.
- Where the child is able to express themselves, a parent talking on behalf of their child with no sense of the child's experience of symptoms/impact on their life.

**Practice point:**  
***If one of the signs above is present, the treating doctor should look for others.***

In these cases, there may be a number of underlying reasons for the presentation, including genuine concern and worry for the child. In fabricated or induced illness the parent, who is most often the child's mother, **has an underlying need for child to be recognised as ill (when not ill) or as more ill than the child is.** Parental behaviour may be motivated by anxiety and erroneous belief about the child's state of health and/or by gain for the parent/s and parental behaviour may or may not include deception.

Specifically in cases of fabricated or induced illness, the process can be described as follows:



The commonest presentation is reporting false information about the child's symptoms, history, test results, medical opinions, interventions and diagnoses. There might 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.

Much less common is physical actions – these will nearly always include some kind of deception. Examples of this include:

- falsifying documents,
- 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,
- illness induction in the child (at the extreme end)

All of these are carried out in order to convince health professionals, especially paediatricians, about the child's poor state of health or illness.

***Practice point***

***There is no direct correlation between the underlying motivation of the parent and the severity of harm experienced by the child. It is this harm that constitutes abuse or maltreatment.***

***Practice point***

***It is not always possible to predict which parents will progress from talking to inducing illness. In the small proportion of parents who move to illness induction, child mortality is estimated to be 5-8%.***

#### **4. The Child's Experience**

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).

A child's daily life in situations of fabricated or induced illness, can be severely limited. Their experience of medical and/or psychological care can include repeated examinations/ assessments, unnecessary, painful procedures and even unneeded operations. A child could be silently trapped in the falsification of illness or diagnosis around them.

In terms of their education and social activities, children may experience isolation from peers, limited or interrupted school attendance and education, and limited normal daily life activities. They may have been put into a sick role and be made to use aids, such as wheelchairs that they do not need, or be made to follow a severely restricted diet due to unproven food allergies/ intolerance.

The behaviour of their parent can cause a child to feel anxiety or confusion about their state of their physical and emotional health or take a false view of themselves as sick and vulnerable. Some children may collude with their parent so as not to go against them or to gain acceptance from them earning a special role within the family. They may themselves report the symptoms, and this is described as 'medically unexplained symptoms.'

***Practice point***

***We must consider the lived experience of the child to understand the effects on them of the behaviour of their parent.***

***Practice point***

***Consider early discussion with staff who know a child and their family well – this includes allocated disability social workers, community children's nurses and other staff dedicated to the child's health and wellbeing if they are already involved in care.***

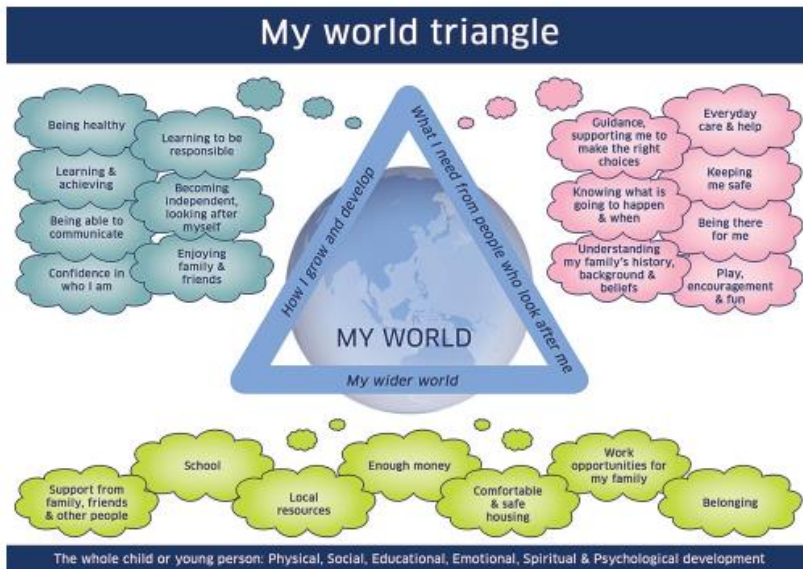


Fig. 2: My World Triangle.

The use of the 'My world triangle' is a way of highlighting the area that a child is impacted by the behaviour or difficulties of their parent.

## 5. Response to alerting signs

If health staff are concerned that alerting signs are present, they must look for others. The concerns should be discussed with a senior, and advice should be sought from Child Protection nurse Advisors (Health) or the Named Doctor for Child Protection, Raigmore or the Lead Nurse and Lead Paediatrician for Child Protection.

### 5a. Responses to alerting signs if a child is on the ward and staff considerations

Staff should be mindful that parents are usually extremely stressed in the ward environment and naturally worried about their child. Families may feel they are being talked about or treated differently if concerns over their mental health or actions are raised. Staff must be mindful of this and of the impact on family interactions with professionals if there is a lack of trust, and also with the child. Feeling under scrutiny will cause even more distress and anxiety for families, so discretion and maintaining confidentiality and professional boundaries is critical.

The important consideration at this time is to determine the risk to the child's health or life. The table below outlines the steps in this approach.

## 6. Response to concerns and role of responsible paediatrician

Concerns raised by medical, nursing, allied health or mental health staff but NO evidence of illness induction, falsification of document or results (i.e. overt deception). The child's Paediatrician will lead the response with advice from the Child Protection team.

They will:

<ul style="list-style-type: none"> <li>Explore the family's views and the family functioning.</li> </ul>	This step includes understanding how the child's illness affects the family (such as giving up work) and asking about sources of support such as social media and support groups.
<ul style="list-style-type: none"> <li>Collate the current health involvement</li> <li>Understand who has given reported diagnoses and if these are based on</li> </ul>	A full chronology may not be necessary at this point. Consider discussion with GP, other consultants, private doctors etc.

parental report or professional observations.	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. If discrepant reports continue, this will require constant nurse observations (see Appendix 2).
<ul style="list-style-type: none"> <li>Agree the assessment process with the family.</li> </ul>	<p>The responsible paediatrician will explain the planned assessment process and the fact that it will include getting information from other caregivers, health professionals and education and social care if they are already involved with the family. This will likely include professionals meetings.</p> <p>NB: Families are entitled to seek a second opinion, but seeing multiple alternate opinions raises concern of FII.</p>
	<p>Child's responsible paediatrician should ask for additional information from education – school attendance, school performance or other concerns and any support or early help school may have implemented to help the family.</p>
	<p>Where possible, families should be informed about professionals meetings and the outcome of discussions as long as doing so does not place the child at additional risk. Care should be given to ensure that notes from meetings are factual and agreed by all parties present.</p> <p>Notes from meetings may be made available to parents, <b>on a case by case basis</b>.</p>
	<p>Child concern forms: these must be filed in the notes and not removed even if later found to be incorrect.</p>
	<p>A member of CAMHS staff and a member of the child protection team should be present for professionals meetings.</p>
	<p>The responsible clinician must ensure that they take minutes or have a minute taker present for the meeting. In these cases it is important that all at the meeting have a shared understanding of the issues and each agency files the minutes/shared agreement in their agency records.</p>
<ul style="list-style-type: none"> <li>Establish the current state of the child's health and their functioning</li> </ul>	<p>The term 'perplexing presentation' can and should be explained to the parents and child (as appropriate to development). The paediatrician should reflect with parents about the different perceptions that they and the health team have of the child's difficulties and any possible harm to the child as a result.</p>

## 7. Response to concerns and role of CAMHS consultant or psychologist

Concerns may present to child and adolescent mental health services primarily. In this case, the following actions must be considered when **no obvious deception** is evident to staff.

<ul style="list-style-type: none"> <li>• CAMHS consultant or psychologist calls professional meeting of health staff to understand concerns and aim to reach a consensus view.</li> </ul>	<p>Same principles for professionals meetings apply as above. A member of the child protection team must attend. Notes should be kept and agreed as factual by all present. They may be released to families on a case by case basis.</p>
	<p>It is recognised that staff working with families may have very different views but all must agree what the risks are, if any to the child of family behaviour.</p>

## 8. Purpose of professional meetings

The purpose of the meetings described above, led by paediatric staff or CAMHS is:

- To achieve a clear consensus on the concerns and how this is impacting on the child
- To agree a rehabilitation plan for the child to resume normal functioning
- To agree a communication plan as to which profession will be the main point of contact for the family and what information is central to communicate.

If a consensus view cannot be agreed, there will need to be a clear majority view and this should be documented. It is recognised that not all staff members may be entirely in agreement but all professionals working with the family should agree their approach to resolving the issues causing any impairment of the child's functioning.

### ***Practice point***

***When considering 'risk' ask: Risk of what? Risk to whom? Risk from whom?***

## 9. Meeting with family to communicate findings and plan

Once the plan is agreed, there should be a meeting between the family and their paediatrician, with a member of the CAMHS team present. If the issues have been raised mainly by CAMHS they must consider who best to be present at the meeting. There must be two clinicians present, including the lead CAMHS staff member. The purpose of the meeting is:

- To communicate to the family that no medical cause or mental health diagnosis has been found in the child to cause the level of impairment reported
- To agree rehabilitation plan that can include support from CAMHS and allied health professionals.
- The plan will support the child back to normal functioning (the clinicians should help the family form an acceptable narrative to explain recovery to others,) including:
  - a return to school,
  - withdrawal of unnecessary medical equipment or aids,
  - stopping unwarranted medication

- To explain to parents the next steps that will be considered, depending on their response.

### **10. Next steps**

If parents accept the plan, then proceed with the rehabilitation plan, ensuring that follow up is planned with the responsible clinician.

If parents do not accept the plan, disengage or request a new medical team:

- Discuss concerns with lead doctor for child protection
- Refer to social care (speak and follow up in writing with child concern form)
- Agree what is communicated to parents and who is responsible for this

In general terms, a new medical team is not offered routinely and all such cases must be discussed with the lead doctor for child protection.

### 11. Communicating with the multi-agency team

Health staff must be clear in communicating their concerns to colleagues in police and social care. The aim is that colleagues understand the risks to the child's functioning and that medical issues are not considered to be the underlying reason for the child's presentation. Understanding that any legal measures will apply to the child alone, be clear in what your concerns and expectations are.

If social work teams are already involved i.e. children and families disability teams, then work with colleagues to communicate concerns wherever possible.

**Practice point**

***When presenting such cases consider describing a typical day for a child so the listener fully understands how their life is limited. Be factual and clear.***

**Practice point**

***Consider illness induction if:***

- ***Clear deception by the mother (main carer)***
- ***Parents disagree & dispute independent /clinical observations***
- ***Request more investigations***
- ***Seek further medical opinion (when >1 already obtained)***
- ***Decline rehabilitation plan & child not functioning e.g. not attending school fully***
- ***Rehabilitation not proceeding (not lack of resources)***

***Refer to child protection services because child's functioning is being avoidably impaired by parent(s)***

### 12. Multi-Agency Pathway for Perplexing Presentations – for concerns WITH CLEAR EVIDENCE OF DECEPTION by a parent or main carer

Evidence of deception can include interfering with samples or results, falsification of documents or illness induction. The clinical team MUST determine: Is this child in immediate danger?

The multiagency team including the responsible paediatrician or CAMHS consultant or psychologist will consider the following actions to be taken without undue delay if deception is discovered:

<ul style="list-style-type: none"> <li>• Referral to social work with clear communication of risk and immediate danger</li> </ul>	<p>Consider holding a health professionals meeting to get a consensus view of health issues – do not allow this to delay referral to social work if you are concerned for a child's safety. Discuss concerns with colleagues and involve the associate lead nurse for child protection or the lead doctor for child protection. Involve other professionals who know the family (i.e. Social Worker for Complex Health Needs/Child Health and Disability Team or aim to gather their views confidentially).</p>
<ul style="list-style-type: none"> <li>• Consider the need for information sharing</li> </ul>	<p>Parents do not have to be informed of a child protection concern if it is felt that this would put a child at greater risk. This is an unusual situation and information sharing should be considered case by case. The responsible clinician (paediatrician or CAMHS) must be clear with colleagues invited</p>

	to any subsequent meeting what has been shared and what has not, with the child's family.
<ul style="list-style-type: none"> <li>Request IRD (inter-agency referral discussion).</li> <li><b>IRD discussion meeting held quickly to discuss concerns.</b></li> </ul>	<p>IRD is the immediate mechanism by which agencies will consider a safety plan. Consultant paediatrician to be invited to the IRD meeting.</p> <p>Consider risk to child of:</p> <ul style="list-style-type: none"> <li>Immediate harm</li> <li>Need for compulsory measures</li> <li>Need for measures to protect child/ separate child from parent.</li> </ul> <p>If evidence of crime – police will lead.</p>
<ul style="list-style-type: none"> <li>Hold multi-agency meeting. In this situation, parents may not be informed of the meeting. All staff must speak about the meeting <b>only</b> if they know for certain the family are aware.</li> </ul>	<p>Multi-agency professional meeting to discuss concerns &amp; agree health or care plan.</p> <p>This is attended by:</p> <ul style="list-style-type: none"> <li>Responsible paediatrician/ CAMHS clinician</li> <li>Police</li> <li>Child Protection nurse Advisor</li> <li>Social worker</li> <li>Education rep if child is known to them</li> <li>Child's Named Person</li> </ul> <p>Others at request of police or social care</p> <p>Consider what resource will be needed for i.e.</p> <ul style="list-style-type: none"> <li>From health: an assessment of the child's current functioning +/- health chronology.</li> <li>From education: an assessment of the child's current functioning in terms of access to education and opportunities for social functioning.</li> <li>From social care/ police: understanding of any family involvement to date.</li> </ul>
<ul style="list-style-type: none"> <li>Agree communication plan</li> </ul>	<p>Agree what will be communicated to parents and which professionals will lead this i.e. social worker and paediatrician (see appendix 8).</p>

## **Appendix 1: Examples of presentations that may raise concern of a perplexing presentation**

- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequent passing of urine, vomiting, or fits, resulting in unnecessary investigations and treatments.
- Exaggerating symptoms, again resulting in unnecessary investigations and treatments.
- Obtaining specialist treatments or equipment for children that are not required i.e. wheelchair.
- Alleging unfounded psychological illness/ difficulties in a child.
- Placing significant restrictions on a child,(i.e. dietary due to unproven allergies) that lead to harm to the child, or trying to keep them in an infantile state that impairs normal child development.
- Deliberately inducing symptoms by administering medication or other substances (this includes non-accidental poisoning), or by intentional suffocation or starvation.
- Interfering with treatments by over-dosing, not administering medication, or interfering with medical equipment such as infusion lines, gastrostomy or nasogastric tubes etc.
- Falsifying test results and observation charts.

## **Appendix 2: Children's Unit Admission Protocol**

Senior charge nurse or ward manager must be made aware of the admission and reason for admission.

If you are planning an admission, it is advised that you make the wider multi-disciplinary team aware before the admission to gain agreement on the observation protocols and avoid professional splitting by including CAMHS consultation. 'Splitting' is commonplace in these cases unless there is space for staff to safely reflect on conflicting feelings which arise. In these cases, it is not unusual for a parent to ally with certain members of the team and disparage others making staff who are placed in the 'good camp' advocate for the misunderstood parent and those in the 'bad camp' feel rejected and useless at their job and avoidant of the family.

For example, if you agree a child will be monitored at meal times or in the bathroom and the parent informs nursing staff that the dieticians said this was not required – it will avoid disputes if all staff and parents are clear beforehand what is needed.

1. The protocol for admission must be agreed with parents with the child's lead consultant before the admission.
2. It is the decision of the nurse in charge of the unit, based on the needs of all the inpatients if the child will go into a bay or cubicle.
3. The parents may not specify which nurse(s) takes observations or attends to the child's care. This is the decision of the nurse in charge of the ward based on clinical needs of the ward patients.
4. The parents may not use their own measuring equipment from home i.e. weigh scales
5. Nursing staff will record factual, direct observations.
6. Communication will be led by the child's responsible paediatrician and any questions or comments by parents will be directed to that paediatrician.
7. The paediatrician will work closely with the nursing staff also supporting the family, such as community nurses, epilepsy nurse, diabetic team etc. to ensure everyone has been able to express their concerns.

Parents can be kept updated – if any staff member considers there to be a risk to the child from the parents then they must escalate their concerns and discuss with the child protection team and the child's responsible paediatrician.

Please note that support for staff is available through the Health Psychology team.

### **Appendix 3: When parents seek a further opinion/ change of paediatrician**

Typically in such situations parents will seek other opinions from doctors, or they may personally email other specialists to try to draw out an opinion they prefer, or look for non-NHS specialists or private clinic referrals. This is known as 'splitting'. The aim of the joint health meeting (detailed in the pathways above) is to avoid any confusion that has arisen as different specialists have been involved. Where possible all staff involved in a child's care should be invited to participate.

Non-NHS medical staff remain bound by GMC guidance and have a duty to share information where there are child protection concerns.

Any parent may choose to request a change of paediatrician within the department but there must be no change of paediatrician in these circumstances. Wider discussion should occur within the paediatric team with advice from the child protection team where there are child protection concerns and the responsible paediatrician wishes to discuss further.

### **Appendix 4: Complaints**

It is highly likely that parents who are unhappy with the process will make a complaint. Complaints may be made to individuals i.e. Child health commissioner, the service manager, the health board etc.

All complaints must be managed in the same way to provide consistent responses for staff and families.

- If parents complain about a paediatrician, the complaint is seen and managed by the clinical lead for either acute or community paediatrics and paediatric manager.
- If a complaint is made about a CAMHS staff member, the complaint is seen and managed by the CAMHS service manager.
- Complaints about paediatric nursing staff are seen and managed by the paediatric senior nurse manager.
- Complaints about child protection nurse advisors are seen and managed by the Lead Nurse for Child Protection.
- Complaints about allied health professionals are seen and managed by the AHP lead.

**Any complaint received by any other member of staff must be redirected to the appropriate person. Please discuss with the clinical governance team if any doubts arise.**

Within NHS Highland, if the clinical lead or service manager feels a wider response is required or the case is very complex, or if this is a second complaint from the same family - they must discuss it with the paediatric service lead and request assistance from the service manager. A decision should be made to consider seeking further advice from:

- Clinical governance manager
- Associate medical director (for Raigmore issues)
- Named doctor for Child Protection, Raigmore or Lead Doctor or Lead Nurse for Child Protection

The complaint response must be agreed by the clinical lead and the service manager where there is a known concern regarding perplexing presentations or if a learning review or debrief is planned.

## Appendix 5: Escalation of Concerns Between Agencies

If you are concerned that a member of the multiagency team is not acting in accordance with the guidance you must discuss this with your manager or team lead. You should give that agency an opportunity to present their view and reasons for their decisions. If no agreement is reached concerns can be escalated to agency managers.

All staff must adhere to professional codes.

## Appendix 6: Chronologies/ Documentation of concerns/ Parental requests to see medical records /Subject Access Requests

### CHRONOLOGIES

When evidence is gathered health staff should ensure health chronologies also consider the health histories of all siblings. This may establish evidence of previous indicators/ course of conduct which can be used as part of later investigations.

Chronologies should also include information from different areas as some families move frequently across the country. There may be a need to collate health, social work and police data on these families who could have multiple addresses. Agencies should agree who will take responsibility for finding this information.

### DOCUMENTATION IN HOSPITAL OR CLINIC NOTES

It is important that any staff member making an entry in the medical notes is clear and factual, and it should be obvious to anyone reading the notes what is opinion and what is fact. For example:

'report from lab – blood in baby's nappy is mum's. Diagnosis - FII.' Or,

'Significant concerns raised over discrepancy of mothers report and lab reports indicating...Action taken....'

Compared to:

'date/ time. Called by Dr XX, biomedical scientist. Blood found in nappy has been typed and matches [mum's name]. Dr [responsible Paediatrician] informed.'

'date/ time. Informed that blood in nappy matches with mother [name]. Positive for both samples from different days. Impression- evidence of deliberate deception and falsification of symptoms. Highly likely in my opinion to be fabricated illness. Plan...'

### CHILD CONCERN FORMS

Child concerns forms are filed in the medical notes and are a part of the health record, subject to all usual controls. These should not be shared with parents where there is a concern of FII. Sharing of concerns should be agreed following the multi-agency meeting as part of a communication plan with both medical and social work in agreement as to how this is done.

## ACCESS TO MEDICAL RECORDS

Requests for access to medical records either made by parents or through a complaints process should go through medical records manager. Subject access requests by parents also managed by medical records manager. Advice for staff can be sought from clinical governance team.

*GMC guidance: Protecting children and young people: The responsibilities of all doctors (2012, updated 2018)*

'Medical records are made to support safe and effective care but they may be used for other purposes. For example, they may be used when making decisions about a child's or young person's safety or welfare, as they can help build up a picture over time. They may also be used as evidence in court. It is particularly important that records relating to the possible abuse or neglect of a child or young person are full, accurate, dated and timed, and distinguish between clinical findings, your opinions and information provided by others. You should clearly record any continuing uncertainty about the risk of abuse or neglect to a child or young person because this information may be relevant if put together with other information about the child or young person or their family.

If there is not enough evidence to support your concerns that a child or young person is being abused or neglected, or the evidence shows that your concerns are not correct, you should record this clearly in the child's or young person's medical record and in their parents' records. You should explain to the child or young person and their parents why information about these events will remain on their medical records.'

## **Appendix 7: Meeting with parents to explain no underlying cause for symptoms or severity of symptoms has been found.**

This meeting takes place after a period of assessment, and when the lead paediatrician is clear that the symptoms described cannot be explained by an underlying disorder. This potentially difficult meeting must be handled sensitively and without causing unnecessary distress.

Two members of the team should be present including the responsible paediatrician. Detailed notes must be taken. You may wish to consult with a member of the Clinical Health Psychology Service, or other CAMHS team member before the meeting, as they may be able to offer follow up to support rehabilitation. The carers should have a full explanation of the evidence and what further action is needed.

The purpose of the meeting is to inform the family:

- that it has not been possible to give a physical diagnosis or to define the child's problem medically but that the symptoms are not life threatening or indicative of any severe underlying disease;
- the child needs to be helped to function alongside his or her symptoms and will not come to harm as a result;
- that further investigations are not needed and would be likely to cause harm;

A plan for rehabilitation of the child back to normal functioning, including helping them to form a narrative to explain their recovery to enable a return to school, withdrawal of unnecessary medical equipment or aids, and stopping unwarranted medication should be outlined.

## **Appendix 8: Meeting with parents after multi-agency team agree FII is most likely reasons for child's difficulties.**

Meeting must be held in private and away from the bedside. Social worker and responsible lead paediatrician, +/- police should be present. At this meeting, it is important to explain to parents that FII is the most probable cause for the child's signs and symptoms, and why that is the case.

Also need to explain what the plan for any ongoing management and further investigation is. Parents need to understand any restrictions that have been decided on their visiting or access to their child.

Supportive services available for a carer who is suspected of abuse and for a non-abusing carer; and follow-up arrangements, including a plan for further discussions (consistent with the multi-agency plan agreed at the strategy discussion) should be discussed.

**Appendix 9: Further information for professionals** (taken from presentation on FII given by Dr D Glaser)

FII is defined by a main carer who uses their words or **erroneously reports** (fabricates) history, symptoms or signs *by*

- Exaggerating
- Misconstruing real phenomena on basis of mistaken *belief*
- Reporting actual phenomena which only occur in the mother's presence – i.e. situation specific and therefore not a disorder located solely in the child
- Inventing

BUT, they may or may not have an intention to deceive.

FII is defined by a main carer who **deceives by using 'hands'** to make the child appear ill through:

- Falsifying or interfering with investigations
- Inducing signs or illness in the child by
  - e.g. Poisoning / over medication (laxatives, salt), suffocating, starving

Doctors contribute to the underlying needs of the main parent by:

- Examines & investigates the child
- Treats the child
- Supports *or* does not dispute the need for
  - Poor school attendance
  - Use of e.g. wheelchairs
  - Financial & other support for care of sick child

Medical mismanagement of the child can occur with:

- Lack of direct observation of child
- Over-reliance on
  - parental reports
  - more & more investigations & over-reliance on results
- Taking eye off child's **functioning**
- Treating symptoms and results
- Omitting to look at current harm of this process to the child

Barriers to recognising and managing perplexing presentations:

Concern re missing treatable disorder

Doctors usually work **with** parents

Discomfort: disbelief/suspicion of parent

Discomfort of thinking ill of a mother

Discomfort of wrongly suspecting/blaming

Doctor powerless - bound by:

history given by a parent, signs & results of investigations could be induced by parent

Difficult to say 'I do not understand' feeling foolish, being wrong

Rising to diagnostic challenge (encouraged by mother's flattery or doubting)

Fear of:

complaints, reports to licensing authorities, litigation Time taken to process suspicions Uncertainty about: when to mention suspicion what to say to parent(s) what to write in medical file Losing control over child protection process
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If you recognise these difficulties then consider discussing the case with child protection colleagues and take the next steps.

Next steps: Establish what is wrong or not: This may take significant time and involves meeting parents separately and speaking to the child separately.

- Coordinate medical views
- Compile health chronology, noting who observed/reported and what the outcome was i.e.:

Event	Observed or reported	By whom	Outcome for the child (including impact i.e. Positive, negative or unknown)

- **Obtain full account of child’s daily functioning incl. school, activities, aids**
- Elicit parents’ explanations for the child’s reported difficulties.
- Observe the child: including inpatient admission. Admission protocol must be agreed with all staff beforehand.
- Carry out further **definitive warranted** investigations to exclude differential diagnoses.