MANCHESTER SAFEGUARDING CHILDREN BOARD

Perplexing presentation / Fabricated and Induced Illness (FII) spectrum

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Introduction to Safeguarding Children.

Course Housekeeping




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Training Information

- Confidentiality
- Avoid Assumptions
- Respect other trainees and their organisation
- Safety Warning – some content can be upsetting
- All questions are good questions
- Keep to time

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Manchester Safeguarding Children Board

- Role is to coordinate local work to safeguard and promote the welfare of children
- Ensure the effectiveness of individual and inter agency working.
- Develop and agree inter-agency policies and procedures for safeguarding and promoting the welfare of children.

"Every child and young person in Manchester should be able to grow up safe; free from abuse, neglect or crime; so allowing them to enjoy a happy and healthy childhood and fulfil their potential."(MSCB vision statement)

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Learning outcomes

- Recognise the potential signs and symptoms of fabricated or induced illness in a child
- Identify the spectrum of behaviours of parents/carers/adults behaviour in FII
- Consider the voice of the child harmed by FII
- Summarise the referral pathways available in Manchester
- Summarise the role of early help and other options available
- Complete a MSB Action Plan

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History

- 40 years since Prof Roy Meadow described Munchausen Syndrome by Proxy
- Royal College Paediatrics and Child Health (RCPCH) adopted the term Fabricated and Induced Illness by Carers in 2002
- RCPCH FII guidance 2009
- RCPCH Child protection Companion 2013 extended FII to embrace perplexing presentations

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What do we call it?

- Lots of discussion about nomenclature:-
- Medically unexplained symptoms
- Over diagnosis syndrome
- Medical Child Abuse
- In USA still called Munchausen Syndrome by Proxy
- New national guidance currently being written
- For now we will call it Perplexing Presentation(PP)/Fabricated and Induced Illness spectrum (FII)

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What is it?

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It is..

- One end of spectrum of health seeking behaviour and ***which causes harm to the child:-***
- Exaggeration of real symptoms/conditions/disability
- False reporting of symptoms
- Fabrication: by altering records/samples etc.
- Withholding nutrients or medication to produce signs
- Illness induction; for example by poisoning/smothering

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The Spectrum of Health Care Seeking by Parents for Children

Induce

Invent symptoms

Exaggerate symptoms

Anxious about trivial symptoms

Normal response

Lackadaisical

Marked non-compliance

Jeopardise health

Ignores symptoms: neglect

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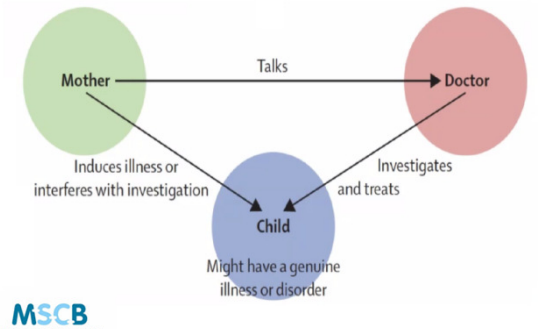
How Harm Occurs:



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Rare type of child abuse?

- Reported cases suggest low incidence 2/100,000 but this is "tip of the iceberg"
- Only dramatic induced or unusual cases reported- does not include the "lower level" cases
- Not recorded as FII on Child Protection Plans
- Most large UK centres report around 50 suspected cases at any one time
- Paediatric consultation line set up in Manchester January 2018 received 48 referrals in first year
- Royal College Paediatrics and Child Health (RCPCH) survey of paediatricians in 2018 will provide better idea of incidence

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Public perception

"I am neither a doctor nor a lawyer, but all too often our legal and medical establishment gets swept along by new fangled theories and facts.... Munchausen Syndrome by Proxy (MSbP) is the latest in a long line of theories that has now been discredited."

Commons, Hansard 24 Feb 2004

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THE SUNDAY TIMES

Mumbo-jumbo syndrome

I hope that medical science will record that I am the inventor of an entirely new, if related, mental illness, Munchausen's syndrome by proxy by proxy, to describe doctors who make up illnesses for other people to suffer from in order to draw attention to themselves

Mail Online

Bungling social services allowed Munchausen's mother to abuse her own children for years

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Challenges in current system

- Difficulty obtaining paediatric opinion
- Reluctance to be involved; multiple Doctors involved
- Pressure on paediatricians to "diagnose" FII
- Tensions around definition and evidential basis in safeguarding and legal processes
- "Lower level" and earlier presentations can be difficult to recognise, assess and manage
- Cases can take a long time to be recognised- evolving picture and/or escalating behaviour
- Difficulty in conveying the basis and level of concern when making referrals;- why refer now?
- Confusion about who should lead;- "different" procedures

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Challenges 2

- Perpetrators are plausible, manipulative, "expert", intimidating
- Difficult to assess motivation, insight, capacity to change
- Often seek 2nd opinion, use private health
- Make complaints, demand change of professionals, GP, move schools
- Use of social media
- Professional failure to look at child's functioning
- Voice of the child lacking (but the child may be convinced of their own ill health)

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Aimee

- Mother has repeatedly taken 18 month old Aimee to the GP and A&E reporting Aimee has severe diarrhoea and poor weight gain
- Mother takes stool samples to show the GP and to send for testing
- Child has always looked well but weight gain is a concern
- One day presents at A&E very poorly, dehydrated and is admitted to hospital
- Ward nurse witnesses mother giving Aimee large dose of laxatives

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Who is this?

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Daniel Pelka

- Attended school
- Noted to be withdrawn
- Took food from other children and off the floor
- Mother told school he had a medical condition so couldn't eat at school
- No-one talked to Daniel

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Perplexing Presentation (PP) Fabricated and Induced Illness (FII) spectrum

In more detail

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Who is involved?

- Mother 85-90% of cases
- Fathers/male carers seldom involved
- May collude or be "side-lined" by expert mother
- May be absent, unaware or suspicious
- Mother may be supported by grandparents or extended family
- Previously medical/ nursing background common; now Dr Google sufficient

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Focus of concerns

- Should focus be on parental behaviour and motivation or on harm to the child?
- In UK, focus is on harm to the child
- The parent may not intend for there to be harm to the child and may not engage in deliberate deception; ***these are not necessary to prove FII***
- But ***because*** of behaviours and motivations, the child suffers harm
- There is inadvertent harm through medical involvement

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Maternal motivation

- Underlying need for the child to be recognised as ill or more ill or disabled than they really are;-
  1. Child is used to fulfil carer's needs and gains
  2. Carer has erroneous beliefs about the child's health
- Both require the involvement of Doctors to investigate, confirm anxieties, continue to treat
- Harm is caused directly by mother's behaviour and by well-intentioned actions by Doctors

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Motivation-Carer's needs and gains

- Unmet emotional needs EG in personality disorder
- Financial or material gain
- Deflecting blame for parenting difficulties or child's behaviour problems
- Maintaining closeness to the child
- Justification for negativity towards the child
- There may be a history of abuse or FII in mother's own childhood

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Motivation-Erroneous beliefs

- Extreme anxiety
- Delusional
- Parental autism
- These motivations rarely lead to deliberate deception but can lead to significant harm

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Do not get lost in parental motivation!

- As people and professionals we want to 'make sense' of why someone could cause harm to their child this way. Therefore we can become preoccupied in trying to understand the motivation.
- WE MAY NEVER KNOW.
- FII is complex and often there is no clear understanding of why this is taking place. When we focus on motivation, as well as the parental narrative, or become caught in the games, then the child gets lost.
- Professionals can become scared of parents which inhibits progress.

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Role of Mother

- Almost always mother
- Use of mouth (verbal reporting)-common
- Use of hands (acting to deceive)
- Use of hands to induce illness-relatively rare
- Not mutually exclusive.

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15 Minute Break

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Use of Mouth

- Use of ***mouth*** to ***report*** symptoms and signs (may or may not involve deception)
- Exaggerating
- Misconstruing real phenomena on the basis of mistaken belief
- Inventing
- Lying
- Use of social media
- The child may have a genuine illness and disabled children are more vulnerable

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Use of hands

- Uses ***hands*** or takes action to ***make the child appear ill or actually cause illness (always includes deception);-***
- Falsifying reports
- Obtaining aids eg crutches, wheelchair
- Interfering with specimens
- Inducing illness by poisoning, smothering, starving, withholding medical treatment
- Neglecting real health needs
- Intent may not be to harm the child but may show a callous disregard for their welfare

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Typically child's conditions rely on parental reporting

- Fits/epilepsy
- Allergies
- Abdominal problems
- Mobility problems, hypermobility
- Sleep problems
- Behaviour problems, Autism Spectrum Disorder (ASD) Attention Deficit Hyperactivity Disorder (ADHD)
- Distorted or false medical and family history
- Disability BUT easy to fabricate and exaggerate when child is disabled

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Parental behaviour

- Doctor shopping
- Missed appointments
- Seeking emotional support from wider family and social media
- Preventing or hampering direct observation of the child
- Interfering with professionals working together
- Refusing consent for information sharing
- Complaints

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Role of Doctor

- Investigates and treats
- Supports or does not dispute the need for;-
  - Reduced school attendance
  - Restricted participation
  - Use of equipment e.g. a wheelchair
  - Need for financial or other support

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Why?

- Ethos of working *with* parent
- Concern about missing treatable disorder
- Fear of looking foolish
- Diagnostic challenge
- Focus on diagnosis rather than child's functioning
- Lack of direct observation of the child
- Fear of complaints
- *Raising concerns about FII is difficult- search for elusive evidence, hard to prove, hard to convey concerns and convince other agencies.*

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Harm to child

- Whether carer deliberately fabricates illness, genuinely believes child is ill or is unduly anxious, harm arises from:
  - Frequent and invasive medical investigations and procedures
  - Unnecessary treatments
  - Missed education
  - Social isolation
  - Limitation in daily life, child becomes "sick or disabled"
  - *These can lead to;-*
  - Child becoming anxious or confused about health
  - Behaviour disturbance
  - Poor self esteem
  - Depression
  - Death – rare and not parental intention

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Voice of the Child

- *"Mum says one thing and does another"*

  -(child angry, frustrated, confused and tearful whilst talking about this)
- *"Mum makes up things, about naughty things, I've never done"*
- *"Mum is against me"*

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Professionals' observations of effect on the child

- "Excessive use of fabrication which she does with ease and fluidity"
- "Uses fabrication to attract attention from school staff"
- "Has caused major issues with social interactions"
- "Lacks any solid friendships"
- "Lacks confidence, self–worth and has no real understanding of her own identity"

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Nature of the abuse

- Mixture of emotional, physical and neglect
- Neglect of child`s real needs if they don't fit with parental needs or beliefs
- Breach of trust with distorted relationship between parent and child, other family members or professionals
- Threats can be overt or covert
- Distortion of child's perceptions of their own body and health

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Types of emotional abuse and effects in childhood

- **Isolating**- removing the child from normal social experiences and preventing development of friendships
- **Terrorising**- bullying the child or mounting a campaign which makes child believe the world is hostile
- **Rejecting**-abandoning the child physically or emotionally or rejecting real physical and emotional needs

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Disabled children

- Special difficulties identifying FII
- One parent often more involved in care
- Seeking 2nd opinion is normal
- Parent being an expert in the condition is normal
- Campaigning for benefits is normal
- Consulting the child can be more difficult
- Motives for adopting disabled child

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Recent developments

- In UK there has been a move to earlier identification and intervention without the need to prove deliberate deception
- Cases are increasingly being identified by agencies other than health
- Trend towards being more open with families about concerns at an earlier stage
- Multi agency work in Manchester progressing

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Recent developments

- Recognition of PP/FII spectrum
- Acceptance that some early cases can be managed openly with the family
- Role of Early Help
- Identification of Champions in Multi Agency Safeguarding Hub (MASH), Children Social Care (CSC), Early Help
- Development of pathways of care and MASH pathway
- Establishment of consultation line to obtain paediatric advice
- Clarification of role of Lead Paediatrician
- Planned training

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Chronology

- Time consuming!!!
- Does not prove what is happening ***now***
- Current template is not user friendly
- Proposal to use template which includes
  - Date, Source, Event and Impact on the child
  - Or a case summary by year with comment and analysis
- Some referrals may be submitted with short chronology initially
- We should be working to a multi-agency, FAMILY chronology

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Chronology Template

Date	Incident of sequence of incidents relevant to the child's welfare	Impact on the child
12/01/2016 – 16/19/17	Jodie has been off school a total of 23 times due to various illness, hospital appointments and check ups. Mother has reported that the child has epilepsy and struggles with their joints/balance and has to have support when walking. She is not allowed to do PE.	Jodie has missed a significant amount of school which is impacting on her learning and her socialising. She struggles to make friends and does not talk about home at all. Jodie also has been in school with walking aids and is on medication for her epilepsy. School have never observed her to have any difficulty walking or running or having a fit. When school have tried to speak to Jodie's mum about her health she has threatened to home school her and said that everyone discriminates against the family. Jodie became very upset at this time.

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What to do if you are worried…

- ***Refer to the MASH if worries about significant harm 0161 234 5001.***
- For emerging concerns;-
- Discuss with manager/safeguarding lead
- Start to record everything (dates, absences, hospital appointments etc.) Consider starting chronology
- Try to get consent to collate information (e.g. if a child has health complications then there should be a coordinated plan and regular communication for everyone to work together- health visitor, school nurse, GP, school staff ETC.)
- Try to work with families and professionals without splitting meetings/information
- Consider Early Help if the worries are perplexing but not harmful.

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What to do if you are worried 2

- If paediatric advice is needed this can be obtained by contacting the Coral Suite 0161 232 4220
- If needed, a lead paediatrician will be agreed via the Coral Suite
- When appropriate, a rehabilitation plan will be developed for the child and agreed with all agencies involved
- Paediatrician meets with and shares plan with family
- Role for Early Help in support and monitoring
- Sometimes Children Social Care already involved at this stage
- Even if there is compliance with plan, there will be a need for careful ongoing monitoring

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What to do 3

- If there is no agreement from the family or non compliance/ disguised compliance-
  - Referral to MASH
  - Or escalation of concerns if Children Social Care already involved
- Usually family can be told about referral
- Concerns are around neglect and emotional abuse

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Management

- Assessment of harm to the child
- Voice of the child
- Multi-agency, family chronology
- Challenges of assessing perpetrator
- Prognostic factors
- Insight
- Capacity to change
- Likely to be long term problem
- Legal challenges

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Prognostic Factors in FII (1)

Jones et al 2000

Domain	Poor Prognosis	Better Prognosis
	Induced harm Sadistic element Accompanying Child Sexual Abuse or Physical Abuse Deaths of previous children Harm to animals	Fabrication Shorter duration of FII
	Developmental delay Physical sequelae of FIP Developmental of somatising behaviour	Absence of delay or sequelae of abuse
	Personality disorder Denial Lack of compliance Alcohol/substance abuse Abuse in childhood – unresolved	Personality strengths Acknowledgement of abuse Compliance Treatment responsive mental illness Adapted to childhood abuse

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Prognostic Factors in FII (2)

Jones et al 2000

	Poor Prognosis	Better Prognosis
child interaction	Disordered attachment Lack of empathy for child Own needs before child	Normal attachment Empathy for child
	Domestic violence Multigenerational abuse	Non-abusive partner Supportive extended family
	Lack of informed resources	Partnership with parents Long-term psychological treatment and social casework
	Violent, unsupportive neighbourhood Isolation	Local child support facilities Social support

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Considerations for rehabilitation

- Significant implications for child and carer
- Child's health now improving
- May need narrative to explain to others
- Child may need to adjust to new state of health
- Strategies to "fill the gap" in their lives
- Psychological work

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Checklist of worries:

Worries	Date/Frequency
Regular non-attendance due to ill health	
Many health appointments	
Unusual/changing diagnosis	
New health complications	
Bizarre and extreme family history	
Child not observed to have symptoms	
Complaints/very difficult behaviour when challenged	
Refusal to accept wellness in child	
Refusal to allow for consent to sharing information	
Splitting of professionals	
Refusal for direct observation/work with child	
Aids which were not prescribed by Dr but obtained	

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Summary

- PP/FII is part of a spectrum of behaviour
- It is not necessary to "diagnose FII"
- It is not necessary to prove deception
- It is not necessary to unpick carer motivation
- What is important is harm to the child- usually emotional abuse and/or neglect
- Some PP cases can be managed earlier and openly with carers
- Where this approach has failed or there is already evidence of harm, referral is needed
- MASH process agreed
- Cases should be managed by senior staff

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Feedback and Impact Evaluation

There is a statutory function on the Local Safeguarding Board to: `evaluate the effectiveness of any training`
(Regulation 5: Working Together 2018)

It is important that all trainees complete:-

- Online feedback
- Action Plans
- Impact Evaluation Questionnaire will be need to be completed online in 3 months after attending this course to attain the training certificate.

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