

Chapter 13: Perplexing Presentation (including FII)

Good Practice Recommendations

1. Professionals should follow local interagency procedures and the RCPCH guidance¹.
2. The need for a detailed chronology is paramount.
3. Paediatricians should avoid iatrogenic harm and only undertake tests or treatments that are clearly indicated.
4. Admission to hospital can be helpful for close observation to differentiate between erroneous and true reports of symptoms and signs.

13.1. An approach to 'perplexing presentations'

- 13.1.1. The common starting point for both 'Perplexing Presentations' and fabricated or induced illness (FII) is that the child's clinical presentation is not adequately explained by any confirmed genuine illness, and the situation is impacting upon the child's health or social wellbeing. There is a spectrum of presentations, with the rarer 'true' FII involving deliberate deception of medical services by the carer; which may involve actions to falsify specimens or investigations, or induction of actual illness in the child, and the commoner wider range of 'perplexing presentations' or 'Medically Unexplained Symptoms' that should be considered in the same way but do not necessarily involve deliberate deception^{2,3,4,5}. These presentations are primarily verbal accounts and descriptions by the carer.
- 13.1.2. Presenting features may include:
- A carer reporting symptoms and observed signs that are not explained by any known medical condition
 - Physical examination and results of investigations do not explain the symptoms or signs reported by the carer
 - The child has an inexplicably poor response to prescribed medication or other treatment, or intolerance of treatment
 - Acute symptoms and signs are exclusively observed by/in the presence of one carer
 - On resolution of the child's presenting problems, the carer reports new symptoms or reports symptoms in different children in sequence
 - The child's daily life and activities are limited beyond what is expected due to any disorder from which the child is known to suffer, for example partial or no school attendance and the use of seemingly unnecessary special aids
 - The carer seeks multiple opinions inappropriately.
- 13.1.3. Doctors may feel under pressure to investigate and treat the child, without really understanding what condition the child is suffering from. The clinical information may simply 'not add up', and experienced paediatricians may be reduced to scratching their heads and muttering 'What's Going On?' (colloquially known as 'WGO Syndrome').

They may attempt to explain the child's symptoms by inventing a brand new, previously un-described or medically illogical hypothesis to explain the child's symptoms.

- 13.1.4. It is very important at an early stage in this process to avoid iatrogenic harm and only to undertake tests or introduce treatments that are clearly indicated. For inpatients, the key to differentiating between erroneous and true reports of symptoms and signs is a period of close or constant observation of the child. This is overt nurse observation, not covert surveillance. For out-patients, as many sources of information as possible should be explored; in particular, the child's functioning at school. If careful medical assessment suggests that the child does not have any medical condition and that the symptoms are 'medically unexplained', this can be presented to the child's family as 'good news', with reassurance that most children spontaneously improve over time, coupled with a clear medical plan that no further investigations or treatments will be initiated unless the situation changes. A plan for rehabilitation of the child to normal activities, stopping any current unnecessary medical treatment and ongoing medical monitoring will be needed. Involvement of local Child and adolescent mental health services (CAMHS) services may be helpful; in particular the family may need to be helped to think through how their lives will be different if the child is no longer ill and be helped to construct a credible narrative about the child's 'recovery'.
- 13.1.5. It is often unclear in these cases whether the carer is actively fabricating their child's illness, whether they are simply anxious parents with a rather distorted view of their child's state of health, whether the carer holds inappropriate beliefs or expectations about health and illness, or if the parent and child are interacting in a way that involves the child assuming the 'sick role' or the role of a disabled child. Sometimes there are familial or cultural styles of 'illness behaviour' that affect how children are presented to doctors. Most of these cases, at least in the initial stages, do not need a safeguarding approach and are probably not 'true' FII cases.
- 13.1.6. After attempting a reassuring, non-invasive approach to the perplexing symptoms and reported signs, if the carers reject the doctor's hypothesis and insist on further intervention or further opinions, or if they 'sack' the doctor concerned and demand a change of doctor, or if the child develops unexplained physical symptoms or signs (e.g. faltering growth), then a judgment will need to be made as to whether the carers' actions are placing the child at risk of significant harm and a safeguarding referral is indicated.
- 13.1.7. If a further opinion is sought it is important that the person giving the opinion is fully aware of the background and concerns. Paediatricians should never allow themselves to be 'browbeaten' into arranging tests or treatments that are not indicated.
- 13.1.8. It is important that the situation for the child is resolved and that they are able to return to a more normal lifestyle. If that does not happen despite attempts by the treating team to help, or if contact is broken so that no information is available, a safeguarding referral is indicated.

- 13.1.9. In a minority of cases, there may be clear evidence that the carer is an unreliable historian. If, for example, aspects of the history have been convincingly proven not to be true, mutually exclusive accounts have been given, the history is medically implausible and cannot be attributed to anxiety, limited ability or disordered health beliefs, then that is a significant risk factor that requires referral under safeguarding procedures. It may be that the child's illness is totally fabricated (i.e. the carer is deliberately lying) or the child may have some genuine illness and only some aspects of the problem may be fabricated. Examples of illnesses that are vulnerable to fabrication include:
- Apnoea
 - Seizures
 - Vomiting
 - Asthma or allergies
 - Blood loss.
- 13.1.10. These are all conditions where the child may appear well between 'episodes' and definitive testing to confirm or refute the condition may not be available. It is likely that a fabricating parent learns by 'trial and error' to fabricate convincingly and that doctors may inadvertently 'coach' the parent in the course of taking repeated clinical histories from the parent.
- 13.1.11. Some carers may also falsify supporting evidence of their child's 'illness' e.g. putting glucose or egg albumin in urine samples, blood in nappies or urine samples, spitting in a CSF sample bottle, spitting in the child's ear to mimic a CSF leak, falsifying a 'fit chart' or rapid blood glucose readings etc. This should be regarded as dangerous behaviour likely to place the child at severe risk.
- 13.1.12. If there is evidence of illness induction (i.e. the parent is physically doing things to the child to make them ill), that is an ominous and potentially fatal situation that must be addressed urgently through safeguarding procedures. These cases are rare but memorable and have a huge impact upon the treating team. Examples of induced illness, with the results of which the child is repeatedly presented to doctors, may include:
- Smothering to induce apnoea or anoxic seizures
 - Poisoning (e.g. with anticonvulsants, psychiatric drugs, narcotics, laxatives or salt) most commonly presents with drowsiness, vomiting or disorientation which may initially be investigated as an encephalopathy
 - Deliberately withholding food to cause failure to thrive
 - Deliberately withholding medication that is necessary for some genuine medical condition
 - Physically harming the child to cause rashes or other physical signs, or applying caustic or noxious substances to the child's body
 - Injecting faeces
 - Removing blood from the child to cause anaemia
 - Induced feeding difficulties mimicking a dysmotility syndrome.
- 13.1.13. Some of these presentations are so bizarre and traumatic that it is almost impossible to believe that a carer could behave in this way.

- 13.1.14. Cases where there is confirmed, deliberate fabrication, falsification or induction of illness constitute what paediatricians would regard as 'true' cases of FII, but the impact on the child is similar whether they are victims of 'true' FII or are part of the wider spectrum of Perplexing Presentations.
- 13.1.15. The presence of a proven chronic medical condition does not exclude a diagnosis of FII; the two commonly co-exist (in about half of all FII cases⁶). This may be because children with other health needs are more vulnerable or their illness could have been a consequence of FII.
- 13.1.16. Physical abuse would not normally be described as FII even if the parent/carer did not disclose the cause, but where presentations to doctors are repeated and appear to be designed to assume a sick role by proxy they would be considered to be part of this spectrum.
- 13.1.17. Rarely, carers who have delusional disorder or other mental illness may also present their children to paediatricians with bizarre or implausible histories of illness, but these are usually easily recognisable as the carer lacks insight and is not able to make their history sound plausible. This would also usually require a safeguarding intervention but the approach will be different and these cases would not usually be included as FII.
- 13.1.18. Most perpetrators of FII abuse are mothers, possibly because mothers usually play the most active role in parenting in most Westernised societies. However, a significant minority of cases involve the male carer or both carers colluding together^{7,8}.
- 13.1.19. The paediatrician always has to keep an open mind in case there is a genuine medical explanation for the child's presentation. Where there is residual doubt, or if the child continues to be ill even when the carer is not present, a careful case note review should be conducted and the situation discussed with colleagues; ideally in a multidisciplinary meeting.

13.2. Common medical presentations in FII

- 13.2.1. Certain medical conditions are more amenable to deliberate fabrication or induction ('True' FII) than others. This is because the diagnosis rests mainly on history and there are no simple and reliable signs or test results which would refute the diagnosis.

Table 1. Presenting features in 97 'FII' cases^{1,9}

Presenting feature	All FII cases
Fits	24
Apparently life threatening events (ALTE)	22
Drowsy, Coma	13
Blood loss in vomit or rectally	13
Failure to thrive, feeding difficulty	11
Bowel disturbance	9
Asthma	9

Vomiting, Gastro-Oesophageal Reflux	8
Blood loss, haemoptysis	5
Skin lesions	4
Fabricated disability	3
False allegations of abuse	3
Blood in urine	3
False disclosure of accidental overdose	3

13.2.2. The spectrum of cases seen under the wider ‘perplexing presentations’ umbrella is probably different and is likely to include more older children and more children with non-organic disabilities or chronic symptoms.

13.3. The impact of ‘perplexing presentations’ on the child

13.3.1. The child is likely to experience some of the following:

- A disordered perception of illness and health, leading to anxiety about health and abnormal illness behaviour
- (Inadvertent) iatrogenic harm including admission to hospital, exposure to hospital acquired infection, blood tests or X-rays
- A greater degree of invasive medical attention than is truly justified. In extreme cases this may include surgical procedures, insertion of venous lines, artificial feeding, anaesthesia or more prolonged hospital admissions
- Interference with normal life, including school attendance, social activities, relationships or educational achievement
- Older children may support their parents/carer in the perplexing presentation, even to the point of being complicit with active deceit
- Child victims of FII may be subject to prolonged legal proceedings and are at risk of further abuse and on-going morbidity due to abuse¹⁰.

13.3.2. With illness induction comes further heightened risk:

- The pain and distress of induced illness, including the possibly severe physical abuse or starvation
- A significant risk of death (around 10% in some studies; though there is likely to be selection bias)^{8,11}
- A risk of under-treatment for real conditions.

13.4. Action when FII is suspected

13.4.1. Refer to Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians¹ and Safeguarding Children in whom Illness is Fabricated or Induced¹².

13.4.2. In some cases there is a need for immediate action, e.g. where acute suffocation or poisoning are suspected, if the child has been physically harmed in the context of FII or if there is an urgent need to secure forensic samples.

13.4.3. If at any stage there is an acute ‘event’ that could represent an act of physical abuse, do not delay but make an immediate referral to children’s social care and the police.

- 13.4.4. Secure 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.
- 13.4.5. Examine the child for injuries and consider whether conventional 'NAI' investigations are needed.
- 13.4.6. Do not accuse the parent/carer or confront them, but explain that you are very concerned about the child and need to institute very close observation in hospital to find out what is wrong with them.
- 13.4.7. Other cases present in a more chronic or evolving way and can initially at least be managed conservatively with time to 'pause and plan'.
- 13.4.8. With all perplexing presentations there are general principles:
- Avoid iatrogenic harm and stop any procedures, tests or treatments that are not clearly indicated. **It is unacceptable to cause the child further iatrogenic harm whilst a diagnosis of FII is being considered, or in a child with a perplexing presentation where the presence of an organic illness has not been confirmed.**
 - A period of overt, close or constant observation of the child may be indicated as the history and reports cannot be relied upon
 - If there is a medical investigation that could confirm the presence or absence of an organic disease this should be undertaken promptly, but the temptation to keep investigating must be resisted. Explain to the carers that you intend to conduct investigations as follows and then stop, because further investigations are likely to cause more harm than good.
 - Likewise, can the possibility of FII easily be excluded in some way? For example, if the child is reported to have had 'episodes' when the carer was not present, this history should be explored in detail
 - Ensure that while decisions are being made, the child's daily functioning is also being restored nearer to normality
 - Consider the differential diagnosis outlined in RCPCH 2009: could the child's presentation be explained by anxiety, misunderstanding or unusual beliefs about illness? (If so, the child may still be suffering harm, but a different multiagency plan may be needed). Is the child adopting a sick role due to unusual parent-child dynamics? Could the parent be mentally ill?
 - Is there any evidence of 'true' FII (deliberate deception or illness induction)?
 - Consider discussing the child with the family GP, who may have important background knowledge of the wider family dynamic
 - If the conclusion is that this is a 'perplexing presentation' but not 'true' FII, then a conservative plan of action towards rehabilitation is usually appropriate (see Chapter 13.1)
 - If you remain concerned that this is FII and/or the child is at risk of significant harm, then a referral to children's services will be appropriate in line with national guidance
 - If you are not sure what is going on with the child, a chronology of health records may be helpful at this stage but this should not delay making a referral if there are concerns about the child's welfare.

- 13.4.9. If a diagnosis of FII seems likely and/or a conservative approach has failed:
- At this stage the carers should not be alerted to the FII concerns
 - Agree who will assume the role of 'Responsible Paediatric Consultant' (RPC). The RPC should become the main conduit for medical information sharing and clinical decision making, and will take a lead in liaising with other agencies.
 - Document early concerns in the child's case notes. This is important in case the child is seen by other clinicians who are not aware of the concerns. The carers' access to the records may have to be restricted.
 - Discuss concerns with colleagues including Named or Designated doctor, other consultants, nursing and/or therapy staff
 - Consider convening a professionals meeting or, if this is logistically difficult within a reasonable timescale, contact relevant people individually to discuss the case.
 - Consider measures to reduce risk immediately. Is the child in need of immediate protection?
 - Are any medical investigations or further opinions likely to assist? This must be consistent with avoiding iatrogenic harm.
 - Consider closer observation of the child in hospital.
 - Consider asking for an opinion from a colleague with expertise in the relevant field.
 - **If there is concern that a child may be at risk of significant harm and that concern cannot be resolved quickly and simply then a referral to Children's Social Care should be made.**
 - **Do not wait to confirm the diagnosis before referring to children's social care as delay may be detrimental to the child.**

13.5. Action after making a safeguarding referral

- 13.5.1. Detailed advice on managing cases is contained in the HM Government¹² and RCPCH guidance¹ documents. It is important that the RPC maintains their overview of the case and shows leadership, including working in partnership with statutory agencies.
- 13.5.2. Further action will include:
- Attendance at strategy meeting(s) or child protection conferences as necessary.
 - Consider whether this is this one of the rare cases where CVS by the police may be appropriate (refer to RCPCH 2009¹ for more advice).
 - Working with Children's Social Care and/or the police to disclose the concerns to the child's carers and plan immediate child protection measures.
 - Compiling a detailed medical chronology, including the sources of the information. This may be very time consuming but ideally all health records should be included. Usually the RPC will be responsible for this but if there are local issues the Named Doctor should be approached to help decide how this should be progressed.
 - Writing a detailed report for Children's Services (that may also later be used as a professional witness report for the court).
 - Following the child up to monitor their health and development and confirm what, if any, genuine medical conditions they have.

- Attempting to assist the suspected abusive carer in accessing support for their own needs.
- Opinions vary on the need to, or value of, reviewing the carer's records in this context. There are confidentiality issues in relation to access to the carer's own records, but conversely there may be important information that would influence the medical diagnosis of the child to some extent, e.g. if the carer was clearly shown to have fabricated their own 'epilepsy' in the past and the child is now presenting with abnormal episodes of loss of consciousness, or if the carer presents with a complex medical background suggestive of somatisation disorder. It is probably reasonable to ask the child's GP (if they are also the GP for the carer) to review the carer's records and disclose only those elements that are directly relevant to the welfare of the child. The purpose of doing this is not to establish a diagnosis of the carer but to assist with the diagnosis and risk assessment of the child. GMC guidance covers this area and should be heeded^{13,14}.

13.6. The paediatric report in FII cases

13.6.1. As well as the usual general principles of report writing (see Chapter 16) in child protection cases, a report on a suspected FII case should include:

- A detailed chronology, ideally of all health records (including siblings).
- Clarification of what genuine illnesses the child has had, supported by evidence.
- Analysis of which of the child's reported symptoms or signs were not supported by evidence.
- A consideration of what causes, other than FII, could have led to the child's various presentations.
- An analysis of the likely mechanisms for the abuse (if abuse is confirmed).
- A paediatric contribution to risk assessment, i.e. the impact of the abuse on the child and any further comments that are justified by the evidence, e.g. recurrence risk, morbidity and prognosis.

13.7. Management of specific situations

13.7.1. **Unexplained school absence**

13.7.2. Perplexing presentations are likely to disrupt the child's education considerably. Where these concerns arise, liaison with school may be very helpful. Important issues may include:

- Attendance may be very poor
- The school may be able to confirm or refute some of the history given by the carer
- There may be discrepancies between the child's observed functioning at school and that reported by the carer
- The carer may have sought additional special educational support that was inappropriate
- The child may make relevant allegations to school staff
- The school may have relevant background information.

- 13.7.3. The concerns may primarily relate to school, or may be primarily medical presentations with an impact on school life.
- 13.7.4. **Child psychiatric presentations**
- 13.7.5. Examples of perplexing presentations may include reported ADHD symptoms, features of eating disorders or Autistic Spectrum Disorders. It may be difficult sometimes to know whether the parent genuinely believes that the child has the reported diagnosis or not. Sometimes parents have a 'vested interest' in a diagnosis such as ADHD or ASD because it creates a focus on the child rather than questioning the quality of parenting. Some children may develop an ADHD or ASD 'phenocopy' (i.e. clinical features resembling that condition) arising as a result of previous abuse or neglect. Pecuniary advantage such as DLA or the acquisition of stimulant drugs for illicit use may also be an issue.
- 13.7.6. **FII and disability**
- 13.7.7. Perplexing presentations may be associated with profound restriction of normal activities. In other cases the parent may genuinely believe that their child has disability or needs to be 'protected' from the outside world. This comes within the spectrum of perplexing presentations.
- 13.7.8. Conditions such as hearing loss, vision impairment or inability to walk may be fabricated.
- 13.7.9. Other children with a genuine disability may become victims of FII as they are vulnerable and place great demands on their carers.
- 13.7.10. Finally, illness induction may cause disability, for example due to asphyxial brain injury in suffocation cases, limitation of developmental opportunities or prolonged sedation with drugs.
- 13.7.11. **FII and false allegations of child abuse**
- 13.7.12. Deliberate fabrication of sexual abuse events in a child may result in repeated medical assessments and involvement of other agencies. This would be harmful for a child and bears similarities to FII. Whether it should strictly be regarded as type of FII is debatable, but where there is a coexistence of true 'medical' FII and fabrication of sexual abuse they may be regarded as two parts of the same problem. In the context of acrimonious divorce or disputed contact, a parent may misconstrue a child's account or behaviour to indicate sexual abuse by the other parent.
- 13.7.13. As with all these situations, if the carers' behaviour results in harm to the child or places them at risk, a referral is indicated.

13.7.14. Sudden infant deaths and FII

13.7.15. There are rare cases where children have suffered FII abuse before dying as a 'Sudden Infant Death' (SID), and there is a high rate of previous sudden infant deaths in siblings of FII cases. Death 'per se' cannot be an FII, but there is clearly an association in some families^{15,16,17}. All unexpected deaths in the UK should be investigated in line with the Kennedy Protocol¹⁵. See Chapter 15.

13.7.16. FII during pregnancy

13.7.17. When a pregnant woman fabricates illness in herself this raises serious concerns about the welfare of the child after birth and justifies a pre-birth strategy meeting and probably a case conference.

13.7.18. If the woman is jeopardising the unborn child by her actions then this is an urgent situation which should be discussed in a multiagency context.

13.7.19. There is no evidence base from which to predict the outcome for the child in these cases but anecdotally in many FII cases the carer has a very complex obstetric history and in some there is clear evidence of fabrication or induction of their own illness during pregnancy or precipitation of a premature delivery¹⁸.

13.7.20. Covert Video Surveillance (CVS)

13.7.21. CVS is seldom needed if a comprehensive health chronology has been compiled and the possibility of FII has been discussed in a multiagency context, but there may be occasional cases where there is no other viable way of safeguarding the welfare of the child. It is conducted by the police under the Regulation of Investigatory Powers Act (RIPA) 2000¹⁹ and would never be undertaken by health staff acting alone. Further details are contained in RCPCH guidance¹.

13.8. The interface between paediatricians and other professionals

13.8.1. Adult mental health

13.8.2. The abusive carer should be helped to access mental health support if they are willing to accept it. This should be discussed in the strategy meeting. The GP will usually be the best point of contact for referring the carer.

13.8.3. Despite widespread misconceptions, 'Munchausen Syndrome by Proxy' (MSbP) is not (and never was) a psychiatric diagnosis. It was this widespread confusion amongst public and professionals alike that led RCPCH to introduce the term FII in 2002, as a direct replacement for the old MSbP terminology. FII is the paediatric diagnosis and answers the key question: 'What is the cause of this child's reported (or possibly actual) illness?' The psychiatric contribution to the assessment asks the important secondary question: 'Why is the child's carer behaving in this way?' The absence of a defined mental health diagnosis does not in any way contradict a paediatric diagnosis

of FII and there is no discrete 'psychological profile' associated with FII. However, perpetrators of FII abuse often do have mental health concerns. Bass (2012) and Bools *et al.* (1994) have reported the following mental health associations in perpetrators of FII abuse^{20,21}:

- Somatisation or Somatoform disorders in 57-72%
- Factitious disorders in 64%
- Self-harm in 46-54%
- Substance misuse or addictive behaviours in 11-18%
- A forensic history in 16-36%
- Personality disorder in 75-89%

13.8.4. At a later stage in proceedings a psychiatrist may be involved in a forensic assessment of the perpetrator for the courts²². It will be important for them to have a good understanding of exactly what the carer has done to the child and the impact of that behaviour. The paediatrician may have a useful role to play here, although this will obviously be at the court's discretion. It is important that adult mental health professionals do not assume the role of advocate for the child's carer and support them in denying the abuse. What is required of adult mental health professionals here is a diagnosis, and indication of the requisite treatment and its duration, and a prognosis of the likelihood of positive change in the carer.

13.8.5. **Child and adolescent mental health services (CAMHS)**

13.8.6. Arguably all cases with perplexing presentations will meet criteria for involvement of a CAMHS service. For many, the main task will be to help the family to adjust to a new view of the child as well; or at least less ill than before.

13.8.7. Again it is important for the CAMHS team to be well-informed about the paediatric background and what the concerns are.

13.8.8. It may be helpful to say to the carer that 'it must be stressful dealing with your child's chronic illness; you may find it helpful to talk to someone.' Older children may also be engaged in this way.

13.8.9. If safeguarding procedures are necessary, the situation may enter the legal arena and it may be difficult to involve CAMHS to work with the family therapeutically. They may be able to work with the child individually or with a foster carer. Multiagency discussion on how best to help the child may be appropriate.

13.8.10. **Other medical specialties**

13.8.11. Where there are concerns about FII and a child is referred for a specialist opinion it is imperative that those concerns are shared and the role of the specialist is clarified, i.e. what questions are being asked of them. Specialists are less likely to have an overview of the child's medical history and may be less familiar with safeguarding procedures than the general or community paediatrician, so the risk of delay in diagnosis of abuse or causing further iatrogenic harm is significant. This is particularly the case where children are transferred to distant centres for tertiary care or opinions. The situation is clearer if one paediatrician assumes the role of RPC and keeps an overview of the

case. This would usually be the DGH (secondary level) general or community paediatrician.

13.8.12. **Primary care teams**

13.8.13. Children with perplexing presentations often have a history of frequent presentations to the GP and may have had extensive involvement of health visitors. There may be a large amount of background information which would be relevant in considering the child's diagnosis, particularly when the initial concerns about FII arise. Early communication may lessen the extent of iatrogenic harm and speed up the diagnosis of abuse in these cases. It is legitimate for the GP to disclose information about the parent if it is in the child's interests, but this should be limited to that information which is relevant and proportionate^{13,14}.

13.8.14. The GP should not assume the role of advocate for the carer as s/he is also the child's GP; the paramount consideration should be the welfare of the child, as is the case for all professionals. The paediatrician may have an important liaison role and it is important that the GP is kept abreast of the concerns.

13.8.15. **Children's social care**

13.8.16. Children's social care has lead responsibility for investigating child protection issues in children. Health professionals should comply with all reasonable requests for assistance and should seek to work in close partnership. This is especially important in suspected FII cases because of the uniquely medical nature of the concerns. The RPC will have an important role in informing the social workers about the medical issues and should ideally have on-going involvement in discussions about the child's welfare.

13.8.17. **Police**

13.8.18. The police are responsible for investigating possible crime. They should be involved early if illness induction is suspected and all specimens should be carefully retained. The police will have requirements in terms of evidence gathering and interviewing witnesses and health professionals should work closely with them so that each can understand the other's needs. The police will probably require witness statements from key health professionals and these requests should always be complied with. Support and advice on preparing witness statements and attending court can be accessed via the Named and/or Designated Doctor for Safeguarding.

References

1. Royal College of Paediatrics and Child Health. Fabricated or induced illness (FII) by carers - a practical guide for paediatricians. 2009. Available from <https://www.rcpch.ac.uk/resources/fabricated-or-induced-illness-fii-carers-practical-guide-paediatricians>
2. Stirling J. Beyond Munchausen syndrome by proxy: identification and treatment of child abuse in a medical setting. *Pediatrics* 2007;119(5):1026-1030. Available from <https://www.ncbi.nlm.nih.gov/pubmed/17473106>
3. Roesler T.A., Jenny C. Medical Child Abuse: Beyond Munchausen Syndrome by Proxy. 1 ed. American Academy Pediatrics; 2008.
4. Meadow R. What is, and what is not, 'Munchausen syndrome by proxy'? *Arch Dis Child* 1995;72(6):534-538. Available from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1511135/>
5. Eminson M., Postlewaite, R. Munchausen Syndrome by Proxy Abuse: A Practical Approach. 1 ed. Butterworth-Heinmann; 2000.
6. McClure R.J., Davis P.M., Meadow S.R., *et al.* Epidemiology of Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. *Arch Dis Child* 1996;75(1):57-61. Available from <https://www.ncbi.nlm.nih.gov/pubmed/8813872>
7. Meadow R. Munchausen syndrome by proxy abuse perpetrated by men. *Arch Dis Child* 1998;78(3):210-216. Available from <https://www.ncbi.nlm.nih.gov/pubmed/9613349>
8. Rosenberg D.A. Web of deceit: a literature review of Munchausen syndrome by proxy. *Child Abuse Negl* 1987;11(4):547-563. Available from <https://www.ncbi.nlm.nih.gov/pubmed/3322516>
9. Davis P. The Cardiff Leeds study of alleged Munchausen Syndrome by proxy, non-accidental poisoning and non-accidental suffocation. *Welsh Paediatrics Journal* 2000;13:32-41. Available from <https://www.welshpaediatrics.org.uk/welsh-paediatric-journal>
10. Davis P., McClure R.J., Rolfe K., *et al.* Procedures, placement, and risks of further abuse after Munchausen syndrome by proxy, non-accidental poisoning, and non-accidental suffocation. *Arch Dis Child* 1998;78(3):217-221. Available from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1717484/>
11. Sheridan M.S. The deceit continues: an updated literature review of Munchausen Syndrome by Proxy. *Child Abuse Negl* 2003;27(4):431-451. Available from <https://www.ncbi.nlm.nih.gov/pubmed/12686328>
12. HM Government. Safeguarding children in whom illness is fabricated or induced. 2008. Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf
13. General Medical Council. Protecting Children and Young People: The Responsibilities of All Doctors. 2012. Available from <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people>
14. General Medical Council. 0-18 years: guidance for all doctors. 2007. Available from <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years>
15. The Royal College of Pathologists, Royal College of Paediatrics and Child Health. Sudden unexpected death in infancy: A multiagency protocol for care and investigation.

2004. Available from https://www.sudiscotland.org.uk/wp-content/uploads/2015/06/The_Kennedy_Report_2004.pdf
16. Meadow R. Suffocation, recurrent apnea, and sudden infant death. *J Pediatr* 1990;117(3):351-357. Available from <https://www.ncbi.nlm.nih.gov/pubmed/2391589>
 17. Southall D.P., Plunkett M.C., Banks M.W., *et al.* Covert video recordings of life-threatening child abuse: lessons for child protection. *Pediatrics* 1997;100(5):735-760. Available from <https://www.ncbi.nlm.nih.gov/pubmed/9346973>
 18. Jureidini J. Obstetric factitious disorder and Munchausen syndrome by proxy. *J Nerv Ment Dis* 1993;181(2):135-137. Available from <https://www.ncbi.nlm.nih.gov/pubmed/8426171>
 19. HM Government. Regulation of Investigatory Powers Act 2000. 2000. Available from <http://www.legislation.gov.uk/ukpga/2000/23/contents>
 20. Bools C., Neale B., Meadow R. Munchausen syndrome by proxy: a study of psychopathology. *Child Abuse Negl* 1994;18(9):773-788. Available from <https://www.ncbi.nlm.nih.gov/pubmed/8000908>
 21. Bass C., Jones D. Psychopathology of perpetrators of fabricated or induced illness in children: case series. *Br J Psychiatry* 2011;199(2):113-118. Available from <https://www.ncbi.nlm.nih.gov/pubmed/21804147>
 22. Adshead G., Bluglass K. Attachment representations in mothers with abnormal illness behaviour by proxy. *Br J Psychiatry* 2005;187:328-333. Available from <https://www.ncbi.nlm.nih.gov/pubmed/16199791>

Update information

Date last updated: 2013

Next review due: Pending