GSCP Joint Protocol for the Management of Perplexing Presentations Including Fabricated or Induced Illness

2023

Locally, cases of suspected FII have previously been managed under Gloucestershire Safeguarding Children's Board (GSCB) Joint Section 47 Enquiry Protocol: Outline Process for Joint Investigations of Suspect Induced or Fabricated Illness. (May 2018). This protocol replaces that document and reflects the revised RCPCH Guidance and learning from recent research.

Gloucestershire Safeguarding Children Partnership

Joint Protocol for the Management of Perplexing Presentations Including Fabricated or Induced Illness

Contents

Document Revision Table

Revision	Date	Comment
1.0	January 2023.	Guidance signed off by GSCP Executive Published on GSCP Website and included in Published arrangements

Context

1.1 Since the publication of the Royal College of Paediatrics and Child Health (RCPCH) initial guidance on Fabricated or Induced Illness' by Carers (FII) in 2002 (subsequently updated in 2009), there have been significant developments in the field. The RCPCH Child Protection Guidelines (2013) extended the definition of FII by introducing the term Perplexing Presentations (PP) and setting out suggestions for its management. These are cases in which harm to the child is predominantly caused by misunderstandings around health symptoms, which may lead to doctors ordering treatments and investigations that may be harmful. There remains the potential for some such cases to progress to FII but not at this early stage.

1.2 In February 2021, the RCPCH published its updated guidance 'Fabricated or Induced Illness by Carers: a practical guide for paediatricians'. This reflected the work of an expert working group and consultation with a diverse range of organisations and commissioning groups. It represents the current view and supersedes the previous RCPCH guidance. While primarily written for paediatricians, the RCPCH guidance is also of direct relevance to GPs, other specialists, social care and education practitioners. Locally, cases of suspected FII have previously been managed under Gloucestershire Safeguarding Children's Board (GSCB) Joint Section 47 Enquiry Protocol: Outline Process for Joint Investigations of Suspect Induced or Fabricated Illness. (May 2018).

1.3 This protocol replaces that document and reflects the revised RCPCH Guidance and learning from recent research which suggests that multi-agency arrangements need to be sufficiently flexible to take account of the wider spectrum of cases that can emerge, whilst continuing to respond to child safeguarding concerns in a timely and appropriate manner. It has been approved by Gloucestershire's Safeguarding Children Partnership following consultations with local safeguarding partners, the Parent Participation Forum (PPF) and Parent Carer Alliance (PCA). It also draws upon the guidance from the Professional Association for Social Workers (BASW:2022) Fabricated or Induced Illness and Perplexing Presentations: Abbreviated Guidance for Social Work Professionals.

1.4 The protocol aims to provide a framework for medical practitioners, other practitioners and parents and carers and children to work in an open and collaborative way to progress matters when concerns about the potential for PP/FII emerge, avoiding the need the need to escalate these through child safeguarding arrangements, unless absolutely necessary.

The flow diagram at Appendix 1 summarises the steps for local agencies with child safeguarding responsibilities to follow in meeting the requirements of this protocol. This protocol will be subject to regular review by Gloucestershire's Safeguarding Children Partnership (GSCP) who will also receive regular updates on its operation. We will undertake an initial review 6 months after implementation, including the views of parents and carers, and relevant incidents and outcomes. It is not intended that this protocol replicates in full either the RCPCH or BASW Guidance, which provides detailed guidance for paediatricians and social workers respectively, but rather it provides a framework for multiagency working when cases of PP/FII emerge.

As BASW and the RCPCH Guidance acknowledge, instances of fabricated and induced illness are rare, whereas, perplexing presentations are more likely. This protocol aims to promote a graduated approach to child safeguarding, taking account of that learning.

2.0 Terminology and definitions

2.1 Fabricated or Induced Illness by carers (FII) can cause significant harm to children. FII can involve a well child being presented by a carer as ill or disabled, or an ill or disabled child being presented with a more significant problem than he or she has in reality, and suffering harm as a consequence.

2.2 Recent research suggests that the majority of suspected FII cases encountered by paediatricians can be more accurately described as 'perplexing presentations'. Perplexing (medical) Presentations (PP) involve a child reported to have symptoms that impact significantly on their everyday functioning, and yet thorough medical evaluation has not revealed an adequate and realistic medical explanation. PP is distinguished from other medically unexplained symptoms (MUS) by the parents/carer being reluctant to support a rehabilitative approach and insisting instead upon continued investigations or medical intervention.

2.3 A Perplexing Presentation (PP) is when a child or young person is presented by their parents/care givers with a condition which cannot be medically explained and an alerting sign to possible Fabricated or Induced Illness (FII) (BASW 2022 – page 3).

2.4 This protocol reflects the current terminology and definitions provided by the RCCPH Guidance (2021), as follows:

Term	**Definition**	**Synonyms**
Medically Unexplained Symptoms (MUS)	The child's symptoms, of which the child complains, are which are genuinely experienced, are not fully explained by any known pathology but with likely underlying factors in the child (usually of a psychosocial nature), and the parents/caregivers acknowledge this to be the case. The health professional and parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child or young person. MUS can also be described as 'Functional disorders' and abnormal body sensations which cause pain and disability by affecting the normal function of the body.	Non-organic symptoms, Functional illness, Psychosomatic symptoms
Perplexing Presentations (PP)	Presence of alerting signs when the actual state of the child's physical/mental health is not yet clear but there is no perceived risk of immediate serious risk to the child's physical health or life.	
Fabricated or Induced Illness (FII)	FII is a clinical situation in which a child is, or is very likely to be, harmed due to caregiver(s) behaviour and actions, carried out in order to convince doctors and other professionals that the child's state of physical and/or psychological health is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect including iatrogenic harm.	Munchausen Syndrome by Proxy; Paediatric Condition Falsification; Medical Child Abuse; Parent Fabricated Illness in a Child; (Factitious Disorder Imposed on Another,

		when there is explicit deception.)

3.0 Key operating principles

3.1 This protocol provides a framework for the local multi-agency response to concerns about Perplexing Presentations or FII as an integral element within Gloucestershire's multi-agency child safeguarding procedures.

3.2 Its operation will be underpinned by the following principles:

- The safety and welfare of the child(ren) is the paramount concern rather than the perceived severity or type of parental motivations, actions and behaviours.
- Transparent and ongoing dialogue between agencies, practitioners and parents is key – particularly when concerns are unresolved.
- Unless there is a significant risk of immediate, serious harm to the child's health or life, the need for sharing information between different practitioners involved with the child should be disclosed with the child/young person and their parents.
- Parental behaviour may be motivated by anxiety and erroneous belief about the child's health – it also may or may not include deception.
- A lead health professional will be identified to co-ordinate the health response to concerns.
- The development of a comprehensive account of the child's involvement with health and establishing a professional consensus – will be key elements in the multi-agency response to emerging concerns.
- Access to advocacy support may be needed for parents/carers and the child/young person.
- Support for social care practitioners will be provided by Advanced SW Practitioners who have had additional training with health Safeguarding Teams.
- A Health and Education Rehabilitation Plan (HERP) agreed by professionals and families is an essential feature of all cases, whether or not children' social care are involved. The HERP should be considered as a framework for working openly and transparently with parents, carers and the children concerned. Its purpose is to assist in better understanding the child's experience and of resolving differences between parents/carers and professionals, with a focus on rehabilitation.

3.3 As BASW advise, there is a need for social workers to be fully committed to responsibly safeguard all children from any harm, however, they also have a duty to ensure parents/care givers are appropriately supported, rather than them being subjected to unnecessary child protection proceedings, when inappropriate and wrongful accusations of FII are made.

4.0 Alerting Signs

4.1 The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviours. Alerting signs may be recognised within the child or in the parents' behaviour. A single alerting sign by itself is unlikely to indicate possible fabrication and it is important to look at the overall picture, which includes the number and severity of alerting signs. These 'alerting signs' are suggestive rather than indicative of FII - their presence should initially be regarded as PP.

4.2 Whilst it is not possible to be exhaustive, the alerting signs listed below are generally accepted being suggestive of PP. Concerns about FII will be appropriate only if there is clear evidence of fabrication or deception:

Context

- The experience of parents/carers is important – the stress and pressures they are dealing with and the quality and nature of support they are receiving.
- The nature of the prior relationships between parents/carers and health practitioners; any additional needs of the parents/carers.

In the child

- Reported physical, psychological or behavioural symptoms and signs not observed independently in their reported context.
- Unusual results of investigations (e.g. biochemical findings, unusual infective organisms)
- Inexplicably poor response to prescribed treatment.
- Some characteristics of the child's illness may be physiologically impossible e.g. persistent negative fluid imbalance, large blood loss without drop in haemoglobin.
- Unexplained impairment of child's daily life, including school attendance, aids, social isolation.

Parent Behaviour

- Parents insistence on continued investigations instead of focusing on symptom alleviation, when reported symptoms and signs not explained by any known medical condition in the child.
- Repeated reporting of new symptoms.
- Repeated presentations to and attendance at medical settings, including emergency departments.
- Inappropriately seeking multiple medical opinions.
- Providing reports by doctors from abroad, which are in conflict with UK medical practice.
- Child repeatedly not brought to some appointments, often due to cancellations.
- Not able to accept reassurance, or recommended management, and insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments (sometimes based on internet searches).
- Objection to communication between professionals.
- Frequent vexatious complaints about professionals.
- Not letting the child be seen on their own.
- Talking for the child/child repeatedly referring or deferring to the parent.
- Repeated or unexplained changes of school (including to home schooling), of GP or of paediatrician health team.
- Factual discrepancies in statements that the parent makes to professionals or others about their child's illness.
- Parents pressing for irreversible or drastic treatment options where the clinical need for this is in doubt or based solely on parental reporting.

4.3 When working with children and their families where there are concerns about PP or FII, professionals should explicitly explore whether the child is experiencing or has previously experienced adverse childhood experiences such as physical, sexual or emotional abuse, neglect, domestic abuse or exploitation in all its forms. Adverse childhood experiences (ACEs) can have a detrimental impact on the physical, mental and emotional wellbeing of a child. Professionals should also be alert to the potential for parents having experienced ACEs.

4.4 BASW have highlighted the need for professionals to exercise professional curiosity with parents and carers of children with neuro-developmental and/or complex dynamic health conditions.

5.0 Response to Alerting Signs and Perplexing Presentations

5.1 The flow diagram attached at Appendix 1 outlines an incremental approach towards alerting signs that may be suggestive of Perplexing Presentations (PP) escalating to Fabricated or Induced Illness (FII). It seeks to engage parents/carers in a continuing dialogue with professionals, underpinned by a comprehensive appreciation of the child's involvement with health and their current functioning. An important caveat to this approach occurs when alerting signs are accompanied by indicators of deception or potential induction of illness by the carer, or other significant harm, which will necessarily require a child safeguarding referral to be commenced immediately.

BASW: Recommendations for social work practitioners:

- Social workers need to exercise professional curiosity when a referral is made suggesting a child has a perplexing presentation or a Fabricated or Induced Illness (FII).
- Social workers need to be aware of the lack of evidence for currently used indicators for FII and perplexing presentations and the high incidence of these indicators identifying children where illness is neither fabricated or induced.
- Social workers need to be aware that the behaviour of autistic and neuro-divergent parents and children is easily mistaken for FII as is the case in multi-systemic conditions such as Myalgic Encephalomyelitis and Ehler's Danlos Syndrome
- Social workers need to understand that complex presentations in suspected FII can often be due to rare or misdiagnosed illnesses, so it is essential to work with parents/ caregivers and children to determine what support is required and to ensure specialists with knowledge of relevant conditions are involved.
- Social workers need to accept the potential for inter-professional differences about FII and be confident in their knowledge and skills to promote a social perspective.
- Social workers should use reflective supervision to support their own learning and confidence in FII, identifying the potential for their own biases and limitations in their understanding of different conditions/presentations.
- Social workers need to refer to the BASW Code of Ethics to ensure their practice aligns with the principles of human rights, social justice, and professional integrity.

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

5.2.1 The term Perplexing Presentations (PP) denotes the presence of alerting signs to possible FII, in the absence of the likelihood of immediate and significant risk to the child's health or life. At this initial stage, it is the professionals who are perplexed by the presentation. If initial concerns emerge in a non-health setting, professional should explain to the parents that information is required from health to understand the concerns e.g. poor attendance at setting. As such, the approach at this early stage (which needs to be carefully explained to the carers and child) is to establish as quickly as possible the child's current state of health and all involvement with health services. It is also important to understand the parents' concerns, fears, hopes and explanations for the child's difficulties.

5.2.2 The relevant professional/agency observing the alerting signs shall document their initial concerns and complete a single agency chronology for review/oversight with their manager and/or agency safeguarding lead. The chronology should be developed collaboratively with parents/carers, with any differences in views fully recorded.

5.2.3 For initial concerns emerging in a non-health agency/setting, contact should be made with the child's GP, following consultation with parents. In support of this, it is important that the agency provides a full account of the situation of the child and the nature of the alerting signs that are

'perplexing' practitioners, consulting with parents as this is progressed. The purpose at this stage is to enable the GP to undertake a full review of primary care involvement with the child in order to resolve the concerns of practitioners. If the GP has concerns they should refer the child(ren) to a Consultant Paediatrician. The concerns should be discussed with parents with the aim of resolving those concerns and coming to a consensus on the best way to continue to support the child(ren).

5.2.4 If concerns are unresolved, the next stage is for health to collate a comprehensive overview of the involvement of the child(ren) with local health services/practitioners, their treatment (current and proposed) and level of functioning. In some cases, the child may be under the care of several health practitioners (including private consultations) and services. It is important to note that at this stage this information gathering is not for child safeguarding purposes but rather to enable health practitioners to have a comprehensive appreciation of the situation of the child and establish a consensus between health professionals on their clinical response to the current concerns. The provenance of all reported diagnoses should be verified and a single designated health lead should be identified at this stage to co-ordinate all evidence and act as the conduit for future communications with the parents and carers. The identified lead health professional shall be supervised by the named Doctor for Safeguarding. The Named Doctor involved in the case shall in turn be supervised by the Designated Doctor.

5.2.5 An important part of this process will be to meet with the child, if possible on their own, in order to ascertain their beliefs, concerns and expectations about their state of health, and mood. A further important source of information about the child will be their nursery/day care or school and their observations about the child's attendance, symptoms and functioning, and any events reported to have taken place there. Although both will require the consent of parents, (unless the child is deemed competent) the emphasis should be on moving forward on the basis of consensus.

5.2.6 Parents are occasionally reluctant for the processes of agency information gathering and ascertaining of the child's views to take place. While the reasons for this need to be understood through open dialogue with parents/carers, this might be an additional alerting sign. Parents should be made aware of this so that they are clear on the approach and thinking of professionals. If parents do not agree to a health assessment and the sharing of information about the child, the agency/setting having the initial concerns may need to reflect and consider a referral to children's social care. Parents should be informed of this potential step. It is important to note that if a safeguarding referral is progressed it is doing so due to concerns about the child's health and must therefore do so with the support and input from health professionals.

5.2.7 Research highlights that for families, when concerns about FII emerge, the interactions between them and social care can compound their sense of feeling victimised and disempowered (BASW:2022). The parents' reactions can often become the focus of the concern at the expense of the needs, risks and circumstances of the child. FII is extremely rare and many parents/care givers can mistakenly be perceived as creating or exaggerating their child's difficulties when there is only speculative, non-factual evidence to support this notion.

5.2.8 Having collated all health information about the child and their functioning, the lead health practitioner, together with a colleague, shall meet with parents and explain the current medical formulation of the child's problem. This will include what diagnoses are objectively present and what impairments this causes. In support of this process and in advance of any meeting with parents/carers, it is good practice to convene a consensus meeting of all health professionals involved, including the general practitioner (GP) in order to agree a way forward. Failure to reach consensus at least initially is not uncommon and may reflect a professional's singular commitment to either the family or to a particular diagnosis. It is important that partial feedback is not given to the parents/carers before a definitive consensus meeting has been held.

5.2.9 In some cases a period of 'watchful waiting' may be appropriate where this is deemed safe, or further definitive and warranted investigations and opinions may be required. This protocol proposes a restorative approach by halting iatrogenic harm to the child by further unnecessary investigations and treatment, restoring the child's daily life to optimal normality (allowing for any confirmed health problem) and enabling the child to develop a more reality-based understanding or her/his state of health.

5.2.10 The question of future harm to the child hinges upon whether the parents recognise the harm and able to adjust their beliefs and actions in such a way as to reduce or remove the harm to the child. Exploring this can be assisted through the co-production of a plan what has been termed a 'Health, Education and Rehabilitation Plan (HERP)' with the parents and child and subsequent implementation of that plan. This could utilise an existing format such as MyPlan/MyPlan plus. It will require Hospital, GP and community health services - possibly including physiotherapy and occupational therapy, psychology, child and adolescent mental health and education professionals working together. Goals should be clearly defined and achievable, for example, reducing or stopping any unnecessary medication, increasing range of foods in the child's diet and, where relevant, returning to full oral food intake, a graded mobilisation plan and re-establishing phased school attendance and engagement with community activities. Where necessary and when supported by the parent/carers, psychosocial work with the child and family will be commissioned to support the programme of change.

5.2.11 In exceptional cases admitting a child may be necessary. Any admission in these circumstances needs to be carefully planned to include what tests are to be undertaken and who will undertake daily ward reviews. Senior nursing staff should be explicitly briefed about any concerns and the reason for admission. All notes about the child must clearly state who observed or reported whatever is noted. As during normal school days, it is anticipated that parents will leave during school hours for school age children.

5.2.12 The purpose of any admission, namely constant observation of the child, needs to be discussed with the carers and child. If agreement cannot be reached with the parents about an admission or the planned assessment is thwarted, this may require a child safeguarding referral to be progressed not for suspect FII, but rather to enable the doctors to establish what is, and is not, wrong with the child.

5.2.13 If there are continuing concerns and/or parents/carers refuse consent to see the child or gather information from all relevant (inc non-health) agencies, it may be helpful to obtain an agreed independent, specialist paediatric view on all the health information gathered to date. Upon completion of their review, the lead health practitioner and independent paediatrician, shall meet with parents and explain the current medical formulation of the child's problem. This will include what diagnoses are objectively present and what impairments this causes.

5.2.14 It will also be important to communicate the potential next steps if parents are not in support of the professional proposals arising out of the independent specialist review. This may involve the convening by health of a multi-agency professionals' discussion as the precursor to commencing child safeguarding procedures. The identified lead health professional, in consultation with the Named Doctor for Safeguarding, may seek an independent specialist view of all the health information to date. Advocacy support for children has been commissioned by GCC and is available to children and young people involved in this protocol. It is acknowledged that caring for a child with complex medical needs can be stressful and even traumatic in some cases. With that in mind, where concerns do emerge it is important that advocacy support is made available to parents should they require it.

5.2.15 As set out above, there are a range of potential outcomes following the process of gaining a comprehensive picture about the child's current state of health:

The child may be found to have a previously unrecognised condition that can then be treated appropriately, and the child and family enabled to cope optimally with this condition through the continued support of health and other practitioners.

Most commonly there is no clear evidence of illness induction or deception and the child's reported symptoms and signs are either absent or persist but remain unexplained. There may be good clinical evidence for the absence of an illness that explains these symptoms. Unlike MUS where the child is 'owner' and main complainant of the reported symptoms, in PP the caregiver is the main narrator of the child's difficulties. The willingness of parents/carers to engage with an observational and restorative approach that seeks to avoid iatrogenic harm (due to unnecessary medical procedures) and the development of an HERP will be key to the agency response to emerging concerns of PP/FII and potential for child safeguarding procedures to be commenced.

Rarely, during the process of observation, explicit deception or evidence of illness induction becomes apparent. In this case, a child safeguarding referral shall immediately be made in accordance with local procedures.

It is essential that when matters are resolved the outcome is clearly recorded on all records for the child and the parents/carers informed in writing. PP/FII concerns can often emerge in the context of children with complex, dynamic conditions and it is essential that any prior concerns are fully understood when exploring current or emerging concerns.

5.3 Alerting signs – Immediate serious risk to child's health/life

Whenever alerting signs are present, the most important question to consider is whether the child may be at immediate risk of serious harm, particularly by illness induction. This is rare in practice and most likely to occur when there is evidence of frank deception, interfering with specimens, unexplained results of investigations suggesting contamination or poisoning, or actual illness induction, or concerns that an open discussion with the parent might lead them to harm the child. Illness induction and evident deception by parents are clear indicators of likely FII and require referral to Children's Social Care. What differentiates PP from FII is the parents' positive response to the proposed medical change of direction – away from investigation towards observation and rehabilitation.

5.3.1 In these situations, the following are important considerations:

- An urgent referral must be made to children's social care as a case of potential significant harm due to suspected or actual FII, leading to a strategy discussion that must involve relevant health representatives. The safety of siblings shall be considered.
- Securing any potential evidence (e.g. feed bottles, nappies, blood/urine/vomit samples, clothing or bedding if they have suspicious material on them).
- Considering whether the child needs immediate protection and measures taken to reduce the immediate risk.
- Documenting concerns to the child's health records in case the child is seen by other clinicians who are not aware of the concerns.
- In very rare cases, covert video surveillance may be used as part of multi-agency decision making and is led by the police.

5.3.2 In all circumstances in which a referral to children's social care might be necessary practitioners shall consider if notifying parent of the referral would place a child at increased risk of harm. In such circumstance parents shall not be informed prior to a multi-agency discussion usually in the form of a formal strategy discussion.

5.3.3 If at any stage in the process parents persist or return to their quest for more investigations and diagnoses, seek further medical opinions, decline or do not participate in the HERP this should now be considered as persistent and unresolved PP and the child is at potential risk of harm. A referral to child safeguarding services is now indicated and the family will be informed of this.

5.3.4 Within the Children Act (1989), the threshold for significant harm can be either ill-treatment – actually causing or likely to cause harm to the child, or impairment of child's health and functioning attributable to the care given or not given to the child. The preferred approach under this protocol is to refer the child on the basis of the impairment of the child's current functioning, attributable to the parents' unwillingness or inability to allow their child to participate in and benefit from a rehabilitative approach. At this stage the parents are now recognised as unreliable informants and should be informed of this.

5.3.5 In order to ensure Children's Social Care can respond appropriately, a comprehensive referral from health will be needed encompassing:

- A statement of verified diagnoses with a clear explanation of their functional implications for the child ('so what').
- A description of the:
    - Parent/carers' reports of the child's difficulties;
    - The child's perception of their problems (if relevant)
    - Independent observations of the child's actual functioning and symptoms (e.g., reported symptoms/signs that were absent when the child was directly observed);
    - Information given to parents about diagnoses and their implications;
    - Help and support offered to the parents and child to improve the child's functioning;
    - Parents' response to the help/support offered and/or concerns of professionals.
    - An advocacy report if available
- An explanation of the harm to the child arising from the above.

5.3.6 The referral should be supported by the chronology previously developed by health as part of their comprehensive overview of the case. The chronology may well show previous episodes of reported ill-health of the child with repeated involvement of the medical professional investigating and treating the child but with negative/inconclusive findings. While not evidence of current fabricated illness, it is very important as a past predictor of future repetitions, of which the child's current presentation may be one.

5.3.7 As part of the implementation of this protocol and in support of social care practitioners involved in cases of perplexing presentations or FII, a number of Advanced Practitioners within Children's Services will be provided with training and guidance by the Health Safeguarding Team. The Advanced Practitioners will in turn provide advice and guidance to locality teams to inform assessment, planning and intervention.

6.0 Conclusions

6.1 Fabricated or Induced Illness (FII) is a complex and relatively infrequent child safeguarding issue. Recent research and the revised RCPCH (Feb:2021) and BASW Guidance (2022) suggest that many of the cases of concern notionally emerging as potential FII can be more accurately described as Perplexing Presentations (PP), characterised by discrepancies in the reports/observations of parents and those of professionals. The response of parents to an approach based on rehabilitation and away from further investigations is a further distinguishing feature between FII and PP. All cases of suspected PP/FII shall be reviewed by a consultant paediatrician.

6.2 The aim of this protocol is to ensure agencies and professionals work in an open and transparent way with parents/carers whilst also ensuring that concerns about the safety and welfare of children are responded to in a timely and proportionate manner. Key to this is a graduated, rehabilitative approach that seeks to avoid further medical intervention and/or the commencement of child safeguarding procedures unless shown to be necessary in the best interests of the child or to ensure they are effectively safeguarded. A comprehensive appreciation of the child's health and the nature of parent/carer support or engagement with a rehabilitative approach will be key determinants for the approach taken under this protocol.

6.3 Complex or rare presentations are not easily identifiable, requiring the input of health and social care professionals with expertise in the signs and symptoms being presented. The issue in question must be that just because someone expresses a concern of FII, it does not necessarily mean the social worker immediately initiating a child protection response. FII is extremely rare but research and good practice guidance from both RCPCH and BASW suggest that Perplexing Presentations are more prevalent, requiring a graduated child safeguarding approach engaging with parents and carers who may be highly anxious or suspicious of professionals. This protocol aims to provide a framework for local safeguarding practitioners to follow a graduated approach, taking account of the detailed guidance published by RCPCH and BASW.

Appendix 1: Multi-agency pathway to be followed after identification of alerting signs