Appendix 2

Possible warning signs of fabricated or induced illness

1. The order of numbering in the template does not indicate the relative important of each category.

2. 'Symptoms' are subjective experiences reported by the carer or the patient. 'Signs' are observable events reported by the carer or patient. 'Signs' are observable events reported by the carer or observed or elicited by professionals. Set out below are some examples of behaviour to look out for.

3. Professionals should bear in mind the limits of the template, which is to give an indication of whether fabricated or induced illness is a possibility.

Category	Possible warning signs Please not categories 8 and 10 relate explicitly to parent/carer or siblings of the child concerned
1.	Reported signs and symptoms found on examination are not explained by a medical condition from which the child may be suffering. Here the doctor is attempting to put all the information together to make a diagnosis but the signs and symptoms do not correlate with any recognised disease or where there is a disease known to be present. A very simple example would be a skin rash which did not correlate with any known disease. An experienced doctor must be on their guard if something described is outside their previous experience.
2.	Physical examination and results of medical investigations do not explain reported symptoms and signs. Physical examination and appropriate investigations do not confirm the reported clinical story. For example it is reported a child turns yellow (has jaundice) but no jaundice is confirmed when the child is examined and a test for jaundice, if appropriate, is negative. A child with frequent convulsions every day has no abnormalities on a 24 hours video-telemetry (continuous video and EEG recording) even during a so-called 'convulsion'.
3.	There is an inexplicably poor response to prescribed medication and other treatment for the agreed condition does not produce the expected effect. This can result in escalating drugs with no apparent response, using multiple medications to control a routine problem and multiple changes in medication due to either poor response or frequent reports of side effects. On investigation, toxic drug levels commonly occur but may be interspersed with low drug levels suggesting extremely variable administration of medication fluctuating for over-medication to withdrawal of medications. Another feature may be the welcoming of intrusive investigations and treatments by the parent.

4.	New symptoms are reported on resolution of previous ones. New symptoms often bear no likely relationship to the previous set of symptoms. For example, in a child where the focus has been on diarrhoea and vomiting, when appropriate assessments fail to confirm this, the story changes to one of convulsions. Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.
5.	Reported symptoms and found signs are not seen to begin in the absence of the carer, i.e. the perpetrator is the only witness of the signs and symptoms. For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly realise anxiety of FII where the severity and/or frequency of symptoms reported are such that the lack of independent observation is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. In the case under review there was evidence that the school described episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.
6.	The child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer. The carer limits the child's activities to an unreasonable degree and often either without knowledge of medical professions or against their advice. For example, confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child's school attendance.
7.	Over time the child is repeatedly presented with a range of signs and symptoms. At its most extreme this has been referred to as 'doctor shopping'. The extent and extraordinary nature of the additional consultations is orders of magnitude greater than any concerned parent would explore. Often consultations about the same or different problems are concealed in different medical facilities. Thus the patient might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different medical set of problems (or even the same) without informing these various medical professionals about the other consultations.
8.	History of unexplained illnesses or deaths or multiple surgeries in parent/carer or siblings of the family. The emphasis here is on the unexplained. Illness and deaths in parents or siblings can frequently be a clue to further investigation and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the general practitioner through to the extreme of Munchausen's syndrome where there are multiple presentations with fabricated or induced illness resulting in multiple (unnecessary) operations. Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially

	might have been subject to FII abuse and their medical history should also be examined.
9.	Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above). This is a planned separation of perpetrator and child which it has been agreed will have a high likelihood of proving (or disproving) FII abuse. It can be difficult in practise, and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child's bedside, is unusually close to the medial team and thrives in a hospital environment.
10.	Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported. This is an extension of category 8. On exploring reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They were largely or wholly fictitious.
11.	Incongruity between the seriousness of the story and the actions of the parents. Given a concerning story, parents by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of the FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. This is incongruity between their express concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend crucial assessments (somebody else's birthday, thought the hospital was closed, went to outpatients at one o'clock in the morning, etc). We have used a term 'piloting care', for this behaviour.
12.	Erroneous or misleading information provided by parents. These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc). An extreme example of this is spreading the idea that the child is going to die when in fact no one in the medical profession has ever suggested this. Changing or inconsistent stories should be recognised and challenged.