Pan Cheshire and Merseyside Guideline for Management of Perplexing Presentations and Fabricated or Induced Illness

POLICY INFORMATION SHEET	
Date effective from	September 2021
Policy Owner	All Safeguarding Children Partnerships within Pan Cheshire and Merseyside
Date of Review	April 2028 Due to the complex nature of this guidance, it is important to note that should there be significant changes in national guidance, this document may be reviewed before the agreed due date.
Status • **Mandatory (all staff named must adhere to guidance unless for valid reasons)** • **Optional (Procedures and practice can vary between teams)**	Mandatory
Target Audience	Staff from all partner agencies including Health, Children's Social Care, Police and Education, covered by Cheshire East, Cheshire West & Chester, Warrington, Halton, Liverpool, St. Helens, Knowsley, Sefton, Wirral Safeguarding Children Partnerships
Date of Ratification	April 2025
Related Document (s)	The National Guidance https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/ Some elements of best practice have been sought from other regional FII/PP practice guidance.

CONTENTS

Appendices

Glossary

PP – Perplexing Presentation

FII – Fabricated or Induced Illness

CSC – Children's Social Care

HERP – Health and Education Rehabilitation Plan

CVS – Covert Video Surveillance

LADO – Local Authority Designated Officer

MUS – Medically Unexplained Symptoms

VOC – Voice of the child

MASH – Children's Social care front door E.G; CHECS I-ART

Perplexing Presentations and Fabricated or Induced Illness (FII)

1. Introduction

1.1 **Fabricated or induced illness** is a rare form of child abuse and is a clinical situation where a child is, or is very likely to be, harmed due to parents'/carers' behaviour and action, carried out in order to convince health care professionals that the child's state of physical and/or mental health or neurodevelopment is impaired (or more impaired than is actually the case).

1.2 The term 'Fabricated or Induced Illness by Carers' was first introduced by the Royal College of Paediatrics and Child Health (RCPCH) in 2002.

1.3 As there is on-going debate about terminology, it is prudent to define the terms of Medically Unexplained Symptoms (MUS), Perplexing Presentation (PP) and Fabricated or Induced Illness (FII) for the sake of this policy.

- **Medically Unexplained Symptoms** - the child complains of symptoms or are presumed to be genuinely experienced which are not explained by any known pathology but there are likely underlying (usually psychosocial) factors in the child. This may include observations of symptoms if the child is pre- or non- verbal. The symptoms are likely based on underlying factors in the child (usually of a psychosocial nature) and this is acknowledged by both clinicians and parents. MUS can also be described as 'functional disorders' and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body. The health professionals and parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child or young person.
- **Perplexing Presentations** – the actual state of the child's physical/mental health is not clear yet but there are alerting signs of possible FII. There is no perceived risk of immediate serious risk to the child's physical health or life.
- **Fabricated or Induced Illness** – this is a form of child maltreatment in which a child is, or is very likely to be, harmed due to caregivers' behaviour and actions which are carried out in order to convince health professionals that the child's health is impaired (or more impaired than is actually the case).

1.4 The Royal College of Paediatrics and Child Health guidance states, "There has been a shift towards earlier recognition of possible FII (which may not amount to actual or likely significant harm), and intervention without the need for proof of deliberate deception. Children and Young people with perplexing presentations often have a degree of underlying illness, and exaggeration of symptoms is difficult to prove and even harder for health professionals to manage and treat appropriately. The challenge is to correctly identify any underlying illness present whilst at the same time avoiding unwarranted investigations or interventions driven by exaggerated reporting of symptoms.

1.5 It is worthy of note that:

- MUS, PP or FII may also present in children with disabilities.
- The presence of a proven chronic medical condition does not exclude harm. Proven and unproven medical conditions co-exist in almost half of cases.
- In investigating and managing MUS, PP or FII, one must consider the needs of the child first and foremost. It is also important to consider the wider context including any secondary gains for the carers e.g. to retain or qualify for financial gains such as enhanced benefits etc. However, often, parental behaviour may be motivated by misplaced anxieties and erroneous beliefs based on parents' own experiences of illness and health.
- FII is not a diagnosis of exclusion. It is a clinical diagnosis which must be based on a full consideration of the child's clinical features, including the child's past and present medical history, examination

findings and all test results. As with most diagnosis of abuse, the diagnosis is not based on a single finding or event but often on a series of different events over a period of time.

1.6 When working with children and their families where there are perplexing illnesses or concerns about fabricated or induced illness, professionals should explicitly explore whether the child is currently experiencing, or has previously experienced, **adverse childhood experiences (ACEs)** such as physical, sexual or emotional abuse, neglect, domestic abuse, child sexual or criminal exploitation, bereavement, parental/caregiver alcohol or drug misuse, severe parental mental health issues, or a parent going to prison. Adverse Childhood Experiences such as these can have a detrimental impact on the physical, mental, and emotional wellbeing of a child. Professionals should also be mindful that parents and care givers may themselves have experienced adverse childhood experiences impacting their ability to understand and report effectively the presentation of illness in their child. There is a higher incidence of neurodiversity in parents where perplexing presentation and FII is suspected, understanding of their perception and presentation of perceived illness symptoms may enable better support of the child and family.

1.7 Multi-agency working involving education, social care, and other health services such as adult mental health services and primary care is key in achieving a good outcome. **Please see Appendix (A) Summary Diagram** (adapted from 2021 RCPCH Guidance). This Diagram outlines the pathway to be followed, after identification of alerting signs.

2. Alerting Signs of PP & FII

2.1 Although not exhaustive, below is a list of indicators of PP or possible FII, that could serve as alerting signs for practitioners.

A carer reporting symptoms and signs that are not explained by any known medical condition.
Physical examination and 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 to 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 for medical symptoms that are often vague in nature, frequent unexplained absences from school and particularly from PE lessons, use of seemingly unnecessary special aids or equipment.
The carer seeks multiple opinions inappropriately.
Objective evidence of fabrication – history of events given by different observers may be in conflict or be biologically implausible (e.g. small infants with a history of very large blood losses but do not become anaemic, infants with large negative fluid balance who do not lose weight; Test results such as toxicology studies or blood typing; evidence of fabrication or induction on covert video surveillance (CVS).

The carer expressing concern they are under suspicion for FII, or relatives raising concerns about FII.
Exaggerating symptoms that cannot be verified, necessitating unnecessary investigations that could be invasive and potentially harmful or dangerous to the child.

2.2 Health Professionals involved with the child's parents may at times be alerted to these concerns when they note the child being drawn into the parents' illnesses.

2.3 Non-Health professionals working with the child e.g. teachers, nursery staff, social workers may be alerted to concerns of PP/FII, when they notice a discrepancy between the reported illnesses/behavioural problems by the carer and their own observations of the child.

3. Involvement by the Child

3.1 Some older children may learn to collude with their carer in the management of a non-existent condition, before eventually fabricating illness in themselves or develop a somatisation disorder.

3.2 The child may also be involved in perpetuating the "sick" role, that may vary on a continuum from unawareness through to passive acceptance, active collusion or active self-harm.

3.3 It is important for professionals to speak directly to the child, provided it does not increase the risk of harm to the child, after establishing rapport and gaining their trust. Listening to the voice of the child should help gain valuable insight into their daily lived experience, recognising that children may learn or adopt parental behaviours, actively or passively, that could adversely impact on their overall health and emotional wellbeing.

3.4 It is also important to consider the impact of such behaviour on the siblings and other family members.

4. Managing Concerns of PP or FII

4.1 It is often not clear during initial presentations to a health care setting, whether it is related to PP or FII as there is often insufficient evidence, and the nature and severity of risk to the child may be unclear.

4.2 Should a practitioner have emerging concerns of PP or FII, they should review the case with an experienced colleague / safeguarding lead / manager to identify any current risks that may require urgent attention and to review the potential impact on the child.

4.3 A management plan must be put in place and communicated to professionals involved with the family. Consideration should be given to a referral to the Early Help Hub for targeted services support if appropriate. If concerns of significant harm / risk are identified at any point - refer to Children's Social Care.

4.4 It is important to establish the facts to reduce uncertainty. This could be facilitated by completing a chronology, using the template in **Appendix (E)**, by all lead professionals involved in the care of the child e.g. GP / primary care professional, Consultant Paediatrician, Social Worker, Staff in education etc.

4.5 Where children and families are already open to children's social care and the allocated social worker identifies emerging concerns of PP / FII then the social worker should review the case and seek supervision from a social work team / senior manager. It is also essential that discussions at

this point are held with the relevant health care professionals involved, to gain an understanding if the child / young person has any health needs and secure clarity regarding their presentation. It is a key part of the process to gain an understanding if there are any current risks that may require urgent attention.

4.6 Listed below are general principles for professionals to follow when dealing with cases of PP or FII.

Health professionals should always ensure there is a lead health professional identified, ideally a consultant paediatrician, consultant psychiatrist or experienced general practitioner who is responsible for co-ordinating health investigations and management plans. All cases ought to be discussed with their relevant Named Doctor for Safeguarding Children; Any professional disagreements ought to be escalated to the Designated Doctor for Safeguarding Children.
Maintain focus on safeguarding, promoting the welfare of the child at all times.
Complete a chronology using the standard template **Appendix(E)**, listing the evidence where available. It is best to complete a chronology and start collecting evidence even before referral to Children's Social Care, unless the concerns are urgent or there is already evidence of significant harm. Timescales for chronology review need to be determined by the lead health professional in conjunction with the other practitioners involved.
Cross reference the chronologies for different children in the family as illness behaviour can switch between different children in the family.
List inconsistencies and clarify the same by seeking more information from family members and other professionals involved.
Continue to observe child and family for any emerging patterns.
Keep detailed records and be specific around the evidence base and source of information e.g. Direct observation, Informed opinion, Hearsay etc.
Test alternative explanations by discussing with a senior colleague or expert; complete medical tests and/or social care assessments.
Continuously reassess the situation in the light of any new information.
In many cases, Perplexing Presentations in particular, it is advisable to discuss concerns with the parents/carers at an early stage, after discussion with child safeguarding leads. It is important to agree and document by all agencies, what is or is not appropriate to be discussed with the parents/carers, ensuring every attempt is made to be as open and transparent as possible. It is also important to agree, who is going to lead the discussion with parents and when, dependent on circumstances. In summary, all material information should be shared with the parents and/or those with legal parental responsibility UNLESS there is a reasonable belief that to do so would pose a risk of harm to the child.
It is usually not appropriate to share concerns of true FII with parents during the early stages of investigation if that may increase the risk of harm to the child, but plans need to be agreed between the lead paediatrician, Police if relevant and Children's Social Care regarding the appropriate response to managing concerns in order to protect the child.
Evaluate alternatives; as Sherlock Holmes said, "Exclude the impossible and the solution lies in what remains, however unlikely".

Refer to national and local guidance and seek legal assistance where relevant.

5. Action in cases of suspected PP or FII

5.1 Perplexing Presentation

5.1.1 Cases of suspected PP often present in a chronic or evolving way and may be managed conservatively i.e. within a single agency and without need for a formal referral to Children's Social Care as a child safeguarding issue, at least in the initial instance.

5.1.2 The Named Child Safeguarding Leads in each organisation/agency must be made aware in all cases of suspected PPs and consulted at the earliest opportunity.

5.1.3 If a Paediatrician or CAMHS consultant is not already involved, it may be appropriate to complete a referral to the relevant health professional to explore any underlying medical illness. The paediatrician/CAMHS consultant may need to refer for specialist tests and advice in some cases.

5.1.4 Parents should be kept fully informed of any outcomes of medical assessments and investigation results by the paediatrician as appropriate.

5.1.5 If no underlying cause has been found after careful assessment, observation and investigations, the same should be communicated clearly to the parents/carers and child if old enough, in a non-confrontational manner, that the child does not have any medical condition, and the symptoms are medically unexplained. This can be presented to the family as good news, with reassurance that most children spontaneously improve over time, and that no further investigations or treatment is necessary unless the situation changes. The term Perplexing Presentations and management approach can and should be explained to the parents and the child, if the child is at an appropriate developmental stage. Reflecting with parents about the differing perceptions that they and the health team have of the child's presenting problems and possible harm to the child may be very helpful in some cases, particularly if it is done at an early stage.

5.1.6 A health professionals' meeting may need to be convened along with other agency professionals already involved e.g. Education in a school-aged child, and chaired by the Named lead for Safeguarding Children, ideally the Named Doctor for Safeguarding Children, especially if concerns do not settle with the above approach. The family should be made aware (unless doing so is likely to increase risk of harm to the child) of the usefulness and need to gather information from partner agencies, including Children's Social Care, Education etc, to inform future care and arrange appropriate support for the child and family.

5.1.7 There may need to be one or more professionals' meetings to gather information, and these can be virtual meetings, chaired by the Named Professional for Safeguarding Children, ideally the Named Doctor for Safeguarding Children. If the Named Doctor is directly involved in the care of the child, another clinician experienced in child safeguarding must chair the meeting to maintain objectivity and preserve doctor-patient relationship. Consensus about the child's state of health needs to be reached between all health professionals involved with the child and family, including GPs, Consultants, private doctors, and other significant professionals who have observations about the child, including education and children's social care, if they have already been involved. Where possible, families should be informed about these meetings and the outcome of discussions, if doing so would not place the child at additional risk. Care should be given to ensure that notes from meetings are factual and agreed by all parties present. Notes from meetings may be made available to parents, on a case-by-case basis and are likely to be released to them

anyway, should there be a Subject Access Request for the health records, in a proportionate manner if it does not compromise child's safety.

5.1.8 At the professionals' meeting, consensus needs to be reached about the following issues:

Either

- That all the alerting signs and problems are explained by verified physical and/or psychiatric pathology or neurodevelopmental disorders in the child and there is no FII (false positives).
- Medically Unexplained Symptoms from the child are free from parental suggestion.
- That there are perplexing elements, but the child will not come to harm as a result.

Or

- That any verified diagnoses do not explain all the alerting signs
- Risk of actual or likely harm to the child and/or siblings

And agree all the following.

- Whether further investigations and seeking of further medical opinion as relevant is warranted in the child's interests; If yes, it is important to communicate deliberations of the meeting.
- How the child and the family need to be supported to function better alongside any remaining symptoms, using a **Health and Education Rehabilitation Plan Appendix (I).** Guidance is available in Appendix H.
- If the child does not have a secondary care paediatric Consultant involved in their care, consideration needs to be given to involving local secondary care paediatric services, CAMHS etc. Consideration may also need to be given to involve other services such as adult services for the carers, Early Help etc.
- The health needs of siblings
- Who will meet with the family to outline the outcome of the meeting and convey the Health and Education Rehabilitation Plan and when
- Next steps in the eventuality that parents disengage or request a change of paediatrician in response to the communication meeting with the responsible paediatric consultant, about the consensus reached and the proposed Health and Education Rehabilitation Plan.

5.1.9 If a clear consensus cannot be reached on the child's health needs at the professionals' meeting, the matter would need to be escalated to the Designated Doctor for Safeguarding Children. If there are concerns regarding the way the child is being managed by any health care provider, the matter may need escalation to the relevant Medical Director.

5.1.10 Using a clear **Health and Education Rehabilitation Plan** for the child, drawn up at the professionals' meeting, the family must be helped to think through how their lives would be different if the child is no longer ill, and be helped to construct a credible narrative about the child's recovery. Involvement of local CAMHS services may be helpful. All the above should be clearly documented in the child's records.

5.1.11 Whilst some parents can be appropriately reassured or helped to respond appropriately to the child's actions and behaviours, others hold on to their beliefs, remain anxious and are likely to present repeatedly to health care settings requesting investigations and treatment.

5.1.12 In such cases, a decision must be made whether it is a case of FII or Perplexing Presentation where it is likely to cause harm to the child, that often requires multiagency input and may therefore warrant a referral to Children's Social Care. Detailed Chronologies may need to be compiled. Refer to **Appendix (D)** and **Appendix (E)**. Early professional intervention including

multi-agency input for these families may help prevent further escalation of the illness-seeking behaviour.

5.1.13 Concerns around FII/PP should not be shared with the parent/carer if it is likely to compromise the safety of the child or jeopardise any child protection / criminal investigations. However, particularly in cases of PP in the absence of significant harm, a collaborative approach with parents needs to be adopted and consideration given to involving CSC, to assist and support parents/carers comply with the Health and Education Rehabilitation plan and reduce risk of any future harm.

5.2 Child at risk of significant harm or is suffering harm i.e. Fabricated or Induced Illness or Perplexing Presentations where parents do not support an Education and Health Rehabilitation plan

5.2.1 Refer to Children's Social Care (CSC)/Police immediately, where the child has been significantly harmed or is at risk of significant harm e.g. acute suffocation, poisoning etc. so statutory safeguarding proceedings may be initiated.

5.2.2 Secure any potential evidence e.g. feed bottles, infusion sets, nappies, blood/urine/vomit samples, clothing or bedding if they have suspicious material in them.

5.2.3 Do not share the reason for the referral with the parent/carer if it would compromise the safety of the child.

5.2.4 Referral to CSC can be made by any agency, although it is likely to be made by health professionals given it is extremely unlikely for a health professional not to be involved in cases of FII.

5.2.5 Very urgent protection of the child is best obtained by contacting police who can use their police protection powers, as it may take CSC a few hours to obtain an Emergency Protection Order. However, CSC must be contacted at the same time as the police who may liaise with each other and decide on the best way forward. If the Named Doctor or responsible paediatric consultant are of the opinion that threshold for likely or actual significant harm is possibly met as per criteria under section 47 of Children Act 1989, either as a matter of urgency or in a planned manner, a referral must be made using local pathways.

5.2.6 Once the child's safety has been ensured, steps outlined below from 7.2 onwards must be followed.

6. Case Tracking & Support

6.1 The Named Doctor/Safeguarding Children's Team will maintain a database of cases of PP/FII for their relevant organisation. The Data Base will include basic demographics and a list of services the child is known to, multi-agency support being given, including Education and Children's Social care.

6.2 The Named Doctors/Named GP/Safeguarding Children's Nursing Team will provide support and supervision as relevant to the lead professionals involved with the case. The Named Doctors/Named GP/Named Nurse for Safeguarding children will in turn be supported and supervised by the Designated Doctor for Safeguarding Children.

6.3 The Designated Doctor for Safeguarding Children will offer supervision meetings with case holders (Named Doctor/Named GP / Named nurse for safeguarding children / lead clinician) to discuss cases and provide advice and support on individual case management as required and the data base updated as appropriate.

6.4 Frontline practitioners must ensure senior managers/safeguarding lead professionals within their agency/organisation, as relevant, are consulted at every stage for guidance and support. Senior managers within the police, children's social care and safeguarding leads within education can request additional guidance and support regarding individual complex case management from the designated doctors to support care and safety planning.

6.5 Practitioners can utilise **Appendix (D)** the Clarification of Concerns Document for use in the consideration of possible Perplexing Presentation/Fabricated or Induced Illness cases

6.6 The closure and archiving of a PP / FII case will be agreed within the supervision meeting and evidence to support this decision will be uploaded on to the Data base e.g. copy of or outcome of Case Conference meeting.

7. Role of Children's Social Care

7.1 Risk of harm

7.1.1 In relation to Perplexing Presentations and possible Fabricated Induced Illness, the identification and management of risk is not solely a health agency responsibility. Children's Social care as a key partner undoubtedly have a role and responsibility within the course of this procedure and any subsequent work with the family and child that comes about from initiating this process.

7.1.2 In respect of a child where there are suspicions of FII, this raise concerns not only in relation to medical neglect, but also physical and emotional abuse and thus a referral must be made to Children's Social Care in line with local Safeguarding Children Partnership guidelines. Similarly, if parents do not co-operate with the Health and Education Rehabilitation Plan in cases of Perplexing Presentations, it may also amount to medical neglect, physical abuse or emotional abuse and put the child at risk of harm and would also require a referral to Children's Social Care to safeguard the child.

7.1.3 Should the referral not be accepted for assessment by Children's Social care and the referrer feels that the child will remain at risk of significant harm then it will be the responsibility of the referrer to escalate using the local escalation/resolution policy. In line with the escalation policy, it is also the responsibility of Children's Social Care to respond.

7.1.4 It is worth noting that any agency professional or member of the public may inadvertently refer a child directly to Children's Social Care in keeping with standard pathways of referral for other types of child abuse or because of misinterpretation of this guidance. In such cases, Children's Social Care must liaise with the referrer and relevant health professionals or Named Doctor/GP for Safeguarding in the relevant organisation/area to establish facts, and consensus reached on the next steps of management.

7.2 Acceptance of the referral

7.2.1 Once a referral has been accepted by Children's Social Care, the case will be transferred to the relevant team in Children's Social Care, who will take lead responsibility for further assessment into the risk of significant harm.

7.2.2 Children's Social Care will work in conjunction with the lead paediatrician and relevant health professional and other key agencies, including who will make decisions around if and when to contact the family.

7.2.3 Children's Social Care will request an updated collection of detailed chronologies on the standard template **Appendix (E)** from relevant professionals involved with the child from all

agencies to build a picture of the child's lived experience and gain insight into the child's developmental needs, parenting capacity, family and environmental factors that may be impacting on the parent/carer's behaviour. **All chronologies are to be submitted to Children's Social care within 3 weeks of the request.** The responsibility for completing the chronology rests with individual frontline professionals but Line Managers / Named Child Safeguarding Leads within relevant organisations should provide support and supervision to frontline staff completing chronologies and assist with the analysis of the information within the chronology.

7.3 Multi-agency strategy meeting

7.3.1 On receipt of the completed chronologies, Children's Social Care will convene a multi-agency professionals meeting within 4 weeks of the referral. It is recommended that Children's Social Care announce the date of this meeting as soon as a referral is accepted, to allow for professionals to adjust their diary commitments and enable attendance. This multi-agency professional meeting must be convened and chaired by a suitably qualified senior manager in CSC. This should generally be the Service Manager or above.

Contact details of professionals are not to be shared with the families unless explicit permission has been given for the same by the relevant professional.

7.3.2 The following professionals must be invited to the multi-agency meeting:

- The referrer (if a professional)
- Consultant Paediatrician/lead health professional for the child
- Named Doctor and/or Nurse for Safeguarding Children (acute/community)
- GP / Primary Care Professional
- CAMHS representative (if indicated)
- Health Visitor and/or School Nurse as appropriate
- Community Paediatric staff
- Any private practitioners
- Medical professional with relevant expertise in the relevant illness e.g. tertiary centre specialist
- Designated Doctor for Safeguarding Children (if indicated)
- Designated Nurse for Safeguarding Children (if indicated)
- Named GP for Safeguarding Children (if indicated)
- Children's Social Care representative
- Education / Early Years setting representative
- Police
- Any other relevant professional involved with the family for example Parental Mental Health staff.
- Local Authority Legal adviser

7.3.3 Children's Social care and all professionals in attendance need to consider the issues to be discussed at the meeting. Issues to be addressed at the meeting include **Appendix (F)**

- Whether it is FII or a case of PP likely to cause harm to the child
- Whether a Section 47 enquiry needs to be initiated and if so, how a Children & Families assessment will be undertaken.

- Any further information that may be required about the child and family and how it should be obtained and recorded.
- Confirmation of a lead consultant paediatrician
- What information is to be shared with the family, when and by whom along with what information is going to be shared?
- How to ensure security of child's records to ensure child's welfare
- Whether the child requires a period of admission in hospital for observation
- Whether the child and/or carers require constant observation by staff if child is admitted as an in-patient; if yes, by whom and which agency is responsible for arranging constant observation.
- Any factors, such as the child and family's race, ethnicity, language, cultural background and beliefs which should be considered.
- Needs of any siblings or other children who the perpetrator may come into contact.
- Needs of the parent/carer
- Any Police investigations required including forensic analysis of any samples, Covert Video Surveillance

7.3.4 The outcome of the multi-agency professionals meeting may be one of the following:

- Concerns not substantiated and no evidence of FII / PP.
- Concerns substantiated and decision to progress to Strategy Meeting
- Concerns not sufficiently substantiated and needs ongoing monitoring.

7.3.5 Proceedings of the meeting should be recorded, and the minutes circulated to all relevant professionals. Consideration should be given towards other interventions such as Early Help / Child in Need interventions even if concerns are not sufficiently substantiated. If concerns are substantiated and decision made to proceed to Strategy meeting/Section 47 enquiry, subsequent processes should follow routine child safeguarding procedures as outlined in "Working Together – 2023".

7.3.6 Children's Social Care will support the development of any Health and Education Rehabilitation Plan.

8. Role of Police

8.1 In relation to Perplexing Presentations and possible Fabricated Induced Illness, the identification and management of risk is not solely a health agency responsibility. The police as a key partner undoubtedly have a role and responsibility within the course of this procedure and any subsequent work with the family and child that comes about from initiating this process.

8.2 During the process of information sharing and assessment it may become apparent that there are indicators that a crime has been committed. This should be taken into due consideration during all stages of assessment and interventions, and the police will provide direction regarding professional intervention in order to avoid disrupting any possible criminal investigation/process.

8.3 All relevant information gathered by the Police ought to be shared at multi-agency meeting to help plan how the situation will be managed, unless by doing so it is likely to jeopardise any criminal proceedings.

8.4 If it is decided at a multi-agency strategy meeting to employ Covert Video Surveillance (CVS), it is the responsibility of the Police to lead on this by applying for appropriate approvals under the Regulation of Investigatory Powers Act (RIPA) 2000. The use of CVS is not to be taken lightly and can only be decided at a multi-agency meeting and requires due procedures under the Regulation of Investigatory Powers (RIPA) are to be followed.

8.5 All staff need to be appropriately trained to ensure co-operation with the Police, maintain secrecy where required and ensure the child's safety.

8.6 The primary purpose of CVS is to establish if illness is being induced in the child, and obtaining evidence for criminal prosecutions is secondary.

8.7 In criminal investigations, suspects' rights should be protected by adherence to Police and Criminal Evidence Act 1984.

9. Role of Professionals in General Practice and Primary Care

9.1 When a safeguarding concern arises for a child involving possible fabricated or induced illness (FII) / perplexing presentation (PP), the GP and other professionals working in primary care have an important role to play in safety planning and clinical management.

9.2 The GPs / primary care professionals' involvement and contribution to the management of PP/ FII concerns is essential to ensure that all key information regarding the child is shared. GPs / primary care professionals will also be aware about parental health issues – including both physical and mental health – and these should be taken into consideration as part of any assessment and information sharing.

9.3 If a primary care professional is the first person to raise a concern about possible PP/FII, they should review the case with an experienced colleague /their safeguarding lead / manager. Consideration should be given to understanding the impact on child, the child's immediate needs, and any current risks requiring urgent attention.

9.4 If there are concerns about the welfare of a child and FII is a consideration, the child's needs are paramount, and the GP / primary care professional has a duty to share any relevant and proportionate information that may impact on the welfare of a child. This includes sharing relevant information about parents and carers as well as the child.

9.5 GPs / primary care professionals are well placed to recognise early symptoms and signs of PP/FII in a child, and as the primary record keeper of all health records, can play a key role in recognising patterns of worrying behaviour from multiple presentations at different settings.

9.6 If there are concerns about PP/FII and the child is not known to a Consultant they should be referred to a Paediatrician, Consultant Child Psychiatrist or Consultant Clinical Psychologist (dependent upon the presenting issues) with expertise in symptoms and signs that are being presented. The GP / primary care professionals should make it clear about their concerns re possible PP/ FII in the referral letter and what has been discussed with the parents. If the family decline the referral, consultation with the Named Doctor will advise on next steps (usually to proceed to professionals' meeting and / or to refer to Children's Social Care).

9.7 Timeliness of the referral will depend on presentation. For example, if there are signs or symptoms of induced illness such as suffocation or poisoning then same day referral is needed with a concurrent urgent referral to Children's Social Care (CSC).

ALL CODING/CORRESPONDENCE ABOUT POSSIBLE FII SHOULD BE HIDDEN FROM ONLINE ACCESS TO RECORDS AS PARENTAL AWARENESS OF THE CONCERN MAY ESCALATE THE RISK TO THE CHILD.

9.8 GPs / primary care professionals should also discuss concerns with the Named GPs for Safeguarding, Named Nurse for Safeguarding children in the community/acute services or Designated Health Professionals for Safeguarding Children, as applicable.

9.9 If a professionals' meeting is to be held, the GP / primary care professional will be invited and should attend whenever possible. It is advisable for the GP / primary care professionals to discuss the case with the practice safeguarding lead to determine who is best placed to attend and to consider relevant primary care information prior to attendance. Depending on the nature of the

concerns and risks, the parents may or may not be aware of the plan for a professionals meeting hence it is important that the GP / primary care professional does not inform the parents without prior agreement with the meeting chair. The outcome and minutes of the meeting will be shared with the GP / primary care professional.

9.10 It is essential that GPs / primary care professionals are kept fully informed and involved in the management of children with perplexing presentations or where there are concerns about FII so they can support children and their families as appropriate as well as work in partnership with other professionals involved to ensure the best outcomes for children.

9.11 When a GP / primary care professional is made aware of concerns of possible PP/FII, the safeguarding lead of the practice should be informed. An internal flag on the clinical system should be placed on the record of the child and, as for all child protection concerns, this should be linked to other household family members. Codes to be considered are 'child is cause for SG concern' with free text note if possible 'PP/FII' pending the outcome of the safeguarding investigation.

Code – Child is cause for safeguarding concern – 836881000000105
Code - Child in family is safeguarding concern – 1064961000000107

9.12 Where FII concerns are substantiated, the outcome of a professionals meeting includes the production of a HERP (Health and Education Rehabilitation Plan). This is a coordinated multi-disciplinary / multi-agency plan to achieve the wellbeing of the child, detailing actions needed with intended outcomes and identified timescales. Typically, it will include specific plans to address each individual health concern (e.g. stopping unnecessary medication, phased withdrawal of wheelchair use) and for reintegrating into fulltime education. The professionals meeting will have identified a key professional who will hold responsibility for co-ordinating and monitoring the plan. The GP's / primary care professionals' role in the individual elements of the plan should be explicitly agreed. The HERP should be clearly documented in the patients record with relevant SNOMED coding applied to the index child and all household members.

9.13 The GP / primary care professional may be well-placed to contribute to decision making about supporting the psychological needs of the adult whose behaviour is the source of concern. If needed, the GP / primary care professional will facilitate referral of the parent to adult mental health services.

9.14 All children who have required a Health and Education Rehabilitation Plan, unless there is a permanent positive change in the primary caregiver, will require long-term follow up by a professional at the closure of the plan.

9.15 A recognised pattern in PP/FII is that after a period of reduced activity in the concerning behaviour of the adult can reappear in relation to the index child and / or other siblings. It is advisable for the patient record to have SNOMED codes linking to index child applied long term to enable early recognition of and response should further concerning behaviours arise.

10. Role of Early Years and Education Settings:

10.1 Initial alerting signs can be identified within Early Years and Education settings

10.2 As professionals working with children and young people daily, education staff are in a prime position to identify inconsistencies in what they are being told about the child's needs versus how the child is presenting. Education settings are well-placed to notice prolonged or frequent absence. Parents or carers involved in fabricated illness may seek support or attention from their child's educational setting. Be aware of the following signs:

- The child has limited/interrupted attendance and education.

- The child's normal daily life activities are limited by the parent (not allowed to join in with physical education (PE) for example
- The child assumes a sick role (such as the unnecessary use of aids such as wheelchairs)
- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.
- There is an inexplicably poor response to prescribed medication and other treatment.
- New symptoms are reported after resolution of previous ones.

10.3 Where initial concerns arise directly from school as opposed to health, it is recommended that school explain to the parents that information is required from relevant health professionals to understand the concerns. Those relevant health professionals would be the health professionals that provide a universal health service such as a School Nurse or a GP or HV in an Early Years setting. Relevant health professionals should be contacted to confirm the reported condition/conditions/symptoms. This information can support the development of a Health and Education Rehabilitation Plan (HERP). The parent may share the name of the specialist health professional such as the Continence Nurse, NDNT (Neuro Development Nursing Team), Community Paediatrician, GP / primary care professional, Diabetic Specialist Nurse etc.

10.4 Actions for Education when perplexing presentations arise – Please see education pathway **Appendix (C)**

Teacher to discuss with parent/parents/carer – asking 'how best to support your child in education'. Include VOC. Seek consent to obtain health information from relevant health professional/professionals such GP and/or specialist.
If consent is provided, obtain details of who to contact and education staff to contact relevant health professionals
Once condition/conditions are confirmed, complete a HERP with parents/carers and the child/young person reflecting on the child's needs and how support can be provided whilst in education. Consider whether any additional training is required for relevant staff.
Discuss referral to early help if indicated with parents/carer, and child/young person. Seek consent and complete referral if agreed. Include VOC
If there are any discrepancies in health information compared to the parents/carers/child's account, seek advice from the Designated Safeguarding Teacher/SCIE Lead and discuss with parents, and seek consent to have a meeting with a health professional, parents and teacher. Include VOC.

10.5 If consent is not provided.

Education staff to seek advice from Designated Safeguarding Teacher/SCIE lead. Completion of chronologies may be required.
Designated Safeguarding Teacher/SCIE lead to seek advice from the 0-19 school nursing service. The school nurse may require advice from their safeguarding children's team. Next steps for Education will be advised. This may be a referral to Children's Social Care.

If at any stage Education staff feel the child is at immediate risk of significant harm, then local safeguarding policy and procedures should be initiated.

11. Pre-Birth Planning

11.1 If there is history of FII perpetrated by a pregnant woman in another child/sibling, before or during pregnancy, referral to CSC is needed, to consider the safety of the unborn child after delivery. This may require a strategy meeting and pre-birth child protection conference if Section 47 Enquiry reveals the child is likely to be at risk of harm following birth. If it is the first pregnancy and there are alerting signs of FII/PP, standard procedures outlined above should be followed.

11.2 All relevant professionals should be made aware of the concerns and assessments/monitoring should continue postnatally.

12. Allegations against staff

12.1 Children may sometimes be abused by staff who work with them in a variety of settings. If there are concerns around FII ascribed to any member of staff, the above procedure should be followed, and a referral made to the LADO (Local Authority Designated Officer).

13. Understanding complaints in the context of PP/FII investigations

13.1 Employing organisations, and their legal departments, should provide appropriate support for their staff working in this field of safeguarding. This includes providing appropriate time and resources for professionals to fulfil their duties in what are often particularly resource-intensive, professionally, emotionally challenging cases.

13.2 Complaints departments will benefit from knowledge about the complex dynamics involved between parents and professionals in these types of cases. They should be aware that repeated and escalating complaints by parents about professionals can be part of the pattern of harmful adult behaviour seen in FII and may of itself be a safeguarding concern. Investigations into complaints and support to parents should take this into account and the need for staff to be supported by their employing organisation to discharge their safeguarding responsibilities understood.

13.3 If complaints are made to an NHS Trust/organisation in a case where there are safeguarding concerns regarding PP or FII, the response should be advised by the Named Doctor and Named Nurse for the organisation. If complaints are made to Children's Services or the Safeguarding Partnership, the response should be advised by the Service Lead and Assistant Director for the Locality.

13.4 It is recommended that employing organisations, in meeting their safeguarding children's duties and their duty of care to their staff, should be aware that provision of occupational health / counselling support may be required by staff managing cases of FII / PP. This is particularly important when an individual's professional integrity is challenged, and their reputation and / or personal safety are threatened.

14. Conflict

14.1 Given the uncertainties associated with FII and Perplexing Presentations, there is an increased likelihood of professional disagreements and conflicts. Normal local escalation procedures ought to be followed in such circumstances.

14.2 There is also an increased possibility of complaints by Parents/Carers against professionals involved. This should not however detract from maintaining the focus on the child. Staff need to be appropriately supported to deal with any complaints by their managers and child safeguarding teams.

15. Record keeping and information sharing

15.1 The ownership for documents submitted by staff to any multi-agency meetings rests with the individual staff member and their relevant employing authority.

15.2 Parents may apply for access to documents including chronology, analysis reports, minutes of meetings etc. through normal channels. In such cases, standard procedures for sharing of documents with parents/carers apply.

15.3 The employing authority must consult with the author of the document first, prior to sharing any document with parents/carers, to decide if it requires redaction prior to sharing, in case any information shared may increase the risk of harm to the child.

15.4 It is advisable to consult with the relevant agency/organisations' legal team prior to sharing any information with parents/carers. The rights of the potential victim i.e. the child to be treated humanely must be balanced against the rights of the potential perpetrator(s) to be made aware of the investigations being pursued, recognising that ultimately safeguarding the child is paramount. A decision on when to share the information, what information is to be shared and by whom, has to be made as quickly as possible at a multi-agency forum.

15.5 Information held by any partner agency that was originally submitted by another agency, may not be shared with parents/carers by the partner agency, without explicit consent of the agency that provided the information in the first place.

15.6 It is generally advisable, especially in cases of FII, to set up relevant child safeguarding alerts in the child's records within all agencies including primary, secondary and tertiary care providers in Health. It is important for the alert to be comprehensive in describing the action required. It is essential that the alerts are reviewed and updated accordingly and closed when no further action is to be taken. It is also important to share concerns with child safeguarding leads in neighbouring secondary/tertiary health care providers, so appropriate alerts could be set up in the relevant hospitals' patient record systems, in case parents/carers go doctor shopping. This is to forewarn health colleagues in these hospitals, so any concern reported by parents/carers is treated with "respectful scepticism" to avoid unnecessary escalation of medical investigations/treatment in the child. In these situations, it is equally important to communicate any true illnesses in the child too, so health professionals in other provider centres do not mistakenly ignore genuine symptoms as FII, that may result in harm to the child.

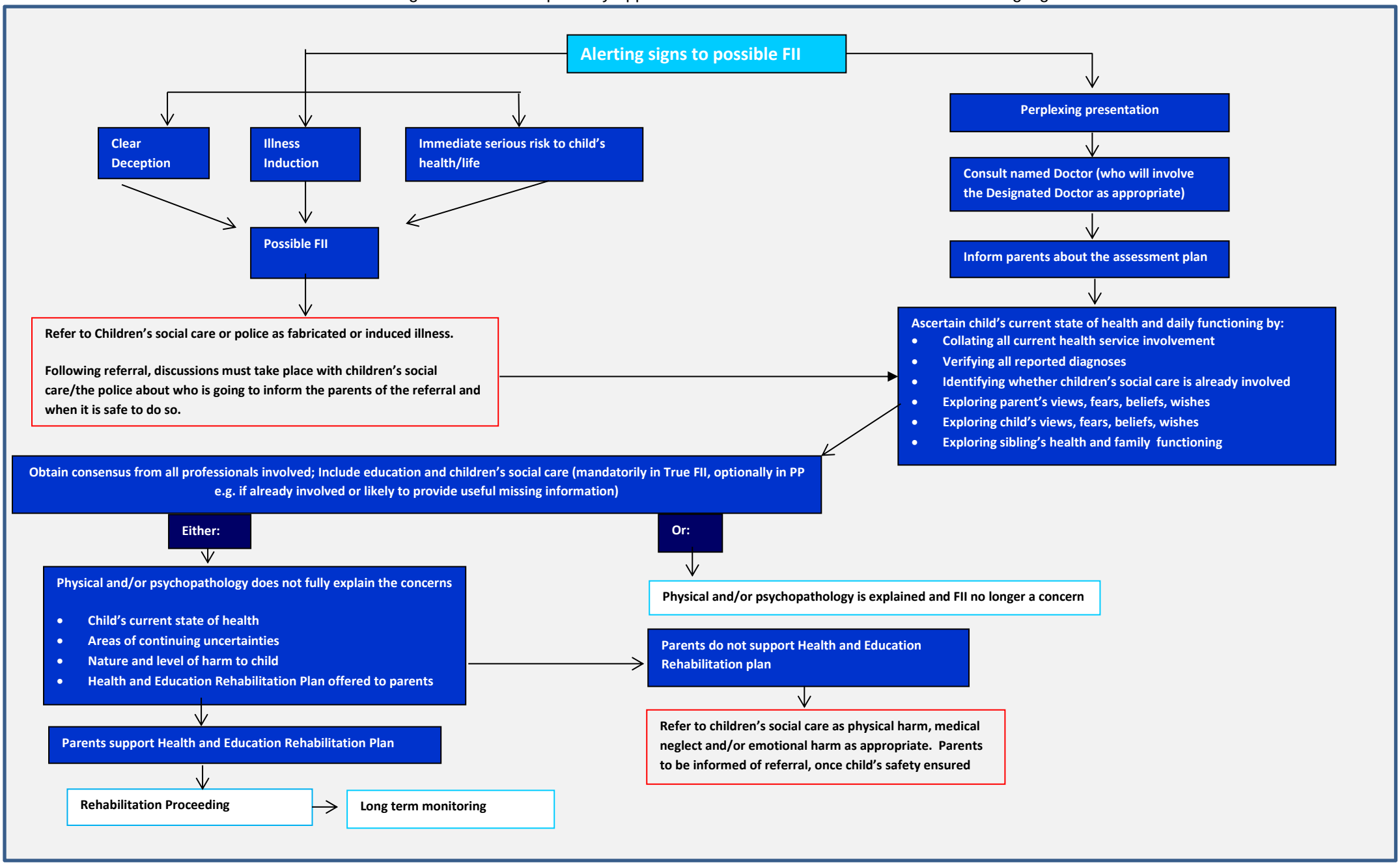
16. References

1. Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH Guidance 2021
2. Child protection Companion 2013 – Royal College of Paediatrics and Child Health.
3. Working Together Working Together to Safeguard Children 2023 - A guide to multi-agency working to help, protect and promote the welfare of children. HM Government

Appendix (A)

Summary Diagram *(adapted from 2021 RCPCH Guidance)* `

This Diagram outlines the pathway approach to be followed after identification of alerting signs.



Appendix (B) Perplexing Presentations Pathway

Concerns identified — *Practitioner*

to review the case with experienced colleague / safeguarding lead /manager to identify any current risks that may require urgent attention and to review the potential impact on the child. Ensure management plan in place, communicate plan to professionals involved with the family. Consider referral to the Early Help Hub for targeted services support if appropriate. If concerns of significant harm / risk are identified at any point - refer to CSC.

No concerns for PP / FII

Ensure clear and open collaboration with family. Continue to support with Early Help, Specialist Case Planning, MDT, TAF meetings as needed. Update GP. Continue to document progress against previous PP/FII concerns. Rediscuss if further concerns arise

Concerns for possible PP / FII

Discuss with safeguarding team and the child's lead consultant (if involved). Collate and analyse concerns including the pattern of behaviour with the child and previous siblings, impact on child, current functioning.
Identify all professionals involved with child and parents education, Mental health, SALT, YOT etc. Inform child's GP.

Identify a Lead Paediatrician / CAMHS Consultant. If the child is not under the care of a consultant consider a referral to a General Paediatrician and consider the development of a support / monitoring plan if deemed appropriate.
If the family decline – consider a professionals meeting.

Lead Paediatrician / Consultant to review the health information to formulate a full health history including an interpretation of illness behaviour. The review and assessment of the child must be considered.
Lead Paediatrician to obtain a parent / carers health history – discussion to be held with the GP.

Consultation with child and parents:
Detailed conversation with parents. Clear management plan agreed. Plan made to explain to child.
Written summary of conversation sent to parents and copied to professionals

Discuss with Named Doctor:
- Agree and document management plan
- Detail and requests any further medical opinion(s) / investigations to clarify/exclude organic component to symptoms
- Consider whether Professionals' Meeting is required
- Consider whether single agency (health) management remains appropriate / referral to Children's Services, Adult Social Care, Early Help

Decision made to hold Professionals meeting (PM):
Discuss with Children's Services (CSC) - If already involved with family multi – agency management likely & agree whether SW to attend PM
Inform parents of meeting and make arrangements for feedback. If parents do not consent*, PM can proceed if proportionate and in child's best interests; consider threshold for CP referral to CSC

Professionals Meeting convened. Meeting chaired by Named Doctor / delegated consultant
Outcomes:
- If SW not at PM, discuss with Children's Services if indicated
- Create Health and Education Rehabilitation Plan (HERP)
- Lead Consultant / Paediatrician to liaise with the GP regarding the whole family management. Consider CAMHS review for the child and a psychological / psychiatry review for parent/s /carers.
- Agree indications for escalation

Parents and Child comply with the rehabilitation plan: Continue to support. Review and document progress against previous PP/FII concerns. At the point the HERP closes, a consultant led decision to agreed regarding the most appropriate health professional to maintain long term oversight. Closure plan to be communicated to all professionals involved and the GP.

Parent does not engage with the HERP or further escalation of concerning FII behaviours

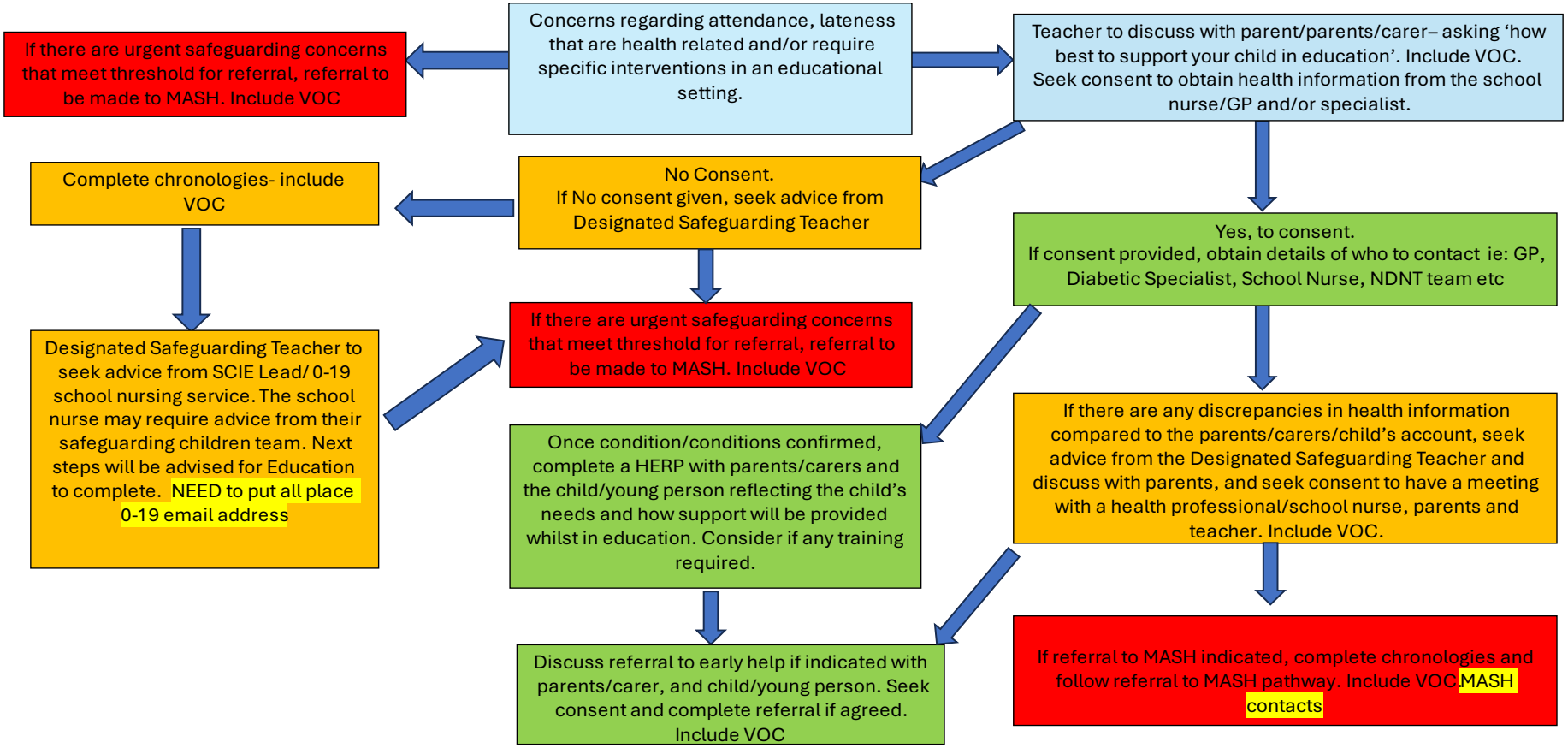
-If CSC already involved – escalate to the relevant Social Worker / Team Manager. If CSC not involved – refer to CSC for a joint children's and adult assessment.
-Consider informing parents that the referral is being made – UNLESS concerns that informing parents will heighten risk to the child (ren) and / or the adult.
-Convene Strategy Meeting to consider joint children's and adult assessment for Neglect / Emotional Abuse.

Where cases are not progressed or accepted follow local escalation procedures and / or the SCP Escalation guidance for further direction.

Appendix (C) Education Pathway

Emerging Concerns of Potential Perplexing Presentation (PP) /Fabricated or Induced Illness (FII) Aid memoir for Education

Please do not record FII/PP on the child's records as only a Doctor can make this diagnosis



Appendix (D) Clarification of Concerns Document for use in the consideration of possible Perplexing Presentation / Fabricated or Induced Illness

Pages 1 and 2 to be completed by the practitioner / caseload holder/ SW/ other professional with the initial concern about the child

Child's name	**Address**
Date of Birth	**School**
NHS number / Liquid Logic Number	**GP / primary care professional**

Who has initially raised the concern about this child and shared this with you?

(Yourself / Allied Health Professional / Nursery / GP / School / Social Worker)

Please provide a <u>summary</u> as to why are you concerned about possible PP or FII.

What are you worried about? Briefly list your worries and the timescale. This will inform what action is needed next.	**What is working well?**

Current health professionals involved with this child?

Health Professional	**Community / Hospital Based / Organisation**	**Contact Details – Name / Email / Contact number**
Physiotherapist	e.g. Specialist school	

Health visitor / School nurse		
Consultant Paediatrician	Hospital	
GP / primary care professional		
Other Doctor		
Speech and Language Therapist		
CAMHS		
Specialist Nursing team		
Health visitor / School nurse		

Health Practitioner/ Other professional summary:

To be completed by the professional highlighting the initial concern to demonstrate the indicators of FII / PP. Tick all applicable indicators and include supportive evidence.

Indicators	**Tick**
The carer seeking multiple opinions inappropriately	
A carer reporting to professionals that a diagnosis has been made by another professional when this is not true and giving conflicting information to different professionals.	
Missed appointments especially if the appointments are not leading in the desired direction for the carer	
The child's daily life and activities being 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 unnecessary special aids	
Acute symptoms that are exclusively observed by /in the presence of the carer	
Physical examination and results of investigations that do not explain symptoms or signs reported by the carer	
The child having an inexplicably poor response to prescribed medication. Or other treatment, or intolerance of treatment	
A carer reporting symptom and observed signs that are not explained by any known condition	
On resolution of the child's presenting problems, the carer reporting new symptoms in different children in sequence	
Objective evidence of fabrication - for example, the history of events given by different observers appearing to be in conflict or being biologically implausible (large blood loss in small infants who do not become anaemic); or test results such as toxicology or blood typing: evidence of fabrication	
The carer expressing concern that they are under suspicion of FII, or relatives raising concerns about FII	

What do you think needs to happen?

Name	
Role	
Date / Time	

Safeguarding Team or Named Safeguarding Professional Review / Advice.

Summary of the information provided decisions about the next steps including the timescale for the chronology and the rationale for this.	
Health Practitioner / professional details	
Date	
Time	

Chronology Any support required in the completion of the Impact Chronology?

Include a summary regarding the planned scope for a chronology and over what time frame.		
Identify a professional to lead with the completion of a chronology.	Name:	Role:
Manager / Service lead review and authorization:	Name:	Date:
Chronology Completion	Name:	Date:

Supervision oversight plan:

Supervision date / time	**Supervising SG professional**	**Plan:**

Appendix (E) Chronology Professional Opinion *(Please summarise key points and offer your professional opinion here with the rationale for the same; Non medics to ensure any opinions expressed are consulted with their relevant child safeguarding lead professional)*

Name of Child **DOB** **Child's Address** **Author of Chronology** **Job Title and Contact Details** **Agency** **Date Of Completion**							
Date & Time	**Age of Child**	**Source of Information** *(GP Records / Hospital Records / Education / Nursery / Hearsay / Direct Observation / Informed Opinion etc.)*	**Details of Event / Episode** *(Presenting history; Witnessed events by staff of carer's interactions; Specify if it was Hearsay, Direct observation, or Informed opinion;)*	**Relationship of person accompanying the child**	**Category**	**Outcome** *(What was the diagnosis; Investigations undertaken; Was diagnosis based on reported history or on objective signs and/or investigation results; Treatment given; Duration of stay if admitted etc.)*	**Comments / Analysis** *(Impact on the child of any interventions undertaken, particularly if it was based on reported history without any objective signs. i.e. any potential for Iatrogenic Harm etc.* ***Please ensure any analysis included has been consulted with the relevant child safeguarding lead within your organisation****)*

Appendix F Professionals Meeting Guidance Template

The professionals' meeting should be structured and minutes taken. Structure agenda example:

	Agenda	**Note**
1	Confidentiality statement	
2	Introductions. *Names, designations and contact details should be provided by all attendees*	
3	Summary of concerns leading to the suspicion of possible FII	
4	Clinical health summary	
5	Hear from each professional in attendance detail of their service's involvement with the family (index child, siblings and parents).	
6	Consideration of each of the symptoms / signs and presentations: ***See Appendix (H) for guidance on descriptors and warning signs of FII***	
6a	Identify medically confirmed problems / areas of consensus	
6b	Identify areas of uncertainty	
6c	Identify features concerning for FII: Consider: -misrepresentation -misleading professionals -falsification -exaggeration -abnormal response to medical illness -anxiety -trauma / family experience	

7	Clarify areas of agreement, areas of disagreement and actions required to address these. Consider MSP Escalation guidance if needed	
8	Consider the voice of the child and the child's lived experience.	
9	Impact analysis What is the impact on the child from each of the concerning behaviours? Consider school attendance, mobility, isolation, anxiety, illness behaviour, invasive procedures, unnecessary medication, hospitalization, outpatient attendance What is the overall impact on the child / Children and functioning of the family?	
10	Reach and document an analysis of PP / FII concerns and risk assessment	
11	Consider whether safeguarding referral to Children's Social Care (CSC) is needed. Consider the cumulative information for all family members and whether the overall impact on the family's functioning is such that there is a risk of significant harm	

12	Draft a Health and Education Rehabilitation Plan	
13	If single agency management is to continue, agree and document indications for escalation to safeguarding referral to CSC	
14	Arrange review meeting with family to finalize HERP	
15	Agree time interval to next meeting, whether any indication for further professionals' only meeting	
16	Minutes to be circulated to all those invited to attend. Agree circulation date and contact point for attendees if minutes not received	

In the rare circumstance that a significant difference of opinion between agencies about safeguarding planning for the child cannot be resolved within a multi-agency professionals meeting, consideration should be given to the local SCP escalation policy.

Appendix (G) Warning Signs of FII

Category	Warning signs of Fabricated or Induced Illness
1.	Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.
2.	Physical examination and results of medical investigations do not explain reported symptoms and signs.
3.	There is an inexplicably poor response to prescribed medication and other treatment.
4.	New symptoms are reported on resolution of previous ones.
5.	Reported symptoms and signs are not seen to begin in the absence of the carer.
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.
7.	Over time the child is repeatedly presented with a range of signs and symptoms.
8.	History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.
9.	Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5, above).
10.	Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.
11.	Incongruity between the seriousness of the story and the actions of the parents.
12.	Erroneous or misleading information provided by parent.
0	No concerns about a contact.

(The order of numbering does not indicate the relative importance of each category)

Appendix (G) Warning Signs of FII continued

(The order of numbering does not indicate the relative importance of each category)

Category	Warning signs of Fabricated or Induced Illness
1.	**Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.** Here the doctor is attempting to put all of the information together to make a diagnosis, but the symptoms and signs 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 skin disease and had, in fact, been produced by the perpetrator. An experienced doctor should be on their guard if something described is outside their previous experience, i.e. the symptoms and signs do not correlate with any recognisable disease or with a disease known to be present.
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-hour 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.** The practitioner should be alerted when 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 from over- medication to withdrawal of medication. 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 raise anxiety of FII where the severity and/or frequency of symptoms reported is 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 professionals 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 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 surgery in parents 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 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 practice, and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child's bedside, is unusually close to the medical 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 FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is incongruity between their expressed 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 for 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 parent.** 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.
0	This is included to encourage a thorough review of contacts into concerning and non-concerning ones to give a balanced view.

APPENDIX (H) Guidance for creating a Health and Education Rehabilitation Plan

NB: All children who have required a Health and Education Rehabilitation Plan, unless there is a permanent positive change in primary caregivers, will require long term follow up by a professional at the closure of the plan.

In this document the term parent is used to refer to the caregiver(s) whose behaviour is the cause for safeguarding concern.

A. Timescales and intended outcomes should be specified and should be proportionate to risk assessment

B. Ensure there is a clear management plan for both the child and the parent

- Specific medical considerations may include:
    - Reducing/stopping unnecessary medication (e.g., analgesics, continuous antibiotics)
    - Resuming oral feeding
    - Offering graded physical mobilization

- Confirm who will be the responsible paediatric consultant (most likely to be a secondary care paediatrician).
- Consider any actions needed for siblings / other vulnerable connected people.
- Identify what support the family require to help them to work alongside professionals to implement the HERP. e.g. Early Help, family network.
- Consider if referral to children's social care is needed and document reasons.
- Consider if referral to adult social care for parent is needed and document reasons.
- Agree role of GP / primary care professional in supporting the management and care of the patient and the parent.
- The plan should be clearly documented in the patient record with relevant SNOMED codes applied to the index child and all household members.
- Consider whether referral by the GP to adult mental health services is needed for the parent whose behaviour is the cause for safeguarding

concern. This is in order for both the parent and professionals to better understand the nature of the caregiver's actions, motivations, any mental health diagnoses, likely capacity for change, indication for treatment to effect change and who is likely to provide treatment.

- Detail in the plan how the child and the parent will be psychologically supported. This is multifaceted and may or may not involve CAMHS, depending on local referral criteria. Psychological support should aim to:
    - Help the child to adjust to a better state of health, e.g. by using coping strategies for symptoms with a cognitive behavioural approach. The child might also need support for the loss of gains associated with being a sick child
    - Help the child and the family, including the siblings, to construct an account which explains the evolution of the child's difficulties as well as the improvement in the child. This needs to be truthful and may be distressing to the child who will need support.
    - Explore the parent's motivations, including anxiety, compassion, beliefs, fulfilment of needs, and the implications and likely changes for the parent when the child's state of health is improved, and the child is functioning optimally. This will require helping the parent to adjust to having a well or better child.

C. <u>Agreement needs to be reached by the family and the professionals involved about who will review the plan and when:</u>

- Agree the lead professional who will hold responsibility for coordinating and monitoring the HERP
- For a child already on a Child in Need or a Child Protection Plan, the social worker will lead the coordination in conjunction with identified key contact from health, education and any other involved agencies
- Apply safeguards against disguised compliance e.g. check prescription frequency, attendance at appointments
- Agree how the plan will be conveyed to the child. Ensure parents are aware of

plan for conveying this information to the child. Seek agreement from parents about positive reinforcement to the child about the agreed plan

- Agree identification of and escalation plan for non-engagement / disguised compliance / failure to improve despite achieving outcomes
- Agree review dates for the Health and Education Rehabilitation Plan.

Appendix (I) Health & Education Rehabilitation Plan (HERP)

Date plan activated:

Date plan closed:

Point	Descriptor	Plan		
1	Agree Lead Professional who will hold responsibility for coordinating and monitoring the HERP	Name Email Contact Number		
2	Identify professionals from health, education and any other involved agencies	Name Email Contact Number Name Email Contact Number Name Email Contact Number		
3	Confirm Lead Consultant	Name Email Contact Number		
Point	**Descriptor**	**Plan**	**Outcome**	**Additional Narrative**
4	Consider if referral to children's social care is needed; document reasons as to if or if not			
5	Consider any actions needed for siblings / other vulnerable connected people			
6	Agree role of GP / primary care professionals in supporting management and care of child, young person and adults along with lines of communication			
7	Professionals to ensure relevant Read codes applied to the index child and all household members			
8	Consider any health/support needs of the parent/carer, including consideration for adult mental health, neurodiversity, Learning Disabilities and additional factors such as Adverse Childhood Experiences (ACES)			

9	Identify support the family require to help them to work alongside professionals to implement the Plan e.g. Early Help, psychological support, family network.			
10	Agree how the plan will be conveyed to the child and by which professional. Ensure parents are aware of plan for conveying to the child. Seek agreement from parents about positive reinforcement to the child about the agreed plan.			
11	Agree review dates for the Health and Education Rehabilitation Planning. Agree responsibility for convening review meetings and business administration support for notes and actions			
12	Agree attendees for the HERP review meetings. The health lead professional should attend the review HERP / Core group meetings and scheduling of meetings should take their availability in to account. If the health lead is not able to attend, they should identify a suitable deputy to attend on their behalf			
13	Where possible each child to be seen by the same health professional within any health provider organisation to improve continuity and reduce the opportunity for parental versions of symptoms and diagnoses leading to unnecessary health interventions.			
14	Determine which professionals should meet with parents to explain the plan.			
15	Should practitioners become concerned in respect of immediate harm of PP/FII to the children, they need to initiate their agency safeguarding policy and procedures prior to contacting the lead professional identified in point 1 of this plan.			

16	Contingencies are in place should parents disengage with this plan.			
Using the specific plan elements, populate as many specific elements of the HERP as needed e.g. • Reducing/stopping unnecessary medication • Resuming oral feeding • Offering graded physical mobilisation • school attendance and reintegration schedule				
1	Specific Plan Element			
2	Specific Plan Element			
3	Specific Plan Element			
4	Specific Plan Element			
5	Specific Plan Element			
Closure Plan				
Date	**Detail**	**Monitored by**	**Ongoing professional involvement**	**Shared with whom**
	• Review and amend alerts • Contact details of professionals involved • Health review arrangements to be agreed			