Fabricated & Induced Illness and Perplexing Presentations Guidance 2022

Practical guidance to support safeguarding children who present with Perplexing Presentations (PP) and Fabricated & Induced Illness (FII)

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2. Introduction

2.1 This new guidance replaces the guidance published in 2009 and updated in 2016. It offers guidance for Safeguarding Children who present with Perplexing Presentations (PP) and FII and offers practical advice for paediatricians on

- When and how to recognise
- How to assess risk
- How to manage the presentation in order to obtain better outcomes for children

2.2 Earlier recognition of the presentation of FII has led to uncertainty about whether there is risk of significant harm to the child and this guidance offers a collaborative approach with families and children and clear definitions of PP and/or FII and how they differ from MUC (medically unexplained symptoms).

2.3 There is new emphasis on working collectively with other health professionals however the paramount consideration for a paediatrician should be the impact of the situation on the child.

3. Essential Principles

3.1 Please note that throughout this guidance we have chosen to use the term parents, an inclusive term for all primary caregivers with or without parental responsibility.

- Updated definitions of medically unexplained symptoms (MUS), Perplexing Presentations (PP) and a wider view of fabricated or induced illness (FII).
- The importance of the functional implications of diagnoses rather than the mere fact of the diagnoses.
- The essence of FII is the parents' focus on engaging and convincing doctors about the parents' erroneous view of the child's state of health.
- Parental behaviour may or may not include deception.
- Parental behaviour may be motivated by anxiety and erroneous belief about the child's state of health and/or by gain for the parent/s. Alerting signs for possible FII must be considered and investigated appropriately. FII should not be a diagnosis of exclusion but should be considered with the same rigor as organic disease.
- Unless illness induction or deception are found, establishing FII depends initially on clarifying the actual state of health of the child and then gauging parental actions and response in the light of these findings.
- There is often a need to observe independently what is reported.
- The focus must be on the harm to child rather than the perceived severity or type of parental motivations, actions and behaviours.
- Unless there is significant risk of immediate, serious harm to the child's health or life, the need for sharing information between different professionals involved in the child's life should be discussed with the child/young person and their parents. This should be done in a non- confrontational manner, by discussion of the perplexing nature of

some aspects of the child's presentation, and explanation of the usefulness of gathering information to inform care.

- A Health and Education Rehabilitation Plan agreed by professionals and families is an essential feature of management in all cases of FII, whether or not children's social care are involved.
- Paediatricians must reflect on their duties to practise evidence-based medicine, whilst retaining professional curiosity and setting appropriate boundaries in their practice.
- An empathetic, considered but boundaried approach is required. Honest communication of professional concerns is important unless this might place the child at risk of serious harm.
- Responsibility for the initial management, including collating of current health involvement, is with the responsible consultant. This is the consultant paediatrician who has the main responsibility for the child's care. If this is in dispute, the Named Doctor will liaise with the Consultants involved to decide who the responsible consultant is to enable them to lead on the child safeguarding issues.
- The responsible consultant should seek advice and support from senior colleagues and tertiary specialists when appropriate.
- In the unusual circumstance that there is no consultant paediatrician or child psychiatrist involved, then we encourage both education and/or primary care to refer to a consultant paediatrician or child psychiatrist who will then become the responsible consultant.

Named and Designated Professionals are responsible for supporting the responsible consultant and the clinical team, for oversight of the safeguarding aspects of the child's care and for achieving a health consensus.

4. Terminology and Definitions

Term	Definition	Synonyms
Medically Unexplained Symptoms (MUS)	The child's symptoms, of which the child complains and 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 acknowledge this to be the case. The health professionals 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 are abnormal bodily sensations which cause pain and disability by affecting the normal functioning 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 harm 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 parent(s') behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health or neurodevelopment 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)

5. Features of PP and FII

5.1 Parent/Caregiver motivation and behaviour

5.1.1 Clinical experience and research indicate that the mother is nearly always involved or is the instigator of FII. The involvement of fathers is variable – they may be unaware, suspicious but side-lined or may be actively involved. Rarely, fathers are solely involved. They may be actively supported by grandparents and an intergenerational pattern. Rarely, foster carers have been known to be involved in FII but there is currently no data on same sex parental couples.

5.1.2 FII is based on the parent's underlying need for their child to be recognised and treated as ill or more unwell/more disabled than the child actually is. FII may involve physical, and/or psychological health, neurodevelopmental disorders and cognitive disabilities. There are two possible motivations underpinning the parent's need: the parent experiencing a gain and their erroneous beliefs. A parent themselves may not be conscious of the motivation behind their behaviour. Both motivations may be present although usually one predominates.

5.1.3 It is important to stress that understanding the parents' motivation is not essential to the paediatric diagnosis of PP/FII in the child. The paediatrician is not expected to understand parental motivation, but simply to understand the cause of the child's presenting illness.

5.1.4 In FII, parents' needs are primarily fulfilled by the involvement of doctors and other health professionals. The parent's actions and behaviours are intended to convince health professionals about the child's state of health. The parent is not usually ill-intentioned towards their child. Nonetheless, they may cause their child direct harm, unintentionally or in order to have their assertions reinforced and believed. Parents engage health professionals, in the following ways:

- The most common form is by presenting and erroneously reporting the child's symptoms, history, results of investigations, medical opinions, interventions and diagnoses. There may be exaggeration, distortion, misconstruing of innocent phenomena in the child, or invention and deception. The parents may not be actually intending to deceive, such as when they hold incorrect beliefs and are over-anxious, to the child's detriment.

5.1.5 It is important not to confuse the reporting of situation-specific difficulties with FII, providing the parent accepts that difficulties which only occur in their presence and which are not reported elsewhere (e.g., at school) are unlikely to be indicators of a problem in the child but, rather, reflect a difficulty in the way in which the parent engages with the child.

- A less common way of engaging health professionals is by the parent's physical actions which nearly always include an element of deception. They range from falsifying documents, through interfering with investigations and specimens such as putting sugar or blood in the child's urine specimen, interfering with lines and drainage bags, withholding food or medication from the child and, at the extreme end, illness induction in the child. All of these are carried out in order to convince health professionals, especially paediatricians, about the child's poor state of health or illness.

5.1.6 Support groups and social media provide an important source of support for parents and families. Paediatricians and parents should, however, be aware that some support groups also exist for a number of conditions about which there is divided medical opinion. Furthermore, some social media / support groups may post inaccurate information, discuss diagnoses and how to obtain them, which can lead to harm.

5.1.7 Parental mental ill-health is not a prerequisite for FII, but if present it may help to explain the motivations and behaviours of some of the parents as well as indicating prognosis for change. Personality disorders are most likely to be found in parents who derive a clear gain from having their child regarded as ill/more ill. Anxiety disorders may lead the parent to have unfounded anxieties about their child's health, to an extent which is harmful to the child. Rarely a psychotic illness or autism spectrum disorder (ASD) in the parent may underpin fixed beliefs about the child's ill-health.

5.2 Doctors' Involvement

5.2.1 Most of what doctors do in the management of children, including where the presentation is not understood, is regarded as good medical practice. It consists of:

- Taking a history
- Examining the child
- Ordering investigations to ascertain the correct diagnosis/es
- Supporting and/or not disputing the need for
  - Limited school attendance
  - Use of aids e.g., wheelchairs
  - Financial and other support for care of the sick child
- Accepting the parent as the conduit of information between professionals
- Initiating or agreeing to further referrals, medications and other treatments.

5.2.2 In children with unrecognised FII, some of these actions may contribute to iatrogenic harm.

5.2.3 The practice of repeating previous, no longer relevant, or not independently substantiated problems/diagnoses in medical correspondence and documents, perpetuates an erroneous view of the child's state of health.

5.2.4 In children with FII, iatrogenic harm is caused by the doctor's need and wish to trust and work with parents, which is fundamental to most elements of paediatric practice. Even in cases where FII might be suspected, there is still a tendency to believe parents, to avoid complaints, and sometimes uncertainty about how to proceed in what are usually complex cases. The child often has an existing medical diagnosis which will make assessment more difficult. The parent's accounts may therefore be true, partially true, or mixed with other accounts that are fabricated or misconstrued. All doctors need to be thorough in appraising parental requests for further opinions and repeat investigations, and parental failures to bring children to appointments.

5.3 Harm to the child

5.3.1 Harm to the child takes several forms. Some of these are caused directly by the parent, intentionally or unintentionally; others are brought about by the doctor's actions, the harm being caused inadvertently. FII is not a category of maltreatment in itself, harm may be expressed as emotional abuse, medical or other neglect, or physical abuse. There is also often a confirmed co-existing physical or mental health condition. When it is felt that a child is at risk of significant harm and a referral to Children's Social care is required it is necessary to ensure that the harm or potential harm to the child is clearly indicated within the referral.

5.4 Severity

5.4.1 Severity of FII can be considered in two ways: a) severity of the parent's actions, b) severity of the harm to the child.

a) Severity of the parent's actions

5.4.2 This can be placed on a continuum of increasing severity which ranges from anxiety and belief-related erroneous reports to deception by fabricating false reports, to interfering with samples through to illness induction. However, there is no evidence about the likelihood or factors associated with a parent moving from one point on this continuum to another.

b) Severity of harm to the child

5.4.3 The different aspects of harm to the child may coexist. Severity of the harm to the child needs to be assessed according to both the intensity of each aspect of the harm, and by the cumulative effect of all the aspects.

5.4.4 It is important to focus on the harmful effects on the child, rather than gauge severity by what the parent is saying or doing. However, if there are clear deceptive parental actions or illness induction, it is likely that the harm to the child will be more severe.

5.4.5 Child's health and experience of healthcare

- The child undergoes repeated (unnecessary) medical appointments, examinations, investigations, procedures & treatments, which are often experienced by the child as physically and psychologically uncomfortable or distressing

- Genuine illness may be overlooked by doctors due to repeated presentations
- Illness may be induced by the parent (e.g., poisoning, suffocation, withholding food or medication) potentially or actually threatening the child's health or life.

5.4.6 Effects on child's development and daily life

- The child has limited / interrupted school attendance and education
- The child's normal daily life activities are limited
- The child assumes a sick role (e.g., with the use of unnecessary aids, such as wheelchairs)
- The child is socially isolated.

5.4.7 Child's psychological and health-related wellbeing

- The child may be confused or very anxious about their state of health
- The child may develop a false self-view of being sick and vulnerable and adolescents may actively embrace this view and then may become the main driver of erroneous beliefs about their own sickness. Increasingly young people caught up in sickness roles are themselves obtaining information from social media and from their own peer group which encourage each other to remain 'ill'
- There may be active collusion with the parent's illness deception
- The child may be silently trapped in falsification of illness
- The child may later develop one of a number of psychiatric disorders and psychosocial difficulties.

5.5 Siblings

5.5.1 In some families, only one child is subject to FII or has a PP and this child may initially have had a genuine illness which began the relationship between the parent and health professionals. In other families, several children may be affected by FII or have a PP simultaneously or sequentially. Siblings who are not subject to FII or have a PP may become very concerned and distressed by the apparent ill-health of their affected sibling or may feel and be neglected.

5.6 Other victims

5.6.1 There have been reports of FII perpetrators also abusing spouses or animals. There may need to be consideration of referral to Adult Safeguarding or the RSPCA.

5.7 Adverse Childhood Experiences

5.7.1 Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

5.7.2 Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with:

- substance use problems
- mental health problems
- instability due to parental separation or household members being in jail or prison

5.7.3 ACEs can have lasting, negative effects on health, well-being, as well as life opportunities such as education and job potential. These experiences can increase the risks of injury, sexually transmitted infections, maternal and child health problems (including teen pregnancy, pregnancy complications, and foetal death), involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide.

5.7.4 ACEs and associated social determinants of health, such as living in under-resourced or racially segregated neighbourhoods, frequently moving, and experiencing food insecurity, can cause toxic stress (extended or prolonged stress). Toxic stress from ACEs can change brain development and affect such things as attention, decision-making, learning, and response to stress.

5.7.5 Children growing up with toxic stress may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, jobs, and depression throughout life. These effects can also be passed on to their own children. Some children may face further exposure to toxic stress from historical and ongoing traumas due to systemic racism or the impacts of poverty resulting from limited educational and economic opportunities.

5.7.6 In summary ACEs are linked to chronic health problems, mental illness, and substance use problems in adulthood. ACEs can also negatively impact education, job opportunities, and earning potential. It is however important to note that exposure to ACE's are an indicator of possible negative outcomes, and not a prediction and preventative strategies can build resilience.

5.8 A Trauma-informed Approach

5.8.1 A trauma-informed approach promotes understanding and care and shifts the focus from "What's wrong with you?" to "What happened to you?" It acknowledges the importance of having a complete picture of somebody's life situation – past and present. Adopting trauma-informed practices can potentially improve engagement, promote treatment adherence and health outcomes. A Trauma-informed care seeks to:

- Realise the widespread impact of trauma and understand paths for recovery;
- Recognise the signs and symptoms of trauma in patients, families, and staff;
- Integrate knowledge about trauma into policies, procedures, and practices; and
- Actively avoid re-traumatisation.

5.8.2 A trauma-informed approach can be implemented in any type of service setting or organisation and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing. It is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with this definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration.

6. PP and FII Alerting Signs

6.1 Altering Signs

6.1.1 Alerting signs are not evidence of FII. However, they are indicators of possible FII if associated with possible harm to the child, they amount to general safeguarding concerns. Some alerting signs are initially recognised by community or primary health care professionals such as health visitors, GPs or community paediatricians, or by professionals in pre-school/early years, schools and other educational settings. Others are first noted by hospital-based paediatricians or in Child and Adolescent Mental Health Services (CAMHS). 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 parent's behaviour. A single alerting sign by itself is unlikely to indicate possible fabrication. Paediatricians must look at the overall picture which includes the number and severity of alerting signs.

6.2 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 balance, large blood loss without drop in haemoglobin
- Unexplained impairment of child's daily life, including school attendance, aids, social isolation.

6.3 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.

6.4 Response to alerting signs

6.4.1 If one alerting sign is present, it is essential to look for others. Alerting signs should be discussed with the Named Doctor, Named Nurse or health safeguarding team. Alerting signs by themselves do not amount to fabrication but mandate further investigation to ascertain whether the child has an underlying illness. While it may transpire later that the alerting signs were not indicative of FII, it is imperative that their presence is acted upon. If alerting signs are found in primary care or by education or allied health professionals in the community, it is appropriate that a paediatrician/CAMHS professional becomes involved as the resolution lies in ascertaining the actual state of the child's health. One of two courses of action need to be followed depending on whether there is or is not an immediate serious risk to the child's health/life.

6.5 Immediate serious risk to child's health / life

6.5.1 The most important question to be considered is whether the child may be at immediate risk of serious harm, particularly by illness induction. This is 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. In this situation, the following are important considerations:

- An urgent referral must be made to children's social care as a case of likely significant harm due to suspected or actual FII, and this should lead to a strategy discussion that includes health representatives supported by their named or designated doctor. The safety of siblings also needs to be considered.
- Securing any potential evidence (e.g., feed bottles or giving sets, nappies, blood/urine/ vomit samples, clothing or bedding if they have suspicious material on them).
- Documenting concerns in the child's health records (e.g., 'this unusual constellation of symptoms, reported but not independently observed, is worrying to the extent that, in

my opinion, there is potential for serious harm to the child'). This is important in case the child is seen by other clinicians who are not aware of the concerns.

- Considering whether the child is in need of immediate protection and measures taken to reduce immediate risk.
- In very rare cases, covert video surveillance may be used as part of multi-agency decision-making and is led by the police.

6.5.2 All practitioners should be mindful of situations where to inform the parents of the referral would place a child at increased risk of harm. In this situation, carers would not be informed of the referral before a multiagency discussion has taken place. This would usually be in the form of a formal strategy discussion.

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

6.6.1 The term Perplexing Presentations (PP) denotes the presence of alerting signs to possible FII, in the absence of the likelihood of immediate serious risk to the child's physical health or life. Perplexing Presentations nevertheless indicate possible harm to the child which can only be resolved by establishing the actual state of health of the child. They therefore call for a carefully planned response. This will be led by the responsible clinician with advice from the Named Doctor for the organisation by which the clinicians are employed. The essence of the response is to establish the current state of health and functioning of the child and resolve the unexplained and potentially harmful situation for the child. 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.

6.6.2 If the initial concerns arise directly from school as opposed to health, it is recommended that school explain to the parents that information is required from health to understand the concerns e.g., poor school attendance. It is then appropriate for either the parents or education to contact health (either GP, consultant paediatrician or child psychiatrist) with their query about the actual health of the child. If the parents do not agree to a health assessment and the sharing of information about the child, we recommend that schools will then need to decide what action they should take following their national safeguarding guidance. At this stage, professionals should refrain from using FII terminology, as the state of the child's health has not yet been assessed. If primary healthcare is the only contact for the child, then they may wish to refer to a paediatrician for further assessment of the child's health. If the response from health is felt to be inadequate, education can contact either the Named GP or Named Doctor for Safeguarding Children for the Hospital or community trust as appropriate, for advice. If concerns arise within General Practice, we recommend that there should be consultation with the Named GP for Safeguarding Children in the first instance. At any stage during this process, should new information come to light to suggest that the child is currently suffering from significant harm, referral to children's social care and/or the police must be made, alongside the process outlined in this guidance. The urgency with which this is done and whether or not parents are informed about the referral before a professional multiagency discussion will vary according to the circumstances of each case.

7. Response to Perplexing Presentations

7.1.1 This is a complex and time-consuming process, led by the Responsible Paediatric or CAMH Consultant with advice from the Named Doctor and the health safeguarding team (who do not have clinical responsibility for the child) – all should be supported and have protected time to provide the necessary focus. Responding to PP requires a multidisciplinary approach, although it is imperative that the responsible consultant continues to have overall clinical responsibility for the child and that the background safeguarding processes are supported by the Named Doctor and the health safeguarding team. If the responsible consultant is also the Named Doctor, then support and consultation could be sought from the Designated Doctor.

7.1.2 The essence of management is establishing, as quickly as possible, the child's actual current state of physical and psychological health and functioning, and the family context. The responsible paediatric consultant will need to explain to the parents and the child (if old enough) the current uncertainty regarding the child's state of health, the proposed assessment process and the fact that it will include obtaining information about the child from other caregivers, health providers, education and social care, as well as likely professional's meetings. Wherever possible this should be done collaboratively with the parents. If they do not give agree for this to happen, the parents' concerns about this process should be explored and can often be dispelled. However, under the NHS' interpretation of General Data Protection Regulations (GDPR) for the UK information sharing can take place without consent if: there are safeguarding concerns, it is in the best interests of the child, is necessary and proportionate and is done in a manner according to the regulations. Strong parental objections could indicate a referral to children's social care on the grounds of medical neglect - that the doctors are unable to establish the state of health and medical needs of the child.

7.1.3 When paediatricians become concerned about a perplexing presentation, an opinion from an experienced colleague or a tertiary specialist may be necessary. Parents themselves may request another opinion and it is their right to do. However, this opinion giver should be supplied with all the background information to help in informing the opinion and to avoid the repetition of investigations unnecessarily. The seeking of multiple alternative opinions, particularly when there has already been a reasonable diagnostic formulation, is almost always harmful to the child and may well increase concern about FII.

7.1.4 There may need to be one or more professionals' meetings to gather information, these can be virtual meetings. Where possible, families should be informed about these meetings and the outcome of discussions as long as 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.

8. The Child's Health & Wellbeing

8.1 The responsible paediatric consultant should:

- Collate all current medical/health involvement in the child's investigations and treatment, including from GPs, other Consultants, and private doctors, with a request for clarification of what has been reported and what observed. (This is not usually a request for a full chronology, which would need to include all past details of health involvement and which is often not relevant at this point).
- Ascertain who has given reported diagnoses and the basis on which they have been made, whether based on parental reports or on professional observations and investigations.
- Consider inpatient admission for direct observations of the child, including where relevant the child's input and output (fluids, urine, stool, stoma fluid as applicable), observation chart recordings, feeding, administration of medication, mobility, pain level, sleep. If discrepant reports continue, this will require constant nurse observations. Overt video recording may be indicated for observation of seizures and is already in widespread use in tertiary neurology practice to assess seizures (which must be consented to by parents).
- Consider whether further definitive investigations or referrals for specialist opinions are warranted or required.
- Obtain information about the child's current functioning, including school attendance, attainments, emotional and behavioural state, peer relationships, mobility, and any use of aids. It is appropriate to explain to the parents the need for this. If the child is being home schooled and there is therefore no independent information about important aspects of the child's daily functioning, it may be necessary to find an alternative setting for the child to be observed (e.g., hospital admission).

8.2 Parents' views

The responsible paediatric consultant should:

- Obtain history and observations from all caregivers, including mothers and fathers; and others if acting as significant caregivers.
- If a significant antenatal, perinatal or postnatal history regarding the child is given, verify this from the relevant clinician.
- Explore the parents' views, including their explanations, fears and hopes for their child's health difficulties.
- Explore family functioning including effects of the child's difficulties on the family (e.g., difficulties in parents continuing in paid employment).
- Explore sources of support which the parent is receiving and using, including social media and support groups.

- Ascertain whether there has been, or is currently, involvement of early help services or children's social care. If so, these professionals need to be involved in discussion about emerging health concerns.
- Ascertain siblings' health and wellbeing.
- Explore a need for early help and support and refer to children's social care on a Child in Need basis, where appropriate depending on the nature and type of concerns, with agreement from parents.

8.3 Child's view

The responsible paediatric consultant should:

- Explore the child's views with the child alone (if of an appropriate developmental level and age) to ascertain:
    - the child's own view of their symptoms;
    - the child's beliefs about the nature of their illness;
    - worries and anxieties;
    - mood;
    - wishes.
- Observe any contrasts in verbal and non-verbal communication from the child during individual consultations with the child and during consultations when the parent is present.

It is important to note that some children's and adolescent's views may be influenced by and mirror the caregiver's views. The fact that the child is dependent on the parent may lead them to feel loyalty to their parents and they may feel unable to express their own views independently, especially if differing from the parents.

The RCPCH have developed resources, with input from children and young people, to aid their communication with health professionals. The 'Being Me' resources help children and young people to share who they are, how they are feeling and what support they would like. The materials include feelings poster, children's health and wellbeing passport and top tips for doctors. These tools are especially effective for children and young people that do not feel comfortable to freely share their experiences, as described by this young person:

Download RCPCH 'Being Me' resources:

https://www.rcpch.ac.uk/resources/being-me-supporting-children-young-people-care

Access 'Me first' resources:

https://www.mefirst.org.uk/

The responsible paediatric consultant should provide signposting advice for children, young people and their parents on where appropriate to access more information or support.

9. Reaching a consensus

9.1 Reaching a consensus formulation about the child's current health, needs, and potential or actual harm to the child

9.1.1 The aim of the full medical and psychosocial review is to gain clarity about any verified illnesses, and any remaining Perplexing Presentations. Binary thinking about difficulties, regarding them as either physical or psychological is unhelpful, as both will be relevant.

9.1.2 As is often the case, several doctors and other health professionals will have been involved in diagnoses and treatment.

9.1.3 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. A multi-professional meeting is required in order to reach consensus. This professionals meeting should be chaired by the Named Doctor (or a clinician experienced in safeguarding with no direct patient involvement) to ensure a degree of objectivity and to preserve the direct doctor-family relationship with the responsible clinician. Parents should be informed about the meeting and receive the consensus conclusions with an opportunity to discuss them and contribute to the proposed future plans (see below).

9.1.4 The decision that has to be made is whether, on the one hand, the perplexing presentation can be explained by either a verified condition/s or by medically unexplained symptoms emanating from the child or, on the other hand, whether there is concern that the child is coming to harm either by fabrication of symptoms by the parents and/or there by their fixed erroneous beliefs about the child's health.

9.1.5 In order to resolve these concerns, a decision needs to be made about whether the perplexing presentation is explained and resolved by a verified medical condition in the child, or whether concerns remain.

9.1.6 In order to resolve this, a consensus needs to be reached in a meeting between all professionals 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 free from parental suggestion
- That there are perplexing elements but the child will not come to harm as a result.

Or

And agree all of the following

- Whether further investigations and seeking of further medical opinions is warranted in the child's interests

- How the child and the family need to be supported to function better alongside any remaining symptoms, using a Health and Education Rehabilitation Plan (see below for details)
- If the child does not have a secondary care paediatric Consultant involved in their care, consideration needs to be given to involving local services (for tertiary services)
- The health needs of siblings
- 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.

9.1.7 Significant disagreements between health professionals about any important aspects of the diagnosis and medical management of the child, will need to be resolved. In such cases, the Named or Designated Doctor for Safeguarding Children should convene and chair a Health Professionals Meeting to agree on the medical issues. The Designated Doctor can only perform this role if they have never been clinically involved with the case. A Designated Doctor from a neighbouring area will chair such a meeting in the eventuality that this is required. There must be a clear escalation policy to the Medical Director where there are significant concerns about how a case is being managed within any healthcare organisation. Clear record keeping of meetings, discussions and decisions is vital and is further discussed in Section 8.

10. Communication to Parents and Child

10.1.1 Once health consensus has been achieved, a meeting should be held with the parents, the responsible paediatric consultant and a colleague (never a single professional). The meeting will explain to the parents that a diagnosis may or may not have implications for the child's functioning, and that genuine symptoms may have no diagnosis. It is preferable to acknowledge the child's symptoms rather than use descriptive 'diagnoses'. It is often useful to use the term 'issues/concerns' in clinical letters rather than 'diagnoses' in these circumstances.

10.1.2 The current consensus opinion is offered to the parents with the acknowledgment that this may well differ or depart from what they have previously been told and may diverge from their views and beliefs. A plan is then made with the parents about what to explain to the child and what rehabilitation is to be offered and how this will be delivered. This plan should be negotiated with the parents and child if of sufficient maturity, as engagement in such a plan is necessary for it to work. The plan should be explained to younger children even if they are not sufficiently mature to be involved in the plan's construction. It is premature, and important not to discharge the child from paediatric care even if there is no current verified illness to explain all the alerting signs, until it is clear that rehabilitation is proceeding.

10.1.3 The RCPCH have developed guidance for paediatricians and health professionals on how best to achieve consensus with parents, particularly on the prevention, recognition and management of conflict in paediatric practice, some of the principles are applicable to general routine care.

11. Whether to refer to children's social care at this point

11.1.1 If there is actual or likely harm to the child or siblings, the implication is that the child has been subject to FII. The question of future harm to the child hinges on whether the parents recognise the harm and are able to change their beliefs and actions in such a way as to reduce or remove the harm to the child. In order for this to be tested the consensus medical view about the child's actual state of health and the consequences needs to be discussed with the parents and the child in terms of likely reduced medical intervention, the child's improved daily functioning and a revised view of the child's state of health. This requires the co-construction of a Health, Education and Rehabilitation Plan with the parents and child and implementation of this plan (see details below). However, the question arises as to whether in addition to this, there needs to be a referral to children's social care at this point.

11.1.2 Working Together (2018) guidance for England states variously:

- 'Anyone who has concerns about a child's welfare should make a referral to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so.'
- 'If a practitioner has concerns about a child's welfare and considers that they may be a child in need or that the child has suffered or is likely to suffer significant harm, then they should share the information with local authority children's social care and/or the police.'
- 'Where a child's need is relatively low level, individual services and universal services may be able to take swift action. Where there are more complex needs, help may be provided under section 17 of the Children Act 1989 (children in need). Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989.'
- In some situations, the severity of the harm to the child therefore mandates immediate referral to children's social care due to the level of harm that has been, or is likely to be, caused to the child. However, outside the court arena, there is no absolute clarity about when harm reaches the threshold of significance. Arguably, in some cases, if parents and child (if of an appropriate developmental level) are able to understand the need for and are able to agree a Health and Education Rehabilitation Plan, immediate referral to children's social care may not be necessary as long as the plan is being monitored carefully, proceeding satisfactorily and agreed goals are being reached. The decision whether to refer to children's social care at this point in the process lies ultimately with local health professionals working within their multi-agency procedures. If a referral is made, the reasons for this referral will need to be discussed with the family beforehand and, from a health point of view, the Health and Education Rehabilitation Plan will need to continue wherever possible regardless of referral.
- Professionals in health should be aware that they do not always have all the pieces of the safeguarding jigsaw puzzle. When a decision is being made about whether to refer children to children's social care, professionals should consider whether they have all

the information from other agencies which is required to inform their risk assessment about levels of harm. If there is concern that they do not have this information particularly when parents decline to give consent for information sharing, a referral to children's social care may be necessary because of professional inability to assess the level of harm without the intervention of children's social care.

12. Liaising with General Practitioners (GPs)

12.1 GPs hold lifelong relationships with patients. They may have extensive knowledge and relationships with multiple generations of families. It is essential that GPs 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.

13. Health and Education Rehabilitation Plan

13.1.1 This plan should be developed and implemented, whatever the status of children's social care involvement is.

13.1.2 Development of the Health and Education Rehabilitation Plan requires a coordinated multidisciplinary approach and negotiation with parents and children and usually will involve their attendance as appropriate at the relevant meetings. The Plan is led by one agency (usually health) but will also involve education and possibly children's social care. It should also be shared with an identified GP. The Plan must specify timescales and intended outcomes. There needs to be agreement about who in the professional network will hold responsibility for coordinating and monitoring the Plan, and who will be the responsible paediatric consultant (most likely to be a secondary care paediatrician). It is important that the Trust employing the professional with this responsibility provide the clinician with adequate resources for this task to be fulfilled. Consideration needs to be given to what support the family require to help them to work alongside professionals to implement the Plan. This may include psychological support and / or referral to children's social care for additional support.

13.1.3 The Plan requires health to rationalise and coordinate further medical care and may include:

- Reducing/stopping unnecessary medication (e.g., analgesics, continuous antibiotics)
- Resuming oral feeding
- Offering graded physical mobilisation.

13.1.4 There should be a discussion with the patient's registered GP regarding what role they may be able to take in supporting the management and care of the patient.

13.1.5 Optimal education needs to be re-established (when the child is of school age), with appropriate support for the child and family.

13.1.6 An example Health and Education Rehabilitation Plan template has been provided in Appendix 1.

13.2 Psychological work

13.2.1 The Health and Education Rehabilitation Plan should detail how the child and caregivers will be psychologically supported. This is multifaceted and requires a coordinated child and family mental health approach, which may or may not involve CAMHS, depending on local referral criteria.

13.2.2 Psychological support should aim to:

- Help the child to adjust to a better state of health, 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
- Consider the need for referral of the parent by the GP to adult mental health services. This is in order for both the parent and professionals to better understand the nature of the parent's actions, any mental health diagnoses, motivations, prognosis and likely capacity to change, indication of treatment to effect change and who is likely to provide treatment.

13.3 Regular review of Plan

13.3.1 The Health and Education Rehabilitation Plan needs to be reviewed regularly with the family according to the timescales for achieving the specified outcomes, especially regarding the child's daily functioning. This should continue until the aims have been fulfilled and the child has been restored to optimal health and functioning and the previous alerting signs are no longer of concern. Agreement needs to be reached by the professionals involved and the family about who will review the plan and when. It is essential to identify a lead professional to coordinate care and organise regular review of the plan. This may be the previous responsible consultant paediatrician or another more appropriate health professional as decided by the multi-disciplinary team. Appropriate health professionals to lead on the plan will vary on a case by case basis and could include:

- Consultant Hospital Paediatrician
- Consultant Community Paediatrician
- Consultant Child and Adolescent Psychiatrist

13.3.2 If the child has either a Child in Need or a Child Protection Plan it may be appropriate for a social worker to take the lead in coordination in conjunction with health and education teams, as the aims of the Health and Education Rehabilitation Plan would form part of that plan. It is important to guard against what might be seen as disguised compliance by the parents.

13.3.3 An important aspect of the fulfilment of the Health and Education Rehabilitation Plan is the parent's ability to now hold a realistic view of the child's health and health-related needs and to be seen to have to communicated this to the child.

13.4 Long term follow-up

13.4.1 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. Depending on individual circumstances it is advisable to continue to be alert to possible recurrence of concerns either in the child(ren) or their siblings. Education and primary health are the appropriate professionals to monitor the children's progress and to identify re-emerging or new concerns.

14. When the Rehabilitation Plan isn't working

14.1.1 If the parents disagree with the consensus feedback, an effective Health and Education Rehabilitation Plan cannot be negotiated, or it becomes apparent that there is lack of engagement with the agreed Plan, it is necessary to refer the child to children's social care. This is on the basis that the child's functioning and/or development is being avoidably impaired by the parents' behaviour and any harm caused has now become significant. Parental disagreement may take the following forms: active dispute, requesting additional unwarranted investigations, seeking further inappropriate medical opinion(s), continuing to seek unnecessary or alternative further diagnoses, declining the Plan, and / or the rehabilitation process fails to proceed (e.g., if the plan requires to attend school and they are no longer doing so).

14.1.2 The referral to children's social care should be discussed with parents and the reasons for professional concern explained. The emphasis should be on the nature of the harm to the child including physical harm, emotional harm, medical or other neglect and avoidable impairment of the child's health or development.

14.1.3 In order to help to ensure that the referral is acted upon appropriately it should describe the concerns, define the harm and provide evidence of inability of the health professionals to manage the situation on a voluntary basis. The referral should include all of the following, using plain language:

- A clear explanation of any verified diagnoses with a clear description of the functional implications of the diagnosis(es) for the child
- Details of the nature of the concerns
- Description of independent observations of the child's actual functioning, medical investigations, detailing all medical services involved and the consensus medical and professional view about the child's state of health
- Information given to the parents and child about diagnoses and implications

- Description of the help offered to the child and the family to improve the child's functioning (e.g., the Health and Education Rehabilitation Plan)
- The parents' response
- Full description of the harm to the child, and possibly to the siblings, in terms of physical and emotional abuse, medical, physical and emotional neglect.

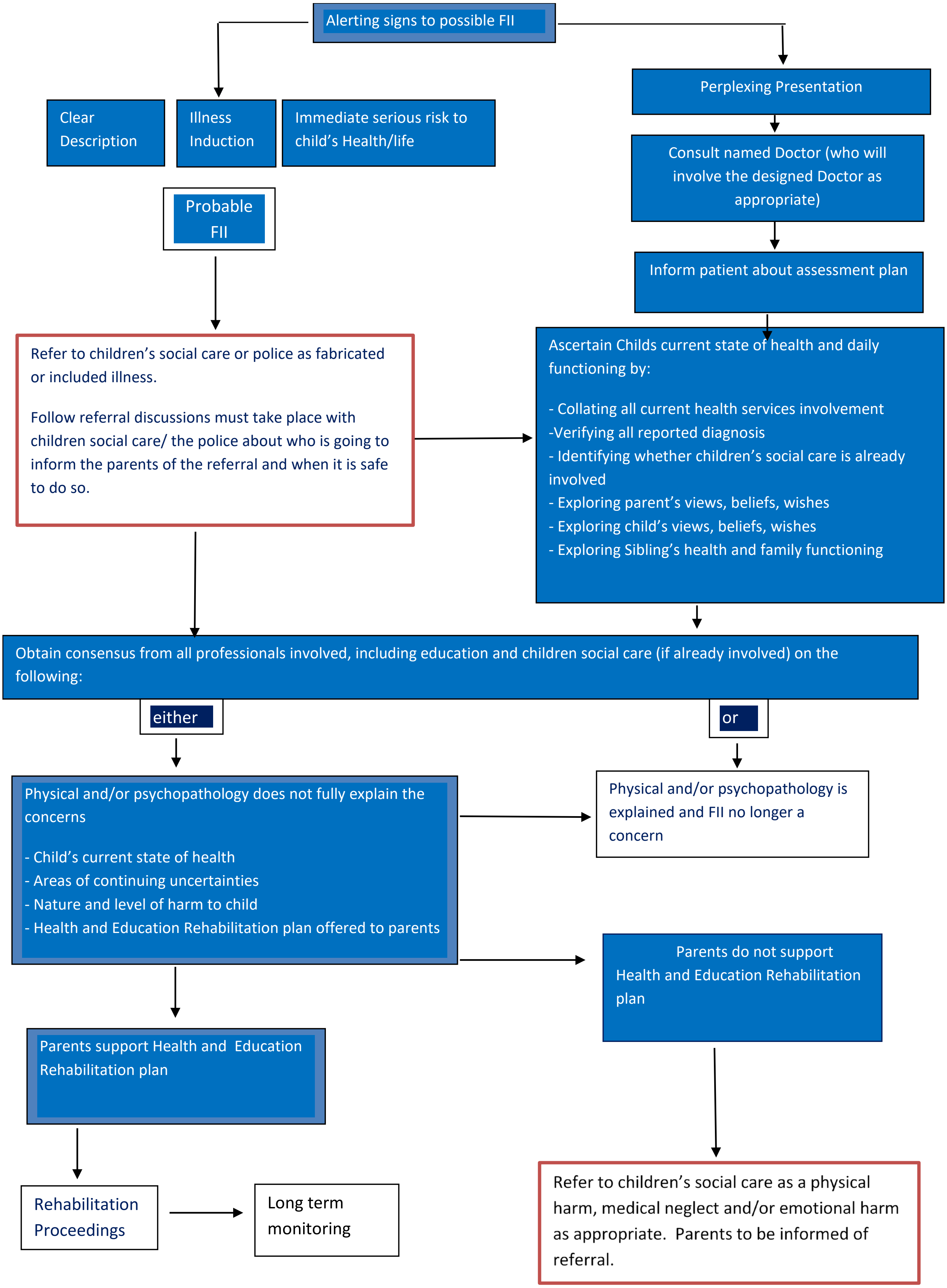
14.1.4 A chronology of the child's health and healthcare is often requested at the point of referral. However, preparing a full chronology (see below) is extremely time-consuming, and is not actually needed immediately. Awaiting the preparation of a full chronology will delay the process during which the child might be left at ongoing risk while a chronology is being compiled.

14.2 Response Requested from Children's Social Care

14.2.1 The reason for referring the child to social care is the need to reduce the harm to the child. Children's social care in turn undertake an assessment to determine whether the significant harm threshold has been reached, what the child's needs are and to intervene to reduce or prevent harm. The RCPCH recommends that this should include supporting the Health and Education Rehabilitation Plan. In addition, the child will need to be protected from being taken to health professionals unnecessarily by the parent if they continue to give unreliable information about the child, as health professionals unaware of the full context will not have the necessary information on which to assess the child which may be to the detriment of the child's health and wellbeing.

14.2.2 If the referral is declined as not reaching the threshold for children's social care assessment and support, or the response does not appear to be appropriate, then every effort should be made for health and children's social care to understand each other's professional opinions. Named and Designated Doctors and Nurses can play a key role here in communication with children's social care and should be involved at this point. Where appropriate, concerns about decisions should be escalated to senior management within the Local Authority. The LA Escalation Process should be employed.

14.2.3 Children's social care may request a chronology from health to inform their assessment. In cases of professional dispute, the evidence contained within a full chronology may be invaluable, along with the comprehensive referral (described above) with a health assessment report outlining evidence of professional concerns, the impact on the child and actions taken so far by health professionals to attempt to resolve the issues.



Alerting signs to possible FII

Clear Description

Illness Induction

Immediate serious risk to child's Health/life

Probable FII

Refer to children's social care or police as fabricated or included illness.

Follow referral discussions must take place with children social care/ the police about who is going to inform the parents of the referral and when it is safe to do so.

Perplexing Presentation

Consult named Doctor (who will involve the designed Doctor as appropriate)

Inform patient about assessment plan

Ascertain Childs current state of health and daily functioning by:

- Collating all current health services involvement
-Verifying all reported diagnosis
- Identifying whether children's social care is already involved
- Exploring parent's views, beliefs, wishes
- Exploring child's views, beliefs, wishes
- Exploring Sibling's health and family functioning

Obtain consensus from all professionals involved, including education and children social care (if already involved) on the following:

either

Physical and/or psychopathology does not fully explain the concerns

- Child's current state of health
- Areas of continuing uncertainties
- Nature and level of harm to child
- Health and Education Rehabilitation plan offered to parents

or

Physical and/or psychopathology is explained and FII no longer a concern

Parents support Health and Education Rehabilitation plan

Rehabilitation Proceedings

Long term monitoring

Parents do not support Health and Education Rehabilitation plan

Refer to children's social care as a physical harm, medical neglect and/or emotional harm as appropriate. Parents to be informed of referral.

15. Record Keeping

15.1.1 All notes about a child's condition should clearly state who reported the concerns, what was observed, and by whom.

15.1.2 Records of key discussions and safeguarding supervision notes about the child's care should be kept within every organisation's main health record pertaining to the child. If an organisation has more than one clinical record, a flagging system should be in place to cross-reference concerns held in the main health record. The minutes of professionals' meetings shared across all participant organisations will avoid discrepancies in individual's recollection/recording across the multi-professional group and is preferable to individual entries in notes.

15.1.3 These minutes should be factual and agreed by all parties present. Records must provide a clear statement of what has and has not been discussed with parents. Legal advice and GMC rulings suggest that individual doctors and health teams could be potentially criticised in any subsequent legal proceedings for not keeping a single record accessible to the whole health team, and their evidence could be undermined in court if this is not done. Any emails between clinicians about a child, between parents and clinicians, and between children and clinicians, form part of the health record.

15.1.4 Subject Access Requests from parents in PP and FII cases are not uncommon. They are easier to manage if there has been open communication with parents previously. If it is thought that the Subject Access Request may result in concerns about the child's welfare, appropriate legal advice needs to be sought within the Trust about what material should be disclosed and any material to be withheld.

15.1.5 All correspondence regarding a child should be copied to all health providers involved, not only the GP and the parents, as is best practice in all paediatric care

16. Chronology

16.1.1 A full chronology consists of a list of significant past events that have occurred during the child's life, by date and time. They are usually compiled using a template which has a number of headed columns with information about the source of the entry, what actually happened or was observed and by whom, what was said, and an analysis of this. A standard chronology template should be used across all agencies so that they can easily be merged into one document. *See Appendix 4 for chronology template*

16.1.2 Chronologies are useful in understanding recurring patterns of behaviour and concerns in PP and FII. In cases involving PP, the initial assessment should focus on understanding the child's current functioning and any discrepancies between what is reported and what the child is observed or considered to be able to achieve. Chronologies are particularly valuable when there is uncertainty about the extent or pattern of past reported illnesses/significant events and/or there is a requirement to make a case for a significant harm threshold for child protection or court proceedings.

16.1.3 Although very useful, chronologies are usually time consuming to compile and are not always necessary. Assessment of current functioning and a management plan should not await the production of chronologies as appropriate action for the child should not be delayed.

16.1.4 Health chronologies should be compiled by multi-professional health teams and must include an experienced and senior health professional that fully understands the presenting health issues so as to interpret significant events through this lens (usually a consultant paediatrician or a Child and Adolescent Psychiatrist).

16.1.5 Chronologies should aim to be objective and must contain balanced information, including significant positive information about family functioning or test/observation results not necessarily in keeping with the overall concerns. Recording of facts should be kept separate from opinion and analysis, but it is important that this is included in order for non-health professionals to easily make sense of the information presented.

16.1.6 Chronologies can be misleading without a summary and overall analysis. This analysis should include proven diagnoses, important comments by both parents and child, information about parent/child perception of illness, important discrepancies in reporting and observed health information and recurring patterns of behaviour/presentation. This analysis could include commentary on whether the overall situation is likely to meet the significant harm threshold.

17. Transitions

17.1.1 Once children are 16 years old, they are presumed in law to be competent to make decisions about their health. Young people aged 16 and 17 years old require particular support as many start their journey towards independence at this time. For those with health conditions, there can be many challenges as they start the transition from children's health services to adult health services. Great care needs to be taken that young people in this age group who have medically unexplained, functional disorders and perplexing presentations, or where there are concerns about FII, don't fall off a 'cliff edge' between child and adult services. Timely and robust information sharing between child and adult services as well as with the young person's GP is essential to ensure the young person continues to be supported and their needs met. Coordinated care, ideally through meetings with the key professionals and/or young person and their family will ensure safe and efficient information sharing and planning for their future care.

17.1.2 All doctors and health professionals practising in England and Wales should be aware of The Mental Capacity Act (MCA) 2005 (amended in 2019). The MCA applies to people aged 16 and over and is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. The principles of the MCA are:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise
- wherever possible, help people to make their own decisions

- don't treat a person as lacking the capacity to make a decision just because they make an unwise decision
- if you make a decision for someone who doesn't have capacity, it must be in their best interests
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

17.1.3 Where the 16 or 17 years old is assessed as lacking the capacity to make decisions about their health care, parents can consent to investigation and treatment that are in the young person's best interests or treatment can be provided in the young person's best interests without parental consent, although the views of the parents may be important in assessing the young person's best interest. In the event that there is a dispute about what is in the patient's best interest then a court of protection decision may be required https://www.gmc-uk.org/

17.1.4 Professionals have a unique opportunity when working with young people aged 16 and 17 years to explore what the young person's views on their health are, their concerns and what their hopes for the future are. There is an opportunity to empower the young person to make decisions about their own health as well as other aspects of their life and link them with other appropriate services and professionals who can support them. In this situation it may be the parents' wishes for their child are considered but the informed decision(s) about their health and treatment are made by the young person themselves. NHS (2018) Making decisions for someone else: Mental Capacity Act. Mental Capacity Act - NHS (www.nhs.uk)

18. Training, Supervision & Support

18.1 Paediatricians

All Paediatricians should receive training about the management of both Perplexing Presentations (PP) and Fabricated and Induced Illness (FII) as it is expected that all Paediatricians will encounter patients with alerting signs and possible FII. The syllabus for Paediatricians in training is set by the RCPCH Progress Curriculum. Almost all parts of this syllabus are relevant to developing the skills to be able to prevent, recognise and manage PP and FII. The domains across the three training stages include the development of professional knowledge and values, communication skills, patient management, patient safety, information sharing, leadership and team working. All of these are vitally important in this field of work in addition to the broad principles laid out in the specific safeguarding children domain.

- RCPCH safeguarding courses are available at: https://www.rcpch.ac.uk/resources/safeguarding-learning-resources
- RCPCH Progress curriculum is available at:

  https://www.rcpch.ac.uk/education-careers/training/progress
- RCPCH paediatric guide to the ICD is available at:

https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies

- e-Learning for Healthcare Safeguarding Children and Young People - Level 3 available at: https://portal.e-lfh.org.uk/Component/Details/39110

18.2 GPs and other health professionals

18.2.1 GP's and allied medical specialities which include Child and Adult Psychiatrists and Psychologists, nursing specialities which include Paediatric Nurses, Health visitors, Public Health School Nurses, and allied health professionals which include Dieticians, Physiotherapists, Speech and Language Therapists and Occupational Therapists are also required to have specific knowledge and skills leading to competencies about recognising and managing PP and FII as laid out in the Intercollegiate Document (ICD), '*Safeguarding children and young people: roles and competencies for healthcare staff*' which is supported by the RCPCH. The ICD applies to all colleagues in the health service, providing a common understanding. Additional learning opportunities can also be captured and recorded as learning hours (as per the ICD) via attendance at courses, lectures, and readings, including case discussions and de-briefs with Named and Designated Professionals and other experienced safeguarding professionals.

18.2.2 Commissioners and service planners should also ensure that the training requirements within the ICD are implemented and monitored by health inspectorate bodies.

18.3 The role of the Named and Designated Doctors

18.3.1 The role of the Named and Designated Doctors and the safeguarding teams involved in case management has been outlined previously in the guidance. Named and Designated Doctors for Safeguarding Children and the safeguarding teams within which they operate play a pivotal role in delivery of formal training about PP and FII, providing supervision and support for health staff, and advising on case management. Their own additional needs for development of general safeguarding competencies and those particular to PP and FII are specified in the ICD.

18.3.2 All consultant paediatricians in a health service should share in acting as the responsible consultant paediatrician for PP and FII cases encountered on their caseload. They should not all be the responsibility of one individual. When there are concerns about significant harm within complex cases, the safeguarding oversight should not be provided by the responsible consultant paediatrician, to ensure objectivity and relative freedom from duress.

18.4 Leadership and Supervision

18.4.1 The Named and Designated professionals should establish local peer support networks for regular discussion of anonymised cases. Supervision and professional support will be sought from other Designated Doctor peers across the ICB and cross cover and peer supervision and support for Designated Professionals or their equivalents will be available. Named and Designated Health Professionals should be included in all strategy discussions pertaining to cases where FII is a concern. Designated Professionals should ensure that local guidance reflects this recommendation.

18.4.2 The leadership, support, supervision, and advice provided by paediatricians in these specialised roles is a vital component of ensuring the best outcomes for children and determining the threshold for potential significant harm which mandates referral to children's social care and the police. The Named and Designated professionals and their safeguarding teams should coordinate and provide supervision, either by case management or in a more reflective manner.

18.5 Organisational and Professional Support

18.5.1 It is important to recognise that FII/PP cases can be both medically very complex and highly contentious and places considerable demands and burden on Paediatricians, other health professionals and partner agencies and needs to be supported by experienced peers and underpinned by access to specialist advice.

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

18.5.3 Complaints departments and Patient Advice and Liaison Service (PALS) should understand the complex dynamics involved between parents and health professionals in these types of cases, and their investigations and support to parents should take this into account. Health staff should be supported by their Trust employers, Human Resource Departments and Professional Bodies in dealing with repeated communications from parents.

18.5.4 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. Named Professionals should escalate concerns about lack of appropriate support through escalation systems within their provider organisations and if necessary, to the Designated Professionals. Named professionals should receive professional support from their Designated Doctor and management support from their Medical Director and Executive Lead for Safeguarding Children within their provider organisation. Designated professionals should seek management support from the Executive Director for Safeguarding Children within their CCG.

18.5.5 In addition to this support, it is recommended that employing organisations, in meeting their safeguarding children duties and their duty of care to their staff, should also provide occupational health / counselling support to any paediatrician or other member of staff that requires it. This is particularly important when an individual's professional integrity is challenged, and their reputation and / or personal safety are threatened. Paediatricians are encouraged to follow the British Medical Association's 'Social media guidance for doctors', to protect themselves in this arena. Paediatricians can also request support from their defence organisations, the RCPCH and the BMA, amongst others. On occasion, collusive and unprofessional relationships can develop between parents and members of the health team. This needs to be addressed by the responsible Consultant Paediatrician or the Named or Designated Doctor

19. Private Practice

19.1.1 Wherever a doctor is practising and in whatever context, they are bound by GMC standards relating to safeguarding children. The Designated Doctor has a duty towards the whole health economy in the area they cover and any doctor in private practice can approach them with regard to how to access training and supervision if they are in doubt about this.

19.1.2 Unlike in the NHS, where referrals to consultants are made by other doctors who know the child, consultants working in the private sector may see children referred by the parents. It is good practice for doctors operating privately to request a GP referral letter as this will contain relevant background information and makes the GP aware of the parents' request for a private assessment. The GP must then alert the private Consultant to any known safeguarding concerns. In cases of unrecognised FII, the history given by the parents may not reflect the whole or an accurate picture. For this reason, it is advisable for private consultants to ascertain by whom the child has already been seen and request information from the other doctors. Equally, while a parent may wish for their child to be seen privately, if, in cases of PP or FII an NHS doctor becomes aware of this proposed consultation, it is appropriate to ensure that the private doctor is provided with full information about the child.

19.1.3 All doctors, regardless of where they practice, should maintain their competencies with regards to safeguarding children. Doctors who practice within the NHS, as well as privately, will be able to maintain their safeguarding children competencies through their NHS employment. Those who practice privately full time are still required to maintain their safeguarding children competencies. If there are any concerns about how they achieve this, they should discuss this with the Designated Doctor for the area in which they practice. All doctors have their competencies appraised annually in order to be revalidated to practice by the GMC.

20. Continuing Statutory Processes

20.1.1 Once a referral is received Children's Social Care should decide, and record within one working day, what response is necessary. Unless there is felt to be an immediate risk to the child by doing so it is the responsibility of the referring agency to inform the parents and, if appropriate, the child that the referral to CSC has been made.

20.1.2 The majority of the children where the risk to the child is more serious will be dealt with through investigations by the Police and Children's Social Care under Section 44 of the Children Act 1989. However, children to whom the risk is very great may be in need of immediate protection. Children subject to such immediate risk can be removed to a place of safety or prevented from leaving hospital by the Police through the Police Protection Powers or through an application by the Local Authority for an Emergency Protection Order. Such significantly interventionist action however requires clear medical evidence of the child being at imminent risk of significant harm through action attributable to their parents/carers.

20.1.3 Any suspected case of fabricated or induced illness may involve the commission of a crime and therefore the police should always be involved during the investigation stage.

20.1.4 Any involved professional can request that a strategy meeting be held although this is usually the role of social care.

20.1.5 The strategy meeting will be chaired by an experienced Independent Reviewing Officer (IRO), or other personnel as per local guidance of each LSCB, who have sufficient understanding of managing the complexities involved in possible FII

20.2 The Strategy Meeting:

20.2.1 If there is a reasonable cause to suspect that the child is suffering, or likely to suffer, significant harm, or that parent(s) actions have significant negative impact on the child, children's social care (CSC) should convene and chair a strategy meeting, in line with section 47 child protection enquiries, involving all the key professionals.

20.2.2 Participants must include as a minimum:

- Chaired by IRO (or an alternative chair as per CSAP guidelines)
- Team Manager and Allocated Social Worker from Children social care
- Police
- The "responsible Paediatrician".
- School/ nursery as applicable
- GP and report

20.2.3 As medical information is crucial in these meetings, it is extremely important that as much as possible, the date, time and place of the meeting should be suitable for the GP and Paediatrician to attend. Other professionals are invited as appropriate and may include:

- A senior ward nurse if the child is an in-patient;
- A medical professional with expertise in the relevant branch of medicine;
- Allied health professionals
- Health visitor or school nurse;
- CAMHS services
- Named/ designated safeguarding professionals.
- Local authority Legal Advisor (In some LSCBs this is a must attend)

20.2.4 The participants in the strategy meeting would examine evidence of FII and explore the impact of carer's actions on the child and other children in the family.

20.3 Chronologies

- If health professionals have come to a consensus formulation about the current health, needs and potential or actual to the child during their meetings there may not be a need for a chronology. These children 'not at risk of imminent harm' will have a HERP which should be shared at the point of referral.

- If a health chronology has been produced then it should also be shared at the point of referral. However, if the decision is made to add information from CSC, Education and Police for the child and sibling and parental information to the chronology this will need to be co-ordinated by CSC.
- Chronologies from different agencies should eventually be merged together into a multiagency chronology. This is usually done by CSC.
- For children deemed to be at risk of imminent harm there will rarely be a chronology to share are the point of referral.
- For all cases the need or not for a full, multiagency chronology should be decided at the first strategy meeting.
- If deemed necessary chronologies should then be available for a subsequent strategy meeting to ensure informed decision making.
- As the child's circumstances are likely to be complex, it may be necessary to have more than one strategy meeting.
- Staff attending the strategy meeting should be sufficiently senior to be able to contribute to the discussions of very complex information, and to be able to make decisions on behalf of their agency

20.4 Outcome of the Strategy meeting

20.4.1 If the outcome of the strategy meeting(s) is that section 47 enquiry is needed, the following issues should be determined:

- The level of risk of harm to child and siblings, and any immediate steps necessary to reduce such risks
- Communication with carers and confidentiality (including how, when, and by whom they should be informed of any child protection concerns). It is advisable that informing parents should be done jointly by CSC and health, with police involved if criminal aspect is suspected.
- The planning of further medical and nursing assessment, including any outstanding investigations. This may include cancelling unnecessary medical procedures or instituting closer observation of the child.
- The development of an integrated health (and other) chronology (and agreement on who should do this)
- Whether the carers should be allowed on the ward if the child is an inpatient
- The level of professional observation required
- The need for forensic sampling, special observation or Covert Video surveillance (CVS)
- The needs of carers, particularly after disclosure of concerns
- Clarification of who will be the responsible paediatric consultant for the child (if not already explicit)
- In many cases of suspected FII, information about siblings and carers, including their past medical history, current health and any treatment, equipment, and benefit they

receive, are very relevant to the case discussed. Such information is very likely to aid in the diagnosis of FII and need to be shared.

- What information is to be shared with the child or young person and who is responsible for sharing it.
- Participation of child/ young person including direct work, which resources have been used, and/or a referral to advocacy services if appropriate.

20.5 Outcome of Section 47 investigation

- Investigation may show that concerns are not substantiated (e.g., tests may identify a medical condition that explains the signs and symptoms).
- It may be that no protective action is required, but the family should be provided with the opportunity to discuss whether they require support.
- As in all areas of chid protection certainty is not required but evidence – written, verbal and observed, should be considered and professional judgement on the likelihood of risk of actual harm should be made on the balance of probability. To protect children, we must concentrate on assessing harm to the child.
- Concerns may be substantiated, but an assessment may be formed that the child is not at continuing risk of harm. In this case, the decision not to proceed to a child protection conference must be endorsed by the LA children's social care manager or child protection advisor
- Where concerns are substantiated and the child is judged to be suffering, or at risk of suffering, significant harm, a child protection conference must be convened. All evidence should be thoroughly documented by this stage and the protection plan for the child already in place.
- Child protection investigations in FII may take more time than usual. However, professionals should ensure that any child protection conference is held within 15 working days of the last strategy meeting, and that regular strategy discussions take place throughout the investigation.
- The maximum timeframe for the assessment to conclude, such that it is possible to reach a decision on next steps, should be no longer than 45 working days from the point of referral. H. If, in discussion with family and other professionals, an assessment exceeds 45 working days the social worker should record the reasons for exceeding the time limit. Whatever the timescale for assessment, where particular needs are identified at any stage of the assessment, social workers should not wait until the assessment reaches a conclusion before commissioning services to support the child and their family. In some cases, the needs of the child will mean that a quick assessment will be required.
- If concerns are not substantiated and child/ young person not deemed at risk of harm then there needs to be planning re: level of intervention and support – CIN, Early help, Health Lead etc.

20.6 Covert Video Surveillance (CVS)

20.6.1 The use of covert video surveillance should be the last resort in FII investigation. It may be considered when there is no alternative way of obtaining information to explain child's signs and symptoms.

20.6.2 The decision to use CVS will be made by the police.

20.6.3 The use of CVS is governed by the Regulation of Investigatory Power Act (the 2000 Act). The operation is controlled by the police and accountability for it is held by police manager. They will need to demonstrate that the use of CVS may lead to detection or prevention of crime.

20.6.4 Police officers should carry out any necessary monitoring. All personnel, including nursing staff, who will be involved in its use, should have received specialist training in this area.

21. Appendix 1: Health and Education Rehabilitation Plan Template

Child's Name:		Name of responsible clinician:	

What does the child need?	Actions to achieving goal:	Who will ensure this happens?	When by?	Outcome for child:	Date for review:

22. Appendix 2: FII Warning Signs Template (WST)*

Category	Warning signs of Fabricated or Induced Illness
1.	Reported symptoms and signs are not explained by any medical condition from which the child may be suffering.
2.	Physical examination and results of medical investigations do not support/ 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 when the carer is not present.
6.	Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear.
7.	Repeated presentation to a variety of doctors with the same or different health problems.
8.	History of unexplained illnesses or deaths or multiple surgery in parents or siblings.,
9.	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.
10.	Incongruity between seriousness of story and action of parents
11.	Erroneous or misleading information provided by the parent.
12.	Exaggerated catastrophes within other extended family members are reported.

***Please Note:** The categories within the template are not absolutes – there may be numerous possible explanations one of which is possible FII.

23. Appendix 3: FII Warning Signs Template - signs explained

Category	Warning Signs - explanation
1.	**Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.** Information obtained through history and physical examination 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.
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 videotelemetry (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, for example asthma medications not making any difference to described wheezing and cough. 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**, In this respect, 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. Example would be school describing episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.
6.	**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.
7.	**Repeated presentation to a variety of doctors with a same or different health problems**. 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.	**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
10.	**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).
11.	**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. Accurate and detailed documentation is key here.
12.	**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.

24. Appendix 4: The Chronology

Date	Source	Event	Action Taken	Action / Potential Impact / Harm On Child	Template category corresponding to FII Warning Signs