Perplexing Presentations and Fabricated or Induced Illness Guideline
### POLICY INFORMATION SHEET

<table>
<thead>
<tr>
<th>Date effective from</th>
<th>May 2019</th>
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<tbody>
<tr>
<td>Policy Owner</td>
<td>Cheshire East and Cheshire West &amp; Chester Local Safeguarding Children’s Board and Warrington Safeguarding Partnership</td>
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<tr>
<td>Date of Reviews</td>
<td>May 2021</td>
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<tr>
<td>Status</td>
<td>Mandatory</td>
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<td>• Mandatory (all staff name must adhere to guidance)</td>
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<td>• Optional (Procedures and practice can vary between teams)</td>
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<tr>
<td>Target Audience</td>
<td>All staff based within Cheshire East, Cheshire West &amp; Chester and Warrington areas</td>
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<tr>
<td>Date of Policy and Procedures Ratification</td>
<td>February 2019</td>
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<td>Related Document (s)</td>
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Perplexing Presentations and Fabricated or Induced Illness

1. Introduction

1.1 The terminology used to describe fabrication or induction of Illness by a carer is a subject of considerable debate amongst professionals. It has been known by a number of terms including

- Munchausen syndrome by Proxy
- Factitious Illness by Proxy
- Illness induction syndrome

Fabrication or Induced Illness (FII) is now the commonly used terminology, as it maintains focus on the child.

1.2 There are three main ways a carer may deliberately deceive medical services. Whilst not mutually exclusive, they include:

1.2.1 Fabrication of signs and symptoms including past medical history
1.2.2 Fabrication of signs and symptoms along with falsification of specimens, investigations, hospital charts and records including medical documents, letters etc.
1.2.3 Induction of actual illness; E.g. smothering to induce apnoea or anoxic seizure; Poisoning with salt, laxatives, narcotics, psychiatric drugs, anticonvulsants leading to vomiting, diarrhoea, drowsiness etc. resulting in unnecessary investigations; Deliberately withholding food causing failure to thrive; Deliberately withholding medication meant for a genuine medical condition; Causing a rash by applying caustic substances to child’s skin; Injecting faeces; Removing blood to cause anaemia;

1.3 FII may also occur in children with disabilities.

1.4 Presence of proven chronic medical condition does not exclude FII. The two often coexist in about half of all FII cases.

1.5 In investigating and managing FII, one has to consider the needs of the child first and foremost. It is also important to consider any secondary gains for the carers E.g. to retain or qualify for financial gains such as Disability Living Allowance etc.

1.6 FII is not a diagnosis of exclusion. It is a clinical diagnosis which must be based on a full consideration of the child’s clinical features including the child’s past and present medical history, examination findings and all test results. As with most diagnosis of abuse, the diagnosis is not based on a single finding or event but often on a series of different events over a period of time.

1.7 A more common presentation than true FII is that of “Perplexing Presentations” or “Medically Unexplained Symptoms” that primarily involves verbal accounts and descriptions by carer that are not aimed at deliberate deception, or the carer may simply exaggerate genuine symptoms and signs. However, this ought to be considered within the spectrum of FII, as the impact on the child is similar and can lead to iatrogenic harm, a disordered perception of health and illness in the child and interfere with the child’s education and cause harm to their emotional and psychological wellbeing.
2. Recognition

2.1 Although not exhaustive, below is a list of indicators of possible FII or Perplexing Presentations.

2.1.1 A carer reporting symptoms and signs that are not explained by any known medical condition.
2.1.2 Physical examination and investigations do not explain the symptoms or signs reported by the carer.
2.1.3 The child has an inexplicably poor response to prescribed medication or other treatment, or intolerance to treatment.
2.1.4 Acute symptoms and signs are exclusively observed by/in the presence of one carer.
2.1.5 On resolution of the child’s presenting problems, the carer reports new symptoms or reports symptoms in different children in sequence.
2.1.6 The child’s daily life and activities are limited beyond what is expected due to any disorder from which the child is known to suffer, for example partial or no school attendance for medical symptoms that are often vague in nature, frequent unexplained absences from school and particularly from PE lessons, use of seemingly unnecessary special aids or equipment.
2.1.7 The carer seeks multiple opinions inappropriately.
2.1.8 Objective evidence of fabrication – history of events given by different observers may be in conflict or being biologically implausible (E.g. small infants with a history of very large blood losses but do not become anaemic, infants with large negative fluid balance who do not lose weight; Test results such as Toxicology studies or blood typing; evidence of fabrication or induction on covert video surveillance (CVS).
2.1.9 The carer expressing concern they are under suspicion for FII, or relatives raising concerns about FII.
2.1.10 Deliberately inducing symptoms in children
2.1.11 Exaggerating symptoms that cannot be verified, necessitating unnecessary investigations that could be invasive and potentially harmful or dangerous to the child.

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

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

3 Involvement by the Child

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

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

4 Managing Concerns of Perplexing Presentations / True FII

4.1 It is often not clear during initial presentations to health care setting, whether it is related to FII / Perplexing Presentation as there often is not sufficient evidence, and the nature and severity of risk to the child can often be unclear.
4.2 It is important to establish facts in order to reduce uncertainty by completing a Chronology, using the template in Appendix A, by all lead professionals involved in the care of the child eg. GP, Consultant Paediatrician, Social Worker, Staff in education etc.

4.3 Listed below are general principles for professionals to follow when dealing with cases of Perplexing Presentations or FII.

4.3.1 Maintain focus on safeguarding and promoting welfare of the child at all times;
4.3.2 Complete a Chronology using the standard template (Appendix A), listing the evidence where available. Best to complete a chronology and start collecting evidence even before referral to Children’s Social Care, unless the concerns are urgent or there is already evidence of significant harm;
4.3.3 Cross reference the chronologies for different children in the family as illness behaviour can switch between different children in the family;
4.3.4 List inconsistencies and clarify the same by seeking more information from family members and other professionals involved
4.3.5 Continue to observe child and family for any emerging patterns
4.3.6 Keep detailed records and be specific around the evidence base and source of information eg. Direct observation, Informed opinion, Hearsay etc.
4.3.7 Test alternative explanations by discussing with a senior colleague or expert; Complete medical tests and/or social care assessments;
4.3.8 Health professionals should ensure there is a lead health professional identified, ideally a consultant paediatrician. All cases ought to be discussed with their relevant Named Doctor for Safeguarding Children; Any professional disagreements ought to be escalated to the Designated Doctor for Safeguarding Children;
4.3.9 Continuously reassess the situation in the light of any new information;
4.3.10 It is usually not appropriate to share concerns of FII with parents during the early stages but plans need to be agreed between the lead paediatrician and children’s social care manager regarding the appropriate response to managing concerns in order to protect the child. Also important to agree and document by all agencies, what is or is not appropriate to be discussed with the parents, depending on circumstances, whilst also trying to be as open and transparent as possible;
4.3.11 Evaluate alternatives; As Sherlock Holmes said “Exclude the impossible and the solution lies in what remains, however unlikely”;
4.3.12 Refer to national and local guidance and seek legal assistance where relevant;

5 Action in cases of suspected True FII / Perplexing Presentation

5.1 Child at risk of significant harm or is suffering harm

5.1.1 Refer to Children’s Social Care (CSC)/Police immediately, where the child has been significantly harmed or is at risk of significant harm E.g. acute suffocation, poisoning etc.

5.1.2 Secure any potential evidence E.g. Feed bottles, Infusion sets, nappies, Blood/Urine/Vomit samples, Clothing or Bedding if they have suspicious material in them;

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

5.2 No immediate risk of harm

5.2.1 Cases often presenting in a more chronic or evolving way and may be managed conservatively, at least in the initial instance.
5.2.2 If no Paediatrician already involved, arrange referral to a Paediatrician to explore any underlying medical illness. The paediatrician may need to refer for specialist tests and advice in some cases.

5.2.3 Parents should be kept fully informed of outcomes of medical assessments and investigation results by the paediatrician.

5.2.4 If no underlying cause has been found after careful assessment, observation and investigations, the same should be communicated clearly to the parents/carers that the child does not have any medical condition and the symptoms are medically unexplained. This can be presented to the family as good news, with reassurance that most children spontaneously improve over time, and that no further investigations or treatment is necessary unless the situation changes;

5.2.5 A clear medical plan for rehabilitation of child to normal activities needs to be drawn up and the family helped to think through how their lives would be different if the child is no longer ill and be helped to construct a credible narrative about the child’s recovery. Involvement of local CAMHS services may be helpful. All of the above should be clearly documented in the child’s records.

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

5.2.7 In such cases, a decision has to be made whether it is a case of true FII or Perplexing Presentation likely to cause harm to the child, that often requires multiagency input and may therefore warrant a referral to ChECS at CSC. Detailed Chronologies may need to be compiled. Refer to Appendix A and Appendix B. Early professional intervention including multiagency input for these families may help prevent further escalation of the illness seeking behaviour.

5.2.8 The Named Safeguarding Leads must be made aware in all cases of suspected FII/Perplexing presentations and consulted at the earliest opportunity.

5.2.9 Concerns around FII should not be shared with the parent/carer if it is likely to compromise the safety of the child or jeopardise any child protection / criminal investigations.

6. Children’s Social Care (CSC)

6.1 Once a referral has been accepted by CSC, the case will be transferred to the Child in Need (CIN) team, who will take lead responsibility for further assessment into the possibility of FII / Perplexing Presentation, working in conjunction with the paediatrician and professionals from all relevant agencies.

6.2 CSC will co-ordinate collection of detailed Chronologies on the standard template (Appendix A) from relevant professionals involved with the child from ALL agencies, to build a picture of the child’s lived experience and gain insight into the child’s developmental needs, parenting capacity, family and environmental factors that may be impacting on the parent/carer’s behaviour.

6.3 All chronologies to be submitted to CSC within 3 weeks of the request. The responsibility for completing the chronology rests with frontline professionals but Line Managers / Named Child Safeguarding Leads within relevant organisations ought to provide support and supervision to frontline staff completing chronologies.
6.4 On receipt of the completed chronologies, CSC will convene a multiagency professionals meeting within 4 weeks of the referral. It may be best for CSC to announce the date of this meeting as soon as a referral is accepted to allow for professionals to adjust their diary commitments and enable attendance.

6.5 The multiagency professionals meeting must be chaired by a suitably qualified senior manager in CSC. This is generally the Service Manager.

6.6 The following professionals must be invited

6.6.1 The referrer, if a professional
6.6.2 Consultant Paediatrician of the child, Medical professional with relevant expertise in the relevant illness E.g. Tertiary centre specialist, GP, Designated Doctor for Safeguarding Children, Named Doctor and/or Nurse for Safeguarding Children, Named GP for Safeguarding Children, Health Visitor and/or School Nurse as appropriate, Community Paediatric staff;
6.6.3 Staff in Education / Early Years setting
6.6.4 Police
6.6.5 Any other relevant professional involved with the family E.g. Mental Health staff etc.
6.6.6 Local Authority Legal adviser

6.7 Issues to be addressed at the meeting include

6.7.1 Whether it is true FII or a case of Perplexing Presentation
6.7.2 Whether a Section 47 enquiry needs to be initiated and if so, how a core assessment will be undertaken – what further information is required about the child and family and how it should be obtained and recorded
6.7.3 Confirmation of a lead consultant paediatrician
6.7.4 What information is to be shared with the family and by whom
6.7.5 How to ensure security of child’s records to ensure child’s welfare
6.7.6 Whether the child requires a period of admission in hospital for observation
6.7.7 Whether the child and/or carers require constant observation by staff if child is admitted as an in-patient; If yes, by whom and which agency is responsible for arranging it
6.7.8 Any particular factors, such as the child and family’s race, ethnicity and language which should be taken into account
6.7.9 Needs of any siblings or other children who the perpetrator may come into contact
6.7.10 Needs of the parent/carer
6.7.11 Any Police investigations required including forensic analysis of any samples, Covert Video Surveillance (CVS) etc.

6.8 The outcome of the multiagency professionals meeting may be one of the following

6.8.1 Concerns not substantiated and no evidence of FII / Perplexing presentations
6.8.2 Concerns substantiated and decision to progress to Strategy Meeting
6.8.3 Concerns not sufficiently substantiated

6.9 Proceedings of the meeting should be recorded and the minutes circulated to all relevant professionals
6.10 Consideration should be given towards other interventions such as Early Help / Child in Need interventions even if concerns not sufficiently substantiated
6.11 If concerns substantiated and decision made to proceed to Strategy meeting/Section 47 enquiry, subsequent processes should follow routine child safeguarding procedures as outlined in “Working Together – 2018”

7. Police

7.1 All relevant information gathered by the Police ought to be shared at multiagency meeting to help plan management, unless likely to jeopardise any criminal proceedings.

7.2 If it is decided at a multiagency strategy meeting to employ Covert Video Surveillance (CVS), it is generally the responsibility of the Police to lead on this by applying for appropriate approvals under the Regulation of Investigatory Powers Act 2000.

7.3 All staff need to be appropriately trained to ensure co-operation with the Police, maintain secrecy and ensure the child’s safety.

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

7.5 In criminal investigations, Suspects’ rights should be protected by adherence to Police and Criminal evidence Act 1984.

8. Allegations against staff

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

9. Pre-Birth Planning

8.1 If there is history of FII perpetrated by a pregnant woman in another child/sibling, before or during pregnancy, referral to CSC is needed, to consider the safety of the unborn child after delivery. This may require a strategy meeting and pre-birth child protection conference if Section 47 Enquiry reveals the child is likely to be at risk of harm following birth.

10. Conflict

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

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

References

1. Child protection Companion 2013 – Royal College of Paediatrics and Child Health;
2. Fabricated or Induced Illness by Carers – A Practical Guide for Paediatricians 2009; Royal College of Paediatrics and Child Health;
3. Safeguarding Children in whom illness is fabricated or induced – Department for Children Schools and Families, HM Government 2008;
4. Incredibly Caring - Department for Education and Skills 2007;
CHRONOLOGY TEMPLATE

Please construct a comprehensive chronology (starting with first contact) of involvement by your agency.

Name of Child:
DOB:
Address:
Author:
Job Title and Contact Details:
Agency:
Date of Completion:
## The Template Categories Summary

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Warning signs of Fabricated or Induced Illness</th>
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<tbody>
<tr>
<td>1</td>
<td>Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.</td>
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<tr>
<td>2</td>
<td>Physical examination and results of medical investigations do not explain reported symptoms and signs.</td>
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<tr>
<td>3</td>
<td>There is an inexplicably poor response to prescribed medication and other treatment.</td>
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<tr>
<td>4</td>
<td>New symptoms are reported on resolution of previous ones.</td>
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<tr>
<td>5</td>
<td>Reported symptoms and signs are not seen to begin in the absence of the carer.</td>
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<tr>
<td>6</td>
<td>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.</td>
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<td>7</td>
<td>Over time the child is repeatedly presented with a range of signs and symptoms.</td>
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<tr>
<td>8</td>
<td>History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.</td>
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<tr>
<td>9</td>
<td>Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5, above).</td>
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<tr>
<td>10</td>
<td>Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported.</td>
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<tr>
<td>11</td>
<td>Incongruity between the seriousness of the story and the actions of the parents.</td>
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<tr>
<td>12</td>
<td>Erroneous or misleading information provided by parent.</td>
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<tr>
<td>0</td>
<td>No concerns about a contact.</td>
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The Template Categories Explained

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Warning signs of Fabricated or Induced Illness</th>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.</strong> Here the doctor is attempting to put all of the information together to make a diagnosis but the symptoms and signs do not correlate with any recognised disease or where there is a disease known to be present. A very simple example would be a skin rash, which did not correlate with any known skin disease and had, in fact, been produced by the perpetrator. An experienced doctor should be on their guard if something described is outside their previous experience, i.e. the symptoms and signs do not correlate with any recognisable disease or with a disease known to be present.</td>
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<td>2.</td>
<td><strong>Physical examination and results of medical investigations do not explain reported symptoms and signs.</strong> 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’.</td>
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<td>3.</td>
<td><strong>There is an inexplicably poor response to prescribed medication and other treatment.</strong> The practitioner should be alerted when treatment for the agreed condition does not produce the expected effect. This can result in escalating drugs with no apparent response, using multiple medications to control a routine problem and multiple changes in medication due to either poor response or frequent reports of side effects. On investigation, toxic drug levels commonly occur but may be interspersed with low drug levels suggesting extremely variable administration of medication fluctuating from over- medication to withdrawal of medication. Another feature may be the welcoming of intrusive investigations and treatments by the parent.</td>
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<td>4.</td>
<td><strong>New symptoms are reported on resolution of previous ones.</strong> 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.</td>
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<td>5.</td>
<td><strong>Reported symptoms and found signs are not seen to begin in the absence of the carer,</strong> i.e. the perpetrator is the only witness of the signs and symptoms. For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly raise anxiety of FII where the severity and/or frequency of symptoms reported is such that the lack of</td>
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independent observation is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. In the case under review there was evidence that the school described episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.

6. The child’s normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer. The carer limits the child’s activities to an unreasonable degree and often either without knowledge of medical professionals or against their advice. For example, confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child’s school attendance.

7. Over time the child is repeatedly presented with a range of signs and symptoms. At its most extreme this has been referred to as 'doctor shopping'. The extent and extraordinary nature of the additional consultations is orders of magnitude greater than any concerned parent would explore. Often consultations about the same or different problems are concealed in different medical facilities. Thus the patient might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different set of problems (or even the same) without informing these various medical professionals about the other consultations.

8. History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family. The emphasis here is on the unexplained. Illness and deaths in parents or siblings can frequently be a clue to further investigation and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the general practitioner through to the extreme of Munchausen syndrome where there are multiple presentations with fabricated or induced illness resulting in multiple (unnecessary) operations. Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially might have been subject to FII abuse and their medical history should also be examined.

9. Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above). This is a planned separation of perpetrator and child which it has been agreed will have a high likelihood of proving (or disproving) FII abuse. It can be difficult in practice, and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child's bedside, is unusually close to the medical team and thrives in a hospital environment.

10. Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported. This is an extension of category 8. On exploring
reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They were largely or wholly fictitious.

| 11. | **Incongruity between the seriousness of the story and the actions of the parents.** Given a concerning story, parents by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is incongruity between their expressed concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend for crucial assessments (somebody else's birthday, thought the hospital was closed, went to outpatients at one o'clock in the morning, etc). We have used a term, 'piloting care', for this behaviour. |

| 12. | **Erroneous or misleading information provided by parent.** These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc). An extreme example of this is spreading the idea that the child is going to die when in fact no-one in the medical profession has ever suggested this. Changing or inconsistent stories should be recognised and challenged. |

<p>| 0 | This is included to encourage a thorough review of contacts into concerning and non-concerning ones to give a balanced view. |</p>
<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Age of Child</th>
<th>Source of Information (GP Records / Hospital Records / Education / Nursery etc.)</th>
<th>Details of Event / Episode (Presenting history; Witnessed events by staff of carer's interactions; Specify if it was Hearsay, Direct observation or Informed opinion;)</th>
<th>Relationship of person accompanying the child</th>
<th>Category</th>
<th>Outcome (What was the diagnosis; Investigations undertaken; Was diagnosis based on reported history or on objective signs and/or investigation results; Treatment given; Duration of stay if admitted etc.)</th>
<th>Comments / Analysis (Impact on the child of any interventions undertaken, particularly if it was based on reported history without any objective signs i.e. any potential for iatrogenic Harm etc.)</th>
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Professional Opinion *(Please summarise key points and offer your professional opinion here with the rationale for the same)*
Management Pathway for "HEALTH" following concerns around possible Fabricated or Induced Illness (FII)

- Parents/Carers NOT to be informed of concerns at any stage whilst investigations for FII are ongoing.
- Designated Doctor/Nurse to be consulted in the event of any disagreements at any of the below stages.

Frontline Professional has concerns about possible FII/Perplexing presentation

Liaise with senior colleague/Line manager

Agree and document next steps with senior colleague / Named Child Safeguarding Lead

Concerns remain / Not sure

Discuss with Named Child Safeguarding Lead (Named Doctor and/or Nurse) for child safeguarding for relevant organisation

Concerns remain / Not sure

Agree and document next steps with senior colleague / Named Child Safeguarding lead

Any immediate risk of significant harm to the child

Urgent referral to CSC for strategy meeting to decide on next steps and ensure safety of child

Refer to CSC who would obtain chronologies* in electronic format, using standard template, from all relevant staff in Health, by liaising with the Named Child Safeguarding Leads and other partner agencies, within 3 weeks;

Completed Health chronologies to be discussed with Named Child Safeguarding leads and forwarded to CSC and Designated Doctor for Safeguarding Children within 3 weeks of request

CSC to convene multiagency strategy meeting

* Responsibility for completing the Chronology rests with the staff member who is/was leading the care of the child. In most cases this would be the child’s Consultant/GP. The Named child safeguarding leads may be approached for assistance, particularly for historic cases.
Cheshire East, Cheshire West and Warrington multi-agency guidelines for concerns of Fabricated or Induced Illness

**Stage 1**
Emerging Concerns
The Professional must discuss with their manager and/or child safeguarding lead and gather evidence to support referral to CSC. Gathering evidence may involve liaising with other agency staff. Referral can be made by any agency staff and is not solely the responsibility of Health. Health Staff must also discuss with the Named Doctor/Named GP/Named Nurse for Safeguarding Children, as relevant. The concerns should not be discussed with parents/cares.

**Stage 2**
Referral to i-Art/ChECS with supporting evidence, including chronology (if available); i-Art/ChECS gathers/reviews the information and may contact the referrer and/or other agencies for additional information. i-Art/ChECS will aim to make a decision WITHIN 24 HOURS. A preliminary multi-agency strategy discussion may be required.

**Stage 3**
If there is sufficient information to suggest FII, the case will be referred to the CiN/CP team. At this stage CHRONOLOGIES WILL BE REQUESTED (Appendix A) by the allocated Social Worker. The GP, other Health Professionals (e.g. The Named Doctor/GP/Nurse for safeguarding children, Health Visitor, School Nurse, Mental Health etc) Education and other relevant organisations involved with the family must be contacted for information.

**Stage 4**
The CiN team will convene a multi-professional meeting chaired by a Service Manager. All agencies should attend this meeting with completed chronologies. The Designated Doctor for Safeguarding Children must be invited for this meeting. The Meeting will review all the chronologies and decide if there are significant concerns.

**Stage 5a**
No evidence of significant harm – consideration should be given at this stage for other interventions. E.g. Early Help/CiN (Consent is required for these interventions)

**Stage 5b**
Evidence of significant harm or risk of significant harm – Strategy meeting to be convened.

All the above can be undertaken without the parents’/carers knowledge or consent