Cheshire West and Chester
Safeguarding Children
Partnership

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

St Helens
Safeguarding Children
Partnership

POLICY INFORMATION SHEET	
Date effective from	September 2021
Policy Owner	All Safeguarding Children Partnerships within Pan Cheshire and Merseyside
Date of Review	August 2024
Status • **Mandatory (all staff named must adhere to guidance unless for valid reasons)** • **Optional (Procedures and practice can vary between teams)**	Mandatory
Target Audience	Staff from all partner agencies including Health, Children's Social Care, Police and Education, covered by Cheshire East, Cheshire West & Chester, Warrington, Halton, Liverpool, St. Helens, Knowsley, Sefton, Wirral Safeguarding Children Partnerships
Date of Ratification	September 2021
Related Document (s)	

CONTENTS

	Glossary	4
1.	Introduction	5
2.	Alerting Signs	6
3.	Involvement by Child	7
4.	Managing concerns of True FII / PP	7
5.	Action in cases of suspected True FII / PP	8
6.	Role of Children's Social Care	11
7.	Role of Police	12
8.	Allegations against staff	13
9.	Pre-Birth Planning	13
10.	Conflict	13
11.	Record Keeping and Information Sharing	13
12.	References	14

Appendices

Appendix A – Summary Diagram	15
Appendix B – Chronology Template	16
Appendix C - Multi-agency guidelines for concerns of Fabricated or Induced Illness or Perplexing Presentations likely to cause harm to the child i.e parents/carers not supportive or compliant with Health and Education Rehabilitation Plan	23

Glossary

PP – Perplexing Presentation

FII – Fabricated or Induced Illness

CSC – Children's Social Care

EHRP – Education and Health Rehabilitation Plan

CVS – Covert Video Surveillance

LADO – Local Authority Designated Officer

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; Eg. 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 the wider context including any secondary gains for the carers Eg. to retain or qualify for financial gains such as Disability Living Allowance etc. However, more often than not, parental behaviour may be motivated by misplaced anxieties and erroneous beliefs based on parent's own experiences of illness and health.

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" (PP)** or **"Medically Unexplained Symptoms" (MUS)** 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 may need to be considered within the spectrum of FII, as the impact on the child can be significant and can lead to iatrogenic harm, a disordered perception of health and illness in the child, interfere with the child's education and cause harm to their emotional and psychological wellbeing.

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

present whilst at the same time avoiding unwarranted investigations or interventions driven by exaggerated reporting of symptoms.

1.9 In **Medically Unexplained Symptoms (MUS)**, a child's symptoms, of which the child complains and which are presumed to be genuinely experienced, are not fully explained by any known pathology. The symptoms are likely based on underlying factors in the child (usually of a psychosocial nature) and this is acknowledged by both clinicians and parents. MUS can also be described as 'functional disorders' and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body. The health professionals and parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child or young person. Experienced clinicians report that, on occasion, MUS may also include PP or FII.

1.10 The term **Perplexing Presentations (PP)** is used to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. 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 behaviour.

1.11 **Fabricated or Induced Illness (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 and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident. It is important to distinguish the relationship between FII and physical abuse / non-accidental injury (NAI). In practice, illness induction is a form of physical abuse (and in Working Together to Safeguard Children, fabrication of symptoms or deliberate induction of illness in a child is included under Physical Abuse17). In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not there are recurrent presentations to health and other professionals. This particularly applies in cases of suffocation or poisoning.

1.12 When working with children and their families where there are perplexing illnesses or concerns about fabricated or induced illness, professionals should explicitly explore whether the child is currently experiencing, or has previously experienced, **adverse childhood experiences (ACEs)** such as physical, sexual or emotional abuse, neglect, domestic abuse, child sexual or criminal exploitation, bereavement, parental/caregiver alcohol or drug misuse, severe parental mental health issues, or a parent going to prison. Adverse Childhood Experiences such as these can have a detrimental impact on the physical, mental and emotional wellbeing of a child. Professionals should also be mindful that parents and care givers may themselves have experienced adverse childhood experiences.

2. Alerting Signs

2.1 Although not exhaustive, below is a list of indicators of Perplexing Presentation or possible Fabricated or Induced Illness, that could serve as alerting signs for practitioners.

- 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 be biologically implausible (Eg. 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 Eg. teachers, nursery staff, social workers may be alerted to concerns of FII/PP, 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.

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

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

4 Managing Concerns of True FII / PP

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 Any alerting signs should be discussed with the relevant Named Child Safeguarding leads

4.3 It is important to establish facts in order to reduce uncertainty. This could be facilitated by completing a Chronology, using the template in Appendix B, by all lead professionals involved in the care of the child Eg. GP, Consultant Paediatrician, Social Worker, Staff in education etc.

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

4.4.1 Maintain focus on safeguarding and promoting welfare of the child at all times;

4.4.2 Complete a Chronology using the standard template (Appendix B), 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;

4.4.3 Cross reference the chronologies for different children in the family as illness behaviour can switch between different children in the family;

4.4.4 List inconsistencies and clarify the same by seeking more information from family members and other professionals involved

4.4.5 Continue to observe child and family for any emerging patterns

4.4.6 Keep detailed records and be specific around the evidence base and source of information Eg. Direct observation, Informed opinion, Hearsay etc.

4.4.7 Test alternative explanations by discussing with a senior colleague or expert; Complete medical tests and/or social care assessments;

4.4.8 Health professionals should always ensure there is a lead health professional identified, ideally a consultant paediatrician who is responsible for co-ordinating health investigations and management plans. All cases ought to be discussed with their relevant Named Doctor for Safeguarding Children; Any professional disagreements ought to be escalated to the Designated Doctor for Safeguarding Children;

4.4.9 Continuously reassess the situation in the light of any new information;

4.4.10 In the vast majority of cases, Perplexing Presentations in particular, it is advisable to discuss concerns with the parents/carers, after discussion with child safeguarding leads. It is important to agree and document by all agencies, what is or is not appropriate to be discussed with the parents/carers, ensuring every attempt is made to be as open and transparent as possible. It is also important to agree, who is going to lead the discussion with parents and when, dependent on circumstances. In summary, all material information should be shared with the parents and/or those with legal parental responsibility UNLESS there is a reasonable belief that to do so would pose a risk of harm to the child.

4.4.11 It is usually not appropriate to share concerns of true FII with parents during the early stages of investigation that may increase the risk of harm to the child, but plans need to be agreed between the lead paediatrician, Police if relevant and Children's Social Care regarding the appropriate response to managing concerns in order to protect the child.

4.4.12 Evaluate alternatives; As Sherlock Holmes said "Exclude the impossible and the solution lies in what remains, however unlikely";

4.4.13 Refer to national and local guidance and seek legal assistance where relevant;

5 Action in cases of suspected True FII / PP

5.1 Child at risk of significant harm or is suffering harm i.e. True Fabricated or Induced Illness or Perplexing Presentations where parents do not support Education and Health Rehabilitation plan (cf. section 5.2.10 to 5.2.13 below)

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 Eg. acute suffocation, poisoning etc. so statutory safeguarding proceedings may be initiated.

5.1.2 Secure any potential evidence Eg. 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.

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

5.1.5 Very urgent protection of the child is best obtained by contacting the police who can then use their police protection powers, as it will take children's social care a number of hours to obtain an Emergency Protection Order. However, children's social care should be contacted at the same time as the police. If the Named Doctor or responsible paediatric consultant are of the opinion that the threshold for likely or actual significant harm is possibly met (as per the criteria under section 47 of the Children Act 1989) either as a matter of urgency or in a planned manner, they must make a referral using appropriate local pathways.

5.1.6 Once child's safety has been ensured, steps outlined below from 6.2 onwards must be followed.

5.1.7 In cases where the risk of harm to the child or the diagnosis is not clear cut, steps outlined below from 5.2.6 onwards need to be followed. Also, refer to Appendix A.

5.2 No immediate risk of harm i.e. Perplexing Presentation

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

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

5.2.3 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.

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

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

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

5.2.7 There may need to be one or more professionals' meetings to gather information, and these can be virtual meetings, chaired by the Named Professional for Safeguarding Children, ideally the Named Doctor for Safeguarding Children. If the

Named Doctor is directly involved in the care of the child, another clinician experienced in child safeguarding must chair the meeting to maintain objectivity and preserve doctor-patient relationship. Consensus about the child's state of health needs to be reached between all health professionals involved with the child and family, including GPs, Consultants, private doctors and other significant professionals who have observations about the child, including education and children's social care, if they have already been involved. Where possible, families should be informed about these meetings and the outcome of discussions, 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, in a proportionate manner as long as it does not compromise child's safety.

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

Either

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

Or

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

And agree all of the following

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

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

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

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

5.2.12 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 Children's Social Care. 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.

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

6. Role of Children's Social Care (CSC)

6.1 In cases of true FII, the child may be at immediate risk of significant harm. If parents do not co-operate with Health and Education Rehabilitation Plan in cases of PP, it may amount to medical Neglect and put the child at risk of harm. In both of the above situations, urgent referral to CSC is required to safeguard the child. Any agency professional may refer to CSC. Although in practise it may be the lead health professional who often completes the referral, it still remains a collective decision to refer by all at the professionals' meeting.

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

6.3 CSC will co-ordinate collection of detailed Chronologies on the standard template (Appendix B) 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.

6.4 All chronologies to be submitted to CSC within 3 weeks of the request. The responsibility for completing the chronology rests with individual frontline professionals but Line Managers / Named Child Safeguarding Leads within relevant organisations should provide support and supervision to frontline staff completing chronologies and assist with the analysis of the chronologies.

6.5 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.

6.6 The multiagency professionals meeting must be chaired by a suitably qualified senior manager in CSC. This should generally be the Service Manager or above.

6.7 The following professionals must be invited

- 6.7.1 The referrer, if a professional
- 6.7.2 Consultant Paediatrician of the child, 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, any private practitioners involved, Medical professional with relevant expertise in the relevant illness Eg. Tertiary centre specialist;
- 6.7.3 Staff in Education / Early Years setting
- 6.7.4 Police
- 6.7.5 Any other relevant professional involved with the family Eg. Mental Health staff etc.
- 6.7.6 Local Authority Legal adviser

6.8 Issues to be addressed at the meeting include

- 6.8.1 Whether it is true FII or a case of Perplexing Presentation likely to cause harm to the child
- 6.8.2 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
- 6.8.3 Confirmation of a lead consultant paediatrician
- 6.8.4 What information is to be shared with the family, when and by whom
- 6.8.5 How to ensure security of child's records to ensure child's welfare
- 6.8.6 Whether the child requires a period of admission in hospital for observation
- 6.8.7 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
- 6.8.8 Any particular factors, such as the child and family's race, ethnicity, language, cultural background and beliefs which should be taken into account
- 6.8.9 Needs of any siblings or other children who the perpetrator may come into contact
- 6.8.10 Needs of the parent/carer
- 6.8.11 Any Police investigations required including forensic analysis of any samples, Covert Video Surveillance (CVS) etc.
- 6.8.12 What information is going to be shared with the family, when and by whom

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

- 6.9.1 Concerns not substantiated and no evidence of FII / Perplexing presentations

- 6.9.2 Concerns substantiated and decision to progress to Strategy Meeting

- 6.9.3 Concerns not sufficiently substantiated and needs ongoing monitoring

6.10 Proceedings of the meeting should be recorded and the minutes circulated to all relevant professionals

6.11 Consideration should be given towards other interventions such as Early Help / Child in Need interventions even if concerns not sufficiently substantiated.

6.12 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. Role of 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 the responsibility of the Police to lead on this by applying for appropriate approvals under the Regulation of Investigatory Powers Act (RIPA) 2000. Use of CVS is not to be taken lightly and can only be decided at a multiagency meeting, and requires due procedures under RIPA to be followed.
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

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

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

10. Conflict

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

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 by their managers and child safeguarding teams.

11. Record Keeping and Information Sharing

11.1 The ownership for documents submitted by staff to any multiagency meetings rests with the individual staff member and their relevant employing authority.

11.2 Parents may apply for access to documents including Chronology, Analysis Reports, Minutes of meetings etc. through normal channels. In such cases, standard procedures for sharing of documents with parents/carers apply.

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

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

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

11.6 It is generally advisable, especially in true cases of FII, to set up relevant child safeguarding alerts in the child's records within all agencies including primary, secondary and tertiary care providers in Health. It is also important to share concerns with child safeguarding leads in neighbouring secondary/tertiary health care providers, so appropriate alerts could be set up in the relevant hospitals' patient record systems, in case parents/carers go doctor shopping. This is to forewarn health colleagues in these hospitals, so any concern reported by parents/carers is treated with "respectful disbelief" to avoid unnecessary escalation of medical investigations/treatment in the child. In these situations, it is equally important to communicate any true illnesses in the child too, so health professionals in other provider centres do not mistakenly ignore genuine symptoms as FII, that in itself may result in harm to the child.

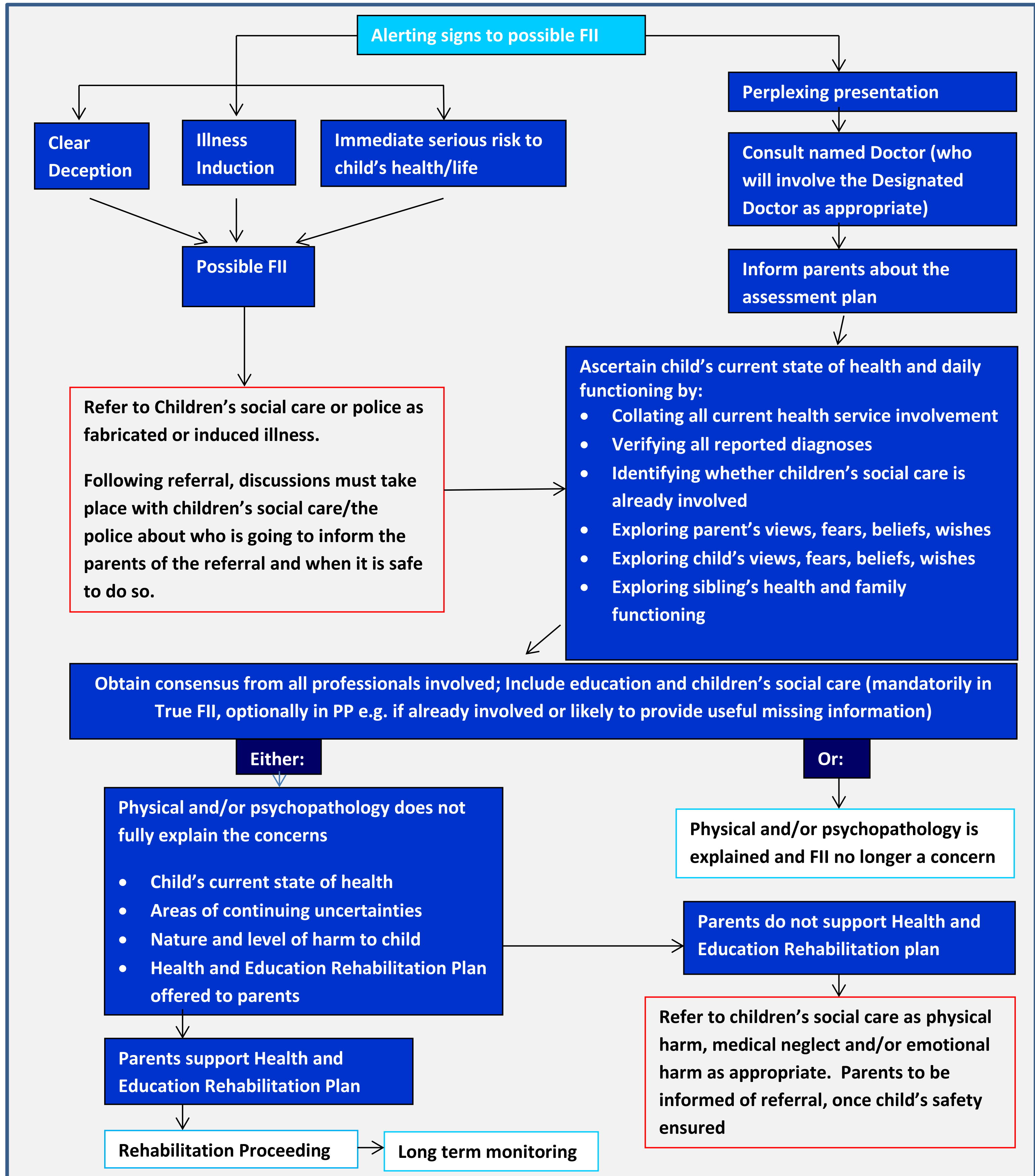
References

1. Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH Guidance 2021
2. Child protection Companion 2013 – Royal College of Paediatrics and Child Health;
3. Safeguarding Children in whom illness is fabricated or induced – Department for Children Schools and Families, HM Government 2008;

Appendix A **Summary Diagram**

(adapted from 2021 RCPCH Guidance)

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



Appendix B

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)

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

The Template Categories Explained

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

Category	Warning signs of Fabricated or Induced Illness
1.	**Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering.** Here the doctor is attempting to put all of the information together to make a diagnosis but the symptoms and signs do not correlate with any recognised disease or where there is a disease known to be present. A very simple example would be a skin rash, which did not correlate with any known skin disease and had, in fact, been produced by the perpetrator. An experienced doctor should be on their guard if something described is outside their previous experience, i.e. the symptoms and signs do not correlate with any recognisable disease or with a disease known to be present.
2.	**Physical examination and results of medical investigations do not explain reported symptoms and signs.** Physical examination and appropriate investigations do not confirm the reported clinical story. For example, it is reported a child turns yellow (has jaundice) but no jaundice is confirmed when the child is examined and a test for jaundice, if appropriate, is negative. A child with frequent convulsions every day, has no abnormalities on a 24-hour 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. This can result in escalating drugs with no apparent response, using multiple medications to control a routine problem and multiple changes in medication due to either poor response or frequent reports of side effects. On investigation, toxic drug levels commonly occur but may be interspersed with low drug levels suggesting extremely variable administration of medication fluctuating from over- medication to withdrawal of medication. Another feature may be the welcoming of intrusive investigations and treatments by the parent.
4.	**New symptoms are reported on resolution of previous ones.** New symptoms often bear no likely relationship to the previous set of symptoms. For example, in a child where the focus has been on diarrhoea and vomiting, when appropriate assessments fail to confirm this, the story changes to one of convulsions. Sometimes this is manifest by the parents transferring consultation behaviour to another child in the family.
5.	**Reported symptoms and found signs are not seen to begin in the absence of the carer**, i.e. the perpetrator is the only witness of the signs and symptoms. For example, reported symptoms and signs are not observed at school or during admission to hospital. This should particularly raise anxiety of FII where the severity and/or frequency of symptoms reported is such that the lack of

	independent observation is remarkable. Caution should be exercised when accepting statements from non-medically qualified people that symptoms have been observed. In the case under review there was evidence that the school described episodes as 'fits' because they were told that was the appropriate description of the behaviour they were seeing.
6.	**The child's normal, daily life activities are being curtailed beyond that which might be expected for any medical disorder from which the child is known to suffer.** The carer limits the child's activities to an unreasonable degree and often either without knowledge of medical professionals or against their advice. For example, confining a child to a wheelchair when there is no reason for this, insisting on restrictions of physical activity when not necessary, adherence to extremely strict diets when there is no medical reason for this, restricting child's school attendance.
7	**Over time the child is repeatedly presented with a range of signs and symptoms.** At its most extreme this has been referred to as 'doctor shopping'. The extent and extraordinary nature of the additional consultations is orders of magnitude greater than any concerned parent would explore. Often consultations about the same or different problems are concealed in different medical facilities. Thus the patient might be being investigated in one hospital with one set of problems and the parent will initiate assessments elsewhere for a completely different set of problems (or even the same) without informing these various medical professionals about the other consultations.
8.	**History of unexplained illnesses or deaths or multiple surgery in parents or siblings of the family.** The emphasis here is on the **unexplained**. Illness and deaths in parents or siblings can frequently be a clue to further investigation and hence a diagnosis in naturally occurring illness. In FII abuse, perpetrators frequently have had multiple unexplained medical problems themselves, ranging from frequent consultations with the general practitioner through to the extreme of Munchausen syndrome where there are multiple presentations with fabricated or induced illness resulting in multiple (unnecessary) operations. Self-harm, often multiple, and eating disorders are further common features in perpetrators. Additionally, other children either concurrently or sequentially might have been subject to FII abuse and their medical history should also be examined.
9.	**Once the perpetrator's access to the child is restricted, signs and symptoms fade and eventually disappear (similar to category 5 above)**. This is a planned separation of perpetrator and child which it has been agreed will have a high likelihood of proving (or disproving) FII abuse. It can be difficult in practice, and appear heartless, to separate perpetrator and child. The perpetrator frequently insists on remaining at the child's bedside, is unusually close to the medical team and thrives in a hospital environment.
10.	**Exaggerated catastrophes or fabricated bereavements and other extended family problems are reported**. This is an extension of category 8. On exploring

	reported illnesses or deaths in other family members (often very dramatic stories) no evidence is found to confirm these stories. They were largely or wholly fictitious.
11.	**Incongruity between the seriousness of the story and the actions of the parents.** Given a concerning story, parents by and large will cooperate with medical efforts to resolve the problem. They will attend outpatients, attend for investigations and bring the child for review urgently when requested. Perpetrators of FII abuse, apparently paradoxically, can be extremely creative at avoiding contacts which would resolve the problem. There is incongruity between their expressed concerns and the actions they take. They repeatedly fail to attend for crucial investigations. They go to hospitals that do not have the background information. They repeatedly produce the flimsiest of excuses for failing to attend for crucial assessments (somebody else's birthday, thought the hospital was closed, went to outpatients at one o'clock in the morning, etc). We have used a term, 'piloting care', for this behaviour.
12.	**Erroneous or misleading information provided by parent.** These perpetrators are adept at spinning a web of misinformation which perpetuates and amplifies the illness story, increases access to interventions in the widest sense (more treatment, more investigations, more restrictions on the child or help, etc). An extreme example of this is spreading the idea that the child is going to die when in fact no-one in the medical profession has ever suggested this. Changing or inconsistent stories should be recognised and challenged.
0	This is included to encourage a thorough review of contacts into concerning and non-concerning ones to give a balanced view.

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

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

Appendix C - Multi-agency guidelines for concerns of Fabricated or Induced Illness or Perplexing Presentations likely to cause harm to the child i.e parents/carers not supportive or compliant with Health and Education Rehabilitation Plan

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 first Eg. Education may liaise with Health in the first instance. Referral can be made by any agency staff and is not solely the responsibility of Health, once concerns substantiated. Health Staff must discuss with Named Doctor/Named GP/Named Nurse for Safeguarding Children, as relevant. The concerns should not be discussed with parents/cares, but only if discussing is likely to compromise safety of child, especially in the early stages.

Referral to CSC with supporting evidence, including chronology (if available); CSC gathers/reviews the information and may contact the referrer and/or other agencies for additional information. CSC should make a decision within 24 hours. If child at imminent risk of harm, child's safety must be ensured first. A preliminary multi-agency meeting may be required.

If there is sufficient information to suggest FII/PP that puts child at risk of harm, the case must be allocated to the CiN/CP team. At this stage, chronologies (Appendix B) will be requested by the allocated Social Worker, (unless already received) for submission within 3 weeks and a date set for multiagency meeting in 4 weeks. The GP, other Health Professionals (e.g The Named Doctor/Named GP/Named Nurse for safeguarding children, Health Visitor, School Nurse, Mental Health etc), staff in Education and other relevant organisations involved with the family including private providers must be contacted for chronologies, to be completed in the standard template (Appendix B) and submitted within 3 weeks of request.

Following receipt of chronologies, CSC will convene a multiagency professionals 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.

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)

Evidence of significant harm or risk of significant harm – Section 47 enquiry to be commenced.