LRI Emergency Department and Children's Hospital

Safeguarding Children Guideline: Guideline for dealing with perplexing presentations / fabricated or induced illness

Staff relevant to:	Medical and Nursing staff working within UHL Children's Hospital
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Contents

1. Introduction and Who Guideline applies to

Fabricated or Induced Illness (FII) is a complex issue which can be difficult to identify. National guidance has introduced new terms to capture the complexity of presentations which usefully assist practitioner responses. It has introduced the terms Medically Unexplained Symptoms (MUS) and Perplexing Presentations (PP), alongside FII. This guideline incorporates new guidance from the RCPCH on perplexing presentations and FII and is intended for use by all Paediatric staff within UHL NHS Trust.

What is covered in this guidance?

- Updated terminology and definitions for Perplexing Presentations (PP), Fabricated or induced illness (FII) and Medically Unexplained Symptoms.
- Features of PP and FII including the relationships between parent, doctor and child, and alerting signs of possible FII
- Response to alerting signs of FII
- Developing and implementing a Health and Education Rehabilitation Plan
- When to refer to children's social care and how to escalate concerns

Related documents;

Safeguarding Children UHL Policy

Safeguarding Children 20 - Use of Covert Video Surveillance UHL Guideline

Flow chart showing overview of management of medically unexplained symptoms, perplexing presentations and fabricated or induced illness

Concern re perplexing presentation / suspected FII

Immediate concerns re child's health?

Yes

Refer to Children's Social Care as physical harm, neglect and/or emotional harm, as appropriate.

Refer to child protection team 15770.

Request Strategy Discussion.

Children's Social Care should decide, within one working day, what response is necessary.

Professionals will agree who is going to inform the parents of the referral and when it is safe to do so.

A chronology may be required led by the 'responsible consultant' with support from Named Safeguarding Doctor.

No

Consultant discusses with Named Doctor

'Responsible consultant' informs parents and leads a **Health Professionals Meeting**, including a review of health records and confirmation of diagnosis.

The Health Professionals Meeting is to agree:

- The child's state of health
- Whether there are any Perplexing Presentations requiring a Health and Education Rehabilitation Plan.
- Whether Perplexing Presentations and parental behaviour could be alerting signs to FII and therefore the requirement to refer to Children's Social Care.

Immediate Concerns

- Suspicions of FII (e.g. illness induction and clear deception)

Refer immediately to social care and raise concerns

Alerting signs to FII

- Refer to Children's Social Care
- Commence **Health and Education Rehabilitation Plan**

Perplexing Presentation

Commence **Health and Education Rehabilitation Plan**

Medically Unexplained Symptoms

Parents and professionals working together.

No Further Safeguarding Action. The outcome reported back to agency that raised initial concerns.

The Health and Education Rehabilitation Plan HERP Meeting(s)

Parents are informed about and invited to the meetings

It should be noted that information given to professionals by parents and carers outside of the Health and Education Rehabilitation Plan needs to be clarified with other Health agencies.

The HERP meeting(s) will define:

- The child's current state of health
- Areas of continuing uncertainty
- The nature and level of harm to the child
- Whether to refer to Children's Social Care

The meeting(s) will agree (at any point):

- Date of next review meeting
- The requirement for Specialist Psychological Therapy
- Whether to commence a chronology

Parents do not support the Health and Education Rehabilitation Plan

Refer to Children's Social Care. This is on the basis that the child's functioning and/or development is being avoidably impaired by the parent's behaviour

Parents to be informed of referral

Parents support and adhere to the Health and Education Rehabilitation Plan

Long-term monitoring agreed.

If the parents fail to adhere to the plan, refer to Children's Social Care. This is on the basis that the child's functioning and/or development is being avoidably impaired by the parent's behaviour

Parents to be informed of referral

2. Background

'The common starting point for concern about Fabricated or Induced Illness (FII) is that the child's clinical presentation is not adequately explained by any confirmed genuine illness, and the situation is impacting upon the child's health or social wellbeing' (RCPCH). In FII, the child suffers harm through the misleading, erroneous or deceptive report or action of a parent/carer, so that the child is presented as ill when they are not ill, or more ill than is actually the case. 'Perplexing presentation' has been introduced 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.

In FII parents have an underlying need for their child to be recognised and treated as ill, or more unwell / more disabled than the child actually is (when the child has a verified disorder, as many of the children do). This need is thought to arise from: 1) parental gain (e.g. from sympathetic attention or material gain); 2) parental erroneous beliefs (e.g. mistaken beliefs about their child's needs or health). Either way, the child comes to harm.
This guideline covers both fabricated or induced illness, and also perplexing presentations where FII may be one of the differential diagnoses. Other differential diagnoses for perplexing presentations include: a true medical cause; parental over anxiety or inexperience; mental illness in parent affecting their perception of child's symptoms. FII overlaps with emotional and physical abuse.

3. Definition of Fabricated or induced illness, Perplexing Presentations and Medically unexplained symptoms

FII (fabricated or induced illness)

- FII is 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 docto FII is 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 abuse, physical abuse and neglect including iatrogenic harm.

Perplexing Presentations (PP)

- Presence of alerting signs of FII 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.

Medically unexplained symptoms

- 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.
- 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.

4. When to consider FII?

FII should be considered if a child is being presented as ill when they are not, or as more ill than is the case, because of the parent or carer's reports or actions (usually the mothers). Often there is discrepancy between parental accounts of illness and observations of professionals, and puzzlement within the health team.
FII is not a diagnosis of exclusion, it should be considered when alerting signs for FII are present (**Table 2 Alerting signs to possible FII**) although note that some of these may occur in genuine medical presentations.

"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". RCPCH 2021

4.1 Why is it important to recognise and respond to FII?

It is important to recognise and respond appropriately to FII because children are harmed and sometimes killed by it. The child can be harmed directly both physically and emotionally (through illness induction and taking on a sick role) and indirectly due to the medical response (where the child suffers unnecessary examinations, investigations, procedures, and treatments). This results in:

- Unnecessary painful, harmful investigations / procedures;
- Unnecessary admissions leading to missed school
- Morbidity/Death;
- Chronic invalidism;
- Actual disease;
- Significant psychological damage;
- FII behaviour as an adult.

Harm to the child can be summarized under the following three areas: health and experience of healthcare; development and daily life; psychological health and wellbeing (see table 3 How perplexing presentations / FII can cause harm).

It is important to distinguish the relationship between FII and physical abuse / non-accidental injury (NAI). 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 Abuse). For 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 there are recurrent presentations to health and other professionals. This particularly applies in cases of suffocation or poisoning.

Table 2: Alerting signs to possible FII

Child

- Reported physical, psychological or behavioural symptoms and signs not observed independently in their reported context by any professional.
- 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**.

Parent / carer

- 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.
  - Results of examination and investigations have already not explained the reported symptoms or signs.
- 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 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), or 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.

Table 3: How perplexing presentations / fabricated or induced illness can cause harm

Child's health and experience of healthcare

• Child undergoes repeated (unnecessary) medical appointments, examinations, investigations, procedures and treatments. These may be experienced as physically and psychologically uncomfortable or distressing.

•Genuine illness may be overlooked due to repeated presentations.

•Illness may be induced by the carer (e.g., poisoning, suffocation, withholding food or medication and potentially threatening the child's health or life).

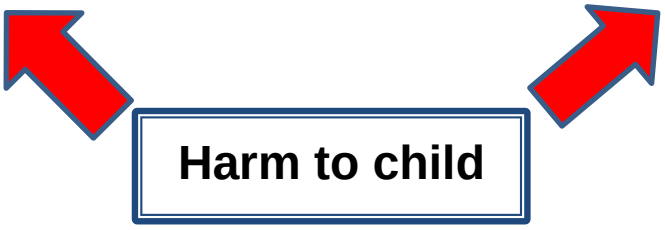
Child's development and daily life

•The child's education is limited or interrupted.

•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.



Harm to the child from FII/ PP takes several forms:

- Direct harm by parent (intentionally or unintentionally), but may be supported by the doctor.
- Harm caused by doctor's actions, the harm being caused inadvertently.
- As **FII is not a category of maltreatment in itself**, these forms of harm may be expressed as **emotional abuse**, **medical or other neglect, or physical abuse**.

Child's psychological and health-related wellbeing

•The child may be confused or anxious about their state of health.

•The child may develop a false self-view of being sick and vulnerable. Adolescents may embrace this and may then become the main driver of the behaviour. Social media may encourage this.

•There may be active collusion with the carer's behaviour.

•The child may be silently trapped in the falsification.

•The child may later develop a psychiatric disorder or psychosocial difficulties.

5. Overall approach to Perplexing Presentations / FII

Children who are suspected to have illness fabricated or induced require coordinated help from a range of agencies.

For Perplexing Presentations, a key step is to ascertain the child's current state of health and daily functioning, define areas of continuing uncertainty, and the nature and level of any harm to child.

Consultation with peers or colleagues in other agencies is an important part of the process of making sense of the underlying reasons for these signs and symptoms.

The characteristics of fabricated or induced illness are that:

- There is a lack of the usual corroboration of findings with signs or symptoms.
- In circumstances of diagnosed illness, lack of the usual response to effective treatment.

It is this puzzling discrepancy which alerts the medical staff to possible harm being caused to the child.

5.1 Medical Evaluation

Where there are concerns about possible FII, the signs and symptoms require careful medical evaluation for a range of possible diagnoses. Agree a lead clinician to do this. Referral to a specialist paediatrician may be needed for review of specific symptoms.

If several consultant paediatricians are involved, the lead consultant should usually be the person most involved in the area where FII concerns are manifesting. If there is difficulty identifying a lead clinician, this should be discussed with the Named Doctor who will advise who should take on this role.

In general the following should be considered:

- Professional consensus about child's current state of health and daily functioning, areas of continuing uncertainty, nature and level of harm to child;
- Collation of all health service involvement;
- Verify all reported diagnoses, with (if necessary) paediatric opinion on specific symptoms;
- Explore parents' and child's views, fears, beliefs, wishes;
- Explore siblings' health and family functioning;
- Chronology;
- Preserve evidence (if relevant);
- Clear report from all;
- Multi-Agency meeting - may include social care;
- Consider early help / support / clear guidance to parents;
- Clear Health and Education Rehabilitation Plan agreed with parents;
- Review outcome of plan;
- Discussion with named / designated doctors;
- Discussion with or referral to social care;
- If admission needed, requires careful planning.

Where, following any investigations (if needed), a reason cannot be found for the reported or observed signs and symptoms of illness, further specialist advice may be required.

Parents should be kept informed of further medical assessments / investigations/tests required and of the findings. Normally the consultant paediatrician will tell the parent(s) that they do not have an explanation for the signs and symptoms and record the parental response.

Concerns about the reasons for the child's signs and symptoms should not be shared with parents if this would jeopardise the child's safety and compromise the child protection process and/or any criminal investigation. See **Working Together to Safeguard Children.**

A diagnosis of FII may take a considerable amount of time, including collation of information, formulating a plan and communicating that to the parents, and then implementing the plan and monitoring progress.

5.2 Chronologies

The purpose is to build a clear picture of all potentially relevant events in the child's life, with analysis, to help make a judgement on the nature and level of risk to the child. Chronologies can be time consuming to compile, and this process, although still very important, should not delay assessment of current functioning and decisions about management. Service managers should ensure that the lead clinician has sufficient time to compile the chronology.

Key Points

- Use Appendix 1: FII Chronology Template;
- Summarise key information – don't just replicate the child's health record;
- Pay particular attention to the specific concerns that have been raised about the child;
- Clearly state what has been said, by whom and to whom;
- Record what has been reported or observed and whether this was observed by professionals;
- Record the source of information e.g. 'History taken from Mother';
- Write in a way that can be understood by colleagues from other non-medical or professional backgrounds.
- Where appropriate, condense a large amount of information into short summary sentence. e.g. 'Jack was on the ward between 1 June and 4 June there are no recorded incidents of vomiting.'
- The comments section of the chronology can be used to highlight where there are particular 'warning signs' as identified in Table 2 - Alerting signs to possible FII.
- Add comments to entries as relevant e.g. "mother presented him with vomiting - no vomiting seen".
- Chronologies should go back as far as possible. It is important where possible to confirm or refute specific information e.g. where a child is said to have been given a specific diagnosis, evidence of that diagnosis should be sought. Where evidence is not found, the chronology should show that evidence has not been located.

5.3 Preserving evidence

- Keep any substances / equipment / clothes that might constitute evidence for a later police investigation.
- Ideally these should be locked away by two professionals working together to preserve chain of evidence or given to police.

5.4 Keep thorough records

- Events should be documented in detail including professional details of all staff involved.
- Where concerns regarding FII document 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.

6. Management of medically unexplained symptoms, perplexing presentations and fabricated or induced illness if Immediate risk of harm

Follow this pathway if risk of serious harm, or evidence of illness induction or deception:

- Presentation is a life threatening symptom e.g. turning blue, fits;
- Evidence of deception;
- Evidence of physical actions by carers to produce an illness picture (interfering with reports, specimens, investigations, withholding medications or food, poisoning).
- Concerns that an open discussion with the parent might lead them to harm the child.

Examples where immediate risk of harm

- Inducing symptoms e.g. a rash through application of chemical to the skin; smothering until loss of consciousness; poisoning e.g. through giving excessive salt by mouth or nasogastric tube; injecting insulin;
- Fabricating or tampering with investigation processes to produce abnormal results e.g. false data on charts; warming thermometers; adding blood to urine;
- Interfering with treatment processes and equipment: e.g. withholding or substituting medication; infecting intravenous lines; turning oxygen down or off; tampering with ventilation equipment.

6.1 Immediate Action if immediate risk of harm

Ensure Safety

- If there is immediate or potential serious threat to the child take urgent steps to secure the child's safety and prevent further harm;
- If not already an in-patient, consider immediate admission via ambulance (not allowing carers to bring child in alone).
- If inpatient, move child into bay so that child can be closely monitored.

Escalate and Refer

- Escalate to the most senior medical and nursing staff on site, call police immediately and secure any evidence (e.g. feed bottles, giving sets, nappies, blood/urine/vomit samples, clothing or bedding if they have suspicious material on them). Inform the consultant;
- Make urgent referral to social Care (remember city / county), who should make a rapid decision and respond immediately. The safety of siblings needs to be considered.

- Refer to the police. Urgent protection of the child is best obtained by contacting the Police who can consider the use of their Police protection powers, as it will take Children's Social Care a number of hours to obtain an Emergency Protection Order.

Urgent strategy meeting

- Usually an urgent strategy meeting will be arranged which must include the paediatrician with primary responsibility for the case.

Seek safeguarding advice

- Advice should be taken at the earliest opportunity from the Named doctor for children's safeguarding, and the safeguarding team, phone 15770.

Review Management

- Review medical management plans in the light of the new information. Some planned investigations, procedures or treatments may now be inappropriate;
- This may include stopping administration of a harmful substance or inappropriate treatment, replacing equipment, or taking specimens for toxicology.

Preserve evidence

- Keep any substances or equipment or clothes that might constitute evidence for a later police investigation in secure storage (such as a controlled drugs cabinet / lines / bedding);
- Ideally these should be locked away by two professionals working together to preserve chain of evidence or given to police.

Keep thorough records

- Events should be documented in detail, along with professional details of all staff involved. Document 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.

Don't confront parents.

- Confronting parents with concern about FII is best avoided at this point. It may sometimes increase risk to the child, or compromise any criminal or safeguarding process. Discussions must take place with children's social care/police about who is going to inform the parents and when it is safe to do so. This should be agreed at the strategy meeting.

7. Alerting signs of FII / perplexing presentation pathways - child not deemed at immediate risk.

This pathway should be followed where the child has presented in a perplexing or unusual way and the possibility of fabricated or induced illness is being considered, but the risk of harm to the child is deemed to be low.

The key is to quickly establish the child's actual current state of physical and psychological health and functioning, and the family context. The parents are told about the current uncertainty regarding their 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 if already involved with the family, as well as professionals meetings.

An early decision should be made about whether the child is at immediate risk, and if so, the Immediate risk of harm pathway would be more appropriate, this should be kept under review throughout.

- This Pathway is slower paced and may take weeks or months: the urgency and timescale is proportionate to the degree of risk and likelihood of FII;
- Regularly consider whether any of the spectrum of presentations outlined in Table 2 may apply.

7.1 Actions to be taken if alerting signs of FII / perplexing presentation but child not deemed at immediate risk.

Identify lead clinician for the child

- Identify which clinician will take a lead for the health aspects of the process. For inpatients, this will be the lead consultant managing the patient. They will be the main channel of communication with the parents and lead in decisions about further investigation;
- If the lead clinician is also the Named Doctor, then another clinician will need to undertake this consultative role, possibly the Designated Doctor. This means that safeguarding decisions can be made objectively, free from duress, threats and complaints and the responsible clinician has appropriate support in these challenging cases.

Get Safeguarding advice

- Advice should be taken at the earliest opportunity from the Named doctor for children's safeguarding, and the safeguarding team, phone 15770.

Establish child's current status

The lead clinician should review the situation and establish the child's current status with regard to:

- **Child's health and wellbeing.**
    - Collate all current medical/health involvement, request for clarification of what has been reported and what observed. (not usually a request for a full chronology)
    - Ascertain who has given reported diagnoses and the basis on which they have been made,
        - E.g. whether based on parental reports or on professional observations and investigations.

- Consider inpatient admission for direct observation of the child.
- 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).

- **Parents' views**
  - Obtain history and observations from all caregivers, including mothers and fathers; and others if acting as significant caregivers;
  - 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.
- **Child's view (if appropriate developmental level and age)**
  - 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;
  - 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;
  - Consider use of '**Being Me**' and '**Me first**' resources to help children and young people to share who they are, how they are feeling and what support they would like. These resources have been co-designed and developed with children and young people.

7.2 Reach multi-professional consensus regarding FII / PP concerns.

Consensus about the child's state of health needs to be reached between all health professionals involved with the child and family, (GPs, Consultants, private doctors and other significant professionals who have been involved in child's care, including education and Children's Social Care if they have already been involved). In order to reach a consensus a professionals meeting is required.

Multi-professional meeting

- A Professionals meeting is required to reach consensus about the child's state of health needs.
- Should be chaired by the Named Doctor.
- 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). It is the number and severity of the concerns in the alerting signs which led to the need to investigate the perplexing presentation.
- Consensus needs to be reached in the meeting 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 perplexing presentation / 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;
  - The actual or likely harm to the child and or siblings;

- Agreement will need to be reached on 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;
  - 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.

  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.

7.3 Consider involving social care

Not always necessary at this point, but needs to happen if FII thought quite likely, or other social issues have been identified, or a social care perspective might help towards understanding the child's problems.

Consider carefully whether to inform parents at this stage, and if in doubt, take advice from Named professionals. The child's welfare and safety is the overriding priority;

Early help approaches may be applicable and helpful.

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.'

8. Agree a Health and Education Rehabilitation Plan (HERP)

HERP should be developed and implemented, whatever the status of children's social care involvement is. Requires a coordinated multidisciplinary approach and negotiation with parents and children and usually will involve their attendance as appropriate at the relevant meetings.

There may well be several acceptable approaches and in most cases engagement and agreement by the child and family is pivotal to the success of the Plan.

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. It must specify timescales and intended outcomes.

- Agree who in the professional network will hold responsibility for coordinating and monitoring the Plan, and who will be the responsible lead clinician.
- Consider what support the family require to help them to work alongside professionals to implement the Plan (e.g. psychological support and / or referral to children's social care for additional support);
- 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 a graded return to normal activity (including school attendance).
- Psychological input may be helpful;
- Social care or other agencies may also be involved.

Avoid medical testing /treatment that is not clearly indicated, restore normality

- Harm to the child can be mainly through the excessive response of (usually health) professionals, in terms of over-investigation and treatment;
- Aim to draw a line and reach the point where parents can be told "We have investigated enough";
- This may need multi-professional or multi-speciality discussion. If a further opinion is sought, they need to be aware of the context, and investigations already done;
- Where possible, aim to restore the child's daily functioning to nearer normality.

A period of admission may be helpful for closer observation

- Occasionally in cases of medical uncertainty, a period of in-patient admission is helpful to observe in detail what is happening.
- This is arranged transparently with the family, explaining that this is part of good practice in these situations and the ward team will ideally be involved in all the details of the child's care and observation.;
- All staff involved should be clear about the nature of the concerns, and the purpose of the admission, including what is to be particularly observed, and how this should be documented;
- Seek advice from Named professionals.

Support for parents

- Where excessive parental anxiety is part of the presentation, this should be contained through having a lead person, avoiding mixed messages, avoiding continued investigation, appropriate and repeated reassurance (including in writing) and having clear pathways of support (what to do and who to contact if…);
- Attention should be given to the parent(s)' own support networks and mental and physical health, if these are thought to be contributing to anxiety. A referral for mental health support may be appropriate

Communication to parents and child

- Once health consensus has been achieved and a draft Health and Education Rehabilitation Plan formulated, a meeting should be held with the parents, the responsible clinician 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;
- The current, as of now, 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. The draft Health and Education Rehabilitation Plan is explained to the parents, including what to explain to

the child and what rehabilitation is to be offered and how this will be delivered. Negotiation about the plan details can take place with the parents at this stage, provided that the final Plan is consistent with the consensus reached by the multi-professional meeting.

- Often the process outlined above has led to clarity amongst all professional involved where they can say to parents "We are confident there is no serious underlying medical problem, and we want to work with you to enable your child to live as normally as possible despite any symptoms". This message should be given positively with constructive planning to limit the impact of on-going symptoms on the child's well-being.

9. When the Health and Education Rehabilitation Plan is not working – necessary referral to Children's Social Care, strategy meeting and on-going management

If the parents disagree with the consensus feedback and an effective Health and Education Rehabilitation Plan cannot be negotiated, or it becomes apparent that there is lack of engagement with the Plan which had been agreed with them, then it is necessary to refer the child to Children's Social Care.

Outcomes that would increase concerns regarding FII would include:

- Parents wishing new lead clinician and refusing to work with them.
- Attempting to move the child out of area or to a different hospital.
- Refusal to engage with any agreed process.
- Increasing physical symptoms (still without any medical explanation).
- New or/ more dangerous symptoms.

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.

Referral to social care / Police

FII is a form of child abuse. If there are concerns about possible FII a referral should be made to City / county Social Care and the Police.

A strategy meeting should be convened involving appropriate professionals (health, social care, police, and consider legal and education).

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.

- 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.

Strategy Meeting

Where HERP is felt to not be working a strategy meeting must be convened between health, police, education and any other professionals involved in child's care.

The strategy meeting should consider:

- level of risk to the child and any siblings;
- how the child might be given opportunity to share their story;
- need for further investigations, observations, management;
- need for a police investigation;
- information sharing with parents (what should be shared, when, and by whom);
- needs of carers, particularly after disclosure;
- If the strategy meeting identifies that a professional should talk to the child this should be someone trained in achieving best evidence.

Detailed chronology and multi-professional working

Professionals involved should compile their own chronologies and agree who is responsible for merging these. Advice can be sought from named professionals. Compiling a full chronology should not delay the process.

Aim is to build up a clear understanding of all the child's health presentations, and who is involved. It is helpful to talk to the child about their own concerns, anxieties and beliefs about their symptoms. Reports and records of other professionals should be sought, including the child's GP, who may have important background knowledge. It may be appropriate to approach school or nursery. It is important to build up a full picture of the child's daily functioning including school, activities, aids etc.

All of this should be done openly with parents where possible unless this would put the child at risk. Parents will usually be pleased that their concerns are being taken seriously and information is being gathered together to make a thorough assessment. Lack of engagement with the process, or refusal for further information to be sought, would increase concern.

Observation

A (further) period of admission may be helpful for closer observation and decisions about management.

- Needs to be planned carefully.
- Staff involved need clear instructions and should understand issues.
- Significant improvement while under close observation may add to the concern about FII.

10. Outcome of Section 47 Enquiry and Single Assessment

Concerns Not Substantiated:

- e.g. tests may identify a medical condition, which explains the signs and symptoms;
- It may be that no protective action is required, but the assessment concludes that services should be provided to the child and family to support them and promote the child's welfare as a Child in Need, or through early help. In these circumstances, appropriate assessment should be completed and planning meetings held to discuss the conclusions, and plan any future support services with the family;
- It may be appropriate for further management to follow the Yellow pathway, including consideration of a Health and Education Rehabilitation Plan.

Concerns Substantiated and Continuing Risk of Significant Harm

- Where concerns are substantiated and the child judged to be suffering or likely to suffer Significant Harm, an Initial Child Protection Conference may be convened or the child may be made subject to orders e.g. an Interim Care Order.

11. Meeting Minutes

All meetings about perplexing presentations where FII is being considered should be minuted, recording who was present, observations, discussion and decisions reached.

For a Strategy discussion Childrens Social care have responsibility for minuting the discussion / meeting.

Draft minutes should be circulated by the agency who minuted the meeting for approval by all present, followed by final agreed minutes. This is important for clarity of process, and because of potential medico-legal or criminal proceedings that may follow.

12. Covert video surveillance (CVS)

It is only in very exceptional circumstances that CVS may be considered for use within the acute hospital setting. CVS should not be considered without detailed discussion with safeguarding team and involvement of the police as they are the lead investigative agency in any case requiring CVS.

Education and Training

Training on this guidance is provided to registrars.

Monitoring Compliance

None required

Supporting References

LSCB Multi-agency management of MEDICALLY UNEXPLAINED SYMPTOMS, PERPLEXING PRESENTATIONS AND FABRICATED OR INDUCED ILLNESS (FII) accessed May 2023

Perplexing presentations (PP) Fabricated or induced illness (FII) RCPCH guideline 2021

Key Words

Child protection, disclosure, safeguarding children.

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Dr D Bronnert Consultant Paediatrician, Named Doctor)	**Executive Lead:**
Details of Changes made during review:	

Appendix 1 Chronology pro forma

CHRONOLOGY TEMPLATE

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

Name of Child: DOB: S number:

Author: Job Title and Contact Details:

Agency: Date of Completion:

Template Categories Summary

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.

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.*

Appendix 2: Health and Education Rehabilitation Plan template (HERP)

Name:

Date of birth:

S number:

Consultant:

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