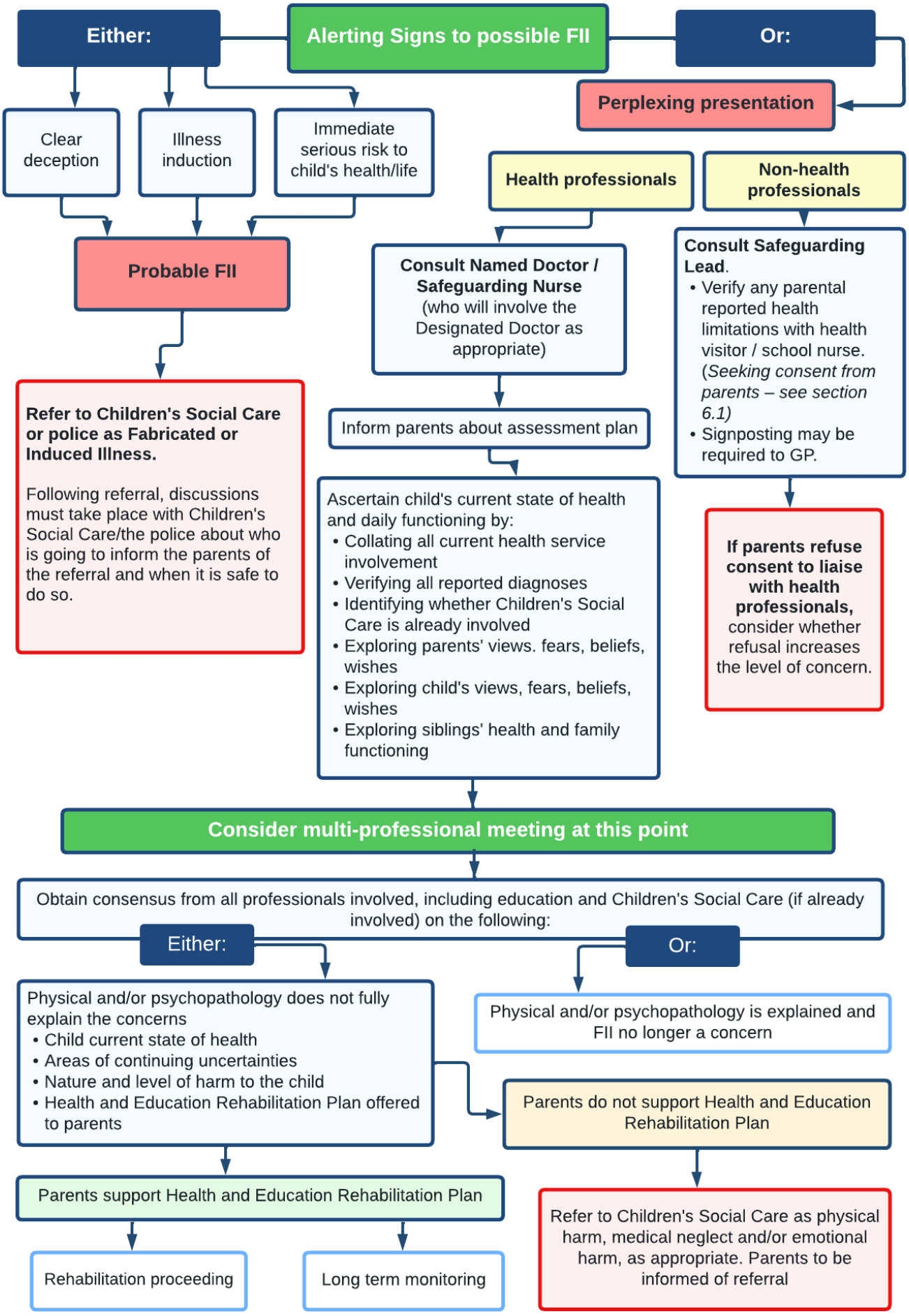
MULTI-AGENCY PRACTICE GUIDANCE

PERPLEXING PRESENTATIONS / FABRICATED OR INDUCED ILLNESS

GATESHEAD safeguarding children partnership

Contents

Process


Either:
Alerting Signs to possible FII
Or:
Perplexing presentation
Clear deception
Illness induction
Immediate serious risk to child's health/life
Health professionals
Non-health professionals
Probable FII
Consult Named Doctor / Safeguarding Nurse (who will involve the Designated Doctor as appropriate)
Consult Safeguarding Lead.
• Verify any parental reported health limitations with health visitor / school nurse. (Seeking consent from parents – see section 6.1)
• Signposting may be required to GP.
Refer to Children's Social Care or police as Fabricated or Induced Illness.
Following referral, discussions must take place with Children's Social Care/the police about who is going to inform the parents of the referral and when it is safe to do so.
Inform parents about assessment plan
If parents refuse consent to liaise with health professionals, consider whether refusal increases the level of concern.
Ascertain child's current state of health and daily functioning by:
• Collating all current health service involvement
• Verifying all reported diagnoses
• Identifying whether Children's Social Care is already involved
• Exploring parents' views. fears, beliefs, wishes
• Exploring child's views, fears, beliefs, wishes
• Exploring siblings' health and family functioning
Consider multi-professional meeting at this point
Obtain consensus from all professionals involved, including education and Children's Social Care (if already involved) on the following:
Either:
Or:
Physical and/or psychopathology does not fully explain the concerns
• Child current state of health
• Areas of continuing uncertainties
• Nature and level of harm to the child
• Health and Education Rehabilitation Plan offered to parents
Physical and/or psychopathology is explained and FII no longer a concern
Parents do not support Health and Education Rehabilitation Plan
Parents support Health and Education Rehabilitation Plan
Refer to Children's Social Care as physical harm, medical neglect and/or emotional harm, as appropriate. Parents to be informed of referral
Rehabilitation proceeding
Long term monitoring

1.0 Introduction

This condensed guidance has been developed in response to the RCPCH Perplexing Presentation / Fabricated or Induced Illness published in February 2021 and should be read in conjunction with this in order to fully understand the context of Fabricated and Induced Illness and perplexing presentations (reference 6).

There has been a shift to earlier recognition of possible FII without need for evidence of significant harm. In the absence of clear evidence about risk or harm the recognition of possible FII is better termed **perplexing presentation.** (See below for definitions).

In order to respond and navigate the highly complex nature of this form of abuse a systematic multiagency approach is essential to identify indicators at the earliest opportunity and prevent any further harm to the child.

2.0 DEFINITIONS

2.1 Fabricated or Induced Illness (FII)

In cases of FII a child is suffering or likely to suffer harm as a result of parent/carer behaviours or actions carried out to convince healthcare professionals that the child's physical/mental health or neurodevelopment are impaired (or more impaired than in the case).

FII can cause physical, emotional abuse, neglect as a result of these actions, behaviours or beliefs and also as a result of doctors response to these (for example overtreatment or over investigation).

The motivation of the parents may not always be clear and cases can be FII without definite deception. The parents may fabricate illness (e.g. seizures, mental illness), induce illness (e.g. Salt poisoning, withhold medication) or falsify test results resulting in unnecessary interventions. In some cases, parents will misrepresent information when giving history to professionals. Parent may say a particular professional said X had to happen when child presented with Y.

2.2 Perplexing presentations

In perplexing presentations, a child's presentation is not clearly explained by any genuine illness and there may be alerting signs of possible FII, but the actual state of child's physical or mental health is not yet clear. Although the situation may be impacting on the child's health or emotional well-being, (e.g. non-attendance at school, use of aids etc.) there is **no perceived immediate risk of serious harm**.

This situation is far more common than FII. Often parents may have sought numerous opinions. There are often discrepancies between reporting from parents and observations of the child. e.g Parents feel child too anxious to attend mainstream school but when has attended in past school have said they did not display anxiety and did well.

2.3 Medically unexplained physical symptoms

In these cases, the child's symptoms are genuinely experienced but not explained by any known pathology or disease, they are more likely driven by child factors (usually psychological) for e.g. Child who suddenly goes off legs and all investigations normal including neurological examination and imaging. The parents are often on board with diagnosis and will work together with health professionals in children's best interests to restore health and

well-being. These cases should be managed in health by MDT including paediatrician, Physiotherapy, psychologist, Occupational therapy, 0-19 service with support from school as needed to rehabilitate.

3.0 POSSSIBLE PRESENTATION OF FABRICATED OR INDUCED ILLNESS OR PERPLEXING PRESENTATIONS

3.1 Parent/carer motivation and behaviour in cases of PP or FII

Research shows there is often a parental/carer's need for their child to be perceived as ill or more ill than the child actually is. It is more common for mothers to be perpetrators and fathers may not be aware. **In a significant number of cases, the child does have a verified diagnosis.**

There are often two different motivations and they may both be present:-

(i) Parents/carers experience gain from recognition and treatment of child being unwell. Some parents/carers who struggle with management of a child may seek a mental health diagnosis. Material gains include financial support

(ii) Second motivation is erroneous beliefs, extreme concern or anxiety about the child's health. Unlike most typical parents/carers, they are often not reassured by health care professionals or negative investigations. This results in changes of doctor or professionals.
See RCPCH guidance for further information (reference 5)

3.2 Presenting features

The commonest presentation is erroneous reporting of e.g. symptoms, history, results of previous tests, medical opinions, interventions and diagnoses.

Examples:

Reporting of symptoms or signs not witnessed	Exaggeration of symptoms or signs	Manipulation or omission of medication	Induction of illness
Falsifying test results	Obtaining specialist equipment that child does not need	Labelling child with mental /health behavioural diagnosis not confirmed	Parent/carer persistently requesting behavioural assessments for e.g. ASD/ADHD

It is important to acknowledge and not confuse situation specific behaviour with FII/PP e.g. if a child's behaviour only occurs with one parent/carer and not seen outside of home for e.g. at school. **This is an example of situation specific presentation and could be due to the parent/carer and child relationship rather than the parent/carer fabricating the phenomena.**

4.0 HARM TO THE CHILD

Emotional abuse, physical abuse or medical neglect can all be consequences of FII and PP. There is often a confirmed coexisting medical illness in some cases. Both FII and PP can impact in similar ways:

- FII is not a category of maltreatment – so harm can be expressed as emotional abuse, medical or other neglect, or physical abuse
- **Consider the following 3 aspects when assessing potential harm to the child** (they can co-exist)

The child's health and experience of healthcare

- Repeated / unnecessary appointments, examinations, investigations, procedures and treatments – often physically and psychologically uncomfortable or distressing
- Genuine illness overlooked by professionals due to repeated presentations
- Illness induced by the parent (eg suffocation, poisoning etc) – threatens child's health or even life

Effects on the child's development and daily life

- Limited / interrupted school attendance and education
- Limited normal daily activities
- Assumes a sick role (eg using wheelchair)
- Social isolation

Child's psychological and health-related wellbeing

- Confusion or anxiety about their health
- Develop a false self-view of being sick and vulnerable – they may then actively embrace this view and become the main driver of erroneous beliefs
- Collusion with parents illness deception
- Silently trapped in falsification of illness
- Later development of psychiatric disorder / psychosocial difficulty

- When considering severity of FII, focus on the harmful effects on the child – by assessing the intensity of each aspect of harm, and by the cumulative effect
- Severity can be considered by severity of the parents' actions – on a continuum, from anxiety and belief-related erroneous reporting, to deception, to interfering with samples, to illness induction – but this bears little relation to severity of harm to the child (with exception of illness induction)
- In families where only one child is subject to FII, consider harm to siblings – they may become very concerned and distressed by the apparent ill-health of the index child, or may be (or feel) neglected

5.0 ALERTING SIGNS

Alerting signs may be present in the child or in the behaviour of the caregiver. The paediatrician should consider the overall number and severity of alerting signs.

5.1 Examples in the child

- Physical, psychological or behavioural symptoms and signs reported but not witnessed independently.
- Unusual test results e.g. unusual organisms on culture
- Very poor response to treatment that would normally be very effective
- Reported problems that are physiologically impossible e.g. large blood loss without a change in haemoglobin (blood count)

- Unexplained impairment in child's quality of life such that they require additional aids and are reportedly unable to attend school

5.2 Examples of caregiver's behaviour

- Insistence on continued investigations instead of working with the medical team on alleviating symptoms, especially when the investigations completed already demonstrate no worrying cause for the symptoms described.
- Repeatedly reporting new symptoms
- Repeatedly attending health care settings, potentially attending different hospitals and seeking the opinion of different doctors.
- Providing reports from overseas doctors or private clinics which conflict with best practice and evidence based practice in the UK
- Repeated non-attendance at appointments, especially for investigations which may disprove the reported symptoms
- Objection to communication between professionals
- Frequent complaints about professionals, especially if challenged about reporting of signs and symptoms
- Talking for the child or not allowing the child to be seen on their own
- Repeated, unexplained change of school (including home schooling) or GP/medical team
- Inaccurate statements that the parents make to other professionals about their child's illness, usually exaggeration.
- Requests for drastic interventions which clinically are not felt to be required

6.0 ROLES AND RESPONSIBILITIES

It is the responsibility of a **Paediatric Consultant or Psychiatrist/ CYPS professional** (if involved) to determine whether presentation of child by parents is indicative of FII or Perplexing Presentation but requires all professionals involved with the child to respond to any emerging concerns by seeking further information from other professionals involved with child and family.

6.1 Professionals from a non-health setting including Education/Early Years/Early Help/Children's Social Care

Professionals may have concerns because parents are describing a child's illness or health needs which are not witnessed by the professionals. In such situations professionals should consider the other warning signs. If they remain concerned they should discuss the child with the safeguarding lead within their organisation.

When a parent/carer reports restrictions/limitations for normal school activities due to reported 'health' issues, **it is important this is verified with health professionals** via liaison with the health visitor or school nurse. Consent from the parents to do this should be sought on the grounds that that **this is usual practice where a child has an illness which is impacting on their health or development**. At this stage, the concern about possible PP/FII should not be disclosed to the parent/carer. If parents refuse consent for a discussion with health professionals then this should be discussed with the safeguarding lead to consider whether refusal increases the level of concern.

Professionals should keep careful and secure records of absences and reasons given by parents for absences so that these can be corroborated. The professionals should listen to the child and document what they are saying.

If the concerns are raised in **education or early years settings** the practitioner should discuss with health professionals from the **0-19** health service in the first instance.

If the concerns are raised by **children's social care**, then health information should be requested from the child's **general practitioner** on potential impact of these diagnoses on the health and development of a child and attendance at school. If this information highlights the child is known to a **consultant/ CYPS professional** then information should be sought from that consultant/CYPS professional on the medical diagnoses and the potential impact of any diagnoses on the health and development of a child and attendance at school.

6.2 Professionals from Health Setting

6.2.1 0-19 - Health Practitioners:

Where practitioners have concerns that a parent/carer is impairing a child's health, development or functioning, they should meet with parents/carers to discuss the child's illness, parental concerns and ascertain which other health professionals are involved.

Parental anxiety and worry about a child's illness or concerns that their child's health needs are not being met can be common. This can lead to health-seeking behaviours or exaggeration of symptoms. The practitioner should seek parents/carers consent to discuss the child with those professionals involved including the consultant in an attempt to allay any anxieties at an early stage.

Where the practitioner has on-going concerns about FII/PP and the child is already known to other health professionals, then information should be sought from those professionals regarding the medical illness/diagnosis, and advice or an appropriate care plan should be provided. Although at this point consent is not required, it is good practice to inform the parents that you'll be discussing health concerns with the relevant professionals as a standard practice. Concerns about possible FII must be shared with the other health professionals and especially the GP.

In all cases of suspected fabricated and induced illness advice, support and supervision where necessary should be sought from the Safeguarding Children Team or Named Nurse / Named Doctor.

Several different Consultants with different specialities may be seeing child and therefore requires careful co-ordination of health information due to indicator of repeated attendance at health care settings, potentially attending different hospitals and seeking the opinion of different doctors.

The Lead Clinician should be considered on a case by case basis following consultation between the Named Doctor from the child's local NHS hospital and the Designated Doctor. The lead clinician will be the one who is overseeing child's care locally. If all care is at the Children's hospital in Newcastle then the named doctor/ member of the safeguarding team may need to liaise with the GNCH team to agree who will act as the lead clinician. Depending on the child's presentation, a paediatrician may need to be allocated locally.

6.2.2 Midwives

Midwives may be alerted to possible FII/PP by mothers own health-seeking behaviour, history of unusual/unexplained illness, unusual complications of pregnancy, and unexplained deaths of previous children. If concerns are raised then previous pregnancy notes should be obtained and the midwife should discuss concerns with the Safeguarding Children Team.

6.2.3 General Practitioners (GPs)

In cases of suspected PP/ FII, the GP is likely to have had a higher level of involvement and knowledge of the child and family than other health professionals.

If there are concerns about PP/FII and the child is **not known** to a consultant they **must** be referred to a Paediatrician /or Consultant Child Psychiatrist with expertise in symptoms and signs that are being presented. Where parents refuse for a referral to be made to a local paediatrician or child psychiatrist consideration should be given to the impact this may have in the child.

If no immediate risk of harm i.e. PP, GP should explain need for referral to paediatrician for diagnosis and appropriate management plan. Concerns about PP should be mentioned in referral letter so it is allocated to correct clinic and clinician.

GPs should also discuss concerns with the named doctor or Designated Health Professionals for Safeguarding Children. **GPs should ensure that these concerns are recorded within the child's clinical record.**

If there is concern about fabrication or induction of illness then an urgent referral by phone to the **on call Paediatric Consultant** at relevant acute hospital and a **safeguarding referral** should be made at the same time to children's services who will then involve the police and any other relevant agency.

6..2.4 Mental Health Workers (including Child and Adolescent MH, Adult MH & Learning Disability services)

Staff within Mental Health may also be alerted to concerns about possible FII/PP in the process of evaluating children for mental health and behavioural difficulties.

Initial concerns about a child's presentation should be shared with the Trust's Safeguarding & Public Protection team. If concern remains this should be discussed with the Paediatrician or GP that referred the patient and other relevant health professionals. If concerns continue then the trust's named doctor or named nurse should be involved.

In Adult MH if a patient who is a parent is known to fabricate or induce illness themselves this may increase the risk to the child in relation to possible FII/PP. If an adult mental health worker has any concerns of this nature about a child's welfare they should be discussed with the Trust's Safeguarding & Public Protection team. **Confidentiality may need to be breached without consent in order to protect the child as there is a statutory obligation on all professionals to act in the best interests of children in order to safeguard.**

6.2.5 Allied Health Professionals

If staff have concerns about FII/PP in children they are providing therapy and care for they should discuss with the Safeguarding Children Team within their Trust and GP or the practitioner who referred to their service.

6.2.6 Consultant Paediatricians or Consultant Child Psychiatrist

All cases of suspected FII/PP should be led by a Consultant Paediatrician or, Consultant Child Psychiatrist/ CYPS professional with advice from the named doctor and safeguarding team.

6.2.7 Named Doctor/Named Nurse for Safeguarding Children

The Named Doctor/named nurse is there to provide advice and support to the lead consultant; they will be expected to chair health professionals meetings. If the named doctor is also the lead paediatrician then the designated doctor will provide advice and support.

6.2.8 Health Care Practitioners including other Consultant Specialists:

If a Health Care Practitioner including Consultant, other than a Paediatric or CAMHS Consultant, has a concern about PP/FII in a child in their care they should refer to a Consultant Paediatrician or discus with Safeguarding Children Team.

6.2.9 Designated Professionals for Safeguarding Children

Designated doctors can offer safeguarding supervision or facilitate professional discussions, particularly where the presenting issues are very complex. If named doctor is also child's paediatrician then designated doctor will provide advice and support and chair professional meetings.

7.0 RESPONSE TO ALERTING SYMPTOMS AND SIGNS

7.1 Actions to be taken if there is immediate serious risk to the Child's health and life - these cases should be managed as FII

This is particularly important in cases of illness induction and deception such as tampering with specimens or feeding tubes and also in cases where open discussion with parents my lead to further harm to the child.

Actions to be taken:

Urgent referral to children's social care and/or police by the responsible consultant

- parents should not be made aware of the referral at this point if it is felt this would increase parental behaviour and risk of harm to child.

Strategy meeting should be convened with named/designated health professionals in attendance

Evidence should be secured (such as feeding bottles giving sets, nappies, blood urine)

Concerns should be documented in the Child health records re FII and handed over to all relevant staff

An alert should be put on the child's hospital record and communicated to GP and 0-19 service

- so that all clinicians and health professionals seeing the child are aware of the concerns.
- This should be done even before the diagnosis of fabricated induced illness has been confirmed at strategy and Case conference

Consider need for immediate protection

- If there are serious concerns that the parents may try to remove the child particularly in hospital and immediate protection is needed and this is best obtained by contacting the police who can use their police protection powers.

Decisions about what and when to inform parents of concerns should be decided at the strategy meeting

In all cases where the police are involved, the decision about when to inform the parents (about referrals from third parties) will have a bearing on the conduct of police investigation.

7.2 Actions be taken if there is no immediate risk to the Child's health and life: perplexing presentations - perplexing presentations

These cases can be managed as perplexing presentations but as they may go on to cause actual harm or likely harm to the child; they require a carefully planned response.

In these cases it is good practice to call a multi-professional meeting or health professionals meeting via the trusts Safeguarding Teams.

7.3 Multi Professionals Meeting

A multi professionals meeting should be convened by the Lead Clinician in conjunction with the Trust(s) Safeguarding Children Team(s) when there are concerns about perplexing presentations and the child is not at the immediate risk.

Each professional should provide a **summary of their involvement** to share at the meeting and a chronology of their involvement may be requested in some instances to support any conflicting information parents are reporting to professionals about their child's health. Social care may not routinely be invited to this meeting, however if child is known to a social worker or early help then they should be invited as professionals involved in child's care.

If after the meeting or at any point during the investigation and information gathering there are sufficient concerns that a child may be suffering or is likely to suffer significant harm**, a referral should be made to Children's social care as soon as possible** in line with safeguarding children multi-agency procedures.

- Consensus about the child's state of health needs to be reached between all health professionals – including GPs, consultants, private doctors – and other significant professionals who have observations about the child – including education and social care if involved
- This is done by holding a professionals meeting – chaired by the Named Doctor (or Designated Doctor) with notes taken by Safeguarding Admin
- Parents should be informed about the meeting and receive feedback about the conclusions
- Notes from the meeting must be factual and agreed by all parties present – they should form part of the child's health record, so would be released if parents make a Subject Access Request
- A consensus should be reached between..

All the alerting signs and problems are explained by verified physical and / or psychiatric pathology or neurodevelopmental disorders in the child – There is no FII	Any verified diagnoses do not explain the alerting signs
OR	
Medically Unexplained Symptoms from the child (free from parental suggestions) – There are perplexing elements but the child will not come to harm as a result	There is actual or likely harm to the child and / or siblings

And to agree:

- Are further investigations / referrals warranted and in the child's interests?
- How should the child and family be supported to function better alongside any remaining symptoms? What needs to go in the Health and Education Rehabilitation Plan?
- Does the child need a secondary care Paediatrician (if not already involved)?
- Next steps if parents disengage or request change of paediatrician

- If there is significant disagreement between health professionals about important aspects of diagnosis / management, it will need to be resolved via a health professionals meeting – this will be chaired by the Named or Designated Doctor
- Once a consensus has been achieved – the responsible consultant, accompanied by a colleague, should feedback to the parents
    - Genuine symptoms may have no diagnosis, and a diagnosis may or may not impact on the child's functioning
    - The current consensus opinion is shared – acknowledging this may be different from what they have previously been told and / or what they believe
- A plan is made with parents about what to explain to the child, and what the rehabilitation will involve
- The child should remain under the care of the responsible clinician even if there is no verified illness
- GPs and 0-19 service should be kept fully informed and involved in the management of Perplexing Presentations or where there are concerns about FII

See appendix 1 for meeting template

7.4 The health and educational rehabilitation plan.

The lead clinician together with other professionals involved in the child's care will develop a Health Education Rehabilitation Plan (*Appendix 2*) together with the family.

In a significant number of perplexing presentations, the family will engage with health professionals and the child will work towards a recovery by following the rehabilitation plan. It is important that the child is followed up by the lead clinician to ensure that the plan is being followed.

Referrals to early help may be necessary to support this plan and if a Child in Need or Child Protection plan is already in place already then it may be appropriate to combine them.

8.0 RECORD KEEPING

All notes about a child's condition should clearly state the facts: who reported the concerns, what was observed, and by whom. If your opinion is that the differential diagnosis includes FII/PP, then this should be clearly stated in the notes. This information may need to be redacted if the notes are shared with the parent/carer.

Records of key discussions and safeguarding supervision notes about the child's care should be kept within every organisation's main health record pertaining to the child to ensure that the child does not come to further harm.

GP notes should have flags on when there are ongoing concerns about perplexing presentations or FII with a clear plan of referral and management should the child present to the service out of hours or acutely.

9.0 INFORMATON SHARING, CONSENT AND CONFIDENTIALITY

Parents should be informed of the need to share information between different professionals involved in the child's life. If the parents are not in agreement and you have concerns about the welfare of the child then you must share the information with other professionals without the parents' consent. If you choose not to share information with other health professionals and this should be clearly documented in the notes. (reference 6)

10.0 CHRONOLOGIES

Although chronologies are not essential in management of most cases of PP/possible cases of FII, they are needed in complex cases and cases referred to social care. The preparation of the chronology should not delay a referral to Children's Social Care (CSC) or any other interventions if this would put the child at risk of harm.

11.0 REFERRAL TO SOCIAL CARE

Indications for referral to social care:

If there is immediate risk to the child's health / life – an immediate referral should be made - This is most likely to occur if there is frank deception, interfering with specimens, unexplained results of investigations (suggesting contamination or poisoning), or actual illness induction.

If the consensus opinion following Perplexing Presentations process that there is actual or likely harm (ie FII) – then whether or not this is 'significant' needs to be decided according to multi-agency thresholds.

Factors to consider:

- If the parents recognise the harm, and are able to change their beliefs and actions to reduce / remove the harm – then a referral may not be required at this point – this would require engagement with the Health and Education Rehabilitation Plan
- If parents do not engage with the plan, or progress is not made to reduce harm to the child (see section 7) – then a referral may be required
- Health professionals do not always have all the pieces of the safeguarding jigsaw – when deciding about referral to Children's Services, the professional should consider if they have all the information to be able to risk assess the level of harm – if they don't and parents decline consent for information sharing, a referral may be needed due to inability to assess level of harm without children's social care involvement

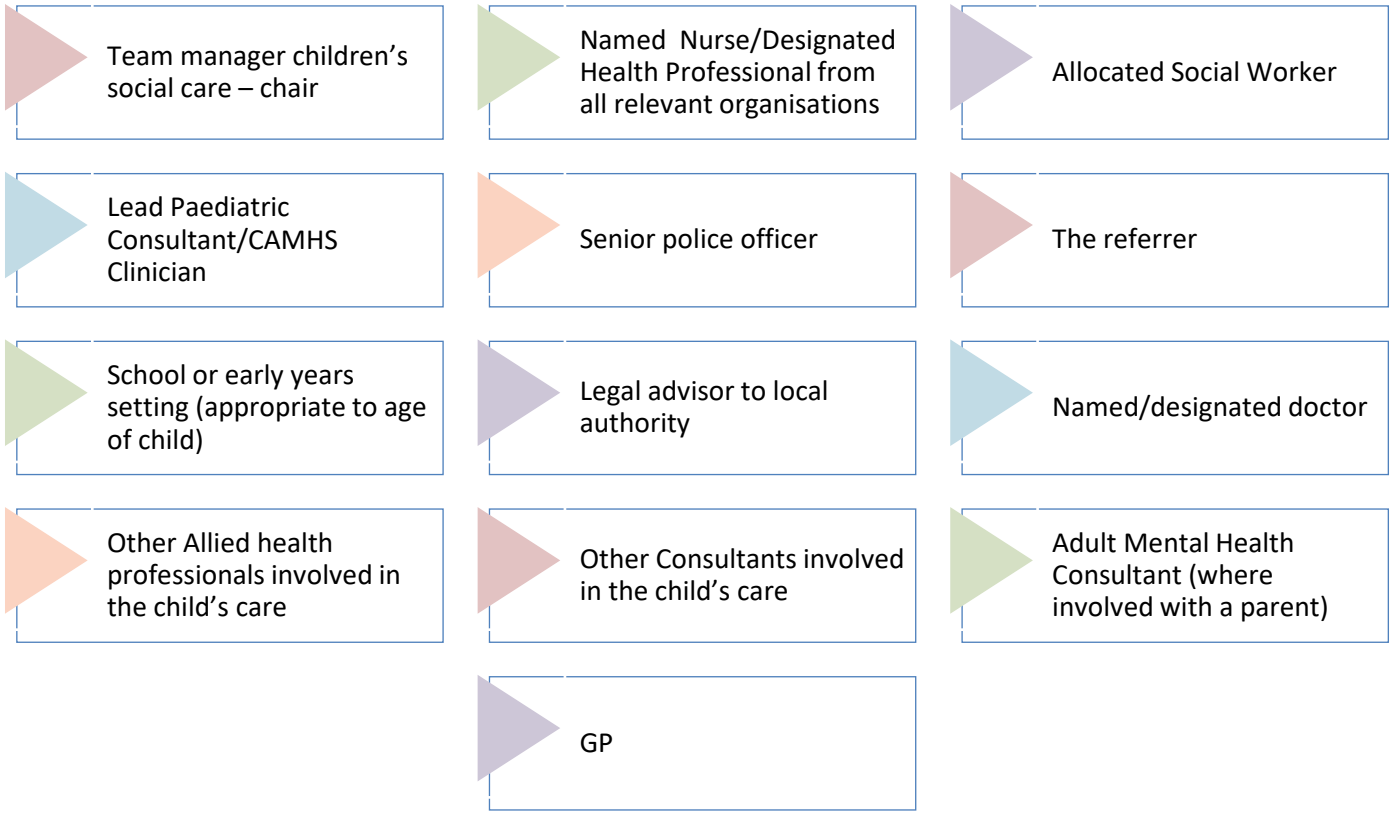
If a referral is required, the reasons should be discussed with family (unless to do so would place the child at risk of immediate harm) – and the Health and Education Rehabilitation Plan will still need to be continued

12.0 RESPONSE BY CHILDREN'S SOCIAL CARE

Children's social care will decide and record **within 1 working day** what action is required in response to the referral. Lead responsibility for action taken to safeguard and promote the children's welfare lies with social care.

In all cases where it is believed the information indicates suspected FII there should be an **assessment** undertaken which may result in a multi-agency strategy meeting which considers all children within the family.

Non-attendance of one or two professionals should not delay the meeting if it is indicated the child may be at risk of significant harm however. **Key professionals will include:**



During the strategy meeting specific consideration must be given to what information is to be shared with the parents and when. In addition, decisions about involving the child in discussions must also take place and consideration must be given to any relevant therapeutic work.

12.1 Police response

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

13.0 DECISION MAKING

The Strategy Meeting should decide whether to initiate a formal enquiry under **Section 47.** For complex cases, more than one **Strategy Discussion** may be required.

The discussion should include:

13.1 Assessment of risk and safety planning

1. The level of harm the child has already suffered;
2. Whether police need to progress criminal investigation;
3. The risk of future harm and any complicating factors;
4. Current safety arrangements already in place;

5. Whether an immediate safety plan is needed to reduce the risk of harm e.g.:
   - Cancelling unnecessary medical procedures;
   - Instituting closer observation of the child;
   - Whether the carers should be allowed on the ward if the child is an inpatient. If this is deemed to be unsafe then an emergency order may be required which will need to be instituted by either the police or the local authority.
6. Any potential implications for other patients or their carers who are on the ward at that time;
7. Consideration of the child's safety network and how it may be used to provide immediate safety;
8. Consideration of how all involved health professionals can work together to ensure a coordinated, informed response to any health problems.

13.2 Information Gathering

1. Any outstanding investigations, further information gathering, and opinions that would be helpful;
2. The planning of further medical and nursing assessment;
3. The need for forensic sampling or special observation
4. The development of an integrated health chronology (and agreement on who should do this);
5. Any further opinions needed (including specialist child protection opinion or to address a specific clinical issue);
6. What is known about the carers' past behaviour, medical history, current health state and any treatment, equipment, aids or benefits being received either for them or the child;
7. Strengths within the family.

13.3 Action Planning

1. Plan for communication with carers including how, when, and by whom they should be informed of any child protection concerns;
2. How the child can be given an opportunity to tell their story;
3. Responsibility for the Child & Family Assessment;
4. The level of professional observation required;
5. Addressing the needs of siblings and other children in the family;
6. Addressing the needs of carers, particularly after disclosure of concerns;
7. Clarification of who will be the lead Clinician for the child (if not already explicit); for example paediatrics or CYPS.

13.4 Possible outcomes of the Strategy Meeting(s):

- No further action by Children's Social Care;
- Provision of Services by one or more agencies; (EARLYHELP)
- Continued monitoring by identified professionals of specific concerns;
- Child & Family Assessment;
- Child in need plan
- Section 47 Assessment;
- The police start a criminal investigation;
- Immediate Action to protect the child(ren);
- A further Strategy Meeting or series of meetings, and/or an **Initial Child Protection Conference** once the Section 47 investigation is completed.

14.0 DISCLOSURE OF CONCERNS TO CARERS

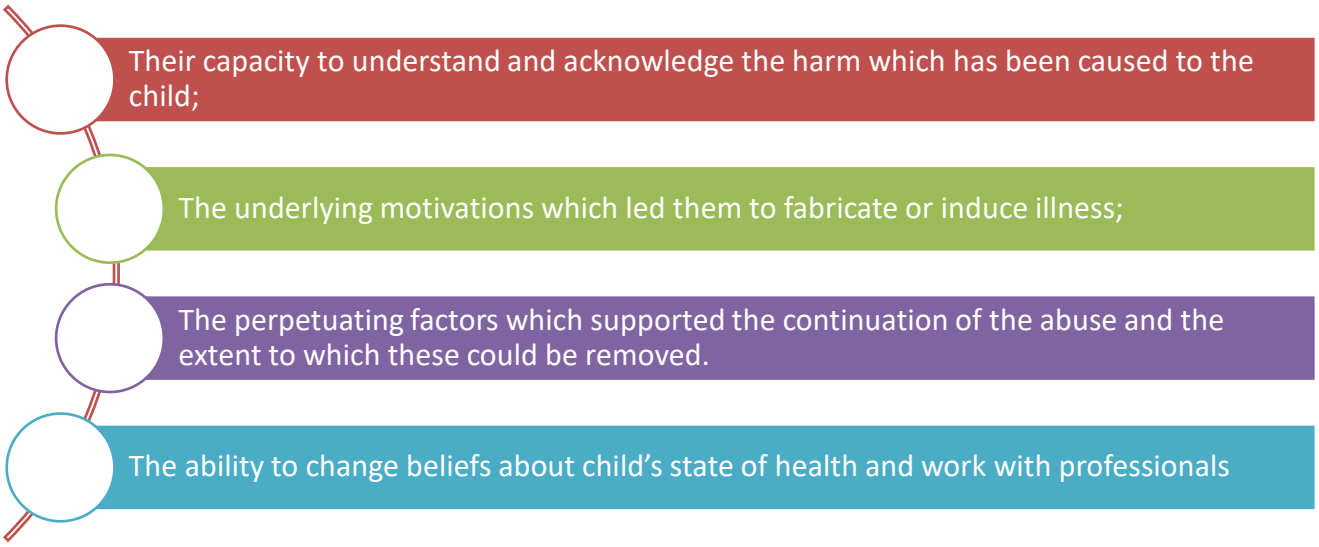
Professionals should be supported through the process of disclosure and the approach should be agreed and carefully planned beforehand dependent on the circumstances of the case and risk. This discussion should not be done as single agency. A representation from health (preferably the Lead Consultant) and social care who are going to work with family should be at this discussion with family. **A detailed note of the discussion should be made in the child's case notes.**

15.0 CHILD PROTECTION CONFERENCE

If the case proceeds to a child protection conference it is essential that the conference is organised so that key professionals (including the lead clinician) can attend.

16.0 WORKING WITH CARERS WHO HAVE FABRICATED ILLNESS AND THEIR CHILDREN

To gauge the prognosis for positive change in carers who have fabricated or induced illness it is essential to gain an understanding of:



It is important to explore what life will be like now that the child has been found to be well or better than previously thought. Carers will require help with constructing an accurate narrative of the past which they can share with significant others in their life, including the family.

In cases involving older children it is important to ascertain the child's perceptions, beliefs, and feelings about their state of health, particularly their anxieties and beliefs about their future wellbeing. It is also important to elicit the child's view of their experiences of medical care

17.0 REFERENCES

1. Working Together to Safeguard Children – a guide to inter-agency working to safeguard and promote the welfare of children (2015)

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Appendix 1

Template for Professionals Meeting

Name of Child;
DOB;
NHS number;
Chair (Name and Role);

Professionals Present

Name	Role	Organisation

Summary of Concerns

Alerting Signs	Present?
Reported symptoms and signs not observed independently – these can be physical, psychological or behavioural	
Unusual results of investigations	
Inexplicably poor response to treatment	
Physiologically impossible characteristics – eg persistently negative fluid balance, large blood loss without drop in hb	
Unexplained impairment of daily life – eg school attendance, aids, social isolation	
Reported symptoms / signs not explained by any known medical conditions, with insistence on continued investigations instead of focusing on symptom management	
Repeated reporting of new symptoms	
Repeated presentations to medical settings	
Inappropriate seeking of multiple medical opinions	
Providing reports by doctors abroad which conflict with UK medical practice	
Repeatedly not bringing the child to some appointments, including cancellations	
Unable to accept reassurance or recommended management, with insistence on more unwarranted investigations / referrals / treatments	
Objecting to communication between professionals	
Frequent complaints about professionals	
Not letting the child be seen alone	
Talking for the child	
Repeated or unexplained changes of school (including home-schooling), of GP, or of any health teams	
Factual discrepancies in statements to professionals about their child's illness	
Pressing for irreversible or drastic treatment options where the clinical need is in doubt or based solely on parents' reports	

Harm	Evidence
Repeated / unnecessary appointments, examinations, investigations, procedures and treatments – often physically and psychologically uncomfortable or distressing	
Genuine illness overlooked by professionals due to repeated presentations	
Illness induced by the parent (eg suffocation, poisoning etc) – threatens child's health or even life	
Limited / interrupted school attendance and education	
Limited normal daily activities	
Assumes a sick role (eg using wheelchair)	
Social isolation	
Confusion or anxiety about their health	
Develop a false self-view of being sick and vulnerable – they may then actively embrace this view and become the main driver of erroneous beliefs	
Collusion with parents illness deception	
Silently trapped in falsification of illness	
Later development of psychiatric disorder / psychosocial difficulty	

Consensus

All the alerting signs and problems are explained by verified physical and / or psychiatric pathology or neurodevelopmental disorders in the child – There is no FII	Any verified diagnoses do not explain the alerting signs
OR	
Medically Unexplained Symptoms from the child (free from parental suggestions) – There are perplexing elements but the child will not come to harm as a result	There is actual or likely harm to the child and / or siblings

- Is a Health Professionals Meeting needed (to resolve any significant disagreements about important aspects of diagnoses / management)?
- If so, who will chair?

Plan

Are further investigations / referrals warranted and in the child's interests?	**No** **Yes – specify;**
What needs to go in the Health and Education Rehabilitation Plan? **How should the child and family be supported to function better alongside any remaining symptoms?**	
Does the child need a secondary care Paediatrician (if not already involved)?	
Do the siblings have any health needs? **How should they be addressed?**	
Next steps if parents **1. Disengage** **2. Request change of paediatrician**	

Appendix 2

Health and Education Rehabilitation Plan

Name of Child…… Name of Responsible Clinician……..

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

Appendix 3

Gateshead NHS Foundation Trust – Combined Health Chronology

RE: [name] (dob:)

THE CONTENT OF THIS DOCUMENT IS CONFIDENTIAL AND MAY NOT BE DISCLOSED WITHOUT THE CONSENT OF THE AUTHOR

Please include information from **ALL health records** including digital, paper and databases; some teams may have separate records

Date	Significant events/information about the child/family What was reported? By whom?	What was observed? By whom? Voice of the Child	Agency involvement/ action/response What was the outcome?	Analysis	Source of Info

Overall Summary / Analysis;

Author; Date;