

Multiagency Practice Guidance on the Management of Fabricated or Induced illness in Children including Management of Perplexing Presentations

A summary of the Guidance developed by the Royal College of Paediatrics and Child Health on "Perplexing Presentations (PP) / Fabricated Illness (FI) in Children"

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Multiagency Practice Guidance on the Management of Fabricated or Induced illness in Children including Management of Perplexing Presentations.

1. Introduction

This Multiagency Guidance provides a summary of the Guidance developed by the Royal College of Paediatrics and Child Health on “Perplexing Presentations (PP) / Fabricated Illness (FII) in Children” which was updated in February 2021.

The full guidance is available [Perplexing Presentations \(PP\)/Fabricated or Induced Illness \(FII\) in children – guidance – RCPCH Child Protection Portal](#)

The RCPCH guidance proposes that in the absence of clear evidence about the risk of immediate serious harm to the child’s health, the early recognition of possible FII which does not meet the threshold of likely or actual significant harm is better termed **Perplexing Presentations**.

The management of Perplexing Presentations requires an active approach by health professionals and an **early collaborative approach with children and families**. The aim of this approach is to provide a framework for earlier intervention to explore the concerns of children, families and professionals and to address the issue of perplexing presentations well before significant harm has occurred to the child or young person.

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 that the child is too anxious to attend mainstream school but when the child has attended in the past, school have said they did not display anxiety and did well.

It is the responsibility of a **Paediatric Consultant or Child Psychiatrist** (if involved) to determine whether the presentation of the 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 the child and family.

2. Definitions

2.1. Fabricated or Induced Illness (FII)

FII is a clinical situation in which 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 is actually the case). FII results in emotional and physical abuse and neglect including iatrogenic harm (resulting from overtreatment or over investigation.)

2.2. Perplexing Presentations (PP)

Presence of alerting signs when the actual state of 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.

2.3. Medically Unexplained Symptoms (MUS)

The child’s symptoms of which the child complains, and which are genuinely experienced, are not fully explained by any known pathology but with likely underlying factors in the child (usually of a psychosocial nature,) and the parents acknowledge this to be the case. The health professionals and parents work collaboratively to achieve evidence based therapeutic work in the best interest of the child or young

person. Children with Medically unexplained Symptoms are not managed within the FII/Perplexing presentation Framework unless there are additional safeguarding concerns.

3. Harm to the Child

A child may experience harm due to a number of reasons, some of these may be caused directly by the parent either intentionally or unintentionally and some may be caused by the actions of medical staff inadvertently as they respond to the medical problems being presented to them.

FII is not a category of maltreatment in itself; forms of harm may be expressed as emotional abuse, medical or other neglect, or physical abuse.

When assessing potential harm, the following 3 aspects should be considered.

- **Child's health and experience of health care**

- The child undergoes repeated (unnecessary) medical appointments, examinations, investigations, procedures and treatments.
- Genuine illnesses may be overlooked by doctors responding to repeated presentations
- Illnesses may be induced by the parent (e.g.: poisoning, suffocation, withholding medication or food) resulting in potential or actual life-threatening harm to the child

- **Effects on child's development and daily life**

- The child has limited / interrupted school attendance and education
- The child's normal daily life activities are limited /social isolation
- The child assumes a sick role (e.g. using a wheelchair)

- **Child's psychological and health-related well being**

- The child may be confused or very anxious about their health.
- They may develop a false self-view of being sick and actively seek out other young people with similar difficulties such as via social media which may result in them wishing to remain "ill"
- The child may actively collude with the parent's illness deception
- There is an increased risk of developing psychiatric disorders and psychosocial difficulties

3.1. Assessing Severity of FII and impact on the child

Severity of FII can be considered in two ways:

1. **Severity of the parent's actions.** This can be placed on a continuum of increasing severity which ranges from anxiety and belief-related erroneous reports to deception by fabricating false reports, to interfering with samples through to illness induction. There is **no evidence about the likelihood or factors associated with a parent moving from one point on this continuum to another.**
- ii) **Severity of harm to the child.** The different aspects of harm to the child may coexist. The severity of the harm to the child needs to be assessed according to both the intensity of each aspect of the harm, and by the cumulative effect of all the aspects. It is important to focus on the harmful effects on the child rather than assessing the severity of harm based on what the parents are reporting **except** where there is illness induction. Where there are clear deceptive parental actions or illness induction it is likely that harm to the child will be more severe.

4. Alerting Signs to possible FII

Alerting signs are not evidence of FII but are indicators of **possible FII**. Concerns may be raised when there are discrepancies between reports and, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviours. A single alerting sign by itself is unlikely to indicate possible fabrication. However, if one alerting sign is present it is essential to look for others.

If alerting signs are identified by primary care or by allied health professionals in the community or by education or non-health professionals it is appropriate that a paediatrician or CAMHS professional becomes involved so that the actual state of the child's health can be ascertained. Concerns should be discussed with their Safeguarding lead.

If alerting signs are identified by hospital staff, they should discuss their concerns with the Named Doctor or Safeguarding Children Team.

Possible alerting signs are included in the following table which can be used to clarify the level of professional concern. (See [Table 1](#))

5. Concerns raised by 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 have not been witnessed by staff. In such situations professionals should consider any other alerting 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 professionals should refrain from using FII terminology as the state of the child's health has not yet been assessed. 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 any school 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 a child has not been seen by a paediatrician and there are ongoing health concerns being reported, it may be appropriate for the child to be referred for further assessment.

If the concerns are raised by **Children's Social Care**, then health information should be requested from the child's general practitioner on the 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 /Mental health professional**, then information should be sought from that health professional on the medical diagnoses and the potential impact of any diagnoses on the health and development of a child and attendance at school.

(See [Flow Chart 1. Management of Possible FII/Perplexing Presentations by non – health staff](#))

6. Concerns raised by Health Professionals

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.

6.1. GP's/Primary Care staff

In cases of suspected 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 Perplexing Presentation/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 do not agree for a referral to be made to a local paediatrician or child psychiatrist consideration should be given to the impact this may have on the child.

If there is no immediate risk of harm i.e. Perplexing Presentation, the GP should explain the need for referral to a paediatrician for diagnosis and appropriate management plan. Concerns about Perplexing Presentation should be mentioned in referral letter so that the child is allocated to the correct clinic and clinician.

GPs could also discuss concerns with the Named GP, Named Doctor or Designated Health Professionals for Safeguarding Children.

GPs should ensure that these concerns are recorded within the child's clinical record taking into consideration the need to restrict online access to records until concerns have been shared with the family if and when appropriate to do so.

6.2. Midwifery Services

Midwives may be alerted by a mother's 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 Named Midwife and Safeguarding Children Team.

6.3. Allied Health Professionals

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

6.4. Mental Health Staff

Staff within Mental Health Services may also be alerted to concerns about possible Perplexing Presentation/FII 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 concerns remain these 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 at CNTW should be involved.

In Adult Mental Health, 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 Perplexing Presentation/FII. 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 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 them.**

6.5. Hospital Medical Staff

Several different Consultants from different specialities may be seeing the child and therefore this requires careful co-ordination of health information due to the possibility of repeated attendance at health care settings, potentially attending different hospitals and seeking the opinion of different doctors. A Lead Clinician should be identified, and this should be a Consultant with support from the Named Doctor or Designated Doctor for Safeguarding Children

The Lead Clinician should be considered on a case-by-case basis following consultation between the Named Doctor and the Designated Doctor. The lead clinician will be one who is overseeing the child's care. The Named or Designated Doctor will ensure that all information in relation to attendances at other hospitals including private consultations is collated and considered and that all health professionals are aware of the concerns.

When any practitioner has on-going concerns about Perplexing Presentation and possible FII 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 will 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/Named GP

7. Response to Alerting Signs

If one alerting sign is present, it is essential to look for others. Alerting signs by themselves do not amount to fabrication but do mandate further investigations to ascertain whether the child has an underlying illness. It is also imperative that a decision is made as to whether there is an immediate risk to the child's health/ life, or not

8. Actions to be taken if IMMEDIATE Serious Risk of harm to the Child

If there is concern about Fabrication or Induction of illness with **immediate risk of harm** to the child, then a referral to Children's Social Care and Police should be made.

These cases should be managed as likely Fabricated /Induced illness. 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 may lead to further harm to the child.

Actions to be taken:

- Urgent referral to children's social care +/- 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.
- Consider the 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 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 the police investigation.

9. Actions to be taken if there is NO immediate risk to the Child's health and life: Perplexing Presentations

In the absence of the likelihood of immediate serious risk to the child's physical health or life, cases can be managed as Perplexing Presentations but as they may go on to result in actual harm or likely harm to the child; they require a carefully planned response.

The responsible paediatric consultant should collate all current medical /health involvement in the child's care and clarify any reported diagnoses and whether the diagnosis was confirmed by parental reporting or on professional observations +/- investigations. A period of hospital admission may be necessary for direct observation of the child. A referral for additional specialist opinion or additional investigations may be indicated.

The consultant should explore with the parents' their views and explanations for their child's presentation as well as exploring any past medical, family and social history within the family and clarify what services are involved and what support they have.

The consultant should seek the child's views of their symptoms and beliefs about their illness on their own (if developmentally appropriate) including their worries, anxieties and mood as well as their wishes. 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 should be documented. It is important to note that some children's and adolescent's views may be influenced by and mirror the caregiver's views. The fact that the child is dependent on the parent may lead them to feel loyalty to their parents and they may feel unable to express their own views independently, especially if differing from the parents.

It is imperative that the responsible consultant continues to have overall clinical responsibility for the child and that they are supported by the Children's Safeguarding team and Named Doctor. It is important to clarify the child's actual current state of physical and psychological health and functioning and the family context.

The responsible paediatric consultant will need to explain to the family and the child (if old enough) that there is current uncertainty around the child's health and that information is required from other health providers, care givers, education (and social care if already involved.)

In these cases, it is good practice to arrange a multi-professional meeting or health professionals meeting via the Hospital Trust's Safeguarding Teams.

10. Multi Professionals Meeting

A multi professionals meeting should be convened by the Lead Consultant in conjunction with the Trust's Safeguarding Children Team when there are concerns about Perplexing Presentations and the child is NOT at 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 will not routinely be invited to this meeting, however if the child is known to a social worker or Early Help, then they should be invited as professionals involved in the 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 state of health needs to be reached between all professionals- including GP's, Consultants, private doctors and other significant professionals who have observations about the child including education and social care if involved.
- The multi professionals meeting is chaired by the Named or Designated Doctor for Safeguarding Children or Senior Safeguarding professional and attended by the Safeguarding Children team and health professionals involved in the child's care. Notes should be taken. It may be helpful for professionals to complete the [Alerting Signs Template](#) to help clarify the level of concern.
- Notes from the meeting must be factual and agreed by all parties present- they should form part of the child health record and so would be released to parents if they made a Subject Access request.
- The outcome of the meeting should agree whether the Perplexing Presentation can be explained by either a verified physical and/or psychiatric pathology or neurodevelopmental disorder in the child and there is no FII or that there are perplexing elements to the child's presentation, but they will not come to harm as a result.

Or

- That any verified diagnoses do not explain the alerting signs and that there is actual or likely harm to the child and /or siblings.
- The meeting should agree whether any further investigations or referrals are warranted and in the child's best interest and any health needs of the siblings.
- The meeting should agree how best to support the family and propose a [Health and Education Rehabilitation Plan](#)
- Parents should be informed about the meeting and receive feedback about the conclusions.
- Next steps should be agreed if the parents disengage or request a change in Paediatrician.

Once consensus is agreed in relation to the child's health, a meeting should be held with the parents and the responsible Paediatric Consultant accompanied by another colleague to feedback and explain:

- A diagnosis may or may not have implications for the child's functioning and that genuine symptoms may have no diagnosis.
- Acknowledge that this is a consensus opinion and that it may differ from what they have been previously told or that they have previously believed.
- Agree a plan as to what to tell the child and what will be included in the Health and Education Rehabilitation Plan
- The child should continue under Paediatric follow up

11. Health and Education Rehabilitation Plan

The lead clinician together with the other professionals involved in the child's care will develop a **Health and Education Rehabilitation Plan** together with the family. (See [Health and Education Rehabilitation Template](#)) The Plan must specify timescales and intended outcomes and identify a lead professional to coordinate care and organise regular review of the plan. **Referrals to Early Help** may be helpful in supporting this plan. **It is important that the child continues to be followed up by the lead consultant to ensure that the plan is being followed.**

12. Psychological support.

The Health and Education Rehabilitation Plan should detail how the child and caregivers are going to be psychologically supported through this process. Consideration should be given to referring for appropriate mental health support for the child +/- parents. Psychological support for the child should aim to help the child to adjust to a better state of health and to develop coping strategies to manage their worries and anxieties in relation to their health. A referral to adult mental health services by the parent's GP may be required to provide assessment about the parent's motivation as well as their anxieties and health beliefs and their ability to adjust to their child functioning optimally.

13. Referrals to Children's Social Care

If there is actual or likely harm to the child or siblings identified, then this implies that the child has been subject to FII. The consensus medical view about the child's actual state of health should be discussed with the parents and the importance of reducing medical intervention and ensuring that the child has improved daily functioning alongside a revised view of the child's state of health. A referral to Children's Social Care may be indicated if there has been significant harm to the child but, if the professionals and the family are able to agree and adhere to the Health and Rehabilitation Plan, it may be that a referral to Children's Social Care is not necessary. This will depend on the opinion of the team supporting the child and family and the careful monitoring of the agreed Plan. **If a referral is made to Children's Social Care the reason for the referral should be discussed with the family.**

If parents disagree with the consensus opinion and a Health and Education Rehabilitation Plan or disengage with the Plan which they had previously agreed to, it is necessary to refer the child to Children's Social Care. The referral should be discussed with the family and the reasons for professional concern explained.

The reason for referring the child to Children's Social Care is the need to reduce the harm to the child.

The referral should include:

- 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 the independent observations of the child's actual functioning, medical investigations, detailing all the medical services involved and the consensus medical and professional view about the state of the child's 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 siblings in terms of physical and emotional abuse, medical harm and physical and emotional neglect.

Although health chronologies are not essential in the management of most cases of Perplexing Presentations/Possible FII; they are required in complex cases and in those cases referred to Children's Social Care. The preparation of a health chronology should not delay a referral to Children's Social Care. Health Chronologies should be completed using a Chronology template (See Link to NUTH Template Appendix 18.3) and should be objective and contain balanced information including significant positive information about the family. They should also include an analysis of the safeguarding concerns.

14. Response by Children's Social Care

On receipt of a referral to Children's Social Care where FII is suspected there will be an initial assessment within the Multiagency Safeguarding Hub and a decision made about the need for a Multiagency Strategy meeting to consider information about all the children in the family.

A Multiagency Strategy meeting for suspected FII

Key professionals should include:

- Team Manager Children's Social Care (Chair)
- Safeguarding Children's Health Advisor/Named Nurse
- Initial Response Social Worker
- Referrer
- Lead Paediatric Consultant
- Named/Designated Doctor
- Police representative
- Education staff
- Allied health professionals
- GP
- Legal advisor to Local Authority

It may be necessary to have more than one strategy discussion. A decision will be made about whether a Section 47 enquiry will be undertaken. Consideration should be given to what information is to be shared with the parents and when.

The information shared at the Multi agency Strategy meeting may indicate that a crime has been committed. The Police will lead on any criminal investigation and advise professionals in order to avoid influencing any possible criminal investigation.

15. Decision Making

The strategy discussion should include:

15.1. 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.

15.2. 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, 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.

15.3. 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).

15.4. Possible outcomes of the Strategy Meeting(s):

- No further action by Children's Social Care
- Provision of Services by one or more agencies (eg. Early Help)
- Continued monitoring by identified professionals of specific concerns
- Child & Family Assessment
- Child in need plan
- Section 47 Assessment
- The police commence 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.

15.5. Response if referral to Children's Social Care is declined

If the referral to Children's Social Care is declined as not reaching the threshold for Children's Social Care assessment and support; or the response does not appear to be appropriate, then every effort should be made for health and Children's Social Care to understand each other's professional opinions. Any concerns should be discussed with the Named or Designated Doctor who should then have direct communication with colleagues in Children's Social Care to discuss the referral. Where appropriate, concerns about decisions should be escalated to senior management within the Local Authority as per the Escalation Policy.

16. 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 representative 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.

17. Record Keeping

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

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. These records should be factual and agreed by all parties present. Records must provide a clear statement of what has and has not been discussed with parents. Any e mails between clinicians about a child, between parents and clinicians and between children and clinicians form part of the health record.

GP notes should indicate the level of concerns about perplexing presentations or FII and whether there is a Health and Education Rehabilitation Plan in place.

Subject Access requests from parents in FII/Perplexing Presentation cases are not uncommon. It is easier to manage these requests if there has been open communication with parents about the level of concerns about Perplexing Presentations. Legal advice should be sought if there are concerns that the Subject Access request may impact on the child's welfare and a decision made about what material should be disclosed and any material to be withheld.

18. 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 Consultant can attend.

19. Appendices

[Alerting Signs to Possible FII - Template](#)

[Health and Education Rehabilitation Plan](#)

[Health \(NUTH\) Chronology Template including the Lead Consultant can attend](#)

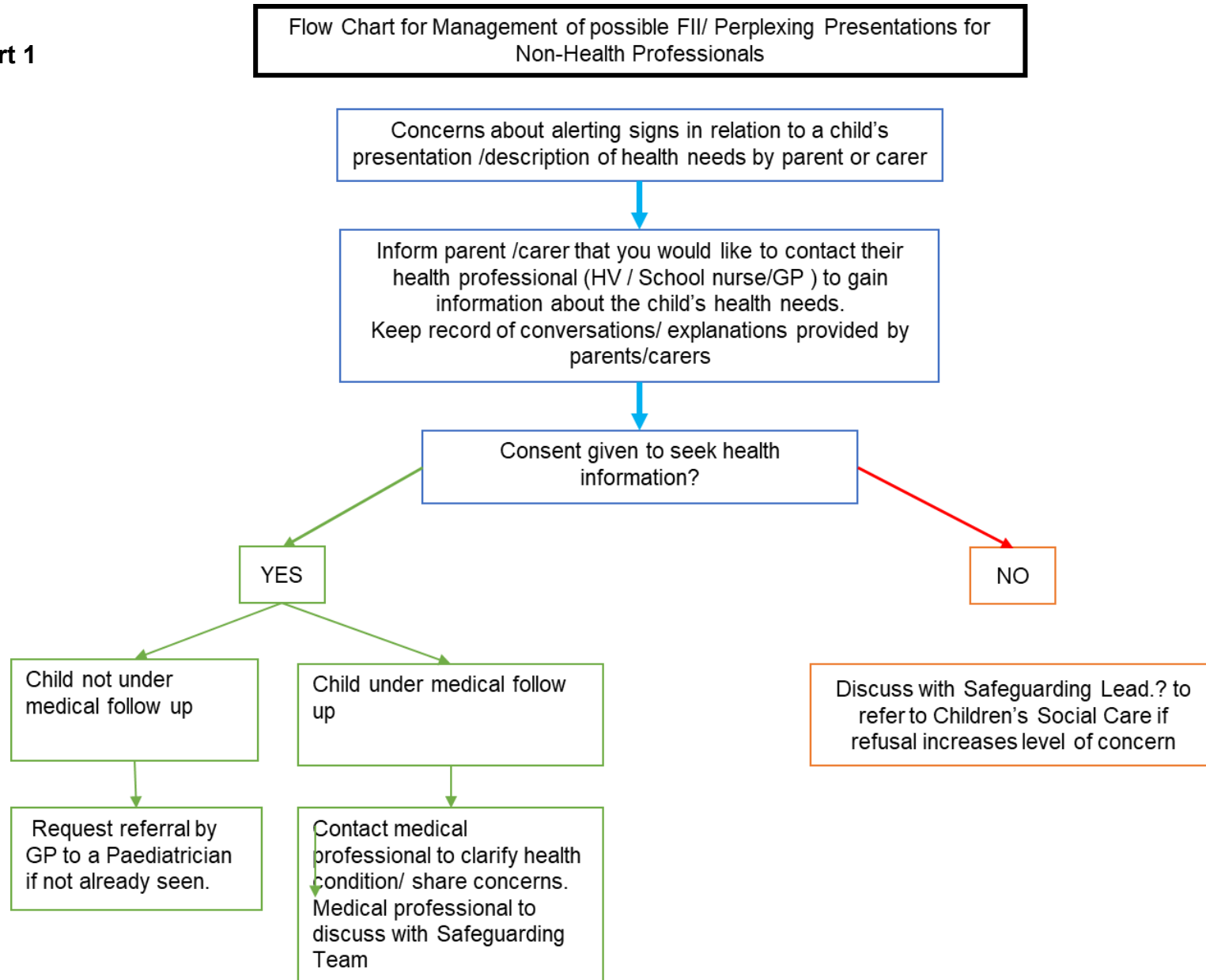
Table 1: Alerting signs to Possible FII

Category	Alerting Signs of Possible Fabricated or Induced Illness in the Child	Examples seen in this child's case / within this family	Examples of strengths / appropriate behaviour not supportive of category	Conclusion about whether criteria met – Yes / No / Possibly / Not known
1	Reported physical, psychological or behavioural symptoms and signs are not observed independently in their reported context			
2	Unusual results of investigations			
3	Inexplicably poor response to prescribed medication and other treatment.			
4	Some characteristics of child's illness may be physiologically impossible			
5	Unexplained impairment of child's daily life including school attendance, use of aids, social isolation			

6	Parents insisting on continued investigations when results of previous investigations have not explained any medical condition			
7	Repeated reporting of new symptoms			
8	Repeated attendances at medical settings including Emergency Department			
9	Inappropriately seeking multiple medical opinions			
10	Providing medical reports from abroad (which are in conflict with UK medical practice)			
11	Child repeatedly not brought to some appointments often due to parental cancellation of appointment			
12	Objection to communication with professionals			
13	Frequent vexatious complaints about professionals			

14	Inability to accept reassurance or recommended management. Insistence on unwarranted investigations, referrals, continuation of or new treatments			
15	Not letting child be seen on their own			
16	Talking for child/ child repeatedly referring or deferring to parent			
17	Repeated or unexplained changes of school (including home schooling)			
18	Factual discrepancies in statements that parents make to professionals or others about child's illness			
19	Parental request for irreversible/dramatic treatment options where the clinical need for this is in doubt			

Flow Chart 1



Flow Chart 2 – Management of Possible FII/Perplexing Presentation following Identification of Alerting Signs

