POLICY FOR THE MANAGEMENT OF CASES OF PERPLEXING PRESENTATIONS, OR, SUSPECTED FABRICATED OR INDUCED ILLNESS

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1.0 Introduction

1.1 This policy on the management of cases of Perplexing Presentations (PP), and suspected Fabricated or Induced Illness' (FII) is based on the guidance from the Royal College of Paediatrics and Child Health (RCPCH 2021) and learning from previous Serious Case Reviews. It should also be used in conjunction with Working Together to Safeguard Children 2018.

1.2 The RCPCH (2021) has defined FII as 'immediate risk of serious harm' particularly by illness induction with clear deception. They then consider management of Perplexing Presentations (PP), that indicate possible harm to the child, and need a carefully planned approach, and differ in having earlier parental involvement in planning.

1.3 The 2021 guidance provides procedures for safeguarding children who present with PP and FII and offers practical advice for paediatricians on when and how to recognise them, how to assess risk and how to manage these types of presentations to obtain better outcomes for children.

1.4 Where concerns are raised by Professionals other than Health, such as schools, where there is no allocated responsible clinician, they should liaise with school nursing service to discuss with GP and/or refer to CAMHS/Community Paediatrician. School Nurses should discuss with their line manager and Safeguarding lead for advice and support with this. School nurses are not expected to raise referrals to the MASH on behalf of other services/agencies.

1.5 For children living outside the borough but have a GP placed in Borough or live in Borough with an out of borough GP the named GP who receives the concern should liaise with their Named GP colleague in the Borough where the child lives to agree how this will be taken forward.

1.6 In probable FII, parents should not be informed until there is a multiagency agreement to do so. In PP, the lead clinician will agree a plan of action with the named doctor including when to notify the parents as part of the plan.

1.7 Practitioners need to respond appropriately to safeguarding concerns other than, or additional to, FII or PP. If parents do not agree to a referral to health, or information sharing then safeguarding guidance should be followed.

1.8 In both FII and PP cases there needs to be a health lead (usually a consultant paediatrician or CAMHS practitioner or GP [1]who will liaise with the named doctor). The named doctor for safeguarding should involve the designated doctor as appropriate.

1.9 The aim of this guidance is to put the RCPCH in context for Bromley based practitioners. Whilst this is mainly health guidance, this multiagency policy applies to all frontline staff working with children, young people, and their families. The term 'children' or 'child' applies to all children and young people who have not yet reached their 18th birthday as per the

[1] **Designate Doctor and Named Doctor in the Community to provide support for GPs including convening any relevant meetings.**

Children Act 1989. The fact that a child has reached 16 years of age; is living independently or is in further education; is a member of the armed forces; is in hospital; in prison or in a young offender's institution, does not change his or her status or entitlement to services or protection under the Children Act 1989.

2.0 Purpose

The purpose of this policy is to:

- To provide a single consistent approach, across local providers and staff in the management of PP, or suspected FII.
- Provide staff with the information and guidance they need to fulfill their statutory duties to safeguard and protect children and young people when there is suspected PP or FII.
- To clearly define roles and responsibilities so that the process is transparent, and staff understand the complexities involved and have realistic expectations about the timeframes within which any given case can be managed.
- To show what good collaborative and multi-agency working looks like and how to effectively manage FII.
- Support and protection of health professionals, social workers or any of the agency colleagues who are dealing with these cases.

3. 0 Definitions /description

3.1 Alerting signs

Illness may not be independently verified, there may be unusual results, unexpectedly poor treatment response, impaired daily living more than expected.
Parents may want more investigations, multiple opinions or present with new symptoms. Despite this, the child may not be taken to appointments, and may not be able to be seen alone. Parents may object to communication between professionals.
The paramount consideration for health professionals is the impact of the situation on the child's health and wellbeing.

3.2 Medically Unexplained Symptoms (MUS)

The symptoms which the child complains, and which are presumed to be genuinely experienced are not fully explained by any known pathology. These are usually psychosocial and may be part of PP or FII.

3.3 Perplexing presentations (PP)

Alerting signs only; There may be discrepancies between reports, presentations and observations, or implausible descriptions, findings, or parental behaviors, (not yet amounting to likely or actual significant harm). Needs a specified Paediatric /CAMHS/GP lead[1] to collate and assess all information, supported by Named Doctor to assess risk, and a multi-professional and holistic medical and psychosocial consensus approach to agree when to gain views and involve parents and child in the discussions. Any second opinion must include all background information and must be reasonable. Lack of engagement or concerns may lead to referral to Children's social care.

3.4 **Fabricated and Induced Illness (FII)**
Clear deception/ illness induction or immediate, serious risk to life/ health

4.0 Identification of Alerting signs.

4.1 Illness may not be independently verified, there may be unusual results, unexpectedly poor treatment response or impaired daily living more than expected.

4.2 Parents may want more investigations, multiple opinions or present with new symptoms. Despite this, the child may not be taken to appointments, and may not be able to be seen alone. Parents may object to communication between professionals and there may be frequent complaints about professionals.

4.3 These signs may not amount to probable FII or PP but should also be considered under general safeguarding concerns as to whether they may be harmful to the child.

5.0 Immediate action if there is evidence of FII, where there is imminent risk to child's health/ life

5.1 When there is evidence of deception, interfering with specimens, unexplained results of investigation suggesting contamination or poisoning or actual induction of illness or concerns that open discussion with parent might lead them to harm about a child's health this should be discussed urgently with the child's GP, the practitioners safeguarding lead, and with the child's Paediatrician if known to their service.

5.2 Concerns regarding the possibility of FII **must not** be shared with parents/carers as this may increase the risk to the child and this should be reiterated as part of the discussion. Decision should be made as to the urgency of any further meeting or referral to children's social care.

5.3 If intervention is required immediately due to concern about immediate harm to the child e.g., observed that medication / feeds tampered with in hospital, medical staff (supported by the clinical and safeguarding lead) should call the Police using the '999' service, otherwise a referral should be made to the Police and MASH with a request for an urgent strategy discussion.

5.4 The practitioner should inform their line manager and seek support and advice from their Safeguarding Children Team/Lead.

5.5 Referral should be made to Children's Social Care and the Police, with explicit evidence that the referral meets the threshold for level four in order for a strategy discussion to be convened.

5.6 The formal strategy meeting should take place as soon as possible involving as a minimum the lead clinicians and safeguarding lead, and Designated Professionals from SEL ICB Bromley for Safeguarding Children should be invited. Involved clinicians should all be invited, including the GP. All invitees must prioritise attendance at this meeting even if it means rescheduling other appointments. If attendance of a professional is still not possible then a

fully briefed substitute must attend. It is important that the substitute be able to make decisions on behalf of the professional. All professionals are expected to attend the meeting fully prepared and able to discuss their concerns and understand that concerns should not be shared with the parents at this stage.

5.7 If at any time the practitioner considers their concerns are not being taken seriously or responded to appropriately; they should discuss this with the Named safeguarding professional, or the Designated Safeguarding Children professionals within the ICB. Concerns should be escalated in accordance with this policy.

5.8 Agreement is needed about the safeguarding response, and when and who should inform the parents. This should be discussed and agreed at the strategy meeting.

5.9 The health practitioner, with the support of the Safeguarding Professional, should prepare a medical chronology (see chronology template in appendix 4).

5.10 The practitioner should continue to record their concerns and observations accurately and objectively in the child's health record so that other clinicians have access to the information. In such cases parent/carer's access to the record will need to be restricted, with a clear note to reflect this, if there would be risk to the child.

5.11 A follow up Professionals' Meeting with the Designated Doctor and all other involved healthcare professionals will be arranged by the Responsible Paediatrician /CAMHS Lead/GP for feedback of the outcome and any further action required. If the child had been referred to CSC, then this should be prior to discharge from CSC oversight and otherwise within six weeks to allow time to gather any further information if needed.

5.12 A flowchart of the procedure can be found at appendix 1.

6.0 To further identify /assess if there is probable FII

6.1 There may be clear deception, or illness induction, or serious immediate risk to life/health and it will be essential to act directly as for probable FII (section 5 above). Where the risk is not immediate and the consultant has reasonable cause to suspect that a child is suffering or likely to suffer significant harm (*from probable FII or other reason*), a referral should be made with explicit evidence that the threshold for Level 4 has been met to the police and local authority's Children's MASH Services for an urgent strategy discussion with professionals involved with the child.

6.2 If the child is not under the care of a consultant, the GP will need to make a referral to an appropriate Consultant Paediatrician. This referral will be facilitated by the Named/ SEL ICB Bromley Designated Doctor and should reiterate the need not to alert the parents/carer to the possibility of FII at this stage when obtaining consent for the assessment. The 'Responsible Paediatrician'/ 'Responsible CAMHS doctor'/'Responsible GP' will arrange for a medical evaluation to take place as appropriate.

6.3 Identification of probable FII can be a difficult and protracted task and may require a multi-agency approach and expertise and relatively long periods of observation.

6.4 Information gathering is usually needed to understand if this is Probable FII, or PP, or MUS as the management is very different. (See section 8.0 Considerations for medical evaluation).

6.5 If concerns persist about probable FII, and it is still unclear whether this meets the threshold for referral to children's social care i.e., as for 'probable FII' above, then, with the support of their Safeguarding Lead, the lead clinical practitioner will arrange an initial professional's Meeting to take place within 10 working days, or earlier if required.

6.6 All health professionals involved in the child's care should be invited. The MASH manager or a delegated social worker can be invited to Pre-MASH referral MDT meetings in an advisory capacity. Where appropriate, representation from the school should be sought.

6.7 All invitees must prioritise attendance at this meeting even if it means rescheduling other appointments. If attendance of a professional is still not possible then a fully briefed substitute must attend. It is important that the substitute be able to make decisions on behalf of the professional. All professionals are expected to attend the meeting fully prepared and able to discuss their concerns and) understand that concerns should not be shared with the parents at this stage.

6.8 The meeting should explore and find agreement about any deception, or illness induction, and if there is potential serious or immediate risk to the child's life as well as any other safeguarding risk.

6.9 The decision from this meeting should consider;

- If this is 'Probable FII' with immediate serious risk to the child's health or life (see section 5.0).
- If this should be managed as a perplexing presentation
- If there are any other safeguarding risks including for other children.
- A detailed composite chronology should be completed by all involved practitioners regarding their own involvement with the child within 10 days (see chronology template in appendix 4).and shared with the Named Doctor or if not already involved, the Designated Doctor.

6.10 The 'Responsible Paediatrician'/ 'Responsible CAMHS doctor'/'Responsible GP' will chair this meeting supported by the Named Doctor or the SEL ICB Bromley Designated Doctor. Clear terms of reference and records of the meeting must be made available at the time, the arrangement of these made by the chair. In cases where the child is not under care of any doctor, the SEL ICB Bromley Designated Doctor will chair the meeting.

6.11 Whilst professionals should in general, discuss any concerns with the family and, where possible, seek agreement to making referrals to Children's Social Care, this should only be done where such discussion and agreement-seeking will not place a child at increased risk of significant harm, and for probable FII should only be shared after agreement at the multiagency discussion.

6.12 At this stage explicit evidence that a referral made to social care and the police meets the threshold for level four must be provided in order for a strategy discussion to be convened.

6.13 If there is no obvious deception, illness induction and no serious immediate risk, in which case the clinical management should be managed as Perplexing Presentations (see section 7.0 for Perplexing Presentations)

7.0 Perplexing Presentations

7.1 Alerting signs are present. E.g., Illness not independently verified, or results are not as expected, or the child has impaired daily life more than expected and the parents may want more investigations or opinions, and may be reluctant to allow professionals to communicate, or allow discussion with the child on their own.

7.2 The 'Responsible Paediatrician'/ 'Responsible CAMHS doctor'/'Responsible GP' will arrange for a medical evaluation to take place as appropriate. If the child is not under the care of a paediatrician, the GP will need to make a referral to an appropriate Consultant Paediatrician with relevant information. This referral will be facilitated (re timescales / specific outcomes) by the SEL ICB Bromley Designated Doctor and should reiterate the need *not* to alert the parents/carer to the possibility of FII at this stage (see 6.2).

7.3 If it assessed that there is NO clear deception, NO illness induction, and NO immediate serious risk to life or health, then these are treated as PP.

7.4 There must be a lead/responsible clinician who should discuss with the Named Doctor of the trust/provider organisation or the SEL ICB Bromley Designated Doctor. If the concern arises in General Practice, then the Named GP should be consulted.

7.5 Other clinicians and therapists should discuss with their supervisor, who will need to discuss with the Named Doctor in the trust. There needs to be a carefully planned approach.

7.6 The responsible clinician should obtain a history and observations from caregivers, explore parental views, family functioning and support and any need for/previous early help or social care involvement. (A chronology should be completed, see chronology template in appendix 4).

7.7 The child's view should be explored alone, to find out their view and beliefs as well as worries, mood and wishes. The Three Houses tool is useful to explore their views, or RCPCH tools referenced in the 2021 guidance. (See section 12. References).

7.8 There may be safeguarding, or welfare needs that are unmet, and these must be considered separately to the clinical picture; these may need action independent of any consideration of immediate risk relating to the clinical picture.

7.9 There needs to be an assessment of risk, and a consensus reached between all health professionals known to the child. A Professionals meeting may need to be convened. if there is no immediate risk, the responsible clinician will involve parents in the assessment plan.

7.10 If the referral is from school, then the school should tell the parents that they need information from health to understand e.g., poor attendance. If the parents to do not agree with this health referral, then the school should follow safeguarding guidance as to whether to escalate to children's social care**.** **Do Not** use the terminology Fabricated and Induced Illness.

7.11 With PP, the 'Responsible Paediatrician'/ 'Responsible CAMHS doctor'/'Responsible GP' needs to maintain a clinical oversight and continue to see the child even after usual discharge from care.

7.12 The Named doctor will take the safeguarding decisions to ensure clinical continuity of care. The child's consultant should collate all information including diagnoses, investigations, and referrals, as well as information from school and other professionals. Notes from meetings may be given to parents. Any second opinion should be reasonable**.** Safeguarding and clinical care are kept separate by two different clinicians.

7.13 It is essential to try to reach a consensus in a health professionals meeting with information from all involved health professionals, as to whether perplexing presentation is explained, and resolved, or concerns remain; the Named Doctor / Designated Doctor should chair this meeting and the parent informed of this.

The outcome of this meeting needs to achieve consensus about the following.

- Medically explained/unexplained symptoms.
- Actual or likely harm
- Further investigations
- Support needs of family
- Health of siblings
- Consider Local service consultant if only tertiary care
- What to do if parents disengage
- Plans for meeting with parents (two professionals will attend)

7.14 If there is no consensus, then this may need the SEL ICB Bromley Designated Doctor to chair a subsequent health professionals meeting

7.15 The Responsible Consultant (with Named professional or safeguarding lead) should meet with the parents to share the consensus and plan which can be negotiated with the young person if possible

7.16 A co-constructed plan should be made with Education to get a child back to school and be carefully monitored by health and education. This should be led by the Lead professional who should call a Team around the Child (TAC) meeting (this plan may be called a Health and Education Rehabilitation plan). If the child has already been referred to CSC and escalated, then this would be included in the CIN or CP plan.

7.17 Referral to children's social care may be needed, and the reasons shared with the family, for example if the parents do not support a Health and Education Rehabilitation plan.

7.18 The child's GP should always be informed and be able to give a view as to the plan

Parents and young people should be informed of the outcomes of professional meetings if it is safe to do so.

8.0 Considerations for Medical Evaluation

8.1 All signs and symptoms must be subject to careful medical evaluation for a range of possible diagnoses.

8.2 All tests and their results should be fully and accurately recorded, including those with a negative result. It is important that the child's records are not tampered with, or test results altered in the child's notes.

8.3 If the child is not currently in hospital, consider whether a planned admission with careful observation would help to elucidate the clinical diagnosis.

8.4 Carefully consider whether any immediate investigations or further opinions are likely to assist in the diagnosis.

8.5 Stop any harmful treatments or invasive procedures unless they are clearly indicated. It is unacceptable to cause a child further harm from medical actions, whilst the diagnosis of FII is being considered.

8.6 Do not wait to confirm the diagnosis before referring to children's social care as a delay may be detrimental to the child. Referral is indicated if there is a risk of immediate harm to the child through illness induction, or harm through the carer's disagreement with the need for further observation or with paediatric consensus about the child's state of health.

8.7 A chronology of health involvement from all health agencies should be prepared to provide comprehensive information, an overall picture and evidence.

8.8 Concerns about the reasons for the child's signs and symptoms should not be shared with parents if this information is likely to jeopardise the child's safety.

9.0 Considerations for MASH on receipt of referral

9.1 Once a referral is received by MASH, MASH managers will consider whether the threshold is met to progress to a Strategy discussion. This will be dependent on the quality of the referral and medical information provided at the point of referral. It is therefore important that the expert Medical Opinion outlines the concerns in detail.

9.2 Upon receipt of the referral MASH follow the London Safeguarding Procedures:
[London safeguarding children procedures Perplexing Presentations]

9.3 Imminent or probable risk to child's health/ life from FII or another cause, with explicit evidence that the referral meets the threshold for level four in order for a strategy discussion to be convened, should involve as a minimum the lead clinicians and safeguarding lead, and

Designated Professionals from SEL ICB Bromley for Safeguarding Children should be invited. Involved clinicians should all be invited, including the GP. No information should be shared with the parents (see sections 5 and 6 above).

9.4 If referral received and uncertain that there is evidence of FII, this will still always need consideration of any harm to the child and needs discussion with the clinical lead consultant for the child / Named Doctor (or the Designated Doctor if there is no allocated consultant yet and the referral is for example from Education). Parents must not be informed of the progress at this stage, but the case may be managed as for perplexing presentations in the first instance (section 7).

9.5 Failure to progress in the management of perplexing presentations will need a professional's meeting with an agreed plan.

9.6 At any stage in the process a safeguarding referral may be made because of likely /experienced harm and will need to be managed as usual through the MASH process. This decision must be taken in consultation with the consultant paediatrician/lead clinician responsible for the child's health care, or the designated doctor SEL ICB, and the police because any suspected case of fabricated or induced illness may also involve the commission of a crime.

10.0 Record Keeping

10.1 Medical records should be kept in accordance with the Data Protection Act 1998. Practitioners should also follow the principles of record keeping set out in guidance documents supplied by their Professional bodies.

10.2 Detailed, accurate and informative medical records are pivotal to the management of a suspected FII case. If a child moves between clinical teams or between organisations, it is best practice for the notes to follow the child. This may not always be possible and so a clinical summary must accompany the child.

10.3 It is essential that the records include a health chronology of the child's medical presentation, including aspects which may indicate FII. It is crucial to record the source of information, e.g., whether a symptom or sign was independently observed by staff or reported by a parent / carer.

10.4 If FII is suspected, requests by a child's parent / carer to access their records under the Data Protection Act 1998 may be refused if:

- The disclosure would be likely to cause serious harm to the physical or mental health or condition of the child
- The child has provided the information in the expectation that it would not be disclosed to the parent / carer
- The data was obtained because of an examination or investigation to which the child consented in the expectation that the information would not be so disclosed
- The child has expressly indicated that the information should not be so disclosed.

11.0 Training and Supervision Requirements

11.1 All professionals who encounter children or their families should have appropriate safeguarding training and an understanding of PP and FII. Those specialising in the care of children or families need additional training to ensure a higher level of awareness and understanding of PP and FII.

11.2 All professionals should seek support and supervision in dealing with cases of PP or suspected FII. The facilitation of debriefing sessions can be helpful in providing support for all members of the team both during and coming out of cases. Ensuring staff know that from the onset what support they have available to them and where to access it.

12.0 Management of Social Media

12.1 On occasions there have been incidents when members of staff involved in these cases have been identified/criticised on social media platforms and in the press.

12.2 Normally when the press is involved, they would come to the organisation for a statement before publishing and are a regulated agency.

12.3 However, social media platforms sadly continue to be largely unregulated. Where staff have concerns or become aware of adverse social media presence regarding these cases both personally and organisationally, they should inform their line manager (if applicable) and discuss with the Executive Lead for Safeguarding, HR and the comms team for advice and support to consider the best approach. Following discussion, a plan may be developed to consider the best action to take to support both the families and staff.

For example, there may be occasions when reaching out to parents to offer other routes such as the complaints policy may be appropriate, on other occasions this could be inflammatory.

12.4 Finally, staff should be supported to access Occupational Health support and other services as appropriate. This may include the Keeping Well in Southeast London support service offer. [Keeping Well South East London (keepingwellsel.nhs.uk)]

13.0 References

13.1 Children Act 1989. http://www.legislation.gov.uk/ukpga/1989/41/contents

13.2 Children Act 2004. http://www.legislation.gov.uk/ukpga/2004/31/contents

13.3 NHS Choices, 2012. Fabricated or Induced Illness:
Overview - Fabricated or induced illness/NHS

13.4 Schreier H (2004) Munchausen by proxy. Current Problems in Pediatric and Adolescent Health Care, 34(3): 126-143.

13.5 Working Together to Safeguard Children 2018:
Working Together to Safeguard Children 2018

13.6 Davis P, et al; 2018. 40 years of fabricated or induced illness (FII): where next for paediatricians? Paper 1: epidemiology and definition of FII Arch Dis Child
Epidemiology and definition of FII

13.7 Sheridan (2003) The deceit continues: an updated literature review of Munchausen Syndrome by Proxy. Child Abuse and Neglect 431-451:
Munchausen by proxy - PubMed (nih.gov)

13.8 RCPCH (2021) PP or Fabricated Induced Illness in Children guidance:
RCPCH (2021) PP or FII Children's Guidance

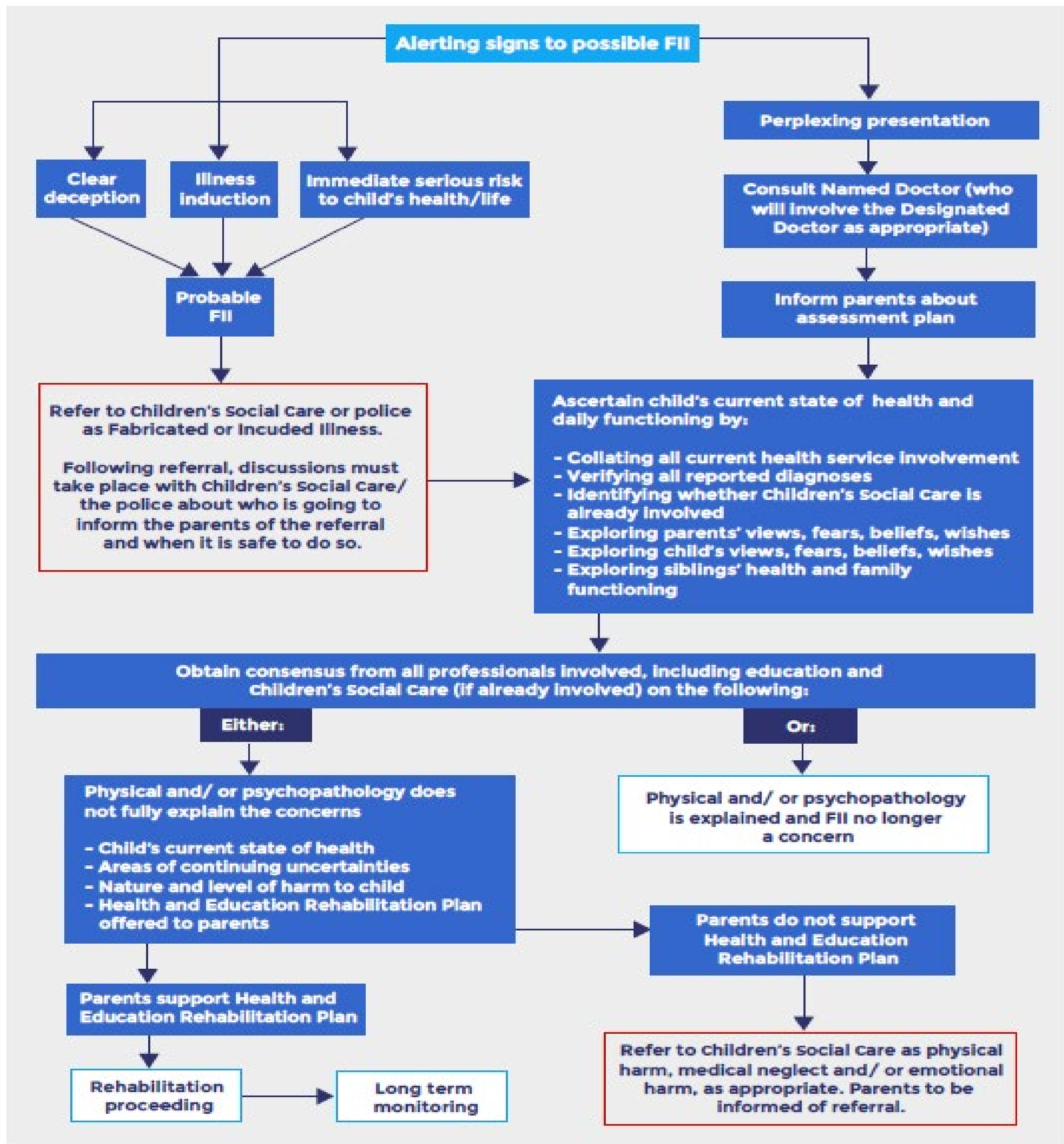
13.9 Fabricated or Induced Illness and Perplexing Presentations Abbreviated Practice Guide for Social Work Practitioners: **Abbreviated Practice Guide**

13.10 **Three houses guidance .pdf (partneringforsafety.com)**

13.11 Upon receipt of the referral MASH will follow the London Safeguarding Procedures:
London safeguarding children procedures Perplexing Presentations

APPENDIX 1 – Generic flow chart when there are alerting signs

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



APPENDIX 2 – Probable/Possible Fabricated Induced Illness or Perplexing Presentations Flowchart for Bromley Professionals

Where there is explicit evidence of FII and risk to child's health/ life Immediate action is required

A referral should be made to Children's Social Care and the Police, with explicit evidence that the referral meets the threshold for level four in order for a strategy discussion to be convened.

Police: 999
Multi-Agency Safeguarding Hub (MASH) on 0208 461 7373/ 7379/ 7026
Email mash@bromley.gov.uk.
MASH -Out of hours/weekends/public holidays: 0300 303 8671

To further identify /assess if there is possible FII or Perplexing Presentations where there are no immediate concerns. Frontline professionals (including teachers)/ their safeguarding leads should discuss with any of the Responsible Health Clinicians

The 'Responsible Paediatrician'/ 'Responsible CAMHS doctor'/'Responsible GP' should seek support from the Named Doctor of the trust/provider organisation or the SEL ICB Bromley Designated Doctor to identify whether further medical evaluation is indicated.

If concerns persist about possible FII, and it is still unclear whether this meets the threshold for referral to children's social care i.e., as for 'probable FII' above, then, with the support of their Safeguarding Lead, the lead clinical practitioner will arrange an initial professional's Meeting to take place within 10 working days, or earlier if required.

Possible Fabricated Induced Illness
If concerns persist following Professionals meeting a detailed composite Chronology is to be completed and referral made to MASH.

Perplexing Presentation
If it assessed that there is NO clear deception, NO illness induction, and NO immediate serious risk to life or health, then these are treated as PP.
There needs to be an assessment of risk, and a consensus reached between all health professionals known to the child. Following the Professionals meeting if there is no immediate risk, the responsible clinician will involve parents in the proposed assessment and treatment plan.

If parents are compliant with assessment and the treatment plan. the 'responsible Paediatrician'/ 'responsible CAMHS doctor'/'responsible GP' needs to maintain a clinical oversight and continue to see the child even after usual discharge from care.

If the parents do not support a Health and Education Rehabilitation plan, a referral to Children's Social Care may be needed, and the reasons shared with the family.

Appendix 3- Spectrum of cases where FII concerns may arise (RCPCH, 2013)

Starting point: A child is presented for medical attention, possibly repeatedly, with symptoms or signs suggesting significant illness; an appropriate clinical assessment suggests that the child's illness is not adequately explained by any disease.				
Example 1	**Example 2**	**Example 3**	**Example 4**	**Example 5**
Type of Presentation				
Simple anxiety, lack of knowledge about illness, over interpretation of normal or trivial features of childhood; may in some cases be associated with depressive illness in carer	Child's symptoms are misperceived, perpetuated, or reinforced by the carer's behaviour; carer may genuinely believe the child is ill or may have fixed beliefs about illness	Carer actively promotes sick role by exaggeration, non-treatment of real problems, fabrication, or falsification of signs, and/or induction of illness (sometimes referred to as 'true' FII)	Carer suffers from psychiatric illness (e.g., delusional disorder) which leads them to believe child is ill	Unrecognized genuine medical problem becomes apparent after initial concern about FII
Underlying factors				
Carer's need to consult a doctor may be affected by inability to cope with other personal or social stresses, such as mental health issues	'Illness' may be serving a function for carer, and subsequently for an older child too (secondary gains)	There may be a history of frequent use of, or dependence on, health services; carer may have personality disorder or the child's illness may be serving a purpose for the carer	Carer's mental health problems	
Carer's insight				

It is usually possible to reassure carer although they are likely to present again in the future	Difficult to reassure carer; carer and professionals may not agree on the cause of symptoms and/or the need to consult or investigate further	It is not possible to reassure carer; carer's objectives are diametrically opposed to those of professionals	Carer lacks insight into their involvement in the child's illness	Carer's 'illness behaviour' will usually be inappropriate for the signs displayed by child, although any child protection interventions may affect carer's behaviour
Level of Risk				
Seldom reaches threshold of significant harm	May be disabling for the child; often some risk of significant harm, including emotional or educational harm, or social isolation	High risk of harm; always some resultant harm, often severe	May be risk of harm	Risk of harm due to inappropriate child protection process and delay in correct diagnosis
Iatrogenic harm				
Possible iatrogenic harm	Significant risk of iatrogenic harm	Very high risk of iatrogenic harm Usually low risk of	Usually, low risk of iatrogenic harm	See above
Management				

Discuss carer's concerns openly; manage case primarily by reassurance; try to address any wider needs of carer	Discussion with carer may need to be handled very sensitively; if in doubt discuss with appropriate colleague; firm reassurance will be needed; avoid iatrogenic harm by not conducting further unnecessary investigations and treatments; multiagency assessment may be needed to gain an understanding of what underpins carer's behaviour; child protection referral may be indicated	Local Safeguarding Children Board procedures apply; take immediate steps to reduce iatrogenic harm if possible; do not disclose concerns to carer(s) without first discussing the case with the safeguarding team	Discuss with carer whether they feel that they have any mental health needs and how these might be addressed; consider discussing with GP or other relevant professional (bearing in mind the constraints of confidentiality); take steps to address carer's mental health needs; child may be a 'child in need' (Section 17, Children Act 1989)	Consult widely with colleagues if a 'false positive' child abuse diagnosis seems likely; if safeguarding procedures already activated, request immediate strategy discussion, and discuss situation with carers without delay; the possibility of 'false positive' child abuse diagnosis must always be considered; the child's clinical progress should always be monitored in case genuine illness has been missed

Appendix 4 – Sample of Chronology Template

Date / Time And Agency	What Was Reported	Source Of Information	What Was Observed By Whom	What Action Was Taken And On What Basis	Outcome Of Action	Analysis	Comment