Reframing the Problem in PP/FII: From "Perpetrator" to "Traumatised" Parent/Carer

January 2026

Dr David OSOBA
Designated Doctor for Safeguarding Children
Bromley ICS

https://cerebra.org.uk/wp-content/uploads/2023/11/FII-Final-report-2023-Nov-01.pdf?utm_source=chatgpt.com

BSCP PP/FII Guidance

Aims:

1. Centring the child/YP in their experience of 'medical trauma' or 'medical child abuse'

2. Seeks to minimise system-induced harm through coordinated, transparent, and consistent multi-agency working – in a 'trauma-informed' way.

3. View the parent/carer(s) through the lens of 'potential' trauma and/or psychopathology.

4. Aiming for 'therapeutic' recovery and rehabilitation alongside protection.

RCPCH

Factitious disorder imposed on another (FDIA)

Factitious Disorder Imposed on Another (FDIA): What It Is

https://my.clevelandclinic.org/health/diseases/9834-factitious-disorder-imposed-on-another-fdia

RCPCH PP/FII Guidance

Definition of Key Terms

Fabricated or Induced Illness (FII)

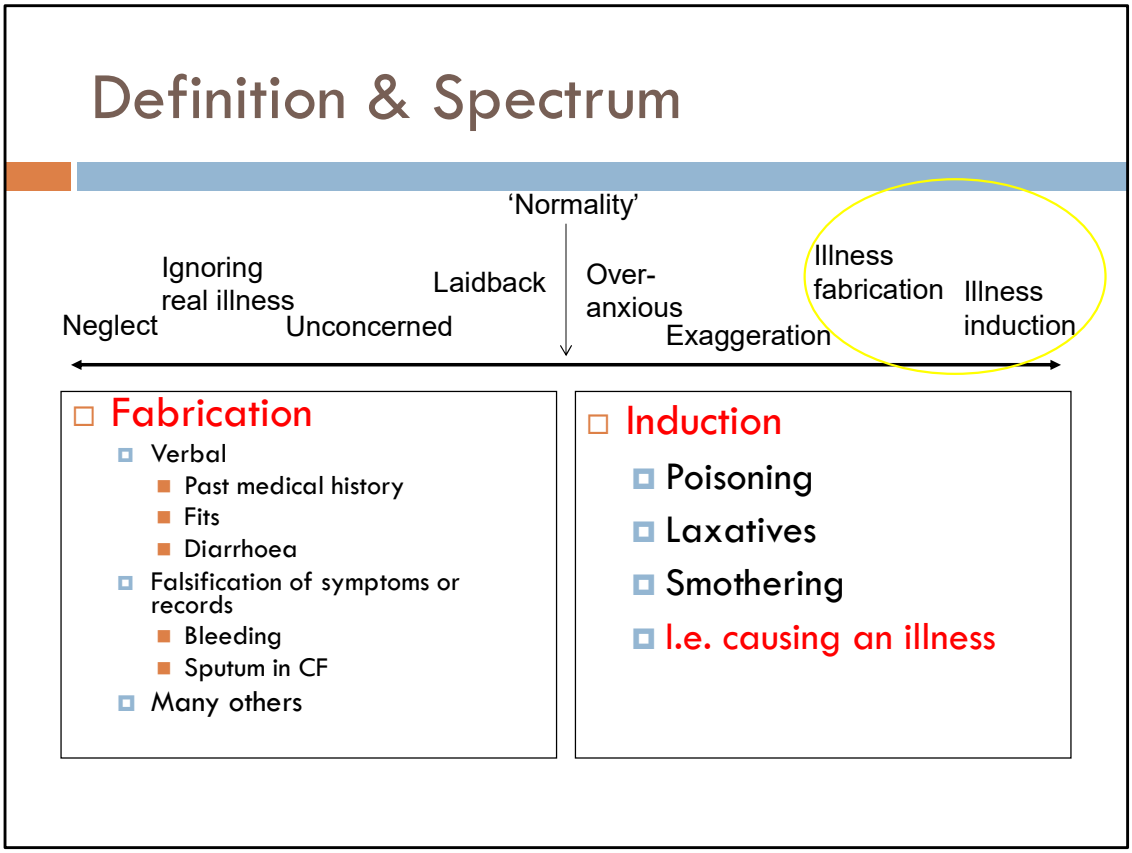
FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these.

The parent does not necessarily intend to deceive, and their motivations may not be initially evident.

It is important to distinguish the relationship between FII and physical abuse / non-accidental injury (NAI). In practice, illness induction is a form of physical abuse (and in Working Together to Safeguard Children, fabrication of symptoms or deliberate induction of illness in a child is included under Physical Abuse). In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not there are recurrent presentations to health and other professionals. This particularly applies in cases of suffocation or poisoning.

RCPCH

FII is a clinical situation in which a child is, or is very likely to be, harmed due to parent(s) behaviour and action, carried out in order to convince doctors that the child's state of physical and/or mental health and neurodevelopment is impaired (or more impaired than is actually the case). FII results in physical and emotional abuse and neglect, as a result of parental actions, behaviours or beliefs and from doctors' responses to these. The parent does not necessarily intend to deceive, and their motivations may not be initially evident.



The term Munchausen syndrome is based on the story of a German cavalry officer named Baron Munchausen who was known to brag about exaggerated tales. In the first case report on Munchausen syndrome *by proxy* (MSbP), Prof Meadow (UK) described it as a form of child abuse where parents falsify or induce symptoms resulting in unnecessary harmful medical procedures in children. Even though other contemporary terms have since been suggested, MSbP continues to be used widely in the USA.

The term "Factitious Disorder Imposed on Another (FDIA)", defines the psychopathology and actions of the perpetrator. The World Health Organization (WHO) states that FDIA is "characterized by feigning, falsifying, or inducing, medical, psychological, or behavioural signs and symptoms or injury in another person, most commonly a child dependent, associated with identified deception". Notably, "the deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g., obtaining disability payments)"

In the USA the term "medical child abuse (MCA)", define the abuse of the victim, rather than on the mental status or motivation of the perpetrator who caused the signs and/or symptoms.

Perplexing Presentation and Fabricated or induced illness by carers are terms introduced in the UK by the RCPCH (Royal College of Paediatrics and Child Health), since 2021.

RCPCH PP/FII Guidance
Definition of Key Terms

Perplexing Presentations (PP)

The term Perplexing Presentations (PP) has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to or likely actual /significant harm), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.

RCPCH

The term Perplexing Presentations (PP) has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.

Terminology Comparisons – UK vs USA

Aspect	UK	USA
Preferred safeguarding term	Fabricated or Induced Illness (FII)	Medical Child Abuse (MCA)
Psychiatric diagnosis	Not required / discouraged	FDIA (DSM-5-TR)
Focus	Child harm & risk	Perpetrator behaviour + child harm
MSBP usage today	Historical only	Historical / academic
Legal emphasis	Threshold of harm	Evidence of deception + harm

RCPCH

Historical Timeline:

1951 – Origin of "Munchausen Syndrome"
Who: Dr Richard Asher (UK)
What: Described adults who fabricate illness in themselves
Key idea: Deliberate deception for psychological gain
Relevance: Laid the conceptual groundwork for MSBP

1977 – Munchausen Syndrome by Proxy (MSBP)
Who: Professor Sir Roy Meadow (UK paediatrician)
Publication: The Lancet

Definition:
- A caregiver (usually a parent) fabricates, exaggerates, or induces illness in a child

-Motivation: psychological need to assume the sick role by proxy

Impact:
-Rapidly adopted in UK, USA, and Europe

-Became the dominant term for ~30 years

1980 – DSM-III (USA)
MSBP status: Not formally recognised
Related concept: Factitious Disorder (self)
Issue: Children seen as victims, but perpetrators not well classified diagnostically

1994 – DSM-IV (USA)

Term used: Factitious Disorder by Proxy (descriptive, not headline diagnosis)
Focus: Psychiatric classification of the perpetrator
Limitation: Still insufficient emphasis on child safeguarding

1998–2002 – Growing Criticism of MSBP

Concerns in UK & USA:

- Over-focus on motive rather than harm
- Legal misuse and diagnostic overreach
- Association with Roy Meadow during controversial court cases

Shift toward behaviour-based safeguarding language

2002 – "Fabricated or Induced Illness" (FII) Introduced
Who: UK Department of Health
Guidance: Safeguarding Children in whom Illness is Fabricated or Induced
Why the change?

- Move away from psychiatric labels
- Focus on observable harm to the child
- Applicable even when motivation is unclear

Key definition:
A child suffers harm due to a caregiver fabricating symptoms, falsifying records, or inducing illness

2008 – NICE & Safeguarding Integration
FII embedded into:

- Working Together to Safeguard Children
- Child protection frameworks

MSBP becomes discouraged terminology in official UK practice

2013–2015 – FII Consolidated
Updated statutory guidance
Clear statement:

- FII is child abuse
- Not a diagnosis
- Requires multi-agency response

MSBP retained only as historical/academic term

<u>USA Terminology Shift</u>

2013 – DSM-5
New term: Factitious Disorder Imposed on Another (FDIA)
Key features:

Psychiatric diagnosis of the perpetrator
Includes deception, falsification, or induction of illness
Victim identified explicitly

Important distinction:
DSM diagnosis ≠ child protection determination

2016–2018 – American Academy of Pediatrics (AAP)
Emphasised:

Use of medical child abuse in safeguarding contexts
DSM diagnosis not required to protect a child

"Medical Child Abuse" gains traction clinically and legally

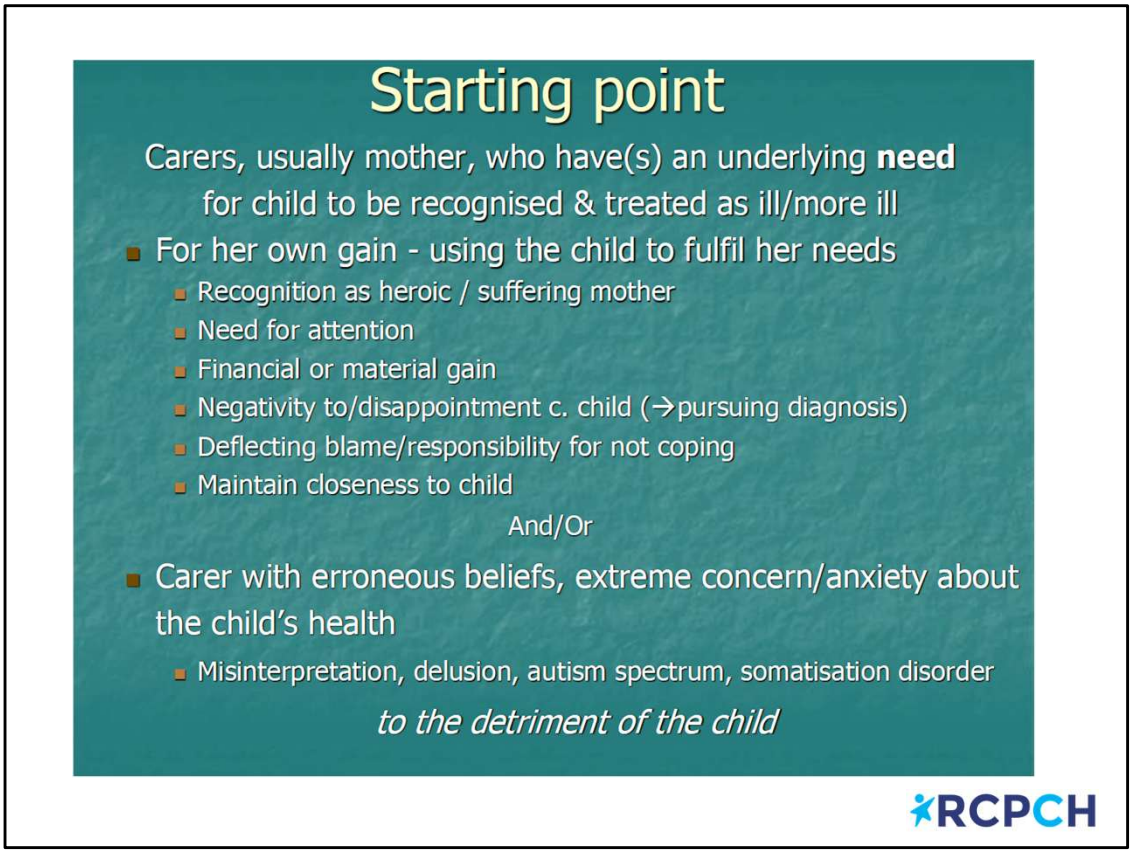
2022 – DSM-5-TR
FDIA retained
Language clarified to:

Reduce ambiguity
Emphasise intentional deception

Still distinct from child protection terminology

<u>Key Conceptual Shift Over Time</u>
From: Why is the caregiver doing this?
To: Is the child being harmed, and how do we stop it?
This shift explains why MSBP fell out of favour, even though the behaviours it described are still very much recognised.

<u>Current Accepted Language (2026)</u>
UK clinical & safeguarding practice:
✓ Fabricated or Induced Illness (FII)
US child protection:
✓ Medical Child Abuse (MCA)
Psychiatric diagnosis (USA):
✓ Factitious Disorder Imposed on Another (FDIA)



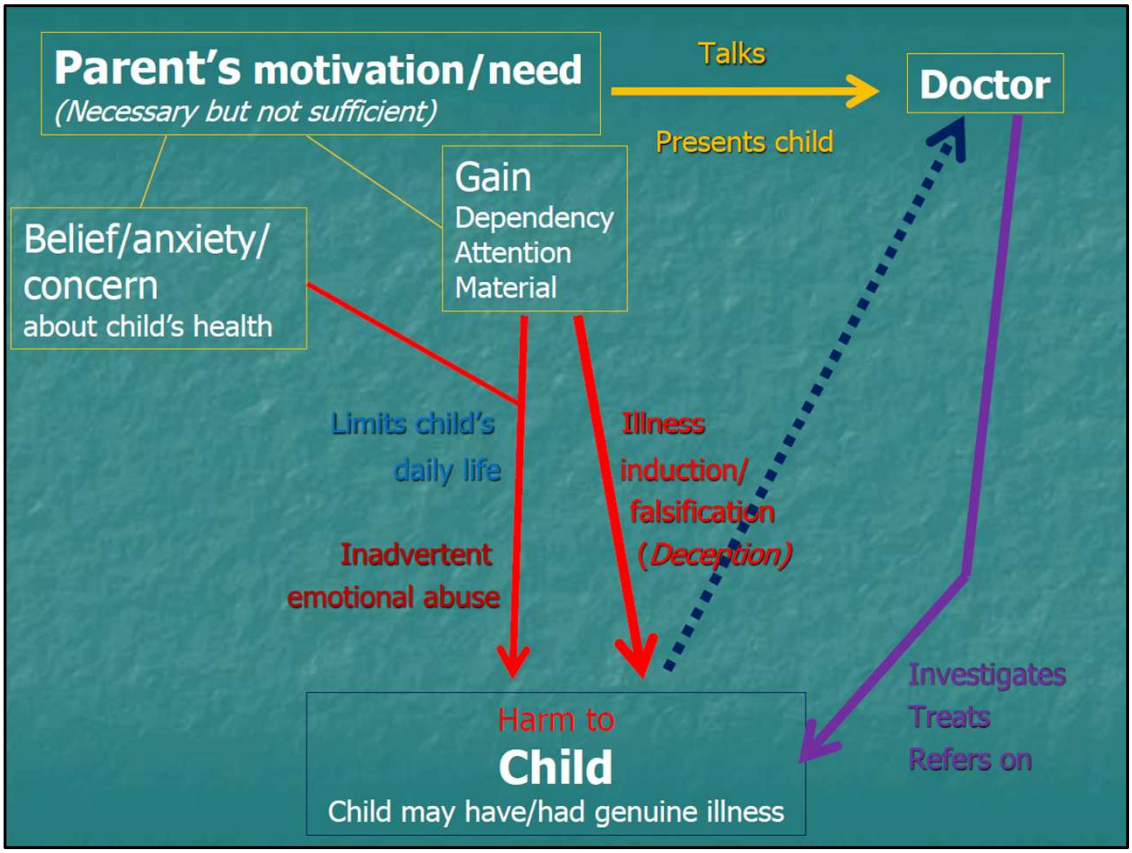
Alerting Signs:

Direct Fabrication: Falsifying medical histories, symptoms, test results, or diaries.
Induction of Illness: Actively causing harm through poisoning (e.g., with salt, drugs, cleaning agents), suffocation, inducing seizures, withholding food, or injecting contaminants.
"Doctor Shopping": Persistently seeking opinions from multiple professionals and hospitals until concerns are validated.
Escalation: Symptoms often worsen in a medical setting or when challenged; new symptoms appear as old ones are disproven.
Medical Savvy: Frequently displays detailed medical knowledge, may work in healthcare, and forms inappropriately close relationships with medical staff.
Insistence on Interventions: Demands invasive tests, procedures, feeding tubes, or surgeries, often appearing "perfectly devoted" during the process.
Evasion & Control: Resists or sabotages plans for discharge, second opinions, or information sharing between professionals. May become hostile when doubted.

Pathological Need for Attention/Significance: Gains profound psychological reward from the "sick role" of the victim and their own role as the heroic, devoted caregiver in a medical drama.

· Identity & Self-Worth: Identity is enmeshed with being a caregiver of a complex patient. Their self-esteem depends on this role.

· Lack of Insight & Denial: Profoundly rejects the possibility of fabrication, even when faced with objective evidence. Genuinely may not consciously connect their actions to the harm.


Parent's motivation/need
(Necessary but not sufficient)
Talks
Doctor
Presents child
Gain
Dependency
Attention
Material
Belief/anxiety/
concern
about child's health
Limits child's
daily life
Inadvertent
emotional abuse
Illness
induction/
falsification
(Deception)
Investigates
Treats
Refers on
Harm to
Child
Child may have/had genuine illness

Why?

- **Concern re missing treatable disorder**
  - Diagnostic challenge
  - Difficult to say 'I do not understand'
- Doctors' need to work ***with*** parents & maintain relationship with family
- Discomfort of disbelief/suspicion/blaming of parent v. pressure to refer to csc
- Dilemma when child complains of symptoms
- Doctor powerless - bound by history given
- Consumerism

BSCP PP/FII Guidance

Change in Guidance

- Old approach maintained when child at risk of serious harm or death
- New approach to situations where presentation is perplexing regardless of the alerting signs.

- **In this situation important to first ascertain the child's current state of health and whether there is evidence of 'significant harm'.**

RCPCH

Trauma-informed approaches may help emphasise the following themes:
Understanding behaviour in context and recognising how past trauma may shape interactions with health and social care.
Collaboration and empowerment by involving families in decision-making rather than imposing interpretations without shared understanding.
Ensuring children and families aren't retraumatised by further unnecessary investigative processes, adversarial assessments or misattribution of intent.
System-caused trauma — where families feel wrongly accused or harmed by processes, especially when children are eventually returned to their families.

BSCP PP/FII Guidance

Aims:

1. Centring the child/YP in their experience of 'medical trauma' or 'medical child abuse'

2. Seeks to minimise system-induced harm through coordinated, transparent, and consistent multi-agency working.

3. View the parent through the lens of 'potential' trauma and/or psychopathology.

4. Aiming for 'therapeutic' recovery and rehabilitation alongside protection.

RCPCH

Features in Carer:
High incidence of comorbid personality disorders (particularly Borderline, Narcissistic, or Histrionic), anxiety, depression, and a history of Factitious Disorder Imposed on Self (FDIS).
· Trauma & Loss History: Often a personal history of childhood abuse, neglect, medical trauma, or unresolved grief. Common history of adverse experiences, including childhood abuse/neglect, parental loss, or extreme stress.

· Deception: The deception is compulsive and convincing, often extending to all areas of life. They may believe their own lies (psychological denial).
· Absence of Obvious External Incentive: The primary gain is psychological, not tangible (like financial benefit), which distinguishes it from malingering.
· Social Isolation: Often isolates the family from extended family and friends, citing the child's medical needs. The medical team becomes their primary social circle.
· Dynamics with the Partner: The partner (if present) is typically passive, absent, or in denial, often dominated by the perpetrator. They may be deliberately excluded from medical consultations.
· "Ideal Parent" Facade: Presents as exceptionally caring, attentive, and "too good to be true." This disarms professionals.
· Reaction to Challenge: When confronted or doubted, reacts with intense indignation, threats of litigation, or rapid discharge against medical advice to seek a new provider.
· Emotional Bond Paradox: May appear intensely bonded, yet the child's authentic self is ignored. Love is conditional on the child being ill.
· Lack of Developmental Concern: Shows little authentic joy at the child's improvements

and may report symptoms that contradict observed milestones.
· System Manipulation: Expertly manipulates healthcare, social care, and education systems, playing professionals off against each other.
- **Relationship Dynamics**: Enmeshed or overly dependent relationship with the victim; prioritizes own psychological needs (attention, control, sympathy) over the child's welfare. May target specific children (e.g., youngest, those with genuine conditions) or show intermittent periods of non-abuse.
- **Denial and Escalation**: Strong denial even when confronted; behaviour often escalates over time, with efforts to conceal actions and split staff opinions.

BSCP PP/FII Guidance

Remember Adverse Childhood Experiences

- Domestic Abuse
- Parental alcohol /drug misuse
- Parental mental health issues
- Parents learning disability
- Bereavement
- Professionals should also be mindful that parents and caregivers may themselves have experienced adverse childhood experiences.

RCPCH

Low cortisol in Chronic Stress /PTSD /ACEs is best understood as the end result of a maladaptive adaptation to long-term stress. The body's stress system, overwhelmed by persistent alarm signals, recalibrates by hypersensitizing its own shut-off mechanism. The theory is that the system becomes "burned out" or overly compensated due to long-term overdrive.

Chronic stress leads to persistently high CRH from the hypothalamus. Over time, the pituitary gland (which responds to CRH by releasing ACTH) can become desensitized to this signal—it stops "listening" as well.

· So, you have a high CRH signal (gas pedal pressed), but a sluggish pituitary response (engine doesn't rev), leading to low ACTH and consequently low cortisol production.

This leads to a system that is paradoxically both "on edge" (high CRH in brain causing anxiety/arousal) and "underpowered" (low peripheral cortisol), contributing to the complex symptoms of PTSD.

Important Nuances:

Not Universal: Not every person with PTSD has low cortisol. Some have normal or even high levels. Heterogeneity exists based on trauma type, genetics, timing, and comorbidities (e.g., depression alone is often linked to high cortisol).

Diurnal Rhythm Flattening: Even if morning levels are normal, the typical diurnal rhythm (high in AM, low at night) is often flattened in PTSD, meaning less variation and lower overall output.

Developmental Timing: Trauma experienced in childhood can permanently alter the "set point" of the HPA axis, leading to a lifelong pattern of dysregulation.

Long-term demand for cortisol may, in some cases, outpace the adrenal glands' ability to synthesize it, leading to reduced output.

The Consequences of Low Cortisol:
Low cortisol isn't protective; it's problematic and contributes to PTSD symptoms:
Impaired Fear Extinction: Cortisol is needed to consolidate safety memories. Low cortisol may make it harder to learn that a once-threatening cue is now safe.
Enhanced Inflammation: Cortisol is a potent anti-inflammatory. Low levels can lead to a pro-inflammatory state, linked to depression, pain, and other somatic symptoms common in PTSD.
Dysregulated Arousal: Contributes to hypervigilance, irritability, and an exaggerated startle response.
Flashbacks and Intrusions: Some studies link low cortisol to a greater frequency of intrusive traumatic memories.

BSCP PP/FII Guidance

Trauma-informed practice:

- **1) Identify root cause(s) of emotional pain - Foundational wound**
- **2) What is the survival pattern being displayed - fight/flight/freeze/fawn**
- **3) If dysregulation, what are the triggers (perceived threats or loss of control)**
- **4) Understanding behavioural patterns (responses to or reactivation of trauma) and offering mitigation**
- **5) Explain Trauma response is NOT pathology**

RCPCH

RCPCH PP/FII Guidance

- **6) Principles of trauma-Informed Care**
  - Safety
  - Transparency and Trustworthiness
  - Choice
  - Collaboration and Mutuality
  - Empowerment

RCPCH

Research indicates that experience of traumatic events in childhood can have a profound adverse impact on brain development leading to both physical and behavioural changes as the child tries to adapt to environmental stressors. If trauma occurs over a prolonged period, it can rupture the child's internal stress system which then contributes to physical and mental health problems over the life course, making children more vulnerable to difficulties with emotional regulation from birth and is often linked to difficulties with cognition such as problems with attention and focus in early and later childhood.
Survivors of adverse childhood experiences can often be reluctant to disclose voluntarily, due in part to feelings of shame, guilt and anxiety about their experiences and the act or consequences of disclosure. However, survivors have suggested that these issues can either be exacerbated or alleviated by the responses of the person listening to their disclosure. Furthermore, health and social care practitioners have described an unwillingness or discomfort with the idea of having to ask people about childhood adversity and trauma.

RCPCH PP/FII Guidance

Child's View

- Explore child's view if possible
- Include the child's view of symptoms
- Their beliefs around illness
- Worries and anxieties
- Mood and wishes
- Contrast between verbal and non-verbal communication of the child in consultations and whether this is affected by parental presence.

RCPCH

CASE VIGNETTES

- **Case Vignette 1 – Child Aged 6**

Maya has attended her GP and urgent care multiple times over the last six months with abdominal pain, bloating and intermittent loose stools. Her mother reports that Maya is frequently tired and 'not herself' and has reduced her gluten and dairy intake at home because foods seem to make symptoms worse.

- **Case Vignette 2 – Child Aged 12**

Leo has been brought repeatedly to GP and A&E over four months with headaches, fatigue and dizziness. Examinations and basic investigations have been normal. His mother keeps detailed symptom diaries and has requested urgent specialist referrals and brain imaging.

- **Case Vignette 3 – Young Person Aged 17**

Aisha attends clinic for ongoing dizziness, nausea and 'chemical sensitivity'. Her step-father believes that environmental toxins and black mould are poisoning her and brings samples and photographs to appointments. He insists Aisha is too unwell to attend college and restricts her diet to a limited range of foods and supplements.

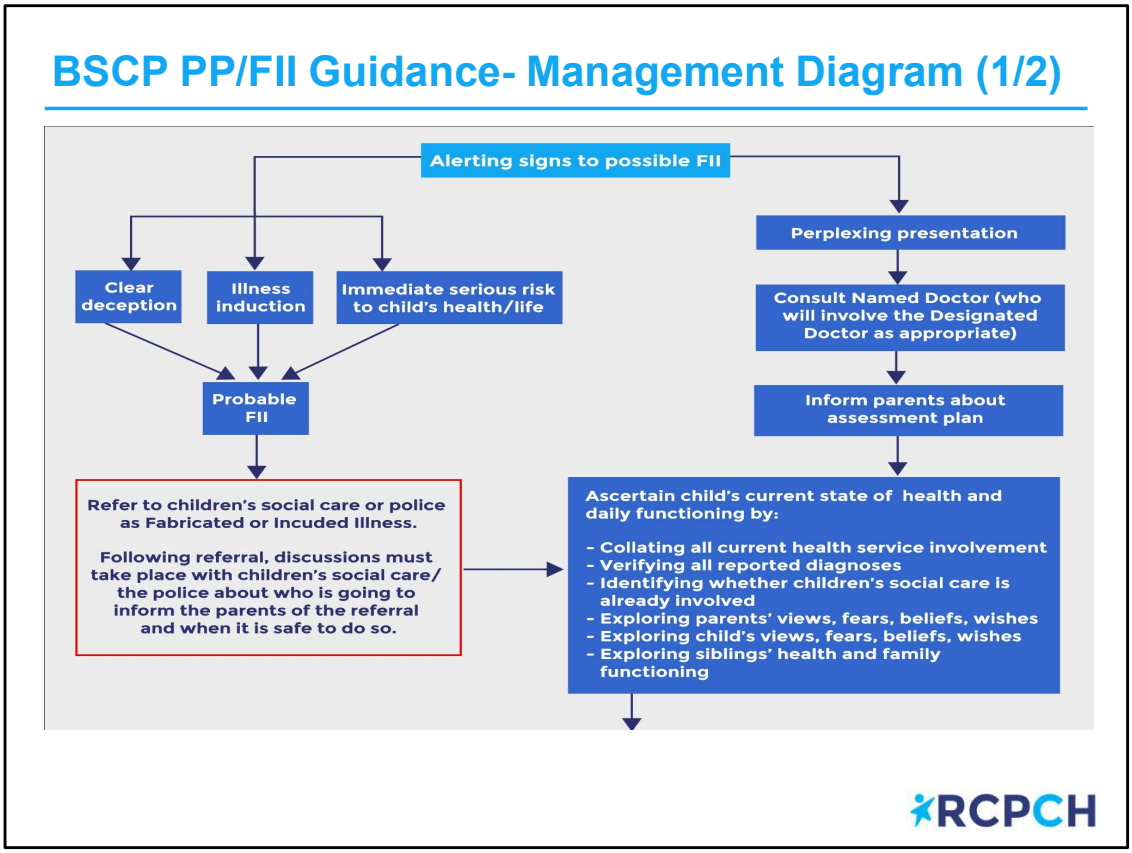
- **Case Vignette 4 – Child Aged 11**

Jocelyn continues to experience intermittent abdominal pain, joint pains and occasional ear discomfort. Symptoms fluctuate and have persisted for over a year. Extensive investigations have not identified a clear diagnosis and ENT and audiology assessments have resulted in discharge.

RCPCH

Trauma-informed principles in practice:

- **Safety and minimizing harm**: The overarching goal is to protect the child from both potential abuse and iatrogenic harm (e.g., unnecessary procedures, hospitalizations, or school absence), while avoiding processes that could retraumatize families through abrupt separation or stigma.
- **Trustworthiness and transparency**: Professionals are encouraged to discuss concerns with families (unless immediate risk exists), share information collaboratively, and involve parents in planning where possible.
- **Collaboration and empowerment**: Emphasis on multi-agency working, seeking second opinions, and considering family dynamics holistically rather than assuming perpetrator intent.
- **Avoiding re-traumatization**: By framing many cases as arising from anxiety or misunderstanding (rather than deliberate deception), and promoting early, supportive interventions, the guidance seeks to reduce the secondary trauma often reported in FII investigations (e.g., family separation, distrust of services).



Key goals include:

1. **Immediate Harm Reduction and Safety**: Modify or stop deceptive/harmful behaviors to prevent further misuse of medical resources, unnecessary procedures, or induced harm. This often involves removal of the child from the perpetrator's care, multidisciplinary monitoring (e.g., supervised visitation), and restricting the perpetrator's role in medical decisions.

Immediate and sustained child safety

Cessation of fabrication/induction

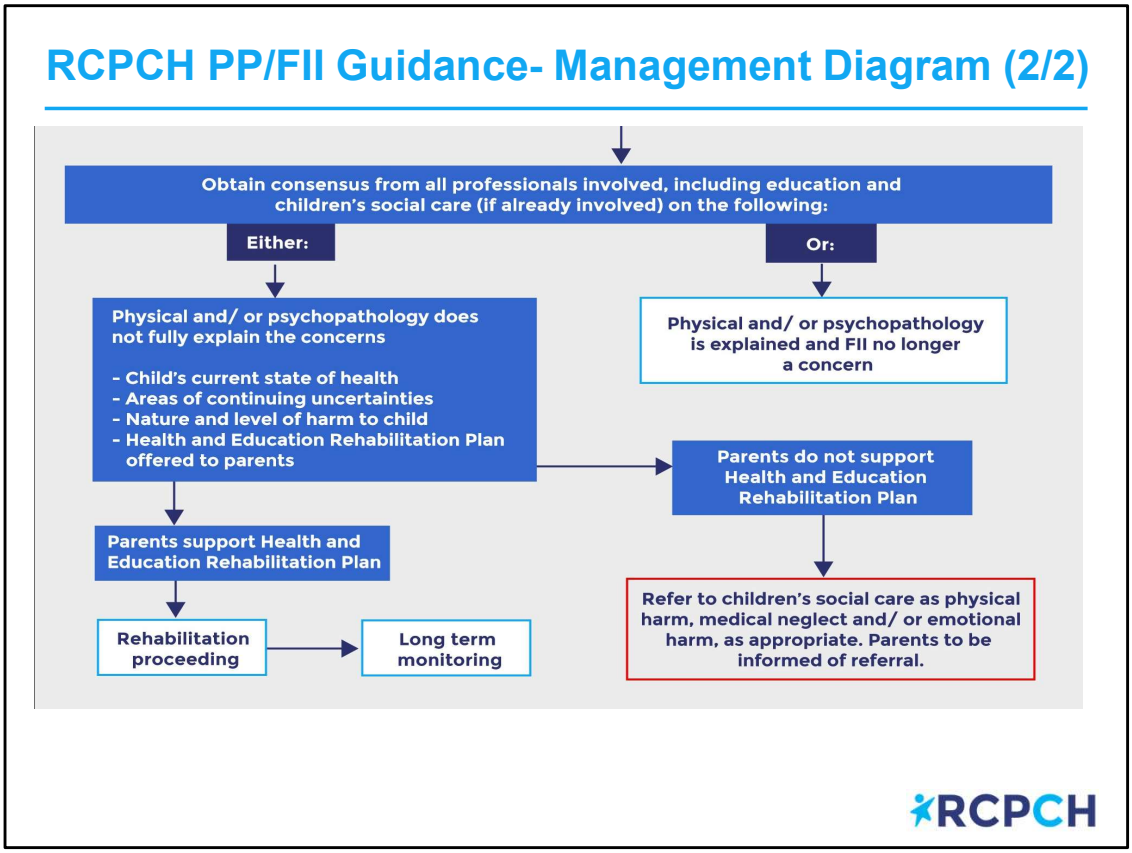
Reduction of medical harm

Stabilisation of the child's physical and psychological wellbeing

Often requires:

- Supervised care
- Restrictions on medical access
- Placement decisions (temporary or permanent)

2. **Acknowledgment and Accountability**: Achieve full admission of the abusive behavior (including details), acceptance of responsibility, and demonstration of empathy for the victim's suffering. Partial or absent acknowledgment typically precludes reunification.
3. **Behavior Change and Coping Skills**: Develop healthier ways to meet psychological needs (e.g., attention, control) without deception. This includes deconstructing illness-focused narratives, learning honesty, and building adaptive coping strategies.
4. **Address Underlying Issues**: Treat comorbidities through evidence-based therapies such as (CBT) to challenge distorted thinking, dialectical behaviour therapy (DBT) for emotional regulation, or trauma-focused CBT for histories of abuse/neglect. Psychotropic medication may target co-occurring conditions.



Treatment Goals:

1. Achieve Accountability and Insight:
   · Break Denial: The foundational goal is to move the perpetrator from complete denial to acknowledgment of their harmful actions. This is a painstaking process, often using objective evidence.
   · Separate Identity from Illness: Help them understand the psychological drivers (need for significance, trauma re-enactment) and develop a new, healthy identity not tied to the "caregiver of a sick child" role.
   · Accept the Diagnosis: Acknowledge the problem and its chronic, relapsing nature.
2. Address Underlying Psychopathology:
   · Treat Comorbid Disorders: Intensive therapy for underlying personality disorders, trauma (using modalities like Dialectical Behaviour Therapy - DBT or Trauma-Focused Therapy), anxiety, and depression.
   · Develop Healthy Coping Mechanisms: Replace the pathological need for medical drama with skills for emotional regulation, distress tolerance, and authentic self-worth.
3. Prevent Future Harm: medical restrictions, managed care with oversight, educational reintegration

BSCP PP/FII Guidance

Key Steps

Appropriate action where there is immediate threat of significant harm

- Immediate referral to the Police/Children's Social Care in cases of induction
- Referral to Children's Social Care/Police if professional opinion is that the child is at risk of serious harm
- Discuss with Children's Social Care/Police about what to tell parents (often at strategy meeting)

RCPCH

RCPCH PP/FII Guidance

Key Features

Information gathering from all professional sources (health, school, social care if involved)

- Health including private practice
- School or nursery
- Children's Social Care if involved
- Any other involved professional

RCPCH PP/FII Guidance

Key Features

Obtaining health consensus about child's actual state of health

- Often important for health to meet (actually or virtually)
- Differences of opinion are often resolved when information is shared in this manner
- Important to reach a consensus about what is agreed and what remains a matter for disagreement
- How can disagreement be resolved?

(remember to include parent's views and child's views)

RCPCH

RCPCH PP/FII Guidance

Key Features

Health and Education Rehabilitation Plan

- This needs to be negotiated with parent and child
- Aim to rationalise and coordinate further medical care
- Aim is to arrange for optimal education to recommence
- Often includes graded physical mobilisation
- May also include oral feeding
- May include CAMHS input
- Ensure with liaison with primary care

RCPCH

RCPCH PP/FII Guidance

Key Features

Threshold for referral to Children's Social Care

- Refer immediately if concerned about serious harm.
- Refer for early help and Child in Need with parental consent.
- Work with Children's Social care if already involved.
- Refer to Children's Social Care if Health and Education rehabilitation plan not proceeding.

RCPCH

RCPCH PP/FII Guidance

Duties of a Doctor

- Duty to practice evidence-based medicine
- Training and supervision
- Setting appropriate boundaries
- Empathetic approach
- Honest communication
- Appropriate information sharing
- Duty to remain the same in private practice

RCPCH

Trauma-informed approaches may help emphasise the following themes:
Understanding behaviour in context and recognising how past trauma may shape interactions with health and social care.
Collaboration and empowerment by involving families in decision-making rather than imposing interpretations without shared understanding.
Ensuring children and families aren't retraumatised by further unnecessary investigative processes, adversarial assessments or misattribution of intent.
System-caused trauma — where families feel wrongly accused or harmed by processes, especially when children are eventually returned to their families.

RCPCH PP/FII Guidance

Record Keeping

- Accurate, contemporaneous, thorough
- What was observed, by whom
- Record of key discussions, minutes of meeting should be kept in health records (safeguarding teams can keep separate records to track but content should be similar)
- Cross referencing between records
- Emails form part of the record
- Subject Access Requests (SARs)

RCPCH

RCPCH PP/FII Guidance

Chronology

- Provides overall picture of events – helpful but time consuming
- Immediate concern is ascertaining child's current state of health
- Chronology of key events in template form, with source, what happened, who observed, analysis
- What is recorded exactly will vary on a case by case basis
- Useful for all services to have the same template in a locality to allow easy merging.

RCPCH

RCPCH PP/FII Guidance

Transitions

- Increasing complexity when young person becomes 16/17 years of age
- Try to shift focus on communication with young person
- Young person will normally be competent to make decisions about their health
- Extremely difficult to change sickness role behaviour at this stage
- Plan for transition (will often be to primary care only)

RCPCH

BSCP PP/FII Guidance

Role of Named and Designated Safeguarding Professionals

- General / Community paediatrician retains case responsibility as the responsible paediatrician
- Support from Named Doctor and Supervision from Named Doctor
- Named / Designated Doctor to chair consensus meetings
- Named Doctor to escalate concerns to Designated Professionals, if required
- Designated Professionals should be supported by their Medical Director and Executive Lead for Safeguarding Children
- Designated Professionals may received support from other Designated Professionals in adjoining localities.

RCPCH

BSCP PP/FII Guidance

Support

Support from

- Colleagues
- Named Doctor for Safeguarding Children
- Designated Doctor for Safeguarding Children
- Employing organisations

PALS/ Complaints

Medical defence organisations

RCPCH

BSCP PP/FII Guidance

Training

- All paediatricians likely to encounter patients with alerting signs to possible PP/FII
- Intercollegiate document contains more specific detail about knowledge, skills and competencies around FII:

https://child-health-safeguarding.rcpch.ac.uk

- Supervision and peer review
- ElfH and other lectures/courses