

Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH guidance

'Fabricated or Induced Illness by Carers: A practical guide for paediatricians' –
last published in 2009. Updated February 2021

Perplexing Presentations (PP) / Fabricated or Induced Illness (FII) in Children RCPCH guidance

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1. Introduction

Since the publication of the Royal College of Paediatrics and Child Health (RCPCH) guidance on Fabricated or Induced Illness by Carers (FII) in 2009¹, there have been significant developments in the field. The RCPCH Child Protection Companion 2013 extended the definition of FII in 2013 by introducing the term Perplexing Presentations with new suggestions for management². This new guidance provides procedures for safeguarding children who present with perplexing presentations and FII and offers practical advice for paediatricians on when and how to recognise it, how to assess risk and how to manage these types of presentations in order to obtain better outcomes for children.

There is often uncertainty about the criteria for suspecting or confirming PP/FII and the threshold at which safeguarding procedures should be invoked. In the UK, there has been a shift towards earlier recognition of possible FII (which may not amount to likely or actual significant harm³), and intervention without the need for proof of deliberate deception. While earlier presentations and those involving erroneous reporting form the majority of cases seen by paediatricians, most cases in the literature report deliberate physical abuse by the carer. Children and young people with perplexing presentations often have a degree of underlying illness, and exaggeration of symptoms is difficult to prove and even harder for health professionals to manage and treat appropriately. This guidance proposes that, in the absence of clear evidence about risk of immediate serious harm to the child's health or life, the early recognition of possible FII (not amounting to likely or actual significant harm⁴) is better termed Perplexing Presentations, requiring an active approach by paediatricians and an early collaborative approach with children and families. It is important to recognise any illnesses that may be present, whilst not subjecting children to unnecessary investigations or medical interventions, always bearing in mind the fact that verified illness and fabrication may both be present. The advice of colleagues is always helpful and tertiary specialist opinion may be very helpful if these specialists are provided with the holistic picture before assessment. The guidance aims to provide a framework for earlier intervention to explore the concerns of children, families and professionals in order to try, if this is possible, to address the issue of a perplexing presentation well before significant harm has come to the child or young person whilst also outlining when immediate action may be required.

Within this challenging field of work, there is evidence that paediatricians and other health professionals play a role in inadvertently contributing to harm to the child. This guidance encourages paediatricians to practise evidence-based medicine, whilst retaining professional curiosity and setting appropriate boundaries in their practice. Paediatricians should not underestimate indicators of family dysfunction and what is already known about the child and family by the wider professional network when assessing the needs of children. The challenge is to correctly identify any illness present whilst at the same time not performing unwarranted investigations or interventions driven by exaggerated reporting of symptoms.

1 Royal College of Paediatrics and Child Health (2009) Fabricated or Induced Illness by Carers (FII): Practical Guide for Paediatricians. October 2009.

2 Royal College of Paediatrics and Child Health (2013) Fabricated or Induced Illness by Carers (FII): Practical Guide for Paediatricians (2009). Update statement.

3 UK Government. 1989. Children Act 1989. Available at: <https://www.legislation.gov.uk/ukpga/1989/41/contents>

4 UK Government. 1989. Children Act 1989. Available at: <https://www.legislation.gov.uk/ukpga/1989/41/contents>

This guidance outlines the current evidence-base from the literature, takes into account views from extensive consultations and the findings from a recent survey of RCPCH members. It provides clear definitions of Perplexing Presentations and FII, the features of both and how these differ from Medically Unexplained Symptoms (MUS). Practical advice is offered for the recognition of and response to alerting signs of possible FII (not amounting to likely or actual significant harm⁵), including: the role of Named and Designated Doctors, reaching a consensus, multi-professional and multiagency working, communication with parents/caregivers, accurate documentation and the content of the Health and Education Rehabilitation Plan.

Children have a right to the best possible health, privacy and for their views to be sought. They are also entitled to protection from all forms of abuse and to rehabilitation when they have been maltreated. These principles are enshrined in Articles 12, 13, 16, 19, 24 and 39 of the [UN Convention on the Rights of the Child](#) (UNCRC), which state that:

- Every child has the right to express his or her own views freely in all matters affecting the child with their view being given due weight in accordance with their age and maturity
- Every child must be free to express their thoughts and opinions and to access all kinds of information, as long as it is within the law;
- Every child has the right to privacy. The law should protect the child's private, family and home life, including protecting children from unlawful attacks that harm their reputation;
- Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and bad treatment by their parents or anyone else who looks after them;
- Every child has the right to the best possible health;
- Children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect and social life⁶.

Read as a whole, the guidance provides advice for paediatricians managing cases of Perplexing Presentations and FII. The aim of the guidance is to recommend early recognition and intervention in order to explore the possible causes of a perplexing presentation. There is a need to establish whether perplexing presentations are fully explained by a verified condition in the child, or whether there has been some element of exaggeration or fabrication of illness with consequent physical, emotional, social or educational harm to the child. Harm can also involve adoption of dysfunctional health beliefs by the child, with long term consequences for this child and their potential future children. Working collaboratively with other health professionals, children and families to address the issues of concern to all parties is important. However, the paramount consideration for a paediatrician should always be the impact that the situation is having on the child's health and wellbeing⁷.

We realise that the devolved nations have similar but differing legislation, interagency guidance, health service structures and terminology for paediatricians fulfilling named and designated doctor roles. However we feel this guidance is equally applicable to paediatricians working in the devolved nations who can apply the key principles outlined in this document to the national context within which they practise.

5 UK Government. 1989. Children Act 1989. Available at: <https://www.legislation.gov.uk/ukpga/1989/41/contents>

6 UNICEF. A summary of the UN Convention on the rights of the child. UNICEF: United Kingdom

7 The term health is used throughout this document, pertaining to both physical and mental health, unless otherwise specified.

1.1 How this guidance was developed

The RCPCH convened an expert working group to develop this guidance, led by the RCPCH Officer for Child Protection and involving representative Consultants currently practising within the National Health Service from paediatrics, child and adolescent mental health, neurology, allergy, rheumatology and safeguarding. We also considered the limited published evidence on prevalence and management of FII. In the absence of published evidence, we relied on extensive consultation and expert consensus from those with extensive clinical experience of managing these conditions.

The guidance has been subject to a thorough consultation period and views have been incorporated from a range of organisations and a number of commissioning groups and provider Trusts across the UK. The following agreed to be listed as having been consulted:

- RCPCH Child Protection Standing Committee
- The Child Safeguarding Practice Review Panel, Department for Education
- NHS England and Improvement
- British Medical Association
- General Medical Council
- Medical Defence Union
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Psychiatrists
- British Society of Paediatric Endocrinology
- Young People's Health Special Interest Group.

We have also sought the views of senior social work practitioners.

We have considered the experiences of children, young people and families in the development of this guidance.

We recommend that the guidance is read as a whole, as it follows a pathway approach to the management of Perplexing Presentations and FII in order to ensure the best outcome for children.

This guidance presents the current view and supersedes previous RCPCH guidance on this subject.

While written primarily for paediatricians, this guidance is also of direct relevance to GPs, other specialists, social care and education.

1.2 Essential principles in this new guidance

Please note that throughout this guidance we have chosen to use the term parents, an inclusive term for all primary caregivers with or without parental responsibility.

- Updated definitions of medically unexplained symptoms (MUS), Perplexing Presentations (PP) and a wider view of fabricated or induced illness (FII).
- The importance of the functional implications of diagnoses rather than the mere fact of the diagnoses.
- The essence of FII is the parents' focus on engaging and convincing doctors about the parents' erroneous view of the child's state of health.
- Parental behaviour may or may not include deception.
- Parental behaviour may be motivated by anxiety and erroneous belief about the child's state of health and/or by gain for the parent/s.
- Alerting signs for possible FII must be considered and investigated appropriately. FII should not be a diagnosis of exclusion but should be considered with the same rigor as organic disease.
- Unless illness induction or deception are found, establishing FII depends initially on clarifying the actual state of health of the child and then gauging parental actions and response in the light of these findings.
- There is often a need to observe independently what is reported.
- The focus must be on the harm to child rather than the perceived severity or type of parental motivations, actions and behaviours.
- Unless there is significant risk of immediate, serious harm to the child's health or life, the need for sharing information between different professionals involved in the child's life should be discussed with the child/young person and their parents. This should be done in a non-confrontational manner, by discussion of the perplexing nature of some aspects of the child's presentation, and explanation of the usefulness of gathering information to inform care.
- A Health and Education Rehabilitation Plan agreed by professionals and families is an essential feature of management in all cases of FII, whether or not children's social care are involved.
- Paediatricians must reflect on their duties to practise evidence-based medicine, whilst retaining professional curiosity and setting appropriate boundaries in their practice.
- An empathetic, considered but bounded approach is required. Honest communication of professional concerns is important, unless this will place the child at risk of serious harm.
- Responsibility for the initial management, including collating of current health involvement, is with the responsible consultant. This is the consultant paediatrician who has the main responsibility for the child's care. If this is in dispute, the Named Doctor will liaise with the Consultants involved to decide who the responsible consultant is to enable them to lead on the child safeguarding issues.
- The responsible consultant should seek advice and support from senior colleagues and tertiary specialists when appropriate.
- In the unusual circumstance that there is no consultant paediatrician or child psychiatrist involved, then we encourage both education and/or primary care to refer to a consultant paediatrician or child psychiatrist who will then become the responsible consultant.
- Named and Designated Professionals, or their equivalents in the devolved nations, are responsible for supporting the responsible consultant and the clinical team, for oversight of the safeguarding aspects of the child's care and for achieving a health consensus. Named and Designated Professionals in Scotland are Paediatricians with a Special Interest and Lead Paediatricians or Nurses for Child Protection. Throughout this guidance, we will refer to this group as Named and Designated Professionals.

2. Epidemiology and research evidence

Literature in this field recognises that there is a gap within the existing evidence-base surrounding the incidence and prevalence of PP and FII⁸. We acknowledge that there is a lack of data in this field, in particular for perplexing presentations, and the exact incidence and prevalence is therefore unknown. Data is not routinely captured and recorded through NHS Digital reporting of Hospital Episode Statistics. Within a context of limited information, the RCPCH conducted a survey of paediatricians to better understand the frequency with which paediatricians encounter cases in practice. Based on these survey results, existing literature and extensive verbal reports, it is likely that the literature currently underestimates the true prevalence of FII.

2.1 Incidence and prevalence

Literature searches on this topic have identified that the term 'Munchausen Syndrome by Proxy' yields all relevant literature hits on Medline (an online literature database), with additional search terms not identifying any further papers. This could be explained in part, due to the covert and complex nature of such presentations, but particularly because a key focus within the literature is upon illness induction which, in practice, is far less common than the presentations which are brought about by erroneous reporting by parents.

Of the more recent publications, relatively few are from the UK. The significance of the drop off in UK and US reports is understandable as the common presentations have been well described and only exceptional cases are now reported. Since Sheridan's 2003 review describing 451 cases⁹, there have been many case reports most of which describe one or two cases with novel or unusual clinical presentations, with likely reporting bias in favour of more dramatic abuse involving illness induction. In recent poisoning reports, no significant new patterns were identified, although cases involving hypoglycaemic agents have been published¹⁰. Munchausen by proxy by internet is reported as a new phenomenon in which caregivers present online considerable distortion of information received from doctors, describing escalation of the severity of their children's illnesses and consequent requests for online donations for their children's health needs¹¹. Covert video surveillance has not appeared in the literature since 2005 and in practice is now rarely ever used.

As yet, there is no published literature on the prevalence of Perplexing Presentations.

8 Bass, C.B. & Glaser, G. (2014) 'Early recognition and management of fabricated or induced illness in children', *The Lancet*, 383(9926), pp.1412-1421.

9 Sheridan, M.S. (2003) 'The deceit continues: An updated literature review of Munchausen Syndrome by Proxy', *Child Abuse Negl*, 27(4), pp.431-51.

10 Davis, P. Murtagh, U. & Glaser, D. (2019) '40 years of fabricated or induced illness (FII): Where next for paediatricians?' Paper 1: epidemiology and definition of FII, *Arch Dis Child* 2019, 104, pp.110-114.

11 Brown, A. et al. (2014) 'Caretaker blogs in caregiver fabricated illness in a child: A window on the caretaker's thinking?', *Child Abuse & Neglect*, 38, pp.488-497.

2.2 RCPCH survey

In 2018, the RCPCH surveyed members on the topic of Perplexing Presentations to inform the update of this guidance. For the survey, a proposed definition of Perplexing Presentations was used: 'a child with an undiagnosed functional impairment / medically unexplained symptoms in whom rehabilitation is being compromised to the extent that you are actively considering the child's safety or may have already referred for multi-agency investigation'. This was a proposed definition and has subsequently been refined (see Table 1), partly as a result of the responses to the survey.

We received a total of 216 responses from across the UK. The survey was promoted among RCPCH members generally, but especially those with an interest in safeguarding. We acknowledge the limitations in the survey methodology and suspect that those paediatricians who had involvement with these situations previously were more likely to have responded to the survey resulting in some bias in response. However, we are of the view that the survey results still provide important insight on this topic.

The results have uncovered the scale at which paediatricians are faced with Perplexing Presentations, as 92% of respondents recall seeing at least one perplexing presentation within the previous 12 months and 30% have seen more than five. The survey highlighted the complexity of these cases with respondents reporting 69 different condition presentations. The most common presentations were: feeding difficulties, challenging behaviour, musculoskeletal symptoms (including hEDS) and gait disorders.

In the majority of cases reported, erroneous reporting and avoidance strategies by carers were the main concern, with only a few cases of falsification of records or illness induction. 80% of respondents had not witnessed falsification and 56% had not witnessed illness induction, confirming the rarity of these being seen in practice.

Results were encouraging in revealing that paediatric colleagues were typically liaising well with other paediatricians, social work and education services in the decision-making process. Respondents highlighted three reasons for referring perplexing cases to children's social care: the child's function impaired beyond any known condition, parents not accepting the situation and requesting further investigation, and parents not accepting the situation and requesting second opinion or a change in responsible consultant inappropriately. These reasons for referral reflect a greater awareness of how some forms of Perplexing Presentations might cause physical and emotional harm to children, which must be communicated with colleagues in other organisations. However, it is concerning that over 56% of survey respondents have had to escalate concerns about inadequate responses from social care on at least one occasion.

Importantly, the survey demonstrated the need for support to be provided to safeguarding teams dealing with Perplexing Presentations cases. Respondents indicated concerns they are faced with, specifically highlighting 'missing a rare but potentially treatable condition' and 'potential risk to the child while investigations into possible FII continue' as their top worries. Furthermore, dealing with Perplexing Presentations is resource-intensive, with 37% of respondents stating that it would be 'impossible to quantify' the amount of time spent on a typical case, highlighting the need for dedicated resource for this work.

3. Terminology and definitions

We acknowledge that there is ongoing debate regarding terminology but currently recommend the use of Medically Unexplained Symptoms (MUS), Perplexing Presentations (PP) and Fabricated or Induced Illness (FII) respectively, as defined below.

There is often a confirmed co-existing physical or mental health condition in the child.

3.1 Terminology

Since Professor Sir Roy Meadow first described the condition 'Munchausen Syndrome by Proxy' (MSbP) in 1977¹², a number of terms have been introduced in the literature, all of which essentially refer to the same entity. The RCPCH adopted the term 'Fabricated or Induced Illness by Carers' (FII) in 2002, now the term used in the UK by professionals and in guidance, and also in Australia and New Zealand. In the USA terms such as 'Pediatric Condition Falsification', 'Medical Child Abuse' and 'Caregiver-Fabricated Illness in a Child' have been variously introduced in the literature and practice, although MSbP is still widely used. In adult psychiatry, the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) produced by the American Psychiatric Association (DSM-5) replaces Factitious Disorder by Proxy (FDP) with Factitious Disorder Imposed on Another (FDIoA) as an adult diagnosis, an approach also now adopted by ICD-11, which is an international classification of diseases that defines health conditions¹³. However, as DSM-5 and ICD-11 stipulate that the carer behaviour is associated with identified deception, this excludes many carers involved in paediatric FII.

3.2 Definitions

3.2.1 Medically Unexplained Symptoms (MUS)

In Medically Unexplained Symptoms (MUS), a child's symptoms, of which the child complains and which are presumed to be genuinely experienced, are not fully explained by any known pathology. The symptoms are likely based on underlying factors in the child (usually of a psychosocial nature) and this is acknowledged by both clinicians and parents. MUS can also be described as 'functional disorders' and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body. The health professionals and parents work collaboratively to achieve evidence-based therapeutic work in the best interests of the child or young person. In 2018, the Royal College of Psychiatrists and the Paediatric Mental Health Association (PMHA) developed a [guide](#) to assessing and managing medically unexplained symptoms (MUS) in children and young people¹⁴ and a recent editorial is very helpful¹⁵. Experienced clinicians report that, on occasion, MUS may also include PP or FII.

12 Meadow, R. (1977) 'Munchausen Syndrome by Proxy: The hinterland of child abuse', *The Lancet*, 310(8033), pp.343-345.

13 Reed P. et al (2019) 'Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders', *World Psychiatry*, 18(3), pp.3-19.

14 Blake, L., Davies, V., Conn, R. & Davie, M. (2018) *Medically unexplained symptoms (MUS) in children and young people. A guide to assessing and managing patients under the age of 18 who are referred to secondary care.* August 2018.

15 Heyman, I. (2019) 'Mind the gap: integrating physical and mental healthcare for children with functional symptoms', *Archives of Disease in Childhood*, 104(12), pp 1127-1128.

3.2.2 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 likely or actual significant harm¹⁶), 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.

3.2.3 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 Abuse¹⁷). 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.

Table 1: Definitions of key terms

Term	Definition	Synonyms
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 interests of the child or young person. MUS can also be described as 'functional disorders' and are abnormal bodily sensations which cause pain and disability by affecting the normal functioning of the body.	Non-organic symptoms, Functional illness, Psychosomatic symptoms.

¹⁶ UK Government. 1989. Children Act 1989. Available at: <https://www.legislation.gov.uk/ukpga/1989/41/contents>

¹⁷ HM Government (2018) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Crown Copyright: July 2018.

<p>Perplexing Presentations (PP)</p>	<p>Presence of alerting signs when the actual state of the child's physical/ mental health is not yet clear but there is no perceived risk of immediate serious harm to the child's physical health or life.</p>	
<p>Fabricated or Induced Illness (FII)</p>	<p>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 or neurodevelopment is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect including iatrogenic harm.</p>	<p>Munchausen Syndrome by Proxy; Pediatric Condition Falsification; Medical Child Abuse; Parent-Fabricated Illness in a Child; (Factitious Disorder Imposed on Another, when there is explicit deception)</p>

4. Features of PP and FII

This section describes the respective involvement of and relationships between the parent, the doctor and the child. Alerting signs of possible FII (not amounting to likely or actual significant harm¹⁸) are detailed and the difference between Perplexing Presentations and FII is explained.

4.1 Parent / Caregiver motivation and behaviour

Both clinical experience and research indicate that the mother¹⁹ is nearly always involved or is the instigator of FII^{20,21}. The caregiver may be a single parent, or may be acting alone, unbeknown to the father. The involvement of fathers is variable. The father may be unaware, be suspicious but side-lined or may be actively involved. Rarely, fathers are solely involved. The parent may be actively supported by grandparents and there may be an intergenerational pattern. Rarely, foster carers have been known to be involved in FII. There is currently no data on same sex parental couples.

FII is based on the parent's underlying need for their child to be recognised and treated as ill or more unwell/more disabled than the child actually is (when the child has a verified disorder, as many of the children do). FII may involve physical, and/or psychological health, neurodevelopmental disorders and cognitive disabilities. There are two possible, and very different, motivations underpinning the parent's need: the parent experiencing a gain and the parent's erroneous beliefs. It is also recognised that a parent themselves may not be conscious of the motivation behind their behaviour. Both motivations may be present although usually one predominates.

- (i) In the first, the parent experiences a gain (not necessarily material) from the recognition and treatment of their child as unwell. The parent is thus using the child to fulfil their needs, disregarding the effects on the child. There are a number of different gains - some psychosocial and some material. Some parents benefit from the sympathetic attention which they receive; they may fulfil their dependency needs for support, which might include the continued physical closeness of their child. Parents who struggle with the management of their child may seek an inappropriate mental health diagnostic justification in the child such as Attention Deficit Hyperactivity Disorder (ADHD) or Autism Spectrum Disorder (ASD). Material gain includes financial support for care of the child, improved housing, holidays, assisted mobility and preferential car parking.
- (ii) The second motivation is based on the parent's erroneous beliefs, extreme concern and anxiety about their child's health (eg nutrition, allergies, treatments). This can include a mistaken belief that their child needs additional support at school and an Education Health and Care Plan (EHCP). The parent may be misinterpreting or misconstruing aspects of their child's presentation and behaviour. In pursuit of an explanation, and increasingly aided by the internet, the parent develops a belief about what is wrong with their child. In contrast

18 UK Government. 1989. Children Act 1989. Available at: <https://www.legislation.gov.uk/ukpga/1989/41/contents>

19 Throughout the rest of the document, we will refer variously to mother, parent, or caregiver whichever seems more appropriate in the context that it appears.

20 Davis, P. Murtagh, U. & Glaser, D. (2019) '40 years of fabricated or induced illness (FII): Where next for paediatricians?' Paper 1: epidemiology and definition of FII, Arch Dis Child 2019, 104, pp.110-114.

21 Yates, G. & Bass, C. (2017) 'The perpetrators of medical child abuse (Munchausen Syndrome by Proxy) – A systematic review of 796 cases', Child Abuse & Neglect, 72, pp.45-53.

to typical parental concern, the parent exhibiting such behaviour cannot be reassured by health professionals or negative investigations. More rarely, parents may develop fixed or delusional psychotic beliefs about their child's state of health. The parent's need here is to have their beliefs confirmed and acted upon, but to the detriment of the child.

These two motivations appear to be in opposition to each other, the first putting the parent's needs before the child's needs and the second being disproportionately over-concerned about the child's health. However, both face health professionals with dilemmas and both lead to similar forms of harm to the child (with one notable exception, illness induction, which leads to direct physical harm to and, on extremely rare occasions, the death of the child). For these reasons, and illness induction notwithstanding, both motivations are included within FII. It is important to stress that understanding the parents' motivation is not essential to the paediatric diagnosis of PP/FII in the child. This is important because a paediatrician is not expected to understand parental motivation, but simply to understand the cause of the child's presenting illness.

In FII, parents' needs are primarily fulfilled by the involvement of doctors and other health professionals. The parent's actions and behaviours are intended to convince health professionals, particularly paediatricians, about the child's state of health. It is important to note that, as is common in child neglect, the parent is not usually ill-intentioned towards their child per se. Nonetheless, they may cause their child direct harm, unintentionally or in order to have their assertions reinforced and believed. Parents engage health professionals, in the following ways:

- (i) The most common form is by presenting and erroneously reporting the child's symptoms, history, results of investigations, medical opinions, interventions and diagnoses. There may be exaggeration, distortion, misconstruing of innocent phenomena in the child, or invention and deception. In their reports, the parents may not be actually intending to deceive, such as when they hold incorrect beliefs and are over-anxious, to the child's detriment.

It is important not to confuse the reporting of situation-specific difficulties with FII, providing the parent accepts that difficulties which only occur in their presence and which are not reported elsewhere (eg at school) are unlikely to be indicators of a problem in the child but, rather, reflect a difficulty in the way in which the parent engages with the child.

- (ii) A less common way of engaging health professionals is by the parent's physical actions. These actions nearly always include an element of deception. They range from falsifying documents, through interfering with investigations and specimens such as putting sugar or blood in the child's urine specimen, interfering with lines and drainage bags, withholding food or medication from the child and, at the extreme end, illness induction in the child. All of these are carried out in order to convince health professionals, especially paediatricians, about the child's poor state of health or illness.

Support groups and social media provide an important source of support for parents and families where there is childhood illness. Paediatricians and parents should, however, be aware that some support groups also exist for a number of conditions about which there is divided medical opinion. Furthermore, some social media / support groups may post inaccurate information, discuss diagnoses and how to obtain them, which can lead to harm.

While parental mental ill-health is not a prerequisite for FII, if present it may help to explain the motivations and behaviours of some of the parents as well as indicating prognosis for change. Personality disorders are most likely to be found in parents who derive a clear gain from having their child regarded as ill/more ill. Anxiety disorders may lead the parent to have unfounded anxieties about their child's health, to an extent which is harmful to the child. Rarely a psychotic illness or Autism Spectrum Disorder (ASD) in the parent may underpin fixed beliefs about the child's ill-health. Some parents have illness anxiety disorder related to themselves, previously called hypochondriasis. Others have a somatic symptom disorder, in which the person genuinely feels pain or other symptoms which are, however, not based on any identified pathology and can be related to unrecognised or unarticulated underlying emotional difficulties and conflicts. In malingering and factitious disorder, there is unacknowledged deception about the reported symptoms and signs. Both these are associated with gain for the person, the former material gain and the latter psychological or other gain.

4.2 Doctors' involvement

Most of what doctors do in the management of children, including where the presentation is not understood, is regarded as good medical practice. It consists of:

- Taking a history
- Examining the child
- Ordering investigations to ascertain the correct diagnosis/es
- Supporting and/or not disputing the need for
 - Limited school attendance
 - Use of aids eg wheelchairs
 - Financial and other support for care of the sick child
- Accepting the parent as the conduit of information between professionals
- Initiating or agreeing to further referrals, medications and other treatments.

However, in children with unrecognised FII, some of these actions may contribute to iatrogenic harm.

In addition, the practice of repeating previous, no longer relevant, or not independently substantiated problems/diagnoses in medical correspondence and documents, perpetuates an erroneous view of the child's state of health.

In children with FII, iatrogenic harm is caused by the doctor's need and wish to trust and work with parents, which is fundamental to most elements of paediatric practice, and not to miss any treatable cause of illness. Even in cases where FII might be suspected, there is still a tendency to believe parents, to avoid complaints, and sometimes uncertainty about how to proceed in what

are usually complex cases. A child often has an existing medical diagnosis, or had started out with an underlying illness, which will make assessment more difficult. The parent's accounts may therefore be true, partially true, or mixed with other accounts that are fabricated or misconstrued. This makes it more difficult to explore their credibility. There is no escaping the reality of the impact on the child in these circumstances however. All doctors need therefore to be thorough in appraising parental requests for further opinions and repeat investigations, and parental failures to bring children to appointments.

A doctor's unease, uncertainty or worry may lead to over-medicalisation of the child's reported symptoms²² which must be avoided wherever possible.

4.3 Harm to the child

Harm to the child takes several forms. Some of these are caused directly by the parent, intentionally or unintentionally, but may be supported by the doctor; others are brought about by the doctor's actions, the harm being caused inadvertently. The following three aspects need to be considered when assessing potential harm to the child. As FI is not a category of maltreatment in itself, these forms of harm may be expressed as emotional abuse, medical or other neglect, or physical abuse. There is also often a confirmed co-existing physical or mental health condition.

1. Child's health and experience of healthcare

- The child undergoes repeated (unnecessary) medical appointments, examinations, investigations, procedures & treatments, which are often experienced by the child as physically and psychologically uncomfortable or distressing
- Genuine illness may be overlooked by doctors due to repeated presentations
- Illness may be induced by the parent (eg poisoning, suffocation, withholding food or medication) potentially or actually threatening the child's health or life.

2. 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
- The child assumes a sick role (eg with the use of unnecessary aids, such as wheelchairs)
- The child is socially isolated.

3. Child's psychological and health-related wellbeing

- The child may be confused or very anxious about their state of health
- The child may develop a false self-view of being sick and vulnerable and adolescents may actively embrace this view and then may become the main driver of erroneous beliefs about their own sickness. Increasingly young people caught up in sickness roles are themselves obtaining information from social media and from their own peer group which encourage each other to remain 'ill'
- There may be active collusion with the parent's illness deception
- The child may be silently trapped in falsification of illness
- The child may later develop one of a number of psychiatric disorders and psychosocial difficulties.

22 Petska, H.W. et al. (2017) 'The Intersection of Medical Child Abuse and Medical Complexity', *Pediatric Clinics North America*, 64, pp.253-264.

4.3.1 Severity

Severity of FII can be considered in two ways: a) severity of the parent's actions, b) severity of the harm to the child.

a) 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. However, there is no evidence about the likelihood or factors associated with a parent moving from one point on this continuum to another.

b) Severity of harm to the child

The different aspects of harm to the child may coexist. 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.

Moreover, with the exception of illness induction (which can lead to serious illness and occasionally death of the child) the nature of the parent's motivations and the severity of their actions bear little relation to severity of harm to the child.

Therefore, in assessing the severity of the situation, it is important to focus on the harmful effects on the child, rather than gauge severity by what the parent is saying or doing. Although if there are clear deceptive parental actions or illness induction, it is likely that the harm to the child will be more severe.

4.3.2 Siblings

In some families, only one child is subject to FII or has a PP and this child may initially have had a genuine illness which began the relationship between the parent and health professionals. In other families, several children may be affected by FII or have a PP simultaneously or sequentially. Siblings who are not subject to FII or have a PP may become very concerned and distressed by the apparent ill-health of their affected sibling or may feel and be neglected.

4.3.3 Other victims

There have been reports of FII perpetrators also abusing spouses or animals. There may need to be consideration of referral to Adult Safeguarding or the RSPCA.

4.4 Alerting signs to possible FII

Alerting signs are not evidence of FII. However, they are indicators of possible FII (not amounting to likely or actual significant harm²³) and, if associated with possible harm to the child, they amount to general safeguarding concerns. Some alerting signs are initially recognised by community or primary health care professionals such as health visitors, GPs or community paediatricians, or by professionals in pre-school/early years, schools and other educational settings. Others are first noted by hospital-based paediatricians or in Child and Adolescent Mental Health Services (CAMHS). The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviours. Alerting signs may be recognised within the child or in the parent's behaviour. A single alerting sign by itself is unlikely to indicate possible fabrication. Paediatricians must look at the overall picture which includes the number and severity of alerting signs.

4.4.1 In the child

- Reported physical, psychological or behavioural symptoms and signs not observed independently in their reported context
- Unusual results of investigations (eg biochemical findings, unusual infective organisms)
- Inexplicably poor response to prescribed treatment
- Some characteristics of the child's illness may be physiologically impossible eg persistent negative fluid balance, large blood loss without drop in haemoglobin
- Unexplained impairment of child's daily life, including school attendance, aids, social isolation.

4.4.2 Parent behaviour

- Parents' insistence on continued investigations instead of focusing on symptom alleviation when reported symptoms and signs not explained by any known medical condition in the child
- Parents' insistence on continued investigations instead of focusing on symptom alleviation when results of examination and investigations have already not explained the reported symptoms or signs
- Repeated reporting of new symptoms
- Repeated presentations to and attendance at medical settings including Emergency Departments
- Inappropriately seeking multiple medical opinions
- Providing reports by doctors from abroad which are in conflict with UK medical practice
- Child repeatedly not brought to some appointments, often due to cancellations
- Not able to accept reassurance or recommended management, and insistence on more, clinically unwarranted, investigations, referrals, continuation of, or new treatments (sometimes based on internet searches)
- Objection to communication between professionals
- Frequent vexatious complaints about professionals

- Not letting the child be seen on their own
- Talking for the child / child repeatedly referring or deferring to the parent
- Repeated or unexplained changes of school (including to home schooling), of GP or of paediatrician / health team
- Factual discrepancies in statements that the parent makes to professionals or others about their child's illness
- Parents pressing for irreversible or drastic treatment options where the clinical need for this is in doubt or based solely on parental reporting.

4.5 Adverse Childhood Experiences

When working with children and their families where there are perplexing illnesses or concerns about fabricated or induced illness, professionals should explicitly explore whether the child is currently experiencing, or has previously experienced, adverse childhood experiences such as physical, sexual or emotional abuse, neglect, domestic abuse, child sexual or criminal exploitation, bereavement, parental/caregiver alcohol or drug misuse, severe parental mental health issues, or a parent going to prison²⁴. Adverse Childhood Experiences (ACEs) such as these can have a detrimental impact on the physical, mental and emotional wellbeing of a child²⁵. Professionals should also be mindful that parents and caregivers may themselves have experienced adverse childhood experiences.

24 Scottish Government (2020) Adverse Childhood Experiences (ACEs). Available at: <https://www.gov.scot/publications/adverse-childhood-experiences-aces/>

25 WHO. Adverse Childhood Experiences International Questionnaire. Available at: https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/

5. Response to alerting signs

If one alerting sign is present, it is essential to look for others. Alerting signs should be discussed with the Named Doctor, Named Nurse or health safeguarding team. Alerting signs by themselves do not amount to fabrication but mandate further investigation to ascertain whether the child has an underlying illness.

At the point of alerting signs being identified, consideration of possible mental ill-health in the parent is not immediately relevant. While it may transpire later that the alerting signs were not indicative of FII, it is imperative that their presence is acted upon. If alerting signs are found in primary care or by education or allied health professionals in the community, it is appropriate that a paediatrician/CAMH professional becomes involved as the resolution lies in ascertaining the actual state of the child's health. One of two courses of action need to be followed depending on whether there is or is not an immediate serious risk to the child's health/life.

5.1 Immediate serious risk to child's health / life

The most important question to be considered is whether the child may be at immediate risk of serious harm, particularly by illness induction. This is most likely to occur when there is evidence of frank deception, interfering with specimens, unexplained results of investigations suggesting contamination or poisoning or actual illness induction, or concerns that an open discussion with the parent might lead them to harm the child. In this situation, the following are important considerations:

- An urgent referral must be made to the police and children's social care as a case of likely significant harm due to suspected or actual FII, and this should lead to a strategy discussion that includes health representatives as per the latest interagency guidance. The safety of siblings also needs to be considered.
- Securing any potential evidence (eg feed bottles or giving sets, nappies, blood/urine/vomit samples, clothing or bedding if they have suspicious material on them).
- Documenting concerns in the child's health records (eg 'this unusual constellation of symptoms, reported but not independently observed, is worrying to the extent that, in my opinion, there is potential for serious harm to the child'). This is important in case the child is seen by other clinicians who are not aware of the concerns.
- Considering whether the child is in need of immediate protection and measures taken to reduce immediate risk.
- In very rare cases, covert video surveillance may be used as part of multi-agency decision-making and is led by the police.

All practitioners should be mindful of situations where to inform the parents of the referral would place a child at increased risk of harm^{26, 27, 28, 29}. In this situation, carers would not be informed of the referral before a multiagency discussion has taken place. This would usually be in the form of a formal strategy discussion.

26 HM Government (2018) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Available from <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>.

27 Scottish Government (2014) National guidance for child protection in Scotland. Available at <https://www.gov.scot/publications/national-guidance-child-protection-scotland/>

28 Department of Health (2017) Co-operating to Safeguard Children and Young People in Northern Ireland. Available at <https://www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland>

29 Welsh Government (2019) Working Together to Safeguard People. Available at <https://gov.wales/safeguarding-guidance>

Very urgent protection of the child is best obtained by contacting the police who can then use their police protection powers, as it will take children's social care a number of hours to obtain an Emergency Protection Order. However, children's social care should be contacted at the same time as the police. If the Named Doctor or responsible paediatric consultant are of the opinion that the threshold for likely or actual significant harm is possibly met (as per the criteria under section 47 of the Children Act 1989³⁰) either as a matter of urgency or in a planned manner, they must make a referral using appropriate local pathways. Procedures in the devolved nations will differ somewhat according to their national guidance^{31, 32, 33}.

Once the child's safety has been ensured and child protection plans are in place, the steps described below from 5.3.1 onwards will still apply.

5.2 Alerting signs with no immediate serious risk to the child's health / life – Perplexing Presentations (PP)

The term Perplexing Presentations (PP) denotes the presence of alerting signs to possible FII, in the absence of the likelihood of immediate serious risk to the child's physical health or life. Perplexing Presentations nevertheless indicate possible harm to the child which can only be resolved by establishing the actual state of health of the child. They therefore call for a carefully planned response. This will be led by the responsible clinician with advice from the Named Doctor, usually in the secondary, and occasionally tertiary centre, in which paediatricians or CAMHS clinicians are employed. The essence of the response is to establish the current state of health and functioning of the child and resolve the unexplained and potentially harmful situation for the child. The term Perplexing Presentations and management approach can and should be explained to the parents and the child, if the child is at an appropriate developmental stage. Reflecting with parents about the differing perceptions that they and the health team have of the child's presenting problems and possible harm to the child may be very helpful in some cases, particularly if it is done at an early stage.

If the initial concerns arise directly from school as opposed to health, it is recommended that school explain to the parents that information is required from health to understand the concerns eg poor school attendance. It is then appropriate for either the parents or education to contact health (either GP, consultant paediatrician or child psychiatrist) with their query about the actual health of the child. If the parents do not agree to a health assessment and the sharing of information about the child we recommend that schools will then need to decide what action they should take following their national safeguarding guidance. At this stage, professionals should refrain from using FII terminology, as the state of the child's health has not yet been assessed. If primary healthcare is the only contact for the child, then they may wish to refer to a paediatrician for further assessment of the child's health. If the response from health is felt to be inadequate, education can contact either the Named GP or Named Doctor for Safeguarding Children for a Community or Hospital Trust / Health Board as appropriate, for advice. If concerns arise within General Practice, we recommend that there should be consultation with the Named GP for Safeguarding Children in the first instance.

30 HM Government. Children Act 1989. Available from <http://www.legislation.gov.uk/ukpga/1989/41/contents>

31 HM Government. The Children (Scotland) Act 1995 Available from <https://www.legislation.gov.uk/ukpga/1995/36/contents>

32 HM Government. The Children and Young People (Scotland) Act 2014. Available from <http://www.legislation.gov.uk/asp/2014/8/contents/enacted>

33 HM Government. The Children (Northern Ireland) Order 1995. Available from <https://www.legislation.gov.uk/nisi/1995/755/contents/made>

At any stage during this process, should new information come to light to suggest that the child is currently suffering from significant harm, referral to children's social care and/or the police must be made, alongside the process outlined in this guidance. The urgency with which this is done and whether or not parents are informed about the referral before a professional multi-agency discussion will vary according to the circumstances of each case.

5.2.1 Response to Perplexing Presentations (PP)

This is a complex and time-consuming process, led by the Responsible Paediatric or CAMH Consultant with advice from the Named Doctor and the health safeguarding team (who do not have clinical responsibility for the child) – all should be supported and have protected time to provide the necessary focus. Responding to PP requires a multidisciplinary approach, although it is imperative that the responsible consultant continues to have overall clinical responsibility for the child and that the background safeguarding processes are supported by the Named Doctor and the health safeguarding team.

If the Responsible Paediatric or CAMH Consultant (who may change during the process) is also the Named Doctor, then another paediatrician in the Trust / Health Board will need to undertake this consultative role, possibly the Designated Doctor. This means that safeguarding decisions can be made objectively, free from duress, threats and complaints and the responsible paediatric consultant has appropriate support in these challenging cases.

The essence of management is establishing, as quickly as possible, 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 parents and the child (if old enough) the current uncertainty regarding the child's state of health, the proposed assessment process and the fact that it will include obtaining information about the child from other caregivers, health providers, education and social care if already involved with the family, as well as likely professional meetings. Wherever possible this should be done collaboratively with the parents. If they do not give agree for this to happen, the parents' concerns about this process should be explored and can often be dispelled. However, under the NHS' interpretation of General Data Protection Regulations (GDPR) for the UK information sharing can take place without consent if: there are safeguarding concerns, it is in the best interests of the child, is necessary and proportionate and is done in a manner according to the regulations³⁴. Strong parental objections could indicate a referral to children's social care on the grounds of medical neglect - that the doctors are unable to establish the state of health and medical needs of the child.

When paediatricians become concerned about a perplexing presentation, an opinion from an experienced colleague needs to be obtained and a tertiary specialist may be necessary. Parents themselves may request another opinion and it is their right to do. However, this opinion giver should be supplied with all the background information to help in informing the opinion and to avoid the repetition of investigations unnecessarily. The seeking of multiple alternative opinions, particularly when there has already been a reasonable diagnostic formulation, is almost always harmful to the child and may well increase concern about FII.

There may need to be one or more professionals' meetings to gather information, and these can be virtual meetings. Where possible, families should be informed about these meetings and the outcome of discussions as long as doing so would not place the child at additional risk. Care should be given to ensure that notes from meetings are factual and agreed by all parties present. Notes from meetings may be made available to parents, on a case by case basis and are likely to be released to them anyway should there be a Subject Access Request for the health records.

5.2.2 Child's health and wellbeing

The responsible paediatric consultant should:

- Collate all current medical/health involvement in the child's investigations and treatment, including from GPs, other Consultants, and private doctors, with a request for clarification of what has been reported and what observed. (This is not usually a request for a full chronology, which would need to include all past details of health involvement and which is often not relevant at this point).
- Ascertain who has given reported diagnoses and the basis on which they have been made, whether based on parental reports or on professional observations and investigations.
- Consider inpatient admission for direct observations of the child, including where relevant the child's input and output (fluids, urine, stool, stoma fluid as applicable), observation chart recordings, feeding, administration of medication, mobility, pain level, sleep. If discrepant reports continue, this will require constant nurse observations. Overt video recording may be indicated for observation of seizures and is already in widespread use in tertiary neurology practice to assess seizures (which must be consented to by parents).
- Consider whether further definitive investigations or referrals for specialist opinions are warranted or required.
- Obtain information about the child's current functioning, including: school attendance, attainments, emotional and behavioural state, peer relationships, mobility, and any use of aids. It is appropriate to explain to the parents the need for this. If the child is being home schooled and there is therefore no independent information about important aspects of the child's daily functioning, it may be necessary to find an alternative setting for the child to be observed (eg hospital admission).

5.2.3 Parents' views

The responsible paediatric consultant should:

- Obtain history and observations from all caregivers, including mothers and fathers; and others if acting as significant caregivers.
- If a significant antenatal, perinatal or postnatal history regarding the child is given, verify this from the relevant clinician.
- Explore the parents' views, including their explanations, fears and hopes for their child's health difficulties.
- Explore family functioning including effects of the child's difficulties on the family (eg difficulties in parents continuing in paid employment).
- Explore sources of support which the parent is receiving and using, including social media and support groups.

- Ascertain whether there has been, or is currently, involvement of early help services or children's social care. If so, these professionals need to be involved in discussion about emerging health concerns.
- Ascertain siblings' health and wellbeing.
- Explore a need for early help and support and refer to children's social care on a Child in Need basis, where appropriate depending on the nature and type of concerns, with agreement from parents.

5.2.4 Child's view

The responsible paediatric consultant should:

- Explore the child's views with the child alone (if of an appropriate developmental level and age) to ascertain:
 - the child's own view of their symptoms;
 - the child's beliefs about the nature of their illness;
 - worries and anxieties;
 - mood;
 - wishes.
- Observe any contrasts in verbal and non-verbal communication from the child during individual consultations with the child and during consultations when the parent is present.

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.

The RCPCH have developed resources, with input from children and young people, to aid their communication with health professionals. The 'Being Me' resources help children and young people to share who they are, how they are feeling and what support they would like. The materials include: feelings poster, children's health and wellbeing passport and top tips for doctors. These tools are especially effective for children and young people that do not feel comfortable to freely share their experiences, as described by this young person:

"Emojis are an easy and fun way for us to tell doctors how we are feeling when we can't fully explain or don't want to. Children can point to an emoji or draw with their doctor." RCPCH & Us Voice Bank, 2018.

Health professionals should consult the 'Me first' communication model for guidance; these training and materials have been co-designed and developed with children and young people.

Download RCPCH 'Being Me' resources:

<https://www.rcpch.ac.uk/resources/being-me-supporting-children-young-people-care>

Access 'Me first' resources:

<https://www.mefirst.org.uk/>

The responsible paediatric consultant should provide signposting advice for children, young people and their parents on where appropriate to access more information or support.

5.3 Reaching a consensus formulation about the child's current health, needs, and potential or actual harm to the child

The aim of the full medical and psychosocial review is to gain clarity about any verified illnesses, and any remaining Perplexing Presentations. Binary thinking about difficulties, regarding them as either physical or psychological is unhelpful, as both will be relevant. As is often the case, several doctors and other health professionals will have been involved in diagnoses and treatment.

Consensus about the child's state of health needs to be reached between all health professionals involved with the child and family, including GPs, Consultants, private doctors and other significant professionals who have observations about the child, including education and children's social care if they have already been involved. A multi-professional meeting is required in order to reach consensus. This professionals meeting should be chaired by the Named Doctor (or a clinician experienced in safeguarding with no direct patient involvement) to ensure a degree of objectivity and to preserve the direct doctor-family relationship with the responsible clinician. Parents should be informed about the meeting and receive the consensus conclusions with an opportunity to discuss them and contribute to the proposed future plans (see below).

It is the number and severity of the concerns in the alerting signs which led to the need to investigate the perplexing presentation. The decision that has to be made is whether, on the one hand, the perplexing presentation can be explained by either a verified condition/s or by medically unexplained symptoms emanating from the child or, on the other hand, whether there is concern that the child is coming to harm either by fabrication of symptoms by the parents and/or their by their fixed erroneous beliefs about the child's health.

In order to resolve these concerns, a decision needs to be made about whether the perplexing presentation is explained and resolved by a verified medical condition in the child, or whether concerns remain.

In order to resolve this, a consensus needs to be reached in a meeting between all professionals about the following issues:

Either

- That all the alerting signs and problems are explained by verified physical and/or psychiatric pathology or neurodevelopmental disorders in the child and there is no FII (false positives).
- Medically Unexplained Symptoms from the child free from parental suggestion
- That there are perplexing elements but the child will not come to harm as a result.

Or

- That any verified diagnoses do not explain all the alerting signs
- The actual or likely harm to the child and or siblings

And agree all of the following

- Whether further investigations and seeking of further medical opinions is warranted in the child's interests
- How the child and the family need to be supported to function better alongside any remaining symptoms, using a Health and Education Rehabilitation Plan (see below for details)
- If the child does not have a secondary care paediatric Consultant involved in their care, consideration needs to be given to involving local services
- The health needs of siblings
- Next steps in the eventuality that parents disengage or request a change of paediatrician in response to the communication meeting with the responsible paediatric consultant about the consensus reached and the proposed Health and Education Rehabilitation Plan.

Significant disagreements between health professionals about any important aspects of the diagnosis and medical management of the child, will need to be resolved. In such cases, the Named or Designated Doctor for Safeguarding Children should convene and chair a Health Professionals Meeting to agree on the medical issues. Where there is no Designated Doctor in post / available, then local escalation policies should be followed (RCPCH recommends that all Designated Doctor posts should be filled³⁵). The Designated Doctor can only perform this role if they have never been clinically involved with the case. Trusts / Health Boards need to establish alternative arrangements for another Designated Doctor from a neighbouring area to chair such a meeting in the eventuality that this is required. There must be a clear escalation policy to the Medical Director where there are significant concerns about how a case is being managed within any healthcare organisation. Clear record keeping of meetings, discussions and decisions is vital and is further discussed in Section 8.

5.3.1 Communication to parents and child

Once health consensus has been achieved, a meeting should be held with the parents, the responsible paediatric consultant and a colleague (never a single professional). The meeting will explain to the parents that a diagnosis may or may not have implications for the child's functioning, and that genuine symptoms may have no diagnosis. It is preferable to acknowledge the child's symptoms rather than use descriptive 'diagnoses'. It is often useful to use the term 'issues/concerns' in clinical letters rather than 'diagnoses' in these circumstances.

35 Royal College of Paediatrics and Child Health (2019) Focus on: Vulnerable children and families paediatric workforce. London: RCPCH: November 2019.

The current, as of now, consensus opinion is offered to the parents with the acknowledgment that this may well differ or depart from what they have previously been told and may diverge from their views and beliefs. A plan is then made with the parents about what to explain to the child and what rehabilitation is to be offered and how this will be delivered. This plan should be negotiated with the parents and child if of sufficient maturity, as engagement in such a plan is necessary for it to work. The plan should be explained to younger children even if they are not sufficiently mature to be involved in the plan's construction. It is premature, and important not to discharge the child from paediatric care even if there is no current verified illness to explain all the alerting signs, until it is clear that rehabilitation is proceeding.

The RCPCH have developed guidance for paediatricians and health professionals on how best to achieve consensus with parents, particularly on the prevention, recognition and management of conflict in paediatric practice, some of the principles are applicable to general routine care³⁶.

5.3.2 Whether to refer to children's social care at this point

If there is actual or likely harm to the child or siblings, the implication is that the child has been subject to FII. The question of future harm to the child hinges on whether the parents recognise the harm and are able to change their beliefs and actions in such a way as to reduce or remove the harm to the child. In order for this to be tested the consensus medical view about the child's actual state of health and the consequences needs to be discussed with the parents and the child in terms of likely reduced medical intervention, the child's improved daily functioning and a revised view of the child's state of health. This requires the co-construction of a Health, Education and Rehabilitation Plan with the parents and child and implementation of this plan (see details below). However, the question arises as to whether in addition to this, there needs to be a referral to children's social care at this point.

Working Together (2018) guidance for England states variously:

- 'Anyone who has concerns about a child's welfare should make a referral to local authority children's social care and should do so immediately if there is a concern that the child is suffering significant harm or is likely to do so.'
- 'If a practitioner has concerns about a child's welfare and considers that they may be a child in need or that the child has suffered or is likely to suffer significant harm, then they should share the information with local authority children's social care and/or the police.'
- 'Where a child's need is relatively low level, individual services and universal services may be able to take swift action. Where there are more complex needs, help may be provided under section 17 of the Children Act 1989 (children in need). Where there are child protection concerns (reasonable cause to suspect a child is suffering or likely to suffer significant harm) local authority social care services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989.'

36 Linney, M. et al. (2019) 'Achieving consensus advice for paediatricians and other health professionals: on prevention, recognition and management of conflict in paediatric practice', *Archives of Disease in Childhood*, 104, pp.413-416.

In some situations, the severity of the harm to the child therefore mandates immediate referral to children's social care due to the level of harm that has been, or is likely to be, caused to the child. However, outside the court arena, there is no absolute clarity about when harm reaches the threshold of significance. Arguably, in some cases, if parents and child (if of an appropriate developmental level) are able to understand the need for and are able to agree a Health and Education Rehabilitation Plan, immediate referral to children's social care may not be necessary as long as the plan is being monitored carefully, proceeding satisfactorily and agreed goals are being reached. The decision whether to refer to children's social care at this point in the process lies ultimately with local health professionals working within their multi-agency procedures. Some local authorities or safeguarding children's partnerships offer a consultation service on an anonymised basis, prior to referral. However, if a referral is made, the reasons for this referral will need to be discussed with the family beforehand and, from a health point of view, the Health and Education Rehabilitation Plan will need to continue wherever possible regardless of referral.

Professionals in health should be aware that they do not always have all the pieces of the safeguarding jigsaw puzzle. When a decision is being made about whether to refer children to children's social care, professionals should consider whether they have all the information from other agencies which is required to inform their risk assessment about levels of harm. If there is concern that they do not have this information particularly when parents decline to give consent for information sharing, a referral to children's social care may be necessary because of professional inability to assess the level of harm without the intervention of children's social care.

5.4 Liaising with General Practitioners (GPs)

GPs hold lifelong relationships with patients. They may have extensive knowledge and relationships with multiple generations of families. It is essential that GPs are kept fully informed and involved in the management of children with perplexing presentations or where there are concerns about FII so they can support children and their families as appropriate as well as work in partnership with other professionals involved to ensure the best outcomes for children.

6. Health and Education Rehabilitation Plan

This plan should be developed and implemented, whatever the status of children's social care involvement is.

Development of the Health and Education Rehabilitation Plan requires a coordinated multidisciplinary approach and negotiation with parents and children and usually will involve their attendance as appropriate at the relevant meetings. A co-ordinated multidisciplinary approach in Scotland should use the GIRFEC (Getting It Right For Every Child) Framework. There may well be a number of acceptable approaches and in most cases engagement and agreement by the child and family is pivotal to the success of the Plan. The Plan is led by one agency (usually health) but will also involve education and possibly children's social care. It should also be shared with an identified GP. The Plan must specify timescales and intended outcomes. There needs to be agreement about who in the professional network will hold responsibility for coordinating and monitoring the Plan, and who will be the responsible paediatric consultant (most likely to be a secondary care paediatrician). It is important that the Trust / Health Board employing the professional with this responsibility provide the clinician with adequate resources for this task to be fulfilled. Consideration needs to be given to what support the family require to help them to work alongside professionals to implement the Plan. This may include psychological support and / or referral to children's social care for additional support.

The Plan requires health to rationalise and coordinate further medical care and may include:

- Reducing/stopping unnecessary medication (eg analgesics, continuous antibiotics)
- Resuming oral feeding
- Offering graded physical mobilisation.

There should be a discussion with the patient's registered GP regarding what role they may be able to take in supporting the management and care of the patient.

Optimal education needs to be re-established (when the child is of school age), with appropriate support for the child and family.

An example Health and Education Rehabilitation Plan template has been provided in Appendix A.

6.1 Psychological work

The Health and Education Rehabilitation Plan should detail how the child and caregivers will be psychologically supported. This is multifaceted and requires a coordinated child and family mental health approach, which may or may not involve CAMHS, depending on local referral criteria.

Psychological support should aim to:

- Help the child to adjust to a better state of health, by using coping strategies for symptoms with a cognitive behavioural approach. The child might also need support for the loss of gains associated with being a sick child
- Help the child and the family, including the siblings, to construct an account which explains the evolution of the child's difficulties as well as the improvement in the child. This needs to be truthful and may be distressing to the child who will need support
- Explore the parent's motivations, including: anxiety, compassion, beliefs, fulfilment of needs, and the implications and likely changes for the parent when the child's state of health is improved and the child is functioning optimally. This will require helping the parent to adjust to having a well or better child
- Consider the need for referral of the parent by the GP to adult mental health services. This is in order for both the parent and professionals to better understand the nature of the parent's actions, any mental health diagnoses, motivations, prognosis and likely capacity to change, indication of treatment to effect change and who is likely to provide treatment.

6.2 Regular review of Plan

The Health and Education Rehabilitation Plan needs to be reviewed regularly with the family according to the timescales for achieving the specified outcomes, especially regarding the child's daily functioning. This should continue until the aims have been fulfilled and the child has been restored to optimal health and functioning and the previous alerting signs are no longer of concern. Agreement needs to be reached by the professionals involved and the family about who will review the plan and when. It is essential to identify a lead professional to coordinate care and organise regular review of the plan. This may be the previous responsible consultant paediatrician or another more appropriate health professional as decided by the multi-disciplinary team. Appropriate health professionals to lead on the plan will vary on a case by case basis and could include:

- Consultant Hospital Paediatrician
- Consultant Community Paediatrician
- Consultant Child and Adolescent Psychiatrist

If the child has either a Child in Need or a Child Protection Plan it may be appropriate for a social worker to take the lead in coordination in conjunction with health and education teams, as the aims of the Health and Education Rehabilitation Plan would form part of that plan. It is important to guard against what might be seen as disguised compliance by the parents.

An important aspect of the fulfilment of the Health and Education Rehabilitation Plan is the parent's ability to now hold a realistic view of the child's health and health-related needs and to be seen to have to communicated this to the child.

6.3 Long term follow-up

All children who have required a Health and Education Rehabilitation Plan, unless there is a permanent positive change in primary caregivers, will require long term follow up by a professional at the closure of the plan. Depending on individual circumstances it is advisable to continue to be alert to possible recurrence of concerns either in the child(ren) or their siblings. Education and primary health are the appropriate professionals to monitor the children's progress and to identify re-emerging or new concerns.

7. When the Health and Education Rehabilitation Plan is not working – necessary referral to children’s social care

If the parents disagree with the consensus feedback and an effective Health and Education Rehabilitation Plan cannot be negotiated, or it becomes apparent that there is lack of engagement with the Plan which had been agreed with them, then it is necessary to refer the child to children’s social care. This is on the basis that the child’s functioning and/or development is being avoidably impaired by the parents’ behaviour and any harm caused has now become significant. Parental disagreement may take the following forms: active dispute, requesting additional unwarranted investigations, seeking further inappropriate medical opinion(s), continuing to seek unnecessary or alternative further diagnoses, declining the Plan, and / or the rehabilitation process fails to proceed (eg if the plan requires to attend school and they are no longer doing so).

The referral to children’s social care should be discussed with parents and the reasons for professional concern explained. The emphasis should be on the nature of the harm to the child including physical harm, emotional harm, medical or other neglect and avoidable impairment of the child’s health or development³⁷.

In order to help to ensure that the referral is acted upon appropriately it should describe the concerns, define the harm and provide evidence of inability of the health professionals to manage the situation on a voluntary basis. The referral should include all of the following, using plain language:

- A clear explanation of any verified diagnoses with a clear description of the functional implications of the diagnosis(es) for the child
- Details of the nature of the concerns
- Description of independent observations of the child’s actual functioning, medical investigations, detailing all medical services involved and the consensus medical and professional view about the child’s state of health
- Information given to the parents and child about diagnoses and implications
- Description of the help offered to the child and the family to improve the child’s functioning (eg the Health and Education Rehabilitation Plan)
- The parents’ response
- Full description of the harm to the child, and possibly to the siblings, in terms of physical and emotional abuse, medical, physical and emotional neglect.

A chronology of the child’s health and healthcare is often requested at the point of referral. However, preparing a full chronology (see below) is extremely time-consuming, and is not actually needed immediately. Awaiting the preparation of a full chronology will delay the process during which the child might be left at ongoing risk while a chronology is being compiled.

37 Glaser, D. & Davis, P. (2019) ‘For debate: Forty years of fabricated or induced illness (FII): where next for paediatricians? Paper 2: Management of perplexing presentations including FII’, Archives of Disease in Childhood, 104, pp:7-11.

7.1 Response requested from children's social care

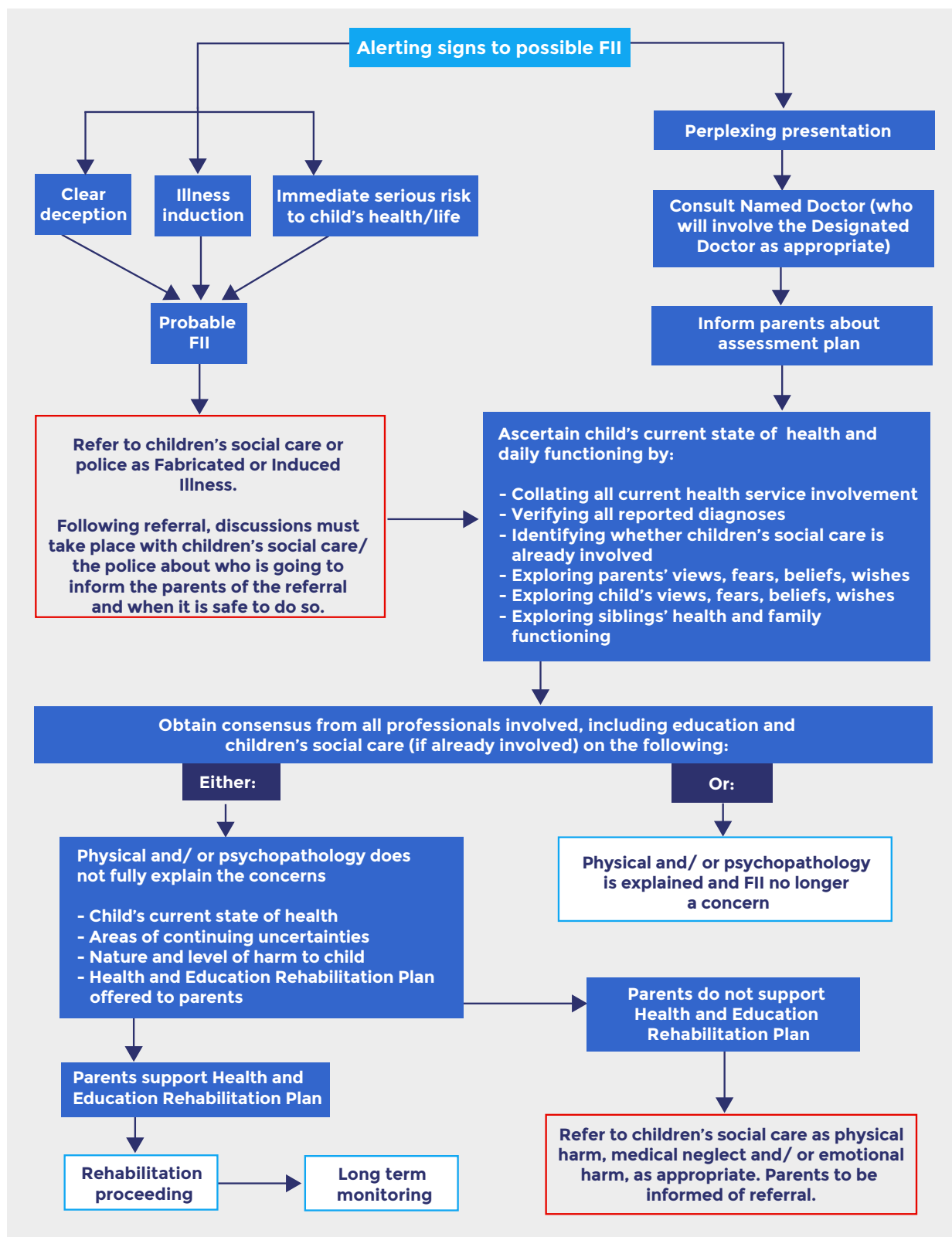
The reason for referring the child to social care is the need to reduce the harm to the child. Children's social care in turn undertake an assessment to determine whether the significant harm threshold has been reached, what the child's needs are and to intervene to reduce or prevent harm. The RCPCH recommends that this should include supporting the Health and Education Rehabilitation Plan. In addition, the child will need to be protected from being taken to health professionals unnecessarily by the parent if they continue to give unreliable information about the child, as health professionals unaware of the full context will not have the necessary information on which to assess the child which may be to the detriment of the child's health and wellbeing.

If the referral 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. Named and Designated Doctors and Nurses can play a key role here in communication with children's social care. Where appropriate, concerns about decisions should be escalated to senior management within the Local Authority. We recommend that Local Authorities should have embedded expertise and dedicated pathways to assess such cases/situations.

Children's social care will often request a chronology from health to inform their assessment. In cases of professional dispute, the evidence contained within a full chronology may be invaluable, along with the comprehensive referral (described above) with a health assessment report outlining evidence of professional concerns, the impact on the child and actions taken so far by health professionals to attempt to resolve the issues.

7.2. Summary diagram

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



8. 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 to ensure that the child does not come to further harm (as per recommendations from the Victoria Climbié Inquiry³⁸). If, for any reason, an organisation has more than one clinical record, a flagging system should be in place to cross-reference concerns held in the main health record pertaining to the child. A formal agreed consensus document or minutes of professionals' meetings shared across all participant organisations will avoid discrepancies in individual's recollection/recording across the multi-professional group, and is preferable to individual entries in notes.

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. Despite the difficulties of this approach, legal advice and GMC rulings suggest that individual doctors and health teams could be potentially criticised in any subsequent legal proceedings for not keeping a single record accessible to the whole health team, and potentially their evidence could be undermined in court if this is not done. This does not mean that the Named Doctor, or safeguarding team, cannot hold replica tracking records, but they must be cross referenced to the main health record and not contain substantially different material. Any emails between clinicians about a child, between parents and clinicians, and between children and clinicians, form part of the health record.

Subject Access Requests from parents in PP and FII cases are not uncommon. They are easier to manage if there has been open communication with parents previously. If it is thought that the Subject Access Request may result in concerns about the child's welfare, appropriate legal advice needs to be sought within the Trust / Health Board about what material should be disclosed and any material to be withheld.

All correspondence regarding a child should be copied to all health providers involved, not only the GP and the parents, as is best practice in all paediatric care

8.1 Chronology

A full chronology consists of a list of significant past events that have occurred during the child's life, by date and time. Chronologies are usually compiled using a template which has a number of headed columns with information about the source of the entry, what actually happened or was observed and by whom, what was said, and an analysis of this. It is useful for organisations within a particular locality to have the same chronology template so that information can be merged easily from different health providers. However, the exact chronology format may vary on an individual case basis, dependent on the child's need / circumstances.

38 Lord Laming (2003) The Victoria Climbié Inquiry. Crown Copyright 2003. Available from: <https://www.gov.uk/government/publications/the-victoria-climbié-inquiry-report-of-an-inquiry-by-lord-laming>

Suggested headings for chronologies:

- When and what was reported;
- By whom;
- What was observed;
- By whom;
- What action was taken and on what basis;
- What the outcome of the action was;
- Analysis.

Chronologies of significant health events are useful in understanding recurring patterns of behaviour and concerns in PP and FII. In cases involving PP, the initial assessment should focus on understanding the child's current functioning and any discrepancies between what is reported and what the child is observed or considered to be able to achieve, given objective medical information about proven pathology (physical and psychiatric). Chronologies are particularly valuable when there is uncertainty about the extent or pattern of past reported illnesses/significant events and/or there is a requirement to make a case for a significant harm threshold for child protection or court proceedings.

Although very useful, chronologies are usually time consuming to compile and are not always necessary. Assessment of current functioning and a management plan should not await the production of chronologies as appropriate action for the child should not be delayed.

Health chronologies should be compiled by multi-professional health teams and must include an experienced and senior health professional that fully understands the presenting health issues so as to interpret significant events through this lens (usually a consultant paediatrician or a Child and Adolescent Psychiatrist).

Chronologies should aim to be objective in determining which significant events are included. They must contain balanced information, including significant positive information about family functioning or test/observation results not necessarily in keeping with the overall concerns. Recording of facts in chronologies should be kept separate from opinion and analysis, but it is important that this is included in order for non-health professionals to easily make sense of the information presented.

Although chronologies are often requested as standalone documents, they can be misleading without a summary and overall analysis. This analysis should include proven diagnoses, important comments by both parents and child, information about parent/child perception of illness, important discrepancies in reporting and observed health information and recurring patterns of behaviour/presentation. This analysis could include commentary on whether the overall situation is likely to meet the significant harm threshold.

9. Transitions

Once children are 16 years old, they are presumed in law to be competent to make decisions about their health. Young people aged 16 and 17 years old require particular support as many start their journey towards independence at this time. For those with health conditions, there can be many challenges as they start the transition from children's health services to adult health services. Great care needs to be taken that young people in this age group who have medically unexplained, functional disorders and perplexing presentations, or where there are concerns about FII, don't fall off a 'cliff edge' between child and adult services. Timely and robust information sharing between child and adult services as well as with the young person's GP is essential to ensure the young person continues to be supported and their needs met. Coordinated care, ideally through meetings with the key professionals and/or young person and their family will ensure safe and efficient information sharing and planning for their future care.

All doctors and health professionals practising in England and Wales should be aware of The Mental Capacity Act (MCA) 2005 (amended in 2019). The MCA applies to people aged 16 and over and is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. The principles of the MCA are:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise
- wherever possible, help people to make their own decisions
- don't treat a person as lacking the capacity to make a decision just because they make an unwise decision
- if you make a decision for someone who doesn't have capacity, it must be in their best interests
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.³⁹

Professionals have a unique opportunity when working with young people aged 16 and 17 years to explore what the young person's views on their health are, their concerns and what their hopes for the future are. There is an opportunity to empower the young person to make decisions about their own health as well as other aspects of their life and link them with other appropriate services and professionals who can support them. In this situation it may be the parents' wishes for their child are considered but the informed decision(s) about their health and treatment are made by the young person themselves.

39 NHS (2018) Making decisions for someone else: Mental Capacity Act. Available at: <https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/>

10. Training, supervision and support

All paediatricians should receive training about the management of both PP and FII, as it is expected that all paediatricians will encounter patients with alerting signs and possible FII, which is reported with more frequency in certain specialities. Learning is encouraged through attendance at courses/lectures/talks, reading, case discussion with colleagues and safeguarding supervision with named professionals or experienced colleagues. Management of PP and FII cases is challenging and clinicians require appropriate support from colleagues, Named and Designated Professionals, their employers and professional bodies.

10.1 Training

The syllabus for paediatricians in training is set by the RCPCH Progress curriculum. Almost all parts of this syllabus are relevant to developing the skills to be able to prevent, recognise and manage PP and FII. The domains across the three training stages include the development of professional knowledge and values, communication skills, patient management, patient safety, information sharing, leadership and team working.

All of these are vitally important in this field of work in addition to the broad principles laid out in the specific safeguarding children domain (domain 9).

All paediatricians are required to have specific knowledge and skills leading to competencies about recognising and managing PP and FII as laid out in the Intercollegiate Document (ICD), 'Safeguarding children and young people: roles and competencies for healthcare staff'⁴⁰, which is supported by the RCPCH. The ICD applies to all colleagues in the health service, providing a common understanding across different medical specialities as well as nursing specialities and allied medical specialities. Therefore, paediatricians, GPs, child and adult psychiatrists and psychologists, health visitors, public health school nurses, dieticians, physiotherapists, speech and language therapists and occupational therapists should all be aware of PP and FII and share a common understanding. Commissioners and service planners should ensure that the training requirements within the ICD are implemented and monitored by health inspectorate bodies.

RCPCH safeguarding courses are available at:

<https://www.rcpch.ac.uk/resources/safeguarding-learning-resources>

RCPCH Progress curriculum is available at:

<https://www.rcpch.ac.uk/education-careers/training/progress>

RCPCH paediatric guide to the ICD is available at:

<https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies>

e-Learning for Healthcare Safeguarding Children and Young People - Level 3 available at:

<https://portal.e-lfh.org.uk/Component/Details/391100>

10.2 Role of Named and Designated Doctors

The role of the Named and Designated Doctors, or their equivalents in the devolved nations, and the safeguarding teams involved in case management has been outlined previously in the guidance.

Named and Designated Doctors for Safeguarding Children and the safeguarding teams within which they operate play a pivotal role in delivery of formal training about PP and FII, providing supervision and support for health staff, and advising on case management.

Their own additional needs for development of general safeguarding competencies and those particular to PP and FII are specified in the ICD.

The leadership, support, supervision and advice provided by paediatricians in these specialised roles is a vital component of ensuring the best outcomes for children and determining the threshold for potential significant harm which mandates referral to children's social care and the police. Named and Designated Health Professionals should be included in all strategy discussions pertaining to cases where FII is a concern. Designated Professionals should ensure that local guidance reflects this recommendation.

Safeguarding children supervision is essential to safe practice, whether this be part of formal or more informal group supervision, Peer Review or one to one sessions. The Named and Designated professionals and their safeguarding teams should coordinate and provide supervision, either by case management or in a more reflective manner. The Named and Designated professionals should establish local peer support networks for regular discussion of anonymised cases.

Named Professionals should escalate concerns about lack of appropriate support through escalation systems within their provider organisations and if necessary to the Designated Professionals (who sit within commissioning organisations in England).

Named professionals should receive professional support from their Designated Doctor and management support from their Medical Director and Executive Lead for Safeguarding Children within their provider organisation.

Designated professionals should seek management support from the Executive Director for Safeguarding Children within the CCG in England and to those with corresponding responsibilities in the devolved nations. It is recommended that they seek supervision and professional support from other Designated Doctor peers in the adjoining localities. Consideration should be given to formal arrangements being negotiated for cross cover and peer supervision and support for Designated Professionals or their equivalents.

10.3 Support

All consultant paediatricians in a health service should share in acting as the responsible consultant paediatrician for PP and FII cases encountered on their caseload. They should not all be the responsibility of one individual.

When there are concerns about significant harm within complex cases, the safeguarding oversight should not be provided by the responsible consultant paediatrician, to ensure objectivity and relative freedom from duress.

Employing organisations, and their legal departments, should provide appropriate support for their staff working in this field. This includes providing appropriate time and resources for paediatricians and other health professionals to fulfil their duties in what are often particularly resource intensive, professionally and emotionally challenging cases. Complaints departments and Patient Advice and Liaison Service (PALS) should understand the complex dynamics involved between parents and health professionals in these types of cases, and their investigations and support to parents should take this into account. Health staff should be supported by their Trust in dealing with repeated communications from parents.

If complaints are made to an NHS Trust/organisation in a case where there are safeguarding concerns regarding PP or FII, the response should be advised by the Named Doctor, or their equivalent in the devolved nations.

In addition to this support, it is recommended that employing organisations, in meeting their safeguarding children duties and their duty of care to their staff, should also provide occupational health / counselling support to any paediatrician or other member of staff that requires it. This is particularly important when an individual's professional integrity is challenged, and their reputation and / or personal safety are threatened, often through social media. Paediatricians are encouraged to follow the British Medical Association's 'Social media guidance for doctors', which outlines how professionals can manage disagreements and protect themselves within such situations⁴¹. Paediatricians can also request support from their defence organisations, the RCPCH and the BMA⁴², amongst others.

In these types of situations, on occasion, collusive and unprofessional relationships can develop between parents and members of the health team. This needs to be addressed by the responsible consultant paediatrician or the Named or Designated Doctor.

41 British Medical Association. Social media guidance for doctors. Available online at: <https://www.bma.org.uk/advice/employment/ethics/social-media-guidance-for-doctors>. Created: 27 February 2017

42 The British Medical Association provides counselling and peer support, free of charge to all doctors. BMA membership is not required. They are both accessed by calling 0330 123 1245 and the number is answered 24/7.

10.4 Private practice

Wherever a paediatrician is practising and in whatever context, they are bound by GMC standards relating to safeguarding children⁴³. The Designated Doctor, of their equivalent in the devolved nations, has a duty towards the whole health economy in the area they cover and any paediatrician in private practice can approach them with regard to how to access training and supervision if they are in doubt about this.

Unlike in the NHS, where referrals to consultant paediatricians are made by other doctors who know the child, paediatricians working in the private sector may see children referred by the parents. It is good practice for doctors operating privately to request a GP referral letter as this will contain relevant background information and makes the GP aware of the parents' request for a private assessment. The GP can then alert the private Consultant to any known safeguarding concerns. In cases of unrecognised FII, the history given by the parents may not reflect the whole or an accurate picture. For this reason, it is advisable for private paediatricians to ascertain by whom the child has already been seen and request information from the other doctors⁴⁴. Equally, while a parent may wish for their child to be seen privately, if, in cases of PP or FII an NHS doctor becomes aware of this proposed consultation, it is appropriate to ensure that the private paediatrician is provided with full information about the child.

All paediatricians, regardless of where they practice, should maintain their competencies with regards to safeguarding children. Paediatricians who practice within the NHS, as well as privately, will be able to maintain their safeguarding children competencies through their NHS employment. Paediatricians who practice privately full time are still required to maintain their safeguarding children competencies. If there are any concerns about how they achieve this, they should discuss this with the Designated Doctor for the area in which they practice. All paediatricians have their competencies appraised annually in order to be revalidated to practise by the GMC.

43 General Medical Council (2012) Protecting children and young people: The responsibilities of all doctors. Available from: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people>

44 Larcher, V. & Brierley, J. (2020) 'Second medical opinions in paediatric practice; proposals for a framework for best practice', *Archives of Disease in Childhood*, 105 (3), pp.213-215.

11. Summary and conclusions

The overall aim of this guidance is to ensure that children receive the most appropriate healthcare for their individual needs, ultimately improving their health and wellbeing outcomes. Whenever possible, this should be done by working collaboratively with their parents.

We acknowledge that there is ongoing debate regarding terminology in this field; however, it remains important whatever terminology is used, to frame concerns about harm in terms of emotional abuse, physical abuse, neglect of medical and other needs.

It is important to recognise that this work places considerable demands and burden on paediatricians. Their work in this field needs to be supported by experienced peers and underpinned by access to specialist advice. Employing organisations must provide appropriate support, time and resources to health professionals involved in assessing and managing Perplexing Presentations and Fabricated or Induced Illness.

Whilst this guidance is written for paediatricians, we consider that it has direct relevance for other agencies. It is clear that the best outcomes for children are achieved by working together collaboratively with other agencies, as per statutory guidance. This involves joint multiagency training, agreeing referral pathways and responses to these situations, as FII can be both medically very complex and highly contentious. Paediatricians who fulfil the Designated Doctor role are ideally placed to inform and influence local safeguarding partnerships' understanding and arrangements in this challenging field.

12. Appendices

12.1 Appendix A

Health and Education Rehabilitation Plan Template

Child's name: Name of responsible clinician:

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

