



Fabricated and Induced Illness - Regional Multi-Agency Practice Guidance

**THE MID AND WEST WALES
SAFEGUARDING BOARD**

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Fabricated and/or Induced Illness

1. Introduction

This new guidance provides procedures for safeguarding children who present with Perplexing Presentations (PP) and Fabricated and Induced Illness (FII) and offers practical advice for all multi-agency frontline practitioners on when and how to recognise it, how to assess risk and how to manage these types of presentations 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 harm) and intervention without the need for proof of deliberate deception. While earlier presentations and those involving erroneous reporting form the majority of cases, most case studies 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.

In line with recent literature and updated guidelines from the RCPCH^(iv), 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 harm) is better termed Perplexing Presentations, requiring an active approach by all professionals 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 simultaneously. The advice of colleagues is always helpful and tertiary specialist opinion may be very helpful if these specialists are provided with the full 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.

2. Perplexing Presentations

The term Perplexing Presentations (PP) has been introduced to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm). At this stage the child's actual state of 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 or inconsistencies between reports from parents/carers and that observed by independent sources.** At this stage of the deliberations we need to avoid FII terminology.

3. Alerting Signs with no immediate serious risk to the child's health / life

Perplexing Presentations indicate possible harm to the child which can only be resolved by establishing the actual state of health of the child. This therefore requires 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 initial response needs to establish the current state of health and functioning of the child and assess any unexplained symptoms and signs.** The term Perplexing Presentation and subsequent responses should be explained to the parents and the child, if the child is at an appropriate stage of development to understand this. Reflecting with parents about the differing perceptions that they and the professional team have got may be helpful in some cases particularly in the early stages.

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 e.g. poor school attendance and they should be encouraged to seek medical help and/or assessment (either via their 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, schools will then need to decide what action they should take in accordance with the Wales Safeguarding Procedures^(v). There might be a role for the Education Welfare Officer (EWO) at this stage/and or advice may need to be sought from the Local Authorities Education Safeguarding Lead to decide if further support needs to be requested or put in place.

Some children identified to have PP may already be in receipt of services from social care due to other identified needs which could be early help services or more formal care and support plans or child protection plans. In these circumstances the allocated key worker would be expected take the lead in co-ordinating any further required health assessment and supporting and working

alongside Health professionals in the pursuit of establishing the state of the child's health.

It must be emphasised that professionals should refrain from using FII terminology, as the state of the child's health has not yet been fully assessed.

If primary healthcare is the only contact for the child, a GP may discuss with the practice GP Safeguarding Lead initially and refer for a paediatric assessment for further clarification of the child's health if needed. Consultation with the Health Board Named Doctor for Safeguarding Children can be requested.

At any stage during this process, should new information come to light to suggest that the child is currently suffering from significant harm, a 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 and an assessment of any risks to the child.

4. Response to Perplexing Presentations (PP)

This is a complex and time-consuming process, led by the responsible paediatric or CAMHS consultant. This is done with advice from the Named Doctor and the health safeguarding team (who do not have clinical responsibility for the child). All professionals should be supported and have protected time to dedicate the necessary focus. Responding to PP requires a multidisciplinary approach. It is, however, imperative that the responsible consultant continues to have overall clinical responsibility for the child. The background safeguarding processes are supported by children's social care, the Named Doctor and the health safeguarding team.

If the Responsible Paediatric or CAMHS Consultant (who may change during the process) is also the Named Doctor, then consideration will need to be given to another paediatrician in the Health Board taking over the role. This means that safeguarding decisions can be made objectively, free from duress, threats and complaints and the responsible paediatric consultant has appropriate support with these challenging cases.

It is important to establish as quickly as possible, the child's actual current state of physical and psychological health and functioning within the family context. The responsible paediatric consultant will need to explain to the parents and the child (if age/developmentally appropriate) the current uncertainty regarding their 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 consent or agree for this to

happen, the parents' concerns about this process should be explored and can often be dispelled.

However, under the General Data Protection Regulations (GDPR) for the UK (Data Protection Act 2018) information sharing can take place without consent if there are safeguarding concerns. This should be done in the best interests of the child, where necessary, proportionate and in a manner according with GDPR. [The Mid and West Wales Regional Safeguarding Board Information Sharing Protocol for the Safeguarding of Children, Young People and Adults-at-risk](#) may also be referred to.

Strong parental objections could indicate a referral to children's social care on the grounds of medical neglect - where 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 may need to be obtained and a tertiary specialist may be necessary. Parents themselves may request another opinion and it is their right to do so. Often the GP is the key healthcare professional involved in such referrals and needs to be kept fully informed. However, this opinion giver should be supplied with all the background information (including private healthcare providers) 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 should there be a Subject Access Request for the health records.

Please note that practitioners also need safe spaces to test out and discuss hypotheses which may not be clearly in evidence.

5. Fabricated and / or Induced Illness (FII)

FII happens when a parent or carer exaggerates or deliberately causes symptoms of illness in a child. It 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 or non-accidental injury (NAI). In practice, illness induction is a form of physical abuse. In order for this physical abuse to be considered under FII, evidence will be required that the parent's motivation for harming the child is to convince doctors about the purported illness in the child and whether or not there are recurrent presentations to health and other professionals. This particularly applies in cases of suffocation or poisoning.

6. Alerting signs to possible Fabricated or Induced Illness (FII)

Alerting signs are not evidence of FII. However, they are indicators of possible FII (not amounting to likely or actual significant harm) and, if associated with possible harm to the child, they amount to general safeguarding concerns. Some alerting signs are initially recognised by primary care/community health 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 are;

- the presence of discrepancies or inconsistencies between reports or presentations of the child and independent observations of the child
- implausible descriptions.
- unexplained findings.
- parental behaviours that cause concern.

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. The multiagency team must look at the overall picture which includes the number and severity of alerting signs.

7. 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 concerns that an open discussion with the parent might lead them to escalate harm to 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 meeting/ discussion (chaired by a senior manager) that includes health representatives as per the Wales Safeguarding Procedures, 2019). The safety of siblings as well as other children that the parents may come into contact with (such as professionally) also needs to be considered.
- Consideration for securing any potential evidence in conjunction with the police (e.g. feed bottles or IV 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 (e.g. this unusual constellation of symptoms, reported but not independently observed, is worrying to the extent that there is potential for serious harm to the child). This is important in case the child seen by other clinicians who are not aware of the concerns. It needs to be borne in mind that not all clinicians will have access to the same set of records.
- Considering whether the child needs immediate protection and measures taken in order to reduce immediate risk.
- In very rare cases, covert video surveillance may be used as part of multi-agency decision making, which is led by the police.

All practitioners must be mindful of situations where informing the parents of the referral to Children's services, would place a child at increased risk of harm. 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.

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 must be contacted at the same time as the police.

Once the child's safety has been ensured and child protection plans are in place, the steps to ensure multi-agency working would need to continue in the child's best interests.

8. Doctors Involvement

Most of what doctors do in the management of children, including where the presentation is not properly understood, is regarded as good medical practice. It consists of taking a history, examining the child, ordering investigations to ascertain the correct diagnosis, initiating or agreeing to further referrals, medications and other treatments. Supporting and/or not disputing the need for:

- Limited school attendance.
- Use of aids e.g. wheelchairs.

- Financial and other support for care of the sick child.
- Accepting the parent as the conduit of information between professionals.

However, in children with unrecognised FII, some of these actions may contribute to harm caused inadvertently by the doctor (iatrogenic). In addition, the practice of repeating previous, no longer relevant, or not independently substantiated problems/diagnosis 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 in partnership with parents, which is fundamental to most elements of paediatric practice, and not to miss any cause of illness that are amenable to treatment. 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. Therefore, all doctors need to be thorough in appraising parental requests for further opinions and repeat investigations as well as failures to bring children to appointments (please refer to the "Was not Brought" policy in your Heath Board).

A document that encompasses the medical history and concerns for the multi-agency team may be helpful in certain cases (please see Appendix D).

9. **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 has been observed and by whom. (This is not usually a request for a full chronology, which would need to include all past details of health involvement, and which is not 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 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, attainment, emotional and behavioural state, peer relationships, mobility and use of any aids. It is appropriate to explain the need for this to the parents. This would include any wider identified social needs and services including any early help services or services provided via a care and support plan.
- 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. In such circumstances the Local Authorities Education Safeguarding lead can be approached to help and assist with the gathering of any relevant information required.

10. 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 psychological review is to gain clarity about any verified illnesses and any remaining PP. 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.

If possible, 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 multiagency professionals meeting may be helpful to reach consensus. This professionals meeting should be chaired by Social Services to ensure a level of objectivity. Parents should be informed about the meeting and receive the conclusions with an opportunity to discuss them and contribute to the proposed future plans if appropriate, as long as doing so would not place the child at additional risk.

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 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.

A consensus needs to be reached in a meeting between all professionals (this could be only health or include education and social care) 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).
- That there are 'Medically Unexplained Symptoms' in the child who is free from parental suggestion and there are perplexing elements **but the child will not come to harm as a result.**

Or -

- That any verified diagnoses do not explain all alerting signs.
- That there is 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, such as by using existing process's that may be in place via the provision of early help services and/or a Care and Support Plan or via a Health and Education Rehabilitation Support Plan.
- If the child does not have a Paediatric Consultant involved in their care, consideration needs to be given to involving local paediatric services.
- The health needs of siblings.
- Consider and plan next steps in the eventuality that parents disengage or request a change of paediatrician.
- Re-evaluate initiating safeguarding procedures if there is evidence of actual or likely harm.

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 Support Plan, an 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 in a timely manner. If formal wider care and support needs in addition to health have already been identified and services are already in place, health

and rehabilitation needs as outlined above can and should be managed as part of this statutory process.

However, in the absence of any formal care and support services, 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. Discussion can take place with local authority children's social care prior to referral. From a health point of view, the Health and Education Rehabilitation Support Plan will need to continue wherever possible regardless of referral to social care.

Health professionals 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.**

In some cases, there may be significant disagreements between health professionals about important aspects of the diagnosis and medical management of the child. These will need to be resolved and 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). The Designated or Named Doctor can only perform this role if they have never been involved with the case. Health Boards need to work together in order to enable cross-border working by named safeguarding professionals, for example, to chair meetings. There must be escalation to the Medical Director where there are significant concerns about how a case is being managed within any health care organisation. Clear record keeping of meetings, discussions and decisions is vital.

11. Referral to Children's Services

In the event professionals form a judgement:

- That there is actual or likely harm to the child and/or siblings and FII is likely, a formal referral to social services should be made, however 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 experiencing or is at risk of abuse, neglect or other kinds of harm.

and

- has needs for care and support (whether or not the authority is meeting any of those needs).

If there is actual or likely harm to the child or siblings, the implication, in this instance, is that the child has been subject to FII. Unlike most referrals to Children's services, in these cases parents/carers are **NOT** usually informed of the safeguarding concerns and referrals. This is due to the potential for escalation in risk to the child by increased levels of fabrication or illness induction by a parent/carer.

Following a referral to children's social care, if the initial checks, following a report, conclude that social services have reasonable cause to suspect that a child is at risk of significant harm as described in (The Children Act 1989,) they should convene a multi-agency strategy discussion/meeting to determine whether section 47 enquiries should be initiated, and how these enquiries should be undertaken. In such circumstances, a relevant health professional from the safeguarding team should be invited to take part in the strategy discussion/meeting.

The purpose of the strategy discussion/meeting is to:

- share and discuss, in detail, all information gathered to date, as well as the nature of the suspicion.
- decide whether to initiate section 47 enquiries, or continue with them if they have already begun, to determine whether the child is suffering or at risk of suffering significant harm.
- establish what, if any, immediate action is required to safeguard the child if they are at imminent risk of significant harm and/or what interim services and support should be provided.
- consider the needs and safety of other children who may be affected, including siblings, adults at risk and other children in contact with the alleged abuser and whether to extend any enquiry to include any of these children and agree on any necessary action to keep them safe from harm.
- determine if any immediate legal action is required.
- draw on the information to determine if a care and support plan can be put into place.

Additional considerations when FII is a concern:

- Consider each child separately and any impact on the child's daily life.
- Share information and plan to produce a detailed multi-agency chronology of all of the issues, with clear recognition of confirmed signs and symptoms. Health has a particular responsibility to explain the significance of the medical information. In addition to a multi-agency chronology a timeline of the information available may be of assistance.

- Confirm the key health professionals and key professionals from all agencies.
- Representation of all agencies by senior staff throughout is essential.
- Clarify and possibly limit the number of health professionals seeing the child for example where possible ensure that the same GP responds to requests for consultation.
- Consider the need to access family health records. This should be facilitated via their GP, Named and/or Doctor and Nurse.
- Focus on harm and impact rather than trying to work out parental traits or motivations at this stage (or parents own medical needs).
- Consider the level of harm the child(ren) may have / has already suffered.
- Consider the risk of future harm and any complicating factors.
- Establish the current state of health and functioning (if not yet established, what needs to happen).
- Any medical procedures booked which need to be postponed urgently?
- How many departments is the child currently open to?
- What medication is currently being taken by the child?
- Consider independent observations? E.g.: school / health / SW / family members.
- What do the parents know about the current concerns?
- Does the parent acknowledge / accept the concerns and what are their responses?
- Is a Health and Education Rehabilitation Support Plan in place? Explore content and progress made.
- Who is the responsible consultant?
- What are the current safety arrangements already in place?
- Consideration of the child's safety network and how it may be used to provide immediate safety.
- Update from partner agencies.
- If parents are not aware, who will share the concerns and when? 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.

Timescales

- The strategy discussion initiating section 47 enquiries and should be held within one working day of the decision to hold a discussion. For out of hours service/EDT these strategy discussions should be held immediately.
- Section 47 enquiries need to be conducted within 10 working days of the strategy discussion/meeting, where the decision was made to initiate them.
- If the outcome of the section 47 enquiries and/or any subsequent strategy meeting/ discussion conclude that the case should proceed to initial child

protection conference the conference should be held within 15 working days of the strategy meeting that agreed to proceed to section 47.

- At any stage of the process sufficient information may be gathered that indicates the child is not suffering or at risk of suffering significant harm. If this is the case, the outcome should be recorded, and the family informed.
- There may be exceptional circumstances when it is not in the child's interests to work to the above timescales. For example, complex cases such as fabricated and induced illness; suspected organised abuse. Any decision to work outside of the timescales should be made by the senior manager with responsibility for safeguarding and recorded.

Multi-agency participation in strategy discussions/ meetings

At a minimum, appropriate senior practitioners, with responsibility for child protection in police and social services, should be involved. Other practitioners should contribute as required:

- community-based health practitioners can provide advice and guidance about any medical assessments that may be required and can co-ordinate the gathering of relevant information about the health of the child/ren and their family.
- the social worker in consultation with their line manager, should consider inviting a professional who has expertise in the field of fabricated or induced illness and a medical professional such as a paediatrician with knowledge of the particular symptoms and illness processes caused by the suspected abuse for example, gastroenterology, neurology, respiratory illness and other specialist areas. The medical professionals can provide essential specialist assistance to the conference participants in making sense of all the information presented.
- where a medical examination may be required a consultant paediatrician from the providing service should be involved
- the practitioner making the report should also participate.
- practitioners from education should contribute if they have worked, or are working, with the child.

The engagement of other practitioners will depend on the individual nature of the case.

The practitioners participating in the strategy discussion should:

- share all relevant and available information.
- agree on any subsequent assessment process.
- establish the way information about the strategy discussion is to be shared with the family and by whom. Practitioners should keep families fully informed unless such information sharing may place the child at risk of

significant harm and/or jeopardise police investigations into any alleged offence(s).

- identify the needs of other children and adults at risk who may be affected, such as siblings or those children in contact with alleged abusers.

The staff involved in the discussion must be authorised to make decisions on behalf of their agency.

Chairing

The strategy discussion/meeting should be chaired by a senior social services practitioner who has the authority and expertise to chair these meetings, this will generally be determined by local arrangements.

The chair should:

- ensure child-focused discussions that centre on the child's well-being and safety and actual and potential risk of significant harm.
- establish actions to be taken: who, why and when.
- determine what information is shared with the child and family (if the police are involved in consultation with them).
- record agreed actions and ensure actions are carried out. If changes to these records are required the chair must agree these.

Recording the strategy discussion/ meeting and decisions

A record must be taken of the strategy discussion/meeting and saved within the case record of each child. This recording as a minimum should include:

- a list of attendees and apologies received.
- a record of the discussion and decisions taken.
- a list of action points and their purpose.
- agreed timescales for actions including assessments.
- the persons responsible for carrying out identified actions.
- the agreed mechanism and timescale for sharing the outcome of any designated actions and determining next steps.
- agreed mechanisms to escalate concerns and timescales for the completion of agreed actions.
- whether a child protection medical examination is required.

Any information shared, all decisions reached, and the basis for those decisions, must be clearly recorded and circulated within 1 working day to all parties relevant to the discussion. It is important that practitioners' assigned tasks at the discussion/meeting are clear about those tasks and can initiate ascribed actions without waiting to receive the record.

Further/ additional strategy meetings/ discussions

More than one strategy meeting/discussion may be appropriate, depending on the circumstances of the case. Therefore, it is important children's social care, and if a joint enquiry, the police, decide whether to reconvene a strategy meeting/discussion to:

- check on progress.
- consider factors that may be impeding progress.
- gather more information.
- assess new information.
- make decisions.

Practitioner disagreements

If a practitioner disagrees with the strategy discussion/meeting decision, he/she should make representation to their own line manager. Consider the use of the [Regional Safeguarding Board Resolution Protocol](#).

The medical examination

Consideration should always be given to the need for a medical examination of each child, about whom there are concerns.

- the social worker co-ordinating the enquiry should discuss the need for a medical examination with a suitably qualified and experienced paediatrician or forensic medical examiner/physician and agree the timing and location of the examination taking account of the best interests of the child.
- there should also be consideration of the need for other children in the household or in contact with the alleged perpetrator to be medically examined.
- although a medical examination is not a requirement in every section 47 enquiry, it needs to be considered regardless of whether the child has any apparent or visible injuries or appears neglected. The medical examination should be dispensed with only if those managing the enquiry are satisfied that they can achieve the purposes of the enquiry without it. This must involve discussion with the appropriate paediatrician. Those reasons will need to be clearly recorded by all professionals involved.

Drawing on section 47 analysis & making decisions: 'determinations'

Children's social care are responsible for making a decision about action to take and how to proceed, following section 47 enquiries.

- This is after discussion between those who have conducted or been significantly involved in the enquiries from different agencies.
- The format for these discussions between practitioners should be agreed at the initial strategy meeting and reviewed as the enquiry progresses.
- In complex circumstances a meeting is likely to be the most effective way of discussing the child's well-being and planning future action. A record of the discussion should be in accordance with a format agreed amongst partners.
- If the concerns are substantiated and the child is judged to be at continued risk of significant harm a child protection conference should be convened by social services within 15 working days of the strategy meeting that determined Section 47 Enquiries were required.

The outcomes to be considered are:

Determination 1: Concerns of Significant harm are not substantiated

- Safeguarding concerns are unsubstantiated, but the child may have unmet care and support needs. Therefore, recommend a care and support needs assessment under section 20 of the Social Services and Well-being Act (Wales) 2014. (Referred to as Determinants 1 and 2 in Handling Individual Cases vol 5)).

Determination 2: Concerns of Significant harm are substantiated, but the Child is not at Continuing Risk of Significant harm

- Child's future safety and wellbeing needs can be developed without having a Child Protection Conference. Part 3 (Wellbeing Assessment) should be completed, with parental consent and consideration of any care and support needs.

Determination 3: Concerns substantiated, and the Child is judged to be experiencing or At Risk of Abuse, Harm or Neglect

- Continuing risk of significant harm. Social services should convene a child protection conference.

Timing of the initial child protection conference

The initial child protection conference should take place within 15 working days of the last strategy discussion/meeting that agreed the Section 47.

The chair of the conference should be satisfied, however, that sufficient information is likely to be available, in order for the conference to make an informed judgement about continuing risk of harm to the child. In exceptional circumstances the chair may wish to postpone the conference, but in doing so

must be satisfied that the child is protected, and the conference is rearranged as soon as is possible.

The social worker report for conference

The social worker's report and the chronology **will not routinely be shared** with parents before the conference following allegations of fabricated or induced illness. The social worker and other professionals should discuss this course of action at the child protection strategy meeting and with the independent child protection conference chair before the conference.

Outcomes and Actions Following A Child Protection Conference

In the event a Child Protection Conference concludes a child is experiencing/or is at continuing risk significant harm or has needs for a care and support plan, any risks and needs identified and associated with perplexing presentations and FII can be managed as part of this statutory process and the requirements of any health and rehabilitation plan as Appendix C will be considered and reviewed alongside the statutory responsibilities akin to the Wales Safeguarding Procedures and the Social Services and Well-being (Wales) Act 2014.

In the event a child is not judged to be at risk of Significant harm and is not eligible for a care and support plan, any existing needs associated with unresolved perplexing presentations can be managed where agreed via the use of Health and Education Rehabilitation Plan as outlined below. This can be managed outside of formal statutory process's if appropriate however will usually need a multi-disciplinary approach and a consensus will need to be reached between practitioners and professional as who will lead and co-ordinate this.

Further guidance

For further information about the process from this point onwards staff should refer to the Wales Safeguarding Procedures and their local authority local processes as well as the [BASW Fabricated or Induced Illness and Perplexing Presentations Abbreviated Practice Guide for Social Work](#) Practitioners.

Following either decision in the Child Protection Conference, the child will be supported following the relevant policies and procedures as specified in the Wales Safeguarding Procedures and the Social Services and Wellbeing (Wales) Act 2014.

12. Communication with parents and child

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 and Education Rehabilitation support Plan with the parents and child and implementation of this plan. However, the question arises as to whether in addition to this, there needs to be a referral to children's social care if not already done.

Once a 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 (or problems, issues, concerns) rather than use the term 'diagnoses'.

The current consensus opinion is offered to the parents with the understanding that it 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 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 progressing.

13. Developing and Reviewing the Health and Education Rehabilitation Plan (HERP)

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

Development of the HERP requires a coordinated multidisciplinary approach and negotiation with parents and children and usually will involve their attendance as appropriate at the relevant meetings. There may well be several 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 the child's 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 Health Board employing the professional with this responsibility provides 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 or/and 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 (e.g.: analgesics, continuous antibiotics).
- Resuming oral feeding.
- Offering graded physical mobilisation.

There must be a discussion with the patient's registered GP regarding what role they may 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.

The HERP 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 reviews 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 and consultant child and adolescent psychiatrist.

If the child and their family is in receipt of early help of preventative services such as Flying Start or Team Around the Family/ Family Support Network (FSN), or equivalent for example, it may be appropriate for another agency or practitioner to take the lead in coordination in conjunction with health and education teams, as the aims of the Health and Education Rehabilitation

Support Plan would form part of that plan. Practitioners need to be alert to the possibility of disguised compliance which is best addressed by verification from multiple professionals involved in the child's care and education.

An important aspect of the fulfilment of the Health and Education Rehabilitation Support 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 communicated this to the child.

14. Long term follow up

All children who have required a Health and Education Rehabilitation Support Plan (HERP), 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. Education and primary health are the appropriate professionals to monitor the children's progress and to identify re-emerging or new concerns.

When the HERP is not progressing as expected: a referral to children's social care must be made which can include a re-referral if services have previously been provided and stepped down for example from a child protection plan or Care and Support Plan.

If the parents disagree with the consensus feedback and an effective Health and Education Rehabilitation Support Plan cannot be negotiated, or it becomes apparent that there is lack of engagement with the plan which had been agreed, 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 if the rehabilitation process fails to proceed (e.g. if the plan requires school attendance and they are no longer doing so).

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

In order to help to ensure that the referral is acted upon appropriately it should describe the concerns, define the harm / impact on the child and provide

evidence of inability of the health professionals to manage the situation on a voluntary basis. The referral should include the following:

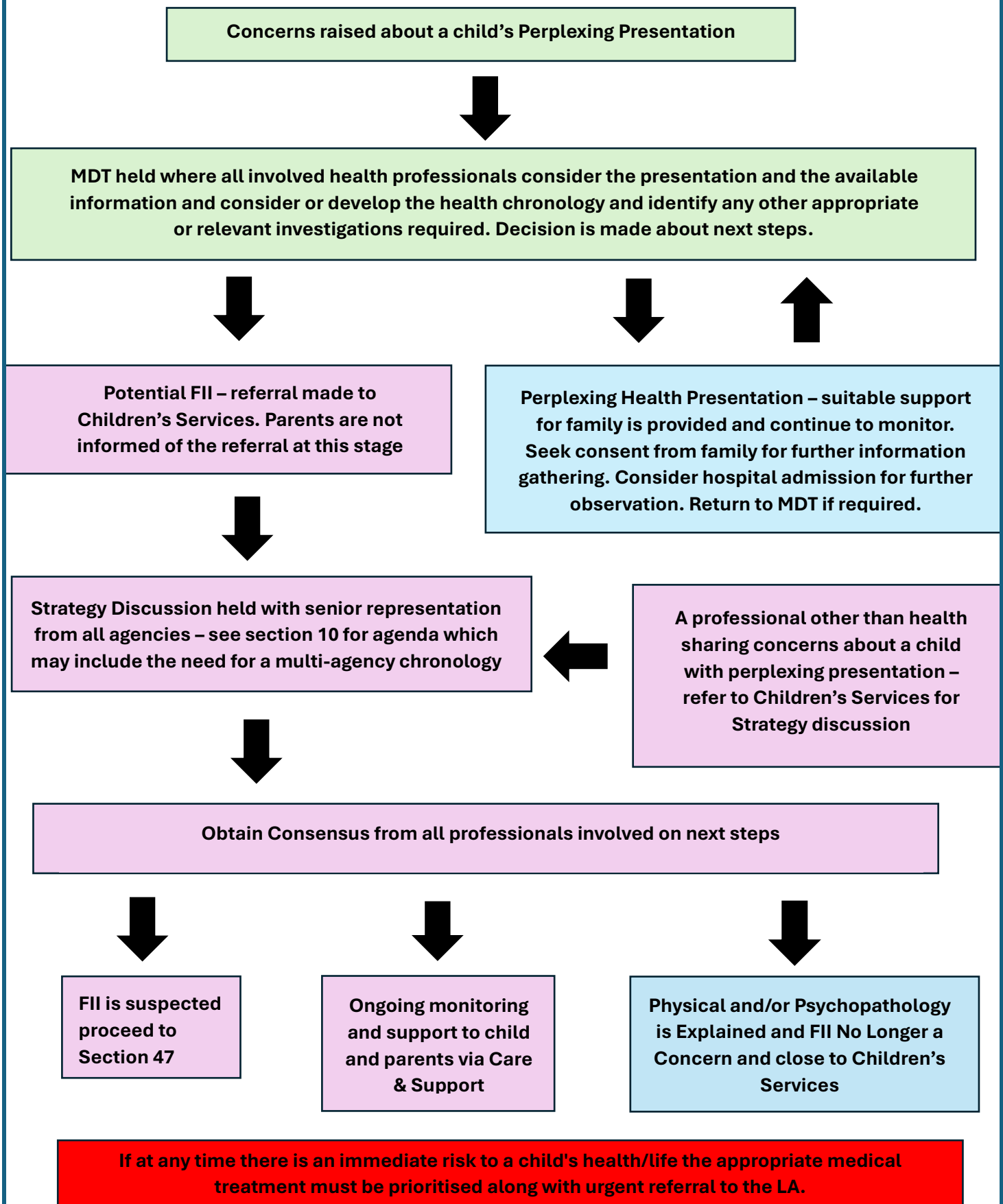
- A clear explanation of any verified diagnoses with a clear description of the functional implications of the diagnosis for the child.
- Details of the nature of the concerns.
- Description of independent observations of the child's actual functioning, medical investigations, detailing all medical services 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 (e.g. the Health and Education Rehabilitation Support Plan).
- Description of 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 by social care at the point of referral. There will be multiple professionals who need to prepare chronologies and this process is best delegated as early in the process as possible to avoid delay. However, preparing a full chronology 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.

15. References

- (i) Data Protection Act (2018) General Data Protection Regulation ((EU) 2016/679) (EU GDPR) <https://www.gov.uk/data-protection>
- (ii) Mid and West Wales Regional Safeguarding Board Information Sharing Protocol for the Safeguarding of Children, Young People and Adults-at-risk within the Mid and West Wales region <https://cysur.wales/media/e43jueu5/safeguarding-isp-assured-sept-2021.pdf>
- (iii) Mid and West Wales Regional Safeguarding Board Multi-agency Protocol for the Resolution of Professional Differences <https://cysur.wales/media/bjpprbqn/resolution-of-professional-differences-protocol-approved-20230124.pdf>
- (iv) Royal College of paediatric and Child Health Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children – guidance (2021) <https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/>
- (v) Wales Safeguarding Procedures <https://safeguarding.wales/en/>

Appendix A: Flowchart for the identification of FII



Appendix B- Examples of Types of Abuse in FI

This list is not exclusive however includes examples of cases and evidence where FI has occurred:

- exaggerating, distorting or lying about their child's symptoms, medical history, tests or diagnoses
- falsifying documents
- deliberately contaminating or manipulating clinical tests to fake evidence of illness, for example, by adding blood or sugar to urine samples
- poisoning their child with unsuitable and non-prescribed medicine
- infecting their child's wounds or injecting the child with dirt or faeces
- inducing unconsciousness by suffocating their child
- not treating or mistreating genuine conditions so they get worse
- withholding food, resulting in the child failing to develop physically and mentally at the expected rate

Case Examples

An example of Perplexing Presentation (PP) with alerting signs of a possible Fabricated and Induced Illness (FI)

For example, 11-year-old boy referred to LA by school due to 23% school attendance. Family reports him as frequently ill with chest and other infections, severe hypermobility, painful weak legs therefore unable to play, dyslexia, autism and ADHD. Care and Support plan initiated by LA. Strategy meeting to share information with health, police, school and social services confirms discrepancies between parental reports and professionals' observations. There is no immediate risk to child and more information needs to be gathered from health. Meanwhile Care and Support package was continued with plan to transfer to the 'long term team' at social services. Reconvene Strategy meeting in few weeks.

An example of Fabricated and Induced illness

For example, 8-year-old boy has been brought to A&E by mother on 3 occasions over a 3-week period with severe tummy pain. Examination shows no abnormalities on the initial 2 occasions; doctors try to reassure mother after giving explanations. On the 3rd occasion his pain seems very severe and is on the right-hand side of the tummy. His urine sample is bright red and tests positive for blood. He gets lots of tests and follow up with consultants who are puzzled by the lack of an underlying cause for the symptoms and findings. 3 months later the boy tells his father, who is separated from mother, that mum had asked him to scream when tummy was examined and point to the right-hand side as location of the pain. Mum had used a razor blade from her handbag to cut her own tongue and drop some blood into the urine sample prior to handing to the nurse for testing. Father alerted LA and Child Protection action was taken all the way to Case Conference.

Appendix C

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:

Appendix D

MEDICAL OVERVIEW

May be appropriate in certain cases of Perplexing Presentations (PP) / Fabricated or Induced Illness (FII)

or if Health and Education Rehabilitation Support Plan (HERP) IS not progressing
(NOT a replacement for Multiagency or health Chronology)

Summary of case history

Presentations to different specialists / other medical history in date order if appropriate

Summarise:

E.g.: numbers of presentations,

Clarification if different presentations in different settings,

Summarise investigations & results

Questions for consideration:

1. What medical diagnoses have been confirmed in the CYP?
Or list any symptoms/problems and say if no medical diagnosis at this stage.
2. What medical management is recommended for this problem?
3. Have there been occasions when medical interventions or tests have been unnecessary?
4. Is it my opinion that the case presentation represents fabricated or induced illness?
5. Does this represent a perplexing presentation?
 - 1) Results of physical examination and investigations do not explain the symptoms reported.
 - 2) Response or intolerance to / lack of engagement with recommended medications / management strategies / multidisciplinary pain team.
 - 3) History of consistent / repeated failure of parents to be reassured by normal investigations / results with the seeking of multiple medical / surgical opinions.
 - 4) Limitations of daily life / school attendance seemingly out with that expected for the known disorder.

6. Are there child protection concerns or other safeguarding issues?

7. Further considerations examples:

The possibility that child or carers' presentations could be explained by anxiety, misunderstanding or unusual beliefs about illness.

Child/Young Person (CYP) may be adopting a sick role due to unusual parent-child dynamics.

The possibility that parental mental illness or disorder may be contributing to these persistent beliefs and behaviour. This would depend on the opinion of their GP and an adult psychiatrist if needed.

Age of YP and safeguarding - do the above concerns need to be considered with transition to adult services?

8. Recommendations examples:

Multiagency safeguarding investigation (including assessment of siblings) with further action to safeguard child from the ongoing risks listed in case.

Specify if manage under FII protocols.

Clarification and resolution of the ongoing cycle of medical investigations for CYP.

Support for family to engage with recommended medical services e.g.: specialist pain management.

CYP should be enabled to return to a normal lifestyle including education.