

Multi-agency management of MEDICALLY UNEXPLAINED SYMPTOMS, PERPLEXING PRESENTATIONS AND FABRICATED OR INDUCED ILLNESS (FII)

This Leicester, Leicestershire & Rutland (LLR) procedure is a summary of the **Royal College of Paediatrics and Child Health (RCPCH) guidance (RCPCH: 2021)**.

This procedure aims to provide clarity around the responsibility and accountability of professionals/practitioners (both medical and non-medical) when concerns regarding potential Fabricated or Induced Illness (FII) are identified. It provides a step-by-step guide to the management of Perplexing Presentations and FII and signposting for LLR practitioners.

This is outlined in the [flowchart](#) below. Practitioners are to use the [flowchart](#) to comply with the RCPCH guidance.

For the full RCPCH guidance, please refer to:

<https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/>

Essential principles

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.

This procedure has updated definitions of Medically Unexplained Symptoms (MUS), Perplexing Presentations (PP) and a wider view of Fabricated or Induced Illness (FII).

The essential principles are:

- 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.
- There should be a move away from the inability to appropriately challenge parents because of concern about FII except where challenging would put the child at immediate risk.
- Alerting signs for possible FII must be considered and investigated appropriately. The emphasis should be on the harms that are occurring to the child rather than the need to confirm evidence for FII, with the welfare of the child being at the centre of any discussion.
- If there is a criminal investigation, then the needs of the investigation should be incorporated into the multi-agency response. If necessary, this may require senior managers to agree strategies that can be managed alongside the safeguarding response.

- 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 the child rather than the perceived severity or type of parental motivations, actions and behaviours.
- There is a need for continuous professional curiosity across the multi-agency partnership.
- 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 (see [FLOWCHART](#) STAGE 5).
- The responsible consultant should seek advice and support from senior colleagues and tertiary specialists when appropriate.

Terminology

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 people. Experienced clinicians report that, on occasion, MUS may also include PP or FII.

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 harm), when the actual state of the child's physical, mental health and neurodevelopment

is not yet clear, but there is no perceived risk of immediate serious harm to the child’s physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.

Fabricated or Induced Illness (FII)

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

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

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
Perplexing Presentations (PP)	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.	
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 or neurodevelopment is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect including harm / illness caused by medical examination or treatment.	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

Table 2: Responding to alerting signs of FII

Response to alerting signs of FII

The [alerting signs of FII](#) are detailed below.

Alerting signs by themselves do not amount to fabrication but mandate further investigation to ascertain whether the child has an underlying illness. If one alerting sign is present, it is essential to look for others.

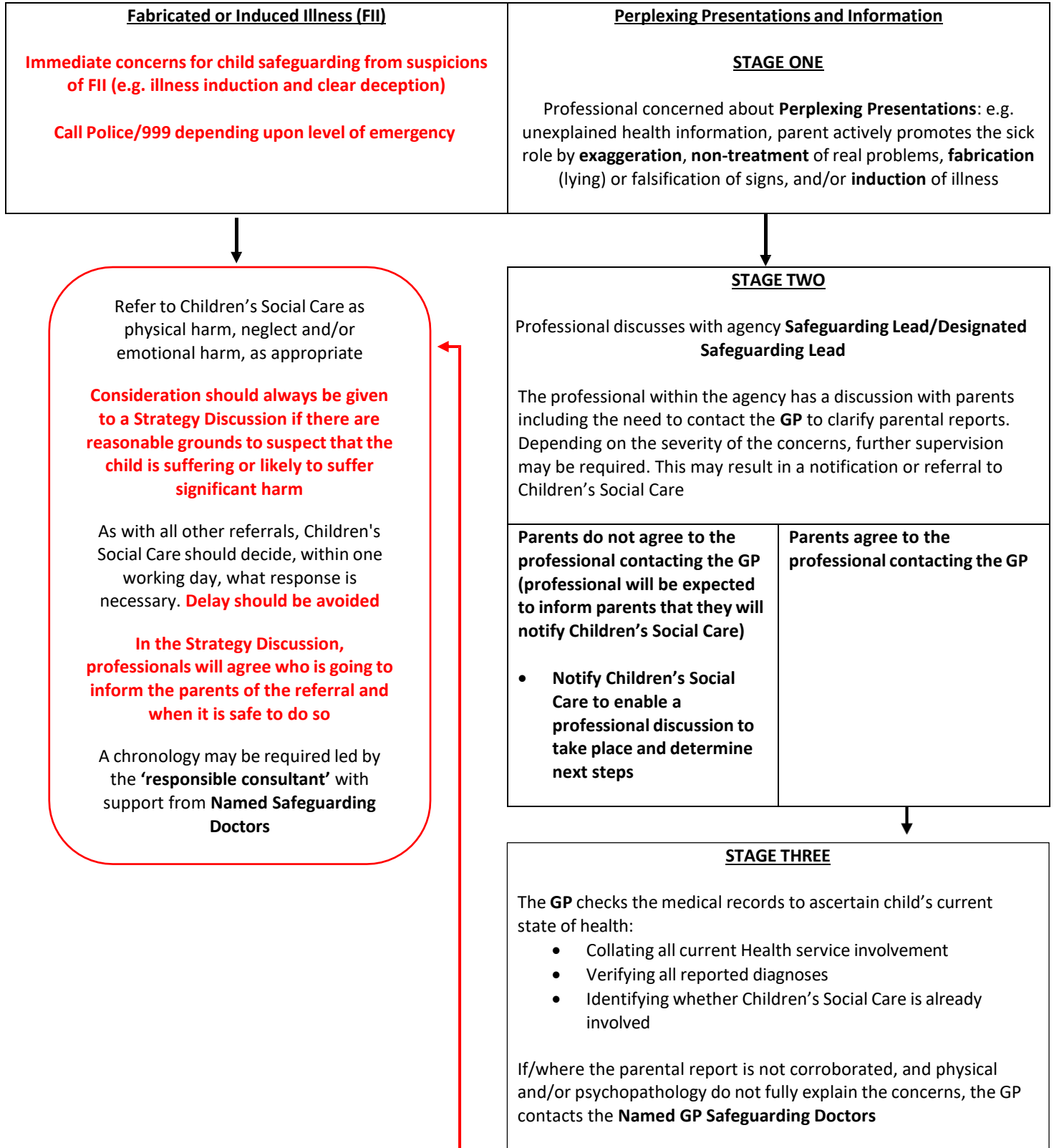
In response to alerting signs, one of two courses of action need to be followed depending on whether there is or is not an immediate serious risk to the child's health/life. These are outlined in the [flowchart](#) below.

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/CAMHS professional becomes involved as the resolution lies in ascertaining the actual state of the child's health.

Multi-agency management of

MEDICALLY UNEXPLAINED SYMPTOMS, PERPLEXING PRESENTATIONS AND FABRICATED OR INDUCED ILLNESS FLOWCHART

Unless there is 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.



STAGE FOUR

Named GP Safeguarding Doctors inform the **Safeguarding Doctor** in relevant Health agency to determine the lead **'responsible consultant'**. This is the consultant paediatrician who has the main responsibility for the child's care

If it is not possible to identify the lead Health Agency or there is no other Health Agency involved, the **Named GP Safeguarding Doctors** will discuss the case with the **Designated Doctor for Children's Safeguarding**. The **Designated Doctor** will then make the final decision on who the lead agency will be or next steps

If the child needs to be referred to a Health agency, the **GP** should follow normal referral processes and the **Named GP Safeguarding Doctors** will share the patient details with the **Health agency Named Doctor for Children's Safeguarding**

STAGE FIVE

The **'responsible consultant'** informs the parents and leads a Health Professionals Meeting, including a review of health records and confirmation of diagnosis.

The Health Professionals Meeting is to agree:

- The child's state of health
- Whether there are any Perplexing Presentations requiring a Health and Education Rehabilitation Plan
- Whether Perplexing Presentations and parental behaviour could be alerting signs to FII and therefore the requirement to refer to Children's Social Care

Health Professionals Meeting confirms	Health Professionals Meeting confirms	Health Professionals Meeting confirms	Health Professionals Meeting confirms
There are immediate concerns for child safeguarding from suspicions of FII (e.g. illness induction and clear deception)	Alerting signs to FII	Perplexing Presentations and commences Health and Education Rehabilitation Plan	No Perplexing Presentations
Call Police/999 depending	Refer to Children's Social Care and commence Health and Education Rehabilitation Plan		Medically Unexplained Symptoms, with parents and professionals working together
			No Further Safeguarding Action. The outcome

<p>upon level of emergency Refer to Children's Social Care as physical harm, neglect and/or emotional harm, as appropriate</p>			<p>reported back to agency that raised initial concerns</p>
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The 'responsible consultant' leads the **Health and Education Rehabilitation Plan Meeting** whether or not Children's Social Care are involved. The meeting includes the **Designated Safeguarding Lead from Education**



STAGE SIX

The Health and Education Rehabilitation Plan Meeting(s)

The parents are informed about and invited to the meetings

The meeting(s) will define:

- The child's current state of health
- Areas of continuing uncertainty
- The nature and level of harm to the child

The meeting(s) will agree (at any point):

- **Whether to refer to Children's Social Care**
- Whether to commence a chronology
- Date of next review meeting
- The requirement for Specialist Psychological Therapy for the parent and child

It should be noted that information given to professionals by parents and carers outside of the Health and Education Rehabilitation Plan needs to be clarified with other Health agencies

<p>Parents do not support the Health and Education Rehabilitation Plan</p> <p>Refer to Children's Social Care. This is on the basis that the child's functioning and/or development is being avoidably impaired by the parent's behaviour</p> <p>Parents to be informed of referral</p>	<p>Parents support and adhere to the Health and Education Rehabilitation Plan</p> <p>Long-term monitoring agreed</p> <p>If the parents fail to adhere to the plan, refer to Children's Social Care. This is on the basis that the child's functioning and/or development is being avoidably impaired by the parent's behaviour</p>
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	Parents to be informed of referral
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At any stage during this process, should new information come to light to suggest that the child is currently suffering from 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.

Parent / Caregiver motivation and behaviour

Both clinical experience and research indicate that the mother is nearly always involved or is the instigator of FII. 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 sidelined 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 (e.g. 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 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.

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 (e.g. 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.

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 e.g. 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 medically induced 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, medically induced 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 symptoms which must be avoided wherever possible.

Harm to the child

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 (e.g. 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 (e.g. 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.

Severity

Severity of FII can be considered in two ways:

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.

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.

Alerting signs to possible FII

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. 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 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.

In the child

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

- Unexplained impairment of child's daily life, including school attendance, aids, social isolation.

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 complaints about professionals
 - Sometimes, these can be used to mask safeguarding concerns
 - Sometimes, these can be used to change the professionals involved

(Consideration should be given to the accurate recording of each complaint, minor or major, if achievable, as this would be helpful in recognising the problem and supporting the diagnosis)

- 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.

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 prison.

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 multi-agency guidance. Good multi-agency representation in Strategy Discussions is essential so that a full picture of the child's life can be formulated. The safety of siblings also needs to be considered.
- Securing any potential evidence (e.g. 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 (e.g. '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 evidence gathering may be used as part of multi-agency decision-making and is led by the Police. This is an issue that needs to be discussed between multi-agency senior managers.
- All practitioners should be mindful of situations where to inform the parents of the referral would place a child at increased risk of harm. In this situation, carers would not be informed of the referral before a multi-agency 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 consider the use of 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 1989), either as a matter of urgency or in a planned manner, they must make a referral using appropriate local pathways.

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

Alerting signs with no immediate serious risk to the child's health / life – Perplexing Presentations (PP) (See [FLOWCHART STAGE ONE](#))

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 Paediatrician with advice from the Named GP Safeguarding Doctors.

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.

Concerns raised at school/Education setting

If the initial concerns arise directly from school as opposed to health, it is recommended that school explains to the parents that information is required from health to understand the concerns e.g. poor school attendance (see [FLOWCHART STAGE TWO](#)). It is then appropriate for either the parents or education to contact the Child's GP 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.**

GP Check of Medical Records (see [FLOWCHART STAGE THREE](#))

If the parental reports are not corroborated by information in the child's health record, the GP contacts the Named GP Safeguarding Doctors **who will mobilise the health agency Safeguarding Doctors to** to determine the lead '**responsible consultant**'. This is the consultant paediatrician who has the main responsibility for the child's care. This may be a paediatrician or CAMHS Consultant.

At any stage during this process, should new information come to light to suggest that the child is currently suffering from 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.

Response to Perplexing Presentations (PP)

This is a complex and time-consuming process, led by the Responsible Paediatric or CAMHS 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 multi-disciplinary 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 agency Safeguarding Doctor, and or the Named GP Safeguarding Doctors and the agency health safeguarding team.

If the Responsible Paediatric or CAMHS 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 professionals meetings. Wherever possible this should be done collaboratively with the parents. If they do not 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 regulations. 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.

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 (e.g. 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.

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 adolescents' 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.

You can download RCPCH 'Being Me' resources from here:

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

You can access 'Me first' resources here:

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

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

Reaching a consensus formulation about the child's current health, needs, and potential or actual harm to the child (see [FLOWCHART STAGE FIVE](#))

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 (see [FLOWCHART STAGE FIVE](#)). 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 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. Clear record keeping of meetings, discussions and decisions is vital and is further discussed.

Communication with 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.

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.

There should always be good communication between professionals. Parents and carers should not be relied on to pass on health information. There is a need for continuous professional curiosity across the multi-agency partnership.

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 and Education 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.'

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 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.

Working across more than one geographical area

Often these cases involve agencies in more than one geographical area. In such cases the relevant staff should ensure they work together to safeguard the child by effective sharing of information and co-ordinated working. The responsibilities of each agency should be agreed and clearly documented to avoid duplication and ensure continuity of care.

Medical device to assist feeding

When a medical device, including a device to aid feeding, is used for a child, where the reason for this is not clear, responsibility for a plan leading to cessation of use of that device should rest with a senior clinical practitioner. The plan should be regularly reviewed.

Health and Education Rehabilitation Plan (see [FLOWCHART STAGE SIX](#))

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 multi-disciplinary approach and negotiation with parents and children and usually will involve their attendance as appropriate at the relevant meetings. 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. If the child is Home Educated, an education officer from the Inclusion Service should be consulted and attend any meeting if required. The plan 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 (e.g. analgesics, continuous antibiotics)
- Resuming oral feeding
- Offering graded physical mobilisation.

Information given to professionals by parents outside of the Health and Education Rehabilitation Plan needs to be clarified with other health agencies.

There should be a discussion with the child's registered GP regarding what role they may be able to take in supporting the management and care of the child. GP practices in primary care are normally the repository of all health information, including medical opinions from the private sector. It is important to access this information when there are concerns about a child at an early stage.

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 below:

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

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.

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 conjunction with health and education teams. The aims of the Health and Education Rehabilitation Plan would form part of the Child in Need or Child Protection 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 communicated this to the child.

Where a child has an EHCP, a parent's attempt to have it changed based on information from private practitioners and resources should not take place without proper discussion in the Health and Education Rehabilitation Plan meeting.

If parents are complying with the plan it may be appropriate for the Lead Paediatrician to take the lead in these meetings.

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.

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 (e.g. 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 development.

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 (e.g. 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.

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.

The Leicester, Leicestershire & Rutland procedures for Resolving Practitioner Disagreements and Escalation of Concerns are [here](#).

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.

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.

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 Inquiry). 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 General Medical Council 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.

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.

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.

The time that a full chronology takes to prepare should be allowed for by agencies and practitioners should be granted sufficient time to undertake this task

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, do not 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.

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.

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.

It is recognised that dealing with a case of perplexing presentation is time consuming and agencies need to allow for this in their response to such cases.

Whilst the RCPCH guidance is written for paediatricians, this LLR procedure, based on the national guidance, 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 multi-agency training, agreeing referral pathways and responses to these situations, as FII can be both medically very complex and highly contentious.