

Fabricated or Induced Illness in England: Examining Mortality and Serious Harm

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Abstract:

The term Fabricated or Induced Illness (FII) has been used in England since 2002 to cover a situation in which a parent or carer exaggerates the child's symptoms, or deliberately causes illness in their child, to convince medical professionals that their child is ill. There is an absence of published evidence on its incidence, prevalence, and on the alerting signs used to identify it. This study examined mortality and morbidity in England due to FII by analysing serious case reviews (SCRs) published from 2010 to 2021. During this twelve-year period there were no reported deaths of children in England due to FII in the SCRs nor in a literature review. In the rare cases which found serious harm the study suggests that strengthening standard medical practices rather than searching for evidence of parental culpability might have provided better outcomes for the children. The paper calls for guidance on FII which suggests there are high rates of mortality and morbidity to be re-evaluated.

Keywords:

Child protection, Fabricated or Induced Illness, Morbidity, Mortality, Munchausen's syndrome by proxy, Safeguarding

Teaser Text:

Fabricated or Induced Illness (FII) is a term used in England since 2002 to describe situations where a parent or caregiver either exaggerates a child's symptoms or intentionally makes the child sick. They do this to convince doctors that the child is unwell. However, there's not much evidence available about how often this happens, how to identify it, or how to treat or prevent it.

This study looked at the rates of death and illness caused by FII in England by examining serious case reviews (SCRs) published from 2010 to 2021. SCRs are required in all cases where a child has died where abuse or neglect is known or suspected or where a child has been seriously harmed and there is concern about the way in which staff have worked together to safeguard the child. Over that twelve-year period, there were no reported cases of children dying from FII in England in SCRs. A review of literature also found no deaths in the UK in publications over the same period.

In the four cases where serious harm was found, the study suggests that following accepted medical practices might be a more effective way to prevent harm to children than focussing on the behaviour and truthfulness of parents. The paper recommends changing guidance on FII, which suggests high rates of death and illness.

Fabricated or Induced Illness in England: Examining Mortality and Serious Harm

Fabricated or induced illness (FII) is the term used in the United Kingdom for a form of child abuse in which a parent or carer exaggerates the child's symptoms, or deliberately causes illness in their child, to convince medical professionals that their child is ill. According to an explanatory article in the *British Journal of Nursing*: "Although FII is relatively uncommon, it is associated with high morbidity and mortality" (Ban & Shaw, 2019 p. 1289). The government's statutory guidance, in force in England between 2008 and 2022, suggested that FII involved high risk of mortality or serious harm to children, stating that up to 10% of children subjected to FII die, whilst about 50% suffer long-term morbidity (HM Government, 2008 p.10) the same figures are cited in the Welsh Assembly Government's 2008 guidance which remains in force. However, the research behind these figures has been challenged for overestimating deaths (Pankratz, 2010, Morgan, 1999).

This study aims to identify the incidence of deaths and serious harm due to FII in England. It analyses Serious Case Reviews (SCR) which are required in England in all cases where a child dies and there is concern about abuse or neglect or if a child is seriously harmed; abuse or neglect is suspected; and there is concern about how the authority, their Board partners or other relevant persons have worked together to safeguard the child. Serious harm includes, but is not limited to:

serious and/or long-term impairment of child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health (HM Government 2018, p. 83).

Serious case reviews (now called safeguarding practice reviews) are reports by an independent expert to identify improvements; learning from the case; and establish and explain the reasons why the events occurred as they did. Since 2010, the government requires

SCR's to be anonymised and published. This paper analyses SCRs published in England from 2010 to 2021 where FII was mentioned. This should cover all deaths and, due to the interagency partnerships required in response to FII, all children seriously harmed where FII was suspected. In addition, the study provides a literature review of papers published in this period that report deaths from FII in the UK.

Background

The term FII and its predecessor, "Munchausen's Syndrome by Proxy" (MSbP), have a controversial history and ongoing debate regarding their definition (eg. Gullon-Scott and Long, 2022). The term MSbP was coined by paediatrician Roy Meadow in 1977 to describe cases where mothers fabricated their child's illness to gain attention from medical staff. In 1995 Meadow (1995, p.534) himself raised concerns about the application of the term to many situations that "should not be classified as Munchausen syndrome by proxy." In 2002, following widespread criticisms of Meadow's work on MSbP in the media (eg Sweeney and Law, 2001) and in Parliament (Hansard, 2001), the Department of Health introduced new guidance, introducing the term FII as a form of child abuse.

The Royal College of Paediatrics and Child Health (RCPCH) played a significant role in defining FII and later in expanding the reach of the term. In 2002 (RCPCH, 2002) FII was introduced and broadened from MSbP to include various behaviours beyond deliberate fabrication or deception. In 2009, the RCPCH introduced nine key indicators to raise suspicion of FII. The focus on the harm to families caused by misdirected investigations was substantially reduced from the earlier guidance, and the definition of FII was further widened. In 2013, the concept of "perplexing presentations" (PP) was introduced for cases with alerting signs of FII but unclear medical explanations. The 2021 guidance expanded the number of alerting signs to 21. It removed warnings about misidentification and the harm that

misidentification can cause that had been part of the 2002 and 2009 versions of the guidance. These changes have sparked criticism for extending the number of children who are likely to come under scrutiny as PP cases and put through a traumatic and intrusive medical process, often unnecessarily (Clements & Aiello, 2023; Gullon-Scott et al 2020; and Long et al, 2022).

Evidence-base for FII

The RCPCHs 2021 guidance acknowledged an “absence of published evidence” on FII, saying that they had developed their recommendations based on “consultation and expert consensus” (2021 p.6). This consultation has been criticised for “an absence of organisations representing key safeguarding bodies including social work, education, and the police.” (Long et al, 2022 p. 4). The research prior to 2002 into MSbP is not only covering a more narrowly defined concept than FII but, with regard to mortality, is potentially tainted by the acceptance of the discredited (Hill, 2004) aphorism known as Meadow’s Law that:

One sudden infant death is a tragedy, two is suspicious and three is murder until proved otherwise (Meadow 2000, p.29).

A literature review of papers using the term Fabricated and/or Induced Illness and covering the period 2002 to February 2023 (Bilson et al, in press) identified fifty papers. Forty-four included no empirical evidence. Among the six empirical papers, there were three case studies and three case study series. This review confirmed Glaser & Bass’s (2019 p. 10) statement that there was no prospective research on RCPCH’s alerting signs providing evidence of their sensitivity or specificity. This is concerning as the misidentification of children as having alerting signs of FII under the label of perplexing presentations was found to be traumatising to children and parents in Clements and Aiello’s survey (2023). There have been concerns that the alerting signs are likely to identify as “possible FII” many more

children with rare and difficult to diagnose illnesses than children whose parents were fabricating their illness (Bilson, 2020; GullonScott & Long, 2022; Long et al, 2023).

The review also identified literature on iatrogenic harm caused by responses to FII. This included mothers wrongfully imprisoned and prosecuted for murder of their children. In one case, a child suffered serious harm because treatment for her brain tumour was significantly delayed by an FII allegation (Wrennal 2008). Gullon-Scott and Bass (2018) give three examples of parents with autism whose behaviour was misidentified as FII and their children were wrongly removed into care or proceedings were under way. A recent study by Clements and Aiello (2023) found almost 400 cases where FII had been alleged and most of these cases were discontinued (84%) and almost all the children remained with their parents (95%). Clements and Aiello's study described the trauma and severe outcomes of this experience which caused long-term harm to parents and children. Consequences included missing treatment for real but undiagnosed illnesses, breaking up families, undermining the confidence and sometimes the health of parents with these problems impacting directly on all children in the family. It also led to distrust of the medical and social work professions. One parent described the outcome of her child being wrongfully taken into care as follows:

I cleared my name and my child was eventually returned 2 years later on hospice care, I will spend the rest of my life carrying the weight of the knowledge that this accusation and the significant change to my child's medical care for that period of time has almost certainly significantly shortened their life. (Bilson et al, in press)

The likelihood of over-identification of FII cases and the long-term harm that this can cause to children and their families was highlighted in earlier RCPCH guidance (2002) but has become minimised in recent iterations of RCPCH guidance.

Mortality, serious harm, and FII

As mentioned above official guidance has stressed the high rate of mortality and morbidity. The study by McClure, Davis, Meadow, and Sibert (1996) is a key source of these claims. This was a prospective study conducted across the UK to determine the extent of MSbP, non-accidental poisoning and suffocation. Eight of the 128 children suffering from one or more of these three forms of abuse were reported to have died during the two-year period covered by the study. 92 of the children met the study's criteria to be considered MSbP. The RCPCH guide (2009, p.13) said only one of these deaths was due to MSbP. However, drawing from this study, a mortality rate of 6% is often wrongly linked to MSbP (e.g. HM Government 2008 p.10) and Glaser cites McClure et al as showing a rate of 15% "mostly refer[ing] to cases of illness induction" (Glaser, 2020, p.2) without explanation of how this figure was derived from a study which gives no breakdowns for deaths due to illness induction.

Other figures cited for mortality rates come from international analyses of case studies or case series, which often cover cases during the period before the term FII came into use (Yates and Bass, 2017; Sheridan, 2003; Rosenberg, 1987). For example, Yates and Bass (2017) reviewed literature published between 1965 and 2015 including all case reports and case series of medical child abuse, MSbP and FII. This identified the outcomes of 354 children, twenty-seven (7.6%) of whom died. The number of deaths in the UK within this finding of two deaths a year world-wide is not reported. This is cited in FII literature as a 7.6% mortality rate. However, this figure only applies to cases covered in the published case reviews and case series. It is highly unlikely that the seven cases a year reported in this review are a representative of cases of MSbP or the more widely defined FII. Publications are likely to represent the more serious or unusual situations, thus significantly over-stating child deaths amongst FII. However, these figures continue to be widely cited as relating to FII in

policy and guidance. For example, the Royal College of Psychiatry's guidance (2019 p.17) states:

This care-giver behaviour carries a high risk of harm to children. Illness induction is known to carry a 6–9% mortality rate ...with similar rates for longterm disability.

Mortality rates in these reviews are likely to be inflated by including cases diagnosed by Meadow. Meadow reported 81 child deaths over 18 years where he acted as advisor. In many of these cases children were originally thought to have died of natural causes, and following his involvement were judged to have been killed by parents mostly as cases of MSbP. More than half the families had more than one dead child. Here we see the impact of his views on multiple deaths and the misuse of statistics for which he was later criticised in appeal courts and by the Royal Society of Statistics, when he states they were found to have killed their child (1999; p. 11):

because the courts were impressed by evidence that it was highly improbable for two or more children to die in infancy of undiagnosable natural causes: "if there is a 1/1000 chance of a child dying suddenly and unexpectedly of natural causes in the first year of life, the chance of two children within a family so dying is 1/1000 000".

In a recent paper Abdurrachid, & Marques (2022) carried out an international literature review of papers on MSbP in PubMed published between 2004 and 2019. This identified six child deaths, none of which were from the UK.

A literature search using a several databases including Medline and PsycInfo was undertaken to identify child deaths in the UK associated with FII published during the period of the SCR study from 2010 to 2021 (details and findings are in the supplementary materials). The search used a range of synonyms for FII and deaths and identified 75 papers. A search of these

papers and their references found nine papers covering 13 child deaths internationally. None of these deaths were in the UK.

Methodology

The paper provides a study of serious case reviews published since 2010 when the government guidance made the publication of SCRs mandatory. It used the NSPCC's National Case Review Repository which contained 1,766 SCRs in the period 2010 to 2021. The Repository was searched in early 2022 using the keyword "Fabricated or Induced Illness" to identify relevant SCRs. Further full text searches were undertaken using the terms "fabricated or induced illness", "Munchausen syndrome by proxy", "Munchausen", "Paediatric Condition Falsification", "Factitious Disorder" and these added no further SCRs.

McClure et al (1996) claimed that a large proportion of children who are suffocated, asphyxiated or poisoned are FII cases. To ensure such cases were not missed, SCRs where there was mention of children having been suffocated, asphyxiated or poisoned were searched and checked to see if there were indications that illnesses had been fabricated. These searches identified no further SCRs.

The SCRs were examined to determine if FII was established as a cause of death or serious harm; the nature of the FII (ie was it illness induction or other forms of fabrication); and what evidence was there that the parent was fabricating the illness to convince medical practitioners that the child was ill.

Since this research analyses anonymised data already in the public domain ethical approval has not been sought.

Results

Ten serious case reviews and a practice review not meeting the criteria for an SCR were identified in which FII was mentioned. These are summarised below:

1. Child A (Published 2021)

This concerned a child who had suffered serious harm through over-medicalisation. A series of escalating medical interventions occurred from soon after the child's birth until the child was aged 11-years-old, when the SCR was instigated. The child was prescribed escalating amounts of fentanyl (an opioid) for over six years with inadequate professional oversight, alongside significant medical interventions for poor feeding, lack of weight gain, bowel problems and later urinary retention and pain. The SCR identified how, at each stage of this case, good professional practice and more holistic oversight should have ended the escalating harm caused by misdiagnosis and over-medicalisation.

Both parents and a range of professional staff contributed to this series of harms to the child. Practitioners did not listen to the voice of the child; accepted what mother said and responded without any objective assessment leading to inappropriate medical intervention; lack of professional challenge and curiosity culminated in the ongoing medicalisation and an insufficient response in meeting educational needs.

There was a child protection investigation which found that "FII was not substantiated" (p.19). The SCR identified several shortcomings in the investigation including that the child wasn't seen on their own and that key health professionals were not contacted. However, "the review identified that practitioners did not actually believe that FII was evident" (p.30) and according to this SCR, investigating FII:

potentially distracted professionals from trying to better understand the underlying issues and root cause of Child A's 'perplexing presentations'. It diverted them from looking more closely at the possibility that Child A may have been subject to medical harm as a consequence of invasive investigations and treatments. (p. 30)

The SCR also raised concern that this child was one of several children:

given an unsubstantiated diagnosis, experienced a lack of regular review and were receiving ongoing medical interventions and treatment.

The SCR called for processes to be put in place to identify when over-medicalisation / misdiagnoses of children are clustered within a single paediatric department. It found that the focus of FII on the actions of individual parents can draw attention away from such patterns of poor practice.

2. Charlie (Reported 2021)

The presenting issue was an overdose of medication by an adolescent girl in 2019. Charlie's mother was found unconscious by ambulance services after taking a drug overdose and had reportedly given Charlie tablets. Charlie had a history of asthma, poor school attendance and repeated hospital attendances and was suspected to have been the subject of fabricated or induced illness FII in the past. The SCR was equivocal, stating:

suspected to have been the subject of fabricated or induced illness in the past and there are features of her recent presentations in hospital which could suggest that this might have been a continuing issue. At the same time, there was a considerable gap between the original concerns which could suggest the contrary.

The report underlines that unexplained symptoms should have been investigated in greater depth:

It is notable, however, that during the years following suspicions about fabricated or induced illness, there were no satisfactory assessments of Charlie's needs or family relationships.

The review highlights the absence of multi-agency work and ignoring complexity of family circumstances and over-emphasis on medical presentations.

3. Child V (published 2020)

The SCR suggests that Child V was the subject of both serious physical maltreatment and neglect, as well as FII. The physical harm included a fractured femur whilst the child was an inpatient in hospital but in the care of mother; a hospital admission with a subdural hematoma with retinal haemorrhages; bruises on the child's face; and an admission with high salt and glucose levels, leading to concerns about possible salt poisoning. Neglect included poor weight gain, being cold and left on the floor, and lack of parental visiting during numerous hospital admissions. The SCR stated:

Mother continued to present a child with complex health needs and this was how the child continued to be viewed by medical practitioners and hence received unnecessary, invasive, investigations and treatment. ... It appears that some of the diagnoses of Child V's medical conditions were based on parental reporting and there was an over-reliance on Mother's reporting. (p.19)

It also highlighted discrepancies between what mother was reporting and clinical observations and results of tests. The SCR outlines numerous occasions when "investigations

did not follow procedures, were not sufficiently thorough nor brought to a robust conclusion.” (p.27) These were accompanied by many examples of poor communication and inadequate medical practice.

Overall, the SCR suggests there was a lack of effective information-sharing, multi-agency planning and effective child protection responses which led to missed opportunities to identify likely physical maltreatment, neglect and long-term unnecessary, invasive, investigations and treatments, including being fed enterally, administered oxygen and prescribed medication for epilepsy.

4. Baby Z (published 2019)

Baby Z was prematurely born and placed on a child protection plan (CPP) before birth because of her mother’s self-harming and suicide attempts. FII was discussed because 1) on a second hospital admission for the baby’s serious illness, a toxicology report identified that Dihydrocodeine was present in Baby Z’s urine – a medication prescribed to the mother; and 2) mother reports suffering from various conditions but then refuses being tested.

However, there was no indication that the mother was trying to convince doctors that her child was ill and the review states:

At no time in the period under review was there any suspicion that Baby Z had in any way been subject to having an illness fabricated or induced and there is no evidence that staff should have been aware of this risk.

5. Children F, G & H (published 2018)

The SCR identified FII causing long standing physical and emotional harm to the three children. The children received unnecessary and invasive medical procedures over a

significant period, including after tests had shown that any medical symptoms had resolved. Several practitioners had suspicions about over-medicalisation from 2005 and more strongly in 2009 but it was not until 2013 that multi-agency action was taken to safeguard the children. During 2010, letters were sent to three hospitals raising concerns about the children being over-investigated and over-treated due to the symptoms presented by their mother, in a pattern of simultaneous over-medicalising and not complying with doctors' advice. Mother was said to be over-anxious and the harm was caused by doctors carrying out invasive medical treatments including surgical interventions based on the mother's reporting of both symptoms and the children's response to treatments.

6. Child Y (Published 2017)

Serious health and developmental impairment of a teenage boy due to FII over several years. Child Y and his younger sister had attended hospital emergency departments over 250 times in four years, in three different hospital trusts, with no medical causes found for many of the symptoms. Medical treatment was sought in relation to: chest pains and breathing difficulties; bowel problems; endoscopy and colonoscopy, appendectomy, tonsillectomy. Both siblings had undergone medical interventions, including medication, intrusive investigations and surgery. The FII resulted in:

significant loss of school attendance and associated delay in educational and social development; unnecessary medical intervention including intrusive investigation; unnecessary surgery and medication that served no purpose and may have had harmful side-effects. The worst known of these has been a degenerative spinal condition and the development of an addiction to opiates administered by health professionals.

There were numerous occasions when medical staff raised the issue of over-medicalisation but, despite a range of meetings, effective action was not taken. The SCR explores the causes of this failure to act.

7 Young person (Published 2015)

This 16-year-old girl had a diagnosis of atypical Asperger's, anxiety, and a longstanding history of constipation. On 8 February 2013, she collapsed suddenly at home and died having suffered a cardiac arrest. It is thought this was caused by significant abdominal distension arising from serious and longstanding constipation. There was concern about the mother's role in the case, but the SCR said, referring to the 2009 RCPCH guidance, that:

'True' FII ... should be reserved for cases where the evidence points to the child's carer deliberately lying about illness or deliberately causing illness in the child and presenting the child for medical attention, often repeatedly, in an attempt to 'dupe' the doctors and procure medical investigation and treatment ... That is unlikely to be the dynamic here as the number of presentations of the young person to doctors for physical health ailments was fairly modest considering the problems she had, and the only persistent physical complaint, constipation, was genuine. (p.15)"

8. Katie (Published 2014)

This case did not meet the statutory criteria for undertaking a serious case review but a light touch practice review was carried out to learn from experience and review services. The practice review concerned a mother who repeatedly took her child to health services from age 4-months to 3-years reporting seizures, fits and vomiting. The child was placed on a child protection plan when eighteen months-old under the category neglect following the mother reporting to A&E that the child had ingested a cube of cannabis. At 3 years 3 months the

child was removed into local authority care and the Court made a Finding of Fact that the child does not have epilepsy and that the mother fabricated the child's ill health but also fabricated her own health history.

The SCR identified a litany of errors by physicians who prescribed medication without diagnosis. Mother who claims to have learning disability was said to have misled several medical professionals and there was an “over-reliance by professionals on self-reporting by the mother of the child's health problems, in the absence of medical evidence or observable concerns”

9. Child E (published 2012)

This SCR concerns a child who had a series of bruises and eventually more serious physical injuries. The child had been hospitalised and had complex health care needs. At 6 months old when child E was recovering in hospital there was an “*incident which prompted hospital staff to consider the possibility of fabricated or induced illness (FII).*” (p.3) No formal investigation of this was conducted and the focus of the SCR was on physical abuse.

10. Child F (Published 2011)

This SCR concerned a review into agency involvement over a five-year period with a child who killed himself by hanging aged 12. Child F was the victim of bullying and panic attacks after witnessing a serious assault at school. On several occasions, he said he wanted to be dead including saying to a child psychiatrist that he “would rather be dead than continue to be picked on” and was referred to CAMHS twice having said he wanted to die and being found with a plastic bag over his head. Despite this CAHMS never did a risk assessment for suicide and he was offered a programme of undirected play therapy. The SCR was of the view that Child F’s case was generally poorly managed by the key agencies despite regular

multidisciplinary meetings with good representation. There was evidence of poor practice throughout which included both single agency failings and generally poor inter-agency communication and collaboration including no action being taken on mother's allegations to CAMHS, teachers, school nurses and others that F's father was frequently drunk and neglectful on contact visits. F was said to have experienced emotional abuse and neglect perpetrated by both parents which were not investigated. He was diagnosed and receiving treatment for Major Depressive Disorder and ADHD.

The SCR suggested there was a failure to consider FII as part of a differential diagnosis and a contributing factor to his difficulties. This was based on the mother reporting an "unwitnessed attempt by Child F to take his own life and a number of incidents of suicidal ideation which were never verified with Child F"; that the child had suffered from ADHD and dyslexia which the school did not identify; and that mother said in her statement to the police that he may have been autistic. None of these occurrences were investigated and the child had made several witnessed suicide threats and attempts before killing himself.

11. Child EQ (Published 2011)

EQ's mother was reported to be a childcare worker. Between the ages of 3 and 9½ months, EQ had 25 separate medical assessments including 8 admissions to hospital and 7 Out of Hours emergencies. EQ had been alright up to 3 months though mother reported "*the baby was difficult to feed and was vomiting*". At 3 months EQ was admitted with vomiting and diarrhoea, discharged and readmitted 2 days later for a short period due to mother's concerns about not feeding. At this time the hospital had a meeting in "line with the Fabricated and/or induced illness protocol" which led to child in need support. Although a psychologist had found the mother to have a "vulnerable personality" state this did not lead to changes in the way the case was handled. Between 6 and 9 months EQ was admitted to a "*number of local*

hospitals on several occasions for viral illnesses and poor feeding.” At 9 months EQ was admitted for 10 days observation and assessment. Two days after discharge as fit and well EQ was readmitted by ambulance acutely unwell and having a convulsion. Tests showed that EQ had been “*administered drugs which would only be prescribed to an adult.*” EQ was then accommodated with foster carers with the parents’ agreement and reported to be safe and well. A police investigation was unable to establish proof sufficient to meet the thresholds for a criminal prosecution of either parent.

The CSR found that the hospital’s meeting about FII did not follow the protocol in that police and social work were not invited, a chronology was not produced and the referral to children’s services was a child in need referral only to be treated as child protection if the parents did not cooperate with the support plan. It did not mention FII. This was identified as a missed opportunity to protect the child at an earlier stage.

Overview

Three of the eleven SCRs explicitly ruled out FII (cases 4, 7 and 9) and one (case 2) presented no evidence and was equivocal about whether FII was part of the episode that led to the SCR. In a further case (case 1), the SCR found insufficient evidence for FII to be identified, noting that the child was one of a cluster of 12 children from a unit that had “*routine / frequent misdiagnoses*” and that the term FII was unhelpful as the: “*investigation focus[ed] on establishing the culpability of the parents, rather than on the well-being of the child.*” In a sixth case (case 10) the SCR suggested that FII should have been considered as a possible contributing factor in a child’s suicide. This SCR suggested this possible FII was evidenced by the mother’s personality; the mother reporting an unwitnessed suicide attempt and incidents of suicidal ideation not verified with her son; and her believing that her child had ADHD and autism. However, the child made several witnessed suicide attempts,

witnessed incidents of desire to commit suicide and eventually hanged himself. He was diagnosed and treated for ADHD and Major Depressive Disorder and no evidence was given that the points referred to were fabrications. Case 8 did not meet the criteria for a serious case review though it did describe learning from a complex case involving FII including medication prescribed without a diagnosis (case 8).

Thus, in SCRs published over this 12-year period there were four where FII was said to be a factor associated with serious harm (cases 3, 5, 6,11) and one further case substantiated FII (case 8) but did not meet the statutory criteria for an SCR. No cases involved deaths due to an illness being found to be fabricated or induced. None of these SCRs provided evidence that the “parent’s motivation for harming the child is to convince doctors about the purported illness in the child” (RCPCH 2021, page 11) a key requirement for cases to be considered FII. In one case there was evidence that the child had been given adult medication but, whilst the SCR showed that this had followed a history of high levels of medical intervention there was no discussion of the motivation for the administration of adult medicines nor of whether earlier medical engagement had been undertaken to convince medical personnel that the child was ill. The other cases did not involve induction though in one (case 3) there was concern that the child may have been poisoned with salt and on another occasion the mother had syringes with four times the required amount of medication which she said she would administer. Neither of these incidents were investigated further or reported to children’s social care.

In all reported FII cases involving serious harm the SCR suggests that the harm could have been curtailed if standard medical procedures had been followed. In two of the four SCR cases (cases 3 and 5) and in case 8 there was a high incidence of medical error and over-medicalisation that the SCR found could have been prevented if standard medical practice

had been followed. According to the SCRs, this included medical investigations not following procedures and not sufficiently thorough nor brought to a robust conclusion (case 3); medical procedures being given after tests showing medical symptoms were resolved (case 5); the child (case 8) was labelled “a known epileptic” without formal diagnosis and this medication was provided for three years without proper review. Concerns were expressed about over-intervention and over-medicalisation at an early stage in three cases (5, 6 and 11) with no response to these medical errors. In case 5 a consultant paediatrician wrote to local hospitals expressing concerns about over-medicalisation three years before action was taken. In case 6 over-medicalisation was identified and discussed on numerous occasions without a medical response. In case 11 there was a meeting about concerns that the child was over-medicalised when the child was 3 months-old, 6 months before the incident that precipitated the SCR.

Discussion

The review of SCRs and the literature reviewed raise issues about the concept of fabricated or induced illness and the response to it. This includes: an exaggeration of mortality and morbidity; over-medicalisation and medical error; and the lack of an evidence base for FII. These are now discussed in turn following a discussion of the limitations of the study.

The study of SCRs can only consider those cases where a child died or was seriously harmed, the SCR process was instigated, and the report was placed in the NSPCC database. SCRs are instigated whenever a child dies and abuse or neglect is known or suspected to be a factor. This will exclude child deaths or serious harms due to FII where abuse was not suspected. Serious harm to a child triggers an SCR where abuse or neglect was known or suspected and there was cause for concern about the way staff worked together. Since 2015, these criteria

were further strengthened and cases of serious harm can only be excluded from the process where there is definitive evidence that there are no concerns about inter-agency working (Dickens et al, 2022 p. 9). SCRs may not have been triggered due to different interpretation about what constitutes serious harm and in some cases of serious harm where there were no concerns about the response of agencies involved. Given the inter-agency nature of responses to FII it is unlikely that many children suffering “long-term disability” or other serious harm where FII was suspected would avoid being subject of a SCR.

Mortality

Over the twelve years covered by the SCRs analysed in this research there were no deaths reported due to an illness being fabricated or induced. The literature review also found no deaths of children in the UK over this period due to FII. Similarly, there was no evidence from SCRs of deaths by poisoning, asphyxiation, or suffocation in cases whose presentation suggested fabrication of illness. This suggests that deaths due to FII are extremely rare in England.

The literature and previous government guidance which cites high mortality rates mainly rely on misinterpreting the data from McClure et al (1996) and on the inclusion of historical data from the period when Meadow’s law was widely accepted and cases of multiple sudden infant deaths were thought to be murders. The literature also cites proportions of deaths amongst articles on MSbP as if this is a mortality rate. This data should now come under serious question and the risk of FII being associated with child deaths should be reassessed.

Morbidity

The reported rates of morbidity claimed to result from FII range from 50% of children suffering long-term morbidity according to the English (DfE, 2008) and Welsh (Welsh

Assembly Government, 2008) guidance to the 6 to 9% suffering long-term disability cited in the Royal College of Psychiatry's guidance (2019). In the 12-year period covered by this study, there were four SCRs where FII was a factor leading to serious harm. In one SCR (case 11) the child was harmed by poisoning with adult medications but was reported to be safe and well in foster-care once treated suggesting no ongoing morbidity or disability. In the other three cases the children had been subjected to unnecessary and harmful medical procedures. These three SCRs did not quantify the degree or nature of long-term morbidity that stemmed from their experience though these children are likely to have suffered serious ongoing harm. Whilst no level of ongoing harm is acceptable this level of findings of serious harm suggests that morbidity following FII is significantly over-estimated.

Over-medicalisation and medical error

In the four cases where there was serious harm due to FII, the SCRs identified medical errors and shortcomings including missed opportunities to respond to concerns about over-medicalisation – that is children receiving unnecessary or harmful medical care that should have been avoided by standard medical practices being followed. The focus on placing responsibility on parents, mainly mothers, risks distracting attention from these medical shortcomings which, in some cases, were identified years before action was taken. There may have been a better chance of prevention of harm and identification of serious cases if the focus was on over-medicalisation rather than parental responsibility. This was specifically raised in case 1 where the SCR said that the focus on investigating the mother distracted from misdiagnoses and over-medicalisation in a cluster of such concerning practice in a single paediatric department. This cluster alone outnumbers the four cases where FII was deemed to have led to serious harm.

Conclusion

There are significant gaps and concerns regarding the FII and its associated guidance. After more than twenty-years, its definition still lacks clarity, and there remains an “absence of published evidence” (RCPCH 2021, p.6). The existing literature consists of case studies many of which predate the use of the term. In particular there is a lack of empirical research to support the use of alerting signs as a basis for identifying children likely to be suffering from FII. The incidence and prevalence of FII remain uncertain, with a rise in investigations reported but no epidemiological studies or statistics and no published evidence of positive outcomes to justify this increasing level of interventions. Iatrogenic harm caused by misidentification of FII is highlighted, with cases of misdiagnosis, wrongful imprisonment, and delayed diagnoses of underlying medical conditions. The use of research into deaths and morbidity due to MSbP in the period prior to the use of the term FII is questioned because of concerns about the quality of much of this research and because the definition of FII has considerably expanded beyond cases covered by the MSbP definition.

In the study of SCRs over a 12-year period, overmedicalization and/or medical errors were identified at an early stage in the four cases where serious harm was attributed to FII. The SCRs highlighted how the failure to follow standard medical practices led to missed opportunities to respond to medical errors, which played a central role in the harm faced by children. One SCR identified a cluster of concerning practices in a single paediatric department, emphasizing that the focus on individual cases distracted from addressing this systemic issue. The focus on placing responsibility on carers, principally mothers, is criticized for diverting attention from these medical shortcomings. Better responses to overmedicalization and medical error rather than a focus on parental responsibility may have led to improved prevention of harm and identification of serious cases.

Regarding mortality, the analysis of SCRs over a twelve-year period found no deaths due to fabricated or induced illness in England. The literature review also found no reported deaths of children in the UK due to FII over the same period. Additionally, there was no evidence of deaths caused by poisoning, asphyxiation, or suffocation in cases where the presentation suggested fabrication of illness in the SCRs. The literature and previous government guidance that cite high mortality rates are criticized for relying on misreporting data and including historical data from articles on Munchausen Syndrome by Proxy (MSbP) from a period when false convictions and wrongful assumptions about multiple sudden infant deaths as murders occurred.

Similarly, the findings on serious harm challenges the accuracy of procedures and guidance that suggest high rates of morbidity and disability. These procedures and guidance need to be seriously questioned, and the association of FII with high rates of child deaths and morbidity needs to be reassessed.

Overall, this study challenges the view that a focus on FII is needed because of high levels of mortality and morbidity and suggests that, in the rare cases which found serious harm, strengthening standard medical practices rather than searching for evidence of parental culpability would have provided better protection for the children involved.

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