Fabricated or Induced Illness in children and young people by Carers (FII)
HIPS multiagency guidance

Version 1	Created	08/08/2018	Reviewed	Oct 2021 –
Version 2	Created	01/08/2022	To be reviewed	August 2025

This guidance has been written designated doctors in full consultation with agency partners from primary and secondary healthcare, social care, police and education

Contents

1. Why this guidance?

Children can sometimes be presented to professionals by parents/carers (hereafter, referred to as 'parents') as having physical or mental health problems when the child has no recognised medical condition and/or the symptoms cannot be accounted for by any known illness. If these actions are causing, or putting a child at risk of, significant harm, the situation may be referred to as 'Fabricated or Induced Illness by carers' (FII).

This multiagency guidance assists practitioners in managing FII. It includes how to recognise FII (Section 4), how to determine the likely/actual significant harm to the child (Section 5) and how to manage these cases (Sections 6 – 14), including where significant harm is being considered rather than suspected (which the Royal College of Paediatrics and Child Health (RCPCH) might refer to as a 'perplexing presentation').

2. National guidance

The following guidance has been issued by government and by standard setting organisations:

Working Together 2018 does not mention FII and FII is not a specified form of child abuse. It states that, "Physical abuse may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child". (Page 106, WT 2018)
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

The guidance: 'Safeguarding children in whom illness is fabricated or induced (supplementary guidance to Working Together to Safeguard Children) DCSF, HM Government 2008, is no longer current and has been removed from the government website.

The National Institute for Health and Care Excellence (NICE) guidance: Child maltreatment: when to suspect maltreatment in under 18s, updated in Oct 2017, contains limited guidance on when to consider or suspect FII (Paras 1.2.11-12). https://www.nice.org.uk/guidance/cg89

The RCPCH published updated FII guidance in 2021: 'Perplexing presentations/fabricated or induced illness in children'. This guidance is written primarily for paediatricians but can be helpful for other health professionals.
https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/

The Royal College of Psychiatrists produced guidance for psychiatrists last updated in March 2020: 'Assessment and management of adults and children in cases of fabricated or induced illness(FII)' https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/cr223.pdf?sfvrsn=658db320_2

3. Terminology

3.1 Fabricated or Induced Illness

Lord Justice Ryder wrote, in a court judgement from 2005:

The terms 'Munchausen Syndrome by Proxy' and 'Factitious (and Induced) Illness (by Proxy)' are child protection labels that are merely descriptions of a range of behaviours, not a paediatric, psychiatric or psychological disease that is identifiable.

In reality, the use of the label is intended to connote that in the individual case there are materials susceptible of analysis by paediatricians and of findings of fact by a Court concerning fabrication, exaggeration, minimisation or omission in the reporting of symptoms and evidence of harm by act, omission or suggestion (induction).

For my part, I would consign the label MSBP to the history books and however useful FII may apparently be to the child protection practitioner I would caution against its use other than as a factual description of a series of incidents or behaviours that should be accurately set out (and even then only in the hands of the paediatrician or psychiatrist/psychologist).

What I seek to caution against is the use of the label as a substitute for factual analysis and risk assessment.

[2005] EWHC 31 (Fam) https://www.familylawweek.co.uk/site.aspx?i=ed109

This guidance strongly promotes the recommendations of Lord Justice Ryder

Fabricated or Induced Illness is a term used increasingly by professionals from all agencies involved in safeguarding and protecting children. However, there remains debate and disagreement about the nature and definitions of Fabricated or Induced Illness (FII).

For the purposes of this guidance, FII is considered as, 'a clinical situation where a child has suffered or is likely to suffer significant harm through the fabrication, falsification or induction of illness by a carer and/or from responses to these parental actions by health professionals'.

- By using the term FII, health professionals are expressing their concerns that the child has suffered or is likely to suffer significant harm.
- in describing the harm, all professionals, health and non-health, are encouraged to use the language of Working Together, which is multi-agency.

When making interagency contacts the focus should be on harm described as physical abuse, emotional abuse or neglect, not as 'FII'.

3.2 Terms from NICE guidance

The following terms, taken from NICE guidance CG89, are used in this guidance:

Alerting Features – these are clinical features associated with child maltreatment that may be observed when a child presents to healthcare professionals.

Consider – to consider child maltreatment means that maltreatment is one possible explanation for the alerting feature.

Suspect – to suspect child maltreatment means a serious level of concern about the possibility of child maltreatment but not proof of it.

4. Recognising significant harm in children when FII is suspected.

In recognising the harm caused by FII, the effect and impact on the child should be the major concern of professionals caring for the child. Professionals are encouraged to consider the lived experience of the child and to listen to the voice of the child.

Rather than concentrating on diagnoses, professionals should consider the following:

- How is the child in terms of health and well-being?
- Is the child living as normal a life as possible?
- What is preventing the child reaching their expected and achievable outcomes?

Induction of illness, falsification and fabrication describe different clinical situations as listed below:

4.1 Induced Illness

Induction of illness is rare. The commonest forms of induced illness are poisoning and suffocation. Commonly, the "poisons" used by the perpetrator are prescription medications. When the illness induction stops, the child may return to normal health but can still remain at risk of further harm. Further harm is likely to occur from medical interventions to investigate the cause of the child's illness (iatrogenic harm) and the emotional impact on the child.

In the situation where illness has been induced by poisoning and/or suffocation, practitioners are encouraged to use the terms “induction of illness by poisoning” and/or “induction of illness by suffocation” rather than just ‘induced illness’.

4.2 Falsification of illness

Falsification of illness is also rare. Clinical samples reported to be from the child can be tampered with or may not come from the child. For example, (e.g., non-human blood on clothing reported to have come from the child; urine samples can have sugar or blood added to them; thermometers can be warmed up with hot water).

Results of medical tests can be falsified or letters reportedly from health practitioners can be forged. Photographs reportedly of the child may be from another child or faked to look like a medical condition.

4.3 Fabrication of illness

Fabrication of illness is commonly encountered by health professionals. The situation can often be resolved through open discussion and careful management. Where this is not possible, the child can sometimes experience significant harm.

The parental description of a child’s health will depend upon multiple factors including parental health and health beliefs, culture, previous experience of healthcare and experience of childcare. Naïve exaggeration and deceitful lying could both be described as fabrication but are very different in how they should be managed. Parents may or may not realise that they are giving an incorrect account of the child’s health.

4.4 Alerting features for possible FII

RCPCH 2021 guidance lists some alerting features that can be associated with FII and acknowledges that there is a lack of research evidence in this area. They state that any alerting signs must be considered and investigated appropriately, and that FII should be identified with the same rigour as organic disease. In practice, the most indicative alerting features are often when there are discrepancies between parental reports and independent observations of the child, or when descriptions or findings are implausible and contradictory.

As with any situation where child safeguarding concerns are considered, the assessment must consider the overall picture. Multiple alerting features are more likely to suggest a child is being harmed than are one or two features.

If FII is considered or suspected clinicians need to actively seek corroborating evidence. This could be done as a single agency or in conjunction with education or other agencies. Making complaints, requesting further opinions or disagreeing with a diagnosis do not in themselves cause harm to children and the focus should remain on the child (as above).

5. Harm to the child

Harm includes both ill-treatment and the impairment of health (physical and mental) and development (Children Act 1989, Section 31).

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The harm caused by medical investigations and treatments always has to be balanced against their benefits. Carrying out tests, giving medicines or performing surgery on a child whose symptoms are misreported is more harmful than if symptoms are genuine. Harm can be caused directly by the parent, intentionally or unintentionally, and this harm may be reinforced by health professionals who cause iatrogenic harm inadvertently.

Harm should be judged by severity of harm to the child rather than severity of a parent's actions. Severity of harm to the child should be assessed both by the intensity of each aspect of harm and by the cumulative effect of all the aspects.

Whilst the motivation of the parent/carer is irrelevant to the determination of whether the child has suffered or is likely to suffer harm, motivation needs to be taken into account when considering how to manage the problem.

In the context of Fabricated or Induced Illness:

5.1 Physical abuse might include:

- Poisoning, suffocation, withholding of food, marking to skin to simulate illness
- Pain and discomfort from unnecessary surgery, anaesthetic, medical investigations, procedures & treatments
- Precipitation of physical illness from withholding medication needed e.g., asthma attacks, epileptic seizures

5.2 Emotional abuse might include:

- Failure to have basic emotional needs met e.g., protection from unnecessary pain, need for security, development of autonomy and competence
- Making the child unnecessarily anxious about their health and/or experience of healthcare
- Unwarranted social isolation
- Induction of psychiatric disorders and psychosocial difficulties, including abnormal illness behaviours
- The child's sense of self is damaged, and the sick role reinforced through unnecessary treatment, aids, appliances, or medical equipment

5.3 Neglect might include

- Child's education is disrupted with unnecessary school absence and/or parental restrictions on participating in school activities leading to reduce educational achievement
- Inappropriate limitation of normal daily life and activities
- Restriction of activities through unnecessary treatment, aids, appliances, or medical equipment
- Developmental delay resulting from lack of opportunity to make usual developmental progress.
- Genuine illness being overlooked

6. Discussions with children and parents

6.1 Voice of the child

The child's views are important and should be explored with the child on their own to find out how they view their symptoms and any concerns or anxieties they might have. Trusting relationships may need to be built up over time. Children should be given multiple opportunities to have their views explored in settings where they feel safe, recognising that children can find it difficult to express views independently of their parents.

6.2 Engaging with parents

Previous FII guidance suggested that parents should not be informed of safeguarding concerns until multiagency assessment had taken place. However, it is now agreed that parents should be kept informed unless this would place the child at real risk of further harm.

If professionals are to address alerting features before further harm is caused to a child, it is important that they are able have honest discussions with parents and children at the earliest opportunity, so that a plan can be agreed to ensure the child's wellbeing.

If it is considered that a child is being harmed through FII, as with any other safeguarding concern, professionals should inform parents (and children if appropriate) about referral to Children's Services unless this would place the child at risk of further harm. An example where parents might not be informed of contact with Children's Services is in induced illness where poisoning is suspected. In this situation immediate protection may be needed to keep the child safe.

If the decision is made not to share safeguarding concerns with parents, there should be a well-considered risk assessment with clear documentation and early multi-agency discussion. Advice on whether to share safeguarding concerns in the context of FII can be obtained from Designated and/or Named Health Professionals.

7. Record keeping

Careful, factual clinical records should be kept, detailing who reported any concerns, what was observed, and by whom. Records of discussions, including about safeguarding concerns, should be kept within the child's main health record, , to ensure that this information is readily available to those involved in the child's care, aiming to prevent further harm.

Professionals should be cautious about using the term 'Fabricated or Induced Illness' in records. Records should include a clear explanation of the specific concerns and, where appropriate, a risk analysis based on the concerns and the professional's opinion of these. Similarly, documentation of the harm to a child should use the recognised forms of harm.

Records must include a clear account of what has or has not been discussed with the child and parents. Subject Access Requests are easier to deal with if there has been open communication. If it is thought that providing parents with information could adversely affect the child's welfare, this should be discussed with appropriate Trust leads to see if any material should be withheld.

Correspondence should be copied to all health providers as well as the GP and, wherever possible, the child and their parents.

8. Actions if there are alerting features for FII - See flowchart 1

8.1 Management if concerns are raised by a professional who is not in Secondary Care

For the purpose of this guideline, secondary care includes hospital, community paediatric or CAMHs services.

If the child is not under the care of a secondary health team, the professional should discuss the child with their GP. The professional should explain to parents that they need information from health to understand the concerns, e.g., poor school attendance. If parents do not agree to health assessment or sharing of information, advice can be sought from organisational safeguarding leads and/or from Named or Designated Health Professionals.

The GP will need to form an opinion about the case based on knowledge of the child and the family. The GP may request to see the child to assess the concerns further. If at any stage, the GP has concerns that the child has suffered or is likely to suffer significant harm, then MASH or, in Southampton, the Children's Resource Centre (CRS) should be contacted (see Section 8/flowchart 2).

If the GP's opinion is that a further assessment of the child's is required, then consider the following courses of action:

- If the alerting features relate to an overt physical, developmental or mental health need, the child should be referred to an appropriate secondary care consultant whose practice lies within the main symptoms the child is being presented with. The referral should be explicit about any alerting features.
- If the alerting features do not suggest a physical, developmental or mental health need, e.g., the issues seem primarily behavioural, social or emotional, the GP should discuss the child at their local multidisciplinary team if available or discuss with the Named GP, Named Consultant for Secondary Care provider and/or Designated Doctor.

All consultant paediatricians and CAMHs psychiatrists should accept appropriate referrals which describe alerting features. These children should not be the responsibility of one or a few secondary care health professionals.

If a health or non-health professional has concerns about alerting features and that a child is not being protected appropriately, organisational escalation policies should be followed.

8.2 Secondary care management when significant harm is considered but not suspected

A 'Responsible Consultant ', i.e., a consultant paediatrician (or, in cases of fabricated mental illness, a senior CAMHs practitioner), will lead on case management with a focus on the child's voice and their current state of health, functioning, and involvement with health services.

The Responsible Consultant discusses with the child and family:

- A clear explanation of medical findings from examination and investigation and what health conditions have or have not been diagnosed.

- After full appraisal of the situation, where appropriate, an agreement should be made with the family to reframe the medical management from primarily investigative and diagnostic to rehabilitation.
- The need to liaise with other non-health agencies involved with the child, particularly education, and share relevant information about the child.

An honest, empathic, considered, but boundaried approach is needed. Discussions may be prolonged and may need to be progressed in stages. Several consultations may be needed. It is important to give the child and family time and space, but there also needs to be an appropriate timeframe so that any impact on the child's physical and psychological well-being is minimised. The timeframe will depend on the impact of the symptoms on the child.

The Responsible Consultant should lead in liaising with all the other professionals involved to reach consensus about the child's health and management. Wherever possible this should be completed before any referral is made to social care.

The Responsible Consultant should inform the family that they will discuss the child with all agencies involved, for example, the family's GP, health visitors/school nurses, education and Children's Services. The Responsible Consultant needs to obtain a full understanding of the child's health, which will include objective evidence. Admission to hospital might be useful to assess the child's health and how the child can function.

Where there are concerns about more than one child in a family, each child may have a different or the same Responsible Consultant depending on the needs of the children involved.

If there is disagreement about who should be the Responsible Consultant for a child, this should be discussed with the Named and/or Designated Doctor.

8.2.1 Rehabilitation

Health professionals should always be willing to reassess their clinical formulation. There may be an inherent difficulty for the Responsible Consultant as the management plan for the child is usually based on a clinical formulation and so a family's request for further investigations and opinions may seem reasonable. Advice should be sought from colleagues and Named or Designated Doctors.

Once the child and family agree the formulation, the Responsible Consultant, in collaboration with the wider professional team, will be able to develop a plan to rehabilitate the child. This can be a formal single or multi-professional rehabilitation plan or might involve continued reassurance and gradual improvement.

However, in some situations, rehabilitation might be difficult to achieve. This may be due to parental or child factors such as continued reporting of symptoms which cannot be verified objectively but where the impact on the child does not amount to significant harm. In this situation, monitoring and containment may be more appropriate

The aims of monitoring and containment are:

- To prevent further harm to the child
- To provide continuity of care
- To provide reassurance and improvements in health and well-being

The child should not be discharged until they are functioning at the expected level.

8.3 Secondary care management when significant harm is suspected

At regular intervals, the Responsible Consultant should re-assess the impact of existing and/or new alerting features on the child and whether the child is suffering harm, including the cumulative harm associated with delays in return to normal functioning.

If at any stage, the Responsible Consultant has concerns that the child has suffered or is likely to suffer significant harm, then MASH/CRS should be contacted (see Section 8/flowchart 2).

If the child and family receive support from Children's Services, it is important that the Responsible Consultant and social work team communicate and liaise effectively to support and agree an effective plan of support.

9. Protection of the child at risk of significant harm - See flowchart 2

The process for the management of cases where there are concerns that a child has suffered or is likely to suffer significant harm from FII is the same as for any other case of child maltreatment. Working Together 2018 provides a framework for managing individual cases of significant harm to a child.

If there is evidence of illness induction or frank deception, such as interfering with specimens or medicine charts, urgent contact should be made with MASH/CRS, or, if needed, out-of-hours, with police and/or children's services.

A Responsible Consultant should work closely with other agencies and should lead the health input to the multi-agency actions. This will include:

- Attendance at multi-agency meetings which should be arranged taking into account the availability and location of the Responsible Consultant, whose presence at these meetings is key.
- Providing a clear opinion on the harm that the child has suffered or is suspected to have suffered which will be included in a Child Protection Report. The protection of the child should not be delayed whilst waiting for a written Child Protection Report

Where there is a risk of significant harm, other agencies should have a Responsible Professional for the child to lead the response from their agency.

10. Chronologies - See flowchart 3

Chronologies are not routine or needed in every case.

Chronologies should:

- Answer specific questions related to the suspected suffering of harm

- Have an agreed scope and timespan. They should give a complete picture of attendances, non-attendances and appointments cancelled at short notice, but they do not need to include each and every contact with the child. They should not consist of a simple print-out of the child's entire case record.
- Include an analysis/comment on each episode listed
- Not be commenced until there is agreement on who will overview and analyse the multiagency chronology.

Chronologies should be compiled by individuals who have the expertise and ability to recognise and comment on any significant episodes. For health organisations, it is suggested that Named Nurses or other members of the safeguarding team write the chronology for their service.

The Responsible Consultant is usually best placed to overview and analyse the combined multi-agency chronology and provide a report on this. The Responsible Consultant can request non-health agencies to overview and analyse their chronologies and provide a single agency report to the Responsible Consultant. The Responsible Consultant would then be better informed to provide a multi-agency overview report. The capacity and timescale for this work needs to be agreed in advance. The Responsible Consultant is encouraged to discuss this work in advance with their Named and/or Designated Doctor.

In cases which are likely to go to court, the overview of the multi-agency chronology may be provided by an Expert Witness.

See Appendix 1 for the agreed multiagency chronology format. It is important that the headings and format are agreed across organisations and agencies so that they can be collated easily. See RCPCH guidance for more information about chronologies.

11. What to do if parents/carers do not engage with the management plan

When FII is considered and/or suspected, parental non-engagement, disguised and/or partial compliance are common, and need to be managed by the Responsible Consultant, together with the multi-agency team. As with any situation in health care, if the parents do not engage and/or oppose professionals plan for the child, the professional will have to consider whether the parents' actions or non-actions might lead to the child suffering significant harm and so whether referral to children's services is indicated.

If parents do not engage with the plan and the child is not considered to be at risk of significant harm the case should be reviewed to see whether monitoring and containment are appropriate. Advice may sought from named or designated health professionals.

If the child has a social worker allocated by Children's Services, Children's Services will take the lead for safeguarding, working closely with the multi-agency team, particularly health and education, who will take the lead for their aspects of the case.

12. What to do if other professionals do not agree about the level of harm

In most circumstances, there is agreement between professionals as to whether or not a child is at risk of significant harm and the process that should be followed. However, professional challenges should be seen as part of healthy professional working relationships.

If there are concerns about the health response from professionals (including concerns from education settings), advice can be sought from the Named GP, the Named Doctor for Safeguarding in a community or hospital trust, or from Designated Health Professionals.

If there are disputes about rare or controversial diagnoses the named and designated doctors are often best placed to review the evidence base, seek expert health advice and advise what, if any referrals are needed.

In addition, for professional disagreements between agencies, see the 'HIPS joint working protocol for the professional challenge and resolution of professional disagreement' https://hipsprocedures.org.uk/skyyty/safeguarding-partnerships-and-organisational-responsibilities/escalation-policy-for-the-resolution-of-professional-disagreement

13. Roles of Named and Designated Health Professionals

Named GPs for safeguarding children

- Advice and support to GPs in case management
- Assist case escalation, as required

Named Doctors for safeguarding children

- If dispute - liaises with consultants to decide who should be the Responsible Consultant
- Leads on the safeguarding aspects (therefore should not be default Responsible Consultant)
- Chairs multi-professional meetings to reach consensus
- Notified of any complaints and helps coordinate a response
- Attends strategy discussions

Other Named Professionals for safeguarding children and the safeguarding team

- Attend strategy discussions and case conferences
- Alongside Named Doctor, escalate to Designated Health Professionals where needed
- Assist with compiling chronologies
- Training and peer review

Designated Doctors for safeguarding children

- Professional support to the named doctor
- Attends strategy discussions as required with or in place of Named Doctors
- Safeguarding lead if the named doctor is the Responsible Consultant
- If significant disagreements between health professionals, named or designated doctor convenes a health professionals meeting to agree the medical issues

All Designated Health Professionals for safeguarding children

- Advice and support for named professionals

- Assistance in case escalation, as required
- Training and peer review

14. Workload

Organisations should support and recognise the (enormous) time required for professionals where FII is considered and/or suspected.

It is vital that appropriate resources and support can be provided to all professionals involved in this important safeguarding work.

Chronology of events

Date chronology finalised

Name of child: ..... **Date of birth:** ..... **NHS number (if known):** .....

Produced by (name): ..... **Designation:** ..... **Organisation:** .....

Key Questions for the chronology to consider:

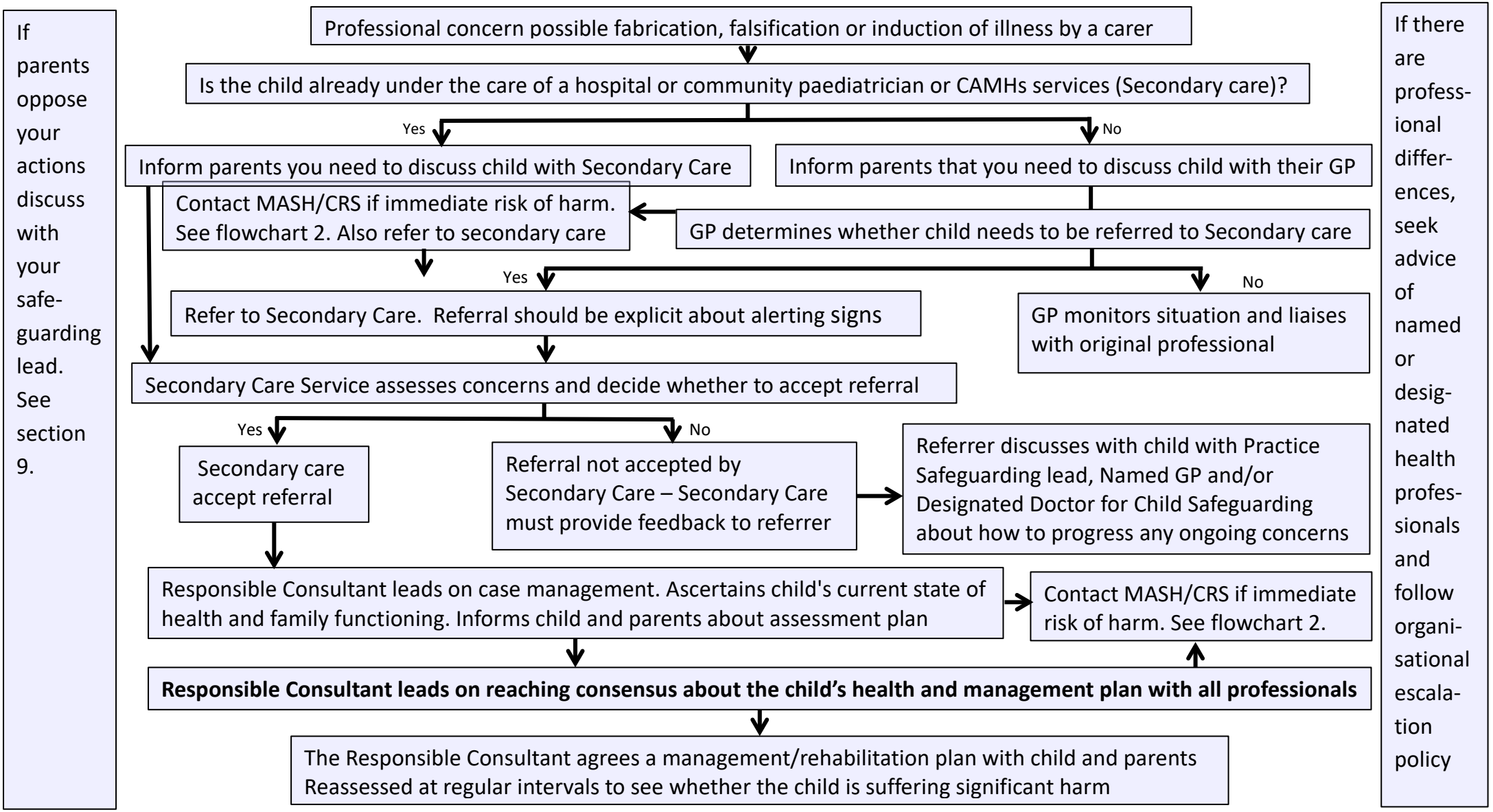
1. .....
2. .....
3. .....

(add additional questions as required)

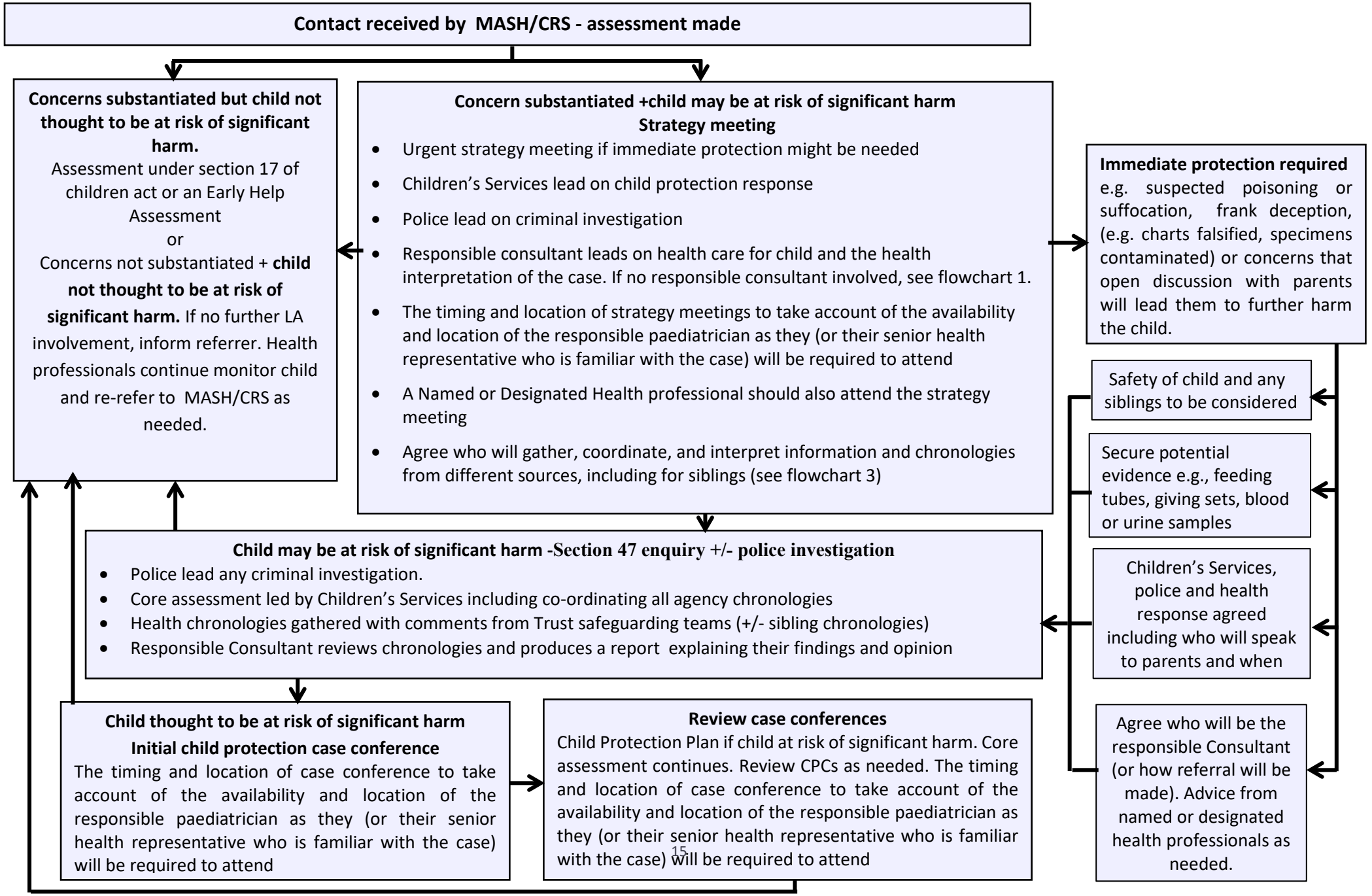
Date MUST USE FORMAT: Day/mth/yr: Eg 03/07/2018	**Time of action**	**Organisation + job title of professional**	**Contact type** e.g. letter, phone, e-mail and **source of information**	**Description.** i.e. a **summary** (unless words used are significant when exact wording should be reproduced). Include **who** reported concerns, parent's explanations, whether symptoms were **independently observed**, , any **potential harms**, actions taken and any **changes of health care professional** with reason for the change.	**Was child seen or spoken to? What was observed or communicated by the child?**	**Comments by chronology author re significance**

N.B - It is vital that the chronology is completed to this format and that whenever abbreviations are used a glossary is provided

Flowchart 1. Actions if there are alerting features for FII



Flowchart 2: Actions if significant harm is suspected



Flowchart 3: Summary of process for a chronology.