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Fabricated or Induced Illness

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What is FII?

The Royal College of Paediatrics and Child Health "RCPCH" defines Fabricated or Induced Illness as:

"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 or mental health or neurodevelopment is impaired (or more impaired than is actually the case). FII results in emotional and physical abuse and neglect including iatrogenic harm."

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What is FII? (2)

- A County Council and A Mother and A Father and X,Y and Z [2005] EWHC 31, Ryder J:

FII is a “child protection label” – not a diagnosis.

“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”

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RCPCH Guidance 2021

"*Best practice advice for paediatricians in the medical management of PP and FII cases*"

Definitions:

Medically unexplained Symptoms (MUS):

Can also be described as "functional disorders".

child's symptoms are genuinely experienced but not fully explained by any known pathology. symptoms are likely based on underlying psychosocial factors.

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"Perplexing Presentations"

Perplexing presentations

- 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

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What are “alerting signs?”

- “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”

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Definition of FII

- **Fabricated or Induced illness**
- A clinical situation in which 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 physical and/or mental health and neurodevelopment is (or is more) impaired
- Results in physical and emotional abuse as result of parental actions, behaviours and beliefs **and** doctors' responses to these

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Definition of FII (cont)

- Parent does not necessarily intend to deceive
- Motivations may not be initially evident
- **Motivation does not need to be established in order to identify FII**

Two very different categories of motivation are identified in the guidance (but both may be present)

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Potential motivation (1)

(i) the parent experiences a gain (not necessarily material) from recognition and treatment of child – thus using the child to fulfil their needs, disregarding effect on child.

- Gain might be sympathetic attention, fulfilment of dependency needs, financial gain (housing, benefits, charitable donations, holidays), or to justify inability to manage their child (eg seeking ASD/ADHD diagnosis)

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Potential motivation (2)

- (ii) the parent has false beliefs, extreme concern and anxiety about child's health; misconstruing or misinterpreting aspects of behaviour and presentation. Internet may feed their beliefs. Parent cannot be reassured by health professionals or negative investigations. The parent's need is to have beliefs confirmed and acted on, but to detriment of child

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"Alerting signs - the stuff of FII

- Repeated reporting of new symptoms
- Repeated presentations at medical settings
- Inappropriately seeking multiple opinions
- Child missing appointments
- Not accepting reassurance or management
- Insistence on more investigations, referrals, continuation of, or new, treatments
- Inexplicably poor response to prescribed medication or treatment

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“Alerting signs” (cont)

- Objecting to communication between professionals
- Not letting child be seen on their own
- Repeated changes in professionals involved
- Complaints about professionals
- Discrepancies in information to professionals
- Pattern of mismatch between parental report and clinical observation

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"Alerting Signs" (cont)

- Child's normal daily life compromised more than would be expected for condition – eg missing school, reliance on wheelchair/ventilator/inhalers etc
- Unexplained discrepancies in test results – tampering with samples or specimens
- Induction of illness (unusual) – maybe smothering, poisoning, withholding or overdosing medication

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What if alerting signs are identified?

- If “alerting signs” are identified *but* no immediate serious risk to the child’s health or life is identified, this means the case falls into the category of “perplexing presentations”.
- Guidance says a lengthy, coordinated response is appropriate, with parental discussion and involvement and multi-disciplinary assessment
- Aim is to identify baseline of child’s health by consensus so that parental behaviour can be properly assessed

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RCPCH Guidance (cont)

- Once one or more alerting signs are identified, clinicians should identify whether child may be at immediate risk of serious harm - eg if evidence of frank deception, interfering with specimens, unexplained results suggesting contamination or poisoning or illness induction
- If induction is identified the case will fall squarely into FII – because there is plainly an immediate risk of serious harm

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RCPCH Guidance (cont)

- Once conclusion reached may warrant a safeguarding referral *if conclusion is that there is likely or actual harm* to the child or siblings
- ALL cases should result in development and implementation of a Health and Education Rehabilitation Plan

- Specifying outcomes and timescales
- Including how family will be psychologically supported

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Post safeguarding referral

- Guidance says multi-professional health team should provide a full Chronology (pre or post)
- Likely Strategy discussion(s)
- S.47 Enquiry by LA
- Initial CPC
- Police investigation
- Potential for ABE interview of child(ren)

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Relevance to proceedings

- RCPHC guidance is helpful but is aimed at clinicians
- For our purposes, what started as “perplexing presentations” likely merges to be part of the wider/longer picture of alleged FII
- London *Borough of Newham v A Mother and Ors* [2024] EWFC 51 – language of PP starts to creep into pleading of FII
- *Redcar & Cleveland BC v AB [2023] EWFC 139* – language of PP used by expert paed

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Child's underlying health

- "Real" illness or disability is often present in children where FII is demonstrated – this can complicate identification of existence and extent of FII ("parent warrior" persona).
- Relies on detailed clinical and expert evaluation.
- Note report of charity CEREBRA suggesting discrimination resulting from guidance–"*disabled parents appear to be four times more likely to be accused of FII than non-disabled parents*" and results in discrimination against disabled children: https://cerebra.org.uk/wp-content/uploads/2023/11/FII-Final-report-2023-Nov-01,pdf

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Commonly reported conditions in FII

Parent often focuses on conditions that are sporadic or phasic, meaning clinical evaluation and comparison is more difficult.

- Fitting
- ALTE's
- Vomiting
- Diarrhoea
- Feeding issues
- Joint pain

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Perpetrators – what is known

- Relatively little research base
- In 2017, Yates/Bass reviewed 96 case reports and studies since 1965
- Concluded perpetrators almost all women, usually the mother, most married, a number had fabricated illnesses in relation to themselves. Many worked in health care professions, and appeared to have an exaggerated view of selves as heroic caregivers. Obstetric complications and ACE's featured.

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Scale of risks to children

- Illness induction is known to carry a 6–9% mortality rate (Flaherty and MacMillan 2013; Sheridan, 2003), with similar rates for long term disability.
- In over half of children affected, there is indirect psychological harm (relating to emotional abuse or neglect), which can result in anxiety, behaviour problems, and poor daily functioning (eg poor school attendance).

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Risks to children (cont)

- Unnecessary investigations and treatments are "unpleasant" for children, and further impair normal daily functioning.
- Siblings of these children are known to be at increased risk of illness and mortality.

Source: Report of Royal College of Psychiatrists, "Assessment and Management of Adults and Children in cases of FII" (2020)

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I've got a new FII case…

- Obtain *all* medical records AS SOON AS POSSIBLE
- Including records from private clinics/therapists
- Ask specifically for disclosure of hospital Safeguarding records – kept separately
- Consider DWP disclosure order
- Consider research of social media profiles/JustGiving/GoFundMe etc

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Case preparation (cont)

- parents' medical records – (if necessary filtration by CG's team for relevance)
- full school records including CPOMS
- HV records; potentially midwifery records
- Police disclosure
- LA disclosure of strategy/other internal meetings, s47, visit notes etc
- Phones?

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Case Preparation (cont)

- Consider instructing a chronology service – especially if records are 000's of pages
- May well not substitute for your own detailed chronology but likely to help
- Set aside sufficient prep time – detailed study of records is paramount
- Get counsel in early! (they will have to read the records … ;-))

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Expert evidence

- Main expert will be consultant paediatrician, although others may be necessary.
- For all:
  - Scrutinise CV
  - Search Baillii for cases involved in
  - Check availability
  - Provide realistic estimate of bundle size
  - Tailor letter of instruction
  - Prior authority

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Expert evidence (cont)

- Try to identify early if a geneticist is necessary – late instruction will derail timetabling
- Post removal health of child(ren) will be a crucial aspect. Ensure up to date evidence is available for expert and for trial.
- Consider asking for foster carer notes but note balance of risk as to what children may say to carers

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Preparing for fact finding

- LA pleadings *must* be Re A compliant. A generalised pleading of "exaggeration" is not sufficient – must be linked to clinical examples in the records
- However it's a balance between focus on minutiae and having regard to the "big picture": Williams J in Kent CC v a Mother [2021] EWHC 3750 (Fam) paras 102-103
- Statements on behalf of parent are likely to require a lot of time and input

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Preparing for fact finding

- Take instructions on the detail of history recorded by any clinician relied upon. Often a parent won't remember the detail – but if they dispute that they gave the history recorded, the challenge should be signalled in evidence.
- In present era of truncated listings, argue Oxfordshire proportionality to narrow the issues/evidence relied upon

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Fact Finding Hearing

- Ask the Judge to consider hearing clinical evidence first, *before* expert evidence (particularly expert paediatrician)
- Consider actions of clinicians versus RCPCH guidance – has the Guidance been followed? If not, what, if anything, can you make of it for the parent?
- Be methodical and dogged for parent – requires stamina!

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Evidence of motivation

- Determining parental motivation is not necessary to find FII
- However, judges must have an eye to the broader canvas, and it may assist to explore motivation to some degree:

Williams J in *Kent County Council v The mother* [2021] EWHC 3750 (Fam) : “parking of “motive”…seems to me to pre-empt the outcome and to deprive both the LA and CG of a line of enquiry which might have benefited the understanding of the case”

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Wider canvas

- Focus on medical evidence tends to "dehumanise" parent – try to counter if possible

- For a case where wider exploration of the mother's background of parenting and life in general benefited the court (and the mother's case), see:

  Re AB (a child: diabetic care) [2023] EWFC 149, (HHJ Wildblood KC)

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Risk of Bias

- Risk that bias arises particularly in cases of clear (or admitted) induction: "*if she did X, then of course she did Y and Z*"
- See paragraphs 15 & 16 of "legal directions" in EWHC 3750 (Fam)
- DfE's 2013 definition: "Hindsight bias occurs when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event…Outcome bias occurs when the outcome of the incident influences the way it is analysed."

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Risk of Bias (cont)

HHJ Wildblood identifies risks of hindsight bias, outcome bias, confirmatory bias and blame bias

- Confirmatory bias – someone takes a view at an early stage and drags the developing information into confirming initial view
- Blame bias – decision maker feels a need to ensure someone is found to blame for consequences
- Draw attention of judge to all these risks and point to need for forensic rigour

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Welfare Stage

The Child:

- A Health and Education Rehabilitation Plan
- May need a separate expert child psychologist/psychiatrist assessment although this is very much dependent on the facts of the case.
- An agreed (if possible) narrative is essential for child to come to understand events

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Risk Assessment

- A risk assessment of the perpetrator by an expert psychiatrist will be necessary
- Check for expertise in FII prior to instruction.
- Refer to *"Assessment and Management of Adults and Children in Cases of Fabricated or Induced Illness (FII)"* (2020) Royal College of Psychiatrists

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Psychiatric evaluation

- There is no one profile of behaviour, personality or psychiatric diagnosis for the perpetrators of FII.

- People who exaggerate illness in their children are almost always women (they are after all usually the main carer) and findings from studies of female perpetrators have shown high levels of reported privation child abuse and significant loss and bereavement. There is overrepresentation of borderline personality disorder in such mothers.

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Psychiatric evaluation (cont)

- Research has demonstrated an increased prevalence of somatoform or somatisation disorders in perpetrators of FII
- A particular aspect of FII is the involvement of the medical system; commonly mothers can appear very devoted, spending much time with the child and there can be an over-reliance on the history given by the parent.
- Strong investment in being the parent of an ill child

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Rehabilitation

- Successful rehabilitation is associated with perpetrator showing acknowledgement of what happened, and a willingness to work and cooperate with helping agencies.

- Factors which indicate a poor prognosis are:

a. Finding of induced harm to child
b. Denial/non acceptance of findings
c. Evidence of Somatisation

- Cognitive behavioural therapy, schema-based therapy or psychodynamic therapies are recommended.

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Treatment

From Sanders, Bursch (2019) Journal of Clinical Psychology in Medical settings "Psychological Treatment of Factitious Disorder Imposed upon another/Munchausens by Proxy Abuse."

- Their model indicates 6 factors or stages that lead to successful rehabilitation: acknowledge, coping, empathy, parenting, support, taking charge

However, sensible and realistic in many cases to prepare perpetrator of FII for limited future involvement in children's lives and restricted exercise of parental responsibility.