Fabricated or Induced Illness

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What does it mean?

- FII is a clinical situation in which a child is (or is likely to be) harmed as a result of caregiver(s) trying to convince doctors that the child's state of physical or mental health or neurodevelopment is impaired.

Medically unexplained Symptoms

In MUS, the child's symptoms (of which the child complains, and which are genuinely experienced) are not fully explained by any known pathology.

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.

Perplexing Presentation

- This term is used to describe the presence of alerting signs when the actual state of the child’s physical or mental health is not yet clear and there is no perceived risk of immediate serious harm to the child's physical health or life.

Motivations

- FII is motivated by a parent or carer's need for their child to be recognised as 'being ill'.
- This need may be based on a parent or carer's mistaken beliefs or extreme anxiety about their child.
- Alternatively, the parent or carer may experience an emotional gain from their child being ill.
- It most cases, it is not the parent or carer's intention to harm the child.
- Nonetheless, the child may still be harmed, either directly (via the misguided actions of the parent or carer) or indirectly (through well-intended but unwarranted medical action).

General Pattern

Cases of FII can only be identified after careful assessment and discussion.

For FII to be suspected, health professionals must be confident that the child's presentation cannot be explained by a medical condition and that MUS can be ruled out.

FII may overlap with other forms of abuse (physical, emotional, neglect).

Patterns in Parental Behaviour

- Most cases of FII are associated with the child's mother.
- It is possible to think of FII as a spectrum of abnormal parenting behaviours, from 'mild' erroneous belief or overanxiety at one end, through manipulative fabrication to 'severe' imminently dangerous induction of illness at the other end.

- However, this approach means that the effect on the child can often be underestimated.
- Even milder abnormal parental behaviours may result in difficult situations for the paediatric team.

Pattern of Effect on the Child

- The child may be affected physically, behaviourally or emotionally.
- This may vary from mild anxiety or illness behaviour to significant mental health issues, long-term emotional effects, or long-term chronic ill-health.

Limitations

It is important to remember that these alerting signs should not be classed as evidence of FII.

Instead, they should be viewed as indicators of possible FII (not amounting to likely or actual significant harm) and, if associated with possible harm to the child, may amount to general safeguarding concerns.

Management

Situations in which FII is suspected can initially feel complex but may not be as difficult as they first appear.

Above all, remember that cases of suspected FII are not burdens to be borne by a single individual.

This is a difficult area of practice and, if FII is suspected, it is wise to seek expert advice at an early stage.

Most regions will have a safeguarding team who will be able to offer advice and help with joint input.

Scenario 1

- Dear Dr Smith,
- Referral of Aaron, Beth and Dwayne Ramsay.
- I would be grateful for your opinion on the following children:
- Aaron, Age 18 months.Developmental delay and cough.
- Beth, Age 3 years., Mother reports continual cough and poorly controlled asthma.
- Child is well at nursery and when she attends my surgery.
- Dwayne, Age 7 years, Poor growth and asthma similar to his sister's.
- I am concerned that the symptoms reported by the children's mother do not seem to equate to those seen by ourselves.
- The children's health visitor and Dwayne's school nurse are also concerned about the extent of the children's reported symptoms.
- Current treatment:
- Ventolin® PRN, Becotide® 100mcg inhaler 2 puffs bd., Montelukast.
- Prednisolone 3 courses in the last 3 months.
- I have told the children's parents that we would appreciate a further assessment of their asthma.
- Yours sincerely
- GP Green

Principles

- Be mindful to listen to the voice of the child during any assessment.
- Where possible, attempt to verify the information provided by parents or carers; for example, by speaking with the neonatal intensive care unit or health visitor.
- Consider whether the child is suffering significant harm and whether safeguarding thresholds have been met.
- Seek advice and support from safeguarding colleagues about how and when to refer to social care, and communicate with the family.

Paeditrician

- collating all current medical or health involvement for the child's investigations and treatment, including from GPs and private doctors
- noting what has been reported and what has been observed
- ascertaining who has given reported diagnoses and the basis on which they have been made (parental reports or professional observations and investigations)
- considering inpatient admission for direct observations of the child (input and output, feeding, medication, mobility, pain level, sleep, standard overt video recording for seizures)
- considering if further definitive investigations are required, but try to avoid overinvestigation
- obtaining information about the child’s current functioning (school attendance, attainments, emotional or behavioural state, peer relationships, mobility, aids needed)
- if the child is home schooled, trying to observe them in an alternative setting

Purpose of MDT meeting

- Typically, a consensus meeting will cover:
- all diagnoses and their implications for treatment and the child's daily functioning
- whether the alerting signs are fully explained by the child’s physical or psychiatric pathology
- whether the reported symptoms or signs are life-threatening or not
- whether further investigations and seeking of further medical opinions is unwarranted and not in the child's interests
- the risk of actual or likely harm to the child
- whether the child and the family need to function better and manage any remaining symptoms
- whether the child will not come to harm as a result
- whether the child needs to be referred to a secondary care paediatric consultant (if not already)
- the needs of any siblings

Concensus

- The current consensus opinion is offered to the parents/caregivers with the acknowledgement that this may well differ or depart from what they have previously been told.
- A plan is then made about what to explain to the child and rehabilitation is offered. 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.

Further action

- Once consensus has been achieved, a meeting should be held involving the parents or caregivers, the responsible paediatric consultant and a colleague (never a single professional).
- The meeting will explain to the parents or caregivers 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’.

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- If there is actual or likely harm to the child or siblings at this point, it should be agreed that the child has been subject to FII.
- In some cases, this will mandate immediate referral to children's social care, due to the severity of the harm that has been caused to the child.
- In other cases, immediate referral to children's social care may not be necessary, so long as the parents or caregivers and child (if of an appropriate developmental level) agree to a health and education rehabilitation plan and comply with the terms laid out in that plan.

Attendence

- A consensus meeting will normally be attended by:
- health professionals (such as a GP or health visitor)
- education representatives (from school)
- support setting representatives (from nursery)
- Children's social care may also be present (but only if they are already involved with the child or family).

Sharing of information

- Normally, information about the parent's health cannot be shared at a consensus meeting without permission (this is not a Section 47 child protection conference).
- However, in this instance, Dorothy and Bob have been kept informed and have agreed to the sharing of their medical information.
- If the parents refuse to give permission and there are concerns about possible harm, consideration should be given to sharing the information under child protection.

Outcome

- The professionals attending the consensus meeting came to the following agreements:
- this may be FII but, at this stage, there is no urgent or immediate risk of harm to the children
- as such, a child in need (early help) referral is appropriate
- currently, there is insufficient information to back a Section 47 child protection referral
- close monitoring is required and any changes in status may require this to be revisited
- as things stand, it is not appropriate to discuss FII with the parents
- however, the parents should be kept fully informed of the early help and support process
- a referral for early help will require consent and should be fully discussed with the parents
- a health and education rehabilitation plan should be agreed with the parents

Key learning point

- The purpose of a consensus meeting is for multi-agency professionals to share information.
- Ensure that the voice of the child and the impact on them is not forgotten.
- A chronology may be needed to summarise and analyse health information and its impact.
- At this stage, it is not appropriate to discuss possible FII with parents or carers.
- However, parents or carers should be kept informed about any meetings and discussions.

Questions?