Fabricated or Induced Illness
A label ready to be assigned to the history books?

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A label ready for the history books?

In 2002 amid controversies about miscarriages of justice concerning Munchausen's Syndrome by Proxy (MSbP), the Royal College of Paediatrics and Child Health (RCPCH) and the Department of Health issued guidance on safeguarding children in whom illness is fabricated or induced. This launched a new label, Fabricated or Induced Illness (FII). Not long afterwards Ryder J (as he then was) in *A County Council v A mother and others* [2005] EWHC 31 (Fam) at [178] offered the caution that:

"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 then be accurately set out"

This paper argues that, rather than being useful to the child protection practitioner, the FII label is harmful, misleading and unnecessary and should be assigned to the history books.

The controversial beginnings of FII

FII was developed from the discredited label of MSbP, coined by paediatrician Roy Meadow in 1977. Initially described in two extreme cases where mothers were said to have fabricated or induced illness in their children, Meadow characterised MSbP as a behaviour driven by a parent's need for attention from medical professionals. Over time, however, the label was applied more broadly. By 1995[1], Meadow acknowledged that the criteria commonly used to identify MSbP lacked specificity and were wrongly used in a wide range of situations.

The concept became increasingly problematic through what became known as "Meadow's Law": the claim by Meadow that multiple unexplained infant deaths in one family were almost certainly murder. This assertion was used in court, notably in the wrongful conviction of Sally Clark, where Meadow's flawed statistical evidence was later strongly criticised. Subsequent appeals and professional reviews highlighted deep concerns about the scientific validity and application of MSbP. A 2002 RCPCH survey revealed scepticism among some paediatricians, who described MSbP as anecdotal, overused, and influenced by a small number of dominant voices. The use of MSbP in child protection was increasingly seen as lacking an adequate evidence-base and a source of significant miscarriages of justice. It was against this background that Ryder J said that MSbP does not reflect an established body of clinical knowledge, nor are there internationally agreed medical criteria for its use. As will become clear later, the same is true of FII.

Widening definitions

In 2002, the RCPCH guidance rejected MSbP and adopted the label FII. It expanded the behaviours associated with FII, without any evidential basis. However, it acknowledged the risk of misdiagnosis, the harm of false allegations, and the difficulty in distinguishing fabrication from exaggeration—particularly where parental concern or overprotectiveness was unlikely to cause significant harm.

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[1] Meadow, Roy. "What is, and what is not, 'Munchausen syndrome by proxy'?." *Archives of disease in childhood* 72, no. 6 (1995): 534.

In 2002 the government produced guidance based on the RCPCH guide and in 2008 published a review which made minimal changes. In 2009 new RCPCH guidance significantly broadened the definition of FII to include a spectrum of behaviours ranging from deliberate deception to anxiety, misperception, or genuine belief that a child is ill—further departing from definitions of MSbP and the DSM-5's definition of the mental illness associated with MSbP, factitious disorder imposed on another. It introduced nine alerting signs without supporting evidence and made symptom exaggeration—previously treated with caution—central to the definition, encouraging child protection responses even where children were later found to have genuine medical conditions.

In 2013, the RCPCH introduced the concept of "perplexing presentations" (PP), which it formalised in its 2021 guidance. The 2021 guidance also introduced an idiosyncratic definition of medically unexplained symptoms (MUS) which says that symptoms both lack a medical explanation and are psychosomatic. Parents who challenge this are escalated to the PP category —a stance that pathologizes disagreement. Broadening the definition of FII to include MUS risks significant unintended consequences. MUS affect 10% to 30%[2] of adolescents and often include symptoms linked to conditions later correctly diagnosed after periods of uncertainty. A recent study of over 3,000 patients with autoimmune rheumatic diseases, many starting in childhood, found that misdiagnoses as psychosomatic caused long-term harm, including mental health difficulties, loss of trust in professionals, reduced self-worth, and changes in healthcare engagement[3].

Although framed as enabling early intervention, the RCPCH guidance concedes there is no evidence that PP progresses to FII or that early intervention prevents harm. Crucially, it removes earlier warnings about the likelihood of misdiagnosis of genuine medical conditions and the potential harm caused by unwarranted child protection involvement.

The 2021 guidance also presents FII and PP as part of a single continuum, ranging from undiagnosed conditions and parental anxiety to deception and illness induction—despite acknowledging there is no evidence that parents move along this spectrum, or that these behaviours have shared causes. This approach thus applies a uniform investigative framework to a wide range of distinct situations that demand tailored, proportionate responses.

Although a range of guidance and journal papers suggest that FII is associated with high risk of mortality or serious harm in as many as 10% of cases[4], analysis of serious case reviews in England from 2010 to 2021 found no child deaths resulting from FII and only four cases of serious harm, all linked to earlier concerns about overmedicalisation or clinical error[5]. A future paper in this journal will examine the evidence on FII-related mortality in more detail.

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[2] Geist, Rose, Michael Weinstein, Lynn Walker, and John V. Campo. "Medically unexplained symptoms in young people: the doctor's dilemma." *Paediatrics & Child Health* 13, no. 6 (2008): 487-491.
[3] Sloan, Melanie et al. "'I still can't forget those words': mixed methods study of the persisting impact on patients reporting psychosomatic and psychiatric misdiagnoses." *Rheumatology* (2025): keaf115.
[4] HM Government, (2008) Safeguarding children in whom illness is fabricated or induced: Supplementary guidance to Working Together to Safeguard Children. Department for Children, Schools and Families. https://www.londonsafeguardingchildrenprocedures.co.uk/files/sg_ch_fab_ill.pdf
[5] Andy Bilson, Alessandro Talia, "Assessing the Evidence-base of Fabricated or Induced Illness and the Claims of High Mortality and Morbidity" British Journal of Social Work bcaf089, (2025) https://doi.org/10.1093/bjsw/bcaf089

Alerting Signs

The RCPCH's 2021 guidance outlines 20 alerting signs for FII and PP, yet these indicators lack an evidence base which raises serious concerns about reliability and misuse. FII and PP are not diagnosable conditions but concerns about harm to children, and the broad, subjective nature of the alerting signs means they are vulnerable to wide misinterpretation. Many signs depend on the accuracy of an underlying diagnosis—something especially problematic given the high error rates in diagnosing rare and complex conditions and severe difficulties in obtaining diagnoses for conditions such as autism. Additionally, behaviours commonly exhibited by parents advocating for children with complex needs—such as seeking multiple opinions or refusing to accept uncertain diagnoses—are pathologized within this framework.

Further issues arise from ambiguous criteria (e.g., "vexatious complaints") and from systemic pressures that turn determined parents into "warrior parents" who may inadvertently trigger suspicion. The risk of false positives is particularly high in cases involving rare diseases, where parents themselves have disabilities, developmental conditions, or emerging diagnoses like long Covid where medical knowledge is evolving and parental persistence is often essential. As a result, the use of these alerting signs can lead to high levels of misidentification, undermining trust, delaying accurate diagnosis, and causing harm to families and children.

Lack of an Evidence Base

Despite the adoption of the term FII for over two decades, the RCPCH's 2021 guidance (p. 8) concedes that "all relevant research" falls under the contested MSbP label and there is an "absence of published evidence" to support its approach, which is instead based on expert consensus and consultation. However, this consultation lacked input from key safeguarding stakeholders, including national organisations representing social work, education, judiciary and the police.

A recent literature review using the Psychinfo, Medline, and PubMed databases, identified 50 papers referencing FII since 2002[6]. Forty-four contained no empirical research. Only a handful of case studies were identified—none from the UK within the relevant timeframe—and just one UK-based case series covered mainly MSbP (ie before FII was introduced). No studies assessed the reliability of the alerting signs used to identify FII, nor the efficacy or safety of the recommended therapeutic or preventive interventions. Even the originators of the alerting signs and proposed responses[7] have acknowledged that these have not been systematically tested. As such, the current guidance lacks the core elements required for an evidence-based approach, including research into diagnostic accuracy, prognostic markers, and effective treatment strategies.

Epidemiology

There is a notable lack of evidence on the incidence and prevalence of FII and state agencies do not record data on FII. The RCPCH's 2021 guidance acknowledges this, and the above literature

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[6] Andy Bilson, Alessandro Talia, Taliah Drayak, Mary Margaret, Sarah Smith, Michelle Spence (2025 forthcoming) *Fabricated or Induced Illness: The controversial history, missing evidence-base and iatrogenic harm* In L. Clements and A. Aiello (eds) Understanding Parent Blame: Institutional Failure and Complex Trauma. Bristol, Policy Press

[7] See Glaser, Danya, and Paul Davis. "For debate: Forty years of fabricated or induced illness (FII): Where next for paediatricians? Paper 2: Management of perplexing presentations including FII." *Archives of disease in childhood* 104, no. 1 (2019): 7-11.

review found no population-based studies. The most frequently cited data comes from a 1990s survey of paediatricians about MSbP. This study had significant methodological weaknesses, including problematic criteria for identifying MSbP and conflating it with poisoning and suffocation. It included many cases of children whose siblings had died and took place when Meadow, a coauthor, was promoting the view that multiple sudden infant deaths were murders[8].

Whilst the NHS guidance[9] says that FII is rare, proponents of the RCPCH approach say that there were upwards of 50 suspected cases at any one time in larger UK hospitals[10]. A range of sources suggest a sharp rise in investigations into alleged FII, particularly among families of children with chronic illness or disability. Surveys of specific populations including children with autism, Myalgic Encephalomyelitis, Pans and Pandas, Long Covid identify large proportions of respondents under suspicion. A recent UK survey[11] found that 84% of alleged FII cases were discontinued, with 95% of children remaining with their families. These findings suggest not under-identification, but widespread misidentification, and underscore the absence of robust data needed to inform policy and service provision.

Harm

Some children suffer serious harm and in extremely rare cases death because a parent induces illness by administering substances or suffocating them or by lying or exaggerating symptoms to get medical staff to see their child as being ill. The number of children harmed in this way is not known but is likely to be small. A search of Bailii in the 10 years from 1st April 2015 to 31st March 2025 found 19 care proceedings where children met the threshold for entry to care because of FII. A study of the NSPCC database of serious case reviews in the 12 years 2010 to 2021 found four cases where FII caused serious harm.

In contrast, there is growing evidence of the scale and seriousness of the harm caused by misidentification of FII. The recent survey of parents of autistic children by the Association of Directors of Adult Social Services[12] found that 1 in 6 were accused of FII. Parents wrongly accused of FII were particularly traumatised and their children's mental health deteriorated with many reporting an increased risk of suicide. Whilst the respondents may not be representative of the 110,000 autistic children in the UK[13] the study suggests harm of this kind is likely to be widespread. The surveys of a range of different disabilities mentioned earlier, show harm caused by misidentification is common and impacts on the whole family. Parents report

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[8] Meadow advised on 81 child deaths many thought to have died of natural causes but later judged to be killed by parents:

> *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".*

These pseudo-statistics were discredited by appeal courts and genetic research. Meadow, Roy. "Unnatural sudden infant death." *Archives of disease in childhood* 80, no. 1 (1999): 7-14.

[9] https://www.nhs.uk/mental-health/conditions/fabricated-or-induced-illness/overview/

[10] Glaser and Davis

[11] Clements, Luke, and Ana Aiello. *The prevalence and impact of allegations of Fabricated or Induced Illness (FII).* Cerebra. University of Leeds (2023).

[12] Ferguson L. & Hollingsworth, D., *Blamed Instead of Helped: How parents of autistic children experience parental blame when they approach services for support.* ADASS (2024) available from https://www.wm-adass.org.uk/media/xprf2qx3/adass-autism-rep-oct24-final-fp7-approved-online.pdf

[13] Knapp, Martin, Renee Romeo, and Jennifer Beecham. *The economic consequences of autism in the UK*. Foundation for People with Learning Disabilities, 2007.

devastating and life-long trauma in some cases with worsened child health, loss of education, cultural erasure, family breakups, long-term mental health consequences, stigma, children wrongly taken into care, and the breakdown of trust with medical and social work professionals.[14] In some cases withholding necessary treatment leads to serious harm to children.[15]

Surveys such as that by Clements and Aiello (2023) reveal that most FII allegations are unsubstantiated. Despite this, the trauma and practical impact of these investigations is severe. Parents describe being treated as guilty from the outset, with their concerns dismissed and attempts to advocate for their children interpreted as further evidence of abuse. These experiences, echoed by numerous parent groups and case studies, demonstrate the urgent need to address the harm caused by misidentification of FII and to reconsider the use of a label that can trigger disproportionate and damaging interventions.

Why FII should be consigned to the history books

There are many reasons why the label FII is unhelpful and in many cases harmful:

Significant and widespread harm through misidentification

The previous section outlined the serious harm that arises from misidentification. The widened criteria throwing attention on MUS, affecting 20% to 30% of adolescents, indicates the lack of adequate focus and alarmism in the RCPCH guidance.

In a safeguarding context

Safeguarding procedures and training in children's services, health and education raise alarm and encourage over-identification of FII. They encourage a wide range of staff to raise concerns about complex medical issues in which they have no competence. They do not provide a balanced picture acknowledging the high likelihood of alerting signs leading to misidentification and the harms this causes. Concerns about current guidance led the British Association of Social Workers to produce a guide[16] which warns social workers about the danger of a range of illnesses being misidentified as FII; the lack of evidence for the indicators used to identify FII put forward in the RCPCH Guidance; and the likelihood of a high incidence of them "identifying children where illness is neither fabricated or induced". However, this still leaves social workers having to challenge the power of medics who are backed by misleading guidance exaggerating risk.

In a medical context

The expansion of FII to MUS significantly widens the locus of suspicion to up to 30% of all adolescents. The idiosyncratic view that parents need to acknowledge their child's MUS as psychosocial, pathologizes disagreement and likely widens the serious harm recently found in treating undiagnosed autoimmune rheumatic diseases as MUS to many conditions where diagnosis is difficult and misdiagnosis common.

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[14] For example see Clements and Aiello 2023 and Bilson et al 2025

[15] see for example Bilson et al 2025, Wrennall, L. (2008). Misdiagnosis of Child Abuse Related to Delay in Diagnosing a Paediatric Brain Tumour. Clinical medicine. Pediatrics, 1, CMPed-S739.

[16] Long, C, Eaton, J, Russell, S, Gullon-Scott, F & Bilson, A (2022) Fabricated or Induced Illness and Perplexing Presentations: Abbreviated Practice Guide for Social Work Practitioners. Birmingham: BASW. https://www.basw.co.uk/resources/fabricated-and-induced-illness-practice-guide

The high levels of misidentification found in the surveys discussed earlier not only leads to significant harm to children and their families but also to considerable extra work for those exploring whether there is FII.

Placing the focus on investigating parental wrongdoings draws attention away from the actions of medical staff who are directly responsible for the harm caused by over-medication and failure to follow standard medical procedures in a high proportion of FII cases causing serious harm[17]. It can lead to a failure to identify systemic shortcomings such as those in a serious case review where the focus on investigating maternal wrong-doing drew attention from many failures to follow standard medical practices, or to identify a cluster of concerning practices in a single paediatric department[18].

In a legal context

Ryder J's caution about the use of the label FII was echoed more recently by Mr Justice Poole.[19] He noted that FII is not a medical disorder: it describes in general terms various forms of behaviour that may, or may not, amount to child abuse. Whether this is the case in any particular case depends on weighing broader facts and is outside the competence of medical staff. The Supreme Court of Queensland in *R v. LM* [2004] QCA 192 (cited with approval by Ryder J at para 174) expressed this succinctly in the context of an MSbP allegation.

> *The fact other people have done similar things in the past in unknown places and circumstances is not ordinarily the subject of admissible expert evidence. It has no or very limited relevance to the determination of whether this appellant has done acts or given false reports to intentionally harm her children.*

Conclusion

The legacy of MSbP with its exaggeration of the likelihood of murders lingers in the responses and concerns in the child protection system. The lack of research into all aspects of FII and the reliance on findings from the discredited MSbP misleads professionals. The untested alerting signs lead to understandable behaviours by parents with concerns about their child being treated with suspicion or formal investigation. Even where a suspicion is unfounded harm continues with medical records flagging a previous concern whenever a family member needs medical care.

The label FII is associated with a high level of misidentification causing harm to children disproportionate to the harms the use of the term is aimed to prevent. Whilst there are a small number of cases where parents/carers seriously harm their children, the FII label neither helps to prevent this nor to focus on the systemic underpinnings of over-medicalisation which cause the majority of harm to children. The very small number of cases where parents induce illness are crimes which should be investigated by the police.

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[17] Bilson and Talia

[18] See https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/filetransfer/2021CityAndHackneyChildAOverview.pdf?filename=CC18C70DB7C8C3D49403BB94EB176F95207E5F66235DCA89651F5ED2BA5DA9311A353B626CC31241A3DF9A46C646BD4F0695CA5374712D83BBD00C422BC93C365BAE68AE090A9032B357BF895387C1B37DE479DED2975E4A9A78A96BEC924919DF80339084&DataSetName=LIVEDATA

[19] BR & Ors (Three Families: Fabricated or Induced Illness: Findings of Fact) [2023] EWFC 326