

Preserving Immunity for Reporters of Medical Child Abuse

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All American jurisdictions have laws protecting children from abuse and neglect. Mandated reporters, including health professionals, whether their suspicions ultimately are substantiated or unfounded, are entitled to immunity when their reports are entered in good faith. When harm takes the form of medical child abuse (MCA, also known as Munchausen syndrome by proxy or factitious disorder imposed on another), its origin is ambiguous, at least initially. Questions arise as to whether the caregiver intended to deceive medical professionals and if the condition improved when the child was separated from the caregiver. Clinicians may have an obligation to report MCA in difficult-to-diagnose cases or those where parents press for hospitalizations and procedures. Substantiated cases may lead to removal of children from homes and criminal prosecution of parents. This can result in backlash against the reporter by the parents, with claims of malpractice, official misconduct, intentional harm, fraud or conspiracy to commit fraud, defamation (libel or slander), or all of the above. This article examines case law regarding alleged departures from good-faith reporting of MCA and explores potential limitations to immunity provided to mandated reporters. The findings include no significant instances in which the immunity shield for good-faith reporting was pierced.

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The need for communities to protect children from abuse and neglect has evolved into federal and state laws.^{1,2} The system for identification and investigation of perpetrators depends on mandated and voluntary reporters. Reporters, in turn, are expected to provide information on abuse and neglect in “good faith,” defined as the reporter having reason to believe that the child in question was being subjected to abuse or neglect.¹ The term good faith refers to the underlying rationale behind the report as being guided by proper moral, ethics, and medical professional guidelines. The receiving agency then decides whether or not to open an investigation, which could include a variety of downstream consequences: removal of a child, determination that the allegations were unfounded, determination that

abuse or neglect has likely taken place, dependency proceedings, and termination of parental rights (permanency hearing). It must be emphasized that, under ordinary circumstances, the original good-faith reporting is an event removed from the outcome of the investigation and proceedings, except that a reporter could be called to testify as to the facts of the report.

The Child Abuse Prevention and Treatment Act (CAPTA) of 1974,² updated in 2016,³ provides immunity for good-faith reporters. For criminal and civil actions arising from unfounded claims, immunity can be voided by bad-faith, knowingly false, or malicious reports.¹ The most common example of these situations is when one parent makes a knowingly false claim of child sexual abuse against the other. This may occur in the context of custody proceedings,⁴ for example, in children affected by parental relationship distress or in scenarios informally termed “parental-alienation.”⁵ It is not the place of a reporter to judge the underlying matter of abuse or neglect. Once the investigation is done, if the facts do not confirm abuse, the good-faith reporter is not liable for damages on the basis of false claims.

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Health professionals have a statutory duty to report child abuse and neglect, with guidelines on physician liability for failing to report, evolving from the 1976 landmark Supreme Court of California decision in *Landeros v. Flood*.⁶ Gita Landeros, an 11-month old child with multiple unexplained injuries was examined and returned home by Dr. Flood, who did not identify and report “battered child syndrome.” The child suffered additional injuries that, during the next medical visit, were identified as nonaccidental, prompting her removal from the home. In the personal-injury litigation against Dr. Flood, the doctor demurred, arguing that the subsequent injuries were not foreseeable. The trial court agreed, and Ms. Landeros appealed; the matter reached California’s high court. In its reversal of the trial court’s decision, the opinion cited that, since the battered child syndrome is an ongoing matter, it would be a matter for expert testimony, as well as circumstantial evidence, to help determine whether the discharge of the baby was negligent and that medical negligence was material to the subsequent injuries. The implication for Medical Child Abuse (MCA) cases is that, to the degree that MCA is analogous to battered child syndrome, clinicians have a duty to report it. The ambiguity of presentation and symptomatology in MCA cases complicates the question of negligence.

MCA falls under the current definition of abuse and neglect under CAPTA: “any recent act or failure to act of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation”; or “an act or failure to act which presents an imminent risk of serious harm.”¹ Failure of a mandated reporter to report can lead to negative consequences, including criminal prosecution. This reality, coupled with a low reporting threshold and downstream immunity, leaves professionals comfortable to report, which is CAPTA’s ostensive goal.

Cases of caregivers who knowingly create illness or injury in a child, or who subject a child to unnecessary medical procedures and examinations, are recognized under the label Factitious Disorder Imposed on Another in *DSM-5*.⁷ The situation has also been known as factitious disorder by proxy, Munchausen syndrome by proxy,⁸ caregiver-fabricated illness,⁹ and medical child abuse.¹⁰ While *DSM-5* recognition may give the appearance that perpetrators of MCA are mentally ill, for practical purposes such cases, where children or incapacitated persons are involved as victims, are generally regarded as criminal rather than

psychiatric matters.¹¹ Psychopathology in the perpetrator is not a prominent concern, at least until a court requests risk assessment; it adds confusion to the assessment.¹² Stating that an abusing caregiver experiences factitious disorder misplaces emphasis onto the abuser, whereas emphasis should always be on the child.¹¹ As a rule, a child injured by MCA will improve when separated from the offending caregiver.¹¹ The exact dynamics can then be considered in a dependency hearing.

MCA is a form of nonaccidental injury to a child. The term MCA, while placing emphasis on abuse, also refers to unnecessary and harmful treatments or procedures done to children but always instigated by a caregiver, not by health professionals. Generally, health professionals who perform interventions and procedures under the insistence of abusive caregivers are not considered complicit in the abuse itself but could be accountable for medical negligence. There could also be liability risk for clinicians who fail to suspect abuse (a standard-of-care matter) and thereby fail to report it (a statutory matter).^{6,13} In emergency room settings, MCA can be diagnosed and reported but, when time is limited and records are not always available, the path of least resistance may be for professionals to acquiesce to the caregivers’ wishes. More thorough screening tends to reduce the occurrence of false-negative reports,¹⁴ but it is not established that education in child abuse recognition increases overall reporting.¹⁵ When abuse is overlooked and there is subsequent harm, it may be possible for the examining physician to be sued for malpractice, but not all jurisdictions permit it.¹⁶ At the other extreme is the position that mandatory reporting can increase false negatives which, while not a malpractice concern for the immunized reporter, can create chaos and trauma within families as well as extra workload for authorities and their limited resources.¹⁷

Since MCA has been discussed extensively in professional literature and portrayed in media,^{18,19} it is worthwhile to revisit the principle of reporter immunity. This article explores allegations that certain reports of MCA have fallen outside good-faith reporting and are therefore fair targets of litigation. As will be demonstrated, most appellate decisions defer to the reporters.

Clinical and Ethics Domains of MCA Reporting

The need to protect children from caregivers is an unfortunate fact of life for health professionals, child-welfare agencies, and courts. MCA, because it presents as a medical problem, especially in the hands of a

medically knowledgeable caregiver,¹² raises questions for clinicians. For example, in young victims who cannot speak for themselves, gathering informant history is frustrated by caregivers' lying and alternate explanations for harm. Although emergency personnel and pediatricians are trained to identify these presentations of child abuse, MCA is not as easily detected in the first instance nor is the training to detect MCA by these providers adequate. As Yates and Bass put it, "Perpetrators of MCA exaggerate, falsify, simulate, or actively induce illness in children to convince pediatricians that medical attention is warranted," rendering history-taking invalid (Ref. 12, p 45). This is compounded by the fact that most pediatric conditions can be fabricated¹² and by the obligation clinicians have to conduct diagnostic investigations in the service of differential diagnosis.

Identification of MCA

There has been much published about the detection of MCA, which is beyond the scope of this article.¹¹ While the presentation of MCA is clinical, the result is often legal. It is unusual for forensic psychiatrists to be involved in the early stages of investigation, since caregiver characteristics are in the background. Accordingly, there is little literature on perpetrator characteristics. When Yates and Bass¹² reviewed the characteristics of 796 cases, over 95 percent of abusers were the victims' mothers, most married and in their twenties but with little identifying psychopathology (factitious disorder [imposed on self], 30.9%; personality disorder, 18.6%; and depression, 14.2%). It is apparent that improving detection of MCA will not succeed by screening parents for risk factors, profiling their psychopathology, or broadening the identification net, which would produce false positives.¹⁷ Indeed, we emphasize that using profiling heuristics to identify MCA perpetrators cannot be endorsed.

MCA represents a fraction of all child abuse, with estimates generally running under 1 percent.¹² It is sometimes seen within the broader category of false reports.²⁰ In MCA, the false information is made by the caregiver, with several dynamics identified for the tactical use of such false claims (usually for the purpose of harming a co-parent). Petherick²⁰ has listed several scenarios: angry children accusing their parents, one spouse attempting to alienate the other from the family, child custody disputes, delusional ideas of the reporter, revenge, mistaken belief, and others. When the

accused is arrested, prosecuted, and disgraced in the community, great damage has been done, not entirely reversible by recantation or exonerating evidence. In the case of MCA, an abuser may play the victim and, when cornered, accuse health professionals and welfare systems of malfeasance or defamation.

Ethics Considerations

Although good-faith reporting of all child abuse is required of health professionals, it would not be appropriate for clinicians to diagnose it and bypass appropriate diagnostic procedures. The adage "never worry alone" applies here. The determination of MCA is a calculus of index of suspicion and diagnostic rule-outs. Therefore, it is imperative that the initial impression be shared among various professionals, whether in an emergency setting or elsewhere. Having too low a threshold and labeling caregivers as perpetrators of MCA may result in legal action against clinicians and facilities. An impulsive, overzealous, or poorly conducted examination may result in missing an underlying medical condition. Faulty investigations leading to removal of children have been challenged on the basis of information verifying nonfabricated conditions and exonerating the caregivers. Whereas reporters, acting in good faith, are immune to claims of malpractice, and investigators who determine that abuse was unfounded are similarly protected, carelessly or maliciously conducted reporting, investigations, and testimony may incite angry parents. Sharing the responsibility to initiate a well-grounded child abuse report respects both the child and the caregiver. Since the workup may take time, the typical principle is for the facility to retain the child. In this way, the problem of premature discharge, as seen in the case of Gita Landeros, can be avoided. The parents may be angry and indignant and raise the specter of legal action, but this, by itself, is not diagnostic. The best approach is for a clinical team to confer with the caregivers, rather than having a single evaluator become a lightning rod and later a defendant. The balance between protection of children and respect for the autonomy of parents is a difficult, but navigable, task. While it is unusual for a psychiatrist to be called to "diagnose" MCA, we see potential for early involvement, either to assist in the identification of MCA or in the logistics of approaching caregivers.

The need for protection of reporters, agencies investigating reports, law enforcement officers and others acting under the auspices of the state must also be addressed. This protection comes often in the form of

qualified immunity, a legal concept employed by defendants in a lawsuit. When successfully invoked, it can lead to summary judgment for defendants,²¹ which can be appealed.²² Granting summary judgment may resolve insubstantial claims and spare government officials the burden of litigation, thus supporting reporters.²¹ The prospect of summary judgment has no place in the ethical analysis of developing a threshold for reporting MCA. That is a clinical matter with a legal mandate that must never be addressed by a reflex mentality.

The following section includes examples of lawsuits initiated by parents who believed they were wronged but whose cases were halted by defendants' immunity. The references, used for illustrative purposes, are to appellate decisions, limiting the scope of review.

Case Law Vignettes

The legal searches on Nexis Uni and Google Scholar used search terms such as "Munchausen AND malpractice," and "Munchausen AND defamation OR slander" in federal and state jurisdictions. There will be no attempt to apply metrics to these cases since, in the authors' view, they do not yield a representative sample of litigation in America, only examples of legal reasoning. The following cases were identified as scenarios likely to be involved in litigation concerning perceived adverse outcomes relating to MCA reporting. They include court-ordered evaluations and legal proceedings, clinical practice, and the agencies responsible for investigating and managing reports of abuse.

Evaluators in Legal Proceedings

Individuals ordered by courts or acting as arms of the court (e.g., child-protection investigators) encounter a variety of psychopathology among evaluatees. During the course of their duties, evaluators may initiate the reporting process for individuals they determine are at risk of MCA as the unwitting party in factitious disorder imposed on another, namely children. The reporting process and management are no different from other situations, but the mention of MCA can be inflammatory.

Doe v. Sywulak (2010)²³

A psychologist diagnosed MCA (Munchausen by proxy) in a situation where a seven-year-old boy, T.K., was reported to have homicidal and suicidal ideations

during the court-ordered custody evaluation. The psychological findings in 2007 included that T.K.'s mother, the plaintiff, taught him to mimic psychiatric symptoms such as bipolar disorder. The trial court awarded custody to the father and limited visitation to the mother. A year later, the report was disqualified for its Munchausen by proxy finding. In 2009, the mother sought restitution, charging the psychologist with malpractice, negligence, breach of contract, civil rights violations, defamation of character and intentional infliction of emotional duress under federal (42 U.S.C. §§ 1983, 1985, and 1988; hereafter § 1983²⁴) and Pennsylvania laws. The defendant psychologist argued entitlement to judicial immunity.

The U.S. District Court found in favor of the defendant, Dr. Sywulak, dismissing the federal counts with prejudice. The state claims were dismissed without prejudice (lack of jurisdiction). This decision was grounded in a Third Circuit opinion from 2001: *Hughes v. Long*²⁵ stated that court-appointed doctors charged with conducting custody evaluations are viewed as "arms of the court" and receive judicial immunity because of the important "quasi-judicial" functions they perform during child custody proceedings. Thus, irrespective of what the court determined was an unfounded accusation of a psychological problem in the plaintiff, and the chaotic results therefrom, the defendant could not be held responsible for alleged harm. Ultimately, the parents achieved joint custody. The federal court did not have jurisdiction over a malpractice claim.

Cooney v. Rossiter (2009)²⁶

Deborah Cooney lost the custody of two children following a court-ordered psychiatric evaluation finding MCA (Munchausen by proxy). She sued the judge, all attorneys involved, and experts, including the court-appointed psychiatrist, defendant Dr. Lyle Rossiter, in Illinois state court. She claimed "numerous . . . conspiratorial acts and violations" (Ref. 26, p 970) as bases for the litigation. The trial judge dismissed her suit, as did a federal district court, which cited immunity for the judge, psychiatrist, and attorney for the child. Ms. Cooney appealed.

The appellate decision dismissed the claims against all parties involved, as there was no evidence of conspiracy among defendants in addition to the immunities noted. Thus, the court affirmed that court-appointed professionals, including psychiatrists, and attorneys acting in the interest of children are

absolutely immune from liability when they are acting at the direction of the court. The appellate court stated: “Experts asked by the court to advise on what disposition will serve the best interests of a child in a custody proceeding need absolute immunity to be able to fulfill their obligations without the worry of intimidation and harassment from dissatisfied parents” (Ref. 26, p 970, internal citation omitted). By acting as arms of the court, experts were granted immunity.

Evaluators in the Clinic and Summary Judgment

There are many responsibilities in clinical practice, stemming from state and federal regulations, to protect children and other vulnerable populations. These groups are afforded extra protections and may need proxies to protect their interests. Given the amount of exposure faced by clinical providers, the mandate to report may lead to backlash from aggrieved parents.

Myers v. Steiner (2011)²⁷

Dawn Myers, a divorced woman in Ohio, had three children, one of whom died from mitochondrial dysfunction. The youngest child, M.M., had similar symptoms and received the same diagnosis. Mitochondrial disorders often present with reports of multiple neurological symptoms, typically nonfocal, or present with failure-to-thrive symptoms. This limits the likelihood of a prompt diagnosis such that MCA concerns may be raised before the actual diagnosis itself is made.^{28,29} During M.M.’s hospitalization for nasal congestion and fever in 2007, there was a noted disparity between the reported condition and the physical examination findings, triggering suspicion. The attending referred the matter to Dr. Daryl Steiner, a pediatrician, who convened clinicians who had treated M.M. over time. No one could determine who made the diagnosis of mitochondrial dysfunction, and the group concluded that Ms. Myers’ reporting had been suspicious. Dr. Steiner reported to Children Services that the scenario was consistent with Munchausen by proxy. The Children Services representative concluded that M.M. should be removed from Ms. Myers’ custody, and, with the assistance of M.M.’s guardian *ad litem*, the child was moved to the father’s care. Dr. Steiner testified as to the basis for his conclusion, citing the consensus opinion of clinicians.

Ms. Myers sued Dr. Steiner and his employer for medical malpractice (incorrect “diagnosis” of MCA),

fraud (knowingly making false statements), and defamation (making false statements during the emergency custody hearing). Dr. Steiner and the hospital moved for summary judgment, claiming statutory immunity for the report and testimony and that the doctor had no doctor–patient relationship with Ms. Myers. The trial court granted the motion, and Ms. Myers appealed.

On the question of immunity, Ms. Myers presented an interesting legal argument to the effect that Dr. Steiner stepped outside of his role of mandated reporter when he discussed the matter with others, including the attorney who had represented M.M. during divorce proceedings. The appellate court rejected this argument and granted Dr. Steiner absolute immunity for his testimony, which was related to the underlying case. The plaintiff also accused the defendant of failing to act in good faith during hearing testimony, and the appellate court rejected this too. The plaintiff having failed on all counts, the decision affirmed the trial court’s finding of immunity and granting summary judgment. Specifically, Dr. Steiner faithfully discharged his duty to report child abuse, had no duty of care to Ms. Myers, provided protected testimony, and did not defame Ms. Myers by virtue of the MCA formulation. There was a dissenting opinion to the effect that, while Dr. Steiner enjoyed statutory immunity for reporting and related testimonial privilege, his statements to M.M.’s former guardian *ad litem* fell outside statutory immunity. The dissent also suggested that Dr. Steiner went outside of his role by diagnosing a condition in Ms. Myers, a person he had not examined, thus raising a legal concern.

Deeths v. Packard Children’s Hospital (2013)³⁰

Dr. Christine Deeths, a family physician and adoptive mother, had her children removed following an emergency room evaluation of her four-year-old daughter, R.D., by pediatrician Dr. Anthony Thomas in 2011. Dr. Thomas concluded there was MCA, although it appears he had mistaken R.D. for another patient with cystic fibrosis. The doctor transmitted information to others that this was a Munchausen by proxy case, and after two weeks, the child was transferred to the Stanford facility. Dr. Deeths lost custody of both children. In her civil rights suit (§ 1983), she claimed that Dr. Thomas “knowingly and falsely” misrepresented facts, resulting in a conspiracy to perpetuate the harmful MCA diagnosis and out-of-home

placement of her children. Dr. Thomas responded that he was not working for the state and not subject to § 1983 and that he had immunity in the context of a juvenile dependency proceeding, thus entitling him to dismissal. Dr. Thomas failed to persuade the court, which dismissed the other defendants. The district court ruled that Dr. Thomas, while not an extension of the court, had been functioning similarly to a law enforcement officer. In 2014, Dr. Thomas was dismissed from the suit. The ultimate outcome did not favor the contention of Dr. Deeths, but nevertheless, the court denied the motion made by Dr. Thomas. In a related matter, in early 2013, on behalf of Child Protective Services, Kern County settled with Dr. Deeths and removed her name from the child abuse registry.³¹

The holdings of the court suggest no absolute immunity from claims of fabricating evidence during an investigation for a juvenile dependency proceeding, though the question was not tried. It appears that, prior to these proceedings, the county returned the children.³¹ Nevertheless, the limits of good faith are implied here. While it is not clear that Dr. Thomas maliciously used his position to remove Dr. Deeth's children, there is a gray area between an honest mistake and a negligent act that could add traction to a lawsuit and nullify an argument for immunity.

Investigating Agencies

After reports are made, the investigating agencies assume the responsibility discharged by the reporter to determine if abuse can be substantiated and to recommend further action. These groups vary state to state and even county to county. They consist of a wide variety of individuals with qualifications ranging from high school/undergraduate-educated individuals to masters-level clinicians. No patient-provider relationship exists, akin to that of court-ordered evaluators, but they have been targeted for legal recourse following investigation of MCA reports.

Nash v. Cleveland Clinic Foundation (2015)³²

This case, originating in 2002, involved twins, S.C. and A.B., the former dying in foster care in 2004. The premature newborns had been drug-exposed and were placed into the foster care of the Bajc family. Following a report of Munchausen syndrome by proxy they were removed from the Bajcs and placed in separate homes. S.C.'s death was determined to be accidental (aspirated vomitus), and A.B. was returned to the Bajcs. The plaintiff, Amy Nash, was the administrator of S.C.'s estate.

Table 1. Sources of False Allegations of Abuse⁵

Cultural beliefs and investigative biases
Ideological agendas
Judicial and legislative changes
Moral crusades
Suggestive interviewing
Misinterpretation of real events
Miscommunications regarding sexual consent
Cognitive biases
Individual motives and drivers
Self-serving false narratives of abuse
Providing an alibi
Seeking revenge or retribution
Obtaining sympathy and attention
Financial gain
Sincerely believed false allegations
Partly true allegations
Parental alienation syndrome and custody disputes
Factitious disorder and Munchausen syndrome by proxy (MCA)
False confessions

She and the Bajc family filed a claim of wrongful death with allegations that the county employees of the investigating agency created a false suspicion of MCA and thereby interfered with her guardianship interests for the twins by defaming her. The ultimate outcome was summary judgment for the defendants.

The holdings stated that employees of a political subdivision of the county or state are immune from liability unless the acts or failures to act were done with some malicious purpose, in bad faith, or in a wanton or reckless manner. Such immunity was expressly imposed for civil liability protection.

Discussion

There are many circumstances that give rise to false allegations of abuse. Goodyear-Smith⁵ has identified them as cultural beliefs, investigative biases, and individual motives and drivers. Individual dynamics are listed in Table 1. It is apparent that sorting among these scenarios before making a report would be a daunting task for both mandated reporters and investigators. Yet errors in interpreting social or medical findings and individually motivated deceptions are themes that pervade litigation in child dependency cases. Litigation in MCA cases has added complexity, as it involves attribution of deception to the caregiver and demands objectivity and honesty of the reporter or investigator.

Although the case review did not disclose significant civil exposure for reporters, the findings included causes of action well beyond simple negligence or malfeasance. In the vignettes, complaints included malpractice,

negligence, breach of contract, civil rights violations, defamation of character and intentional infliction of emotional duress (*Doe v. Sywulak*),²³ conspiracy (*Cooney v. Rossiter*),²⁶ fraud (*Myers v. Steiner*),²⁷ fabricating evidence (*Deeths v. Stanford*),³⁰ and wrongful death (*Nash v. Cleveland Clinic*).³² The suggestion of MCA, especially characterized as Munchausen syndrome by proxy, as a basis for litigation has extended into social media³³ and news reporting³⁴ domains via claims of defamation. Journalists are not immune if they publish wrong and harmful statements that a person has a “foul or loathsome disease,”³⁴ which easily could include MCA (often misinterpreted as a condition in the perpetrator, as seen in the cited cases).

With MCA becoming a flashpoint in civil litigation, especially as Munchausen has become a household word and the subject of print and television drama,^{18,19,35} there could be a chilling effect on mandated reporters fulfilling their duty.³⁶ Though we did not investigate it, the subject is ripe for inquiry. Nevertheless, from a provider’s and an investigator’s standpoint, reporting MCA could represent risks. Immunity *per se* provides minimal comfort, since the fact of being sued and the attendant stress and stigma, compounded by legal processes to obtain summary judgment (not assured), are dreaded prospects.

Appropriate diagnostic measures must be taken when MCA is suspected prior to labeling a potential perpetrator of abuse.³⁷ This could include hospital observation of the child, whose condition is likely to abate upon separation. Nevertheless, the reporting process should and must proceed amid these concerns. Having too low a threshold for an MCA impression may raise the risk of legal action against clinicians, facilities, and the agencies investigating reports. Too high a threshold can lead to further suffering or death. This is salient in situations where MCA is coupled with false statements by indoctrinated children.³⁸ Other forms of distortion are cultural, as a Canadian legal scholar noted, whereby revulsion of bad mothers “invites professionals to infuse alleged cases of [Munchausen syndrome by proxy] with morality, gender attributions, and social judgements” (Ref. 39, p 217).

There is much work to be done to help clinicians calibrate interpretations of intrafamilial dynamics, including children’s statements.⁴⁰ The European Court of Human Rights has observed that in a case where MCA was reported prematurely, “the Court stressed that the doctors involved should have made arrangements to discuss their concerns with the parents and should have given them an opportunity to dispel

those concerns” (Ref. 41, p 120). The key, according to an article from the United Kingdom, resides in good-faith reporting, as painful as it may be to diagnose MCA in a family known to the provider.⁴² Nevertheless, as a legal commentator observed, the rights of parents to make medical decisions has led to false positive MCA determinations due to a faulty medical lens.⁴³ We again emphasize the need to broaden the array of clinical eyes on a child and family before an MCA determination is set in motion. The focus could be sharpened by the employment of forensically attuned clinicians within a multidisciplinary team.

The cases from the United States and Europe generally protected reporter immunity when individuals acted as arms of the court, in their official capacity on behalf of the court, and when no legitimate claims of bad-faith reporting were made. Immunity applied to clinical practitioners and investigating bodies. No clear instance of substantiated bad-faith reporting warranting effective recourse in civil litigation was identified in this review of appellate decisions. Defendants in these cases sought summary judgment by asserting qualified immunity status in the context of having no open legal questions. When qualified immunity is granted, there is no need for further legal proceedings in these civil matters. This shielding of government officials has extended to those acting in their capacity as mandated reporters.

The courts opined that good faith must be given broad definition to ensure that mandated reporters feel protected in stating the bases of their reports. Following CAPTA^{1,2} and *Landeros v. Flood*,⁶ it is crucial to ensure protections for reporters such that they continue to endeavor to protect children despite the potential attempts for legal recourse sought by disgruntled parents. These protections survive despite added scrutiny in the cases in claims of MCA, whether rooted in arguments of character defamation, negligence, or conspiracy.

The cases reviewed largely involved instances in which the plaintiffs, reported for MCA, lost their children and filed suit against mandated reporters and the investigating agencies claiming defamation, conspiracy, or negligence. Reporters often do not participate in pre-litigation proceedings and may benefit from a variety of steps described by Roesler and Jenny.¹⁰ These include correction of the underlying harmful behaviors, a multidisciplinary team assessment, placement of the child, and others. In this way, the false-positive rate for MCA would be reduced. In the event of litigation, the original reporter, while named in the

complaint, will be less stigmatized and isolated. Claims against mandated reporters that have merit must be explored, since unfounded MCA reports create significant distress and disruptions among families who feel violated by the process. Reporters nonetheless must be vigilant in maintaining focus on the victims of abuse amid the allure of analyzing perpetrators' psychopathology.⁴⁴ The process continues to maintain emphasis on the protection of immunity when reporting child abuse, thus supporting good-faith reporting. The presumption of immunity will continue to be heavily weighted in the judicial decision process.

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