

Reporting Child Abuse and Neglect: Good Faith Immunity for Health Care Providers*

Theodore R. LeBlang, J.D.

Abstract

To protect the health, safety and well being of children, the Illinois Abused and Neglected Child Reporting Act grants good faith immunity from liability to those who are required to report suspected child abuse or neglect. This author explicates the legal concept of good faith immunity and uses key legal cases to frame its applicability in health care settings. Discussion is offered regarding the conditions under which such immunity is available. Emphasis is placed on the importance of the reporter's motives in making a report.

Introduction

Under the Illinois Abused and Neglected Child Reporting Act (Reporting Act),¹ physicians, hospitals, and other health care providers are among an extensive group of persons required to report suspected child abuse or neglect. This reporting mandate forms part of a comprehensive scheme intended to advance the state's important interest in identifying child abuse and neglect and protecting the health, safety, and best interests of children.²

The Reporting Act requires health care providers and various other persons to report immediately to the Department of Children and Family Services (DCFS) any child encountered in a professional or official capacity whom the reporter has reasonable cause to believe may be abused or neglected.³ To overcome concern about potential liability in connection with making reports as required by law, and to affirmatively encourage such reporting, the statute provides immunity from liability as follows:

Any person, institution or agency, under this Act, participating in good faith in the making of a report or referral, or in the investigation of such a report or referral or in the taking of photographs and x-rays or in the retaining [sic] a child in temporary protective custody or in making a disclosure of information concerning reports of child abuse and neglect in compliance with Sections 4.2 and 11.1 of this Act shall have immunity from

any liability, civil, criminal or that otherwise might result by reason of such actions. For the purpose of any proceedings, civil or criminal, the good faith of any persons required to report or refer, or permitted to report, cases of suspected child abuse or neglect or permitted to refer individuals under this Act or required to disclose information concerning reports of child abuse and neglect in compliance with Sections 4.2 and 11.1 of this Act, shall be presumed.⁴

Significantly, this immunity, which derives from section 9 of the Reporting Act, attaches when a person participates in good faith in the making of a report of child abuse or neglect. Nearly every case construing section 9 immunity involves litigation against a physician, hospital, or other health care provider—thus the emphasis of this article. Moreover, in each of these cases, critical focus is directed at answering the following questions: What is “good faith”? And, when a reporter's good faith is presumed, what evidence is needed to rebut this presumption? The following case review offers a meaningful legal framework for consideration of these and other related questions.

I. Good Faith Immunity From Liability

The often-cited case of *Lehman v Stephens*⁵ sets forth an excellent discussion of good faith immunity as it applies to health care providers who make a report of suspected child abuse or neglect. There, plaintiffs took their 16-month-old son, Matthew, to Carle Foundation Hospital after he suffered an injury to his right leg. The examining physician, Dr. Frank Stephens, inquired about the child's injury. The plaintiffs informed Dr. Stephens that Matthew had been playing in their home by himself or with his older brother when they heard him cry out. They found him on the floor in another room, crying and unwilling to bear weight on his right leg.

Dr. Stephens diagnosed the child's injury as a spiral fracture of the right tibia. He considered the

*Reprinted with permission of the Illinois Bar Journal, Vol. 92 #7, July 2004. Copyright by the Illinois State Bar Association.

injury to be “suspicious” given the “twisting type” of force typically needed to cause such a fracture, and what he viewed as the less than satisfactory explanation given by the parents. Because this injury normally does not occur when a child falls down, and because Dr. Stephens felt the parents seemed somewhat “unconcerned” about the severity of the injury, he decided to admit the child to the hospital for observation despite the parents’ objections. He also made a report of possible child abuse or neglect to DCFS in accordance with the requirements of the Reporting Act.

A DCFS caseworker contacted Dr. Stephens to discuss the case. She also interviewed the parents. Two days later, the child was released from the hospital and returned home. Apparently, the caseworker concluded that there was no credible evidence of child abuse or neglect, and determined the case to be “unfounded.”

A lawsuit was subsequently initiated against several defendants, including Dr. Stephens and Carle Hospital, claiming they were guilty of slander, unlawful restraint, false imprisonment, and battery. Dr. Stephens and Carle filed a motion to dismiss on the basis that they were statutorily immune from liability under the Reporting Act.

In an affidavit to support the motion, Dr. Stephens stated “he believed ‘to a reasonable degree of medical certainty’ that Matthew may have been an abused or neglected child.”⁶ Further, Dr. Stephens explained that he made his report to DCFS in good faith, based upon his examination of the child, his conversation with the parents, and his clinical skill and expertise. The trial court entered an order dismissing the action against Dr. Stephens and Carle.

Numerous issues were raised on appeal, including the constitutionality of the Reporting Act and its immunity provisions. Finding the statute to be constitutional,⁷ the court reviewed the nature and scope of the immunity provided to those who report suspected child abuse or neglect to DCFS.

In this regard, the court noted that the statutory immunity provisions do not afford absolute immunity but rather “good faith immunity.” This immunity is specifically available to “reporters.” Moreover, the good faith of such persons is presumed. Accordingly, the court stated that “the defendants here are statutorily presumed to have acted in good faith, and therefore be [sic] immune from suit, when they reported a case of suspected child abuse or neglect.”⁸ Furthermore, because the presumption of good faith is rebuttable, it is “incumbent upon the

party against whom the presumption operates to come forward with evidence sufficient to meet the presumption.”⁹

The court emphasized that Illinois recognizes a “bursting bubble” theory with respect to such presumptions. That is to say, “once evidence is introduced contrary to the presumption, the bubble bursts and the presumption vanishes.”¹⁰ Accordingly, when a party endeavors to rebut the presumption, evidence must be offered that is “sufficient to support a finding of the nonexistence of the presumed fact.”¹¹

Against the background of these considerations, including evidence to suggest that DCFS had determined the case to be “unfounded,” the court ruled that the plaintiffs had failed to present any evidence that would rebut the presumption of good faith running in favor of Dr. Stephens. Accordingly, the judgment of the lower court, dismissing the plaintiffs’ complaint, as it related to Dr. Stephens’ report of child abuse or neglect, was affirmed.

The *Lehman* case offers a more comprehensive analysis and discussion of these issues than is reflected above. Nevertheless, the case firmly roots the immunity protections granted to health care providers who report cases of suspected child abuse or neglect in accordance with state law. It also sets what may be viewed as a notably high bar for plaintiffs who seek to rebut the presumption of good faith that applies in this context.

Similar judicial thinking is apparent in numerous cases decided since *Lehman*.¹² One case is *Franciski v University of Chicago Hospitals*.¹³ Under the facts of this case, Keegan Evanauskas was born in June of 2000 at Community Hospital in Munster, Indiana. He was transferred to University of Chicago Hospitals (UCH) and placed in the neonatal intensive care unit because of a diagnosis of congenital diaphragmatic hernia. Keegan underwent various operations to correct his condition and spent the first seven months of his life at UCH.

Following discharge in January of 2001, it was necessary to readmit Keegan to the hospital on two occasions. During the first readmission, one of Keegan’s parents, Sherry Franciski, became angry because of a particular incident in the hospital. Her behavior caused hospital staff to make a report to Indiana Child Protective Services (ICPS), which indicated she had been “combative and verbally abusive.”¹⁴ Shortly thereafter, during a second hospitalization at UCH, a blood infection was discovered. Keegan was admitted to the Pediatric Intensive Care Unit (PICU) in early February of 2001, where he

remained until his death, approximately four months later.

During the course of this hospitalization, the relationship between Keegan's parents and hospital staff was difficult. There were several situations in which Keegan's parents verbally abused nursing staff and other hospital employees. On one occasion in late May of 2001, an angry interaction occurred that concluded with Franciski demanding to see a supervisor. The PICU Medical Director, Dr. Madelyn Kahana was contacted. She asked the on-call hospital administrator to speak to the parents.

The administrator arrived and the angry interaction resumed. When the administrator asked the parents to calm down, they refused, and he warned them he would call security. The situation became worse, hospital security was contacted, and the parents were escorted from the premises. The administrator and the charge nurse who were involved in the incident reported the matter to Dr. Kahana. She was aware of various complaints regarding prior incidents during which the behavior of Keegan's parents included loud, hostile, and aggressive interactions with hospital staff. Accordingly, the following day, Dr. Kahana asked the UCH social worker to contact ICPS to request an investigation because it appeared that Keegan would be discharged soon and Dr. Kahana had concerns about whether the parents would be able to control their anger at home.

An investigation was promptly conducted by ICPS, which resulted in an "unsubstantiated" determination. Keegan's caseworker informed UCH staff that Keegan could be discharged "as soon as he was medically ready."¹⁵ At about this same time, hospital administration refused to allow Keegan's parents further visitation until they met with hospital representatives to discuss appropriate behavior within the hospital. Before any such meeting had taken place and when Keegan's condition unexpectedly deteriorated, his parents were permitted to visit him without restriction. Keegan died in the hospital days later.

A lawsuit was subsequently initiated against UCH on numerous grounds, including a claim that the hospital defamed Keegan's parents by reporting them to ICPS. A motion for summary judgment on all grounds was filed by UCH and the district court granted the motion in its entirety, relying, *inter alia*, on the immunity provisions of the Reporting Act. On appeal, with respect to the defamation claim, the parents asserted that the district court improperly ruled "that they failed to rebut the good-faith presumption accorded reporting physicians under the Illinois

Abused and Neglected Child Reporting Act...."¹⁶ The question of whether or not the immunity provisions of the Illinois Reporting Act applied to a report made to ICPS, as opposed to DCFS, was not before the court.

In considering the parents' claim, the court noted that, under the Illinois Reporting Act, "any physician...having reasonable cause to believe a child known to them in their professional or official capacity may be an abused child or a neglected child shall immediately report or cause a report to be made...."¹⁷ Moreover, any physician "participating in good faith in the making of a report or referral...shall have immunity from any liability, civil, criminal or that otherwise might result by reason of such actions."¹⁸ The Reporting Act also specifies that the good faith of a physician making such a report is presumed. Nevertheless, the court observed that this presumption is rebuttable. However, "the party seeking to rebut the presumption must present evidence 'sufficient to support a finding of the nonexistence of the presumed fact.'"¹⁹ Thus, the court stated: "[a]ppellants must offer evidence that tends to show Dr. Kahana reported them to ICPS in bad faith—a showing they simply cannot make."²⁰

In the view of the court, Dr. Kahana's decision to cause a report to be made was based on the nature of the parents' outburst in the PICU, as well as complaints from UCH staff regarding similar improper behavior on previous occasions. Furthermore, Dr. Kahana believed "Keegan was a medically complex child in need of constant care and attention—something parents quick to 'fly off the handle' might be ill equipped to perform."²¹

Keegan's parents argued that Dr. Kahana reported them despite lack of direct evidence of abuse, such as an injury. The court explained, however, that Illinois law contemplates the possibility of future abuse as a basis for child abuse reporting.²² Accordingly, the court stated: "Given [the parents'] behavior over the several months that Keegan was hospitalized at UCH, and in particular the Memorial Day [PICU] incident, Dr. Kahana had reasonable cause to report them in good faith to ICPS."²³ The decision of the district court, granting summary judgment in favor of UCH, was therefore affirmed.

II. Rebutting the Presumption of Good Faith

As reflected in the Lehman and Franciski decisions, courts appear to favor the presumption of good faith when applying statutory immunity to health care providers who report suspected child abuse or neglect.

Only palpably wrongful conduct seems adequate as a basis for effectively rebutting this presumption. One case that merits consideration in this regard is *Lipscomb v Sisters of St. Francis Health Services*.²⁴

In *Lipscomb*, the plaintiff took her eight-year-old daughter, Nicole, to the defendant's Chicago Heights hospital emergency room for treatment of a fever. Various laboratory tests were performed, including a urinalysis. When test results became available, the plaintiff was informed that the urinalysis indicated the presence of "trace amounts of spermatozoa." Because of this finding, the plaintiff was informed that the defendant was obligated to report to DCFS and the local police department that Nicole may have been sexually abused.

Chicago Heights police immediately arrived at the hospital and questioned the plaintiff. She insisted there must be some mistake with the testing and asked for a second urinalysis. Although the repeat urinalysis revealed that no spermatozoa were present, the defendant insisted on performing a vaginal examination. This examination revealed no evidence of abuse. The defendant then apologized to the plaintiff for any humiliation or distress caused by the mistake. Separately, the defendant explained that Nicole's fever could not be treated at its Chicago Heights location and that she would be transferred to the defendant's Olympia Fields location by ambulance.

Following transfer and admission, health care providers at Olympia Fields questioned the plaintiff and Nicole about child abuse. They insisted on performing further vaginal examinations and they apparently recontacted DCFS about possible child abuse. Moreover, they told the plaintiff that she would not be allowed to take her daughter home until DCFS authorized the release. The plaintiff made repeated efforts to apprise the defendant's staff at Olympia Fields that the Chicago Heights personnel indicated there had been a laboratory error and that they had determined Nicole was not a victim of sexual abuse. The defendant still refused to allow the plaintiff to take Nicole home on December 24, 2000, despite the fact that Nicole's fever had subsided.

On December 25, the plaintiff conveyed her dismay to a hospital physician that DCFS had not yet contacted her regarding the allegations of abuse and the physician agreed to call DCFS. At that point, a DCFS employee explained there was no record of a case report but that the physician's call on December 25 would constitute such a report. It was not until December 26 that Nicole was officially "cleared and released" by DCFS.²⁵

A lawsuit was subsequently initiated against the defendant alleging false imprisonment, invasion of privacy, battery, intentional infliction of emotional distress, and defamation. The trial court dismissed the lawsuit on the basis that the defendant was immune from liability under section 9 of the Reporting Act.

On appeal, the court reviewed the immunity provision contained in the Reporting Act, noting that section 9 immunity is provided to a person who, in good faith, makes a child abuse report or referral or investigates the same. The court also noted that the good faith of any person required or permitted to report is to be presumed. In this regard, the court emphasized that the presumption of good faith applies only with respect to "reporting" under the statute. Section 9 does not afford a presumption of good faith in the context of "investigating" such a report.²⁶

The court went on to explain that, following the rationale in *Lehman*, if the defendant is entitled to a presumption of good faith, such a presumption may be rebutted under the "bursting bubble" theory. Thus, if the party intending to rebut the presumption comes forward with evidence that supports "a finding of the nonexistence of the presumed fact," then "the presumption would cease to operate."²⁷ At that point, the issue in dispute, i.e., the good faith of the reporter, "would be determined as if no presumption ever existed."²⁸

The court then examined the challenged behavior at the defendant's Olympia Fields location. There Nicole was subjected to questioning about child abuse and multiple vaginal examinations, despite the fact that the second urinalysis and vaginal exam at the Chicago Heights location did not reveal any evidence of sexual abuse, and even resulted in an apology. The court stated: "Aside from the first urinalysis which was misidentified as Nicole's, none of defendant's questioning or examinations demonstrated any evidence that Nicole had been sexually abused."²⁹

Although DCFS apparently was "recontacted" about possible abuse while Nicole was at the Olympia Fields location, the court viewed the defendant's behavior at that location as involving primarily an investigation of child abuse rather than a report. Consequently, the court found the presumption of good faith did not apply. Nevertheless, the court stated as follows: "Assuming *arguendo* that the acts complained of were 'reporting,' the allegations in the complaint, if taken as true, along with plaintiff's affidavit, raise questions of fact so as to rebut any presumption of good faith at this stage of the proceedings."³⁰

Despite this observation, the court emphasized that the question of whether the plaintiff would eventually prevail at trial was not before the court. Rather, the court focused solely on whether the plaintiff's allegations could withstand a motion to dismiss. The court found that they could and the order of the trial court was reversed.

Lipscomb thus illustrates a fact pattern where the court was willing to rule that the statutory presumption of good faith could be rebutted, at least for purposes of considering a motion to dismiss. However, the evidentiary bar to success in this regard was set quite high.³¹

III. The Relationship Between Good Faith Immunity and Medical Negligence

It is clear that when a health care provider participates in good faith in making a report of child abuse or neglect, he or she is immune from civil or criminal liability. Will this immunity be lost, however, if a health care provider is negligent in making the diagnosis that gives rise to a report of child abuse or neglect? Case law seems clear that the answer to this question is "no". However, when a health care provider's negligent conduct is entirely separate from actions necessary to make a diagnosis or a report of child abuse, section 9 immunity will not be applicable.

In *Nosbaum ex rel. Harding v Martini*,³² divorced parents Laurence Nosbaum and Monica Harding had joint custody of their minor daughter, Jesse. In July of 1996, Mr. Nosbaum brought Jesse, then age five, to the emergency room at Lutheran General Hospital. He stated that she was suffering from vaginal irritation and suggested she may have been sexually abused by Monica's husband, Scott.³³ The matter was referred to the hospital's child protective services (CPS) team. Dr. Susan Martini was a member of this team. According to Dr. Martini, Mr. Nosbaum provided her with additional information to suggest that Jesse may have been the victim of sexual abuse, including a statement that "Jesse said she 'played doctor' with her stepfather (Scott)."³⁴

Dr. Martini then performed a colposcopic examination on Jesse, concluding that the diameter of her transhymenal opening was 20 or 21 millimeters, which she described as abnormal. Dr. Martini stated that such an opening might be indicative of sexual abuse or that it may have resulted from digital manipulation by Jesse. She suggested to Mr. Nosbaum that he make a report to DCFS, but he declined. She also requested that Kim Seltzer, a hospital social worker,

call DCFS to find out if they thought a report should be filed. Ms. Seltzer then spoke to Mr. Nosbaum. Based on the history elicited from him, Ms. Seltzer made an oral report of suspected child abuse to DCFS three days later. In her subsequent written report, filed seven days after the oral report, Ms. Seltzer indicated that evidence of suspected abuse included Mr. Nosbaum's "concerns about Jesse's statements & behavior" and the "abnormal medical exam."³⁵

In a separate custody proceeding, Mr. Nosbaum then filed a petition requesting, inter alia, that he be given custody of Jesse, based on his concerns about his daughter's behaviors, the abnormal findings following colposcopy, and the hospital's report of suspected child abuse. Temporary custody of Jesse was transferred solely to Mr. Nosbaum. During the course of the custody proceedings, and approximately nine months after the colposcopic examination was performed, Dr. Martini notified Mr. Nosbaum's attorney that her initial measurement of transhymenal diameter was incorrect due to an error resulting from confusion regarding "one of the magnifying powers used on the colposcope."³⁶ She explained that the correct diameter actually was four millimeters, which is within normal range. A few months later, the pending custody proceedings concluded with an order terminating joint custody and granting sole custody of Jesse to her mother.

A lawsuit was later commenced against numerous defendants by Jesse, her mother, and her stepfather alleging, among other things, that they suffered damages as the result of negligence, including Dr. Martini's negligent colposcopic examination and diagnosis. The complaint was subsequently dismissed by the trial court, primarily on the basis of section 9 immunity under the Reporting Act. With respect to Dr. Martini, the trial court found that her conduct involved participation in the making of a report of suspected child abuse to DCFS by providing information to the hospital social worker.

On appeal, the court initially considered the question of whether immunity under the Reporting Act was available to Dr. Martini. Concluding that it was, the court indicated that, because Dr. Martini's report of an "abnormal medical exam" was included in the written report made to DCFS by the hospital social worker, Dr. Martini had *participated* in the making of the report.³⁷ Of interest in this regard was the court's further determination that, even though the oral report to DCFS was not made "immediately," as required by the statute,³⁸ this would not affect the applicability of section 9 immunity. Such immunity,

the court said, is not conditioned on timely and immediate reporting.

The court then turned its attention to the plaintiffs' contention that statutory immunity should not be available to Dr. Martini because the injuries suffered by the plaintiffs arose from Dr. Martini's negligent colposcopic examination and not from the report made to DCFS. The court recognized that Dr. Martini's incorrect diagnosis of an abnormal transhymenal diameter, which was consistent with sexual abuse, may have been the dominant basis for the grant of custody of Jesse to her father—one of the primary bases for the claim of damages in the present lawsuit. Accordingly, the court considered "whether (for purposes of immunity under the Act) a child-abuse report should be viewed separately from the examination that preceded it."³⁹ Stating that this was a novel issue, not yet addressed by previous case law, the court ruled as follows:

If it is determined that the damages claimed flow independently from defendant Martini's misdiagnosis and not from the incorporation of that misdiagnosis into the DCFS report, then the trial court's dismissal of this action shall stand as reversed as well as vacated. If on the other hand the court determines that the damages resulted from the DCFS report and not solely from the independent negligence of the doctor, then the trial court's dismissal of this action shall be reinstated.⁴⁰

The trial court's ruling on the immunity issue was vacated and remanded for clarification and reevaluation in light of the above standard.

A subsequent decision, in the case of *Doe v Winny*,⁴¹ followed the holding in *Nosbaum* and meaningfully amplified upon it. There, a malpractice lawsuit was brought against Dr. George Winny, a psychiatrist, claiming among other things that John Doe, a minor in the custody of DCFS, was injured as the result of a negligent course of therapy during which Dr. Winny focused on such themes as physical and sexual abuse. The lawsuit further alleged that Dr. Winny improperly diagnosed the boy as being a victim of physical and/or sexual abuse.

Dr. Winny sought summary judgment on the basis that he was entitled to immunity from liability under the Reporting Act. His motion was denied. The trial court ruled that there was a

question of fact regarding whether or not Dr. Winny acted in good faith, as required by the statute. Two questions were certified for the appellate court to address in the context of an interlocutory appeal:⁴²

1. Does the good faith immunity provided by 325 ILCS 5/9 shield a physician from liability for his failure to meet accepted medical standards in providing care and treatment to his patient?
2. Is evidence that a physician failed to meet accepted medical standards sufficient to create a question of fact over whether that physician acted in "good faith" within the meaning of 325 ILCS 5/9?

In addressing the first question, the plaintiff argued that the Reporting Act only immunizes a physician from liability when he has participated in good faith in the making or investigation of a report of child abuse, and not for negligent care and treatment. The defendant asserted that immunity must apply to negligent medical care and treatment that forms part of an investigation of child abuse.

The court observed that the statute plainly indicates "the legislature did not intend to immunize a physician for liability arising from negligent care and treatment administered to a patient."⁴³ Rather "the accorded immunities were intended to protect individuals from damages alleged to have resulted directly from the reporting and investigation of child abuse under the Act."⁴⁴ Included among such damages, the court listed the following: "loss of companionship, mental anguish, libel, slander, or other injury arising from the report of child abuse and/or the removal of a child from his parents."⁴⁵

Agreeing with *Nosbaum*, the court stated that the applicability of section 9 immunity will depend upon whether damages result from the act of reporting or investigating child abuse or whether they are a result of an independent act or acts of medical negligence. However, the court was very clear in specifying that section 9 immunity will apply to preclude a plaintiff from recovering "for mental anguish and loss of society and companionship simply because of a physician's misdiagnosis of child abuse."⁴⁶ In the view of the court, "diagnosis of child abuse is necessarily related to the investigation and reporting of such abuse and is immunized under the Act."⁴⁷

This being said, the court emphasized that, in situations where the negligent conduct of a physician is separate and distinct from actions necessary to make a diagnosis or a report of child abuse, immunity would not apply. To be clear, the court illustrated its ruling by explaining that the Reporting Act would not “immunize a physician who negligently repaired a child’s broken leg in the event that the physician suspected that the leg was broken as a result of child abuse and reported the suspected abuse to DCFS.”⁴⁸

With respect to the second certified question, the court considered whether evidence that a physician acted negligently in diagnosing or reporting child abuse or neglect is alone sufficient to raise a question of fact regarding whether the physician acted in good faith. The court emphasized that the threshold question is whether damages are alleged to arise from a diagnosis of child abuse or neglect that was made and reported to DCFS, as opposed to a separate and distinct act of negligence. In the former situation, statutory immunity is applicable, and “a physician’s good faith is not measured solely by his compliance with the standard of care.”⁴⁹ Rather, for there to be “a question of fact as to a physician’s good faith, the plaintiff must introduce evidence of malice.”⁵⁰ Negligence or bad judgment is insufficient. The evidence must show malice, bad faith, or an improper motive or purpose.⁵¹

Thus, in the present case, to the extent Dr. Winny was negligent in wrongfully diagnosing John Doe as having been a victim of physical or sexual abuse, he would not be denied section 9 immunity, provided he acted in good faith. Because there was no evidence that Dr. Winny acted maliciously or with an improper purpose in this regard, the court found no question of fact as to Dr. Winny’s good faith. He was therefore immunized from liability as to the claim based upon his misdiagnosis of child abuse. With respect, however, to acts of malpractice that may have otherwise been committed by Dr. Winny in his care and treatment of John Doe, the court held that section 9 immunity would not be available.

IV. Conclusion

Immunity from liability is granted to health care providers who participate in good faith in the making of a report of child abuse or neglect under the Illinois Abused and Neglected Child Reporting Act. Moreover, a health care provider’s good faith in this regard will be presumed.

Courts have set a notably high evidentiary bar for plaintiffs who would attempt to prove that a health care provider did not act in good faith in the context of making such a report. Evidence of negligence in diagnosing the abuse or neglect, or in making the report, is not sufficient to raise a question of fact regarding whether a health care provider acted in good faith. To prevail in this regard, courts have indicated that a plaintiff must be able to show that a health care provider acted dishonestly, maliciously, or for some improper purpose. This is a substantial burden for the plaintiff to bear. Accordingly, it seems evident that health care providers may act with confidence in fulfilling their important reporting responsibilities under Illinois law—responsibilities intended to help uncover child abuse and neglect and thereby protect the health, safety, and best interests of children.

Notes

1. 325 ILCS 5/1 et seq.
2. See 325 ILCS 5/2; *Lehman v Stephens*, 148 Ill App 3d 538, 499 NE2d 103, 111 (4th D 1986).
3. 325 ILCS 5/4.
4. 325 ILCS 5/9.
5. *Lehman v Stephens*, 148 Ill App 3d 538, 499 NE2d 103 (4th D 1986).
6. 499 NE2d at 107.
7. Noting that the state has a substantial interest in uncovering child abuse or neglect, the court concluded “that the ‘good faith’ immunity provided for mandated and permitted reporters under the Act is clearly justified, and is in no way inconsistent with the Illinois Constitution.” *Id.* at 111.
8. *Id.* at 112.
9. *Id.*
10. *Id.*
11. *Id.*
12. See, e.g., *Pryweller v Cohen*, 282 Ill App 3d 899, 668 NE2d 1144 (1st D 1996) (presumption of good faith was not overcome even though child abuse reporter’s belief that abuse occurred may have been contradicted by the determination of others); *Poulos v Lane*, 276 Ill App 3d 524, 659 NE2d 34 (1st D 1995) (where physician relied on laboratory report indicating positive test for gonorrhea from throat culture taken on two-year-old boy, plaintiffs failed to overcome statutory presumption of good faith in connection with physician’s report of child abuse). See also *Martin v Mt. Sinai Hosp.*, 1990 US Dist LEXIS 3870 (ND Ill 1990) (fact that it later turned out child who was subject of abuse report was not abused did not affect court’s willingness to apply statutory presumption of good faith).
13. *Franciski v University of Chicago Hospitals*, 338 F3d 765 (7th Cir 2003).
14. *Id.* at 766.
15. *Id.* at 768, n.1.
16. *Id.* at 770.
17. *Id.* (citing 325 ILCS 5/4).
18. *Id.* (citing 325 ILCS 5/9).
19. *Id.* (citing *Lehman*, 499 NE2d at 112).
20. *Id.*
21. *Id.* at 771.
22. *Id.* (citing 325 ILCS 5/3, which defines an abused child to include “a child whose parent...creates a substantial risk of physical injury...by other than accidental means...”). *Id.* at 770.
23. *Id.* at 771.
24. *Lipscomb v Sisters of St. Francis Health Services*, 343 Ill App 3d 1036, 799 NE2d 293 (1st D 2003).
25. 799 NE2d at 296.
26. *Id.* at 298 (citing *Falk v Martel*, 210 Ill App 3d 557, 569 NE2d 248 (3d D 1991)).
27. *Id.* (citing *Lehman*, 499 NE2d at 112).
28. *Id.* (citing *Lehman*, 499 NE2d at 112).
29. *Id.* at 304 (emphasis added).
30. *Id.* at 299.
31. See also *Evans v Torres*, 1995 US Dist LEXIS 19472 (ND Ill 1995).
32. *Nosbaum ex rel. Harding v Martini*, 312 Ill App 3d 108, 726 NE2d 84 (1st D 2000).
33. 726 NE2d at 87.
34. *Id.*
35. *Id.*

36. Id. at 88.
37. Id. at 90.
38. See 325 ILCS 5/4, 5/7.
39. *Nosbaum*, 726 NE2d at 90.
40. Id. at 95 (emphasis added).
41. *Doe v Winny*, 327 Ill App 3d 668, 764 NE2d 143 (2d D 2002).
42. 764 NE2d at 144.
43. Id. at 148.
44. Id. at 149.
45. Id.
46. Id. at 150.
47. Id.
48. Id. at 151. Nor would a physician “be immunized for his negligence in failing to observe a cancerous tumor on a child’s labia simply because the physician was examining the child as part of an investigation of a report of child abuse under the Act.” Id. (citing *Nosbaum*, 726 NE2d at 90-91).
49. Id. at 154.
50. Id.
51. Id. In reaching this decision, the court cited and discussed various cases, including the following: *Pryweller v Cohen*, 282 Ill App 3d 899, 668 NE2d 1144 (1st D 1996); *Falk v Martel*, 210 Ill App 3d 557, 569 NE2d 248 (3d D 1991); *Brown v Farkas*, 158 Ill App 3d 772, 511 NE2d 1143 (1st D 1986); *Michaels v Gordon*, 211 Ga App 470, 439 SE2d 722 (1993); *B.W. v Meade County*, 534 NW2d 595 (SD 1995); *Elmore v Van Horn*, 844 P2d 1078 (Wyo 1992).

Mr. LeBlang is Professor of Medical Jurisprudence and Chair of the Department of Medical Humanities at Southern Illinois University (SIU) School of Medicine. He is also a Professor at SIU School of Law. A graduate of the University of Illinois College of Law, Mr. LeBlang is President of the American College of Legal Medicine. He is Editor Emeritus of the *Journal of Legal Medicine*, serves on numerous journal editorial boards, and is co-annotator of the *Code of Medical Ethics: Current Opinions with Annotations*, published by the American Medical Association. Mr. LeBlang has written and spoken extensively on various issues in legal medicine and is co-author of *The Law of Medical Practice in Illinois*, published by West Group.